# Can Team-Based Care and Novel Therapies Improve Outcomes in Moderate to Severe Pediatric Atopic Dermatitis?

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# Disease Burden and the Pathophysiology of AD

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# Introduction[1,2]

The prevalence of AD is estimated to be
15% to 20% in children and 1% to 3% in adults

The disease course of AD is commonly chronic in adults
and more relapsing/remitting in children

The burden of symptoms can be profound, adversely impacting quality of life

↓

Depression, anxiety, sleep disturbance, and other atopic conditions
are frequent comorbidities

1. Nutten S. *Ann Nutr Metab.* 2015;66(suppl 1):8-16. 2. Fishbein AB et al. *J Allergy Clin Immunol Pract*. 2020;8:91-101.

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# Family History of Atopic Disease Increases the Risk of Atopic Dermatitis[1]

One parent with atopic disease raises the risk **1.5 fold**

Both parents with atopic disease raises the risk **3-fold to 5-fold**

Up to 70% of patients with atopic dermatitis have family histories of atopic disease

1. Eichenfield LF et al. *J Am Acad Dermatol*. 2014;70:338-351.

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# Distribution of AD by Age[1]

**Infant**
*(Birth-2 years)*
- Face (cheeks), scalp, ears
- Extensor extremities
- Seborrheic dermatitis overlap

**Childhood**
*(2 years-puberty)*
- Face (cheeks)
- Flexural extremities

**Teenager-Adult**
- Localized flexural extremities
- Hands, dorsum feet

1. Sugerman DT. *JAMA*. 2014;311:636.

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# Diagnostic Features of AD[1,2]

**Essential features**
must be present

- Pruritus
- Eczema (acute, subacute, chronic): typical morphology and age-specific patterns; chronic or relapsing history

**Key features in diagnosing AD**

*Patterns include:* (1) facial, neck, and extensor involvement in infants and children; (2) current or prior flexural lesions in any age group; (3) sparing of groin and axillary regions

**Important features**
seen in most cases, adding support to the diagnosis

- Early age of onset
- Atopy: personal and/or family history; IgE reactivity
- Xerosis

**Associated features**
help to suggest the diagnosis of AD but are too nonspecific to be used for defining/detecting AD for research or epidemiologic studies

- Atypical vascular responses (eg, facial pallor, white dermographism, delayed blanch response)
- Keratosis pilaris/pityriasis alba/hyperlinear palms/ichthyosis
- Ocular/periorbital changes
- Other regional findings (eg, perioral changes/periauricular lesions)
- Perifollicular accentuation/lichenification/prurigo lesions

1. Eichenfield LF et al. *J Am Acad Dermatol*. 2003;49:1088-1095. 2. Eichenfield LF et al. *J Am Acad Dermatol*. 2014;70:338-351.

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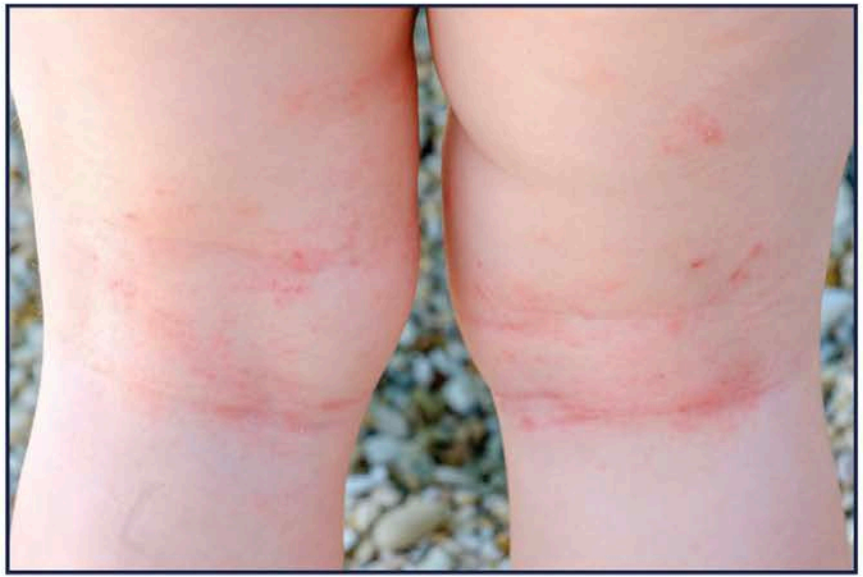
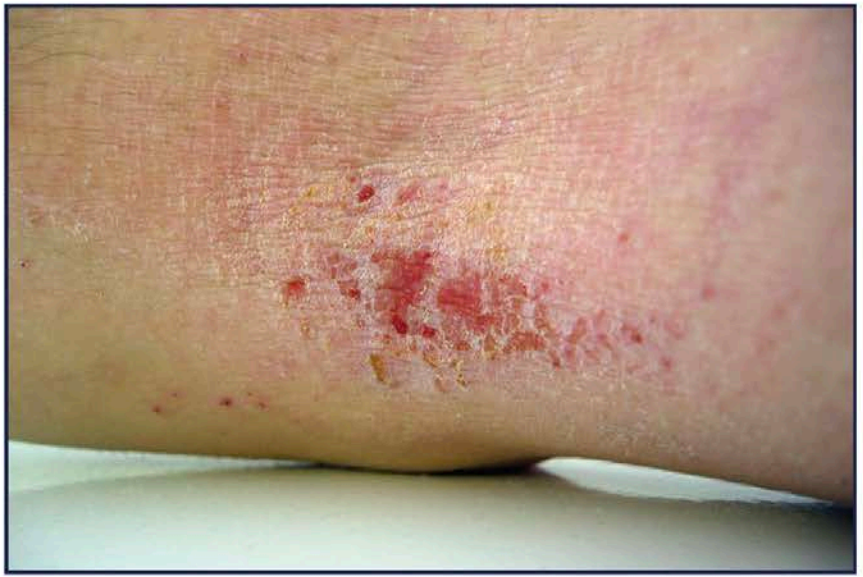
# AD in Patients of Lighter Skin





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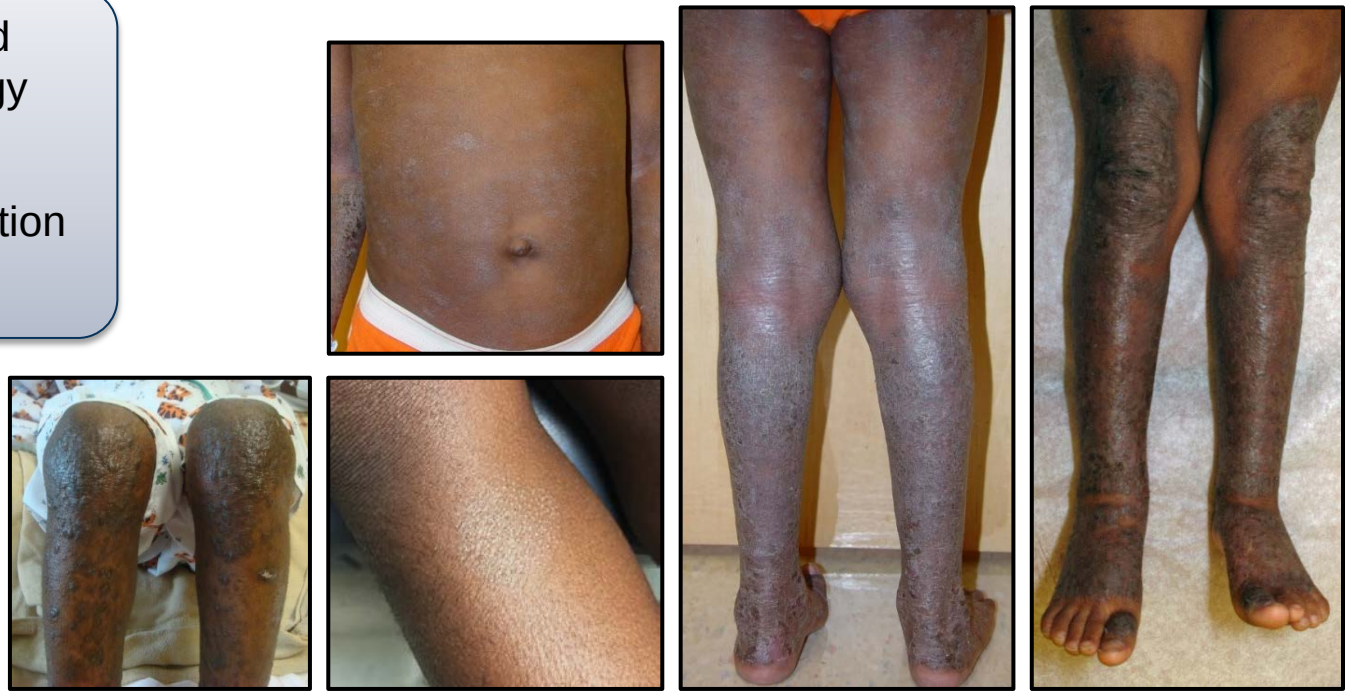
# AD in Patients of Darker Skin: More Common Features[1-4]

