Defining long-term management strategies in chronic hand eczema:

Consensus from an international expert panel

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Sonja Molin,[1] Andrea Bauer,[2] Marie-Noëlle Crépy,[3,4] Ana Maria Giménez-Arnau,[5] Marie-Louise Schuttelaar,[6] Richard Woolf,[7] Firas George Hougeir[8]
1. Department of Dermatology, Venerology and Allergy, Charité – Universitätsmedizin Berlin, Berlin, Germany; 2. Germany University Hospital Carl Gustav Carus, Dresden, Germany; 3. Department of Occupational and Environmental Pathologies, Hotel Dieu Hospital, Paris, France; 4. Department of Dermatology, Cochin Hospital, University of Paris-Centre, Paris, France; 5. Hospital del Mar Research Institute, Universitat Pompeu Fabra, Barcelona, Spain; 6. Department of Dermatology, University Medical Center Groningen, University of Groningen, Groningen, Netherlands; 7. St John's Institute of Dermatology, Guy's and St Thomas' NHS Foundation Trust, London, UK; 8. Southeast Research Specialists, Atlanta, Georgia, USA.

Conclusions

From an international expert panel:

- CHE should be recognised and managed with a proactive long-term plan rather than repeated treatment of individual flares.
- Assessment should span visible signs, symptom burden, hand function, QoL, and occupational impact; visible signs alone may understate disease burden.
- Treatment success means sustained control to the patient's satisfaction. Failure to improve after an adequate course of treatment (≤4 weeks) or if TCS cycling is repeated without sustained control, should prompt timely change.
- Treatment response should be regularly assessed against the patient's own goals for treatment and treatment approach should be reconsidered promptly in case of an inadequate response.

Key takeaway

International expert consensus findings support recognising CHE as a chronic disease requiring long-term control rather than repeated flare management. Failure to improve after an adequate course of treatment, or TCS cycling without sustained control, should prompt timely change.

Introduction

- CHE is an inflammatory skin disease causing persistent signs and symptoms, including visible inflammation, impaired hand function, reduced QoL, and occupational impact. Chronicity is established when hand eczema persists for more than 3 months, or relapses twice in one year.[1]
- Care has traditionally focused on visible signs during individual relapses, in many cases through reactive courses of TCS.[1,2] This approach often leaves long-term goals unmet and imposes a cumulative treatment burden.[3]
- Practical guidance is needed to recognise chronicity, assess disease burden, and structure long-term treatment decisions within a continuous management framework. This global expert consensus proposes an approach to long-term treatment planning, with regular review aligned to each patient's individual goals.

Methods

- Consensus recommendations were developed through an international modified Delphi process.
- The panel comprised 20 dermatology experts: a chair, a 6-member steering committee, and a 13-member Delphi panel.
- Three rounds of voting were conducted.
- Consensus was defined *a priori* as ≥80% of respondents voting 'agree' or 'strongly agree' (≥16/20).

Results

- Across the Delphi process, 106 statements were considered, of which 102 (96%) achieved consensus.
- Four statements did not achieve consensus: two were referred for further expert insight, and two did not progress beyond the steering committee surveys. A further three statements achieved consensus only after revision and revoting.
- Consensus statements spanned eight topic areas across the patient pathway, shown in **Figure 1**.

11	acknowledging the chronicity of CHE
21	assessing the patient condition
23	reviewing current treatment
14	triggers for changing treatment
7	continuing current treatment
10	changing treatment approach
8	selecting and initiating maintenance
8	reassessing condition and response

- The key statements from each section are shown in **Figure 2**.

