This population-based study of older adults (≥ 65 years old) with PsO found no evidence that biologics increase the 6-month risk of serious infections compared with systemic nonbiologics or phototherapy. Infection risk beyond the first 6 months of therapy remains to be evaluated. Independent of treatment, there is a twofold increased risk of serious infections among older adults with PsO vs. those without PsO.

In the era of highly effective psoriasis treatments, older adults should be offered the same level of disease control as all patients with psoriasis, in the context of shared decision making.

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Assessing uptake of the Harmonising Outcome Measures for Eczema (HOME) Core Outcome Set and recommended instruments

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Dear Editor, The Harmonising Outcome Measures for Eczema (HOME) initiative has recommended a Core Outcome Set (COS) for atopic eczema clinical trials.1 Adherence to this COS in future clinical trials of atopic eczema treatments will ensure outcomes are measured and reported consistently, thus allowing direct comparison and minimizing bias.2 The COS consists of domains (what should be measured) and instruments (how to measure it). In 2011 four core domains were agreed: (i) clinician-reported signs, (ii) patient-reported symptoms, (iii) dermatology-specific quality of life (QoL) and (iv) long-term control. The Eczema Area and Severity Index (EASI) (2013) and Patient-Oriented Eczema Measure (POEM) (2015) are the agreed instruments for signs and symptoms, respectively. EASI combines the severity of the signs of eczema with the extent to which the body is affected,3 and POEM is a seven-item questionnaire that captures the frequency of symptoms of eczema experienced over the previous week.4 Using the World Health Organization International Clinical Trials Registry Platform (WHO ICTRP), a network of international clinical trials registers, we sought to quantify uptake of the HOME core outcomes in clinical trials over time.

We included Phase III/IV treatment trials involving adults and/or children with atopic eczema registered within the WHO ICTRP between 24 January 2005 and 16 June 2018. We excluded trials of interventions for primary eczema prevention and those that never commenced. We independently screened records for eligibility (C.McW. and R.V.) and extracted data for signs, symptoms and skin-related QoL domains. The long-term control domain was excluded because the HOME group had not defined this domain when we conducted our review. At the instrument level, EASI and POEM uptake was explored for clinician-reported signs and patient-reported symptoms, respectively. To assess change over time, trials were ordered by registration date and divided into 5-year blocks, from which the percentage of trials reporting the COS over the previous 5-year period was calculated (Figure 1).

Of 241 records, 177 were identified as eligible. The included trials were registered in ten different trial registries, with 122 of 177 (69%) registered on Clinical Trials.gov. Of those 177, 120 (68%) were registered prospectively, 122...
(69%) were industry sponsored and 111 (63%) were multi-centre trials. Median sample size was 150 (interquartile range 53–375).

In 54 of 177 trials (31%), participants comprised adults only; in 72 (41%), children only; and in 51 (29%), adults and children. The average overall collection of the COS (signs, symptoms and QoL) from 2005 to 2018 was 25% (45 of 177), increasing to 33% (4 of 12) in the year 2018. EASI and POEM collection also increased: in 2018 they were used in 92% (11 of 12) and 17% (2 of 12) of trials, respectively (Figure 1).

We found an increase in the proportion of atopic eczema treatment trials that included the recommended domains of signs, symptoms and dermatology-specific QoL, with uptake of the specific instruments of EASI and POEM. The overall increase in patient-reported symptoms and QoL could reflect increasing recognition of the importance of patient-reported outcomes in trials. Uptake of the QoL domain has remained low. It is worth noting that QoL instruments were recommended in 2019,1 after our data collection had taken place.

