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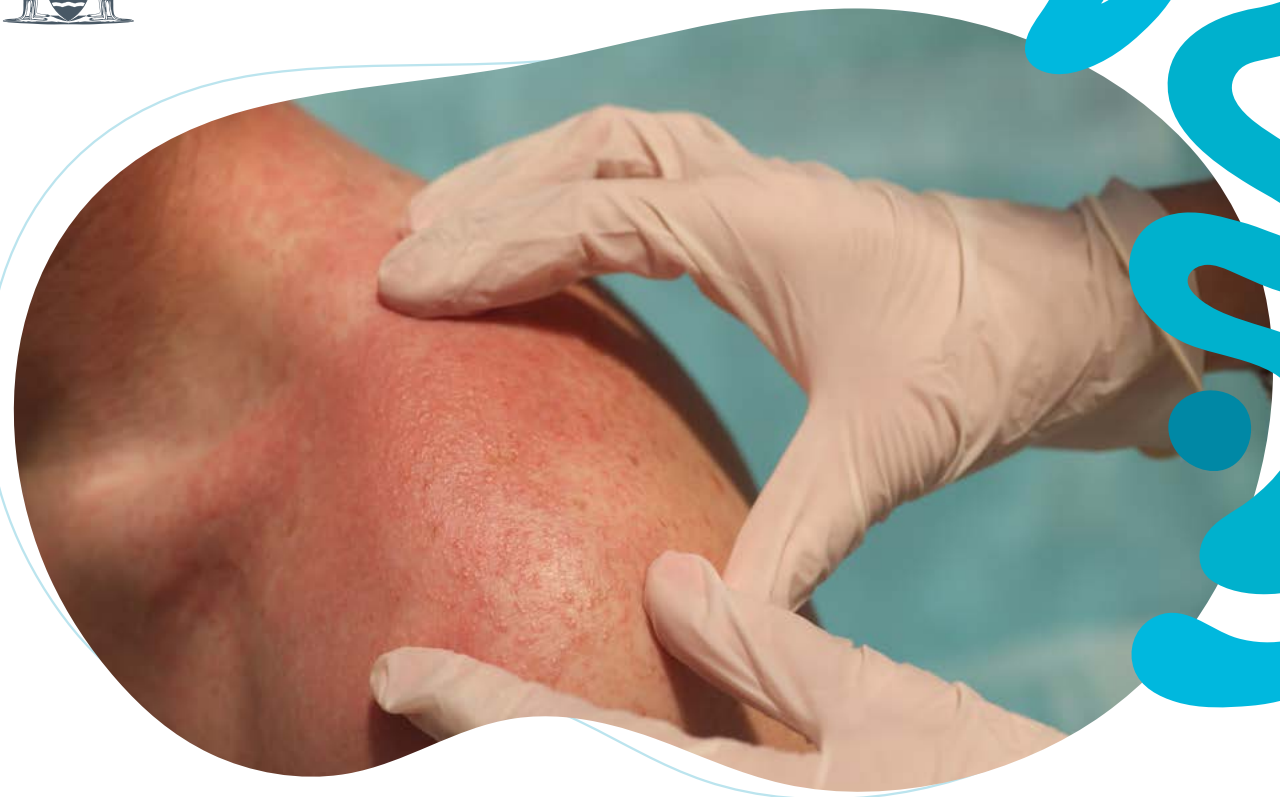

# Enhanced Access Community Pharmacy Pilot

## Mild to moderate atopic dermatitis

## Clinical practice guideline

**Service restricted to patients aged 6 months or over.**

Ineligibility for treatment as part of a prescribing service does not preclude a patient from accessing services provided as part of usual pharmacy care.

The information and content in this clinical practice guideline do not constitute medical advice, diagnosis, or treatment recommendations for individual patients. Pharmacists must exercise professional discretion and judgement consistent with their qualifications and legislative authority. This guideline does not override the responsibility of the pharmacist to undertake clinical assessments and to make decisions appropriate to the circumstances of the individual and the relevant standards of care, in consultation with the patient and/or their parent/caregiver. This clinical practice guideline may only be used by pharmacists who have been approved by the Department of Health to participate in the Enhanced Access Community Pharmacy Pilot (EACPP) and are authorised to prescribe under the *Medicines and Poisons Regulations 2016* (WA). This document alone does not provide an authorisation for a pharmacist to prescribe.

