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Original Article

Consensus statements on pediatric atopic dermatitis from dermatology and pediatrics practitioners in Japan: Goals of treatment and topical therapy

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ABSTRACT

Background: Pediatric atopic dermatitis (PAD) is a pluricausal disease and is frequently seen in dermatological and pediatric practice. Therefore, it is important to find common views in clinical practice and to promote consensus among practitioners. Aiming to obtain common views among dermatologists and pediatricians and to disseminate them widely in clinical practice, we held the PAD Consensus Forums described herein.

Methods: Questionnaire surveys of treatment goals and drug therapy were conducted to prepare topics for discussion at the PAD Consensus Forums. Reaching consensus was defined as agreement among at least 70% of the participants.

Results: As a result of discussion among 24 dermatologists and 25 pediatricians, consensus was obtained on 7 topics. These topics configure 3 consensus of treatment goals (Attainment targets were divided into the short/medium term and the long term. Attainment targets were associated with the primary evaluation domains of the Harmonising Outcome Measures for Eczema (HOME) roadmap, etc.) and 4 consensus of drug therapy (The number of applications of topical anti-inflammatory drugs in the acute phase and selection and ideal intervals between applications of topical anti-inflammatory drugs in proactive therapy, etc.).

Conclusions: The consensus is expected to help practitioners set appropriate treatment goals in clinical practice and facilitate the choice of drugs for treatment.

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Introduction

Atopic dermatitis (AD) is a disease in which the main lesion is eczema with pruritus, which repeats remission and relapse. The repeat of inflammation and pruritus become chronic.^{1,2} In most

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patients with AD, the disease develops in their childhood and achieves remission by puberty.^{3,4} AD has a variety of onset factors and exacerbation factors,⁵ and exacerbation of AD during childhood can lead to development of asthma and allergic rhinitis (atopic march),⁶ therefore, multiple factors need to be considered when determining diagnosis and treatment strategy. Because AD is frequently seen in daily clinical practice, its appropriate diagnosis and treatment methods need to be understood not only by AD specialists, but also other physicians with different specialties.

To obtain common views of evaluation and treatment methods for AD, international consensus meetings have been held. In particular, to harmonize international common views of outcome measures for eczema in clinical studies, consensus meetings on the theme of Harmonising Outcome Measures for Eczema (HOME) have been held 6 times.^{7–11} As for the primary evaluation domains of the HOME roadmap, which are the sign, symptom, quality of life (QoL), and long-term control domains, a consensus that the Eczema Area Severity Index (EASI) is to be used for the sign domain and Patient-Oriented Eczema Measure (POEM) is to be used for the symptom domain has been obtained. Although specific outcome measures for long-term control have not been selected, a consensus that the sign, symptom, and QoL domains and a patient global instrument are to be used in the long-term control domain has been obtained. In Italy, a consensus meeting on the theme of clinical management of pediatric atopic dermatitis (PAD) has been held.¹²

At the time of this PAD Consensus Forums, the “Japanese Guidelines for Atopic Dermatitis 2015” by the Japanese Society of Allergology, and “Clinical Practice Guidelines for the Management of Atopic Dermatitis 2016” by the Japanese Dermatological Association were prepared in Japan,^{13,14} while these integrated guideline have been released on November 2018.¹⁵ These guidelines are intended for physicians involved in diagnosis and treatment of AD, and describe basic methods of diagnosis and treatment. However, because these guidelines focus on basic matters, for example, specific details regarding achievement of treatment goals are not described. Moreover, these guidelines were prepared separately by two different academic societies based on their own views. Therefore, as with other countries, Japan is expected to endeavor to find common views through cooperation among the practitioners of dermatology and pediatrics, the main clinical departments in which patients with AD are seen, to establish appropriate methods for diagnosis and treatment during childhood.

With this background, aiming to obtain common views regarding diagnosis, treatment, and evaluation methods for pediatric AD, as well as adherence, cooperation among the practitioners of dermatology and pediatrics, prevention of the disease from becoming chronic, and to disseminate obtained common views into clinical practice to supplement the guidelines, we held the Pediatric Atopic Dermatitis (PAD) Consensus Forums (April 2015) on 3 themes: “treatment goals,” “drug therapy,” and “chronic scratching.”

Methods

Conduction of questionnaire surveys

A web-based questionnaire survey regarding treatment goals was commissioned to Anterio Inc. and conducted in October and November 2015. A web-based questionnaire survey regarding drug therapy was commissioned to Macromill, Inc. and conducted in September and October 2016.

Dates of PAD consensus forums

The PAD consensus forums on the theme of treatment goals were held on March 13, 2016 and March 26, 2017, and the PAD

consensus forum on the theme of drug therapy was held on March 26, 2017.

Participants in the PAD consensus forums

Forty-nine AD specialists in Japan (hereinafter, PAD members), 24 dermatologists and 25 pediatricians participated in the PAD consensus forums ([Supplementary Table 1](#)). Among them, 2 physicians were selected for each theme, of treatment goals and of drug therapy, as representatives who would be involved in the management of the forums and the planning and preparation of questionnaires (facilitators), and 4 physicians who would be involved in the operations of planning and preparation of questionnaires (working group) were selected for each theme.

Questionnaire surveys

Maruho participated in the preparation of a draft. The physicians of facilitators and working group members (representatives) independently discussed and prepared a 9-item questionnaire regarding treatment goals and an 11-item questionnaire regarding drug therapy, resulting in a total of 20 questionnaire items ([Supplementary Tables 2 and 3](#)). A written version of the questionnaire survey regarding treatment goals was conducted with the PAD members, and a web-based version with non-allergists who were not PAD members (WEB panel), consisting of 210 dermatologists and pediatricians who were not certified as specialists by the Japanese Society of Allergology. The questionnaire survey regarding drug therapy was conducted on the web with the PAD members.

Formulation of topics and compilation of tentative consensus

The representatives for each theme prepared topics and compiled tentative consensus for the PAD Consensus Forums based on responses to the questionnaire surveys.

Formation of consensus

At the PAD consensus forums, the topics and tentative consensus were discussed and were put to a vote. “A consensus has been reached” was defined as 70% agreement or higher.

Results

Members of 46 PAD and 210 WEB panel responded to the questionnaire survey on treatment goals and 46 PAD members responded to that on drug therapy ([Supplementary Materials 1 and 2](#)). Based on the questionnaire survey results, the facilitators and working group members formulated topics and compiled tentative consensus ([Table 1](#)), and sought the PAD members' opinions. As a result, consensus on 3 topics of treatment goals and 4 of drug therapy were obtained.

Goals of treatment

Important points in the short/medium- and long-term treatment goals ([Table 2](#))

In the questionnaire survey results, many respondents among both PAD and WEB panel members selected “Itch is suppressed,” “Eczema is suppressed or if present, mild,” or “Controlled by drug therapy” as short-term and medium-term attainment targets. As long-term attainment targets, many respondents among the PAD members selected “Controlled by skin care (washing and moisturizing) alone” and many respondents from the WEB panel selected “Daily life is not impaired, and QoL is high” or “Eczema is

Table 1

Topics and tentative consensus.

Topic 1: Important points in short/medium- and long-term treatment goals		
• Divide attainment targets into the short/medium term and the long term. • Link outcome measures to the primary endpoints of the HOME roadmap. • Set criteria for an itch based on the criteria below.		
Daytime		Nighttime
(1) Unbearably itchy		(1) Having little sleep
(2) Scratching in public		(2) Waking at night
(3) Sometimes scratching by hand		(3) Can sleep after scratching
(4) Itchy, but without an urge to scratch		(4) Can sleep without scratching
(5) Feeling little itchy		(5) Feeling little itchy
• Set attainment targets for the short/medium and the long term as described below.		
Term in which to attain treatment goals	Attainment targets	Primary evaluation domains of the HOME roadmap
Short/medium term (> 6 months from first visit)	Eczema is suppressed or mild	Sign
	Controlled by drug therapy	
	Itch is suppressed	Symptom
Long term (6 months or longer)	Daily life is not impaired, and QoL is high	QoL
	Controlled by skin care alone	Long-term control
• Specify the indicators of QoL by consulting CDLQI and IDQOL.		
Topic 2: Need for outcome measures for treatment goals		
• In addition to visual evaluation, it is better to utilize objective outcome measures as needed, which are not limited to TARC.		
Topic 3: Need to explain the treatment schedule to patients		
• It is better to explain the treatment schedule to patients, together with clear treatment goals.		
Topic 4: Number of applications of topical anti-inflammatory drugs in the acute phase		
• The default number of applications is twice a day, but if necessary, increase or decrease the number of applications, taking severity, adherence, etc., into account		
Topic 5: Tapering topical steroids		
• Taking the severity, efficacy of the drug, adherence, etc., into account, switch to a weaker class or decrease the number of applications.		
Topic 6: Proper use of topical steroids and tacrolimus ointment in proactive therapy		
• Taking the efficacy and safety of the drugs, etc., into account, consider topical medium-class steroids for patients younger than 2 years of age and tacrolimus ointment for patients 2 years of age or older.		
Topic 7: Proper use of topical steroids and tacrolimus ointment for severe patients		
• No tentative consensus proposed.		
Topic 8: Criteria for discontinuing proactive therapy		
• If proactive therapy is working well, consider discontinuing it.		
Topic 9: Regarding the experience of using tacrolimus ointment on the scrotum		
• No tentative consensus proposed.		
CDLQI: the children's dermatology life quality index, HOME; Harmonising Outcome Measures for Eczema, IDQOL: infant's dermatology life quality index; QoL; quality of life.		

Table 2

Obtained consensus: Important points in the short/medium- and long-term treatment goals.

Treatment goals of pediatric atopic dermatitis (PAD)		
Important points in short/medium- and long-term treatment goals		
- When instructing patients, divide time to attaining treatment goals into "short/medium term" and "long term." - Modify the length of these terms of each patient based on the physician's judgment. - Associate attainment targets in the short/medium and the long term with the primary evaluation domains of the HOME roadmap.		
Time to attainment of treatment goals	Attainment targets [†]	Primary evaluation domains of the HOME roadmap [‡]
Short/medium term	Eczema is suppressed or mild Controlled by drug therapy No scratching	Sign
Long term	Controlled by skin care alone Daily life is not impaired	Long-term control QoL

HOME, Harmonising Outcome Measures for Eczema; QoL, quality of life.

[†] Use the same attainment targets irrespective of severity.

[‡] Do not use the symptom domain (subjective symptoms), as it may not be evaluable in some children.

suppressed or if present, mild" ([Supplementary Material 1, Q4](#)). Based on the results, which showed the short/medium term attainment targets were the same, a tentative consensus, "Divide attainment targets to be set into those for the short/medium term and those for the long term," was proposed, and was agreed on. Because the length of these terms varies among patients, it has been decided that the length should be modified according to the physicians' judgment.

Next, attainment targets were discussed. Based on the responses to the questionnaire survey described above, tentative consensus on attainment targets for the short/medium term and the long term was reached ([Table 2](#)). In addition, the attainment targets set were associated with the primary evaluation domains of the HOME roadmap (the sign, symptom, long-term control, and QoL domains). After discussing the tentative consensus, the following attainment targets proposed in the tentative consensus were agreed on: "Eczema is suppressed or mild (sign)," "Controlled by drug therapy (sign)," and "Controlled by skin care alone (long-term control)." An attainment target that had not been agreed on, "Itch is suppressed (symptom)," was modified to "No scratching (sign)" and was agreed on. This modification was made because there was an opinion that for children, younger children in particular, who cannot describe their itch properly, it is more appropriate to evaluate their itch by the sign domain, which physicians can judge, than the symptom domain, which is based on subjective symptoms. Another attainment target that had not been agreed on, "Daily life is not impaired, and QoL is high," was also modified by removing "QoL is high" from the long-term attainment targets, because there was no common view regarding the most appropriate indicator of QoL in a systematic review¹⁶ or the HOME meeting^{7–11}; following the modification a consensus was obtained.

As for need to set different attainment targets for the short/medium term versus the long term depending on the severity of patients, more than 70% were of the opinion, "Use the same attainment targets irrespective of severity".

