Atopic Eczema for Healthcare Professionals

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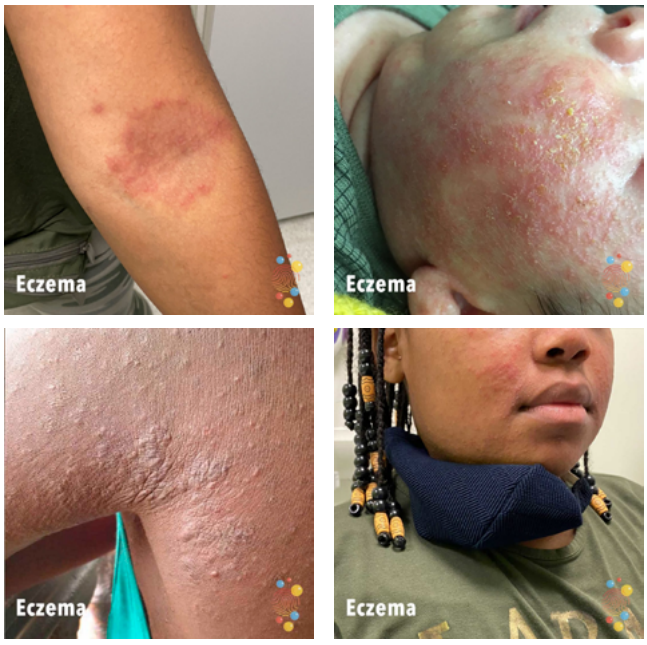
Section 1: Introduction to atopic eczema

Written by Julie Van Onselen, Dermatology Lecturer Practitioner, Dermatology Education Partnership Ltd and University of Stirling

What are the signs and symptoms of eczema?

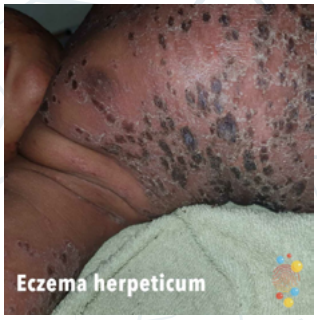
Atopic means an inherited tendency to develop eczema, asthma and/or hay fever. Eczema (ekzema=eruption in Greek), describes a skin condition caused by inflammation and complex immune responses. Atopic eczema has genetic manifestations (atopy - an inherited allergic tendency to develop asthma, eczema, rhinitis and some food allergies; and filaggrin mutations leading to an abnormal skin barrier) and there are correlations between IgE auto reactivity and disease severity[1]. Atopic eczema is also known as atopic dermatitis.

Atopic eczema generally starts in childhood. 60% of all children with atopic eczema develop it in the first six months of life. 75% of children improve, but 25% continue to have atopic eczema into adulthood, which is a long term relapsing and remitting chronic condition. For some, it can be a severe and debilitating chronic disease[2].



Eczema will always be itchy, and the skin will be dry, scaly, and sometimes cracked. During flares of eczema the skin can become red, or in skin of colour hyperpigmented, sore, and weepy. The eczema flare can become worse with scratching, which is a response to the incessant itch.

Bacterial infection, commonly with staphylococcus aureus, causes the skin to weep with small vesicles forming with golden crusts. Rarely, viral infection can occur, usually on first exposure to the herpes simplex virus, the skin becomes very painful, and with linear vesicles. This is called eczema herpeticum.



Eczema chronic	Eczema flare	Eczema infection
• Dry skin • Scaly skin • Intermittent itching • Sleep may be disturbed	• Dry skin • Scaly /cracked skin • Frequent itching • Red or darker patches of skin • Eczema may bleed, weep/ooze • Sleep is disturbed	• Dry skin • Scaly/cracked skin • Frequent itching • Red and darker patches of skin with golden crusts • Eczema will weep/ooze • Small vesicles may appear **If skin suddenly becomes very painful with lines of vesicles – seek urgent referral– this may be a viral skin infection, which needs treating within 48 hours**

Other symptoms of eczema include sleep disturbance, itch, pain and discomfort. These can affect everyday activities, including school and work, and impact on psychological well-being (discussed in section 3).

References:

1. Roesner L and Werfel T (2019) Autoimmunity (or Not) in Atopic Dermatitis. Frontiers in Immunology; Vol 10, Artilce 2128: 1- 8.
2. Thomsen S. Atopic dermatitis: natural history, diagnosis and treatment. ISRN Allergy. 2014; 2014:354250.

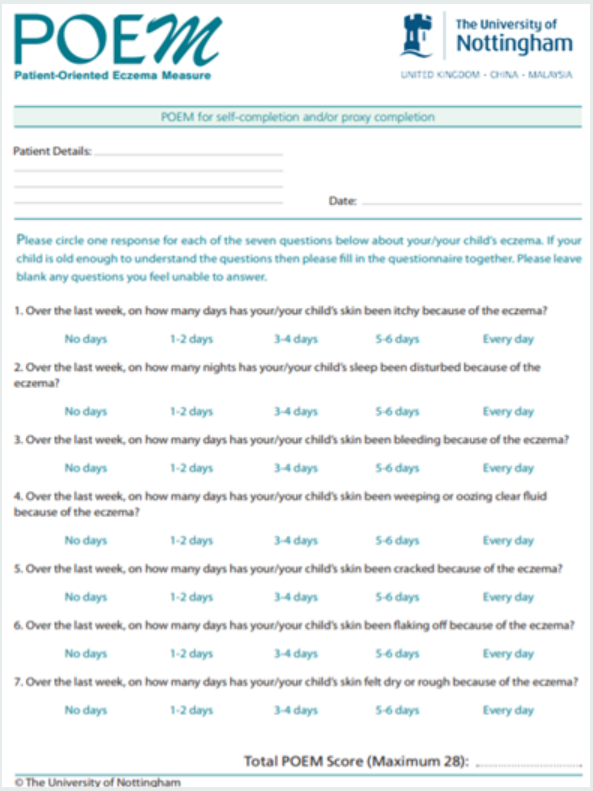
How will eczema be assessed?

All patients with atopic eczema should have regular reviews with a healthcare professional. When atopic eczema is diagnosed, a holistic assessment should include full skin examination, with areas of the body affected by eczema and severity noted. A skin history should be taken to include general health, past medical history, current medications and allergies. The skin assessment should include questions on individual eczema triggers. The healthcare professional should ask about past and current topical treatments, as well as asking general questions on skin care, including any use of health remedies and personal hygiene products. It is important to ask about regular skin care routines and how skin treatments are applied, how long for and the effectiveness of treatment. Patient assessment can be enhanced by assessment tools, which help the patient understand and track improvements in managing their eczema, and how it affects their quality of life.

Healthcare professionals should include the following assessment questions:

- Ask about eczema signs and symptoms and perform a full skin examination.
- Take a skin and medical history and ask questions about general health, past medical history, current medications, and allergies (including individual eczema triggers).
- Ask about past and current topical treatments, including general questions on skin care, personal hygiene products, and any skin remedies. What is the patient's regular skin care routine (emollients), and when do they use skin treatments (topical steroids and topical calcineurin inhibitors)?
- Discuss how eczema affects their quality of life.
- Encourage patients to self-assess their eczema over a few weeks. The POEM tool (which has a free app) is very useful for patient self-assessment, as eczema fluctuates between chronic-sub-acute and acute patterns.

