

Ep49 Smart Skin Care

Lynita: [00:00:00] Hi there and welcome to the Eczema Breakthroughs Podcast. When your child is first diagnosed with eczema, the first piece of advice you're likely to hear is moisturize the skin. But as a parent suddenly faced with a condition you may know little about, it is easy to take that guidance at face value, without stopping to ask the crucial follow-up questions: How much moisturizer, when should I apply it, and where to exactly? Moisturizer therapy is the cornerstone of eczema care, but to get the most out of it, how you [00:01:00] do it matters.

Our guest today is one of the foremost experts in eczema care. She will be sharing the details of how best to care for your child's eczema skin backed by evidence-based research. She coauthored the 2022 European guidelines on managing atopic eczema and has been instrumental in multiple studies examining the relationship between food allergies and eczema. She's the director of Children's Allergy Doctors, and previously served as head of the Pediatric Allergy and Immunology at Evelina Children's Hospital in London. Dr. Helen Brough, welcome to the podcast.

Dr. Brough: Thanks so much, Lynita. I'm really delighted to be here, and I'm keen to convey some practical evidence-based strategies to help parents and children suffering with eczema.

Lynita: Well we're really delighted to have you with us on the podcast. Why do we use moisturizers? What benefit do they provide?

Dr. Helen Brough: Moisturizers are one of the most important tools because they repair and [00:02:00] strengthen the skin barrier, and you can reduce eczema flares by up to 50% by regular use of moisturizers.

The skin barrier is often compromised in children and adults with eczema, this allows water to escape from the skin, which is why skin is dry with eczema, and it also allows allergens or irritants to enter the skin. This can then lead to inflammation and flareups and can also allow pathogens like bacteria, viruses or fungi to enter the skin and lead to more severe eczema.

Lynita: Right, so we should get onto it straight away when we first get that diagnosis of eczema. So the next step is the pharmacy to buy something. What does the research say about the best types of moisturizers?

Dr. Helen Brough: There are a multitude of different lotions, creams, gels, and ointments that can be used as moisturizers, and this can be quite overwhelming for parents. There was in fact a recent [00:03:00] study which found that actually it didn't matter which moisturizer was used as they all helped. However, 37% of children had one or more adverse event, but there was less stinging with ointments. There was another study which found that 75% of the moisturizers used contained at least one contact allergen, so it's very important to choose the right moisturizer that's not going to irritate the skin.

One of the most commonly studied irritants in creams is SLS...

Lynita: and SLS just stands for sodium lauryl sulfate, right?

Dr. Helen Brough: Yes, and there are now many regulatory bodies that recommend against the use of SLS in products.

Lynita: We are actually gonna hear more about contact allergens in the second half of this podcast that I'm recording with Doctor Atwater soon.

Dr. Helen Brough: Great. The other thing that needs to be considered when choosing a moisturizer is that there's now more and more evidence that children are becoming allergic through the skin, [00:04:00] particularly when certain foods are being applied onto the skin of a child before they have started to eat the food themselves. There was a large study in 2003, which showed that 90% of peanut allergic children with eczema have been exposed to creams containing Aracis or peanut oil in the first six months of life. Following this there have been multiple case studies of immediate hypersensitivity following cutaneous application of food oils in skin. These have been shown for sesame, almond, sunflower seed, macadamia, soy, and of course, peanut. Therefore, I recommend avoiding moisturizers on skin, particularly in the first year of life before the child has had the opportunity to introduce that food into their diet.

Since then, 1300 babies were followed over three years, [00:05:00] and there was a significant association between the frequency of moisturizer application at three months of life and the risk of developing food allergy. Now, the most common moisturizers that were used in this study were olive oil, sunflower seed oil, almond oil, and coconut oil.

Lynita: Thank you. So nut oils are something to avoid. How do you feel about oat based moisturizer?

Dr. Helen Brough: When it comes to oat based skincare, the exact terminology matters, because many of the products that use oat based emollient have colloidal oat meal as a signature active ingredient, and this is made of finely ground oat kernels that are processed to preserve the active ingredient in the oat, and this is then suspended in water or another liquid, so it's not the same as just using plain oats.

