Transcript Details

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Are You On Top of Pediatric Atopic Dermatitis? Expert Guidance for Leveraging the Latest Advances in Systemic Therapy

Announcer:
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Wendy Smith-Begolka:
Our first panel discussion is going to be, how do patient- and caregiver-reported outcomes inform your assessment of pediatric patients with atopic dermatitis in terms of what standardized questions or tools you might use and other questions you might ask? And I'll start with Dr. Swanson as our pediatric dermatologist. So how would you answer this?

Dr. Swanson:
So I think most of the time in clinic, I just have a discussion with the patient and their family about how the eczema is affecting them as a family unit. How is sleep? How is school? How is work? How are friendships? Are we going to sleepovers? Are we playing the sports that we like? What is the true impact of the atopic dermatitis? And is the current regimen that we're on helping to control and normalize that, or are we still struggling?

I think if I use a standardized tool, I probably use the ADCT, the Atopic Dermatitis Control Tool, which is just 6 questions that the patient and their family answer about kind of the state of control of their eczema. But most of the time, I'm a conversation girl.

Wendy Smith-Begolka:
Sounds good. And Dr. Lio, how would you answer that?

Dr. Lio:
I really like the conversation part, too. In the last few years, I've become a bit of an evangelist for this special tool called the Atopic Dermatitis Control Tool, or ADCT. And I really love it because it gives a little bit of structure and gives us a number at the end that I find a lot of my patients really, maybe they didn't even expect to like it, but now they sort of talk about it when they come in and they tell me the update, because they can do it themselves, too, but it really gives just a little structure to that conversation. I never thought I would say that about a tool like this, but this one has kind of stolen my heart.

Wendy Smith-Begolka:
Gotcha. And so how do you think—because you both mentioned the Atopic Dermatitis Control Tool, how do you think that that has allowed you maybe to get a sense of disease progress or maybe regression over time?

Dr. Swanson:
Go ahead, Dr. Lio.

Dr. Lio:
Yeah. I'll just finish my thought with this. What really has been interesting for me is that sometimes a patient will come in and say, you know, how are you doing? How are things? And they'll be like, 'oh, I'm pretty good. Everything's pretty good,' and it looks pretty good that day, so maybe they're feeling good. But then I ask these questions, and by question number 3, they're kind of like, 'oh, maybe I'm not that good.' And I've had some patients start to cry and say, 'you know, I thought I was feeling pretty good today, and I maybe I am, but you're right, in the last few weeks, and especially this last week'— because that's really how the ADCT is structured, it's like— 'I actually have had some hard times still, so maybe I'm not out of the forest yet.' You know, we're still, we're still sort of in some trouble. So I think it can be enlightening from that perspective.

Dr. Swanson:
And I think to that point, a lot of patients come in, and maybe they've been started on a novel topical or their first systemic agent, and they are improved from where they were at. And so to them, that feels like, 'wow.' But they might not fully realize the impacts that are kind of hiding that they're not even thinking about because they have been solely acclimating to the burden of atopic dermatitis during their disease course.

Sometimes I think that, you know, there's that analogy that you can burn to death in a slowly heating bathtub, and I think eczema can be that slowly heating bathtub for a lot of families, because they just don't fully realize the impact. So you make that a little bit better, and they're pleased, but then you point out the other impacts that are still a problem with something like the ADCT.

Wendy Smith-Begolka:
That's so interesting, pointing out the things that even maybe the patients or caregivers aren't appreciating. And so Dr. Swanson, maybe can you elaborate a little more, is there a particular aspect that you think is most often overlooked?

Dr. Swanson:
I mean, I tend to focus a lot on sleep, both for the patient and their family members, because if one little kid has eczema in the family, the entire family unit suffers. And sleep is so important for so many things. So I dive into that, and I think most families are aware of the impact on their sleep.

I think one thing that's probably overlooked by families until we start talking about is the impact of eczema on growth? We know that kids with bad eczema tend to be small on growth curves for height, and there are a lot of theories as to why. I subscribe to the theory that it's due to poor sleep. So when you have eczema, you don't sleep as well, and you don't enter REM as long or as often, and it's during REM sleep that growth hormone is secreted. So physiologically, these kids have lower growth hormone, and so if you make that better, then you allow them to grow. And I found that talking about growth is a needle mover, if you will, pun intended, when talking about potential systemic therapy for atopic dermatitis.

Wendy Smith-Begolka:
That's super interesting. Dr. Lio, anything to add on that?

Dr. Lio:
No, I think that says it all. I love it.

Wendy Smith-Begolka:
Wonderful. Well, thank you both for that first brief panel discussion, and I think that that's a great lead-in to the next section of our presentation today, which is on leveraging patient- and caregiver-reported outcomes to address the burden of pediatric atopic dermatitis.

And we're going to go ahead and start with a poll again, which is around which of the following statements is a myth regarding the real-world burden of pediatric atopic dermatitis? Is it A, children with moderate to severe AD often experience sleep disturbances due to nocturnal itching. Is it B, caregivers of children with atopic dermatitis frequently report minimal interference with daily routines and emotional well-being. Or is it C, the impact of pediatric AD extends beyond physical symptoms to include social and psychological challenges for both the patient and family. Go ahead and cast your votes, and this is which one is the myth.

Okay, so we've got about 66% correctly identifying the myth here, which is that the caregivers of children frequently report minimal interference. And that is definitely, definitely the case here. And let's talk a little bit more about that here on the next few slides.

And so the burden of atopic dermatitis is definitely multidimensional, and you've heard our panel members already speak to that a little bit today. And it's something that can affect really every aspect of an individual's life, with much of it being unseen and only really able to be ascertained from the patient or caregivers' sort of self-report.

