ConferMED™ Connecting Primary Care to the Future

Eczema Pearls

Tips on the Assessment and Management of Eczema in Children and Adults

Jerri Hoskyn, MD, FAAD | November 6, 2025

Disclosures

- None

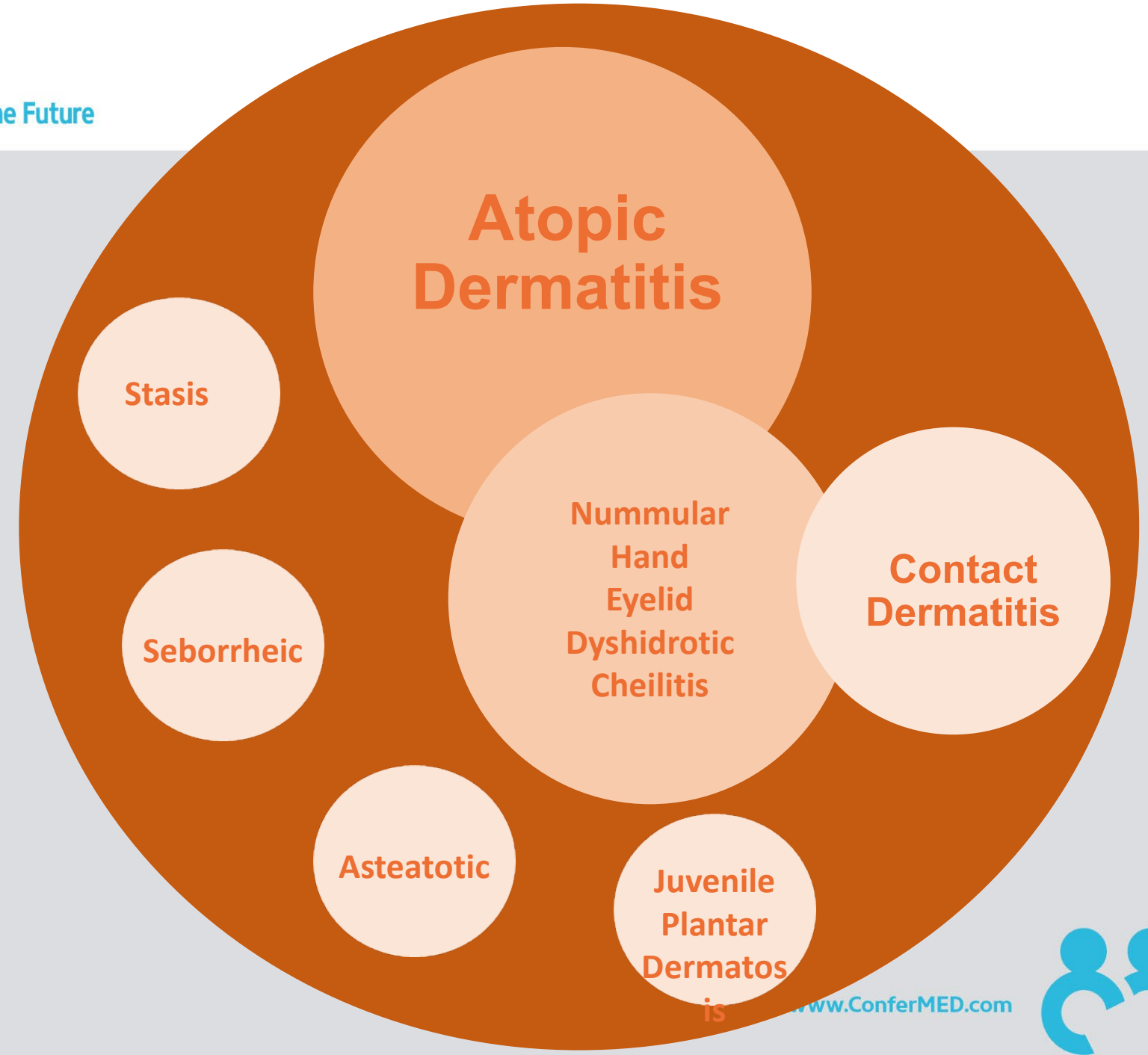
Learning Objectives

1) Review definition of eczema and subtypes
2) Review clinical and etiologic aspects of atopic dermatitis
3) Review management strategies for atopic dermatitis in adults and children

What is Eczema?

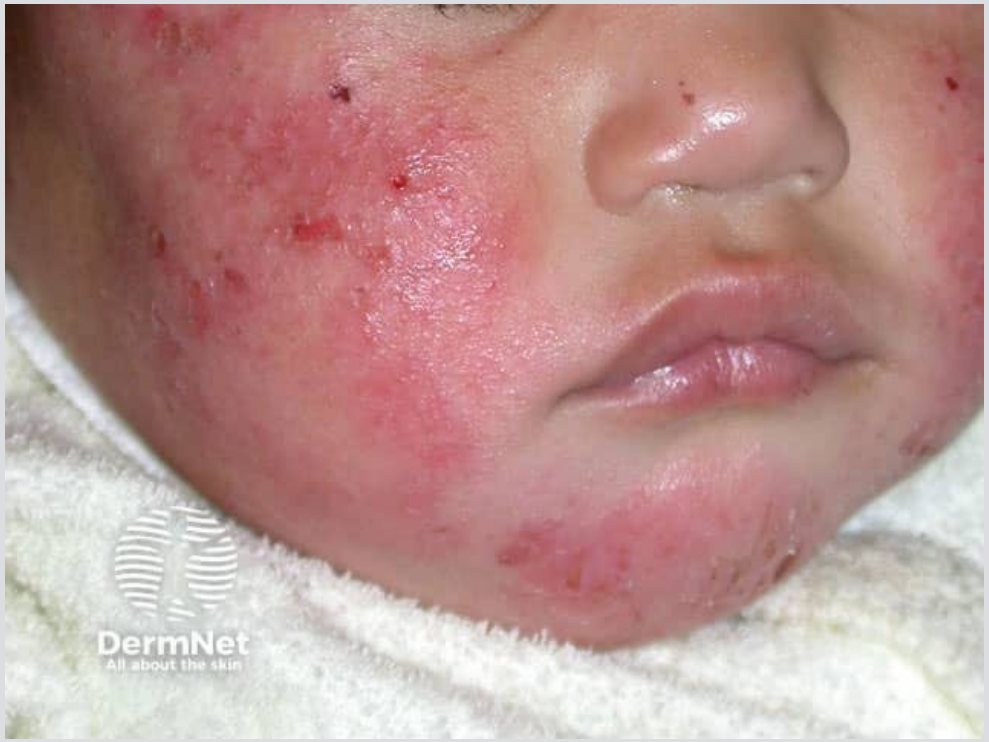
Eczema

- Skin inflammation
- Erythema, scale
- May crust, ooze



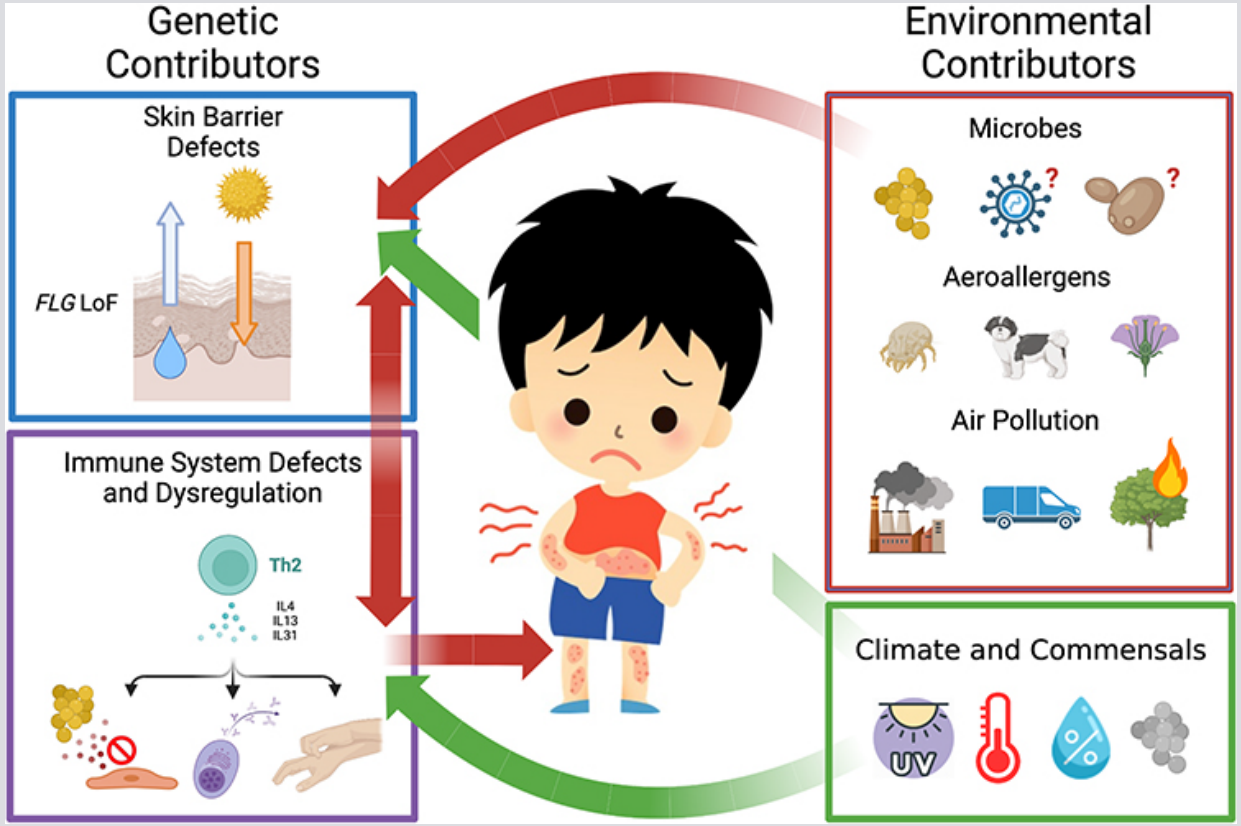
Atopic Dermatitis

Epidemiology



- **Prevalence in US**
  - Children = 13%
    (Black children 22%)
  - Adults = 8%
- **Presentation**
  - 60% by age 1
  - 85% before age 5
  - Adult onset in 25% affected adults

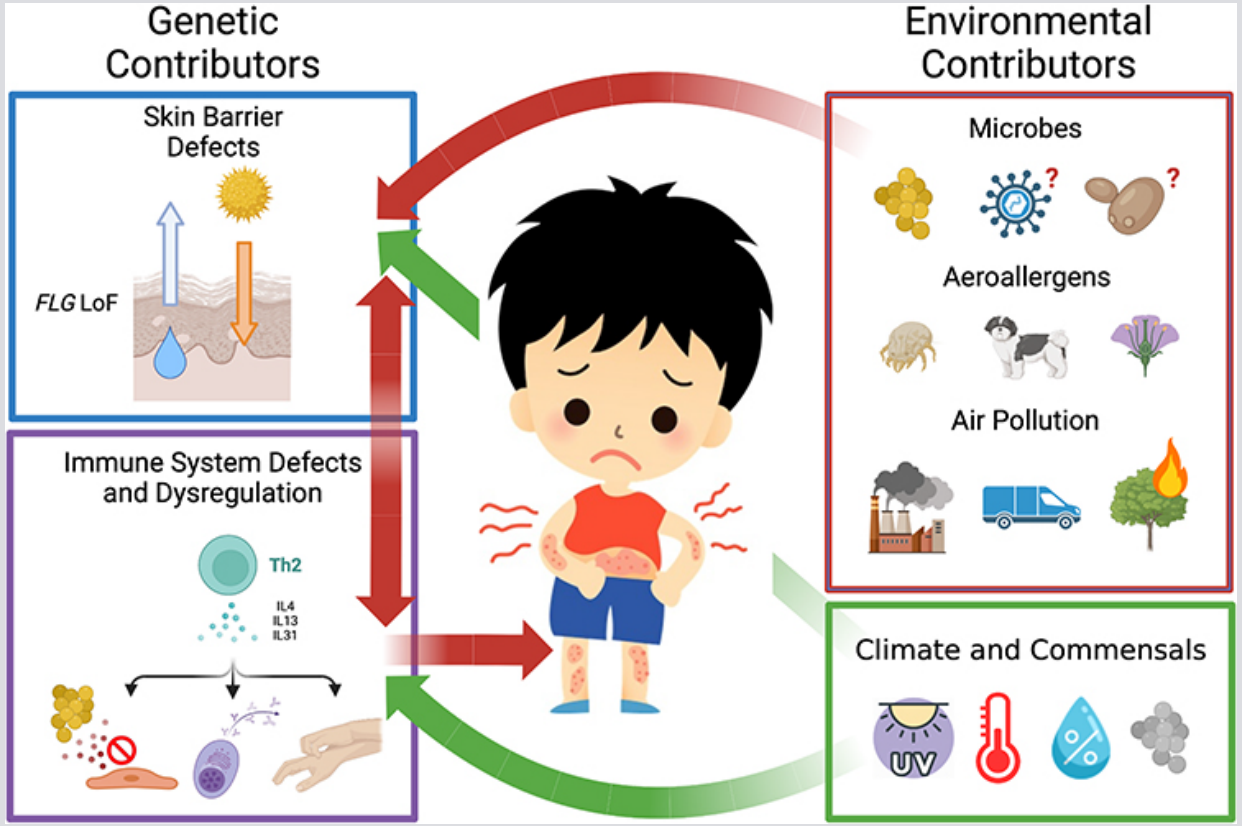
Risk Factors



- **Genetics**
  - FH of Atopy 70%
    - 1 parent: 2-3x
    - 2 parents: 3-5x
  - FLG mutations
  - Immune Dysregulation TH2→ IL-4, IL-13, IL-31
  - Skin barrier dysfunction

Chong AC, Visitsunthorn K, Ong PY. Genetic/Environmental Contributions and Immune Dysregulation in Children with Atopic Dermatitis. *J Asthma Allergy*. 2022;15:1681-1700

Risk Factors

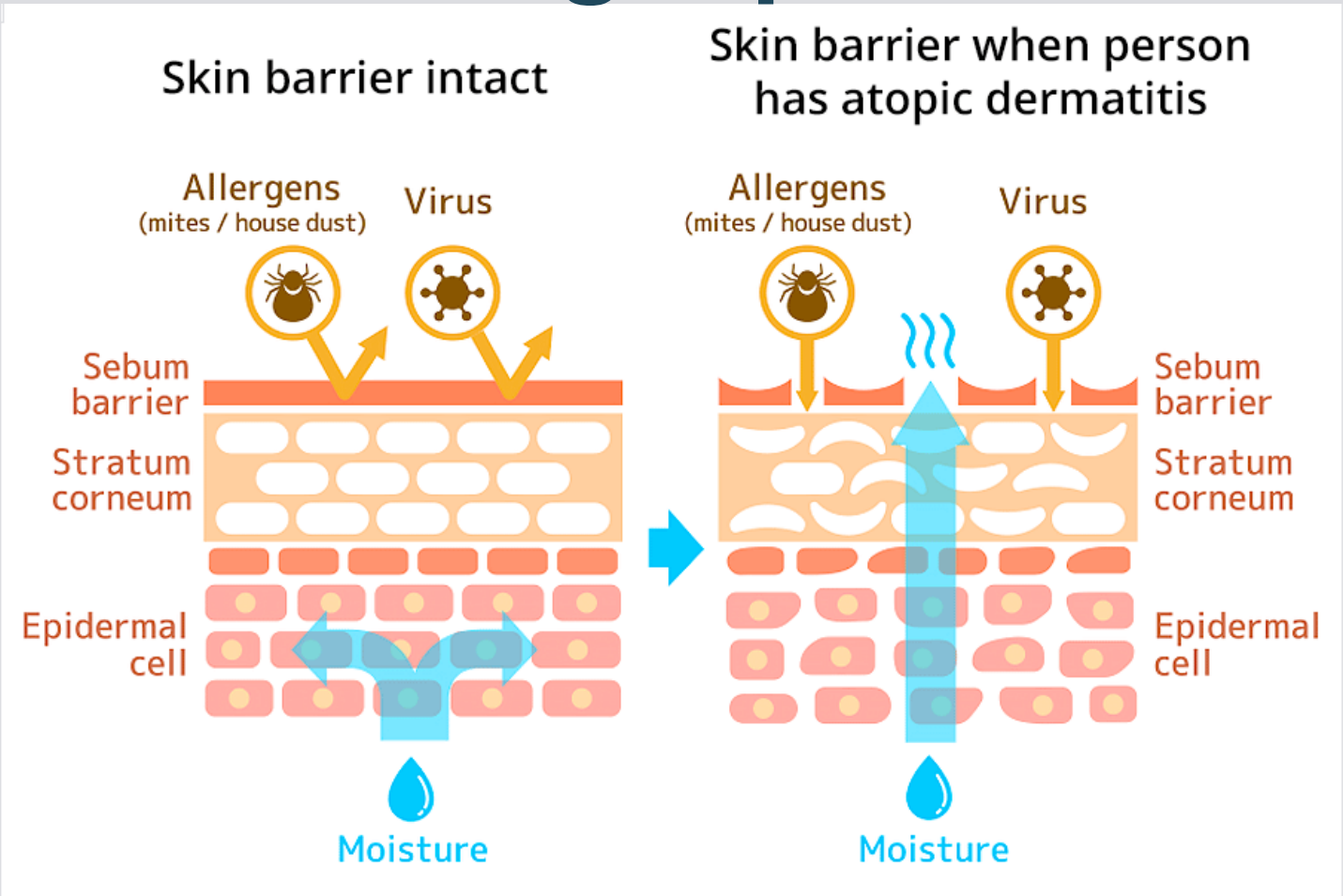


- **Environmental**
  - *Staphylococcus aureus*
    - Up to 70% lesional skin
    - Toxins (superantigens) drive immune dysregulation
  - Aeroallergens and air pollution as triggers (especially kids)
  - Climate: low humidity, higher indoor heat (HVAC), winter
  - Hard water

Chong AC, Visitsunthorn K, Ong PY. Genetic/Environmental Contributions and Immune Dysregulation in Children with Atopic Dermatitis. *J Asthma Allergy*. 2022;15:1681-1700

Clinical Pearl #1

AD Counseling Tip: Skin Barrier



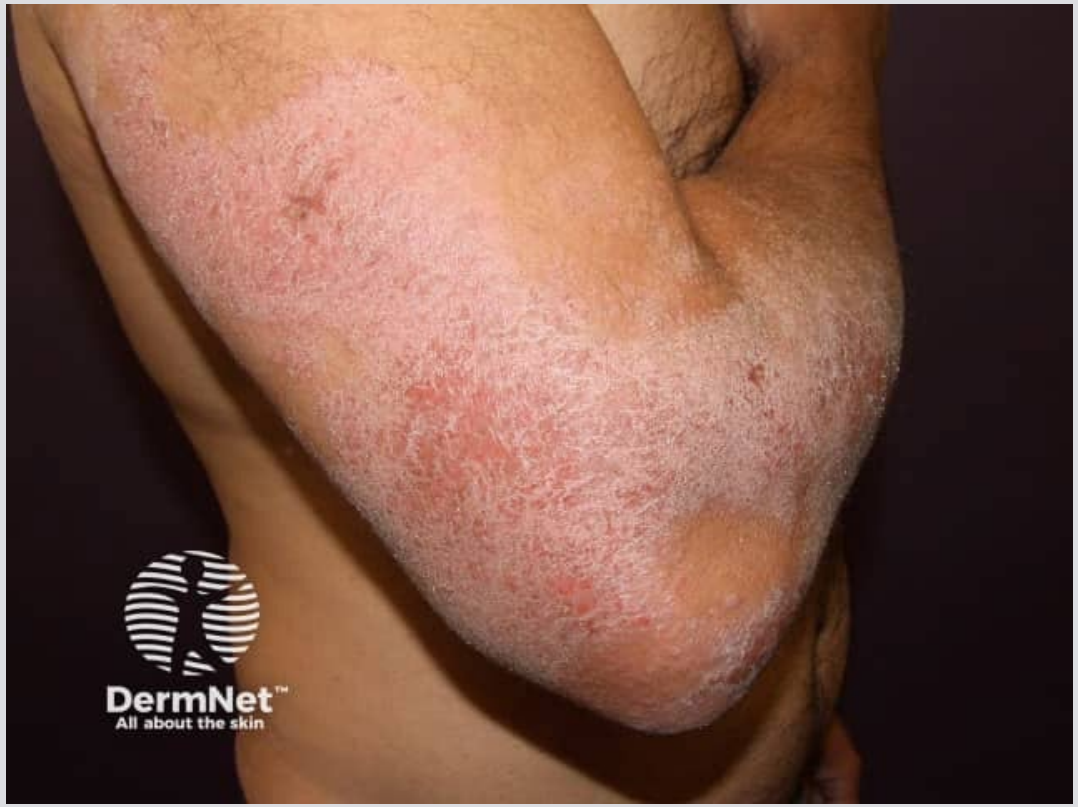
https://www.aad.org/public/diseases/eczema/types/atopic-dermatitis/causes

