

All About Contact Dermatitis



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All About Contact Dermatitis

Introduction

This booklet is for people who may have contact dermatitis or those who are waiting for a referral to a contact dermatitis clinic or who have been diagnosed with contact dermatitis and need more information on prevention, management and work issues.

What is contact dermatitis?

Contact dermatitis, or contact eczema ('dermatitis' and 'eczema' can be used interchangeably - both refer to the inflammation of the skin) is the name given to types of eczema that occur as a result of contact with irritants or allergens in the environment.

Contact dermatitis can be broadly divided into two types: **irritant contact dermatitis (ICD)**, where the eczema develops as a result of contact with substances that directly damage or irritate the skin (not an allergy); and **allergic contact dermatitis (ACD)**, which develops when an individual becomes sensitised or allergic to something in the environment. However, there is overlap between the two and it is possible to have both simultaneously.

What does contact dermatitis look like?

Contact dermatitis can vary from mild to severe. The skin will become dry and scaly with inflammation (red or darker patches depending on your skin colour).



Irritant contact dermatitis

If you have severe contact dermatitis, tiny blisters (called vesicles) may appear that can burst and weep. The skin can become wet, weepy, and sore.

The most distressing symptom of contact dermatitis is the itch, which can make it very hard not to scratch!

If the contact dermatitis is severe, the skin can develop painful cracking and splitting. Often this involves the fingertips.

What will my healthcare professional need to know about my contact dermatitis?

Your healthcare professional cannot make a diagnosis just by looking at your skin. They will also need to ask you a number of questions. Your answers will help them diagnose whether you have contact dermatitis and, if so, whether it is irritant or allergic. The questions may include:

- **Onset** When did your skin first become red or darker than your usual skin colour, itchy and sore?
- **Duration** How long has the condition been present?
- **Site** What areas of the body are affected? If it is on the hands, which hand and what part of the hand?
- **Pruritus (itch)** How great is the degree of pain, itching and soreness associated with the dermatitis? What measures are used to cope with this, and how does it impact on your life? Have you noticed what makes the rash better or worse?
- **Family history** Is there or has there been anyone else in the family with skin disease, atopic eczema, asthma or hay fever?
- **Occupation** What types of products are used? What kind of protection is used at work (e.g. clothing, gloves and barrier creams)? Does the skin improve when not at work? (See pages 11–15).
- **Hobbies and leisure time** What types of hobbies do you have? Do they involve contact with particular materials and substances, pets and animals, plants or exposure to sunlight?
- **Clothing** What types of clothing fabrics are usually worn and which fabrics flare or irritate the eczema?
- **Jewellery** What types of watches and jewellery are worn?
- **Impact on quality of life** How are school, work, family and relationships affected by the eczema?
- **Skincare** What everyday products are used for washing (body and hair), make-up, perfumes and after-shave? Are your symptoms related to use of any of these products or do they cause irritation?
- **Medication** What medicines are taken regularly? What topical treatments are used?
- **Allergies** Do you have any known allergies to medicines or substances that come into contact with or are applied to the skin?
- **Food** Does handling any particular food make the dermatitis worse? What sort of contact reaction occurs?

If the contact dermatitis is made worse by being at work, a detailed description of the work environment will be needed (see page 12).

Irritant contact dermatitis (ICD)

An irritant is a chemical that in most people is capable of producing skin damage if applied for a sufficient length of time and in a sufficient concentration.

The effects increase over time. At the beginning the damage to the skin may be invisible and it is only later that the damage can be seen.

ICD occurs when there is frequent contact with everyday things such as soap, detergents, oils, hair cosmetics, bleach, household cleaning products, cold wind and raw food. ICD is far more common than ACD. Whether or not ICD develops will depend on:

- What irritants the skin is exposed to and their strength – for example, wet cement is a strong irritant and detergent is a weak irritant.
- The amount of exposure.
- How often the skin is exposed to the irritant.

Other factors that may predispose you to ICD

If you have a history of atopy (eczema, asthma or hay fever), you are more likely to have a sensitive skin and therefore your skin is more vulnerable to ICD.

If your hobbies or occupation involve you putting your hands in and out of water all day, your skin is more likely to develop ICD. This is particularly likely if the hands are not well dried or if rough paper towels are used to dry your hands.

However, most people are not often in contact with water alone. If you are using water plus detergent or other chemicals, these may cause your skin to become gradually drier and contact dermatitis may develop.

Over washing hands with soap or constant use of alcohol gel is a common cause of ICD.

