LEARNING OBJECTIVE
At the conclusion of this activity, participants should be better able to:

- Answer common patient questions about the course of atopic dermatitis (AD) and effective strategies for treating its symptoms

LAWRENCE F. EICHENFIELD, MD: I’m Dr. Larry Eichenfield, Professor of Dermatology and Pediatrics and Chief of Pediatric Dermatology at Rady Children’s Hospital. Welcome to this discussion of frequently asked questions about atopic dermatitis. I have great co-faculty.

JONATHAN I. SILVERBERG, MD, PHD, MPH: I’m Dr. Jonathan Silverberg, Assistant Professor of Dermatology, Preventive Medicine and Medical Social Sciences at Northwestern University Feinberg School of Medicine.

WYNNIS L. TOM, MD: And I’m Dr. Wynnis Tom. I’m Associate Professor of Dermatology and Pediatrics at the University of California, San Diego.

DR EICHENFIELD: I now will take the role of the annoying patient who has lots of questions. Question 1. “The pharmacist told me to only use a little bit of my medicine. What am I supposed to do?”

DR TOM: We realize underuse of medications occurs often, especially when we ask patients and parents to bring in the tubes and we see very little has been used despite months of treatment. There are a couple of ways to help guide patients about this. One strategy I like to use is the fingertip method. The amount of cream that you put at the edge from the last joint to the fingertip should be enough to cover 2 palm-sized areas of involved skin.

DR EICHENFIELD: I usually say, “I want you to use an 80-gram tube during the next week or two weeks” – depending on the size of the patient – “and bring
it back because I want to look at it.” When I’m doing initial disease control I give them a certain quantity of medication and I say, “You could probably use that for 2 months without a problem, but we’re going to guide you through that.” I’m trying to establish what a safe quantity of use is over time so they’re not nervous. Jonathan, any tricks?

DR SILVERBERG: Often when dealing with adult patients who have a much larger body surface area, it’s hard for me to even anticipate fully what that quantity will be. Especially if I’m giving a patient a 1-pound jar of a mid-potency topical steroid, I try to give them a realistic expectation of how it should look when they apply it. The idea is that, if they rub it in totally and they can’t see it anymore, they’re probably not using quite enough. You want to see a visible shine to know that you’ve applied a high-enough quantity. That strategy tends to work fairly well and is eye-opening to them, because often they think they’re supposed to rub it in to the point where they don’t see it or feel it anymore.

DR EICHENFIELD: Next question: “How long should I use my medication for?”

DR SILVERBERG: I get this question a lot: “Doc, how long am I going to be on this medication?” It really depends. For patients who have more episodic disease, you can use a topical medication for 3 or 4 weeks and be done with it. And you may be off the medication for the next 6 months until the next flare. But for patients who have more chronic disease, I often will tell them, “I don’t have a crystal ball. I don’t know when this flare will burn out. It might burn out, we hope it will, but until that time you need to know that you could be on a treatment long-term.” When I recognize that the patient will need a long-term approach, I develop a treatment strategy that would be safe for that period of time.

DR EICHENFIELD: “Will the eczema ever go away?”

DR TOM: Another good question. In many, yes, it will go quiet. We know that 25% of kids in the US have atopic dermatitis, but only several percent will continue to have it as adults. Somewhere along the way the inflammation diminishes. Typically, these individuals still end up with some sensitive skin that will need moisturizers. It’s hard to predict. You have to watch and see what the course of disease is for each child. Even mild disease can go on for a while. Hopefully some of our severe patients will not be affected for long, but certainly some have long-term chronic disease as well.
DR EICHENFIELD: One of the pleasurable things we’ve seen with some of our systemic therapy patients who have very severe pediatric disease is that over time the disease burns out. They may not be totally disease-free, but they have pretty mild disease down the line. It’s going to be exciting as we do more aggressive early therapy with newer agents to see how that strategy mediates the course over time.

DR SILVERBERG: What gets a little tricky sometimes is that active disease will calm down, but some of the symptoms – the winter itch, the dryness, the intolerance to wools or heat and sweat – may persist for life. It’s important to encourage patients to maintain those good skin-care habits, even when the disease has cleared. Avoiding irritants and using cleansers and the moisturizers continues to be necessary as they enter adulthood, even with their milder burnt-out disease.

DR EICHENFIELD: Another common question is: “How frequently should I bathe?” I’ll take that one.

I typically ask the family whether they ever gotten conflicting information on this. Because I know that’s a common problem. Sometimes they’re told “Don’t bathe ever,” while others will tell them “You should never leave the bath.” In some cases, the advice varies depending on geographic location, such as in areas with different levels of ambient humidity. Some experts recommend avoiding bathing because they figure that bathing will dry out the skin. Others find that bathing can help hydrate the skin and also increase the penetration of topical medicines.

