A CLINICAL PRACTICE GUIDELINE FOR PEDIATRIC ATOPIC DERMATITIS FOR THE NURSE PRACTITIONER IN THE AMBULATORY CARE DEPARTMENT

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A Clinical Practice Guideline for Pediatric Atopic Dermatitis for the Nurse Practitioner in the Ambulatory Care Department

By

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ABSTRACT

A CLINICAL PRACTICE GUIDELINE FOR PEDIATRIC ATOPIC DERMATITIS FOR THE NURSE PRACTITIONER IN THE AMBULATORY CARE DEPARTMENT

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It is estimated that 10% of the pediatric population is diagnosis with pediatric atopic dermatitis and 80% of outpatient visits for PAD were made to an emergency room (Romeo, 1995). This scholarly project describes the development of a clinical practice guideline for pediatric atopic dermatitis (PAD) for use by the nurse practitioner (NP) in the ambulatory care department. Orem's Self-Care Deficit Theory of Nursing provides the framework for it's development. The guideline provides the NP with a reference to facilitate the most appropriate decisions regarding the treatment of PAD, avoiding misdiagnosis and mismanagement of the disease. An educational pamphlet accompanies the guideline in order to reinforce teaching given to the parent(s) by the NP during the initial visit. Both the guideline and educational pamphlet are based on scientific knowledge and research and should assist the nurse practitioner in assuming a stronger role as a primary care provider by promoting a positive patient outcome. Implications for practice, education, and research are examined.

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Introduction

The primary function of the skin is to protect the body from the environment; it is the largest organ of the body and accounts for approximately 20% of the body's weight (McCance & Huether, 1994). The skin measures between .3mm to 5.4mm in thickness and is made up of many layers including the epidermis and dermis (McCance & Huether). Due to the fact that children have thinner skin, they are at an increased risk for developing skin disorders (Singleton, 1997). Romeo (1995) estimates that 10% of the pediatric population is diagnosed with pediatric atopic dermatitis (PAD).

Romeo (1995) categorizes atopic dermatitis (AD) into three stages: infantile, childhood and adolescent/adult. The infantile stage affects the child between the ages of 2-6months and usually resolves in half of those affected by age 2-3 years. Infantile AD is characterized by pruritis, erythema, exudation, and crusts. The areas that are most likely affected are the cheeks, forehead, scalp, and extensor surfaces of the arms and legs; the diaper area is rarely affected. Childhood AD affects children ages 4-10 years and presents with a chronic form of dry, scaly, itchy patches to the wrists, ankles, antecubital and popiteal spaces. Adolescent/adult AD presents as chronic exudation and crusting, and is reflective of external irritation and secondary infection. The areas of the body that are most affected are flexor folds, face, neck, back, arms, and dorsal aspects of the hands, feet, fingers and toes.

While much of the literature focuses on AD in the adolescent/adult, it is a problem primarily encountered in the pediatric population (Romeo, 1995). AD initially occurs in infancy and childhood; 60 percent of children diagnosed with AD experience onset in the

first year of life and 85% of the children experience onset before the age of six (Romeo,1995).

Skin disorders account for 20-25% of all patients seen in primary care (McCarthy, 1991) and also account for 20-30% of pediatric primary care visits (Singleton, 1997). The skin disorders that bring these patients in for treatment include: skin infections, inflammatory response, insect bites, and infestations (Singleton). McCarthy (1991) states that 50-75% of skin complaints are cared for by primary care providers without referral to a dermatologist. Romeo (1995) states that 80% of outpatients' visits for all types of atopic dermatitis during a one month period were made to emergency rooms by patients primarily covered by public insurance. It is estimated that the total national cost of pediatric AD is 364 million dollars annually (Lapidus & Schwartz, 1993). These facts suggest it is important that primary care providers have the knowledge and skills to diagnose and manage the dermatology complaint of pediatric atopic dermatitis.

Statement of Problem

Practice guidelines give health care providers specific recommendations for the diagnosis and treatment of patients in typical circumstances (Bernstien & Hilborne, 1993). Practice guidelines should be based on scientific evidence and expert opinion with flexibility based on presenting symptoms. With a growing number of nurse practitioners (NPs) providing care in the ambulatory care setting (ACD), it is essential that the NP utilize practice guidelines that will positively influence their patients by decreasing return visits and increasing patient satisfaction.

Since dermatology complaints in children account for 20-30% of pediatric primary care visits (Singleton, 1997), the NP must be able to correctly identify and manage the

disease process. Misdiagnosis and mismanagement of dermatology conditions can lead to increased return visits, increased cost, and decreased patient satisfaction (McCarthy et.al., 1991). Clinical practice guidelines for the NP regarding pediatric atopic dermatitis should promote accurate diagnosis and management. Such guidelines have not been developed for the NP in the ambulatory care department.

Purpose and Significance

The product of this scholarly project is the development of a clinical practice guideline (CPG) for the nurse practitioner (NP) working in the ambulatory care department (ACD) . The CPG should enable the NP to make the most appropriate decisions regarding the treatment of children with the dermatology complaint of AD, avoid misdiagnosis and mismanagement of this common childhood skin disorder. The guideline is based upon scientific knowledge and research and includes defining symptoms and/or characteristics, treatment options, referral and follow-up recommendations. An educational pamphlet, a resource for distribution by the NP to the parent(s) of patients who are newly diagnosed with AD, accompanies the guideline.

Conceptual Framework

Self-Care Deficit Theory of Nursing

Dorothea Orem's Self- Care Deficit Theory of Nursing (S-CDTN) provides the framework for this project (Figure 1). The basic concepts of this theory include self-care, self-care agency, therapeutic self-care demand, self-care deficit, nursing agency and nursing systems. The concepts of self-care, self-care agency, therapeutic self-care demand and self-care deficit relate to the person in need of nursing, while the concepts of