- Follicular/papular and nummular morphology
- Obscured erythema
- Prominent lichenification
- Dyspigmentation



**AD is more common in Black individuals**

1. Boguniewicz M et al. *J Allergy Clin Immunol Pract*. 2017;5:1519-1531. 2. Poladian K et al. *Cutis*. 2019;104:164-168.
3. Siegfried EC, Hebert AA. *J Clin Med*. 2015;4:884-917. 4. Images courtesy of Peter Lio, MD.

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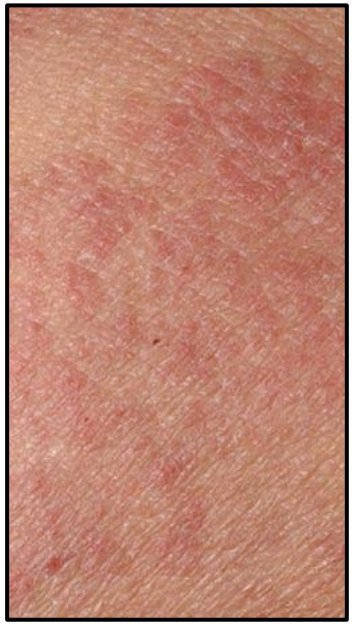
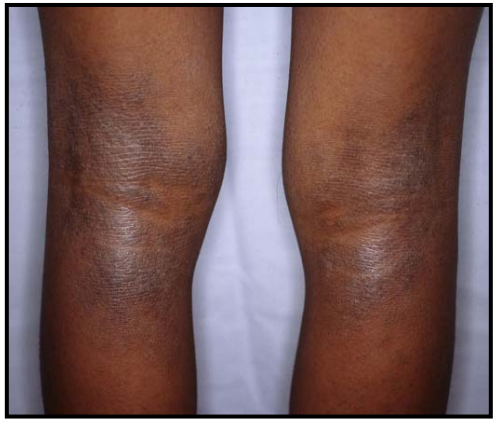
# Mild AD[1]

- Hyperpigmented, hypopigmented, or pink skin
- No crusting or oozing
- Barely swollen or thickened skin





1. Images courtesy of Ruchi S. Gupta, MD, MPH.

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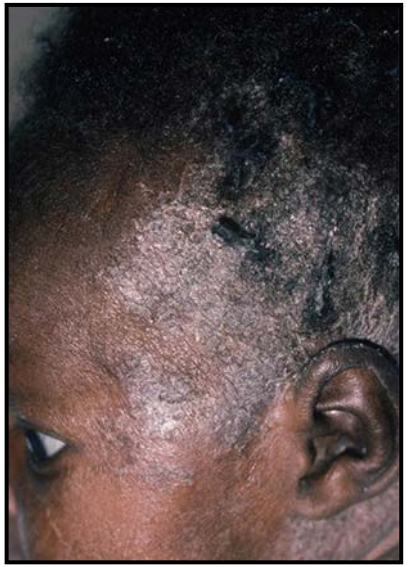
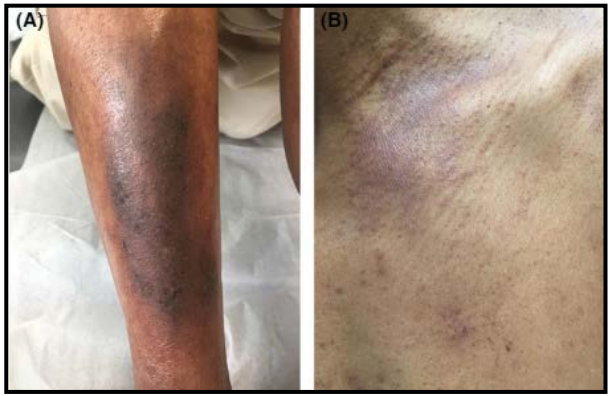
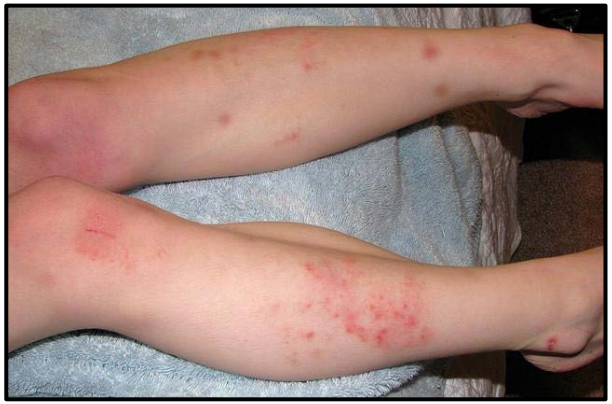
# Moderate AD[1]

- Clearly perceptible erythema
- Clearly swollen, raised, or thickened skin
- Mild oozing and crusting might be present





1. Images courtesy of Ruchi S. Gupta, MD, MPH.

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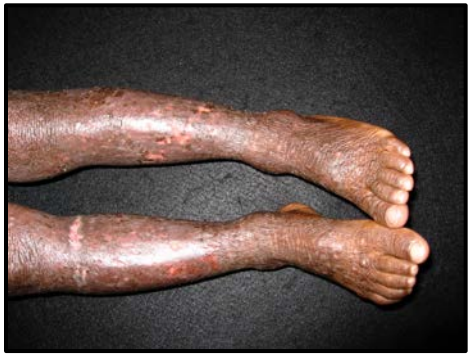
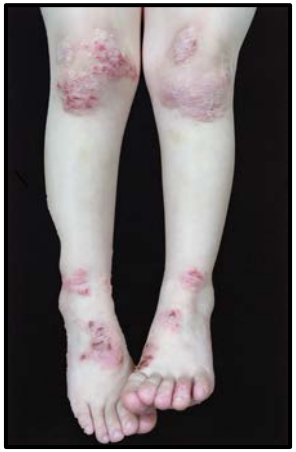
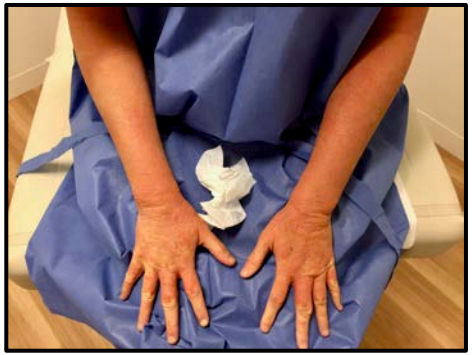
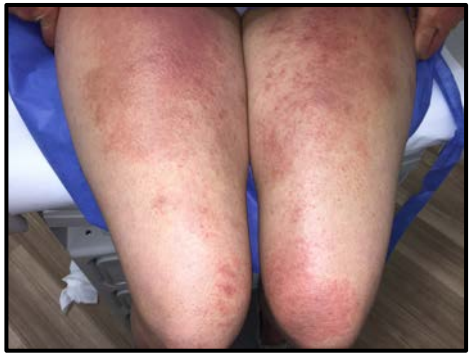
# Severe AD[1]

