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Introduction

Nurses, midwives, school nurses and health visitors are in an ideal position to promote the care of the skin, to educate and support those with skin disease and their carers, and to work towards prevention. This booklet is a broad overview of current practice and knowledge in the management of eczema. Three key themes are: education and understanding about the disease; the therapies; and the psychological and social implications and impact on quality of life.

Eczema is a common, inflammatory, dry, scaly skin condition that affects about 10% of the population at some point in their lives. Patients can be affected by eczema at any time in their life. For some patients, it will be a lifelong condition. It has an impact on the whole family – not just the patient – and lack of understanding can cause misery, loneliness and frustration. The genetic component is often very worrying in pregnancy and parents often carry a burden of guilt.

Clinical presentation of eczema

The presentation can vary depending on the type of eczema and the site affected. Eczema may be acute, sub-acute or chronic. The skin can appear inflamed, hot or oedematous with dryness and flakiness. Vesicles may be present that weep, and crusting may occur when the skin is infected. The skin can become lichenified (thickened) with repeated trauma from scratching or picking. Erythema (redness) may be difficult to assess in some ethnic patients.

The eczema may be localised with cut-off marks or generalised. This skin is very unstable and prone to infection.

Types of eczema

It is important that the diagnosis is correct, so that the correct treatment and lifestyle advice can be given and potential wider implications can be discussed. Most dermatologists use the terms eczema and dermatitis synonymously.

Atopic eczema

This is the most common type of eczema and is linked to asthma and hay fever. It has a genetic component and potential environmental component. The skin lacks one of the essential fatty acids – hence it does not hold water, leading to dry skin. This can allow the penetration of antigens. The genetic factor means that there is an abnormal IgE response to presenting antigens, which results in the release of histamine and makes the skin more inflamed and itchy.
Seborrhoeic dermatitis
There are two types – infantile and adult.

Infantile seborrhoeic dermatitis: Cradle cap is common in children and may not be associated with seborrhoea. There is yellow, waxy scale thick and confluent on the scalp and hair, which is difficult to remove. Inflammation can occur and involve the face, chest or napkin area.

Adult seborrhoeic dermatitis: The adult form is associated with the skin colonisation of pityrosporum (yeast) leading to an increase in dandruff, itching and erythema. It usually occurs in the regions where sebaceous glands are most active: upper lip; nasolabial folds; eyebrow area; glabella; and chest. It is seen as a butterfly facial rash and papules may be present.

Contact dermatitis
There are two types – contact irritant and contact allergic dermatitis.

Contact irritant dermatitis: This is more common and is caused either by exposure to acute toxic insult (e.g. exposure to acids) or by cumulative damage from irritants (e.g. water, detergents).

Contact allergic dermatitis: This accounts for 85–98% of occupational skin disease. It is a type IV (cell-mediated or delayed) hypersensitivity. First contact causes no problem. However, with repeated exposure over a period of time, the allergen enters the skin and sets up an immune response resulting in an inflammatory eczematous reaction.
**Stasis or varicose eczema**
This is associated with venous incompetence and may also be referred to as gravitational eczema.

**Discoid or nummular eczema**
The cause of this type of eczema is not known. Several coin-shaped lesions appear that are red, scaly and very itchy, and raised papules or vesicles may be present.

**Pompholyx or dishydrotic eczema**
Pompholyx eczema involves the hands and feet, often appearing along the fingers and toes in the form of vesicles that are very itchy and can result in fissures. The cause is not really known, but it often occurs with hot weather and is prone to secondary infection. It is seen in people with atopic or contact dermatitis.

**Photodermatitis**
Drugs (topical or systemic) or chemicals on the skin can interact with ultraviolet light to cause photosensitive eczema. Sun-exposed skin is involved, such as the ‘v’ and nape of the neck, the hands and the face. The areas under the chin, on the upper lip and under the nose are usually spared. Several exposures to ultraviolet light would be needed before the skin erupts with erythema, scaling, vesicles and bulla.

**Neurodermatitis or lichen simplex**
This type of eczema arises when small patches of skin are rubbed or scratched at times of worry.

