Uncapping Potential in the Diagnosis & Management of Atopic Dermatitis

Atopic Dermatitis: The facts

Skin is our largest organ, acting as a protective barrier from infections and diseases. However, skin conditions can affect this vital barrier, leading to further impacts on an individual's health and wider society.

Moderate-to-severe atopic dermatitis, also known as atopic dermatitis (AD), is a chronic inflammatory autoimmune condition that causes the skin to become itchy, inflamed, dry and cracked.[1]

- It is estimated that about 10 – 30% of children, and about 2 – 10% of adults are living with this condition.[2]
- Atopic dermatitis can increase the risk of bacterial skin infections and viral skin infections, which can become more serious if not treated.[3]
- While treatments can relieve symptoms of atopic dermatitis, there is **currently no cure.**[1]
- There is widespread variation in waiting times for dermatological services across England, ranging between 7 to 17 weeks across integrated care systems (ICSs).[4]
- One of the significant challenges in dermatology currently is due to workforce shortages with some integrated care systems having as few as 0.6 dermatologists per 100,000 patients.[5]

Key recommendations:

1. Integrated care system's should implement clinical pathways for the diagnosis and management of atopic dermatitis in line with NICE guidelines to ensure a consistent approach across the country.
2. The Government and NHS England should increase the number of dermatology specialists, with compulsory dermatology training in primary care and greater opportunities for GPs with extended roles in dermatology.
3. Patient education on AD is important so they can make more informed decisions about their own care, improving self-management, outcomes and reducing pressure on primary care as a result. NHS regional teams and dermatology clinical networks must therefore ensure the provision of adequate patient education and supported self-management as a core part of the treatment pathway.
4. ICSs, GPs, dermatology services, mental health teams, and the dermatology patient community should collaboratively establish formal processes to provide mental health support for dermatology patients.

Atopic Dermatitis, The Impact:

Atopic dermatitits can have substantial financial, social, and mental health impact on both patients and society:[6,7]

78%

of patients said dermatitis had negatively impacted their mental health(n = 237)

23%

of patients reported taking off more than 15 days of work due to their condition(n = 92)

£6,741 to £14,166

per patient in productivity lost per year for patients with atopic dermatitis

People diagnosed with atopic dermatitis should first be offered a topical cream from their GP in primary care.[8] In the event that initial treatment does not improve symptoms, they should then be referred to specialised dermatologists in secondary care.

However, challenges exist in making this a reality, including:

- Public awareness of atopic dermatitis.
- An overburdened and stretched NHS workforce.
- Challenges in equitable access to specialist support.
- Potential tensions between local pathway prescribing and primary care.

Despite the significant impact of atopic dermatitis on patients, the NHS and the broader economy, improving access to support for patients living with atopic dermatitis is not currently a policy priority at either a national or local level.

Integrated care systems (ICSs) have competing priorities across a range of disease areas, limiting their capacity to sufficiently prioritise atopic dermatitis despite its impact. Specialist dermatology services are often understaffed, oversubscribed, and overloaded with cases across 4,000 skin conditions.

There is also limited ICS bandwidth for prioritising atopic dermatitis, meaning specialist clinicians are important advocates. It is vital that ICSs focus on and implement Dermatology Clinical Networks consistently across the country.

While there is clear NICE guidance on atopic dermatitis,[8] challenges throughout the pathway and their implementation at a local level can impede patient access to treatments in line with this guidance, leading to a postcode lottery in both care and patient outcomes.

It is vital that all people living with atopic dermatitis are equally supported across the whole pathway to better manage their condition.

Map of England ICSs

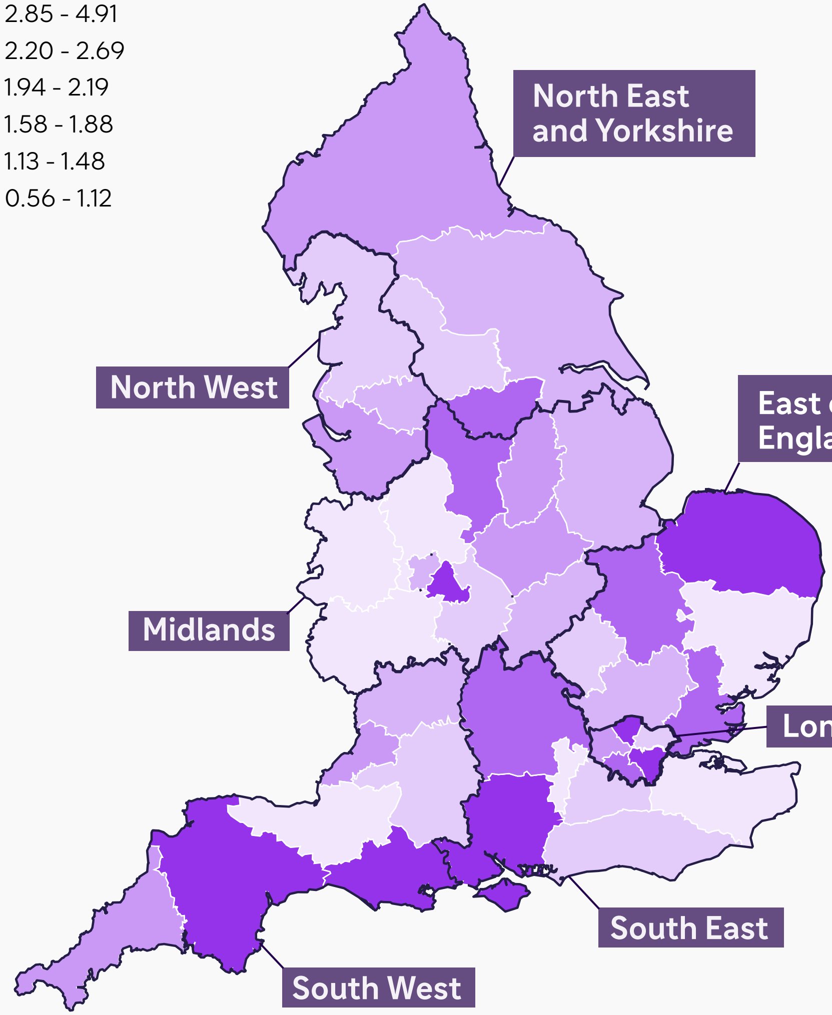
To see a breakdown of data in your specific integrated care system, please click on your respective region below

Regions workforce

As of March 2024

Key: Rate (Per 100,000 people)

