Understanding Topical Treatment Experiences in Patients with Moderate-to-Severe Atopic Dermatitis: Results from a US Cross-sectional Survey

Peter Lio[1], Autumn Burnette[2], Alexa Hetzel[3], Zach Dawson[4], Evangeline Pierce[4], Rosie Fielding[5], James Haughton[5], Linda Stein Gold[6]

[1]Northwestern University Feinberg School of Medicine, Chicago, USA; [2]Howard University Hospital, Washington DC, USA; [3]Schweiger Dermatology Group, Windsor, NJ, USA; [4]Eli Lilly and Company, Indianapolis, IN, USA; [5]Adelphi Real World, Bollington, UK; [6]Ford Health System, Detroit, USA.

Sponsored by Eli Lilly and Company

OBJECTIVE

- To characterize the real-world use and impact of topical therapies – including topical monotherapy (TM) and topical + advanced systemic (TAS) therapy among adult and adolescent patients with moderate-to-severe atopic dermatitis (AD) in the US.

BACKGROUND

- Topical therapies remain the cornerstone in the management of AD.[1]
- Recently, several novel systemic therapies have been introduced.[2]
- However, real-world data on usage patterns of topical monotherapy or in combination with advanced systemics is limited, underscoring the need to better understand the patient experience.[3]

CONCLUSION

- Many patients reported frequent application of topical medications, along with disruption in their daily routines, impact on clothing choices, and interference with sleep.
- Nearly one-third of patients experienced eczema flares while using topical treatments, regardless of concurrent systemic therapy.
- These findings highlight the burden associated with topical medication use.
- Incorporating patient-reported experiences is essential for developing effective treatment strategies for the management of AD.

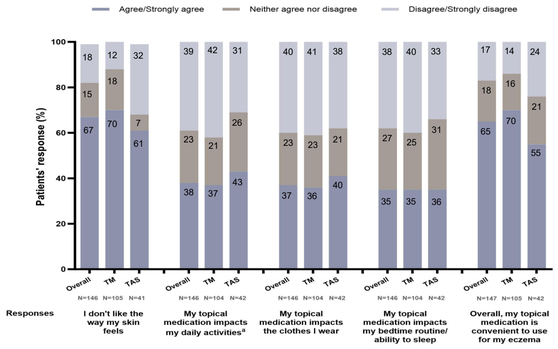
Fall Clinical Dermatology Conference (Fall CDC); Las Vegas, USA; 23-26 October 2025

KEY RESULTS

Time to apply[a]	How often are topicals applied?[b]
5 min or less **81%**	Twice a day **53%**
TAS: 73% **TM: 84%**	**TAS: 38%** **TM: 59%**

Reduction in responses may be attributed to the use of pen-and-paper data collection by patients, which occasionally resulted in incomplete questionnaires; Numbers may add up to more than 100% due to some patients selecting multiple responses, such as "*once a day*" but also "*dependent on my eczema symptoms*". [a]Overall, N=145; TM, n=104; TAS, n=41; [b]Overall, N=142; TM, n=102; TAS, n=40
TAS: topical + advanced systemic (oral JAK-i or biologic); TM: topical only monotherapy (no concomitant systemic treatment).

Most patients (67%) don't like the feeling of topical medication on their skin, and more than a one-third reported that it impacts their daily activities



[a]e.g. washing up, getting dressed, cooking and preparing food;
Percentages exclude patients who did not provide a response; Reduction in responses may be attributed to the use of pen-and-paper data collection by patients, which occasionally resulted in incomplete questionnaires. Patients not providing a response are not accounted in the percentages shown in the graph.
N, total number of patients responding; TAS: topical + advanced systemic (oral JAK-i or biologic); TM: topical only monotherapy (no concomitant systemic treatment).

