

INVESTIGATIVE REPORT

Effects of Topical Tacrolimus and Polyunsaturated Fatty Acids on *In vivo* Release of Eicosanoids in Atopic Dermatitis During Dermal Microdialysis

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Atopic dermatitis (AD) is a multifactorial inflammatory skin disease with release of distinct inflammatory signals. This study investigated the presence of eicosanoids in AD skin and the effect of topical agents with potential to suppress inflammation. Twelve patients with moderate AD received topical treatment on either arm with tacrolimus 0.1% ointment or a lotion containing 12% ω -6 fatty acids (polyunsaturated fatty acids; PUFA) twice daily for 5 consecutive days. Interstitial fluid was collected *in vivo* via dermal microdialysis from 4 defined skin areas: lesional, non-lesional and topically treated skin (tacrolimus or PUFA). Markers of oxidative stress (F2-isoprostanes; 5- and 8-prostaglandin F₂ α) and inflammation (9 α ,11 α -prostaglandin F₂ α ; and prostaglandin E₂) were determined by gas chromatography-mass spectrometry. All eicosanoid levels were reduced in non-lesional and tacrolimus-treated skin. A significant reduction was observed in total F2-isoprostanes; 9 α ,11 α -prostaglandin F₂ α ; and prostaglandin E₂ in non-lesional skin and in 9 α ,11 α -prostaglandin F₂ α in tacrolimus-treated compared with untreated AD skin. In conclusion, treatment with tacrolimus compared with PUFA appears to suppress eicosanoids more efficiently in AD skin. **Key words: atopic dermatitis; tacrolimus; omega fatty acids; dermal microdialysis.**

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Atopic dermatitis (AD) is a chronic inflammatory, predisposed, multifactorial pruritic skin disease. The prevalence of AD has almost tripled in industrial countries during the last decade. It is associated with a disturbance of the epidermal barrier function and elevated immunoglobulin E (IgE) levels caused by sensitization to environmental allergens, and is often associated with other atopic disorders, such as asthma and allergic rhinitis (1, 2).

On the basis of a deficient cornified envelope combined with skin inflammation in patients with AD, local oxidative stress and specific immune responses

to exposure to environmental allergens are induced (3, 4). An impaired skin barrier function exposed to environmental allergens, an altered immune response and release of cytokines is associated with the production of prostaglandins, such as prostaglandin E₂ (PGE₂) from keratinocytes, monocytes or endothelial cells in AD (5). AD pathophysiology involves increased levels of oxidative stress, mediated by the release of free radicals. In addition, 8-isoprostanes are enhanced in AD and are primarily detected when exhaled (3, 6–9).

Tacrolimus, a topical immune modulator and calcineurin inhibitor, is usually applied twice daily at a concentration of 0.1% in adults and has been used as an effective topical treatment for moderate to severe AD with proven efficacy in various clinical trials (10). However, treatment can be associated with undesired side-effects: skin burning, which occurs mainly at the beginning of treatment and pruritus, folliculitis (11, 12) as well as local immunosuppression (resulting in cutaneous bacterial, viral or fungal infections or the risk of developing cutaneous malignancies, although the last factor has not been clearly demonstrated so far), may occur (13, 14).

Although omega (ω)-6-fatty acid supplementation, mainly evening primrose or borage oil, has been used as an alternative treatment option (15–17), there is currently insufficient evidence to show beneficial effects of oral supplementation on disease severity in patients with AD. Furthermore, the beneficial effects of topical ω -6 fatty acids have not been evaluated in larger clinical trials. However, reports suggest that they may contribute to restoration of the skin barrier (18).

There are no comparative published studies on topical treatment with tacrolimus and supplementation of ω -6-fatty acids in AD and there are no reports on whether tacrolimus treatment affects eicosanoid release in AD.

Polyunsaturated fatty acids (PUFA), including ω -6 PUFA gamma linolenic acid (GLA) and linoleic acid (LA), have anti-oxidative, anti-proliferative and anti-bacterial properties and maintain skin barrier integrity (19, 20). PUFA shift the metabolism towards the production of more anti-inflammatory series 1 eicosanoids, such as prostaglandin E₁. Therefore, PUFA may prevent the generation of pro-inflammatory series 2 eicosanoids (19).

In this study, we first tested the effect of tacrolimus and ω -fatty acids on the release of eicosanoids *in vitro* as a proof of concept. For this, we used irradiated HaCaT keratinocytes as a previously well-established model to study release of eicosanoids and potential inhibitors (6, 21, 22). We then used dermal microdialysis, a method whereby a semi-permeable membrane is implanted into the skin dermis and flushed with a pump to quantify the recovery of eicosanoids *in vivo* using an animal model and to detect the levels of mediators within the interstitial skin *in vivo* in patients with AD. The aim was to determine whether there is a difference in the levels of eicosanoids in the skin (clinically lesional and non-lesional skin *in vivo*) of AD. Finally, we determined whether topical treatment with either standard tacrolimus 0.1% or ω -6 fatty acids affected eicosanoid release in lesional skin.

