Dear Editor, The COVID-19 pandemic has accelerated the use of telehealth, defined as the delivery of healthcare via remote technologies, with widespread adoption of live-interactive video visits across the USA. Yet, it is important to avoid exacerbating healthcare disparities for vulnerable populations such as older adults, who traditionally have more technological literacy barriers. Our aim was to explore dermatologists’ experiences of using telehealth with older adults, in order to identify and summarize recommendations to improve telehealth care.

Author I.d.V.H. conducted 23 in-depth, semistructured interviews (February to August 2021) over video with dermatologists who had self-reported experience of caring for adults age > 65 years using telehealth. We conducted an inductive thematic analysis of the full interview transcripts, using a constant comparison and mind-mapping approach. This study was approved by the Stanford Institutional Review Board.

Of the 23 dermatologists interviewed, 13 were female and 10 were male, with 14 attendings and nine residents from eight different states. Seven participants identified as Asian, four as black or African American and 12 as white. Every dermatologist interviewed for this study thought that telehealth ‘is here to stay’. The following core themes regarding dermatologists’ experience (E1–E5) of telehealth use with older adults were extracted.

E1. Perceived benefits of telehealth for older adults. The perceived benefits of patients being able to stay in their own home for an appointment stretched beyond the context of the pandemic. Examples cited included the reduction in travel time and associated expense, which could be particularly pertinent to older adults with transport limitations, need for assistance from caregivers or mobility issues. E2. Works well for ‘stable chronic disease’, but concerns about diagnosis of malignant lesions. An inability to perform biopsies or whole-skin exams often made evaluation of potential neoplastic lesions challenging via telehealth. In contrast, situations in which the dermatologist was not dependent on virtual image quality, but rather the subjective patient report, were emphasized as well suited to virtual visits. E3. Technology presents a barrier for many, but not all, older adults. There was considerable variation in experiences, with many examples of issues with technological difficulties arising, although some providers reported being ‘impressed and surprised’ with how older adults adapted to telehealth. E4. Can’t see the whole patient and feel the skin. Practical issues that limit patient examination and procedures were cited as limitations of telehealth and reasons for transition to in-person care. E5. Can be more difficult to communicate virtually. This theme encompasses both personal connection and rapport, and practical communication issues such as ‘if the patient speaks a different language’, with access to an interpreter being complicated via telehealth.

Five themes summarizing recommendations (R1–R5) for use of telehealth with older adults were identified. R1. Give comprehensive instructions ahead of time. This included requests for high-quality photos (and guidelines on how to take them) irrespective of access to video in the telehealth visit, as well as detailed login instructions. R2. Appropriate appointment triage is crucial. Interviewees differed in their opinions regarding how this triage should manifest; some expressed a preference ‘to see all new patients in person’, while others found telehealth visits an effective adjunct to triage in itself. Frustrations around failure of effective triage for both patient and provider were cited. R3. Don’t make assumptions about patient comfort with technology. Although there were many accounts of technological issues arising with elderly patients, many of the providers’ preconceptions about older adults’ ability to use telehealth were not borne out in practice. R4. Important to manage patient expectations about what can be achieved in a telehealth visit. The importance of patient education regarding what can be achieved in a telehealth visit was emphasized: ‘the patient’s perception was suddenly [that] we could take care of things on the computer and they didn’t have to come in, which of course turns out not to be true’. R5. Need to make telehealth accessible for all. There is a potential paradox to telehealth access: although telehealth offers tremendous capacity to improve healthcare access, those who might benefit most are often least well equipped to access the technology required. Some participants felt optimistic about the ability of the future telehealth landscape to increase...
accessibility, particularly in rural areas, for example with use of ‘telemedicine kiosks’ in pharmacies suggested. See Table 1 for categorization of themes and illustrative quotations.

The COVID-19 pandemic has transformed healthcare systems. We have the opportunity to bring together technological innovations with a commitment to reducing digital health disparities, so that telehealth meets the
needs of vulnerable groups with lower technological literacy. We call for active optimization of telehealth systems along with patient education to ensure usability for all.

