Consensus-based European guidelines for treatment of atopic eczema (atopic dermatitis) in adults and children: part I

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Background: AE is one of the most common non-communicable skin diseases which affects up to 20% of children and 2–8% of adults in most countries of the world. Most AE cases can be regarded as mild, whereas less than 10% of patients suffer from severe eczematous skin lesions.

Scope of guidelines: This is a consensus-based S2k guideline, although it has an additional strong focus on evidence from the literature. This guideline has been prepared for physicians, especially dermatologists, pediatricians, allergists, general practitioners and all specialists taking care of patients suffering from AE. This first part of the guideline covers methods, patient perspective, general measures and avoidance strategies, basic emollient treatment and bathing, dietary intervention, topical anti-inflammatory therapy, phototherapy and antipruritic therapy.

ACADEMIC P.E.A.R.L.S

Pediatric Evidence And Research Learning Snippet

Consensus-based European update on atopic eczema (atopic dermatitis) in children

Few highlights from the paper are:

Management of AE must consider the individual clinical variability of the disease; highly standardized treatment rules are not recommended.

•**Basic therapy is focused on treatment of disturbed barrier function by hydrating and lubricating topical treatment, besides further avoidance of specific and unspecific provocation factors.**

•A regular use of emollient has a short- and long-term steroid sparing effect in mild-to-moderate AE.

•Topical anti-inflammatory treatment based on glucocorticosteroids and calcineurin inhibitors is used for flare management and for proactive therapy for long-term control. Topical corticosteroids remain the mainstay of therapy, whereas tacrolimus and pimecrolimus are preferred in sensitive skin areas and for long-term use.

•Patient fear of side-effects of corticosteroids (corticophobia) should be recognized and adequately addressed to improve adherence and avoid under-treatment.

•The applied amount of topicals may also follow the fingertip unit rule: A fingertip unit (FTU) is the amount of ointment expressed from a tube with a 5-mm-diameter nozzle and measured from the distal skin crease to the tip of the index finger (~0.5 g); this is an adequate amount for application to two adult palm areas, which is approximately 2% of an adult body surface area.

•There is not enough evidence to support the general use of both first- and second-generation H1R antihistamines for the treatment of pruritus in AE. These may be tried for the treatment of pruritus in AE patients, if standard treatment with TCS and emollients is not sufficient. Long-term use of sedative antihistamines in childhood may affect sleep quality and is therefore not recommended.

•Pollen avoidance measures can be recommended during the pollen season. House dust mite avoidance measures may be tried in selected cases. All children diagnosed with AE should be vaccinated according to the national vaccination plan.

EXPERT COMMENT

“These guidelines are very useful for pediatricians in the management of Atopic eczema or Atopic dermatitis, as we come across such cases frequently in outdoor practice. It reinstated the importance of barrier therapy (Emollients) for protection and use of topical low potency steroids in condition of flares or more severe cases only. These guidelines also underlines the importance of parent education in order to avoid intermittent flares.”

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With warm regards,

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Reference

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