NHS
South West London

Management of Adult Atopic Eczema

This guideline provides clinicians in primary care with guidance on how to manage atopic eczema in adults.

History and Examination

Focused history

- Age of onset
- Triggers & family or personal history of atopy
- Severity assessment (mild/moderate/severe)
- Quality of life assessment

Examine

- Distribution, severity, morphology - dry skin, redness, excoriation, lichenification, co-existing infection.
- Images of patients with atopic eczema can be found on The Primary Care Dermatology Society website.

Exclude

- Symptoms or signs suggestive of eczema herpeticum (acutely tender punched-out lesions): contact dermatology on-call/ emergency department for advice.
- Symptoms or signs suggestive of secondary bacterial infection consider:
  - sending bacterial swab
  - treatment with topical corticosteroids
  - commencing oral antibiotics in addition to topical steroids if systemically unwell or worsening symptoms
- Exclude scabies (especially in immunocompromised or at-risk patients).

General treatment

Emollients are effective and are the mainstay of treatment for all patients with eczema. Refer to the SWL Joint Medicines Formulary for preferred emollients.

Topical Emollients

- Regular, liberal use of emollient (recommended quantities used in generalised eczema is 600g per week for an adult), emollients can also be used as soap substitute.
- Prescribe emollients according to the dryness of the skin and individual preference/ tolerance. Avoid emollients containing with sodium lauryl sulphate (SLS) such as aqueous cream
- Emollients containing antimicrobials (e.g., Dermol® 500) should only be used for infected eczema and stopped once infection resolves.
- Emollients may make the skin and surfaces slippery. Patients should be warned to take extra care when bathing / showering.
- Apply in one direction along the direction of hair growth.
- Emollient pump dispensers, if available, may minimise the risk of bacterial contamination.

- Provide the patient with eczema information leaflet produced by the British Association of Dermatologists.

Topical corticosteroids

- Avoid direct contact with eye (risk of cataracts and glaucoma).
- Avoid moderately potent steroid to inner thigh (risk of striae), neck and groin/axillary region.
- Refer to the manufacturer's product information for individual products for further information, including use in pregnancy and breast feeding.
- Advise patients to use enough to make the skin look shiny or to use fingertip units (see below).
- Consider escalating topical corticosteroid potency prior to referral to secondary care if poor or no response to initial treatment. Restart once daily topical corticosteroids for 2 weeks if patients experience a flare during maintenance treatment for 2 consecutive days per week.
- MHRA advises that rare, severe adverse effects can occur on stopping treatment with topical corticosteroids, often after long-term continuous or inappropriate use of moderate to high potency products. To reduce the risks of these events, prescribe the topical corticosteroid of lowest potency needed and ensure patients know how to use it safely and effectively. See MHRA guidance for further information, Topical corticosteroids: information on the risk of topical steroid withdrawal reactions.

Topical Calcineurin Inhibitor (Pimecrolimus / Tacrolimus)

- Treatment to be initiated on the recommendation of a specialist, which can be done using Advice and Guidance via electronic Referral Service (eRS).
- Advise cautious use at initiation due to known irritation ('stinging-like'); should lessen with recurrent use. Irritation ('stinging-like') may occur at initiation, therefore cautiously. Increase the application area as tolerated.
- Avoid use prior to exposure to sunlight. Do not use tacrolimus ointment under occlusive dressings.
- Use in pregnancy: tacrolimus (Protopic®) 0.1% ointment should not be used in pregnancy unless necessary. See manufacturers advice Protopic® 0.1% ointment manufacturers information.
- Tacrolimus ointment / pimecrolimus cream both have an AMBER 1 RAG rating on the SWL Joint Medicines Formulary (AMBER 1: Recommendation by a specialist, but is considered non urgent and therefore could be started in primary care at the discretion of the GP after the GP's consideration).

Treatment of flares

Mild-to-Moderate

- For **Acute Flares consider** topical corticosteroid ointment mild potency for the face and moderate potency for the body (e.g., hydrocortisone 1%, clobetasone butyrate 0.05%, betamethasone valerate 0.025%) daily for up to 14 days, then twice weekly for up to 14 days.
- If topical steroids are contraindicated, consider topical steroid-sparing agents for head and neck (e.g., tacrolimus 0.1% use Advice and Guidance via eRS, initiate on the recommendation of a specialist) twice daily for up to 14 days, then twice weekly for up to 2 weeks

- If **frequent recurrent flares consider** use of topical corticosteroids once daily on two consecutive days each week, e.g., weekends, over affected areas for up to 4 months after completing the daily regime.