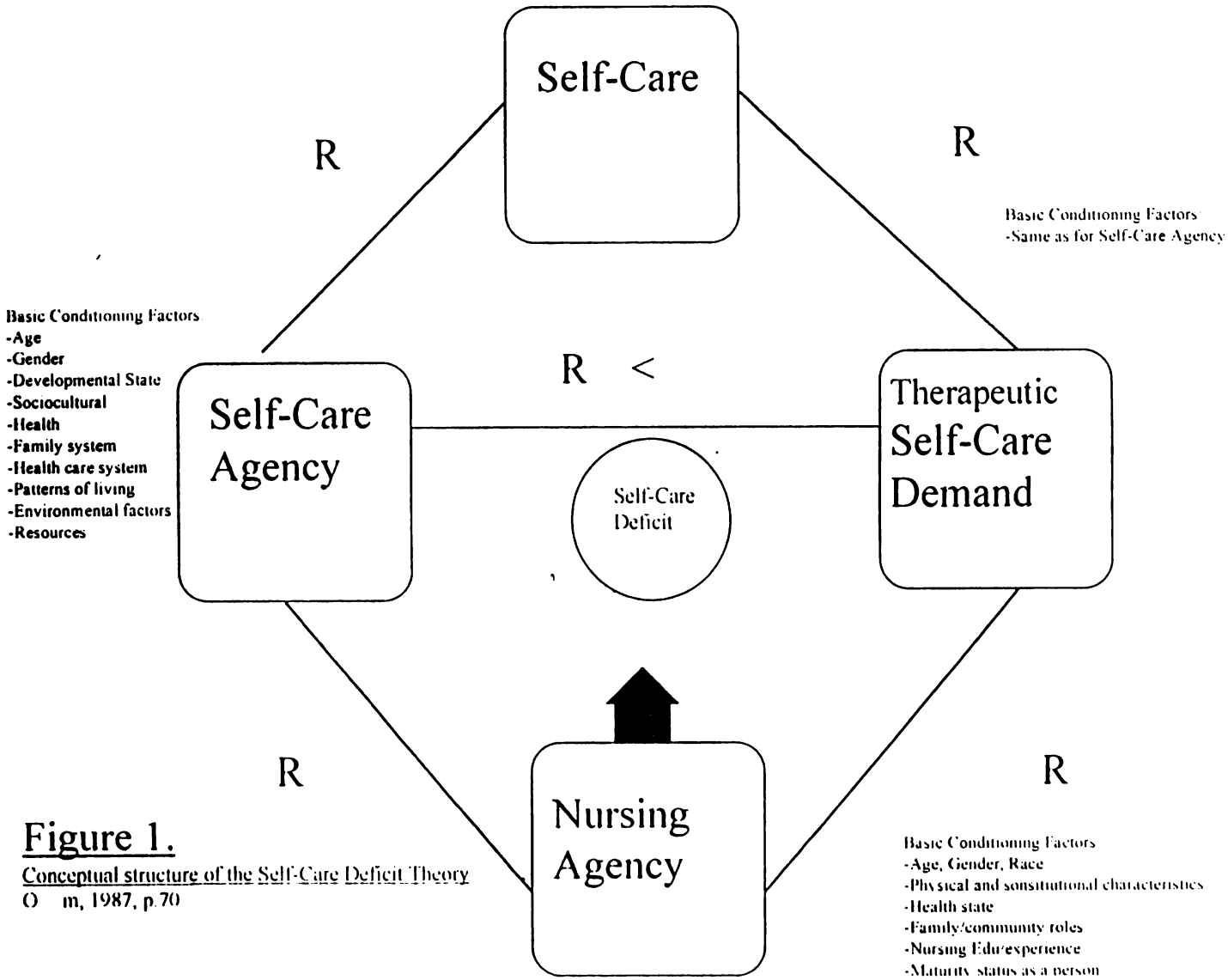


Figure 1.

Conceptual structure of the Self-Care Deficit Theory
O m, 1987, p.70

nursing agency and nursing systems refer to the nurse and his/her actions (Hartweg, 1991).

Self-Care is defined by Orem as "the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being" (Orem, 1991, p.117). Self-Care Requisites are the actions used to provide self-care and are made up of three categories which include: universal, developmental and health deviation (Wesley, 1990). Universal Self-Care Requisites are those requisites that every person must have to sustain life such as water, food, shelter, and social interaction. Developmental Self-Care Requisites arise from developmental aspects in the life cycle such as pregnancy or death. Health Deviation Self-Care Requisites result from illnesses, injury or disease, including seeking medical assistance, and carrying out treatment. The concept of Self-Care Agency is the individual's ability to perform self-care activities. While not reflected in Figure 1, Orem describes the Self-Care Agency as being made up of two agents: the Self-Care Agent and the Dependent Care Agent (Wesley). The Self-Care Agent is a person who is able to provide Self-Care to themselves and the dependent care agent is a person other than the individual who provides care, as in a parent to a child.

Therapeutic Self-Care Demands are those self-care activities that are required to meet the self-care requisites including actions to maintain health and well-being. Self-Care Deficit is the "relationship between self-care agency and therapeutic self-care demands of individuals in which capabilities for self-care, because of existent limitation, are not equal to meeting some or all of the components of their therapeutic self-care demands" (Orem, 1991,p.173). The development of the Self-Care Deficit is identified on the model by the symbol R < which means that a deficit results when Therapeutic Self-Care Demands exceed the Self-Care Agency's ability to perform the additional functions.

Orem (1985) defines Nursing Systems as " all the actions and interactions of nurses and patients in nursing practice situations" (p.148). There are three types of nursing systems: wholly compensatory, partly compensatory, and supportive-educative (Hartweg, 1991). Wholly compensatory is when the patient's Self-Care Agency is so limited that the patient must rely on others entirely for personal well-being. Partly compensatory is when the patient can meet some of his/her self-care requisites, but needs the nurse to meet others. Supportive-educative is when the patient can meet self-care requisites, but needs assistance with decision making, behavior control, or knowledge acquisition skills. The nurse attempts to promote the Self-Care Agency.

The Nursing Agency refers to the "specialized abilities of nurses for diagnosing, prescribing, and producing nursing care that result in meeting the individual's Therapeutic Self-Care Demand or in increasing Self-Care Agency" (Hartweg, 1991,p.44). When the relationship between Nursing Systems and Nursing Agency is "activated", it produces diagnosis, prescription, and regulation of Self-Care for the person with Self-Care Deficits and a Nursing System is produced (Hartweg). In summary, the nurse must first utilize the Nursing System during the initial interaction with the patient and if a need for nursing is identified the Nursing Agency is activated and the nurse must then determine which type of Nursing System will be utilized, the wholly compensatory, partly compensatory, or the supportive-educative system. Orem's conceptual structure might be altered to include all three types of nursing systems along with the Nursing Agency.

Orem also describes in her theory basic conditioning factors related to the patient concepts of Self-Care Agency, Therapeutic Self-Care Demand, and Nursing Agency . The basic conditioning factors which are related to the Self-Care Agency and Therapeutic Self-

Care Demand include: age, gender, developmental state, health state, sociocultural orientation, health care system elements, family system elements, patterns of living, environmental factors, resource availability and adequacy (Hartweg, 1991). The basic conditioning factors that are related to the Nursing Agency include: age, gender, race, physical and constitutional characteristics, health state, family/community roles, nursing educational preparation, nursing experience, and maturity/status as a person (Hartweg). These factors are interrelated and actively influence the quality and quantity of Self-Care Agency, Therapeutic Self-Care Demand and the Nursing Agency.

The relationships between the concepts of the S-CDNT are also reflected in the conceptual structure (Figure 1). The relationship (R) between Self-Care and Self-Care Agency refers to the person who is performing self-care to maintain health and well-being. This may be an individual providing self care or a dependent care agent providing care to another person. The relationship (R) between Self-Care and Therapeutic Self-Care Demand suggests that the individual must know the therapeutic self-care demand or component of self-care demand before the individual can engage in self-care. Once known the adequacy of Self-Care Agency is assessed in relation to the known Self-Care Demand (Hartweg, 1991).

The relationship (R) between Self-Care Agency and Therapeutic Self-Care Demand proposes that a Self-Care Deficit exists when the Self-Care Agency is less than the Therapeutic Self-Care Demand (Orem, 1887). Thus, when the Self-Care Agency lacks knowledge regarding the treatment of a disease, the Therapeutic Self-Care Demand to maintain health and well-being will not be met and a Self-Care Deficit results.

The relationship presented between the Nursing Agency and Self-Care Deficit suggests that the Nursing Agency is needed when a Self-Care Deficit develops. The relationship (R<) between the Self-Care Agency and Therapeutic Self-Care Demand indicates that the Nursing Agent helps the Self-Care Agent meet Therapeutic Self-Care Demands by utilizing one of the nursing systems. When looking at Figure 1, the Nursing Agency is activated when the Therapeutic Self-Care Demands exceed what the Self-Care Agency can provide and a Self-Care Deficit develops.

