ATOPIC ECZEMA -GUIDELINES FOR PRIMARY CARE MANAGEMENT v6

General points -as with other chronic skin conditions:

- Time is needed by the GP / practice nurse to discuss the condition, advise on how best to use emollients and to provide an individual management plan
- Provide patient information leaflets (http://www.bad.org.uk/site/578/default.aspx) and/or direct to appropriate websites (http://www.pcds.org.uk/resources/websites-disease-specific)
- Advise on a pre-payment exemption certificate where appropriate
- At each step it is essential to ensure patient compliance and to make sure that copious amounts of emollients are being used

Step I -Initial consultation

For patients presenting with relatively mild eczema – go to Step II

For patients presenting with a flare – in both children and adults it is more effective and safer to 'hit hard' using more potent treatments for a few days than it is to use less potent treatments for longer periods of time:

- Use a moderate/potent topical steroid e.g. Elocon ® (Mometasone) cream od until things settle down. Patients may also need an appropriate systemic antibiotic i.e. flucloxacillin (erythromycin if allergic) for one week
- If the eczema is relatively localised consider using Fucibet ® cream instead, without a systemic antibiotic. Use this for a short course – bd for 1-2 weeks and then revert to ordinary steroid. Do not use Fucibet or Fucidin H on an ad hoc basis. This encourages resistance.
- For marked sleep disturbance consider a sedating anti-histamine at night e.g. adults – Atarax ® (Hydroxyzine) 25-50 mg, and children – Piriton ® (chlorphenamine) or Phenergan ® (promethazine). There is almost no role for non-sedating antihistamines in the management of eczema, the only exception is patients needing treatment for co-existent hay fever
- Take a skin swab if not settling
- Review the patient in 2 weeks to discuss long-term management

Step II -Long-term management

i) Emollients -should be the mainstay of therapy. Good evidence shows that the more emollients are used, the less topical steroids are needed. Compliance is essential and so always review patients to check they are happy with what has been prescribed – it may be necessary to try a range of emollients before the patient settles on the best combination.

Moisturisers

- Creams and gels are better tolerated but ointments are more effective if the skin is very dry. Ointments are also less likely to cause contact allergic dermatitis as they do not contain preservatives (this is for both emollients and topical steroids)
- It can be helpful to prescribe both a cream / gel AND an ointment if the skin is very dry -patients may wish to use the cream though the day and the ointment at night
- Encourage appropriate usage by prescribing generous amounts, e.g. 500 g. per week of moisturisers to use regularly (often QDS)
- As with other topical treatments, moisturisers should be gently rubbed into the skin until they are no longer visible. They should be applied downward in the direction of the hairs to lessen the risk of folliculitis
- Warn that they may sting for the first couple of days before soothing the skin
- Ointments come in tubs and so can easily become cross infected with bacteria from the skin – patients must not place hands into tubs but instead use a utensil to scoop out the ointment
- Patients can be shown how to apply moisturisers properly at the surgery or they can obtain a DVD (http://www.pcds.org.uk/resources/websites-disease-specific)

Bath / shower gels

- Does the patient bath or shower more?

Source: Primary Care Dermatology Society guidelines for eczema

- Patients getting frequent flares will probably benefit from emollients with an anti-septic property e.g. Dermol ® 600 Bath Emollient or 200 Shower Emollient, Emulsiderm ® Liquid Emulsion or Oilatum ® Plus Bath Additive
- Patients must pat themselves dry after bathing
- Careful consideration must be given as to whether or not to use these products in patients with poor mobility due to the increased risk of slipping in the bath or shower
- Soap substitutes
- Although patients like soaps as they make a lather, they damage the skin barrier and so should be avoided where possible
- Although specific soap substitutes can be prescribed it is probably more cost effective to use one of the prescribed moisturisers as a wash – ointments in particular can provide an effective wash

ii) Topical steroids for long-term control of inflammation -use the lowest appropriate potency and only apply thinly to inflamed skin. Allow to dry into skin for 20 minutes before applying moisturiser. Avoid using combined steroid/antibiotic preparations on a regular basis (e.g. Fucibet and Fucidin-H cream) as it will increase the risk of antibiotic resistance. Strength of steroid to be determined by the age of patient, site and severity:

- Child face: mild potency e.g. 1% Hydrocortisone
- Child trunk and limbs: moderate potency e.g. Eumovate ® (Clobetasone butyrate 0.05%) or Betnovate-RD ® (Betamethosone valerate 0.025%)
- Adult face: mild or moderate potency e.g. Eumovate
- Adult trunk and limbs: potent e.g. Betnovate ® (Betamethasone valerate 0.1%), Elocon ® (Mometasone)
- Palms and soles: potent or very potent e.g. Dermovate ® (Clobetasol propionate 0.05%)

If used appropriately it is uncommon to develop steroid atrophy, however extra care needs to be taken in the following sites:

- Around the eyes: unless used very infrequently topical steroid preparations should be avoided due to the risks of glaucoma
- The face -the regular use of topical steroids should be avoided
- Lower legs in older patients / others at risk of leg ulcers -as above
- The flexures (axillae and groins) where steroids are absorbed more readily due to occlusion

Where there are concerns that the patient may be using too much topical steroid, especially on the sites referred to above, or there are signs of atrophy go to step IV.

Step III -Treatment of flare-ups

- **For infrequent flares (every 4-8 weeks)** manage as in step I
- **For more frequent flares**
  - Check compliance
  - Swab the skin -for frequent infections it is useful to take nasal swabs and if positive for S.Aureus treat with nasal Bactroban ® cream bd for one week
  - Consider the Elocon weekend regime for both children and adults -Elocon should be applied thinly to inflamed areas od for two weeks and then alternate days for a further two weeks. Once the eczema is under control use Elocon on two consecutive days (e.g. Saturday and Sunday) of each week to the areas that tend to flare. The treatment must be applied even if the skin in not inflamed – the aim is to reduce the frequency of flares
  - An alternative to the Elocon weekend regime is to use Protopic ® ointment or pimecrolimus (an immunomodulator -see below) -as above the eczema first needs to be brought under control by more frequent use of the proptopic and then reduce down to twice a week

Patients not responding to the above -consider the possibility of a contact allergic dermatitis. Go to Step

Source: Primary Care Dermatology Society guidelines for eczema

Step IV -Treatment with immunomodulators

- The topical immunomodulators, Protopic ® (tacrolimus) and Elidel ® (pimecrolimus) are calcineurin inhibitors
- Their main benefit is that they are not steroid based and so do not cause skin atrophy
- Formulations
    - Protopic 0.03% ointment and Elidel cream are licensed for ages 2 years and above
    - Protopic 0.1% ointment is licensed for ages 16 yeas and above
- Local adverse effects include stinging, burning, itch, irritation and slight photosensitivity appropriate sun protection is recommended. Adverse effects are more common with Protopic but in many patients are transient. Immunomodulators should be temporarily discontinued when the skin is infected
- When to consider immunomodulators:
    - Eczema involving the eyelids and peri-orbital skin
    - Patients regularly using topical steroids on the face
    - Patients regularly using topical steroids on the lower legs in elderly patients and others at risk of leg ulcers
    - Any signs of skin atrophy
    - When eczema is widely distributed AND patients are using too much topical steroids -see step III
- In milder cases use Elidel cream, although if this is ineffective or in the first instance the eczema is of a greater severity consider Protopic ointment. Protopic can also be used on a twice weekly regime, as in step III to reduce the frequency of flares. Protopic should be allowed to dry into the skin for 60 minutes before applying moisturisers, whereas with Elidel patients only need wait 20 minutes
- While short-term data has showed no serious adverse effects, the possible long-term adverse effects of immunomodulators are not yet known -however the risks are likely to be minimal especially when the treatments are used in the ways described above. For patients using larger quantites (i.e. more frequent applications to larger areas), especially of Protopic, referral to a specialist is advisable

Step V -Referral to BICS

The following patients should be referred to a specialist:

- Diagnostic uncertainty
- Severe eczema
- Moderate-severe eczema only partially responding to steps I-IV – include Dermatology Life Quality Index (DQLI) (http://www.dermatology.org.uk/quality/quality-dlqi.html)
- Steroid atrophy or concerns regarding the amount of topical steroids / Immunomodulators being used
- Possible cases of contact allergic dermatitis

Source: Primary Care Dermatology Society guidelines for eczema

Manage in Primary Care:	**Route to BRIGHTON AND HOVE SKIN CARE if:**	**Route to SECONDARY CARE if:**
Mild to Moderate eczema. See above Guidance	Moderate to severe eczema Simple contact allergic dermatitis Diagnostic uncertainty without other co-morbidities	Severe eczema Complex contact allergic dermatitis Diagnostic uncertainty with complex co-morbidities