What kinds of treatments help?

MOISTURIZERS. Ointments such as petroleum jelly are best unless 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 used in creams or ointments that your doctor may prescribe (e.g. hydrocortisone, mometasone, desonide, triamcinolone). They are not the same as the anabolic steroids some athletes misuse. Corticosteroid medicines are very helpful. Often they are the only treatment that can calm the inflamed skin. Use of steroid ointments and creams requires good judgment and careful supervision. They come in many strengths from mild to super-potent. Hydrocortisone, a very mild steroid, is quite safe. The more potent ones can cause thinned skin, stretch marks, and even growth retardation or suppression of the adrenal gland if used too many days in the same areas of the body. Parents should monitor the child’s use. Ask the doctor about potency and side effects of prescribed corticosteroid medicines and follow the product insert instructions carefully.

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 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.

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.

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.
ECZEMA: Atopic Dermatitis in Children

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.”

What are trigger factors?
Trigger factors may be different in different people. Most children get worse when they get a cold or other infection. Most have worse problems in the winter; but others cannot stand being hot, humid summer weather. Let’s look at the trigger factors that seem to affect every child with AD.

DRY SKIN.
The skin’s main function is to provide a barrier against dirt, germs, and chemicals from the outside. We don’t notice this function until it gets dry, and then it’s too late. Dry skin is brittle — moist skin is soft and flexible.

STRESS.
Stress is another trigger. People with AD often react to stress by having red flushes, itching, and irritation. Special problems for children with AD include a tendency to itch excessively.

HEAT AND SWEATING.
Most people with atopic dermatitis (AD) have a defect in their skin so it won’t stay moist. It is especially bad in winter when the heat is on in the classroom. It can happen from exercise, from too many warm bedclothes, or rapid changes in temperature from cold to warm.

ALLERGENS.
Allergenic factors may be different in different people. Most adults with AD are likely to have one or more of the diseases. If both parents have AD, 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.

Are there other trigger factors?
Children with AD will be helped by reducing 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?

Keep the skin barrier intact. MOISTURIZE!

Wear soft clothes that “breathe.” Avoid fabrics of wool, nylon, or stiff material.

If sweating causes itching, find ways to keep cool:

Reduce exertion, especially during times of flare. Layer clothes and adjust to temperature changes. Don’t overheat rooms, especially the bedroom. Use light bedclothes.

When sweating from stress, dust, pollen, or other environmental factors, take a bath or a shower. Use the slower, continuing, chronic eczema of AD may be difficult to tie to specific allergens. Food allergies can trigger flares, especially for children with severe AD. Pollens, dust mites, and pets can seldom be shown to trigger eczema in young children. Of the available tests for allergy, skin testing is the most useful. It is the only reliable way to discover what causes an allergy. Patch tests, by contrast, can diagnose eczema response in some cases such as allergies to ingredients in personal care products.

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

AD inflammation results from too many reactive inflammatory cells in the skin. Research is seeking the reason why these cells over-react. Patients with AD (asthma or hay fever) are born with these over-reactive cells. When something triggers them, they don’t turn off as they should. We try to control AD by controlling the trigger factors that “turn on” inflamed skin, or by “dampening the flames” with anti-inflammatory therapies.

What are the symptoms of AD?
In addition to rashes, people with AD often have redness, itching, and irritation. They may also have WAX and WANE, but it keeps coming back.

The appearance of the rash
The appearance of the rash is probably the least helpful clue, because it may be very different from one person to another. Scratch marks are often seen, along with scaly dry skin. The skin may be infected and yellow or crusty. A red, scaly patch, near a sweat gland, may thicken from long-term scratching and rubbing.

4. Heat and sweating
Most people with atopic dermatitis (AD) have a defect in their skin so it won’t stay moist. It is especially bad in winter when the heat is on in the classroom. It can happen from exercise, from too many warm bedclothes, or rapid changes in temperature from cold to warm. It is especially bad in winter when the heat is on in the classroom. It can happen from exercise, from too many warm bedclothes, or rapid changes in temperature from cold to warm.

5. Allergens
Allergenic factors may be different in different people. Most adults with AD are likely to have one or more of the diseases. If both parents have AD, 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.

1. Timing of onset.
This type of eczema usually begins during the first year of life and almost always within the first five years. It is seldom present at birth, but it often comes on during the first six weeks. Other rashes also can start at any time, but most rashes 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 involve 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 hand eczema at some time in their life. Flashes on the feet, scalp, or behind the ears are other clues that might point to AD. Be advised, though, that these symptoms may also indicate other conditions, such as seborrheic dermatitis.

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5. Heredity.
If other family members or relatives have AD, asthma or hay fever, the diagnosis of AD is more likely. If other family members or relatives have AD, asthma or hay fever, the diagnosis of AD is more likely. One in five children with AD have one or more of the diseases. If both parents have AD, 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.

How do we know if it’s atopic dermatitis?

1. Timing of onset.
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The BOTTOM LINE: Be sure to get your child diagnosed by a physician before we diagnose the condition is atopic dermatitis.

National Eczema Association
nationaleczema.org

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Do not hallucinate.