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https://reachmd.com/programs/cme/push-past-in-ad-treatment-escalation-in-moderate-to-severe-atopic-dermatitis/56569/

Released: 11/17/2026
Valid until: 11/17/2028
Time needed to complete: 60 minutes

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Push Past in AD: Treatment Escalation in Moderate to Severe Atopic Dermatitis

Opening:
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Chapter 1: Welcome and Introductions

Kristine Kucera:
Hello, and thank you so much for joining. Very excited to be able to present this program today called Push Past AD: Treatment Escalation in Moderate to Severe Atopic Dermatitis. And this is going to be extremely exciting because I have a patient here with me today, Chava Wald, and she is going to share her journey with atopic dermatitis.

And we are going to get started because lots of great information. These are our disclosures Learning objectives today, we're going to evaluate AD, we're going to identify patients who are uncontrolled, optimize treatment selection, look at efficacy and safety of some newer therapies, and talk about individualized treatments.

Chapter 2: Beyond the Rash: Evaluate the Full Burden of AD

Kristine Kucera:
So let's get started. We're going to talk about evaluating the full burden of atopic dermatitis. Visible skin findings are not enough, and we know this. We really do need to look at the patient as a whole.

And so what we're going to do today is we're going to start with Chava and her journey and how it started. So she's 39 years old. Chief complaint, widespread itch and rash. Initially appeared on the legs, then it went to the arms, face, neck, and chest. Medical history, diagnosed with severe AD as a baby and asthma as a child.

And we do know that those two sometimes go hand in hand. And what has she used in the past? Topical and oral steroids, of course, oral antihistamines, acupuncture, UV light therapy, topical nonsteroidals, and biologics. So she's kind of been through everything. Current medications she takes, she has high blood pressure, that's it.

And her BSA was as high at some point as 90%. That means 90% of her body was covered in disease. Her itch score, 10 out of 10. This is a scale that's zero to 10, 10 being the worst, so she was at the worst. Sleep score, same thing, zero to 10, 10 being that she wasn't sleeping at night.

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And then IGA, Investigator Global Assessment is severe, so she had severe disease. Now, what we want to think about when we see a patient like this, how do you assess this patient? And what is going to be your initial treatment approach? Now, Chava was started on a biologic. Thank goodness. She did have severe disease, dupilumab, in 2018.

And we will discuss this with her in just a few slides. But I do want to talk about how to go about looking at your patient, of course, visually, but also we need to know about quality of life and how they're feeling and how their disease is affecting them. So how do we do this? These are, these are some tools that you can use, of course.

An EASI score is important. It's used in clinical trials. It's from zero to 72. It's a mathematical equation. But it's also important that you put this in your clinical note because a lot of insurance companies are asking for EASI score now, and it looks at erythema, induration, excoriation, and lichenification, and across 4 body regions. Zero to 72, zero meaning they have absolutely no disease, 72 meaning that they actually have a full suit of armor of atopic dermatitis.

Then you have the IGA, Investigator Global Assessment, and this is also a visual rating of overall disease severity. And then you have a body surface area, which actually you measure the surface area that is covered, and it's zero to 100%. It is the rule of 9s. And remember, the easy way to do it is 1% is the patient's palm, and so you can kind of do a quick calculation with that.

And then there's something called SCORAD, and this kind of combines the extent, intensity, and patient-reported itch and sleep all together. So clinical takeaway here important to use as many of these endpoints as you can.

And then let's move on to the burden, the hidden burden of many, many effects of this disease on patients.

Not only itch and sleep, mental health, quality of life, work and productivity, treatment dissatisfaction, and comorbidities. You know, patients, the main thing that they will complain about with this disease is the chronic intense itching, not only during the day, but at night, and they can't sleep. Mental health, they have a risk of depression.

Quality of life, over 50% of patients report they have lifestyle limitations. It does affect their work and productivity. And look at how many patients feel that their current therapy fails to meet expectations, approximately 75% of patients. So we're not doing our jobs if this is still happening as clinicians.

