ORIGINAL REPORT

Clinical Characteristics and Therapeutic Management of Atopic Dermatitis in Elderly Patients Compared with Young Adult Patients: A Prospective Multicentre Study

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Atopic dermatitis (AD) is the most common chronic inflammatory dermatitis in developed countries, and has a major impact on those affected. Little is known about AD in elderly patients. This prospective multicentre observational study described the clinical characteristics and burden of AD in elderly subjects ≥ 65 years, as well as the therapeutic options chosen for this population in routine care, and compared findings with those in young adults with AD < 30 years. Cohort data from adult patients with moderate-to-severe AD enrolled in a French national prospective registry (December 2020 to May 2023) were analysed. Patients ≥ 65 years made up 12.5% of the total adult cohort and presented less head-and-neck and extremity involvement, and were less affected by generalized forms than young adult patients. Elderly patients predominantly had late-onset AD and had similar disease severity to younger adults. Although the overall impact of AD appeared to be lower in elderly patients and treatment was initially less used in this age group, the substantial impact on sleep and psychiatric comorbidities was similar in older and younger adult patients. Better understanding of AD in elderly patients and the establishment of age-specific treatment guidelines may help dermatologists manage the disease in older people.

Key words: aged; dermatitis; atopic; observational study; prevalence; registries; therapeutics.

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SIGNIFICANCE

Although atopic dermatitis is common and has a major impact on those affected, little is known about atopic dermatitis in the elderly. Our study sought to address this using information from a French national health registry. We found that, although the overall impact of atopic dermatitis seems to be lower in elderly patients, the impact of atopic dermatitis on sleep, and mood and depression is similar in elderly and young adult patients, with many being severely affected. Better understanding of atopic dermatitis in people aged ≥ 65 years and the establishment of age-specific treatment guidelines may help dermatologists manage atopic dermatitis in older people.

Atopic dermatitis (AD) is the most common form of chronic inflammatory dermatitis in developed countries, and its prevalence continues to grow across most continents in the 21st century (1). AD has major repercussions on the quality of life (QoL) of patients and their families, with negative effects in terms of social, academic, and professional life (2–4).

Although AD has always been a particularly significant concern in the paediatric population, it can also persist or appear in adulthood, affecting individuals of all ages, without exception. Its clinical manifestations tend to change with age. *Three distinct age-associated* phases – infantile, childhood, and adult – define the usual distribution of AD lesions (5). It is likely that the prevalence of AD in elderly patients is underestimated (6, 7), and AD characteristics and impact in this specific population are still insufficiently described. Indeed, while there is comprehensive information available on adult AD, there remains an under-representation of elderly subjects ≥ 65 years in clinical studies, both observational and interventional (8). We do not know whether AD in the elderly can be considered to be a fourth distinct form of this inflammatory dermatitis. In particular, the question is raised as to whether AD in the elderly presents any clinical similarities or distinctions in comparison with the

classic adult form, and more specifically with the form observed in young adults < 30 years, which is inextricably linked to AD in adolescents. Additionally, the burden of AD on elderly patients has not been accurately described to date. Lastly, treatment guidelines do not specifically address the issue of AD management for elderly patients, and the consequences for treatment options chosen in routine care have not yet been established (9).

The aim of our prospective multicentre observational study was to describe the clinical characteristics and the burden of AD in elderly subjects ≥ 65 years, as well as the therapeutic options chosen for this population in routine care, and to look for distinctive features relative to young adult patients with AD.

MATERIALS AND METHODS

This was a prospective multicentre observational study based on cohort data from the Observatoire des Maladies Cutanées Chroniques Inflammatoires (French Observatory of Chronic Inflammatory Skin Diseases) (OMCCI). The OMCCI is a French national prospective registry, launched in December 2020, with contributions from 22 dermatology investigation centres, comprising hospitals (n = 16) and private centres (n = 6). Adult patients with moderate-to-severe AD, who were seen in consultation and gave informed consent to participate in the study, were enrolled following the initiation or modification of systemic conventional, biologic, or Janus kinase inhibitor (JAKi) treatment. Patients taking part in interventional therapeutic trials were excluded. The study was approved by the French National Data Protection Authority and the national Institutional Review Board (CNRIPH 20.05.27.35855 / ID 8375).

