Guidelines for the management of eczema in children under 12 years

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**Definition:**
Eczema (atopic eczema/dermatitis) is the commonest inflammatory condition of the skin, characterised by itching, diffuse redness and dry skin, as well as sometimes oozing, crusting, scaling, skin thickening and changes in skin pigmentation (not all of these symptoms will necessarily occur together). Images can be viewed on the Primary Care Dermatology Society website.

**Assessment**
Diagnose and assess the physical severity of eczema. Remember to consider the impact on quality of life and psychological wellbeing of the child and family when choosing treatment options (the CDLQI – children’s DLQI) can be used if necessary. The following descriptors can be used as a guide:

<table>
<thead>
<tr>
<th>Physical severity of disease</th>
<th>Impact on quality of life and psychological well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLEAR - Normal skin, no evidence of active atopic eczema</td>
<td>NONE – no impact</td>
</tr>
<tr>
<td>MILD - Areas of dry skin, infrequent itching (with or without small areas of redness)</td>
<td>MILD – little impact on everyday activities, sleep and psychosocial wellbeing</td>
</tr>
<tr>
<td>MODERATE - Areas of dry skin, frequent itching, redness (with or without excoriation and localised skin thickening)</td>
<td>MODERATE – moderate impact on everyday activities and psychosocial wellbeing, frequently disturbed sleep</td>
</tr>
<tr>
<td>SEVERE - Widespread areas of dry skin, incessant itching, redness (with or without excoriation, extensive skin thickening, bleeding, oozing, cracking and alteration of pigmentation)</td>
<td>SEVERE – severe limitation on everyday activities and psychosocial functioning, nightly loss of sleep</td>
</tr>
</tbody>
</table>

**Treatment recommendations**

- Treat according to the recommendations in the flow charts and/or formulary that follow. Hyperlinks to the eczema NICE pathway are provided in the flowcharts. Remember that patient education on preventative measures and on how to use treatments effectively is crucial in the management of eczema (see appendices 1 and 2 for supporting information and links to external websites). Provide an information leaflet (click on hyperlink or access via EMISweb) and signpost to patient support groups (see appendix 2) as useful resources to reinforce key messages.

- Various factors may play an important role as ‘triggers’ of eczema. NICE recommends identifying and managing suspected triggers. Patients are advised to avoid suspected/identified triggers, such as:
  - irritants (soaps/detergents, wool or synthetic clothing, chemical products, perspiration) – use emollients as a soap substitute
  - contact allergens
  - food/dietary factors: suspect in those who have reacted previously to a food with immediate symptoms, or in infants and young children with moderate or severe atopic eczema not optimally managed – particularly when associated with gut dysmotility or failure to thrive. See separate NICE recommendations and Cow’s Milk Protein Allergy guidelines
  - inhalant allergens particularly in those with seasonal flares, asthma, allergic rhinitis, atopic eczema on the face over the age of 3;
  - climate and environmental factors (e.g. extremes of temperature/humidity, air pollution, tobacco smoke, sun-/ultraviolet-light);
  - microbial colonisation/infection; concurrent illness and disruption to family life.
Guidelines for the management of eczema in children under 12 years

Treatment of TRUNK and LIMBS

Emollients
Use regularly even when skin is clear. Use as soap substitute also. Offer a range of emollients. Most effective emollient is the one the patient will use. Please refer to Emollient prescribing guidelines for further detail including choices. Educate patient on regular use of emollients to prevent flares.

Treatment Options:
(1) Mild potency steroid - Hydrocortisone 1% cream or ointment applied once daily
(2) Moderate potency steroid - Clobetasone butyrate 0.05% ointment /cream applied once daily

Reinforce key messages on safe use of topical corticosteroids

Patient presents with mild disease
Check for infection

Consider twice weekly use of mild to moderate potency steroid to previously affected skin to prevent flares

Improvement

Treatment Options:
(1) Moderate potency steroid - Clobetasone butyrate 0.05% cream or ointment once daily or if needed:
(2) Potent steroid – Betamethasone valerate 0.1% cream/ointment once daily
(3) Potent steroid - Mometasone Furoate 0.1% cream or ointment once daily

Avoid potent steroids in children <12 months old

NB: Only use for 7-14 days on vulnerable sites e.g. axillae/groin

Review & reinforce key messages on safe use of topical corticosteroids

No improvement:
Check triggers. Treat infection

No improvement:
Check triggers. Treat infection

Treatment Options:
(1) Potent steroid - Betamethasone valerate 0.1% cream/ointment once daily
(2) Potent steroid - Mometasone Furoate 0.1% cream or ointment applied once daily

