ANTIBIOTIC GUARDIAN

Pledge to become an Antibiotic Guardian at www.antibioticguardian.com

NHS Vale of York Clinical Commissioning Group

Referral Support Service

Dermatology

D04
Atopic Eczema

Definition

- An itchy skin condition (or reported scratching/rubbing in a child)
- Plus three or more of the following:
  - History of itchiness in skin creases
  - History of asthma or hay fever
  - General dry skin in the past year
  - Visible flexural eczema
  - Onset in the first 2 years of life
  - History of atopy in 1st degree relative

Exclude Red Flag Symptoms

- Eczema herpeticum-consider in an ill, feverish child or unwell adult with widespread vesicles or vesico-pustules. Very occasionally fatal.
  - Treat with oral aciclovir or refer for specialist advice especially with lesions near the eyes.
- Admit to hospital with widespread eczema herpeticum
- Urgent referral if failure to respond to oral antibiotics for infected eczema

General Points

- Atopic eczema is a common disease affecting up to 15% of children.
- Involvement of the face frequently occurs in infants with adoption of characteristic flexural distribution by the age of 18 months.
- Spontaneous improvement tends to occur throughout childhood with complete clearance by teenage years in 50%.
- Realistic treatment aims need to be discussed with the patient and parents.

Management

General

- Encourage smoking cessation
- Encourage weight loss (if appropriate)
- Avoid direct contact with detergents including all soaps, shower gels, shampoos etc. as much as possible. Wash hair over the side of the bath, use gloves, use emollients instead of soap (see below).
- Avoid itchy clothing e.g. wool.

Responsible GP: Dr Alison Hunter
Responsible Consultant: Julia Stainforth
Responsible Pharmacist: Laura Angus
Clinical Research & Effectiveness approved: May 2016
Date published: May 2016
Next Review: May 2018

- Manage itching-avoidance/distraction, cotton gloves at night
- Keep cool, nails short and filed smooth.

Treatment

Complete emollient therapy - is mainstay of treatment for all patients – see Guidance/Medal ranking on emollients for advice and preferred options.

- Please note emollient shower gel products are not commissioned and should not be prescribed. Patients should use regular emollient creams as soap substitutes.

Topical steroids - The prescription of topical steroid cream or ointment for red, inflamed skin should be considered. Use of the lowest potency and amount of topical corticosteroid necessary to control symptoms should be advised, depending on the severity of the flare. Steroid treatment should be continued for 48 hours after the flare has been controlled.

- Mild topical corticosteroid – e.g. **hydrocortisone 1% cream/ointment**
- Moderate eczema — prescribe a moderately potent corticosteroid – e.g. **clobetasone butyrate 0.05% as Eumovate®**
- Severe eczema — prescribe a potent topical corticosteroid – e.g. **mometasone fuorate 0.1% as cream or ointment = Elocon®** (potent)
- Use appropriate strength for different areas of skin, mild topical steroid for face and neck down to the clavicles, 0.5-1% for eyelids, moderate/potent for most other areas in adults but milder steroid creams in children. Areas such as axillae and groins are more prone to side effects so use moderate/potent preparations for short periods (7-14 days) only.
- Use of ointments is preferable (fewer preservatives, more moisturising) but patient preference is important too.
- Prescribe adequate quantities to encourage use. Treat early to minimise flares.
- Topical steroids are frequently underused due to concerns about side effects.

Topic Calcineurin Inhibitors – Tacrolimus or **pimecrolimus** are recommended 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, especially 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'.
- There is a theoretical cancer risk in long term use
- Can burn for the first few applications and can pre-dispose to widespread viral warts (stop use if molluscum, chicken pox, skin infection or multiple viral warts develop)
- Limit continuous use to 1 year (in primary care). Refer if considering longer term use.

Antihistamines - Sedative antihistamines promote sleep and may help break the itch-scratch cycle during severe flares (**chlorphenamine, hydroxyzine** with appropriate care)

Infection – Using topical antibiotics or adding them to steroids in eczema management encourages resistance and does not improve healing.