AD Counseling Tip: Skin Barrier

- **Transepidermal Water Loss (TEWL)**
  - **TEWL increased in lesional & nonlesional skin**
  - **TEWL Increases itch, worsens with flares**
- **Can help patients understand need for skin care and medication**
- **Treatment goal = Restore skin barrier**

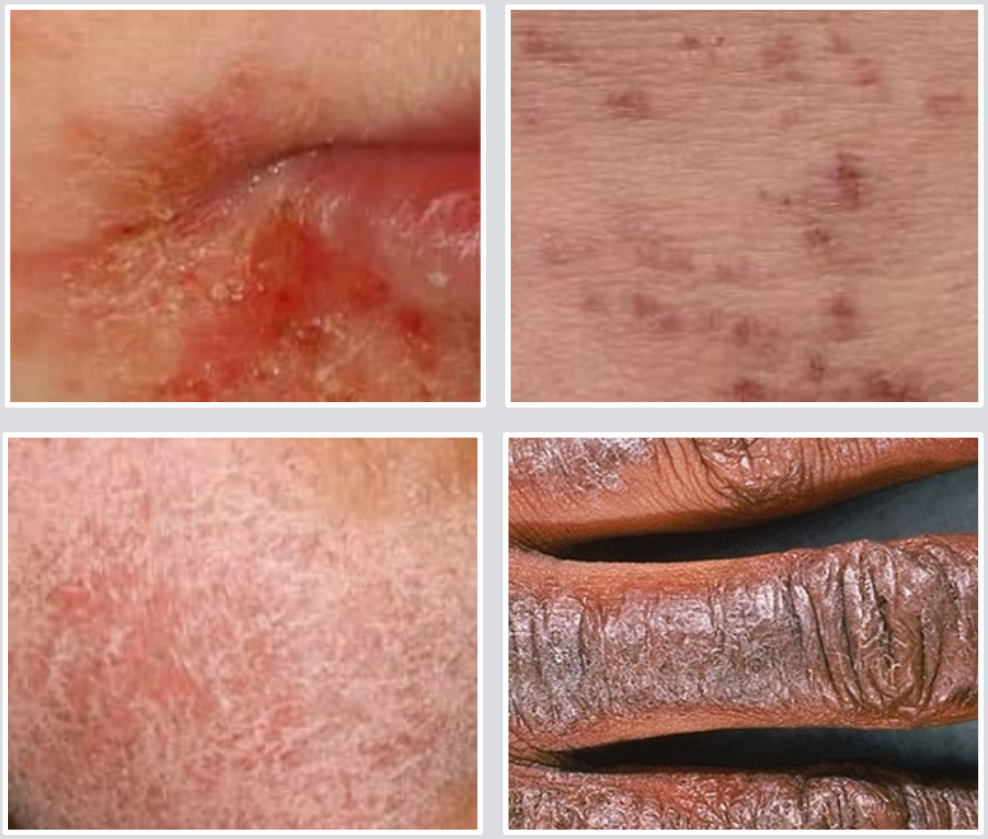
Clinical Features

Key Features



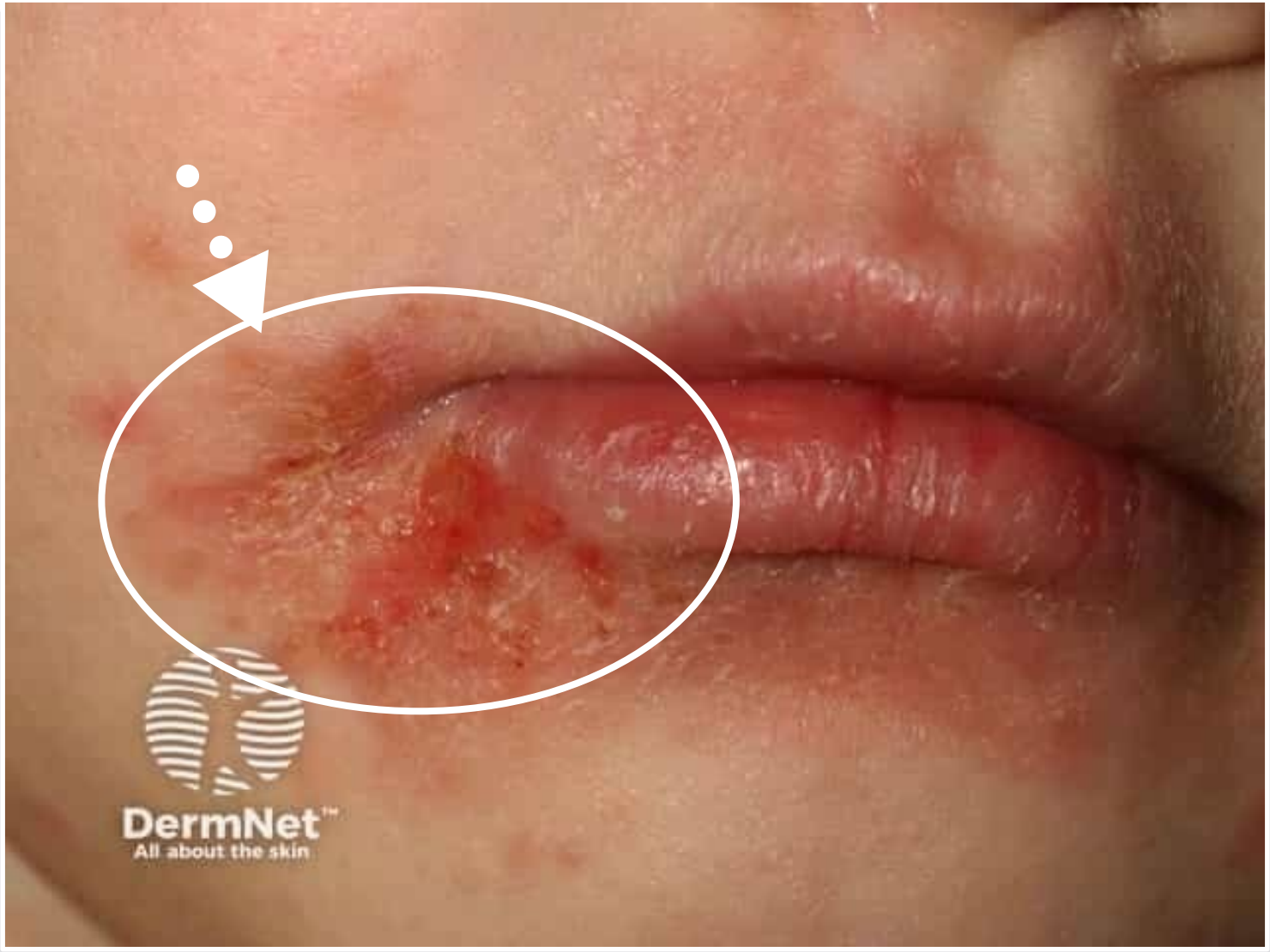
- Pruritus
- Eczematous lesions
- Dry Skin
- Present/past flexural involvement (not if age < 4)
- Chronic/relapsing
- Often: personal or FH of atopy
  - AD, allergic rhinitis, asthma, food allergy

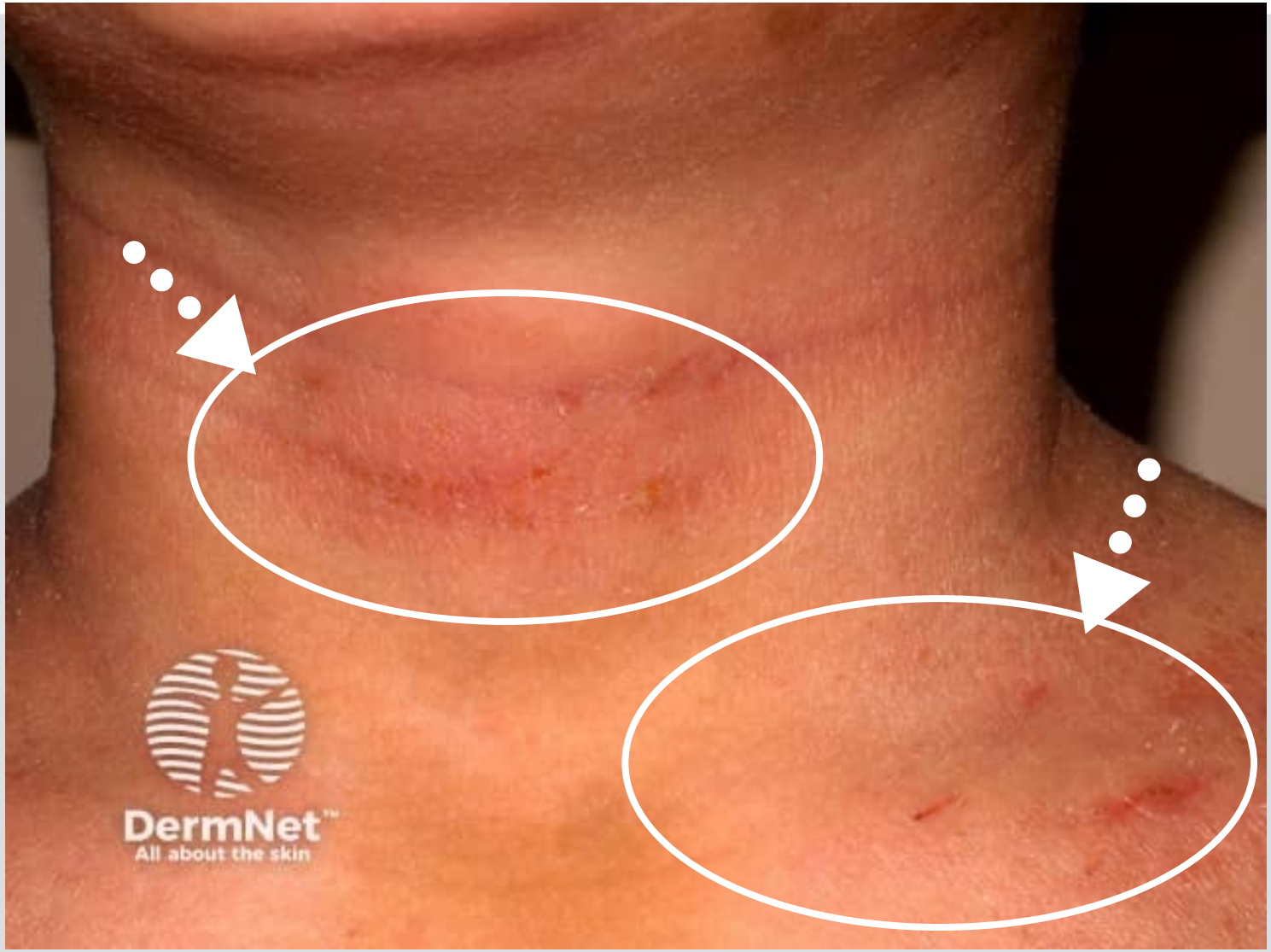
Findings

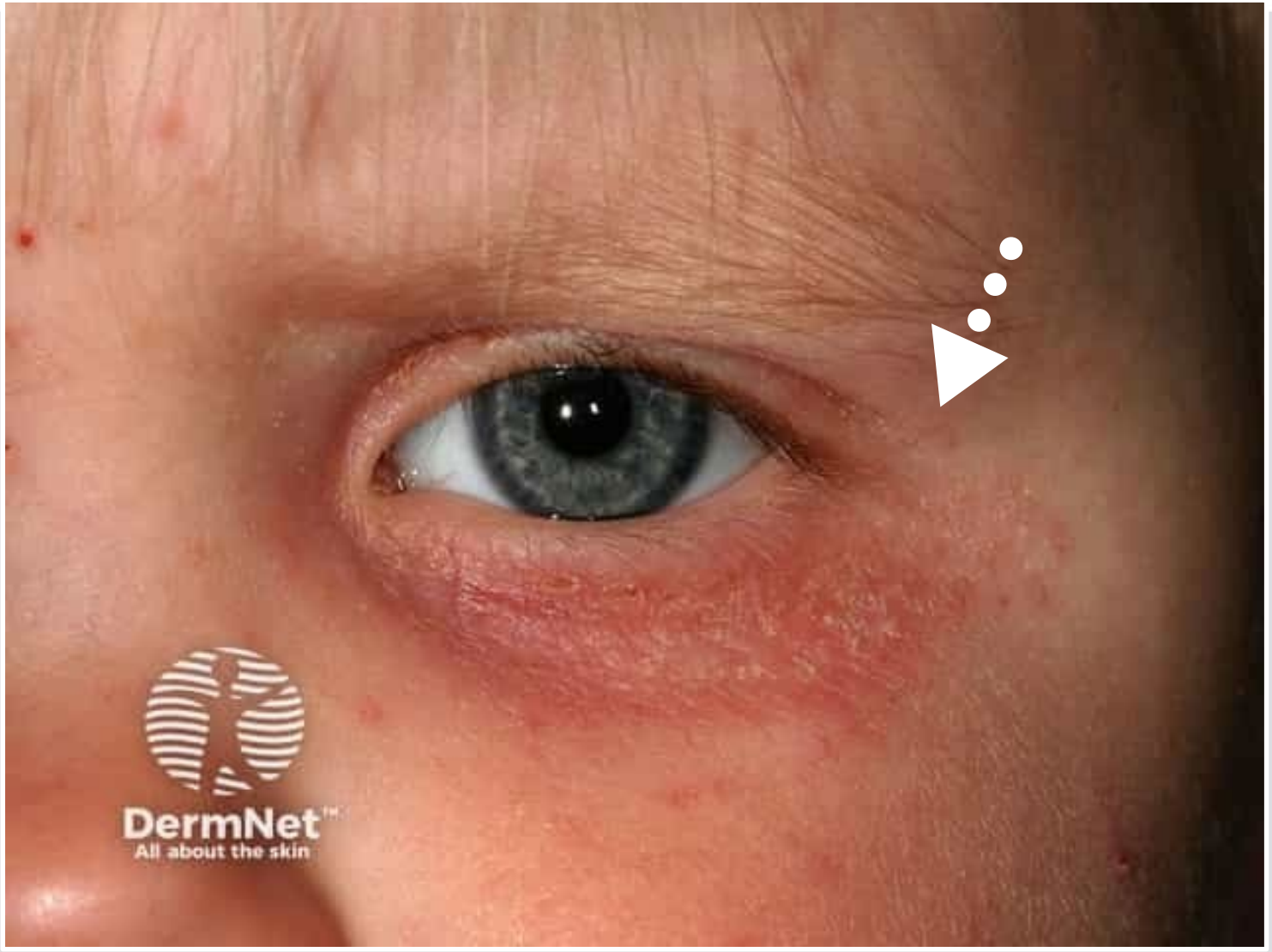


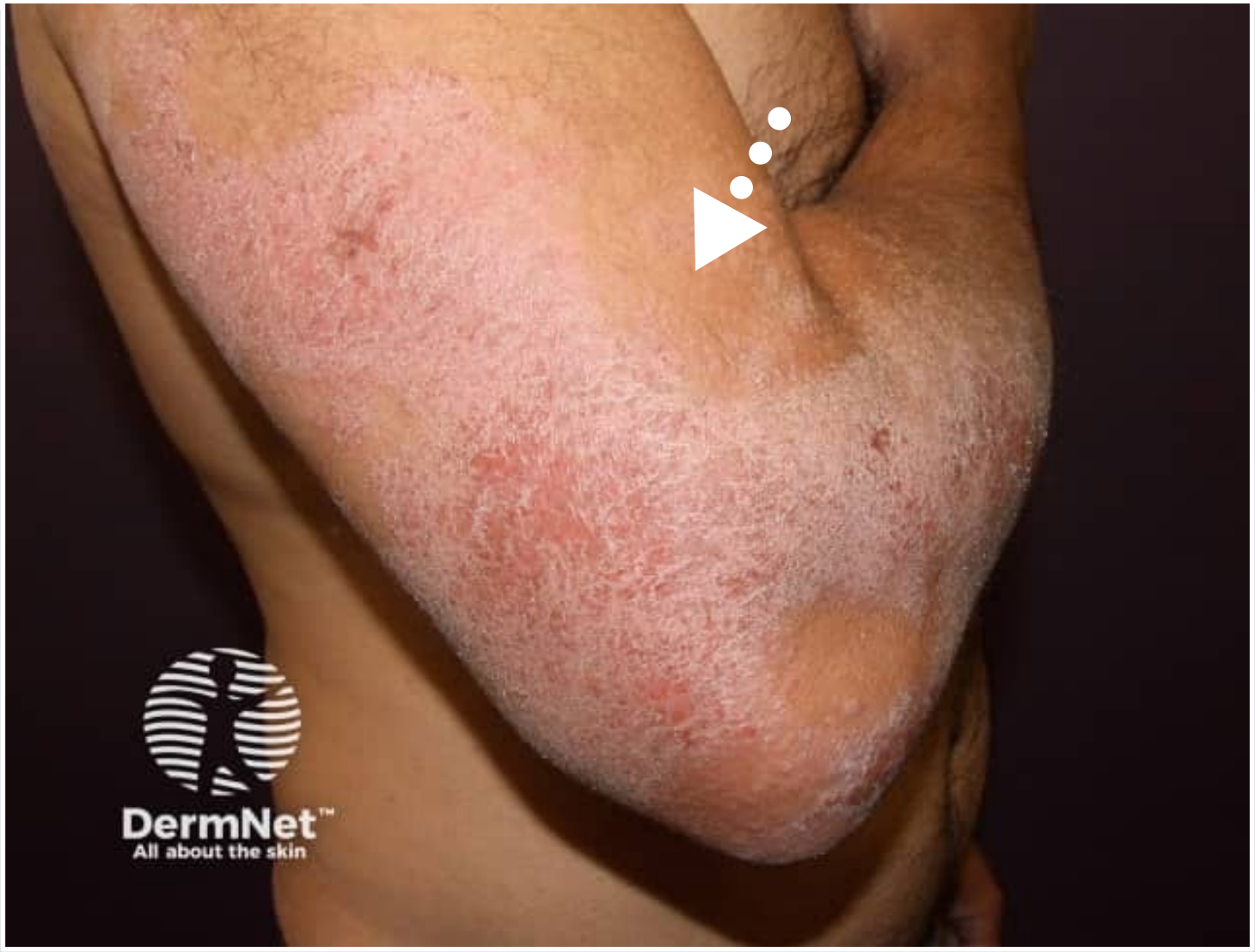
- **Morphology**
  - Papules, plaques
  - Scale, crust, erosion
  - Lichenification
  - Excoriations
  - Hyperpigmentation
  - Hypopigmentation
- **Duration affects appearance**

