Recent increased attention to the safety of topical calcineurin inhibitors has dermatology care providers re-thinking their approach to management of atopic dermatitis. Most remain confident in the efficacy of these products and are familiar with suitable approaches to ensure if not enhance their safety in real-life applications. Nonetheless, recent developments remind us that TCIs aren't appropriate for every patient, nor are they a panacea. Rather, they may be part of a comprehensive management approach to AD that encompasses everything from appropriate moisturizers and cleansers to topical corticosteroids and even systemic therapies.

**Patient Assessment and Education**

Key to successful management of AD is to devise a treatment regimen that the patient—and in most cases the parents and/or other family members—can live with. Sometimes a combination of three to four agents may seem like the best approach to AD management, but if patients won't actually receive the treatments as directed, they will not benefit. Therefore, it's best to avoid complex regimens. Identify the primary care provider (mother, father, grandparent) and determine whether he or she will be able to comply with instructions and the time demands of treatment. Consider the age and activity of a child. Older children who go to school (and thus wear school clothes or even uniforms) may require different vehicles or different application schedules than young children.

**Patient-Centered Approaches to Atopic Dermatitis Management**

Recent warnings about TCIs have us re-evaluating eczema care and returning to the basics. Here are tips on establishing effective regimens.

By Coyle S. Connolly, DO
Introducing one simple step to hydrate, lubricate and desquamate.

New prescription Salex™ Cream (6% Salicylic Acid), also contains ammonium lactate, glycerin and dimethicone to moisturize skin and loosen scales.

- Patented Multivesicular Emulsion System (MVE) provides time-released delivery to minimize irritation
- Enhanced hydration upon application to help repair barrier function
- Elegant, odorless cream formulation spreads well and absorbs quickly
- Indicated for: Ichthyosis vulgaris, Keratosis pilaris, Psoriasis
- Salex™ Cream should not be used in any patient known to be sensitive to salicylic acid or any other listed ingredients. Salex™ Cream should not be used in children under two years of age. Excessive erythema and scaling conceivably could result from use on open skin lesions.

Please see next page for brief summary of prescribing information. © 2004 Healthpoint, Ltd. 137038-0604 Healthpoint is a registered trademark and Salex is a trademark of Healthpoint, Ltd. www.healthpoint.com

AVAILABLE IN 400 GRAM BOTTLE.
SALEX® (6% Salicylic Acid) Cream

Rx Only

FOR TOPICAL USE ONLY. NOT FOR OPHTHALMIC, ORAL OR INTRAVENOUS USE.

INDICATIONS AND USAGE
For Dermatological Use: SALEX® Cream is an exfoliant with keratolytic properties for comedonal, actinic, keratotic, seborrheic, scars, keloids, postburn, radiotherapy, actinic keratoses, acne vulgaris, mild psoriasis, and eczema vulgaris (including body, scalp, palms and soles).

For Pediatric Use: SALEX® Cream is a topical aid in the treatment of warts on hands and feet and palmoplantar hyperkeratotic lesions. Topical preparations of 5% salicylic acid have been reported to be safe and effective for these conditions in children and adults.

CONTRAINDICATIONS
SALEX® Cream should not be used in any patient known to be sensitive to salicylic acid or any of its ingredients. SALEX® Cream should not be used in children under 3 years of age.

WARNINGS
Prolonged use on large areas, especially in children and those patients with significant renal or hepatic impairment, could result in salicylates.

Concurrent use of other drugs which may contribute to elevated serum salicylate levels should be avoided as there is potential for toxicity to present. In children under 12 years of age and those patients with renal or hepatic impairment, the area to be treated should be limited and the patient monitored closely for signs of salicylate toxicity: nausea, vomiting, dizziness, loss of hearing, tremor, hyperactivity, diarrhea, and psychotic disturbances.

In the event of salicylate toxicity, the use of SALEX® Cream should be discontinued. Fluids should be administered to promote urinary excretion. Treatment with sodium bicarbonate (oral or intravenous) should be instituted as appropriate.

