key points

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Atopic eczema is the most common endogenous type of eczema in infants and children and affects around 15-20% of school-age children in the UK. Its prevalence is highest in children under the age of two and subsequently diminishes with age. It has a chronic, relapsing course. Discoid eczema may occur in children with a background of atopic eczema or independently.

Allergic contact dermatitis is unusual in infants and children, and the most common example is the localised eczematous eruptions observed around nickel fastenings. However, irritant contact dermatitis is relatively common, a good example being nappy rash (ammoniacal dermatitis) caused by prolonged skin contact with urine and faeces. Those children with a tendency to atopic eczema are more prone to irritant dermatitis. Infantile seborrhoeic dermatitis is common and usually resolves before the child's first birthday.

Limited data exist on the benefit of reducing exposure to environmental allergens on improvement or prevention of atopic eczema. As a result testing for type 1 allergy tends not to be offered routinely in the management of atopic eczema unless there is evidence suggesting an allergic precipitant, such as a convincing history of acute food reactions, or in patients with no improvement despite intensive topical therapy. For these patients a skin prick test and specific IgE antibody blood tests may be undertaken, following a focused allergy history, by an experienced team. Patch testing should be undertaken in children when an allergic contact (type 4) allergy is suspected. Patch testing is undertaken in a dermatology department, but children should be referred to the appropriate allergy or paediatric service for skin prick and IgE testing. Elimination diets should only be undertaken with input from paediatric dietitians.

Emollient therapy forms the mainstay of eczema treatment, helping to restore and maintain the skin barrier, in addition to reducing itch and increasing the effectiveness of topical corticosteroids and calcineurin inhibitors. The strength of topical corticosteroids should be tailored to the severity of the eczema. Treatment should be once daily, tapering down to alternate days, then twice weekly as symptoms improve. A mild corticosteroid should be the first choice for delicate areas such as the face, neck, axillae or groin, the exception being the use of moderate potency corticosteroids during severe flares for 3-5 days. Oral antihistamines should not be used routinely in atopic eczema.

An emergency referral to a dermatologist or paediatrician should be made via telephone when there is a suspicion of eczema herpeticum or eczema coxsackium. Other indications for referral include diagnostic uncertainty, recurrent secondary infection, when control remains poor despite topical treatments, and for patients with emotional distress or significant sleep disturbance.