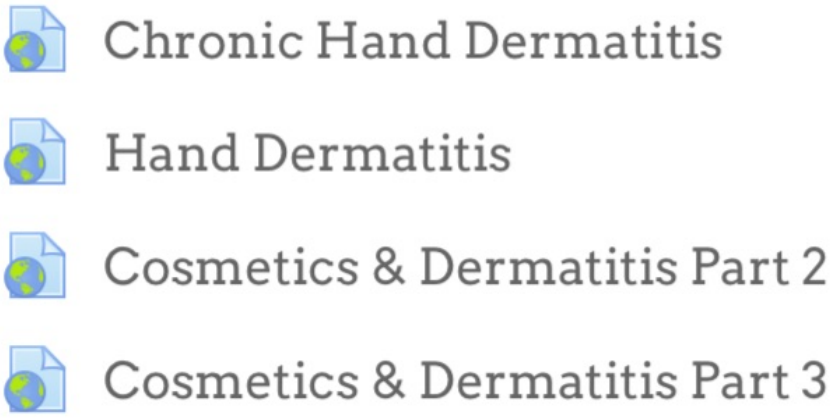
بسم الله الرحمن الرحيم

تفريغ الجزء الأول ⟸
لمادة السكند من
الفديوهات الموجودل
عالموودل




اللهم لا سهل إلا ما جعلته سهلاً، وأنت تجعل الحزن إذا شئت سهلاً

هلأ هون عنا article بتحكي عن الmanagement of chronic hand dermatitis

Eczema | Family Practice | Onychomycosis

# Management of Chronic Hand Dermatitis: A Practical Guideline for the General Practitioner

By **STL FP Volume 11 Number 1** - October 1, 2015

نلاحظ هون بحكيلي chronic

فبدنا نشوف الفرق بين ال chronic وال acute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## Introduction

Hand dermatitis (HD) can have a significant impact on quality of life of those affected. It may interfere with activities both at work and in the home and can be associated with social and psychological distress.[1,2] The chronic form, chronic hand dermatitis (CHD) affects up to 10% of the population, which can have a considerable societal impact.[2] Canadian Guidelines for the management of chronic hand dermatitis have been published to help guide management of this burdensome condition.[3] This article provides helpful practical guidance for the general practitioner in the management of patients with HD.

***Abbreviations:*** *CHD – chronic hand dermatitis; ENT – ear, nose, and throat; HD – hand dermatitis; KOH – potassium hydroxide; QoL – quality of life; TCI – topical calcineurin inhibitors; TCS – topical corticosteroid(s)*

## Diagnosing HD – Important points to cover:

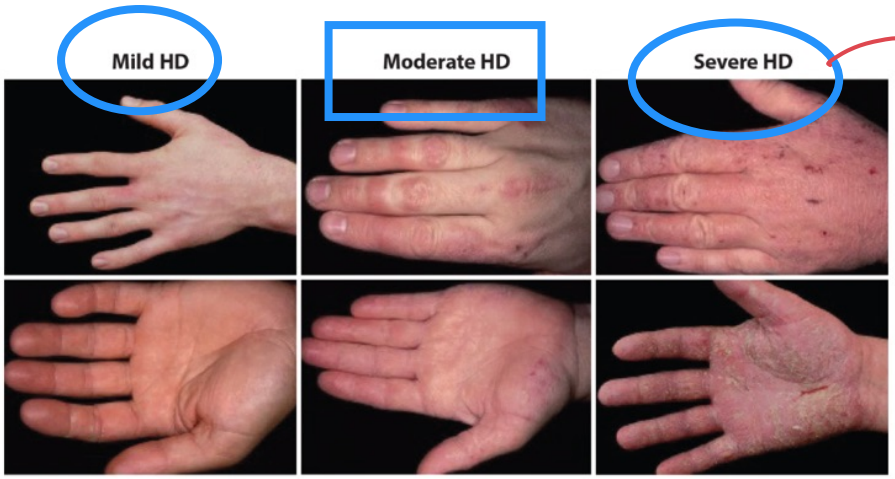
- Determine if the patient has eczema, or a childhood history of eczema (erythematous, scaling patches with some fissuring in typical locations).
- Ask about a personal or family history of atopy, including asthma, seasonal ENT allergies, nasal polyps.
- Ask about a history of psoriasis and comorbidities such as psoriatic arthritis.
- Does the patient have occupational exposures that could lead to allergic or irritant contact dermatitis?
- Has the patient had any recent exposure to irritants? Frequent handwashing?

في أشياء مهمة لما نحكي عن موضوع ال hand dermatitis منها اني اعمل diagnosis صحيح ...

موضوع ال diagnosis هاد رح نتركه لل dermatologist لانه مش لازم نفتي خصوصي لو ما كان واضح كتير لانه ممكن يكون ال dermatitis اصلها Atopic dermatitis ، يعني في ناس عندهم history وجينيا هم مهيئين يصير عندهم dermatitis

وممكن نخربط بين ال dermatitis وال psoriasis او بينها وبين fungal infection موجود عالايد

- Do a skin scraping for fungal KOH and culture to rule out *tinea manuum* as needed.



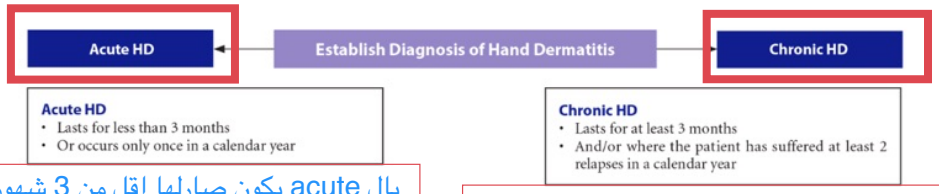

هون صار عنا fissuring وبعض ال desquamation

احيانا ال dermatologist ممكن يطلب يعمل زراعة لحتى يتأكد انه ما في fungal infection ويكون هاي الحالة ناتجة عن inflammation بسبب هاد ال infection
فمهم جدا اني احدد انه هاد فعلا هو hand dermatitis مش اشي تاني

**Figure 1.**
Examples of hand dermatitis(HD)

ال psoriasis عادة ما بكون فيها itching مقارنة بال dermatitis وكمان بال psoriasis بكون في اماكن تانية involved مو بس الايدين

## Determining if HD is Acute or Chronic




بال acute بكون صارلها اقل من 3 شهور او ممكن تصير مرة بالسنة عند هاد الشخص

بسميها chronic لما الشخص يعاني منها بالسنة مرتين او اكتر او صارلها 3 شهور على الأقل

**Figure 2.**
Establish diagnosis of acute hand dermatitis and chronic hand dermatitis (CHD). HD – hand dermatitis

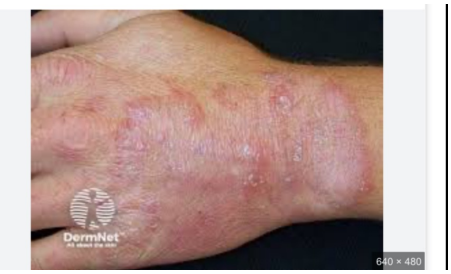
حكينا مهم جدا نعمل اول اشي differential diagnosis to exclude the other diseases اللي ممكن تكون شبيهة بال dermatitis مثل ال psoriasis وال fungal infection
ثانيا بدي احدد يا هي acute or chronic

- It is important to first differentiate between acute and chronic forms of HD, as the treatment options may vary.
- Acute HD lasts less than 3 months or occurs only once in a calendar year.
- CHD lasts for at least 3 months and/or patients experience at least 2 relapses in a calendar year.

| Differential Diagnosis: Acute HD |
| --- |
| • Dishydrotic dermatitis (pompholyx)<br>• Acute allergic contact dermatitis |

## Differential Diagnosis: Acute HD

- Dishydrotic dermatitis (pompholyx)
- Acute allergic contact dermatitis
- Irritant contact dermatitis
- *Tinea manuum*




الدكتورة جابت هاي الصورة من جوجل عشان نشوف الفرق بين ال fungal infection وال dermatitis وحكت الدكاترة ممكن يطلبوا هون زراعة، فمش لازم مثلا لو شفنا هاي الحالة على طول نتسرع ونحكي انها dermatitis وعلى السريع نقرر نعطيه كورتيزون بهاي الحالة احنا رح نكون زدنا حالة ال fungal infection عنده

## Differential Diagnosis: Chronic HD

- Allergic contact dermatitis
- Irritant contact dermatitis
- Psoriasis
- *Tinea manuum*
- Cutaneous T cell lymphoma
- Bowen's disease

### TIP: Could This Be Tinea?

- Check the feet for signs of *tinea pedis* and onychomycosis.
- Look for an active border suggestive of tinea.
- Take a skin scraping for KOH microscopy and culture.

لانه ال tinea infection بكون في الها border واضح

### TIP: Could This Be Psoriasis?

- Check the feet, scalp, elbows, knees, gluteal cleft and umbilicus for signs of psoriasis.
- Check the nails for signs of psoriasis: pitting, onycholysis, subungual hyperkeratosis, splinter hemorrhages, salmon patches (oil drops).