NOTE: Healthcare professionals will often assess a patient's images of eczema and ask them to include a selection of images. Remember to inform patients that selfies can often be blurred, so it is better if someone else takes the image.



POEM
Patient-Oriented Eczema Measure

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

POEM for self-completion and/or proxy completion

Patient Details:

Date:

Please circle one response for each of the seven questions below about your/your child's eczema. If your child is old enough to understand the questions then please fill in the questionnaire together. Please leave blank any questions you feel unable to answer.

1. Over the last week, on how many days has your/your child's skin been itchy because of the eczema?
No days | 1-2 days | 3-4 days | 5-6 days | Every day

2. Over the last week, on how many nights has your/your child's sleep been disturbed because of the eczema?
No days | 1-2 days | 3-4 days | 5-6 days | Every day

3. Over the last week, on how many days has your/your child's skin been bleeding because of the eczema?
No days | 1-2 days | 3-4 days | 5-6 days | Every day

4. Over the last week, on how many days has your/your child's skin been weeping or oozing clear fluid because of the eczema?
No days | 1-2 days | 3-4 days | 5-6 days | Every day

5. Over the last week, on how many days has your/your child's skin been cracked because of the eczema?
No days | 1-2 days | 3-4 days | 5-6 days | Every day

6. Over the last week, on how many days has your/your child's skin been flaking off because of the eczema?
No days | 1-2 days | 3-4 days | 5-6 days | Every day

7. Over the last week, on how many days has your/your child's skin felt dry or rough because of the eczema?
No days | 1-2 days | 3-4 days | 5-6 days | Every day

Total POEM Score (Maximum 28):

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What does the POEM score mean?

0-2:	Clear or almost clear
3-4:	Mild eczema
8-16:	Moderate eczema
17-24:	Severe eczema
25-28 :	Very severe eczema

Patient Oriented Eczema Measure. Nottingham.ac.uk. 2020. [online] [Accessed December 2022].

Physical signs and psychological assessment tools

Children's Life Quality Index (CLQI) – cartoon version

Dermatology Life Quality index (DLQI)

Eczema Area and Severity Measure (EASI)

NICE holistic assessment tool

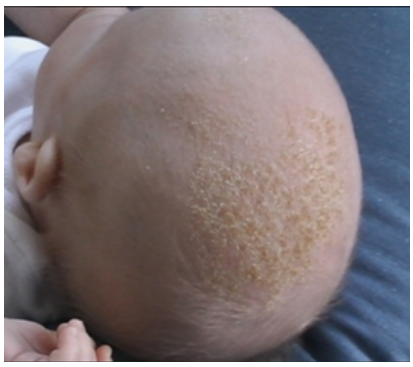
Patient Orientated Eczema Measure (POEM)

All assessment tools can be downloaded and used free of charge in any clinical area. Scoring and interpretation guides are included in all websites.

What other skin conditions look like eczema?

Healthcare professionals need to recognise differential diagnoses, here are some common differential diagnosis, and practical tips on recognition:

Infantile seborrheic dermatitis (cradle cap)



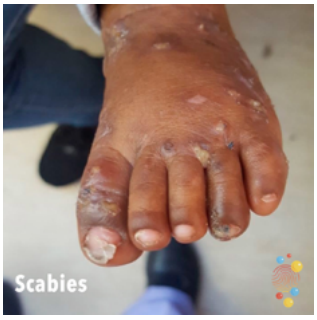
A very common type of eczema, caused by temporary over production of grease from the sebaceous glands, causing yellow, greasy scales on the scalp, and sometimes salmon pink patches on the body. Seborrheic dermatitis usually resolves at six months. A key clinical sign is the infant is not disturbed or itchy. If an infant with seborrheic dermatitis starts to scratch, this is likely to be atopic eczema, which often starts on the face/scalp.

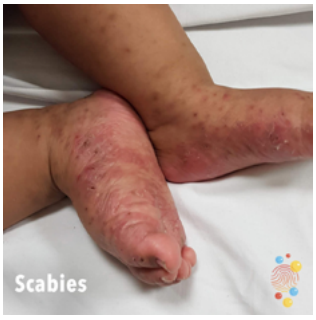
Nappy rash

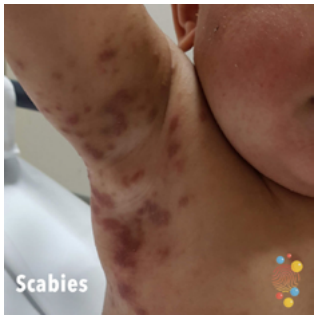
This is usually due to an irritant dermatitis, caused by contact with urine/f atopic eczemaces, rubbing or not cleaning frequently. Generally, infants with eczema often have clear areas of skin in their nappy area, as they are unable to frequently scratch this area. An infant with very severe nappy rash, and diarrhoea and often with a perioral inflammation, should be investigated for acrodermatitis enteropathica, a disorder of zinc deficiency. This is very rare, and cased by a defective gene. symptoms occur in bottle fed babies, within days, and breast-fed infants after weaning.

Visit Skin Deep for images of nappy rash.

Scabies

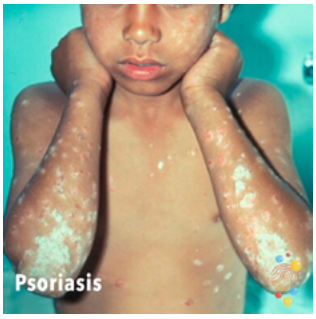


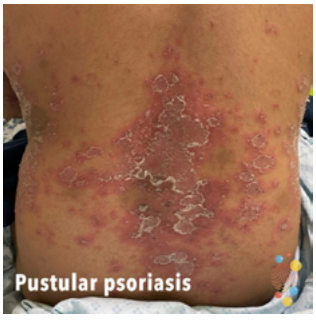


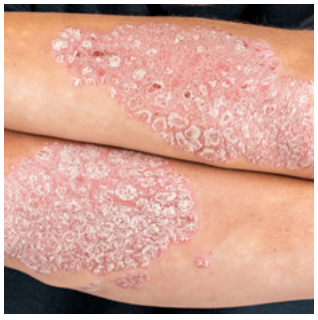


A skin infestation, caused by a mite, which is passed on by skin-to-skin contact. Scabies is very itchy and often worst at night. Allergy to the scabies mite causes inflammation. The scabies burrows into finger webs and wrists, sometimes male genitals and axilla. In infants, scabies mites burrow into palms and soles. Generally, more than one member of the family is itching as scabies is very contagious, and intense scratching can result in skin infection, with staphylococcus aureus.