In addition to using water and chemicals, if you are also working outside, possibly in very cold temperatures, then additional chapping may occur. Extremes of temperature, humidity – particularly a lack of it – will also be important elements and may indeed be the sole factor causing ICD.

Age-specific ICD

ICD and ACD can affect all ages. Here we cover issues relating to ICD in different age groups.

Infants and children

Infants and children are susceptible to ICD due to everyday exposure to common irritants coming into contact with their skin. These include:

- **Nappy rash** (also called diaper rash, nappy dermatitis, diaper dermatitis or irritant diaper dermatitis) is one of the most common skin conditions found in infants. The wearing of nappies causes an increase in skin wetness and alkalinity. If the wetness is prolonged, this can lead to the softening and breaking down of skin (maceration), which makes it more susceptible to friction from the surface of the nappy. It also increases the risk of further skin damage and other problems caused by exposure to irritants – especially faeces, which contain proteases and lipases, and ammonia in urine. Other factors that may aggravate or lead to worsening of the rash

include repetitive skin cleansing, inadequate skincare, infections, antibiotics, diarrhoea and problems with the gut or urinary tract. If nappy rash is persistent or severe, especially if your baby is rubbing or scratching the area, this may be an eczema flare rather than contact dermatitis. Speak to your GP about assessment and additional eczema treatment.



- **Teething** commonly causes ICD around the mouth and chin due to the constant wetness from dribbling saliva.
- **Exposure to facial irritants** Runny noses, messy foods when weaning and exposure to harsh weather can have an irritant effect on babies' faces.

- **Baby wipes** and wet wipes can also irritate the skin, causing ICD and in some cases ACD – due to alcohol, which dries the skin, and fragrance, which irritates the skin. This is more likely when babies have atopic eczema. If wipes are used, choose ones that are alcohol- and fragrance-free or water-only. It is preferable to clean your baby's skin with emollient spread onto damp cotton pads.
- **Messy and wet play** As they play and learn, young children inevitably become involved with messy activities that may irritate their skin, especially at nursery and school. A common culprit is slime, which is known to cause ACD.

Teenagers

Teenagers are exposed to a variety of potential irritants and sensitisers: soaps, detergents, perfumes, shaving products, make-up, hair dyes, and heat and sweat from physical activities. Hobbies and part-time or weekend work may also expose them to potential irritants or sensitisers.

*See National Eczema Society's *Guide for Teenagers with Eczema* for more information, which you can download from the National Eczema Society website.

Adults

Adults are exposed to common irritants throughout their lives but are more susceptible to ICD on a daily basis due to occupational and lifestyle triggers. For example, new mums often experience problems due to the increased hand washing associated with caring for a baby: nappy changes, making feeds etc. Constant wet work such as housework, DIY and activities at home can also cause ICD.

Older people

Older people experience problems with ICD for several reasons. As we age, the skin barrier function is affected and our skin becomes more prone to irritation from soaps, over-washing, temperature changes and exposure to irritants and wet work associated with hobbies. In older people ICD can also affect the buttocks and genital area if there are problems with urinary or faecal incontinence (incontinence-associated dermatitis). This can be made worse by over-washing, the use of wipes and the type of pad used to cope with the incontinence.

It may be impossible for your doctor, nurse or dermatologist to tell whether you have ICD or ACD simply by looking at your skin. There are, however, various sites that are particularly prone to developing ICD.

Hands Irritants such as dust and chemicals can collect:

- Under rings.
- In the web spaces between the fingers.
- On the backs of the hands.

Face ICD can be caused by:

- Changes in temperature.
- Cosmetics, especially some anti-aging cosmetics containing retinol-type chemicals.
- Toiletries, particularly 'washes', 'toners' and make-up removers.
- Highly perfumed preparations.

Body If the skin is very dry then simply friction from clothes may produce ICD.

Allergic contact dermatitis (ACD)

Although many people may have contact with chemicals, only a very few develop an allergy to them. In these people the body's defence mechanisms learn to recognise the chemical. They therefore develop a reaction when the chemical contacts the skin again. The allergy is 'remembered' by the body for many years. In medical terms the body has become 'sensitised' to a chemical.

Common sensitisers

The most common contact dermatitis allergens in Europe are: fragrance, thiomersal (antiseptic), cobalt (cement), nickel, paraphenylenediamine (hair dye, henna, temporary tattoos) and formaldehyde (chemical preservative).

