Itch in the Elderly – handout version

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Elderly Skin

• Is drier

• Is Thinner

• Is more fragile

• More likely to itch
Causes of itchy elderly skin

• Primary rashes, e.g. eczema or psoriasis

• Metabolic disorder

• Result of mental state

• Medicament related

• Unknown cause
Primary Rashes

- **Eczema** is the commonest itchy rash - atopic, irritant, gravitational, asteatotic or discoid

After that in approximate order

- Psoriasis
- Urticaria
- Fungal
- Scabies
- Lichen Planus
- Rare causes - Bullous pemphigoid, pemphigus, dermatitis herpetiformis, lichen planus, cutaneous lymphoma
How to sort out the cause

• History – general/dermatological

• Examination

• Tests, including therapeutic trials
History

• Past history of skin disease

• Any new drugs started recently?

• Any over the counter Rx?

• Any complementary/alternative therapies?

• What are you using on the skin?

• Does anyone else in the house also itch?
Specific History of the Itch

• When did the itch start?

• Where does it itch?

• When does it itch? All day/at night/when warm

• Anything make it worse? Heat/Bathing?
Causes in the Elderly

• 20% about have a Dermatosis

• 30% Metabolic Causes

• Approximately 50% Idiopathic
Metabolic Causes

In the elderly 30% can have a metabolic cause

– Iron Deficiency
– Thyroid problems
– Cholestasis
– Renal failure
– Polycythaemia
– Lymphoma
– Paraneoplastic – due to cancer somewhere
Investigations

• Clinical exam
• LFTs
• U and E
• FBC
• Ferritin
• TSH
• CXR
• Urinary dipstix
Examination

- General examination
  - Dry skin
  - Rash or just excoriations
  - Butterfly sign
  - Weight loss
  - Signs of burrows – scabies
  - Mouth
  - Nails
  - Genitalia
Secondary Features of Itch

- Excoriations
- Papular / Nodular lichenification
- Shiny Nails
- Secondary Infection
- Hyperpigmentation
- Healing Scars
- Butterfly sign
Eczema Treatment

• Avoid Soap

• Treat infection

• Plenty moisturisers

• Topical steroids
Crusted (‘Norwegian’) Scabies

• A severe form of scabies
• Thousands of mites are present
• Due to poor immune system, and neurological diseases
• Very contagious
• Epidemics in nursing homes
• Oral Ivermectin
Cellulitis

- **One sided** red hot swollen area
- Can be ill with rigors
- Comes on quickly
- CRP raised, White count raised
- Temperature
Lipodermatosclerosis

• Lipodermatosclerosis is a disease of the lower legs caused by venous insufficiency

• It produces dark woody feeling skin

• Is often mistaken for cellulitis

• Can lead to champagne bottle deformity of the leg
Allergic contact dermatitis

• Allergy to a substance which contacts the skin

• Can be sorted out with patch testing

• On the legs topical creams, support stockings, dressings, topical steroids, antiseptics can all cause contact dermatitis
Irritant Contact Dermatitis

- Irritants include such everyday things - water, soaps, detergents, antiseptics, topical creams and friction
- The eczema is often well demarcated with a glazed surface
- Patch tests may be needed to rule out allergic contact dermatitis
Nicorandil

- K+ channel opener for angina
- Severe perianal ulcers. Also peristomal, perivulval
- Mouth ulcers
- Leg ulcers
- Ulcers and fistulae formation
- On average starts **2 years** after therapy (5-66 months)
- Mean dose 60 mg (40-120 mg a day)
- Healing within 12 weeks of discontinuation (2-16 weeks)
- ? Vascular steal
- Oral ulcers reported as low as 10mg a day
- SPC lists is an rare side effect but often not recognised
Aqueous Cream

• Never meant as a leave on cream

• Is a wash product only

• Not a good moisturiser

• Does sting many people (sodium lauryl sulphate)

• Can exacerbate eczema
Treat Infection

• Swab

• Most likely
  – Strep
  – Staph

• Can be both
Management 1

• Correct low humidity
• Avoid synthetic fabrics
• Pare nails
• Avoid excessive or over hot bathing
• Soap substitutes and good moisturisers
• Topical steroids
• Gate out itch with 1% menthol in a moisturiser - Dermacool®
• Support hose/Tubigrip/Flight socks
# Moisturisers

<table>
<thead>
<tr>
<th>Part</th>
<th>Amount (g)</th>
<th>Volume (mls)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>15-30</td>
<td>100</td>
</tr>
<tr>
<td>Both Hands</td>
<td>25-50</td>
<td>200</td>
</tr>
<tr>
<td>Scalp</td>
<td>50-100</td>
<td>200</td>
</tr>
<tr>
<td><strong>Both Arms or legs</strong></td>
<td><strong>100-200</strong></td>
<td><strong>200</strong></td>
</tr>
<tr>
<td>Trunk</td>
<td>400</td>
<td>500</td>
</tr>
<tr>
<td>Groins and genitalia</td>
<td>15-25</td>
<td>100</td>
</tr>
<tr>
<td><strong>Whole body</strong></td>
<td><strong>605 - 805</strong></td>
<td><strong>1300</strong></td>
</tr>
</tbody>
</table>

This is BD use for an adult for 1 week from BNF Section 13.
Topical Steroids

- Don’t be frightened of stronger topical steroids
- Give big enough tubes AND permission to use enthusiastically for 2-3 weeks
- Also stronger topical steroids will switch off itch
- Topical steroids MUCH SAFER than oral steroids
Management 2

• Topical Steroids if skin inflamed
• Occlusive Bandages
• Antihistamines if dermographic/urticarial
• Systemic sedative antihistamines at night
• Revisit things
• Explore physical /cognitive
• Review medication including OTC
• Avoid Polypharmacy
Less common things do occur

- Bullous pemphigoid
- Lichen planus
- Pemphigus
- Dermatitis herpetiformis
- Cutaneous lymphoma
Pemphigoid

- Characterised by bullae, scabs and erosions
- No oral lesions
- Blisters lower in epidermis, hence large, tense blisters
- Refer by telephone

Pemphigus

- Less common than pemphigoid, more severe
- Blisters occurs higher in the epidermis, hence smaller burst easily
- Often see just erosions no blisters
- Oral lesions
Lichen Planus

- Intensely itchy mauve, flat topped papules with Wickham's striae
- Classic sites - flexor aspect of wrists and lower back
- Look for oral and genital lesions
- 50% have buccal involvement
- Favours scar sites (Koebner phenomenon)
- Undressing the whole patient is very useful in LP since typical lesions may be scattered
Summary

- In generalised Pruritus with itch/scratch damage with complete sparing of the areas not accessible to the patients hands suggests that the rash is due to **scratching** rather than a primary skin disease.

- Most widespread pruritus is due to a dermatosis rather than to systemic disease.
Tips

• In generalised pruritus with no rash look for skin dryness, dermographia and subtle scabies before investigating systemic cause

• Common things are common, but rare things still occur

• Whatever the problem emollients and moisturisers will give some relief while you are sorting out the cause