treating AD has been shown to be an important determinant of treatment satisfaction, improving primary care provider comfort with treating pediatric AD is of paramount importance.

STATEMENT OF THE PROBLEM

Since the American Academy of Pediatrics published its initial clinical report on AD in 2014,[6] the landscape of pediatric AD has been rapidly changing, particularly as it relates to comorbidities and treatment options. This clinical report reviews pediatric AD and provides an up-to-date approach to skin-directed management that incorporates recent advances, including mental health and quality of life in children with AD, implications of the Learning Early About Peanut allergy (LEAP) trial for children with AD, and emerging topical therapies. This information will allow pediatricians and other pediatric primary care clinicians to provide effective and up-to-date care for most children with AD.

CLINICAL FEATURES AND DIAGNOSIS

The diagnosis of AD remains primarily clinical, based on the presence of characteristic features (Table 1).[6] Major clinical features include relapsing and remitting dermatitis that is pruritic, with onset of the disease usually occurring before 1 year of age. A family history of atopic dermatitis and/or a personal or family history of other atopic conditions may be supportive. Erythema, scaling, excoriations, and lichenification are often present in typical plaques of AD (Figure 1). In patients with darkly-pigmented skin, erythema may be more subtle (Figure 2), while dyspigmentation and follicular eczema may be more prominent. The distribution of the eczematous plaques varies with age, with cheeks, trunk, and extremities being the most characteristic areas of involvement in infancy (Figure 3), flexures being most characteristic in childhood, and hands and feet being most characteristic in teenagers and young adults.[7] It is important to consider other skin conditions that may mimic AD, including scabies, contact dermatitis, psoriasis, and seborrheic dermatitis. In young infants, there may be an overlap of concurrent seborrheic dermatitis and AD, consisting of characteristic features of both conditions.[8] Generally, tests such as laboratory testing and skin biopsies are not needed nor helpful in confirming the diagnosis of AD but may be useful when alternate diagnoses are being considered.

Black and Hispanic children are disproportionally affected by AD. Black infants are more likely to develop AD.[2] Compared with white children, eczema severity is increased in both Black and Hispanic children,[9] and both groups are more likely to miss school because of AD.[10] Black and Hispanic children are also more likely to receive medical care for AD in the primary care and emergency

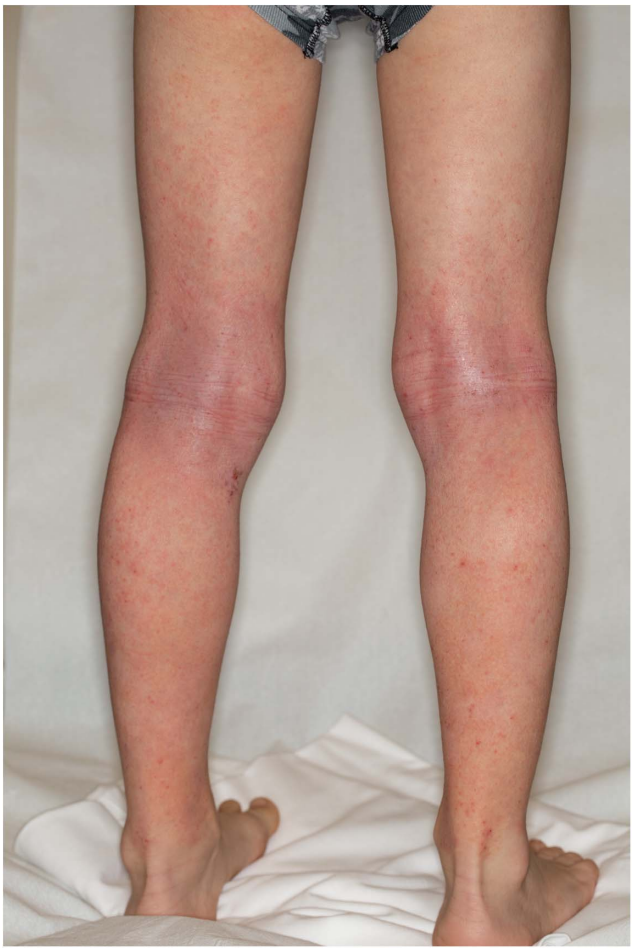

FIGURE 1.
Poorly-defined erythema in the popliteal fossae, a typical distribution for pediatric atopic dermatitis.

TABLE 1. Clinical Features in Atopic Dermatitis

Major Clinical Features	Minor Clinical Features
Itching/pruritus	Early age of onset
Typical dermatitis with a chronic/relapsing history	Dry skin/xerosis
Patient or family member(s) with atopy	Keratosis pilaris
Typical distribution and age-specific patterns	Ichthyosis vulgaris
	Lip dermatitis
	Hand eczema
	Lichenification
	Elevated IgE level
	Itching with sweating
	Recurrent infections
	Pityriasis alba
	Dermatographism
	Eye symptoms: cataracts, keratoconus, inflammation