

Outcome Measures, Case Definition, and Nomenclature Are All Important and Distinct Aspects of Atopic Eczema: A Call for Harmonization

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TO THE EDITOR

In his comment on our paper recently published in the *Journal of Investigative Dermatology* (Schmitt *et al.*, 2011), Dr Hanifin (2011) expresses concerns that variants in the nomenclature may impede the efforts of the international community to harmonize outcome measures for studies on atopic eczema/atopic dermatitis (Schmitt and Williams, 2010).

Our call for a standardization of outcome measures for atopic eczema trials and for record keeping in clinical practice resulted in considerable interest and support from the international research community and patient groups throughout the world (Schmitt *et al.*, 2011). To harness such interest, the Harmonising Outcome Measures for Eczema (HOME) initiative (<http://www.homeforeczema.org>) was founded in July 2010 at the International Symposium on Atopic Dermatitis/New Trends in Allergy meeting in Munich, Germany, consisting of about 40 clinical researchers and outcomes research methodologists (Schmitt and Williams, 2010). At this meeting, the majority of participants, including Hanifin, expressed a clear interest in proceeding further into working on identifying core outcomes for eczema research. A further HOME meeting was held in Amsterdam in June 2011, which also included industry scientists and methodologists who endorsed the core outcome domains (i.e., the aspects of atopic eczema that should be regularly measured in future clinical trials) identified in the initial international Delphi exercise (Schmitt *et al.*, 2011). This has led to a series of projects to identify which measures are best suited for such domains.

The HOME initiative is also linked with other international outcome measures initiatives beyond the field of dermatology, such as COMET (Sinha *et al.*, 2008, 2009) and OMERACT (Tugwell and Boers, 1993).

There are two main reasons why we decided to call our initiative the Harmonizing Outcomes Measures on Eczema (HOME)-initiative. First, as Hanifin correctly emphasizes, “eczema” is a term commonly used by patients and by many physicians around the world. As our initiative has a strong focus on patients’ perspectives, it is a necessary prerequisite for its success to use terminology that is widely understood. The second reason why we use the term “eczema” relates to the international multidisciplinary focus of our group. Even though it may be criticized for the reasons pointed out by Hanifin, “eczema” is the term that the World Allergy Organization (WAO) nomenclature committee, which included a number of dermatologists, agreed on (Johansson *et al.*, 2004). The main rationale for the revised nomenclature was that the widespread use of the term “atopic” in “atopic eczema” or “atopic dermatitis” was unscientific because large population studies show that anything from 20 to 100% of such clinical phenotypes do not show evidence of sensitization to environmental allergens (Flohr *et al.*, 2004). There was no underlying agenda to promote the possible role of IgE in such a disease. Indeed, two of the authors (CF and HW) have been among the most vociferous critics of the preoccupation with the dubious etiological role of atopy in eczema (Williams and

Flohr, 2006; Flohr *et al.*, 2008). We agree with Hanifin that people with the clinical phenotype of eczema do not need testing for IgE in order to make the diagnosis; however, if that is the case, it is not logical to call them “atopic”, a term that has a precise scientific definition. It is also important to point out that the WAO does not suggest that the term “eczema” should be applied loosely to all forms of eczema/dermatitis such as nummular, venous, or seborrheic, but just to the phenotype of what Hanifin calls “atopic dermatitis”. The overarching structure of the WAO classification starts with “dermatitis”, which is then subdivided into “eczema” (which can either be “atopic eczema” or “non-atopic” eczema, depending on whether allergen testing has been positive), “contact dermatitis” (which can either be “irritant” or “allergic”), and other forms of dermatitis.

We are aware that much scientific energy has gone into debating what to call “non-atopic” eczema and terms such as “intrinsic” or “atopiform” have emerged without any clear agreement or widespread adoption (Williams, 2000; Brennkmeijer *et al.*, 2008). We agree with Hanifin in suggesting that the role of atopy in eczema might have been overemphasized in that it adds little to our clinical predictive ability, and it may well be the case that other factors such as filaggrin skin barrier gene mutation carriage may become a better and more logical way of dividing up eczema in the future (Wuthrich and Schmid-Grendelmeier, 2003; Rodriguez *et al.*, 2009). It is for this reason that every consensus—regardless of whether concerning core outcome domains, nomenclature, or diagnostic criteria—should be forever

Abbreviations: HOME, Harmonising Outcome Measures for Eczema; WAO, World Allergy Organization

preliminary and may be revised in the future based on new knowledge.

The letter by Hanifin suggests that an international consensus project concerning the terminology of “atopic eczema”/“atopic dermatitis” might be indicated. This would clearly be a separate initiative, independent from HOME, and would need to include different stakeholders (at least dermatologists, pediatricians, and allergists); if Hanifin would like to proceed from this discussion to an international consensus initiative, we would be very happy to participate.

We are delighted that Hanifin is supporting the HOME initiative to address the multiplicity of scales that hampers current comparability of trials of atopic eczema between countries and over time and look forward to this and other collaborative efforts to strengthen evidence-based research and improve medical care of patients with (atopic) eczema.

CONFLICT OF INTEREST

The authors state no conflict of interest.

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