And so by far and away, the most burdensome symptom of atopic dermatitis is reported in numerous studies, and if you got a group of

patients together, I'm confident you'd hear the same thing: it's going to be the itch. And it gets this rank because the impacts of itch are really 24/7 and really sort of lead to a number of other downstream impacts that are shown by example in this slide. And it certainly starts with the itch, leading to scratching and leading to open sores or wounds and to the sleep loss. And we've touched on that a little bit, but it then can kind of continue down this cascade and have a lot of different interrelated impacts on their life as well as culminating in impacts to their mental health as well.

And so in the next few slides, we're going to highlight some of these aspects in a little bit greater detail.

So starting first with looking more quantitatively at itch per se, as you might suspect, with increasing disease severity, as shown by the sort of stoplight colors here of green, yellow, and red, you can see that, as with increasing disease severity, you can see that itch goes sort of up and to the right. This is actually looking at the pruritus numeric rating scale on a 0 to 10 scale. And you can see that for the most severe of individuals, you typically are getting scores anywhere above 6, 7, upwards of even closer to 10, and that really is sort of holding regardless of what age of patient that you're looking at or caregiver report.

And so—but even for those with mild disease, I want to point out as well that the amount of itch that is shown here is certainly lesser by comparative to moderate or severe disease, but it by no means is considered minimal in the broadest of senses when looking at it from a patient burden perspective.

When we also look at beyond itch, one of the things that was highlighted on the slide is that you can also get skin pain from itch, but you can also have skin pain in and of itself as a symptom. And this is something that has become to be appreciated as a slightly sort of newer aspect of understanding the patient burden of disease.

But once again, regardless of whether we're looking at mild or moderate or severe disease, you have the same sort of up and to the right with increasing severity, you have increased patient report of this symptom, and you have increased severity of this particular symptom. And again, this one is using a pain NRS scale instead of the pruritus NRS scale, but the same intention still holds.

When we look at sleep, this one is looking at it slightly differently. And as you might again suspect, that higher and/or increased atopic dermatitis severity is associated with more frequent sleep disturbance. This is both not only the level of sleep impairment from a standpoint of getting to sleep but also staying asleep. And it can be quite profound. If we focus really on the, I would say, sort of the orange and the purple aspects of this graph, you can see that, you know, definitely upwards of 70% of individuals that have severe disease are saying either every day that their sleep is affected or at least 5 days out of the week their sleep is affected. This goes commensurately down with disease severity. But again, I think you can see with even with individuals that have mild disease, they're having some sleep effects and sleep impacts on their life.

And as Dr. Swanson indicated, you know, this lack of sleep is actually compounded for individuals in the pediatric population, for the caregivers, because when the kids don't sleep, the parents aren't sleeping. And what I really appreciate about this slide is that the quotes on the right-hand side convey, you know, in a more qualitative way, you know, from the perspective of a patient or caregiver, you know, the stark reality of what it means for affected individuals and what it means to not have sleep, which can have a lot of downstream effects on their personal life as well as their social life, which then takes us to more of a sense of quality-of-life impact.

So this is a very broad category, but again, essentially what you're seeing using the same sort of stoplight approach is sort of that up and to the right. This is actually looking at the CDLQI, which is the Childhood Dermatology Life Quality Index, where anything that's a score above 13 means that they're having a very or extremely significant and negative effect on their quality of life. So again, not surprising that those that are in the moderate and severe camp are definitely well above that scale, but those that are on—even in the mild section of it, in the green—can have individuals that are approaching a more significant impact to their quality of life. And this severity is also associated with other tangible impacts, such as increased school absences, especially for the pediatric population.

And then as we look beyond sort of the physical aspects of things, you know, we're moving into the space of mental health in this slide. What this slide is showing is that there can be significant stigma that is attached to having a visible skin disease like atopic dermatitis. And so if we look at the data on the right, but I'll just read the bullets that are on the left, you know that adolescents with atopic dermatitis actually experience an increased frequency of bullying compared to those without atopic dermatitis, and that children with this skin disease are actually reporting, you know, discrimination related to their visible symptoms. They can have fewer friendships or challenges with forming friends and having different abilities to engage more socially, because they also can choose to have decreased school and extracurricular involvement. So sort of that external stigma actually compounds some of the internal stigma that these patients are also experiencing, really resulting in atopic dermatitis often being a very isolating disease for individuals.

And then while we've also talked about, sort of, now, the burden of physical disease, we talked a little bit about the burden on mental health, you know, this is looking at the burden of treatment, at least a little bit, both from a time perspective, but also the concerns about

using certain therapies. And this is talking here specifically about the burden of using topical corticosteroids. We know that this is a very commonly used therapy, and it certainly has its place in atopic dermatitis care. Later, we'll hear about other options, but there certainly is a lot of anxiety amongst the caregivers and amongst children that are using different topical corticosteroids, whether it's about using them for the long term, or concern about side effects or how well they're going to work.

And then, as we've already touched on, you know, while we're talking about the patients and the caregivers, collectively, this slide is really focused on the impact of atopic dermatitis on caregivers, and they can have a very similar profile of burden of disease, but as we've been talking about, you know, atopic dermatitis, when it affects a pediatric patient, can be something that really is affecting the whole family unit. You know, so you have disruption of family time here. We've already talked about loss of sleep, but can have other sort of tentacles, if you will, into the family life, with leading to different aspects of financial worry, care coordination, work productivity, and then other relationships between other members of the family as well, when so much attention and focus is given to the child who is affected.

And so sort of coming back then to where we started, you know, there are a number of different ways that these different elements of burden can be captured in clinical practice. Several of those tools are shown on this slide specifically and were highlighted in some of the previous slides. And the idea here is to pick one that best picture your practice best and can help you really identify opportunities to work with your patients, to understand how these tools can be useful adjuncts to asking other questions, as Dr. Swanson indicated, to align on the progress that they might be making with treatments, or how to uncover different unseen aspects of the disease burden and ultimately align on therapies that are going to work best.