MATERIALS AND METHODS (for complete details see Appendix S1¹)

For *in vitro* experiments, 2×10^7 HaCaT keratinocytes were seeded on 25-cm Petri dishes overnight and irradiated with 100

mJ/cm² and then exposed to 1, 10, 100 μ M of either tacrolimus, ω -3 fatty acids or ω -6 fatty acids in Dulbecco's Modified Eagle Medium (DMEM) 10% foetal calf serum (FCS) for 24 h. Levels of 5-iso and 8-iso-PGF_{2 α} and 9 α ,11 α -PGF_{2 α} and PGE₂ in cell culture supernatants and HaCaT keratinocytes stored intracellularly were determined by gas chromatography-mass spectrometry negative-ion chemical ionization (GC/MS) (21, 24). Recovery of eicosanoids was determined by retrodialysis *in vivo* in anaesthetized domestic pigs (Fig. S1A–B¹). Four microdialysis catheters (20 kDa cut-off membranes CMA70 60/20) were placed within the dermal porcine skin (25). Microdialysis catheters were perfused at 0.5 and 1 μ l/min with 100 ng/ml of 5-iso-PGF_{2 α} , 8-iso-PGF_{2 α} , 9 α ,11 α -PGF_{2 α} and PGE₂ in NaCl 0.9% and 5% ethanol. Perfusates were replaced at 20-min intervals and the dialysates were pooled and analysed with GC/MS. For clinical microdialysis, 12 18–39-year-old patients with moderate clinically affected AD skin (minimum 10 $\times$ 10 cm²; SCORing Atopic Dermatitis (SCORAD) < 50) were randomized in a mono-centre clinical trial to treatment areas of either no treatment, treatment with tacrolimus 0.1% ointment (Protopic 0.1%) or 12% ω -fatty acid lotion (Eucerin 12% Omega lotion[®]). The patients applied the treatment twice daily for 5 days. On day 6, dermal microdialysis was performed in untreated, treated lesional and non-lesional AD skin. After flushing the 20 kDa cut-off CMA 70/20 membranes at a rate of 5 μ l/min for 1 h for equilibration, all 4 membranes were perfused at a flow rate of 0.5 μ l/min with NaCl 0.9%. Microdialysate samples were collected at 30-min intervals for 8 h and analysed using GC/MS as described previously (21, 24).

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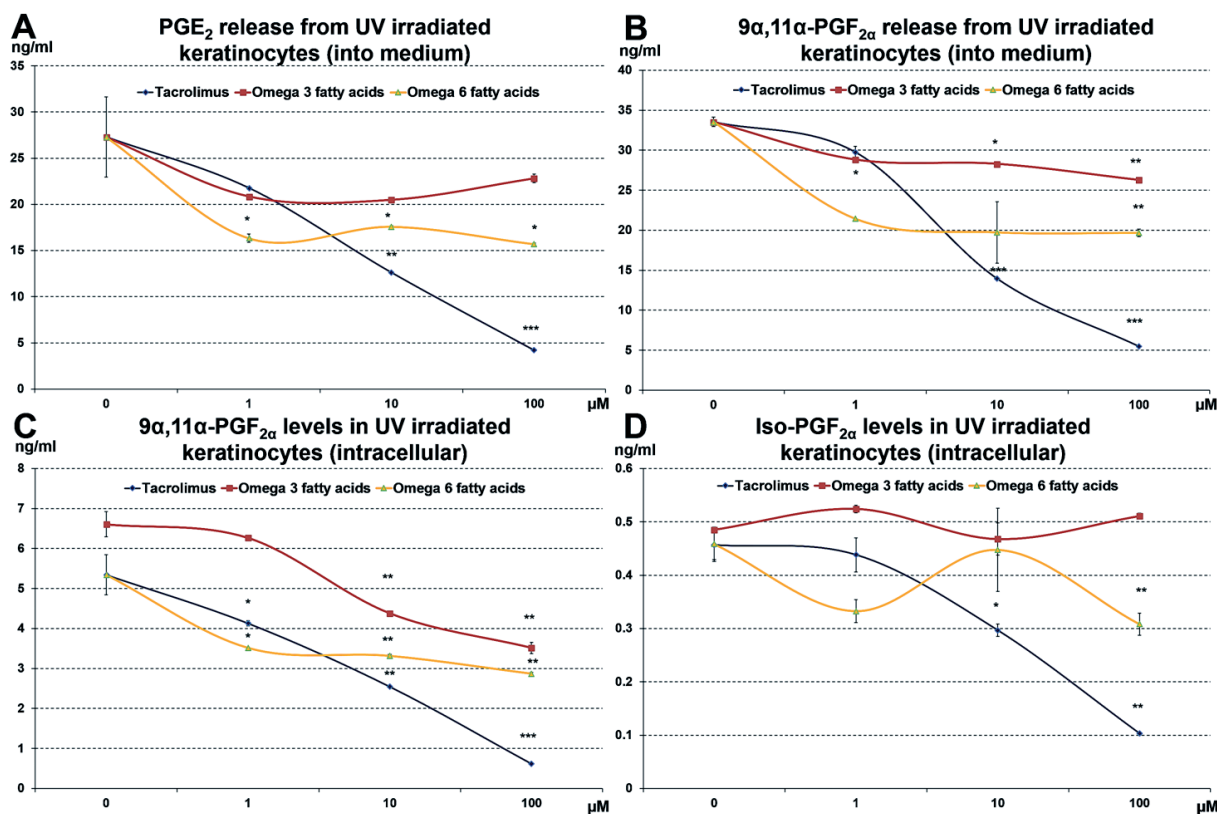


Fig. 1. Levels of prostaglandins and isoprostanes released into the supernatant (medium) or remaining intracellularly were examined in HaCaT keratinocytes following 100 mJ/cm² ultraviolet B (UVB) irradiation with or without treatment with tacrolimus, ω -3 or ω -6 fatty acids. (* p < 0.05 indicates significance, ** p < 0.01 indicates high significance, *** p < 0.001 indicates very high significance as determined by Student's *t*-test).

