When to Patch Test

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What is most likely to be ACD?

- Pruritus
- Severe
- Starts out localized
- Can be intermittent or persistent
- Atopics who have unusual distributions
- Any dermatitis not responding to therapy

What is most likely to be ACD?

- Morphology: Epidermal (scaling, vesicles, lichenification, etc)
- Classically asymmetric; except with symmetric contact i.e. cosmetics, textile dermatitis
- Geographic appearance ("outside job")
- Photo-distribution

What is most likely to be ACD?

- Distribution
  - Most likely are:
    - Head and neck (especially eyelids, lips)
    - Hands
    - Dorsal feet
    - Upper back
    - Anterior/posterior axillae

What is most likely to be ACD?

- Distribution
  - Least likely are:
    - Scattered and widespread
    - Classic atopic distribution
  - Remember: hands and scalp are relatively immune privileged and have a higher threshold of reactivity

When to Patch Test

- Any dermatitis that is worsening in severity
- Dermatitis not improving with therapy or rebounding as soon as therapy is discontinued
- Dermatitis in high yield patterns
- Any chronic dermatitis not in a typical atopic distribution
- Prior to initiating systemic immunosuppressant
When to Patch Test

- To predict patient tolerance to materials
  - Prior to surgical procedure in pt w/ h/o perioperative rash
  - Post implant failure
- Prior to implant surgery in a pt w/ h/o metal allergy or previous implant failure
- Occupational Dermatosis
- Previous patch testing limited (i.e. inadequate number of allergens tested)

When to consider patch testing the AD pt

- Adult/adolescent onset of AD
- Therapy resistant dermatitis that becomes generalized or more severe
- Atypical dermatitis distribution or pattern suggestive of ACD
- Recalcitrant hand eczema in the working population
- Prior to initiating systemic therapy

When to consider not patch testing

- Stable dermatitis in AD distribution
- Dermatitis affecting the patch test site
- Pregnancy/ lactation
- Current/recent exposure to immunosuppressive agents

Expert Opinion

Meds less likely to impact patch test results

- Methotrexate (ideally < 0.25 mg/kg/wk)
- Prednisone < 10 mg/day
- Biologic therapy
- Low dose cyclosporine (< 2 mg/kg)
- Azathioprine (dose dependent)
- Mycophenolate mofetil (dose dependent)
- Tacrolimus, systemic (dose dependent)

Expert Opinion

Treatments likely to impact patch test results

- Phototherapy/prolonged UV exposure within the last 1-3 weeks
- Topical steroids at patch testing site w/in 3-7d
- Prednisone > 10 mg/day
- High dose cyclosporine (> 2 mg/kg)
- Intramuscular triamcinolone (avoid for 4 weeks)

Approach to Patch Testing Patients on Systemic Immunosuppressive Treatments

- Avoid systemic immunosuppression for 5 half-lives of the drug in question (usually 1 month acceptable)
- When unavoidable, use the minimum dose required
- Stronger patch test reactions are more likely to appear, although more weakly than they would have otherwise appeared
- Carefully consider weak positives/indeterminate reactions
- Consider repeat testing when off immunosuppression
Summary

- Patch testing is recommended for any chronic or treatment refractory dermatitis, or for prevention of dermatitis in select cases
- Patch testing should be considered prior to initiating systemic therapy
- Always optimize patient conditions: clear the back and minimize any immunosuppressants