At the inclusion, for all subjects ≥ 65 years and < 30 years satisfying entry criteria in the registry, the baseline severity of AD was assessed by a dermatologist, using the Eczema Area and Severity Index (EASI) (an EASI score < 7 indicates mild AD, an EASI score ≥ 7 and < 21 indicates moderate AD, and an EASI score ≥ 21 indicates severe AD). The anatomical regions affected were classified into 1 of 2 categories: segmental (1 or more areas affected from the limbs, torso, head and neck, extremities, and external genitalia) or generalized (involvement of the torso, all 4 limbs, head, and neck). In addition, all treatments prescribed for AD over the previous 6 months before the enrolment were recorded, as well as any changes that occurred at the time of the enrolment visit. The number of hospitalizations related to a severe worsening of atopic dermatitis in the previous 6 months was also recorded.

Patients reported the impact of AD on several aspects of their lives at the inclusion visit. QoL was assessed using the Dermatology Life Quality Index (DLQI) (range: 0–30; ≤ 5 indicates no or little impact, 6–10 indicates a moderate impact, and ≥ 11 indicates significant impact on QoL). The impact of AD on sleep and on low mood or depression over the previous 7 days was stratified into 4 levels of severity according to patients' responses: none, mild ("rarely"), moderate ("sometimes"), or severe ("very often or all the time"). The overall discomfort caused by AD was stratified into 4 levels of severity: none, mild ("a little uncomfortable"), moderate ("quite uncomfortable"), and severe ("very uncomfortable").

These physician- and patient-reported results were included in a conventional electronic case report form (eCRF) and were subject to standard control procedures.

Statistical analysis

Data management and statistical analyses were performed using SAS® software (version 9.4; SAS Institute, Cary, NC, USA). Qualitative variables were expressed as numbers (n) and percentages (%). Quantitative variables were expressed as means with standard deviations (SD) or medians with interquartile ranges (IQR). The results obtained in patients aged ≥ 65 years were compared with those obtained in young adults aged 18 to 29 years. The definition of young adults was determined by the age range distribution of the French population, according to the National Institute of Statistics and Economic Studies (INSEE) (10). The test χ^2 or Fisher's exact test (when the number of participants was less than 5) was used for qualitative variables, and the Mann–Whitney test was used for quantitative variables. The type I error (α) was set at 0.05 for all tests.

RESULTS

Between December 2020 and May 2023, 587 adult patients with AD were seen in consultation and provided data for analysis. The overall mean (SD) age of the population was 39.9 (17.5) years, with a median (IQR) age of 36 (25–50) years.

A total of 73 patients were aged ≥ 65 years (12.5%), with a mean (SD) age of 74.1 (7.3) years (extremes 65–91 years). The group aged < 30 years consisted of 207 patients (35.5%), with a mean (SD) age of 23.4 (3.2) years. The age distribution of the patients with AD is shown in **Fig. 1**. The sex ratio was 0.83 males to 1 female in those aged ≥ 65 years, and 0.97 males to 1 female in those

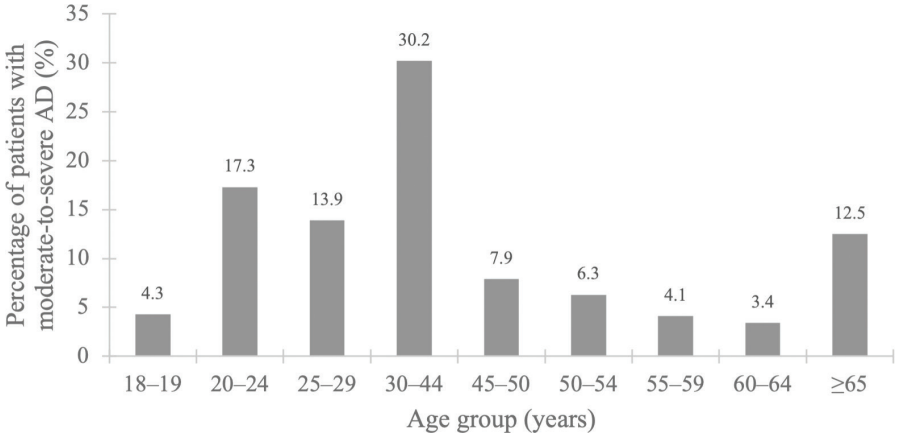

Fig. 1. Distribution of patients with moderate-to-severe AD, by age range. AD: atopic dermatitis in the OMCCI register.

aged <30 years. This difference in gender distribution was not significant.

