

As clinicians, we have to walk that tightrope between safety and efficacy a lot, and we know that to do it wisely we can often build up on our therapeutic ladder. We'll take the easiest, safest things first. Avoiding triggers, using emollients or moisturizers. We'll build up slowly and steadily depending on the disease severity and the treatment response. I think that's important too.

Some patients look worse than they are, others don't look so bad, and unfortunately those people often get dismissed, but they're really suffering in silence. So we want to really meet their needs and connect with our patients so that we know we're getting them better and that they're happy with it. As we increase on our potential therapies, we know that those risks often come up along with them, so we want to be really mindful about that.

And of course this opens up the door for a number of unmet needs. We need other topical agents that are safer and more effective. We definitely need new systemic agents that are going to offer different age groups new treatment potential for people that are stuck or that are not responding or can't use some of the existing treatments. And importantly, we have to keep learning from each other about what the best approach to a given patient is and what to do if things are not responding.

Sometimes it really means just getting another opinion and looking at it from a fresh vantage point. Sometimes we realize that it may not have been what we thought it was all along. Atopic dermatitis with its heterogeneity sometimes can trick us. It can look like something that we think that we're treating, and then we say, gosh, you know, actually this isn't AD alone. Maybe this is co-infected with tinea.

Maybe there is a significant stuff component. Maybe, in an adult, it's cutaneous T-cell lymphoma that we've been barking up the wrong tree the whole time. So all of these pieces can come together when we have a good communication between the patient and the provider, and we're really open to finding what works for a given patient and family.

For the mildest patients you may find just good skin care. Don't use that fragrant soap. Don't scrub with that harsh towel. Use gentle cleanser and moisturize right after, that may be enough. As we get into the more mild and moderate patients, we're going to probably use our topical corticosteroids. Again, they're very inexpensive and accessible. They tend to be very safe when used correctly and extremely effective. Most patients will respond, but we're going to be watching them.

And if it seems like they're overusing or not responding, then we want to be mindful and jump in before there's a problem. We don't want to wait till they're having stretch marks or skin thinning before we change things up. We can then think about some of the other pieces, including phototherapy, the systemic immunosuppressants, and even potentially the dupilumab biologic agent for a number of these patients because they've gone up that therapeutic ladder to the point where now we have to consider these risks and benefits together.

And for many families, if the phototherapy is not an option, be it with time or money, or if it's not effective, it helps probably on the order of 60% of patients with atopic dermatitis, then I think we really need to think about a systemic agent. And what I find is that as my comfort level has grown in the last few years of using it, I tend to want to use something more targeted first. So for me, dupilumab often is my first choice systemic agent, unless there is a compelling reason not to.

Part of the issue is that if we go with a conventional immunosuppressive agent, even if they work great and it is often very effective, my agent of choice tends to be cyclosporine. I still have a number of patients who use it. But even if they're doing great, I view it as a temporizing measure. I don't want any patient on it for longer than a year. And ideally, I want patients on it for just a few months because I want to really minimize the risks both in terms of the drug itself, potential infections, and even neoplasia that can happen while you're immunosuppressed.

But even the fact that they have to come in every month and get blood draws, there is a small but real risk to that. The coming to and fro, the getting the draw, checking those labs, and making sure that everything's OK. And sometimes it's not. Sometimes we see the kidneys responding in a negative fashion. Sometimes we have liver enzyme elevation.

So we really would prefer to shield the patients from this if we can. And even if we can't, we're going to do this for a few months and then we'll stop. But if they go back to where they were, then, in good faith, we can say to the insurance company and the family and the world, we can say look, we went up the ladder. Here's why we're using this agent, and for those patients, it often can be a sense of home. Because they find they can use something that is relatively safe and very effective, and that can be used for a longer period of time to give them many months or sometimes even many years of relief without needing these other aspects, and that can be extremely liberating.