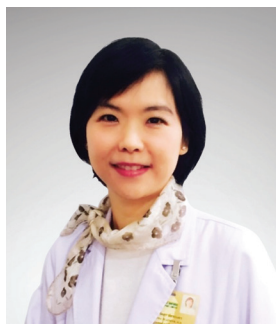


A Survey of Japanese Children with Atopic Dermatitis in Bangkok, Thailand

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Abstract

OBJECTIVES: This study aims to evaluate the understanding of atopic dermatitis (AD) among Japanese families living in Thailand.

MATERIALS AND METHODS: We performed a descriptive study collecting data through an online survey. The survey was sent to parents of children aged 0-15 years with atopic dermatitis in Bangkok, Thailand from 2018 – 2021.

RESULTS: Of the 65 responses, 33 children had 1 allergic condition and 32 had 2-4 conditions. Conditions included atopic dermatitis (n = 48), food allergy (n = 28), allergic rhinitis (n = 19), and asthma (n = 6). Furthermore, 49.2% felt they lacked sufficient knowledge to care for their children. Many respondents had limited knowledge of oral food challenge tests (61.6%) and oral immunotherapy treatment (58.4%). 26.2% were aware of the fingertip unit, 41.7% were unaware of the impact of water temperature on atopic dermatitis flare-ups, and 71.2% were unaware of the proactive drug use to prevent disease flare-ups. Notably, all respondents used bath water at a higher temperature than recommended. 41.0% encountered difficulties finding allergists despite having no trouble scheduling hospital visits for other concerns.

CONCLUSION: Many families would benefit from receiving accurate and useful information about usual care and a list of nearby allergists in taking care of their children's AD.

Keywords: atopic dermatitis, knowledge, parenting, Japanese, foreigner.

Atopic dermatitis (AD) is a chronic recurrent pruritic eczematous disease that often presents early in life.^{1,2} Multiple factors are suspected to strongly correlate with AD, including non-specific irritants, saliva, sweat, contact allergens, inhaled allergens, soap, and bathing water temperature.^{3,4} Genetic factors also found to be related with AD. Studies have shown that individuals with a family history of AD, asthma, or allergic rhinitis are at higher risk of developing the condition. In the Japanese population, AD is strongly influenced by FLG mutations, immune response genes (IL-4, IL-13, CARD11), and TSLP-related genes. These genetic factors contribute to skin barrier dysfunction and an exaggerated allergic response. However, environmental triggers (such as climate, diet, and urbanization) also play a role in AD prevalence and severity.⁵⁻⁷

The prevalence of AD in the pediatric population worldwide is 15-20%.⁸ In Japan, the prevalence of atopic dermatitis is 8.9-22.9% in patients 4 months through 13 years old.^{4,9,10} AD causes a significant burden on patients' quality of life and increases public health problems.

AD may precede other atopic diseases such as asthma, allergic rhinitis, or food allergies, the colloquially known allergic march.^{11,12} Early and appropriate management of eczema is theorized to result in better skin condition and prevent further development of other allergic diseases.

Current Thai and Japanese guidelines for AD treatment and management^{2,13} consists of three recommendations. Topical corticosteroids or other topical

Received: September 13, 2024
Revision received: February 12, 2025
Accepted after revision: February 18, 2025
BKK Med J 2025;21(1): 42-48.
DOI: 10.31524/bkkmedj.2025.11.006
www.bangkokmedjournal.com

anti-inflammatory drugs are the main treatment, topical emollients help maintain skin moisture and improve skin barrier function, and lastly avoiding suspected or known exacerbating factors.

It is important to note that the patients' families play a crucial part in treatment, so they should understand the condition and treatment plan. Providing specific advice about daily life activities promotes a good doctor-patient relationship that in turn improves adherence and medication compliance. (14) Reaching and maintaining a state of absent or mild symptoms that reduce disturbances of daily activities and the need for drug therapy are the ultimate treatment goals of AD.^{1,2}

Moving to live in a foreign country can cause patients and their parents to experience difficulties obtaining information about their illness and appropriate treatment. The consequences of misinformation or maltreatment will make them suffer during disease flares. The aim of this study is to evaluate whether Japanese patients in Thailand with atopic dermatitis and their families have an appropriate understanding of atopic dermatitis and its treatment. By analyzing this data, Thai pediatric allergists will be able to provide better care for Japanese children with atopic dermatitis.

