Eczema in children – consultation on draft scope
3–28 October 2005

National Institute for Health and Clinical Excellence

Stakeholder	Section	Comments	Developer's response
ABPI	General	The ABPI welcomes this guideline. This is a common disease in children and yet it is often poorly managed and therefore a guideline will be very useful. We have no specific comments on the guideline but would recommend that the guideline development group recognise the recently published British National Formulary for Children as a key reference document.	Thank you for this comment. The BNF for children will be used in the same way that the standard BNF is used by NICE guideline developers.
Addenbrookes NHS Trust	General	Children are usually defined as up to the age of 16. It does not seen very logical to have the cut off age for this guideline as 10 years old.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Association of Child Psychotherapists	3b.	We suggest that an addition be made to: "atopic eczema which is associated with inherited allergic conditions, such as asthma and hay fever, and as yet poorly defined environmental factors" **as well as possible exacerbation by psychological stressors.**	Thank you for your comments. This change has been made.
Association of Child Psychotherapists	3f.	We would like to propose an extended piece to the "profound psychosocial impact on the lives of children and their families/carers…" by adding that visible symptoms can affect a child's self esteem **and peer and social acceptance**, and that the sleep disturbance due to itchy **skin and severe pain at times** can disrupt the whole family's sleep patterns. We would like to see reinforced the fact that **psychosocial support and education is essential in the management of eczema** in children It would be helpful to add that "**education should be provided by the GP practice or community Paediatric service or specialist hospital team by a trained nurse or play specialist. Some children and families will need specialist psychosocial support from the local**	Thank you for this recommendation. Psychological and psychosocial support and education are important issues that will be addressed during development of the guideline. However, how the support is delivered, and by whom, are service issues which are beyond the scope of this guideline.

Stakeholder	Section	Comments	Developer's response
		Child and Adolescent Mental Health Service (CAMHS) or hospital liaison service.	
Association of Child Psychotherapists	4.1.1 a)	We have a question here: Why does this guideline not include pre-pubescent children aged 11 to 12 years old?	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Association of Child Psychotherapists	4.3 d)	As regards the management of eczema during flare-ups, we would like to add the consideration of, not only the frequency and location of flare-ups, **but also the exploration of the child's personal and family circumstances at the time of the flare-up with a view to identifying possible emotional or psychological stressors**	Thank you for this comment. These issues will be addressed under section 4.3f) (psychological/psychosocial effects).
Astellas Pharma Ltd	General	Why is the guideline only covering children up to 10 years old?	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Astellas Pharma Ltd	General	There have been further publications on tacrolimus ointment since the Technology Appraisal No. 82 (2004) 'Atopic dermatitis (eczema) – pimecrolimus and tacrolimus'. We will submit as evidence at appropriate time.	The Guideline Development Group (GDG) will cross-refer to the NICE technology appraisal relating to pimecrolimus and tacrolimus, but they will not update it (nor search for evidence published since the technology appraisal was produced).
Astellas Pharma Ltd	General	We are unaware of any new data for our products hydrocortisone butyrate 0.1% (Locoid) and hydrocortisone 1% lipocream (Mildison) since the Technology Appraisal No. 81 (2004) 'Atopic dermatitis (eczema) – topical steroids'	The GDG will cross-refer to the NICE technology appraisal relating to the frequency of application of topical corticosteroids, but they will not update it (nor search for evidence published since the technology appraisal was produced).

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Barts and the London NHS Trust	4.41	Reference: Papp et al. J Am Acad Dermatol 2005; 52: 247-53. This recently published paper might effect advice on vaccinations in those using Elidel cream. Fujisawa have similar data on file about Immune system and Protopic use (presented at international meeting) but not published yet.	Thank you – the guideline developers will carry out systematic searches to identify published evidence – they will also invite stakeholder organisations to submit (lists of) evidence.
Barts and the London NHS Trust	General	Perfectly good adequate treatments exist for the majority of patients with atopic eczema and they should be managed in the primary care setting. We do not have adequate expertise or services in primary care to deliver this care and PCTs never seem to prioritise dermatology. The NSF for child health may help push this issue and whilst it may be unrealisitic to train all GPs adequately in dermatology – each PCT could provide specialist GPs/nurses with paediatric friendly facilities to improve this process. Improving service delivery is far more important than improving therapies.	Service delivery is beyond the scope of this guideline, which will focus on clinical care and the treatment options.
British Association for Counselling and Psychotherapy	3 (f)	BACP is pleased that the psychosocial impact of eczema in children on sufferers and families/carers will be considered. However, to ensure specific psychological impacts of the condition are not overlooked, we recommend that this paragraph refer to the 'psychological /psychosocial impact' of eczema in children rather than the 'psychosocial impact' alone.	Thank you for this comment. This change has been made.
British Association for Counselling and Psychotherapy	4.3 (g)	This should read; 'How psychological/psychosocial effects of eczema should be identified and managed…'	Thank you for this comment. This change has been made.
British Association of Dermatologists	4.1.1	The upper limit of age should be 12 not 10 years.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
British Association of Dermatologists	4.1.2	There is some overlap between the "excluded" eczemas and atopic eczema, so reference should be made to them	The scope has been revised to clarify that the diagnostic criteria apply only to atopic eczema. Children with other

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		in the criteria for diagnosis - see 4.3 (a).	forms of eczema are excluded from the guideline, except where these conditions occur in association with atopic eczema.
British Association of Dermatologists (2)	General	The scope omits to consider the optimal management of the pregnant mother, of breastfeeding and the possibility (or otherwise) of preventing eczema.	The guideline will not cover prevention of atopic eczema. This has been clarified in the scope (section 4.3i).
British Association of Dermatologists (2)	General	While we agree it is reasonable to prepare a Guideline for the management of atopic eczema in Children, NICE should aim to produce similar material for Adolescents and Adults	We suggest that you propose this to the Department of Health. To help you, there is a facility on the NICE website where you can suggest topics.
British Association of Dermatologists (2)	3.	We have concerns that there are significant variations in practice for example between allergists and dermatologists. This is a good reason for developing multidisciplinary guidance	Thank you for this comment.
British Association of Dermatologists (2)	4.1.1	0-10 years is not a recognised grouping for NHS administration or practice. We accept that different approaches may be necessary for adolescents and adults with eczema. It does seem sensible to separate guidance for children from adults although this does create a further need for guidance in the other age groups. The feedback from the BAD was inconsistent but perhaps the upper limit of age should be 12 not 10 years.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
British Association of Dermatologists (2)	4.1.2	There is some overlap between the "excluded" eczemas and atopic eczema, it may be difficult to exclude contact dermatitis so reference should be made to these differential diagnoses in the criteria for diagnosis – see 4.3 (a).	The scope has been revised to clarify that the diagnostic criteria apply only to atopic eczema. Children with other forms of eczema are excluded from the guideline, except where these conditions occur in association with atopic eczema.
British Association of Dermatologists (2)	4.3.e	Possible areas of contention may be around the role of allergy testing, dietary interventions, alternative and complimentary therapies. Rigorous appraisal of the evidence in these areas will be required. We would like to see the scope including individual alternative therapies give separate consideration as some e.g. chinese herbal treatment although inadequately researched have more potential value than others e.g. kinesiology and patients do need guidance on which treatments not to use.	Thank you for your comment The guideline developers will search for and appraise all evidence relating to complementary therapies. The main areas where evidence is expected to be identified are homeopathy, and Chinese and Western herbal medicine. The scope has been revised to clarify this. Note that the guideline will assess clinical and cost effectiveness of complementary therapies only in the NHS setting. Information about diet is covered under section 4.3h).
British Association of Dermatologists (2)	4.3	Children with atopic eczema are prone to development of allergy to foods and later to environmental allergens. The	Thank you for your comment. Information about diet is covered under section 4.3h).

