TITLE

Atopic Eczema in Children General Practice Update

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OVERVIEW

Atopic eczema is a common, chronic, relapsing, itchy skin disorder which can affect up to 20% of children and up to 8% of adults. It requires regular application of emollients to restore the skin barrier and targeted treatment with topical corticosteroids (TCS) or topical calcineurin inhibitors (TCI) to control itch and inflammation during disease flares. Infective exacerbations require management with antibiotics or antivirals if the patient is systemically unwell. The majority of atopic eczema cases can be managed in general practice. Where eczema is unresponsive to management in primary care dermatology referral is recommended for consideration of systemic therapies.

AIMS

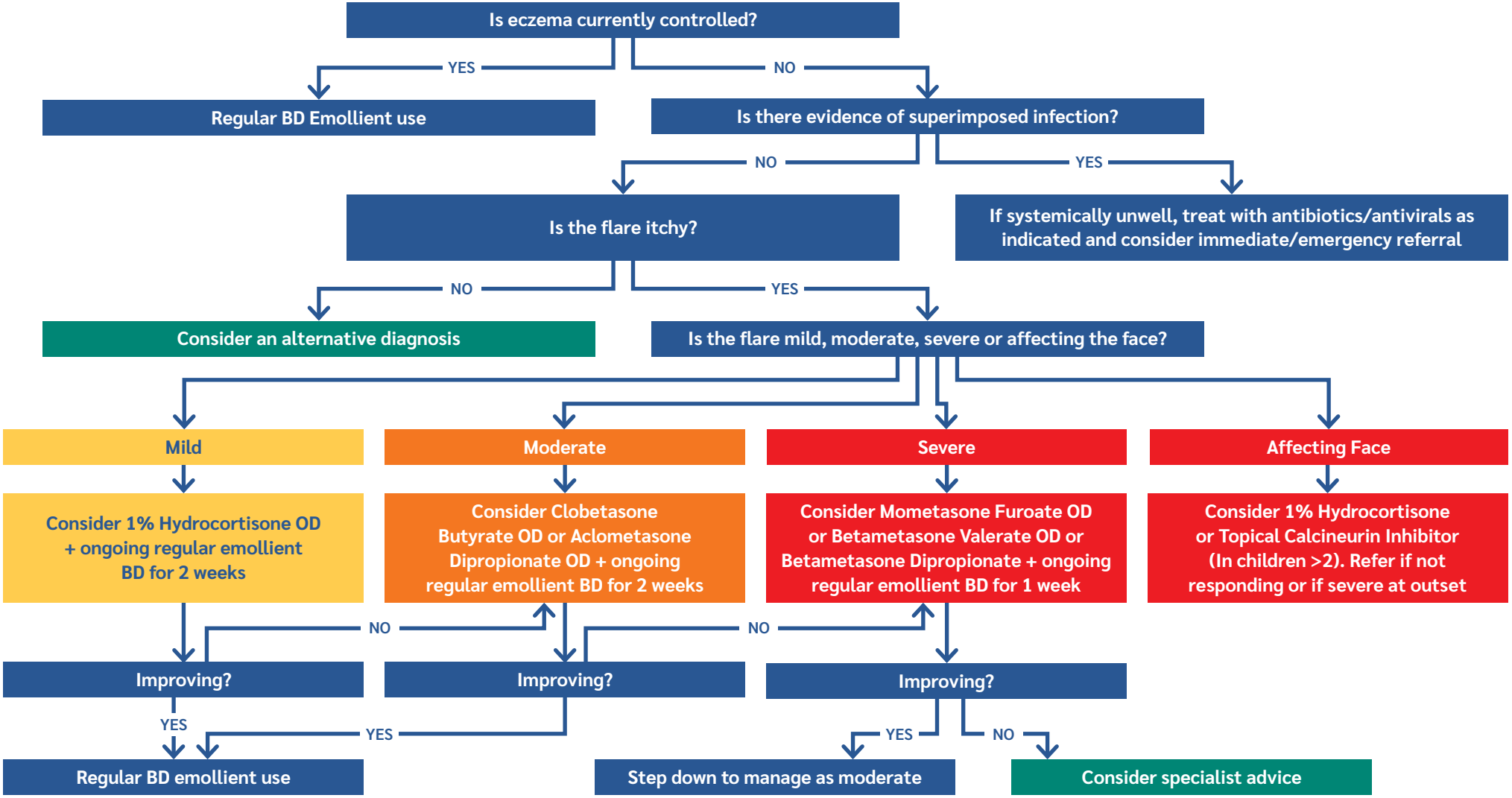
The aim of this General Practice Update (GPU) is to provide practical advice to general practitioners (GPs) on the diagnosis and management of Atopic Eczema in children up to 12 years old in the context of Irish general practice.

