

## Dinner Symposium on Management of Eczema

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Venue: Sheraton Hotel, Hong Kong  
Organisers: The Hong Kong Society of Dermatology and Venereology and The Hong Kong Society for Paediatric Dermatology

### Consensus on management of Seborrhoeic dermatitis in Asians

Speaker: Dr. Yeung Chi Keung

Honorary Clinical Associate Professor, Faculty of Medicine, University of Hong Kong, Chairman of the The Hong Kong Society for Paediatric Dermatology, Hong Kong

Seborrhoeic dermatitis occurs in infancy and adulthood. It presents as greasy scalp with dandruff, well defined erythematous greasy looking scales on the face, scalp, eyebrows and nasolabial folds. Differential diagnoses include atopic dermatitis, contact dermatitis, rosacea, psoriasis, dermatomyositis, lupus erythematosus and drug-induced photosensitivity. The prevalence of seborrhoeic dermatitis is around 1-5% of adults. Eighty percent of the patients belong to the mild to moderate group. It may also be associated with HIV infection. The grading of severity depends on the degree of erythema, scaling, extent of lesion and symptom (itch).

The pathogenesis involves *Malassezia* yeast, seborrhoea, immune dysfunction, neurogenic and emotional stress. Medications for treatment include imidazole shampoo, antifungal agent to decrease *Malassezia*, selenium sulphide, ciclopirox, zinc pyrithione shampoo, tar

shampoo and salicylic acid for seborrhoeic dermatitis of the scalp. Other options include lithium succinate, topical steroids, topical calcineurin inhibitors (for facial seborrhoeic dermatitis), mild topical steroid +/-azole antifungal agent and ketoconazole cream. A short course of systemic antifungal agent (itraconazole, fluconazole) with topical agents may be used for severe disease. Topical calcineurin inhibitors have anti-inflammatory properties and decrease erythema, scaling and pruritus.

The ideal topical treatment should be a non-steroidal agent with minimal side effects and be cosmetically acceptable. The speaker introduced Sebclair® as a non-steroidal agent with an action on inflammation, *Malassezia*, scaling, xerosis and antioxidant effects. Sebclair® can be used by patients aged above 12 and may be applied three times per day. Investigator Global Assessment scores with respect to erythema, scaling and pruritus showed more success in the Sebclair® group (68%) than the placebo group (11%). It may be used for mild to severe seborrhoeic dermatitis.

#### Learning points:

Seborrhoeic dermatitis is a chronic relapsing disorder and treatment is only symptomatic rather than curative. Long term maintenance treatment is needed. Sebclair® may be used for mild and severe seborrhoeic dermatitis.

## Proper management of atopic dermatitis

Speaker: Professor Adelaide Ann Hebert  
Director of Paediatric Dermatology, The University of Texas Medical School, Houston, USA

There is no United States Food and Drug Administration approved systemic medication for atopic dermatitis currently. Topical therapy and phototherapy are used and only off-label systemic therapies are available for treatment. Treatment of atopic dermatitis is based on evidence-based medicine, physician experience, patient's need and expectation.

Prevention, barrier therapy, antipruritic treatment and emollient therapy are important aspects in management. There is no strategy generally accepted as effective measure for prevention of atopic dermatitis. Asians have the poorest barrier to mechanical trauma when compared with Caucasians and Africans. Itch threshold is lower in the skin of atopic dermatitis. Itch affects sleep; growth; mental and emotional well-being as well as school and work performance. Itch specific neuron MrgprA3+ was isolated and found to transmit itch only. It is associated with acute and chronic itch with exclusion of pain. According to the Japanese Guidelines of Atopic Dermatitis, scratch addiction most often occurs between the ages of 16 and 25. Severe eye rubbing can result in retinal detachment and occurs in 0.5% of all patients and 2% of severe patients. Serum gastrin-releasing peptide level is related to pruritus and the severity in patients with atopic dermatitis.

New concepts for the pathogenesis of atopic dermatitis involve the interplay of barrier, allergy and pruritus. The initial stage of disease is due to a defective barrier function with increased transepidermal water loss. A ten percent decrease in skin hydration will have a crucial effect in the induction of itch. Impairment of barrier function will lead to entry of irritants and itch-causing agents. The ideal moisturiser, apart from being

hypoallergenic and well-tolerated, should repair barrier function and relieve itching.

The speaker introduced Atopiclair™ as an emollient that contains glycyrrhetic acid, vitis vinifera extract, telmesteine and butyrospermum. It does not contain steroid, calcineurin, paraben, lanolin, fragrance or milk derivative. Atopiclair™ can maintain the hydration of skin for up to 72 hours. It has anti-inflammatory and anti-pruritic effects and may be applied as monotherapy two to three times per day to maintain the skin barrier and to reduce itch and inflammation. It may also be used with topical steroids and calcineurin inhibitors. Use of Atopiclair™ results in a greater improvement of the mean itch score compared with vehicle, resulting in early and lasting reduction of itch. Atopiclair™ is easy to apply, non-irritating and has a good efficacy-safety profile. It is useful in the acute and maintenance treatment of atopic dermatitis.

### **Learning points:**

Prevention, barrier therapy, antipruritic treatment and emollient therapy are important in the management of atopic dermatitis. An ideal emollient should be hypoallergenic and well-tolerated as well as reduce itch and transepidermal water loss. Atopiclair™ is an emollient with anti-inflammatory and anti-itch properties useful in the acute and maintenance treatment of atopic dermatitis.