

XXV CONVEGNO NAZIONALE

DERMATOLOGIA PER IL PEDIATRA

*Mamma, raccontami il futuro
Cosa dire ai genitori*



23-24 Maggio 2025
Palazzo dei Congressi, Riccione



LE TRE COSE PIU' IMPORTANTI DA DIRE AI GENITORI DI UN BAMBINO CON: **DERMATITE ATOPICA**

Mazzotta Francesco

Prof. Inc. Università «Guglielmo Marconi»-Roma

DERMATOLOGIA PEDIATRICA
BARLETTA
Asl BAT



DERMATITE ATOPICA ECZEMA ATOPICO ECZEMA COSTITUZIONALE

E' una malattia a prevalente impegno cutaneo, **infiammatoria** di tipo eczematoso, essudativo o con lichenificazione, **intensamente pruriginosa, cronico recidivante**; interessa soggetti con storia personale e/o familiare di asma, rinite o dermatite atopica



Meneghini C.L., Bonifazi E., 1989

Taylor B. et Al - Lancet dec 1 , 1255-57, 1984
In Inghilterra la prevalenza dal
5,1% del 1946 era passata al
7,3% nel 1958
al 12,2% nel 1970

**Prevalenza :15-20% in età pediatrica
10% nell'adulto**

**15-30% in età pediatrica
8-15 % nell'adulto**

Torrelo Fernández A, Vicente A, Martin-Santiago A, de Lucas Laguna R, Armario-Hita JC, Moro R, Díaz-Cerezo S, Lizán L, Núñez M.

Humanistic and Economic Burden of Atopic Dermatitis in Pediatric Patients in Spain: A Systematic Review. Actas Dermosifiliogr. 2025 Apr;116(4):365-377

Ständer S. Atopic Dermatitis.

N Engl J Med. 2021 Mar 25;384(12):1136-1143.

**E' la malattia infiammatoria cutanea con il più alto grado di
«disability-adjusted life year (DALY)» ovvero il numero di anni
persi a causa della malattia per disabilità !**

Particulate matter causes skin barrier dysfunction

Byung Eui Kim,^{1,2} Jihyun Kim,^{2,3} Elena Goleva,¹ Evgeny Berdyshev,⁴ Jinyoung Lee,³ Kathryn A. Vang,¹ Un Ha Lee,⁵ SongYi Han,³ Susan Leung,¹ Clifton F. Hall,¹ Na-Rae Kim,³ Irina Bronova,⁴ Eu Jin Lee,³ Hye-Ran Yang,⁶ Donald Y.M. Leung,¹ and Kangmo Ahn^{2,3}

¹Department of Pediatrics, National Jewish Health, Denver, Colorado, USA. ²Department of Pediatrics, Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, South Korea. ³Environmental Health Center for Atopic Diseases, Samsung Medical Center, Seoul, South Korea. ⁴Department of Medicine, National Jewish Health, Denver, Colorado, USA. ⁵Department of Dermatology, Sanggye Paik Hospital, Inje University College of Medicine, Seoul, South Korea. ⁶Seoul Metropolitan Government Research Institute of Public Health and Environment, Seoul, South Korea.

Kim BE, Kim J, Goleva E, Berdyshev E, Lee J, Vang KA, Lee UH, Han S, Leung S, Hall CF, Kim NR, Bronova I, Lee EJ, Yang HR, Leung DY, Ahn K. Particulate matter causes skin barrier dysfunction. JCI Insight. 2021 Mar 8;6(5):e145185.

The molecular mechanisms that underlie the detrimental effects of particulate matter (PM) on skin barrier function are poorly understood. In this study, the effects of PM_{2.5} on filaggrin (FLG) and skin barrier function were investigated in vitro and in vivo. The levels of FLG degradation products, including pyrrolidone carboxylic acid, urocanic acid (UCA), and *cis/trans*-UCA, were significantly decreased in skin tape stripping samples of study subjects when they moved from Denver, an area with low PM_{2.5}, to Seoul, an area with high PM_{2.5} count. Experimentally, PM_{2.5} collected in Seoul inhibited FLG, loricrin, keratin-1, desmocollin-1, and corneodesmosin but did not modulate involucrin or claudin-1 in keratinocyte cultures. Moreover, FLG protein expression was inhibited in human skin equivalents and murine skin treated with PM_{2.5}. We demonstrate that this process was mediated by PM_{2.5}-induced TNF- α and was aryl hydrocarbon receptor dependent. PM_{2.5} exposure compromised skin barrier function, resulting in increased transepidermal water loss, and enhanced the penetration of FITC-dextran in organotypic and mouse skin. PM_{2.5}-induced TNF- α caused FLG deficiency in the skin and subsequently induced skin barrier dysfunction. Compromised skin barrier due to PM_{2.5} exposure may contribute to the development and the exacerbation of allergic diseases such as atopic dermatitis.



The Impact of Air Pollution on Atopic Dermatitis

Austin Lai¹ · Kelly Owens¹ · Surya Patel² · Matilda Nicholas^{2,3} 

Accepted: 6 May 2023
© The Author(s), under exclusive licence to Springer Science+Business Media, LLC, part of Springer Nature 2023

Abstract
Purpose of Review Atopic dermatitis (AD) remains a dermatological disease that imposes a significant burden on society. Air pollution has previously been linked to both the onset and severity of atopic dermatitis. As air pollution remains a critical environmental factor impacting human health, this review seeks to provide an overview of the relationship between different air pollutants and AD.
Recent Findings AD can develop from multiple causes that can be broadly grouped into epidermal barrier dysfunction and immune dysregulation. Air pollution imposes significant health risks and includes a wide variety of pollutant types. AD has been linked to outdoor air pollutants such as particulate matter (PM), volatile organic compounds (VOC), gaseous compounds, and heavy metals. Exposure to indoor pollutants such as tobacco smoke and fungal molds has also been associated with an increased incidence of AD. While different pollutants impact distinct molecular pathways in the cell, they mostly converge on ROS product, DNA damage, and dysregulated T-cell activity and cytokine production.
Summary The presented review suggests a strengthening tie between air pollution and AD. It points to opportunities for further studies to clarify, as well as potential therapeutic opportunities that leverage the mechanistic relationships between air pollution and AD.

Keywords Atopic dermatitis · Air pollution · Particulate matter · Eczema

Lai A, Owens K, Patel S, Nicholas M. The Impact of Air Pollution on Atopic Dermatitis. Curr Allergy Asthma Rep. 2023 Aug;23(8):435-442. doi: 10.1007/s11882-023-01095-w. Epub 2023 May 26. PMID: 37233850; PMCID: PMC10214316.

LA CERTEZZA DI DOVER CURARE NUMEROSI CASI DI
DERMATITE ATOPICA HA INNESCATO CIRCUITI A
RISCHIO PER IL PAZIENTE E PER IL PEDIATRA !

Dermatologo poco esperto in Dermatologia Pediatrica

FARMACISTA

Nutrizionista

Medico Omeopata

INTERNET



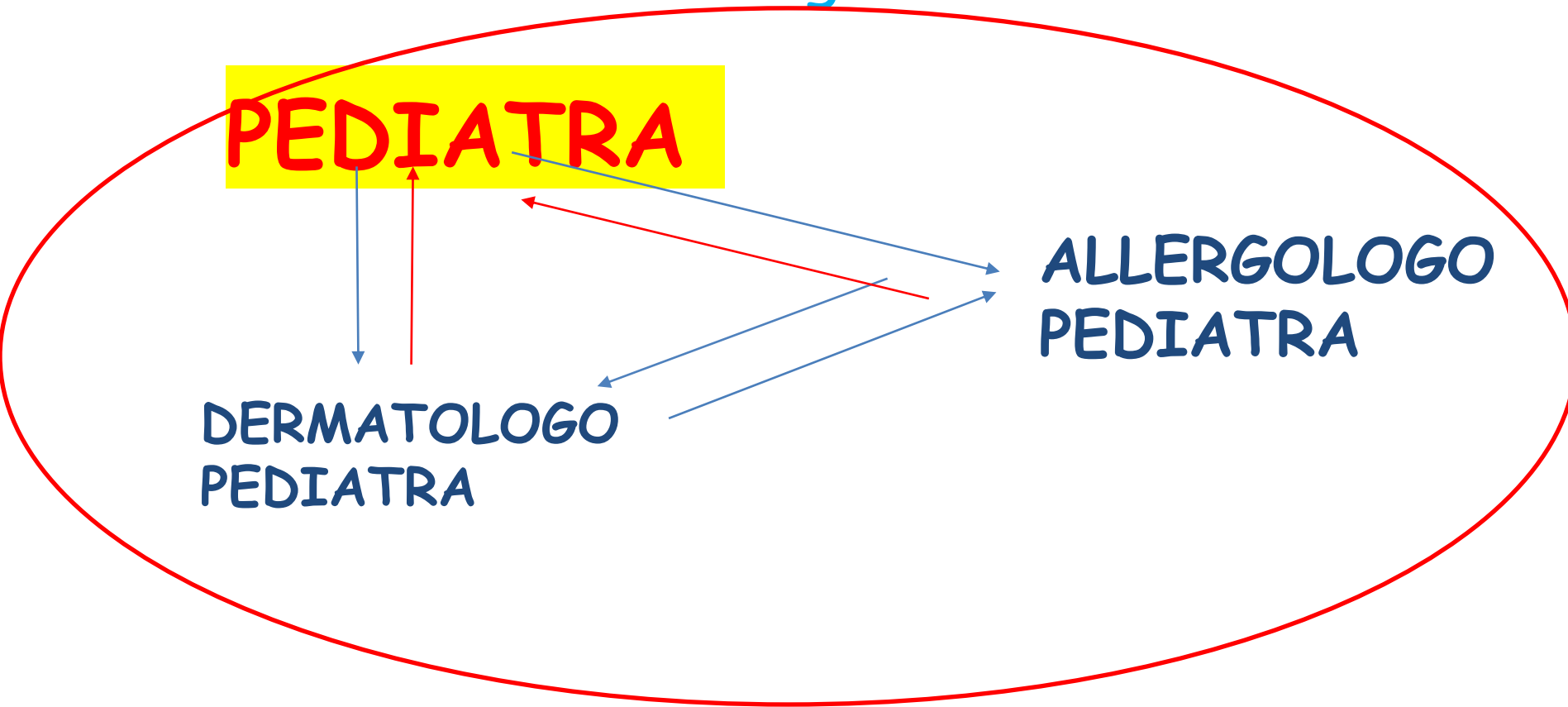
TRUFFA



Nota AIFA

Sulla base degli accertamenti analitici effettuati presso laboratori privati Aur Derm Crema non è riconducibile a prodotti aventi una composizione a base di soli ingredienti naturali, contenendo invece ben quattro diverse sostanze farmacologicamente attive quali **clobetasolo propionato, procaina, benzocaina e lidocaina,**

A chi spetta il compito di curare la Dermatite Atopica dopo una diagnosi clinica corretta



Il Circolo Virtuoso !