Application of Orem's Theory to Clinical Practice Guidelines for Pediatric AD

In order to apply Orem's theory to a clinical practice guideline (CPG) for pediatric atopic dermatitis (PAD) in the ambulatory care department (ACD) a modified conceptual structure of the S-CDNT, Figure 2, has been developed. This modified structure shows the relationship between the concepts of significance for this project. The first relationship (R1) is between Self-Care and Self-Care Agent. Self-Care refers to the universal, developmental, and health deviation self-care requisites essential to the health and well-being of the child with PAD. The Self-Care Agent refers to the parent or guardian who provides basic self-care needs for the child with PAD. It is also necessary to address the basic conditioning factors that influence the quality of care the parent/guardian provides; they include such factors as age, developmental state, sociocultural, health, health care system, patterns of living, environmental factors, and resources. Because there may be limitations on what the parent may be able to for the child, i.e., if the parent and child live in a homeless shelter they may be unable to maintain consistent temperature and provide frequent baths, the NP will need to address these basic conditioning factors prior to developing a management plan.

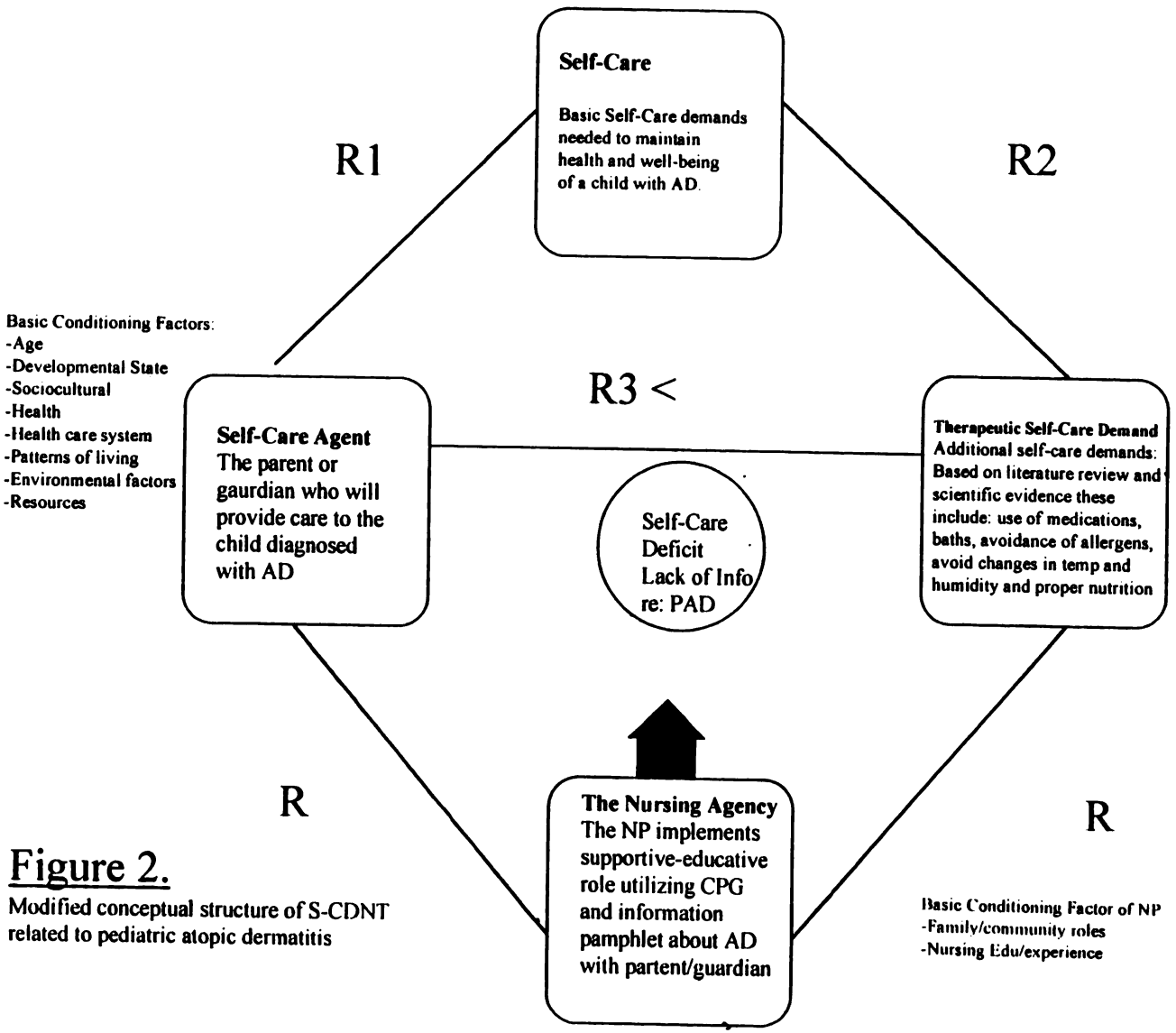


Figure 2.

Modified conceptual structure of S-CDNT related to pediatric atopic dermatitis

The relationship (R2) between Self-Care and Therapeutic Self-Care Demands focuses on factors of care, i.e., medications, baths, avoidance of allergens, avoidance of extreme temperature changes and proper nutrition. These factors maintain the child's health and help to prevent PAD reoccurrence. The relationship (R3) between the Self-Care Agent and Therapeutic Self-Care Demands recognizes that a Self-Care Deficit may occur when the parent or guardian has limited knowledge of treatment and management of the disease and is unable to provide the additional factors of care appropriate to the diagnosis of PAD. The Nursing Agency may utilize the supportive-educative role when a Self-Care Deficit arises.

The basic conditioning factors related to the Nursing Agency, i.e., nursing education and experience, family and community role, influence the NP's ability to function in the supportive-educative role. They may limit or enhance the quality of teaching the NP provides and the resources the NP shares with the child and family. Given a developed clinical practice guideline, the NP is in a position to teach the child, parent(s) or guardian the information needed to meet the Therapeutic Self-Care Demand of the child. This increased knowledge should promote the child's health and well-being by: (1) preventing the reoccurrence of PAD and (2) securing appropriate treatment when acute episodes present. Through the use of a clinical practice guideline and an information pamphlet for the child and family, it is anticipated that a decrease or elimination of the Self-Care Deficit related to PAD would occur.

Conceptual Definitions

The review of literature provided guidance in the identification and definitions of the conceptual concepts discussed throughout the project. The concepts include nurse

practitioner, clinical practice guideline, ambulatory care department, and pediatric atopic dermatitis.

Nurse Practitioner

The role of the nurse practitioner is one that can be confusing to the lay public as well as the health care community. Varying educational preparation, scope of practice, and interchangeable terms cause barriers in developing a strong role in the health care field. Three terms: (a) NP, (b) Clinical Nurse Specialist (CNS), and (c) Advanced Practice Nurse (APN) are used interchangeably; however, different definitions of each occur in various journal articles.

The role of the NP was developed in 1965 at the University of Colorado when a program for the education of the Pediatric Nurse Practitioner (PNP) was developed (Farton & Brykcynski, 1994). The NP role emphasizes increased access to primary health care to address physician shortages and focuses on direct patient care. The NP possesses a broad knowledge base related to diagnosis, treatment and prevention which includes: performing physical examinations, ordering laboratory tests, developing diagnostic treatment plans and making referrals (Page & Arena, 1994).

The CNS role was developed in 1954 at Rutgers University by Peplau and was broadly defined as a nurse who holds a masters degree in a specific area (Farton & Brykcynski, 1994). The CNS role emphasizes improving the quality of care delivered to patients by educating those who give direct patient care and keeping the expert specialized nurse at the bedside (Page & Arena, 1994).

The term APN includes both the CNS and NP along with Certified Nurse Anesthetist (CAN), and Certified Nurse Midwive (CNM). Thus, APN is a general term

which describes nurses with advanced preparation and degrees. The term APN often does not distinguish between the different roles.