**Eczema craquelé or asteatotic eczema**
Eczema craquelé presents as dry skin in the elderly, exacerbated by the overuse of soap or due to underlying metabolic dysfunction. The latter should be investigated if there is no improvement after the use of emollient therapy.
Assessment

Treatment should be based on assessment of the patient and the impact of skin disease on their quality of life. The assessment should be carried out in a place that offers privacy and where patients can feel comfortable. With small children, ask the parents to undress them. With shy children and adults, you might have to work slowly around the body, exposing all areas in turn. You might miss an important clinical sign if you just assess exposed skin.

Ask the following questions:

- How long has the skin been dry, itchy or inflamed?
- What is their normal routine of skin care?
- Did they notice any trigger prior to the flare?
- Is it worse when at work? Is it better at weekends or on holiday?
- What is their sleep pattern? How many hours’ sleep do they get?
- Does scratching interfere with activities of living/sleeping?
- Do they have any known allergy?
- Is there any activity they can no longer do (e.g. swimming)?
- Have they started any new hobby or activity?

Observe the following:

- Body language and type of clothing – is it correct for the season?
- Extent and area of the body involved.
- Severity – dryness, inflammation, excoriations.
- Signs of infection – if crusty, take swabs.
- Extent of lichenification (thickening) and areas involved.

A recording using a body chart can be useful for review and establishing a baseline, with analogue scales 1–10 to score for itchiness, redness and dryness. These can be reviewed on return visits.

Demonstration of treatments

A practical demonstration of the treatments will be invaluable to ensure a clear understanding of the procedures. Once you have decided on the appropriate treatments, use samples for patients to try in the clinic prior to prescribing, explaining the difference between them and their role in treating eczema. Demonstrate the techniques of topical therapies or other strategies so that they have confidence to use them, and supplement this with written information.

Set a review date – review progress, step down topical therapies and reinforce education.
Basic treatments

Soap substitutes

Ordinary soap must be avoided as its alkaline content and fragrance will irritate the skin. There are various soap substitutes available, both for use in the bath or shower and for washing hands and face between bathing. The patient may have to try several before finding one they like.

Soap substitutes can be applied to the entire body including the face prior to the bath or shower and rinsed off in the water. Or they can be used in the bath or shower as you would use a normal soap bar or liquid. This serves to remove surface debris such as dried blood and skin scales.

Aqueous cream is perhaps the commonest soap substitute and is cosmetically acceptable to most adult patients. However, some children may be sensitive to the preserving agent in aqueous cream and may need to be offered an alternative.

Aqueous cream is a good substitute for shaving cream.

Other soap substitutes include emulsifying ointment, Aqueous Bar, Epaderm, Dove (unscented) and Neutrogena.

Bathing

Bathing daily with emollient bath oil added to the water is very beneficial to the patient with eczema. However, hard water can irritate the skin and have a more drying effect. Water softeners may be of some benefit, but they can be very expensive, and are not guaranteed to help eczema patients.

Bathing is an ideal way of keeping the skin free from debris, reducing the risk of infection. Bathing in water alone will dry out the skin, therefore it is imperative that a suitable bath emollient is used. Using bath emollients ensures that the skin is lubricated both on entering and on leaving the bath. This will prevent dryness and moisturise the skin at the same time.

Encourage the patient to try several bath emollients to find out which one is most suitable for their particular skin. For optimum benefit the patient should be encouraged to soak in the bath for 15–20 minutes. If the skin is cracked and painful, this may not be possible. Ensure that the patient knows to have the water at body temperature (37°C) – if it is too hot, the capillaries in the skin dilate as the skin tries to cool itself and evaporates more water from the skin surface, making the skin drier.

There are several bath emollients to choose from, including Emulsiderm, Aveeno, Balneum and Alpha-Keri. Please note that some products may contain fragrance.

If showering, the emollient oils can be applied with a wet sponge or flannel. Encourage the use of emollient shower products, such as QV or Dermaveen bath and shower oils.

Patients who do not have free access to bath or shower facilities should be encouraged to sluice down using emollient oils.
Using oils and soap substitutes in the bath or shower make them very slippery, which can be hazardous for children and adults alike. Children and the elderly should not be left unsupervised and others may actually require assistance to get in and out of the bath. A bath mat may be of some benefit.

After bathing, the skin should be patted dry with a soft towel, not rubbed as this can cause irritation.

