Eczema – Adult – Primary Care Treatment Pathway

What is Eczema?
Eczema (also known as atopic eczema or atopic dermatitis) is a common, chronic, relapsing, inflammatory skin disorder. The skin function is impaired leading to porous and dry skin that easily becomes inflamed, susceptible to infection and itchy. Chronically scratched skin may become thickened (lichenified).

Assessment
An holistic approach is essential
- History of itchy rash often with onset in childhood
- Relevant family/social history – eczema, asthma, hayfever, smokers, pets
- Distribution and clinical signs
- Impact on quality of life and sleep
- What treatments are being and have been used; how long for; what helped and what did not

Management Principles – ABC Rule

A Avoid triggers; soaps or anything that lathers, cigarette smoke, irritant clothing
B Bland moisturisers; an absolute essential part of treatment. Should be fragrance free. Applied ideally 3-4 times a day; prescribe adequate quantities (at least 500g/week); patient choice improves concordance; bath additives are not recommended; use emollients to wash (apply before wetting the skin). Ideally wash hair over the sink to avoid shampoo on skin causing irritation
C Control inflammation
- Topical steroids matched to severity and anatomical site – mild (face & flexures), moderate, potent
- Topical steroids use once daily for 1-6 weeks until settled, decreasing to twice weekly use for maintenance if frequent flares
- Step-up use to daily during a flare, then wean back down for maintenance therapy (reduces frequency of flares)
- Calcineurin inhibitors (eg topical tacrolimus or pimecrolimus) are useful as second line and particularly useful in delicate sites (eyelids, face, flexures)

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Other Considerations
- No evidence of benefit with non-sedating anti-histamines
- Sedating anti-histamines short-term may aid sleep and break the itch-scratch cycle
- Directing to patient support groups eg National Eczema Society
- Complications – suspect infections in rapidly deteriorating eczema (bacterial or viral), take swabs, consider oral antibiotics or antivirals. Avoid long-term use of combination topical agents (eg clotrimazole or fusidic acid with a topical steroid)
- No good evidence for alternative therapies

When to Refer
- Diagnostic uncertainty
- Failure to respond to treatment
- Cutaneous atrophy from chronic topical steroid use
- Suspicion of allergic contact dermatitis (especially if new onset of eczema of face and hands) for patch testing
- Refer urgently: severely infected eczema eg bacterial or HSV in a systemically unwell adult or erythroderma (>90% body surface)

For further information:
Primary Care Dermatology Society: www.pcds.org.uk
National Eczema Society: www.eczema.org
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Please note this guidance is the views of the contributors and does not consider costs of treatments

Stasis (Varicose) Eczema

Clinical Features
- Bilateral erythematous, scaly, pruritic, rash of lower legs, often oedematous
- Commonly misdiagnosed as bilateral cellulitis which is extremely rare. Cellulitis is unilateral, associated with ascending erythema, patient may have systemic signs of infection
- May co-exist with contact dermatitis from dressings

Specific Treatment
- Full emollient regime
- Consider potent steroid 2-4 weeks then step down to twice weekly maintenance or use tacrolimus 0.1%
- Consider paste or compression bandages

Discoid Eczema

Clinical Features
- Multiple round shaped plaques that are sometimes weepy with exudative crusts
- Often misdiagnosed as impetigo, or more commonly, a fungal infection. Scrape any scale and send mycology if in doubt
- Usually extremely itchy

Specific Treatment
- Full emollient regime
- Potent topical steroids 4-6 weeks
- May need super-potent topical steroids up to 2 weeks
- Consider maintenance therapy twice weekly

Pompholyx

Clinical Features
- Extremely itchy clear vesicles on hands and feet

Specific Treatment
- Full emollient regime
- Super-potent topical steroids for 2 weeks. May need to use under occlusion with clingfilm overnight
- Then twice weekly maintenance regime
- Treat any co-existing athlete’s foot after confirming with skin scrapings

Contact Dermatitis

Clinical Features
- Worsening eczema at defined sites secondary to a contact allergen

Specific Treatment
- Full emollient regime
- Take detailed history eg occupational & recreational
- Consider potent steroid 2-4 weeks then step down to twice weekly maintenance or use tacrolimus 0.1%
- Refer for patch testing if contact allergen cannot be identified accurately from history

Asteatotic Eczema (also known as eczema craquelé)

Clinical Features
- Often seen in the elderly
- Dry skin with superficial cracked (dried-up riverbed) appearance
- Areas of excoriation, erythema and bleeding may be evident due to rubbing or scratching

Specific Treatment
- Full emollient regime
- Steroids rarely needed
- Ideally avoid an overly warm environment