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skin

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July 2019

Rosacea

Conference
Report
Melbourne

Renal Pruritus

Nursing Profile

Paediatric Gastroenterology
Clinical Nurse Specialist



GLOSSARY

Dermatological Terms and Conditions

future
events



PAGE

6



WHAT'S YOUR POINT OF VIEW

Rating My Hospital Experience

7



PROFESSIONAL DEVELOPMENT

Renal Pruritus

10



NURSING PROFILE

Clinical Nurse Specialist
Paediatric Gastroenterology

13



PROFESSIONAL DEVELOPMENT

Rosacea

19



ERICA'S STORY

Rosacea

20



INTERNATIONAL CONFERENCE REPORT

Australian Dermatology Nurses' Association

9



GLOSSARY

12



FUTURE EVENTS

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#:RA: Rheumatoid Arthritis. AS: Ankylosing Spondylitis. PsA: Psoriatic Arthritis. CD: Crohn's Disease. pCD: Paediatric CD. UC: Ulcerative Colitis. JIA: Polyarticular Juvenile Idiopathic Arthritis. Ps: Psoriasis. pPs: Paediatric Psoriasis. Nr-axSpA: Non-radiographic Axial Spondyloarthritis. HS: Hidradenitis Suppurativa. Uv: Uveitis.

PHARMAC Pharmaceutical Schedule: HUMIRA is fully subsidised under Special Authority for the treatment of patients with rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, ulcerative colitis, severe chronic plaque psoriasis and juvenile idiopathic arthritis. Refer to Pharmaceutical Schedule for full Criteria. HUMIRA is not funded for ulcerative colitis, non-radiographic axial spondyloarthritis, enthesitis-related arthritis, uveitis and hidradenitis suppurativa

Please review full Data Sheet before prescribing. Full Data Sheet is available on request from AbbVie Limited by calling 0800 900 030, or on the Medsafe website. www.medsafe.govt.nz/profs/Datasheet/h/humirainjpeninj.pdf. Humira is a Prescription Medicine containing adalimumab 10 mg/0.2 mL, 20 mg/0.4 mL or 40 mg/0.8 mL for injection. **INDICATIONS:** **Rheumatoid Arthritis (RA):** Reducing signs & symptoms, and inhibiting the progression of structural damage, in adults with moderate to severely active RA; including patients with recently diagnosed moderate to severely active disease who have not received methotrexate. Humira can be used alone or in combination with methotrexate. **Polyarticular Juvenile Idiopathic Arthritis (pJIA):** in combination with methotrexate is indicated for reducing the signs and symptoms of moderately to severely active pJIA in patients aged 2 years of age and older. Humira can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. **Enthesitis-Related Arthritis (ERA):** Treatment of ERA in patients, 6 years of age and older, with an inadequate response, or intolerance to, conventional therapy. **Psoriatic Arthritis (PsA):** Treatment of signs and symptoms, and inhibiting the progression of structural damage, of moderate to severely active PsA in adult patients with inadequate response to DMARDs. **Ankylosing Spondylitis (AS):** Reducing signs and symptoms in patients with active AS. **Non-radiographic Axial Spondyloarthritis (nr-axial SpA):** Treatment of adults with severe axial spondyloarthritis without radiographic evidence of AS but with objective signs of inflammation by elevated CRP and/or MRI, who have had an inadequate response to, or are intolerant to NSAIDs. **Crohn's Disease (CD) in Adults and Children (≥6 years):** Treatment of moderate to severe CD, to reduce the signs and symptoms of the disease and to induce and maintain clinical remission in patients with; inadequate response to conventional therapies or, who have lost response to, or are intolerant to, infliximab. **Ulcerative Colitis (UC):** Treatment of moderately to severely active UC in adult patients with intolerance, medical contraindication, or inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA). **Psoriasis in Adults and Children (≥4 years):** Treatment of moderate to severe chronic plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy. Humira Version 35 Date of Preparation: May 2018, based on Data Sheet last updated 26 April 2018 2 of 3 **Treatment of severe chronic plaque psoriasis in children and adolescent patients from 4 years of age, with an inadequate response to, or are inappropriate candidates for, topical therapy and phototherapy.** **Hidradenitis Suppurativa (HS) in Adults and Adolescents (≥12 years):** Treatment of active moderate to severe HS (acne inversa) in patients with an inadequate response to conventional systemic HS therapy. **Uveitis:** Treatment of non-infectious intermediate, posterior and pan-uveitis in adult patients with inadequate response to corticosteroids, those in need of corticosteroid-sparing, or in whom corticosteroid treatment is inappropriate. **Paediatric Uveitis (≥2 years):** Treatment of paediatric chronic non-infectious anterior uveitis, in patients with inadequate response, or intolerance to conventional therapy, or in whom conventional therapy is inappropriate. **CONTRAINDICATIONS:** Severe infections including sepsis, active tuberculosis, opportunistic infections; concurrent anakinra administration; moderate to severe heart failure (NYHA class III/IV); known hypersensitivity to HUMIRA or its excipients. **PRECAUTIONS:** Infections (bacterial, mycobacterial, invasive fungal e.g. histoplasmosis, viral or other opportunistic); hepatitis B, TB (reactivation, new onset or latent); demyelinating disorders* (central or peripheral; neurologic evaluation required prior to initiation and ongoing for patients with intermediate uveitis); haematologic events; live vaccines; immunosuppression; new or worsening CHF; renal, hepatic impairment; malignancy; hypersensitivity reactions; autoimmune processes (auto-antibodies, lupus-like syndrome); use in psoriasis with phototherapy; concurrent biologic DMARDs or other TNF antagonists; elderly; pregnancy, lactation, surgery. *Refer to Datasheet under Neurologic Events. **ADVERSE REACTIONS:** Respiratory tract infections, leukopaenia, anaemia, lipid increase, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash, musculoskeletal pain, injection site reaction are very commonly seen adverse events. Benign neoplasm and skin cancer including basal cell and squamous cell carcinoma were commonly reported. Fatal infections such as TB and invasive opportunistic infections have rarely been reported. For others, see full Data Sheet. **DOSAGE & ADMINISTRATION:** Humira doses are to be administered by subcutaneous injection. Refer to the Datasheet for full dosing instructions. **RA, PsA, AS and nr-axial SpA:** 40 mg fortnightly as a single dose. **pJIA & ERA:** Paediatric Patients (≥2 years for pJIA, ≥6 years for ERA) 10 kg to < 15 kg = 10 mg fortnightly; 15 kg to < 30 kg = 20 mg fortnightly; ≥ 30 kg 40 mg fortnightly. **CD and UC (Adults): Induction:** 160 mg (as four 40 mg injections on Day 0 or two 40 mg injections on Day 0 and two 40 mg injections on Day 1), then a second dose 80 mg (as two 40 mg injections) on Day 14, then Maintenance: 40 mg starting on Day 28 and continuing fortnightly. **pCD: Paediatric Patients ≥6 years:** < 40 kg – Induction: 80 mg (as two 40 mg injections) on Day 0, then a second dose 40 mg (as one 40 mg injection or two 20 mg injections) on Day 14, then Maintenance: 10 mg (moderate CD) or 20 mg (severe CD) starting on Day 28 and continuing fortnightly. ≥ 40 kg – Induction: 160 mg (as four 40 mg injections on Day 0 or two 40 mg injections on Day 0 and two 40 mg injections on Day 1), then a second dose 80 mg (as two 40 mg injections) on Day 14, then Maintenance: 20 mg (moderate CD) or 40 mg (severe CD) starting on Day 28 and continuing fortnightly. **Psoriasis & Uveitis (Adults):** Initial dose of 80 mg, followed by 40 mg fortnightly, starting one week after the initial dose. **Paediatric Plaque Psoriasis (≥4 years):** Induction: Doses to be given weekly for the first two doses, then Maintenance: continuing fortnightly. Dose based on body weight: < 30 kg = 20 mg; ≥ 30 kg = 40 mg. **HS (Adults):** Induction: 160 mg (as four 40 mg injections in one day or two 40 mg injections per day for two consecutive days) on Day 1, followed by 80 mg (as two 40 mg injections in one day) on Day 15, then Maintenance: 40 mg starting on Day 29 and continuing weekly. **HS (Adolescents ≥12 years, weighing ≥ 30 kg):** Induction: 80 mg (two 40 mg injections) at Week 0, then Maintenance: 40 mg fortnightly, starting at Week 1.

