DERMATOLOGY insights

a patient's guide to healthy skin, hair & nails

AAD 1938 AMERICAN ACADEMY OF DERMATOLOGY

Volume 3, Number 1

A Closer Look at Sports and Skin

Sun safe sports
Excessive sweating
Itching, chafing and rashes
Health club hazards

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Keeping fungus on the run

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Does the Dead Sea offer relief for psoriasis?

Perilous parlors
The dangers of indoor tanning

PLUS: Deborah Norville gives the inside story on self-esteem and eczema

Nail injuries
Post op care of skin
Psoriatic arthritis

Compliments of the American Academy of Dermatology and:

Sports and Safety

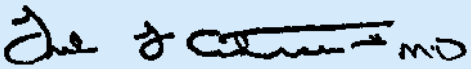
In all seasons and in all kinds of weather, Americans strive for athletic excellence, both in their personal lives and in competition with others.

Sprains, fractures and breaks are not the only injuries that can sideline an athlete. Blisters, warts, acne and rashes are common to those participating in athletics.

Health-conscious individuals who engage in sports must protect their entire body, including their skin. This issue of *Dermatology Insights* will address the causes and treatments for some common sports-related skin conditions, but it is not just participants who need to exercise caution. Sports enthusiasts who spend time outdoors watching their favorite events should be aware of proper protection from the sun's harmful rays. At the other end of the spectrum, well-hidden from the sun's rays, fungi tends to grow in dark, moist places, so caution must also be exercised indoors at spas and health clubs.

Beyond the realm of sports, we have included a number of informative articles about conditions affecting skin, hair, and nails. Nearly 15 million people — many of them children — are currently living with a chronic, life-altering skin disease called atopic dermatitis (otherwise known as eczema). Last November, the AAD launched a public awareness campaign, *"Outside & In: Healthy Living With Eczema,"* to share information about the latest treatment advancements for eczema. A public service announcement about atopic dermatitis featuring Emmy award-winning journalist Deborah Norville has been shown nationwide in recent months. Norville gave an exclusive interview for this issue of *Dermatology Insights.* In her story, Norville says, "Information is power" and backs up that statement with some useful information about eczema and self-esteem.

More information about your skin, hair and nails can be found in the Patient Information section of the AAD Web site, www.aad.org.



Fred F. Castrow II, M.D.
President, American Academy of Dermatology, 2002

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Corrections: In the Fall 2001 issue of *Dermatology Insights,* "Curing the Hair Color Blues" was written by Karen Wagner and "Scaling Back on Winter Skin Problems" was written by Ruth Carol. Also thanks to Dr. Terrence Cronin for his photo to our feature on tattoos.

EDITORIAL & ADVERTISING STATEMENT
Dermatology Insights is published twice per year by the AAD as an informational resource to consumers. Readers are cautioned, however, not to use information from the magazine as a substitute for regular professional health care. Consult your dermatologist before using any medication or therapy.

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The American Academy of Dermatology is the largest and most representative of all dermatologic associations. The Academy is committed to advancing the science and art of medicine and surgery related to the skin; advocating quality dermatological care for everyone, education, and research in dermatology; supporting and enhancing patient care, and promoting lifelong healthy skin, hair and nails.

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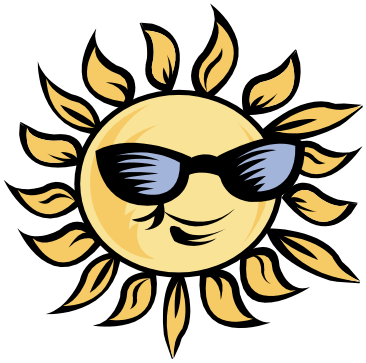

PROOF THAT A TAN NEVER FADES

A special ultraviolet camera makes it possible to see the underlying skin damage done by the sun. And since 1 in 5 Americans will develop skin cancer in their lifetime, what better reason to always use sunscreen, wear protective clothing and use common sense.

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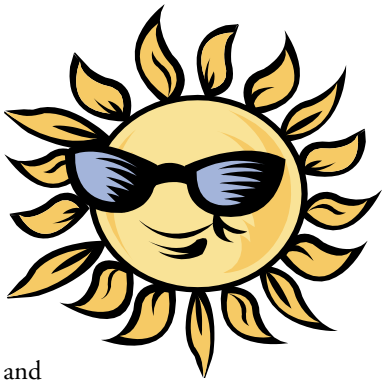
May *is* Melanoma/Skin Cancer Detection and Prevention Month



May is the American Academy of Dermatology's (AAD's) 18th Annual Melanoma Skin Cancer Detection and Prevention Month. During May, as well as throughout the year, take advantage of one of the free skin cancer screenings offered by as many as 2,000 dermatologists nationwide. Screenings conveniently take place often at local hospitals and work places, in conjunction with health fairs and as part of other special events. To locate a screening in your area, log on to the patient information section of the AAD Web site, www.aad.org.

Early detection and prevention of skin cancer through screenings are two main weapons in the war against skin cancer, the most common form of cancer in the United States.

THE SHADOW KNOWS!

If your shadow is shorter than you are, the sun's ultraviolet rays are at their most damaging. Trade your place in the sun for a spot in the shade — before you burn.

This year's Detection and Prevention Month will kick off May 6, "Melanoma Monday." Melanoma Monday is a day set aside by the AAD to encourage skin self-examination as a lifelong habit to aid in the early detection of the deadliest form of skin cancer, melanoma.

Since 1985, volunteer dermatologists have conducted more than 1.2 million screenings and have detected more than 116,000 suspicious lesions, including approximately 15,150 suspected melanomas.

Self-examination consists of regularly looking over your entire body, including the back, scalp, soles of feet, palms of hands and between toes and fingers. You should see your dermatologist if you notice any changes in the size, color, shape, or texture of a mole, discover a new mole, or find any other unusual changes in the skin.

The AAD recommended sun protection guidelines include restricting outdoor activities when the sun's rays are the strongest, seeking shade when possible, wearing broad-spectrum sunscreen with a sun protection factor (SPF) of 15 or higher, and wearing sun-protective clothing and accessories. Remember to follow the "shadow rule"— if your shadow is shorter than you are, the sun's damaging rays are at their strongest and you are likely to burn.

For more information about skin cancer detection and prevention, go to the American Academy of Dermatology Web site, www.aad.org. Di

ABCDs *of* Melanoma

During a skin cancer screening, as well as recommended patient self-screenings, dermatologists commonly apply the ABCD rule to diagnose melanoma. Skin lesions are more likely to be malignant melanoma when one or more of the following is observed:

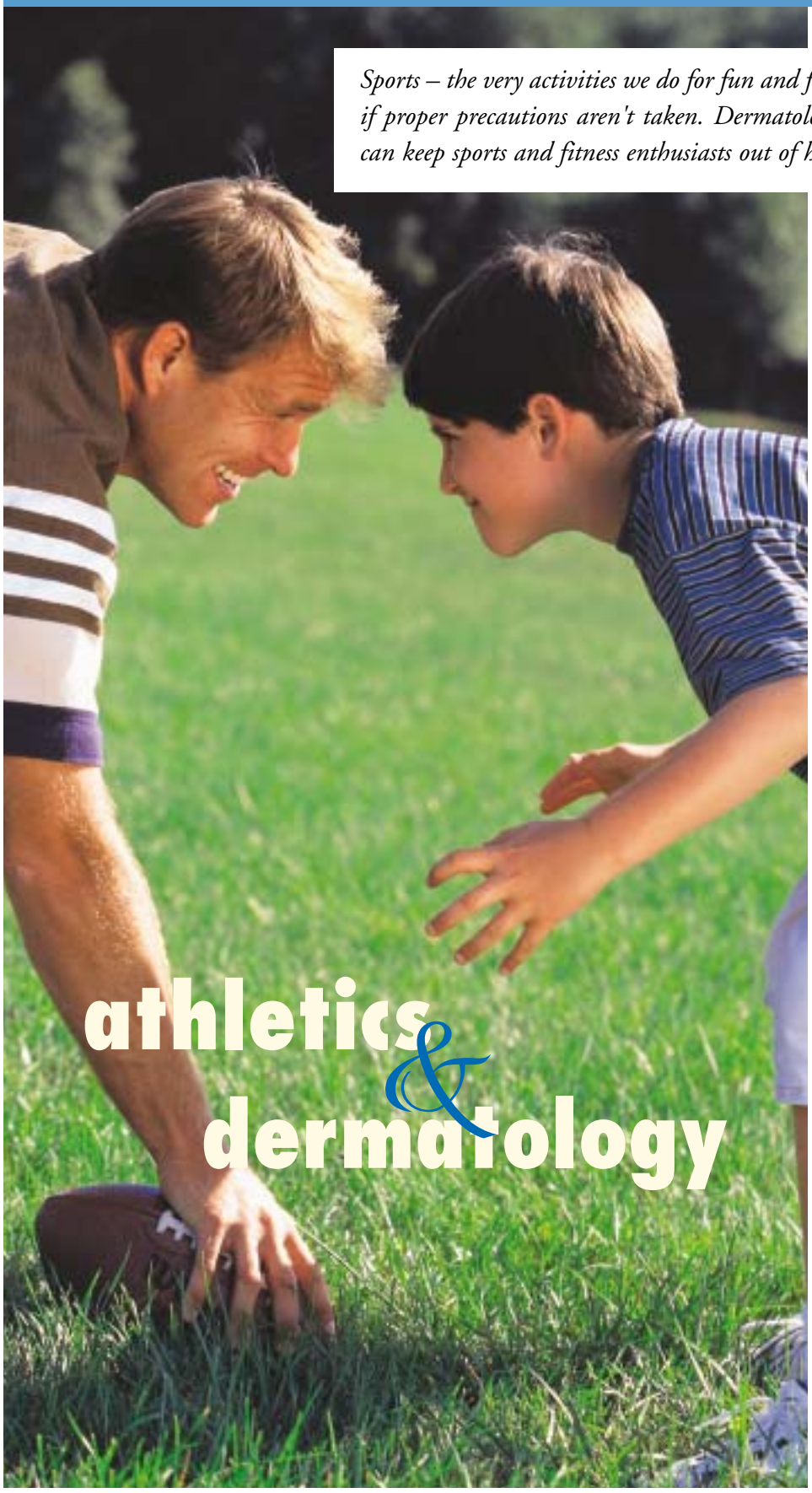
Asymmetry: One side of a mole doesn't look like the other side.

Border: The edges of a mole are ragged or uneven.

Color: More than one color is present in a single mole. Melanoma may include streaks of tan, brown, black, red, white, and blue.

Diameter: A mole becomes larger than pencil eraser size or changes its shape.

A CLOSER LOOK AT: ATHLETIC



athletics & dermatology

Sports – the very activities we do for fun and fitness – can hurt skin if proper precautions aren't taken. Dermatologists say simple steps can keep sports and fitness enthusiasts out of harm's way.

DON'T SWEAT THE SWEATING

Joel E. Holloway, M.D., a board certified dermatologist who practices in Norman, Okla., explained that perspiration is a necessary bodily function that cleanses the skin and keeps the body from becoming overheated (see related article about excessive sweating on page 12). Problems resulting from perspiration can occur when restrictive clothing is worn, which prevents air from reaching the skin and evaporating perspiration.


Wear loose clothing while exercising.

"Occluding the skin can cause miliaria rubra, a type of heat rash," explained Dr. Holloway. "When the skin becomes too hydrated, the clothing occludes the little hole that the sweat tries to come out of, and causes big red bumps on the skin. This practice can also cause an elevated body temperature, which could lead to heat stroke or heat exhaustion."

Dr. Holloway suggests wearing loose clothing that allows sweat to soak through the fabric and run off.

RUBBED THE WRONG WAY

Chafing occurs when athletes wear clothing made of synthetic materials or clothing that does not fit well. Wearing athletic equipment, such as athletic supporters and cups, as well as staying in a wet bathing suit for hours after swimming, are other common causes of chafing. Rubbing against equipment can exacerbate folliculitis, which is an

CS AND SKIN


Avoid frostbite by wearing protective clothing.

infection of the hair follicles. If chafing does not get better on its own, Dr. Holloway recommends the topical use of petrolatum jelly.

SPORTS AND ACNE

Acne mechanica is a form of acne that results from heat, pressure, occlusion and friction, often caused by protective gear. To avoid this type of acne, dermatologists recommend that athletes wear clean, cotton clothing that doesn't fit too close to the skin. They should also wash the affected areas immediately following athletic activity and apply a keratolytic solution, such as one containing salicylic acid and resorcinol, directly to the rash. Dr. Holloway also cautioned that wearing makeup during sports activities could irritate acne.


Remove makeup before sports activities to avoid skin irritation.

FOOT FIT

Alexa Boer Kimball, M.D., a board certified dermatologist and assistant professor at Stanford University Medical Center, Stanford, Calif., said blisters are a big problem for endurance athletes. "People have dropped out of races because of them," she related.

Dr. Kimball said athletes should make sure that their shoes fit well, and that their socks help to keep their feet dry because the wetter the feet, the greater the likelihood of friction and blisters. "It's a good idea for athletes to wear wool socks because wool keeps their feet warm but manages to keep moisture away. Polypropylene is usually pretty good. Cotton is horrible for socks," she said. "Wearing more than one pair of socks is helpful because then the friction is between the socks and not between your foot and the shoe."

Another tip: Don't break in a new pair of shoes during a long-distance race. Rather, train with a new pair of shoes until you are sure they fit well.

If it becomes necessary to pop a painful blister during an event, Dr. Kimball advises making a small incision about ¼-inch at the base of the blister and applying a dressing to the wound. "My favorite dressings are healing strips (available at most drug stores). These are soft pads applied to the blister or scrape. They also promote wound healing and can be worn for days without rubbing off the feet," she said.

Athletes, especially runners, hikers and others who depend on their feet, should buy shoes that fit correctly and replace shoes once they start to wear out. According to Dr. Holloway, shoes need to fit so that "toe box" is adequate and athletes don't slam their toes into the end of their shoes when they stop quickly. Shoes should also be laced tightly so that the toes don't slide around inside the shoe.

