atopic dermatitis 2025 summit

summit proceedings

atopic dermatitis summit

saturday may 10, 2025 | 10 a.m. to 1 p.m. ET | virtual summit

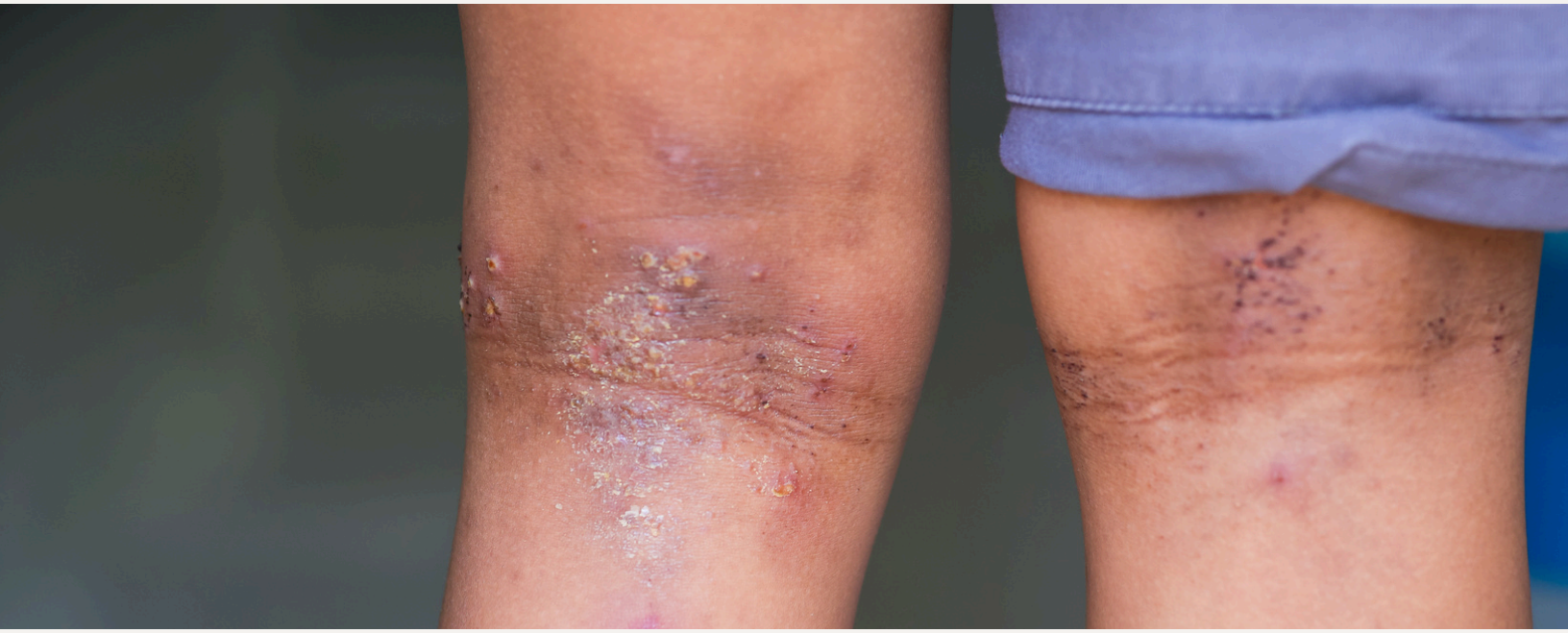
Invisible burdens, visible impact

Real world strategies for atopic dermatitis management

This report has been prepared for the exclusive use of registrants to the 2025 Atopic Dermatitis Summit. It provides a summary of the Summit highlights from May 10, 2025.

Atopic dermatitis (AD), commonly referred to as eczema, is one of the most prevalent chronic inflammatory skin conditions worldwide. Despite its complex pathophysiology and the significant—often invisible—psychosocial burdens it places both on patients and their caregivers, it is frequently dismissed “as just a rash.” This misconception can lead to under diagnosis and inadequate treatment— challenges further compounded in Canada by specialist shortages, fragmented care, and financial barriers.

On a more encouraging note, recent advances in both clinical understanding and therapeutic development have led to more holistic approaches that address the full spectrum of patient needs. At the 2025 Atopic Dermatitis Skin Summit, clinicians discussed the multi-faceted burden of AD and explored strategies to improve outcomes across diverse patient populations. The Summit was chaired by **Dr. Marissa Joseph**, a Toronto-based dermatologist.



A brief overview of atopic dermatitis throughout history

Dr. Joseph Lam, a Clinical Associate Professor of Pediatrics and Associate Member of the Department of Dermatology and Skin Sciences at the University of British Columbia, opened the session by delving into AD's historical trajectory—the good, the bad, and the downright dangerous.

"Although pruritic skin conditions have been described for centuries, these early accounts do not always correspond with today's clinical definition of eczema," he said.

