An overview of eczema management for community nurses

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This article provides an overview of the common eczematous conditions that patients may present with in the community. With early diagnosis and treatment, including patient education and effective care planning, eczema can be managed successfully by community nurses, not only relieving pain, itch and irritation, but also improving patients’ quality of life. When formulating a comprehensive management plan, community nurses will need to be able to recognise, diagnose and treat the different presentations of eczema as well as understanding the main therapies, including emollient and topical steroid therapy.

KEYWORDS: Skin care | Eczema | Complete emollient therapy | Patient education

Eczema describes a variety of inflammatory skin disorders that are characterised by dry skin — this may be acute or chronic and sometimes both. Due to its complexity, diagnosing the different eczema presentations and arriving at the correct management strategy can be challenging for community nurses.

In the author’s experience a large proportion of eczema care is delivered by community nurses, particularly when it comes to the management of lower limb conditions such as venous eczema. The aim of treatment is to rehydrate the skin, reduce inflammation and improve patients’ quality of life (Turnbull, 2003).

WHAT IS ECZEMA?

According to Peate (2011), there are three main eczema classifications:

- **Endogenous**: this develops from conditions such as venous hypertension or from internal factors such as atopy (a syndrome characterised by a tendency to be ‘hyperallergic’, as in allergic rhinitis [hayfever], eczema itself or asthma)
- **Exogenous**: this kind of eczema develops from external factors, such as contact with chemicals allergens or the environment
- **Unclassified**: this is where there is no known endogenous or exogenous cause.

Eczema may be widespread or more localised, with common signs including (Buxton, 1999):

- Inflammation
- Pruritus: itchiness
- Erythema: reddening of the skin caused by dilated capillaries
- Vesicles: blistering on the surface of the skin
- Pustules
- Scaling
- Hyperkeratosis: abnormal thickening of the outer layer of the skin (not as common).

The most common symptom of eczema is pruritus (itch). In the author’s clinical experience patients often describe this as ‘burning’, ‘irritating’ and even painful.

Commonly seen presentations also include ‘oozing’ of serous fluid in acute eczema or ‘crusting’ in infected eczema. Lichenification or thickening of the skin can occur in chronic eczema or in repeatedly scratched itchy skin (for instance in lichen simplex eczema), where the skin thickens as a way of protecting itself.

Eczema commonly affects the face, scalp and flexures (i.e. the skin in the creases of the elbows and backs of the knees) in younger patients and may be classed as atopic when the history taking and findings support this diagnosis. Atopic eczema is quite common in young children.

A history of atopy in the immediate family may provide further evidence of the atopic nature of an individual’s eczema presentation (Ashton et al, 2005).

Eczema on the extensors (e.g. the outer surfaces of the elbows) or surfaces such as the hands and lower limbs may recur in patients who experienced atopic eczema when they were younger (Ashton et al, 2005).

Eczema, however, can present anywhere on the skin at any age — including the scalp, the skin on the genitalia and sometimes the nails — often in a discoid shape and/or generalised widespread pattern.

The acute phase of eczema is characterised by the development of vesicles on the patient’s skin (Ashton et al, 2005); whereas a thickening of the skin characterises chronic disease.

Psychosocial symptoms

In addition to the physical discomfort associated with eczema, patients experience of living with the condition can significantly impact on their quality of life (Penzer and Ersser, 2010).
The itch associated with eczema can be very disabling and the sore, inflamed and hot skin can be particularly painful. From a cosmetic perspective, the constant shedding of dry skin can be difficult to hide. In the author’s clinical experience, patients can find the condition very embarrassing and difficult to live with and in some cases this can lead to low mood and depression.

The financial cost of treating eczema is also significant, with time spent attending appointments, loss of working or school days, prescription costs, as well as hospital admissions, all resulting in a significant burden for the healthcare economy, not to mention patients themselves (Schofield et al, 2009).

**SPECIFIC TYPES OF ECZEMA**

**Seborrhoeic eczema**
Seborrhoeic eczema is a common, chronic or relapsing form of eczema/dermatitis that mainly affects the scalp, face and chest and has childhood and adult forms. Certain factors may dispose people to the severe adult form of seborrhoeic eczema (Oakley, 2014a):
- Seborrhoea (oily skin)
- Family history of psoriasis
- Procedures or conditions that compromise the individual’s immune system such as organ transplant or human immunodeficiency virus (HIV)
- Certain neurological and psychiatric conditions, including Parkinson’s disease, tardive dyskinesia, depression.

