Protocol for Management of Acute Exacerbations of Mild to Moderate Atopic Dermatitis

The Victorian Community Pharmacist Program

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OFFICIAL

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1. About

This Protocol has been developed to provide pharmacists authorised under the Drugs, Poisons and Controlled Substances Regulations 2017 (the Regulations) a clear framework to supply the Schedule 4 poisons documented in this Protocol for the management of acute exacerbations of mild to moderate atopic dermatitis under a structured prescribing arrangement. It is a requirement of the Secretary Approval: Community Pharmacist Program that pharmacists comply with this Protocol when supplying Schedule 4 poisons for treatment of acute exacerbations of mild to moderate atopic dermatitis. It is also a requirement of the Secretary Approval: Community Pharmacist Program that pharmacists have completed the current training requirements specified in the departmental guidance before supplying Schedule 4 poisons.

Pharmacists authorised to supply Schedule 4 poisons under the Regulations must:

- Operate at all times in accordance with the Drugs, Poisons and Controlled Substances Act 1981, the Regulations and all other applicable Victorian, Commonwealth and national laws.
- At all times act in a manner consistent with the Pharmacy Board of Australia's (the Board) Code of Conduct and in keeping with other professional guidelines and policies as set out by the Board as applicable.

Pharmacists are also expected to exercise professional judgment in adapting treatment guidelines to presenting circumstances.

1.1. Definitions and acronyms

Authorised prescribing health practitioner: A health practitioner authorised under the Drugs, Poisons and Controlled Substances Regulations 2017 to issue a prescription.