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		evidence for dietary and environmental manipulation should be included the scope.	
British Association of Dermatologists, The	General	While I agree it is reasonable to prepare a Guideline for the management of atopic eczema in Children, NICE should aim to produce similar material for Adolescents and Adults.	Thank you for this comment. We suggest that you propose this to the Department of Health. To help you, there is a facility on the NICE website where you can suggest topics.
British National Formulary (BNF)	Section 3, paragrap h c	Amend to 'The cardinal symptom of eczema is dry skin which causes itching...'	Thank you for this comment. Dry skin is, however, a clinical sign and not a symptom, although we agree that it may provoke itching. Itching may also occur without dry skin. Section 3a) of the scope has been revised to clarify this.
British National Formulary (BNF)	Section 3 para	Amend 'cyclosporin' to 'ciclosporin' which is the current British Approved Name (BAN).	This change has been made.
British National Formulary (BNF)	Section 3 para	Correct typo, add full stop after e.g	This change has been made.
British National Formulary (BNF)	Section 3 para	Add hyphen between 'side' and 'effects' (i.e. side-effects).	The guideline developers are following the NICE style guide.
British National Formulary (BNF)	Section 4.1.1 paragrap h a	Does this imply that children over 10 years should be treated in the same way as adults? Psychosocial implications can be greatest at puberty and adolescence. Treatment choice may also change after 10 –12 years of age due to concordance issues in adolescents and long-term use of preparations.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
British National Formulary (BNF)	Section 4.3,para c	Add hyphen between 'flare' and 'ups' (i.e. flare-ups).	The guideline developers are following the NICE style guide.
British National Formulary (BNF)	Section 4.3 paragrap h d	Interventions that minimise absence from school should also be considered as part of cost-effectiveness. Consider the effect of using medications (e.g. sedating antihistamines) or management options (e.g. wet wraps) at school.	Thank you for this comment. Cost effectiveness will only look at NHS costs.
British National Formulary (BNF)	Section 4.3, general	It would be helpful to provide guidance on: ▪ the role of topical antiseptics and antibacterials for infection prophylaxis in the light of antibiotic resistance ▪ the role of topical antibacterials versus oral antibacterials to treat infection associated with	It was thought that these issues were covered implicitly under section 4.3c) of the scope. However, the scope has been revised to make their inclusion explicit.

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		eczema. Which antibiotics should be used? ▪ the effectiveness of non-sedating antihistamines for itching associated with dry skin #whether the practice of applying a topical corticosteroid shortly after an emollient is advisable. Are the concerns over dilutingthe corticosteroid with the emollient unfounded?	This issue will be addressed under section 4.3c) – 'effectiveness of interventions used alone or in combination'.
Centre of Evidence Based Dermatology		This organisation was approached but did not respond.	
Changing Faces	GENERAL	Broadly in favour but think that a child's experience of eczema in the context of schooling/education needs to be formally recognised – it is at school where many problems can arise and the new Children's Act and SENDA arrangements for joint working can support a child effectively if properly developed.	Thank you for this comment. We agree that schooling/education is an important issue. However, who provides support and how it is delivered are service issues which are beyond the scope of this guideline.
Changing Faces	3.f	Suggest revising/adding "… For example, the highly visible symptoms can affect a child's self-esteem and self-confidence" to reflect the fact that his/her social interactions are likely to be complicated.	This change has been made.
Changing Faces	3.h	Suggest adding/revising "… to ensure appropriate referral for specialist dermatological, psychological and other help" to reflect the concept that other interventions are available.	This issue will be covered under sections 4.3f) and 4.3h) of the scope.
Changing Faces	4.2	Suggest including the very important link to Education as above.	This issue will be covered under section 4.3h) of the scope.
Changing Faces	4.3.g	Suggest adding/revising instead of "loss of self-esteem" to "… the impact of eczema on self-esteem and self-confidence"	Section 4.3f) has been revised to include the impact of atopic eczema on self-confidence.
Changing Faces	4.3.i	Suggest "What information and skills should be made available…"	This issue will be covered under section 4.3h) of the scope. Recommendations made by the guideline developers in relation to other parts of section 4.3 will also help to identify information and skills that should be made available. This could be used during implementation of the guideline to influence training/education for healthcare professionals.
Clinovia Ltd		This organisation was approached but did not respond.	

Stakeholder	Section	Comments	Developer's response
Community Practitioners and Health Visitors Association		This organisation was approached but did not respond.	
Community Practitioners and Health Visitors Association / Amicus	1 and 4.1.1	Discussed at stakeholder meeting and I think that a decision to change the upper age limit to 12 years makes a lot of sense. Medicines often have licences from 12 years. I realise that this age range needs to be tight to make it workable. However children who still suffer badly from atopic eczema after the age of 7 seems to have to cope with this disease well after the age of 12.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Community Practitioners and Health Visitors Association / Amicus	4.1.2	A lot of the children I see have seborrhoeic eczema running alongside there atopic. I can see why just seborrhoeic eczema alone in babies (cradle cap) does not need to be included. I do see a need to link some guidelines for treatment for both when to the parent they seem to merge into one problem.	The scope has been revised to clarify that the diagnostic criteria apply only to atopic eczema. Children with other forms of eczema are excluded from the guideline, except where these conditions occur in association with atopic eczema.
Community Practitioners and Health Visitors Association / Amicus	4.2 and 3 b	I believe that these guidelines need to be strongly rooted in the primary and community side of the health care setting. Children are better treated in the community, in their own homes, away from the antibiotic resistant strains of bacteria found within a hospital setting. Many of the treatments that are used as an inpatient could be given at home if the dermatology team were able to offer outreach support and teaching to the parents and health staff already out in the community. So it is important that the guideline group consists of some generalists who work in the community, not within an area with a centre of dermatology excellence. But perhaps a rural area, or urban with few consultant dermatologists and very few inpatient beds. As noted in 3b atopic eczema is a common cause for consultation in general practise and takes up many hours within the health visiting team, offering support, first line treatment and education.	The GDG will include a school nurse or health visitor or community nurse as well as two general practitioners and two dermatology specialist nurses.
Community Practitioners and Health Visitors Association / Amicus	4.3b,c,d	Will a child be said to have severe eczema for 3 weeks a year (during flares) and moderate to good the rest of the time. Or will this classification be able to look at the condition of the skin over a period of time. Would this classification make it harder or easier for families applying	Thank you for these comments. Section 4.3b) of the scope has been revised to clarify that classification of the severity of atopic eczema will include consideration of the fact that the condition tends to be

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		for disability living allowance? Will the government office who deals with this be involved in looking at the guidelines? Cost effectiveness and clinical effectiveness I have found changes from child to child. Each treatment has to be personalised to that child and family. Will this guideline be able to take that into account?	chronic with acute flare ups. There will be two patient/carer representatives on the GDG.
Community Practitioners and Health Visitors Association / Amicus	4.3 e, f	Does **f** mean complications from alternate therapies or the eczema in general?	This refers to complications of atopic eczema itself.
Community Practitioners and Health Visitors Association / Amicus	4.3 g	How far do we go on the complication front? For example, are the guidelines to look at the use of sedating anti-histamines, family therapy for acute behaviour problems from perhaps the affected child or a sibling who has suffered from the lack of attention by the parents? There are many complications out there, how are the guidelines going to be chosen? And how are some of the treatments to be funded?	The complications considered under section 4.3e) are limited to medical complications, particularly infections. Behavioural problems will be covered under section 4.3f). Side effects of anti-histamines will be covered under section 4.3c). Provision of funding for implementing the guideline is outside the remit of the GDG. However, the group will agree the priorities for implementation (i.e. key recommendations that would make major differences to practice).
Community Practitioners and Health Visitors Association / Amicus	4.3 h	Specialist dermatological advice, does this mean referral to secondary care, consultant doctor, consultant nurse or could it be specialist HV or community nurse?	The term used in the scope is deliberately all-inclusive.
Community Practitioners and Health Visitors Association / Amicus	4.3 i	Education should start with the parents before a child at risk of atopic eczema is born. Regarding advice on breast feeding, extra support for breast feeding as long as possible. To avoid getting the family pet, to keep soft toys to a minimum and having hard floors, easily washed in the child's bedroom etc. General advise to all parents is surely to stop using soap and stripping the skins natural oils from birth. Could the guidelines look this far ahead? As brought up in the stakeholder meeting, some input from the education departments to involve the whole school in helping the child with atopic eczema. Not just teachers, but to educate dinner ladies etc on applying creams. Whoever the child feels is most appropriate. Will this guideline look at the use of mattress protectors	Primary prevention of atopic eczema is outside the scope. This has been clarified in section 4.3i). Avoidance of allergens and irritants will be covered under section 4.3h) in so far as it relates to improved outcomes for children with eczema. Diagnosis and management of allergies except in the context of management of atopic eczema is outside the scope.

