needed to fully determine their validity, reliability, and sensitivity to change.^{10 11}

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- 1 Williams H, Robertson C, Stewart A, Ait-Khaled N, Anabwani G, Anderson R, et al. Worldwide variations in the prevalence of symptoms of atopic eczema in the international study of asthma and allergies in childhood. *J Allergy Clin Immunol* 1999;103:125-38.
- 2 DerSimonian R, Laird N. Meta-analysis in clinical trials. *Control Clin Trials* 1986;7:177-88.
- 3 Deeks JJ, Altman D, Bradburn MJ. Statistical methods for examining heterogeneity and combining results from several studies in meta-analysis. In Egger M, Davey Smith G, Altman DG, eds. *Systematic reviews in health care*. London: BMJ Publishing, 2001:285-312.
- 4 Higgins JP, Thompson SG, Deeks JJ, Altman DG. Measuring inconsistency in meta-analyses. *BMJ* 2003;327:557-60.

- 5 Whalley D, Huels J, McKenna SP, Van Assche D. The benefit of pimecrolimus (Elidel, SDZ ASM 981) on parents' quality of life in the treatment of pediatric atopic dermatitis. *Pediatrics* 2002;110:1133-6.
- 6 Drake L, Prendergast M, Maher R, Breneman D, Korman N, Sato Y, et al. The impact of tacrolimus ointment on health-related quality of life of adult and pediatric patients with atopic dermatitis. *J Am Acad Dermatol* 2001;44:S65-72.
- 7 Queille-Roussel C, Paul C, Duteil L, Lefebvre MC, Rapatz G, Zagula M, et al. The new topical ascomycin derivative SDZ ASM 981 does not induce skin atrophy when applied to normal skin for 4 weeks: a randomized, double-blind controlled study. *Br J Dermatol* 2001;144:507-13.
- 8 Kyllonen H, Remitz A, Mandelin JM, Elg P, Reitamo S. Effects of 1-year intermittent treatment with topical tacrolimus monotherapy on skin collagen synthesis in patients with atopic dermatitis. *Br J Dermatol* 2004;150:1174-81.
- 9 Iskedjian M, Piwko C, Shear NH, Langley RG, Einarson TR. Topical calcineurin inhibitors in the treatment of atopic dermatitis: a meta-analysis of current evidence. *Am J Clin Dermatol* 2004;5:267-79.
- 10 Charman C, Williams H. Outcome measures of disease severity in atopic eczema. *Arch Dermatol* 2000;136:763-9.
- 11 Charman C, Chambers C, Williams H. Measuring atopic dermatitis severity in randomized controlled clinical trials: what exactly are we measuring? *J Invest Dermatol* 2003;120:932-41.

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Commentary: Itching for a solution

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Ashcroft et al¹ illustrate a tension that exists between scientists and patients over the use of topical agents to treat atopic dermatitis, with doctors caught in the middle.

It must be difficult for those without eczema to understand how frustrating and distressing it can be. Having developed atopic eczema in early childhood, I have been living with it for over 60 years. As a boy, the insides of my arms and the backs of my legs itched ferociously and incessantly. My face was dry, flaking, and sore. The area between my upper lip and nose was dry, cracked, and crusted, as was the skin around my ears. I scratched endlessly, and my appearance embarrassed me dreadfully, which suited those who taunted me about it.

In the early days, the only treatment prescribed for me was hydrocortisone cream, which helped but provided no solution over time. Emollients were never mentioned. Slowly, I became more adept at managing my eczema and concealing it from others. The discovery of the benefits of moisturisation helped, as did a switch to cotton clothing. Today my eczema is well managed, but it still takes me about 20 minutes longer to get ready in the morning than it would if I had normal skin. All of which is why those of us who live with eczema are desperate for a cure—or at least for treatments better than those that have been available to date. It is also why we may occasionally be a little impatient with scientists who sometimes seem more preoccupied with the analysis of evidence than with patients' needs.

Non-adherence to treatment regimens is a major cause of treatment failure in the management of atopic eczema. High among the several causes of non-adherence is "corticosteroid phobia."²

As chief executive of the National Eczema Society in the late 1990s, I became acutely aware of the large proportion of callers to our helpline who were reluctant to use topical corticosteroids on themselves

or on their children. Their reluctance was caused chiefly by fear of damage to the skin but sometimes by confusion between topical corticosteroids and anabolic steroids.

Ashcroft et al acknowledge the importance of corticosteroid phobia in their paper (see bmj.com) but make no reference to it in their discussion or conclusions, although the paper to which they refer³ makes clear the extent of such a phobia. And, given that eczema often affects the face and flexures, Ashcroft et al seem to underestimate the implications for patients of the inappropriateness of using topical corticosteroids on those areas.

Their conclusions have clearly been reached through careful and dispassionate analysis of the data, and we agree that more research is needed. Patients, however, long for treatments that are at least as effective as topical corticosteroids, have none of the side effects (real or imagined) that encourage corticosteroid phobia, and can be used safely on the face and flexures.

Tacrolimus and pimecrolimus seem to meet those requirements, which is why patients welcome them. The dilemma, of course, is the doctor's.

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- 1 Ashcroft DM, Dimmock P, Garside R, Stein K, Williams HC. Efficacy and tolerability of topical pimecrolimus and tacrolimus in the treatment of atopic dermatitis: meta-analysis of randomised controlled trials. *BMJ* 2005;330:516-22.
- 2 Beattie PE, Lewis-Jones MS. Parental knowledge of topical therapies in the treatment of childhood atopic dermatitis. *Clin Exp Dermatol* 2003;28:549-53.
- 3 Charman CR, Morris AD, Williams HC. Topical corticosteroid phobia in patients with atopic eczema. *Br J Dermatol* 2000;142:931-6.

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