

# Case-Based Peer Perspectives

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**Dermatology**  
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# Real-World Approaches to Nonsteroidal and Systemic Atopic Dermatitis Treatment

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# Nonsteroidal Approaches to Chronic and Severe Atopic Dermatitis

Emma Andrus, Editor

In a recent *Dermatology Times Case-Based Roundtable* custom event, “Beyond Steroids: Exploring Topical and Nonsteroidal Therapies for Atopic Dermatitis,” Robert Casquejo, PA-C, focused on real-world patient cases of atopic dermatitis (AD) in a conversation with fellow dermatology professionals. Casquejo, a board-certified physician assistant at the Skin & Cancer Center of Scottsdale in Arizona, and attendees explored the evolving treatment landscape, including systemic and topical therapies, as well as challenges in managing chronic and treatment-resistant cases.

## Case 1 Chronic AD in a Patient With Skin of Color

The first case involved a 53-year-old male patient with chronic, untreated AD who had lived with the condition his entire life. The discussion centered on the varying morphology of AD depending on patient age, ethnicity, and disease chronicity or acuity.

A main point of debate was whether the physical appearance of the disease should influence therapeutic decisions. The consensus was that chronicity, evidenced by lichenification and persistent lesions, often creates a need for systemic therapy.

Although some participants highlighted the effectiveness of newer topical medications—especially given their improved safety profiles compared with corticosteroids—the prevailing opinion was that patients with long-standing, refractory disease might benefit more from systemic treatment. “The consensus in the room was that this is a patient; once you start getting into chronic disease, even on a first visit, they are automatically thinking of systemic medication,” Casquejo said.

The discussion also touched on patient perception. Many clinicians felt that the patient’s frustration likely stemmed from years of inadequate treatment and an aversion to continuously applying ointments. This reinforced the importance of



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Robert Casquejo, PA-C

addressing patient fatigue when devising a management plan.

## Case 2 AD in Sensitive Areas

Another case involved a female patient, aged 62 years, with AD affecting her eyelids. Given the delicate nature of this area, participants immediately considered the limitations of corticosteroid therapy due to risks such as skin atrophy and glaucoma, particularly in patients with diabetes or preexisting ocular conditions.

“This is a slam dunk situation where novel topical medications have a distinct advantage because they do not carry the side effect profile, for instance, that a steroid does,” Casquejo noted. “With steroid use, really there are a ton of disadvantages. You can only use them for a short amount of time. You can’t use very potent ones, so that raises some problems.”

Novel nonsteroidal topical therapies were discussed as a clear advantage in such cases. Although calcineurin inhibitors have traditionally been an option, their common adverse effect of burning and stinging has been a drawback for many patients. Newer topical medications, such as Janus kinase (JAK) inhibitors and PDE4 inhibitors, appear to mitigate these issues while providing strong therapeutic effects.

## Case 3 Persistent AD With Treatment Failure

The third case focused on a 33-year-old female patient with persistent pruritus who had failed multiple topical treatments. The discussion emphasized the importance of considering systemic therapy in such cases, particularly with the advent of targeted biologics and JAK inhibitors that offer novel mechanisms of action.

A key barrier identified in this case was insurance-imposed step therapy requirements. Many clinicians expressed frustration over the necessity to prescribe older treatments, such as topical steroids and calcineurin inhibitors, before gaining approval for newer, more effective therapies. The consensus was that patients already familiar with and having failed traditional treatments could more easily access novel therapies. However, treatment-naïve patients often had to endure a trial-and-failure approach dictated by insurance requirements.

“There was an agreement that we’re in the day and age that vehicles may not be as relevant because the mechanism is making up for a lot of what vehicles may lack,” Casquejo said. “The efficacy, the mechanism by which they work, still carries a robust therapeutic effect, despite the fact that they are creams and not ointments.”

## Insurance and Access Barriers

The panelists discussed 2 key scenarios:

- **Patients with prior treatment history.** Those who had already used corticosteroids and calcineurin inhibitors were more likely to receive insurance approval for newer medications.
- **Treatment-naïve or long-untreated patients.** These patients often faced more significant barriers, as they were required to cycle through older therapies before gaining access to novel treatments, despite the clinicians' preference for starting with more effective and safer options.

