# Treating childhood eczema: a topical solution for a topical problem

It is estimated that 20% of New Zealand children are affected by eczema, with disproportionally higher rates in Māori and Pacific children. After a diagnosis of eczema has been made, the cornerstone of management is the use of emollients and topical corticosteroids, alongside the provision of comprehensive education and support to the parents and caregivers. This includes providing information and practical advice about the benefits of daily bathing with wash-off emollients (not soap), twice-weekly diluted bleach baths, avoiding the itch-scratch-itch cycle by minimising exposure to triggers and irritants and encouraging the frequent use of emollients and appropriate use of corticosteroids.

Emollients need to be prescribed in sufficient quantities to allow for application several times a day; 250 – 500 g per week is a reasonable amount. Parents should be advised to continue treatment with an emollient when their child's eczema has cleared, and also to concurrently use an emollient during topical corticosteroid treatment. Prescribe the emollient that is preferred by the child/parent to increase adherence with treatment. Subsidised emollients are Fatty Cream (HealthE) and cetomacrogol cream (PSM), which are available in 500 g tubs, and Sorbolene cream (which contains cetomacrogol + 10% glycerol) which is available in 500 g and 1 kg pump dispensers.

Despite the regular use of emollients and the avoidance of triggers and irritants, many children experience flares and require treatment with a topical corticosteroid. As with emollients, underuse of topical corticosteroids is more common than overuse, and parents need to be reassured, that when used correctly, topical corticosteroids result in minimal adverse effects.

The potency of the topical corticosteroid should be matched to the severity of the child's eczema flare and the area of the body affected:

- Mild eczema flare – mild topical corticosteroids, e.g. hydrocortisone 1%
- Moderate eczema flare – moderate topical corticosteroids, e.g. triamcinolone acetonide
- Severe eczema flare – potent topical corticosteroids, e.g. hydrocortisone butyrate 0.1%

Infants aged less than one year with eczema on the trunk, legs or arms can usually be managed with a low potency corticosteroid. Pre-school aged children generally require a moderate or potent topical corticosteroid and school-aged children often require a potent topical corticosteroid.

Applying the topical corticosteroid once daily is sufficient for most children; parents should be advised to use the adult fingertip unit (FTU) to judge how much to apply.

Topical corticosteroids should only be applied to areas of active eczema (including broken skin) and are usually discontinued when the flare has resolved. If the flare does not resolve within approximately two weeks, treatment should be reassessed. Some children experience frequent flares (two or three per month); in these cases it may be useful to continue topical corticosteroid treatment between flares. There are two ways to do this – either step down to the lowest potency product that controls symptoms or use the same potency product less frequently, i.e. "weekend treatment". If topical corticosteroids are ineffective or contraindicated, short-term use of pimecrolimus cream 1% may be considered. Oral antibiotics may be required if the child's eczema has become infected. A short trial of antihistamines may be considered for children aged over two years with severe itch, to aid sleep.

Although most children with eczema can be managed in primary care with these measures, specialist paediatric or dermatological advice may be required, e.g. for children with severe or persistent eczema, if eczema herpeticum is suspected or if the diagnosis is uncertain.

## Peer group discussion points:

1. What resources, if any, do you use to help reinforce key messages about eczema management to parents/caregivers? Do you think it is difficult for parents to follow management advice?
2. How do you decide what emollient to prescribe? Do you think that most parents/caregivers use emollients correctly and in enough quantities?
3. What factors influence the selection of a topical corticosteroid for a child with eczema? Do you have a method for calculating an appropriate amount to prescribe?
4. Have you had to refer many children with eczema to secondary care? If so, what were the reasons for doing so?
5. Are there any other methods, products or interventions that you recommend for managing eczema in children?

Original article in BPJ 67 (April, 2015)