**Emollients**

Emollients restore the moisture that the skin loses by replacing the barrier of fatty materials that is so important in preventing dryness of the skin. Emollients are a mixture of water, waxes, fats and oils in varying proportions. There are a variety of emollients available.

Emollients have no harmful effects and it is recommended that they be used as frequently as necessary to ensure that skin is soft and well hydrated. Depending on the skin condition, this can be 2–3 hourly. The patient may have to try several emollients before finding one that suits their skin. One method of doing this is to apply one to one side of the body and another to the other side and then to assess which offers the best effect.

A minimum of 500 g weekly needs to be prescribed for adults and children with moderate to severe eczema. Carrying out a constant skin-care routine can be extremely monotonous and time consuming, but it is vital for the successful management of eczema. Comfort is an important factor, and both adults and children will develop their own preferences. If the skin gets drier, it should be moisturised more frequently until it has recovered.

**How to apply emollients:** Emollients should be applied with clean hands. If in a tub, the emollient should be decanted using a clean spoon, which will prevent contamination of the pot and so reduce the risk of infection. Using emollients in a pump dispenser will reduce cross-contamination. Emollients should be applied thinly and evenly to the entire body and gently smoothed onto the skin so that the skin just glistens. To minimise plugging of hair follicles, emollients should be applied in a downward motion in the direction of hair growth.

**Cautions:** Emollients should not be applied thickly, as this blocks hair follicles and messes up clothing. Emollients should not be applied when the skin is warm – after exercise, on a hot day or after a hot bath – as this makes the skin itchy by trapping body heat. Emollients should never be heated in a microwave as this could burn the skin.
**Shampoos**

Unless the scalp is directly affected, ordinary shampoos can be used. Hair care should be performed separately from the bath as the suds can irritate the skin. It may be necessary to use a medicated shampoo. Tar products such as Polytar and T-Gel can cause orange staining. In this instance, a non-tar product can be used such as Oilatum Scalp Shampoo, Infaderm or Imuderm. Hair driers should not be used, as applying direct heat to the scalp will cause dryness and itching.

**Topical steroids**

Topical steroids are the most common treatment for inflammation in eczema. They do not cure eczema but act by reducing the inflammation that makes eczematous skin red, itchy and sore and by reducing the itch sensation. There are four potency groups so that the appropriate steroid can be chosen for the severity of the inflammation, extent and location of the eczema and the age of the patient. The four groups are: mild, moderate, potent and very potent. The *Monthly Index of Medical Specialties (MIMS)* has a useful chart listing all the steroids in potency groups.

Support and supervision of the patient in an acute phase is important and will allow more potent steroids to be used. To prevent rebound, it is important to explain to the patient how to step down in potency once the obvious signs of healing have occurred (they can see the skin improving) and then to continue for the same amount of time at the lower potency before stopping. Confidence in using these preparations is key to controlling the symptoms. If the skin flares, they should use the stronger potency steroid, as under-treatment turns acute eczema into chronic eczema. Written information is essential to support the verbal discussion. It should outline the emollient therapy and topical steroids to be used, stating what their strongest potency treatment is and what they should step down to. It is important for both patient and health professional to have regular reviews to build a therapeutic relationship and to gain knowledge about the effectiveness of the treatments.

**Adverse reactions to topical steroids do worry patients and it is important to give balanced advice to encourage concordance.**

There are misconceptions about topical steroids as people confuse them with anabolic steroids used by athletes. So patients or parents are either too scared to use them on their own or their child’s skin or believe that a tube of cream cannot do any harm and apply it everywhere.

There are circumstances when topical steroids can cause harm. Clear discussion and understanding between health professional and patient are essential, with appropriate intervention and supervision. Thinning of the skin and telangiectasia (broken blood vessels) can occur if potency of the steroid is too strong for the severity and location of the eczema, and if no emollient therapy is being used. Occlusion of topical steroids under dressings or bandages can also lead to increased absorbency. Remember that children have a greater body-surface-to-weight ratio.
Topical steroids can suppress symptoms of skin infections, so it is essential that the patient is educated in identifying other signs.

Topical steroids are available in creams, lotions, ointments, gels and foams. Creams are helpful on wet eczema and ointments are more suitable for dry eczema. Creams have more additives to bind the elements together and ointments are more occlusive. Steroids should be applied to the affected skin only and not used to prevent eczema occurring.