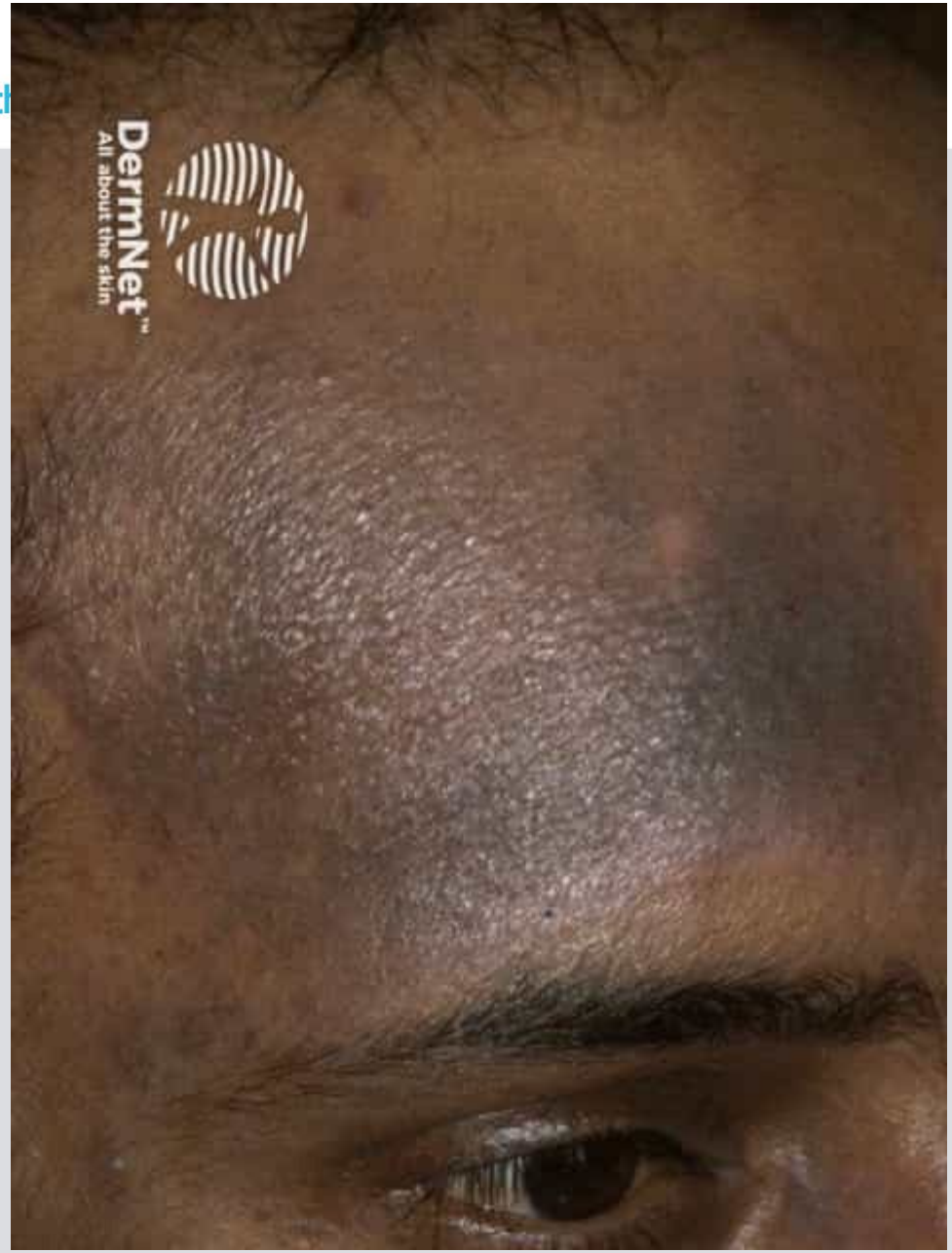
- **Acute**

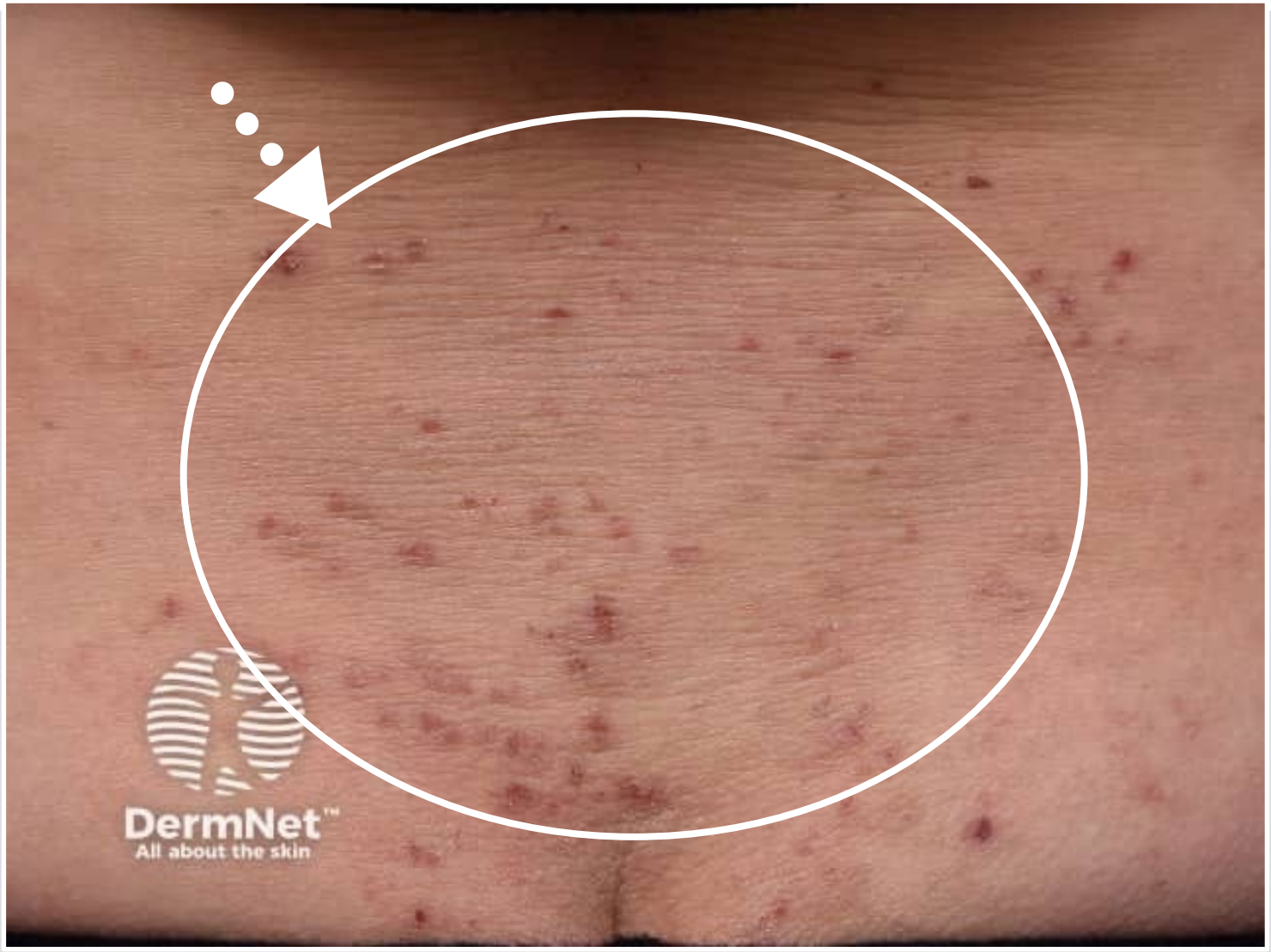

DermNet™
All about the skin

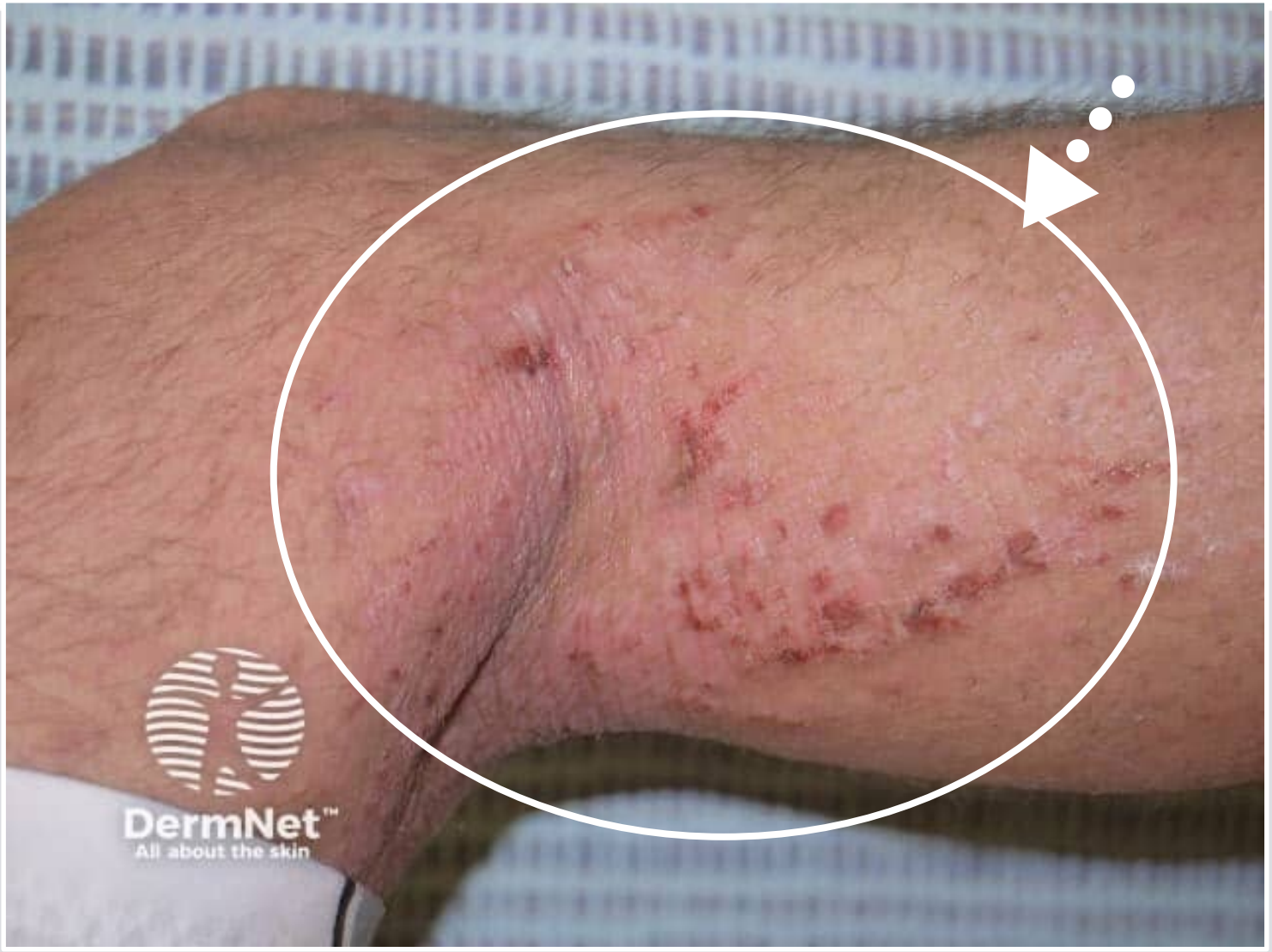

DermNet™
All about the skin


DermNet™
All about the skin

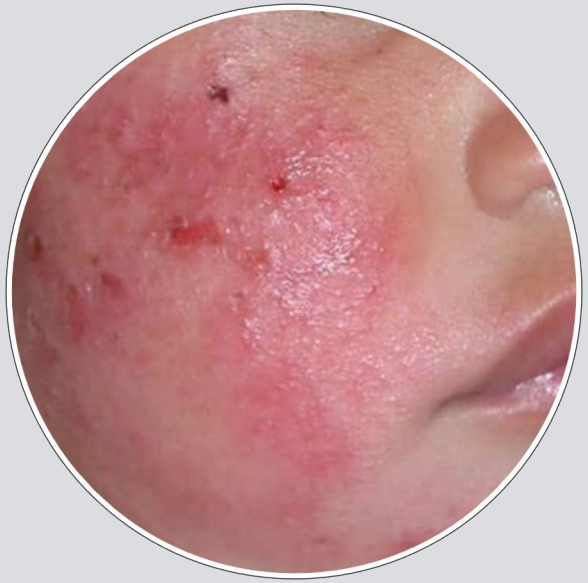

DermNet™
All about the skin


DermNet™
All about the skin

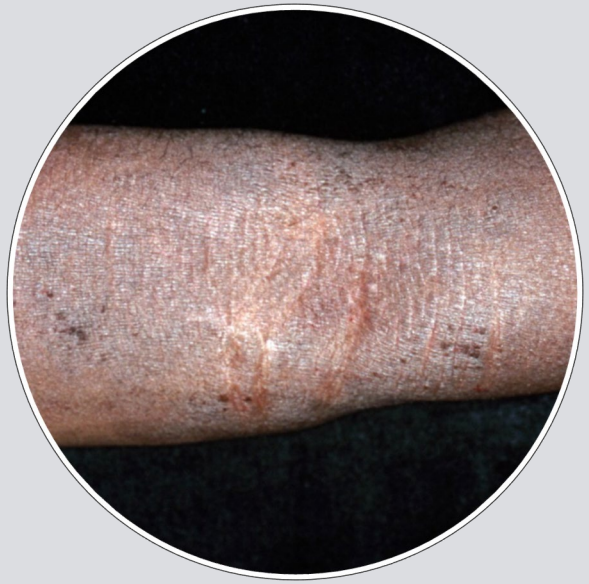

DermNet™
All about the skin


DermNet™
All about the skin

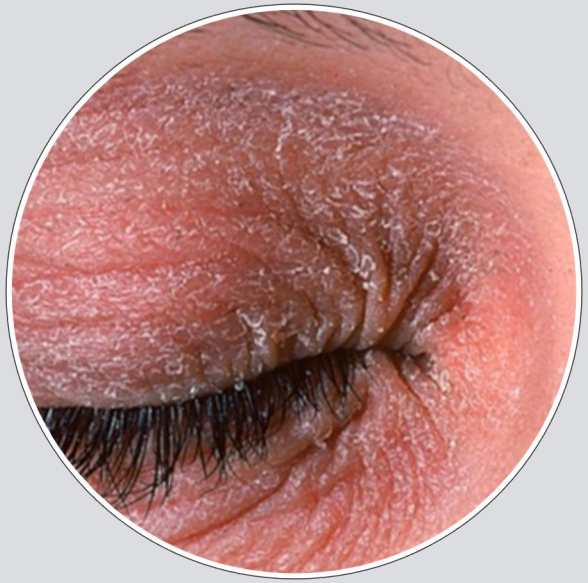
Impact of Age



- **Infants (0-2)**
  - Extensor, face
  - Crusting, exudate

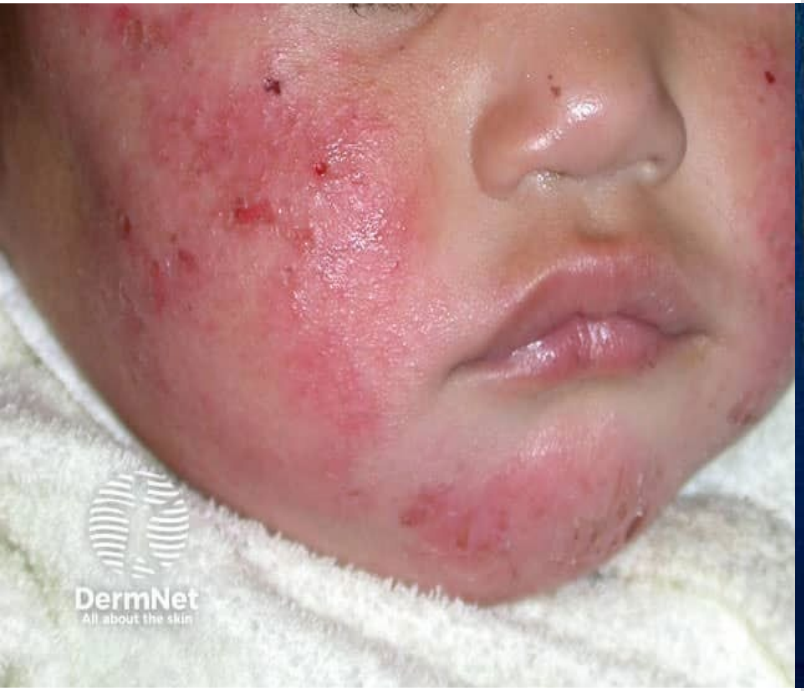


- **Older Kids (2-16)**
  - Flexures
  - Wrist, ankle, neck
  - Lichenification



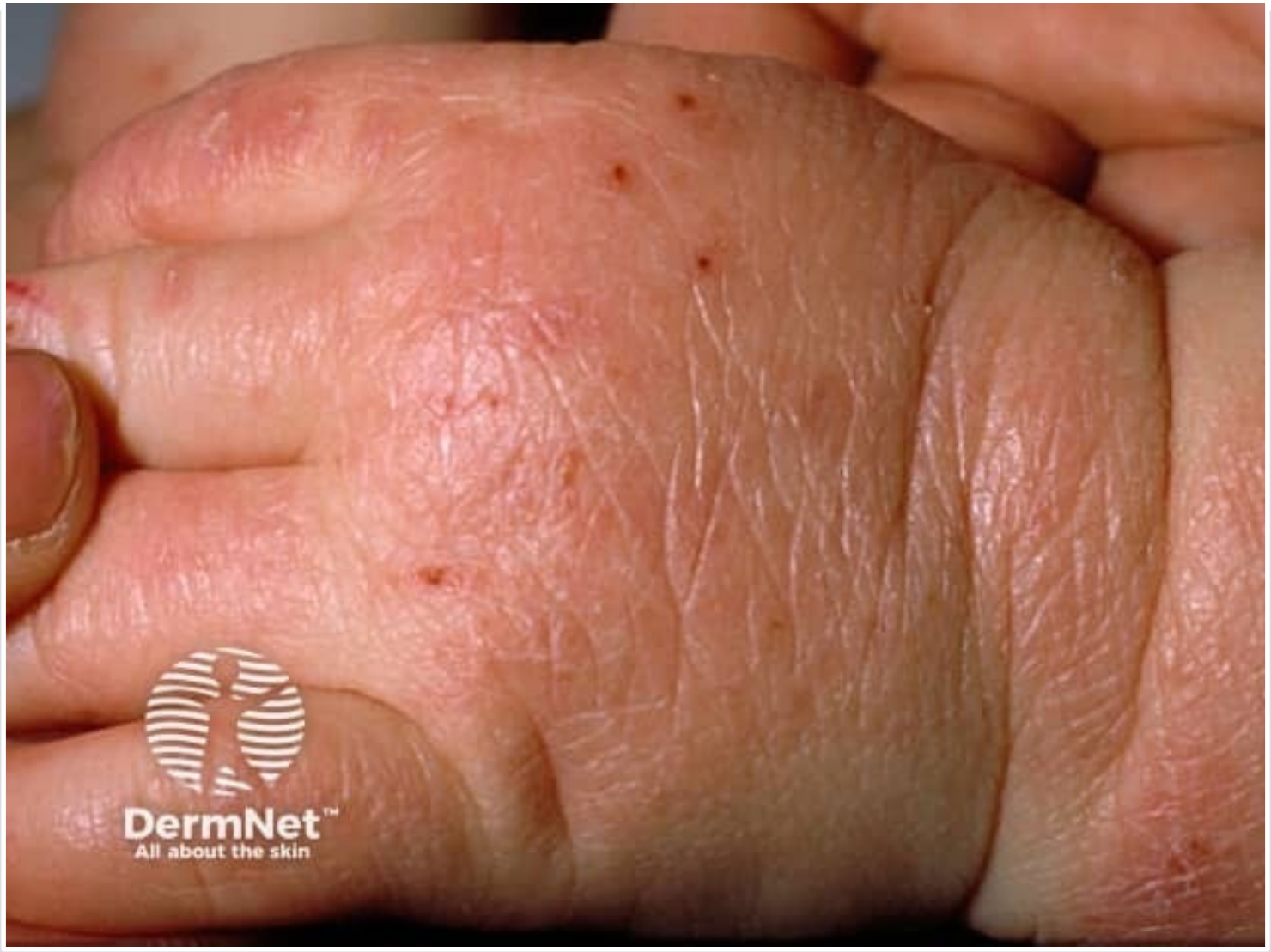
- **Adults**
  - Face, neck, hands
  - Flexures

