Standardising the diagnosis and management of atopic dermatitis in India: A consensus statement by the modified Delphi method by IADVL Special Interest Group of Pediatric Dermatology (STAND AD)

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Abstract

Background: Atopic dermatitis (AD) is a chronic, relapsing inflammatory skin disorder with a significant impact on psychosocial health and quality of life. Despite growing prevalence in India, particularly among adults, a comprehensive, India-specific guideline incorporating recent advances is lacking.

Objective: To develop a standardised, evidence-based consensus on the diagnosis and management of paediatric and adult AD in India through a modified Delphi methodology.

Methods: A total of 14 dermatology experts across India, with over 15 years of clinical and academic experience, formed the Special Interest Group of Paediatric Dermatology under IADVL. A systematic literature review was conducted using databases such as PubMed, Embase, and Cochrane, focusing on Indian and global literature up to December 2024. Based on this, 29 draft statements were generated covering domains of diagnosis, severity assessment, non-pharmacological measures, and topical and systemic therapies. A two-round, web-based, modified Delphi process was conducted anonymously to reach consensus. Statements with ≥75% agreement were retained.

Results: Consensus was achieved on all 29 statements. Thirteen statements were finalised after the first round, and 16 were refined and approved in the second round. Key recommendations included the use of modified Hanifin and Rajka criteria for diagnosis, SCORAD and IGA for severity assessment, therapeutic patient education, and individualised use of moisturisers, topical corticosteroids, and topical calcineurin inhibitors. For systemic therapy, cyclosporine remains first-line for moderate-to-severe AD, with conditional recommendations for methotrexate, mycophenolate, and JAK inhibitors such as abrocitinib. Emerging therapies like topical tofacitinib and crisaborole were discussed with caution due to limited Indian data.

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Limitation: Although several new therapies—such as abrocitinib and dupilumab—have been approved for pediatric atopic dermatitis, consensus among Delphi panelists remains limited. There is lack of sufficient clinical experience and pediatric-specific data on these agents, highlighting the urgent need for more robust studies to inform expert alignment and clinical practice.

Conclusion: This updated Indian consensus guideline provides comprehensive, evidence-based, and context-sensitive recommendations for diagnosing and managing AD across age groups. It addresses previously unmet needs in adult AD. This consensus is expected to enhance clinical outcomes and standardise AD management nationally.

Keywords: Atopic dermatitis, consensus statement, India, modified Delphi method, systemic therapy

Introduction

Atopic dermatitis (AD) is an inflammatory dermatological condition that affects approximately 10% of adults and up to 20% of children in high-income nations.[1] The prevalence of AD is increasing in India, largely driven by evolving environmental conditions.[2]Globally published guidelines for AD often reflect region-specific recommendations tailored to local ethnic, socioeconomic, resource-based, and demographic factors. India, with its unique humid, subtropical climate, exhibits distinct variations in the natural history, etiopathogenesis, clinical patterns, and management of AD compared to Western countries. Within India itself, regional differences in climate, socioeconomic factors, and access to care can influence disease presentation, treatment preferences, and adherence. Different dietary and weaning practices also impact the onset and course of the disease. Among the Indian population, atypical manifestations are often reported, for example, generalised skin darkening, sweat dermatitis, follicular dermatitis, fissures in the infra-auricular and retro-auricular regions, eyelid and genital involvement, dermatitis on the posterior thighs, and juvenile plantar dermatosis. These factors reflect the need for separate comprehensive recommendations in Indian patients with AD.[3,4]

The last Indian guideline on AD was published in 2019, with a consensus update in 2021.[5,6] Since then, new therapeutic agents like janus kinase (JAK) inhibitors (e.g.,abrocitinib and topical tofacitinib)have been approved, necessitating a revision of these guidelines. This updated evidence-based consensus statement, developed by the Special Interest Group (SIG) in paediatric dermatology (SIGPD) under the Indian Association of Dermatologists, Venereologists and Leprologists (IADVL), focuses on the Indian context to address the evolving needs. The document incorporates a review of the literature available until December 2024.

Methods

In June 2024, 14 dermatology experts from across different parts of the country, with over 15 years of experience in clinical and paediatric dermatology, were invited to participate in the guideline development process led by RS. The selection criteria included clinical expertise, international publications, and experience in creating guidelines in the field of pediatric dermatology, AD, and eczema. Efforts were made to ensure diversity of the representative panel in terms of geographic, institutional, and specialty representation. Panellists were selected from different regions across India, north, south, east, west, and central, to include variations in clinical practice. The group included dermatologists from government and private medical college hospitals, including institutes of national importance and private hospitals, ensuring institutional diversity. Subspecialty expertise included paediatric dermatology and AD, with a few members having prior experience in developing guidelines or contributing to national dermatology forums.

