EMIRATES DERMATOLOGY SOCIETY
2024
ANNUAL CONFERENCE

8th YEAR
08-10 November 2024
InterContinental Dubai - Festival City
United Arab Emirates

EMIRATES DERMATOLOGY SOCIETY

CASES FROM THE PREGNANCY SKIN CLINIC

Dr S A Vaughan Jones

Consultant Dermatologist UK

27TH WORLD CONGRESS OF DERMATOLOGY 2031
DUBAI - CANDIDATE CITY

Conflict of Interest

- I have no conflict of interest to declare

CONTENTS OF TALK

- Pregnancy Skin clinic
- How to assess the pregnant patient
- Immune system changes in pregnancy
- Cases from Pregnancy Clinic
- Safe Treatment in pregnancy
- Educational Resources

PREGNANCY SKIN CLINIC

- Monthly Teaching Clinic
- Referral Guidelines website
- Referrals received from:

  Community midwives, O&G Colleagues

  Local GPs, Tertiary referrals
- Pregnancy Referral Proforma

Ashford and St. Peter's Hospitals NHS Foundation Trust

PREGNANCY SKIN CLINIC REFERRAL PROFORMA

Please complete details and E mail to Dr Samantha Vaughan Jones
Email: S.vaughanjones@nhs.net

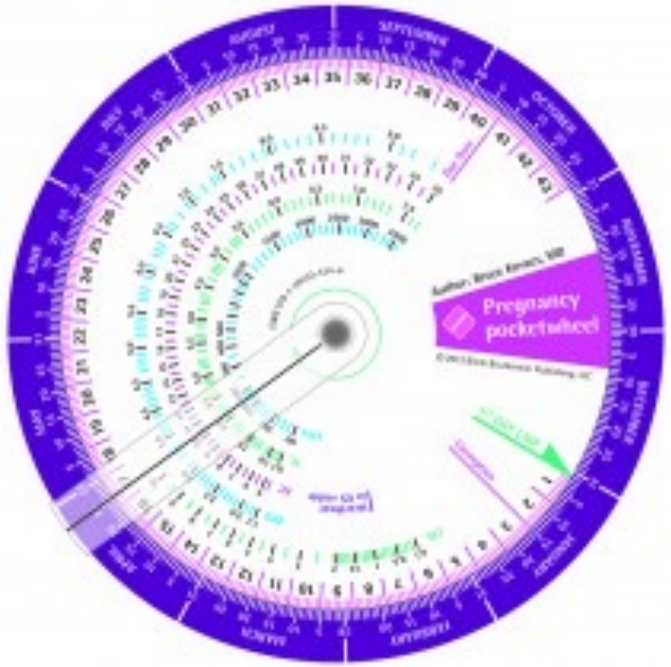
Please include any photos of the patient's skin eruption (with their consent) and e mail to our Dermatology Photos team on asp-tr.dermphotos@nhs.net

Patient Name & address:	**Hospital Number:**
DOB:	**NHS number:**
Mobile Number:	**E mail address:**
Referred by: (Dr / Midwife)	**Consultant Obstetrician:**
Gestation:	**Parity:**
Relevant blood results: Haemoglobin, Ferritin levels, serum bile acids	
Clinical History:	**Treatment given so far:**
Expected date of Delivery:	
Date of Referral:	**ROUTINE / URGENT (please circle)**

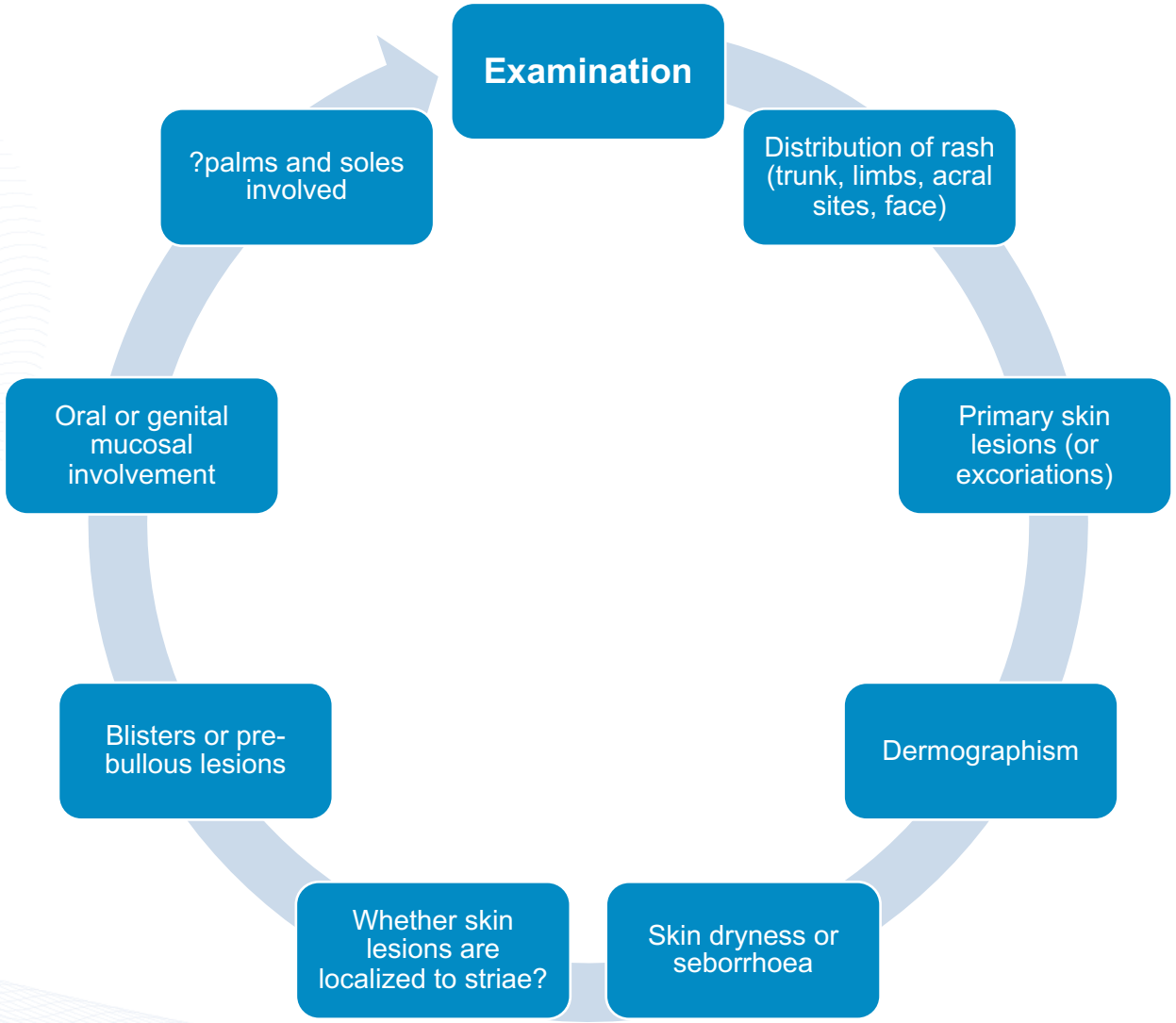
THE PREGNANT PATIENT – HISTORY

History:

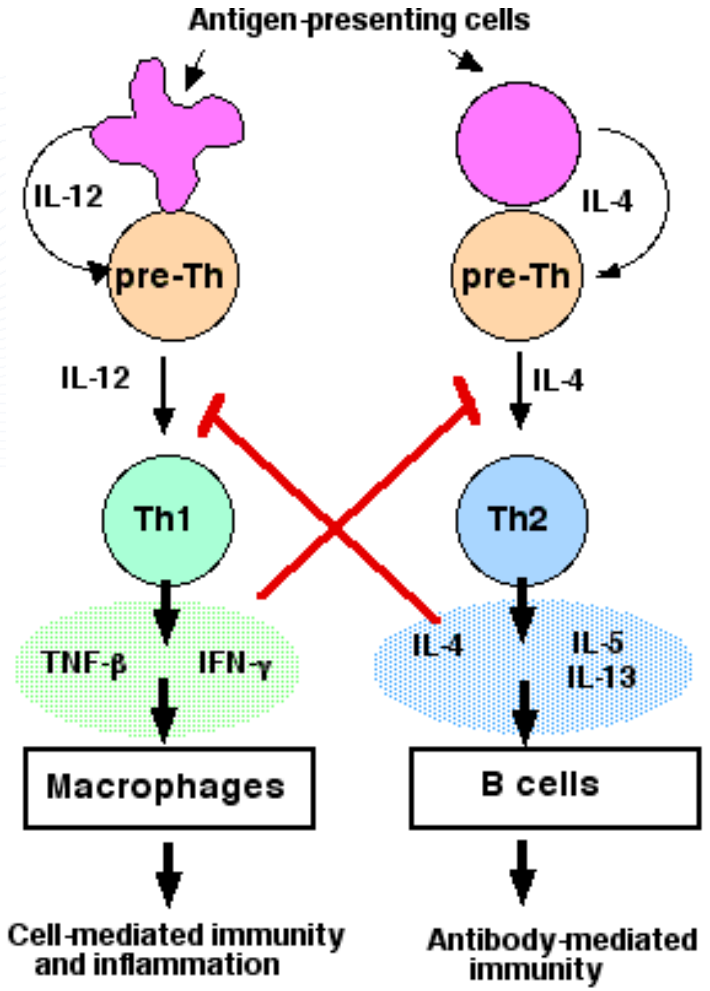
- Pregnancy History - Gestation, Parity, Miscarriages, Stillbirths.
- EDD - Expected Date of Delivery
- Skin History (Eczema, Acne, Psoriasis)
- Family History (Atopy, Auto-Immune Disease)
- When rash/skin lesions started (?which trimester)
- Where rash/skin lesions started (?trunk, limbs)
- Consultant & Midwife in charge of patient
- Growth scans, relevant blood results



THE PREGNANT PATIENT – EXAMINATION

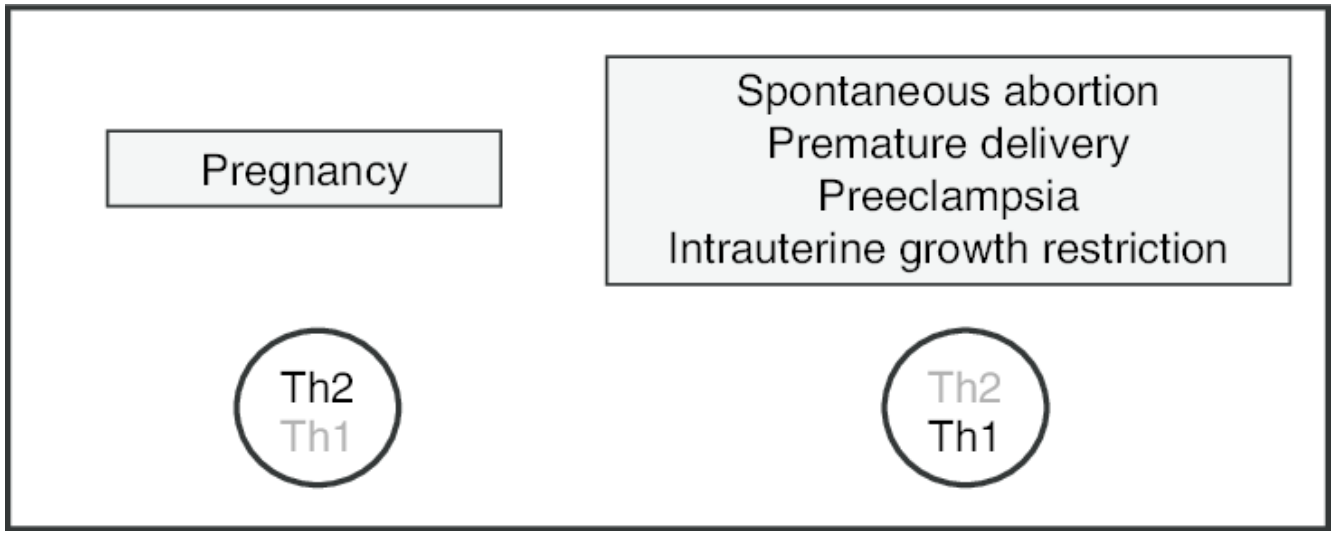


IMMUNE CHANGES IN PREGNANCY



For Normal Pregnancy & Foetal tolerance

- Increased tendency to Atopic disease (Th2)
- Increased susceptibility to infections – reduced CMI (Th1)
- Improvement in psoriasis (Th1)
- Increase in B cell autoantibdy production (Th2)



PREGNANCY CLINIC 2023

58 patients seen in 1 year

AEP – 25 (43%)

PEP – 10 (17%)

Acne/Rosacea – 13 (22%)

Pemphigoid gestationis – 1

*Miscellaneous – 9 (16%) – see below

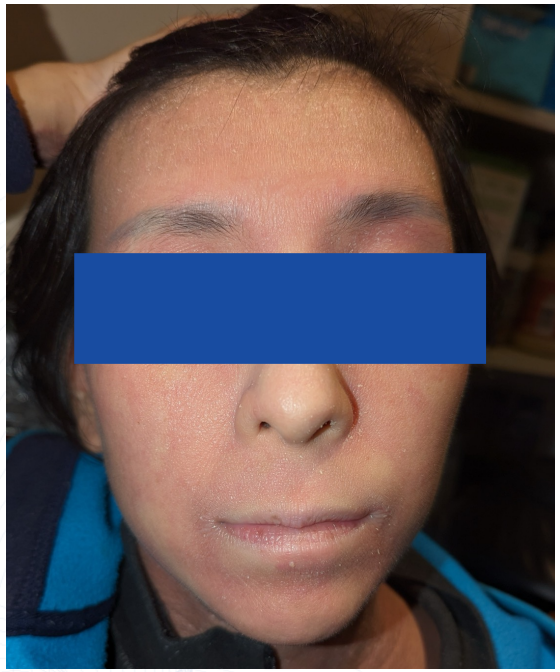
* E. Nodosum, Skin infections, Psoriasis, Drugs, Pityriasis rosea