Due to potential risk of developing Reye’s syndrome, SALEX® Cream should not be used in children and teenagers with varicella or influenza, unless directed by a physician.

PRECAUTIONS
For external use only. Avoid contact with eyes and other mucous membranes.

DRUG INTERACTIONS
The following interactions are from a published resource and include reports concerning both salicylate and non-salicylate interactions. The reader is referred to the prescribing information of the individual drugs for binding to serum albumin the following drugs: salicylates, aspirin, probenecid, sulfinpyrazone, salicylamide, diclofenac, salicylc acid.

Derm Perspectives

Welcome to Derm Perspectives. This quarterly newsletter is designed to help PAs in dermatology practice hone their diagnostic and treatment skills while offering valuable insight on key professional development issues.

Physician assistants play a critical role in the treatment of dermatology patients nationwide. As practices continue to grow, patients continue to grow for quality care, even more dermatologists will reach out to PAs as partners in patient care. Recognizing the valuable service you provide, Coria Laboratories has made this publication possible through an unrestricted educational grant. I thank them for their generous support of dermatology PAs.

I hope that you will turn to Derm Perspectives on a consistent basis for helpful information you’ll put right into practice. In order for you to serve best, we want to know what you think of this issue and what you’d like to see covered in future installments. Please send your comments to the editorial staff at pwinnington@avondalemedical.com or mail a traditional letter to the address below. On behalf of the dermatology community, I thank you for your service and wish you continued success in your clinical endeavors.

Best wishes,
Coyle S. Connolly, DO
Medical Editor

Coyle S. Connolly, DO, Editor
Assistant Clinical Professor of Dermatology, Philadelphia College of Osteopathic Medicine. President, Coyle S. Connolly, DO Dermatology and Dermatologic Surgery, Linwood, NJ

Joe Monroe, PA-C
President-elect, SDPA. Department of Dermatology, Springer Clinic, Tulsa, OK

Tell Us What You Think

Derm Perspectives is a resource for PAs in dermatology practice. In order for each quarterly installment to enhance your professional development, we need to know what you think!

We’d like to know what topics matter most to you. What are your greatest clinical challenges? What practice development issues do you most frequently grapple with?

Send your comments via e-mail to: pwinnington@avondalemedical.com

Or via traditional mail c/o:
Avondale Medical Publications, LLC
630 West Germantown Pike
Suite 123
Plymouth Meeting, PA 19462
Help Overcome Hurdles Facing Dermatology PAs

PAs have seen their role in dermatology practices blossom over the past decade, but there are still some growing pains. Here’s how to work to promote the specialty.

By Joe Monroe, PA-C

P hysician Assistants in dermatology continue to grow both in numbers and strength. With about 1,000 PAs represented in the Society of Dermatology Physician Assistants (SDPA) and an estimated 1,000 more practicing in dermatology offices but not yet members, our numbers are equivalent to about 20 percent of medical dermatologists nationally. While dermatologists continue to debate a “manpower shortage” and argue the need for more dermatology residency slots, Physician Assistants are being sought out to fill gaps in care. Without doubt, we are becoming a critical link in the provision of care to patients with skin disease, not just extending the reach of medical care to rural and underserved areas, but also enhancing the efficiency and effectiveness of larger practices in urban and suburban settings.

With our growth—which has been most notable in the past decade, though we have worked in dermatology for over 30 years—we have firmly established our role in dermatology practices by contributing significantly to the care of patients with skin disease. Yet critical issues continue to face dermatology PAs that could significantly impact us, the patients we serve, and the physicians we work with.

Three key issues face PAs in dermatology. From simple measures to more organized efforts, action now will help ensure the best outcomes.

