

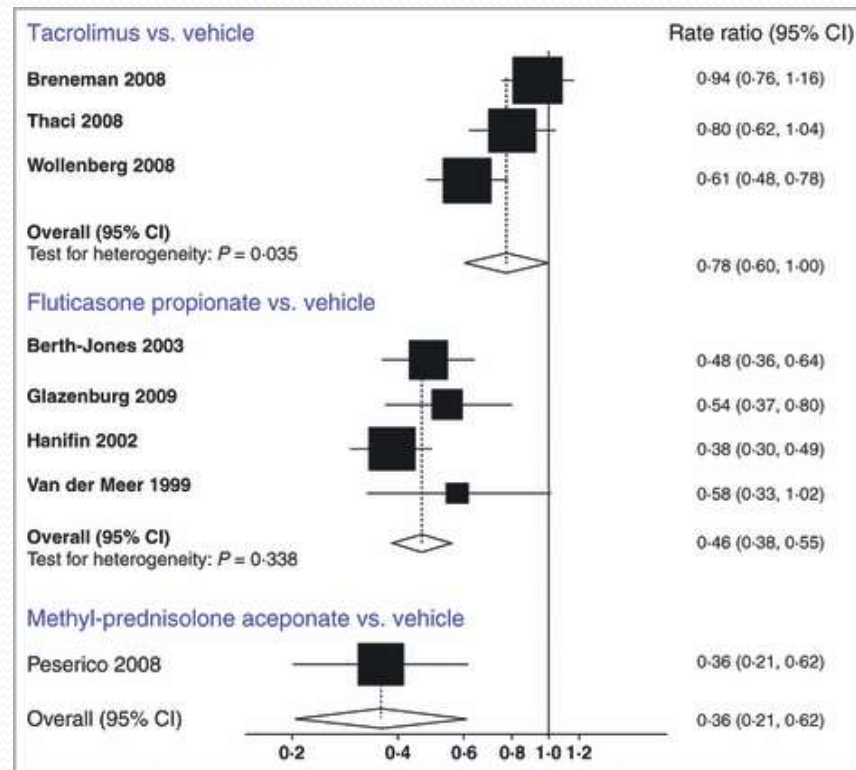
# Are the concepts of induction of remission and treatment of subclinical inflammation in atopic dermatitis clinically useful?