And then remember, with any systemic inflammatory disease, you can have comorbidities, and with AD, you want to ask about asthma, allergic rhinitis, food allergies, and then remember anxiety is something that these patients frequently suffer from. And here's some burden capturing tools that will...

It's really good for patient-reported outcomes. You don't have to use them all. You can just use 1 or 2, and it doesn't take very long. They're very easy for the patient to answer. There's a, there's a POEM, which is the Patient-Oriented Eczema Measure. It's just seven items. The DLQI seems to be one that a lot of providers like to use because it's very easy.

It's 10 questions, and patients just literally check the boxes. You also have in the middle here, a Peak Pruritus Score if you want to dive into how itchy the patient is. The PROMIS AD this kind of goes over several symptom measures and quality of life impact, and this is over a week. And then the sleep.

I think sleep is super important as well as itch to talk to the patients about and get their get them to answer these questionnaires because it talks about nightly sleep loss, and I don't think we realize how many patients suffer every single night they cannot sleep. And then of course, you can use the anxiety and depression scale if you're more interested in diving into that.

But just remember the easy scores, the BSA alone underestimate disease burden, and you need to dive into the patient's quality of life as well.

So now we're going to talk to Chava, and the question is, did your clinician use any assessment tools to assess your response to the biologic? And kind of what we want to hear from you is when you were diagnosed, I want to know, did they even talk to you about your quality of life, or was it just a visual inspection and say, "Okay, here. We're going to see how you're doing. We're going to give you this

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drug, and then you come back, and then we'll just see how you're doing"?

Chava Wald:
Absolutely. It would be a pleasure to share. So as you mentioned, Kristine, I've been living with severe AD my entire life, so almost 4 decades now, and I'll say that a lot has changed personally, and then I think medically, a lot has changed.

As a young, young child coming to a doctor, I was completely oblivious to the discussions that were taking place. I just knew I was in pain. I was seeing someone that I was hoping would be able to make me walk again and get dressed properly without clothes being peeled off my body without the blood and further irritating my skin.

I wasn't aware of whatever, I would say, paperwork or assessments that the, the clinician was trying to achieve during the appointment. And even into adult life, I really wasn't that aware. It was the same intention. It was like, just make it get better. And that really all, all shifted for me when I became a patient advocate and I was more interested in understanding, not just for my...

Obviously, I wanted my skin to get better, but with a perspective of I'm doing this to try to help others, right? My experience is not always the same as everyone else's. And so I took a greater interest in taking note of what my physician was doing because frankly, if you don't have a medical background it, it can feel overwhelming and most people don't even want to know.

They don't care what assessment is being done. And so only recently I'm starting to notice like if they're looking at my body, oh, like are they using an assessment tool? What are the numbers? What do they look like? But one thing that I will just want to stress is that I think so often patients feel that it just, they come in and they're just getting a head-to-toe scan, and if everything's clear on that given day, then they're going to be sent on their merry way and they don't feel like they're given an opportunity to really share some of their struggles.

Sorry. Some of the struggles they've been experiencing in between appointments and utilizing some of the other assessment tools that exist that not only will help capture different aspects of how the condition impacts individual, I really think from a psychological standpoint, there's tremendous value for the patient.

They feel like there's, they have a share in this and that they're not being dismissed and it's a joint decision, whatever it is. And so regardless of which if it's a POHM, the DQLI or whatever it is that you feel might be best it's so critical to use that because so often I hear as a patient advocate how patients feel that the doctors don't even listen to them.

Kristine Kucera:
Absolutely. Thank you for sharing that because that is something that I even heard as a clinician when an AD patient would come in and see me and I was maybe their second or third clinician that they had seen. And I would ask them, "Well why did you come to me?" And they're like, "Well, I don't, I wasn't feeling like the doctor understood how the disease was affecting me, and I wasn't being heard."

So thank you for bringing that up. We really do need to listen to our patients.

