# Atopic dermatitis in children

E.V. Pechenina
("Center for Energy Information Medicine", Samara, Russia)

One of the most common childhood diseases - from 17 to 25% - is atopic dermatitis. Starting at an early age, this disease acquires a recurrent course, leading to a decrease in the child's social adaptation.

Atopic dermatitis is a genetically determined, chronic, recurrent skin disease, clinically manifested by primary itching, lichenoid papules (in infancy

papulovesicles) and lichenification.

It has a clear seasonal dependence: in winter - exacerbations and relapses, in summer - partial or complete remissions. White dermographism is characteristic. The factors provoking the development of atopic dermatitis include frequent respiratory diseases, especially at an early age, the presence of foci of chronic infection in the nasopharynx and oral cavity in a child. The main risk factors for the development of atopic dermatitis include:

- burdened own and family allergological history;
- violations of the mother's diet during pregnancy and lactation;
- smoking mother and other negative factors during pregnancy and lactation;
- early artificial feeding and improper diet of children, late attachment to the breast;
- violations of the daily routine and improper skin care;
- violation of the rules of vaccination;
- unfavorable living conditions, negative social and environmental factors;
- antibiotic therapy during pregnancy, lactation, as well as antibiotic therapy in infancy;
- dysfunctions of the gastrointestinal tract from birth, enzymopathy, intestinal dysbiosis, etc.;
- food allergens.

Food allergens occupy a leading place among the causal factors in atopic dermatitis (AD), and in children of the first year of life, as a rule, they are the first cause of the development of the disease - this is the initial sensitization (hypersensitivity to food), against which, due to the similarity antigenic structure and the development of cross-allergic reactions between different in groups antigens, formed hypersensitivity to other types of allergens (pollen, household, epidermal).

Almost any food product can cause the development of blood pressure, but children in the first year of life most often develop sensitivity to dairy products, eggs, food grains, soybeans, fish.

The theory of allergic genesis of dermatitis is widespread, atopic which links the appearance of the disease with congenital sensitization and the ability to form reagin (IgE) antibodies. In patients with atopic dermatitis, the content of total

immunoglobulin E, which includes both antigen-specific IgE antibodies to various allergens and IgE molecules. Patients with AD have an imbalance of Th1 / Th2 lymphocytes, impaired phagocytosis, other nonspecific factors of immunity, and barrier properties of the skin. This explains the susceptibility of patients with AD to various infections of viral, bacterial and fungal genesis.

Immunogenesis of blood pressure is determined by characteristics genetically programmed immune response to an antigen under the influence of various provoking factors. Long-term antigen exposure, stimulation of Th2 cells, production of allergen-specific IgE antibodies, degranulation of mast cells, eosinophilic infiltration and inflammation, exacerbated by damage to keratinocytes due to scratching, all lead to chronic inflammation in the skin with AD, which plays a critical role in the pathogenesis of cutaneous hyperreactivity.

Arouses interest and the hypothesis of intradermal suction staphylococcal antigens, which cause a slow, sustained release of histamine from mast cells, either directly or through immune mechanisms. An important role in the pathogenesis can be played by disorders in vegetative nervous system.

Clinical manifestations

Exudative form - characterized hyperemia, swelling exudation (oozing) of the skin, the formation of crusts. Erythematous-squamous form - hyperemia, itchy nodules, small blisters, erosion, crusts, peeling, lack of wetness. Erythematous-squamous form with lichenification - the presence of papules and foci of lichenification is characteristic. Lichenoid form - dryness, accentuated skin pattern, edema, infiltration. Pruriginous form - a rash against the background of lichenified skin in the form of multiple, isolated dense edematous papules, on top of which small vesicles with a dense cover are revealed.

There are three stages of the disease

- infantile stage: observed in children aged from birth to 2 years old;
- children: from 2 to 10-12 years old;
- teenage: from 10-12 to 18 years old.

It should be emphasized that the age stages, although they are clinically justified, are to some extent conditional. Thus, in some children 5–10 years old, there may be manifestations typical of adolescence (prevalence of lichenification, etc.).

Infant stage

In early childhood, blood pressure occurs in the form of 2 forms of skin lesions: exudative ("weeping") and erythematous-squamous ("dry"). With an exudative form of blood pressure in the period of exacerbation, hyperemia, edema of the skin, vesicles (cavity formation, slightly rising above the surface of the skin, filled with transparent contents) are clinically determined, papulovesicles, erosion, weeping areas covered with serous and serous-purulent crusts. Papulovesicular rashes are located in the main

image on the face, upper and lower extremities, tend to symmetry and are accompanied by intense itching. Papular and vesicular elements are localized for the most part scattered, but sometimes they are clustered, acquiring the character of well-contoured foci. The bubbles are unstable, easily open with the formation of point erosion, from which a clear liquid oozes. Weeping areas, edematous bright erythema with serous crusts are located either localized (more often in the face area - cheeks, forehead, chin, scalp), or spread to

the extensor surface of the upper and lower extremities, neck, trunk, groin and axillary regions, buttocks. The lesion of the skin in dry form of blood pressure in the period of exacerbation is characterized by the presence of pronounced dryness of the skin, hyperemia, slight swelling in the foci. The main elements are epidermal itchy papules. A lot of secondary elements are revealed: erosion, crusting, peeling, excoriation (combs).

