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How Sure Is a Diagnosis of Atopic Dermatitis?

A Scientific Proof that Skin is More Dry During the Winter Season

In an extensive study of 487 persons, Löffler et al. confirm that water loss from the skin is higher in the winter season than in the summer if the skin is subjected to an irritant factor as soap. Many clinicians will say: As if we didn't know! I sometimes tell my students that "dermatology" is a specialty where you are really busy for nine months but can relax during the three summer months as skin diseases normally improve due to sun and high temperatures – at least in my part of the world! The authors' documentation is both extensive and convincing and they have developed formulas whereby future studies on skin barrier function can calculate the TEWL value for further comparison with the measured value. This would be an interesting topic for research on atopic eczema and on how "irritant contact dermatitis" is involved in this disease. It might explain the "angry back syndrome" (patch testing on sensitive skin induces a great many positive reactions) because increased ability of skin irritancy is too high for patch testing. The study underlines an important thing for us dermatologists, namely that the use of emollients during the winter season is very important. This has also been shown in long-term studies of children and adults with atopic dermatitis where the placebo-arm, i.e. the use of vehicle only, can have surprisingly high efficacy in controlling eczema. The cosmetological industry has known this for years and we should learn from that and urge our cosmetological and pharmaceutical companies to keep on developing even better emollients for our patients. Yes – skin is more dry and does become more responsive to irritants during the winter season. Think of it in your daily practice.

In this issue of *Acta Dermato-Venereologica,* Benn and her co-workers present their findings on the sensitivity and specificity of diagnosing atopic dermatitis in infants (<2 years) by means of telephone interviews of the mothers. They conclude that "Telephone interviews can be used to diagnose atopic dermatitis in young children in large-scale epidemiological investigations". This would obviously be important for logistical reasons, as studies on atopic dermatitis and environmental factors rely on large-scale investigations. The study does not indicate how many children were found to have atopic dermatitis based on the 100,000 interviews. However, a previous study in *Acta Dermato-Venereologica* (Böhme et al., 2001;81:193-7) had prevalences of atopic eczema of around 25%, based on interviews among infants in the Stockholm area. In Table II of the Benn et al. paper, the authors list the questions needed to achieve a sensitivity of 81% and a specificity of 91%. This looks very good, but their questions were established from 390 calculated combinations of answers and, as stated by the authors, these are "to a large extent data-driven". Of 60 children diagnosed to have atopic dermatitis and examined by a dermatologist, 15% had no skin disease at all and only 62% (less than 2/3) had atopic dermatitis. This means that 38% of the children included in the study because they had atopic dermatitis diagnosed via a telephone interview will also be included in the evaluation of which environmental factors may influence their "atopic eczema". Is this a valuable result – apart from underlining how difficult it is to diagnose atopic eczema – especially in infants? Yes, it is indeed valuable for studies examining "associations", but the results cannot be used for studies on the pathophysiology or aetiology of the disease.

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