Athlete's foot is another common problem among athletes. The bothersome fungal infection can be avoided by keeping feet as dry and clean as possible. Antifungal powders and creams, purchased over the counter, can help, too (see related article on page 30).

SUN SAFE

Athletes who compete and train outdoors must protect their skin from ultraviolet rays by applying sunscreens with a sun protection factor (SPF) of 15 or higher. Dr. Kimball suggests that endurance athletes consider gel-based sunscreens because they go on easily over sweaty or hair-bearing areas. Those who sweat a lot or swim should reapply sunscreens at least every two hours. Some experts suggest athletes wear clothing that offers SPF protection, however, Dr. Holloway suggested that regular clothing offers adequate protection. Drs. Holloway and Kimball agree that athletes should wear hats with extra material hanging down to cover the neck and ears.


Protect your skin from ultraviolet rays by applying sunscreen with an SPF of 15 or higher.

OUT IN THE COLD

According to Dr. Holloway, one of the biggest problems experienced by those who participate in cold weather sports or exercise is frostbite, a condition where feet, toes, hands or fingers freeze, causing inadequate circulation. Frostbite can be avoided by wearing protective clothing, such as facemasks, hats, gloves and boots. Anyone who suspects they have frostbite should seek medical attention immediately.

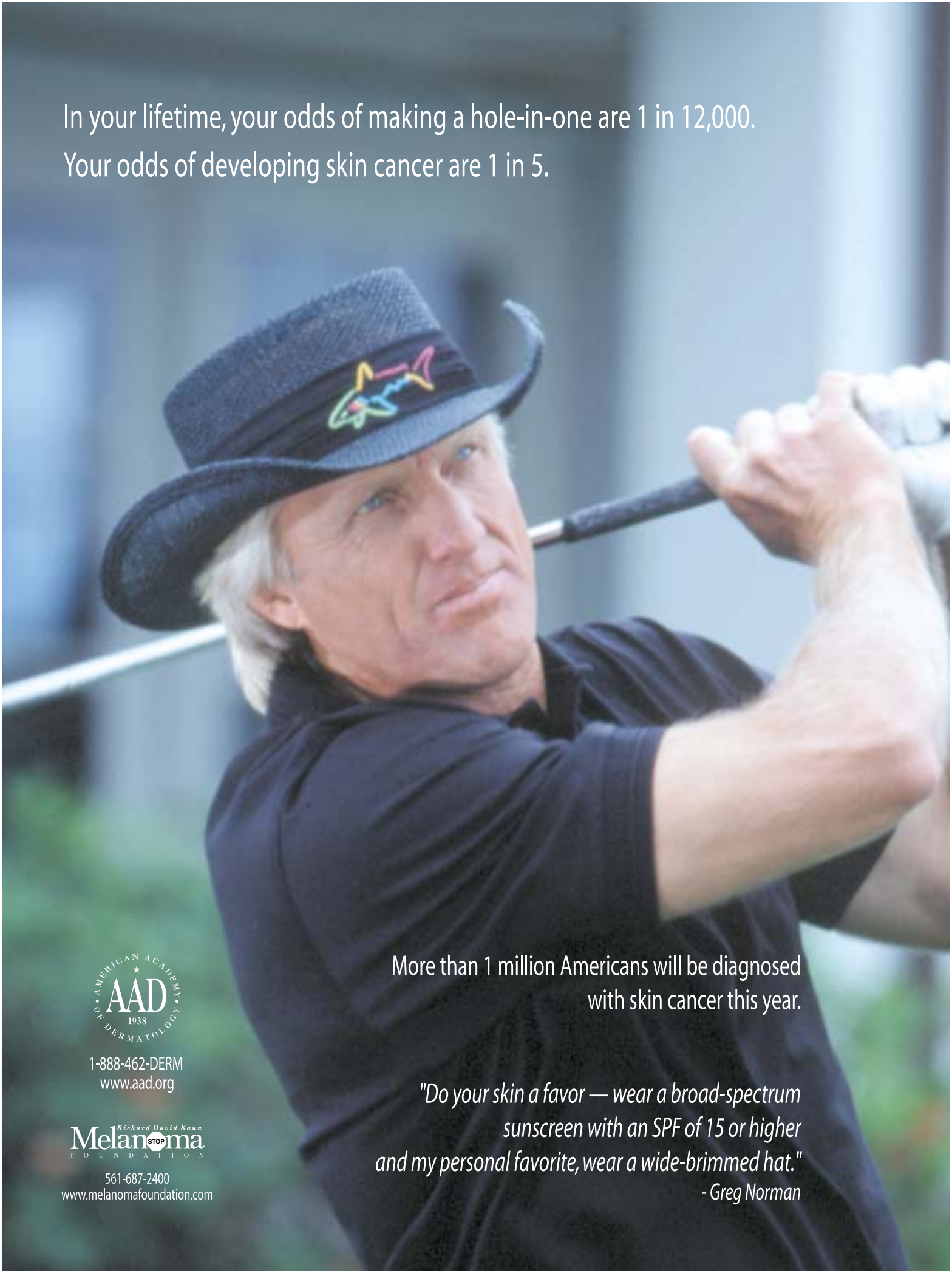
CONTACT SPORTS

Dr. Holloway warned that athletes who compete in judo, wrestling and other skin-to-skin contact sports must not compete if they have cold sores, molluscum or other transmittable skin diseases. "We've got good medicines [to treat these athletes] now," he said. "Affected athletes ought to see a dermatologist right away so that they can get back to their sports as soon as possible."

WATER SPORTS

The wrinkled skin that results from spending extended periods immersed in water is more prone to injury, rashes and chafing. In general, skin will

see Athletics & Dermatology page 9


In your lifetime, your odds of making a hole-in-one are 1 in 12,000.
Your odds of developing skin cancer are 1 in 5.
More than 1 million Americans will be diagnosed with skin cancer this year.
"Do your skin a favor — wear a broad-spectrum sunscreen with an SPF of 15 or higher and my personal favorite, wear a wide-brimmed hat."
- Greg Norman
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After water sports, apply a moisturizer to avoid skin dehydration.

dehydrate after being in the water unless moisturizers are used.

Another problem, encountered by fair-haired swimmers, is "green hair." Too much chlorine is usually the culprit. "Problems also occur if the chemicals in the pool are too acidic and leach copper ions from the copper piping in the system; thus, dumping copper into the pool," Dr. Holloway said. According to Dr. Kimball, there are shampoos on the market that remove chlorine and copper from hair.

Ocean swimming presents other skin hazards, such as jellyfish stings and other bites. Swimmers who are bitten should see a dermatologist for treatment. Wet suits can protect athletes engaging in ocean-related sports.

SWEETNESS AND LIGHT

Some people react to exposure to ultraviolet light in combination with chemicals (such as perfumes or colognes). Those who wear fragrances and sweat in the sun could end up with a photoallergic or phototoxic reaction. Many perfumes and colognes contain oil of bergamot, an extract of the peel of a specific orange grown in the South of France and the Calabria district of Italy. When this oil comes in contact with the skin and the skin is exposed to sunlight, the oil of bergamot can cause the skin to discolor, a condition called *berloque dermatitis.* With repeated exposures to sunlight, the discoloration may become permanent. Sensitivities can also occur when people wear a deodorant-antiperspirant combination. The antiperspirants contain aluminum chloride, which when mixed with water can become hydrochloric acid and can cause burns under the arms, according to Dr. Holloway.

LIP SERVICE

"Some lip balm use can result in a cycle — if you don't put it on, your lips become cracked and hurt, and if you do, they become irritated and shiny," Dr. Holloway said. "I see it everyday with teenage kids who come to my office." When it comes to protecting the lips indoors, some dermatologists believe the best thing is petrolatum jelly or bees' wax — not a commercial lip balm. When out in the sun, however, lips need the same protection as any other exposed part of the body, therefore a lip protection balm with SPF 15 protection or greater is recommended. Di

Lisette Hilton


Lips need protection too. Apply a lip balm with an SPF of 15 or greater.

Tips for Sun Safe Sports Activities

Athletes who participate in outdoor sports, as well as outdoor sports spectators, are at risk for high sun exposure and should take proper precautions to protect their skin. Bruce Robinson, M.D., a board certified dermatologist who practices in Manhattan and is a clinical professor at Lenox Hill Hospital, New York City, offers these tips for sun-safe sporting.

If you can, pick a time for your sports other than the hours of 10 a.m. to 4 p.m. Those are the peak times when you get the most ultraviolet exposure.

Use a proper SPF sunscreen — at least a number 15, but preferably a 30. It's not necessary that you choose a sunscreen that claims to be waterproof. Instead, Dr. Robinson urges sports enthusiasts to find a sunscreen that is less irritating to the eyes, so that when you sweat the sunscreen won't be a concern. Micro-sized zinc oxide and titanium dioxide sunscreens are now available that work right away. Unlike other chemical sunscreens, you don't have to apply them 20 to 30 minutes before doing sports.

Reapply, reapply, reapply. Apply sunscreen frequently — especially if you're sweating a lot. If you're a swimmer, you should apply it every time you get out of the pool. Apply a good amount of sunscreen (one palm full for each body area) in a thin layer.

Protective clothing is key. Today, you can purchase clothing made with tighter weaves, specifically designed to offer sun protection. There are even new fabric treatment products that add UPF (ultraviolet protection factors) to clothing when added to the laundry.

Don't forget the hat. Baseball caps shouldn't be your first choice. Rather, wear hats with a four-inch brim to protect your cheeks, ears and nose from the sun. "We see quite a number of skin cancers on the ears," Dr. Robinson said.

Protect the whole body. "If you look statistically at young women, the majority of melanomas occur on the lower legs. Apply sunscreen and wear proper clothing to protect all body parts," Dr. Robinson said. "Wear long sleeves to cover the arms if you can, and don't forget sunglasses with UVB and UVA protection. If you're a spectator, consider an umbrella."

Don't be fooled by winter sports. Whether you're ascending a ski slope, or scaling Mount Everest, your sun resistance is going downhill. Because of the reduced atmosphere, you get more ultraviolet light as you increase in elevation. And while you might feel cooler skiing on the slopes, the truth is that the ultraviolet light bouncing off snow results in additional strong sun exposure for your skin. Some of what people deem windburn is really sunburn. Wear sunscreen as you would during summer sports.

Beware of skin changes. Make it a point to check brown spots on your body for changes. Look for the warning signs of skin cancer (see page 5). Di

Lisette Hilton

We Can Work It Out

stay skin safe while exercising in health clubs

Working out in a health club might protect an exerciser from the outdoor elements, such as sun exposure; nevertheless, the indoor environment presents skin hazards of its own.

Experts agree that people should look for gyms and health clubs that appear clean and encourage cleanliness. Exercisers also can take simple steps to protect themselves from fungal, bacterial and viral diseases that can be transmitted at health clubs, spas and gyms.

"Exercisers need to approach the health club environment or any gym or workout facility as a significant source of possible infectious or contagious diseases," said John E. Wolf, Jr., M.D., a board certified dermatologist and professor and chairman of the department of dermatology at Baylor College of Medicine in Houston.

FUNGAL TRANSMISSIONS

Health clubs, pools and spas do not pose an increased risk of fungal infection. Fungal transmissions can occur in any setting — and are as common in everyday life as they are in the locker room. Infected people walking barefoot in locker rooms, shower stalls and in and around hot tubs and saunas can spread these fungi, however. Dr. Wolf suggests that people protect themselves by wearing sandals or slippers and keep their feet as dry and clean as possible to avoid athlete's foot and toenail fungi.

While the same fungus, T. rubrum, usually causes athlete's foot and toenail fungus, treatments for the two are different. *Athlete's foot* can be treated with various over-the-counter antifungal remedies (see story on page 30). Toenail fungus, which leads to thickening and deformity of the toenail, is generally treated with oral or topical medications prescribed by a dermatologist. Proper treatment is important because toenail fungus can lead to other infections, open cuts or sores. "This is particularly a problem in patients who have diabetes. Diabetics who have toenail fungus or athlete's foot fungus are more likely to develop secondary bacterial infections and ulcers of the skin," Dr. Wolf said. "Athlete's foot medications are not effective against toenail fungus. Toenail fungus is very hard to treat. Oral medications are often used to treat toenail fungus."

Exercisers should watch for fungi of the groin and other body areas. These tend to be caused by heat and humidity, as well as contact with infected equipment or skin. Make sure machines and mats are clean, and use a towel and protective clothing when working out.

Many of these fungal infections show up as rashes on the body. Dr. Wolf recommends seeing a dermatologist rather than trying to self-treat these rashes. Dermatologists can distinguish between fungal infections and other types of skin irritations with simple in-office tests and better target treatment.

BACTERIAL INFECTIONS

Exercise equipment can harbor the organisms that cause bacterial infections, such as impetigo, a mixed infection of streptococcus and staphylococcus bacteria. Impetigo, described as weeping, oozing and crusting of the skin in localized, honey-colored patches, often requires treatment with prescription antibiotics. Occasionally, it may appear as a blister or group of blisters.

A possible source for bacterial infection is the hot tub, according to K. William Kitzmiller, M.D., a board certified dermatologist who practices in Cincinnati, Ohio, and a volunteer clinical professor of dermatology at the University of Cincinnati Medical Center. "If the club's management doesn't keep the balance of chemicals right and doesn't clean the tubs, you can get into difficulty with hot tub folliculitis. It's a bacteria that gets lodged in the hair follicles and produces a superficial skin infection — like heat rash," he explained.

Dr. Kitzmiller recommends using an antibiotic soap to wash the body after exposure to a hot tub. Sometimes, exercisers who get folliculitis can treat it with a topical antibiotic ointment (such as over-the-counter medications like polysporin or bacitracin). "If that doesn't produce prompt resolution, you should see your dermatologist," Dr. Kitzmiller said.

"This is an environment where you have multiple people using the same hot tub so it's very difficult for the spa managers to keep those truly clean," Dr. Wolf added.

