ATOPIC ECZEMA

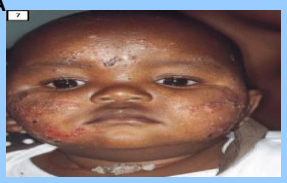
DRM-1 Protocol and Pathway – Dermatology Specialty (29/03/2011)

Patient presents

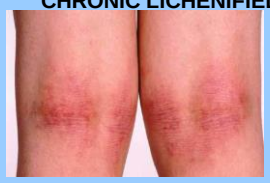
Patient history and initial diagnostic examination.

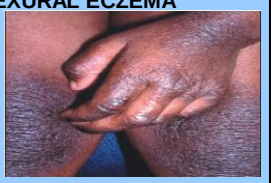
•The skin usually feels dry.
•Some areas of the skin become red and inflamed. The most common areas affected are next to skin creases such as the front of the elbows and wrists, backs of knees, and around the neck. However, any areas of skin may be affected. The face is commonly affected in babies.
•Inflamed skin is itchy. If you scratch a lot it may cause patches of skin to become thickened (also called lichenification)
•Sometimes the inflamed areas of skin become blistered and weepy.
•Sometimes inflamed areas of skin become infected.

ACUTE INFECTED ECZEMA

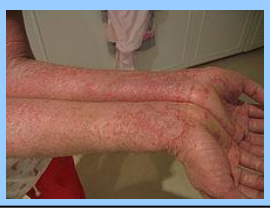


CHRONIC LICHENIFIED FLEXURAL ECZEMA





ACUTE ERYTHRODERMIC ECZEMA



Primary Care treatment for each condition:
See next page

Following GP level intervention, then refer:

Treatment at community outpatient centre for following reasons:
•Moderate to Severe Eczema.
•Failure to respond to topical therapy where there is a low index of suspicion of a food allergy.
•For additional advice and support.

Onward referral to Consultant Dermatologist:
•Relapse of disease which has failed to respond to topical therapy
•Input from Dermatology nurses input needed i.e. for education/support, wet wraps.
•Child is failing to thrive or grow.
•For assessment of suspected food or contact allergens.
•Consideration for systemic therapy.
•Eczema Herpeticum.

Follow up

Key

Patient presents

GP level intervention

Alternative Outpatient Service

Acute hospital

Red flag

Ongoing treatment in primary care by GP

Mild Disease
•Bath emollients +/- antiseptic for infected eczema
•Soap substitutes and emollients used regularly
•Mild /moderate potency topical steroids to affected areas on trunk/limbs
•Mild topical steroid to the face

Moderate disease
•Bath emollients +/- antiseptic
•Soap substitutes and emollients used regularly
•Moderate potency topical steroids to affected areas on trunk/limbs.
•Consider a short course of potent topical steroids for flares
•Mild topical steroid to the face
•1% Ichthammol in zinc ointment/paste bandages for flexures.
•When bacterial skin infection is suspected use topical antibiotics if localised or oral antibiotics if widespread. Consider skin swab and nasal swab for nasal carriage of Staph Aureus
•Consider antihistamines.
•Consider switching topical steroids within the same group i.e. mild steroids as tachyphylaxis (failure to respond to one steroid) can limit effectiveness of treatment.

Therapeutic Tips

•Advise patient to continue normal diet unless clear history of reacting to specific foods.
•Prescribe adequate quantities of emollients, soap substitutes (+/- antiseptics) and bath additives.
•Reassure patient that weak or moderate topical corticosteroids are safe and effective when applied to active areas of eczema only
•Give advice on lifestyle factors (avoid biological washing powders and fabric conditioners, cigarette smoke or hairy pets).
•Advise patient to use cotton clothing.
•In adults and adolescents give advice on suitable career options.
•History of adverse reaction to topical treatment may be an indication for patch testing.
•Consider secondary bacterial infection if eczema weeping or crusted.