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Journal Club: Comparing Recommendations from Different AD Guidelines

Peter Lio, MD:
Hello everyone and welcome to Practical Dermatology's Atopic Dermatitis Journal Club where we'll be discussing all aspects of atopic dermatitis: from pediatric eczema to drug pipeline issues to safety research. I'm Peter Lio. I'm a Clinical Assistant Professor of Dermatology and Pediatrics at Northwestern University Feinberg School of Medicine, and I'm here today with an esteemed guest, Dr. Robert Sidbury, Professor and Chair of Dermatology at Seattle Children's Hospital. Thank you so much for joining us, Rob.

Robert Sidbury, MD, MPH:
Thanks for having me, Peter.

Peter Lio, MD:
Oh, it's a pleasure. Well, today's topic is really a neat one. We are going to be comparing the differences in recommendations from two new atopic dermatitis guidelines, and I think it's always fun to see guidelines come out because it really represents lots and lots of years of research and knowledge and growth of understanding. And then it is a collaborative effort. It really has to do with the spirit of the group. And I always find it particularly exciting because even though we're working with basically the same raw material, you have the same studies, the same evidence, the same data, sometimes there are little bits of differences in interpretation.

So the two guidelines we're talking about today are, the first ones are the Annals of Allergy Asthma Immunology Joint Task Force guidelines. So this is an allergy and immunology centric one. I was one of the token dermatologists on there. And we're going to compare those to the Journal of the American Academy of Dermatology guidelines that were published by the AAD, and Dr. Robert Sidbury was part of that task force as well. So we're going to look at these allergy centric and dermatology centric guidelines and we're going to go over them today.

I'd love to jump right in, and the first question I'd like to ask is, when we think about bleach baths, there are subtle differences in how they're discussed in these guidelines. Can you tell us a little bit about the history of bleach baths and your particular use of them and maybe how that's changed or evolved over time?

Robert Sidbury, MD, MPH:
For sure. Thanks, Peter. And again, thanks for having me. I'll just start by reiterating your comment about the interesting aspect of having the same data and yet ending up with different conclusions. Used to be, years ago, dermatologists and allergists with regard to atopic dermatitis were like the Hatfields and McCoys, weren't we? And it's different now. We converged to a place where you were part of the allergy guidelines. We had a wonderful allergist, Anne-Marie Singh as part of our atopic dermatitis guidelines from the dermatology world. So you'd think that that confluence would lead to more homogeneous reports. And in general, they do. But there's some important differences like bleach baths to your question.

Bleach baths are fascinating. They came from the epidermolysis bullosa world years ago called Dakin's Solution. And your colleague in Chicago, my fellowship mentor, Amy Paller, took that to the atopic dermatitis world in 2008, 2009 with her publication in Pediatrics, which showed that in concert with nasal, intranasal Mupirocin, patients with atopic dermatitis got fewer staph infections. And so for years, many of us had used it in that way as a prevention of Staphylococcal super infection. And we've seen not only anecdotally, but in that paper that she published, atopic dermatitis severity got better. Not just left fewer infections, but severity got better. And it's now been shown that in fact, the concentrations that we use for bleach baths in atopic dermatitis are not even antibacterial, they are anti-inflammatory. They work through the NF-κB pathway, and I pitch them to my parents and my patients as a non-steroidal topical anti-

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inflammatory. That is how I pitch them. And yes, it may prevent staph super infections, isn't that lovely? No matter what, but it's also a non-steroidal topical, and don't we need more of those for all atopic dermatitis patients?

Peter Lio, MD:
I love it. And as with so many things, I think you and I are so aligned. It's been neat to learn that it wasn't really killing staph the way we thought it was, but yet it still helps. So my favorite phrase for that is right answer, wrong reason, but still the right answer for some patients. So it's neat.

In the allergy guidelines, the Joint Task Force guidelines, they concluded that they were conditionally in favor for moderate to severe disease, but conditionally against it for mild disease. And I like their rationale. I thought this was different. They really focused on the patient perspective. They brought in patients and parental caregivers, and that actually had a pretty big effect. And I think the next one we're going to talk about even more of an effect, but they said: "Some patients may not have access to a bathtub and may find bleach baths too much effort. In patients with mild disease, the limited magnitude of improvement was not felt to justify the burden." So I love that there really, you can say, yes, it works or it doesn't, but then you get to do the second level analysis and say, we agree that it's doing something, but maybe it's not worth the bang for its buck. Or maybe for certain patients it's not. I really like that it's a different nuance and a different take on the whole thing.