# Prevention, Avoidance and Patient

# Prevention, Avoidance and Patient Education

مهم جدا هاد الموضوع في ال hand eczema treatment
لو قد ما أعطيناه كورتيزون، لو ما وضحنا شو لازم يعمل وشو مش لازم وكيف يعمل moisturizing للجلد وكم يحط، العلاج بكون كله عالفاضي

من اساسيات انه اللي عنده اكزيما يتحسن هو ال compliance وال education وفهمه للاكزيما لانه انا ما بقدر احكي I can cure eczema

- Every patient with HD, whether acute or chronic, should protect their hands and avoid irritants and exacerbating factors.
- Avoid wet work, frequent hand washing and alcohol-based hand sanitizers.
- Gloves should be worn to protect the hands: cotton gloves at home, or during the night; gel padded gloves for friction and protective gloves for wet work and irritant exposure.
- The following tips are provided for patients on what to use, what to avoid and helpful common practices.

ما في اشي اسمه cure للاكزيما احنا بس لازم نشيل الاسباب اللي بتعمل عنده الاكزيما عشان ما ترجعله لانه طول ما هو عم يتعرض لهاد ال aggravating factor رح يضل يصير عنده هاد ال inflammatory response
فال patient education مهم جدا لاني بدي احكيله يبعد عن هاي الامور اللي بتسبب عنده هاد ال inflammation

| Do | Don't |
|---|---|
| • Moisturize hands regularly with an emollient<br>• Wear gloves when possible to protect hands<br>• Keep fingernails trimmed and clean<br>• Follow the treatment plan | • Rub, scratch or pick at loose skin<br>• Wash hands or expose hands to water frequently (avoid wet work)<br>• Expose hands to irritants: liquid hand soaps, disinfectants, shampoos, hand sanitizers |

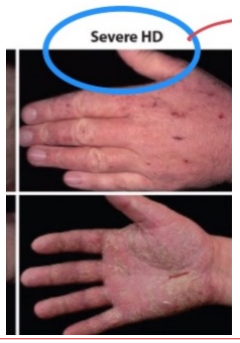
بالنسبة للترطيب لازم نحكيله يحط كمية منيحة ويغطي المنطقة بحيث يعمل barrier حتى يترك مجال للطبقات اللي تحت من الجلد انها تعمل healing
اذا كان بحط كميات بسيطة هاد الحكي ما رح يزبط
فلازم يستخدم frequent moisturizer وبالليل يحط thick layer of lipid rich moisturizer

## Assessing and Encouraging Patient Adherence

لما ييجي مريض على الصيدلية بعد ما اكون نصحته وبيجي يحكيلي ما استفدت بدي اروح اعمل assessment لموضوع ليش هو ما استفاد رح الاقي غالبا السبب هو ال compliance
وعدم استخدام مرطب بشكل صحيح و الابتعاد عن ال exacerbating factors
في ناس بفكروا انه يحطوا مرطب يعني الصبح مرة و بالليل مرة، هاد الحكي ما بزبط، هاد بكون من اهم اسباب انه ما ينجح العلاج بال moisturizer
ال emollient therapy اذا استخدمت بطريقة صحيحة وحطها liberally وحطها frequently وابتعد عن اي مسبب للاكزيما، رح يكون هاد الحكي كافي في كثير من الاحيان انها تجنب المريض من انه يدخل بال topical treatment and other treatments

- Ask patients to bring products and prescriptions to follow up appointments to assess usage.
- More frequent patient follow up visits improve adherence.
- Provide education on the disease, treatment options and potential side effects of therapy.

- Choose treatment in agreement with the patient.
- Suggest joining a support group or organization, such as the Eczema society of Canada ( https://eczemahelp.ca/).




في ال hyperkeratotic eczema مثل الصورة،
هاي عشان نساعد المريض انها تنشال بعطيه
emollient بيحتوي على keratolytic agents زي
ال urea وال salicylic acid

## Emollient Therapy

- All patients with HD should use a bland, rich emollient to help restore the skin barrier, and apply frequently throughout the day.
- Regular application may prevent itching and reduce the number of flares.
- For hyperkeratotic eczema, patients should use an emollient with keratolytic agent (salicylic acid 10-20% or urea 5-10%).
- Unscented petroleum jelly is inexpensive and helpful for many patients. وخاصة بالليل

بالنسبة لل management مثل ما حكينا كتير مهم انه نميز انه
ال hand dermatitis هي acute ولا chronicلانه في
اختلافات بسيطة بموضوع العلاج
اذا كانت acute اللي هي حكينا عادة ما
بتستمر اكتر من 3 اشهر وازا بدها تصير بتصير
مرة بالسنة

## Management of Acute HD

- It is important to make a diagnosis of acute HD so that treatment can be started as quickly as possible to maximize the outcome and prevent chronic involvement.
- Patients with HD should be adequately counselled on prevention and avoidance strategies.
- Avoidance of irritants, potential allergens and regular use of emollients is essential.
- Early treatment includes control of flares with a potent or super-potent topical corticosteroid (TCS) applied twice daily. For example, clobetasol propionate 0.05% ointment applied twice daily is generally effective in acute flares.
- For less severe flares, consider betamethasone valerate 0.1% ointment applied twice daily until controlled.
- In more severe cases, systemic steroids (prednisone, intramuscular triamcinolone) should be considered. Prednisone starting at 40-50 mg orally once a day and tapering over three weeks is an effective treatment course.

نيجي هلأ لموضوع ال flares up، شو يعني ؟
يعني لسا بحس انه بشرته فيها احمرار وعنده
رغبة بالحكة فهون بدنا نعمل treatment و
control لل flare up
عادة بيستخدموا بال corticosteroids بنحب
نستخدم the lowest concentration
with the lowest frequency اللي تقدر
تعالج طبعا وتعطينا effect

يعني لفترة قصيرة جدا لاني بس بدي
اعمل controlling لل flare up مش
عشان يضل يستخدمها طول الفترة اللي
بتضل الاكزيما على ايده هي فقط
تستخدم لتخفف اعراض الحكة والاحمرار
المزعجة
بال acute بضل استخدمها فقط until we
can control the flare up وبعد هيك
برجع لل regular emollient therapy
والابتعاد عن ال irritants

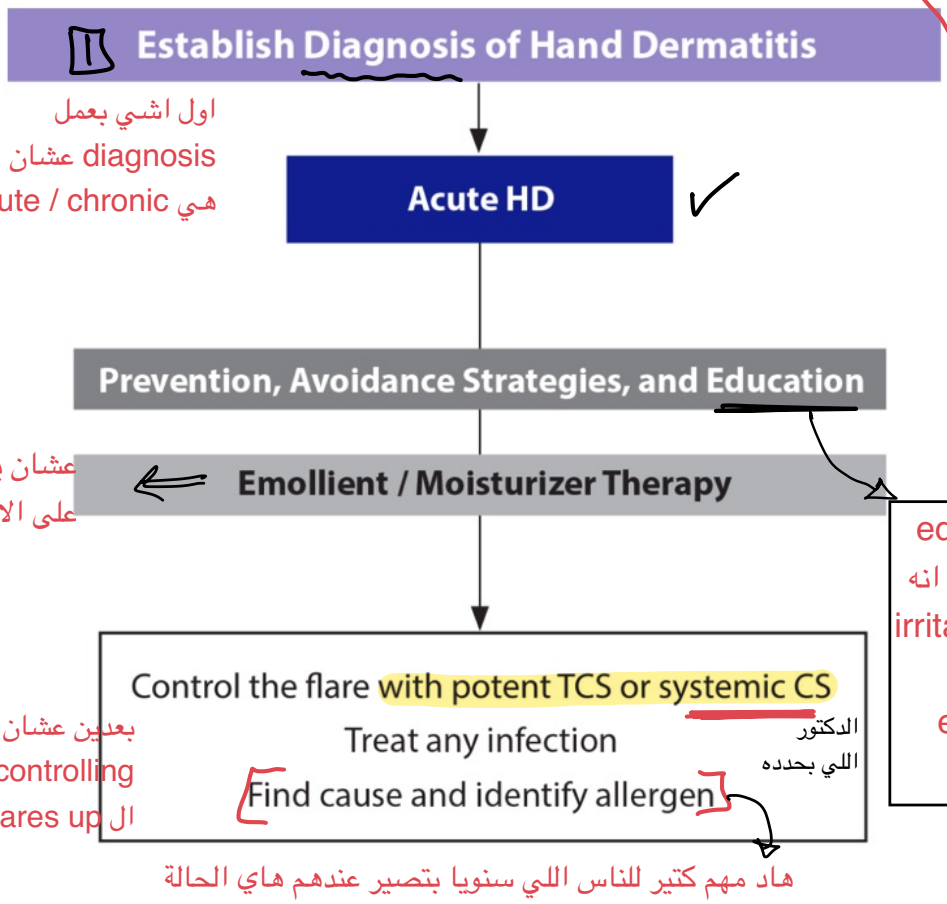
بهاي
الحالات
الدكتور هو
اللي
بيوصفها

مش راح نحكي عنه بالتفصيل

- Avoid short courses of prednisone as the condition may flare again, so a tapering dose is advised.
- Look for signs of infection and treat concomitantly.
- Try to identify any allergen exposures and recommend avoidance. If allergy is suspected, the patient should be referred for patch testing.
- Once controlled, consider maintenance therapy with topical calcineurin inhibitors (TCIs), such as tacrolimus 0.1% ointment twice daily when necessary, or twice weekly as maintenance therapy.