Psoriasis

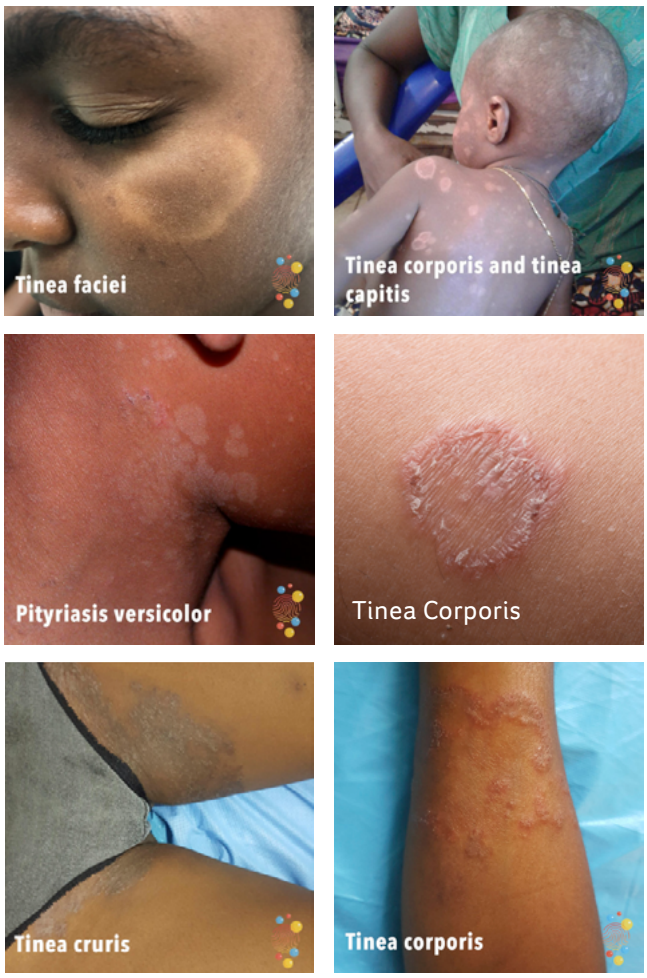






Is a common skin condition, which like eczema, is auto immune. Eczema and psoriasis rarely occur together. People with psoriasis often have a family history, and skin develops round/oval plaques, often on the elbows, knees, lower back and scalp. The plaques are usually symmetrical, red/darker, and very scaly, they can also be itchy.

Fungal infections



These can be frequently misdiagnosed as eczema, particularly discoid eczema (which is a common pattern in atopic individuals). Dermatophyte infections, caused by tinea, are very common and can appear as a solitary or multiple patches on the body – commonly called 'ringworm'. They appear as rings with a scaly and inflamed border, and generally not itchy. Fungal infections can also be caused by yeasts, pityriasis versicolor, is more common in late teens/twenties, and appears on the body as pink or fawn coloured /or darker patches, which are scaly but not itchy. People with eczema are no more susceptible to fungal infections than the general population.

Vitiligo

This is another auto immune skin condition, which results in loss of skin pigment, appearing as lighter patches. There are no skin symptoms. Vitiligo can affect people of any skin type, but is more common in people with skin of colour. It can appear at any age.

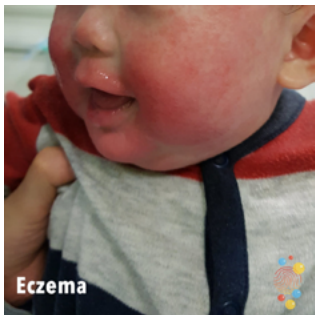
What does eczema look like on skin of colour?

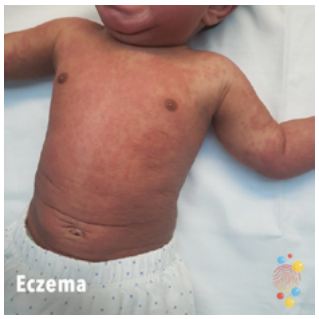
Eczema can affect anyone of any ethnicity and race. Eczema has a different appearance in skin of colour, so it can often be missed, or the severity of symptoms not clearly recognised.

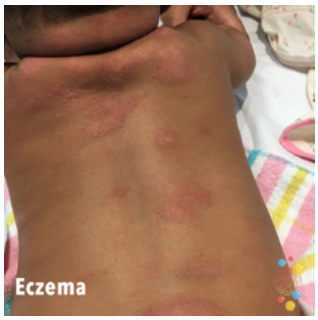
Skin of colour is a definition which includes individuals of racial groups with skin darker than Caucasians.

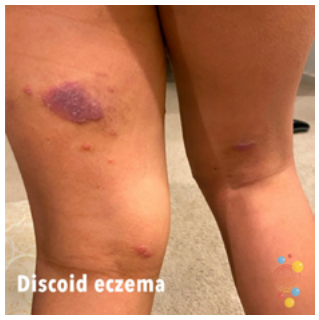
There are several studies which show eczema to be the most common skin complaint in people with skin of colour in the UK and USA[1]. Black children living in the USA or UK, are twice as likely as their counterparts to develop atopic eczema. In the UK, atopic eczema is more common in children who live in urban settings[2]. London-born Afro-Caribbean children prevalence of eczema is 16.3% compared with 8.7% for white children[3]. Discoid eczema is also more common in children with skin of colour. A study has shown that children with skin of colour are six times more likely to have severe eczema, compared with their white peers.

Redness (inflammation)





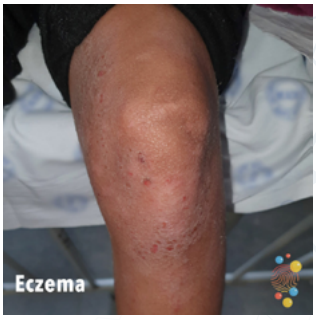


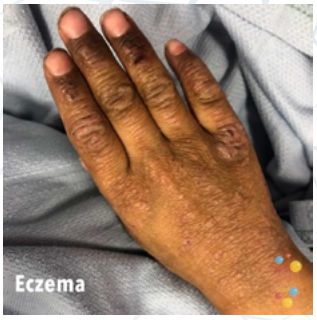


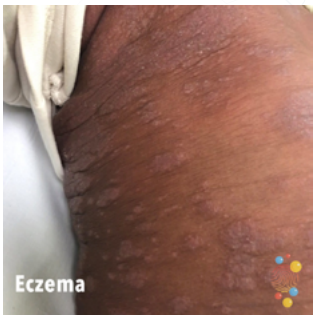
Redness (inflammation) is a key symptom of an eczema flare. Inflammation is often described as red, painful, tender and swollen skin – but the description of 'red' skin is not accurate in skin of colour. In skin of colour, inflammation is seen as red, red-brown, brown-red, grey, purple, violaceous or darker brown/black.

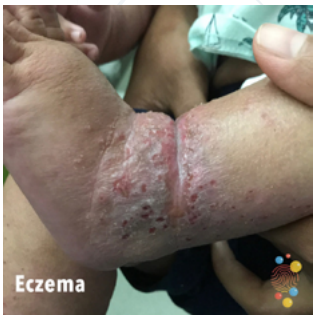
Hyperpigmentation

When skin is broken by constant scratching, melanin is released. This results in hyperpigmentation, seen as darker patches of skin, which is more pronounced in people with skin of colour (but can also be seen on white skin as grey patches).