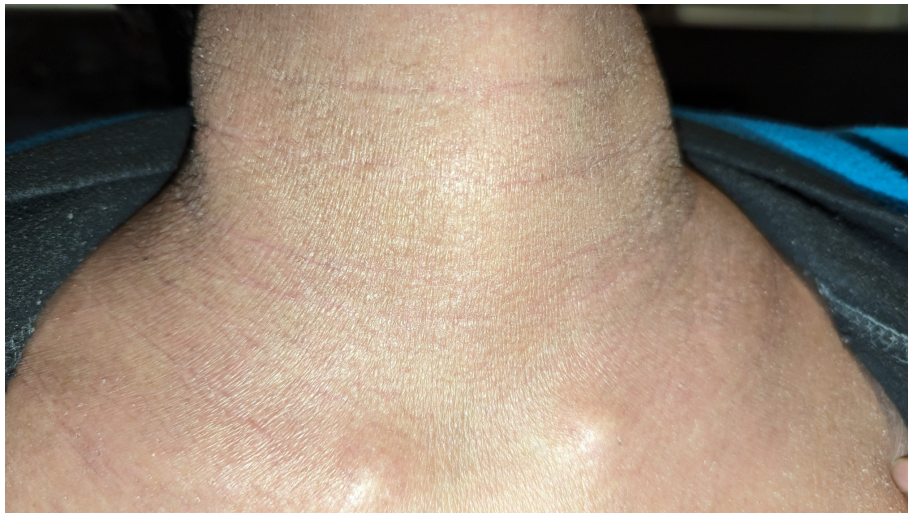
CASES FROM THE PREGNANCY SKIN CLINIC

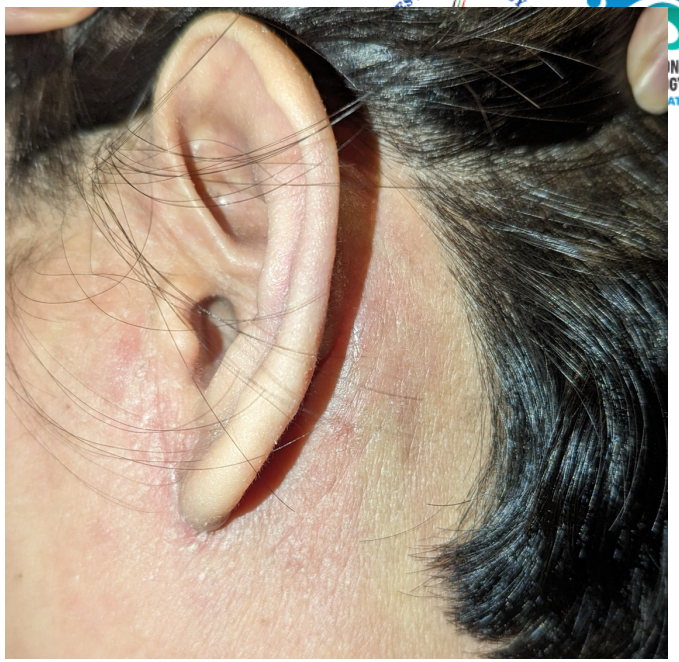
Case 1. HISTORY

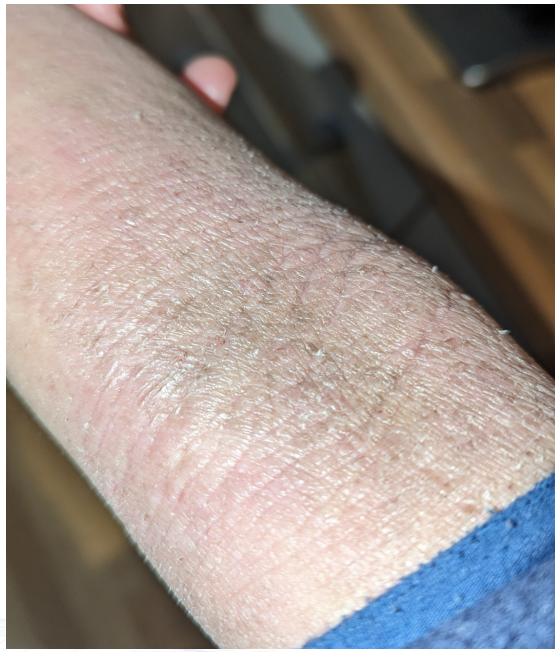
- 37 year old woman
- Atopic eczema (since aged 3).
- Currently 12/40 in 2nd pregnancy
- Previous Rx systemic steroids & Chinese herbs
- No previous phototherapy or systemic therapy
- Previously lived in Hong Kong
- Recent Rx – emollients only

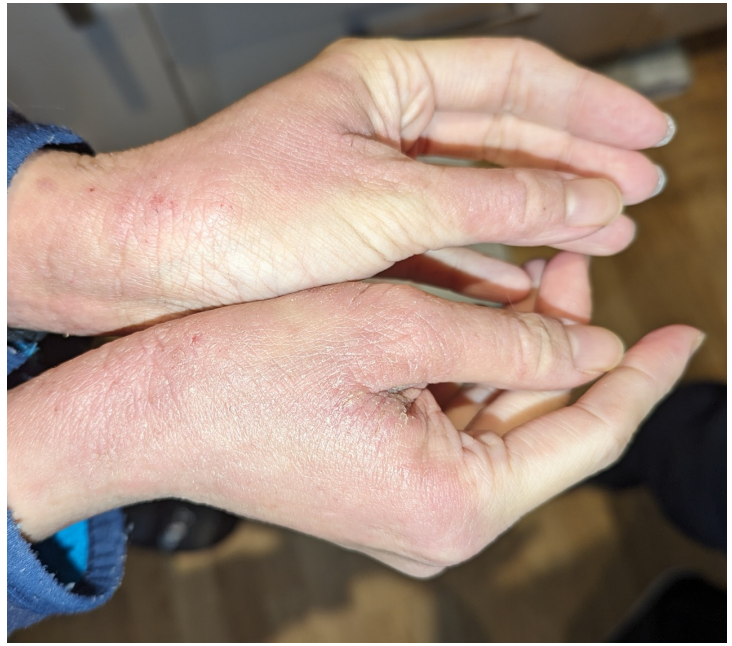
Case 1.











Case 1. INVESTIGATIONS

- Blood results- FBC, U&Es, LFTs - normal.
- Serum Ferritin levels 37 (low normal).
- Serum IgE levels >5000
- Vitamin D levels 102 (normal).
- Skin swabs:
  - Heavy growth of Staph. aureus
  - Moderate growth of group A Beta haemolytic Strep.
  - Sensitive to Flucloxacillin & Phenoxymethylpenicillin.

Case 1. TREATMENT

- Emollients – Menthoderm, CeraVe, Dermol 500 cream & lotion
- Topical Steroids – Dermovate, Elocon, Eumovate
- Flucloxacillin 500 mg qds & Phenoxymethylpenicillin 500 mg qds for 1 week.
- Ferrous sulphate 200 mg once daily.
- TCI- Protopic ointment 0.1% - twice daily to face & neck for 2-4 weeks
- Loratadine 10 mg daily.
- Tubifast bandages to arms and legs at night.
- Bleach baths twice weekly (using Milton sterilising fluid).
- Referral for Urgent Phototherapy - Narrowband UVB
- Oral prednisolone 30 mg daily - reducing by 5 mg/week (if needed)

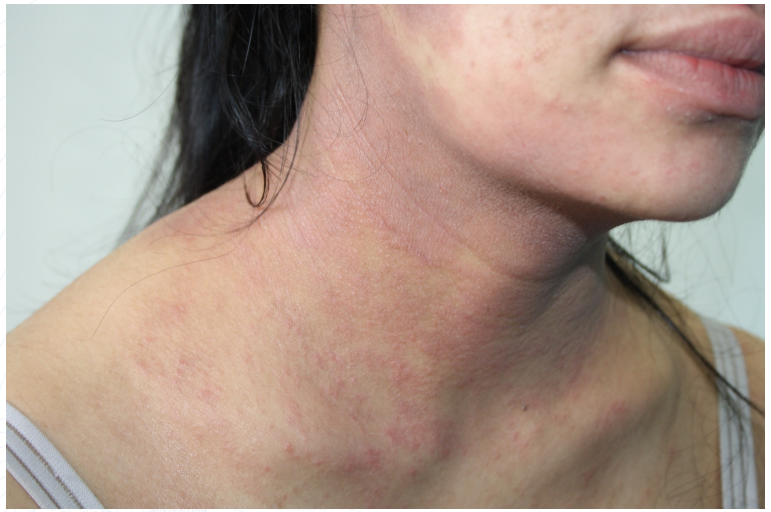
Case 1. PROGRESS

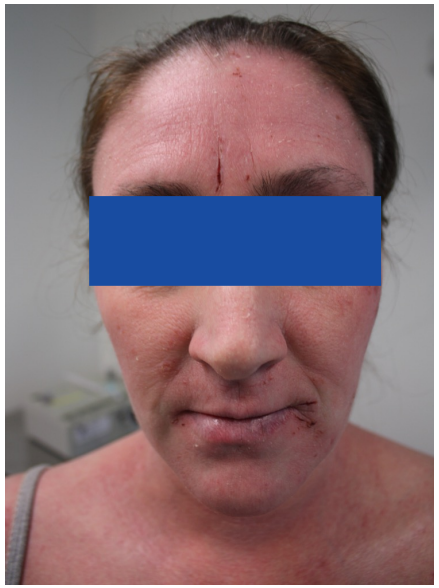
- Good response to phototherapy
- Discussed systemic Rx- patient not keen on Ciclosporin or Dupilumab
- Awaiting delivery
- Continued phototherapy for rest of pregnancy
- Good response
- Oral prednisolone 5-10 mg daily – until delivery
- Maternal BP and urinalysis stable
- Baby born 2.3kg - small for dates
- No flare of eczema post partum

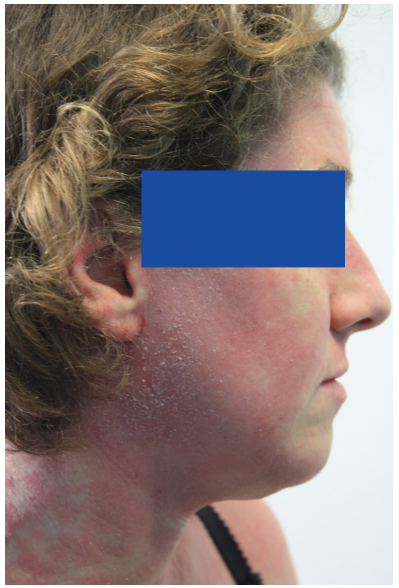
ATOPIC ERUPTION OF PREGNANCY

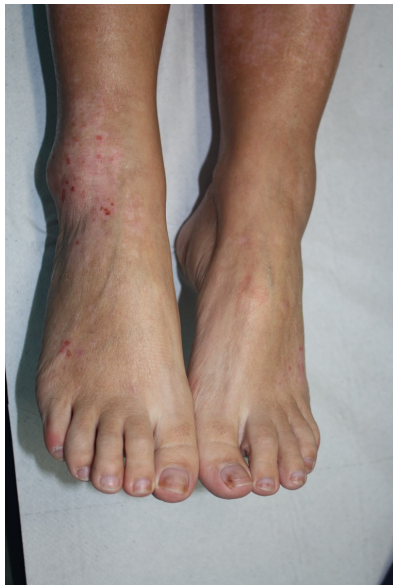
- 80% cases present with de novo Atopic Eruption
- 20% pre-existing chronic Atopic Dermatitis (prev. pregnancies)
- Family history of atopy (eczema, asthma, hay fever)
- Rare in multiple pregnancy
- Onset in 2nd trimester
- Predominantly involving limbs > trunk
- Lesions Eczematous, Follicular, Papular, Urticated or Prurigo.
- Ix - Serum IgE levels may be elevated – often normal
- Ix - Iron deficiency may co-exist (check serum ferritin levels)