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		etc against dust mite? Will this type of appliance be able to be offered to poorer families if found to be effective? Many families ask about skin testing , will this guideline look at this?	
Crookes Healthcare Ltd	4.1.1	We would support an extension of the age range to an upper limit of 12 years. It is generally accepted that "Children's" doses of medicines apply (and are licensed) up to the age of 12, and "Adult" doses apply thereafter; if this guideline stops at 10 years, there will be a two year gap for which no advice is available.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Crookes Healthcare Ltd	4.3.i	Related to the point about what education should be offered to children with eczema, we would recommend that the NICE Guidelines should take into account the views of the DfES, to avoid conflict between NICE recommendations, and any relevant guidance issued to teachers from the Education department.	Thank you for this comment. It will be brought to the attention of the GDG.
Department for Education and Skills		This organisation was approached but did not respond.	
Department of Health		The Department of Health is content with the scope of the NICE guideline, Eczema in Children, as drafted. We have no further comments.	Noted with thanks.
Derbyshire Mental Health Services NHS Trust		This organisation was approached but did not respond.	
Developing Patient Partnerships		This organisation was approached but did not respond.	
GlaxoSmithKline UK		Thank you for the opportunity to comment on the scope for the clinical guideline on the management of eczema in children. I am writing to let you, know that we have reviewed the scope and do not wish to submit any comments from GlaxoSmithKline. However we would like to continue to be involved as stakeholders. .	Noted with thanks.
Health and Safety Executive		This organisation was approached but did not respond.	
Healthcare Commission		This organisation was approached but did not respond.	

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Hertfordshire Partnership NHS Trust		This organisation was approached but did not respond.	
Luton and Dunstable Hospital NHS Trust		This organisation was approached but did not respond.	
Maidstone and Tunbridge Wells NHS Trust		This organisation was approached but did not respond.	
Medicines and Healthcare Products Regulatory Agency (MHRA)		This organisation was approached but did not respond.	
Mid Yorkshire NHS Trust		This organisation was approached but did not respond.	
National Eczema Society	4.1.1.	The group covered should be children up to the age of 12. Adults prescribing usually starts at 12. Leaving the age at 10 could lead to prescribers being unsure of how to treat 10-12 year olds.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
National Eczema Society	4.3. (e)	There are many alternative therapies used by carers of children with eczema. It will be a lengthy task to look at all of them. Some therapies can be dismissed in a couple of sentences and It will be important for the Group to spend time looking at the most popular which are Homeopathy, Chinese Herbs and Western Herbal Medicine.	Thank you for your comment. The guideline developers will search for and appraise all evidence relating to complementary therapies. The main areas where evidence is expected to be identified are homeopathy, and Chinese and Western herbal medicine. The scope has been revised to clarify this. Assessment of cost effectiveness will only cover NHS costs.
National Eczema Society	General	The one area which is lacking in the guidelines is looking at the triggers for eczema flare ups. In our view this should be an essential part of the guidelines, particularly as it is an area often not discussed with patients by primary care health professionals.	Thank you for your comment. This issue will be considered under section 4.3h) of the scope.
National Eczema Society	General	The first person many people consult about eczema is their pharmacist and given the increasing role they will be playing in the care of chronic illness the Society feels it is vital that a pharmacist should be included in the Development Group.	We agree – the development group will include a pharmacist.
National Patient Safety Agency		This organisation was approached but did not respond.	

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National Public Health Service - Wales		This organisation was approached but did not respond.	
NHS Health and Social Care Information Centre		This organisation was approached but did not respond.	
NHS Plus		This organisation was approached but did not respond.	
NHS Purchasing & Supply Agency		This organisation was approached but did not respond.	
NHS Quality Improvement Scotland		This organisation was approached but did not respond.	
Novartis Pharmaceuticals UK Ltd	Page 2, Section 3 e)	The second paragraph of this section states that pimecrolimus may be tried in "more severe" cases. This is misleading and inconsistent with the recommendations on pimecrolimus as detailed in NICE Guidance No. 82. which states "Pimecrolimus is recommended, within its licensed indications, as an option for the second-line treatment of moderate atopic eczema on the face and neck in children aged 2 to 16 years that has not been controlled by topical corticosteroids (see Section 1.4), where there is a serious risk of important adverse effects from further topical corticosteroid use, particularly irreversible skin atrophy." In order to avoid any potential confusion we suggest that the reference to "more severe" cases should be removed and that the section should be amended in line with the above recommendations as taken from the current guideline	The GDG will cross-refer to the NICE technology appraisal relating to pimecrolimus and tacrolimus, but they will not update it (nor search for evidence published since the technology appraisal was produced).
Novartis Pharmaceuticals UK Ltd	Page 4, Section 4.3 b)	We welcome the provision of guidance on how severity of eczema should be classified. This should take into account the fact that eczema is a chronic, relapsing condition with episodic flare ups over a period of time. Any assessment of severity should therefore take into account the fluctuating nature of this condition over a period of time and not be a single snapshot.	Thank you for your comment. Section 4.3b) of the scope has been revised to clarify that classification of the severity of atopic eczema will include consideration of the fact that the condition tends to be chronic with acute flare ups.
Nutricia Ltd		This organisation was approached but did not respond.	

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PERIGON (formerly The NHS Modernisation Agency)		This organisation was approached but did not respond.	
Primary Care Dermatology Society		This reply is from the PCDS committee members and represent the greater view of GPs and GPSI in Dermatology about the scope of the guidelines. We agree in principle with the scope of the guidelines but would like to add the following:	Thank you for your comments.
Primary Care Dermatology Society		More emphasis on patient education and GP and Primary Care teams education about eczema and management , need for having enough time to spend with patients at consultations.	Thank you for this comment. We agree that education is an important issue. However, who delivers support, and how it is delivered, are service issues which are beyond the scope of this guideline.
Primary Care Dermatology Society		We feel dermatology hasn't got much weight in Primary Care at the moment as there is not money attached to it in the new contract; having eczema clinics for children in Primary Care maybe run by nurses which also manage other chronic diseases like asthma (atopy link) may be a good way ahead and should be included in the guidelines.	Thank you for this comment. Service configuration is beyond the scope of this guideline.
Primary Care Dermatology Society		Clear referral criteria should also be outlined. However, the quality of referrals will only improve if the majority of eczema is well managed in Primary care to start with.	We agree that clear referral criteria will need to be identified by the guideline developers. The aim of the guideline is to improve care in all sectors, including primary care.
Royal College of General Practitioners		The RCGP has reviewed the draft scope and has no comments to make at this stage.	Noted with thanks.
Royal College of Nursing (RCN)	1.1 Short title	Atopic Eczema in Children may be a more accurate title given that other forms of eczema are to be excluded.	This change has been made.
Royal College of Nursing (RCN)	2.b Backgrou nd and general	The appropriate NSF to be supported by this guideline is the NSF for Children and Young people up to the age of 19 years. The cut off age as 10 years thus seems rather arbitrary and consideration should be given to raising this.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Royal College of Nursing (RCN)	3.c Clinical	Patterns of eczema differ in different racial groups and black or Asian children may present with reverse pattern	Thank you for these comments.