Need for outcome measures for treatment goals

In the results of the questionnaire survey, a generally high proportion of respondents among both PAD and WEB panel members responded that they were "not using" objective indicators, but some PAD members responded that they were using "serum TARC" as an indicator ([Supplementary Material 1, Q5](#)). A

Table 3

Obtained consensus: Need for outcome measures for treatment goals and the explanation of the treatment schedule with clear treatment goals.

Treatment goals of pediatric atopic dermatitis (PAD)
Need for outcome measures for treatment goals
In addition to visual evaluation, it is better to utilize objective outcome measures as needed, which are not limited to TARC.
Need to explain the treatment schedule to patients, together with clear treatment goals
It is better to explain the treatment schedule to patients, together with clear treatment goals.

systematic review on the correlation between biomarkers and the severity of AD¹⁷ reported that TARC is the biomarker that correlated most strongly with severity, while clinical findings are important in evaluating treatment goals. Therefore, a tentative consensus, "In addition to visual evaluation, it is better to utilize objective outcome measures as needed, which are not limited to TARC," was proposed and agreed on ([Table 3](#)).

Need to explain the treatment schedule, together with clear treatment goals to patients

Ways to explain treatment goals to patients based on the attainment targets obtained were discussed. In the results of the questionnaire survey, a high proportion of the respondents answered that an advantage of explaining treatment goals is that "it increases patients' motivation for treatment" (72% of PAD and 63% of WEB), while a disadvantage is that "it increases examination time" (66% of PAD and 60% of WEB) ([Supplementary Material 1, Q8](#)). Moreover, 81% of the PAD members responded that they "always explain" or "usually explain" the treatment schedule with clear treatment goals to patients, while a lower proportion of the WEB panel, 44%, had the same responses ([Supplementary Material 1, Q7](#)). Therefore, the PAD members' opinions were sought on a tentative consensus, "It is better to explain the treatment schedule to patients, together with clear treatment goals," and a consensus was obtained ([Table 3](#)).

Drug therapy ([Table 4](#))

Number of applications of topical anti-inflammatory drugs in the acute phase

As for the number of applications of topical anti-inflammatory drugs, among pediatricians, the most common response was

Table 4

Obtained consensus: Drug therapy of pediatric atopic dermatitis (PAD).

Drug therapy of PAD
Number of applications of topical anti-inflammatory drugs in the acute phase
- The default number of applications is twice a day. - If necessary, increase or decrease the number of applications, taking severity, adherence, etc., into account
Tapering topical steroids
Taking the severity, efficacy of the drug, adherence, etc., into account, switch to a weaker class or decrease the number of applications.
Proper use of topical steroids and tacrolimus ointment in proactive therapy
- Taking the efficacy and safety of the drugs, etc., into account, use them as follows: - For patients younger than 2 years of age, use topical medium-class steroids. - For patients 2 years of age or older, use tacrolimus ointment.
Ideal intervals between applications of topical anti-inflammatory drugs in proactive therapy
It is ideal that the lesion can be controlled by once-a-week application (assuming that proactive therapy is applied to a lesion that was "moderate" in severity at the first visit and had undergone recurrent exacerbation).

"twice a day for all topical drugs" (excluding the answer, "do not prescribe"), and among dermatologists, the most common response was similarly "twice a day for strong-class, medium-class, and weak-class topical drugs" (Supplementary Material 2, Q1). Both pediatricians and dermatologists thought that severity and adherence are important in determining the number of applications (Supplementary Material 2, Q2). Based on these results, as for the number of applications of topical anti-inflammatory drugs in the acute phase, a tentative consensus, "the default number of applications is twice a day, but if necessary, increase or decrease the number of applications, taking severity, adherence, etc., into account" was proposed and agreed on.

Tapering topical steroids

As for the methods for tapering topical steroids, both pediatricians and dermatologists selected "switching to a weaker class, decreasing the number of applications, or both" in a similar ratio (Supplementary Material 2, Q3), and many of them responded that they thought "the severity, efficacy of the drug, and adherence" are important in selecting methods (Supplementary Material 2, Q4). Based on these results, as for the methods for tapering topical steroids, a tentative consensus, "Taking the severity, efficacy of the drug, adherence, etc., into account, switch to a weaker class or decrease the number of applications," was proposed and agreed on.

Proper use of topical steroids and tacrolimus ointment in proactive therapy

The most common response by both dermatologists and pediatricians was that "medium-class topical steroids are used for patients younger than 2 years of age and tacrolimus ointment 0.03% for Pediatric (hereinafter tacrolimus ointment) is used for patients 2 years of age or older" (Supplementary Material 2, Q7). The most common response as reasons for selection was that the "efficacy and safety of the drugs are thought to be important" (Supplementary Material 2, Q8). Based on these results, as for the proper use of topical steroids and tacrolimus ointment in proactive therapy, a tentative consensus, "Taking the efficacy and safety of the drugs, etc., into account, consider applying proactive therapy with topical medium-class steroids for patients younger than 2 years of age and tacrolimus ointment for patients 2 years of age or older," was proposed and agreed on.

Ideal intervals between applications of topical anti-inflammatory drugs in proactive therapy

The number of applications in proactive therapy was discussed, although a tentative consensus for this had not been prepared in advance. When opinions were sought as to the ideal intervals between applications for a hypothetical lesion that was "moderate" in severity at the first visit and had undergone recurrent exacerbation, with the choice of "once every 2 weeks" or "once a week," the consensus, "It is ideal that the lesion can be controlled by once-a-week application," was obtained.

Discussion

In the PAD Consensus Forums, which were held to obtain common views among dermatologists and pediatricians, 2 themes were discussed: those of treatment goals and drug therapy. Consensus was reached on 3 topics of treatment goals and 4 of drug therapy. Representative topics were the attainment targets to achieve short/medium-, and long-term treatment goals and the proper use of topical anti-inflammatory drugs (topical steroids and tacrolimus ointment in proactive therapy), which were supplementary to the Japanese Guidelines for Atopic Dermatitis 2015 and

Clinical Practice Guidelines for the Management of Atopic Dermatitis 2016.

Attainment targets for the short/medium and the long term were set in association with the primary evaluation domains of the HOME roadmap. A consensus that short/medium-term attainment targets should be linked to "sign" domain and long-term attainment targets to "long-term control" and "QoL" domains was obtained. Regarding drug therapy, a consensus was reached for the number of applications of topical anti-inflammatory drugs in the acute phase, which was twice a day. Moreover, consensus by age was obtained for the proper use of topical steroids and tacrolimus ointment in proactive therapy, which had not been described specifically in the guidelines. In the new guidelines, the selection of strength of topical steroids has been changed, and it is no longer considered necessary to use weaker classes depending on the age of a patient.¹⁵ Conceivably, the consensus on drugs used in proactive therapy obtained in the forums can be supplementary to the new guidelines.

On the other hand, there were topics that were selected for discussion but for which no consensus was obtained for (Table 1). For the proper use of topical steroids and tacrolimus ointment for severe patients, no consensus was obtained. One reason for this may be that dermatologists and pediatricians assumed different age groups of patients for the treatments. When their opinions were sought regarding the selection of topical anti-inflammatory drugs for patients younger than 2 years of age, for those 2–12 years of age, and for those 13–15 years of age, it was found during discussion that pediatricians assumed children before entering elementary school (2–5 years old) as typical patients of 2–12 years of age, while dermatologists assumed older children. For example, for patients aged 2–12 years, 38% of the dermatologists responded that they use a very strong class of topical anti-inflammatory drugs on the head in the introduction period, while only 14% of the pediatricians had the same response. In contrast, 46% of the dermatologists responded that they use a strong class, while 64% of the pediatricians had the same response. In principle, for infants and children, steroids weaker than those used for adults by 1 class are selected,¹⁴ which suggests the importance of defining age groups properly to obtain a consensus on pediatric drug therapy. As for tacrolimus ointment, there were opinions of both dermatologists and pediatricians that tacrolimus ointment can be a first-line drug in remission maintenance in patients 2 years of age or older, although it may cause irritation in remission induction. However, no specific consensus was obtained. One reason for this may be that a limit on the amount of tacrolimus ointment to be applied in Japan makes it difficult to gather specific opinions regarding its concurrent use with a steroid. No consensus was also reached regarding the prescription of tacrolimus ointment 0.03% on the scrotum. The scrotum is a difficult site to treat requiring appropriate selection of drug therapy, for which further study should be conducted in the future.

PAD is treated in various clinical departments, including dermatology and pediatrics, and clinical management tends to be different because of the specialty of each department.^{18,19} Although eczema is the main lesion in AD, AD can subsequently lead to other allergic diseases.⁶ Therefore, it is desirable to form consensus among the specialists in each department. Consensus meetings on the theme of the diagnosis and treatment of AD involving various specialists have been reported.^{12,20,21} Although the need to explain treatment goals to patients has been reported in previous literature,²⁰ the formation of specific consensus regarding attainment targets for the short/medium and long term is a new development obtained through our activities. As for the selection of topical anti-inflammatory drugs, selecting the strength of steroids based on the

severity of eczema was the same consensus as those previously reported. However, a consensus regarding the selection of drugs based on age in proactive therapy had not been reported previously, and the number of applications was different from those described in a previous report.¹²

Questionnaire surveys were conducted prior to the Consensus Forums to identify similarities and differences between dermatologists and pediatricians and between specialists and non-specialists, and then in the forums, dermatological specialists and pediatric specialists held discussions to obtain common views leading to the formation of consensus, which took account of the needs of non-specialists in clinical practice. In the current study, the frequency of explaining treatment goals to patients was found to be different between specialists and non-specialists. In order to explain treatment goals, attainment targets for the short/medium and the long term, which were not described specifically in the guidelines, have been specified by dermatological specialists and pediatric specialists. Attainment targets for the short/medium and long term that were prepared by specialists and clearly described as common views are expected to contribute to diagnosis and treatment of AD by non-specialists.

A limitation of this activity is that no study has been conducted to verify the obtained consensus. For example, it has not been verified as to whether setting attainment targets for the short/medium and long term motivates patients to treat disease or improves therapeutic effects. In proactive therapy, a direct comparison between topical steroids and tacrolimus ointment has not been performed and the ideal number of applications has also not been verified. In many literature, the ideal number of applications was twice a week or more in many reports,^{22–24} but one report demonstrated no statistically significant difference between once weekly and thrice weekly applications.²⁵ Consensus obtained from these Consensus Forums was derived from common views based on physicians' opinions, and therefore, verification studies based on the obtained consensus will be needed to discuss differences from previous reports.

As described above, consensus on several topics has been obtained regarding treatment goals and drug therapy for pediatric AD. For some topics, no consensus has been obtained, but causes and issues were suggested. Further discussion will be needed to form consensus in the future. The results from these Consensus Forums is expected to contribute to treatment for pediatric AD.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.alit.2019.08.006>.

Conflict of interest

HA, KI, IO, IK, NK and KY received a research grant from Maruho. KI, IK and KY received lecture fees from Maruho. AK and TNo are employees of Maruho. The rest of the authors have no conflict of interest.

Authors' contributions

HA, IK, NK, NS, and HM contributed to the management of the Consensus Forums, the preparation of questionnaires, and the analysis of the results of questionnaire surveys. KI, IO, YK, TNa, KH, TF, and KY contributed to the preparation of

questionnaires and the analysis of the results of questionnaire surveys. AK and TNo produced the main draft of this manuscript. All authors reviewed the manuscript and approved the submission of the final version.