Topical steroids are usually applied 30 minutes after a moisturiser has been applied. However, they can be applied immediately after a bath or shower, as an emollient soap or bath oil would have been used to help moisturise the skin.

**Application technique:** The topical steroid should be applied with clean hands. It should be decanted, a small amount at a time, and not used directly from the tube. The steroid should be applied to all affected skin in smooth strokes so that the skin glistens. Any leftover should be discarded and the hands rewashed (unless there is eczema on the fingers).

**Systemic steroids**

In acute exacerbation of eczema, systemic therapy or intramuscular injection is used. This treatment is usually done under the supervision of a dermatologist, rather than by a GP, and a reduce-dose strategy is used.

**Topical immunomodulators**

**Tacrolimus** therapy was originally developed for transplant patients to prevent organ rejection by suppressing the immune system. New research has found that topical application of tacrolimus can have an effect on atopic eczema. It does this by affecting the skin at the site of the immune balance to stop the inflammatory process, ie the IgE abnormal response.

Less of the topical immunosuppressant is absorbed compared to using systemic steroids, but the full effect of any adverse reaction of tacrolimus is not yet known. However, it is thought to be very safe, hence it is licensed for use in children and adults with moderate to severe eczema. Dermatologists are advising patients to take care in the sun and not to use tacrolimus on infected skin.

**Pimecrolimus** is a weak immunomodulatory drug, which is applied as a cream to the skin. It acts on the cells in the skin that cause inflammation, redness and itching. In the UK, pimecrolimus cream is licensed for adults and children aged two years and above who have mild-to-moderate atopic eczema. It is not a steroid.

Topical pimecrolimus cream has been specially developed to treat and manage atopic eczema and can be used at the first signs of redness and itching. Topical pimecrolimus cream is thought to be very safe for use in the short term. However, the long-term side effects of pimecrolimus are not known.
These two products have very different user instructions, so please refer to those or to the British National Formulary (BNF). Patient information sheets on both products are available from the Eczema Association.

**Bandaging**
Paste bandages are an ideal way of treating eczema of the limbs, especially chronic or lichenified eczema. Wet-wraps are ideal for treating extensive eczema that is not controlled on a more conventional regimen.

In both instances, it is crucial that patient or parent receives a practical demonstration and ongoing support and that a follow-up plan is implemented. The health professional initiating this form of treatment must undertake regular reviews.

*No occlusive dressing should be applied if the skin is infected.*

Please consult the Eczema Association’s information sheet *Wet-wraps: How and when to use wet-wrapping in the treatment of eczema* for information.

**Antihistamines**
Antihistamines can assist in a good night’s sleep. Sleep is important for healing the skin and for coping. Antihistamines do not actually treat the eczema but they may reduce itching and so minimise damage through scratching. The sedative antihistamine will also ensure a degree of sleep for the patient and family.

There is no evidence to show that the regular use of antihistamines has an adverse effect. It is important that the antihistamine be taken on a regular basis and around the same time of day. As with any oral medication, patients must follow the instructions on the bottle or leaflet. Administration time for children will depend on bedtimes and what time they get up for school or nursery.

*Antihistamine creams should not be used on eczema because of the incidence of hypersensitivity.*

**Complementary treatments**
Eczema is a multi-factorial disease and, due to the impact on quality of life and the amount of time it takes on a daily basis to carry out skin care, patients and families begin to explore alternative therapies such as homeopathy, herbalism and acupuncture.

If a patient asks your advice about complementary treatments, here are some important points to raise:

- Few complementary or alternative treatments have been scientifically tested.
- Just because a therapy is natural, it does not mean that it is safe.
- Eczema can spontaneously improve and it is tempting to attribute this to the latest treatment tried.
• Anybody can set themselves up as a practitioner of alternative medicine and, although they may belong to a national body, it does not mean that the treatment is valid for eczema.

• Any medicine – systemic or topical – should be supplied with instructions and an additive list, with monitoring blood tests as necessary (for example, in the use of Chinese herbs). The responsibility for the monitoring of these preparations belongs to the prescribing or supplying practitioner.

• Ask the local dermatologist if they can recommend an alternative therapist.

