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Skin Health Q&A

Cheryl Penna

QUESTION: Please could you recommend a treatment approach for Melasma (patient using Mirena).

There is very little research on levonorgestrel (progestin) but this article has shown an improvement when used in women who were switched from the OCP to progestin. Remember that progestin is not natural progesterone and therefor may vary in reaction from women to women.

https://www.medicaljournals.se/acta/content_files/files/pdf/95/5/4315.pdf

There is a genetic component to Melasma, as well as a range of triggers that can cause the onset of this skin pigmentation. These include hormonal changes such as pregnancy and menopause, as well as side effects from oestrogen-based medications such as OCP. Underlying issues can include thyroid and autoimmune disorders, chronic stress & illness. All these need to be investigated as part of your treatment protocol as well as addressing gut health and immune related issues. Nutritional support would be based on the client's requirements, but vitamin D3 & B12 deficiency has been clinically reviewed as a contributing factor. This article gives a great summary of the condition and current treatments. As was mentioned in the seminar presentation, topical agents such as Azelaic acid and tyrosinase inhibitors can be used effectively.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5574745/pdf/13555_2017_Article_194.pdf

I would suggest supporting the skin's barrier to improve cellular defence and reduce inflammation and oxidative stress. Sun avoidance is advised, not only on face but hands and chest as reaction to pigmentation is stimulated on all skin exposure. It is essential to use a sun block on all exposed skin parts, every day. Topical skin therapy could include a range of products that help reduce pigmentation. These products contain tyrosinase inhibitors that block tyrosinase production and melanin synthesis in the skin. I would also recommend avoiding skincare products that contain fragrances and essentials oils, as these can increase inflammatory reactions in the skin. For those who do not have access to medical based skincare range, I would suggest that you work with a qualified skin therapist who can tackle the topical application whilst you address the underlying health issues for the client.

QUESTION: How do you manage your treatment plans with skin conditions, so you don't have major breakouts?

Before commencing any skincare treatment, you need to assess the client's diet for food related intolerances. I often start them on an anti-inflammatory eating program. We know there is a very strong connection between the gut and skin, so starting here will help minimise skin reactions along the way. It is necessary to assess their digestive function form beginning to the end.

A comprehensive stool assessment can help identify issues with bile acids and fat malabsorption that is essentials for digestive function as well as assimilation of food into nutrients and waste. Depending on the Functional Stool test that you use, you should be able to check for fungal and yeast overgrowth that may be a factor impacting their skin health. It is essential that they are moving their bowels every day; poor elimination of waste will impact skin health as it is an organ of elimination. Once you have addressed digestive blockage as well as lymphatic congestion and elimination you should have less skin break outs once you begin your treatment.

QUESTION: Dyshidrotic Eczema: what to use topically when skin barriers is compromised/stinging with creams?

Dyshidrotic eczema is associated with a condition of excess sweating that causes watery filled, itchy blisters that arise on the hands, sides fingers and soles of feet. Common triggers have been linked to fungal infection, seasonal allergies, and compromised immunity. Metal allergies such as nickel, have been shown to be a trigger.

Firstly, you need to check what products they are using. Ingredients such as essential oils, fragrances, chemical preservatives, and long-term use of cortisone creams will irritate and damage the skin's barrier. Whilst it is important to keep the area moist, creams containing water will aggravate a compromised skin whose barrier is damaged, causing the stinging sensation. A water free cream or lotion would be my recommendation to help decrease transdermal water loss and aid barrier repair.

When it comes to the skin, I only work with the dermaviduals skincare range that follows these principles. The base range of dermal moisturisers are water free and contain a high amount of phosphatidylcholine that is found naturally in cell membrane structures. Ingredients that are often considered for skin irritations such as eczema would include lipid soluble serums such as Evening Primrose oil, Linseed oil, Boswellia, Echinacea and D-panthenol. Urea is also an ingredient to look out for that may help reduce inflammation and itching in skins that tend to be prone to barrier disorders and dryness.

QUESTION: Just wondering on advice for chronic pruritis ani? Has undergone food sensitivity testing and OATs test.

Chronic pruritis ani can be caused by a combination of issues that include food allergies, especially histamine, chronic dermatosis, autoimmune conditions, and systemic illness. With the OATs test I would focus on assessing the mould and yeast markers as well as gut bacterial section of the report.

