

Eczema in the elderly

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Atopic eczema is on the increase and has trebled in frequency over the past 30 years. As it is most common in children and young people, the focus of attention has centred on this group. It is important to remember however that eczema also affects the older generation and, as our population gets healthier and more of us are living longer, it is likely to become more of an issue. Eczema does not respect age or general health. It can affect anybody, at any age, and does not require any background genetic pre-disposition. It can present in unusual ways in the elderly, have different causes or aggravating factors compared to eczema in the young and can present challenges when recommending treatment. In this article I will discuss the most common types of eczema that may affect older people and suggest which treatments are suitable.

Asteatotic eczema

It is known that skin becomes drier as we grow older and this usually manifests in our 50s, often initially affecting the lower legs. This change is thought to be due in part to a disturbance in the fatty layer present in the very outer part of skin that helps retain moisture.¹ It can be exacerbated by increasing age, underlying illness, malnutrition, skin cleansers/solvents, minor trauma, low humidity and dry, cold, windy weather.

This disturbance in skin barrier function may lead to asteatotic eczema (also known as eczema craquelée or winter eczema). It

consists of dry, scaly skin, usually on the shins, but which may also involve the arms and hands. The skin appears dry with fine superficial cracking sometimes referred to as a 'crazy-paving' pattern.

Sometimes bleeding may occur due to this cracking of the skin. It often starts in winter and may clear in summer, but eventually can cause problems all year round.

As in most forms of eczema, the treatment is to minimise water loss as much as possible and the use of moisturisers (emollients) is essential. These should be used at least twice a day, along with appropriate moisturising bath or shower preparations. Avoiding abrupt temperature changes can also be helpful (e.g. taking lukewarm baths or showers).

Reducing the frequency of bathing can also be helpful and short baths or showers are recommended in order to minimise water loss in the skin.

Moisturising soap substitutes should be used, as soap tends to dry out the skin and worsen the condition.

Stasis dermatitis or varicose/gravitational eczema

As humans walk upright, the leg veins are under enormous pressure throughout our lives. Decades of pumping blood back up the legs to the heart can eventually lead to wear and tear of these delicate structures. Valves that stop blood from going back down into the legs again can

become leaky leading to large, dilated and tortuous veins (varicose veins).

This process may be exacerbated if the patient has a history of deep venous thrombosis, a family history of varicose veins, is overweight, has damaged joints or muscles in the leg that may stop blood being pumped back up the veins effectively, or sits for long periods of time with their legs hanging down.

Varicose veins can cause varicose eczema to appear, and both are common in the elderly. It is thought that as many as 20% of people over 70 may suffer with this condition. The skin changes are thought to be the result of damage to the small blood vessels in the skin, which is secondary to increased pressure in the veins.

Red, scaly areas that are often itchy can develop. They usually appear initially on the inner lower leg, but can spread if untreated to involve other areas on the same leg, the other leg, or occasionally on other parts of the body.

Varicose eczema can also occur directly over a varicose vein. The main aim of treatment is to correct the venous hypertension that is causing the problem. This may be done with support stockings or compression bandages, which help to pump blood back up the leg.

Venous surgery in the form of vein 'stripping' or injection may be recommended in suitable patients. Lifestyle changes are important, i.e. losing weight, calf muscle exercises, etc. Skin treatments include the liberal and regular use of bland moisturisers

and also moderately potent steroid ointments (if required).

All skin treatments of varicose eczema should be kept as simple as possible as it is known that these patients and those with venous ulcers are particularly prone to developing contact allergies to constituents of creams, ointments, dressings and sometimes even bandages.²

If a contact allergy is suspected then patch testing to suspected chemicals should be performed by a dermatologist. It is important to recognise and treat varicose eczema and any underlying venous hypertension, as their existence means that the skin of that leg is very vulnerable and at high risk of developing a venous ulcer. As in most things, prevention is better than cure – once a venous ulcer has developed it may take many months of intensive treatment to heal again.

Allergic contact dermatitis

This condition occurs when an individual becomes allergic to a specific substance in their environment. The skin retains specialised white cells (lymphocytes) that 'remember' this allergy and will cause a strong reaction when the skin is re-exposed to it. This eczematous reaction is often worst at the site of re-exposure.

For example, if a person who has become allergic to nickel commonly handles money (which contains this metal), the hands will often be the worst-affected area. It has been suggested that contact allergy in general becomes less common with advancing age.

However, older people seem to be more susceptible to becoming allergic to some chemicals frequently used in skin creams, ointments and dressings. This is thought to be due to the fact that older people tend to use a lot of these products in the treatment of dry skin, leg ulcers, etc.

Care should be taken when interpreting positive/allergic patch test results in elderly people as the intensity of positive reactions tends to be less

and the development of positive reactions may be delayed compared to the younger age group.³

Discoid eczema

Discoid eczema (also known as nummular eczema) is a type of eczema characterised by the typical round or coin-shaped areas of eczema that develop, usually on the limbs and buttocks. It can be an



intensely itchy condition and may cause significant distress.

The lesions can be very inflamed, red and weeping, or more commonly are thickened and scaly in texture. It is classically seen in elderly males, particularly in winter, although women may also develop this unpleasant condition. The initial patch usually arises on the lower leg and may then spread to other areas. Infection with bacteria, often caused by scratching, can occur.