SUMMARY

- Atopic Eczema is a chronic disorder of disruption of the skin barrier. Regular emollients to restore this barrier are the cornerstone of treatment.
- Infective flares can be treated with antibiotics or antivirals if the patient is systemically unwell.
- Generally, at least ten times more emollients than TCS or TCI should be used per month.
- Inflammatory, itchy flares should be treated with TCS or TCI to control itch and inflammation.
- Once daily TCS is sufficient in most cases.
- Match the potency of TCS to the severity of the flare – use of TCS and TCI in children is safe once used within guidelines.
- Newer generation TCS such as Mometasone Furoate 0.1% have a better risk-benefit ratio over earlier generation TCS such as Betamethasone Valerate.
- There is no evidence that one emollient is better than another. The best emollient is the one the child or parents/carers will use regularly.

JUMP TO...

SUGGESTED MANAGEMENT OF EPISODIC ATOPIC ECZEMA IN CHILDREN FLOW CHART



Atopic Eczema in Children General Practice Update – EVIDENCE UPDATES

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DISCLAIMER AND WAIVER OF LIABILITY

This General Practice Update (GPU) has been developed on behalf of the Quality and Safety in Practice (QSiP) committee following a careful review of the evidence available at the time of publication. The purpose of this update is to set out evidence based current practice in this area and does not replace clinical judgment. This update is an education tool to assist the GP in providing care for their patient. This is a general update, and it is acknowledged that there will always be particular circumstances where it may be neither possible nor appropriate to follow this document, for example due to resource availability. GPUs are not policy documents. Every effort has been made to ensure the accuracy and updating of the content; however errors and omissions may occur, especially as the evidence changes and clinical practice evolves.

EVIDENCE SUMMARY

GPUs are produced after a review of the literature of the relevant topic area. The aim is to summarise the best available evidence in the context of Irish General Practice. Systematic review evidence is presented where possible.

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DECLARATIONS OF INTEREST

None declared at time of publication.

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LIST OF ABBREVIATIONS

GP	General Practitioner
PIL	Patient Information Leaflet
SD	Seborrhoeic Dermatitis
SLS	Sodium Lauryl Sulphate
TCI	Topical Calcineurin Inhibitor
TCS	Topical Corticosteroid

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INTRODUCTION

Eczema is a condition characterised by dry itchy skin and the breakdown of the normal skin barrier. This GPU covers atopic eczema in children up to the age of 12 years old. Atopic Eczema passes through phases of exacerbations and remission and in over 60% of cases will resolve by adulthood.[1] It is important to manage symptoms of Atopic Eczema as they can severely affect quality of life of both patients and families/carers alike.

CLINICAL FEATURES AND DIAGNOSIS

Atopic eczema is a dry and itchy skin condition,[2] driven by underlying skin barrier dysfunction.[3] If there is little to no itch then an alternative diagnosis should be considered.[4] Most clinical features of AE arise from scratching the skin, which further compromises its barrier function.[5]

The diagnosis is a clinical one without the need for specific blood tests or skin biopsy. It is based on a child having an intensely itchy rash usually starting before the age of two, often affecting characteristic sites such as cheeks in younger children and flexures as they get older. Paradoxically, the nappy area in children with Atopic Eczema is often spared. Table 1 displays diagnostic criteria (requiring one major feature and at least three minor features).[6]