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Editorial

Read this poem by Rob Wright who expresses so very eloquently how **Remarkable** our skin really is.

Review the interesting professional development topics such as renal pruritus and rosacea along with Eric's story of living with rosacea. Other features include profiling a paediatric gastroenterology clinical nurse specialist and an international conference report.

Regroup in Wellington for the 14th NZDNS National Conference at the Museum of New Zealand, Te Papa. We look forward to seeing you there.



Tracy Fenton



Ann Giles

My Skin

My skin renews itself. Old layers slough
Away in showers, soap and steam. My face
Remains the same face, nonetheless — enough
Alike at least for me to see the place
Where it was cut when I was ten. It's strange
How chains of cells remember what they are;
How all the molecules are so arranged
That they emerge unblemished or as scars.
What is this memory? Where is it stored?
There's some Platonic template of my skin,
A mask that I'm condemned to wear. If bored
At looking at the features I live in,
I know that time will pull them to the bone
In small degrees, like lichens rimed on stone.

by Rob Wright

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What's your point of view

by Jill Gravatt

RATING MY HOSPITAL EXPERIENCE

I had this brilliant idea at the beginning of this summer. The new guttering on my neighbour's house looked fabulous. I could have that too and repaint the peeling fascia boards at the same time. Climbing up and down a ladder to paint until dark was rewarding after a busy working day as a dermatology nurse. The new guttering was installed and painting was going well.

After four months I began wondering if my 'do it yourself' determination was not the best approach as a mature woman. At my regular plasma donation appointment my haemoglobin dropped. This has never happened before. Colleagues asked if I had lost weight. A patient asked if the theatre scrubs were one size fits all! I was fatigued and breathless climbing stairs or the ladder causing occasional palpitations but my determination to complete my house renovation never faltered.

More recently after a satisfying but exhausting three hours weeding the garden I noticed palpitations as I was doing the dishes along with breathlessness and nausea. No chest pain though, so I was confident I would revert to a normal heart rate while sleeping, as had happened before. I woke at 5am to begin the day and the breathlessness was worse. I knew it was time to be sensible and go to hospital. Nursing training reminded me not to drive myself. Here best friends are invaluable. So started my journey through Resus at the local hospital.

At the Emergency Department I explained that I had an irregular heartbeat that was not resolving. The triage nurse took my details and attached the finger pulse oximeter. "Your pulse rate is all over the place!", she said. I was then pushed very fast in a wheelchair to a Resus cubicle. Intravenous (IV) lines were expertly inserted in both arms and IV fluids started, blood pressure cuff and ECG leads were attached, bloods taken and a portable chest x-ray completed. The delivery of emergency care was very efficient. The nurses, and medical team assessed me and communicated calmly. I was treated with dignity and respect. I felt safe. Within an hour the diagnosis of atrial fibrillation from thyrotoxicosis was confirmed from a high thyroid hormone blood level and I was admitted to hospital for treatment.

I am the sort of person who 'gets on with things'. I now realise I missed linking my own signs and symptoms of not being well in the pursuit of achieving a personal goal. My ED and Resus experience was very positive. I rated them very highly for providing quality care when I needed them most.

