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LETTER TO THE EDITOR

French guidelines for the management of atopic dermatitis

Dear Editor,

The Centre of Evidence (CDP) and the Atopic Eczema Research Group (GREAT) of the French Society of Dermatology (SFD) have developed evidence-based guidelines for the management of atopic dermatitis. These include a user-friendly algorithm designed for daily practice. To create these guidelines, we adapted the 2022 guidelines on atopic dermatitis from the European Dermatology Forum (EDF)[1,2] based on systematic reviews (SR) conducted from 2013 to 2020, with their permission. At the time of their publication, these guidelines represented the most current and methodologically robust document available, meeting the expectations of the French Health Authorities (HAS) and closely aligning with French clinical practices.

This letter aims to share the interests and limitations encountered during the methodological process of adapting recommendations.

The ADAPTE method[3] was used, which was validated by the HAS. A steering committee assessed the EDF guidelines using the AGREE II grid.[4] A multidisciplinary working group (WG) of 13 physicians, with no conflicts of interest, updated the literature search from 2020 to 2022 for the questions previously addressed by the EDF recommendations. The living systematic review and network meta-analysis by Drucker et al.[5] was used for systemic treatments. New questions of interest were also defined by the WG (Table 1). Relevant SRs were selected and assessed using the AMSTAR 2 grid and extracted according to a predefined form.

In case of shortcomings in the literature (where no SR met the inclusion criteria), 14 experts (dermatologists, paediatricians, allergists) were consulted to review a list of questions.

After analysing the selected SRs and the experts' opinions, the WG established recommendations by grading the evidence levels using the terminology suggested by the GRADE WG.[6]

A 31-member panel, including dermatologists, allergists, paediatricians, general practitioners, pharmacists, patients, parents, psychologists, occupational physicians and nurses, rated each recommendation on a scale of 1 (total disagreement) to 9 (total agreement). If 80% voted 8 or 9, consensus was reached; otherwise, the panel revisited and potentially modified the recommendation.

The WG produced a comprehensive set of recommendations in French for practitioners and patients and synthesized the work into a practical decision-making algorithm (Figure 1). Both will be freely accessible on the CDP website (https://reco.sfdermato.org/en/).

The strength of these recommendations lies in the ADAPTE method, a rigorous and reproducible methodology useful for adapting existing clinical practice recommendations to a specific health system. This process included new questions and expert advice.

Although the latest European/French marketing authorizations have been incorporated into the recommendations, the updating and adapting process remains lengthy. Therefore, there was a 2-year delay between the end of the literature review and the publication of the guideline. As a result, recent data on new systemic and topical treatments (e.g. nemolizumab, and topical JAK inhibitors) could not be included.

To address this issue, 'living guidelines',[7] defined as 'an optimisation of the guideline development process to allow updating individual recommendations as soon as new relevant evidence becomes available', should be considered, as done by the Euroguiderm team (2024 updated version[8]), even though the population included in phase 3 trials may limit real-world applicability. The CDP is developing a general methodology for updating and adapting recommendations, which comprises two parts: a literature review (to incorporate new relevant evidence) and expert opinions on specific questions not covered in the literature, including clinical vignettes. Real-world evidence and clinician feedback will be discussed in future guidelines updates, which will be regular and faster than the process of developing recommendations because they will only target certain key points.

The objective is to provide updated, practical guidelines for clinicians treating skin conditions that benefit from newly marketed drugs, while maintaining high methodological standards.

The guidelines were presented orally at the *Journées Dermatologiques de Paris* in December 2024, Paris, France.

TABLE 1 New questions of interest for the French guidelines on the management of atopic dermatitis.

