Caring for children and young people with atopic eczema

Guidance for nurses

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Contents

Introduction 1
What is atopic eczema? 2
What is the nurse’s role? 2
Nursing management 3
Treatments 3
Family support and education 8
Support for professionals 8
References 9
Further reading 9

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Introduction

Every nurse who works with children – in the community, in school, in emergency care or in children’s wards or outpatient departments – is likely at some time to care for children and young people with atopic eczema. This Royal College of Nursing (RCN) guidance for nurses highlights the wealth of information available on managing childhood eczema, signposts resources and outlines some of the practical issues nurses need to address when working with children, young people and their families.

Well-informed, consistent and practical nursing advice provides families with the knowledge to manage the condition themselves with the minimum of disruption to the family, school and social life, and fosters a near-normal life for the affected child. Appropriate support provides families with the backup they need to understand the range of treatment options, particularly if a child’s condition deteriorates.

For more detailed clinical information, the National Institute for Clinical Excellence (NICE) has published a full clinical guideline on the management of atopic eczema from birth up to the age of 12 years (NICE, 2007). This provides evidence-based and systematically reviewed advice for a stepped approach to management of the condition. It includes a short summary and helpful algorithms which practitioners may find helpful: www.nice.org.uk
What is atopic eczema?

Atopic eczema is the most common inflammatory skin condition in childhood, affecting 15 to 20% of school age children. The skin becomes red, dry and flaky in appearance, which can cause the child to scratch. In babies and small children it is common on the cheeks, forehead and outer limbs. In older children it most often affects the skin creases, such as the folds of the elbows and behind the knees (Robinson, 2011). In children and young people from a black or minority ethnic background, atopic eczema can appear on extensor surfaces rather than flexures and can produce thick, lumpy or papular skin or follicular eczema, with a marked increase or decrease in pigmentation when the eczema has settled down (Robinson, 2007).

The effects of atopic eczema vary in complexity from a minor irritating rash to a complex, long-term condition which can be a major challenge to living a ‘normal’ life. In severe or poorly controlled cases it may have a disruptive effect on the whole family. There is no cure for atopic eczema, but it can usually be controlled with treatment and support and it is realistic to hope that a child may grow out of it.

Atopic eczema usually first presents in children under the age of two years with an itchy rash, dry skin which may be cracked or weeping, and/or a personal or family history of asthma or hay fever (PCDS/BAD, 2003). The skin barrier is known to be damaged in patients with atopic eczema and the dryness associated with eczema can be made worse by the use of products that will further irritate and dry the skin (Cork et al, 2006).

What is the nurse’s role?

Atopic eczema usually responds well to the right treatment, consistently applied. So nurses must develop knowledge of the principles of treatment and the wide range of products and treatment options available to children and young people. These will include topical medications available both on prescription and ‘over the counter’, as well as other interventions such as special diets and complementary therapies, which many parents will ask about and want to try.

Parents should use caution when considering high street allergy testing and they should also be aware that steroid content can be present in some plant treatments.

Your role as a nurse is to:

✦ support the child, young person and their family
✦ help them to understand the principles of treatment and accept the lifestyle changes eczema brings
be aware of the effects of medication, whether conservative or unorthodox, and be able to advise accordingly

- support and empower children and young people to manage and understand their own skin condition and access the right treatment
- help them to understand how eczema can appear in their child and when to use appropriate treatments
- help them to recognise the appearance of infected eczema and guide them on when they should seek medical help.

As with any long-term condition, you should encourage patients with eczema towards self-care and management. Children and young people will benefit from support which helps them understand their condition and its treatment, so that they can achieve the independence to manage their own condition.

**Nursing management**

We recommend that you undertake a holistic patient assessment, exploring the psychological and social aspects of the condition as well as the physical. This assessment should be an ongoing process (Buchanan and Courtenay, 2007). You can then develop a long-term management plan to improve the condition of the patient’s skin and its hydration, reduce the inflammation, and enhance the quality of life for the child and their family.

The emphasis is on working in partnership with the child or young person and family to achieve the best possible outcomes and the least disruption to home, school and social life.

Be aware that families may have been offered a lot of advice or found much information about eczema from diverse sources, some of it conflicting in nature. They may be confused by which path to take, especially in the early stages of the condition.

**Treatments**

Treatments for atopic eczema include a range of products which should be used in a stepped approach to control and manage the atopic eczema (NICE, 2007). The aim of treatment is to rehydrate the skin, reduce inflammation and so improve quality of life (Turnbull, 2003).