When looking at the comparison of the three definitions they can be summarized as the following: (1) the CNS is the specialty nurse whose focus is acute care and remaining at the bedside, (2) the NP focuses on providing primary health care to patients and focuses on direct patient care, and (3) the APN includes both of the above mentioned terms and does distinguish between them.

Standard, Protocol or Practice Guideline

It is noted in the literature that the terms (a) practice standard, (b) protocol, and (c) practice guideline are used interchangeably. However, it is important to note that their definitions differ. The use of these terms can cause confusion for health care providers, the patient and their families and thus requires review.

A practice standard stipulates a specific series of actions and includes what is always expected without exception (Bernstein & Hilborne, 1993). It is usually written by authorities in the related health field, is not necessarily based upon scientific research, is utilized as written, and does not allow for variation (Sullivan, 1991). A protocol is defined as "a framework within which the processes of multidisciplinary care are made explicit; care processes are outlined within a precise and detailed plan for members of the care team to follow" (Antrobus, 1996,p.38).

Bernstein and Hilborne (1993) define a practice guideline as "a specific recommended course of action taken for a typical patient in a typical circumstance" (p. 502). Thus, a guideline includes the minimum requirement for safe care based on updated scientific knowledge. Such a guideline is viewed as narrow in scope, includes specific

recommendations essential for specific situations, but remains flexible. This allows for deviation in certain clinical circumstances (Sullivan & Mann, 1994). A guideline is typically based upon scientific evidence and expert opinion.

As the NP develops a more active role as a primary care provider in the health care arena, it is vital that his/her professional role be strengthened. The clinical practice guideline enables the NP to provide the highest standard of care for specific disease processes based on scientific research (Antrobus, 1996). The use of a guideline will help the NP identify, diagnose, and treat the common dermatology complaint of AD in the pediatric client. Through the use of a CPG, the NP can be confident in the management of PAD and facilitate positive client outcomes.

The term clinical practice guideline was chosen for this project due to the above mentioned definition of the term. The goal of the project is the development of a clinical practice guideline for use in the ambulatory care department where patients do not commonly present as "typical". A clinical practice guideline will give the NP a reference in the treatment of PAD, but will also allow for deviation based upon the NP's clinical judgment.

Ambulatory Care Department

Emergency rooms have begun to develop fast tracks or minor emergency areas in order to increase patient satisfaction, decrease patient length of stay and decrease emergency department congestion (Buchanan & Powers, 1997). The minor emergency area in the ambulatory care department (ACD) sees patients who present with quickly diagnosable and treatable illnesses and injuries (Wright, Erwin & Blanton, 1992).

Definitions for this Project

For this project the following definitions of the identified concepts are used.

Nurse Practitioner: A Masters prepared Registered Nurse who has been certified in the family or emergency specialty.

Clinical Practice Guideline: Flexible recommendations for the diagnosis and management of atopic dermatitis in pediatric clients based on scientific evidence and expert opinion.

Ambulatory Care Department: A minor emergency area affiliated with an Emergency Room that treats minor illnesses and complaints.

Pediatric Atopic Dermatitis: A common skin disorder in pediatric patients, ages birth to 10, characterized by pruritus, vesicles with exudate and crusts most commonly observed on the cheeks, forehead, scalp and extensor surfaces of the arms and legs.

Literature Review

The following review of literature discusses the developing role of the nurse practitioner (NP) in the ambulatory care department (ACD) , the background of pediatric atopic dermatitis (PAD), and the development of a clinical practice guideline (CPG).

The Nurse Practitioner in the Ambulatory Care Department

The role of the NP has expanded in primary care to include all types of outpatient and inpatient settings (Hupcey, 1993). These include private offices, clinics, universities, and ambulatory care departments (ACD).

In a study of 56 emergency rooms (ERs), 58% reported already having a minor emergency area and 25% were considering developing one (Buchanan,1997). Buchanan and Powers (1997) showed that the NP increased patient satisfaction, employed better interpersonal skills than physicians, demonstrated technical skills and patient outcomes

equivalent or superior to physicians, and improved client access to care (Buchanan & Powers). The ten most common diagnosed disorders in minor emergency rooms were: (1) contusions, sprains, and fractures, (2) eye, ears, throat, and dental conditions, (3) lacerations, (4) respiratory complaints, (5) follow-up of previous treatment provided, (6) mechanical back pain, (7) rashes and dermatitis, (8) urinary tract infections/sexually transmitted diseases, (9) soft tissue injury, and (10) burns.

According to Buchanan and Powers (1997) the three key issues that impact the NP's scope of practice are legal authority, prescriptive authority, and reimbursement. A collaborative practice agreement begins with definitions of the collaborative practice, purpose of the document, role/job descriptions, and an organizational chart. The agreement defines specific clinical issues such as guidelines and references, diagnostic laboratory requests, prescriptions, emergency coverage as well as financial information, compensation arrangements, and licensure information (Sebas, 1994). Written guidelines can help to create a standard of care to guide the NP when providing treatment to clients (Sebas,1994).In states where collaboration is required, preapproved written guidelines specific to practice areas may be necessary when the collaborating or supervising physician is not available. Although there is no requirement for physician collaboration or supervision in Michigan as of February, 1998; this may be required if Senate Bill No. 104 is passed.

The largest barrier noted in the literature pertaining to the NP in an ACD is the limited research on the topic. Although there are programs that formally prepare registered nurses to function in an expanded role in the ACD, there is limited information about the role and the factors which enhance or limit role development and practice. Thus,

mechanisms which would clarify the role and practice, e.g., a clinical practice guideline, would be a valued addition. It is important to note that there are guidelines available based on the medical model (Uphold and Graham, 1994), which currently provide physicians with appropriate guidelines to care. A guideline typically includes: (1) a definition (2) the pathogenesis (3) the clinical presentation (4) the diagnosis/evaluation and (5) a plan/management. The guideline can provide a basis for the NP, but needs to be expanded to include a nursing framework which promotes nursing diagnosis and appropriate referral to a physician when necessary.

The Clinical Practice Guideline

The clinical practice guideline (CPG) has been part of the medical community for 50 years and its significance has become more prominent due to rising health care costs, practice variations, and inappropriate care (Woolf, 1990). The clinical practice guideline represents one approach to decreasing health care costs by determining whether specific treatment options are necessary, by judging the appropriateness of procedures, and by standardizing practice which decreases practice variation (Woolf).

In order to be assured that the developed guideline is decreasing costs and improving outcomes, it is important to have clinical indicators to evaluate the quality of care provided to the patient. Clinical indicators monitor the outcome(s) of a particular process of care and thus measure: (1) the ultimate outcome of what happens to a patient, (2) the extent of morbidity and mortality, and (3) patient satisfaction (Bernstein & Hilborne, 1993). Improved outcomes following implementation of a guideline should validate the guideline or if there is no improved outcome(s) the need for guideline revision would be indicated (Bernstein & Hilborne). Due to the fact that nursing is turning its focus

to outcome measurement and quality practice, a CPG can offer a format to organize and deliver care in a way that promotes quality without increasing cost (Sullivan & Mann, 1994).

. According to Sullivan and Mann (1994), in order for a CPG to assist the NP in decision making and management of the patient it needs to be written narrowly to address a specific concern, be flexible, and be based on research and expert opinion. Sullivan and Mann state that a guideline can be developed in a variety of ways, e.g., at the federal level by the Federal Agency for Health Care Policy and Research, at a state level by a professional organization such as the Michigan Nurses Association, or at an individual level by a clinical practice expert, or a group of nurses with special interest in developing a guideline for local use in a specific practice setting.

