LEGISLATIVE COMMITTEE MINUTES

SB358

Bill as Introduced

SB 358 - AS INTRODUCED

2022 SESSION

22-3029
05/08

SENATE BILL ***358***

AN ACT establishing October 2022 as eczema awareness month.

SPONSORS: Sen. Carson, Dist 14; Sen. Cavanaugh, Dist 16; Rep. Dolan, Rock. 5; Rep. Lundgren, Rock. 5; Rep. Thomas, Rock. 5; Rep. Baldasaro, Rock. 5

COMMITTEE: Executive Departments and Administration

ANALYSIS

This bill establishes October 2022 as eczema awareness month.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 358 - AS INTRODUCED

22-3029
05/08

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Two

AN ACT establishing October 2022 as eczema awareness month.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 1 Eczema Awareness Month. The governor shall proclaim October 2022 to be eczema awareness
2 month in order to raise awareness of the disease, the burden it places on patients and caregivers,
3 and the need for care and treatment that is reflective of the multi-dimensional nature of the disease.
4 The governor shall urge the citizens of the state to observe the month with appropriate activities and
5 events.
6 2 Effective Date. This act shall take effect 60 days after its passage.

SB 358 - AS AMENDED BY THE HOUSE

4May2022... 1645h

2022 SESSION

22-3029
05/08

SENATE BILL ***358***

AN ACT relative to the joint legislative committee on administrative rules.

SPONSORS: Sen. Carson, Dist 14; Sen. Cavanaugh, Dist 16; Rep. Dolan, Rock. 5; Rep. Lundgren, Rock. 5; Rep. Thomas, Rock. 5; Rep. Baldasaro, Rock. 5

COMMITTEE: Executive Departments and Administration

AMENDED ANALYSIS

This bill increases the number of members and alternate members on the joint legislative committee on administrative rules, as well as establishes three equal divisions within the committee and specify that a final objection shall only be entered into by the entirety of the regular members on the committee.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Two

AN ACT relative to the joint legislative committee on administrative rules.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 1 Administrative Procedure Act; Definitions; Committee. Amend RSA 541-A:1, III to read as
2 follows:
3 III. "Committee" means the joint legislative committee on administrative rules***, as well as***
4 ***the divisions of said committee***, unless the context clearly indicates otherwise.
5 ***III-a. "Entire committee" shall mean the entirety of the appointed regular members***
6 ***of the joint legislative committee on administrative rules.***
7 2 Administrative Procedure Act; Joint Legislative Committee on Administrative Rules. Amend
8 RSA 541-A:2, I and II to read as follows:
9 I. There is hereby created a joint legislative committee to be known as the joint legislative
10 committee on administrative rules. The committee shall be composed of [~~10~~] ***15*** members of the
11 general court and [~~10~~] ***15*** alternates to be appointed for 2-year terms ending on the first Wednesday
12 in December of even-numbered years as follows: [~~5~~] ***9*** members of the house of representatives,
13 appointed by the speaker of the house in consultation with the minority leader, not more than [~~3~~] ***5***
14 of whom shall be from the same party; [~~5~~] ***6*** members of the senate, appointed by the senate
15 president in consultation with the minority leader, not more than [~~3~~] ***4*** of whom shall be from the
16 same party; [~~5~~] ***9*** alternate members of the house of representatives appointed by the speaker of the
17 house in consultation with the minority leader, not more than [~~3~~] ***5*** of whom shall be from the same
18 party; and [~~5~~] ***6*** alternate members of the senate, appointed by the senate president in consultation
19 with the minority leader, not more than [~~3~~] ***4*** of whom shall be from the same party. If a member of
20 the committee is unable, for any reason, to attend a meeting or a portion of a meeting of the
21 committee, the chair shall designate an alternate member to serve regardless of the number of other
22 senators or representatives who attend the meeting. The committee shall elect a chair and a vice-
23 chair from among its members, provided that the chair shall rotate biennially between the house and
24 senate members.
25 II. The joint legislative committee on administrative rules shall ***be divided into 3***
26 ***divisions, each consisting of 2 senators and 3 members of the house, with an equal number***
27 ***of alternates. A quorum of a division shall be 3 members. Each division shall meet***
28 ***separately to conduct its business, and have the authority of the full committee, except that***
29 ***a joint resolution resulting from a final objection shall be approved by the entire***
30 ***committee. Each division shall*** meet at least once each month and more often as necessary for
31 the prompt discharge of its duties. The director of legislative services shall provide services to the

committee. The joint legislative committee on administrative rules shall adopt rules to govern its operation and organization. [~~A quorum of the committee shall consist of 6 members.~~] Members of the committee shall be entitled to legislative mileage as provided to members for attendance at sessions of the general court.

3 Administrative Procedures Act; Review by the Joint Legislative Committee on Administrative Rules; Entire Committee for Final Objection Required. Amend RSA 541-A:13, VII to read as follows:

VII.(a) The provisions of this paragraph may be used by the ***entire*** committee as an alternative to or in addition to the final objection procedure employed by the committee in paragraph V.

(b) If an agency responds to a preliminary or revised objection but the basis for objection has not been removed or the response creates a new basis for objection, the ***entire*** committee may, within 50 days from the date on which the objection response was due and by majority vote of the entire committee, recommend legislative action through sponsorship of a joint resolution to implement its recommendation. Such vote shall prevent the rule from being adopted and filed by the agency for the period of time specified in subparagraph VII(c).

(c) If the ***entire*** committee votes to sponsor a joint resolution pursuant to subparagraph VII(b), the joint resolution shall be introduced in the house of representatives or senate within 20 business days of such vote when the general court is in session and 20 business days of the start of the following legislative session if such vote occurs when the general court is not in session. If a joint resolution is not introduced within this time frame, the agency may adopt the rule. If a joint resolution is introduced within this time frame, the agency shall be prevented from adopting and filing such rule until final legislative action is taken on the resolution or the passage of 90 consecutive calendar days during which the general court shall have been in session, whichever occurs first. The 90 calendar day period shall commence on the date such joint resolution has been introduced. If the session of the general court adjourns prior to the sixtieth calendar day after such joint resolution has been introduced, then the agency shall be prevented from adopting and filing such rule until 90 calendar days, beginning with the next session of the general court, have passed.

(d) The provisions of this paragraph shall apply to only the specific portion of the agency's rule identified in the joint resolution. The provisions of this paragraph shall not prevent an agency from adopting and filing the remainder of the rules in the final proposal under RSA 541-A while the ***entire*** committee pursues legislative action under this paragraph, nor shall it prevent the committee from also voting to enter a final objection pursuant to paragraph V.

(e) Nothing in this section shall prevent the general court from introducing legislation which addresses any matter included in a joint resolution introduced under the provisions of this section.

(f) Notwithstanding any house or senate rules to the contrary, a joint resolution which the ***entire*** committee votes to sponsor under subparagraph VII(b) may be introduced at any time

1 during the legislative session. It shall be subject to the same rules as any other bill introduced at
2 the beginning of the legislative session.
3 4 Effective Date. This act shall take effect 60 days after its passage.

Committee Minutes

SENATE CALENDAR NOTICE
Executive Departments and Administration

Sen Sharon Carson, Chair
Sen John Reagan, Vice Chair
Sen Denise Ricciardi, Member
Sen Kevin Cavanaugh, Member
Sen Suzanne Prentiss, Member

Date: January 14, 2022

HEARINGS

Wednesday	02/02/2022
(Day)	(Date)

Executive Departments and Administration	State House 103	9:00 a.m.
(Name of Committee)	(Place)	(Time)

9:00 a.m.	**SB 398**	relative to building code and fire code enforcement.
9:15 a.m.	**SB 360**	relative to national guard educational benefits.
9:30 a.m.	**SB 358**	establishing October 2022 as eczema awareness month.

EXECUTIVE SESSION MAY FOLLOW

Sponsors:

SB 398
Sen. Carson, Sen. Cavanaugh, Sen. Prentiss, Rep. McGuire, Rep. Goley, Rep. Pimentel

SB 360
Sen. Carson, Sen. Bradley, Sen. Watters, Rep. Baldasaro, Rep. Moffett

SB 358
Sen. Carson, Sen. Cavanaugh, Rep. Dolan, Rep. Lundgren, Rep. Thomas, Rep. Baldasaro

Chantell Wheeler 271-1403

Sharon M Carson
Chairman

Senate Executive Departments and Administration Committee

Chantell Wheeler 271-1403

SB 358, establishing October 2022 as eczema awareness month.

Hearing Date: February 2, 2022

Time Opened: 9:30 a.m. **Time Closed:** 9:33 a.m.

Members of the Committee Present: Senators Carson, Reagan, Ricciardi, Cavanaugh and Prentiss

Members of the Committee Absent : None

Bill Analysis: This bill establishes October 2022 as eczema awareness month.

Sponsors:

Sen. Carson	Sen. Cavanaugh	Rep. Dolan
Rep. Lundgren	Rep. Thomas	Rep. Baldasaro

Who supports the bill: Senators Carson and Cavanaugh

Who opposes the bill: None

Who is neutral on the bill: None

Summary of testimony presented in support:
Senator Carson

- This bill was brought at the request of a constituent who has been impacted by eczema. A prior bill in 2020 passed this committee but died on the table during the pandemic.
- Eczema can lead to other health problems.
- 31.6 Americans suffer from eczema which can be socially and physically debilitating.

Summary of testimony presented in opposition: None

Neutral Information Presented: None

cbw
Date Hearing Report completed: February 2, 2022

Speakers

Senate Executive Departments and Administration Committee

Date: 02/02/2022 | Time: 9:30 a.m. | Public Hearing on: **SB 358**

Please check box(es) that apply.

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☑	☑	☐	Senator Carson	SD 14
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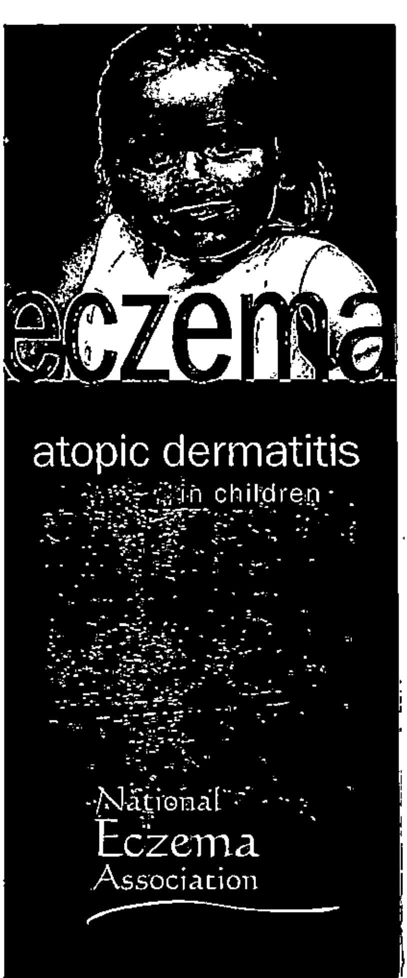
Senate Remote Testify

Executive Departments and Administration Committee Testify List for Bill SB358 on 2022-02-02
Support: 1 Oppose: 0

Name	Title	Representing	Position
Cavanaugh, Senator Kevin	An Elected Official	Myself	Support

Testimony


eczema
atopic dermatitis
in children
National
Eczema
Association

What is Atopic Dermatitis (AD)?

Atopic dermatitis (AD), often called *eczema* (pronounced "EK-zema") or *atopic eczema*, is a very common skin disease. It affects an estimated 10%-20% of all infants and children. The exact cause is not known, but AD results from a combination of family heredity and a variety of conditions in everyday life that triggers the red, itchy rash.

How do we know if it's atopic dermatitis?

1. *Time of Onset.* This type of eczema usually begins during the first year of life and almost always within the first five years. It's seldom present at birth, but it often comes on during the first six weeks. Other rashes also can start at any time, but most rashes disappear within a few days to weeks. AD tends to persist. It may wax and wane, but it keeps coming back.

2. *Itching.* Atopic dermatitis is a very itchy rash. Much of the skin damage comes from scratching and rubbing that the child cannot control.

3. The *location* of the rash can also help us recognize AD. In babies, the rash usually starts on the face or over elbows and knees, places that are easy to scratch and rub. It may spread to involve all areas of the body, although moisture in the diaper region protects the skin barrier. Later in childhood, the rash is typically in the elbow and knee folds. Sometimes it only affects the hands, and at least 70% of people with AD have hand eczema at some time in their life. Rashes on the feet, scalp or behind the ears are other clues that might point to AD. Be advised, though, that these symptoms may also indicate other conditions, such as seborrheic dermatitis.

4. The *appearance* of the rash is probably the least helpful clue, because it may be very different from one person to another. Scratch marks are often seen, along with scaly dry skin. The skin may become infected and show yellow crusts or little, pinpoint, pus-containing bumps. The skin also may thicken from long-term scratching and rubbing.

5. *Heredity.* If other family members or relatives have AD, asthma or hay fever, the diagnosis of AD is more likely.

The bottom line: Be sure to get your child diagnosed by a physician before assuming that the condition is atopic dermatitis.

The Atopic Triad

AD falls into a category of diseases called Atopy, a term originally used to describe the allergic conditions asthma and hay fever. AD was included in the atopic category because it often affects people who either suffer from asthma and/or hay fever or have family members who do. Physicians often refer to these three conditions as the "atopic triad".

Does it run in families?

AD is a familial disease, though the exact way it passes from parents to children is unclear. If one parent has AD, or any of the other atopic diseases (asthma, hay fever), the chances are about 50% that the child will have one or more of the diseases. If both parents are atopic, chances are even greater that their child will have it. However, the connection is not an absolute one: As many as 30% of the affected patients have no family members with any of these allergic disorders.

What causes atopic dermatitis?

AD is not contagious. People with AD cannot "give" it to someone else.

AD inflammation results from too many reactive inflammatory cells in the skin. Research is seeking the reason why these cells over-react. Patients with AD (asthma or hay fever) are born with these over-reactive cells. When something *triggers* them, they don't turn off as they should. We try to control AD by controlling the *trigger factors* that "turn on" inflamed skin, or by "damping the flames" with anti-inflammatory therapies.

What are trigger factors?

Trigger factors may be different in different people. Most children get worse when they get a cold or other infection. Most have worse problems in the winter, but others simply cannot stand the sweating during hot, humid summer weather. Let's look at the trigger factors that seem to affect every child with AD.

Dry skin. The skin's main function is to provide a barrier against dirt, germs and chemicals from the outside. We don't notice this barrier unless it gets dry, and then it's scaly, rough and tight. *Dry skin is brittle - moist skin is soft and flexible.* People with AD have a defect in their skin so it won't stay moist. It is especially bad in winter when the heat is on in the house and the humidity drops. Other things that dry the skin are too much bathing without proper moisturizing. *The challenge: Prevent skin dryness.*

Irritants. Irritants are any of the substances outside the body that can cause burning, redness, itching or dryness of the skin. *The challenge: Avoid irritating substances.*

Stress. Emotional stress comes from many situations. People with AD often react to stress by having red flushing and itching. Special problems for children with AD include frustration, anger or fear. And, of course, AD itself, and its treatments, are a source of stress! *The challenge: Recognize stress and reduce it.*

Heat and sweating. Most people with atopic dermatitis notice that when they get hot, they itch. They have a type of prickly heat that doesn't occur just in humid summertime but anytime they sweat. It can happen from exercise, from too many warm bedclothes, or rapid changes in temperature from cold to warm.

Infections. Bacterial "staph" infections are the most common, especially on arms and legs. Such infections might be suspected if areas are weeping or crusted or if small "pus-bumps" are seen. A common virus infection of children, *Molluscum*, tends to be more severe in children with AD. *Molluscum* infections look like small bumps, often with a central white core. Herpes infections (such as fever blisters or cold sores) and fungus (ringworm or athlete's foot) can also trigger AD. If some lesions look different ask your doctor. If they turn out to be infected, they can be treated with antibiotics or other, effective medications. These are generally benign, superficial infections for AD patients and they do not seem to be especially contagious for other people. The challenge: *Recognize and treat pustules or crusted lesions in consultation with a physician.*

Allergens. Allergens are materials (such as pollen, pet dander, foods, or dust) that cause allergic responses.

Allergic diseases such as asthma and hay fever, which flare quickly, are easy to tie to allergens. Allergic symptoms, such as itching and hives, appear soon after exposure to airborne allergens and last only briefly. But the slower, continuing, chronic eczema of AD may be difficult to tie to specific allergens. Food allergies can trigger flares, especially for children with moderate to severe AD. Of the available tests for allergy, scratch tests and RAST tests are only brief reactions and do not diagnose allergen-triggered eczema. Patch tests, by contrast, can diagnose eczema response in some cases such as allergies to skin care products.

Are there other trigger factors?

Children with AD will be helped by reducing the major trigger factors described above. But individuals may be subject to other trigger factors, and it is important to be alert for those as well.