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# Background

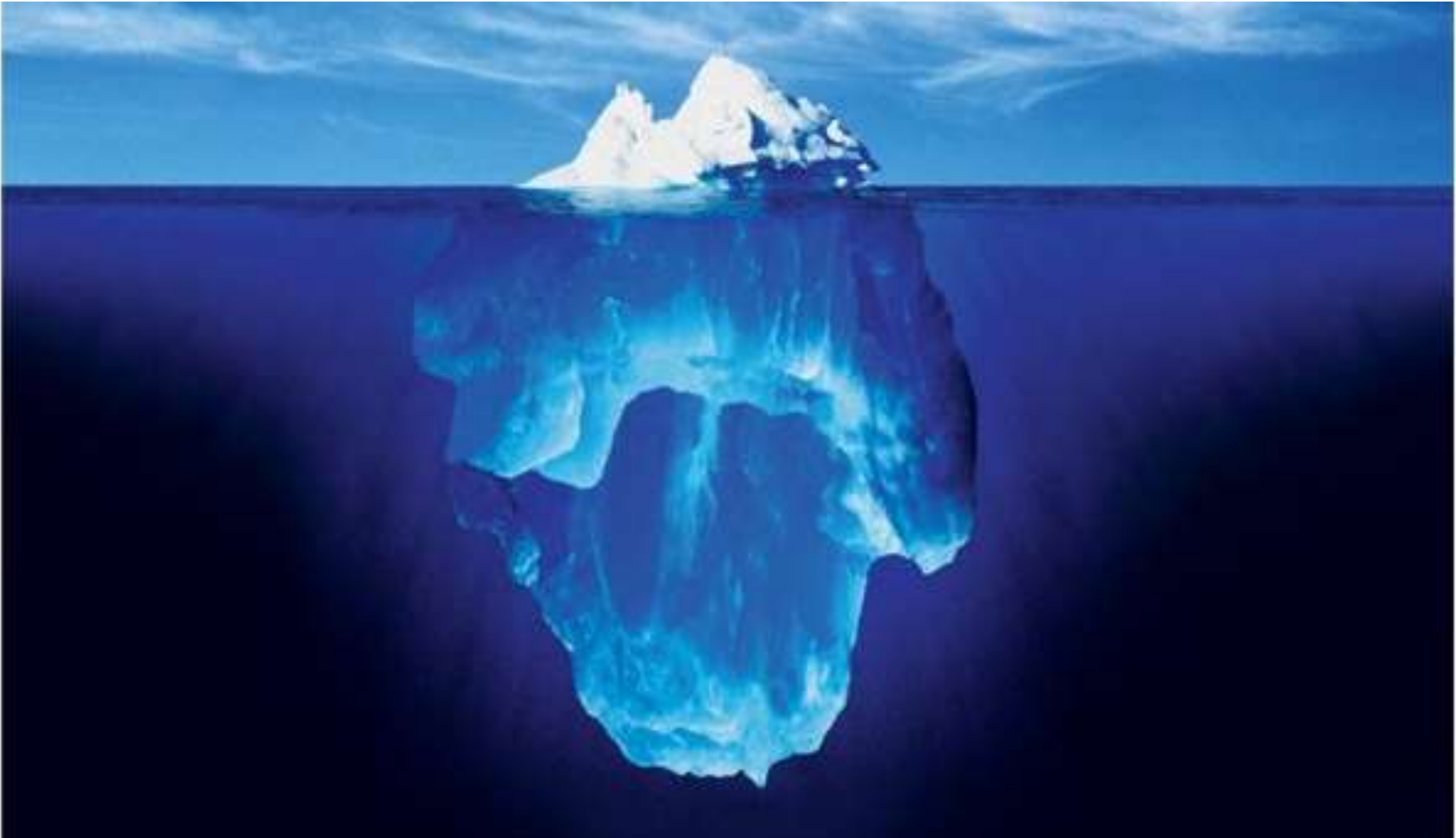


Schmitt et al. Br J Dermatol. 2011 Feb;164(2):415-28. doi: 10.1111/j.1365-2133.2010.10030.x. Epub 2010 Nov 23



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- (i) Is the notion of “subclinical inflammation” scientifically sound?
- (ii) Does treatment corrects this subclinical inflammation?
- (iii) Do different strategies for initial clearance of atopic dermatitis impact on long-term disease control



