Journal of Advances in Drug Research

ISSN: 2230-7761
www.jadr.co.in

Volume 17, Issue 05 | Received 27.10.2026 | Accepted 1.11.2026 | Online 6.11.2026

UDC 616.5-002.2 + 615.89 + 615.26

CLINICAL EFFICACY OF MODIFIED GOOSE-FAT-BASED TOPICAL OINTMENTS IN CHRONIC ALLERGIC DERMATITIS: A COMPARATIVE CLINICAL ANALYSIS

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ABSTRACT

Chronic allergic dermatitis encompasses persistent or recurrent eczematous conditions with pruritus, erythema, excoriation and epidermal barrier dysfunction. This study examines clinical changes reported during the use of two modified goose-fat-based topical formulations compared with conventional betamethasone treatment. The source manuscript describes 268 patients treated between 2018 and 2024 at clinical facilities of Bukhara State Medical Institute and classified into three treatment groups: goose fat, aloe extract and betamethasone; goose fat and aloe extract; or topical betamethasone. Lesion counts were documented at baseline, one month and three months, alongside descriptions of laboratory, immunological, morphological and formulation assessments. Across all three groups, reported counts of papules, vesicles and excoriations decreased during follow-up. In the combined-formulation group, papular findings declined from 71 at baseline to 16 at three months, vesicles from 51 to 5, and excoriations from 60 to 10. Corresponding baseline-to-three-month papule counts were 78 to 3 in the goose-fat–aloe group and 81 to 11 in the betamethasone group. However, inconsistencies in stated denominators, incomplete allocation and safety details, and conflicting scratch-mark percentages limit formal between-group comparison. This revised analysis places the results in the context of contemporary evidence on skin-barrier repair and topical anti-inflammatory therapy. The observed within-group improvements are encouraging, but the independent benefits and safety of the experimental formulations require confirmation in rigorously reported controlled studies.

Keywords: chronic allergic dermatitis; eczema; goose fat; Aloe vera; betamethasone; topical formulation; clinical response; skin-barrier function; pruritus; comparative analysis.

INTRODUCTION

Chronic allergic dermatitis represents a heterogeneous clinical category encompassing atopic dermatitis, allergic contact dermatitis and other persistent eczematous presentations. The disorders share symptoms of pruritus, erythema, scaling, dryness and excoriation, but differ in their immunopathology and diagnostic requirements. Global modelling indicates

Journal of Advances in Drug Research
ISSN: 2230-7761
www.jadr.co.in
Volume 17, Issue 05 Received 27.10.2026 Accepted 1.11.2026 Online 6.11.2026

that atopic dermatitis affects approximately 204 million people and has substantial implications for patients' quality of life and healthcare systems [1]. Contemporary clinical reviews emphasize the reciprocal interactions between epidermal barrier dysfunction, immune activation and repeated exposure to environmental triggers [2,3]. Accordingly, a clinically relevant treatment strategy should aim both to suppress active inflammation and to restore or preserve cutaneous barrier integrity.

Guideline-supported topical management relies on moisturizers and carefully selected anti-inflammatory agents, including topical corticosteroids and, where indicated, steroid-sparing treatments [4–7]. Patients with recurrent disease may benefit from formulations that combine an emollient vehicle with an effective anti-inflammatory component; nevertheless, the characteristics of the vehicle, potency of the active agent, application schedule and baseline dermatitis phenotype can all influence treatment response. Interest in lipid-rich preparations derived from traditional raw materials has encouraged investigation of goose-fat-containing formulations. The present clinical manuscript examines their performance with aloe extract, with or without betamethasone, while retaining conventional topical betamethasone as a comparator.

The objective was to examine the reported longitudinal evolution of visible inflammatory lesions following the three treatment approaches, contextualize the findings using published evidence on eczema management, and identify the methodological information required to establish comparative effectiveness and safety. Because the supplied clinical summary does not include patient-level data, formal equivalence across arms or causal attribution to individual formulation components cannot be assumed.

LITERATURE REVIEW

The scientific rationale for topical barrier-directed therapy originates in the altered structure and function of the stratum corneum in eczematous disease. Elias and Wakefield described how changes in epidermal proteins, lipid processing and lamellar-body secretion can compromise the extracellular lipid matrix and increase transepidermal water loss [3]. Subsequent work has distinguished ordinary moisturizing from physiologically targeted barrier repair and has emphasized that lipid composition, not merely occlusion, contributes to restoration of epidermal function [9]. Evidence from a randomized study of a ceramide-dominant moisturizing regimen illustrates the feasibility of measuring barrier recovery with objective outcomes rather than relying only on lesion counts [8]. Although these findings support lipid-based skin care, they do not independently validate goose fat as a specific therapeutic ingredient.