How can you avoid trigger factors?

1. Keep the skin barrier intact. MOISTURIZE!

2. Wear soft clothes that "breathe." Avoid fabrics of wool, nylon, or stiff material.

3. If sweating causes itching, find ways to keep cooler. Reduce exertion, especially during times of flare. Layer clothing and adjust to temperature change. Don't overheat rooms, especially the bedroom. Use light bedclothes.

4. When itching from sweating, dust, pollen or other exposures, take a cooling shower or tub bath, and don't forget to moisturize afterwards, within 3 minutes after the child has been gently toweled. **Refer to the NEA Bathing & Moisturizing educational brochure for more information.**

5. Learn to recognize signs of infection and treat early.

6. If you suspect food allergy, be systematic. Likely offenders are eggs, milk, peanuts, soy, wheat and seafood, but any food can do it. Can you exclude the most likely offender for a week? Substitute hydrolysate (e.g. Alimentum® or Nutramagen®) for cow's milk formula. Keep a food diary. When the skin clears up, try the food. Watch for signs of itching or redness over the next two hours. Eliminate a food group if it causes hives or face swelling. **Don't exclude multiple food groups at the same time—it's rare to have more than one or two food allergies that impact the eczema, and your child can get malnourished with prolonged avoidance of many foods. Always make sure that any food manipulation is performed with the advice of a physician.**

7. With allergy-prone kids furry animals are a risk. If you must have pets, keep them outside or at least off beds, rugs and furniture where the child plays. Dust mites collect in bedroom carpets and bedding. Simple control measures include coverings for pillows and mattresses, removing bedroom carpets and frequent washing of bedclothes in hot water.

8. Think about stress-causing events and ways to cope with them. Review problems with your doctor or a mental health professional. Consider clinicians who specialize in approaches including mindfulness. Try to make AD treatments part of a daily, family routine. Encourage children with AD to do what they can on their own.

What kinds of treatments help?

Moisturizers. Ointments such as petroleum jelly are best unless they're too thick and cause discomfort. Creams may be fine for moderately dry skin or in hot, humid weather. Apply them to wet skin, immediately after bathing. Lotions are not rich enough and often have a net drying effect on AD skin.

Corticosteroids. Often called topical ("applied to the skin") steroids, these are cortisone-like medications used in creams or ointments that your doctor may prescribe (e.g. hydrocortisone, mometasone, desonide, triamcinolone). They are not the same as the anabolic steroids some athletes misuse. Corticosteroid medicines are very helpful. Often they are the only treatment that can calm the inflamed skin. ***Use of steroid ointments and creams requires good judgment and careful supervision.*** They come in many strengths from mild to super-potent. Hydrocortisone, a very mild steroid, is quite safe. The more potent ones can cause thinned skin, stretch marks and even growth retardation or suppression of the adrenal gland if used too many days in the same areas of the body. Parents should monitor the child's use. Ask the doctor about potency and side effects of prescribed corticosteroid medicines and follow the product insert instructions carefully.

Topical Immunomodulators (TIMs). This family of topical medications has been available for the past 10 years. TIMs work to inhibit the skin's inflammatory response (which is what causes the redness and also contributes to itching). At this time there are two FDA approved non-steroid drugs: tacrolimus and pimecrolimus. TIMs are not steroids and do not cause thinning of the skin but they can suppress the immune system in the skin so that the use of sun protection for the children receiving this therapy is recommended.

For children less than two years of age these medications are only used off-label and as always, with any medication, they should be used with careful supervision of a physician.

Tar preparations. Tar creams or bath emulsions can be helpful for mild inflammation.

Antibiotics. Oral or topical antibiotics reduce the surface bacterial infections that may accompany flares of AD.

Antihistamines. Often prescribed to reduce itching, these medicines may cause drowsiness but seem to help some children, largely due to their sleep-inducing side effects.

When will my child outgrow atopic dermatitis?

For any given child, it is difficult to predict. The majority of babies with AD will lose most of the problem by adolescence, often before grade school. A small number will have severe AD into adulthood. Many have remissions that last for years. The dry skin tendency often remains. Most people learn to use moisturizers to keep their dermatitis controlled. Occasional episodes of AD may occur during times of stress or with jobs that expose the skin to irritants and wet work.

Will AD effect my child's career choice?

Someone who has had eczema should avoid jobs that can injure the skin. Military service automatically excludes people with AD or asthma. Wet work in restaurants or hospitals is especially damaging to hands predisposed by AD to drying and cracking. Generally, it's better to pick "clean" indoor work such as with people, computers, papers or books, given the choice.

National Eczema Association

For additional information, or to receive a sample of our quarterly newsletter, please contact us.

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EASE

Acknowledgments

The National Eczema Association acknowledges Drs. John Crossen, Jon Hanifin, Amy Paller, Hugh Sampson, and Mary Spraker for their editorial contributions to this brochure.

This information sets forth current opinions from recognized authorities, but it does not dictate an exclusive treatment course. Persons with questions about a medical condition should consult a physician who is knowledgeable about that condition.

The National Eczema Association (NEA) improves the health and quality of life for individuals with eczema through research, support, and education. NEA is entirely supported through individual and corporate contributions and is a 501(c)(3) tax-exempt organization. NEA is the only organization in the United States advocating solely for eczema patients.

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ECZEMA
HAND ECZEMA
NATIONAL
Eczema
ASSOCIATION

What is hand eczema?

Hand eczema (also known as hand dermatitis) is a common condition affecting up to 10% of the population. It results from a combination of factors, both internal (e.g. your genetic make-up), and external (e.g. contact with irritants and allergens such as chemicals). The irritant nature of some chemicals means that hand eczema is particularly common in people with jobs involving cleaning, catering, hairdressing, healthcare and mechanical work. It is an inflammatory condition and is not contagious, but it can still have a major effect on people's work, social lives and self-esteem.

The main symptoms of hand eczema include one or more of the following:

- Redness (erythema)
- Itching
- Pain
- Dryness, to the point of peeling and flaking
- Cracks (fissures)
- Blisters (vesicles)

There is also a specific type of hand eczema called pompholyx (pronounced *Pom-foe-licks*, from the Greek word for bubble). The cause of pompholyx is unknown and it tends to occur more commonly in women. Each outbreak consists of the appearance of itchy small blisters on the palms of the hands. The condition may come and go over the course of many years, and is notoriously difficult to treat effectively.

What happens at the doctor's office? It's only a starting point...

If your hand eczema symptoms have been present for more than a few weeks and do not seem to be getting any better, you should seek treatment from your doctor. Because your hands are in constant use, it is much more difficult to treat hand eczema after it has been present for a while. Your skin will begin to thicken and harden in response to constant rubbing and scratching in much the same way that a callus forms on the bottom or side of a heel. This will make it more difficult for any medication to penetrate deeply enough to have a satisfactory effect. The likelihood of suffering from persistent and chronic hand eczema increases the longer the condition goes undiagnosed and untreated.

Your doctor will ask you about the kinds of activities you engage in at home and at work. It's very important to be as thorough as you can with your answers, so your doctor can help determine what might be causing the problem. If your hand eczema has persisted for a long time or is unusually severe, the doctor may suggest that you be patch tested to determine if you are allergic to any of the chemicals and allergens you are exposed to on a daily basis at home or at work. Patch testing involves putting different substances on your skin to see how it reacts.

You may receive a prescription for a corticosteroid medication to put on your eczema. (Hint: It will soothe your itching better if you keep it in the refrigerator.) Use topical corticosteroids only as needed—that is, when your hand eczema is actively flaring. Prolonged use of these drugs can cause thinning of the skin, and there are other side effects to consider as well. Perhaps your doctor will recommend a non-corticosteroid topical medication such as tacrolimus (Protopic) or pimecrolimus (Elidel). These agents are approved for use by adults and children two years of age or older, and they do avoid many of the side effects of corticosteroids. They should not be used long-term on sun-exposed portions of skin, like the backs of the hands; sunscreen must always be used. Sometimes oral antihistamine pills can help eczema too. You'll probably also receive suggestions for hand cleansers or moisturizers free of ingredients that could worsen your eczema.

Beyond that, clearing up your hand eczema depends largely on how you change your day-to-day habits. These changes may be difficult. Following is a collection of tips for living with hand eczema.

What can I do to protect my hands at home?

- "Dishpan hands" are actually a form of hand eczema. It occurs because constant wetting and drying breaks down the skin's protective outer barrier. Perfumes and preservatives in soaps and irritants in household cleansers can make things worse. If you already have hand eczema or are recovering from an episode, you need to avoid wetting your hands whenever possible.

- When you need to sanitize your hands, wash your hands with lukewarm water and a perfume-free mild cleanser, then blot your hands dry gently and immediately apply a moisturizer. The best moisturizer is petroleum jelly, but creams in a jar or tube are also effective. You should keep a good moisturizer next to every sink in your house. If it feels tacky on your hands, wipe off the excess. You only need a very thin layer.

- When making your hands sanitary isn't an issue, try waterless hand washing. Use the same gentle cleanser you normally use — but without any water. Blot it off gently. Avoid waterless or antibacterial sanitizers if you are in the midst of a flare-up; they generally contain solvents and other ingredients that may make your problem worse. If your hands are clear, the latter products may actually help prevent hand eczema.

- Keep several pairs of cotton gloves around the house to protect your hands while doing chores. Even folding laundry can irritate tender skin. When these gloves get dirty, wash them in a perfume-free and dye-free soap. If your fingertips aren't affected by hand eczema, you can cut the glove tips off to stay cooler in hot weather. For wet work, put on your cotton gloves and then cover them with unlined powder-free vinyl or neoprene gloves. (The latex in rubber gloves can cause allergies.) Afterward, wash eczema reusable gloves inside-out and let them air dry thoroughly. If a reusable vinyl glove gets a hole in it, throw it away. Wearing a glove with a hole in it is worse than wearing no glove at all. If water gets in your glove, take it off immediately; blot your hand dry, and use a new glove.

- Wear gloves when peeling potatoes and when working with meat, onions, peppers, or acidic fruit, like citrus and tomatoes. We recommend disposable vinyl gloves. When you finish preparing these foods, just throw the gloves away.

- Never wear a waterproof glove for more than 15 or 20 minutes at a time.

- Ask someone else to shampoo your hair for you. Or wash your hair wearing your waterproof/cotton liner glove combination. Use rubber bands on your forearms to keep water out.

- Rings can trap irritants underneath them. Remove them when doing housework and before washing and drying your hands. Also, clean your rings regularly by soaking them overnight in one tablespoon of ammonia in a pint of water.

- Use the washing machine and the dishwasher, not your hands, to do laundry and dishes. If you must wash dishes by hand, do it under running water. Use a long-handled scrubber to minimize hand damage from hot water.

- For outdoor work, wear unlined leather or thick fabric gloves to protect your hands. Leather gloves also will protect your hands in dry, windy, or cool weather. Avoid wool because it may be prickly and irritating

What tools will help?

You can find 100-percent cotton "T-shirt knit" gloves at many hobby and craft stores and at professional camera supply stores. Many drug stores and beauty salons also carry them. These are lifesavers for your hands, either worn alone or as liners beneath vinyl or other waterproof gloves. Many people are reluctant to wear "household gloves" because they can cause sweating, which leads in turn to itching and burning. But wearing a pair of cotton gloves will absorb most of the sweat, and will ensure that your medication or moisturizer stays in contact with your skin. If possible, buy your outer waterproof gloves in a larger size to accommodate the use of liners. Many people go to pharmacy/medical supply stores to purchase boxes of vinyl exam gloves, which come in a variety of sizes, including extra small sizes that will work for older children.

How can I protect my hands at work?

If your job is causing your hand eczema, your doctor will help you determine what irritating chemicals or work practices are contributing to your condition. In addition to modifying those risks, many of the same hand-protective strategies you use at home can help you at work. Here are some ideas:

- Use heavy-duty vinyl or neoprene gloves in tandem with cotton glove liners when doing wet work. Wash the cotton gloves regularly, as well as the vinyl gloves if they aren't disposable.

- Wear leather or clean, heavy-duty fabric gloves for dry work.

- Avoid using industrial hand cleansers or waterless or antibacterial cleansers that contain irritating ingredients such as alcohol and solvents, especially when your hand eczema is flaring.

- Carry your own hand cleanser, moisturizer, and prescription medication to work, and use them to prevent problems.

- Keep your work clothes, protective clothing, tools, and work surfaces clean; irritant residues on them can aggravate your problem.

- Treat all minor wounds on your hands, and bandage them, in order to avoid giving irritants and allergens an easy route into your skin.

What about moisturizers?

Ironically, the more water there is in a lotion or moisturizer, the more likely it is to worsen your hand eczema. Moisturizers usually contain more water than oil, and when the water evaporates they have a net drying effect on the skin. The very best moisturizer for hand eczema is a greasy one. It has very few ingredients, it holds the skin's

natural moisture in, and it provides a protective barrier to keep irritants out. This turns out to be petroleum jelly, also known as petrolatum (Vaseline is one brand, and there are others as well). You should apply it to your hands immediately after you bathe, and each time you wash your hands. Carry a small tube with you and reapply it throughout the day.

Once your eczema has cleared and you are no longer using a prescription ointment, your doctor may also suggest using petroleum jelly or a prescription medication on an ongoing basis at night with cotton gloves. In this case, wear the same gloves over and over to help contain the medication. If you dislike petroleum jelly, the next best alternatives are, in order, lubricants, hydrating gels, and creams (like Cetaphil, Neutrogena, and Curél). Urea and lactic acid are helpful ingredients because they help the skin absorb moisture. You need to read all labels carefully to make sure that products don't contain any ingredients that should be avoided. NEA has more information about these ingredients. Eventually you'll be a skilled reader of labels for lotions, shampoos, and other cosmetics.

What ingredients should I avoid?

Patch testing can help to determine if you are allergic to specific components of personal care products; after you have been patch tested, your dermatologist will assist you with finding appropriate products. If your doctor has told you that you are sensitive or allergic to a specific substance, avoid products that contain that too. There are a wide variety of additional ingredients, usually preservatives, which can cause skin irritation or allergy, and it's best to avoid them if you already have hand eczema. When in doubt, use plain petrolatum. It only has one ingredient.

What about "alternative" therapies?

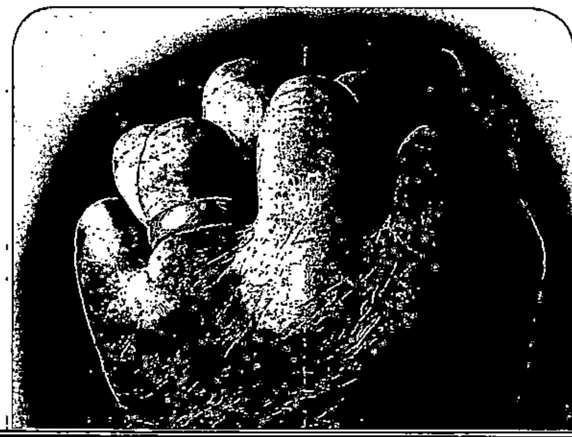
Once you have an episode of hand eczema, your risk of having another one increases greatly. For some people, hand eczema becomes chronic. The lack of an easy fix from conventional medicine has led some hand eczema patients to seek alternative treatments. The efficacy of most of these treatments remains unproven. If you do find an alternative that works for you, please share it with the National Eczema Association to help others. If you do decide to try an alternative therapy for your hand eczema, be sure to tell your doctor about it. This is important for coordination of your care.

What about future therapies?

The results of some early studies on the use of oral alitretinoin in patients with chronic hand dermatitis resistant to topical corticosteroid therapy have already been published and studies in the United States are ongoing. NEA will keep you apprised of all research and new treatments.

What is the bottom line?

Unfortunately, there is no quick and easy solution to hand eczema. Clearing up an episode of the condition can take several months, and you will need to continue caring for your hands for as long as a year, even though they appear eczema free.



Be creative with your hand care and tell us what works!

Many people write to NEA to communicate tips, products, and treatments they have discovered to help their hand eczema. Please stay connected with us to learn more and share what works for you!

NATIONAL Eczema ASSOCIATION

For a complimentary copy of the NEA print newsletter, *The Advocate*, and an eczema information package, please contact us. We are always here to help!

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This information sets forth current opinions from recognized authorities, but it does not dictate an exclusive treatment course. Persons with questions about a medical condition should consult a physician who is knowledgeable about that condition.

The National Eczema Association (NEA) improves the health and quality of life for individuals with eczema through research, support, and education. NEA is entirely supported through individual and corporate contributions and is a 501(c)(3) tax-exempt organization. NEA is the only organization in the United States advocating solely for eczema patients.