Consensus workflow

An extensive literature search was done in PubMed, Embase, Cochrane Library, Web of Science, and Scopus using the following terms: "atopic dermatitis," "management," "recommendation," "diagnosis," "counselling," "systemic treatment," "topical treatment," "non-pharmacological interventions," and "India." Relevant studies on the epidemiology, aetiopathogenesis, and management of AD were identified, following which 29 statements were drafted by three senior dermatologists. Subsequently, the experts were invited to participate in the Delphi rounds via a secure, online, web-based platform (Google Forms) between June and October 2024. Participants were asked to respond to questions using a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Open-ended questions allowed for discussion and sharing of individual clinical experiences.

After each round, responses were analysed, and summary reports were shared with participants to refine their answers for the subsequent round. Two rounds were conducted anonymously to reach a consensus. Some questions were modified based on feedback received in the first round, and additional questions were incorporated. Statements with ≥75% agreement remained unchanged. Recommendations were graded based on the articles published in the last 10 years, based on the quality of evidence with regard to GRADE [Table 1]. The complete consensus workflow has been depicted in Figure 1.

Results

The first in-person meeting discussed all 29 statements, reaching a positive consensus on 13. The remaining 16 were revised based on detailed discussion and reconsidered in a second virtual meeting, where consensus was achieved on all.

Table 1: Level of evidence	
Level	**Research study design**
1a	Systematic review of RCTs, meta-analysis
1b	Individual RCTs
2a	Systematic review of cohort studies
2b	Individual cohort study (including low-quality RCT)
3a	Systematic review of case-control studies
3b	Individual case-control study
4	Case series (and poor-quality cohort and case-control studies)
5	Expert opinion

RCT: Randomised controlled trial.

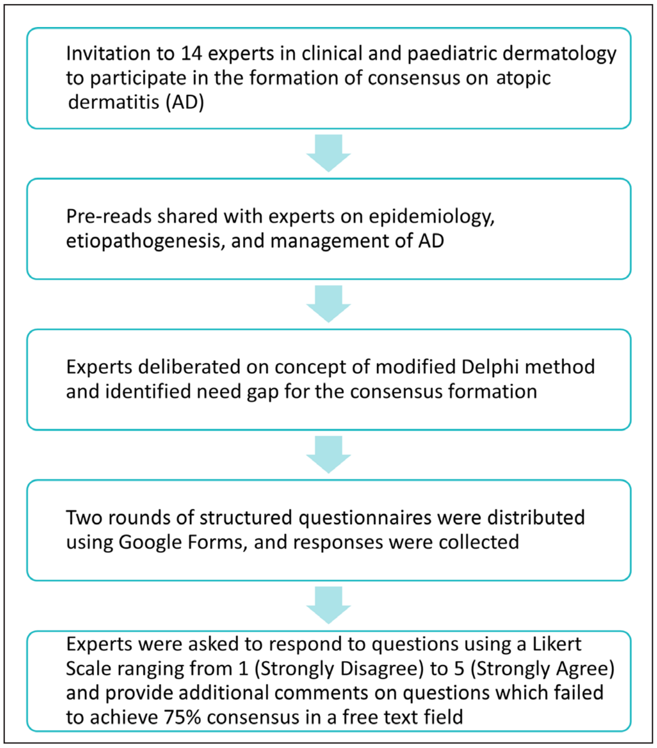

Figure 1: Consensus workflow.

Detailed recommendations and levels of evidence of all statements have been shown in Figures 2a-c.

General measures

A. Assessment

1. Diagnosis

In 1981, Hanifin and Rajka created criteria for diagnosing AD, as there was no objective laboratory test, and there was inconsistency in nomenclature.[7,8]

The expert panel here recommended that, for the diagnosis of AD, clinical features and modified Hanifin and Rajka criteria can be used [Table 2]. Skin biopsy is rarely confirmatory in AD, although it can occasionally assist in excluding causes other than eczema, especially in adults. The panel also recommended against total IgE for routine diagnosis and severity monitoring, as it was felt to be neither sensitive nor a specific marker. While it may be of limited value in distinguishing extrinsic vs. intrinsic AD, the panellists felt that the distinction remained more academic in nature and did not alter the management decisions. However, they recommended total IgE if primary immunodeficiency disease was suspected.

2. Assessment of severity

Currently, 60 metrics have been employed to gauge the severity of AD, with wide variations in content, scale, directions, validity, and concordance. Some of them, like Eczema Area and Severity Index (EASI), Investigator's Global Assessment (IGA) score, Total Body Severity Assessment (TBSA), SCORAD (Scoring AD) index, are widely used in clinical practice.[9] Experts recommended that SCORAD be used for severity assessment if time permits, else IGA can be used, especially in a busy OPD. Experts also recommended using validated patient-reported outcome (PROs) measures like the Patient-Oriented Eczema Measure (POEM) and the Dermatology Life Quality Index (DLQI) to capture sleep disturbances and a reduced quality of life (QoL), especially in studies related to AD. Table 3[9-12] shows the summary of AD severity assessment tools.

B. Prevention

The panel strongly recommended Therapeutic Patient Education (TPE) to prevent treatment failure and elevate patients' QoL. Education should include information about the chronic and relapsing nature of the disease, correct use of topical therapies and moisturisers, identification and avoidance of individual triggers, and expected treatment outcomes. Treatment compliance should be insisted on for optimal results. The various components of TPE, discussed and agreed upon, were as follows:

Avoidance of aeroallergens: Panellists recommended to enquire about and avoid exposure to dhoopbattis, agarbattis, tobacco smoke, traffic exhaust, pollen, and proximity to construction and industrial sites, especially in patients who gave a history of concomitant asthma and allergic rhinoconjunctivitis, in addition to AD.

