ATOPIC DERMATITIS MANAGEMENT (Part 1 of 2)

Therapy		Strength	Dosage form	Dosing/frequency	Recommendations
NONPHARMACOLOGIC					
Topical moisturizers	Emollients (glycol and glyceryl stearate, soy sterols)	—	crm, oint, gel, lotion, oil	Liberal and frequent reapplication. Apply soon after bathing to improve skin hydration.	• Mild AD: main primary treatment. • Moderate to severe AD: incorporated into regimen.
	Occlusives (petrolatum, dimethicone, mineral oil)				
	Humectants (glycerol, lactic acid, urea)				
Prescription emollient devices	Palmitoylethanolamide-, glycyrrhetinic acid-, or other hydrolipid-containing preparations	—	crm	2–3 times daily.	• Adjunct to treatment and maintenance. • More costly than topical moisturizers but not superior.
Bathing	Water	—	—	Once daily for 5–10mins (warm water). Apply moisturizer immediately after bathing. *Severely inflamed skin:* up to 20mins; apply topical anti-inflammatory therapies (TCS) immediately after without towel drying.	• Use of nonsoap-based surfactants and synthetic detergents (syndets) are often recommended. • Limit use of neutral-to-low pH, hypoallergenic, and fragrance-free nonsoap cleansers. • Limited data on the addition of oils, emollients, and other related additives to bath water, and the use of acidic spring water (balneo-therapy) and water-softening devices; not recommended.
Wet-wrap therapy	Topical agent covered by wetted first layer (tubular bandage, gauze, cotton suit) and dry second layer	—	—	Up to 24hrs at a time for up to 2wks.	• For significant flares and/or recalcitrant disease. • Use with or without TCS for moderate to severe AD (caution with medium to higher potency TCS).[1]
Phototherapy	UVB	Narrowband (309–312nm)	—	Administer to affected areas 2–5 times weekly	• Last-line therapy for non-immunocompromised patients with topical treatment failure.
PHARMACOLOGIC[2]					
Topical Corticosteroids[3]					
Very high potency	augmented betamethasone dipropionate (oint)	0.05%	crm, oint, lotion, foam, soln, gel	*Treatment:* apply twice daily until lesions improve, for up to 2–4wks at a time; for high potency TCS, may apply once daily. Use 0.5g for an area of 2 adult palms. *Maintenance:* apply 1–2 times weekly for frequent, repeated flares at same site.	• First-line pharmacologic therapy for mild to moderate AD if uncontrolled by moisturizers or irritant avoidance. • Use concomitantly with moisturizers. • Use least potent TCS that is effective. • Lower potency TCS should be used on the face and skin folds and medium to high potency TCS on the body. • Monitor cutaneous side-effects during long-term, potent steroid use. Routine monitoring of systemic effects is not recommended.
	clobetasol propionate	0.05%			
	diflorasone diacetate (oint)	0.05%			
	halobetasol propionate	0.05%			
High potency	amcinonide	0.1%			
	augmented betamethasone dipropionate (crm)	0.05%			
	betamethasone dipropionate	0.05%			
	desoximetasone	0.25%			
	desoximetasone (gel)	0.05%			
	diflorasone diacetate (crm)	0.05%			
	fluocinonide	0.05%			
	halcinonide	0.1%			
	mometasone furoate (oint)	0.1%			
	triamcinolone acetonide	0.5%			
Medium potency	betamethasone valerate	0.1%			
	clocortolone pivalate	0.1%			
	desoximetasone (crm)	0.05%			
	fluocinolone acetonide	0.025%			
	flurandrenolide	0.05%			
	fluticasone propionate	0.05%, 0.005%			
	mometasone furoate (crm)	0.1%			
	triamcinolone acetonide	0.1%			
Lower-medium potency	hydrocortisone butyrate	0.1%			
	hydrocortisone probutate	0.1%			
	hydrocortisone valerate	0.2%			
	prednicarbate	0.1%			
Low potency	alclometasone dipropionate	0.05%			
	desonide	0.05%			
	fluocinolone acetonide	0.01%			
Lowest potency	hydrocortisone acetate	0.5–1%			
	hydrocortisone base	0.25–1%			

(continued)

ATOPIC DERMATITIS MANAGEMENT (Part 2 of 2)

