

DERMATOLOGY

insights

AMERICAN ACADEMY
AAD
1938
OF DERMATOLOGY

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

Fall 2000

Year of the Child

- Caring For Kids' Skin
- What's That Rash?

Acne Awareness

Melanoma Treatment
on the horizon

Rejuvenate
your skin

Rosacea Red Alert
questions & answers

Indoor Tanning
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insights

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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.



Children are a Priority

Childhood is a time of wonder, exploration, and accomplishment. It can also be a time of insecurity, especially if a child is dealing with disfiguring and sometimes painful skin conditions, such as birthmarks, atopic dermatitis, acne, psoriasis, fungal infections, and warts.

To ensure that children receive the best possible dermatologic care, I have recently launched the *Year of the Child* program to assist in the prevention, diagnosis, and treatment of the skin, hair and nail conditions that can be barriers to a happy, confident childhood. Since the program began, this initiative has evolved into a successful nationwide campaign teaching millions of children and their caregivers about the treatment of childhood dermatologic conditions and the importance of sun protection.

As part of the program, the American Academy of Dermatology (AAD) lent its support to the Treatment of Children's Deformities Act pending before Congress, which would ensure coverage of procedures associated with childhood deformities, disfigurements, and congenital defects, including port-wine stains.

Caring for kids' skin is our theme for this second issue of *Dermatology Insights*. You will find several articles that discuss child-related skin conditions and the key role that dermatologists play in the treatment of these disorders.

In other features, dermatologists offer tips for healthy skin, hair and nails. You'll also learn about some skin rejuvenation procedures that can give people a boost, and how dermatologists and dermatopathologists work together to help ensure the highest quality care, and to help manage your dermatologic health.

I thank you for all the positive comments we've received about the premiere issue of *Dermatology Insights*. Please continue to write us with your ideas or topics for future issues. The publication will be available in your dermatologist's office, and bring you medically reliable information, timely articles and the latest news on a wide range of dermatologic disorders.

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s with adults, skin conditions in children aren't just a health concern. They can affect many aspects of a child's life including the development of self-esteem. That's where dermatology comes in. Dermatologists diagnose and treat many skin conditions that are seen only in children or begin in childhood, such as birthmarks, eczema, warts, and a variety of genetic afflictions. Here are some common children's skin conditions, how to recognize them, and when to seek medical help.

BABIES' BIRTHMARKS

Many babies have "birthmarks" when they're born. They can be tan, brown, blue, pink, or red. While some of these spots disappear while the baby is still young, others last for awhile. The most common types are *macular stains*, *hemangiomas* and *port-wine stains*.

It is important for parents to realize that there are treatment options available for their children that can reduce the visibility of most birthmarks. And it's never too early to consult a dermatologist or dermatologic surgeon about removing birthmarks. They treat children as young as newborns.

"When a child is born with a *vascular birthmark*, it's important to try to distinguish the type, because the prognosis and intervention may differ," says Amy S. Paller, M.D., professor of pediatrics and dermatology at Northwestern University Medical School, and head of dermatology at Children's Memorial Hospital, in Chicago, Ill. In some cases, making the diagnosis requires continuing observation, since these lesions are rarely dangerous. Vascular birthmarks can be flat or raised, pink, red, or bluish discoloration.

If you notice a light red or pink birthmark on the body, it may be a macular

stain or salmon patch, a flat area of discoloration caused by an increased number of capillaries (small blood vessels). When found on the forehead or eyelids, these birthmarks are commonly called "*angel kisses*" and usually disappear by the time the child is age two. Similar birthmarks found on the neck, called "*stork bites*," remain through adulthood in about half of patients. Neither requires medical treatment.

Many parents of children with hemangiomas report that they have experienced difficult and trying times because of concern over the appearance of these vascular lesions. *Hemangiomas* may appear anywhere on the body during the first months of a child's life. There are two types of hemangiomas: superficial and deep, although hemangiomas may be mixed. A superficial hemangioma is raised and bright red because its blood vessels are close to

the surface of the skin. Deep hemangiomas are blue and are deep under the skin. Both types can grow very quickly, but in most cases grow no more than 2-3 inches in diameter. After the first year, hemangiomas will stop growing and will gradually turn white and begin to shrink, in most cases clearing up by 10 to 12 years of age.

Most hemangiomas do not require treatment, although half leave subtle to significant scarring. Treatments include corticosteroid medication (by mouth or through injection), laser treatments, surgery, and interferon. Dermatologists who prescribe corticosteroids to children must closely monitor them because of the drug's risks.

Port-wine stains — flat, pink, red or purple skin discolorations — occur in three of every 1,000 births, most commonly on the face, neck, arms and legs. Port-wine stains grow as children grow

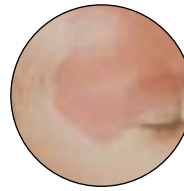
and may become thickened and darken, particularly during adulthood. Depending upon their locations, these persistent disfiguring lesions may have a psychosocial impact on affected patients. One in every four cases of port-wine stains on the face, forehead and eyelids have been linked with seizures (Sturge-Weber syndrome) and/or glaucoma, which is more common if the cheek is involved. Some people use special makeup to cover up the stains. Laser treatment can be costly, but may lead to significant fading of stains on the face and neck. A less common type of birthmark is *congenital nevus* or *birthmark mole*.

Although the risk of change of small congenital nevi to melanoma during adulthood is greater than that of normal skin, the true incidence is still unclear. Giant congenital nevi have a 6 to 8 percent lifetime risk of becoming malignant, especially during childhood. It is appropriate for a dermatologist to examine any moles, whether present at birth or not, that have an asymmetrical or irregular shape, are larger than a pencil eraser, do not have the same color throughout, or display shades of tan, brown, white, red or blue.

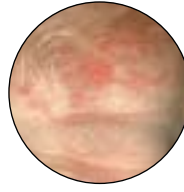
ATOPIC DERMATITIS

A growing number of children each year are affected by *atopic dermatitis*, a non-contagious and chronic skin disease. Atopic dermatitis usually makes the skin itch, ooze and crust. It is commonly characterized by intense itching, and inflamed, swollen, dry, scaling, flaking skin. Although it can emerge almost anywhere on the body, children get it on the scalp, face, neck, hands or folds of the elbows, wrists and knees. To diagnose the condition, your dermatologist will take a history and perform a skin examination.

