MIND&BODY

DocTalk

Mystery of 'red-type' eczema in babies solved

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"My baby gets these red areas on his skin and he scratches."

I am looking at the five-month-old baby as much as I am at his mother.

She is concerned about the possibility of food allergies arising in the future.

Although most babies with eczema do not have food allergy, this is a common question and many babies are brought in by their parents to check if they have such allergies.

The key point of interest for me was that the baby's skin was not the usual dry or rough type that is seen in most infants, or older children and adults with eczema.

There were some small areas of redness and almost no dry skin.

These "red rashes" were flat and did not look like hives, which are the usual rashes expected in a typical food allergy reaction.

Hives usually occur in batches of red or white itchy wheals, patches or rings that can vary in shape and size, with the surrounding skin becoming red.

The baby's mother was tired. She had been moisturising him many times a day, to no effect.

She said her baby was still being exclusively breastfed and did not take any solids or cow's milk formula.

I asked her about her diet.

Then I told her that her baby already has a food allergy.

Based on her description of her diet, I suspected the culprit to be cow's milk.

The dairy products she was taking coincided with each episode of redness she described.

In some allergic babies, even a tiny amount of food protein through breast milk can cause a flare – an episode where the itch and discomfort from the eczema is particularly bad.

The mother agreed for the baby to have a skin-prick test and, sure enough, the results showed that he had an allergy to cow's milk.

I asked her to avoid dairy and also suggested applying a weak steroid cream on the baby intermittently for the redness.

When they next came, a few weeks later, the episodes of redness and itching from red rashes the baby had been experiencing were mostly gone.

There remained only small areas of dry skin, where moisturiser was applied once a day.

In another case, an eight-month-old baby had dark red skin all over her body. She, too, was exclusively breastfed.

Copious amounts of moisturisers and topical steroids applied by the parents had no effect.

I could not do any skin tests as she had no normal skin left.

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I opted for blood tests, which came back positive to everything that was tested.

But to have the breastfeeding mother avoid all the suspected foods would be nearly impossible, for both practical and nutritional reasons.

In addition, doctors with an interest in allergies know that "positive" results for either skin or blood tests, especially if many results are positive in the same patient, can be false positives.

In other words, positive results do not always equal to a true allergy.

Here, again, taking a detailed history provided the critical clue.

The mother had noticed that her baby's skin got worse when she took dairy, egg or peanut, but not wheat, soya or other foods that I asked about.

Cow's milk, egg and peanut also happened to be the three foods for which the tests showed her baby was most allergic to.

We agreed that she should avoid dairy, egg and peanut only.

She continued breastfeeding her baby, while still consuming wheat, soya and the other foods, which tests had shown her baby was allergic to as well.

At the next visit, I could not recognise the baby. Her skin had become almost normal.

Her parents had even stopped applying topical steroids because of the improvement.

These cases are examples of what I call the "red-type" eczema in infants.

The clue to this condition comes from the parents' own accounts – many remember that the eczema started with red skin, and not dry or rough skin.

When the babies are examined, they have red areas far exceeding the dry, rough areas of skin.

The classic form of eczema, even during a flare, has obvious dry, rough areas that exceed the red areas.

One important reason to pick this up is the frequent presence of a food allergen, which may not be apparent and, when avoided, leads to dramatic improvement in the skin.

Some patients may still require moisturisers and topical steroids, but at a far lower amount than when exposure to the allergen is ongoing.

Another reason is appropriate care. For some time now, dermatologists have advocated the proactive application of steroids regularly to prevent flares in patients with eczema.

This applies mostly to "red type" eczema.

The classic form, with sufficient moisturisers, rarely needs proactive regular steroids because the moisturisers stop the itch-scratch cycle.

In contrast, "red type" eczema may still require topical steroids and even immunomodulators which weaken the immune system to reduce inflammation.

It is frustrating and tiring for parents to moisturise a baby with "red type" eczema 20 times a day and see no improvement in the redness or itching.

Better that they devote their time and energy to the appropriate and effective care for the baby, which is to avoid the food triggers, and application of topical steroid cream.

However, this need for regular topical steroids I am suggesting leaves many parents concerned.

Will their children need the steroid creams long term?

Will they outgrow the eczema?

Fortunately, my observation is that infants with "red type" eczema tend to get better over the next few years, reducing the need for topical steroids with good skincare and avoidance of the allergen.

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