East Lancashire Health Economy Medicines Management Board
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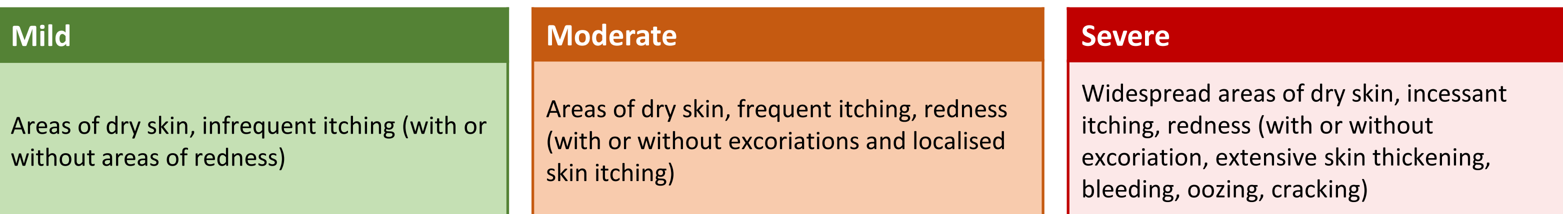
Eczema Guideline for Primary Care

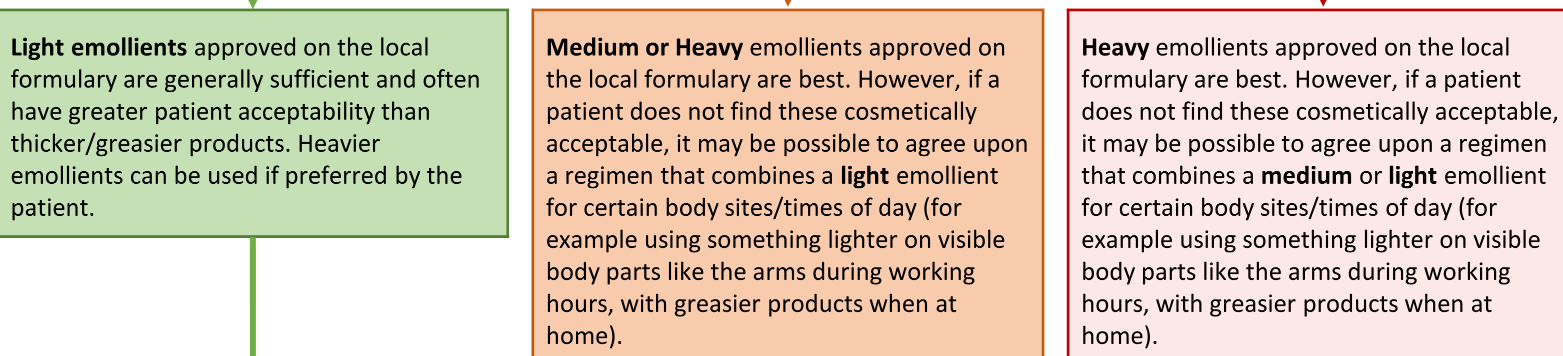
NHS
East Lancashire Hospitals
NHS Trust

Eczema Severity Definitions and Recommended Treatments



Emollients

These smooth, soothe, hydrate and protect the skin. They should be used in all patients with eczema. Patient choice is key.

