Mycophenolate Mofetil Is Effective in the Treatment of Atopic Dermatitis

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Objective: To evaluate whether mycophenolate mofetil, a new immunosuppressive agent, is effective for treating moderate-severe atopic dermatitis (AD).

Design: In an open-label pilot study, mycophenolate mofetil, 1 g, was given orally twice daily for 4 weeks. At week 5, the dosage was reduced to 500 mg twice daily until study end (week 8). Patients were followed up for 20 weeks.

Setting: University hospital dermatology department.

Patients: Ten consecutive patients with moderate-severe AD nonresponsive to standard therapy.

Main Outcome Measure: Severity of AD as measured using the subjective SCORAD [SCORing Atopic Dermatitis] index.

Results: Clinical efficacy was measured every 2 weeks using the subjective SCORAD index. Treatment with mycophenolate notably reduced the severity of AD within 4 weeks in all patients (P<.05), and after 8 weeks the mean±SD SCORAD index dropped from the pretreatment value of 49.2±13.8 to 21.9±26.5 (P<.01). One patient had to discontinue mycophenolate therapy after 4 weeks because of the development of herpes retinitis. Except for this event, mycophenolate was tolerated well in all patients. Six of 7 patients who had responded to mycophenolate monotherapy had no relapse of disease during 20-week follow-up. In the 7 patients who finished the study, the SCORAD index was reduced by 74%, from 44.0±7.8 before treatment to 11.4±5.9 at 20-week follow-up.

Conclusions: Mycophenolate is a highly effective drug for treating moderate-severe AD, with no serious adverse effects occurring in any patients. Thus, mycophenolate might develop into a promising alternative in the therapy of moderate-severe AD.

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PATIENTS AND METHODS

Ten patients with moderate-severe AD (mean SCORAD [SCORing Atopic Dermatitis] index, 49.2±13.8) were included in the study (initial subjective SCORAD index, 49.2±13.8). These patients did not respond to conventional topical treatment or to systemic treatment with oral glucocorticoids, phototherapy, or cyclosporine. Treatment with mycophenolate significantly reduced the severity of AD within 4 weeks in all patients (SCORAD index, 27.5±11.7; range, 16-53; \( P<.05 \)) (Figure 1). After 4 weeks, 7 of 10 patients had cleared completely. Two patients primarily responded well to mycophenolate therapy, but after 5 to 6 weeks of treatment we observed a relapse of AD, although mycophenolate therapy was continued. One patient had to stop mycophenolate therapy after 4 weeks because of the development of herpes retinitis. Six of the 7 responders had lasting remission during 20-week follow-up (for a clinical example see Figure 2), and only 1 patient experienced a partial relapse, with an increase in the SCORAD index from 12 (at week 8) to 24 (at week 20). Nevertheless, in the 7 patients who completed the study, the SCORAD index at week 20 (11.4±5.9; range, 6-24) was reduced by 74% compared with the initial index (44.0±7.8; range, 38-60) \((P<.001)\) (Figure 1).

Overall, mycophenolate therapy was well tolerated in all but 1 patient, who experienced herpes retinitis at week 4. Routine laboratory tests, including blood cell counts, liver and renal function tests, and electrolyte levels, were performed before the study and at biweekly intervals. Test results remained unremarkable throughout the study in all patients. In particular, leukopenia, anemia, and changes in liver function were not observed.

The results of this pilot study demonstrate that mycophenolate is highly effective in the treatment of moderate-severe AD. Because of the effectiveness of mycophenolate therapy in patients who relapsed while receiving conventional treatment with systemic glucocorticoids or cyclosporine, one may conclude that mycophenolate might be superior for treating...
moderate-severe AD. Adverse effects observed in patients undergoing transplantation treated with mycophenolate include gastrointestinal tract symptoms, leukopenia, and anemia. The actual risk of an increased incidence of viral and bacterial infection due to treatment with mycophenolate has been a matter of controversial discussion. Recent studies of mycophenolate therapy for blistering autoimmune diseases do not report an increase in the incidence of infections, as has been reported for patients receiving a transplant. However, patients in the transplant studies were receiving other immunosuppressive agents concomitantly. One of our patients had to discontinue mycophenolate therapy because he developed herpes retinitis, which resolved quickly after treatment with acyclovir. Although there is no direct evidence of mycophenolate being a major cause of herpes retinitis, in this patient it seems likely that this might be due to immunosuppression resulting from mycophenolate therapy. However, to our knowledge, it has not been reported until now that mycophenolate monotherapy is associated with a significant increased risk of bacterial or viral infection such as herpes infection. Therefore, we have no evidence that regular antiviral therapy is necessary before starting mycophenolate therapy. In addition, it has been shown that mycophenolate strongly potentiates the antiherspes activity of acyclovir, ganciclovir, and penciclovir in vitro and in vivo, suggesting that it is sufficient to start antiviral therapy when clinical signs of herpes infection occur.

The results of this pilot study in 10 patients demonstrate that the adverse effects of mycophenolate therapy are acceptable, with no serious adverse effects occurring in any patients. In addition to being a highly effec-
tive drug in the treatment of moderate-severe AD, mycophenolate is also characterized by a low toxicity profile, causing only moderate adverse effects. Compared with the unwanted adverse effects of systemic glucocorticoid, azathioprine, or cyclosporine use, mycophenolate seems to have an improved risk-benefit ratio. In 6 of 10 patients, lasting remission for 20 weeks was observed. After the end of mycophenolate monotherapy (week 8), patients were allowed to use class 2 to 3 topical glucocorticoids in localized areas if necessary. This was considered a significant improvement by patients and dermatologists because before mycophenolate therapy, AD in all patients had been resistant to potent topical glucocorticoids and systemic immunosuppressive treatment (Table). Thus, mycophenolate might develop into a promising alternative for treating AD.

These promising initial results warrant initiation of controlled clinical trials comparing the safety and effectiveness of mycophenolate with that of conventional immunosuppressive agents. Because of the long-lasting remission in responders to mycophenolate therapy, intermittent mycophenolate modalities should be evaluated.

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REFERENCES