Renal PRURITUS

reduces quality of life

by Tracy Fenton

Renal/uraemic pruritus is also called chronic kidney disease associated pruritus (CKD-aP) (Vyas, 2010). Uraemia refers to excessive urea in the blood and occurs when both kidneys stop working (renal failure) (Vyas, 2010). This is a common and bothersome symptom among patients with end-stage-renal-disease (Kobin, 2018). This condition strongly reduces the patient's quality of life (Mettang & Kremer, 2014) and is associated with impaired sleep, depression and increased mortality (Combs et al., 2015).

Epidemiology

In the early days of dialysis treatment CKD-aP was a very common occurrence afflicting up to 85% of patients (Mettang & Kremer, 2014). In the eighties this incidence reduced to 50 -60% and now studies show that about 40% of patients undergoing haemodialysis suffer from CKD-aP. Some studies suggest the prevalence may be decreasing with more effective dialysis and better access (Kobin, 2018). Some patients complain of pruritus only during or after dialysis, whereas others report symptomatic exacerbation during this same period (Freedberg et al., 2003). The severity of the pruritus is variable (Combs et al., 2015).

Etiology and Pathogenesis

The pathophysiology of uraemic pruritus is poorly understood (Kobin, 2018) and has been studied less extensively than pruritus in general (Combs et al., 2015).

Furthermore, pruritus in renal disease may be caused by mechanisms different than those underpinning pruritus from other etiologies. It is thought to be due to a combination of factors including (Vyas, 2010):

- Dry skin
- Reduced sweating
- Abnormal metabolism of calcium and phosphorus/raised parathyroid hormone
- Accumulation of toxins
- Sprouting of new nerves
- Systemic inflammation
- Co-existing medical problems, particularly diabetes and liver disease.

Diagnosis and differential diagnosis

The diagnosis of CKD-aP can be challenging. Patients are usually in advanced stages of kidney disease and are suffering from other conditions such as cardiovascular diseases, diabetes mellitus, chronic liver or haematological diseases which by itself or by medication given to treat these entities may provoke itch (Mettang & Kremer, 2014).

A significant number of diseases can cause pruritus in patients with and without kidney disease (Kobin, 2018). The presentation of pruritus in CKD-aP can be variable, so it may be difficult to differentiate it from other causes of itching. A non-uraemic cause for pruritus should be considered in patients who are refractory to a reasonable treatment trial (Combs et al., 2015). Such conditions as lymphoma cholestasis (due to primary biliary cholangitis or viral hepatitis) and hypersensitivity reactions can cause pruritus among dialysis patients and it is particularly important that clinicians consider these (Kobin, 2018).

Clinical manifestation and presentation

Uraemic pruritus is characterized by daily bouts of itching that tend to worsen at night and may prevent sleep (Vyas, 2010). It is most commonly described as a daily or near-daily occurrence that spans large bilaterally symmetrical surface areas (Simonsen et al., 2017). It does not exhibit a dermatomal pattern and there is no associated primary lesion (Simonsen et al., 2017). Intensity and spatial distribution of pruritus in patients with chronic renal insufficiency may vary significantly over time (Mettang & Kremer, 2014).

Clinically the skin can appear normal or dry (Xerosis) (Freedberg et al., 2003) however, the pruritus can lead to secondary skin lesions including excoriations (scratch marks) and chronic prurigo (picked sores) (Griffiths et al., 2016). Scratching can lead to impetigo (skin infection) and chronic lichenified eczema (Vyas, 2010).

Treatment and Management

Managing refractory pruritus can be a great challenge for healthcare providers and patients (Wang et al., 2014). High quality evidence on which to base recommendations for the treatment of uraemic pruritus is limited as most guidelines are based on anecdotal reports and small uncontrolled clinical trials (Kobin, 2018). Further complications include the interpretation of studies as most have used different scoring systems for the intensity of pruritus (Kobin, 2018). Therefore recommended treatment regimens remain largely based on expert opinion (Combs et al., 2015).

Treatment involves a stepwise approach that depends on the severity of symptoms and the response to initial therapies (Kobin, 2018). The first step in the treatment is optimizing dialysis efficacy using the generally accepted targets (Kobin, 2018). The optimization of the aspects of chronic kidney disease that are most relevant to pruritus including serum parathyroid hormone, calcium and phosphorus management are important (Combs et al., 2015). Treatment of dry skin (see Management of Dry Skin – General Measures) with emollients should also be mandatory as a baseline therapy, cooling substances such as menthol may further improve the antipruritic effect (Mettang & Kremer, 2014). It is also important to educate patients on the importance of avoiding or minimizing scratching (Combs et al., 2015).

Treatment options include (Mettang & Kremer, 2014):

- Topical treatment
- Antihistamines
- Gabapentin
- Drugs with an anti-inflammatory action
- Phototherapy

Skin hydration with aqueous cream emollient and baby oil both have been shown to reduce skin dryness and the severity of CKD-aP and to improve patient quality of life when applied two to four times daily (Combs et al., 2015). However, there are no good comparative trials among various emollients for uraemic pruritus (Kobin, 2018).

In small placebo-controlled trials capsaicin ointment has shown symptom relief (Combs et al., 2015). However, this was mainly tried for small well-circumscribed areas of pruritus and it is not recommended for large areas of generalized pruritus as in CKD-aP (Kobin, 2018).

Antihistamines may have beneficial effects which are believed to be mediated via both their sedating properties and ability to stabilize mast cell membranes (Kobin, 2018). However, they have been inadequately tested for the treatment of CKD-aP and several reviews have speculated that any perceived benefit was caused by sedation rather than a true antipruritic effect (Combs et al., 2015).

If anti-histamines don't relieve the symptoms gabapentin can be tried. Gabapentin is an anticonvulsant and centrally acting calcium-channel blocker (Mettang & Kremer, 2014). Studies have shown it to be effective in reducing pruritus in CKD-aP and the drug is largely well tolerated (Mettang & Kremer, 2014). The largest body of evidence was found for the effectiveness of gabapentin (Combs et al., 2015).