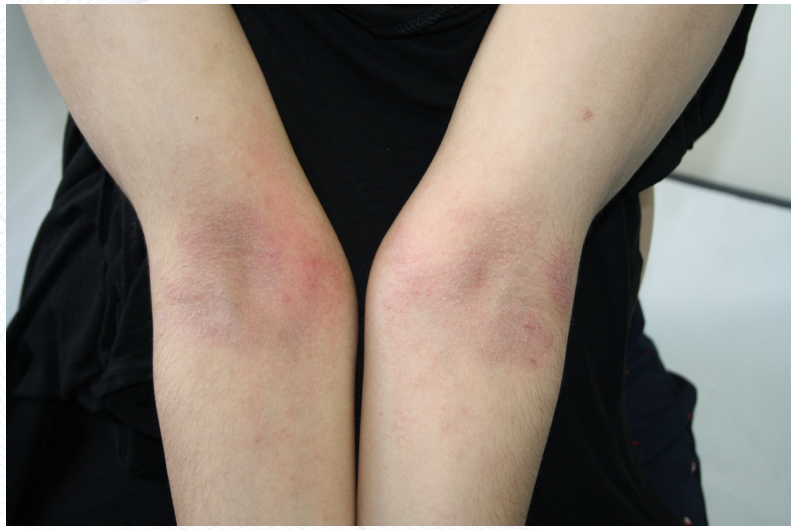
ATOPIC ERUPTION OF PREGNANCY

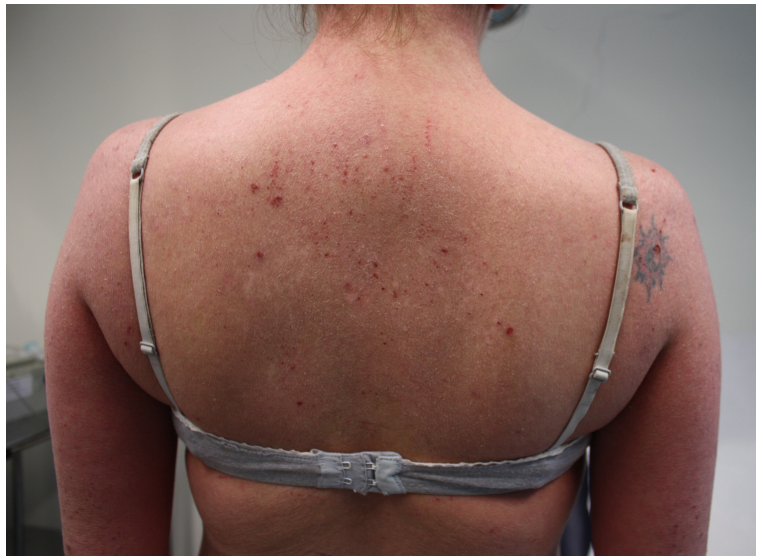


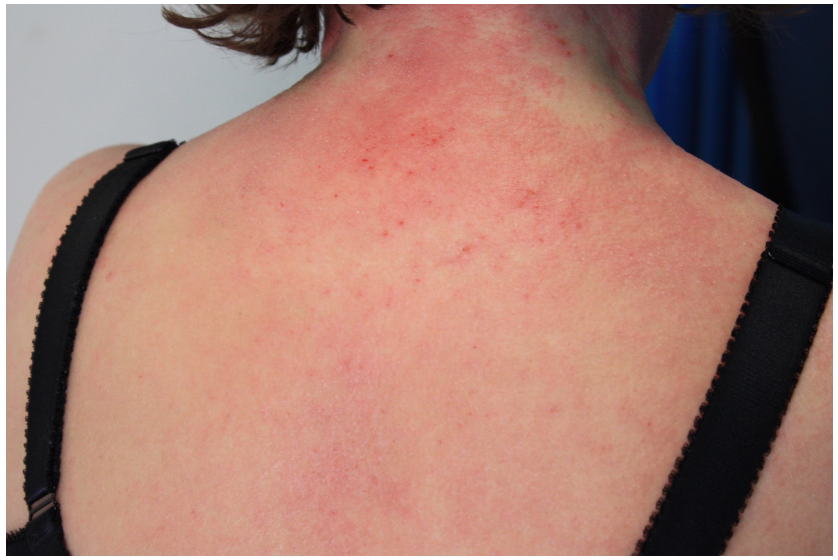












ATOPIC ERUPTION OF PREGNANCY & IDA

- 36 patients with AEP seen over last 2 years
- 18 patients with ferritin levels <30 at presentation (50%)
- In 10 cases ferritin levels not measured (but Hb <105)
- In 2 cases ferritin levels <10ng/ml
- Several patients had prurigo nodules

Current Ix – FBC, Blood group, Rhesus, Hep B,C, HIV, Syphilis

Should serum ferritin levels be measured routinely at booking appointment (8 -12 weeks gestation)?

IRON DEFICIENCY/ ANAEMIA

- Iron is an essential element (oxygen transport, red cell production, DNA synthesis, muscle metabolism)
- Iron deficiency is the main cause of anaemia
- Most prevalent nutritional deficiency worldwide
- Iron deficiency anaemia affects:
  - 29% non-pregnant women
  - 38% of pregnant women
  - 43% of children worldwide

Serum Ferritin is 1st test to become abnormal as iron stores decrease (<30)

WHO 2025 target – to halve global anaemia in women of reproductive age

IRON DEFICIENCY ANAEMIA IN PREGNANCY

Pregnancy causes 2-3 x increase in iron requirements

Anaemia - commonest medical disorder in pregnancy

Iron deficiency anaemia in pregnancy associated with:

- Increased maternal morbidity
- Infection
- Post partum haemorrhage
- Preterm labour
- Low birth weight
- Abnormal neonatal neurological development
- Autism, ADHD.

Risk factors for IDA

- *Multiple pregnancy*
- *Multiparity*
- *Teenage pregnancy*
- *Previous anaemia*
- *Previous PPH*
- *Vegan/Vegetarian diet*
- *Malabsorption*
- *Recent bleeding*
- *Haemoglobinpathies*

SYMPTOMS OF IRON DEFICIENCY ANAEMIA (IDA)

- Fatigue
- Dizziness & fainting
- Itching & skin dryness
- Pica (cravings for non-food items)

Effects on Skin, Hair, Nails:

- IDA weakens the skin barrier
- Increased Transepidermal Water Loss
- Skin dryness (exacerbation of AEP)
- Telogen effluvium
- Nail splitting, breakage

Normal Haemoglobin in pregnancy

Ist Trimester - Hb >110
2nd Trimester - Hb >105
3rd Trimester - Hb >105

DUPILUMAB

- Only used for severe, refractory disease
- IgG4 type IL4 / IL13 Monoclonal Antibody
- Transported across cord low conc in 1st & 2nd T
- Increased transport in 3rd T due to fetal Fc receptors developing
- No evidence of harm, animal studies no teratogenicity but VERY small numbers
- Classified in same category as Omalizumab as possibly safe - use in severe disease only
- **Small no. of case reports in AEP**

Case Reports in Dermatology

Case Rep Dermatol 2021;13:248–256

DOI: 10.1159/000515246
Published online: May 4, 2021

© 2021 The Author(s)
Published by S. Karger AG, Basel
www.karger.com/cde

OPEN ACCESS

This article is licensed under the Creative Commons Attribution-NonCommercial 4.0 International License (CC BY-NC) (http://www.karger.com/Services/OpenAccessLicense). Usage and distribution for commercial purposes requires written permission.

Case and Review

Atopic Dermatitis Treated Safely with Dupilumab during Pregnancy: A Case Report and Review of the Literature

Dermatol Ther (Heidelb) (2020) 10:1215–1228
https://doi.org/10.1007/s13555-020-00457-w

REVIEW

Immunosuppressive and Immunomodulating Therapy for Atopic Dermatitis in Pregnancy: An Appraisal of the Literature

Sofine Heilskov · Mette S. Deleuran · Christian Vestergaard

PREGNANCY TREATMENT ALGORITHM

Substance	Recommended washout time before conception	Preconceptive	Pregnancy
Topical therapy			
Moisturizers	No restrictions		
Mild- to medium-potency TCS §	No restrictions		
High- to ultra–high-potency TCS	No restrictions	‡	‡
TCI	No restrictions		
Crisaborole	NA		
UV therapy			
Broad- or narrow-band UVB	No restrictions		
UVA1	No restrictions		
PUVA	3 months*		
Systemic therapy			
SCS	No restrictions		
CsA	No restrictions		
MTX	3-6 months*		
AZA	No restrictions		
MMF	3 months *		
Dupilumab	No restrictions		
Tralokinumab	No restrictions		
Baricitinib	1 week†		
Upadacitinib	4 weeks†		

Systemic Drugs safe in Pregnancy:

- Systemic Corticosteroids
- Ciclosporin A
- Azathioprine

Unsafe:

Methotrexate; Mycophenolate; JAK inhibitors

Dupilumab – not recommended at present

(+++) the best evidence on possible treatment available / first line

(++) therapy possible if necessary or in special areas / second line

(+) first reports on possible therapy available, but not recommended at the present time due to limited evidence

(±) no data on teratogenic / harmful effect is known, but the therapy is not recommended due to limited evidence

– contraindication / teratogenic / harmful effect is known

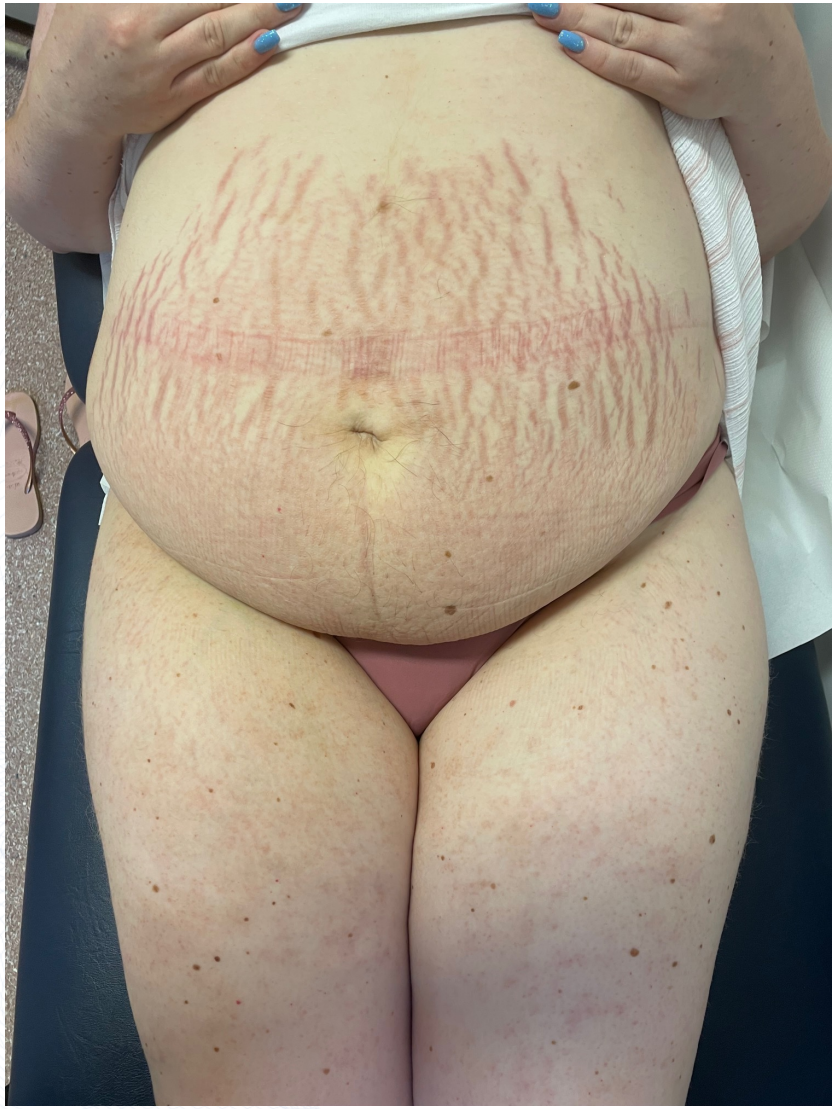
FIG 5. Summary on the use of AD drugs during pregnancy and before conception. *AZA*, Azathioprine; *MMF*, mycophenolate mofetil; *NA*, no information available; *PUVA*, Psoralen plus UVA; *TCI*, topical calcineurin inhibitor. *Information from different expert recommendations and position papers. †Information available from product information (label). ‡For high-potency TCSs, the amount of 200 mg/mo should not be exceeded; ultra–high-potency TCSs should only be used as a short-time treatment, rescue therapy, or therapy in particular areas. §Fluticasone propionate is not recommended for use during pregnancy because of the lack of metabolization by the placenta.

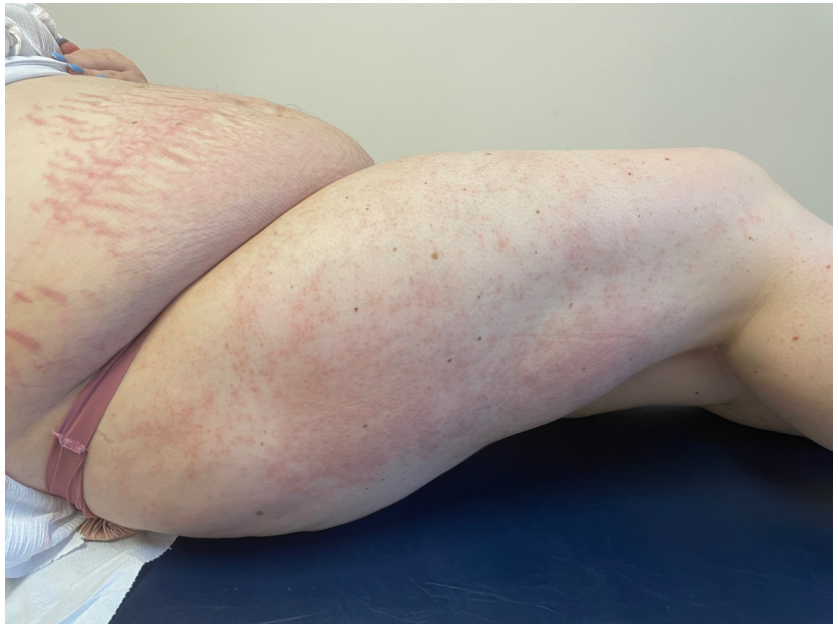
Atopic dermatitis and Pregnancy Balakirski G, Noval N. J Clin Immunol 2022; 149(4); 1185-94

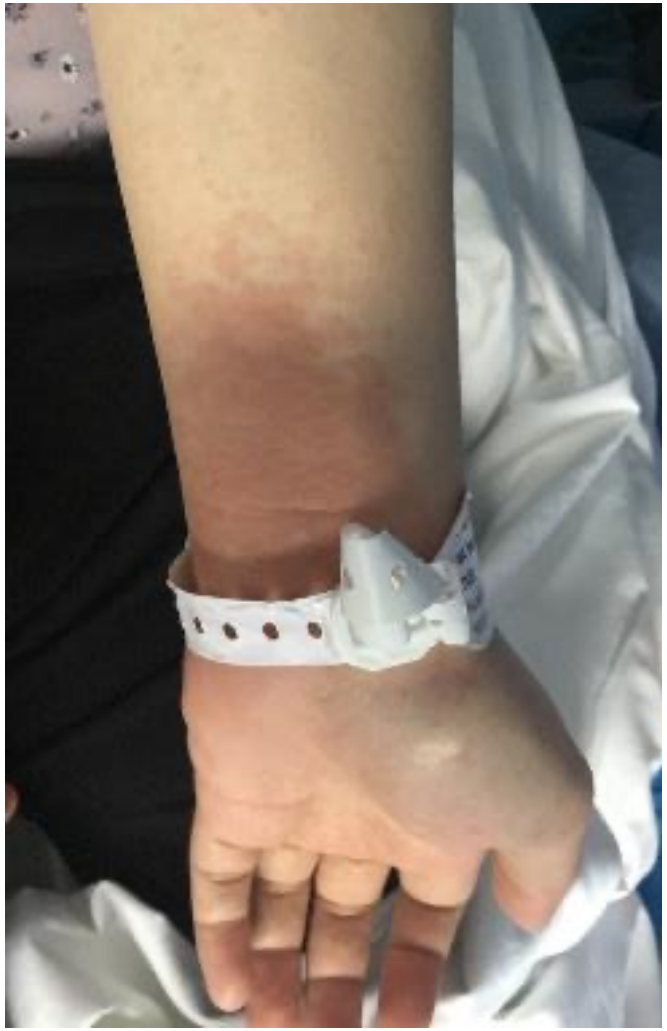
Case 2. HISTORY

- 35 year old woman
- Recent skin eruption – 2 days post partum
- Itchy skin eruption on lower abdomen, arms and legs
- Itchy rash in groins
- Some blisters on toes
- Twin pregnancy - emergency LSCS at 35 weeks gestation
- Gestational diabetes
- Iron deficiency anaemia

Case 2.