Questions	Conclusion of the French recommendations	Strength
Patient perspective and impact of illness		
What is the impact of AD on family life?	We recommend assessing the impact on family life	↑↑
Comorbidities		
How should comorbidities be managed in children and adults with atopic dermatitis?	We recommend searching for atopic comorbidities associated with atopic dermatitis: food allergy, asthma, allergic conjunctivitis and allergic rhinitis, particularly in patients with risk factors (severe, early and/or persistent atopic dermatitis).	↑↑
How should other comorbidities associated with AD be managed?	We recommend screening for cardiovascular risk factors in adult patients with atopic dermatitis, particularly when initiating systemic treatment with cyclosporine or JAK inhibitors.	↑↑
	We suggest screening for bone mineralization disorders according to the same recommendations as for the general population.	↑
	We cannot make a recommendation on screening for hemopathy given the heterogeneous data concerning the association between atopic dermatitis and hemopathy.	0
	We suggest regular screening for skin cancers in patients with atopic dermatitis, particularly if they have one or more risk factors (including phototherapy, immunosuppressive treatments).	↑
	We recommend screening for non-cutaneous cancers identical to those of the general population in patients with atopic dermatitis.	↑↑
Skin hygiene		
What is the role of baths in secondary prevention?	We suggest taking short, lukewarm baths or showers with cleansing products without allergens or irritants, with a pH between 5 and 6. The choice of washing frequency is left to the convenience of the patient or parent (showering or bathing every day does not change the severity of atopic dermatitis).	↑
Infectious complications		
In what situation should a microbiological sample be taken? Which one?	Bacteriological sampling only for extensive impetiginized lesions (more than 6 lesions or surface superior or equal to 2% or rapid extension of the lesions)	Experts' opinion
What are the benefits of antiseptics in AD?	We recommend against the use of topical antiseptics either for the treatment of flare-up atopic dermatitis or for the treatment of impetiginization.	↓↓
Atopic dermatitis and diet		
How to adapt dietary diversification for secondary prevention in AD?	We recommend carrying out dietary diversification from 4 months for all foods and not making preventive avoidance.	Experts' opinion
Are dietary supplements and vitamins recommended for the management of AD?	We cannot make a recommendation with respect to the use of dietary supplements and antioxidants in the management of atopic dermatitis.	0
	We recommend against the use of evening primrose oil and borage oil in the management of atopic dermatitis.	↓↓
	We cannot make a recommendation on the use of vitamin D in the management of atopic dermatitis. Its use in the general population, in children and adolescents, is already recommended in France up to the age of 18.	0
Therapeutic education		
How to detect and manage corticophobia?	We recommend addressing corticophobia from the first consultation and during therapeutic education sessions to limit possible fears of the patient and those around them linked to the use of topical corticosteroids.	↑↑
Alternative therapies		
What is the benefit of thermal treatments in the management of AD?	There is no evidence in the literature about the effectiveness of thermal treatments, but they can be suggested for certain patients after explaining the advantages and limitations and in a place that is adapted to atopic dermatitis.	Experts' opinion

TABLE 1 (Continued)

Questions	Conclusion of the French recommendations	Strength
Systemic treatments		
On what criteria should we propose therapeutic relief or modify current treatment in the event of remission?	We suggest the following course of action for therapeutic relief in the event of complete or almost complete remission under systemic treatment: • for cyclosporine, dose reduction upon complete or almost complete remission and without exceeding a total treatment duration of 1 year. • for methotrexate, dose reduction after 6 months of complete or almost complete remission in stages until a minimum effective dose. • for dupilumab, spacing of injections possible after 6 months of complete or almost complete remission. • for lebrikizumab, the marketing authorization allows for a spacing of injections every 4 weeks after complete or almost complete remission after 16 weeks of treatment. • for tralokinumab, the marketing authorization provides for a possible spacing of injections every 4 weeks after complete or almost complete remission after 16 weeks of treatment. • for JAK inhibitors (baricitinib, upadacitinib and abrocitinib), possible reduction to the lowest dose available after at least 6 months of complete or almost complete remission.	Experts' opinion
What are the main differences in the management of AD in the elderly?	For elderly people requiring systemic treatment, we recommend in order of preference: biologics, methotrexate at the minimum effective dose, JAK inhibitors at the lowest dose available. We do not recommend using cyclosporine.	Experts' opinion

Note: 2 green arrows: Strong recommendation for use. 1 green arrow: Weak recommendation for use. Purple zero: No recommendation for or against. 1 pink arrow: Weak recommendation against use. 2 red arrows: Strong recommendation against use. Orange: Experts' opinion.