The inclusion of core domains in atopic eczema trials was already increasing at the time of the initial HOME domain recommendations in 2012. This may be because the eDelphi consensus on domains published in 2010 encouraged their inclusion even before the HOME consensus publication in 2012.5

While uptake of a COS and associated instruments is a step forward it is not, by itself, sufficient. Unless domains and instruments are measured at comparable time points and data presented in a suitable format for meta-analysis, difficulties in synthesizing data will remain. HOME have begun to address this by recommending that all trials, for each primary outcome, report mean and standard deviation at baseline and end of treatment as a minimum.6

In summary, we present a systematic assessment of the uptake of the HOME COS. The published COS and instruments, agreed by a consensus methodology encompassing all stakeholders in the decision-making process, appears to have supported adoption of the HOME recommendations by the research community. Other COS development groups should be encouraged by these findings. Further work is needed by funders, journal editors and systematic reviewers to promote and mandate use of COSs.

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Antiseptic use in Mohs micrographic surgery: British Society for Dermatological Surgery and Australasian College of Dermatologists survey

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Dear Editor, In Mohs micrographic surgery (MMS), cleansing the surgical site to reduce the risk of wound infection is performed with a range of antiseptic agents. A recent Cochrane review in 2015 suggested that 0.5% chlorhexidine in methylated spirits is superior in reducing surgical-site infections, although more evidence is needed. These commonly used chlorhexidine-based antiseptics have been examined in a recent review by Steinsapir and Woodward, and shown to be toxic to the cornea and middle ear. Many of these cases reviewed in 2015 suggested that chlorhexidine-based antiseptics were causing skin irritation, two and five cases of skin irritation, respectively. Iodine-based antiseptics were reported as causing one case of ocular irritation, and two and five cases of skin irritation, respectively. Iodine-based antiseptics were reported as causing one case of skin irritation in BSDS and three cases in ACD.

In each of the BSDS and ACD, comprising approximately 6500 and 8000 cumulative MMS cases annually among responders, respectively, chlorhexidine-based antiseptics were reported as causing two and one case of ocular irritation, and two and five cases of skin irritation, respectively. Iodine-based antiseptics were reported as causing one case of skin irritation in BSDS and three cases in ACD.

A total of 62% of BSDS and 20% of ACD responders were not aware of the recent review highlighting the risks of chlorhexidine-based antiseptics. Four BSDS responders and one ACD responder reported that in the last 12 months, they have reduced chlorhexidine-based antiseptic use on the head region. One ACD responder also reported changing to using chlorhexidine in an alcohol base, although our study did not specifically seek details of the base of chlorhexidine used, being either alcohol or aqueous.

A similar study by Collins et al. was completed in American College of Mohs Surgery (ACMS) members in 2015 with 168 responses (estimated 10% response rate). ACMS members are primarily working privately (75%) and performing over 500 MMS cases annually (48%). Similar to BSDS and ACD, members of ACMS follow the trend of preferring chlorhexidine-based antiseptics in all sites excluding periorcular, with a smaller proportion (18% layers, 19% repairs) of normal saline (50% layers, 47% repairs) followed by iodine-based (26% layers, 26% repairs) and chlorhexidine-based (24% layer, 26% repairs) antiseptics. ACD preference in the periorcular area was iodine-based (40% layers, 40% repairs) or normal saline (36% layers, 40% repairs), with a minority still using chlorhexidine-based (14% layers, 24% repairs) antiseptics.

Table 1

| Antiseptic use in MMS (average of use in MMS layers and repairs) | ACD (n = 25), % | BSDS (n = 34), % |
|---|---|---|
| **Periocular** | | |
| Chlorhexidine based | 22 | 25 |
| Iodine based | 40 | 26 |
| Normal saline | 38 | 49 |
| **Ear** | | |
| Chlorhexidine based | 60 | 84 |
| Iodine based | 24 | 15 |
| Normal saline | 16 | 2 |
| **Head (not periocular or ear)** | | |
| Chlorhexidine based | 84 | 85 |
| Iodine based | 14 | 15 |
| Normal saline | 4 | 0 |
| **Neck and below** | | |
| Chlorhexidine based | 88 | 91 |
| Iodine based | 8 | 9 |
| Normal saline | 4 | 0 |

BSDS, British Society for Dermatological Surgery; ACD, Australasian College of Dermatologists; n, total number of responders.