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Journal Club: Pediatric Treatment Adherence

Dr. Larry Eichenfield:
Hi, I am Dr. Larry Eichenfield, working down at UCSD and Rady Children's Hospital in San Diego.

Dr. Jason Hawkes:
Hi, I'm Jason Hawkes, medical dermatologist and principal investigator at the Oregon Medical Research Center in Portland, Oregon.

Dr. Larry Eichenfield:
And we had an interesting article on a treatment adherence in pediatric atopic dermatitis, and this was a systematic review that was looking at sort of issues of treatment adherence, looking at different factors associated with that. But let's bring it down to sort of clinical practice. How much of a challenge is adherence impacting on our outcomes in atopic dermatitis and pediatric?

Dr. Jason Hawkes:
Yeah, I mean really this is one of the many chronic diseases. I think patients, when they come in, they struggle to realize that this isn't just going to go away and stay away. So I think adherence comes in part from that sort of lack of education and the understanding that what they're dealing with is a chronic condition. So we give them a couple of creams here and there, we explain it and they use it for a little while, and then we see that kind of drop off over time. And obviously what the article's getting at is this is multifactorial, but we see it across the board. In fact, I'm surprised when patients come in and they've done exactly what we said.

Dr. Larry Eichenfield:
Yeah, I do think it's crucial. Now, it varies to a degree in terms of what patient knowledge is when they come in. But as the article pointed out, I mean, education's a major factor. Now, on the other hand, I'll say that things shift a little with systemic therapy because you still have a burden of topical care with systemic therapy, but not the same. And just the complexity of regimens that we come up with is markedly different when we go to systemic medicines versus topical, but it'll let you get a base understanding of why it is that they're doing it and what they do. And you pointed out a really important point, which is that they're often sort of figuring out what the cause is. And to a degree you can tell them it's because they have atopic dermatitis, but then you need to move over to how to handle it therapeutically.

Dr. Jason Hawkes:
Yeah. And I like to, as you said, try to simplify the regimen. And I think when you're talking about pediatrics, it's even more complex because you throw in that third party individual that really can control the regimen or even the injections.

Dr. Larry Eichenfield:
You mean the parent or caregiver.

Dr. Jason Hawkes:
The parents, right. Caregiver, exactly. And I think we wanted to make sure that they both really understand what we're doing. But when we were trained, and maybe it was same with you, is that it was like, well, we want to do this for the face and this for the body and this for the hands and feet. And even things like ointments over creams, it didn't take very long in practice to realize that patients hate the ointment. So whether they're more potent or not, it didn't really matter because they weren't using it. So I've tried to kind of move away to what's something patients are actually going to use, and when we can use something that can be used across multiple body for the topical patients.

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Dr. Larry Eichenfield:
Well, certainly the non-steroidals really help because you can use them on any skin surfaces. You're not necessarily doing that mix or match. But I do think also as someone who I train residents, sort of a rookie mistake is to line up 14 things to do in different areas. And it's hard. But we also, I think the article pointed out some of the issues that aren't our issues. We want to educate, but the resources of the parent and the family matter, how much other stuff they have to do. If someone has two other, three other kids at home, I mean they're pulled in real life. Yet the outcomes matter are totally affected. Any other strategies you have to try to get the best outcomes?

Dr. Jason Hawkes:
Yeah, I mean I think it's really critical, especially for those that are in training or just starting out, is that you have to know when to move patients from the topical regimens, which I think overall just have a lower adherence because people get burnout. Even if they're doing it the right way, it's even more of a burden. So we don't want to just push people on systemics for no reason, but those patients that aren't responding or having to really struggle with these regimens, moving them to something like, I think for most patients, actually some of the injections or even a pill to some degree is easier to apply. They can take it on the way to work or right before work.

Dr. Larry Eichenfield:
I totally agree. It's really crucial. I mean, the article reflects most of the literature historically of atopic dermatitis, which is based upon these complicated topical regimens. And it's a different world when you get to systemics. In a way if someone's bad enough to need systemics, it's much easier. Although we have issues of adherence with systemics as well, which are interesting to discuss as well. But there's no question that it's easier.

Finishing up on that area of adherence with systemic therapy. It is interesting. So initially you have to get, especially in pediatrics, you have to get them through injections. If we're doing injection systemic therapy, which under-12 basically is what we generally use because there's not a lot of cyclosporine or methotrexate being used for our pediatric atopic dermatitis patients. And then also in my teens, I got to make sure they come back because when they're doing well they'll disappear. So we had to institute a policy. I'd like to see patients back one month depending on how bad they were, then three or four months. But after that, if they're rolling on a systemic, we need to see them back five, six months in order to keep the prescription going because otherwise they disappear and I didn't know if they disappear because they're clear or almost clear or just they came off med.

Dr. Jason Hawkes:
Yeah, it's a great point. And I try to talk to patients about that you're going to get better and you're going to think I should stop these medications. So I tried to plant the idea that if you want your disease to come back, you can stop your medication because it will come back. The vast majority of cases we see. Very rarely do we see it in adults, for example, just suddenly go away. But I also like to plant the seed that some patients are afraid of medications. They're thinking by adding this medication, what am I adding to my body that's harmful? And I like to balance that with the idea of the comorbidities. Here's the risk of the disease on your overall health by not adequately treating it. So I think we start to give them a little bit of an anchor to balance that concern for the risk because we know that the chronic inflammation on the body has a real impact and even some of the comorbidities. So we start talking about systemic therapies that have the benefit for multiple diseases. It gives them, again, another reason to kind of stick to that treatment.

Dr. Larry Eichenfield:
That's a great point. So we end up trying to give consistent messaging, whether it's a topical regimen or a systemic regimen where we're trying to get our outcomes of minimal rash, minimal itch, minimal sleep disturbance, and then these secondary benefits. But I also said years ago there were these eczema schools, especially in Europe, in Germany, it's this approved process where they go through eight, two hour things. It was like, wait a minute, we don't have psoriasis schools because we had biologic agents a decade and a half before we had it for atopic derm. And right now, I think it's probably moving towards that where we need to do our intensive education across the board, but maybe not as much so with now what we have different medicines in our armament area.

Dr. Jason Hawkes:
Yeah, no. One, you trigger this thought I had that with a lot of the early providers that are I think are just learning and we established the way that we work. But even now to this day, if there's a patient that I just say, this patient needs a little bit more time, it's okay to say, I really need half an hour with this patient. You just have to do that. There are those patients. And I think the pressures of the system, which add to this as well, sort of driving the outcomes, the finances, there's appropriate times to just stop and say, this patient needs a little bit more attention here. And sometimes initially, and then we can get them to the point where they can fall into that regular routine. And I think that's an important pro-tip.

Dr. Larry Eichenfield:
That's a good one. So I think a summary of that is that we still have our burdens as healthcare professionals, atopic dermatitis is harder in a way than some other diseases.

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Dr. Jason Hawkes:
For sure.

Dr. Larry Eichenfield:
And that it still requires that time and that time may be variable depending on the family. But getting them to do the stuff we want them to do and that they agree to do makes a big difference in the outcomes.

Dr. Jason Hawkes:
For sure.

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