Healthcare professionals should be aware that in Asian, Black Caribbean and Black African children, atopic eczema may have hyperpigmentation rather than redness, can affect the extensor surfaces rather than the flexures and discoid (circular) or follicular (around hair follicles) patterns may be more common.[6]

Eczema can be graded in severity characterised by the impact the condition is having on the child and family's life.[6] (See Table 2)

Table 1. *Diagnostic criteria for atopic eczema*

Must have:
An itchy skin condition (or report of scratching or rubbing in a child)

Plus at least **three** of the following:

1. History of itchiness in skin creases such as folds of the elbows, behind the knees, fronts of ankles, or around neck (or cheeks in children under four years).
2. History of asthma or hay fever (or history of atopic disease in a first degree relative in children under four years).
3. General dry skin in the past year.
4. Visible flexural eczema (or eczema affecting the cheeks or forehead and the outer limbs in children under four years).
5. Onset in the first two years of life (not always diagnostic in children under four years).

Table 2. *NICE grading for severity of Eczema*[6]

Mild: little impact on everyday activities, sleep, and psychosocial wellbeing

Moderate: moderate impact on everyday activities and psychosocial well-being, and frequently disturbed sleep

Severe: severe limitation of everyday activities and psychosocial functioning, and loss of sleep every night

DIFFERENTIAL DIAGNOSIS

The differential diagnosis for an erythematous itchy rash can be broad. Table 3 sumarises these alternative diagnoses with differentiating features.

Table 3. *Differential diagnosis of Atopic Eczema*

DIFFERENTIAL DIAGNOSIS	SIMILARITIES TO ATOPIC ECZEMA	DIFFERENCES FROM ATOPIC ECZEMA
Seborrhoeic dermatitis	Appearance and distribution similar Onset <2 years	Less itch Can have cradle cap May involve nappy area No FH of atopy
Psoriasis (guttate)[4]	Generalised rash but with small plaques	No itch Resolves in six to 12 weeks May have a history of streptococcal infection
Scabies	Itch Generalized eczematous rash	No flexural rash A close contact who is also scratching Burrows around the ankles, wrists or between the finger web spaces*
Contact allergic dermatitis[7]	Itch	Less common in children Rash at site of contact
Tinea infections	Itchy	Asymmetrical rash and lack of response to TCS** and/or TCI may give clues to a fungal rash May be anular
Dermatitis Herpetiformis[4]	Generalised eczematous rash Intense itch	Distribution of rash opposite to Atopic Eczema, it affects the backs of the elbows, the front of the knees and the posterior scalpfamily history of coeliac disease. Tiny vesicles

* Children with Atopic Eczema may get scabies and scabies treatments is the same for children with and without eczema but scabies treatments are often irritating and may worsen Atopic Eczema.[8]

** The typical clinical signs may be altered by the inappropriate use of topical steroids (Tinea incognito).

Table adapted with permission – See reference 4.

TREATMENT

The cornerstone of treatment is 'The Four Es':

- **Emollients** to restore skin barrier
- **Ease** the itch
- **Eliminate** infections, irritants and consider allergens
- **Educate** the parents/carers and child on appropriate skin care

EMOLLIENTS

Emollients are effective at reducing the severity of Atopic Eczema, the frequency of flare-ups and are steroid sparing.[9] There is no evidence that one emollient is better than another[9] and the best emollient is the one the child or parents/carers will use regularly. Greasy ointments are messy and sticky but remain longer on the skin. Light, creamy emollients are cosmetically more acceptable and do not stain clothing. Parents/carers can be given a choice of a few possible emollients to see which one helps their child's dry skin the best and which is the most acceptable to the child.[4]

Some emollients come in pump action bottles which helps to keep the contents sterile and minimise risk of introducing superimposed infection. If using a tub, a spoon can be used to prevent contamination of the contents. Keeping the emollient in the fridge may help prevent contamination of the

tub but may reduce compliance.[10] Sufficient quantities need to be supplied and a child may need up to 250–500g/week for extensive dry skin. As a general rule the parents/carers should be encouraged to use at least ten times more emollients than TCS or TCI per month.