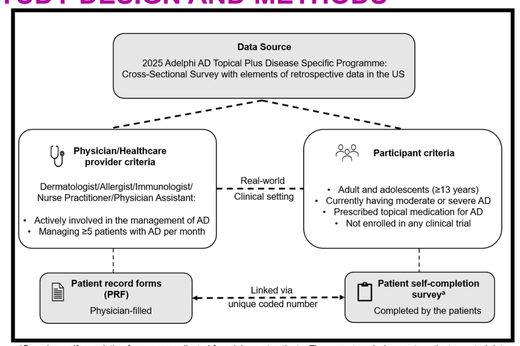
Twenty-nine percent of patients were prescribed TAS treatment.
Among patients prescribed TM or TAS, nearly one-third of patients were experiencing a flare at the time of data collection, mainly of moderate severity.
Topical PDE/PDE-4 inhibitors were prescribed to 31% of patients in the TM group and to 15% in the TAS group

Clinical Characteristics and Disease Pattern, n (%)[a]	Overall (N=161)	TM (n=115)	TAS (n=46)
Proportion of patients experiencing flare at the time of data collection[b]	**52 (32%)**	**38 (33%)**	**14 (30%)**
Severity level of flare[c]			
Mild	**2 (4%)**	**2 (5%)**	**-**
Moderate	**32 (62%)**	**23 (61%)**	**9 (64%)**
Severe	**18 (35%)**	**13 (34%)**	**5 (36%)**

Currently prescribed regimen, n (%)	Overall (N=161)	TM (n=115)	TAS (n=46)
Topical corticosteroid	139 (86%)	99 (86%)	40 (87%)
Topical calcineurin inhibitors	51 (32%)	36 (31%)	15 (33%)
Topical PDE/PDE-4 inhibitors[d]	43 (27%)	36 (31%)	7(15%)
Biologics	37 (23%)	-	37 (80%)
Topical JAK inhibitor	26 (16%)	19 (17%)	7 (15%)
Emollients/moisturizers	25 (16%)	16 (14%)	9 (20%)
Topical aryl hydrocarbon receptor agonist	19 (12%)	17 (15%)	2 (4%)
Oral JAK inhibitor	9 (6%)	-	9 (20%)
Oral/Injected corticosteroid	2 (1%)	-	2 (4%)
Other	39 (24%)	33 (29%)	6 (13%)

[a]Responses as per data collected through PRF; [b]Acute episode of worsening AD symptoms as identified by physician assessment; [c]Indicate the severity of the patient's acute episodes (flares) as a result of their AD; [d]Includes Crisaborole and Roflumilast
AD: Atopic dermatitis; PRF, Patient record-form; N, total number of patients; n, number of patients in a specific group; TAS: topical + advanced systemic (oral JAK-i or biologic);TM: topical only monotherapy (no concomitant systemic treatment).

STUDY DESIGN AND METHODS



[a]Caregiver self-completion forms were collected for adolescent patients. The current analysis reports patient-reported data.
AD: Atopic dermatitis.

- Results were stratified by type of treatment:
  - **TM: topical monotherapy (no concomitant systemic treatment)**
  - **TAS: topical + advanced systemic (oral JAK-i or biologic)**
- Data were analyzed descriptively using n and % for categorical variables and mean and standard deviation (SD) for continuous variables.

RESULTS

Patient Demographics

Characteristic	Overall (N=161)	TM (n=115)	TAS (n=46)
Age (years), mean (SD)	32 (17.5)	33 (17.8)	32 (17.0)
Female, n (%)[a]	89 (55)	60 (52)	29 (63)
BMI, mean (SD)	25 (4.8)	24 (4.4)	26 (5.3)
Race, n (%)[b]			
White	104 (65)	73 (63)	31 (67)
Black/African American	34 (21)	25 (22)	9 (20)
East/Southeast Asian	11 (7)	8 (7)	3 (7)
Indian subcontinent	4 (2)	4 (3)	-
Other races[c]	13 (8)	9 (8)	4 (9)

[a]Biological sex, as stated in their medical record; [b]Categories were not mutually exclusive; physicians were able to select all categories that were applicable for each patient. [c]Includes: South/Central American Native (N=3), Native Hawaiian/Pacific Islander (N=3), Middle Eastern/North African (N=3), American Indian/Indigenous American/Alaska Native (N=2), and other races (N=2).
BMI, body mass index; N, total number of patients; n, number of patients in a specific group; SD, standard deviation; TAS: topical + advanced systemic (oral JAK-i or biologic); TM: topical only monotherapy (no concomitant systemic treatment).

