Editorial

Patchy Eczema of Elderly Patients

William D. James, MD

Having clinics devoted to patients with difficult to diagnose or treat conditions, combined with a career-long interest in patch testing, has led to many patients presenting to me with the following scenario. A man or woman aged 60 to 70 years has red, scaly, and itchy areas present for many months to years. The face, palms, soles, axillae, and groin are spared in most cases, as well as the neck and uppermost trunk. The condition usually begins on the legs, with subsequent involvement of the arms, and finally, in those patients with longer standing eruptions, the trunk. The patients are frequently awakened at night with itching, which is worsened by the heat, and may state life is not worth living if their condition does not improve. The patient's partner, tired from being awakened by the patient's nocturnal tossing, turning, and scratching, or a concerned adult son or daughter, accompany the patient to provide transportation, moral support, or more demanding advocacy. The physical examination reveals an elderly, tired, and frustrated patient with varying degrees of hopelessness. The skin is diffusely dry with small white scales. Numerous patches of erythema and scale typically are present on the legs, arms, and at times, the lower back, buttocks, and lower abdomen. Excoriations, lichenification, and a craquelé appearance are variable findings.

Prior evaluation often has included a large array of laboratory data, such as several biopsies that read chronic spongiotic dermatitis or psoriasiform dermatitis. The diagnoses considered are drug eruption, contact dermatitis, hypersensitivity eruption, paraneoplastic condition, psoriasiform or nummular dermatitis, and adult-onset atopy. Drug holidays, TRUE Tests®, antihistamines, and strong topical steroids have nearly always been used to treat the inflamed patches. Many patients come to my office having been treated with courses of the following drugs: oral prednisone, methotrexate, mycophenolate mofetil, and narrowband UVB or psoralen plus UVA, all having offered a minimal response or no response at all.

The practice of clinical dermatology in a medical center has its advantages and disadvantages. One advantage is that patients arrive with lots of information, such as laboratory data and the results of prior drug holidays and biopsies. One disadvantage is that patients have been seen by one or several astute, innovative, experienced clinicians and are indeed tough to diagnose and treat.

When I see these patients, I usually do not reach for my North American Contact Dermatitis Group screening tray. Instead, I first treat the whole skin aggressively with a soak and smear regimen.[1] In many cases, this regimen is combined with discontinuance of oral immunomodulatory therapy. Patients should be given extensive education on the importance of hydration in a tub of plain water, followed by application of triamcinolone acetonide ointment 0.1% before bedtime. The patient also is instructed to avoid soap in the shower, except in the axilla and groin, and apply moisturizer afterward, and is given a handout for home reinforcement. I am confident in asking to see patients in 2 to 3 weeks to confirm the clearance of their condition. During this visit, plans to taper the medicine are made. Triamcinolone acetonide ointment is applied nightly (without bathing first) for another 1 to 2 weeks. After, only moisturizers are used at bedtime.

My main point is to be cautious in making the diagnosis of psoriasiform, nummular dermatitis, or adult-onset atopy in an elderly patient. Subsets of these patients simply have very dry skin requiring aggressive hydration, good basic skin care, and repair of the abnormal barrier. Soaking and smearing often works in these patients—try it!

REFERENCE

1. Gutman AB, Kligman AM, Sciacca J, et al. Soak and smear: a standard technique revisited. *Arch Dermatol*. 2005;141:1556-1559.

From the Department of Dermatology, University of Pennsylvania School of Medicine, Philadelphia.
The author reports no conflict of interest.