ممكن يصير عنا خلال الاكزيما secondary infection انه مع الاكزيما يصير عنده كمان bacterial or fungal infection بهاي الحالة مع ال emollient لازم اعمل control لهاد ال infection فبعطيه antimicrobial treatment سواء كان topical or oral هون الدكتور بحدده

هلا مرات الشخص اللي بتصير عنده سنوياً يفضل انه يروح لطبيب جلدية او طبيب مناعة او تحسس ويعمل ال patch testing عشان يعرف شو المادة اللي عم تعمله هاد التحسس لحتى يتجنبها




هدول عبارة عن immune modulators ممكن يستخدموهم بدل ال corticosteroids حسب هاي ال guideline بحكيلي اني استخدمها ك maintenance therapy مو بشكل يومي
ممكن مرتين باليوم لما بحس انه رجعت عنده الحالة او مرتين بالاسبوع

اول اشي بعمل diagnosis عشان اعرف acute / chronic هي

عشان يسيطر على الاكزيما

موضوع ال education مهم جدا عشان يعرف انه لازم يبعد عن ال irritants وكيف يستخدم ال emollient therapy بالطريقة الصحيحة

بعدين عشان يعمل controlling على ال flares up

الدكتور اللي بحدده

هاد مهم كتير للناس اللي سنويا بتصير عندهم هاي الحالة

**Figure 3.**
Severity-based treatment algorithm for the management of hand dermatitis (HD). CS – corticosteroid; TCS – topical corticosteroid

مثل ال clobetasol او ال less potent اللي هو betamethasone

## QoL Consideration

- Patients with mild or moderate CHD who have a significant impact on QoL should be managed as severe CHD.

هون بنصحنا ما نستخدم ال hydrocortisone
لانها هي نفسها ممكن تعمل حساسية و كمان
rarely effective
عادة بروحوا لل
potent and
super potent
cortisone for a
short period of
time

Did You Know?

- Hydrocortisone topical agents should not be recommended for most cases of HD because it is rarely effective and patients may become sensitized.
- Hydrocortisone is responsible for the majority of allergies to topical steroid products.

# Management of Chronic HD

هلا نيجي لل chronic
حكينا متى بعتبره chronic, وانه ال criteria اللي
لازم تتحقق عشان نعتبره chronic انه المريض
تستمر عنده الاعراض لاكتر من ٣ شهور وانه تتكرر
الحالة عنده اكتر من مرة بالسنة
يعني مرتين او اكتر ،،

- The treatment plan for CHD depends on whether it is mild, moderate or severe.

## Management of Mild CHD

بال chronic hand dermatitis في عنا grading
عنا mild,moderate and severe
لنفرض انا عندي mild CHD
ساعتها نفس الشغلة ال
education,prevention, avoidance,
regular emollient therapy

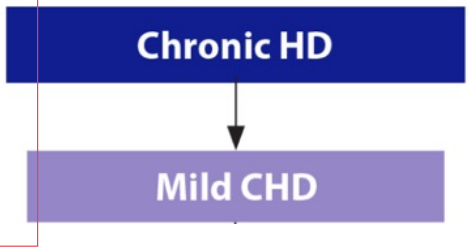
- Patients with mild CHD should be educated on proper prevention and avoidance strategies as outlined earlier.
- Regular emollient therapy should be used to restore and maintain the skin barrier.
- TCS therapy should be initiated with betamethasone valerate 0.1% ointment twice daily for 4-8 weeks.
- If not responding, adherence to the treatment plan should be assessed. Ask the patient to bring medication to follow up appointment to assess amount of product actually used.
- The patient can then be counselled on proper use of the product and provide support for ongoing management.
- If not responding with an adequate trial, a higher potency TCS, such as clobetasol priopionate 0.05% ointment should be prescribed as next line therapy. Reassess after 2 weeks.
- If not responding to an adequate trial of a potent or super potent TCS, the patient should be considered to have moderate CHD.

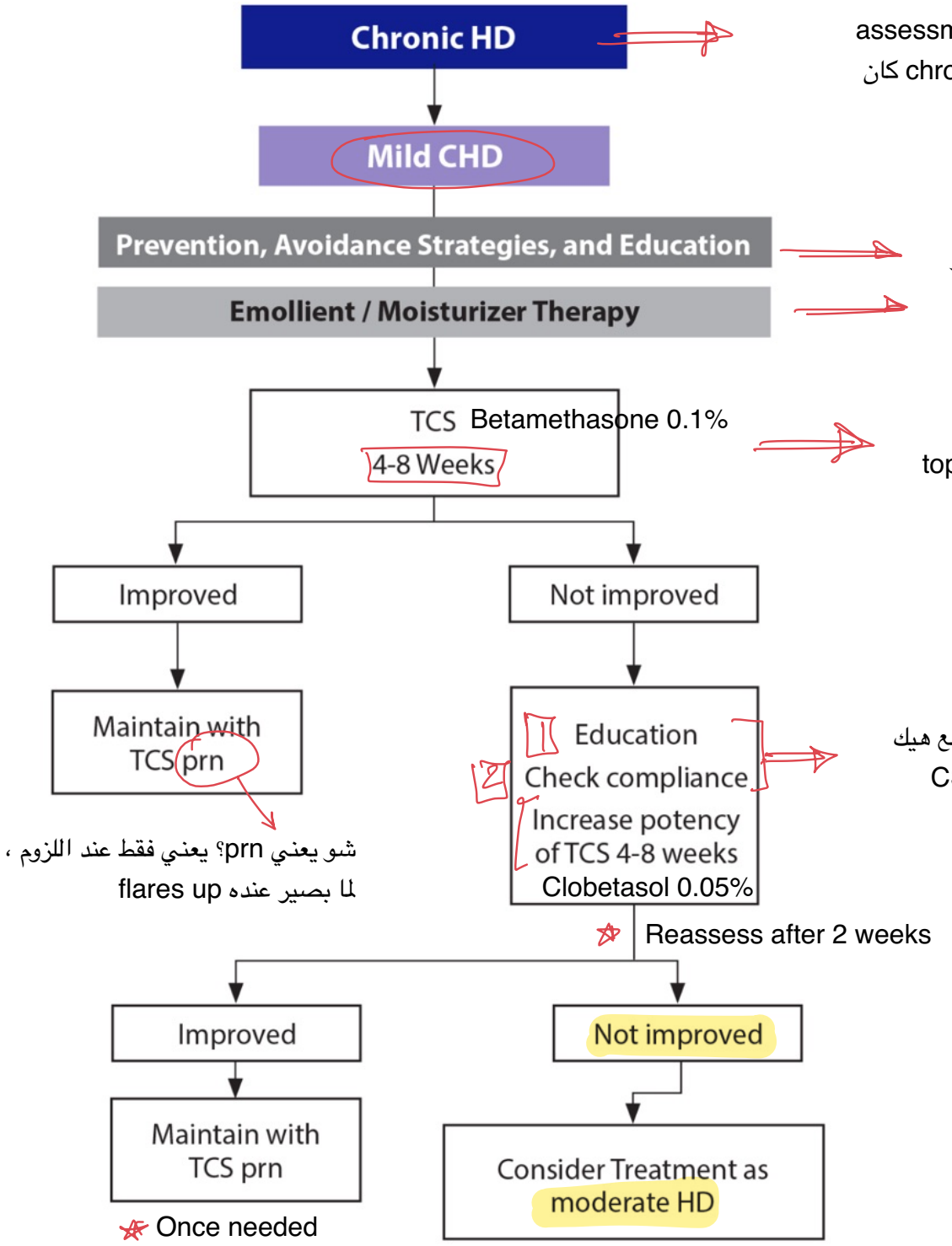
نيجي لل topical corticosteroids,
حكينا بال acute ال topical corticosteroids
تستخدم لفترة قصيرة من الزمن to control the
flaring up لكن في حالة ال chronic ما
بستخدمها فقط to control flare up لوقت بسيط
لا هون بيوصفوها مرتين باليوم لمدة ٤-٨ اسابيع

ازا المريض اجانا عالصيدلية وما كان مستفيد، ما
بروح بوصفله corticosteroid اقوى، لا!
بهاي الحالة عالاغلب بكون المريض مش ملتزم بالدوا
خاصة بموضوع ال emollient therapy والابتعاد
عن ال aggravating factors .

بعد ما بعمل proper counseling واتاكد من
انه المريض ملتزم بالدوا وعامل كل اشي صح ومع
هيك مش متحسن بهاي الحالة ممكن اعطيه
corticosteroid اقوى
بدل ال betamethasone valerate اعطيه
clobetasol priopionate وبعطيه طريقة
استخدامه وبعد ما يستخدمه صح يرجعلي بعد
اسبوعين

اذا حتى بعد ما اعطيته دواء
اقوى ومشي عليه صح و كل
اشي تمام ومع هيك ما استفاد
معناها هاد المريض حالته بطّل
mild صار moderate






اجا المريض وعملنا assessment وكان chronic و ك chronic كان mild

زي ما حكينا هاي الامور جدا ضرورية

بعدها ببدا مع المريض ب topical corticosteroids

ازا كانوا هدول تمام ومع هيك ما في تحسن بعطيه CS تاني اقوى

شو يعني prn؟ يعني فقط عند اللزوم ، لما بصير عنده flares up

**Figure 4.**

Treatment algorithm for the management of mild chronic hand dermatitis (HD). CHD – chronic hand dermatitis; TCS – topical corticosteroid

**TIP:** Always assess adherence, reconsider the diagnosis and rule out contact allergens, concomitant infection or colonization when patients do not respond to therapy.