Prevalence of contact allergens can change over time, for example, there is a new epidemic of (meth)acrylate allergy in the UK, brought about by the trend for acrylic nails (Rolls, Rajan, Shah, 2018).



ICD under ring



ACD to nickel in watch strap

Nickel Nickel allergy can affect all ages and is one of the most common causes of ACD. It develops in places where nickel-containing metal touches the skin: for example, the earlobes (from earrings), the wrists (from a watch strap), the lower abdomen (from a jeans stud) and from other clothing and accessories such as jewellery, belts and dummy clips.

Perfume/fragrance Many products such as cosmetics, toiletries and hand washes contain perfume. A perfume has many chemicals within it, some of which may sensitise. Allergy to perfume is the commonest cause of ACD following contact with cosmetics and toiletries. Limonene (citrus) and linalool (herbal/flower) are common fragrances

added to skin and household products. They are known contact allergens.

Methylisothiazolinone (MI) and Methylchloroisothiazolinone (MCI)

Methylisothiazolinone (MI) and Methylchloroisothiazolinone (MCI) belong to the family of isothiazolinones. They are preservatives found in cosmetics and household products. In Europe they were a leading cause of ACD. However, European and UK legislation in 2016 banned MI/MCI from leave-on products, and in 2017 MI was banned and MI/MCI only permitted in reduced amounts in rinse-off products only. MI/MCI allergy a contact allergy seen in approximately 2% of patients with ACD in 2025, but this has dramatically reduced from 6% in 2017. The MI/MCI ban does

The top 10 most common allergens

Annually, the European Society of Contact Dermatology compile a list of the top 10 most common contact allergens in Europe. In 2024, this was the most recent top ten:

1. Nickel
2. Fragrances mix
3. Cobalt – metal allots
4. Methylchloroisothiazolinone (MCI/MI) –preservatives
5. PPD (p-phenylenediamine): hair dyes and temporary tattoos
6. Formaldehyde – preserving fluid
7. Myroxylon pereirae resin – Balsam of Peru - cosmetics, sunscreens, foods
8. Thiomersal – make up, soap, topical antibiotics
9. Potassium Dichromate –leather, inks and dental implants
10. Chromate – cement, building materials

One example of a rising contact allergen is the chemical methyl methacrylate (MMA), found in acrylic and gel nails. Nail ACD is increasing as gel nails became more popular. MI has reduced from approximately 6% in 2027 to 2% in 2025.

not apply in the USA where allergy levels are up to 15%, so be aware if you buy personal products which are US-made.

Preservatives Preservatives are used to prevent the growth of bacteria and fungi and are used in household goods, industrial chemicals, textiles, cosmetics, skincare products (including creams, topical corticosteroids, lotions), medications and eye and ear drops. Common sensitising preservatives include parabens, formaldehyde and MI/MCI. Rarely topical treatments can cause ACD.

Paraphenylenediamine

Paraphenylenediamine (PPD) is found in photographic developer and lithography plates, photocopying and printing inks, black rubber, oils and greases. It is also a common ingredient in permanent hair dyes, textile dyes, dark-coloured cosmetics and temporary tattoos. Black henna or 'natural henna' tattoos contain PPD at very high levels in order to produce a dark colour quickly. The high concentration of henna on the skin can cause chemical burns and lead to allergic reactions. In its natural form henna is a red/orange colour; black henna is not 'true' henna and should be avoided.

Footwear ACD in reaction to footwear can occur as many materials, chemicals, glues (e.g. colophony, and para-tertiary-butylphenol formaldehyde resin), dyes (e.g. PPD) and metals (e.g. nickel and cobalt – found on buckles and decorations) are used in

the manufacturing process. Rubber accelerators (used to speed up manufacture) and chromates (e.g. potassium dichromate, used in leather tanning) can be a problem, as can formaldehyde (used in the tanning of white leather shoes). Another potent allergen that permeates the leather is dimethyl fumarate (placed in sachets in shoe boxes to prevent mould growth).

Adhesives Elastoplast has rosin or colophony as its 'sticking' agent and can cause ACD. There are now adhesive tapes available which are less likely to sensitise.

Acrylic nails There has been an increase in nail/fingertip contact dermatitis as a result of the trend for acrylic nails. These allergies may be due to acrylic chemicals, dip powder and gel colour/decoration.

Rubber Goods made from natural rubber (e.g. rubber gloves and rubber tyres), have many chemicals added to the liquid latex. These chemicals are known as accelerators, retardants or antioxidants and can sensitise.

