Government of **Western Australia**
South Metropolitan Health Service
Fiona Stanley Fremantle Hospitals Group

Dermatology pre-referral guidelines – eczema (atopic dermatitis)

Fiona Stanley Hospital Dermatology

Disclaimer

These guidelines have been produced to guide clinical decision making for general practitioners (GPs). They are not strict protocols. Clinical common-sense should be applied at all times. These clinical guidelines should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient. Clinicians should also consider the local skill level available and their local area policies before following any guideline.

Introduction

Eczema (atopic dermatitis) is a very common skin condition that often begins in infancy or early childhood. Most affected children develop eczema before the age of two years, and it usually improves by the age of eight. There is often no single trigger for an eczema flare. The environmental conditions (especially humidity and allergens in the air) play a major role.

There are other causes of dermatitis eg irritant contact dermatitis or allergic contact dermatitis that might look like atopic dermatitis but often has a different history.

Food allergy is more common in children with eczema who also have a family history of allergic disease. Managing eczema well in infants may reduce their chance of developing food allergy. Allergy testing is not routinely recommended for children with eczema and food elimination diets are also not routinely recommended. Skin prick testing and food challenges are usually only helpful in severe cases of eczema where there is a clinical history of allergic reaction, and in this situation, a referral to Immunology is required.

Pre-referral management

For paediatric eczema refer to:

- Eczema in children - Clinician Assist WA
- Managing eczema in children: A guide for clinicians

The following suggestions are not prescriptive but are a guide for short term use.

GP review is advised after two weeks to assess the child's response to treatment.

Severity	Scalp	Face	Body/limbs
Very mild	Soap free shampoo +/- Hydrocortisone 1% cream twice daily	Hydrocortisone 1% ointment twice daily	Hydrocortisone 1% ointment twice daily
Mild	Methylprednisolone aceponate 0.1% lotion or desonide 0.05% lotion once daily	Methylprednisolone aceponate 0.1% fatty ointment once daily	Methylprednisolone aceponate 0.1% fatty ointment once daily
Moderate	Methylprednisolone aceponate 0.1% lotion or Mometasone furoate 0.1% lotion once daily	Methylprednisolone aceponate 0.1% fatty ointment once daily	Mometasone furoate 0.1% ointment once daily

Severe	Mometasone furoate 0.1% lotion once daily	Methylprednisolone aceponate 0.1% fatty ointment once daily	Betamethasone dipropionate 0.05% ointment once daily
Hydrocortisone: all ages[1], **Methylprednisolone aceponate:** ≥ 4 months[1], **Desonide / Mometasone furoate:** ≥ 1 month[1], **Betamethasone dipropionate:** ≥4 months[2]			

- Skin swabs for bacterial or viral infections if weepy or eroded areas.
- Swabs of potential staphylococcal aureus carriage sites should be considered in patients with recurrent episodes of infected eczema or skin infection. Suggested swab sites are nose, throat, axilla and wound. Refer to ChAMP Monographs and Guidelines for Staphylococcus aureus decolonisation-paediatric.

Common reasons for suboptimal management:

- Inadequate strength, amount and formulation of topical corticosteroid prescribed.
- Determined by child's age, eczema severity and affected site(s).
- Wrong base of topical steroid - creams will sting open skin, but ointments are too greasy for older patients and hair bearing areas and can cause miliaria if used in very hot environments.
- Secondary infection of skin may be present and not treated.
- Advising corticosteroid use for a certain number of days rather than using daily until the eczema has completely cleared i.e. skin feels smooth and itch has resolved.
- Failure to provide streamlined authority scripts for increased/adequate quantities of topical steroids or patients taking scripts to a non-PBS pharmacy (so being charged per tube, which becomes very expensive).
- If treatment is ceased before the skin has returned to normal, it is more likely to flare again quickly.
- Severe disease requiring escalation of treatment.
- Alternative diagnosis, eg tinea, contact allergy.

When to refer

- Uncontrolled moderate or severe eczema that may require light treatment, systemic therapy (eg eczema that never clears) or admission.
- Already on optimal treatment with a topical corticosteroid of moderate to high potency and not responding as expected.
- Persistent or frequent facial eczema requiring frequent use of topical corticosteroid.
- Recurrent episodes of infected eczema.
- Patients with erythroderma (>80% skin involvement).
- Patients with eczema requiring frequent courses of oral steroids for control.

- Infants with eczema and other features such as diarrhoea, hair loss, failure to thrive or recurrent infections – could indicate an immune deficiency.
- Any patient with eczema or significant concern to the parent or GP that does not meet the above criteria.

Refer to Immunology Department if:

- There is clear history of skin rashes after a particular food exposure.
- If your concern relates to a suspected food allergy.

It is important to remember that eczema is a chronic disease characterised by intermittent flares. If a patient is able to control the flare with topical steroids the fact that they flare from time to time is not sufficient to warrant referral to a tertiary hospital.

Essential information to include in your referral

- Severity and duration of eczema.
- Type of treatment used in the past (response and side effects) and currently being used.
- If the patient has failed to respond to optimal first-line treatment.

References

1. Australian Medicines Handbook Children's Dosing Companion Online [internet] Australia: Australian Medicines Handbook Pty. Ltd.; 2022.
2. Weston, Stephanie (Consultant Dermatologist), Expert Opinion, Perth Children's Hospital, February 2022.

Useful resources

- Eczema- ED Guideline
- Managing eczema in children: A guide for clinicians
- Australian College of Dermatologists Consensus Statement Topical Corticosteroids in Paediatric Eczema
- Clinician Assist WA
- Staphylococcus aureus Decolonisation - ChAMP Guideline
- Staphylococcus aureus treatment - Health Fact sheet
- Atopic dermatitis skin of colour clinician toolkit

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Compiled: Department, Fiona Stanley Fremantle Hospitals Group, May 2025, Review: May 2028