Eczema Pathway

Clinical Assessment/Management Tool for Children

Healthier Together

NHS

Primary and Community Care Settings

Priorities of Clinical Assessment

- Ask about other atopy e.g. allergic rhinitis, asthma
- Can occur in all ages
- Triggers include soap/bubble bath, allergies e.g. pollen, pet fur, house dust mites and sometimes food

History

- Assess severity and duration: thickening, bleeding, weeping
- Assess impact: sleep, growth and school (quality of life)
- Assess Triggers:
  - Consider treatment if evidence of hay fever
  - If eczema is only symptom, food allergy is unlikely.

Also see the PIL Eczema (what to do if your child has eczema)

Red Flags

- Faltering growth
- Bacterial infection (crusting lesion with brown seepage)
- Herpes infection
- High fever

	Symptoms	Treatment	Management	
Red	• Itches all the time • Covers large area • Broken skin (worsened by scratching) • Larger areas of thickening or bleeding • Keeps child awake often	• Regular emollients 3-4 hourly • Optimisation of topical steroids over affected areas is the mainstay of treatment. • Antibiotics if signs of secondary infection, most children do not need antibiotics. • Review for response and ensure clear advice about systemic symptoms (infection, sepsis and erythroderma)	• Continue regular emollients in high amounts, min 4 times per day • Optimise and increase topical steroids as per ladder to affected area. Use as soon as flare and for 48 hours after improvement • Consider oral steroids where appropriate • Antibiotics may be needed if signs of infection • Consider sedating antihistamine at night, Fexofenadine • Consider Pimecrolimus/Tacrolimus as a useful steroid alternatives for the face in individual circumstance, may require specialist discussion (causes stinging in all initially - warn patient)	• Bandages/Therapeutic garments – Bandages are useful for thickened skin: use for a week and repeat as required (how to apply treatment videos) – Consider elasticated garments/therapeutic clothing (various eczema specific brands available) for all severe eczema patients heavily excoriated areas (not if infected) e.g. Derma Silk – Apply over topical steroids for one week then one week emollient
Amber	• Itches quite often, • Broken skin (worsened by scratching) • Localize thickening or bleeding • Keeps your child awake occasionally	• Regular emollients 3-4 hourly • Steroids as prescribed	• Continue emollients • Start steroid cream once daily and for 48 hours after improvement	**Steroid ladder link**
Green	• Itches sometimes • Some redness • Some dryness	• Regular emollients 3-4 hourly • Observe for worsening signs	• Moisturizers/Emollients – Mainstay of treatment – Use every day, up to 4 times per day (or 3-4 hourly) – Use in large amounts all over the body – Examples are: Hydromol and Epaderm and 50/50	• Bath/washing – Reduce frequency of bath/shower – Use emollient as replacement for bath/shower

Diet and Eczema

- Most children with eczema can have a normal diet
- Prolonged elimination diets may be harmful (NICE Guidance), extensive elimination or any elimination in those <2 years should only be recommended under specialist care.
- 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

Referral Criteria

Routine referral

- Diagnostic uncertainty
- Management not satisfactory or prolonged requirement for potent steroids
- Possible contact allergy
- Significant psychosocial impact
- Faltering growth

EMERGENCY REFERRAL (same day)

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

This guidance has been reviewed and adapted by healthcare professionals across North East and North Cumbria with consent from the Hampshire development groups

Eczema Pathway

Clinical Assessment/Management Tool for Children

Healthier Together

NHS

Primary and Community Care Settings

Back to front page

1- First choice | 2- Second choice

STEROID LADDER

Healthier Together

Very Potent

Dermovate (clobetasol proprionate 0.05%)
Dermovate scalp lotion (clobetasol proprionate 0.05%) **Etrivex shampoo** (clobetasol proprionate 500 micrograms/g)

See Drug safety update

Corticosteroids: rare risk of central serous chorioretinopathy with local as well as systemic administration

Potent

Betnovate (betamethasone valerate 0.1% in a water miscible base)
Betacap (betamethasone valerate 0.1% containing coconut oil derivative)
Locoid (hydrocortisone butyrate 0.1%)
Synalar (fluocinolone acetonide 0.025%)
Elocon (mometasone furoate 0.1%)

With antibacterial
Fucibet (betamethasone valerate 0.1%, fusidic acid 2%)
Synalar C (fluocinolone acetonide 0.025%, clioquinol 3%)

Synalar N (fluocinolone acetonide 0.025%, neomycin sulfate 0.5%)

With salicylic acid
Diprosalic
(betamethasone diproprionate 0.05%, salicylic acid 3%)

Moderate

Betnovate RD (betamethasone valerate 0.25%)

Eumovate (clobetasone butyrate 0.05%)

Fludroxycortide Tape (4 micrograms/cm2)

Modrasone (Alclometasone dipropionate 0.05%)

With Urea
Alphaderm (hydrocortisone 1%, urea 10%)

With antifungal and antibacterial
Trimovate
(clobetasone butyrate 0.05%, oxytetracycline 3%, nystatin 100,000units/g)

Mild

Hydrocortisone 1%
Synalar 1 in 10 Dilution (fluocinolone acetonide 0.0025%)

With antibacterial
Fucidin H
(hydrocortisone 1%, fusidic acid 2%)

With antifungal
Canestan
HC hydrocortisone 1%, clotrimazole 1%)
Daktacort (hydrocortisone 1%, miconazole nitrate 2%)
Nystaform HC
(hydrocortisone 1%, nystatin 100,000units/g, chlorhexidine 1%)

Clinicians are reminded that a prescription for treatment of mild dry skin should not routinely be offered in primary care as the condition is appropriate for self-care.

Products containing antibacterials should be applied twice daily for 7-14 days maximum per infective flare (check individual product details). Patients should then revert to a steroid that does not contain antimicrobials to control flares unless the skin is infected.

This has been reviewed and adapted by healthcare professionals across North East and North Cumbria with consent from

Recommendation:

Steroid first to clean dry skin, wait 15 mins and then apply moisturiser.

The aim of treatment is to induce remission using appropriate strength for appropriate duration on affected areas.

Information:

No evidence that bath emollients work, encourage use of emollients as soap substitute with safety advice explanation of chronicity, appropriate confident management of flares, long term use of regular emollients.

Advice:

Keep cool, light cotton clothing, keep nails short, and use dust mite covers on beds.

For acute itching use cool packs