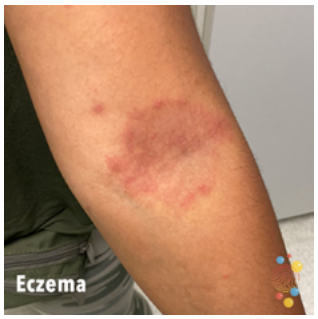


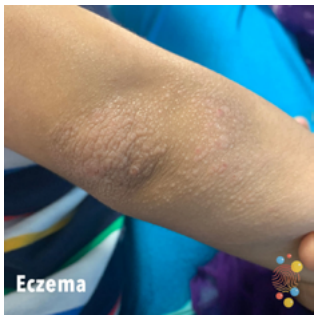




Flexures

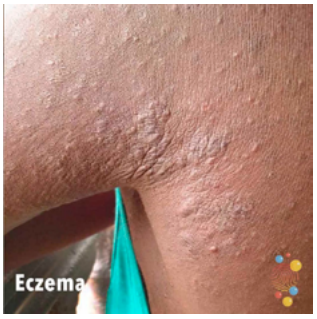
Eczema is often described as affecting fold of skin (flexures). In skin of colour, there is a unique pattern, which means that eczema can appear on the front of the knee or elbow or wrap around the flexure.





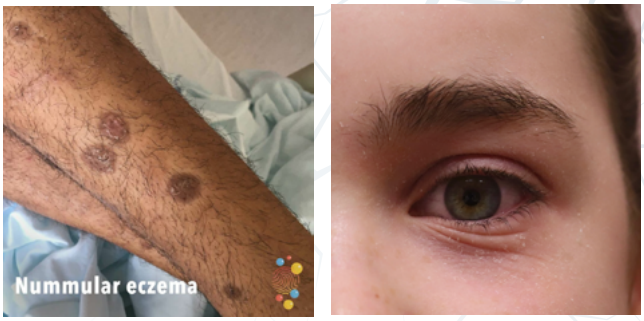
Follicular or papular eczema

The front and back (trunk) of the body can often have a bumpy appearance, called follicular or papular eczema. This can sometimes be more easily felt than seen, although itch will always be present.



Hyperpigmentation and hypopigmentaion

Hyperpigmentation or darker areas of skin, is commonly seen when eczema is flaring, but sometimes hypopigmentaion/lightening of skin can be seen. Dark circles can also be seen under the eyes, which is also a common sign of severe eczema and hyperpigmentation.



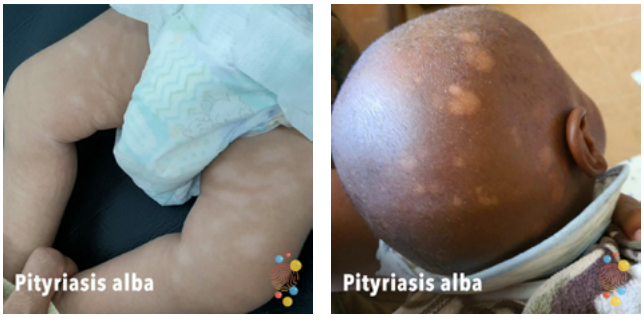
Hyperpigmented lesions

As the eczema flare settles, skin of colour generally becomes lighter, which can be very distressing. This is skin discolouration, called hypopigmentation, and is a response to settling eczema. This can last for months, after eczema has settled, and can be as distressing as active eczema.

Hypopigmented areas of skin

Pityriasis alba

There is a very mild form of atopic eczema, called pityriasis alba, which appears as small light patches. It is seen in children with white skin, but usually not as visible, as it is in children with skin of colour.



Differences in appearance of eczema between skin of colour and white skin

Skin of colour	White skin
Darker (hyperpigmented) skin, maybe red-brown, brown-black, grey or violaceous	Red skin
Eczema can be flexural or wrap around knees and elbows	Eczema always flexural (in folds, behind knees/elbows)
Follicular (popular eczema) on trunk	Patches of eczema on trunk
Dark /hyperpigmented circles under eyes	Dark circles under eyes
Post eczema flare, skin can be hyperpigmented/ discoloured	Little skin colour change, post eczema flare

It is very important that healthcare professionals understand the differences and appearance of eczema in skin of colour, and recognise eczema flares promptly, so prompt and correct treatment is prescribed.

Here are some useful websites:

National Eczema Society – Skin pigmentation and eczema

Don't forget the bubbles – Paediatric atopic eczemadiatric dermatology (including eczema)

Eczema in Skin of Colour (USA website)

Centre of Evidence-Based Dermatology – Skin of Colour resources

What guidelines do UK healthcare professionals follow to treat eczema?

These are the UK guidelines that healthcare professionals can use to inform the correct treatment of eczema:

NICE Atopic eczema in the under 12s: diagnosis and management

NICE Secondary bacterial infection of eczema and other common skin conditions: antimicrobial prescribing

PCDS Eczema -Paediatric atopic eczemadiatric (0-12 years) – Primary Care Treatment Pathway

PCDS Adult – Primary Care Treatment Pathway

SIGN (Scotland) – Management of atopic eczema in primary care

NHS111 (Wales) – Eczema (atopic)

NIDirect (Northern Ireland)

BAD Atopic Eczema Patient Information

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3. Williams H, Pembroke A, Forsdyke H, et al. (1995) 'London-born black Caribbean children are at increased risk of atopic dermatitis' Journal of the American Academy of Dermatology, 32 (2): 212-217

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Section 2: Treatment options

Written by Margaret Kelman, Specialist Allergy Nurse, Allergy UK

Emollient therapy

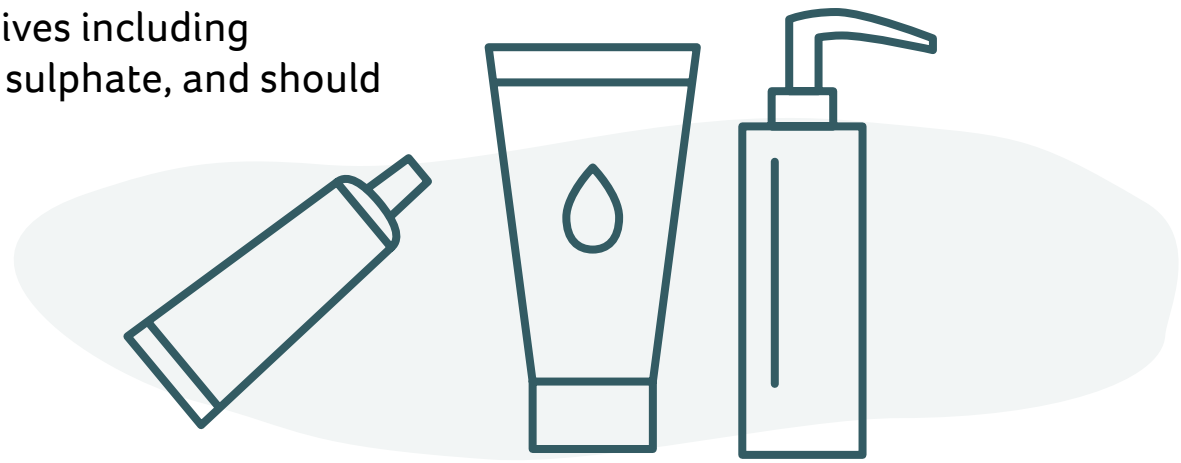
Emollients (or moisturisers) are the main stay of treatment for atopic eczema. They help soften the skin and relieve the itch caused by excessive dryness. Leave on emollients are designed to be left on the skin and used frequently on the whole body. They should be prescribed in large enough quantities that encourage regular liberal application.

