Atopic dermatitis (AD) is a chronic skin disease associated with a heterogenous clinical presentation. This diversity extends to the patient age at disease onset, intensity of disease signs and symptoms, disease trajectory, and emergence of comorbid conditions during the “atopic march”, the progression of atopic conditions from AD to allergic rhinitis and asthma in young patients. AD treatment guidelines have been developed to guide clinicians in decision-making when treating patients with this disease; however, there are inconsistencies among these guidelines. Heterogeneity in disease presentation, divergent treatment guidelines, and an increasingly broad therapeutic landscape can result in ambiguity with regards to diagnosis and treatment in a real-world clinical setting. The clinical variability in the diagnosis, treatment, and management of AD in Asia, Africa, North America, Latin America, Europe, and the Middle East has been described in the literature. Here, we discuss an analysis to investigate the consistency of the AD patient journey in Spain, from the perspective of dermatologists in a real-world clinical setting.

Carrascosa et al evaluated the perception of a group of dermatologists in Spain regarding the diagnosis, treatment, and long-term management of AD. After conducting a systematic literature review to identify statements regarding AD diagnosis and treatment, the authors convened a scientific committee to discuss the outcomes of this review and propose a list of items for inclusion in a Delphi questionnaire. The Delphi questionnaire was then distributed online to a panel of Spanish dermatologists to assess their consensus on various topics. The degree of consensus on each topic was determined based on an analysis of the responses and an established consensus threshold from the Delphi survey technique guidelines.

A total of 17 dermatologists completed the survey. Despite the existence of detailed guidelines for the diagnosis of AD and the treatment of patients with AD, Carrascosa et al revealed a lack of consensus among the dermatologists in Spain concerning essential aspects of routine diagnosis and treatment. Of the 58 items included in the Delphi questionnaire, consensus was reached on 22 items (37.9%), including 5 of 22 items (22.7%) on patient presentation and diagnosis, 11 of 27 items (19.0%) on therapeutic approaches to managing AD, and 6 of 7 items (86.0%) on long-term management and flare treatment (Table 1). Consensus was not reached on many clinical aspects of AD, including Delphi items regarding diagnostic criteria and severity rating scales, and treatment.
| Block 1: Patient Presentation and Diagnosis | Strength of consensus (median) |
|-------------------------------------------|------------------------------|
| **Patient Journey**                      |                              |
| The dermatologist is the professional who usually makes the differential diagnosis of moderate-to-severe forms of AD | 10                           |
| In addition to the dermatologist, the following specialists should typically be involved in the management of patients with mild AD: pediatricians, allergists, general practitioner | 8                            |
| **Assessment of risk factors**           |                              |
| [No items reached consensus]             |                              |
| **Diagnosis Criteria and Severity Rating Scales** |                              |
| For the diagnosis of AD, the specialist’s opinion prevails over other criteria, such as rating indexes and scales | 8                            |
| Measures that assess the patient’s quality of life should be added to adopt a comprehensive approach to the management of patients with AD | 10                           |
| Mobile phone apps featuring disease severity scales are useful in usual clinical practice | 8                            |

| Block 2: Therapeutic Approaches to the Management of AD |                              |
|------------------------------------------------------|------------------------------|
| **Emollient recommendation**                         |                              |
| In routine clinical practice, patients with atopic dermatitis are usually prescribed a specific emollient | 8                            |
| **Hygienic measures**                                |                              |
| In terms of bathing practices as nonpharmacological measures for the treatment of atopic dermatitis, a daily frequency is recommended | 8                            |
| **Educational actions**                              |                              |
| At the office visit, patient involvement in the treatment of atopic dermatitis is usually sought to ensure good therapeutic results | 9                            |
| Educational measures are usually implemented in clinical practice to achieve greater patient involvement in the treatment of AD and the prevention of flare | 8                            |
| **Scope of nonpharmacological treatment**            |                              |
| Adjuvant nonpharmacological treatment is essential to achieve good therapeutic results, even with the new generation of drugs used for AD | 9                            |
| In mild–moderate forms of atopic dermatitis, or between flares, non-pharmacological measures are typically proactively supplemented with preventive pharmacological treatments | 8                            |
| **Topical treatment**                                |                              |
| Lesion location is more relevant than age of the patient for determining the potency of a topical corticosteroid | 8                            |
| Corticosteroid wet wrap therapy is a common strategy in the management of moderate–severe AD in children | 8                            |
| Topical calcineurin inhibitors are used as second-line therapy after corticosteroids for the topical treatment of AD | 9                            |
| **Phototherapy**                                     |                              |
| [No items reached consensus]                         |                              |
| **Systemic therapy**                                 |                              |
| Antihistamines are commonly prescribed in patients with moderate–severe AD | 8                            |
| Based on the data available at the moment, systemic therapy with Janus kinase (JAK) inhibitors could potentially have a relevant role in the systemic treatment of patients with moderate–severe atopic dermatitis | 9                            |
| **Assessment of effectiveness**                      |                              |
| [No items reached consensus]                         |                              |

| Block 3: Long-Term Management and Flare Treatment   |                              |
|------------------------------------------------------|------------------------------|
| **Proactive (maintenance treatment)**                |                              |
| The intermittent use of topical corticoids as maintenance therapy is common in clinical practice | 9                            |
| The use of calcineurin inhibitors as maintenance therapy is common in clinical practice | 9                            |
| **Pharmacological approach to the treatment of flares** |                              |
| Stress is frequently a triggering factor in an AD flare | 8                            |
| In the dermatological visit during a flare, factors such as a lack of treatment compliance, infection, or contact dermatitis are assessed before intensifying treatment | 9                            |
| **Patient commitment**                              |                              |
| “Steroid phobia” (the rejection of corticosteroids due to safety concerns) often compromises patient compliance with treatment involving these drugs | 9                            |
| Low treatment compliance is a common obstacle in the long-term management of AD | 9                            |

Items were rated on a 10-point scale, where 1 meant “totally disagree” and 10 “totally agree”.