International guidance consistently supports regular emollient use, while placing topical anti-inflammatory drugs at the center of treatment when dermatitis is active. The American Academy of Dermatology recommendations identify moisturizers, topical corticosteroids and several nonsteroidal agents as evidence-based options in adults [4]. The AAAAI/ACAAI guideline reaches similarly strong recommendations for moisturizers and established anti-inflammatory therapy, although specific choices depend on disease severity and patient factors [5]. A systematic review of guidelines by van Halewijn and

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ISSN: 2230-7761
www.jadr.co.in

Volume 17, Issue 05 | Received 27.10.2026 | Accepted 1.11.2026 | Online 6.11.2026

colleagues found variation in the recommended use of emollients, bathing practices and corticosteroid regimens, illustrating the importance of reporting the complete topical treatment protocol [6]. A Cochrane review concluded that moisturizers provide measurable benefits and may reduce flare frequency or corticosteroid requirements, while evidence has not established one universally superior moisturizer [7].

The pharmacological component of the goose-fat–aloe–betamethasone preparation has a separate evidence base. Topical corticosteroids act on inflammatory signalling and are effective for many inflammatory dermatoses; the 2024 Cochrane network meta-analysis identified potent corticosteroid preparations among the most effective topical anti-inflammatory options in eczema trials [10]. However, potency, site, duration and treatment adherence matter. A systematic review of longer-term corticosteroid safety found that available comparative evidence has limitations and that safety assessment should be differentiated by exposure and adverse-event type [11]. These findings caution against attributing an improvement observed during use of a betamethasone-containing formulation entirely to its lipid vehicle or aloe component.

Diagnostic classification is equally important. Atopic dermatitis and allergic contact dermatitis may produce similar lesions, but the latter requires consideration of exposure history and, when appropriate, patch testing and allergen avoidance [12,13]. Guidance on chronic hand eczema likewise highlights the need to distinguish inflammatory subtypes and to identify occupational or environmental drivers [14]. A study combining several eczematous phenotypes without explicit criteria may therefore yield findings that are difficult to generalize across diagnoses. Similarly, therapeutic response should ideally be measured with validated severity instruments, for example the Eczema Area and Severity Index, and supported by patient-centered outcomes such as the Dermatology Life Quality Index [17,18].

Evidence for Aloe vera preparations is biologically and clinically less specific to allergic dermatitis. A systematic review of clinical trials examined Aloe vera in wound prevention and healing, but its population and endpoints cannot be treated as proof of efficacy in chronic allergic or atopic eczema [15]. In related work, Karimova evaluated a goose-fat–aloe–betamethasone preparation in a preclinical excision-wound model, providing preliminary formulation-specific information about tolerability and wound repair rather than confirmatory evidence of human dermatitis efficacy [16]. Together, these publications suggest a plausible formulation-development rationale but reveal an important evidence gap: well-characterized human trials are needed to distinguish vehicle effects, the contribution of Aloe vera, and the effects of an established corticosteroid. The present clinical series is therefore valuable as an initial description but must be interpreted within these evidentiary boundaries.

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Table 1. Representative literature informing the present clinical analysis and its interpretation.

Evidence domain	Representative sources	Relevance / limitation
Disease burden and mechanism	Tian [1]; Langan [2]; Elias & Wakefield [3]	Epidermal barrier dysfunction and inflammatory pathways; neither establishes goose-fat efficacy.
Guideline-supported topical care	Sidbury [4]; Chu [5]; van Halewijn [6]	Moisturization and anti-inflammatory treatment; efficacy depends on formulation and protocol.
Emollient and barrier outcomes	van Zuuren [7]; Spada [8]; Elias [9]	Clinical and biophysical rationale for barrier repair; no evidence of equivalence among lipid sources.
Anti-inflammatory efficacy and safety	Lax [10]; Harvey [11]	Efficacy of corticosteroids; need for defined potency, duration and adverse-event follow-up.
Differential diagnosis	Chan [12]; Dickel [13]; Thyssen [14]	Distinguishes atopic, allergic contact and other eczematous phenotypes.
Formulation and outcome measures	Hekmatpou [15]; Karimova [16]; Hanifin [17]; Finlay [18]	Aloe wound-healing literature, preclinical formulation study, EASI and DLQI instruments.