Products such as Emulsifying Ointment, Aqueous Cream and Silcock's Base are all reimbursable for patients with a full medical card. Some studies recommend against using them as a leave on emollient as they all contain sodium lauryl sulfate (SLS). This is a detergent that may break down oil. In practice, the best emollient is the one used regularly.[11] A greasy emollient will remain on the skin much longer and usually only has to be applied twice a day, except on the hands, where they should be applied more often, as the emollient rubs off or is washed off more frequently. A greasy emollient should be rubbed between hands to liquify prior to application and should always be rubbed downwards, especially on hairy parts of the body, as rubbing upwards can irritate the hairs and may cause folliculitis. Petroleum based emollients may be flammable and should not be used near naked flames (including lit cigarettes) especially if the child's clothing is stained with the flammable emollient. They can also pose a slipping risk.

Appendix 1 includes emollients commonly available in Ireland (please note this is not an exhaustive list).

TOPICAL CORTICOSTEROIDS

Topical Corticosteroids (TCS) are both safe and very effective for treating acute exacerbations where there is intense itch without infection.[12] Written instructions on the safe use of topical steroids in children may help with compliance by overcoming parental anxiety in relation to the fear of side effects of TCS such as skin atrophy, easy bruising, telangectasia and hypertrichosis (increased hair thickness and length).[13] (*Appendix 2 PIL*)

During an **eczema flare**, once daily application of TCS at bedtime is probably as effective as twice daily dosing.[14] Tapering should not be initiated until two days after symptoms subside.[6] Overall compliance with treatment may be improved by applying emollients without TCS in the morning and applying TCS at bed-time to the badly affected areas 10 to 20 minutes after applying emollients.[12]

For **chronic relapsing** Atopic Eczema, a proposed regime, is to apply TCS at night to the itchy areas for one to two weeks to control the acute attack, then apply TCS for two consecutive days per week (for example Monday and Tuesday) to the areas that tend to flare frequently, so as to prevent a relapse ("proactive treatment").[14]

Ointment based TCS are preferable to cream based for dry eczema as ointments last longer on the skin and are more moisturising than creams. Ointments are also safer as they contain less preservatives.[15]

TCS come in four strengths (*Table 4*). 1% Hydrocortisone cream can be purchased without prescription and can be used on the face in children and adults. It is also effective for mild Atopic Eczema on the body in children. The ointment version is a prescription only medication in Ireland and is considered slightly more potent and more effective than the cream version. However, 1% Hydrocortisone ointment may not be strong enough to treat more moderately severe Atopic Eczema on the body. In this situation, it is safe and more appropriate to use a moderate potent TCS in children on the body (but not on the face). Moderate potency TCS are highly unlikely to cause skin atrophy or adrenal suppression from systemic absorption when used appropriately in children.[7] Super potent steroids such as clobetasol propionate (Dermovate ointment) should never be used in children. Specialist advice should be sought before considering oral steroids for severe Atopic Eczema in children.[16]

Table 4: *Topical steroid potency*

POTENCY	EXAMPLE (BRAND NAME/S OF PREPARATIONS AVAILABLE IN IRELAND)	POTENCY RATIO*[17]
Super potent	Clobetasol propionate (Dermovate)	600
Potent	Mometasone furoate (Elocon)	100
	Betamethasone valerate (Betnovate)	
	Betamethasone dipropionate (Diprosone)	
	Hydrocortisone butyrate (Locoid)	
Moderately potent	Clobetasone butyrate (Eumovate)	25
	Alclometasone dipropionate (Afloderm/Modrasone)	
Mild	Hydrocortisone 0.1–2.5%	1

* See Reference 17

Table 5 shows the safe amount of TCS that can be used for chronic use in various age groups. Higher amounts can be used over short periods of time (one or two weeks) for acute exacerbations. It is helpful to explain the fingertip unit to parents/carers (*Appendix 2 PIL*). This is the amount of ointment required to spread from the distal interphalangeal joint crease to the tip of the nail in an adult´s hand.[18] This equates to 0.5g of ointment and is enough to cover an area of skin the size of two flat adult hands with the fingers together.

