

Seborrhoeic dermatitis in adults factsheet

Seborrhoeic dermatitis is a common scaly rash that typically affects the scalp, face and chest, but can affect other areas, too. 'Dermatitis' is another word for 'eczema'. 'Seborrhoeic' (pronounced sebor-a-ik) simply means that the condition appears in those areas of skin with large numbers of grease (sebaceous) glands, such as the scalp and sides of the nose.

There are two types of seborrhoeic dermatitis: adult and infantile. This factsheet is for adults with seborrhoeic dermatitis. Seborrhoeic dermatitis in infants (known as 'cradle cap') differs from the adult form and is covered in a separate Eczema UK factsheet: Seborrhoeic dermatitis in infants.

Who gets it and why?

Seborrhoeic dermatitis affects 4% of the adult population and is more common in men than women. The adult form of seborrhoeic dermatitis can develop from puberty but more usually occurs in adulthood – prevalence rises sharply over the age of 20, with a peak at 30 years for men and 40 years for women.

Seborrhoeic dermatitis is commonly found in areas of the skin with grease glands, the scalp, face, upper chest and back.

As with other forms of eczema, the skin of people with seborrhoeic dermatitis is typically dry. Adult seborrhoeic dermatitis is believed to be an inflammatory reaction related to an overgrowth of normal skin inhabitants – *Malassezia* yeasts (*malassezia furfur*, also known as *pityrosporum ovale*). The yeasts are part of normal skin flora, but for an unknown reason some people are more susceptible to a sensitivity to skin yeasts, the main trigger for seborrhoeic dermatitis.

Seborrhoeic dermatitis is not contagious or related to diet, but it may be aggravated by illness, stress, tiredness, changes of season and a general deterioration of health.

People with an immunodeficiency (especially infection with HIV), a heavy alcohol intake, or a neurological disorder such as Parkinson's disease or stroke, are more prone to it. This is estimated at up to 80% for those with HIV and 50% for those with Parkinson's Disease.

Psoriasis is another common skin condition and often coexists with seborrhoeic dermatitis.

Psoriasis frequently causes a very scaly scalp (it is estimated that 80% of sufferers have some scalp involvement).

Unfortunately, the irritation caused by seborrhoeic dermatitis aggravates psoriasis and this can produce a particularly difficult condition that does not settle unless the seborrhoeic dermatitis element is controlled. Sometimes this is referred to as 'sebo-psoriasis'.

Once the skin has become inflamed with any form of eczema, exposure to detergents, soaps, shampoos etc. will aggravate it further. This can be a major factor in causing the seborrhoeic dermatitis to become more severe and persistent.

Many skin irritants can make the condition worse. Care should therefore be taken to limit exposure to DIY materials such as solvents and chemicals.

What does it look like?

The most common sites for seborrhoeic dermatitis are the scalp, eyebrows, forehead, creases around the nose and cheeks, ears, front of the chest, between the shoulder blades and in skin flexures (folds). In people with lighter skin tones, the skin appears scaly and faintly red. In people of colour, affected areas are scaly and lighter or darker in colour than the surrounding skin, and may have no redness. In people with darker skin, scaling can have a flower-like shape.

Dandruff (also known as pityriasis capitis) is a mild form of seborrhoeic dermatitis only seen in the scalp, it can affect up to 50% of adults at some point and is treated with medicated shampoos bought over the counter. Seborrhoeic dermatitis includes symptoms of more severe dandruff, with inflammation and affecting other areas as well as the scalp.

In more severe seborrhoeic dermatitis, flexural areas, such as the armpits and groin may be affected but the scale may be absent, and the skin can look a bit more glazed. On more exposed areas, the scale can become quite marked and yellowish.

Seborrhoeic dermatitis may or may not be itchy and can vary from day to day.

Usually, one or two areas of skin are involved, but seborrhoeic dermatitis can be extensive, involving:

- **Scalp:** On the scalp it can range from a mild flaking of the skin (dandruff) to inflamed, scaly areas, which can sometimes weep.
- **Face:** Typically, the skin around the sides of the nose and in the creases, and sometimes the cheeks, can become red or lighter or darker than the surrounding skin (depending on skin tone), and scaly. The inner half of the eyebrows can develop 'dandruff'. Sometimes the eyelids and eyelashes become involved, a condition known as 'blepharitis'.
- **Ears:** Seborrhoeic dermatitis may occur around the ears. Eczema can occur in the ear canal (otitis externa), on the earlobe or behind the ears. For more information, please see Eczema UK's Ear eczema factsheet.
- **Generalised:** Very rarely, the dermatitis can become severe and extensive, covering large areas of the body and needing more aggressive management. This is most likely in people who are immunosuppressed (for example people with HIV).

How is it diagnosed?

