

Guidelines *in practice*

Guidelines for the management of atopic eczema

- ▶ Dr Tom Poyner explains how the Primary Care Dermatology Society (PCDS) developed guidelines that are clinically relevant to primary care
- ▶ PCDS atopic eczema guideline summary from [Guidelines](#)

Supplement

PCDS atopic eczema guidelines optimise GP management



Dr Tom Poyner explains how the PCDS developed guidelines for the management of atopic eczema that are clinically relevant to primary care

The most frequent dermatological consultation in primary care is for a child with atopic eczema.¹ The prevalence of atopic eczema in children is 15–20% and increasing, and most cases in children are of mild severity.^{2,3} In adults, the prevalence is 2–10% and the condition is a cause of significant morbidity.

By far the largest number of patients with atopic eczema are managed in primary care. New outline guidelines for the management of atopic eczema, from the Primary Care Dermatology Society (PCDS) are designed to help optimise this care.

Development of the guidelines

The PCDS wanted to develop guidelines for the management of atopic eczema that would be clinically relevant to primary care. The aim of the guidelines was to help GPs manage patients in their own practices.

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A working party consisting of five GPs with dermatological expertise and two with guidelines and governance expertise was drawn up (see Box on p.6). The working party planned to review the best currently available evidence to produce provisional clinical practice guidelines, which would then be reviewed by the Society's committee and membership.⁴

There were already validated diagnostic criteria for atopic eczema.⁵ Previous guidelines for the management of atopic eczema existed, but

they were becoming dated and had not been formulated specifically for primary care.⁶

Dr Julia Newton-Bishop, based in Leeds, had used a multidisciplinary approach and national opinion leader input to develop comprehensive guidelines for eczema treatment in the hospital sector.⁷ These are currently undergoing discussion and review, prior to publication.

This work was kindly made available to our group. There was a very limited amount of relevant evidence-based medicine; however, any relevant information will be incorporated as it becomes available.⁸ The referral guide for children with atopic eczema produced by NICE, which is currently being piloted at various sites around the country, was used as a basis for referral guidelines.⁹

Subsequent to the meeting of the PCDS working party, the documents were presented to and accepted by



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• Primary Care Dermatology Society •

- This information is a broad guideline only. Treatment of an individual patient should always be modified according to need and circumstances and may involve a multidisciplinary approach
- Eczema affects 15–20% of school children and 2–10% of adults
- Allergen avoidance is ineffective in the vast majority of patients

Diagnostic criteria for atopic eczema

- *Must have:*
 - an itchy skin condition (or report of scratching or rubbing in a child)
 - *plus three or more of the following:*
 - history of itchiness in skin creases such as folds of the elbows, behind the knees, fronts of ankles, or around neck (or the cheeks in children under 4 years)
 - history of asthma or hay fever (or history of atopic disease in a first-degree relative in children under 4 years)
 - general dry skin in the past year
 - visible flexural eczema (or eczema affecting the cheeks or forehead and outer limbs in children under 4 years)
 - onset in the first 2 years of life (not always diagnostic in children under 4 years)

• **If it does not itch it is very unlikely to be eczema**

Diagnosis and patient assessment

- *Enquiry about and discussion of the following:*
 - family and personal history of atopy and eczema
 - distribution of disease
 - onset of disease

- exposure to pets within the household
- aggravating factors such as exposure to irritants
- sleep disturbance due to itching/rubbing
- previous treatments
- effect on school work, career, or social life
- most distressing thing for the patient or family
- patient's or family's expectations from treatment and their understanding of optimal use
- evidence of clinical infection, suggested by the presence of crusting or weeping in bacterial infection, or grouped vesicles and punched out erosions indicative of herpes simplex infection
- other considerations are the impact on the quality of life, dietary restrictions tried and other medications being taken (e.g. steroids for asthma)
- a growth chart should be completed and updated in children with chronic severe eczema

Recommendations for referral to secondary care

- Severe infection with herpes simplex (eczema herpeticum) is suspected
- The disease is severe and has not responded to appropriate therapy in primary care
- The rash becomes infected with bacteria (manifest as weeping, crusting or the development of pustules) and treatment with an oral antibiotic plus a topical corticosteroid has failed
- The rash is giving rise to severe social or psychological problems; prompts to referral should include sleeplessness and school absenteeism