This type of eczema unfortunately tends to be chronic and is often worse in winter. Treatments include emollients (creams and/or bath oils to correct dryness) and strong topical steroid ointments. Antiseptic creams or lotions to control infection can be useful and antibiotics may be required if secondary infection of the plaques of eczema with bacteria occurs.

If potent topical steroids are of no help, the newer topical immunosuppressant ointments such as tacrolimus have been reported to be of use. Coal tar preparations either on their own or in combination with weak topical steroids can be helpful. Phototherapy (light treatment) either in the form of UVB or PUVA (UVA light + psoralen tablets) will often help to clear acute attacks.

Atopic eczema

Readers of this magazine will be well versed in the background and treatments of atopic eczema. Although less common in older people, atopic eczema may arise 'out of the blue' in some, or may persist throughout adulthood in others.

Treatment is as for atopic eczema in the young, i.e. regular moisturiser use, topical steroids (preferably the weakest

strength possible that controls symptoms), soap substitutes, lukewarm baths or showers, wearing cool, non-wool clothing, and taking sedative anti-histamines at night if required.

A number of older people will also be taking a variety of other medication, which may interact with anti-histamines. These tablets may also cause confusion or an excessive sedative effect in the elderly and caution should be advised.

Other treatments may include phototherapy or the immunosuppressants topical tacrolimus or pimecrolimus. Oral immunosuppressant therapy may be recommended in severe cases.

Seborrhoeic eczema

This condition commonly affects babies and is known as cradle cap. In adults, it tends to start in puberty as it is linked to activation of the sweat glands in the skin and an abnormal reaction to the common yeast known as *Malassezia*. It is not infectious.

Although generally less severe, the condition is often found in the elderly. It tends to affect the areas of skin where sweat glands are most prevalent, i.e. scalp, face and upper trunk. Scalp dandruff is often associated. Red, flaky skin may develop on the forehead, eyebrows, eyelashes, around the nose and on the chest and back.

There is no permanent cure for seborrhoeic dermatitis but the condition can be suppressed with treatment. Medicated shampoos to control dandruff, mild topical steroids (often combined with an anti-yeast cream), ketoconazole cream and frequent washing with soap and water can all be useful. Phototherapy and

oral anti-yeast tablets have been used in severe outbreaks.

Eczematous drug eruptions

Many medications may cause a rash as a side effect. In some cases this may be mistaken for eczema. The risk of developing an adverse reaction to a medication increases as one gets older, is higher in those taking multiple medications (often the elderly), and is thought to be more common in women.

If a rash begins suddenly it is always worth looking at any recent new medication to see if it may be to blame. The GP can usually change any suspected drug for an alternative preparation. Don't forget that over-the-counter medicines such as painkillers, cough treatments, vitamins can also cause reactions.

The same is true for herbal remedies, homeopathic treatments and Chinese medicines. Always tell your doctor if you are taking anything 'extra' that they may not be aware of.

The rash caused by a drug reaction may take many weeks or months to resolve and until it does treatment should take the form of that for eczema – i.e. emollients, topical steroids if required, soap substitutes and good general skin care.

The treatment of eczema in older people can be challenging due to a number of factors:

- Most forms of eczema are extremely itchy and can cause marked distress. This can be severe in the elderly as they may live alone and have no support. Symptoms are often worse if there is no one to turn to. Understanding and empathy are very important.

- Creams can be tricky to apply. Is the person even able to open the tube? If they have visual impairment, how will they know what is a moisturiser and what is a steroid? Arthritis in the fingers can make it extremely difficult to squeeze out and put on treatments. If the eczema is on the back or lower legs, are they able to reach these areas? If an individual has any of these difficulties, who is going to help them – a family member, friend, carer or district nurse? As most treatments are at least twice daily this can be a huge commitment. It is important to recognise that an elderly patient may need help and lots of support if their eczema is going to be treated well.
- Does the person understand the diagnosis and the treatment plan? If they have visual or hearing difficulties this can be a problem. I have found that older people are extremely polite and want to please the doctor by agreeing that they have understood everything, whereas the truth is that they haven't been able to hear or fully follow the conversation. The result is that both patient and doctor become frustrated the skin condition does not improve. It can be extremely helpful if a friend or relative is present during the consultation.
- Many older people are on a large number of medicines for other conditions. This needs to be taken into account when recommending tablet therapy for eczema (e.g. antihistamines, immunosuppressant treatments such as ciclosporin or azathioprine) as interactions may occur with their existing medicines.
- Attendance at either the local GP practice or dermatology department

may be required on a regular basis, e.g. for application of treatments, for assessment, or for phototherapy. A number of elderly people either don't drive or have given up their licenses. Although patient transport is available, in my experience this may be unreliable and time-consuming. They may therefore need to enlist the assistance of family or friends for transport.

Due to the above confounding factors, it is often necessary to admit elderly people to dermatology wards for the treatment of eczema. This will become more difficult in the years to come with an expanding elderly population and a shrinking number of dermatology beds.

Although the treatment of eczema is similar in all age groups, some specific points should be kept in mind for the elderly group. Treatments should be kept simple as confusion can occur if too many creams or tablets and instructions are given. Written information can be helpful as can the presence of a family member or friend. As with all forms of eczema, it is vital that the patient understands that this is not infectious and cannot be passed on to anyone else. This is a common misconception, especially in the elderly. Most elderly patients are extremely stoical and view eczema as something they just have to put up with. It is massively rewarding to be able to help relieve the symptoms of eczema and to help people adjust to living with eczema and not being controlled by it.

References

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