# Question 1



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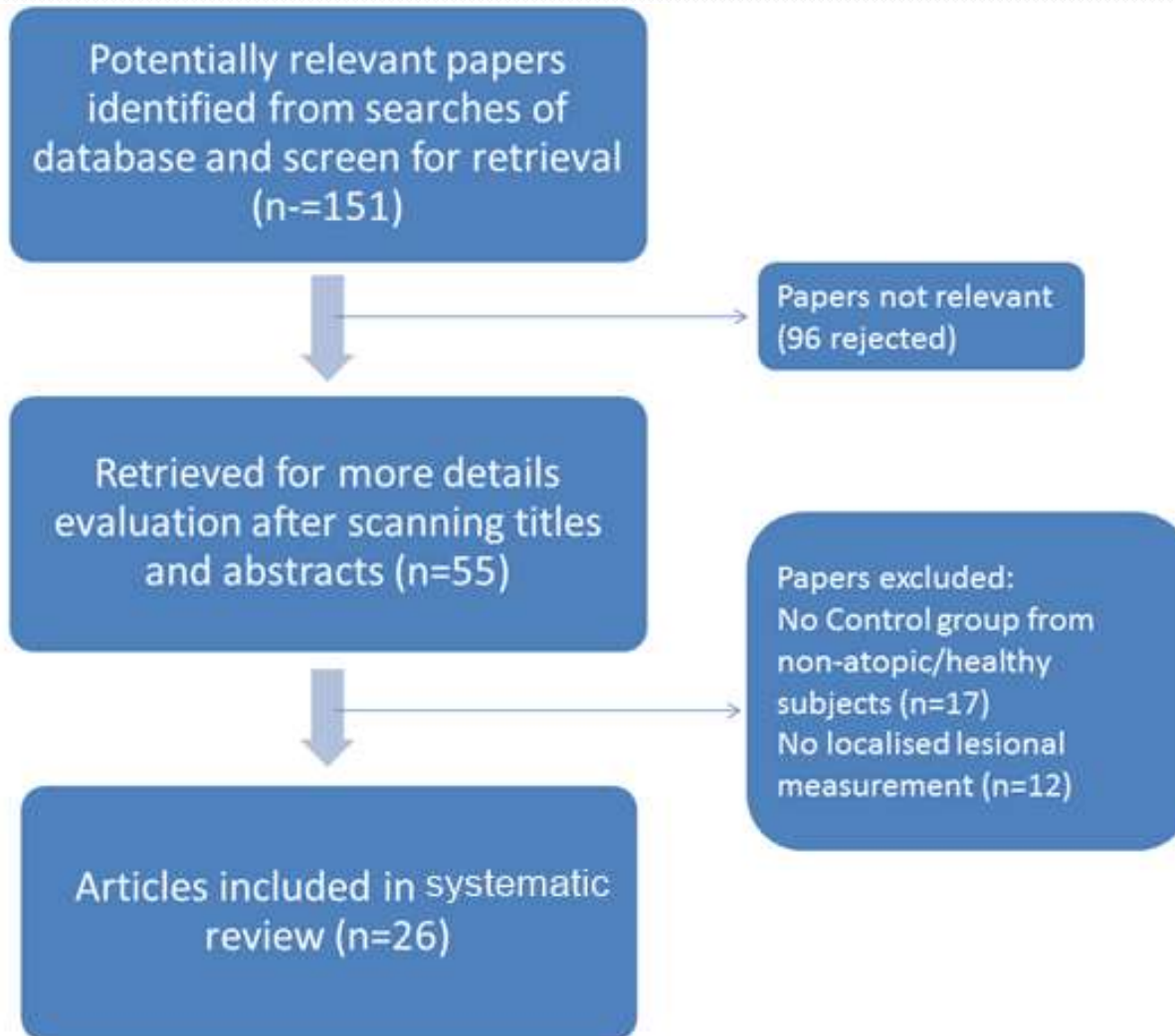
‘Is the notion of  
**“subclinical inflammation”**  
scientifically sound?’

# Definition



	Signs	Symptoms	Science (biological markers)
Objective active lesion	✓	✓	✓
“eczema under the skin”		✓	✓
Non-lesional/ subclinical inflammation			✓

# Search Results



# Results

	Non-lesional skin from patients with atopic dermatitis	Treated skin (previous active dermatitis)
Barrier dysfunction	4/5	0
Subclinical inflammation	6/10	4/4
Bacterial colonisation/ antibacterial peptides	3/3	0
Imaging	1/1	0
Others	3/3	0



# Results

normal skin

atopic non-lesional

atopic lesional



Fig 1 Characterization of ANL and AL skin compared with normal skin. A-D , Representative IHC staining of the proliferation markers K16 (Fig 1, A ) and Ki67 (Fig 1, B ) and of T cells (CD3 + cells; Fig 1, C ) and myeloid dendritic cells (CD11c + cell...

Suárez-Fariñas et al, **Nonlesional atopic dermatitis skin is characterized by broad terminal differentiation defects and variable immune abnormalities.** Journal of Allergy and Clinical Immunology, Volume 127, Issue 4, 2011, 954 - 964.e4

# Answer 1

“Nonlesional skin in atopic individuals is not normal.”