**Representation of Dermatology PAs.** The SDPA represents the interests of dermatology PAs across the country in various arenas, such as CME provision, legislation, reimbursement, licensing, etc. Obviously, as president-elect of the society I encourage dermatology PAs to join. Those who choose not to should at least remain in contact with the society to keep informed about our CME offerings as well the Society’s various programs and initiatives that impact all of us. For more information, visit dermpa.org.

Thankfully, numerous pharmaceutical companies now recognize the important role of PAs in dermatology practices and continue to work with and support us as significant prescribers of their products. Pharmaceutical companies have initiated or financed CME and professional development programs and financially supported our society and its annual meeting. We will continue to work to develop and expand these positive and mutually beneficial relationships.

PAs in practice can acknowledge the support of companies even at a local level. Just a brief “thank you” spoken to your rep can be meaningful. PAs, like many physicians, may find themselves so busy with patient care that they cannot “find” time to meet with pharmaceutical reps. However, PAs who make time for interactions with reps can see benefits. Reps can provide access to drug and research information, provide assistance to your patients in need, and keep you abreast of patient support and education programs. Key to successful interactions with reps is to maintain control of your time and the focus of meetings. Don’t be afraid to set parameters, including scheduling and duration of meetings. Medical care providers who develop relationships with pharmaceutical companies often find opportunities for professional development, such as participating in studies or joining advisory panels and speakers’ bureaus.

**Liability Insurance, continued from p. 1**

a claim is filed. In fact, your own personal defense attorney—who looks after your interests alone—is provided in the event of a claim.

Individual policies can be written to provide you coverage should you wish to moonlight. Additionally, if you accept a position and then decide you want to take a position elsewhere, your individual coverage can follow you. This is true even if your previous employer paid the premiums for your coverage, though the AAPA warns your previous employer may request reimbursement.

In the event that your employer will not cover liability premiums for a personal policy for you and you cannot afford a policy of your own, then your employer must include you as a rider on his/her policy. AAPA suggests you obtain and analyze a copy of the certificate of insurance—consider the following five questions:

- Is the rider’s form occurrence coverage or claims-made?
- Under a claims-made policy, will your former employer be responsible for paying the cost of the tail coverage should you change employers?
- Are legal costs included in the limits of liability, or will they be paid in addition to policy limits?
- Are you listed by name on your employer’s policy?
- Is the policy available in all 50 states?

For more information on liability coverage, visit www.aapa.org/gandp/risky.html. To investigate policies available through AAPA, go to www.epreceptor.com/aapa_insurance/index.html.

By Joe Monroe, PA-C
PAs should continue to work to promote the public image of our specialty. We know from our own experiences that most patients who have the opportunity to receive care from a PA are quite satisfied with the quality of care and attention they receive, because they tell us so and they subsequently return to us. We represent access to care for vast numbers of patients who would otherwise wait upwards of two to four months to see a dermatologist. We have become key providers of dermatology services for patients, providing them with a high level of support and education consistent with our philosophy of patient care. As our ranks continue to swell, we will have the opportunity to impact the lives of many more patients.

But there are some who remain unfamiliar with us and the work we do. As individuals, we can raise the profile of dermatology PAs by participating in community health events, providing public education services, and otherwise being visible and active in our own communities. As more and more patients gain exposure to PAs, our services, and our philosophy, they and we will benefit.

Advancing Public Policy. Derm PAs can and do work with dermatologists, pharmaceutical companies, and patient advocacy groups to advance policies that protect the best interests of patients and medical professionals. PAs, including outgoing SDPA President Gordon Day, PA-C, actively participated with the AAD to defend the safety and benefits of isotretinoin, even participating in Congressional hearings on the matter. Issues such as Medicare reimbursements and other drug oversight, approval, and regulatory concerns come before policy makers on a regular basis. Whether by writing to legislators or mobilizing with local and national medical societies (including SDPA) we can directly influence outcomes in these matters. Speaking with one powerful voice, we can have a much greater impact than as individuals.