Avoidance of house dust mites (HDMs): Panellists agreed that the use of carpets, sofas, curtains, drapes, and all other upholstered furniture must be minimised. Bedsheets, blankets, pillow covers, and other linen must be washed in warm or hot water to kill HDMs. Sun drying of bed linen was also recommended as it reduces moisture content, moulds, and bacteria that worsen AD symptoms. Soft, fluffy toys must be avoided. Experts recommended vacuum cleaning or wet dusting and wiping of surfaces (in case of financial constraints) at least once a week.

Food allergy (FA) and dietary restriction: Experts felt that a blanket food restriction was not advisable, as it may predispose the children to growth delays and nutritional deficiencies if they are on a restricted diet for an extended period of time. They recommended maintenance of a food

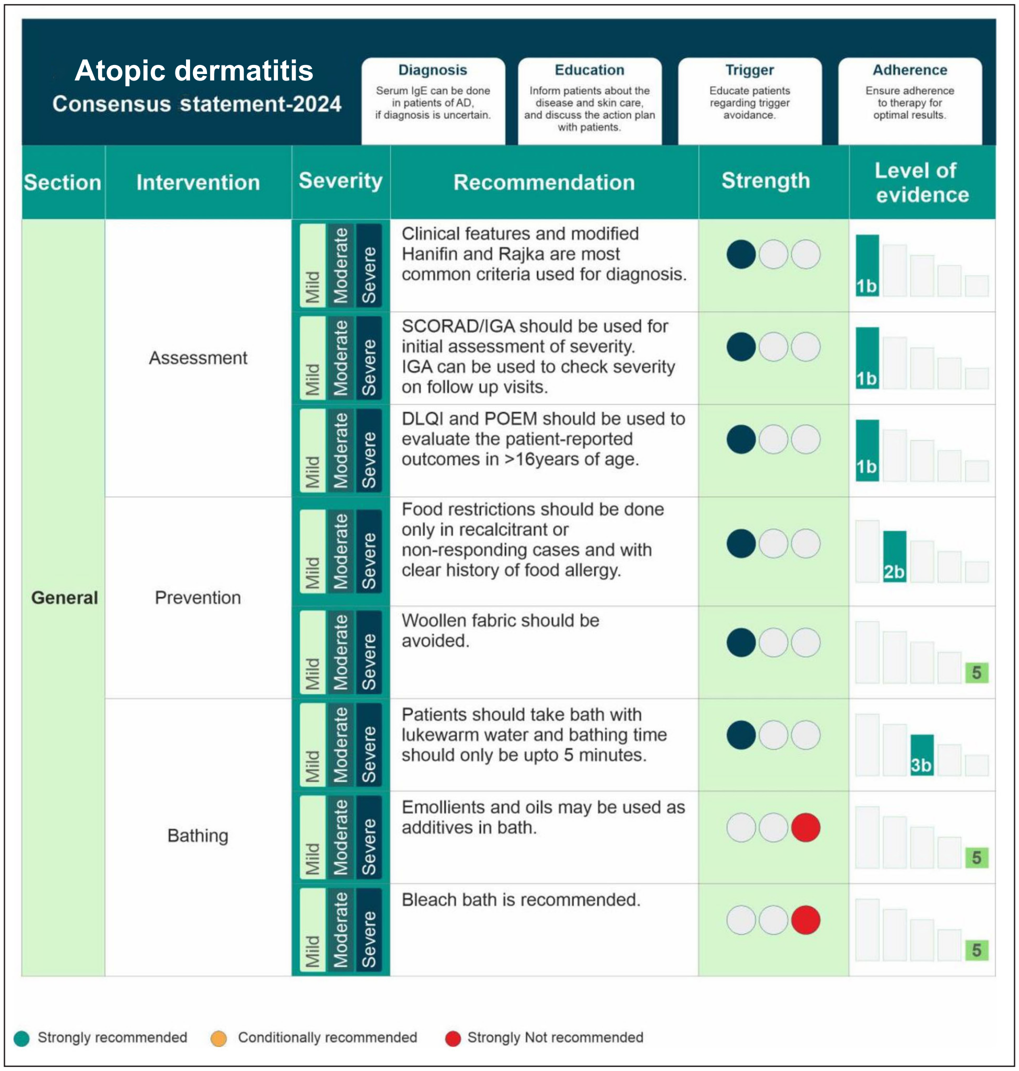

Figure 2a: Recommendations and levels of evidence with respect to general management.

diary and dietary restriction only in patients with recalcitrant or non-responding eczema with documented evidence of FA.

