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

	Conventional immunomodulatorydrugs		Interleukin-13-Inhibitors			Interleukin-13-Inhibitors	JAK-Inhibitors			Rescue therapy
	Ciclosporin	**Metho-trexate**	**Dupilumab**	**Lebrikizumab**	**Tralokinumab**	**Nemolizumab**	**Abrocitinib**	**Baricitinib**	**Upadacitinib**	**Systemic corticosteroids**
Recom-mendation	↑↑	↑	↑↑	↑↑	↑↑	↑↑	↑↑	↑↑	↑↑	↑
Dose for adults[1]	licensed ≥ 16 years of age; 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	licensed ≥ 6 months of age; dosage adults: initially 600 mg s.c. day 1 followed by 300 mg s.c. Q2W	licensed for ≥ 12 years of age; dosage adults: initially 500 mg s.c. day 1 and 15 followed by 250 mg s.c. Q2W up to week 16. Some patients with initial partial response may further improve with continued treatment Q2W up to week 24. Once clinical response is achieved, the recommended maintenance dose is 250 mg Q4W. **From week 24 onwards, generally Q4W**	licensed for ≥ 12 years of age; dosage adults: initially 600 mg s.c. day 1 followed by 300 mg s.c. Q2W; consider Q4W after week 16 in those achieving clear or almost clear skin	licensed for ≥ 12 years of age; dosage adults: initially 60 mg s.c. day 1 followed by 30 mg s.c. Q4W; after week 16 recommended maintenance dose of is 30 mg Q8W for patients who achieve clinical response	licensed for ≥12 years of age; dosage adults: 100 mg or 200 mg once daily based on individual patient characteristic: starting dose of 100 mg: patients at higher risk of VTE, MACE and malignancy. If the patient does not respond adequately to 100 mg once daily, the dose can be increased to 200 mg once daily. starting dose of 200 mg: patients who are not at higher risk of VTE, MACE and malignancy with high disease burden or for patients with an inadequate response to 100 mg once daily. Upon disease control, dose should be decreased to 100 mg once daily. If disease control is not maintained after dose reduction, re-treatment with 200 mg once daily can be considered.	licensed for ≥ 2 years of age; dosage adults: 4 mg once daily. A dose of 2 mg once daily should be considered for patients who have achieved sustained control of disease activity with 4 mg once daily and are eligible for dose tapering 2 mg once daily is recommended for patients at higher risk of VTE, MACE and malignancy, for patients aged ≥ 65 years and for patients with a history of chronic or recurrent infections. A dose of 4 mg once daily may be considered for patients who do not achieve adequate control of disease activity with 2 mg once daily dose. A	licensed ≥ 12 years of age; dosage adults: 15 mg or 30 mg once daily based on individual patient characteristi: starting dose of 15 mg once daily is recommended for patients at higher risk of VTE, MACE and malignancy starting dose of 30 mg once daily may be appropriate for patients with high disease burden who are not at higher risk of VTE, MACE and malignancy or patients with an inadequate response to 15 mg once daily. The lowest effective dose to maintain response should be used. For patients 65 years of age and older, the recommended dose is 15 mg once daily	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	4-6	4-6	4-8	4-8	1-2	1-2	1-2	1-2

Time to relapse (weeks)[2]	<2	>12	>8	>8	> 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,	not required	not required	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	Conjunctivitis, upper respiratory tract infections, arthralgia	Conjunctivitis, nasopharyngitis, headache, dry eyes, allergic rhinitis	Conjunctivitis, upper respiratory tract infections;	Injection site reactions, nasopharyngitis, upper respiratory tract infections, headache	upper respiratory tract infections, increase in LDL cholesterol; thrombocytopenia, increased creatine phosphokinase, nausea and abdominal pain herpes virus infections, acne From a medical point of view, the risk of MACE, VTE and malignancy are relevant but low and applies to all JAK-Inhibitors in the same way	upper respiratory tract infections, increase in LDL cholesterol; thrombocytosis, nausea and abdominal pain herpes virus infections, acne From a medical point of view, the risk of MACE, VTE and malignancy are relevant but low and applies to all JAK-Inhibitors in the same way	upper respiratory tract infections, increase in LDL cholesterol, anaemia and neutropenia, increased creatine phosphokinase, nausea and abdominal pain, headache, herpes virus infections, acne From a medical point of view, the risk of MACE, VTE and malignancy are relevant but low and applies to all JAK-Inhibitors in the same way	skin atrophy, weight gain, sleep disturbance, mood changes, hyperglycaemia or new onset diabetes, peptic ulcers/gastritis, osteoporosis

