

Tips and Tricks for Controlling Eczema



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KEYWORDS

- Eczema • Dupilumab • Topical corticosteroids • Immunosuppressants
- Topical calcineurin inhibitors • Moisturizers

KEY POINTS

- Eczema is a chronic, relapsing, and remitting disease that requires daily skin care to prevent transepidermal water loss.
- Topical therapies are the preferred first step for treatment of eczema.
- Biological therapies are promising targeted treatment options for patients with moderate to severe eczema.
- For patients with recalcitrant eczema, it is important to rule out other diagnoses that may mimic the appearance of eczema.

INTRODUCTION

Eczema is a chronic inflammatory skin condition that affects 10% to 30% of children and is secondary to an impaired skin barrier.^{1,2} This disease typically presents between birth and 5 years of age, and although most patients have resolution by adolescence, 10% to 20% can persist into adulthood.² Eczema, also commonly known as atopic dermatitis, is often the first sign of atopy and is associated with other atopic diseases including asthma, allergic rhinitis, and food allergy. The relapsing and remitting nature of eczema can make it difficult to control flare-ups. This article discusses different ways to help manage eczema and flare-ups.

SYMPTOMS

Impaired skin barrier function leads to increased transepidermal water loss, which ultimately leads to the presence of eczematous lesions. The presentation of eczematous lesions differs based on chronicity and age. Acute lesions can present with erythema,

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papules, vesicles, and occasionally serous exudate, whereas chronic ones can present with lichenification and hyperpigmentation.

In infancy and early childhood, typical lesions will be found on head, neck, and extensor surfaces. In adolescence and adulthood, however, the distribution is mainly on the flexural surfaces. There may also be distribution on the palms, soles, head, and neck. Eczema typically spares moist areas of the body, including the groin and axillary regions.³

DIAGNOSTIC TEST/IMAGING STUDY

Diagnosis of eczema is a clinical diagnosis, and there have been many different sets of proposed criterion over time. Hanifin and Rajka were the first to put together diagnostic criteria for eczema in 1980, with pruritus, relapsing nature, distribution, and atopy being identified as being major features along with several minor features. There have been many other iterations of proposed criterion, with the American Academy of Dermatology being the most used in the United States.⁴

In addition to physical features of eczema, there are also proposed scoring systems to determine severity of disease. This is important to differentiate because treatment options vary based on severity. The SCORing Atopic Dermatitis (SCORAD) is a commonly used tool to score severity. The SCORAD uses both objective measures of disease (body surface area affected and clinical features) along with the patient’s subjective symptoms of itch and sleeplessness.⁵ The objective measures are based on the expertise of the interpreting physician, and the subjective symptoms are based on the patient’s perception, which gives a fully encompassing picture of the extent of disease and its impact on quality of life.

DIFFERENTIAL DIAGNOSIS

Conditions can mimic or overlap with eczema that can make it difficult to discern the underlying cause (Table 1). Severe eczema in infancy, especially those refractory to treatment, should be evaluated for possible underlying immunodeficiency. These

Table 1 Eczema mimics		
Examples of Similarly Presenting Diseases	Associated Signs and Symptoms	Typical Time of Presentation
Immunodeficiency: Netherton syndrome Wiskott-Aldrich DOCK8 Hyper IgE syndrome	All: Failure to thrive Recurrent infections Eczema that recalcitrant to topical therapies	Infancy
Inflammatory diseases: Psoriasis Viral exanthem Contact dermatitis	Thickened plaques with silvery scale Morbilliform rash Pruritic, vesicular, in area of contact	Mainly in adolescence to adulthood Viral exanthems can present in infancy
Malignancy: Cutaneous T-cell lymphoma	Patchy eczematous rash Recalcitrant to topical steroids	Adulthood
Nutritional deficiency: Biotin Zinc	Failure to thrive Weight loss	Infancy/early childhood

patients tend to present with other associated symptoms including failure to thrive and recurrent infections. Inflammatory conditions such as seborrheic dermatitis, contact dermatitis, and nummular dermatitis often present with erythematous, scaling, pruritic rashes that are commonly mistaken for eczema. Infectious conditions such as impetigo present with crusting and irritation and may be secondary to complications from eczema. Lastly, in endemic areas of the world, nutritional deficiencies of zinc or biotin can lead to a dry, pruritic rash that is similar to eczema.⁶ There are many rashes that can present similarly to eczema, and therefore it is important to differentiate between these conditions in order to provide optimal treatment.

