Practical Education for Parents Aids Eczema Care

Success of eczema therapy is jeopardized if there is no informed parental backup at home, study finds.

BY BETSY BATES
Los Angeles Bureau

VANCOUVER, B.C. — The battle against atopic dermatitis and eczema is often won or lost in the home, and educating parents by giving them simple and practical instructions can enhance the daily management of the diseases in children, Alfons Krol, M.D., said at the annual meeting of the Pacific Dermatologic Association.

The message that meaningful parental education is pivotal to success, and that without it, no other therapy is bound to be successful, is highlighted in a provocative study from the United Kingdom, said Dr. Krol, professor and director of pediatric dermatology at Oregon Health and Science University, Portland.

In the study from Sheffield (England) Children's Hospital, a specialist dermatology nurse spent at least 40 minutes demonstrating how to apply topical therapy and offering general eczema education to the families of 51 children with poorly controlled atopic dermatitis.

Lessons were reinforced by the nurse at subsequent visits (Br. J. Dermatol. 2003;149:582-9).

Within 1 year, eczema severity had declined 89%, attributable to a remarkable 800% increase in the use of emollients. There was no overall increase in the use or potency of topical steroids.

Dr. Krol suggests giving parents tangible, concrete advice.

For example, Dr. Krol draws on a study from Wales in prescribing topical medications according to fingertip units. The medications can be easily squeezed out onto a parent's pointer finger, to ensure they are applying a proper amount (Br. J. Dermatol. 1998;138:293-6).

At another recent meeting, Alfred Lane, M.D., cited the same Sheffield Children's Hospital study and explained how its principles can be applied to emollients.

He instructs families to use petroleum jelly according to the size of the jars. Parents of a 4- or 5-year-old should be using a 14-ounce tub every other week, he said.

"I try to talk [teenaged patients] into using a pound a week," said Dr. Lane, professor of dermatology and pediatrics and chairman of dermatology at Stanford (Calif.) University.

At each visit, he simply asks patients or parents how many jars they've used, Dr. Lane said at the annual meeting of the California Society of Dermatology and Dermatologic Surgery.

Other educational messages are vital to convey as well. These include:

▶ **Atopic dermatitis is not a food allergy.** Many children with eczema have IgE antibodies to molds, pollens, and grasses, and they may have food allergies as well; parents should be clear about the fact that their children's eczema is not caused by what they eat.

Dr. Lane described an infant who developed zinc deficiency and severe protein malnutrition when a foster mother accepted a naturopath's advice to limit the child's diet to goat's milk and rice milk in the belief that everything else was worsening the child's atopic dermatitis.

He emphasized that extreme diets do not improve eczema and may pose serious risks to children.

▶ **Topical steroids are not what's worrying Congress and major league baseball.** The word steroid brings to mind oversized muscles, " 'roid rage," and testicular shrinkage. Physicians should not assume that parents understand that there is a difference between the substances that are banned in competitive sports and the medicines prescribed for atopic dermatitis.

▶ **Emollients don't have to be fancy to work.** "There's certainly nothing cheaper and nothing as nonsensitizing as petrolatum," Dr. Krol said.

He advises parents to apply it within 1 minute of bathing, all over a child's body before swimming, and over the perioral area before and after feeding a baby who has atopic dermatitis.

▶ **Bathing is good. Sponging is bad.** A 15- to 20-minute, not-too-hot daily bath followed by a coating of petroleum jelly is beneficial for atopic dermatitis.

"Sponging is the worst thing for a child's skin," Dr. Krol explained.

"It chaps it, encourages microfissures, and worsens eczema," he said. ■

Topical Calcineurin Inhibitors Can Still Be Used in Children

BY ROBERT FINN
San Francisco Bureau

BLAINE, WASH. — Topical calcineurin inhibitors remain an excellent second-line treatment for atopic dermatitis in children, despite a public health advisory by the Food and Drug Administration earlier this year and the promise of a black-box warning in the near future, Robert Sidbury, M.D., said at a conference sponsored by the North Pacific Pediatric Society.

Dr. Sidbury, of the University of Washington, Seattle, addressed the questions of when and how to use the topical calcineurin inhibitor (TCI) tacrolimus (Protopic) and pimecrolimus (Elidel) for atopic dermatitis in light of the FDA warning.

TCIs should be used only for short-term or intermittent long-term treatment, he said. They should not be used continually, on large body-surface areas, or on children younger than 2 years of age except in unusual circumstances.

