Nappy Rash Pathway

Clinical Assessment/Management tool for Children

Healthier Together

NHS

Primary and Community Care Settings

History and Differential Diagnosis

Nappy rash is an acute inflammatory reaction of the skin in the nappy area, which is most commonly caused by an irritant contact dermatitis.

History

- Location, nature, and duration of rash.
- Types of treatment tried.

Non-infective Causes

- Allergic contact dermatitis
- Psoriasis
- Infantile seborrheic dermatitis
- Atopic eczema
- Zinc deficiency
- Neglect (refer to local child safeguarding policies)

Infective Causes

- Fungal skin infection-tinea corporis
- Perianal streptococcal dermatitis (consider swab)
- Eczema herpeticum or coxsackium
- Scabies

Examination

Features typical of nappy rash:

- Erythema, scattered papules over surfaces in contact with nappy with sparing of the groin skin creases
- Skin erosions, oedema, and ulceration
- Candidiasis: white pustules, satellite lesions

Bacterial features:

- Erosions, golden crusting
- Examine the rest of the skin on the body
- Skin swabs are not generally recommended for the management of nappy rash as the results are difficult to interpret.

Images available at: https://dermnetnz.org/topics/napkin-dermatitis-images/

Red Flags, Risk Factors and High Risk Groups

- Deterioration despite advice or treatment
- An immunocompromised patient
- Allergy, e.g. CMPA
- Faltering growth

Risk factors for the development of nappy rash:

- Type of nappy used — more likely with reusable cotton nappies
- Skin care practice (e.g. how often the area is cleaned and the nappy changed) prolonged skin contact with urine and faeces predisposes to irritant contact dermatitis. Consider neglect, refer to local child safeguarding policies.
- Exposure to chemical irritants — such as soaps, detergents, or alcohol-based baby wipes.
- Skin trauma — for example, mechanical friction from skin contact with nappies or over-vigorous cleaning.
- Medication — recent broad-spectrum antibiotics, in particular, predispose to candida colonisation; other drugs that increase stool frequency may also increase the risk.
- Gestational age — pre-term infants are at increased risk of developing nappy rash and secondary infection due to the reduced barrier function of immature skin.
- Diarrhoea — including conditions associated with increased stool volume and pH, such as gastroenteritis, malabsorption, and liver conditions such as hepatitis (rare)

Stage	Features	Management	Consider referral to a paediatric dermatologist if:
Standard treatment for all nappy rash		• Stop irritants, e.g all wipes, bubble bath, soap, sanex, child's farm etc. • Use emollient on cotton pad / wool to gently clean at every nappy change, e.g cetraben, aproderm • Apply emollient again after cleaning • Then topical treatment as advised below, followed by a thin layer of barrier cream to the inflamed / red / dry areas only. Avoid applying thickly all over as this can affect the function of the nappy. • If emollient stings use an ointment e.g. cetraben ointment • Do not use fabric conditioner in re-useable nappies	• There is uncertainty about the diagnosis. • The rash persists despite optimal treatment in primary care. • There are recurrent, severe unexplained episodes. • If there is a community vulval service in your area, consider referral to this service
Mild	Mild erythema, mild scaling and asymptomatic	• Barrier preparations to protect the skin, which are available to buy over-the-counter. • Options include Sudocrem®, Metanium® ointment, and Bepanthen®	
Moderate	Moderate erythema, oedema and discomfort	• Topical hydrocortisone 1% cream BD until symptoms settle. (Maximum 7 days) • Apply hydrocortisone after cleaning (see advice above) and wait 30 minutes before applying the barrier preparation. • Keep using barrier preparation with every nappy change	
Severe	Skin erosions, oedema and ulceration	• Treat with topical Trimovate® BD for 7 days • Follow standard advice above	
Candida Infection	Satellite lesions, white papules	• Prescribe Canesten HC or Daktacort® BD for 7 Days thinly and evenly to the affected area • Follow standard advice above • Continue antifungal treatment (without steroid) for 7 days after the rash has cleared	
Bacterial Infection	Erosions, golden crusting	• Topical Trimovate® BD for 7 days. • If no improvement, swab and consider oral flucloxacillin for 7 days. (Clarithromycin for 7 days if penicillin allergy). Caution – very rare to have a bacterial infection and oral antibiotics can worsen nappy rash due to diarrhoea	

This guidance has been reviewed and adapted by healthcare professionals across West Yorkshire with consent from the Hampshire development groups