

General Commissioning Policy

Treatment	Atopic Eczema
For the treatment of	Atopic Eczema
Background	<p>NHS Scarborough and Ryedale CCG (SRCCG) commissions' healthcare on behalf of its local population across primary, secondary and tertiary care sectors. Commissioning policy including clinical referral pathways and thresholds have been developed and defined using appropriate NICE guidance and other peer reviewed evidence and are summarised here in order to guide and inform referrers</p> <p>This policy defines the SRCCG commissioning position for Atopic Eczema</p>
Definition	<p>Diagnostic criteria for atopic eczema (McHenry et al 1995)</p> <ul style="list-style-type: none"> • An itchy skin condition (or reported scratching/rubbing in a child) • Plus three or more of the following: <ul style="list-style-type: none"> - history of itchiness in skin creases - history of asthma or hay fever - general dry skin in the past year - visible flexural eczema - onset in the first 2 years of life - history of atopy in 1st degree relative <p>Exclude red flag symptoms</p> <ul style="list-style-type: none"> • Eczema herpeticum – consider in an ill, feverish child or unwell adult with widespread vesicles or vesico-pustules. Very occasionally fatal • Treat with oral acyclovir or refer for specialist advice especially with lesions near the eyes <p>General points</p> <p>Atopic eczema is a common disease affecting up to 15% of children</p> <p>Involvement of the face frequently occurs in infants with adoption of characteristic flexural distribution by the age of 18 months</p> <p>Spontaneous improvement tends to occur throughout childhood with complete clearance by teenage years in 50%</p> <p>Realistic treatment aims need to be discussed with the patient and parents</p>

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Responsible Consultant –Dr Kathryn Thomson, YHFT	Date published: July 2017
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<p>Management</p>	<p>General</p> <ul style="list-style-type: none"> • Encourage smoking cessation • Encourage weight loss (if appropriate) <p>Avoidance of irritants</p> <ul style="list-style-type: none"> • Avoid direct contact with detergents including all soaps, shower gels, shampoos etc. as much as possible. Wash hair over the side of the bath, use gloves, use emollients. • Avoid itchy clothing e.g. wool • Manage itching – avoidance/distraction, cotton gloves at night, sedative antihistamines (chlorphenamine, hydroxynine with appropriate care). • Keep cool • keep nails short and filed smooth
<p>Treatment</p>	<p>Complete emollient therapy – is mainstay of treatment for all patients – see emollient ranking for advice and preferred options. Ensure adequate quantities of emollient are prescribed. For an adult with whole body eczema 500g for a week is appropriate.</p> <p>Please note that emollient shower gel products are not commissioned and should not be prescribed. Patients should use regular emollient creams as soap substitutes.</p> <p>Topical steroids – the prescription of topical steroid cream or ointment for red, inflamed skin should be considered. Use of the lowest potency and amount of topical corticosteroid necessary to control symptoms should be advised, depending on the severity of the flare. Steroid treatment should be continued for 48 hours after the flare has been controlled.</p> <ul style="list-style-type: none"> • Mild topical corticosteroid – e.g. hydrocortisone 1% cream/ointment • Moderate eczema – prescribe a moderately potent corticosteroid e.g. clobetasone butyrate 0.05% as Eumovate® • Severe eczema – prescribe a potent topical corticosteroid e.g. mometasone furoate 0.1% as cream or ointment = Elocon® (potent) • Use appropriate strength for different areas of skin, mild topical steroid for face and neck down to the clavicles, 0.5-1% for eyelids, moderate/potent for most other areas in adults but milder steroid creams in children. Areas such as axillae and groins are more prone to side effects

