Strategies for Managing Pediatric Atopic Dermatitis

"The list of things that we can consider for our pediatric patients is growing by the month, and that is very exciting," says Dr Lisa Swanson.

Riya Gandhi, MA, Associate Editor

Elizabeth "Lisa" Swanson, MD, FAAD, is a board-certified dermatologist who specializes in pediatric dermatology at Ada West Dermatology in Meridian, ID. She is a former treasurer, vice president, and president of the Colorado Dermatologic Society.

In this interview, Dr Lisa Swanson shares her effective methods for diagnosing and assessing atopic dermatitis (AD) in children, emphasizing personalized care. She discusses simplifying treatment regimens to improve adherence, educating families on daily management, addressing common challenges, balancing medication options, and minimizing the psychological impact of the condition.

The Dermatologist: What are some effective strategies you employ to diagnose and assess the severity of AD in pediatric patients?

Dr Swanson: One of the most important things when you are evaluating a pediatric patient with AD is to examine their skin and look at the areas that are involved. I often describe these areas to patients and their families as hotspots. I will say, "Some patients with eczema always get their eczema in certain places. We refer to them as hotspots. Where are your child's hotspots?" Let that direct you to where you should examine the patient. Once I think it looks like AD, then I would have a more detailed conversation with the patient and their family and ask about symptoms. How itchy are they? Are they sleeping? Is it interfering with school? Because severity of AD is not just determined by body surface area and how active it is on that day in your office, we also want to get a good sense for how the patient is experiencing their condition and how much they might be struggling so we can appropriately determine a good treatment strategy for them.

The Dermatologist: Can you share any specific tips or techniques for improving adherence to treatment regimens in children with AD?

Dr Swanson: Adherence to treatments is always a common problem in the world of dermatology because so many of our treatments are topical. Some of them are used twice a day. Sometimes we are telling patients and their families to use one thing twice a day on their face, and one thing twice a day on their body, and a different thing for prevention and maintenance, and a different thing on top as a moisturizer. I think we can make their lives easier by coming up with a relatively simple regimen that they could keep up with and not making it overly complicated for them. Set them up for success by making the regimen something that is easy to do. We can also think about some of our more advanced therapies in situations where patients struggle with the application of topical cream. And sometimes it is not just that the routine is too complicated, but it is that the medicines burn and sting. These patients might have tactile sensitivities that make it difficult to keep up with the regimen and they fear the application of the topical medicines.

Sometimes our more advanced therapies, like our injectables that are once or twice a month or a pill that is once a day, come in handy for patients who are struggling to keep up with a topical routine or patients who simply do not tolerate a topical routine. I would frequently have that conversation with patients and their families where we could try to simplify the topical regimen in this way or that way but because of the problem with applying these topical creams, do we want to think about something like a shot or a pill? Would that be easier, and would it give you a better chance for success?

The Dermatologist: How can dermatologists effectively educate parents and caregivers about the daily management of AD in children?

Dr Swanson: I think it is so important to emphasize the use of sensitive skin care products. This is something that I must remind myself of in clinic because over the past 14 years of practice, I have talked about sensitive skin care products a billion times. But to the patient who you are talking with, maybe they have never had that conversation. Sometimes I find that I assume somebody along the way talked to them about the importance of sensitive skin care products, but that is not always the case. I have certainly had

instances where I am treating a child for AD, I am doing everything right, and the child is not getting better. I trust that the family is using the products, but it turns out as I dive deeper, they are using a laundry detergent that is causing a contact dermatitis component to their AD to flare.

We need to remember to go back to basics when we are having these discussions with patients and their families. Do not assume that they have heard any of this. And even though we say it all day every day, it might be the first time that they are hearing it. Take the time to go through that. My personal strategy is I created a list called Dr Swanson's Favorite Things, and it lists the products that I like the best. It has a sensitive skin care section, a face care product section for those dealing with acne, and a sunscreen section, and it saves me so much time because I have all those products just listed there ready to go. I will frequently use the back side of my Dr Swanson's Favorite Things list to include notes for the patient and their family of what we talked about that day.