Avoid use of potent steroids in children <12 months old

NB: Only use for 7-14 days on vulnerable sites e.g. axillae/groin

Review after 7-14 days and reinforce key messages on safe use of topical corticosteroids

Patient presents with moderate disease
Check for infection

Patient presents with moderate disease
Check for infection

Patient presents with severe disease
Check for infection

Consider twice weekly use of moderate potency steroid to previously affected skin to prevent flares

See TCI algorithm

Consider twice weekly use of potent steroid to previously affected skin to prevent flares

See TCI algorithm

Consider referral using checklist

Improvement

No improvement:
Check triggers. Treat infection

Unable to reduce daily topical steroids
See TCI algorithm

No improvement:
Check triggers. Treat infection

No improvement:
Check triggers. Treat infection

Patient presents with severe disease
Check for infection

Consider referral using checklist

Always educate patient on use of product
Refer to most recent BNF / BNFc or the Summary of Product Characteristics for up-to-date prescribing information

Phototherapy
Step down to twice weekly application to normal skin to prevent flares

Bandages and dressings
‘wet wrap technique’

Topical calcineurin inhibitors (TCI)
Pimecrolimus 1% cream or Tacrolimus ointment 0.03%. Apply twice daily (see TCI algorithm)

Consider twice weekly use of mild to moderate potency steroid to previously affected skin to prevent flares

See TCI algorithm

Improve

Refer to specialist

Systemic therapy

Refer queries to: lamccg.medicinesoptimisation@nhs.net or 0203 049 4197 (Lambeth). souccg.medicines-optimisation@nhs.net or 0207 525 3253 (Southwark).
Treatment of FACE and NECK

Emollients
Use regularly even when skin is clear. Use as soap substitute also. Most effective emollient is the one the patient will use. Please refer to Emollient prescribing guidelines for further detail including choices. Educate patient on regular use of emollients to prevent flares.

Patient presents with mild disease
Treatment Options:
Mild potency steroid - Hydrocortisone 1% ointment applied once daily
Encourage use of sunscreens
Consider TCIs if needing ongoing mild corticosteroids

In older children consider twice weekly use of mild - moderate potency steroid to normal skin to prevent flares; review within 3 months, consider need for TCIs

Patient presents with moderate or severe disease
Treatment Options:
Moderate potency steroid - Clobetasone butyrate 0.05% ointment applied once daily
Review after 5 days; Reinforce key messages on safe use of topical corticosteroids.

No improvement: Check triggers. Treat infection

Potent corticosteroids
Systemic therapy
Phototherapy

Step down to twice weekly application

Always educate patient on use of product
Refer to most recent BNF / BNFc or the Summary of Product Characteristics for up-to-date prescribing information

Consider referral using checklist

No improvement: Check triggers. Treat infection

No improvement: Check triggers. Treat infection

Potency corticosteroids

Topical calcineurin inhibitors (TCIs) (9)
Pimecrolimus cream 1% (Licence: for mild to moderate eczema from 2 years of age) or Tacrolimus 0.03% ointment (Licence: moderate - severe eczema, 2-16 years) Apply twice daily
Encourage use of sunscreens
Consider use in those requiring long-term or frequent use of mild or moderate topical corticosteroid or whose eczema is not well controlled by corticosteroids (>4 flares/year)
(see TCI algorithm (9))
Guidelines for the management of eczema in children under 12 years

TCI Algorithm
The place of topical calcineurin inhibitors in the management of atopic eczema in children and young people

Diagnosis of moderate – severe eczema
Emollients plus appropriate potency corticosteroids

Steroid related concerns:
- concerns about atrophy,
- lesions on eyelids/ocular side effects, other side effects

Topical steroid failure in absence of infection:
- No or inadequate response after 5 days of moderate potency steroids (face) or after 14 days of potent steroids (trunk, limbs, body flexures)

Review and treat active infection. Exclude cold sores nearby

Consider Topical calcineurin inhibitors (TCIs)
- Pimecrolimus cream 1% ( Licence: for mild to moderate eczema from 2 years of age) or Tacrolimus 0.03% ointment (License: moderate-severe eczema, 2-16 years or 0.1% Licence: >16 years)
  - Apply 15-30 minutes before or after emollients; may cause tingling after application.
  - Do NOT use under occlusive dressings.
  - Advise use of sunscreens.

TCIs should be initiated (2nd line) by practitioners experienced/confident in using them, following the use of moderate topical corticosteroids.
Refer to specialist for further advice/management.

