Patch testing has great potential!
- Inform which products to use and avoid
- Reduce treatment requirements
- Cure symptoms/dermatitis
- Solve challenging cases
- **Improve patients' quality of life**

We will discuss **ten tips** for the referring practitioner that can be divided into three general principles of patch testing:

A. **Identify** allergens
B. **Avoid** culprits
C. **Improve** dermatitis

**Identify allergens**

1. Allergy testing: What’s available? **Know some of the available testing options and questions they can answer.**
   - Skin prick testing
   - Repeat open application test (ROAT)/Use test
   - Patch testing: T.R.U.E. Test™, comprehensive series and extended patch testing, photopatch testing

2. What information is helpful for patients before their visit? **Provide patients with information throughout the process.**
   - General information about what patch testing involves
   - What to expect after patch testing
   - Alternatives to patch testing

3. Can immunosuppressants be used during patch testing? **Patch testing can be done while patients are on immunosuppressants.**
   - Ideally patients would be off immunosuppressants during testing and for some time beforehand. But in reality…
     - Some patients are unlikely to come off immunosuppressants. **Examples: Transplant patients or patients with severe, widespread dermatitis**
     - Some patients will flare off immunosuppressants and the ability to place patches may be limited
   - General recommendations are to avoid (Fowler et al 2012):
     - Topical corticosteroids to patch test sites for 3-7 days (Experts divided evenly between 3 and 7 days)
     - UV-treatment/significant sun exposure at patch test site for 0-2 weeks (Consensus: 1 week)
     - Prednisone for 1-14 days (Consensus: 3-5 days)
       - Prednisone 10-20 mg by mouth daily is okay (Consensus: 10 mg, but discontinue if possible)
     - Triamcinolone 40 mg IM for 3-4 weeks (Consensus: 4 weeks)
     - Azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus have a dose-dependent inhibition
     - Methotrexate, TNF inhibitors, ustekinumab unknown to little/no effect (Consensus)

4. Other special populations? **Can test children; typically avoid in pregnant/breastfeeding patients.**
Avoid culprits

5 How to interpret patch test results? Categorize by reaction type, look for clinical relevance, focus on the recommendations, and continue communication post-patch testing.

6 What to do after patch testing? A stepwise approach after patch testing is helpful.
• It may take 3-4 weeks (or more) to see improvements
• Reasons that patients may not improve
  o Examples: Non-adherence, inadvertent exposure to allergens, other diagnoses
• What to do?
  o Follow-up visit to review products and take an interval history
  o Consider testing for other allergens or make additional adjustments
  o Further workup and/or alternative treatments

Improve dermatitis

7 When is the answer a simple one? A simple explanation may exist in otherwise complex patients when it comes to contact allergens.

8 Systemic allergic contact dermatitis: Truth or myth? Systemic allergic contact dermatitis does exist and can even be exacerbated by ingesting foods with high contents of specific allergens such as nickel or cobalt.

9 What if a patient is still not improving post-patch testing? Testing does not always provide answers, but other options exist.
• Short term/rapid response
  o Examples: prednisone, cyclosporine
• Longer term/slower response
  o Examples: phototherapy, methotrexate, mycophenolate mofetil, azathioprine
• The future: biologics?


References

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