

LETTER TO THE EDITOR

When should allergy and dermatology collaborate in atopic dermatitis? A proposal for structured referral criteria

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To the editor,

Atopic dermatitis (AD) is a chronic, heterogeneous, type 2 inflammatory disease increasingly recognized as a systemic disorder extending beyond the skin (1). In addition to epidermal barrier dysfunction, cutaneous inflammation and immunologic dysregulation, AD frequently coexists with asthma, allergic rhinitis, food allergy, and eosinophilic gastrointestinal disease, reflecting shared immunologic pathways that contribute to cumulative morbidity (2). Despite major therapeutic advances, structured interdisciplinary referral pathways in AD remain poorly defined.

Dermatologists appropriately lead the diagnosis and management of cutaneous disease. However, collaboration with Allergy and Clinical Immunology specialists often occurs in a reactive and non-standardized manner, typically prompted by the presence of respiratory symptoms or suspected IgE-mediated food allergy. Although contemporary guidelines provide detailed therapeutic algorithms, they offer limited operational guidance on structured inter-specialty referral (3,4). The 2023 AAAAI/ACAAI guidelines recommend allergy-immunology referral for patients with AD poorly controlled despite optimal topical treatment, but do not address the broader question of when joint evaluation can optimize therapeutic selection and disease management in the era of targeted systemic therapies (3). In daily practice, this gap may result in delayed multidisciplinary evaluation, indiscriminate allergy testing, prolonged empirical dietary restrictions, or systemic treatment decisions undertaken without comprehensive assessment of type 2 comorbidities.

The therapeutic landscape of AD has evolved substantially with the introduction of biologics targeting type 2 inflammation and Janus kinase inhibitors (5). As treatment strategies increasingly overlap across AD and other atopic diseases, fragmented management risks suboptimal therapeutic selection, duplicated investigations, and inconsistent monitoring. Multidisciplinary approaches in AD have been proposed to improve comprehensive assessment, therapeutic optimization, and patient outcomes, particularly in patients with moderate-to-severe disease (6). In this context, clearer interdisciplinary pathways are warranted.

Based on bidisciplinary clinical experience within a tertiary referral center, these criteria were developed through iterative discussion between Dermatology and

Allergy/Clinical Immunology clinicians involved in AD care. The proposed triggers were selected according to recurring clinical scenarios in which joint evaluation was considered most likely to influence diagnosis, comorbidity assessment, therapeutic selection, or monitoring. They should therefore be interpreted as pragmatic expert-opinion recommendations requiring prospective validation, rather than rigid thresholds.

Joint evaluation should be considered when at least one of the following conditions is present (Figure 1):

1. Moderate-to-severe AD requiring systemic immunomodulatory therapy, particularly when therapeutic selection is uncertain.

When moderate-to-severe AD requires biologic agents or Janus kinase inhibitors, joint evaluation can facilitate systematic screening for coexisting type 2 conditions and therapeutic alignment (7). This is particularly relevant given that certain treatments, such as dupilumab, are approved for concurrent management of AD, asthma, allergic rhinitis with nasal polyps, and eosinophilic esophagitis, while others target AD alone. Coordinated assessment can help identify patients who would benefit most from therapies addressing multiple atopic manifestations and avoid duplicated monitoring protocols.

2. Presence of established or suspected atopic comorbidities

Coexisting asthma, allergic rhinitis, or eosinophilic gastrointestinal disease justifies coordinated evaluation, as shared inflammatory mechanisms can allow harmonized treatment strategies and avoidance of duplicated investigations (2,8). AD severity is also associated with increased risk of atopic comorbidities, and early-onset severe AD represents a particular risk factor for progression to

asthma (8). Multidisciplinary approaches in AD support therapeutic alignment, comprehensive assessment, and optimized patient management (6).

3. Early-onset, unusually severe, or atypical presentations suggesting possible immune dysregulation.

Clinical features such as erythroderma, recurrent or severe infections, growth impairment, markedly elevated total IgE levels, particularly when disproportionate to AD severity or accompanied by other atypical features, or poor response to optimized treatment should prompt joint assessment (3). These scenarios may raise suspicion of immune dysregulation syndromes, inborn errors of immunity, or rare monogenic disorders requiring specialized immunologic investigation, though such cases represent a small subset of patients.

4. History of immediate hypersensitivity reactions to food or persistent disease despite optimized topical therapy in young children.

Current guidelines recommend against routine food allergy testing and elimination diets in AD (3,9). However, targeted allergy evaluation is appropriate in specific circumstances: young children with moderate-to-severe AD that persists despite optimized management and topical therapy, or patients with a reliable history of immediate allergic reactions (urticaria, angioedema, anaphylaxis) after ingestion of specific foods (3,9). Structured allergy evaluation prevents unnecessary dietary restrictions, reduces patient anxiety, and avoids missed alternative diagnoses.

Joint evaluation is not intended to replace routine Dermatology follow-up. Rather, it should occur at key decision points, particularly before initiation or switching of systemic therapy, when relevant atopic comorbidities are suspected or

uncontrolled, or when atypical features raise concern for immune dysregulation. Subsequent reassessment should be individualized according to disease course, treatment response, and comorbidity burden.

Multidisciplinary approaches in AD are increasingly recognized as a means to improve comprehensive assessment, therapeutic optimization, and patient-centred care (6). Given the comparable immunologic complexity and systemic implications of AD, formalizing referral criteria represents a pragmatic step toward reducing fragmentation of care and advancing precision medicine. We acknowledge that these proposed criteria are based on expert consensus and clinical experience rather than prospective comparative data. Prospective evaluation of structured referral pathways is warranted to determine their impact on clinical outcomes, healthcare efficiency, and cost-effectiveness.

Nevertheless, in the biologic and Janus kinase inhibitor era, coordinated Dermatology–Allergy collaboration should be considered a foundational component of comprehensive, endotype-oriented AD management for appropriately selected patients.

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Figure 1. Dermatology-Allergy joint evaluation criteria

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