Treatment Patterns, Inadequate Disease Control and Burden/Unmet Need among Adult Patients with Moderate-to-Severe Atopic Dermatitis: Results from the Adelphi Real World Disease Specific Programme

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KEY TAKEAWAYS/CONCLUSIONS

- Long-term disease control is a key treatment goal for patients with moderate-to-severe atopic dermatitis (msAD) that is frequently not met by available therapeutic options. Itch relief and improved patient well-being were also among the top 3 treatment goals.
- 48% of patients with msAD who were receiving treatment at the time of data collection were initiated on their current therapy due to a flare, suggesting reactive prescribing.
  - High topical corticosteroid (TCS) use persisted across 1st, 2nd and 3rd treatment regimens, whereas advanced systemic treatment (AST) use increased from 1st to 3rd regimen peaking at 28%.
- However, nearly half of all patients and approximately a third of AST patients with msAD experienced no improvement in flare frequency or severity after receiving at least 3 months current therapy.

INTRODUCTION/OBJECTIVE

- To describe treatment patterns, disease control and burden in patients with msAD across US/Europe (France/Germany/Italy/Spain/United Kingdom).

METHODS

- Data were drawn from the Adelphi Atopic Dermatitis (AD) Disease Specific Programme™, a cross-sectional survey, with retrospective data collection from physicians on their patients with AD in US/Europe collected between August 2022-April 2024[1-4].
- Adult patients with current physician-assessed msAD were analyzed.
- We assessed patient demographics, treatment patterns, and clinical characteristics collected from patient record forms.
- All analyses were descriptive.

RESULTS

Treatment burden

Table 1. Physician-reported patient demographics

	All patients (n=3238)	Current msAD patients (n=1484)
Patient age (years), mean (SD)	37.4 (15.0)	37.3 (15.5)
Patient sex, female, n (%)	1575 (49)	712 (48)
BMI (kg/m²), mean (SD)	25.0 (5.8)	25.2 (3.9)
Patient race/ethnic origin, n (%)	(n=2705)	(n=1202)
White/Caucasian	2345 (87)	1022 (85)
Other*	360 (13)	180 (15)
Region, n (%)		
EU5	2491 (77)	1051 (71)
US	747 (23)	433 (29)
Patient employment status, n (%)	(n=3154)	(n=1457)
Working full time	1897 (60)	845 (58)
Comorbidities, n (%)		
Presence of atopic triad	1135 (35)	481 (32)
Time since diagnosis (years), mean (SD)	(n=1581)	(n=780)
	7.1 (9.7)	6.1 (8.9)

Patient race asked in US/ethnic origin in EU4 (not asked in France). *Other includes; Black or African American, Afro-Caribbean, Asian, Asian (Indian subcontinent), South-East Asian, Asian (other), Native Hawaiian and other Pacific Islander, Hispanic/Latino, Middle Eastern and other. Atopic triad = Allergic Rhinitis or Asthma as a diagnosed comorbidity. Change in patient number due to don't know/missing data.

- 76% of patients were receiving TCS, mainly moderate or potent/very potent TCS at the time of data collection **(Table 2)**.
- 26% were receiving an AST (a biologic or oral JAKi) at the time of data collection **(Table 2)**.
- 48% of patients receiving treatment at the time of data collection were initiated on their current treatment due to a flare **(Table 2)**.

Table 2. Physician-reported current treatment regimen, duration and initiation in response to a flare

n (%)	Current msAD patients (n=1418)
Prescribed emollients	502 (35)
PDE4 (Staquis)	62 (4)
TCS (grouped)	1078 (76)
TCS: Mild potency	124 (9)
TCS: Moderate potency	579 (41)
TCS: Potent/ Very potent	497 (35)
TCI	299 (21)
O/ICS	253 (18)
IS	239 (17)
Biologics (grouped)	266 (19)
Dupixent/ dupilumab	221 (16)
Adbry/ tralokinumab	45 (3)
Oral JAKis (grouped)	103 (7)
Rinvoq/ upadacitinib	43 (3)
Cibinqo/ abrocitinib	32 (2)
Olumiant/ baricitinib	28 (2)
Duration of current regimen (Months)	Mean: 15.7, Median 6.5 (n=1123)
Was this current treatment regimen initiated in response to an acute episode (flare), yes	682 (48) (n=1414)

All patients receiving treatment at the time of data collection. Change in patient number due to don't know responses/missing data.

- TCS was the most frequently prescribed therapy class across all regimens **(Table 3)**.
- AST use increased with each regimen with 11% of patients receiving AST at first line, 20% at second line and 28% at third line **(Table 3)**.