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Supplementary Table 1: Names and affiliations of PAD members[†]

Name	Affiliations [‡] :
Facilitators[§] (assigned themes)	
Michiko Aihara (Chronic scratching)	Department of Environmental Immuno-Dermatology, Yokohama City University Graduate School of Medicine, Yokohama, Japan
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Ichiro Katayama (Treatment goals)	Department of Dermatology, Course of Integrated Medicine, Graduate School of Medicine, Osaka University, Suita, Japan
Norito Katoh (Drug therapy)	Department of Dermatology, Kyoto Prefectural University of Medicine, Graduate School of Medical Science, Kyoto, Japan
Naoki Shimojo (Drug therapy)	Department of Pediatrics, Graduate School of Medicine, Chiba University, Chiba, Japan
Takao Fujisawa (Chronic scratching)	Allergy Center, Mie National Hospital, Tsu, Japan
Working group members (assigned themes)	
Ken Igawa (Drug therapy)	Department of Dermatology, Dokkyo Medical University, School of Medicine, Shimotsuga, Japan
Ikuo Okafuji (Drug therapy)	Department of Pediatrics, Kobe City Medical Center General Hospital, Kobe, Japan
Sakae Kaneko (Chronic scratching)	Department of Dermatology, Faculty of Medicine, Shimane University, Izumo, Japan
Yasusuke Kawada (Treatment goals)	Kawada Children and Allergy Clinic, Hamamatsu, Japan
Yasuyuki Sumikawa (Chronic scratching)	Department of Dermatology, Sapporo Medical University School of Medicine, Sapporo, Japan
Takeshi Nakahara (Treatment goals)	Division of Skin Surface Sensing, Department of Dermatology, Graduate School of Medical Sciences, Kyushu University, Fukuoka, Japan
Shunji Hasegawa (Chronic scratching)	Department of Pediatrics, Yamaguchi University Graduate School of Medicine, Ube, Japan
Kazumi Hiraba (Drug therapy)	Mokubo Pediatric Clinic, Marugame, Japan
Tatsuki Fukuie (Treatment goals)	Division of Allergy, Department of Medical Subspecialties, National Center for Child Health and Development, Tokyo, Japan
Hiroyuki Murota (Treatment goals)	Department of Dermatology, Course of Integrated Medicine, Graduate School of Medicine, Osaka University, Suita, Japan
Chikako Motomura (Chronic scratching)	Department of Pediatrics, National Hospital Organization, Fukuoka National Hospital, Fukuoka, Japan
Keiichi Yamanaka (Drug therapy)	Department of Dermatology, Mie University, Graduate School of Medicine, Tsu, Japan
PAD Consensus Forum Participants	
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Kazumori Ishiguro	Ishiguro Dermatology Clinic, Sakai, Japan
Norihiro Inoue	Department of Pediatrics, National Hospital Organization Osaka Minami Medical Center, Kawachinagano, Japan
Yuzaburo Inoue	Department of Pediatrics, Eastern Chiba Medical Center, Togane, Japan
Takanori Imai	Department of Pediatrics, Showa University School of Medicine, Tokyo, Japan
Takafumi Etoh	Department of Dermatology, Tokyo Teishin Hospital, Tokyo, Japan
Tamotsu Ebihara	Department of Dermatology, Keio University School of

Yukihiro Ohya	Medicine, Tokyo, Japan Division of Allergy, Department of Medical Subspecialties, National Center for Child Health and Development, Tokyo, Japan
Kuniyuki Okada	OKADA Kodomonomori Clinic, Kasukabe, Japan
Kazumoto Katagiri	Department of Dermatology, Dokkyo Medical University Saitama Medical Center, Koshigaya, Japan
Naoyuki Kando	KANDO Kid's Allergy CLINIC, Toyoake, Japan
Naotomo Kambe	Department of Dermatology, Kansai Medical University, Hirakata, Japan
Seigo Korematsu	Department of Pediatrics, Nakatsu Municipal Hospital, Nakatsu, Japan
Yasuto Kondo	Department of Pediatrics, Fujita Health University Hospital, Nagoya, Japan
Hidehisa Saeki	Department of Dermatology, Nippon Medical School, Tokyo, Japan
Makoto Sugaya	Department of Dermatology, International University of Health and Welfare, Narita, Japan
Takumi Takizawa	Department of Pediatrics, Graduate School of Medicine, Gunma University, Maebashi, Japan
Hiroshi Tachimoto	Department of Pediatrics, The Jikei University School of Medicine, Tokyo, Japan
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Kenta Horimukai	Department of Pediatrics, Jikei University Katsushika Medical Center, Tokyo, Japan
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Setsuko Matsukura	Department of Dermatology, Saiseikai Yokohamashi Nanbu Hospital, Yokohama, Japan
Tomoyo Matsubara	Department of Pediatrics, Dokkyo Medical University Saitama Medical Center, Koshigaya, Japan
Akira Manki	Department of Pediatrics, Okayama City Hospital, Okayama, Japan
Katsushi Miura	Department of Allergy, Miyagi Children's Hospital, Sendai, Japan
Shoji Mihara	Mihara Dermatology and Allergy Clinic, Hiroshima, Japan

[†]A member of the Japanese Society of Allergology or the Japanese Dermatological Association

[‡]As of March 31, 2018

[§]Physician who was in charge of the management of the forums and the planning and preparation of questionnaires

[¶]Physician who was in charge of the planning and preparation of questionnaires

Supplementary Table 2: Questionnaire items regarding treatment goals

Q1: Do you have the 2012 or 2015 edition of the “Japanese Guidelines for Atopic Dermatitis” of the Japanese Society of Allergology?

Q2: Have you ever seen the “Clinical Practice Guidelines for the Management of Atopic Dermatitis 2009” of the Japanese Dermatological Association?

Q3: Do you perform treatment in accordance with the guidelines, reflecting the pediatric atopic dermatitis treatment goals of each guideline?

Q4: If the treatment goals for reducing skin symptoms of pediatric atopic dermatitis are divided into the short-, medium-, and long-term, please select the items you put the greatest emphasis and the second greatest emphasis on for each term.

	Short-term treatment goals (First visit to 1 month later)	Medium-term treatment goals (1 month to 6 months later)	Long-term treatment goals (6 months to $\geq$ 1 year)
(1) Eczema is suppressed or if present, mild.			
(2) Although mild symptoms persist, acute exacerbation is rare and not prolonged.			
(3) Itch is suppressed.			
(4) Symptoms are being controlled by drug therapy.			
(5) Symptoms are being controlled by skin care (washing/moisturizing) alone.			
(6) Neither drug therapy nor skin care (washing/moisturizing) is necessary.			
(7) Daily life is not impaired, and QoL is			

high.			
(8) Other (free description)			

Q5: Do you generally use objective indicators as a method of assessment of the treatment goals of pediatric atopic dermatitis? Please select the item you put the greatest emphasis on for each term.

	Short-term treatment goals (First visit to 1 month later)	Medium-term treatment goals (1 month to 6 months later)	Long-term treatment goals (6 months to $\geq$ 1 year)
(1) Serum TARC	☐	☐	☐
(2) EASI	☐	☐	☐
(3) SCORAD	☐	☐	☐
(4) Itching VAS	☐	☐	☐
(5) Not used	☐	☐	☐
(6) Other (free description)			

Q6: How much time do you think it actually takes to achieve the treatment goals of pediatric atopic dermatitis?

	Mild	Moderate	Severe	Most severe
(1) Short-term (first visit to < 1 month)	☐	☐	☐	☐
(2) Medium-term (1 month to < 6 months)	☐	☐	☐	☐
(3) Long-term (6 months to $\geq$ 1 year)	☐	☐	☐	☐
(4) Until remission	☐	☐	☐	☐
(5) Patient not seen	☐	☐	☐	☐

<Severity classification of the Japanese Society of Allergology, based on the Japanese Guidelines for Atopic Dermatitis 2015>

Mild: Only mild eczema are observed, irrespective of the area.

Moderate: Eczema with severe inflammation are observed over less than 10% of the body surface area.

Severe: Eczema with severe inflammation are observed over $\geq$ 10% to < 30% of the body surface area.

Most severe: Eczema with severe inflammation are observed over $\geq$ 30% of the body surface area.

Q7: Do you usually explain to your patients about the treatment schedule from the perspective of the treatment goals of pediatric atopic dermatitis?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Not very often
- ☐ Not at all

Q8: What do you consider to be advantages and disadvantages of explaining the treatment goals of pediatric atopic dermatitis? (Multiple answers allowed)

Advantages

- ☐ Increases patients' motivation for treatment.
- ☐ Increases treatment compliance.
- ☐ Increases improvement rate of eczema.
- ☐ Reduces dropout rate of patients
- ☐ Reduces guardians' anxiety
- ☐ Other [free description]

Disadvantages

- ☐ Increases examination time
- ☐ Increases physician's burden by additional contents of explanation
- ☐ Response to poor control cases
- ☐ Other [free description]

Q9: What do you consider to be challenges in explaining the treatment goals? [Free description]

Supplementary Table 3: Questionnaire items regarding drug therapy

Q1: Regarding the number of applications of each topical anti-inflammatory drug in the treatment of acute-phase pediatric atopic dermatitis, please select the applicable category(ies) as the instructions for each prescription (multiple answers allowed).

		Once a day	Twice a day	≥ 3 times a day	Never prescribed
Topical steroids	Strongest class	☐	☐	☐	☐
	Very strong class	☐	☐	☐	☐
	Strong class	☐	☐	☐	☐
	Medium (mild) class	☐	☐	☐	☐
	Weak class	☐	☐	☐	☐
Tacrolimus ointment 0.03%		☐	☐		☐

Q2: Please select the degree of emphasis for the following items in determining the number of applications of topical anti-inflammatory drugs in the treatment of acute-phase pediatric atopic dermatitis.

	Much emphasis	Some emphasis	Neutral	Not much emphasis	No emphasis
Contents of guideline	☐	☐	☐	☐	☐
Evidence	☐	☐	☐	☐	☐
Severity	☐	☐	☐	☐	☐
Efficacy	☐	☐	☐	☐	☐
Safety	☐	☐	☐	☐	☐
Duration of prescription	☐	☐	☐	☐	☐
Adherence	☐	☐	☐	☐	☐
Economic burden of the patient	☐	☐	☐	☐	☐
Time burden of the patient	☐	☐	☐	☐	☐
Other ()	☐	☐	☐	☐	☐

Q3: Regarding the method of tapering topical steroids in the treatment of pediatric atopic dermatitis in patients whose symptoms improved from the acute phase at the time of revisit, please select the applicable category(ies) as instructions when prescribing (multiple answers allowed).

Switched to a weaker class	%
Switched to a weaker class with a decreased number of applications	%
The number of applications is decreased.	%
	100%

Q4: Please select the degree of emphasis for the following items in determining the method of tapering topical steroids in the treatment of pediatric atopic dermatitis.

	Much emphasis	Some emphasis	Neutral	Not much emphasis	No emphasis
Contents of guideline	☐	☐	☐	☐	☐
Evidence	☐	☐	☐	☐	☐
Severity	☐	☐	☐	☐	☐
Efficacy	☐	☐	☐	☐	☐
Safety	☐	☐	☐	☐	☐
Duration of prescription	☐	☐	☐	☐	☐
Adherence	☐	☐	☐	☐	☐
Economic burden of the patient	☐	☐	☐	☐	☐
Time burden of the patient	☐	☐	☐	☐	☐
Other ()	☐	☐	☐	☐	☐

Q5: Please select the degree of emphasis for the following items in proper use of topical steroids and tacrolimus ointment in the treatment of pediatric atopic dermatitis in patients ≥ 2 years of age.

	Much emphasis	Some emphasis	Neutral	Not much emphasis	No emphasis
Site of eczema	☐	☐	☐	☐	☐
Period of use (Remission induction and remission maintenance)	☐	☐	☐	☐	☐
Severity of eczema	☐	☐	☐	☐	☐
Efficacy	☐	☐	☐	☐	☐
Safety	☐	☐	☐	☐	☐
Dosage form	☐	☐	☐	☐	☐
Limitation of dosage	☐	☐	☐	☐	☐
Request of patient/guardian	☐	☐	☐	☐	☐
Time spent for explanation to patients and guardians	☐	☐	☐	☐	☐
Economic burden of the patient	☐	☐	☐	☐	☐
Time burden of the patient	☐	☐	☐	☐	☐
Other ()	☐	☐	☐	☐	☐

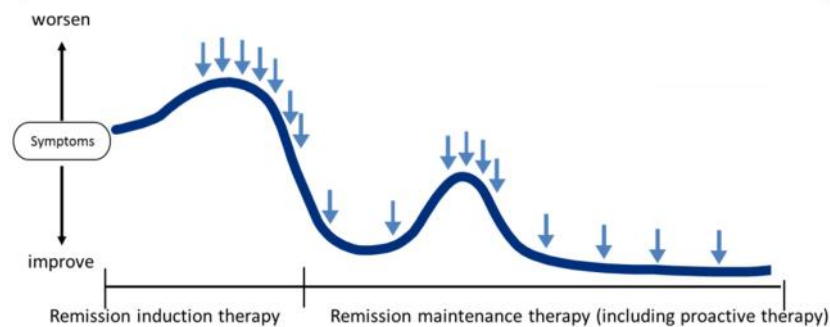
Q6: In the case of severe eczema at each of the following sites at the time of the first visit in the treatment of pediatric atopic dermatitis, please select the applicable category for each item regarding the topical anti-inflammatory drugs you use as the first-line drug.

