NHS
South West London

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

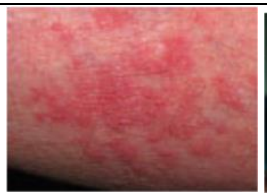
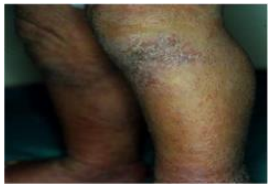
Exclude

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

Severe eczema

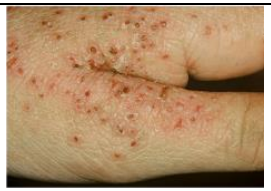
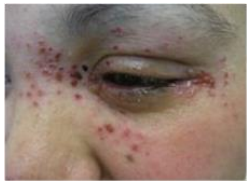
- Widespread areas of dry skin, incessant itching, redness (with or without excoriation, extensive skin thickening, bleeding, oozing, cracking and alteration of pigmentation)
- Severe limitation of everyday activities and psychosocial functioning, nightly loss of sleep

Images courtesy of Derm.net

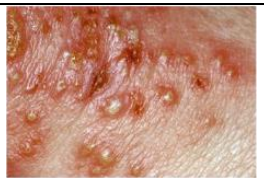
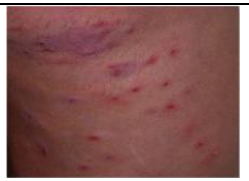
Eczema herpeticum

- 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

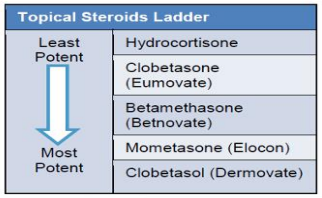
- Consider in areas of erythema or swelling and eroded crusted lesions
- Fissuring may be associated
- May be pustules/folliculitis
- Usually Staphylococcus or Streptococcus – always take a swab before initiating oral antibiotics

General considerations

- Ensure liberal supply of emollient of preference (250-500g every week). The choice of emollient should be according to patient preference – see local 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 with
- Reduce Staph. aureus load (e.g .Dermol washes) only if history of recurrent infections

Mild eczema	Moderate eczema	Severe eczema
For acute flares apply a mildly potent topical steroid (e.g. Hydrocortisone) OD for at least two weeks. **If frequent flares:** Consider maintenance treatment with mildly potent topical steroid OD on 2 consecutive days each week (weekender regime) over areas affected by recurrent flares for up to 4 months. Restart daily regime for 2 weeks if patient experiences flare-up during weekend maintenance regime.	For acute flares apply a topical moderately potent steroid (e.g. clobetsone) OD for at least two weeks. **If frequent flares:** Consider maintenance treatment with moderately potent topical steroid OD on 2 consecutive days each week (weekender regime) over areas affected by recurrent flares for up to 4 months. Restart daily regime for 2 weeks if patient experiences flare-up during weekend maintenance regime. **If no response**: Consider topical calcineurin inhibitors (see below) BD for up to 3 weeks then reduce to OD until clear. Use Advice and Guidance if unsure	For acute flares apply a topical potent steroid (e.g. mometasone) OD for at least two weeks. **If frequent flares:** Consider maintenance treatment with potent topical steroid OD on 2 consecutive days each week (weekender regime) over areas of recurrent flares for up to 4 months. Restart daily regime for 2 weeks if patient experiences flare-up during weekend maintenance regime. **If no response**: Consider topical calcineurin inhibitors (see below) BD for up to 3 weeks then reduce to OD until clear. Use Advice and Guidance if unsure



Finger tip units required for body site

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 **ointments** rather than **creams.** Tell patients to use enough to make the skin look shiny or use fingertip units as above.
2. Use mild potency steroids for the face and neck apart from short term use (e.g. 5 days) of moderate potency (e.g. Eumavate) for severe flares
3. Use moderate potency for short periods e.g. 14 days for vulnerable sites such as groin and axillae
4. Topical calcineurin inhibitors- tacrolimus 0.03% and pimecrolimus are licensed for 2 years and over in moderately severe eczema. Topical tacrolimus 0.1% is licensed from 16 years
    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