

## Scratching below the surface: Confidently diagnosing allergies

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Allergic dermatitis is one of the most common conditions encountered in small animal practice, affecting a significant proportion of canine patients. Despite its prevalence, accurate diagnosis remains challenging due to overlapping clinical signs among major differentials, including atopic dermatitis, cutaneous adverse food reactions (AFR), and flea allergy dermatitis. A systematic, stepwise approach is essential to confidently diagnose and appropriately manage these cases.

Allergic dermatitis is a diagnosis of exclusion. A thorough history and dermatologic examination are critical first steps in the diagnostic process. Key historical factors include age at onset, seasonality, diet history, pruritus severity, response to prior therapies, and the presence of gastrointestinal signs. Atopic dermatitis typically presents between 1–4 years of age and may initially be seasonal, whereas AFR can occur at any age and is more often nonseasonal. However, clinical overlap is common, and these distinctions are not definitive.

Pruritus is the hallmark clinical sign of allergic disease, often presenting as bilaterally symmetric, initially lesionless itching. Common manifestations include paw licking, scratching, head shaking, and recurrent otitis externa. Secondary lesions such as erythema, alopecia, lichenification, and hyperpigmentation develop over time due to chronic inflammation and self-trauma. Importantly, clinical presentation alone does not reliably differentiate atopic dermatitis from food allergy.

A critical component of the diagnostic workup is the exclusion of other pruritic conditions. Ectoparasites must be ruled out in every pruritic patient, regardless of negative diagnostic tests, as false negatives are common. Empirical treatment with appropriate parasiticides is often warranted. Secondary infections—including bacterial folliculitis, *Malassezia* dermatitis, and otitis externa—must also be identified and treated, as they significantly contribute to pruritus and may obscure the underlying diagnosis.

Once ectoparasites and secondary infections have been addressed, a dietary elimination trial is required to evaluate for AFR. This remains the gold standard diagnostic test. Serum, saliva, and hair testing for food allergy are unreliable and should not be used. Successful diet trials require strict adherence to a prescribed novel or hydrolyzed diet, with complete elimination of all other food sources. Clinical improvement is typically observed within 3–8 weeks; lack of response by 4–6 weeks makes AFR unlikely. Confirmation requires dietary challenge with the original diet to assess for recurrence of clinical signs.

If pruritus persists despite appropriate parasite control, infection management, and a properly conducted diet trial, a diagnosis of atopic dermatitis is made by exclusion. Allergy

testing (intradermal or serum IgE) is not used to diagnose atopy but may be employed to guide allergen-specific immunotherapy following diagnosis.

Effective communication with clients is essential throughout the diagnostic process. Owners must understand the stepwise nature of the workup, the importance of compliance—particularly during diet trials—and the time required to reach a definitive diagnosis.

In summary, confident diagnosis of canine allergic dermatitis requires a methodical approach emphasizing thorough history-taking, exclusion of ectoparasites and secondary infections, and appropriate use of dietary trials. Atopic dermatitis remains a diagnosis of exclusion, and accurate identification of the underlying cause is essential for successful long-term management.