That began to change in medieval Persia—a period known in Europe as The Dark Ages but celebrated as the Islamic Golden Age (8th to 14th centuries) where some of the first records of a condition resembling eczema emerge. "Avicenna, the renowned Persian polymath, was among the first to link frequent bathing with skin dryness, an insight that still appears today in our patient handouts."

THE PRINTING PRESS ARRIVES— WITH A PROLIFERATION OF MISINFORMATION

The advent of the printing press during the European Renaissance brought the first textbooks related to dermatology. However, as Dr. Lam noted, these did not guarantee scientific accuracy.

"The etiology of eczema was still thought to be based on the Hippocratic or humoral theory, believing that eczema's oozing was the body's attempt to expel toxins," he said. According to this view, suppressing symptoms such as itching or discharge could worsen the condition—so treatment often meant doing nothing at all.

This misinformed approach persisted well into the modern era, with the International Congress of Dermatology in 1889 still echoing elements of the "evil" humoral theory. "Patients were treated with ineffective—and often downright dangerous—remedies like sulfur, arsenic, and mercury," he noted. "Some were wrapped in rubber to try to draw the toxins out, and leeches were commonly used."

THE BIRTH OF A TERM—AND A SCIENTIFIC TURNING POINT

A major step occurred in 1818, when English physicians Robert Willian and Robert Bateman coined the term “eczema” derived from the Greek word meaning to erupt or boil over. This ushered in a more precise understanding of the disease, laying the foundation for the evidence-based treatments available today.

“The first publications on topical hydrocortisone for eczema appeared in 1952,” Dr. Lam said, “Since then, we’ve seen the development of a wide range of corticosteroids, spanning low-to-high potency formulations. Fifty years later, a new class of medications emerged: topical calcineurin inhibitors. This was followed by the introduction of the phosphodiesterase-4 (PDE4) inhibitor crisaborole and most recently the approval of the topical JAK inhibitors in 2021 in the U.S. and in 2024 in Canada.”

“On reflection, we can see how progress works. We do the best with the knowledge we have, and right now there are so many medical advances for eczema in the future,” he concluded.

Dr. Joseph Lam

Vancouver

Dr. Joseph Lam is a Clinical Associate Professor of Pediatrics and an Associate Member of the Department of Dermatology and Sciences at the University of British Columbia. He practices at the BC Children's Hospital and in his private clinic on East 10th Avenue in Vancouver.

Identifying and managing sensitive skin triggers

What does sensitive skin look like?

If your patient's skin responds strongly to chemicals, dyes, or fragrances found in products that touch their skin, or they sometimes experience rashes and irritation from their clothing, they may have sensitive skin.

Some of the most common signs and symptoms of sensitive skin include[1]:

- Red skin with or without swelling.
- Skin that itches, stings, or burns.
- Dry skin that may peel, crack, blister, or bleed.
- Patches of skin that feel dry, hard, and leathery.

Developed in association with:

Dr. Carrie Lynde

LLB, MD, FRCPC, Dermatologist

Identifying Common Triggers of Sensitive Skin

Taking the time to investigate potential irritants in the patient's workplace, outside environment, and home can help to make the connection between the trigger and their reactive skin.

"I recommend taking the time to do a series of elimination questions to find irritants and remove them from the patient's environment. Keeping a skin diary can also help identify patterns and potential skin irritation triggers. If there are multiple triggers, it can be helpful to eliminate all of them and slowly reintroduce them one at a time to isolate the specific trigger."

There are three main areas to explore:

Occupational Triggers:	Environmental Triggers:	Personal Care and Home Triggers:
• What type of work does the patient do? • Are they exposed to soaps, chemicals, latex gloves, or frequent hand washing?	• Does the patient spend a lot of time outdoors? • Have they recently come in contact with poison ivy, oak, or sumac?	• Is the patient using skincare products with potentially irritating ingredients like retinol or glycolic acid? • Is a fragrance-free, dye-free detergent, fabric conditioner, and dryer sheet being used?

To view the full list of sensitive skin triggers, visit www.pgsciencebehind.com/en-ca/free-gentle

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The role of textiles in sensitive skin

Laundry products are frequently overlooked as a possible trigger of sensitive skin. Many patients are unaware of the irritation that fragrance can cause, and clothing and bed sheets washed in scented laundry detergents can lead to widespread rashes. *"As a dermatologist, I always recommend my patients use hypoallergenic, fragrance-free, dye-free laundry products like the Tide, Downy, and Bounce Free & Gentle regime as the first step in managing their sensitive skin."*

The entire laundry routine needs to be free!

When talking to patients about their laundry routine, it is important to remind them that the entire routine needs to be "free" from dyes and perfumes to avoid skin rashes and sensitivity. This includes fabric conditioners and dryer sheets.

#1 Dermatologist Recommended Laundry Products
Hypoallergenic. Free of perfumes.

* Tide Free & Gentle Liquid Laundry Detergent, Tide PODS Free & Gentle Laundry Detergent, and Downy Free & Gentle Liquid Fabric Conditioner have all earned the Eczema Society of Canada Seal of Acceptance. ™ Trademark of Eczema Society of Canada/Société canadienne de l'eczéma, used under license.