Chapter 3: Therapeutic Sequencing Made Simple: Identifying Uncontrolled AD

Kristine Kucera:
We're going to go to identifying uncontrolled atopic dermatitis. This is a little section on how we need to recognize patients who need escalation rather than continuation. Again, don't let your patients suffer. Move on when you need to. So going back to Chava, your first biologic, dupilumab, was twenty eighteen.

Three to six months of treatment cleared the eczema, but the side effects were worse and more painful. I believe you said that you had a bunch of eye problems. 2019, clinical trial for a topical JAK inhibitor. You didn't find that that helped the fissures or the dyshidrotic eczema on hands and feet.

At the same time, it seemed to increase outbreaks of eczema herpeticum on face, which is no fun to have that side effect. 2021, you were started on a new biologic called tralokinumab. Similar results without the red face, so that's good. Stayed on it longer. EASI score was still high with frequent flares and constant itch, so we were not controlling your disease at that point.

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And how do we define the moderate to severe uncontrolled disease? Clinician assessed, you can look at their EASI score, of course. You can look at the investigator global assessment score. If EASI is greater than 16, if the investigator global assessment is greater than 3, which is moderate if they're having recurrent flares, if a patient is having more than 2 flares every 6 months, then we probably need to get them on something where they can have more control.

Of course, our patient-reported outcomes that we talked about. Check about their itch score, especially in the last week. Their DLQI if it's over ten, it's very large effect on their life. Look at their POINTs scores. Look at their you know, any, any of these that you want to use, any of these questionnaires that you think will help you, let the patient fill them out or just ask them.

You just have to ask the questions. And then functional or global. Is the patient having sleep disturbance more than three nights a week? Is it impairing their work or school? And patient assessment of inadequate control. We were talking with Chava, and she did just tell us about her sleep. You have to remember that sleep pours over into the next day.

She a lot of times was not able to go to school because she was exhausted So we need to think about our patients as a whole again. Now, treat to target. These are some guidelines. These are from 2025, so they're new, and this is thresholds for disease control. What is an acceptable response?

At 3 months or more, patients should have at least a 50% improvement in their body surface area and at least a 4-point improvement in their itch Optimal response at 6 months, a 75% improvement in their disease, plus itch should be less than 4, so it should come down to less than a 4 score, and the DLQI should come down to less than a 5.

If they have low disease activity sustained, that means that they have a investigator global assessment score of zero or one, which is clear or almost clear, EASI score of less than 7, and they're not itching as much. Their itch score is less than 2. And then very low disease activity is defined as a zero or 1, which is clear or almost clear, an EASI less than 2, and an itch score less than 1.

So these are the things we need to strive for as clinicians, and if we're not giving this to our patient, it's time to move on to another treatment. So just kind of looking at the stepwise treatment approach and algorithm, adults and pediatrics both, you do need to escalate based on severity and response.

Step one, the foundation. We all know that daily skin care is very important. Emollients, bathing avoid triggers if you can identify ones that will make your AD flare. Education, we really do need to educate our patient about the disease and not only the patient, but also the family, if it's a child and mom and dad are with them.

And then topical anti-inflammatories three months and over. You can use the TCS, the topical corticosteroids. You can use the calcineurin inhibitors, tacrolimus or pimecrolimus, and those are for 2 years of age and older. You also have the tapinarof and roflumilast. Those are kind of our newer nonsteroidals that seem to be working very well.

You can throw in phototherapy if you need to. Narrowband is preferred. Systemic biologics, moderate to severe AD. We have a lot available now. We've got dupilumab, tralokinumab, lebrikizumab, nemolizumab, and they're all strongly recommended. And then step 5, we have the oral JAK inhibitors for refractory disease, and this is upadacitinib, abrocitinib, and they are also strongly recommended.

Clinical takeaway. Step one has to be maintained throughout. Patients still need to take care of their disease and their skin on a daily basis, and everyone agrees systemic corticosteroids should be avoided.