EASI Eczema Area and Severity Index

MHR My Health Record

PBS Pharmaceutical Benefits Scheme

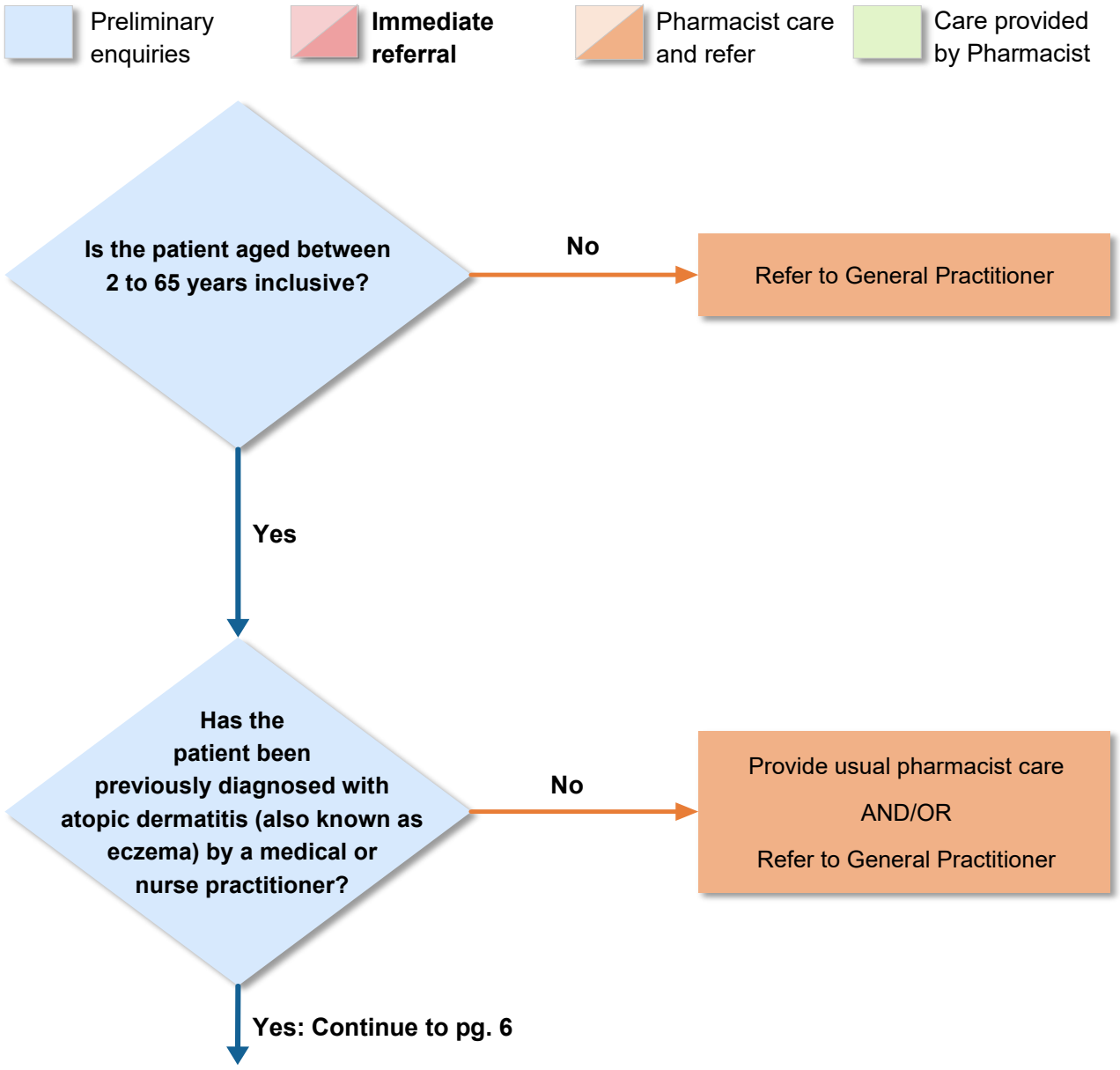
SCORAD SCORing Atopic Dermatitis index

TCS Topical corticosteroid

2. Protocol for Management of Acute Exacerbations of Mild to Moderate Atopic Dermatitis

2.1. Key to colours used in this protocol

Where the protocol indicates to "Refer to General Practitioner," the Pharmacist may refer to a medical practitioner or other authorised prescribing health practitioner as clinically appropriate. If timely access to a GP is not available, referral to the Victorian Virtual Emergency Department (VVED) or an urgent care clinic may be considered as an alternative pathway.



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Does the patient present with signs and symptoms of a suspected recent flare up (< 2 weeks) of mild to moderate atopic dermatitis (eczema) following stable/intermittent symptoms, with typical features including both itch and rash.

Examples of likely atopic dermatitis:

- Itchy, dry, erythematous patches
- Typically on the face*, flexures, wrists, ankles, neck, and groin.

No →

Consider potential differential diagnoses (e.g. contact dermatitis, psoriasis, fungal infection, scabies) and provide usual pharmacist care

AND/OR

Refer to General Practitioner

Yes ↓

**Patients with dermatitis involving the face are not eligible for management under this protocol and should be referred to a medical practitioner for assessment.*

Does the patient/parent/caregiver consent?*

No →

Refer to General Practitioner

**The patient must be physically present at the pharmacy.*

Yes ↓

Assess:

Patient history

- Review MHR, where available
- Onset, duration, nature, location, severity, and extent of atopic dermatitis,
  - Tools such as SCORAD or EASI can be used to assess extent and severity
- History of recent or previous flare ups
- Impact on quality of life and psychosocial wellbeing (e.g. itch, reduced sleep, failure to thrive)
- Aggravating factors or triggers
- Medical history, including personal and family history of atopy, pregnancy, and/or breastfeeding
- Medication history, including response and application technique for any previous topical treatments
- Medication allergies or adverse effects

Conduct clinical review

Examination

Confirm presenting signs and symptoms indicative of an acute exacerbation of mild to moderate atopic dermatitis by performing a skin examination (Refer to supplementary notes including **Assessing severity of atopic dermatitis**)

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Does the patient report or present with any of the following red flag criteria?

- Severe, widespread, or painful rash
- Non-blanching purple rash
- Widespread erythema involving most of the body or multiple body regions
- Signs of sepsis, systemic illness or other complications, including fever, lethargy, nausea, vomiting, or headache
- Blistering of the skin, mucous membranes, or eyes
- Suspected eczema herpeticum, particularly with eye involvement

Yes → Refer for immediate emergency medical care

No, to all

Does the patient meet any of the following exclusion criteria?