Soap substitutes are just as important as the emollient, and most leave on emollients can additionally be used as soap substitutes for washing. Ordinary soap and non-medicated bathing products often contain irritants and allergens, such as fragrance and preservatives including sodium lauryl sulphate, and should be avoided.

Choice of emollient

Emollients are available in a wide range of different forms, including ointment, cream, gel and lotion based preparations. When choosing an emollient with your patient, consider the skin state, as well as taking into account lifestyle factors and personal choice. The best emollient is the one the patient prefers and will use regularly. Informed choice is crucial in the choice of emollient and adherence to any skin care regime.

The University of Bristol has developed a moisturiser decision aid to help guide the choice of emollient.



Identify any potential allergens and irritants

Eczema is multi-factorial, so there can be so many factors that can exacerbate eczema, that it can often be difficult to identify them all. Commons irritants and allergens include skin infection, the weather, sudden changes in temperature, stress, soaps and detergents, washing powders, bathing and shower products, perfumes and fragrance, clothing and fabric e.g coarse or non-breathable fibres, animal dander, house dust mite, pollens, mould and food.

Topical corticosteroids

Topical corticosteroids are recommended as the first line treatment for atopic eczema. They work by dampening down the immune response to reduce the symptoms of inflammation, itch and rash.

Topical corticosteroids are categorised according to potency mild, moderate, potent and very potent. The potency to be prescribed depends on the age of the individual, the severity of the eczema and the area to be treated. Mild to moderate potency topical corticosteriods are typically used where the skin is thinner, such as the face and genital areas. The more potent topical corticosteriods are used on the palms of the hand or soles of the feet, where the skin is much thicker.

NOTE: Patients and families often worry about the long-term effect of topical corticosteriod use. They will often use less than prescribed or not use them at all. Patient education around side effects, correct application (including fingertip measurement unit), how to step down topical corticosteriod treatment and importance of regular emollient therapy, is essential to support the correct application of topical corticosteriod adherence to therapy and improvement to the skin condition.

Weekend therapy - Patients with more persistent eczema may benefit from "weekend therapy". This is the use of a topical corticosteroid for two consecutive days (not necessarily Saturday/ Sunday), as a "maintenance" treatment. This therapy can be very effective for more chronic eczema or eczema which frequently flares. Weekend therapy must be used alongside regular emollient therapy.

Topical calcineurin inhibitors

Topical calcineurin inhibitors work by blocking the effects of key inflammatory chemical messengers, inhibiting proliferation of T cells and suppressing the production and release of inflammatory mediators. Topical calcineurin inhibiters are suitable for use in both children and adults. They are used for more difficult to treat eczema, to reduce steroids dependency or where topical steroids have not been tolerated. The main reported side effects are skin irritation and a burning sensation when first used, although this does settle with repeated application. Topical calcineurin inhibiters can make the skin more sensitive to sun light. Sun avoidance advice and a suitable sunscreen should be advised at the time of prescribing. They can be used as maintenance twice weekly.

NOTE: Topical calcineurin inhibiters should not be used on skin where there is suspicion or known infection, due to the risk of immune suppression with this medication.

Bandages, dressings and wet wraps (SIGN 2011)

Bandages and dressings provide a physical barrier and can be useful to manage persistent scratching of the skin that can cause further damage. It also improves retention of the emollient to aid healing (SIGN 2011).

Bandages: These can be dry to cover and keep in place other dressings, or can be impregnated with soothing ingredients including tar, ichthammol or zinc.

Occlusive and semi occlusive dressing: These can include vapour-permeable films and membranes and hydrocolloid dressings. Some dressings are impregnated with corticosteroids.

Wet wraps: A layer of bandages. The bottom layer is soaked in warm water, squeezed out and then put onto the skin over the topical preparation. The top layer is dry.

NOTE: Bandages / dressings should **not** be used on wet or infected eczema.

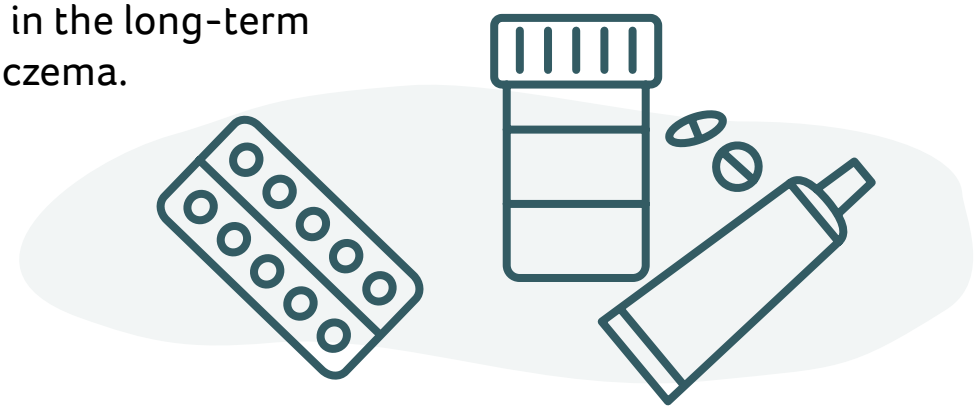
The potency of a topical corticosteroid will increase under occlusion e.g bandages and dressings, so a lower potency steroid should always be used when occluding an area of skin that requires topical corticosteroids.

Antihistamines

Oral antihistamines are not effective at controlling the itch of eczema. Sedating antihistamines are sometimes used for short periods, while initiating a treatment regime to aid deep sleep, which may help inhibit scratching during sleep. They are not usually useful in the long-term management of eczema.

Moderate to severe eczema

For the majority of individuals with atopic eczema, standard therapy with topical treatment will help alleviate symptoms. However, there are some individuals whose eczema symptoms cannot be controlled using standard topical therapy, or where the diagnosis of eczema is uncertain. These individuals will require referral to specialist dermatology departments for assessment, and may need to be managed with treatments that modify the immune system to gain symptom control. These treatments can include phototherapy, systemic immunosuppressive medication, such as cyclosporine or methotrexate. Also more recently biologic therapies, including Monoclonal Antibodies (MABs) and Janus Kinase (JAK) inhibiters, have been found to be very effective in the treatment of severe eczema.



Phototherapy

Phototherapy involves using UVB or UVA light waves to treat skin conditions, including eczema. It is suitable for children and adults. Phototherapy is managed within dermatology departments as a prescribed treatment. The length of the course will be determined by skin severity and ongoing assessment of improvement to the skin condition.