Clinical characteristics

The mean (SD) age at AD diagnosis was 40.8 (31.6) years in patients aged ≥65 years and 6.2 (7.6) years in those aged <30 years. In patients aged ≥65 years, 63.6% were diagnosed with AD in adulthood (≥18 years), vs 11.7% of those aged <30 years. In elderly patients, over half were diagnosed with AD after the age of 51 years and 34.8% received this diagnosis after the age of 65 years. For patients aged <30 years, the disease was diagnosed in childhood (<12 years) in 76.0% of cases, vs 31.8% for those aged ≥65 years ($p<0.001$, **Table I**).

The mean (SD) EASI score was 17.8 (10.3) among patients aged ≥65 years and 20.1 (13.4) among patients aged <30 years ($p=0.343$). The distribution of severity scores was also broadly similar in the 2 groups ($p=0.130$). A severe EASI score was observed in 31.5% and 42.6% of patients aged ≥65 years and <30 years, respectively. A significantly higher proportion of patients aged ≥65 years had been hospitalized at least once over the past 6 months (12.3%) compared with patients aged <30 years (4.9%) ($p=0.032$).

The anatomical sites affected differed significantly between age groups ($p=0.043$). Patients aged ≥65 years had less involvement of the extremities (55.6% vs 68.9%, $p=0.059$) and significantly less head and neck involvement (62.3% vs 85.6%, $p<0.001$) than patients aged <30 years. The limbs and torso were found to be frequently involved in both age groups. Generalized involvement was reported in a smaller proportion of elderly patients than young adults (9.6% vs 20.5%), while segmental involvement was more frequent (87.7% vs 78.6%) ($p=0.043$).

Table I. Demographic and clinical characteristics and impact on quality of life of moderate-to-severe atopic dermatitis at inclusion, by age group

Factor	Patients ≥65 years ($n=73$)	Patients <30 years ($n=207$)	p-value
Age, median (IQR), years	72 (68–77)	23 (21–26)	
Women, *n* (%)	40 (54.8)	105 (50.7)	0.550
Age at diagnosis, years, median (IQR)	51 (3–70)	2 (1–11)	<0.001
0–11 years, *n* (%)	21 (31.8)	149 (76.0)	<0.001
12–17 years, *n* (%)	3 (4.5)	24 (12.2)	
≥ 18 years, *n* (%)	42 (63.6)	23 (11.7)	
≥ 65 years, *n* (%)	23 (34.8)	-	
EASI score (0–72), mean (SD)	17.8 (10.3)	20.1 (13.4)	0.343
mild, *n* (%)	12 (16.4)	38 (18.6)	0.130
moderate, *n* (%)	38 (52.1)	79 (38.7)	
severe, *n* (%)	23 (31.5)	87 (42.6)	
Anatomical sites affected, *n* (%)			0.043
None (clear)	2 (2.7)	2 (1.0)	
Segmental involvement	64 (87.7)	162 (78.6)	
limbs	55 (88.7)	145 (89.5)	0.863
torso	45 (72.6)	105 (64.8)	0.269
head and neck	38 (62.3)	137 (85.6)	<0.001
extremities	35 (55.6)	111 (68.9)	0.059
external genitalia	7 (11.3)	20 (12.3)	0.828
Generalized involvement	7 (9.6)	42 (20.4)	
DLQI score (0–30), mean (SD)	8.2 (4.8)	12.3 (6.7)	<0.0001
mild, *n* (%)	26 (35.6)	37 (18.0)	<0.001
moderate, *n* (%)	27 (37.0)	50 (24.3)	
severe, *n* (%)	20 (27.4)	119 (57.8)	
Itching, pain, burning sensations			0.576
not at all	4 (5.5)	7 (3.4)	
a little	17 (23.3)	42 (20.6)	
a lot or a great deal	52 (71.2)	155 (76.0)	
Impact on sleep, Likert scale			0.164
never, *n* (%)	9 (12.7)	19 (9.3)	
mild, *n* (%)	11 (15.5)	16 (7.8)	
moderate, *n* (%)	13 (18.3)	35 (17.1)	
severe, *n* (%)	38 (53.5)	135 (65.9)	
Impact on low mood and depression, Likert scale			0.578
never, *n* (%)	14 (19.2)	29 (14.1)	
mild, *n* (%)	11 (15.1)	43 (21.0)	
moderate, *n* (%)	27 (37.0)	71 (34.6)	
severe, *n* (%)	21 (28.8)	62 (30.2)	
Overall impact, Likert scale			0.164
never, *n* (%)	2 (2.9)	3 (1.5)	
mild, *n* (%)	12 (17.1)	27 (13.3)	
moderate, *n* (%)	33 (47.1)	78 (38.4)	
severe, *n* (%)	23 (32.9)	95 (46.8)	

Not all patients provided data for each variable.
DLQI: Dermatology Life Quality Index; EASI: Eczema Area and Severity Index; IQR: interquartile range; SD: standard deviation.