- ■ 2.85 - 4.91
- ■ 2.20 - 2.69
- ■ 1.94 - 2.19
- ■ 1.58 - 1.88
- ■ 1.13 - 1.48
- □ 0.56 - 1.12

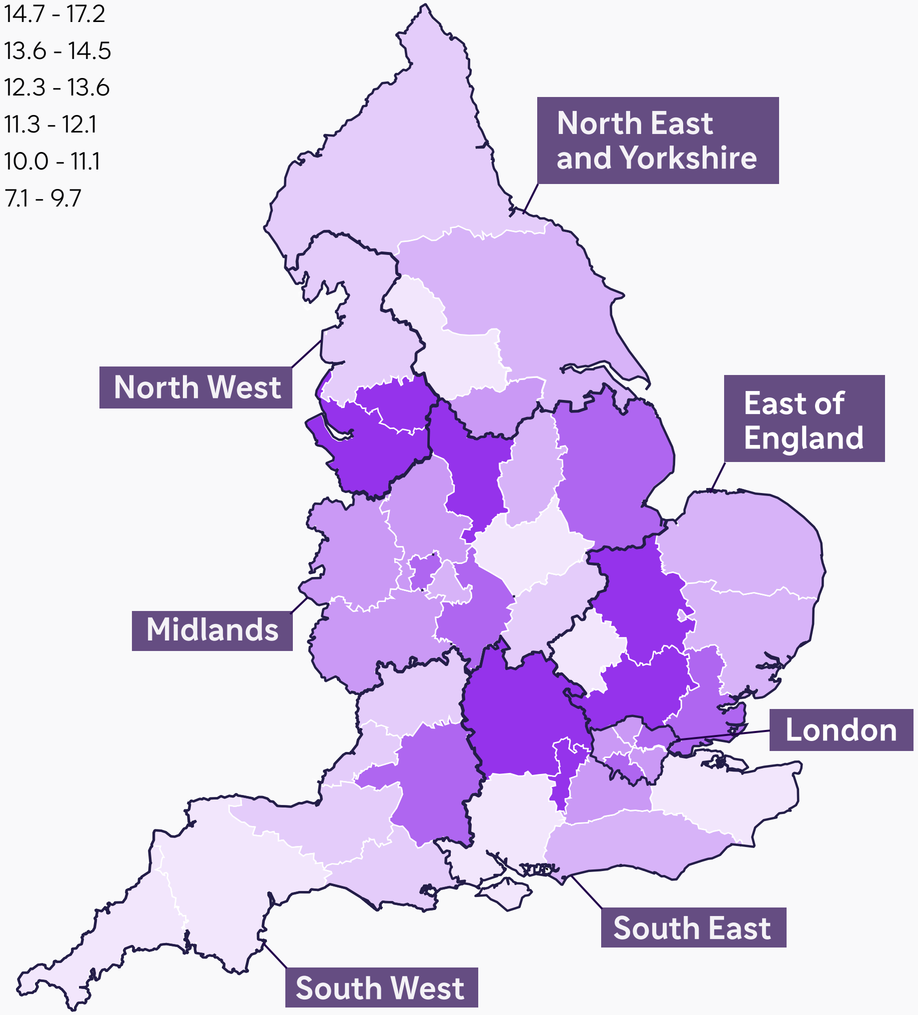


Waiting times

As of July 2024

Key: Time (in weeks)

- ■ 14.7 - 17.2
- ■ 13.6 - 14.5
- ■ 12.3 - 13.6
- ■ 11.3 - 12.1
- ■ 10.0 - 11.1
- □ 7.1 - 9.7



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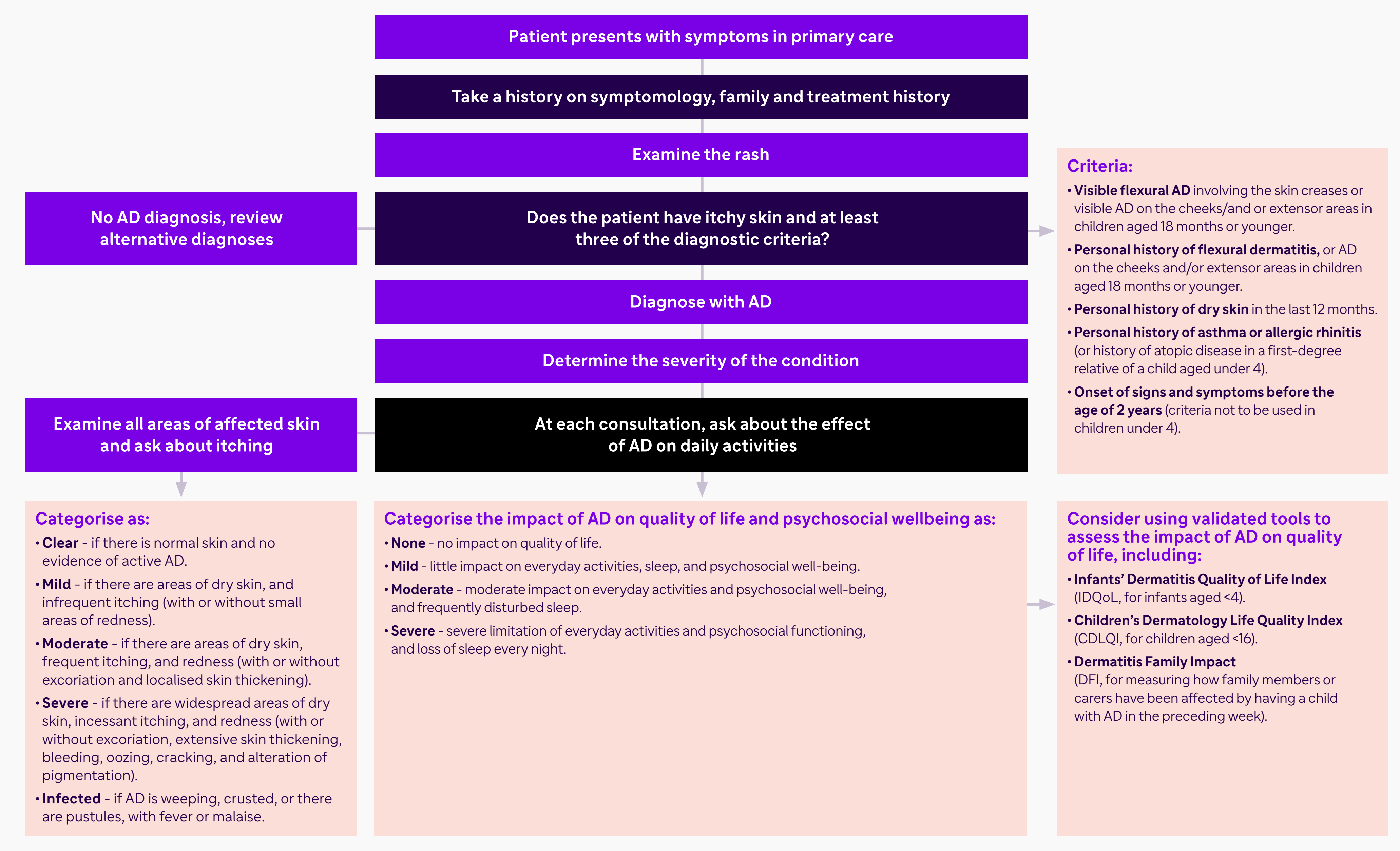
Sanofi Data on File derived from patient list sizes published by NHS Catalyst and Staff in Post publications