Per tanti anni abbiamo:

- a) utilizzato una narrazione «scorretta» sulla durata enfatizzando l'autorisoluzione della dermatite dopo primi 10 anni di vita,
- b) la dieta è stata messa al primo posto
- c) abbiamo indotto la corticofobia indiscriminata (diluendo creme cortisoniche in creme base)



NON ABBIAMO UTILIZZATO I VOSTRI PREZIOSISSIMI SOFTWARE PER ESTRAPOLARE DATI BASATI SULL'EVIDENZA DEL DECORSO CLINICO, RISPOSTA ALLA TERAPIA, COMORBIDITA' !

Article original

Dermocorticoïdes et exposition solaire: un malentendu?

Dermocorticoides and sun exposure: A misunderstanding?

A. Sacko^a, E. Bourrat^b, O. Bourdon^{a, c, d}, S. Prot-Labarthe^{c, e}  

[Show more](#) 

 Add to Mendeley  Share  Cite

<https://doi.org/10.1016/j.pharma.2021.01.001> 

[Get rights and content](#) 



Conclusion

The false belief of DC/sun incompatibility in DA is strong among pharmacists and impacts on patients' advice.

The role of the official team in dispensing dermocorticoids is essential: training and information for professionals helps to fight false information.

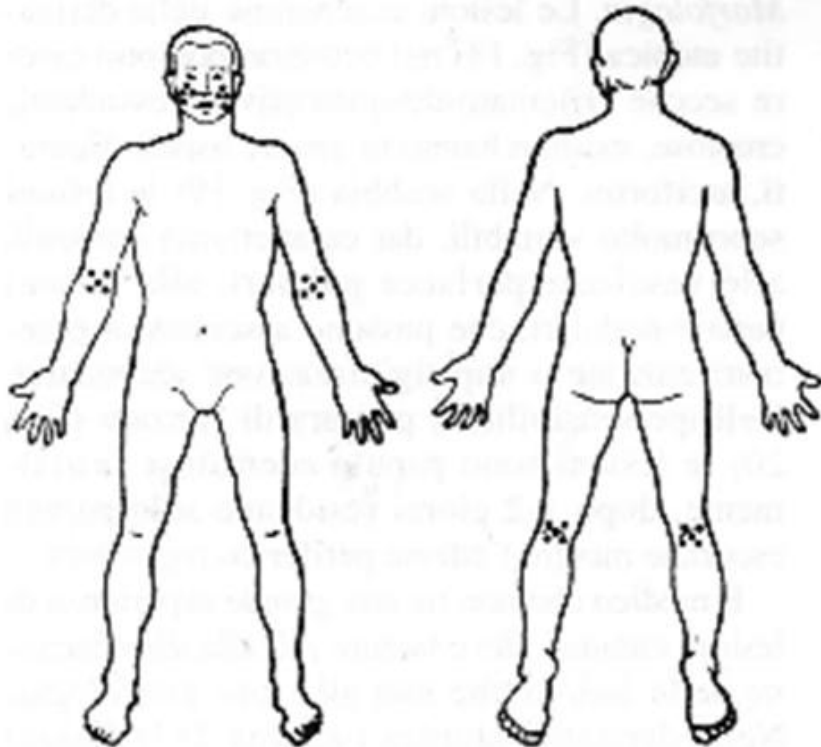


The Heterogeneity of Atopic Dermatitis

R. Chovatiya, MD, PHD¹, J.I. Silverberg, MD, PhD, MPH²

¹ Department of Dermatology, Feinberg School of Medicine at Northwestern University, Chicago, IL USA;

² Department of Dermatology, The George Washington University School of Medicine and Health Sciences, Washington, DC USA;



Schema 2: Dermatite atopica

- Le pieghe di gomiti e ginocchia sono presenti solo nel 58% ma in alcune popolazioni le superfici estensorie prevalgono (Est Asiatici).
- Col progredire dell'età le forme essudative vengono sostituite dalle forme follicolari, lichenoidi, nummulari e prurigo nodulare.

In età puberale può comparire oltre al prurito il dolore neuropatico definito pungente

Le autorisoluzioni definitive entro i primi 10 anni di età sono poco frequenti l'80% deve proseguire terapie in età pediatrica per «gestire» la dermatite con remissioni in media di circa 6 mesi.

Molti studi segnalano che nel 40-60% si manifesta in età adulta.

Non bisogna mai fermarsi ad osservare le lesioni che fanno vedere le mamme ma far spogliare il paziente per valutare i segni della malattia sull'intera superficie cutanea



Invited review article

Exacerbating factors of itch in atopic dermatitis

Hiroyuki Murota*, Ichiro Katayama

Department of Dermatology, Course of Integrated Medicine, Graduate School of Medicine, Osaka University, Osaka, Japan



CrossMark

Photodermatoses in patients with atopic dermatitis:
A 10-year retrospective cohort studyShawn Afvari¹, Jonathan H Zippin²Affiliations

Affiliations

¹ Department of Dermatology, Weill Cornell Medical College, New York, New York; New York Medical College School of Medicine, Valhalla, New York.² Department of Dermatology, Weill Cornell Medical College, New York, New York. Electronic address: jhzipin@med.cornell.edu.

PMID: 38372681 PMID: PMC11823502 DOI: 10.1016/j.jaad.2024.01.032

No abstract available

Keywords: allergic contact dermatitis; atopic dermatitis; contact dermatitis; dermatitis; eczema; patch test; photoallergy; photopatch test; photosensitivity; type IV hypersensitivity.

1072 Research Letters

J AM ACAD DERMATOL
MAY 2024

Table I. Demographics of phototested patients

Diagnosis	Allergic contact dermatitis	Photoallergic contact dermatitis*	Photosensitivity	Solar urticaria	Polymorphic light eruption	Photodrug reaction	Collagen vascular disease
			Delayed light induced reaction with diagnostic clinical presentations and biopsy proven histopathology	Immediate (min) urticarial reaction to a light source	Delayed light induced reaction with diagnostic clinical presentations and biopsy proven histopathology	Delayed light induced reaction with relevant drug histories	Delayed light induced reaction with diagnostic clinical presentations and biopsy proven histopathology
Criteria	Sensitivity to an allergen 72 h after patch test	Sensitivity to an allergen 72 h after UV-A exposure					
Total tested (N)	70	86	101	101	101	101	101
Total positive, n (%)	60 (85.7)	26 (30.2)	47 (46.5)	26 (25.7)	10 (9.9)	11 (10.9)	2 (2.0)
Gender							
Male, n (%)	16 (26.7)	9 (34.6)	14 (29.8)	8 (30.8)	1 (10.0)	5 (45.5)	0 (0.0)
Female, n (%)	44 (73.3)	17 (65.4)	33 (70.2)	18 (69.2)	9 (90.0)	6 (54.5)	2 (100)
Age (y)							
Mean	47	51	45	41	41	55	38
Range	14-85	24-74	8-75	8-70	14-63	24-75	24-52

DERMATITE ATOPICA E SOLE

doi: 10.1111/j.1398-9995.2006.01209.x.

Effect of climatic change in children with atopic eczema

G Byremo¹, G Rød, K H Carlsen

Affiliations + expand

PMID: 17073869 DOI: 10.1111/j.1398-9995.2006.01209.x

Abstract

Background: Climate and sunlight (ultraviolet radiation) influence activity of atopic eczema.

Objective: To evaluate the effect of moving from a subarctic/temperate climate to a sunny subtropical climate on children's atopic eczema.

Methods: Children, 4-13 years, with severe atopic eczema were randomized to stay 4 weeks in Gran Canary (index patients = 30) and home in Norway (controls = 26), with a follow up of 3 months. SCORing of Atopic Dermatitis (SCORAD) was primary variable, and secondary were Children's Dermatology Life Quality Index (CDLQI), Staphylococcus aureus skin colonization and pharmacological skin treatment.

