Clinical Algorithms

Facial rashes

R MARKS

The skin of the face, with its many large hair follicles and sebaceous glands, rich vascularity, and puny dermal connective tissue, is different from the skin of all other areas. It is also the part of the skin most consistently exposed to climatic vicissitudes. These differences probably account for the special nature of facial rashes. Some skin disorders, such as rosacea, affect the face only, whereas others, such as acne, affect the face predominantly. When solar irradiation plays a part in the cause of a skin disease the rash is often localised to the face, though other areas also exposed to light—for example, the backs of the hands, the V of the neck, and the lower legs in women—may also be affected. This is the explanation for the occurrence of the lesions of lupus erythematosus on the face.

Facial appearance is important in communication, and rashes on the face cause considerable embarrassment. If the disorder is persistent the sufferer may feel rejected and become withdrawn and socially isolated. The unhappiness that this causes should be recognised as patients need much sympathy and reassurance.

Acne is the commonest of all skin disorders that affect the face; most people are affected to some degree during adolescence. Diagnosis is not usually a problem as the greasy skin, blackheads, and inflamed papules are easy to recognise. Rosacea usually first appears in middle age and is characterised by frequent flushing and a background of erythema. Acute episodes of swelling and papules punctuate the course of the disease, which is also often accompanied by blepharitis and conjunctivitis. Rosacea rarely affects other areas of skin.

Several types of eczema occur on the face, and in trying to sort out the cause such environmental causes as light or exposure to an allergen should be ruled out. A detailed history is of prime importance in reaching a diagnosis, though a diagnostic suspicion may have to be confirmed by "patch tests" to suspected allergens or "light tests" to determine if there is an abnormal reaction to light.

Atopic eczema often affects the face, particularly around the eyes and on the forehead. The disorder is always extremely pruritic and is associated with scratch marks and areas of thickening with accentuation of skin markings (lichenification). Seborrhoeic eczema is also common on the face, causing scaling areas in the nasolabial grooves, behind and in the ears, and around the eyes. "Dandruff" is probably a mild variety of this.

When the face develops a red rash suddenly that is not eczematous in nature and there are no acutely inflamed papular lesions, as in rosacea, the possibility of acute systemic lupus erythematosus or dermatomyositis should be considered. Obstruction of the superior vena cava can also cause sudden swelling and redness of the face.

The acutely red face should always be considered to be a potentially serious problem. Interestingly, facial skin is also distinguished by not being affected in some generalised skin disorders. Psoriasis is rare on the face as is lichen planus.

Diagnosis

Sometimes a biopsy is necessary to confirm the diagnosis. If performed with due regard for the crease lines and with care facial skin heals well and there should be no scar. Patch tests are essential to sort out a suspected allergic contact dermatitis. Usually a battery of allergens is applied, as well as the suspected offending material.

Treatment

Treatment of disorders of facial skin must take into account the special nature of this part of the integument. Potent corticosteroids should not be prescribed as on the face the skin is thinner than elsewhere and skin atrophy can rapidly follow their use. This is especially important in rosacea, in which there is pre-existing dermal disorganisation. Use of corticosteroids for this disorder can result in worsening of the redness and telangiectasia. This area is also much more sensitive to irritants than other parts of the skin, and care has to be taken in prescribing topical treatments that other areas can tolerate easily. Tars, dithranol, salicylic acid, sulphur, and benzoyl peroxide can all irritate facial skin if prescribed in too high a concentration. If these substances are indicated for treatment of a facial rash (and sulphur and benzoyl peroxide often are for acne) the lowest concentrations should be prescribed at first and the patient warned of the possibility of irritation.

If there is doubt about the diagnosis of a facial rash and some application is required to relieve symptoms a simple emollient should be prescribed as this often gives relief and there is no danger of aggravating the disorder. Treatment for acne that is more than mild should be with tetracyclines in the first place. Erythromycin may help some patients who cannot tolerate tetracycline. Isotretinoin (13-*cis*-retinoic acid), a new retinoid derivative that is available only from hospital departments, is dramatically successful in patients with severe or cystic acne.

Facial rashes are always a diagnostic and therapeutic challenge. Because of the importance of this relatively small area of the skin surface patients should be referred to the local specialist department if there is any doubt about their management.

Further reading

- Cunliffe WJ, Cotterill JA. *The acnes*. London: W B Saunders, 1975.
R Marks. *Common facial dermatoses*. Bristol: John Wright, 1976.
Strauss JS, Peck GL, Olsen TG, Downing DT, Windhorst DB. Alteration of skin lipid composition by oral 13 *cis* retinoic acid: comparison of treatment and pretreatment values. *J Invest Dermatol* 1978;70:223.

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