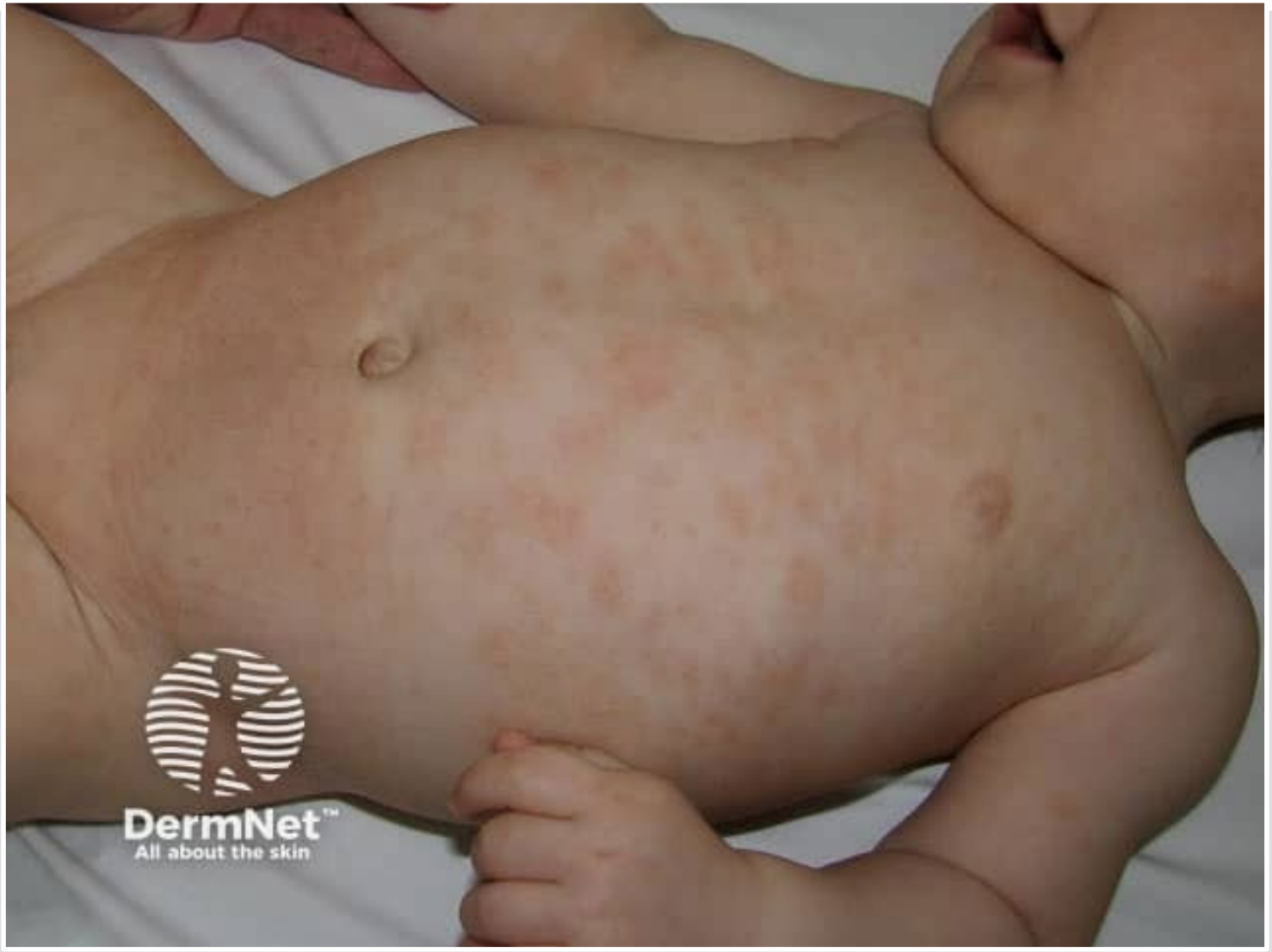
Infants & Little Kids


DermNet
All about the skin

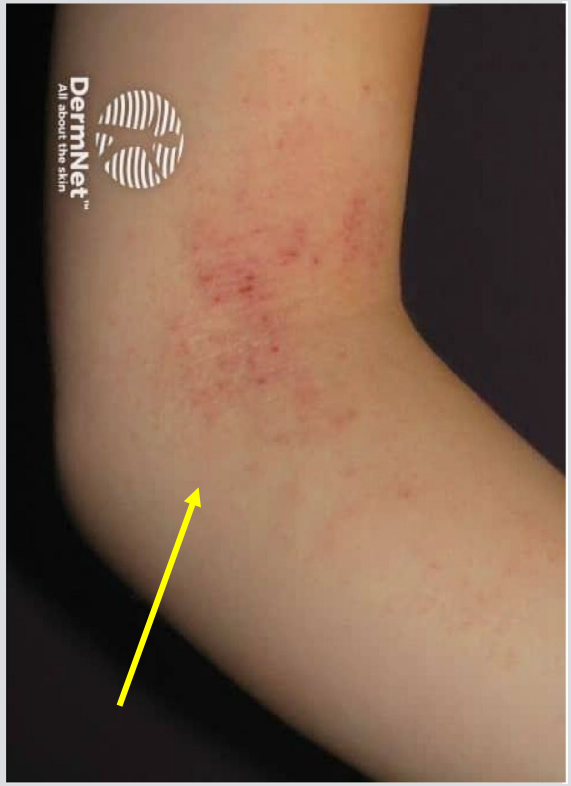

Te Whatu Ora
Health New Zealand

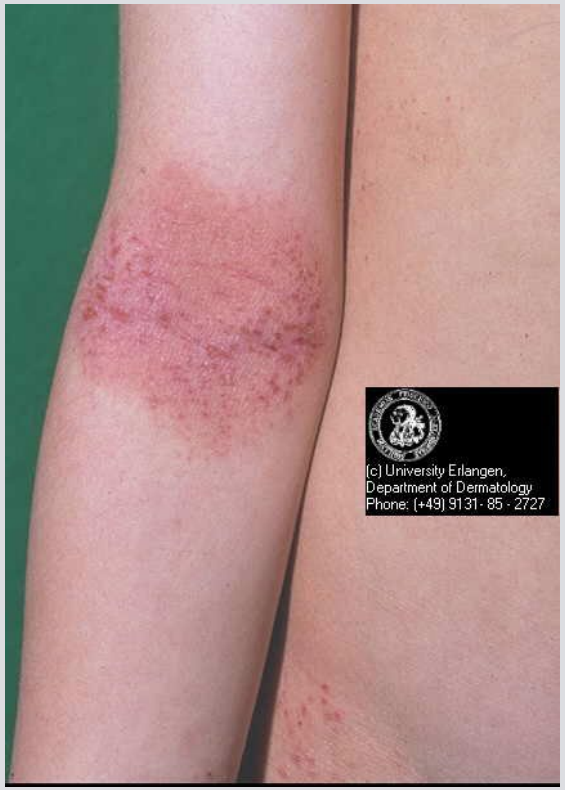

DermNet™
All about the skin

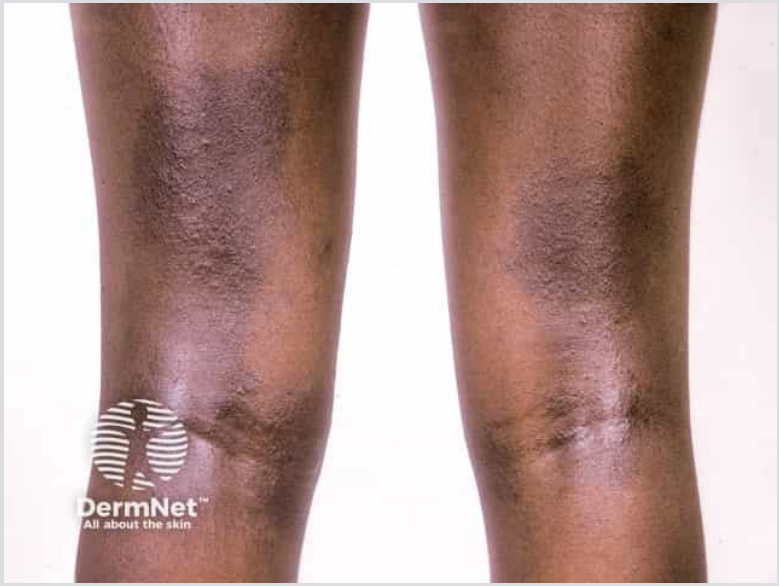

DermNet™
All about the skin

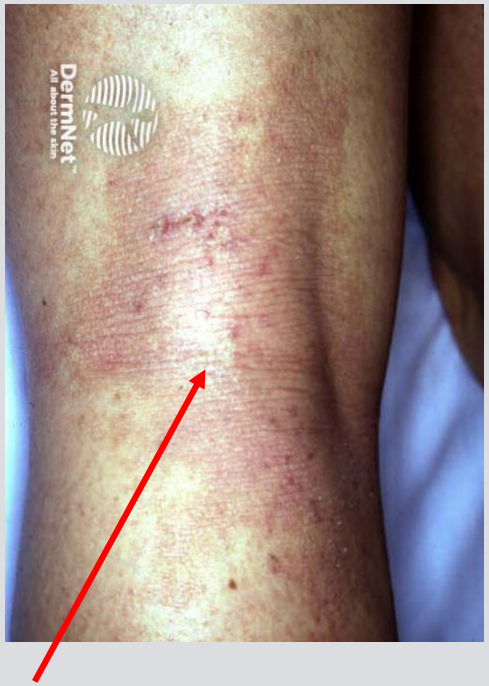

DermNet™
All about the skin

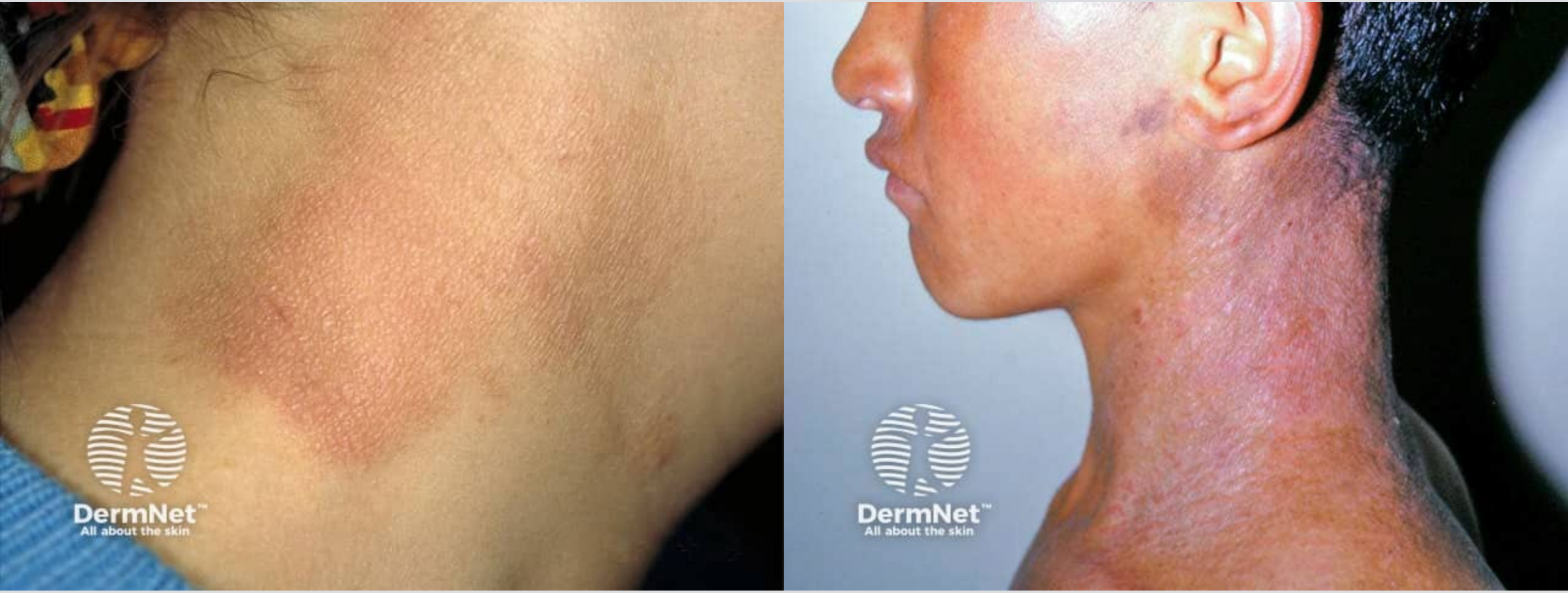
Older Kids & Adolescents

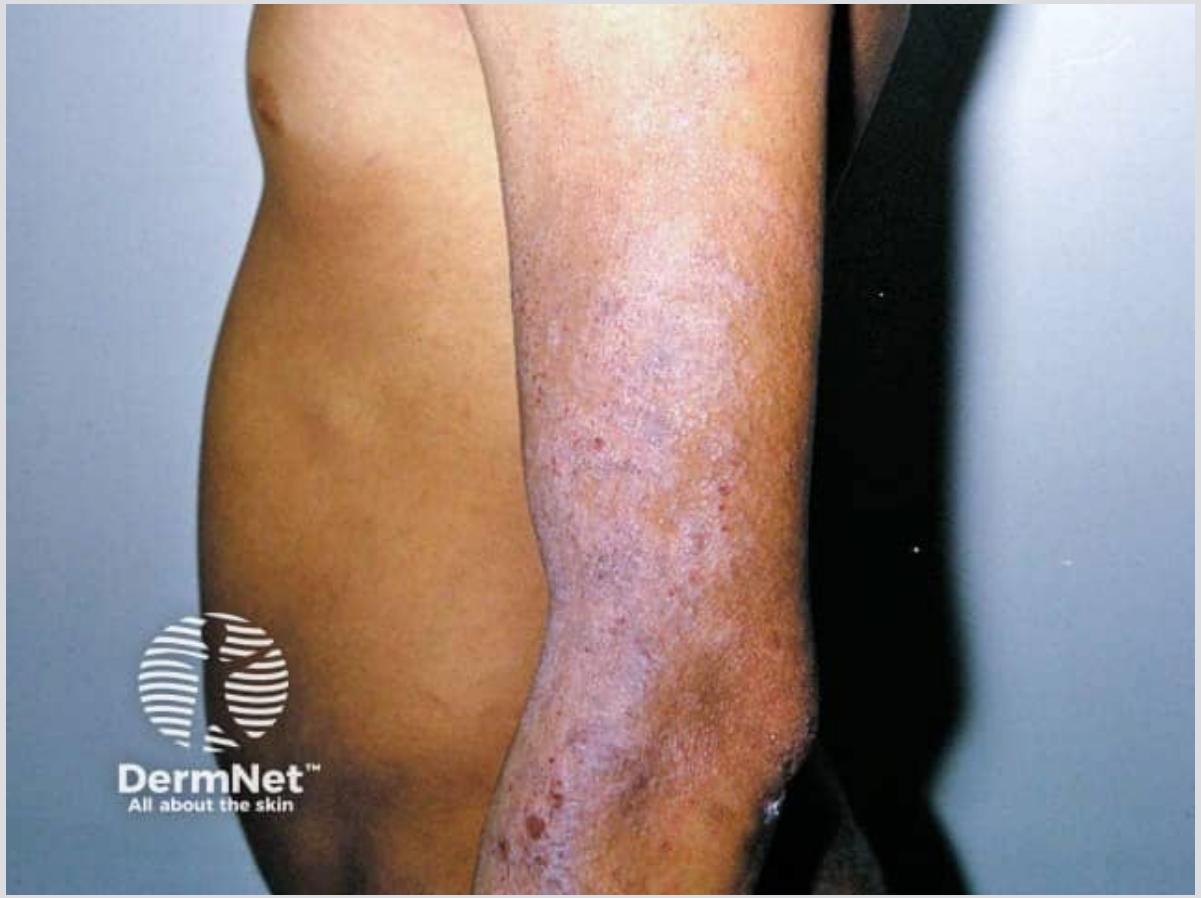

DermNet™
All about the skin

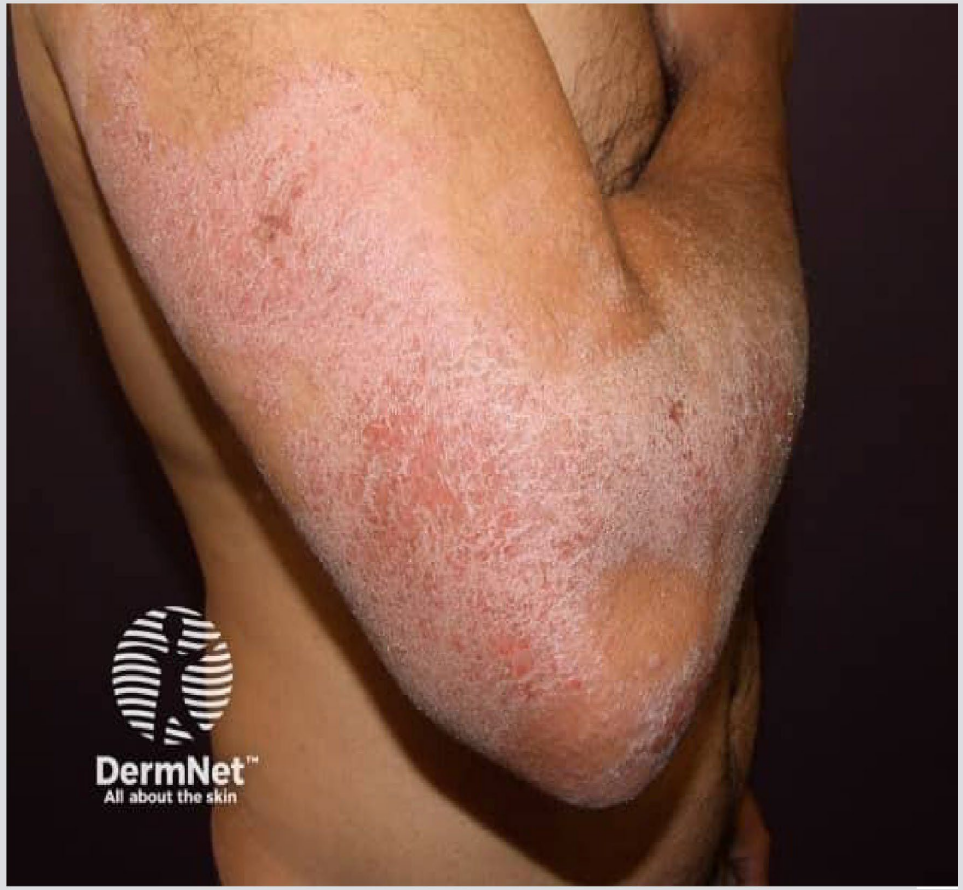

(c) University Erlangen,
Department of Dermatology
Phone: (+49) 9131- 85 - 2727

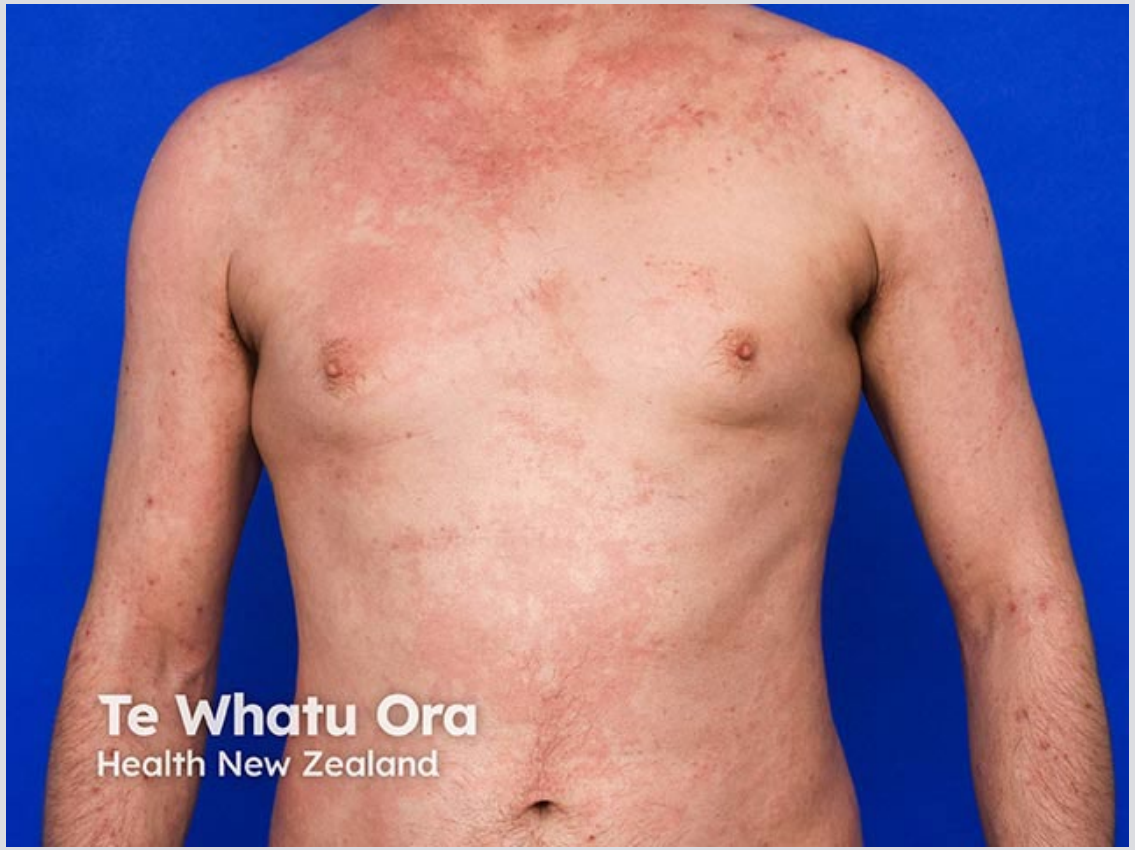

DermNet™
All about the skin

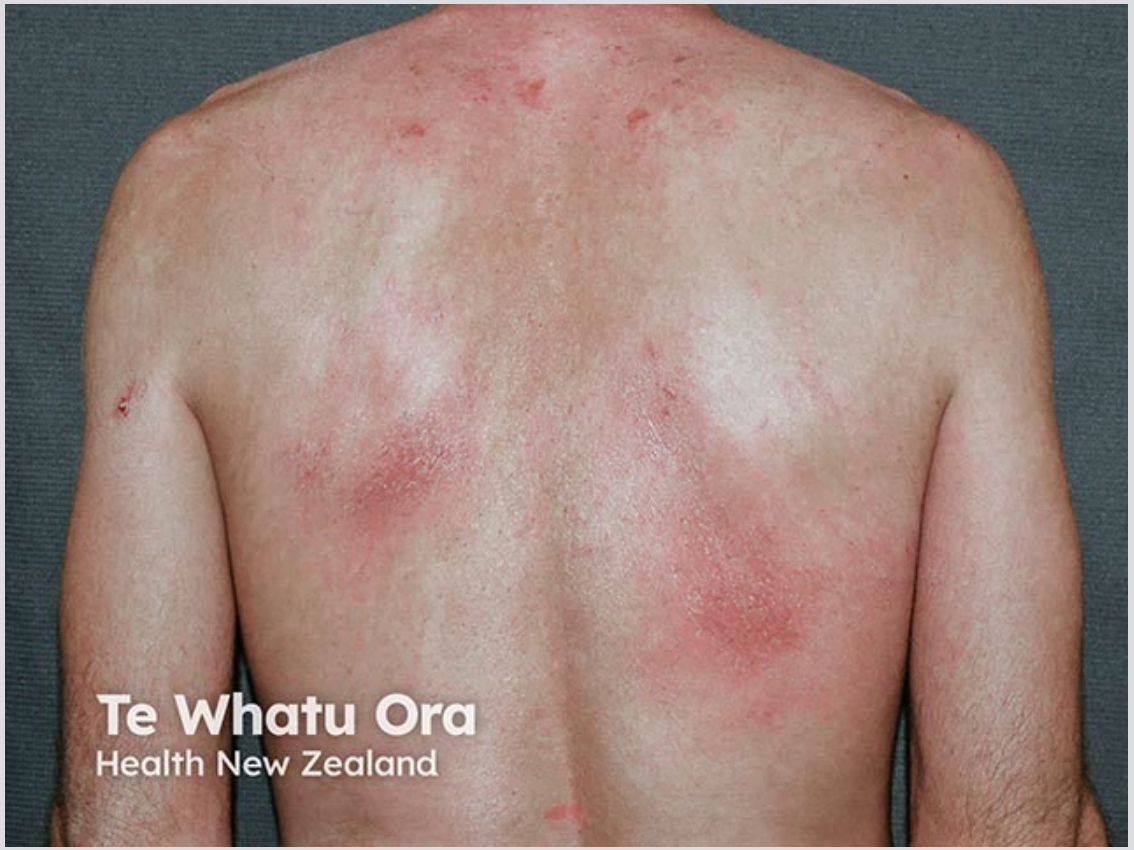

DermNet™
All about the skin


DermNet™
All about the skin
DermNet™
All about the skin


DermNet™