## Contents

# Guideline overview

## Meet service and professional obligations

- Initial patient eligibility and suitability for management within the scope of the service
- Patient informed consent (including consent for communication with other health practitioners if relevant)

## Patient history and assessment

- Patient history
- Examination:
  - clinical features and severity
  - assessment (see Appendix 1 for template)

## Develop management plan

- Eczema action plan
- Non-pharmacological measures
- Pharmacotherapy:
  - topical treatments

## Confirm management is appropriate

- Contraindications, precautions, and interactions
- Pregnancy and lactation

## Communicate agreed management plan

- Medication counselling
- General advice and patient information
- When to seek further care and/or treatment
- Communication with other health practitioners

## Clinical review

- Response to treatment
- Continue, modify, or stop treatment
- Communication with other health practitioners

## Refer when

- The patient is aged below 6 months (does not preclude a patient from accessing usual pharmacy care)
- Unclear diagnosis
- Widespread rash with painful skin
- Raised purple rash that doesn't blanch
- > 90 per cent skin involvement (urgent referral)
- Blistering of skin and mucous membranes
- Systemic signs or symptoms
- Chronic sores or ulcers
- Severe symptoms (SCORing Atopic Dermatitis (SCORAD)) score > 51 or Eczema Area and Severity Index (EASI) score > 21.1
- Child with a history of immediate or delayed-type hypersensitivity to food, poor feeding or sleep, concerns about failure to thrive
- The patient presents with eczema herpeticum or cellulitis
- Inadequate response to optimal treatment.

## Treat and concurrently refer

- > 30 per cent skin involvement
- The patient is planning a pregnancy, is, or could be pregnant
- The patient is immunocompromised or has diabetes
- Quality of life is significantly affected.

## Key points

- Both pruritus and a rash must be present for a diagnosis of atopic dermatitis (AD)[1].
- AD imposes a significant financial, psychological, and social burden on the lives of patients and their families, and is associated with poor sleep, depression, anxiety, poor self-esteem, and reduced quality of life[2, 3].
- Secondary bacterial infection is a common complication of AD e.g. secondary impetigo or cellulitis[4]. If impetigo is present, it can be treated by the pharmacist as per the WA Enhanced Access Community Pharmacy Pilot Clinical Practice Guideline for Impetigo. If cellulitis is present the patient should be referred to an appropriate healthcare provider.
- Patients with AD are more likely to have an immediate or family history of atopic conditions e.g. allergic rhinitis and asthma[5].
- The mainstay of treatment for active AD is topical corticosteroids (TCS) in combination with emollients, identification and avoidance of triggers, and the early treatment of infection[6].

## Refer when

Refer the patient to an appropriate healthcare provider (including emergency services if required) in the following situations:

- the patient is aged below 6 months (does not preclude a patient from accessing usual pharmacy care)
- unclear diagnosis
- widespread rash with painful skin
- raised purple rash that doesn't blanch
- > 90 per cent skin involvement (urgent referral)
- blistering of skin and mucous membranes (including mouth and eyes)
- systemic signs or symptoms, including fever, lethargy, nausea, vomiting, headache
- chronic sores or ulcers
- severe symptoms (SCORAD score > 51 or EASI score > 21.1)
- child with a history of immediate or delayed-type hypersensitivity to food, poor feeding or sleep, concerns about failure to thrive
- presentations with eczema herpeticum or cellulitis
- inadequate response to optimal treatment.

## Treat (if clinically appropriate) and concurrently refer

Provide initial treatment and concurrently refer to an appropriate healthcare provider in the following situations:

- > 30 per cent skin involvement
- the patient is planning a pregnancy, is, or could be pregnant
- the patient is immunocompromised or has diabetes
- quality of life is significantly affected.

# Patient history and assessment

AD is usually diagnosed clinically, based on patient history and physical findings[7, 8].