Note1) Please see the table below for definitions of remission induction therapy and remission maintenance therapy, and severity criteria.

Note2) Please see the diagram below for definitions of remission induction therapy and remission maintenance therapy.

	Severity of eczema
Severe	Erythema associated with severe swelling/edema/infiltration or lichenification, multiple papules, severe scales, scab, vesicle, erosion, multiple scratch marks, prurigo nodules
Moderate	Erythema, scales, a few papules, scratch marks, etc. of up to moderate severity
Mild	Dry and mild erythema, scales
Insignificant	Primary symptoms of dryness lacking inflammatory conditions

Symptom Status in Atopic Dermatitis Treatment



< Remission induction therapy >

A treatment method of rapidly reducing the itching and inflammation using topical steroids and tacrolimus ointment.

< Remission maintenance therapy >

A method of continuing to use topical anti-inflammatory agents after rash has subsided to some degree in patients who have achieved remission induction but cannot maintain the symptoms or those with frequent relapses (including proactive therapy)

<Remission induction/maintenance therapy in patients <2 years of age>

Remission induction/maintenance therapy	Topical steroids				
	Strongest class	Very strong class	Strong class	Medium (mild) class	Weak class
Head	□/□	□/□	□/□	□/□	□/□
Face (excluding periocular area)	□/□	□/□	□/□	□/□	□/□
Periocular area	□/□	□/□	□/□	□/□	□/□
Cervical region	□/□	□/□	□/□	□/□	□/□
Flexural areas	□/□	□/□	□/□	□/□	□/□
Trunk and extremities (excluding flexural areas)	□/□	□/□	□/□	□/□	□/□
Scrotum	□/□	□/□	□/□	□/□	□/□

<Remission induction/maintenance therapy in patients 2 to 12 years of age>

Remission induction/maintenance therapy	Topical steroids					Tacrolimus ointment
	Strongest class in patient	Very strong class	Strong class	Medium (mild) class	Weak class	
Head	□/□	□/□	□/□	□/□	□/□	□/□
Face (excluding periocular area)	□/□	□/□	□/□	□/□	□/□	□/□
Periocular area	□/□	□/□	□/□	□/□	□/□	□/□
Cervical region	□/□	□/□	□/□	□/□	□/□	□/□
Flexural areas	□/□	□/□	□/□	□/□	□/□	□/□
Trunk and extremities (excluding flexural areas)	□/□	□/□	□/□	□/□	□/□	□/□
Scrotum	□/□	□/□	□/□	□/□	□/□	

<Remission induction/maintenance therapy in patients 13 to 15 years of age>

Remission induction/maintenance therapy	Topical steroids					Tacrolimus ointment
	Strongest class	Very strong class	Strong class	Medium (mild) class	Weak class	
Head	□/□	□/□	□/□	□/□	□/□	□/□
Face (excluding periocular area)	□/□	□/□	□/□	□/□	□/□	□/□
Periocular area	□/□	□/□	□/□	□/□	□/□	□/□
Cervical region	□/□	□/□	□/□	□/□	□/□	□/□
Flexural areas	□/□	□/□	□/□	□/□	□/□	□/□
Trunk and extremities (excluding flexural areas)	□/□	□/□	□/□	□/□	□/□	□/□
Scrotum	□/□	□/□	□/□	□/□	□/□	

Q7: Which topical drug(s) do you use in the treatment of pediatric atopic dermatitis with proactive therapy using topical anti-inflammatory drugs? (Multiple answers allowed)

<Patients < 2 years of age>

Topical steroids	Strongest class	☐
	Very strong class	☐
	Strong class	☐
	Medium (mild) class	☐
	Weak class	☐
No proactive therapy performed		☐

<Patients 2 to 12 years of age>

Topical steroids	Strongest class	☐
	Very strong class	☐
	Strong class	☐
	Medium (mild) class	☐
	Weak class	☐
Tacrolimus ointment		☐
No proactive therapy performed		☐

<Patients 13 to 15 years of age>

Topical steroids	Strongest class	☐
	Very strong class	☐
	Strong class	☐
	Medium (mild) class	☐
	Weak class	☐
Tacrolimus ointment		☐
No proactive therapy performed		☐

Q8: Please select the degree of emphasis for the following items in choosing either topical steroids or tacrolimus ointment in the treatment of pediatric atopic dermatitis with proactive therapy in patients ≥ 2 years of age.

	Much emphasis	Some emphasis	Neutral	Not much emphasis	No emphasis
Evidence	☐	☐	☐	☐	☐
Efficacy	☐	☐	☐	☐	☐
Safety	☐	☐	☐	☐	☐
Duration of prescription	☐	☐	☐	☐	☐
Dosage form	☐	☐	☐	☐	☐
Limitation of dosage	☐	☐	☐	☐	☐
Request of patient/guardian	☐	☐	☐	☐	☐
Economic burden of the patient	☐	☐	☐	☐	☐
Time burden of the patient	☐	☐	☐	☐	☐
Treatment drug prior to proactive therapy	☐	☐	☐	☐	☐
Other ()	☐	☐	☐	☐	☐

Q9: Would you stop proactive therapy when the proactive therapy is working well in the treatment of pediatric atopic dermatitis?

Q10: When proactive therapy works well in the treatment of pediatric atopic dermatitis, please select the degree of emphasis for the following items as the criteria for discontinuation of proactive therapy (how long the therapy should be continued).

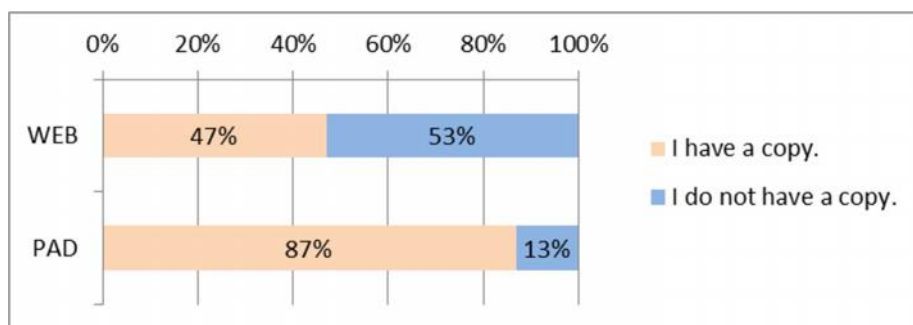
	Much emphasis	Some emphasis	Neutral	Not much emphasis	No emphasis
Duration	☐	☐	☐	☐	☐
Intervals between relapses	☐	☐	☐	☐	☐
Severity of symptoms of the most recent relapse	☐	☐	☐	☐	☐
Request of patient/guardian	☐	☐	☐	☐	☐
Other ()	☐	☐	☐	☐	☐

Q11: During the course of treatment of pediatric atopic dermatitis in patients 2 to 15

years of age, do you consider choice of tacrolimus ointment as an option for a case of severe eczema on the scrotum at the time of the first visit?

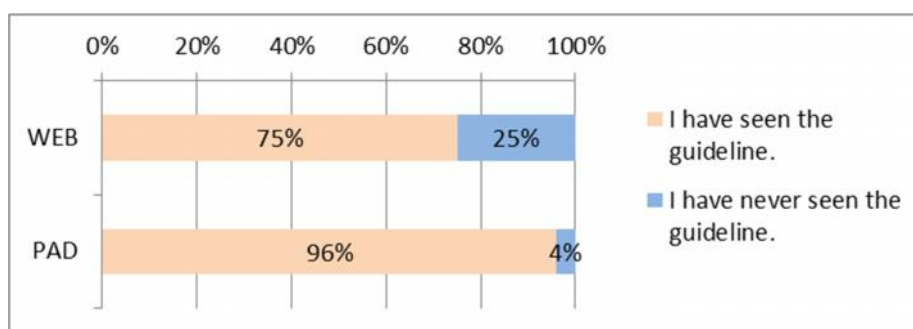
Supplementary Material 1: Responses to the questionnaire items regarding treatment goals

Q1: Do you have the 2012 or 2015 edition of the “Japanese Guidelines for Atopic Dermatitis” of the Japanese Society of Allergology?



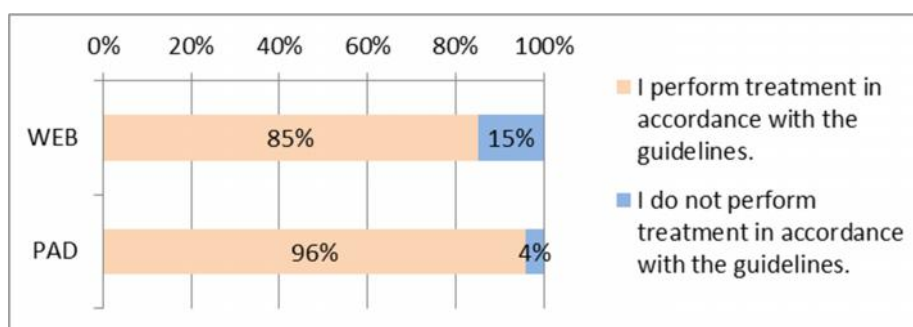
WEB (n = 210), PAD (n = 47)

Q2: Have you ever seen the “Clinical Practice Guidelines for the Management of Atopic Dermatitis 2009” of the Japanese Dermatological Association?



WEB (n = 210), PAD (n = 47)

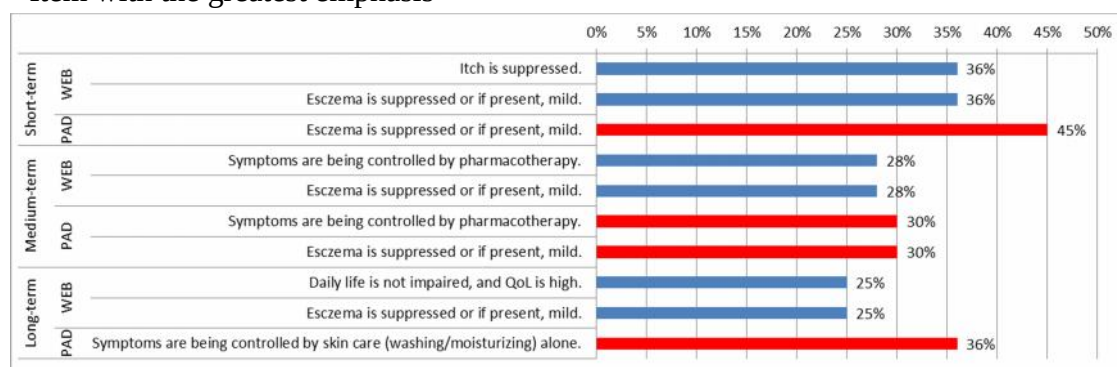
Q3: Do you perform treatment in accordance with the guidelines, reflecting the pediatric atopic dermatitis treatment goals of each guideline?