Results: SCORing of Atopic Dermatitis decreased from 37.2 (29.4-44.9) to 12.2 (9.0-15.4) [mean (95% confidence intervals)] after 4 weeks and 21.2 (17.2-25.1) 3 months thereafter in index patients ($P < 0.0005$), much less in controls. Children's Dermatology Life Quality Index in the index group improved from 8.7 to 2.2 and 4.5 after 4 weeks and 3 months ($P < 0.0005$), not in controls. Bacterial skin colonization with *S. aureus* decreased in the index group from 23/30 (77%) to 12/30 (40%; $P = 0.001$) and 12/30 (40%; $P = 0.005$) after 1 month and 3 months, and the use of local steroids decreased in index patients but not in controls.

Conclusions: The change from a subarctic/temperate to a subtropical climate for 4 weeks improved significantly skin symptoms (SCORAD) and quality of life, even for 3 months after return.

- Effetto immunomodulante
- Aumento della Vitamina D
- Apoptosi della cellule infiammatorie
- Inibizione delle cellule di Langerhans
- Riduce la colonizzazione dello *S. aureus*

Potential role of reduced environmental UV exposure as a driver of the current epidemic of atopic dermatitis

Jacob P. Thyssen, MD, PhD,^a Matthew J. Zirwas, MD,^b and Peter M. Elias, MD^c *Hellerup, Denmark, Columbus, Ohio, and San Francisco, Calif*

The basis for the sudden and dramatic increase in atopic dermatitis (AD) and related atopic diseases in the second half of the 20th century is unclear. The hygiene hypothesis proposes that the transition from rural to urban living leads to reduced childhood exposure to pathogenic microorganisms. Hence instead of having the normal T_H1 bias and immune tolerance because of repeated exposure to pathogens, urban dwellers have T_H2 cell immune activity and atopic disease in a more sterile environment. Various other environmental exposures have been implicated in the explosion of AD (and atopic disorders in general), including breast-feeding, tobacco smoking, alcohol consumption, and exposure to domesticated furry pets. Notably, the key role of a compromised barrier of neonatal skin as a predisposing factor in the development of childhood AD has recently been demonstrated. In this article we review the salubrious effects of suberythemogenic doses of UVB irradiation for the skin barrier. We then discuss how the lack of sufficient UVB exposure could have contributed to the rapid increase in the incidence of AD in developed countries. This hypothesis offers a separate but not competing partial explanation, which should be viewed as not discounting the role of the etiopathogenic factors that also could influence the prevalence of atopic disorders. (*J Allergy Clin Immunol* 2015;136:1163-9.)

Key words: Atopic dermatitis, filaggrin, irradiation, pathogenesis, phototherapy, skin, UV

Abbreviations used

AD: Atopic dermatitis
AMP: Antimicrobial peptides
TSLP: Thymic stromal lymphopoietin
VD3: Vitamin D₃

Early-onset AD is caused primarily by skin barrier abnormalities commonly caused by filaggrin gene (*FLG*) mutations in Northern Europeans and Asians, which lead to downstream immunologic activation, including both the synthesis and secretion of specific IgE against absorbed allergens, again contributing to the barrier abnormalities.² Although AD is immunologically characterized by T_H2 predominance in the acute phase, additional pathogenic roles for T_H1 and T_H22 cells emerge in chronic disease.³

The basis for the sudden and dramatic increase in AD and related atopic diseases in the second half of the 20th century is unclear. Various exposures have been implicated in the etiopathogenesis of AD (and atopic disorders in general), including breast-feeding, tobacco smoking, alcohol consumption, and exposure to domesticated furry pets,⁴ but none of these account for the recent explosion of AD. Nonetheless, before focusing on our new hypothesis, some of these older hypotheses are worth examining here.

The hygiene hypothesis proposes that the transition from

The Role of Photoprotection in Optimizing the Treatment of Atopic Dermatitis

Jaime Piquero-Casals  · José Manuel Carrascosa · Daniel Morgado-Carrasco ·
Midvika Narda · Carles Trullas · Corinne Granger · Gabriella Fabbrocini

Received: December 22, 2020 / Accepted: January 23, 2021 / Published online: February 13, 2021

Dermatol Ther (Heidelb) (2021) 11:315–325

321

Table 1 Criteria for sunscreens suitable for skin with atopic dermatitis

Criteria for sunscreens suitable for skin with atopic dermatitis

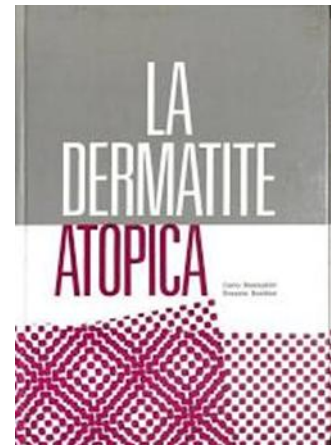
Avoids patient-specific AD triggers
Mineral-based sunscreen ingredients: titanium dioxide (TiO ₂) and zinc oxide (ZnO) or a combination of chemical and inorganic filters
Improved sensory attributes for better compliance
SPF 30 or greater
Provides broad-spectrum protection from both UVB and UVA rays
Lightweight texture that protects and repairs an impaired skin barrier
Water resistant
Noncomedogenic and formulated to minimize skin allergies (hypoallergenic)
Contains functional vehicle ingredients such as dexpanthenol, ectoine, vitamin E, bisabolol

Attualmente una volta fatta la diagnosi di Dermatite Atopica la dobbiamo gestire con farmaci e misure preventivo terapeutiche molto efficaci nella regressione delle manifestazioni infiammatorie e nel contenere i disturbi soggettivi.

Obiettivi della Terapia della DA

- Ridurre il più possibile il prurito e la conseguente irrequietezza psichica
- Bloccare le manifestazioni essudative e limitare quelle infiltrative lichenoidi
- Evitare le superinfezioni microbiche, specie da piogeni e quelle da virus dell'herpes simplex

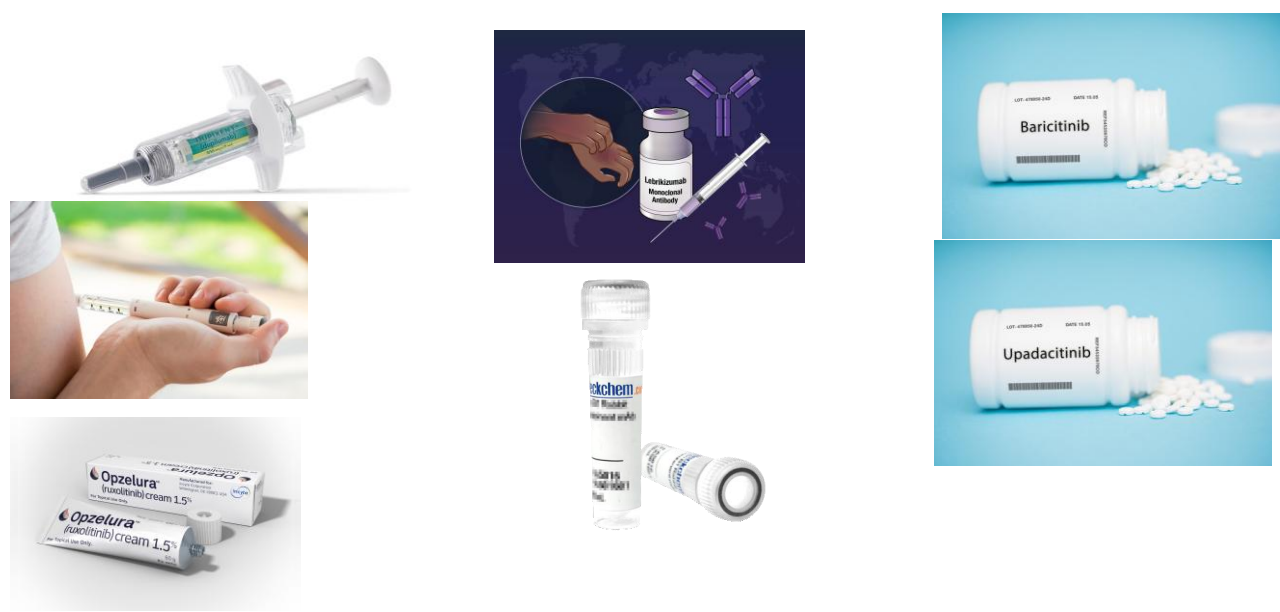
Meneghini C.L, Bonifazi E., 1989



L'INIZIO DI UNA NUOVA ERA

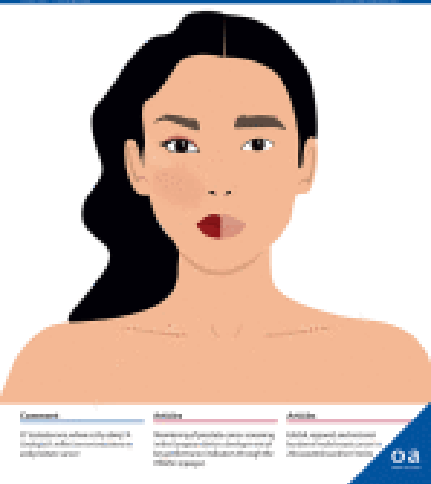


La Medicina Translazionale trasforma le scoperte scientifiche provenienti dagli studi di laboratorio in nuovi strumenti clinici e applicativi che migliorano la salute



PER LE FORME GRAVI
CREME E BENDAGGI
RESTERANNO UN
VECCHIO RICORDO !