- Prominent erythema
- Very swollen, raised, or thickened skin
- Oozing and crusting may be present
- Rash is widespread









1. Images courtesy of Peter Lio, MD.

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# Clinical Assessment Tools[1]

| Validated Sign and Symptom Scoring Tools | Mild | Moderate | Severe |
|---|---|---|---|
| **EASI** | 1.1 to 7 | 7.1 to 21 | 21.1 to 50<br>50.1 to 72 (very severe) |
| **POEM** | 3 to 7 | 8 to 16 | 17 to 24<br>25 to 28 (very severe) |
| **PO-SCORAD** | <25 | >25 to <50 | >50 |
| **SCORAD** | <25 | >25 to <50 | >50 |
| **Other Tools** | **Scoring** | | |
| **DLQI**<br>*Validated questionnaire on the impact of AD on QOL* | Each question 0 (not at all) to 3 (very much) | | |
| **Pruritus (itch) score**<br>*Patient's subjective assessment of itch* | VAS from 0 (none) to 10 (severe) | | |

1. Gooderham MJ et al. *J Cutan Med Surg*. 2018;22(suppl 1):10S-16S.

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# Objective Assessment of AD Severity[1]

## Validated Investigator Global Assessment for Atopic Dermatitis (IGA)

| Score | Morphological Description |
|---|---|
| **0 – Clear** | No inflammatory signs of atopic dermatitis (no erythema, induration/papulation, lichenification, or oozing/crusting). Postinflammatory hyperpigmentation and/or hypopigmentation might be present. |
| **1 – Almost Clear** | Barely perceptible erythema, barely perceptible induration/papulation, and/or minimal lichenification. No oozing or crusting. |
| **2 – Mild** | Slight but definite erythema (pink), slight but definite induration/papulation, and/or slight but definite lichenification. No oozing or crusting. |
| **3 – Moderate** | Clearly perceptible erythema (dull red), clearly perceptible induration/papulation, and/or clearly perceptible lichenification. Oozing and crusting might be present. |
| **4 – Severe** | Marked erythema (deep or bright red), marked induration/papulation, and/or marked lichenification. Disease is widespread in extent. Oozing or crusting might be present. |

1. Simpson E et al. *J Am Acad Dermatol*. 2020;83:839-846.

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# Sleep Burden in Pediatric AD Is Significant for Patients and Families[1,a]

| AD Disease Activity of Severity | Difficulty Falling Asleep (Adjusted OR, 95% CI) | Early Morning Awakening (Adjusted OR, 95% CI) | | Odds of Nightmares (Adjusted OR, 95% CI) | | |
|---|---|---|---|---|---|---|
| | No Asthma or AR | Asthma or AR | No Asthma or AR | Asthma or AR | No Asthma or AR | Asthma or AR |
| **Overall active AD** | 1.37 (1.20, 1.56) | 1.49 (1.24, 1.79) | 1.40 (1.21, 1.61) | 1.56 (1.27, 1.91) | 1.47 (1.28, 1.69) | 1.71 (1.41, 2.07) |
| **“Very bad AD”** | 1.73 (1.22, 2.45) | 1.44 (0.96, 2.16) | 1.81 (1.24, 2.66) | 1.57 (1.00, 2.45) | 1.63 (1.14, 2.34) | 2.19 (1.45, 3.31) |

**Call to Action:** Pediatricians should consider screening all children with atopic dermatitis for sleep disturbances, even if their disease is mild or no longer active

[a] N = 13,988 children enrolled in the Avon Longitudinal Study of Parents and Children, a population-based birth cohort in Avon UK; n = 4,938 children with AD; measures of sleep duration were repeated between ages 2 to 16 years.

1. Ramirez FD et al. *JAMA Pediatr*. 2019;173:e190025.

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# Family Impact of AD in Infants/Preschoolers: Results From EPI-CARE[1]

Results from an international, cross-sectional web-based survey (September 2018 to December 2019) of 1,489 parents/caregivers of children aged 6 months to <6 years with AD

Mean DFI score of >10 (representing moderate to high alteration in quality of life) was reported in

- 42.1% among those with children who had mild AD
- 58.7% among those with children who had moderate AD
- 78% among those with children who had severe AD

1. Barbarot S et al. 2021 Revolutionizing Atopic Dermatitis Conference (RAD 2021). Abstract 654.

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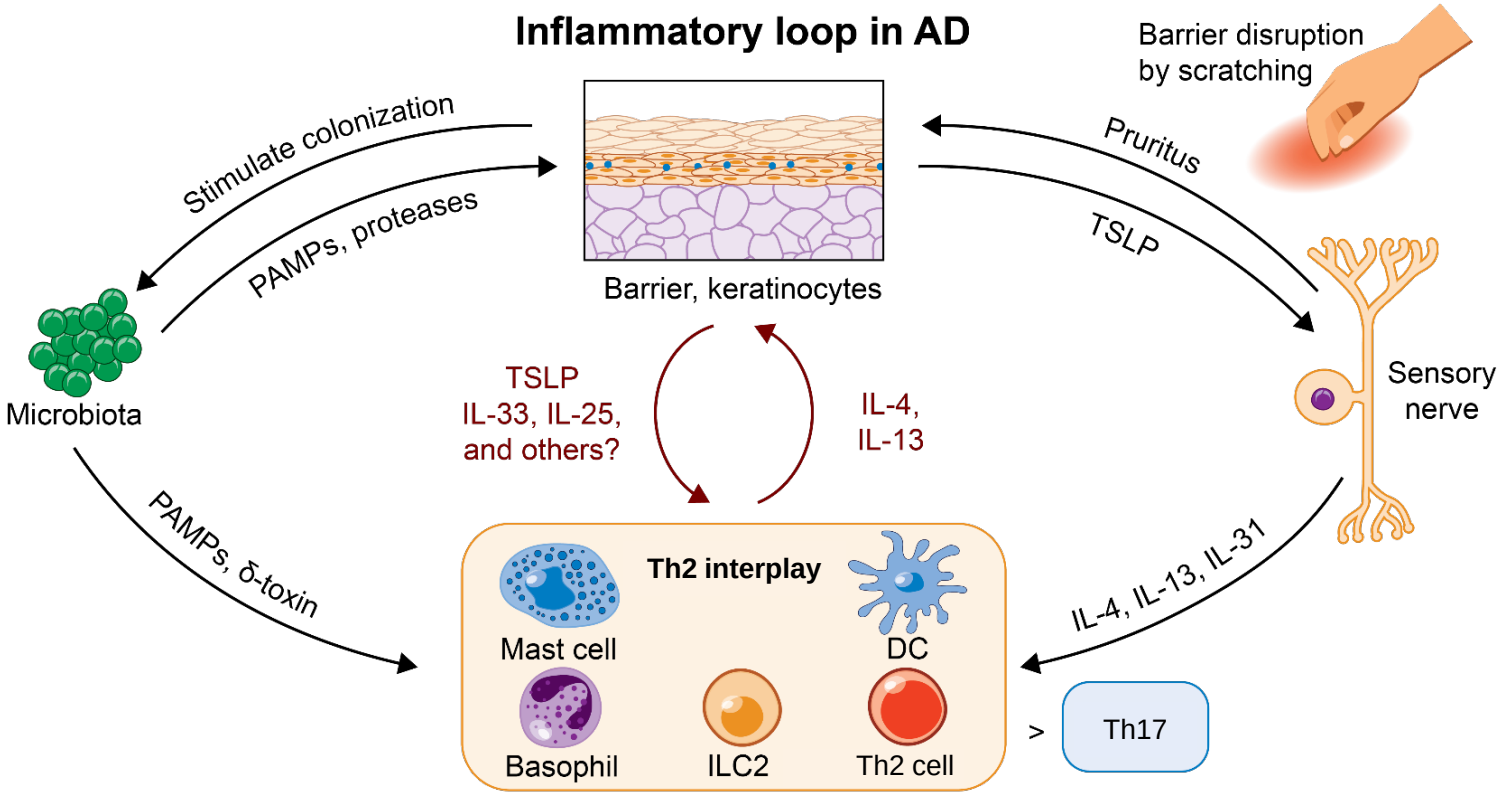
# Pathogenesis of AD: Role of Type 2 Inflammation[1]