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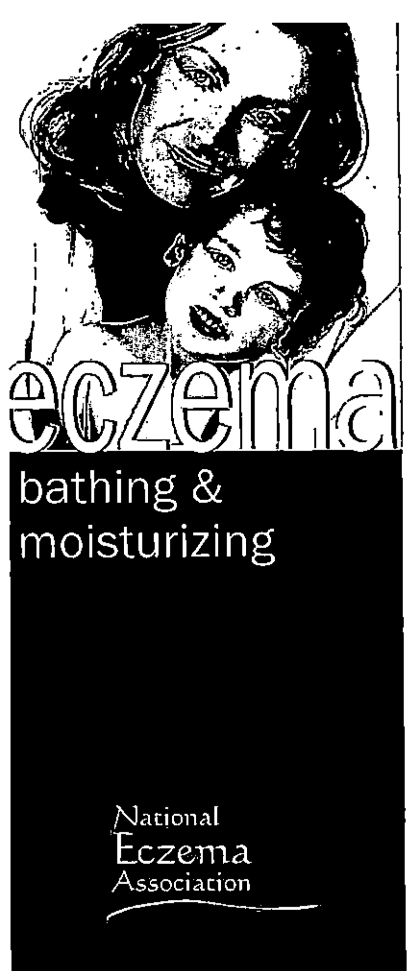

eczema
bathing &
moisturizing
National
Eczema
Association

What is eczema?

Eczema is a chronic recurring skin disorder that results in dry, easily irritated, itchy skin. There is no cure for eczema, but good daily skin care is essential to controlling the disease.

What are the characteristics of dry skin?

When your skin is dry, it is not because it lacks grease or oil, but because it fails to retain water. For this reason, a good daily skin care regimen focuses on the basics of bathing and moisturizing.

What other factors create dry skin?

Wind, low humidity, cold temperature, excessive washing without use of moisturizers, and use of harsh, drying soaps can all cause dry skin and aggravate eczema.

How do I take care of my dry skin?

The most important treatment for dry skin is to put water back in it. The best way to get water into your skin is to briefly soak in a bath or shower and to moisturize immediately afterwards.

Use of an effective moisturizer several times every day improves skin hydration and barrier function. Moisturizer should be applied to the hands every time they are washed or in contact with water.

The goal of bathing and moisturizing is to help heal the skin. To repair the skin, it is necessary to decrease water loss.

Some dermatologists recommend that you perform your bathing and moisturizing regime at night just before going to bed. You are unlikely to further dry out or irritate your skin while sleeping, so the water can be more thoroughly absorbed into your skin.

If you have *hand* eczema dermatologists recommend that you soak your hands in water, apply prescription medications and moisturizer (preferably an ointment), and put on pure cotton gloves before going to sleep.

If I am on prescription drugs for my eczema, do I still need to moisturize?

Basic skin care can enhance the effect of prescription drugs, and it can prevent or minimize the severity of eczema relapse.

What are the basics of Bathing & Moisturizing?

Take at least one bath or shower per day. Use warm, not hot, water for at least 5 to 10 minutes. Avoid scrubbing your skin with a washcloth.

Use a gentle cleansing bar or wash, no soap. During a severe flare, you may choose to limit the use of cleansers to avoid possible irritation.

While your skin is still wet (within three minutes of taking a bath or shower), apply any special skin medications prescribed for you and then liberally apply a moisturizer. This will seal in the water and make the skin less dry and itchy.

Be sure to apply any special skin medications to areas affected with eczema before moisturizing. The most common skin medications used to treat skin inflammation are prescription and non-prescription topical steroids or prescription topical immunomodulators (TIMS). Be sure to use these medications as directed. Remember that TIMS can sting if applied to wet skin, so apply a thin coat to affected areas only.

Be sure to apply moisturizer on all areas of your skin whether it has or has not been treated with medication. Specific occlusives or moisturizers may be individually recommended for you.

Moisturizers are available in many forms. Creams and ointments are more beneficial than lotions. Petroleum jelly is a good occlusive preparation to seal in the water; however, since it contains no water it works best after a soaking bath.

How does water help my skin?

Water hydrates the stratum corneum (the top layer of skin).

Water softens skin so the topical medications and moisturizers can be absorbed.

Water removes allergens and irritants.

Water cleanses, debrides, and removes crusted tissue.

Water is relaxing and reduces stress.

Is water an irritant or a treatment?

Water *irritates* skin IF...

- Skin is frequently wet without the immediate application of an effective moisturizer.
- Moisture evaporates, causing the skin barrier to become dry and irritated.

Water *hydrates* skin IF...

- After skin is wet, an effective moisturizer is applied within 3 minutes.
- Hydration is retained, keeping the skin barrier intact and flexible.

What are some cleansing tips?

Gently cleanse your skin each day.

Use mild, non-soap cleansers.

Use fragrance-free, dye-free, low-pH (less than 5.5) cleansing products.

Moisturize immediately after cleansing while your skin is still wet.

Avoid scrubbing with a washcloth or towel; pat instead.

What cleansing product should I use?

Our skin surface is much more acidic than soap; the average pH of soap is 9-10.5 while the normal pH of skin is 4-5.5. Some non-soap cleansers are specially formulated with a lower pH to be less irritating. Following are a few suggestions:

Aquaphor® Gentle Wash & Shampoo
AVEENO® Advanced Care Body Wash
Basis® Sensitive Skin Bar
CeraVe™ Hydrating Cleanser
Cetaphil® Gentle Cleansing Bar
Cetaphil® Gentle Skin Cleanser
Dove® Sensitive Skin Unscented Beauty Bar
Eucerin® Calming Body Wash
Exederm® Cleansing Wash
Mustela® Stelatopia Cream Cleanser
Oilatum® Cleansing Bar

What are some cleansing pitfalls?

Scrubbing

Use of astringents

Cleansing without moisturizing

Use of harsh soap-based cleansers

- Harsh surfactants can damage epidermal barrier.
- Soaps with an alkaline pH can further disrupt skin barrier proteins and lipids.

What does cleansing remove?

Sebum (an oily substance produced by certain glands in the skin)

Apocrine and eccrine secretions (skin gland secretions, discarded cells)

Environmental dirt

Bacteria, fungus, yeast and other germs

Desquamated keratinocytes (dead skin cells that are the normal product of skin maturation)

Cosmetics, skin care products, medications

What is preferable, a bath or a shower? For how long?

Either a bath or shower (about 10-20 minutes long) will keep the skin from drying out.

Do NOT rub your skin.

Do NOT completely dry your skin after your shower or bath. Instead, pat yourself lightly with a towel if needed.

What type of bath should I take?

A soak in a tub of lukewarm water for 10-20 minutes will help the skin absorb water. You may wish to try one of the following for specific treatment:

Bleach Baths: Bleach baths make the tub into a swimming pool! Soak for about 10 minutes and rinse off. Use 2-3 times a week. Bleach baths decrease the bacteria on the skin and decrease bacterial skin infections. Use 1/2 cup household bleach for a full bathtub, 1/4 cup for a half bath.

Vinegar Baths: Referred to as the "pickle the patient" treatment. Add one cup to one pint of vinegar to the bath. Can be used as a wet dressing too as it kills bacteria.

Bath Oil Baths: Oils in the bath are a favorite of some providers and patients. Bath oils can leave the tub slippery—be careful. They can also leave a hard-to-clean film. See if they work for you.

Salt Baths: When there is a significant flare the bath water may sting or be uncomfortable. Add one cup of table salt to the bath water to decrease this side effect.

Baking Soda Baths: Added to a bath or made into a paste it can be used to relieve the itching.

Oatmeal Baths: Added to a bath or made into a paste it can be used to relieve the itching.

What does moisturizing do?

Moisturizing improves skin hydration and barrier function.

Moisturizers are more effective when applied to skin that has been soaked in water.

What are the different kinds of moisturizers?

There are three basic classes of moisturizers:

Ointments are semi-solid greases that help to hydrate the skin by preventing water loss. Petroleum jelly has no additional ingredients, whereas other ointments contain a small proportion of water or other ingredients to make the ointment more spreadable. Ointments are very good at helping the skin retain moisture but they are often disliked because of their greasiness.

Creams are thick mixtures of greases in water or another liquid. They contain a lower proportion of grease than ointments, making them less greasy and more liked. A warning: creams often contain stabilizers and preservatives to prevent separation of their main ingredients, and these additives can cause skin irritation or even allergic reactions for some people.

Lotions are mixtures of oil and water, with water being the main ingredient. Most lotions do not function well as moisturizers for people with dry skin conditions because the water in the lotion evaporates quickly.

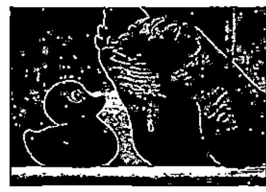
What moisturizer should I use?

The importance of moisturizing cannot be over emphasized as a treatment for eczema and sensitive skin. Moisturizers maintain skin hydration and barrier function. Generic petroleum jelly and mineral oil (without additives) are two of the safest, most effective moisturizing products.

Following are a few suggestions:

Aquaphor® Healing Ointment
AVEENO® Advanced Care Moisturizing Cream
Ceratopic® Ceramide Replenishing Cream
CeraVe™ Moisturizing Cream
Cetaphil® Moisturizing Cream
Crisco Regular Shortening
Eucerin® Calming Creme
Eucerin® Original Creme
Exederm® Intensive Moisture Cream
La Roche-Posay® Lipikar Balm
Moisturel® Therapeutic Cream
Mustela® Stelatopia Moisturizing Cream
Theraplex® Emollient or Lotion
Triple Cream®
Vanicream™ Moisturizing Skin Cream
Vaseline® Petroleum Jelly

Apply moisturizer to your skin immediately after your bath or shower and throughout the day whenever your skin feels dry or itchy. Some people prefer to use creams and lotions during the day and ointments and creams at night. If you can't find the product you want, ask a pharmacist to order it for you in the largest container available. Buying your moisturizers in large containers like one-pound jars may save you a great deal of money.



What are proper moisturizing techniques?

Just as it is important to use proper bathing techniques, it is important to properly apply moisturizers to your skin within three minutes of showering or bathing.

While your skin is still wet, apply prescription medications, and then apply a moisturizer to all your skin.

A thick bland product is best.

Dispense the moisturizer from large jars with a clean spoon, butter knife, or pump to avoid contamination.

Take a dollop of moisturizer from the jar, soften it by rubbing it between your hands, and apply it using the palm of your hand stroking in a downward direction.

Do NOT rub by stroking up and down or around in circles.

Leave a tacky film of moisturizer on your skin; it will be absorbed in a few minutes.

Everyone has different preferences concerning how products feel on their skin, so try different products until you find one that feels comfortable. Continue use of the moisturizer(s) even after the affected area heals to prevent recurrence.

How can I reduce skin irritation?

After bathing and moisturizing, the next important step is to attempt to reduce skin irritation.

Don't scratch or rub the skin. These actions can worsen any itch. Instead, apply a moisturizer whenever the skin feels dry or itchy. A cool gel pack can provide some relief from itch.

Wash all new clothes before wearing them. This removes formaldehyde and other potentially irritating chemicals which are used during production and packing.

Add a second rinse cycle to ensure the removal of soap if you are concerned. Use a mild detergent that is dye-free and fragrance-free.

Wear garments that allow air to pass freely to your skin. Open-weave, loose-fitting, cotton-blend clothing may be most comfortable. Avoid wearing wool.

Wet wrap therapy can effectively rehydrate and calm the skin. Soak in a bath, and then apply moisturizer. Medication should also be applied if currently prescribed. The bandages, moistened in warm water until they are slightly damp, are then wrapped around the area. Dry bandages are wrapped over the wet bandages. In place of bandages, athletic socks, or moistened pajamas worn underneath a set of dry pajamas can be used with children and infants.

Work and sleep in comfortable surroundings with a fairly constant temperature and humidity level. Cooler temperatures are preferred but not so cool as to initiate chilling.

Keep fingernails very short and smooth by filing them daily to help prevent damage due to scratching.

Make appropriate use of sedating antihistamines, which may reduce itching to some degree through their tranquilizing and sedative effects.

Use sunscreen on a regular basis and always avoid getting sunburned. Use a sunscreen with an SPF of 15 or higher. Sunscreens made for the face are often less irritating than regular sunscreens. Zinc oxide or titanium dioxide–based products are less irritating.

Go for a swim, which can provide good hydration. Chlorine can also decrease bacteria on the skin that can cause itching or develop into an infection. Of course, residual chlorine or bromine left on the skin after swimming in a pool or hot tub may be irritating, so **take a quick shower or bath immediately after swimming,** washing with a mild cleanser from head to toe, and then apply an appropriate moisturizer while still wet.

National Eczema Association

For additional information, or to receive a sample of our quarterly newsletter, please contact us.

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For more educational resources and tips, visit the Eczema & Sensitive Education program at www.easeeczema.org

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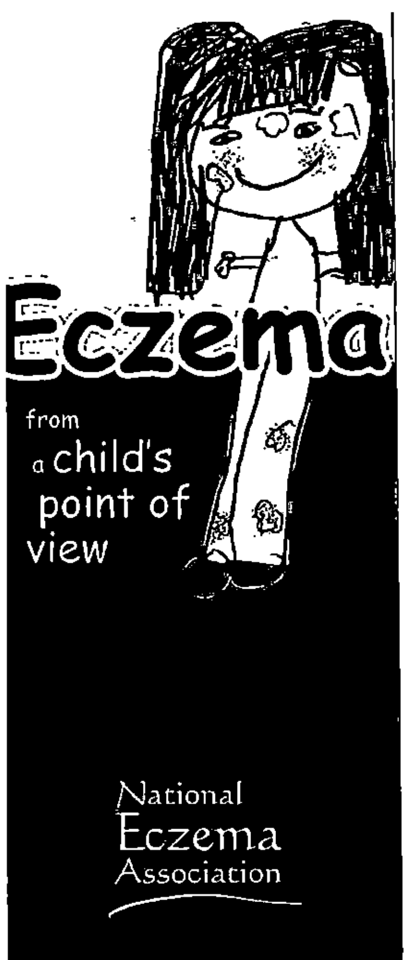
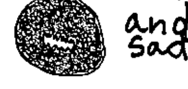

Eczema
from
a child's
point of
view
National
Eczema
Association

How do you see eczema?

- a skin disease *
- A rash that never can be treated and sometimes sore.
- a skin disease with food allergies
- unbearable
- painful
- an everyday problem
- red with your eyes
- like chicken pox
- itchy, dry skin *
- red spots *
- a rash *
- evil
- special



What color would you give eczema?

- red *
- pink *
- pinkish reddish
- blue
- orange
- pink or brown
- tan, skin color
- green with pink polka dots.

How does eczema make you feel?

- mad
- itchy *
- sad *
- upset *
- different *
- frustrated
- self conscious
- uncomfortable
- It makes me feel like I have a very bad rash.
- I don't really care.
- not sad, not happy
- Strong. I see my sister everyday and see how strong she is, it makes me stronger too.

How do people who you meet on the street see you?

- They just see my rash.
- They think it is poison ivy. *
- chicken pox *
- stare
- odd
- no way
- different
- normal *
- diseased
- fine and ok
- They see red.
- contagious, gross
- They see me coming.
- Some people don't even know I have it.

How do you think your parents see eczema?

- a rash
- itchy
- lotions
- same as me
- dry, itchy skin
- a skin disease
- terrible burden
- He has red stuff.
- red "ichey" spots *
- breaks out and gets red
- They have to deal with it.
- For mine, it's a very bad itchy rash.
- A rash that is severe, leaving blood opened wounds that won't heal until treated.
- Something that needs to be cured.
- a horrible and unbeatable disease. *
- A terrible skin problem people get.
- Stop scratching, it will make it worse. *
- A really bad skin disease that has affected our lives.
- They would use scientific phrases.

How about your teachers, how do they see eczema?

- They see red.
- They think it is bad.
- They see a rash. *
- dry skin
- red spots
- They think it is poison ivy.
- They feel sorry for me.
- chicken pox
- a skin disease
- uncomfortable
- My mom sells them.
- Teachers say "no scratch".
- They just think it's an itchy rash.
- They feel bad, tell you not to scratch.
- I don't think they know I have it. *

...and your friends?

- They think it is "Pozin ivey". *
- They see red spots.
- a rash *
- a skin disease
- I don't know. *
- They feel bad for you.
- not normal, odd
- like chicken pox *
- a common problem
- They see kids scratching
- Too bad you have eczema.
- They don't know about it or think it's just a rash.

*said by lots of kids . . . .

What are some of the problems kids face having eczema?

- itching ★
- scratching
- sleeping a lot
- boo boos
- breaking out
- itchiness and pain
- trying to stop scratching
- itches until it bleeds, get scabs
- getting up a lot at night and itching
- feeling left out
- My brother's friends desert him sometimes.

I feel bad

Who do you feel the most comfortable talking to about eczema?

- Mom ★
- my family ★
- parents ★
- brother ★
- sister
- friends ★
- specialists
- no one

What helps you deal with eczema?

- medicine ★
- lotion ★
- cream ★
  - wrapped hands
  - something cold
  - a warm shower and a ton of cream
    - a book
    - comics
    - relaxing
  - playing with my friends
- activities like video games
- people not noticing it right away
- my parents
- Nothing really, I guess just knowing it will go away soon.