**Hand dermatitis**
Hand dermatitis is a common disorder affecting patients of all ages and with a range of presentations. Contact irritant dermatitis is the commonest form of hand eczema (Ashton et al, 2005) and protecting the skin barrier is of great importance, as is identifying any potential contact allergens or irritants that might contribute to the condition.

People with hand eczema may also have a history of atopy and dermatitis may be related to the person’s occupation (Jensen et al, 2011). Sometimes the diagnosis is not clear and a tinea (fungal) infection or psoriasis may need to be considered — if there is any doubt the community nurse should refer the patient to a dermatology specialist to confirm the diagnosis.

**Discoid eczema**
Discoid eczema or nummular dermatitis is a common type of eczema/dermatitis characterised by ‘crusty’ scaly skin and may be wet or dry with round or oval-shaped lesions (Oakley, 2014b) (Figure 1). Complete emollient therapy, topical steroids and combined antibiotic topical steroids (see below) may be required. A potent topical steroid applied twice daily is required to treat discoid eczema (Ashton et al, 2005) — in practice 2–4 weeks of treatment may be required before ‘stepping’ the potency down as the condition settles.

**Atopic eczema**
Atopic eczema can present at any time of life but usually develops in childhood. It is increasingly being seen by community nurses as health care is moved from hospitals into the community. Patients with eczema were traditionally seen in hospital departments and may have received inpatient care for some treatments. More recently the number of inpatient dermatology beds has been vastly reduced and greater numbers of patients are self-managing their topical treatment regimens with the support of community nurses.

Atopic eczema is the most common inflammatory skin condition in children, affecting 15–20% of school-aged children (RCN, 2013). In adults, the condition mainly affects those who have an atopic background.

**Varicose eczema**
Eczema of the lower limb may be varicose in nature and include signs of lipodermatosclerosis — a symptom of long-standing venous disease that results in inflammation of the subcutaneous fat, tightening the skin.

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**THE SCIENCE — WHAT IS AN EMOLLIENT?**

The terms ‘emollient’ and ‘moisturiser’ are often used interchangeably. The lack of consistency in terminology can be confusing, especially as many products have both occlusive and moisturising properties.

However, an emollient should reduce the clinical signs of dryness (rough or ‘scaly’ skin), as well as calming itching and the sense of ‘tightness’ in the skin. They should also be acceptable to patients cosmetically, helping them to maintain their lifestyle.

Emollients moisturise the skin by increasing the water content of the stratum corneum and depending on the particular ingredients, they do this either by occlusion (‘trapping’ moisture into the skin), or by ‘drawing’ moisture into the skin.

*Source: British Dermatological Nursing Group (BDNG) Best Practice in Emollient Therapy. Available online: www.bdng.org.uk/documents/emollientbpg.pdf*
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3 out of 4 patients prefer AVEENO® Cream

- Uniquely formulated with colloidal oatmeal
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- Suitable for all skin types from 3 months

References:
1. Netdoctor.co.uk and AVEENO® Dry Skin study – February 2008 (n=133 participants at Week 2).

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SKIN CARE

Five-minute test

Answer the following questions about this topic, either to test the new knowledge you have gained or to form part of your ongoing practice development portfolio.

1 – What is the aim of complete emollient therapy?
2 – What are the common features of eczema?
3 – Name the most effective treatments for eczema.
4 – Are you familiar with the different types of eczema?
5 – Would you know how to identify the signs of infection in eczema?

and causing significant pain. There may also be signs of venous insufficiency such as ankle flare, atrophy blanche (white patches of scarring on the lower leg caused by poor blood supply) or prominent varicose veins requiring compression therapy (see below under ‘management’). Older people can develop varicose eczema as a result of venous hypertension and damaged veins and valves, which can cause itchy dry skin.

SKIN ASSESSMENT

A healthy skin barrier provides the body with a protective layer against the external environment, preventing the penetration of allergens and irritants and ensuring the skin does not lose excess moisture from its deeper layers. Dry skin and eczema can develop — or continue to deteriorate — when the skin’s barrier is compromised. This can affect all age groups, but particularly younger and older people and/or those with an inherited predisposition to atopic eczema and other dry skin conditions.

Community nurses are ideally placed to inform patients about skin care including the prevention of dry skin as they see a lot of patients and can identify any dry skin issues early on. This enables them to advise and prevent further deterioration by commencing complete emollient therapy. Accurate assessment is essential and can involve a head-to-toe examination of the patient’s skin for signs of skin disease, including the soles of the feet, the scalp, ears and nails — it is also occasionally found in the buccal mucosa (soft inner lining of the cheek) or the genitals.