TREATMENT

Nonpharmacologic Treatments

Dry skin care

The cornerstone of eczema treatment is prevention of transepidermal water loss. Because of the dysfunctional skin barrier, water loss is a chronic issue and requires daily skin care. Soaking baths in lukewarm water should be done at least once a day and should last about 10 minutes. Soaps should be bland and not contain any dyes or fragrances to avoid skin irritation. After bathing, the skin should be patted dry, allowing some moisture from the bath to remain on the surface, and should be immediately followed by application of moisturizer. The moisturizer will act as a sealant to lock in the moisture from the bath and will help keep the skin hydrated as well as restore the epidermal barrier.

Moisturizers

There are many different types of moisturizers available, including emollients, occlusive, and humectants ([Table 2](#)).

Emollients

The most commonly used moisturizers are emollients, which are used to soften the skin. Although emollients include both creams and lotions, cream-based emollients are preferred. Lotions contain higher percentage of water that is adequate for normal skin barriers. In eczematous skin, however, an impaired skin barrier leads to evaporation of the water-based lotion, leading to a paradoxical drying effect. Lotions are reserved for use on areas where there is less concern for water loss. Cream-based emollients, however, have a hydrophobic oil base that prevents rapid evaporation.⁷

There are many types of emollients on the market and they use a variety of additives to help bolster therapeutic efficacy. Prescription and over-the-counter preparations are available, but there have not been any studies to show that one preparation is more effective than another.

Occlusives

Ointments have higher lipid content than creams and provide an occlusive barrier. This may make ointments effective moisturizers. These formulations are generally greasier, however, which can make them more difficult to deal with and can lead to folliculitis or acne on more sensitive skin. Although they can be used on open skin without significant irritation or burning, patients may develop a contact reaction to ingredients such as lanolin, which can lead to worsening of eczema.^{3,7,8}

Humectants

Humectants contain ingredients that help draw water toward itself and when used on the skin, will help hydrate the stratum corneum. Urea, lactic acid, and hyaluronic acid are the most commonly used humectants. They are effective moisturizers and can be

Table 2
Different types of moisturizers

Type of Moisturizer	Mode of Action	Common Additives	Advantages	Disadvantages
Emollients	Oil in water emulsion that fills in cracks of skin with oil leading to smoothing and softening of skin	Ceramides Cholesterol	Many options to choose from Smoothes over skin Softens skin	May not provide enough moisturization for severely dry skin Irritation or burning sensation with certain preparations
Occlusives	Hydrophobic barrier over skin to prevent transepidermal water loss	Lanolin Mineral oil Petrolatum Dimethicone	Provides thick layer to prevent water loss and can be very effective for severely dry skin	Greasy Can block follicles Can lead to contact dermatitis (lanolin)
Humectants	Attract water to itself, leading to hydration of the stratum corneum	Lactic acid Urea Glycerol	Can be very hydrating to dry skin	Can cause burning sensation on open skin

used on severely dry skin. They can cause a burning sensation on open skin, which may prohibit use and should mainly be used on intact skin.^{3,7,8}

Bleach baths

Staphylococcus aureus colonization can lead to worsening of skin lesions and also superinfection. Dilute bleach baths have been used to decrease colonization of both lesional and nonlesional skin. These baths are cost-effective and generally well tolerated and have been recommended for use in eczema skin care. Recent studies, however, have reviewed the studies on bleach baths and although they do decrease colonization, there does not seem to be any advantage to the use of bleach over plain water baths.^{9,10}

Wet wrap therapy

For patients with moderate to severe eczema the use of emollients and other topical therapies may not provide adequate relief. Wet wrap therapy is an affordable treatment that can be efficacious in refractory cases. In this therapy the patient soaks in warm water before patting dry. Application of an emollient is placed on skin followed by application of wet dressings on the affected areas. A dry dressing is placed over the wet dressing and is left in place for up to 24 hours. Dressings should be made of nonirritating, breathable fabric such as gauze or cotton. If full body treatment is needed, long underwear can be used as surrogate for wraps.¹¹ Use of topical corticosteroids in addition to wet wrap therapy has been shown not only to be efficacious but also works faster than wet wrap therapy with emollients alone.¹²

Although wet wrap therapy offers many advantages, particularly in moderate to severe eczema, it can be cumbersome. This does require time and cooperation from the patient and can be uncomfortable. Therefore, this therapy may be best used on those with difficult-to-treat eczema rather than a first-line therapy.

