NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Centre for Clinical Practice – Surveillance Programme

Clinical guideline

CG57: Atopic Eczema in children. Management of atopic eczema in children from birth to the age of 12 years.

Publication date

December 2007

Surveillance report for GE

January 2014

Key findings

			Potential impact on guidance	
			Yes	**No**
Evidence from evidence update				✓
Feedback from Guideline Development Group Chair				✓
Anti-discrimination and equalities considerations				✓
No update	Rapid update	Standard update	Transfer to static list	Change review cycle
✓				

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Surveillance review of CG57: Atopic Eczema in children. Management of atopic eczema in children from birth to the age of 12 years

Background information

Guideline issue date: 2007
4 year review: 2011 (no update)
NCC: NCC Women's and Children's Health

Main conclusions from previous surveillance review

1. CG57 previously underwent a surveillance review in 2011 when the review recommendation was that the guideline should not be considered for an update. Through the 2011 surveillance review stakeholders and the GDG felt that the evidence regarding emollients including: their lack of effectiveness, potential for microbial contamination during use and the potential for harms of aqueous creams may warrant future consideration if the evidence base becomes more established.

Current six year surveillance review

2. A literature search for systematic reviews was carried out between October 2010 (the end of the search period for the last review) and October 2013 and relevant abstracts were assessed. Clinical feedback on the guideline was obtained from three members of the GDG through a questionnaire.

3. No new evidence that may impact on recommendations was identified relating to any of the clinical areas within the guideline.

4. The majority of the GDG felt that CG57 Atopic Eczema does not require an update and that there is no evidence that would change the current recommendations.

5. The GDG chair indicated that they thought the scope of the guideline to be extended to include children and young people up to 19 years and for prevention of atopic eczema to be included. The 6 year process does not allow for areas outside the original guideline scope to be considered. Hence these areas will be considered at the 8 year review.

On-going Research

6. The ChildRen with Eczema Antibiotic Management study (CREAM) is a 3-arm, double-blind RCT which aims to determine the clinical and cost effectiveness of the most commonly used oral and topical antibiotics (in addition to topical corticosteroids) in the management of suspected infected atopic eczema in children. This study is due to complete in 2015.

Anti-discrimination and equalities considerations

7. None identified

Implications for other NICE programmes

8. None identified

Conclusion

9. Through the surveillance review of CG57, no new evidence which may potentially change the direction of guideline recommendations was identified.

Surveillance recommendation

10. GE is asked to consider the proposal to not update the guideline at this time. GE are asked to note that as a 6 year surveillance review this 'no to update' proposal will not be consulted on.

Mark Baker – Centre Director
Sarah Willett – Associate Director
Katy Harrison– Technical Analyst

Appendix- Decision Matrix

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
Diagnostic criteria and classification of severity			
57-01: What criteria should be used to diagnose atopic eczema in children and how do they vary between ethnic groups?			
4-year review (2011) No new evidence was identified	No relevant evidence identified.	None given	No relevant evidence identified
57-02: What measures should be used to classify the severity of atopic eczema in children in the setting of clinical management?			
4-year review (2011) A study related to CADIS, found that this measure had adequate test-retest reliability, concurrent validity, and discriminative validity. A responsiveness evaluation demonstrated that the CADIS also accurately measures change in patients whose disease improves [1]. New evidence was considered unlikely	No relevant evidence identified	None given	No relevant evidence identified

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
to impact on guideline recommendations.			
Management during and between flare-ups			
57-03 What are the potential triggering factors for atopic eczema in children (including environmental irritants and allergens, dietary and psychol6gical factors)?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	One GDG member highlighted that there may be new evidence on soap. But no references were provided.	No relevant evidence identified
57-04 How should triggering factors for atopic eczema in children be identified and managed?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-05 What clinical tests should be used to identify relevant allergens and which children with atopic eczema would benefit from their use?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	This area was highlighted as an area with new evidence. However the guideline cross refers to CG116 which would include this population.	New evidence/feedback is unlikely to impact on guideline recommendations
57-06 How should food allergies in children with atopic eczema be identified and managed?			
4-year review (2011) Results from 2 small poorly reported studies indicated that there may be some benefit in using an egg-free diet in infants with suspected egg allergy who have positive specific IgE to eggs.	No relevant evidence identified	None given	No relevant evidence identified