# Question 2

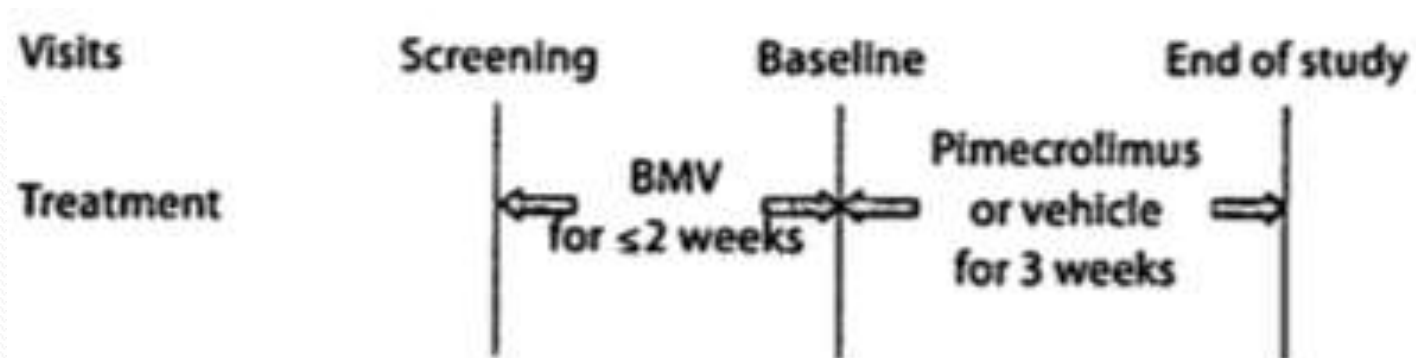


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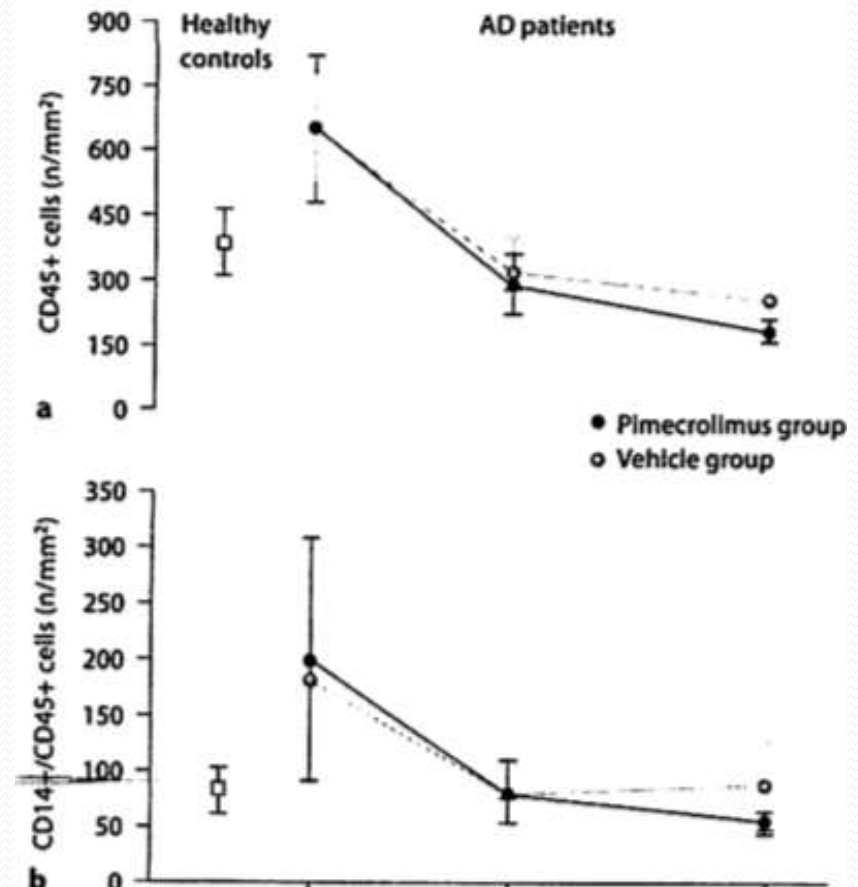
**‘Does treatment corrects  
subclinical inflammation?’**

- One double-blind RCT was found
  - n=67
  - Patient: mild to moderate eczema
  - Intervention:
    - Open label, run-in period for all participants with topical betamethasone 0.1% ointment until clear (EASI $\leq$ 1) for up to 2 weeks
    - Double-blind phase: 3 weeks of topical Pimecrolimus 1% cream or vehicle cream twice-daily
  - Outcome: IGA, EASI, skin biopsy



# Results

- Less drop out rate in pimecrolimus group (11.8% vs. 42.4%.  $P < 0.05$ )
- In **pimecrolimus group**, **53%** remained in remission at end of 3 weeks follow up, compared to **27%** in the **vehicle group** ( $p = 0.03$ ).