Dermatologists say atopic dermatitis



port-wine stain



stork bite



congenital nevus



hemangioma



atopic dermatitis

“the emotional effects can weigh heavily on patients and their families.”

occurs in about 10 percent of American infants and 85 percent of those affected develop the condition before age four. Babies tend to get it on their faces and scalps, but sometimes all the skin is involved. It's probable most children will outgrow the disease — as 80 percent of patients do, but they still may have sensitive skin later on. The rest live with its frustrating, painful flare-ups their entire lives.

The skin is extremely sensitive to environmental factors, allergens and stress, and the dryness of winter. Patients can be more susceptible to respiratory problems, hay fever, asthma, and food allergies.

The emotional effects can also weigh heavily on patients and their families. "Children with atopic dermatitis are miserable — they're itching and scratching," says Lawrence Schachner, M.D., professor of dermatology at the University of Miami School of Medicine, in Miami, Florida. "There's also an inordinate amount of attention directed towards them that can cause problems in families. There may even be difficulty in bonding between parents and child — because the parents feel so helpless."

"It becomes a disease of the whole family. Often times, these kids can't sleep because of constant itching and scratching. And, if the kids can't sleep — nobody sleeps!" says Dr. Schachner. In addition, its ability to change a child's appearance can lead to lives filled with teasing by classmates and social isolation.

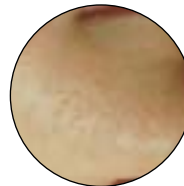
"The sleep deprivation and chronic restlessness can also affect a child's functioning in school," says Dr. Paller. "Parents must be savvy about talking to teachers about their child's atopic dermatitis, treating the child like their other children — and seeking counseling if necessary."

To help prevent any flare-ups, follow a consistent skin care regimen, including quick baths with mild soaps in lukewarm water (never hot). To minimize dryness, apply a moisturizer within a few minutes after leaving the bath, while the skin is still moist. Dermatologists may also prescribe topical corticosteroids, anti-histamines and antibiotics to treat skin infections.

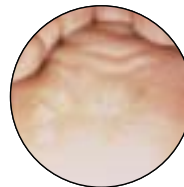
You and your dermatologist can work together to form a regular treatment schedule. To help your child and family cope successfully with atopic dermatitis, it is important to stay informed about the disorder and teach your child about the disease with accurate and age-appropriate information.

WARTS

Some children are just more likely to catch the wart virus than are others. Often far more uncomfortable than harmful, these non-cancerous growths are commonly found on fingers, the backs of the hands, bottom of the feet, or wherever skin has been broken. Warts are caused by a viral infection, the Human Papillomavirus (HPV) that attacks the top layer of the skin (or mucous membranes). Warts range from skin-colored to dark, and from rough to smooth. They include common, flat and plantar warts. Common warts



flat warts



plantar warts

are found around nails, fingers, backs of hands or where skin is broken, and are especially "common" with school children due to bites, bitten nails and hangnails.

Flat warts are smaller and smoother than other warts, but tend to grow in large numbers (20-100) at any one time. They can occur anywhere, but are most common in children on the face.

Plantar warts may appear in clusters on the soles of feet and can be painful because they get pushed back into the skin from standing or walking on them. Some warts will go away without treatment. But, because warts and their viruses are highly contagious and spread quickly, it's best to treat warts as soon as possible. Over-the-counter creams, solutions or lotions that contain salicylic acid can often do the trick. But for those stubborn warts, many visit the dermatologist for weekly "paintings" of cantharidin to remove them, or for removal through cryotherapy (freezing), electrosurgery (burning them off), or laser.

"Many over-the-counter medications will remove warts," says Dr. Schachner, "but if your child has a large number of warts or large warts, you should seek help from a skin specialist."



molluscum

Mollusca, like warts, are small, harmless growths caused by a virus. They may be transmitted among children through close contact, swimming, or shared towels. Similar in appearance to pimples, mollusca, will grow, appear waxy and pink, and develop a pit-like center. Although no treatment cures molluscum or its accompanying virus, if the lesions become visible, red and sore, they should be removed by a blistering agent, liquid nitrogen or surgery with a small instrument called a curet. Dj

Carol Levin and Patricia Murphy



diaper rash

Oh no!

Is your baby prone to diaper rash?

Another type of dermatitis primarily affecting infants between 9 and 12 months of age is diaper dermatitis or diaper rash. It is usually a reaction to irritation caused by the bacteria in feces, moisture and/or friction.

Frequent diaper changes can prevent and treat it. If a rash is present, dermatologists suggest that parents change junior's diaper at least every two hours during the day and once at night. Dermatologists advise cleaning skin only after bowel movements and applying protective ointments when a rash appears or in rash-prone babies providing a barrier between the urine and feces, and the skin.

Diaper dermatitis appears to be lessening because of better disposable diapers that deliver emollient protection to the skin. Currently under study are diapers that can deliver both emollient and zinc oxide to help protect skin.

DesOwen Lotion 0.05% (benzocaine lotion)

FOR ANESTHESIOLOGICAL USE ONLY - NOT FOR OPIUMABUSE USE

DESCRIPTION: DesOwen Lotion 0.05% (benzocaine lotion) contains 0.05% benzocaine (ethyl p-aminobenzoate) in a base of purified water, containing also, propylene glycol, stearic acid, isopropyl alcohol, methyl paraben, hydroxyethyl paraben, sodium chloride, sodium hydroxide, hydroxyethyl paraben, and water.

Directions: See the following information for use.



DesOwen has the molecular weight of 164.17. It is a white, to off-white, odorless powder which is soluble in methanol and practically insoluble in water.

Each gram of DesOwen Lotion contains 0.5 mg of benzocaine in a base of purified water, containing also, propylene glycol, stearic acid, isopropyl alcohol, methyl paraben, hydroxyethyl paraben, sodium chloride, sodium hydroxide, hydroxyethyl paraben, and water.

Each gram of DesOwen Lotion contains 0.1 mg of benzocaine in a base of purified water.

Each gram of DesOwen Lotion contains 0.5 mg of benzocaine in a base of purified water, containing also, propylene glycol, stearic acid, isopropyl alcohol, methyl paraben, hydroxyethyl paraben, sodium chloride, sodium hydroxide, hydroxyethyl paraben, and water.

CLINICAL PHARMACOLOGY: Like other topical anesthetics, benzocaine has not demonstrated significant anti-inflammatory properties. The mechanism of its local anesthetic activity at the topical site, is presumed to be similar to that of other topical anesthetics, which is thought to be the inhibition of propagation of action potentials, which is caused by the blockage of sodium channels. It is presumed that these proteins and the breakdown of protein molecules of information such as neurotransmitters and hormones by inhibiting the release of their contents prevent analgesia and anesthesia and to inhibit their membrane permeability to neurotransmitters.