In the late 1970 it was reported that patients with CKD-aP did not respond to long-wave UVA radiation treatment but 9 out of 10 patients treated with UVB phototherapy reported a marked



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MANAGEMENT OF DRY SKIN GENERAL MEASURES

- Avoid excessive bathing or bathing in hot water
- Use fragrance-free sensitive washes
- Limit the use of soap by washing with a soap substitute
- Avoid wearing rough clothing such as wool
- Use mild/sensitive detergent for washing clothes and rinse well
- Keep fingernails short and clean
- Try not to rub or scratch itchy areas
- Keep the house cool and humid
- Use topical emollients

reduction in pruritus. A quasi-experimental study by Wang et al., (2014) supported the efficacy of narrowband UVB phototherapy in alleviating renal pruritus. The risk for skin malignancies following UVB phototherapy and long-term immunosuppression remains a matter of debate; especially in immunocompromised patients suffering from advanced disease or in those scheduled to receive immunosuppressive treatment after renal transplantation (Mettang & Kremer, 2014).

Future direction

The current evidence base for the treatment of CKD-aP is weak and limited by small studies with a high risk of bias. There are also currently no universally accepted scales for measuring CKD-aP severity, characteristics or its effect on quality of life (Shirazian, 2017). Large,

methodologically rigorous, parallel-arm RCT's are urgently needed (Simonsen et al., 2017). Universally accepted scales and definitions for CKD-aP are critical given the highly subjective nature of this disease, so that treatment effects and decisions about efficacy can be standardized across studies (Shirazian, 2017). Because optimal treatment is uncertain, patients and physicians are justified in trying different treatment for individual patients (Simonsen et al., 2017).

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Radiation therapy - treatment of disease using x-rays (radiant energy).

Radiculopathy - a condition due to irritation or injury of a nerve root and may result in localised itch, pain, tingling, numbness or weakness.

Rash - a widespread eruption of lesions on the skin.

Raynaud phenomenon - a vasospastic response to cold in which fingers and/or toes turn white and numb and are bluish on rewarming before returning to normal.

Recalcitrant - a disease or condition that is persistent and refractory, that is, difficult to clear up.

Recurrence - the return of symptoms after the remission of an illness or condition.

Remission - a temporary or permanent reduction in the severity of disease or pain.

Renal - pertaining to the kidney.

Resection - (also known as excision) the surgical removal of an organ or tumour.

Rete - a network. In epithelial tissue, rete are the extensions of the epithelium that project into the connective tissue.

Reticular - a network or net-like structure.

Reticular dermis - the lower portion of the dermis. It is composed of coarse elastic fibres and thick collagen bundles parallel to the skin surface.

Retinoic acid - a compound derived from Vitamin A, and used in topical creams for the treatment of skin conditions.

Rhytid - an undesirable wrinkle in the skin.

Rhytidectomy - surgical removal of wrinkles.

CLINICAL NURSE SPECIALIST PAEDIATRIC GASTROENTEROLOGY

A REWARDING ROLE

by Lisa Dudley

Why did you choose nursing as a career, where did you do your training and what nursing experience led you to working with children who have liver disease?

For as long as I can remember I had wanted to be a nurse, so as soon as I left school at 18 years old I went into nursing training. I was brought up in Yorkshire and trained in Leeds, which is the largest teaching hospital in Europe. I remember my training as one of the most special times in my life. Our training was very different then to now. We wore hats and capes, spent hours learning how to make beds and scrub dressing trolleys and were introduced to the ups and downs of shift work very early on. This all makes me sound very old but it always amazes me how much nursing as a profession has changed and evolved.

As part of my general training I completed my paediatric placement on a children's medical ward, specialising in looking after children with cystic fibrosis, gastroenterology problems and liver disease. After

my second shift I knew I wanted to become a paediatric nurse. These children with debilitating chronic illness were so brave and uncomplaining and just got on with life, with their treatment and their play. I completed my 2 year sick children's registration in Leeds and worked in general medicine, surgery and in the Paediatric Intensive Care Unit (PICU) and then took the opportunity to travel.

When I returned from my overseas adventures I started my first job as a children's liver nurse specialist and did my post graduate training in Birmingham in paediatric liver disease. In 2000 Leeds was commissioned as the third supra regional centre of paediatric liver disease and transplantation and I was part of the senior nursing team involved in setting up the new unit. Over the last 20 years liver transplantation has completely revolutionised the lives of children with liver disease. When I first started looking after these children in the mid 1990's, paediatric liver

transplantation was uncharted territory and the children were very sick with uncertain outcomes. But now, due to advances in surgical technique, such as splitting liver grafts and live donor transplants, advances in immunosuppression therapy and PICU, we now have excellent outcomes for these children. We are able to ensure better quality of life for them and their families. I am so proud to be involved in an area of medicine that has become so successful in my lifetime and continues to enable children to be well enough to live their best lives.

I was born in NZ and had always wanted to come back, and so in 2015 my daughter and I came out to have a taste of NZ life. We both love it and are here to stay. My first job at Starship Children's Hospital was as the dermatology nurse specialist, where I gained experience looking after children with eczema and other skin conditions. I was very well taught by the dermatology team in an area I had limited experience.

I then moved on to the speciality I was familiar with when a post became available with the Children's Gastroenterology Team.

What is a typical day in your work life like including your role in the team, decision making and important skills and abilities required?

In my job, every day is different and very full on. I work with two other nurse specialists and we look after children and families both as inpatients and after discharge. We coordinate care of children with liver disease and intestinal failure, providing education and support for the children and families and lead discharge planning. Some of our day is spent teaching children and families how to give their medicines and what sort of signs and symptoms they need to look out for at home. We are the main point of contact for families when they go home and on some days our phone does not stop ringing.

We also see children in outpatient clinics and have a post liver transplant clinic on a Thursday morning. We all enjoy this because this is a time when we get to see the children doing well, getting back to school and their "normal" life.

