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I'd like to discuss two very common questions that are asked about dupilumab in our pediatric age group. One is about duration of therapy, and the other is about monotherapy versus combinations of therapy. I'll start with the second one first.

It's pretty much standard for me to recommend that patients who are on dupilumab still use their moisturizers and still use their topicals, steroids or non-steroids, as needed to try to drive them to the most clear skin that they can get.

Now in clinical practice, I'll tell you that, especially my pediatric patients and my adolescents in particular, when they're on systemic therapy, they're really happy to lay off of their topicals partially because many have sort of topical medicine exhaustion. And they're happy just to go with their systemic medicine. But I do cheerleading to try to get them to clear up the rest of their skin, because I think it's an appropriate thing for them to do, minimize both the symptoms and the signs of the disease.

So it's standard practice to use topicals plus the systemics, at least in terms of what we recommend for our patients. But it can take, as I said, some cheering on to get them to do that.

The question about duration of therapy-- so everyone has their different ways of discussing it with their patients. I standardly recommend to my patients that with the decision for dupilumab, I'm going to plan on a year of therapy to get started, and we'll assess the clinical response in six months.

That verbiage that I use is just coming with experience in sort of what I want where I want my patient's expectation to be. I don't want them to look at where they're at in six weeks or eight weeks and go, oh, maybe we're not going to respond as well as others. I set up an expectation that we'll sort of see where their response is at six months.

But I'll also explain to them that I've had many patients who responded decently in six months, but they weren't in that clear or almost clear group. But when they were at nine months, they were doing incredibly well. So you can have continued improvement over time, especially in our more severe patients.

And I say it's basically a year to get started, because with a biologic agent where you could, if you stop start, potentially end up with a situation of developing more anti-drug antibodies. I generally want patients to use their drug and continue to use it. So I'll generally say, let's use it for a year. And as we're crossing towards the end of that year, make that decision whether we extend to the second year, which most of my patients have been doing.

Now, what we don't know is whether if I do two years of therapy or three years of therapy or 1 and 1/2 years of therapy for a certain type of pediatric patient with atopic dermatitis, is that enough to kick them into a sustained remission or to change their disease state or what the average time will be off of their systemic agent if we stopped it, in terms of figuring out what their disease would be like down the road.

These are questions I'll have to figure out over time. But the quick question is basically a year to get started, six months to assess where we're at, and then many extending beyond a year of therapy. And then it's case by case basis, in terms of whether one wants to stop the therapy and see if they remain in remission, so to speak, or if they have more active disease over time.