Sanofi Data on File derived from NHS Monthly Referral to Treatment Time Publications

Diagnosing Atopic Dermatitis (AD) Dermatitis

Ideal diagnostic pathway as derived from recommendations in NICE Guideline [CG 57]



Patient presents with symptoms in primary care

Take a history on symptomology, family and treatment history

Examine the rash

Does the patient have itchy skin and at least three of the diagnostic criteria?

No AD diagnosis, review alternative diagnoses

Criteria:

- **Visible flexural AD** involving the skin creases or visible AD on the cheeks/and or extensor areas in children aged 18 months or younger.
- **Personal history of flexural dermatitis,** or AD on the cheeks and/or extensor areas in children aged 18 months or younger.
- **Personal history of dry skin** in the last 12 months.
- **Personal history of asthma or allergic rhinitis** (or history of atopic disease in a first-degree relative of a child aged under 4).
- **Onset of signs and symptoms before the age of 2 years** (criteria not to be used in children under 4).

Diagnose with AD

Determine the severity of the condition

Examine all areas of affected skin and ask about itching

At each consultation, ask about the effect of AD on daily activities

Categorise as:

- **Clear** - if there is normal skin and no evidence of active AD.
- **Mild** - if there are areas of dry skin, and infrequent itching (with or without small areas of redness).
- **Moderate** - if there are areas of dry skin, frequent itching, and redness (with or without excoriation and localised skin thickening).
- **Severe** - if there are widespread areas of dry skin, incessant itching, and redness (with or without excoriation, extensive skin thickening, bleeding, oozing, cracking, and alteration of pigmentation).
- **Infected** - if AD is weeping, crusted, or there are pustules, with fever or malaise.

Categorise the impact of AD on quality of life and psychosocial wellbeing as:

- **None** - no impact on quality of life.
- **Mild** - little impact on everyday activities, sleep, and psychosocial well-being.
- **Moderate** - moderate impact on everyday activities and psychosocial well-being, and frequently disturbed sleep.
- **Severe** - severe limitation of everyday activities and psychosocial functioning, and loss of sleep every night.

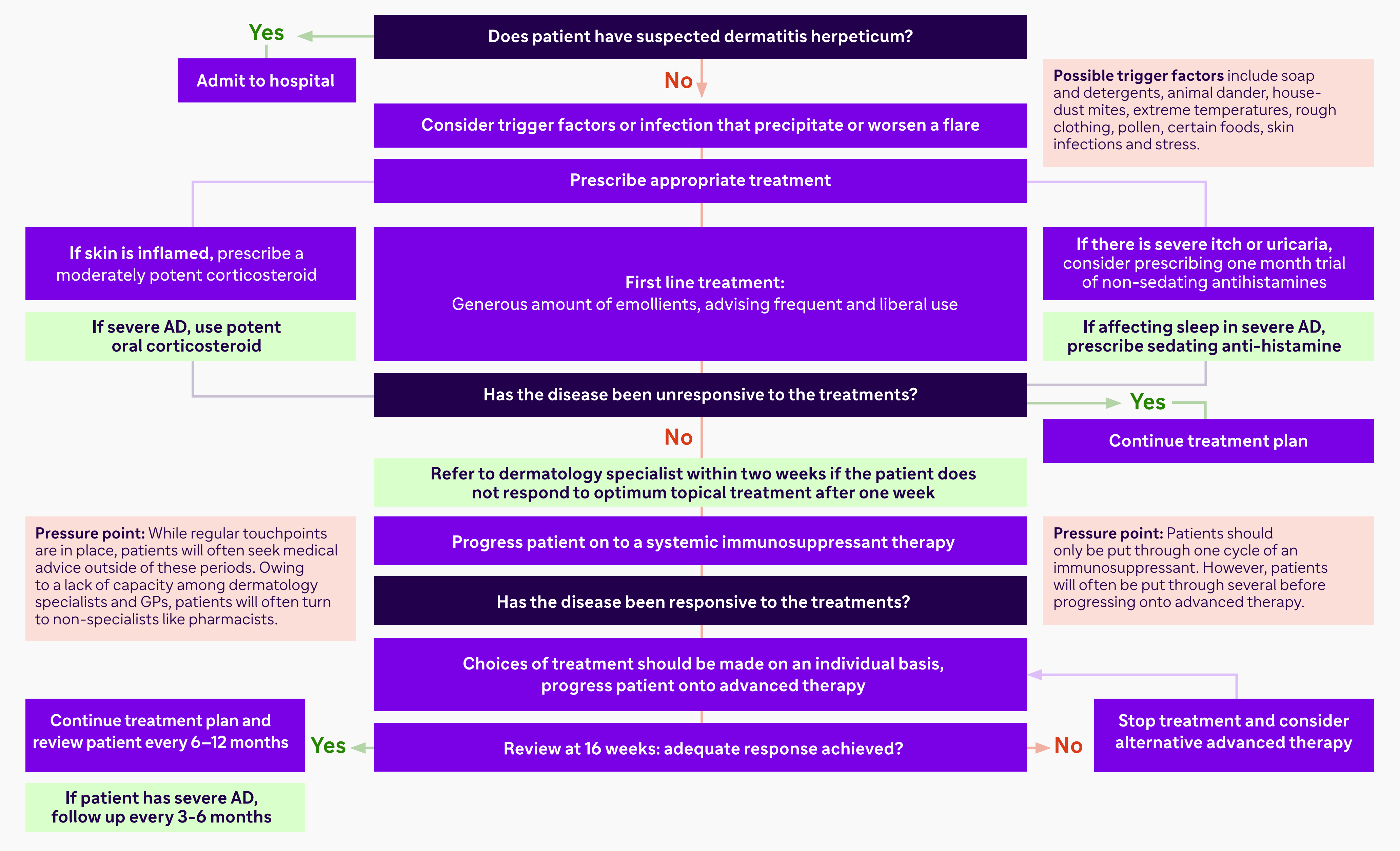
Consider using validated tools to assess the impact of AD on quality of life, including:

- **Infants' Dermatitis Quality of Life Index** (IDQoL, for infants aged <4).
- **Children's Dermatology Life Quality Index** (CDLQI, for children aged <16).
- **Dermatitis Family Impact** (DFI, for measuring how family members or carers have been affected by having a child with AD in the preceding week).

