ORIGINAL ARTICLE

Clinical Impact of Systemic Treatment Choices Made in Current Practice in Elderly Patients with Atopic Dermatitis

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Increasing life expectancy will lead to more elderly people with atopic dermatitis; however, analyses of the impact of atopic dermatitis therapy on the elderly are lacking. This prospective, multicentre observational study assessed the effect of treatment choice on the efficacy of atopic dermatitis therapies in patients with atopic dermatitis aged ≥65 years vs <65 years in France. Clinical endpoints assessed included changes in Eczema Area and Severity Index scores, atopic dermatitis-related hospitalizations, and quality of life. Between December 2020 and October 2024, 679 patients were included in the study (≥65 years: *n* = 83; <65 years: *n* = 596). At baseline, most patients had moderate/severe atopic dermatitis. Biological therapy was the most common treatment initiated at the enrollment visit (≥65 years: 72.3%; <65 years: 54.0%). At 12 months, the mean Eczema Area and Severity Index score decreased similarly in both groups (*p* = 0.845), from 17.6±9.6 to 3.7±5.2 for patients aged ≥65 years and from 18.4±12.3 to 4.3±5.5 for those aged <65 years. The reduction in number of atopic dermatitis-related hospitalizations was significant and similar in both groups, and quality of life improved across all areas. Overall, results suggest that therapeutic choices made by dermatologists have a positive impact on elderly patients with atopic dermatitis.

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

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SIGNIFICANCE

The number of elderly people with atopic dermatitis is expected to increase in the future, but data from clinical trials in the elderly are lacking. This study analysed data from 679 patients with atopic dermatitis aged ≥ 65 (*n* = 83) and < 65 (*n* = 596) years from initiation of treatment by a participating dermatologist. Results showed that treatment was as effective in elderly patients as in younger patients. Treatment improved both measures of disease and quality of life, which suggests it is possible to significantly improve the burden of atopic dermatitis in elderly patients using standard treatments with a good risk–benefit profile.

Atopic dermatitis (AD) is an inflammatory dermatosis and one of the chronic diseases with the greatest physical and psychological impact (1, 2). For a long time, AD was perceived as a disease that mainly occurred in childhood, with good outcomes and permanent remission in over 50% of patients by adolescence (3–7). Since the end of the twentieth century, as the incidence of AD in children in developed countries has risen, so have cases of AD in adults (7, 8). Recent epidemiological data suggest that patients aged ≥ 65 years now account for 9–10% of patients with AD, with an estimated prevalence of between 1% and 4% in developed countries (8–10). Two subgroups can be identified among elderly patients with AD: those with a history of childhood AD followed by a period of remission before relapse and those who developed the disease later in life. The late onset of AD is thought to be the result of a combination of a vulnerable genetic predisposition and destabilizing factors such as decline in skin barrier function, exposure to atmospheric pollutants, and the orientation of adaptive immunity towards a T-helper type 2 response (11).

We can foresee that increasing life expectancies will lead to a constant rise in the number of elderly patients with AD, and this scenario poses therapeutic challenges. Although the phenotype of AD in the elderly presents

several particularities, the overall clinical severity and psychological burden imposed by AD in the elderly is identical to that observed in younger adults (12). Given the relatively recent characterization of AD in the elderly, analyses of the consequences of therapeutic choices in terms of efficacy and safety in such patients are rare, and more in-depth analysis is required. Although targeted immunomodulatory therapies have revolutionized the treatment of AD, elderly patients represent a very small proportion of the patients with AD included in randomized trials because they have a higher risk of adverse effects (13). Furthermore, therapeutic guidelines do not specifically address the management of AD in elderly patients, which raises doubt about their applicability in this population (14, 15). As a result, dermatologists may be uncertain regarding treatment choices for AD in elderly patients.

The aim of this study was to assess the consequences, in terms of efficacy and safety, of dermatologists' therapeutic choices in the treatment of patients aged ≥65 years with AD and to compare them with those of younger adults from the viewpoints of both clinicians and patients.

