Steroid, is quite safe. The more potent ones can cause from mild to super-potent. Hydrocortisone, a very mild and careful supervision. They come in many strengths steroid ointments and creams requires good judgment only treatment that can calm the inflamed skin. Use of steroid medicines are very helpful. Often they are the anabolic steroids some athletes misuse. Cortico-
desonide, triamcinolone). They are not the same as have a net drying effect on AD skin.

When will my child outgrow atopic dermatitis? For any given child, it is difficult to predict. The majority of babies with AD will lose most of the problem by adolescence, often before grade school. A small number will have severe AD into adulthood. Many have remissions that last for years. The dry skin tendency often remains. Most people learn to use moisturizers to keep their dermatitis controlled. Occasional episodes of AD may occur during times of stress or with jobs that expose the skin to irritants and wet work.

Will AD affect my child’s career choice? Someone who has had eczema should avoid jobs that can injure the skin. Military service automatically excludes people with AD or asthma. Wet work in restaurants or hospitals is especially damaging to hands predisposed by AD to drying and cracking. Generally, it’s better to pick “clean” indoor work such as with

What kinds of treatments help? MOISTURIZERS. Ointments such as petroleum jelly are best until they’re too thick and cause discomfort. Creams may be fine for moderately dry skin or in hot, humid weather. Apply them to wet skin, immediately after bathing. Lotions are not rich enough and often have a net drying effect on AD skin. CORTICOSTEROIDS. Often called topical (“applied to the skin”) steroids, these are cortisone-like medications that can cause thinning of the skin but they can suppress the immune system in the skin so that the use of sun protection for the children receiving this therapy is recommended. For children less than two years of age these medications are only used off-label and as always, with any medication, they should be used with careful supervision of a physician. Tacrolimus and pimecrolimus both currently have a “black box” warning, which is a precautionary statement given to the medication by the Food and Drug Administration.

TAR PREPARATIONS. Tar creams or bath-emulsions can be helpful for mild inflammation. ANTIBIOTICS. Oral or topical antibiotics reduce the surface bacterial infections that may accompany flares of AD. ANTIHISTAMINES. Often prescribed to reduce itching, these medicines may cause drowsiness but seem to help some children, largely due to their sleep-inducing side effects.

Topical Immunomodulators (TIMs) This family of topical medications has been available for the past 10 years. TIMs work to inhibit the skin’s inflammatory response (which is what causes the redness and also contributes to itching). At this time there are two FDA approved non-steroid drugs: tacrolimus and pimecrolimus. TIMs are not steroids and do not cause thinning of the skin but they can suppress the immune system in the skin so that the use of sun protection for the children receiving this therapy is recommended. For children less than two years of age these medications are only used off-label and as always, with any
Atopic Dermatitis in Children

Atopic dermatitis (AD), often called eczema (pronounced “Ek-zema”) or atopic eczema is a very common skin disease. It affects around 10% of all infants and children. The condition is not known, but AD results from a combination of family history and a variety of conditions in everyday life that triggers the red, itchy rash.

How do we know if it’s atopic dermatitis?

1. **TIME OF ONSET.** This type of eczema usually begins during the first year of life and may vary within the first five years. It’s seldom present at birth, but it often comes on during the first six weeks. Other rashes also can start at any time. It’s most rash es disappear within a few days to weeks. AD tends to persist. It may wax and wane, but it keeps coming back.

2. **ITCHING.** Atopic dermatitis is a very itchy rash. Much of the skin damage comes from scratching and rubbing that the child cannot control.

3. **THE LOCATION OF THE RASH** can also help us recognize AD. In babies, the rash usually starts on the face or over elbows and knees, places that are easy to scratch and rub. It may spread to the buttocks and other areas of the body, although moisture in the diaper region protects the skin barrier. Later in childhood, the rash is typically in the elbow and knee folds. Sometimes it only affects the hands, and at least 70% of people with AD have eczema on their ears at some time in their lives. Rashes on the feet, scalp or behind the ears are other places that might clue us to AD. Be advised, though, that these symptoms may also indicate other conditions, such as seborrheic dermatitis.

4. **THE APPEARANCE OF THE RASH** is probably the most helpful clue, because it may be very dif- ferent from one person to another. Scratch marks are often seen, along with scaly dry skin. The skin may become infected and show yellow crusts or little, pinpoint, pus-containing bumps. The skin also may thicken from long-term scratching and rubbing.

