Pimecrolimus cream is licensed for mild to moderate atopic eczema. Tacrolimus ointment is licensed for moderate to severe atopic eczema. The long-term safety of both drugs is still being evaluated and they should not usually be considered first-line treatments unless there is a specific reason to avoid or reduce the use of topical corticosteroids. Treatment with pimecrolimus or tacrolimus should be initiated only by prescribers experienced in treating atopic eczema.

BNF (March 2012)

Topical calcineurin inhibitors (TCIs) have been available now for the treatment of atopic eczema in the UK for over a decade. This advisory group of dermatology experts met to review existing treatment guidelines, guidance and current best practice as well as the impact of their clinical experience over this period. Our intention being to ensure that all patients receive best treatment.

The latest guidance from the BNF (March 2012) advises Health Care Professionals (including GPs) that treatment of eczema with a TCI can be initiated in primary care. Since 97% of children with eczema are treated exclusively in primary care, this group proposes that existing guidelines for the treatment of atopic eczema should be re-visited to incorporate that recommendation.

With GP commissioning, it is essential that primary care makes appropriate and cost-effective use of secondary care resources. The mandatory dermatology tariff price for a single outpatient attendance is £112 for an adult and £149 for a paediatric appointment. A single follow-up appointment is £69 and £107 respectively.

We recommend that when a TCI is an appropriate therapeutic option, GPs should acknowledge the guidance in the BNF and consider initiating this treatment without necessarily always referring to secondary care.

References
Simplifying Topical Calcineurin Inhibitors for Primary Care – Reducing the Referral Burden to Secondary Care

Chairman: Dr Stephen Kownacki
Contributors: Professor Malcolm Rustin, Dr Chris Bower, Dr Sue Lewis-Jones, Dr George Moncrieff, Dr Stuart Wolfman, Dr Tom Poyner, Dr Christine Clark, Julie Van Onselen

Diagnosis
Atopic eczema on face, neck, eyelids & other thin skin areas (ie axillae & groin)

Emollients (Complete Emollient Therapy¹)

Mild
Complete Emollient Therapy
Mild potency topical corticosteroids or emollient alone

Moderate
Complete Emollient Therapy
Moderate to potent topical corticosteroids or topical calcineurin inhibitors

Severe
Complete Emollient Therapy
For severe flares use potent corticosteroids for 3-5 days and topical calcineurin inhibitors

1st line

Pimecrolimus
(Elidel Cream)

Pimecrolimus
(Elidel Cream)

Tacrolimus 0.03%
(Protopic Ointment) for ages <16

Tacrolimus 0.1%
(Protopic Ointment) for ages >16

2nd line

Pimecrolimus
(Elidel Cream)

Pimecrolimus
(Elidel Cream)

Tacrolimus 0.03%
(Protopic Ointment) for ages <16

Tacrolimus 0.1%
(Protopic Ointment) for ages >16

Not responding to treatment – refer to secondary care if:
- the diagnosis is uncertain
- optimal topical treatment has not controlled the condition
- other complications that warrant further investigation or management
(See NICE Guidelines⁴)

Notes:
1. Complete Emollient Therapy: Healthcare professionals should offer children with atopic eczema the choice of unpreserved emollients to use every day for moisturising, washing and bathing. This should be suited to the child’s needs and preferences, and may include a combination of products or one product for all purposes. Leave-on emollients should be prescribed in large quantities (250-500g/weekly) and easily available to use at nursery, pre-school and school.

* Short term license for TCIs is for use until the condition improves, with re-assessment if no improvement after 6 weeks with pimecrolimus, or 3 weeks with 0.03% tacrolimus. Tacrolimus ointment is licensed for the prevention of flares with twice weekly application for up to one year.

References
3. Kempers S et al. A randomized investigator-blinded study comparing pimecrolimus cream 1% with tacrolimus ointment 0.03% in the treatment of pediatric patients with moderate atopic dermatitis. JAAD 2004; 51: 515-525


Patient Resources
National Eczema Society, Talk Eczema and Eczema Scotland

UK/ELI/12/0041 September 2012