Okay, so with that, we're now moving to our posttest question, our first one here, which is that now we have a 7-year-old child with atopic dermatitis who presents with worsening pruritus and sleep disruption despite ongoing topical therapy, the caregiver reports increased emotional distress and absenteeism from school. Which of the following tools would best support shared decision-making about advancing therapy? Is it the IGA, the Investigator Global Assessment? Is it B, the Eczema Area and Severity Index, the EASI score? Is it C, the Patient-Oriented Eczema Measure, or POEM? Or is it D, the SCORing Atopic Dermatitis, or SCORAD? Please enter your answer.

Okay, so how do we do? Still a little all over the place with this, but the majority of individuals got the correct answer, which is our POEM score, because this is a validated patient-reported outcome tool that is going to capture our symptom severity from the patient or caregiver's perspective over the prior week. And so it's going to focus on those quality of life issues that we've talked about: itch, sleep, and a few other things. And so it really is very helpful. And in contrast, some of the other tools are really more clinician assessed, and may not fully capture that burden, but they can still be very helpful for sure.

So with that, I think we are going to move to our next panel discussion. Here we go. I invite Dr. Lio and Swanson to come back. Wonderful. And we're going to start to talk about a few different questions that are on the slide here around different therapies that we might be using for children with atopic dermatitis based on some of the burdens that we've spoken. So let's talk first about some of the limitations of topical therapies for children with atopic dermatitis. And this time, let's start with Dr. Lio.

Dr. Lio:
So we know that topical therapies, they're really the keystone of all the treatment. We're going to start everybody on them first. And when we move to systemic, sometimes you'll hear people say, ‘oh, like once you're on the systemic therapy, now you can stop your topical.’ No way. Like, your topicals are still important. Now, ideally, you're going to be using them much less and maybe less potent ones and stuff when you're on the systemics, but they're still really important.

That said, there's a lot of limitations. Sometimes it's just too severe, like, I'll try even pretty strong topicals, and it's like not budging, it just laughs at it, or it doesn't do enough.

The second situation is, when it's too much body surface area, it's really hard to consistently put medicine on more than, I would even say more than 20% of your skin, 30% for sure. You know, you're putting stuff all over the place, and it really gets tiring for patients and families.

And then the third piece is the limitation for especially our topical steroids, and frankly, our topical JAK inhibitor as well, the ruxolitinib, is they really have sort of a time limit on them. You can't consistently, continuously use those. You should take breaks. Some of the other ones are okay, but all these are limitations that make it tricky.

Wendy Smith-Begolka:
So Dr. Swanson, given all of those limitations, when would you be considering a systemic therapy for a child with atopic derm?

Dr. Swanson:

Well, and I would even throw two other limitations that kind of lend itself to thinking about systemic therapy. Number one, burning and stinging. So a lot of patients with atopic dermatitis have tactile sensitivities, and a lot of things will burn and sting, which makes topical therapies just really hard to manage.

The second thing is families that feel like they're playing a game of Whack a Mole, so they get the eczema cleared up over here, and then, lo and behold, it pops up over here, and they just never feel like they're getting ahead of it.

So I think anytime optimized topical therapy is not achieving milestones, I'm going to talk about systemic therapy. And that boils into a lot of things, like how it looks in the office, the patient-reported, you know, symptoms of itch and sleep and school and sports and all that kind of stuff, and then what therapies that they've tried and failed?

Wendy Smith-Begolka:
And so you mentioned something really interesting there, just about optimized topical therapy. So how are you assessing that for your patients?

Dr. Swanson:
I think it's a lot of patient-to-patient dependent. You know, I'm making sure that I talk about the importance of sensitive skin care, that I don't forget to talk about that. And then I talk about the topical therapy options available to them, given age and severity of their atopic dermatitis. And we've kind of selected a good combination, or a good one or two topical therapies. And then I see them back, and they're just still not getting there.

And I actually had a patient just today that I was talking to Dr. Lio about before we started, where I had him, he had had atopic dermatitis for years and years and years. He's 13 now. It started when he was about 1 year of age, and he had been through all the topical steroids and wet wraps and topical calcineurin inhibitors and even prednisone intermittently, not by me but from other people. And then I met him for the first time 8 weeks ago, and I talked to them about some of the new-level topicals, because he only has about, I don't know, maybe 10, 12% BSA. And so we chose topical ruxolitinib, and I saw him back today, and it hadn't budged at all, which is surprising, because topical ruxolitinib is quite effective. And so you put your brain through the paces of, Am I sure this is atopic dermatitis given that failure? Yes, it still looks like atopic dermatitis. And so we talked through all the systemic therapy options, and we picked one, and we started it today, and hopefully it'll yield the positive results we're looking for.

Wendy Smith-Begolka:
Yeah. That's great, and appreciate you sharing that recent experience as well. And so with that, maybe we'll go ahead and transition over to Dr. Lio to tell us a little bit more about systemic therapy in children with moderate to severe atopic dermatitis.

Dr. Lio:
Thank you, Wendy, so much. Yes. So this is when things heat up to a certain level, we need to go to that next step, but let's do some polling questions first. Which of the following is a myth about targeted systemic therapies in pediatric atopic dermatitis? Would you say A, targeted systemic therapies are generally considered for children with moderate to severe disease who have failed optimized topical treatments; B, all children with AD are eligible for targeted systemic therapies, regardless of disease severity or prior treatment history; or C, clinical trials have demonstrated that targeted systemic therapies are safe and effective in pediatric populations.

Okay, good. So a lot of people picked the second choice, B, as the myth, and I think that's pretty good, because we know they're not really designed for all severity levels or prior treatment history. We really want to make sure they've used some of those things. So I think that's correct answer. Excellent.

