Greater Manchester guidelines for the management of Eczema in primary care *Adapted from guidelines by Primary Care Dermatology Society and British Association of Dermatologists (2009)*

Eczema: a group of inflammatory conditions affecting the outer layer of the skin, the epidermis.

Patient presents to GP for the first time. History and examination to include:

- Family and personal history of atopy and eczema
- Distribution of disease
- Onset of disease
- Aggravating factors e.g. pets, exposure to irritants
- Impact on quality of life e.g. sleeplessness, impacting career/education, social life
- Check for bacterial infection
- Check for herpes simplex infection

Differential diagnoses:

- Rule out scabies.
- If not itchy, unlikely to be eczema – consider alternative diagnosis

Red flag – urgent referral to local provider and initiate antiviral treatment:

- Severe infection with suspected herpes simplex (eczema herpeticum)

Suspected atopic eczema

Suspected contact eczema

Specific pattern involving e.g.:

- Periorbital
- Contact with metal fasteners
- Hair dye allergy

Refer to local provider if no better in 6-8 weeks. Consider the following if appropriate:

- Advise to avoid allergens
- Treat rash as suspected atopic eczema first line

EMOLLIENT TREATMENT and avoid foaming products/soap. Advice on topical therapy application.

Advise patient to avoid exacerbating factors and how to keep skin hydrated:

- Anything known to increase disease severity, where practicable e.g. irritants: soaps, shampoos, pets, house dust mite, alcohol intake, stress.
- Reduce water loss and need for topical steroids by the regular and liberal application of appropriate emollient – explain quantity and frequency of application to achieve maximum effect e.g. every 4 hours or at least twice a day, preferably when skin is moist until erythema/pruritus improves.
- Keep nails short, consider garments.
- Prescribe emollients in the recommended quantities for generalised eczema – in 500/1000g quantities for 1-2 weeks for instance.

Clinicians are reminded that prescriptions for the management of

- Mild irritant dermatitis
- Mild dry skin

should not routinely be offered in primary care as the conditions are appropriate for self-care

STEROID TREATMENT

Mild: face & eyelids – treat with 1% hydrocortisone. Trunk and limbs -1% HC or clobetasone butyrate 0.05% ointments.	**Moderate:** Clobetasone butyrate 0.05% (face) or betamethasone 0.025% ointments to trunk and limbs.	**Severe:** clobetasone butyrate 0.05% to face and betamethasone valerate 0.1% cream potent steroid to trunk and limbs

Wean off topical steroids to avoid withdrawal flare. For flares continue treatment up to 48 hours after clearance usually not for more than 2 weeks. For those with frequent flares (2-3 months) consider treating for 2 consecutive days per week or twice weekly for maintenance.

Patient presents with exacerbation.

- Swab/look for infection
- Consider oral antibiotics or topical steroid/antibiotic combined therapy + dermol 500 lotion to wash with
- Query herpes simplex – **red flag**

Refer to local provider if:

- Diagnosis is/has become uncertain
- Patient not responding to multiple therapeutic interventions when applied sufficiently
- Eczema becomes infected with bacteria (manifest as weeping, crusting or the development of pustules) and treatment with an oral antibiotic and topical corticosteroid has failed
- Patient experiencing psychological problems/condition impacting quality of life e.g. sleeplessness, impacting career/education, social life
- **Specialist nurse clinic** - may benefit from additional advice on application of treatments e.g. bandaging techniques
- Dietary factors are suspected and dietary control is a possibility (rare)

Links to Supporting Information

- CKS atopic eczema topic (https://cks.nice.org.uk/eczema-atopic#!management);
- PCDS management of atopic eczema clinical guideline (http://www.pcds.org.uk/clinical-guidance/atopic-eczema)

Guideline date: April 2019
Review date January 2022