I. de Vere Hunt (1, i), S. van Egmond, (1) V. Nava, (1) R. Khodosh, (2) J. Lester (1, 2) A.S. Chiou (3) and E. Linos (1, i)

In investigating the reasons for treatment discontinuation in chronic diseases permits the assessment of both the safety and the effectiveness of a given treatment in a clinical practice setting. Our aim was to investigate the frequency and reasons for discontinuation of dupilumab in adults with AD, and the alternative subsequent treatment strategies.

We conducted a retrospective multicentric (16 tertiary referral hospitals) study in adult patients with moderate-to-severe AD for whom dupilumab was discontinued (defined as discontinuation ≥ 1 month) between March 2017 and September 2020.

From a total of 968 patients treated with dupilumab during the study period, 150 patients (15.5%) discontinued treatment after a median treatment duration of 5 months [interquartile range (IQR) 3–10]. Among the 150 patients who discontinued treatment, the main reasons for discontinuation were side-effect(s) in 61 patients (40.7%), lack of efficacy in 22 patients (14.7%), lack of efficacy and side-effect(s) in 23 patients (15.3%), planned pregnancy in 12 patients (8%), disease remission in six patients (4%) or various other reasons for 26 patients (17.3%). Among the six patients who stopped treatment owing to AD remission, the median duration of treatment was 57 weeks (IQR 44.25–65.25). One of these patients relapsed 6 months after discontinuation, requiring reintroduction of dupilumab. Side-effects that led to dupilumab discontinuation were, among others, ophthalmological side-effects (36 patients, 24%), facial erythema (12 patients, 8%), diffuse AD exacerbations (10 patients, 6.7%), asymptomatic eosinophilia (six patients, 4%), alopecia areata (four patients, 2.7%) and induced psoriasis (four patients, 2.7%) (Table 1). Although herpes infections were frequently reported as a side-effect, no patient stopped dupilumab treatment for this reason.

Patients with atopic comorbidities (allergic conjunctivitis and asthma) were more likely to discontinue dupilumab because of side-effects rather than lack of efficacy (44.3% vs. 9.1%). Demographic characteristics, such as age, sex, AD phenotype or age at initiation of dupilumab treatment were not associated with any particular reason for discontinuation. Treatment strategies after discontinuation of dupilumab were as follows: initiation of another systemic treatment (60 patients, 40%), topical treatments alone (45 patients, 30%) or reinitiation of dupilumab treatment (31 patients, 20.6%) (Table 1). For this latter strategy, the median time of dupilumab restart was 13 weeks (IQR 8–28), with a single 600-mg loading dose (15 patients, 48.4%) followed in the majority of cases (24 patients, 77.4%) by regular injections at 2-week intervals. Among the 31 patients who restarted dupilumab, full remission was observed in 13 patients (41.9%). In patients who stopped because of side-effects, and subsequently restarted treatment (five of 31 patients), the strategy was to gradually increase the dosage interval to between 3 and 8 weeks depending on the disease control in each patient. There was no recurrence of side-effects and the efficacy was maintained in three of five patients.

References

1 NEJM Catalyst. What is telehealth? Available at: https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0268 (last accessed 8 December 2021).
2 Kennedy J, Arey S, Hopkins Z et al. Dermatologist perceptions of teledermatology implementation and future use after COVID-19: demographics, barriers, and insights. JAMA Dermatol 2021; 157:595–7.
3 Price KN, Thiede R, Shi VY, Curiel-Lewandrowski C. Strategic dermatology clinical operations during the coronavirus disease 2019 (COVID-19) pandemic. J Am Acad Dermatol 2020; 82: e207–9.
4 Zachrisson KS, Yang Z, Schwamm LH. Changes in virtual and in-person health care utilization in a large health system during the COVID-19 pandemic. JAMA Netw Open 2021; 4:e2129973.
5 Zhai Y. A call for addressing barriers to telemedicine: health disparities during the COVID-19 pandemic. Psychother Psychosom 2021; 90:64–6.
6 Hargittai E, Piper AM, Morris MR. From internet access to internet skills: digital inequality among older adults. Univers Access Inf Soc 2019; 18:881–90.
7 Ziebland S, McPherson A. Making sense of qualitative data analysis: an introduction with illustrations from DIPEx (personal experiences of health and illness). Med Educ 2006; 40:405–14.