VIRAL INFECTIONS

Viral infections may be spread in health club facilities. For instance, infected people walking barefoot on health club facility floors may transmit plantar warts, a wart on the sole of the foot that, because of pressure, develops a callus. For the most part, however, the risk of most viral infections like warts and herpes is low if the health club is clean and well-maintained. "I think people can work out comfortably in health clubs," Dr. Kitzmiller said. "You should use common sense: use your own towel to exercise on, shower after with an antibacterial soap, and if the facility doesn't look clean, don't exercise there." **Di**

Lisette Hilton

The Darker Side of Tanning

Despite some tanning facility claims to the contrary, there's no such thing as a "safe tan" whether it's gotten in the sun or at a tanning parlor. In fact, many of the claims that tanning parlors make about safe tanning are misleading and dangerous, according to dermatologists.

"Tanning parlors are cooking our patients and increasing their risk of melanoma," said Shelly Sekula-Rodriguez, M.D., a board certified dermatologist, practicing in Houston, Texas, and a clinical assistant professor at Baylor College of Medicine, in Houston.

Dr. Sekula-Rodriguez was instrumental in authoring legislation requiring tanning parlors to post and provide written statements about the dangers of tanning in a salon. But that's not enough, Dr. Sekula-Rodriguez said, because regulations often go unheeded and tanning salons continue to distribute misleading literature.

According to Vincent DeLeo, M.D., chairman of dermatology at St. Lukes/Roosevelt and Beth Israel Medical Centers, New York City, the risks associated with tanning salon usage are essentially the same as sun exposure of any other sort. "There has been a misrepresentation by the tanning industry that tanning in a tanning salon is safer than tanning at the beach and that just is not the case," he said.

According to Dr. DeLeo, tanning salons use a greater proportion of ultraviolet long waves, or UVA radiation, than of UVB, or short waves. "The tanning salon industry would suggest that the ultraviolet A rays are the tanning rays and ultraviolet B rays are the burning rays, and the rays that cause skin cancer. In fact, we know now that UVA is also capable of producing redness and skin cancer, even if it's used alone," he said.

Studies have also shown that all of the effects that one can get from tanning at the beach are the same as tanning in a salon. Those effects include photo aging; skin cancer induction; photo immune suppression; photosensitivity disease development (such as sun poisoning); photo drug reactions; and lupus erythematosus development.

People end up with burns from tanning salons, and they can end up in emergency rooms, Dr. DeLeo said. They can have eye damage, if eye protection is not sufficient.

Photo immune suppression is another potential problem. According to Dr. DeLeo, studies now show that when people get any kind of sufficient radiation their immune system is temporarily depressed for a week or two. "What it means clinically we're only beginning to understand. We know that it is related to your susceptibility to certain infection and it probably plays a role in skin cancer induction in humans," he said.

Tanning salons are supposed to notify tanners that they shouldn't get tans if they're taking specific medications, including diuretics and some antibiotics, because sun exposure can cause dangerous reactions to the medications. Sun poisoning, which according to Dr. DeLeo occurs in 10 or 15 percent of the population, can also occur in tanning parlors. And many people who have lupus, a chronic inflammatory disease, are photosensitive. Tanning salons can trigger skin rashes and systemic effects of the disease, according to Dr. DeLeo.

Dr. Sekula-Rodriguez said that she's seen a lot of deep black freckling on her patients who visit tanning parlors. The freckling often occurs in areas that one wouldn't normally see freckling, including on the abdomen and behind the knees. Dermatologists can diminish the freckling with laser treatments, liquid nitrogen and intense-pulsed light, but the fact that it's there, she said, "is a sign that your body is telling you that you've overdone it." Di

Lisette Hilton

TANNING FACILITY REQUIREMENTS

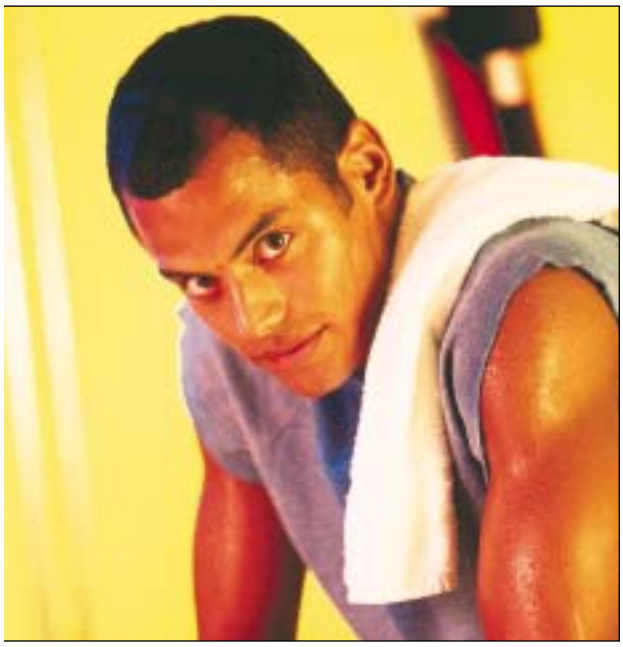
The American Academy of Dermatology supports the following requirements for indoor tanning facilities:

- A warning statement defining potential hazards and consequences of exposure to UVA should be signed by each patron.
- No minor should be permitted to use a tanning bed without written consent of a parent or guardian.
- No person or facility should advertise the use of any UVA or UVB tanning device using wording such as 'safe,' 'safe tanning,' 'no harmful rays,' 'no adverse effect,' or similar wording concepts.

For more information, visit the AAD Web site, www.aad.org/PressReleases/exposure.html.

"tanning parlors are cooking our patients and increasing their risk of melanoma."

don't sweat it... Treatments Stop Excessive Perspiration



Sweating is accepted by most people as a bi-product of increased physical activity, exposure to warmer conditions or stressful situations.

Sweating under the arms, on the back and on the chest is common in the regulation of body temperature. Most people deal with natural sweating under their armpits with the use of antiperspirants and deodorants. But although sweating is the body's way of naturally regulating its temperature, a small percentage of the population experiences excessive amounts of sweating, something most find intolerable. The condition is referred to as *hyperhidrosis.*

excessive sweating can be treated as "one less thing to worry about."

WHAT IS HYPERHIDROSIS?

Several forms of hyperhidrosis exist. Excessive sweating is rarely associated with other medical conditions or treatments. More often, it results from psychological issues. Sometimes excessive sweating is accompanied by severe odor that common deodorant/antiperspirant products treat ineffectively.

However, excessive sweating may be part of such underlying conditions as hyperthyroidism, endocrine treatment for certain types of cancer, severe psychiatric disorders, obesity, and menopause. Often such conditions can promote excessive sweating over the entire body.

Hyperhidrosis without any known or obvious cause is generally more localized in one or several locations on the body. One example is sweating on the palms of the hands, one of the most worrisome conditions. With sweaty palms, the degree of sweating can range from moderate moistness to dripping wet. Because the hands are more exposed in social and professional situations, people tend to limit or avoid such bodily contact as shaking hands, and choose professions where they don't have to handle materials sensitive to moisture, including paper.

Other areas where hyperhidrosis is common are the feet, armpits (especially embarrassing because of the wet marks visible on clothing), the face and the thighs. Sweating can appear suddenly or be a constant problem. Some people relate their excessive sweating to high outside temperatures and/or emotional stress, but hyperhidrosis may appear without any obvious reason.

"A person who is uncomfortable with his or her sweating can be considered to have hyperhidrosis," said Mervyn Elgart, M.D., a clinical professor of dermatology at the George Washington University Medical Center in Washington, D.C. "However, if someone takes issue with normal temperature-regulating sweating, I simply advise them to limit physical activity and stay calm. Sweat over the chest and back shouldn't be controlled because it is physiologically necessary."

DRIP OR DRY?

Why do some people sweat while others stay bone dry? It depends on how many sweat glands you have. Genetics play a role — everyone's born with a certain number of sweat glands, ranging anywhere from two million to four million. Infants and small children may sweat, but sweat glands become more active when individuals reach puberty. The highest concentration of sweat glands occur on the feet, while the least concentrated area of sweat glands is on the back. Women have more sweat glands than men, but men's sweat glands are more active, which is why men tend to sweat more than women.

NO SWEAT!

Some dermatologists use botulinum toxin injections to control sweat gland secretion.

The dermatologist uses a starch iodine test under the arm of this patient to determine the range of excessive sweating.

After botulinum toxin injections, the affected area begins to diminish...

...until problem perspiration is under control.

PHOTOS, PATRICIA WEXLER, M.D.

TREATMENT OPTIONS

Your dermatologist can evaluate your condition and determine which of the various treatment options would be appropriate to control your excessive sweating. One of the easiest and most effective treatments for the underarm area is to use a more powerful prescription-strength antiperspirant. Several versions of the antiperspirant are available for purchase, often without a prescription.

"Typically, an antiperspirant with a 20 to 25 percent make-up of aluminum chloride hexahydrate applied two or three times a week seems to be adequate to treat most mild to moderate cases of hyperhidrosis," explained Dr. Elgart.

The high-powered antiperspirant solution can also be applied to the hands for several nightly treatments and covered with a glove to prevent staining, he said.

However, if you find the more powerful antiperspirants irritating or ineffective, your dermatologist may suggest the use of *iontophoresis.* Iontophoresis is a non-chemical way to stop sweating. Mild electrical currents from a battery-operated device plug the sweat ducts to temporarily stop sweating. The procedure needs to be done daily, or every other day, for two to three weeks and then repeated as needed. You can get the treatment in your dermatologist's office or you can purchase equipment and do the treatment at home.

Your dermatologist may suggest *botulinum toxin* injections as a treatment option. Most commonly known as a wrinkle treatment, botulinum toxin has proved effective in stopping the production of certain sweat glands in the area where it is injected.

"With botulinum toxin, we are able to achieve a perfection in dryness unmet by all other treatments," said Patricia Wexler, M.D., assistant clinical professor, Mount Sinai Medical School in New York.

The treatment involves a series of tiny superficial injections to the problem area, including underarms, hands, feet, forehead, and back of neck. According to Dr. Wexler, the treatment is quite long lasting. Patients may experience relief from sweating up to nine months with these injections, she said.

"Botulinum toxin helps break the vicious cycle of anxiety over sweating that causes more profuse sweating," said Dr. Wexler. "Knowing you can successfully eliminate embarrassing sweating that inhibits social and professional interaction is very liberating."

According to Harold Brody, M.D., a dermatologist in Atlanta, Ga., dermatologic surgical tumescent liposuction of the fat and sweat glands (performed under local anesthesia as an outpatient procedure by your dermatologic surgeon) is a wonderful addition to surgical treatments for sweating under the arms. The treatment was pioneered by dermatologic surgeons.

"After the skin is swollen with dilute solution of local anesthesia, very small instruments called 'cannulas' are used to suck out the sweat glands in a bloodless fashion, " Dr. Brody said. "With almost no bruising afterwards, decreased sweating occurs, and botulinum toxin use may be reduced or unnecessary. Also, the patient may return to work the next day."

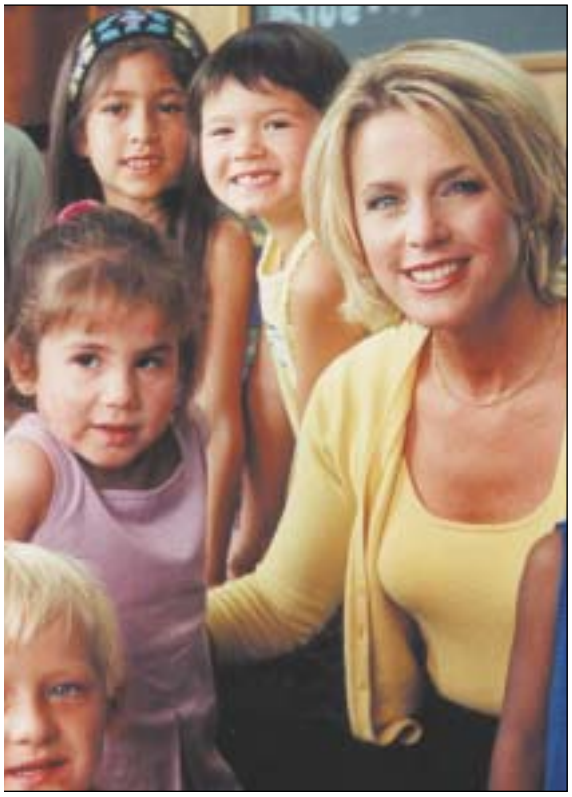
The important thing to note, said Dr. Elgart, is that excessive sweating can be treated as "one less thing to worry about." Di

Ruth Ann Grant

What is Sweat?

Although the body is approximately 55 to 60 percent fluid, sweat is not made up entirely of water. Sweat consists of ammonia, calcium, chloride, copper, creatine, iodine, iron, lactic acid, magnesium, manganese, phosphorus, potassium, sodium, urea and uric acid.

Yes, all that in a little drop of sweat. The highest concentrations, however, are phosphorus and sodium, which is why sweat can sting the eyes and taste rather salty.



Deborah Norville's got news for you... about eczema and self-esteem

The Emmy Award-winning anchor of television's *Inside Edition,* Deborah Norville has been providing powerful information to the public for more than 20 years as a broadcast journalist. Recently Norville's been raising awareness about a story that she says the public is still largely uninformed about — atopic dermatitis. More commonly known as eczema, atopic dermatitis is a skin condition that affects more than 15 million Americans, most of them children. It is characterized by skin that becomes extremely itchy, inflamed, swollen, dry, cracked and crusted. Additionally, eczema sufferers frequently develop feelings of self-consciousness. Work and school performance and sleep are often affected as well.

"Statistics show an appalling number of people don't ascribe the proper degree of seriousness to eczema," Norville told *Dermatology Insights.* "And when you see the results of quality of life studies, it underscores how negatively eczema patients can be affected by this."

Norville was in New York City last November to moderate a forum, *Outside and In: Healthy Living With Eczema.* The event was part of an American Academy of Dermatology (AAD) campaign, which includes AAD public service announcements about eczema featuring Norville and five-year-old Alex Restaino, who has had eczema since she was a toddler. Restaino was one of the invited guests at the forum, which included eczema patients (many of them children) who came in from across the nation to share their personal struggles with the life-altering skin condition. The campaign also features a toll-free number for eczema sufferers, and a Web site with information about this common skin disease.