Irritant avoidance

Patients with eczema are at risk of developing other atopic diseases, including food allergy, asthma, and allergic rhinitis. The abnormal skin barrier increases sensitization to food, environmental, and contact allergens. Exposure to these irritants can lead to flares.

Food allergens

Eczema has been associated with food allergen sensitization that can result in different reactions. The most concerning reaction is an immediate immunoglobulin E (IgE)-mediated reaction leading to anaphylaxis. In these patients, allergy testing and strict avoidance of the implicated food is the standard treatment. Some patients, however, do not experience an immediate reaction and instead have a delayed eczematous flare in response to food ingestion. There have been several studies that have looked at patients with elevated IgE/IgE sensitization to foods. Patients with moderate to severe eczema tended to show improvement in their skin with elimination of the identified food trigger.^{13–15} This correlation between foods and eczematous flares is mainly seen in the pediatric population and does not seem to extend to the adult population.¹⁵

Although there has been evidence of improvement with elimination diets in patients with IgE-mediated sensitization to foods and delayed eczematous flares, there is concern for possible risks associated with food elimination. Removing foods that contain nutrients important for growth, such as protein and calcium, from the diet can lead to nutritional deficiencies and growth retardation.¹⁵ If foods are removed from the diet, it is important to ensure that the patient is getting appropriate

supplementation and maintaining on their growth curve. Recent data have also shown that up to 19% to 83% of patients sensitized to foods without a previous history of immediate IgE-mediated reactions can develop them after a period of elimination.^{15,16} It is therefore important to exercise caution and balance the risks and benefits before proceeding with allergy testing and elimination diets.

Aeroallergens

Contact reactions from aeroallergens have been associated in patients with eczema. Lesions tend to be on exposed areas of the body such as the neck and face. Dust mite has been the most implicated aeroallergen, with positive patch tests in up to 40% of patients.¹⁷ Studies on dust mite avoidance, however, have shown conflicting results. One study showed that instituting several dust mite avoidance measures (dust mite encasings, vacuuming, and acaricides) showed significant improvement in eczema severity in comparison to placebo.¹⁸ Other studies looking at dust mite encasements alone did show decrease in levels of dust mite antigen but did not see a significant improvement in eczema.¹⁹ Other allergens have been implicated, including pet dander, cockroach, and pollens. The evidence on the efficacy of allergy immunotherapy has been mixed.²⁰

Other irritants

Contact dermatitis is a type IV hypersensitivity reaction that can occur in conjunction with eczema. It is unclear, however, what the true prevalence is with reports varying between 27% and 95.6%.²¹ Lanolin, metals, antibiotics, and fragrances are commonly associated contact allergens identified in those with eczema.²² These contact allergens can be found in topical products including emollients and antimicrobials that are used to treat eczema, which can lead to paradoxical worsening. Patch testing is the gold standard to diagnose contact dermatitis and should be considered in patients who have persistent symptoms or worsening after treatment.

Pharmacologic Therapies

Topical corticosteroids

Topical corticosteroids (TCS) are considered first-line therapy for eczema. There are many different formulations and potencies that allow treatment to be tailored to severity and location (**Table 3**). Topical steroid potency ranges from low potency (Class 7) to super potency (Class 1), and they can be used for both acute and chronic management of eczema. Mild eczema and thinner-skinned areas, such as eyelids and face, should be treated with lower potency TCS to minimize potential side effects. More severe eczema and lichenified lesions, however, may require much stronger formulations to improve skin conditions.

In addition to potency of TCS, the amount of medication is also an important measure to be aware of. This, similar to potency, depends on the area of the body that is being treated. The finger-tip unit was first described in 1991 by Long and Finlay²³ as a practical measurement of topical therapies. It is described as the amount of ointment expressed from a tube with 5-mm diameter nozzle applied from the distal skin crease to the tip of the index finger. This amount varies slightly from men to women (0.49 g in men and 0.43 g in women) and covers 257 to 312 cm² of skin area.