However, it is still a food and therefore there is a risk of sensitization and [00:06:00] there are case reports of sensitization to oat following application of oat based moisturizers.

There was a recently published study which looked at the application of a colloidal oat, and ceramide based moisturizer in young infants to see if this could prevent the development of eczema. They found that despite just using the moisturizer for the first eight weeks of life, there was a 50% reduction in the prevalence of eczema at one year of age. The study investigators were actually asked if there was an increased risk of oat allergy and they found that no family reported allergic reactions to OAT in any of the children in the study.

When I see a patient in my clinic, if they're using an oat based moisturizer and they find that it's working really well for their child, I won't ask 'em to stop this. But I will encourage them to ensure that that child is eating lots of oats in their diet.

Lynita: [00:07:00] So given that a lot of people are using it and there's a small amount of oat allergies, that's probably not something to be too concerned about. Particularly if your child is already eating oats.

Dr. Helen Brough: Absolutely,

Lynita: So we've talked about irritants and allergens but are there any other features of emollient we should look for?

Dr. Helen Brough: Yes. There are several other features of emollient. One particular area is ceramides, because these have been shown to support the skin's lipid matrix and to help restore barrier function.

If a child has low levels of ceramides in the skin, this has been associated with early onset eczema. And there are other creams called tri lipid creams that contain a specific ratio of cholesterol free fatty acids and ceramides that restore the skin barrier and significantly reduce eczema severity in children. And this is one of the creams that we are studying in the stopping eczema and allergy study.

Lynita: Thanks. And what about other things? I [00:08:00] often hear researchers talk about petrolatum based moisturizer. Is that just petroleum jelly or Vaseline?

Dr. Helen Brough: Yes, petrolatum based moisturizers are just petroleum jelly or Vaseline, and they're very effective at trapping moisture inside the skin.

Lynita: Okay. Now that we've been to the chemist or pharmacy and we've chosen a moisturizer, how do we apply it? Because I, along with many parents, learned the hard way that allergy can be passed through the skin.

Dr. Helen Brough: It's so important that parents are instructed on the correct way to apply moisturizers. Firstly, it's really important to wash your hands before applying moisturizers onto your child. This is important because you could be transferring food allergens and also bacteria onto your child's skin.

Secondly, it's really important that if you have a pot or tub of a moisturizer, that you use the correct way to take that [00:09:00] moisturizer out of the tub. Many families that I see have not been instructed not to put their hands into that tub of moisturizer. And then when they do this, they insert bacteria into that pot, and then the bacteria inside the pot will grow at room temperature. Every time the parents are putting moisturizer on their child's skin, they're putting more bacteria, more pathogens like viruses or fungi, on the skin from the moisturizer. Try avoiding these pots or tubs of emollient and instead buy a tube or a pump. However, if you have purchased a pot or tub, then please just use a clean spoon or spatula to take the moisturizer out, making sure that the hands never go inside the pot.

Lynita: So don't put your hands in a pot of cream, ever; Make sure that you are washing your [00:10:00] hands before you put any cream on your child's skin; And if you have a choice, buy a pump or a tube.

Dr. Helen Brough: Yes, that's correct. I'm really keen to disseminate this message to all parents of children with eczema because once a child has infected eczema, then their eczema is much harder to control and is much more likely to continue to be severe. Additionally, infected eczema significantly impacts food allergy because we know that the bacteria on the skin of infected eczema, *Staphylococcus aureus*, produces a toxin that makes the immune system on the skin much more likely to see something innocuous, like peanut, as a pathogen, and then respond to it in allergic way.

In the learning early about peanut study in over 640 children with moderate to severe eczema or egg allergy. They found that the children that were colonized with this bacteria, *Staphylococcus aureus*, [00:11:00] were much less likely to be able to prevent peanut allergy using early peanut introduction. They were also much less likely to outgrow classically transient food allergies like egg. So it's not just about the eczema, it's also about preventing food allergies, treating food allergies, and even outgrowing food allergies.