Norville lends her name and support to several worthy causes for children — she was the 2001 spokesperson for The March of Dimes and served on the board of the Girl Scout Council of Greater New York. "You'll see a pattern in what I get involved in. It's very kid-centered, because that's what my life is all about right now," said Norville, who is the mother of three children.

The AAD estimates one-fifth of all school-age children have eczema, and 60 percent of those children will continue to have one or more symptoms into adulthood. As a young woman in Georgia, Norville became aware of the difficulties young eczema sufferers cope with while growing up.

"I had a girlfriend living down the street from me who had severe eczema — huge patches," Norville said. "She really struggled with it, and in her 40s, still does. She was in marching band with me and I remember her suffering from low self-esteem because of her eczema. There were times she said 'I don't want to do the football game tonight' because she was having a huge breakout on her legs."

Later in life, Norville learned hard lessons of her own about self-worth. "Having had a period in my professional life when things went south, really fast, I understand the loss of self esteem issues that go along with that."

The rapid journey south that Norville refers to is not a trip back home to Georgia, but her much publicized fall from television grace in the late 1980s.

Norville had been a fast-rising star — from a job as a television reporter while still in college, to local news coverage in Georgia, to a prime spot for NBC news in Chicago — and eventually ascended through the ranks on NBC's *Today Show* to the co-host chair alongside Bryant Gumbel.

Not long into her new position, however, she found herself at odds with some of the *Today Show* crew. At the same time, the press had a field day criticizing and mocking her. When she left the *Today Show* to go on maternity leave for the birth of her first child, she didn't return. She left television entirely, bewildered, with her self-esteem in tatters.

"I thought: 'I'll never work in television again, the entire world hates me'," Norville said. "You really begin to question yourself. And what I learned in my own personal journey in trying to get back on track both professionally and personally is you've got to know who you are."

How did Norville deal with the crisis in her personal and professional life and get back on track? She took the needling she was getting in the press and put it to good use — literally. "I sew. I'm a really good

seamstress. That was what got me through it. No matter how horrible things were, I could come home and get a lot of aggression worked out in sewing and say, 'I did that. That looks great. I'm not so awful after all.' "

Norville said when eczema patients are troubled by the results of the illness it's hard for them to have many good things to say about themselves. "People think about themselves: 'I'm ugly, I break out, people cringe when they see my skin.' This is going to chip away at all the things that they have on the positive side of the ledger. So I say, find something about yourself that's great. Something that you do well."

Deborah Norville moderated a forum on eczema with pediatric dermatologist, Dr. Amy Paller (left). Eczema sufferer Alex Restaino, 5, also participated.

Norville does a lot of motivational speaking around the country and recommends that people with self esteem issues keep a list of "positives" in their wallet at all times. "What you're good at, happy memories, whatever it is — put it on a piece of paper. And someone suggested you make it a colorful piece of paper so that when you tuck it in your wallet you don't even have to pull it out and read it. Seeing that flash of color reminds you — there's a whole list of stuff I'm really pretty good at.' You have to practice something called 'thought stopping.' And having that piece of paper helps you stop those negative thoughts and transition them into something that's more positive."

A big positive for eczema patients is the new class of drugs called topical immunomodulators (TIMS), the latest breakthrough advancement for the treatment of eczema in more than 40 years.

"Don't give up on all those wonderful special things that make you uniquely you..."

"...find something about yourself that's great. Something that you do well."

Approved by the FDA in December of 2000, TIMs are now widely available through prescription. Norville said she hopes the AAD-sponsored *Outside and In: Healthy Living With Eczema* campaign will encourage people with eczema to call the toll free number (1-888-462-DERM) or go to the Web site (www.aad.org) to get more information and seek out a doctor. The National Eczema Association for Science and Education (NEASE) is another recommended resource.

The NEASE Web site is www.nationaleczema.org or contact them by phone (1-800-818-7546).

"This campaign, in and of itself, isn't going to cure anybody's skin issues," Norville said. "But what it is going to do is empower consumers to feel strong enough to know that it doesn't have to be like this. People will say 'There may be a treatment better than what we've been dealing with. Let's go find it.' I hope this gives them that new little push of energy and enthusiasm to go forward and make their lives better."

Norville believes getting the information is the first step towards wellness. "That's my personal message to a patient who suffers from eczema," she said. "Sure, your skin may be icky right now. Talk to your dermatologist, make sure that doctor is aware of some of the newer medications that might work for you. But ancillary to that — don't give up on yourself. Don't give up on all those wonderful special things that make you uniquely you — whether you've got eczema or not. Information is power. That's my mantra. The better informed we are, the better decisions we can make." Di

Dean Monti

RESEARCH HORIZONS

TOPICAL TREATMENTS *help* ECZEMA

A new class of drugs, called topical immunomodulators (or TIMS) has been developed to aid in the treatment of eczema. These steroid-free treatments are being used effectively without the side effects found with using corticosteroids (which can cause a number of side effects, including thinning of the skin, formation of dilated blood vessels, stretch marks and infection).

There are two new FDA-approved treatments for eczema, *tacrolimus* and *pimecrolimus*.

Tacrolimus helps adults and children suffering from moderate to severe eczema.

Pimecrolimus has shown promising results in clearing mild to moderate eczema.

Mark Lebwohl, M.D., professor and chairman, department of dermatology, The Mount Sinai School of Medicine New York, reported on these latest advances when he spoke last October at the American Academy of Dermatology's Derm Update 2001 in New York. "Patients find the ointments easy to use and the results, in some cases are almost immediate," said Dr. Lebwohl.

For more information, EczemaNet is a comprehensive eczema information resource on the Web at www.skincarephysicians.com.

American Academy of Dermatology

Luxiq®

℞only

(betamethasone valerate) Foam, 0.12%

BRIEF SUMMARY For Dermatologic Use Only Not for Ophthalmic Use

INDICATIONS AND USAGE Luxiq is a medium potency topical corticosteroid indicated for relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses of the scalp. **CONTRAINDICATIONS** Luxiq is contraindicated in patients who are hypersensitive to betamethasone valerate, to other corticosteroids, or to any ingredient in this preparation. **PRECAUTIONS General:** Systemic absorption of topical corticosteroids has caused reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency after withdrawal of treatment. Manifestations of Cushing's syndrome, hyperglycemia, and glucosuria can also be produced in some patients by systemic absorption of topical corticosteroids while on treatment. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings. Therefore, patients applying a topical steroid to a large surface area or to areas under occlusion should be evaluated periodically for evidence of HPA axis suppression. If HPA axis suppression is noted, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function is generally prompt upon discontinuation of topical corticosteroids. Infrequently, signs and symptoms of glucocorticosteroid insufficiency may occur requiring supplemental systemic corticosteroids. For information on systemic supplementation, see prescribing information for those products. Pediatric patients may be more susceptible to systemic toxicity from equivalent doses due to their larger skin surface to body mass ratios. (See **PRECAUTIONS-Pediatric Use.**) If irritation develops, Luxiq should be discontinued and appropriate therapy instituted. Allergic contact dermatitis with corticosteroids is usually diagnosed by observing a failure to heal rather than noting a clinical exacerbation, as with most topical products not containing corticosteroids. Such an observation should be corroborated with appropriate diagnostic patch testing. In the presence of dermatological infections, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, use of Luxiq should be discontinued until the infection has been adequately controlled. **Information for Patients:** Patients using topical corticosteroids should receive the following information and instructions: 1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes. 2. This medication should not be used for any disorder other than that for which it was prescribed. 3. The treated scalp area should not be bandaged or otherwise covered or wrapped so as to be occlusive unless directed by the physician. 4. Patients should report to their physician any signs of local adverse reactions. 5. As with other corticosteroids, therapy should be discontinued when control is achieved. If no improvement is seen within 2 weeks, contact the physician. **Laboratory Tests:** The following tests may be helpful in evaluating patients for HPA axis suppression: ACTH stimulation test; A.M. plasma cortisol test; Urinary free cortisol test. **Carcinogenesis, Mutagenesis, and Impairment of Fertility:** Long-term animal studies have not been performed to evaluate the carcinogenic potential or the effect on fertility of betamethasone valerate. Betamethasone was genotoxic in the *in vitro* human peripheral blood lymphocyte chromosome aberration assay with metabolic activation and in the *in vivo* mouse bone marrow micronucleus assay. **Pregnancy Category C:** Corticosteroids have been shown to be teratogenic in laboratory animals when administered systemically at relatively low dosage levels. Some corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. There are no adequate and well-controlled studies in pregnant women. Therefore, Luxiq should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. **Nursing Mothers:** Systemically administered corticosteroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. It is not known whether topical administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in breast milk. Because many drugs are excreted in human milk, caution should be exercised when Luxiq is administered to a nursing woman. **Pediatric Use:** Safety and effectiveness in pediatric patients have not been established. Because of a higher ratio of skin surface area to body mass, pediatric patients are at a greater risk than adults of HPA axis suppression and Cushing's syndrome when they are treated with topical corticosteroids. They are therefore also at greater risk of adrenal insufficiency during and/or after withdrawal of treatment. Adverse effects including striae have been reported with inappropriate use of topical corticosteroids in infants and children. Hypothalamic-pituitary-adrenal (HPA) axis suppression, Cushing's syndrome, linear growth retardation, delayed weight gain, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include low plasma cortisol levels and an absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches, and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children. **ADVERSE REACTIONS** The most frequent adverse event was burning/itching/stinging at the application site; the incidence and severity of this event were as follows:

Incidence and severity of burning/itching/stinging				
Product	Total incidence	Maximum severity		
		Mild	Moderate	Severe
Luxiq Foam: n=63	34 (54%)	28 (44%)	5 (8%)	1 (2%)
Betamethasone valerate lotion: n=63	33 (52%)	26 (41%)	6 (10%)	1 (2%)
Placebo Foam: n=32	24 (75%)	13 (41%)	7 (22%)	4 (13%)
Placebo Lotion: n=30	20 (67%)	12 (40%)	5 (17%)	3 (10%)

Other adverse events which were considered to be possibly, probably, or definitely related to Luxiq occurred in 1 patient each; these were paresthesia, pruritus, acne, alopecia, and conjunctivitis. The following additional local adverse reactions have been reported with topical corticosteroids, and they may occur more frequently with the use of occlusive dressings. These reactions are listed in an approximately decreasing order of occurrence: irritation; dryness; folliculitis; acneiform eruptions; hypopigmentation; perioral dermatitis; allergic contact dermatitis; secondary infection; skin atrophy; striae; and miliaria. Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. **OVERDOSAGE** Topically applied Luxiq can be absorbed in sufficient amounts to produce systemic effects. (See **PRECAUTIONS**) **DOSAGE AND ADMINISTRATION** Note: For proper dispensing of foam, can must be inverted. For application to the scalp invert can and dispense a small amount of Luxiq onto a saucer or other cool surface. Do not dispense directly onto hands as foam will begin to melt immediately upon contact with warm skin. Pick up small amounts of foam with fingers and gently massage into affected area until foam disappears. Repeat until entire affected scalp area is treated. Apply twice daily, once in the morning and once at night. As with other corticosteroids, therapy should be discontinued when control is achieved. If no improvement is seen within 2 weeks, reassessment of the diagnosis may be necessary. Luxiq should not be used with occlusive dressings unless directed by a physician. **HOW SUPPLIED** Luxiq is supplied in 100-gram (NDC 63032-021-00) and 50-gram (NDC 63032-021-50) aluminum cans. Store at controlled room temperature 68-77°F (20-25°C). **WARNING *FLAMMABLE. AVOID FIRE, FLAME OR SMOKING DURING AND IMMEDIATELY FOLLOWING APPLICATION.*** Keep out of reach of children. Contents under pressure. Do not puncture or incinerate container. Do not expose to heat or store at temperatures above 120°F (49°C).

Manufactured for: Connetics Corporation, Palo Alto, CA 94303 USA
By: Mitsubishi Pharmaceuticals (UK) Limited, Runcorn WA7 1NU United Kingdom

MBSLB-0184 r3 January 2002

OLUX™ Foam, 0.05%

℞only

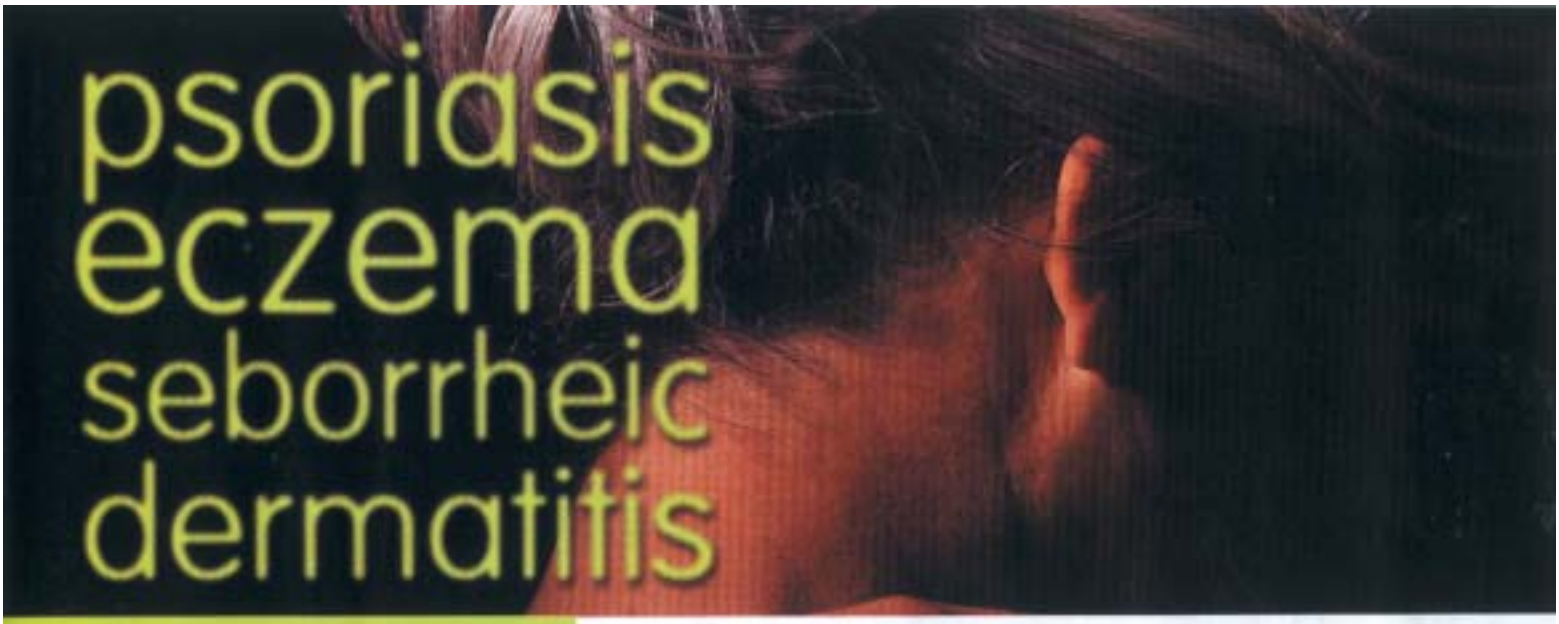
(clobetasol propionate)