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	need for the guideline	extensor eczema, lichenification, papular or follicular eczema and pigmentary changes. Given the multiracial nature of Britain today this should be included. This is very relevant to section 4.3. It may be more accurate to say that itching usually causes sleep loss as not all children are awake at night scratching.	Section 3d) of the scope has been revised to clarify that racial differences in presentation may occur. This will also be considered under section 4.3a) (diagnosis). Sections 3d), 3g) and 4.3f) have also been revised to clarify that sleep loss occurs frequently (but not always).
Royal College of Nursing (RCN)	3.e	The term "various bandages" may be misleading. Conventional crepe bandages which can be bought over the counter are used by families in desperation at times but are not helpful. The use of occlusive paste bandages which are prescribable are a recognised treatment option.	Thank you for this comment. Section 3 is intended to provide a brief overview of the reasons why the guideline is needed – it does not make recommendations about the care that should be offered. The final guideline recommendations will specify the forms of bandages/dressings that should (and should not) be offered.
Royal College of Nursing (RCN)	3.f	Not all families are profoundly affected psychologically by eczema although many certainly are so to say "eczema may have a profound psychosocial impact "may be more accurate. Non-concordance may be the term of choice rather than "non-compliance".	Thank you for these comments. The revised scope clarifies that psychological/psychosocial impacts may occur (section 3g). The term non-adherence is used in place of non-compliance in the revised scope.
Royal College of Nursing (RCN)	4.3 general and (i)	Currently the provision of nursing services to support these children and their families and carers is very variable. There are relatively few children's dermatology specialist nurses and many children receive specialist input from adult based dermatology nurse specialists. In the community younger children may receive input from health visitors and many community children's nursing teams are active in providing support and education for families. Given that the provision of information about eczema and its treatment is so important the guideline should look at how this is done and make recommendations for future service developments.	Thank you for this comment. The ability to access information plays an important role in the management of eczema in children. It will be addressed during the guideline development process. The GDG will include a school nurse or a health visitor or a community nurse, as well as specialist dermatology nurses.
Royal College of Nursing (RCN) (2)	1. Title – population	Why is there an age limit of 10 in the guideline title for the management of eczema in children? Does their eczema stop at age 10? Eczema in children implies eczema in all children not just those 10 years old and under.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that

Stakeholder	Section	Comments	Developer's response
		Could it not just be called 'management of atopic eczema in children?'	children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Royal College of Nursing (RCN) (2)	1. Title – populatio n	The rationale for the age limit is not clear and seems to contradict the National Service Framework (NSF) which states that atopic eczema can be very difficult to manage in teenagers especially with exams, so support and guidance is required. We consider that the age limit should be increased to 12 years in line with many licence recommendations for pharmaceutical products and transition to secondary school. (This was discussed at the stakeholders' meeting). As scopes are said to support the appropriate National Service Frameworks, the NSF is for children and young people up to the age of 19 and this should be taken into account.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Royal College of Nursing (RCN) (2)	Title – populatio n	Totally agree that it should be a separate guideline from adults in view of the special needs infants and children have which are very different from adults.	Thank you for this comment.
Royal College of Nursing (RCN) (2)	Title – definition	Atopic – it would be useful to have a definition of what the word means. There was discussion at the stakeholders' meeting regarding the word '*atopic'* and its definition or use in the future in relation to eczema in children. At this stage we are of the opinion that it should be used as it is commonly used and helps to differentiate from other types of eczema seen in children, which are being excluded from this guideline.	Thank you for this comment. The guideline developers are using the term 'atopic' as it is commonly used, and the term will be defined in the full guideline.
Royal College of Nursing (RCN) (2)	Clinical Need 3 c)	Suggest add in this section that with atopic eczema there is a familiar 'itch-scratch-cycle'.	Thank you for this comment. Section 3 of the scope is intended to give a broad outline of the condition and why a guideline is needed. Scratching is mentioned in sections 3f) and 4.3f).
Royal College of Nursing (RCN) (2)	3 c)	Note that itching can usually (but not always) cause sleep loss.	Sections 3d), 3g) and 4.3f) have also been revised to clarify that sleep loss occurs frequently (but not always).
Royal College of Nursing (RCN) (2)	3 c)	It should be noted that there are racial differences in the presentation of atopic eczema in children and this should be taken into consideration in developing the guideline. Britain is a multiracial country and the definition cited refers to Caucasian children. Asian, black African and Caribbean children often have a reverse pattern of	Thank you for these comments. Section 3d) of the scope has been revised to clarify that racial differences in presentation may occur. This will also be considered under section 4.3a) (diagnosis).

Stakeholder	Section	Comments	Developer's response
		extensor surface eczema. They are also more likely to have lichenified, papular or follicular eczema and accompanying pigmentary changes. Perhaps this could be summarised as "flexural pattern appearing later. However there may be racial differences in presentation."	
Royal College of Nursing (RCN) (2)	3 d & e)	In these sections the clinical need for the guideline is discussed in a general way. But consider that for the guideline, it should be more specific and say 1st, 2nd and 3rd Line Treatments and then list under each with rationale for use i.e. First Line: • Emollients for cleansing and moisturising the skin • Topical Corticosteroids to reduce Iritation and inflammation • Systemic antibiotics for infection etc for other treatments.	Thank you for these comments. Section 3 of the scope is intended to give a broad outline of the condition and the need for the guideline. The final guideline will clarify whether particular forms of treatment should be considered as first-, second- or third-line treatments.
Royal College of Nursing (RCN) (2)	3 e)	Change to >>>>application of various bandages and *dressings…* The term various bandages is very vague and does rather imply that any bandage can be used which is incorrect. Occlusive paste bandages which are prescribable may be used and we think this needs to be made clear.	Thank you for this comment. Section 3 is intended to provide a brief overview of the reasons why the guideline is needed – it does not make recommendations about the care that should be offered. The final guideline recommendations will specify the forms of bandages/dressings that should (and should not) be offered.
Royal College of Nursing (RCN) (2)	3 e)	It was agreed at the Stakeholders' information meeting that *complementary therapies* should be changed to *complementary treatments, o*therwise suggests cessation of conventional treatments.	Thank you for this comment. The term 'complementary therapies' has been retained in the revised scope because this is an all-inclusive term (it covers medical and non-medical treatments).
Royal College of Nursing (RCN) (2)	3 e)	Other management options – include *allergen avoidance* with alterations to diet.	This change has been made.
Royal College of Nursing (RCN) (2)	3 e)	Note Cyclosporin now spelt as ciclosporin.	This change has been made.
Royal College of Nursing (RCN) (2)	3 f)	Non – compliance – consider changing to *Non-Concordance*? - the term non compliance is often failure of health care professional rather than the family because they have not been given the information to be compliant?	The term non-adherence is used instead of non-compliance in the revised scope.
Royal College of Nursing (RCN) (2)	3 f)	Consider rewording to read *lack of knowledge and/or information* about treatments and their appropriate use	This change has been made.