Plants Many plants can sensitise. *Primula obconica*, chrysanthemums and members of the daisy family are particular culprits.

Organic oils Essential oils applied directly to the skin, often found in natural moisturisers and household products, can cause ACD. Organic oils that most commonly cause sensitisation are lemongrass, ylang-ylang, clove, jasmine and tea tree oil.

Patch testing

If ACD is thought to be a possibility, then you need to be referred to a dermatologist who may recommend patch testing.

Patch testing is very safe. It is used to detect allergies to substances that come into direct contact with skin.

NICE guidance also advises referral for patch testing if ACD is suspected in cases of persistent atopic eczema or facial, eyelid or hand atopic eczema.

It is appropriate for infants and children, as well as adults, but requires time and preparation in order to be successful. There is a standard battery of patch tests – depending on your history, you may be patch tested for a range of different substances.

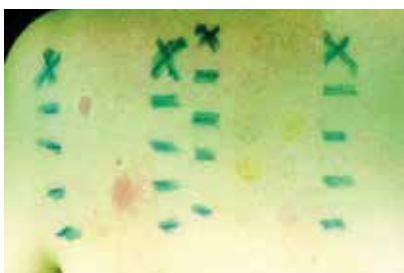
Patch testing is not used to detect ICD and neither is it used for diagnosing food allergy. The choice of sensitisers tested will depend on a number of factors such as:

- Where the eczema is.
- Your occupation or hobbies.
- Personal use of cosmetics or creams, lotions and ointments.

The sensitisers are placed in small amounts in chambers attached to adhesive tape. The skin on your back is usually chosen for testing. The chambers are placed on the back and left in place for 2 days. They are then removed and the skin is examined. This is known as the 'first reading'. After a further 2 days a 'second reading' is taken. The dermatologist is looking for an area of a positive reaction to one of the



Patch tests in situ



Positive results

sensitisers. A positive reaction will be an itchy, raised patch that is red or darker than your usual skin colour, depending on skin tone, and is sometimes blistered.

"I have had 'patch testing' but it didn't help to identify the cause of my allergy. What went wrong?"

Sometimes the results of patch testing are negative and no allergies are found. Although you may feel frustrated that the cause of your problem has not been identified, patch testing has been helpful in that it has excluded the likelihood that your dermatitis is caused by an allergy.

"I had atopic eczema as a child, so am I more likely to develop contact dermatitis?"

The answer is yes and no! If you have, or have had, atopic eczema, your skin is more vulnerable to developing ICD, particularly if the atopic eczema affected your hands, as atopic eczema is likely to have left you with a skin sensitive to irritants. However, ACD is not more common in those people

who are 'atopic' than in the general population.

Adults with a history of atopic eczema may find that in later life the condition reappears on their hands as a result of contact with irritants such as detergents.

Hand eczema

Eczema affecting the hands is common and can be very disabling. The hands can be affected by ICD or ACD and sometimes by both at the same time. Whatever the type of hand eczema, the clinical picture will be of hands that are:

- Itchy.
- Scaly, dry and red or darker than your usual skin colour, depending on skin tone.
- Often accompanied by blistering, soreness and cracks or splits in the skin.

Not all these symptoms and signs may be seen. Some people may have blistering, while others may have a thick, scaly skin.

Hand ICD is particularly common. It is primarily caused by over-washing the hands and using alcohol gels and



Hand ICD with a glazed surface, redness and scaling.

irritants in the home and working environment.

Hand ACD may also occur both on its own and with a background of atopic hand eczema. An example of a sensitizer would be to chemicals in rubber gloves. A list of the common sensitizers appears on pages 6-8.

*See National Eczema Society's Hand eczema factsheet for more information, which you can download from the National Eczema Society website.

Pompholyx eczema

Pompholyx is a particular type of eczema that occurs on both the hands and feet and its cause is unknown. The onset of pompholyx eczema can be very sudden. Blisters commonly occur on the palms of the hands, the sides of the fingers and the soles of the feet. The skin is initially very itchy and it may be hard to resist scratching. If you scratch, the blisters burst causing soreness and weeping. The skin will then dry out and often peel.

Factors such as stress, nickel sensitivity and hot, humid conditions may play a part, but usually no cause



Pompholyx eczema

is found. Pompholyx can occur as an isolated solitary event, or may reoccur, coming and going in cycles. However, pompholyx is only rarely due to contact dermatitis.