Key: ■ Severe Atopic Dermatitis Specific 🟪 Moderate / Severe Treatment Pathway ☐ Additional information & Pressure points

Treating Atopic Dermatitis (AD)

Ideal treatment pathway as derived from recommendations in NICE Guideline [CG 57] and NICE Clinical Knowledge Summaries



Consider trigger factors or infection that precipitate or worsen a flare

Possible trigger factors include soap and detergents, animal dander, house-dust mites, extreme temperatures, rough clothing, pollen, certain foods, skin infections and stress.

Prescribe appropriate treatment

If skin is inflamed, prescribe a moderately potent corticosteroid

If severe AD, use potent oral corticosteroid

First line treatment:
Generous amount of emollients, advising frequent and liberal use

If there is severe itch or uricaria, consider prescribing one month trial of non-sedating antihistamines

If affecting sleep in severe AD, prescribe sedating anti-histamine

Refer to dermatology specialist within two weeks if the patient does not respond to optimum topical treatment after one week

Pressure point: While regular touchpoints are in place, patients will often seek medical advice outside of these periods. Owing to a lack of capacity among dermatology specialists and GPs, patients will often turn to non-specialists like pharmacists.

Progress patient on to a systemic immunosuppressant therapy

Pressure point: Patients should only be put through one cycle of an immunosuppressant. However, patients will often be put through several before progressing onto advanced therapy.

Has the disease been responsive to the treatments?

Choices of treatment should be made on an individual basis, progress patient onto advanced therapy

If patient has severe AD, follow up every 3-6 months

Key: ■ Severe Atopic Dermatitis Specific ■ Moderate / Severe Treatment Pathway ■ Additional information & Pressure points

Despite this clear pathway, there are a few headline challenges which can prevent best practice care:

1. **There are few contact points** between patients and clinicians given that most treatments for atopic dermatitis are administered in the home, making it difficult for patients to frequently discuss their care. Touchpoints between clinicians and patients are key to supporting the tailoring of treatment options to patient's needs in line with NICE guidelines.[9]

2. **Insufficient dermatology specialists in primary care.** There is a lack of dermatology training among primary care professionals like GPs, pharmacists and nurses working in primary care where AD care is mostly centred. The majority of AD patients will never see a specialist in secondary care, instead pharmacists are becoming more and more commonly the first point of contact for patients.[10] Shortages overall mean: [10]
   - **a.** Long waits for specialists
   - **b.** Increasing use of high-cost locum staff
   - **c.** Considerable variation across the country in care provision and outcomes.

3. **Corticophobia.** Studies have also shown that concerns around treating flare ups with topical corticosteroids have led to some patients developing phobias, leading to treatment non-compliance and ultimately reduced disease control particularly with patients under the age of 12.[11]

4. **While the majority of AD patients will never see a dermatology specialist, for the few that need to – they face long waits of up to one year** (in 27% of cases) with an average wait time of 3 months, as opposed to the two weeks recommended. Notably, individuals from a higher socioeconomic background were also more likely to receive specialist referrals for atopic dermatitis pointing to potential variation in care associated with deprivation.[12]

Making the case for a streamlined Atopic Dermatitis patient pathway

Unequal knowledge of atopic dermatitis across primary care can lead to disparate diagnoses

There is variation in the time taken to diagnose moderate-to-severe atopic dermatitis. Average referral-to-treatment waiting times for dermatology services in England can range from 7 to 17 weeks across England's integrated care systems (ICSs). In some ICS's, only 51% of all patients are being seen within 18 weeks.[4]

Dermatology cases reflect 15 – 20% of GPs workload.[14] Yet, training on dermatology is not compulsory in UK medicine studies, with educational resources for primary care professionals often seen as optional.[13,14] It is vital that GPs and other healthcare professionals receive sufficient training on dermatology to ensure timely and accurate diagnoses.

Furthermore, more than two-thirds of healthcare professionals (n = 30) consulted in our survey think there is a lack of awareness amongst GPs on how to manage and treat atopic dermatitis.[6]

GPs may not be well informed enough to accurately diagnose patients with atopic dermatitis in the first instance or understand the severity of their condition.[14] In turn, this can lead to delays in patient referral to secondary care.[14]

ICSs need to implement increased and equitable training on dermatology conditions across primary care to improve patient diagnosis.

Unequal prescribing of full treatment options impacts patient outcomes through the pathway.

Immunosuppressants

People with moderate-to-severe atopic dermatitis may be referred to specialist care services in secondary care, where they can be prescribed immunosuppressants or biologics.[9]

Immunosuppressants can help to suppress or control the body's immune system to slow the symptoms of atopic dermatitis.[15] These can be prescribed to children and adults with moderate-to-severe atopic dermatitis for a short time to help stop itching, in turn allowing the skin's protective barrier to heal.[15] Immunosuppressants can have side effects, such as an increased infection risk, the increased risk of certain types of cancer, and an upset stomach or vomiting.[15]

While these treatment options can support patient outcomes, challenges with their prescribing remain.

Immunosuppressants for atopic dermatitis are intended for short-term use, with patients intended to be changed to a topical treatment for their long-term condition management.[15] However, patients can be prescribed multiple immunosuppressant cycles with little respite. Dermatologists must be provided with adequate support and capacity to move patients through the pathway, either onto a topical treatment where appropriate, or on to other treatment classes.

In addition to benefiting patient care and outcomes, supporting patients to move through the pathway can also help to minimise capacity challenges in the dermatology workforce. Patients on immunosuppressants can require careful monitoring,[9] including for example regular blood tests. This monitoring can be time-consuming and labour intensive for an already stretched workforce.