Lynita: I didn't realize there was such a strong link between exacerbating food allergies or increasing the longevity of food allergies. So it really is important that we keep *Staph aureus* off the skin as much as possible by using clean hands when we moisturize and uncontaminated creams.

Okay, so we've applied our moisturizer for the first time. When are we gonna apply it next?

Dr. Helen Brough: Moisturizers should be applied at least twice a day consistently, to prevent flareups even when the skin appears normal, because if you were to look under a microscope, you would see [00:12:00] that the skin is actually porous, inflamed, and that there are fragmented parts of the upper areas of the skin.

When there is a flare up, it's important to increase the number of applications. In a large Cochran review in 2022, they found that daily emollient use led to a 32% reduction in the number of flares requiring topical steroids. And also the time to a first flare would be delayed by four to six weeks in those using emollient regularly.

Lynita: Okay.

Dr. Helen Brough: Bathing is another really important aspect to managing the child's eczema. And the most important time to apply the moisturizer is after your child has had a bath. I recommend bathing the child in luke warm water because we know that heat is often a trigger for eczema. So this is not hotter than 32 degrees centigrade and not for long periods of time because sitting in water, [00:13:00] which is actually drying, can make the skin more fragile.

So I recommend a bath for no longer than 10 minutes. And actually applying the cream onto the child's skin before going into the bath so that they have a protective layer when in the water. I recommend using a cream-based wash, not detergent based wash, and I don't recommend putting any bath oils in the bath

because this has now been shown to increase the risk of the child's eczema getting worse.

So once the child has had their cool short bath gently pat the skin dry, and while it is still slightly damp, apply the moisturizer generously over the whole body and face. I know in the US they call this soak and seal and that they recommend applying it within three minutes of the bath.

It is also important that parents use enough moisturizer because the moisturizer is trapping the water inside the skin and [00:14:00] restoring the skin barrier. I recommend that the child should look white or have a thick glistening layer of moisturizer and that's a sign that enough is being used.

The guidelines for the quantity of moisturizer to be used is 250 grams in infants under two years of age, 250 to 500 grams per week in children two to 10 years of age. And at least 500 grams per week in older children and adults.

Lynita: Great.

Dr. Helen Brough: The next thing I advise parents is how they apply the moisturizer on their child's skin. It's very important to do this gently and in the direction of the hair, so gentle downward strokes, and not rubbing it in because that can irritate the hair follicle and that can lead to folliculitis, which is a common skin condition where the hair follicles become inflamed and they can look like red or pus filled spots, sometimes with a [00:15:00] tiny hair visible in the middle.

Lynita: So to recap, baths should be five to 10 minutes long and no hotter than 32 degrees Celsius, which is 90 degrees Fahrenheit. Pat dry the skin afterwards and liberally apply moisturizer with clean hands straight after the bath, using gentle strokes in the direction of the hair.

Dr. Helen Brough: Yes. The next step is then advising how to apply the topical anti-inflammatory treatments if the child's skin is not controlled with just moisturizers alone.

Common topical anti-inflammatories are topical steroids or topical calcineurin inhibitors. They reduce the inflammation in the skin and restore the skin barrier and they've also been shown to restore a healthy skin microbiome by reducing the *Staphylococcus aureus* in the skin.

Lynita: A lot of parents are really concerned about using topical steroids. Because they're worried that their child might develop topical steroid [00:16:00] addiction, which then leads to withdrawal. How common is topical steroid withdrawal syndrome?

Dr. Helen Brough: if topical steroids are used appropriately for short periods of time, or intermittently and only to the affected areas, then topical steroid withdrawal is very rare.

There was a systematic review published in 2021 which showed that in 34 studies with over 1,200 patients with steroid withdrawal syndrome, that over 85% had used topical steroids for more than 12 months, and all patients had been using topical steroids daily. Importantly, they also showed that only 0.3% were under three years of age.

