

Treatment guidelines for Atopic eczema (dermatitis)

Atopic eczema (also known as atopic dermatitis) is a chronic, itchy, inflammatory skin condition that affects people of all ages, although it presents most frequently in childhood. It is typically an episodic disease of flares (exacerbations, which may occur as frequently as two or three times each month) and remissions; in severe cases, disease activity may be continuous. The term 'atopic' is used to describe a group of conditions (eczema, asthma, hay-fever, and food allergy) that are linked by an increased activity of the allergy component of the immune system. The term 'eczema' comes from the Greek word 'to boil' and is used to describe itchy, red, dry skin which can sometimes become weeping, blistered, crusted, scaling, and thickened.

DIAGNOSTIC CRITERIA

Atopic eczema is likely if the following criteria are fulfilled (although alternative diagnoses may need to be excluded):

- **An itchy skin condition (or parental report of scratching) *plus* three or more of the following:**
 - Visible flexural eczema involving the skin creases, such as the bends of the elbows or behind the knees (or visible eczema on the cheeks and/or extensor areas in children aged 18 months or younger).
 - Personal history of flexural eczema (or eczema on the cheeks and/or extensor areas in children aged 18 months or younger).
 - Personal history of dry skin in the last 12 months.
 - Personal history of asthma or allergic rhinitis (or history of atopic disease in a first-degree relative of a child aged under 4 years).
 - Onset of signs and symptoms before the age of 2 years (this criterion should not be used in children younger than 4 years of age).

TRIGGER FACTORS

- Irritant allergens such as soaps, detergents, and chemicals
- Irritant clothing/fabrics
- Skin infections
- Contact allergens – preservatives, latex, perfume based products
- Inhaled allergens – pollen, dust mites, fur
- Hormonal triggers
- Climate – extremes of temperature
- Concurrent illness and disruption of family life – stress, lack of sleep
- Dietary factors

Most people do not need allergy testing - if a food allergy is suspected, manage in primary care if the expertise and support are available, otherwise refer to secondary care. **If other types of allergies are suspected,** refer to secondary care as appropriate.

Treatment guidelines for Atopic eczema (dermatitis) in adults

SEVERITY ASSESSMENT

Skin/physical severity	
Clear	Normal skin, no evidence of active atopic eczema
Mild	Areas of dry skin, infrequent itching (with or without small areas of redness)
Moderate	Areas of dry skin, frequent itching, redness (with or without excoriation and localised skin thickening)
Severe	Widespread areas of dry skin, incessant itching, redness (with or without excoriation, extensive skin thickening, bleeding, oozing, cracking and alteration of skin pigmentations)

Three validated scoring systems for assessing the severity of atopic eczema are; SCORing Atopic Dermatitis (SCORAD), Eczema Area and Severity Index (EASI) and Patient Orientated Eczema Measure (POEM).

QUALITY OF LIFE ASSESSMENT

Psychological impact	
None	No impact on quality of life
Mild	Little impact on everyday activities, sleep and psychosocial well-being
Moderate	Moderate impact on everyday activities and psychosocial well-being and frequently disturbed sleep
Severe	Severe limitation of everyday activities and psychosocial functioning and loss of sleep every night

There is correlation between the severity of eczema symptoms and some aspects of quality of life (QoL). Consider using questionnaires to give an objective measure of quality of life. For example, the Children's Dermatology Life Quality Index (CDLQI) and Adult's Dermatology Life Quality Index (ADLQI), Infant's Dermatitis Quality of Life index (IDQOL).

Refer to dermatology specialists if:

- Diagnosis is uncertain
- Severe eczema or facial eczema not responding to treatment
- Moderate to severe eczema not responding/partially responding to treatments
- Steroid atrophy or concerns regarding the amount of topical steroids/immunomodulators being used
- Recurrent secondary infections
- If eczema is associated with severe and recurrent infections, especially deep abscesses or pneumonia.
- Admit to hospital if eczema herpeticum is suspected

Treatment pathway for Atopic eczema (dermatitis)

MILD TO MODERATE ATOPIC ECZEMA	<p>1st line treatments (see CCG guidelines on emollient prescribing link)</p> <p>Topical treatment include;</p> <ol style="list-style-type: none"> Complete emollients therapy to improve inflammation and dry skin condition. Emollients should be applied liberally and frequently as possible, at least 3-4 times per day. Ideally every 4 hours. Some patients may require a combination of creams, ointments and emollients to replace soap. Mild – moderate potency topical corticosteroids – prescribe strength of topical steroid to match the severity of the eczema. Topical corticosteroids can be prescribed to treat acute flares and as long term maintenance treatment for chronic eczema and regular review of steroid therapy to ensure appropriate step-up or step down of treatments as appropriate. These should always be used in combination with complete emollient therapy. Moderate – potent topical corticosteroids – prescribe strength of topical steroid to match the severity of the eczema. Topical corticosteroids can be prescribed to treat acute flares and as long term maintenance treatment for chronic eczema and regular review of steroid therapy to ensure appropriate step-up or step down of treatments as appropriate. These should always be used in combination with complete emollient therapy. <p>Add-on therapy</p> <ol style="list-style-type: none"> Antihistamine – for patients with severe itch or urticaria consider prescribing one month trial of non-sedating antihistamine. If itching is affecting sleep then a sedating antihistamine might be appropriate. Note antihistamines are not licensed for atopic eczema however there are for allergic conditions including urticaria. Dry Bandages Antibiotics – for patient with extensive infected eczema, swab skin and then prescribe oral antibiotics such as flucloxacillin or Clarithromycin for penicillin allergic patients
MODERATE TO SEVERE ATOPIC ECZEMA	<p>2nd line – Moderate to severe atopic eczema and inadequate response to topical corticosteroid treatment refer to dermatology for consideration of the following:</p> <ol style="list-style-type: none"> Topical calcineurin inhibitors - Tacrolimus or pimecrolimus – patients who have failed to be controlled on topical steroid therapy. Can be used for the treatment of acute flares and as maintenance therapy for patients who have responded to an initial 6 weeks of treatment. Maximum course of maintenance therapy is 12 months (pimecrolimus is not appropriate for continuous treatment). Treatment should be initiated only by physicians with special interest and experience in dermatology. Phototherapy –Narrow band UVB therapy Systemic immunosuppressants – under shared care AMBER <ul style="list-style-type: none"> ○ Ciclosporin ○ Methotrexate ○ Azathioprine ○ Mycophenolate
SEVERE ATOPIC ECZEMA	<p>Hospital prescribing only</p> <p>Biologic therapies may only be initiated in severe atopic dermatitis in adult patients that have not responded or are intolerant of/have contraindications to standard systemic therapies</p> <p>Dupilumab in line with NICE TA534</p>

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