We are part of multi-disciplinary team, including a social worker, psychologist, pharmacist, dietitian and doctors. Children with liver disease and post liver transplant need a lot of close monitoring, blood tests, clinic visits and medications. Our extra busy weeks are when we are coordinating a pre transplant assessment. The family come to Starship to learn all about what having a liver transplant involves and if it is the right time for the child to be put on the transplant waiting list.

We very much have a team approach to difficult decision making and we have a big sit

down ward round on a Wednesday, where everyone attends and can contribute. I feel hugely supported by our team and this makes life easier especially on the days when we are looking after children who are very sick and parents who are very stressed.

I find my role rewarding most days and I find my role difficult most days

I think in my role it is important to stay calm in difficult situations, not take things too personally and to always remember a sense of humour helps!

I have been doing this role for a long time and I think it helps to be able to reassure families that we are an experienced team who have now been looking after children needing a liver transplant since 2002.

What are the most rewarding and most challenging aspects of your role?

I find my role rewarding most days and I find my role difficult most days.

My favourite moments are when I feel that I have been able to teach families aspects of their child's care that they thought they were never going to be able to understand. Some parts of medicine can be so daunting. I find it truly rewarding being able to break information down and give parents and children confidence to deal with their health and care.

There are also those times when you see a child start to feel well again: be able to play with their brother or sister for the first time, when they can go home and go back to school to be with their friends.

The days I feel like I've not done a very good job, are the days when I've

not had enough time to spend with our children and families and feel like I'm rushing around to prioritise the most important thing, not being able to listen as for as long as I need to.

How do you educate families about the importance of skin care before and after transplantation?

I have been able to use my dermatology experience in my current speciality. If you have had an organ transplant it is very important that you take good care of your skin. There is an increased risk of skin cancer for anyone who has had a solid organ transplant. Everyone

post-transplant is on lifelong immunosuppression and it is this medication that increases that skin cancer risk. We don't see skin cancers in children but all transplant patients are at risk of developing skin cancer with unprotected sun exposure and the risk increases with time. It is therefore so important to educate children and their families from the beginning that they need to be sun smart always. We address the importance of skin care in the pre transplant assessment phase, at time of discharge and also at outpatient clinic visits.

Tell us a short story to illustrate the uniqueness and importance of your role.

Last year we looked after a very young baby who went into liver failure and needed an urgent liver transplant. She was very sick for many weeks. Her mother was by her side at all times. She was a young parent who had just finished school herself. Her baby eventually was ready for discharge, but needed a cocktail of medicines and sub cutaneous injections, to keep her well. Part of my role was to teach the mother all the cares she needed to know to look after her baby at home. I was able to develop a relationship with the mother, which enabled

a very shy, very scared teenage girl to be able to give her baby everything she needed following a liver transplant. She is not out of the woods yet and we see the family in clinic regularly but the baby is lucky to have a superb mother, who is confident with the extra care that her baby needs. I am reminded of the importance of our role when the baby's mother phones me for advice, with sensible, well thought out questions and raises the alarm promptly when needed.

What nursing preparation, educational or other work would you recommend for someone wanting to become a nurse in your speciality?

I would always recommend that a nurse wanting to have a career in any area of paediatrics starts on a general medical ward. This gives you the grounding that you need to be able to develop assessment skills and clinical judgment in all aspects of paediatrics. Children with liver disease are looked after on the

medical speciality ward at Starship and the liver team run study days at least twice a year to teach all interested nursing staff..



Lisa Dudley is a Paediatric Gastroenterology Clinical Nurse Specialist at Starship Hospital, New Zealand's first children's hospital



19th Edition of International Conference on Dermatology and Melanoma

19-20 August 2019

Tokyo, Japan

<https://dermatology.euroscicon.com/>

14th New Zealand Dermatology Nurses' Society Incorporated Annual Conference

22-23 August 2019

Te Papa, Wellington, New Zealand

www.nzdermatologynurses.nz

48th European Society for Dermatological Research Annual Meeting

18-21 September 2019

Bordeaux, France

<http://esdrmeeting.org/>

Scope 19th Annual Meeting

Skin Care in Organ Transplant Patients Europe

26-29 September 2019

Barcelona, Spain

<https://conference-service.com/SCOPE2019/access.html>

28th European Academy of Dermatology and Venereology Congress

9-13 October 2019

Madrid, Spain

<https://eadvmadrid2019.org/>

20th Skin Disease Education Foundation Annual Las Vegas Dermatology Seminar

7-9 November 2019

Las Vegas, USA

<https://www.globalacademycme.com/conferences/sdefs-20th-annual-las-vegas-dermatology-seminar/welcome-sdefs-las-vegas-dermatology-seminar>

10th World Congress on Itch

17-19 November 2019

Sydney, Australia

<https://ifsi2019.com.au/>



FACING UP TO ROSACEA

by Ann Giles

Rosacea is a common, non-infectious or contagious, benign, chronic and incurable but poorly understood inflammatory facial skin disease.

It affects more women than men in the earlier stages with the exception of rhinophyma meaning swelling mass or bulb. Rhinophyma of the nose is almost always found in men. While rosacea tends to be milder in women, it worsens with age, leading to lowered self-confidence, self-esteem and avoiding public contact. People with fair skin and blue eyes of Celtic origin that blush easily predispose to rosacea although it has been diagnosed in people with greater skin pigmentation including those from Asian or the Pacific Islands. Temporary, intermittent, or continual, mild to severe rosacea appearing on the nose, cheeks, forehead, glabella area between the eyebrows and chin shows symptoms including flushing, redness, telangiectasia or swollen/broken blood vessels, red bumps and pimples. Blackheads are not present. The eyes may be affected in people with rosacea (Freedberg et al., 2008).

Displayed in the Louvre, Paris, the painting "The Old Man and his Grandson" by Ghirlandajo (1449-1494) depicts the condition

rhinophyma on the nose and skin damage from rosacea in his portrait of the old man.



in the 14th century who referred to the characteristic red lesions he observed across the face of patients.