"If I felt that an infant was using so much topical steroid that I was worried, I would use [a TCI] in a heartbeat, and with the cleanest conscience that I know how to have," Dr. Sidbury said.

TCIs seem to work best on skin folds and on the head and neck. These happen to be the areas where the use of topical steroids is most problematic, since thinning of the skin is a well-known side effect of these agents. Additionally, topical steroids carry the risk of glaucoma and cataracts when used near the eyes.

TCIs are least effective on palms and soles; on thick, lichenified areas; and on hyperkeratotic areas such as those seen in psoriasis.

These agents tend to sting quite a bit when used on open, excoriated areas, and Dr. Sidbury suggested pretreating those areas with topical steroids before introducing a TCI.

TCIs should be applied twice daily to affected areas to induce remission and then as needed for flares. To avoid continual use, they can be alternated with topical steroids, thus decreasing the potential for side effects from both agents. And TCIs should be part of a total skin-care regimen, including bathing, moisturizing, avoiding irritants and allergens, and using antibiotics and antihistamines when appropriate.

There are some differences between tacrolimus and pimecrolimus. Tacrolimus is said to be better for moderate to severe atopic dermatitis, whereas pimecrolimus is said to be better for mild to moderate disease.

Tacrolimus comes in two strengths, 0.03% and 0.1% in an ointment base. The lower dose is approved for children aged 2-15 years, and the higher dose is approved for adults and children older than 15 years. Pimecrolimus comes in a single, 1% cream formulation that's approved for use in children older than 2 years.

A review of three randomized head-to-head studies indicated that tacrolimus is more effective on thicker, more refractory areas and has a faster onset of action. Pimecrolimus, on the other hand, stings less (J. Am. Acad. Dermatol. 2005;52:810-22). ■

Improvements in Atopic Dermatitis Attributed to Ongoing Hypnotherapy

BY NANCY WALSH
New York Bureau

GLASGOW, SCOTLAND — Hypnotherapy led to marked and persistent improvements in symptoms and quality of life in a pilot study of patients with moderate to severe atopic dermatitis, Susannah E. Baron, M.B., reported at the annual meeting of the British Association of Dermatologists.

The study included seven adults, five of whom were women whose mean age was 49 years, and two children, a 12-year-old girl and a 5-year-old boy. Baseline assessments included the severity scoring of atopic dermatitis (SCORAD) index and a patient-completed visual analog scale (VAS). Adults also completed the dermatology life quality index (DLQI) and the hospital anxiety and depression scale (HADS). Children completed the child dermatology life quality index (CDLQI), and their parents completed a family impact questionnaire (FIQ).

Hypnotherapy may help by reducing symptoms, breaking the itch-scratch habit cycle, and reducing anxiety associated with flare.

Throughout the 12-month study, patients used topical emollients and corticosteroids.

All participants underwent three or four sessions of hypnotherapy and were taught self-hypnosis techniques, which they were encouraged to continue.

Symptoms rated on the SCORAD index improved in all adults and one child during the course of hypnotherapy, and improved in all when rated according to VAS.

Mean SCORAD index reduction was from 43.5 at baseline to 32.8, representing a 25% improvement. Mean VAS reduction was from 5.9 to 3.5, which was an improvement of 41%, Dr. Baron explained in a poster session.

Improvements continued through the yearlong follow-up, with mean SCORAD index ratings of 29.9, 20.8, and 21.1 at 3, 6, and 12 months, respectively.

Mean DLQI improved from 15.4 to 7.3 (53%), while the mean CDLQI improved from 17 to 8.5 (50%) over the course of treatment. Mean FIQ was reduced from 18 to 6.5 (64%).

At 12 months there was a further reduction in mean CDLQI to 5 and in mean FIQ to 2.5.

Mean anxiety scores decreased from 9.1 to 5.2, and mean depression scores decreased from 5.6 to 2.4 during the course of treatment. HADS and DLQI improvements were maintained throughout follow-up.

"Hypnotherapy may be beneficial in the management of atopic dermatitis by reducing symptoms, breaking the itch-scratch habit cycle, and reducing the anxiety associated with flare," wrote Dr. Baron of the dermatology department of the General Infirmary at Leeds (England).

In addition, patients enjoyed the hypnotherapy sessions and reported that they found self-hypnosis to be a useful skill for the long-term management of their disease, she noted. ■