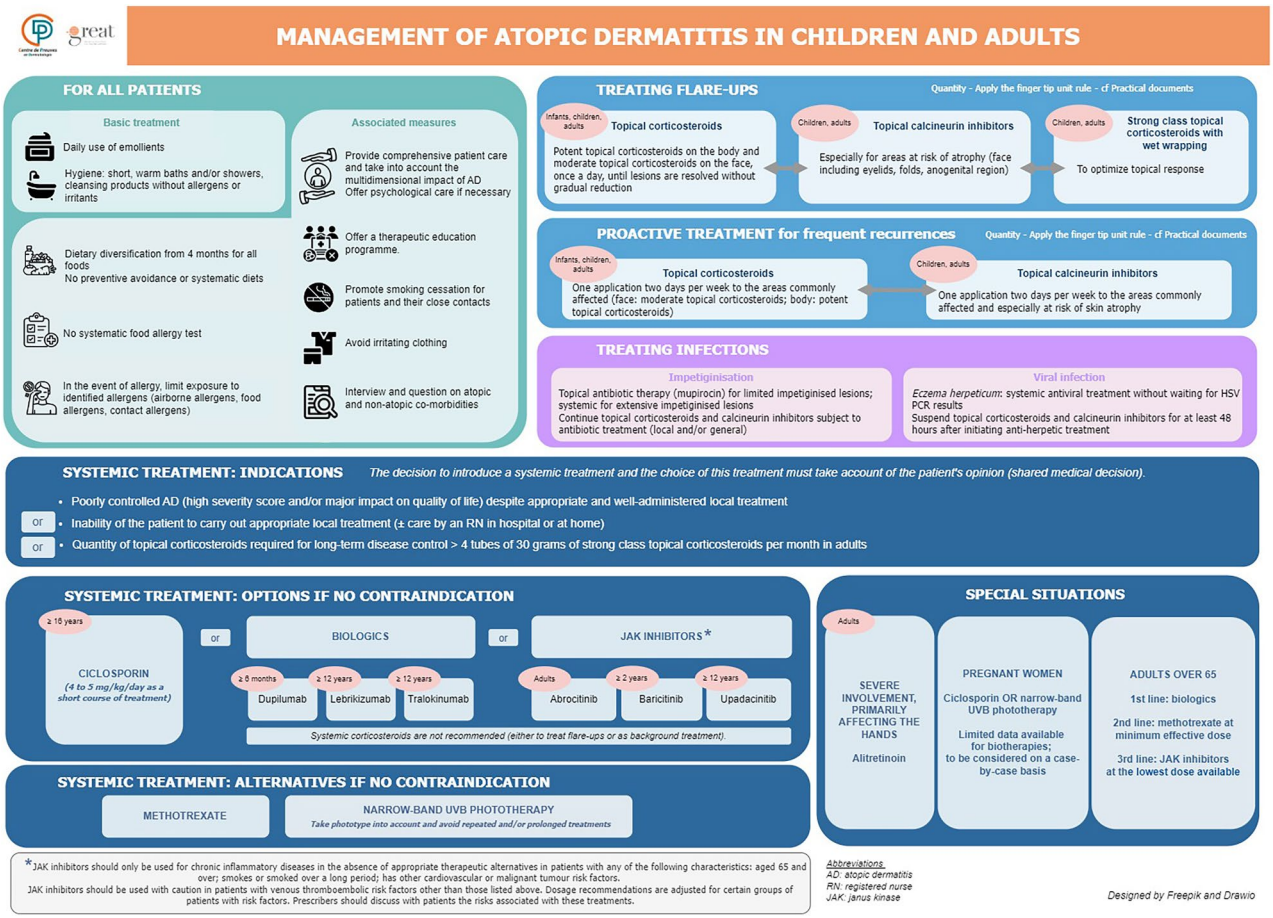

FIGURE 1 French guidelines for atopic dermatitis: Management algorithm.

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CONFLICT OF INTEREST STATEMENT

Working group: N. Sigg, S. Leducq, C. Ertus, C. Hurson, N. Lachaume, D. Lannoy, B. Mille, F. Payot, D. Penso-Assathiany, E. Proux, V. Reynaud and P. Zukervar have nothing to disclose. M-S. Doutre received travel support from Pfizer.

Steering committee: B. Guillot and O. Chosidow have nothing to disclose. S. Barbarot is an investigator or speaker for Almirall, Sanofi-Genzyme, Abbvie, Galderma, Novartis, Janssen, Leo-Pharma, Pfizer, Eli Lilly, UCB Pharma and Incyte. Delphine Staumont-Sallé is an investigator or speaker or a member of the advisory board for Abbvie, Almirall, AstraZeneca, Eli Lilly, Galderma, Janssen, Leo-Pharma, Novartis, Pfizer, Sanofi-Genzyme and UCB Pharma.

Experts and reviewers were not required to have an absence of conflicts of interest, as the final decision to modify the text always rested with the working group.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

ETHICAL APPROVAL

Not applicable.

ETHICS STATEMENT

Not applicable.

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[Correction added on 30 June 2025 after first online publication: The author, Delphine Staumont Salle, has been corrected to Delphine Sallé-Staumont.]

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