Pharmacokinetics: The extent of dermal absorption of topical anesthetics is determined by many factors including the vehicle and the integrity of the epidermal barrier. In clinical studies with hydrocortisone for up to 74 hours have not been demonstrated to increase penetration, because of the barrier of hydrocortisone by 74 hours, mainly within a penetration. Topical anesthetics can be absorbed from normal intact skin. Information on the extent of absorption in the skin may increase penetration.

Studies performed with DesOwen Lotion cream, ointment and lotion have shown that benzocaine is absorbed in the skin in a manner similar to that of other topical anesthetics.

INDICATION AND USAGE: DesOwen Lotion, Ointment and Lotion are used to relieve pruritus, numbness, itching and pain of the skin and to provide analgesia of superficial lacerations.

CONTRAINDICATIONS: DesOwen Lotion, Ointment and Lotion are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

PRECAUTIONS:
General: Systemic absorption of topical anesthetics can produce toxicity (hypertension, tachycardia, CNS and respiratory) which is caused by gastrointestinal malabsorption after absorption of benzocaine. Absorption of benzocaine is increased in patients with impaired absorption of topical anesthetics who are treated.

Patients applying a topical anesthetic to a large surface area or to many sites on the body should be monitored carefully for evidence of CNS depression. The use of benzocaine should be limited to the relief of pruritus, numbness, itching and pain of the skin and to provide analgesia of superficial lacerations.

If CNS depression is noted, an attempt should be made to relieve the drug, to reduce the frequency of application, or to substitute a less potent anesthetic. Recovery of CNS activity is generally prompt and complete upon discontinuation of topical anesthetics. Intoxication, signs and symptoms of gastrointestinal malabsorption may occur requiring supportive therapy. Intoxication, signs and symptoms of gastrointestinal malabsorption may occur requiring supportive therapy. Intoxication, signs and symptoms of gastrointestinal malabsorption may occur requiring supportive therapy.

If children develop DesOwen Lotion, Ointment or Lotion should be discontinued and appropriate therapy initiated. Major contraindications with benzocaine is usually they need to obtain relief for their skin before using a local anesthetic in with and topical products are containing benzocaine. Such an observation should be combined with appropriate diagnosis and therapy.

If benzocaine is indicated for use in children, or in patients with impaired absorption of topical anesthetics, it is recommended that the use of DesOwen Lotion, Ointment, or Lotion should be discontinued and the patient should be appropriately monitored.

Information for patients: Patients using topical anesthetic should receive the following information and instructions:

1. The medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. The medication should not be used for any itching other than that for which it was prescribed.
3. The treated area should not be scratched or otherwise rubbed or scraped as it is to be rubbed when directed by the physician.
4. Patients should report to their physician any signs of local adverse reactions.

Subsidiary tests: The following tests may be helpful in monitoring patients for CNS depression:

ACTH stimulation test:
A.R. plasma cortisol test:
DesOwen has not been tested for

Cardiovascular, neurological, and impairment of function: Long-term animal studies have not been performed to evaluate the long-term potential in the effect on reproduction with the use of DesOwen Lotion, Ointment, and Lotion.

Prepregnancy, pregnancy, and lactation: DesOwen Lotion, Ointment, and Lotion have been shown to be teratogenic in laboratory animals when administered systemically at clinically low dosage levels. Some contraindications have been shown to be teratogenic after dermal application in laboratory animals. Inbred reproductive studies have not been conducted with DesOwen Lotion, Ointment, or Lotion. It is also not known whether DesOwen Lotion, Ointment, or Lotion can cross the placenta when administered to a pregnant woman or can affect reproduction capacity.

DesOwen Lotion, Ointment, and Lotion should be given to a pregnant woman only if clearly needed.
Nursing mothers: Systemically administered anesthetics appear to be secreted in milk and could appear in breast milk with significant concentrations, in most other topical anesthetics. It is not known whether topical administration of benzocaine could result in milk secretion. Discretion is advised when this question is faced with milk secretion. Discretion is advised when this question is faced with milk secretion.

DesOwen Lotion, Ointment, and Lotion should be given to a nursing woman.

Patients use: Safety and effectiveness in pediatric patients have not been established. Because of a higher rate of skin sensitivity in baby skin, patients should use as a general rule that adults at 100 mg/kg equivalent when they are treated with topical anesthetics. They are therefore also prohibited of gastrointestinal malabsorption after absorption of benzocaine which may have been reported with increasing use of topical anesthetics in infants and children.

NSAID use: Significant systemic absorption of benzocaine has been reported in children receiving topical anesthetics. Malabsorption of topical anesthetics in children include low plasma cortisol levels, and absence of response to ACTH stimulation. Malabsorption of topical anesthetics include being headache, headache, and dizziness malabsorption.

ADVERSE REACTIONS: In controlled clinical trials, the most common adverse reactions associated with the use of benzocaine are approximately 1%. These were: tingling and burning, numbness, pruritus, redness, dizziness, headache, weakness, feeling of fullness, nausea, heartburn, vomiting, and drowsiness, and skin rash 2%.

The following additional local adverse reactions have been reported infrequently with other topical anesthetics, and they may occur more frequently with the use of benzocaine during, especially with higher potency anesthetics. These reactions are listed in no approximate the following order of occurrence: headache, dizziness, weakness, hypotension, partial paralysis, weakness, skin rash, skin stinging, stinging, and itching.

OVERDOSE: Topical application DesOwen Lotion, Ointment and Lotion is usually safe. However, if used in excessive amounts, it can be absorbed in sufficient amounts to produce systemic effects. See PRECAUTIONS.

DOSE AND ADMINISTRATION: DesOwen Lotion, Ointment or Lotion should be applied to the affected area on the first two or three times daily depending on the severity of the condition. SMALL CHILDREN WILL BEHAVE AS ADULTS. As with other topical anesthetics, benzocaine should be discontinued when control is obtained. If an improvement is seen within 7 weeks, continuation of therapy may be necessary.

DesOwen Lotion, Ointment and Lotion should not be used with occlusive dressings.

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Storage Conditions: Store between 2° and 8°C (36° and 66°F).

CAUTION: Federal law prohibits dispensing without a prescription.

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DesOwen, March 1995.

what's that rash?

Six-year-old Katy had sores on her hands and face that were itchy and painful. When they spread, her parents became concerned and called a dermatologist, who suggested Katy may have been exposed to impetigo.

Impetigo often begins at the site of a minor skin injury such as scratches or bites. Impetigo is a skin infection caused by bacteria. Signs include blister-like lesions with their yellow itchy crust that forms from dried pus. Lesions should be cleaned with soap and water and covered with warm compresses to ease the itch. When necessary, dermatologists prescribe oral or topical antibiotics. It's best to keep affected children away from school and from close contact with others until crusts have dried out.