Table 3. Treatment regimens and durations

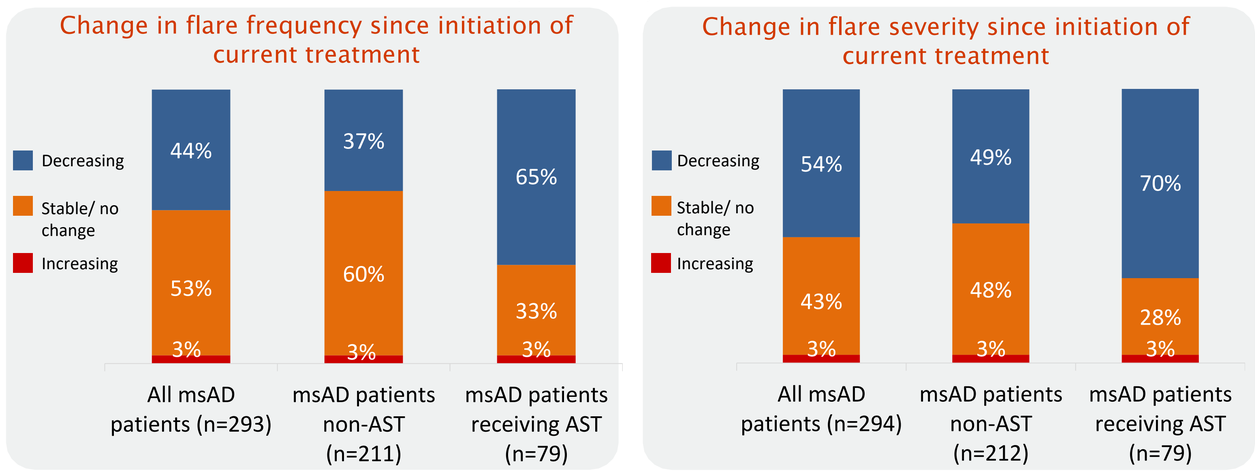
n (%)	1st treatment regimen (n=1082)	2nd treatment regimen (n=525)	3rd treatment regimen (n=218)
Prescribed emollients	384 (35)	171 (33)	79 (36)
PDE4 (Staquis)	58 (5)	33 (6)	5 (2)
TCS (grouped)	853 (79)	340 (65)	155 (71)
TCS: Mild potency	132 (12)	61 (12)	17 (8)
TCS: Moderate potency	441 (41)	169 (32)	85 (39)
TCS: Potent/ Very potent	369 (34)	154 (29)	87 (40)
TCI	150 (14)	131 (25)	48 (22)
O/ICS	170 (16)	87 (17)	35 (16)
IS	139 (13)	105 (20)	51 (23)
Biologics (grouped)	88 (8)	74 (14)	48 (22)
Dupixent/ dupilumab	69 (6)	65 (12)	40 (18)
Adbry/ tralokinumab	20 (2)	9 (2)	8 (4)
Oral JAKis (grouped)	29 (3)	30 (6)	13 (6)
Rinvoq/ upadacitinib	10 (1)	18 (3)	8 (4)
Cibinqo/ abrocitinib	14 (1)	7 (1)	2 (1)
Olumiant/ baricitinib	6 (1)	5 (1)	3 (1)
Duration of regimen (Months)	Mean: 20.9, Median 10.4 (n=648)	Mean: 14.4, Median 6.0 (n=355)	Mean: 9.8, Median 4.5 (n=153)

All patients with full treatment history data. Base drops due to don't know responses/missing data.

- After a minimum of 3 months on their current treatment, around half of all current msAD patients experienced no improvement in flare frequency or severity **(Figure 1)**.
- This was also the case for 36% and 31% of msAD patients receiving AST for at least 3 months, who reported no improvement in flare frequency or severity, respectively **(Figure 1)**.

Lack of improvement in flare frequency and severity

Figure 1. Physician-reported change in flare frequency/severity since initiation of current treatment at least 3 months previously

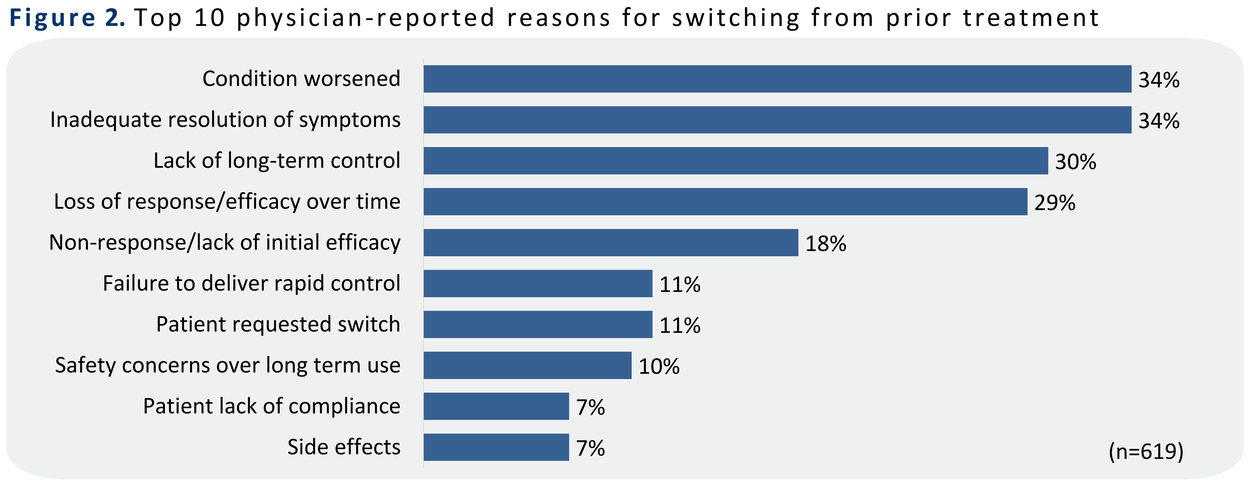


All patients receiving their current treatment for ≥3 months at the time of data collection. Don't know responses were removed.