1. Dainichi T et al. *Nat Immunol*. 2018;19:1286-1298.

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# A Team-Based Approach to Individualize the Management of Pediatric AD

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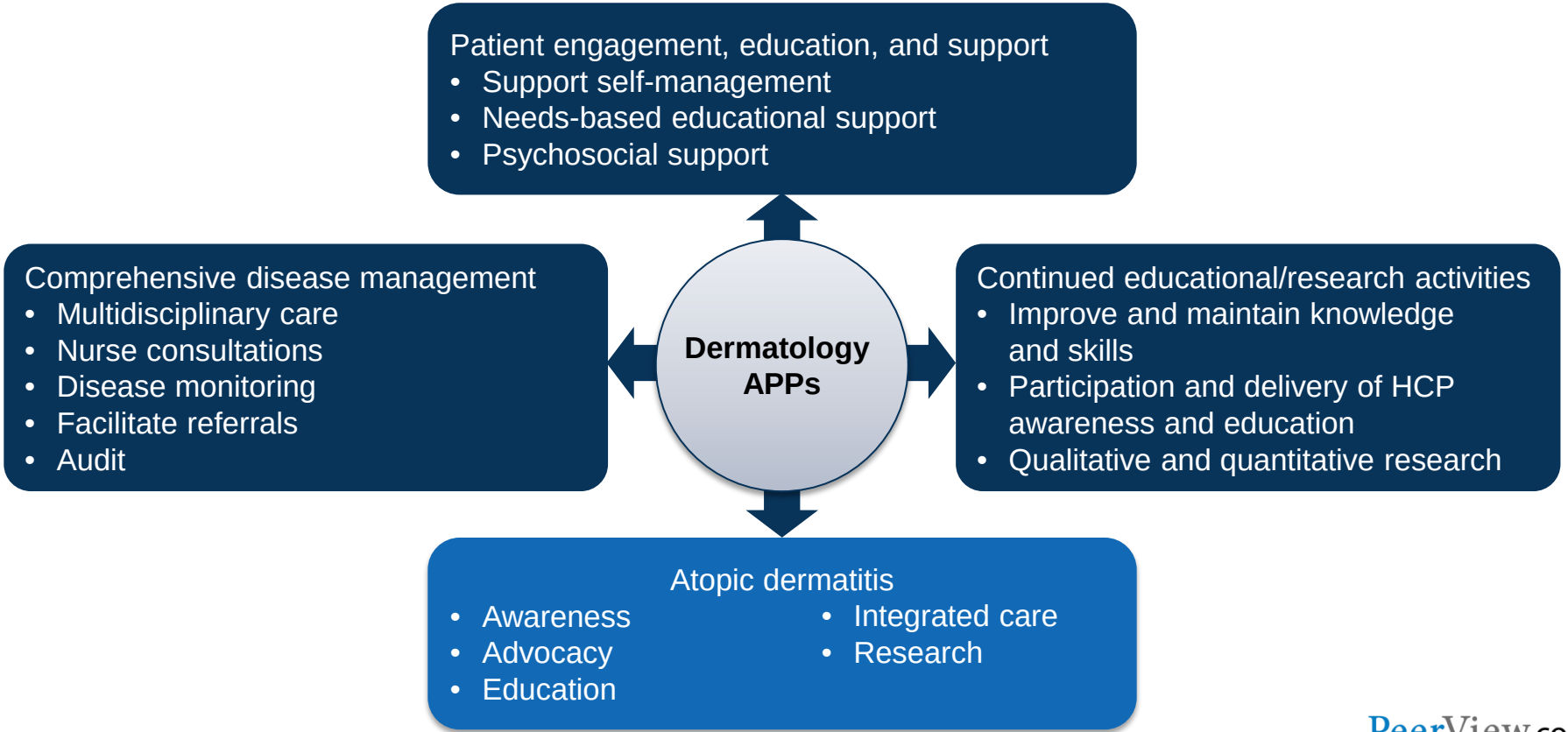
# The Role of Specialty Advanced Practice Providers in AD

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# AD: Goals of Treatment


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# Evaluating the Whole Patient

**Query**
patients about sleep quality

**Assess**
patients for comorbid condition

**Look**
for mental health and psychosocial impact

**Discuss**
ways to avoid flare triggers

**Educate**
patients and caregivers

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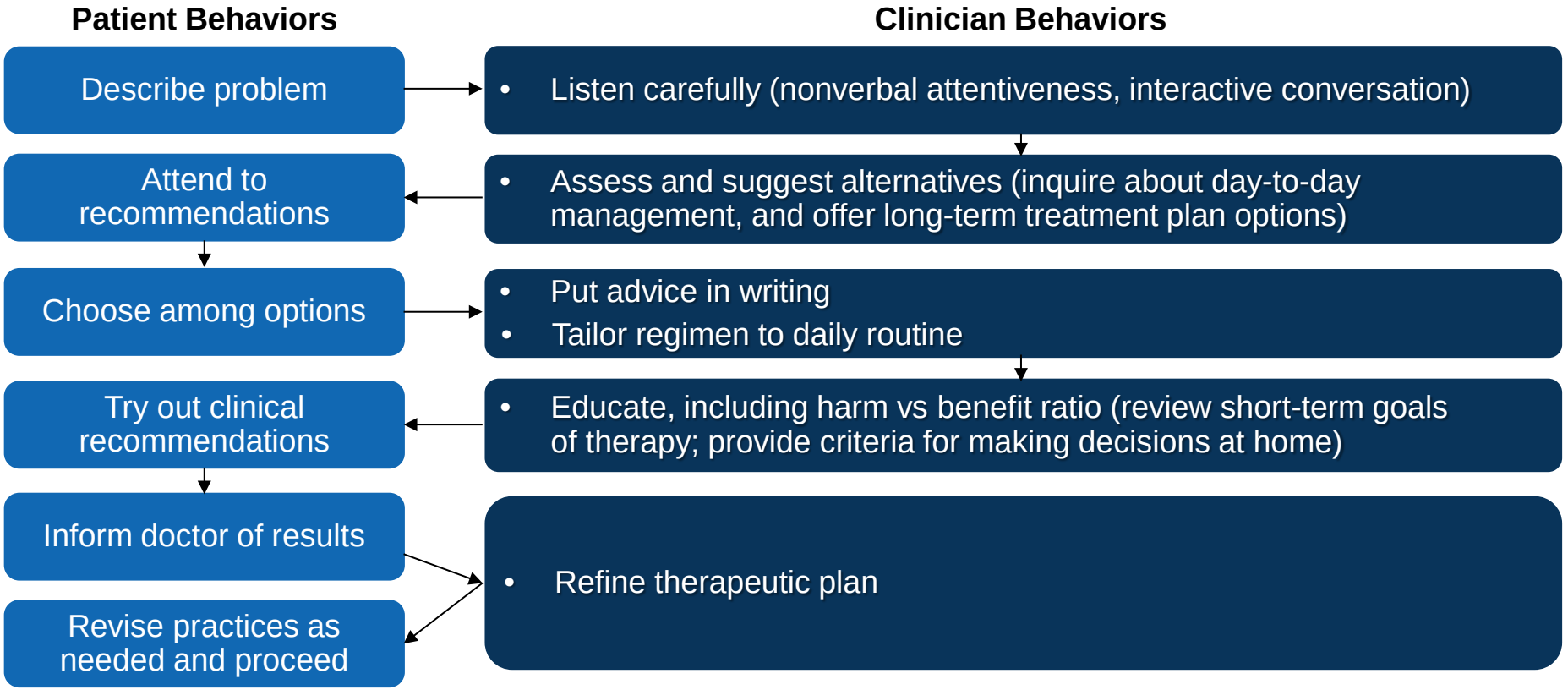
# Importance of Patient–Caregiver Communication and Education[1]