TCS therapy is used in addition to daily skin care and should not be used as a replacement for moisturizing. Appropriate therapy generally requires twice daily application to the affected areas until the skin is clear. In patients with frequently relapsing eczema, TCS can be used as maintenance therapy in addition to the acute treatment. Application of low or medium potency TCS at commonly affected sites twice weekly has been shown to decrease flares.⁷

Table 3 Steroid potency ranges of topical corticosteroids			
Steroid Potency	Examples	Location of Use	Eczema Severity
Class 7: Least potent	Hydrocortisone cream 1%	Face	Mild
Class 6: Mild	Desonide cream 0.05%	Thinner-skinned areas of body such as eyelids	
	Hydrocortisone cream 2.5%		
	Betamethasone valerate lotion 0.1%	Scalp	
	Fluocinolone acetonide oil 0.01%		
Class 5: Lower Mid-Strength	Fluticasone propionate cream 0.05%	Use on trunk and extremities	Mild
	Desonide ointment 0.05%	Avoid thinner-skinned areas and face	Moderate
	Hydrocortisone valerate cream 0.2%		
	Betamethasone valerate ointment 0.1%		
Class 4: Mid-Strength	Triamcinolone acetonide cream 0.1%		Moderate
	Mometasone furoate cream 0.1%		
Class 3: Upper Mid-Strength	Fluticasone propionate ointment 0.05%	Use: Trunk	Moderate to severe
	Desoximetasone cream 0.05%	Extremities	
	Betamethasone ointment 0.1%	Palms	
	Fluocinonide cream 0.05%	Soles	
Class 2: Potent	Mometasone furoate ointment 0.1%	Lichenified areas	Severe
	Fluocinonide ointment 0.05%	Avoid: Face	
Class 1: Superpotent	Clobetasol propionate cream 0.05%	Thinner-skinned areas	Reserve use for severe eczema
	Betamethasone dipropionate ointment 0.05%		

Overall TCS are generally well tolerated, affordable, and effective, making them the ideal choice for first-line therapy. Potential adverse effects from TCS can occur, however, and include hypopigmentation, striae, acne, and skin atrophy. Choosing the appropriate strength and amount for the affected area can minimize these side effects.

Topical calcineurin inhibitors

Topical calcineurin inhibitors (TCIs) are a nonsteroidal topical therapy option for eczema. Currently there are 2 TCI options available in the United States. Pimecrolimus is available as a 1% cream and tacrolimus is available in both 0.1% and 0.03% ointment. Tacrolimus 0.1% is not approved for patients younger than 15 years, whereas the 0.03% ointment is approved for those from age 2 to 15 years.

TCIs can be used, similarly to TCS, for both acute and maintenance therapies. Treatment is usually twice daily on the affected area until the skin clears and can also be used prophylactically twice weekly to prevent flares. The finger-tip unit also applies to use of TCIs. Unlike TCS, however, TCIs do not cause skin atrophy and may be preferred for more delicate, thinner-skinned areas such as eyelids. For patients with severe eczema and large body surface area affected, there may be concern about systemic absorption of TCS. TCIs are a good alternative for these patients or can be used adjunctively on portions of the body as a steroid-sparing agent.

Major adverse effect with TCIs are burning and stinging and this is more noticeable on open, inflamed areas, which can preclude use if the patient is unable to tolerate this. The burning sensation tends to dissipate with consistent use and can be ameliorated by using a TCS on the area before using TCI or by placing the medication in the fridge before use.⁷ TCIs do not have as many options as TCS; therefore, insurance coverage, availability, as well as cost may also be prohibitive for patients.

Crisaborole

More targeted topical therapies have recently been approved. Crisaborole is an anti-phosphodiesterase-4 (PDE4) inhibitor. PDE4 is an enzyme that is preferentially expressed in inflammatory cells. Anti-PDE4 oral therapies have been used in other dermatologic conditions such as psoriasis but were associated with gastrointestinal (GI) side effects.²⁴ Crisaborole is the first anti-PDE4 topical therapy available and has shown positive effects in 2 large-scale double-blinded studies. There was a greater percentage of clearing of eczema in the crisaborole arm than those with placebo vehicle ointment.²⁵ There were, however, many patients in the placebo arm who also had improvement in their symptoms, which may demonstrate the efficacy of the vehicle used in both arms in addition to the crisaborole.^{24,25}

Crisaborole provides another topical nonsteroidal option for pediatric patients in addition to TCIs. Similar to TCIs, the major side effects are irritation, burning, and stinging at the site of application.