So in children under three years of age it's virtually unheard of.

Lynita: So statistics show that out of all the people studied, 0.3% were children under three. So it's very unlikely that an infant is [00:17:00] going to develop this.

How would you know if your child was developing an addiction to topical steroids?

Dr. Helen Brough: The symptoms of topical steroid withdrawal syndrome are different to eczema because they include symptoms like burning, stinging, and redness that spreads beyond the original eczema area. What you can see is shiny or swollen skin, and this often occurs in a cycle when the redness and discomfort worsens when stopping the topical steroids abruptly.

I would always recommend consulting a healthcare professional in this situation.

Lynita: Definitely. I know with my son there was no getting on top of the flare. So, what do parents do when the eczema comes back as soon as you stop using steroids? Is there a routine that we can follow to mitigate the risk of developing topical steroid addiction?

Dr. Helen Brough: Yes, absolutely. So the first thing will be to use moisturizers regularly in the right way. And then the use of topical anti-inflammatories needs to be only to the areas of the skin that the [00:18:00] eczema is inflamed. And make sure that the lowest potency of topical steroid is being used for the

shortest possible time to calm the skin down, and then using the topical anti-inflammatory on a daily basis until the skin flare is controlled, and thereafter using it twice a week to prevent recurrence of the eczema flare. The reason for doing this is that even when the skin looks normal, there will be subclinical inflammation.

Lynita: And subclinical means it's still there, but we're just not seeing it. Right?

Dr. Helen Brough: Exactly, so it's just under the skin, and using the topical steroids twice a week prevents the eczema flare from coming back, and also provides gaps in treatment for the skin to recover, and therefore not lead to topical steroid addiction,

In one UK based study, proactive steroids, reduced the frequency of eczema flares by up to 60%, and children that were using proactive topical steroids twice weekly were eight [00:19:00] times less likely to have an eczema relapse.

Lynita: So we are going to use less topical steroids on our kids if we follow this regime of getting on top of it and reducing the flares, and then continuing to use it after the visible flare is gone, just twice a week.

Dr. Helen Brough: Yes, and studies have shown by using proactive topical steroids, you actually reduce the overall amount that are used.

Lynita: Great.

Dr. Helen Brough: When I see a child that is needing to use topical steroids quite frequently. I will often recommend that they step down from the topical steroids to topical calcineurin inhibitors such as pimecrolimus or tacrolimus, especially on the face and neck. Because these anti-inflammatory creams do not have the same potential topical steroid side effects such as skin thinning.

There is now very strong safety data. For both Pimecrolimus and Tacrolimus. For example, the use of tacrolimus Protopic, 0.03% ointment over 10 years [00:20:00] in children found no increased risk of cancer. Because of this Pimecrolimus is now licensed from three months of age in some countries such as the UK and Canada.

There are also other anti-inflammatory creams coming onto the market such as phosphodiesterase four inhibitors and topical JAK inhibitors but they are not widely available.

Lynita: It's good to know that there are alternatives out there. But bringing it back to what we were discussing earlier, this proactive treatment really is helping with the eczema flares, And it's potentially helping reduce food allergies as well.

Dr. Helen Brough: Yes. In fact, there was a study in Japan which showed that proactive topical steroid use was able to reduce proven egg allergy in children with mild to moderate eczema. And children that had uncontrolled eczema had significantly higher food allergies for each month that the proper management of eczema was delayed using proactive topical steroids.

Lynita: So the [00:21:00] longer we have flaring skin, the more chance that we might have a food allergy as well. Where can parents find more information about this proactive treatment?

Dr. Helen Brough: I recommend a free online eczema education program, which is highly interactive called [eczema care online.org.uk](http://eczema.careonline.org.uk).

This is a non-industry funded, free online resource with no adverts and it is free from any commercial influence. There are videos and lots of top tips from other people living with eczema.

In people who had access to the website there was a significant improvement in eczema compared to people who were just having their standard usual healthcare.

Lynita: Thank you.

