DISCOID ECZEMA

What are the aims of this leaflet?

This leaflet has been written to help you understand more about discoid eczema. It tells you what it is, what can be done about it, and where you can find out more about it.

What is discoid eczema?

Eczema (also called dermatitis) is a term used to describe conditions where there is inflammation affecting mainly the outer layer of the skin (the epidermis). There are several different types of eczema, and in some cases the cause is known whilst in others it is not.

Discoid eczema is one type of eczema with characteristic round or oval red patches of inflamed skin. Discoid eczema is sometimes also called “nummular” eczema - nummular meaning coin-shaped and discoid meaning disc-shaped.

Discoid eczema is more common in men than women. Men tend to develop the skin condition over the age of 50, whilst women are more likely to develop it in their teens or twenties. It is rare in children; however, it can be seen in both sexes at any time of life.

What causes discoid eczema?

The cause of discoid eczema is unknown. Similar appearances of round or oval red patches of skin can occasionally occur in other types of eczema, including atopic eczema, allergic and irritant contact dermatitis, but these are not true discoid eczema.

Like other types of eczema, discoid eczema can be worsened by scratching, local infection, and dryness of the skin.

Is discoid eczema hereditary?

No, it cannot be inherited.

What are the features of discoid eczema?

- It is a highly inflamed type of eczema, and is typically extremely itchy.
- It is usually worse on the arms and legs, although it is uncommon on the face and scalp, but the whole body can be affected.
- Each patch begins as a small group of red spots and tiny bumps or blisters, which cluster together and grow rapidly into a red, swollen, sometimes moist, round patch. The appearance of discoid eczema may look similar to an infection, but it actually begins as a red inflamed itchy patch; however, it may become infected at a later stage. After a while the patches become dry and scaly.
- There may be several patches on each limb and on the body; most are between 1-3 cm in diameter, although they can be larger. Some patches may be a red circle with clear (normal) skin in the middle.
- If untreated, discoid eczema may persist for months or years, often worsening and improving, and sometimes coming back at the same sites each time.
- Patches may disappear without a trace, however in darker skin types, light or dark marks may persist for months.

How will it be diagnosed?

Discoid eczema is usually diagnosed by its typical round or oval appearance. Tests may be needed to rule out other conditions; for example, taking a skin biopsy (a procedure in which a sample of skin tissue from one of the patches is removed under local anaesthetic, processed, and examined under a microscope); patch tests (identifying whether a substance that comes in contact with the skin is causing inflammation of the skin (contact dermatitis); skin scraping (examination of skin scales for a fungal infection); swabs may be taken to check for a bacterial infection.

Can discoid eczema be cured?

No, treatments help to control the condition, but do not cure it. Whilst discoid eczema has been known to disappear for no apparent reason, there is no guarantee that it will not reoccur.

How can it be treated?

- Mild topical steroids are inadequate for discoid eczema. The mainstay of treatment is a potent or super potent steroid cream or ointment. This should be applied once or twice daily (depending on which topical steroid has been prescribed) to all affected areas, avoiding the surrounding normal skin, until the inflammation is completely suppressed. Treatment should be restarted at the first sign of recurrence.
- Other non-steroid creams such as tacrolimus ointment or pimecrolimus cream can be helpful.
- If infection occurs an antibiotic will be necessary, either as a combined preparation with the topical steroid or in tablet form.
- An emollient (moisturising) cream or ointment is essential if the surface of the chronic patches are dry and scaly; this should also be applied to unaffected skin, especially if it is dry. The emollient should be continued indefinitely, even after the patches have cleared and the steroid preparation has been discontinued. Soap substitutes may also be recommended.
- Occasionally, ultraviolet light treatment may be considered by your doctor. In more severe cases, courses of steroid tablets may be required, but this treatment is rare. Persistent and troublesome discoid eczema is occasionally treated with immunosuppressant medications such as methotrexate, azathioprine or ciclosporin.

CAUTION: This leaflet mentions 'emollients' (moisturisers). Emollients, creams, lotions and ointments contain oils which can catch fire. When emollient products get in contact with dressings, clothing, bed linen or hair, there is a danger that a naked flame or cigarette smoking could cause these to catch fire. To reduce the fire risk, patients using skincare or haircare products are advised to be very careful near naked flames to reduce the risk of clothing, hair or bedding catching fire. In particular smoking cigarettes should be avoided and being near people who are smoking or using naked flames, especially in bed. Candles may also risk fire. It is advisable to wash clothing daily which is in contact with emollients and bed linen regularly.

Where can I get more information about discoid eczema?

Web links to detailed leaflets:
http://dermnetnz.org/dermatitis/nummular-dermatitis.html

http://www.nhs.uk/conditions/Eczema-(discoid)

Links to patient support groups:

National Eczema Society
Hill House
Highgate Hill
London, N19 5NA
Web: www.eczema.org
Tel: 0800 089 1122

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

BRITISH ASSOCIATION OF DERMATOLOGISTS
PATIENT INFORMATION LEAFLET
PRODUCED DECEMBER 2006
UPDATED DECEMBER 2009, APRIL 2013, JUNE 2016
REVIEW DATE JUNE 2019