Stakeholder	Section	Comments	Developer's response
		may lead to treatment failure…..	
Royal College of Nursing (RCN) (2)	3 (f)	Whilst the scope of the guideline acknowledges the psycho-social impact on the lives of children and their families, the example given only provides a narrow view of the true impact of the condition. In necessitating the need for the guideline, should a wider view be considered; to incorporate impact on schooling and educational achievement of the child, socialisation, bullying that can be encountered by the child with eczema, the time consuming process that is often necessary to apply treatments, as well as potential economic impact for the family (some allergen avoidance measures can incur additional costs to the family, also some parents/carers may find it difficult to go to work when faced with the responsibility of the care regimen for their child with eczema).	This is a guideline for the NHS. Although it will be relevant to schools, nurseries and childcare establishments, it will not make recommendations exclusive to these sectors. It will, however, include consideration of the psychological and psychosocial effects of atopic eczema (see section 4.3f).
Royal College of Nursing (RCN) (2)	3 (general)	Could we also consider adding the following needs for the guideline….. • To dispel any misconceptions that there may be of eczema care • The scope includes provision of guideline for primary care staff to advise and support the child/family in the community setting thus preventing the need for secondary/tertiary care. It should be noted that successful projects using Health Visitor eczema clinics are already established and should be highlighted as good practice. • There is a need for guidance on preventative measures (to help with avoiding infections). • Pointers on the recognition of infected eczema to enable early and effective management.	Thank you for these suggestions. Section 3 of the scope is intended to be a broad outline of the condition and the need for the guideline. The suggestions will, however, be brought to the attention of the GDG.
Royal College of Nursing (RCN) (2)	4.1.1 a) – Population	As commented in Section 1 – Change age range Can these groups be 'children' (not just up to the age of 10) presenting with atopic eczema?	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that

Stakeholder	Section	Comments	Developer's response
			children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Royal College of Nursing (RCN) (2)	4.1.2 a)	Add in napkin dermatitis.	This is an irritant dermatitis and will only be considered by the GDG in the specific context of treatment guidelines for atopic eczema.
Royal College of Nursing (RCN) (2)	4.2	Add Intermediate and tertiary care Terminology - with the action on dermatology and recognition of Practitioner with a special interest you now have intermediate dermatology services not just primary (GP & NP) community (HV) and secondary (hospital).	Thank you for this comment. The question of involvement of different health professionals in the management of children with atopic dermatitis will not be considered within the remit of the scope document.
Royal College of Nursing (RCN) (2)	4.2	Include school nurses in Primary Care unless felt to be implicit within the age range covered by the guideline.	The guideline will apply to staff who provide care to children under the NHS. The GDG will include a school nurse, a health visitor or a community nurse
Royal College of Nursing (RCN) (2)	Clinical Management 4.3 a)	To include a description of how to undertake the physical assessment including for pigmented skins.	Thank you for these comments. Section 3d) of the scope has been revised to clarify that racial differences in presentation may occur. This will also be considered under section 4.3a) (diagnosis).
Royal College of Nursing (RCN) (2)	4.3 a)	As commented earlier (3 c) it is useful to mention that Black and Asian children may not present with typical flexure pattern. Also note the fact that it may be difficult to see erythema or inflammatory reaction to eczema in very pigmented black skin. Pigmentation may occur after the inflammation rather than at the same time.	Thank you for these comments. Section 3d) of the scope has been revised to clarify that racial differences in presentation may occur. This will also be considered under Section 4.3a) (diagnosis).
Royal College of Nursing (RCN) (2)	4.3 a)	What tools are to be used to classify severity?	The guideline development process will determine the tools needed to classify severity.
Royal College of Nursing (RCN) (2)	4.3 c)	Need to define what flare up is.	The guideline development process will define what is meant by a 'flare up'. A lay explanation of the term has been added to section 4.3a) of the scope.
Royal College of Nursing (RCN) (2)	4.3 c)	Note that children with pigmented skin are prone to changes such as post inflammatory hypo pigmentation or hyper pigmentation as a result of the eczema. Some professionals wrongly ascribe these changes to the administration of topical steroids.	Thank you for these comments. Section 3d) of the scope has been revised to clarify that racial differences in presentation may occur. This will also be considered under section 4.3a) (diagnosis).
Royal College of Nursing (RCN) (2)	4.3 d)	There are issues around support of parents and schools to enable children to access emollients during the day.	The guideline is for the NHS. It will also be relevant to practice in schools, nurseries and childcare establishments, but it will not make recommendations

Stakeholder	Section	Comments	Developer's response
			exclusively in these settings. This has been clarified in section 4.2b) of the revised scope.
Royal College of Nursing (RCN) (2)	4.3 e)	Alternative *treatments* rather therapies.	Thank you for this comment. The term 'complementary therapies' has been retained in the revised scope because this is an all-inclusive term (it covers medical and non-medical treatments).
Royal College of Nursing (RCN) (2)	4.3 f)	Need to define complications – herpes, bacterial infections, itch, lack of sleep, burden of care delivery on the family.	The term 'complications' refers to infections. This has been clarified in the revised scope. Sleep loss and psychological/psychosocial affects of atopic eczema are covered under section 4.3f).
Royal College of Nursing (RCN) (2)	4.3 f)	Also identification of complications to include description of signs and symptoms. Infected eczema/ eczema herpeticum / Molluscum contagiosum	The term 'complications' refers to infections. This has been clarified in the revised scope.
Royal College of Nursing (RCN) (2)	4.3 (g	Should this section also consider; who will provide the education and support to ensure consistency and continuity of care in managing the psychosocial effects of eczema.	We agree that education and psychosocial support are important issues. However, who delivers support, and how it is delivered, are service issues which are beyond the scope of this guideline.
Royal College of Nursing (RCN) (2)	4.3 i)	Also include access to play specialist and psychologists in the community.	Who delivers support, and how it is delivered, are service issues which are beyond the scope of this guideline.
Royal College of Nursing (RCN) (2)	4.3 i)	Education should also include choice of emollients and demonstration of how to apply therapies.	This is covered under sections 4.3c and 4.3h) of the scope.
Royal College of Nursing (RCN) (2)	4.3 (i)	Should the word "support" be added to read – "education and support to be offered" instead of "education" on its own, to correspond with 3(f) last sentence "psychosocial support and education…"	This change has been made.
Royal College of Nursing (RCN) (2)	4.3 (general)	Does the section on clinical management need to consider: Identification of who is responsible for specific aspects of clinical management?	The question of involvement of different health professionals in the management of children with atopic eczema will not be considered in the guideline. These issues relate to service configuration and service delivery, which are outside the remit of the GDG.
Royal College of Nursing (RCN) (2)	4.3 (general)	Does this section also need to consider the support of children with eczema in school?	The guideline is for the NHS. It will also be relevant to practice in schools, nurseries and childcare establishments, but it will not make recommendations exclusively in these settings. This has been clarified in section 4.2b) of the revised scope.
Royal College of Nursing (RCN) (2)	General	Also take into consideration issues of professionals trained in adult health but allowing access to dermatology but without paediatric knowledge.	Recommendations made by the guideline developers will help to identify information and skills that should be made available. This could be used during implementation of the

Stakeholder	Section	Comments	Developer's response
			guideline to influence training/education for healthcare professionals.
Royal College of Nursing (RCN) (2)	General	Consider that the document cited below may be useful to the developers. **Document:** Date of Issue: March 2005 Reference: 1448-2005DCL-EN Managing Medicines in Schools and Early Years Settings (Department For Education and Skills and Department of Health).	Thank you. If felt appropriate by GDG members, it will be reviewed and appraised alongside other literature.
Royal College of Nursing (RCN) (2)	General **Clinical Questions:**	Could the following clinical questions be addressed: 1. Is there evidence that nurses can improve outcomes for children with eczema? 2. Is non-medical prescribing influencing clinical outcomes? 3. Do allergy tests make a difference in the diagnosis of atopic eczema? 4. Do measures taken during the antenatal and postnatal period improve the outcomes for these children? 5. Is there an unmet need in relation to providing psychological support and the use of a child psychologist / family therapy? Could the following questions be addressed under 'Clinical Management': • What things make eczema worse? • Wet wrapping-effective or not?	Thank you for these comments. Who delivers care is outside the remit of the GDG. Non-medical treatments will be considered under sections 4.3c and 4.3d. Diagnosis and management of allergies except in the context of management of atopic eczema are outside the scope. However, information about potential associations between eczema and allergies is covered under section 4.3h). Primary prevention of eczema is outside the scope. This has been clarified in section 4.3i). This will be covered under section 4.3f). This is covered under section 4.3h) (triggers). This is covered under section 4.3 c).
Royal College of Nursing (RCN) (2)	General	Other epidemiological evidence for background / consideration when formulating further clinical questions: **ISAAC 2000 Report on asthma, atopic eczema and allergic rhino-conjunctivitis in school children of Dhaka, Bangladesh using International Study of Asthma and Allergies in Children (ISAAC) Protocol. Institute of Child and Mother Health, Dhaka, Bangladesh** ISSAC Study http://isaac.auckland.ac.nz/	Thank you. If felt appropriate by GDG members, it will be reviewed and appraised alongside other literature.