RESULTS

In vitro experiments

First, we investigated whether tacrolimus or ω -3 and ω -6 fatty acids affected eicosanoid release from human HaCaT keratinocytes, which has been established as a reliable *in vitro* model to study generation of eicosanoids and to test potential inhibitors (6, 21, 22). For this, we used the same dose of ultraviolet B (UVB) irradiation (100 mJ/cm²) to induce eicosanoid generation and treated the HaCaT keratinocytes with either tacrolimus or ω -3 and ω -6 fatty acids. We observed that tacrolimus treatment significantly and dose-dependently reduced the release of PGE₂ and 9 α ,11 α -PGF_{2 α} into the surrounding medium and intracellular 9 α ,11 α -PGF_{2 α} and isoprostanes (which are not released into the extracellular space) (Fig. 1). ω -6 (more than ω -3) fatty acids also reduced PGE₂ and 9 α ,11 α -PGF_{2 α} levels in the surrounding medium and intracellular 9 α ,11 α -PGF_{2 α} starting with the 1 μ M dose. However, the effect of ω -6 fatty acids was much lower compared with tacrolimus. ω -6 fatty acids, but not ω -3 fatty acids, reduced isoprostane levels at a dose of 100 μ M.

In vivo recovery of eicosanoids in pig skin

Using microdialysis, we determined the *in vivo* recovery of eicosanoids in the skin, which is unknown (Fig. S1¹). As expected, the recovery of the small molecular weight eicosanoids through the 20 kDa microdialysis membrane was >80% for all mediators at a flow rate of 0.5 μ l/min and was consistently higher than the flow rate of 1 μ l/min. Therefore, a flow rate of 0.5 μ l/min was further used for clinical dermal microdialysis experiments.

Clinical microdialysis

Finally, we initiated a mono-centre clinical trial to test whether there were differences in eicosanoid release in lesional vs. non-lesional skin of AD patients and to test whether there were any inhibitory effects after treatment with topical tacrolimus 0.1% ointment or 12% ω -6 fatty acid lotion (Fig. 2). Twelve patients (mean $\pm$ SD 24.14 $\pm$ 1.89 years of age) with moderate AD (mean SCORAD 42.09 $\pm$ 1.00) (Table S1¹) were enrolled in this study by simple randomization. Overall, we observed lower mean area under the curve (AUC) values for isoprostanes (5- and 8-iso-PGF_{2 α}), total isoprostanes, 9 α ,11 α -PGF_{2 α} and PGE₂ in non-lesional compared with

lesional AD skin (Fig. 3). This decrease was significant for the sum of isoprostanes, 9 α ,11 α -PGF_{2 α} and PGE₂ (Table S1¹) as detected by dermal microdialysis. In addition, lesional and non-lesional AD skin differed significantly for skin erythema and darkness levels. Patients with AD exhibited more skin darkness and erythema levels for lesional skin than non-lesional skin (see Fig. 3 and Table S11¹).

Treatment with tacrolimus and ω -6 fatty acids reduced the mean AUC values for 5- and 8-iso-PGF_{2 α} , all isoprostanes and 9 α ,11 α -PGF_{2 α} compared with lesional AD skin. This reduction was significant for 9 α ,11 α -PGF_{2 α} when treated with tacrolimus 0.1% ointment. For 8-iso-PGF_{2 α} , the mean AUC value was even lower than in non-lesional skin. Tacrolimus treatment, in contrast to skin treated with ω -6 fatty acids, reduced the mean AUC value of PGE₂. These results were supported by the findings of skin chromatometry. We found that tacrolimus significantly reduced skin erythema. In contrast, skin erythema reductions with ω -fatty acid treatments were much lower and skin darkness increased (Table S11¹).

However, there were inter-individual differences. In 2 patients (numbers 5 and 10), treatment with ω -6 fatty

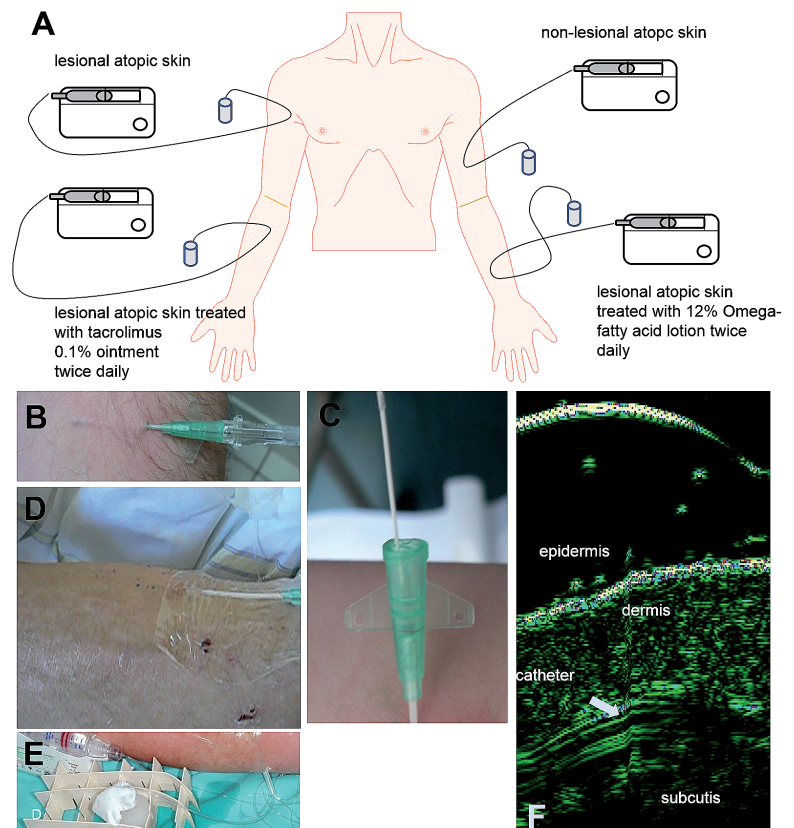


Fig. 2. Scheme of clinical microdialysis: Patients were randomized to four areas: lesional atopic skin left untreated, atopic skin treated with tacrolimus 0.1% ointment or 12% ω -fatty acid lotion for 5 days and non-lesional atopic skin (a). Introduction of CMA70 catheters via 18G i.v.-catheters (b, c) into the atopic skin were fixed with transparent self-adhesive dressings (Mepithel film[®], Mölnlycke, Erkrath, Germany) (d). Microdialysate samples were kept on ice during the experiment (e). Catheter placement was guided by high resolution ultrasound (22 MHz, f).

