Seborrheic dermatitis (SD) is possibly the most frequently encountered dermatosis. It affects adults of both sexes, at any age and evolves in outbreaks, that are often triggered or exacerbated by psychological stress. Although seborrheic dermatitis is located in areas that home a large quantity of seborrheic glands, it is not linked to a hyperseborrhea but to a secondary local inflammatory reaction to the normal presence of yeast on the skin (Malassezia). The cause of this inflammation is unknown. Infantile seborrheic dermatitis (sometimes known as the Leiner-Moussous disease) is a different entity to adult SD.

Establish the diagnosis

It is usually easy: SD manifests itself as red plaques, that are more or less squamous, non pruriginous with a characteristic topography:
- Primarily on the nasogenial folds, sides of the nose and eyebrows.
- Also on the forehead at the hairline, ears and anterior mid-thoracic area.

SD evolves in outbreaks, often more frequent in the winter, and preferentially triggered by stress.

If many dermatoses have a psychological component, SD is the one which is the most linked to situations of emotional stress and this is often noticed by the patient.

To not confuse SD with other inflammatory dermatoses of the face:

Rosacea predominantly affects the cheeks and nose, it associates erythema, telangiectasia, and papulo-pustules.

Psoriasis of the face, rarely in isolation, can closely resemble SD. We use the term of "sebo-psoriasis".

Acne that persists long after adolescence also involves clearly follicular lesions, comedons or papulo-pustules.

Prescribing a treatment

At present, the treatment of first intention involves topical antifungal agents that are both anti-fungal and anti-inflammatory and very well tolerated. These include ciclopiroxolamine, imidazoles, present in numerous specialties.
Low dose dermocorticosteroids (hydrocortisone, desonide) are only used for acute outbreaks. Strong dermocorticosteroids must be avoided as they can lead to cortico-dependence and to peri-oral dermatitis. These side effects are difficult to predict and it is not recommended to use them too frequently and in large quantities.

On the scalp, keratolytic and/or antifungal shampoos are recommended. Powerful corticosteroids may also be used for a short period, particularly for highly inflammatory forms. Corticosteroid lotions are used, or the mousse form which is an excellent alternative since it is easy to apply, non-greasy and requires no rinsing. It is convenient for patients to use, making the treatment more acceptable. This therefore leads to improved compliance and effectiveness. The patient must be warned that these treatments will only suspend the symptoms so that they are not disappointed when a new outbreak occurs. There are no side effects when local treatments that do not contain dermocorticosteroids are prolonged.

Numerous dermocosmetic products contain active products that have an anti-inflammatory and anti-fungal effect, in a lesser degree than the treatments mentioned above. These treatments are therefore useful especially for a maintenance treatment.

**What needs to be said**

SD is benine, but lasts a long time and although it is possible to reduce the outbreaks it is not possible to prevent them.

If the patients are warned then they will not be surprised by the occurrence of an outbreak and will be able to start the treatment quickly in order for it to be more effective.

Sun exposure tends to have a favourable effect. We can therefore recommend to sunbathe in the summer but to wear adequate protection so as not to burn.

SD lesions heal without leaving scars.

Dermocorticosteroids rapidly reduce the inflammation of SD but there can be negative effects that will enhance atypical outbreaks and peri-oral dermatites. Therefore they must be used as prescribed, for periods that are as short as possible.

Finally, it is important to know, without necessarily saying it, that widespread SD can sometimes be observed in the case of an HIV infection. However, in the presence of SD and in the absence of any other signs it is not indicated to recommend an HIV serology.