- Unclear diagnosis or atypical presentation, different to historical flares
- Insufficient response to treatments in **Medicines List**, despite appropriate trial
- Severe atopic dermatitis (e.g. intense persistent itch with widespread rash or severe lesions, or SCORAD >50 or EASI >21)
- Significant body surface area involvement (>30% body surface area)
- Complex presentation, such as signs of secondary viral or bacterial infection
- Chronic broken skin, sores, ulcers, or crusts (more than 4 weeks)
- Paediatric patient with a history of immediate or delayed-type hypersensitivity to food, poor feeding or sleep, or concerns about failure to thrive
- Pregnant or planning a pregnancy
- Immunocompromised
- Dermatitis involving the face (including periorbital or perioral regions)

Yes → Refer to General Practitioner

No to all: Continue to pg. 8

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Does the patient meet any of the following 'treat and refer' criteria?

- The condition is having a marked negative emotional and social effect on the patient (quality of life is significantly affected)
- The patient does not have an eczema care plan OR the patient/carer is uncertain about their long-term management approach (e.g. symptoms are recurrent, not well controlled, or changing in pattern)

Yes → Proceed to Pharmacotherapy AND/OR Refer to General Practitioner for immediate review and follow up

No

Does the patient have allergies, medicine interactions or any other contraindications to management options?

Yes → Where therapy is considered the appropriate treatment option but all recommended treatments under this protocol are contraindicated, **refer patient to a medical practitioner**

No

Provide TCS treatment, where indicated.

- Determine body site(s) affected
- Use the table below to select appropriate TCS option(s)
- Supply quantities adequate for **7 days** of treatment (refer to Medicines List for guidance on recommended supply quantities under this Program)

Area(s) of body affected	TCS treatment options
Sensitive areas (neck, axillae, or groin)	Hydrocortisone 1% ointment
Trunk, limbs, flexures, palms, soles, or thickened lichenified areas	Methylprednisolone aceponate 0.1% ointment or fatty ointment, **OR** Mometasone furoate 0.1% ointment
Scalp (adults)	Methylprednisolone aceponate 0.1% lotion, **OR** Mometasone furoate 0.1% lotion or hydrogel, **OR** Betamethasone dipropionate 0.05% lotion
Scalp (children)	Methylprednisolone aceponate 0.1% lotion

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Provide non-pharmacological and self-care advice

1. Ensure the patient has access to an **Eczema Care Plan** **and** other written resources as appropriate (e.g. Self-care fact card).
   - Support the patient/carer to identify when a review or update of their care plan may be required with their medical practitioner
2. Provide advice on general management of atopic dermatitis:
   - Everyday skin care, including generous application of moisturiser to entire body
   - Avoid aggravating factors or triggers

Confirm management plan is appropriate with regards to contraindications, precautions, interactions, pregnancy and lactation status

Communicate agreed treatment plan to patient/carer and other healthcare professionals:

- Dispense medicines via pharmacy dispensing software and label according to legislative requirements outlined in the Drugs, Poisons and Controlled substances Regulation 2017
- Provide clear application instructions for TCS, including:
  - Where and how much to apply
  - Expected response
  - Duration of use (short-term use for flare management) and the expectations around resolution of symptoms
- Advise when to seek review with a medical practitioner for further care:
  - No improvement, or worsening of symptoms within 7 days
  - Further supply of TCS is required, or
  - Symptoms are recurrent, worsening, or not well controlled

Document the consultation and share a record of the service with the patient, patient's usual treating GP or medical practice where the patient has one

3. Clinical Documentation Requirements

The pharmacist must make a clinical record of the consultation that contains:

- Sufficient information to identify the patient (Medicare number and date of birth are usually recorded when dispensing prescriptions)
- Date of treatment
- Name of the pharmacist who undertook the consultation and their Healthcare Provider Identifier Individual (HPI-I) number
- Consent given by the patient regarding: program participation, costs, pharmacist communication with other healthcare practitioners (e.g. patient's usual treating general practitioner) and access to the patient's My Health Record for the purpose of checking inclusion/exclusion criteria and uploading information relating to the consultation as required
- Any information known to the pharmacist that is relevant to the patient's diagnosis or treatment (including TCS preparations used previously to treat atopic dermatitis) and any observations and assessments including allergies and adverse drug reactions
- Any clinical opinion reached by the pharmacist
- Actions taken by the pharmacist (including any medications supplied or referrals made to a medical practitioner)
- Particulars of any medications supplied to the patient (such as form, strength and amount)
- Information or advice given to the patient in relation to any treatment proposed by the pharmacist who is treating the patient

The pharmacist must share a copy of the record of the service with the patient and, if the patient consents, with the patient's usual treating medical practitioner or medical practice, where the patient has one.