# Answer 2

“More longer term studies needed for treatment of subclinical inflammation.”

# Question 3

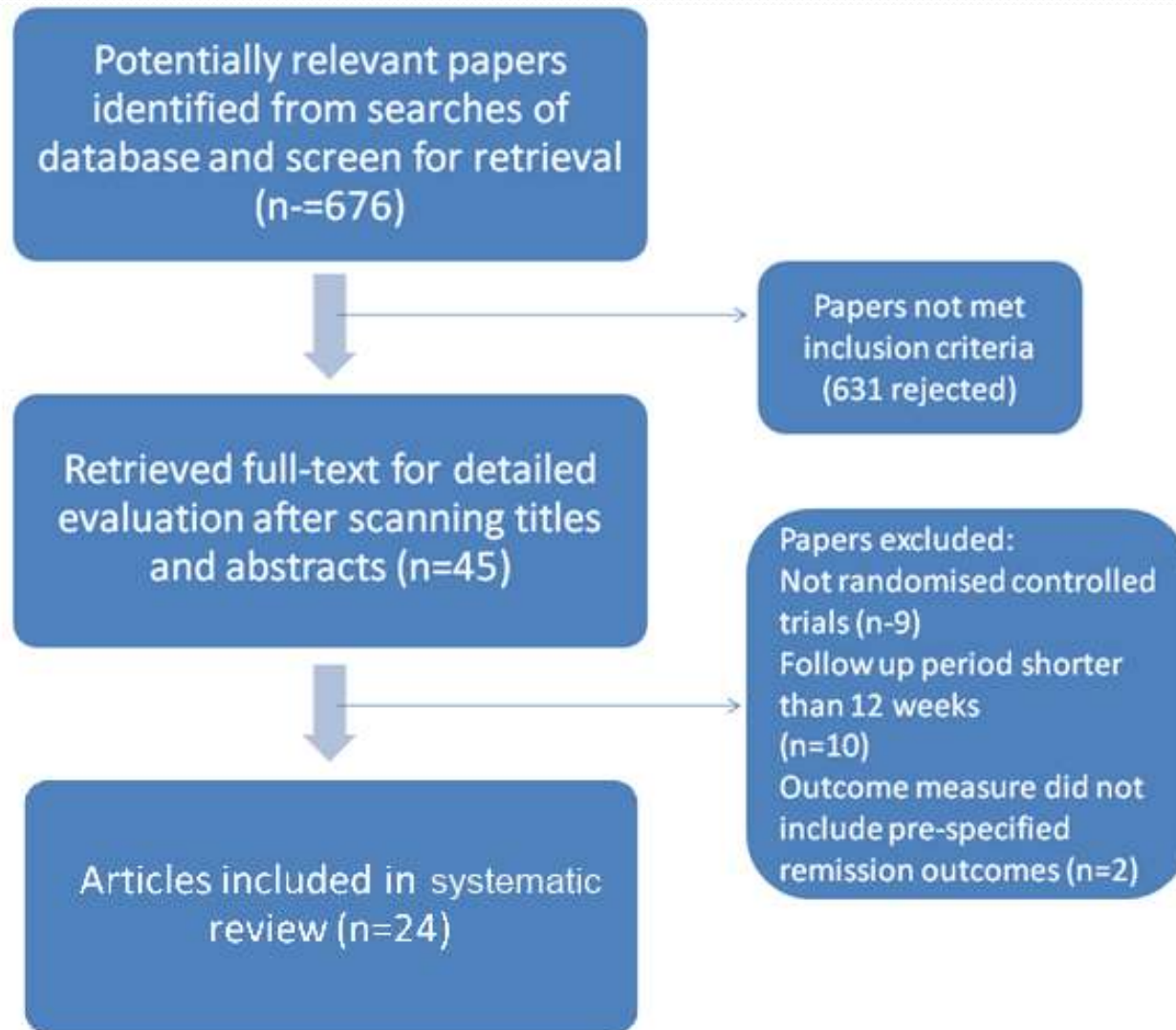


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‘Do different **strategies** for initial clearance of atopic dermatitis impact on **long-term disease control?**’