WEB (n = 210), PAD (n = 46)

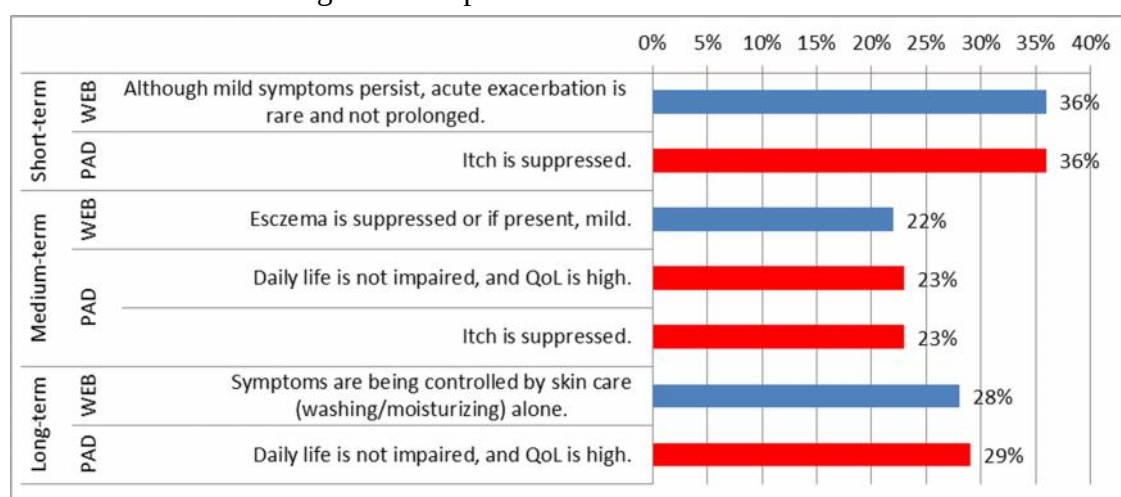
Q4: If the treatment goals for reducing skin symptoms of pediatric atopic dermatitis are divided into short-, medium-, and long-term, please select the item you put the greatest emphasis on and the second greatest emphasis for each term.

<Item with the greatest emphasis>



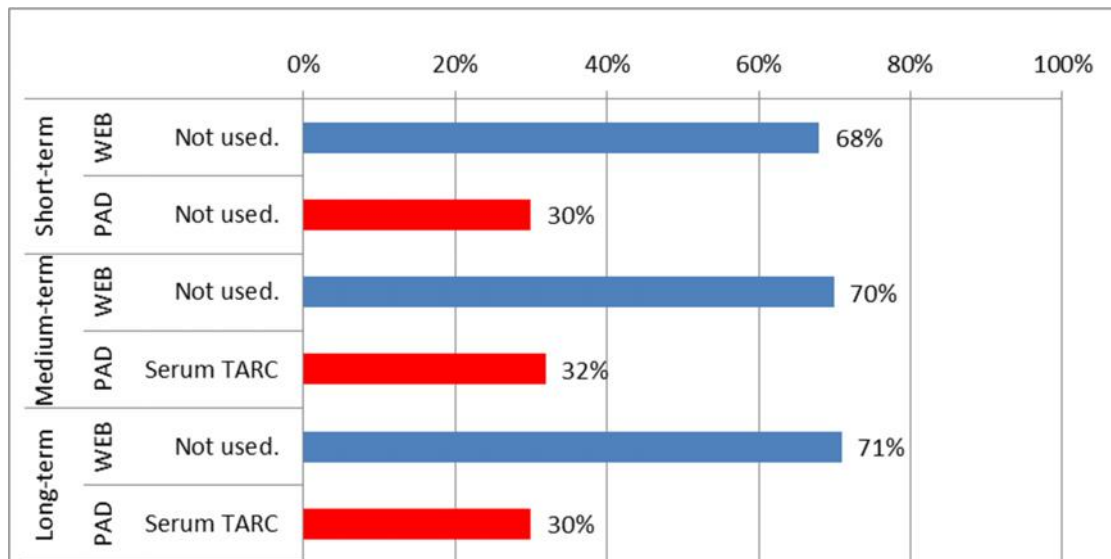
WEB (n = 210), PAD (n = 46)

<Items with the second greatest emphasis>



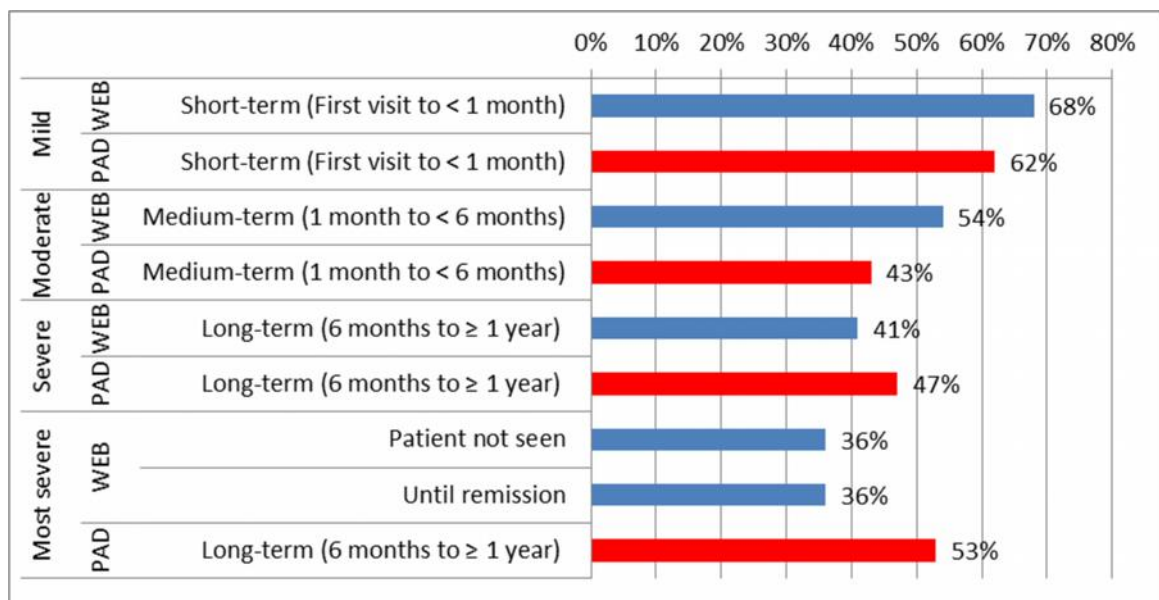
WEB (n = 210), PAD (n = 46)

Q5: Do you generally use objective indicators as a method of assessment of the treatment goals of pediatric atopic dermatitis? Please select the item you put the greatest emphasis on for each term.



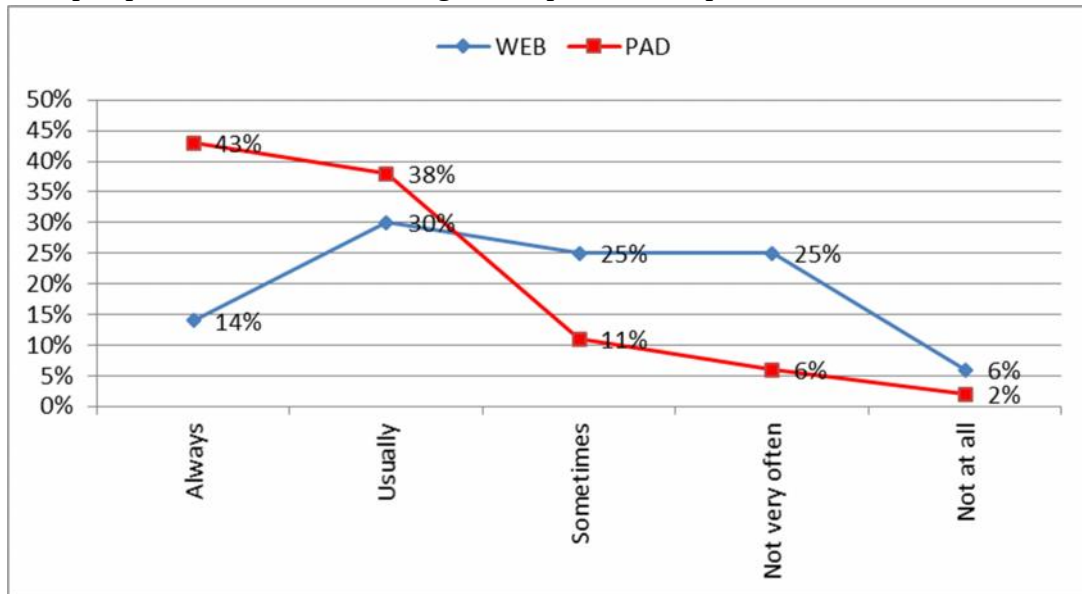
WEB (n = 210), PAD (n = 43)

Q6: How much time do you think it actually takes to achieve the treatment goals of pediatric atopic dermatitis?



WEB (n = 210), PAD (n = 43)

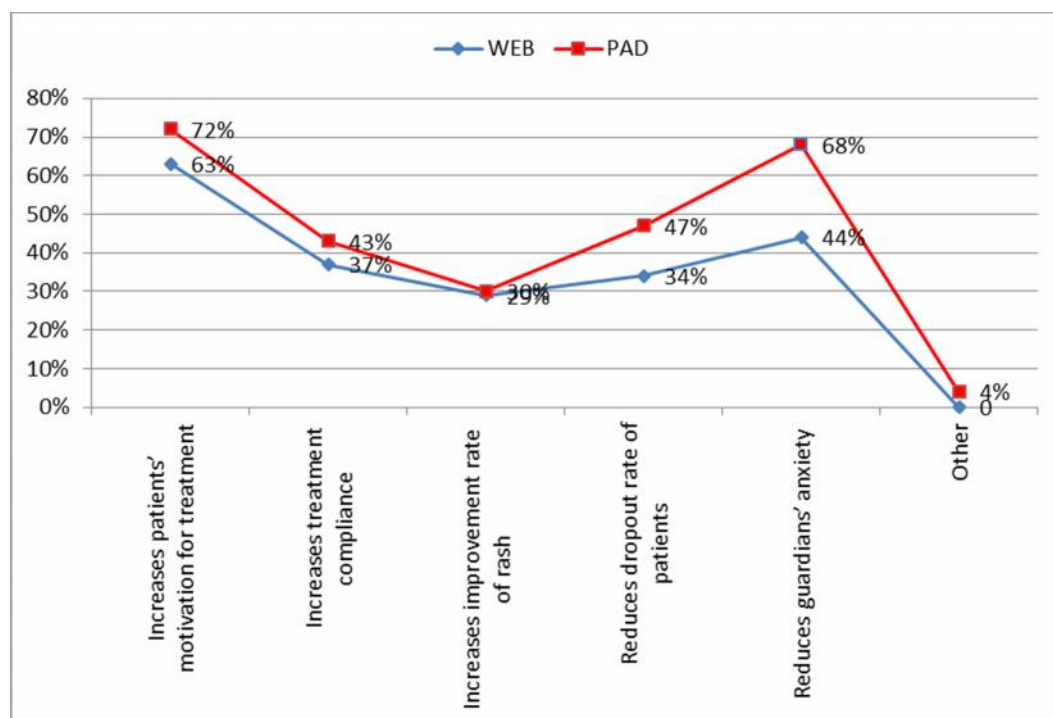
Q7: Do you usually explain to your patients about the treatment schedule from the perspective of the treatment goals of pediatric atopic dermatitis?



