

BASIC GUIDANCE AND ROLE OF COMMUNITY PHARMACISTS IN MANAGING ATOPIC DERMATITIS

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OBJECTIVES

To To develop a care algorithm for the management of atopic dermatitis (AD) in community pharmacy settings. The algorithm is intended to be adapted to local practice models and may be particularly valuable in regions with limited access to dermatologists, where skin care relies more heavily on other healthcare professionals.

BACKGROUND

OVERVIEW

Atopic dermatitis (AD), the most frequently encountered skin condition in community pharmacies, is a chronic inflammatory skin disease characterized by pruritus and significant impact on quality of life, including stigmatization and psychological burden.^{1,2}

AD involves epidermal barrier dysfunction, immune dysregulation, inflammation, and microbiome imbalance or dysbiosis.³ AD commonly begins in childhood but may persist or first occur in adulthood.⁴ Prevalence reaches up to 20% in children and 10% in adults.¹

Diagnosis may be delayed by an average of two years; patients commonly self-manage with OTC products and seek pharmacist advice prior to medical consultation.^{5,6}

CLINICAL FEATURES & SYMPTOMS

AD has an episodic course with flares and periods of improvement or remission. Flares may be triggered or worsened by endogenous and environmental factors.⁷



Images source from DermaNet

Flare: an acute, clinically significant worsening of signs and symptoms of AD requiring therapeutic intervention

Skin lesions are erythematous, dry, scaly papules and plaques; they can occur everywhere.^{2,3,7} Pruritus is common, and scratching can cause excoriations, bleeding, and sleep disturbance. Lesions can occur anywhere, and severity and appearance vary between patients, with erythema often less noticeable in darker skin.⁸

METHODS

A literature review on the pharmacist's role in dermatological care was conducted in December 2025 using PubMed and AI-assisted research tools. Current AD management guidelines were also identified and reviewed.

An online survey was conducted among FIP members in March–April 2026 to assess current practices, knowledge, and perceived barriers to greater pharmacist involvement. A structured online questionnaire was distributed by FIP, and 142 completed responses from 51 countries were included in the final analysis.

Based on the literature review and survey findings, an expert FIP panel of 13 pharmacists from five continents recommended developing practical guidance on AD and other skin conditions to enhance pharmacists' skills and support pharmacy practice.

An algorithm illustrating the pharmacist's role across the patient journey was developed as basic guidance for AD management.

AD MANAGEMENT DERMATOLOGY GUIDELINES

AD management focuses on symptom relief and long-term control through trigger avoidance, regular emollient use, suitable hygiene and anti-inflammatory therapy, including topical agents for mild cases and systemic therapy for severe disease.⁹⁻¹¹

Knowledge gaps among pharmacists were identified that could potentially contribute to inappropriate or suboptimal treatment practices.^{12,13}

FIRST LINE Basic therapy for all severities

- Trigger avoidance
- Emollient/emollient plus
- Hygiene (pH 5.5)
- Broad-spectrum sunscreen
- Patient education

MILD

- TCS (acute)
- Reactive TCI

MODERATE

- Proactive TCS OR TCI
- NB-UVB and medium dose UVA1
- Psycho-somatic counselling

SEVERE

- Conventional systemic drugs
- Biologics
- JAK-inhibitors

Modified from Wollenberg 2025 (10).
TCS, Topical corticosteroids.
TCI, Topical calcineurin inhibitor.

RESULTS & DISCUSSION

FIRST LINE HEALTHCARE

Patients with AD at all severities may benefit from referral to a dermatologist or other appropriate healthcare professional. Pharmacists can support on basic skincare, patient education, and referral during active disease, while playing a broader role during the maintenance phase. These activities should align with country-specific practices.

Pharmacists can counsel on trigger avoidance, such as use of harsh soaps, fragrances, and irritating fabrics, and guide patients on proper hygiene (pH 5.5, soap-free, skin-neutral), taking showers over baths, avoiding hot water, etc.^{5,6} They also advise on moisturizer use, which is recommended for frequent and liberal application at all AD severities by European guidelines and the American Academy of Dermatology.⁹⁻¹¹ In addition to standard emollients, emollient "plus" are moisturizers containing active non-pharmacological ingredients such as saponins, flavonoids, and bacterial lysates (e.g., *V. filiformis*).¹⁴ They help improve AD lesions by restoring barrier lipids, preventing water loss, moisturizing the skin, and reducing inflammation and itch.

Pharmacists can help patients select moisturizers and other adjunctive treatments according to individual preferences and routines to ensure regular use and improve adherence.^{5,6} They also refer patients to a physician if flares occur or the condition worsens.

REDFLAGS - WHEN TO REFER

- Suspected AD requiring diagnostic confirmation
- Unresolved AD flares despite appropriate therapy
- Evidence of infection (*S. aureus*)
- Significant psychosocial disruption (e.g. poor sleep, school/work absence)
- Frequent recurrence of flares or uncontrolled disease
- Concern about adverse events

PHARMACOLOGIC THERAPY

Pharmacists are ideally positioned to:

- Ensure patients' understanding of disease and treatment.
- Educate patients on TCS use, address corticophobia and promote adherence.
- Assess therapy effectiveness and disease impact on QoL, referring patients to appropriate physicians when needed.
- Prevent post-inflammatory hyperpigmentation by recommending sun protection, especially for darker skin types.

ADJUNCTIVE THERAPY

Conventional pharmacologic treatments and biologics often do not fully resolve all symptoms, particularly the itch-scratch cycle, requiring a holistic approach. Pharmacists can guide patients in the choice and use of emollients or emollients+.