Funding sources: E.L. receives funding from the National Institute of Aging (grant number K76 AG054631) and the National Institutes of Health (grant Number R21AG066980).

Conflicts of interest: the authors declare they have no conflicts of interest.

Reasons for discontinuation of dupilumab in adult atopic dermatitis in clinical practice

DOI: 10.1111/bjd.20883

Dear Editor, Dupilumab, an anti-interleukin-4/2 monoclonal antibody, has shown a positive benefit–risk ratio when treating moderate-to-severe atopic dermatitis (AD) in clinical studies. (1) High persistence for patients on atopic dermatitis has recently been reported in a clinical practice setting, with 77% of patients remaining in treatment for 12 months in a retrospective study that included 1963 patients with AD; however, reasons for discontinuation were not investigated. (2) Investigating the reasons for treatment discontinuation in chronic diseases permits the assessment of both the safety and the effectiveness of a given treatment in a clinical practice setting. Our aim was to investigate the frequency and reasons for discontinuation of dupilumab in adults with AD, and the alternative subsequent treatment strategies.

From a total of 968 patients treated with dupilumab during the study period, 150 patients (15.5%) discontinued treatment after a median treatment duration of 5 months [interquartile range (IQR) 3–10]. Among the 150 patients who discontinued treatment, the main reasons for discontinuation were side-effect(s) in 61 patients (40.7%), lack of efficacy in 22 patients (14.7%), lack of efficacy and side-effect(s) in 23 patients (15.3%), planned pregnancy in 12 patients (8%), disease remission in six patients (4%) or various other reasons for 26 patients (17.3%). Among the six patients who stopped treatment owing to AD remission, the median duration of treatment was 57 weeks (IQR 44.25–65.25). One of these patients relapsed 6 months after discontinuation, requiring reintroduction of dupilumab. Side-effects that led to dupilumab discontinuation were, among others, ophthalmological side-effects (36 patients, 24%), facial erythema (12 patients, 8%), diffuse AD exacerbations (10 patients, 6.7%), asymptomatic eosinophilia (six patients, 4%), alopecia areata (four patients, 2.7%) and induced psoriasis (four patients, 2.7%) (Table 1). Although herpes infections were frequently reported as a side-effect, no patient stopped dupilumab treatment for this reason.

Patients with atopic comorbidities (allergic conjunctivitis and asthma) were more likely to discontinue dupilumab because of side-effects rather than lack of efficacy (44.3% vs. 9.1%). Demographic characteristics, such as age, sex, AD phenotype or age at initiation of dupilumab treatment were not associated with any particular reason for discontinuation. Treatment strategies after discontinuation of dupilumab were as follows: initiation of another systemic treatment (60 patients, 40%), topical treatments alone (45 patients, 30%) or reinitiation of dupilumab treatment (31 patients, 20.6%) (Table 1). For this latter strategy, the median time of dupilumab restart was 13 weeks (IQR 8–28), with a single 600-mg loading dose (15 patients, 48.4%) followed in the majority of cases (24 patients, 77.4%) by regular injections at 2-week intervals. Among the 31 patients who restarted dupilumab, full remission was observed in 13 patients (41.9%). In patients who stopped because of side-effects, and subsequently restarted treatment (five of 31 patients), the strategy was to gradually increase the dosage interval to between 3 and 8 weeks depending on the disease control in each patient. There was no recurrence of side-effects and the efficacy was maintained in three of five patients.