Atopic Eczema

Herefordshire and Worcestershire Medicines and Prescribing Committee

NHS
Herefordshire and Worcestershire
Clinical Commissioning Group

Atopic eczema (also known as atopic dermatitis) is a chronic, itchy, inflammatory skin condition that affects people of all ages, although it presents most frequently in childhood.

Diagnostic criteria[1,4]

Atopic eczema is likely if the following criteria are fulfilled (although other conditions may need to be excluded)

Must have itchy skin condition plus three or more of the following:

- Past involvement of the skin creases, such as the bends of the elbows or behind the knees
- Personal or immediate family history of asthma or hayfever
- Tendency towards a generally dry skin
- Flexural eczema (visible or from history)
- Onset under 2 years of age

If the skin is not itchy it is very unlikely to be eczema

Recommendations for referral[1,4]

- If diagnosis is uncertain
- If eczema is uncontrolled or failing to respond to appropriate primary care treatment despite full patient adherence
- Eczema herpeticum or eczema associated with severe or recurrent infections
- Eczema associated with significant social or psychological problems
- Suspected allergic contact dermatitis that requires patch testing
- Steroid atrophy

General principles of primary care management[1,2]

- Educate patient/ carer on use of topical treatments (ideally demonstrating how to use) with details of application and quantities.
- Give advice on measures to maintain the skin and reduce the risk of flares
  - Encourage the frequent and liberal use of emollients, even during periods where the skin is clear.
  - Where possible, they should avoid trigger factors known to exacerbate eczema, such as certain clothing (they should avoid wearing synthetic fibres), soaps or detergents (they should use emollient substitutes), animals, and heat (they should keep rooms cool).
  - House-dust mite avoidance strategies are generally not recommended as they are time consuming and of limited benefit.

- Avoid scratching the eczema (if possible), and simply rub the area with fingers to alleviate itch. Nails should be kept short, and anti-scratch mittens should be used in babies with eczema.

- Patients should not alter their diet unless under specialist advice; complementary therapies are not recommended for the management of atopic eczema.
- Provide patient information leaflets and information on eczema support groups. For example:

  - The British Association of Dermatologists (BAD) has produced an information leaflet on ***Atopic Eczema***.
  - The National Eczema Society has various ***factsheets on eczema*** and treatments available on their website.

Emollient

- Emollients should be applied as liberally and frequently as possible.
- See ***Emollient guidance*** for product choice and general guidance.
- Many patients underestimate the quantity needed and frequency of application to achieve maximal effect and education on emollient use is essential. Generally emollient use should exceed steroid use by 10:1 in terms of quantity for most patients.
- In line with national (NHSE) guidance the prescribing of bath and shower preparations is not supported.[7]

Topical Corticosteroids[1,2,3,4]

See ***topical corticosteroid guidance*** for choice of product and general information.

- Match the potency of the topical steroid with the severity of the eczema e.g mild potency for mild disease, moderate potency for moderate disease and potent topical corticosteroids reserved for short term use in severe eczema. It is also reasonable to start with a mild potency topical corticosteroid, especially on the face in children, and increase to a moderate potency corticosteroid only if necessary.
- Topical steroids should be initially used once a day because there is a lack of clear evidence that twice daily application gives any significant clinical advantage over once daily.
- Advise patients to start treatment as soon as signs of flare appear and to continue for 48 hours after symptoms subside. Use is generally in short bursts of 3-5 days to gain control, and for up to two weeks in moderate to severe disease. Treatment should be weaned down to alternate days or a less potent topical steroid to prevent flares. Please ensure an adequate quantity of topical corticosteroid is prescribed according to the Topical Corticosteroids guideline
- Ointments provide the strongest emollient effect, contain fewer preservatives (therefore less potential allergens) and may be more effective. Creams are often preferred by patients, especially when used on visible areas.
- If the flares are frequent (two to three per month) consider treating with topical corticosteroids for two consecutive days per week or twice weekly as maintenance treatment once the eczema has been controlled. Review this strategy every 3-6 months.

Bacterial infection[2,3,4]

- Bacterial infection is suggested by crusting, weeping, pustulation and/or surrounding cellulitis with erythema of otherwise normal looking skin.
- For clinically infected skin in line with local ***Primary Care Antimicrobial Guidance***:

  - Topical fusidic acid alone for very localised lesions only to reduce risk of resistance, NOT for repeated use
  - Oral flucloxacillin (or clarithromycin for penicillin allergic patients)

- The use of topical antibiotic and corticosteroid combination products are not routinely recommended.
- There is a lack of evidence from controlled trials to support the use of topical antibiotics to treat infected atopic eczema, with only one randomized controlled trial investigating this. Data from trials comparing the use of topical antibiotic and corticosteroid combination products have not shown the addition of an antibiotic component provides benefit beyond that of a corticosteroid alone and their regular use will increase the risk of antibiotic resistance.
- Swabs for bacteriology may be useful if patients do not respond to treatment, in order to identify antibiotic resistant strains of *S. aureus* or to detect additional streptococcal infection.

Immunomodulatory treatments[5] (Tacrolimus or pimecrolimus)

- In line with NICE TA 82: tacrolimus and pimecrolimus are recommended, within their licensed indications, as an option for the second-line treatment of moderate to severe atopic eczema in adults and children aged 2 years and older that has not been controlled by topical corticosteroids, where there is a serious risk of important adverse effects from further topical corticosteroid use, particularly irreversible skin atrophy.
- Should be initiated only by physicians (including general practitioners) with a special interest and experience in dermatology, and only after careful discussion with the person about the potential risks and benefits of all appropriate second-line treatment options.

Antihistamines[4]

- Antihistamines are not recommended for routine use in the management of atopic eczema. They have shown poor efficacy in controlling atopic eczema-associated itch.
- A one month trial of a non-sedating antihistamine can be considered where there is severe itching or urticaria.
- A 7–14 day trial of an age-appropriate sedating antihistamine can be offered to children aged 6 months or over during an acute flare of atopic eczema if sleep disturbance has a significant impact on the child or parents or carers. This treatment can be repeated during subsequent flares if successful.

Dry bandages and medicated dressings including wet wrap therapy[2,4]

- Occlusive dressings or dry bandages may be of benefit for severe eczema only; however, treatment should only be started by a healthcare professional trained in their use.

Silk Garments[6,7]

- In line with national (NHSE) guidance the prescribing of silk garments is not supported.
- The evidence relating to the use of silk garments for eczema is weak and of low quality.

References

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