Asteatotic Eczema (Eczema Craquelé)

Synonym: asteatotic eczema

‘Craquelé’ in French means ‘covered with cracks’, as seen on the surface of old china. It was first described by the French dermatologist Brocq in 1907. The condition is thought to be the result of excess water loss from the epidermis and a reduction in free fatty acids in the stratum corneum. Shrinkage of cell volume leads to reduction of skin elasticity and the formation of fissures.[1]

Epidemiology[2]

The condition is common in the elderly. The average age of presentation is 69 years, although it is not unknown in young people. Men are more affected than women. The incidence is highest in the winter and in cold climates.

Risk factors[1]

- Low-humidity environments (eg, central heating).
- Dehydration.
- Frequent prolonged bathing in hot water.
- Contact with irritants (eg, soaps, detergents, wool).
- Malnutrition (zinc and fatty acids).
- Discontinuation of steroid therapy.
- Degreasing agents.
- Anti-androgen therapy.
- Diuretics.

Presentation

The typical presenting picture is an elderly patient complaining of itchy, dry skin in the winter. Younger age groups and even children can, however, be affected. The classical distribution is on the legs, although hands, arms and trunk can also be affected. The appearance is of slightly scaly fissured skin, which has been described as crazy paving or cracked porcelain.[3] Areas of excoriation, erythema and bleeding, due to rubbing or scratching, may be evident. Most patients have a localised condition but a more severe generalised form is sometimes seen.

Differential diagnosis[2, 3]

- Cellulitis.
- Contact dermatitis (allergic or irritant).
- Stasis dermatitis.
- Discoid (nummular) eczema (a chronic eczema causing irritating coin-shaped lesions on the arms, back, buttocks and legs).
- Thrombophlebitis.
- Scabies.

Associated diseases[1, 3]

- Atopic dermatitis.
- Any condition causing reduced sweating - eg, hypohidrotic ectodermal dysplasia.[4]
- Myxoedema.
- Malignancies (with the generalised form): breast cancer, large-cell lung carcinoma, colorectal carcinoma and malignant lymphoma.[5] Also, other rarer tumours.

Investigations[1]

- Most cases are diagnosed by clinical appearance and do not need further investigation.
- Laboratory tests may be required to exclude associated diseases if clinically suspected.
- Histology of a skin biopsy shows:
  - Spongiosis (increased intracellular fluid in the epidermis).[6]
  - Some inflammatory dermal infiltrate.

These are unfortunately nonspecific findings found in many inflammatory conditions and the diagnosis is usually made clinically.

Management[1]

- Avoid long hot baths, excessive use of soap and harsh skin cleansers. Air-conditioned rooms should be humidified.
Petroleum-based emollients and moisturisers should be used liberally. Mid topical steroids may be required for patients who do not respond to these measures. For resistant cases, a mid-strength steroid (eg, triamcinolone) under an occlusive dressing for 24-48 hours is the first-line treatment. Some studies have reported benefit with pimecrolimus or tacrolimus cream.[7] N-palmitoylethanolamine and N-acetyylethanolamine are endogenous lipid emollients which have been shown to have a greater effectiveness than traditional emollients.[8]

Prognosis
The condition normally responds rapidly to treatment but aggravating factors need to be addressed to prevent it from recurring.

Further reading & references
1. Eczema craquelé; DermNet NZ
3. Asteatotic eczema; DermIS (Dermatology Information System)
6. Spongiosis; Dermatology Glossary

Disclaimer: This article is for information only and should not be used for the diagnosis or treatment of medical conditions. Patient Platform Limited has used all reasonable care in compiling the information but makes no warranty as to its accuracy. Consult a doctor or other healthcare professional for diagnosis and treatment of medical conditions. For details see our conditions.