All about the skin

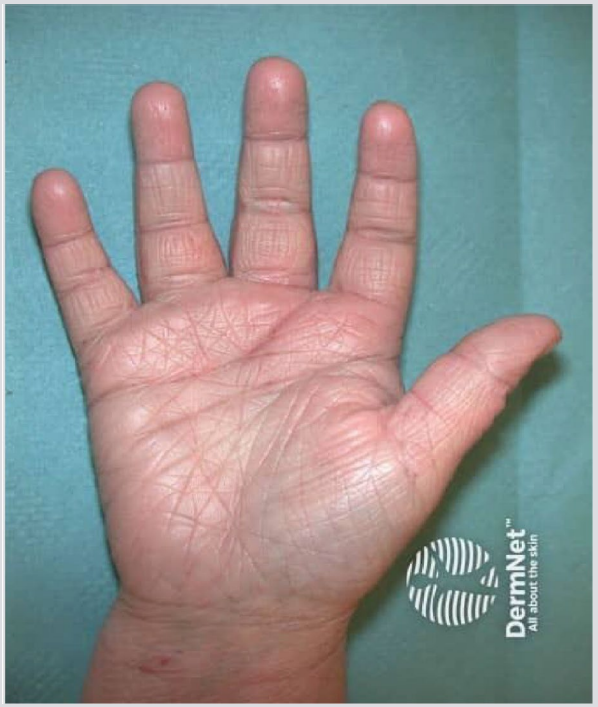

DermNet™
All about the skin


Te Whatu Ora
Health New Zealand

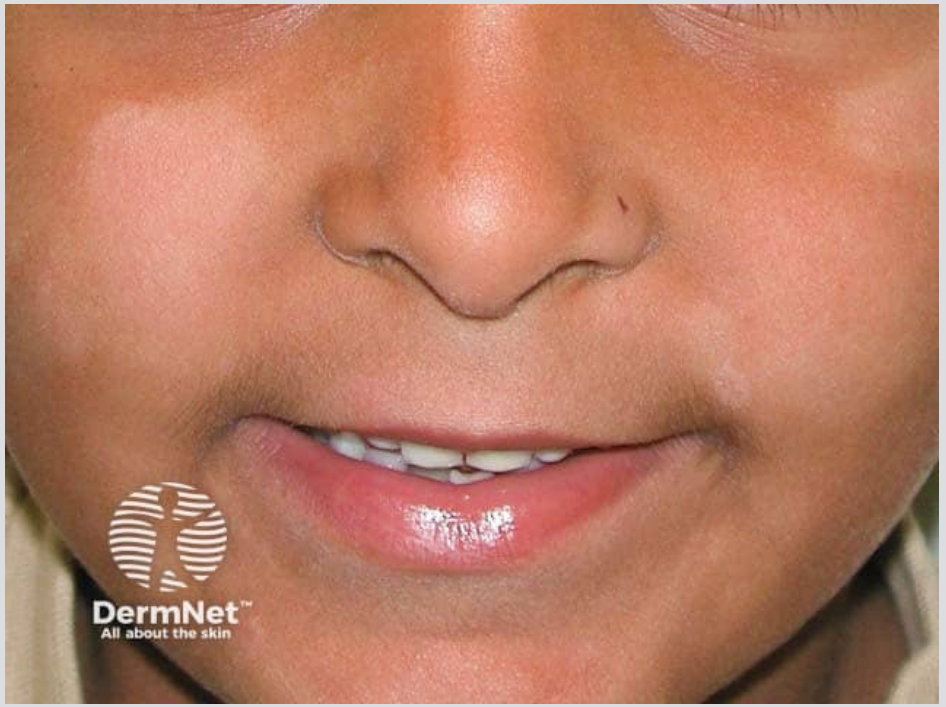

Te Whatu Ora
Health New Zealand

Clinical Pearl #2

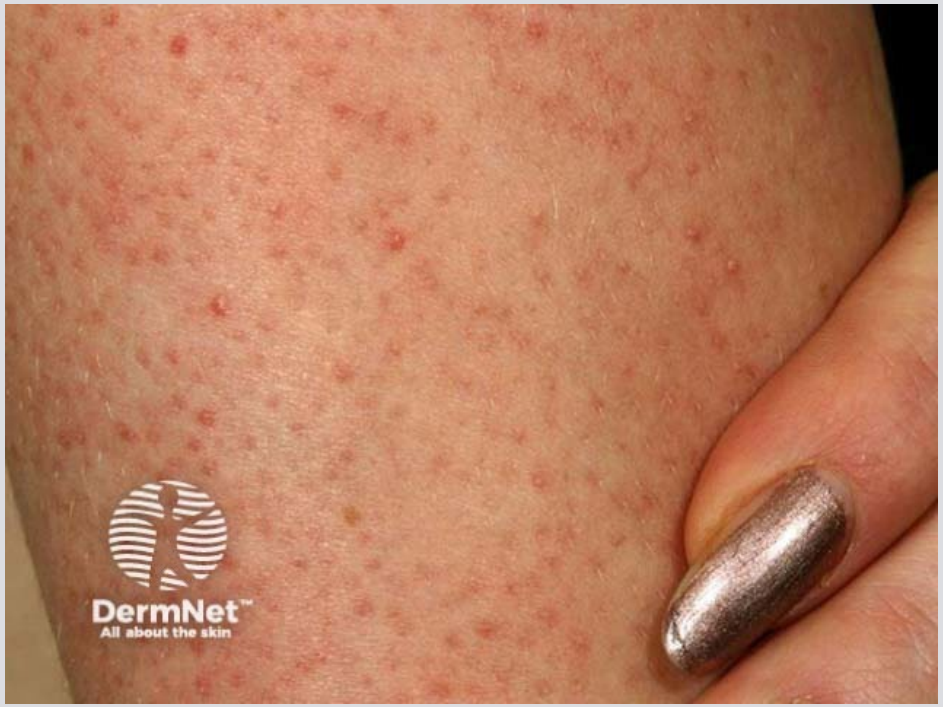
Associated Conditions



Hyperlinear Palms



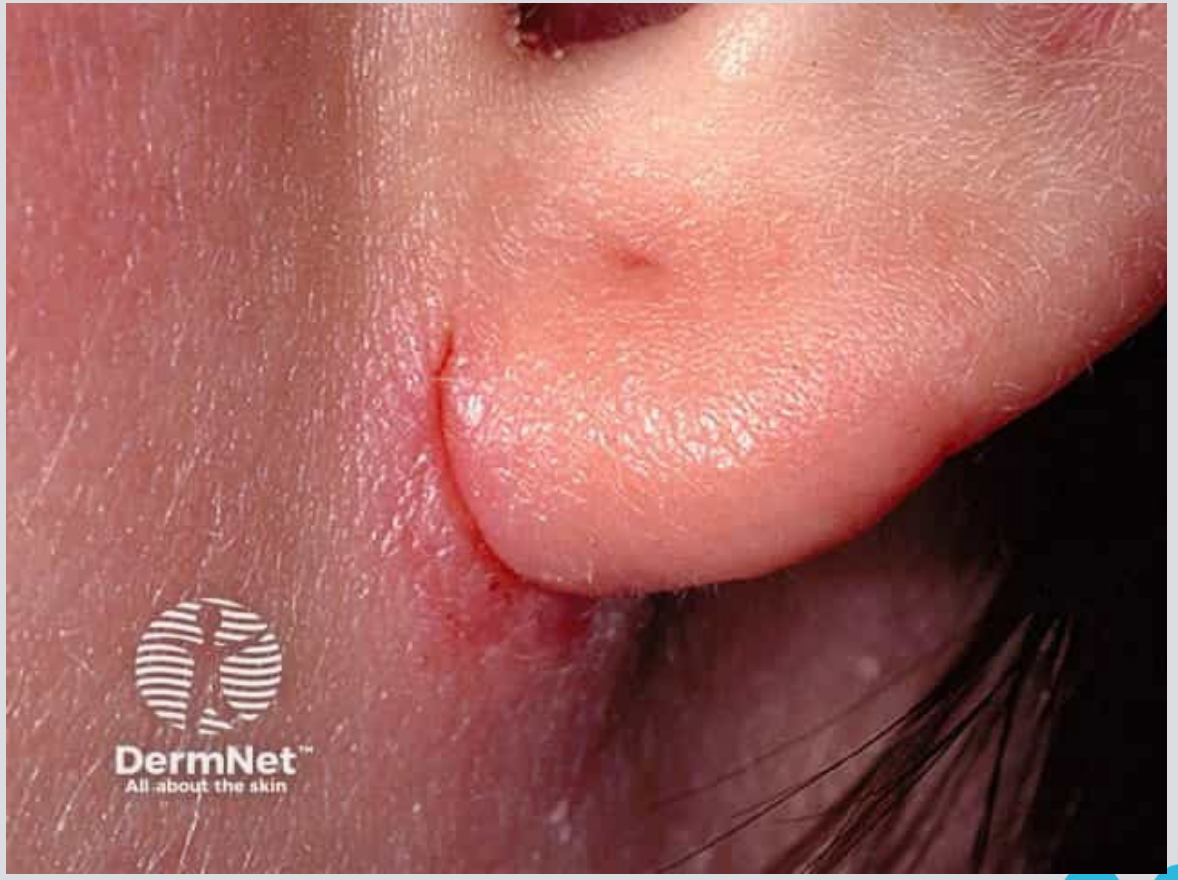
Pityriasis Alba



Keratosis Pilaris

Infra-Auricular Fissure

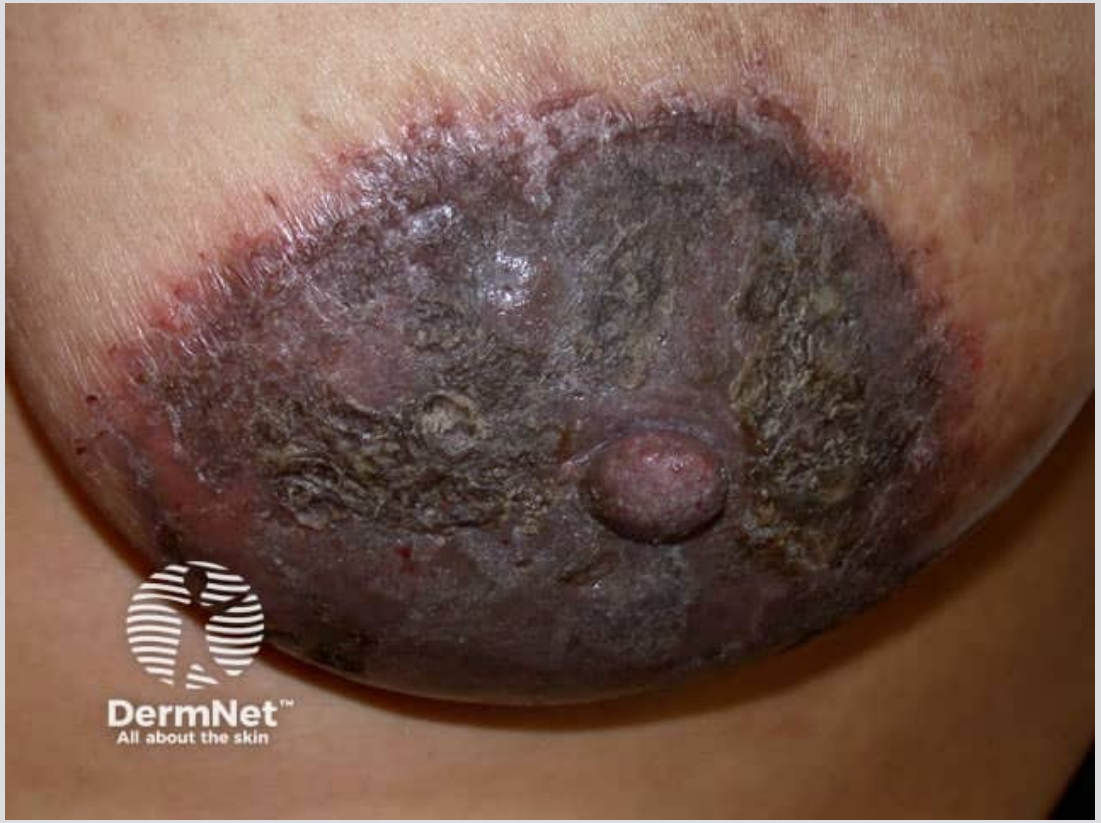
- High prevalence in AD
- May correlate with severity
- More common in childhood-onset AD



Tada J, Toi Y, Akiyama H, Arata J. Infra-auricular fissures in atopic dermatitis. Acta Derm Venereol. 1994 Mar;74(2):129-31.

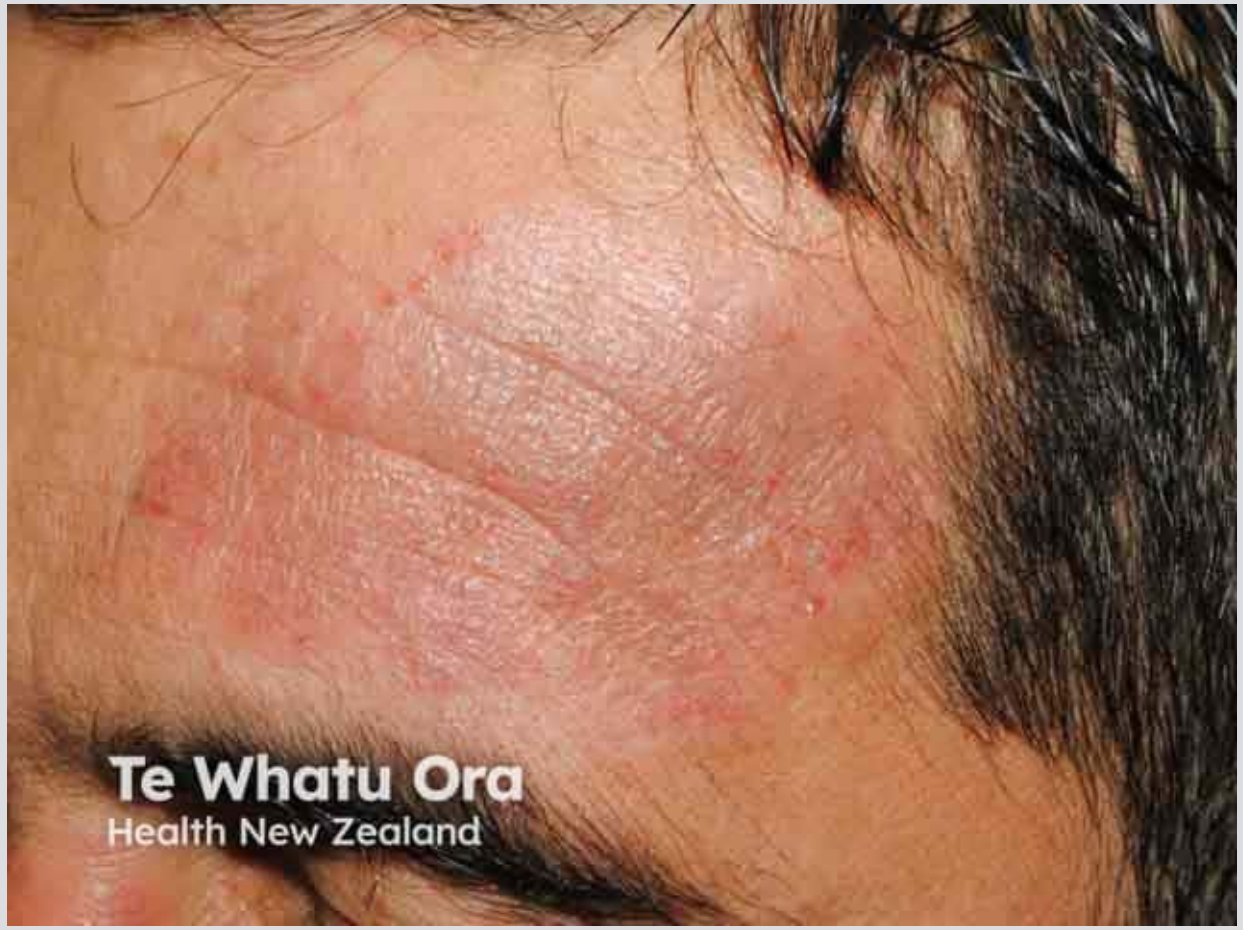
Nipple Eczema

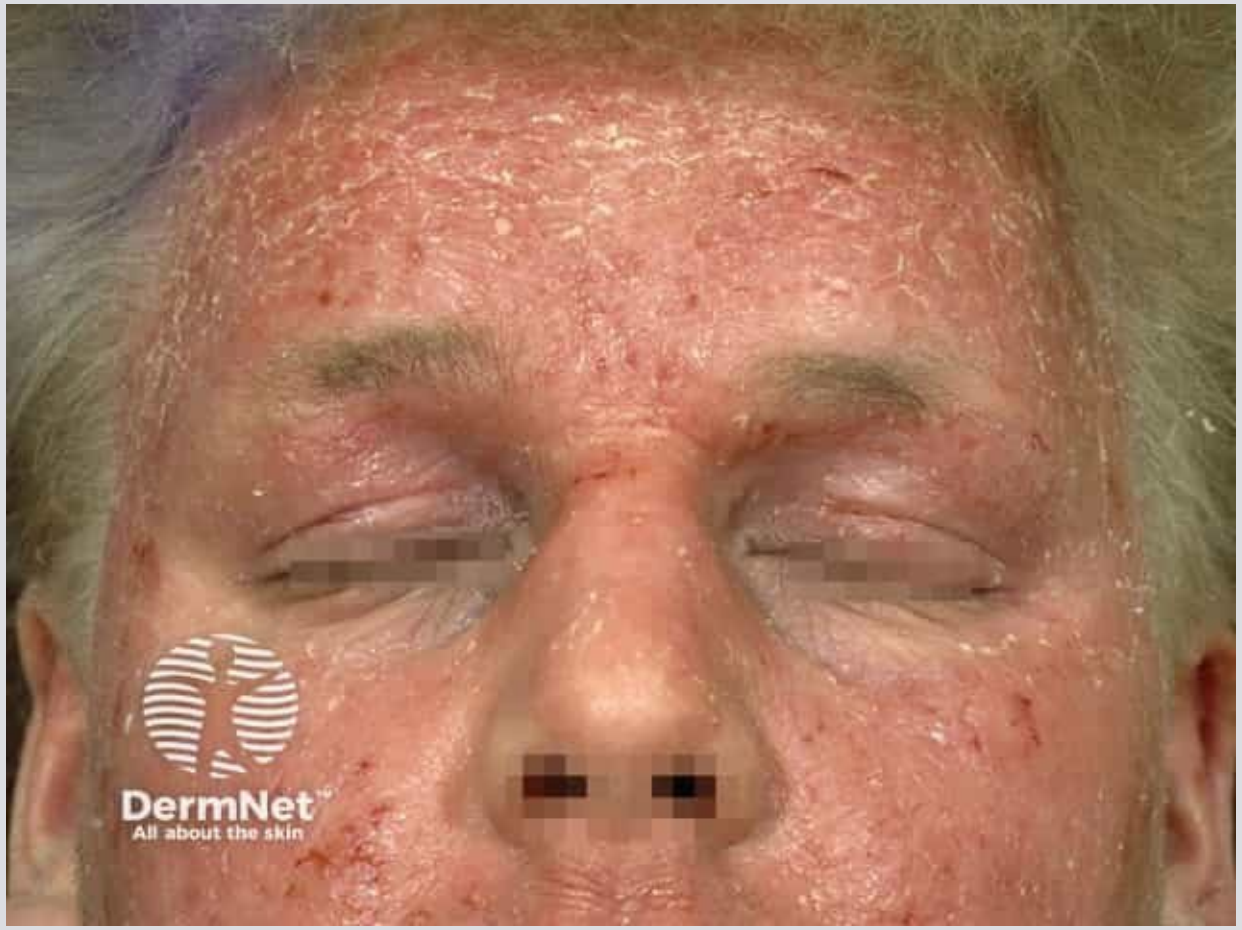
- Prevalence 8-23%
- Adolescent and young women mostly
- Very itchy
- Often oozes
- Distressing