The term rosacea is a near borrowing of the Latin *rosaceus*, "made of roses". The term "acne rosacea" was described in English medical texts at the beginning of the nineteenth century. Rosacea was also termed, "pimples of wine" or "brandy face", as it was commonly attributed to the consumption of too much alcohol. The word "acne" became discarded towards the end of the nineteenth century due to lack of evidence of a relationship between acne vulgaris or common acne and rosacea (Al-Dabagh et al., 2014; Oakley, 2016; Oakley & Ngan, 2014; Rainer et al., 2015; Rainer, Kang & Chien, 2018).

The first individual known to describe rosacea as a medical condition was French surgeon, Dr Guy de Chauliac,

Global estimates of prevalence suggest 1% to 22% in adults, more frequently effecting women and phymatous skin changes more frequently in men. A more recent review suggests 5.46% mostly aged 45-60 years with variation depending on diagnostic methods (Gether et al., 2018). It occasionally occurs in adolescents and rarely in children. A family history may predispose people to developing rosacea however, a genetic association has not been identified (Dahl, 2019).

Pathophysiology and diagnosis

The exact cause of rosacea is unclear. It is not just a chronic relapsing skin disease, but has many contributing factors and signs and symptoms that assist in diagnosis. There are no blood tests to confirm rosacea. If the diagnosis is uncertain a skin biopsy may be helpful to exclude other skin conditions (Dahl, 2019). People may have characteristics of more than one rosacea subtype or variant developed by the National Rosacea Society (NRS) in the USA (Gallo et al., 2017). Studies have also found rosacea is associated with systemic comorbidities (Rainer et al., 2015). Most importantly rosacea predominantly involves the face and therefore affects physical

appearance leading to psychosocial distress including low self-esteem, embarrassment, anxiety, depression, missed work and isolation from society (Rainer et al., 2018).

Contributing factors to developing rosacea

(Dahl, 2019; Oakley, 2016; Rainer, 2018).

Immune dysfunction

Immune dysfunction involves a response to microorganisms, UV damage, chronic inflammation and vascular skin changes.

Microorganisms associated with rosacea

- *Demodex folliculorum*. Increased density of a tiny harmless hair follicle mite found on normal skin which feeds on keratin, sebum or bacteria is not thought to be a major contributing factor to rosacea but an inflammatory reaction to the mite may be a part of the condition (Freedberg et al., 2008).



Demodex folliculorum hair follicle mite

- *Bacillus oleronorum* is found with *Demodex* mites. Its contribution to rosacea is uncertain but may cause inflammation.

- *Helicobacter pylori* in the gastrointestinal tract may contribute to skin erythema but evidence is lacking as treatment with antibiotic therapy also improves rosacea.

Studies have shown other bacteria in the small intestine could be linked to rosacea but their significance needs more investigation.

- *Staphylococcus epidermidis* a skin flora, may play a role in pustular rosacea (Whitfield et al.,).

- *Chlamydia pneumonia*, a bacteria causing respiratory tract infections may have a role in the inflammatory process (Holmes, 2013).

Ultraviolet radiation (UVR)

UVR is an exacerbating factor especially in fair skinned people.

Vascular hyperreactivity

Vascular hyperreactivity is related to hypersensitive skin receptors, triggers of flushing, increased skin blood flow and increased epithelial water loss which reduces skin barrier function.

Genetics and family history

Recent studies suggest a genetic relationship but the mechanism is uncertain. Those with a family history have a greater chance of developing rosacea (Griffiths et al. 2016).

Diagnostic criteria and clinical features

Diagnosis is based on a comprehensive patient history, medical history, examination of symptoms and the presence of one or more primary or secondary features (Table 1).

Other conditions with similar appearance to rosacea

- Acne vulgaris
 - Rosacea fulminans
 - Contact dermatitis
 - Steroid rosacea
 - Perioral dermatitis
 - Seborrhoeic dermatitis
- (Oakley, 2016; Wilkin et al., 2002)

NRS Classification - subtypes and variants

NRS classification of rosacea is based on morphological characteristics such as shape, size and colour rather than pathogenesis and disease progression (Table 2).

GUIDELINES FOR THE DIAGNOSIS OF ROSACEA

TABLE 1










(Freedberg et al., 2008; Maier, 2019; Wilkin et al., 2002)

Presence of one or more of the following primary features
Frequent blushing or flushing or transient erythema. May worsen other features, e.g. inflammatory
Persistent redness or nontransient erythema of the skin in the centre of the face
Dome-shaped red papules with or without pustules or nodules, erythema and skin sensitivity
Telangiectasia is common but not necessary
May include one or more of the following secondary features
Burning or stinging with dryness with or without scaling or dermatitis in malar or cheekbone area.
Elevated red plaques
Dry, rough and scaling skin, may resemble dermatitis
Oedema may follow facial erythema or flushing
Ocular manifestations including burning or itching, lid inflammation or styes
Peripheral location have been reported but frequency and occurrence is ill-defined
Phymatous changes including follicles spread widely from a central point. The skin has irregular surface nodularities, thickening or fibrosis, and enlarged bulbous appearance. While rhinophyma of the nose is most common, phymas can occur on the jaw, forehead, ears and eyelids.

SUBTYPES AND VARIANT OF ROSACEA AND THEIR CHARACTERISTICS

TABLE 2

(Gallo et al., 2017; Wilkin et al., 2002)

		Rosacea subtypes and variant	Key features
		Subtype 1 Erythematotelangiectatic	FACIAL REDNESS Flushing and persistent central facial erythema with or without telangiectasia
		Subtype 2 Papulopustular	BUMPS AND PIMPLES Persistent central facial erythema with transient, central facial papules or pustules or both.
		Subtype 3 Phymatous	SKIN THICKENING Thickening skin, irregular surface nodularity and enlargement. May occur on the nose, chin, forehead, cheeks or ears
		Subtype 4 Ocular	EYE IRRITATION Foreign body sensation in the eye, burning or stinging, dryness, itching, ocular photosensitivity, blurred vision, telangiectasia of the sclera or other parts of the eye or periorbital oedema.
		Variant Granulomatous	Noninflammatory; hard; brown, yellow or red cutaneous papules or nodules of uniform size

Images from dermnet with permission <http://www.dermnetnz.org>

Associated diseases or comorbidities

Results of a case control study by Rainer et al., (2015) suggest prevalence, co-morbidity and associated disease severity is related to rosacea severity.

