

Assessment of a child with atopic eczema:

1. Confirm diagnosis ([What are the clinical features of atopic eczema?](#))
 2. Assess severity including impact on activities of daily living (ADLs) - see severity assessment p2.
 3. Is there psychosocial impact?
 4. Is the child growing normally?
 5. Consider triggers:
 - **Irritants:** **Avoid soap and shower gels, and reduce frequency of shampoo.** In under 12 months no need for shampoo
 - **Contact allergy:** Is there a sudden flare of previously controlled eczema? Reaction to skin treatment or other products?
 - **Food allergens:** **Eczema increases the risk of food allergy and the association is stronger in severe eczema. Most cases present with classical features of food allergy with immediate symptoms involving at least two organ systems (<1 hour after exposure) e.g. urticaria/angiodema, GI or respiratory symptoms. Food allergy causing eczema is rare and cannot be diagnosed by tests (blood or skin tests).**
 - if immediate symptoms (<1 hour) of non-milk food allergy refer to local allergy service
 - if symptoms of cows milk allergy, follow management guidelines
 - if non-immediate symptoms for food allergy
 - eczema and symptoms in another organ (e.g. poor growth or gastrointestinal symptoms) refer to local allergy service
 - if eczema is only symptom, as it is unusual for food allergy to cause eczema, refer to dermatology for assessment.
- Prolonged elimination diets may be harmful (NICE Guidance), extensive elimination or any elimination in those <2 years should only be recommended under specialist advice. For those currently tolerating food without immediate symptoms, avoidance may increase the likelihood of developing immediate reactions (due to loss of tolerance) so trials of elimination should be kept short (2-4 weeks) and should ideally be assessed in conjunction with a paediatric allergist or GP with an interest in paediatric allergy.
- Inhalant:** seasonal flares? Asthma and hay fever? Facial eczema, especially around eyes, in > 3 years. **Consider trial of antihistamines**
- **Infection: Bacterial** - Weeping, crusting, not responding to treatment or worsening, unwell. Note: most children with infected eczema do not benefit from antibiotic therapy (oral or topical) - except those with a severe infection. Optimisation of topical steroids is the mainstay of treatment in these patients
 - **Viral** (Eczema herpeticum): rapid worsening, fever/lethargy, clustered blisters, punched out erosions

Treatment of atopic eczema in children

1. See treatment ladder for management of active eczema and subsequent preventer treatment: page 2
2. Provide family with clear information about how to apply topical treatment ([How to apply treatment videos](#))
3. Decide if referral to secondary care is required (See page 2)
4. [Patient information leaflet](#) from British Association of Dermatologists can be helpful on atopic eczema

Bandages/Therapeutic garments

Bandages are useful for thickened or heavily excoriated areas (not if infected)

- Apply over topical steroids for one week rotating with use over emollients for a further week and repeat as required ([How to apply treatment videos](#))

Consider elasticated garments/therapeutic clothing (various eczema specific brands available) for all severe eczema patients

Atopic eczema in children clinical pathway



Primary care treatment ladder for managing atopic eczema in children

All patients (even when atopic eczema clear) to use regular [Emollients](#) (ointments are preferred) to moisturise and wash (250-500g/week)
 NOTE: [Fire risk with all paraffin and non-paraffin containing emollients](#). Antihistamines not routinely used in eczema ([exceptions to the rule](#)). Oral Prednisolone not recommended. Use the weakest effective corticosteroid treatment [How to apply treatment videos](#)

