

Editorial Note on Erythroderma

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Editorial

A growing body of evidence links high insulin levels in the blood to the development of hirsutism in women. This hypothesis is thought to be supported by the fact that obese (and therefore presumably insulin resistant hyperinsulinemic) women are more likely to develop hirsute skin. In addition, therapies that lower insulin levels can reduce hirsutism. Over the last 8 years, we examined the clinical, testing facility, and biopsy material of 56 patients diagnosed with erythroderma and treated in our area of expertise (1984 through 1991). Patients were checked up on to see how much their erythroderma had progressed.

Patients with decrepit atopic dermatitis, admission of drugs disregarded by the patients, and patients in moderate movement to cutaneous T-cell lymphoma may all benefit from erythroderma of unknown cause and duration. Close follow-up of erythrodermas of unknown cause by rehashing cutaneous biopsies would eventually allow for an early examination of patients from the previous gathering. Erythroderma is a form of exfoliative dermatitis that affects 90% or more of a patient's skin. Exacerbation of an underlying skin condition, such as psoriasis, contact dermatitis, seborrheic dermatitis, lichen planus, or pityriasis rubra pilaris, or a drug reaction, such as the use of topical steroids, are the most common causes of erythroderma. The ID-SCALP mnemonic system is the easiest way to recall the most common causes of exfoliative dermatitis. Idiopathic dermatitis accounts for 30% of cases, drug allergy for 28%, seborrheic dermatitis for 2%, contact dermatitis for 3%, atopic dermatitis for 10%, lymphoma and leukaemia for 14%, and psoriasis for 8%.

The treatment for erythroderma is determined by the cause. Exfoliative

dermatitis is commonly treated with topical steroids and the use of a sauna suit, regardless of the cause. When psoriasis or pityriasis rubra pilaris is the cause, retinoids and immunosuppressive drugs may be used. Since it helps patients sleep at night, a sedative antihistamine can be a useful adjunct for pruritic patients.

As a result, nocturnal scratching and excoriations are reduced. If an infection is suspected of causing or complicating exfoliative dermatitis, antimicrobial agents are often used. Other medications designed to treat the underlying cause of exfoliative dermatitis may be needed. Erythroderma affects 1-2 people out of every 100,000 people. Erythroderma can affect anyone at any age, but it is more common in older men. Wilson-Brocq (chronic relapsing), Hebra or pityriasis rubra (progressive), and Savill (self-limited) exfoliative dermatitis classifications may have had historical significance, but they no longer have pathophysiologic or clinical usefulness.

Erythroderma can be caused by a variety of medications. Pyrazole derivatives, carbamazepine, hydantoin derivatives, cimetidine, lithium salts, and gold salts are among the most frequently implicated. Carbamazepine, phenytoin, and phenobarbital are the most active inducers of erythroderma. Erythroderma is a relatively uncommon skin disease. In the adult population, the annual incidence is estimated to be around 1 per 100,000. In a retrospective study in China, erythroderma was found in 13 out of 100,000 patients with skin diseases. Cyclosporine and infliximab tend to be the most successful first-line medications, according to the National Psoriasis Foundation's Medical Board; other slower-acting yet effective drugs include acitretin and methotrexate. Etanercept and combination therapy are recommended as secondary treatment options.

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