St George's University Hospitals NHS
NHS Foundation Trust

Guidelines for the management of atopic eczema in children

History and examination

Focused history

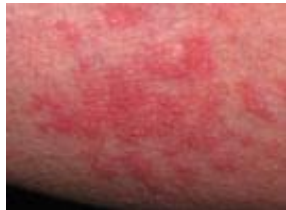
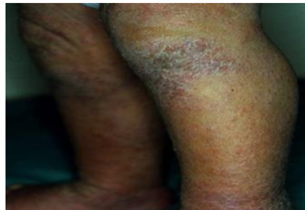
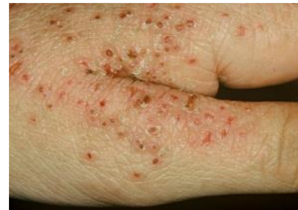
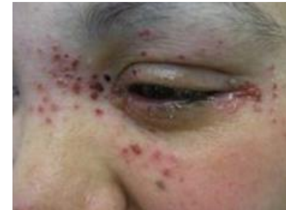
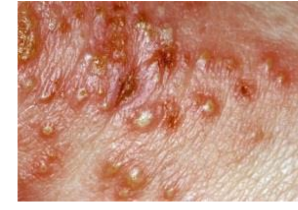
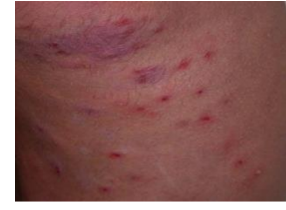
- **Age on onset**
- **Triggers**
- **Family history of atopy**
- **Quality of life assessment (sleep disturbance/school attendance/poor concentration)**

Examine

- **Distribution, severity, morphology – dry skin, redness, excoriation, lichenification, co-existing infection**

Exclude

- **Symptoms or signs suggestive of <u>eczema herpeticum</u> (acute tender punched out lesions) – contact Dermatology SPR on call for advice**
- **Symptoms or signs of <u>secondary bacterial infection</u> – send bacterial swab and consider oral antibiotics (Flucloxacillin first line if no penicillin allergy)**

Severe eczema

- Widespread areas of dry skin, incessant itching, redness (with or without excoriation, extensive skin thickening, bleeding, oozing, cracking and alteration of pigmentation)
- Severe limitation of everyday activities and psychosocial functioning, nightly loss of sleep

Eczema herpeticum

- Areas of rapidly expanding painful eczema
- Clusters of monomorphic punched out blisters
- Punched out erosion (1-3mm) that may coalesce to form larger eroded crusted areas
- Possible fever, lethargy, oral lesions, sore throat and distress

Secondary bacterial infection

- Consider in areas of erythema or swelling and eroded crusted lesions
- Fissuring may be associated
- May be pustules/folliculitis
- Usually Staphylococcus or Streptococcus – always take a swab before initiating oral antibiotics

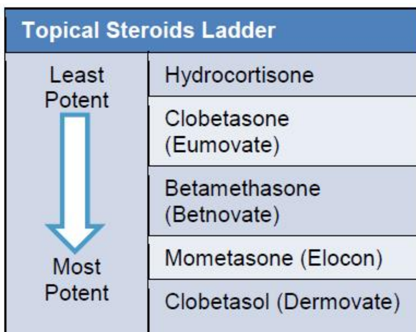
General considerations

Ensure liberal supply of emollient of preference (250-500g every week). The choice of emollient should be according to patient preference – see CCG emollient guidelines
Emollients should be applied in a downward direction following the direction of hair growth with clean hands.
Emollient sprays can be useful for children during school hours and before swimming but be careful with slipping
Avoid irritants (e.g soaps/ SLS/bubble baths) and prescribe a soap substitute to wash as well as a bath oil
Reduce Staph. aureus load (e.g bleach baths twice a week, Dermol washes) especially if history of recurrent infections

Images courtesy of Derm.net

Guidance for prescription and management

Mild eczema	Moderate eczema	Severe eczema
For acute flares apply a topical steroid (e.g. Hydrocortisone) daily for at least two weeks Consider maintenance treatment with twice weekly consecutive days applications	For acute flares apply a topical moderately potent steroid (e.g. clobetsone) daily for at least two weeks. Consider topical calcineurin inhibitors e.g. tacrolimus ointment <u>(can contact via KINESIS (Advice & Guidance) for specialist advice if needed).</u> Consider maintenance treatment with twice weekly consecutive days applications.	For acute flares apply a topical potent steroid (e.g. mometasone) daily for at least two weeks. Consider topical calcineurin inhibitors e.g. tacrolimus ointment<u>(can contact via KINESIS (Advice & Guidance) for specialist advice if needed).</u> Consider maintenance treatment with twice weekly consecutive days applications.



Topical Steroids Ladder	
Least Potent	Hydrocortisone
	Clobetasone (Eumovate)
	Betamethasone (Betnovate)
	Mometasone (Elocon)
Most Potent	Clobetasol (Dermovate)

1 Finger Tip Unit = from tip of finger to first line (roughly 0.4-0.5g)

AGE	FACE & NECK	1 ARM & HAND	1 LEG & FOOT	TRUNK (FRONT)	TRUNK (BACK) INCLUDING BUTTOCKS
3–6 MONTHS	1	1	1.5	1	1.5
1–2 YEARS	1.5	1.5	2	2	3
3–5 YEARS	1.5	2	3	3	3.5
6–10 YEARS	2	2.5	4.5	3.5	5
10+ –ADULTS	2.5	4	8	7	8

1. In general use steroid **<u>ointments</u>** rather than **<u>creams</u>**
2. Use mild potency steroids for the face and neck apart from short term use of moderate potency (eg Eumavate) for severe flares
3. Use moderate potency for short periods eg 14 days for vulnerable sites such as groin and axillae
4. Topical tacrolimus and pimecrolimus are licensed for 2 years and over in moderately severe eczema
    1. Advise cautious use at initiation due to known irritation ('stinging-like'), should lessen with recurrent use
    2. Increase the surface area as tolerated
    3. Avoid use prior to exposure to sunlight
5. Antihistamines are not effective in the management of atopic dermatitis in children and should not be prescribed routinely
6. Wet wrapping should only be initiated by clinicians trained in their use or via Specialist Derm CNS advice
7. In those patients using wet wraps, should be advised to avoid if clinical signs of infection
8. Consider a diagnosis of food allergy and referral to Allergy Services for testing and dietician input if
    1. reacted previously to a food with immediate symptoms,
    2. moderate or severe atopic eczema that has not been controlled by optimum management, particularly if associated with gut dysmotility (colic, vomiting, altered bowel habit) or failure to thrive