• **If set on trying a complementary treatment, patients should continue to use their emollients and discuss their treatment with their doctor to ensure that no drug interaction occurs.**

There are lots of treatments available for eczema from around the world. However, invisible steroids or immunosuppressives have been found in a number of them. These herbal creams can be bought openly in markets and can cause long-term damage.

**The Eczema Association has information sheets on complementary medicine and homeopathy.**

**Fighting the itch**

 Patients will often tell you that it is the itching that causes most distress and they are often desperate for help in how to combat this. This is very difficult, but some factors that influence a degree of itching can be identified and resolved:

• Dry skin tends to be more itchy – frequent application of emollients should be encouraged.

• Hot skin tends to be itchier, so baths should be warm and hot environments should be avoided.

• Cotton next to the skin is the coolest option.

• Anxiety, stress and tiredness can aggravate eczema. Encourage rest and relaxation – this may be achieved through a relaxing bath, or finding a distracting game or hobby.

Exposed skin is easier to scratch and damage. The skin should be covered with loose cotton clothing. This is particularly beneficial at night when more protection may be needed.
The itch–scratch cycle

Itching is a sensation and our natural behaviour is to scratch. Eczema is very itchy and there is nothing more frustrating to a patient than to be told not to scratch! In inflammation histamine is released, which stimulates the itch. The quickest and most effective way to release this is to scratch. However, the more friction or damage there is to the skin, the more histamine is released.

The vicious circle of chronic eczema

Emollient therapy is crucial to the management of dry skin, but the behavioural pattern of patients who learn to scratch as a response to generalised triggers should also be considered.

Using a combined approach of emollients, topical steroids, education and behaviour modification (through raised awareness using a tally counter and then adapting behaviour), chronic eczema can be eradicated. This process follows the self-care model, enabling the patient to choose to participate in their own care while at the same time being cared for by the nurse.

If acute episodes are managed well, damage to skin such as lichenification and the habit of scratch will be avoided. However, this can be labour-intensive, especially with children, as activities of distraction such as play require supervision. If children are left unsupervised to watch TV or videos, they may then learn to behave (scratch) every time it is on.

Women who are able to wear false nails may find that they are very effective. Acrylic in nature, they are too soft to break the skin and – as they can be expensive – they worry about breaking the nails if they are used for scratching.
Eczema and infections

When exacerbated, all types of eczema are prone to infection. This is often related to persistent scratching and damage to the skin, as eczema is very itchy in this inflammatory phase. Patients should always have clean, smooth short fingernails to limit damage to the skin and prevent infection.

Patients should be made aware of signs of infection. If their skin flares and does not respond after four days of increased-potency treatment, they should contact their nurse or GP for skin swabbing. If they feel febrile or their skin is becoming confluent erythematous, they should access the nurse or GP immediately. The most important factor is the correct identification of the infection – whether it is bacterial, viral or fungal – so that the correct treatment can be initiated.

Bacterial infections

Atopic eczema is most often infected with *Staphylococcus aureus*, which makes the eczema worse and slower to heal.

The contagious pustular skin disease impetigo can lead to infected eczema. Skin swabs should be taken to identify the causative organism and sensitivity to antibiotic. With a host response, systemic antibiotics should be prescribed for 14 days. For small, localised areas, topical antibiotics or antibacterial steroid creams or ointments (eg Fucibet or Betnovate-C) could be used for up to 14 days. These should be used with caution, as resistance to the antibiotic or potential sensitivity to the preparation can occur, especially in varicose eczema. Remember to check the potency of the combined preparation so that it is applied to the appropriate area of skin.

Some dermatologists prescribe soap substitutes and bath oils that have an antibacterial component to reduce colonisation on the skin surface. The skin-care regimen will need to be modified to treat wet, weepy eczema or blistered areas of skin during infections. Normal oily bath and soap substitutes should be stopped and substituted with antibacterials, such as the Dermol range, Emulsiderm or Oilatum Plus.

For weepy skin, diluted potassium permanganate soaks (gauze soaked in a one in 10,000 dilution of potassium permanganate) can be applied. *This must not be taken orally.* One or two crystals should be diluted into a clean jam jar and then added to warm water until a light pink colour is achieved. The gauze should then be soaked and applied wet to the skin and kept in place for 10 minutes. The gauze will turn brown as it oxidises and will dry the skin. If the dilution is too strong, it can cause discomfort and stain the skin brown. This procedure should be stopped once the skin is dry (in 2–4 days).