We have done quick studies, both in atopics and non-atopics, that show that if you bathe and then moisturize, either immediately afterward or even with a delay, then you end up with better hydration levels than if you didn’t bathe. But if you bathe and didn’t moisturize afterwards, you actually ended up a little bit drier. And if you didn’t bathe and just moisturize, then you end up with the longest hydration for over several hours. The bottom line is that there’s variability. From an evidence-based standpoint, the guidelines for atopic dermatitis from the Academy of Dermatology are basically are not prescriptive. If you’re following a good regimen of care otherwise, it probably doesn’t matter whether you’re bathing daily or every other day, which is probably what most experts recommend. But most experts do not recommend general avoidance of bathing. Is that fair to say?

DR SILVERBERG: Right.
DR EICHENFIELD: “Can atopic dermatitis start in adulthood?”

DR SILVERBERG: It’s a great question. There’s some controversy around this point. A number of studies show very high rates of self-reported adult onset of atopic dermatitis. The tricky part, though, is that perhaps these patients had atopic dermatitis as infants and totally forgot about it. Or the disease was so mild that it wasn’t even recognized early on. This would not be a true adult onset, but more of an adult recurrence. To me this is largely semantics; it doesn’t matter that much. The key point is that you can have a patient who has no recollection of any childhood or adolescent disease and who shows up in an office in their thirties or later with some really severe atopic dermatitis that meets all clinical criteria. In such cases it’s important to rule out things in the differential diagnosis, such as contact dermatitis or cutaneous T-cell lymphoma. But if you’ve done that, you don’t have to biopsy them 30 times, because at some point you can accept that, yes, this is atopic dermatitis and can then manage them appropriately. And that will become more important as we move forward with more targeted approaches. You want to be comfortable in the diagnosis, but you also have to be able to say, “Look, this is atopic dermatitis that would benefit from some of these newer treatments.”

DR EICHENFIELD: Last frequently asked question: “How do I figure out what food is causing my child’s atopic dermatitis?”

DR TOM: Another common question that we get. It’s important to take the time to explain to patients and parents that, not infrequently, food allergies co-occur with atopic dermatitis, but that doesn’t mean the allergy necessarily drives eczematous lesions. You can have hives, you can have swelling, you can have gastrointestinal symptoms, or you may have nothing, depending on what type of test is used. It’s important to clarify that you can have allergy, you may have reactions, and to determine if that is related to the eczema or whether it’s a separate concern. I usually tell my parents and patients to try to keep a diary. There are many different things that you can look for and test for, so you want to look for things that are relevant. For example, you should only consider the foods that they are actually eating. It doesn’t matter if they have an allergy to a food that is not part of their diet. You should also look for things that they think are repeated potential triggers. It’s easier when you have negative tests. If you have a negative serum IgE test or skin prick test, then you know that something is not causing an allergy or atopic dermatitis. It’s the positive tests that require a lot of analysis.
DR EICHENFIELD: There’s a real sea change in the allergy world now because, for a long time, allergists would do serum IgE testing or skin-prick testing and label someone as allergic, and then try to avoid the food as a way of fixing the eczema.

The question of peanut allergy comes up often. There have been clinical studies on children who had skin-prick tests, and even if they were positive – unless they had large wheals, 6 mm or higher – they were fed peanut products as a way to prevent peanut allergy. And those patients appeared not to have exacerbations of their eczema, as compared to if they avoided peanut. So the outcome of the eczema wasn’t affected. The new NIAID guidelines recommend that approach. That fail strategy makes sense. Food may still be important in sensitizing some individuals in the establishment of atopic dermatitis. But it’s a common question and it’s certainly a tricky one to deal with because we don’t want to have everyone get broad allergy testing. The utility of a positive serum IgE in those big studies that were done around the peanut was actually less predictive than they thought before. Approximately 25% of the time, serum IgE is associated with a real clinical allergy.

DR SILVERBERG: I think it’s also important to understand the limitations of any diagnostic test. We know that IgE levels are not at all a biomarker for atopic dermatitis. But if you look back to some of the old NHANES data from 2005, they found that if you were to randomly sample people and do skin-prick testing, 1 in every 2 people in the general population would test positive for at least 1 allergen. These were patients who had no any history of problems. The technology has gotten a little bit better over time, but we know that those false positives happen all the time. And in our atopic children and adults, they have whopping high levels of IgE that are often irrelevant. If you go down that road of doing skin-prick testing or IgE testing, you’re going to find many people with positive results. Such findings may mean nothing, but now you’d have to follow up and put them on these restrictive diets and so on. That poses its own challenges.

DR EICHENFIELD: Clinical history is really crucial. We need to educate families so they understand these complicated issues. Yes, children with atopic dermatitis have a higher risk of real food allergy, but that allergy may not necessarily be the driver of the disease.

I hope you enjoyed our answers to some frequently asked questions.

Faculty Disclosures

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