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Eczema treatment: it takes time to do no harm

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Linked Article: Ridd et al. *Br J Dermatol* 2017; **177**:719–734.

This issue of the *BJD* includes an important systematic review on self-management interventions for people with eczema.¹ Twenty studies (3028 participants, mostly children in secondary care) were analysed on the efficacy of the intervention, which was measured by outcomes such as reduced disease severity and increased quality of (family) life. Due to lack of use of standardized outcome measures,^{2,3} lack of blinding of assessing disease severity and the diversity of the interventions, no thorough meta-analysis could be performed or anything substantially concluded on which interventions works best and – more importantly – why. That's a pity, because some interventions reduced disease severity way beyond the established mean clinically important differences of some outcome measures used.

The review shows that eczema treatment is complex, mainly carried out by patients themselves (or their carers) and difficult to adhere to. It also shows that there are caring physicians and nurses, who also developed educational programmes to improve outcomes and even found the time and means to measure its effects. Being a patient myself, with eczema since birth, those findings resonated deeply, because I still remember those carers who alleviated my burden.

Two publications from 2003 about improving eczema through patient education really caught my attention. Cork et al. showed that by educating and guiding the parents of children with eczema, adherence to emollient therapy improved, and subsequently eczema severity decreased by 89% without increasing the (potency of) active topical treatment.⁴ That same year, Beattie and Lewis-Jones showed the lack of knowledge among carers of children with eczema on the potency, benefits and potential harms of topical corticosteroids.⁵ What I took from both studies is this: it really takes time and effort to optimize eczema treatment.

Ridd et al.¹ – the review at hand – found that only five of the 20 reviewed interventions were based on a theoretical framework and suggest that interventions could follow the PRECEDE/PROCEED model.⁶ Eczema treatment consists of not only 'doing things' for benefit but also 'abstaining from things' to reduce harm, and all this needs to be embedded in daily routine. Therefore educational programmes will have to address multiple cognitive and behavioural factors. An interesting approach to such an underpinning framework might be found in an article by Wan et al. in the *World Journal of Diabetes*.⁷ In their article, Wan et al. introduce the acronym KMAP-O, relating to a patient's **K**nowledge, **M**otivation, **A**ttitude and **P**erformance as a predictor for **O**utcome. One might think that providing adequate information could address the four KMAP constructs, but to improve self-management skills, individually tailored approaches might be needed. For example, the complex issue of corticosteroid phobia^{8,9} makes clear that increasing knowledge does not necessarily change attitudes.

Regardless of the method, the programme or the setting of care, treating people with eczema takes time, which is scarce in health care. Nonetheless it is important to realize that investing time in eczema care is not only intended to improve outcomes but also to prevent unnecessary disease burden and in some cases even to prevent harm. I would therefore encourage all those treating people with eczema to read this review and invest in educating their patients with eczema, whichever way,¹⁰ as that certainly causes no harm and might even prevent it.

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Conflicts of interest

None to declare.

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Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher's website:

Audio S1. Author audio.

Confocal microscopy facilitates the 'one-stop-shop'

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The increasing incidence of basal cell carcinoma (BCC) and the consequent impact it has on our health service systems requires an interventional approach to streamline care and reduce the number of hospital visits patients require. Kadouch and colleagues¹ acknowledge that reflectance confocal microscopy (RCM) can be used to diagnose BCC with a high sensitivity and specificity against set diagnostic criteria^{2,3} and on this basis, RCM is trialled in this multicentre, randomized study.

In this study, 100 patients with low-risk lesions clinically suspicious of BCC were randomized. Their aim was to investigate the whole test–treatment pathway with the primary outcome of tumour-free margins by using punch biopsy/excision vs. RCM/excision. In the RCM group all patients had tumour-free margins (40 of 40); in the punch biopsy

group, 94% (31 of 33) had tumour-free margins. The two patients with incomplete margins were of a low-risk subtype on the excision specimens. The conclusion of the study is that RCM is noninferior to the standard practice of punch biopsy for use as a way of facilitating a one-stop-shop for BCC care.

There are several points to address with this study, as the methodology does not fully reflect real practice in a one-stop-shop clinic; a complete surgical excision is normally undertaken only if a biopsy suggests BCC or clinical suspicion persists after the biopsy. In addition, in many cases of low-risk BCCs, therapeutic curettage or direct excision is performed without a preceding diagnosis. In this study, surgical excision is taken after every RCM or punch biopsy; this in practice would increase patient visits. Performing the study in this manner it becomes a comparison study of RCM vs. pathology; however, as the authors did not cite the RCM diagnosis of BCC subtype in the 40 cases confirmed,⁴ it is not possible to determine if the six cases of aggressive BCC subtype (confirmed histologically) were detected using RCM – only that the prescribed excision margins used were tumour free. Furthermore, it is not clear to which arm of the study the incorrectly diagnosed melanoma or squamous cell carcinoma belonged. Appropriate training in confocal microscopy is essential and it is well reported that diagnostic accuracy increases with years of experience;⁵ as the authors state, this likely explains some of the diagnostic inaccuracies in this study.

RCM is likely to play a valuable role in the one-stop skin cancer clinic; its versatile imaging modality can obviate the need for invasive procedures to make the diagnosis and, in addition, can assess tumour margins.⁶ The authors have coordinated the multicentre approach well and if the additional qualities of RCM were utilized it might elevate the use of this technology to optimum care.

Conflicts of interest

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