Topical steroid creams should be used instead of ointments, as creams are easier to apply to wet, sore skin.

When clear of infection, the patient should revert to their previous regimen of skin care. If the skin gets re-infected, the patient should switch to antibacterial cleansers.
for long-term use. In the case of varicose eczema, the dermatologist may advise
long-term oral antibiotics.

**Viral and fungal infections Herpes simplex virus:** The cold sore virus herpes simplex can
cause severe infection in patients with eczema. Patients and parents need to ensure that
there is no skin-to-skin contact between anyone with a cold sore and the patient with
eczema. Eczema infected with the herpes simplex virus can lead to eczema herpeticum,
a very serious and potentially fatal viral illness, which may require hospitalisation and
treatment with a systemic or intravenous antiviral drug such as acyclovir. Individual
vesicles can leave punched-out erosions on the skin surface that can spread very quickly,
especially across the face. The symptoms may be flu-like and the skin can feel sore and
tender, rather than itchy. If eczema herpeticum is suspected, the patient should see a
dermatologist, GP or A&E doctor immediately, stating that they suspect infection with
herpes simplex, so that treatment can be given promptly.

**HIV and hepatitis C:** HIV and hepatitis C are spread through contact with blood or other
bodily fluids. Some people with HIV do develop certain types of eczema and other skin
diseases that may require treatment by a dermatologist. If any of your patients are
positive for HIV or hepatitis C, encourage them to talk to their healthcare provider about
how this has affected their skin.

**Fungal infections:** Where thrush (candidiasis) or ringworm (athlete’s foot) are
present, a topical steroid/antifungal cream with an antibacterial can be used.

**Eczema in children**
Caring for a child with eczema can impose a huge
burden on a family, and it should be recognised
that they may be in need of a great deal of
support. The main carer of the child may find it
exhausting and – despite putting in lots of time
and effort – there is often little reward.
Treatments tend to be time-consuming and
monotonous, and motivation is crucial.
The parent must be encouraged to develop and
adhere to a consistent skin-care regimen for their
child. This can often prove difficult at times when
little or no improvement in the child’s eczema is
perceived. Additional support may be indicated if
the child rebels against the skin care.
**Skin care**
Encourage parents to make bath time as pleasurable as possible, allowing the child to play with suitable toys in the bath. Parents should try not to get into conflict with the child over bathing. It may be necessary to negotiate, especially if the child has suffered discomfort in the bath at some time. Encourage play with emollients, such as putting dots of cream all over the body or making ‘worm shapes’ from the pump dispenser.

Recommend completion of all treatment in the bathroom to prevent exposure to varying temperatures, as long as the room is not overheated. Ensure that parents are aware of the rationale for not using any scented child-care products, including nappy wipes.

*Persistent under-treatment of a child, resulting in unnecessary discomfort or pain, should be discussed with your named child-protection nurse.*

**Immunisation**
Overall the advice is consistent and clear that parents of children with eczema are not putting them at increased risk by following the normal immunisation programme. However, nurses should allow parents to discuss their concerns about immunisation. Parents of children whose eczema is due to food allergy may be particularly concerned about vaccinations. The only food that may be a problem is egg. There is no problem for children who just dislike the taste of eggs. MMR vaccine may contain traces of egg protein and children who have suffered allergic reactions to egg could theoretically be at risk. Research has shown that 99% of children with egg allergy can safely receive the MMR vaccine. If a child has suffered a severe rash, swollen mouth or throat, or had difficulty in breathing after eating egg, then you should arrange for special care to be taken when the child receives the MMR vaccine. It may be necessary for the MMR vaccine to be given in a hospital setting.