Figure 1. Consensus decision tree for the management of CHE

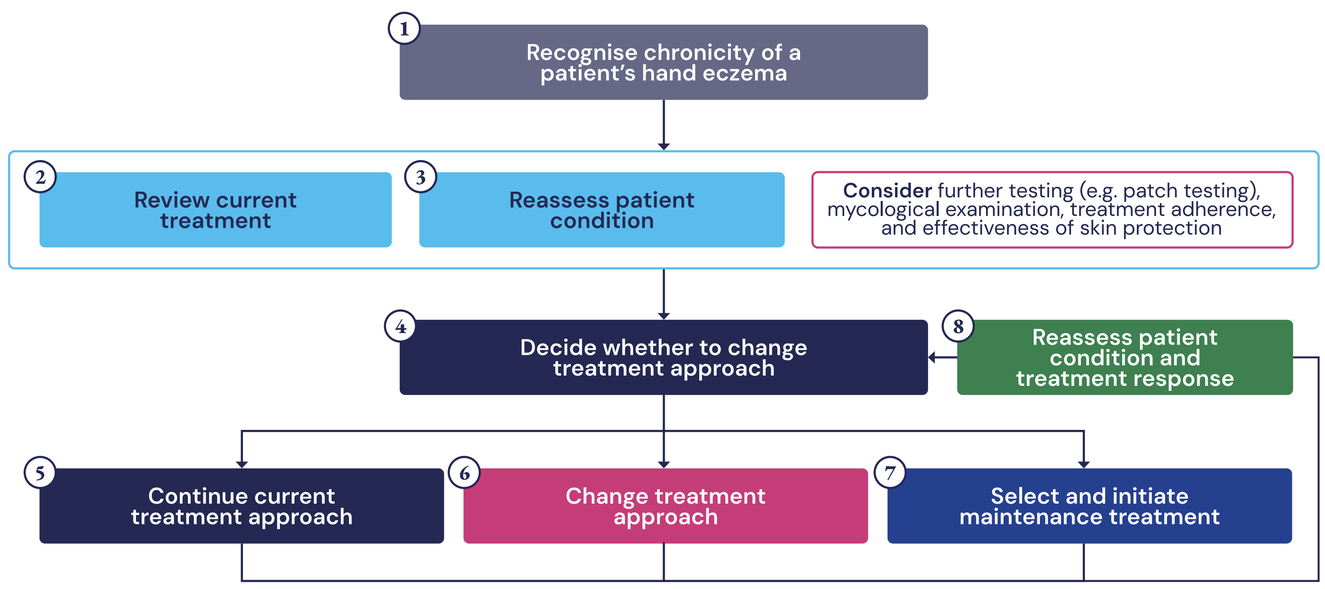

Figure 2. Key statements from each section of the consensus, (% consensus)

1 Recognising chronicity	• Repeated relapse after appropriate topical treatment supports the diagnosis of CHE as a chronic condition. (95%) • CHE should be recognised as a long-term condition requiring a proactive management plan, rather than being managed solely as a series of recurrent flares. (95%) • Early recognition of chronicity in hand eczema is essential to prevent prolonged ineffective treatment and cumulative treatment-related harm. (90%)
2 Review current treatment	• Assessment of current treatment for CHE should include an evaluation of whether the patient has received an adequate course of that treatment in terms of dose, duration and correct use. (100%) • Short-lived improvement followed by rapid relapse should be considered an inadequate treatment response in CHE. (80%)
3 Reassess patient condition	• CHE should be assessed across different clinical presentations using the same core domains of severity, symptom burden, and functional impact. (100%) • Visible signs of CHE may not correlate with symptom burden, functional impact, or QoL impact. (100%) • Symptom burden and impact in CHE should be assessed, even when visible signs appear mild. (95%)
4 Decide whether to change treatment approach	• Inadequate response in CHE should be defined as failure to achieve meaningful improvement in signs, symptoms, or function after an adequate trial of therapy. (90%) • In CHE, meaningful clinical improvement should be observed within 2 weeks of appropriate use of an ultra-high potency TCS (80%) or 2–4 weeks of appropriate use of a moderate or high potency TCS. (85%) • In moderate to severe CHE, failure to achieve meaningful improvement after an adequate TCS trial should prompt timely consideration of alternative treatment options. (100%) • Repeated cycling of TCS without sustained disease control should prompt reassessment of the overall treatment strategy in CHE. (100%)
5 Continue current treatment approach	• TCS have an important role in hand eczema management but should not be relied upon indefinitely in chronic disease. (90%) • Long-term management for CHE should include periodic reassessment for patients still receiving treatment, even when disease appears controlled. (90%)
6 Change treatment approach	• Failure to achieve sustained disease control in CHE after an adequate treatment trial should prompt escalation or change in treatment strategy. (100%) • Non-steroidal topical treatments have an important role in the management of moderate to severe CHE following inadequate response to TCS. (90%)
7 Select and initiate maintenance treatment	• In CHE, relapse after treatment withdrawal, despite avoidance of relevant irritants or allergens, should prompt active modification of maintenance therapy or consideration of treatment escalation. (90%) • The goal of maintenance treatment is to prevent relapse and maintain long-term disease control. (100%) • Maintenance treatment should be considered for patients with CHE who relapse after stopping active treatment. (90%) • Treatment modality for CHE (e.g. regular proactive use vs reactive use at early signs of relapse) should be individualised based on patient characteristics and disease pattern. (100%)
8 Reassess patient condition and treatment response	• CHE management should be based on an ongoing cycle of assessment, treatment adjustment and reassessment. (95%) • Patients with CHE should be reassessed at planned intervals to confirm treatment response and adjust management when needed. (95%) • Rapid relapse after stopping treatment should prompt reconsideration of the treatment approach in CHE. (85%)

Abbreviations: CHE, chronic hand eczema; QoL, quality of life; TCS, topical corticosteroids.
References: 1. Thyssen JP, et al. *Contact Dermatitis*. 2022;86:357–378; 2. Bauer A, et al. *Dermatol Ther (Heidelb)*. 2026;16:1241–1253; 3. Molin S, et al. *Acta Derm Venereol*. 2025;105:42596.
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