1. van Boven JFM et al. *J Allergy Clin Immunol Pract.* 2016;4:835-846.

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# AD: Evolving Algorithm[1]

| | MILD | MODERATE | SEVERE | Next Steps |
|---|---|---|---|---|
| **Acute Treatment** | **Apply TCS to inflamed skin**<br>• Low- to medium-potency TCS, twice daily for 2 wk, daily x1 wk, few days beyond clearance<br>Alternative: Consider crisaborole 2% or TCI or ruxolitinib 1.5% | **Apply TCS to inflamed skin**<br>• Medium- to high-potency TCS, 2x/day for 2 wk, 1x/day for 1 wk, 2x/wk to "hot spots," few days beyond clearance<br>• Low-potency TCS for sensitive areas or consider crisaborole 2% or TCI<br>Alternative: Consider crisaborole 2% or TCI or ruxolitinib 1.5% | **Apply TCS to inflamed skin**<br>• Medium- to high-potency TCS, 2x/day for 2 wk, 1x/day for 1 wk, 2x/wk to "hot spots"; 3-7 days beyond clearance<br>• Lower potency for sensitive areas or consider crisaborole 2% or TCI<br>• **If unresolved after 7 days, reconsider next step** | • Nonadherence<br>• Infection<br>• Misdiagnosis<br>• Contact allergy to medications<br>• Referral |
| **Maintenance Treatment** | *(Basic Management)*<br>**1. Skin care**<br>– Liberal, frequent moisturizer use<br>– Daily warm bath/shower, followed by moisturizer<br>**2. Trigger avoidance**<br>– Common irritants; allergens if proven<br>– Consider comorbidities | **Basic Management + Maintenance TCS**<br>– Medium potency, 2-3x/wk ("proactive") to recurrently active areas of involvement<br>– Low potency TCS several times/wk for sensitive areas<br>**Maintenance TCI**<br>– 2-3 times/wk up to 2x/day (proactive approach) OR<br>**Crisaborole 2%, 2x/day ≥2 years** OR<br>– Several times/wk<br>**Ruxolitinib 1.5%, 2x/day ≥12 years**<br>– Several times/wk<br>**Consider: Add bleach baths**<br>– 2-7x/wk based on severity and tendency to develop crusting at sites of excoriation | *(Basic + Moderate Management + **REFERRAL** to AD Specialist)*<br>**1. Phototherapy**<br>**2. Dupilumab ≥6 months**<br>**3. Tralokinumab (adults)**<br>**4. Abrocitinib (adults)**<br>**5. Upadacitinib ≥12 years**<br>**6. Systemic immunosuppressants**<br>– Cyclosporine A<br>– Methotrexate<br>– Mycophenolate mofetil<br>– Azathioprine<br>– Corticosteroids<br>**7. Consider acute treatment for some patients to help gain control**<br>– Wet wrap therapy<br>– Short-term hospitalization | |

**Advance: when symptomatic despite appropriate use of medications and adherence to management and/or persistence or frequent flaring**

1. Boguniewicz M et al. *Ann Allergy Asthma Immunol*. 2018;120:10-22.

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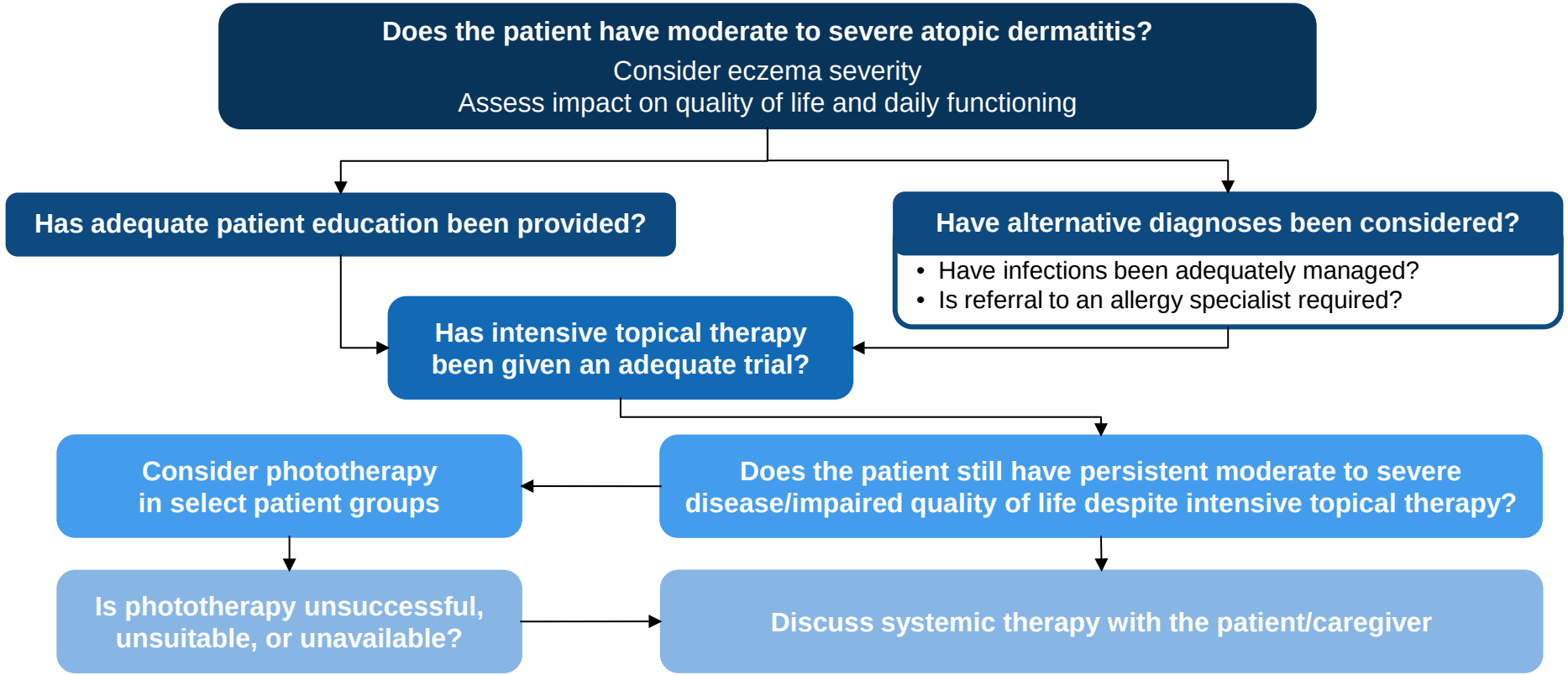
# Step-Up Care in AD: When Is It Time for Systemic Therapy?[1]