Therapy		Strength	Dosage form	Dosing/frequency	Recommendations
Phosphodiesterase 4 (PDE4) Inhibitor					
crisaborole	**Eucrisa**	2%	oint	*Mild to moderate:* **≥3mos:** apply a thin layer to affected areas twice daily.	• First-line treatment
Topical Calcineurin Inhibitors					
tacrolimus	**Protopic**	0.03%, 0.1%	oint	*Moderate to severe:* **≥2yrs**[4]**:** apply a thin layer to affected areas twice daily. 2–15yrs: use 0.03% strength. ≥16yrs: use 0.03% or 0.1% strength. May use 2–3 times weekly as maintenance therapy to prevent recurrent flares.	• Second-line therapy for short-term and non-continuous chronic treatment of AD in non-immunocompromised patients with inadequate response to topical prescription therapies or when they are not advisable. • Preferred for sensitive areas (eg, face, skin folds). • Not recommended during active infections of lesions. • May be combined with TCS sequentially or concomitantly. • Long term safety has not been established due to association with skin malignancies and lymphoma; avoid continuous long-term use in any age group.
pimecrolimus	**Elidel**	1%	crm	*Mild to moderate:* **≥2yrs**[4]**:** apply a thin layer to affected areas twice daily. May use 2–3 times weekly as maintenance therapy to prevent recurrent flares.	
Interleukin-4 Receptor Alpha Antagonist					
dupilumab	**Dupixent**	100mg/0.67mL, 200mg/1.14mL, 300mg/2mL	SC inj	*Moderate to severe:* **6–17yrs** (15–<30kg): initially 600mg (two 300mg inj at different sites) followed by 300mg every 4wks; (30–<60kg): initially 400mg (two 200mg inj at different sites) followed by 200mg every other week; (≥60kg): initially 600mg followed by 300mg every other week. **≥18yrs:** initially 600mg followed by 300mg every other week.	• Reserved for patients with inadequate response to topical prescription therapies or when they are not advisable. • May use with or without TCS. • Topical calcineurin inhibitors may also be used, but should be reserved only for problem areas (eg, face, neck, intertriginous and genital areas).
tralokinumab-ldrm	**Adbry**	150mg/mL	SC inj	*Moderate to severe:* **≥18yrs:** initially 600mg (four 150mg inj), followed by 300mg (two 150mg inj) every other week. After 16wks, may consider 300mg every 4wks for patients weighing <100kg who achieve clear or almost clear skin.	
Janus Kinase Inhibitor[5]					
abrocitinib	**Cibinqo**	50mg, 100mg, 200mg	tabs	*Moderate to severe:* 100mg once daily; may increase to max 200mg once daily if inadequate response after 12wks.	• Reserved for refractory patients with inadequate response to other systemic therapies, including biologics, or when they are not advisable.
ruxolitinib	**Opzelura**	1.5%	crm	*Mild to moderate:* **≥12yrs:** apply a thin layer to the affected areas (up to 20% BSA) twice daily; max 60g/wk.	• For short-term and non-continuous chronic treatment of AD in non-immunocompromised patients with inadequate response to topical prescription therapies or when they are not advisable. • Not recommended during active infections, and for use with biologics, other JAK inhibitors, or potent immunosuppressants (eg, azathioprine, cyclosporine).

NOTES

Key: **AD** = atopic dermatitis; **BSA** = body surface area; **crm** = cream; **JAK** = Janus kinase; **MACE** = major adverse cardiovascular events; **oint** = ointment; **soln** = solution; **UVB** = ultraviolet B; **TCS** = topical corticosteroid

[1] Increased absorption of mid- to higher-potency TCS applied under the wraps may cause hypothalamic-pituitary-adrenal axis suppression.

[2] Systemic immunosuppressants (eg, methotrexate, mycophenylate mofetil, azathioprine) have been recommended for severe AD in patients with topical treatment failure.

[3] See Topical Steroid Potencies chart for more drug information.

[4] For children aged <2yrs with mild to severe disease, off-label use of tacrolimus 0.03% or pimecrolimus 1% can be recommended.

[5] Increased risk of serious infections, all-cause mortality, malignancies, MACE, and thrombosis in patients treated with JAK inhibitors for inflammatory conditions.

Not an inclusive list of medications and/or official indications. Please see drug monograph at www.eMPR.com and/or contact company for full drug labeling.

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