# Search Results

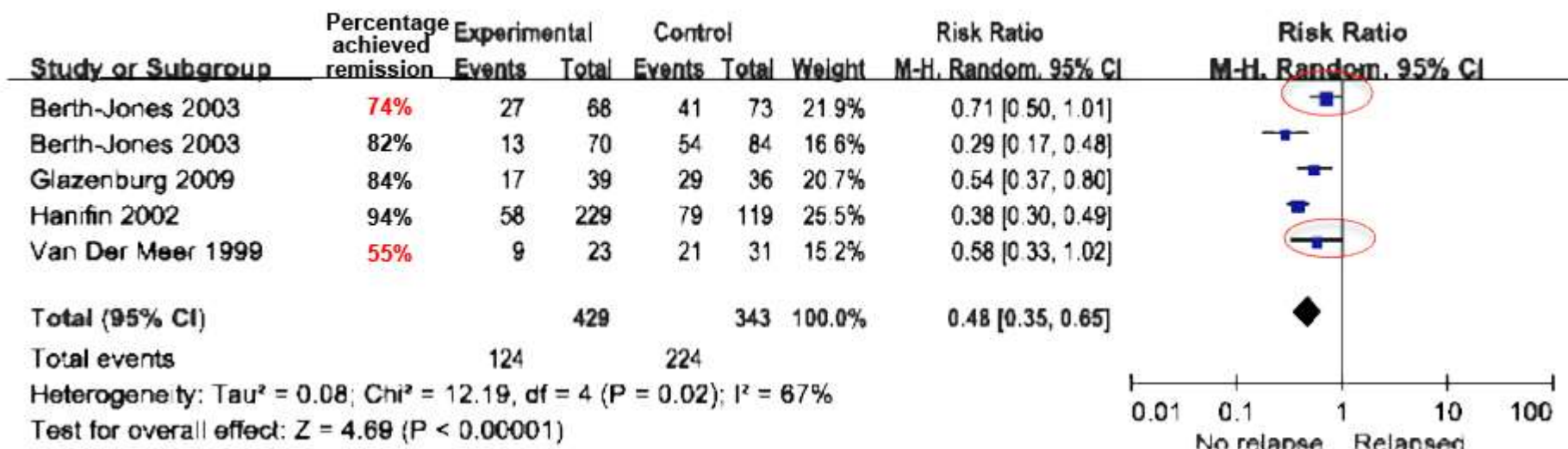




# Results – Topical treatments

- Induction of remission/stabilisation duration ranging from 2 to 16 weeks
- Only 9 out of 14 studies reported predefined definition of remission
- Failure to get control of atopic dermatitis with initial therapy was associated with a higher risk of relapsing.
  - Fluticasone studies (RR = 1.31, 95% CI = 1.02-1.68)
  - Tacrolimus studies (RR= 1.36, 95% CI = 1.12- 1.66)

# Results - fluticasone



- Ciclosporin
  - After a single 12-week course of ciclosporin
    - Mean duration of remission was 66 days
    - Three patients (16%, 95% CI = 4.2% -37%) remained in remission for nine months after one course of 12-week therapy.
- PUVA vs. UVA
  - The median length of remission after 15 treatments each: 12 weeks after PUVA vs. 4 weeks after UVA therapy (P = 0.012).
  - Two of 15 PUVA-treated patients (13%, 95%CI =2.3-37.5%) remained free of relapse for longer than 12 months, but none of the UVA-treated patients did.