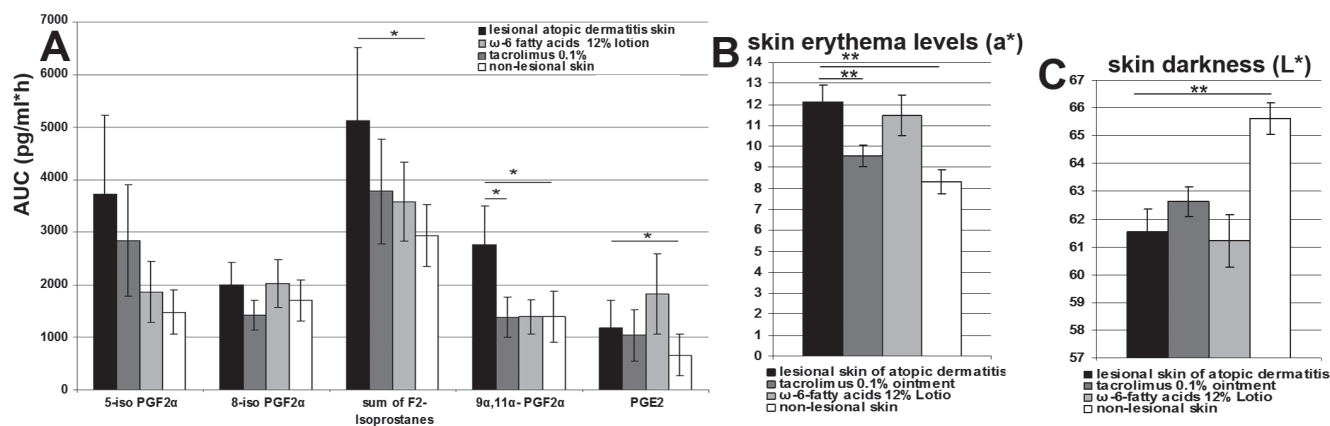


Fig. 3. (A) Mean area under the curve values (AUC) of F₂-isoprostanes, 5- and 8-iso-prostaglandin F_{2α} and prostaglandin E₂ (pg/ml*h) and standard deviation (SD) obtained from 12 patients with atopic dermatitis (AD). Dermal microdialysis was performed in lesional, non-lesional atopic, or atopic skin treated with 0.1% tacrolimus ointment or with 12% ω-6 fatty acid lotion (mean ± SD; **p* < 0.05 indicates significance as determined by the Wilcoxon rank-sum test). Levels of erythema (B; e* > 0 indicates increasing erythema) and skin darkness (C; L*, black = 0, white = 100) with SD from lesional, non-lesional atopic, or atopic skin treated with 0.1% tacrolimus ointment or 12% ω-6 fatty acids lotion (**p* < 0.05 indicates significance, ***p* < 0.01 indicates high significance according to the Wilcoxon rank-sum test, comparison with untreated lesional skin).

acids increased the inflammatory eicosanoid release and skin erythema. These patients reported treatment failure and a burning sensation in the related treatment areas. In 2 patients (numbers 7 and 8, Table SI¹) treated with tacrolimus 0.1% ointment, the levels of all eicosanoids increased, but erythema levels did not increase (Table SII¹). These patients reported that the treatment failed to improve their symptoms, but that the treatment did not worsen the treated lesional skin areas.

In general, tacrolimus treatment was more effective than ω-6 fatty acid treatment regarding the decrease in eicosanoid release and skin erythema (Tables SI and SII¹).

DISCUSSION

Dermal microdialysis has been used in patients with AD to study the penetration of topical drugs (31) and the effects of PGE₂ on skin vasodilatation (32). Dermal microdialysis has also been used to study the effect of cyclosporine on histamine and PGD₂ release in the skin of dogs (33). PGE₂ and leukotriene B₄ are present in biologically active and detectable concentrations in the lesional skin of patients with AD (34, 35). However, most of this research was performed decades ago, and previous experiments using the method of suction blisters to collect interstitial fluid failed to show any differences in the levels of PGE₂ between lesional and non-lesional skin of patients with AD and psoriasis, but did show differences in leukotriene B₄. Increased levels of 9α,11α-PGF_{2α} have been detected in the urine of children with AD.

We used dermal microdialysis for the first time to study skin inflammation and eicosanoids in patients with AD and the possible suppressive effects of topical tacrolimus and ω-6 fatty acid treatment. We detected significant differences in the mediators of inflammation (prostaglandins) and oxidative stress (isoprostanes)

between lesional and non-lesional skin and after treatment with tacrolimus 0.1% ointment, which is one of the standard treatments for patients with AD.

A limitation of this study includes the lack of a base ointment or cream of topical tacrolimus and PUFA as a control treatment. Since both galenic bases are very different, and due to limited treatment areas, they were not included.

There are 3 possible reported mechanisms through which tacrolimus could suppress the generation of prostaglandins PGE₂ and 9α,11α-PGF_{2α}. First, tacrolimus could indirectly inhibit nuclear factor of activated T cells (NFAT)-signalling through binding to immunophilins (FK-binding protein). This regulates cyclooxygenase-2 (36, 37). Secondly, tacrolimus could directly inhibit cyclooxygenase-1 (38). Lastly, tacrolimus could inhibit the pro-inflammatory cytokines interleukin (IL)-1β (39) and tumour necrosis factor alpha (TNF-α) (40), which would otherwise stimulate the release of prostaglandins, through DNA-binding to modify their transcription.