## Patient history

Obtain sufficient information from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- weight
- pregnancy and lactation status (if applicable)
- onset, duration, nature, location, severity and extent of patches and plaques, including recent or previous relapses or flare ups
- response to any previous treatment/s
- impacts on quality of life and psychosocial wellbeing including sleep and learning
- dietary history and changes in diet
- underlying and associated medical conditions including asthma, allergic rhinitis, allergic conjunctivitis, allergic contact dermatitis, food allergy, and depression
- exposure to potential triggers or irritants
- other factors including family history, environmental factors (e.g. exposure to smoking and airborne pollution) and infectious factors
- current and recently ceased treatments (including prescribed medicines, vitamins, herbs, other supplements, and over-the-counter medicines)
- drug allergies/adverse drug reactions.

A comprehensive assessment template to assist with patient history is provided at Appendix 1.

### Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies, and current medical conditions.

## Examination

### Clinical features

- AD is characterised by dry, scaly erythematous patches with the primary hallmark being itch[9]. While AD can affect any area of skin, patches typically occur on the:
  - face
  - inside of the elbow/arm and back of the knee (cubital and popliteal fossae)
  - wrists and ankles.
- For a diagnosis of AD to be made, both signs of itching and a rash must be present[7].
- Further information on clinical features is available from the Therapeutic Guidelines: Dermatology (Atopic dermatitis)[10] and Dermnet NZ: Guidelines for the diagnosis and assessment of eczema[11].
- The skin signs of AD may vary depending on age and ethnicity[7, 12].
- People with AD are at higher risk of allergic contact reactions (e.g. nickel is a common contact allergen) and are prone to other viral skin infections (e.g. common warts and molluscum contagiosum)[4].
- For patients without an existing diagnosis of AD, other conditions with similar clinical features, symptoms and presentations that may be considered are outlined in Dermnet NZ: Guidelines for the diagnosis and assessment of eczema[11].

### Severity

For the purposes of the service, the SCORing Atopic Dermatitis (SCORAD) index[5] or the Eczema Area and Severity Index (EASI)[5] can be used to assess the severity of the AD to determine whether the patient requires referral, to inform the treatment plan and to monitor treatment effectiveness:

- mild AD is indicated by a score of < 25 (SCORAD) or < 7 (EASI)
- moderate AD is indicated by a score 25 to 50 (SCORAD) or 7.1 to 21 (EASI)
- severe AD is indicated by a score > 50 (SCORAD) or > 21.1 (EASI)[2, 13].

Conventional scoring systems may underestimate AD severity and erythema in people with darker skin tones[8]. Consider the skin tone when assessing erythema and where there is uncertainty, severity can be assessed by using the EASI and upgrading the score by one grade or more for heavily pigmented skin (e.g. from mild to moderate)[5, 13].

## Complications of AD

- Secondary bacterial infections (impetiginisation) are the most common complication of AD[4, 12]:
  - treatment of concurrent infection is important for successful management of active AD[6, 10]
  - suspected impetigo can be assessed and treated as per the WA Enhanced Access Community Pharmacy Pilot Clinical Practice Guideline for Impetigo or referred to an appropriate healthcare provider
  - suspected cellulitis must be referred to an appropriate health care provider.
- Eczema herpeticum is an infection of the AD with herpes simplex virus (HSV)[4, 12]:
  - vesicles usually develop in areas of active or recent AD, followed by the onset of high fever and adenopathy[4]
  - painful corneal lesions will develop if the eye is involved and if the HSV infection becomes systemic, it may be fatal[4]
  - refer to an appropriate healthcare provider if eczema herpeticum is suspected.

# Develop management plan

**Pharmacists must ensure that they are prescribing medicines according to the specified sections of the current online version of the Therapeutic Guidelines.**

Pharmacist management of mild to moderate AD involves:

- **development of an Eczema Action Plan:**
  - based on the Australasian Society of Clinical Immunology and Allergy (ASCIA) Action Plan for Eczema template[14]
- **non-pharmacological measures:**
  - advice regarding skin care and minimising aggravating factors as per the Therapeutic Guidelines: Dermatology (Atopic dermatitis)[10] and the Australian Medicines Handbook: Eczema[15]
- **pharmacotherapy [NB1]:**
  - a topical treatment for the management of mild to moderate atopic dermatitis in accordance with the Therapeutic Guidelines: Dermatology (Atopic dermatitis)[10].

