From a therapeutic standpoint, we approach everyone, to some degree, at the same starting point. We have even the mildest patients where we want to make sure we're avoiding known triggers. We want to make sure we're supporting their skin barrier, usually with a good moisturizer.

And as we get increasing severity, we begin to go up that therapeutic stepladder. So for the mild patients, maybe all they need is a moisturizer. As we get a little bit more mild to moderate, they probably are going to need some therapy. And the most common first step would be a topical corticosteroid-- inexpensive, very well tolerated by most, and extremely effective. That's often the first step.

But as we get to more moderate and severe, two things start to happen. First, we sometimes have primary therapeutic failure. The steroid didn't work well enough to clear them. And those are really more significant cases where we're really stuck sometimes. Even with more potent topical steroids, we don't get the response we need.

Much more commonly, however, is the inability to use them safely. So people are putting on their topical corticosteroid, and as soon as they stop, they flare right back up. For those patients-- who, again, I would argue are, by definition, moderate or severe just because of the need for treatment-- for those patients, we have to start thinking a little bit more broadly. Topical steroids aren't going to be the whole answer.

And this is where we bring in things like our topical calcineurin inhibitors, crisaborole, phototherapy, and our host of systemic therapies, both the classical systemic therapies, which really are modern immunosuppressants-- cyclosporine, azathioprine, methotrexate, mycophenolate, and even though we don't like to use it, it is technically FDA-approved-- prednisone. So we can use those sparingly in certain situations, but they, of course, have a host of side effects and have significant risks that we have to discuss with each patient, not to mention the fact that everything except prednisone on that list is actually not technically FDA-approved for the treatment of atopic dermatitis in children or adults.

And then, of course, we have our newest entry into the systemic domain, which is dupilumab. And dupilumab is, of course, a monoclonal antibody that is a biologic agent, very similar in terms of its overall pluses and minuses to many of the other biologics that we have in medicine right now, particularly in psoriasis, in that by being more targeted, we can avoid broad immunosuppression and all of the associated side effects and risks that come along with that, and yet we trade very little of the efficacy. And arguably, some patients respond even better than they might to a conventional immunosuppressant.

So we can sort of go up this therapeutic ladder, meeting the needs of each patient. To some degree, regardless of how they might look initially, that diagnosis of severity is somewhat flawed, because the way a patient looks on a given day may not necessarily be how they look throughout the year. And importantly, it may not predict all the time how they're going to do to therapy. I have some patients that don't look that bad but are extremely therapy-resistant and require much stronger medicines. Other patients come in looking quite frightening on that first visit, and even the simplest therapies will turn things around. They'll call me in a week and say, I'm doing great. I'm barely needing a steroid medication. The moisturizer feels great, and I'm doing much better overall.