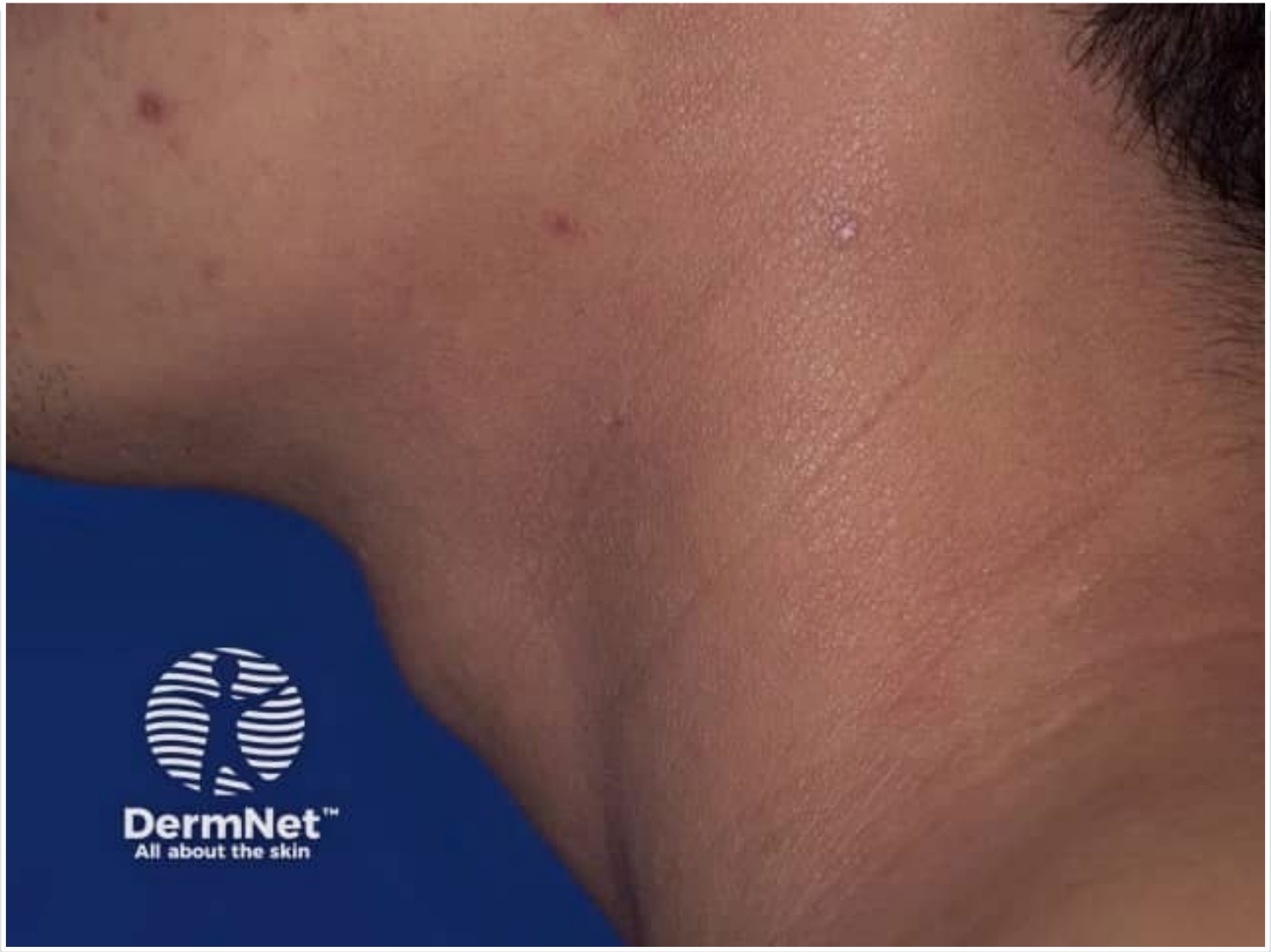


Lee JM et al. 2025. Real-world prevalence and associated factors of nipple eczema in patients with atopic dermatitis. Ann Dermatol 37(2): e4.

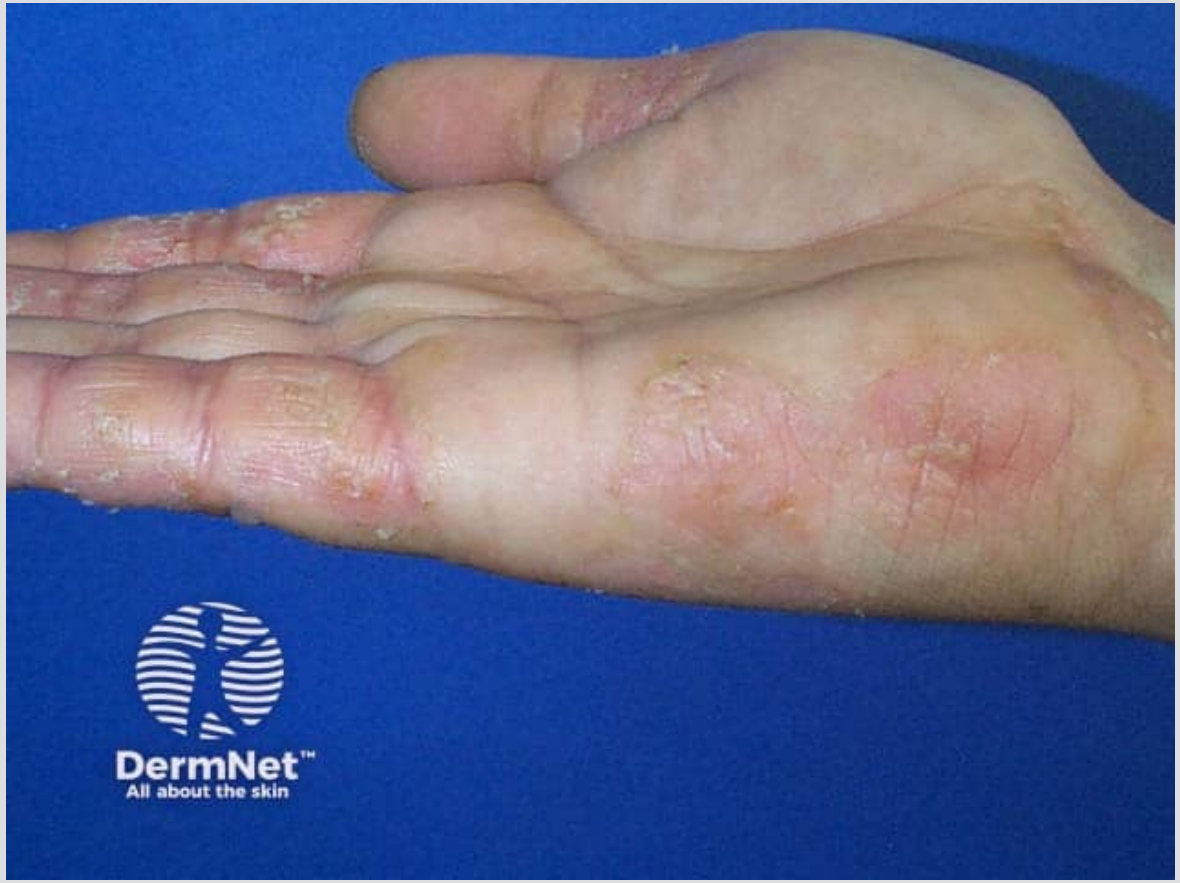
Adults


Te Whatu Ora
Health New Zealand


DermNet™
All about the skin


DermNet™
All about the skin


Te Whatu Ora
Health New Zealand


DermNet™
All about the skin

Clinical Pearl #3

Remember Contact Dermatitis

- Important DDX for face, eyelids, lips
- If patient's AD pattern has changed

DDX for Atopic Dermatitis

- Irritant/Allergic Contact Dermatitis
- Seborrheic Dermatitis
- Psoriasis
- Scabies
- Eczematous Drug Eruption
- Tinea Corporis
- Cutaneous T-Cell Lymphoma (Mycosis Fungoides)

Disease Severity

Severity Considerations

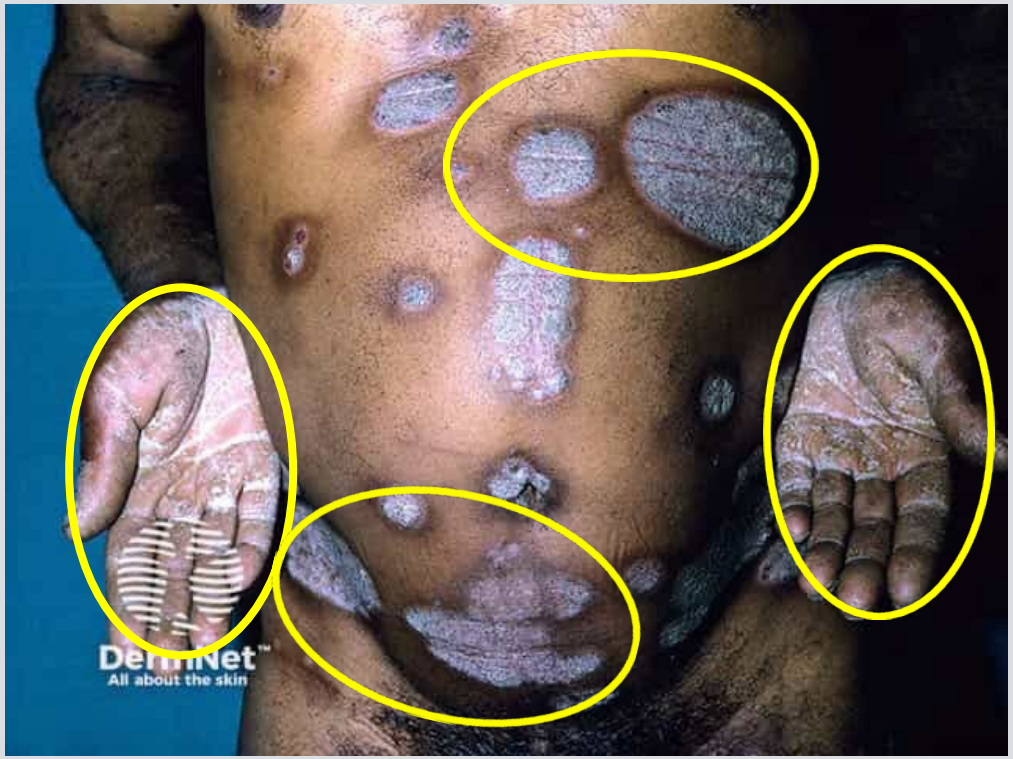
- **BSA Involved**
  - Mild: <3%
  - Moderate: 4-9%
  - Severe: 10+%
- **Other Factors:**
  - **Symptoms/Severity**: Itch, erythema, pain, oozing, cracking
  - **Sensitive Areas**: face, eyelids, hands, feet (low BSA, locally severe)
  - **Activity**: Constant vs Flares
  - **QOL**: Sleep, ADLs, Job
  - **Resistance to therapy:** failure of topical steroids, non-steroidals, etc
  - **Secondary Infections**

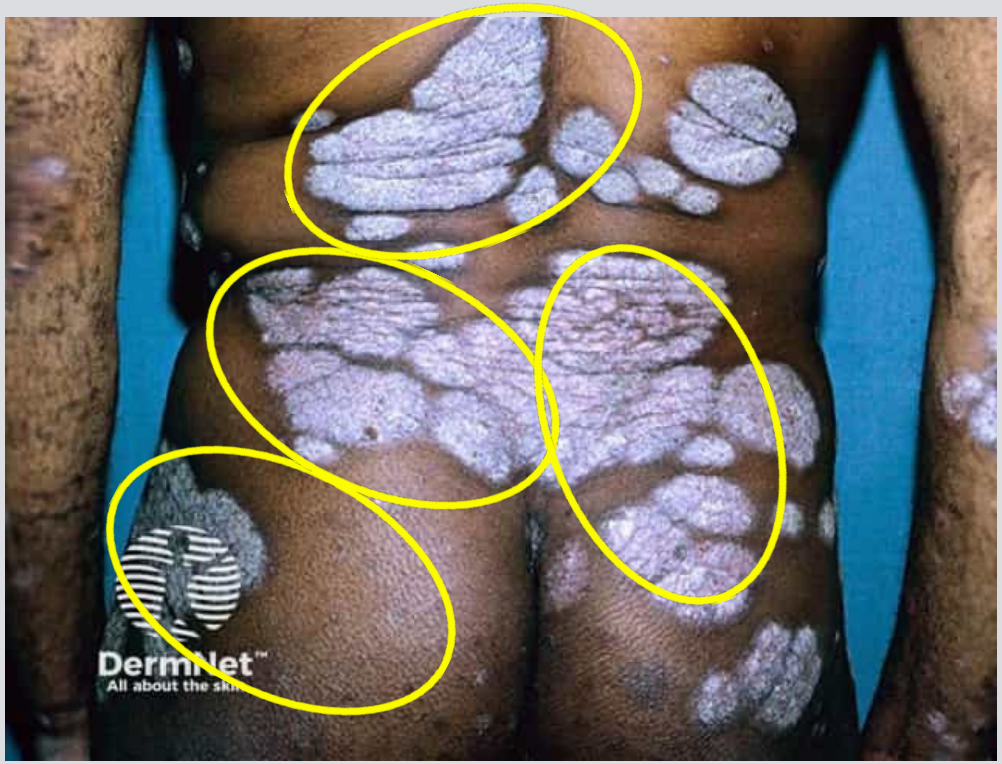
Estimating BSA Involved

- Patient's palm = 1% BSA

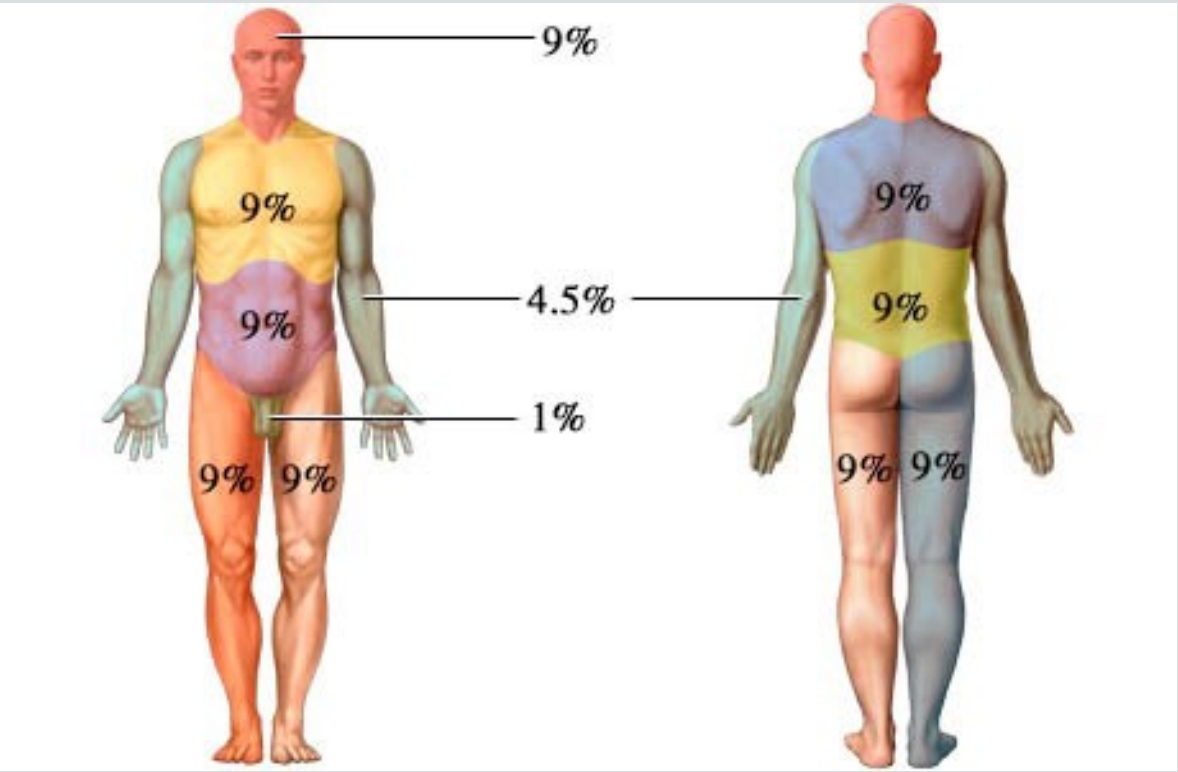
Estimating BSA Using Palm

Total = 8%



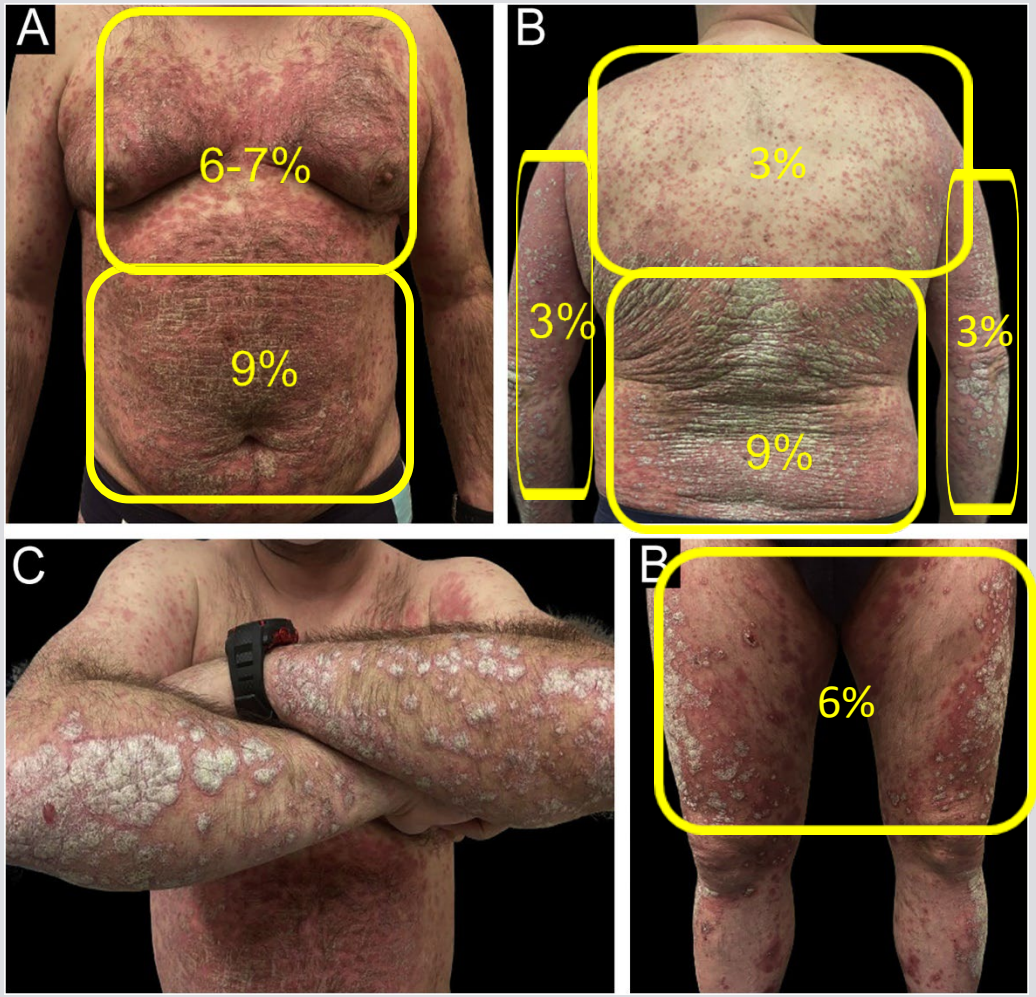


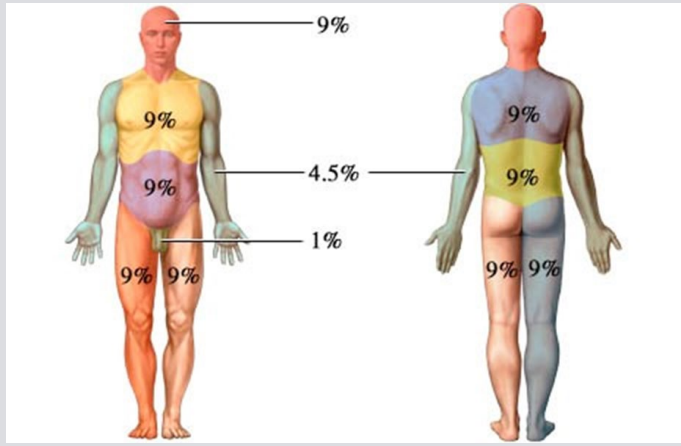
Estimating BSA For Large Areas: Rule of 9s