Community nurses should document any findings at each patient contact, paying particular attention to the severity of the eczema, the distribution over the body, the condition of the skin and any associated symptoms, such as itching, weeping, discomfort and pain. Even those with some training in managing patients with eczema can feel challenged by the extensive range of eczematous presentations, the difficulty of managing the associated symptoms, and selecting the appropriate treatment preparations.

Where a diagnosis of eczema is not clear, or there is a significant psychological impact on the patient, a referral to a specialist dermatology service should be made. Similarly, if the condition is moderate-to-severe or very widespread, or where treatment has not been effective, a referral is required. In some cases, further investigations such as patch testing may be indicated. Patch testing involves applying to patients’ skin samples or ‘patches’ of substances that they may frequently come into contact with, e.g. preservatives, perfumes etc, and which may trigger the skin problem. Higher-level treatments — for example systemic immunosuppressive therapies such as azathioprine — may also be required.

Community nurses should be aware of any associated symptoms, such as ankle flare, atrophy blanche (white patches of scarring on the lower leg caused by poor blood supply) or prominent varicose veins requiring compression therapy (see below under ‘management’). Older people can develop varicose eczema as a result of venous hypertension and damaged veins and valves, which can cause itchy dry skin.

Fifteen-minute test

1 – What is the aim of complete emollient therapy?
2 – What are the common features of eczema?
3 – Name the most effective treatments for eczema.
4 – Are you familiar with the different types of eczema?
5 – Would you know how to identify the signs of infection in eczema?

Patients require a management plan that is tailored to their individual needs. This should take into account how they wash and the type of emollients they prefer to use, as well as considering any cultural differences, for example, not ‘soaking’ in the bath or washing regularly before prayer.

An exhaustive list of all the treatment options for community patients with eczema is hard to define, but would include the following:

- Emollients
- Soap substitutes
- Bath additives/shower preparations
- Topical corticosteroid preparations
- Combined topical preparations
- Antibiotic therapy
- Antiviral therapy (if eczema herpeticum is suspected or presents (National Institute for Health and Care Excellence [NICE], 2007)
- Sedating antihistamines for short term use to support sleep patterns (Ashton et al, 2005; NICE, 2007)
- Bandages, including tubular bandages and cotton or silk garments: these are helpful in keeping topical treatments in place and are occlusive. They can help very dry itchy skin, eczemas and thickened lichenified eczema, but should not be used when the skin is infected. Silk garments can help to reduce feelings of heat, itch and friction and is worn usually under the patient’s normal clothes
- Pain relief for severe/infected eczema (see Figure 2)
- Potassium permanganate soaks for very wet ‘weepy’ eczema
- Medicated paste bandages for lichenified eczema and nodular forms of eczema (such as nodular

Figure 2.
Infected eczema.
Adverse Effects:
Balneum Plus Cream has been reported to cause a burning sensation, erythema, pruritus or the formation of pustules, aggravation of eczema if applied to inflamed skin areas. Contact allergy has also been reported.

Legal Category: GSL.

Marketing Authorisation Number(s): PL 33016/0010.


Marketing Authorisation Holder: Almirall Hermal GmbH, Scholtzstrasse 3, 21465 Reinbek, Germany.

Further information is available from: Almirall Limited, 1 The Square, Stockley Park, Uxbridge, Middlesex, UB11 1TD, UK. Tel: (0) 207 160 2500. Fax: (0) 208 7563 888. Email: almirall@professionalinformation.co.uk.

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Relief from Dry Itchy Skin

Urea 5% and lauromacrogols 3%

Balneum Plus Cream

Lauromacrogols 3.0 % w/w and urea 5.0 % w/w.

Active Ingredient: lauromacrogols 3.0 % w/w and urea 5.0 % w/w.

Indication: For the treatment of pruritus, eczema, dermatitis and scaling skin conditions where an antipruritic and/or hydrating effect is required. It may also be used for the continued treatment and follow-up treatment of these skin diseases.

Dosage and Administration: Adults, the elderly and children: Apply to each affected area twice a day. The duration of treatment depends on the clinical response. For external use only.

Contraindications, Warnings, etc: Contraindications: Patients with known hypersensitivity to any of the ingredients. It should not be used to treat acute erythroderma, acute inflammatory, oozing or infected skin lesions. Precautions: May cause irritation if applied to broken or inflamed skin. Interactions: None known.