The pharmacist must make a record in the pharmacy software, and an IT system approved by the Victorian Department of Health, regarding the supply.

Supplementary information

The supplementary information below provides additional guidance and information to Victorian pharmacists participating in the Community Pharmacist Program (the Program). It is intended to be used together with the guidelines and other resources referred to here to assist pharmacists in adhering to the management protocol and facilitate delivery of a safe and high-quality service to the community for the management of acute exacerbations of mild-to-moderate atopic dermatitis.

4. Gather information and assess patient's needs

4.1. Patient history

Sufficient information must be obtained from the patient, to assess the presenting condition, and the safety and appropriateness of any recommendations and medicines. Review MHR where available and appropriate.

Considerations include:

- Age
- Pregnancy and lactation status, including patients planning pregnancy (if applicable)
- Previous diagnosis of atopic dermatitis and any current or past management plan
- Potential differential diagnosis or complications such as secondary infection
- Onset, duration, nature, location, severity, and extent of dermatitis
- Recent or previous flare ups
- Impact of symptoms on quality of life and psychosocial wellbeing, including sleep, employment, and learning
- Response to any previous treatment or management strategies for atopic dermatitis:
  - Bathing/showering duration and temperature
  - Use of soap, soap-free cleansers, shampoos, and/or bath additives
  - Moisturiser use, application location, frequency, and quantity applied
  - Any previous TCS use, types, sites of application and quantity applied (e.g. number of tubes per week)
  - Adverse reaction to topical agents, e.g. stinging, topical steroid-induced perioral dermatitis
- Underlying and associated medical conditions, including asthma, allergic rhinitis, allergic conjunctivitis, allergic contact dermatitis, food or environmental allergy and depression
- Exposure to potential aggravating factors or triggers (e.g. heat, soaps and detergents, abrasive clothing, emollients containing sodium lauryl sulphate, contact allergens, food, fragrances or skin products, and inhalant triggers)
- Other factors including family history and environmental factors (e.g. exposure to smoking/vaping and airborne pollution)
- Current and recently commenced medicines
- Medication allergies and/or adverse effects

4.2. Examination

Prior to commencing patient examination, pharmacists should consider implementing infection control steps in line with the Australian Guidelines for the Prevention and Control of Infection in Healthcare 2019 to their specific setting and circumstances.

Physical examination of the patient's skin is required to identify, assess, and classify the severity of atopic dermatitis. Both rash and itch must be present for a diagnosis of atopic dermatitis.

A. Presenting signs and symptoms

Atopic dermatitis (also known as eczema) is a chronic or relapsing inflammatory skin condition that is characterised by the presence of both rash and itch.

- Rash: Atopic dermatitis rash usually presents as dry, scaly, rough, erythematous patches. It can affect any area of skin, but typically occurs on the face, the flexures (inside of elbow/arm, back of knee), wrists, ankles, neck, and groin. Lichenification may be present. Skin signs of atopic dermatitis may vary depending on age and ethnicity.
- Itch: Excoriation may be present. Itch may be difficult to assess in young children. Signs may include “wriggling” or rubbing on sheets, carpet, and clothing.

Patients with atopic dermatitis are more likely to have an immediate or family history of atopic conditions such as atopic dermatitis, allergic rhinitis, or asthma. Atopic dermatitis is often associated with poor sleep, depression, anxiety, poor self-esteem, reduced quality of life, and can impose a significant financial, psychological, and social burden on the lives of patients and their families.

Only patients who have previously been diagnosed with atopic dermatitis by a medical or nurse practitioner can be managed by pharmacists under this Protocol.

B. Assessing severity of atopic dermatitis

Consider the extent of affected skin, intensity of signs such as erythema, swelling, oozing/crusting, excoriation, lichenification and dryness, and effect on quality of life to determine the severity of atopic dermatitis.

Patients with severe atopic dermatitis (e.g. intense persistent itch with widespread rash or severe lesions that have a major impact on sleep and daily life) must be referred to an appropriate healthcare provider for management.