During the infectious stage, change and launder clothes and linens daily.



impetigo

Shortly after ten-year-old Alex used a friend's comb, he developed tinea capitis or "ringworm of the scalp," an itchy, scaly rash of the scalp in children.

Tinea capitis is caused by a fungus that prefers hair follicles. The affected hairs can harbor the fungus for a year or more.

Tinea capitis is contagious and can last for years. It is spread by combs, brushes, caps, pillowcases, and cloth chairs. It's best treated with oral anti-fungal medications and by regular hair cleansing with a special shampoo.

Many children also get scabies, a rash caused by a tiny mite that burrows into the skin. The rash is usually found on the wrists, elbows, buttocks, or between the fingers. In infants, the rash may appear on the head, neck, or body.

Mites can survive only briefly if not on the human body, so scabies spreads from direct contact with someone else or by sharing an infected person's clothes. Over-the-counter insecticide

lotions and prescription creams are used to kill the mites. A child with scabies should stay away from childcare or school for one day after finishing treatment. Wash and dry all clothes, bedding, and towels in hot water.

Be sure to consult your dermatologist for an examination and advice about any itch or lesion that will not go away or concerns you.



tinea capitis
'ringworm'



scabies

More information on children's skin conditions can be found through the following associations or support groups:

American Academy of Dermatology: 1-888-462-DERM (3376); www.aad.org

The National Eczema Association for Science & Education (N.E.A.S.E.): 503-228-4430; www.eczema-assn.org

Hemangioma & Vascular Birthmark Foundation: 518-782-9637; www.birthmark.org

Society for Pediatric Dermatology: 773-583-9780; www.spdnet.org

National Congenital Port-Wine Stain Foundation: 516-867-5137

A WIN-WIN *for* KIDS' SKIN!



Let's face it. We can't afford to take our child's skin for granted or dismiss skin care regimens until a problem is discovered. For a win-win situation for young skin, a skin routine with preventive care is key. Here are a few tips for a lifetime of happy, healthy skin.

Clean it. Great skin starts with good hygiene and good protection, says Dr. Paller. "Start with a regimen of mild soaps or cleansers. Use moisturizer when the skin appears dry," says Dr. Paller, "and of course, use sun protection." Sunscreen can be used on infants as young as six months, according to the Food and Drug Administration (FDA). However, since infants are not mobile, covering them and

keeping them in the shade should suffice.

Treat it. If you suspect a skin problem, see a dermatologist who can help you start a skin treatment regimen to head off more serious problems. "While you can't prevent many skin conditions, start early with good skin care and treatment to prevent unnecessary problems or complications." "Certainly you can help prevent some skin conditions, like skin cancer and premature aging of the skin," says Dr. Schachner.

"It's as easy as 1-2-3."

1 Apply sunscreen (SPF 15 or higher) generously or like you would moisturizer and remember to cover the nose, lips, ears and shoulders.

2 Cover up children when outdoors with cool, cotton clothing, hats with a four-inch brim, and sunglasses.

3 Seek shade! If your shadow is shorter than you, you are likely to burn. Remember, skin can burn in less than 15 minutes!



Beware of Winter!

Winter weather can be harsh on children's skin. During winter, your child's skin can become dry and rough. Wind, sun and low humidity also can cause red cheeks. Before you child goes outside, use a lotion with sunscreen to help lock in moisture and keep skin soft.



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ROCHESTER, MN 55901-6298

ACNE awareness



Sixteen-year-old Sarah says she breaks out badly every few weeks. "I don't go out much when this happens because I feel gross and embarrassed about how I look. I cancel dates, avoid after-school activities, and when it's really bad, I will not go to school. My parents keep telling me this is part of being a teenager. Whenever they say this, I want to scream because that doesn't make it any better. I feel like it will last forever."

Sarah is not alone. She and many of her teenage friends have acne, the most common skin disorder in the U.S. Acne affects about 17 million Americans, and can attack self-esteem as well as the skin.

Acne is a skin disease that develops when cells block the opening of pores and clog hair follicles with oil, dead cells or bacteria. Acne appears on the skin in the form of whiteheads, which form when the blocked pore is not visible, and blackheads, which form when the blocked pore is visible. The pimples most commonly appear on the face, back and chest.

More severe cases of acne are characterized by inflammatory acne lesions that can be papules, which are pinkish-red and dome-shaped; pustules, which have superficial accumulations of pus; and nodules, which are deep inflammations that affect more than one oil gland. Nodules are often tender and may hurt because they extend deep into the skin, close to the nerve endings.

For most patients, acne is just part of the body's normal changes. Genetics seem to play a role. "Basically, acne is a part of growing up," says Zoe D. Draelos, M.D., clinical associate professor of dermatology at Wake Forest University, High Point, N.C. "It's related to the point in time when the hormones turn on in the body and oil production begins. And, when oil production begins, then you have all the raw materials for acne."

Because acne is most likely to happen during hormonal changes, teenagers, women near menopause and women who have started or stopped taking birth control pills are most susceptible. However, there are actually different types of acne that can strike people of all ages, from babies who are affected by the estrogen level of their mothers, to senior citizens who can also break out with pimples. But you don't have to be very young, adolescent or even very old to get those unsightly bumps.

"You can get acne at any age," says Boni E. Elewski, M.D., professor of dermatology at the University of Alabama in Birmingham. "It's a myth that (acne) is a teenage disease."

Many women struggle to control their acne through the teenage years and adulthood. Dr. Elewski says that a large percentage of her practice consists of women older than 30 who have acne. Often, she says these women mistake the acne for a rash. When Dr. Elewski gives her patients this diagnosis, she says a common response is, "I'm 38. How could I have acne?"

Acne does affect more than 85 percent of all teenagers, but it also occurs in 60 to 70 percent of all adults. While for teens acne is a result of hormones that cause increased production of oil, Dr. Elewski says for many of her older female patients the cause is often stress, makeup, or hair products that may contain heavy oils and chemicals that can promote acne. Women are sometimes afraid of drying out their skin so they don't cleanse their face properly. Oil and dirt build up, clog pores and result in acne.

Dr. Elewski points out there are many conditions that mimic acne, such as rosacea, an adult disease that looks like acne but is treated differently. Folliculitis, an infection of the hair follicle that causes pimples, also resembles acne but is caused by bacteria that are commonly picked up from unclean water. "A dermatologist could differentiate all these and know the proper treatment," she says.

Q

What causes acne?