## Conclusion

As the therapeutic landscape changes, dermatology clinicians must balance efficacy, patient preference, and real-world limitations to optimize care for patients with AD, Casquejo emphasized. ■

## Key Takeaways

1. Patients with long-standing, severe AD are likely candidates for systemic treatment, even at initial visits.
2. Novel topical agents have significant advantages over steroids and calcineurin inhibitors in delicate regions such as the eyelids.
3. Step therapy and insurance restrictions remain challenges in accessing newer, more effective medications.

# A Case-Based Approach to Topical and Nonsteroidal AD Management

Marie Bosslett, Assistant Editor

In a recent *Dermatology Times Case-Based Roundtable* custom event titled, “Exploring Topical and Nonsteroidal: Atopic Dermatitis Management Approaches,” Matthew Zirwas, MD, led a collaborative conversation for clinicians to explore challenging and complex cases regarding atopic dermatitis (AD) care. Zirwas, a board-certified dermatologist based at Bexley Dermatology in Columbus, Ohio, shared insights on differentiating between similar conditions and tailoring therapies for optimal patient outcomes.

## Case 1 A 40-Year-Old Chemical Plant Worker With Chronic Hand Dermatitis

The first case involved a 40-year-old man with a 6-month history of hand eczema, possibly exacerbated by his recent work at a chemical plant. The dermatologists initially focused on differentiating between irritant, allergic,

and endogenous causes of hand eczema, noting the importance of dorsal and palmar involvement. They emphasized taking a thorough history, including what the patient had already tried, how itchy vs irritated the rash was, and details about his work environment, especially glove reuse and application.

“We’re all very aware of the idea that if you occlude a pharmaceutical, it makes it more potent,” Zirwas said. “So...part of educating people about glove use is making sure that they don’t ever put the gloves on while their hands are not fully rinsed of soap.”

The experts discussed the challenges of

occupational contact dermatitis, where identifying the specific allergen at work is often less helpful than finding ways to minimize exposure. They also debated the value of patch testing in general, noting its high sensitivity but low specificity, and the difficulty of patient adherence.

“As somebody who did almost nothing but patch test for 15 years, my general experience was that they’re not that useful,” Zirwas said. “You hit some home runs, but it is the most miserable thing we do to patients.”

After this initial contact dermatitis diagnosis, the patient’s patch test came back negative, and treatment with topical corticosteroids provided only partial relief with frequent flare-ups. Because of this, the clinicians switched their diagnosis to AD.

The discussion then shifted to the



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limitations of topical steroids such as clobetasol, particularly their potential to impair barrier function with long-term use. They also touched on the role of paraffin wax baths in improving barrier function for irritant dermatitis, and the practical challenges of patient adherence.

As the patient is concerned about long-term steroid use, the clinicians discussed strategies on how to ease concerns and slowly introduce the idea of steroids in prior visits. The dermatologists settled on applying the systemic treatment of ruxolitinib (Opzelura; Incyte Corporation).

### **Case 2 A 32-Year-Old Office Worker With Worsening AD on Neck and Shoulders**

The second case revolved around a 32-year-old female office worker who has had a history of AD since childhood but has noticed worsening on her neck and shoulders over the past year. Her body surface area is 7% and her Investigator's Global Assessment score is 4. She had constant itch, sleep disturbance, and difficulty focusing on work. She also had asthma, which is well controlled with a corticosteroid inhaler.

Zirwas and the panelists debated whether the rash was contact dermatitis or AD. Contact dermatitis from hair products was suspected, and hypoallergenic hair products were recommended. They also considered the patient's asthma history, with some suggesting dupilumab (Dupixent; Sanofi) as a potential treatment option if systemic therapy was pursued.

For initial treatment, the clinicians considered topical corticosteroids such as clobetasol, injections such as triamcinolone, or a topical calcineurin inhibitor (TCI) such as tacrolimus. Tacrolimus can cause burning, so they mentioned desoximetasone as a possible alternative.

When the TCI proved ineffective, the patient was started on upadacitinib

(Rinvoq; AbbVie Inc). The dermatologists discussed the importance of providing context to patients on Janus kinase inhibitors, emphasizing the lack of increased risk despite the “scary-sounding” warnings on the box. Later, the patient switched to topical ruxolitinib in preference to oral medication and saw great results at the 3-month follow-up. The clinicians discussed its overall efficacy, with its rapid pharmacologic effect beginning in as little as 15 minutes.