Roads to remission: evolving treatment concepts in type 2 inflammatory diseases

Marek Lommatzsch,^a Katharina Blumchen,^b Lisa A. Beck,^c Jean Bousquet,^{d,e} Guy G. Brusselle,^e Wytske J. Fokkens,^f Eckard Hamelmann,^g Susanne Lau,^h Hagen Ott,ⁱ Oliver Pfaar,^j Hugh A. Sampson,^k Josef S. Smolen,^l Christian Taube,^m Ingo H. Tarner,ⁿ Martin Wagenmann,^o Thomas Werfel,^p Margitta Worn,^q and Harald Renz^{r,*}

- ^aDepartment of Pneumology and Intensive Care Medicine, University of Rostock, Germany
- ^bDepartment of Pediatrics, Goethe University, Frankfurt, Germany
- ^cDepartment of Dermatology, University of Rochester, Rochester, USA
- ^dInstitute of Allergology, Charité – Universitätsmedizin Berlin, Corporate Member of Freie Universität Berlin and Humboldt-Universität zu Berlin, Berlin, Germany
- ^eDepartment of Respiratory Medicine, Ghent University Hospital, Ghent, Belgium
- ^fDepartment of Otorhinolaryngology, University Medical Centers (UMC), Amsterdam, the Netherlands
- ^gDepartment of Pediatrics, University of Bielefeld, Bielefeld, Germany
- ^hDepartment of Pediatrics, Charité, University Medicine Berlin, Berlin, Germany
- ⁱDepartment of Pediatric Dermatology and Allergology, Children's Hospital Auf der Bult, Hannover, Germany
- ^jDepartment of Ear, Nose and Throat Medicine, Philipps University Marburg, Marburg, Germany
- ^kJaffe Food Allergy Institute, Icahn School of Medicine at Mount Sinai, New York, USA
- ^lDepartment of Rheumatology, University of Vienna, Vienna, Austria
- ^mDepartment of Pulmonary Medicine, University Hospital Essen - Ruhrlandklinik, Essen, Germany
- ⁿDepartment of Rheumatology, Clinical Immunology, Osteology and Physical Medicine, Kerckhoff-Klinik, Bad Nauheim, Germany
- ^oDepartment of Ear, Nose and Throat Medicine, Heinrich Heine University of Düsseldorf, Düsseldorf, Germany
- ^pDepartment of Dermatology and Allergology, University of Hannover, Hannover, Germany
- ^qDepartment of Dermatology, Charité, University Medicine Berlin, Berlin, Germany
- ^rInstitute of Laboratory Medicine and Pathobiochemistry, Molecular Diagnostics, Philipps University Marburg, Marburg, Germany
- ^sFraunhofer Institute for Translational Medicine and Pharmacology ITMP, Allergology and Immunology, Berlin, Germany

Summary

Non-communicable diseases (NCDs) characterised by type 2 inflammation, including asthma, allergic rhinitis, chronic rhinosinusitis with nasal polyps, atopic dermatitis, food allergies and eosinophilic esophagitis, are increasing in prevalence worldwide. Currently, there is a major paradigm shift in the management of these diseases, towards the concept of disease modification and the treatment goal remission, regardless of severity and age. Remission as a treatment goal in chronic inflammatory NCDs was first introduced in rheumatoid arthritis, and then adopted in other non-type 2 inflammatory diseases. Among diseases with type 2 Inflammation, this concept is novel and currently most advanced in asthma. This new paradigm has been developed based on a better understanding of the pathophysiology of type 2 inflammation and the advent of highly effective drugs selectively interfering with type 2 pathways. Here, we review the evolution of the new remission concepts in type 2 inflammatory diseases and discuss associated challenges and future research needs.

Funding None.



eClinicalMedicine
2025;80: 103050

Published Online 8 January
2025
<https://doi.org/10.1016/j.edim.2024.103050>

Concetti da chiarire e definire

1. In quali casi iniziare i trattamenti mirati e per quanto tempo ?
2. La remissione della Dermatite Atopica porta all'arresto della Marcia Atopica?

Consenso sul concetto di Remissione nella Dermatite Atopica

Per un anno intero

1. Assenza di sintomi cutanei
2. Assenza di prurito
3. Assenza di disturbi del sonno
4. Non dover assumere cortisonici sistemici



EDUCAZIONE TERAPEUTICA E SCUOLA DELL'ATOPIA

Arch Dermatol Res

. 2020 Dec;312(10):685-695. doi: 10.1007/s00403-020-02060-7. Epub 2020 Apr 15.

Efficacy of health education on treatment of children with atopic dermatitis: a meta-analysis of randomized controlled trials

Yunling Li 1, Ting Han 2, Wei Li 1, Yin Li 1, Xiaoxuan Guo 1, Lei Zheng 3

Abstract

Atopic dermatitis (AD) seriously affects the quality of life of children and their families. This meta-analysis aimed to comprehensively analyze health education on the treatment of children with AD and the quality of life of the patient's family. A comprehensive search of reference lists in PubMed, Embase, Cochrane Library, Wanfang, CNKI, and VIP databases from inception until April 2018 was performed. The weighted mean difference (WMD) with 95% confidence interval (CI) was calculated. A total of eight randomized controlled trials studies were included in the analysis. The heterogeneity among enrolled studies was statistically significant, and the random effects model was used. The meta-analysis showed that the health education group had significantly lower SCORing Atopic Dermatitis (SCORAD) (WMD = 7.57 [95% CI 2.77, 12.36], P = 0.002 at 3 months; WMD = 6.88 [95% CI 2.68, 11.08], P = 0.001 at 6 months; WMD = 8.67 [95% CI 3.67, 13.67], P = 0.0007 at 12 months), objective SCORAD (WMD = 7.60 [95% CI 1.37, 13.83], P = 0.02 at 6 months; WMD = 5.15 [95% CI 1.89, 8.41], P = 0.002 at 12 months), and Infants' Dermatology Quality of Life Index (WMD = 0.96 [95% CI 0.06, 1.86], P = 0.04 at 3 months, and WMD = 1.50 [95% CI 0.33,

2.67] at 6 months, P = 0.01) scores compared with the non-health education group. **Health education could improve the treatment of children with AD and promote disease control.**



PROGRAMMI EDUCATIVI

- PULIZIA E BAGNO
- SKIN CARE QUOTIDIANA
- TERAPIA COMPORTAMENTALE
- COME AFFRONTARE LO STRESS

2022 International League of
Dermatological Societies (ILDS)
International League of
Dermatological Societies
Willan House
4 Fitzroy Square
London W1T 5HQ
United Kingdom
Phone: +44 (0)20 7388 6515
Email: info@ilds.org

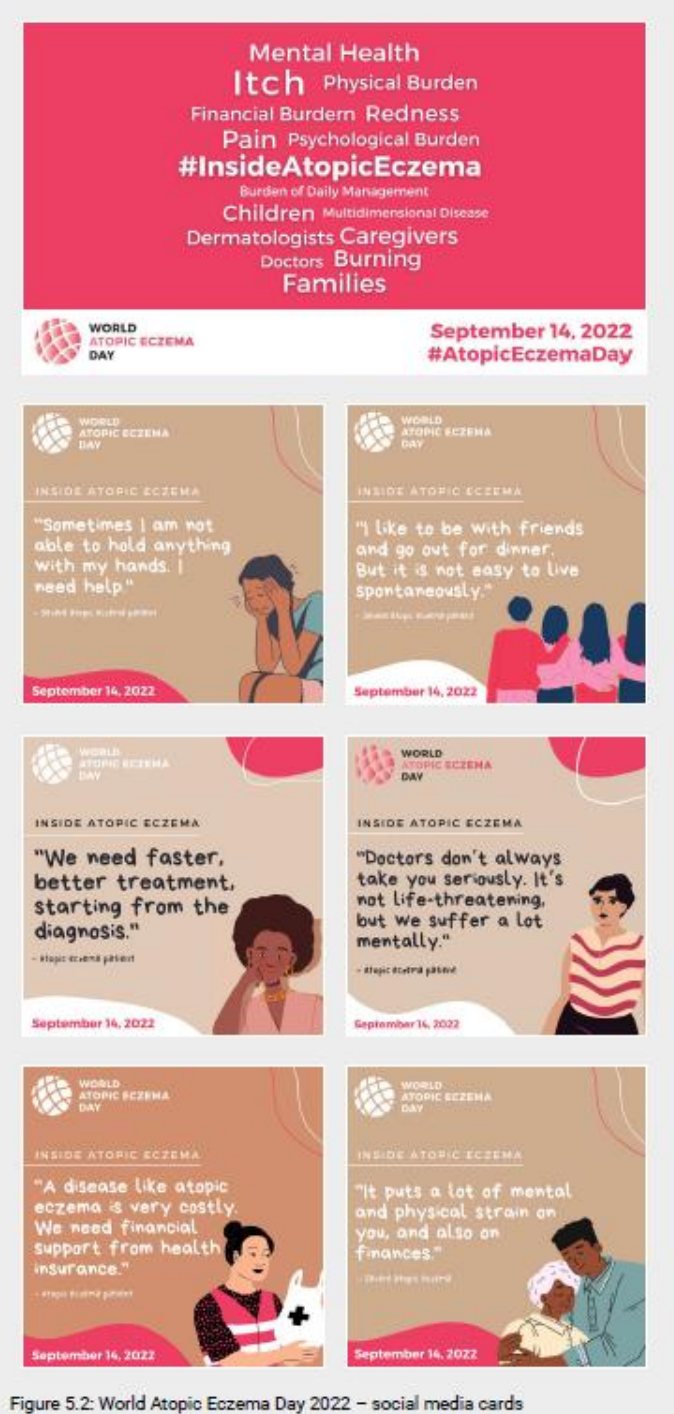
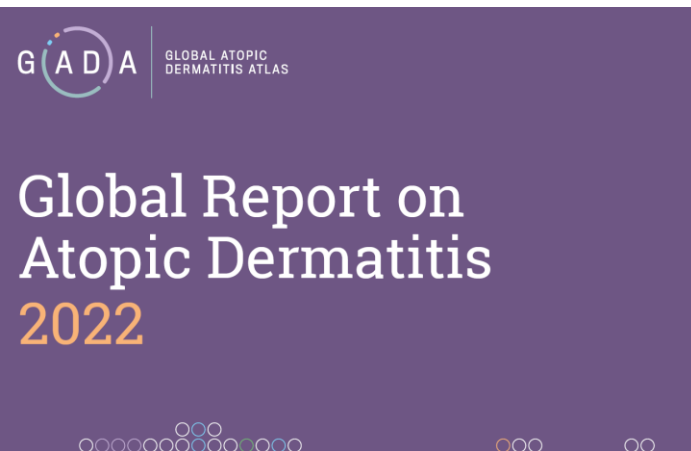