Okay, we know that when we look at the whole population, it could be as high as 1/3 of the pediatric patients with moderate to severe atopic dermatitis. Those patients seem to be inadequately controlled with topical therapies.

And honestly, one of the interesting things, it's a bit of a moving target. I think our threshold continues to get lower and lower to switch somebody up to systemic. You know, 15 years ago, we had nothing, so I think we were kind of like, well, you're doing okay. I don't think we want to put you on an off-label immunosuppressant. It was a much bigger deal, much bigger risk-benefit trade-off. But now, when we have safer, more targeted treatments, it's like, well, we can do better than this, and I think we can actually change the calculation for these patients.

But we know there's a pretty sizable group of kids out there that are not doing as well as they could be. Why does that matter? Well, it matters because they're suffering, right? They're really miserable, and it affects everybody, as you've heard. So it's not for fun. It's not a cosmetic thing. You know, we're not trying to put it in the water or sell something. We're really trying to get these patients to a point where they're comfortable.

And I think that discussion has to happen between patients and families and caregivers. It's a real shared decision-making thing.

And I never push. I always tell families, I meet a lot of families who kind of feel hesitant about especially stronger treatments. And they're like, 'We're afraid, we don't want to do this. Do you feel like we need it?' And I'll say, you know, our main piece is when we've done a good job with our topicals, but we really feel like we're still struggling, we're having especially sleep issues, especially potential for recurrent infections, these are big deals.

So I put take all this into account. We look at the severity of disease, and we have a heart-to-heart and I never push. If they don't want to do it that day, then I'll say, You know what, why don't we see how things go? We can make some tweaks. We can re-optimize topicals. And I'm like, you come tell me when you're ready. And a lot of the family, sometimes they'll call me that night and say, 'You know, we've been thinking about it, and we really do think we're ready,' especially around bedtime, when the kid is scratching and uncomfortable, and they're like, 'All right, we really, we've done our best.' And again, I'm old enough to tell you that there was a period when we really didn't have great answers, at that point, where we just sort of said, well, good luck. And now I'm so happy that we do.

So when we think about this in general, we're really trying to use as little systemic therapy as we can. We're not trying to overdo it. We're always using our adjunctive therapies. I often talk about a finite timeline. And some of the companies get mad at me when I say this, like, the pharmaceutical companies will say, 'Well, we really like to think of it as a chronic treatment.' I'm like, I get it, like, I understand your perspective. Let me tell you my perspective and the patient's perspective, that this is a disease of vicious cycles.

So my dream here is to break the bad cycle, the vicious cycle that we're stuck in, itch, scratch, skin barrier, damage, dysbiosis, sleep problems, break that cycle, go to a virtuous cycles. Healed skin Barrier, better behavioral patterns, better sleep, better microbiome, right? And then at some point, maybe 6 months, maybe a year, maybe a few years, it just depends, there's a potential for getting rid of these systemic agents or spacing them out. In fact, some of them, as you'll hear about in just a couple minutes, they actually have a built-in plan to increase the dosing interval, less medicine over time. That's what I'm talking about. So that's really what we're thinking about.

One thing I think everybody agrees with is that we want to avoid systemic corticosteroids. I meet lots of clinicians who say, 'Oh, we do it all the time, prednisone, prednisolone,' we really don't want to do those unless we're up against a wall. They have the potential to make things worse, and that's why it's a little bit of Russian roulette.

And of course, we had a lot of agents that we used historically prebiologic era, like cyclosporine, azathioprine, methotrexate, mycophenolate. These are fine medicines, and they can help. I've used many of them over the years, but they are really a bad risk-benefit calculation in general. They're things we don't want to do. Look at azathioprine and methotrexate, 8 to 12 weeks to kick in. We know all of these have multiple boxed warnings. They're troublesome for a lot of patients. So I really try not to use them. Do I still use them sometimes? I do. I run out of options even today.

But now we have an abundance of great things from dupilumab, which came out in March of 2017 in the US, tralokinumab, sort of its cousin that binds to IL-13 and its more recent cousin, lebrikizumab, they kind of both work similarly on blocking IL-13. Dupilumab blocks IL-4 and IL-13 receptor, that shared subunit called IL-4 receptor alpha, and then, most recently, nemolizumab, which is kind of neat, because that binds to the IL-31 receptor, the master itch blocker. So that's kind of nice.

And then, of course, we have our oral JAK inhibitors. In the US, we have two of them, abrocitinib and upadacitinib. Baricitinib we have for alopecia areata, and that's available in some other markets for atopic dermatitis.

So this is kind of a lay of the land. This is the landscape of our treatments, and this is incredible. And everything really started in 2017, so less than a decade, essentially 8 years, where we've really had all of this stuff, and it is coming fast and furious. The guidelines are getting outdated basically as soon as they come out.

Now, are any of these perfect drugs? No. Is there such a thing? They all have real potential issues. They all have real potential drawbacks, but they also can be incredibly helpful. And I think all of us can attest, these have literally changed the lives of so many patients, and have altered the field of atopic dermatitis, how we approach it. And again, I say it as somebody who really gets to straddle the line between pre biologics and post biologics. It is a brave new world. It's incredible.

So dupilumab came out in 2017 in the US. Really impressive improvement in these patients. And then it got approved down younger and younger and younger. And now it has a very cool distinction. It is approved down to 6-month-old babies, which is incredible. And it has one of the lowest indications. The other biologics are actually all approved down to age 12 years. So dupilumab goes all the way down to 6 months, which is really great for the kids.

So tralokinumab, quite similar, even though it binds slightly different. So dupilumab binds IL-4 receptor, which affects both IL-4 and IL-13. Tralo binds to IL-13 directly, and it definitely works. When there are these network metaanalyses that try to compare them—we don't

have any direct head to heads—but it seems like tralokinumab might be a little bit less effective, but honestly pretty comparable. And I've had some patients do really well on it as well.