LIMITATIONS

- The cross-sectional design of the DSP does not allow for causal relationships.
- All analyses were descriptive, and no multivariate methods were applied; therefore, the results were not adjusted for confounding factors.
- The sample of the DSP did not constitute a true random sample as individuals with more severe disease or frequent consultations may have been represented due to inclusion criteria, and participation was determined by willingness to complete a patient/caregiver self-completion form.
- Responses may be inaccurate due to recall bias from retrospective data collection and the use of self-reported data without independent verification.

References:
1. Ring J. et al. *J. Eur. Acad. Dermatol. Venereol.* 2012;26(9):1176-93.
2. Puar N. et al. *Ann Allergy Asthma Immunol.* 2021;126(1):21-31.
3. Boytsov NN et al. *J. Dermatol. Treat.* 2022 Apr 3;33(3):1707-17.

Scan the QR code for supplementary data

Scan the QR code for a list of all Lilly content presented at the congress. Other company and product names are trademarks of their respective owners.

Acknowledgments: Eshita Sharma, an employee of Eli Lilly and Company, provided medical writing support.

Disclosures: PL Writing support: Eli Lilly; Consulting fee: Alphyn Biologics, AbbVie, Almirall, Amryris, Arcutis, ASLAN, Boston Skin Science, Bristol-Myers Squibb, Burt's Bees, Castle Biosciences, Codex Labs, Concerto Biosci, Dermavant, Eli Lilly, Galderma, Janssen, Johnson & Johnson, Kimberly Clark, LEO Pharma, Lipidor, L'Oreal, Merck, Micreos, MyOR Diagnostics, Regeneron/Sanofi Genzyme, Sibel Health, Skinfix, Sonica, Suneco Technologies, Theraplex, UCB, Unilever, Verdant Scientific, Verrica, Yobee Care; Honoraria/speaker's bureau or travel grants: AbbVie, Arcutis, Eli Lilly, Galderma, Hyphens Pharma, Incyte, La Roche-Posay/ L'Oreal, MyOR Diagnostics ParentMD, Pfizer, Pierre-Fabre Dermatologie, Regeneron/Sanofi Genzyme, Verrica; Stock options: Alphyn Labs, Codex Labs, Concerto Biosci, LearnSkin/Learn Health, Medable, Modernizing Medicine, Suneco Technologies, Yobeee Care, Verdant Scientific; Patent/royalties: Theraplex AIM. **AB**, Consulting fee: Eli Lilly, Astra Zeneca, Amgen, Sanofi, Regeneron, Arcutis, Dermavant (now Organon); Honoraria/ speaker's bureau or travel grants: Eli Lilly, Astra Zeneca, Amgen, Sanofi, Regeneron, Dermavant (now Organon); Participation in advisory board: Astria. **AH**, Honoraria/speaker's bureau: Eli Lilly, J&J, UCB, Incyte, Sanofi/Regeneron, Abbvie, BMS, Pelthos, Arcutis, Pfizer; Travel support and Leadership or fiduciary role in other board, society, committee or advocacy group: Dermatology Education Foundation; Participation in advisory board: Eli Lilly, J&J, Novartis, Amgen, Abbvie, BMS, Pfizer, Journey; Other financial or non-financial interests (Clinical trial): Amgen, Leo, J&J, Sanofi/Regeneron, Dermavant, Takeda, Menlo, Abbvie, Eli Lilly, Arcutis, BMS. **ZD** and **EP**, employees and stockholders of Eli Lilly and Company. **RF** and **JH**, employees of Adelphi Real-world, who received funding from Eli Lilly and Company to conduct this research. **LSG**, Writing support: Eli Lilly; Grants: Abbvie, Amgen, Arcutis, BMS, Galderma, Incyte, J&J, Lilly, Regeneron, Sanofi, Takeda; Consulting fee: Abbvie, Amgen, Arcutis, BMS, Galderma, Incyte, J&J, Leo, Lilly, Regeneron, Sanofi, Takeda; Honoraria/speaker's bureau: Abbvie, Amgen, Arcutis, BMS, Galderma, Incyte, J&J, Leo, Lilly, Regeneron, Sanofi, Takeda, Organon; Expert testimony: Abbvie, Ortho Derm.