† Earned National Psoriasis Foundation Seal of Recognition, excluding Bounce Free & Gentle dryer sheets.

References: 1. McCallum K. Sensitive Skin: Symptoms, Common Triggers & How It's Treated. Houston Methodist Hospital – Texas Medical Center. Feb. 2, 2022. Available at: https://www.houstonmethodist.org/blog/articles/2022/feb/sensitive-skin-symptoms-common-triggers-how-its-treated/

JAK inhibitors in atopic dermatitis

Up to 30% of children and approximately 10% of adults are affected by AD. For many of these patients, Janus kinase (JAK) inhibitors have emerged as a transformative treatment option. According to **Dr. Feras Ghazawi,** a double board-certified dermatologist who holds a Master's degree in Cancer Biology and a PhD in immunology, optimizing therapy with JAK inhibitor therapy depends on many factors.

"It's critical to recognize how atopic dermatitis may present differently across skin types," the Ottawa dermatologist pointed out. "For example, patients with darker skin tones may present with symptoms such as follicular accentuation and post-inflammatory hyperpigmentation instead of erythema."

Managing more pronounced lichenification in these populations begins with trigger avoidance, he said. "Identify common environmental allergens such as dust mites, dander, and chemical irritants such as soaps and detergents. I also encourage selective dietary testing when food allergies are suspected."

In terms of first line therapy for moderate to severe AD, Dr. Ghazawi recommended dupilumab. "While it's generally well tolerated, there are some limitations, such as its injectable form and relatively slower onset of action that may limit its appeal in some cases."

JAK INHIBITORS OFFER A DIFFERENT MECHANISM

JAK inhibitors target the Janus kinase (JAK)-STAT signalling pathway to dampen the pro inflammatory cytokine activity. Several agents have been approved or are currently in clinical trials including tofacitinib, baricitinib, upadacitinib, and abrocitinib, all with slightly different selectivity profiles. However, despite their advantages, Dr. Ghazawi emphasized that JAK inhibitors were not suitable for all patients as a first-line option.

"Ideal candidates must be selected," he said. "These are often the ones with severe to moderate AD who do not respond to topicals or who are unable to access biologic therapies. However, before initiating JAK inhibitors, we must carefully weigh the comorbidities, infection risk, and factors such as malignancy and thrombosis risk."

JAKi DOSING CONSIDERATIONS

Dosing is generally based on age and weight and must be adjusted in patients with renal or hepatic impairment, he explained. He also stressed the importance of baseline and ongoing monitoring to ensure patient safety.

“When monitoring at baseline, clinicians should look out for drug interactions. Lab tests should include complete blood count, liver function tests, lipid profile, and tuberculous screening, with continued monitoring at regular intervals.”

“Infection risk is real,” he cautioned. “These patients must be monitored closely. Thrombosis remains a concern as well, so I advise patients to be educated on early warning signs and seek immediate attention if these warning signs arise.”

Ultimately, Dr. Ghazawi recommends an individualized treatment strategy. ““Recognize the diversity in AD presentation and tailor treatment therapy to the specific needs, risks and preferences of each patient.”

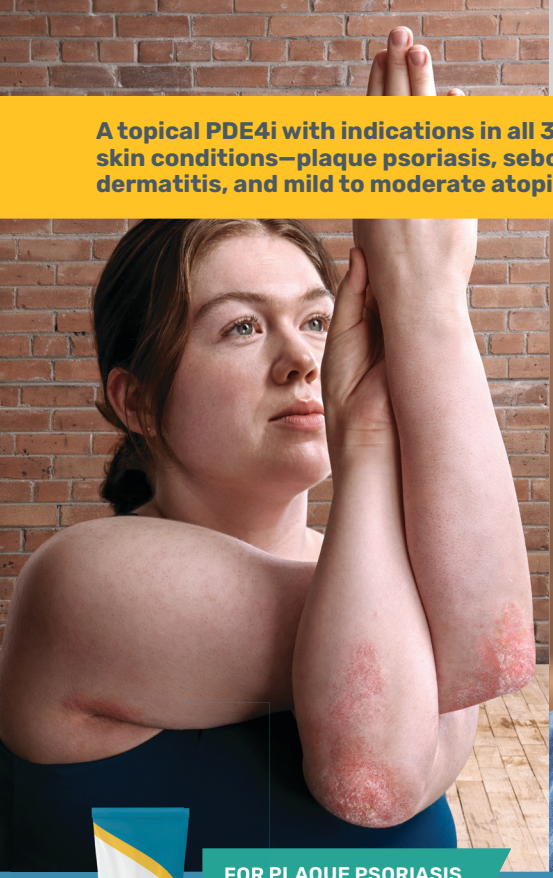
Dr. Feras Ghazawi

Ottawa

Dr. Feras Ghazawi is a double board-certified dermatologist in the United States and Canada.

Dr. Ghazawi holds a Master’s degree in Cancer Biology and a doctorate (PhD) degree in Immunology, which laid the foundation for his career in medicine. Graduating from McGill University with a medical degree, Dr. Ghazawi’s expertise spans dermatology and immunology.