MATERIALS AND METHODS

The submitted clinical study describes observation of 268 patients with chronic allergic dermatitis treated between 2018 and 2024 at clinical facilities of Bukhara State Medical Institute. According to the reported management approach, participants received one of three topical regimens: a modified ointment combining goose fat, Aloe vera extract and betamethasone (Group I); goose fat and aloe extract without betamethasone (Group II); or conventional betamethasone topical treatment (Group III). Clinical examinations were performed before treatment and at approximately one and three months. The source reports assessments of erythema, pruritus, infiltration, dryness and the presence of papules, vesicles, excoriations and scratch marks. It also mentions laboratory chemistry, cytokine measurements, local immunity markers, histological examination of skin biopsy specimens, and physicochemical testing of ointment pH, rheology and absorption characteristics; however, numerical results for most of these domains were not included in the supplied manuscript.

The source identifies SPSS Statistics and Microsoft Excel as analysis tools and names variation, correlation and receiver operating characteristic (ROC) analyses. The precise sampling strategy, diagnostic criteria, enrollment and attrition details, group denominators, random allocation, blinding, concomitant treatment, dosing frequency, formulation concentrations, predefined primary endpoint and ethics approval number are not documented in the supplied text. Therefore, the present revision does not infer a

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Volume 17, Issue 05 Received 27.10.2026 Accepted 1.11.2026 Online 6.11.2026

randomized study design, calculate formal comparative treatment effects, reconstruct an unavailable patient-level database or report missing safety data. Absolute symptom counts have been transcribed as supplied, and simple percentage changes have been recalculated directly from each reported baseline count. Such descriptive change estimates are not equivalent to patient-level response rates or between-group treatment effects.

The published background literature was selected for direct relevance to atopic and contact dermatitis, topical anti-inflammatory therapy, moisturizers, formulation safety and validated clinical endpoints. Sources are summarized narratively and were not subjected to a registered systematic-review search or meta-analysis. The clinical results in this article therefore represent a structured re-presentation and cautious interpretation of the author-supplied data, not independently verified new measurements.

Table 2. Reported treatment approaches and information required for reproducibility.

Group	Reported intervention	Missing protocol details
I	Goose-fat-based ointment + Aloe vera extract + betamethasone	Dose and potency; component concentrations; dosing frequency; treatment duration; group n.
II	Goose-fat-based ointment + Aloe vera extract	Composition and stability; use of concurrent standard therapy; group n; adverse events.
III	Topical betamethasone (standard protocol)	Concentration and formulation; application regimen; group n; rescue medications.

4. RESULTS

Across the three reported treatment groups, the number of papular, vesicular and excoriated findings generally decreased between baseline and the third month (Table 3). In Group I, which received the combined goose-fat–aloe–betamethasone preparation, papules fell from 71 at baseline to 35 after one month and to 16 after three months, equivalent to a descriptive baseline-to-month-3 decrease of 77.5%. Vesicles declined from 51 to 18 and then to 5 (90.2%), excoriations from 60 to 28 and then to 10 (83.3%), and scratch marks from 16 to 11 and then to 4 (75.0%). These trajectories are consistent with gradual resolution of visible inflammatory lesions during treatment, although the underlying number of unique patients represented by each count and the reported group denominator require confirmation.

In Group II, treated with goose fat and aloe, the papule counts decreased from 78 at baseline to 6 at month 1 and 3 at month 3, corresponding to a 96.2% reduction from the stated baseline. Vesicles declined from 58 to 10 and then to 7 (87.9%); excoriations decreased from 58 to 28 and then to 15 (74.1%). Scratch marks followed a different pattern, increasing from 10 at baseline to 28 after one month before decreasing to 15 after three months. Relative to baseline, the third-month count represents an increase of 50.0%, not an improvement; the original manuscript's reported 46.4% reduction corresponds instead to the change from month 1 (28) to month 3 (15). This distinction is clinically meaningful,

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ISSN: 2230-7761
www.jadr.co.in
Volume 17, Issue 05 Received 27.10.2026 Accepted 1.11.2026 Online 6.11.2026

because persistent or increased scratch marks may indicate residual pruritus or scratching behavior, and should not be interpreted as an objective sign of epidermal repair.

In Group III, conventional betamethasone treatment was associated with a decrease in papules from 81 at baseline to 22 after one month and 11 after three months (86.4% reduction). Vesicles declined from 51 to 14 and then to 7 (86.3%), excoriations from 59 to 17 and then to 9 (84.7%), and scratch marks from 16 to 6 and then to 3 (81.3%). All values are presented as descriptive changes in the reported counts. The original report gives chi-square statistics of 28.47 (six degrees of freedom) for one treatment trajectory and 20.48 (six degrees of freedom) for the betamethasone group. The corresponding upper-tail probabilities are approximately 0.000077 and 0.00227, respectively; thus, the second statistic does not support the stated threshold $p < 0.001$. Without a complete contingency table and an account of repeated observations, neither chi-square result can be independently validated as an appropriate longitudinal test.

