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The Future of Pediatric Atopic Dermatitis Treatment

**Announcer:**
You're listening to *On the Frontlines of Pediatric Skin Health* on ReachMD. Here's your host, Dr. Brian McDonough.

**Dr. McDonough:**
Welcome to *On the Frontlines of Pediatric Skin Health* on ReachMD. I'm Dr. Brian McDonough, and joining me to discuss the future of pediatric atopic dermatitis management is Dr. Mercedes Gonzalez. She's a Clinical Assistant Professor at the FIU Herbert Wertheim School of Medicine and the Philip Frost Department of Dermatology at the Miller School of Medicine in Miami. She also serves as the Medical Director at Pediatric Skin Research. Dr. Gonzalez, I want to welcome you to the program.

**Dr. Gonzalez:**
Thank you so much. It's a pleasure to be here.

**Dr. McDonough:**
To start us off, how would you describe the current treatment landscape for pediatric atopic dermatitis, and what do you see as the biggest unmet needs today?

**Dr. Gonzalez:**
It's really an exciting field right now. It's not a bad time to have atopic dermatitis if you're a child. There are so many new options available that are nonsteroidal topical treatments, something that we've been waiting for for a very long time.

For a very long time, the approach to pediatric atopic dermatitis was different-potency topical steroids. And we know that they can have a number of side effects when you use them long-term. They can thin the skin. They can lead to acne in the area. They can lead, most importantly and concerningly in small pediatric patients, to systemic absorption from prolonged topical steroid use, where they absorb some of the steroid into their blood, and that reduces their own ability to produce cortisone. And we know the direct impact that systemic absorption of corticosteroids can have on growth, as well.

And so there was that long unmet need for non-steroidal topical treatment approaches. And now, we have so many options. I would say, if you're six years and above, there are more options than if you're less than six years of age. But very, very soon, those topical treatments are going to now become available down to three months of age.

That's what we hope, at least—that many of these will get the age indication down to three months of age, because we know that many patients will have the first sign of atopic dermatitis before a year of eight. Roughly 60 percent of children will have the first sign of atopic dermatitis before one year of age. 90 percent have the first sign of atopic dermatitis before five years of age. So it's really a pediatric disease, and the age indication needs to be down to three months of age. So that's a big unmet need right there, right? We need to lower that age indication for the newer topicals.

And then, similarly, it's when these patients need systemic treatments after you have optimized your topical treatment approach. Sometimes patients are still unable to get prolonged periods of clear skin—itch-free, roughness-free, redness-free skin. If they're unable to get a prolonged, meaningful period of that with the topical treatments alone, then we need systemic options.

And fortunately, we now have a lot of systemic options that are targeted biologics, but many of those are limited to 12 years and above. So there's a big unmet need in that three month to 11-year-old period for more systemic targeted biologics there. And hopefully they're coming, because I know many studies are underway.

**Dr. McDonough:**

Let's talk about targeted therapies for a moment. From your perspective, what's driving the move toward a more targeted approach, and how have you seen it changing in day-to-day care?

**Dr. Gonzalez:**
As we learn more about the exact pathophysiology and pathomechanisms underlying the immunologic component of atopic dermatitis, these targeted biologic therapies really hit the nail on the head, where they're targeting the key player that's really leading to the perpetuation of the Th2 inflammation in the skin. It's targeting that key cytokine or cytokines without targeting other parts of the immune system and providing the long-lasting skin clearance and itch relief that these children need without targeting any other parts of the immune system and with fewer side effects.

Also, these medications have helped us learn more about the pathophysiology. When you use an antibody, you block that cytokine, and you see that blocking IL-13 leads to significant itch reduction and skin clearance. We know that IL-13 is one of the major players in atopic dermatitis. And so these targeted therapies have really revolutionized our approach to the systemic treatment of atopic dermatitis. They've been highly effective, and we're looking forward to that expanded age indication down lower. So right now, we have antibodies that target IL-4 and IL-13. We have some antibodies that target IL-13 alone, and then we have an antibody that targets IL-31, and that specifically is a game-changer when it comes to itch relief in patients with atopic dermatitis.

**Dr. McDonough:**
Looking at newer and emerging therapies, what stands out to you as the most promising for children with atopic dermatitis?

**Dr. Gonzalez:**
A few things come to mind when I think about this. Number one is, in children, it's fewer injections. We need things that can prolong the lasting effect of the medication. And so there are things out there that prolong the function of that antibody and prolong that blockade of the IL-13 so that the dosing can then be every three months, instead of every two weeks, as we have now.

