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Chronic Hand Eczema: Guideline-Based Strategies for Diagnosis and Management

Announcer:
You're listening to *DermConsult* on ReachMD, and this episode is sponsored by LEO Pharma Inc. Please note that this episode was recorded *before* delgocitinib was approved by the FDA. And now, here's your host, Dr. Charles Turck.

Dr. Turck:
This is *DermConsult* on ReachMD, and I'm Dr. Charles Turck. Joining me today to review the latest guidelines for diagnosing and treating chronic hand eczema is Dr. Raj Chovatiya. He's an Associate Professor at the Rosalind Franklin University Chicago Medical School as well as the Founder and Director of the Center for Medical Dermatology and Immunology Research in Chicago. He's also one of our very own *DermConsult* hosts. Dr. Chovatiya, welcome to the program.

Dr. Chovatiya:
Thank you so much for having me. Always fun to be on this side.

Dr. Turck:
Well, why don't we start with the big picture, Dr. Chovatiya. Chronic hand eczema, which is defined as eczema of the hands that persists longer than 3 months or recurs at least twice a year, presents a significant burden for patients and clinicians alike. So how are current guidelines, both in the US and internationally, shaping clinical practice today?

Dr. Chovatiya:
It's a great question. And with chronic hand eczema, I like to say that there is definitely a huge body of work and research and focus outside of the US, and frankly, that's been more of a driving feature and factor in our understanding of the disease than even what's happened in the US itself. Chronic hand eczema as an entity has so heavily been researched and understood through the lens of an occupational disease in Europe, and thus, a lot of years of research have gone on to really understanding how we diagnose it, how we characterize it, and how we approach treatment.

It's a bit of a newer entity in the United States, in part because we are very much splitters when it comes to chronic hand eczema, and so very much in our dermatology training and my training—which wasn't that long ago, but is pretty similar—is that people try to think about chronic hand eczema as either atopic dermatitis or irritant contact dermatitis or allergic contact dermatitis, or protein contact dermatitis or contact urticaria. And thus, historically, our approaches have often been very individual to those different disease elements. And what we've learned is that this is actually a heterogeneous, multifactorial, multi-etiology disease, meaning that most people are going to actually have a combination of each of these different entities. So it's really hard to dissociate in true, real-world practice when somebody has driving features of both contact dermatitis and atopic dermatitis. And for that reason, there's been an effort to really try to have treatment approaches and guidelines that reflect that.

So at least out of the United States, there was always a big emphasis, let's say, on diagnostics, and this includes things like patch testing for allergic contact dermatitis before thinking about treatment. And outside of the US, there is one approved treatment, historically, which was alitretinoin, an oral medication, and more recently, delgocitinib, a topical medication. In the United States, we've never really had approved treatments for chronic hand eczema in that sense, and so our guidelines have always been somewhat incomplete and largely based on using broad-acting topical therapies like corticosteroids and calcineurin inhibitors, and then stepping up to a variety of systemic agents that may or may not potentially have good utility and safety for this particular disease state.

Bottom line: a lot of hurdles we still have to overcome, but a lot of steps finally in the right direction now that in the United States, we're

really recognizing chronic hand eczema as a singular entity.

Dr. Turck:
Now, when it comes to diagnosing chronic hand eczema, the European and North American guidelines differ on routine patch testing. For instance, the European Society of Contact Dermatitis guidelines recommend routine patch testing in all patients who have hand eczema for at least 3 months, but the North American Contact Dermatitis Group recommends reserving patch testing for patients who don't respond to treatment or patients who are suspected of having allergic contact dermatitis. So my question for you is, why is there so much debate about using patch testing to diagnose chronic hand eczema? And how can we navigate this in clinical practice?

Dr. Chovatiya:
It's funny, whenever the idea of allergic contact dermatitis and patch testing comes up with chronic hand eczema, you can definitely ignite some passions among people in the room depending on how strongly they feel about this being a mandatory requirement for diagnosis before treatment or one that's a little more targeted. I tend to fall a little more on the individualized treatment strategy approach. And we recently even published our views on this in terms of trying to understand how patch testing should be selectively incorporated for patients with chronic hand eczema.