Table 3. Reported absolute clinical finding counts at baseline, month 1 and month 3 (source manuscript).

Treatment group	Clinical finding	Baseline	Month 1	Month 3
I: goose fat + aloe + betamethasone	Papules	71	35	16
I: goose fat + aloe + betamethasone	Vesicles	51	18	5
I: goose fat + aloe + betamethasone	Excoriations	60	28	10
I: goose fat + aloe + betamethasone	Scratch marks	16	11	4
II: goose fat + aloe	Papules	78	6	3
II: goose fat + aloe	Vesicles	58	10	7
II: goose fat + aloe	Excoriations	58	28	15
II: goose fat + aloe	Scratch marks	10	28	15
III: betamethasone	Papules	81	22	11
III: betamethasone	Vesicles	51	14	7
III: betamethasone	Excoriations	59	17	9
III: betamethasone	Scratch marks	16	6	3

Table 4. Descriptive baseline-to-month-3 percentage change calculated from reported counts.

Group	Outcome	Counts (B → M3)	Change (%)	Direction
Group I	Papules	71 → 16	-77.5%	Decrease
Group I	Vesicles	51 → 5	-90.2%	Decrease
Group I	Excoriations	60 → 10	-83.3%	Decrease
Group I	Scratch marks	16 → 4	-75.0%	Decrease
Group II	Papules	78 → 3	-96.2%	Decrease

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Group	Outcome	Counts (B → M3)	Change (%)	Direction
Group II	Vesicles	58 → 7	-87.9%	Decrease
Group II	Excoriations	58 → 15	-74.1%	Decrease
Group II	Scratch marks	10 → 15	+50.0%	Increase
Group III	Papules	81 → 11	-86.4%	Decrease
Group III	Vesicles	51 → 7	-86.3%	Decrease
Group III	Excoriations	59 → 9	-84.7%	Decrease
Group III	Scratch marks	16 → 3	-81.2%	Decrease

Figures 1–3 show the trajectories of the four recorded cutaneous findings for each treatment group. These charts use the manuscript's reported raw counts rather than inferred denominators or adjusted effect sizes; they are descriptive and must not be interpreted as head-to-head treatment comparisons. The source also describes improvements in itching, erythema, infiltration, remission and dermatology-related quality of life, but provides no longitudinal scores, variance estimates, adverse-event frequencies or intergroup tests for these outcomes. Accordingly, the magnitude and statistical significance of changes in these domains cannot be quantified from the information currently available.

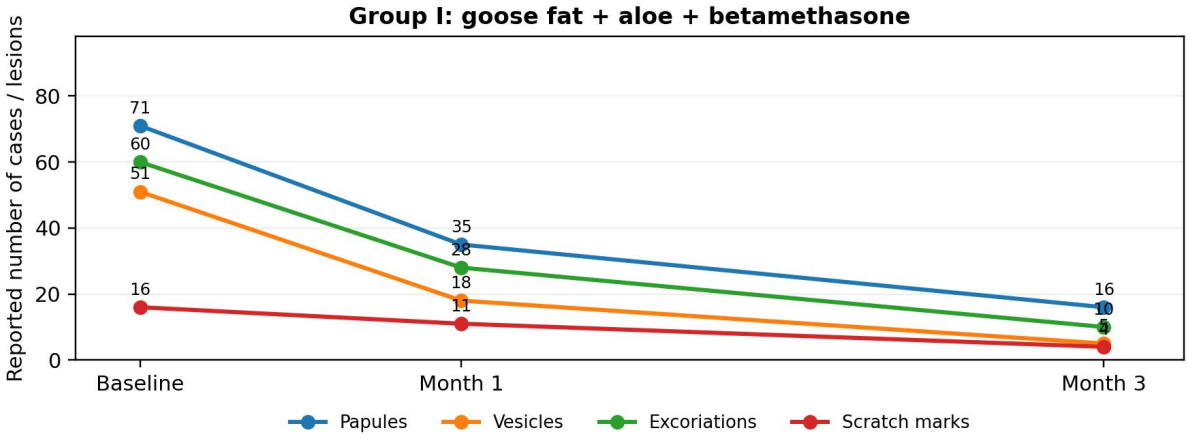


Figure 1. Reported evolution of cutaneous findings in Group I (goose fat, Aloe vera and betamethasone). Values are manuscript-reported counts, not verified patient-level data.