The NHS Workforce

The NHS is currently experiencing considerable workforce pressures across the board, but this problem is particularly acute in dermatology, caused in part by long-term restrictions on the number of new dermatology training posts. To manage these pressures, the NHS has often employed the use of high-cost locum consultants – reducing the amount invested into training new dermatologists, ultimately contributing to long-term workforce shortages.[10]

In 2021, the Getting It Right First Time (GIRFT) report on Dermatology found that at least 10 NHS Trusts had no dermatologists at all while 1/3rd had very severe shortages.[10] These shortages impact on both the timely diagnosis and the efficient treatment of patients with atopic dermatitis, the variation in dermatology staffing also ultimately leads to inconsistencies in care outcomes across the country.[16]

Our recent research found that this considerable workforce variation remains an issue at the integrated care board level. Some integrated care systems had as many as 5.22 dermatologists per 100,000 patients while several integrated care systems had less than one dermatologist per 100,000 patients.[5] Slightly over ½ of all integrated care systems in England have less than two dermatologists per 100,000 patients.[5]

Geographical disparities in the dermatology workforce exist across England. South East London has the highest dermatologists to patient ratio at 4.91 (per 100,000), followed by Norfolk and Waveney at 3.55 (per 100,000) and Birmingham and Solihull at 3.30 (per 100,000).[5] However, Shropshire, Telford and Wrekin has the lowest dermatologist to patient ratio at 0.56 (per 100,000), alongside Kent and Medway at 0.59 (per 100,000) and Frimley at 0.83 (per 100,000).[5]

As a result, dermatology patients face inequity in direct access to an NHS dermatologist which is essential in delivering optimal care for patients and ensuring they are on the best treatment option that works for them. Instead, patients will often seek advice from primary care pharmacists, practice nurses and GPs. This may lead to conflicting guidance and delay diagnosis as some may go through multiple tests and GP visits before seeing a specialist who can diagnose their condition first time.[10]

The disparities also mean that patients in areas with a lower dermatologist to patient ratio may receive a lower standard of care and an even more stretched workforce in cases where patients on immunosuppressants need to be monitored.

This ultimately culminates in a considerable postcode lottery in care for dermatology, a condition under prioritised at a national level despite its considerable primary care burden.

The Government and NHS England must increase the number of dermatology specialists, with compulsory dermatology training in primary care.

ICSs should include a focus on local dermatology pathways in their ICS plans to ensure smooth patient pathways.

Patients experience challenges in being fully informed on atopic dermatitis, often self-managing at home.

People living with atopic dermatitis can face challenges across treatment and condition management – from patient choice and information, to support for mental and emotional wellbeing. Patients can be left to self-manage their condition at home, with limited input from healthcare professionals and insufficient access to information.

Patient choice and information on condition management

Patients may not be fully informed of the various condition management options available. To secure greater patient choice and empowerment, it is vital that patients and carers receive improved education on long-term condition management options for atopic dermatitis from healthcare professionals.

70%

of surveyed patients state that dermatitis has affected their self-esteem or made them self-conscious[6]

It is our vision that people living with atopic dermatitis become genuine partners in their own care, empowered to ask for their preferred condition management.

Impact on patient mental health and access to psychological support

Patients need to be supported to better manage their condition and their mental health through education and the provision of wider psychological services.

As noted, atopic dermatitis can have negative impacts on an individuals' mental health and daily life – including on everyday activities, social life, sleep, and personal relationships.[6] This can further lead to comorbidities with mental health conditions such as depression and anxiety, as well as suicidal ideation, which are more common amongst people with moderate-to-severe atopic dermatitis.[6,17]

Despite the clear and stark impact of atopic dermatitis on an individuals' mental health, there is insufficient support available for patients. 100% of surveyed healthcare professionals do not think there is adequate mental health support for patients with atopic dermatitis.[6] Patients have reported mixed experiences with advice and support for their mental health. Some patients have received generic advice from healthcare professionals, such as to exercise more but not understanding that this may worsen their condition.[14] However, other patients have received empathetic care from a range of healthcare professionals they engage with.[14]

ICSs, GPs, dermatology services, mental health teams, and the dermatology patient community should collaboratively establish formal processes to provide mental health support for dermatology patients.

There is also limited healthcare professional knowledge or referral to psychological support groups. NHS psychodermatology services are reliant on specialists with an understanding of the relation between mental health and dermatology conditions – a limited pool of healthcare professionals.[14] Additionally, 93% of surveyed patients themselves were not aware that psychological support services even existed.[6]

Healthcare professionals and patient groups to collaboratively increase awareness of psychological support for dermatology patients.

