Key points for: Dermatology Trainees

1. Atopic dermatitis resolution after childhood:
   - A. AD can persist into adulthood, more than was previously thought
   - B. Predictors of persistent childhood AD:
     - severe AD, asthma, AR, FHx atopy, non-white, low SES
   - C. Duration of disease x burden = ++ impact on quality of life years
2. Adult-onset atopic dermatitis:
   - A. More common than we thought (new onset, vs return of previously resolved AD)
   - B. Often moderate to severe eczema
   - C. Second peak of dermatitis in elderly (don't just think MF)
3. AD drugs in the elderly
   - A. RCT criteria often exclude by age, or also by comorbidity
   - B. More data is required

Key points for: General Practitioners

1. Atopic dermatitis is not only a disease of children
   A. Can be childhood that persists into adulthood – more common than previously thought
   B. Can be resolved AD that came back
   C. Can be new-onset AD
2. While we want to rule out MF in the elderly with a new-onset rash, there is also a second peak of AD in the elderly
3. AD in adults is often moderate to severe
   A. RCTs do not include elderly or those with comorbidity – data lacking

Key points for: Adult-Adolescent Patients

1. It's not unusual to have AD as an adult
   A. It can stick around from childhood
   B. It can start in adulthood, or be AD that was forgotten because it resolved, but then it comes back
   C. It's actually common to get in the elderly
2. Adult AD may be more severe than childhood AD
   A. It is less common than having childhood AD (10% vs 2%)
   B. But if you have it in adulthood, it is more often moderate to severe disease
3. We need more data on systemic therapies for people who are older or have other conditions
   A. Because of the way they are designed, clinical trials often exclude people who are older or who have other medical conditions
   B. This means we have less information about how these types of people do on some medications that are taken by mouth or by needle

What added information is needed for... ?

1. Dermatology Trainees (e.g. for a fellowship curriculum)
   A. Any guidelines available for AD in the elderly (eg: how much of a paraneoplastic workup to do, how many biopsies before MF dx ruled out etc), first line and 2nd line therapies in the elderly
2. General practitioners (e.g. For an accredited course)
   A. Variable nature of AD – why you need to talk to/believe the patient
   B. How patterns of presentation of AD change with age
   C. How much steroid and what strength to use
3. Adult-adolescent patients (e.g. for an Eczema school)
   A. How AD looks in an adult vs child
   B. Flare vs maintenance therapy
   C. Practical information - how much steroid to use, what strength of steroid to use

Three points most relevant to my practice?

1. Incidence of AD
2. Reminder of QALY
3. Reflects difficulties encountered in clinical practice

Points relevant to my practice not found and/or irrelevant info?

1. All relevant
2. Information on adult AD and atopic march – phenotypic differences

Prepare 2-3 post-video questions for derm trainees

(Multiple choice, true/false, and/or short-answer questions from topic)

- Question 1: Which of the following is true about atopic dermatitis?
  1. AD that persists into adulthood is milder
  2. 50% of patients with childhood AD will still have adult AD
  3. There is a peak of AD in the elderly (Answer)
  4. The prevalence of AD is 2% of children and 10% of adults in Ontario
- Question 2: Name 3 predictors of persistent childhood AD
  - Answer: Severe AD, asthma, AR, FHx atopy, non-white, low SES

Key Takeaway: Vote via Annotation

1. Atopic dermatitis resolution after childhood: (5/13 dermatologists)

2. Adult-onset atopic dermatitis: (6/13 dermatologists)

3. AD drugs in the elderly; (2/13 dermatologists)