*See National Eczema Society's Pompholyx eczema factsheet for more information, which you can download from the National Eczema Society website.

Contact dermatitis at work

For some people the development of contact dermatitis may be due to their working environment. Skin problems are a major cause of time off work, and from the statistics available it would appear that contact dermatitis is particularly important.

It cannot be stressed too much that early investigation is essential if you suspect that you have contact dermatitis. An early diagnosis will help to reduce time off work. Your dermatologist or occupational health nurse or doctor may need to thoroughly investigate your working environment.

Contact dermatitis can develop on any part of the body. Occupational hand eczema is common. An airborne irritant or sensitiser can lead to facial

eczema. Even covered skin can be affected if working clothes come into contact with sensitisers and irritants.

What will happen when I see the dermatologist?

If your working environment is suspected, your dermatologist will need to ask you a number of questions and will ask you to describe your working practices and environment.

Below are examples of some of the basic questions you are likely to be asked. The dermatologist is looking for clues that will indicate what may be causing your contact dermatitis, the protective clothes and barrier creams available to you and whether the skin problem affects other members of staff in the same job.

Basic questions you may be asked:

- Do you work inside or outside?
- Can you explain the processes involved in your work and provide safety data sheets for the chemicals you work with?
- What washing or showering facilities are available to you?
- Do you use barrier creams or after-work creams?
- What kind of temperature and humidity do you work in?
- How long have you been employed in your job?



ACD on eyelids due to epoxy resin

- How many hours do you work per day?
- Are there other members of the workforce who may be affected?

Once the dermatologist has a general picture of your working conditions and working practices, they will probably ask you questions that are specific to your job. Again, your answers will provide clues to the possible cause of your dermatitis.

Specific questions a dermatologist may ask about your work:

- Are you involved in wet or dry work?
- Do you use detergents or solvents?
- Are you handling specific chemicals or any other materials?
- How often are you handling chemicals?
- How powerful are the chemicals you are handling?
- How much of your work involves handling chemicals?

- Does your work involve oils or grease?
- Does your work involve friction to the hands (e.g. by the regular use of tools)?
- Is there a lot of dirt in your job?
- Do you wear protective clothing and, if yes, what sort of clothing?
- Describe all the areas visited during your day at work.

Your answers to these questions will help to build a complete picture of the irritants and sensitisers you come into contact with and particularly the precautions that are being used to reduce contact with an irritant or sensitiser. As with all other types of eczema, your occupational health nurse, doctor or dermatologist will want to know if you have a history of eczema or sensitive skin.

Investigation

The dermatologist will need details of specific irritants you are exposed to and may want to carry out 'patch testing' (see pages 8-9) on these individual occupational irritants. If your dermatologist suspects that your working environment is causing your contact dermatitis, you will be asked to bring with you a list of the substances used in your work and the safety data sheets. Finding the cause of contact dermatitis can be a long process as a

great deal of care needs to be exercised. Both you and your employer will need to be patient.

Prevention

Most ICD and ACD is preventable (but this is not always easy) by taking the following precautions:

Avoid irritants

The most common irritants are soaps and detergents, although water itself is also an irritant. A good skin protection routine is needed to keep the skin strong and healthy. Most ICD involves the hands. Gloves are therefore the mainstay of protection. For general purposes and household tasks, rubber or PVC household gloves, possibly with a cotton liner or worn over cotton gloves, should suffice.

It is important to remove the gloves frequently as sweating may aggravate existing dermatitis.

Below are some practical tips.

In the home:

- Avoid frequent contact with water and use protective gloves for household tasks.
- Ensure the gloves give complete protection and that the insides of the gloves remain dry.

- Wash hands with your leave-on emollient as a soap substitute or an emollient wash, and then rinse off.
- Use plenty of moisturiser and reapply frequently throughout the day.
- Do not wear rings while carrying out household tasks.
- Disinfectants and cleansers should be used as little as possible.
- Protective gloves should be:
 - worn for as short a time as possible;
 - kept dry and clean; and
 - possibly worn with cotton gloves underneath as well.
- Moisturise the skin at frequent intervals (during tea, coffee and lunch breaks).
- Avoid wearing rings where possible.

In the workplace:

- Do not use abrasive skin cleaners and keep the use of disinfectants to a minimum.

Avoid sensitisers

Whenever sensitisers have been identified, measures should be in place

A word about protective clothing

For sensitisers and irritants, suitable preventive clothing should be made available to you at work, including the correct gloves for the materials you are handling. Gauntlets should also be provided by your employer if they are necessary for adequate protection.

