DERMATOLOGY
REFERRAL GUIDELINES – ATOPIC DERMATITIS

Reviewed and approved, May 2013

This protocol is a general guideline and does not represent the professional standard of care required of the health care provider.

This pathway should be modified as indicated, based on the health care provider's professional judgment, to meet the needs of individual patients.

Atopic Dermatitis

For atopic dermatitis, the primary care physician should initiate family/patient education on the nature of the disease, need for topical emollients, need to minimize harsh soaps, stressing the need for avoidance of irritants, etc.

A useful tool for patients is the Eczema Center website: www.EczemaCenter.org. This site can be accessed to reinforce your advice and illustrates how to apply wet wraps.

The goal of treatment is to control symptoms, not cure disease.

Bathing

- Bathe using tepid water (bathing may range from daily to every few days)
- Limit bathing to no greater than 10 minutes
- Use moisturizing or soapless cleanser (e.g. Cetaphil)
- Avoid fragrance containing cleansers, bubble baths
- After bathing, pat skin dry and immediately apply topical medication followed by application of emollient or an emollient alone.

For those patients with significant recurrent disease who may suffer from repeated bacterial infections, bleach baths twice a week may be helpful. 1/4 cup of household bleach should be added to a tub half full of water and mixed before the pt enters. After 10-15 minutes, the patient should rinse off, and apply moisturizers or topical medications as directed. This concentration of bleach is akin to a chlorinated swimming pool exposure. Irritation may occur, but is minimized by rinsing and application of moisturizers after the soak.

Emollients

There is evidence that emollients alone are effective as first-line agents in the management of atopic dermatitis and may be steroid sparring. Ointments and creams are preferred over lotions. Emollients should be applied frequently.

- Examples include Cetaphil, Eucerin, Aveeno, Aquaphor, Vaseline, Cerave
- The least expensive of these options is petrolatum (regular Vaseline).

General Measures

- Avoid the use of clothing that may act as an irritant (e.g. wool, synthetics), cotton clothing is preferable
- Avoid overheating
- Keep the skin covered by clothing to minimize exposure to irritants and reduce scratching
- Wet wraps, consisting of a layer of moisturizer or steroid applied to moist skin, and then covered with moist gauze or clothing, over which a layer of dry gauze or clothing is placed, often provides a soothing protective treatment for children with significant disease. These dressings may be kept in place overnight, and as needed during the day for children with significant disease. They inhibit the child's ability to scratch and provide a soothing moist environment for a prolonged period to affected areas.
- For more information, access the website www.EczemaCenter.org
- Infection is a concern for patients with AD, particularly those who are not responding to appropriate therapy. Both bacterial (particularly Staph aureus) and Viral (usually HSV) infections can occur. Consider therapy and referral in recalcitrant cases. Obtain appropriate cultures prior to therapy when concern for MRSA or Viral infection exists.

Antihistamines

Data regarding the use of oral antihistamines for Atopic Dermatitis are conflicting. However, these agents may facilitate sleep. To avoid daytime sedation, consider adding these sedating agents at bedtime. If nighttime waking is present consider hydroxyzine (Atarax) .5mg/kg – 1.0mg/kg qhs

Use of Topical Corticosteroids

Multiple comparative trials have documented the efficacy of low to mid potency topical steroids in the management of Atopic Dermatitis for the pediatric patients.

These agents are first line therapy for the management of atopic dermatitis exacerbations.

Topical steroids should be used once or twice a day, (never more than twice a day); there is no evidence that more frequent application is effective.

- Ointments or oil formulations are generally recommended.
- Once control is achieved, topical steroids should be tapered to a less potent preparation or withdrawn. Pulsed utilization of such products, applying them two days a week, or on weekends, may decrease the incidence of flares while minimizing the risk of adverse effects.

Use of Topical Steroids

MILD AD: Low potency topical steroids

- Hydrocortisone 2.5% cream or ointment
- Alclometason diproprionate 0.05% ointment o Desonide ointment 0.05%
- Flucinolone acetonide 0.01% in oil

MODERATE AD: Mid potency topical steroids may be used twice daily and as needed for flares. They should not be used on the face, neck, groin, or axillae.

- Triamcinolone 0.1% ointment
- Fluticasone proprionate 0.05% ointment
- Synalar ointment .0.025% ointment

SEVERE AD: Immediate referral to Dermatology. May begin mid potency topical steroid twice a day, not on face, neck, groin, or axillae. Patients should be counseled to avoid long-term use of these products. The use of wet wraps can be very beneficial.

- Triamcinolone 0.1% ointment
- Fluocinonide 0.05% (short term use only)
- Oral corticosteroids are exceedingly rarely used for atopic dermatitis. If they are being considered the patient should be seen by a dermatologist first.

Both topical Pimecrolimus and Tacrolimus have been approved for use in the treatment of atopic dermatitis in children 2 years of age and older. **While not FDA approved for use in children younger than two years of age, they are used in off-label fashion by Pediatric Dermatologists in children whose disease requires such therapy.**

- Pimecrolimus 1% cream can be used as a second-line therapy for the management of mild to moderate atopic dermatitis.
- Tacrolimus 0.03% ointment should be used as second-line therapy for the management of moderate or severe atopic dermatitis.
- Pimecrolimus/Tacrolimus should be employed for episodic, and not prolonged continuous use.
- Because of concerns regarding the potential for the development of cutaneous malignancy, patients being treated with Pimecrolimus/Tacrolimus should be counseled about the use of appropriate sun protection, including application of sunscreen.

REF: Eichenfield, LF; Hanifin, JM; Luger, TA; Stevens, SR; Pride, HB. Consensus conference on pediatric atopic dermatitis. *J AM Acad Dermatol.* 2003;49:1088-1095.