“There’s nothing in the pipeline that is close to as fast or that overall has as much efficacy as ruxolitinib,” Zirwas said. “It is as close as I think we will ever get to a perfect topical.... It’s crazy that we’ve got a drug that works that well.”

### **Case 3 A 35-Year-Old Teacher With Persistent AD**

The final case was that of a 35-year-old high school teacher with a scaly, itchy rash and open excoriations on his face, neck, hands, arms, and legs. The rash began 8 months prior during a stressful period involving intense home renovations and a difficult school semester; this caused sleep deprivation, affected his work, and made him self-conscious due to student reactions.

The patient's excessive hygiene regimen included hydrocortisone cream 1% applied all over 3 to 4 times a day, calamine lotion for itch, nightly diphenhydramine that made him groggy during

morning classes, and various “natural” moisturizers with lavender and citrus oils. The main challenge in this case was the patient's resistance to changing his habits. The dermatologists discussed strategies for managing patients who use non-evidence-based products. The preferred approach was to consider the patient's existing practices, acknowledging their perceived benefits, and suggesting ways to enhance their effectiveness.

“Use the word ‘boost.’ I learned that during my residency.... There's very little that patients like better than the word ‘boost,’” Zirwas advised.

The panelists noted the rash's poorly demarcated appearance, suggesting AD rather than allergic contact dermatitis. They discussed the patient's overuse of topical steroids, raising the topic of topical steroid withdrawal. To prevent rebound symptoms, the hydrocortisone cream was gradually tapered, and all irritating products were discontinued.

Initially, tacrolimus ointment, triamcinolone acetonide cream, and a daytime antihistamine were prescribed, with pimecrolimus (Elidel; Bausch Health) added later. After 6 weeks, the patient had marked improvement, but he still noted persistent lesions, intermittent flares, and discomfort with the pimecrolimus cream. Ruxolitinib was prescribed twice daily, and he achieved improved itch, less visible dermatitis, and a reduction in flare-up. ■

### **Key Takeaways**

1. Nonsteroidal atopic dermatitis (AD) therapies are gaining attention due to their rapid effectiveness and ability to offer an alternative to long-term steroid use.
2. A personalized and holistic approach to AD is vital for each patient, so address lifestyle and occupational factors, medical history, and potential treatment risks.
3. When patients with AD are resistant to change, gradually offer evidence-based alternatives that can enhance their existing practices and improve overall adherence.

# Case-Based Insights on Ruxolitinib vs Corticosteroids for Atopic Dermatitis

Kaitlyn Bader, Assistant Managing Editor

At a recent *Dermatology Times Case-Based Roundtable* custom event, “Balancing Efficacy and Comfort: Strategies for Effective Use of NonSteroidal Topicals in Atopic Dermatitis,” James Q. Del Rosso, DO, shared perspectives on topical therapies for atopic dermatitis (AD). Del Rosso, a board-certified dermatologist and research director at JDR Dermatology Research in Las Vegas, Nevada, discussed the challenges associated with AD management, the limitations of topical corticosteroids, and the benefits of newer nonsteroidal treatments.

## Case 1 A 15-Year-Old Student With Severe Hand and Foot Eczema

Del Rosso presented the case of a 15-year-old high school student with significant eczematous dermatitis primarily affecting his hands and feet. His condition was characterized by intense pruritus, fissuring, and painful splits in the skin. The involvement of his hands was particularly distressing due to social concerns and affected self-esteem. Sleep disturbances caused by intense itching further compounded his concerns.

The patient had a long-standing history of AD, with a family history of allergic rhinitis and other atopic conditions. He and his family were hesitant about prolonged corticosteroid use due to concerns about skin thinning and other potential adverse effects.

Ruxolitinib 1.5% cream (Opzelura; Incyte), a topical JAK inhibitor, was initiated twice daily, leading to a rapid reduction in itching and noticeable improvement in the skin’s appearance within days. By the 2-week follow-up, the patient reported



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James Del Rosso, DO

significantly better sleep and a marked decrease in lesions. The regimen was maintained as needed: Treatment resumed when symptoms flared but was discontinued during remission. According to Del Rosso, the ability to cycle treatment effectively without prolonged exposure to corticosteroids was a key benefit in this case.