Mild potency TCS are suitable for mild Atopic Eczema, moderate potency TCS are suitable for moderately severe Atopic Eczema and potent TCS are suitable for severe Atopic Eczema. However, potent TCS should not be used on children under the age of one year and they should not be used on the face or flexures in childhood up to 12 years. Prolonged use or large quantities of potent TCS may lead to skin atrophy and possibly adrenocortical suppression, growth retardation, systemic absorption and hypercortisolism.[19]

Table 5: *Maximum amount of topical corticosteroids (TCS) per month for chronic use* (greater than two month's duration) (Higher amounts can be used for a short period of time in acute flare ups.)*

POTENCY	AGE: ADULT (>12 YEARS)	4–12 YEARS	1–3 YEARS	INFANT <12 MONTHS OLD
Mild	No max	No max	200g***	100g***
Moderate	200g	100g	60g	30g
Potent**	90g	30g	15g. (Daily for 1–2 weeks or 2/week prophylaxis)	Avoid
Super potent	30–60g For acute use only	Avoid	Avoid	Avoid

*= adapted from: Position paper on diagnosis and treatment of Atopic Eczema. EADV (2005) 19,286–295.[20]

** = four times this amount can be prescribed if using "Betnovate RD".

***= this is for demonstration purposes only. In practice it would be impractical to use this much mild topical steroid in a child. They probably need a moderate potent TCS rather that large quantity of mildly potent TCS.

Latest generation potent TCS such as mometasone furoate 0.1% have a better risk-benefit ratio over earlier generation TCS such as betamethasone valerate.[21] A short course (one week) of a potent TCS such as mometasone furoate 0.1% applied daily to the affected areas of the body can be very useful for severe exacerbations in children over the age of one year. After one week of daily use, the potent TCS should be **stepped down** to a moderately potent TCS such as Clobetasone Butyrate or the frequency of application of the potent TCS should be reduced to two consecutive days per week to the areas on the body that tend to flare frequently.[10]

Diluting a potent TCS, for example by using "Betnovate RD" (which is "Betnovate" ready diluted: one part "Betnovate" in four parts paraffin ointment), instead of using full strength "Betnovate" does not necessarily reduce the potency. The diluted potent TCS should still be considered a potent TCS and be used with caution in children, avoided in children less than one year old and never be used on the face or flexures.[22]

Written instructions on the prescription and on the label attached to the tube such as "not for the face", "use for a maximum of two weeks", "can use up to 30g/month" or "do not repeat" are helpful as everyone including the parents/carers and pharmacists know the plan.

TOPICAL CALCINEURIN INHIBITORS

Topical Calcineurin Inhibitors (TCIs) are licenced in the treatment of moderate to severe Atopic Eczema in adults and children over the age of two who do not respond to or are unable to tolerate topical steroids. The ETFAD/EADV (European Task Force on Atopic Dermatitis/European Academy of Dermatology and Venereology) Eczema task force 2020 recommends the off-label use of topical tacrolimus in children below the age of two for Atopic Eczema not responding to mild or moderate TCS as the risks of side effects with TCIs are less than those associated with potent TCS in children.[10] This is an off-label indication and should be explained to the parents/carers before prescribing.

TCIs have the same anti-inflammatory effects as potent TCSs without the risks of skin atrophy or adrenal suppression. They can safely be used anywhere on the body including the face and flexures. In comparison to TCS, they are more expensive however they are covered on GMS/DPS schemes. TCIs should not be used in the presence of obvious skin infection. There is currently only one TCI commercially available in Ireland, tacrolimus ointment.