Chapter 4: Optimizing Treatment Selection

Kristine Kucera:
So we'll go back to Chava, and she did dupilumab. The topical JAK didn't work out great because of some side effects. Tralokinumab was doing okay. Her EASI score's still high. She was having flares and constant itch, so we know we're not giving her adequate disease control. So what happened then?

2022, she began an oral JAK inhibitor, upadacitinib, and a quote from you, Chava, which is amazing. "For the first time in my life, I felt

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like I finally started sleeping for more than 2- to 3-hour stretches. The underlying itch, which I hadn't even realized had been keeping me up for all these decades, finally subsided. Can't imagine finally getting relief from itching."

And then in 2024, you added a new biologic, lebrikizumab. And I actually would like, if you would, at this point, to just kind of chat about your treatment journey here and, and how you felt when you got, finally got to an oral JAK inhibitor and got some relief.

Chava Wald:
Absolutely. It was very surreal to experience discomfort and pain very physical discomfort. And like you've been saying how it spills over in so many other aspects of one's life, and within 12 hours to see it slowly go away, it's really hard to even put into words, you know? As someone who's been on this journey for so long and the treatment landscape has changed drastically, but when all I had for so long was steroids that frankly I was using it head to toe and it wasn't even...

I never had it under control as a kid. It didn't even seem possible that there would be something that could actually you know, I can actually have clear skin and so quickly So it was, it was very surreal.

Kristine Kucera:
Thank you for sharing. I can't imagine. I mean, that is a long time to suffer until you finally got some sleep.

Okay, so let's look at the approved systemic therapies, mechanisms at a glance. Dupilumab is an interleukin-4/13 inhibitor. It's considered a first-line anchor. It is approved for littles, 6 months old, all the way to adults. So it's nice to actually have something we can give kiddos. But it has a lot of other indications that actually can help our patients with AD.

It can help with asthma and then CSU and some other things. So you could actually treat several aspects of the disease with this. Higher conjunctivitis risk compared to the selective IL-13 inhibitors is, is a sub-Q injection. You have tralokinumab and lebrikizumab. Those are selective IL-13 inhibitor, so not inhibiting four anymore, only 13.

More selective cytokine blockade. Approved tralo is approved for 18 years of age and older. Lower conjunctivitis rates. Responders may extend dosing interval after induction, which is kind of nice, and it is also sub-Q. And then our lebrikizumab, it is for 12 years of age and older. Similar ocular safety profile to tralokinumab.

Flexible long-term maintenance strategy. These patients can actually take their medication after a period of time every eight weeks, which is kind of nice to give patients less injections. Then we have kind of the newer kid on the block, nemolizumab, which is an IL-31 receptor antagonist. Approved for ages 12 years and older.

We over the course of looking at AD, we found that IL-31 is a neuroimmune cytokine that plays a key role in itch, and that's why it has actually been doing well in patients that have AD, gets rid of the itch very quickly. No conjunctivitis risk, and also the, it is subcutaneous, but they can do a, a longer dosing schedule in between.

Then we have our JAK inhibitors. These are oral. Upadacitinib and abrocitinib. They are selective JAK1 inhibitors, and they are for ages 12 years and older. Most rapid onset these drugs work very quickly, and as Chava said, when she did take upadacitinib, she got itch relief within 12 hours, which is amazing.

So remember to keep these in mind. They are very rapid onset And then we need to remember to get beyond cycling by habit. These should be some decision drivers. Tailor to therapy, don't rotate just by default. Mechanism match. Think about what mechanism of action you want to use in the patient.

What prior treatment have they have, and did they fail? Was it an inadequate response? Could they not tolerate it? Think about that when you're considering your next switch or mechanism of action. Speed of onset needed. You want to give somebody immediate relief. JAK inhibitors do deliver rapid itch relief.

Biologics do offer itch relief rapid as well, even though the JAK inhibitor is considered a little bit faster. Comorbidities. You have to think about the comorbidities of patients when you're actually selecting a treatment therapy. Conjunctivitis history, and if a patient overall is healthy if they've had any kind of cardiovascular risk they've had any anything in the past.