BRIEF SUMMARY For Dermatologic Use Only Not for Ophthalmic Use

INDICATIONS AND USAGE OLUX Foam is a superpotent topical corticosteroid indicated for short-term topical treatment of the inflammatory and pruritic manifestations of moderate to severe corticosteroid-responsive dermatoses of the scalp. In a controlled pharmacokinetic study, 3 of 13 patients experienced reversible suppression of the adrenal following 14 days of OLUX Foam therapy. Treatment beyond 2 consecutive weeks is not recommended, and the total dosage should not exceed 50 g per week because of the potential for the drug to suppress the hypothalamic-pituitary-adrenal (HPA) axis. Use in children under 12 years of age is not recommended. **CONTRAINDICATIONS** OLUX Foam is contraindicated in patients who are hypersensitive to clobetasol propionate, to other corticosteroids, or to any ingredient in this preparation. **PRECAUTIONS General: Clobetasol propionate is a super-potent topical corticosteroid that has been shown to suppress the adrenal at 7.8 g of OLUX Foam per day. Lesser amounts of OLUX Foam were not studied.** Systemic absorption of topical corticosteroids has caused reversible adrenal suppression with the potential for glucocorticosteroid insufficiency after withdrawal of treatment. Manifestations of Cushing's syndrome, hyperglycemia, and glucosuria can also be produced in some patients by systemic absorption of topical corticosteroids while on treatment. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings. Therefore, patients applying a topical steroid to a large surface area or to areas under occlusion should be evaluated periodically for evidence of adrenal suppression. If adrenal suppression is noted, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function is generally prompt upon discontinuation of topical corticosteroids. Infrequently, signs and symptoms of glucocorticosteroid insufficiency may occur requiring supplemental systemic corticosteroids. For information on systemic supplementation, see prescribing information for those products. Pediatric patients may be more susceptible to systemic toxicity from equivalent doses due to their larger skin surface to body mass ratios. (See **PRECAUTIONS-Pediatric Use.**) If irritation develops, OLUX Foam should be discontinued and appropriate therapy instituted. Allergic contact dermatitis with corticosteroids is usually diagnosed by observing a failure to heal rather than noting a clinical exacerbation, as with most topical products not containing corticosteroids. Such an observation should be corroborated with appropriate diagnostic patch testing. In the presence of dermatological infections, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, use of OLUX Foam should be discontinued until the infection has been adequately controlled. **Information for Patients:** Patients using topical corticosteroids should receive the following information and instructions: 1. This medication is to be used as directed by the physician and should not be used longer than the prescribed time period. It is for external use only. Avoid contact with the eyes. 2. This medication should not be used for any disorder other than that for which it was prescribed. 3. The treated scalp area should not be bandaged or otherwise covered or wrapped so as to be occlusive unless directed by the physician. 4.Patients should report to their physician any signs of local adverse reactions. **Laboratory Tests:** The following tests may be helpful in evaluating patients for adrenal suppression: ACTH stimulation test; A.M. plasma cortisol test; urinary free cortisol test. **Carcinogenesis, Mutagenesis, and Impairment of Fertility:** Long-term animal studies have not been performed to evaluate the carcinogenic potential of clobetasol propionate. Clobetasol propionate was non-mutagenic in three different test systems: the Ames test, the *Saccharomyces cerevisiae* gene conversion assay, and the *E. coli* B WP2 fluctuation test. Studies in the rat following subcutaneous administration of clobetasol propionate at dosage levels up to 0.05 mg/kg per day revealed that the females exhibited an increase in the number of resorbed embryos and a decrease in the number of living fetuses at the highest dose. **Pregnancy: *Teratogenic Effects: Pregnancy Category C:*** Corticosteroids have been shown to be teratogenic in laboratory animals when administered systemically at relatively low dosage levels. Some corticosteroids have been shown to be teratogenic after dermal application to laboratory animals. Clobetasol propionate has not been tested for teratogenicity by the topical route; however, it is absorbed percutaneously, and when administered subcutaneously, it was a significant teratogen in both the rabbit and the mouse. Clobetasol propionate has greater teratogenic potential than steroids that are less potent. Teratogenicity studies in mice using the subcutaneous route resulted in fetotoxicity at the highest dose tested (1 mg/kg) and teratogenicity at all dose levels tested down to 0.03 mg/kg. These doses are approximately 1.4 and 0.04 times, respectively, the human topical dose of OLUX based on body surface area comparisons. Abnormalities seen included cleft palate and skeletal abnormalities. In rabbits, clobetasol propionate was teratogenic at doses of 0.003 and 0.01 mg/kg. These doses are approximately 0.02 and 0.05 times, respectively, the human topical dose of OLUX based on body surface area comparisons. Abnormalities seen included cleft palate, craniorachisis, and other skeletal abnormalities. There are no adequate and well-controlled studies of the teratogenic potential of clobetasol propionate in pregnant women. OLUX Foam should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Nursing Mothers:*** Systemically administered corticosteroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. It is not known whether topical administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in breast milk. Because many drugs are excreted in human milk, caution should be exercised when OLUX Foam is administered to a nursing woman. ***Pediatric Use:*** Safety and effectiveness of OLUX Foam in pediatric patients have not been established; therefore, use in children under 12 years of age is not recommended. Because of a higher ratio of skin surface area to body mass, pediatric patients are at a greater risk than adults of adrenal suppression and Cushing's syndrome when they are treated with topical corticosteroids. They are therefore at greater risk of adrenal insufficiency during and/or after withdrawal of treatment. Adverse effects including striae have been reported with inappropriate use of topical corticosteroids in infants and children. Adrenal suppression, Cushing's syndrome, linear growth retardation, delayed weight gain, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include low plasma cortisol levels and an absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches, and bilateral papilledema. ***Geriatric Use:*** Clinical studies of OLUX Foam did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy. **ADVERSE REACTIONS** In a controlled trial (188 patients) with OLUX Foam, the only reported adverse reactions were one case each of dry skin, eczema, and skin hypertrophy. In larger controlled trials with other clobetasol propionate formulations, the most frequently reported adverse reactions have included burning, stinging, irritation, pruritus, erythema, folliculitis, cracking and fissuring of the skin, numbness of the fingers, skin atrophy, and telangiectasia (all less than 2%). The following additional local adverse reactions have been reported with topical corticosteroids, but they may occur more frequently with the use of occlusive dressings and higher potency corticosteroids such as OLUX Foam. These reactions are listed in an approximate decreasing order of occurrence: irritation, dryness, folliculitis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, secondary infection, skin atrophy, striae, and miliaria. Systemic absorption of topical corticosteroids has produced reversible adrenal suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. **OVERDOSAGE** Topically applied OLUX Foam can be absorbed in sufficient amounts to produce systemic effects. (See **PRECAUTIONS.**) **DOSAGE AND ADMINISTRATION** Note: For proper dispensing of foam, hold the can upside down and depress the actuator. OLUX Foam should be applied to the affected scalp area twice daily, once in the morning and once at night. Invert the can and dispense a small amount of OLUX Foam (up to a maximum of a golf-ball-size dollop) into the cap of the can, onto a saucer or other cool surface, or directly on the lesion, taking care to avoid contact with the eyes. Dispensing directly onto hands is not recommended, as the foam will begin to melt immediately upon contact with warm skin. Move the hair away from the affected area of the scalp so that the foam can be applied to each affected area. Gently massage into affected scalp area until the foam disappears. Repeat until entire affected scalp area is treated. OLUX Foam is a super-high-potency topical corticosteroid; therefore, treatment should be limited to 2 consecutive weeks and amounts greater than 50 g/week should not be used. Use in pediatric patients under 12 years of age is not recommended. Unless directed by a physician, OLUX Foam should not be used with occlusive dressings. **HOW SUPPLIED** OLUX Foam is supplied in 100-gram (NDC 63032-031-00) and 50-gram (NDC 63032-031-50) aluminum cans. Store at controlled room temperature 68-77°F (20-25°C). **WARNING *FLAMMABLE. AVOID FIRE, FLAME OR SMOKING DURING AND IMMEDIATELY FOLLOWING APPLICATION.*** Keep out of reach of children. Contents under pressure. Do not puncture or incinerate container. Do not expose to heat or store at temperatures above 120°F (49°C).

Manufactured for: Connetics Corporation, Palo Alto, CA 94303 USA
By: Mitsubishi Pharmaceuticals (UK) Limited, Runcorn WA7 1NU United Kingdom

PRM-OLU1-038 September 2001



As with any prescription medication, some people may experience side effects.

Information about Olux: The most frequent side effects of medicines containing clobetasol propionate are burning, stinging, or itching at the application site. These side effects should disappear shortly after application. There are other side effects associated with the chronic use of clobetasol propionate. Speak to your doctor for more information.

Information about Luxiq: The most frequent side effects associated with the use of Luxiq include mild burning, stinging, or itching at the site of application. These side effects typically disappear soon after application.

Let your doctor know if you have any unusual side effects that you do not understand, if you notice any irritation of the treated skin area, or if the affected area does not seem to be healing after 2 weeks of using Olux or after several weeks of using Luxiq.

connetics

References: 1. Data on file [003], Connetics Corporation. 2. Data on file [002], Connetics Corporation.

Consider the problem.

Frustrated by the messy gels, solutions, creams, lotions, and ointments typically used to treat scalp dermatoses?

Now consider foam.

Now there are two elegant ways to treat the problem: Olux® Foam, and Luxiq® Foam. These foam-based products produce highly effective results without making your life more difficult. They're both easy to apply, fragrance-free, nongreasy, nondripping, and stain-free, so they won't stain clothes or linens.[1] Additionally, foam spreads easily and dries quickly, so you can get dressed right after application.

Olux and Luxiq—two medications that come in a unique foam vehicle preferred by 80% of patients surveyed.[2] All in all, they are winning products well worth considering.

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Dead Sea Offers New Life for Skin

Located 15 miles outside of Jerusalem, at more than 1,300 feet below sea level, the Dead Sea is one of the best known climatotherapy (climate therapy) sites in the world. For centuries, it has been touted for its health benefits due to the unique mineral composition in the water and sun-filtering haze. Over the last 30 years, the Dead Sea has developed into a major psoriasis treatment location, housing more than a dozen hotels and medical facilities that cater to skin disease sufferers.

In 1995, the *International Journal of Dermatology* reported that of 1,448 psoriasis patients treated at the MOR Clinic on the shores of the Dead Sea, 88 percent experienced improvement in their psoriasis by 80 to 100 percent or better, with 58 percent of the patients achieving total clearing.

What's so unusual about the Dead Sea?

According to the National Psoriasis Foundation (NPF), popularity of psoriasis treatment at the Dead Sea is based on two factors: exposure to the filtered sunlight and bathing in the sea's unusually high salt-concentrated waters.

"Although prolonged exposure to the sun and sunbathing can be damaging to the skin, patients who received treatment at the Dead Sea report that some limited exposure to the filtered sunlight may be beneficial in the treatment of the scaly plaques and lesions associated with psoriasis," said Molly Marshall, a spokesperson for the NPF.

The Dead Sea is the lowest place on the surface of the earth, and may allow psoriasis patients to expose their skin to the sun for longer periods of time without burning due to the scattered and filtered ultraviolet rays.

"I believe a strong factor of the Dead Sea's successful psoriasis therapy is the influence of ultraviolet light," said dermatologist Michael David, M.D., Rabin Medical Center, Beilinson Campus, Department of Dermatology, Israel. "There is a mineral-enriched haze that contains evaporating sea water that is hanging above the water here."

According to the NPF, a recent study of the ultraviolet light at the Dead Sea reveals that the unusual filtering affects the shorter wavelengths of ultraviolet B (UVB) rays, which are potentially more damaging to skin in the short-term (sunburns).

Upper wavelengths of UVB and all of ultraviolet A (UVA) rays are also filtered by the Dead Sea's haze, but less so than the more damaging, low-end UVB rays.

"At the Dead Sea, it is possible for the skin to get higher doses of therapeutic wavelengths with a diminished risk of immediate sunburn," said Dr. David. "As a result, psoriasis therapy may include a short period of time in the sun."

Dr. David added that the patients' overall skin health is always a concern and patients are encouraged to spend only a small amount of time in the sun, if any at all.

Another factor in the treatment of psoriasis at the Dead Sea is the distinctive water composition, which is said to have a therapeutic effect on the skin due to its high salt and mineral content.

"The Dead Sea is about 33 percent salt," said Dr. David. "In comparison, the Mediterranean Sea contains about 3 percent. You can actually float on the water of the Dead Sea it's so thick."

Experts are not exactly sure how the Dead Sea water may help psoriasis patients. It is often speculated that the trace minerals and salts are absorbed through the skin, slowing down the proliferation of skin cells, or perhaps they create other immunological changes in the body.

"It's a combination of both the therapy and relaxation that gives the best results," said Nicholas Lowe, M.D., Clinical Professor of Dermatology, UCLA School of Medicine. "If you combine both water and filtered sun treatment, there is typically an 83 percent improvement, compared to 72 percent for those who received filtered sun only, and around 17 percent for those who bathed in the water only."