A

Rising hormone levels during adolescence or puberty cause the oil or sebaceous glands of the skin to produce more sebum or oil. Sebaceous glands are found with a hair shaft in a unit called a sebaceous follicle. During puberty, the skin cells that line the follicle begin to shed more rapidly. In acne-prone people, cells shed and stick together more so than in people whom do not develop acne. The mixture of oil and cells also helps bacteria in the follicles grow. These bacteria make chemicals that can cause the wall of the follicle to break. Then sebum, bacteria and shed skin cells spill into the skin causing redness, swelling and pus — a pimple.

Q

Can eating chocolate or certain foods cause breakouts?

A

Not usually, unless you have particular food sensitivity. Some people claim that chocolate or greasy foods promotes acne, but research hasn't yet confirmed that any food is suspect. Still, a balanced diet is always important. If you notice breakouts after you eat a specific food, stop eating it and see what happens.



Q

How do you know when it's time to see a specialist for acne?

A

It's a good idea to see a dermatologist for treatment when acne first appears. Luckily, dermatologists have many medications and procedures that are proven effective to greatly reduce the number and severity of acne lesions. While some patients try to conceal acne with a tan, the sun's harmful rays age the skin and can cause skin cancer, wrinkles and other skin aging.

Through consistent treatment, acne can be controlled. Most acne treatments require prolonged care that should be carefully monitored by a dermatologist. "See a dermatologist when you first see the earliest signs of acne," says Dr. Draelos, "because if you treat acne early before it gets bad, one, it's easier to treat and two, many or most cases can be improved."

Different kinds of skin need different types of care. What works for one individual may not necessarily help another. For example, those with dry skin want to avoid drying it out further, since it may more easily become red and irritated. Combination skin that is usually oily in the T-zone (forehead, nose, and chin), and dry elsewhere, needs to be treated differently. The most effective treatment depends on whether the acne is mild, moderate or severe.

MILD TO MODERATE CASES

Mild cases of acne generally clear up in 4-6 weeks, and virtually all cases of acne respond to appropriate treatment. Your dermatologist may prescribe topical treatments, such as a retinoid and benzoyl peroxide, for mild and moderate cases involving whiteheads and blackheads. Dr. Elewski compares retinoids to drain cleaners that unclog sinks. "It opens your pores, just like Drano® opens your sink. And it keeps those pores from plugging up. The plug in the pore is the beginning of all acne lesions," she explains. Retinoids can leave the skin more sun-sensitive, and overuse can cause irritation. Benzoyl peroxide, an ingredient in both over-the-counter and prescription medications, kills bacteria, decreases oil, and peels and dries acne.

MORE DIFFICULT CASES

For more difficult cases, topical and oral antibiotics, such as clindamycin and tetracycline, kill bacteria and may also reduce inflammation.

SEVERE CASES

Isotretinoin, an oral medication, is prescribed for severe cases of acne, involving nodules. It contains synthetic vitamin A derivative that lowers oil production.

Dr. Elewski says she has received letters from patients who used the medication nearly 20 years ago and are still thankful for the impact it has had on their abilities to look people in the eye and not feel self-conscious about their skin. "Since it (Isotretinoin) came out, the medication has made a difference in the lives of millions of people globally who will testify to how it's dramatically improved their life."

Side effects can include dry skin and dry lips. The medication has strict FDA guidelines and is not for everyone, such as women who are pregnant, think they might be, or are intending to be.

SCARRING

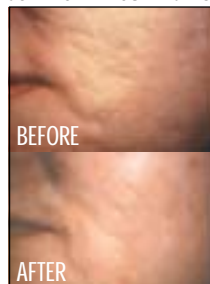
Early treatment is the most effective way to help prevent lifetime scarring. Most scarring can be surgically improved. *Dermabrasion* is a common dermatologic treatment for severe acne that has left deep scars. For this technique, dermatologists use a rotating wire brush or spinning diamond instrument to remove the top layers of the skin and level out irregular scars. A new layer of fresh skin offers a smoother appearance.

LASER TREATMENT

Two recent types of laser treatment are the Erbium: YAG and the CO₂. The Erbium: YAG emits light through short bursts of energy that is absorbed by the water in the skin. This laser treatment actually changes the shape of irregular scars. The CO₂ laser produces more heat than the Erbium: YAG so the bursts of energy penetrate deeper into the skin and tighten the skin's collagen fibers. This tightening causes the depressed scars to elevate and provide a more normal look.

"The laser never returns the skin to its normal appearance. That's why acne treatment, especially early on, is so important," Dr. Draelos says. Surgical treatment for acne scars also includes soft tissue fillers such as collagen and collagen producing materials, and direct excision of pits and pores. **Dj**

CO₂ LASER RESURFACING



courtesy of Bruce E. Katz, M.D.

Karen Wagner

impact of acne

The physical and emotional aspects of acne can be devastating. According to a survey by the American Academy of Dermatology, acne makes one out of 10 teens like themselves less and is the worst thing about adolescence. Studies report that the presence of acne can negatively impact social and academic performance and affect employment prospects because patients may feel self-conscious during interviews, for example.

"Treating acne is important because the times when you tend to get acne are times of big, social changes in a person's life," Dr. Draelos comments. "Treatment is important not only to keep nice-looking skin throughout life, but also to have a feeling of personal well-being."

teen acne

DO

- Wash with mild cleanser that is pH balanced for facial skin.
- Use cosmetics that are labeled "noncomedogenic," or do not tend to cause acne.
- Always wear sunscreen with an SPF of 15 or higher; choose those that are oil free.
- Eat a healthy, well-balanced diet with plenty of fruits and vegetables and drink plenty of water.
- See a dermatologist to keep acne under control.

DON'T

- Use cosmetics that aggravate acne.
- Use alcohol-based cleansers.
- Squeeze a lesion; this may force infected material deeper into the skin causing additional inflammation and scarring.

MYTHS

- Eating greasy foods causes acne.
- Washing your face 10 times a day will get rid of acne.
- The sun helps acne.

FACTS

- A healthy diet is important for providing the raw materials for healthy skin, but greasy foods, like hamburgers and fries, do not cause acne — unless you rub them on your face.
- A proper cleaning regimen — such as cleansing your face with a mild soap twice a day — is important, but acne can't be washed away.
- The sun may actually make acne worse by damaging follicular walls and clogging pores, resulting in acne that may not surface for 3-4 weeks after sun exposure.



other acne resources

Online

- American Academy of Dermatology - www.aad.org
- AcneNet - www.skincarephysicians.com/acnet
- In Your Face! Acne and Its Treatment - <http://kidshealth.org/teen/body/mind/body/acne.html>
- American Society for Dermatologic Surgery - www.asds-net.org



For a free educational pamphlet on Acne, available in both English and Spanish call the American Academy of Dermatology at: 1-888-426-DERM or send a self-addressed, stamped envelope to AAD, P.O. Box 4014, Schaumburg, IL 60165-4054.