Being a constituent organization of the AAPA, we have a powerful ally in dealing with threats to our profession. Integrating with the AAD. The greatest task facing dermatology PAs may be integrating more fully with the American Academy of Dermatology (AAD), particularly with regard to the AAD’s annual meetings policy. Despite the fact that an estimated 25 percent of all medical dermatology offices have welcomed PAs onto their staff, the Academy itself has not fully embraced us. Fortunately, they have indicated their understanding that we’re here to stay as a part of the team.

According to current policies, a PA cannot attend the AAD Annual Meeting or the Academy summer meetings unless his or her supervising physician also attends. Such a policy makes it virtually impossible for most PAs to attend the conferences. One of the reasons for having a PA on staff is so that he or she can continue to see patients while the physician is away. For a number of dermatology practices, sending both the PA and physician to the conference would mandate closing the practice to patients for several days. This is an expensive proposition with an obvious negative impact on access to care. As noted already, PAs do work with the AAD in various capacities, but there is still much to do to strengthen and enhance that relationship.

Get Active
PAs pride ourselves on the level of personal attention we give to each individual patient, focusing on one-on-one education and counseling. We can employ these same skills to enhance our standing as a profession. By involving both the general public and policy-makers/legislators, we can help influence our own professional future. Key challenges facing dermatology PAs that require action and perseverance. Our efforts need not be heroic. Every effort helps.

### 7 Easy Ways to Advance Dermatology PAs

1. Join the Society of Dermatology Physician Assistants (dermpa.org). Be an active member, or at least stand up and be counted. Attend SDPA CME events.
2. Foster relationships with pharmaceutical companies. Avail yourself of worthwhile services offered.
3. Get involved in your community, especially health/education programs.
4. Inform your community through educational programs, editorials, etc.
5. Educate policy-makers, legislators, etc. Support efforts to protect and enhance patient care.
6. Keep abreast of local regulatory policies and proposed changes that may affect your scope of practice. Stay in touch with SDPA and the AAPA. When necessary, take appropriate action.
7. Work to enhance the standing of PAs within the AAD. Involve the dermatologists you work with.

---

### Managing Rosacea Subtype 1

Relatively new guidelines now classify rosacea according to four main subtypes: Erythematotelangiectatic (ETR), Papulopustular (PPR), Phymatous (PR), and Granulomatous (GR).

Patients with the ETR subtype are more likely than those with other subtypes to complain of cosmetic intolerance and facial skin sensitivity, says Michelle T. Pelle, MD of UCSF. Such patients should opt for soap-free cleansers, bland emollients, and light liquid foundation make-up over alternative skin care options, she says. They should apply the bland emollient twice daily to improve barrier function and minimize sensitivity.

Dr. Pelle recommends the following treatment regimen for patients with ETR.

**Phase I, For Extremely Sensitive Skin:**
- Begin with sodium sulfacetamide/sulfur cleanser left on for two minutes once to twice daily immediately followed by bland emollient. Then progress to phase II.

**Phase II, For Less Sensitive Skin:**
- Begin with sodium sulfacetamide/sulfur cleanser followed by application of metronidazole cream or azelaic acid gel once or twice daily.

**Phase III, Long-term Maintenance:**
- Initiate topical tretinoin therapy either at the start of or after about two months of Phase II.
- Patients should apply an oil-in-water barrier emollient followed by tretinoin 0.025% cream. Gradually increase to 0.05% and then 0.1% cream over four to six months. With significant reversal of actinic damage (about one year of therapy) decrease application to two to five nights per week.
- Stress sun avoidance and protection.

### Treatment Tips

**Photo Courtesy of National Rosacea Society**
Atopic Dermatitis
Continued from p. 1

Assess the family’s financial situation, prescription coverage, and ability to purchase prescription and OTC agents. As I’ll discuss below, my preference tends to be for brand-name agents, but there are effective generic options to consider when cost is an issue.