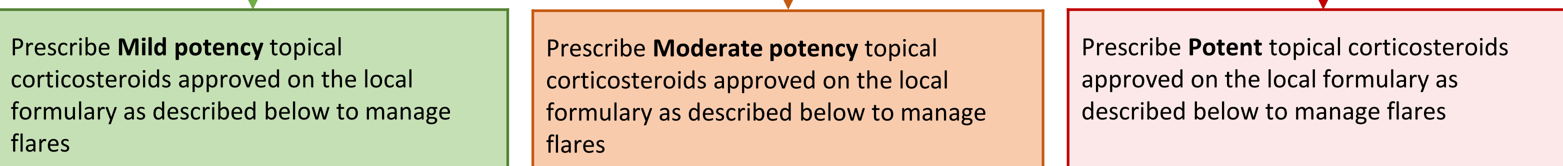


Routine

Wash using the emollient as a soap substitute. Apply emollient in a downward direction. Patients with mild eczema should apply as required throughout the day. Patients with moderate to severe eczema should apply 3-4 times daily. All emollients on formulary (except Zerodouble Gel and WSP:LP) can be used as soap substitute. Aqueous cream is not recommended as an emollient because it can cause stinging in a high proportion of patients. Paste bandages may be considered in patches of lichenified eczema on limbs. Generally an adult using regular emollients will require 500 g and a child 250 g per week. More detail about quantities in table below.

Topical Steroids

Important for controlling flares of eczema. Safe for repeated use with appropriate counselling on treatment breaks



- Apply to affected areas once or twice daily (before or after emollient, waiting at least a few minutes between the two) until redness and itching has completely settled, and then continue for a further two days then reduce frequency of application not potency. Restart as soon as redness and itching appears.
- Consider secondary infection if not improving with a potent steroid after 14 days.
- Use mild topical steroids for face and neck but moderate for 3-5 days during flares.
- Use moderate or potent steroids for 7-14 days max in flexures.
- It may take 6 weeks of a potent topical steroid to gain control in some cases. Consider a combined antibiotic and topical steroid preparations for localised infections but do not use for more than 2 weeks (e.g. hydrocortisone acetate 1% with fusidic acid 2% cream **or** Betamethasone 0.1% with fusidic acid 2% cream).
- Do not use very potent steroid (e.g. clobetasol cream/ ointment) without specialist advice.
- Complete a treatment plan and give to the patient/ carer.
- Consider using fingertip units to ensure patients use the correct quantity of steroid. 1 finger tip unit is enough to cover an area of affected skin that is the size of two adult palms.

Adult Quantities of Topical Steroids per week

	Once daily application	Twice daily application
Face and neck	7.5 - 15 g	15 - 30 g
Both hands	7.5 - 15 g	15 - 30 g
Scalp	7.5 - 15 g	15 - 30 g
Both arms	15 - 30 g	30 - 60 g
Both legs	50 g	100 g
Trunk	50 g	100 g
Groin + genitals	7.5 - 15 g	15 - 30 g

Adult Quantities of Emollients per week/month

	Creams or ointments		Lotions	
	Per week	Per month	Per week	Per month
Face	15 - 30 g	60 - 120 g	100 mL	400 mL
Both hands	25 - 50 g	100 - 200 g	200 mL	800 mL
Scalp	50 -100 g	200 - 400 g	200 mL	800 mL
Both arms + legs	100 - 200 g	400 - 800 g	200 mL	800 mL
Trunk	400 g	1600 g	500 mL	2000 mL
Groin + genitals	15 - 25 g	60 - 100 g	100 mL	400 mL

Child Quantities of Topical Steroids per week

The BNF for Children should be consulted for suitable quantities. The amount required depends on the age and size of the child. The FTU should be measured using an adult finger and the area affected established be using the palms of adult hands.

Child Quantities of Emollients per week

Generally, approximately half of the quantities in the table above would be sufficient for children. Quantities required will vary with the size of the patient, the severity and extent of skin dryness