*The Eczema Association has an information sheet available for parents on Immunisation of Children with Atopic Eczema.*

**Dietary treatment**
Parents are often in receipt of confusing and conflicting information on the causes of eczema and many are led to believe that food – especially cow’s milk – is the cause. If an elimination diet is medically indicated, it is generally dairy and egg products that are avoided. However, *any dietary manipulation must only be undertaken with full medical and dietetic support.*

Weaning is generally introduced around 16 weeks of age. First foods that should be given are baby rice, pureed vegetables and fruits (not citrus). Eggs, wheat and dairy products should not be given until after the child’s first birthday. Dietary advice should be obtained from the health visitor. If the parents feel that the child’s eczema has worsened since the introduction of solids, it is advisable to refer to a dermatologist.
**Home visits**
A home visit is invaluable, both for assessment and to work out a practical routine for the family. Eczema is erratic and no two people will be the same, therefore individualised treatment regimens need to be devised. Parents should be encouraged to discuss the child’s eczema and any problems they may experience. Be aware that caring for a child with eczema can undoubtedly lead to extra strain and tension all round, and be prepared to give additional advice and support when needed.

**Nursery and school**
Nursery and school should not present problems for the child with eczema if time is taken to ensure that the teachers and nursery nurses have access to both verbal and written information. Parents should approach these establishments and explain that the child has eczema and what measures can be taken to ensure optimum comfort for the child. This should be done well before the term starts. Where appropriate, children should be encouraged to apply emollients at break times to avoid interrupting classroom sessions. It may be necessary for the child to wear protective cotton gloves during certain activities such as painting. It is important that the child is encouraged to lead as normal a life as possible and does not stand out from their peers. Swimming is fine if the child does not have a problem with chlorinated water and is able to shower with and apply emollient after the activity.

Although the school or nursery must hold details of a child’s medical condition and needs, parents should be informed that teachers are not legally obliged to oversee the application of topical treatments or the administration of medication.

**Practical help for eczema patients**

**Laundry**
Biological detergents and perfumed fabric conditioners should be avoided as they can irritate sensitive skin. Some patients may be able to use unperfumed fabric conditioners. Laundry should be well rinsed and patients may need to be advised to give an extra rinse to ensure that all detergent is removed from laundry. Clothes and linen should be washed frequently as creams and ointments can stain them. Many people with eczema are allergic to the droppings of the house-dust mite, and washing laundry at 60°C will kill the mites. This additional laundry can be expensive and time-consuming.
**Clothes and bedding**
Loose, unrestricted cotton clothing is preferable for comfort. Cotton scratch mitts or gloves may help to prevent skin damage from scratching. All-in-one sleep-suits are recommended and these can be worn by day if the child is particularly itchy or sore. Ideally, bed linen should also be cotton as this is kinder to the skin. It can also be washed at 60°C to kill the house-dust mite. As the mite and its droppings will be found in abundance in mattresses, it is recommended that anti-house-dust-mite mattress and pillow protectors be used, especially for children and those with facial eczema. Not all families can afford these essentials and may need to improvise such as using cotton socks as gloves. Refer to social security for financial advice and assistance.

*Hot water bottles and electric blankets should not be used as over-heating leads to dryness and itchiness.*

**Position in classroom or office**
When choosing where to sit, the patient needs to be aware of where the radiators are in relation to their desk and avoid sitting in direct sunlight by a window. The need to sit away from radiators and windows should be explained to the school staff or the office manager. Air conditioning will dry out the skin, so place a bowl of water or a plant nearby.

**Rest and sleep**
It is important to recognise the body’s need for rest and sleep when it is trying to deal with inflammation. The increase in applications of emollients and topical steroids is time-consuming. To ease recovery it would be better to take a couple of days off school or work for a period of rest and intensive treatment, rather than struggling on and potentially ending up with infected eczema that may cause sleep deprivation and require a long period of time off and the use of systemic antibiotics.

**Identifying triggers**
With assistance, patients or parents can identify possible triggers (house-dust mites, pets, bubble bath or use of perfume or after-shave worn by other members of the family). Strategies for coping with triggers such as stress, over-tiredness and seasonal weather changes can be developed – for example, exercising to alleviate stress, regulating sleep pattern (using sedating antihistamines) and increasing the application of emollients if the skin becomes drier.

**Access when required**
Patients with chronic skin disease would benefit from earlier assistance, with access for advice (via the phone or in person) or obtaining prescriptions via an SOS system rather than by regular appointments.
Further reading


‘A different level of information and support is needed by the health profession when dealing with eczema.’
Dr Andrew Wright, Consultant Dermatologist

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