Tools such as the Palmar Method can be used to assess how much skin/Body Surface Area (BSA) is involved e.g. the palmar surface of a patient’s own hand, spanning from the distal wrist crease to the closed tips of all five digits, is equal to 1% of Total BSA. While primarily a burn assessment tool, it is also used in dermatology to estimate the surface area of skin affected by conditions like dermatitis.

Tools such as the **SCORing Atopic Dermatitis (SCORAD)** index or the **Eczema Area and Severity Index (EASI)** can be used to assess the extent and severity of atopic dermatitis:

Severity of atopic dermatitis	Mild	Moderate	Severe
SCORAD	< 25	25-50	> 50
EASI	< 7	7.1-21	> 21

Conventional scoring systems may underestimate severity and erythema in people with darker skin tones. Consider skin tone when assessing erythema. Where there is uncertainty, use EASI and upgrade the score by 1 grade or more for heavily pigmented skin (e.g. from mild to moderate).

Secondary infection in atopic dermatitis

Atopic skin is susceptible to bacterial infection (e.g. staphylococci, streptococci) and viral infection (e.g. herpes simplex virus, molluscum contagiosum virus, human papillomavirus).

Patients with **signs or symptoms of secondary infection of atopic dermatitis** (e.g. weeping, yellow crusts or pustules, grouped vesicles, punched-out erosions, persistent dermatitis despite

appropriate topical therapy) must be referred to an appropriate healthcare provider for management.

Patients with **suspected eczema herpeticum (secondary infection of atopic dermatitis with herpes simplex virus), particularly with eye involvement,** should be referred for immediate emergency medical care including ophthalmology assessment where relevant.

C. Red flag signs or patient ineligibility criteria i.e. patient to be referred to another authorised prescriber (medical or nurse practitioner)

Patients must be immediately referred for emergency medical care if they meet any of the following criteria:

- Severe, widespread, or painful rash
- Non-blanching purple rash
- Widespread erythema involving most of the body or multiple body regions
- Signs of sepsis, systemic illness or other complications, including fever, lethargy, nausea, vomiting, or headache
- Blistering of the skin, mucous membranes, or eyes
- Suspected eczema herpeticum, particularly with eye involvement

Patients must be referred to their General Practitioner for management if they meet any of the following criteria:

- **Unclear diagnosis or atypical presentation** of atopic dermatitis, different to historical flares
- **Insufficient response to treatments in** Medicines List, despite appropriate trial
- **Severe atopic dermatitis** (e.g. intense persistent itch with widespread rash or severe lesions, or SCORAD >50 or EASI >21)
- **Significant body surface area involvement** (>30% body surface area)
- **Complex or complicated presentation**, such as signs of secondary viral or bacterial infection of dermatitis
- **Non-healing broken skin, sores, ulcers, or crusts that are chronic** (more than 4 weeks)
- **Paediatric patient with a history of immediate or delayed-type hypersensitivity to food, poor feeding or sleep, or concerns about failure to thrive**
- **Pregnant or planning a pregnancy**
- **Immunocompromised patients**
  - due to underlying medical condition (e.g. transplant recipients, patients with malignancies, patients receiving chemotherapy, HIV infection, uncontrolled diabetes, advanced age)
  - due to medication taken by the patient (such as immunomodulatory therapy, extended prednisolone therapy)
- **Dermatitis involving the face** (including periorbital or perioral regions)

Patients must be referred to their General Practitioner, but may also be provided treatment if:

- The condition is having a marked negative emotional and social effect on the patient
- The patient does not have an eczema care plan OR the patient/carer is uncertain about their long-term management approach (e.g. Symptoms are recurrent, not well controlled, or changing in pattern)

5. Management and treatment plan

General management of atopic dermatitis:

- **Everyday skin care**, including:
  - Bathing/showering in lukewarm water for up to 5 minutes, using a non-soap cleanser and/or bath oil.
  - Regular moisturiser use - pat skin dry after washing (or swimming) and, using clean hands, applying a generous or thick amount of moisturiser to entire body (i.e. top-to-toe, not just areas affected by atopic dermatitis). Apply moisturiser after TCS.