This paper gives a detailed overview of the condition and related causes that I suggest reviewing. There has been some research that found a topical application of cream containing capsaicin 0.006% had good results in reducing substance P in nerve cell ending and reducing the itch response. I have found that removing histamine foods, gluten and dairy as a trial provides good results in many of my clients, but the cause needs to be investigated as outlined in this paper.

https://www.racgp.org.au/download/documents/AFP/2010/June/201006maclean.pdf

Hayley Fogarty

QUESTION: What would you recommend for folliculitis?

Folliculitis is swelling or inflammation of the hair follicle. There are a few different types of folliculitis. Is it fungal folliculitis which usually presents as itchy bumps around the hairline and forehead or on the chest or back?

Or is it bacterial folliculitis which present as pus filled pimples caused by the bacteria - staphylococcus aureus.

I see amazing results with folliculitis using Lotion P and plutioderm plus in the Dermaviduals skincare range. They contain ingredients such as urea (helps reduce the itch), salicylic acid and antimicrobial herbs alongside barrier repairing ingredients to support overall skin health and balance the pH of the skin which should be 5.5!

QUESTION: What are your thoughts on using natural topical products for acne vs chemical products?

I think understanding the terminology first is important. A chemical ingredient doesn't mean it's unfavourable for the skin! Zinc is a chemical for example and has numerous benefits for the skin. I say pure vs toxic.

I recommend using ingredients that are bioavailable for the skin cells to utilise. Does the skin cell recognise that particular ingredient in the skincare and can it use it to help improve skin cell health. If the skin cell doesn't recognise an ingredient (something toxic) then it'll either shut off to that ingredient or it will penetrate through the cell membrane where it'll have to be detoxified much like how our liver detoxifies toxins but the skin is a lot less efficient.

Geraldine Georgiou

QUESTION: Great presentation - why was metformin used in these cases?

Metformin was mentioned as this is a medication to helps with insulin sensitivity. Metformin is derived from the herb galega officinalis and has been used for metabolic disease for many years. Metformin, a biguanide hypoglycemic drug, and has been show to improve insulin sensitivity, decreases insulin levels, help correct ovarian and functional adrenal hyperandrogenism in PCOS, and also leads to clinical improvement of acne. Combining metformin with lifestyle changes, low GI, balanced lean protein and good fats can lead and exercise can help improve insulin resistance dramatically and overall help with management of acne, psoriasis, eczema and HS.

QUESTION: Omega-3 Index blood test, would you use this?

An omega 3 index blood test could be very helpful in identifying levels of omega 3 fats (EPA/DHA) in the blood. I have not utilised this in my practice as generally most of patients do not consume adequate amounts in their diet and if they are showing inflammatory conditions and poor oral intake of these from a diet history I will still ask the patient to increase omega 3 fats in their diet.

QUESTION: Why do dermatologists recommend roaccutane, antibiotics and benzyl peroxide to their patients with major acne ? They are very toxic to the body and will cause a further imbalance in the body.

Dermatologists do recommend roaccutane, antibiotics and benzyl peroxide to their patients with major acne as they traditionally take the scientific medical approach first especially if the patient is at risk of scarring etc. Often this can help accelerate improvement of skin sooner and help the patient experience an improved quality of life sooner than later. Also many patients have infectious acne and often only visit the doctor when they have a severe case.

I agree these treatments can be harsh but I also believe dermatologists and ourselves as health practitioners need to take a multidisciplinary approach and work together for both short term and long term positive health outcomes in acne and other skin health conditions.

QUESTION: What is your advice for urticaria patients other than gluten?

Urticaria is characterised by angioedema and/or wheals. Chronic urticaria (CU) is a common disabling disorder that affects 15%–25% of the population over their lifetime. It has an average duration of 3–5 years in adults, but always lasts more than six weeks.

Physical urticaria can be triggered by food additives / food chemicals and account for 20% and nearly 5% of such patients, respectively, with the remaining diagnosed as having chronic idiopathic urticaria (CIU). The aetiopathogenesis of CU can associated with autoimmune mechanisms. In fact, similar to CD, CU has been shown to have a genetic link with the human leukocyte antigen HLA-DQ8.

Emotional stress and systemic diseases can also trigger CU. Chronic infections such as hepatitis B and C, sinus infections and even Helicobacter pylori. Around 35 to 40 per cent of cases of CU are due to

an autoimmune response, releasing histamines and pro inflammatory molecules responsible for the itching.

What can we do:

- Consider elimination diet of salicylates, glutamate, amines and sulphites
- Try low chemical diet
- Consider Gut microbiome – GI testing
- Rule out coeliac disease/NCGS
- Consider comorbidities such as Helicobacterial pylori of Gut parasites.