A thoughtful brochure created by children for children.

All the pictures and words in this brochure were collected at a NEA patient conference where children could express themselves through artwork and answer important questions about how it feels to be affected by eczema.

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The ADVOCATE

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A QUARTERLY PUBLICATION OF THE NATIONAL ECZEMA ASSOCIATION

2014 NEA CONFERENCE RECAP:

BASIC SKIN CARE

ECZEMA AND ALLERGIES

MEDICATIONS AND TREATMENTS

NATIONAL
Eczema
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National Eczema Association is a national nonprofit patient-oriented organization dedicated to eczema education and research. The association was founded in 1988 in Portland, Oregon, by individuals with eczema, nurses, physicians, and others concerned with the enormous social, medical, and economic consequences of this disease. The association is supported by individual and corporate donations.

Cover Photo: This issue is the first of two magazines celebrating NEA's 2014 Patient Conference. Enjoy adaptations of conference presentations (pages 4, 9, 18, and 23), and hear directly from attendees about their conference experiences (page 30). And don't forget to celebrate eczema hero Irene Crosby on page 29 too!

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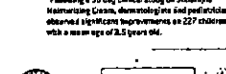

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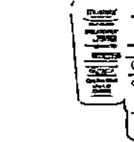

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BASIC SKIN CARE *for* ECZEMA

Adapted from a presentation by Margaret Lee, MD, PhD, at the 2014 National Eczema Association Patient Conference

Let's Learn from Each Other

As a doctor, I learn continuously from my patients, and I know that all of my patients and families are unique. Each person is an individual; each family has their individual issues. But you are not alone. Birds of a feather who flock together are happier. You are fortunate to have a support organization like the National Eczema Association. Not all patients do.

I Can Relate

I'm sure many of you go to the doctor, and think, "You have perfect skin, so how do you know what it's like to be itchy all the time?" I actually did grow up as an itchy kid. While I have not had the severity of full-body eczema that some patients suffer with, I relate to having really sensitive skin and contact allergies. Some of the tips that I've come up with to help patients with atopic dermatitis come from things that I have benefited from myself or would be willing to try.

Not Just Eczema, but Atopic Dermatitis

Eczema is actually a diagnosis that's derived from the words that mean "to erupt" or "to boil" and is a bit more broad than atopic dermatitis: eczema is any condition that involves itchy, flaky, inflamed skin. Most of you are here to learn more about atopic dermatitis, which is chronic or recurring eczema in a person who is prone to inflammation and allergies.

A Compromised Skin Barrier

A basic skin care regimen should focus on the fundamental aspects of atopic dermatitis. In atopic dermatitis there's a skin barrier function problem. The people with the worst atopic dermatitis have absent or abnormal skin proteins in which the cells at the upper layers of the skin, called keratinocytes, are not producing appropriate proteins. That can reduce the skin's ability to do all of the things that it's supposed to do.

For example, because we're mostly made of water, normally the skin is supposed to keep water in. When you have the impaired skin barrier that comes with atopic dermatitis, the skin isn't able to hold water in, and so it gets very dry. (Dry skin is the leading cause of itch for anyone, whether they have atopic dermatitis or not.)

What's more, that compromised skin barrier allows for the penetration of many chemical irritants and potential allergens, which may become true allergens for an individual. On top of that, once those microbes have gotten through, an increased number of microbes can penetrate the skin barrier, and the skin is less capable of combatting bacteria and viruses to prevent a full-blown infection.

An Increased Itch Factor

People with atopic dermatitis skin are fundamentally more physically sensitive to sensations and itch. Over the years, publications have shown that with atopic dermatitis, you may have increased proteins that signal for itch and increased nerve endings that help pick up the itch sensation and transmit that sensation to your brain.

Managing Atopic Dermatitis Requires a Multifaceted Approach

Think of maintaining healthy atopic dermatitis skin as supported by a three-legged stool that simultaneously requires attention toward limiting bacteria, causes of inflammation, and itching/scratching. If you can't manage, maintain, or fight any of these individual things, you can worsen an already impaired skin barrier, which then causes problems in the other two areas. It becomes a vicious cycle of discomfort, leading to that eruption of fiery inflammation.

Fighting Inflammation Like a Fire

How do we fight a house fire? With water. We also use water when tending to atopic dermatitis. We need to rehydrate that dry skin — and no moisturizer is as effective at rehydrating dry skin than plain water. You need to bathe and soak in lukewarm water for 10 to 15 minutes, which is long enough to rehydrate but not so long as to further weaken the skin barrier significantly. When you add bleach (sodium hypochlorite) to the water, you have a low-risk treatment that bacteria can never become resistant to.

Another way to fight fire is with a fire extinguisher. That's how I think of topical steroids and other anti-inflammatory medications. We must learn to use them cautiously but effectively, in pulses, like fire extinguishers.

You also can fight fire by smothering it — my analogy for eczema skin occlusion with barrier ointments, clothing, or plastic wrap. Occlusion helps retain moisture, blocks entry of irritants, allergens and microbes, and promotes healing by creating a physical barrier against scratching.

Preventing the Fire from Erupting

In order to prevent the fire, or eczema flare-ups from appearing, many of the same strategies apply: you need to soak in water to hydrate, reduce microbes with bleach or soap-free cleansers, and protect the skin barrier with barrier creams, ointments, and other forms of occlusion.

For some patients who have eczema that really bounces back, using the fire-extinguisher approach — short, strong bursts of corticosteroid or regular pulsed use of medications — can be very helpful. A schedule can be worked out

with your physician, and just how many medications are included in the regimen depends on the patient.

Finding the Right Ointments/Occlusives In a Sea of Selections

There are many products designed to maintain skin moisture and it can be overwhelming to choose. Every now and then, I cruise through the pharmacy aisles, just to see the options for patients. The truly hypoallergenic products are not always organized together.

To help make the process a little less daunting, I recommend a few products that can help. (And, I'd also like to disclose that I'm not being paid to talk about any of the specific products I mention here.) My favorite thing to talk about is actually vegetable shortening because most people don't think about using it to help their skin and it's really inexpensive. If you think about what all these barrier compensation creams or ointments do, it's to help seal the water into your skin once it's already wet from the bath or the shower. Vegetable shortening does the same thing. If you have a lot of food allergies, however, make sure you're not allergic to the vegetable ingredients that the oil is derived from, because we can't speak to how well it's purified.

Dermatologists also recommend petroleum jelly a lot because it is generally well tolerated, even for patients who are truly sensitive and for whom many products sting. Of course, petroleum jelly can be tricky in that it's heavy, sticky, and can get onto furniture and clothing. So while smearing petroleum jelly all over the body can be particularly messy, I encourage applying it on what I call your "hot spots," places on the body where the fire tends to recur, because those patches of skin are going to be the most sensitive to chemical irritants and other ingredients.

Because ointments like petroleum jelly, Hydrolatum, and Aquaphor don't contain the type of ingredients that are added to cream and lotion moisturizers to keep them emulsified and creamy, they can often be tolerated by a lot of people. But again, everyone's an individual. I've had patients or parents tell me that Hydrolatum stings. And since Aquaphor contains a lanolin derivative, people theoretically could become allergic to it. It's a good idea to work with your physician to figure out what's best for you.

Natural and Organic Options + Product Costs

For those who are worried about impurities in petroleum (though Vaseline Petroleum Jelly is highly purified, and we

don't know of problems with impurities in it), or the environmental impact of using petroleum products, there are products like Un-Petroleum Multi-Purpose Jelly. California Baby products are popular, as are a few other products that bill themselves as being "organic" and "all natural."

However, for severely atopic and allergic patients, make sure that there are no allergies or sensitivities to the plant derivatives that are in some of these natural or organic products. Also keep in mind that such patients are at increased risk of developing new plant allergies from these products. Remember, poison ivy is "all natural," too. These "all natural" products can also be more expensive, at an approximate cost of $7 per ounce as compared to a petroleum product at about 35 cents per ounce.

More expensive creams aren't necessarily better. I say, save the money for college or a vacation!

Wrap It Up: Skin Strategies for Little Kids

Parents have seen that when it comes to babies' skin, the diaper area tends to be the smoothest and most hydrated. When it comes to babies with atopic dermatitis, more often than not, we often see that their skin can be the best in the diaper area. If we could diaper the whole body, then kids suffering with atopic dermatitis would do really well. But since we can't diaper the whole body, what we need to do is come up with other ways to compensate by providing a physical barrier for that inherently impaired atopic dermatitis skin.

Everybody has to try different things and decide what works for them, but I like plastic wrap for focal rashes. I don't suggest securing the wrap onto the skin with tape because a lot of kids can develop allergies to the adhesive in tape itself. In order to conceal the plastic wrap and make the look more fun for kids, covering the wrap with colorful duct tape sold at hardware stores (though not in a way that the tape could stick on the skin) helps disguise the weird-looking wrap, possibly creating something kids might be willing to wear to school.

Wet Wraps and Gloves

When we prescribe wet-wrap therapy, that doesn't necessarily mean using gauze wraps on the skin; you can use clothing to help seal in moisture. Soft, smooth cotton clothing with reduced seams can be great to cover the child for bedtime. For another alternative, long sleeve cotton thermal underwear can be flipped inside-out so the seams don't touch the skin.

Sometimes you perform the whole wet wrap or wet pajama routine and you're okay for a while. If you wake up itchy in the middle of the night because the wet wrap cloth has dried out, you may need to start over, wetting the skin again and applying more barrier cream or ointment. Reassess what you are covering the wet wrap/clothes with. It can be challenging if sweating occurs, so trial and error is needed to find what works for you during different seasons.

If you have hand or wrist dermatitis, wearing fingerless gloves can help protect the skin while still allowing for finger dexterity, e.g., for holding pens and pencils.

Kinder, Gentler Bleach Baths

We love to recommend bleach baths but know these don't work for everyone. Bleach baths can be painful because they're often called for at the time when the skin is flaring and has a lot of open wounds. One tip I like to suggest is to get into the bath with dressings still on. This will allow the skin to re-equilibrate and help alleviate some of that initial discomfort of getting into the bath, before you start pulling the wraps off. Another way to help tolerate getting into bleach baths is to put a little antibacterial ointment or petroleum jelly in the cracks of the skin. For children, you can distract the child with toys or an activity during the first couple of minutes of a bleach bath, so they're focused on something other than the changing skin sensation that takes place in the first few minutes after getting in the tub.

Schedule "Spa Time"

I encourage older kids and adults to use the evening bath time as their "spa treatment." It's a time to say, "This is how I'm taking care of myself. I'm really going to relax, decompress, and get ready for bed." Bedtime is usually the most itchy time for people.

Instill Itch Intervention

Just as you all should have a plan for when you see a fire starting in your home, you and your whole family should have a plan for when you see that you're having a more significant degree of itching or repeated itching in a particular place. You want to stop the sparks before the fire starts. And we all know that the command, "stop scratching" doesn't work, right? If anything, it might actually make your child more anxious, which can lead to anxiety and more scratching. I came up with something called the **Instant Itch Intervention Plan** to help find an active, behavioral replacement for scratching constantly itchy skin:

Step One: Skin Action

This can vary per person, but your skin action might mean applying a moisturizer and paying attention to how that helps. Or try wetting your skin before applying

a moisturizer. Some may want to use a cold compress, , or take a shower in order to rinse off sweat, irritants, and allergens, and to rehydrate dry skin. Others might want to adjust the bath routine so as to take a couple of really short baths or showers on that day, if needed.

We know from studies that applying a moisturizer or wrap is not as effective in long-term control of itch as using a corticosteroid. You still can get a lot of comfort from moisturizing and wrapping the skin because you're doing barrier compensation — even if it's just for 30 minutes, just to get over the itch episode.

If putting on moisturizer or adding a wrap isn't quite enough, then you might want to use a steroid before you see the rash (and you know that if you keep scratching, that rash is bound to appear). I like to use the steroid on a hot spot just before it really flares up. You and your health provider can talk about where or when you can also use a corticosteroid for maintenance control.

Step Two: Distraction Action/Focus on Something Else
As soon as you've treated the skin the way that is right for you, know that the itch isn't going to settle down instantaneously. Treatment needs a few minutes to work. While your skin action(s) take effect, do something fun to distract the mind from the itch. (This is one of the few times I would advocate playing video games.)

Try a relaxing activity before bed, like reading a book or telling a story, doing meditation, or listening to music. The idea is to find as many healthy ways as possible to forget about scratching. Laughing and doing fun or relaxing things increases dopamine, serotonin, and endorphins. All these brain chemicals can make you feel better and reduce itch.

Sometimes you might be able to notice that you're itchy, accept that you're an itchy person, and just let it be. If you've taken action to help provide relief, believing in it and giving it time to work can sometimes quell the compulsion to scratch. There is no "one answer." You've got to find what works for you.

Margaret Lee, MD, PhD, is an instructor in Dermatology at Harvard Medical School and a pediatric dermatologist at Boston Children's Hospital. ●

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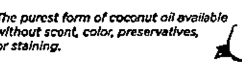

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ECZEMA MEDICATIONS *and* TREATMENTS

Adapted from a presentation by Elena Hawryluk, MD, PhD, at the 2014 National Eczema Association Patient Conference

Topical Medicines, Oral Medicines, and Phototherapy: An Overview

All of our therapies target what we call "the cornerstones of eczema" — the itch, infection, inflammation, dryness, and inherent barrier defects that are involved with eczema. Because we unfortunately don't have a cure that will reverse eczema right now, we focus our therapies on these cornerstones.

Similar to many skin diseases, the treatment for eczema is not a "one size fits all" situation. Eczema treatment evolves over time for each individual patient. What works for you at one point in time might not work in a different season or 10 years from now. This can affect whether you need more or less therapy. You have to work very closely with your team of caregivers to ensure your treatment is best tailored for any given situation.

It's also important to practice a strong foundation of skin care outside of what's prescribed. All of our medicines are helpful, but they're even more helpful if you're already working with a strong foundation and a strong skin care routine. That baseline skin care — which includes engaging in healthy bathing practices, and the use of gentle products, moisturizers, and emollients — can also help as you taper off some medicines, which is really important as we look at your overall care.

Topical Therapies

In regard to topical therapies, among our first-line medications are topical corticosteroids, because they provide excellent effects for inflammation and itch. They can also combat dryness, depending on the thickness of emollient used. It's important to remember that not all corticosteroids are created equal; they come in many different strengths and have different chemical structures which can impact how effective they are. The vehicles in which they're prepared can also have a big impact on efficacy. So whether you're using steroid in an oil, ointment, solution, lotion, or cream can have an impact on how effective it may be.

Topical steroids are divided into seven classes, which range in potency from Class 1 (very potent steroids) to Class 7 (very weak steroids). The same steroid can have different levels of potency, depending on the solution in which they're prepared. For example, in ointment form, mometasone falls in a high-potency class, but when you use the very same steroid as a cream, it falls in the medium-potency class. Knowing the name of the steroid doesn't necessarily offer you all the information about the treatment because potencies can vary depending on how they're formulated.

It's also important to keep in mind that the percentages of active ingredients don't always tell the whole story in terms of how strong the steroid may be. For example, hydrocortisone 1% ointment or cream (which can be found over the counter and is very common) is very mild and is categorized in the weakest class. But one of the strongest topical steroids has a listed concentration of 0.05%, (which is a very tiny number compared to the 1% hydrocortisone ointment or cream, even though it's much stronger).

In terms of their chemical structure, steroids are divided

into classes, A, B, C, and D. Those within the same class have a similar chemical structure. If you're looking to switch to a different steroidal medication, we often move to a different chemical class when picking which steroids to use.

The 2014 Consensus Statement on the Management of Eczema, published in sections in the *Journal of the American Academy of Dermatology*, gives us guidance regarding choice of topical steroids. We use very different steroids on infant skin than we do on adult skin, for example. Areas of the body can also effect our choice of best steroid, such as whether we're treating thick skin (on the scalp or the back) or thin skin (on the eyelid or genitals). Certainly, the degree of dryness can impact whether we might want to use an ointment or a cream preparation as well. Patient preference is another important consideration. I've had many patients who have told me, "I'll do whatever you say but if you prescribe an ointment, I'm just not using it." Because it doesn't help to prescribe a medicine a patient won't use, it's important for doctors and patients to take preferences into account. Finally, cost plays a part in steroid choice. Some insurance companies cover different steroids at different degrees, and some steroids are, unfortunately, a little harder to get than others. We take that into account when selecting the best steroid option for a patient.

Generally speaking, it's recommended that steroids be applied twice a day. Fortunately, the skin can tell us when it's absorbing too much medicine; this is when we start to see side effects in the patient. Side effects of topical steroids most commonly initially present on the skin with signs such as increased blood vessels or thinning of the skin. We provide physical exams to monitor for skin side effects. If we see a lot of side effects on the skin, then we also begin to think about how systemic side effects may affect the body internally. This is especially important to watch for when using steroids on large surface areas of children's skin, in patients who have a lot of skin breakdown, or when the steroid application is covered (occlusion) in order to increase potency.