Regional Spotlight

1. North East and Yorkshire[4,5]

Patient list size
9,238,699

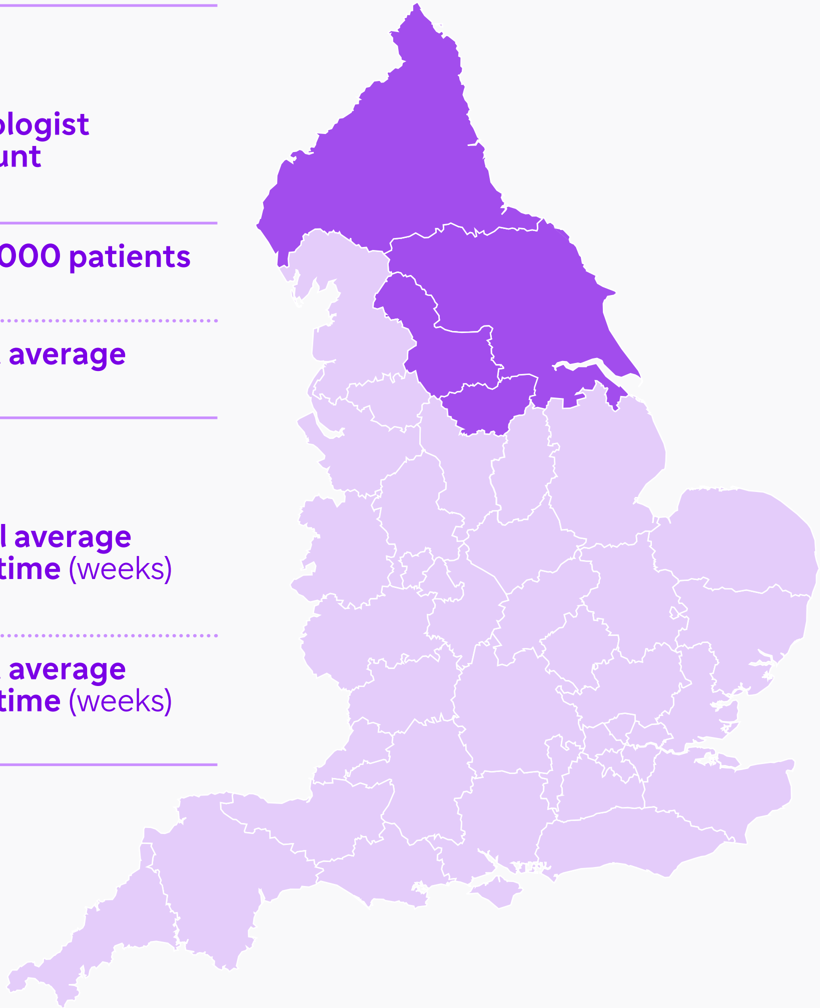
Dermatologist Headcount
177

Per 100,000 patients
1.92

National average
2.00

Regional average waiting time (weeks)
10.9

National average waiting time (weeks)
12.4



2. North West[4,5]

Patient list size
7,927,791

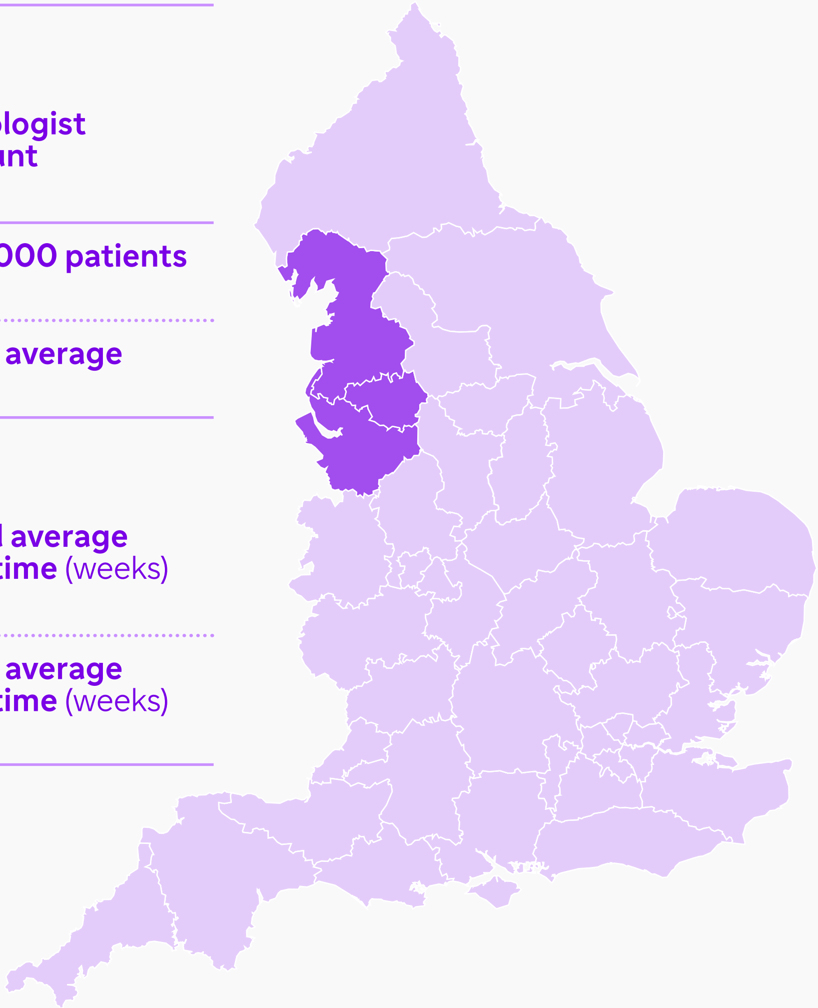
Dermatologist Headcount
138

Per 100,000 patients
1.74

National average
2.00

Regional average waiting time (weeks)
14.4

National average waiting time (weeks)
12.4



Regional Spotlight

3. Midlands[4,5]

Patient list size
11,968,840

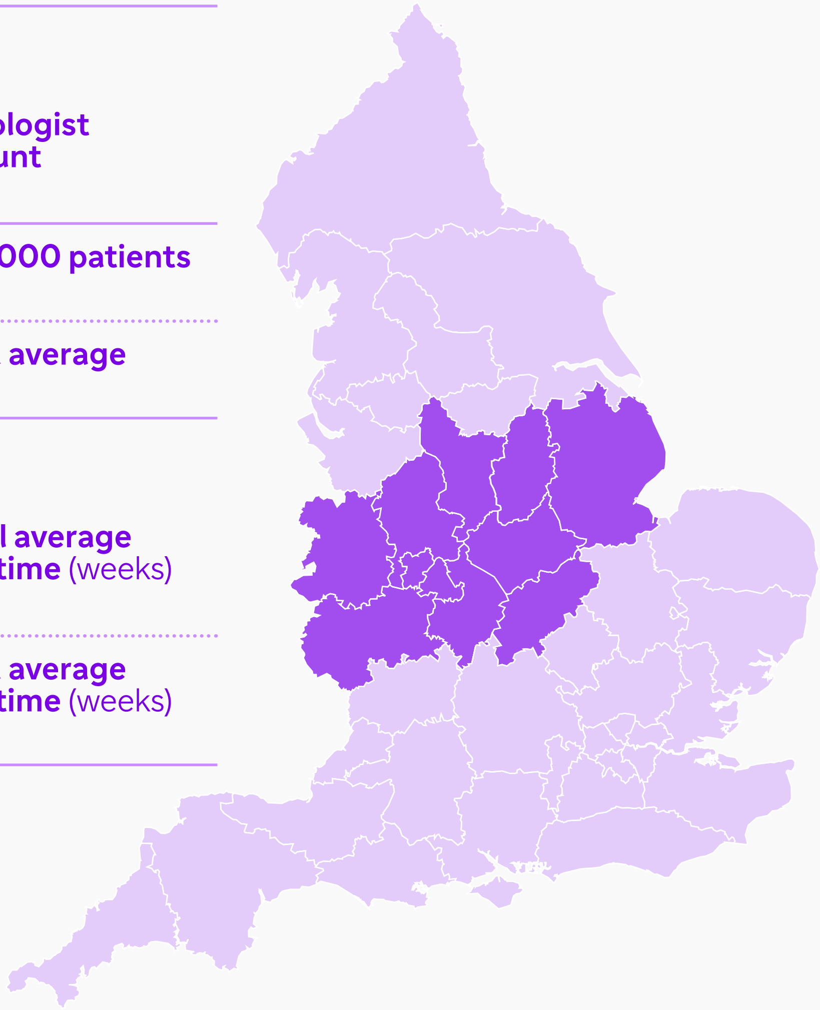
Dermatologist Headcount
232

Per 100,000 patients
1.94

National average
2.00

Regional average waiting time (weeks)
12.6