Figure 5.2: World Atopic Eczema Day 2022 – social media cards

EuroGuiDerm Guideline on Atopic Eczema

Stepped-care plan for children and adolescents with atopic eczema

- Add antiseptic/antibiotic/antiviral/antifungal treatment in cases of infections
- Consider compliance and diagnosis, if therapy has insufficient effect
- Refer to table 3 for TCS classes recommended

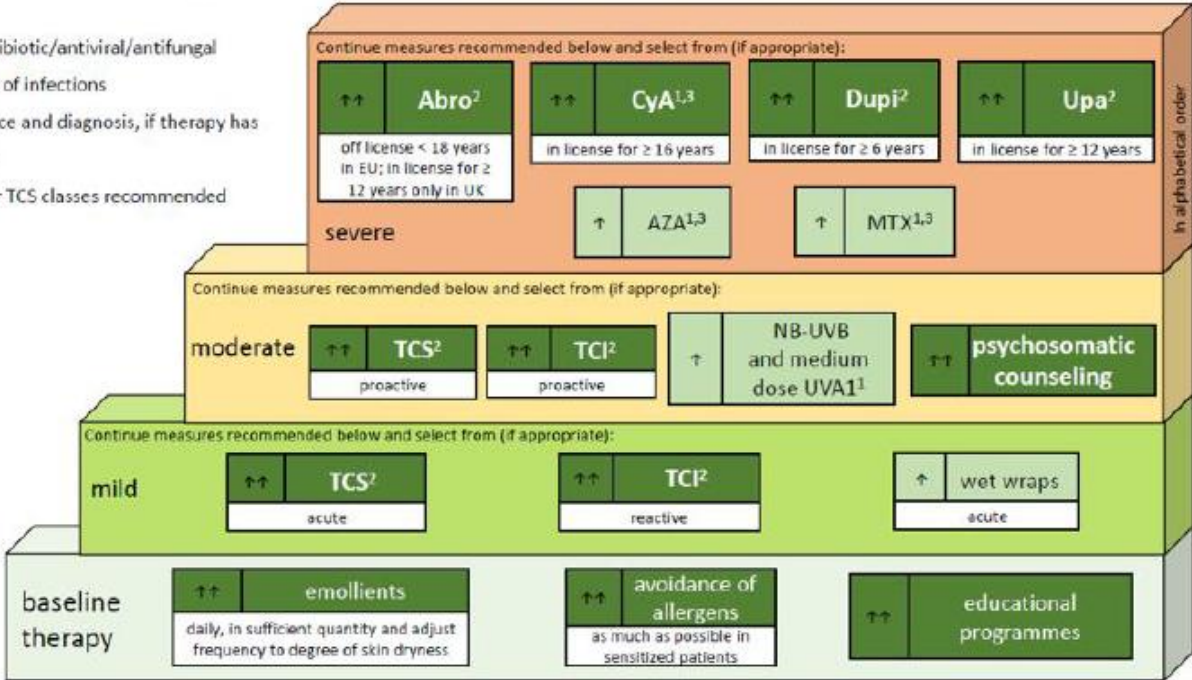


Figure 1. Stepped-care plan for children and adolescents with atopic eczema

SEVERE:
SCORAD >50 / or persistent eczema

Hospitalization, systemic immunosuppression: cyclosporine A², methotrexate², azathioprin², mycophenolate mofetil^{1,2}

MODERATE:
SCORAD 25-50 / or recurrent eczema

Proactive therapy with topical tacrolimus² or class II or III topical glucocorticosteroids², wet wrap therapy, UV therapy (UVB 311 nm)¹, psychosomatic counseling, climate therapy

MILD:
SCORAD <25 / or transient eczema

Reactive therapy with topical glucocorticosteroids class II² or depending on local cofactors: topical calcineurin inhibitors², antiseptics incl. silver, silver coated textiles

BASELINE:
Basic therapy

Educational programmes, emollients, bath oils, avoidance of clinically relevant allergens (encasings, if diagnosed by allergy tests)

L'igiene della pelle del paziente atopico è fondamentale per il successo terapeutico!
Potrebbe esser meglio nominata:

Terapia di Base per la cura della pelle Atopica

- Deve essere applicata indipendentemente dalla Terapia Farmacologica Topica o Sistemica

Non esiste il detergente o la crema emolliente ideale
va sempre valutato il grado di secchezza della pelle, le lesioni, il clima, l'attività fisica del paziente e le possibilità economiche della famiglia!

Acta Dermato-Venereologica ActaDV

CLINICAL REPORT  Check for updates 1/7

Cost-effectiveness of Emollients in the Prevention of Relapse among French Patients with Atopic Dermatitis

Elise CABOUT¹, Sébastien EYMERÉ¹, Robert LAUNOIS¹, Sophie SEITÉ², Véronique DELVIGNE², Charles TAÏEB^{3,4} and Ziad REGUIAI⁵
¹Réseau d'Évaluation en Économie de la Santé (REES), Paris, ²La Roche-Posay Dermatological Laboratories, Levallois-Perret, ³European Market Maintenance Assessment, EMMA, Fontenay sous-bois, ⁴Hôpital Necker Enfants-Malades, Santé Publique, Paris and ⁵Service de Dermatologie, Polyclinique Courlancy-Bezannes, Reims, France

Atopic dermatitis affects up to 20% of children and quite frequently persists in adulthood. Follow-up, treatment, and prevention of relapses have an impact on healthcare spending. The aim of this study was to assess the cost-effectiveness of different emollients prescribed for patients with atopic dermatitis in France. A 3-health state Markov model was designed, using French data for resource utilization, price and transition probabilities. The effects of the use of 5 different emollients (A, B, C, D, E) or no emollient were compared. The selected outcome was time (years) without flare-up. The 5-year cost for emollient A is 1,575.64€, and the effectiveness is 3.89 years without flare-up. Strategy A is the most effective. Compared with treatment E, which was the least expensive emollient, A is more expensive (+481.84€) and more effective (0.082

SIGNIFICANCE

Emollients are recommended as treatment for atopic dermatitis. The model used in this study aims to assess the cost-effectiveness of different emollients in the French setting. The effectiveness of the treatment was evaluated by measuring the relapse-free period. When accounting for consultation, hospitalization, and medication costs, as well as productivity losses, the use of emollients was found to be cost-effective compared with no emollient. The strategy of using of no emollients was worse based on 2 of the 4 selected comparators: it is both more expensive and less effective. Dominant cost-effective strategies should be preferred by physicians.

Acta Derm Venereol 2021; 101: adv00509.

CLINICAL REVIEWS

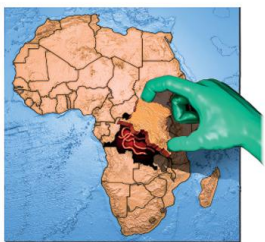
A sticky mess—Are moisturizers overused in dermatitis care?



Susan Nedorost, MD^{a,b}

Microbial dysbiosis is increasingly understood to influence allergic sensitization and skin barrier defects in dermatitis. Occlusion, such as from moisturizers, fosters microbial dysbiosis, and increases itch in many patients with dermatitis. Nevertheless, use of moisturizers in dermatitis remains part of dermatologic guidelines. This is a review of the evidence of benefits and adverse effects of moisturizers in dermatitis and a proposal for moderation in their clinical use. (J Am Acad Dermatol 2024;91:1171-6.)

Key words: atopic dermatitis; contact dermatitis; emollients; high value care; microbial dysbiosis; moisturizers.



"Concerns that COVID-19 will now steer attention away from the need to close the deal with Ebola control in DR Congo are real."

See Editorial page 912

Editorial	Articles	Articles	Articles	Series
COVID-19: protecting health-care workers (page 912)	Skin emollients and early complementary feeding to prevent infant atopic dermatitis (page 962)	Daily emollients during infancy for prevention of eczema (page 962)	Risk of tuberculosis in children after chloroquine (page 962)	Comparative effectiveness of oral and intravenous antibiotics in children (page 962)

NON E' UTILE
APPLICARE
EMOLLIENTI
SULLA PELLE DEL
NEONATO SANO
PER PREVENIRE
LA DERMATITE
ATOPICA



Daily emollient during infancy for prevention of eczema: the BEEP randomised controlled trial

Joanne R Chalmers, Rachel H Haines, Lucy E Bradshaw, Alan A Montgomery, Kim S Thomas, Sara J Brown, Matthew J Ridd, Sandra Lawton, Eric L Simpson, Michael J Cork, Tracey H Sach, Carsten Flohr, Eleanor J Mitchell, Richard Swinden, Stella Tarr, Susan Davies-Jones, Nicola Jay, Maeve M Kelleher, Michael R Perkin, Robert J Boyle, Hywel C Williams on behalf of the BEEP study team

Summary

Background Skin barrier dysfunction precedes eczema development. We tested whether daily use of emollient in the first year could prevent eczema in high-risk children.