As a general rule of thumb, we use the fingertip unit of measurement to decide how much of a steroid we need to apply. The fingertip unit refers to the amount of steroid in a small strip on that very last portion of your finger (from the last joint to the fingertip). That one fingertip unit will be enough medication to cover the skin on two adult hands. From there, we scale the amount up or down accordingly.

We also encourage proactive use of a topical steroid treatment on "hot spots," or areas that commonly flare. If you've worked very hard to get your eczema under control, and things are nice and quiet, a lot of times we recommend intermittent use of the topical steroids as maintenance therapy because continuing the use of steroids on those hot spots can prevent relapses. This has been found to be more effective than just using emollients alone.

Calcineurin Inhibitors

Another category of topical treatments consists of the calcineurin inhibitors, tacrolimus and pimecrolimus. They also work to reduce inflammation, improve itch, and can combat dryness—especially when used in an ointment formulation. It's important to talk about these options with your doctor before starting them because they have an FDA black box warning, which was added to the package labeling in 2006 as a response to a strong increase in use of topical calcineurin inhibitors as an alternative to steroids, and there is data suggesting an increased risk of cancer (which is particularly important if these medications are used in their oral formulations for long periods of time at high doses, such as with immunosuppression conditions). I like to have an up-front talk with my patients about this potential risk and explain to them that our use is topical, in limited focal areas, and that I find (along with the American Academy of Dermatology and many other providers) these topicals to be very safe for long-term use in a controlled manner for eczema. It's important for patients to be informed of this labeling prior to picking up a prescription for the first time and noticing the FDA warning on the packaging.

In many situations, the use of a topical calcineurin inhibitor is preferred over that of a topical steroid. One instance is when the skin has become resistant to steroid use in sensitive areas, such as the eyelid or the lips. A topical calcineurin inhibitor may also be the best choice when side effects from topical steroids begin to show in the folds of the skin, where you might have too much steroid absorption. Topical calcineurin inhibitors can also be helpful in places that are already showing signs of steroid-induced changes such as atrophy. Similarly, if you've been on a topical steroid for a long time and are looking for a break from steroid use and would prefer to rotate another medication in, topical calcineurin inhibitors can be very helpful.

Topical Antimicrobials and Antiseptics

Topical antimicrobials and antiseptics are medicines that are applied topically in efforts to reduce bacteria, though the 2014 Consensus Statement on the Management of Eczema designates only specific scenarios where they are recommended for eczema, specifically, in patients who have moderate to severe eczema and signs of infection on top of their eczema (called secondary bacterial infection or superinfection). For these patients, dilute bleach baths and mupirocin used intranasally to reduce the colonization of bacteria on the skin are often recommended to reduce the severity of eczema.

Topical antihistamines also help many patients, but the 2014 Consensus Statement does not recommend their use for eczema specifically, mainly due to the risks of absorption and contact dermatitis that patients can develop from them. Many patients do benefit from them, however, so this is another one of those situations where individual patient preferences and conditions must be taken into account.

Other topical treatments available that have been used for eczema include tar, biologic devices, and others in development. Tar has been used for many years and studies have shown that tar is about as effective as 1% hydrocortisone. There are biologic devices, such as Epaderm and Atopiclair, which are prescription-only topicals designed to work on the skin barrier. There are also topicals in development such as the phosphodiesterase inhibitors, which may be used to treat eczema in the future.

Phototherapy

Phototherapy is the controlled delivery of ultraviolet (UV) light for anti-inflammatory purposes. It's effective for many patients, but safety is always a priority. With this in mind, when patients start phototherapy, their first treatments are sometimes as short as 15 seconds of exposure. Over time, the length of sessions in the phototherapy unit gradually increases. Treatments are individually tailored depending on skin type, tendency to burn, the amount of pigmentation, and the response of the patient's eczema. There are different types of wavelengths of light that can be delivered, including UVB, UVA1, or a combination of ultraviolet lights. Often patients start out with three sessions a week, and typical phototherapy courses last three to five months. I tell my patients to expect to undergo 15 treatments (for a duration of at least five weeks) before considering whether it is helpful. This is not a quick fix, so I make sure that everyone knows that it's a commitment, because I want my patients to give it a fair shot.

Sometimes patients are prescribed psoralen, which is a photo-activating medication that can be taken orally or applied topically before light exposure; it gives patients an extra boost of a response. Finally, in some parts of the country the Goeckerman Therapy regimen is used. In this therapy, tar is applied to the skin lesions, which also makes patients more sensitive to the light from phototherapy. Selection between these options depends on local availability. Cost is also an issue, as many insurance companies, unfortunately, are charging co-pays with every phototherapy visit. Patient skin type, current medications, and whether patients have had skin cancer in the past are also factors in how light therapy impacts skin. For example, some patients exposed to phototherapy may have a more vigorous response if they are also taking certain antibiotics and/or hypertensive medications that are common in the general population. All of these factors must be taken into consideration.

According to the 2014 Consensus Statement, phototherapy is considered a second-line treatment. If the use of emollients, topical steroids, and topical calcineurin inhibitors fail, then phototherapy can be used as a maintenance therapy. Phototherapy should be performed under the supervision of a doctor who is experienced in managing the treatment. Additionally, phototherapy units are sold

for home use, and can deliver the therapy safely as well.

Mother Nature's phototherapy is also called "heliotherapy." In my experience, patients who do well with phototherapy tend to tell me that their skin is best in the summer. This may be due to a combination of natural sunlight and summer activities, such as spending more time in the swimming pool (something that may deliver a bleach bath-like effect). I take patients' input very seriously in considering whether phototherapy might be an appropriate option.

Oral Medications

Antibiotics, antihistamines, and many anti-inflammatory medicines are used as oral medications for eczema. Antibiotics can be particularly helpful if there is clear evidence of active Staph infection, as an antibiotic may help alleviate oozing and painful skin. For those patients who improve with frequent administration of antibiotics (which signals they may have a high burden of bacteria that may be aggravating their eczema), I often suggest regular dilute bleach baths or other decontamination measures.

Antihistamines tend to work for eczema by helping to induce sleep and reduce loss of sleep. Antihistamines can also help patients who have eczema and allergies or eczema and hives concurrently. When looking at eczema alone, however, antihistamines haven't really been shown to change the skin disease itself. In the absence of hives, non-sedating antihistamines are not recommended for the management of eczema.

Systemic Anti-Inflammatories

Systemic anti-inflammatories are generally indicated for patients who do not respond to the optimal topical regimens and have tried many different iterations of topical steroids. For these patients, working closely with their doctor to tailor treatment for their needs is important. I always start by talking about systemic corticosteroids or oral prednisone because so many patients tell me that they were on prednisone for either their skin, or asthma, or another reason, and found that their skin improved quickly. Unfortunately, when patients stop taking the medicine, the skin flares like wildfire, often harder to control than prior to oral steroids, so that's something to be aware of.

It's thought that systemic corticosteroids are best avoided when it comes to long-term management for eczema patients, because the temporary benefit is outweighed by the short- and long-term risks. However, they can be used for a short period of time in order to help transition to another medication or phototherapy to get the disease under control. Systemic corticosteroids can be a quick fix, but unfortunately can pose problems if you're not focused on how you're going to taper off from these oral steroids.

In terms of other systemic treatment options, there is evidence-based data for a number of medicines. The 2014 Consensus Statement addresses four of them: cyclosporine, methotrexate, mycophenolate mofetil, and azathioprine. I don't like to use these medicines unless absolutely necessary, because they all have significant toxicities. They do have a place in care for when they're really needed, but when we do use them, we like to use them at the lowest possible dose for the shortest amount of time in order to minimize the associated risks. Unfortunately, they're not perfect and they're not a cure. They are helpful in many situations and I think based upon the guidelines, we do want to make sure that we're all aware of them.

Cyclosporine was originally isolated from a soil sample in Norway in 1969 and some people consider it natural because it's from the soil. It was developed as an immunosuppression medication used to prevent rejection of organs after transplantation. In my experience, Cyclosporine works very quickly and we think of it as a rescue medication to be used for a short period of time to get skin under control. When prescribing cyclosporine, I make sure that I'm screening the patient appropriately, monitoring the patient closely, and educating the patient of the many things to consider. I think about which medications it may interact with and whether the patient has an underlying cancer, since cyclosporine impacts the immune system. It's also important to monitor blood pressure in these patients and at least two baseline normal blood pressure measures are needed before a patient can start this medicine. Some side effects of cyclosporine include hypertension and elevating lipids, so we monitor patients very closely with monthly labs in order to minimize these potential side effects. We also try to keep this medication course very short: six months at the maximum.

Methotrexate was initially discovered as a compound similar to folic acid and has also been around for quite a long time. In the late 1940s, it was used for children with leukemia, and at high doses methotrexate is still used as a chemotherapy. At low doses it's pretty well tolerated for autoimmune diseases. Methotrexate is given once weekly, and can be given orally or by injection. It does have serious medication interactions and affects fertility. It can also cause side effects in both the liver and the lungs, so we monitor patients regularly, especially as the dose is being adjusted. In all, this medication is one that we're comfortable using when we need it because has been around for a very long time and is used for a number of different purposes.

Azathioprine is another serious medication that was initially developed as a cancer drug in the late 1950s. Because it interferes with the synthesis of DNA, azathioprine relies on the body to metabolize it. We all have an enzyme in our bodies called thiopurine methyltransferase (TPMT), and for patients who have low levels of this enzyme naturally, azothiaprine can build up in the bloodstream and cause serious unwanted effects. For these reasons, we always check for the levels of this enzyme before using azathioprine so we know whether the medicine is safe to take. We're also concerned about medication interactions and side effects, including sun sensitivity, trouble with fertility, and even more side effects when used as chemotherapy. It requires the monitoring of labs and is a serious immunosuppressant, which is one reason why I'm glad that there is another medication that targets the same pathway: mycophenolate mofetil.

Most people know mycophenolate mofetil by the brand name CellCept, a drug tolerated without difficulty by many patients. Though it targets the same DNA synthesis pathway as azothiaprine with far fewer side effects, it still causes serious side effects, which require monitoring. The most common side effects include gastrointestinal issues, like nausea or irregular bowels. For patients taking this drug, we monitor for bone marrow and liver toxicity as well, in order to make sure the medication is being tolerated safely. It is also harmful during pregnancy.

Ongoing Studies

There are ongoing studies for a number of medicines. We have patients at Boston Children's Hospital with both immune deficiencies and eczema, who really benefit from treatment with intravenous immunoglobulin, also called IVIG. When these patients' own immunoglobulins are not at sufficient levels, we find that when given infusions of IVIG, their eczema and skin seems to improve. Another drug, interferon gamma, has been shown to be effective in many trials. Unfortunately, it has side effects which sometimes limit its use. And, of course, I want to mention Dupilumab, which is the new medication I recently read about and discussed previously. It's very early, but hopefully, very promising for all of our patients.

Currently, on clinicaltrials.gov there are 82 open studies for atopic dermatitis. Many supplements are being tested for benefit for eczema, along with some new moisturizers. Though the pathways are different, we are starting to see whether biologics relevant to psoriasis might be helpful in eczema. There are many more drugs in development. Finally, the National Eczema Association website contains ongoing information about how to access to these clinical trials: nationaleczema.org

Summary

It's helpful to remember that prescription medications work best when used in conjunction with a strong skin care foundation. It takes a lot of teamwork to address patients' changing needs, so work together with your prescriber to make sure that the regimen is exactly right for you and that treatment adjustments are made during flares. The skin can flare for so many different reasons — whether it be environmental or incidental illness — so you need to understand what to do to ramp up therapy when you need it and how to scale down when you don't. Of course, we love scaling down, getting back to that baseline foundation whenever we can. Hopefully with all of these efforts, you'll be happy with some improvements in disease, and we can all keep our fingers crossed and hope for an actual cure in the future.

Elena Hawryluk, MD, PhD, is a dermatologist at Boston Children's Hospital and Massachusetts General Hospital. ●

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My Life With Eczema: An Adult Perspective,
Excerpted from a presentation by Suzanne Hadley at the 2014 National Eczema Association Patient Conference.

In looking back at my life, I think I've had eczema for a reason. I think it's helped my kids, and it's definitely drawn me closer to my sisters and my family.

Family History

I'm the third of four girls raised in the Midwest. In my family history, I have a huge atopic triad on both sides of the family. All four of my kids have dry skin. My son Jack, who is at the Military Academy at West Point, has mild eczema. He had been medically disqualified because of his skin three times and it took him six months to get into the academy. My daughter Ellen has mild eczema. Stress definitely flares in our family, so all of my children are somewhat affected by the correlation between stress and eczema.

My sister Becky was sick from birth and never had a normal life. She was not expected to live beyond 10 or 12 years old and she made it to 33 — which is a blessing. She got married, went to college, had a job, and achieved many milestones that thrilled my parents. But she was terribly impacted with asthma and eczema. And there just weren't the medications then that there are now. Becky was supposed to be in my wedding as a bridesmaid, but she was too sick to attend and even though I told myself that she would get better, like she did so many times before, Becky passed away while I was on my honeymoon. Becky being chronically ill was a big part of my life.

Next to Becky, Elizabeth was the second most-sick sister. Elizabeth has had enormous problems with her asthma in her lifetime, but it's now well-controlled thanks to the drugs that are available, which makes me think kindly about these big pharmaceutical companies that have saved the life of my sister.

Denial

Growing up with Elizabeth and Becky, I didn't think I had a condition because when you have two chronically-ill sisters sick with life-threatening asthma, comparatively, I was "well." By the age of 10, I had Sahara-dry skin and allergies, and then at 13, when puberty hit, I woke up one day and was covered — and I mean just covered — with eczema. I've had a systemic Herpes infection for decades, from 13 to now, at the age of nearly 51. But because I didn't have severe asthma like my sisters did, nobody paid attention to anything I had, and I didn't think I had anything serious. I just thought, "Why can't I get this together? Why can't I sit still like other people? Why can't I wear clothes that other girls wear?" But I didn't really think about it too much, because I had sick sisters. This is what I think of as the "denial phase" of my life, when I didn't think I really had anything because I wasn't as bad off as my sisters. And, maybe it was good for me because I didn't feel sorry for myself. I didn't dwell on it — I just plowed ahead and didn't really think about it.

Delay

Next came what I call my "delay phase," where I knew I had something but didn't act on it. In Atlanta, right out of college, I was diagnosed by an allergist — though he didn't even tell me everything. Instead, he wrote a letter to my gynecologist or my internist and gave me a copy. He said, "I think you should read this." It was the first time that anybody had indicated I had total body involvement with eczema. I was shocked reading in that letter that I needed "some significant help."

By now, I was in my 20s and while it was kind of a relief in a way to be diagnosed with eczema, it was also kind of scary. I was told that because I was moving around so much, I should just wait on seeking treatment. "Senior citizens don't have bad eczema, allergies get better, and time is on your side," they said. Yadda yadda yadda. So I just figured that doctors would treat me down the road; I had hope and I really thought things would get better.

Distraction

After I had one ... two ... three kids came my "distraction phase." Pregnancy didn't knock it out of my system, like it did for some. (I'll tell you menopause hasn't knocked it out of my system either). I continued to get worse and I couldn't find a way to make it better. I worked to get my mind off of the problem. This was probably the least helpful phase, to be honest. I just fought it and tried to push it down too much. I'm not proud of that period but it was a tough time. I was stuck in California — a state this Midwestern kid didn't expect to be raising a family in. California was expensive, felt really high pressure, and the whole physical appearances thing was just wearing me down. I felt (and sometimes still feel) like an imposter. It is rough, as my sister said, to feel like a physical freak in the land of beauty, in the land of Hollywood, of athletics, of swimsuits, and pornography. When all you want to do is cover up, stay inside, turn on the air conditioning, and wear cotton, it's difficult. It's made me tougher, it's made me better, it's made me more compassionate, but the last 18 years were tough years for me in California.

Despair

The fall of 2011 was a challenge and by Christmastime my hair was coming out in clumps. I was humiliated. Why my hair? I'm a freak in Southern California with my body — and now my hair gets taken from me? All I could make of it was "I need to deal with this, I need to do more of *something*." I didn't need to clamp down harder and I didn't need to work harder, because whatever I was doing wasn't working.

My husband was so encouraging. But it wasn't until this point that I came clean with him. I've known my husband 25 years but until four or five years ago, I hadn't shared with him how significantly I was struggling. I thought I was doing him a favor by not passing the stress on to the family. I just thought, "I don't need to share my junk. This is my problem and I'm going to do the best I can." But it didn't work for me and everything fell apart.