Looking forward, what do you think we still need to learn in this area?

Dr. Helen Brough: There's lots of exciting research that's ongoing in this field spanning from the prevention of eczema. To effective management of eczema and prevention of food allergy.

For example, The PEBBLES study is a randomized [00:22:00] controlled trial using a tri lipid cream in children before the onset of eczema to assess whether this can prevent eczema and food allergy.

There are several microbiome targeted therapies. For example, dietary diversity has been shown to prevent eczema and all forms of allergy with particular focus on vegetables in the pregnant mother's diet, and yogurt, which is a fermented food, which provides fiber and dietary factors for good bacteria in the gut.

There was also a recently published study which looked at the benefits of exclusive colostrum feeding in the first few days of life for the baby.

Then there is work around trying to mitigate the effects of exposure to oral antibiotics around the time of birth.

And then there is a study which is now looking at whether using water softeners in hard water areas can be used to prevent the development of eczema.

Lynita: Fantastic. [00:23:00] We'll definitely keep an eye out for the research. So to sum up for our families, can we review the key points?

Dr. Helen Brough: There are several do's and don'ts, which I advise all of the families I see in my clinic when it comes to managing your child's eczema. Ensure that they're having a daily bath with the use of cream wash, no bubble bath, no bath oils, in tepid water for no longer than 10 minutes.

Using a moisturizer, which is fragrance-free, unscented and safe for the skin without irritants or vegetable oils. Using gentle downward strokes and sufficient quantity of moisturizer.

Washing hands before applying creams, not using a sanitizer instead of washing your hands as well as making sure no hands go inside pots or tubs of ointment.

Judicious use of topical anti-inflammatory creams is important, whether that be topical steroids, topical calcineurin inhibitors, or other [00:24:00] creams or ointments. For moderate eczema, start immediately with proactive topical steroids or topical calcineurin inhibitors, which means using it daily to calm down the skin, and then twice weekly for up to 16 weeks to prevent recurrence.

We hope to publish the results from the stopping eczema and allergy trial so that we can provide clear evidence-based guidelines on how managing eczema can prevent food sensitization and allergy within the next three years.

Lynita: That's a great summary. Thank you, Dr. Brough, for helping explain the basics of skincare based on our latest research. I look forward to learning more about proactive skincare as the research is published. Thanks so much.

Dr. Helen Brough: Thank you so much for inviting me onto this podcast. It's been great to talk to you about some practical tips to help parents get control and keep control of their child's eczema.

Lynita: In the second half of this podcast, we are discussing how to choose the best [00:25:00] moisturizer for Eczema Management. Why? Well, a study from 2017 of the most popular moisturizers found that only 12% were free from allergens, and 45% of ‘fragrance free’ moisturizers contained a fragrance derivative. So to unpack the benefits and potential pitfalls of choosing the right moisturizer, we’re joined by Dr. Amber Reck Atwater.

Doctor Atwater is a clinical associate professor of dermatology at George Washington University and owns Distinctive Dermatology in Vienna, Virginia. She's a nationally recognized leader in allergic contact dermatitis and patch testing, and is past president of the American Contact Dermatitis Society. She has extensive clinical experience in treating atopic dermatitis and allergic contact dermatitis.

Dr. Atwater, welcome to the podcast.

Dr. Atwater: Thank you so much. I'm excited to be here.

Lynita: Your talk at the [00:26:00] American Academy of Allergy Asthma and Immunology Conference caught the attention of our executive director Korey Capozza earlier this year. Can you tell us a little of what you talked about?

Dr. Atwater: Yeah, sure. So my talk was about patients who have both allergic contact dermatitis and atopic dermatitis or eczema. Historically we believed that patients shouldn't be able to have both allergic contact dermatitis and eczema at the same time because they're driven by, we actually thought, two very different parts of the immune system. But what we found, over time, is that there's a lot more overlap in the portions of the immune system that are responsible for these two skin conditions and maybe they can happen at the same time.

