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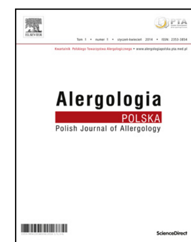

Reprint/Przedruk

Current guidelines for the evaluation and management of atopic dermatitis – A comparison of the Joint Task Force Practice Parameter and American Academy of Dermatology Guidelines

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ABSTRACT

Atopic dermatitis (AD) is a chronic, remitting-relapsing inflammatory dermatitis often managed by a multidisciplinary group of providers including allergists, dermatologists, and primary care practitioners. As the pathogenesis of AD is complex and multifactorial, there are numerous approaches to therapeutic management. Current AD management guidelines cover a broad range of interventions, from treating acute flares to environmental modifications. Allergists and dermatologists have both common and distinct approaches to AD management highlighted in their respective guidelines, providing multiple approaches to disease management. We compare and contrast the recent AAAAI/ACAAI JTF 2012 AD Practice Parameter and AAD 2014 guidelines, highlighting differing approaches to disease management.

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Introduction

Atopic dermatitis (AD) is a chronic, remitting-relapsing inflammatory dermatitis often managed by a multidisciplinary group of providers including allergists, dermatologists, and primary care practitioners. As the pathogenesis of AD is complex and multifactorial, there are numerous approaches to therapeutic management. Current AD management guidelines cover

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Methods

We reviewed and compared the following published guidelines:

1. The 2014 American Academy of Dermatology (AAD) guidelines:

   Guidelines of Care for the Management of Atopic Dermatitis: Section 1–4

2. The 2012 Joint Task Force (JTF) Practice Parameter Update, representing the American Academy of Allergy, Asthma & Immunology (AAAI); the American College of Allergy, Asthma & Immunology (ACAAI); and the Joint Council of Allergy, Asthma and Immunology:

   Atopic Dermatitis: A Practice Parameter Update 2012

The AAD guidelines and JTF Practice Parameter used similar review processes to develop their guidelines and recommendations, by performing a systematic search of PubMed and the Cochrane Library for relevant articles using subject headings such as *atopic dermatitis*, *eczema*, *topical corticosteroid*, and *calcineurin inhibitor*, among others [1, 2]. However, the AAD additionally utilized the Global Resources for Eczema Trials database (GREAT) for all newly identified clinical questions while JTF excluded this source [2].

The Practice Parameter was developed by the JTF, which has contributed 33 practice parameters to the field of allergy and immunology, including the original parameter on AD [1]. These guidelines were created primarily subspecialists in allergy and immunology, but also included dermatologists from the United States and Europe, as well as a psychologist. In contrast, the AAD work group generally consisted of academic dermatologists. Both sets of work group participants are experts in the field of atopic dermatitis.

The JTF Practice Parameter was an update of the 2004 parameter on AD, while the previous AAD Guidelines were also published in 2004. The JTF Practice Parameter is a single document with an executive summary, followed by evidence based summary statements and an annotated flow chart of the diagnosis and management of AD. For simplicity, the JTF Practice Parameter will be hereon referred to as the "JTF guidelines." The AAD guidelines are organized into 4 separate publications with data highlighted in tabular form. The AAD work group ranked the strength of their recommendations in descending order from "A" to "C" and the JTF used a similar strength of recommendation scale from "A" to "D" – both were based on the strength of evidence available for these clinical practices (Tables Ia and Ib) [1, 2].

Definitions and diagnosis

Both guidelines define AD as a chronic, pruritic inflammatory disease that commonly presents in the pediatric population, but can also affect adults. While both guidelines agree that the disease may be familial, only the AAD guidelines associate AD with an additional history of type I allergies, allergic rhinitis, and asthma [1, 2].

Both guidelines concur that AD is diagnosed clinically based on the patient's history, characteristic clinical findings, and the exclusion of other dermatoses [1, 2]. While the AAD guidelines distinguish atopy as an important, but not required, feature for diagnosis of AD, the JTF guidelines assert the necessity of an atopic history [1, 2]. The JTF guidelines outline the typical appearance according to the chronicity of AD lesions as pruritic, erythematous papulovesicular lesions associated with excoriation and serous exudate in the acute setting, whereas findings of lichenification, papules, and excoriations can be seen in chronic AD (JTF: D). In contrast, AAD guidelines delve further into standardized criteria based on revised Hanifin and Rajka diagnostic schemes (Table II) [1, 2].

Additionally, while the AAD guidelines mandate the exclusion of other common cutaneous disorders prior to diagnosis, such as contact dermatitis and cutaneous lymphomas, the JTF guidelines suggest this thorough re-evaluation particularly in patients recalcitrant to optimal therapeutic management [1, 2]. Other considerations discussed by the AAD work group include the lack of specific biomarkers required for diagnosis or severity assessment (AAD: BII), and the recommendation against obtaining routine IgE levels (AAD: AI) [1, 2].

Nonpharmacologic interventions

Bathing practices

Recommendations for bathing practices largely stem from expert consensus, with few objective measures documented in the literature. The JTF and AAD guidelines both recommend bathing with warm water followed by application of moisturizers (JTF: D, AAD: CIII) [1, 3].

Table Ia – Strength of recommendation from AAD.

Level I	Good-quality patient-oriented evidence	Level A	Recommendation based on consistent and good-quality patient-oriented evidence
Level II	Limited-quality patient-oriented evidence	Level B	Recommendation based on inconsistent or limited-quality patient-oriented evidence
Level III	Other evidence including consensus guidelines, opinion, case studies, or disease-oriented evidence	Level C	Recommendation based on consensus, opinion, case studies, or disease-oriented evidence

Adapted from Eichenfield et al. [2].

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