Dr. Ghazawi’s passion for scientific exploration is evident through his impressive portfolio of over 87 published peer-reviewed papers and several influential book chapters. His groundbreaking research has significantly advanced the understanding of dermatological, immunological, and oncological conditions, earning him recognition and the prestigious Canadian Dermatology Research Award in 2019.



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Reference: 1. ZORYVE® Product Monograph. Arcutis Canada, Inc. March 2025.

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Food allergies & atopic dermatitis

What comes first: food allergies or AD? **Dr. Zainab Abdurrahman** dispelled some of the common misconceptions.

“The atopic march is pretty set, and it starts with AD,” she said. “From there, individuals may go on to develop food allergies, followed by the other atopic diseases such as asthma and allergic conjunctivitis.” Dr. Abdurrahman is an allergist and Assistant Clinical Professor of the School of Medicine at Toronto Metropolitan University as well as an adjunct Assistant Clinical Professor in Pediatrics at McMaster University, Hamilton.

She noted that AD usually presents around two months of age. “At that stage, infants aren’t really eating much. When we start introducing foods closer to about six months, we see food allergies emerge, typically with in a six-to-twelve-month window. This supports the evidence showing that its AD that causes food allergy rather than the other way around.”

DEBUNKING MYTHS AROUND FATAL FOOD ALLERGIES

“Patients tell me they’re afraid to introduce certain foods to their babies because they believe the risk of anaphylaxis is high,” she said. “In reality, deaths from food allergies are thankfully quite rate and have been steadily decreasing over the past 25 years. The estimated risk of dying from food anaphylaxis is somewhere just around under one in 10 million to over one in 10 million—lower than the risk of a fatal car accident in childhood.”

THE ROLE OF EARLY ALLERGEN EXPOSURE IN BUILDING TOLERANCE

Avoiding common food allergens in babies such as peanuts and eggs can actually increase the risk of developing an allergy to those foods, Dr. Abdurrahman emphasized. “The GI pathway is geared to be more pro tolerance versus the cutaneous track which leans more toward sensitization—especially in individuals genetically predisposed to producing immunoglobulin E [IgE].”

So how can parents help infants develop this tolerance? By feeding early and feeding often, Dr. Abdurrahman advised. “You need to introduce a new food frequently on a weekly basis, especially during the first two years of life when the GI tract is maturing and developing that tolerance.”

SENSITIZATION DOES NOT EQUAL ALLERGY

When it came to skin testing, she clarified that a positive test doesn’t necessarily mean a clinical allergy. “We actually have a really high risk of false positives in patients with atopic dermatitis because they have high levels of IgE. So, they are just going to react with whatever you put on their skin. This can cause more harm than good if the person starts avoiding certain foods because they believe they are allergic to them. As a result, they could actually develop an allergy because their body is losing tolerance to that food over time.”

Take-away message? “Feed the baby, don’t feed the skin,” she concluded.

Dr. Zainab Abdurrahman

Mississauga, Ont.

Dr. Zainab Abdurrahman (she/her) is the President of the Ontario Medical Association (as of May 1, 2025) and a practicing allergist and clinical immunologist in the Greater Toronto Area. She serves as an Assistant Clinical Professor of the School of Medicine at the Toronto Metropolitan University, and is an adjunct Assistant Clinical Professor in Pediatrics at McMaster University.

Dr. Abdurrahman earned her Doctor of Medicine from the University of Toronto and completed her pediatrics residency and subspecialty training in Allergy and Clinical Immunology at McMaster University. She also holds a Master’s degree in Statistics with a specialization in Biostatistics.

Deeply committed to advancing health equity, she has been a key contributor to the Black Scientists Taskforce on COVID-19 Vaccination Equity and the Black Health & Vaccine Initiative, in partnership with the Black Physicians’ Association of Ontario (BPAO).

Beyond equity work, Dr. Abdurrahman is passionate about the intersection of technology and medicine. She is dedicated to leveraging innovation to enhance patient care and is a strong advocate for advancing the medical profession through inclusive leadership and systemic change.

Management of pediatric atopic dermatitis

Sponsored by Bausch Health Canada

AD often presents in infancy or early childhood, yet it remains significantly undertreated. According to Dr. Marissa Joseph, this affects patients and their caregivers in a number of ways. She is the Medical Director of the Ricky Kanee Schacter Dermatology Centre at Women's College Hospital in Toronto and also works at the Hospital For Sick Children where she manages children with complex dermatologic disease in outpatient and inpatient settings, as well as a pediatric laser treatment program.

"Sleep deprivation is a major issue for caregivers," she noted. "About 44 per cent of caregivers experience sleep loss related to their child's atopic dermatitis. This lack of restorative sleep is compounded by feelings of helplessness and anxiety watching a child suffer during a flare up. Parents also face taking time off work off for medical appointments, and the financial burdens of buying various remedies. There's a real risk of caregiver burnout when caring for younger children with eczema."

