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Editorial

Managing atopic dermatitis: Have we reached a consensus?

Patients often hope that a simple solution or "magic bullet" can cure atopic dermatitis. Until this 'Holy Grail' is found, many innovative therapies will be put on trial. Their safety and efficacy should be evidence-based. The current therapeutic armamentarium can control atopic dermatitis and may even modify its course when used appropriately. In fact, the majority (70%) of childhood atopic dermatitis achieves remission by adolescence.

The management of atopic dermatitis should be holistic. Time should be spent on listening to patients and parents with empathy; assessing disease severity, response and adherence to previous treatments, how the disease impacts on sleep, daily activities, quality of life, and family members etc. Multi-disciplinary care may be indicated if there are comorbidities including asthma, allergic rhinitis, food allergy, growth, nutrition, stress and psychiatric disturbances.

Education should stress the chronic relapsing course of atopic dermatitis; its multifactorial aetiology, complex interaction of genetic and environmental factors; the underlying pathogenesis including skin barrier and immune dysfunction. After discussion of available treatments, an individualised treatment plan can be devised with the cooperation of patient and parents.

Basic therapy for prevention and maintenance include regular emollients, avoidance of irritants and trigger factors. The importance of emollient therapy in the long term control of atopic eczema regardless of severity should be stressed. Stepwise additional therapy is indicated according to disease severity or unsatisfactory response to first and second line therapies.

Treatment of mild to moderate eczema involves short courses (e.g. <two weeks) of topical steroid or topical calcineurin inhibitor daily as anti-inflammatory agents for control of flare-ups. Proactive maintenance therapy (e.g. topical calcineurin inhibitor once or twice per week) may be considered for sites predisposed to frequent relapses. This should prolong the period of remission and reduce the frequency of relapses. The issue of steroid phobia or potential side-effects from long term steroid misuse should be addressed. Oral anti-histamines have often been prescribed at night for patients with itching that disturbs sleep.

For severe widespread eczema or eczema unresponsive to first and second line therapy, consideration of wet-wrap therapy, hospitalisation, phototherapy or systemic immunosuppressive agents would be necessary. However it is important to first exclude or treat clinical infection beforehand.

Atopic dermatitis is associated with significantly elevated rate of bacterial, viral and fungal cutaneous infections. Appropriate antimicrobial agents are given as guided by clinical diagnosis, culture and sensitivity result. Systemic antibiotics are only indicated for overt signs of clinical bacterial infection. Diluted potassium permanganate soaks have been used for infected exudative lesions. Diluted bleach baths with nasal topical mupirocin have been reported beneficial in moderate to severe atopic

dermatitis with frequent bacterial infections, particularly for maintenance.[1]

There is a high rate of *Staphylococcus aureus* (*S. aureus*) colonisation in patients with atopic dermatitis. *Staphylococcus aureus* colonisation may itself exacerbate inflammation and barrier dysfunction. In this issue, Cohen and Orlow's article reviewed the evidence on the utility of specific anti-microbial treatment in patients without signs of overt superinfection. Anti-inflammatory treatment with topical corticosteroids or tacrolimus, without specific antibiotic treatment, is often sufficient to reduce *S. aureus* burden and the severity of atopic dermatitis in patients without signs of clinical bacterial infection.

There are concerns that the indiscriminate use of antibiotics may promote wider antimicrobial drug resistance, and topical antimicrobial use is also associated with contact dermatitis. There is less concern about development of bacterial resistance with diluted bleach, but further local study is awaited on its efficacy and treatment duration.[2]

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References

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