FACIAL ECZEMA

Eczema often affects the face, and facial eczema can be especially distressing because it is so visible. In addition, facial skin is very sensitive, and even the mildest degree of inflammation can feel sore, itchy and uncomfortable. For some individuals, facial eczema is a short-lived problem, lasting only a week or two, whilst for others it may be more longstanding with a negative impact on quality of life. Like eczema on other areas of the body, affected skin is red, dry and flaky, and sometimes weeping, crusting or blistering. If the skin has been repeatedly rubbed, it may take on a wrinkled, lined appearance (the medical term for this is ‘lichenification’).

Facial eczema may occur as an isolated area or as part of a generalised eczema. In most people there is no identifiable cause, but usually there is a history of atopic eczema – an in-built or constitutional eczema affecting other body areas. In some cases, contact with an external irritant chemical or allergen can be the cause (contact dermatitis). If allergy is suspected, a referral to a dermatologist for patch testing is often required, as it is not always possible to tell if someone has an allergic facial eczema by appearance alone.

Atopic eczema/dermatitis

This is the most common form of eczema in childhood and it often involves the face. The cheeks are one of the first parts of the body to be affected by infantile eczema, and this usually occurs within the first few months of life. Eczema then typically spreads to other areas such as the arm and leg folds. Affected skin is red, dry, flaky and itchy and, at times may become weepy and crusted or blistered. Weeping and crusting can be a sign of bacterial infection. In older infants and children, the eyelids, upper lip, ear folds and neck folds are typically affected, with generalised dryness of all facial skin. Although most childhood eczema clears in the teens, it sometimes persists into adulthood, and may predominantly affect the head, neck and upper torso with a shawl-like distribution in this age group. However, all children who have had eczema can be left with a sensitive skin and eczema can return at any age.

Seborrhoeic dermatitis/eczema

Probably the most common form of facial eczema in adults, this complaint is often mild, appearing simply as dry scaly skin around the creases of the ears and eyebrows. However, some people suffer from considerable irritation and soreness, especially when the eyelids or ear canals are involved.

Dandruff is an example of mild seborrhoeic dermatitis of the scalp. Like seborrhoeic dermatitis elsewhere, it tends to be a long-term complaint, which can improve with treatment, but cannot be permanently cured. Seborrhoeic eczema may also occur on other parts of the body including the chest, underarms and groin. Affected areas tend to be those with high levels of skin grease (sebum). This encourages overgrowth of a skin yeast called Malassezia which appears to trigger an inflammatory reaction in people who have become sensitised to it. In order to reduce yeast levels, anti-yeast shampoos and creams are widely used in the management of seborrhoeic eczema. Environmental factors such as sun, temperature and humidity may also trigger flares, and the condition tends to worsen when an individual is run down or under prolonged psychological stress. (For more information see the NES factsheet on Sebhorrhoeic Dermatitis.)
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Irritant contact eczema/dermatitis

Most people use a range of cosmetics and toiletries in daily life and these can cause irritation. Examples include soap, foaming washes, exfoliating scrubs, cleansers, toners, make-up, sunscreens and shaving foam. Repeated use, especially in someone with an eczema tendency, can lead to dryness and soreness of the skin. Remember that skin care products can cause irritation even if they are labelled ‘dermatologically-tested’, ‘natural’ or ‘organic’. None of these terms guarantees that a product will be trouble-free, especially if it is used by someone with an existing facial eczema. Cosmetic products should be avoided when facial eczema is active, as they are only intended for use on normal/unaffected skin.

Changes in temperature and humidity often aggravate eczema. Some people find that their skin improves in the summer while others find that hot weather makes them itch and scratch more. Many find that their skin tends to be worse in the winter when the face in particular is exposed to harsh winds, rain, sleet and snow. Moving from the cold into the dry heat of centrally heated buildings can also make the condition worse.