Antimicrobials/antifungals

The microbiome of eczematous lesions can vary with age. *S aureus* is found in 70% of eczematous lesions and 39% of unaffected skin in patients with eczema.²⁶ It can produce toxins that can lead to worsening inflammation and pruritus leading to worsening flares. Topical mupirocin or oral antibiotics can be used in patients with crusting and superinfected flares. For adolescents and adults, head and neck atopic dermatitis can be colonized with fungi. *Malassezia furfur* is the most implicated organism.²⁷ Azole antifungals, particularly topical ketoconazole, can be used to decrease flares in those who are colonized with *M furfur*. Use of antimicrobial or antifungal therapy can be a good adjunctive treatment in patients with difficult-to-control flares.

Systemic Therapy

Oral steroids

Oral corticosteroids are potent antiinflammatory medications and can provide rapid improvement to severe and persistent eczema. Because of the quick resolution with oral steroids, they are frequently prescribed and are often preferred by patients. Unfortunately, oral steroids can cause a rebound effect with worsening flares after the course of steroids is finished, which can lead to a cycle of oral steroid use to calm down the flares. They also can lead to significant systemic adverse effects, hypothalamus-pituitary-adrenal axis suppression, growth retardation, weight gain, obesity, and diabetes, in addition to the skin effects that can be seen with TCS. Oral steroids should be avoided in the treatment of eczema.²⁸

Oral immunosuppressants

For severe, recalcitrant eczema immunosuppressant therapy may be helpful in controlling flares. These therapies should be reserved for patients who have not responded to other treatments because they do carry the risk for potentially severe side effects. In this section the authors review 4 of the most commonly prescribed immunosuppressants used in severe eczema. All of these medications are used as off-label treatments.

Cyclosporine

Cyclosporine is a potent T-cell inhibitor and was originally used to prevent rejection in transplant patients. It has been used as off-label in the treatment of refractory eczema with moderate success.

Initial pediatric dosing should be 3 to 6 mg/kg/d and improvement should be seen within 2 to 6 weeks of initiating therapy. Nephrotoxicity and hepatotoxicity should be monitored for with baseline levels and repeat levels every 2 weeks for the first 3 months and then monthly thereafter. Common side effects include elevated blood pressure, headaches, hypertrichosis, and gingival hyperplasia. Therapy can be short-term (3 months) or long-term (12 months).²⁸

Azathioprine

Azathioprine is a purine analogue that affects DNA synthesis in rapidly proliferating cells including T cells. It has been used in refractory eczema with modest success. Metabolism of azathioprine involves an enzyme called thiopurine methyltransferase. Low enzyme levels can lead to toxicity and should be evaluated before starting this medication.

Initial pediatric dosing should be 2.5 to 4 mg/kg/d. Common adverse effects include nausea and vomiting and headache. More severe side effects can include hepatotoxicity and leukopenia. It is recommended to check liver function tests, renal function, and complete blood counts before starting treatment. They should be reevaluated twice monthly for the first 2 to 3 months and then monthly after that. This treatment should not be used in conjunction with phototherapy, as there is a risk of skin malignancy with ultraviolet A (UVA) exposure.²⁸

Methotrexate

Methotrexate is an antifolate metabolite that can affect T-cell function through disruption of DNA and RNA synthesis. Improvement in symptom scores is generally seen over 10 to 12 weeks. It can be given in oral or injectable form, based on patient preference.

Studies have shown improvement in eczema symptom scores with varying doses of methotrexate, which leads to a wide range of recommended dosing. Initial dosing ranges from 0.2 to 0.7 mg/kg/wk. Severe adverse effects include myelosuppression, hepatotoxicity, and pulmonary fibrosis. Laboratories should be followed with a complete blood count and liver function weekly for the first month. Once stable, laboratories can be checked every 3 months. If patients develop a cough, consider performing a chest radiograph to evaluate for pulmonary fibrosis.²⁸

Mycophenolate mofetil

Mycophenolate mofetil (MMF) blocks purine biosynthesis and preferentially affects T and B cells. There have been variable results for the efficacy of MMF. Overall studies show that it can be an option of refractory eczema.