The effects of tacrolimus on oxidative stress have been conflicting (41, 42). Topical tacrolimus can repigment the skin in patients with vitiligo, which uses its anti-oxidative properties (43), and similar effects have been reported for the reduction in inflammation and oxidative stress in a myocardial infarction model in mini-pigs (42). Even though the exact mechanisms of how tacrolimus reduces oxidative stress are unknown, it might be reached by decreasing the amount of pro-inflammatory T cells.

PUFAs might be beneficial for patients with AD. In a diet-fed, AD, hairless mouse model, only supplementation with ω-6, but not ω-3, fatty acid reduced AD symptoms, such as itch-related scratching and skin inflammation. However, there is currently insufficient evidence of beneficial effects from clinical trials with evening primrose or borage oil (15–17, 44).

In patients with AD, the most important effects of ω -6 fatty acids might be the restoration of a proper skin barrier (18); the metabolic shift towards the production of anti-inflammatory series 1 eicosanoids; and the anti-oxidative properties of PUFAs (19). When ω -6 fatty acids were added to emollients for one week, similar effects on severity score, itch intensity, erythema and transepidermal water loss were observed than with topical 1% hydrocortisone (20). In this study, we observed a non-significant reduction in isoprostanes, but not in prostaglandin PGE₂.

In conclusion, using dermal microdialysis, we demonstrated that the levels of eicosanoids are increased in clinically lesional skin compared with non-lesional AD skin and that treatment with tacrolimus appears to suppress the interstitial release of eicosanoids with inflammatory (prostaglandins) and pro-oxidative (isoprostanes) properties *in vivo* and *in vitro*. Together, these effects significantly reduced skin erythema. Topical treatment with ω -6-fatty acid also reduced the level of isoprostanes, but not prostaglandin PGE₂.

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The authors declare no conflict of interest.

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Appendix S1.

MATERIALS AND METHODS

In vitro experiments

For *in vitro* experiments, we used human HaCaT cells, which are immortalized human keratinocytes that differ from the *in vivo* situation of the deficient epidermal skin in AD, but have been established as an *in vitro* model to study the generation of eicosanoids and to test potential inhibitors (6, 21, 22). 2×10^7 HaCaT keratinocytes were seeded on 25-cm Petri dishes overnight and irradiated with 100 mJ/cm² ultraviolet B (UVB) (Waldmann UV 3003K, Herbert Waldmann GmbH & Co. KG, Villingen-Schwenningen, Germany), which is a sublethal dose known to induce apoptosis of HaCaT keratinocytes and release the eicosanoids 9 α ,11 α -prostaglandin F_{2 α} (9 α ,11 α -PGF_{2 α}) and 8-iso-prostaglandin F_{2 α} (8-iso-PGF_{2 α}), (21, 23).

After irradiation, HaCaT keratinocytes were exposed to 1, 10, 100 μ M of either tacrolimus (Prograf[®] 1 mg, Fujisawa Germany, Munich, Germany), ω -3 fatty acids (Salmon Oil, Sigma Aldrich, Hamburg, Germany) or ω -6 fatty acids (Gamma-linolenic acid/linoleic acid, Sigma Aldrich, Hamburg, Germany) in Dulbecco's Modified Eagle Medium 10% FCS for 24 h. The levels of F2-isoprostanes (5-iso and 8-iso-PGF_{2 α}) and prostaglandins (9 α ,11 α -PGF_{2 α} and PGE₂) in the cell culture supernatants and in HaCaT keratinocytes stored intracellularly were determined by gas chromatography–mass spectrometry negative ion chemical ionization, as previously described (21, 24).

In vivo recovery of eicosanoids

The recovery of eicosanoids was determined by retrodialysis *in vivo* in anaesthetized domestic pigs (*in vitro* experiments are not well suited for the determination of *in vivo* recovery (Fig. S1A–B¹). Porcine skin, due to its similarity to human skin regarding permeability, density, diameter of hair follicles, epidermal and dermal skin structure (thickness, lipids, elastic fibres), is a good *in vivo* model to study recovery with microdialysis (25). However, both, retrodialysis and porcine skin are models that are approaching the human *in vivo* situation, but do not completely reproduce it. For retrodialysis, 4 microdialysis catheters (20 kDa cut-off membranes for the detection of eicosanoids and CMA 70 60/20 membranes (CMA Microdialysis, Solna, Sweden) were placed within the dermal porcine skin, which has the best dermal properties of all animals in relation to human skin (25). The microdialysis catheters were placed at a depth of 0.9–1.2 mm and were controlled by a 22-MHz ultrasound (taberna pro medicum, Luneburg, Germany). The microdialysis catheters were perfused at 0.5 and 1 μ l/min with 100 ng/ml of eicosanoids (5-iso-PGF_{2 α} , 8-iso-PGF_{2 α} , 9 α ,11 α -PGF_{2 α} and PGE₂; Cayman Chemical, Axxora, Lörrach, Germany) in a solution containing NaCl 0.9% and 5% ethanol. The perfusates were replaced at 20-min intervals and the dialysates were pooled for analysis. Recovery was calculated as the difference between the starting concentration and the concentration found in the dialysate, which was the percentage of mediators that passed through the membrane into the surrounding dermal tissue.

Clinical microdialysis

Twelve 18–39-year-old patients with moderate AD clinically present on both arms (SCORAD < 50) with a necessity for topical immunosuppressive treatment were recruited from the outpatient service of the clinic of dermatology and venereology

at the Otto-von-Guericke University Magdeburg to be included in a mono-centre clinical trial.