Case 2 - INVESTIGATIONS.

Investigations:

- Full blood count normal
- Ferritin levels at 18 (January 2022) and low platelet count at 117.
- Previously elevated CRP levels - now normalising.
- Skin biopsy - consistent with Polymorphic Eruption of Pregnancy
- Direct IMF negative for IgG, C3, IgA and IgM.
- Mycology groins – positive

- **Working Diagnosis: Polymorphic Eruption of Pregnancy (+tinea pedis)**

Case 2. TREATMENT

Topical Treatment:

- Emollients - Dermol 500 cream, Doublebase gel – 2-3 x daily
- Mometasone cream once nocte - to residual areas.
- Clobetasone butyrate cream o/d to abdomen for 2- 4 weeks
- Terbinafine cream to groins twice daily

Oral Treatment:

- Iron supplements - Ferrous Fumarate once daily

Good response to treatment – skin cleared

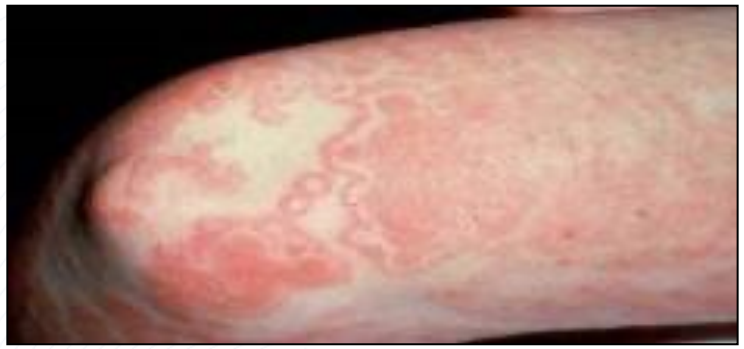
POLYMORPHIC ERUPTION OF PREGNANCY

Syn.: Pruritic urticarial papules and plaques of pregnancy (PUPPP)

- Usually Presents in 1st pregnancy (Primigravidae 70%)
- Presents in late pregnancy - 3rd T or postpartum (15%)
- Commonest skin eruption in multiple pregnancy
- Starts on abdomen (striae) then spreads elsewhere
- ?Link to excessive maternal weight gain
- ?Link to male sex
- True aetiology still unclear

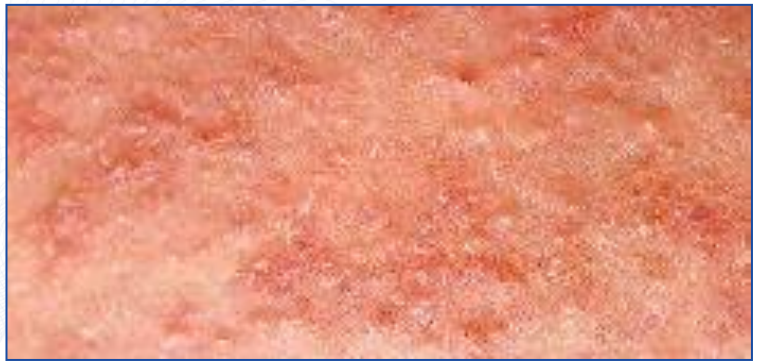
Rudolph CM et al., BJD 2006; Regnie et al., JAAD 2008

Polymorphic Eruption of Pregnancy

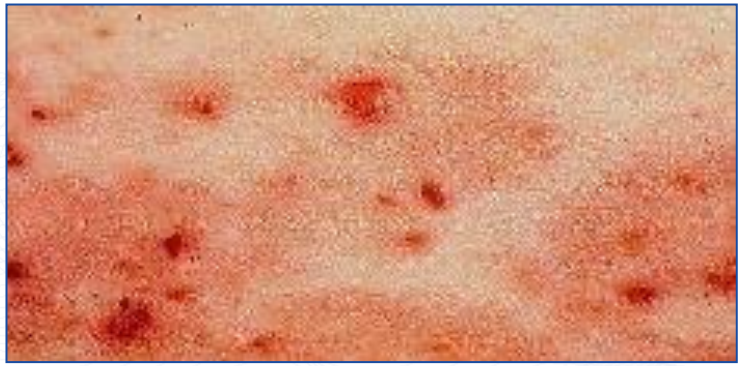


Clinical variants

Target lesions / Erythema, 6%



Vesicles, 17%



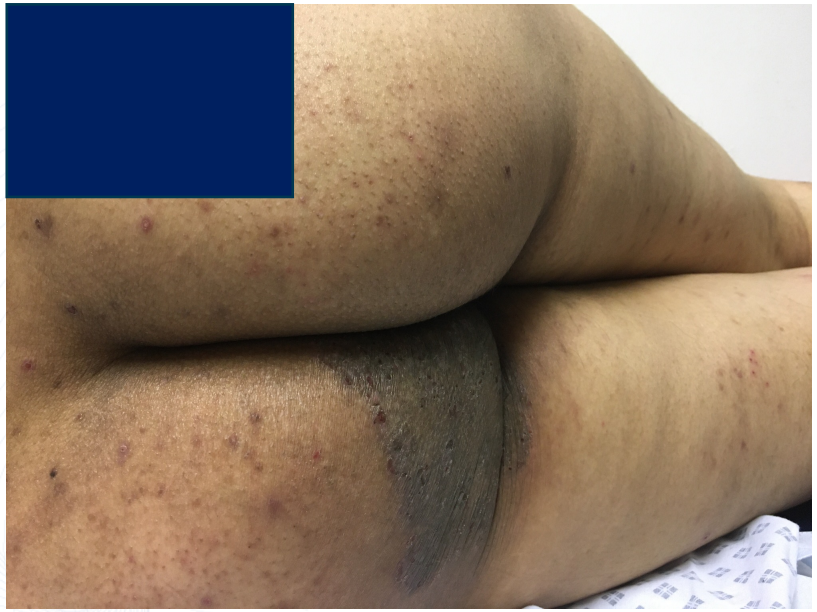
Eczematous changes, 22%

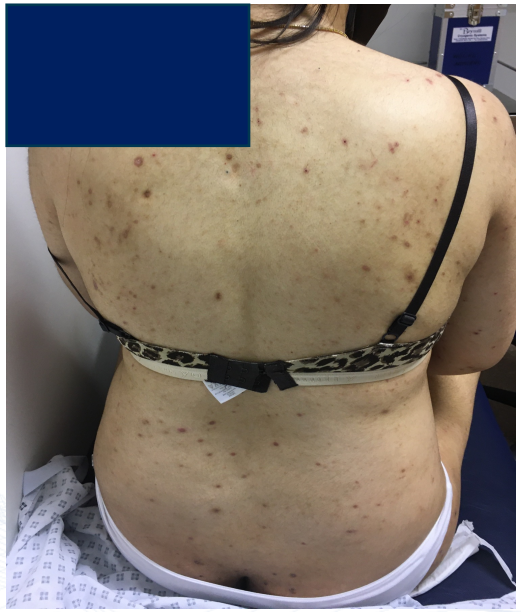
Rudolph CM et al. BJD 2006

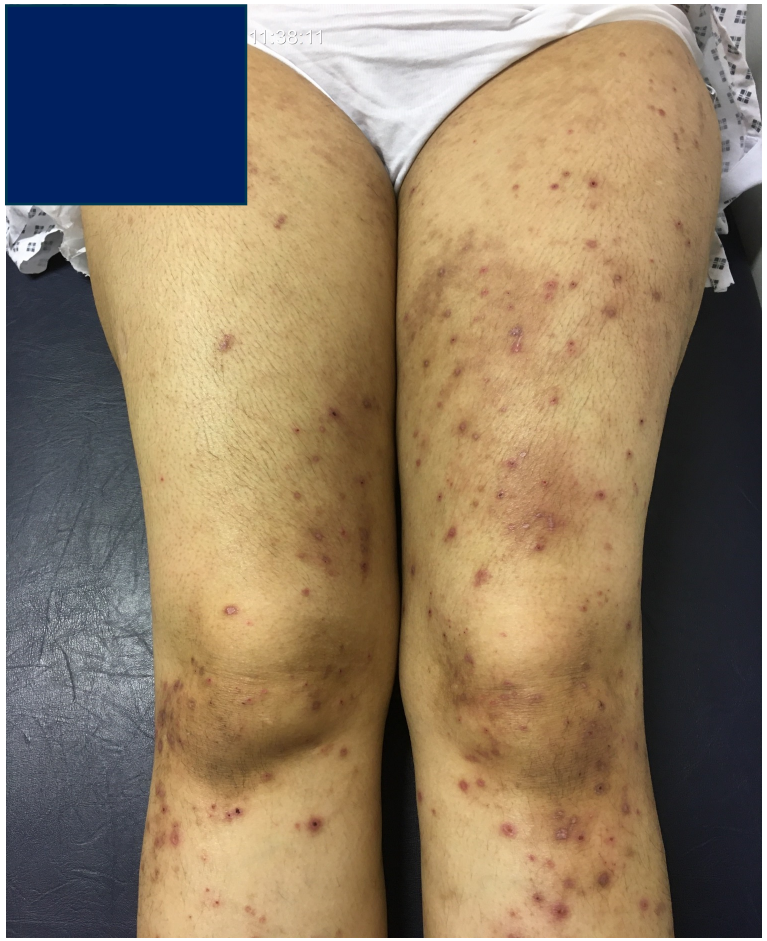
Case 3. HISTORY

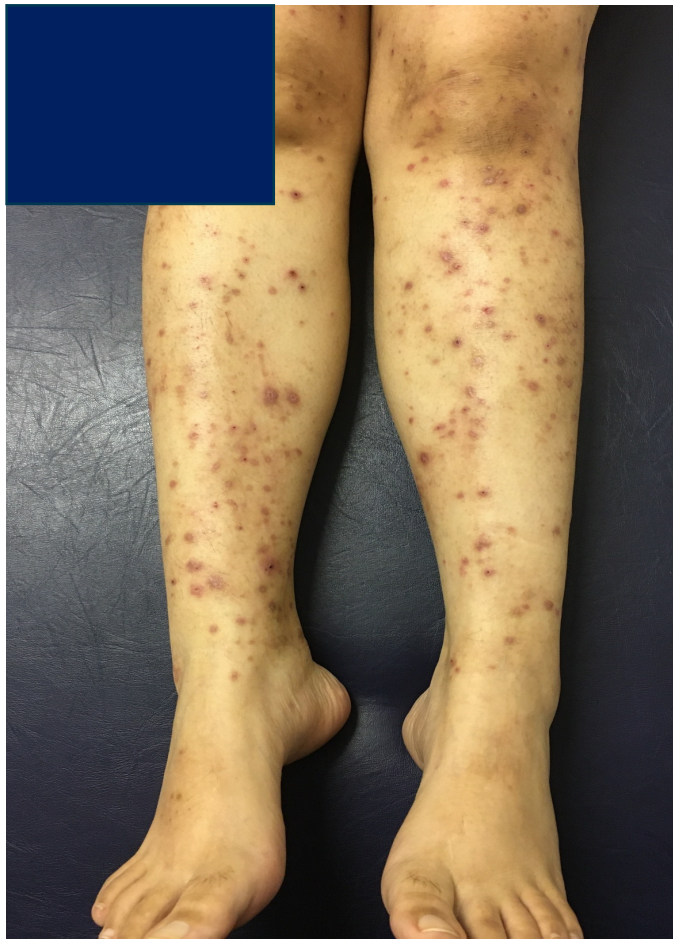
- 35 year old woman – Middle Eastern origin
- Presented at 31/40 in 2nd pregnancy
- Previous miscarriage at 5/40 gestation
- PMH – acne, hay fever, iron deficiency
- **Sore patch on L buttock 6 months**
- **Itchy rash on arms and legs**
- GP prescribed 1% HC and Eumovate – made rash worse

Case 3. EXAMINATION









Case 3. DIFFERENTIAL DIAGNOSIS

- Fungal infection with secondary ID reaction
- Tinea Incognito
- Atopic eruption of pregnancy with iron deficiency
- Nodular prurigo (secondary to iron deficiency)
- Scabies?

