Challenges of Managing Eczema in Teenagers

No one is happy when they do not outgrow their childhood eczema—carrying this uncomfortable, potentially disfiguring, chronic skin disease into their teen and young adult years. Although eczema, also referred to as atopic dermatitis, peaks in infancy, the dry skin and tendency to develop itchy rashes is lifelong. Even if eczema has apparently resolved, it can reappear again when children enter their adolescence, and parents no longer supervise skin care and bathing practices. Who isn't familiar with a teen that enjoys long, steaming hot showers with lots of trendy, scented, lathering soap? For those whose disease has persisted throughout childhood into adolescence, fatigue due to the extra effort required to care for dry skin sets in, with a lapse of the necessary daily moisturizing and application of medications to rashes. This, too, will lead to exacerbations of itchy eruptions, and sometimes to bacterial skin infections.

Many children and teens with eczema also deal with other chronic allergic conditions, such as seasonal respiratory allergies (hay fever) and asthma. The energy required to manage multiple chronic diseases is in short supply as teens focus outward on social interaction, academics, sports, and other extracurricular activities. Some of those activities can lead to flares of eczema: For example, heat and sweating during the physical exertion of sports can cause increased itching in eczema patients. Adolescents may feel embarrassed when the appearance of their dry and/or inflamed skin sets them apart from friends, leading to social isolation. In addition, the lack of sleep and psychological pressure many teens experience as they face the academic challenges of high school and college admissions can worsen atopic dermatitis.

Eczema Therapy in Teens

The goal of eczema treatment in teens is to allow him or her to maintain their usual pursuits with minimal disruption: good sleep, steady concentration in school, and normal social activities. With the right clinical approach, atopic dermatitis in teens can be controlled, allowing for an active life unlimited by chronic skin disease.

First, the clinician needs to investigate the adolescent patient's and the parents' ideas about eczema, then dispel myths and misunderstandings. (Table 1). Explaining that eczema is caused by a genetic predisposition to (1) overreaction of the immune system in the skin and (2) a defective cutaneous oil barrier that causes dry skin might help both child and family understand why the problem is so persistent.

One should then review the teen's lifestyle, from what time they get up in the morning and go to sleep at night to academic, after-school, and social activities. Skin care habits must be assessed in detail (Table 2). All cleansers can be irritating, so recommend that soap be applied only to the face, underarms, hands and feet and that shampoo be rinsed off thoroughly. Advise that baths or showers be lukewarm and no more than 20 minutes in duration. Emollients applied after bathing will alleviate the dryness in the skin that underlies eczema. Moisturizers should be thick, lipid-laden creams or ointments, not watery lotions; the patient should at least a use a cream, if not a grease like petrolatum (Table 1). One should always ask teens about sunbathing and tanning bed use. Eczema patients may

TABLE 1: TEEN ECZEMA MYTHS AND REALITIES

MYTH	REALITY
Everyone outgrows eczema by their teen years.	Although eczema peaks in infancy, it can persist throughout life. Even if the itchy rashes go away, the underlying dry, sensitive skin and tendency to develop eczema will remain.
Eczema is caused by food allergies to dairy and gluten.	In some infants with eczema that does not respond to treatment, food allergies play a role. By adolescence, if not already known to be a factor, food is not a significant trigger for most people.
Soap must lather to cleanse.	Lather is produced by detergents, which are irritating to those with sensitive skin. Many non-lathering soaps that eczema patients can use without irritating their skin are available.
For dry skin, lotions work as well as thick creams.	Few children over age 8 or 9 like using heavy moisturizers such as thick creams, cocoa butter, and white petrolatum. However, these are best for treatment of dry skin associated with eczema.
All cortisone creams thin the skin.	It is best to avoid chronic use of very strong prescription topical corticosteroids, but low-to-medium potency agents can be used safely for long periods of time with medical supervision.

TABLE 2: SKIN CARE HISTORY FOR TEENS WITH ECZEMA

QUESTION	WRITE YOUR ANSWER HERE
Bath or shower? How frequent?	
Heat of water ("How hot do you like the water: steaming, lukewarm, or cool?")	
Type of soap: Lathering or nonlathering, scent	
How much soap: Lather all over, or just in some areas, such as armpits and groin?	
Pat or rub dry after shower?	
Moisturizer: What type, how much, and on which areas of the skin?	
What type of sunscreen, makeup, deodorant, acne care, and shave and after-shave products?	
Sunbathing or tanning bed use?	
Sunburn history?	

TABLE 3: GENTLE SKIN CARE PROGRAM FOR ECZEMA IN TEENS

A.M.
Apply prescription topical corticosteroid to rashes as directed.
Apply a layer of moisturizer cream to arms, legs, and any other eczema-prone areas; can substitute sunscreen in an emollient base on exposed skin like face, neck, and arms.
P.M.
Shower with lukewarm water, using a non-lathering unscented liquid cleanser; if old enough to shave, use this same type of cleanser or an unscented gentle shaving cream.
Pat dry after shower.
Apply prescription topical corticosteroid to rashes as directed.
Apply a layer of moisturizer cream to arms, legs, and any eczema-prone areas.
Take antihistamine 20 minutes before bedtime (ideally before 11 p.m.) if directed.

self-treat their disease with UV outdoors or at salons. This practice increases the risk of both non-melanoma and melanoma skin cancer and should be avoided completely. Patients may not volunteer this information, so clinicians need to inquire directly about the issue.* Asking about sunburns and addressing sun protection habits is also good preventative care for all adolescents, including those with eczema.

Finally, it is critical that one determine how itching is impacting an adolescent's life. In some studies in adults, itch has been found to interfere more with well-being than pain. Is itch keeping them awake at night? Is scratching at school getting in the way of concentrating in class or on homework?

Physical examination should be head to toe. Look for extra scaling in the scalp (it may be more than dandruff); dry skin and inflamed rashes on the head, neck, and body; and signs of secondary infection such as crusting or scabbing.

If the rash and itch are mild (pink, a little scaly) low-potency topical steroids followed by moisturizer should take care of the problem. If inflammation is more severe (redness, marked thickening, open areas from scratching), moderate strength topical steroids or even a short pulse of a potent agent with tapering after a week will provide rapid relief. If there are signs of bacterial infection, an antimicrobial regimen should be instituted (two weeks of oral antibiotics, chlorhexadine washes, and/or bleach baths, depending on severity). Antihistamines at bedtime such as hydroxyzine or diphenhydramine can provide relief of itching at night and help teens sleep better without impacting sleep cycles. One should make sure these are taken by 11 p.m., or there may be a most unwelcome leftover sleepiness in the morning (so-called antihistamine hangover). Nonsedating antihistamines during the day do not help pruritus much, but they will control symptoms of allergic rhinitis.

A therapeutic, gentle skin care regimen should be outlined in writing, in a practical AM/PM schedule as outlined in Table 3. When the teen comes in for follow-up, ask him or her to bring all skin care and oral agents they are using in a plastic bag so you can review their routine with them in detail and ensure their compliance with the gentle skin care program and prescriptions.

If initial measures do not control eczema, referral to a dermatologist can be very helpful. Allergists also play an important role in managing teens' chronic eczema, especially when there is concomitant hay fever and/or asthma.

*When indicated, dermatologists may recommend judicious sun exposure to patients with darker skin. Dermatologists also treat severe atopic dermatitis with brief exposures to carefully measured, narrow spectrum (usually UVB) energy in specialized calibrated boxes in their office or at a phototherapy clinic. UV light is anti-inflammatory but can increase risk of skin cancer when not used properly.

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