Dr. David adds that psychological reactions are also important in effective psoriasis treatment at the Dead Sea.

PHOTOS, AMIT BATZRI

"You have to also take into account the patients' state of mind here," said Dr. David. "They're away from home, away from stress, and able to relax and focus on only their disease."

To get the best results, Dead Sea dermatologists recommend a treatment of at least four weeks, but this length of time is often not convenient or affordable for many Americans. While thousands of European psoriasis patients stay at Dead Sea treatment facilities with the help of government-run insurance companies, most, if not all, of American insurance companies will not cover climatotherapy treatment.

"Research shows that you may get some improvement in a shorter time period," said Dr. David, "but not as well as in four weeks, and the psoriasis may come back sooner if you stay a shorter period of time."

According to Dr. David, one possible way to speed up the treatment process is to pre-treat your lesions with calcipotriene, a prescription ointment. A recent study showed that patients who used calcipotriene for four weeks before going to the Dead Sea and for two weeks while at the Dead Sea had similar results to those who received four weeks of Dead Sea therapy without the use of calcipotriene.

It is recommended that psoriasis sufferers view a trip to the Dead Sea as a medical treatment and seek medical supervision so that the safest amount of time in the sunlight and water be determined, monitored and changed if needed.

"There is more to it than swimming in the water," said Dr. David. "Medical treatment is advised. For some patients we might recommend 20 minutes a day in the sun, for others it may be increased or decreased. Everyone's skin condition is different."

Plaque-type and acute guttate psoriasis seem to respond best to the Dead Sea sun, while pustular, inverse, hand and foot psoriasis is a little more difficult to treat, "but all patients with psoriasis, including arthritis, could receive relief and benefit," said Dr. Lowe.

Little is known about long-term side effects from the Dead Sea treatment, but according to Dr. David it is likely that the risks are similar to those associated with sun exposure anywhere. In addition, short-term side effects may include irritation to the hair follicles (folliculitis), minor eye and ear infections, and allergic reactions to the minerals and salt in the water.

The length of remission varies from patient to patient, but Dead Sea dermatologists report that their patients receive an average improvement of six to eight months.

There are, however, no studies available today to prove these figures, just numerous testimonies reported by the NPF and the Dead Sea Psoriasis & Arthritis Treatment Foundation. Most patients interviewed by NPF representatives at the Dead Sea have reported significant improvement in their condition, even noting that after past visits their psoriasis returned less severely than it did before their Dead Sea therapy.

For more information about treatments for psoriasis, visit the American Academy of Dermatology Web site at www.aad.org, or ask your dermatologist. Di

Amy Gall

SECOND PHOTO, AMIT BATZRI

PSORIASIS MYTHS *and* FACTS

Dr. Nicholas Lowe addresses some common psoriasis myths:

Myth: You can catch psoriasis by touching someone with it or their clothing.

Truth: Psoriasis is not contagious. Although the lesions can be unsightly, you cannot "catch it" or pass it on to someone else.

Myth: Scrubbing the scales off your psoriasis lesions will help them disappear.

Truth: Scraping or scrubbing your lesions will irritate the psoriasis and may even make it worse. Following the therapy recommended by your dermatologist is the best way to fight psoriasis outbreaks.

Myth: If you have psoriasis you will have unsightly lesions for the rest of your life.

Truth: While there is no cure for psoriasis, there are many different treatments that may clear psoriasis for periods of time. Your dermatologist may have to experiment to find the best treatment for you, but long periods of clearance or improvement to the lesions is possible in most cases.

Myth: There is only one form of psoriasis.

Truth: There are several forms of psoriasis. While plaque psoriasis, defined by red, raised lesions, is the most common, other forms include:

Guttate: characterized by small dot-like lesions.

Pustular: characterized by weeping lesions and intense scaling.

Inverse: characterized by intense increased inflammation and little scaling.

Erythrodermic: characterized by intense sloughing and painful inflammation of the skin.

Psoriatic Arthritis is Chronic

but pain doesn't have to be

Psoriatic arthritis is a painful and chronic form of arthritis that affects 10 to 30 percent of three million psoriasis sufferers in the United States today.

Characterized by inflammation of the skin, joints and connective tissues, psoriatic arthritis can start slowly with mild symptoms, or it can develop quickly. But almost always, psoriasis precedes the arthritis. Psoriatic arthritis affects men and women equally and most often develops between the ages of 30 and 50, but may occur at any age.

The National Psoriasis Foundation (NPF) reports that the cause of psoriatic arthritis is not yet known, but since it has been found to run in families, it may be partly inherited. It is not contagious, however.

SYMPTOMS

Symptoms of psoriatic arthritis include:

- stiffness, pain, swelling and tenderness of the joints and soft tissue
- reduced range of motion
- fatigue and stiffness in the morning
- changes to the nail bed, including pitting or lifting of the nail
- redness and pain of the eye, such as conjunctivitis

The most common affected areas are the hands, feet, lower back, neck and knees, with movement in these areas becoming severely limited.

DIAGNOSIS

In some patients, the diagnosis of psoriatic arthritis may be difficult if the arthritis precedes the psoriasis. "In approximately one out of seven cases, patients have arthritis for decades before psoriasis eventually appears," said Florida dermatologist Michael Caruso, M.D.

Currently, there is no laboratory test designed to diagnose psoriatic arthritis, so diagnosis is generally made on clinical observations.

"Blood tests may reveal an increase in sedimentation rate, pointing to inflammation in the joints or other body organs, but not specifically psoriatic arthritis," said Dr. Caruso.

Physicians may also withdraw fluid from a swollen joint and take X-rays to rule out other closely resembled conditions, such as rheumatoid arthritis. Rheumatism is negative in approximately 90 percent of psoriatic arthritis patients.

"A definitive diagnosis cannot be made until other symptoms of psoriatic arthritis occur, such as nail and skin changes, anemia or elevated levels of uric acid in the blood," said Dr. Caruso.

TREATMENTS

While there is no current cure for psoriatic arthritis, there are a wide range of treatment options that will alleviate the pain and discomfort (which can range from mild to severe) associated with this disease. Treatment may involve a combination of medicine, therapy and medical procedures.

"Non-steroidal anti-inflammatory drugs (NSAIDs) may provide relief from pain and inflammation by blocking the body's production of inflammation-causing chemicals and are prescribed in varying dosages depending on the severity of the condition," said Dr. Caruso.

Corticosteroids, may also be injected directly into a joint to give immediate relief to severe pain and inflammation. And topical creams containing calcipotriene, coal tar, salicylic acid or moisturizers may also be prescribed to control flare-ups of psoriasis lesions.

Mark Lebwohl, M.D., dermatologist at Mount Sinai School of Medicine, New York, and member of the American Academy of Dermatology Ad Hoc Task Force: Psoriasis Education Initiative, said that methotrexate injections, gold injections, sulfasalazine and oral cyclosporin are currently being used in the fight against psoriatic arthritis. Etancerept is also providing relief for psoriatic arthritis and was recently approved for use by the U.S. Food and Drug Administration (see Research Horizons on next page). As always, check with your dermatologist regarding the best course of treatment.

Moderate exercise designed to increase flexibility may also relieve joint stiffness and discomfort and improve range of motion and normal joint movement. However, improper exercise may make psoriatic arthritis pain worse and the NPF recommends consulting a physician before beginning an exercise program.

"Splinting a wrist or finger may help minimize joint destruction and aid in stability during while working or exercising," said Dr. Caruso.

Sometimes, when all other treatment options fail, surgery may be the only hope for psoriatic arthritis sufferers. Synovectomy is a procedure designed to remove diseased portions of a joint. Physicians may also perform arthroplasty, replacing the natural joint with a synthetic one to restore its function. Di

Amy Gall

5 types of psoriatic arthritis

Asymmetric (oligoarticular) Arthritis. The most common type of psoriatic arthritis, asymmetric arthritis typically involves one to three joints, and does not occur in the same joints on both sides of the body. When it affects the hands and feet, it may create a "sausage" appearance from the swelling and inflammation of tendons. Often the swollen joints are tender and red.

Symmetric Arthritis. Unlike asymmetric arthritis, symmetric arthritis affects the same joints on both sides of the body, usually in multiple matching pairs, and may be disabling. It occurs in approximately 15 percent of psoriatic arthritis sufferers.

Arthritis Mutilans. Arthritis mutilans is a severe, deforming and destructive form of arthritis that occurs in less than 5 percent of psoriatic arthritis sufferers.

Distal Interphalangeal Predominant (DIP). Occurring in only 5 percent of psoriatic arthritis suffers, DIP primarily involves the small peripheral joints in the fingers and toes, also known as distal joints. DIP is sometimes misdiagnosed as osteoarthritis, another chronic disease associated with pain in the joint and tissues.

Spondylitis. Spondylitis affects approximately 5 percent of psoriatic arthritis sufferers, and is characterized by inflammation in the spinal column and stiffness in the neck, lower back and pelvic region, making motion difficult and painful.

Like a Visitation

The late Dennis Potter, English author who wrote the screenplay for *Pennies From Heaven*, suffered from severe psoriatic arthritis and dramatized its debilitating effects in his television series, *The Singing Detective.* He also described it in his book *Potter on Potter.* "With the extreme psoriatic arthropy that I have you can't find a point of normal skin. Your pores, your whole face, your eyelids, everything is caked and cracked and bleeding, to such a degree that without drugs you could not possibly survive. It was physically like a visitation, and it was a crisis point, an either or situation: either you give in, or you survive and create something out of this bomb-site which you've become — you put up a new building. That's what it amounted to."

RESEARCH HORIZONS

NEW TREATMENTS *for* PSORIATIC ARTHRITIS

A recent study by Seattle rheumatologist Philip Mease, M.D., in association with dermatologist Bernard S. Goffe, M.D., of Minor and James Med Derm Clinic, Seattle, demonstrated that etanercept, already approved for the treatment of rheumatoid arthritis, significantly relieves the clinical symptoms of psoriatic arthritis.

During the 12-week study of 60 randomized patients, 87 percent of the patients who took etanercept experienced significant improvement and reduction in their joint pain and swelling, compared to 23 percent who received a placebo.

Etanercept belongs to a new class of drugs that works by targeting an immune system protein called tumor necrosis factor (TNF), which causes pain and inflammation to psoriasis patients when it is produced in excess. Etanercept works by preventing the TNF from binding with cells.

Based on the positive results of the test studies the U.S. Food and Drug Administration expanded etanercept's approved labeling to include psoriatic arthritis in 2002. Other medications currently approved for rheumatoid arthritis, which are now being studied to treat psoriatic arthritis, include infliximab and leflunomide.

Two new studies from Northwestern University Medical School have indicated that the disease modifying antirheumatic drug leflunomide, approved for use in rheumatoid arthritis, may also be an effective therapy for recalcitrant psoriatic arthritis and psoriasis.

From Peaches 'n' Cream to Raspberry Red

Patient Perspective by Shanna Germain

Shanna in 2000.

"I felt like I'd been cursed by an evil witch."

Shanna's wedding day, 2001.

Rosier times without the cheeks to match.

As a teenager, I had bad eyesight, bad teeth and, now that I think about it, pretty bad hair. But despite the glasses, braces, and big bangs, I did have one thing that other girls in my school gushed over — perfect skin. Unlike many of my classmates, I never had blemishes. All through high school and college, people commented on my peaches-and-cream complexion. "I guess it's just genetics," I'd always say. I just took it for granted that I would always be blessed with a clear complexion.

Then, the year I turned 25, my skin started to change. When I worked out, my cheeks and nose would turn red and bumpy, and I started getting big blemishes across my chin. I tried not to worry about it, but I couldn't stop staring at myself in the mirror; I felt like I'd been cursed by an evil witch. I switched soaps, but to no avail. I even tried over-the-counter acne medication, but it made my face burn and itch. Even the sunscreen I'd used for years suddenly caused my face to break out.

"I was so excited to hear someone validate the problems I'd been going through and give it a name."

I also started getting styes in my eyelids, infected spots that would swell and make my entire forehead tender. I stopped wearing my contact lenses, afraid I was doing something to make the problems worse. Wearing my thick glasses again made me feel like I was back in high school — only without the clear skin. For the first time in my life, I felt embarrassed to go out; I didn't want people to see my face and wonder what was wrong with my skin.

Unfortunately, it got worse before it got better. The week I was supposed to start a new job, I woke up with red eyes and puffy eyelids. I decided I needed help in my battle, and made an appointment with a dermatologist. As soon as I stepped into the dermatologist's office, she took one look at my face and asked "Have you ever heard of rosacea?"

I could have cried. Although I didn't know what rosacea was, I was so excited to hear someone validate the problems I'd been going through and give it a name. She explained that rosacea was a genetic condition that occurred most often in fair-skinned people like myself. Although there was no cure for rosacea, she said it could be controlled through antibiotics and a special face cream.

My dermatologist also told me about the triggers of rosacea: wind, alcohol, sun, caffeine, spicy foods, strenuous exercise, and stress. I couldn't go for a run without my nose turning bright red and feeling inflamed. Wind made my cheeks burn and my eyes turn bright pink; sunshine did the same. Thai food, mochas, strawberry margaritas — they were all no-no's now.

But with my dermatologist's help, I've learned how to control my rosacea through diet and lifestyle. I've cut down on the foods that trigger my rosacea. I wear a scarf during the winter and I chew on ice cubes or eat frozen pieces of fruit in the summer. A hat and sunscreen are my new fashion accessories. I've also changed the way I work out — instead of running, I walk or ride my bike. And when I play sports now, I make sure to drink lots of ice water and take frequent breaks. My dermatologist also recommended a simple skin care routine of mild soap and PABA-free sunscreen, which helps control the flare-ups.

Now, my rosacea is very much under control. Some days it's worse than others — the heat and the wind are still fierce enemies — but other days I actually forget about it entirely until I get ready to put my cream on before I go to bed. I feel comfortable going out in public, whether my face is red or not, because I've learned that people react more to my personality than my skin. And when people ask me what's wrong with my face, I try to educate them about rosacea, so they can be more understanding next time they meet someone with my condition.