The first line treatment for patients with atopic eczema should be a complete emollient therapy (CET). The use of a CET is one of the simplest, safest and most effective methods to control atopic eczema and uses emollient cream/ointments, emollient soap substitutes and emollient bath and shower products. Bathing is the more effective method
of application as the CETs are better absorbed than in the shower.

Mild atopic eczema can often be controlled with an emollient regime alone, but it may be necessary to use intermittent topical corticosteroids to control acute flare-ups, and/or topical or systemic antibiotics/antiviral drugs if the skin becomes infected.

**Emollients**

Emollient is the medical term for moisturiser and it is important that nurses and families understand the synonymous use of the terms. These are the first line treatment in atopic eczema, providing a protective layer for the outer layer of skin.

A varied range of products are available, with many emollients listed in the British National Formulary for Children (NICE, 2007). Washing with soaps and detergents can affect skin dryness and barrier function. Soaps and detergents should therefore be replaced with an emollient which is suitable for use as a soap substitute, in the bath and as a skin moisturiser (DTB, 2007). Products must not be fragranced. It is important that you recommend complete emollient therapy – not only a cream or ointment applied directly to the skin, but a bath or shower product and a soap substitute as well (NICE, 2007).

For the greatest effect, emollients should be applied at least twice a day and usually up to four times, as well as at night if there is scratching and dryness. The cardinal rule is to always keep the skin moist and to reapply emollient whenever the skin feels dry.

You should make families aware that they need to continue treatments even when the skin appears clear, and that the amount and frequency of emollient used will need to increase at the first sign of any worsening of the condition.

**Product selection**

Emollients are available as ointments, creams, lotions, gels, sprays and bath additives – an extensive choice. You will need a broad knowledge of the products so you can advise and encourage families to use the best sort of product for their individual child’s skin. Different products will suit different people – for example, some are reported to cause stinging and discomfort in some children.

Children and young people may prefer creams and lotions because

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1 The National Patient Safety Agency has recently warned about the fire risk associated with paraffin-based ointments in concentrations of over 50% when issued in quantities of 100g+. They have issued a list of potentially hazardous products and recommend that information on fire risks should be issued.
these are less greasy and can provide a more acceptable cosmetic result – if a treatment is less noticeable, it can encourage patient concordance.

Personal choice plays a large part in a successful emollient regime. Advise families carefully, and allow them to try several products to find the ones that suit them best. With experience and understanding, some families will find the best results from using different products at different times of the day and in different conditions.

It is worth making the family aware that it may take more than one consultation to find a suitable regime (BDNG, 2012)

Application

We recommend that emollients are applied to the skin by smoothing, not rubbing. They should be applied in a stroking motion in the direction of hair growth, to prevent plugging of the hair follicles (Robinson, 2007).

The best way to illustrate the application technique, and the amount, is by demonstrating it. This gives you the time to spend with the child and family to get to know them better. Product manufacturers often supply leaflets with clear diagrams showing how emollients should be applied.

The effects of all emollients are short-lived, so frequent application of large quantities is needed to keep the skin moist. It is recommended that at least 250g and up to 500g a week is needed to achieve good eczema control (NICE, 2007).

Recommended amounts can seem excessive to health care professionals inexperienced in managing atopic eczema. So learn what 250g looks like by checking the quantities in the tubs and jars. Many products are dispensed in 500g tubs, so for these, at least half a tub should be prescribed and used every week.

Once you have agreed a suitable regime with the family, help them ensure that they always have enough supplies on hand, especially over weekends and holidays. Children and young people at nursery, school or college should always take their emollient with them and be encouraged to use it regularly throughout the day, and especially before their skin is exposed to things that might dry or irritate it such as messy play, swimming or extremes of temperature.

Products dispensed with a pump are fine for creams but not suitable for ointments. These must be decanted for use to minimise cross infection in the container. Smaller tubs can be prescribed for use at school or to be carried when away from home. Decanting of large tubs into small containers is not ideal because of the risk of contamination, but may
be necessary to ensure that the child or young person has access to a supply of their emollient wherever they are.

**Bathing**

Children and young people are often prescribed a bath emollient, and they are advised to bathe at least daily for 10 to 20 minutes to allow full emollient absorption. After 20 minutes the drying effects of the water become counter-productive as the skin gets waterlogged. The bath water should be lukewarm, and the room not too hot as extremes of temperature may irritate the skin. To prevent inadvertent skin damage, children should be patted dry with a soft towel, and not rubbed. Bathing is the most effective method of application – showering is not recommended as it does not provide the same moisturisation. For some families a daily bath might be difficult to accommodate into their routine and your advice should be tailored to meet the social and economic circumstances of the family.

