# Eczema Center Emphasizes Research, Education

BY DOUG BRUNK

*San Diego Bureau*

Since its debut in April of 2007, the Eczema Center at Rady Children's Hospital in San Diego has received hundreds of e-mails, phone calls, and visits from families in western states and some from the East Coast, many desperate to find relief for their children's eczema.

The bustle of activity illustrates the rising prevalence of eczema, which has more than doubled among American children since 1960, from a prevalence of 7% to a range of 15%-20%. "There is clearly a rising prevalence of atopic dermatitis in the United States and throughout the world, and it seems to parallel other allergic conditions which include asthma, allergic rhinitis, and food allergy," the center's director, Dr. Lawrence F. Eichenfield, said in an interview. "This creates a whole set of questions regarding why and how can it be mediated. It also raises the question: Are these conditions related? We know that life-threatening food allergies are much more common than they used to be, and we know that food allergies are much more common in atopic dermatitis patients. But how important are food allergies in atopic dermatitis? That's a different question."

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DR. EICHENFIELD

The three key components to the Eczema Center include clinical, translational, and basic science research; comprehensive, individualized patient care; and an intensive educational intervention for patients and their families, including "atopic dermatitis school" led by a nurse with expertise in the disease, and detailed eczema management handouts which can be downloaded from the center's Web site (www.eczemacenter.org).

The education component is crucial, Dr. Eichenfield said, because studies in the medical literature have demonstrated that intensive education is more effective in impacting eczema than is traditional education. A study in Germany found that children whose parents received 6 weeks of intensive education in the management of atopic dermatitis fared better at 1 year follow-up compared with those who did not (BMJ 2006;332:933-8).

To illustrate the success of the Eczema Center model, Dr. Eichenfield described the recent case of a 2-year-old child who had severe inflammatory eczema with a secondary bacterial infection that involved 60%-70% of body surface area, recalled Dr. Eichenfield, chief of pediatric and adolescent dermatology at Rady Children's Hospital.

Dr. Eichenfield prescribed aggressive topical corticosteroid therapy with wet wraps and a standard course of antibiotics. The family members attended atopic dermatitis school in which they learned to not fear using an appropriate quantity of mid-strength topical corticosteroid. In 2-3 weeks, the child was 90%-95% better and "was easily transitioned to a maintenance regimen of only intermittent prescriptive medicines with excellent disease control over the next 4 months," he said. "The intervention wasn't different than what we did before the Eczema Center was established, but having the dedicated nurse to explain how to do the wet wrap therapy, and providing the opportunity for the parents to explore their questions and concerns about safety with other families in the atopic dermatitis school, made them feel comfortable taking on a regimen that was very effective in treating the disease with a minimum of stronger medicine."

The mission of the medical center also includes efforts to improve the education of health professionals about eczema. Dr. Eichenfield and his associates recently received a Program for Innovative Continuing Medical Education in Dermatology grant from the American Academy of Dermatology to develop new ways to educate providers about the disease using podcasts and other Web-based material. And the center will cosponsor the annual meeting of the National Eczema Association in San Diego July 24-27.

The center, which moved into dedicated office space in April of 2008, operates in conjunction with the pediatric and adolescent dermatology department at Rady and the University of California, San Diego; the dermatology research unit at Rady; the department of pediatrics and the division of dermatology in the department of medicine at the university; and Children's Specialists of San Diego, a group of more than 150 specialists in child care. ■

## Quality of Sleep Is a Marker of Severity

LA JOLLA, CALIF. — How has your sleep been? When last was your skin totally clear? Those are the two questions Dr. Lawrence F. Eichenfield asks his atopic dermatitis patients.

"It's amazing how families don't tell you about sleep disturbance unless you ask about it," he said at a meeting sponsored by Rady Children's Hospital and the American Academy of Pediatrics. "I view sleep disturbance as a marker for out-of-control disease."

Another way to gauge the severity of disease is to ask when the last time the patient's skin was totally clear, as well as asking how the skin has been over time.

The first phase of treating atopic dermatitis is what he termed "induction therapy." He recommends a course of topical corticosteroids for 1-3 weeks, depending on severity, as a first line of treatment.

