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PREVENTION OF ALLERGIC SKIN DISEASES, THEIR ACHIEVEMENT DURING AND DURING PREGNANCY

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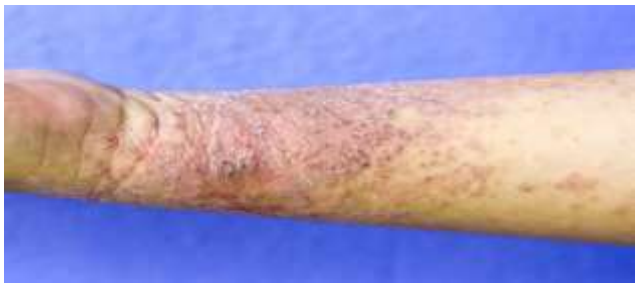
ABSTRACT:

This article discusses the cause, development and exacerbation of dermatitis associated with a cause such as pregnancy, as well as maintenance therapy, treatment methods and possibilities for their elimination.

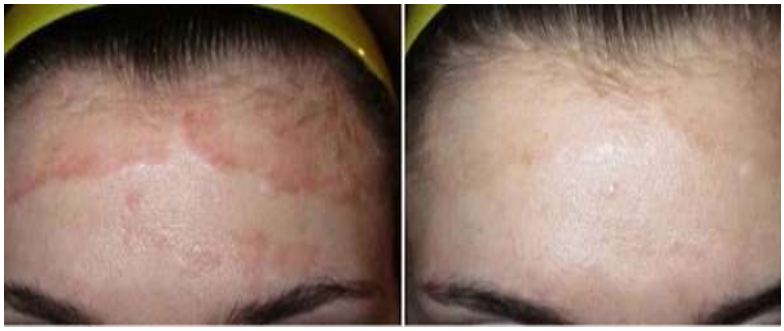
INTRODUCTION. The three main categories of pregnancy-related skin conditions are: 1. Benign skin diseases resulting from normal hormonal changes. 2. Pre-existing skin diseases that change during pregnancy. 3. dermatoses specific to pregnancy. Benign skin changes. Skin conditions caused by normal hormonal changes during pregnancy including stretch marks of pregnancy and hyperpigmentation. Striaegravidarum. Striae of pregnancy (stretch marks) occur in 90% of pregnant women. Striae appear as pink-purple atrophic lines or stripes on the abdomen, buttocks, chest, thighs or arms. Often found in women with larger children and higher body mass index. The cause of striae is multifactorial: physical factors and hormonal factors. To prevent stretch marks, numerous creams, emollients and oils are used (for example, vitamin E cream, cocoa butter, Aloe vera lotion, olive oil). but, these methods may not be effective. However, two topical treatments may help prevent stretch marks. One contains centellaasiatica extract, as well as hydrolysates of alpha-tocopherol and collagen-elastin. Another preparation contains tocopherol, an essential fatty acid, panthenol, hyaluronic acid, elastin or menthol. However, none of these products are widely available, and the safety of using centellaasiatica during pregnancy and the components responsible for their effectiveness are unclear. Further research is needed

before these treatments are used, and commonly used creams and emollients may be recommended for widespread use. Most stretch marks fade to pale or flesh-colored lines and improve after childbirth, although they usually do not disappear completely. Treatment is not specific and there is limited evidence base. Postpartum treatment includes topical tretinoin (Retin-A) or oral tretinoin.

HYPERPIGMENTATION Almost all women experience some degree of hyperpigmentation during pregnancy. These changes are usually more pronounced in women with darker complexions. The areolas, armpits and genitals are most often affected. Scars and nevi may also darken. The lineanigra is a line that often forms when the lineaalba darkens during pregnancy. Melasma (chloasma or mask of pregnancy) may be the most cosmetically problematic skin condition associated with pregnancy. This disease occurs in 70% of pregnant women and can also occur in women taking oral contraceptives. Exposure to sunlight and other ultraviolet radiation worsens melasma; Therefore, using highly effective broad-spectrum sunscreens and avoiding overexposure to sunlight can prevent the development or worsening of melasma. Although no specific treatment is indicated during pregnancy, doctors can reassure patients that melasma in most cases goes away after childbirth. However, it may not go away completely and may recur with subsequent pregnancies or with the use of oral contraceptives. Severe postpartum epidermal melasmais usually treated with a combination of topical tretinoin, hydroquinone (Eldoquin Forte), and corticosteroids.



Pre-existing skin conditions (eg, atopic dermatitis, psoriasis, candida and other fungal infections, skin tumors including molluscum fibrosis gravidarum and malignant melanoma) may change during pregnancy. Atopic dermatitis and psoriasis can get worse or better during pregnancy. Atopic changes may be associated with pruritus during pregnancy and usually worsen but may improve during pregnancy. Psoriasis is more likely to get better than worse. Fungal infections usually require a longer course of treatment during pregnancy. Soft tissue fibroids (skin tags) can occur on the face, neck, upper chest, and under the breasts during late pregnancy. These fibroids usually disappear after childbirth. Impetigo herpetiformis, a form of pustular psoriasis, is a rare skin disease that appears in the second half of pregnancy. Systemic signs and symptoms of impetigo include: nausea, vomiting, diarrhea, fever, chills and lymphadenopathy. There is usually no itching. Complications may occur (eg secondary infection, septicemia, hyperparathyroidism)



Treatment of impetigo herpetiformis includes systemic corticosteroids and antibiotics to treat secondary infected lesions. Prednisolone may be required at a dose of 15 to 30 mg or up to 50-60 mg per day, followed by a slow dose reduction. The disease usually resolves after delivery, although it may recur during subsequent pregnancies. Pemphigoid gravidarum is a rare skin lesion consisting of itchy papules, vesicles and bullae that occurs during pregnancy or the postpartum period. Diagnosis is made clinically or by biopsy. Treatment with local or systemic corticosteroids. Pemphigoid occurs in 1/2000–50,000 pregnancies; the disease manifests itself during the 2nd or 3rd trimester, but can also appear in the 1st trimester or immediately after childbirth. Pemphigoid typically recurs in subsequent pregnancies and occurs in approximately 25% of women taking oral contraceptives. Exacerbations often develop 24-48 hours after birth and are possible during subsequent periods or ovulation The rash is accompanied by severe itching. They appear first around the navel and then spread throughout the body. Dermatitis in pregnant women, as a rule,
includes: adherence to a hypoallergenic diet, drinking fluids
1 liter of clean water +1 liter in the form of other liquids per day. In case of exacerbation, take sorbents such as Filtrum or Enterosgel paste.

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