Childhood stage

In children from 2 to 10-12 years of age, an erythematous-squamous form of blood pressure is formed with the first signs of lichenification (thickened skin with accentuated diamond pattern, with rough (pebbled leather)). The emergence of evidence of the chronicity of the disease. looseness, dryness and hyperpigmentation of lichenification - a bright clinical Clinical symptoms of the childhood stage
BP includes erythema, indurative (dense) edema of the skin, the appearance of erythematous-squamous foci with the presence of flat small and follicular papules. Often there is a pronounced dryness of the skin, signs of lichenification - thickening and strengthening of the skin pattern, peeling of the skin with a large number of small-lamellar and pityriasis scales,
numerous excoriations (combs). Lesions are displaced into natural folds and folds, as a rule, tend to symmetry.

Teenage stage

In children over 10 years of age and adolescents, lichenoid or prurigoid variants of blood pressure can be stated. With the lichenoid form of blood pressure in the exacerbation phase, infiltration prevails (from the Latin "seepage", tissue soaking; foci of compaction arising from the release of lymphocytes into the skin from the vessels) and lichenification of the skin against the background of acute inflammatory erythema and non-intense edema. The primary morphological element is epidermal papules, in places merging into areas
continuous infiltration. With great consistency m is determined by dry skin, peeling, intensive itching. Dermal rashes are localized mainly on the face, wrist joints, neck, elbow and popliteal fossa, on internal On the lower thighs, crotch area.
A less common prurigi-like form is characterized by rashes against the background of lichenified skin in the form of multiple isolated dense edematous papules, at the apex of which small vesicles with a dense lid are revealed. The rash is often located on the extensor surfaces of the limbs, buttocks.

Cutaneous status of an asymptomatic atopic patient

The skin of those suffering from atopic dermatitis during the period of remission or "dormant course" is characterized by dryness and ichthyosiform peeling. The incidence of ichthyosis vulgaris in atopic dermatitis varies from 1.6 to 6%, according to different phases of the disease. Hyperlinearity of the palms (folded palms) is observed when combined with vulgar ichthyosis.

The skin of the trunk and extensor surfaces of the limbs is covered with shiny, flesh-colored follicular papules. On the lateral surfaces of the shoulders, elbows, sometimes in the area of the shoulder joints, horny papules are determined, usually regarded as Keratosis pilaris. At an older age, the skin is distinguished by dyschromic variegation with the presence of pigmentation and secondary leukoderma. Often in patients in the cheek area,
whitish spots of Pityriasis alba.

During the period of remission the only ones showed minimal with atopic dermatitis can be barely flaky weakly infiltrated spots or even cracks at the bottom edge attachment of the auricle lobe. In addition, such signs can be cheilitis, recurrent seizures, a median fissure of the lower lip, as well as erythemosquamous lesions of the upper eyelids. Periorbital darkening, pallor of facial skin with an earthy tinge can be important indicators of atopic personality.

Knowledge of small symptoms skin manifestations atopic predisposition is of great practical importance, since it can serve as a basis for the formation of high-risk groups.

Atopic march

The atopic march is a natural course of the development of manifestations of atopy. It is characterized by a typical developmental sequence
clinical symptoms of atopic disease, when some symptoms become more pronounced, while others decline. Usually, the clinical symptoms of atopic dermatitis precede the onset of bronchial asthma and allergic rhinitis. According to several studies, approximately half of patients with atopic dermatitis subsequently develop bronchial asthma, especially in severe cases, and two-thirds develop allergic rhinitis. In children with the mildest course of the disease, there was no development of allergic rhinitis or bronchial asthma. The severity of atopic dermatitis can be considered a risk factor for bronchial asthma. According to research data, with severe atopic dermatitis, the risk of developing bronchial asthma is 70%, with mild - 30%, and in general among all children - 8-10%. That is why it is so important

I will give a visual example from practice.

Patient G., born in 2002 turned to LLC "TSEIM" on 24.06.08 with complaints of allergic manifestations in the form of atopic dermatitis. Suffers from this condition from 1 year. 1 month According to the patient's mother, the diagnosis was not immediately established and he received treatment for lichen. There was no effect. Examined by an allergist,

identified allergens, adhered to a hypoallergenic diet. If the diet was followed, the skin became "cleaner." History of chronic otitis media, tonsillitis, adenoid vegetation 2 tbsp. It is registered with a rheumatologist (joints were swollen in infancy, the cause is not determined). Marked "bend" on the Mantoux test.

The examination revealed a mental load of 5 tbsp. on the gallbladder, biliary tract, kidneys, lean part of the small intestine, skin; Intox II in the immune system in the form of bacterial and fungal burdens, food allergies (less sensitive) and allergens (food, household, phyto-) have been identified. In the gallbladder and bile ducts, a parasitic load was detected; fungal dysbiosis of the small intestine, impaired water-salt metabolism in the kidneys (oxalates) and fungal toxic information are tested; birth injury in the cervical spine.

The approach to treatment is complex:

1. Resonant frequency therapy - 10 sessions for parasitic, fungal, bacterial flora.
2. Bioresonance therapy with the preparation of private BR-preparations (2, 3 Gotovsky strategies were used).
3. Treatment with nosodes, autonosodes.
4. Additional treatment by an osteopath (birth injury).
5. Medical nutrition.

In the course of treatment, attenuation of the manifestations of atopic dermatitis was noted. After 6 months from the start of treatment, all manifestations disappeared and did not return again, even if the diet was not followed. Adenoid vegetation decreased to 1 tbsp. The Mantoux test was carried out without preliminary drug preparation, the "bend" was not noted. The patient feels well and is now completing treatment with an osteopath.

Conclusion: the use of the vegetative resonance test and bioresonance therapy allows you to quickly and without complications achieve good results in the treatment of atopic dermatitis, despite the age and severity of clinical manifestations.

E.V. Hepatica Atopic dermatitis in children //

"IMEDIS", 2009, v.1 - p. 103-110