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Royal College of Paediatrics and Child Health	4.3.2	The exclusion of infantile seborrhoeic eczema should be reconsidered, or ensure the criteria in 4.3 a) help differentiate atopic eczema from seborrhoeic to reduce misdiagnosis.	Thank you for this comment. The issue of the differential diagnosis and various clinical presentations of atopic eczema will be addressed during the development process.
Royal College of Paediatrics and Child Health	4.3e	The alternative therapies to be considered in the scope should be defined. The diagnosis of atopy or allergy by alternative practitioners leads to a therapy, e.g. dietary restriction. I would argue that the diagnostic technique, not just the therapy, needs consideration. There is also an opportunity to include over the counter preparations.	Thank you for your comment. The guideline developers will search for and appraise all evidence relating to complementary therapies. The main areas where evidence is expected to be identified are homeopathy, and Chinese and Western herbal medicine. The scope has been revised to clarify this. Note that assessment of cost effectiveness will be limited to NHS costs. Information about diet is covered under section 4.3h). The guideline will not cover diagnosis and management of allergies (including food allergies), except in the context of management of atopic eczema.
Royal College of Paediatrics and Child Health	4.3h	Indicators for referral to specialist paediatric advice should be added, e.g. other atopic disease the dermatologist will not be dealing with.	Diagnosis and management of allergies except in the context of management of atopic eczema are outside the scope. This has been clarified in section 4.3j). However, information about potential associations between eczema and allergies is covered under section 4.3h).
Royal College of Paediatrics and Child Health	General	General concern is age up to 10 years - our group felt all children should be included, and certainly all pre pubertal children. Ten years seems arbitrary.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Royal College of Paediatrics and Child Health	3 Clinical need	There is a need for guidance on the role that exposure to food and inhalant allergens plays in the pathogenesis of eczema, and the effect that manipulation of diet and control of exposure to inhalant allergens has on the management of eczema. The role of food allergy in atopic eczema has been controversial. Over the past decade a number of clinical and laboratory studies have supported a causal association. Clinical studies show that ingestion of	Primary prevention of atopic eczema is outside the scope. This has been clarified in section 4.3i). Avoidance of allergens and irritants will be covered under section 4.3h) in so far as it relates to improved outcomes for children with atopic eczema. Diagnosis and management of allergies except in the

Stakeholder	Section	Comments	Developer's response
		a food can trigger eczema, that elimination of a causal food can ameliorate symptoms and that dietary exclusion of certain allergenic foods in infancy has a protective effect on the development of eczema. The prevalence of IgE mediated food allergy in childhood eczema varies from 35-60% depending on the age of the child and severity of the eczema. It is widely believed by allergists worldwide that eczema and food allergy are strongly associated in the first year of life. See Hill et al Paed Allergy Immunology 2004 Recent high quality reviews are: Leung DY, Boguniewicz M, Howell MD, Nomura I, Hamid QA.New insights into atopic dermatitis. J Clin Invest. 2004 Mar 1; 113(5): 651-657.Leung DY, Bieber T. Atopic dermatitis. Lancet. 2003;361:151–160. Spergel JM, Paller AS. Atopic dermatitis and the atopic march. J. Allergy Clin. Immunol. 2003;112:S128–S139. The role of environmental manipulation and exposure to inhalant allergens needs coverage too.	context of management of atopic eczema is outside the scope. Thank you for the list of evidence.
Royal College of Paediatrics and Child Health	4.3 Clinical management	The role of food and inhalant allergies in children with eczema:	Primary prevention of atopic eczema is outside the scope. This has been clarified in section 4.3i). Avoidance of allergens and irritants will be covered under section 4.3h) in so far as it relates to improved outcomes for children with atopic eczema. Diagnosis and management of allergies except in the context of management of atopic eczema is outside the scope.
Royal College of Paediatrics and Child Health		i) Diagnosis and treatment of food allergy in childhood eczema	Primary prevention of atopic eczema is outside the scope. This has been clarified in section 4.3i). Avoidance of allergens and irritants will be covered under section 4.3h) in so far as it relates to improved outcomes for children with atopic eczema. Diagnosis and management of allergies except in the context of management of atopic eczema is outside the scope.

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Royal College of Paediatrics and Child Health		ii) Diagnosis and treatment of inhalant allergies in childhood eczema	Primary prevention of atopic eczema is outside the scope. This has been clarified in section 4.3i). Avoidance of allergens and irritants will be covered under section 4.3h) in so far as it relates to improved outcomes for children with atopic eczema. Diagnosis and management of except in the context of management of atopic eczema allergies is outside the scope.
Royal College of Physicians		The Royal College of Physicians has seen a copy of the comments on the above subject produced by the British Association of Dermatologists. The College wishes to endorse the comments made by the BAD.	Noted with thanks
Royal College of Physicians of London		This organisation was approached but did not respond.	
Scottish Intercollegiate Guidelines Network (SIGN)		This organisation was approached but did not respond.	
Sedgefield PCT	3 in general	For the vast majority of children (perhaps up to 98% are mild to moderate) it needs simple emollients, reassurance and +/- a splash of steroid. Whilst the guideline must cover the management of those at the top of the clinical pyramid- those with troublesome or severe eczema, please do not lose sight of the reality of General Practice when drafting your guideline.	Thank you for your comment.
Sedgefield PCT	3h	Referral to dermatologists is specified. Community clinics: GPSIs, Nurse-led, Community Dermatolgists – are these included?	The wording is intended to be all-inclusive.
Sheffield Children's Hospital NHS Trust	General	The document has been discussed by our multidisciplinary team whom feel that the scope does not make sufficient reference to the extended role, and resultant contribution made, by specialist nursing staff. They also feel that the document does not highlight the benefit of working with Health Visitors and other community specialist staff for the 0 – 5 years patient group.	Thank you for your comments. Who delivers care is a service issue, that is outside the remit of the GDG.
Skin Care Campaign	4.1.1	"…up to the age of 10 years…" seems too arbitrary. Might not "Children developing [or 'diagnosed with'] atopic eczema between birth and the age of 10 years" be more	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children

Stakeholder	Section	Comments	Developer's response
		appropriate? By implication, it would make the management options more open-ended.	reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
Skin Care Campaign	3 e) and 4.3 e)	At risk of sounding dreadfully pedantic, there is inconsistency here, with "…the use of complementary therapies" referred to in 3 e) and "The place of alternative therapies in the treatment of eczema" appearing in 4.3 e). Alternative and complementary 'therapies' are not one and the same or interchangeable. 'Alternative' means 'alternative to or instead of [conventional treatment]'; 'complementary' means 'in support of or addition to [conventional treatment]. Also, the word 'therapy' is misused in both sub-paragraphs. 'Therapy' means 'curative treatment', which no alternative or complementary treatments are where atopic eczema is concerned. The word 'therapy' should be replaced with 'treatment' wherever it occurs in the document.	The term 'complementary therapy' is now used consistently throughout the scope. The term 'complementary therapies' has been retained in the revised scope because this is an all-inclusive term (it covers medical and non-medical treatments).
Steifel Laboratories	3a	Aetiology of Eczema In order to give the final guidance additional context within primary care, we believe a short section describing the most up to date evidence for the aetiology of eczema would be beneficial. This is pertinent because the effective management of eczema and education of patients is contingent upon the physician having some understanding of the underlying cause of the disease. Our understanding of the aetiology of eczema has evolved rapidly over recent years, and many doctors within primary care may be unaware of the latest thinking. We would therefore suggest that a short review of the aetiology of Eczema is included within the scope. There is an excellent review by Leung & Bieber in the Lancet; Lancet. 2003 Jan 1;361(9352):151-60. **Atopic dermatitis.** **Leung DY**, **Bieber T**.	Thank you for this comment. The aetiology of atopic eczema will be considered during development of the guideline, but only in so far as knowledge of the aetiology improves outcomes for children with atopic eczema. This is relevant to sections 4.3a), 4.3b) and 4.3h) of the scope.