Methods We did a multicentre, pragmatic, parallel-group, randomised controlled trial in 12 hospitals and four primary care sites across the UK. Families were approached via antenatal or postnatal services for recruitment of term infants (at least 37 weeks' gestation) at high risk of developing eczema (ie, at least one first-degree relative with parent-reported eczema, allergic rhinitis, or asthma, diagnosed by a doctor). Term newborns with a family history of atopic disease were randomly assigned (1:1) to application of emollient daily (either Diprobase cream or DoubleBase gel) for the first year plus standard skin-care advice (emollient group) or standard skin-care advice only (control group). The randomisation schedule was created using computer-generated code (stratified by recruiting centre and number of first-degree relatives with atopic disease) and participants were assigned to groups using an internet-based randomisation system. The primary outcome was eczema at age 2 years (defined by UK working party criteria) with analysis as randomised regardless of adherence to allocation for participants with outcome data collected, and adjusting for stratification variables. This trial is registered with ISRCTN, ISRCTN21528841. Data collection for long-term follow-up is ongoing, but the trial is closed to recruitment.

Findings 1394 newborns were randomly assigned to study groups between Nov 19, 2014, and Nov 18, 2016; 693 were assigned to the emollient group and 701 to the control group. Adherence in the emollient group was 88% (466 of 532) at 3 months, 82% (427 of 519) at 6 months, and 74% (375 of 506) at 12 months in those with complete questionnaire data. At age 2 years, eczema was present in 139 (23%) of 598 infants with outcome data collected in the emollient group and 150 (25%) of 612 infants in the control group (adjusted relative risk 0.95 [95% CI 0.78 to 1.16], $p=0.61$; adjusted risk difference -1.2% [-5.9 to 3.6]). Other eczema definitions supported the results of the primary analysis. Mean number of skin infections per child in year 1 was 0.23 (SD 0.68) in the emollient group versus 0.15 (0.46) in the control group; adjusted incidence rate ratio 1.55 (95% CI 1.15 to 2.09).

Interpretation We found no evidence that daily emollient during the first year of life prevents eczema in high-risk children and some evidence to suggest an increased risk of skin infections. Our study shows that families with eczema, asthma, or allergic rhinitis should not use daily emollients to try and prevent eczema in their newborn.

Funding National Institute for Health Research Health Technology Assessment.

Copyright © 2020 The Author(s). Published by Elsevier Ltd. This is an Open Access article under the CC BY 4.0 license.

Lancet 2020; 395: 962–72

Published Online

February 19, 2020

[https://doi.org/10.1016/S0140-6736\(19\)32984-8](https://doi.org/10.1016/S0140-6736(19)32984-8)

See [Comment](#) page 923

Centre of Evidence Based
itology (J R Chalmers PhD,
Prof K S Thomas PhD,

l Davies-Jones, R J Boyle PhD,
Prof H C Williams DSc) and
ngham Clinical Trials Unit

(R H Haines MA,
L E Bradshaw MSc,

rof A A Montgomery PhD,
E J Mitchell BA, R Swinden,
S Tarr BSc), University of
ngham, Nottingham, UK;

Research Group, School of
Medicine, University of

Dundee, Dundee, UK
(Prof S J Brown MD);
artment of Dermatology,

ells Hospital and Medical
School, Dundee, UK
(rof S J Brown); Population

th Sciences, University of
Bristol, Bristol, UK
(dd PhD); Rotherham NHS

Foundation Trust, UK
(rton MSc); Department of
matology, Oregon Health

and Science University,
Portland, OR, USA
(L Simpson MD); Sheffield

Dermatology Research,
artment of Infection and
Immunity, University of

Sheffield, Sheffield, UK
Prof M J Cork PhD); Health



GLI EMOLLIENTI
HANNO UNA
MODESTA AZIONE
SUL PRURITO E IN
ALCUNI CASI,
SOPRATTUTTO SU
CUTE LESA CAUSANO
BRUCIORE E
INCREMENTO DEL
PRURITO !

Articles



Effectiveness and safety of lotion, cream, gel, and ointment emollients for childhood eczema: a pragmatic, randomised, phase 4, superiority trial



Matthew J Ridd, Miriam Santer, Stephanie J MacNeill, Emily Sanderson, Sian Wells, Douglas Webb, Jonathan Banks, Eileen Sutton, Amanda Roberts, Lyn Liddiard, Zoe Wilkins, Julie Clayton, Kirsty Garfield, Tiffany J Barrett, J Athene Lane, Helen Baxter, Laura Howells, Jodi Taylor, Alastair D Hay, Hywel C Williams, Kim S Thomas

Summary

Background To our knowledge, there are no trials comparing emollients commonly used for childhood eczema. We aimed to compare the clinical effectiveness and safety of the four main emollient types: lotions, creams, gels, and ointments.

Methods We did a pragmatic, individually randomised, parallel group, phase 4 superiority trial in 77 general practice surgeries in England. Children aged between 6 months and 12 years with eczema (Patient Orientated Eczema Measure [POEM] score >2) were randomly assigned (1:1:1:1; stratified by centre and minimised by baseline POEM score and age, using a web-based system) to lotions, creams, gels, or ointments. Clinicians and parents were unmasked. The initial emollient prescription was for 500 g or 500 mL, to be applied twice daily and as required. Subsequent prescriptions were determined by the family. The primary outcome was parent-reported eczema severity over 16 weeks (weekly POEM), with analysis as randomly assigned regardless of adherence, adjusting for baseline and stratification variables. Safety was assessed in all randomly assigned participants. This trial was registered with the ISRCTN registry, ISRCTN84540529.

Findings Between Jan 19, 2018, and Oct 31, 2019, 12 417 children were assessed for eligibility, 550 of whom were randomly assigned to a treatment group (137 to lotion, 140 to cream, 135 to gel, and 138 to ointment). The numbers of participants who contributed at least two POEM scores and were included in the primary analysis were 131 in the lotion group, 137 in the cream group, 130 in the gel group, and 126 in the ointment group. Baseline median age was 4 years (IQR 2–8); 255 (46%) participants were girls, 295 (54%) were boys; 473 (86%) participants were White; and the mean POEM score was 9·3 (SD 5·5). There was no difference in eczema severity between emollient types over 16 weeks (global p value=0·77), with adjusted POEM pairwise differences of: cream versus lotion 0·42 (95% CI –0·48 to 1·32), gel versus lotion 0·17 (–0·75 to 1·09), ointment versus lotion –0·01 (–0·93 to 0·91), gel versus cream –0·25 (–1·15 to 0·65), ointment versus cream –0·43 (–1·34 to 0·48), and ointment versus gel –0·18 (–1·11 to 0·75). This result remained unchanged following multiple imputation, sensitivity, and subgroup analyses. The total number of adverse events did not significantly differ between the treatment groups (lotions 49 [36%], creams 54 [39%], gels 54 [40%], and ointments 48 [35%]; p=0·79), although stinging was less common with ointments (12 [9%] of 138 participants) than lotions (28 [20%] of 137), creams (24 [17%] of 140), or gels (25 [19%] of 135).

Interpretation We found no difference in effectiveness between the four main types of emollients for childhood eczema. Users need to be able to choose from a range of emollients to find one that they are more likely to use effectively.

Funding National Institute for Health and Care Research.

Copyright © 2022 The Author(s). Published by Elsevier Ltd. This is an Open Access article under the CC BY 4·0 license.

Lancet Child Adolesc Health
2022; 6: 522–32
Published Online
May 24, 2022
[https://doi.org/10.1016/S2352-4642\(22\)00146-8](https://doi.org/10.1016/S2352-4642(22)00146-8)
Population Health Sciences
(Prof M J Ridd PhD, S Wells MSc, D Webb MSc, E Sutton PhD, L Liddiard BSc, J Clayton PhD, H Baxter PhD, Z Wilkins, Prof A D Hay MD) and **Bristol Trials Centre** (S J MacNeill PhD, E Sanderson MSc, K Garfield PhD, Prof J A Lane PhD, J Taylor PhD), **University of Bristol**, Bristol, UK; **National Institute for Health Research Applied Research Collaboration West** (J Banks PhD) and **South West Medicines Information and Training** (T J Barrett MSc), **University Hospitals Bristol and Weston NHS Foundation Trust**, Bristol, UK; **Centre of Evidence-Based Dermatology**, **University of Nottingham**, Nottingham, UK (L Howells PhD, Prof H C Williams PhD, Prof K S Thomas PhD); **Primary Care Research Centre**, **University of Southampton**, Southampton, UK (Prof M Santer PhD); **Nottingham Support Group for Carers of Children with Eczema**, Nottingham, UK (A Roberts BSc)
Correspondence to:
Prof Matthew J Ridd, Population Health Sciences, University of Bristol, Bristol BS8 2PS, UK
m.ridd@bristol.ac.uk

A sticky mess—Are moisturizers overused in dermatitis care?

Susan Nedorost, MD^{a,b}



Microbial dysbiosis is increasingly understood to influence allergic sensitization and skin barrier defects in dermatitis. Occlusion, such as from moisturizers, fosters microbial dysbiosis, and increases itch in many patients with dermatitis. Nevertheless, use of moisturizers in dermatitis remains part of dermatologic guidelines. This is a review of the evidence of benefits and adverse effects of moisturizers in dermatitis and a proposal for moderation in their clinical use. (J Am Acad Dermatol 2024;91:1171-6.)

Key words: atopic dermatitis; contact dermatitis; emollients; high value care; microbial dysbiosis; moisturizers.