And then lebrikizumab, the newest of this trio, also binds to IL-13. It binds at a different point, and it binds with a really high affinity. So this one does seem to be comparable to dupilumab when they do these analyses. And a lot of my patients who failed dupilumab for one reason or another have actually done really well with lebrikizumab. So it's pretty neat.

They are slightly different, although, admittedly, they're kind of like different types of cola, where the fourth member of the family, nemolizumab, is sort of like an uncola. You know, it's maybe a different type of drink altogether. So this one is IL-31 receptor blocker, and that's pretty neat. So targeting mostly itch, we would say itch first, but it turns out it actually does help against the skin as well. It just kind of works in a slightly different way. Very safe.

It starts out with a monthly dosing, where the other ones, depending on the age, but generally they all start at every 2-week-dosing for the older kids and the adults, and this starts out at monthly. And when people are better with lebrikizumab and tralokinumab, they can space out from every 2 weeks to every 4 weeks. With nemolizumab, they start at every 4 weeks, they go to every 8 weeks when they're doing better, which is really kind of neat. So it's potentially just six shots per year, which makes it nice.

Now, we know the good thing is, these are done at home, so patients can do it themselves, which is great. They're literally studied when topicals have failed, so we know that they're quite effective, even for those tough patients. We know that the effect is durable, like dupilumab has data out for, like, you know, 5 years and 5 years plus. I mean, it's been out for so long, and even the other ones have multiple years of durability data, and none of them require any kind of lab monitoring, which is great.

Now, again, there are some things that are important to keep in mind. Conjunctivitis can happen for some people with IL-13, so dupilumab, tralokinumab, lebri, they can all affect the eyes, and it's usually not dangerous, but it can be an issue, and we want to get ophthalmology involved. They can all cause injection site reactions. Some of them have things like headache and upper respiratory tract infections, and we shouldn't do any live vaccinations while they're on them.

Now, we also know that the JAK inhibitors are really powerful, the oral JAK inhibitors once daily. And again, we have two of them in the US, and that's abrocitinib and upadacitinib. Super fast, super powerful, but they have boxed warnings that talk about things like risk of cancer, risk of blood clots, risk of major adverse cardiovascular event, mortality, all this kind of stuff which is a little bit off-putting for patients, and they do require lab monitoring. So that's the comparison, where the biologics don't have that monitoring, the JAK inhibitors do. And even though we know they're quite safe in our atopic dermatitis patients, for some patients and families, this can be an issue, although, again, I have many patients doing great on these medicines. They kind of tend to be sort of the third line for our patients, but they are fantastic when we need them.

So we'll wrap this section up with a posttest, which of the following clinical profiles most strongly indicates the need to initiate targeted systemic therapy in a pediatric patient with atopic dermatitis? A, a 5-month-old with AD currently uncontrolled with moderate potency topical steroids; B, a 14-year-old with AD refractory to optimized topical therapy and history of conjunctivitis; C, a 6-year-old with moderate AD responsive to emollient therapy; or D, a 16-year-old with moderate AD with a history of moderate flares during winter and wishes to get early control. Which most strongly indicates the need to initiate targeted systemic therapy?

Okay, I think we can push forward. Thank you. So a little bit mixed results here. This is a hard question. I think maybe the best answer here would be B, a 14-year-old with AD refractory to optimized topical therapy and history of conjunctivitis. I think the kind of the distractor here was the conjunctivitis, and it turns out that it's actually not a contraindication to give it to somebody with a history of conjunctivitis. It's possible that they may have a slightly higher risk, but you don't have to worry about it. So somebody with AD refractory to doing good topicals, they probably are still a good candidate. Even though they've had some conjunctivitis, I still think it's reasonable for that patient. I think that's the purpose of that question.

So now Wendy's going to take us back through a panel discussion. Great.

Wendy Smith-Begolka:
Well, thank you, Dr. Lio, for that whirlwind tour of the different systemic options. So I'm going to go ahead and start with you. How are you then bringing up all of these options with your patients and caregivers to think about which one they might want to pick?

Dr. Lio:
It's getting harder and harder. There's so many to talk about now. So the good thing is that I have a little print out, and we kind of go over them, and a lot of my patients have already failed one of them by the time they get to me. So I tend to be a referral center for folks that have already failed. So my discussion might be a little bit different, but a lot of times it's the same kind of basic thing. Here are the pluses and minuses. Here's what I think will be a very good fit for you.

So we were talking kind of before this started, Dr. Swanson and I were saying, like, the different considerations of when you're going to try different things. So I think part of the question is, is there something that's very appealing to the individual patient, for example, every 4 weeks to start, going out to every 8 weeks, the injection pain or injection site reaction, the risk of conjunctivitis—maybe that patient has read about this and says, 'You know, I don't want anything that can cause conjunctivitis, because my cousin had it. Can we try one that doesn't?'

So now we have enough options to go over it.

But I confess, there is a lot of art and not as much science here, because they're all pretty good. And for the right patient, it can be hit or miss. I can't predict, and no doubt about it, sometimes we just say, okay, if this one didn't work, let's just try the next one.

Wendy Smith-Begolka:
Yeah, understood. And maybe I'll go ahead and ask you, Dr. Swanson, to comment on that, but then also I'll have you start to answer one of the questions that was submitted, which was that, given the need for long term management of atopic dermatitis, how can you actually prepare patients for that ongoing treatment while balancing those expectations and adherence challenges?

Dr. Swanson:
Sure, sure. So going back to the treatment options, I totally agree with Dr. Lio, as I typically always do. We have a wealth of options, and that's wonderful. It does make our visits a little bit longer and a little bit more complex, because I really like my patients to know all the options that are available for them, given their age primarily and then their severity of their atopic dermatitis. And so I actually write them out, and I go through them one by one and kind of pros and cons of each one, and I hold them up on a clipboard so they can see the names of the medicines, because all of these words are foreign to them. And so that's how I do it in clinic.