Exclusion criteria were: systemic or local immunosuppressive treatment (including extensive UV light, corticosteroids and calcineurin-inhibitors); any pre-treatment with ω -fatty acids within the last 6 weeks prior to inclusion; and bacterial or mycotic skin superinfections. Informed consent was obtained from each patient, and the protocol was approved by the local ethics committee (approval 43/06) in accordance with the principles of the Declaration of Helsinki and good clinical practice.

Patients with clinically affected skin (minimum 10 $\times$ 10 cm²) with equal levels of skin darkness and erythema as assessed by a skin chromameter (Chromameter CR-300, Minolta, Osaka, Japan; (26–29)) were randomized by simple randomization (numbers assigned to the specific treatment and area) to areas with either no treatment, treatment with tacrolimus 0.1% ointment (Protopic 0.1%, Astellas Pharma, Munich, Germany) or 12% ω -fatty acid lotion (Eucerin 12% Omega lotion[®] (currently known as: AtopiControl[®] Lotion), Beiersdorf AG, Hamburg, Germany). The patients applied the treatment twice daily for 5 days, according to the dermatologist's instructions (see the scheme in Fig. 1A).

12% ω -fatty acid lotion contains 12% ω -6 fatty acids (from evening primrose oil sources containing 85% of Gammalinolenic acid and 14% of linolenic acid (LA) and grape-seed oil containing 75% LA and flavonoids, such as licochalcone A). On day 6, dermal microdialysis was performed in untreated, treated lesional and non-lesional AD skin. After flushing the 20 kDa cut-off membranes (CMA 70, CMA Microdialysis, Solna, Sweden) at a rate of 5 μ l/min for 1 h (for equilibration) and performing basal microdialysis to compensate for catheter insertion, all 4 membranes were perfused at a flow rate of 0.5 μ l/min with NaCl 0.9% using a CMA107 microdialysis pump (CMA Microdialysis, Solna, Sweden).

Microdialysate samples were collected at 30-min intervals for 8 h. The collected microdialysates were kept on ice during the experiment, and butylhydroxytoluene was added to a final concentration of 0.1% after collection. The samples from each of the 4 membranes were analysed together to quantify the lipid mediators and markers of oxidative stress. 5- and 8-iso-PGF_{2 α} (F2-isoprostanes peak I; peak II co-eluting with the authentic standards of 5- and 8-iso-PGF_{2 α}); markers of inflammation; and prostaglandins (9 α ,11 α -PGF_{2 α} and PGE₂) were measured using gas chromatography-mass spectrometry and negative-ion chemical ionisation, as previously described (21, 24).

Skin chromametry had been used not only to evaluate UVB damaged skin (28), but also erythema levels in AD patients challenged with 2% sodium dodecyl sulphate (26, 27). Previously, levels of skin erythema were correlated with levels of eicosanoids found in the skin (29). Therefore, skin darkness and erythema were measured in all test areas at the end of microdialysis (Chromameter CR-300, Minolta, Osaka, Japan) in 10 of 12 patients (30).

Statistics

The mean values, standard deviation (SD), and Student's *t*-tests for the *in vitro* experiments were calculated with Microsoft Excel (Version Office 2007, Microsoft Germany, Unterschleißheim, Germany). For statistical calculation, area under the curve (AUC) values from each, tacrolimus 0.1% treated skin, omega-6 fatty acids treated skin and non-lesional skin, were compared with those from untreated lesional skin intra- and inter-individually. A non-parametric Wilcoxon rank-sum test for the AUC values was used for the *in vivo* experiments and was calculated using MedCalc 10 (MedCalc beba, Mariakerke, Belgium).

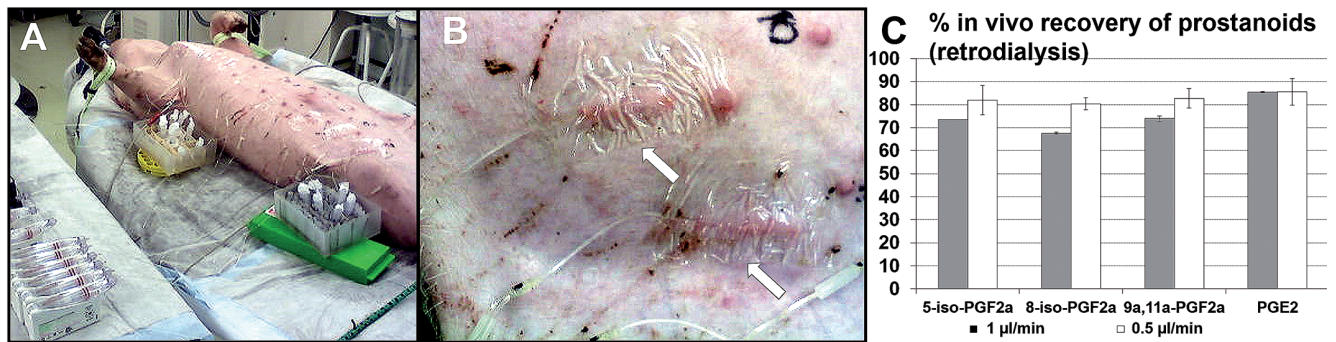


Fig. S1. In vivo recovery of eicosanoids tested in porcine skin determined by retrodialysis *in vivo* in anaesthetized domestic pigs. Microdialysis catheters (20 kDa cut-off membranes for the detection of eicosanoids and CMA70 60/20 membranes (CMA Microdialysis, Solna, Sweden) were placed within the dermal porcine skin (A) and microdialysis catheters were perfused at 0.5 and 1 μ l/min with 100 ng/ml of prostanoids (5-iso-Prostaglandin $F_{2\alpha}$, 8-iso-Prostaglandin $F_{2\alpha}$, 9 α ,11 α -Prostaglandin $F_{2\alpha}$ and Prostaglandin E_2) resulting in skin erythema surrounding the dermally placed catheters (B, white arrows). Recovery was calculated as the difference between the starting concentration and the concentration found in the dialysate, which was the percentage of mediators that passed through the membrane into the surrounding dermal tissue.

