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Distinguishing Chronic Hand Eczema from Hand Atopic Dermatitis

Announcer:
You're listening to *DermConsult* on ReachMD. This episode is sponsored by LEO Pharma. And now, here's your host, Dr. Shelina Ramnarine.

Dr. Ramnarine:
This is *DermConsult* on ReachMD. I'm Dr. Shelina Ramnarine, and joining me to explore how we can distinguish chronic hand eczema from hand atopic dermatitis in clinical practice is Dr. Christopher Bunick, Associate Professor of Dermatology at Yale University School of Medicine in New Haven, Connecticut.

Dr. Bunick, thanks for being here.

Dr. Bunick:
Thank you so much for having me.

Dr. Ramnarine:
Let's start with the big picture, Dr. Bunick. Hand atopic dermatitis and chronic hand eczema can look remarkably similar on exam, yet they're distinct conditions with different underlying drivers. Why is it so important clinically to recognize which one you're dealing with?

Dr. Bunick:
Well, I first want to talk about chronic hand eczema as an umbrella term. So one type of chronic hand eczema is hand atopic dermatitis, and then there's several others that qualify as types of chronic hand eczema. It is very important to distinguish hand atopic dermatitis from other causes of chronic hand eczema because ultimately it helps drive treatment decisions and behavioral modification decisions. And ultimately, in terms of trying to get the patient better, if you don't really understand what they have, it can be problematic.

The trick for the clinician, however, is that when you deal with chronic hand eczema, over half the patients, based on some studies, have more than one type of chronic hand eczema. Therefore, you could have hand atopic dermatitis plus something else. And we know that the skin barrier breakdown of atopic dermatitis patients predisposes them to things like irritant or allergic contact dermatitis. And this is where treating chronic hand eczema is so complicated, because you often have more than one type, and they often do look similar. You can't always tell them apart just by looking at the hands.

Dr. Ramnarine:
And when it comes to hand atopic dermatitis, we're generally talking about Th2-dominant inflammation, while chronic hand eczema involves a more heterogeneous set of immune pathways. Can you explain how the difference in immune polarization translates into what you see in everyday practice?

Dr. Bunick:
So the simple way to say this is we know that atopic dermatitis is a Th2-driven disease, and what that means is certain cytokines like interleukin-4, 13, and 31 play a big role in driving this atopic diathesis. And we know atopic dermatitis is linked with things like asthma and allergic rhinitis genetically.

When it comes to chronic hand eczema, certainly, the atopic dermatitis component has this strong Th2 immune signal. But when it comes to irritant contact dermatitis, for example, it has more of a Th1 or Th17 immune polarization. And then when it comes to other types of chronic hand eczema, like allergic contact dermatitis, it's even more nuanced because it depends on the allergen. So for example, something like a metal, like nickel, may be more of a Th1 or Th17 driver, but something like poison ivy might be more of a Th2

or Th22 driver.

And this, again, speaks to what I said in the earlier question—that there is a heterogeneity in not only in the clinical morphology but in the immune drivers of that morphology. And this is why treating chronic hand eczema has historically been rather challenging—because there are these different immune drivers depending on what type or types of chronic hand eczema a patient has.

Now, if you have hand atopic dermatitis, the really good thing is that we have a number of FDA-approved therapies for atopic dermatitis, and those therapies are not limited to only atopic dermatitis on the trunk or extremities or the head. They also qualify for the hands. So therefore, patients with hand atopic dermatitis have a certain number of therapies that can hit that Th2 polarization and quiet that immune system, but that doesn't mean all types of chronic hand eczema will be treated with those therapies.

Dr. Ramnarine:
Beyond differences in the underlying biology, guidelines and consensus statements have outlined specific factors to help distinguish these two conditions. How do you incorporate those factors into your assessment of these patients?

Dr. Bunick:
Well, it's very important to do two things. Number one is to get a really good history of present illness, right? We were taught back in medical school that 2 HPI and past medical history are very important things to take, and they really are with hand eczema, too. But also doing a really good exam, and that exam is not limited to the hands. When it comes to hand atopic dermatitis or eczema, I also want to know, do they have eczema elsewhere on the body? I'm looking at their upper extremities and their lower extremities. I'm asking them, have they ever had eczema anywhere else on their body—the head, the extremities, or anywhere else on the trunk? That could be a clue that they have atopic dermatitis of the hands or atopic dermatitis, again, more extensively all over the body, and that would definitely drive treatment decisions.

We also know that, again, atopic dermatitis is linked with allergic rhinitis as well as asthma, and therefore, I'm asking about history. Have you had a history of asthma, or do you have bad seasonal allergies? Because that can clue me in as to whether the patient has some type of atopic dermatitis. Occupation is really important. When it comes to chronic hand eczema, especially irritant contact dermatitis, which is actually the most common type or subtype of chronic hand eczema, irritant contact dermatitis is often driven by certain chemicals and other things we're exposed to. Therefore, I'm always getting an occupation history, or even if someone's in school or university, are they an artist? Are they a machinist? What are they involved in? Because the type of exposures environmentally really does matter and can be confusing. And therefore, certain patients who may have an allergic response to a certain chemical are who we as clinicians might think about doing allergy patch testing or some other type of testing to help differentiate potentially the underlying drivers of the chronic hand eczema.

Dr. Ramnarine:
For those just joining us, this is *DermConsult* on ReachMD. I'm Dr. Shelina Ramnarine, and I'm speaking with Dr. Christopher Bunick about how we can recognize differences in hand atopic dermatitis and chronic hand eczema.