Now, if a patient and their family selects a systemic agent, like, let's say the only one approved under 12 is dupilumab. So let's say I'm seeing a 5-year-old, and we make the decision to start dupilumab. One of the most common questions is, 'How long is my child going to need to be on this medicine?' And I say, you know, it's a bit open-ended. I'd say it depends on the patient. If I'm treating a 55-year-old man that has had eczema his whole life, he's probably not coming off therapy, because it's unlikely that he will outgrow the disease state at that point in his life. However, a 5-year-old, completely different story. They could outgrow it, could become more mild. We are going to treat them with this medicine and get them better, and we're going to keep them better for a little while, and then once we feel confident with that, we will start increasing the time between the S-H-O-Ts to kind of set the stage and test the waters, to eventually go off of it.

And so that's how I approach that question in the office. It's a very common question.

Wendy Smith-Begolka:
Yeah, Dr. Lio, do you have anything to add to that?

Dr. Lio:
No, I think beautifully put, including spelling out S-H-O-Ts, that's my favorite, Dr. Swanson.

Dr. Swanson:
Never say the word shot. Never do it.

Wendy Smith-Begolka:
Absolutely great. Great pearl. Thank you both.

Okay, well, now we're ready to pivot to our next presentation, which will be Dr. Swanson on the collaborative patient- and caregiver-centered approaches to managing pediatric atopic derm. Dr. Swanson?

Dr. Swanson:
Awesome. Awesome. So excited. Hope you guys are excited. Hope you guys are H-O-T T-O G-O for this last section, and then you get to enjoy your dinner or maybe a little television. There's so much good television out there.

Let's start with a poll. Which of the following is a myth about atopic dermatitis action plans and disease triggers in children? A, an effective AD action plan includes clear instructions for daily maintenance, flare management, and identification of individual triggers; B, common triggers like heat, sweat, and allergens can vary in severity and relevance between pediatric patients; C, although triggers can vary from patient to patient, standardized action plans can be applied universally without personalization. So which one is a myth? Let you guys choose. Jeopardy music. Imagine Jeopardy music.

Okay, I feel like we can close it. Let's see. And the poll shows, wow, look at you guys. 100%, way to go. Love that you guys did a good job answering that question. You guys are learning stuff tonight. I'm so proud of you. Okay, and so yep, most of you got it right.

Awesome, awesome.

So let's talk about assessing atopic dermatitis severity. So when I see a patient in clinic, I'm taking a lot of things into account as I consider what severity of atopic dermatitis they have. And something I like to say, mild atopic dermatitis is easy to pick out and easy to identify. Severe atopic dermatitis is easy to pick out and easy to identify. Moderate is kind of an ambiguous gray area where a lot of things factor in: A, the severity of, like, the overall extent, body surface area wise; B, the impact on the patient; C, the chronicity. Do we see lichenification? Are we seeing pigmentary change?; and D, prior treatment failures. All of those things kind of bundle up in that moderate section and kind of put patients either on the mild end of that or the severe end of that.

So for mild to moderate atopic dermatitis patients, I emphasize the importance of sensitive skin care. You know, our non-pharmacologic measures, and I optimize topical therapy to see if we can get control of it.

In patients that have moderate to severe atopic dermatitis, I'm again making sure to talk about non-pharmacologic and topical options, because it's important for families to know everything that's out there. And sometimes you're surprised. You know, sometimes you think a patient is clearly heading towards systemic therapy, and then you do a last-ditch Hail Mary in the topical realm before you move on, and bingo, it's perfect for them.

So I think it's important to really think through that. We have these wonderful systemic agents, but some of these patients, you'd be surprised, can get by with some optimized non-pharmacologic and topical options. Then if you're still struggling, you think about systemic therapy. And what I tend to do in clinic, I'm an option giver. I give people all of the options, anything that they meet criteria for in terms of their age and the severity of their eczema. I'm going to tell them about it, and so I'm going to tell a patient about systemic therapy, even if I feel like at that point in time, topical therapy would probably do a pretty good job. I'm still going to tell them about systemic therapy, because everybody is different in their patient preferences and their personal preferences, and it's important for them to know all the options that they have available, because there are so many.

We have so many now that we needed updated guidelines. And we got them. We needed them, and we got them from the American Academy of Dermatology. These are the 2025 guidelines for baseline therapy for AD and ongoing management, which we'll get to in the coming slides. And it has been a long time since these guidelines were updated. I think the last time they were updated, Mel, the golden bachelor, was in high school. Just kidding. It probably wasn't that long ago, but it's been a good 10, 12, 15 years. So we needed new guidelines, especially with all the new medicines that we have.

So we still want to go over baseline management. We want to assess disease severity. We want to, you know, assess quality of life and burden of disease. We want to emphasize the importance of identifying any known allergens or irritants that are contributing to the thing. And sometimes, you know, I talk about this stuff all day, every day in clinic, and I tell people about sensitive skin care all day, every day. And sometimes I think, you know, maybe I'll skip that step, either intentionally or unintentionally, or maybe the patient tells me they've seen 18 other clinicians. And so I feel like, okay, I probably don't need to go through the song and dance of the sensitive skincare.

And then occasionally, lessons are taught to me in the clinic. I had a patient the other day that wasn't responding as expected, and I was like, okay, wait, let's back up. Let's break down sensitive skin care. And it turns out they were using a laundry detergent that's a notorious aggravator for atopic dermatitis. So it is important to go back to basics. Even though you've talked about sensitive skin care for 18 times already that day, it might actually be the first time somebody has really gone through that with the patient and their family. And so emphasizing the role of moisturizers and emollients.