Keep things as simple as possible. Simplify the regimen. Simplify the disease education provided to the patients/parents. Simplify your tips and recommendations. We could easily spend a half hour or more with every new patient just reviewing the “basics” of atopic dermatitis. But they would be overwhelmed and retain little of what we tell them. Remember, just as eczema is a chronic disease, education is an ongoing process. Offer some basics, stress the need for a long-term commitment to the treatment regimen, provide important general tips (avoiding dyes and perfumes in detergents and cleansers), and direct individuals to informative, accredited sources for more information, such as the AAD’s website (www.aad.org/public/Publications/pamphlets/EczemaAtopicDermatitis.htm).

Finally, provide clear, specific written instructions regarding use of each agent, including time and amount to apply. Also, provide instructions on the prescription as specifically as possible: “Apply each morning and evening to red, itchy areas” versus “Apply twice daily to affected areas.” This increases compliance, promotes better treatment outcomes, and helps avoid calls to the office from confused parents.

Instruct patients to call you immediately if they encounter any problems with access to medication (non-coverage, limited availability, etc.).

The Basics
Everything that an eczema patient applies to the skin potentially affects their condition. Skin cleansing tactics warrant discussion with the patient. Generally, atopic dermatitis patients of any age should select soap-free, fragrance-free moisturizing cleansers, of which there are various options. While some parents believe it best to bathe infants and small children infrequently, this is not necessarily so. Bathing with plain water debrides dead skin cells, can help prevent infections, and hydrates. Advise parents to use cleansers sparingly, limiting use only to areas that need it.

The next critical factor is regular application of an appropriate moisturizer. The importance of moisturization in AD management is well known. Improved barrier function and increased transepidermal water loss (TEWL) are known characteristics of the skin in atopic dermatitis. Furthermore, studies show that a decrease in ceramides in the stratum corneum may contribute to impaired barrier function and skin dryness in patients with AD. Emollients and/or moisturizers are commonly used to help break this dry skin cycle. Technically, emollients differ from moisturizers. Emollients help to smooth the skin by interspersing between desquamating corneocytes; they may or may not moisturize. Moisturizers work either by occlusion to prevent TEWL or through humectant ingredients that absorb moisture into the stratum corneum. Because moisturizers are now marketed in specific formulations for a wide range of patients and concerns, a multitude of options are available. Many moisturizers contain emollients, antioxidants, preservatives, and other active ingredients or excipients that can actually deteriorate already abnormal barrier function. Therefore, it is necessary to guide patients to appropriate products.

Moisturizers containing urea help reduce TEWL in AD, while petrolatum has an immediate barrier-repairing effect. Until recently, no marketed emollient or moisturizer was shown to improve the ceramide deficiency in the stratum corneum that contributes to impaired barrier function. Studies now demonstrate that a ceramide dominant emollient formulation used in conjunction with traditional AD therapies produced decreases in TEWL with slow but significant increases in stratum corneum integrity and hydration in treated patients. CeraVe (Corta Laboratories), a new line of ceramide-based skin care products formulated with patented multivesicular emulsion (MVE) delivery technology, is now available in pharmacies nationwide. Because of its unique ceramide-containing formula, CeraVe lotion or cream may be an especially good choice of moisturizer for patients with AD.

Topical Corticosteroids
Topical corticosteroids long reigned as the treatment of choice for atopic dermatitis, and in many cases they remain the “go to” therapy. These agents produce rapid clearing and prompt control of symptoms. Unfortunately, the risks associated with long-term topical corticosteroid use, including striae, telangiectases, atrophy, glaucoma, and HPA-axis suppression, preclude their use as long-term maintenance therapy.

There are some questions regarding choice of an appropriate strength or class of topical corticosteroid. In general, the dermatology community embraces an approach that might be considered somewhat “aggressive” by general practitioners or pediatricians. In practice, a short course of a higher-potency steroid will yield more rapid clearing and may actually limit overall exposure to the corticosteroid versus prolonged application of a low potency agent that will take much longer to produce similar effects. Therefore, for the vast majority of patients I initiate treatment with a corticosteroid in the mid- to high-potency range, depending on the severity of the presentation.