MATERIAL AND METHODS

Study design

This was a prospective real-life observational study conducted as part of the Observatoire des Maladies Cutanées Chroniques Inflammatoires (OMCCI). The OMCCI is a French multicentric national prospective cohort of 32 hospital and private dermatology centres, aiming to assess the impact on quality of life and therapeutic management of the 4 most frequent chronic inflammatory skin diseases in adults (AD, psoriasis, hidradenitis suppurativa, chronic urticaria) (16). Data provided by the investigating dermatologists were collected using a standardized electronic case report form, which was completed at inclusion and then annually. The data provided by the patients were collected using a questionnaire filled in independently by the patients during the scheduled visits. This study was approved by the national ethics committee (Comité de Protection des Personnes) under reference CNRIPH 20.05.27.35855 / ID 8375.

Inclusion criteria

We included all adult patients with AD attending a consultation with one of the 46 investigating dermatologists in chronological order between December 2020 and October 2024. Patients were enrolled following the initiation or modification of systemic conventional, biologic, or Janus kinase (JAK) inhibitor treatment. All patients agreed to take part in the study and provided verbal informed consent to have their data published, in accordance with the French reference methodology MR-003.

Clinical severity or evaluation criteria

The dermatologist systematically assessed the clinical severity of the AD at enrolment using the Eczema Area and Severity Index (EASI, where a score of 0 to ≤ 7 indicates mild clinical involvement, 7 to ≤ 21 indicates moderate, and > 21 indicates severe). The number of hospitalizations related to a severe worsening of AD in the previous 6 months was also recorded.

Related quality of life was assessed using 3 different scores: the Dermatology Life Quality Index (DLQI; score 0–30; ≤ 5 indicates no or little impact, 6–10 indicates a moderate impact, and ≥ 11 indicates a significant impact on quality of life); the 12-Item Short-Form health survey (SF-12), taking into account the mental component and the physical component (both scored from 0 to 100; a score < 50 indicates poor quality of life); and a visual analogue scale (VAS) to assess the impact on daily life and family life, graded from 0 (no discomfort) to 10 (very significant discomfort). In order to take into consideration the absence of professional activities, which characterizes the majority of patients aged ≥ 65 years, we adapted the DLQI to the geriatric population by subtracting the 3 points of the item on professional repercussions (score from 0 to 27). The impact of AD on sleep was assessed using a Likert scale with 3 levels of severity: low for "never" or "rarely", moderate for "sometimes" or "often", and severe for "very often" or "constantly". Itching, pain, and burning sensations were assessed using item 1 of the DLQI and were stratified into 3 levels of severity according to patients' responses: low for "not at all", moderate for "a little", and severe for "a lot" or "very much".

The dermatologist investigator recorded any treatments the patient had received in the 6 months before the inclusion visit and any changes that had occurred by the time of the inclusion visit. Treatments were stratified as follows: no treatment, topical treatment (glucocorticoid, calcineurin inhibitor), systemic immunomodulator (methotrexate, ciclosporin, azathioprine, mycophenolate mofetil, retinoid), biologics (dupilumab, tralokinumab), or JAK inhibitor. Compliance was assessed using the GIRERD questionnaire from the French health insurance scheme (available from: https://www.ameli.fr/sites/default/files/Documents/5074/document/evaluation-observance-traitement_assurance-maladie.pdf), which includes 6 questions covering the following areas: forgetting to take the medication that morning, lack of medication since the last consultation, memory problems leading to forgetfulness, delay in taking the medication, impression of an unfavourable benefit–risk balance, and impression of too many pills to take. If all the questions are answered "no", the patient is considered to have "good compliance"; if 1 or 2 are answered "yes", the patient is considered to have "minor non-compliance", and if at least 3 are answered "yes", the

patient is considered "non-compliant".