Materials and Methods

A descriptive study was conducted at Samitivej Sukhumvit Hospital, Bangkok, Thailand between January 2018-November 2021.

Using a prevalence of 8.9% for Japanese pediatrics AD patients, the calculated population size is 125 patients.⁹

For enrollment, researchers reviewed the medical records of children aged 0-15 diagnosed with AD. The Japanese Dermatological Association's diagnostic criteria were used, requiring all three of the following: pruritus, typical eczema morphology and distribution, and a chronic or relapsing course, irrespective of symptom severity.^{1,2} A Google form survey and consent form were sent to all parents of AD pediatrics patients via email or SMS.

Our questionnaire was modified from Enomoto M's questionnaire of AD in Japanese. It was designed to obtain details of specific knowledge gaps and accessibility of medical care. Our questionnaire used Japanese language to reduce the language barrier.

Data analysis

The baseline characteristics and all the outcomes were analyzed by descriptive statistics using STATA 15.1/IC (StataCorp) software package.

Ethics

The study was reviewed and approved by the Institutional Review Board of Bangkok Hospital Head Quarters.

Results

Sixty-six of all recipients responded to the questionnaires. One response was excluded because the informed consent form was not obtained.

Demographic data of patients is shown in Table 1. The survey results are shown in Table 2. 55.4% of the respondents were parents of children aged 0-15 years old, and most of the children were born in Japan but currently live in Thailand.

Among the 65 children, 33 had 1 allergic condition and 32 had 2-4 conditions, including atopic dermatitis (n = 48), food allergy (n = 28), allergic rhinitis (n = 19), and asthma (n = 6). Different types of food allergies are shown in Table 2.

The frequency of hospital visits varied from once every few years to once every few weeks. The majority of parents reported no difficulty finding hospitals or time to go to the hospital; however, 41.0% of families reported difficulty finding outpatient allergists to visit. 70.8% of respondents underwent skin or blood allergy tests.

Table 1: Baseline characteristics (n=65).

Characteristics	n (%)
Age	
0-2 years	7 (10.8)
3-6 years	36 (55.4)
7-10 years	12 (18.4)
11-14 years	7 (10.8)
15 years up	3 (4.6)
Gender	
Male	30 (46.1)
Female	35 (53.9)
Current country	
Thailand	60 (92.3)
Japan	5 (7.7)
Born place	
Thailand	10 (15.4)
Japan	53 (81.5)
Others	2 (3.1)
AD Medication use	
Moisturizer that is currently used.	
Bought it from a drugstore or supermarket.	17 (27.9)
Prescribed by a doctor at the hospital.	32 (52.5)
Not use for now	12 (19.7)
Topical steroid use	
Yes	4 (6.8)
Everyday	29 (49.1)
Only during flare	26 (44.1)
No	0 (0)
Antihistamine use	
Yes	10 (16.4)
Everyday	25 (41.0)
Only during flare	26 (42.6)
No	0 (0)

Twenty per cent of patients did not use moisturizer regularly. The majority of respondents used topical steroids, but most parents had concerns about long-term side effects and were not certain regarding the concentration, amount, or frequency of medicine to apply. Therefore, most surveyed parents reported only using topical steroids or oral antihistamines for AD flare treatment.

All respondents took daily baths and at hotter temperatures than recommended. 36.2% of immigrants did not experience a change in their skin condition after emigrating, while 15.5% and 27.6% reported that their skin condition became better and worse, respectively.

Table 2: Questionnaire responses (n = 65).

Question	n (%)
Type of allergic condition	
Food allergy	28
Asthma	6
Atopic dermatitis	48
Allergic rhinitis	19
Other allergic condition	9
Food allergy	
Egg	17
Cow's milk	4
Wheat	5
Bean	0
Fish's egg	2
Peanut	3
Shrimp / crab	3
Soba	0
Others	14
Frequency of hospital visit	
Once in 1-2 years	6 (9.2)
Once in 6-11 months	6 (9.2)
Once in 3-5 months	11 (16.9)
Once in 1-2 months	18 (27.7)
Once in 2-3 weeks	5 (7.7)
No regular schedule	19 (29.2)
Difficulties in finding doctors/allergists	
Very difficult	6 (9.8)
Difficult	19 (31.2)
Ok	23 (37.7)
Not difficult at all	13 (21.3)
Can you find time to come to the hospital?	
Very difficult	3 (5.0)
Difficult	8 (13.3)
Ok	20 (33.3)
Not difficult at all	29 (48.3)
Can you find a hospital for the treatment of your child's allergy?	
Very difficult	4 (6.7)
Difficult	8 (13.3)
Ok	20 (33.3)
Not difficult at all	28 (46.7)