Flares: Treat infection;
- Initiate twice-daily Topical calcineurin inhibitors therapy for up to three weeks (children); this may cause tingling initially.
- Add appropriate strength topical corticosteroids once daily if needed

Maintenance: (>4 flares per year): initiate twice-weekly therapy (Leave 2-3 days between applications eg Monday and Thursdays)

Review need for treatment: reduce to once daily after 3 weeks in children. If no improvement is seen after two weeks, consider other treatment options.

Stop therapy after 12 months and review need for ongoing treatment

Refer to secondary care if:
- Diagnostic concerns
- GP not confident to prescribe TCIs
- Inadequate response
- Recalcitrant infection
- Psychosocial issues

Acknowledgement: This document was developed by clinicians of NHS Lambeth CCG, NHS Southwark CCG, Departments of Dermatology and Pharmacy GSTFT & KCH
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## Guidelines for the management of eczema in children under 12 years

### TOPICAL INFECTIONS FORMULARY

<table>
<thead>
<tr>
<th>INFECTION TYPE</th>
<th>TREATMENT</th>
<th>DURATION</th>
</tr>
</thead>
</table>
| Topical/localised infections    | Flexures: Hydrocortisone 1% and Fusidic acid (Fucidin H*) cream (mild potency steroid)  
| -                              | Trunk / limbs: Betamethasone valerate 0.1% and Fusidic acid (Fucibet*) cream (potent steroid)  
| -                              | Face / neck: Hydrocortisone 1% and Fusidic acid (Fucidin H*) cream or ointment (mild potency steroid)  
| -                              | Timodine® cream (mild potency steroid)  
| -                              | For severe infection unresponsive to topical and oral treatment seek specialist advice. | Maximum of 2 weeks               |
| Systemic treatment of Staphylococcus aureus and streptococcal infections | 1st LINE TREATMENT  
| -                              | Flucloxacillin (oral) (usually for 7 days)  
| -                              | Eg. refer to latest BNFc / BNF for dose and available formulations | 1st line - Clarithromycin twice daily (oral) for 7 days  
| -                              | 2nd line – Erythromycin four times daily (oral) for 7 days  
| -                              | Eg. refer to latest BNFc / BNF for dose and available formulations | Refer to latest BNFc / BNF for treatment duration |
| Adjunct therapy (at appropriate dilutions) to decrease bacterial load in cases of recurrent infected atopic eczema – swab nose and axillae for culture (swab family members also if positive for Staphylococcus aureus and recurrent despite treatment) Consider referral to specialist if recurrent infection despite optimising topical therapy | Dermol® cream  
| -                              | Eczmol® cream (lotion)  
| -                              | Dermol 500® lotion  
| -                              | Dermol 600® bath emollient with antimicrobial  
| -                              | Treat nasal carriage with Naseptin four times daily application to each nostril for 7 days  
| -                              | (contains peanut oil) OR Mupirocin nasal ointment twice daily in each nostril for 7 days | Avoid long-term use |

### Herpes Infection: If a child with atopic eczema has a lesion on the skin suspected to be herpes simplex virus, an emergency referral to a dermatologist or paediatrician for same-day/next-day review should be arranged by telephone where there is clinical suspicion of eczema herpeticum.

### Signs of eczema herpeticum:
- areas of rapidly worsening, painful eczema
- clustered blisters consistent with early-stage cold sores
- punched-out erosions (circular, depressed, ulcerated lesions) usually 1 – 3 mm that are uniform in appearance (these may coalesce to form larger areas of erosion with crusting)
- possible fever, lethargy or distress
APPENDIX 1 Safe use of topical corticosteroids and Finger Tip Unit (FTU) Guide

Continuous use of topical corticosteroids may result in permanent skin damage and other adverse effects, causing:

- irreversible skin atrophy and striae
- psoriasis to become unstable
- systemic side effects when applied continuously to extensive psoriasis (for example more than 10% of body surface area affected).

It is important that patients and their families / carers are educated on the risks of overuse of topical corticosteroids and discuss how to avoid them:

- Very potent topical corticosteroids should not be used continuously at any site for longer than 4 weeks
- Potent topical corticosteroids should not be used continuously at any site for longer than 8 weeks
- Do not use very potent corticosteroids in children and young people
- A break of at least 4 weeks should be observed between courses of topical corticosteroid
- Offer an annual review to assess for adverse effects in (1) children using any topical corticosteroids on a regular basis and (2) for adults using potent or very potent topical corticosteroids either as short courses or intermittent use.