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You have to do really, really thorough histories on these patients that you're starting on these systemic therapies. And a patient preference. You know, some patients just do not want to give themself an injection no matter what, and they prefer an oral therapy, and some just don't want to do anything that they have to do a lot of lab work with.

So it's important that you talk to your patients about that. And then, of course, the elephant in the room, which we all have to talk about, we sometimes want to give our patients something, but you have to think about access. Insurance, a lot of times, kind of blocks things. And that's why it's important, we talked about not only doing visual documentation, the BSA, and the EASI-Score in your chart, but use those patient-reported outcomes.

It will help you get a drug for a patient. So let's think about all of that when we're trying to decide our next treatment And now we're going to ask Chava about—Chava, tell me. You started on upadacitinib; you got great itch relief. What has your current experience been?

Chava Wald:
So while I would say that being on an oral JAK inhibitor, it does really deliver in the promise that the efficacy in terms of clearing the skin. For me personally, it also has brought along some challenges. Again, this is not necessarily for everyone, but this is my experience, and that has been that I'm at increased occurrence of shingles and just in general, like immune suppressant.

So I'm battling a really bad cold right now, and I had one 2 weeks ago. No one else in the family has it, you know? So I just find that I'm far more susceptible to getting sick. And then when that happens, I need to pause the medication because my body needs to just be able to recover. So it is a bit of a double-edged sword.

But when it is working, it's, it's still worth it to be on it for these little dips or whatever you want to call it, these little setbacks. The quality of sleep that we've been alluding to a few times already, it, it, it's like even if you get one night's sleep as opposed to I'd rather have a cold once every I don't know how many weeks, but then six weeks of, of solid sleep so I can actually function, not be a zombie in between those colds.

That's been my experience. It's tough, but not being on it, I think, was far more challenging.

Kristine Kucera:
And thank you for sharing that because that brings us to our next section we're going to go through which is efficacy and safety. And you always have to do benefit-risk, and I have had multiple patients like yourself suffer so much that a cold or an upper respiratory infection along the way is not as bad as suffering with your AD.

So you really do have to take everything into consideration. So we have one question here, and then we'll move on to efficacy and safety.

Chapter 5: Comparative Efficacy & Safety

Kristine Kucera:
Okay, so let's look at efficacy and safety. So again, these are not head-to-head. These are just kind of all the different drugs we have listed out. And the EASI 75/90 score, meaning that the patient is getting 75% or 90% improvement in the IGA of zero or 1, which is clear or almost clear, and if the patient can get a significant itch reduction as well.

So you've got dupilumab, tralokinumab, lebrikizumab, nemolizumab, abrocitinib and upadacitinib, and all their different trials are listed there as far as the EASI scores. And if you kind of look, of course, the upadacitinib tends to be the highest EASI score reduction. The EASI 90 reduction is 55% to 66%.

And then also in itch scores as well, it kind of takes the cake there with the itch less than you know, four sixty to 66%. And also an IGA of zero or 1. Remember, that's clear or almost clear. So that's pretty much some patients getting 100% clearance, and they can do that 52% to 62%.

So upadacitinib tends to be the one, just kind of looking at all the numbers here, that can give us our best results.

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Chava Wald:
I think it's so important that obviously that the healthcare provider understands the different from the slide prior, I just don't know the right medical term, but I guess like the potential efficacy. And I think it's important if that information is relayed to the patient. You know?

Like, if a patient knows that there is a potential that it could take X amount of time, and you could actually get to X amount of clearance, I think it might attribute to a little bit better I'm blanking out on the word, but adherence, right? Yes. Because sometimes patients think, oh, they're going to use something.

And yes, in, in JAK inhibitors, and as more people are on them, and people talk about it, people are going to see, oh, it is a quick—well, it might seem like a quick fix. There are other summers like biologics that you might see initially some relief but not realize that it could take up to week 16 or week 20 to fully see that efficacy and those improved, markings that you're looking for, those percentages.