- The most frequently reported reasons for treatment switch were condition worsened, inadequate symptom resolution, lack of long-term control, and loss of response/efficacy over time **(Figure 2)**.

Lack of long-term control a main reason for switch

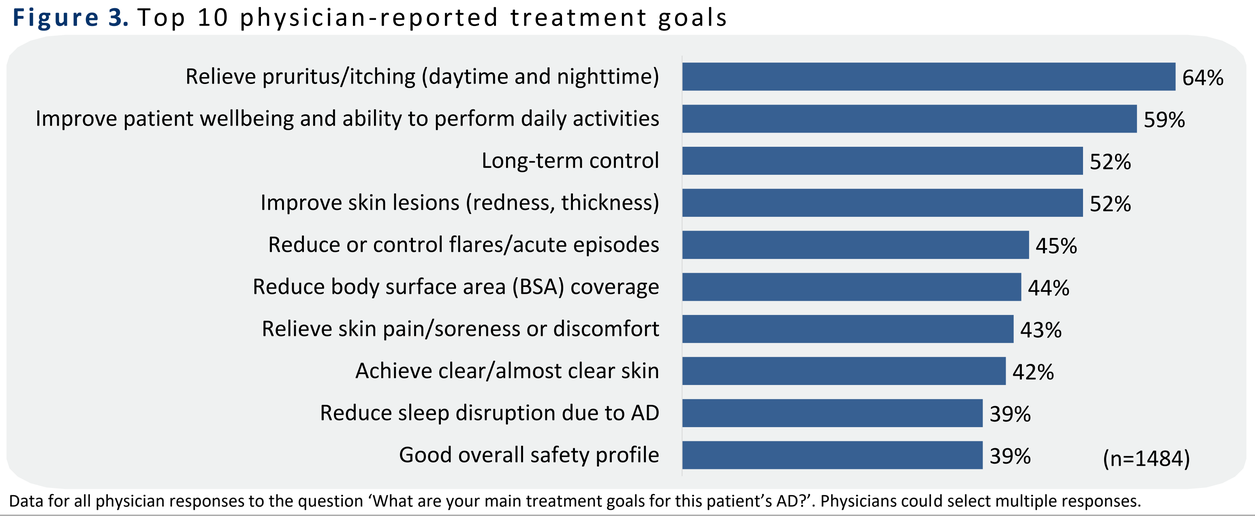
Figure 2. Top 10 physician-reported reasons for switching from prior treatment



All patients receiving treatment at the time of data collection with a reported prior treatment. Physicians could select multiple responses.

- Relief of itch (64%), improvement of patient wellbeing/ability to perform daily activities (59%), long-term control (52%), and improvement of skin lesions (52%) were the most frequent physician-reported treatment goals **(Figure 3).**

Figure 3. Top 10 physician-reported treatment goals



Data for all physician responses to the question 'What are your main treatment goals for this patient's AD?'. Physicians could select multiple responses.

DISCLOSURE:

JS has received honoraria as a consultant and/or advisory board member for Abbvie, Aldena, Aldena, Amgen, AObiome, Apollo, Arcutis, Arena, Asana, Aslan, Attovia, Bodewell, Boehringer-Ingelheim, Bristol-Meyers Squibb, Cara, Castle Biosciences, Celgene, Connect Biopharma, Corevitas, Dermavant, Eli Lilly, FIDE, Formation Bio, Galderma, GlaxoSmithKline, Incyte, Inmagene, Invea, Kiniksa, Leo Pharma, Merck, Nektar, Novartis, Optum, Pfizer, RAPT, Recludix, Regeneron, Sandoz, Sanofi-Genzyme, Shaperon, TARGET-RWE, Teva, Triveni, UCB, Union, UpToDate; speaker for Abbvie, Arcutis, Dermavant, Eli Lilly, Galderma, Leo Pharma, Pfizer, Regeneron, Sanofi-Genzyme; received institutional grants from Galderma, Incyte, Pfizer. **KD** is an employee of Amgen Inc. **AS** is an employee of Amgen Inc. **JQ** is an employee of Kyowa Kirin, Inc. **JP, PA, OH, CM** are employees of Adelphi Real World, Bollington, UK.

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ABBREVIATIONS:

AD, atopic dermatitis; **msAD**, moderate-to-severe atopic dermatitis; **AST**, advanced systemic therapy; **SD**, standard deviation; **BMI**, Body Mass Index; **TCS**, topical corticosteroid; **TCI**, topical calcineurin inhibitor; **O/ICS**, oral/ injected corticosteroid; **IS**, immunosuppressant; **JAKi**, janus kinase inhibitor; **BSA**, body surface area.