مهم جدا دايما نعمل assessment لل adherence واذا هو فعلا بعيد عن ال allergens وازا في infection مهم جدا نعرف لانه اذا كان عنده اكزيما وصار بعدها عنده infection وهو بيتعالج بالكرتيزون هاد الاشي بسبب infection to flourish and lead to complications

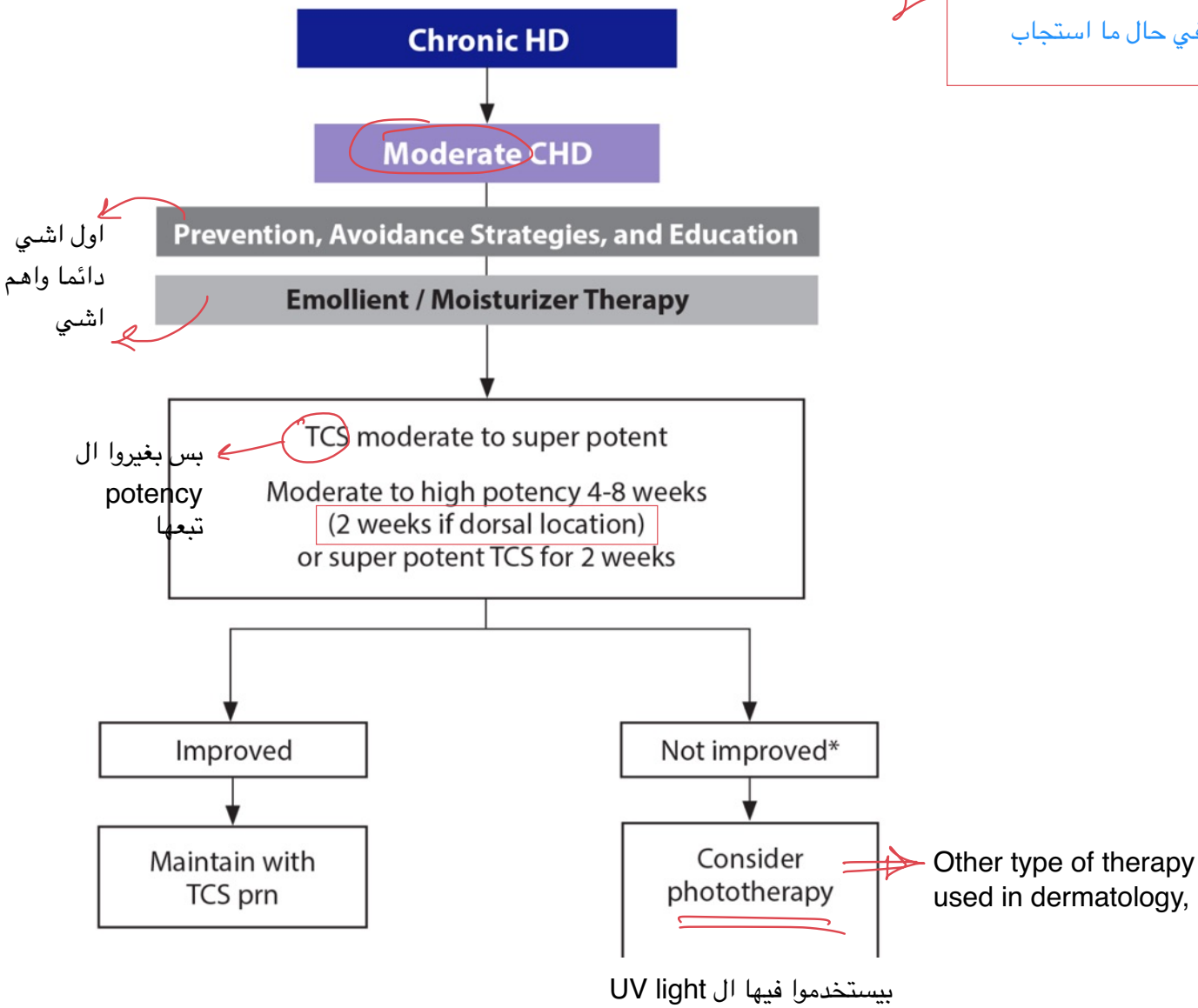
# Management of Moderate CHD

- In addition to regular use of emollients, patients with a diagnosis of moderate CHD should be given a 4-8 week trial of a moderate TCS, such as betamethasone valerate 0.1% ointment, or a super potent TCS, clobetasol propionate 0.05% ointment for a 2-week trial. If improved, the patient can continue this as necessary, for control of the condition.
- Another option is maintenance with a TCI, such as tacrolimus 0.1% ointment twice a day as needed, or twice weekly for maintenance. If not improved, reconsider the diagnosis and assess the patient for adherence.
- If a diagnosis of moderate CHD is confirmed, consider treating the patient with a course of phototherapy, if accessible. If unavailable or the patient does not respond, consider treating as severe CHD.

هلا عنا option تاني اللي هو اني اعطي المريض calcineurin inhibitor وممكن يستخدمهم ك maintenance therapy

ممكن طبيب الجلدية يستخدم ال phototherapy وهو طريقة اخرى للعلاج عند طبيب الجلدية

اذا ما نفع وقتها رح نغير ال diagnosis وراح يصير في عنا severe hand dermatitis ، في حال ما استجاب




اول اشي دائما واهم اشي

بس بغيروا ال potency تبعها

بيستخدموا فيها ال UV light

*Ensure patient education and check compliance. Consider reassessment to rule out infection and infestation, or consider differential diagnosis.

**Figure 5.**
Treatment algorithm for the management of moderate chronic hand dermatitis (HD). CHD – chronic hand dermatitis; TCS – topical corticosteroid

## Safety Tip

When patients show signs of adverse effects to TCS, including atrophy or telangiectasias or they cannot tolerate topical steroid
use, consider TCI (tacrolimus ointment 0.1%) as a non-steroid topical therapy option for treatment and maintenance.

هون بحكيلي اذا المريض بدت تظهر عليه اعراض جانبية من ال TCS or the patient is not tolerating TCS بحوّل ل ال topical calcineurin inhibitors الاسم التجاري elidel

## When to Refer

- Patients with CHD should be referred to a dermatologist when:
  - They may require patch testing
  - They are not responding to therapy
  - Condition is worsening instead of improving
  - Require phototherapy

## Management of Severe CHD

هلأ نيجي لل severe هون بيتطلب انه يستخدم المريض systemic treatment وما رح ندخل فيها لانها مو شغلتنا انه نوصف systemic treatment بنقدر بس نقرأها قراءة

- Patients who are diagnosed with severe CHD, patients with mild to moderate CHD who have failed an adequate trial on therapy, or patients who have a significant impact on the QoL, should be treated as having severe CHD.
- Treatment should be initiated with a potent or super-potent TCS, such as clobetasol propionate 0.05% ointment twice a day for 4-8 weeks (2 weeks on dorsal hands if super potent). If improved, patients may continue to use on an as needed basis, or switch to a TCI for ongoing maintenance therapy.
- Patients should be reassessed at 4-8 weeks. If they are not

لهون الدكتورة وقفت شرح وما بدها تدخل بالتفاصيل وراحت على اللي بعده

| Drug Class Generic Name (Trade Name) | Level of Evidence | Summary |
|---|---|---|
| Acitretin (Soriatane®) | B | • Small scale single-blind RCT (n=29) showed efficacy of acitretin 30 mg OD[8] |
| Alitretinoin (Toctino®) | A | • Large scale, double blind RCTs showing superior efficacy compared to placebo in those refractory to TCS use<br>• 48% patients 'clear/almost clear'[4] after 12-24 weeks |
| Cyclosporine (Neoral®) | B | • Small RCT showed low dose cyclosporine was as effective as betamethasone dipropionate[9] |
| Topical calcineurin inhibitor | B | • Small trials showing pimecrolimus and tacrolimus were slightly more[7] effective than vehicle but did not reach statistical significance<br>• TCIs not indicated for use in CHD but can be steroid sparing |
| Topical corticosteroids | B | • Mainstay of topical therapy for CHD despite a paucity of well controlled trials<br>• Efficacy proven in short term with relapse noted after discontinuation<br>• Ongoing use with maintenance |

هاي الصفحة واللي بعدها الدكتورة ما حكت عنهم اشي بس هم عبارة عن summary و conclusion شوفوهم اذا بدكم

| | | |
|---|---|---|
| | | • Ongoing use with maintenance dosing is required to maintain benefit[6] |

**Table 1.**Summary of evidence
**Evidence levels:**

A. Good-quality patient-oriented evidence, for example, large sized, double-blind, randomized clinical trials (RCTs)

B. Limited quality patient-oriented evidence, for example, small RCTs, non-controlled or observational studies

C. Other evidence, for example, consensus guidelines, extrapolations from bench research, opinion, or case studies

## Conclusion

HD can have a significant burden on the patient with an impact on
QoL. Early diagnosis of acute or chronic HD is important for optimal
management. Other conditions such as tinea manuum and psoriasis
need to be ruled out and managed appropriately. Once a diagnosis of
HD is confirmed, treatment depends on the severity of the disease.
A treatment algorithm has been developed to assist the general practitioner to make a diagnosis and either refer or treat accordingly.
Whichever treatment option is prescribed, all patients should be
educated on emollient therapy, hand protection and avoidance of
irritants or allergens, which may be contributing to their disease.

