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Q1 One of your recent publications focuses on harmonised topical treatment procedures for children with atopic dermatitis (AD) in Norway. What was the most significant challenge in getting consensus among an interdisciplinary group of doctors and nurses, and what do you hope will be the biggest impact of these new guidelines on patient care?

The most significant challenge in achieving consensus was bridging the differences in clinical practice philosophies. This included aligning approaches between dermatologists and paediatricians, as well as harmonising regional variations in care routines across hospitals and clinics in Norway. Differences in treatment protocols contributed to inconsistent advice and practices, making agreement complex.

Our aim was to establish a more consistent, evidence-based standard of care nationwide, hoping to reduce confusion for families and support better treatment adherence. With clearer, unified guidelines, clinicians can provide more confident and coordinated care. In turn, families are likely to experience less uncertainty, fewer disease flares, reduced stress, and ultimately a better quality of life for their children.

Q2 Your work has shown that treatment adherence is often low due to patients receiving conflicting information or having a 'phobia' of treatments. Beyond providing harmonised guidelines, what strategies are you exploring to improve patient education and combat these psychological barriers?

Beyond harmonised guidelines, one of our key strategies is structured education targeting healthcare personnel, general practitioners, and families. Our aim is to improve treatment adherence and address psychological barriers such as steroid phobia by increasing knowledge and confidence around AD care. We run a multidisciplinary educational programme for caregivers of children with AD, offered as a 2-day course held four times a year. The course includes sessions led by a dermatologist, a nurse, a psychologist, a social worker, and patient organisation representatives, and is designed to provide both practical guidance and emotional support. To reduce confusion around topical treatment, we have also developed a standardised written treatment plan, which helps families understand exactly how and when to apply therapies. In parallel, we offer regular training sessions for general practitioners and other healthcare professionals, helping ensure consistency of care across settings. Additionally, we have created educational videos on topical corticosteroids and emollients, which are freely available on YouTube (San Bruno, California, USA) and intended as

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accessible resources for patients and their families.

Q3 You have a strong interest in systemic treatments for AD, particularly during conception, pregnancy, and breastfeeding. What was the most surprising finding from the interdisciplinary consensus you helped build, and what does this project reveal about the current limitations in evidence for treating this specific patient population?

This project really highlighted the emotional and ethical complexity of treating pregnant or breastfeeding patients with moderate-to-severe AD, especially when disease control is poor and the impact on quality of life is profound. Clearly, we are still operating with major evidence gaps. Most drug safety data come from post-marketing surveillance or registry studies, not from prospective, controlled trials in pregnant patients. As a result, we rely heavily on interdisciplinary consensus and expert judgement, rather than clear, guideline-backed protocols. Our goal with

this project was to create a practical, risk-balanced framework for clinicians that supports shared decision-making, considers both maternal and fetal well-being, and acknowledges that untreated disease can be harmful too. In the end, the process revealed that while we're making progress, we urgently need more targeted research and long-term safety data for this specific population, who have been largely excluded from clinical trials for natural reasons.

Q4 As the head of a major tertiary referral centre for dermatology, you handle complex cases in both children and adults. What is the biggest difference in managing AD in these two groups, and how does your department's research directly address those unique challenges?

One of the biggest differences in managing AD between children and adults is the complexity of disease expression and comorbidity burden. In children, we often deal with parental

anxiety, treatment adherence, and preventing long-term disease progression. The focus is on education, early intervention, and building trust with families. In contrast, adult patients often present with chronic, treatment-resistant disease, sometimes complicated by psychological distress, sleep disruption, or occupational impacts, and they may carry years of inconsistent care or undertreatment. From a clinical standpoint, this means that our approaches must be age-specific: paediatric care needs more behavioural support and parent-led education, while adult care often requires multidisciplinary management, including psychology, allergology, and sometimes rheumatology. Our department's research is structured to reflect this reality. For example, we've developed harmonised topical treatment protocols for children, aimed at reducing conflicting advice and steroid phobia. At the same time, we're involved in clinical trials and biomarker studies in adults, particularly focusing on biologic and JAK inhibitor responses.



Q5 Your research group is focused on inflammatory skin disorders. Do you see a future where we can tailor topical treatments for a patient's specific genetic profile, moving beyond the current one-size-fits-all approach to emollients and corticosteroids?

Absolutely, and I think that we're closer than we realise. AD is increasingly understood as a spectrum of endotypes rather than a single disease. Patients can have very different underlying drivers, from *FLG* mutations and barrier defects to distinct immune pathway activations. So yes, I believe the future lies in precision therapy, where we tailor not just systemic treatments, but even emollients and topical anti-inflammatory treatments based on a patient's genetic, molecular, or microbiome profile. The challenge will be making these approaches accessible, not just technically feasible, but practical for everyday clinical use.

Q6 Beyond the currently approved drugs, what's on the horizon for treating AD? Are there any specific new drug targets or classes that you are most optimistic about in the next 5–10 years?

There are several promising drug targets and classes in the pipeline for AD beyond what is already approved. Some are refinements of current approaches; others are novel mechanisms. I'm especially excited about the pruritus-specific targets, like the IL-31 inhibitors, and I hope these drugs will become available in Norway shortly.

Q7 The field of AD has seen significant breakthroughs with biologics and JAK inhibitors. In your opinion, where is the next frontier of innovation? Is it in prevention, personalised medicine, or finding a definitive cure?

The introduction of biologics and JAK inhibitors has been a game-changer in AD treatment, especially for patients with moderate-to-severe disease. But we're still far from a definitive solution, and in my view, the next frontier of innovation lies in personalised medicine. While biologics and small molecules have expanded our toolbox, not every patient responds the same way. The future lies in precise endotyping, understanding the distinct immunological and genetic subtypes of AD, and tailoring treatment accordingly. We're moving towards a model where biomarkers will guide therapy choice, dosing, and treatment duration, improving outcomes and reducing unnecessary exposure to systemic drugs.

Q8 Considering your work and your role as a departmental head, what advice would you give to a young dermatologist who wants to combine clinical practice with impactful research, especially in a specialised area like AD?

Be curious and authentic. If you can hold on to those two traits, surround yourself with good people, and stay rooted in patient care, your work has the potential to be both scientifically meaningful and genuinely transformative. The most impactful research often begins with something simple: a clinical observation, a recurring question, or a frustration in daily practice. Pay close attention to those moments: unmet needs,

treatment gaps, or patterns you keep seeing in your patients. Let those real-world insights shape your research agenda. It will keep your work grounded, relevant, and ultimately more impactful.

Collaboration is essential, especially early on in your career. Don't be afraid to reach out beyond your specialty to paediatricians, nurses, psychologists, pharmacists, or even health economists. AD, like many chronic conditions, is multifaceted. Cross-disciplinary input not only strengthens your work but also helps you see the full picture of patient care.

And don't wait for the perfect big project. Start with what's manageable: a quality improvement initiative, a retrospective review, or a simple patient survey. These smaller projects are valuable stepping stones.

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