key points

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In atopic eczema there appears to be a genetic deficiency of the barrier function of the epidermis making the skin excessively permeable and susceptible to damage by environmental factors. In the UK, 38% of patients with atopic eczema are adults. Despite evidence-based guidelines produced by NICE and SIGN, standards of care in the community setting can vary, and there is still a tendency to undertreat and not follow up and monitor some patients with atopic eczema adequately. Moreover, patients are not always given adequate information to help them understand and manage their condition.

The diagnosis of uncomplicated atopic eczema is based on clinical history and visual assessment. Atopic eczema may be complicated by secondary infection, particularly staphylococcal and streptococcal, and herpes simplex virus may cause extensive cold sore formation (eczema herpeticum), which is very uncomfortable and potentially dangerous.

Written information, in the form of patient information leaflets about atopic eczema, eczema herpeticum and topical corticosteroids, is available from the British Association of Dermatologists. Patients or carers should receive a full explanation of how to use topical treatments and a demonstration of how to apply dressings, if applicable. Emollients are the mainstay of treatment. They should be applied liberally and frequently and their use continued during periods of treatment with corticosteroids.

The SIGN guideline for atopic eczema made the novel recommendation that topical corticosteroids need be applied, initially, just once daily. SIGN also recommends that consideration be given to maintenance therapy with topical corticosteroid applied twice weekly to eczema-prone areas during remissions, in addition to daily emollients, as a safe means of reducing the frequency of flaring.

Topical calcineurin inhibitors are non-steroidal immunomodulating agents, and should be considered, in patients two years and older, for the acute treatment of moderate and severe atopic eczema that has not been controlled by topical corticosteroids or if there is a serious risk of important adverse effects from further corticosteroid use. Paste dressings can be very effective by providing a physical barrier to scratching, improving retention of emollient, and being soothing and intrinsically anti-inflammatory. Oral antibiotics are not recommended in the routine treatment of non-infected atopic eczema, but their short-term use in infected eczema is encouraged.

Food allergy and intolerance (IgE- and non-IgE-mediated) is common in patients with atopic eczema. Dietary exclusion is not recommended in the management of atopic eczema in the absence of a confirmed food allergy. Consider referral of children with moderate to severe atopic eczema and adults with severe atopic eczema to an allergy specialist if they do not respond satisfactorily to standard topical medication.