Topical tacrolimus ointment comes in two strengths (0.03% for children from the age of two years and older and 0.1% for adults and children older than 15 years old). Topical tacrolimus should be applied to the itchy areas twice a day for three weeks, then once a day for three weeks and then twice a week (e.g. Wednesdays and Saturdays) for six to twelve months to the areas that tend to flare frequently to prevent flare-ups in chronic relapsing Atopic Eczema (See Table 6). Patients using TCIs should protect their skin from UV light as there is a theoretical risk that they may be predisposed to lymphoma and skin cancer, although more recent studies appear to refute this link.[23] Tacrolimus should not be used with phototherapy. TCIs can sometimes cause transient pruritus and burning sensation in the first week of use in up to 50% of patients and all parents/carers should be warned about this possibility.[24] Most will improve in the second and subsequent weeks. In severe flares of Atopic Eczema, it might be more effective to improve the Atopic Eczema with a TCS first and then change to a TCI as the Atopic Eczema improves for maintenance treatment.[10]

Table 6: *Suggested treatment algorithm for topical Tacrolimus in chronic relapsing Atopic Eczema*

For chronic relapsing Atopic Eczema apply topical tacrolimus to the itchy areas:

- Twice daily for three weeks then;
- Once daily for three weeks then;
- Twice weekly (e.g. Wednesdays and Saturdays) for six to 12 months

BATH ADDITIVES AND SOAP SUBSTITUTES

Recent studies have indicated that emollient bath additives have not been proven to help.[25] Bubble baths and other perfumed bath additives should not be used. Short baths are recommended (less than five minutes) and the temperature of the bath water should be tepid (27–30 degrees celcius).. Children with Atopic Eczema should wash with a soap free wash and soap

free shampoos. Soap substitutes such as "Aqueous Cream", "Silcock's Base", "Elave Wash" or "Elave Shampoo" can be used in those areas that require deeper cleaning such as the axilla, genitals, feet and scalp. Pat-drying is better than rubbing. One small study did not show any difference between daily baths and twice weekly baths.[9] Emollients should be applied immediately after pat drying to seal in the hydration from the bath water ("soak and seal").

SKIN INFECTIONS

All children presenting for review with Atopic Eczema should be assessed for signs of skin infection. Staphylococcus aureus is a commensal in 10% of children who have no skin problems but is found in up to 90% of children with Atopic Eczema. This may increase the risk of Staph. aureus infection.[26] Currently HSE antibiotic prescribing guidelines and NICE guidelines (2020) do not recommend the use of topical or oral antibiotics unless the child is systemically unwell.[27, 28] In these instances, more severe and/or extensive infected Atopic Eczema may require antibiotics. Further details on treatment options available at *antibiotic prescribing*.

Strategies to reduce the burden of colonisation of Staphylococcus Aureus such as with "Milton" (Bleach) Baths twice a week (2mls per litre of bath water) have been recommended in the past, particularly in children with severe Atopic Eczema or those with recurrent skin infections however the evidence for this is equivocal.[29]

Children with Atopic Eczema are also susceptible to viral infections including herpes simplex virus (HSV). Infections with HSV can cause eczema herpeticum which is a rare but potentially life threatening infection in children with Atopic Eczema (See images 1–3). It is more common in young children with severe Atopic Eczema. It presents as a cluster of vesicles or monomorphic, punched out small 1–3mm ulcers which may become secondarily infected with crusting, weeping and may look like impetiginised eczema usually on the face and neck. It fails to respond to topical steroids and topical or oral antibiotics. The child usually has a fever, is systemically unwell and has lymphadenopathy. Children with eczema herpeticum should be treated with oral acyclovir or valaciclovir and have a high risk of serious systemic illness including sepsis. Have a low threshold for referral to paediatrics or transfer to hospital as appropriate including emergency referral to opthalmology if there is eye/eyelid involvement. TCS can be continued during treatment but TCI should be temporarily stopped until the infection clears.[30]

