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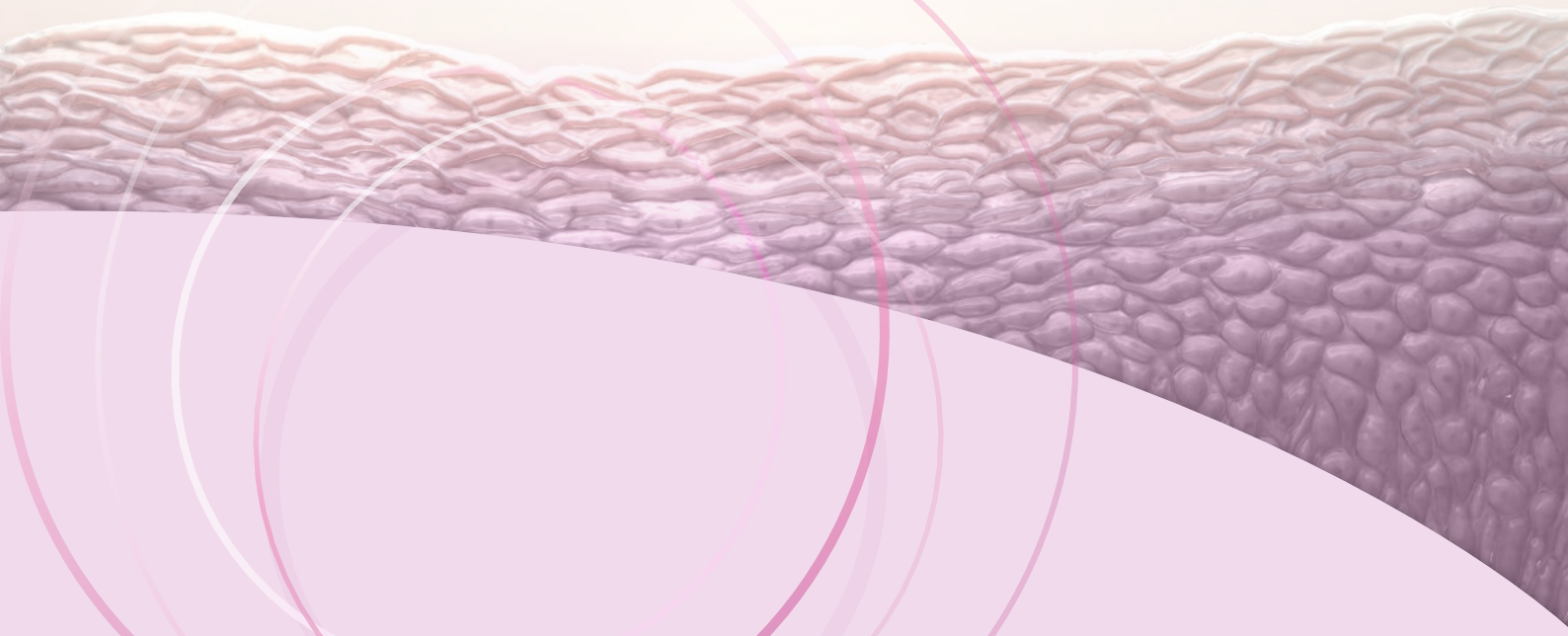
Information Leaflet
for Patients



ATOPIC ERUPTION OF PREGNANCY (AEP)

The aim of this leaflet

This leaflet is designed to tell you more about Atopic Eruption of Pregnancy (AEP). It tells you what the condition is, what causes it, and what can be done about it.

ATOPIC ERUPTION OF PREGNANCY (AEP)

What is Atopic Eruption of Pregnancy?

Atopy is the term used for the tendency to develop eczema, asthma and/or hay fever.

Atopic eczema is an inflammation of the skin causing dry and itchy skin. It can affect any part of the skin, including the face, but the areas most commonly affected are the skin creases of the elbows, knees, wrists, and neck. It affects both sexes equally and usually starts in the first weeks or months of life. It is most common in children, affecting at least 10% of infants. It can carry on into adult life or, after a silent period, may recur in the teenage or early adult life. Many "environmental" factors can make eczema worse. These include heat, dust, contact with irritants such as soap or detergents, stress, and infections. Also during pregnancy, eczema frequently gets worse (see below).

AEP includes women who already have eczema but experience a flare-up of the disease (approximately 20% of AEP patients), and women with their first occurrence/case of eczema during pregnancy (the remaining 80% of cases). These patients present with *atopic* skin changes for the first time during pregnancy, but they often have a history of sensitive skin with a tendency toward dryness and irritation (called *atopic diathesis*) and often have first-degree relatives with eczema, asthma, and/or hay fever.

AEP usually develops during the first half of pregnancy (75% before the third trimester). AEP was also previously known as "prurigo of pregnancy," but this name has been abandoned because it did not cover the whole variety of skin changes that can be seen.

What causes Atopic Eruption of Pregnancy?

This is still not fully understood. *Atopy* runs in families (see below) and is part of your genetic make-up. *Atopic* people have an overactive immune system and their skin easily becomes inflamed (red and sore). Their skin "barrier" does not work well, so their skin may become dry and prone to infections. During pregnancy, the immune system changes considerably, which may lead to worsening of pre-existing eczema or to a first development of *atopic* skin changes. These changes are usually reversible after delivery; however, a small number of women may continue to have eczema in following pregnancies.

Does Atopic Eruption of Pregnancy run in families?

