Guidelines of care for the management of atopic dermatitis

Section 4. Prevention of disease flares and use of adjunctive therapies and approaches

Work Group: Robert Sidbury, MD (Co-chair),[a] Wynnis L. Tom, MD,[b] James N. Bergman, MD,[c] Kevin D. Cooper, MD,[d] Robert A. Silverman, MD,[e] Timothy G. Berger, MD,[f] Sarah L. Chamlin, MD, MSCI,[g] David E. Cohen, MD,[h] Kelly M. Cordoro, MD,[f] Dawn M. Davis, MD,[i] Steven R. Feldman, MD, PhD,[j] Jon M. Hanifin, MD,[k] Alfons Krol, MD,[k] David J. Margolis, MD, PhD,[l] Amy S. Paller, MD,[g] Kathryn Schwarzenberger, MD,[m] Eric L. Simpson, MD,[k] Hywel C. Williams, DSc,[n] Craig A. Elmets, MD,[o] Julie Block, BA,[p] Christopher G. Harrod, MS,[q] Wendy Smith Begolka, MBS,[q] and Lawrence F. Eichenfield, MD (Co-chair)[b]

Seattle, Washington; San Diego, San Francisco, and San Rafael, California; Vancouver, British Columbia, Canada; Cleveland, Ohio; Fairfax, Virginia; Chicago and Schaumburg, Illinois; New York, New York; Rochester, Minnesota; Winston-Salem, North Carolina; Portland, Oregon; Philadelphia, Pennsylvania; Memphis, Tennessee; Nottingham, United Kingdom; and Birmingham, Alabama

Atopic dermatitis is a common, chronic inflammatory dermatosis that can affect all age groups. This evidence-based guideline addresses important clinical questions that arise in its management. In this final section, treatments for flare prevention and adjunctive and complementary therapies and approaches are reviewed. Suggestions on use are given based on available evidence. (J Am Acad Dermatol 2014;71:1218-33.)

Key words: aeroallergens; allergy testing; atopic dermatitis; calcineurin inhibitors; complementary therapy; corticosteroids; diet; education; flare; food allergy; topicals.

DISCLAIMER

Adherence to these guidelines will not ensure successful treatment in every situation. Furthermore, these guidelines should not be interpreted as setting a standard of care or be deemed inclusive of all proper methods of care nor exclusive of other methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the propriety of any specific therapy must be made by the physician and the patient in light of all the circumstances presented by the individual patient, and the known variability and biologic behavior of the disease. This guideline reflects the best available data at the time the guideline was prepared. The results of future studies may require revisions to the recommendations in this guideline to reflect new data.

From the Department of Dermatology,[a] Seattle Children's Hospital; University of California, San Diego and Division of Pediatric and Adolescent Dermatology,[b] Rady Children's Hospital, San Diego; Department of Dermatology and Skin Science,[c] University of British Columbia, Vancouver; Department of Dermatology,[d] Case Western University; private practice,[e] Fairfax; Department of Dermatology,[f] University of California San Francisco; Department of Dermatology,[g] Northwestern University Feinberg School of Medicine, Chicago; Department of Dermatology,[h] New York University School of Medicine; Department of Dermatology,[i] Mayo Clinic, Rochester; Department of Dermatology,[j] Wake Forest University Health Sciences, Winston-Salem; Department of Dermatology,[k] Oregon Health & Science University, Portland; Department of Biostatistics and Epidemiology,[l] University of Pennsylvania School of Medicine, Philadelphia; Kaplan-Amonette Department of Dermatology,[m] University of Tennessee Health Science Center, Memphis; Centre of Evidence-Based Dermatology,[n] Nottingham University Hospitals National Health Service Trust, Nottingham; Department of Dermatology,[o] University of Alabama at Birmingham; National Eczema Association,[p] San Rafael; and the American Academy of Dermatology,[q] Schaumburg.

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Reprint requests: Wendy Smith Begolka, MBS, American Academy of Dermatology, 930 E Woodfield Rd, Schaumburg, IL 60173. E-mail: wsmithbegolka@aad.org.