We know patients with eczema have skin barrier dysfunction, which means that maybe some things that wouldn't normally easily go through that skin layer can. And because they [00:27:00] regularly apply moisturizers, emollient, and medications to their skin that might increase their risk.

Lynita: Sure.

Dr. Atwater: Nothing that we apply has nothing in it. Right? Everything we apply has something in it, and some chemicals are more common problems for patients with eczema. It's important to keep in mind that nothing is completely hypoallergenic or allergen free, even if it says that on the front of the product.

Lynita: Can we talk about some of those things that might be an issue?

Dr. Atwater: The things that I really look for, for patients with eczema, are fragrance free. And then a preservative that has a low allergenic potential, and possibly also avoid lanolin. So all of those categories can be difficult.

Fragrance free does not always mean fragrance free. It's not a legal definition, right? [00:28:00] Unscented is often not correct. But the only way to really know for sure is to read the label. And so when you look at the back and the list of the ingredients, you look for the word fragrance.

But then it gets so much more complicated for us because there's a bunch of other fragrance chemical names that might be on the label that we might not know.

I might be careful with products that say plant-based. There are some plants that are clearly fragrance, like if it says rose, that is a fragrance.

I can tell you that. Even for children's products, so many of them contain fragrance, and that's because we as a society believe that children should smell a certain way, especially babies. And that's a nice baby smell. That's fragrance, which we want to avoid for our eczema patients.

Talking about preservative, there are a couple that are more allergenic for eczema [00:29:00] patients. One of them being methylisothiazolinone, which is usually written that way on the label. And the whole class of formaldehyde releasing preservatives, one of which is Quaternium-15. Those are a few we like to avoid. Sure, preservative free is always great on the label, but nothing will survive forever on the shelf without a preservative. And so even if the label says preservative free, there's likely something in there keeping it good even if it's not a traditional preservative.

Lynita: It is a minefield for parents.

Dr. Atwater: I recommend, for parents, choose products with a low number of ingredients. If you see 25 chemical names on the back of that product, that might not be the best choice for a patient with atopic dermatitis.

Lynita: That's a real tip and a bit of a short cut for our parents. Look for low list of ingredients, low list of plant [00:30:00] products.

Dr. Atwater: Yeah.

I'll usually recommend a cream or an ointment because creams and ointments are thicker, and will be more moisturizing than, for example, a lotion. You will find that ointments usually have fewer ingredients than creams do. Okay? Because ointments don't usually need as many preservatives to keep it good on the shelf.

Lynita: Is there anywhere parents can go to find a list on the internet?

Dr. Atwater: Yeah, there is a website called Skin Safe that has a list of what they call the Skin Safe 100. I cannot completely 100% endorse it because I don't know their programming, but for the most part, it looks pretty good. And you can sort by product and see moisturizers in this case that you could potentially use for yourself or for your children.

Lynita: Thank you. I'll share the link with this podcast.

So if we come back to allergic contact [00:31:00] dermatitis, if a child has eczema, they probably have a barrier defect and therefore other things that we apply to their skin are more likely to become an allergic contact dermatitis, right?

Dr. Atwater: Well, chemicals that could cause an allergic contact dermatitis may more easily affect those patients because of their barrier defect. And not every eczema patient has a barrier defect, but many do.

Lynita: And we could be inadvertently causing a allergic contact dermatitis by applying variety of things to their skin.

Dr. Atwater: We may be increasing their risk. Of developing it. Yes.

Lynita: Right. There's other ingredients that come up: propylene glycol?

Dr. Atwater: Yeah, propylene glycol is an allergy that some people have. It didn't come up as a common allergy specific to eczema, but it is a common allergen. Not only can it be in personal care products like a moisturizer, [00:32:00] but it could also be used in a medication that someone has prescribed to you. There are a number of atopic dermatitis approved topicals, that do

contain propylene glycol. So it is something to think about if you are allergic to it.

Lynita: How would a parent go about figuring out that their child has an allergic contact dermatitis to something like propylene glycol, or any of the other contact allergens we've talked about, because their child's skin is already red and inflamed. And how do we know?

