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**Diagnosis/Definition:**

Atopic dermatitis (atopic eczema) is a chronically relapsing inflammatory disease of the skin characterized by intense itching and a dry, erythematous scaly rash. Atopic dermatitis tends to occur in individuals with a personal or family history of atopy (allergic rhinitis, atopic dermatitis, asthma, and/or urticaria).

The dry, erythematous, scaly plaques of atopic dermatitis preferentially involve face, scalp, trunk, and extensor surfaces in infants. The characteristic sites in older children and adults are antecubital and popliteal fossae and posterior neck. Some older children and adults may have clearing of flexural areas but develop chronic hand dermatitis or hand and foot dermatitis. The eruption may involve other areas of skin and be quite extensive. Excoriations and thickened (lichenified) skin, indicative of scratching, are commonly seen. Particularly in persons with naturally dark sin, the skin may be noticeably hyperpigmented in areas that have been inflamed.

Atopic dermatitis frequently first appears in infancy or early childhood. For many individuals, atopic dermatitis gradually improves during childhood, but there is a lifelong tendency to have sensitive skin.

**Initial Diagnosis and Management:**

Atopic dermatitis is primarily a clinical diagnosis based on a constellation of findings. Skin biopsy is not diagnostic and is generally not indicated in the primary care setting. The differential diagnosis is large and includes, for example, other forms of dermatitis such as allergic contact, irritant contact, dry skin, nummular, and seborrheic dermatitis, papulosquamous conditions such as psoriasis, lichen planus, pityriasis rosea, mycosis fungoides, and polymorphous light eruption; and infections such as scabies and dermatophytosis (tinea).

Patients should be informed that atopic dermatitis is treatable, and, if the patient is a child, there is a good chance of significant improvement as the child grows older. They should also be informed that the condition is a chronic one and that treatment requires effort.

For most patients, the single most important part of therapy is good hydration and lubrication of the skin. The patient may be given the written dry skin care instructions, available in English and Spanish. Following the instructions on the dry skin handout will help the atopic dermatitis. Briefly, the principles are getting water into the skin through taking a short 10 minute lukewarm bath without soap, then getting out of the tub and immediately applying a barrier to evaporation of water while the skin is still moist. In general, the greasier the preparation is, the better barrier to evaporation of water. In areas of skin that are quite dry, petroleum jelly, Aquaphor, or Eucerin cream may be excellent choices. In areas of skin where dryness is relatively mild, a lubricating lotion such as Lubriderm or Eucerin lotion may be sufficient. Daily baths are beneficial if they are done properly. If bath is taken and the barrier to evaporation is not put on, the bath may be counterproductive.

Frequent hand washing is the initiating factor for many cases of dermatitis involving the hands. If frequent hand washing is unavoidable, a mild soap such as Dove should be used, and heavy lubricant such as petroleum jelly or Eucerin cream should be applied to the hands after each washing and prn dryness.

For mild atopic dermatitis or atopic dermatitis in a child, topical steroid therapy with a low potency ointment is appropriate. For adults, a medium or high potency ointment may be chosen for initial therapy. Medium or high potency preparations should not be used on the face, groin, axillae, or breasts. In those locations, low potency steroids should be chosen. [Formulary examples are desonide 0.05% ointment (low potency). Triamcinolone ointment (medium potency), and fluocinolide 0.05% ointment (high potency).]

In general, ointments are preferred over creams. Compared with creams, ointments are superior at trapping moisture in the skin and also delivering medication into the skin. In addition, ointments do not require preservatives but creams do. Thus, there is one less additive in the preparation that may irritate or cause contact dermatitis. Creams are sometimes preferred on the face for cosmetic reasons. In some cases heat retention is a problem if ointments are applied over large areas of the skin, and creams may be preferred in that situation as well.

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**Initial Diagnosis and Management:**

Ointments are applied once to twice daily. Applications more frequent than twice daily are not necessary for ointment-based steroids. It is best for one of the applications to be used immediately after bath. The medication penetrates into the skin better when the skin is moist, and therefore the medication will be more effective. The steroid ointment may be used as the barrier to evaporation on the areas where the skin is broken out, and the non-medicated lubricant can be used on the normal-appearing skin.

Oral antihistamines such as hydroxyzine may decrease scratching substantially. It is advisable not only to warn the patient about drowsiness, but to document that you have done so.

If the lesions are crusted, that is often a sign of Staph infection. A short course of oral antibiotics to cover Staph may be very useful in these cases. Other adjunctive measures include keeping fingernails short and wearing non-irritating clothing such as soft cotton.

Except possibly in rare cases, food allergy has no demonstratable role in atopic dermatitis.

Systemic steroids are almost never indicated in the treatment of chronic atopic dermatitis and are generally best avoided even with acute atopic dermatitis. Although some physicians do use systemic steroids for flares, there are problems (in addition to the usual concern about steroid side effects) associated with their use. First, the case of taking a pill provides a disincentive to do doing what is more effective in the long run and also much safer – that is, hydration of the skin followed by application of a topical steroid and emollient. Second, it is not unusual to have a rebound flare following the discontinuation of the systemic steroid, and the rebound flare may be severe.

**Ongoing Management and Objectives:**

Dry skin plays a large role in exacerbations of atopic dermatitis. Patients should be strongly encouraged to continue good hydration and lubrication of the skin and to minimize the use of soap.

Topical steroids may be used chronically for eczema, but patients should be monitored for side effects if they are receiving more than a low potency steroid. Systemic side effects almost never occur, particularly in the adult patient, but local side effects are not unusual. Local side effects are more likely to occur in the face, groin, axillae, and breasts, when medium or higher potency topical steroids are used. The avoidance of such steroids on these areas will minimize the risk. Local side effects include atrophy, which may manifest as fine wrinkling, telangiectasia, and stretch marks, and on the face there may be rebound redness and rosacea.

**Indications for Specialty Care Referral:**

In cases where the diagnosis is not clear, referral to dermatology for diagnostic evaluation is appropriate.
If continued treatment for 2 to 3 months has not helped substantially, referral should be considered.
If the atopic dermatitis is severe, referral to dermatology for initial care and management is reasonable.

| Test(s) to Prepare for Consult: | Test(s) Consultant May Need To Do: |
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**Criteria for Return to Primary Care:**

Atopic dermatitis is stabilized on standard therapy and the long-term treatment plan has been reviewed.

**Revision History: Created Revised**