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		Division of Pediatric Allergy and Immunology, National Jewish Medical and Research Center, Denver, CO 80206, USA. leungd@njc.org Atopic dermatitis is a highly pruritic chronic inflammatory skin disorder affecting 10-20% of children worldwide. Symptoms can persist or begin in adulthood. It is also the most common cause of occupational skin disease in adults. This disease results from an interaction between susceptibility genes, the host's environment, pharmacological abnormalities, skin barrier defects, and immunological factors. New management approaches have evolved from advances in our understanding of the pathobiology of this common skin disorder.	
Steifel Laboratories	4.3	Clinical Management Effective management of eczema in order to contain the symptoms of the disease and prevent 'flare-ups' is dependant upon the proper use of the various treatments available and patient concordance with their prescribed regimen. There is currently a paucity of training for health care providers, carers and patients that are managing eczema, resulting in sub-optimal treatment of the condition. Poorly managed eczema may result in additional consultations within primary care and referrals to secondary care where increasingly aggressive and expensive treatment options are employed. We believe that by training health care professionals and patients on Eczema and its management, for example, the value of optimised emollient therapy, the condition could be better managed in many sufferers. pecifically, we believe that the inclusion of specific advice within the final guidance on the training of GPs and nurses in primary care could establish best practice for patient education in eczema, and so improve both concordance and ultimately treatment outcomes. We therefore ask that this be considered for inclusion within the scope.	This issue will be covered under section 4.3h) of the scope. Recommendations made by the guideline developers in relation to other parts of section 4.3 will also help to identify information and skills that should be made available. This could be used during implementation of the guideline to influence training/education for healthcare professionals.
Steifel Laboratories	4.3	Clinical Management Another important driver of concordance is patient choice.	Thank you for these comments. One of the main aims of producing the guideline is to promote informed patient

Stakeholder	Section	Comments	Developer's response
		For example, it is common practice for newly diagnosed people with Eczema to be offered a range of emollients to take home and trial; the patient then selects the product that they prefer and will tend to persevere with this. The very act of offering the patient this choice and providing them with options from which to select drives concordance, and so improved outcomes. We believe that this is an example of best practice in the management of eczema that should be included within the scope of the guidance.	choice. This is one of the reasons why there will be two patient/carer representatives on the GDG.
Tameside and Glossop Acute Services NHS Trust		This organisation was approached but did not respond.	
The Association of the British Pharmaceutical Industry (ABPI)		This organisation was approached but did not respond.	
The British Dietetic Association		This organisation was approached but did not respond.	
The British Psychological Society		This organisation was approached but did not respond.	
The National Pharmaceutical Association		This organisation was approached but did not respond.	
The Royal Society of Medicine	3c	First sentence, change to 'The first signs are often dry skin and inflammation, which in infants frequently start on the face and spread to the distal flexures of the limbs'.	Thank you for this comment. This section of the scope has been revised in line with your suggestions.
The Royal Society of Medicine	3d	First sentence, change to 'Conventional management involves advice on the avoidance of irritants and allergens, the use of emollients to cleanse and moisturise the skin, and topical corticosteroids to reduce irritation and inflammation'.	This change has been made.
The Royal Society of Medicine	4.1.2	Pompholyx not pompholytic eczema.	This change has been made.
The Royal Society of Medicine (2)	1 Guideline Title	Suggest age should be raised to 12 years: ie children of primary school age primary & cut off age for drug prescribing.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.

Stakeholder	Section	Comments	Developer's response
The Royal Society of Medicine (2)	3 a)	Neil Cox: *Not all eczema is chronic, even in children. Itch is the clinical hallmark, not 'irritation' which is a very non-specific term Suggest substitute:* Eczema (dermatitis) is a condition characterised by itch due to inflammation of the skin. It may be acute or chronic depending on the type and cause, and if chronic often exhibits variation in intensity over time.	Thank you for this comment. The text of this section has been revised to clarify that atopic eczema tends to be of a chronic nature with acute flare ups.
The Royal Society of Medicine (2)	3 b)	Pain is uncommon in uncomplicated eczema in children with the exception of fissures. Fissures are not common in children except in the hands & feet. Common in JPD (juvenile plantar dermatosis) but this condition has been excluded. Suggest substitute ….pain from fissures *may* also be a problem.	Thank you for this comment. Section 3d) has been revised to state that pain from fissures, particularly on the hands, *may* be a problem in chronic eczema.
The Royal Society of Medicine (2)	3d)	d) Sugest add: Conventional management involves advice *on the avoidance of irritants and, where relevant, allergens*,	This change has been made.
The Royal Society of Medicine (2)	3d)	I believe that topical antibiotic/ steroid combinations should be **avoided** in the management of AE (except short 5 day courses) as this may lead to the development of antibiotic resistance. The incidence of fucidin resistance in dermatology patients has risen steeply over the last decade. It should also be strongly discouraged in primary care.	Thank you for your comment. Paragraph 3d) provides background to the guideline. It does not specify what treatments the GDG will recommend. We have revised section 4.3c) to include the issue of antibiotic resistance.
The Royal Society of Medicine (2)	3 e	Neil Cox: The indications for the use of pimecrolimus / tacrolimus should be defined. It is often site, chronicity and desire to reduce steroid use, rather than 'severity', that determines their use.	The GDG will cross-refer to the NICE technology appraisal relating to pimecrolimus and tacrolimus, but they will not update it (nor search for evidence published since the technology appraisal was produced).
The Royal Society of Medicine (2)	3 e	What complementary therapies are to be included? These should be spelt out & clear distinction made between those that are effective & those for which there is no evidence of their effectiveness.	Thank you for this comment. This section has been expanded to list the main types of complementary therapy for which evidence is expected to be identified (homeopathy, and Chinese and Western herbal medicine). The guideline developers will search for and appraise all literature relating to complementary therapies. This will allow the developers to recommend that specific treatments should (or should not) be offered. Note that assessment of cost effectiveness will only consider NHS costs

Stakeholder	Section	Comments	Developer's response
The Royal Society of Medicine (2)	3 e	Second-line Rx includes the topical immunosuppressant agents. UVB should be used in caution in children & is probably a 'third-line' agent.	Thank you for your comments. This section of the scope has been revised in line with your suggestions.
The Royal Society of Medicine (2)	3 f	Suggest add: Lack of knowledge about treatments *and how to apply them* may lead to treatment failure.	Thank you for this comment. This issue has been addressed by including 'information' in section 4.3h).
The Royal Society of Medicine (2)	3 h	Neil Cox: Specialist help needs to be defined. A lot of dermatology departments have put effort into teaching primary care nurses about management of eczema in children, partly because specialists can't possibly see the 20% of children with this problem, and partly so that there is easy access to support via the local GP practice. There needs to be a pyramid of level of expertise to reflect the pyramid of severity.	The question of involvement of different health professionals in the management of children with atopic eczema will not be considered. This is a service issue, that is outside the remit of the GDG. The term 'specialist dermatological advice' is deliberately all-inclusive.
The Royal Society of Medicine (2)	4.1.1	Age Birth → 12 years.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
The Royal Society of Medicine (2)	4.1.2	Suggest add primary: Children with infantile seborrhoeic eczema, juvenile plantar dermatosis, *primary* irritant and allergic.	This change has been made.
The Royal Society of Medicine (2)	4.1.2	Exclusions: it is important to recognise that there is an overlap group of infants with seborrhoeic eczema, that either are itchy or have a positive family history of atopy with atopic eczema.	The scope has been revised to clarify that the guideline applies only to atopic eczema. Children with other forms of eczema are excluded from the guideline, except where these conditions occur in association with atopic eczema.
The Royal Society of Medicine (2)	4.1.2	Napkin dermatitis should be excluded – it is a sub-group of irritant dermatitis.	We agree. This will only be considered by the GDG in the specific context of an association with atopic eczema.
The Royal Society of Medicine (2)		Neil Cox Tighter definitions needed as: Pompholyx can occur as part of otherwise typical atopic eczema, and both irritant and allergic aspects may exacerbate atopic eczema,. Also need to consider your stand on nappy rash, which may occur in atopics.	The scope has been revised to clarify that the guideline applies only to atopic eczema. Children with other forms of eczema are excluded from the guideline, except where these conditions occur in association with atopic eczema. Nappy rash will only be considered by the GDG in the specific context of an association with atopic eczema.

