

DERMATOLOGY WAIVERS

CONDITION: ATOPIC DERMATITIS (ECZEMA) (ICD 9 692.9)

Revised August 2002

AEROMEDICAL CONCERNS: One of the distinctive features of dermatitis is the itching, which may be severe and easily triggered. This can be distracting in the aviation environment. Some dermatitides may also interfere with proper wear of equipment. Patients with atopic dermatitis are often more susceptible to contact irritants found in the aviation environment.

WAIVERS:

1. Initial Applicants (All Classes): Any history of atopic dermatitis requiring anything more than an occasional use of low potency steroids is disqualifying and an exception to policy must be applied for. Dermatology consultation will be required.
2. Rated Aviation Personnel (All Classes):
 - a. Mild to moderate atopic dermatitis is not disqualifying if the condition is controlled with the use of topical treatments to include tacrolimus ointment and mild steroids ointments (desonide and triamcinalone). This should be noted on the flight physical for information only.
 - b. Moderate to severe atopic dermatitis requiring the need for moderate or high potency steroid ointments or oral medications is disqualifying and a waiver must be applied for. Annual Dermatology Consultation will be required.

ICD9 Code Condition

691 Atopic Dermatitis
692 Contact Dermatitis
708.0 Allergic Urticaria

INFORMATION REQUIRED :

1. Dermatology consultation.
2. Allergy/Immunology evaluation for those with elevated IgE levels or respiratory difficulties.

FOLLOW-UP: Annual dermatology consult.

TREATMENT: Intermittent use of topical steroids over a limited area is considered compatible with continued flight status. Topical tacrolimus (PROTOPIC) is an immunomodulator useful in treatment and is compatible with flight status, but should

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include an initial period of grounding and observation for rare side effects of headache, allergic reaction, and hyperesthesia or skin tingling. Non-sedating antihistamines can be approved for use in treating dermatitis.

DISCUSSION: Atopic dermatitis affects 1-3 percent of the population. Around 90 percent of affected children manifest their disease by 5 years of age. A family history of atopy is quite common (70 percent), and about 50 percent of children with atopic dermatitis, persistent beyond the age of 12, develop either rhinitis or asthma. Patients with atopic dermatitis have frequent immunologic abnormalities, including elevated serum IgE levels (strong association with concomitant asthma and allergic rhinitis), reduced cell-mediated immune responses, and slowed chemotaxis of neutrophils and monocytes. About 20 percent of adults with atopic dermatitis have normal or low IgE levels; others have no IgE at all.

Non-pharmacologic preventive measures should be stressed. Education on bathing, daily moisturizers, avoidance of triggers to include fragrances, wool clothing products, and environment/outdoor activities will help control some of the flaring associated with this chronic process. Acute changes in the otherwise stable atopic patient should raise the question of staphylococcus aureus and the involvement of a super-antigen reaction. These will be more common with deployments, but are easily screened for and treated.

Topical treatment with mild steroid ointments (desonide and triamcinalone) combined with the immunomodulating tacrolimus ointment will control most mild to moderate atopic dermatitis/eczema without the need for waiver.

For more severe cases requiring oral medication, the aircrew should be grounded during treatment and may be returned to flight status when off medication and the chance of possible side effects of treatment is minimized. By convention, this is commonly after approximately three half lives of the medication have passed. If chronic oral therapy is required, the aviator must be grounded and the case reviewed at USAAMA.

REFERENCE:

Andrew's: Diseases of the Skin – Clinical Dermatology 9th Edition, W.B. Saunders 2000. Chapter 5, ISBN-0-7216-5832-6.

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