Table 1: General recommendations for systemic drugs for AE adult patients, who are candidates for systemic treatment (for details see corresponding chapter)

	Conventional systemic treatments			Biologics		JAK-inhibitors			Rescue therapy
	Ciclosporin	**Methotrexate**	**Azathioprine**	**Dupilumab**	**Tralokinumab**	**Abrocitinib**	**Baricitinib**	**Upadacitinib**	**Systemic corticosteroids**
Recommendation	↑↑	↑	↑	↑↑	↑↑	↑↑	↑↑	↑↑	↑
Dose for adults[1]	licensed ≥ 16 years; standard dosage adults: 2.5-5 mg/kg per day in two single doses	off-label; commonly used dosage adults: initial dose: 5-15 mg/ per week; maximum dose: 25 mg/ week	off-label; commonly used dosage adults: 1-3 mg/kg per day	licensed ≥ 6 months; adults: initially 600 mg s.c. day 1 followed by 300 mg Q2W	licensed for adults; initially 600 mg s.c. day 1 followed by 300 mg Q2W; consider Q4W dosing at week 16 in those achieving clear or almost clear skin	licensed for adults; dosage adults: 200 mg per day, reduction to 100 mg per day possible, depending on treatment response; age ≥ 65: 100 mg per day; the lowest effective dose for maintenance should be considered	licensed for adults; dosage adults: 4 mg per day, reduction to 2 mg per day possible, depending on treatment response	licensed ≥ 12 years; dosage adults: 15 or 30 mg per day based on individual patient presentation; age ≥ 65: 15 mg per day; the lowest effective dose for maintenance should be considered	general unspecific licence for adults and children for steroid responsive skin disease; dosage maximum: 1 mg/kg per day
Time to response (weeks)[2]	1-2	8-12	8-12	4-6	4-8	1-2	1-2	1-2	1-2
Time to relapse (weeks, based on expert experience)[2]	<2	>12	>12	>8	> 8	<2	<2	<2	<2
Monitoring	complete blood count, renal and liver profile, blood pressure,	complete blood count, renal and liver profile, PIIINP if available, screen for chronic infections	complete blood count, renal and liver profile, TPMT activity if available, screen for chronic infections	not required	not required	complete blood count, lipid profile, liver profile	complete blood count, lipid profile, liver profile	complete blood count, lipid profile, liver profile	not required for short-term treatment, consider blood glucose and testing for adrenal gland suppression with high doses/longer-term treatment

Selection of most relevant adverse events	serum creatinine↑, blood pressure ↑	nausea, fatigue, liver enzymes ↑, myelotoxicity	gastrointestinal disturbances, idiosyncratic hypersensitivity reactions, hepatotoxicity, myelotoxicity	Conjunctivitis, upper respiratory tract infections, arthralgia	upper respiratory tract infections; conjunctitivitis	upper respiratory tract infections,, increase in LDL cholesterol; thrombocytopenia, increased creatine phosphokinase, nausea and abdominal pain herpes virus infections, acne	upper respiratory tract infections,, increase in LDL cholesterol; thrombocytosis, nausea and abdominal pain herpes virus infections, acne	upper respiratory tract infections, acne; headache, anaemia and neutropenia, CK elevation, increase in LDL cholesterol, nausea and abdominal pain herpes virus infections	skin atrophy, weight gain, sleep disturbance, mood changes, hyperglycaemia or new onset diabetes, peptic ulcers/gastritis, osteoporosis

[1] SmPC, [2]expert experience, ↑ rise, AE- atopic eczema; GL – guideline, LDL – low density lipoprotein, PIIINP - Procollagen III N-Terminal Propeptide, TPMT – Thiopurine-S-Methyltransferase

Symbols	Implications (adapted from GRADE [1])
↑↑	We believe that all or almost all informed people would make that choice.
↑	We believe that most informed people would make that choice, but a substantial number would not.
0	We cannot make a recommendation.
↓	We believe that most informed people would make a choice against that intervention, but a substantial number would not.
↓↓	We believe that all or almost all informed people would make a choice against that choice.
	No recommendation.