The largest barrier noted in the literature in relation to the development of a guideline is one of legality. It has been shown that once a CPG has been implemented the NP must follow it or an opportunity for malpractice exists (Montiz, 1992). The CPG provides the NP with the highest standard of care that can be given to a patient in a perfect circumstance (Montiz, 1992). Due to the fact that patients present to the ACD with a variety of circumstances, the NP may need to deviate occasionally from the CPG. Sullivan and Mann (1994) offer the following suggestions in order to decrease the likelihood of malpractice if deviation occurs. These include: (1) have a sound scientific basis for the decision to deviate from the guideline, i.e. ignorance of the guideline is not a defense, (2) clearly document the basis and reason for the decision to deviate and course of action taken, and (3) document a second opinion that supports the decision to deviate.

Another barrier in the literature pertaining to the use of a CPG by the NP is the fact that the majority of the nursing literature focuses on nursing in the acute care area and not in primary care. Only two studies examined the NP in the ACD (Hayden, Davies, & Clore, 1982; Buchanan & Powers,1996).

Pediatric Atopic Dermatitis

Pediatric atopic dermatitis (PAD) or eczema is the most common pediatric dermatosis (Honung & Prose, 1992). The disorder is a chronic, relapsing dermatosis that occurs in patients with a personal or family history of atopy (allergy) and allergic disease (Clark & Kristal, 1996). The disorder affects females and males equally and its pathogenesis is unknown (Hornung & Prose). The cardinal symptom of PAD is pruritus with cutaneous manifestations that typically begin on the cheeks, chin, and extensor surfaces on the arms and legs (Hornung & Prose). The lesions are described as papules, papulovesicles with erythemic backgrounds, serous exudate, and scaling (Clark & Kristal). Associated clinical features include dry skin or xerosis, periorbital dermatitis, and hypopigmented patches on the cheeks, upper arms or shoulders, which are known as pityriasis alba (Clark & Kristal). Complications associated with PAD include cutaneous infections ranging from viral infections such as herpes simplex or papillomavirus to bacterial infections (Clark & Kristal).

Management of the disease begins with the appropriate diagnosis of the disease. It is important that the NP obtains a thorough history including information on bathing habits (frequency and water temperature) and a personal or family history of allergic disease (asthma, allergic rhinitis or AD). A physical exam which includes an examination of the rash, it's characteristics, location, and description is essential. In order for AD to be

diagnosed, the child must present with three or more of the following major factors, i.e., prurits, facial and extensor involvement, exacerbation and remission of the dermatitis, and family or personal history of atopy (Singleton, 1997).

Once the disease has been diagnosed, the NP must then develop a treatment plan. It is important that the NP choose the correct vehicle of treatment when prescribing topical creams and ointments for treatment of the rash since alternative treatment options may produce different results.

Treatment Options

Ointments have the best efficacy for use on lichenified or thickened skin; creams are best to use on moist areas; and lotions and gels are best for the scalp (Romeo, 1995). The correct potency is also important for the NP to prescribe. Romeo states that for lichenified, the use of a moderate potency steroid ointment, such as 0.1% Elocon or 0.1% Valisone, be applied twice a day for two weeks. For a moist dermatosis as well as for treatment on the face, groin, or eyelids, the use of a low potency cream such as 0.25%-2.5% hydrocortisone cream, should be used twice a day for seven to ten days. For use on the scalp, Romeo suggests a moderate potency gel once a day for two weeks. Use of antipruritics is also recommended for the treatment of AD. The use of the medications Benadryl or Atarax will improve the comfort of the patient by decreasing itching (Clark & Kristal, 1996). Use of an oral antibiotic may be indicated if a secondary bacterial infection develops.

Information for Parents/Guardians

Avoiding exacerbating factors is essential in order to prevent reoccurrence of PAD. Initially parents should know that the disease is primarily a disease of the pediatric

population with 50% of those affected outgrowing the disease by two to three years of age and 75% of the population not having a reoccurrence past adolescence (Singleton, 1997). Parents should be taught that their child(ren) with PAD should avoid extreme temperature changes since the sudden lowering of temperatures or prolonged heat exposure can cause itching and irritation. It should be recommend that the child remain in temperatures ranging from 68-75 degrees Fahrenheit (Clark & Kristal, 1996) Decreasing humidity can cause drying of the skin and cause the skin to become more fragile and easily irritated. Humidity should range between 45-55 percent (Clark & Kristal, 1996).

Excessive washing of the skin should also be avoided; baths should be limited to 15-20 minutes with water temperatures remaining warm, but not hot. Parents should pat the child's skin dry (rather than rubbing) and then liberally apply moisturizers, e.g., Eucerin , Curel, or Lubriderm, immediately after bathing to increase moisture of the skin. Parents may repeat the bathing and application of moisturizers two to three times per day (Habif, 1985). Parents should also be educated on the importance of avoiding irritating substances such as wool sweaters that could cause itching and the need to keep the child's nails trimmed to prevent further irritation from scratching. It should be emphasized that the parent's understanding of PAD is an important key in the management and prevention of the reoccurrence of the disorder (Hornung & Prose, 1992).

In general the review of literature revealed relative consistency regarding the treatment of PAD (Hornung & Prose, 1992; Habif, 1985; Romeo, 1995; & Singleton, 1997). While medical guidelines for the treatment of PAD were found, there were no guidelines identified which had been developed for the NP in the ACD or pamphlets to give to parents with children newly diagnosed with PAD. Due to the fact that prevention is

the key to successful management of PAD, it is essential that parents be given preventative information. Because the NP will have limited teaching time in the ambulatory care area the pamphlet will provide additional education and act as a resource for the parent at home.

Based upon the literature review the essential components which are essential to a clinical practice guideline are: (a) health history and physical information, (b) defining the characteristics of PAD, (c) differential diagnosis, (d) treatment plan and (e) expected outcomes. An accompanying educational pamphlet which contains information which to guide the parent/guardian in the management and prevention of recurrence of pediatric atopic dermatitis is described.

Discussion

The literature review provides the essential elements in order to develop a clinical practice guideline (CPG) for pediatric atopic dermatitis (PAD) for use by the nurse practitioner (NP) in the ambulatory care department (ACD). This section reflects the author's organization of the elements' information for a CPG for PAD. As previously mentioned, a clinical practice guideline (CPG) can be written by an individual nurse with special interest in developing a guideline for local use in a specific practice setting (Sullivan & Mann, 1994), such as the ambulatory care department. The CPG for PAD is based upon scientific evidence and research; it provides flexibility and thus allows the NP to utilize clinical judgment when developing a management plan for the child.

The Clinical Practice Guideline

By utilizing documented medical guidelines such as Uphold and Graham (1994), an outline utilizing the areas that are important for the NP to assess when managing PAD can be created. The resulting constructed guideline includes: (1) a definition, (2) the

pathogenesis, (3) the clinical presentation, (4) a diagnosis (medical and/or nursing) and evaluation, (5) the management plan, (6) referral and (7) the expected outcomes. PAD is defined as a chronic relapsing dermatitis that occurs in children age two months to ten years of age, who have a personal or family history of atopy (Hornung & Prose, 1992). The cardinal symptom of AD is pruritus; the exact pathogenesis is unknown and the disease affects females and males equally (Hornung & Prose).