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
However, there was little evidence to support the use of various exclusion diets in unselected people with atopic eczema, [2,3]. New evidence was considered unlikely to impact on guideline recommendations.			
57-07 How should flare-ups of atopic eczema in children be identified and managed?			
4-year review (2011) One study evaluated the use of an evidence based treatment algorithm, finding it to be effective and applicable for the management of AE. However it did not show clear advantages compared to individualised treatment in a dermatological setting[4]. New evidence was considered unlikely to impact on guideline recommendations	No relevant evidence identified	None given	No relevant evidence identified
57-08 How should atopic eczema in children be managed and monitored between flare-ups (maintenance therapy)?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-09 What types of emollients are available for atopic eczema in children, how effective are they, what quantities should be used, and how often should they be used?			
4-year review (2011) Three studies addressed the effectiveness of emollients.	No relevant evidence identified	GDG indicated that the data on the management of flares- using tacrolimus used twice per week	New evidence is unlikely to impact on guideline recommendations

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
One study indicated emollient use during corticosteroid treatment improves xerosis and puritus, and maintains clinical improvements after therapy discontinuation[5]. Triclosan-containing leave-on emollient was safe and highly acceptable to patients. However, the overall benefit on day 27 was not significant[6]. A study looking at a ceramide-dominant, physiological-lipid based formulation found it was an effective stand-alone or ancillary therapy for many paediatric patients with AD[7] . It was felt that it may be pertinent to await further evidence, particularly on the harms associated with emollients, before an update is commissioned. **Emollients**: stakeholders felt that the evidence regarding the potential harms of aqueous creams (one type of emollient) requires an update of the guideline. However the evidence came from 3 very small studies that were all conducted on adults, and on anecdotal evidence provided by GDG members and post publication feedback. A large		prevent flares of AE was available. However it was noted that the evidence did not contradict current guidance.	

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
on-going study that is recruiting from the BEEP trial is investigating the effects of emollients on the skin barrier. The estimated completion date for this study is January 2012.In addition the following studies were highlighted: A study of fluticasone propionate ointment showed that the addition of twice weekly FP to standard maintenance therapy significantly reduces the risk of relapse in children with moderate severe AD[8] . A study found that both an emollient or an emollient enriched with furfuryl palmitate were efficacious in treating atopic dermatitis in children, but the emollient cream not containing furfuryl palmitate showed better clinical efficacy[9,10]. One study found that MPA twice weekly plus an emollient provides an effective maintenance treatment regimen to control AD[63].			

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
A further study indicated that pale sulfonated shale oil cream is capable to treat mild to moderate atopic eczema in children more efficaciously than vehicle and is well tolerated.[11] New evidence was considered unlikely to impact on guideline recommendations			
57-10 How effective and safe are topical corticosteroids for atopic eczema in children, and when and how often should they be used?			
4-year review (2011) Results from 1 study demonstrate the safety and efficacy of HCB 0.1% lotion in four weeks of treatment for the treatment of mild to moderate AD in children 3 months to 18 years of age[12]. A second study found that HCB 0.1% in LCr is more effective than its vehicle in paediatric populations down to 3 months of age without significant adverse events when used twice a day for up to 1 month[13]. New evidence was considered unlikely to impact on guideline recommendations	No relevant evidence identified	None given	No relevant evidence identified
57-11 What types of dry bandages and medicated dressings (including wet wrap therapies) are available for atopic eczema in children, how			