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**Answer?**

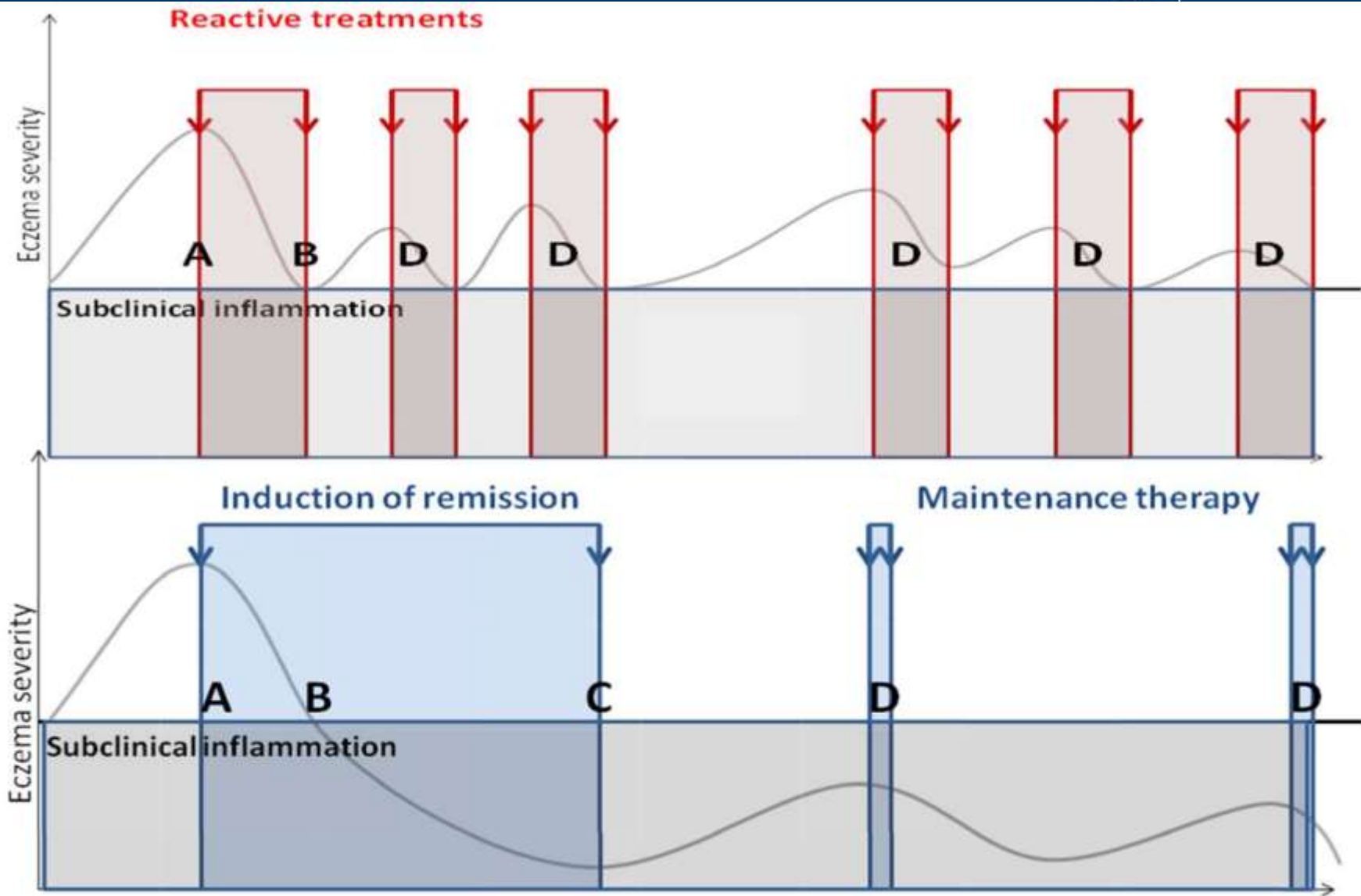


Fig 2. Putative diagram (top) illustrating what might currently happen when the initial induction of remission treatment period (started at point A) ceases once signs and symptoms have reduced (clinical remission or point B) as opposed to what might happen (bottom) if initial induction of remission extended to clear subclinical disease (subclinical remission or point C). Each induction of remission period is followed by maintenance or proactive treatment, requiring 2 consecutive days treatment per week to previously active sites (points D).