- Gli emollienti vanno sempre applicati dopo il bagno su cute umida con massaggio delicato
- NON APPLICARE PIU VOLTE NEL CORSO DELLA GIORNATA

Non Miscellare MAI creme con principi attivi farmacologici con creme emollienti !

International Journal of Pharmaceutics 624 (2022) 121988



Contents lists available at ScienceDirect

International Journal of Pharmaceutics

journal homepage: www.elsevier.com/locate/ijpharm



The effect of dilution of fusidic acid cream and betamethasone dipropionate cream in complex extemporaneous mixes on formulation performance

M.T. Beebejaun^a, M.B. Brown^b, V. Hutter^a, L. Kravitz^a, W.J. McAuley^{a,*}

^a Centre for Research in Topical Drug Delivery and Toxicology, University of Hertfordshire, College Lane, Hatfield AL10 9AB, UK

^b MedPharm Ltd, Unit 3 Chancellor Court, 50 Occam Road, Surrey Research Park, Guildford GU2 7AB, UK

ARTICLE INFO

Keywords:
Atopic dermatitis
Topical corticosteroid
Emollient
Topical antibiotic
Skin permeation

ABSTRACT

The Aron regimen is an unconventional therapy which entails frequent applications of an extemporaneously prepared three component system (a topical antibiotic, a corticosteroid and an emollient), with the intention of decolonising the skin of *S. aureus* whilst treating atopic dermatitis. The impact of heavily diluting these topical medicinal products, to differing extents, on formulation performance is not well understood thus was investigated in this study. Following a single application of a range of compounded Aron mixes (fusidic acid and betamethasone dipropionate diluted to varying extents in an emollient base), significant reductions in the expected drug flux across silicone membrane, *ex vivo* percutaneous absorption and skin retention of both drugs relative to the marketed products were observed. This was attributed to a number of complex formulation effects making such changes difficult to predict in a clinical setting. Further investigations are required to evaluate the impact of frequent applications of the Aron mix to widespread areas on clinical efficacy, antimicrobial resistance and long term side effects.

Sulzberger MB, Witten VH.

The effect of topically applied Compound F in selected dermatoses.

J Invest Dermatol 1952;19:101-102.

Topical treatments for atopic dermatitis (eczema): Systematic review and network meta-analysis of randomized trials



Derek K. Chu, MD, PhD, Alexandro W. L. Chu, BHSc, Daniel G. Rayner, BHSc, Gordon H. Guyatt, MD, MSc, OC, Juan José Yepes-Nuñez, MD, PhD, Luis Gomez-Escobar, MD, MSc, et al

J Allergy Clin Immunol 2023;152:1493-519.



219
RCTs



43 123
Participants

Age Groups
Pediatric + Adult

Eczema Severity
Mild-to-Moderate

Table 3: General recommendations for topical drugs for treatment of atopic eczema (for details see corresponding chapter)

Overall recommendation	TCS ↑↑		TCI ↑↑	
	TCS class I and II	TCS class III and IV	Tacrolimus 0.1% Tacrolimus 0.03%	Pimecrolimus 1%
For further information see background text	class I not suitable for long-term proactive treatment; long-term proactive treatment only class II	acute flare; proactive treatment with TCS class III class IV not for long term daily treatment or head and neck; class IV not recommended for proactive treatment either	acute flare; long-term proactive treatment; especially in face, intertriginous sites, anogenital area	acute flare; especially in face, intertriginous sites, anogenital area
Most important side effects	skin atrophy telangiectasia striae distensae ecchymosis hypertrichosis perioral dermatitis	skin atrophy telangiectasia striae distensae ecchymosis hypertrichosis perioral dermatitis corticosteroid addiction syndrome suppression of adrenal function	initial warmth, tingling or burning	initial warmth, tingling or burning
	TCI class II and III are off label for proactive treatment		in label for proactive treatment	not suitable for proactive treatment
Special considerations				
Suitable for children > 2 to < 16 years of age	yes	yes	yes (0.03%) ²	yes ²
Suitable for babies < 2 years of age	yes	under specialist supervision	yes (0.03%) ¹	yes ² (from the age of three months)
Suitable during pregnancy	yes	yes	yes (0.03% & 0.1%) ¹	yes ¹
Suitable during breastfeeding	yes	yes	yes (0.03% & 0.1%) ¹	yes ¹
Suitable for pruritus	yes	yes	yes (0.03% & 0.1%)	yes

LA TERAPIA
TOPICA
DELLA
DERMATITE
ATOPICA



Practice Parameters

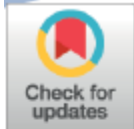
Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma and Immunology Joint Task Force on Practice Parameters GRADE– and Institute of Medicine–based recommendations



LA TERAPIA SISTEMICA DELLA DERMATITE ATOPICA



SYSTEMIC TREATMENTS			MONOCLONAL ANTIBODIES	We recommend adding	Age	Strong in favor	High certainty evidence
MILD	MODERATE	SEVERE					
	MODERATE	SEVERE	BIOLOGICS / MONOCLONAL ANTIBODIES	DUPILUMAB	Age 6mo+	Strong in favor	High certainty evidence
	MODERATE	SEVERE		TRALOKINUMAB	Age 12yo+	Strong in favor	High certainty evidence
	MODERATE	SEVERE		UVB TREATMENT	We suggest adding clinic-based narrow band UVB treatment	Conditional in favor	Low certainty evidence
	MODERATE	SEVERE	SMALL MOLECULE IMMUNOSUPPRESSANTS	ABROCITINIB, BARICITINIB, OR UPADACITINIB	Age varies: 12 or 18 yo+	Conditional in favor	Low certainty evidence
	MODERATE	SEVERE		Suggested daily doses: Abrocitinib 100-200 mg, Baricitinib 2-4 mg, Upadacitinib 15-30 mg			
	MODERATE	SEVERE		BARICITINIB 1 mg DAILY	We recommend adding baricitinib 1 mg daily	Strong against	Low certainty evidence
	MODERATE	SEVERE		AZATHIOPRINE	We suggest against adding azathioprine	Conditional against	Low certainty evidence
	MODERATE	SEVERE		CYCLOSPORINE	We suggest adding cyclosporine	Conditional in favor	Low certainty evidence
	MODERATE	SEVERE		METHOTREXATE	We suggest against adding methotrexate	Conditional against	Low certainty evidence
	MODERATE	SEVERE		MYCOPHENOLATE	We suggest against adding mycophenolate	Conditional against	Low certainty evidence
MILD	MODERATE	SEVERE	SYSTEMIC CORTICOSTEROIDS		We suggest against systemic corticosteroids for all patients with atopic dermatitis	Conditional against	Low certainty evidence



Dietary restriction misconceptions and food allergy education in children with atopic dermatitis

You Hoon Jeon, MD, PhD

Department of Pediatrics, Hallym University Dongtan Sacred Heart Hospital, Hwaseong, Korea

Key message

- Food intake strategies for preventing food allergies have undergone major changes over the past 20 years.
- In children with atopic dermatitis, indiscriminate food restrictions without diagnostic testing leads to nutritional imbalance and poor growth.
- When determining food restrictions for pediatric patients with atopic dermatitis, an accurate food allergy diagnosis must be preceded, and continuous parental education about food intake is required.

Food allergy testing in atopic dermatitis

Hassiel A. Ramírez-Marín, MD,^a Anne Marie Singh, MD,^b Peck Y. Ong, MD,^c and
Jonathan I. Silverberg, MD, PhD, MPH^d



Food allergy and food-related worsening of dermatitis can occur in patients with atopic dermatitis (AD). We reviewed the relationship of AD with food allergen hypersensitivity and the risks and benefits of food allergen testing and avoidance in patients with AD. Skin prick testing and specific immunoglobulin E to aeroallergens may identify patients with immediate hypersensitivity. Atopy patch tests may detect non-immunoglobulin E-mediated reactions but are not standardized or routinely used. Younger children with more severe AD in whom the optimal management failed may have food-triggered AD. Egg, milk, and peanut account for most food allergens. Elimination of relevant food allergens should improve AD but must be guided by appropriate allergy testing and establishing clinical relevance. Serum immunoglobulin E panels for food allergens are discouraged in the primary care setting because of their difficulty of interpretation. Empiric avoidance of foods is entirely discouraged in AD because of their risk of causing nutritional issues, food allergy, and other problems. (JAAD Int 2022;9:50-6.)



A chi spetta il compito di curare la Dermatite Atopica dopo una diagnosi clinica corretta



Il Circolo Virtuoso !

How to Prevent Atopic Dermatitis (Eczema) in 2024: Theory and Evidence



Derek K. Chu, MD, PhD^a, Jennifer J. Koplin, PhD^{b,c}, Tasnuva Ahmed, MBBS, MPH^a, Nazmul Islam, MBBS, MPH^a, Chia-Lun Chang, MSc^{c,d}, and Adrian J. Lowe, PhD^{c,d} *Hamilton, Ontario, Canada; and Brisbane, Queensland; and Melbourne, Victoria, Australia*

LA PREVENZIONE

Of the interventions listed in Table I, probiotic and vitamin D supplementation among pregnant mothers and/or infants, and avoiding unnecessary antibiotic exposure, may modestly reduce the risk of childhood AD. However, uncertain effects combined with concerns about feasibility and burdens (practical and financial) might leave the decision to use supplements sensitive to preference. Newborn BCG vaccination's undefined small preventative effects for AD have additional uncertain applicability, accessibility, and acceptability among non-tuberculosis endemic areas. Patients concerned about developing AD should also be reassured that if it occurs, there are robust AD treatment guidelines addressing multiple safe and effective therapies^{1,6,7} that align with patient values and preferences.¹⁰⁷

CONSIGLIO 1

- LA DERMATITE ATOPICA E' UNA PATOLOGIA CRONICA INFIAMMATORIA, MOLTO FREQUENTE IN ETA' PEDIATRICA.
- IL SISTEMA SANITARIO ITALIANO CI PERMETTE DI CURARE GRATUITAMENTE LE FORME MODERATE E GRAVI ANCHE CON FARMACI INNOVATIVI COSTOSI, PER LE FORME LIEVI E' NECESSARIO ACQUISTARE PRESIDI SPECIFICI CHE VANNO UTILIZZATI CORRETTAMENTE PER EVITARE COMPLICANZE.
- IL SOLE E' IL MIGLIOR ALLEATO DEI VOSTRI FIGLI, MA DOVRETE ESPORLI IN MODO CORRETTO !