Table 2: General recommendations for systemic drugs for special AE patient populations (for details see corresponding chapter)

	Conventional systemic treatments			Biologics		JAK inhibitors			Rescue therapy
	Ciclosporin	Methotrexate	Azathioprine	Dupilumab	Tralokinumab	Abrocitinib	Baricitinib	Upadacitinib	Systemic corticosteroids
Children and adolescents with AE who are candidates for systemic treatment	↑↑	↑	↑	↑↑	↑↑	↑↑		↑↑	
Dose for children	licensed for ≥ 16 years commonly used dosage children: 2.5-5 mg/kg per day in two single doses	off-label; commonly used dosage children: 0.3–0.4 mg/kg per week	off label; commonly used dosage children: 1-3 mg/kg per day	licensed for ≥ 6 months; age 6 months-6 years: from 5kg <15 kg 200 mg Q4W, 15kg <30 kg 300 mg Q4W age 6-11: from 15kg <60kg, initially 300 mg s.c. day 1 &15 followed by 300 mg Q4W, when ≥60 kg, initially 600 mg s.c. day 1 followed by 300 mg Q2W age 12-17: <60 kg: initially 400 mg s.c. day 1 followed by 200 mg Q2W, when ≥60 kg: initially 600 mg s.c. day 1 followed by 300 mg Q2W	licensed for ≥ 12 years; initially 600 mg s.c. day 1 followed by 300 mg Q2W; consider Q4W dosing at week 16 in those achieving clear or almost clear skin	off-label; only in UK approved ≥ 12 years; commonly used dosage children: 100 mg per day	off-label	licensed for ≥ 12 years; age 12-17 (>= 30 kg bw): 15 mg per day	general unspecific licence for children for steroid responsive skin disease;; dosage maximum: 1 mg/kg per day
Pregnancy (in candidates for systemic treatment)	↑	↓↓	↑	0	0	↓↓	↓↓	↓↓	↑ prednisolone (0.5mg/kg/d) *only* as rescue therapy for acute flares
Breastfeeding	↓	↓	↓	0	0	↓	↓	↓	↑ prednisolone (0.5mg/kg/d) *only* as rescue therapy for acute flares

[1] SmPC; Q2W - once every 2 weeks

Symbols	Implications (adapted from GRADE [1])
↑↑	We believe that all or almost all informed people would make that choice.
↑	We believe that most informed people would make that choice, but a substantial number would not.
0	We cannot make a recommendation.
↓	We believe that most informed people would make a choice against that intervention, but a substantial number would not.
↓↓	We believe that all or almost all informed people would make a choice against that choice.
	No recommendation.

Table 3: General recommendations for topical drugs for treatment of atopic eczema (for details see corresponding chapter)

Overall recommendation	TCS ↑↑		TCI ↑↑	
	TCS class I and II	TCS class III and IV	Tacrolimus 0.1% Tacrolimus 0.03%	Pimecrolimus 1%
For further information see background text	class I not suitable for long-term proactive treatment; long-term proactive treatment only class II	acute flare; proactive treatment with TCS class III class IV *not* for long term daily treatment or head and neck; class IV not recommended for proactive treatment either	acute flare; long-term proactive treatment; especially in face, intertriginous sites, anogenital area	acute flare; especially in face, intertriginous sites, anogenital area
Most important side effects	skin atrophy telangiectasia striae distensae ecchymosis hypertrichosis perioral dermatitis	skin atrophy telangiectasia striae distensae ecchymosis hypertrichosis perioral dermatitis corticosteroid addiction syndrome suppression of adrenal function	initial warmth, tingling or burning	initial warmth, tingling or burning
	TCI class II and III are off label for proactive treatment		in label for proactive treatment	not suitable for proactive treatment
Special considerations				
Suitable for **children > 2 to < 16** years of age	yes	yes	yes (0.03%)[2]	yes[2]
Suitable for **babies** < 2 years of age	yes	under specialist supervision	yes (0.03%)[1]	yes[2] (from the age of three months)
Suitable during **pregnancy**	yes	yes	yes (0.03% & 0.1%)[1]	yes[1]
Suitable during **breastfeeding**	yes	yes	yes (0.03% & 0.1%)[1]	yes[1]
Suitable for pruritus	yes	yes	yes (0.03% & 0.1%)	yes

[1] off label use [2] licensed use

Symbols	Implications (adapted from GRADE [1])
↑↑	We believe that all or almost all informed people would make that choice.
↑	We believe that most informed people would make that choice, but a substantial number would not.
0	We cannot make a recommendation.
↓	We believe that most informed people would make a choice against that intervention, but a substantial number would not.
↓↓	We believe that all or almost all informed people would make a choice against that choice.
	No recommendation.

References

[1] Kaminski-Hartenthaler A, Meerpohl JJ, Gartlehner G, Kien C, Langer G, Wipplinger J, et al. [GRADE guidelines: 14. Going from evidence to recommendations: the significance and presentation of recommendations]. Z Evid Fortbild Qual Gesundhwes. 2014;108; 413-420.