Some patients may experience a sunburn like reaction during a course of treatment, or the skin may become dry and itchy.

Systemic immunosuppressive treatments

Systemic immunosuppressive treatments, such as methotrexate and ciclosporin, are designed to suppress the immune system and reduce the inflammatory process. The action of these medications means that they are not selective i.e they have a suppressive effect on the whole immune system.

These treatments are usually started by specialists, however they require regular monitoring including blood testing, to reduce the risk of unwanted side effects.

Biologic therapies

Biologic therapies are usually offered as a fifth line treatment option, under specialist dermatology supervision (see NICE guidelines). They are offered for patients with moderate to severe atopic eczema, where standard systemic therapies such as cyclosporine of methotrexate, have failed to improve the symptoms or where systemic treatments are not suitable or contraindicated.

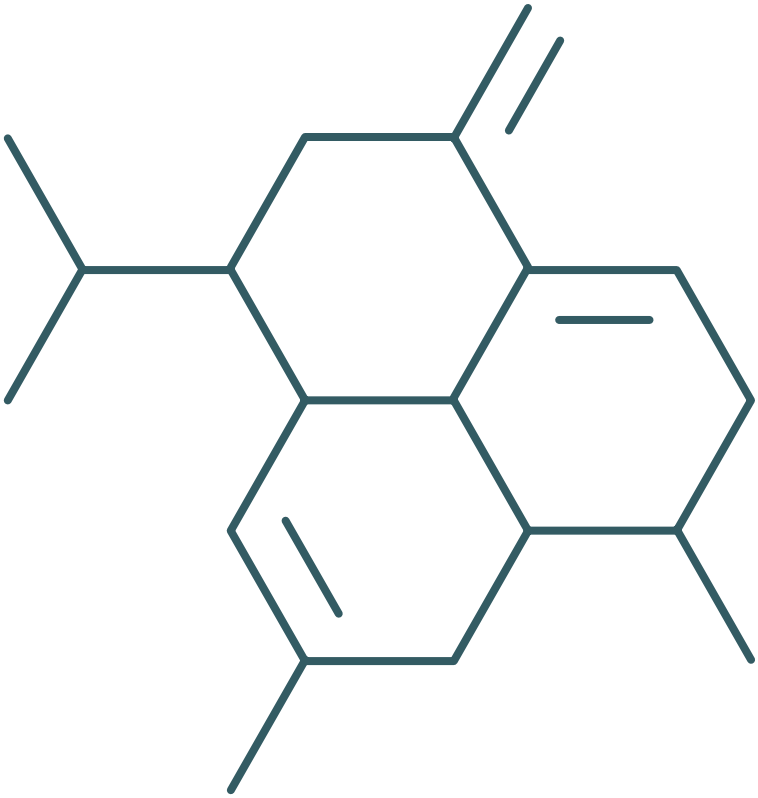
Monoclonal antibodies (MABs)

Monoclonal antibody therapies (MABs) work by blocking specific interleukins and therefore reducing the inflammatory process. Treatment is given by regular injection. Some monoclonal antibody therapies have also been shown to have a therapeutic impact on other atopic co morbidities, including atopic asthma. There are currently two available treatments approved for use by NICE in the UK. They are available within the NHS. One is licensed from age six plus, and the other licensed from age 12 plus for individuals with severe atopic eczema.

Janus kinase inhibiters or JAK inhibiters are designed to target specific areas of the immune system and block the chemical messengers that activate inflammation and itch in eczema. Two oral JAK 1 inhibiter medications have so far been approved for use within the UK for severe atopic dermatitis, with two JAK 1 inhibiters recently licensed for adults and adolescences aged 12 plus, with severe atopic eczema. There are other oral and topical JAK inhibiters in the development phase (phase III) that are not yet licensed.

The use of biologic therapies is closely monitored by the dermatologist and will usually be continued if there is an improvement in symptom severity or psychosocial reporting and no serious side effects. However, if there is no significant improvement after 16 weeks, as per NICE guidelines, then the biologic therapy will stop and different therapy will be sought.

It is important to note that any patient starting on biologic therapy will need long term monitoring. Clinicians must be vigilant and record and report any changes in a persons health status while they are taking the medication.



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Section 3: The psychological impact of eczema

Written by Polly Buchannan, Community Dermatology Nurse Specialist in NHS Fife, Chair of the Scottish Dermatological Nursing Society and Clinical Editor of the British Dermatological Nursing Groups journal, Dermatological Nursing.

Persons living with atopic eczema have to cope with a chronic inflammatory skin condition that is intensely itchy. Just to make things more difficult, atopic eczema may also be complicated with other atopic conditions such as asthma, hay fever, allergic rhinitis and other allergies. It is always complicated with the symptom of intense itch (pruritus) resulting in scratching behaviours, which can be problematic if the excoriated skin becomes infected. Living with atopic eczema and itch can have a profound effect on someone's life. The pathophysiological changes of atopic eczema and pruritus results in inflammation and scratching behaviours[1]. The psychosocial impact of living with a chronic skin condition, like atopic eczema, can be immense and affect every aspect of that person's life[2]. This chapter will seek to raise awareness of the psychosocial impact of living with atopic eczema, as well as provide insight into the interventions available to help individuals and families cope with living with this condition.

Psychosocial impact of atopic eczema

Atopic eczema is classically described as a chronic relapsing and remitting skin condition. The atopic eczematiology is both genetic and environmental[3] [4]. To date, there is no cure for eczema, so all support and management strategies are aimed at reducing the frequency and severity of flares, and reducing the complications associated with eczema. The two most salient complications being itch (pruritus) and secondary skin infection. Psychological morbidities, mainly anxiety and depression, are also more prevalent in persons living

with long term itchy skin[5]. Atopic eczema can impact on every aspect of a person's life, including relationships, hobbies, work and careers, as well as self-concept (body image and self-esteem). There are known triggers to atopic eczema flares, one of which is psychological stress. Stress and atopic eczema are linked[6 7]. Therefore, one must consider any stressors which may be involved in perpetuating flares of eczema. This psychosocial impact is vitally important to consider, alongside any medical management. Therefore, a bio-psycho-social approach is important to be able to ascertain how an individual and/or carers perceive the condition. This in turn, will help understand how to help them cope with the stressors of living with atopic eczema. It may be that coping and social support may not alleviate the effect of stress on an individual, however coping strategies might mediate the impact that stress has on symptoms felt by the individual[8].

Dealing with a health threat

When anyone is faced with a health threat, there are cognitive, emotional and behavioural responses (see appendix 1). This directly relates to how a person copes with the health threat. According to Leventhal's Common Sense Model of Self Regulation and Illness Behaviour[9], whenever one is faced with a health threat, one seeks to answer five key questions:

1. What is this health threat?
2. What is the cause?
3. What is the time span? How long will it last?
4. Is there a cure / can it be controlled?
5. What are the consequences for me?

Depending on the answers to these questions, emotional responses are elicited (eg sadness, worry, fear, anger, disgust, relief, anticipation, trust, joy, resolution). Emotional responses can be both positive and negative. The emotional response can then influence subsequent behaviours on how one copes with the health threat. A negative

emotional response can hopefully be identified and eventually become a positive behavioural response.

