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GUIDELINES

Management of atopic eczema in children aged up to 12 years: summary of NICE guidance

Sue Lewis-Jones,1 Moira A Mugglestone,2 on behalf of the Guideline Development Group

Why read this summary?

Atopic eczema affects one in five children in the United Kingdom1 and accounts for 1 in 30 consultations in community care.2 Recent data suggest that impaired skin barrier function is a major causative factor.34 There may be considerable physical and emotional morbidity for the child and the parents or carers, particularly if the disease is poorly controlled.5 Yet most healthcare professionals receive little or no relevant training in dermatology,6 and lack of knowledge, confusion, and anxiety about many of the available treatments are widespread among parents.57 This article summarises the most recent guidance from the National Institute for Health and Clinical Excellence (NICE) on how to manage atopic eczema in children from birth up to the age of 12 years.8

Recommendations

NICE recommendations are based on systematic reviews of the best available evidence. When minimal evidence is available, a range of consensus techniques is used to develop recommendations. In this summary, recommendations derived primarily from consensus techniques are indicated with an asterisk (*).

Diagnosis and assessment

- Diagnose atopic eczema in children according to the criteria in box 1.
- Adopt a holistic approach to assessing a child’s atopic eczema*, taking account of the physical severity of the eczema (box 2) and its impact on quality of life (which may range from no impact to severe limitation of everyday activities and psychosocial functioning, with loss of sleep each night (box 3). This assessment should guide treatment decisions; no direct relation necessarily exists between physical severity of atopic eczema and impact on quality of life.

Management

- Identify and manage trigger factors, including irritants (soaps and detergents) and, in some children, skin infections, contact allergens, food allergens, and/or inhalant allergens; refer for specialist advice when necessary
- Emollients are the basis of management and should be used even when the skin is clear.
- Adopt a stepped approach to management (box 4), using emollients with or without treatments such as topical corticosteroids, topical calcineurin inhibitors, and bandaging techniques; step treatment up or down according to clinical response, recognising that atopic eczema typically comprises exacerbations (flares) and remissions.
- Use topical antibiotics, including those combined with topical corticosteroids, for localised infection only and for no longer than two weeks
- Offer non-sedating antihistamines if eczema is severe or if severe itching or urticaria occurs; offer sedating antihistamines to children aged over 6 months during acute flares if sleep disturbance is severe for the child or their parents or carers.
- Recognise the indications for referral for specialist dermatological advice (box 5).*

Education and information

- Educate children and their parents or carers about atopic eczema, including practical
demonstrations of the quantities and frequency of treatments to be used.

- Inform them about symptoms and signs of bacterial infection of atopic eczema: weeping, pustules, crusts, eczema failing to respond to treatment, rapidly worsening eczema, fever, and malaise.

- Inform them about how to recognise eczema herpeticum (widespread herpes simplex virus): areas of rapidly worsening, painful eczema; clustered blisters consistent with early stage cold sores; punched-out erosions that are uniform in appearance and may coalesce; possible fever; lethargy; or distress.

- Ask about their use of complementary therapies; explain that the effectiveness and safety of such therapies (homoeopathy, herbal medicine, massage, and food supplements) have not been adequately assessed in clinical studies; and inform them that they should continue to use emollients if they choose to use complementary therapies.

**Overcoming barriers**

If used correctly, the structured approach recommended in this guidance should allow improved quality of care and more cost effective clinical management of atopic eczema. The approach requires an initial investment in time to assess the child’s atopic eczema adequately and discuss parental anxieties about treatments, emphasising that the benefits of topical corticosteroids outweigh possible harms. Written care plans should cover treatment of flares and episodes of infected eczema to educate parents on when topical corticosteroids (and other treatments) are appropriate. This investment should, however, lead to longer term benefits, empowering children with atopic eczema and their parents or carers to take control of management, and potentially reducing the need for frequent monitoring and thus the workload of healthcare professionals.

To support implementation, NICE and the guideline development group have developed a version of the guidance (available from December 2007 at www.nice.org.uk/CG057/PublicInfoEnglish) that can be given to children with atopic eczema and their parents or carers.

**Box 4 Stepped approach to management of atopic eczema**

- Tailor treatment up to severity
- Step treatment up or down according to clinical response. Always use emollients, even when the skin is clear, and add other treatments when required, with specialist advice where recommended

**Mild atopic eczema**—Use mild potency topical corticosteroids

**Moderate atopic eczema**—Use moderate potency topical corticosteroids, topical calcineurin inhibitors, bandages

**Severe atopic eczema**—Use potent topical corticosteroids (short periods only except under specialist supervision), topical calcineurin inhibitors, bandages, phototherapy, systemic therapy

**Box 5 Indications for referral for specialist dermatological advice**

*Immediate (same-day) referral*

- If eczema herpeticum is suspected

*Urgent referral (seen within two weeks)*

- If the atopic eczema is severe and has not responded to optimal topical therapy after 1 week
- If treatment of bacterially infected atopic eczema has failed

*Routine (non-urgent) referral*

If any of the following apply:

- The diagnosis is or has become uncertain
- Atopic eczema on the face has not responded to appropriate treatment
- The atopic eczema is associated with severe and recurrent infections
- Contact allergic dermatitis is suspected
- The atopic eczema is giving rise to serious social or psychological problems for the child, parent, or carer
- The child, parent, or carer might benefit from specialist advice on treatment application
- Management has not controlled the atopic eczema satisfactorily according to a subjective assessment by the child, parent, or carer

Contributors: SL-J and MAM wrote the initial draft of the article using material produced collectively by the entire guideline development group and contributed to its revision and the final draft, having received feedback from every member of the group. MAM established the group and was project director. SL-J chaired the group. See the box on bmj.com for a list of all members of the development group and their affiliations.

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1. Burr ML, Wat D, Evans C, Dunstan FDJ, Doull IJM, on behalf of the development group have developed a version of the guidance (available from December 2007 at www.nice.org.uk/CG057/PublicInfoEnglish) that can be given to children with atopic eczema and their parents or carers.