The clinical presentation of PAD begins in early infancy/childhood and is divided into three stages: infant, childhood and adolescent/adult; this project focuses on the infant and childhood stages (Romeo, 1995). The infant stage refers to infants ranging from birth to four years of age and is characterized by pruritis, erythema, exudation and crusts on the cheeks, forehead, scalp and extensor surfaces of the arms and legs. The childhood stage refers to children between the ages of four and ten and is characterized by a more chronic form of dry, scaly, itchy patches on the wrists, ankles, antecubital and popiteal areas.

Diagnosis and evaluation begins initially with a history which typically suggests a personal or family history of atopy. The NP should inquire about the distribution of lesions and if the condition is chronic or relapsing. There should also be discussion regarding skin care habits at home including: bathing frequency and duration, water temperature, and soaps and lotion used (Romeo, 1995). The physical examination should begin initially by having the child undress completely in order to assess the skin and determine the type and extent of the lesion. Differential diagnoses to consider include; contact dermatitis, seborrheic dermatitis, scabies and tinea (Uphold & Graham, 1994). Nursing diagnoses for consideration would be: (1) alteration in comfort related to itching, (2) Alteration in skin integrity related to lesions, (3) Potential for infection related to possibility for

secondary infection from scratching lesions, and (4) Knowledge deficit related to the diagnosis of PAD.

The literature revealed little variation in regards to the treatment of children who present with PAD lesions (Hornung & Prose, 1992; Habif, 1985; Romeo, 1995; & Singleton, 1997). In the acute phase the treatment needs to focus on the lesions and/or secondary infections, as well as the management of symptoms such as itching. Romeo (1995) suggests the use of a low potency cream, such as 0.25% - 2.5% hydrocortisone cream applied twice a day for seven to ten days, for a moist dermatosis or for application to the face, groin, or eyelids. For the scalp and for areas of lichenfied a moderate potency gel, such as 0.1% Elocon or 0.1% Valison ointment applied twice a day for fourteen days, is recommended. For the management of itching the use of medications such as Benadryl and Atarax will improve the comfort of the child (Clark & Kristal, 1996). Antibiotics may be indicated if a secondary bacterial infection develops (Habif, 1985).

Expected outcomes include: (1) the skin will display evidence of moisture retention with dryness at a minimum, (2) flare-ups will heal with in one to two weeks, and (3) parent/ guardian performance of home care activities will reduce recurrence (Romeo, 1995). Referral is necessary when continued treatment for two to four months has failed to improve the PAD, the condition has worsened or spread in spite of treatment, or if the diagnosis continues to be uncertain (Romeo). The clinical practice guideline for pediatric atopic dermatitis for the nurse practitioner in the ambulatory care department is presented in Figure 3 and in Appendix A.

Clinical Practice Guideline for Pediatric Atopic Dermatitis for the Nurse Practitioner in the Ambulatory Care Department.

I. Definition of Pediatric Atopic Dermatitis:

A chronic form that occurs in children from age 2 months to ten years of age. It is a disease that affects females and males equally and occurs in individuals with a personal or family history of atopy.

II. Pathogenesis: Exact cause is unknown

III. Clinical Presentation:

A. Begins in infancy/childhood, with periods of exacerbation and remission.

B. Cutaneous manifestations usually begin on the cheeks, chin, and extensor surfaces on the arms and legs.

C. Clinical features include: dry skin, periorbital dermatitis, and hypopigmented patches on the cheeks, upper arms, or shoulders.

D. Lesions are described as papules, papulovesicles with erythemic backgrounds, serous exudate, and scaling.

E. The two phases of Pediatric Atopic Dermatitis.

1. Infant phase (2 months to 4 years old): Characterized by pruritis, erythema, exudation, and crusts. Areas most often affected include: cheeks, forehead, scalp, and extensor surfaces of arms and legs. Diaper area rarely affected.

2. Childhood phase (4-10 years old): Characterized by a more chronic form of dry, scaly, itchy patches to wrists, ankles, antecubital, and popiteal areas.

IV. Diagnosis and Evaluation:

A. History:

- Inquire about personal or family history of atopy.
- Question about the distribution of lesions; and if chronic or relapsing.
- Ask about skin care habits at home such as bathing.

B. Physical Exam: Examine the skin and determine type and extent of lesion.

C. Differential Diagnosis:

1. Contact Dermatitis.
2. Seborrheic Dermatitis.
3. Scabies.
4. Tinea.

D. Nursing Diagnosis:

1. Alteration in comfort R/T pruritis.
2. Impaired skin integrity R/T skin lesions.
3. Potential for infection R/T risk of secondary infection.
4. Knowledge deficit (parent/guardian) R/T diagnosis of new disease.

V. Management:

A. Treatment of skin lesion: The aim of treatment in the acute phase is to reduce puritis, diminish lesions, and remove exudates, and crusts (Singleton, 1997).

1. Moist dermatosis and application to face, groin, or eyelids:

   Select a low potency cream such as 0.25% - 2.5% hydrocortisone cream for use bid x 7 days.

2. Scalp:

   Select a moderate potency gel such as 0.1% Elocon or 0.1% Valisone ointment for use bid x 14 days.

3. Litchenfield:

   Select a moderate potency steroid ointment.

4. Pruritis:

   Select Benadryl or Atarax as directed per PDR.

5. Secondary infections may need oral antibiotic if indicated.

B. Provide verbal and written instruction to parent/guardian:

1. Avoid extreme temperature changes.
2. Keep temperatures between 68-75 degrees Fahrenheit.
3. Decrease humidity which can cause drying of the skin.
4. Avoid excessive washing of the skin.
5. Limit baths to 15020 minutes with warm not hot water.
6. Pat don't rub the skin when drying.
7. Use moisturizers liberally, such as Eucerin, Curel, or Lubriderm, immediate after bathing.
8. Avoid irritating substances such as wool sweaters.
9. Keep the nails trimmed.

VI. Education:

A. Review the information in the educational pamphlet.

VII. Referral:

A. Make referral to a physician or dermatologist if lesions fail to heal during treatment course.

VIII. Expected Outcomes:

1. Parent/Guardian apply knowledge needed to treat acute phase and minimize recurrence.
2. Secondary infections minimized and treated appropriately when they occur.
3. Lesions heal within 1-2 weeks with treatment.
4. Pruritis controlled during the acute phase.

Figure 3. Clinical Practice Guideline for Pediatric Atopic Dermatitis

The Educational Pamphlet

Teaching parents to avoid exacerbating factors is an essential component in the management of PAD. The educational pamphlet developed to accompany the clinical practice guideline summarizes the key factors that promote and hinder successful treatment of PAD in Figure 4. Parents should be instructed to maintain temperatures surrounding the child between 68-75 degrees Fahrenheit, and maintain humidity in a range between 45-55 percent (Clark & Kristal, 1996). Changes in temperature and humidity can cause the skin to become more fragile and promote irritation and itching. Excessive washing of the skin should be avoided. Baths should be limited to 15-20 minutes in warm, not hot, water. Moisturizers, such as Eucerin, Curel, or Lubriderm, should be liberally applied immediately after bathing to maintain moisture in the skin.

This educational pamphlet provides the parent(s) with written instruction that compliments the verbal instruction given by the NP during the initial visit. Due to the limited amount of time the NP will be able to spend with the child and his/her parent/guardian, it is essential that prevention strategies be stressed, this information is displayed in Figure 4 and Appendix B. As noted in Falvo (1994) the information that patients and their families retain during a routine visit to a health care provider is no more than 50%. This is due to anxiety, large amounts of information conveyed, minimal medical knowledge, and personal intellectual level. Supplemental written instruction should assist the parent(s)/guardian to remember the provider's instructions when they return home (Falvo, 1994).