People with rosacea have a higher chance of developing:

- Airborne and food allergies
- Respiratory diseases
- Gastrointestinal diseases
- Hypertension
- Metabolic diseases
- Urogenital diseases
- Hormone imbalance in females

compared to age

Moderate to severe rosacea is associated with:

- Hyperlipidaemia
- Cardiovascular disease
- Diabetes
- Coeliac disease
- Multiple sclerosis
- Rheumatoid arthritis
- Parkinson's disease
- Migraine

Triggers that flare rosacea

(Dahl, 2019; Freedberg et al., 2008; Oakley, 2016)

Environmental

- UVR (sunlight) and sun damaged skin with solar elastosis is an important factor
- Stress
- Strong emotions such as anger, rage and embarrassment
- Indoor heat
- Cold temperatures
- Windy weather
- Hot weather and high humidity
- Hot baths/showers
- Intense physical activity
- Skin irritation from cosmetics, facial creams and long term use of strong topical steroids
- Skin barrier disruption such as breaks in the skin from scratching or injury
- Alcohol
- Hot drinks due to temperature but not coffee and tea
- Spicy foods, some fruits, marinated meat, some vegetables, dairy products

Other triggers

- Medications which aggravate flushing such as nicotinic acid and vasodilators
- Menopause

Management

There is no cure for rosacea.

Bloodletting and attaching leeches to skin affected by rosacea were historically used. Modern treatments to delay disease progression and prolong periods of remission include nonpharmacological approaches such as skin care measures, topical pharmacological measures, oral medications and light-based therapies (Rainer et al., 2018; Maier, 2019).

It is important to establish patient's expected outcomes of treatment to reduce unrealistic expectations.

Nurses have an opportunity to discuss accurate and current information with patients to reduce flare-ups and improve quality of life including controlling symptoms, recognising triggers, therapy choices, behavioural changes or lifestyle modifications.

Nonpharmacological approaches for mild rosacea

(Management approaches summarised from Bologna et al., 2018; Freedberg et al., 2008; Griffiths et al., 2016; Maier, 2019; Oakley, 2016; Oakley & Nyan, 2014).

Avoid the sun. Use a SPF 50 or greater oil-free sunscreen that can be tolerated without a burning feeling on the skin or skin irritation

- Control/manage stress with emotional support, psychological counselling and group therapy
- Be prepared for hot and cold weather and sudden changes in temperature. Use fans in hot weather or facial water spray and cover the face on cold or windy days
- Avoid saunas, hot tubs, car heaters, open fireplaces and hot baths/showers
- Participate in low intensity exercise, yoga, deep breathing, meditation or tai chi

- Avoiding irritating skin products such as toners, astringents, chemical exfoliating products, oil based creams and dermabrasion procedures.
- Wash the face with soap free wash and lukewarm water.
- Moisturise skin daily, more often in dry climates and cold weather. Glycerine or petrolatum based products may restore skin barrier function
- Cosmetic camouflage if tolerated on sensitive skin
- Avoid hot drinks, alcohol and trigger foods
- Eyelid hygiene and artificial tears may be useful for ocular rosacea (subtype 4)

Pharmacological measures

Topical treatment for mild and ocular rosacea.

- Studies have been unable to determine the effectiveness of topical metronidazole cream/gel over topical azelaic acid cream/ lotion to reduce erythema and clear inflammatory lesions.
 - Topical antibiotic preparations such as clindamycin and erythromycin are sometimes effective but are unavailable in NZ.
 - Fusidic acid or erythromycin ophthalmic ointment can be used for ocular rosacea (subtype 4) if bacterial infection is evident.
 - Brimonidine gel or oxymetazoline cream to temporarily reduces facial redness are not available in NZ.
 - Calcineurin inhibitors including tacrolimus and pimecrolimus cream may improve erythema.
 - Ivermectin (Soolantra™) cream for papulopustular (type 2) rosacea to control *Demodex* mite and inflammation was considered more effective than metronidazole in a systematic review by Ebbelaar et al., (2018) but is not readily available in NZ.
 - Topical steroids are not appropriate for treating rosacea
- ## Oral treatments for moderate to severe rosacea

The following treatments are

suggested for rosacea which has not responded to other treatments or rosacea with multiple inflammatory lesions (subtype 2) include:

- Antibiotics such as doxycycline, minocycline, erythromycin and cotrimoxazole or metronidazole for resistant rosacea to reduce redness, papules, pustules and eye symptoms, may be more effective with a 6-12 week course for papulopustular and ocular rosacea (subtype 2 & 4).
- Isotretinoin in papulopustular and phymatous (subtype 2 & 3) rosacea may be used in lower doses for longer periods than needed for acne when oral antibiotics are not effective or have intolerable side effects. Isotretinoin side effects may

limit use in some patients.

- Clonidine, a central alpha agonist and carvedilol a beta blocker may reduce vascular dilatation causing flushing.
- Diclofenac a non-steroidal anti-inflammatory may reduce skin redness and discomfort.

Other treatments

- Laser treatment may be more effective for erythematotelangiectatic and phymatous rosacea (subtype 1 & 3).
- Surgical excision reduces proliferated tissue for phymatous rosacea (subtype 3).

Summary

Rosacea which affects millions of people worldwide has been

described and even portrayed in art for the last six to seven hundred years and a cure has not been found. With increased understanding of the condition, treatment has moved on from historically using bloodletting and the application of leeches to affected skin. Advances in topical skin care products, medications and light-based therapies combine to provide symptom management, progression prevention and prolonged remission thus improving patient's quality of life. However, patients with a good understanding of the condition, their personal triggers and adhering to a treatment plan may provide the most effective management of rosacea.