National average waiting time (weeks)
12.4



4. East of England[4,5]

Patient list size
7,305,931

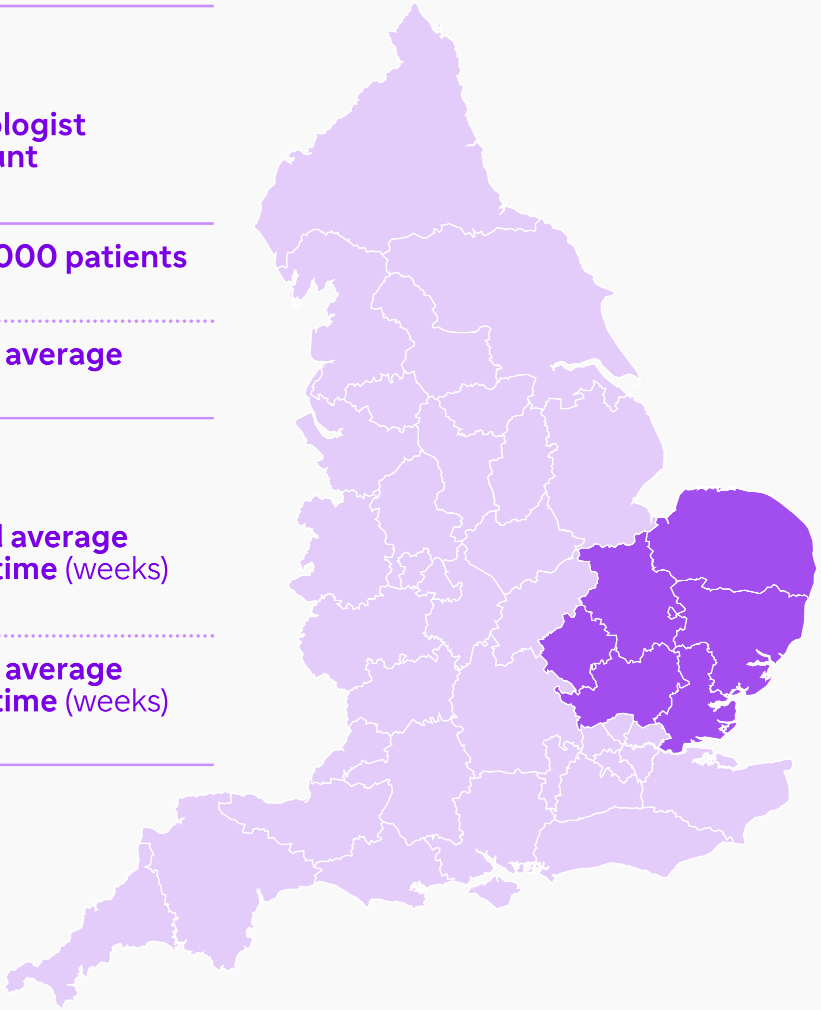
Dermatologist Headcount
147

Per 100,000 patients
2.01

National average
2.00

Regional average waiting time (weeks)
13.1

National average waiting time (weeks)
12.4



Regional Spotlight

5. South East[4,5]

Patient list size
9,834,438

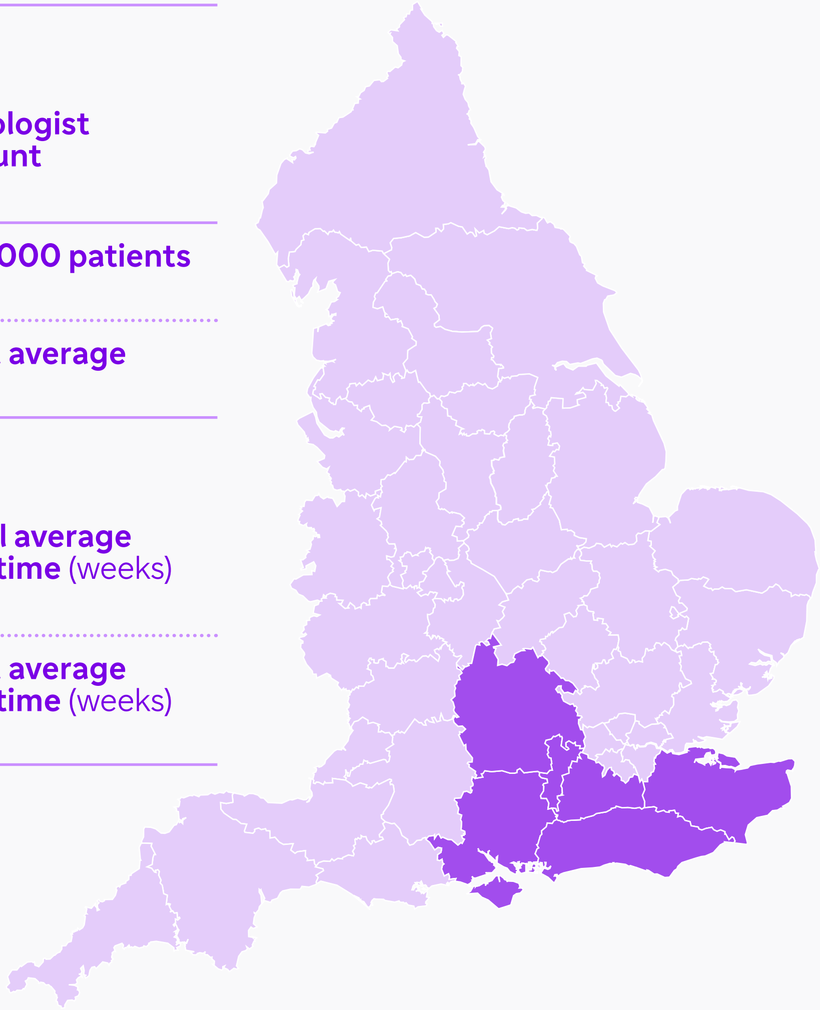
Dermatologist Headcount
161

Per 100,000 patients
1.64

National average
2.00

Regional average waiting time (weeks)
12.4

National average waiting time (weeks)
12.4



6. South West[4,5]

Patient list size
6,130,206

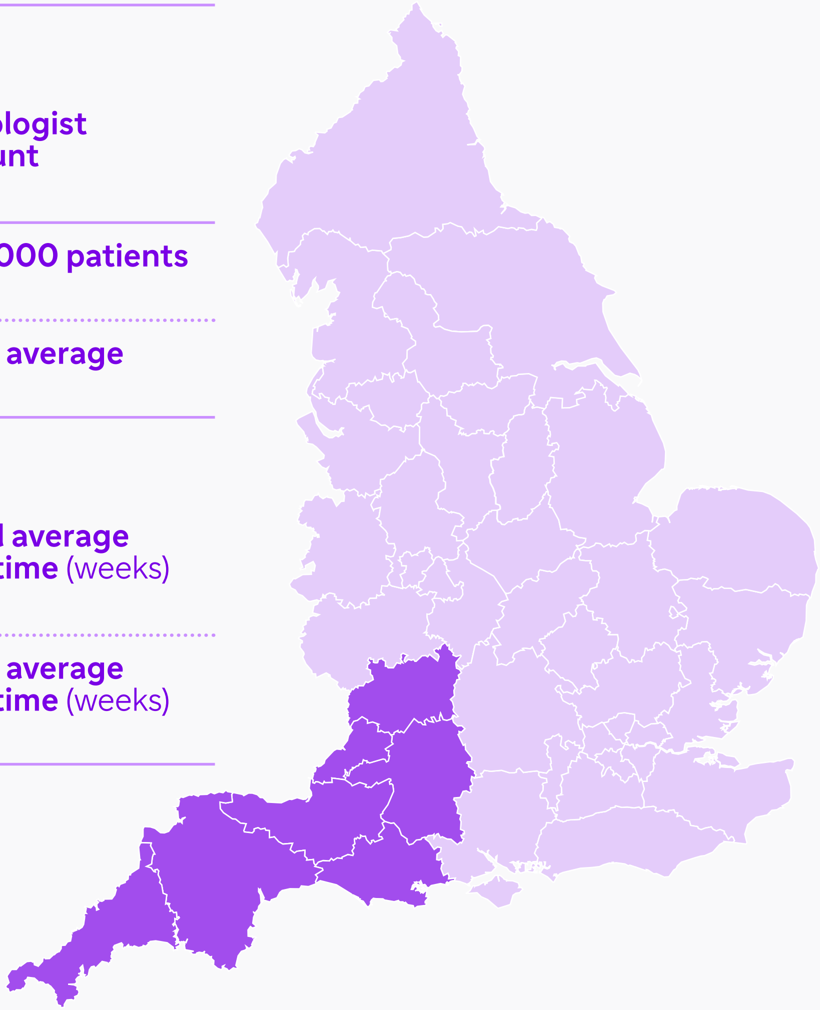
Dermatologist Headcount
133

Per 100,000 patients
2.17

National average
2.00

Regional average waiting time (weeks)
10.5

