BroadcastMed | cmr_011874_faculty_presenter_2_eichenfield_question_4-1080p.mp4

My general approach to therapy is really going to be based upon what's been tried before, if anything, and what the response has been. Pretty much all patients, we start off with topical therapies, the standard routine of appropriate skin care, moisturizers, avoidance of allergies and irritants, and topical anti-inflammatory therapies, which include our topical corticosteroids and then our non-steroid topical calcineurin inhibitors, and now topical PDE4 inhibitors.

And we try to do a mix and match between rapid disease control, many times, using more potent topical corticosteroids, and then long-term disease control with intermittent and topical corticosteroids or calcineurin inhibitors or PDE4 inhibitors. And that's going to be the standard, and the more mild patients are going to respond very well to those. And that'll be the extent of what we do over time.

As we get to a more moderate to severe disease, the question is how effective is that strategy? How clear are patients? What's the time course of clearness, so to speak? In other words, if they clear up after intensive topicals in two weeks, where are they at in four weeks? Can we get to intermittent therapy topically that's safe to use long term, and still maintain them in good shape, or not? And also, what's the burden of that therapy?

I have some patients who can use large volumes of topical agents. And they're 70%, 80% under control. They're OK with it, but when you actually ask them what it's like to keep doing that, to do the topical therapies with the ointments multiple times a day, there's a lot of wear and tear on them. So in other words, there's a burden of topical therapy.

So, well, I then try to then define if I have a patient who is either inadequately responding to topicals or the disease burden is outstripping what they're able to do to keep their disease in good shape, then I'm going to move into the discussions about systemic therapy.

Systemic therapies, I sort of have a step of systemic therapy. Phototherapy is still traditional as, quote, "the first systemic." It can be highly effective. It can be remitted for disease. Generally, I'm talking about ultraviolet B therapy. But it's increasingly hard to do in most of the country.

I live in San Diego. Traffic's not so easy to come down three times a week for 12 weeks into a light box to get adequate UVB therapy. So sometimes it may not be practical, even though it's a reasonable therapy to consider.

Then in pediatrics, our move to systemic therapies that are oral or injections or infusion, we've had a history of not having any approved therapy, other than corticosteroids. And oral or IM corticosteroids aren't really advised to be used, because they can take a ravage on the system.

They are occasionally used for aggressive flare control in short-term usage. It's certainly used with comorbid conditions such as asthma. But they can't be used effectively in a long-term strategy for pediatric and adolescent atopic dermatitis. And so we then move into our other systemic agents.