Whether at home or at work, care needs to be taken when selecting gloves if you are allergic to any materials used in gloves.

For general purposes and household tasks, rubber or polyvinyl chloride household gloves, possibly with a cotton liner or worn over cotton gloves, should suffice.

It is important to take the gloves off on a regular basis as sweating may aggravate existing dermatitis. In the workplace, the type and length of glove worn will depend upon the nature of the chemicals involved. Health and safety information for handling the chemicals should stipulate which gloves should be used.

Further information regarding the use of gloves in the workplace can be found at www.hse.gov.uk/skin/employ/gloves.htm

to reduce contact with them. Avoiding sensitisers you are allergic to is the best way to prevent ACD, but this is often easier said than done.

If you and your dermatologist have identified things you are allergic to, then you will need to pay attention to product labels on things such as cosmetics and perfumes and, because there is no legal obligation to include a complete ingredients list on the label, it may be necessary to contact manufacturers to find out if the sensitiser is present or to identify substitutes.

Employers are required by law to prevent, or where that is not reasonably practicable, to provide adequate controls against, exposure to materials in the workplace that cause ill-health, including dermatitis. More information is available from the HSE (see page 18).

Many products are described as 'hypoallergenic' but what exactly does this word mean? Unfortunately the word gives no idea of what has been included or excluded from a product and without this information, 'hypoallergenic' means very little.

Management and treatment of contact dermatitis

Once contact dermatitis has occurred, management of the skin is very important. Apart from the avoidance of irritants and known sensitisers, treatment of contact dermatitis involves:

- **Emollients** (medical moisturisers) to rehydrate the skin and for washing. While Covid-19 remains a threat, hand washing with soap is recommended to remove Covid particles. We advise washing hands with emollient afterwards to counteract the effects of soap.
- **Topical steroids** – to reduce inflammation.
- **Topical calcineurin inhibitors** – to maintain and prevent flare-ups.
- **Development of a good skincare routine.**

Emollients

The use of emollients is very important. Most can be used as soap substitutes. They soothe and relieve dry skin, producing an oily layer over the skin

surface that traps water beneath it. The aim is to restore the skin's barrier and rehydrate the skin. You may have to try several different emollients until you find the one that suits you best. You may wish to use a lighter, less greasy emollient in the day and a heavier, more greasy one at night.

Topical steroids

Skin that is experiencing a flare-up of contact dermatitis will need topical steroids to bring the contact dermatitis rapidly under control. Topical steroids help to reduce inflammation and speed up the healing of the skin.

Topical steroids for hand eczema need to be prescribed at the correct potency to adequately treat eczema, so a potent or very potent strength may be used for a short treatment burst and then stepped down to a weaker steroid, or used every other day, until the eczema has settled. Generally, very potent or potent steroids are prescribed for the palms of the hands and soles of the feet, where the skin is thicker, whereas if contact dermatitis is on the face, where skin is thinner, a mild or moderate steroid would be prescribed. If topical steroids are prescribed at the correct potency and you follow the instructions of your healthcare professional, side effects are unlikely.

If you have infected eczema, you may also be prescribed a combined

steroid/antibiotic cream or a course of antibiotic tablets to bring the infection under control.

Topical calcineurin inhibitors can be used when the flare-up has settled as a long-term maintenance treatment.

A good skincare routine

Good general skincare measures can help to look after the skin and are essential, particularly for those with hand eczema (see pages 10 and 11). It can take several months for the skin to recover completely from an attack of contact dermatitis, so even when it looks apparently normal it is still vulnerable.

Additional treatments

In severe cases of hand eczema, other treatment including antibiotics (if infected), local light therapy, immunosuppressants, alitretinoin or newer biologics/jak inhibitors.

Outcome – "Why has my contact dermatitis not cleared up?"

There can be a number of reasons why contact dermatitis does not clear up:

- It is not always easy to avoid sensitisers/contact allergens.
- It will depend on how long the problem has been present.
- There may be other factors that need to be considered, e.g. the presence of atopic eczema.

- If atopic eczema is present as well as contact dermatitis, the dermatitis may not clear completely even when the irritant or sensitiser is avoided.

Patch testing should be carried out early and thoroughly to achieve the best outcome if an allergy has been identified. Checking ingredient lists of cosmetics, work chemicals, etc. is very important.