By applying this theoretical framework to atopic eczema, most people will understand the nature of atopic eczema, the cause, the time span and how it may be controlled. It is the final question that will be the issue for the psychosocial aspects of the condition and potential interventions: What are the consequences of atopic eczema for me? How is it impacting on my life? Utilising the Brief Illness Perception Questionnaire[10] can be useful in assessing the individual's perception of the atopic eczema as a long term skin condition (see appendix 2).

It is important to remember that atopic eczema is frequently diagnosed in infancy. Therefore, we must also consider a family centred approach in the psychosocial impact of disease. The parents will be the child's carer and advocate. The parents/carer perceptions of atopic eczema are important to understand in the management of a child with atopic eczema. As the child grows to adulthood, these cognitive, emotional and behavioural responses are important to consider, as the stressors may fluctuate as they cope with the condition.

Bio-Psycho-Social assessment

The biological assessment incorporates the usual medical assessment, which determines general health, the family history, severity, signs and symptoms, distribution, triggers, past and current medications, and allergies. This will give a good indication of what has worked in the past and what has not worked. It will also indicate the type of medical managements, which may be useful and place the individual on a recommended treatment pathway.

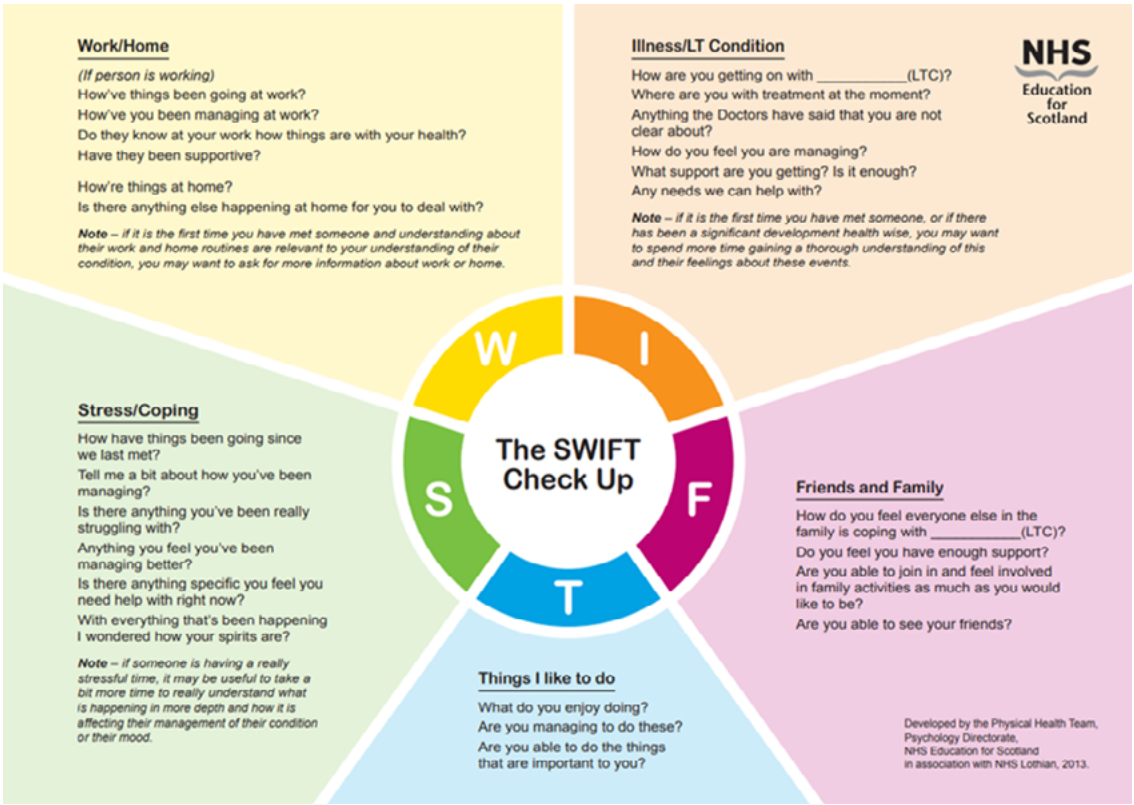
In screening for psychosocial impact, assessing Quality of Life, the Dermatology Life Quality Index (DLQI)[11] is the most frequently used tool in the UK, and is available in formats for children[12] and families[13]. Serial measurements using the DLQI, helps identify aspects of an individual's life which are being impacted upon in relation to the atopic eczema.

Two other useful screening tools are the General Anxiety Disorder (GAD7)[14] questionnaire and the Patient Health Questionnaire (PHQ9)[15], both of which are commonly utilised in General Practice to screen for anxiety and depression respectively.

One of the most useful tools to use for a more detailed psychosocial assessment is the SWIFT Check Up tool, developed by NHS Lothian and NHS Education Scotland to help assess important areas of functioning for persons living with long term conditions. Emotion Matters is an excellent training resource for healthcare professionals, which incorporates the SWIFT Check Up tool[16].

The tool encourages questions about the psychosocial aspects of a person's life, to be able to identify areas of functioning and need. By asking relevant open questions, one can determine how the atopic eczema is affecting the individual's life. This includes how their atopic eczema is triggered, the degree of stress experienced, level of social interaction, stress related to work experiences, school experiences, family and friend relationships. It also explores how much the atopic

The SWIFT Check Up Tool



eczema has interfered with social activities and sports. What support is at home, work and social circles? Only then can a discussion be had, as to how to help overcome any difficulties experienced. By discussing how people cope both emotionally and behaviourally with issues, negative and positive coping strategies can be identified. This in turn, can enhance the outcome of any medical interventions being offered. It may also improve the person's experiences in a healthcare system and improve their Quality of Life and mental well-being.

Psychosocial interventions

Every health professional can enhance their communication skills to help others with the psychosocial impact of atopic eczema. Some of the most useful psychosocial intervention techniques available include:

Communication skills

Active listening[17] is the most important skill of all communication and a prerequisite to any psychosocial interventions. Actively listening is more than just hearing what someone is saying. It involves really focussing on what is being said and feeding back that you have heard and understood. This is usually done by reflecting on what has been said, summarising and paraphrasing. Non-verbal body language, such as eye contact and 'nodding' also indicate that you are focussed and listening.

Active listening goes hand in hand with other strategies, such as Walk and Talk and Touch and Talk techniques,[18] which is becoming popular and now offered by some healthcare professionals, seeking to allow individuals to express their feelings. In dermatology, touch has always been a vital non-verbal communication technique utilised. Giving an individual time to talk about their concerns, be able to prioritise issues and consider options available is an important problem solving approach[19]. This can be very effective in facilitating plans of action for an individual or families.

Motivational interviewing techniques

In order to be successful in communication, active listening and problem solving, consider using motivational interviewing techniques[20]. Motivational interviewing techniques are being used more frequently to help people cope with long term health conditions. Learning modules are available online within NHS resources. It involves three main approaches: leading, guiding and following, then adapting the approach in consultations to encourage self-care. This can be useful in enhancing concordance and behaviour change in eczema management.