Table SI. F_2 -isoprostanes, 5- and 8-iso-prostaglandin F_{2a} and prostaglandins $9\alpha,11\alpha$ -prostaglandin F_{2a} and prostaglandin E2 (pg/ml*h). Area under the curve values for each patient. The means and standard deviations were obtained from dermal microdialysis in lesional, non-lesional atopic, or atopic skin treated with 0.1% tacrolimus ointment or 12% ω -6 fatty acid lotion (mean $\pm$ standard deviation (SD); * $p < 0.05$ indicates significance, as determined by the Wilcoxon rank-sum test, comparison with untreated lesional skin)

Pat. No.	Age, years/ Sex	SCORAD	Eicosanoids	Lesional skin	Tacrolimus 0.1%	ω -6 fatty acids 12% lotion	Non-lesional skin
1	39/F	49.6	5-iso PGF _{2a}	8,029	2,925	3,886	5,002
			8-iso PGF _{2a}	1,035	0	2,952	2,428
			F2-isoprostanes	9,064	2,925	6,838	7,430
			9 $\alpha,11\alpha$ - PGF _{2a}	6,052	4,674	225	470
			PGE ₂	374	980	0	0
2	18/F	38.3	5-iso PGF _{2a}	17,943	13,271	1,156	661
			8-iso PGF _{2a}	1,570	659	1,163	909
			F2-isoprostanes	19,513	13,930	2,319	1,570
			9 $\alpha,11\alpha$ - PGF _{2a}	2,532	547	540	320
			PGE ₂	4,979	3,328	4,392	4,587
3	31/F	47.5	5-iso PGF _{2a}	n.d.	n.d.	n.d.	n.d.
			8-iso PGF _{2a}	5,609	2,613	6,083	2,785
			F2-isoprostanes	5,609	2,613	6,083	2,785
			9 $\alpha,11\alpha$ - PGF _{2a}	3,899	1,185	2,522	5,097
			PGE ₂	555	385	390	455
4	35/M	47.4	5-iso PGF _{2a}	2,031	2,126	2,570	1,084
			8-iso PGF _{2a}	914	825	1,245	723
			F2-isoprostanes	2,945	2,951	3,815	1,807
			9 $\alpha,11\alpha$ - PGF _{2a}	0	40	102	0
			PGE ₂	0	0	0	0
5	27/M	45.3	5-iso PGF _{2a}	366	478	691	557
			8-iso PGF _{2a}	1,358	1,421	1,971	770
			F2-isoprostanes	1,724	1,899	2,662	1,327
			9 $\alpha,11\alpha$ - PGF _{2a}	1,133	823	2,402	1,285
			PGE ₂	1,109	0	6,122	484
6	21/M	48.9	5-iso PGF _{2a}	1,633	1,998	1,374	811
			8-iso PGF _{2a}	750	727	717	529
			F2-isoprostanes	2,383	2,725	2,091	1,340
			9 $\alpha,11\alpha$ - PGF _{2a}	1,336	1,173	1,003	135
			PGE ₂	459	0	0	0
7	19/M	40.4	5-iso PGF _{2a}	3,260	3,229	629	2,975
			8-iso PGF _{2a}	1,760	2,661	710	2,086
			F2-isoprostanes	5,020	5,890	1,339	5,061
			9 $\alpha,11\alpha$ - PGF _{2a}	178	293	463	0
			PGE ₂	0	0	0	0
8	26/M	39.8	5-iso PGF _{2a}	3,041	3,396	6,886	2,525
			8-iso PGF _{2a}	2,508	2,946	2,950	1,907
			F2-isoprostanes	5,549	6,342	9,836	4,432
			9 $\alpha,11\alpha$ - PGF _{2a}	1,925	3,262	3,006	1,737
			PGE ₂	466	2,436	1,181	0
9	21/M	43.3	5-iso PGF _{2a}	340	354	191	158
			8-iso PGF _{2a}	1,854	1,182	471	408
			F2-isoprostanes	2,194	1,536	662	566
			9 $\alpha,11\alpha$ - PGF _{2a}	3,216	550	137	139
			PGE ₂	0	0	615	0
10	23/M	40.2	5-iso PGF _{2a}	453	312	945	527
			8-iso PGF _{2a}	697	421	1,876	1,237
			F2-isoprostanes	1,150	733	2,821	1,764
			9 $\alpha,11\alpha$ - PGF _{2a}	1.5	447	126	452
			PGE ₂	5,312	5,377	7,721	2,417
11	23/M	43	5-iso PGF _{2a}	145	288	311	512
			8-iso PGF _{2a}	1,383	914	552	1,166
			F2-isoprostanes	1,528	1,202	863	1,678
			9 $\alpha,11\alpha$ - PGF _{2a}	8,698	1,932	2,786	3,488
			PGE ₂	0	0	0	0
12	29/M	39.9	5-iso PGF _{2a}	n.d.	n.d.	n.d.	n.d.
			8-iso PGF _{2a}	4,607	2,625	3,618	5,476
			F2-isoprostanes	4,607	2,625	3,618	5,476
			9 $\alpha,11\alpha$ - PGF _{2a}	4,261	1,723	2,842	3,649
			PGE ₂	865	0	1,776	0
Mean $\pm$ SD	24.14 $\pm$ 1.89	42.09 $\pm$ 1.00	5-iso PGF _{2a}	3,722 $\pm$ 1,513	2,838 $\pm$ 1,061 ($p=0.92$)	1,860 $\pm$ 574 ($p=0.85$)	1,481 $\pm$ 423 ($p=0.06$)
			8-iso PGF _{2a}	2,004 $\pm$ 429	1,416 $\pm$ 282 ($p=0.06$)	2,029 $\pm$ 457 ($p=1.00$)	1,702 $\pm$ 392 ($p=0.42$)
			Sum of F2-isoprostanes	5,117 $\pm$ 1,405	3,781 $\pm$ 999 ($p=0.20$)	3,579 $\pm$ 756 ($p=0.52$)	2,936 $\pm$ 591 ($p=0.03$)*
			9 $\alpha,11\alpha$ - PGF _{2a}	2,769 $\pm$ 732	1,387 $\pm$ 377 ($p=0.05$)*	1,391 $\pm$ 331 ($p=0.09$)	1,398 $\pm$ 481 ($p=0.05$)*
			PGE2	1,177 $\pm$ 522	1,042 $\pm$ 486 ($p=0.55$)	1,823 $\pm$ 768 ($p=0.36$)	662 $\pm$ 391 ($p=0.01$)*