1. Simpson EL et al. *J Am Acad Dermatol*. 2017;77:623-633.

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# Topical Calcineurin Inhibitor Immunosuppressants: Steroid-Sparing Anti-Inflammatory Agents[1-4]

## Pimecrolimus

- 1% cream FDA approved for children ≥2 years of age
- Clinical trials supported safety and efficacy in 0 to ≥2 years of age
- For mild to moderate AD

## Tacrolimus

- 0.03% ointment FDA approved for children ≥2 years of age
- 0.1% indicated for patients >15 years of age
- For moderate to severe AD

- Inhibit calcineurin-dependent T-cell activation, impeding the production of proinflammatory cytokines and mediators
- Black box warning: Although a causal relationship has not been established, rare cases of malignancy (eg, skin and lymphoma) have been reported in patients treated with TCIs
  - In 2021, Health Canada approved an update removing the black box warning for tacrolimus[4]


1. Boguniewicz M et al. *Ann Allergy Asthma Immunol*. 2018;120:10-22.
2. Elidel (pimecrolimus) Prescribing Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/021302s018lbl.pdf.
3. Protopic (tacrolimus) Prescribing Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/050777s018lbl.pdf.
4. https://www.leo-pharma.ca/Files/Filer/Protopic_PM_Aug2021_EN.pdf


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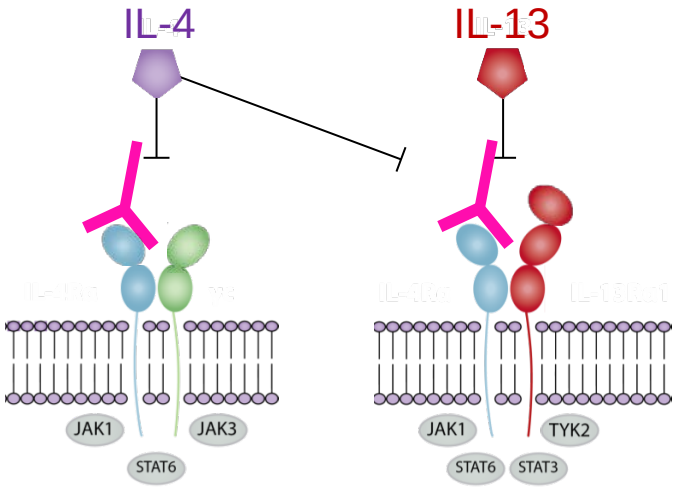
# Dupilumab: Anti–IL-4Rα[1,2,a]




**Type 1 receptor**

B cells, T cells, monocytes, eosinophils, fibroblasts

**Type 2 receptor**

Epithelial cells, smooth muscle cells, fibroblasts, monocytes, activated B cells

- Approved for treatment of patients **aged ≥6 months with moderate to severe AD** whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable
- Can be used ± topical corticosteroids
- **Most common AEs:** injection-site reactions, dry eye, conjunctivitis, blepharitis, eye pruritus, oral herpes

[a] Dupilumab is also approved in Japan, as well as other countries, for use in appropriate patients with moderate to severe AD, in appropriate patients with asthma or CRSwNP in different age populations, and in appropriate patients with eosinophilic esophagitis. Please refer to the prescribing indication for full approval information.

1. Dupixent (dupilumab) Prescribing Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/761055s042lbl.pdf.
2. Gittler JK et al. *J Allergy Clin Immunol*. 2012;130:1344-1354.

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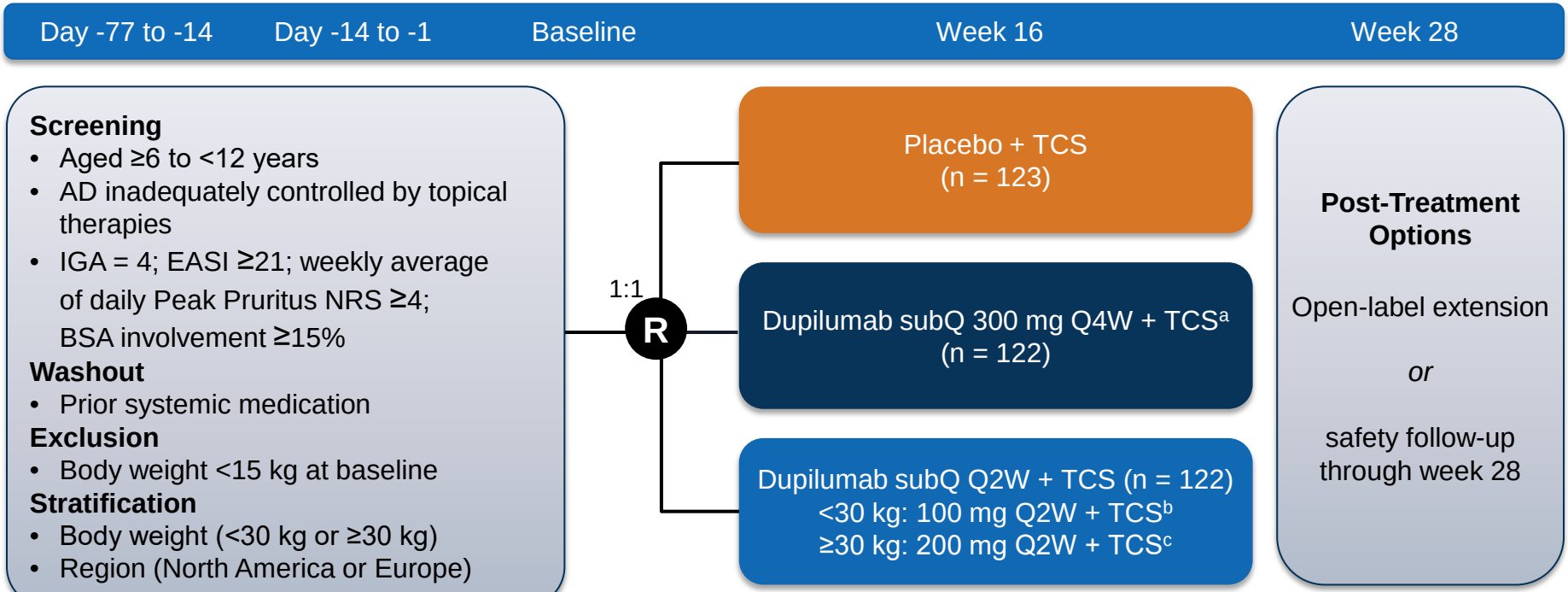
# Dupilumab in Patients Aged 6-12 Years[1]




[a] 600-mg loading dose. [b] 200-mg loading dose. [c] 400-mg loading dose.