https://www.health.state.mn.us/communities/ep/surge/burn/tbsa.html

Estimating BSA: Rule of 9s





Total = 40%

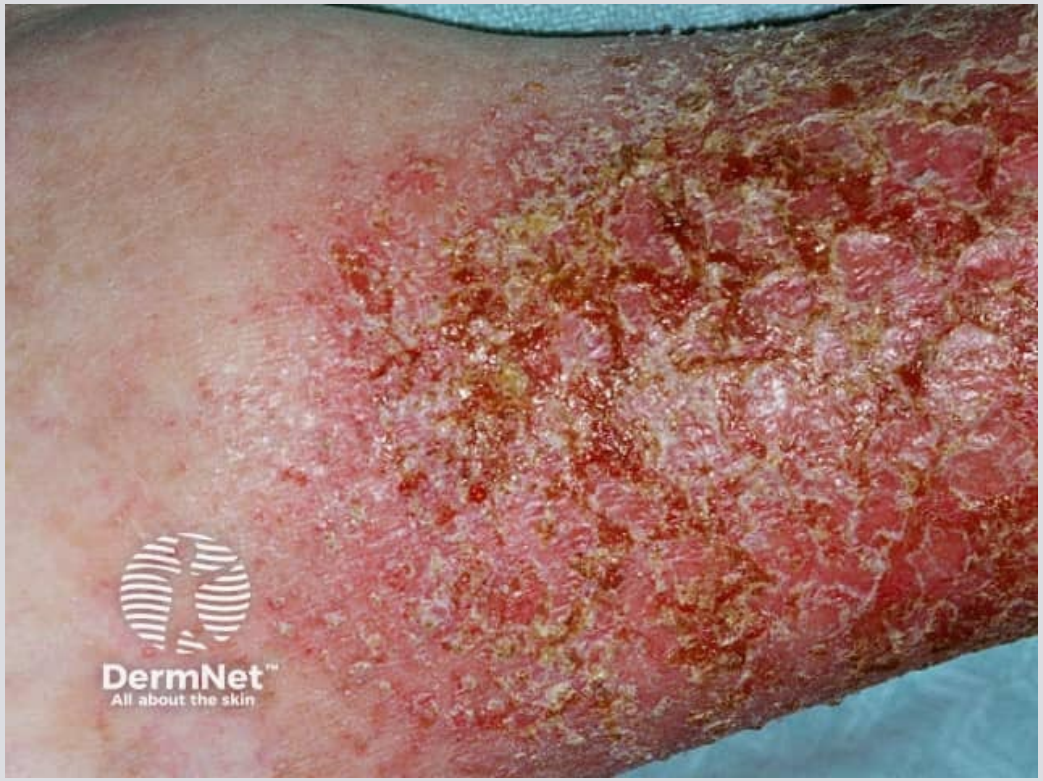
Clinical Pearl #4

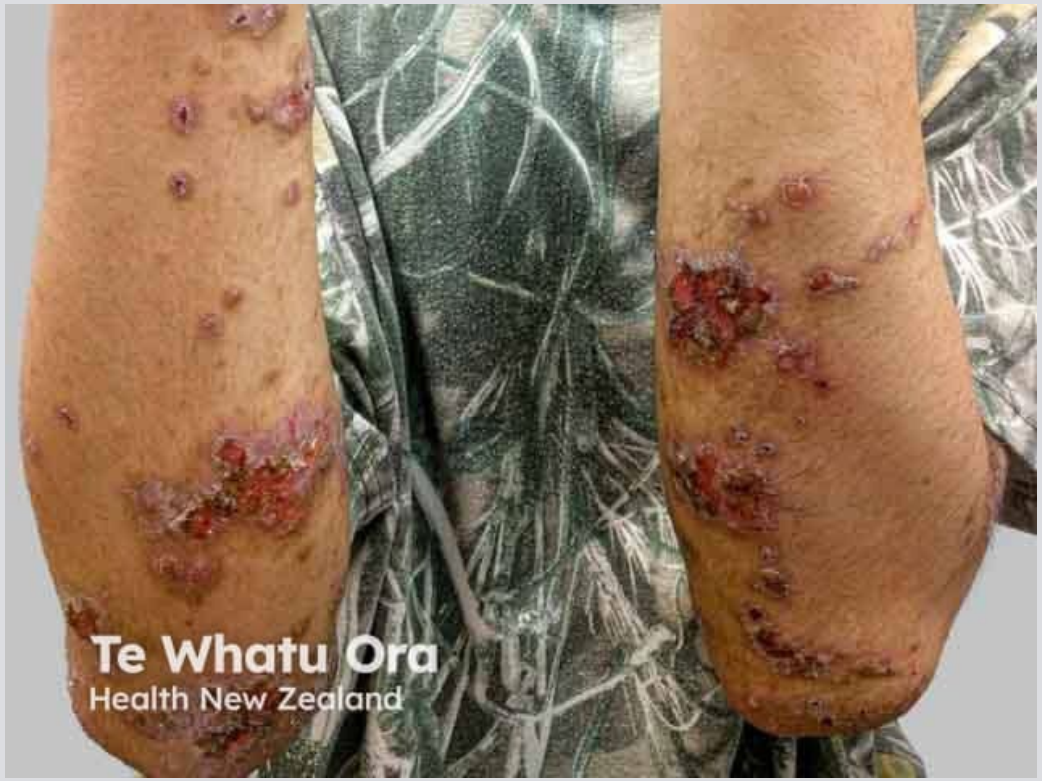
Document Key Indicators of Severity

- BSA
- Severity of Itch (“intractable”)
- Sensitive Area Involvement
- Treatments that failed
- Essential for moderate/severe patients

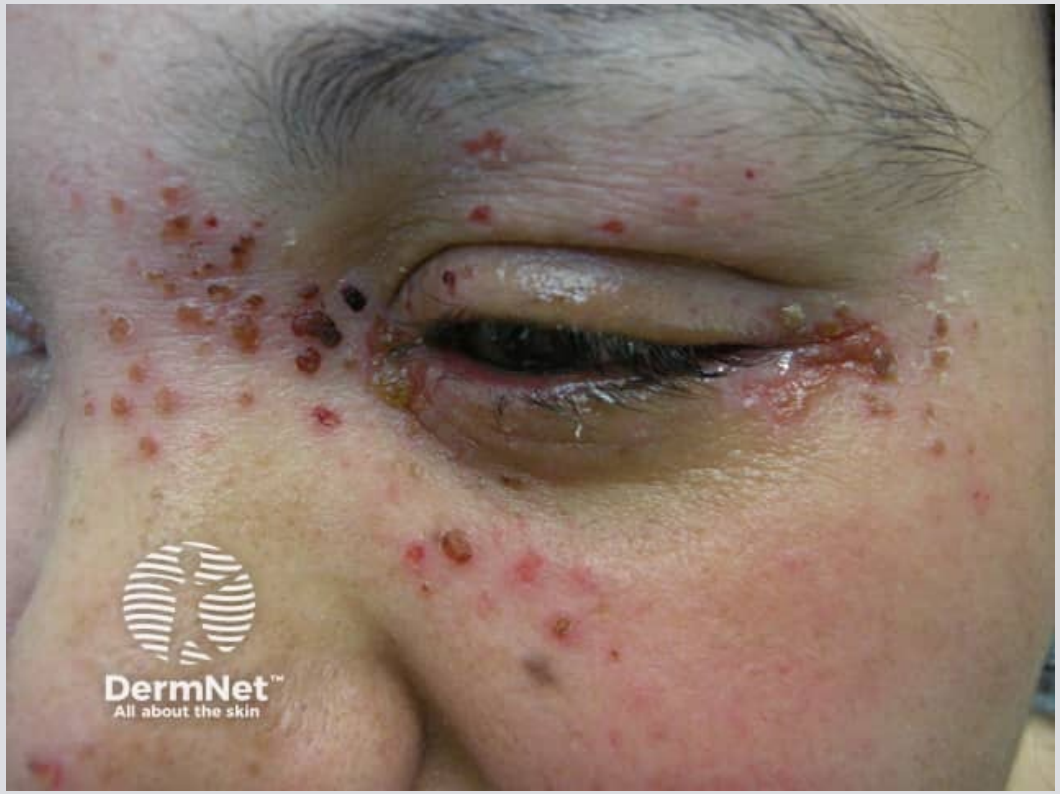
Complications

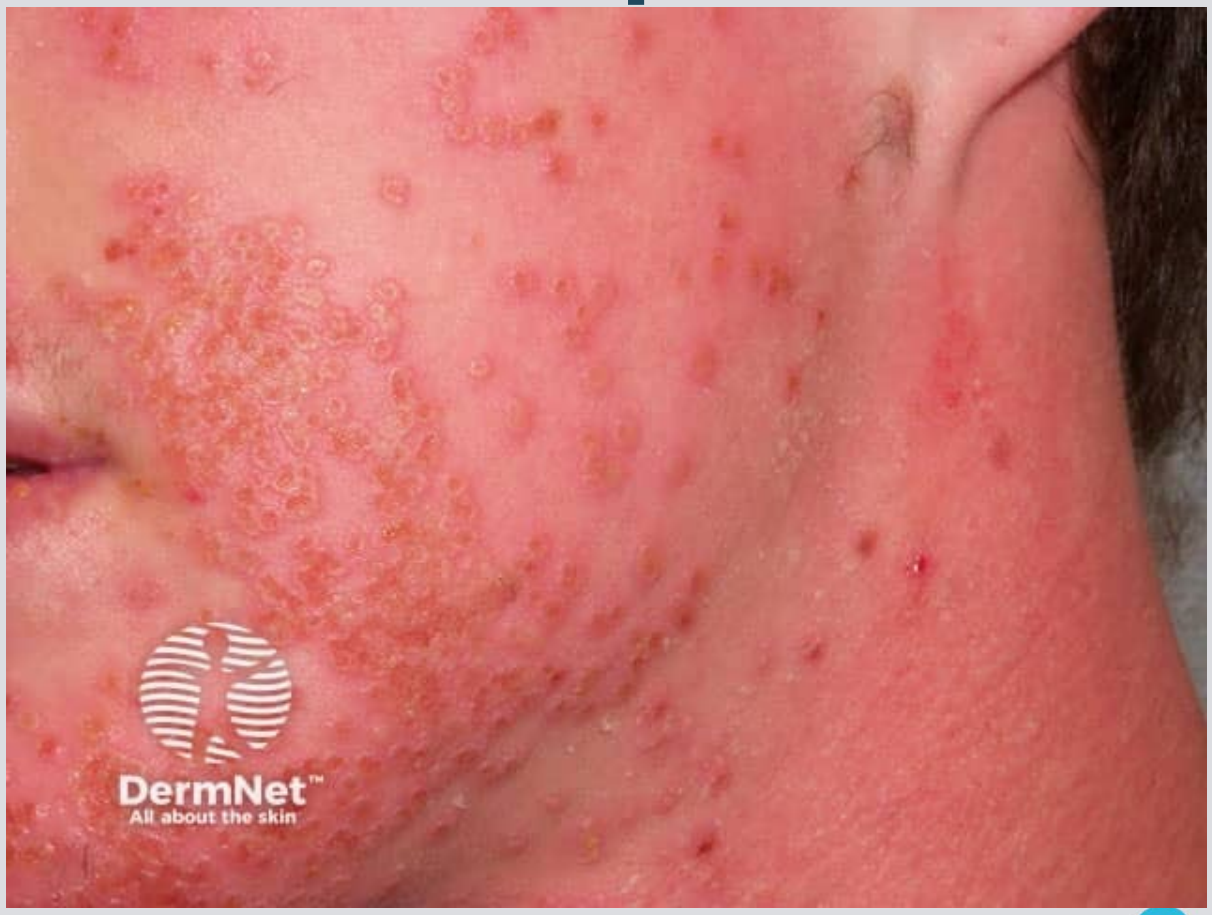
Bacterial Infection: Impetigo





Viral Infection: Eczema Herpeticum





- HSV
- Monomorphous

Management

Bathing

Dermnetnz.org

- **Bathing—limited data**
  - Infants—less often (2-4x/wk)
  - Adolescents/Adults—up to daily
  - No data to support bath vs shower
- **Bleach baths**
  - ¼-½ cup bleach in full bath
  - Soak 10 min, rinse

Emollients

- Immediately after bath or handwashing = key
- 2x/day
- Thick (cream, ointment)
- Fragrance free

Environmental/Food Allergens

- **Controversial**
- **Environmental**
  - Some patients benefit from immunotherapy
- **Food**
  - ~½ pediatric AD patients + skin prick tests
  - Low likelihood contribution to AD
  - Elimination diets do not help, not recommended

Contact Allergens

- **Increased risk of allergic & irritant CD**
- **Not responding to tx, pattern changed**
- **Ingredients in topical medications & personal care products**
  - Many are fragrance sensitive

Topical Therapy

- Topical **Steroids**
- Topical **Calcineurin Inhibitors**
- Topical **PDE4 Inhibitors**
- Topical **JAK Inhibitors**
- Topical **Aryl Hydrocarbon Receptor Agonists**

Topical Steroids

- **Low Potency:**
  - Hydrocortisone 1% & 2.5%, desonide 0.05%
- **Mid-Potency:**
  - Triamcinolone 0.1%, betamethasone valerate 0.1%
- **High Potency:**
  - Fluocinonide 0.05%
- **Ultra-High Potency:**
  - Clobetasol 0.05%, betamethasone dipropionate 0.05%

TCS: Potency Guidelines

ULTRA-HIGH POTENCY

- Palm, Sole, Scalp
- Thick plaques
- Extensor surfaces
- *NOT face, neck, body folds*

MID POTENCY

- Trunk, Arms, Legs
- Limited use in flexural (lichenified AD)
- *NOT face, neck, body folds*

LOW POTENCY

- Face, Eyelid, Genital, Neck
- Intertriginous
- Baby/Young Child
- Mild disease

Topical Formulations

- **Ointment**
  - Absorb best, dry/thick areas, soothing, but greasy/messy
- **Cream**
  - Can rub in, body folds, moisturizing, but increased risk of irritation/allergy
- **Lotion**
  - Easy to spread, limited options
- **Solution**
  - Good for scalp, easy to spread, limited options
- **Oil**
  - Good for scalp, easy to spread, limited options

TCS: Duration Guidelines

*Tailor to severity, taper as tolerated

ULTRA-HIGH POTENCY

< 4 weeks for thick, lichenified areas

MID POTENCY

- < 6-8 weeks for body areas
- (less for flexures)

LOW POTENCY

- < 2 weeks for sensitive areas

Clinical Pearl #5

Best formulation
=
One patient will use

**Ask!*

(we love ointments more than patients do)

Many AD Patients Are Undertreated

- Insufficient quantity of topical medication
- Limiting use of topical steroids to 2 weeks
- Moderate/Severe AD not on systemic therapy

Estimating TCS Quantity

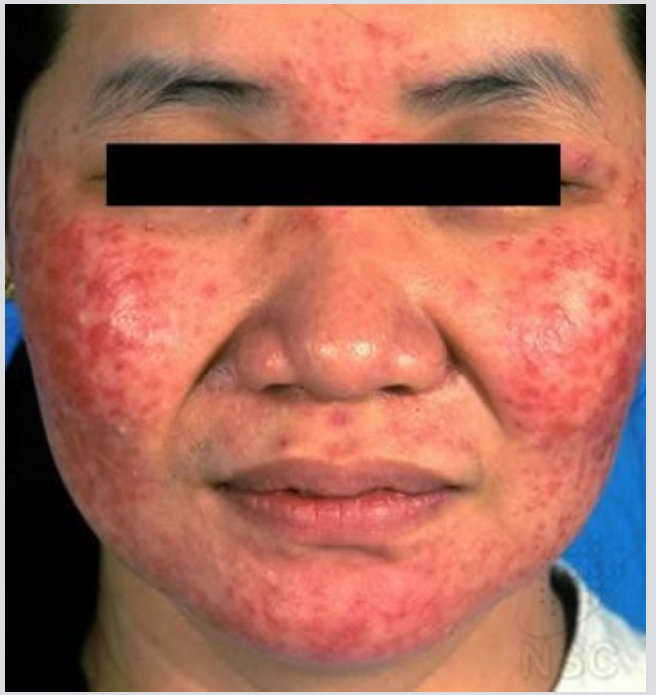
- **Estimate BSA involved**
- **Estimate quantity of TCS needed per day**
- **Fingertip Unit** (FTU) = 0.5 g
  - FTU = 0.5 gram
  - Covers 2% BSA (2 palms)

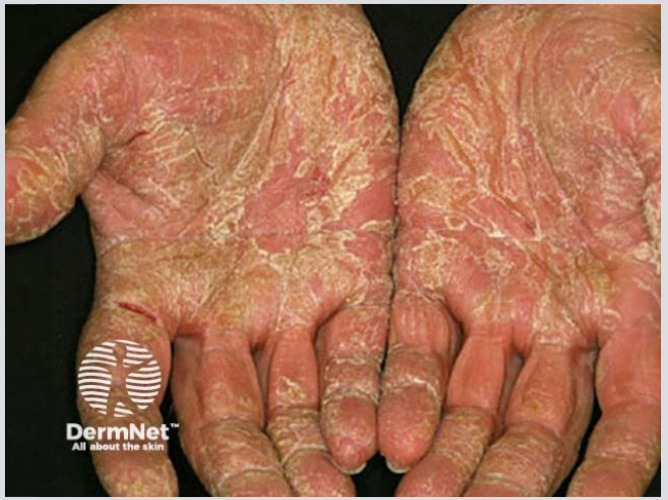
ConferMED™ Connecting Primary Care to the Future

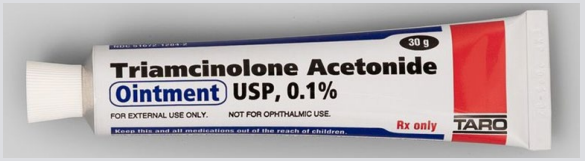
Quantity TCS for 2% BSA

- 2% BSA = 1 FTU per dose
- BID dosing = 2 FTU/day = 2 x 0.5g = 1 g/day
- 1 g/day x 30 days = **30 g**