- **Avoiding aggravating factors for atopic dermatitis**, such as:
  - Topical products that contain soap, fragrances, food-related ingredients (e.g. nuts, coconut, dairy), essential oils, aqueous cream, methylchloroisothiazolinone, methylisothiazolinone, or benzalkonium chloride (in laundry sanitisers, nappy wipes and creams).
  - Overheating (e.g. due to clothing, bath temperature, waterproof mattress protectors, hot cars or classrooms).
  - Prickly fabrics (e.g. thick fibres or wool) or synthetics (e.g. nylon, polyester, viscose). Cut off clothing tags, use cotton clothing, and bed linen.
  - Avoiding scratching (keep fingernails short).

Pharmacotherapy:

- Topical treatments in accordance with recognised guidelines* such as the Quality Use of Medicines Alliance Eczema Management Algorithm or Therapeutic Guidelines. Refer to Medicines List for treatments available under the Program.

***Note:** Pimecrolimus, crisaborole, and liquor picis carbonis (LPC, or coal tar solution) +/- keratolytics (e.g. salicylic acid) are also treatment options for atopic dermatitis. These are not included for supply under the Program, which has focused on supply of TCS.

5.1. Confirm management is appropriate

Pharmacists must consult the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references to confirm the management is appropriate, including for:

- Contraindications and precautions
- Medication interactions
- Pregnancy and lactation (note that patients who are pregnant or planning pregnancy are not eligible for treatment under this Program)

Discuss whether the patient may be eligible for a PBS authority prescription through a medical practitioner which may allow supply of larger quantities of TCS at reduced cost to the patient, particularly for concession card holders.

6. Medicines list

The Program authorises the supply of certain TCS for the treatment of acute exacerbations of mild to moderate atopic dermatitis where these are indicated.

The quantity of TCS supplied should be sufficient for 7 days of treatment. This may require several packs of the topical corticosteroid formulation, depending on the affected body surface area.

Note: There are no changes to the scope for pharmacists to supply Schedule 2 and 3 treatments for atopic dermatitis as appropriate.

Treatment for mild-to-moderate atopic dermatitis

Moisturisers
Encourage regular use of moisturisers, particularly after bathing or showering, to reduce water loss from the skin. Advise use of emollient soap substitutes or fragrance-free bath oils.

Topical corticosteroid formulations	Area(s) of body affected	Dose	Pack size examples
Betamethasone dipropionate 0.05% lotion	Scalp (adults)	Apply once to twice daily to affected areas until skin is clear	30mL
Hydrocortisone 1% ointment	Sensitive areas (neck, axillae, or groin)	Apply once to twice daily to affected areas until skin is clear	30g 50g
Methylprednisolone aceponate 0.1% ointment or fatty ointment	Trunk, limbs, flexures, palms, soles, or thickened lichenified areas	Apply once daily to affected areas until skin is clear	15g
Methylprednisolone aceponate 0.1% lotion	Scalp (children or adults)	Apply once daily to affected areas until skin is clear	20g
Mometasone furoate 0.1% ointment	Trunk, limbs, flexures, palms, soles, or thickened lichenified areas	Apply once daily to affected areas until skin is clear	15g 45g 50g
Mometasone furoate 0.1% lotion	Scalp (adults)	Apply once daily to affected areas until skin is clear	30mL
Mometasone furoate 0.1% hydrogel	Scalp (adults)	Apply once daily to affected areas until skin is clear	15g 45g

7. Communicate agreed management plan

Comprehensive advice and counselling (including provision of self-care fact cards and supporting written information when required) as per the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references, should be provided to the patient regarding:

- **Access to and updating of Eczema Care Plans or other written information** as appropriate
  - Patients who do not have an existing eczema care plan should be referred to a medical practitioner and provided with information on how to access one.
  - Pharmacists may assist patients in identifying when a review or update by a medical practitioner is required, particularly where symptoms are recurrent, worsening, or not well controlled.

7.1. General advice

The patient/parent/caregiver(s) should be provided with clear and simple advice to support the management of atopic dermatitis, to resolve and prevent flares.