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# What is hand dermatitis?

Hand dermatitis is a common acute or chronic eczematous disorder that affects the dorsal and palmar aspects of the hands due to a variety of causes.

Hand dermatitis is also known as hand eczema.

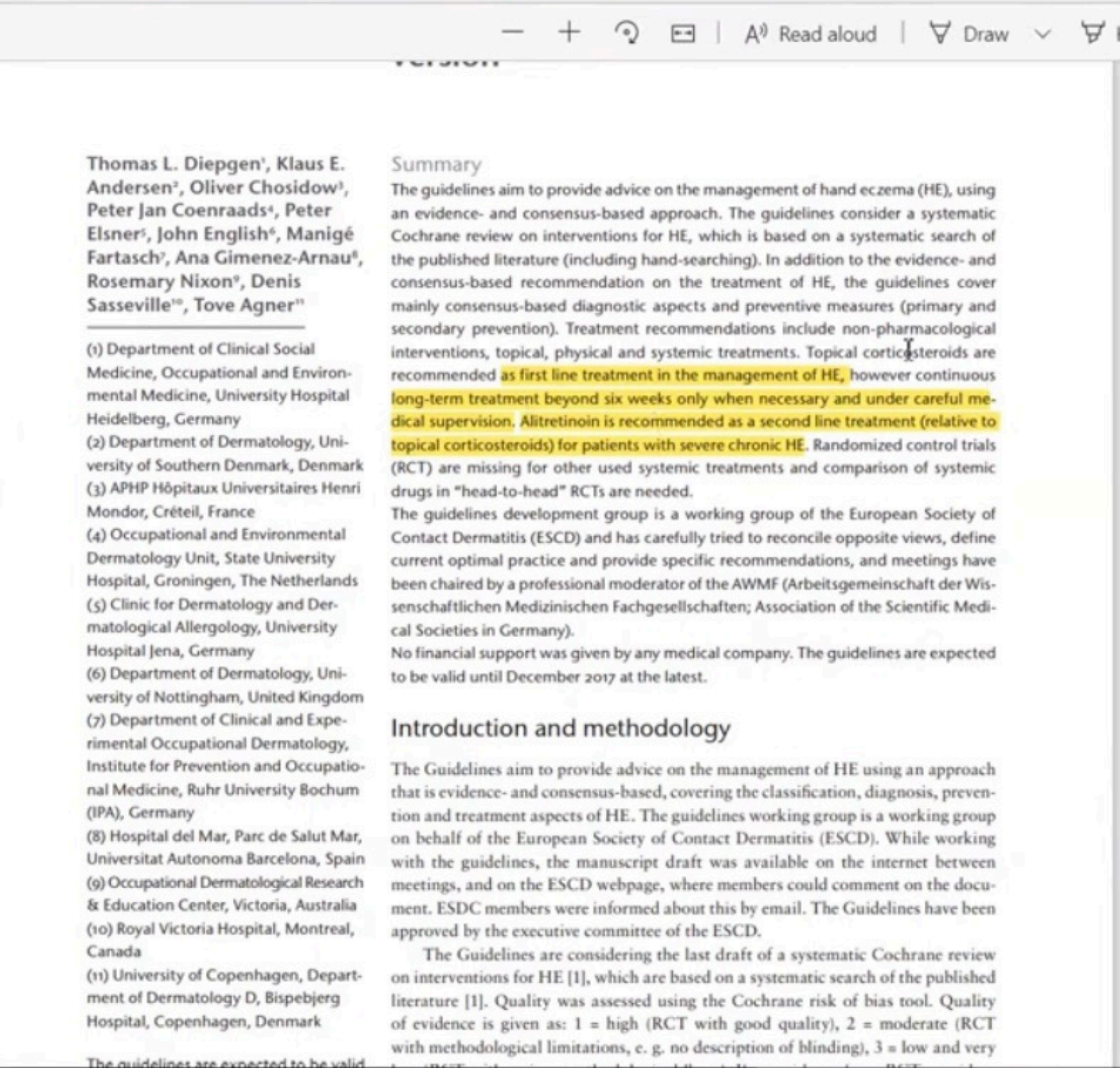
هون بس عشان يوضحلنا كيف شكل ال dermatitis



Palmar dermatitis


حكينا هاي بسميها hyperkeratotic
وبهاي الحالة حكينا لازم نعطي المريض emollient بيحتوي على اليوريا او اي keratolytic agent

هدول الملفات الدكتورة مو منزليتهم على المودل شكلها، بس كانت تفتحهم وتقرأ منهم قراءة كل الحكي الموجود فيهم تقريبا نفسه اللي حكيناه قبل بال article الأولى، الأشياء الزيادة حاولت أكتبها وكنت بصور من الفديو نفسه اذا مش واضحين ارجعوا للفديو و شوفوهم من هناك يمكن يكونوا أوضح 🫠




Thomas L. Diepgen[1], Klaus E. Andersen[2], Oliver Chosidow[3], Peter Jan Coenraads[4], Peter Elsner[5], John English[6], Manigé Fartasch[7], Ana Gimenez-Arnau[8], Rosemary Nixon[9], Denis Sasseville[10], Tove Agner[11]

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(6) Department of Dermatology, University of Nottingham, United Kingdom
(7) Department of Clinical and Experimental Occupational Dermatology, Institute for Prevention and Occupational Medicine, Ruhr University Bochum (IPA), Germany
(8) Hospital del Mar, Parc de Salut Mar, Universitat Autonoma Barcelona, Spain
(9) Occupational Dermatological Research & Education Center, Victoria, Australia
(10) Royal Victoria Hospital, Montreal, Canada
(11) University of Copenhagen, Department of Dermatology D, Bispebjerg Hospital, Copenhagen, Denmark

## Summary

The guidelines aim to provide advice on the management of hand eczema (HE), using an evidence- and consensus-based approach. The guidelines consider a systematic Cochrane review on interventions for HE, which is based on a systematic search of the published literature (including hand-searching). In addition to the evidence- and consensus-based recommendation on the treatment of HE, the guidelines cover mainly consensus-based diagnostic aspects and preventive measures (primary and secondary prevention). Treatment recommendations include non-pharmacological interventions, topical, physical and systemic treatments. Topical corticosteroids are recommended as first line treatment in the management of HE, however continuous long-term treatment beyond six weeks only when necessary and under careful medical supervision. Alitretinoin is recommended as a second line treatment (relative to topical corticosteroids) for patients with severe chronic HE. Randomized control trials (RCT) are missing for other used systemic treatments and comparison of systemic drugs in "head-to-head" RCTs are needed.

The guidelines development group is a working group of the European Society of Contact Dermatitis (ESCD) and has carefully tried to reconcile opposite views, define current optimal practice and provide specific recommendations, and meetings have been chaired by a professional moderator of the AWMF (Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften; Association of the Scientific Medical Societies in Germany).

No financial support was given by any medical company. The guidelines are expected to be valid until December 2017 at the latest.

## Introduction and methodology

The Guidelines aim to provide advice on the management of HE using an approach that is evidence- and consensus-based, covering the classification, diagnosis, prevention and treatment aspects of HE. The guidelines working group is a working group on behalf of the European Society of Contact Dermatitis (ESCD). While working with the guidelines, the manuscript draft was available on the internet between meetings, and on the ESCD webpage, where members could comment on the document. ESDC members were informed about this by email. The Guidelines have been approved by the executive committee of the ESCD.

The Guidelines are considering the last draft of a systematic Cochrane review on interventions for HE [1], which are based on a systematic search of the published literature [1]. Quality was assessed using the Cochrane risk of bias tool. Quality of evidence is given as: 1 = high (RCT with good quality), 2 = moderate (RCT with methodological limitations, e. g. no description of blinding), 3 = low and very

الدكتورة كانت تقرا اللي بالأصفر بس

were discussed, graded and approved in a formal consensus process to reduce bias.

Recommendations were discussed and approved by the working group following a formal consensus process moderated by an external, independent methodologist (Nominal Group Technique).

Declaration of different opinions and minority votes with a substantial rationale was possible. The strength of consensus was determined for each recommendation: 75 %–95 % agreement is consensus; more than 95 % agreement is strong consensus.

## Terminology and classification

- Evidence on classification is lacking and no specific recommendations can be made at the moment. However, in research and clinical trials we recommend that some kind of classification is applied. *Strong consensus-based recommendation (Grade A).*

*Eczema* and *dermatitis* are used as synonyms. *Acute* and *subacute HE* are defined as eczema, localized to the hands, that lasts for less than three months and does not occur more than once per year. *Chronic HE* refers to an eczematous process that lasts for more than three months or relapses twice or more often per year.