Monodox® Doxycycline Monohydrate Capsules



BRIEF SUMMARY: See package insert for full prescribing information.

INDICATIONS AND USAGE: Doxycycline is indicated for the treatment of the following infections: Rocky mountain spotted fever, typhus fever and the typhus group, Q fever, rickettsiosis, and tick fever caused by Rickettsia; respiratory tract infections caused by Mycoplasma pneumoniae; lymphogranuloma venereum caused by Chlamydia trachomatis; Pott's disease (erythema) caused by Chlamydia psittaci; Tachyzoites caused by Chlamydia trachomatis; the infectious agent is not always eliminated as judged by immunofluorescence; inclusion body conjunctivitis caused by Chlamydia trachomatis; Uncomplicated urethral, endocervical or urethral infections in adults caused by Chlamydia trachomatis; Nongonococcal urethritis caused by Ureaplasma urealyticum; Respiratory tract infection due to Brucella abortus; Doxycycline is also indicated for the treatment of infections caused by the following gram-negative microorganisms: Chancroid caused by Haemophilus ducreyi; Pilon's disease (tenosynovitis) formerly Pasteurella penicillata; Tularemia due to Francisella tularensis (formerly Pasteurella tularensis); Chlamydia caused by Vibrio cholerae (formerly Vibrio cholerae); Campylobacter fetus infections caused by Campylobacter fetus (formerly Vibrio fetus); Brucellosis due to Brucella species (in conjunction with streptomycin); Bartonellosis due to Bartonella bacilliformis; Granuloma inguinale caused by Calymmatobacterium granulomatis; Because many strains of the following groups of microorganisms have been shown to be resistant to doxycycline, culture and susceptibility testing are recommended. Doxycycline is indicated for treatment of infections caused by the following gram-negative microorganisms, when bacteriologic testing indicates appropriate susceptibility to the drug: Escherichia coli, Enterobacter aerogenes (formerly Aerobacter aerogenes), Shigella species, Acinetobacter species (formerly Brevibacterium and Henicobacter species); Respiratory tract infections caused by Haemophilus influenzae; Respiratory tract and urinary tract infections caused by Klebsiella species; Doxycycline is indicated for treatment of infections caused by the following gram-positive microorganisms when bacteriologic testing indicates appropriate susceptibility to the drug: Upper respiratory infections caused by Streptococcus pneumoniae (formerly Diplococcus pneumoniae); Skin and skin structure infections caused by Staphylococcus aureus; Doxycycline is not the drug of choice in the treatment of any type of staphylococcal infections. When penicillin is contraindicated, doxycycline is an alternative drug in the treatment of the following infections: Uncomplicated gonorrhea caused by Neisseria gonorrhoeae; Syphilis caused by Treponema pallidum; Yaws caused by Treponema pertenax; Listeriosis due to Listeria monocytogenes; Arthritis due to Bacillus anthracis; Weyers' infection caused by Pasteurella haemolytica; Actinomycetosis caused by Actinomyces israelii; Infections caused by Clostridium species. In acute intestinal amebiasis, doxycycline may be a useful adjunct to amebicides. In severe cases, doxycycline may be useful adjunctive therapy.

CONTRAINDICATIONS: This drug is contraindicated in persons who have shown hypersensitivity to any of the tetracyclines.

WARNINGS: THE USE OF DRUGS OF THE TETRACYCLINE CLASS DURING TOOTH DEVELOPMENT (LAST HALF OF PREGNANCY, INFANCY, AND CHILDHOOD TO THE AGE OF 8 YEARS) MAY CAUSE PERMANENT DISCOLORATION OF THE TEETH (YELLOW-GRAY-BROWN). This adverse reaction is more common during long-term use of the drugs but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. TETRACYCLINE DRUGS, THEREFORE, SHOULD NOT BE USED IN THIS AGE GROUP UNLESS OTHER DRUGS ARE NOT LIKELY TO BE EFFECTIVE OR ARE CONTRAINDICATED. All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in the bone growth rate has been observed in infants given oral tetracycline in doses of 25 mg/kg every six hours. This reaction was shown to be reversible when the drug was discontinued. Results of animal studies indicate that tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Evidence of embryo toxicity has been noted in animals treated early in pregnancy. If any tetracycline is used during pregnancy or if the patient becomes pregnant while taking these drugs, the patient should be apprised of the potential hazard to the fetus. The antibiotic action of the tetracyclines may cause an increase in BUN. Studies to date indicate that this does not occur with the use of doxycycline in patients with impaired renal function. Photosensitivity manifested by an exaggerated sunburn reaction has been observed in some individuals using tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be advised that the reaction can occur with tetracycline drugs, and treatment should be discontinued at the first evidence of skin erythema.

PRECAUTIONS: General: As with other antibiotic preparations, use of this drug may result in overgrowth of non-susceptible organisms, including fungi. If superinfection occurs, the antibiotic should be discontinued and appropriate therapy instituted. Drying, fissuring in infants and benign retroviral hyperkeratosis in adults have been reported in individuals receiving tetracyclines. These conditions disappeared when the drug was discontinued. Incision and drainage or other surgical procedures should be performed in conjunction with antibiotic therapy when indicated. **Laboratory tests:** In several diseases when consistent syphilis is suspected, a dark-field examination should be done before treatment is started and the blood serology repeated monthly for at least four months. In long-term therapy, periodic laboratory evaluations of organ systems, including hematopoietic, renal, and hepatic studies should be performed. **Drug interactions:** Because tetracycline has been shown to depress plasma prothrombin activity, patients who are on anticoagulant therapy may require decreased adjustment of their anticoagulant dosage. Since bacteriostatic drugs may interfere with bactericidal action of penicillin, it is advisable to avoid giving tetracyclines in conjunction with penicillin. Absorption of tetracycline is impaired by antacids containing aluminum, calcium of magnesium, and iron-containing preparations, Bifidobacterium, colismycin, and chelation decrease the full effect of doxycycline. The concomitant use of tetracycline and methoxyflurane has been reported to result in fatal renal toxicity. Concurrent use of tetracycline may render oral contraceptives less effective. **Drug/Laboratory test Interactions:** False elevations of urinary catecholamine levels may occur due to interference with the fluorescence test. **Cardiomyopathy, osteogenesis, impairment of fertility:** Long-term studies in animals to evaluate the carcinogenic potential of doxycycline have not been conducted. However, there has been evidence of cardiomyopathy in rats in studies with related antibiotics, oxytetracycline (axonal and pituitary tumors) and minocycline (thyroid tumors). Likewise, although osteogenesis studies of doxycyclines have not been conducted, positive results in *in vitro* mammalian cell assays have been reported for related antibiotics (tetracycline, oxytetracycline). Doxycycline administered orally at dosage levels as high as 250 mg/kg/day had no apparent effect on the fertility of female rats. Effect on male fertility has not been studied. **Pregnancy:** Pregnancy Category D. (See **WARNINGS**). **Labor and Delivery:** The effect of tetracyclines on labor and delivery is unknown. **Nursing mothers:** Tetracyclines are present in the milk of lactating women who are taking a drug in this class. Because of the potential for serious adverse reactions in nursing infants from the tetracyclines, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. (See **WARNINGS**). **Pediatric use:** See **WARNINGS**.