Images 1–3: *Examples of Eczema Herpeticum rash*

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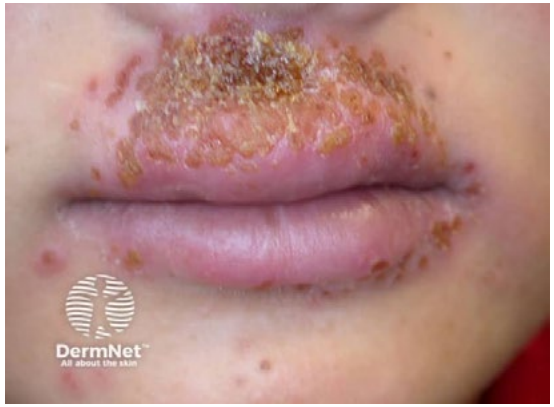
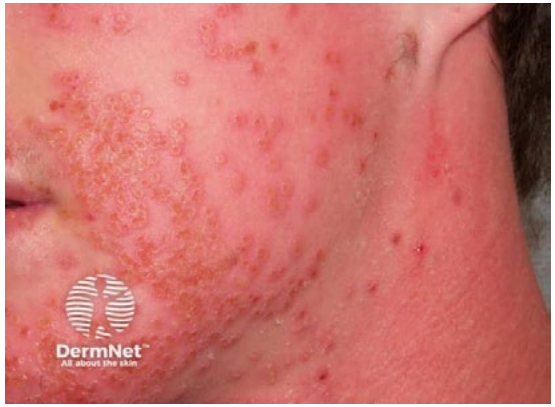
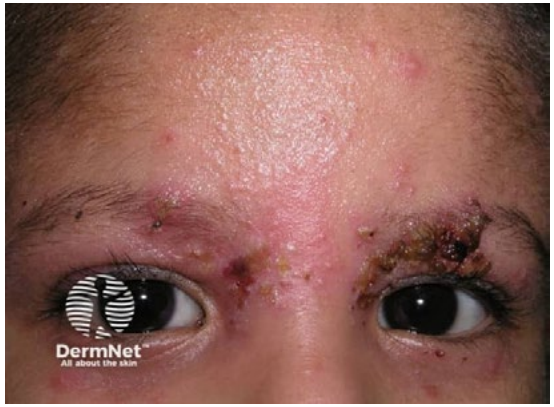
Accessed *here* on 27/01/2025.[31]







IRRITANTS

Parents/carers should be advised to use perfume-free, fragrance-free suitable soap and shampoo substitutes as children with Atopic Eczema have a defective skin barrier function and are far more susceptible to irritants such as soaps, shower gels, shampoos, bubble baths, perfumes, fragrances, SLS or preservatives such as paraben.[6]

Children with Atopic Eczema should try to wear cotton next to the skin and all labels should be removed from the inside of clothing. Woollen clothing should be avoided due to the risk of irritation.[32]

ALLERGENS

Children with Atopic Eczema may develop food allergy, asthma and/or allergic rhinitis, therefore insight can be gained by exploring allergens (contact, food and inhalant) as potential triggers. However parents/carers can be reassured that in the majority of cases children with Atopic Eczema do not need tests for allergies.[6] Medically validated allergy testing should only be considered for children with severe, unresponsive Atopic Eczema and should only be carried out by clinicians experienced in their application and interpretation. For more details relating to food allergies in children please refer to the *Food Allergies in Children QRG*.

There is insufficient evidence that restricting the mother's diet during pregnancy reduces the incidence or severity of Atopic Eczema.[33] Pregnant women can be advised not to restrict their diet beyond usual HSE guidance in an effort to prevent eczema in their offspring There is no convincing evidence that probiotics or dietary supplements including fish oils and vitamins help with Atopic Eczema.[34]

ANTIHISTAMINES

Oral antihistamines should not be used routinely in the management of Atopic Eczema.[6] Children with severe itch may benefit from a trial of a non-sedating antihistamine such as levocetirizine for a month, it should only be continued if there is a significant improvement. Older (first generation) sedating antihistamines such as promethazine hydrochloride ("Phenergan liquid") may be helpful in relieving itch at night-time in children with Atopic Eczema but this is not licensed in Ireland for children under the age of two years. They should only be used short term for a week or two in children for flare-ups of Atopic Eczema.[35]

COMPLEMENTARY MEDICINES

There is a lack of evidence to support the use of traditional Chinese medicine, herbal medicine, homeopathy, naturopathy or osteopathy in children with Atopic Eczema. Kidney and liver failure has been reported with some forms of traditional Chinese medicine.[36] A significant proportion of Chinese herbal ointments have been found to contain super-potent TCS.[37]

