Creating an Action Plan for Eczema Patients

In the United States, almost one-quarter of the population may have eczema. Good skin care is the backbone of therapeutic intervention in these patients. Herein, strategies for developing a personalized eczema action plan are discussed.

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What does your patient need to know at the first visit?

The most essential information to share with patients at the first visit (as well as at all subsequent visits) is your eczema action plan, which should include discussion and potential modification of bathing regimens, use of topical emollients and medications, and exposure to detergents. It also is important to discuss the patient's disease pattern (eg, triggers, seasonal flares, other forms of atopy), medication history, and past treatment responses. The eczema action plan is extremely vital for a variety of reasons. As a physician, I can't be present every time a patient has a severe flare, and it would be difficult—both physically and financially—for patients to come in to my office every time a flare occurs. Patients and their caregivers need to develop a sense of empowerment at the first visit so they can address symptoms as they arise and actively prevent severe flares by following a gentle skin care plan that includes topical emollients and gentle cleansing.

I also like to emphasize to my eczema patients that they are not alone. In the United States, almost one-quarter of the population may have eczema. It's also essential to explain to patients/caregivers that eczema is not caused by food allergies and cannot be cured by food elimination or other dietary modifications. Finally, I like to explain to patients that there is no true cure for eczema and that they will need to follow the action plan throughout their lifetime to help treat and prevent flares. Follow-up visits to review therapeutic response and review the patient's eczema action plan can reinforce adherence and knowledge about the disease.

What are your go-to treatments? Are there any side effects?

Typically I prescribe 3 to 4 medications, which include an agent for the head and neck areas and/or areas of sensitive or thin skin, an agent for the body, an antihistamine to address sleep disturbances, and a rescue medication, which is a somewhat stronger topical agent for severe areas if present. Elimination of triggers such as fragrance and wool can be discussed. Review of *Staphylococcus aureus* as a trigger and addressing this trigger with bleach baths or other modifications (eg, topical antibacterials for crusted areas of skin) is needed.

Eczema treatment is a multistep process that varies by individual as well as by cost. For most eczema patients, treatment typically costs hundreds of dollars per year; therefore, I try to be mindful of the financial hardship that can be brought on by the need for many products. The mainstay of eczema therapy includes topical emollients along with gentle cleansers, laundry detergents, and other topical products. Topical corticosteroids are the first-line treatment and have been used for over 60 years with good outcomes in most patients when used judiciously; however, side effects including striae, glaucoma and hypothalamic-pituitary-adrenal axis suppression can occur. Topical corticosteroids should be selected by class and formulation—ointments and some newer

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base formulations are known to cause the least amount of stinging. In infants, the least potent agent that clears the skin effectively may maximize outcomes and minimize risk for side effects. Topical calcineurin inhibitors may be a good option in patients who do not respond to corticosteroids and are supported by excellent clinical evidence; however, be sure to consider the black box warnings.[1-3] Sedating antihistamines can be prescribed for bedtime usage in pruritic patients who experience sleep disturbances.

How do you keep patients compliant with treatment?

Patients can only comply with treatment if they have an adequate supply of the treatment product. It is important to prescribe the right amount of product needed to treat the affected area. Provision of refills for recurrent disease also can ensure long-term treatment compliance.

It also is important to have a conversation with patients about the nature of their disease flares. In my practice, patients typically report having seasonal flares, especially in midsummer temperatures or when the indoor heating kicks on in late fall. Encourage patients to schedule appointments in advance of these seasons; refilling medications beforehand and liberal application of emollients also can mitigate seasonal flares.

Finally, I try to recommend or prescribe treatments that appeal to patients both physically and emotionally. Some patients have a fear of using topical corticosteroids (known as corticophobia or steroid phobia). For these patients, I maximize the use of topical emollients and/or enhanced emollients (eg, agents with lipid additives and ceramides) to reduce the need for topical corticosteroids. I also have found that many preteen boys dislike "sticky" emollients, so light or midweight creams may be more tolerable for nightly use in this population. Another common scenario is the patient who prefers natural products. There are a variety of natural agents available that can aid in the treatment of eczema, including coconut oil, ceramide-based products, and oleodistillates. I try to refer to the literature to encourage the use of natural products that are backed by good science rather than big hype.

What do you do if patients refuse treatment?

As a physician, I can't force patients or their caregivers to adhere to the therapies I prescribe; however, most patients are genuinely seeking a better quality of life and therefore there usually is at least some aspect of a skin care regimen they will follow to achieve relief when needed. First I make sure that serious issues (eg, bacterial infections) are addressed. I do mention to patients/caregivers that lack of treatment with topical prescription agents may have biological consequences; for example, there is evidence to support the Atopic March (ie, progression of atopic diseases to food allergies, asthma, etc). Consequences also can include discomfort, reduced quality of life, and negative effects on personal relationships; pediatric patients also may be stigmatized by their peers. Exploration of the root cause of treatment refusal usually yields a helpful discussion with the patient/caregiver about their fears as well as alternative treatment agents. Sometimes I engage the pediatrician/primary care physician, an allergist, or a family member in the discussion to enhance compliance and provide patient/caregiver support. At the very least, most patients/caregivers will adhere to trigger avoidance and barrier repair through application of emollients.

What resources do you recommend to patients for more information?

There are many resources available to patients that may enhance the overall management of eczema. I give my patients an educational handout about eczema as well as a hardcopy of their personal eczema action plan. For pediatric patients, I write the child's first name and the date to help his or her caregivers remember when they received the plan. Examples of eczema action plans can be found in published resources ranging from simple to complex regimens and should be tailored to the physician's own patient education and treatment patterns.[4,5] The National Eczema Association Web site (https://nationaleczema.org/) provides many resources for patients, including educational tools and an online community.

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