ADVERSE REACTIONS: Due to oral doxycycline's virtually complete absorption, side effects in the lower bowel, particularly diarrhea, have been infrequent. The following adverse reactions have been observed in patients receiving tetracycline. **Gastrointestinal:** Anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, and inflammatory lesions (with pseudomembranous colitis) in the sigmoid region. These reactions have been caused by both the oral and parenteral administration of tetracyclines. Rare instances of esophagitis and esophageal ulcerations have been reported in patients receiving capsule and tablet forms of drugs in the tetracycline class. Most of these patients took medications immediately before going to bed. **Skin:** Maculopapular and erythematous rashes. Erythematous dermatitis has been reported but is uncommon. Photosensitivity is discussed above. (See **WARNINGS**). **Renal toxicity:** Rise in BUN has been reported and is apparently dose related. (See **WARNINGS**). **Hypersensitivity reactions:** Urticaria, angioneurotic edema, anaphylaxis, drug-induced purpura, pemphigus, and exacerbation of systemic lupus erythematosus. **Blood:** Hemolytic anemia, thrombocytopenia, neutropenia, and eosinophilia have been reported with tetracyclines. **Other:** Blurring of vision in infants and retroviral hyperkeratosis in adults. (See **PRECAUTIONS**-General). When given over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of the thyroid gland. No abnormalities of thyroid function are known to occur.

HOW SUPPLIED: MONODOX® (oral) is available in bottles of 100 capsules, NDC 38115-280(8); MONODOX® (oral) is available in bottles of 50 capsules, NDC 38115-258(4) and in bottles of 250 capsules, NDC 38115-258(7). **STORE AT CONTROLLED ROOM TEMPERATURE 15°-30° C (59°-86° F). PROTECT FROM LIGHT.**

Caution: Federal law prohibits dispensing without prescription.

Manufactured for Oclassen Dermatologics, A Division of Watson Pharmaceuticals, Inc., Corona, CA 91726 by Watson Pharmaceuticals, Inc.

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INDOOR TANNING casts a year-round shadow

Jackie and her college friends routinely visit tanning salons for a pre-tan before heading off to vacation in a warm climate during winter break. Sue, a mother of two, does the same, as do many other people she knows. Most likely, none of them picture themselves as potential candidates for skin cancer. While traditional sunbathing is a seasonal health hazard in most parts of the United States, indoor tanning casts a year-round shadow.

If you're one of those people planning to achieve a tan from a tanning salon and think you are not at danger for skin cancer, think again. The truth is that standing in front of a sunlamp, stepping into a tanning booth, or stretching out on a tanning bed significantly raises the risk of health problems ranging from wrinkles, visual abnormalities, and immune system disorders to malignant melanoma, the deadliest form of skin cancer. In fact, even short-term indoor tanning may produce redness, itching and dry skin.

Despite these facts, the quest for a tan happens millions of times each day in local tanning salons across the country. During the next 12 months, 30 million Americans will visit more than 49,000 salons featuring sunlamps, tanning booths, and tanning beds that give off ultraviolet rays two or three times stronger than natural sunlight. About seven of every 10 tanning parlor patrons are women or teenage girls between the ages of 16 and 60.

About half as many men and adolescent boys are likely to visit tanning salons as females the same age. Many people who patronize tanning parlors think they look healthier and more attractive when they are tan. Some want to avoid looking "pale" in the winter. Others attempt to pre-tan so they can emerge golden before outdoor exposure. Seeking a bronzed look, they also buy into advertising claims that promise a safe experience that won't dry, damage, or age their skin.

Forget the tanning parlors and sunlamps. According to dermatologists, they are not a safe way to tan.

Increasing more rapidly than any other

type of cancer, incidence of melanoma more than doubled among Caucasians between 1973 and 1994. More common than any non-skin cancer in adults between 25 and 29, melanoma is responsible for more than 75 percent of skin cancer deaths. The American Cancer Society estimates that 47,700 new cases of

“solar UV radiation & exposure to sunlamps & sunbeds...a known human carcinogen”

malignant melanoma will be diagnosed this year and the disease will claim 7,700 lives.

Solar UV radiation and exposure to sunlamps and sunbeds was recently listed as a "known human carcinogen" in the National Toxicology Program's 9th Report on Carcinogens 2000, U.S. Department of Health and Human Services, Public Health Service. The report cites data that indicates a causal relationship exists between exposure to solar radiation and melanoma and other skin cancers in humans, and that exposure to sunlamps or sunbeds is associated with melanoma. The report also indicates that skin cancers are observed with increasing duration of exposure, and the effects are especially pronounced in people under 30 and for those who experience sunburn.

Dermatologists say excessive and unprotected exposure to sunlight can have the same potentially disfiguring, disabling, and life-threatening consequences as indoor tanning, but artificial tanning equipment inflicts more damage in less

time. A single 15-30 minute salon session exposes the body to the same amount of harmful UV light as a day at the beach. Tanning beds, booths and sunlamps radiate both UVB rays and long wave UVA rays that penetrate the skin more deeply than sunlight, compound the toxic effects of sun exposure by thinning the skin and impairing its healing properties, and make melanoma a more likely eventuality. The clamshell-like tanning bed so popular

among salon patrons is the worst offender: Customers lie on a light, transparent, thermoplastic shield while being bombarded with UV light from above and below, doubling the skin surface exposed to the harmful rays.



A large bullous lesion on the palm and a crusted lesion on the wrist of a 35-year-old "tanning junkie" — a reaction to chronic tanning bed usage.

Such exposure aggravates some medical conditions such as lupus or diabetes. Research also finds that UVA light has short-term side effects that range from skin redness to itching to dry skin and nausea.