LE TRE COSE PIU' IMPORTANTI DA DIRE AI
GENITORI DI UN BAMBINO CON:
DERMATITE ATOPICA

Mazzotta Francesco
Prof. Inc. Università «Guglielmo Marconi»-Roma

DERMATOLOGIA PEDIATRICA
BARLETTA
Asi BAT



CONSIGLIO 2 PER GENITORI DI BAMBINI DA 0 A 9 ANNI

- LA TERAPIA RICHIEDE IMPEGNO , POSSIBILMENTE UN RESPONSABILE «CARE MANAGER» CHE COORDINI L'IGIENE E MEDICAZIONI TOPICHE O SISTEMICHE.
- LE VISITE DI CONTROLLO PROGRAMMATE VANNO RISPETTATE PERCHE' SI TRATTA DI UNA PATOLOGIA CRONICA E QUINDI UNA GESTIONE MINIMA POTREBBE ESSERE NECESSARIA NEI PERIODI DI REMISSIONE
- LA TERAPIA CONSENTE SEMPRE UN SENSIBILE MIGLIORAMENTO DELLA QUALITA' DELLA VITA DEL PAZIENTE E DI TUTTO IL NUCLEO FAMILIARE.
- I CONSIGLI RICEVUTI PER IL PROPRIO FIGLIO NON HANNO VALORE UNIVERSALE, QUINDI E' INUTILE RIPORTALI SU CHAT E CONFRONTARLI CON LE TERAPIE DI ALTRI PAZIENTI



LE TRE COSE PIU' IMPORTANTI DA DIRE AI
GENITORI DI UN BAMBINO CON:
DERMATITE ATOPICA

Mazzotta Francesco
Prof. Inc. Università «Giuliano Mancini»-Roma

DERMATOLOGIA PEDIATRICA
BARLETTA
Asl BAT



CONSIGLIO N.2

PER I RAGAZZI DAI 10 AI 16 ANNI BISOGNA parlare con loro:

TU SEI IL PROTAGONISTA UNICO CHE PUO' GESTIRE QUESTO PROBLEMA RISOLVIBILE.

DEVI RISPETTARE LE NORME IGIENICHE, SOLLECITARE I TUOI GENITORI AD AIUTARTI AD ESEGUIRE CORRETTAMENTE LA TERAPIA, SEGNALARE OGNI PROBLEMA CUTANEO PRESENTE IN ZONE NON VISIBILI.

RICORDARE PER TEMPO QUANDO DETERGENTI O CREME EMOLLIENTI STANNO PER TERMINARE E TRAMITE IL TUO SMARTPHONE INSERIRE IN AGENDA LE VISITE DI CONTROLLO PER SOLLECITARE I GENITORI AD ACCOMPAGNARTI.



**LE TRE COSE PIU' IMPORTANTI DA DIRE AI
GENITORI DI UN BAMBINO CON:
DERMATITE ATOPICA**

Mazzotta Francesco
Prof. Inc. Università «Guglielmo Marconi»-Roma

**DERMATOLOGIA PEDIATRICA
BARLETTA
Asl BAT**



CONSIGLIO 3

QUALSIASI NOVITA' VA SEGNALATA AL PROPRIO PEDIATRA, CHE IN ACCORDO CON IL DERMATOLOGO DI RIFERIMENTO O L' ALLERGOLOGO, DECIDERA' SE FAR ESEGUIRE TEST ALLERGOLOGICI O INDAGINI CLINICO STRUMENTALI PER EVENTUALI PATOLOGIE ASSOCIATE.

SE SIETE APPASSIONATI DI INTERNET CONSULTATE SITI DI SOCIETA' SCIENTIFICHE UFFICIALI E PRIMA DI PRENDERE DECISIONI CONFRONTATEVI SEMPRE CON IL PEDIATRA



Atopic Dermatitis Information For Patients

Atopic dermatitis is the scientific term for eczema – a red, itchy rash that can appear anywhere on the body. Although it is common among babies and children, it can occur at any age. If you think you or a family member has atopic dermatitis, it is important to see your doctor to be properly diagnosed and to discuss treatment options. Even though the condition is chronic, treatments are available that can help you to manage flare-ups and improve your quality of life.



Member Login

Search our site...

Quick Links

- On-Demand Education
- Strategic Plan
- IEC Journal Articles
- Upcoming Symposia

Latest News

[IEC Opens Council Applications to PhD Researchers](#)
[Meet the Councilor Sara Brown - December 2024](#)
[2024 4th Quarter e-News](#)
Read IEC publications by IEC Fellow.

www.eczemacouncil.org/for-patients



LE TRE COSE PIU' IMPORTANTI DA DIRE AI GENITORI DI UN BAMBINO CON: **DERMATITE ATOPICA**

Mazzotta Francesco
Prof. Inc. Università «Guglielmo Marconi» - Roma

DERMATOLOGIA PEDIATRICA
BARLETTA
Asl BAT



COMMENTARY

From eczema to anxiety: How artificial intelligence shapes parental perspectives

Kripa Ahuja MS¹  | Grace DeSena BA² | Leah Laageide MD³ |
Jinia El-Feghaly MD³ | Peter Lio MD⁴ 

¹Eastern Virginia Medical School, Norfolk, Virginia, USA

²The University of Florida College of Medicine, Gainesville, Florida, USA

³Department of Dermatology, University of Rochester Medical Center, Rochester, New York, USA

⁴Department of Dermatology, Northwestern University, Chicago, Illinois, USA

Correspondence

Kripa Ahuja, Eastern Virginia Medical School, 825 Fairfax Avenue, Norfolk, VA 23507, USA.

Email: ahujak@evms.edu

KEYWORDS: anxiety, artificial intelligence, atopic dermatitis, ChatGPT, children, dermatology, Google, parents

On November 30, 2022, OpenAI (San Francisco, CA) released ChatGPT, a large language model artificial intelligence (AI), with the ability to engage in sophisticated dialog. Features include answering direct prompts, garnering follow-up questions, and even admitting to mistakes in generated responses.¹ The use of ChatGPT in the field of pediatric dermatology has not been fully explored, although the American Academy of Dermatology (AAD) released a viewpoint on the feature stating that while useful, it cannot replace clinical decision making.² Since ChatGPT's full potential is unrealized, we provide a viewpoint on the potential effect of AI on anxiety levels in parents of

AD carries a significant caregiver burden: parents of AD children can experience high levels of self-blame and guilt for the condition.³ Mothers might prioritize caring for their children over other responsibilities, potentially leading to anxiety or depression.³ Taking this psychological background into account with question 4, "Am I a bad parent if my child has atopic dermatitis?", ChatGPT may provide reassurance due to its supportive, encouraging answers. This contrasts Google's first response: a link to a research study that found higher levels of stress in mothers of children with AD. An upset parent would likely experience more relief from Chat GPT's response of "No, you aren't a bad parent" than poten-

Pediatric
Dermatology Volume
40, Issue 5 Sep 2023
Pages 763-939, E1-
E2, 940-971

GRAZIE PER L'ATTENZIONE

INFORMAZIONI GENERALI

Sede

Hotel Mercure - Villa Romanazzi Carducci
Via Di Tullio 82, 70124 Bari

Iscrizione al Congresso

€ 183,00 (IVA è già compresa)

L'iscrizione dà diritto a coffee break e lunch

L'iscrizione è gratuita per:

*iscritti all'associazione Dermatologia Pediatrica

*specializzandi in Dermatologia e in Pediatria

*autori di un caso clinico

(Le schede di iscrizione devono essere inviate per email

all'[Associazione Dermatologia Pediatrica](mailto:info@dermatologiapediatrica.org), partner del

Congresso e responsabile organizzazione scientifica:

info@dermatologiapediatrica.org)

Accreditamento ECM

In corso. Il rilascio della certificazione dei crediti è subordinato alla partecipazione effettiva all'intero programma formativo e alla verifica dell'apprendimento.

Segreteria scientifica: E. Bonifazi

Segreteria organizzativa: F. Mazzotta

Comitato Organizzatore:

L. Garofalo, V. Pisani, T. Troccoli, G. Tarantino, D. Bonamente,
F. Miletto, M. Tagliavanti, M. Ferrante, M. Ferrara, F. Caprio,
P. Chieco, A. Milano

Segreteria Organizzativa
e Promotori ECM

CENTRO ITALIANO CONGRESSI ONLUS
Viale Europa, 20 - 70134 Bari
Tel. 080.5043737 - Fax 080.5043736
Email: info@centroitalianicongressi.it - www.cicconlus.it



Dermatologia Pediatrica Barese
20° Congresso

Bari, 18 ottobre 2025

Hotel Mercure - Villa Romanazzi Carducci

Via De Tullio, 82, 70124 Bari



2010.01.28



2010.01.28