Children, in particular, occasionally suffer from a localised type of irritant contact eczema around the lips, as a result of repeated licking. The habit arises because the person finds that their dry lips are temporarily more comfortable after being licked, but in the long term, the repeated contact between saliva and the skin does more harm than good.

Teething, too, commonly causes irritant contact dermatitis around the mouth and chin due to the constant wetness and irritation from dribbling. In addition, runny noses, and messy foods when weaning can cause problems. Baby wipes containing irritants such as alcohol and fragrance can also aggravate the skin. So, if your baby has eczema, it is best to use damp cotton pads with emollients, as an alternative to baby wipes, for the facial area.

Allergic contact eczema/dermatitis

Allergic contact eczema happens because the immune system in the skin over-reacts to what has hitherto been a harmless substance, the allergen. The face is one of the most common sites for allergic contact dermatitis because skin here comes into contact with many potential allergens in daily life. In rare instances, a person can be affected by airborne, volatile allergens such as industrial chemicals or glues which find their way onto the face and neck.

The most common causes of allergic contact eczema on the face are fragrances/perfumes (both natural and synthetic) and preservative chemicals in toiletries and cosmetics (e.g. methylchloroisothiazolinone (MCI) and methylisothiazolinone (MI), also known as Kathon CG (MCI/MI). Other examples include hair dye and nail varnish (nail varnish allergy often appears on the face rather than the nail area, due to fingers touching the face).
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Many people assume that because they have used a product such as hair dye for several years without any problems, they cannot be allergic to it. Actually it’s the other way around – the more you apply a potential allergen to your skin, the more likely it is that you will one day become allergic to it!

Sometimes, people develop an allergic skin reaction to the treatments used for their facial eczema or for related/unrelated conditions on or around the face (e.g. antibiotic ear drops or eye drops). This may give the impression that a treatment is not working because the rash persists as long as the problematic cream/ointment/medicament is used. It can sometimes be difficult to tell the difference by appearance alone between a skin infection and a strong allergic reaction.

Contact eczema is worst on the part of skin which has been in direct contact with the allergen—so lipstick allergy affects the lips, mascara allergy affects the eyelids etc. Nickel remains one of the most common allergies in women, who often develop their allergy after repeatedly wearing jewellery containing inexpensive metal – this is especially the case with earrings worn in pierced ears.

Allergic contact eczema is an example of a delayed allergy reaction as it appears over several hours or days. It is not to be confused with an immediate stinging or itchy sensation after applying a substance, which is usually just a sign of sensitive skin. The delayed onset of an allergic reaction can make it difficult for the affected person to pinpoint what has caused the problem.

Patch tests can help to identify if someone has allergic contact dermatitis. They involve the application of small quantities of allergens to skin unaffected by eczema, usually on the upper back. This area of skin must be kept dry and will be examined over several days to see if there is a reaction. Patch testing is a very safe and useful way to investigate suspected allergic contact eczema, but it can take considerable skill to interpret the results, and should only be carried out by a specialist who has had appropriate training. Once an allergen has been identified, it is important to avoid or minimise contact with this in the future, as there is at present no way of reversing a skin allergy.

Light-sensitive eczema/dermatitis

Our faces are exposed to sunlight on a daily basis, and this can act as a trigger factor for eczema. On the other hand, many people with eczema find that their skin improves in warm sunny weather, and indeed phototherapy (a prescribed course of ultraviolet therapy, administered and supervised in dermatology departments) is an additional treatment option for chronic, widespread eczema. However, some people with atopic or seborrhoeic facial eczema notice that their skin worsens in strong sunlight. Certain medications for other conditions can cause an individual to become more sensitive to sunshine and burn easily, and this often shows up on the skin and face, upper neck and back of the hands as these are the body parts which are most frequently exposed to the light. Examples include some diuretic tablets taken for high blood pressure, and antibiotics. Shaded areas such as under the chin and behind the ears tend not to be affected and this can be a
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helpful clue that sunlight sensitivity is a problem. Occasionally, allergic light-sensitive eczema can be caused by touching plants followed by sun exposure (known as phytophotodermatitis). Chronic actinic dermatitis is a rare and particularly severe form of sun sensitivity that usually affects older men, and may follow a previous allergic contact dermatitis. High-factor sunscreens usually help, but on rare occasions can themselves cause allergic rashes and irritation.