Dosing used in studies has been variable, so the initial dosing can range from 30 to 50 mg/kg/d. Adverse reactions include headaches and GI upset. Rarely it can cause leukopenia. It is recommended to check complete blood counts, renal function, and hepatic function every 2 weeks for the first month and then monthly.²⁸

Phototherapy

Another option for patients with refractory eczema is phototherapy. This involves use of UVA, ultraviolet B (UVB), or a combination of both. UVB therapy is the most commonly used and can be narrow or broad band. Unfortunately, because of the dearth of head-to-head trials, there are no guidelines on the most efficacious option.

Phototherapy can be used in conjunction with other therapies except TCIs and azathioprine.

Narrowband UVB is the preferred therapy, as it has lower risk profile. Use of UVA and UVA with UVB contain the most risk.

The major side effects associated with phototherapy include redness and burning at the site of exposure, actinic damage, rashes, and rarely malignancy. Therapy regimens vary depending on the type of UV exposure and can be used both intermittently and chronically.²⁸

Phototherapy should be administered by an appropriate facility and the options of phototherapy may be limited by local availability.

Biologics

Biological therapies are novel treatment options that have been emerging for eczema. These therapies have a specific mechanism of action and can target the underlying causes of inflammation while minimizing other side effects.

Dupilumab is an injectable monoclonal antibody that blocks both interleukin-4 (IL-4) and IL-13. Both IL-4 and IL-13 have been implicated in atopic inflammation and believed to be a driving force for eczematous inflammation. IL-4 has been shown in in vitro studies to upregulate other inflammatory cytokines leading to a defective skin barrier, which is the underlying cause of eczema. IL-13 has been shown to be overexpressed in both acute and chronic eczematous lesions.²⁹

Two trials, SOLO 1 and SOLO 2, were performed to evaluate for the efficacy of dupilumab in comparison to placebo on patients with moderate to severe eczema. Patients were given the medication weekly or every other week. There was a statistically significant improvement in both studies in subjective symptoms, signs of eczema, and quality of life. Both regimens showed similar efficacy as well.³⁰ Another study looked at the safety profile of dupilumab with concomitant TCI and TCS use. Twice weekly and weekly dosing of dupilumab was compared with placebo. Although they showed that 39% of patients in both treatment arms achieved significant improvement in their eczema, they did note there was a higher incidence of noninfectious conjunctivitis in the dupilumab group.³¹ This echoed a similar finding in the SOLO 1 and SOLO 2 trials that also showed a higher incidence of conjunctivitis.

The most common side effect of dupilumab is injection site reaction. It is unclear what the underlying cause of the increased conjunctivitis is in the patients treated with dupilumab, but this phenomenon was only seen in the trials for eczema and was not seen in dupilumab trials for other conditions such as asthma.³⁰

At this time, unfortunately, dupilumab is only approved for adult patients with eczema. Pediatric trials are currently underway.

Antihistamines

Pruritus is one of the hallmark signs of eczema and can lead to significant decrease in quality of life for patients with eczema. Although histamine released from mast cells is a known cause of pruritus in atopic disease, it does not seem to be the only or leading cause of pruritus in eczema. Neuropeptides and bradykinin have been identified as inducers of pruritus in eczematous lesions, whereas histamine seems to have only a small effect.^{32,33} Antihistamines may not provide significant relief of pruritus but can be useful with sleep disturbance secondary to pruritus. First-generation antihistamines, which have a sedating effect, can provide some relief at night and help decrease scratching, which can worsen symptoms. Use of these antihistamines during the day, however, can be problematic because of sedation.

Table 4 The severity of eczema and the corresponding treatment options	
Severity of Eczema	Therapeutic Options
Mild	Good skin care and moisturization Mild potency topical steroids for flares
Moderate	Bleach baths Moderate potency topical steroids Topical calcineurin inhibitors Crisaborole
Severe	Wet wraps Phototherapy Systemic immunosuppressants Dupilumab

Management

Eczema is a chronic relapsing disease secondary to an impaired skin barrier. Management requires maintenance therapy to maintain the skin barrier as well as a variety of pharmacologic therapies to help treat flares. For patients with recalcitrant eczema, determining if it is primary eczema versus part of a different disease process is important. Newer biological therapies offer effective results with fewer side effects than systemic oral immunomodulators and steroids. Determining the severity of eczema and underlying triggers will not only help decrease flares but also help determine the best course of treatment ([Table 4](#)).

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