As I mentioned, chronic hand eczema is typically usually multifactorial in terms of its etiologic subtypes, meaning that number one, it's oftentimes not purely driven by allergic contact dermatitis, if that is one of the components of the disease. But also, if somebody was to have a positive patch test with a relevant allergen, it doesn't necessarily guarantee that they would be able to remove that from their life, especially if it's related to their work, or even if we were able to try to avoid that particular contactant, they still may continue to have symptoms. So even patch testing, finding a positive element may not necessarily change the overall course of disease itself, and eventually, you end up having to treat no matter what.

So what we feel is that patch testing should really be selectively applied to the scenarios where it seems like there is a clear trigger that is repetitively causing a very similar phenomenon, whether it seems like this is something directly related to occupation. There are certain groups that oftentimes have a high risk for these things, and in those individuals, it makes sense to think about patch testing.

Broad use of patch testing is complicated for another reason beyond the medicine itself—just the overall burden of patch testing. Especially in the United States, not everybody offers patch testing in their clinic, and they could often just be long waits for patients. And so what ends up happening is that patients oftentimes get lost to care, or they have to suffer with their symptoms for a long period of time; perhaps they have to travel a long distance to actually find somebody.

So what we probably need to be thinking about is making sure that for patients where patch testing is still definitely appropriate, number one, not withholding therapy in those patients and really trying to help improve the signs and symptoms of their disease, hopefully with newer and emerging topical therapies, but then also getting them the patch testing they might need as well.

So I think bottom line, I don't want anyone to walk away with saying, ‘Dr. Chovatiya is saying patch testing is useless,’ which it's not—it has a very important role. But rather, I think we just need to be smart, targeted, and directed about finding the exact right patients where patch testing would be important, but also making sure, even if that is an appropriate diagnostic, those patients are not withheld therapy, and you still continue forward with trying to help the symptoms of their disease.

Dr. Turck:
For those just tuning in, you're listening to *DermConsult* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Raj Chovatiya about how we can manage chronic hand eczema based on the latest guidelines.

Now, if we switch gears and zero in on treatment, Dr. Chovatiya, topical corticosteroids remain a cornerstone of our approach in the first-line setting. So how do you typically initiate them and guide patients on their use and safety?

Dr. Chovatiya:
Topical corticosteroids are a widely utilized therapy in the world of dermatology and highly effective for patients with chronic inflammatory skin diseases. And frankly, it's all we had for a number of years when it comes to thinking about topical options.

Given that, we know a lot more about topical corticosteroids now than we did 50 years ago. We're starting to see a shift and an appropriate dialog around appropriate use of topical corticosteroids to really try to limit some of the known cutaneous and systemic side effects that we can see with these medications—systemic of course being related to long-term absorption of corticosteroids and cutaneous being everything from thinning of the skin, atrophy, loss of subcutaneous fat, and even dyspigmentation, which can really create an undue burden in our patients with darker-toned skin.

So I try to be very intentional in my discussion with my patients, and I talk through them about the ‘why’ in which we're choosing a topical corticosteroid, what they're designed for, and what the limitation is. So I ask my patients to do a really good job of tracking their use and

seeing if it's something that they have to use every single day, twice a day, for weeks in a row, or something that they just need to intermittently use, or something that they use occasional bursts of. And when you start to piece the puzzle together this way, you get a pretty good idea if somebody is using this appropriately as an acute and intermittent therapy or is really requiring regular chronic use. And if regular chronic use is being required, that's when we escalate the discussion to talking about some of our alternatives for topical corticosteroids.

Dr. Turck:
Now, topical corticosteroids might not work for everyone. Some patients don't respond, can't tolerate them, or simply don't want to try them due to side effect concerns. In those instances, what other topical therapies do you turn to, and how do you decide among them?

Dr. Chovatiya:
Your options become more and more limited when you have to pass through topical corticosteroids. But again, we're living in a very different era now than we did previously.

So topical calcineurin inhibitors are one place which we typically turn to, and this includes things like tacrolimus and pimecrolimus ointment and cream that can be helpful. They have limitations in terms of potency. There's also adverse effects and tolerability issues and boxed warnings that sometimes can limit their use as well for patients. But this is one that's gained a lot of use over the past couple of decades.