Bathing: In keeping with the various international guidelines, the Indian expert panel also recommended the duration of bathing to be not more than 5-7 minutes, with lukewarm or room temperature water. Bath should be with a non-fragrant and non-foamy (pH-balanced) soap or body cleanser, and bubble baths should be avoided. Experts recommended against taking a bath more than once a day. Regarding bath additives, the addition of non-scented oils like coconut oil to bath water may be considered. The panel voted against the regular use of bleach baths in AD patients due to the absence of standardised guidelines on the appropriate quantity of bleaching powder and concerns about potential incorrect usage by the patients, leading to irritation and exacerbation of AD symptoms.[13] Cautious use for recurrent infections only was voted by the panel.

Clothing: Panel recommended wearing loose, light coloured, cotton clothes and minimising the use of wool and synthetic fabrics. It was recommended to avoid metal lockets, anklets, bangles, and coloured threads on the extremities, waist, or neck.

Topical therapies

1. Moisturisers

Moisturisers form the cornerstone of management and offer steroid-sparing benefits in the management of AD. Emollients vary in composition, with ingredient selection determining their effectiveness, safety, and barrier-repair capacity. Humectant-based moisturisers enhance hydration by mimicking natural moisturising factors, while colloidal oatmeal-based formulations support barrier repair, reduce pruritus and inflammation, and modulate the skin microbiome. Pseudoceramide-based moisturisers, which mimic natural ceramides, improve hydration and disease severity with good tolerability. 'Emollient plus' formulations, including physiological lipids (such as ceramides), and pH buffers, offer comprehensive barrier restoration and flare reduction.[14,15] The panellists in the present consensus

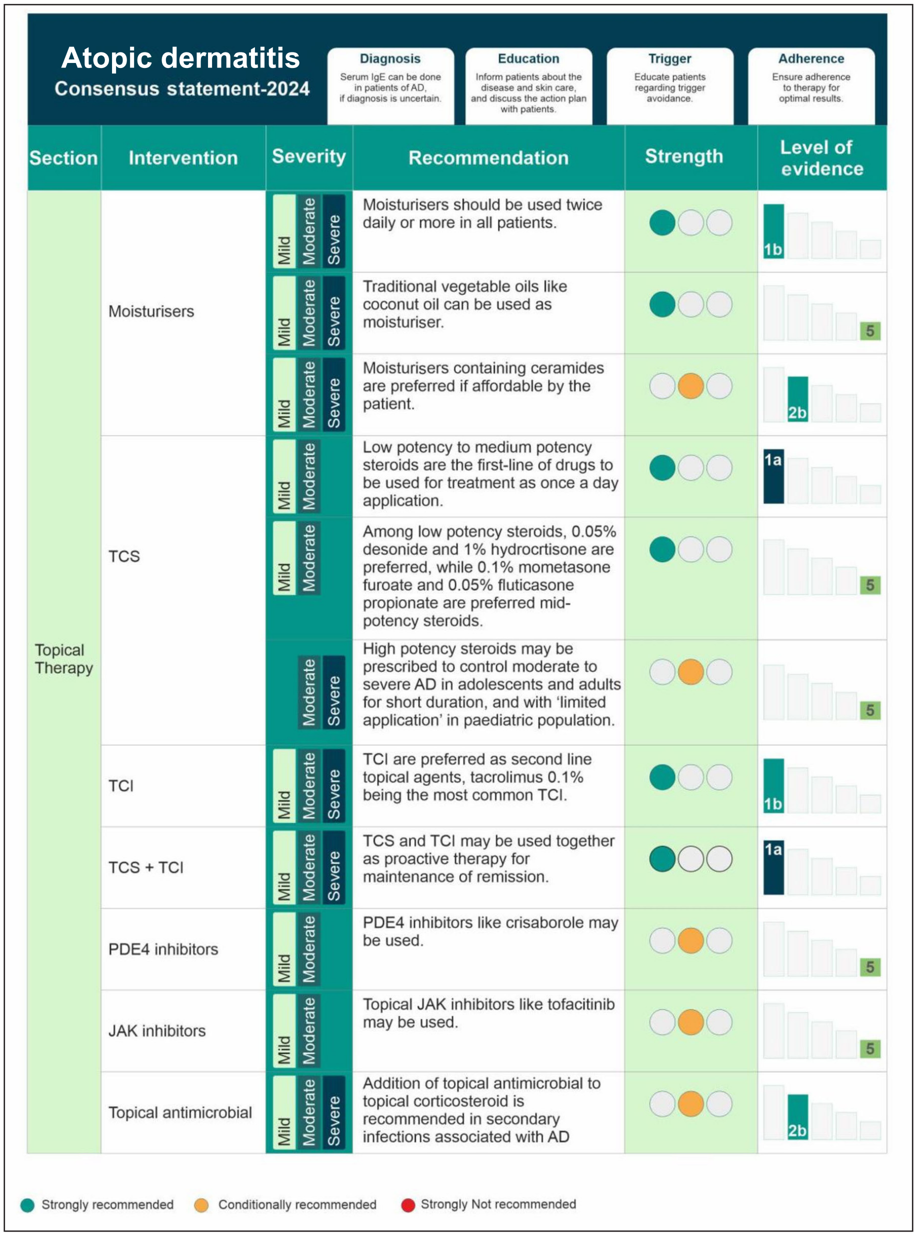

Figure 2b: Recommendations and levels of evidence with respect to topical therapy.

strongly recommended the use of moisturiser at least twice daily in AD, irrespective of age. Emollients should be applied immediately after bathing, within minutes, using the 'soak and smear' technique.