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
effective and safe are they (particularly when combined with topical corticosteroids), and when and how often should they be used?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-12 What is the most effective and safe way of combining different forms of therapy (for example, emollients, topical corticosteroids, bandaging techniques and calcineurin inhibitors)?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-13 How effective and safe are antihistamines in the management of atopic eczema in children of different ages?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-14 How effective and safe are other antipruritic (anti-itching) agents for atopic eczema in children and when should they be used?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-15 What are the indications and precautions for using topical calcineurin inhibitors (pimecrolimus and tacrolimus) for atopic eczema in children and how effective and safe are they?			
4-year review (2011) Six studies reported TCIs were effective at preventing flares and their use was at no additional cost for moderate eczema, and increased cost effectiveness for severe eczema[14-19]. Four studies reported that TCIs were safe and effective for long term use up to 4 years[19-22]. 10 studies found that TCI's were safe and effective, relieving itch and improving QoL[23-32]. 8 additional studies found no increase in		None given	New evidence is unlikely to impact on guideline recommendations

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
adverse effects such as, lymphoma, systemic absorption, malignancy, skin infections, and growth in children who had or were using TCIs[20,33-39] . One study found a TCI/FP combination regimen was equivalent to that of vehicle/FP[40] . One study found tacrolimus to be more effective than topical corticosteroid in 72 of the 93 children (77%) who completed the study[41]. Overall, the identified new evidence does not contradict current recommendations on the use of TCIs to treat moderate to severe atopic eczema. However, the new evidence also suggests that TCIs may be effective in preventing flares, is safe for long-term use, and more effective than corticosteroids. From the evidence and intelligence identified through the process, it suggests that there are developments in this area of the guideline . The licensing of this intervention has changed since the current guideline was published.			

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
This is a small area of the guideline, and may not be significant enough to warrant updating the guideline at this point. Currently, the guideline incorporates the recommendations from TA82 that pimecrolimus and tacrolimus should be used within their licensed indications as second line treatments when conventional therapies have failed. Long term safety data is still lacking and there are ongoing trials that aim to address this. Therefore the existing guideline recommendations still stand. New evidence was considered unlikely to impact on guideline recommendations			
57-16 What are the indications and precautions for using systemic immunosuppressants (such as ciclosporin and azathioprine) for atopic eczema in children, how effective and safe are they, and how should their use be monitored?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-17 What are the indications and precautions for using phototherapy for atopic eczema in children, how effective and safe is it and what form of phototherapy and length of treatment should be offered?			
4-year review (2011) One study indicated that phototherapy is an effective and well-tolerated	No relevant evidence identified	None given	No relevant evidence identified

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
treatment modality in children and it should be considered a possible treatment option for children with diseases including atopic dermatitis [43]. Overall, the new evidence identified does not contradict current recommendations on the use of phototherapy only for the treatment of severe atopic eczema in children when other management options have failed or are inappropriate.			
Complementary therapies			
57-18 How effective and safe is homeopathy for managing atopic eczema in children?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-19. How effective and safe are Chinese, Western and other herbal medicines for managing atopic eczema in children?			
4-year review (2011) One study was identified in the present search which concluded that a TCHM concoction is efficacious in improving quality of life and reducing topical corticosteroid use in children with moderate-to-severe AD[27]. New evidence was considered unlikely to impact on guideline			

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
recommendations.			
57-20. How effective and safe are other complementary therapies (for example, hypnotherapy) for managing atopic eczema in children?			
4-year review (2011) 10 studies addressed the use of probiotics for managing and treating eczema in children. Four studies showed a beneficial effect [44-47]. Six studies showed no beneficial effect [48-53]. Overall, the review concluded that there is still insufficient conclusive evidence on the effectiveness of probiotics.	No relevant evidence identified	None given	No relevant evidence identified
Medical complications			
57-21. What types of clinically significant secondary infections occur in atopic eczema in children and how should they be identified?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-22. Which antimicrobial agents (including antiseptics) are effective and appropriate for treating infected atopic eczema in children?			
4-year review (2011) Seven studies addressing the question were identified. Two studies found a beneficial effect of silk garments treated with an antibacterial agent[54,55]. Overall evidence for the effectiveness	No relevant evidence identified	None given	No relevant evidence identified