Now, recent US data suggests that self-reported provider-diagnosed chronic hand eczema affects roughly one in 10 adults, which is notably higher than we've seen in previous estimates. So Dr. Bunick, why do you think there's still such a gap between how common the condition is and how often it's recognized in practice?

Dr. Bunick:
Well, the reality is I see about five to ten percent of my patients with some form of hand eczema. And therefore, these data that talk about 10 percent are about on par with what I see in my own practice. And I think that it really reflects how five to ten years ago in dermatology, we weren't really talking about chronic hand eczema. Sure, patients had dry skin on their hands. They have fissured skin. We would treat with topical corticosteroids, but we didn't have any other therapies that were FDA approved. And therefore, we largely just really didn't pay attention to it the way we should have.

And it's really unfortunate because patients with chronic hand eczema have significant quality of life burdens—depression, anxiety, and a lot of social life disruption that come from really the pain, the itch, and that social isolation—the feeling you can't shake someone's hand, you can't go out in public. All of these things impact patients tremendously, and therefore, we are paying attention to it now for two reasons, I think. One, we've had a lot more education. We have more therapies for the atopic dermatitis component of the hands, and now we have more therapies to treat the other subtypes of chronic hand eczema. And therefore, when you have the therapies, I think clinicians are very excited to have new things to try, and patients, for sure, are happy to have something other than just steroids to try.

Dr. Ramnarine:
How does distinguishing between hand atopic dermatitis and chronic hand eczema shape your therapeutic approach, especially when it

comes to addressing symptoms like pain, fissuring, and impaired hand function?

Dr. Bunick:
When I think about treatment of chronic hand eczema and hand atopic dermatitis, having the diagnosis of atopic dermatitis really puts me in the bucket where I have not only six FDA systemic therapies; there's four biologics and two oral JAK inhibitor therapies. But then we now have topical non-steroidal therapies, and particularly the topical JAK inhibitor. We have two of them that are approved for either atopic dermatitis, which would be ruxolitinib, or chronic hand eczema, which would be delgocitinib, which differs. They differ because ruxolitinib is what's called JAK1/2 selective; it's a little more selective. And delgocitinib is what's called a pan-JAK inhibitor. It hits a few more of those immune pathways we were talking about earlier and therefore is considered more comprehensive in its ability to hit all the subtypes of chronic hand eczema.

And ultimately, understanding whether a patient has atopic dermatitis or another subtype helps us get medicines approved through insurance for our patients. And that is a part of medicine that can't be overlooked. But having that diagnosis does open the door, and not having the diagnosis can shut the door between getting a therapy that can heal—you mentioned the painful fissures on the hands. And the reality is, we haven't had great medicines to heal the fissures, and they are painful. And for many years, I remember as a resident, I was taught, "Put super glue on them." And actually, in dermatology we do use super glue and other types of glues to try to fill in and protect those fissures. But now, what we've seen in clinical trials with topical delgocitinib is it is absolutely able to help heal fissures on the fingers, and that is one of the most debilitating parts of chronic hand eczema when you talk to patients.

Dr. Ramnarine:
So as we wrap up for today, Dr. Bunick, I'd like to look beyond the initial treatment decision for these patients. How can correctly diagnosing these two conditions early on shape patients' long-term outcomes, especially when it comes to durable disease control?

Dr. Bunick:
Well, in the big scheme of things, again, chronic hand eczema is an umbrella, and it happens to be that atopic dermatitis, which can be a devastating full body skin disease, sort of overlaps in Venn diagram fashion with chronic hand eczema. So sometimes, patients with atopic dermatitis have hand involvement as part of their overall disease, or they may only have hand involvement.

And ultimately, it's our responsibility as the clinician to recognize that, because atopic dermatitis patients have other comorbidities. They have potential for comorbidities of asthma, seasonal allergies, and other types of skin barrier issues, whereas someone with chronic hand eczema due to irritant contact dermatitis—let's say they have just fissures of the fingertips, which is known as pulpitis—you may have a very different approach to treating that. For example, you may just focus on topical treatment and behavior modification in terms of exposures, whereas with atopic dermatitis, you have to consider there's more and more evidence, especially if it's moderate to severe atopic dermatitis, that there's systemic inflammation. And treating with more advanced therapies in combination with topicals might actually be a better strategy.

So ultimately, when you're dealing with patients getting the diagnosis, understanding atopic dermatitis versus other subtypes of hand eczema is incredibly important because not all hand eczema has to last forever, even though it is chronic hand eczema by definition. That just means you've had hand eczema for either three months or two times in a year. But if you treat it properly and eliminate triggers for certain subtypes, you may actually get patients better.

In the case of atopic dermatitis, this is a lifelong autoimmune condition, and we don't have a cure for it, and it's characterized by waxing and waning and unpredictable flares. And how you manage that patient versus a subtype of chronic hand eczema, it is different, and these nuances are what we're dealing with every day in the dermatology clinic. And honestly, it's just great to be able to tell patients, "I have options for you," because five years ago we didn't have many options other than topical or oral corticosteroids.

Dr. Ramnarine:
That's a great way to round out our discussion. I'd like to thank my guest, Dr. Bunick, for joining me to share these strategies for differentiating hand atopic dermatitis and chronic hand eczema. Dr. Bunick, it was great having you on the program.

Dr. Bunick:
Thank you for the discussion.

Announcer Close
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