WEB (n = 210), PAD (n = 46)

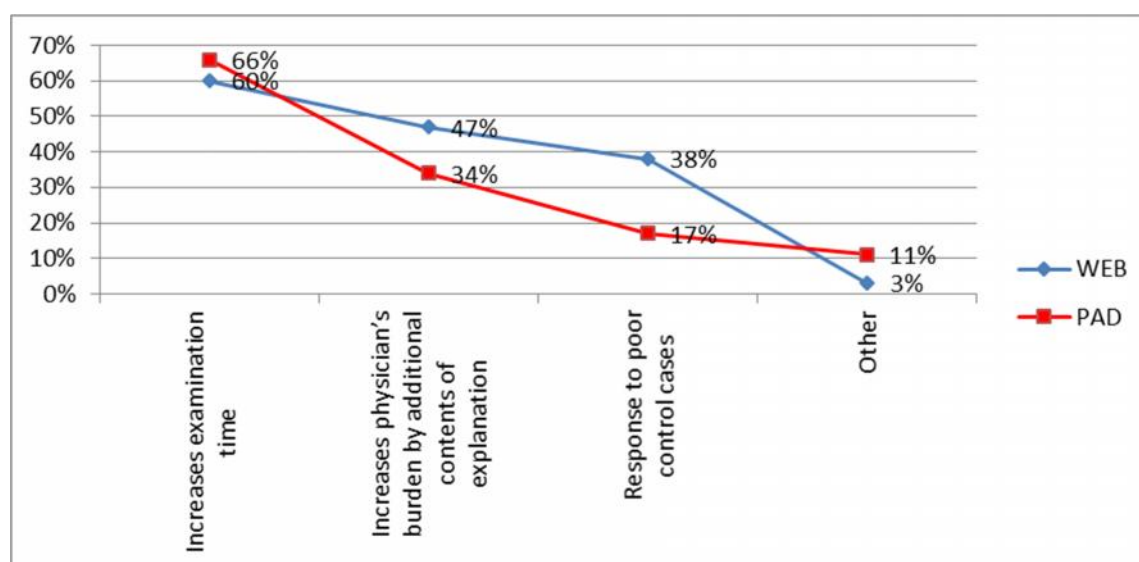
Q8: What do you consider to be advantages and disadvantages of explaining treatment goals of pediatric atopic dermatitis? (Multiple answers allowed)

<Advantages>



WEB (n = 210), PAD (n = 47)

<Disadvantages>



WEB (n = 210), PAD (n = 47)

Q9: What do you consider to be challenges in explaining the treatment goals? [Free description]

WEB Panel	PAD members
Time • There is limited time available for explanation. • Temporal restriction until the treatment goals are fully understood. • Provision of explanation time, and efficiency in explanation Explanation to patients • There are no easy-to-understand brochures available • When mothers' comprehension is insufficient. • It is questionable whether patients understand the contents and comply with the requirements. Gap among targets • What should be done if the target cannot necessarily be a goal. • Cannot proceed as designed. • The goals seem to be clear, but they are not.	Time • When there is not enough time available, it is difficult to provide a time for explanation (e.g., visit by a patient without appointment when there are many patients). • Explanation sometimes needs to be repeated, but there is not always enough time. • It is difficult to sit down and explain. There is no time or opportunity to listen to the thoughts of patients/guardians. Explanation to patients • There are differences in the explanation of contents among physicians. The important explanations, such as adverse reactions to steroids, etc. vary, which significantly affects the treatment behavior of patients. • It is sometimes difficult to make it understood that the treatment goals can only be achieved if the guardians comply with topical therapy and skin care as we expect. Gap among targets • The goals that patients seek vary occasionally. Some patients think that recovering to some extent is sufficient. • It is sometimes difficult to make it understood that the treatment goals can only be achieved if the guardians comply with topical therapy and skin care as we expect.

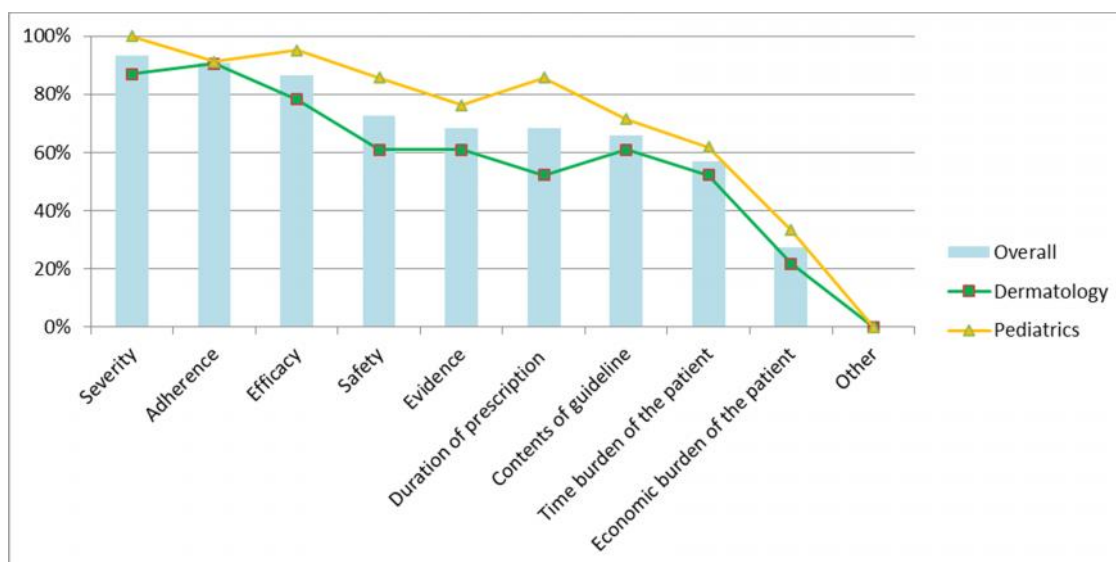
Supplementary Material 2: Responses to questionnaire regarding drug therapy

Q1: Regarding the number of applications of each topical anti-inflammatory drug in the treatment of acute-phase pediatric atopic dermatitis, please select the applicable category(ies) as the instructions for each prescription (multiple answers allowed).

Types of drugs		Department	Number of applications (response rate: %)			
			Once a day	Twice a day	3 times a day	Do not prescribe
Steroid ointment	Strongest	Dermatology	17	13	4	65
		Pediatrics	10	14	5	71
	Very strong	Dermatology	52	48	9	5
		Pediatrics	10	76	10	0
	Strong	Dermatology	44	61	9	0
		Pediatrics	0	91	19	0
	Medium (Mild)	Dermatology	35	70	0	8
		Pediatrics	0	76	24	5
Tacrolimus ointment	Weak	Dermatology	13	35	4	52
		Pediatrics	0	24	0	76
		Dermatology	70	30	0	13
		Pediatrics	24	43	0	33

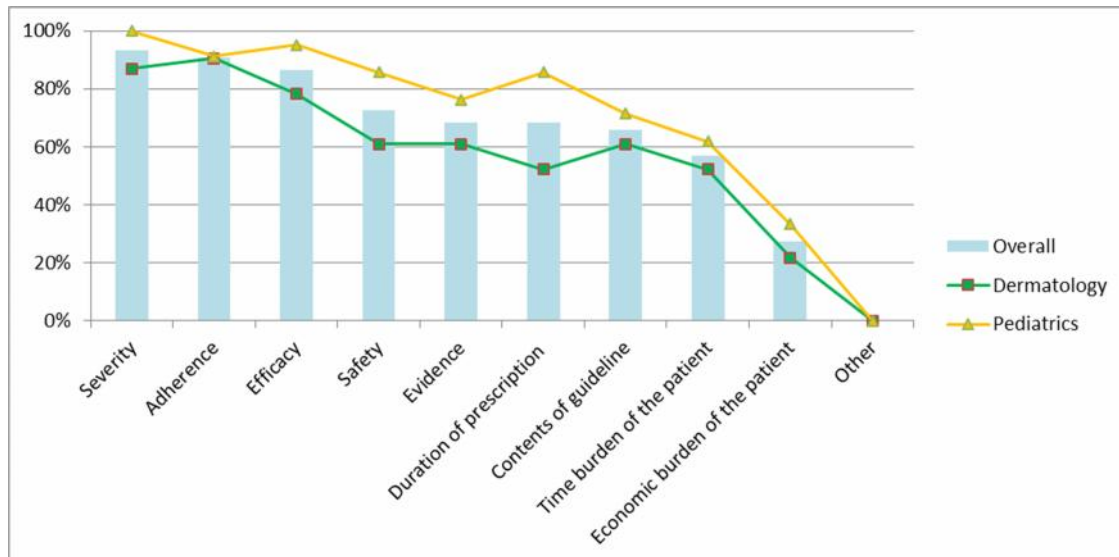
Dermatology (n = 23), Pediatrics (n = 21)

Q2: Please select the degree of emphasis for the following items in determining the number of applications of topical anti-inflammatory drugs in the treatment of acute-phase pediatric atopic dermatitis.



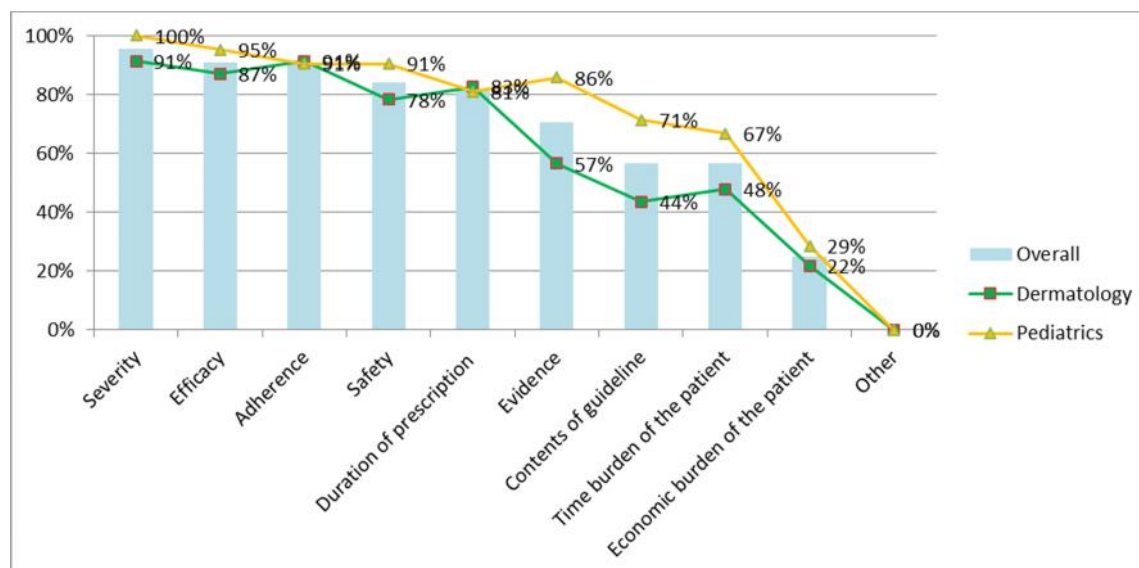
Dermatology (n = 23), Pediatrics (n = 21)

Q3: Regarding the method of tapering topical steroids in the treatment of pediatric atopic dermatitis in patients whose symptoms improved from the acute phase at the time of revisit, please select the applicable category(ies) as the instructions when prescribing (multiple answers allowed).



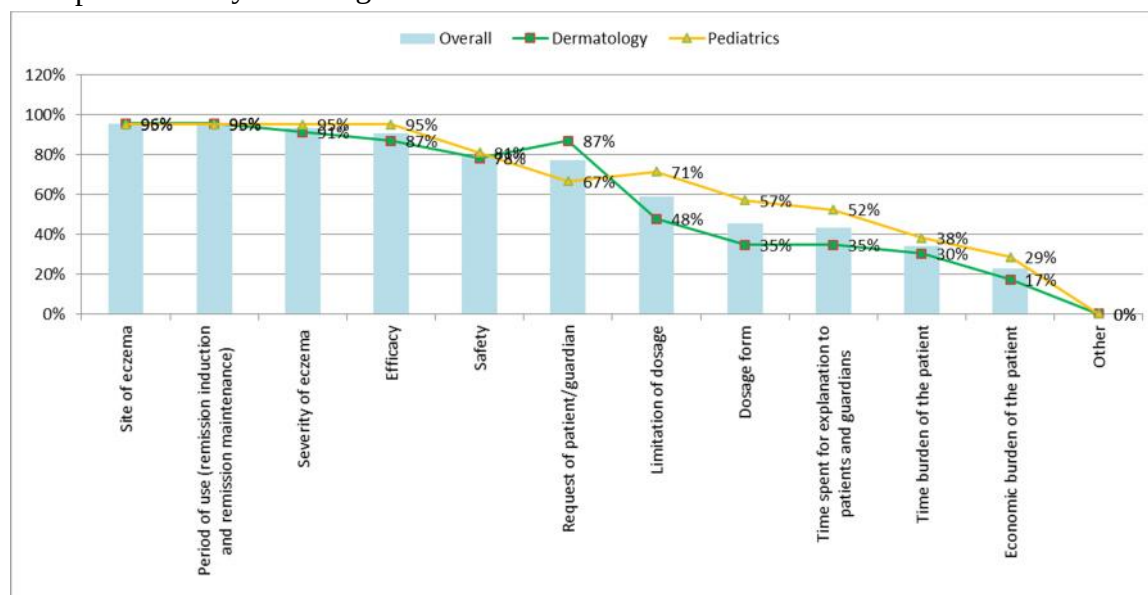
Dermatology (n = 23), Pediatrics (n = 21)

Q4: Please select the degree of emphasis for the following items in determining the method of tapering topical steroids in the treatment of pediatric atopic dermatitis.