Topical corticosteroids should always be used for the least amount of time necessary to control symptoms, and should be applied thinly, avoiding normal skin. The quantity to be applied is specified by the amount of cream/ointment squeezed out of the tube nozzle in a line from the tip of an adult finger to the crease of the first joint (~2.5cm); equivalent to 0.5g of cream/ointment. As a guide, one Finger Tip Unit is enough to cover the palms of both hands. Various areas of the skin may be affected differently – ensure that potency of treatment is tailored according to the severity of each affected part.

Number of fingertip dosage units recommended for a single application are listed below (this guide indicates how much is required to cover the entire area specified. Smaller areas will need correspondingly lower amounts of cream/ointment). [NB the patient.co.uk patient information leaflet repeats this information]

<table>
<thead>
<tr>
<th>Age</th>
<th>Face &amp; neck</th>
<th>Arm &amp; hand</th>
<th>Leg &amp; foot</th>
<th>Trunk (front)</th>
<th>Trunk (back) including buttocks</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-6 mths</td>
<td>1</td>
<td>1</td>
<td>1.5</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>1-2 yrs</td>
<td>1.5</td>
<td>1.5</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3-5 yrs</td>
<td>1.5</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>6-10 yrs</td>
<td>2</td>
<td>2.5</td>
<td>4.5</td>
<td>3.5</td>
<td>5</td>
</tr>
<tr>
<td>Adults</td>
<td>2.5</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Table to show number of adult finger tip units (FTU) per body parts for children and adults

Quantities to be applied once daily to control symptoms

Corticosteroid formulations

- Always apply thinly in accordance with finger tip unit guide
- Apply once daily
- Topical corticosteroid treatment for flares should be started as soon as signs and symptoms appear
- Continue for +/- 48 hours after symptoms subside. Always check for and reinforce avoidance of trigger factors (e.g. soap)
- Ointment preparations are always to be preferred when available, use cream if ointment is unacceptable to the patient
- They can be applied twice weekly to prevent flares but if they are needed daily to prevent flares, consider topical calcineurin inhibitors (see TCI algorithm). Twice weekly use to prevent flares must be monitored and appropriate

Prescribing and dispensing: best practice recommendations

- When prescribing or dispensing topical corticosteroids, the potency of the preparation should be specified on the prescription and the dispensing label. This aids both patient and healthcare professional education and also medicines reconciliation processes when patient care is transferred to another setting

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### APPENDIX 2: Recommended Corticosteroids Products

<table>
<thead>
<tr>
<th>POTENCY</th>
<th>RECOMMENDED PRODUCTS (formulary approved) once daily</th>
<th>COST (BNF 69, DT May 15)</th>
<th>COST / gram</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MILD CORTICOSTEROID</td>
<td>Hydrocortisone 1% cream and ointment</td>
<td>30g (Cream) = £2.30</td>
<td>8p</td>
<td>Not to be prescribed as Hydrocortisone butyrate 0.1% (Locoid) which is a potent steroid. As recommended by the BNF for children, topical corticosteroids may be prescribed children under 1 year. For mild to moderate eczema, flexural or facioll eczema Hydrocortisone 1% is listed as an appropriate topical corticosteroid to use.</td>
</tr>
<tr>
<td>MODERATE CORTICOSTEROID</td>
<td>Clobetasone Butyrate 0.05% (Eumovate) cream or ointment</td>
<td>100g = £5.44</td>
<td>5p</td>
<td>Prescribe Clobetasone butyrate in preference to Hydrocortisone 2.5% Cream/Ointment (lower acquisition cost of clobetasone)</td>
</tr>
<tr>
<td>POTENT CORTICOSTEROID</td>
<td>1st Line – Betamethasone valerate 0.1% (Betenovate) Ointment</td>
<td>100g = £9.60</td>
<td>10p</td>
<td>No robust trial evidence for preferring one over the other, therefore prescribe product with the lowest acquisition cost first. Clinical experience suggests some patients prefer mometasone, finding it more effective either in terms of speed of response or reduced frequency of application; therefore consider a trial of it. Mometasone may sting on initial application. It can be used twice weekly, with review within 3-6 months, to prevent flares</td>
</tr>
<tr>
<td></td>
<td>2nd Line - Mometasone Furoate 0.1% (Elocon) Ointment</td>
<td>100g = £12.44</td>
<td>12p</td>
<td></td>
</tr>
<tr>
<td>Avoid prescribing these items if possible</td>
<td>Betamethasone RD (0.025%)</td>
<td>100g = £3.15</td>
<td>3p</td>
<td>NB: This is a steroid of moderate potency, readily confused with betamethasone 0.1% (Betenovate) which is a potent steroid</td>
</tr>
<tr>
<td></td>
<td>Hydrocortisone butyrate 0.1% (Locoid*)</td>
<td>100g = £4.93</td>
<td>5p</td>
<td>NB: This is a potent steroid</td>
</tr>
<tr>
<td></td>
<td>Fluocinolone 0.025% (Synalar*)</td>
<td>100g = £11.75</td>
<td>12p</td>
<td>NB: Synalar is a potent steroid. Caution with strength if prescribed generically. Higher acquisition cost than Betnovate</td>
</tr>
<tr>
<td></td>
<td>Avoid Hydrocortisone 2.5% cream or ointment</td>
<td>30g (Cream) = £48.14</td>
<td>160p</td>
<td>NB: High acquisition cost. Prescribe clobetasone butyrate 0.05% in preference</td>
</tr>
</tbody>
</table>