Dr. Atwater: So, the things that we would think about is a change in the eczema.

- If your child has had stable eczema and then at teenage years something changes, that's a sign that they could have a new allergy.
- If they have a change in the locations where they have their eczema, so all of a sudden they have it on their hands and they've never had it there before, or a distribution that's more consistent with allergy. So hands, face and eyelids are commonly allergy. Around the mouth, around [00:33:00] the eyes.
- If the eczema spots are much more severe than they used to be, so they used to be very mild and now they're bright red and weeping all the time.
- If we see that a child is having more flares of their eczema than they used to.
- And then if they're not responding to treatment.

Those are all reasons that you should consider that your child might have a new diagnosis of allergic contact dermatitis. Because, believe it or not, the last one I mentioned was: No response or change in response to therapy. Well, maybe it's because whatever you're applying is kind of helping, but you're allergic to it at the same time.

And so then if you get to that point, you can think about having your child get some patch testing to look to see if they're allergic to something that's being applied to their skin.

Lynita: That's really helpful. Thank you. And another question, just on that note, when is it likely in a child's age bracket that [00:34:00] they're going to develop allergic contact dermatitis? Is it rarer in younger infants?

Dr. Atwater: Well, I would say that we used to think it was pretty rare in children, but there's been several research publications written in the last 10 to 15 years showing that it's not as rare as we think it is, so there's not a certain age that's a higher risk. And you can develop allergy at any time. And so if you have

a child that has had any of those changes occur, that could be a sign of allergy, really at any age.

Lynita: So it is a good reason to be really careful about the moisturizers we're choosing to put on our child's skin. Tell us about where the research field is going at the moment and what we really need work on.

Dr. Atwater: So I'm gonna tell you a little story. 10 or more years ago, this very talented atopic dermatitis expert said to me, Hey, I wanna ask you this question. I'm thinking about putting [00:35:00] moisturizer on kids early in their lives to try to prevent eczema. What do you think? And I was like, you're insane. Why would you put products all over kids' skin when they're little, they're all gonna get allergy because that is where my brain focuses all the time.

What I wanna share with you is that same person, Dr. Eric Simpson, just published a study that he did, and this is not the first study he's done on this topic, but he looked at kids who were infants who were not at risk for eczema, and asked them to apply a moisturizer essentially every day for two years.

So they took a group they applied the moisturizer to, and a group that they did not apply the moisturizer to. And they watched those kids for two years and they just published that these kids, who used the moisturizer every day, had a lower risk of eczema by age two.

Lynita: . [00:36:00] Interesting.

Dr. Atwater: Those kids though also were in a home with a dog, but not a cat,

Lynita: Right.

Dr. Atwater: They let them choose between five different moisturizers that are easy for us to find in the United States. They're off the shelf. Things that we recommend. And I took some time to try to figure out which moisturizers they used, because that's always my question, right? And they used great moisturizers, like they'd be on my list. And that was just published online, says July 23rd, which I guess was yesterday. So yeah, that's what I wanna share.

Lynita: So let me just understand... The group that did apply it had lower risk. of having atopic dermatitis.

Dr. Atwater: Yes.

Lynita: I didn't know about this study by Dr. Simpson, and I include it in the links,

Dr. Atwater: So that original conversation that we had, 10 years ago, my main concern was: choose the right moisturizer. I do think it's [00:37:00] appropriate to apply products to children's and adults' skin when it's needed, but it's about choosing wisely, and when we can, choose low allergen products.

Lynita: I have to say, I'm quite curious what the products...

Dr. Atwater: Yes. Now I had to dig deep to find the names of the products in their study. And so we had five products. They included CeraVe cream, CeraVe ointment, plain petrolatum Vaseline, Cetaphil Cream, and VanaCream.

Lynita: Perfect. Dr. Atwater, this has been a really wonderful discussion. I love that we can recommend something that is going to help, and not harm, kids.

Dr. Atwater: Thank you so much. [00:38:00]