Experts strongly recommend the use of white soft paraffin and light liquid paraffin in all patients with AD. Panel also achieved consensus for the use of vegetable oils like coconut oil without fragrance, though some members pointed out that these oils may predispose to miliaria in the hot and humid parts of the country. For ceramide-based moisturisers, experts reserved their use conditionally, considering affordability by the patients.

2. Topical corticosteroids:

Topical corticosteroids (TCS) are the first line of topical treatment for the management of pruritus, lichenification, and active eczematous lesions.

Their efficacy varies greatly, based on how they are prescribed.

The panellists strongly recommended the use of low to medium potency steroids as first-line drugs for the treatment of AD, for once-daily application. It was also recommended as a first-line treatment to manage flares. Low-potency steroids like 0.05% desonide and 1% hydrocortisone cream were recommended in sensitive locations such as the face, genitalia, intertriginous folds, and perianal areas.

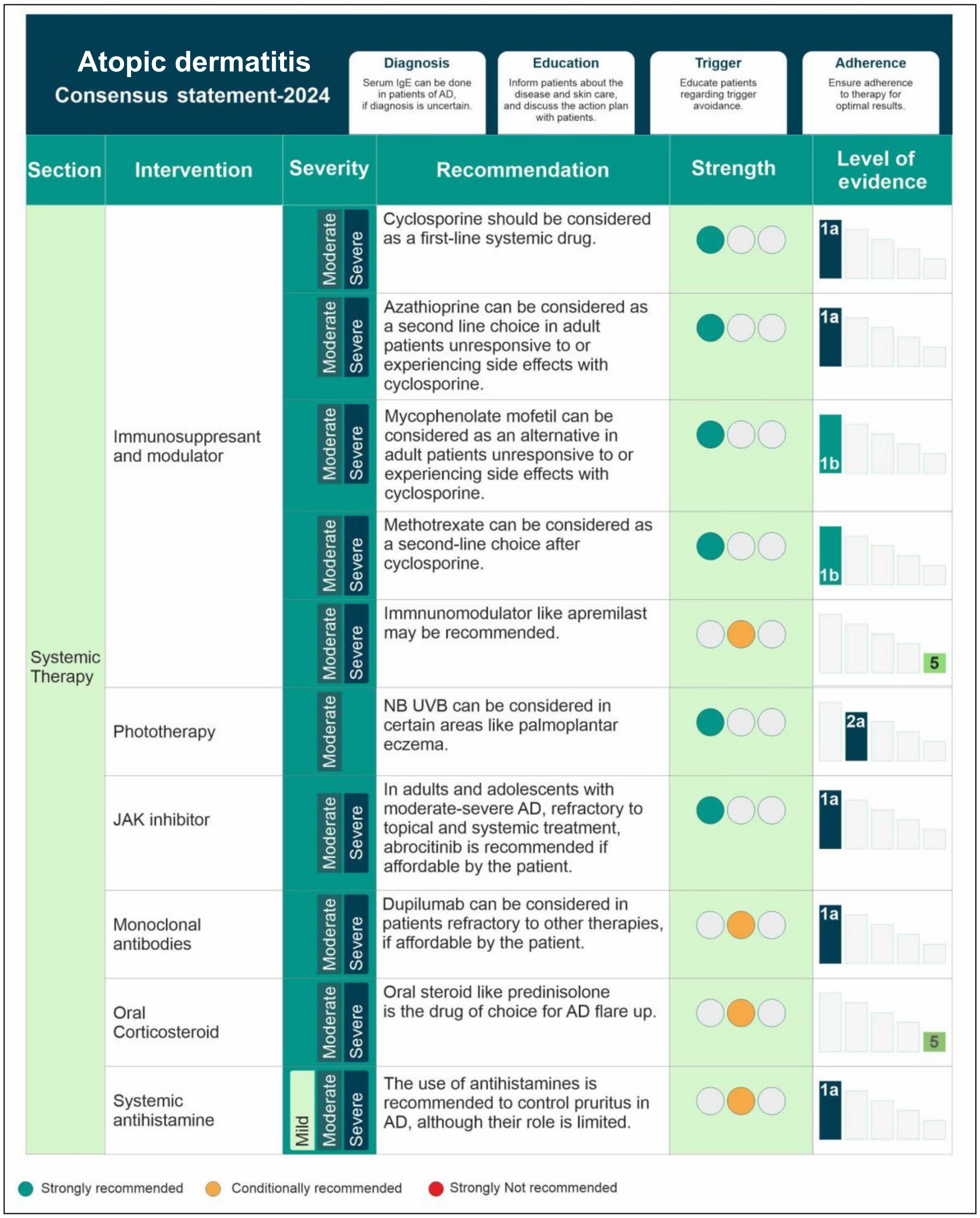

Figure 2c: Recommendations and levels of evidence with respect to systemic therapy.