ANOTHER MAJOR STRESS— STEROID PHOBIA

This fear, amplified by misinformation circulating on social media, is a key challenge in managing pediatric AD, Dr. Joseph said. "I've had parents bring in infants and ask whether their child has steroid withdrawal, even though their baby has never been treated with a topical steroid."

How can clinicians turn these challenges into opportunities to help parents make informed choices they feel comfortable with?

A first step is educating them on the etiology of AD, she advised. "I often use a brick wall analogy to illustrate the importance of skin barrier function. The cracks in the mortar represent dryness in the skin, and increased transepidermal water loss, which leads to an inflammatory response."

TOPICAL THERAPIES FOR CHILDREN UNDER SIX YEARS OF AGE

“Parents must also understand that there is no cure for eczema, but it can be effectively managed,” she explained. “It begins with early treatment to reduce the frequency and intensity of symptoms. Next is maintaining optimal skin hydration, following by strategies to control the itching and minimize scratching. Finally, the goal is to reduce both the occurrence and progression of flare-ups.”

Topical treatments have been the mainstay of treatment in children under the age of six, she added. “While we generally avoid high potency corticosteroids in this age group, low- to mid-potency steroids are certainly reasonable as an initial step. Due to limitations using it [a topical corticosteroid] long term, it Is often reserved for flares.”

For parents still concerned about the safety of steroids she recommended considering non-steroidal alternatives. These options include topical calcineurin inhibitors such as tacrolimus 0.03% ointment—approved in Canada for children aged two to 15 years—and topical phosphodiesterase-4 (PDE4) inhibitors.

“It’s important to highlight that topical steroids are really safe when used appropriately,” Dr. Joseph said. “While rare side effects—such as atrophy, purpura stria, increased hair growth, and impaired wound healing—can occur, the benefits of using the appropriate steroids for acute flare management outweigh the risks.”

Dr. Marissa Joseph

Toronto

Dr. Marissa Joseph completed medical school at Dalhousie University in Halifax and her postgraduate training at the University of Toronto. She is double board-certified in Pediatrics and Dermatology and full-time academic faculty at the University of Toronto. She has received and has been nominated for teaching awards in both undergraduate and postgraduate medical education. She also completed an MSc in Community Health at the Dalla Lana School of Public Health.

Dr. Joseph is the Medical Director of the Ricky Kanee Schachter Dermatology Centre at Women's College Hospital in Toronto. She also works at SickKids hospital where she manages children with complex dermatologic disease as well as within a pediatric laser treatment program.

Dr. Joseph enjoys her diverse practice in general adult, pediatric, and surgical dermatology. Her clinical and research interests include inflammatory skin disorders such as psoriasis, atopic dermatitis, and hidradenitis suppurativa; genodermatoses; and equity, diversity and inclusivity.

Scratching the surface: Hidden challenges in pediatric AD

One of the invisible challenges in pediatric AD is the interplay between disease severity and quality of life.

“There are many things that can give distress, from medical visits to emollient application to personalized, subjective feelings about the disease,” explained **Dr. Luis Fernando Sanchez-Espino,** a Staff Pediatric Dermatologist at the Stollery Children’s Hospital in Edmonton and an Assistant Professor in the Department of Pediatrics at the University of Alberta.
.
He illustrated this with a case study involving a 50-year-old Caucasian woman with a long-standing history of poorly controlled AD. Her symptoms began in childhood and were initially managed with topical corticosteroids applied by her mother. She also developed severe asthma. Over time, her condition worsened, resulting in extensive body surface area (BSA) involvements and frequent hospitalizations—often multiple times a year—for AD or asthma exacerbations.

By adulthood, she had tried many immunosuppressive therapies without relief. Long-term corticosteroid use had left her with visible scarring and hyperpigmentation. Alongside the physical burden was the psychological toll of constantly anticipating her next flare-up. She developed persistent depression and anxiety to the point where outside of work and essential errands, she rarely left the house.

While this may seem like an extreme case, it’s not uncommon—especially in underserved communities. “I’m sure many of you can related to similar experiences or former patients in your practice,” Dr. Sanchez-Espino said.

ADDRESSING COMORBIDITIES

Although it’s not often discussed, he pointed out that patients with AD face an increased risk of developing comorbid conditions such as tumours, lymphoma, or other hematologic malignancies. These risks tend to increase over time and are correlated with disease severity and level of control. North American studies have confirmed these associations and have also identified additional comorbidities including, vitiligo, ocular surface disease, and metabolic complications such as obesity.

CONSIDERING THE IMPACT ON CAREGIVERS

In advocating for a more holistic, patient- and family-centered approach to AD management, Dr. Sanchez-Espino emphasized the critical need to support caregivers.

“One study showed that the more a child’s quality of life was compromised, the more their caregivers’ physical and mental health suffered,” he noted. “There is a delicate balance between caregiver resilience and the very real risk of burnout. Clinicians must remain attuned to the coping thresholds of families.”