Case 3. INVESTIGATIONS

- Blood Results: FBC normal (Hb 131); Ferritin 26;
- LFTs & serum bile acids normal
- Vitamin D levels low at 28 (normal 50-150)
- Mycology scrapings – negative on Microscopy & Culture
- Skin swab – light growth Staph. Aureus (sensitive to Flucloxacillin)

Presumed Diagnosis Fungal Infection (despite -ve mycology)

Case 3. TREATMENT

- Topical Terbinafine
- Flucloxacillin 500mg qds 1 week
- Ferrous sulphate 200mg twice daily; Vit D supplements 3000IU daily

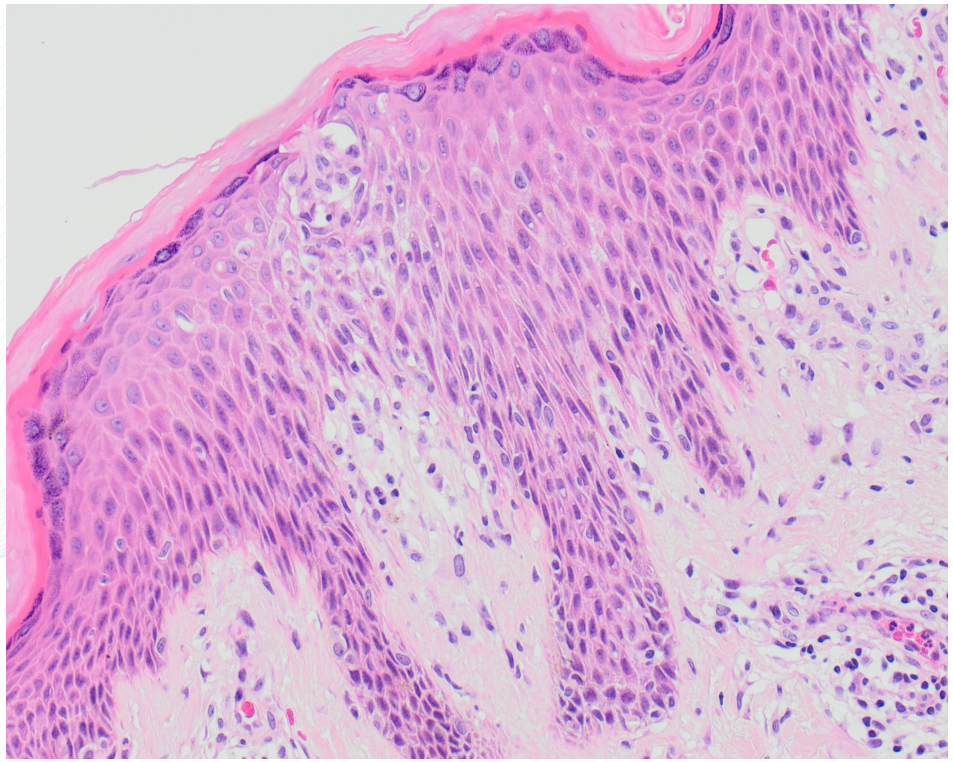
Advised not to take oral antifungal Rx during pregnancy

Patient delivered baby girl at 34/40 – SVD – birthweight 2.08kg

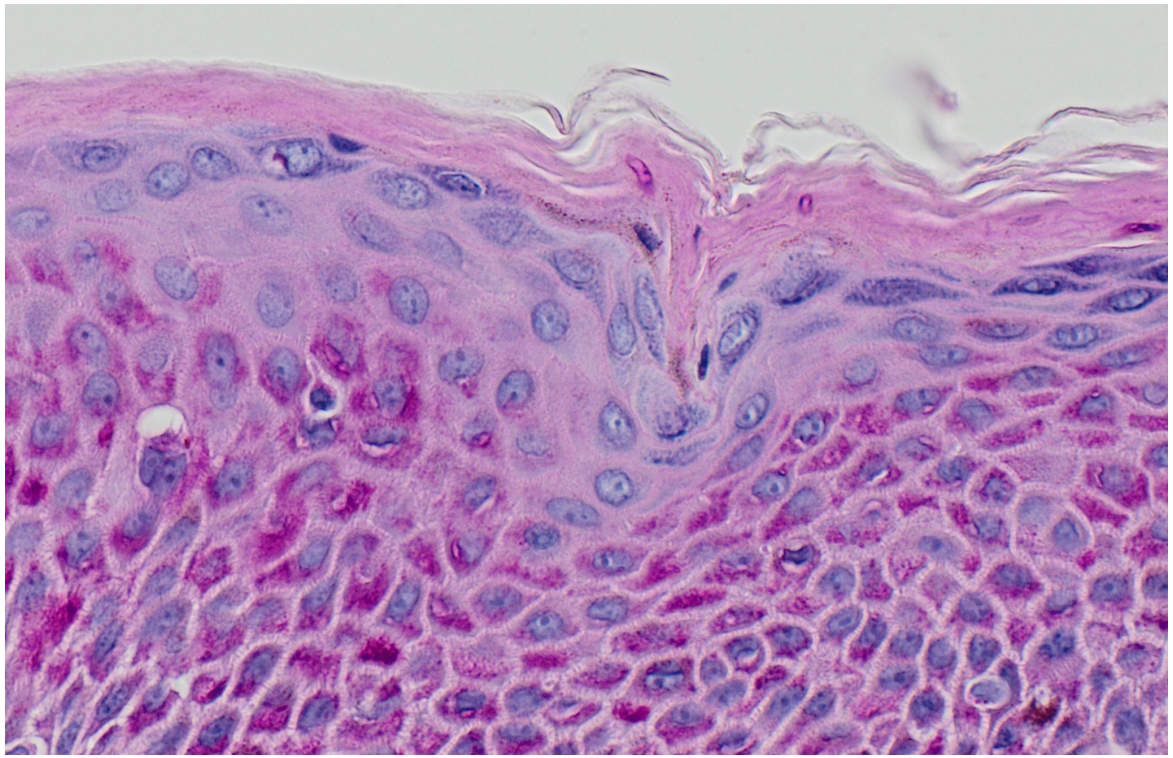
No response to Topical Terbinafine

- Postpartum Rx Terbinafine 250mg orally for 6/52 - No response
- Patient advised to express and discard breast milk
- **Presumed Diagnosis:** Terbinafine - Resistant Fungal Infection
- Skin biopsy for Histopathology & Culture recommended

HISTOPATHOLOGY



High power view - spongiosis



PAS stain positive

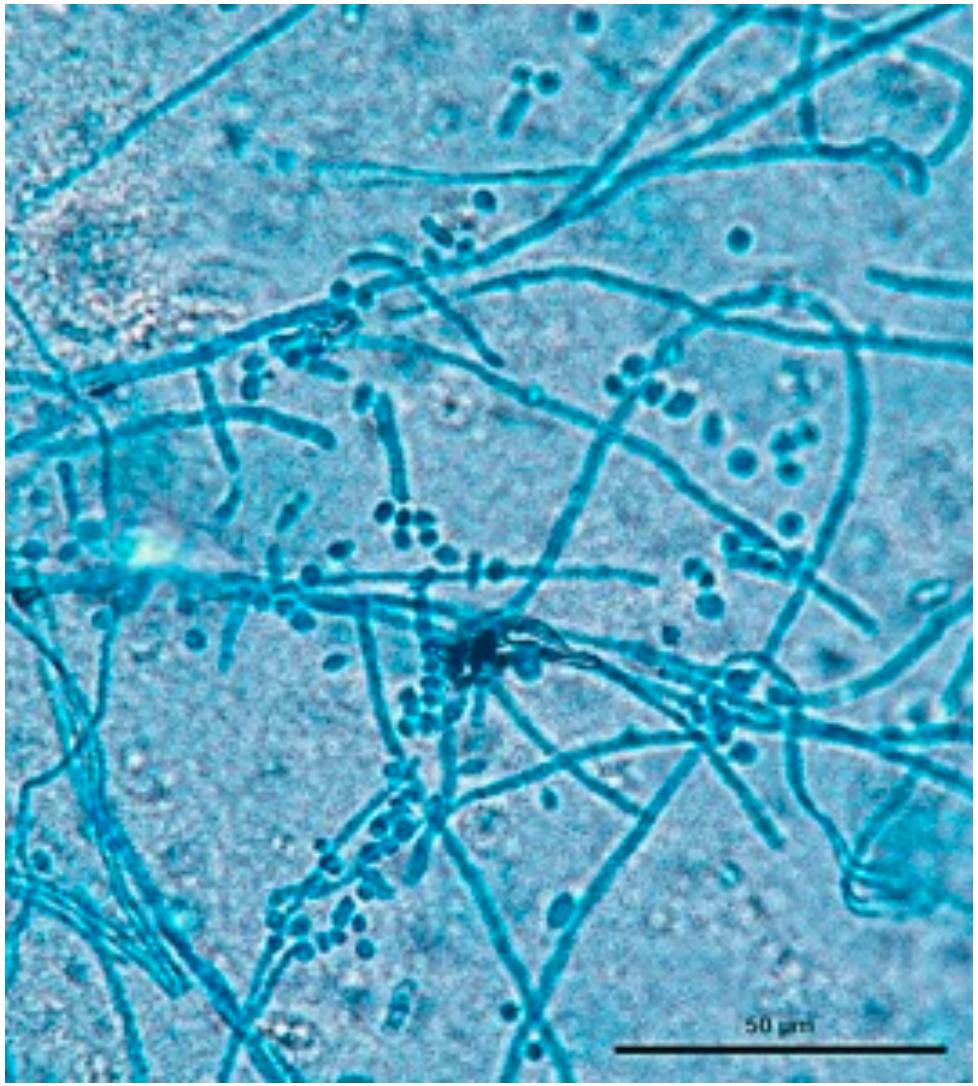
Skin biopsy L buttock : PAS stain – occ fungi within keratin; Alcian blue stain - no increase in dermal mucin; No signs of scabies

Case 3. MYCOLOGY

Biopsy Culture Result

(Bristol Reference Laboratory)

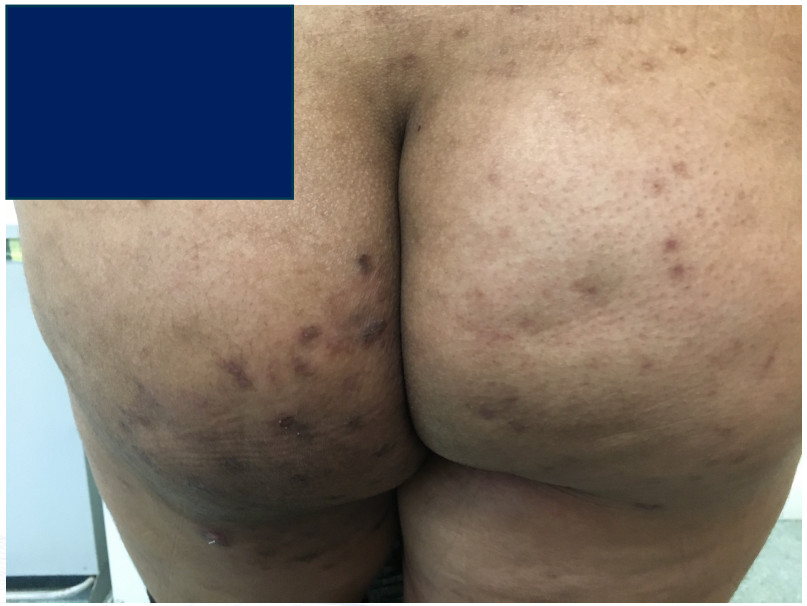
- **Trichophyton mentagrophytes:**
  - Sensitive to Itraconazole
  - Resistant to Terbinafine

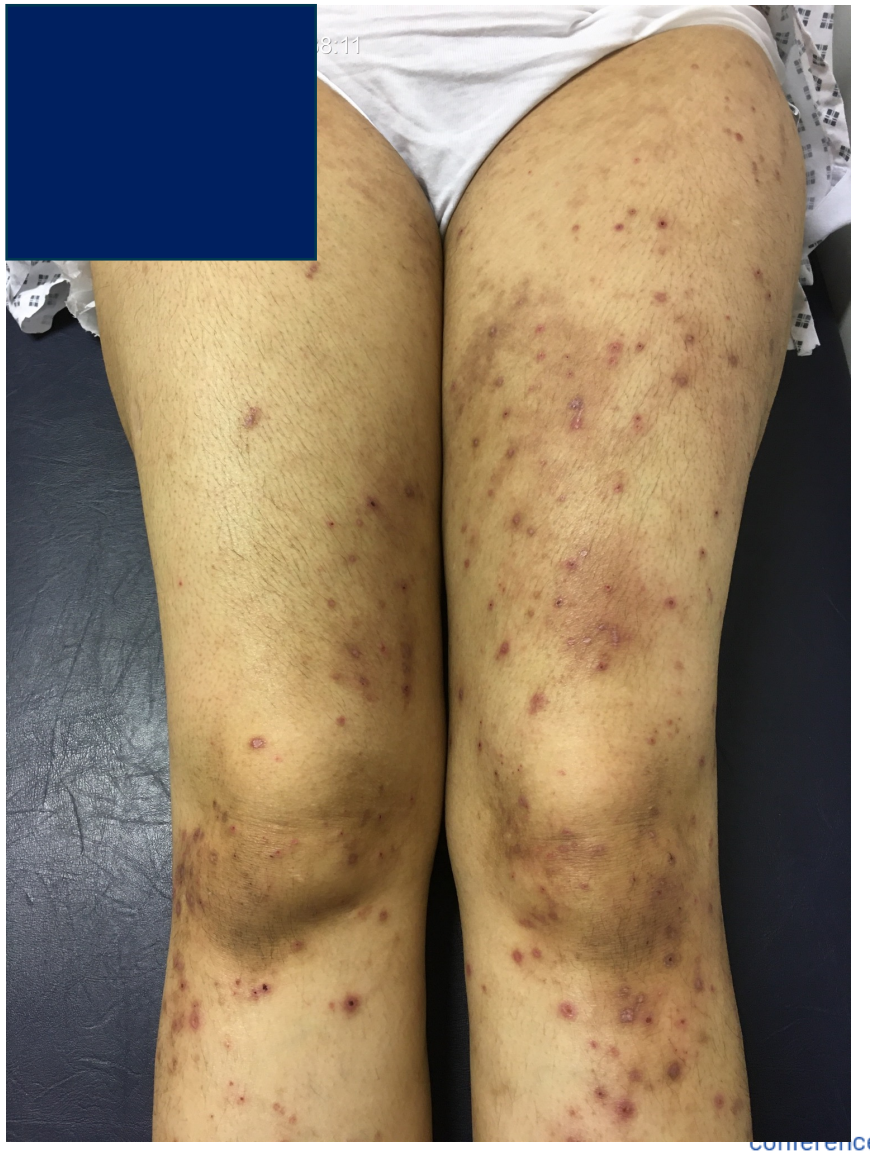


Trichophyton mentagrophytes

Case 3. TREATMENT

- Rx Itraconazole 100mg o/daily 4 weeks
- Discarded breast milk during Rx
- Good response to Treatment
- Itching & Eruption L buttock resolved
- Post-inflammatory hyperpigmentation