Statistics

Participants were divided into 2 groups: age < 65 years and age ≥ 65 years. Clinical evaluation data (EASI score) – quality of life, sleep, and itching, pain, or burning sensations scores – were compared between the 2 groups at inclusion and at 12 months. The percentages of patients with "good" or "minor" non-compliance or who were "non-compliant" were compared between the 2 groups at 12 months. Data were analysed using SAS® software (version 9.4; SAS Institute, Cary, NC, USA). Categorical variables were expressed as numbers and percentages. Quantitative variables were expressed as mean ± standard deviation (SD) or median with interquartile range (IQR; 25–75%). Data were compared between subjects aged ≥ 65 and <65 years using the χ^2 test or Fisher's exact test for qualitative data. The Wilcoxon test was used for quantitative data. Treatment maintenance and discontinuation rates were calculated using the Kaplan–Meier method. The type 1 error (alpha) was set at 5%.

Table I. Clinical characteristics and therapeutic choices at study inclusion, by age group

Factors	Age category		
	< 65 (*n* = 596)	≥ 65 (*n* = 83)	*p*-value
Age, years, median (IQR)	33 (25–45)	72 (68–77)	
Male sex, *n* (%)	281 (47.1)	39 (47.0)	0.978
Age at diagnosis, years, median (IQR)	3 (1–15)	55 (5–70)	< 0.001
EASI score (0–72), mean ± SD	18.4 ± 12.3	17.6 ± 9.6	0.684
Mild, *n* (%)	101 (17.1)	12 (14.5)	
Moderate, *n* (%)	301 (50.5)	46 (55.4)	
Severe, *n* (%)	194 (32.5)	25 (30.1)	
Hospitalized for AD in the previous 6 months, *n* (%)	21 (3.5)	5 (6.0)	0.266
Treatments received in the previous 6 months, *n* (%)			
Topical only	438 (73.5)	62 (74.7)	
Systemic immunomodulator	32 (5.4)[b]	5 (6.0)[a]	
Biologics	40 (6.7)[d]	7 (8.4)[c]	0.945
JAK inhibitor	9 (1.5)	1 (1.2)	
No treatment	74 (12.4)	8 (9.6)	
Others (phototherapy)	3 (0.5)	0 (0)	
Initiated or ongoing treatment received after inclusion visit, *n* (%)			
Systemic	73 (12.3)[f]	8 (9.6)[e]	
Biologics	355 (59.6)[h]	67 (80.7)[g]	0.001
JAK inhibitor	168 (28.2)[j]	8 (9.6)[i]	

[a]Two ciclosporin and 3 methotrexate. [b]19 ciclosporin, 7 methotrexate, 5 alitretinoin, 1 prednisone. [c]Five dupilumab, 2 tralokinumab. [d]35 dupilumab, 5 tralokinumab. [e]Six methotrexate, 2 alitretinoin. [f]53 ciclosporin, 16 methotrexate, 2 alitretinoin, 1 acitretin, 1 phototherapy. [g]43 dupilumab, 24 tralokinumab. [h]281 dupilumab, 74 tralokinumab. [i]Six baricitinib, 1 abrocitinib, 1 upadacitinib. [j]89 baricitinib, 41 abrocitinib, 38 upadacitinib.
IQR: interquartile range; SD: standard deviation; AD: atopic dermatitis; EASI: Eczema Area and Severity Index; JAK: Janus kinase.

RESULTS

From December 2020 to October 2024, a total of 679 patients with AD were included in the OMCCI. The mean ± SD age of the population was 39.9 ± 17.3 years, with a median age of 35 (IQR 26–51) years. Among these patients, 83 (12.2%) were aged ≥ 65 years and 596 (87.8%) were aged <65 years, and the sex ratio slightly favoured women in both groups (**Table I**). The mean age of disease onset was 42.3 ± 30.8 (median 55; IQR 5–70) years in patients aged ≥ 65 years and 10.3 ± 14.4 (median 3; IQR 1–15) years in patients aged <65 years. The mean initial EASI score was 18.3 ± 11.9, with no significant difference between the 2 groups ($p = 0.876$); 51.1% had moderate and 32.2% had severe AD. In the 6 months before the enrolment visit, 6% of patients aged ≥ 65 years had been hospitalized at least once because of worsening AD. In both groups, 73.6% of patients were treated with topical treatments alone (Table I).