MAINTENANCE THERAPY

Longterm maintenance and control of the disease overtime is crucial for optimal quality of life. Pharmacists should:

- Continue therapeutic patient education.
- Monitor for potential relapses.
- Refer patients if disease remains uncontrolled.
- Recommend continuous use of emollients and appropriate hygiene/cleansers to maintain the skin barrier and reduce flares.

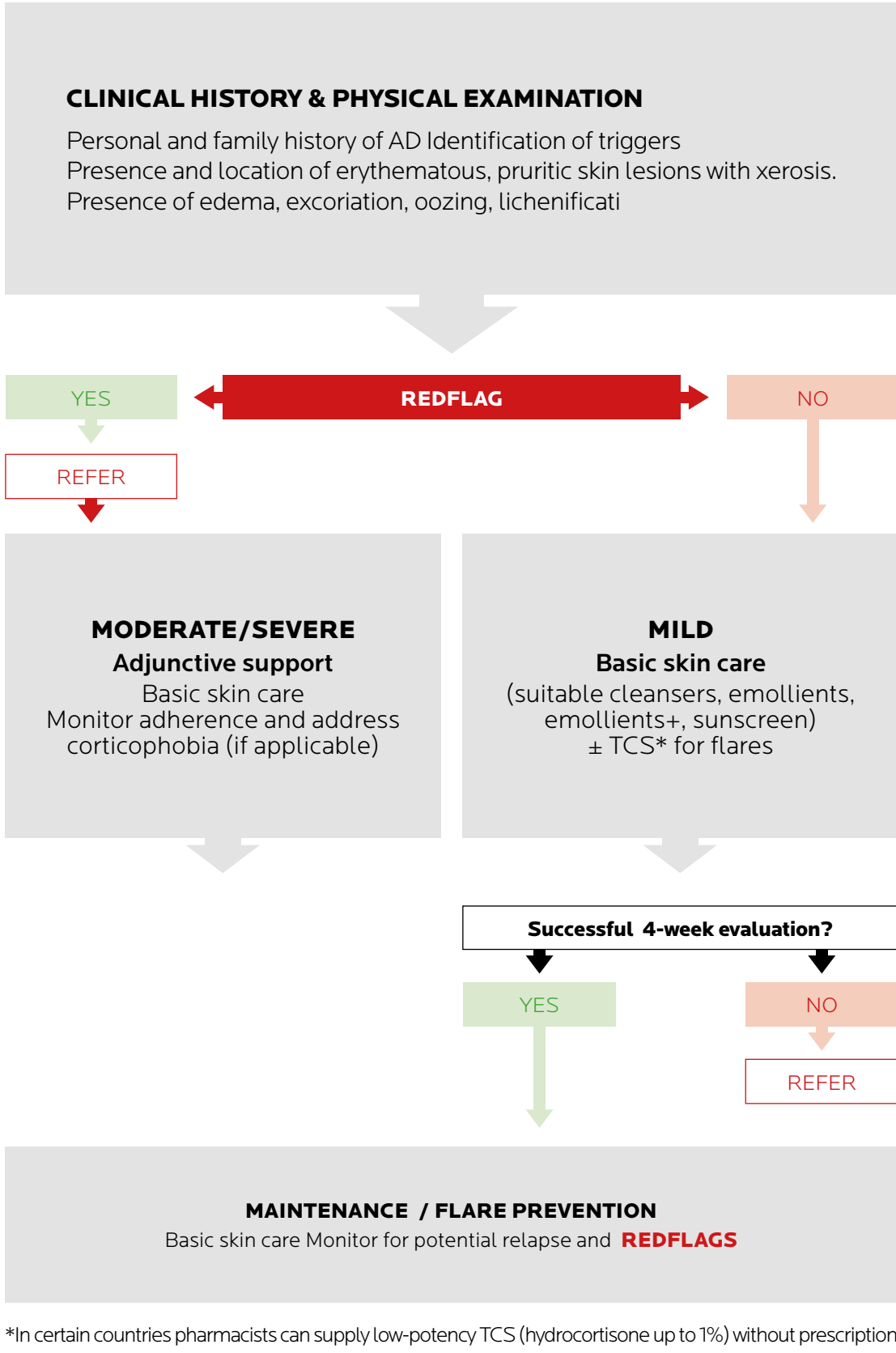
AREAS OF OPPORTUNITY

TCS are first-line treatments for moderate-to-severe AD, but adherence is often limited by corticophobia. Community pharmacists are well positioned to support appropriate TCS use through patient education, although knowledge gaps may contribute to suboptimal counselling.^{5,6,12,13} Enhanced education, practical guidance, and decision-support tools could further strengthen pharmacists' confidence and contribution to AD care.

CONCLUSION

Pharmacists are often the first point of contact for people with AD and can play an important role in patient education, supporting treatment adherence, advising on trigger avoidance, recommending emollients across all disease severities, and facilitating referral. This is country-specific and should be aligned with local practice; it is particularly important in areas with a limited number of dermatologists. In some countries, pharmacists can supply low-potency TCS without a prescription. Pharmacist-led interventions can improve adherence, quality of life, and clinical outcomes, and their implementation should be expanded globally.

PATIENT JOURNEY – THE PHARMACIST ROLE



GOALS OF AD MANAGEMENT

1. Control dermatitis and pruritus
2. Prevent flare recurrence
3. Minimize therapy adverse effects
4. Minimize non-adherence
5. Improve quality of life for patients

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