Atopic eczema

History

•Age of onset/pattern /severity
•Possible trigger factors
•Dietary history
•Family history of atopy
• sleep disturbance

Examination

• crusted erythematous patches + pruritis
• in infancy esp. face
• may have secondary infection
• may co-exist with scabies / Staph or Strep infection

Eczema and allergy

• HDM/cats/dogs/grass pollen / food
• **IgE RAST , skinprick tests**
• **if severe – trial of CMP-free milk (with dietetic support) x 6-8 weeks**

Treatment

• use emollients generously – apply liberally + frequently (min. 2-4 times a day) and mix in bath water
•Sparing topical steroids (0.5-1%hydrocortisone) once per day (enough application on the effected area so that it glistens)
•Recognise+ treat infection

Diagnosis

Itchy dry skin
+
Dermatitis of cheeks and extensor surfaces if < 18m
+
Flexural dermatitis involving skin creases
+/-
Atopy

Trigger factors

Irritants such as soap and detergents
Contact or inhaled allergens
Woollen clothing
Food allergens (if immediate reaction to food or severe uncontrolled eczema)

Flare up of eczema

Emollients + antiseptic in bath water + aqueous cream to wash skin
Topical steroids (1 hour prior to emollients)
main reason for flare up is infection
(watch out for HSV)
90% develop *Staph. Aureus* colonization

Evidence Base

• topical tacrolimus in **over 2 yo** with mod/severe eczema **not** controlled on topical steroids (level of evidence C)

References

•NICE CG 57 2007
•SIGN 125 2011 management of atopic eczema in primary care

TAKE HOME MESSAGES

Liberal use of emollients
Avoid known triggers
Sparing(FTU) topical steroids
Avoid goat's milk
Wet dressing/paste bandages are second line
Have a written care plan
If flare up , think infection

REFERRAL TO DERMATOLOGIST

uncertainty re diagnosis
Poor control /failure to respond
Recurrent secondary infection
Urgent – eczema herpeticum

This algorithm has been produced by the National Paediatric and Neonatology Clinical Programmes. It is aimed at medical, nursing and allied health professionals working in both primary and emergency care settings.

Further amendments following feedback from QIP committee of the ICGP . Secondary treatment denoted in pink

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