The choice of treatment initiated by dermatologists after the enrolment visit was most often a biological therapy, accounting for 72.3% of prescriptions in patients aged ≥ 65 years and 54.0% in patients aged <65 years ($p < 0.001$). Prescription of JAK inhibitors was lower in patients aged ≥ 65 years (8.4%) than in those aged <65 years (26.4%) ($p < 0.001$).

AD had a major impact on patients' quality of life at enrolment in the 2 age groups: 54.7% of patients expressed a significant impact (DLQI score ≥ 11), 76.7% of patients reported experiencing "severe" itching, pain, or burning sensations and 83.7% experienced a moderate to severe impact on their sleep due to their AD (**Table II**). The physical impact of AD, as assessed by the SF-12 score, was higher in the older than in the younger subjects at enrolment ($p = 0.012$), in contrast to the mental impact of the disease, which was lower in the older than in the younger subjects ($p = 0.014$).

At 12 months, 627 patients were still being followed up in the study, and 52 patients (7.6% of the initial enrolment) were lost to follow-up, with proportions similar between the 2 groups. After 1 year of follow-up, the mean EASI score decreased similarly in both groups ($p = 0.845$), from 17.6 ± 9.6 to 3.7 ± 5.2 for patients aged ≥ 65 years and from 18.4 ± 12.3 to 4.3 ± 5.5 for those aged <65 years. The percentage of patients with moderate or severe AD decreased from 85.5% to 13.1% for patients aged ≥ 65 years and from 82.9% to 19.4% for those aged <65 years (**Fig. 1**).

The number of AD-related hospitalizations in the previous 6 months fell from 6.0% (5/83) to 2.6% (2/76) in patients aged ≥ 65 years and from 3.5% (21/596) to 0.7% (4/551) in patients aged <65 years, with no significant difference between the 2 groups at 12 months ($p = 0.158$).

For patients receiving biologics ($n = 324$ with dupilumab, $n = 98$ with tralokinumab), the 12-month treatment maintenance rate was very satisfactory in both groups: 89.6% (60/67) for patients aged ≥ 65 years and 93.0% (330/355) for those aged <65 years. The improvement in mean EASI score for patients receiving biologics was similar in the 2 groups ($p = 0.701$), with a reduction in the mean score for patients aged ≥ 65 years of 17.9 ± 9.4 to 3.4 ± 4.6 at 12 months. Of the patients who were still treated with biologics after 1 year of follow-up, the percentage with severe AD (EASI > 21) decreased from

Table II. Patient perceptions of the impact of atopic dermatitis (AD) on quality of life at study enrolment and after 12 months of treatment

Outcome	Enrolment visit			After 12 months of treatment		
	<65 years ($n=596$)	≥65 years ($n=83$)	p-value	<65 years ($n=551$)	≥65 years ($n=76$)	p-value
DLQI, mean±SD	12.5±6.3	8.2±5.0	<0.001	4.3±5.2	2.6±4.2	<0.001
Adjusted DLQI[a], mean±SD	11.6±5.8	8.1±5.0	<0.001	4.0±4.7	2.5±4.1	<0.001
SF-12 physical, mean±SD	49.37±8.31	46.61±9.45	0.012	54.65±5.03	49.01±9.70	<0.001
SF-12 mental, mean±SD	37.03±11.15	40.25±12.2	0.014	44.35±10.6	45.5±10.02	0.366
VAS impact on daily life, mean±SD	7.14±2.01	6.24±2.11	<0.001	2.82±2.42	2.37±2.34	0.077
VAS impact on family life, mean±SD	5.78±2.72	4.66±2.91	0.001	1.98±2.33	1.54±2.19	0.039
Itching, pain, burning sensations, n (%)						
Low	14 (2.3)	4 (4.8)		227 (41.3)	43 (56.6)	
Moderate	119 (19.9)	21 (25.3)	0.160	244 (44.2)	25 (32.9)	0.041
Severe	463 (77.8)	58 (69.9)		80 (14.5)	8 (10.5)	
Impact on sleep, n (%)						
Low	90 (15.1)	21 (25.3)		403 (73.1)	64 (84.2)	
Moderate	234 (39.3)	38 (45.8)	0.006	111 (20.1)	12 (15.8)	0.016
Severe	272 (45.6)	24 (38.9)		37 (6.7)	0 (0.0)	