*mendation (Grade A).*

- We suggest secondary prevention strategies whenever skin manifestations are already present on the hands. *Strong consensus-based recommendation (Grade B).*
- Skin protection education and training are an important part of secondary prevention, they aim to motivate people to use adequate skin protection, and to foster a feeling of empowerment in terms of taking responsibility for one's own health and we suggest to develop it for high risk groups like hairdressers, health care workers, metal workers etc. *Strong consensus-based recommendation (Grade B).*

## Treatment

- We recommend that acute HE is treated quickly and vigorously to avoid the development of chronic HE. *Strong consensus-based recommendation (Grade A)*[2].
- We recommend identification and avoidance of causative exogenous factors. *Strong consensus-based recommendation (Grade A).*

هون بحكيلي انه بحالة ال acute ضروري جدا يتعالج المريض وما يصبر على حاله ويحكي خليها لبعدين لانه بسهولة ممكن يتحول ال acute ويصير chronic

ضروري المريض يعرف شو هم ال exogenous factors ويبتعد عنهم واللي هم الاشياء اللي بتعمل irritation وبتخلي حالته تصير اسوأ

- Evidence on classification is lacking and no specific recommendations can be made at the moment. However, in research and clinical trials we recommend that some kind of classification is applied. *Strong consensus-based recommendation (Grade A).*

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حكينا مهم يستخدم emollient يكون rich in lipid

Guideline

- We recommend moisturizers/emollients be used in all HE patients. *Evidence level 2 (moderate quality).* (Grade A) [1–4]. The choice of emollient should be individualized according to exposure and skin condition. *Strong consensus-based recommendation.*
- The guideline development group considers that the evidence base is too weak for recommendations on specific moisturizers or emollients. *Strong consensus-based recommendation.*

There exist different treatment options for chronic hand eczema (Table 2).

## Non-pharmacological interventions

Lifestyle change is recommended for all patients. This involting alternatives where possible [5], use of hand protection, and avoiding wet work and mechanical irritation (Table 3). Cases associated with occupational exposure should be notified to the appropriate authority.

## Emollients

Although emollients are very widely used and recommended by physicians, evidence for efficacy is sparse, and depends on the substances included in the specific product [6]. An overwhelming number of formulations are available, and words such as emollients, moisturizers, lotions, skin care products or barrier creams may be used interchangeably.

Emollients with high lipid content accelerate the healing after experimental damage to the skin [8]. Emollients, including humectants, may sometimes improve barrier function. The guidelines development group considers the evidence base for specific recommendations on which moisturizers or emol

- We recommend moisturizers/emollients be used in all HE patients. *Evidence level 2 (moderate quality).* (Grade A) [1–4]. The choice of emollient should be individualized according to exposure and skin condition. *Strong consensus-based recommendation.*
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There exist different treatment options for chronic hand eczema (Table 2).

## Non-pharmacological interventions

Lifestyle change is recommended for all patients. This involves avoidance of identified allergens and irritants, substituting alternatives where possible [5], use of hand protection, and avoiding wet work and mechanical irritation (Table 3). Cases associated with occupational exposure should be notified to the appropriate authority.

حكينا تشمل ال emollient وانه يبتعد عن الامور اللي بتعمل عنده irritation

## Emollients

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Table 2 Skin protection program based on evidence from clinical and experimental studies (Modified from ref [7]).

- Use gloves when performing wet work.
- Protective gloves should be used appropriately but for as short a time as possible.
- Protective gloves should be intact, clean and dry inside.
- When protective gloves are used for more than 10 minutes, cotton gloves should be worn underneath.
- Wash hands in lukewarm, not hot, water. Rinse and dry hands thoroughly after washing.
- Hand washing with soaps should be substituted with alcohol disinfection when hands are not visibly dirty.
- Do not wear finger rings at work.
- Apply moisturizers on your hands during the working day but especially after work and before bedtime. It may be reasonable to use a lighter moisturizing lotion during the day and a greasier fragrance-free, lipid-rich moisturizer before bedtime.
- Moisturizers should be applied all over the hands, including the webs, finger tips and dorsal aspects.
- Take care when doing domestic work. Use protective gloves for dish washing and insulating gloves in the winter.

حكينا قبل عن ال gloves وكيفية استخدامهم

Table 3 Treatment options for chronic HE.

ال systemic ما حكينا عنهم ولا رح نحكي

| Skin protection program | Topical therapies | Systemic therapies (in alphabetic order) | Physical therapies |
|---|---|---|---|
| Education | Emollients | Acitretin | UVB |
| Avoidance and substitution | Topical steroids | Alitretinoin | PUVA |
| Protection | Topical calcineurin inhibitors (tacrolimus, pimecrolimus) | Azathioprine | |
| | *Other topical treatment* (iontophoresis, tar, potassium permanganate, aluminium acetate) | Ciclosporin | |
| | | Corticosteroids | |
| | | Methotrexate | |

حكينا انهم بينفعوا عند الناس اللي ما زبط معهم ال corticosteroids او بدت عندهم ال side effects من ال corticosteroids او اصلا عندهم حساسية من ال CS

There is a risk that use of emollients may be associated with increased penetration of allergens and irritants, especially when applied during working hours [8, 9].

## Topical corticosteroids

- Topical corticosteroids play an essential role in the management of HE, and there is a significant body of evidence for their efficacy. *Evidence level 1 (high quality)*[1]. We recommend topical corticosteroids as first line treatment in the management of HE. *Strong consensus-based recommendation (Grade A).*
- They are very effective in the short term, but they inhibit repair of the stratum corneum and cause skin atrophy, and interfere with recovery in the long-term. *Evidence level 1 (high quality).*
- Development of side effects depends on the potency, the amount applied, the duration of treatment, frequency of use and the anatomical site. *Strong consensus-based statement.*
- Therefore we recommend continuous long-term treatment beyond six weeks be performed only when necessary and under careful medical supervision. *Strong consensus-based recommendation (Grade A).*
- There is limited evidence of efficacy for long-term intermittent use as maintenance therapy. *Evidence level 2 (moderate quality)*[1, 10].

teroids is not uncommon, and should be considered when HE does not respond to treatment [12].

Anecdotal experience suggests that intermittent dosing may reduce the risk of adverse effects, but there is no scientific data to support this at the moment. Clinical experience suggests that alternating or combining a topical corticosteroid with a topical calcineurin inhibitor may be considered in order to reduce adverse effects, although randomized clinical trials are missing and the long-term safety of this approach is unknown.

## Topical calcineurin inhibitors

- Topical calcineurin inhibitors may be considered for HE patients with long-term need for treatment, although evidence for their efficacy is limited *(Evidence level 2, moderate quality). Strong consensus-based recommendation (Grade 0).* Doctors and patients need to be aware that this is an off-label treatment except for patients with HE on an atopic basis.
- The topical calcineurin inhibitors tacrolimus and pimecrolimus are licensed for the treatment of atopic dermatitis when topical corticosteroids have failed or are not been tolerated. Tacrolimus has been shown to be as effective as mometasone furoate, whereas pimecrolimus appears to be non-inferior to a mildly potent topical steroid [13, 14].

استخدام ال calcineurin inhibitors لل dermatitis اللي ما بتكون atopic dermatitis بكون off label use

يعني ال FDA اعطت ال calcineurin ال license انه يتم استخدامهم بال atopic dermatitis لانه بكون الها سبب مناعي او جيني
ولكن استخدام هاد العلاج بال hand dermatitis هي تستخدم ولكن هاد off label use

Topical corticosteroid are very effective in the short term, but they inhibit repair of the stratum corneum [11], and may cause skin atrophy, and interfere with recovery in the long-term. Once daily treatment is sufficient and may even be superior to twice daily application. Effectiveness of topical corticosteroids for irritant contact dermatitis (ICD) in experimental settings is low or non-existent.

In clinical studies there is evidence of efficacy for long-term intermittent monotherapy with mometasone furoate cream for HE [10]; the risk of recurrence is reduced by use of a very potent steroid (clobetasol propionate) compared with a moderately potent preparation.

The disadvantages of topical corticosteroids include cutaneous adverse effects (skin atrophy), tachyphylaxis (theoretically) and adrenal suppression after systemic absorption (very infrequent). Atrophy of the epidermis has been reported as a consequence of topical corticosteroids, and should especially be considered when long-term treatment is used [11]. Corticosteroids have even been reported to cause eczema craquelé. Allergic contact dermatitis caused by topical corticos-

هون بحكيلنا انه استخدامها once daily is sufficient

هون بقارن بين ال signs and symptoms اللي ممكن اخربط فيها بال diagnosis بين ال eczema وال tinea manuum وال psoriasis

**Table 1** Signs and symptoms of superficially similar lesions of the hand.

| Psoriasis | Tinea manuum | Hyperkeratotic hand eczema |
|---|---|---|
| Not usually itchy | Can be itchy | Itchy |
| Painful fissuring | Sometimes fissuring | Painful fissuring |
| Dry, silvery scale | Usually dry, scaly | Vesicular, scaly |
| Well-defined lesions | Active edge on back of hand | More diffuse lesions |
| Nail and knuckle involvement | Nails often involved | Nails can be involved |
| Köbner phenomenon | No Köbner phenomenon | No Köbner phenomenon |
| Can be symmetrical | Asymmetrical | Usually symmetrical |

dermatitis, community pharmacist is the most accessible healthcare professional. Pharmacist can give advice about nature of disease, aims of treatment, duration of treatment, appropriate use of therapeutic agents, importance of compliance and treatment options.

### 1.1. Emollients

Emollients "are almost universally recommended as first-line treatment. Emollients have soothing effect on itching and soreness" (www.medicinesni.com), they may have an anti-inflammatory effects. Technically, emollient is "being something that smoothes and softens the skin, usually via occlusion. The correct emollient is the one that the patient will use. Adherence to emollient treatment is the key to successful therapy for atopic eczema." (www.medicinesni.com). Patient should be advised to use them "liberally and frequently, even when the skin appears improved or is clear" (www.medicinesni.com). Patients should be supplied with big dosage pack for use at home, and smaller dosage pack for use at work, at school, while traveling. Avoidance of using soaps, detergents and bubble bath is general recommendation.