Dermatology (n = 23), Pediatrics (n = 21)

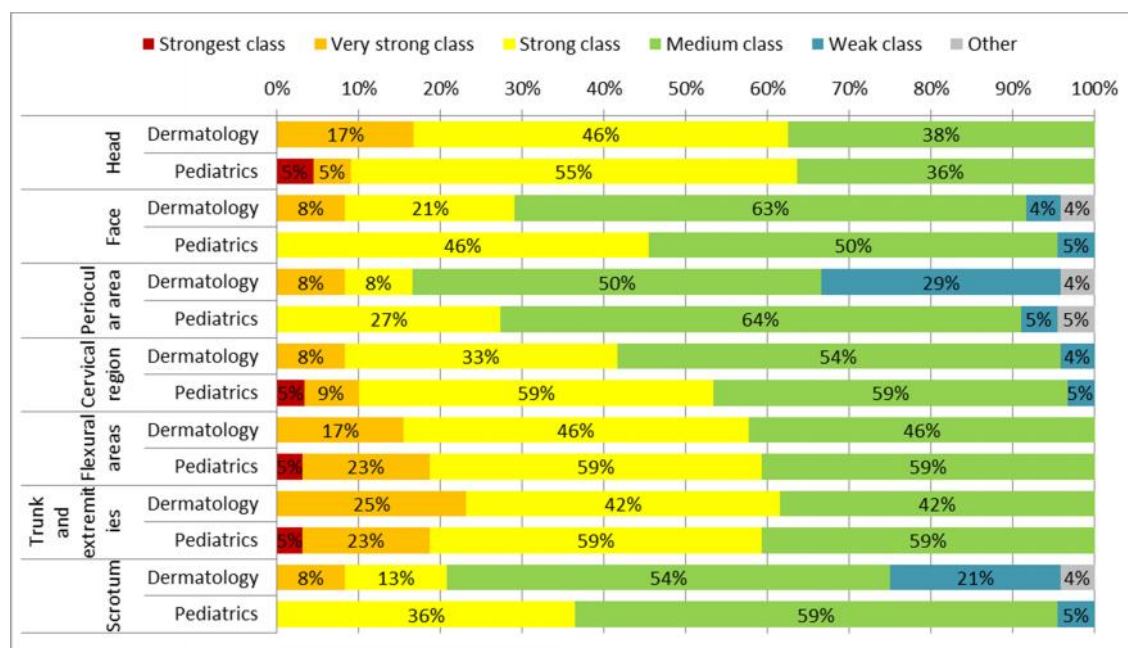
Q5: Please select the degree of emphasis for the following items in proper use of topical steroids and tacrolimus ointment in the treatment of pediatric atopic dermatitis in patients ≥ 2 years of age.



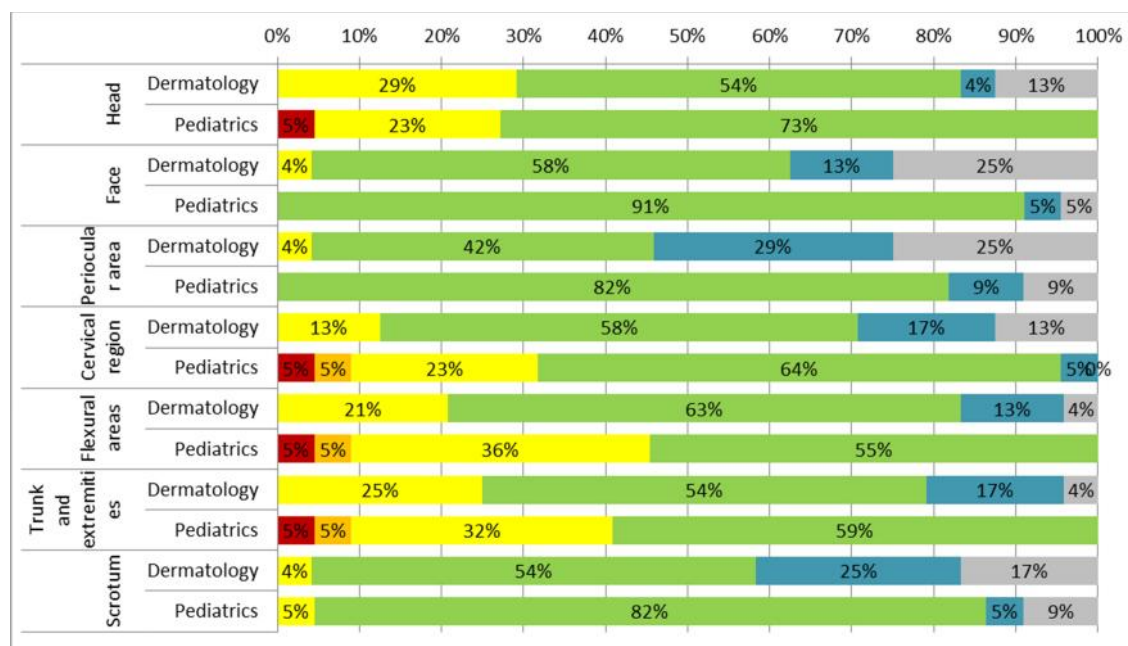
Dermatology (n = 23), Pediatrics (n = 21)

Q6: In the case of severe eczema at each of the following sites at the time of the first visit in the treatment of pediatric atopic dermatitis, please select the applicable category for each item regarding the topical anti-inflammatory drugs you use as the first-line drug.

<Patients < 2 years of age/induction>

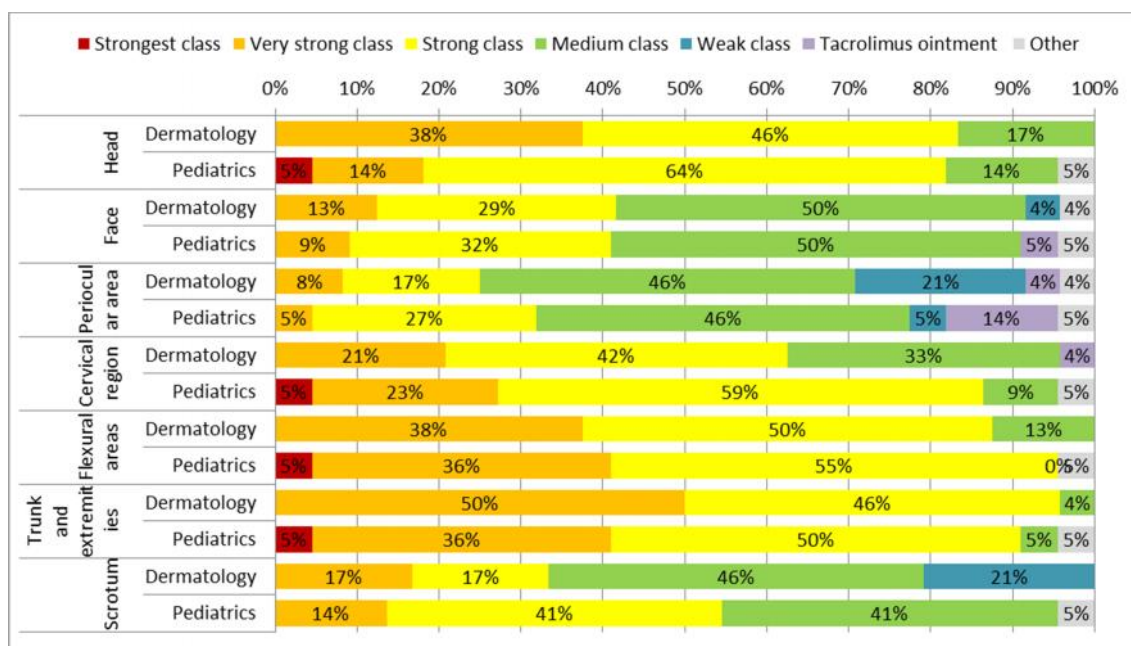


<Patients < 2 years of age /maintenance>

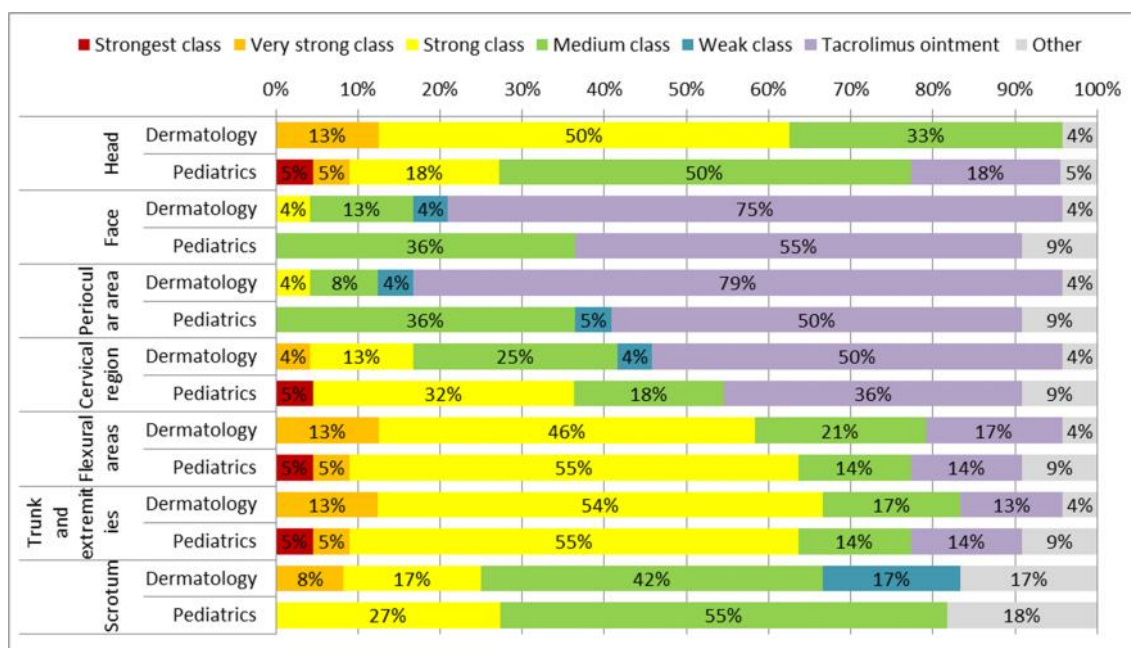


Dermatology (n = 23), Pediatrics (n = 22)

