When the “Family Tree” Causes a Rash

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Both parents have the same allergic condition. So, in every case, family history related to skin issues is very helpful to know. Are we dealing with allergic contact dermatitis? Or is this atopic dermatitis that will be a chronic condition?

JULIE DODGE: Sometimes parents have adapted to their symptoms and they don’t think of them as a condition that can be transmitted. They’re all on antihistamines, and will say: “Well, we all have eczema!” But while they have obviously incorporated the appropriate skin care, they have never associated it with the diagnosis.

If they have not had those issues and had to avoid certain kinds of irritants or allergens, they may not know what is going to really irritate the skin—such as lavender infused soap. It’s helpful knowing what to avoid rather than trying to “cure” or treat it in a “natural” way.

DR. STEIN: That’s an important point. There is a tendency to assume that a “natural” product is necessarily a safe product. But something doesn’t have to be synthetic to be problematic; and many products labeled “natural” include ingredients that are irritants and/or allergens. Research indicates that an average woman is exposed to hundreds of chemicals—synthetic and “natural”—every single day, just through regular grooming and use of makeup. For those with a predisposition to eczema or contact dermatitis the key is to avoid irritants and common allergens.

H&H: So that’s something you can control to some extent, even though it’s difficult. What about family history—how does that impact individual care?

DR. HAMILTON: You simply look at patients in a different way when you know details of their family history. That is not to suggest that we are not thorough in our work with all patients, but we do look at patients more critically when we are aware of existing genetic connections.

For example, I will be quick to do a biopsy on a small mole for the woman who has two brothers with melanoma. Another patient may say that she has three relatives who have psoriasis. She shows me one little spot that, seen alone, you would never think of as being psoriasis because it is missing that classic psoriatic plaque. But knowing her family history, I will approach this in a more aggressive way. Both the patient and I will want to know for sure whether this little spot is, or is not, psoriasis.

JULIE DODGE: Fifty percent of people with psoriasis, on average, have a related family history. So, if you have a positive family history for the condition, it’s significant.

DR. STEIN: I think having genetic information will affect our treatment decisions and level of aggressiveness. When a young teenager comes in with an acne problem, my initial impulse is to be conservative, perhaps recommending effective products or a course of topical treatment with or without oral antibiotics. But then I look at Mom and Dad, and see the scars that are the aftermath of severe cystic acne. It’s evident, or at least highly likely, that this youngster is on the same path. And the question is: should we continue with multiple different treatment regimens that may continue literally for many years, or should we move aggressively to isotretinoin (commonly known as Accutane) sooner for a finite period of time—typically five to six months. That choice—informed by the family history—offers the prospect of actually clearing and being the closest thing to a cure of the problem.

DR. HAMILTON: Then there’s the converse, which are the parents who didn’t have acne. They may find it hard to understand their child’s problem, because they didn’t experience it. But I do point out that every individual is a unique combination of genes and that you can get someone with severe acne whose parents do not have that history.

H&H: In such a case, could something have activated a latent genetic tendency for that child, and what might that trigger be?

JULIE DODGE: Foods are probably number one on the list. High glycemic index foods could be the only one with some people, while others will have trouble with dairy or nut sensitivities. Lack of sleep and stress can be issues. But sugar’s the big one.

DR. STEIN: Dermatology frequently deal with many chronic diseases. We are comfortable with the notion that we cannot always know the answers to the “How, When and Why?” questions. We ask specific questions to address these concerns, and to exclude possible associated problems.

DR. HAMILTON: In some cases, we may think we know precisely the nature of the problem based on first observations, and then—as we dig deeper—we realize that our early conclusion may need to be modified in some way. You learn from these experiences. That’s what keeps it all challenging and interesting.

For more information about skin conditions and treatment, contact:

REGIONAL DERMATOLOGY
OF DURHAM
Elizabeth H. Hamilton, MD, PhD
Amy Stein, MD
Julie Dodge, PA-C
4321 Medical Park Drive, Suite 102
Durham, NC 27704
Telephone: (919) 220-7546 (SKIN)
www.dermatologydurham.com

From left: Julie Dodge, PA-C, Amy Stein, MD, and Elizabeth Hamilton, MD, PhD