Career advice

People with a history of atopic or hand eczema need to consider carefully their choice of career and this is better done while still at school. Many individuals with a background of eczema run into problems if they want to undertake certain occupations because of the materials used – see below for a list of potential problem jobs.

Risk occupations include:

- Hairdressing
- Catering
- Healthcare professionals
- Metal work
- Florists
- Mechanics
- Domestic work
- Some types of engineering
- Printing

"Will patch testing tell me whether I might become allergic in the future?"

Unfortunately there are no tests that can be undertaken to determine whether or not you will become allergic to substances.

Contact urticaria

Urticaria, also known as 'nettle-rash' or 'hives' and often described as a 'weal and flare' reaction, is not eczema. It can occur in anyone but is perhaps more common in atopics. Urticaria is an immediate reaction to a protein. The 'weal and flare' is not always seen and sometimes the immediate reaction will be blistering of the skin.

Urticaria is most commonly seen in people working in the catering industry, who come into contact with raw meat, fish, fruit or vegetables. Animal proteins may cause urticaria in those people working with or handling animals.

Natural rubber latex can also cause contact urticaria.

In all these cases there is a different type of hypersensitivity to that present in contact dermatitis and investigation will be by prick or scratch tests, rather than patch testing.

Key points

- Contact dermatitis is a common problem.
- External agents cause contact dermatitis and these can cause ICD or ACD.
- Hand eczema may be caused by contact dermatitis.
- Avoiding future exposure to the known irritant is a major part of preventing ICD.
- Avoiding known sensitisers is essential in controlling ACD.
- Moisturisers and avoidance of soaps and irritants is important for all types of eczema and contact dermatitis.
- The use of suitable gloves can prevent ACD.
- Patch testing is an important investigation when ACD is a possibility.
- There is no reliable resource giving allergy avoidance advice as manufacturers constantly change formulations.

Further information

BRITISH ASSOCIATION OF DERMATOLOGISTS

Patient information sheet on contact dermatitis

<https://www.bad.org.uk/pils/contact-dermatitis/>

COSMETICS INFO

Information source on personal care products: how they work, data to corroborate safety and science behind commonly used ingredients:

<https://www.cosmeticsinfo.org>

DERMNET NZ

<https://dermnetnz.org/topics/allergic-contact-dermatitis>

and

<https://dermnetnz.org/topics/irritant-contact-dermatitis>

EU COSMETIC INGREDIENT DATABASE

https://single-market-economy.ec.europa.eu/sectors/cosmetics/cosmetic-ingredient-database_en

HEALTH AND SAFETY EXECUTIVE (HSE)

Skin at work:

<http://www.hse.gov.uk/skin>

HSE leaflet: Preventing contact dermatitis and urticaria at work

<http://www.hse.gov.uk/pubns/indg233.pdf>

NHS CHOICES

<https://www.nhs.uk/conditions/contact-dermatitis/>

NICE

Clinical Knowledge Summary

<http://cks.nice.org.uk/dermatitis-contact>

PRIMARY CARE DERMATOLOGY SOCIETY

Allergic contact dermatitis

<https://www.pcds.org.uk/clinical-guidance/eczema-contact-allergic-dermatitis-including-latex-and-rubber-allergy>

ROYAL COLLEGE OF PHYSICIANS

Guidelines on occupational contact dermatitis

<https://www.rcplondon.ac.uk/guidelines-policy/diagnosis-management-and-prevention-occupational-contact-dermatitis-0>

Further information from National Eczema Society

More information than can be given in a booklet of this size is available from National Eczema Society. We have other booklets including:

- **Living with Eczema**
- **Childhood Atopic Eczema**
- **Itching and Scratching**
- **A Guide for Teenagers with Eczema**

National Eczema Society booklets and factsheets can be viewed and downloaded from our website.