**NB1:** Very potent TCS (class IV), and potent TCS (class III containing betamethasone dipropionate 0.05 per cent, betamethasone valerate 0.1 per cent, methylprednisolone aceponate 0.1 per cent, or mometasone furoate 0.1 per cent) should not be used for children aged 12 months or younger[15].

**Additional information for consideration**

- Selecting the correct potency and formulation of TCS is important to avoid both undertreatment and fears around TCS use[16]. Pharmacists should consult:
  - the Therapeutic Guidelines: Dermatology (Considerations in the use of topical corticosteroids)[9]
  - the Australian Medicines Handbook: Corticosteroids (skin)[15]
  - the Australasian College of Dermatologists:
    - Consensus statement: Management of atopic dermatitis in adults[1]
    - Consensus statement: Topical corticosteroids in paediatric eczema[6]
  - other sources e.g. Australian Journal of General Practice: Selection of an effective topical corticosteroid[16].
- Therapeutic regimens for AD can be expensive and complicated, making long-term compliance difficult and leading to poor outcomes. Choice of treatment should consider the impact of factors such as age, socioeconomic status, cost and literacy on the patient's ability to adhere to prescribed therapies[4].

# Confirm management is appropriate

Consult the *Therapeutic Guidelines, Australian Medicines Handbook* and other resources to confirm that management is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

# Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) should be provided to the patient regarding:

- individual product and medicine use (e.g. application instructions for emollients, topical treatments, and wet dressing use)
- non-pharmacological measures
- how to manage adverse effects
- when to seek further care and/or treatment, including recognising secondary infection
- when to return for follow-up.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients (and/or parents/caregivers if applicable), and to ensure compliance with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

## General advice

At the time of initial consultation, patients (and/or parents/caregivers if applicable) should be advised to see an appropriate healthcare provider if:

- signs or symptoms worsen
- new signs or symptoms occur (including systemic signs or symptoms)
- there is inadequate improvement of symptoms within 1 to 2 weeks
- symptoms recur within 2 to 4 weeks of initial resolution
- stable, long-term control of the condition is not achieved
- ongoing impairment is present e.g. pruritus, pain, loss of sleep, learning difficulties
- quality of life is significantly affected.

Treatment may be unsuccessful when there is poor adherence with therapy, skin infection, allergy, or severe dermatitis[4, 8, 15].

Common adverse effects of TCS, such as transient burning, stinging or pain on application, can generally be reversed by stopping the medicine. Refer to an appropriate healthcare provider when adverse effects cannot be managed in the pharmacy setting.

When recommending TCS for AD, pharmacists should reassure patients (and/or parents/caregivers) who have concerns about the safety of TCS that they are safe when used appropriately[6].

Patients (and/or parents/caregivers) should be counselled on the role of emollients in both the management of AD, and the ongoing maintenance of remission after the flare is clear and TCS treatment is ceased[10]. Advice regarding skin care and minimising aggravating factors should be reiterated[10].

# Clinical review

Clinical review with the pharmacist (or the patient's chosen healthcare provider) should occur in line with recommendations in the Therapeutic Guidelines.

Patients should return for a follow up consultation 7 to 14 days after initiation of a new therapy and/or changes to the treatment plan. Clinical review should consider:

- response to treatment (using the SCORAD index or EASI)
- if changes are required to the treatment plan. Decisions to continue, modify or stop treatment should be reflected in the patient's eczema action plan.

If a good response has been achieved, the medication can be stopped, and the patient can continue using regular emollients to maintain remission[9]. If there has been an inadequate response, the pharmacist should check the patient's compliance with the medication and skin care measures, ensuring enough medication is applied[9].

For patients continuing therapy, follow-up should be individualised to the patient's clinical presentation, response to treatment, and therapeutic goals.