“When the disease comes back, he goes back to the therapy, but when the disease is gone, he can stop the therapy but certainly continue moisturization. He was extremely happy about it, and that is a pretty consistent response that we see,” Del Rosso said.

## Case 2 A 23-Year-Old Radiology Technician With Chronic Hand Dermatitis

The second case involved a 23-year-old woman working as a radiology technician. Her AD was primarily localized to her hands, exacerbated by frequent handwashing and glove use. She had tried various topical corticosteroids, including triamcinolone and clobetasol. Although clobetasol provided rapid relief, concerns about long-term use led her to seek alternatives. Triamcinolone was less effective and took longer to alleviate her symptoms.

Her condition was characterized by lichenification and asteatotic-type AD rather than intense erythema. She also experienced severe pruritus, which disrupted her sleep. Given her reluctance to continue high-potency corticosteroids, topical ruxolitinib was introduced twice daily.

Within days, she reported significant relief from itching and better sleep quality. By the 2-week follow-up, her lesions had improved considerably, and she expressed satisfaction with the treatment. Unlike with corticosteroids, she did not need to monitor how frequently she could safely use the medication, as ruxolitinib provided sustained benefits without the concerns associated with long-term steroid exposure.

“She had a lot of difficulty sleeping at night, such as falling asleep and staying asleep. That responded within days, and by the time she came back 2 weeks later, she was extremely happy with the results from the topical ruxolitinib,” Del Rosso said.

## Comparing Ruxolitinib With Corticosteroids

Del Rosso reviewed a pivotal phase 2 clinical trial (NCT03011892) that compared topical ruxolitinib 1.5% twice daily with triamcinolone 0.1% cream twice daily over 4 weeks. The results demonstrated that ruxolitinib performed as well

as, if not better than, the midpotency corticosteroid. Notably, even once-daily ruxolitinib application showed similar efficacy to triamcinolone used twice daily, though the recommended usage remains twice daily for optimal results.

Unlike corticosteroids, ruxolitinib is approved for application on sensitive areas such as the face, eyelids, and genital region without the risk of atrophy or telangiectasia. According to Del Rosso, this makes it a particularly attractive option for patients who require treatment in these areas.

### Safety Considerations

One concern surrounding ruxolitinib is its inclusion of a boxed warning, inherited from systemic JAK inhibitors. However, clinical and real-world data indicate that systemic absorption remains minimal when used on up to 20% body surface area as recommended. Thus, the risk of systemic adverse effects is negligible when the medication is applied appropriately.

Patient education plays a crucial role in ensuring optimal treatment outcomes. Del Rosso emphasized the importance of the following:

- Adherencing to twice-daily application
- Recognizing and avoiding individual triggers
- Using gentle cleansers and moisturizers to maintain skin barrier function
- Understanding that ruxolitinib is a safe and effective nonsteroidal option that can be discontinued and restarted as needed

### Broader Implications

For patients with moderate AD affecting 10% to 20% body surface area, systemic therapy is often considered. However, findings from clinical trials demonstrated that ruxolitinib's pharmacokinetic profile remains favorable even when used on the higher end of the approved body surface area range. This suggests that many patients with moderate AD can effectively manage their disease with topical ruxolitinib before resorting to systemic treatments.

Overall, Del Rosso's roundtable discussion highlighted the evolving landscape of AD management. Topical ruxolitinib offers an effective alternative to corticosteroids, with rapid onset of action, a favorable safety profile, and the ability to treat sensitive areas without the concerns associated with steroid use. ■

### Key Takeaways

1. Topical ruxolitinib 1.5% cream provides rapid relief from pruritus and improves skin appearance in atopic dermatitis (AD) without the risks of skin atrophy or telangiectasia associated with corticosteroids.
2. Patients using ruxolitinib can cycle treatment as needed—applying it during flares and discontinuing during remission—without concerns about prolonged corticosteroid exposure.
3. Unlike corticosteroids, ruxolitinib is approved for use on sensitive areas such as the face, eyelids, and genital region.

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