Prevent Future Outbreaks by

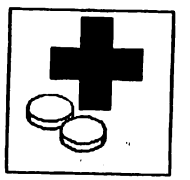
DOING THE FOLLOWING AT HOME

1. Keep your home free of dust, pollens, and animal fur. They can irritate your child's skin.
2. Keep your child's skin well hydrated. Limit baths to 15-20 minutes with warm, not hot water. Pat skin dry, do not rub.
3. Use moisturizers such as Eucerin, Curel or Lubriderm liberally after baths. Apply 2-3 times a day immediately after baths while skin is still damp.
4. Keep temperatures constant. Maintain temperatures between 68-75 degrees Fahrenheit. Avoid extreme temperatures.
5. Keep your child's nails trimmed.
6. Avoid the use of irritating substances such as wool sweaters; they cause itching.

Developed by Erin E. Fitzpatrick R.N.
in partial fulfillment of requirements for
the degree Master of Science in Nursing.
May 1998.

WHEN YOUR CHILD IS DIAGNOSED WITH ATOPIC DERMATITIS.

You can help your child at home



- Atopic Dermatitis is a skin condition that occurs in children who have a personal or family history of allergies.
- This skin condition may go away completely or have times when a rash is present.
- Atopic Dermatitis begins when your child is a baby. Half of the children who have this condition as a baby will not have it occur again.
- The rash of Atopic Dermatitis usually begins on the cheeks, chin and the arms and legs. The rash may also cause itching.
- The most important thing to remember when treating a child with atopic dermatitis is prevention.

Special Care of your Child ...

DRUG NAME:

_____

DRUG DOSAGE:

_____

FOLLOW-UP APPOINTMENT:

_____

HEALTH CARE PROVIDER:

_____

EMERGENCY PHONE #

_____

Watch for signs of infection in your child...

1. When the rash does <u>not</u> go away after you have used the medication as directed by your health care provider.
2. When the rash looks likes it is getting worse, even with the use of medication.
3. When the rash gets red in color and begins to drain a different color.
4. Increased pain or itching.
5. Any unusual concerns or problems that arise.

If any of these signs occur see your health care provider for follow-up.

Figure 4. Education pamphlet information for the parent/guardian

When developing an education pamphlet Doak, Doak, and Root (1997) suggest the following points to be considered to ensure comprehension by people at all literacy levels: (1) write how you talk, use active tense of verbs not passive, (2) use common words, (3) avoid medical jargon, and (4) use 12pt font or larger print. Falvo (1994) states that the material should be organized with clear and specific instructions that reinforce what was discussed during the provider-patient/family contact.

Implications

As the nurse practitioner (NP) assumes a stronger role as a primary care provider it becomes increasingly important to demonstrate the delivery of quality care at reduced costs. Woolf (1990) states that the clinical practice guideline helps to decrease costs by determining whether specific treatment options are necessary, by judging the appropriateness of procedures, and by standardizing practice which decrease practice variation. The following discussion focuses on issues that will require further research in the future and implications for practice by the nurse practitioner who utilizes clinical practice guidelines as well as education.

Research

In order to determine if a clinical practice guideline (CPG) is effective in decreasing costs and improving patient outcomes, it will be necessary to develop clinical outcome indicators. As mentioned by Bernstein and Hilborne (1993) the outcome indicators monitor the outcome of a particular process of care and measure the ultimate outcome of what happens to a patient, the extent of morbidity and mortality, and patient satisfaction. In order to evaluate the effectiveness of the CPG for pediatric atopic dermatitis (PAD), patients who are treated in the ACD for PAD need to be evaluated.

The clinical outcome indicators need to evaluate the management plan developed by the nurse practitioner in the acute phase as well as the educational preventative teaching provided. The evaluation could include the child's response to initial treatment, if return visits were required, the incidence of recurrence, and the development of a secondary infection.

The effectiveness of the clinical practice guideline for pediatric atopic dermatitis can be evaluated initially by the NP who is developing the treatment plan. The NP will need to evaluate if the guideline is easy to follow as well as the adequacy of information provided. The NP will also need to determine if the child and/or parent/guardian understands the discharge and prevention instruction given.

Further evaluation can be done by doing a quarterly chart review. The chart review could include analysis of the NP's treatment plan, the child's response to treatment, the number of return visits made, and the occurrence of a secondary infection. This information will enable the NP and the facility to determine if the CPG is effective in its current format. An additional way to evaluate the guideline is by doing a follow-up call to the parent(s)/guardian. The follow-up call could provide the NP with a way to determine if the discharge instructions were understood by the parent/guardian and if the medications are being used correctly.

By evaluating the effectiveness of the clinical practice guideline the facility will be able to determine if the guideline requires revision. If the expected outcomes are reached, and there is high patient/parent satisfaction accompanied by a decrease in cost, it can be assumed that the guideline is effective and does not require revision. The decrease in cost could be evaluated by observing patterns of return visits for secondary infection and

reoccurrence of the disorder. Patient satisfaction may be defined as increased satisfaction with a decrease in return visits, effectiveness of treatment, response of the child, and if the child and parent/guardian believe that the discharge instructions were clear and understandable.

Practice

The development of a clinical practice guideline for pediatric atopic dermatitis creates a reference for the nurse practitioner (NP) in the ambulatory care department. The guideline is based on research and scientific evidence which enhances the NP role as a researcher. It will be necessary for the CPG to be updated according to new advances in research. It is necessary for nurse practitioners to keep current on new developments in nursing and medicine by attending conferences and reading peer reviewed journals. It will also be important for the NP to perform evaluations of the CPG by doing follow-up calls and quality outcome monitoring to determine the effectiveness of the guideline. The role of evaluator will be utilized through the development of quality outcome monitoring such as quarterly chart review.

By encouraging the nurse practitioner to participate in creating a clinical practice guideline for individual specialty practice the role of the change agent can be utilized. If the individual practitioner participates in governing his/her practice by creating a guideline(s) that provides higher quality care at lower costs, there will be a greater positive recognition of the profession. The nursing profession will be able to further justify the importance and necessity of the NP role in primary care. After initial evaluation of the CPG for pediatric atopic dermatitis the NP can begin to look at other commonly encountered problems in the ambulatory care department and create other guidelines. The

CPG can also facilitate the role of clinician. Clinical practice guidelines should enable the NP to provide each client with effective treatment based on scientific evidence which promotes more positive outcomes for the patient. Through the use of the roles such as change agent and clinician , the NP can utilize positive clinical outcome indicators as leverage when negotiating reimbursement with third party payers as well as showing the benefits of prevention.

The roles of collaborator and consultant can be utilized as the NP develops a scientific evidence based practice by developing clinical practice guidelines. This allows the NP to become a valued team member. With the use of the CPG the NP can advise other members of the team such as those in the other clinics and offices on the effective management of pediatric atopic dermatitis. The information can be shared at advanced practice nursing conferences as well as at health fairs and local nursing associations. This guideline will be utilized in the ambulatory care department at W.A. Foote Memorial Hospital after it has been reviewed and approved by the hospital. It will then be used as a reference for the NP who are practicing in the setting.

Education

The development of an educational pamphlet enhances the NP role of educator. Due to the fact that the ACD is a high volume patient care area, the NP must be efficient during the brief period of time that is allowed when treating patients. The role of educator is an important function of the NP and is crucial when treating pediatric atopic dermatitis (PAD). The educational pamphlet can reinforce the teaching that is provided during the visit and can also provide a reference for the parent/guardian at home. Education also provides the nurse practitioner with another vehicle for health promotion. The NP must be

aware of the broad ranges of educational and economic levels that are encountered in the ambulatory care department and be able to assess the different needs of both the child and family. It is important that the NP be aware of community resources available in the community, such as Catholic Social Services and the Red Cross; these agencies may be able to provide the child and his/her family with medication, shelter, and food.