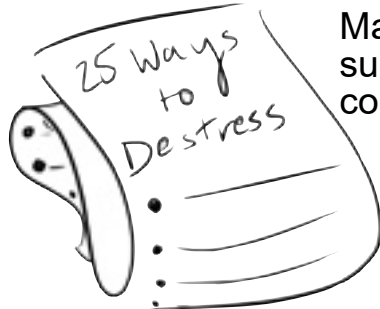
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PREVENTING ROSACEA FLARE-UP



Avoid the sun. Use a comfortable SPF 50 or greater, oil free sunscreen



Manage stress with emotional support such as psychological counselling and group therapy



Low intensity exercise, yoga, deep breathing, meditation or tai chi



Avoid saunas, hot tubs, car heaters, open fireplaces and hot baths or showers



Manage hot and cold weather and sudden changes in temperature. Use fans and facial water spray and cover the face on windy days



Avoiding irritating skin products such as toners, astringents, exfoliating products, oil based creams and dermabrasion procedures. Soap free wash and lukewarm water to wash face
Cosmetic camouflage if tolerated on sensitive skin



Moisturise skin daily, more often in dry climates and cold weather. Glycerine or petrolatum based products may restore skin barrier function



Avoid hot drinks, alcohol and trigger foods



FACING UP TO ROSACEA

Erica's story

Being told that I had rosacea at 59 years old seemed just like another thing to deal with. Little did I know just how much it would impact my life! The diagnosis came after a biopsy on my nose, suspicious for basal cell carcinoma showed no signs of skin cancer, which was a relief. I did not really get rosy cheeks for about 6 months after the diagnosis so it didn't seem so bad. Then it hit me and I had to come to terms with the fact there is no cure.

I have cancelled events that I was meant to go to. Also going shopping at the mall especially in the winter when my cheeks are fine and then the heat in the shops sets it off, so home I go without getting what I went out for. Sometimes the pain and burning can make me feel like hiding away as I know I already don't look that great and then I feel like I don't want to deal with anyone.


The hardest thing with rosacea is finding what triggers it and products including sunscreen that won't exacerbate it. I have always had fair sensitive skin so I don't wear makeup. I have found that sometimes wine, getting really stressed, changes in temperature and the sun are triggers for me. I have learned the importance of always having either a hat or a scarf which can cover my head and sides of my face. Sunscreen is worn every day summer and winter.

A couple of months ago I had what I thought was a flare-up on my right cheek and treated it as I would for rosacea. After three weeks it didn't clear up, but seemed to get worse. I went to the GP and was prescribed an antibiotic for rosacea which I was told could take 3 - 6 weeks to work. After two weeks it wasn't improving. I phoned the

GP and the nurse confirmed that the antibiotic does take a while to work but I didn't expect it to get even worse. So the following week I phoned again and the receptionist said she would get the nurse to phone me, as the doctor I saw was not available that day. No one phoned me, so the next day with a swollen red face I went to ask a nurse at work what she thought. On the way I ran into a couple of dermatologists. One of them said to come to his office saying "I doubt that is rosacea". Thank goodness, as I thought maybe I was just over-reacting. He did a biopsy and the results came back as dermatitis. Now I am more cautious and make sure it is rosacea before leaving it too long to seek help.

I am lucky enough to work in an office away from other people, but the stares and questions do sometimes get to me.

Erica works in the Auckland District Health Board



by Karen Gunson

18th AUSTRALIAN DERMATOLOGY NURSES' ASSOCIATION 2019 NATIONAL CONFERENCE MELBOURNE · AUSTRALIA

Thanks again to NZDNS and the Australian Dermatology Nurses' Association (ADNA) to receive this scholarship to attend the Australian conference. Melbourne is a great city on a sunny day and the city put on a stunning weekend. The huge Melbourne Convention Centre can be daunting but once you find your way, there is many people to talk to and education to translate into clinical practice.

The theme of this year's conference was 'SKIN' and what it stands for: Support, Knowledge, Inspiration and New frontiers.

Dr Geoff Sussman who was guest speaker at our NZ Dermatology Nurses' Society (NZDNS) national conference last year was a speaker at ADNA. He gave his informative talk on Wound Management.

The keynote speaker at the conference was Rob Edwards, an inspirational presenter talking on "It's all about you!" His message

was; we need to be playing the long game in looking after our health. It is important to be doing the little things, which will add up to long term changes. Eating well, exercising, looking after our mental health and utilise the screening tests. "Your No 1 asset – look after it".

We heard Charmaine Peras very informative talk on phototherapy. The basics were outlined on care and management of patients undergoing phototherapy. The key take home message for me was be aware of the risks, ensure your patient understands and have a burn management protocol in case of adverse events.

Vera Koslova-Fu spoke to us as a Dermal Clinician. She is a Dermal Lecturer and they currently spend 3 years gaining a Bachelor of Dermal Science. She was very informative on lasers and the different types available and their indications. Her message was do not attempt the

therapy if you cannot manage a complication. Also never be afraid to refer on if needed.

We heard from Professor Damian on skin cancer prevention for our highest risk patients. You do not need to be sunburnt to cause DNA damage if you are susceptible to skin cancer. Her take home message was you should wear SPF 50 sunscreen on your face every day of the year and to put it next to your toothbrush to remember to apply.

A parent whose children have severe eczema spoke of her journey. Melanie Funk founded a charity "Hands to Hold" and "Eczema Support Australia". This aims to provide support, connection and understanding for people affected by eczema.

Thanks again for the sponsorship. The next ADNA will be in Adelaide in May 2020 and scholarship applications close at the end of February. You can apply if you are a member of NZDNS.

Karen Gunson is a Nurse Specialist at Auckland Skin & Cancer Foundation, NZ



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