Tips for taming atopic dermatitis and managing expectations

Publish date: February 23, 2017
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Internal Medicine News

MIAMI – Tactics for managing patients with atopic dermatitis can go a long way to educate patients, set realistic expectations, and devise strategies for existing therapies, even as clinicians await some promising agents expected on the market soon.

"The good news is this is the Age of Eczema. In the last couple of years we've seen an explosion in the literature," Adam Friedman, MD, of the department of dermatology, George Washington University, Washington, D.C., said at the Orlando Dermatology Aesthetic and Clinical Conference. Some of this research is spurring new therapeutics. a phosphodiesterase 4 inhibitor.

Crisaborole ointment, 2% (Eucrisa), a phosphodiesterase 4 inhibitor, was approved by the Food and Drug Administration in December 2016 for treating patients aged 2 years and older with mild to moderate AD, for example. It is a novel, nonsteroidal anti-inflammatory and the first prescription agent approved in the United States for atopic dermatitis in more than 10 years.

Dr. Friedman has no personal experience with crisaborole, which just became available. "But the data look encouraging. From what I've seen this may be a nonburning alternative to calcineurin inhibitors. It will be interesting to see how this will fit in our practices."

Systemic management of pruritus

There's also promise for patients troubled by one of the top manifestations of AD – the itch. "We have new targeted therapies coming down the pike, some hopefully [gaining approval] in the next few months. We have biologics going after the cytokines of itch. It's a very, very exciting time right now," Dr. Friedman said.

Current clinical trials are not only focusing on AD but also specifically on pruritus, he added.

In the meantime, itch can be managed with prescription and over-the-counter topical agents, as well as systemic therapies such as gabapentin, some antidepressants, and the antiemetic aprepitant. Aprepitant is a substance P antagonist (through blocking neurokinin 1 receptor) and can be effective for some patients when taken three times a week, but it is not indicated for itch, Dr. Friedman said. Because of its off label indication "it's a little tricky getting [insurance] coverage."

Back to basics

"Even with all the excitement, even with the new therapeutics, you have to stick with the basics," he said. "Put the lotion on, put the cream on. You have to put moisturizer on wet skin and be cautious with soaps." He added, "don't be afraid to ask for help. The National Eczema Association has a wonderful website with research, education, tools – you name it."

Keeping it real

For regional eczemas like hand dermatitis, what are the options? "Tell patients they can glove up, there are various latex alternatives … but it probably won't fly in the real world," Dr. Friedman said. Zinc oxide "works like armor, and patients will probably do well," but the aesthetics are unacceptable for most, he added. "Newer alternatives, such as those with aluminum magnesium hydroxide stearate, have similar protecting power, but are not opaque and rub on easier."

A goal of topical therapy is to get rid of the inflammation, and steroids have a long history of evidence supporting their use, but "topical steroid phobia in parents" is a problem, he said.

To counter the reluctance or refusal to use topical steroids, he suggested exploring reasons for noncompliance, dispelling any myths, and working with parent to make it easier to apply the steroids to their child.

Interestingly, there is some evidence that a simpler regimen may work well for some patients. “We always say ‘apply twice a day.’ Why? Because all the clinical trials had participants apply steroids twice a day. But there is no evidence to show twice a day is better than once a day, and in fact, a meta-analysis suggests once a day works just as well” (Br J Dermatol. 2005 Jan;152[1]:130-41).

Topical calcineurin inhibitors are another option. In general, Dr. Friedman prescribes these agents for delicate areas, for patients with thin skin, or for patients who use a topical steroid “on and on and on and can’t seem to get off it.” Calcineurin inhibitors can also be used on in-between days during steroid maintenance therapy, he added. When prescribing, warn patients about the initial burn (due to substance P release) that commonly occurs so that they have realistic expectations.

Education remains essential

“I encourage you to educate your patients and empathize with them,” he said. “Show them how to apply a moisturizer. Also, use your nurses and assistants to help with education – really empower them to be part of the process.”

“Explain, explain, explain, so they have realistic expectations,” and know that there is no cure, so that when they experience a flare, they understand that “it’s not that the steroid didn’t work – this is a chronic disease,” added Dr. Friedman, who recommends providing patients with handouts that answer many of their questions.

Maximize moisturizing

When it comes to moisturizing, more is usually better. Effective products contain all the key ingredients: emollients to soften the skin, an occlusive to keep the water there, and a humectant to bond the water. “Just one or two is not going to cut it,” he said.

“Something we now know is that starting early is key,” he pointed out, referring to recent studies that have shown that in babies at high risk for AD, starting moisturizers early can decrease their risk for developing AD later (J Allergy Clin Immunol. 2014 Oct; 134[4]: 818-23).

“Another study that received a ton of press was in JAMA Pediatrics recently,” Dr. Friedman said. The study concluded that the use of different moisturizers to prevent AD in high risk babies was likely to be cost-effective (JAMA Pediatr. 2017 Feb 6;171[2]:e163909. doi: 10.1001/jamapediatrics.2016.3909). Although some news reports claimed starting babies with Vaseline as a moisturizer will prevent AD, “that’s actually not what the study showed. All the over-the-counter moisturizers they used worked, but Vaseline was the least expensive,” Dr. Friedman noted

Help patients select the right soap

Educate patients to avoid “true soaps” such as Dial, Ivory, Irish Spring, or Lever 2000. “Soaps can be a real enemy here. You want lower pH types of soaps. Depending on skin type, our skin is somewhere between 5.5 and 6.5 pH,” Dr. Friedman explained. “The paradigm shift for your patients is to hydrate, not to clean. Showers are okay if they’re not blaring hot. Baths are okay ... but you should not be sitting in a sudsy bath.”

Also, instruct patients to avoid irritating fabrics, dryer sheets, or harsh laundry detergents that could exacerbate AD.

‘You’re not alone’

Sometimes it’s helpful to assure patients with AD that they’re not alone, and that many researchers and clinicians are working on

effective treatment strategies. “We’re all familiar with atopic dermatitis because there’s so much of it. The numbers are surprisingly high,” Dr. Friedman said. Compared with the estimated 2.2 million Americans with psoriasis, AD eclipses their numbers substantially, affecting about 17 million people.

Dr. Friedman disclosed that he is a speaker for Amgen, Janssen, and Promius; receives research grants from Valeant; and is a consultant and/or advisory board member for Amgen, Aveeno, Biogen, Encore, Exeltis, Ferndale, Galderma, G&W Laboratories, Intraderm, La Roche-Posay, Loreal, Microcures, Nano Bio-Med, Novartis, Oakstone Institute, Occulus, Onset, Pfizer, Promius, Sanova Works, and Valeant. Dr. Friedman is also an editorial advisory board member for Dermatology News.

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