Treatment of facial eczema

Eczema on the face requires careful treatment as the skin here is more easily irritated and vulnerable to the side effects of topical therapy. It is important to consider the possibility of an allergic contact dermatitis in anyone with a persistent facial eczema, even if they have a longstanding, in-built eczema tendency. It is helpful to make a diagnosis of which particular type of facial eczema someone has in order to know what treatment is likely to work best, and to help give an idea of the expected outcome – usually, as eczema is a chronic condition, controlling facial eczema and preventing flares will be the main focus of treatment. In general, treatment of facial eczema involves avoiding further irritation caused by cosmetics and toiletries, switching to a gentle regimen of skin cleansing and actively treating the eczema with emollients and anti-inflammatory therapy (topical steroids or topical calcineurin inhibitors).

Practical points

- Use a gentle (non-soap) skin cleanser every day to remove surface scaling and dirt – preferably a leave-on medical emollient as a soap substitute.
- Pat gently with a soft towel to dry the skin – do not rub.
- Avoid soap, detergents, exfoliating scrubs and toners.
- Apply a bland medical emollient at least twice a day to sore, dry areas.
- Avoid cosmetic moisturisers as these usually contain a much larger number of ingredients and potential allergens than simple medical emollients.
- Products labelled as ‘natural’, ‘dermatologically tested’ or ‘hypoallergenic’ can cause both irritant and allergic reactions.
- Make-up can irritate facial eczema, especially liquid foundation and mascara, so do not use it on affected areas. Mineral make-up is generally less irritant for people with eczema.
- Use medical moisturisers to remove make-up – they are just as efficient and effective as cosmetic make-up remover products.
- If you suspect that your make-up may be an irritant, stop using it and then introduce products one at a time, to see if any particular product is causing irritation.
- Apply mild potency steroid cream or ointment to affected areas once or twice a day, as prescribed, for a short treatment burst.
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- Moderate potency steroids may be used for short periods of time under a doctor’s supervision.
- Potent steroids should be avoided except under close supervision of a dermatologist as if used long term (without supervision) they carry a higher risk of skin thinning and causing permanent redness of the face and rosacea.
- Take special care with long-term use of more potent steroids around the eyes as this can in rare instances lead to cataracts and raised pressure in the eyes (glaucoma).
- Topical calcineurin inhibitors (Elidel and Protopic) are helpful options for the long-term management of facial eczema as they do not carry any risk of skin-thinning. However, they should not be used with strong sun exposure. Topical calcineurin inhibitors are usually initiated by dermatology specialists.
- Anti-yeast ointments or creams are useful in seborrhoeic eczema, with or without a mild topical steroid.
- A sudden painful flare of eczema with development of clustered spots and feeling unwell can be a sign of a widespread cold sore virus, and immediate medical attention should be sought.

Revised September 2016
The National Eczema Society is a charity registered in England and Wales (number 1009671) and in Scotland (number SC043669) and is a company limited by guarantee, (registered in England number 2685083). Office: 11 Murray Street, LONDON, NW1 9RE.

We are dedicated to improving the quality of life of people with eczema and their carers.

Eczema affects FIVE MILLION adults and children in the UK every year.

All our information is clinically evidence based and written by or verified by dermatology experts.

The National Eczema Society receives no Government or Health Service funding, relying entirely on voluntary income from the general public, companies and Trusts.

DISCLAIMER

These details are provided only as a general guide. Individual circumstances differ and the National Eczema Society does not prescribe, give medical advice or endorse products or treatments. We hope you will find the information useful but it does not replace and should not replace the essential guidance given by your general practitioner, dermatologist or dermatology nurse.