ATOPIC ECZEMA

17.1. ATOPIC ECZEMA – MANAGEMENT OF

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A. BACKGROUND

For full atopic eczema management guidelines please refer to -

NICE Clinical Guideline 57 (2007): Atopic Eczema Management in Children: Management of Atopic Eczema in children from birth up to age of 12 years.
http://www.nice.org.uk/nicemedia/live/11901/38559/38559.pdf

If in doubt, please contact either:

- Dermatology Nursing Team: Bleep #161
- Out of Hours: On-Call Dermatologist (STH): STH Switch 77340.

B. TREATMENT OF INFECTED ECZEMA

For overtly infected eczema (e.g. crusting, weeping, pustulation and/or cellulitis):

1. Use a topical antibiotic as a course, two or three times a day, for seven to fourteen days and then STOP.
2. Add a topical steroid, or step up the strength of steroid if using one already.
3. Step up the quantity of emollient used.
4. For moderate or severely infected eczema add an oral antibiotic for 14 days.[1]
5. If unresponsive to oral and/or topical antibiotics, swab for bacterial and possibly viral culture.

Underlying Herpes simplex virus infection also needs to be considered.

C. MINIMIZING THE DEVELOPMENT OF TOPICAL ANTIBIOTIC RESISTANCE

1. Have only plain steroids on repeat prescription, not combinations.
2. Revert to a plain steroid after a 7 to 14 day course if a topical steroid / antibiotic combination has been used.
3. Tell patients to use topical antibiotics as a course for a maximum of fourteen[2] days and not intermittently.

D. IRRITANT CONTACT REACTIONS

- Common, especially on broken skin, and may cause a stinging or burning sensation.
- Irritancy is not reliably demonstrable by patch testing, or by any other test. Diagnosis relies on detailed history, examination and exclusion of contact allergy[3].

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E. ALLERGIC CONTACT REACTIONS

- Allergic contact dermatitis is uncommon in children.
- Medicaments are the most likely offenders, e.g. antibiotics, preservatives, steroids.

F. ANTI-PRURITIC GUIDELINES

Treating the eczema with a complete emollient regime plus topical steroids as required will generally help pruritis.

G. EMOLLIENT ADVICE

Emollient tips:

- The best emollient is one, which the child and parent prefer using, which may well involve an element of trial and error.
- Encourage child and parent(s) to use around 250-500g of their chosen emollient a week, increasing to 1000g or above should the child's eczema become very dry and flaky.
- Remember that a moisturiser should be used in conjunction with an emollient soap substitute and emollient bath oil.
- Ointments such as 50:50 white soft paraffin, Epaderm and Hydromol ointment are often preferred to creams by patients with Afro-Caribbean and Asian skin.
- If napkin dermatitis is present, try E45 nappy cream or Metanium instead of Sudocrem, which contains more preservatives and fragrance. For cleansing the nappy area, one idea is to use the chosen emollient on a cotton wool pad and wipe the bottom clean gently.
- If cradle cap (scalp seborrhoeic dermatitis) is present, massage emollient bath oil neat into the scalp. Leave at least an hour or so and then wash off.

H. TOPICAL CORTICOSTEROIDS

Prescribing guidelines

Topical Steroid Potencies

Which topical steroid?

The weakest steroid should be chosen to control the disease effectively; this may include a temporary step up approach (less potent to more potent), or a step down approach (more potent to less potent).

Mild: **1% Hydrocortisone**, once or twice a day

Moderately Potent: Clobetasone butyrate 0.05% (Eumovate)

Potent: **Mometasone furoate 0.1% (Elocon)**

Potent steroids are usually only used in courses in children, e.g. once a day for 1-2 weeks and then stopped.

Very Potent: Clobetasol propionate 0.05% (Dermovate)

Very potent steroids should not be used in children with atopic eczema in primary care.

Check the potencies of steroids in combination creams.

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Fucidin H is fusidic acid plus a mild steroid, 1% hydrocortisone.
FuciBET is fusidic acid plus betamethasone 0.1%, a potent steroid.

Advice to parents regarding topical steroids:

- Demonstrate how to apply topical steroids and the amount required. This can be calculated using the fingertip unit.
- Check that the parents/patients know which topical steroid goes where. A care plan may be useful for parents to refer to.
- If there is a poor response to topical steroids, check that parents are applying them to well-moisturised skin, as they are poorly absorbed through dry scaly skin.

I. THE WET WRAPPING TECHNIQUE

Who benefits most from wet wraps?

- Younger children and infants with very dry skin.

Infants and children not sleeping due to itching from their dry / eczematous skin.

J. PASTE BANDAGES

Paste bandages are useful for treating eczema on the limbs, particularly if it is of the chronic lichenified variety.

(Section 17.1 reviewed by J. Carr, April 2015)

Management suggestions reflect the experience of the SC(NHS)FT Dermatology Team to date. Principles with an evidence base are referenced. The results of future studies may require alterations in the conclusions or recommendations of this document. Treatment of individual patients may need to be modified to reflect clinical need and social circumstances.

References:

1. Guidelines for the management of atopic eczema. Primary Care Dermatology Society and British Association of Dermatologists. May 2003. www.eguidelines.co.uk and full guidelines from www.bad.org.uk

2. Menday A.P. and Noble W.C. J Dermatological Treatment. 2000; 11:143-149

For other references, please see "Atopic Eczema Guidelines" text on the Intranet.

3. English J. Occupational Dermatology. Manson Publishing; 1998.