1. Paller AS et al. *J Am Acad Dermatol*. 2020;83:1282-1293.

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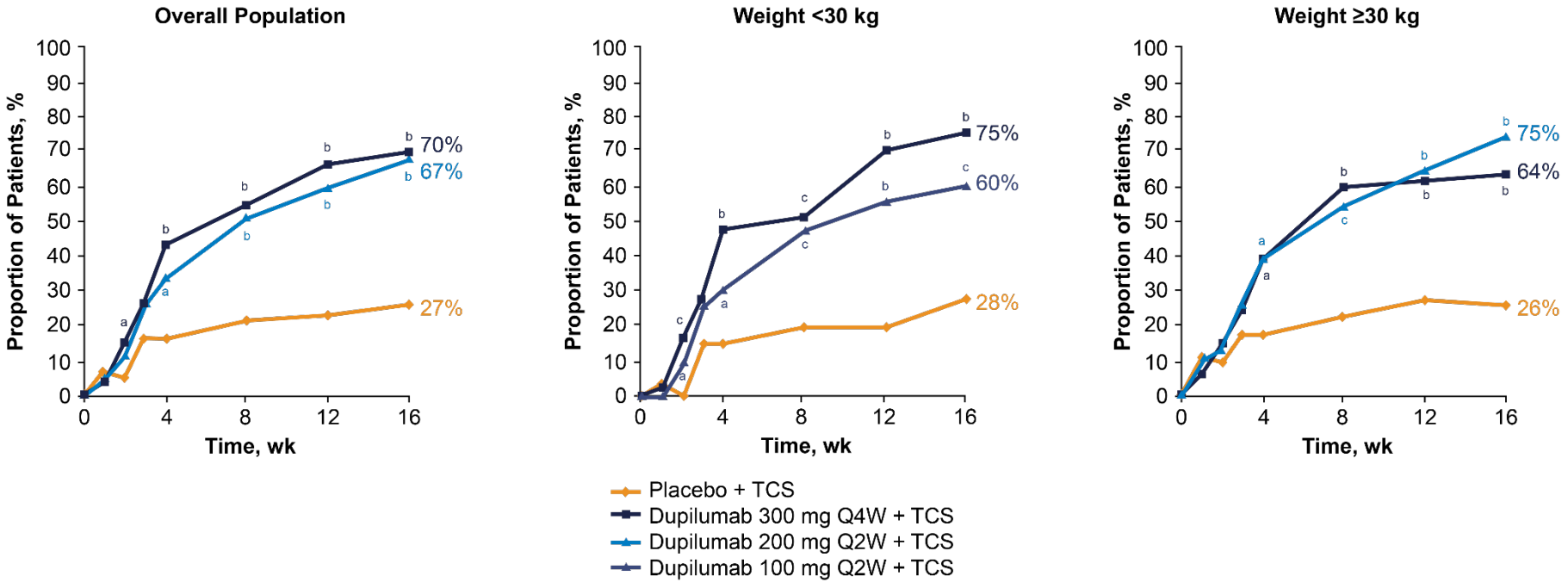
# Proportion of Patients Achieving EASI-75[1]




[a] *P* < .05. [b] *P* < .0001. [c] *P* < .001.

1. Paller AS et al. *J Am Acad Dermatol*. 2020;83:1282-1293.

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# Safety in Patients Aged 6-12 Years[1]

| | Placebo + TCS (n = 120) | Dupilumab 300 mg Q4W + TCS (n = 120) | Dupilumab 100 or 200 mg Q2W + TCS (n = 122) |
|---|---|---|---|
| **Patients with ≥1 TEAE, n (%)** | 88 (73.3) | 78 (65.0) | 82 (67.2) |
| **Patients with ≥1 serious TEAE, n (%)** | 2 (1.7) | 2 (1.7) | 0 |
| **Patients with ≥1 TEAE leading to permanent tx discontinuation, n (%)** | 2 (1.7) | 0 | 2 (1.6) |
| **Deaths** | 0 | 0 | 0 |
| **TEAEs (PT) reported in ≥5% of patients, n (%)** | | | |
| Atopic dermatitis, exacerbation | 17 (14.2) | 8 (6.7) | 10 (8.2) |
| Asthma | 12 (10.0) | 2 (1.7) | 4 (3.3) |
| Nasopharyngitis | 8 (6.7) | 15 (12.5) | 8 (6.6) |
| URTI | 12 (10.0) | 13 (10.8) | 10 (8.2) |
| Viral URTI | 6 (5.0) | 2 (1.7) | 1 (0.8) |
| Vomiting | 8 (6.7) | 6 (5.0) | 6 (4.9) |
| Cough | 9 (7.5) | 3 (2.5) | 5 (4.1) |
| Headache | 10 (8.3) | 6 (5.0) | 7 (5.7) |

| Baseline Weight <30 kg | Placebo + TCS (n = 60) | Dupilumab 300 mg Q4W + TCS (n = 60) | Dupilumab 100 mg Q2W + TCS (n = 63) |
|---|---|---|---|
| **Patients with ≥1 TEAE, n (%)** | 43 (71.7) | 39 (65.0) | 46 (73.0) |
| **TEAEs (PT), n (%)** | | | |
| Atopic dermatitis | 7 (11.7) | 4 (6.7) | 8 (12.7) |
| Asthma | 7 (11.7) | 0 | 4 (6.3) |
| Rhinitis allergic | 2 (3.3) | 1 (1.7) | 3 (4.8) |
| Food allergy | 0 | 1 (1.7) | 3 (4.8) |
| Conjunctivitis cluster[a] | 2 (3.3) | 4 (6.7) | 13 (20.6) |
| Herpes infections (HLT) | 3 (5.0) | 0 | 3 (4.8) |

| Baseline Weight ≥30 kg | Placebo + TCS (n = 60) | Dupilumab 300 mg Q4W + TCS (n = 60) | Dupilumab 200 mg Q2W + TCS (n = 59) |
|---|---|---|---|
| **Patients with ≥1 TEAE, n (%)** | 45 (75.0) | 39 (65.0) | 36 (61.0) |
| **TEAEs (PT), n (%)** | | | |
| Atopic dermatitis | 10 (16.7) | 4 (6.7) | 2 (3.4) |
| Asthma | 5 (8.3) | 2 (3.3) | 0 |
| Rhinitis allergic | 3 (5.0) | 2 (3.3) | 1 (1.7) |
| Food allergy | 0 | 0 | 0 |
| Conjunctivitis cluster[a] | 3 (5.0) | 4 (6.7) | 5 (8.5) |
| Herpes infections (HLT) | 3 (5.0) | 2 (3.3) | 1 (1.7) |

[a] Conjunctivitis cluster includes the PTs conjunctivitis, conjunctivitis allergic, conjunctivitis bacterial, conjunctivitis viral, and atopic keratoconjunctivitis.