And so that is a huge, very exciting area of potential future treatment, right? Next, there is targeting other parts of the immune pathway. So there's the OX40 ligand pathway that's a little bit more upstream and can lead to balancing of the immune system. And for that one, the idea is that it's going to have the potential to be fewer injections, as well. And so when I think of kids, that's the first thing that comes to mind. I think most people in general do not love injections, but when it comes to children, decreasing that frequency of injections is very important.

And then we're moving to oral medications. We know in psoriasis now, some of these biologic antibodies have been able to be formulated via the oral route. And so I'm looking forward to that coming into the atopic dermatitis space,

**Dr. McDonough:**
For those just tuning in, you're listening to *On the Frontlines of Pediatric Skin Health* on ReachMD. I'm Dr. Brian McDonough, and I'm speaking with Dr. Mercedes Gonzalez about how pediatric atopic dermatitis care is evolving.

So, Dr. Gonzalez, as these newer therapies become more widely available, how do you see treatment algorithms evolving for pediatric patients?

**Dr. Gonzalez:**
So the exciting thing that we're seeing now is that these targeted biologic therapies may have the ability to attenuate or prevent other diseases within the atopic march, especially when you're starting them earlier. And I have already seen this evolve in my own practice. I am starting the conversations and actually starting patients on these biologic therapies much, much earlier in their disease course.

I'm not waiting for two or three visits, where they come in and they tell me that the topical treatments have failed to achieve meaningful clinical remission periods. I'm going to—perhaps even on the first visit, when I see that they've already tried sufficient potency topical treatments in the correct way—be prescribing them the targeted biologic therapy, because I know the life-changing potential that it can have. And then, especially clinical data is showing emerging large, retrospective, cohort reviews that have looked at the initiation of these targeted biologic therapies and how they have the ability to attenuate the development of those atopic comorbidities, such as allergic rhinitis and asthma.

**Dr. McDonough:**
Now, what role do safety considerations play in these conversations, and how are we monitoring it in the long-term in these newer agents?

**Dr. Gonzalez:**
So safety is of number one concern in the pediatric world, and that's always the first question that I get when I'm introducing that idea of

any new treatment, but especially with something like a biologic therapy that's administered via injection. That is always the first and foremost question I get from parents.

And fortunately, we now have a biologic that has been approved down to age of six months for some time now—since 2022, I believe, was the indication for down to six months of age for pediatric patients for dupilumab, specifically.

And since then, we've had not only the results of long-term, open-label long-term extension studies iin those patients that have informed the safety data, but we have other pediatric indications as well with the same medication. So we have indications for eosinophilic esophagitis down to one year of age, and that adds to the number of young patients being treated with that same medication where no new safety signals have appeared. So that's very reassuring.

In addition, we continue to collect real-world experience and data and follow registries and reports of any new adverse events coming up related to the medication. You follow those through real-world registries that are ongoing, and really, so far, there haven't been any new safety signals. There are those rare things that have come up since the clinical trials, such as rare reports of arthralgias and facial flushing, but really, the main side effects that we're seeing during the clinical trial programs are the main ones that still need to be communicated to families, which are, for dupilumab specifically, injection site reactions, and conjunctivitis happening in about 10 percent of patients who take it. Most patients who get the conjunctivitis don't stop the medicine, they just treat the conjunctivitis and continue on. There's also reactivation of herpes simplex virus, which is very rare, but it is mentioned in my discussion with families.

The great part about it is, it's different than anything that they've used before, and it's different than prior systemic therapies. This is not a broad immunosuppressant, and so it's something that's more targeted. And really, there's no heightened risk of serious infections when they're on this medication.

So that's pretty reassuring for families as well.

**Dr. McDonough:**
Well, before we wrap up our program, Dr. Gonzalez, do you have any final thoughts you'd like to share with our audience?

**Dr. Gonzalez:**
I think it's a very exciting time for pediatric atopic dermatitis, especially the moderate-to-severe patients. I see patients every day coming in frustrated, and what I tell them is that it doesn't have to be this way. We now have tools. We have tools in our toolbox that can get you to where you have clear skin and you're itch-free, and it's really about using a combination of the currently available therapies to get them to that clear, itch-free skin.

And that's possible. Had we been speaking about five, maybe seven years ago, I wouldn't have said that. And so now I'm excited when I see moderate-to-severe patients, because I know I can get them clear, itch-free skin.

**Dr. McDonough:**
And on that note, I'd like to thank my guest, Dr. Mercedes-Gonzalez, for joining me to explore what's coming next in pediatric atopic dermatitis treatment. Dr. Gonzalez, it was great having you on the program.

**Dr. Gonzalez:**
Thank you so much. It was my pleasure.

**Announcer:**
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