Breakthrough

I talked to my husband and he said, "Of course I know. I know you're getting worse and I know you're struggling." I felt stupid to think I had ever hid it from him. I know it sounds insane to think you can hide something like this from your spouse, but I had four young kids and a husband who owned his own business, and life was going a mile a minute. Somehow, I didn't think we had time to sit down and talk about my issues and healthcare. But when I started to lose my hair, I thought, "Okay, I am totally exposed, I am at rock bottom, and what the heck am I going to do?" And that's when my two sisters encouraged me.

By then my sister Cindy planted an essential seed for me to get help and the care I needed. (I share this because maybe others do this for someone, too). We were talking on the phone and I was bereft. Even though I consider myself a strong person, at this point I had no hope. She told me, "I'll take care of the kids. I know you always talked

about going to National Jewish Health in Denver — you need to go." That was the breakthrough for me. So I said, "Great, I'm going to National Jewish."

That was the summer of 2012 and National Jewish had been in the back of my mind as, literally, my "Hail Mary" last option. I loved it there. I loved the people and the approach because I'm in an atopic triad — so I got everything else (my asthma and allergies) checked out as well. They're tuned in and take a holistic approach, so it's like a one-stop shop for all the issues. I got biofeedback and psychological help. I also I found a doctor who loved atopic dermatitis (AD). It's unbelievably helpful to see a specialist who's seen so many AD cases, that they can immediately say, "I can help you and this is what I want to do." Even if you have to go on an airplane, I suggest traveling to an AD specialist. One year later, my hair started coming in.

Hope

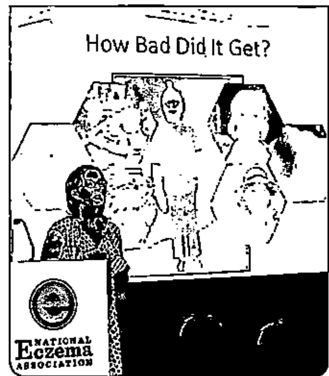
And then, hope. The last part of my story is that I'm calm, I'm comfortable, and I'm not scratching. My kids say you wouldn't know that two years ago I'd lost 80 percent of my hair. The story ends well. But I want to share with you the many things I've tried along the way.

I've done the allergy shots three times in three different states and my allergist has said they certainly don't hurt, but they haven't improved my skin. Antihistamines? I mean I can't live without those. I'm on and off oral antibiotics, though largely since I've been better, I haven't been taking them.

Dust mite control is a huge thing for me. I just can't say enough about this. It is one of my biggest triggers, so I've got my mattresses covered. I only sit in three places in my house. (I share this just because when one of my friends discovered this, she was surprised). I sit in my bed, obviously, which I keep immaculately clean. I sit in one leather chair in my family room, or I sit on a hard chair at my kitchen table. If I go to anyone else's house, I only sit on a hard chair. I will never touch their sofa or their comfy furniture, since upholstery and dust mites are huge irritants for me. Find places that work for you at home and just stick with them.

I tried vigorous exercise for stress relief. Because I am an incredibly stressful person the endorphins from vigorous exercise felt good, but it really irritated my skin.

How Bad Did It Get?



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We've all done food elimination diets, and I've done 100. I was very diligent about them, but it made my life worse. I felt more like a freak because I couldn't visit anybody or go out to eat. It gave me some comfort because it gave me some control, but it didn't help my skin. I learned it's better for me to go easy on myself with the strict diets.

I joined the National Eczema Association (NEA) nine years ago after an allergist suggested I check it out. I can't say enough about the organization. The soak-and-seal concept that I learned from NEA changed my life. I still take a bath about three times a week or as often as I can. I love how it allows me to calm down, relax my mind, and take time to focus on pleasant thoughts at night. I'm also a big fan of bleach baths.

Cotton clothing is all I've lived in for years until literally the last 12 months. Thicker moisturizers have also helped.

In terms of research, there are many clinical trials and the biologics are a game changer. I'm on a biologic right now.

My whole life has changed since last summer. It's only been three years, since 2011 when I lost my hair, and my life is so dramatically improved. My children are thrilled, my husband is thrilled, and I'm so grateful.

My Message to You

While some of the treatments that have worked for me may not work for you, here's what will find people who

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That was the summer of 2012 and National Jewish had been in the back of my mind as, literally, my "Hail Mary" last option. I loved it there. I loved the people and the approach because I'm in an atopic triad — so I got everything else (my asthma and allergies) checked out as well. They're tuned in and take a holistic approach, so it's like a one-stop shop for all the issues. I got biofeedback and psychological help. I also I found a doctor who loved atopic dermatitis (AD). It's unbelievably helpful to see a specialist who's seen so many AD cases, that they can immediately say, "I can help you and this is what I want to do." Even if you have to go on an airplane, I suggest traveling to an AD specialist. One year later, my hair started coming in.

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While some of the treatments that have worked for me may not work for you, here's what will find people who you love and with whom you can really be totally deep down honest about your eczema. My sister (and BFF) Elizabeth has been with me on this journey. It helps immensely to find somebody to walk on the journey with you.

My husband has been a rock. I can't say enough about the value of having somebody to walk with you, to hold your hand, to tell you you're lovable when you don't feel lovable, to tell you you're attractive and desirable when you don't feel attractive and desirable. Share the ups and downs with family and friends whether you're mild to moderate or severe. Share the psychosocial stuff as well as your physical stuff.

Then, when you can, pay it forward — not out of guilt or obligation, but to get on the other side to a slightly better place like I am. I hope if you see someone in the grocery store line who's scratching — someone who could maybe be helped by the NEA website, a NEA brochure, or the NEA online communities — you say, "Hey, I see. I had some of those eczema issues, too, and it's scary. There are people who understand and resources to help." Let's go pay it forward and spread the news, continue to speak up and make a difference, because there is still research to be done.

After nine years as a supporter, Suzanne Hadley became a member of the National Eczema Association Board of Directors in 2014. ●

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ECZEMA *and* ALLERGIES

Excerpted from a presentation by Lynda Schneider, MD, at the 2014 National Eczema Association Patient Conference

The Atopic March

Atopic dermatitis is often the beginning of the atopic march: babies start out with eczema and perhaps food allergies. Later on, asthma develops, possibly along with inhalant allergies, or allergic rhinitis and hay fever. During this time the body's allergic antibodies, the IgE, increase in the blood.

One of the questions is: Why do people get eczema and allergies? This has prompted a chicken-or-the-egg debate. Do we begin with a skin problem due to a defective skin barrier, which allows allergies to get into the body and cause immune dysregulation? Or does it start with an allergic immune system, which leads to inflammation and renders the skin barrier defective, causing eczema in a vicious cycle? I don't think anybody knows the answer to this question.

Over the past several years, we've seen a lot more evidence to indicate that there is an intrinsic skin defect, which allows allergens to enter through the skin. The immune cells in the skin prompt a variety of other cells to form, which cause allergy. Perhaps if more exposure occurred through the gut, we might have a better shot at correcting the immune system, and allowing patients to develop a tolerance. This idea, however, is oversimplified, and differs for individual patients depending on their genetics. The most commonly reported skin barrier protein defect is a filaggrin gene mutation and this increases the risk of eczema. This skin barrier defect allows allergens to enter through the skin. A number of excellent genetic studies have shown that if this skin barrier protein defect is present, there also exists a greater risk of developing peanut allergy and atopic dermatitis.

The interaction of environment and genetics can also play a part. For example, an infant with a filaggrin defect living with a cat in the home has increased risk of developing atopic dermatitis and asthma. Other studies have shown that people with atopic dermatitis with a filaggrin defect also have an increased risk of pollen allergies.

However, when we think about atopic dermatitis, allergens are just one of the triggers, along with dry skin, irritants, anxiety, and stress. As an allergist who has a passion for atopic dermatitis, I often see families come in and say to me, "Tell me what food is causing this eczema." And I have to say, "Well, there are a lot of things going on here, we have to think about the skin barrier and sort of step back from this." Many times, eczema flares can be erroneously attributed to foods; a lot of times these flares can be precipitated by other things such as irritants, detergents, humidity, changes in temperature, stress, and infection.

Skin Care First

That brings us back to skin care because, really, the skin care is of critical importance. Several years ago, Dr. Jon Hanifin and his team at Oregon Health & Science University did a nice study, which showed that after eczema patients with allergy concerns learned and practiced good skin care, their allergy concerns were lessened. We want to do a good job caring for the skin because we know that it can provide a protective barrier. Because we know that allergens can enter through the skin, we're concerned that

by *not* protecting the skin barrier, patients can end up sensitized to the allergen.

I lead a team that includes nurse practitioner Karol Timmons, psychologist Jennifer LeBovidge, and nutritionist Wendy Elverson at the Boston Children's Hospital Atopic Dermatitis Center. Several years ago, one of our fellows completed a review of all AD Center patients in order to see what helped them most. We found that 80 percent of the patients had an improvement in their eczema score. The factor that correlated most with the improved score was not whether the patient eliminated a food from his or her diet or whether he or she engaged in environmental control; it was whether improved adherence to the treatment regimen was possible. If we could give the patient (in this case it was parents caring for pediatric patients) a treatment regimen that they could follow and that decreased their concern of treatment side effects, we found that this correlated with patients getting better.

We know food allergy and atopic dermatitis are highly associated. While not all atopic dermatitis patients have food allergy, up to 20 to 40 percent of children with moderate to severe atopic dermatitis will have an IgE-mediated food allergy. Which brings us to the controversial question: Can food allergies exacerbate atopic dermatitis? We know that the two coexist, but we don't know whether food allergies make atopic dermatitis worse. There are some studies that suggest that patients with positive allergy testing to egg may get better if they eliminate eggs from their diet. This creates some cause for concern because taking the allergen out of a diet may prevent patients from developing an oral tolerance. We do try to be very careful with diagnosing food allergies.

Start with Optimized Skin Care

A few years ago Dr. Hanifin and I had the pleasure of participating on an expert panel that developed guidelines for food allergies. One of the most difficult guidelines to develop was the question of food allergies in atopic dermatitis. I think the panel came to a very good conclusion based on the evidence and expertise that we had: the guidelines say that children less than five years old with moderate to severe atopic dermatitis may be considered for food allergy evaluation for milk, egg, peanut, wheat, and soy, if at least one of the following conditions is met:

1. The child has a reliable history of an immediate reaction (such as hives, swelling, itching, sneezing, coughing, wheezing, vomiting and low blood pressure) after ingestion of a specific food.
2. **The child has persistent atopic dermatitis in spite of optimized management and topical therapy.**

It's best to take care of the skin first, and then look for food allergies.

In my experience, and that of our allergy group and dermatology group at Boston Children's Hospital, when we see infants, who have weeping, unrelenting facial involvement and severe AD starting at a young age, and who don't improve with optimized skin care, then we find that looking for food allergies can be beneficial.

Testing for Allergies

How do we look and test for food allergies? Through skin testing and blood testing which looks at the specific IgE for the allergen. Skin tests are beneficial in that they have greater accuracy and are available for many different allergens. They are also less expensive and deliver same-day results. However, to undergo skin tests, patients have to stop antihistamines.

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Blood testing is a little more convenient; they have a more quantitative result, and they are not affected by antihistamines. Blood tests are particularly preferable to skin testing if the patient is very young or uncoöperative, has had anaphylaxis to a food, or has extensive eczema and there's not a good place on the skin to test.

How Is Food Allergy Testing Interpreted?

A negative result indicates that allergy is very unlikely to be the problem. A positive test means that the allergic antibody is present. However, a positive result doesn't necessarily mean that you'll have an allergic reaction, because there's a very high false positive rate (as high as 50 percent) with test results, which means that even though the test is positive, the patient might actually be able to ingest the food without difficulty.

This is why performing random screening in atopic dermatitis patients isn't particularly helpful, because you'll find positive testing for foods that patients could actually eat. At this point, we need better diagnostic testing to figure out what's true allergy and what's not. Currently, there's a peanut component test in which we look at the specific IgE to individual peanut proteins. Specific IgE to one component *Ara h 2*, is more associated with having peanut allergy than some of the other proteins. Patients

can sometimes test positive for a general peanut specific IgE, but when you look at the components, you'll find that they're positive to the components that cross-react with pollens and other plants and negative to *Ara h2*. In this case the patient would likely tolerate peanut.

Common Food Allergens

Common allergens, such as milk, egg, soy, and wheat can resolve over time, while other allergens are more likely to persist, like peanut, tree nuts, shellfish, or fish. The most common food allergies in patients with atopic dermatitis are milk, egg, and peanuts. There are a number of uncommon allergens, like chocolate. Corn is also less likely to cause allergies. While citrus fruits, berries, and tomatoes are unlikely to cause actual allergic antibody (IgE)-mediated reactions, they may cause facial irritation. Many babies will get red faces when they have tomato sauce and that's okay. It doesn't mean they're allergic, it's just natural chemicals in those foods that cause an irritant reaction.

There has been a lot of public interest in food allergy testing. There was a nice *New York Times* article a few years ago, headlined "Telling Food Allergies From False Alarms". The article is largely based on a study that was done at National Jewish Health in Denver, in which 125 patients, most with AD, were evaluated for food allergy by food challenges. Of all the food challenges that were done, patients passed about 90 percent of the challenges and were able to add foods back into their diet. Until we have better testing, the most reliable way to know whether a food allergy exists is to perform a food challenge, which should be done under medical supervision.

Food Allergy and Atopic Dermatitis Summary

- Patients with atopic dermatitis frequently have food allergy.
- Food allergy testing is recommended for patients who have had allergic symptoms with ingestion of the food.
- Food allergy testing can be considered for children with severe atopic dermatitis who don't respond to aggressive skin care.
- False positive tests may result. If a test has a positive result, a food challenge may be needed to establish whether the patient is truly allergic to the food.
- Food challenges can also be used to determine

whether patients are outgrowing their food allergy (something that commonly occurs with milk and egg allergies). Approximately 20 percent of patients will lose sensitivity to peanut and 10 percent to tree nuts, so food challenges can be used for these foods as well.

Aeroallergen Triggers

When it comes to allergies in the air, inhalant allergens and atopic dermatitis are highly associated and often occur together. Common allergies include pollen, dust mites, dogs, and cats. To diagnose inhalant allergies, we look for a history of itching, sneezing, wheezing, and coughing in a patient with exposure to the allergen. The same kind of allergy skin testing or blood testing is done for inhalant allergies. There are fewer false positives with inhalant testing than with food testing.

What Does the Research Say?

Do allergens cause AD? Are they a trigger of AD? There's not a lot of work on this but there have been a couple studies. In one interesting study done 20 years ago (which I think would be hard to do today), researchers looked at an aeroallergen bronchial challenge. Researchers took 20 atopic dermatitis patients who had a positive skin test to dust mites and gave them small amounts of dust mite by inhalation. They found that 9 of the patients had skin symptoms after they had inhaled the dust mites, primarily in the places on the body where they usually got their eczema. All of these patients also had decreased lung function.

Recently, there's been more work using allergy shots, also known as immunotherapy, including a 2011 review from a practice parameter guideline on using allergy shots. Some data indicates that allergy shots can be effective for atopic dermatitis when associated with inhalant allergies. Additionally, in the review of four placebo controls (in which there was an active arm and an inactive arm), there was significant improvement in atopic dermatitis symptoms for patients who received allergy shots for dust mites.

Dealing with Dust Mites

As of now, there aren't any good studies, which show the correlation between dust mite control and lessening atopic dermatitis. However, because most dust mite control measures are relatively easy to do, we tend to recommend them. Dust mites love humidity, heat, clutter, and skin scale, (which frequently occurs with patients with atopic dermatitis). To help control dust mites, try the following:

- Encase mattresses and pillows in allergen-impermeable covers. When looking for a cover, choose a breathable fabric (a fabric like vinyl, for instance, can cause the body to sweat, which can cause atopic dermatitis to worsen).
- Wash sheets and blankets weekly in hot water, which also kills bacteria.
- Minimize the use of carpet, upholstered furniture, and stuffed animals.
- Keep indoor humidity low.

Blocking Out Pollen

To limit exposure to pollens, use air conditioning. This can also help ease sweating and further itching. Showering or bathing and washing your hair in the evening can also help. Finally, keep outdoor equipment and clothes outside of the bedroom, so you're not bringing the pollen in to sleep with you.

Reducing Dander

If you have allergy symptoms to animals, it's best to find the animal a new home. Otherwise, minimize pet exposure by keeping the animal in certain areas and out of the bedroom, clean frequently, or run a HEPA filter.

Molds

There are not a lot of studies on molds and atopic dermatitis, but I have found molds to be a trigger for selected patients.

Keep humidity less than 40 to 50 percent and clean areas that are prone to mold growth, using dilute white vinegar or dilute bleach to control mold. If you have any areas affected by water damage, you'll likely need to hire a professional to get the space repaired.

Location, Location, Location: Establishing and Testing Contact Dermatitis

With contact dermatitis, the most important thing is recognizing history and the location of the rash. Contact dermatitis experts say: "location, location, location." As in: where is the skin affected? A contact dermatitis rash may look similar to an atopic dermatitis rash. However, it may look a little different in that it may feature vesicles and blisters.