- **30 g will also cover whole body once**

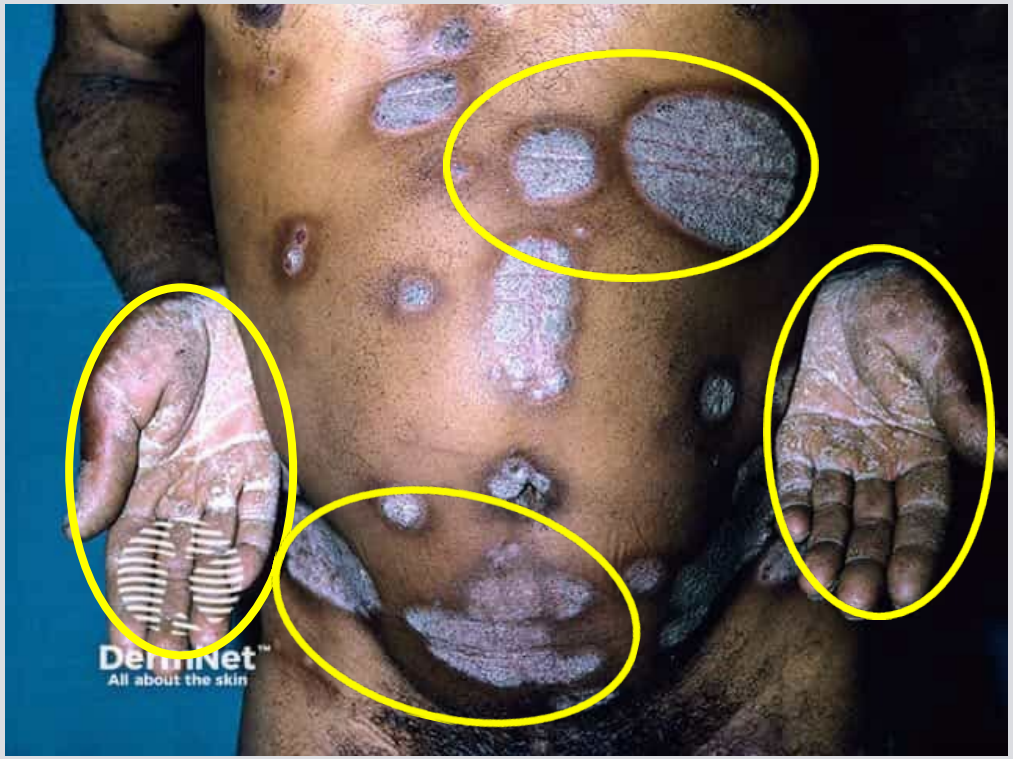


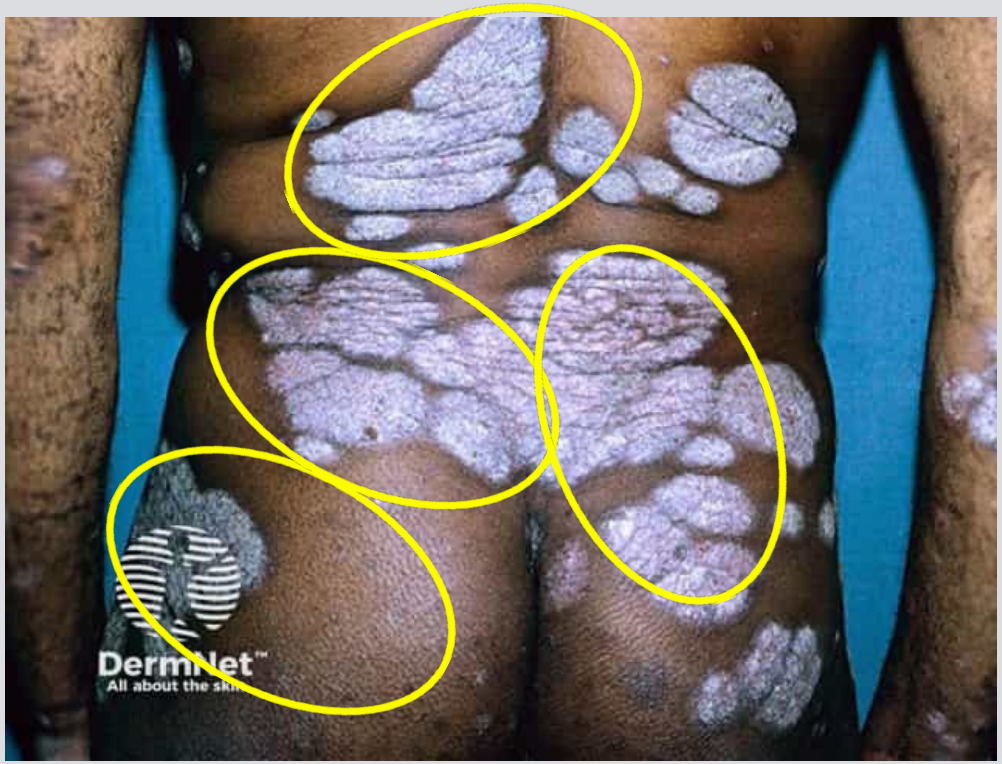




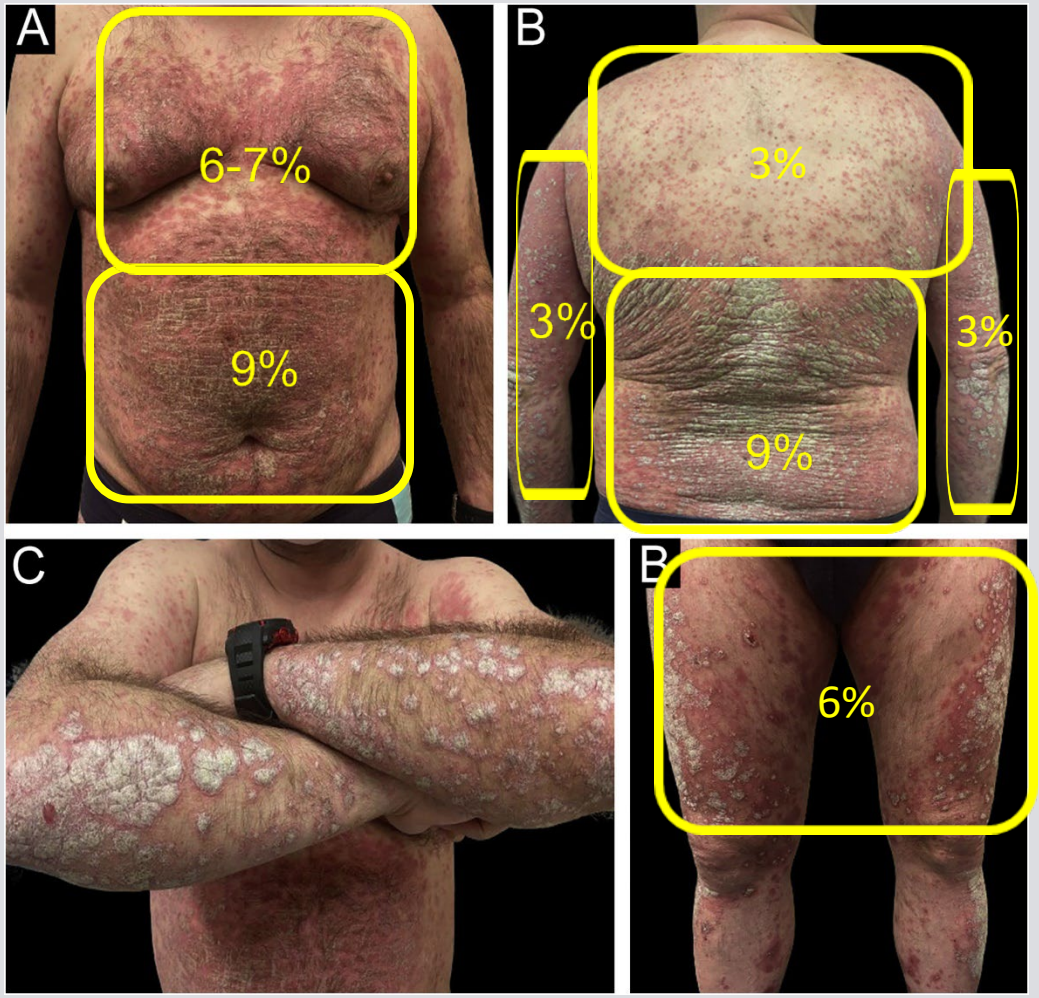
Quantity TCS for 8% BSA

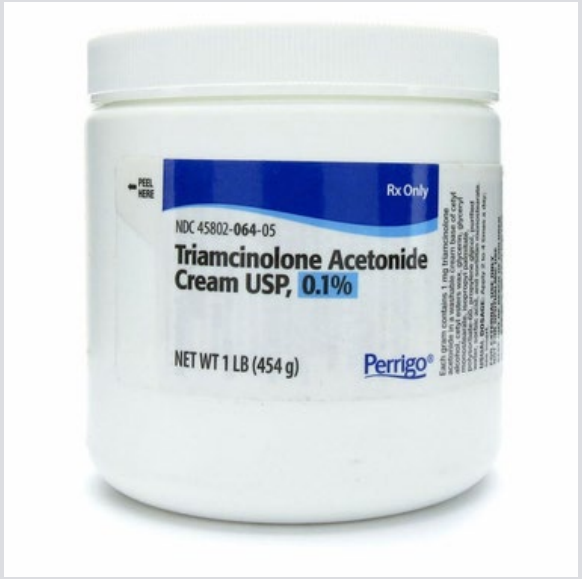
4 x 30 g = 120 g





Quantity TCS for Extensive Disease





TCS Quantity Guidelines

- **Mild/Limited disease**: 30-45 grams
- **Moderate disease**: 60-120 grams
- **Extensive disease**: 454 grams (1lb. jar)
  - Hydrocortisone 2.5%, triamcinolone 0.1%

TCS Quantity Guidelines

- **Mild/Limited disease**: 30-45 grams
- **Moderate disease**: 60-120 grams
- **Extensive disease**: 454 grams (1lb. jar)
  - Hydrocortisone 2.5%, triamcinolone 0.1%

ConferMED™ Connecting Primary Care to the Future

TCS Prescribing Tips

- Know 1-2 TCS at each potency level
- Know available tube/jar sizes
- Sufficient quantity
- Vehicle your patient will use
- Area-specific Rx instructions

Triamcinolone ointment 0.1%
80 g
BID prn to affected areas on body. Not for face, neck, body folds.

Hydrocortisone 2.5% cream
30 g
BID prn to affected areas on face and neck.

Maintenance Therapy Strategies

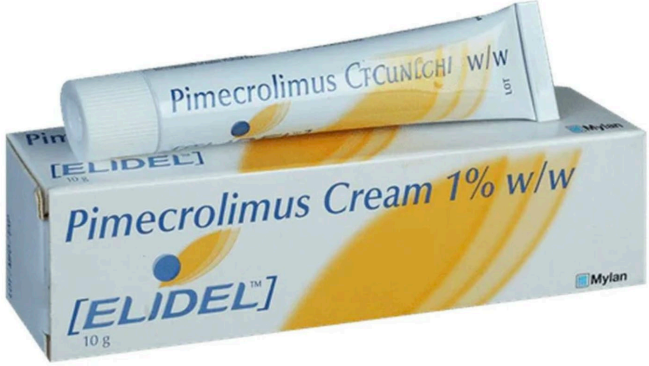
- **Cycle on/off PRN**
- **Intermittent TCS Dosing: 2-3 days/week**
- **Transition to nonsteroidal topicals**
- **Rotate TCS & nonsteroidal**
  - M-F nonsteroidal, Sat-Sun TCS
  - Rotate weeks

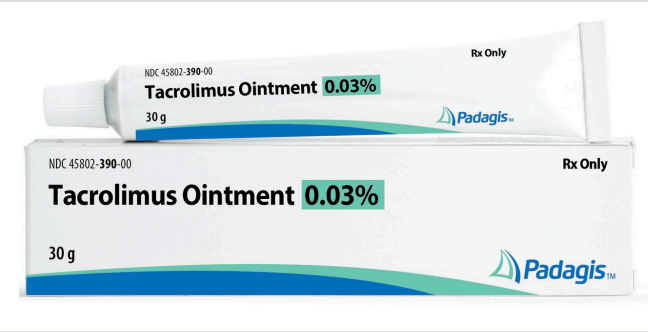
Nonsteroidal Topicals

- **Several Categories**
  - Calcineurin Inhibitors
  - PDE4 Inhibitors
  - Aryl Hydrocarbon Receptor Agonist
  - JAK Inhibitors
- **Most approved for children & adolescents**
- **Good for sensitive areas**

Topical Calcineurin Inhibitors

- **Pimecrolimus 1% cream**
  - Ages 2+ years
- **Tacrolimus 0.03% & 0.1% ointment**
  - 0.03% ages 2+ years
  - 0.1% ages 16+ years
- BID dosing
- Can burn or sting with initial applications
- Black box warning





Topical PDE4 Inhibitors

- **Eucrisa (crisaborole) 2% ointment**
  - Ages 3 mos+
  - BID dosing
  - Burning, stinging
- **Zoryve (roflumilast) 0.15% cream**
  - Ages 6+
  - QDay dosing

Topical JAK Inhibitors

- **Opzelura (ruxolitinib) 1.5% cream**
  - Ages 2+
  - BID dosing
  - Black box warning
- **Anzupgo (delgocitinib) 2% cream**
  - Ages 18+
  - Chronic Hand Eczema
  - BID dosing

Topical Aryl Hydrocarbon Receptor Agonist

- **VTAMA (tapinarof) 1% cream**
  - Ages 2+
  - QDay dosing

Systemic Treatment

- **Biologics (injectable)**
  - Dupixent (dupilumab) IL-4/13, ages 6 mos+
  - Adbry (tralokinumab) IL-13, ages 12+
  - Ebglyss (lebrikizumab) IL-13, ages 12+
  - Nemluvio (nemolizumab) IL-31, ages 12+

- **JAK Inhibitors (oral)**
  - Cibinqo (abrocitinib), ages 12+
  - Rinvoq (upadacitinib), ages 12+

Systemic Treatment: Traditional

- **Phototherapy**
- **Systemic Steroids**
  - Avoid if possible, risk of A/Es, risk of rebound
  - As a rescue, bridge to safer systemic therapy
  - Taper over 10-12 days
- **Immunosuppressants (Not FDA-approved for AD)**
  - Methotrexate
  - Cyclosporine
  - Mycophenolate mofetil
  - Azathioprine

Clinical Pearl #6

Oral Steroids

Avoid short tapers, such as the methylprednisolone packs

Often not enough
Too short
Rebound

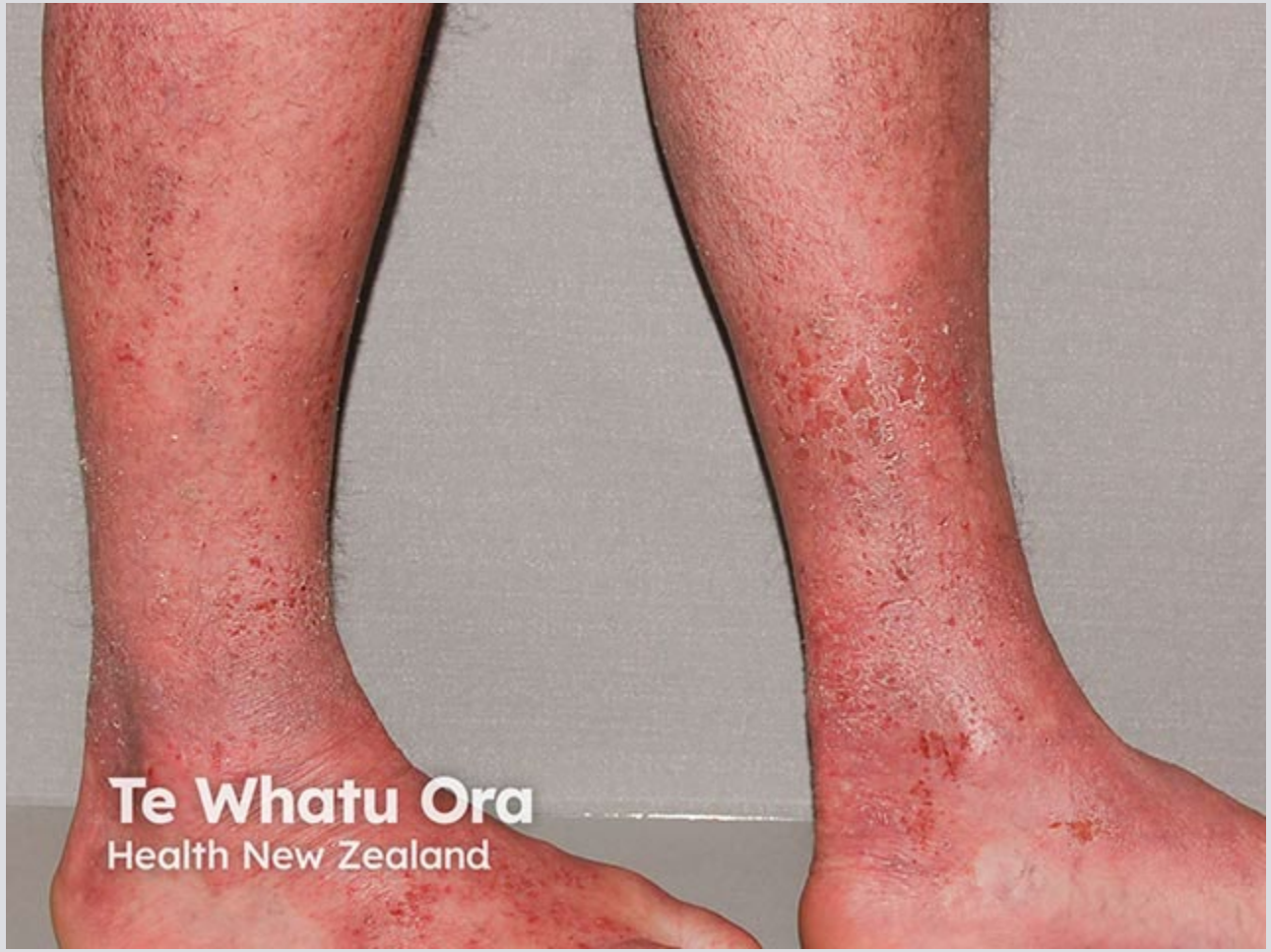
Case Studies

Case #1

45 year old man with history of eczema, now currently flaring.
Patient has multiple medical problems and takes over 10 medications a day.

Patient states he does not want another pill or injection.

What would be a reasonable treatment option?


Te Whatu Ora
Health New Zealand

Which is the best treatment option?

1) Fluocinonide 0.05% cream (120 g)
2) Methylprednisolone taper 6 days: 24 mg, 20mg, 16mg, 12mg, 8mg, 4mg
3) Hydrocortisone 2.5% lotion (60 ml)
4) Triamcinolone 0.1% ointment (15 g)

Which is the best treatment option?

1) Fluocinonide 0.05% cream (120 g)

2) Methylprednisolone taper 6 days: 24 mg, 20mg, 16mg, 12mg, 8mg, 4mg

3) Hydrocortisone 2.5% lotion (60 ml)

4) Triamcinolone 0.1% ointment (15 g)

Case #2

34 year old female
with new onset itchy rash on eyelids.
No new lotions, make up, or other facial products.

Does have a history of perioral dermatitis in the past.

Not active currently but she is getting married
in 4 weeks and does not want a flare up
of perioral dermatitis on her wedding.


DermNet™
All about the skin

Which is the best treatment option?

1) Clobetasol 0.05% cream (15 grams)
2) Pimecrolimus 1% cream (30 grams)
3) Hydrocortisone 2.5% cream (30 grams)
4) Dupilumab 600mg x 1, then 300mg every 2 weeks

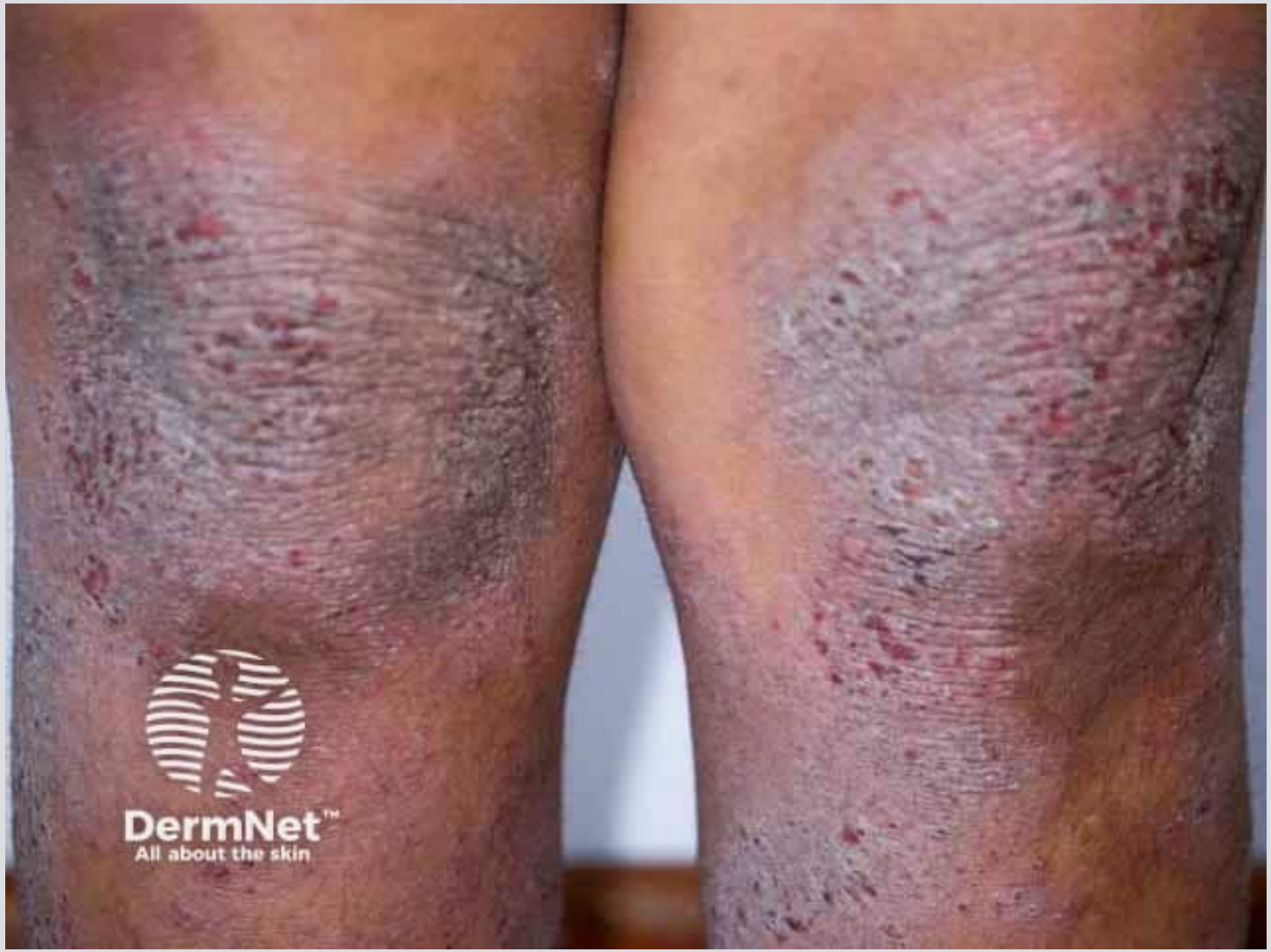
Which is the best treatment option?

1) Clobetasol 0.05% cream (15 grams)
2) Pimecrolimus 1% cream (30 grams)
3) Hydrocortisone 2.5% cream (30 grams)
4) Dupilumab 600mg x 1, then 300mg every 2 weeks

Case #3

25 year old male with longstanding rash on knees
Itches often.
Will scratch until his skin bleeds.

Has tried different topicals in the past
but they were too messy
and left “grease stains” on his clothes


DermNet™
All about the skin

Part 1 of 3 Part Question

What is the main skin finding present?

1) Lichenification

2) Crusting

3) Impetigo

Part 1 of 3 Part Question

What is the main skin finding present?

1) Lichenification

2) Crusting

3) Impetigo

Part 2 of 3 Part Question

Which is the best treatment option?

1) Clobetasol 0.05% ointment (15 g)
2) Triamcinolone 0.1% lotion (59 ml)
3) Fluocinonide 0.05% solution (60 ml)
4) Betamethasone dipropionate 0.05% cream (50 g)

Part 2 of 3 Part Question

Which is the best treatment option?

1) Clobetasol 0.05% ointment (15 g)

2) Triamcinolone 0.1% lotion (59 ml)

3) Fluocinonide 0.05% solution (60 ml)

4) Betamethasone dipropionate 0.05% cream (50 g)

Part 3 of 3 Part Question

What is a reasonable expectation for treatment duration?

1) Use for 2 weeks, then take 2 weeks off, and resume if needed
2) Given the chronicity of his rash, this may need regular treatment for 4-6 weeks or more
3) His eczema should clear in 10-14 days
4) If not better in 7 days, see dermatology

Part 3 of 3 Part Question

What is a reasonable expectation for treatment duration?

1) Use for 2 weeks, then take 2 weeks off, and resume if needed
2) Given the chronicity of his rash, this may need regular treatment for 4-6 weeks or more
3) His eczema should clear in 10-14 days
4) If not better in 7 days, see dermatology

Thank you!

Questions?