Burden of disease

The impact of AD on QoL, as assessed by the DLQI, was lower in patients aged ≥65 years than in patients aged <30 years (mean [SD] scores of 8.2 [4.8] vs 12.3 [6.7]; $p<0.001$). More patients aged ≥65 years (35.6%) reported a mild impact on QoL (DLQI ≤5) than patients aged <30 years (18.0%). A severe score (DLQI ≥11) was reported by 27.4% of patients aged ≥65 years vs 57.8% of patients aged <30 years. The extent of impact on QoL was significantly affected by age group ($p<0.001$). To go into further detail, patients aged ≥65 years reported significantly fewer complexes ($p=0.003$), and less impact on their choice of clothing ($p<0.031$), on their leisure activities ($p=0.005$), and on their relationships with friends and family ($p=0.019$) than patients aged <30 years (**Table II**). Regarding the functional signs of AD (itching, pain, burning sensations), there were no differences in the frequency of symptom intensity, with 71.2% and 76.0% of patients aged ≥65 years and <30 years, respectively, reporting that they experience these symptoms "a great deal" or "a lot" ($p=0.576$) (Table II).

The impact of AD on sleep was comparable between the 2 age groups, reported as being severe in 53.5% of patients aged ≥65 years and in 65.9% of patients aged <30 years, and non-existent in only 12.7% and 9.3% of patients, respectively.

Reports of low mood and depression were not significantly different between the 2 age groups. Mood was severely impacted by AD in approximately 30% of both patients aged ≥65 years and <30 years, and fewer than 20% of patients in both age groups reported their mood never being impacted.

The overall impact of AD reported by patients aged ≥65 years was less severe than that reported by patients

Table II. Details of Dermatology Life Quality Index (DLQI) item results in patients with moderate-to-severe atopic dermatitis (AD) at inclusion, by age group

DLQI items, *n* (%)	Patients ≥65 years (*n* = 73)	Patients <30 years (*n* = 207)	*p*-value
Itching			0.576
not at all	4 (5.5)	7 (3.4)	
a little	17 (23.3)	42 (20.6)	
a lot or a great deal	52 (71.2)	155 (76.0)	
Complex induced by AD			0.003
not at all	21 (28.8)	28 (13.7)	
a little	21 (28.8)	48 (23.5)	
a lot or a great deal	31 (42.5)	128 (62.7)	
Discomfort when shopping, doing housework, gardening			0.638
not at all	30 (41.1)	81 (39.7)	
a little	26 (35.6)	60 (29.4)	
a lot or a great deal	13 (17.8)	49 (24.0)	
not applicable	4 (5.5)	14 (6.9)	
Influence on choice of clothing			0.031
not at all	30 (41.1)	50 (24.5)	
a little	13 (17.8)	52 (25.5)	
a lot or a great deal	29 (39.7)	101 (49.5)	
not applicable	1 (1.4)	1 (0.5)	
Discomfort in leisure or other activities			0.005
not at all	29 (39.7)	55 (26.8)	
a little	25 (34.2)	75 (36.6)	
a lot or a great deal	14 (19.2)	72 (35.1)	
not applicable	5 (6.8)	3 (1.5)	
Discomfort when exercising			<0.001
not at all	19 (26.4)	64 (31.4)	
a little	12 (16.7)	59 (28.9)	
a lot or a great deal	12 (16.7)	63 (30.9)	
not applicable	29 (40.3)	18 (8.8)	
Inability to work or study			<0.001
no	24 (33.8)	162 (83.5)	
yes	0 (0.0)	20 (10.3)	
not applicable	47 (66.2)	12 (6.2)	
Discomfort in work or study			<0.001
not at all	23 (74.2)	47 (28.8)	
a little	4 (12.9)	79 (48.5)	
a lot	4 (12.9)	37 (22.7)	
Discomfort in relationships with friends and family			0.019
not at all	32 (44.4)	84 (41.4)	
a little	26 (36.1)	63 (31.0)	
a lot or a great deal	8 (11.1)	51 (25.1)	
not applicable	6 (8.3)	5 (2.5)	
Discomfort in sexual life			<0.001
not at all	31 (43.1)	74 (37.0)	
a little	11 (15.3)	51 (25.5)	
a lot or a great deal	4 (5.6)	51 (25.5)	
not applicable	26 (36.1)	24 (12.0)	
Impact of treatment (time-consuming, messiness)			0.688
not at all	29 (40.3)	75 (36.9)	
a little	19 (26.4)	64 (31.5)	
a lot or a great deal	17 (23.6)	51 (25.1)	
not applicable	7 (9.7)	13 (6.4)	