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
of topical and systemic antibiotics/ antimicrobials was mixed [4,56-58]. Overall, the identified new evidence supports current guideline recommendations that systemic antibiotics should be used to treat widespread infections and topical antibiotics should be reserved for cases of localised infection. There is still a lack of robust evidence on the effectiveness of silk fabrics treated with an antibacterial agent. The original guideline describes a lack of evidence of the effectiveness of antibiotic treatments for treating infected AD. There was some low quality evidence for the resistance of microorganisms to antibiotic agents. The GDG considered that the rare complications of infected AD had little relevance to routine practice. New evidence was considered unlikely to impact on guideline recommendations.			
57-23. How should antiseptic and antimicrobial resistance be managed in children with infected atopic eczema and what measures can be taken to reduce the risk of resistance developing?			
4-year review (2011)	No relevant evidence identified	None given	No relevant evidence identified

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
No new evidence was identified			
57-24. What factors are involved in growth disturbance in children with atopic eczema and how should they be managed?			
4-year review (2011) One study considered growth in the present search, and this was related to the effects of mometasone furoate and tacrolimus, finding that short-term growth was not affected in children with mild to moderate atopic eczema[59]. New evidence was considered unlikely to impact on guideline recommendations.	No relevant evidence identified	None given	No relevant evidence identified
Psychological and psychosocial effects			
57-25. How can psychological and psychosocial effects in children with atopic eczema and their families/carers be identified in everyday clinical settings?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-26. How effective are behavioural therapy techniques for children with atopic eczema and what other effective psychological interventions are available?			
4-year review (2011) One meta-analysis revealed that psychological interventions had a significant ameliorating effect on eczema severity, itching intensity and scratching in atopic dermatitis patients, but definite conclusions about their	No relevant evidence identified	None given	No relevant evidence identified

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
effectiveness seem premature[60] . New evidence was considered unlikely to impact on guideline recommendations.			
57-27. How should the impact of atopic eczema on families'/carers' quality of life be assessed, and how effective is it to use quality of life and other health-related scales in routine clinical management?			
4-year review (2011) A study looked at Italian versions of the IDQOL and FDI finding both had satisfactory psychometric properties and can be used to evaluate quality of life of infants with atopic dermatitis and their families [61]. New evidence was considered unlikely to impact on guideline recommendations.	A systematic review of the quality of life literature in children with atopic dermatitis was identified [62].Most studies utilised an atopic dermatitis specific tool with the majority of studies indicated an inverse correlation between QOL and severity as well as correlation between various instruments. The review concluded that most AD-specific tools do not provide a standard, quantitative measurement in relation to perfect health as would do preference based studies required for cost-utility analyses.	None given	New evidence is unlikely to impact on guideline recommendations
Referral for specialist dermatological care			
57-28. What are the indications for referral for specialist paediatric dermatological advice?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
Information, education and support			
57-29. What are the epidemiological characteristics of atopic eczema in children (including prevalence, age of onset and resolution, frequency, location and extent of flare-ups, associations with asthma, hay fever and food allergies, and variations in different ethnic groups)?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-30. What management strategies are appropriate for different ages and cultural groups?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-31. What factors contribute to non-adherence to therapy and how can adherence be improved?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified
57-32. How effective are education programmes for children with atopic eczema and their families/carers?			
4-year review (2011) Four studies were identified which found a beneficial effect of educational programmes however non compared different types of intervention[63-66]. The studies found that training/education programmes had effects on all explored psychological variables and long term disease management. Nurse practitioners delivered care that improved eczema severity and quality of life to that provided by dermatologists and attendance at	No relevant evidence identified	None given	No relevant evidence identified

Conclusions of previous reviews	Is there any new evidence/intelligence identified during this 6-year surveillance review (2013) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 6-year surveillance review (2013)
support groups improved pruritus and QoL. New evidence was considered unlikely to impact on guideline recommendations			
57-33. What information and support should be offered to children with atopic eczema and their families/carers?			
4-year review (2011) No new evidence was identified	No relevant evidence identified	None given	No relevant evidence identified

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