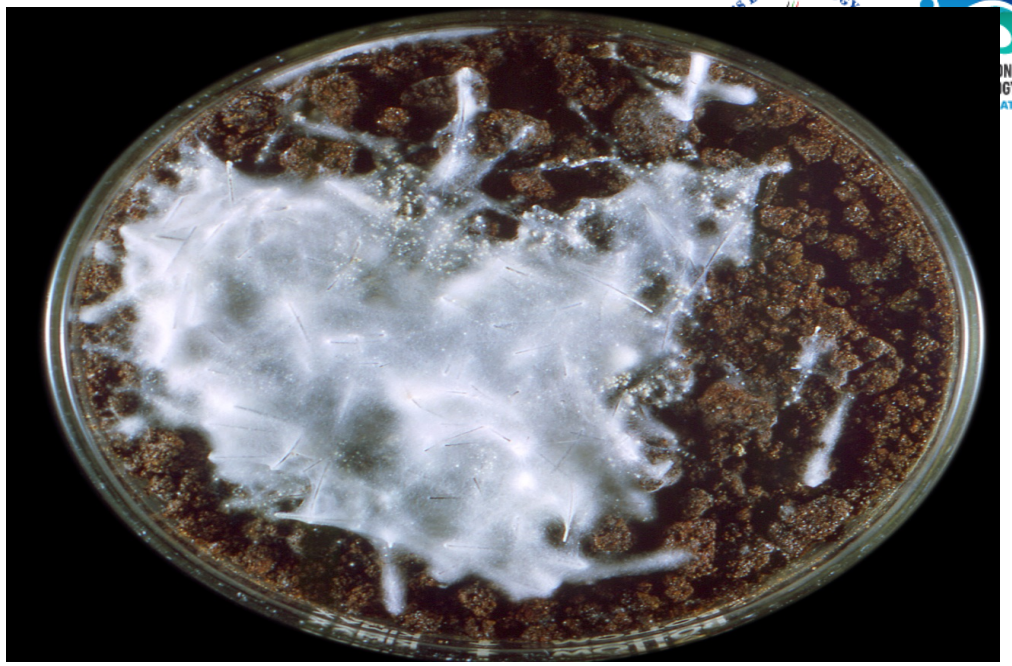




Case 3. DISCUSSION

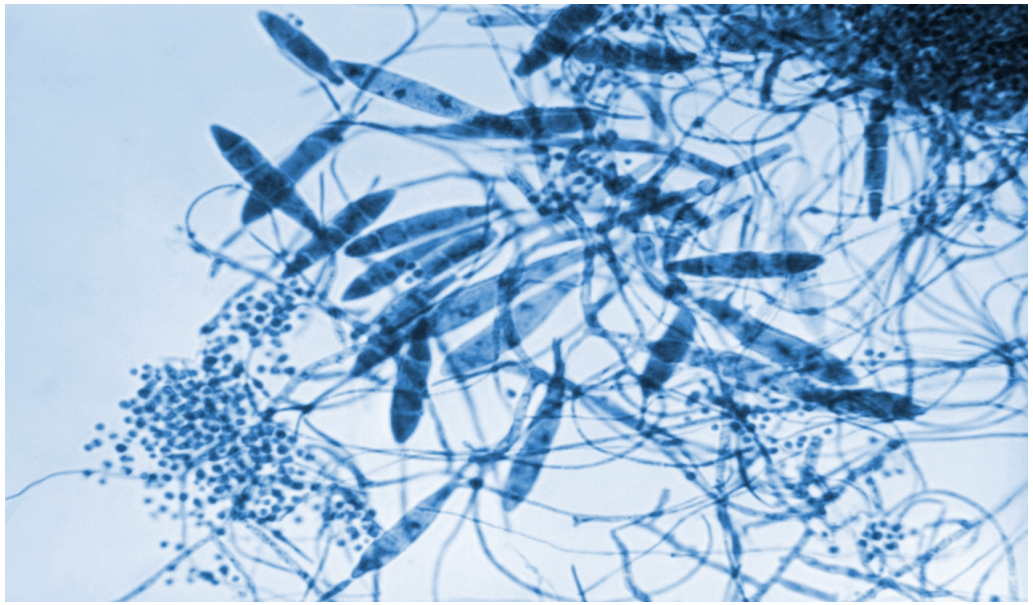
Trichophyton mentagrophytes :

- Increase in cases of treatment-resistant tinea
- Particularly in South East Asia/India



Possible reasons

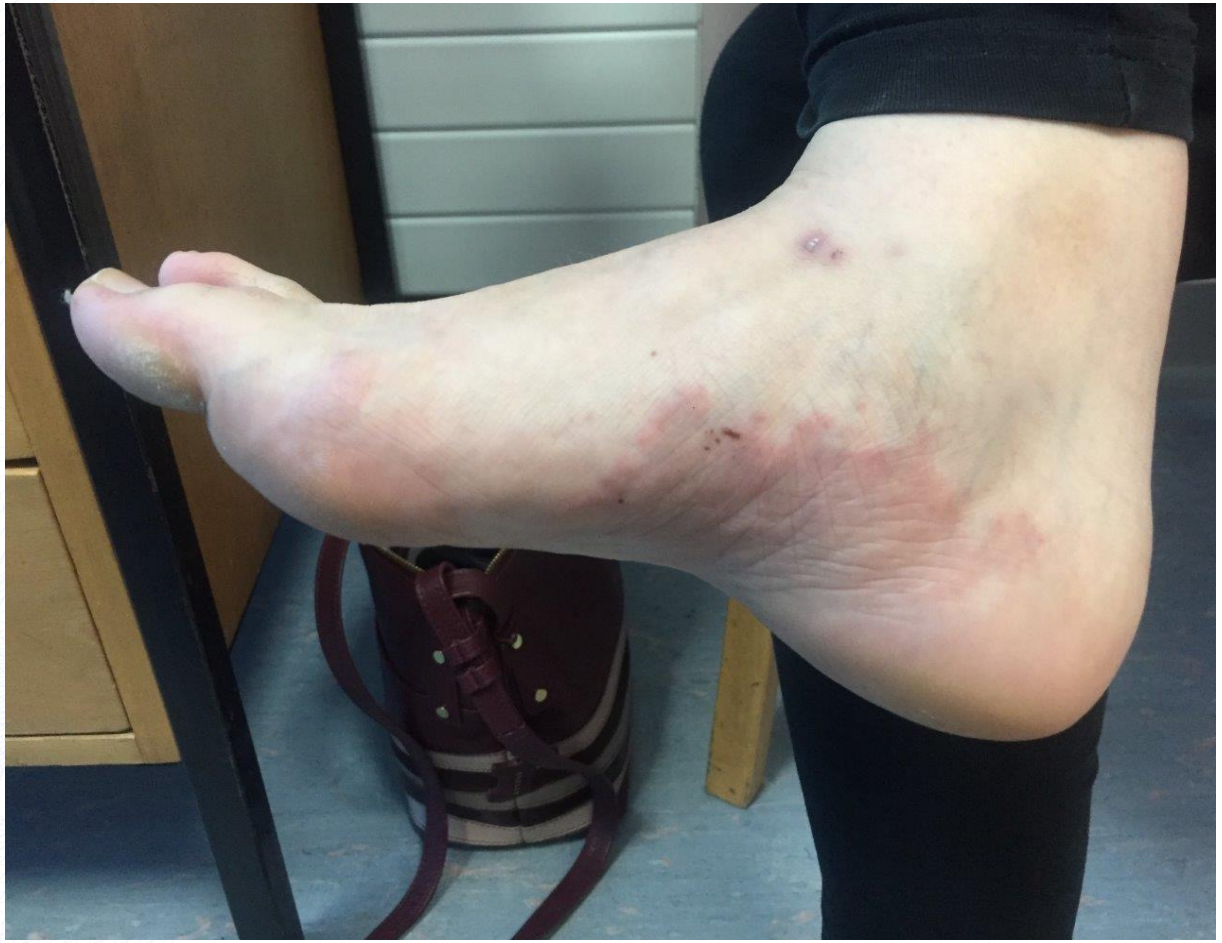
- Combination topical applications (potent steroids and anti fungals)
- Changes in epidermophyte species.



Case 4.

- 39 year old woman
- 22/40 gestation in 5th pregnancy
- 2 previous early miscarriages
- 2 live births (2 sons aged 6 and 8)
- Gestational diabetes mellitus
- Drugs - insulin & metformin
- Urticaria as teenager – worse in last pregnancy

Case 4.



- Urticarial rash inner thighs, lower abdomen & arms
- Annular lesions on feet
- Dermographism

Diagnosis:

? Urticaria ? Granuloma Annulare

? PG

- Rx Dermovate ointment to feet
- Loratadine 10mg daily

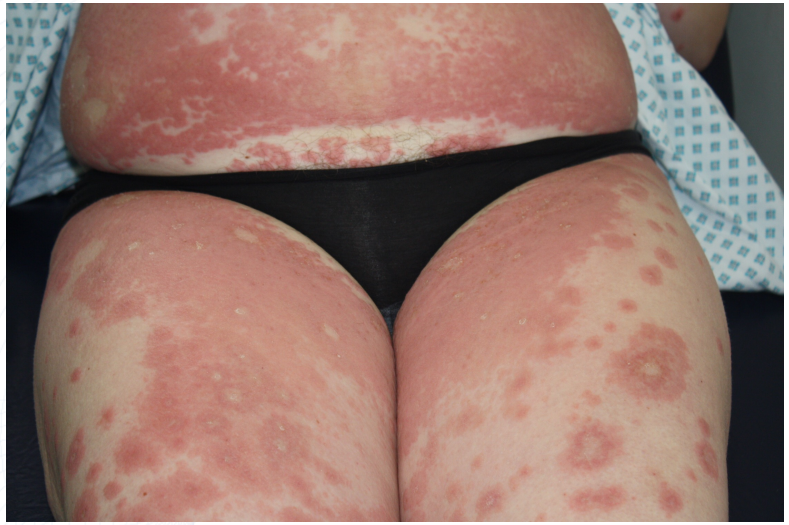
Case 4.

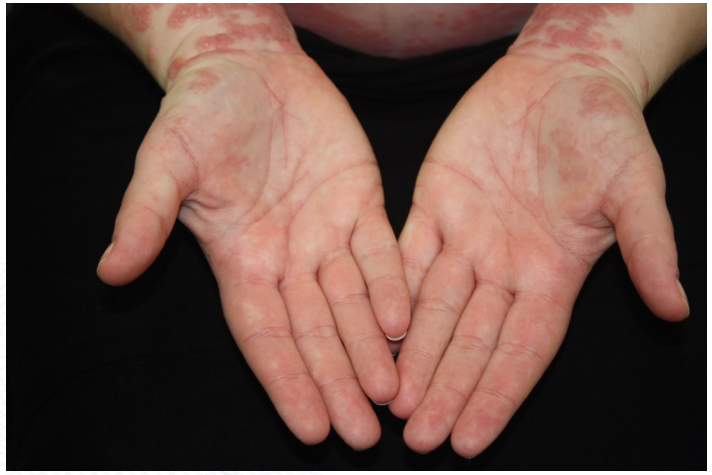
- Skin Biopsy – discussed with patient
- Agreed not necessary as rash was mild
- Improved with treatment prescribed
- Discussed oral corticosteroids (patient not keen)

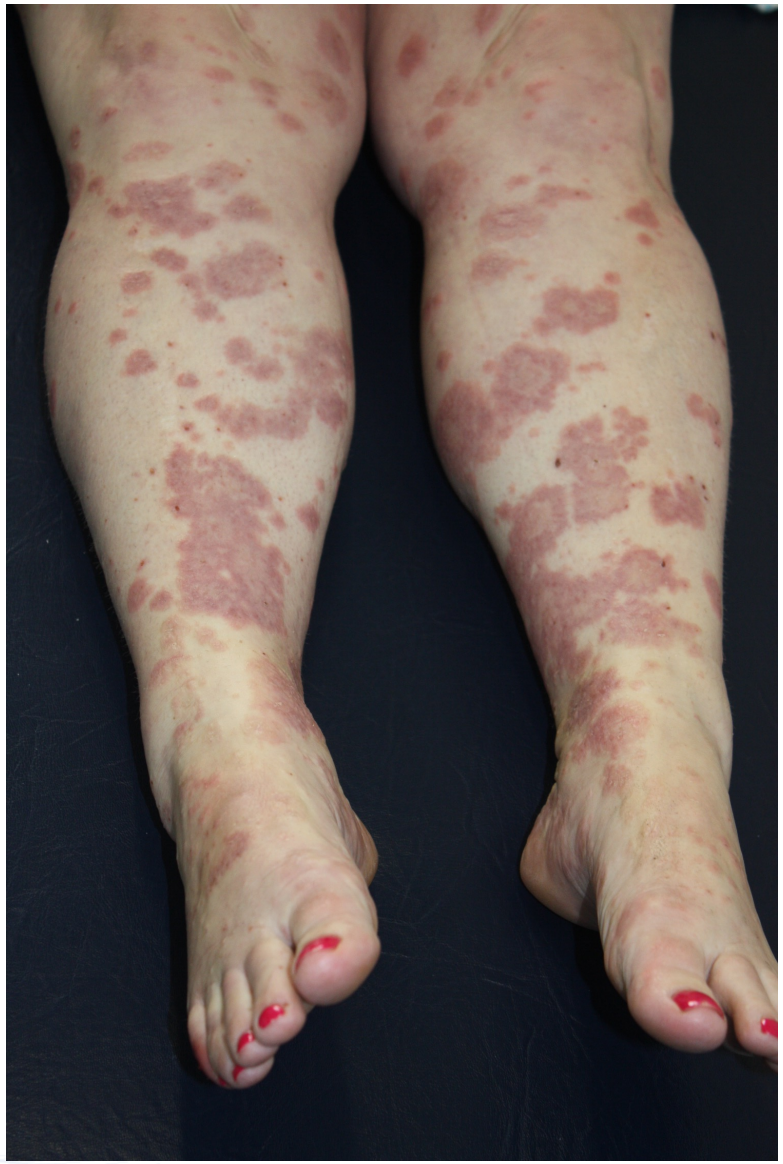
Clinical Review:

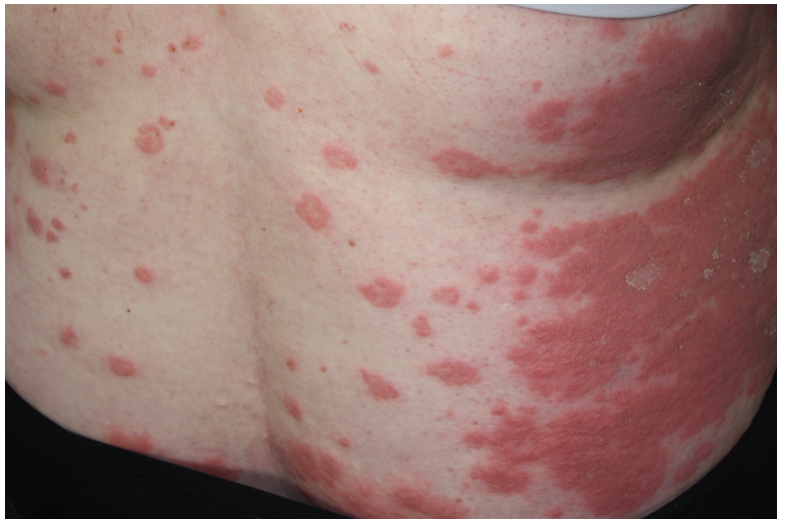
- Patient delivered (SVD) at 37/40
- Baby girl 2.14kg (small for dates)
- Rash recurred day after delivery – worse

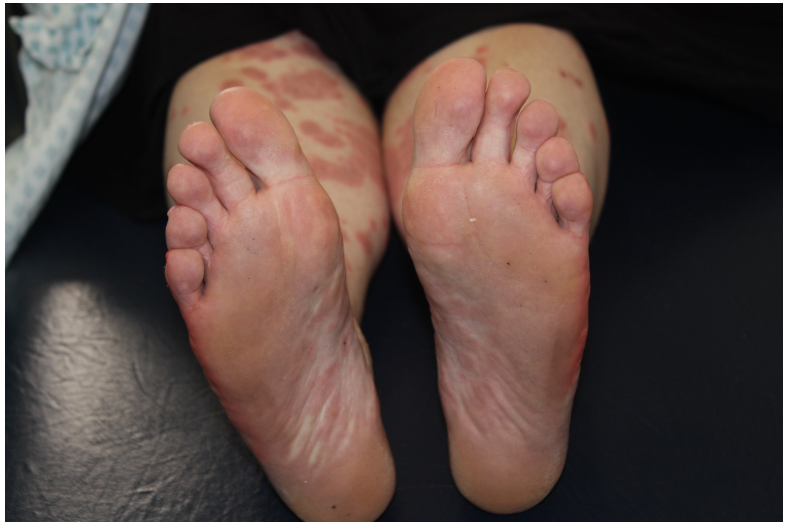
Case 4.











Case 4. Diagnosis

Pemphigoid gestationis

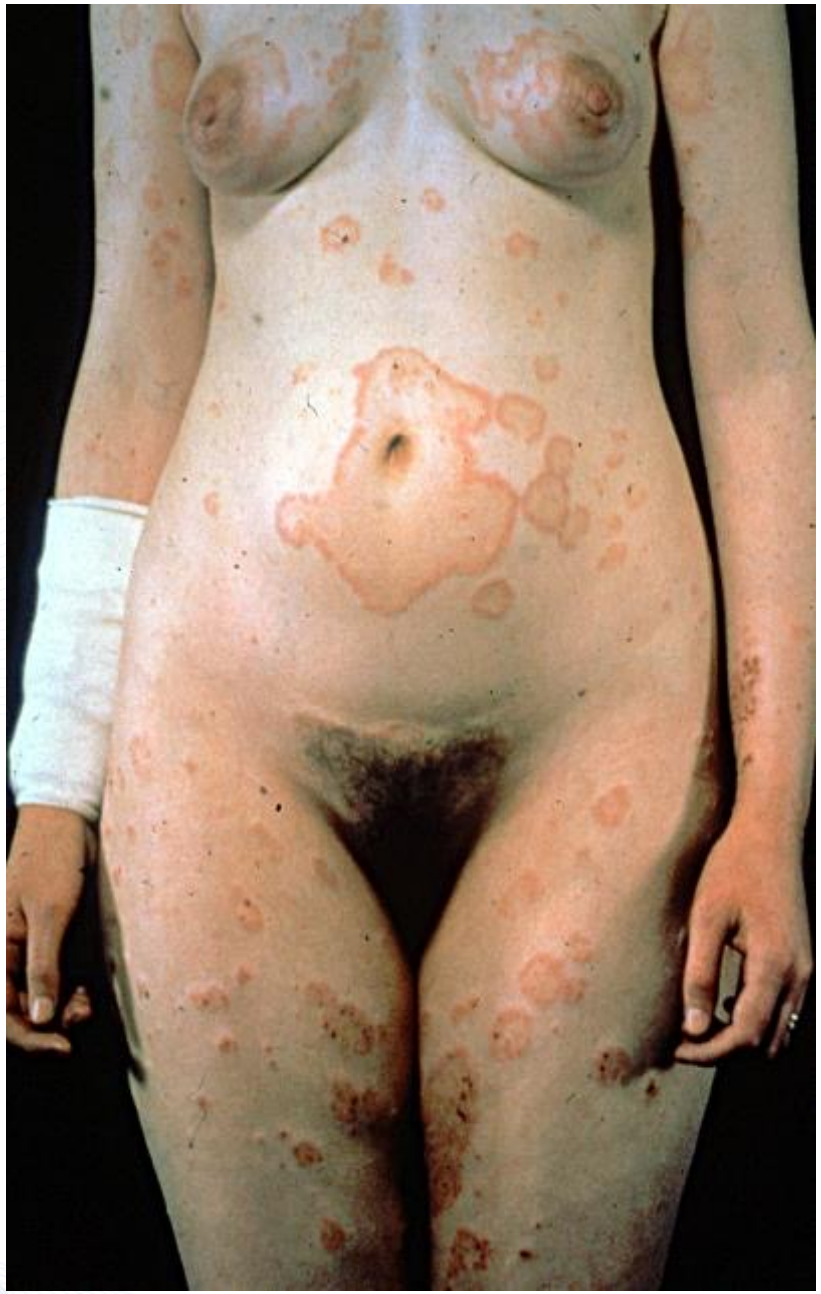
Risk factors:

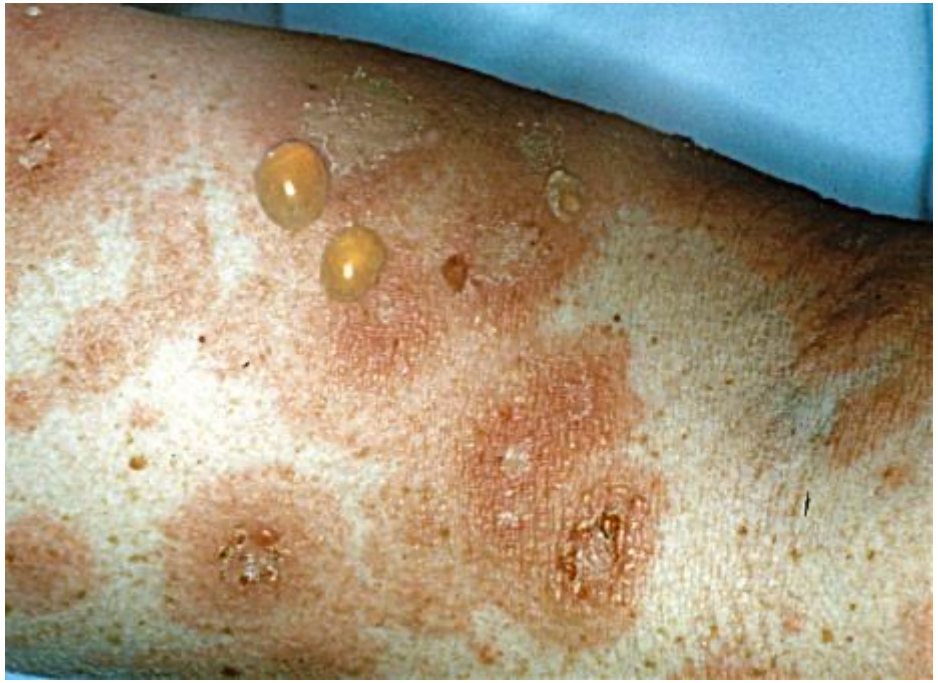
- 2 previous miscarriages
- Premature delivery – 37/40
- Small baby 2.14kg
- Postpartum flare
- Urticarial pre-bullous lesions on soles of feet
- **Management** - Discussed blood test (indirect IMF)
- patient not keen as for academic interest only

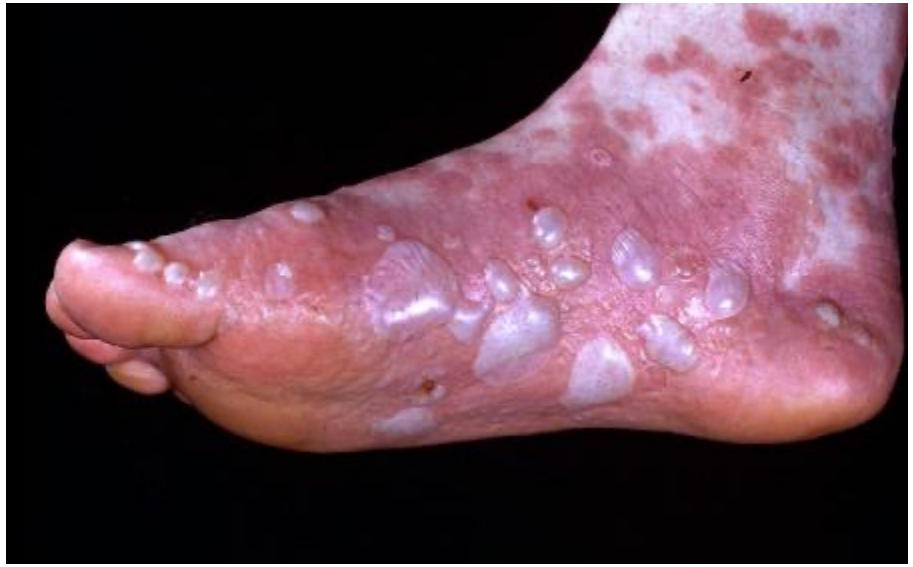
PEMPHIGOID GESTATIONIS

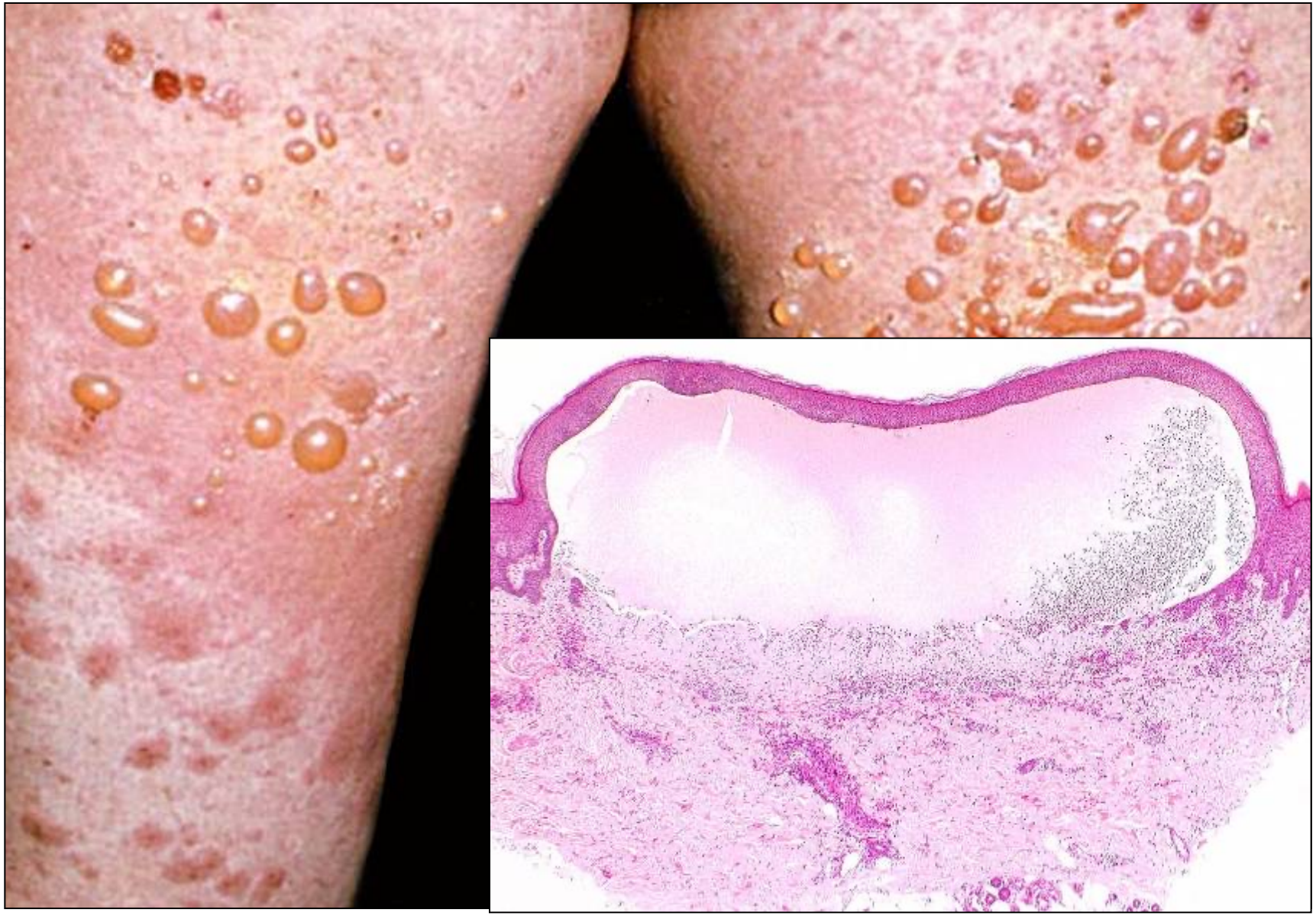
Syn: Herpes gestationis

- Hormonally triggered, bullous autoimmune disease
- Incidence: 1:2,000-1:50,000;
- Associated with HLA DR3 & DR4 subtype
- Onset in 2nd and 3rd Trimesters
- Also seen with trophoblastic tumours & hydatidiform mole
- Autoantibodies are directed against placental matrix antigens, corresponding to the 180 kDa BP-AG2 (type XVII collagen) in skin