[a]Dermatology Life Quality Index (DLQI) out of 27 points, after removing the 3 points for the work-related item.
SD: standard deviation; SF-12: 12-Item Short Form Health Survey; VAS: visual analogue scale.

29.9% to 3.3% in patients aged ≥65 years and from 33.4% to 0.3% in patients aged <65 years (**Fig. 2**). A total of 10 patients aged ≥65 years stopped their biologics during the first year, 6 because of lack of efficacy, 3 at the patient's request, and 1 because of conjunctivitis. The 12-month maintenance rate for JAK inhibitors ($n=95$ baricitinib, $n=42$ abrocitinib, $n=39$ upadacitinib) was 75% (6/8) in patients aged ≥65 years and 74.4% (125/168) in patients aged <65 years. Two patients aged ≥65 years stopped their JAK inhibitor treatment during the 12 months: 1 because of lack of efficacy and 1 at the patient's request.

For patients receiving systemic immunomodulators, the 12-month discontinuation rate was 50% (4/8) in patients aged ≥65 years and 71.2% (52/73) in patients aged <65 years. Among patients aged ≥65 years, the discontinuation rate for methotrexate was 50% (3/6) (2 because of lack of efficacy, 1 because of an adverse event) and was similar to that observed in those aged <65 years (62.5%; 10/16). Overall, compliance with all treatments was significantly better in those aged ≥65 years at 12-month follow-up ($p<0.001$), with none of these patients not complying compared with 6.4% (35/550) in those aged <65 years.

At 12-month follow-up, patients' perception of the impact of AD on their quality of life improved across all areas (see Table II). The mean DLQI scores and the

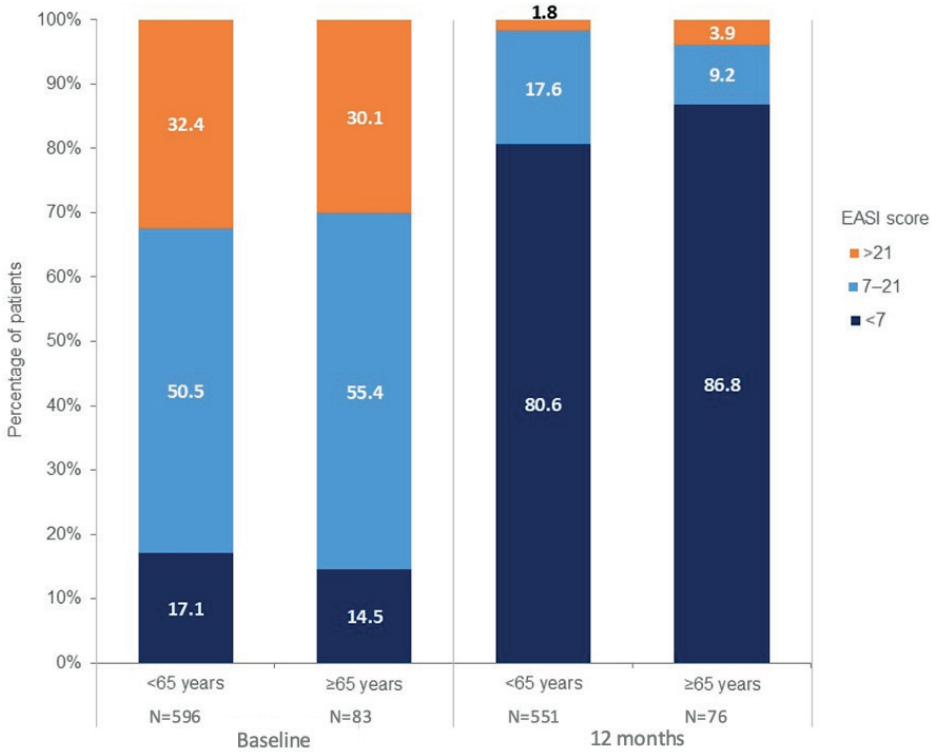

Fig. 1. Evolution of the Eczema Area and Severity Index (EASI) score at inclusion and after 12 months of treatment with any therapy, by age group. Numbers may not add to 100% due to rounding.