Distraction techniques can be very useful for children who are very distressed with itch and scratching, such as video clips, cartoons, music and songs. Saying 'stop scratching' will not work and only serves to increase tensions, which often results in a battle of wits and power. Cuddles, games and laughter and distraction activities are very useful. Distraction can also work very well for adults using mindfulness techniques, relaxation and visualisation techniques.

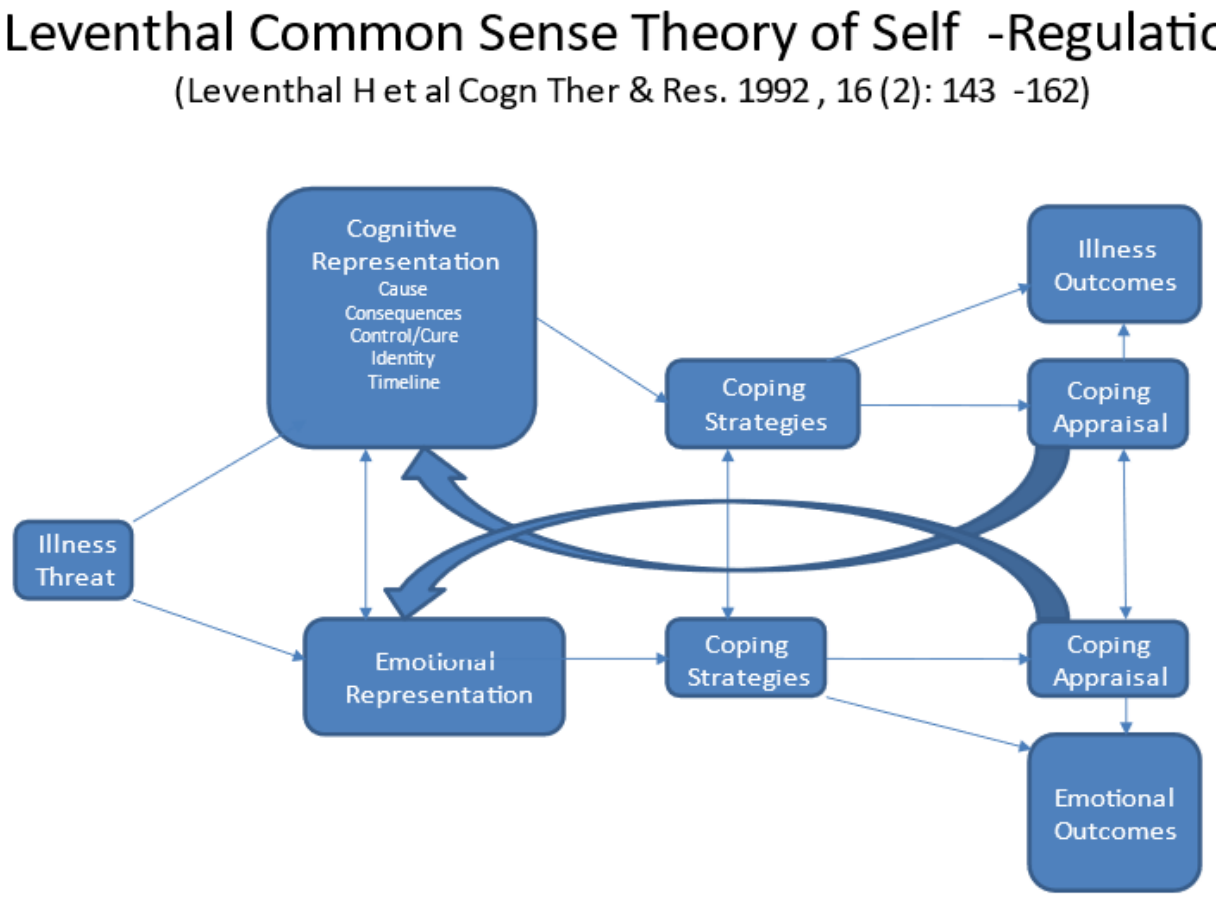
Habit Reversal[21] and Capacitar Self Care techniques[22]

Other strategies are also available with further training, such as Habit Reversal[21] and Capacitar Self Care techniques[22].

Habit reversal is particularly useful in reducing the damage caused to skin by scratching behaviours. It comprises of an awareness programme to identify scratching behaviours and 'at risk' times, as well as adopting an alternative behaviour to scratching such as patting, pinching, rubbing itchy skin or squeezing a 'squidgy' object or ball.

Capacitar techniques are non-interventional healing and self-care techniques, developed by Capacitar International. They are particularly useful for dealing with stress and anxiety, and use various techniques such as tai chi movements, emotional freedom tapping, head holds, finger holds and visualisation. Capacitar Training opportunities are available from Capacitar UK and many of the techniques are available to view on YouTube.

Appendix 1


Leventhal Common Sense Theory of Self -Regulation
(Leventhal H et al Cogn Ther & Res. 1992 , 16 (2): 143 -162)
Cognitive Representation
Cause
Consequences
Control/Cure
Identity
Timeline
Illness Outcomes
Coping Strategies
Coping Appraisal
Illness Threat
Emotional Representation
Coping Strategies
Coping Appraisal
Emotional Outcomes

Appendix 2

Brief Illness Perception Questionnaire Broadbent et al. (2006)

- How much does your condition affect your life?
- How long do you think your condition will continue?
- How much control do you feel you have over your condition?
- How much do you think your treatment can help your condition?

Brief IPQ (continued)

- How much do you experience symptoms form your condition?
- How concerned are you about your condition?
- How well do you feel you understand your condition?
- How much does your condition affect you emotionally?

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Support groups and resources for patients

Local and national support groups are invaluable in helping people cope with a long-term skin condition such as atopic eczema. As health professionals, we should be aware of key support groups including:

National Eczema Society

Eczema Outreach Support

Allergy UK - Eczema

The British Dermatology Association's Skin Support

Eczema care online

University of Bristol Eczema Resources

Itchy sneezy wheezy

The support and information provided by patient organisations can be an added source of information and comfort for families and individuals.

Useful resources for healthcare professionals

- National Eczema Society – Skin pigmentation and eczema
- Don't forget the bubbles – Paediatric atopic eczemadiatric dermatology (including eczema)
- Eczema in Skin of Colour (USA website)
- Centre of Evidence-Based Dermatology – Skin of Colour resources
- Eczema written action plan EWAP
- University of Bristol Eczema Resources
- Primary Care Dermatology Society
- British Association of Dermatologists
- British Society for Adolescent and Paediatric Dermatology
- Eczema Care Online

Assessment tools:

- EASI for clinical signs
- Poem – Patient Orientated Eczema Measure
- SCORAD – SCORing Atopic Dermatitis
- Children's Life Quality Index (CLQI) – cartoon version
- Dermatology Life Quality index (DLQI)
- NICE holistic assessment tool

We're here to help

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Webchat: allergyuk.org
Email: info@allergyuk.org

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Skin deep is working to improve the diversity of skin images online

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