"Patients may require more than one emollient product, depending on lifestyle, time of day, seasonal factors, cite of application or disease severity. Emollients have a steroid-sparing effect, and should be supplied in a 10:1 ratio of emollient to steroid in order to achieve the full benefit. There should be a time interval of at least 30 minutes (1 h for tacrolimus) between the application of topical flare treatments (topical corticosteroids, topical immunomodulators) and emollient." (Moncrief et al. Use of emollients in dry-skin conditions: consensus statement. *Clinical and Experimental Dermatology*, 2013). "Ointments are preferable for dry skin because they are more effective than creams, but creams are preferable on red, inflamed skin because the evaporation of water-based products cools the skin" (www.medicines.ni).

Pump-dispensers are recommended if large amounts of emollients should be used for large areas of skin.

### 1.2. Topical corticosteroids

"Many patients with atopic eczema need to use topical corticosteroid preparations intermittently when the condition flares and a few patients need to use them long-term. Topical corticosteroids are the first-line treatment for flare - ups of atopic dermatitis. They do not cure the condition, but they will control it via anti-inflammatory and immunosuppressive effects. They reduce inflammation and relieve itching. Evidence from controlled trials for effectiveness of this group of drugs is limited. Clinical experience has shown that topical steroids improve eczema over a two to four week period. Initial improvement should be seen within 3 - 7 days of starting steroids" (www.medicinesni.com).

هون بحكيلنا عن ال atopic dermatitis واللي هي تحدث عادة عندالاطفال وبأكد انه حتى بالاطفال ضروري نستخدم ال emollient بالعلاج

يعني بستخدمهم لفترة قصيرة مو زي ال hand dermatitis كان فترة العلاج up to six weeks



لازم كمان يتجنب استخدام الصابون وال bubble bath

حكينا قبل اذا المريض استخدم ال emollients بالطريقة الصحيحة في بعض الاحيان بتكون لحالها كافية انها تخفف هاي المشكلة من غير ما نستخدم ال corticosteroids

هون بحكيلي لما يكون المريض عنده dry skin بفضل اوصفله او اعطيه المستحضر اللي عى شكل ointment اما لو كان عنده red inflamed skin وحتى لو عنده pus وتقيحات بهاي الحالة يفضل اعطيه cream

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There are several sources to categorize topical corticosteroids. According to British National Formulary, there are five groups of topical steroids: mild, moderately potent, potent and very potent. "The potency is measured by its ability to cause vasoconstriction, rather than its clinical effectiveness. Very potent corticosteroids are up to 600 times as potent as mild topical corticosteroids. The choice of topical corticosteroid is based on potency of preparation and the site and severity of the condition." (www.medicinesni.com)

Topical corticosteroids are usually used once-daily in treatment of atopic dermatitis. Twice-daily application could be included if symptoms are not resolved and then stepping down again to once-daily application.

Topical steroids should be used 3 - 7 days for management of flares. Sometimes, courses of 7 - 14 days are necessary. If symptoms are not resolved within 7-14 days, the secondary bacterial or viral infection may be present. Topical corticosteroids are only used to treat affected surfaces and treatment should be continued for 48 hours after symptoms resolve. The recommendation is if moderate potency product is used, to step down to low potency for a few days.

بعض الامهات ممكن يفكروا انه عادي يحطوا على كامل الوجه ولكن هاد الحكي خطا لازم يحطوا الدوا فقط على ال infected area

بهاي الحالة ممكن ندخل antimicrobial treatment

لو سأل المريض متى بقدر اوقفه؟ في حال الاعراض راحت بقدر يستمر عليه لمدة ٤٨ ساعة بعدها خلص يوقفه

## 1.3. Topical calcineurin inhibitors

In this issue, the emphasis is on the first-line therapeutic agents for management atopic dermatitis - emollients and topical corticosteroids. Therefore, the agents for second - line treatment are reviewed just informative.

In Serbia one agent from group of topical calcineurin inhibitors is registered for treatment of atopic eczema:

حكينا بيقدر يستخدمهم المريض بدل ال corticosteroids في بعض الحالات مثل ال elidel واللي هم عبارة عن immunomodulators

## 1.5. Antihistamines

In the treatment of eczema, antihistamines are recommended when itching is the dominant inconvenience.

In the case of a patient having a problem with insomnia, a sedative antihistamine may be included.

مرات ممكن الصيدلاني او الدكتور يعطوا antihistamines وبعطوهم orally طبعا عشان ال sedative effect تبعهم فممكن المريض ينام ليرتاح من شعور الحكة العلاج بال topical antihistamine ما راح يزبط بالعكس ممكن يكون هو نفسه بحالة استخدامه topical يكون allergic

بحكيلي هون انهم عملوا دراسة شافوا فيها انهرفي حال المريض كان عنده atopic dermatitis وهو ماشي على emollient ولكن ما بيستخدمه بالكمية الكافية ولا بالطريقة الصحيحة بكون mainly هاد هو السبب انه المشكلة ما عم تنحل عنده

reported that symptoms resolved.

Pharmacists found that some patients who have previously been diagnosed with atopic dermatitis and already have used emollients, apply them ineffectively- inadequate amount of emollients, inadequate accuracy. This gap of knowledge and understanding leaded to non-compliance and had an impact on disease outcome. The emphasis was on giving an adequate advice about emollients,

## Introduction

Hand eczema is a socially significant disease because of its high prevalence, morbidity and the associated lost working time due to sick leave.[1] Clinically, it is a heterogenous condition under the aspects of aetiology, clinical manifestations and acuteness. The aetiology is manifold from endogenous disease (atopy) to exogenous factors (irritant and/or allergic contact dermatitis) that frequently overlap.[2,3] Clinical manifestations may be diverse, from vesiculous and erosive to hyperkeratotic and desquamative. Its time course may be acute, recurring or chronic and long-lasting. With this wide diversity of aetiological and clinical factors, standard treatment approaches are frequently been developed by various groups over the years (Table 1) and the recent Cochrane review on treatments for hand eczema.[4] The latter clearly stated the current deficits of our knowledge on the treatment of hand eczema[4]: the quality of studies was frequently poor, and the duration of treatment was short, generally only up to 4 months, which is inconsistent with the need for a long-term management in chronic hand eczema defined as 'an eczematous process that lasts for more than three months or relapses twice or more often per year'.[5] Most of the guidelines (Table 1) take a similar approach to the hierarchy of treatments with some differences especially regarding the availability or reimbursement conditions of specific drugs.

زي اللي حكينا عنه قبل

هون عنا article تانية كمان بتحكيلي انه اول اشي لازم نميز بين ال atopic dermatitis واللي هي عادة بكون سببها endogenous or genetical cause او يكون سببها irritation

## Topical therapy

Although a number of systemic compounds for the treatment of hand eczema have become available over the years, topical therapy should always be part of a treatment regimen, even with systemic therapies (Fig. 1). Topical therapies should consider the appropriate choice of vehicles, suitable pharmaceutical vehicle depending on the condition of the skin and the acuteness of the eczema.[20] Generally, the principles 'moist on moist' and 'greasy on dry' propose to use hydrating vehicles on acute lesions of hand eczema and lipid-rich vehicles on chronic ones. This approach, however, is limited by the fact that patients may need to use their hands in everyday life not wishing to leave greasy marks on objects of their environment. Thus, the aspect of possible adherence to topical treatments has to be considered. In addition, the function of the pharmaceutical vehicle is to ensure a stable formulation and to facilitate the bioavailability of the active agent.[20] Some pharmacologically active substances may

هون بحكيلي انه حسب ال lesions الموجودة عندي بدي اختار ال dosage form زي ما حكيناها قبل متى استخدم ال cream ومتى استخدم ال ointment بس هون حاكيها بطريقة تانية

Moist on moist and greasy on dry

**Coal tar, pine tar and sulfonated shale oil preparations**

While topical tar preparations have been used widely in the treatment of recalcitrant hand dermatitis in the past, no clinical

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studies exist proving their efficacy and safety in this condition according to modern evidence-based criteria. Due to the possible risk that tar is a possible carcinogen and the proven urinary excretion of 1-hydroxypyrene in patients with atopic dermatitis treated with topical coal tar,[44] the use of coal tar for the treatment of hand dermatitis has been widely discontinued in recent years. However, sulfonated shale oil preparations seem to have a better safety profile[45] and have been proven to be efficacious in mild-to-moderate atopic eczema in children[46]; thus, they might be tried for topical therapy of hand dermatitis, although no studies on their efficacy and safety in hand dermatitis are available.

هون بحكيلي فيما يخص ال coal tar كانت قديما تستخدم لعلاج الاكزيماولكن حاليا ثبت انه ممكن يكون carcinogen فتوقف استخدامه، ممكن يستخدموا بداله الزيت الصخري اللي هو ال sulfonated shale oil

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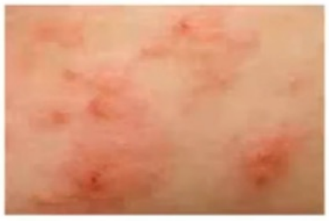
# ECZEMA (ATOPIC DERMATITIS) OVERVIEW

Eczema, also called atopic dermatitis, is a common allergic skin disease that usually starts in early childhood. It can be associated with infection (bacteria, fungi, yeast and viruses) of the skin. Half of patients with moderate to severe eczema also suffer from asthma, hay fever (allergic rhinitis), and food allergies.