Beyond that, in recent times, we've seen a boom of developments of topical therapies, mainly for atopic dermatitis, but then also for psoriasis as well, that are targeted for various elements of the immune pathway that are important in their disease states. So crisaborole ointment, a phosphodiesterase-4 inhibitor, sort of a first-generation one, was one of our first approved options. Again, in the case of chronic hand eczema, it may be a little more useful for the atopic subtypes, not necessarily a broad general medication to use there.

And then in terms of our more recently approved ones, we have roflumilast, a next-generation PDE-4 inhibitor, tapinarof, an aryl hydrocarbon receptor modulator, and ruxolitinib, a JAK1/2 inhibitor. And these are all again approved for atopic dermatitis and helpful in cases where atopic hand eczema might be driving the disease state itself. And they’re very, very safe.

But again, it really highlights a limitation that we've faced in that with chronic hand eczema, you're dealing with a multifactorial, multiple etiology-driven disease, one that has T-cell-mediated immunity across multiple subsets, and thus you need something appropriately broad, but then also something that is going to be targeted and selective. And so we've seen approval outside of the United States for a medication called delgocitinib, which is a pan-JAK inhibitor, one that we're hoping to eventually have approved in the United States as well. And that's one that tries to leverage this idea of really being broader but also being selective as well.

Dr. Turck:
And if we look beyond these topical treatments, what alternative therapies do you consider for patients with more severe or persistent chronic hand eczema?

Dr. Chovatiya:
With persistent and severe chronic hand eczema, we oftentimes have to think about an off-label approach with systemic therapies. And this is always a tough discussion with patients because then you sort of have to debate the pluses and minuses of going with a medication that might be stronger but also have more risk of side effects for a relatively limited amount of body surface area. And for somebody that is simply just dealing with involvement of their hands, they might be totally on board with taking that next step, given that it can cause a lot of quality-of-life impact for patients that are dealing with bad chronic hand eczema.

Historically, our oral immunosuppressants—things like cyclosporine, methotrexate, mycophenolate mofetil, or even shorter courses of prednisone—were ones that we had to lean on. These days, we have targeted therapies for, again, atopic dermatitis. And while they sort of address some of the dysregulation we think about that is more atopic driven, I have to again emphasize that this is a key limitation of our systemic therapies too. They're great for atopic dermatitis, but they aren't necessarily medications that are designed for the heterogeneous T-cell activation that we see in chronic hand eczema. But in the absence of other therapies, oftentimes, this is really the safest approach we can take for systemic therapies.

Dr. Turck:
Now, before we close, Dr. Chovatiya, it's my understanding that a consensus article written by an expert panel is in development. So can you tell us what you’re hoping to see in that publication and how it might influence our approach to managing chronic hand eczema?

Dr. Chovatiya:
When it comes to putting together a consensus publication that really highlights how we should be approaching chronic hand eczema,

there's a few things that I really want to see. One is an acknowledgement of—albeit the importance of—topical corticosteroids, but there are limitations on being chronic therapy for our patients. So I really want to see an emphasis and move forward to targeted novel topical therapies for patients with chronic hand eczema and really making sure our patients are getting away from medications that were designed for more acute use.

Personally, based on writing that myself and others have done, the other thing that I really want to also see as well is a big understanding of some of the benefits but limitations of our diagnostic approaches to this disease state—namely patch testing. I think we all need to make a concerted effort to understand that patch testing should be selectively applied to the right patients, as opposed to a tool utilized to stop patients from getting to appropriate therapy.

Finally, I want individuals to really understand that chronic hand eczema is a highly multifactorial disease that you're not going to necessarily be dissociating every single etiology that's driving it, and thus there are inherent limitations to many of our systemic therapies that might be more appropriate for some subtypes versus another, and hopefully highlighting the fact that we really need more therapeutic development in this area.

Dr. Turck:
Well, I look forward to seeing what's included in that consensus article. But for now, I want to thank my guest, Dr. Raj Chovatiya, for sharing his insights on the latest guidelines for managing chronic hand eczema. Dr. Chovatiya, it was great having you on the program.

Dr. Chovatiya:
Thanks so much. It was my pleasure.

Announcer:
This episode of *DermConsult* was sponsored by LEO Pharma Inc. To access this and other episodes in our series, visit *DermConsult* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!