Best of all, I recently got married, and although there were many stresses involved with the wedding, my rosacea wasn't one of them. Even if my face was a little red, I knew I was lovely and loved, and that was all that mattered. Di

Rosy Cheeks *could be* Rosacea

W.C. Fields' trademark bulbous nose was the result of severe rosacea, called rhinophyma.

We all tend to blush when something embarrassing happens. But if you've been blushing more than usual, and not just when you're embarrassed, it could be rosacea.

This chronic and often progressive skin condition affects as many as 14 million Americans. Although rosacea tends to be more common in fair-skinned individuals and those between the ages of 30 and 50, it can affect people with all skin types at any age.

Rosacea may begin as a tendency to flush or blush easily and progress to permanent redness on the cheeks, forehead, chin and nose. Over time, the redness may become more severe and tiny, acne-like pimples and small blood vessels appear on the face. Many individuals with rosacea say that their skin burns or itches. As many as half of all rosacea suffers have watery or itchy eyes. In severe cases, a condition called rhinophyma may develop, which is characterized by a large, bulbous nose.

How do you know if your redness is really rosacea? "The flushing from rosacea tends to be prolonged, lasting up to an hour at a time," said Allison Vidimos, R.Ph., M.D, staff dermatologist in the Department of Dermatology at Cleveland Clinic Foundation in Ohio.

"It's not only provoked by embarrassment or emotional distress, but also by classical triggering factors like heat or cold exposure and spicy foods," said Dr. Vidimos.

In addition to extreme hot or cold temperatures and spicy or hot foods, common triggers for rosacea include sun exposure, emotional stress, exercise and alcoholic or hot beverages. Dr. Vidimos encourages her patients to keep a diary to help determine their triggers, then avoid them to prevent symptoms from occurring.

STRESS *and* ROSACEA

According to a recent survey by the National Rosacea Society, 91 percent of respondents said that emotional stress caused, or sometimes caused, flare-ups. Stress led to frequent flare-ups for 45 percent of respondents and occasional flare-ups for 42 percent.

The vast majority of respondents —nearly 83 percent — who work to avoid stress found that it helps control the rosacea.

"Stress management is important in succeeding in anything, especially at staying healthy," said Doris J. Day, M.D. When stress creeps up, try taking a deep breath, holding it for five seconds and slowly releasing it. "If nothing else, you're giving yourself a needed break."

PHOTOS, NATIONAL ROSACEA SOCIETY

TREATMENT

Typical case of rosacea.

When symptoms do occur, the first line of treatment is topical medicine and/or antibiotics. Both can relieve redness, inflammation and blemishes. "We try to get rosacea under control over a two- to four-month period, then we start to taper off oral antibiotics," said Dr. Vidimos. "Eventually, we try to get patients off oral antibiotics and keep them in remission with topical medicine. So we hit it hard in the beginning, get it under control and slowly back off." Some modern topical care dressings may be left on for many days and don't need to be changed daily. Some people can stay in remission by avoiding triggering factors and using the topical antibiotic cream daily or every other day.

"The patient and doctor have to work as a team to figure out what triggers make the rosacea worse and what treatments make it better," said Doris J. Day, M.D., clinical assistant professor of dermatology at New York University Medical Center in New York. "Once you get a sense of your pattern of rosacea, you'll begin to recognize the early signs of a flare-up. When you notice that the redness is lasting a little longer, you'll know you're probably going to get a flare the next day, so you can start taking the antibiotics," she said. "As it goes back down, you can taper off the pills and start using the cream." Even once the rosacea is under control, a treatment regimen will be necessary because it is a chronic condition, which has no known cause or cure.

Lasers and intense pulsed light therapy may be used to reduce the red appearance of dilated blood vessels. "Laser treatment is the best way, and sometimes the only way, to diffuse the redness and temporarily get rid of those broken blood vessels," said Dr. Day. Today's lasers are so precise that they can destroy the tiny blood vessels without damaging the surrounding skin. A series of treatments, either laser or light therapy, are performed at three- to 12-week intervals, taking between 15 and 30 minutes each. Patients can experience some redness and swelling for a couple of days afterward, depending on how many blood vessels are being treated, Dr. Vidimos added.

In addition to laser treatment, dermabrasion or electrosurgery can be used to remove excess tissue and sculpt the nose back down to a normal shape and appearance for individuals with rhinophyma. These procedures can be performed on an outpatient basis with a healing time of seven to 10 days.

"People with rosacea should know that they're not alone. It's a very common condition," said Dr. Day. "There are ways to gain control of it if you take care of yourself." Di

Ruth Carol

RESEARCH HORIZONS

FOOD ALLERGENS *cause* DERMATITIS FLARE UPS

A recent study found that avoiding certain balsam-related foods and spices — including tomatoes — may improve a common dermatologic condition known as contact dermatitis. Contact dermatitis is an inflammatory skin condition that produces redness and itching.

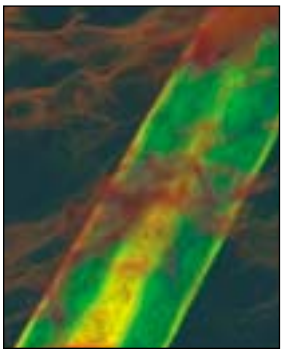
"We found that by eliminating foods from the diet that are linked to flare-ups of contact dermatitis, people in our study showed a significant improvement in their condition," said dermatologist Joseph F. Fowler, M.D., Louisville, Ky., co-author of the study "Balsam-related Systemic Contact Dermatitis," which was recently published in the *Journal of the American Academy of Dermatology.*

In the study, patients with suspected systemic contact dermatitis from balsam-related foods were patch tested and placed into one of three groups. Each group was determined by the patient's positive reactions to the foods and spices identified as allergens. Patients in groups A and B, the groups that followed the balsam of Peru restricted diet, avoided foods such as tomatoes, products containing citrus fruits, spices, colas, and chocolate. Balsam of Peru is a natural plant extract that contains dozens of individual substances, many of which are also found in balsam-related foods. The patients in these groups eliminated all foods on the diet for three to six weeks and then reintroduced one food at a time every one to two days, watching for flare ups.

Of the 45 total patients in groups A and B that followed the balsam of Peru restricted diet, 21 patients (47 percent) reported complete or significant improvement of their dermatitis.

SKIN, HAIR, AND NAIL INSIGHTS

Hair Raising Facts



Most people shed between 50 and 100 hairs each day. Before they scoot from the scalp, however, those hairs have probably been around a while. A typical hair remains on the human head for two to six years. The active hairs (90 percent of scalp hair is active; 10 percent rests) are growing continually all that time, keeping 100 percent of barbers active.

Through Thick and Thin

Did you know that red hair is the thickest hair, while blonde is the thinnest? A red hair is a little more than twice as thick as a blonde hair. Nature makes up for this disparity by giving (on average) blondes more individual hairs than anyone else (and redheads the least, accordingly). So, if there is some relationship between follicles, frequency and fun, blondes may indeed have the edge they claim.

MICROSCOPIC PHOTO, MICHAEL W. DAVIDSON, NATIONAL HIGH MAGNETIC FIELD LABORATORY, THE FLORIDA STATE UNIVERSITY

Just had surgery?

Think Clean, Moist for Care Afterwards

Whether you've just had a mole on your back removed or wrinkles on your face smoothed, your skin will need to heal. You can help the healing process along with a few simple steps.

The diagnosis or treatment of skin cancer is the most common type of dermatologic surgery that results in an open wound. Typically, open wounds are not covered up after surgery. To help the wound heal, it should be cleaned twice daily with a mild soap and water. A liquid cleanser is preferred because it can penetrate the wound better than a hard soap. A diluted acetic acid solution, such as white vinegar and water mixture (one teaspoon of white vinegar with 16 ounces of water) can also be used to clean the area. This mixture removes any crust that may be trying to form and prevents infections.

In order for new skin to grow, it needs a certain amount of humidity. A petrolatum-based ointment can be used to keep the area moist. "Whether it's a plain ointment or one with an antibiotic, it helps prevent an open wound from drying out and forming a scab," said Christopher B. Harmon, M.D., a clinical instructor at the University of Alabama in Birmingham.

Say "no" to scabs

Scabs interfere with the growth of new skin. "Twenty years ago, it was thought that the best treatment barrier for an open wound was to allow a scab to form," explained Jonith Breadon, M.D., co-director of Dermatologic Surgery at Cook County Hospital in Chicago. "However, the emphasis has changed to using more occlusive dressings, which means some sort of barrier that keeps the wound moist and allows the skin to heal more quickly."

Sometimes an open wound must be covered with a dressing, such as an adhesive bandage. In those cases, the nonadherent portion (or white, non-stick part), should be placed over an open wound. "The advantage of a covering is that it keeps the ointment on the open wound and keeps it from rubbing off on clothes or getting wiped off," said Dr. Harmon. It also helps protect the wound from being bumped or bruised and can be used to apply pressure on the wound to keep it from bleeding.

Covering a wound, however, may trap bacteria. Changing the bandage daily can help prevent this from happening. Also, prolonged use of adhesive bandages often cause red, blistering inflamed skin around the wound, known as adhesive contact dermatitis.

Usually, a dressing can be removed as early as 24 hours after surgery, but depending on the procedure performed, it may need to stay on for a few days and may require a doctor or a nurse to change it.

Your doctor can best determine whether your wound requires covering.

Covering a wound may trap bacteria.

Changing the bandage daily can help prevent this from happening.

Caring for stitches

Closed wounds are the result of surgical excisions, which involve cutting into the skin, removing a growth and closing the wound with stitches, sutures, staples or healing strips. Closed wounds should be cared for similarly to open wounds. They should be cleaned, rinsed, patted dry, and have ointment applied.

A closed wound is usually covered with a bandage. Sometimes the bandage is changed daily and other times it must remain in place until the stitches are removed. Caring for the wound until the stitches are removed is important because removing sutures when no blood or scab is around the wound is much easier, she said.

Stitches can break if certain activities are resumed too soon after surgery. Studies have shown that sutured wounds have regained only 20 percent of their original strength three weeks after surgery, said Dr. Harmon. "Any activity that pulls or stretches the area that was operated on should be limited for two to three weeks."

In addition to limited physical activity, stitched wounds require rest and elevation, added Dr. Breadon. The use of ice packs in the first couple of days after surgery may prevent swelling and bleeding. It's also important to avoid things that increase bleeding, such as aspirin and alcohol.

Beginning two to three weeks after surgery, massaging closed wounds, especially on the face, may be beneficial. "This will help reduce the swelling, loosen up the tightness and prevent a scar from forming," stated Dr. Harmon. Although rubbing in a moisturizer is okay, he cautioned against using vitamin E oil from capsules. Vitamin E preparations are not intended for topical use, he said.

If a wound is in a sun-exposed area, a sunscreen with a high sun protection factor (SPF 30 or higher) should be used for three to four months following surgery because the new skin is more sensitive to the sun.

It takes anywhere from 6 to 18 months for a scar to completely heal. "When patients get worried about the way a wound looks, they start buying all kinds of creams to rub on, but these won't hasten the process," said Dr. Breadon. "It's natural for it to take that long to heal." Di

Ruth Carol

Growth Opportunity!

New Hair Transplant Techniques an Option for Men and Women

Hair transplantation, the medical process of relocating hair from the lower back and sides of the head, has long been a way to permanently restore natural living, growing hair to the balding top or front of the head. Over the last 10 years, techniques have dramatically improved to give patients a natural-looking frontal hairline in addition to improved hair density.

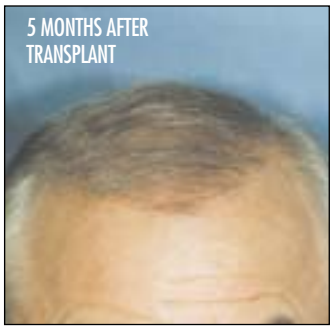
In addition to, or instead of, the plug grafting that most people commonly associate with hair transplants, transplant surgeons now are using "micrografting" and "minigrafting." These newer techniques utilize many smaller grafts with varying numbers of hair follicles (from one to four) to create a fuller, more natural appearance.

"Hair is like plants and the scalp is like garden soil," explained Walter Unger, M.D., clinical professor of dermatology, and co-director of cosmetic dermatologic surgery at Mount Sinai Medical School in New York. "With male pattern baldness, hair loss means there's a problem with the plants, not the soil. Move healthy hair to where there was once balding, and it will grow like healthy plants in dormant soil."

About 20 percent of Caucasian (white) men show signs of male pattern baldness by age 20, and the incidence increases by approximately 10 percent each 10 years of a man's life. But baldness is not only a male condition, increasing numbers of women are experiencing hair loss.

In fact, hair transplants are becoming more popular with women because they are most specifically able to benefit from the newer micrografting and minigrafting, hair transplant methods, according to Dr. Unger. With the older method, healthy hair follicles were removed as a site was punched out of the thinning area, in order to make room for a relatively large hair-bearing plug. Micrografting and minigrafting, however, allow surgeons to transplant new hair *between* existing hair follicles without any being removed. That means hair transplants are now effective for putting hair on a thinning head of hair, not just on a bald scalp.

"Because we can work on areas still bearing hair, we are now better able to camouflage the transplantation site post-operatively. In addition, we can spread the transplant sessions further apart," said Dr. Unger.



PHOTOS, INTERNATIONAL SOCIETY OF HAIR RESORATION SURGERY

Successful hair transplantation can require as few as one or as many as three transplant sessions or surgeries. Each session can take anywhere from one to seven hours depending upon the size and number of grafts moved. A typical session lasts four or five hours, according to Dr. Unger, and involves 700 to 1,500 grafts. Most transplants are done with local anesthetic.

Your hair density, as well as the coarseness, color and wave in your hair will all be factors in the type of transplant surgery you will require and the outcome of the process. Although coarse hair is good because it looks bulkier or denser, finer hair looks more natural when transplanted.

"The best candidates for hair transplants have both fine and coarse hairs on their head," said Dr. Unger.