Mid-potent corticosteroids like 0.1% mometasone furoate and 0.05% fluticasone propionate were recommended for other areas and for lesions exhibiting a higher degree of erythema, scaling, and inflammation. Intermittent use of potent corticosteroids like halobetasol propionate was recommended for body parts like palms, soles, scalp, and lichenified areas. The panel recommended creams for intertriginous areas, while ointments were suggested for palms, soles, and areas with lichenification.

3. *Topical calcineurin inhibitors*

Tacrolimus ointment (0.03% for patients older than 2 years and 0.1% for those older than 12 years) and pimecrolimus cream (1% strength for patients older than 2 years) are the two topical calcineurin inhibitors (TCIs) currently approved by regulatory agencies.[16] The USFDA has approved pimecrolimus for mild to moderate AD and tacrolimus for moderate to severe AD. Though two 6-week comparison studies showed a better effect with tacrolimus therapy than pimecrolimus, both available TCIs reduce the cutaneous symptoms of AD.[17,18]

Panellists strongly recommended TCI as second-line topical agents, with tacrolimus 0.1% being the most preferred TCI. However, over 75% of the experts agreed off-label (i.e., use of drug outside its approved age group, indication, route of administration, and dosage) use of these formulations in younger age groups. Specifically, tacrolimus 0.1% was commonly used in children under 12 years, and both

Table 2: Hanifin and Rajka criteria (Diagnosis requires at least 3 major and 3 minor criteria)

Category	Criteria
Major criteria (Need ≥3)	1. Pruritus
	2. Typical morphology and distribution • Infants and children: face, extensor limbs • Adults: flexural areas
	3. Chronic or relapsing course
	4. Personal or family history of atopy – Asthma, allergic rhinitis, or atopic dermatitis
Minor criteria (Need ≥3)	1. Xerosis
	2. Ichthyosis
	3. Elevated serum IgE
	4. Positive immediate skin test reactivity (e.g., prick test)
	5. Early age of onset
	6. Recurrent skin infections (*Staphylococcus aureus*, HSV)
	7. Non-specific hand or foot dermatitis
	8. Nipple eczema
	9. Cheilitis
	10. Recurrent conjunctivitis
	11. Dennie-Morgan infraorbital folds
	12. Keratoconus
	13. Anterior subcapsular cataracts
	14. Facial pallor or erythema
	15. Periorbital darkening
	16. Exacerbation with sweating or emotional stress
	17. Intolerance to wool or lipid solvents
	18. White dermographism or delayed blanching
	19. Food intolerance or hypersensitivity
	20. Palmar hyperlinearity
	21. Keratosis pilaris
	22. Pityriasis alba
	23. Anterior neck folds

Table 3: Summary of AD severity assessment tools

Tools	Components assessed
SCORAD SCORing Atopic Dermatitis	A - Extent (BSA), B - Intensity (6 signs- dryness, erythema, oedema, oozing, lichenification, excoriation, C - Subjective symptoms (pruritus/sleep loss) SCORAD = A/5 + 7(B/2) + C is the formula
IGA Investigator's global assessment	Erythema, papulation, infiltration, oozing, and crusting are assessed 0 - Clear 1 - Almost clear 2 - Mild disease 3 - Moderate disease 4 - Severe disease 5 - Very severe disease
EASI Eczema area and severity index	Extent and severity (erythema, oedema/papulation, excoriation, lichenification in four regions) Sum of four regions = EASI score

tacrolimus 0.03% and pimecrolimus 1% were used in children under 2 years, without facing any significant adverse events.

4. Topical corticosteroids with topical calcineurin inhibitors

Panellists recommended starting topical steroids and subsequently tapering them based on the individual patient's clinical response. One possible topical tapering regimen in AD agreed upon involved initiating treatment with TCS twice daily, followed by once-daily TCS combined with once-daily TCI, and then transitioning to twice-daily TCI for maintenance (sequential therapy).Another regimen of proactive therapy, which involves weekend use of TCS or TCI on previously affected areas to prevent relapse.[19]Panellists strongly recommended "proactive therapy" as an alternative to "reactive therapy" for treating relapsed AD. They agreed that, compared to moisturiser alone, applying TCS (or TCI) to inactive areas of AD 2 - 3 times per week decreased AD flares. Both sequential therapy and proactive therapy were recommended for maintaining remission in patients with AD.

5. Phosphodiesterase 4 (PDE4) inhibitors

Based on the efficacy and safety shown in numerous RCTs, crisaborole was approved by the FDA for use in patients with mild to moderate AD who are 2 years of age or older.[17]

Panellists recommended prescribing topical crisaborole conditionally only in mild to moderate AD, owing to limited clinical data and experience in Indian patients.