Regarding understanding allergic diseases, 29 out of 59 respondents (49.2%) felt that they did not have adequate knowledge to take care of their children. 61.6% and 58.4% of the respondents had little to no knowledge of oral food challenge testing and oral immunotherapy, respectively. 73.8% did not know the finger-tip unit measurement for topical drug application and 41.7% did not know that water temperature adversely affects atopic dermatitis flares. 71.2 % of the respondents did not know AD medicine could be used prophylactically.

Parents were asked about the difference between Thailand and Japan. Most parents complained about language barriers conversing with doctors or purchasing medication or other products. Some Japanese creams or medications they are used to cannot be found in Thailand. Six parents reported that air pollution and water quality in Thailand worsened their child's skin condition. The tropical climate of Thailand has affected AD in two ways. The humidity reduces itchiness and rash flares, while the hot temperature causes perspiration and increases sweat rash. The accessibility of hospitals and specialists is easier in Thailand.

Table 3: Atopic dermatitis treatment knowledge.

Question	n (%)
Enough allergic knowledge to take care of your child.	
Not enough	7 (11.9)
Somewhat known	22 (37.3)
Enough	20 (33.9)
Plenty	10 (17.0)
Knowledge about finger-tip unit for application of topical medicine/cream	17 (26.2)
Have you heard about the proactive use of medicine?	
Very well	6 (10.2)
Somewhat known	11 (18.6)
Never heard of	42 (71.2)
Do you know if oral antihistamine helps with atopic dermatitis?	
Yes	32 (52.5)
No	18 (29.5)
Don't know	11 (18.0)
Oral food challenge test knowledge	
Very well	23 (38.3)
Somewhat known	26 (43.3)
Never heard of	11 (18.3)
Oral immunotherapy knowledge	
Very well	25 (41.7)
Somewhat known	22 (36.7)
Never heard of	13 (21.7)
Do you know that water temperature affects flare-up of atopic dermatitis?	
Yes	35 (58.3)
No	25 (41.7)

Discussions

Half of the parents felt they lacked sufficient knowledge to care for their children. Many respondents had limited knowledge of oral food challenge tests (61.6%) and oral immunotherapy treatment (58.4%). 26.2% were aware of the fingertip unit, 41.7% were unaware of the impact of water temperature on atopic dermatitis flare-ups, and 71.2% were unaware of the proactive drug use to prevent disease flare-ups. Notably, all respondents used bath water at a higher temperature than recommended.

Many patients with atopic dermatitis have a concurrent food allergy, but testing for food allergies is not required in all children with newly diagnosed AD.¹² Only 15 (23.1%) received oral food challenge tests and 7 (10.8%) were treated with oral immunotherapy. In cases of confirmed food allergy, patients are recommended to avoid specific foods. However, there is little evidence in current literature that dietary restrictions would improve AD symptoms in the absence of food allergies.¹²

Two major differences between Thailand and Japan, language and climate, are both points of concern for parents in our survey. Thailand's tropical climate can affect AD flares, which is why it is important for foreign patients to receive relevant treatment and preventative information. However, non-native language communication in important topics like healthcare issues can pose issues for foreigners. Not being able to fully understand the provided information can impact the correct use of medication or other products, therefore, using interpreters, providing translated brochures, and QR codes to resources or videos in Japanese are some ways to bridge the language barrier.

Although most respondents reported no trouble scheduling hospital visits, 41.0% encountered difficulties finding outpatient doctors or allergists. This highlights a treatment gap that can be reduced by hospital providers supplying patients with lists and locations of available doctors and specialists.

The main treatments of AD include topical therapy, immunomodulation and lifestyle modifications. In children, families hold a significant role in managing treatment, which means disease education is important for both children and parents. However, many parents expressed concerns about the long-term side effects of steroids and lacked information on the correct concentration, amount, and frequency of medication to apply. A previous study by Yamaura¹⁵ states "steroid phobia" to be a common issue in Japan, leading to inadequate topical corticosteroid use, exacerbating skin inflammation and itching.