Patch Testing

Patch testing should be done in order to identify contact allergens. I recommend seeing a contact dermatitis expert because patch testing can be tricky. Patients who undergo testing have patches placed on their skin for 48 hours. About 72 to 96 hours later, some of the allergens are read. Other allergens won't display for up to 5 or 7 days later.

There a lot of substances that cause allergic contact dermatitis, such as poison ivy and other plants, fragrances, hair dyes, adhesives, and even some topical medications made with preservatives. A common allergy is nickel contact dermatitis. I've seen patients with nickel dermatitis on the bridge of the nose from reading glasses, the neck and ears from jewelry, and near the belly button from the snaps of jeans. Fabric dyes and finishes can also pose a problem.

To treat contact dermatitis, identify and remove the allergen, then use topical steroids (or rarely an oral steroid in severe acute cases). If small items like metal snaps are causing irritation, you can use an alternative metal or apply a coat of clear nail polish or some duct tape onto the item in order to help.

Lynda Schneider, MD, is an Associate Professor of Pediatrics at Harvard Medical School and Director of the Allergy Program, Division of Immunology Clinical Research Program, and the Atopic Dermatitis Center at Boston Children's Hospital. Dr. Schneider is also a NEA Scientific Advisory Committee member. ●

ITCHING *to* KNOW

by Irene Crosby, Patient Advocate

"You can get anything you want..."

In what my children refer to as Ancient Times (meaning the 1960s), singer-songwriter Arlo Guthrie wrote a tune called "Alice's Restaurant." It was a simple ditty that managed to inspire not only an eventual movie, but a lifelong career for Arlo. Arlo still sings this song in concerts, bracketed by his very humorous backstory of how the song became an anthem for a generation of people who had something they felt strongly about and needed to say. It takes 18 minutes of your time to listen to this thing in its entirety. Every Thanksgiving Day at noon our local Portland geezer-rock station KINK broadcasts this as a Public Service Announcement celebrating Thanksgiving (the story details events that took place on and around Thanksgiving Day), Alice, gross misunderstandings, and the ingenuity of the American Spirit in one of its more confusing forms. It is a family tradition at our house to listen to it every year.

By now you are probably shaking your head and wondering where I am going with all of this. Understandable, so here is why I immediately thought of "Alice's Restaurant" when I attended our July Patient Conference. While "Alice's Restaurant" had an anti-war, anti-establishment theme, it still relates to anyone who sees the need to make a change. In one of the final passages, Arlo says some really great truths (which I wildly paraphrase here): "If just one person says they have eczema and asks 'What can we do about it?' people will just ignore him. If two people talk about eczema, they'll still be ignored but maybe an eyebrow will be raised. But if THREE people do it, if three people tell everybody they can think of about how eczema affects their lives and how that needs to be recognized, they might be regarded as an Organization. And if FIFTY people form groups and figure out ways to get their message out to the world, they might just become a Movement!"

And that is what I thought as I sat at tables with old friends and new friends for two days in Boston in July. The National Eczema Association grew from Dr. Jon Hanifin's belief that people with eczema needed more than they were getting. Soon we became five and then we became a hundred and now twenty-five years later we have our MOVEMENT and we are legion and still growing. I will not live to see our 50th year as the National Eczema Association (I'm not being morbid, I'm 72 for cat's sake) but I know that some of the patients and caregivers who came to this 2014 conference will, and they can look back as fondly and proudly as I do now on what we all have achieved. ●

"We are all very lucky to have Irene Crosby and all she has done for this organization. Through it all she has suffered with about every complication of eczema but she also has maintained her wonderful sense of humor that helps her to persevere."
— Jon Hanifin, MD

"Irene Crosby is the ultimate volunteer. Every organization needs an Irene Crosby. From the National Eczema Association's early days, Irene was the face of the organization at medical meetings all over the country and with government agency leaders and legislators in Washington DC. She made everyone know what eczema was and how it affected children and adults."
— Vicki Kalabokes, Former NEA CEO

"Irene is brilliant. She has a way with words that is unique. Irene has been the face of atopic dermatitis in much of the United States. She has been able to clearly articulate what it is like to have atopic dermatitis in your life to doctors and fellow sufferers alike."
— Fran Storrs, MD

Irene Crosby is a dedicated eczema patient advocate and one of the National Eczema Association's founders. At the 2014 NEA Patient Conference, Irene was honored for her tremendous contributions as a volunteer for NEA, a founding member of the organization, and an all-around eczema hero. In more than 25 years, Irene's eczema has never kept her from going to Capitol Hill, attending medical professional meetings, or being an articulate and passionate voice of the patient on behalf of all those who suffer from eczema. Irene, we treasure you and celebrate you.

Thank you!

MY NEA CONFERENCE EXPERIENCE

In Their Own Words

Dear NEA,

I recently attended my first NEA Conference and I loved it! I learned more in the two days than I have in the three years since I was diagnosed. The medical and personal presentations were extremely helpful. I talked with people of all ages with varying eczema histories. There are many courageous people out there who deal with eczema every day and manage to have a full life! I feel more empowered now. Thank you all.

An Appreciative Conference Attendee

Dear NEA,

My husband and I learn new things each time we attend the NEA Patient Conference. Eczema is in the middle of a "revolution," as Julie Block stated—and research, practices, and clinical trials are changing. While we heard lots of things at this conference that are tried-and-true parts of life with eczema (wet wraps, moisture, allergies), we also heard new things that will change our practice of managing our child's eczema. Thank you for allowing us a fresh window into the latest in eczema while making deeper, stronger connections with other families who have similar experiences in dealing with it.

Please know that our participation in the NEA Patient Conference was healing, impactful, and beneficial for our family. Thank you, NEA, for allowing us this opportunity.

A Scholarship Family

Dear NEA,

The experts were so great at explaining everything in a way that is easy to understand. It was obvious that they really care and are passionate about eczema. I also appreciated the variety of topics related to eczema. Learning about new developments in research and potential treatment options was phenomenal. This conference means more to me than any of you will ever know. I feel so hopeful!

An Appreciative Conference Attendee

"I feel so hopeful!"

Dear NEA,

Thank you for providing me with a scholarship to attend the NEA Patient Conference. I enjoyed the small group sessions where I was able to meet other people suffering from the same ailment. We all shared our experiences and also solutions for how to handle our eczema. I really enjoyed the tribute to Irene Crosby. I believe everyone, including myself, was touched by that well-deserved tribute. Thank you sincerely.

A Scholarship Recipient

Dear NEA,

On behalf of my family, I'd like to thank you for the 2014 NEA Patient Conference. My spouse and I not only found the conference educational, we really enjoyed it. The kids had a blast in the Kids Camp and loved the field trip to the aquarium. The conference speakers were truly experts—and very helpful, even taking the time to talk to us on a one-on-one basis. We also appreciated the samples in the tote bags and the exhibitor tables. We look forward to the next conference!

An Appreciative Family

Dear NEA,

I have struggled with eczema my whole life. Just a year ago I found NEA—and the NEA Patient Conference has been one of the best surprises I have ever gotten thus far in life.

Amongst my friends and family I am the only person who has eczema. Going to the conference provided me with more information, and it also empowered me to know that I am not the only person dealing with eczema.

While I was there I met so many inspiring people. One in particular was a woman who had a very severe case of eczema but her spirit was so sweet and she had this illuminating energy. Meeting her changed my outlook on life because I often feel self-conscious in public, looking over my shoulder, wondering if anyone will notice my eczema. Here was this woman who had eczema far worse than I, and she was just living life as if she were not affected by eczema at all.

Attending the conference helped me understand that eczema is part of my life, it does not define my possibilities in life, it does not deter them either. I just happen to itch a little more than others and that is just fine.

THANK YOU SO MUCH!!!

A Scholarship Recipient

"Our family will reap the benefits of this conference for years to come."

Dear NEA,

Our daughter's attendance at the NEA Kids Camp provided her with real connections to children just like her! There is so much value in knowing that someone is suffering as she is, and honest, lifelong friendships are the result. She felt safe, loved, and so relaxed in the Kids Camp! She "adopted" some of the smaller children and felt as if she made a difference in their lives by offering them a hand, a piggy-back ride, or help with a craft. She has not stopped talking about the friends she made. Eczema can be isolating for her. This camp helped her self-image through providing connections, a leadership role with younger kids, and true acceptance.

Our family will reap the benefits of this conference for years to come.

An Appreciative Family

Dear NEA,

Thank you from the bottom of our hearts! The sense of community among the eczema patients and their loved ones is amazing. Our daughter was able to attend the Kids Camp and I am sure she made some lifelong friends. Before the conference, she thought she was the only itchy kid in the world, but not anymore. The experts, speakers, and staff were all compassionate, knowledgeable, and down to earth. We can't thank everyone enough.

A Scholarship Family

"It was amazing to be around other people who GET IT."

Dear NEA,

It was so amazing to finally be around other adults and children who GET IT. Hearing different life stories from other attendees was wonderful. I kept nodding my head and thinking, "Yes! That's us!" We learned so many good tips and suggestions. What a wonderful experience, thank you.

An Appreciative Family

Dear NEA,

Our family had a great experience at the NEA Conference. I believe that NEA has helped my children become more confident. Through their conference experience, my children have also gained knowledge about how to deal with eczema. In addition, I learn something new at every NEA Conference.

An Appreciative Family ●

A SUMMARY *of* ATOPIC DERMATITIS RESEARCH PRESENTED *at the* 2014 SOCIETY *of* INVESTIGATIVE DERMATOLOGY ANNUAL MEETING (PART 2)

by Nitin Garg, B.S.

This is part two of our summary of atopic dermatitis (AD)-related research presented at the 2014 Society of Investigative Dermatology Annual Meeting, held May 7–10 in Albuquerque, New Mexico. In this issue, we summarize AD-related research involving barrier disruption, innate and adaptive immunity, and the neurobiology of AD.

EPIDERMAL STRUCTURE AND BARRIER FUNCTION

Filaggrin mutation

The gene for filaggrin, a protein involved in maintenance of skin barrier integrity, has been shown to be mutated in a large proportion of AD patients. Beck et al. sought to further clarify the role of filaggrin, specifically examining the effect of filaggrin deficiency on epidermal tight junctions. They found that filaggrin deficient mice have an alteration in the appearance of their tight junctions (protein structures that adjoin neighboring cells together, forming an impenetrable barrier and preventing molecules from passing across), especially in regards to claudin-1 (CLDN1) and ZO-1 expression, two key components of tight junctions; however, overall barrier function was not compromised by these tight junction alterations.

Filaggrin mutation is not the whole story

Not all individuals with AD have filaggrin mutations, suggesting that other mechanisms of action must be at work. Indeed, previous studies have found that various signaling molecules that are upregulated in AD can inhibit filaggrin levels, supporting the "inside-out" hypothesis; that is, certain processes intrinsic to the immune system promote barrier disruption and AD. At the Atopic Dermatitis Minisymposium, Naeem et al. presented a novel pathway leading to reduction of filaggrin expression independent of filaggrin mutation. They found that individuals with a mutation in RPTOR (raptor) gene had overexpression of RPTOR protein, reducted AKT1 activity, and subsequently reduced filaggrin protein levels.

Similarly, Hanel et al. presented findings at the Atopic Dermatitis Minisymposium that IL-31 weakened the skin barrier and reduced filaggrin expression. Further, antagonizing IL-1 (a downstream effector of IL-31) resulted in normal barrier function while unexpectedly decreasing the secretion of peptides that fight bacteria. The authors therefore concluded that IL-1 and 31 could be promising therapeutic targets for AD, but the negative effect of cytokine blockade on bacterial defense would have to be considered.

Blunder et al. helped decipher the mechanisms involved in PPARα signaling, a nuclear hormone receptor that inhibits skin inflammation and improves skin barrier function. Lee et al. examined the effect of environmental humidity on skin barrier and gene expression. They found that exposure to low humidity in a skin equivalent model resulted in decreased epidermal thickness, disrupted tight junctions, and decreased mRNA expression of filaggrin, loricrin, caspase-14, and SASPase. In all, these studies indicate that the immune system and environment have a strong influence on barrier dysfunction in AD, and need to be considered in addition to filaggrin mutation.

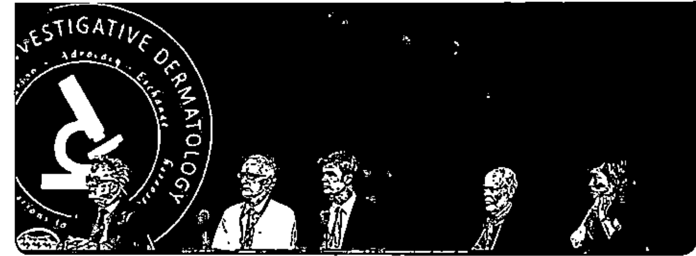
IMMUNOLOGY

Why do AD patients get viral skin infections?

Patients with AD are susceptible to a wide range of skin infections, including, but not limited to, herpes simplex infections (i.e. eczema herpeticum). Czarnowicki et al. presented a study at the Atopic Dermatitis Minisymposium analyzing blood samples of 16 adults with severe AD compared to 16 healthy controls. They found lower levels of interferon gamma-producing cells (which are thought to help fight viral infections) and higher levels of IL-13 and IL-22-producing cells in immune cells that travel to the skin (skin-homing CLA+ T cells). This data may begin to explain why AD patients get viral infections that seem to preferentially affect the skin.

Immune suppression in severe AD

Skabytska et al. discussed the role of myeloid-derived suppressor cells (MDSCs) at the Atopic Dermatitis



Minisymposium. They presented data suggesting that *Staphylococcus aureus* colonization in AD causes immune suppression, an effect mediated by MDSCs. They demonstrated higher levels of MDSCs in the peripheral blood of AD patients compared to healthy individuals, and they were able to show that these MDSCs suppress the activity of immune cells, especially T cells. It is therefore possible that *Staphylococcus aureus* colonization causes immune suppression via its effects on MDSCs, which then makes AD patients more susceptible to other infections down the road, such as herpes virus infections (eczema herpeticum).

TSLP

A molecule called human thymic stromal lymphopoietin (TSLP) has recently received great attention. TSLP production is stimulated by skin barrier impairment, as experienced by AD patients; further, TSLP activates certain immune cells in AD (such as Langerhans and dendritic cells) and therefore may serve as the key "master switch" for induction of allergic reaction. TSLP therefore appears to represent a link between barrier function and immunity in AD. Polak et al. demonstrated that the ability of Langerhans/dendritic cells to induce Th2 polarization correlated with the expression of interferon regulatory factor 4 (IRF4), suggesting IRF4 is a key protein involved in initiating the allergic response in AD. In addition, Kim et al. recently demonstrated that innate lymphoid cells (a recently identified family of immune cells that promote type 2 inflammation in AD) are dependent on TSLP to function properly, and that innate lymphoid cells interact with nearby basophils to help promote inflammation. Tatsuno et al. showed that TSLP interacts not only with Langerhans/dendritic cells, but also with skin homing CD4+ T cells carrying the receptor for TSLP. CD4+ T cells therefore appear to help modulate the inflammatory response via their interaction with TSLP. Clarifying the role of TSLP in the induction of allergic response may lead to attractive therapeutic targets for AD in the future.

Cytokines in AD

It is well-established that AD results in the dysregulation of a wide range of cytokines. Romano et al. studied the effect of transcription factor p63, as recent experiments suggest that it is elevated in patients with AD. They found that transgenic mice overexpressing p63 show a marked increase in the IL-31 and IL-33 cytokine signaling pathways, while also directly influencing genes involved in terminal differentiation and skin barrier maintenance.

At the Innate Immunity and Microbiology Minisymposium, Imai et al. further discussed the role of IL-33 in the pathogenesis of AD. They found that IL-33 induced group 2 innate lymphoid cells (a newly discovered set of immune cells which seem to help orchestrate the inflammatory response to allergens), which go on to produce IL-5 and IL-13. More importantly, IL-33 overexpression in mice was sufficient to produce AD-like disease in mice. DaSilva-Arnold et al. studied STAT-6-VT transgenic mice that were deficient in IL-33 cytokines, finding that these mice developed more severe AD-like disease earlier in life, compared to STAT-6-VT mice with normal IL-33. This suggests that IL-33 may reduce T-cell dependent inflammation in AD (contrary to the results of experiments listed above), warranting further investigation into its mechanism of action.