1. Paller AS et al. *J Am Acad Dermatol*. 2020;83:1282-1293.

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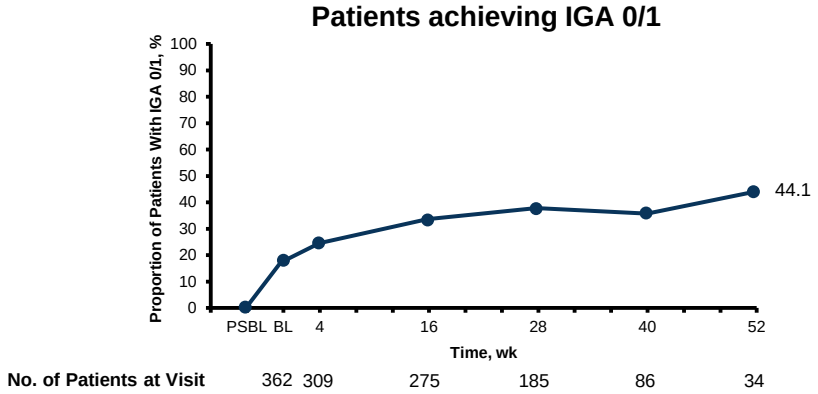
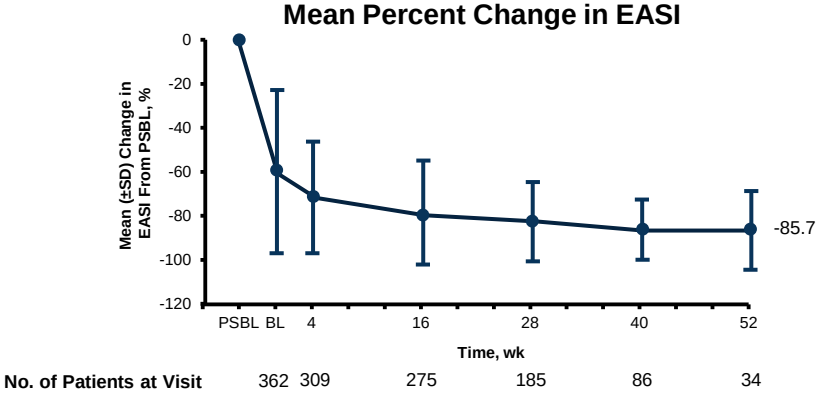
# Long-Term Treatment With Dupilumab Showed Sustained Improvement in Patients Aged ≥6 to <12 Years With Moderate to Severe AD[1]

**LIBERTY AD PED-OLE:** Patients were treated with 200/300 mg of dupilumab every 2 weeks or 300 mg of dupilumab every 4 weeks and had participated in previous dupilumab trials




1. Cork MJ et al. 14th World Congress of Pediatric Dermatology (WCPD 2021). Poster 1623270856177.

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# LIBERTY AD PRE-SCHOOL/INFANT: Phase 2/3 Design—Part B

- Double-blind, placebo-controlled
- N = 162
- Children aged 6 months to <6 years with moderate to severe AD (IGA ≥3) inadequately controlled on topical therapies

1:1 R

- Placebo for 16 weeks
- Dupilumab subQ every 4 weeks
  BL weight ≥5 kg to <15 kg: 200 mg
- Dupilumab subQ every 4 weeks
  BL weight ≥15 kg to <30 kg: 300 mg

**Primary endpoint at week 16:**
proportion of patients with IGA of 0 or 1

**Coprimary endpoint:**
proportion of patients with ≥75% improvement from baseline in EASI 75

**Key secondary endpoints:**
percent change in EASI and percent change in worst scratch/itch score

1. Paller AS et al. RAD 2021. Abstract 690.

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# LIBERTY AD PRE-SCHOOL/INFANT: Phase 2/3 Efficacy—Part B

- All primary and secondary endpoints were met
- At 16 weeks, in patients treated with dupilumab
  - 28% achieved clear or almost-clear skin (IGA 0 or 1) vs 4% with placebo
  - 53% achieved 75% greater overall disease improvement from baseline vs 11% placebo
  - 70% average improvement from baseline in EASI 75 vs 20% placebo
  - 49% average improvement from baseline in itch vs 2% placebo
  - Significantly improved measures of observed patient outcomes (eg, sleep, skin pain, health-related quality of life) as well as caregiver-reported health-related quality of life
- A lower rate of skin infections was also seen in the dupilumab arm (12%) vs placebo (24%)

1. Paller AS et al. RAD 2021. Abstract 690.

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# LIBERTY AD PRE-SCHOOL/INFANT: Phase 2/3 Safety—Part B

**Most Common Treatment-Emergent Adverse Events in the Dupilumab and Placebo Groups**

- Nasopharyngitis (8.4% dupilumab and 9% placebo)
- Upper respiratory tract infection (6% dupilumab and 7.7% placebo)
- Impetigo (3.6% dupilumab and 7.7% placebo)
- Lymphadenopathy (3.6% dupilumab and 7.7% placebo)

1. Paller AS et al. RAD 2021. Abstract 690.

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# Managing a Child's Fear of Injections[1]

- ✔ Teach coping strategies (eg, mindfulness, deep breathing exercises)
- ✔ Focus on the health benefits (improvement of symptoms, itching, etc)
- ✔ Have child sit up; children might be more frightened when they have to lie down
- ✔ Model calmness
- ✔ Administer acetaminophen to relieve moderate pain and swelling at the injection site
- ✔ Apply ice packs at the site before and after the injection
- ✔ Use vibration devices near the injection site

1. https://www.myeczemateam.com/resources/eczema-in-children-tips-to-help-kids-deal-with-injections.

# Other Targeted Therapies[1-4]

## Lebrikizumab

- Phase 3 ADvocate 1 and 2: adults and adolescents ≥12 years of age
- Phase 3 for adults/ adolescents with moderate to severe AD and skin of color

## Tralokinumab

- Phase 3 INJECZTRA: adults and adolescents ≥12 years of age

## Nemolizumab

- Phase 3: adults and adolescents ≥12 years of age
- Phase 2: children 2 -11 years of age


1. https://clinicaltrials.gov/ct2/show/NCT05372419?term=lebrikizumab&cond=atopic+dermatitis&draw=2&rank=2.
2. https://clinicaltrials.gov/ct2/show/NCT05194540?term=tralokinumab&cond=atopic+dermatitis&draw=2&rank=2.
3. https://clinicaltrials.gov/ct2/show/NCT03985943?term=nemolizumab&cond=atopic+dermatitis&draw=2&rank=4.
4. https://clinicaltrials.gov/ct2/show/NCT04921345?term=nemolizumab&cond=atopic+dermatitis&draw=2&rank=2.


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# Summary

- The entire healthcare team, including advanced practice providers, is crucial for the optimal assessment and management of pediatric moderate to severe AD patients and their families

- Patient/caregiver education is critical in making a shared treatment decision, particularly when stepping up from moderate to severe AD treatment, with the use of systemic medications, and when managing patient concerns (eg, needle phobia)

- Targeted biologic therapy with dupilumab has been proven safe and effective for patients aged ≥6 months with moderate to severe AD; other therapies are in development for pediatric and/or adolescent populations (eg, tralokinumab, nemolizumab, lebrikizumab, JAK inhibitors)

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# Audience Q&A


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**Please remember to complete and submit your Program Evaluation.**

**PeerView.com/AD-Survey-WVA**

***Thank you and have a good day.***

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# Abbreviations

AD: atopic dermatitis
AR: allergic rhinitis
DC: dendritic cell
DFI: Dermatitis Family Impact Score
DLQI: Dermatology Life Quality Index
EASI: Eczema Area and Severity Index
HCP: healthcare professional
HLT: high-level term
IGA: Investigator Global Assessment for Atopic Dermatitis
IL: interleukin
ILC2: type 2 innate lymphoid cell
JAK: Janus kinase
LLoQ: lower limit of quantitation
NRS: Numeric Rating Scale
OR: odds ratio
PAMPS: pathogen-associated molecular patterns
PG: peptidoglycan
PO-SCORAD: Patient-Oriented Scoring Atopic Dermatitis
POEM: Patient-Oriented Eczema Measure
PT: preferred term
Q2W: every 2 weeks
Q4W: every 4 weeks
SCORAD: Scoring Atopic Dermatitis
SD: standard deviation
STAT: signal transducer and activator of transcription
TCI: topical calcineurin inhibitors
TCS: topical corticosteroids
TEAE: treatment-emergent adverse event
Th2: T helper 2 cell
TSLP: thymic stromal lymphopoietin
TYK2: tyrosine kinase 2
URTI: upper respiratory tract infection
VAS: Visual Analog Scale

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