<Patients 2 to 12 years of age/induction>

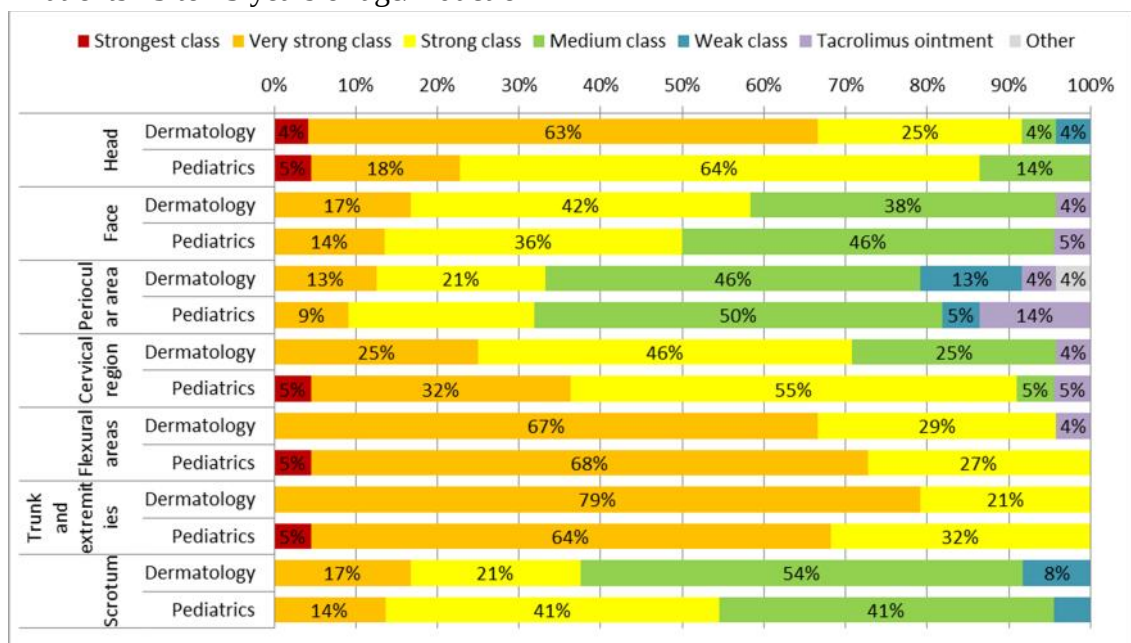


<Patients 2 to 12 years of age/maintenance>

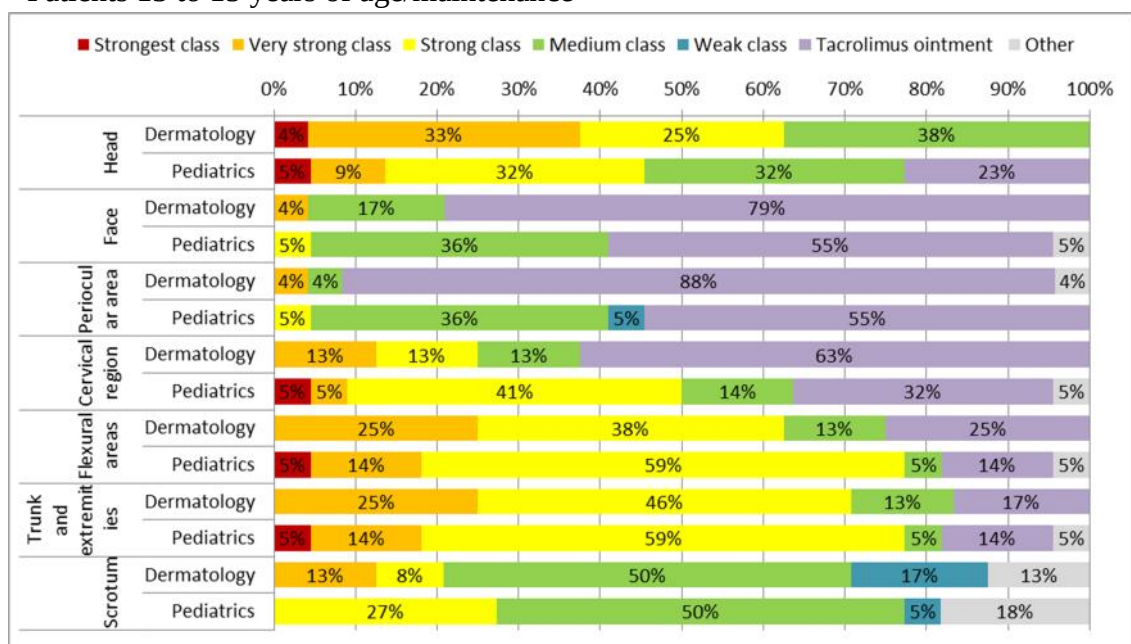


Dermatology (n = 23), Pediatrics (n = 22)

<Patients 13 to 15 years of age/induction>



<Patients 13 to 15 years of age/maintenance>



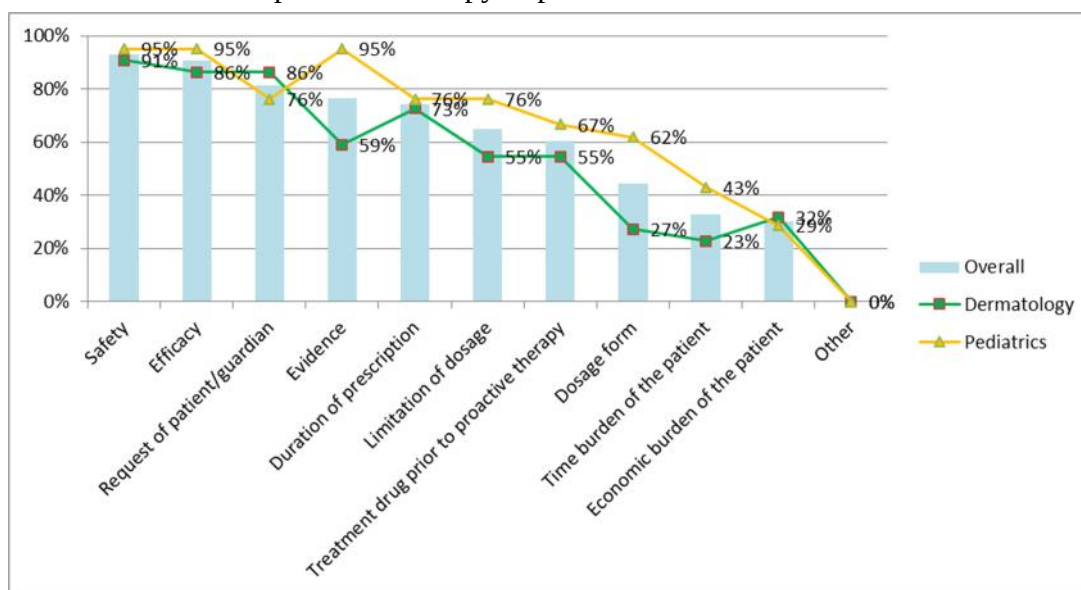
Dermatology (n = 23), Pediatrics (n = 22)

Q7: Which topical agent(s) do you use in the treatment of pediatric atopic dermatitis with proactive therapy using topical anti-inflammatory drugs? (Multiple answers allowed)

Age group of patients	Type of drug	Department (%)	
		Dermatology	Pediatrics
< 2 years of age	Strongest	0	0
	Very strong	0	0
	Strong	22	43
	Medium (Mild)	61	67
	Weak	4	5
	No proactive therapy	22	10
2-12 years of age	Strongest	0	0
	Very strong	9	14
	Strong	35	48
	Medium (Mild)	30	48
	Weak	0	10
	Tacrolimus ointment	74	67
	No proactive therapy	4	0
13-15 years of age	Strongest	0	0
	Very strong	30	19
	Strong	39	62
	Medium (Mild)	17	38
	Weak	0	0
	Tacrolimus ointment	74	62
	No proactive therapy	4	0

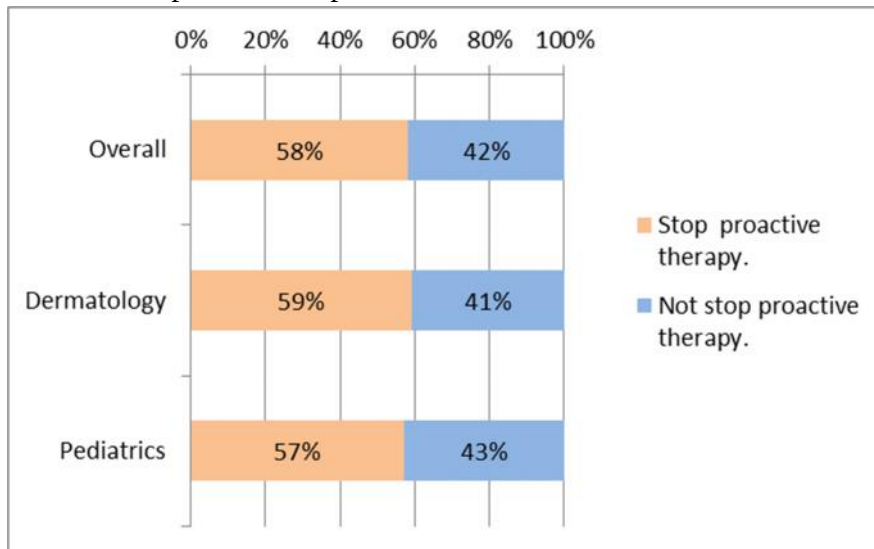
Dermatology (n = 23), Pediatrics (n = 21)

Q8: Please select the degree of emphasis for the following items in choosing either topical steroids or tacrolimus ointment in the treatment of pediatric atopic dermatitis with proactive therapy in patients ≥ 2 years of age.



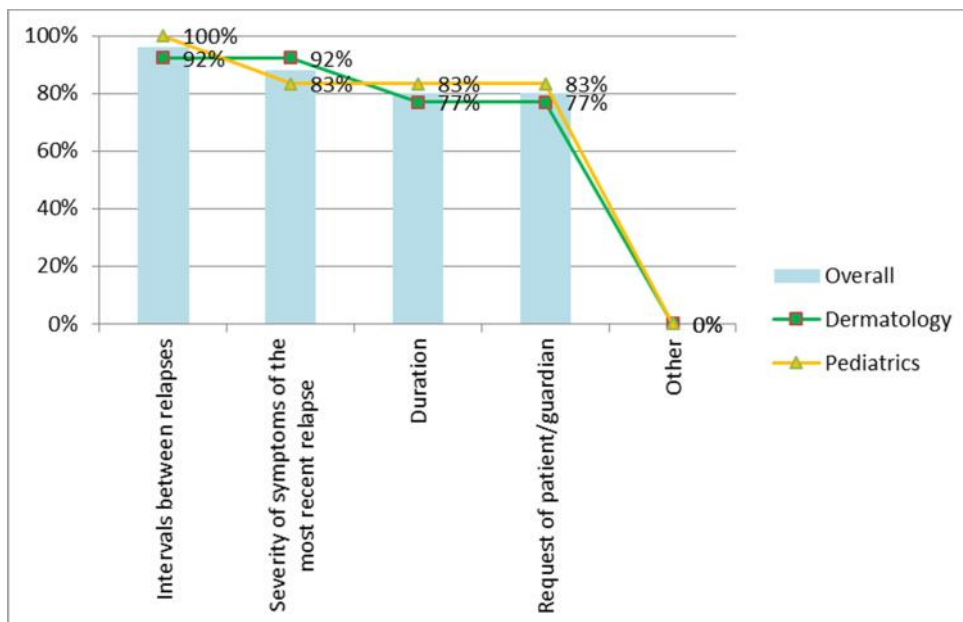
Dermatology (n = 22), Pediatrics (n = 21)

Q9: Would you stop proactive therapy when the proactive therapy is working well in the treatment of pediatric atopic dermatitis?



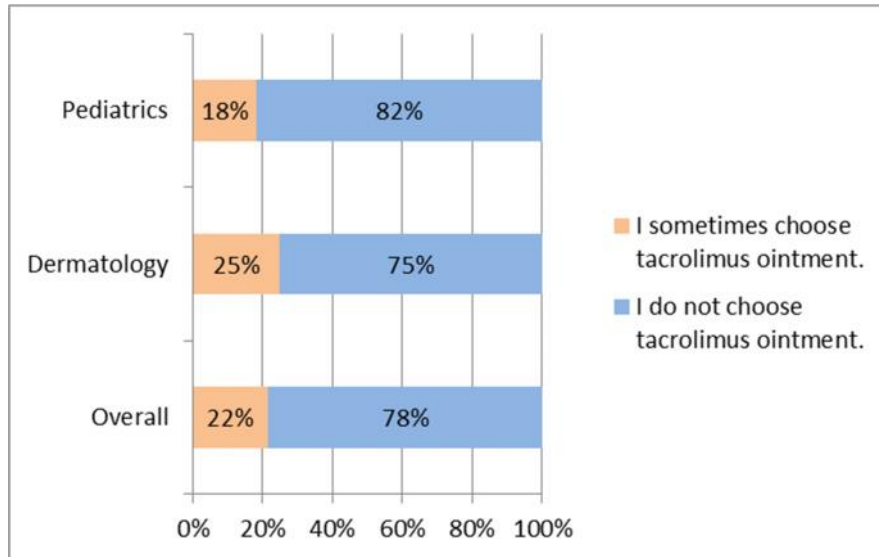
Dermatology (n = 22), Pediatrics (n = 21)

Q10: When proactive therapy works well in the treatment of pediatric atopic dermatitis, please select the degree of emphasis for the following items as the criteria for discontinuation of proactive therapy (how long the therapy should be continued).



Dermatology (n = 13), Pediatrics (n = 12)

Q11: During the course of treatment of pediatric atopic dermatitis in patients 2 to 15 years of age, do you consider choice of tacrolimus ointment as an option for a case of severe eczema on the scrotum at the time of the first visit?



Dermatology (n = 24), Pediatrics (n = 22)