And patients are sometimes like, "Oh, I tried it 2 days, didn't work," you know? And they give up. And if they know, "Oh, it could take a while," and there is a potential for it to get better, it's almost like if, I don't know, this idea just popped into my head, like if you're bidding, you're gambling and it's only another 5 bucks or maybe running a marathon.

I said, I don't know, the idea popped in my head, I don't gamble, so maybe that wasn't a good idea. But you're, you're running a race and you're so tired, but you know the finish line is so close, you're going to push yourself, versus if you're just running and you have no idea how far it is and what the potential benefit, prize, reward is on the other end, people will feel motivated.

So if there's a way that a clinician is able to translate this in a digestible, just to give the patient some hope and realistic expectations, yeah, I can't tell you how often patients are like, oh, like they tried a biologic and they were getting eye infections eye irritations too often.

But if they stuck it through, they could see the benefit and things like that. And ultimately, the patient will do better and everyone will be happy, right?

Kristine Kucera:
Yes. And thank you for saying that because it is very important that we do set expectations for our patients and we tell them, we've heard this before, it is a marathon, not a sprint.

And so you do need to set those expectations and let the patient know, "Now, you may not see a lot going on in the next 2 weeks, but hang in there because it will come with some of these drugs," but definitely something very important. This just kind of looks at itch and sleep outcomes and looking at, and I'm glad they actually did look at this in all these clinical trials with all the drugs we have talked about.

Itch relief dupilumab as early as week 2 and then tralokinumab sleep interference was improved by week 16. Lebrikizumab, a significant itch and sleep response, as well as nemolizumab, abrocitinib and upadacitinib tend to be fastest, but not always. Some of the biologics can work fast as well.

So it is important that we talk about itch and sleep outcomes, and I'm so glad that companies are starting to actually look over the past few years at patient quality of life as well.

This is a, a head-to-head study that was done. We like as clinicians seeing head-to-head. This is JAK inhibitor versus dupilumab, so this was actually upadacitinib versus dupilumab. And just kind of looking at the scores, of course, upadacitinib did outperform dupilumab as far as improvement in the body surface area EASI scores, and it did, was favored for reduction in itch. There were higher rates of acne, herpes zoster, lab abnormalities than dupi, but dupi had more conjunctivitis.

And then looking at LEVEL UP, what's important here is the itch separation as early as day 2. And so this actually can support that JAK inhibitors as option for inadequate biologic response. And then skin clearance and itch control, better quality of life and sleep, patient-reported outcomes here.

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This is looking at patients that can get improvement 90% BSA, as well as have a zero or 1 itch. That is the ultimate goal that we would love to give patients, and this was a clinical trial done with upadacitinib that looked at this, called Level Up and Measure Up 1 and 2, and the quality of life and sleep was very, very well in both these trials.

Quality of life, patients got down to no impact on the patient's life and fewer nights of sleep disturbance. So the clinical takeaway here was there was deep response, not only skin and itch control, and upadacitinib had the largest quality of life and sleep gains. So keep that in mind for patients who are suffering.

And this just kind of just reminds us here that you can get deep response drives quality of life gains. If you can get a patient's skin doing well a 90% improvement or better, and you can get rid of their itching they will have a better quality of life overall. And we have all that data, and it's actually great responses there.

So this is just kind of safety, what to know before you prescribe. So biologics, of course, we talked about conjunctivitis, injection site reactions, head and neck erythema reported with DUPI, no routine lab monitoring required, acceptable safety and long-term extension data. Lots of information out there on the biologics.

Then we have the JAK inhibitors. Remember, there is boxed warning. It did not come from upadacitinib or abrocitinib. It actually did come from an oral surveillance trial in rheumatoid arthritis with another JAK inhibitor. And I always like to say that this is kind of like one child got in trouble, so they all got in trouble.

So remember that when upadacitinib first came out it did not have a boxed warning. It was put on later because of this RA trial. But it is something to keep in mind when you're doing a good history on your patients. Acne, herpes, CPK elevation, lab abnormalities can be seen, but in the clinical trials, usually they kind of just went up, but they went back down, so they were transient.