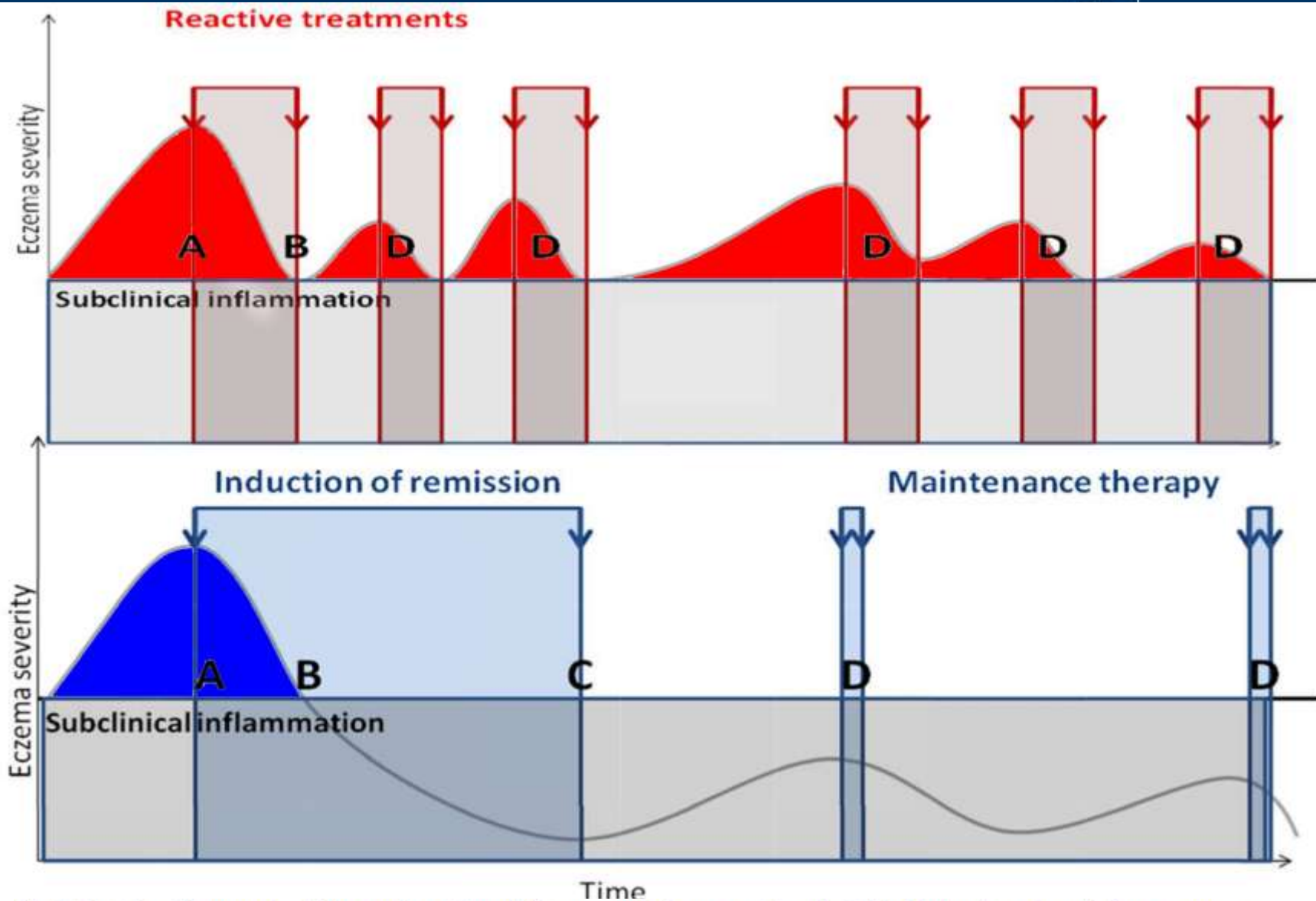


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“Research, the **answer** lies within, and we must based on evidence.”

# Conclusion

- We found consistent evidence of subclinical inflammation in non-lesional normal appearance and treated skins in patients with atopic dermatitis.
- We also found some evidence that treatment may improve these subclinical changes, although longer term studies are needed.
- Lower success rate of inducing remission were associated with higher risk of relapse during long-term follow up.



# Reference

- Tang, T.S., T. Bieber, and H.C. Williams, *J Allergy Clin Immunol.* 2014 Mar 18.
- Nankervis H, Samuels, HJ, Delamere F, Thomas, K, Williams HC. *The Global Resource of Eczema Trials.* Centre of Evidence Based Dermatology.

# Acknowledgement

Prof. Thomas Bieber



Centre of Evidence-based Dermatology, Nottingham





“Treating eczema under the skin.”

“Get control, before keep control.”

Prof. Hywel Williams