I tell families with atopic dermatitis, there are two things that cause eczema. One is that our skin is our barrier, and in kids and people with eczema, their skin barrier doesn't work as well as other people, and they have skin barrier dysfunction, and so we help manage the barrier with good moisturizers, emollients, and sensitive skin care. The second part of eczema is that it's due to too much inflammation in the skin, and it's the inflammation that causes the itch and the rash. And so there are some kids out there, where just optimizing sensitive skin care, does the trick, and they're great, and they're golden, like the K Pop Demon Hunters say, they're golden.

But then most of the patients I see, at least they're doing all the sensitive skin care, they're still not achieving the outcomes I want, then it's time to think about some treatments to help impact the inflammation in the skin.

So going on with the AAD guidelines that goes into topical and maintenance treatment for mild to severe atopic dermatitis. And it talks about all of our topical therapies. We've got topical steroids, which are cheap and are effective, but you have to make sure that you're using them appropriately. We have TCIs that we've known for a long, long time. They came out about 25 years ago.

We have crisaborole, which is a topical phosphodiesterase-4 inhibitor that came out in 2017, and was a little bit of a negative experience for a lot of us. It really burned and stung like crazy. It didn't seem to work all that well. And so the crisaborole experiment was a little bit of a negative one. The one time I will still use crisaborole is that it was studied as twice-a-day maintenance over a year for

patients with atopic dermatitis, and 83% of them didn't have to go back to topical steroid use for a year. So that's kind of cool. And if you're using it for maintenance, it's much less likely to burn and sting.

And then we have our three new and novel topical non-steroids: topical ruxolitinib, which is a topical JAK inhibitor, which tends to work very quickly and very well. Imagine kind of the speed and overall efficacy of a topical corticosteroid without being a steroid. And so that's pretty cool.

We have topical roflumilast, which is a phosphodiesterase-4 inhibitor. It's applied once a day, at bedtime, as needed. A couple cool things about roflumilast. Number one, it's a phosphodiesterase-4 inhibitor, but don't judge it based on the crisaborole experience. It's its own entity, you guys. It's its own person. And roflumilast, they really did a really good job formulating the vehicle, very low rates of burning and stinging with roflumilast. Another special thing about roflumilast was that in the studies, once patients were clear, they had them use it twice a week for prevention and maintenance, and 57% of patients didn't have to go back to daily use for a year. So that's pretty cool too.

And then we have tapinarof, an aryl hydrocarbon receptor modulator, topical, non-steroid applied once a day at bedtime as needed. And it's pretty cool too, because it, you guys, is naturally derived. Yeah, you heard me right. Naturally derived. Its origins come from the guts of worms, you guys. From worm poop to topical therapy for atopic dermatitis. We're thrilled to have it.

And so it's nice to have all these choices. It's a lot of choices, but everybody is different, and each of these options has its place. You can see a conditional recommendation for wet dressings. I think because our therapies have gotten better, we're just leaning on wet dressings less. It doesn't mean they're bad, but we're just having to lean on them less.

And then we are looking at maintenance therapy. The roflumilast was actually studied as part of a maintenance therapy. We like that. Things like ruxolitinib and tapinarof have not been studied that way, but I heard from a little birdie that maybe they're thinking about it.

If you do your best—you are talking about sensitive skin care, you are optimizing topical therapies that, and you think that they are using them, and that patient is not getting better, at least put your brain through the paces of, am I confident this is AD? Because sometimes there are masqueraders, things like contact dermatitis, things like CTCL, things like psoriasis even can be misdiagnosed as atopic dermatitis. So definitely let your brain think about, what else could this be? Maybe do a biopsy, if you have any, you know, concerns or thoughts about that.

Now, if you're doing all that and you've double-checked your diagnosis and you are spot on that it's atopic dermatitis and they are still not better, then it's a systemic therapy time, you guys. Dr. Lio reviewed all of these so, so nicely, and there's not much more to add. I think the one cool thing about dupi is that we have so many long-term studies about its potential impact on the atopic march, its potential impact on growth, its potential impact on potentially even encouraging kids to outgrow their atopic dermatitis when it started early. So we have data from dupi simply because we've had experience with dupi over the past 8-1/2 years.

And dupi changed the world, you guys. It changed the world. I think of my career as BD, before Dupixent, and then AD, after dupilumab, because it's so much changed the world. In fact, when I think about dupi, there's one song that plays in my head, and this is one situation where it's not my beloved Taylor Swift, that song is "My Life Would Suck Without You," by Kelly Clarkson, because dupi changed the game. And thinking back to the days before we had dupi, there were sad times, you guys. Sad times.

The one other thing I want to call out with nemolizumab, or IL-31 inhibitor, so nemo is the least ouchy S-H-O-T in the world. It literally does not hurt, and it starts out with monthly dosing, that Dr. Peter Lio said can be spaced out to every 2-month dosing. That's awesome. And so that's one really nice thing about nemo, is that it really does not hurt, and we love that for our patients.

We see a conditional support of our systemic immunosuppressants. And I've become a bit known for saying that picking a systemic agent before we had wonderful options in our toolbox, like dupi and others, was like picking a porta potty out of a row of porta potties. You know they're all going to suck, but you've got to pick one when you have to go. I was never excited to put a patient on methotrexate or cyclosporine; I did it out of desperation because I had no idea how else to help them. And now we don't have to pick a porta potty anymore, you guys.

And we see this recommendation against systemic corticosteroids. As Peter Lio said, this just aggravates the problem. It just fuels the fire. Do not use systemic corticosteroids. I think we leaned on them in the past because, again, we didn't have as many options, but we don't want to lean on them now. We don't need them anymore. We have so many good things.