And pretreatment, you do have to screen for things with these patients, screen for CV risks, malignancy, infection, lipids, CBC, LFTs. So these patients you do have to keep a little bit more eye on.

And did your clinician, Chava, did they talk to you about these potential side effects of upadacitinib, and were there concerns?

Chava Wald:
Yes. So it was brought up very early on. I would say even before these medications came to market, my doctor was already mentioning, and that's his style generally. He'll let me know of the newer treatments that are in, down the pipeline. It always has given me a great sense of hope to know that if something isn't panning out, then there are other options, which for so long that wasn't the case.

And so as someone who has no medical background other than just being a patient visiting doctors and pharmacies often, I didn't quite understand how, what you just explained. And I wrote in the comments that I love that analogy. You know, I think had I understood that earlier I would have started the treatment much earlier.

My doctor, rightfully so, had to share that it has a black box warning, but what does that mean? I looked up what is black box warning, and it gave the list of whatever it is, and I said, "Nah, my skin's not that bad." And it wasn't until I had attended a session hosted by the National Eczema Association that was geared for patients or family members of patients.

In many cases, it's parents who are making these decisions for kids and explaining why this drug got the black box warning, and it gave me a great sense, great sense of relief knowing that this drug isn't the naughty one and that it was the siblings, like you mentioned. And so the next time I saw my dermatologist and it was not really being managed so well, and knowing that it had potential greater efficacy and faster, I said, "You know what? I'm ready. I want to try it." And so I know that Time with patients is so limited. But the more that you're able to provide information from a reliable resource, not leaving it to the patient's own devices to go home and just start googling it. It can save everyone so much time and really ultimately get a patient on a better treatment plan, which is I think what everyone wants, right?

Kristine Kucera:
Absolutely. And yes, thank you for reminding us that we do need to educate, educate, educate our patients, and they may not understand black box warning, and it's up to us to explain it to them in the way that they can understand it. Because yes, patients do go

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and they do google, and they do find out bad information.

So that is up to us to let them know all that information ahead of time.

Chapter 6: Integrating Guidelines & Evidence

Kristine Kucera:
So let's just look real quickly here in our last few minutes and for grading guidelines and evidence, and we need to individualize our plans. These are some guideline anchors for systemic therapy. We did not have any new guidelines for AD since 2014, and we finally got some, which was amazing.

So the AAD in 2024 and in 2025 focused update, and then the Euro guidelines came in 2025. Basically, the AAD says that strong recommendations for systemic treatment conditional phototherapy and all the older immunosuppressants and no chronic systemic steroids, and we do need to assess patient reported outcomes at every visit.

And then the Euro guidelines, no impact on patient's life as among deep responders. It does endorse the biologic and JAK inhibitors. Definitely switch treatment if you need to. And there are specific guidelines for pediatric, adolescent, pregnant, and breastfeeding patients. So we do have lots of guidelines out there now.

This is building an individualized plan. You need to assess the patient, not only skin signs, but quality of life. Optimize treatment, confirm adherence to their daily skin routine. Optimize topicals, trigger avoidance before declaring a failure. Define control, apply the treat to target thresholds. Document inadequate response objectively.

Match the mechanism, select the therapy assigned with the phenotype, prior failures, comorbidities, patient preference. Monitor and adjust. Reassess your patients. I know we're busy and a lot of clinics are booking months and months in advance, but if you're treating a patient like Chava with atopic dermatitis, just know that it may not be controlling her disease, it may not be the appropriate medication, and you do need to switch.

So you do need to reassess these patients sooner than later. And the key takeaways here the burden assessment must combine, of course, the patient-reported outcomes with visible findings. Uncontrolled AD is multidimensional. There's itch, there's sleep loss, quality of life, recurrent flares, all these things matter.