6. Janus kinase (JAK) inhibitors

Given the significance of JAK-STAT signalling, especially JAK1, for Th2 cytokines, such as IL-4, IL-13, and IL-31, JAK inhibition has been proposed as a potential treatment for AD in recent times.[20]

Currently, topical tofacitinib is a drugs controller general of India (DCGI)-approved for use in AD.[21] Another topical JAK inhibitor, ruxolitinib, was approved by the United States Food and Drug Administration (USFDA) in 2022 as a topical short-term, non-continuous chronic therapy of mild to moderate AD in adults and children aged 12 and above.[22]Similarly, delgocitinib, a pan-JAK inhibitor, was approved in Japan for topical treatment of mild to moderate AD.[20]

Given the limited clinical data and experience, the panel conditionally recommended topical tofacitinib for adult patients with AD in scenarios where conventional treatments were either ineffective, inaccessible, or resulted in adverse effects. The members unanimously agreed that more evidence is required before recommending JAKi's for the paediatric age group.

7. Topical antimicrobials

In patients with AD and eczema, *Staphylococcus aureus* can colonise 80-100% of skin lesions. On the other hand, in only 5-30% of healthy people abraded skin biopsies can isolate *S. aureus*. Furthermore, a direct relationship between the density of *S aureus* colonisation and the severity of eczema/ skin irritation was discovered.[23]

Panellists of the present consensus group strongly recommended adding a short course of topical or oral antibiotic to treat an acute episode of skin and soft tissue infection in patients with AD. Panellists also recommended antibiotic prophylaxis with topical mupirocin or topical fusidic acid for eradication of *S. aureus* colonisation.A topical steroid-antibiotic combination was not recommended.

Systemic therapy

1. Immunosuppressants and immunomodulators

Among the steroid-sparing oral immunosuppressive agents, cyclosporine, methotrexate, azathioprine and mycophenolate are the most commonly recommended systemic therapies for AD. Among these, cyclosporine is regarded as the first-line systemic drug for managing moderate-to-severe AD.[5,6] Cyclosporine has been approved for the short-term treatment of adults with severe AD when conventional therapies are ineffective or unsuitable, based on evidence from multiple randomised controlled trials (RCTs).[24-29]

In moderate to severe AD, experts recommended oral prednisolone or oral cyclosporine as the first-line drug of choice for treating acute episodes, followed by methotrexate, azathioprine, or mycophenolate mofetil for maintenance therapy. It was opined that apremilast is ineffective for treating acute flares, but may be of some value in maintenance therapy, pending more clinical data.

2. Phototherapy

Phototherapy, either as monotherapy or in combination with emollients and topical steroids, has been shown to be effective in managing AD.[30] Clinical studies suggest that it can reduce the need for topical steroids and immunomodulators.[31]While narrowband ultraviolet B (NB-UVB), operating at wavelengths of 311-313 nm, is widely employed as a first-line treatment for various paediatric skin conditions due to its efficacy and favourable safety profile, experts flagged the unavailability of too many studies regarding its efficacy in Indian skin. It was recommended that NB-UVB may be useful in a certain subset of cases, like chronic eczema or prominent palmo-plantar involvement. Experts advised against using phototherapy for acute flare AD due to its potential to aggravate erythema, burning, and itching.

3. Janus kinase (JAK) inhibitors

Among the approved JAK inhibitors for AD, abrocitinib, a selective JAK-1 inhibitor, is currently the only one commercially available in India. It is approved for use in moderate-to-severe AD patients who have failed other systemic therapies (immunosuppressants, corticosteroids, antimetabolites, and injectable biologics). [32-34]Oral tofacitinib, a pan-JAK inhibitor, is being used off-label for AD given its low cost and wide availability. Systemic tofacitinib has demonstrated promising outcomes in adults with refractoryAD, and these findings can be cautiously extrapolated to the paediatric population, provided appropriate evaluation and diligent monitoring are ensured. Experts recommended caution while using oral tofacitinib off-label for moderate-severe AD, given the risk of systemic infections till more clinical data becomes available.[35]Experts noted that abrocitinib has greater selectivity in comparison to tofacitinib. However, its high cost poses a significant challenge in our country. Experts recommended that if choosing to treat AD with abrocitinib, consideration should be given to each patient's unique circumstances, including age, comorbidities, prior therapy, QoL, and treatment tolerance, and should involve the patient and family member for decision making.

4. Dupilumab

Dupilumab is a fully human monoclonal antibody targeting the IL-4 receptor alpha subunit, blocking the signalling of IL-4 and IL-13, which are central to type-2 inflammation in AD.[36]

Approved by the FDA in 2024 for treating moderate-to-severe AD in patients aged 6 months and older,[37] dupilumab has demonstrated significant improvements in AD symptoms with an acceptable safety profile in systematic reviews and meta-analyses.[38] It remains a cornerstone therapy for patients requiring advanced systemic treatment. Currently, due to restricted availability of dupilumab in India, experts have reserved their opinion and advised physicians' discretion while prescribing it.