Three products have received Food and Drug Administration approval for use in patients aged as young as 3 months: desonide nonethanolic foam (Verdeso, Stiefel Laboratories Inc.); desonide aqueous gel (Desonate, SkinMedica Inc.); and fluocinolone acetonide oil (Derma-Smoothe, Hill Dermaceuticals Inc.). "Generally we use 'strength as needed' to get the disease under control," said Dr. Eichenfield, who was involved in clinical studies of the topical agents but has no financial interest in the drugs' manufacturers.

Generic topical corticosteroids, such as triamcinolone 0.1% ointment, are a "cost-effective, short-term intervention for diffuse atopic dermatitis." Using wet wraps—an intensive therapy applying steroids under hydrated gauze wraps, covered by dry wraps—for 3-4 days yields the same results as using topical corticosteroids for 2-3 weeks.

Dr. Eichenfield uses topical calcineurin inhibitors (TCIs) as second-line agents in patients with persistent or frequently recurrent atopic dermatitis. He noted that use of TCIs has dropped about 50% since the FDA's black box warning in 2005 concerning the potential for oncogenesis. "There have been no further data confirming any true risk associated with the use of these medicines topically."

The second phase is maintenance therapy. With severe cases, clearly defined regimens are preferable; in some this may be intermittent topical corticosteroids, in others TCIs intermittently or daily, and in some a mixture of corticosteroids, TCIs, and nonsteroidal barrier creams.

The last phase is "stepped maintenance," in which the agent or agents are decreased as tolerated.

Dr. Eichenfield disclosed that he has been a clinical investigator in trials conducted by Amgen Inc., Astellas Pharma Inc., Ferndale Laboratories Inc., Galderma Laboratories, Graceway Pharmaceuticals, Hill Dermaceuticals Inc., Johnson & Johnson, Novartis Pharmaceuticals Corp., and Medicis Pharmaceutical Corp. He said that he has no relevant interest in any of the companies.

# Tanning Industry Launches Attack Against 'Melanoma Hype'

BY ALICIA AULT

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Does tanning increase the risk of melanoma? Not according to the Indoor Tanning Association, which has launched a print and TV advertising campaign in seven major cities claiming there is no compelling scientific evidence linking tanning to melanoma."Both the sun and tanning beds have been unnecessarily demonized by special interests using junk science and scare tactics," Sarah Longwell, ITA spokeswoman, claimed in a statement.

The organization, which represents manufacturers of tanning beds and tanning salons, cited recent research in the Proceedings of the National Academy of Sciences showing that higher vitamin D levels increased survival in certain types of cancer. A reference was not supplied.

According to the ITA's press release, the association will be running TV commercials in New York, Boston, Washington, Chicago, San Francisco, Seattle, and Pittsburgh—all areas in which the ITA says vitamin D deficiency is common. The ITA is also challenging what it calls "myths" about tanning at two new Web sites (www.sunlightscam.com and www.trusttanning.com).

The association did not respond to multiple requests for comment.

The American Academy of Dermatology issued a statement on the same day in wake of the ITA release. "While the health benefits of vitamin D are well known, it also is well known that exposure to [UV] radiation can cause skin cancer," AAD president Dr. C. William Hanke said in a statement.

In a follow-up interview, Dr. Hanke said, "You really don't need to destroy your skin to get adequate vitamin D." A few minutes of sun exposure is generally enough for vitamin D intake. Dietary sources of vitamin D are superior, he said.

"There is no evidence whatsoever that indoor tanning is safe," said Dr. Hanke, adding, "We're not going to put our patients at risk by condoning indoor tanning." In addition, said Dr. Hanke, "there is substantial evidence that excessive exposure to any form of UV radiation increases the risk of developing melanoma and nonmelanoma skin cancer."

Melanoma incidence has stayed steady since 2000, after rising for almost 30 years, according to the American Cancer Society's latest statistics. In 2008, there will be an estimated 62,480 cases in the United States and 8,420 deaths.

The ITA also is accusing dermatologists—and specifically the AAD—of being corrupt because of money the organization receives from sunscreen manufacturers. On its Web sites, the ITA attacks both the AAD and its current officers, and the Skin Cancer Foundation, which it calls a front group for the sunscreen industry.

Dr. Hanke said that if taking money from manufacturers was the bar, then most medical societies would be considered corrupt. Support from pharmaceutical companies and sunscreen manufacturers is essential to carrying out the educational mission of the AAD, he said. ■