



SUBCORNEAL PUSTULAR DERMATOSIS

(Sneddon-Wilkinson Disease)

What are the aims of this leaflet?

This leaflet has been written to help you understand more about subcorneal pustular dermatosis. It tells you what this condition is, what it is caused by, what can be done about it, and where you can find out more about it.

What is subcorneal pustular dermatosis?

Subcorneal (under the top layer of the skin) pustular (pus forming) dermatosis (skin problem) is a relatively harmless blistering skin condition. Women develop it more often than men (at a ratio of 4:1), and it usually starts after the age of 40. It may come and go, and can eventually resolve and not require any further treatment.

Drs Ian Sneddon and Darrell Wilkinson first described the condition in 1956, which is why it is also called Sneddon-Wilkinson disease.

What causes subcorneal pustular dermatosis?

The cause of subcorneal pustular dermatosis is unknown. It is not infectious or contagious, and it is not cancerous. Most often it occurs on its own, but has been linked to a variety of other diseases, for example inflammatory bowel disease, arthritis, thyroid disease and blood disorders.

Is subcorneal pustular dermatosis hereditary?

No, subcorneal pustular dermatosis does not run in families.

What are the symptoms of subcorneal pustular dermatosis?

Subcorneal pustular dermatosis can be itchy or sore, but often does not cause any discomfort at all. Affected patients are usually well, and any other symptoms may prompt examination and investigation for an underlying disease.

What does subcorneal pustular dermatosis look like?

Any area of skin can be involved, although it is less common for forearms and lower legs to be affected. Skin folds under the breasts, underarm and the groin are common sites of involvement.

The skin condition can develop on areas of normal looking to red skin. Blisters develop quickly i.e. within hours. These become filled with pus, which is not linked to infection. A classic appearance is that of a '*half and half blister*', where the pus settles with gravity into the lower half of the blister. The blisters may be single or in clusters. The top comes off easily, and then a scab forms. When the skin heals, it is often slightly darker than before. This colour will very gradually fade over weeks to months, and scarring does not usually occur.

How is subcorneal pustular dermatosis diagnosed?

Sometimes the diagnosis is made just by looking at the skin, in particular if there are 'half and half blisters'. The diagnosis is not always easy, as other blistering conditions, reactions to medicines and also a form of psoriasis (pustular psoriasis) can look similar.

Often a small skin sample i.e. a punch biopsy needs to be taken under a local anaesthetics for histology to confirm the diagnosis.

Skin swabs or scrapings may be taken to rule out a skin infection, and blood tests to look for an underlying illness

Can subcorneal pustular dermatosis be cured?

Presently there is no cure, but subcorneal pustular dermatosis can usually be controlled with medication.

How can subcorneal pustular dermatosis be treated?

Subcorneal pustular dermatosis usually clears over a period of about 4 weeks when treated with a tablet called dapsone (see separate leaflet). Alternative tablets are sulphapyridine and sulphamethoxypryidazine. Often, intermittent treatment for months or years with a low dose is required to keep the skin clear.

Steroid creams or tablets may not clear the rash fully, other treatments, for example acitretin, colchicine, tetracycline antibiotics, immunosuppressive medication or biological treatments are sometimes helpful. Some patients respond to hospital treatment with ultra-violet light.

The potential side effects of these treatments needs to be carefully balanced against the impact of subcorneal pustular dermatosis, which is a relatively harmless condition.

Where can I get more information about subcorneal pustular dermatosis?

Web links to detailed leaflets:

<http://dermnetnz.org/scaly/subcorneal-pustulosis.html>

http://www.orpha.net/consor/cgi-bin/OC_Exp.php?lng=en&Expert=48377

For details of source materials used please contact the Clinical Standards Unit (clinicalstandards@bad.org.uk).

This leaflet aims to provide accurate information about the subject and is a consensus of the views held by representatives of the British Association of Dermatologists: individual patient circumstances may differ, which might alter both the advice and course of therapy given to you by your doctor.

This leaflet has been assessed for readability by the British Association of Dermatologists' Patient Information Lay Review Panel

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