SD: standard deviation; SCORAD: SCORing Atopic Dermatitis; n.d.: not determined.

Table SII. Levels of skin darkness (d, black=0, white=100) and erythema (e>0 indicates increasing erythema) with standard deviation from lesional, non-lesional atopic, or atopic skin treated with 0.1% tacrolimus ointment or 12% ω -6 fatty acids lotion

Patient	Levels of skin darkness (d) and erythema (e)	Lesional skin of atopic dermatitis	Tacrolimus 0.1% ointment	ω -6-fatty acids 12% Lotion	Non-lesional skin
1	d	61.62 $\pm$ 0.42	62.57 $\pm$ 0.55	58.77 $\pm$ 0.54	63.36 $\pm$ 0.83
	e	9.19 $\pm$ 0.17	8.34 $\pm$ 0.27	8.87 $\pm$ 0.41	7.76 $\pm$ 0.49
3	d	66.78 $\pm$ 0.26	67.48 $\pm$ 0.52	68.22 $\pm$ 0.11	70.78 $\pm$ 0.61
	e	13.16 $\pm$ 0.37	10.36 $\pm$ 0.96	12.70 $\pm$ 0.23	9.95 $\pm$ 0.72
4	d	69.13 $\pm$ 0.48	73.26 $\pm$ 0.69	74.16 $\pm$ 0.59	71.49 $\pm$ 0.77
	e	14.80 $\pm$ 1.19	12.30 $\pm$ 0.47	10.85 $\pm$ 0.63	12.20 $\pm$ 0.52
5	d	60.53 $\pm$ 0.83	60.21 $\pm$ 0.59	55.68 $\pm$ 0.95	64.15 $\pm$ 0.37
	e	12.71 $\pm$ 0.70	9.14 $\pm$ 0.19	15.40 $\pm$ 0.66	10.06 $\pm$ 0.45
6	d	59.03 $\pm$ 0.85	58.66 $\pm$ 0.63	58.59 $\pm$ 0.92	63.89 $\pm$ 0.34
	e	8.52 $\pm$ 0.46	7.87 $\pm$ 0.08	8.41 $\pm$ 0.39	6.51 $\pm$ 0.75
7	d	63.97 $\pm$ 0.18	63.33 $\pm$ 0.21	62.02 $\pm$ 0.25	65.39 $\pm$ 1.02
	e	12.57 $\pm$ 0.32	7.95 $\pm$ 1.33	10.42 $\pm$ 0.85	7.05 $\pm$ 0.47
8	d	60.83 $\pm$ 0.30	59.18 $\pm$ 0.27	60.27 $\pm$ 0.58	65.78 $\pm$ 0.50
	e	9.36 $\pm$ 0.32	8.97 $\pm$ 0.55	8.18 $\pm$ 0.65	6.42 $\pm$ 0.12
9	d	54.87 $\pm$ 0.57	58.33 $\pm$ 0.16	56.29 $\pm$ 0.28	63.72 $\pm$ 0.89
	e	16.61 $\pm$ 0.68	10.95 $\pm$ 0.17	15.43 $\pm$ 0.61	7.51 $\pm$ 0.56
10	d	58.69 $\pm$ 0.62	60.10 $\pm$ 1.08	56.90 $\pm$ 0.52	64.48 $\pm$ 0.33
	e	13.72 $\pm$ 0.49	11.98 $\pm$ 0.75	16.12 $\pm$ 0.86	8.83 $\pm$ 0.56
11	d	60.03 $\pm$ 0.95	63.13 $\pm$ 0.54	61.22 $\pm$ 1.05	63.19 $\pm$ 0.33
	e	10.48 $\pm$ 0.60	7.54 $\pm$ 0.72	8.33 $\pm$ 0.59	6.81 $\pm$ 0.19
Mean $\pm$ SD (p-value)	d	61.55 $\pm$ 1.24	62.62 $\pm$ 1.40 (p=0.16)	61.21 $\pm$ 1.74 (p=0.63)	65.62 $\pm$ 0.91 (p=0.002)**
Mean $\pm$ SD (p-value)	e	12.11 $\pm$ 0.80	9.54 $\pm$ 0.52 (p=0.002)**	11.47 $\pm$ 0.96 (p=0.32)	8.31 $\pm$ 0.57 (p=0.002)**

*p<0.05 indicates significance, **p<0.01 indicates high significance according to the Wilcoxon rank-sum test, comparison to untreated lesional skin.
SD: standard deviation.