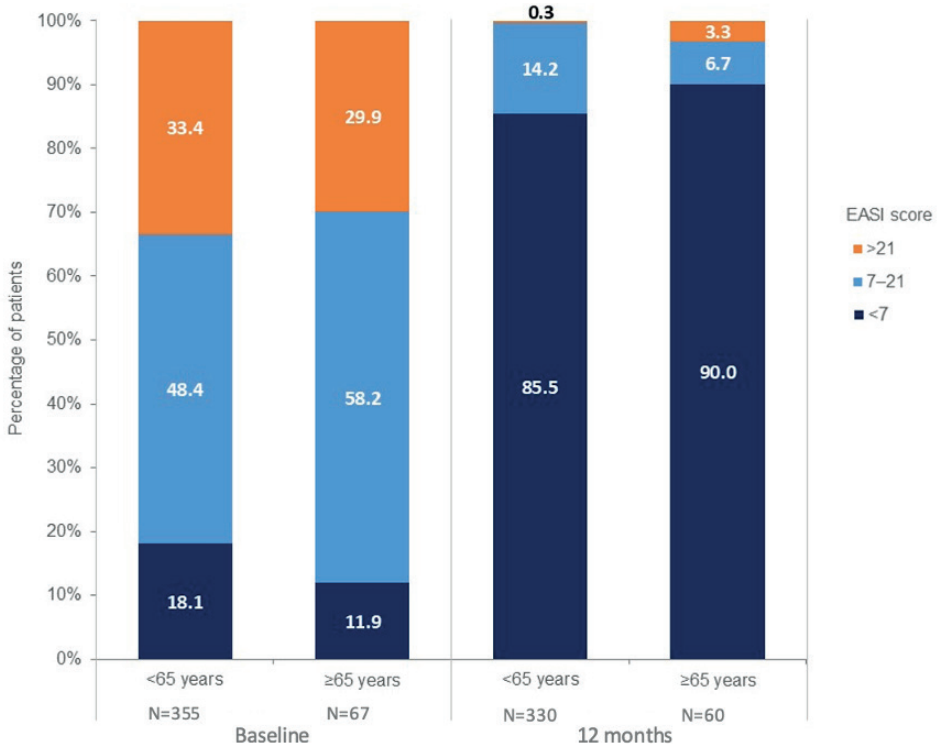

Fig. 2. Evolution of the Eczema Area and Severity Index (EASI) score at inclusion and after 12 months of treatment with biologics, by age group. Numbers may not add to 100% due to rounding.

mean DLQI scores adapted to the geriatric population were both higher in patients aged <65 years at baseline and after 12 months of follow-up ($p<0.001$). The percentage of patients with "severe" itching, pain, or burning sensations was higher in the <65 years group than the ≥65 years group at both baseline and 12 months; however, the between-group difference was significant only at 12 months ($p=0.041$) (Table II). A significantly greater percentage of the <65 years group reported a severe impact on sleep at both baseline and 12 months (Table II). At 12 months, the mean SF-12 physical dimension score was significantly lower in patients aged ≥65 than in patients aged <65 years ($p<0.001$), whereas the SF-12 mental dimension mean score was comparable between the 2 groups ($p=0.366$).