The main symptom is itchy skin. Skin is also often dry. Scratching makes the skin red, chafed and thick.

eczema is now thought to be due to a "leaky" skin barrier. This allows water to leak out, making the skin dry. Leaky skin can be caused by genes inherited from parents or by factors in the environment:

- Faults in the Filaggrin gene cause moderate to severe eczema in up to a third of people of North European and Eastern Asian descent.

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عنا هون اخر article بيحكي عن ال atopic dermatitis والل هو mainly عند الاطفال ببدا بكون اله endogenous factors يعني اله علاقة بال immune system تبع الطفل

عادة اللي بكون عندهم atopic dermatitis بكون عندهم other immune related diseases، يعني ممكن يكون عندهم حساسية من اكل معين بكون عندهم اكزيما فهاد الاشي ممكن يساعدني اميز انه هاي اللي صاير معه هو نتيجة تعرضه ل irritant معين ولا هو سبب مناعي

**Avoidance of Possible Triggers**

Irritants: Irritants such as chemicals, soaps, detergents, fragrances, certain fabrics, and smoke can further irritate the skin in patients with eczema.

The following are steps to perform to reduce irritant exposures:

- Wear comfortable clothing.
- Wash all new clothes prior to wearing them.
- Keep fingernails short and smooth to help prevent additional skin damage from scratching.
- Use broad-spectrum ultraviolet (UV) protective sunscreen (UV-A and UV-B with an SPF of 15 or higher).
- Bathe immediately after swimming to reduce and remove exposure to various chemicals found in swimming pools and beaches.

*Inhaled Allergens:* House dust mites are small, microscopic (you cannot see them with the naked eye) organisms. They are typically found indoors (mattresses, pillows, carpet), typically in areas of high humidity. These have been associated with eczema.

*Foods:* Common allergic foods have been associated with eczema in very young children, but this association is rare in adults. If you consistently notice worsening of your rash after ingesting certain foods, notify your allergist / immunologist for further evaluation. Of particular note, eliminating a variety of foods from the diet that you are not allergic to is rarely helpful in patients with eczema, so any evaluation of a possible food allergy should first be done with careful consultation with an allergist / immunologist.

*Stress:* Stress, including anger and frustration, can cause additional itching, thus potentially worsening the "itch-scratch cycle."

لازم كتير ينتبهوا على حالهم من هاي المواضيع ,عشان هيك بنبههم عليها

وبالنسبة للعلاج ممكن ال adults and children يستخدموا نفس العلاج ولكن اكيد ال doses تختلف وبدي اراعي كمان الوقت لانه الاطفال بتركه على الوجه لوقت اقصر

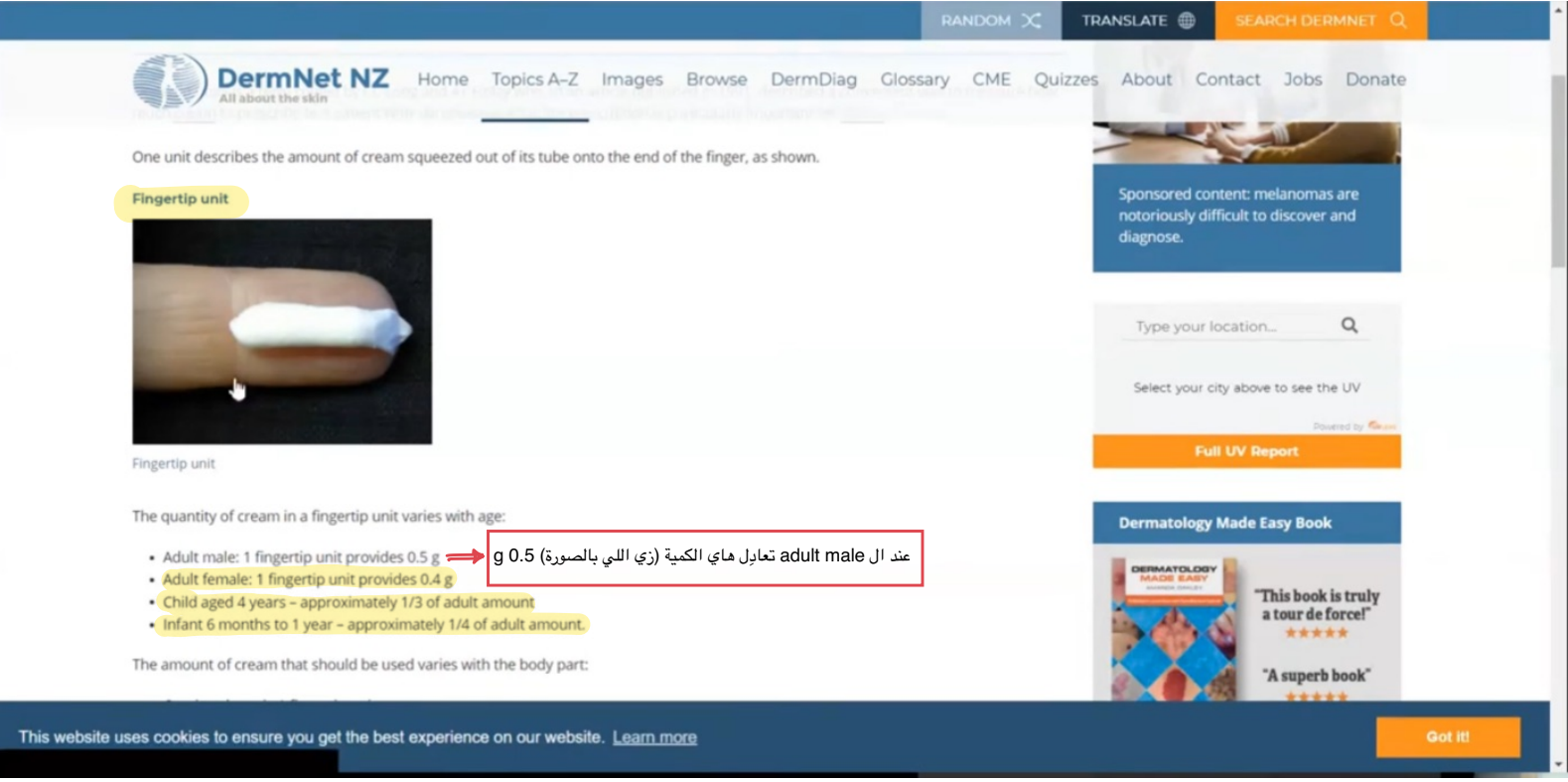
**Antihistamines**

Oral, or pill, antihistamines do not reduce the itch associated with eczema, as it is not triggered by histamine. Sedative antihistamines are sometimes used to help encourage much needed sleep at night. However, there are potential side effects, including increased sleepiness, or sedation during the day, increased dryness, and difficulty urinating. Topical antihistamines should be avoided, as they may worsen your rash.

هاي كمان الشغلة حاكيينها هون وحكينا عنها قبل، لازم بس نستخدم ال oral antihistamines

**Therapies for Associated Infections**

If your allergist / immunologist diagnoses an associated infection with the rash, an antibiotic may be prescribed. Your skin may be infected if there is oozing, crusting, your clothes start to stick to your skin, or you have the development of cold sores or fever blisters.




اخر اشي بدنا نحكي عنه اللي هو كم الكمية المطلوبة من الشخص انه يحطها عشان تعطيه ال effect المطلوب

يعني لنفرض انه المريض بتعالج بكورتيزون ال finger treatment unit هو اصبع الشاهد, زي الصورة

The amount of cream that should be used varies with the body part:

- One hand: apply 1 fingertip unit
- One arm: apply 3 fingertip units
- One foot: apply 2 fingertip units
- One leg: apply 6 fingertip units
- Face and neck: apply 2.5 fingertip units
- Trunk, front and back: 14 fingertip units
- Entire body: about 40 units.

فعشان احكي اني بستخدم الكريم صح وبتعالج صح لازم التزم بالكمية اللي بدي احطها

## Example

An adult female applies a cream once daily to both arms. She uses 2.4 g in one day (2 arms x 3 fingertip units x 0.4 g = 2.4 g). This is 16.8 g per week (7 x 2.4 g).
A 30 g tube should last her two weeks. But if she applies it twice daily (4.8 g/day), the tube will be finished in less than a week (33.6 g/week).

An adult male applies a cream once daily to the dorsal and volar surfaces of both feet and both hands. He uses about 3 g per day (2 feet x 2 units PLUS 2 hands x 1 unit, x 0.5 g = 3.0 g). This works out as 21 g/week (7 x 3 g).
A 50 g tube should last him about 2 1/2 weeks.

A baby has a cream applied twice daily to the entire body, which is about 10 g daily.

يعني هون يفترض الصيدلاني يعطيها العلبة اللي فيها ٣٠ غرام و يا دوب تكفيها شهر اذا كانت بتستخدمها بالطريقة الصحيحة اما لو رجعت وحكت انه مشكلتها ما انحلت بعد شهر و الكريم لسا ضايل منه كتير فمعناها المريضة ما التزمت بالدواء او ما كانت تحط منه الكمية اللازمة

اللهم انفعنا بما علَّمتنا و علِّمنا ما ينفعنا و زِدنا علماً ✨

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