AD transcriptome

DNA microarrays have allowed researchers to detect which genes are differentially expressed in AD, leading to better understanding of the immune and barrier abnormalities that contribute to disease pathogenesis. Ewald et al. noted that previous microarray studies have demonstrated

inconsistencies in differentially expressed genes; they therefore performed a meta-analysis of four AD microarray data sets from previously published studies, resulting in the establishment of a comprehensive AD transcriptome consisting of 405 up- and 218 down-regulated genes in lesional vs. nonlesional AD skin, including several newly identified genes. Suarez-Farinas et al. expanded the transcriptome using RNA sequencing, which is able to detect genes that DNA microarrays may not be able to pick up. They detected 519 up- and 590 down-regulated genes in lesional vs. non-lesional skin; several unknown genes were found, including TREM1 and related genes, which amplify inflammatory responses in response to infections. Esaki et al. even further expanded the transcriptome using laser capture micro-dissection, which is able to detect low abundance genes, while also being able to localize genes to the dermis vs. the epidermis of the skin. Using this technique, they found an even larger number of genes, and were able to classify genes as primarily dermal or epidermal.

Other novel findings

A few groups examined the effect of physiologic stress on AD. At the Atopic Dermatitis Minisymposium, Kashibe et al. demonstrated that activation of epidermal nicotinic acetylcholine receptors (stress receptors) results in decreased expression of peptides that fight bacterial infection, along with increased bacterial survival.

Czarnowicki et al. demonstrated that T cell activation in AD extends beyond the skin. Using flow cytometry methods, they showed that skin-homing memory T cells (which mediate fast immune responses to allergens/infections) are persistently activated in the bloodstream of patients with AD. This may help explain why there are frequent disease exacerbations in different skin regions, while also explaining why localized topical therapy only induces limited remissions in disease.

NEUROLOGY OF AD

Given that one of the cardinal symptoms of AD is itch (mediated by peripheral nerves in the skin), more research is being directed toward the neurobiology of AD. Indeed, for the first time in 2014, the Society of Investigative Dermatology (SID) introduced the translational symposium on neurobiology. Topics discussed in this symposium included the effect of TSLP on afferent nerve-mediated itch, the neural mechanisms of itch in health and disease, along with the interplay between immunology and itch.

Oftentimes, AD patients note that itch precedes their rash, or that psychological stress precipitates their symptoms. In line with these anecdotal observations, Elmariah et al. hypothesized that neural changes may actually precede and trigger inflammatory changes in AD. At the Atopic Dermatitis Minisymposium, they presented a study in which they used in vivo imaging of fluorescently labeled peripheral nerves in mice with eczema-like skin lesions. They found that neural growth occurs early in eczema development, preceding the onset of inflammation. Further, early blockade of neural growth prevented inflammation, itching, and rash development, suggesting neural changes may be crucial to the actual pathogenesis of AD, instead of just being a reaction to inflammation, as previously thought.

Kamata et al. previously reported that semaphorin 3A ointment inhibits nerve growth and itching in skin diseases like AD, and sought to further understand the regulatory mechanisms involved in semaphorin 3A function. They found that activation of RORα, a type of nuclear receptor, increases the expression of semaphorin 3A. This suggests that RORα agonists may be used in the future for anti-itch treatment. Rabinovich et al. found that the effect of neural calcitonin gene-related peptide (CGRP), one of the major mediators of itch and neurogenic inflammation, is markedly downregulated with application of bicyclic monoterpene diol (BMTd). Use of some of these agents for anti-itch therapy has the potential to greatly improve the quality of life of patients with AD.

CONCLUSION

This vast array of new discoveries helps broaden our understanding of the pathogenesis of AD, while identifying several new potential therapeutic targets. Fascinating new insights into neurobiology reinforce the multifactorial nature of AD. Further work will build on this foundation, as we seek to reduce the burden of and/or cure AD.

Nitin Garg is a fourth-year medical student at Northwestern University Feinberg School of Medicine. Part 1 of his Summary of Atopic Dermatitis Research was published in the third quarter 2014 issue of The Advocate. ●

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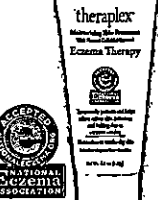

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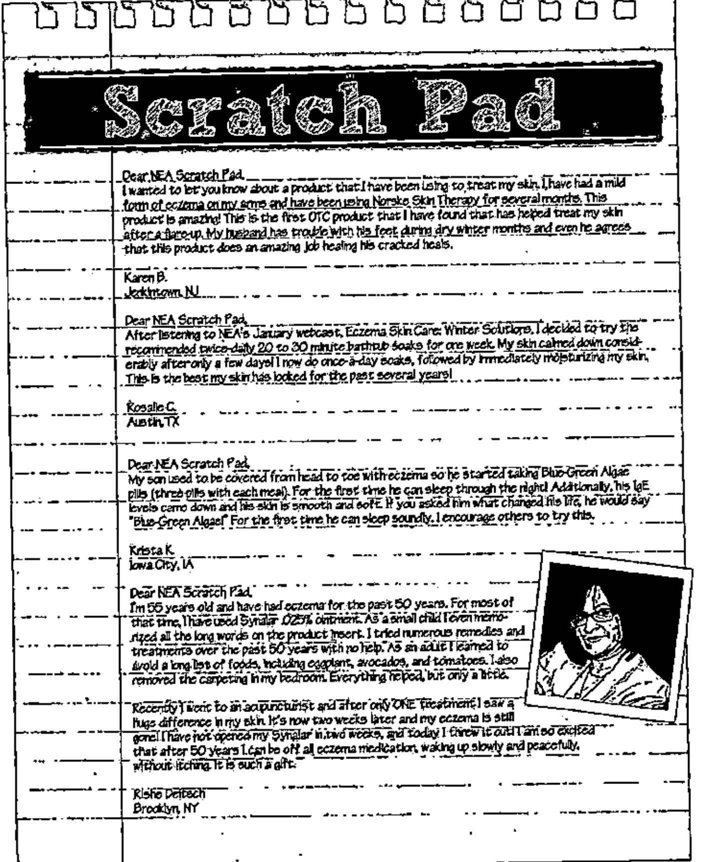


Scratch Pad

Dear NEA Scratch Pad,
I wanted to let you know about a product that I have been using to treat my skin. I have had a mild form of eczema on my arms and have been using Norske Skin Therapy for several months. This product is amazing! This is the first OTC product that I have found that has helped treat my skin after a flare-up. My husband has trouble with his feet during dry winter months and even he agrees that this product does an amazing job healing his cracked heals.

Karen B.
Jenkintown, NJ

Dear NEA Scratch Pad,
After listening to NEA's January webcast, Eczema Skin Care: Winter Solutions, I decided to try the recommended twice-daily 20 to 30 minute bathtub soaks for one week. My skin calmed down considerably after only a few days! I now do once-a-day soaks, followed by immediately moisturizing my skin. This is the best my skin has looked for the past several years!

Rosalie C.
Austin, TX

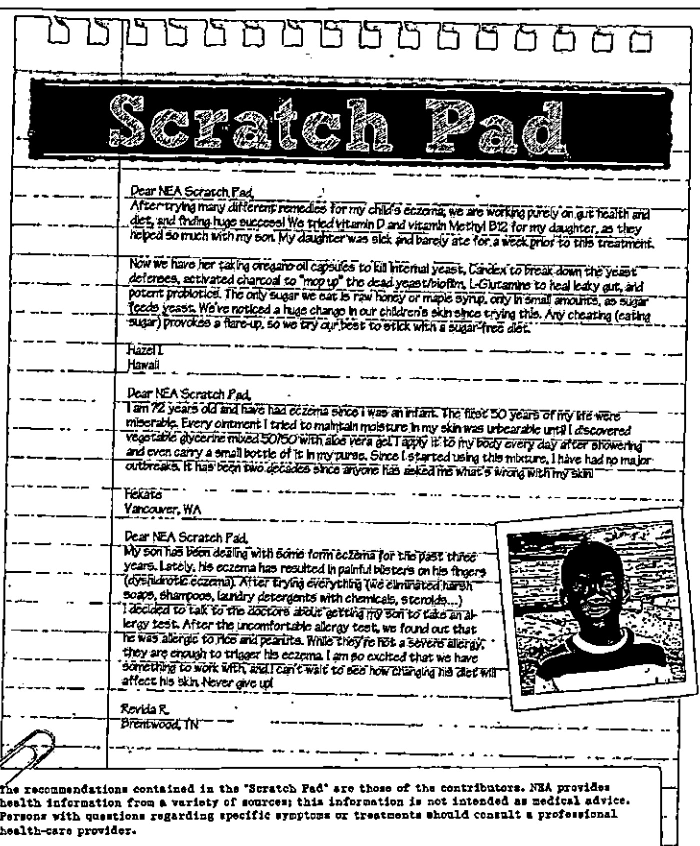
Dear NEA Scratch Pad,
My son used to be covered from head to toe with eczema so he started taking Blue-Green Algae pills (three pills with each meal). For the first time he can sleep through the night! Additionally, his IgE levels came down and his skin is smooth and soft. If you asked him what changed his life, he would say "Blue-Green Algae!" For the first time he can sleep soundly. I encourage others to try this.

Krista K.
Iowa City, IA

Dear NEA Scratch Pad,
I'm 55 years old and have had eczema for the past 50 years. For most of that time, I have used Synalar .025% ointment. As a small child I even memorized all the long words on the product insert. I tried numerous remedies and treatments over the past 50 years with no help. As an adult I learned to avoid a long list of foods, including eggplant, avocados, and tomatoes. I also removed the carpeting in my bedroom. Everything helped, but only a little.

Recently I went to an acupuncturist and after only ONE treatment I saw a huge difference in my skin. It's now two weeks later and my eczema is still gone! I have not opened my Synalar in two weeks, and today I threw it out! I am so excited that after 50 years I can be off all eczema medication, waking up slowly and peacefully, without itching. It is such a gift.

Rishe Deitsch
Brooklyn, NY



Scratch Pad

Dear NEA Scratch Pad,
After trying many different remedies for my child's eczema, we are working purely on gut health and diet, and finding huge success! We tried vitamin D and vitamin Methyl B12 for my daughter, as they helped so much with my son. My daughter was sick and barely ate for a week prior to this treatment.

Now we have her taking oregano oil capsules to kill internal yeast, Candex to break down the yeast defenses, activated charcoal to "mop up" the dead yeast/biofilm, L-Glutamine to heal leaky gut, and potent probiotics. The only sugar we eat is raw honey or maple syrup, only in small amounts, as sugar feeds yeast. We've noticed a huge change in our children's skin since trying this. Any cheating (eating sugar) provokes a flare-up, so we try our best to stick with a sugar-free diet.

Hazel I.
Hawaii

Dear NEA Scratch Pad,
I am 72 years old and have had eczema since I was an infant. The first 50 years of my life were miserable. Every ointment I tried to maintain moisture in my skin was unbearable until I discovered vegetable glycerine mixed 50/50 with aloe vera gel. I apply it to my body every day after showering and even carry a small bottle of it in my purse. Since I started using this mixture, I have had no major outbreaks. It has been two decades since anyone has asked me what's wrong with my skin!

Hekate
Vancouver, WA

Dear NEA Scratch Pad,
My son has been dealing with some form eczema for the past three years. Lately, his eczema has resulted in painful blisters on his fingers (dyshidrotic eczema). After trying everything (we eliminated harsh soaps, shampoos, laundry detergents with chemicals, steroids...)
I decided to talk to the doctors about getting my son to take an allergy test. After the uncomfortable allergy test, we found out that he was allergic to rice and peanuts. While they're not a severe allergy, they are enough to trigger his eczema. I am so excited that we have something to work with, and I can't wait to see how changing his diet will affect his skin. Never give up!

Revida R.
Brentwood, TN

The recommendations contained in the "Scratch Pad" are those of the contributors. NEA provides health information from a variety of sources; this information is not intended as medical advice. Persons with questions regarding specific symptoms or treatments should consult a professional health-care provider.

Email your Scratch Pad tip (along with a photo if you have it) to info@nationaleczema.org, so that we may publish it in an upcoming issue of *The Advocate* and help others!

NEA SUPPORT NETWORK

NEA Boston Support Group Leader Lisa Boyon speaking at the 2014 NEA Patient Conference in Boston.

Thank you Lisa!

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If you'd like information on establishing an eczema Support Group in your area or becoming a Telephone Support Contact, please contact Alexandria Lindsay in the NEA office for information and an application: info@nationaleczema.org or 415.499.3474.

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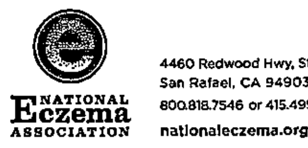

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Voting Sheets

Senate Executive Departments and Administration Committee

EXECUTIVE SESSION RECORD

2022 Session

Bill # SB 358

Hearing date: 2/2/2022

Executive Session date: 2/2/2022

Motion of: OTP **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Carson, Chair	✓			✓	
Sen. Reagan, Vice Chair	✓		✓	✓	
Sen. Ricciardi	✓			✓	
Sen. Cavanaugh	✓			✓	
Sen. Prentiss	✓	✓		✓	

Motion of: consent **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Carson, Chair	✓			✓	
Sen. Reagan, Vice Chair	✓	✓		✓	
Sen. Ricciardi	✓			✓	
Sen. Cavanaugh	✓		✓	✓	
Sen. Prentiss	✓			✓	

Motion of:________ **Vote:**________

Committee Member	Present	Made by	Second	Yes	No
Sen. Carson, Chair					
Sen. Reagan, Vice Chair					
Sen. Ricciardi					
Sen. Cavanaugh					
Sen. Prentiss					

Reported out by: Sen Carson

Notes:________

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE
FOR THE CONSENT CALENDAR

Wednesday, February 2, 2022

THE COMMITTEE ON Executive Departments and Administration

to which was referred **SB 358**

AN ACT establishing October 2022 as eczema awareness month.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS

BY A VOTE OF: 5-0

Senator Sharon Carson
For the Committee

This bill establishes October 2022 as eczema awareness month. In the United States, 31.6 million people suffer with eczema. Eczema is more than just dry skin; in serious cases eczema can be socially and physically debilitating. This bill raises awareness of the seriousness of eczema.

Chantell Wheeler 271-1403

General Court of New Hampshire - Bill Status System

Docket of SB358

Docket Abbreviations

Bill Title: (New Title) relative to the joint legislative committee on administrative rules.

Official Docket of **SB358.**:

Date	Body	Description
12/17/2021	S	To Be **Introduced** 01/05/2022 and Referred to Executive Departments and Administration; **SJ 1**
1/14/2022	S	**Hearing:** 02/02/2022, Room 103, SH, 09:30 am; **SC 4**
2/2/2022	S	Committee Report: Ought to Pass, 02/16/2022; Vote 5-0; CC; **SC 7**
2/16/2022	S	**Ought to Pass**: MA, VV; OT3rdg; 02/16/2022; **SJ 3**
3/23/2022	H	Introduced 03/17/2022 and referred to Executive Departments and Administration
3/30/2022	H	Public Hearing: 04/12/2022 01:45 pm LOB 302-304
3/30/2022	H	Public Hearing on non-germane Amendment **#2022-1229h**: 04/12/2022 01:50 pm LOB 302-304
4/27/2022	H	Executive Session: 04/12/2022 01:45 pm LOB 302-304
4/27/2022	H	Majority Committee Report: Ought to Pass with Amendment **#2022-1645h** (NT) (Vote 14-5; RC)
4/27/2022	H	Minority Committee Report: Inexpedient to Legislate
5/4/2022	H	Amendment # 1645h: AA VV 05/04/2022 **HJ 11**
5/4/2022	H	**Ought to Pass with Amendment** 1645h: MA DV 208-123 05/04/2022 **HJ 11**
5/12/2022	S	Sen. Carson Moved Nonconcur with the House Amendment; Requests C of C, MA, VV; 05/12/2022; **SJ 12**
5/12/2022	S	President Appoints: Senators Reagan, Carson, Cavanaugh; 05/12/2022; **SJ 12**
5/12/2022	H	House Accedes to Senate Request for CofC (Rep. McGuire): MA VV 05/12/2022 **HJ 13**
5/12/2022	H	Speaker Appoints: Reps. Goley, Alliegro, Sytek 05/12/2022 **HJ 13**
5/13/2022	S	Committee of Conference Meeting: 05/18/2022, 8:00 a.m., Room 103, SH
5/17/2022	H	Conferee Change: Rep. Turcotte Replaces Rep. Sytek 05/17/2022
6/8/2022	H	Conference Committee Report: Not Filed

NH House NH Senate

General Court of New Hampshire - Bill Status System

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6/8/2022	H	Conference Committee Report: Not Filed

NH House NH Senate

Other Referrals

Senate Inventory Checklist for Archives

Bill Number: SB 358 Senate Committee: ED/HA

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee
X All Calendar Notices
X Hearing Sign-up sheet(s)
X Prepared testimony, presentations, & other submissions handed in at the public hearing
X Hearing Report
___ Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

___ - amendment # ______ ___ - amendment # ______

___ - amendment # ______ ___ - amendment # ______

X Executive Session Sheet
X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

___ - amendment # ______ ___ - amendment # ______

___ - amendment # ______ ___ - amendment # ______

Post Floor Action: (if applicable) {Clerk's Office}

___ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):
___ Enrolled Bill Amendment(s)
___ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

___ as amended by the senate X as amended by the house
final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

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