In the olden days, meaning more than a year or 2 ago, a lot of people reviewed this pediatric AD action plan with their patients: what to do in a green time when things were actually looking pretty good and you're just doing kind of gentle daily skincare; what to do in a yellow time when you're starting to have a little bit of a flare and what topicals you want to implement; and then what to do when it got really bad and you were in the red phase—Taylor Swift, she has a song called "Red." If you're in the red phase, what do you do in that

situation? I think it'd be interesting to see if people are still utilizing this now, because again, our option lists are so much greater. I don't know how much the green, yellow, red is utilized today, but I think any system you have to convey these action plans to your patients, use that.

We've already reviewed these topical therapies. I think we covered all the high points with these. It's really, really nice to have so many topical options, especially that are non-steroidal, we're grateful for that.

When you're thinking about a systemic therapy, there's a lot of things that bundle up in that consideration. What is their atopic dermatitis phenotype? Do they have eczema-psoriasis overlap? Do they have facial-predominant eczema? What is their phenotype? Do they have a prurigo nodularis type phenotype? So getting to the bottom of that, because some of our different therapies work better for some of those different phenotypes.

Patient comorbidities: do they have asthma? And choosing dupi would help you feed two birds with one scone, if you will. We're not killing birds with stones anymore, you guys. We're feeding birds with scones. It's PETA approved.

If a patient also has alopecia areata, I might consider an oral JAK inhibitor, because they can treat their atopic derm and their alopecia areata very nicely. You also want to consider the risk-benefit profile of the available treatments, patient preferences. Exclamation point. Exclamation point. That's so important to have that shared decision-making. Because if you come up with a solution for them, and they're not a part of that decision-making process, I think your success rates are low. I think, you know, they're unlikely to use that therapy or utilize that therapy in the way that it's intended for them.

And then drug interactions and clinical monitoring. What is their past medical history like? What is their med list like? Make sure the options available are safe options. And then access, access, access. Always the big stickler, right?

When to consider alternative systemic therapy? So when an inadequate response has been seen, at least entertain a switch. And sometimes patients are improved on a therapy, say somebody's on dupi and they're 50% better. Well, that's significant. Being 50% better than being that bad, you know, 12 to 16 weeks ago, that's a big deal. Maybe they're a little bit nervous about making a switch, because they're nervous about a backslide. So talk to them about the options available, about how you think they stack up, and how those options are either good or bad for them.

Always think about using a topical therapy until the new systemic agent is fully effective. Some patients can get off topicals eventually, but typically not at the beginning. And often there's a little bit of an overlap period as you're switching systemic agents. And we think that's okay.

When to discontinue biologics. That big question: how long will my patient need to be on it? Well, these clinical outcome measures somewhat display that. It's a little bit confusing. I'll explain. So these are patients who are on dupilumab 300 mg every 2 weeks, and then they are successful on dupilumab, and they are switched to either staying on every 2 weeks, switched every 4 weeks, or switched every 6 to 8 weeks. And you see, actually, they maintain these clinical outcome measures very nicely, regardless of if they're in the yellow or the orange group where they're every 2 weeks, the green group where they're every 4 weeks, or the blue group where they're every 6 to 8 weeks.

So this is how I do it. I just kind of increase the time between the S-H-O-Ts and see how things go.

Shared decision-making. I mentioned it before. It's worth highlighting. It is everything when you're talking about atopic dermatitis, especially with the choices that we have. So listen and engage with patients and their caregivers. Hear what they have to say and what their desires and preferences are, accommodate the varying economic and appointment needs, facilitate closer follow-up when needed and desired when you just feel like you need to keep tabs on them and hold their hand through it. Consider patient goals, preferences, and cultural skin care practices when you're making these decisions. And of course, this with medication access and support resources, because a medicine can be super great, but if your patient can't get it, it's no good to anybody.

And so we'll go to posttest three. A 12-year-old girl was recently diagnosed with AD. She's anxious about using treatments that may affect her appearance at school. Based on shared decision-making principles, what is the most appropriate next step? A, recommend initiating systemics to achieve rapid symptom relief; B, advise avoidance of known triggers and select a personalized topical regimen that aligns with patient preferences; C, reinforce strict adherence to a standardized treatment protocol as it is the most evidence-based; or D, suggest transition to phototherapy as it avoids systemic exposure. We'll give you a second.

And then let's go ahead and see the results. I bet you guys were relatively fast, and I know we're coming to the end. So let's see. Yes, perfect. So 97% of you guys got it right.

However, I mean, there'd be a part of me that would advocate for choice A, you know, recommend initiating systemic therapy

immediately to achieve rapid symptom relief. It sounds like maybe she's not super excited about topicals. And so that might be something that I would entertain too. So I don't think A is entirely wrong.

So key takeaways: atopic dermatitis significantly impairs the quality of life for both patients and caregivers. Topical therapies remain first line; however, their inappropriate use, or even appropriate use, can cause burdens. Newer systemic options are available for our patients. Engaging patients and caregivers in shared decision-making is imperative to improving self-management, adherence, and quality of life. Develop patient-specific action plans to address barriers to care in atopic dermatitis to optimize outcomes.

And so we did it, you guys, with a minute to spare. Happy to answer any questions. I know we got one as we were going through, happy to answer any other questions if people have them.

Wendy Smith-Begolka:
We did, and I think we have time for maybe one quick question, which is, are you looking at any other functional measures to help track treatment success?

Dr. Swanson:
So functional measures meaning like growth and school, or what are we meaning there?

Wendy Smith-Begolka:
Not a lot of other detail. But I think those are good suggestions to start with.

Dr. Swanson:
Yeah. I mean, one of my favorite things to ask people when they come back and they've been on a systemic therapy is, what were you not doing before that you're now doing? You know, and it might mean swimming or playing outside, because those things can be big-time irritants. It might be trying out for a sports team. It might be finally going to sleepovers because you felt too self-conscious to go before. So I like to see how their behaviors are changing as they respond to treatment.

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