Pharmacists should prescribe a quantity of medicine (including repeats) that aligns with the expected duration of therapy, ensuring sufficient supply until the patient's next review. The total quantity prescribed should not exceed 12 months supply (including repeats).

## Patient resources

- HealthyWA: Eczema (atopic dermatitis)
- Eczema Association Australasia: Managing Eczema
- American Academy of Dermatology Association: Eczema Resource Centre
- Therapeutic Guidelines: Dermatology (Atopic dermatitis - How to apply a wet dressing) and (Atopic dermatitis - How to use the soak and smear technique)

## Pharmacist resources

- Clinician Assist WA:
  - Dermatitis in Adults
  - Eczema in Children
- Therapeutic Guidelines: Dermatology
  - Atopic dermatitis
  - Application and quantity of topical corticosteroids
- Australian Medicines Handbook:
  - Drugs for Eczema
    - General principles: topical treatment of skin conditions
    - Corticosteroids (skin)
    - Topical steroids – how much do I use?
- Pharmaceutical Society of Australia: Australian Pharmaceutical Formulary and Handbook (APF) Treatment guideline for pharmacists (Dermatitis)
- DermNet NZ:
  - Atopic dermatitis
  - Atopic dermatitis (images)
  - Guidelines for the diagnosis and assessment of eczema
  - Fingertip unit
  - Eczema area and severity index (EASI score)
  - SCORAD
- SCORAD calculators:
  - MDApp SCORing Atopic Dermatitis (SCORAD)
  - SCORing Atopic Dermatitis Calculator
- MSD Manual (Professional version): Atopic dermatitis (Eczema)
- Australian Journal of General Practice: Selection of an effective topical steroid
- Australasian Society of Clinical Immunology and Allergy: Action Plan for Eczema
- The Australasian College of Dermatologists:
  - Consensus Statement: Management of atopic dermatitis in adults
  - Consensus Statement: Topical corticosteroids in paediatric eczema
  - A-Z of skin – Atopic dermatitis
  - Taking care of skin: How to recognise and respond to health issues in Aboriginal and Torres Strait Islander Health Peoples (an online course/teaching resource for Aboriginal Health Workers)
- Skin Deep: An open-access bank of high-quality photographs of medical conditions in a wide range of skin tones for use by both healthcare professionals and the public.
- Cardiff University: The Children's Dermatology Life Quality Index (CDLQI)
- University of Nottingham: Patient-Orientated Eczema Measure (POEM)

# Appendix 1 – Assessment template

**Atopic Dermatitis Assessment Template**[17]

**Identification of triggers:**

- irritants
  - soaps and detergents
  - abrasive clothing
  - chlorinated swimming pools
  - emollients containing sodium lauryl sulphate.
- skin infections
  - Staphylococcus aureus
  - Streptococcus pyogenes
  - HSV (eczema herpeticum)
  - molluscum contagiosum.
- contact allergens
- stress
- food and inhalant triggers [NB1].

**Assessment of current and previous treatments:**

- bathing/showering frequency and temperature
- use of soap, soap-free cleansers, shampoos, and/or bath additives
- emollient/moisturiser use, application frequency, and quantity applied
- topical corticosteroids (TCS) use, types, sites of application, and quantity applied [NB2]
- adverse reaction to topical agents e.g. stinging
- antihistamine and antibiotic use.

**Impact of eczema [NB3]:**

- psychosocial impact
- frequency of skin infections
- frequency of days off employment, school/activities, learning
- sleep.

**NB1**: AD is associated with an increased risk of immediate or delayed-type hypersensitivity reactions to food proteins. However, food allergies are more likely to cause urticaria than dermatitis. Modified diets have little benefit. Irritation around the mouth from food is not a food allergy. Applying a greasy barrier to the face and hands prior to eating irritant foods can protect skin and minimise irritation[9].

**NB2**: Underuse of TCS is a common cause of previous treatment failure.

**NB3**: Formal measures may be used e.g. The Children's Dermatology Life Quality Index (CDLQI)[18] or Patient-Orientated Eczema Measure (POEM)[19].

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