The diagnosis is made from the history and appearance of the skin in the affected area. Normally there is no need for any particular test, unless the doctor thinks it may be a fungal infection, in which case skin scrapings are taken for mycology testing. If there is doubt about the diagnosis, a biopsy may be necessary, but this is rare.

How is it treated?

Seborrhoeic dermatitis cannot be cured, because once an individual has become allergic to *Malassezia* on the skin, exposure to it will always cause a problem.

The only way to keep it under control is to use anti-yeast treatments, which will suppress seborrhoeic dermatitis but not eradicate it.

However, it is usually not difficult to keep seborrhoeic dermatitis under control, and topical treatments are safe to use long-term, on the advice of a healthcare professional.

Milder cases are often managed with over-the-counter remedies, and pharmacists should be able to advise on these.

The major reservoir for the yeast is the scalp, so a medicated anti-yeast shampoo should be used.

Even if all signs of the condition have disappeared, it is advisable to use an anti-yeast shampoo once a week as an ongoing preventative measure.

After treating the scalp, it may still be dry, so an emollient should be used.

Moisturising the scalp

Medical emollients can be applied to the scalp by parting the hair and massaging them into the skin.

Ointment-based emollients are not suitable as they are greasebased and difficult to wash out. A list of suitable lotion and spray on emollients can be found in the Eczema UK's Emollient factsheet.

Coconut oil is another option, which, like emollient creams, can be bought in pharmacies. It comes as a solid form that melts at skin temperature.

Olive oil is no longer recommended as it has been found to damage the skin barrier.

People often prefer to moisturise the scalp in the evening, wearing a cotton turban or shower cap to keep the emollient in overnight, and then rinse the product out in the morning.

Treating the scalp

There are many over-the-counter anti-yeast shampoos available. These include:

- Dandrazol (ketoconazole)
- Nizoral (ketoconazole) – also available on prescription
- Selsun – warning: selenium can stain cheap metals and jewellery black
- Dercos shampoo – containing selenium disulfide and salicylic acid.

Use these shampoos as a treatment rather than as a hair wash. Leave them on for 5-10 minutes and then rinse off. Avoid using these more than twice a week as there is a risk of irritation.

For more severe seborrhoeic dermatitis affecting the scalp, a scalp application or lotion containing a steroid and salicylic acid (e.g. Diprosalic scalp application) may be prescribed. This will help control inflammation and scale.

Tar-based shampoos or Dermax (not tar-based) are good for keeping symptoms of flaking and scaling at bay, and they can be alternated with a ketoconazole shampoo. Tar-based shampoos include:

- Neutrogena T/Gel Therapeutic Shampoo
- Capasal Therapeutic Shampoo.

As with the treatment shampoos above, avoid using these more than twice a week as there is a risk of irritation.

If the scalp becomes very scaly, you may need a de-scaling agent such as salicylic acid along with the shampoo. Alternatively, Capasal shampoo is a tar-based shampoo that contains a de-scaling agent.

Elsewhere on the body

Seborrhoeic dermatitis is typically quite mild elsewhere. Anti-yeast creams or ointments are usually effective and can be used safely in the long-term. Examples include clotrimazole, miconazole and nystatin. They are sometimes combined with a mild steroid for a few weeks to settle inflammation.

Sometimes, healthcare professionals advise people to wash their body with an anti-yeast shampoo containing ketoconazole, as well as using it on the scalp.

This can be a good way of treating large areas, such as the chest. Leave the shampoo on the body area for 5 minutes or so before rinsing it off. Since applying shampoo to the body can irritate dry skin, do this no more than twice a week. In between, emollients can be applied if the skin is dry.

It is better to use a cream or ointment rather than a shampoo on smaller areas, such as the face. Sometimes, anti-yeast eardrops are prescribed for the ear canals.

Mild topical steroids should be used for short-term bursts of treatment. The steroid treats the skin inflammation, and once any irritation has settled and the dermatitis is controlled, it is wise to use just the anti-yeast agent.

Mild topical steroids can also be prescribed or purchased from the pharmacist as a combination treatment, recommended as a 7-day treatment course (e.g. Daktacort).

An oral anti-yeast treatment may be needed (e.g. itraconazole or fluconazole) if the seborrhoeic dermatitis becomes severe or extensive. Oral medication is taken over several months.

The important message is that long-term treatment is needed to keep this condition at bay. If it recurs, it is not because the treatment has failed – it is because of the persistent nature of the condition, due to sensitivity to *Malassezia* yeasts. Therefore, ongoing treatment with anti-yeast measures is vital.

If you live in England and you pay for your prescriptions, it may be worth investing in an NHS prescription pre-payment certificate (FP95), which you can apply for online or at some registered pharmacies.

Ask your pharmacy about obtaining a PPC (FP95) form. Most of the treatments are available from a pharmacy without a prescription, although some are quite expensive.

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