Pregnancy and lactation: No clinical data on exposed pregnancies are available. Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryional/foetal development, parturition or postnatal development. There are no specific restrictions concerning its use during pregnancy, but it is not to be used on the breasts immediately prior to breast feeding during lactation. Ability to drive and use machines: None.

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Adverse events should be reported.
Reporting forms and information can be found at www.mhra.gov.uk/yellowcard.
Adverse events should also be reported to Almirall Ltd.
prurigo eczema, a condition characterised by very itchy firm lumps

- Antifungal creams for eborric eczemas
- Compression therapy alongside topical treatments for varicose eczema.

The main treatments that community nurses need to be familiar with are outlined in more detail below.

**Emollients/bath additives and soap substitutes**

Emollients are designed to soften and hydrate the skin and can include:
- Moisturising creams
- Ointments
- Lotions and sprays
- Bath oils and shower products
- Soap substitutes.

As well as these, the British National Formulary (BNF) (Royal Pharmaceutical Society [RPS]; British Medical Association [BMA], 2015) identifies many other preparations including bland ointments and enhanced emollients that contain urea, glycerine or and ceramides (waxy lipid molecules).

Nurses should ensure that the emollient therapy prescribed is cosmetically acceptable to the patient. Complete emollient therapy (CET) involves keeping the skin moisturised at all times through a combination of frequently applied products. It is important that patients, families and carers are educated on how to perform this correctly and safely.

Emollients should be applied in a stroking or ‘smoothing’ motion in the direction of hair growth — this prevents potential ‘plugging’ of the hair follicles and the risk of infection or inflammation (folliculitis) (Robinson, 2007). Leave-on emollients/moisturisers should be applied frequently to prevent dryness and itching and to restore and improve the skin’s barrier function.

With the use of paraffin-based preparations, health and safety issues such as flammability and potential risk of slipping should be discussed with patients and documented (National Patient Safety Agency [NPSA], 2007).

What is known as ‘pot hygiene’ — the use of a spoon or spatula to remove emollient from tubs — is also vital to prevent bacterial contamination of the contents.

In the author’s clinical experience, community nurses may find that cream-based preparations are helpful for ‘wet’ or ‘weezy’ eczema. Creams can help to ‘dry-up’ these types of eczemas whereas ointments tend to ‘slide-off’ or even occlude any underlying infection/exudate, making it worse.

In the case of ‘dry’ and/or ‘scaly’ eczemas such as hyperkeratotic eczema, ointments or enhanced emollients may be of more benefit as they can soften thick scale.

Antimicrobial emollients are designed to be used when the skin is infected and work by reducing the levels of bacterial carriage on the skin. They include antimicrobial ingredients such as benzalkonium chloride, chlorhexidine dihydrochloride or triclosan. There are also antimicrobial emollient bath additives and wash creams for patients who develop an infection or are prone to repeated episodes of skin infection.

Bathing and washing preparations come in oily and ‘milky’ preparations and creams or lotions. Some of the ointments are known as ‘three-in-one’ preparations in that they can be added to baths, applied to the skin before bathing and used for moisturising afterwards.

Emollient ladders are graphic representations that help to identify different groups of emollients, from light lotions, simple and rich creams, enhanced emollients, and heavy greasier occlusive products. They are used in many trusts to support practice and along with local skin formularies can help nurses to differentiate the range of products.

**Topical steroid preparations**

Topical steroids reduce inflammation and can be very effective in controlling eczema flare-ups. Topical steroids should be applied in short treatment bursts unless directed otherwise by the prescriber (once-to-twice per day (NICE, 2004).

In the UK, topical steroids are available as ointments, creams, lotions, scalp applications and as an impregnated steroid in a tape. They are available in four potencies:

- Mild
- Moderately potent
- Potent
- Super-potent.

The BNF (RPS/BMA, 2015) lists the potency of the various preparations available and it is vital to know what strength of steroid is being used to avoid applying a stronger preparation for too long as this will increase the risk of side-effects such as steroid atrophy, which has a range of implications including thinning of the epidermis and dermis.

NICE (2007) and the BNF (RPS; BMA, 2015) recommend the use of a mild potency steroid for mild atopic eczema; a moderate steroid for moderate atopic eczema; and a potent steroid for more severe atopic eczemas. This can be applied to most forms of eczema that present on the body and/or limbs, however, it is not advised to use potent steroid preparations on the face. The stepped
Doublebase™ Gel
Isopropyl myristate 15% w/w, liquid paraffin 15% w/w

Enhanced emollient Gel
An enhanced emollient gel with highly moisturising and long lasting protection.4,5
As little as twice daily application

Doublebase Dayleve™ Gel
Isopropyl myristate 15% w/w, liquid paraffin 15% w/w

atopic eczema care plan (NICE, 2007) recommends stepping-up to a stronger preparation to control flare-ups, before stepping-down to milder steroid as the condition improves.