Key points include:

- Advice on general skin and body hygiene:
  - Everyday skin care, including daily bathing with a non-soap cleanser and/or bath oil
  - Daily generous application of a fragrance-free moisturiser to entire body.
  - Avoiding aggravating factors for atopic dermatitis, such as certain topical products, overheating, prickly fabrics, or scratching.
- Dosing and application instructions for TCS treatment:
  - To explain which TCS formulations to use on which areas of the body.
  - Apply TCS generously (not sparingly) to all areas of active atopic dermatitis (not just to the worst areas), including cracked or open skin. Some improvement would be expected within 7 days of starting TCS.
  - Continue TCS use until the skin is clear. TCS may be restarted at the beginning of a new flare of atopic dermatitis.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients (and parents/carers if applicable), and to ensure these comply with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

Patients/parents/caregivers should be advised to see a medical practitioner if:

- Symptoms do not improve or worsen within 7 days of commencing TCS treatment
- If more than 7 days supply of TCS is required, the patient should see their medical practitioner for review and further prescriptions. A medical practitioner may prescribe TCS at higher quantities with PBS subsidised authority prescriptions.
- Signs and symptoms that suggest infection of atopic dermatitis

8. Follow up / clinical review

Pharmacist follow up or clinical review should only occur where there has been clear improvement in symptoms, and where care can be appropriately managed within usual pharmacist care. If there is no improvement, worsening, or need for ongoing TCS treatment beyond 7 days, the patient should be referred to a medical practitioner for further investigation and management.

9. Resources

9.1. Pharmacist resources

Eczema Management Algorithm (Quality Use of Medicines Alliance):

- https://medcast.com.au/qhub/eczema/resources

Therapeutic Guidelines (Dermatology):

- https://tgldcdp.tg.org.au/viewTopic?etgAccess=true&guidelinePage=Dermatology&topicfile=c_DMG_Atopic-dermatitis_topic_1&guidelinename=Dermatology&sectionId=c_DMG_Atopic-dermatitis_topic_1#c_DMG_Atopic-dermatitis_topic_1

Australian Medicines Handbook: Dermatological drugs

- https://amhonline.amh.net.au/chapters/dermatological-drugs/drugs-eczema/corticosteroids-skin

Treatments for atopic dermatitis (Australian Prescriber):

- https://australianprescriber.tg.org.au/articles/treatments-for-atopic-dermatitis.html

Consensus statement: Management of atopic dermatitis in adults (The Australasian College of Dermatologists):

- https://www.dermcoll.edu.au/fellows/statements-guidelines-resources/

Consensus statement: Topical corticosteroids in paediatric eczema (The Australasian College of Dermatologists):

- https://www.dermcoll.edu.au/fellows/statements-guidelines-resources/

Eczema Clinical Practice Guideline (Royal Children's Hospital Melbourne):

- https://www.rch.org.au/clinicalguide/guideline_index/eczema/

DermNet NZ:

- SCORing Atopic Dermatitis (SCORAD) index: https://dermnetnz.org/topics/scorad
- Eczema Area and Severity Index (EASI): https://dermnetnz.org/topics/easi-score

Victorian Adult Burns Service:

- Palmar method: https://www.vicburns.org.au/burn-assessment/burn-pathophysiology/

Skin Deep:

- Open-access bank of high-quality photographs of medical conditions in a wide range of skin tones for use by both healthcare professionals and the public: https://dftbskindeep.com/

9.2. Patient resources

Eczema Care Plan (Medcast):

- https://medcast.com.au/qhub/eczema/resources

Topical Corticosteroids for Eczema Flare Control (Eczema Support Australia):

- https://www.eczemasupport.org.au/topical-steroids/

Topical steroids – how much do I use? The fingertip unit (Australian Medicines Handbook):

- https://resources.amh.net.au/public/fingertipunits.pdf

Eczema Care Online Toolkit (Eczema Support Australia):

- https://toolkit.eczemasupport.org.au/my-self/eczema-overview/

Eczema (atopic dermatitis) Kids Health Info (The Royal Children's Hospital Melbourne):

- https://www.rch.org.au/kidsinfo/fact_sheets/eczema/

How to treat and manage eczema at home – Information for Parents (The Royal Children's Hospital Melbourne):

- https://ww2.rch.org.au/elearn/eczema/story.html

Eczema (atopic dermatitis) Fact Sheet (Better Health Channel):

- https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/eczema-atopic-dermatitis

Eczema (Atopic Dermatitis) Frequently Asked Questions (Australasian Society of Clinical Immunology and Allergy):

- https://www.allergy.org.au/patients/skin-allergy/eczema