DIETARY INTERVENTIONS

FOOD ALLERGY AND DIETARY EXCLUSION

C	**Dietary exclusion is not recommended for management of atopic eczema in patients without confirmed food allergy.**
☑	Where there is suspicion of food allergy in infants or children with atopic eczema, general practitioners should refer to an allergist or paediatrician with a special interest in allergy.

INFANT FEEDING

A	**The exclusion of foods during pregnancy and breast feeding to prevent the development of atopic eczema in infants is not recommended.**
B	**Parents should be advised that exclusive breast feeding for three months or more may help prevent the development of infant eczema where there is a family history of atopy.**
B	**Hydrolysed formulas should not be offered to infants in preference to breast milk for the prevention of atopic eczema.**

COMPLEMENTARY AND ALTERNATIVE THERAPIES

HERBAL REMEDIES

☑ Patients with atopic eczema and their parents or carers should be informed that:

- they should be cautious with the use of herbal medicines and be wary of any herbal product that is not labelled in English or does not come with information about safe usage
- topical corticosteroids are deliberately added to some herbal products intended for use by patients with atopic eczema
- liver toxicity has been associated with the use of some Chinese herbal medicines intended to treat atopic eczema.

SOURCES OF FURTHER INFORMATION

British Association of Dermatologists
Willan House, 4 Fitzroy Square
London W1T 5HQ
Tel: 0207 383 0266 • Fax: 0207 388 5263
www.bad.org.uk

British Skin Foundation
4 Fitzroy Square
London W1T 5HQ
Tel: 0207 391 6341
www.britishskinfoundation.org.uk

Eczema Scotland
Email: contact@eczemascotland.org
www.eczemascotland.org

National Eczema Society
Hill House
Highgate Hill
London N19 5NA
Tel: 020 7281 3553
Helpline: 0800 089 1122 (8am to 8pm Monday to Friday)
Email: info@eczema.org
www.eczema.org

NHS Choices
www.nhs.uk

This Quick Reference Guide provides a summary of the main recommendations in **SIGN 125 Management of atopic eczema in primary care.**

Recommendations are graded **A B C D** to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

SIGN
Scottish Intercollegiate Guidelines Network
Part of NHS Quality Improvement Scotland

NHS Quality Improvement Scotland

125 Management of atopic eczema in primary care

Quick Reference Guide

March 2011

COPIES OF ALL SIGN GUIDELINES ARE AVAILABLE ONLINE AT WWW.SIGN.AC.UK

DIAGNOSIS AND REFERRAL

SEVERITY ASSESSMENT AND QUALITY OF LIFE

☑ When assessing the severity of atopic eczema, healthcare professionals should take into consideration the adverse effects on quality of life of patients and their families.

REFERRAL

D **An emergency referral to a dermatologist or paediatrician should be arranged by telephone where there is clinical suspicion of eczema herpeticum** *(widespread herpes simplex).*

D **Patients should be referred to a dermatologist where there is:**

- **uncertainty concerning the diagnosis**
- **poor control of the condition or failure to respond to appropriate topical treatments**
- **psychological upset or sleep problems**
- **recurrent secondary infection.**

EMOLLIENT THERAPY

C **Patients with atopic eczema should have ongoing treatment with emollients.**

☑ To optimise adherence to emollient therapy, creams, lotions, ointments, or a combination can be used, depending on patient choice. Prescriptions should be reviewed regularly.

☑ Patients and parents/carers of children should be educated about regularly applying emollients onto dry skin and eczematous areas even when eczema is under control.

☑
- Patients should be advised to apply emollients liberally and frequently (at least 2-4 times a day). It is particularly important to use emollients during or after bathing.
- Sufficient quantity of emollient should be prescribed.
- The emollient should be applied smoothly in the general direction of growth of body hair in order to prevent accumulation at hair bases which might predispose to folliculitis.
- Emollients can become contaminated with bacteria. The use of pump dispensers minimises the risk of microbial contamination. If the emollient is in a pot the required amount should be removed with a clean spoon or spatula. Fingers should not be inserted into pots. Emollients should not be shared with others.

TOPICAL CORTICOSTEROID THERAPY

☑ The choice of TCS potency should be tailored to the age of the patient, the body region being treated, and the degree to which the skin is inflamed. For delicate areas of skin, such as the face and flexures, only mild or moderately potent preparations should be used. On the face, especially in children, it is reasonable to start with a mildly potent TCS.

A **Patients should be advised to continue with emollient therapy during treatment with topical corticosteroids.**

B **Patients with atopic eczema should be advised to apply topical corticosteroids once daily.**

☑ If there is an inadequate response to once daily application, the frequency should be increased to twice daily.

A **Twice weekly maintenance therapy with a topical corticosteroid should be considered in patients with moderate to severe atopic eczema experiencing frequent relapses.**

☑ Patients being treated with intermittent courses of topical corticosteroids should be reviewed every three to six months (depending on TSC potency and site of application) to ascertain response to therapy and assess skin for potentially reversible atrophic changes.

B **Topical corticosteroids should be used with caution in the periocular region.**

☑ The fingertip unit should be used to guide patients on topical corticosteroid quantities required.

☑ Patients should be advised to apply topical corticosteroids in an amount sufficient to adequately cover the areas of inflamed skin even if the skin is excoriated.

TOPICAL CALCINEURIN INHIBITORS

C **Topical tacrolimus should be considered, in patients aged two years and older, for short term, intermittent treatment of moderate to severe atopic eczema that has not been controlled by topical corticosteroids or where there is a serious risk of important adverse effects from further topical corticosteroid use, particularly skin atrophy.**

☑ As a precaution against the possibility that the normal immunological response to infection may be suppressed, topical calcineurin inhibitors should not be applied to skin which appears actively infected.

DRESSINGS

☑ Patients with non-infected moderate to severe eczema should be advised to cover affected areas with dry wrap dressings to provide a physical barrier to scratching and improve retention of emollient.

ANTIMICROBIAL MEASURES

☑ Routine swabbing of skin is not indicated in the management of patients with atopic eczema.

☑ Swabs of potential *S. aureus* carriage sites (of both the patient and family members) should be considered in patients with recurrent infection.

☑ In patients with atypical features, or where there is concern about possible streptococcal infection, skin swabs of affected areas should be considered.

B **Oral antibiotics are not recommended in the routine treatment of non-infected atopic eczema.**

☑ In the absence of a clear evidence base, the current standard practice of short term oral antibiotic treatment for patients with clinically infected eczema should continue. Treatment of bacterial infections should be based on local and regional antibiotic sensitivities.

ANTIHISTAMINES

☑ Short term bedtime use of sedating antihistamines should be considered in patients with atopic eczema where there is debilitating sleep disturbance.

ENVIRONMENTAL FACTORS

☑ Where an irritant effect is suspected, patients should be advised to avoid biological washing powders, fabric conditioners and fragranced products such as soaps and shower gels.