Patient education regarding correct application of the medicine is critical to its successful use. One instructional method to appropriately apply the steroid cream is using a fingertip unit: the amount of medication covering the tip of the index finger to the crease of the distal interphalangeal joint of an adult finger.¹⁶ This amount is approximately 0.5 grams and should be used to cover an area of skin equal to two adult hands. This recommended method can be shown to parents to help ensure proper medication application to patients.

Current guidelines recommend that patients should avoid aggravating factors such as rough clothes, excessive sun exposure, hot temperatures, steam, and hot vapors. In this study, all the patients took a bath or shower with higher temperature than recommended, which is 27-30 degrees Celsius.^{2,13} Although 58.3% know that water temperature affects their children's symptoms, they still use warm bath water or set the shower temperature high. The Japanese lifestyle culture may be hard to adjust to despite moving to a warmer country like Thailand.

Present findings demonstrate knowledge gaps, concerns about treatment, and the need for better communication between healthcare providers and patients. A significant finding is that 49.2% of respondents felt they lacked sufficient knowledge to care for their children's AD. This as much as our other study findings demonstrates a substantial knowledge gap among parents regarding the condition. A notable percentage of respondents (71.2%) did not know that medication could be used to prevent AD flare-ups and 18.6% had little knowledge about it, totaling to 89.8% of respondents. These findings highlight the need for better education on preventive measures.

Multidisciplinary education groups can provide information on clinical conditions, treatment, and care providers options. The goal of these interventions is to improve patient-doctor or other health personnel relationships, which is the strongest predictor of adherence and achieving successful treatment.¹⁴

Conclusion

Many families of children with atopic dermatitis have inadequate knowledge about the disease. Giving accurate and useful information about proper care and a list of nearby allergists would provide benefits in taking care of the children.

Acknowledgments

Varatda Plainetr, Methasit Laochindawat, Naresrut Naruenatwanich, Masahiro Enomoto and Thanan Supasiri have no conflicts of interest or financial ties to disclose.

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Appendices

Appendix 1

The Questionnaire (translated from Japanese)

1. How old is your child?
2. Is your child a boy or a girl?
3. Where do you currently live? (Japan / Thailand / Other countries)
4. Your child was born in which country?
5. Which allergic disease (s) has your child been diagnosed with?
6. How often do you come to the hospital?
7. The information given in this questionnaire might be used for research purpose. Do you give permission to do so?
8. Does your child have food allergy, please specify?
9. Has your child had allergy test in the past?
10. If allergy test was done in the past, which method?
11. Have you heard about oral food challenge test?
12. Had your child had oral food challenge done in the past?
13. Have you heard about oral immunotherapy?
14. Had your child had oral immunotherapy (oral desensitization therapy) done in the past?
15. How difficult is it to find reliable doctor/allergist?
16. School lunch seem to be a problem with your child's allergy?
17. Do you find it difficult to prepare food that suits your child's allergy?
18. Do you have enough information to take care of your child's allergy?
19. Can you find time to come to the hospital?
20. How difficult for you to find a hospital for a treatment of your child's allergy?
21. Moisture (lotion) that your child currently uses at the moment?
22. Does your child uses any topical steroid cream now?
23. How often does your child use topical steroid?
24. What concerns you about topical steroid use? Please describe.

25. Do you know about finger-tip unit for application of topical medicine/cream?
26. Does your child currently uses Protopic (or other calcineurin inhibitor) or not?
27. Have you heard about proactive use of medicine?
28. Does your child take oral anti-histamine?
29. Do you know if oral anti-histamine helps with atopic dermatitis?
30. How often does your shower take a shower or bath?
31. How often does your child take a bath(ofuro)?
32. What temperature of ofuro/shower do you normally set at?
33. Do you know that water temperature has effect on flare up of atopic dermatitis?
34. Does your child have allergy to dust mite?
35. Does your child have animal allergy?
36. Do you have a pet?
37. For people who currently stay outside of Japan only: Does your child's skin condition change since you move to Bangkok?
38. For people who currently stay outside of Japan only: Do you have any downside or upside staying abroad compared to staying in Japan?

Appendix 2

The original 13 responses about steroid concerns were translated from Japanese to English by Google Translate.

