



HAND DERMATITIS / HAND ECZEMA

What are the aims of this leaflet?

This leaflet has been written to help you understand more about the causes and treatment of hand dermatitis.

What is hand dermatitis?

Hand dermatitis is also called hand eczema. It is common and can affect about one in every 20 people. It can start in childhood as part of an in-built tendency to eczema, but is commonest in working-age adults. Hand dermatitis may be a short-lived, mild problem. However, in some people it lasts for years in a severe form that can have a great impact on daily life and restrict someone's ability to work.

Who is most likely to get hand dermatitis?

People who have had eczema in childhood (atopic eczema) and those who work in jobs with frequent water contact (wet work) have a high risk of getting hand dermatitis.

What causes hand dermatitis?

In many people, hand dermatitis happens because of direct damage to the skin by **harsh chemicals or irritants**, especially soap, detergent and repeated contact with water. This is called irritant contact dermatitis.

Skin contact with allergens such as perfumes, rubber or leather can also cause dermatitis in people with an allergy to these substances. This is called allergic contact dermatitis.

In many cases, however, the cause of hand dermatitis is **unknown**, and there is no trigger. It is also common for someone to have more than one cause of their hand dermatitis, for example a combination of in-built and irritant contact dermatitis.

Is hand dermatitis hereditary?

No, it is not hereditary; however the tendency to get hand dermatitis can run in families along with childhood eczema, asthma and hay fever.

What are the symptoms of hand dermatitis?

Like other forms of dermatitis, the affected areas of skin feel hot, sore, rough, scaly and itchy. There may be itchy little bubbles or painful cracks.

What does hand dermatitis look like?

In hand dermatitis, the skin is inflamed, red and swollen, with a damaged dried out surface which makes it look flaky. There may be cracked areas that bleed and ooze. Sometimes small water blisters can be seen on the palms or sides of the fingers. Different parts of the hand can be affected such as the finger webs, fleshy finger pulps or centre of the palms. There are several different patterns of hand dermatitis, but these do not usually tell us its cause and the pattern can change over time in one person.

Hand dermatitis may get infected with bacteria called Staphylococcus or Streptococcus. This causes more redness, soreness, crusting, oozing and spots or pimples.

How is hand dermatitis diagnosed?

Diagnosing hand dermatitis is done by carefully examining the skin. Examining the feet and other body areas will show if it is part of a more widespread skin complaint.

Patch tests are important in finding out if allergic contact dermatitis has helped cause a person's hand dermatitis. The tests are done over several days and at the end need to be read by an expert. Most adults are tested for about 50 common allergies. If someone also handles unusual chemicals at work or during hobbies they may need extra tests put on.

Can other skin complaints look like hand dermatitis?

Psoriasis of the hands can look similar to dermatitis, especially when there are thick, scaly patches on the palms. Ringworm or fungus infection also causes itchy scaly rashes. These usually start on the feet or groin, but can spread to the hands and nails. Skin samples from affected areas can be sent for fungal analysis (mycology) if this needs to be ruled out.

Which occupations often cause hand dermatitis?

Occupations with a high chance of hand dermatitis include cleaners, carers, people who look after young children, chefs, hairdressers, mechanics, surgeons, dentists, nurses, florists, machine operators, aromatherapists, beauticians, and construction workers. Any job which involves repeated contact with water or hand washing more than 10 times a day ('wet work') has an increased chance of causing hand dermatitis.

Can hand dermatitis be cured?

In most cases, treatment controls the condition but does not cure it. Getting effective treatment early may avoid it turning into a chronic complaint. In people with allergic contact dermatitis, avoiding the allergen(s) may help or even clear the hand dermatitis.

How can hand dermatitis be treated?

Moisturisers (emollients) are an essential part of treating hand dermatitis. They help repair the damaged outer skin and lock moisture inside the skin making it soft and supple again. They should be applied repeatedly throughout the day and whenever the skin feels dry.

CAUTION: This leaflet mentions 'emollients' (moisturisers). When paraffin-containing 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 paraffin-containing skincare or haircare products are advised to avoid naked flames completely, including smoking cigarettes and being near people who are smoking or using naked flames. It is also advisable to wash clothing and bed linen regularly, preferably daily.

Soap substitutes are very important as they clean the skin without drying and damaging it like liquid soap and bar soap can.

Steroid creams and ointments are the commonest prescribed treatment for hand dermatitis. They relieve symptoms and calm inflamed skin. Stronger strength steroids are usually needed as mild steroids (1% hydrocortisone) do not work on thick skin. They are applied up to twice a day. When used as suggested by your doctor or nurse topical steroids do not cause problems. If they are over-used, there is a risk of skin thinning so they should be stopped once the dermatitis has settled.

Antihistamine tablets are not always helpful in hand dermatitis. Sedating antihistamines cause drowsiness and can help you sleep.

Potassium permanganate soaks can be useful in severe blistering hand dermatitis to dry the blisters and prevent bacterial infection. (See [BAD leaflet](#))

Topical Calcineurin inhibitors are prescribed as creams and ointments to treat dermatitis instead of steroids. While they may work less well than strong steroids, they do not carry any risk of skin thinning. They can often cause burning or itching after application.

Ultraviolet (UV) Therapy is a hospital-based treatment for very severe hand dermatitis. It involves visiting hospital for treatment two or three times a week for about six weeks.

Steroid tablets may be given for a few weeks for a severe flare of hand dermatitis. The dose is usually decreased gradually over a few weeks. Longer-term use is not advisable due to the side effects.

Alitretinoin is based on vitamin A and is prescribed by specialists for severe chronic hand dermatitis. A treatment course usually lasts up to 6 months. It must never be taken during pregnancy.

Systemic immunosuppressants are powerful treatments sometimes prescribed by specialists to treat severe hand dermatitis. These are usually given to people who have had an organ transplant and include azathioprine, ciclosporin and methotrexate. People taking these tablets need to be watched carefully and have regular blood tests.

Preventing hand dermatitis – what can I do?

Always use protective gloves at work and at home when in contact with irritating chemicals and water. Wear cotton gloves underneath or choose cotton-lined gloves if you have to work for longer.

The best choice of glove material (rubber, PVC, nitrile etc) will depend on which chemicals or allergens are being handled. Gloves should be clean and dry inside and not broken.

If gloves cannot be worn, a barrier cream should be applied before exposure to irritants. After exposure, wash the hands carefully with a soap substitute, rinse, dry thoroughly then moisturise.

The BAD has a leaflet on [How to care for your hands](#).

Where can I get more information about hand dermatitis?

Health and Safety Executive website: www.hse.gov.uk/food/dermatitis.htm

For details of source materials 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 SEPTEMBER 2012
UPDATED JANUARY 2016
REVIEW DATE JANUARY 2019**