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

	Conventional immunomodulatory drugs		Interleukin-13-Inhibitors			Interleukin-31-Inhibitors	JAK-Inhibitors			Rescue therapy
	Ciclosporin	**Metho-trexate**	**Dupilumab**	**Lebrikizumab**	**Tralokinumab**	**Nemolizumab**	**Abrocitinib**	**Baricitinib**	**Upadacitinib**	**Systemic corticosteroids**
Children and adolescents with AE who are candidates for systemic treatment	↑↑	↑	↑↑	↑↑	↑↑	↑↑	↑↑	↑↑	↑↑	
Dose for children	licensed for ≥ 16 years of age; commonly used dosage children: 2.5-5 mg/kg per day in two single doses	off-label; commonly used dosage children: 0.2–0.4 mg/kg per week	licensed for ≥ 6 months of age; dosage: age 6m-5y: from 5kg <15kg: 200 mg s.c. Q4W; 15kg<30kg: 300 mg s.c. Q4W age 6y-11y: from 15kg <60kg, initially 300 mg s.c. day 1 and 15 followed by 300 mg s.c. Q4W, when ≥60 kg, initially 600 mg s.c. day 1 followed by 300 mg s.c. Q2W age 12-17: <60 kg: initially 400 mg s.c. day 1 followed by 200 mg s.c. Q2W, when ≥60 kg: initially 600 mg s.c. day 1 followed by 300 mg s.c. Q2W adults: initially 600 mg s.c. day 1 followed by 300 mg s.c. Q2W	licensed for ≥ 12 years of age (with bodyweight ≥40kg); dosage: initially 500 mg s.c. day 1 and 15 followed by 250 mg s.c. Q2W up to week 16. Some patients with initial partial response may further improve with continued treatment Q2W up to week 24. Once clinical response is achieved, the recommended maintenance dose is 250 mg Q4W. **From week 24 onwards, generally Q4W**	licensed for ≥ 12 years of age; dosage: initially 600 mg s.c. day 1 followed by 300 mg s.c. Q2W; consider Q4W after week 16 in those achieving clear or almost clear skin	licensed for ≥ 12 years of age; dosage adults: initially 60 mg s.c. day 1 followed by 30 mg s.c. Q4W; after week 16 recommended maintenance dose of is 30 mg Q8W for patients who achieve clinical response	licensed for ≥ 12 years of age; dosage: 100 mg per day. If the patient does not respond adequately and there are no risk factors the dose can be increased to 200 mg per daily	licensed for ≥ 2 years of age; dosage: from 10kg<30kg: 2 mg per day; from 30kg: 4 mg per day dosage. A reduction to half the dose should be considered for patients who have achieved sustained control of disease activity with the recommended dose and are eligible for dose tapering.	licensed for ≥ 12 years of age; dosage: age 12-17 with bw ≥ 30 kg: 15 mg per day	general unspecific licence for children for steroid responsive skin disease; dosage maximum: 1 mg/kg per day
Pregnancy	↑	↓↓	↑	0	0	0	↓↓	↓↓	↓↓	↑ prednisolone (0.5mg/kg/d) *only* as rescue therapy for acute flares
Breast-feeding	↓	↓	0	0	0	0	↓	↓	↓	↑ prednisolone (0.5mg/kg/d) *only* as rescue therapy for acute flares

Table: 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.