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	<p>so use moderate/potent preparations for short periods (7-14 days) only</p> <ul style="list-style-type: none"> • Use of ointments is preferable (fewer preservatives, more moisturising) but patient preference is important too • Prescribe adequate quantities to encourage use. Treat early to minimise flares • Topical steroids are frequently underused due to concerns about side effects <p>Topic Calcineurin Inhibitors – Tacrolimus or pimecrolimus are recommended as an option for the second line treatment of moderate to severe atopic eczema in adults and children aged 2 years and older that has not been controlled by topical corticosteroids, where there is a serious risk of important adverse effects from further topical corticosteroid use, especially irreversible skin atrophy. They are particularly useful in areas where topical steroid use is not ideal such as the face and neck.</p> <ul style="list-style-type: none"> • Should be initiated only by physicians (including general practitioners) with a special interest and experience in dermatology and only after careful discussion with the person about the potential risks and benefits of all appropriate second line treatment options • There is a theoretical cancer risk in long term use • Can burn for the first few applications and can predispose to widespread viral warts (stop use if molluscum, chicken pox, skin infection or multiple viral warts develop) • Limit continuous use to 1 year (in primary care). Refer if considering longer term use <p>Antihistamines – sedative antihistamines promote sleep and may help break the itch-scratch cycle during severe flares however they should not be used in long term for young children as they have effects on sleep cycles (chlorphenamine, hydroxyzine with appropriate care)</p> <p>Infection – using topical antibiotics or adding them to steroids in eczema management encourages resistance and does not improve healing. Fucidin in particular should be used with care due to high levels of bacterial resistance.</p> <p>In infected eczema, use antiseptic bath additives and treat with systemic antibiotics as for impetigo if clinically indicated (see emollient guidance for details)</p> <p>Oral flucloxacillin – 500mg-1g QDS for 7 days</p>
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	<p>For patients <18 years see latest BNF for children for accurate dosing information</p> <p>If penicillin allergic: clarithromycin 500mg BD for 7 days Children <12 years of age if liquid formulations are required: erythromycin. See latest BNF for children for accurate dosing information</p> <p>Check North Yorkshire antibiotic prescribing guidance for primary care for full information</p> <p>Consider infection if weeping/pustules/crusts, lack of response to usual Rx, rapid exacerbation, fever or malaise</p> <p>Bandaging</p> <ul style="list-style-type: none"> • Zinc paste bandages used alone or over topical corticosteroids can result in rapid improvement of resistant, particularly lichenified eczema • Wet wrap dressings may also be helpful, particularly at night in small children • Caution is required when using any type of occlusive bandaging in conjunction with topical steroids because the potency of the steroid can be increased by occlusion • All occlusive bandaging should be avoided in infected eczema • Comfast® garments (vests and leggings) are easier to use than bandages and useful at night to cover the creams and prevent overnight scratching. They are prescribable for different ages and can be washed and re-used • Please note that Scarborough & Ryedale CCG do not commission silk dressing products. These should not be prescribed <p>Encourage patient / parent education</p> <ul style="list-style-type: none"> • How to apply emollients and steroids • Comprehensive eczema PILs <p>See BNF for additional prescribing information on any of the above</p> <p>Allergy and additional information <i>Allergy testing</i> No tests are available to confirm or refute food allergy as a cause of worsening eczema.</p>
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	<p>Skin prick tests are not helpful Total IgE/RAST tests to pets or house dust mite or 'common food mix' can be useful. Common food mix covers more than 90% of food allergies but results need interpretation along with patient's history, 5-6+ suggest there may be an allergy to this substance. Many atopic individuals will have positive specific IgE but this is not always clinically significant.</p> <p>House dust mite can worsen eczema in some children</p> <p><i>Food allergy</i> Food allergy e.g. to egg or dairy is RARELY a cause of worsening eczema. Consider exclusion diets only in refractory eczema and abandon if no improvement after 2-4 weeks If exclusion required for more than 2-4 weeks then dietetic advice is needed 'Food allergy' is often a temporary intolerance so the foodstuff should be re-challenged every few months Dermatologists do not perform food allergy tests.</p> <p><i>Patch testing</i> Patch testing is used to investigate specific contact allergic eczema, a rare occurrence in children with atopic eczema. Children <5-6 years old are not able to co-operate with this test</p> <p><i>Evening primrose oil</i> No evidence of benefit</p> <p><i>Chinese Herbs</i> No product licences – not recommended (often contain potent steroids)</p>
<p>Referral Criteria</p>	<ul style="list-style-type: none"> • Only cases of severe or difficult eczema usually need to see a Dermatologist • Lack of adequate progress despite use of adequate quantities of emollients/topical steroid preparations which are correctly applied • Concern about eczema herpeticum • For consideration of second line treatment such as photochemotherapy, cytotoxic drugs and for consideration of longer term topical immunomodulators • If contact allergic dermatitis is suspected for patch testing

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Investigations prior to referral	<ul style="list-style-type: none"> Swabs and treatment of any infection for sudden or persistent exacerbations (although swabs may show S.aureus + as a skin commensal rather than as an infective agent) Check FBC/ferritin in persistently itchy patients or all bloods as per generalised pruritus guideline
Information to include in referral letter:	<ul style="list-style-type: none"> Duration and location of the eczema Treatments tried, duration and their effects Any psychosocial effects, occupational history Impact on daily life A photograph is desirable Relevant past medical/surgical history Current regular medication BMI Smoking status Alcohol consumption
Patient Information Leaflet	<p>Atopic Eczema – www.patient.co.uk/health/atopic-eczema PILS for atopic eczema – emollient information, topical steroids (includes advice about fingertip dosing) and triggers/irritants Eczema Society – excellent website for patients / parents with guides to treatment</p>
Effective from	November 2014 – Reviewed May 2017
Review Date	2019
Contact for this policy	Service Improvement Team Scrccg.enquiries@nhs.net

References:

[Dermnetnz](#)

[NICE CKS Atopic Eczema](#)

[British Association of Dermatologists – Atopic Eczema](#)

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