Frequency and Significance of Major and Minor Clinical Features of Atopic Dermatitis

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We read with great interest the article by Rudzki et al. [1]. The authors evaluated the frequency and significance of major and minor clinical features of atopic dermatitis (AD) as proposed by Hanifin and Rajka [2] in 481 patients. All 4 major features were present in 71.7% and 3 major features in only 28.3% of patients. However, 96% of patients had over 6 minor features. The minor features of great significance were xerosis, white dermographism, DennieMorgan (DM) infra-orbital folds, itch when sweating, anterior neck folds, food intolerance, intolerance to wool, tendency toward cutaneous infections, cheilitis, orbital darkening, ichthyosis and/or keratosis pilaris, recurrent conjunctivitis, nipple eczema and pityriasis alba. Though the data were compared with a few similar studies, surprisingly a few other interesting observations were omitted. In a study by Mevorah et al. [3], palmar hyperlinearity and keratosis pilaris were not found to be of any diagnostic value in patients with AD. In a study done by us in 50 children (up to 12 years old) with AD [4], the minor features found to be highly significant were keratosis pilaris, a tendency towards cutaneous infection, nonspecific hand or tool dermatitis, DM folds, orbital darkening, pityriasis alba, xerosis, early age at onset, recurrent conjunctivitis and itch when sweating. Nipple eczema, cheilitis, perifollicular accentuation, white dermographism, recurrent conjunctivitis and anterior neck folds were not significant in our patients. In a similar study carried out in a Chinese population [5], nipple eczema, cheilitis, conjunctivitis, anterior subcapsular cataract keratoconus and DM folds were found to be not significant in patients with AD. Although Mevorah et al. [6] failed to find any significance of DM folds and anterior neck folds, we found DM folds to be significant. However, the present authors found both folds to be quite significant.

We wish the authors had included some additional minor features in their study such as infra-auricular fissuring, diffuse scaling of the scalp and Hertoghes sign. Infra-auricular fissuring was observed to be quite significant as a minor feature in AD by us [4] and Mevorah et al. [6]. In addition, we observed diffuse scaling of the scalp to be highly significant [4]. Hertoghes sign was however found to be insignificant [7].

We appreciate the authors' attempt to correlate the frequency of minor features with the number of positive major features, age at onset, associated bronchial asthma and serum IgE levels. We also strongly feel that there are different subgroups within the vast entity of AD and the positivity of a particular minor feature probably depends on the subtype of AD. However, ethnic and racial factors might also play a significant role in this context.

Though in the present study the sensitivity of major features of AD was quite high, i.e. 72% for all 4 and 28% for 3 major features, their specificity is not beyond doubt [8]. Therefore, it is the constellation of some features, be it major or minor, in a particular setting, which helps to make a diagnosis of AD. A strict mathematical calculation of 3 major and 3 minor features may not always be appropriate to diagnose each and every case of AD. More often than not, the diagnosis is hardly ever missed by the experienced eye: the major and minor features have their utility only in difficult cases and in research protocols.

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