National average waiting time (weeks)
12.4



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Regional Spotlight

7. London[4,5]

Patient list size
11,049,835

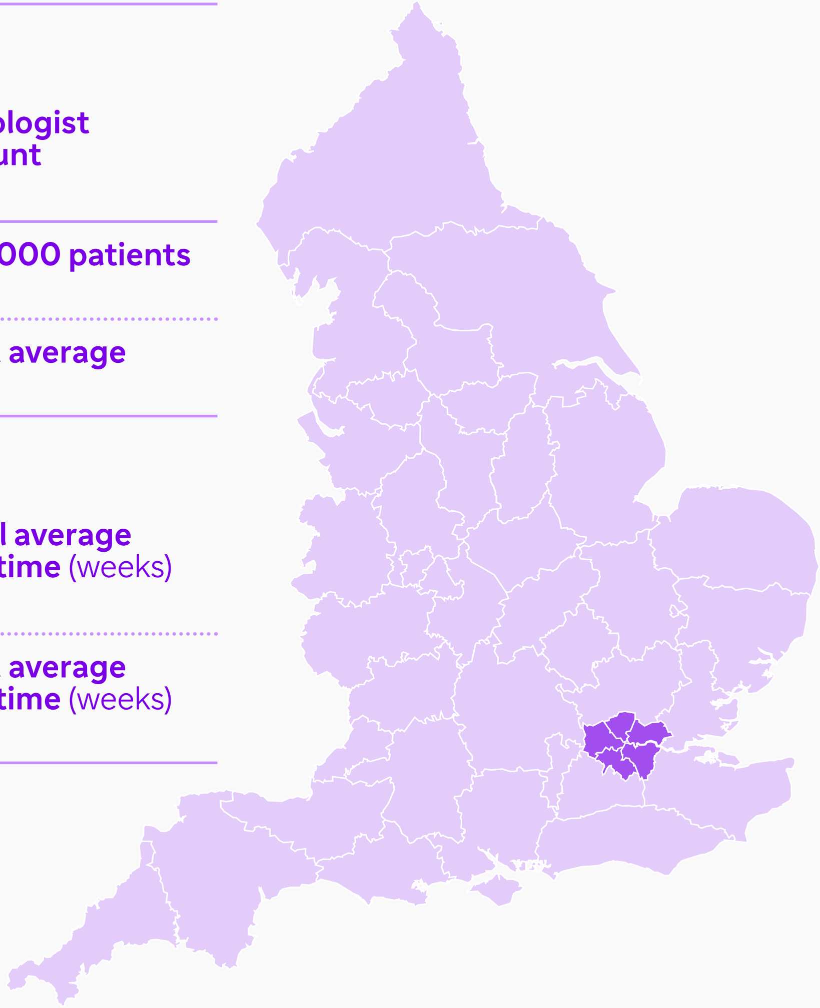
Dermatologist Headcount
290

Per 100,000 patients
2.62

National average
2.00

Regional average waiting time (weeks)
12.9

National average waiting time (weeks)
12.4



About Sanofi

Sanofi is a global life sciences company with a strong heritage and presence in the UK. From prevention to treatment, Sanofi transforms scientific innovation into healthcare solutions.

For further information about our work in dermatology, please contact Nadav Cohen-Keidar, Specialty Care Communications Lead at **nadav.cohen-keidar@sanofi.com**

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