1. Please clarify the amount and frequency to be applied. I'm concerned about the side effects of steroids, so I don't want to use them as much as possible.
2. Worry about side effects. Correct amount, frequency
3. I don't know the strength of the steroids in the drugs I got or bought.
4. That traces remain.
5. It is difficult to obtain information on safety and side effects, such as whether there is a problem with long-term use.
6. Nothing
7. I have been using it since I was born, but I am worried about side effects. I once stopped using steroids and only moisturized abundantly, but then my atopy got worse again,
8. The correlation between application frequency and side effects is not clear.
9. Appropriate amount of steroids and moisturizers to use at one time, when to stop
10. Nothing in particular.
11. Nothing in particular
12. Even if the eczema subsides for a while with steroids, it will return immediately.
13. I'm not sure

Appendix 2

Original 36 survey responses were translated from Japanese to English by Google Translate.

1. Because of the language barrier, it is difficult to understand the details even when visiting a hospital. Since the display of allergens contained in food cannot be read, it is necessary to use a translator, which is troublesome.
2. It is very helpful to have a hospital in Thailand that accepts me at any time of the week.
3. Some teachers have less knowledge of atopy than Japan, so I think it is important to choose a teacher.
4. I felt that the Japan was more advanced in allergy treatment.
5. Nothing in particular
6. Thailand is warm, so there are almost no nasal colds or bronchitis.
7. Epinephrine used during shock is prescribed in a syringe, not a pen type, so it is difficult to use. It can only be used by parents who have been taught how to strike.
8. It is good that the medicine is readily available.
9. The drug price is high.
10. I don't know which over-the-counter body soap or moisturizer is better or can be used for atopy. Some have a fixed minimum age, making it difficult to choose. Japan many products are more expensive, and it is difficult to understand which products are inexpensive and easy to use for a long time.
11. Maybe it's not so dry, or the skin doesn't itch much.
12. My son has been suffering from chronic allergies because of air pollution.
13. Poor water quality, poor air. Lack of communication with doctors.
14. Pros: Easy access to the hospital, even if you feel unwell at night, you can be examined Annoying: Language problems. I understand that it can't be helped, but sometimes I find it difficult to convey what I want to say
15. Nothing
16. I want you to continue to see your treatment and progress.
17. Nothing in particular
18. Just because it's overseas, I don't have any particular problems. The cream I use now will not be available when I return to Japan, so I am worried about what to use.
19. Knowledge level of the doctor Low technical level
20. Immediately taken to the hospital
21. Coming to Thailand, I feel like sweat rashes have increased. The doctor at the hospital introduced me to a moisturizer that suits my skin, so my usual skin condition has improved.
22. Thailand is more humid, so children's skin conditions are better.

23. There is no allergy label on the product packaging. I can't read the letters, so it's easy to buy if there is an allergy label for the ingredients used in 27 items. For children with crustacean allergies, Thai rice is scary.
24. The problem is that the water quality in the bath has deteriorated and the air quality such as PM2.5 has deteriorated. The good thing is that the hospital is easily accessible. When I lived in Japan, there was no dermatology department nearby, I couldn't find a reliable dermatologist, or it was unusually crowded to see a doctor.
25. I am concerned about the impact of water quality and air pollution on children
26. Emergency measures when staying far away and language barriers when visiting the hospital. In many cases, there is no awareness of allergies in the first place. As a result, there are things that the people in the shop do not understand. Since there is no change of seasons, it is good that there is no blurring of skin condition throughout the year.
27. Effects of PM2.5 air pollution on children's bodies. At Samitivej Hospital, I am indebted to Dr. Varatda and feel at ease.
28. The pediatric department of Japan is basically by appointment only, but in Thailand, you can go to a general hospital without making an appointment and see you immediately, which is very helpful.
29. Thailand is hot, so it is easy to sweat, itch and scratch. The room is dried by air conditioning.
30. The effects of water and air pollution are terrible.
31. I don't know which over-the-counter medicine to use, and I rely on the medicine prescribed by the hospital
32. The prescription amount of medicine is small, and there are many troubles because you run out of medicine before it heals, and you have to take your younger child (3 months) to get additional medicine before the next appointment.
33. If you don't collect information yourself, it's hard to get it
34. I don't know the allergy label of commercially available ingredients (because I don't understand Thai)
35. Sometimes I wish I had the medication prescribed by my Japan. The content of the drug was a mixture of Locoid ointment 0.1% and Propet. I applied this medicine all over my body every night to help moisturize. The good thing is that they prescribe Elidel (cream) and cleaning agent (body wash) to use in the bath.
36. It gets worse when you go to Japan, gets better when you come to Thailand