Those interested in hair transplants should keep in mind that hair transplanting is not simply about moving hair from one place to another — it is surgery. Following hair transplant surgery, patients are given relatively mild medications to alleviate mild to moderate overnight pain or discomfort associated with the transplant. Generally, bandages are not necessary. Additionally, transplant surgeons have their patients come in the day after transplantation to have their hair washed and styled. Patients are then instructed to wash their newly transplanted hair twice a day during the week following the procedure.

Studies indicate that keeping an area moist speeds healing and shedding of crusts, so don't be surprised if your surgeon suggests that you apply a three percent solution of minoxidil to the transplantation site. The minoxidil is not used to stimulate growth, as it is normally prescribed for, but to accelerate healing by increasing blood flow to the area.

Because of the shock of being moved, expect that the newly transplanted hair will fall out two to three weeks after the transplant surgery and begin to grow back after about three months. Dr. Unger said he has found that patients using minoxidil after receiving a transplant lose their transplanted hair four to five weeks after surgery and see it grow back after two to two-and-a-half months.

For more information about the hair restoration process, ask your dermatologist. Patient information also is available from the American Academy of Dermatology at www.aad.org. Di

Ruth Ann Grant

Nail tale: Your Nails are One of the Most Telling Indicators of Nutrition

Media reports often tell the public to be aware of nutrition deficiencies by paying attention to changes in weight or overall health. But there is another way you can detect if your body lacks essential vitamins and nutrients — look at the nails on your fingers and toes. Dryness causes most nail breakage, but other health-related factors may also contribute to nail problems.

"Nails are as much a reflection of health as skin is," said Wilma F. Bergfeld, M.D., a dermatologist with The Cleveland Clinic in Ohio, and past president of the American Academy of Dermatology. "In fact, nails are like hair, in that they are influenced by genetic and metabolic factors, endocrinology, and nutrition."

According to Dr. Bergfeld, nail problems — nails that break easily, thinning nail plates, cuticle problems like excessive skin at or around the nail — can be caused by a number of factors. Thyroid disease, renal disease, decreased oxygenation, caustic materials such as cleaning agents, glues used with false fingernails, heavy emery boards, and even gardening without gloves can lead to problems with the nails. For that reason, she suggests that patients with nail problems discuss the following three topics with their doctor:

- Medical situation
- Family history
- Environmental factors

Dystrophic nails — those affected by inadequate nutrition — can be treated with vitamin and mineral supplementation. Dr. Bergfeld indicated that nails are healthier in general when supplements are taken. Nails are composed of proteins, such as keratin, that require several nutrients to grow and remain healthy. For that reason, your nails may change in appearance or weaken if you cheat your body of vitamins such as B-12 and nutrients such as calcium and iron. Inadequate nutrients can also affect the nail bed on which nails grow. In addition to supplements, certain foods can help maintain the proper nutrient levels that improve nail strength and appearance. **Di**

Karen Stein

ARE YOUR NAILS LACKING THESE NUTRIENTS?

Iron. Nails that are thin, brittle, pale, ridged, or easily broken or cracked may indicate a lack of iron in the diet. A flat or spoon-shaped appearance may also be a warning. Iron-rich foods include dark green, leafy vegetables (such as broccoli and kale); nuts; lean cuts of meat; eggs; liver; seeds; and raisins and dates.

Zinc. Brittle nails with white spots or lines that may grow into a crescent shape may be caused by insufficient zinc intake. Whole grains, poultry, and seafood are good sources of zinc.

Fatty acids. Flaking and splitting nails could be a warning that the body lacks enough linoleic acid. Unheated vegetable oils are the best source of linoleic acid. Fungal and bacterial nail infections can be avoided by increasing omega-3-fatty acids, which are found in salmon, cod, bass, broccoli, seeds, nuts, and canola oil.

Vitamins. Vitamin A deficiency can cause nails to split and break. Vitamin B-12 helps prevent nails from becoming flat and thin and encourages healthy growth and coloring. Hangnails, swelling, or reddish-brown spots might be indicative of a need to increase vitamin C intake. Biotin, generally classified as a B-complex vitamin, has been shown to help avoid brittle nails.

Ouch!

Nail Injuries Don't Have to Hang You Up

Because fingernails serve many purposes — protecting the nail bed, grasping tiny objects, and scratching itches, to name a few — it is important to protect nails against injury.

According to Lynn Drake, M.D., of the Harvard Medical School, Department of Dermatology, Boston, and past president of the American Academy of Dermatology, anything that damages the matrix can be called a nail injury.

Nail injuries can be caused by accidents with light or heavy machinery or cutting tools, and even over-aggression with a cuticle tool can potentially damage the nail. Dr. Drake also lists chemicals, warts, psoriasis, infection (bacterial or viral), disease, and trauma as primary causes of nail injury — however, direct injuries, such as slamming a finger in a car door, is commonly to blame.

"The most important thing to remember about nails," said Dr. Drake, "is that the fingernail is in a very tight space. Blood under the fingernail can cause tremendous pain." In fact, if hematoma (collection of blood) forms as a result of nail trauma, intense discomfort may follow — but a visit to a dermatologist or emergency room may provide great relief. "The doctor may use a small heating device that looks like a penlight," Dr. Drake explained. "The loop on the end gets very hot and burns a hole in the nail, which releases the clotted blood, and the patient almost always lets out an immediate sigh of relief." Some dermatologist use a nail drill or #11 blade to drain a hematoma.

But sometimes what appears to be nail trauma is, in actuality, a response to another problem. If a nail suddenly doesn't look or feel right — for example, if it is suddenly cold, hot or cannot bend — it is best to visit a dermatologist to determine the cause of this change.

"If the nail is distorted, you need to find out the reason," said Dr. Drake. "There is usually something underlying the problem. Especially in the case of trauma – you need to make sure there are no broken bones or injury." Di

Karen Stein

Treatment for Injured Nails

The cause of a nail injury determines its treatment. Sutures may be required for tears. Removal of a remaining nail fragment may be necessary to prevent it from catching on something and tearing. A dermatologist may use a culture to determine the presence of onychomycosis (a fungal infection that causes the nails to become thickened, difficult to cut and painful), or perform a biopsy if a tumor is suspected.

Although a dermatologist should determine the course of treatment for nail injury, there are things the patient can do in the interim. Cold compress can help reduce swelling. Dr. Drake cautions against placing ice directly on the injury, but rather placing a compress around the injury. Elevating the hand (or foot) with the nail injury may also be important to minimize the swelling.

Although the prominent location of fingernails makes them more susceptible to injury, there are ways you can protect yourself, such as keeping your nails short to avoid catching them on objects that can lead to tears, and using due care when using tools or machinery.

Getting a Jump on Athlete's Foot

Athlete's foot is a common skin condition that many people will develop at least once in their lives. Dermatologist Amy Paller, M.D., professor of pediatrics and dermatology, Children's Memorial Hospital, Chicago, explains what causes athlete's foot and how to treat it.

athlete's foot

Q: Who gets athlete's foot?

A: It occurs mostly among teenage and adult males, and is uncommon in women and children under the age of 12. If a child displays what appear to be the symptoms of athlete's foot, chances are it's another skin condition.

Q: Why does athlete's foot develop?

A: Athlete's foot is a term used to describe a fungus infection of the feet. The correct term for athlete's foot is *tinea pedis.* The fungi that cause athlete's foot grow in moist, damp places. Sweaty feet, not drying feet well after swimming or bathing, tight shoes and socks, and a warm climate all contribute to the development of athlete's foot. It's commonly believed that athlete's foot is highly contagious — that you can easily catch it from walking barefoot in the locker room. This is not true. Experiments to infect healthy skin with athlete's foot have failed and often one family member may have it without infecting others living in the same house. It's not clear why some people develop athlete's foot and others don't.

Q: What does athlete's foot look like?

A: Athlete's foot may affect different people in different ways. Sometimes, the skin between the toes (especially the last two toes) peels, cracks and scales. In other cases, we see redness, scaling and even blisters on the soles and along the sides of the feet. These skin changes may be accompanied by itching. But not all rashes on the feet are athlete's foot. Before treating a foot rash yourself, you should check with your dermatologist, who can diagnose the condition and prescribe the correct medication. You can make your condition worse if you use an over-the-counter preparation on a rash that is not athlete's foot.

Q: How is athlete's foot diagnosed?

A: A dermatologist examines the feet. The examination may include a scraping of the skin on your feet. The skin scales are then examined under a microscope or placed in special substances to look for growth of the fungus.

Q: How is athlete's foot treated?

A: Once your dermatologist identifies the fungus, he or she will begin treatment immediately. If athlete's foot isn't treated, it can result in skin blisters and cracks that can increase the risk of bacterial infection. For simple cases, anti-fungal powders (such as tolnaftate) and creams (such as clotrimazole and terbinafine) may be recommended. Many products may be purchased over the counter. In more severe cases, your dermatologist may prescribe foot soaks before applying antifungal creams. If your athlete's foot is stubborn, antifungal pills may be prescribed. Toenail infections are difficult to treat, but many medications are now available, most taken by mouth. Always continue the use of your prescribed medication as directed. While your skin may look better, the infection can remain for some time afterwards and could recur.

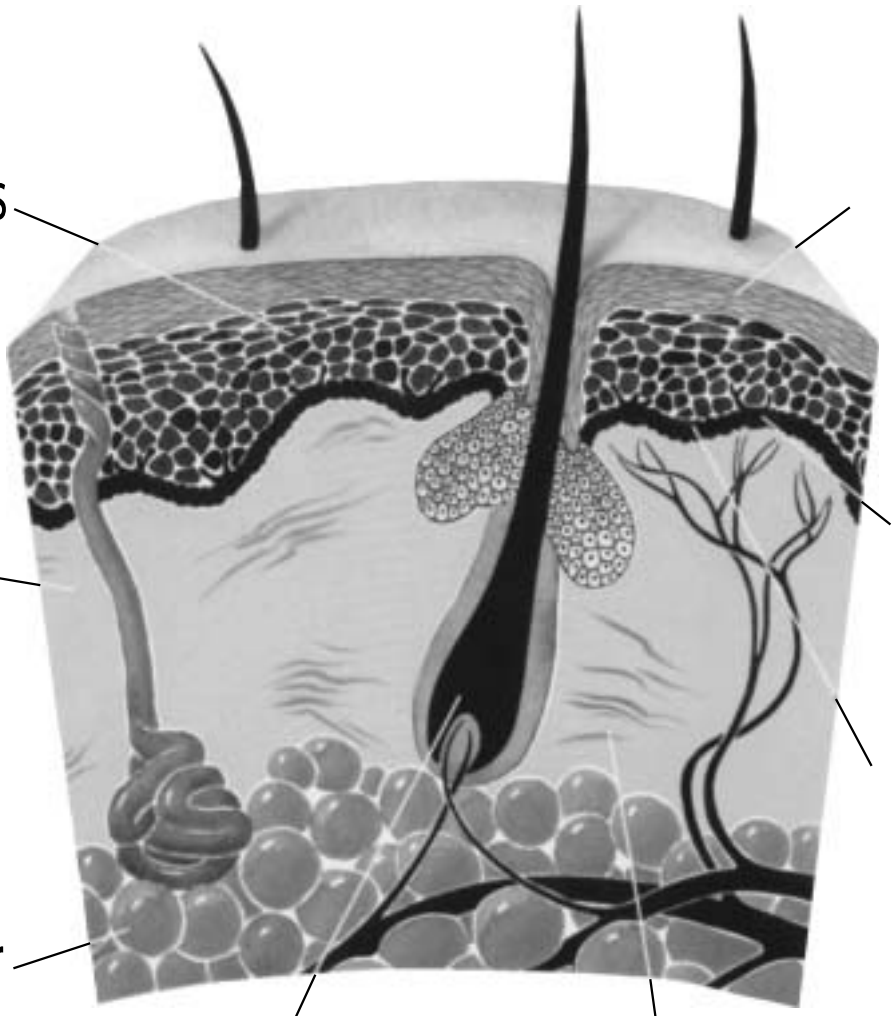
Q: How can you prevent athlete's foot?

A: Wash your feet daily, and always dry your feet thoroughly, especially in between your toes. Avoid tight footwear, especially in the summer. Sandals are the best warm weather footwear. You should also use an anti-fungal powder on your feet and in your shoes during the summer. Alternate shoes so that they have a chance to dry out at least 24 hours before re-wearing them. Cotton socks (or socks made of a material that takes moisture away from the skin) are best and you should change them if they become damp. Whenever possible, go barefoot at home. Athlete's foot does not occur among people who traditionally go barefoot. It's moisture, sweating and lack of proper ventilation of the feet that present the perfect setting for the fungus of athlete's foot to grow.

Questions?

The AAD offers educational pamphlets on many dermatologic conditions, and can provide a list of local dermatologists. Call the AAD toll-free 1-888-462-DERM or log on to our Web site at www.aad.org.

SKIN: The Package You're In



Epidermis
— outer skin layer
— keeps fluids from escaping and germs from entering the body

Stratum corneum
— topmost layer of cells

Dermis
— middle skin layer
— contains blood vessels, nerves and connective tissues, hair follicles and oil glands

Melanocytes
— produce the pigment called melanin

Basal cells
— form at the base of the epidermis

Fatty layer
— or Subcutaneous tissue — provides insulation and stores energy

Pilosebaceous unit
(hair follicle)
— produces sebum, or oil

Collagen fiber
— helps skin keep its shape

AMERICAN ACADEMY OF DERMATOLOGY

Did You Know?

If your skin was removed, it would weigh between seven and nine pounds and stretch out to about twenty square feet.

One square inch of skin is packed with 100 oil glands, 15 feet of blood vessels, and two kinds of sweat glands.

Though tough and very complex, skin is really "paper" thin – varying from 1/25 to 1/8 of an inch deep!

It only takes about an ounce of sunscreen to protect exposed skin from the sun.

Q10 ANTI-WRINKLE SENSITIVE SKIN LINE

Many of the anti-aging products with Retinol and Alpha Hydroxy Acids can be just as irritating as the wrinkles they're supposed to treat. The active ingredient in Eucerin, Coenzyme Q10, is already present in your skin and is one of the most natural ways to fight wrinkles. This exclusive Q10 formula is available in a creme or daily lotion with SPF 15.

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