"Most of the tanning salon customers I see in my practice are young adults who want to

enhance their appearance and feel accepted by their peers," says Vincent DeLeo, M.D., chairman of the department of dermatology at St. Luke's/Roosevelt Hospital, New York.

“forget the tanning parlors and sunlamps! they are not a safe way to tan.”

turning to self-tanners

tanning

"Most of these people are not very different from anybody else. They tend not to realize how serious a risk they are taking."

Shelley Sekula Rodriguez, M.D., clinical assistant professor, Baylor College of Medicine in Houston, believes that the people she describes as **hard-core tanners** have a **psychological addiction to the tanning process.** "Tanning parlors seem to provide some people with a sense of well-being," she says. "It's almost as if they are medicating themselves in some way."

Both dermatologists have treated

patients who are unwilling or unable to break the tanning habit even after developing cancerous or pre-cancerous skin conditions, such as a nurse who still visits a tanning parlor two or three times a week but agreed to wear gloves after developing a painful and unsightly rash on her hands. **Also evidence of this habit is a woman who was reluctant to sell her lucrative tanning salon even after developing two melanomas in early middle age; and a cardiologist's wife who continues to visit her favorite tanning parlor even after developing multiple pre-cancerous lesions.**

If adults who understand the danger inherent in indoor tanning can't or won't throw in the towel, younger, more impressionable people are even more susceptible to the influence of a society that prizes sun-kissed skin.

"The skin and the psyche are more vulnerable at younger ages," Dr. Sekula says, "and no one under 18 should be permitted inside a tanning parlor." Still, an association for the tanning industry indicates that "the stage is set for a new era in sun care — an era based on knowing your skin type, understanding your constitutive risks, using sunscreen appropriately instead of overusing it and planning your active lifestyle accordingly."

Dermatologists recommend that people who like the way they look with a tan and want to preserve the integrity and appearance of their skin should wear themselves from artificial light sources and switch to sunless tanning lotions. *Dj*

Maureen Haggerty

Consumers looking for a golden glow are finding that self-tanning products or sunless tanners are a safe alternative to exposing themselves to damaging ultraviolet radiation.



Sunless or self-tanning lotions contain an active ingredient known as dihydroxyacetone (DHA), that works with the protein in skin cells. The Food and Drug Administration considers the ingredient safe. A single application lasts between three and five days, and the color fades as the skin begins to shed dead cells. Tanning preparations, tan accelerators, bronzers, tanning promoters and tanning pills, are not as effective as sunless or self-tanners containing DHA. Some tanning pills have been linked to hepatitis and hives.

Sunless tanning lotions are readily within our reach. One of the fastest-growing segments of the sun care industry (\$135 million in annual retail sales according to industry research) manufacturers are introducing more and more products — 29 in the past two and a half years. Such lotions even give tans to the cast of Baywatch!

Dermatologists say consumers should be aware that the color is not a base tan so they do need sunscreen. Although self-tanners will darken the skin, these products provide limited sun protections. Some self-tanning products contain minimal protective sunscreens, which remain effective only a few hours after application.



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rosacea red alert

Q: What does President Clinton have in common with a famous artist like Rembrandt, American financier J.P. Morgan, vaudeville comedian W.C. Fields, and Princess Diana?

A: All are reported to have experienced rosacea, a chronic and progressive acne-like skin condition that affects more than 13 million Americans.



rosacea
courtesy of National Rosacea Society

Q: Who most typically develops rosacea?

A: Although anyone can get rosacea, it is more common in people who are over 30 years of age, tend to flush or blush easily with fair skin, and are of Irish, English, Scottish, or northern or eastern European descent. Family history is another strong factor in determining one's potential for developing rosacea. The condition may even strike those who have had a bad reaction to acne medication.

Rosacea is characterized by facial swelling and flushing. The facial redness tends to affect men and women differently. Women have symptoms on the cheeks and chin, while men are more likely to have swelling of the nose associated with advanced cases. Though its appearance may seem random, evidence suggests that this treatable skin disorder may actually be more predictable than once thought.

Q: Can lifestyle factors aggravate rosacea flare-ups?

A: Yes! Facial redness becomes increasingly pronounced by sun exposure, emotional stress, hot weather and cold wind. Other triggers that are irritating to rosacea skin are alcohol, spicy foods, exercise, hot baths, hot beverages, and certain skin care products. Since it's not always possible to avoid these factors, be moderate with them.



At first, Patrick was proud of the "natural" color of his face, the red cheeks that gave him a healthy look. He never thought it was something to worry about or that it could be a clue of a chronic skin disorder. During an appointment with a dermatologist to check a mole, Patrick's physician told him he had rosacea.

Q: How is rosacea recognized?

A: If you notice a redness on your face, let that be a clue and don't ignore getting treatment. At its earliest and mildest stage, rosacea typically consists of a subtle redness appearing on the cheeks or nose, and in some cases the chin or forehead. Beyond flushing or blushing, another sign is facial skin that is easily irritated. The disease progresses with increased redness. Bumps or blemishes may appear. Watery or irritated eyes are another symptom. The development of visible dilated blood vessels represent a later phase. In advanced stages, the nose may become red and swollen from excess tissue. Always check with your dermatologist for accurate diagnosis and proper therapy.

Q: What about treatments?

A: Early treatment seems to prevent later complications. If untreated, symptoms of rosacea tend to worsen over time, and severe cases rarely go away by themselves. Rosacea requires prescription therapy to reduce symptoms. Dermatologists usually treat with topical and oral antibiotics to bring rosacea under immediate control. Long-term treatment with the topical medication alone may follow. In some cases, lasers can be used in the dermatologist's office to erase tiny blood vessels and help reduce redness and flushing, and correct the overgrowth of tissue on the nose. **A good home skin-care program, especially the use of sunblock and products labeled non-comedogenic, which do not tend to produce or aggravate acne, are important to help soothe skin. Unfortunately, there is not yet a cure for rosacea.**

Answers to your questions about rosacea from Jerome Z. Litt, M.D., assistant clinical professor of dermatology at Case Western Reserve University.

more on rosacea

For more information on rosacea, ask your dermatologist for an educational pamphlet from the American Academy of Dermatology or log on to the AAD's Web site at www.aad.org. Information is also available from the National Rosacea Society at 1-888-662-5874; Web site: www.rosacea.org

Send Questions

If you have a question about a dermatologic condition, please send it to: "Ask a Dermatologist," c/o Dermatology Insights, P.O. Box 4014, Schaumburg, Ill., 60173-4014. For free educational pamphlets and 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.