Robert Sidbury, MD, MPH:
Yeah, I agree, Peter. In our 2014 guidelines, the American Academy of Dermatology, we had a patient advocate, Julie Block was head of the National Eczema Association and she was the patient voice. And we did not have that in these guidelines. And I think there were ramifications for that, like you say, and not only is some patients don't have a tub, some patients, for instance, teenagers, you say, "Okay, well, we want you to take a bleach bath twice a week." And they're like, "Are you crazy? I haven't taken a bath since I was three." And so it's just not appropriate for some or some aren't willing to do it. And in fact, it doesn't work for everyone. You cannot be too dogmatic with atopic dermatitis, whether it's frequency of bathing with or without bleach. So I think that's a really critical thing to sort of have that patient perspective. And I think that was a nice benefit and reason for some of the divergent conclusions that we're talking about today.

Peter Lio, MD:
And I'll go so far as to say and not to sound overly diplomatic, and I truly mean this. It's nice to have slightly different viewpoints because it is good to read different ones and say okay, especially when they're well-thought-out and well justified. Well, this comes up even more interestingly with the next one, okay? So topical ruxolitinib is our first and currently our only in the United States, at least topical JAK inhibitor. And this is a neat new addition to our therapeutic armamentarium. But interestingly, the joint task force guidelines concluded, "In adolescent and adult patients with mild to moderate atopic dermatitis refractory to moisturization alone, the JTF panel suggests against adding topical ruxolitinib." And then they talk about the justification because I was a little shocked.

Now, I have to say I was recused from that part. I was working on the systemic part. So I didn't know this really until much later. When they put their justification though, and this is where it really shines, they said, "The panel inferred that most well-informed patients with mild ad would prefer to avoid the uncertain small increase in serious harms over the modest benefit of adding topical ruxolitinib compared with standard care. And in particular when considering other treatments with higher certainty for safety."

So really interesting. I would argue this is a patient perception of safety rather than the real safety because I think we have some data that pretty reassuring in real life, but there is the boxed warning. Of course, the American Academy of Dermatology guidelines state, "We recommend the use of ruxolitinib cream." How do you think about this, both in terms of the guidelines, but also in terms of your clinical practice?

Robert Sidbury, MD, MPH:
Yeah, Peter, this was the place where there was the most substantive difference because one set of guidelines said recommend. One set of guidelines said for the reasons you just articulated, no. And I think there are a couple of reasons for that. One was that patient perspective, which you've already alluded to. And another, I think there was in this case some longer term data that we looked at in the American Academy of Dermatology guidelines may have influenced things a little bit. But where the rubber meets the road, full disclosure, I don't use topical ruxolitinib a lot for atopic dermatitis. I use it a fair bit for vitiligo. Separate discussion, same drug, different disease. But for atopic dermatitis, it's indicated from mild to moderate disease.

I also have about 56, 57% of my patients on Medicaid. So a new medication which is more expensive than old medications or generics, mild to moderate disease. We have a lot of alternatives for mild to moderate atopic dermatitis. So for my money, I don't use it that much for that reason.

But that said, in terms of our recommendations from the American Academy of Dermatology, looking at the data, I agree with you. The

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data has been quite reassuring, particularly if you drill down into the further recommendations of using topical Rux in atopic dermatitis, 12 years of age and older, no more than 20% body surface area or 60 grams a week. So if there's some limitations put on it precisely to get at the idea that we absorb a little bit of anything we put on our skin. But if you put those constraints on, not too much.

And so, I am comfortable with the safety and the recommendation that the American Academy of Dermatology made. But like you say, I understand where your group came from with the allergy guidelines.

Peter Lio, MD:
It's so neat just to see that too. Because yeah, I think both are correct. I think you can go either way. And I have families who straight up say, "I'm concerned about this. I don't want to use it." Because if they say, "You're saying there's no risk?" No, I would never say that. There is some risk. We think it's very small when it's used correctly, and topically. The studies we've seen, it really is reassuring. But no, you're right. You absorb some. And is it possible you could have a systemic JAK inhibitor-like effect from it? I suppose, yes. And of course, things have happened. There are reports. It's just always difficult to quantify that for a patient.

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