Generally, ointment formulations are ideal due to their enhanced potency and moisturizing characteristics. As noted, social factors (school or work) or even cultural attitudes (Caucasian patients may not like ointments, whereas African-Americans generally do) may limit tolerability of ointments. In this case, choose a cream formulation, such as Clocortolone (locortolone privale 0.1%, Coria

Potential for infection is one topic that must be addressed within the first patient encounter. Any obvious signs of infection warrant immediate initiation of antibiotic therapy. Instruct patients to contact you immediately if any signs of infection develop. Without being alarmist, make it clear that patients are at higher risk for infections, that infections can progress rapidly, and that untreated infections can be dangerous to the patient—especially youngsters.

Infection Management

Moisturizers

• Identify the primary caregiver and assess his/her ability to comply with treatment instructions/time requirements.
• Determine insurance coverage for prescription agents and ability to pay for non-covered items.
• Explore patient preferences for vehicles, etc.
• Don’t overwhelm patients/parents with instructions. Do discuss the basics: triggers to avoid (especially detergents, dyes, perfumes, etc.), infection risk, and easy relief strategies, such as use of humidifiers.
• Enhance the level of education at each subsequent visit. Follow-up on and reinforce previous discussions.
• Provide written instructions, clear application directions, and appropriate resources, such as the AAD website.
• Use specific language on the prescription. Provide adequate amounts of medication.
• Encourage parents/patients to become their own advocates.
• Encourage patients/parents to be diligent:
  - in daily application of moisturizers,
  - vigilance for signs of infection,
  - communication with your office regarding infections and flares.

• Avoid long-term use of a single agent that will take much longer to produce similar effects. Therefore, for the vast majority of patients I initiate treatment with a corticosteroid in the mid- to high-potency range, depending on the severity of the presentation.
• Generally, ointment formulations are ideal due to their enhanced potency and moisturizing characteristics. As noted, social factors (school or work) or even cultural attitudes (Caucasian patients may not like ointments, whereas African-Americans generally do) may limit tolerability of ointments. In this case, choose a cream formulation, such as Clocortolone (locortolone privale 0.1%, Coria

Potential for infection is one topic that must be addressed within the first patient encounter. Any obvious signs of infection warrant immediate initiation of antibiotic therapy. Instruct patients to contact you immediately if any signs of infection develop. Without being alarmist, make it clear that patients are at higher risk for infections, that infections can progress rapidly, and that untreated infections can be dangerous to the patient—especially youngsters.

Infection Management

Moisturizers

• Identify the primary caregiver and assess his/her ability to comply with treatment instructions/time requirements.
• Determine insurance coverage for prescription agents and ability to pay for non-covered items.
• Explore patient preferences for vehicles, etc.
• Don’t overwhelm patients/parents with instructions. Do discuss the basics: triggers to avoid (especially detergents, dyes, perfumes, etc.), infection risk, and easy relief strategies, such as use of humidifiers.
• Enhance the level of education at each subsequent visit. Follow-up on and reinforce previous discussions.
• Provide written instructions, clear application directions, and appropriate resources, such as the AAD website.
• Use specific language on the prescription. Provide adequate amounts of medication.
• Encourage parents/patients to become their own advocates.
• Encourage patients/parents to be diligent:
  - in daily application of moisturizers,
  - vigilance for signs of infection,
  - communication with your office regarding infections and flares.