REFERRAL TO SECONDARY CARE

Children with severe, unresponsive Atopic Eczema may need to be referred to a consultant Dermatologist for phototherapy or systemic treatments such as oral steroids, methotrexate, cyclosporine, azathioprine, biologic agents such as monoclonal antibodies.[32] These agents can be very helpful at relieving the itch and can help reduce the amount of TCS required in children with severe or extensive disease. A number of biologic agents are now available for children under specialist care to manage itch and inflammation in severe Atopic Eczema.[38]

Appendix 1: Commonly Available Emollient Preparations in Ireland

Please note this is not an exhaustive list

Creams and Gels:

- Aveeno daily moisturising lotion
- CeraVe cream
- Cetraben cream
- Diprobase cream
- Doublebase Gel
- E45
- Epaderm cream
- Eucerin
- Lipikar AP+ Baume
- Myribase
- Oilatum

Ointments:

- Cetraben ointment
- Diprobase ointment
- Epaderm ointment
- Epimax
- Hydromol

Appendix 2: Patient Information Leaflet – Atopic Eczema in Under 12s

Key Points

- Eczema is an itchy red rash which will likely come and go but in many will resolve by late childhood/early adulthood
- Mainstay of treatment is emollient creams (moisturising creams) which help to form a skin barrier
- Flare-ups of eczema require a steroid cream or an alternative (Tacrolimus) which aims to improve the rash and ease the itch. These are proven to be very safe when used under guidance from your GP
- Never use strong steroid creams on the face
- If infection is present – this may be treated with antibiotics or antivirals alongside regular creams

Emollients (Moisturising creams)

- Moisturise and soften the skin to repair the skin barrier and reduce incidence of infection
- Reduce itching and scratching
- Are safe to be used frequently. Use 2–4 times daily
- Apply in a thin layer frequently in a smooth downward motion (in direction of any body hair) to prevent blocking hair follicles
- Bottles with pumps are preferred as it is more difficult for emollients to become contaminated with infection than in open tubs
- Your doctor or nurse can advise you regarding which emollient to use

Topical Steroids

- When used appropriately and as prescribed by your doctor, steroids are a safe and effective treatment of eczema
- Steroid creams and ointments come in varying strengths and the strength and formulation of the steroid will be chosen by your doctor depending on the site and severity of the eczema
- Unless advised otherwise by your doctor, apply the steroid cream/ointment once per day 30 minutes **after** applying the emollient cream
- How much to use? There is a measure called the Finger Tip Unit (FTU), which is a guide of how much steroid to apply according to the age of the child. One FTU is the amount of topical steroid that is squeezed out from a standard tube along an adult fingertip, from the tip of the finger to the first crease. The following gives a rough guide of how much steroid to use in each area of your child's body according to age:

	3–6 MONTHS	1–2 YEARS	3–5 YEARS	6–10 YEARS
Face & Neck	1 FTU	1.5 FTU	1.5 FTU	2 FTU
Arm & Hands	1 FTU	1.5 FTU	2 FTU	2.5 FTU
Leg & Foot	1.5 FTU	2 FTU	3 FTU	4.5 FTU
Chest, Abdomen	1 FTU	2 FTU	3 FTU	3.5 FTU
Back, Buttocks	1.5 FTU	3 FTU	3.5 FTU	5 FTU

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Bathing

- Short baths are recommended (<5 minutes)
- Water should be tepid (27–30 degrees celcius)
- Children with eczema should wash with soap free wash and soap free shampoos
- 'Pat-dry' rather than 'rub-dry' with towels after as rubbing the skin can increase irritation
- Apply emollient cream immediately after 'pat-drying' to seal moisture into the skin

Complimentary/herbal/natural treatments

- These are not recommended due to a lack of evidence and have not been as closely studied, tested and regulated as prescribed medicines
- Sometimes, these treatments can include very strong steroids which can damage the skin

Referral

The majority of children with atopic eczema will be treated by your GP. Some cases which are very severe or are not responding to conventional treatments may be referred to a dermatologist for specialist treatment

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