Yes, *atopic eczema* (as well as asthma and hay fever) tends to run in families. If one or both parents suffer from eczema, asthma, or hay fever, it is more likely that their children will get it too. Similarly, due to the genetic background, your sister or mother may also have experienced AEP during pregnancy. The probability is high that AEP will recur in future pregnancies.

What are the symptoms of Atopic Eruption of Pregnancy and what does it look like?

The main characteristic is itch, which can be bad enough to interfere with sleeping. The severity of the rash depends on the type of AEP. If you suffer from worsening of pre-existing eczema, it is likely that your skin will be red and dry. When the eczema is very active (during a "flare-up"), you may develop small water blisters on the hands and feet, or your skin may become wet and weepy. In areas that are repeatedly scratched, the skin may thicken in response - a process known as *lichenification*. If you experience AEP for the first time during pregnancy, the rash is usually much milder.

Two-thirds of patients suffer from red, scaly, itchy patches (so called *eczematous*-type or *E-type* AEP) in sites typically affected by *atopic* eczema such as the neck, breasts, and skin creases of the elbows and knees. The other one-third have tiny, red, raised spots (1-2 mm) or slightly larger raised skin lumps (5-10 mm, occasionally with small open wounds [*excoriations*] due to scratching) on the abdomen, back, and limbs (so called *prurigo*-type or *P-type* AEP).

How is Atopic Eruption of Pregnancy diagnosed?

Worsening of existent eczema is usually easy to diagnose by examining your skin and talking with you to obtain your medical history. However, the first appearance of AEP may be more difficult to diagnose, as it can be confused with other skin diseases such as scabies, a skin rash caused by taking oral medication, or other special skin diseases occurring in pregnancy. It is helpful to tell your clinician of a personal and/or family history of *atopy* and signs of the tendency to be *atopic* (see above regarding *atopic diathesis*).

Will the baby be affected by Atopic Eruption of Pregnancy?

No, the mother's rash causes no harm to the baby. However, due to the genetic background of AEP, the child may develop some kind of *atopic* disease (eczema, asthma, and/or hay fever).

Can Atopic Eruption of Pregnancy be cured?

Not really; due to its genetic background, it cannot be cured as such. But there are many ways of controlling it. Especially the first development of AEP usually responds well to therapy and can easily be controlled.

How can Atopic Eruption of Pregnancy be treated?

The primary aim of treatment is to relieve itching and to reduce inflammation and redness in the skin. It is also important during pregnancy to use treatments that are entirely safe for both mother and baby. The treatments used most often are moisturisers and steroid creams or ointments.

Moisturisers (emollient creams and ointments) should be applied several times a day to prevent skin dryness. Many are available, and it is important that you choose one you like to use. Bath emollients and soap substitutes are also helpful in many cases. You should not take baths and showers too frequently, as this will make your skin dry.

Steroid creams or greasier steroid ointments are often necessary to relieve symptoms. The steroid cream or ointment should only be applied to affected areas of skin and a mild (for example hydrocortisone) or moderate steroid cream should be used. The amount should be as small as possible, and ideally only 1-2 small (15-30 g) tubes should be used. However, if the condition is severe, then application of a stronger steroid cream or ointment to the skin in larger quantities is better than steroids given by mouth. Oral steroid tablets are a last resort to control the condition; they should only be given in low doses and for short periods. Prednisolone is the steroid tablet of choice during pregnancy, and it may be required for severe flares of eczema.

Some patients may also benefit from additional ultraviolet light treatment (UVB), which is considered safe in pregnancy.

Antibiotics may be needed if your rash becomes wet and weepy, which may mean that it is infected by bacteria.

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In addition, oral antihistamines may help to relieve the itch.

The following are considered safe in pregnancy:

- Sedating (cause drowsiness): Clemastine, Dimethindene, Chlorpheniramine
- Non-sedating: Loratadine, Cetirizine.

Creams or ointments that suppress the immune system such as tacrolimus (Protopic®) and pimecrolimus (Elidel®) *must be avoided* as they are not licensed for the use in pregnancy. However, incidental use on limited areas has not shown harm to the unborn, but good studies are lacking.

Is the treatment safe for the baby and mother and is any special monitoring required?

Mild- to moderate-strength steroid creams or ointments appear to be safe during pregnancy. However, stronger steroid creams and ointments may cause problems with the growth of the unborn baby, so that they may be born small especially if the mother is using large amounts (more than 50 gm, 1/2 large tube per month or over 200-300 gm, 2-3 large tubes, in the whole pregnancy) of steroid creams or ointments.

Short courses (around 2 weeks) of prednisolone, the steroid tablet of choice in pregnancy, do not usually affect the unborn. However, high doses (above 10mg/day) of oral prednisolone administered during longer periods (over 2 weeks) during the first 12 weeks of pregnancy seem to increase the risk of developing oral/palate clefts. Longer courses of steroid tablets (which are usually not necessary for the treatment of AEP) may also affect the baby's development in general, in particular its growth rate. When steroid tablets are taken, there is also an increased risk of the mother developing diabetes (raised sugar levels) and hypertension (raised blood pressure). Careful observation of blood pressure and urine checks are therefore essential at an antenatal clinic, while ultrasound scans can look for changes in the baby's growth.

Is normal delivery possible?

Yes.

Can women with Atopic Eruption of Pregnancy still breastfeed?

Yes. Even while taking oral steroid tablets, women should still be encouraged to breastfeed as only small amounts of steroids get into breast milk. However, these women are at risk of developing nipple eczema due to their sensitive skin, so regular application of emollients is important. If topical steroids are applied to the nipple, they should be washed off prior to breast feeding to prevent oral ingestion by the infant. ■

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