To support this, caregiver education should extend beyond disease management to include guidance on navigating the healthcare system, understanding regional and local practices, recognizing possible comorbidities and accessing relevant resources.

As Dr. Sanchez-Espino summarized, “Ultimately, we must aim for more than skin clearance—we must strive to support daily life.”

Dr. Luis Fernando Sanchez-Espino

Edmonton

Dr. Luis Fernando Sanchez-Espino is a Staff Pediatric Dermatologist at the Stollery Children’s Hospital in Edmonton and an Assistant Professor in the Department of Pediatrics at the University of Alberta. His clinical practice focuses on the diagnosis and management of varied and complex pediatric dermatologic conditions, with a special interest in inflammatory and immune-mediated disorders, medical and procedural care of vascular anomalies, and rare genodermatoses.

Biologics in atopic dermatitis management

Biologics have been a gamechanger in AD treatment—but how do you select the appropriate patient for therapy? **Dr. Jaggi Rao** discussed the pros and cons of this treatment. He is a certified cosmetic and laser surgeon in Edmonton where he serves as a Clinical Professor of Medicine and Dermatology Residency Program Director at the University of Alberta.

WHAT IS A BIOLOGIC AGENT?

“According to the U.S. National Institutes of Health, a biologic is defined as a substance made from a living organism or its products used to prevent, diagnose or treat diseases,” he said. “In dermatology, they are primarily used to treat moderate to severe psoriasis and chronic spontaneous urticaria.”

The pathophysiology of AD has been more clearly studied over the past decade, he reported, providing a better understanding of the microscopic elements that cause inflammation. “These have to do with the cytokine or cellular messengers, such as interleukins 4, 13 and 31. Interleukins 4 and 13 in particular, are responsible for the key clinical features of AD, including redness, skin thickening, scaling, and the significant itch.”

Today, there are a range of targeted therapies to modulate these cytokines, he noted. “These include members of the JAK inhibitor class, as well as monoclonal antibodies such as dupiliumab, tralokinumab, and lebrikizumab. Depending on where they are acting microscopically, these therapies are classified as interleukin-4 or interleukin-13 inhibitors.”

PROVEN EFFICACY OF BIOLOGICS

In the two pivotal trials required for its approval in Canada, lebrikizumab demonstrated significant efficacy, with nearly a 60% improvement at week 16, said Dr. Rao. “In comparison, tralokinumab achieved a 33 per cent improvement, while dupilumab showed about 51 per cent improvement.”

In addition, he pointed out that all three biologics performed well in terms of itch improvement, and notably, none require routine blood monitoring.

COST CONSIDERATIONS

While extolling the benefits of biologics, Dr. Rao acknowledged a significant drawback: the high cost, which can reach thousands of dollars per year.

“The first requirement in getting these covered is documented disease severity, which must be assessed by a board-certified dermatologist,” he said. ‘The second is a Quality of Life (QoL) score, which considers factors such as the intensity of itching, and the impact of the condition on work or social interactions. Payers also require documentation of prior treatment failures or intolerance to conventional therapies, including topical medication and phototherapy.”

“They also look for measurable signs of improvement in disease severity. This typically involves a repeat EASI [Eczema Area and Severity Index] score at six months or one year. Most payers are looking for a 50 per cent improvement score over baseline, including the QoL. When that level of improvement is documented by a board-certified dermatologist, most payers will approve continued coverage of the therapy.”

Dr. Jaggi Rao

Edmonton

Dr. Jaggi Rao is an award-winning dermatologist, author, innovator, and researcher, licensed in both Canada and the United States. He is also a certified cosmetic and laser surgeon, having completed an accredited fellowship in southern California. Dr. Rao has a very busy and popular practice in the heart of Edmonton, where he serves as a Clinical Professor of Medicine and is the Dermatology Residency Program Director at the University of Alberta. He is also a resource for industry, delivering dozens of lectures every year at local, national, and international meetings, while serving on speakers’ bureaus, research committees, and advisory boards.

Diagnosing atopic dermatitis across the skin spectrum

“How confident are you in describing the differences in the presentation of AD in pigmented skin?” That was the question posed by **Dr. Marissa Joseph** during her second presentation at the AD Summit.

“We often talk about people sharing 98 to 99 per cent of the same DNA,” she said. “Yet even though we may be very similar genetically, endotypes help us understand how biological differences can influence the presentation of dermatologic diseases across diverse skin types. When we fail to recognize how disease manifests in different skin tones, it can lead to misdiagnosis, delayed diagnosis, and an underestimation of disease severity.”

HOW DOES AD PRESENT DIFFERENTLY IN PIGMENTED SKIN?

“It can differ in colour, location, and nummular and follicular variants,” Dr Joseph noted, who presented clinical images of eczema patients with a range of skin tones to underscore her point. In one example of a patient with darker skin and diffuse atopic dermatitis, the active areas appeared grey and ashy—quite different from the intense erythema typically observed in lighter-skinned individual.

She also emphasized that the distribution of lesions can vary significantly across skin types. “We classically teach that AD is in the flexural areas. However, in patients with black and brown skin, it may more commonly involve the extensor areas.”