In infected eczema, use antiseptic bath additives and treat with systemic antibiotics as for impetigo if clinically indicated (see Emollient Guidance/Medal Ranking for details)

Oral flucloxacillin *500mg-1g QDS for 7 days*
For patients <18 years *see latest BNF for children for accurate dosing information*

If penicillin allergic: **clarithromycin** *500mg BD for 7 days*
Children <12 years of age if liquid formulations are required: **erythromycin** *See latest BNF for children for accurate dosing information*

Check North Yorkshire antibiotic prescribing guidance for primary care for full information

- Consider infection if weeping/pustules/crusts, lack of response to usual Rx, rapid exacerbation, fever or malaise.

Bandaging

- Zinc paste bandages used alone or over topical corticosteroids can result in rapid improvement of resistant, particularly lichenified, eczema
- Wet wrap dressings may also be helpful, particularly at night in small children
- Caution is required when using any type of occlusive bandaging in conjunction with topical steroids because the potency of the steroid can be increased by occlusion
- All occlusive bandaging should be avoided in infected eczema
- Comfifast® garments (vests and leggings) are easier to use than bandages and useful at night to cover the creams and prevent overnight scratching. They are prescribable for different ages and can be washed and re-used.
- Please note that Vale of York Clinical Commissioning Group do not commission silk dressing products. These should not be prescribed.

Encourage patient/ parent education

- How to apply emollients and steroids
- Comprehensive eczema PILs

See BNF for additional prescribing information on any of the above.

Allergy and additional information

i) Allergy testing:

- No tests are available to confirm or refute food allergy as a cause of worsening eczema
- Skin prick tests are not helpful.

- Total IgE/RAST tests to pets or house dust mite or "common food mix" can be useful. Common food mix covers more than 90% of food allergies but results need interpretation along with patient's history, 5-6+ suggest there may be an allergy to this substance.

House dust mite can worsen eczema in some children

ii) Food allergy:
- Food allergy e.g. to egg or dairy is RARELY a cause of worsening eczema
- Consider exclusion diets only in refractory eczema and abandon if no improvement after 2-4 weeks
- If exclusion required for more than 2 – 4 weeks then dietetic advice is needed
- "Food allergy" is often a temporary intolerance so the foodstuff should be re-challenged every few months.
- Dermatologists do not perform food allergy tests. Dr Verhese is a Paediatrician with special interest in food allergy in children. Referrals should be sent directly to him.

iii) Patch testing:
- Patch testing is used to investigate specific contact allergic eczema, a rare occurrence in children with atopic eczema. Children <5-6years old are not able to co-operate with this test.

iv) Evening Primrose Oil:
- No evidence of benefit

v) Chinese Herbs:
- No product licences – not recommended (often contain potent steroids)

Referral Information

Referral Criteria
- Only cases of severe or difficult eczema usually need to see a Dermatologist.
- Lack of adequate progress despite use of adequate quantities of emollients/topical steroid preparations which are correctly applied.
- Concern about eczema herpeticum.
- For consideration of second line treatment such as photochemotherapy, cytoxic drugs and for consideration of longer-term topical immunomodulators
- If contact allergic dermatitis is suspected for patch testing

Information to include in referral letter
- Previously tried treatments including emollients and their effects.
- Any psychosocial effects, occupational history
- Relevant past medical / surgical history
- Current regular medication

- BMI/ Smoking status

Investigations prior to referral

- Swabs and treatment of any infection for sudden or persistent exacerbations. (although swabs may show *S. aureus* + as a skin commensal rather than as an infective agent).
- Check FBC/ferritin in persistently itchy patients or all bloods as per generalized pruritus guideline.

Patient information leaflets/ PDAs

- PILS for atopic eczema, emollient information, topical steroids (includes advice about fingertip dosing) and triggers/irritants.
- PILS - from dermatology society, an alternative helpful guide
- Eczema Society - excellent website for patients/ parents with guides to treatment.

References

- Dermnetnz
- NICE CKS Atopic Eczema
- British Association of Dermatologists – Atopic Eczema