On the face and neck a mild potency steroid is usually sufficient to get the eczema under control, except in more severe cases where a moderate potency steroid may be required for 3–5 days. In the skin folds of the axillae (armpits) a milder preparation such as 1% hydrocortisone should be sufficient. Moderate or potent preparations should only used for short periods, for example 7–14 days for flare-ups (NICE, 2007).

On the palms of the hands and the soles of the feet a stronger potency steroid will be needed particularly for adult patients. This is to enable penetration of the steroid through the thicker layers of skin in this area. However, as above, when treating the face or eyelids, or areas where the skin folds meet such as the axillae or groin, then a milder preparation will be required.

Topical steroid ladders (see above) may be helpful to support nurses in using topical steroids alongside the BNF (RPS/BMA, 2015).

Side effects
The side effects of topical steroids include:

- Skin atrophy: thinning of skin, purpura (bruising under the skin), striae (stretch-marks), rosacea, perioral dermatitis, and acne
- Hypertrichosis: excessive hair growth
- Altered skin pigment.

The side effects of a topical steroid preparation are directly related to its potency, the skin site where it is being used, the duration of use, the condition of the skin on which it is used, and the age of the person concerned. All of these factors should be taken into consideration when prescribing for eczema and this is why a stepped approach is advised in the literature, particularly for the management of atopic eczema in children (NICE 2007).

Applying topical steroids using the finger tip unit guide (see Figure 3) helps to ensure treatment is applied safely.

Combined topical preparations
Topical steroid and antifungal preparations
A combination of topical steroid and antifungal preparations can be prescribed for seborrhoeic eczema or eczema combined with fungal infections — these develop in the warm ‘sweaty’ areas of the skin and on the feet (Oakley, 2014c).

Topical steroid and antifungal preparations include mild combinations of hydrocortisone and miconazole nitrate in a cream/ointment (e.g. Daktacort®; Janssen-Cilag) and preparations of clotrimazole and hydrocortisone (e.g. Canesten®, Bayer). More potent preparations are also available, such as betamethasone dipropionate and clotrimazole (e.g. Lotriderm®; Teva UK).

The milder preparations are usually used for periods of 7–14 days; whereas the stronger preparations are recommended for 5–7 days only before being reduced to a milder preparation twice-daily for a further 5–7 days and then stopped altogether (RPS/BMA, 2015).

Topical steroid and antibiotic preparations
Preparations that combine topical steroids (corticosteroids) and antibiotics are commonly used in community settings for locally infected eczemas. These include a combination of anti-inflammatory corticosteroids such as hydrocortisone or betamethasone valerate and fusidic acid, which treats most common bacterial skin infections (e.g. Fucidin® cream; Leo Pharma; Fucibet cream; Leo Pharma).

Antibiotic therapy
Antibiotics may be required if the skin presents with signs of infection such as increased exudate, inflammation and pain. Impetiginised eczema/dermatitis infection occurs with Staphylococcus pyogenes or Staphylococcus aureus and complicates an underlying cutaneous inflammation, especially atopic eczema (Hirschmann, 2001).

Here, the skin can become wet, yellow and crusty and infected patches may be localised — on the limbs for example — or found in a more widespread distribution.

If patients complain of hot inflamed skin on their lower limbs that has begun to ooze or look different — especially with an increase in pain or the development of associated fever — this may indicate infection.

Localised patches of infected eczema on the limbs may require topical therapy, for example a seven-day course of topical fusidic acid and betamethasone cream, whereas a more widespread infection will require a 7–14-day course of oral antibiotic therapy. In very severe infections, intravenous (IV) antibiotic may be warranted (Ashton et al, 2005).

An oral systemic antibiotic (fluclouxacinil) should be used for widespread infected eczema, with erythromycin used in those who have a known allergy to penicillin (Ashton et al, 2005; NICE 2007).

These antibiotics should be used in conjunction with complete emollient therapy and a topical steroid that matches the severity of the eczema — bearing in mind the site of skin being treated, for example a milder steroid being applied to the softer skin on the face than on the body.

