Incorporating New Atopic Dermatitis Medications in Your Practice

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The landscape in atopic dermatitis is promising with many new studies addressing topics such as prevention, therapeutics, and genetics. Herein, tips are provided on managing patients with the currently available therapies, dealing with side effects and steroid phobia, and giving patients and parents/guardians the information they need.

What advice do you give your patients today?

There is more scientific data supporting educational intervention with an eczema action plan as the core of prevention and therapy. Early institution of emollient therapy is preventive of approximately half of atopic dermatitis (AD) cases. Application of emollients immediately after bathing is best for improvement of skin hydration. The art of medicine is deciding how to pick emollients with patients. It is important to avoid patient's allergens, but ultimately the choice comes down to cold weather petrolatum and warm weather thick lotions or creams.

Therapy must still be individually tailored. Head and neck disease is best treated with nonsteroidal agents including low-strength topical corticosteroids and calcineurin inhibitors that have a black box warning, both of which have a track record of efficacy in the care of AD. A newer option is crisaborole, a topical phosphodiesterase inhibitor, which is an alternative for childhood and adult AD. For the body, any of these agents can be used comfortably, but often a mixture of topical corticosteroids of various strengths is chosen to address different sites of disease. When topical corticosteroids fail, the usage of systemic agents or phototherapy may be appropriate. The new prescription injectable dupilumab is approved for adults with AD and therapies such as these will hopefully soon be available for children with severe disease who need intervention to improve their quality of life.

How have you integrated new medications? How do you deal with side effects?

For all the therapies that truly work for AD, there are still many patients with limited to poor response on standard regimens and I offer them newer options and I also review their old regimens. Many patients believe they will be cured in 1 to 2 weeks and stop ongoing care. Counseling on the recurrent and relapsing nature of AD is important. On the other hand, I have AD patients who believe they had or truly have steroid sensitivity including allergy or withdrawal syndromes. I have seen topical steroid atrophy in this setting due to lack of intermittent discontinuation. Other situations in which topical steroid side effects are common in my practice are in the application sites of the thigh and calf in teenaged girls and the chest in teenaged boys, sites where striae are not uncommon naturally during adolescence. In these settings, confirmation of allergy via patch testing may be helpful and offering nonsteroidal agents can allow for remission of disease. Side effects with nonsteroidal agents are common but usually mild including pruritus, burning, and stinging. It is common for these symptoms to dissipate with time; therefore, preemptive education is vital (ie, stopping and restarting a day later) as well as avoidance of application to recently washed skin and limited application initially. Steroid pretreatment sometimes aids in acceptance of a nonsteroidal agent.

What information do patients want to hear?

Patients and guardians believe there has to be a cure for AD and that it will be dietary in nature. They hope I will provide an avoidance diet that will rapidly clear the disease, which I wish was true. In reality, the nature of current research is such that long-term remissions and possible cure do lie on the horizon but today are not readily available. No one can bypass good skin care and the current treatment paradigm. Withdrawal diets may cause malnourishment in children and should not be undertaken without proof of allergy.

How do you deal with steroid phobia?

Steroid phobia has become a hot topic but has existed since the advent of topical agents. Steroid phobia can

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cause nonadherence and poor outcomes. In reality, many topical steroidal agents have good testing and approvals in younger children. Fear is a powerful motivator and hard to break. Therefore, parents/guardians may reasonably opt for nonsteroidal care, which is a fine option when it works. Although little data on real-world combination usage of nonsteroidal and steroidal agents exist, combinations in my practice often enhance clearance.

What patient resources do you recommend?

Quoting study data may be beneficial. One of my favorite studies is historic comparative data of hydrocortisone cream 1% and mometasone furoate cream 0.1% in 48 children with moderate to severe AD (Vernon et al). At completion of the study, mometasone performed better in clearance and the only patient who developed hypothalamic-pituitary-adrenal axis suppression was in the hydrocortisone arm. I use this study to explain to parents why a prescription-strength agent may produce better results with fewer side effects.

Online snake oils abound in AD and the sources for solid information I choose are the websites of the National Eczema Association as well as academic organizations such as the American Academy of Dermatology and the Society for Pediatric Dermatology. Membership in support groups and participation can help parents/guardians and children alike and allow access to early clinical trial data. I sometimes ask parents/guardians to review manufacturer websites to specifically look for quoted clinical trial data. Although all clinical trials are not equivalent, many better eczema care manufacturers have numerous clinical trials in support of their agents, which should give a parent some enhanced comfort level.

SUGGESTED READINGS

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