**Safety**

Emollients are greasy and the child’s skin and bathing areas may become slippery. To prevent accidents, warn your patients and their families to take care in the bath and if they are handling small children and babies. The use of a bath mat and regular bath cleaning prevents the build up of oil and reduces the risk of slipping.

**Topical corticosteroids**

Topical corticosteroids are often needed and patients may need them when emollients alone are not enough, or when the condition gets worse (MeRec Bulletin, 1999). These are always applied in smaller amounts than emollients and often to eczematous areas only (Robinson, 2011).

Ointments last longer and may penetrate deeper. The preparations vary in strength and it can be hard to tell which are more or less potent – you will need to take advice on the most suitable. Topical corticosteroids are generally considered to be safe when used correctly and you should seek advice to make sure your patients are only prescribed the amount they need, for the shortest time possible. Short courses of treatment are often enough to control the condition.

**Bandages**

Wet, dry and paste bandages are prescribed but their use is controversial and there is minimal research based-evidence on their effectiveness. They should never be used as first line management and only by health professionals who are trained and experienced in their use (NICE, 2011).

**Treatment of infection**

Bacterial skin infections occur when the skin barrier is broken and a bacterial organism is introduced,
most commonly staphylococcus aureus. Diagnosis can be difficult and if there is any doubt, ask for an expert opinion. Infections are suggested by dry, crusted skin which is weeping and reddened, but you should consider the possibility of infection when there is any sudden worsening of the skin condition.

Topical or systemic oral antibiotics and a more rigorous skin therapy regime, including the use of bath emollients with antimicrobials, will usually cure the infection and improve the skin. You will need to identify any practices that might be introducing infection. However, make sure that you question the family and patient about this in a non-threatening way, as families can feel they are being blamed for any exacerbation. However, if there are frequent flare ups and infections it may be necessary to review the parents’ knowledge and techniques.

Allergies and irritants
Environmental factors are often thought to exacerbate eczema and some simple measures may reduce irritation and discomfort. Wearing loose cotton clothing and keeping cool, especially in bed, will help, as will avoiding the drying effects of both central heating and air conditioning.

Allergy to house dust mites and the dander of animals are commonly thought to cause flare ups of eczema, and some children may benefit from avoiding some or all of these.

Dietary considerations
Many parents are concerned that diet may be causing their child’s problems and embark on exclusion diets or dietary alterations. However, they should discuss any dietary changes with the medical team and a dietician before they try them. It is extremely important that any dietary exclusions are implemented (and monitored) by a health care professional.

Complementary interventions
The evidence is scant that herbal remedies and Chinese medicine alleviate eczema, though they have been widely used in recent years. Families should be fully aware of the contents of any products they use, and ensure that they are comprehensively labelled in English. Some herbal products have been shown to contain super-potent topical steroids.

Skin irritation should primarily be managed by the use of a good emollient regime and appropriate use of topical corticosteroids. Antihistamine tablets have no real place in the management of eczema, as the itch patients feel is not histamine mediated and therefore an antihistamine is unlikely to help. Sedating antihistamines can occasionally be useful at night to break a cycle of night time irritation and induce good sleep patterns.

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Family support and education

Access to good quality information and support is vital to allow families to manage this chronic long-term condition and to work with the professionals as partners in their child’s care. Eczema is a family condition and the effects on the rest of the family can be profound, putting strain on siblings’ and parents’ relationships.

It may be useful for families to know that they don’t always have to visit their GP for emollient treatment, as many products which are available on prescription are also available over the counter (OTC) from the pharmacy and from supermarkets. Parents do not have to purchase OTC products needed for eczema as they are available on prescription. They may find this more convenient for follow-up treatment.

Parents often feel guilty about eczema flare ups and you should be careful not to apportion blame. Working with the family to gently investigate any recent changes may prevent any further recurrence.

Support groups can be a great help to some families, as can online support. Nurses are in a position to advise families and young people of local resources through their health and community networks. The National Eczema Society is also an excellent source of information and provides resources online and through its helpline (see Support for professionals).

Support for professionals

If you work with children and young people, we advise you to identify local experts in the care of atopic eczema to help when you need them. Find out the name and contact details of the nearest paediatric dermatology nurse specialist, so that you can contact them for advice and information.

Other useful sources of information and resources include:

- Patient information leaflets
  www.bad.org.uk
- British Dermatological Nursing Group
  www.bdng.org.uk
- National Eczema Society
  www.eczema.org
  Helpline: 0800 089 1122
  helpline@eczema.org
- Clinical site useful in identifying eczema and its presentations varying by age:
  http://nottingham.ac.uk/dermatology/eczema/index.html
References


Further reading