Antihistamines
Antihistamine preparations are not routinely used in the management of eczema but may be beneficial for those patients who are disturbed by itching in the night and who are not getting good quality sleep. NICE (2007) advises a one-month trial of a non-sedating antihistamine for children with severe atopic eczema or children with mild or moderate atopic eczema where there is severe itching or urticaria.

In the author’s clinical experience, some adults with eczema may also
benefit from the short term use of a sedating antihistamine when their eczema has flared-up and is disturbing their sleep.

Bandages/occlusive therapy
Tubular bandages and cotton garments may be beneficial in keeping creams and emollients etc in place and can have an occlusive effect, reducing water loss and covering the skin’s surface with a protective film. Tubular bandages and occlusive garments come in different sizes and can be prescribed according to limb size, body size or age. For example, cotton gloves for adults and children with eczema on their hands are available in different sizes and can help to prevent contact dermatitis, while medicated bandages impregnated with substances such as ichthammol (a topical bituminous agent with mild antiseptic and anti-inflammatory properties), or zinc oxide (ZIPZOC®; Smith and Nephew) are applied underneath an outer bandage/tubular bandage and can soothe excoriated and lichenified eczema.

Cotton garments, bandages and other occlusive therapies should not be used when eczema is heavily infected. Infected eczema should not be covered.

Compression therapy
Compression therapy using bandages or hosiery will promote venous return and help to prevent venous ulceration in the future. Compression can also further reduce the discomfort of the inflammation and itch associated with eczema.

A Doppler ultrasound assessment is essential before compression therapy is prescribed and according to NICE (2012), ‘if use of compression stockings is being considered, an assessment is essential including the measure of the ankle-brachial pressure index using a Doppler machine. This is to ensure there are no contraindications such as arterial disease that may prevent safe use of compression’.

Where compression therapy is found to be suitable, patients should be
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endogenous forms such as contact of eczema — particularly the presenting symptoms. Some types personal and family history and of the skin and from the patient’s during the physical assessment is not always easy. A working hand dermatitis. There are a variety of eczemas that community nurses may see, including patient information leaflets and practical instruction with relevant information such as leaflets provided.

Daily complete emollient therapy and use of a topical steroid may be required to treat any varicose eczema before applying compression therapy. Short term use of a topical steroid may be helpful initially to settle the eczema and the potency should be selected according to the severity of the eczema and then stepped down to a milder preparation as the condition improves.

Patients who require long-term use of topical steroids should be monitored by a dermatology specialist and provided with clear guidance on how to use them safely, e.g. twice-weekly or with regular breaks to minimise the risk of atrophy.

Other treatments
As mentioned above, eczema can occasionally become very wet and oozing with crusty skin. In the author’s clinical experience, these symptoms may benefit from a wet soak. The most common of these soaks is potassium permanganate in tablet form dissolved in water, which helps to dry wet, ‘weepy’ varicose eczema. The tablet is placed in a bucket of water where it should dilute to a pale pink ‘rose wine’ colour. It can also be applied by soaking a flannel and applying it to the area for 15 minutes. This treatment does stain the skin (and the bath, sink, etc), so should be used with care.

CONCLUSION
There are a variety of eczemas that community nurses may see, including discoid eczema, atopic eczema, varicose eczema, nodular prurigo eczema, seborrhoeic eczema and hand dermatitis.

Making a diagnosis of eczema is not always easy. A working diagnosis is based on what is seen during the physical assessment of the skin and from the patient’s personal and family history and presenting symptoms. Some types of eczema — particularly the endogenous forms such as contact dermatitis — may need further testing to identify a cause.

In the author’s experience it is important to provide written information and a treatment plan and to demonstrate any treatment techniques so that patients know what is required of them. Patients and nurses need to know when and how to step treatment up or down and how to recognise and treat infected episodes of eczema (NICE, 2007). The side effects of treatments should also be discussed alongside the health and safety issues, for example around the flammability of paraffin products and the risk of slipping with emollients (NPSA, 2015).

Community nurses who have an interest in managing eczema should take advantage of the literature available. Similarly, for community nurses and patients who need to find out more, there are some excellent resources available, including the National Eczema Society (www.eczema.org), DermNet NZ (www.dermnetnz.org), the British Association of Dermatologists (www.bad.org.uk) and the British Association of Dermatological Nurses (BDNG) (www.bdng.org.uk) of all which have excellent resources for nurses to use including patient information leaflets to support clinical practice.

Nurses have an important role to play, not only in treating patients with eczema but also in educating and advising patients on how to use complete emollient therapy, topical treatments and adjunctive therapies, all of which will help people manage their eczema more independently.

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