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Abbreviations used:

AAD:	American Academy of Dermatology
ACD:	allergic contact dermatitis
AD:	atopic dermatitis
APT:	atopy patch tests
HDM:	house dust mite
IgE:	immunoglobulin E
ICD:	irritant contact dermatitis
NIAID:	National Institute of Allergy and Infectious Disease
SCORAD:	SCORing Atopic Dermatitis
SPT:	skin prick tests
TCI:	topical calcineurin inhibitors
TCM:	traditional Chinese medicine
TCS:	topical corticosteroids
RCT:	randomized controlled trial

SCOPE

This guideline addresses the treatment of pediatric and adult atopic dermatitis (AD; atopic eczema) of all severities. The treatment of other forms of eczematous dermatitis is outside the scope of this document. Recommendations on AD management are subdivided into 4 sections given the significant breadth of the topic, and to update and expand on the clinical information and recommendations previously published in 2004. This document is the final in the series of 4 publications and discusses the management and control of AD flares using topical modalities and the utility and timing of allergen testing and avoidance. Also discussed is the use of adjunctive therapies and approaches, such as environmental, dietary, and educational interventions, in addition to complementary therapies.

METHOD

A work group of recognized AD experts was convened to determine the audience and scope of the guideline and to identify important clinical questions in the management of flare progression and the use of adjunctive therapies and approaches (Table I). Work group members completed a disclosure of interests that was updated and reviewed for potential relevant conflicts of interest throughout guideline development. If a potential conflict was noted, the work group member recused him or herself from discussion and drafting of recommendations pertinent to the topic area of the disclosed interest.

An evidence-based model was used, and evidence was obtained using a search of the PubMed and the Global Resources for Eczema Trials[1] databases from November 2003 through November 2012 for clinical questions addressed in the previous version of this guideline published in 2004, and from 1960 to 2012 for all newly identified clinical questions determined by the work group to be of importance to clinical care. Searches were prospectively limited to publications in the English language. Medical Subject Headings terms used in various combinations in the literature search included: atopic dermatitis, atopic eczema, surveillance, long-term management, short-term management, short-term care, long-term care, flare progression, relapse, patient follow-up, patient compliance, contact allergen, contact allergy screen, contact allergy test, desensitization, allergen antibody, antiallergen, antibody, dust mites, environmental, food allergy, irritant avoidance, detergent, clothing, diet, supplement, food introduction, oil, pyridoxine, vitamin, zinc, education, complementary, alternative, herb, supplement, homeopathy, massage, acupuncture, and Chinese medicine.

A total of 2062 abstracts were initially assessed for possible inclusion. After the removal of duplicate data, 287 were retained for final review based on relevancy and the highest level of available evidence for the outlined clinical questions. Evidence tables were generated for these studies and used by the work group in developing recommendations. The Academy's previously published guidelines on AD were evaluated, as were other current published guidelines on AD.[2-5]

The available evidence was evaluated using a unified system called the Strength of Recommendation Taxonomy (SORT) developed by editors of the US family medicine and primary care journals (ie, *American Family Physician*, *Family Medicine*, *Journal of Family Practice*, and *BMJ USA*).[6] Evidence was graded using a 3-point scale based on the quality of methodology (eg, randomized control trial, case control, prospective/retrospective cohort, case series, etc) and the overall focus of the study (ie, diagnosis, treatment/prevention/screening, or prognosis) as follows:

I. Good-quality *patient-oriented evidence* (ie, evidence measuring outcomes that matter to patients: morbidity, mortality, symptom improvement, cost reduction, and quality of life).
II. Limited-quality patient-oriented evidence.
III. Other evidence, including consensus guidelines, opinion, case studies, or *disease-oriented evidence* (ie, evidence measuring intermediate, physiologic, or surrogate end points that may or may not reflect improvements in patient outcomes).

Clinical recommendations were developed based on the best available evidence tabled in the guideline. These are ranked as follows:

A. Recommendation based on consistent and good-quality patient-oriented evidence.