Not all patients provided data for each DLQI item.

aged <30 years. Specifically, 17.1% of patients aged ≥65 years reported a mild general impact and 32.9% of this group reported a severe general impact, as compared with 13.3% and 46.8% of patients aged <30 years, respectively. Only 2.9% of patients aged ≥65 years and 1.5% of patients aged <30 years reported no general repercussions, with no significant effect of age group on overall disease impact.

Treatment

Over the course of the 6 months prior to the enrolment visit, the overall distribution of the different therapeutic classes administered to patients did not reveal any significant differences between the 2 age groups ($p=0.063$) (**Fig. 2**). Among patients aged ≥65 years, 57.5% were treated with topical treatments only, 6.8% with systemic immunomodulators (3 patients with methotrexate and 2 with cyclosporine), and 6.8% with biologics (5 patients with dupilumab). Only 1 patient aged ≥65 years was treated with JAKi (baricitinib). The number of patients aged <30 years who were treated with topical treatments only was significantly lower (43.5%, $p=0.039$).

After the enrolment visit, 86.4% of patients aged ≥65 years and 84.1% of those aged <30 years received systemic treatment. Among patients aged ≥65 years, 9.6% were treated with a systemic immunomodulator (5 with methotrexate and 2 with alitretinoin) vs 8.2% of patients aged <30 years (14 with ciclosporin, 1 with methotrexate, and 1 with alitretinoin) ($p=0.718$), and 68.5% were treated with a biologic (36 with dupilumab and 14 with tralokinumab) vs 45.4% (75 with dupilumab and 19 with tralokinumab), respectively ($p=0.001$). The increase in the rate of biologic prescriptions after enrolment among both those aged ≥65 and those <30 years was significant ($p<0.001$ for each age group). The proportion of patients who were prescribed JAKi treatment was lowest in those aged ≥65 years (8.2% [5 with baricitinib and 1 with upadacitinib] vs 30.4% in those aged <30 years [41 with baricitinib, 16 with upadacitinib, and 6 with abrocitinib]; $p<0.001$) (Fig. 2).

DISCUSSION

In our cohort of adult patients with moderate-to-severe AD, 12.5% were elderly. In France, the "objectifs peau" (Skin Objectives) study found a relatively similar estimate, based on self-assessment questionnaires (9.1% of the ≥15-year-old population diagnosed with AD) (11). In studies from other European countries, this proportion varied according to the methodology used and the defined age range for the study population; however, it generally remained similar to that of our series (7, 12–14). For example, in Finland, national registries show that patients aged ≥65 years represent 15.3% of all patients aged over 14 years with AD (7). Meanwhile, in Italy, they account for almost 11.4% of the adult population with severe AD (14).

We observed 2 main modes of AD onset in elderly patients, as defined by the age at diagnosis: paediatric-onset AD, which tended to persist or recur more or less in late adulthood, and late-onset AD, which appeared in adulthood. Our study revealed that AD in the elderly is predominantly a late-onset condition, with approximately two-thirds of cases occurring in adulthood and one-third occurring from the age of 65 years or later. However, age at diagnosis is not necessarily indicative of the age at onset of the disease. In some cases, diagnosis may be delayed after onset, especially when the diagnosis is not