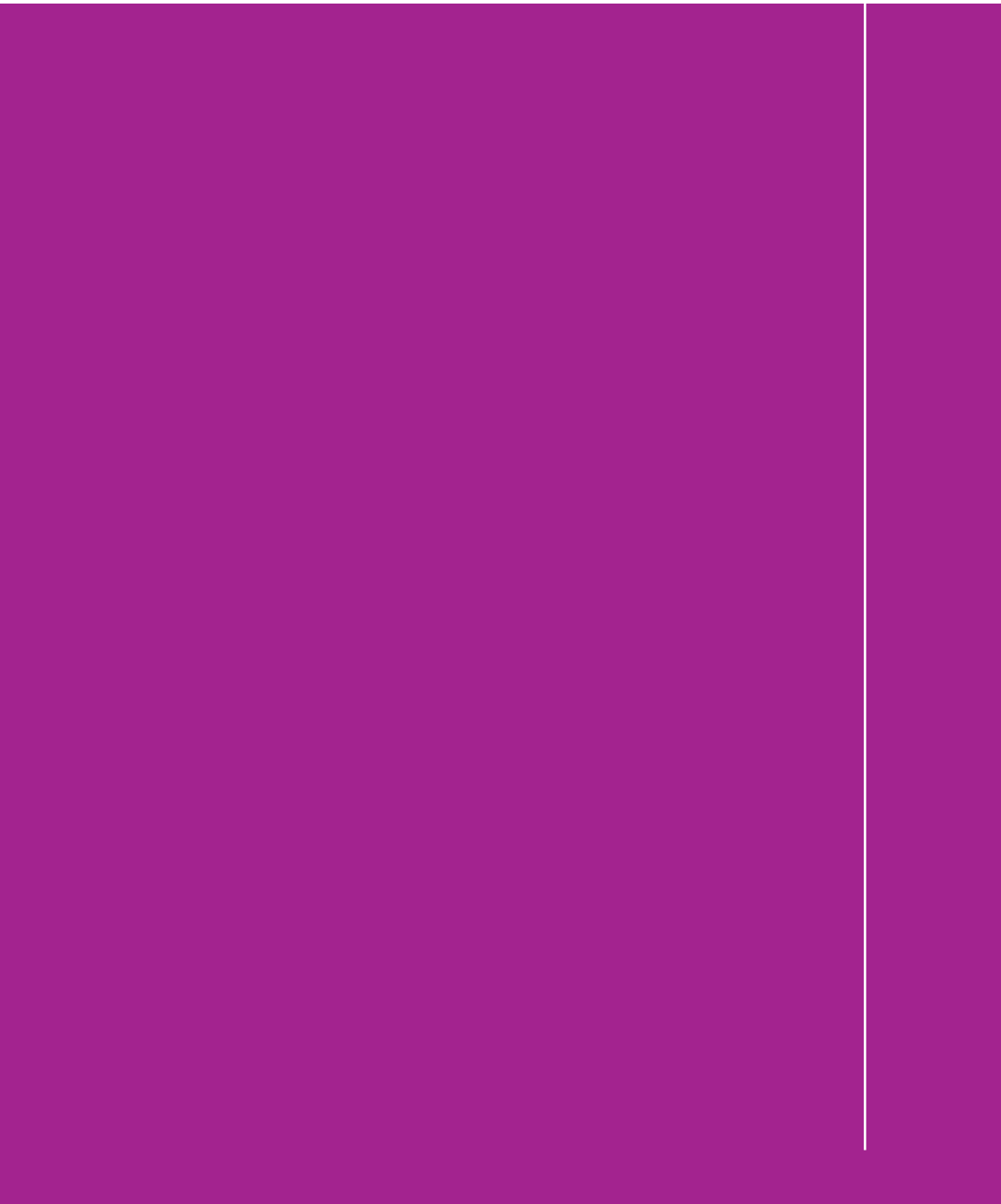
www.eczema.org

We have an extensive range of information on our website to help you live well with eczema and encourage you to visit. We also run webinars and other events about eczema and how best to manage the condition. Please also check out our Facebook, Instagram, X, LinkedIn and YouTube pages for eczema tips and news.

National Eczema Society is a membership charity and we encourage you to join! It costs just £25 per year (more if you live overseas) and members receive the charity's *Exchange* magazine produced twice a year. *Exchange* is packed with:

- Articles on how best to manage eczema
- Features on people sharing their experiences of living with eczema
- Treatment updates and research news
- Experts' replies to your questions.

It's easy to join and become a member through the charity's website www.eczema.org/membership or by telephoning our office on **020-7281-3553**.





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National Eczema Society is registered as a charity in England and Wales (No.1009671) and as a company limited by guarantee (No.2685083).

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The information in this booklet is only a general guide.

Individual circumstances differ and National Eczema Society does not prescribe, give medical advice or endorse products or treatments. We hope you will find the information useful but it does not replace and should not replace the essential guidance given by your doctor and other healthcare professionals.

This edition was reviewed and updated in June 2025, by Julie Van Onselen, Dermatology Nurse Adviser, National Eczema Society.

National Eczema Society is grateful to the St John's Institute of Dermatology for their permission to reproduce the images used in this booklet.

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