Paediatric Eczema

Eczema – Paediatric (0-12yrs) – Primary Care Treatment Pathway

PCDS PRIMARY CARE DERMATOLOGY SOCIETY

What is Eczema?

Eczema (also known as atopic eczema or atopic dermatitis) is a common, chronic, relapsing, inflammatory skin disorder. The skin function is impaired leading to porous and dry skin that easily becomes inflamed, susceptible to infection and itchy. Chronically scratched skin may become thickened (lichenified)

Assessment

An holistic approach is essential

- Onset under 2 years of age; presence of an itchy rash
- Relevant family/social history – eczema, asthma, hayfever, smokers, pets
- Impact on quality of life for child and family (sleep deprivation, schooling, family dynamics)
- Adverse effects on child such as failure to thrive
- What treatments are being and have been used; how long for; what helped and what did not
- Parental expectations and specific questions should be documented/addressed
- Distribution of eczema and other clinical signs eg generally dry skin, weeping, crusting

Management – ABC Rule

A **A**void triggers; soaps or anything that bubbles or lathers, cigarette smoke, irritant clothing

B **B**land moisturisers which are fragrance-free are an absolute essential part of treatment. Ideally applied 3-4 times daily, prescribe adequate quantities (at least 250-500g/week); patient choice improves concordance; bath additives are not recommended; use emollients to wash (apply before wetting the skin); ideally wash hair over the sink to avoid shampoo on skin causing irritation

C **C**ontrol inflammation – match potency of topical steroids (mild, moderate, potent) to the severity of eczema and anatomical site. Use once daily until eczema is settled (usually 1-6 weeks), then decrease to twice weekly use for maintenance. Step-up use to daily during a flare, then wean back down for maintenance therapy (reduces frequency of flares). Topical calcineurin inhibitors are useful as second line treatment, and can be used for children. Topical calcineurin inhibitors are helpful particularly when applied to delicate sites ie flexures, eyelids and the face. Oral steroids should not normally be prescribed for children with eczema in primary care without specialist advice.

There is unjustified TOPICAL steroid phobia amongst healthcare professionals; there is robust evidence of the safety in long-term use in eczema, and using daily for flares and twice weekly for maintenance improves flare intensity and frequency, and reduces overall steroid use

Other Considerations

- Investigation – no routine role for allergy testing or exclusion diets, unless failure to thrive (under 6 months of age) or obvious triggers in the history
- No evidence for the routine use of anti-histamines in improving eczema apart from short-term use of sedating antihistamines may temporarily improve sleep. Some children may benefit with antihistamine treatment if skin worsens in hayfever season.
- Do not prescribe garments routinely; they may help a selective group of eczema patients, such as severe eczema
- Direct to patient support groups eg National Eczema Society and/or other eczema websites; **offer written/ documented advice to families**
- Complications – infection (bacterial or viral) – use of short-term antibiotics or antivirals are appropriate after a swab has been taken if infection is suspected. Avoid long-term use of combination topical agents (eg clotrimazole or fusidic acid with a topical steroid)
- There is no compelling evidence for the use of alternative therapies
- Examples of topical calcineurin inhibitors are pimecrolimus 1% cream (Elidel; licensed from 3 months; potency similar to 1% hydrocortisone); tacrolimus 0.03% and 0.1% ointments (Protopic; 0.03% licensed from age 2 and potency of clobtesaone, and 0.1%, licensed from age 16; off-license can be used in children under 16; potency of mometasone furoate). Do warn that 1 in 10 may suffer transient stinging to the skin, and this usually settles within a week. Prescribing a topical steroid to use concomitantly for a week, or using moisturizer before applying can often reduce stinging. Applied twice daily, then once eczema is controlled, use once a day, twice weekly, similar to topical steroid regimes

When to Refer

- Diagnostic uncertainty
- Failure to respond to treatment
- Steroid atrophy/overuse of topical steroids
- Eczema herpeticum or suspected bacterial infection (eg streptococcal) not responding to treatment
- Severe eczema or systemically unwell child

Allergy & Diet

Infants under 6 months with moderate to severe eczema not responding to optimal topical treatment could be considered for a trial of 4-8 weeks of extensively hydrolysed protein formula whilst awaiting referral to Dermatology. Exclusion diets should not be trialled without dietician guidance or specialist review

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Infant Facial Eczema

Clinical Features

- Moderate to severe exudative facial eczema unresponsive to hydrocortisone

Specific Treatment

- In difficult facial eczema consider moderate potency steroid eg. Eumovate® for 5 days
- For persistent eczema consider topical calcineurin inhibitors

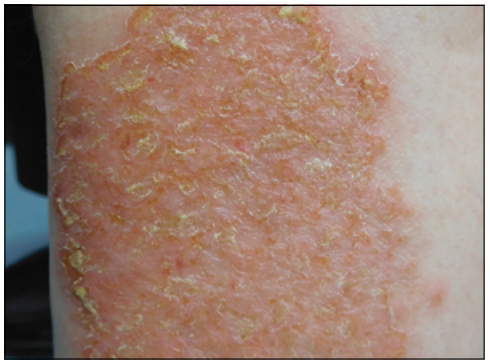
Eczema Herpeticum

Clinical Features

- Punched-out vesicles and lesions that have the same shape and configuration (ie are monomorphic)

Specific Treatment

- Oral aciclovir for localised eczema herpeticum (review in 48-72 hours but provide careful safety-netting and see if worsens ASAP)
- Admit under paediatrics for intravenous therapy if unwell/extensive



Discoid Eczema

Clinical Features

- Single/multiple round shaped patches and lesions, sometimes weepy
- Often misdiagnosed as impetigo, or more commonly, a fungal infection. Scrape any scale and send mycology if in doubt

Specific Treatment

- Tends to need more prolonged courses of moderate to potent topical steroids (for up to 6 weeks) and recurrence is common

Chronic Lichenified Eczema

Clinical Features

- Thickened excoriated skin with increased skin markings

Specific Treatment

- Potent steroids plus occlusion (eg paste bandages or clingfilm wrapped around a limb at night) once daily for up to 2 weeks, then review
- Step down accordingly if improvement is noted

Contributors

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For further information:

Primary Care Dermatology Society:
www.pcds.org.uk

National Eczema Society:
www.eczema.org

Please note this guidance is the views of the contributors and does not consider costs of treatments