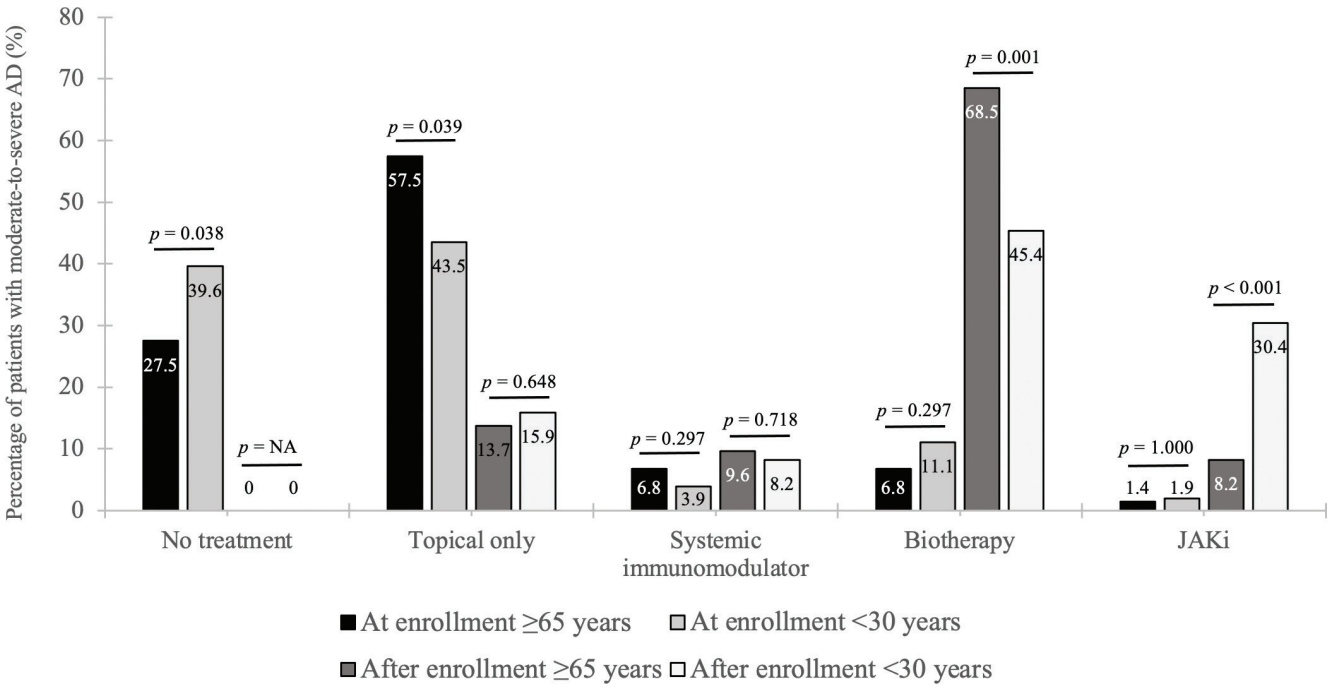

Fig. 2. Treatment options at enrolment and after the enrolment visit for patients with moderate-to-severe AD, by age group. AD: atopic dermatitis; JAKi: Janus kinase inhibitor; NA: not applicable.

easy. This may explain the relatively high proportion of AD diagnoses in the elderly.

In our series, there was no difference in the overall clinical severity of AD between the elderly patients and the young adults, although the intensity of AD in elderly patients resulted in more hospital admissions. However, several phenotypic differences between the 2 age groups were identified in our study. It is well known that patients with AD display different clinical presentations depending on age. The clinical course of infantile, childhood, and adult atopic dermatitis can be speculated to be influenced by the maturation of the adaptative immune system, changes in the sex hormone milieu, age-related barrier dysfunctions in the skin and gut, and environmental stimuli (15). In elderly AD, immunosenescence in combination with a defective aged epidermal barrier dysregulation of innate immune cells, disturbance of sweat function, and skewing of adaptive immunity to a Th2 response, might play an important role in the pathogenesis and the clinical presentation (16). Some studies have reported a tendency for involvement of the cervico-cephalic extremity and the hands in adults AD, as compared with paediatric AD (17, 18). This description does not match our findings in those aged ≥65 years. However, this difference may be related to the fact that these previous studies included a very small number of patients ≥65 years with atopic dermatitis.

Our data also pointed to a notable frequency of genital involvement in adults, although this appeared to diminish with age. To date, there have been very few reports that provide information on the prevalence of genital eczema in DA. The relatively low interest shown by dermatologists in genital eczema in AD may contribute to underestimating this condition in real-life practice studies (19). A US study reported that the involvement of genital lesions in AD was 10.3% in adults, close to the percentage we observed (20). This topography should not be overlooked when examining patients of any age, as it certainly contributes to the burden of adulthood AD.