Table reproduced with permission from Carrascosa JM, de la Cueva P, de Lucas R, Fonseca E, Martín A, Vicente A, et al. Patient journey in atopic dermatitis: the real-world scenario. Dermatol Ther. 2021;11(5):1693-705.

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Although there was limited consensus surrounding aspects of AD symptoms and diagnosis, consensus was reached on the role and variety of specialists involved in patient management and the importance of the role of medicated topical treatments (topical corticosteroids [TCS] and topical calcineurin inhibitors [TCI]) for long-term maintenance of disease control. By contrast, there was a lack of consensus around the use of severity scales and indices for scaling up therapy, suggesting that scales developed for clinical trials may not be applicable to clinical practice.

In patients with moderate-to-severe AD, regular use of TCS and TCI may not be sufficient to control disease. Guidelines recommend scaling up therapy to include the use of advanced systemic therapies in these patients, which includes phototherapy and oral immunosuppressants. This study did not find a consensus on the timing or use of these systemic therapies, which may reflect the increasing adoption of biologic therapies for treating patients with moderate-to-severe AD. Until recently, biologic therapy was limited to the injectable interleukin-4 receptor α antibody, dupilumab. The therapeutic potential of Janus kinase (JAK) inhibition has now become a focus of research. Oral JAK inhibitors, including baricitinib (JAK1/2), upadacitinib (JAK1/2/3/tyrosine kinase 2 inhibitor with preference for JAK1), and abrocitinib (JAK1) have shown efficacy and safety in the treatment of moderate-to-severe AD in pivotal phase 2b and phase 3 clinical trials. Approval for use in moderate-to-severe AD has been granted for baricitinib (Olumiant™), upadacitinib (Rinvoq™), and abrocitinib (Cibinqo™) in the European Union, Korea, Japan, and Great Britain among other countries. Upadacitinib and abrocitinib were recently approved for use by eligible patients with moderate-to-severe AD in the United States, while the FDA decision on baricitinib is pending. Real-world data describing the safety and efficacy of JAK inhibitors in the treatment of patients with moderate-to-severe AD are limited. Regardless, most dermatologists surveyed in this study agreed upon the significant near-term potential of JAK inhibitors for the treatment of moderate-to-severe AD.

Carrascosa et al extend upon a previous Delphi analysis of dermatologists and allergologists in Spain but with a dermatologist-only sample. Although Delphi questionnaires used in previous studies were designed to evaluate consensus on guideline statements, the aim of this study was to assess consensus on the practical aspects of real-world clinical scenarios. One important aspect of AD diagnosis, treatment, and long-term maintenance that was highlighted by this study was the central role of the patient throughout the disease course. Surveyed dermatologists agreed on the importance of considering patient quality of life when establishing a management plan, as well as the need for health education and patient commitment to treatment. Together, these findings highlight the importance of involving patients in their treatment.

Carrascosa et al also found discrepancies in dermatologists’ perspectives that aligned closely with discrepancies across AD guidelines. For example, although a consensus was reached among the surveyed dermatologists on the importance of frequent bathing for patients with AD, the addition of bath additives was not agreed upon, reflecting disparate recommendations on this topic across AD guidelines.

The results of Carrascosa et al are promising and provide valuable insight into the views of dermatologists who interact with AD patients in real-world clinical settings in Spain. Nevertheless, there are limitations to the generalizability of the findings. The analysis included only dermatologists, even though multiple specialists are routinely involved in the treatment of AD. In addition, a relatively small number of dermatologists in Spain answered the Delphi questionnaire. Replicating this analysis in a larger sample of clinicians in other countries could provide a deeper understanding of the global applicability of the results.

Current understanding of the AD patient trajectory in the real-world clinical setting is limited. Although this study suggests a lack of consensus among dermatologists treating AD in Spain, further research is needed to determine how best to address this lack of consensus in a real-world clinical setting. A more unified approach to the development of AD diagnostic and treatment guidelines to address the complexities of diagnosis and management in the real world will become especially necessary as new treatment options for AD continue to emerge.

**Abbreviations**

AD, atopic dermatitis; JAK, Janus kinase; TCI, topical calcineurin inhibitors; TCS, topical corticosteroids.

**Conflicts of Interest**

JMC has received honoraria or fees as investigator, speaker, and/or advisor from Pfizer, Sanofi, Lilly, AbbVie, AstraZeneca, LEO Pharma, and UCB. FJR is an employee and shareholder of Pfizer Inc.

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