Educate patient on use of product
Refer to most recent BNF / BNFc or the Summary of Product Characteristics for up-to-date prescribing information and alternatives if supply issues are experienced

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APPENDIX 3 - Further supporting clinical information

- **Emollients** - Please refer to the Emollients prescribing guidelines for full information and recommended products.
- **Application of more than one topical preparation** - When applying more than one topical formulation to the affected part(s) (e.g. emollient and topical corticosteroid), do not mix the preparations – this can lead to altered properties of the formulations, which could impact on the efficacy of the preparations. Rather, allow several minutes between applications of different formulations.1,7
- **Systemic therapy for urticaria / severe itching**:
  - Sedating antihistamines: Trial for 7 – 14 days in:
    - Children aged 6 months or over during acute flares, if sleep disturbance has a significant impact on the child or parents or carers. This can be repeated during subsequent flares if successful
    - If longer duration treatment required, ensure topical therapy has been optimised. NB: Do not routinely use oral antihistamines in the management of atopic eczema in children
      - 1st line: **Hydroxyzine** (no younger than 6 months) NB: Maximum dose daily dose is 2 mg per kg body weight for children up to 40 kg in weight (39). Do not co-prescribe with drugs that prolong QT interval (e.g. erythromycin and clarithromycin)
      - 2nd line: **Chlorphenamine** or refer to BNFC/BNF
  - Non-sedating antihistamines: Trial for 1 month in:
    - children with severe atopic eczema
    - children with mild or moderate atopic eczema where there is severe itching or urticaria/dermographism
    - children with co-existent allergic rhinitis, asthma or food sensitivity
    - If successful, continue treatment while symptoms persist. Review 3 monthly. NB: Do not routinely use oral antihistamines in the management of atopic eczema in children
      - 1st line: **Loratadine** (from age 2 years and above; see BNFC/BNF)
      - 2nd line: **Cetirizine** (from age 1 year and above; see BNFC/BNF; see Paediatric Formulary)
- **Topical calcineurin inhibitors** - only to be used by practitioners experienced/confident in use, following use of moderate topical corticosteroids. Do NOT use under occlusive dressings. Do NOT use if skin is infected. Refer to specialist for further advice/management.
- **Paste bandages or ‘wet wrap’ garments** – only to be used in patients with non-infected moderate to severe eczema, where an adequate trial of corticosteroids alone or topical calcineurin inhibitors has not adequately controlled the eczema. Parents will require instruction on how to safely apply and use paste bandages or wet wrap garments. A referral should be considered if these interventions do not then adequately control eczema.
- **Patient Education** – GSTFT provide an eczema education programme for Lambeth patients. The Southwark Community dermatology service provides a programme for Southwark patients. Specialist nurses support is also available in the specialist Paediatric Dermatology clinics at KCH

<table>
<thead>
<tr>
<th>Web-links for healthcare professionals:</th>
<th>Web-links for patient information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICE eczema pathway</td>
<td>British Association of Dermatologists (with links to NES and other patient materials)</td>
</tr>
<tr>
<td>Map of Medicine (select ‘patient’ option when viewing content)</td>
<td>NHS Choices</td>
</tr>
<tr>
<td>Primary Care Dermatology Society (PCDS)</td>
<td>National Eczema Society (NES)</td>
</tr>
<tr>
<td>British Association of Dermatologists (BAD)</td>
<td><a href="http://www.patient.co.uk">www.patient.co.uk</a></td>
</tr>
<tr>
<td>Clinical Knowledge Summaries from NICE</td>
<td></td>
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