The Dermatologist: What are the most common challenges you encounter in treating pediatric AD, and how do you address them?

Dr Swanson: One of the biggest challenges I deal with seeing kids with AD is that sometimes I think parents and, to some degree, kids are more afraid of the treatments than they are of the condition. I think this is something that needs to shift because AD can have a whole host of ramifications above and beyond the skin. It is appropriate to think of the side effects of the medication that we are considering but it is also important to consider the side effects of not controlling your child's AD. We know that the list of comorbidities is long and includes things like food allergies, asthma, eosinophilic esophagitis, eye issues like keratoconus and conjunctivitis, potentially cardiovascular issues, growth disturbance, osteoporosis, osteopenia, increased risk of fractures, increased risk of attention deficit hyperactivity disorder, anxiety, depression, learning disabilities, the list goes on. Some parents have been told, perhaps by the internet or by their pediatrician, that the child will eventually outgrow their eczema. And that is true for some. But in the moment when I am seeing a 2-year-old who is really struggling, I do not really care if their future is outgrowing it at age 8, I care about their suffering now and I want to help their skin now. I think there is this false sense that eczema is some transient rite of passage through childhood that does not deserve our attention and our treatment. So, in my clinic I really ty to educate parents about the ramifications of not controlling their child's AD and encourage them to treat their child so they feel better, do better, and look better.

The Dermatologist: How do you balance the use of topical treatments to ensure both efficacy and safety in young patients?

Dr Swanson: It is important in every conversation with a patient and their family to discuss all treatment options that are available for them based, of course, on the child or teenager's age. I write them down. I give them my list of Dr Swanson's Favorite Things, I flip it over, and I write out the options that are available to them. I write topical steroids on the top, then topical calcineurin inhibitors. If they are older than age 6, I might write roflumilast because it just got approved by the US Food and Drug Administration as a 0.15 % cream. Then I might write topical ruxolitinib if they are age 12 or older because it is approved for ages 12 and up. And then I draw a line, and I write our systemic agents: dupilumab if they are older than 6 months, tralokinumab if they are older than age 12, and our oral Janus kinase inhibitors if they are older than age 12.

I briefly go through them one by one, explaining the pros and the cons. Some families hear this and they gravitate toward one treatment. Other families hear the same list, and they gravitate a completely different way. By laying out all the options, I listen to the feedback that the parents provide to me as I go through them, and it helps me with the decision-making process as to what would be best for them. Maybe as I go through the list, they express a desire to avoid topical steroids. Okay, heard. We have these other options that we can discuss in greater detail. Maybe they express a desire to avoid injectables. Okay, got it. Let's dive deeper into these other things. Presenting all the options opens the door for them to share with me the things that are important to them, which then helps guide our treatment plan. We can do some shared decision-making and come up with a plan that we are all happy with.

The Dermatologist: Can you discuss strategies for minimizing the psychological impact of AD on children and their families?

Dr Swanson: The psychological impact of AD for kids and their families is huge. Some families do not even fully realize it because they have made these subtle adjustments to their life and their expectations for their life over the past few months or even years. There is an expression that you can boil to death in a slowly heating bathtub, and I think eczema can be that slowly heating bathtub for patients and their families dealing with this condition. Because the adjustments have occurred so slowly over time, they do not even realize how bad they have it until they go on a medicine or a therapy that helps their child feel better and sleep better. When their child is better, parents who thought that AD was having minimal to mild impact on their life realize they cannot believe they were not actually sleeping soundly because they were hearing their child scratching in the other room, and it was keeping them mildly awake. Or they do not realize how anxious they were from worrying about when the next flare was going to happen, how bad was it going to be, and what impact would it have until the anxiety goes away when their child is better. A lot of times, if families are on the edge of considering a systemic therapy for their child's AD, and I have evaluated the child and I think they would benefit from this, I will just ask them to give me a trial. If we are going to try a biologic, let's give it 4 months. And if you tell me in 4 months that you and your child's life is not better, then we can stop and go back to other therapies or try new therapies we want to consider. But give me that time to show you what your life could be like and what your child's life could be like if we were able to make this better for them. ■