Conclusion

Pediatric Atopic Dermatitis (PAD) is the most common pediatric dermatosis (Honung & Prose, 1992) and accounts for 80% of outpatient visits made to emergency rooms (Romeo, 1995). Due to these facts it is important that the nurse practitioner (NP) who practices in the ambulatory care department be able to identify and appropriately treat the disease. The development of a clinical practice guideline (CPG) for PAD provides the NP with a tool to effectively and efficiently manage the disease. The CPG can also promote a positive patient outcome by increasing patient satisfaction and decreasing the recurrence while providing the service at a lower cost. The educational pamphlet should assist the patient and parent/guardians increase their knowledge base in treating and preventing reoccurrence of the disease. The pamphlet will be utilized as a reference by the parent/guardian at home.

APPENDICES

APPENDIX A

APPENDIX A

Clinical Practice Guideline for Pediatric Atopic Dermatitis for the Nurse Practitioner in the Ambulatory Care Department

The following information provides the nurse practitioner working in the ambulatory care area with a guideline to correctly identify and manage pediatric atopic dermatitis. The guideline's components are: (1) a definition, (2) pathogenesis, (3) clinical presentation, (4) medical and nursing diagnoses, (5) management, (6) education (7) referral, and (8) expected outcomes. The educational information needs to be provided verbally and in writing to reinforce the importance of prevention and give the parent/guardian a reference for use at home. The guideline is presented in an outline form in order for the NP to easily refer to the area in question such as clinical presentation or management.

I. Definition of Pediatric Atopic Dermatitis:

A chronic dermatitis that occurs in children ages birth-ten years old. It is a disease that affects females and males equally and occurs in individuals with a personal or family history of atopy

II. **Pathogenesis**: Exact cause is unknown

III. **Clinical Presentation**:

A. Begins in infancy/childhood, with periods of exacerbation and remission.

B. Cutaneous manifestations usually begin on the cheeks, chin, and extensor surfaces on the arms and legs.

C. Clinical features include: dry skin, periorbital dermatitis, and hypopigmented

patches on the cheeks, upper arms or shoulders.

D. Lesions are described as papules, papulovesicles with erythemic backgrounds, serous exudate, and scaling.

E. The two phases of Pediatric Atopic Dermatitis:

1. Infant phase (2 months to 4 years old): Characterized by pruritis, erythema, exudation, and crusts. Areas most often affected include: cheeks, forehead, scalp, and extensor surfaces of arms and legs. Diaper area rarely affected.

2. Childhood phase (4-10 years old): Characterized by a more chronic form of dry, scaly, itchy patches to wrists, ankles, antecubital, and popiteal areas.

IV. **Diagnosis and Evaluation**:

A. History:

- Inquire about personal and family history of atopy.
- Question about the distribution of lesions; and if the condition is chronic or relapsing.
- Ask about skin care habits at home such as bathing

B. **Physical Exam**: Examine the skin and determine type and extent of lesion.

C. **Differential Diagnosis**:

1. Contact Dermatitis.
2. Seborrheic Dermatitis.
3. Scabies.

4. Tinea.

D. Nursing Diagnosis:

1. Alteration in comfort R/T pruritis.
2. Impaired skin integrity R/T skin lesions.
3. Potential for infection R/T risk of secondary infection.
4. Knowledge deficit (parent/guardian) R/T diagnosis of new disease.

V. **Management:**

A. Treatment of skin lesions: The aim of treatment in the acute phase is to reduce pruritis, diminish lesions, and remove exudates and crusts (Singleton, 1997).

1. Moist dermatosis and application to face, groin, or eyelids:

   Select a low potency cream such as 0.25% - 2.5% hydrocortisone cream for use bid x 7 days.

2. Scalp:

   Select a moderate potency gel such as 0.1% Elcon or 0.1% Valison ointment for use bid x 14 days.

3. Litchenfield:

   Select a moderate potency steroid ointment.

4. Pruritus:

   Select Benadryl or Atarax as directed per PDR.

5. Secondary infections may need oral antibiotics if indicated.

B. **Provide verbal and written instruction to parent/guardian:**

1. Avoid extreme temperature changes.
2. Keep temperature between 68-75 degrees Fahrenheit.
3. Decrease humidity which can cause drying of the skin.
4. Avoid excessive washing of the skin.
5. Limit baths to 15-20 minutes with warm not hot water.
6. Pat don't rub the skin when drying.
7. Use moisturizers liberally, such as Eucerin or Curel, immediately after bath.
8. Avoid irritating substances such as wool sweaters.
9. Keep nails trimmed.

VI. **Education:**

A. Review the information in the educational pamphlet.

VII. **Referral:**

A. Make referral to physician or dermatologist if lesions fail to heal during treatment course.

VIII. **Expected Outcomes:**

1. Parent(s)/Guardian apply knowledge needed to treat acute phase and minimize recurrence.
2. Secondary infections minimized and treated appropriately when they occur.
3. Lesions heal within 1-2 weeks with treatment.
4. Pruritis controlled during the acute phase.

APPENDIX B

APPENDIX B

The completed educational pamphlet can be found in the back of the book.

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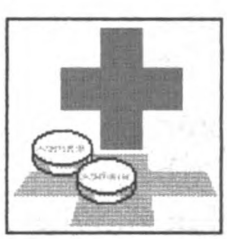
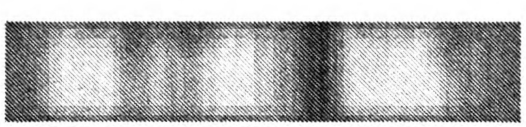
WHEN YOUR CHILD IS DIAGNOSED WITH ATOPIC DERMATITIS.

You can help your child at home





- Atopic Dermatitis is a skin condition that occurs in children who have a personal or family history of allergies.
- This skin condition may go away completely or have times when a rash is present.
- Atopic Dermatitis begins when your child is a baby. Half of the children who have this condition as a baby will not have it occur again.
- The rash of Atopic Dermatitis usually begins on the cheeks, chin and the arms and legs. The rash may also cause itching.
- The most important thing to remember when treating a child with atopic dermatitis is prevention.

Special Care of your Child …

DRUG NAME:

_____

DRUG DOSAGE:

_____

FOLLOW-UP APPOINTMENT:

_____

HEALTH CARE PROVIDER:

_____

EMERGENCY PHONE #

_____

Watch for signs of infection in your child…

1. When the rash does <u>not</u> go away after you have used the medication as directed by your health care provider.
2. When the rash looks likes it is getting worse, even with the use of medication.
3. When the rash gets red in color and begins to drain a different color.
4. Increased pain or itching.
5. Any unusual concerns or problems that arise.

If any of these signs occur see your health care provider for follow-up.

Prevent Future Outbreaks by

DOING THE FOLLOWING AT HOME

1. Keep your home free of dust, pollens, and animal fur. They can irritate your child's skin.

2. Keep your child's skin well hydrated. Limit baths to 15-20 minutes with warm, not hot water. Pat skin dry, do not rub.

3. Use moisturizers such as Eucerin, Curel or Lubriderm liberally after baths. Apply 2-3 times a day immediately after baths while skin is still damp.

4. Keep temperatures constant. Maintain temperatures between 68-75 degrees Fahrenheit. Avoid extreme temperatures.

5. Keep your child's nails trimmed.

6. Avoid the use of irritating substances such as wool sweaters; they cause itching.