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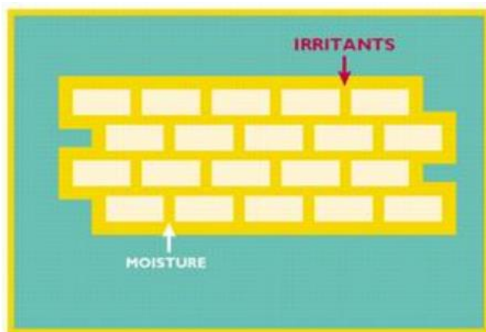
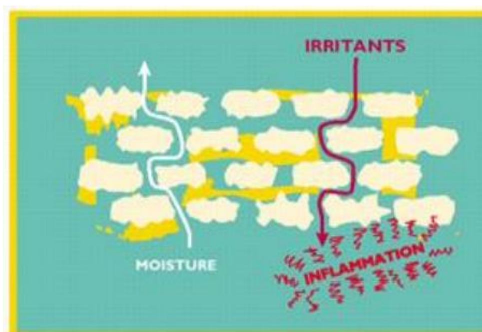
Quality of Life Impact (this should be assessed and documented during consultation, but doesn't necessarily correlate with severity of disease)	
Mild	Little impact on everyday activities, sleep and psychosocial wellbeing
Moderate	Moderate impact on everyday activities and psychosocial wellbeing, frequently disturbed sleep
Severe	Severe limitation of everyday activities and psychosocial functioning, nightly loss of sleep

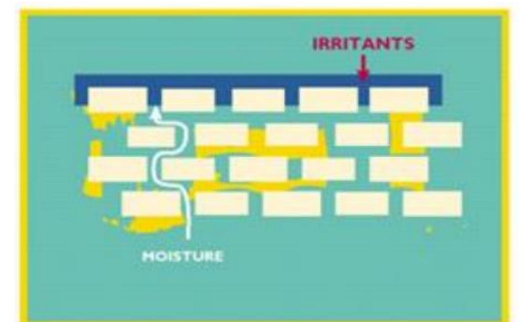
Brick wall analogy: This should be discussed with all patients



Normal Skin



Eczema- An Impaired Skin Barrier



Restoring the skin barrier using an emollient

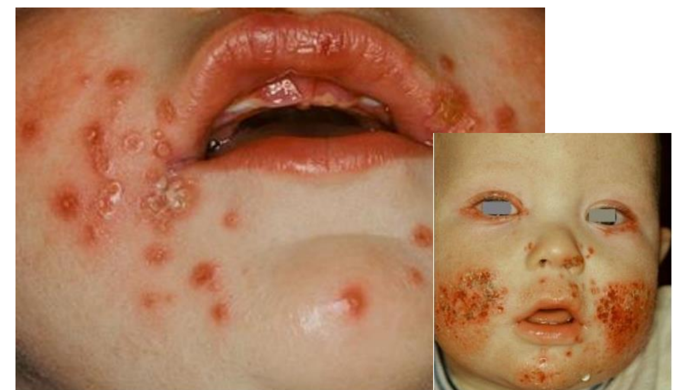
Children with atopic eczema and eczema herpeticum

Children with atopic eczema and their parents or carers should be offered information on how to recognise eczema herpeticum.

Signs of eczema herpeticum are:

- Areas of rapidly worsening, painful eczema.
- Clustered blisters consistent with early-stage cold sores.
- Punched-out erosions (circular, depressed, ulcerated lesions) usually 1–3 mm that are uniform in appearance (these may coalesce to form larger areas of erosion with crusting).
- Possible fever, lethargy or distress.

Eczema Herpeticum:



When to refer for specialist advice for children with atopic eczema

- The diagnosis is, or has become uncertain.
- Management with the correct potency of topical steroid (as overleaf) has not controlled the atopic eczema satisfactorily based on a subjective assessment by the child, parent or carer (for example, the child is having 1–2 weeks of flares per month or is reacting adversely to topical medicaments).
- Atopic eczema on the face has not responded to appropriate treatment.
- The child or parent/carer may benefit from specialist advice on treatment application (for example, bandaging techniques).
- Contact allergic dermatitis is suspected (for example, persistent atopic eczema or facial, eyelid or hand atopic eczema).
- The atopic eczema is giving rise to significant social or psychological problems for the child or parent/carer (for example, sleep disturbance, poor school attendance).
- Atopic eczema is associated with severe and recurrent infections, especially deep abscesses or pneumonia

Guidelines based upon ELMMB formulary and NICE CG57: Atopic eczema in under 12s: diagnosis and management
(v3 08/2023. Review Date: 08/2027)