5. **HEREDITY.** If other family members or relatives have AD, asthma or hay fever, the diagnosis of AD is more likely.

**THE BOTTOM LINE:** Be sure to get your child diag- nosed by a physician before assuming that the condition is atopic dermatitis.

The Atopic Triad
AD falls into a category of diseases called Atopy, a term originally used to describe the allergic conditions asthma and hay fever. AD was included in the atopic category because it often affects people who either suffer from asthma and/or hay fever or have family members who do. Physicians often refer to these three conditions as the “atopic triad.”

Does it run in families?
AD is a familial disease, though the exact way it passes from parents to children is unclear. If one parent has AD, or any of the other atopic diseases (asthma, hay fever), the chances are about 50% that the child will have one or more of these conditions. If both parents are atopic, chances are even greater that their child will have it. However, the connection is not an absolute one: As many as 30% of the affected patients have no family members with any of these allergic disorders.

What causes atopic dermatitis?
AD is not contagious. People with AD cannot “give” it to someone else.

<table>
<thead>
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<th>What are trigger factors?</th>
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<td>Trigger factors may differ in different people. Most children get worse when they get a cold or other infection. Most have worse problems in the winter; but others seem to be more affected by sweating during hot, humid sum- mer weather. Let’s look at the trigger factors that seem to affect every child with AD.</td>
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**DRI SKY.** The skin’s main function is to provide a barrier against dirt, germs and chemicals from the outside. We don’t notice this barrier until it is breached, and then it is scaly and rough. Dry skin is brittle – moist skin is soft, pliable and elastic. People with AD may see it as dry skin so it won’t stay moist. It is especially bad in winter when the heat is on in the house and the humidity drops. Other things that can affect your skin’s natural moisture, like too much bathing or dry air, can be very tough on skin that is already dry. Treatment: Keep skin dry.

IRITANT S. Irritants are any of the substances outside the body that can cause burning, redness, itching or dryness of the skin. The challenge: Avoid irritating substances.

**EMOTIONAL STRESS.** Emotional stress comes from many situations. People with AD react to stress by red flush ing and itching. Special problems for children with AD include frustration, anger, or fear. And of course, AD itself, and the stress it brings, can cause stress. The challenge: Recognize stress and reduce it.

HEAT AND SWEATING. Most people with atopic derma- titis notice that when they get hot, they itch. They have a pretty good idea of how long it takes for their skin to cool down, especially if they are embarrassed by the heat. It’s summer time but anytime they sweat. It can happen from exercise, from too much warm bedding, or rapid changes in temperature from cold to warm.

**INFECTIONS.** Bacterial "staph" infections are the most common, especially on arms and legs. Such infections might be suspected if areas are weeping or crusty or red. "Impetigo" outbreaks are also common. If the skin becomes infected, it often thickens from long-term scratching and rubbing.

**IRRITANTS.** Irritants are any of the substances outside the body that can cause burning, redness, itching or dryness of the skin. The challenge: Avoid irritating substances.

**ALLERGENS.** Allergens are materials (such as pollen, pet dander, foods, or dust) that trigger allergic respons es. Allergic diseases such as asthma and hay fever, which flare quickly, are easy to tie to allergens. Allergic symptoms, such as itching and hives, appear soon after exposure to airborne allergens and last only briefly. But the slower, chronic, continuing eczema of AD may be difficult to tie to specific allergens. Food allergies can trigger flares, especially for children with moderate to severe AD. Pollens, dust mites, and pets are often shown to be trigger eczema in young children. Of the available tests for allergies, scratch tests and RAST tests are the best at detecting the allergens that cause eczema. Patch tests, by contrast, can diagnose reaction in some cases such as allergies to skin care products.

Are there other trigger factors?
Children with AD will be helped by understanding the major trigger factors described above. But individuals may be subject to other trigger factors, and it is important to be alert for these as well.

How can you avoid trigger factors?

1. Keep the skin barrier intact. Moisturize!
2. Wear soft clothes that “breathe.” Avoid fabrics of wool, nylon, or stiff material.
3. If sweating causes itching, find ways to keep cooler. Reduce or avoid warm exercise, especially if it has been hot. Lay down clothes and adjust to temperature change. Don’t over-tighten clothing, especially the roomy, under-light bedclothes.
4. If itching from sweating, dust, pollen or other exposures, take a cooling shower or tub bath, and don’t forget to moisturize afterwards, within 3 minutes after the child has been gently towelled.
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ECZEMA: Atopic Dermatitis in Children