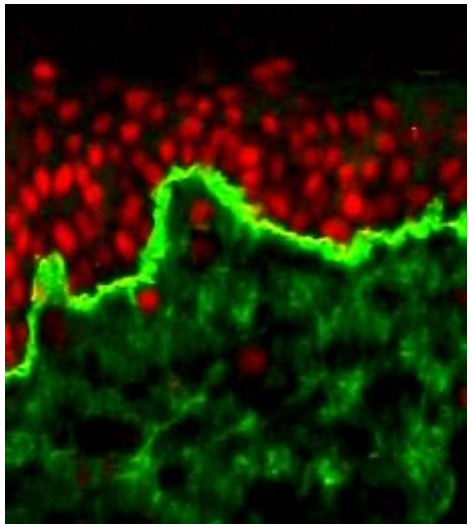




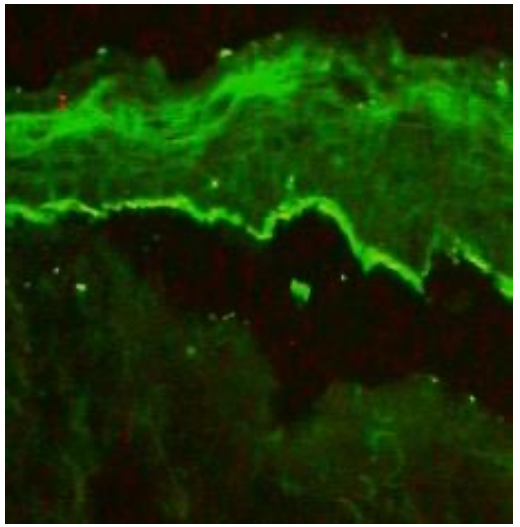
PEMPHIGOID GESTATIONIS

DIRECT IMF:

- **Linear C3 BMZ deposition (100%)**
- **20-25% weaker IgG deposition**



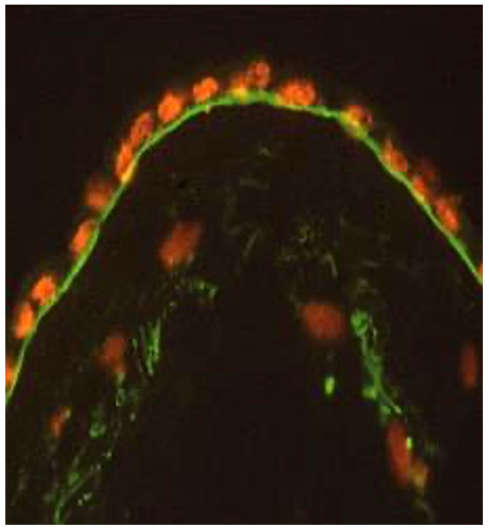
Direct IMF



Indirect IMF

INDIRECT IMF:

- **Circulating complement fixing antibodies (HG factor) in most active cases IgG1 subclass**



Amnion

PEMPHIGOID GESTATIONIS

- Risk for 'small-for-date babies‘ and prematurity
  - No association with corticosteroid treatment but with disease severity
  - Early start and blister formation
- Neonatal PG seen in 10% cases (passive transfer Ab’s)
- Pre-partum: improvement
- Post-partum: flare in 75%
- Self-limited; recurrence with menstruation, hormonal contraception & subsequent pregnancies
- Flares in subsequent pregnancies – more severe, earlier gestation

DERMATOLOGY TREATMENT IN PREGNANCY

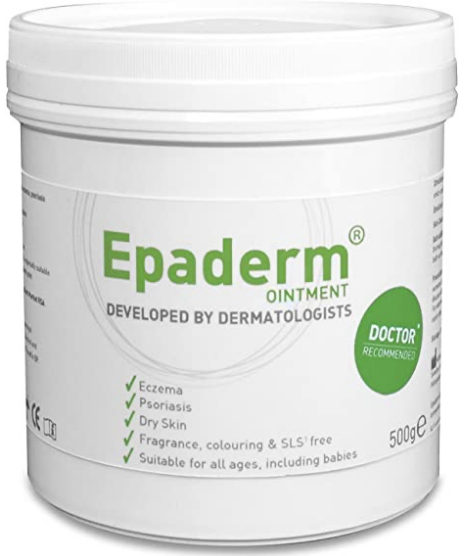
Useful Treatments
Emollients (+menthol 1-2%)
Topical corticosteroids (TCS)
Topical calcineurin inhibitors (TCI)
Phototherapy – narrowband UVB
Systemic antihistamines
Systemic corticosteroids
Other Systemic drugs

EMOLLIENTS

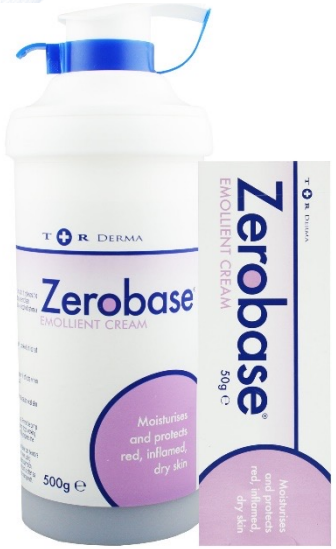

Dermacool
PLUS
20%


DERMAL
Adex Gel
a highly moisturising and protective emollient with an ancillary anti-inflammatory medicinal substance for the treatment and routine management of dry and/or inflamed skin conditions such as mild to moderate atopic dermatitis, various forms of eczema, contact dermatitis and psoriasis.
Helps restore the normal skin barrier and reduce redness and inflammation.
500 g
100 g


EMULSIFYING OINTMENT BP
Skin moisturiser and soap substitute or bath additive
Emollient Moisturiser
FOR EXTERNAL USE ONLY


Epaderm
OINTMENT
DEVELOPED BY DERMATOLOGISTS
DOCTOR RECOMMENDED
Eczema
Psoriasis
Dry Skin
Fragrance, colouring & SLS free
Suitable for all ages, including babies
500g


Doublebase
Dry Skin
Doublebase
250g
Doublebase
DrySkin
EMOLLIENT
250g


TOR DERMA
Zerobase
EMOLLIENT CREAM
Zerobase
50g
Moisturises and protects red, inflamed, dry skin
500g


TOR DERMA
Zerodouble
GEL
Zerodouble
100g
A highly moisturising emollient gel for dry skin conditions
500g

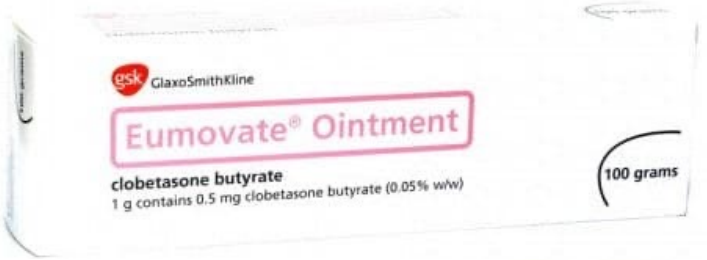

NEW LOOK
Aveeno
DAILY MOISTURISING
body lotion
Nourishes Normal to Dry Skin
Clinically proven to moisturise for 24 hours
Helps reinforce the skin's natural barrier
Suitable for sensitive skin
200ml


CeraVe
DEVELOPED WITH DERMATOLOGISTS
Moisturizing Cream
Moisturizes & helps restore the protective skin barrier
3 ESSENTIAL CERAMIDES
For Normal to Dry Skin


Cetraben
OINTMENT
For problematic dry, sensitive or eczema prone skin
120g

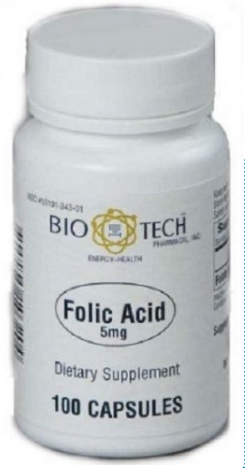
TOPICAL CORTICOSTEROIDS

- Population cohort study (Chi 2013) of 2658 pregnant women vs. 7246 controls
- Significant association between foetal growth restriction and maternal exposure to potent or very potent topical corticosteroids
- Increased risk of low birthweight when amount > 300g
- **Advice – * restrict use of potent/ultra-potent topical steroids to <300g**
- **Caution on inner thighs, breasts, abdomen (↑ risk striae)**
- Recommend Mometasone furoate (Elocon) or
- Clobetasone butyrate (Eumovate) – less risk skin atrophy



Systematic review of the safety of topical corticosteroids in pregnancy.
Chi C C, Wang S-H, Kirtschig G et al. JAAD 2010; 62: 694-705
Evidence-based (S3) guideline on topical corticosteroids in pregnancy.
Chi C C, Kirtschig G, Aberer W et a. BJD 2011; 165: 943-952

PHOTOTHERAPY



- Narrowband UVB safest form of 2nd line therapy in pregnancy
- PUVA mutagenic and should be avoided
- Important to consider photo-degradation of Folic acid
- NB-UVB studies in pregnancy - reduction of folate levels from baseline
- Advise Folic acid supplements 5mg daily in women receiving NB-UVB

Shaheen MA, Abdel Fattah NS, El-Borhamy MI. Analysis of Serum Folate Levels after Narrowband UVB. Egyptian Dermatology Online Journal 2006, 2 (1): 15.

Rose RF, Batchelor RJ, Turner D, Goulden V. Narrowband ultraviolet B phototherapy does not influence serum and red cell folate levels in patients with psoriasis. JAAD 2009; 61(2): 259-62.

ORAL ANTIHISTAMINES

- Sedating 1st generation: Chlorpheniramine, diphenhydramine
- Non-sedating 2nd generation:
- **1st choice: Loratadine**
- 2nd choice: Cetirizine
- Also safe to continue while breastfeeding
- No increased risk for teratogenicity or malformations
- Advise Caution in last 4 weeks of pregnancy
  - uterine contractions
  - withdrawal symptoms
  - retrolental fibroplasia in premature infants

Schaefer et al. Drugs in pregnancy & lactation, 8th Ed, Elsevier 2012
Murase JE, JAAD 2014

SYSTEMIC CORTICOSTEROIDS

- Oral Prednisolone EC systemic corticosteroid of choice
- Largely inactivated in the placenta (10:1)
- Non-halogenated (unlike Betamethasone/Dexamethasone)
- **1st trimester:** ?possible risk for cleft lip/palate (animal studies only)
- Recommended dose 0.5mg/kg – for 3-4 weeks (tapering dose)
- If longer consider alternative 2nd line agent (Ciclosporin)
- **2nd-3rd trimester**: Long term Rx- growth restriction & adrenal insufficiency
- Increased risk of maternal gestational diabetes and hypertension
- Omeprazole and Calcium/Vitamin D can be given safely to reduce side effects

Chi C et al JID 2011; Cochrane Database Syst Review 2009:CD007346
Schaefer et al. Drugs during pregnancy and lactation, 8th ed, Elsevier, 2012

EADV PREGNANCY TASK FORCE

Skin Diseases in Pregnancy - leaflets

EADV Task Force 2009

EUROPEAN ACADEMY OF DERMATOLOGY & VENEREOLOGY

ABOUT EADV | EVENTS | SCIENTIFIC | MEMBERSHIP | EDUCATION | JOURNALS | FUNDING | PATIENT CORNER | MyEADV

The European Academy of Dermatology and Venereology (EADV) produces patient information leaflets on a variety of skin conditions. These leaflets are created by EADV Task Forces, which are groups of expert dermatologists and healthcare professionals who specialize in specific skin conditions.

The EADV patient leaflets aim to provide accurate and reliable information to patients and their families about various skin conditions, their causes, symptoms, and available treatments. They also provide practical advice on how to manage these conditions, such as tips on how to care for the skin and how to avoid triggers that may worsen the condition.

The leaflets cover a wide range of skin conditions, including acne, eczema, psoriasis, rosacea, skin cancer, and many others.

The EADV patient leaflets are a valuable resource for patients and healthcare professionals alike, providing reliable and up-to-date information on a range of skin conditions. They can help patients better understand their condition and how to manage it, and can also assist healthcare professionals in providing effective patient care and support.

Please note that some patient leaflets are in the process of being updated. New versions will be available soon.

EADV PREGNANCY TASK FORCE

Skin Diseases in Pregnancy - leaflets

SKIN DISEASES IN PREGNANCY

- NEW Acne in pregnancy
- NEW Atopic eruption in Pregnancy (AEP) - *NEW*
- NEW Common skin changes during pregnancy
- NEW Genital Condylomata in Pregnancy
- NEW Genital Herpes
- NEW Intrahepatic Cholestasis of Pregnancy (ICP)
- Lupus Erithematosus
- NEW Moles and malignant melanoma
- Mollusca Contagiosa
- Pemphigoid Gestationis (PG)
- NEW Polymorphic eruption of pregnancy (PEP)
- NEW Psoriasis in pregnancy and during breastfeeding
- Pytiriasis Rosea
- NEW Rosacea in pregnancy
- NEW Scabies in pregnancy
- NEW Use of biologics during pre-conception, pregnancy & breastfeeding
- NEW Use of steroid creams in pregnancy
- Vulvo-vaginal candidiasis (Thrush)

EUROPEAN ACADEMY OF DERMATOLOGY & VENEREOLOGY

Information Leaflet for Patients

Rosacea in Pregnancy

QUESTIONS?