• Avoid long-term use of a single agent that will take much longer to produce similar effects. Therefore, for the vast majority of patients I initiate treatment with a corticosteroid in the mid- to high-potency range, depending on the severity of the presentation.
• Generally, ointment formulations are ideal due to their enhanced potency and moisturizing characteristics. As noted, social factors (school or work) or even cultural attitudes (Caucasian patients may not like ointments, whereas African-Americans generally do) may limit tolerability of ointments. In this case, choose a cream formulation, such as Clocortolone (locortolone privale 0.1%, Coria
**A Step-by-Step Approach to AD Management**

<table>
<thead>
<tr>
<th>Mild AD</th>
<th>Severe AD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soap-free, Fragnance-free, Moisturizing Cleanser</td>
<td>Mid-Potency Topical Corticosteroid</td>
</tr>
<tr>
<td>OR</td>
<td>Mid-to-High Potency Topical Corticosteroid</td>
</tr>
<tr>
<td>TCI</td>
<td>Systemic Corticosteroids</td>
</tr>
<tr>
<td>Daily/Maintenance Moisturizer</td>
<td>Consider adjunct oral antihistamines. Institute antibiotics if infection is evident.</td>
</tr>
</tbody>
</table>

When patients do not have prescription coverage or there is concern about non-compliance, a very inexpensive but effective option is to order generic triamcinolone compounded in Eucerin or Aquaphor (Beiersdorf) ointments. The inexpensive compound has the dual benefit of delivering an effective steroid and moisturizer in one step. For patients who can’t or won’t tolerate the ointments, use a lotion base, such as CeraVe Lotion.

Depending on the severity of the presentation, patients should apply corticosteroids once or twice daily for about two to four weeks. Severe cases of AD may warrant initial therapy with an oral corticosteroid. Particularly itchy patients may be candidates for adjunctive oral antihistamines. OTC diphenhydramine (Benadryl, Warner Lambert) is a good, inexpensive first-line option. Hydroxyzine (Atarax, Pfizer) is a suitable prescription agent. Both may be sedating, which may be beneficial for patients kept awake by itch. Administration one to two hours before bedtime is recommended.

Key to safe and effective use of any topical corticosteroid is to offer patients specific application advice. The tip of the finger or FTU is one proposed method to measure the amount of product parents/patients should apply. As the name suggests, one FTU is equivalent to the length of the top third of an adult’s index finger. Unless occlusion is desired, advise parents/patients not to cover the treatment area after application of the topical corticosteroid. Occlusion can boost the potency of a topical corticosteroid significantly, making a topical corticosteroid an effective addition to antibiotic therapy. When patients don’t tolerate the ointments, use a lotion base, such as CeraVe Lotion.

Have patients return within two to four weeks. By this time, the topical corticosteroid should yield significant control of inflammation and itch. If not, consider another two-week course of corticosteroid, two weeks treatment with a higher-potency corticosteroid, or the addition of a systemic antihistamine and/or the use of a systemic corticosteroid.

Once patients achieve acceptable clearance, the majority can taper the corticosteroid and continue maintenance application of moisturizers on a daily basis. Some patients with minor involvement or who are prone to flares can be transitioned to a short course of a topical calcineurin inhibitor (pimecrolimus, Elidel, Novarit; tacrolimus, Protopic, Astellas). Note that TCIs may be an appropriate first-line option for some patients with very mild AD, although a topical corticosteroid may be equally useful.

The recent controversy regarding cancer risks associated with the topical immune-modulating agents has largely died down, and the anticipated addition of a black-box warning to the products’ prescribing information has yet to materialize. Nonetheless, widespread media coverage certainly captured the attention and imagination of the public, prompting questions from concerned patients and parents.

**Transitions**

Regular follow-up is critical to yield and maintain clearance of atopic dermatitis. Each visit is an opportunity to enhance patient/parent education so that eventually they become their own best advocates. Recognizing the individual patient’s socio-economic background, providing clear instructions, keeping regimens and information simple, and being available to answer questions are secrets to successful AD management.

As a dermatologist, you face a new challenge with each patient. At CORIA, we understand the nature of these challenges and help you meet them. Through our commitment to quality and innovation, we develop products for conditions that affect the skin, hair, and nails of your patients. In fact, our name is inspired by the Latin word “corium,” which means true skin. This lets you know that our passion is dermatology and our focus is on making a difference in the lives of your patients.

www.corialabs.com