Treatment selection should follow mechanism, prior response, comorbidities, patient's preference, not habit. Don't just prescribe something because you're used to prescribing it. JAK inhibitors do offer rapid deep skin and itch responses. Biologics offer durable response with simpler monitoring. Apply the treat to target thresholds at twelve to sixteen weeks.

Switch class rather than persist with ineffective therapy. And there are guidelines out there if you would like to review them from the AAD and the European Dermatology Association strongly recommend modern biologics and JAK inhibitors for severe AD, moderate to severe AD.

So this is the National Eczema Association Healthcare Professional Resource Hub. Resources for your patients there's the website there.

And actually, in our last couple minutes Chava, if there's anything you would like to add, and if you would also just talk about how amazing that the National Eczema Association is, and how it's important that we kind of push our patients to getting that good information, not just googling stuff.

Chava Wald:
Absolutely. So firstly, the National Eczema Association is what brought us together here. They've connected us with GLC Healthcare and they really give patients like myself, patient advocates the opportunity to be able to the best of our ability be a voice for so many others.

So many patients are too overwhelmed, too scared and so it's really a privilege to be able to be in this role where I can be in a setting

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talking alongside experts like yourself, Kristine, to others who are I think, I hope, I really believe that want to make, help their patients get better.

And on the flip side, go back to the patients and let them know what the healthcare providers are doing to help them. Because for so long there was status quo, there wasn't a lot of options. And on the flip side, there's now it, it's unbelievable how many options there are, and that can also feel overwhelming.

And internet is great, but leaving the internet as our go-to or only place to look for information can be a great risk. And so you really need to look at places that are reputable. And the National Eczema Association, aside from their website what they have they also have an annual expo, and they host webinars and they're an incredible resource for, for families for patients, for healthcare providers to really make the patient's life a little bit easier.

And if you haven't checked it out, I can tell you that I know personally and from so many others who I've spoken to who are aware of it, the response was always, "Where was this my whole life?" You know? When people felt isolated, confused, alone what they offer is just so tremendously valuable.

Kristine Kucera:
And thank you, Chava, for being an advocate.

You are an amazing advocate, and I love that you want to help other patients with this disease and how to cope with it. I mean, it is coping with something that never goes away. It's controlled but never goes away. We just have a couple minutes left. I want to ask you one thing, Chava.
If one of your providers could have done something different earlier in your disease journey, what would it have been?

Chava Wald:
Aside from the treatments being available earlier in my journey? Yeah, I would say that really the biggest transformation has been the so many options, the amount of options that are available.

That really was a pivotal moment in my eczema journey and managing it. And it almost gave me a second lease on life, you know? Living life now it's like there was chapter one and chapter two, or part one and part two. It's a very different quality of life. You know? Like, when my children were young and I couldn't bathe them because the soaps and everything that they use that are advised for newborns now my hands are—I don't have the fissures. I don't have all the dyshidrotic eczema that I used to have. I couldn't bend my fingers. This could not be done. There were fissures everywhere. And so it meant when my child was a newborn, coordinating with my husband, when can he give the baby a bath pre-dinner, you know?

A newborn baby could want a bath at 5:00 PM, and for someone who has to work and take calls, there's a lot of logistical challenges, and I can never get that back, you know? Like, sitting there next to my daughter when she was a newborn, I'll never get that back. So I guess the biggest change and I guess, what you're saying, the question was on if someone could change something, letting people know the options, right?

Like, just ensuring that patients know there are choices, and that's something that I do all the time. I tell them there are choices. There's safe options. There's a lot of different options. There's all different types to meet everyone, and they all work differently.

As someone who's been on three biologics, another thing I say is it's not a one-size-fits-all. It's very heterogeneous. I use that word, but then I explain what it means. And just letting people know that there are choices is the biggest gift.

Kristine Kucera:
I agree, and I will say I'll leave the clinicians with this. Treat early and treat to target.

And Chava, thank you so, so much for being here and sharing your journey and being such an amazing advocate for patients with atopic dermatitis.

Chava Wald:

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Thank you. Thank you for all that you're doing.

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