Stakeholder	Section	Comments	Developer's response
The Royal Society of Medicine (2)	4.3.a	Diagnostic criteria: Hanifin & Rajka (major criteria only) & Williams Neither define well the definition of AE in young infants.	Thank you. The GDG will search for and appraise relevant evidence relating to diagnosis.
The Royal Society of Medicine (2)	4.3.a	Neil Cox: Diagnostic citeria these have been well validated in publications by Williams HC et al – mainly for epidemiological studies but mainly applicable to clinical use, although some limitations in the very young child.	Thank you. The GDG will search for and appraise relevant evidence relating to diagnosis.
The Royal Society of Medicine (2)	4.3.b	Severity: Several scoring systems: SCORAD; SSSAD Useful for studies but not always pratical for clinical use for clinical use. Quality of life.quality of life measures such as children's DLQI relate to severity in the last week and don't give an overall picture, but can be useful for sequential use]	Thank you. The GDG will search for and appraise relevant evidence relating to classification of severity.
The Royal Society of Medicine (2)	4.3.c	Maintenance: Moisturisers & Topical steroids <u>Moisturisers</u>; choice varies with age of child. Infants & young children greasy unless mild eg community. Older children: personal preference important. <u>Topical steroids:</u> Community: define scope of potency that can be used in primary care beforeneed for referral eg up to moderate potency to trunk & limbs.	Thank you. The GDG will search for and appraise relevant evidence relating to moisturisers and topical corticosteroids. The GDG will cross-refer to the NICE technology appraisal relating to the frequency of application of topical corticosteroids, but they will not update it (nor search for evidence published since the technology appraisal was produced).
The Royal Society of Medicine (2)	4.3 d Maintenance	• Avoid irritants • Other triggers: food, pets, House dust mite measures	Thank you. The GDG will search for and appraise relevant evidence relating to avoidance of irritants and other triggers.
The Royal Society of Medicine (2)	4.3.d Flares	Modify treatment as necessary eg increase in potency of topical steroids.	This is covered under section 4.3c).
The Royal Society of Medicine (2)	4.3.d Flares	Identification cause of flare where possible & treat eg • Infection • Teething • Adverse reaction to ingested or inhaled allergen Intercurrent illness	This information is too detailed for the scope – it will be covered under sections 4.3c) and 4.3h).
The Royal Society of Medicine (2)	4.3.d	Need: management plan of flares for family Rescue plan / hotline if this fails	This will be covered under section 4.3h).
The Royal Society of Medicine (2)	4.3.e <u>Alternative therapies</u>	• Specify effective v non-effective • Clear statement which have no scientific basis • Comment on dietary advice given by alternative practitioners • Often empirical & not supported by advice from a	Thank you for this comment. This section has been expanded to list the main types of complementary therapy for which evidence is expected to be identified (homeopathy, and Chinese and Western herbal medicine). The guideline developers will search for and appraise all

Stakeholder	Section	Comments	Developer's response
		paediatric dietician.	literature relating to complementary therapies. This will allow the developers to recommend that specific treatments should (or should not) be offered. Note that assessment of cost effectiveness will only consider NHS costs. Diet is covered under section 4.3h).
The Royal Society of Medicine (2)	4.3.f Complications:	• Bacterial infection • Viral infections: HSV Molluscum • Allergic contact dermatitis (ACD)	These are included under section 4.3e), except allergic contact dermatitis, which is exclude from the scope.
The Royal Society of Medicine (2)	4.3.g Psychological effects	• Ideally Rx by adequately treating AE • Clinical psychology	Thank you. The GDG will search for and appraise relevant evidence relating to psychological/ psychosocial effects of atopic eczema.
The Royal Society of Medicine (2)	4.3.h Indications for referral	For specialist dermatological advice • Diagnostic doubt • Severe or uncontrolled eczema • If dietary intervention needed / already instituted by family- Restricted diets in children is specialised & needs supervision by a paediatric dietician	Thank you. The GDG will search for and appraise relevant evidence relating to complications. Who delivers care is outside the remit of the GDG. The need for dietary advice, irrespective of who gives the advice, will be considered under section 4.3h).
The Royal Society of Medicine (2)	4.3.i Education	To include: • Treatment demonstration • Avoidance of irritants • Dietary advice including stopping unnecessary dietary restrictions • Avoidance irritants • Career advice • Possible eczema schools as German / Swedish / French models	Thank you. The GDG will search for and appraise relevant evidence relating to information, education and support for children with atopic eczema and their families/carers. Career advice is outside the scope.
The Royal Society of Medicine (2)	**Additional: Investigations**	• Investigations: Place & value of skin prick tests, specific IgEs • Patch testing • Career advice	The guideline will not cover diagnosis and management of allergies (including food allergies), except where they are directly relevant to the management of atopic eczema. Career advice is outside the scope.
The Royal Society of Medicine (2)	**Networked service**	• Development of network of specialised paediatric dermatology nursing network	Who delivers care is outside the remit of the GDG.

Stakeholder	Section	Comments	Developer's response
University College London Hospitals NHS Trust	4.1.1	Suggest birth to 12 or 13 years. Ten is too young as upper limit.	The upper age limit for the guideline has been changed to 12 years. This is related to the differences in the licensing of pharmaceutical products that occurs when children reach the age of 12 years, and the fact that children reach puberty at about this age. The fact that the guideline applies to children of up to 12 years does not imply that children older than 12 years should be cared for as if they were adults – these children are simply outside the scope of the guideline.
University College London Hospitals NHS Trust	4.1.2	Is there any point in excluding 'seborrheic dermatitis' since conditions sometimes difficult to distinguish.	The scope has been revised to clarify that the diagnostic criteria apply only to atopic eczema. Children with other forms of eczema are excluded from the guideline, except where these conditions occur in association with atopic eczema.
University College London Hospitals NHS Trust	4.3.e	"Alternative" How are you defining this term. Would 'alternative (non-medical) interventions' be clearer.	The term 'complementary therapy' is now used consistently throughout the scope. The term 'complementary therapies' has been retained in the revised scope because this is an all-inclusive term (it covers medical and non-medical treatments).
University College London Hospitals NHS Trust	4.3.d	Will "interventions" include assessment of preventative measures – particularly when used as an intervention to reduce flares.	Primary prevention of atopic eczema is outside the scope. This has been clarified in section 4.3i). Measures to reduce flare ups will be covered under sections 4.3c) and 4.3h).
University College London Hospitals NHS Trust	3h	This should include the different types of specialist help – consultant dermatologist, consultant nurse, consultant paediatrician.	Who provides care is a service delivery issue and is outside the remit of the guideline delivery group. This will not prevent the GDG recommending referrals for specific *forms* of care/support under sections 4.3g and 4.3h).
University College London Hospitals NHS Trust	4 2	In many areas – community care is part of primary care.	We agree. The guideline will not distinguish between different care sectors because this relates to service delivery, which is outside the GDG's remit. The guideline will recommend *forms* of care that should (or should not) be offered.
University College London Hospitals NHS Trust	General	Would recommend a community or school nurse might be on the guideline group.	We agree and a school nurse or community nurse (or health visitor) will be included in the GDG.
Walsall Teaching Primary Care Trust		This organisation was approached but did not respond.	
Welsh Assembly Government (formerly National Assembly for Wales)		This organisation was approached but did not respond.	

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Welsh Scientific Advisory Committee (WSAC)		This organisation was approached but did not respond.	
West Middlesex University Hospital NHS Trust		This organisation was approached but did not respond.	