

L'ORÉAL

Dermatological Beauty

CLINICAL SERIES

PEDIATRIC ATOPIC DERMATITIS: BARRIER-FIRST MAINTENANCE FOR WARM WEATHER FLARES

Atopic dermatitis (AD) typically manifests during childhood, affecting up to 30% of children.¹ Between flares, AD can appear well controlled. The skin looks lesion free. Caregivers and patients report improvement. And warmer weather means they're in the clear, right?

THE ENVIRONMENTAL FACTOR

Weather change is known to be flare triggering. Sweat, heat and humidity, and intense sun exposure are all examples of environmental factors that can aggravate AD. With children and families spending more time outside during spring and summer, respiratory allergens such as grass pollen can also induce flares.²

THE SUBCLINICAL FUSE: WHAT PRECEDES A FLARE

Flares do not arise spontaneously. Microbial shifts due to low bacterial diversity and rising *Staphylococcus* populations precede the clinical manifestation of AD flares, rather than simply accompanying them.³ Resolution occurs when bacterial diversity is restored to baseline and *Staphylococcus* populations normalize.³ Underlying these microbial shifts are 3 persistent barrier defects: reduced ceramide content, decreased filaggrin production, and impaired antimicrobial peptide synthesis.⁴ Ceramide deficiency is present in both lesional and non-lesional skin, and when barrier function is reduced, pathogenic colonization, through penetration of external stimuli like allergens, and inflammation follow.^{4,5} For this reason, consistent maintenance therapy is essential to support healthy barrier conditions, instead of treating AD flare to flare.



Caregiver question: *"Do I really have to do all this every single day for my child?"*

Clinical answer: *"Yes, even when skin looks clear, eczema is constantly causing your skin barrier to lose moisture and natural oils. A consistent daily routine is necessary to maintain a healthy barrier and prevent flares. When their affected skin clears, it means we're taking all the right steps to stay ahead of it."⁶*

THE BARRIER-FIRST MAINTENANCE FRAMEWORK

If barrier dysfunction and microbial imbalance are already active before a flare is visible, maintenance therapy should target them directly rather than wait for the next exacerbation.^{3-5,7} European consensus guidelines strongly recommend daily emollient use as basic treatment of the disturbed skin barrier function, applied liberally and frequently in pediatric and adolescent patients.⁷ Building on that guidance, the framework has 2 components: foundational barrier repair as a daily baseline, and proactive anti-inflammatory therapy for patients with recurrent disease.^{6,7}

COMPONENT 1: DAILY EMOLLIENT THERAPY AS FOUNDATIONAL BARRIER REPAIR

Basic emollient therapy is the cornerstone of AD management.⁷ European guidelines strongly recommend daily, liberal application of emollients as first-line treatment for disturbed barrier function, applied immediately after bathing and gentle pat drying using a "soak and seal" technique.⁷ Formulations should be adjusted seasonally, with more hydrophilic in summer, higher lipid content in winter, and all should be free of known contact allergens, particularly in young children.⁷ Beyond acute symptom relief, long-term maintenance emollient use after remission has been shown to prolong flare-free intervals and reduce the need for topical corticosteroids.⁷



Caregiver question: “How often should I be applying my child's moisturizer, and does timing matter?”

Clinical answer: “Both matter a lot. The goal is to apply generously and frequently, especially right after bathing while the skin is still slightly damp. That ‘soak and seal’ approach traps moisture in before it escapes. If their skin feels dry again by the afternoon, that's not the product failing. It's their skin telling you it needs another application. Guidelines recommend at least 2 times a day.”⁷

COMPONENT 2: THE PROACTIVE ANTI-INFLAMMATORY SHIELD

For pediatric patients with moderate-to-severe or frequently relapsing AD, clinical guidelines recommend layering proactive anti-inflammatory therapy on top of the daily emollient baseline.⁷ The European Task Force on Atopic Dermatitis (ETFAD) defines this approach as long-term, low-dose intermittent application of anti-inflammatory treatment to previously affected skin, in combination with continued daily emollient use across the rest of the body.⁶ This synergistic routine provides a coordinated system: the emollient maintains barrier integrity throughout the body, while the anti-inflammatory targets the sites most vulnerable to relapse.⁶ The ETFAD recommends introducing proactive therapy with topical calcineurin inhibitors or mid-potency topical corticosteroids in patients with moderate-to-severe AD.⁶

2-STEP BARRIER-FIRST FRAMEWORK⁷



WHAT THIS MEANS AT THE FOLLOW-UP VISIT

The barrier-first maintenance framework gives the follow-up visit a consistent structure. Rather than responding to the latest flare, the clinician assesses whether the daily emollient regimen is adequate in product selection and frequency, whether soak-and-seal technique is being followed, and whether previously affected areas warrant proactive anti-inflammatory coverage.^{6,7} When the emollient baseline is maintained, flare frequency decreases along with the need for topical corticosteroids.⁷ For caregivers and patients currently cycling through reactive flare management, shifting to this proactive, dual-component maintenance approach moves the treatment goal from crisis response to sustained disease control.⁷



Caregiver question: “My child is flaring up again. I feel like we just keep doing the same thing over and over.”

Clinical answer: “That's exactly the cycle I want to break. We'll treat this flare now, but once their skin clears, we're going to shift to a proactive maintenance plan that keeps the skin barrier strong every day. When the barrier stays strong, the flares have a much harder time breaking through.”⁷

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