As a case in point she shared slides of two patients—one of Hispanic descent and one of South Asian descent— both exhibiting extensive eczema on their extensor surfaces. “These are both very severe cases,” she said. “But if you were to assess severity scores using our current evaluation tools, you might arrive at different numbers. “

REDNESS-BASED METRICS ARE NOT ENOUGH

Traditional eczema severity scoring systems have long relied on the visual assessment of erythema, based on the intensity of the redness as a key diagnostic marker. “These current scales describe a range from faintly detectable erythema to deep, dark red—but the clinical presentation can differ significantly in patients were more deeply pigmented skin,” Dr. Joseph pointed out.

“I’ve shown examples—severe disease in a Black patient may appear as deeply pigmented lesions, while in an Indian patient, plaques may appear ashy. But again, these features are not adequately captured by our traditional redness-based metrics.

“That gap highlights the need for inclusive scoring systems that account for variations in skin presentation. This involves looking at not just redness, but incorporating shades of pink, red, and purple, or purple and brown, and evaluate these lesions based on their prominence and distinguishability.

“These differences must be integrated into our current severity definitions, because they inform treatment decisions and ensue that patients are being properly diagnosed,” she concluded.

Dr. Marissa Joseph

Toronto

Dr. Marissa Joseph completed medical school at Dalhousie University in Halifax and her postgraduate training at the University of Toronto. She is double board-certified in Pediatrics and Dermatology and full-time academic faculty at the University of Toronto. She has received and has been nominated for teaching awards in both undergraduate and postgraduate medical education. She also completed an MSc in Community Health at the Dalla Lana School of Public Health.

Dr. Joseph is the Medical Director of the Ricky Kanee Schachter Dermatology Centre at Women's College Hospital in Toronto. She also works at SickKids hospital where she manages children with complex dermatologic disease as well as within a pediatric laser treatment program.

Dr. Joseph enjoys her diverse practice in general adult, pediatric, and surgical dermatology. Her clinical and research interests include inflammatory skin disorders such as psoriasis, atopic dermatitis, and hidradenitis suppurativa; genodermatoses; and equity, diversity and inclusivity.

AD cases in South America

Social and economic conditions affect the severity and prevalence of atopic dermatitis in Brazil. According to **Dr. Maria Cecilia Rivitti Machado,** a medical dermatologist at the Hospital das Clinicas of the Faculty of Medicine of the University of Sao Paulo (USP) in Brazil, these factors can compromise everything from diagnosis to access to treatment.

“In Brazil, all residents—including foreign nationals—are entitled to public healthcare coverage. Approximately 25 per cent of the population also have access to private insurance, leading to disparities in accessing certain medications.”

There is a broad range of topical steroids and immunomodulators available in the public system, she added. “However, access to the newer advanced topical treatments is limited. We often rely on topical steroids, cyclosporine, methotrexate, antibiotics, and occasionally systemic corticosteroids. In contrast, patients with private coverage may have access to newer therapies such as dupilumab.”

CASE STUDIES

To underscore the impact of social and economic factors on treatment outcomes, Dr. Rivitti Machado presented a series of case studies. One involved a 34-year-old female with progressive atopic dermatitis. “Although she was able to access good dermatologic care, she responded poorly to most of the classic immunosuppressants and began experiencing recurrent bacterial infections,” she noted. “She required two hospital admissions for intravenous treatment which yielded only mild improvement, and we escalated her topical regimen accordingly. Despite these efforts, she struggled with depression and anxiety, was unable to work, and became increasingly housebound.”

Given her access to dupilumab, Dr. Rivitti Machado initiated treatment. “Within the first month, we observed significant improvement, and her skin was nearly clear by eight to nine months. Five years on, she remains on the therapy with sustained results.”

COPING WITH LIMITATIONS

Geographic location also plays a major factor in AD management in Brazil, as dermatologic facilities are often unavailable in rural or underserved areas. How then can these populations be effectively reached and served?

Dr. Rivitti Machado illustrated this challenge with a case study involving a young boy diagnosed with a severe form of atopic dermatitis. One of the primary obstacles, she said, was the patient's distance from the hospital, which affected her ability to initiate systemic therapy since frequent in-person visits for monitoring and medication were not feasible for the mother.

To overcome these barriers, she employed a multidisciplinary approach. "We collaborated with a social worker and local support network to ensure the patient received the care he needed despite the logistical challenges."

She advised clinicians to "Invest in mild cases to prevent progression, identify and address aggravating factors, and equip caregivers with education to improve compliance."

Dr. Maria Cecilia Rivitti Machado

São Paulo, Brazil

Dr. Maria Cecilia Rivitti Machado is a medical dermatologist at the Hospital das Clínicas of the Faculty of Medicine of the University of São Paulo (USP) in Brazil, where she oversees the Pediatric Dermatology Outpatient Clinic and the Acne, Hidradenitis Suppurativa and Hair Follicle Diseases Group. Dr. Rivitti Machado is a Professor of Dermatology at the Metropolitan University of Santos (UNIMES) for undergraduate medical students, focusing on dermatoses of interest to family health and public health.