Moderate

- For **Acute Flares consider** topical corticosteroid ointment (e.g., mometasone furoate 0.1%) daily for up to 14 days, then twice weekly for up to 14 days
- If topical steroids are contraindicated, consider topical corticosteroid–sparing agents for head and neck (e.g., tacrolimus 0.1%; use Advice and Guidance via eRS, initiate on the recommendation of a specialist) twice daily for up to 14 days, then twice weekly for up to 2 weeks
- If **frequent recurrent flares consider** use of mometasone furoate 0.1% daily or tacrolimus 0.1% daily on two consecutive days each week, e.g., weekends, over affected areas for up to 4 months after daily regime.

Moderate to Severe

- For **Acute Flares consider** topical corticosteroid ointment (e.g., mometasone or clobetasol propionate) daily for up to 14 days, then twice weekly for up to 14 days
- If topical steroids are contraindicated, consider topical steroid–sparing agents for head and neck (e.g., tacrolimus 0.1%; use Advice and Guidance via eRS, initiate on the recommendation of a specialist) twice daily for up to 14 days, then twice weekly for up to 2 weeks
- If **frequent recurrent flares consider** use of mometasone daily or tacrolimus 0.1% daily on two consecutive days each week, e.g., weekends, over affected areas for up to 4 months after daily regime.
- Refer to secondary care via eRS if there is no response after 12 weeks of treatment as recommended above.
- Unresponsive atopic dermatitis, refer to the SWL Atopic Dermatitis Drug Pathway.

How much topical corticosteroid to apply and prescribe?

- Application Using fingertip guide
  Fingertip Unit (FTU) is the amount of cream or ointment that just covers the end of one adult finger from the tip to the crease of the first joint when squeezed from an ordinary tube nozzle. One FTU is enough to cover an area of skin the size of two adult hands with the fingers together (roughly 0.4 to 0.5g) (Topical Steroids | Eczema Treatment | Eczema.org).The National Eczema society have produced a factsheet on topical steroids, where a pictorial reference can be seen on page 6.

Number of fingertip unit (FTU) for different parts of an adult's body

- Face and neck
  - 2.5 FTU
- Trunk (front or back)
  - 7 FTU
- One arm
  - 3 FTU
- One hand (one side)
  - 0.5 FTU
- One leg
  - 6 FTU

- One foot
    - 2 FTU

Approximate amount needed for an adult (daily for 7 days (g))

- Face and neck
    - 8.75g
- Trunk (front or back)
    - 24.5g
- One arm
    - 10.5g
- One hand (one side)
    - 3.5g
- One leg
    - 21g
- One foot
    - 7g

No clinical evidence

The following lack clinical evidence: Silk Garments, Water softeners, Topical antibiotics alone (e.g., fucidic acid), non-sedating antihistamines, probiotics, House Dust Mite reduction/avoidance as a measure, not washing on daily basis, oral evening primrose oil and borage oil.

Warning: Risk of severe and fatal burns with paraffin-containing and paraffin-free emollients

The MHRA has warned of the risk of severe and fatal burns with all emollients, whether they contain paraffin or not. Advise patients who use these products not to smoke or go near naked flames (or be near people who are smoking or using naked flames), and warn about the easy ignition of clothing, bedding, dressings, and other fabric that have dried residue of an emollient product on them. Patients' clothing and bedding should be changed regularly, preferably daily because emollients soak into fabric and can become a fire hazard. (See MHRA updates December 2018 and August 2020).

To the best of our knowledge, the information provided in this guideline is accurate and reliable as available at the time of issue. Always consult the Summary of Product Characteristics for full prescribing information.

References

- Frequency of application of topical corticosteroids for atopic eczema (TA81)
- Tacrolimus and pimecrolimus for atopic eczema (TA82)
- Topical corticosteroids: information on the risk of topical steroid withdrawal reactions
- British Association of Dermatologists (bad.org.uk)
- BNF (British National Formulary) | NICE
- Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients
- Emollients and risk of severe and fatal burns: new resources available

Document History
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