Atopic eczema in children clinical pathway

Primary care and community settings

Assessment of a child with atopic eczema:

1. Confirm diagnosis (What are the clinical features of atopic eczema?)
2. Assess severity including impact on activities of daily living (ADLs) - see severity assessment p2.
3. Is there psychosocial impact?
4. Is the child growing normally?
5. Consider triggers:
   - **Irritants:** Avoid soap and shower gels, and reduce frequency of shampoo. In under 12 months no need for shampoo
   - **Contact allergy:** Is there a sudden flare of previously controlled eczema? Reaction to skin treatment or other products?
   - **Food allergens:** Eczema increases the risk of food allergy and the association is stronger in severe eczema. Most cases present with classical features of food allergy with immediate symptoms involving at least two organ systems (<1 hour after exposure) e.g. urticaria/angiodema, GI or respiratory symptoms. Food allergy causing eczema is rare and cannot be diagnosed by tests (blood or skin tests).
     - if immediate symptoms (<1 hour) of non-milk food allergy refer to local allergy service
       - if symptoms of cows milk allergy, follow management guidelines
     - if non-immediate symptoms for food allergy
       - eczema and symptoms in another organ (e.g. poor growth or gastrointestinal symptoms) refer to local allergy service
       - if eczema is only symptom, as it is unusual for food allergy to cause eczema, refer to dermatology for assessment.

Prolonged elimination diets may be harmful (NICE Guidance), extensive elimination or any elimination in those <2 years should only be recommended under specialist advice. For those currently tolerating food without immediate symptoms, avoidance may increase the likelihood of developing immediate reactions (due to loss of tolerance) so trials of elimination should be kept short (2-4 weeks) and should ideally be assessed in conjunction with a paediatric allergist or GP with an interest in paediatric allergy.

Inhalant: seasonal flares? Asthma and hay fever? Facial eczema, especially around eyes, in > 3 years. Consider trial of antihistamines

- **Infection: Bacterial** - Weeping, crusting, not responding to treatment or worsening, unwell. Note: most children with infected eczema do not benefit from antibiotic therapy (oral o topical) - except those with a severe infection. Optimisation of topical steroids is the mainstay of treatment in these patients
- **Viral** (Eczema herpeticum): rapid worsening, fever/lethargy, clustered blisters, punched out erosions

Treatment of atopic eczema in children

1. See treatment ladder for management of active eczema and subsequent preventer treatment: page 2
2. Provide family with clear information about how to apply topical treatment (How to apply treatment videos)
3. Decide if referral to secondary care is required (See page 2)
4. Patient information leaflet from British Association of Dermatologists can be helpful on atopic eczema

Bandages/Therapeutic garments (Mainly guidance for Secondary Care clinicians)

Bandages are useful for thickened or heavily excoriated areas (not if infected)

- Apply over topical steroids for one week rotating with use over emollients for a further week and repeat as required (How to apply treatment videos)
- Consider elasticated garments/therapeutic clothing (various eczema specific brands available) for all severe eczema patient

Atopic eczema in children clinical pathway

Primary care treatment ladder for managing atopic eczema in children

Healthier Together

NHS

EMOLLIENTS

Use **ALWAYS**, i.e. continue even when clear

250-500g / week

Apply liberally & frequently, incl. after bathing

Titrate frequency to degree of disease severity:

Whole body twice daily, **PLUS**

Areas of frequent flares *as required*

LEAST GREASY

LOTIONS
- soothes inflamed skin
- evaporation may cause skin to dry out

CREAMS
- preferred for daytime use as less greasy
- use on open skin

GELS
very greasy but easier to apply than ointments (usually comes in a tube)

OINTMENTS
- most moisturising
- may stain clothes
- may be comedogenic

MOST GREASY

CLEAR

Not itchy or inflamed

Emollients + Preventer Steroid:

Ages 0-2	Ages 2+
Mild potency	Moderate potency

Applied once or twice weekly to commonly affected sites

***Except to face: use only mild potency*

MILD

Occasionally itchy
Mild Psychosocial Impact

Emollients + Rescue Steroid:

Mild potency

Once daily

Up to 7 days

MODERATE

Inflamed, Frequent itch
Excoriations, Thickening
Moderate psychosocial impact

Emollients + Rescue Steroid:

Once daily

Up to 14 days

Face/Neck/ Axillae/Groin	Everywhere Else
Mild potency	Moderate potency

Antihistamines and Prednisolone not routinely used
All emollients flammable, even non-paraffin

SEVERE

Widespread Dry Skin
Oozing, Cracking, Constant itch
Severe psychosocial impact

Emollients + Rescue Steroid:

Consider Bandages & Therapeutic Clothing
Once daily
Duration in days according to years of age
e.g. 5yo treated for 5 days

Face*/Neck/ Axillae/Groin	Everywhere Else
Moderate Potency	Potent

*Except eyelids

Referral Indications

Admit

- Eczema herpeticum
- Erythroderma
- Secondary infection with systemic features

Urgent Clinic

- Severe eczema under 12 mo.
- Severe eczema not responding to treatment

Routine Clinic

- Diagnostic uncertainty
- Possible contact allergy
- Significant psychosocial impact
- Unable to maintain clear skin for more than 1 month

This guidance has been reviewed and adapted by healthcare professionals across the Black Country.

Atopic eczema in children clinical pathway

Primary care treatment ladder for managing atopic eczema in children

All patients (even when atopic eczema clear) to use regular Emollients (ointments are preferred) to moisturise and wash (250-500g/week)
NOTE: Fire risk with all paraffin and non-paraffin containing emollients. **Antihistamines not routinely used in eczema** (exceptions to the rule). **Oral Prednisolone not recommended.**
Use the weakest effective corticosteroid treatment

Active Treatment

All corticosteroid treatments once daily

All body sites:
Mild potency corticosteroid ointment
e.g. 1% hydrocortisone ointment up to 7 days

Then Assess Disease severity

Face/neck/ Axillae/Groin:
Mild potency corticosteroid ointment
e.g. 1% hydrocortisone ointment
(up to 14 days)

Body: (excluding axillae, groin)
Moderate potency corticosteroid ointment
e.g. Clobetasone ointment (up to 14 days)

Then Assess Disease severity

CONSIDER THERAPEUTIC CLOTHING

Under 12 months = urgent referral

Face/Neck/Axillae/Groin
(not on eyelids)
Moderate potency corticosteroid
e.g. clobetasone ointment

Body:
Potent corticosteroid
e.g. mometasone or betamethasone valerate 0.1% ointment

Treatment time minimum 1-3 days
Extend course based on age (1day/yr)
e.g. 5 days for a 5 yrs old

CONSIDER BANDAGES

Then Assess Disease severity

Still severe

Urgent referral
Severe eczema not responding to optimal treatment

Assess Disease Severity

Clear or Almost clear disease
- Not itchy or inflame
- Manage with PREVENTER plan

Mild disease
- Dry skin, infrequent itching
- Mild impact ADLs/sleep/ psychosocial wellbeing

Moderate disease
- Treatment failure of mild eczema
- Dry skin, frequent itch, redness
- Excoriations, localised skin thickening
- Moderate impact ADLs/sleep/ psychosocial wellbeing

Severe disease
- Treatment failure of moderate eczema
- Widespread dry skin, incessant itch
- Redness (+/- excoriation)
- Thickening
- Oozing, cracking, consider swabbing and taking antibiotics if appropriate
- Severe limitation ADLs/psychosocial wellbeing
- Loss of sleep

Preventer treatment

For when skin is clear /almost clear disease not itchy / not inflame

AGE 0-2 years
Mild potency corticosteroid ointment
e.g. 1% hydrocortisone ointment once to twice a week to commonly affected sites

AGE 2+ years
Moderate potency corticosteroid ointment
e.g. clobetasone ointment
once to twice a week to commonly affected sites
(1% hydrocortisone ointment for face)

ADD IN by clinicians experienced in eczema care

Calcineurin inhibitors
STEROID SPARING
Topical tacrolimus ointment
0.03% (2+ years)
0.1% (16+ years)
Routine: 2 x weekly
On advice: 1-2x daily
OR Topical pimecrolimus cream
(2+ years) for facial eczema

Routine referral

- Diagnostic uncertainty
- Management not satisfactory: Preventer treatment not lasting 1 month
- Possible contact allergy
- Significant psychosocial impac

EMERGENCY REFERRAL (same day)

- Possible eczema herpeticum
- Possible bacterial infection with systemic symptoms/features of sepsis
- Erythroderma (≥90% of body surface area affected)

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