DISCUSSION

Our study shows that dermatologists' use of systemic treatments in elderly patients, when the severity of AD requires them, results in both a comparable clinical improvement (EASI score) to that in younger adults and a major improvement in pruritus and sleep quality. The higher mean DLQI scores and the physical dimension of the SF-12 in patients aged ≥65 years compared with younger adults should be interpreted in light of the specific characteristics of the elderly population. In particular, the items relating to professional activity are less relevant, and the basic physical capacity of patients aged ≥65 years is lower than that of younger adults. Our results also provide reassuring information concerning the safety profile of treatments, particularly biologics, in elderly patients. This positive safety profile is enhanced by a very satisfactory rate of treatment persistence and a very good level of compliance, which are comparable to or even better than those of younger adults.

These positive results are particularly important in relation to the considerable remaining therapeutic inertia in prescribers for moderate to severe AD (17). In our study, 84.3% of patients aged ≥65 years were receiving no treatment or only topical treatments at the time of inclusion, which is totally inadequate for the severity of their AD. Nevertheless, we emphasize that the evaluation of therapies in the elderly remains a subject little addressed in the medical literature, which may represent a source of therapeutic restraint. Indeed, the median age of adult patients in the pivotal phase III trials for dupilumab, tralokinumab, and JAK inhibitors was between 34 and 40 years (18–30). Subjects aged > 65 years represent between only 4% and 4.9% of adult patients when details of age distribution are available (31–33). More recently, a pooled analysis of 4 randomized controlled trials evaluated the efficacy and safety of dupilumab in 183 patients aged > 60 years (i.e., 8% of the total population), and both showed efficacy in terms of EASI score, quality of life, and pruritus and reported reassuring data on the safety of dupilumab in this population over a median follow-up of 16 weeks (34).

None of the dermatologists in our study used ciclosporin to treat AD in elderly patients, even though European recommendations include ciclosporin as a first-line systemic treatment for severe AD (15). However, these

recommendations do not account for the patient's age in the therapeutic strategy. To be consistent with clinical practice, dermatologists' reluctance to use ciclosporin in elderly patients, probably due to fears of a higher risk of adverse reactions, should be considered in future evaluations of its place in the therapeutic strategy for AD.

The prescription of JAK inhibitors in patients aged ≥65 years was marginal in our study compared with that of biologics. However, part of the recruitment period coincided with the publication of a warning concerning the prescription of JAK inhibitors, particularly in patients aged ≥ 65 years (33). Nevertheless, although the number of patients treated was small, with a short duration of exposure, in our study we noted a positive risk–benefit profile of JAK inhibitors in older patients, comparable to that in younger patients. The good risk–benefit profile of JAK inhibitors in AD, even in the presence of 1 or more risk factors defined by the Pharmacovigilance Risk Assessment Committee of the European Medicines Agency, has been highlighted in several retrospective and prospective studies (35–37).

Strengths and limitations

The strength of our study lies in its prospective nature, with real-life data, including evaluation from the patients' viewpoints (self-completed questionnaires), from hospital and private healthcare centres throughout France. Furthermore, the diagnosis of AD was made by dermatologists with expertise in chronic inflammatory dermatoses, which is very important given that, in elderly subjects, several differential diagnoses likely to mimic AD must be excluded, such as allergic contact dermatitis and cutaneous T-cell lymphoma. The proportion of patients aged ≥65 years (12%) among the adults with AD included in our study is comparable to figures from international epidemiological studies, indicating that our sample is representative. However, our study has some limitations. The first limitation concerns generalizability, as our results do not apply to patients with a mild form of the disease who are treated by general practitioners. The second limitation concerns the fact that the included study population depended on the voluntary participation of patients and physicians, which may introduce a selection bias in favour of patients who were most involved in their medical care.

Conclusion

The clinical impact of the therapeutic choices made by dermatologists in routine practice for elderly subjects with moderate to severe AD has been very positive in terms of efficacy and safety, making it possible to significantly improve the burden of the disease with a good risk–benefit profile. Dermatologists prefer to prescribe biologics, the efficacy and safety profiles of which are identical in elderly patients to those in younger patients and consistent with results from randomized controlled trials. Of course, further data from routine practice cohorts are needed to confirm these results, but we hope that our data will help to remove the existing therapeutic barriers to the effective treatment of elderly patients with AD.

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