5.Systemic corticosteroids

Experts recommended the use of short-course oral corticosteroids (as an alternative to oral cyclosporine) as first-line therapy for treating acute flares of AD, with prednisolone being the preferred drug of choice. However, long-term use was advised against, due to the potential to develop significant adverse effects, including rebound flares.[39]Short courses of corticosteroids; prednisolone at a dose of 0.5 mg/kg/day with slow tapering may be considered only in exceptional cases, such as bridging therapy to longer-term options.[40]

6. Systemic antihistamines

The effectiveness of oral antihistamines in treating AD is debated.[41] Data from randomised controlled trials (RCTs) on both sedating and non-sedating antihistamines generally suggest a limited role in AD treatment. Experts believe that certain AD patients, especially those with severe itching and a history of allergic conditions like allergic rhinitis and asthma, may benefit the most from antihistamines. Sedating antihistamines might be used short-term under supervision to address sleep disturbances caused by itching, particularly in children under 2years of age.[42]

Discussion

The Global Atopic Dermatitis Report 2022, identified AD as one of the diseases with the highest global burden and affecting children disproportionately.[43] These Indian expert panel recommendations emphasise a holistic approach to managing AD in children and adults.

The panel endorsed the Hanifin-Rajka criteria for diagnosing AD and recommended using SCORAD and IGA to assess disease severity. There is limited evidence available pertaining to the role of specific food allergens in AD.[44] Hence, experts recommended dietary restrictions only in recalcitrant or treatment-resistant cases with a well-documented history of food allergy consistent with Japanese guidelines.[45]

Indian experts echoed international guidelines by recommending daily bathing with lukewarm water, followed by prompt and generous emollient application. The approach of consistent application of moisturisers is strongly endorsed by the Indian expert panel and is aligned with recommendations across all major international guidelines.[43,45-47] The panel also reached consensus on the use of coconut oil,in contrast to the European guidelines that discouraged its application in routine care. Ceramide-containing moisturisers, though costlier, are recommended by the panel based on the patient's affordability, as they offer superior improvement in SCORAD compared to other moisturisers.[48] Our expert panel does not recommend the routine use of bleach baths in patients with AD, reserving it for patients with recurrent skin infections, consistent with European guidelines.[49]

Further, the panel recommended the use of cotton clothes and avoiding pets and triggers, in keeping with all major international guidelinesthat stress educating families about air pollution risks, such as tobacco smoke, volatile organic compounds, and traffic exhaust, and advocate avoidance strategies, especially in children.[46]

For the topical management of AD, the Indian expert panel strongly endorsed low to moderate potency TCS as the first-line therapy, advising once-daily application. To maintain remission, both sequential and proactive treatment strategies were recommended. Most global guidelines advocate for twice-daily application of TCS to maximise efficacy. TCIs form the second line of topical agents, with 0.1% tacrolimus ointment being the preference by the Indian experts. Off-label use of TCIs in younger children was widely accepted among Indian dermatologists, reflecting local practice patterns despite regulatory limitations. Other topical immunomodulators like crisaborole 2 % ointment can be used alternately to TCS and TCIs in mild to moderate AD.The current Indian consensus panel strongly recommended initiating a short course of topical or oral antibiotics for managing acute skin and soft tissue infections in patients with AD. The panel cautioned against the use of topical steroid-antibiotic combination formulations. Other international consensus guidelines echoed the same by advocating against the long-term application of topical antibiotics, due to the risk of resistance development.[47,49]

In systemic therapy, the expert panel recommended cyclosporine or oral prednisolone as the first line of choice for moderate to severe AD. Other molecules, like methotrexate and azathioprine, can be considered for maintenance therapy. Both the S3 and European guidelines support the use of Narrowband UVB and UVA1 phototherapy in the management of AD.[49]Evidence suggests that ultraviolet (UV) therapy can effectively alleviate pruritus associated with AD. In line with this, our panel recommends considering NB-UVB for select patient subsets, particularly those with chronic eczema or significant palmo-plantar involvement. Emerging therapies such as dupilumab and abrocitinib have demonstrated superior efficacy in large-scale randomised controlled trials within paediatric populations. However, their widespread adoption in India remains constrained by cost-related challenges. Our expert panel has advised physicians' discretion while prescribing it.With respect to treatment, compared to previous Indian guidelines (2019, 2021), this consensus incorporates recent drugs such as abrocitinib and tofacitinib.[5,6]The practical barriers for implementing such advanced agents are variability in patient education, financial constraints, access to dermatologic care in rural areas, and restricted availability of such newer drugs.

Limitations

While this consensus aims to provide guidance on the diagnosis and management of AD in India, we would like to acknowledge certain limitations. The process did not involve patients, whose experiences could have added more valuable practical insights. In addition, as with any expert-driven Delphi process, the possibility of potential expert biases cannot be excluded, despite efforts to ensure diverse representation and anonymised responses.

Additionally, while international data support the efficacy of drugs like crisaborole, ruxolitinib and delgocitinib, their generalisability to Indian patients remains limited due to differences in skin type, climate, accessibility, and cost constraints. Hence, these molecules were not discussed in the Delphi consensus.

Conclusion

This consensus guideline aims to provide a comprehensive, evidence-based update on all aspects of paediatric AD management, tailored to the unique clinical landscape of India. By aligning international best practices with local expertise, it serves as a practical resource for dermatologists across the country, empowering them to deliver effective, context-sensitive care for children with AD.

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