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Dr. Marissa Joseph

Toronto

Dr. Marissa Joseph completed medical school at Dalhousie University in Halifax and her postgraduate training at the University of Toronto. She is double board-certified in Pediatrics and Dermatology and full-time academic faculty at the University of Toronto. She has received and has been nominated for teaching awards in both undergraduate and postgraduate medical education. She also completed an MSc in Community Health at the Dalla Lana School of Public Health.

Dr. Joseph is the Medical Director of the Ricky Kanee Schachter Dermatology Centre at Women's College Hospital in Toronto. She also works at SickKids hospital where she manages children with complex dermatologic disease as well as within a pediatric laser treatment program.

Dr. Joseph enjoys her diverse practice in general adult, pediatric, and surgical dermatology. Her clinical and research interests include inflammatory skin disorders such as psoriasis, atopic dermatitis, and hidradenitis suppurativa; genodermatoses; and equity, diversity and inclusivity.

atopic dermatitis summit 2025

summit faculty

Dr. Zainab Abdurrahman

Mississauga, Ont.

Dr. Zainab Abdurrahman (she/her) is the President of the Ontario Medical Association (as of May 1, 2025) and a practicing allergist and clinical immunologist in the Greater Toronto Area. She serves as an Assistant Clinical Professor of the School of Medicine at the Toronto Metropolitan University, and is an adjunct Assistant Clinical Professor in Pediatrics at McMaster University.

Dr. Abdurrahman earned her Doctor of Medicine from the University of Toronto and completed her pediatrics residency and subspecialty training in Allergy and Clinical Immunology at McMaster University. She also holds a Master's degree in Statistics with a specialization in Biostatistics.

Deeply committed to advancing health equity, she has been a key contributor to the Black Scientists Taskforce on COVID-19 Vaccination Equity and the Black Health & Vaccine Initiative, in partnership with the Black Physicians' Association of Ontario (BPAO).

Beyond equity work, Dr. Abdurrahman is passionate about the intersection of technology and medicine. She is dedicated to leveraging innovation to enhance patient care and is a strong advocate for advancing the medical profession through inclusive leadership and systemic change.

summit faculty

Dr. Feras Ghazawi

Ottawa

Dr. Feras Ghazawi is a double board-certified dermatologist in the United States and Canada.

Dr. Ghazawi holds a Master's degree in Cancer Biology and a doctorate (PhD) degree in Immunology, which laid the foundation for his career in medicine. Graduating from McGill University with a medical degree, Dr. Ghazawi's expertise spans dermatology and immunology.

Dr. Ghazawi's passion for scientific exploration is evident through his impressive portfolio of over 87 published peer-reviewed papers and several influential book chapters. His groundbreaking research has significantly advanced the understanding of dermatological, immunological, and oncological conditions, earning him recognition and the prestigious Canadian Dermatology Research Award in 2019.

Dr. Joseph Lam

Vancouver

Dr. Joseph Lam is a Clinical Associate Professor of Pediatrics and an Associate Member of the Department of Dermatology and Sciences at the University of British Columbia. He practices at the BC Children's Hospital and in his private clinic on East 10th Avenue in Vancouver.

atopic dermatitis summit 2025

summit faculty

Dr. Jaggi Rao

Edmonton

Dr. Jaggi Rao is an award-winning dermatologist, author, innovator, and researcher, licensed in both Canada and the United States. He is also a certified cosmetic and laser surgeon, having completed an accredited fellowship in southern California. Dr. Rao has a very busy and popular practice in the heart of Edmonton, where he serves as a Clinical Professor of Medicine and is the Dermatology Residency Program Director at the University of Alberta. He is also a resource for industry, delivering dozens of lectures every year at local, national, and international meetings, while serving on speakers' bureaus, research committees, and advisory boards.

Dr. Maria Cecilia Rivitti Machado

São Paulo, Brazil

Dr. Maria Cecilia Rivitti Machado is a medical dermatologist at the Hospital das Clínicas of the Faculty of Medicine of the University of São Paulo (USP) in Brazil, where she oversees the Pediatric Dermatology Outpatient Clinic and the Acne, Hidradenitis Suppurativa and Hair Follicle Diseases Group. Dr. Rivitti Machado is a Professor of Dermatology at the Metropolitan University of Santos (UNIMES) for undergraduate medical students, focusing on dermatoses of interest to family health and public health.

Dr. Luis Fernando Sanchez-Espino

Edmonton

Dr. Luis Fernando Sanchez-Espino is a Staff Pediatric Dermatologist at the Stollery Children's Hospital in Edmonton and an Assistant Professor in the Department of Pediatrics at the University of Alberta. His clinical practice focuses on the diagnosis and management of varied and complex pediatric dermatologic conditions, with a special interest in inflammatory and immune-mediated disorders, medical and procedural care of vascular anomalies, and rare genodermatoses.

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