A third of the elderly patients with AD in our study reported a severe impact on their QoL. Nevertheless, the overall DLQI score was lower among patients aged ≥65 years compared with young adults, although this result was probably underestimated as the item on occupational consequences did not concern much of our older population. It can nevertheless be observed that the aspects of quality of life most affected during the course of atopic dermatitis in both young and older adults are symptoms and emotional impact, with less impact on social functioning. However, social functioning, such as the complex induced by AD, is more affected in young adults. The results of the International Study of Life with Atopic Eczema (ISOLATE) demonstrated several years ago that more than one-third of patients report that AD has eroded their self-confidence and could lead to social isolation among the youngest (21). Symptoms such as itching, burning sensations, and pain, which are major factors in the burden and activity of AD, are experienced on an equally severe level by both elderly patients and young adults. These symptoms are frequently correlated with substantial sleep disturbances, which affected more than half of our patients, both young and elderly, supporting the notion that AD is a risk factor for sleep disturbances for patients of any age (22). Similarly, the strong asso-

ciation between AD and psychiatric comorbidities was found in the same proportions of young and older adults alike, nearly a third of whom found AD to have a major impact on mood.

At the time of enrolment, 85.0% of patients aged ≥65 years were not receiving any treatment or were receiving only topical treatments, whereas almost 9 out of 10 patients started systemic treatment after the enrolment visit. This observation raises the question of the probable inadequacy of therapeutic management for adults aged ≥65 years with AD, given the severity of their condition. A recent French publication showed that a quarter of dermatologists demonstrated therapeutic inertia with their patients with moderate-to-severe AD (23). This therapeutic inertia affects all adults with atopic dermatitis, regardless of their age, as our study seems to confirm. Besides, some patients were prescribed topical treatment only after the enrolment visit because they were waiting for a pre-therapeutic assessment or because they were no longer eligible for systemic treatment. At the end of the enrolment visit, age did not appear to be an issue for the initiation of any systemic treatment, with just 2 exceptions: ciclosporin, which was not used by any elderly patient, undoubtedly due to the higher risk of adverse effects in these patients; and JAKi, for which the number of prescriptions remained relatively marginal in comparison with those for methotrexate or biologics in patients aged ≥65 years. However, it should be pointed out that part of the enrolment period coincided with the publication of a warning concerning the prescription of JAKi, particularly in patients aged ≥65 years (24). Dupilumab was by far the preferred treatment out of the innovative therapies used by elderly patients in our study. This preference can be correlated with the reassuring data from a real-life study showing good efficacy and no serious adverse events in elderly patients treated with dupilumab (14).

Interestingly, our cohort includes patients from both hospital and private care centres across France, providing real-life data that are representative of the population with AD treated in routine dermatological care in France. Moreover, the diagnosis of AD was made by a dermatologist, guaranteeing optimal diagnostic confidence, unlike in very large-scale studies, which are generally based on data from self-assessment questionnaires or national registries, typically completed by non-dermatologists. The diagnosis of late-onset or elderly AD can be difficult for a non-dermatologist, as physicians have to rely on ruling out several differential diagnoses, without any specific clinical or paraclinical diagnostic criteria (25, 26).

Limitations

However, our study results may be limited by possible memory bias, which may interfere with the progressive history of AD. This issue has been raised in several studies, which have found a higher age of AD onset with self-reporting methods than with methods using a physician assessment at follow-up (27). This is likely to be due to the changing nature of AD, as there may be no disease activity at the time of the clinical examination, but it may be present during interval periods. The second limitation concerns generalizability, as the findings do not necessarily apply to patients with a mild form of the disease who are treated by general practitioners.

Conclusion

Our results highlight that clinical characteristics and therapeutic management of AD in elderly patients are different from those of younger patients. Although the overall impact of the disease seems to be less severe, the impact of AD on sleep and psychiatric comorbidities is similar in older and younger adult patients, with severe impact occurring in the same proportions of each group. Our study shows that dermatologists are adapting and transposing current general recommendations for AD treatment into real life, preferring biologics to ciclosporin or JAKi. Age should not be an obstacle for the prescription of effective systemic treatments if required. More studies in this specific field may help to better describe AD in elderly patients and potentially adapt guidelines in this particular population

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The authors have no conflicts of interest to declare.

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