How Specific Are Major Criteria for the Diagnosis of Atopic Dermatitis?

A.J.		Kanwar
S.		Dhar

Department of Dermatology, Postgraduate Institute of Medical Education and Research, Chandigarh, India

Dr. A.J. Kanwar, Department of Dermatology, Postgraduate Institute of Medical Education and Research, Chandigarh, 160012 (India)

There is no clinical or laboratory gold standard for the diagnosis of atopic dermatitis (AD). In 1980, Hanifin and Rajka [1] proposed an array of major and minor features and suggested that to make a diagnosis of AD with certainty, three from each category should be present. Though these criteria have gained almost universal acceptance, the specificity of some of the minor criteria has been questioned in different studies including one by us [2-5]. We now feel that the so-called major criteria are not very specific either.

Let us take pruritus first. Most if not all eczematous dermatitic disorders are pruritic. Moreover, the threshold of pruritus to bother a person depends on his/her level of tolerance and attachment to work. So the same eczema causing minimum pruritus in a busy executive will provoke severe pruritus in a hypochondriac housewife.

Next is 'chronically relapsing course'. Almost all endogenous eczemas show remissions and relapses. Air-borne contact dermatitis which may closely mimic AD in adults also shows a perennial fluctuation in its severity. Seborrhoeic dermatitis also follows a course punctuated by relapses and remissions.

The personal or family history of atopy is too non-specific to prove or disprove a diagnosis, there being no clinical or laboratory gold standard for the diagnosis of atopy. Moreover, a history of common cold, sneezing, rhinorrhoea and chronic bronchitis/ asthma is so common in the general population that it is extremely difficult to attribute the symptoms solely to atopic manifestations. Finally typical morphology and distribution. Isolated patches of AD or seborrhoeic dermatitis are almost similar in morphology. Lichenification can occur in any eczematous patch if it becomes chronic though it is more

common with AD. Regarding distribution, eczematous lesions in air-borne contact dermatitis may remain restricted to popliteal and cubital fossae as in AD in adults.

Thus we see that none of the major criteria is restricted to AD. On the other hand in a given case where there is a strong clinical suspicion of AD, not all 3 major criteria may be present. In fact minor features are more helpful in making a diagnosis of AD. In a particular case, the presence of only one major feature and 4-5 minor clinical criteria may be sufficient to make a diagnosis of AD with confidence.

So in our opinion, criteria for the diagnosis of AD should not be strictly classified into major and minor, and the practice of strict mathematical calculation that to diagnose AD, 3 major and 3

minor criteria have to be fulfilled should be abandoned. It is a mere constellation of features, be it major or minor, in a particular setting which help to make a diagnosis of AD.

References

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