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ISSN: 2230-7761
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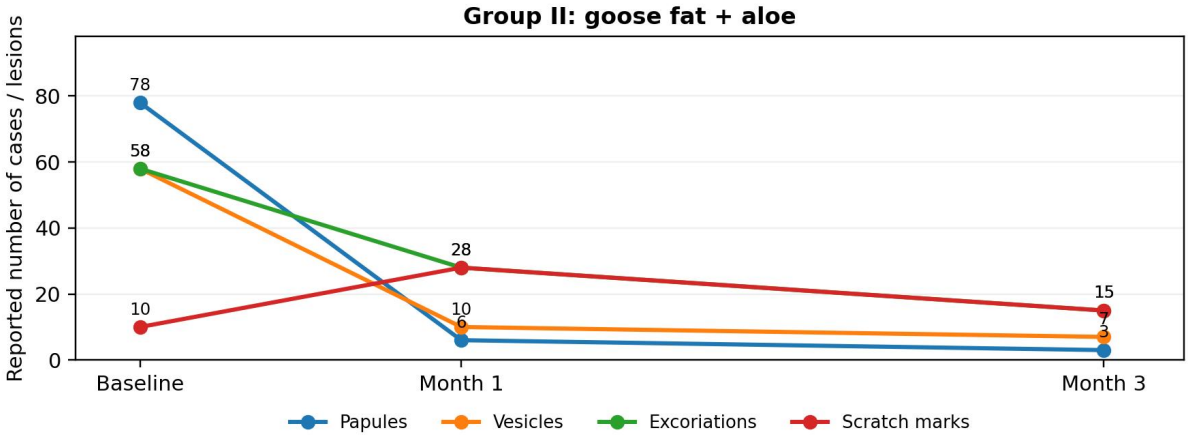


Figure 2. Reported evolution of cutaneous findings in Group II (goose fat and Aloe vera). The month-1 rise in scratch marks should be evaluated rather than interpreted as healing.

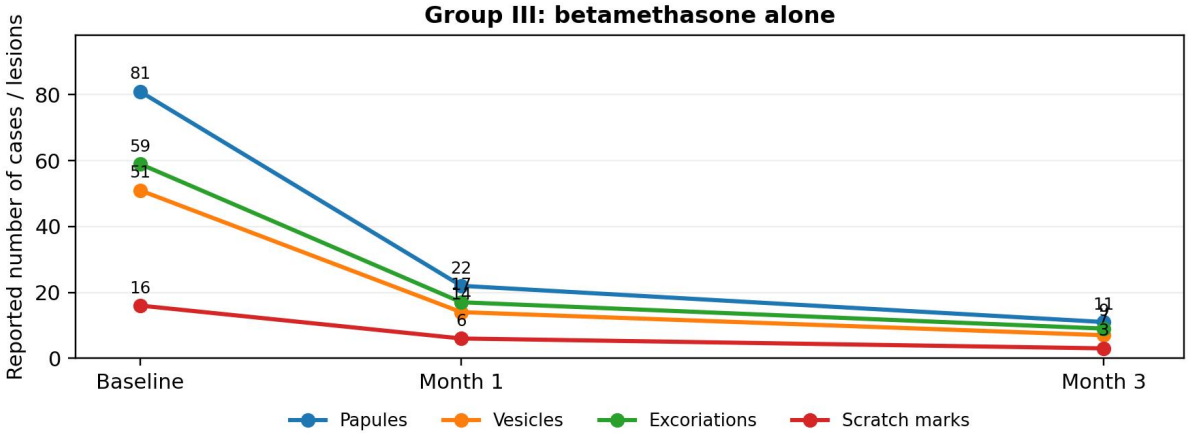


Figure 3. Reported evolution of cutaneous findings in Group III (betamethasone comparator). Curves summarize within-group observations only.

DISCUSSION

The clinical observations suggest a reduction in several visible eczematous manifestations over three months in all three regimens, but do not yet identify a formulation with demonstrated superiority. Both goose-fat-based products and the standard betamethasone regimen were associated with lower papule, vesicle and excoriation counts at the final observation. These findings are broadly compatible with the established importance of topical anti-inflammatory treatment and barrier-directed care, although the absence of standardized severity scores and verified treatment allocation prevents determination of the

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ISSN: 2230-7761
www.jadr.co.in

Volume 17, Issue 05 Received 27.10.2026 Accepted 1.11.2026 Online 6.11.2026

relative contribution of each component [4–10]. For the combined preparation, reductions in lesions may reflect the known pharmacological activity of betamethasone, beneficial vehicle properties, natural disease fluctuation, changes in self-care, or several mechanisms acting together; the supplied data cannot separate these explanations.

The literature review offers a mechanistic rationale for studying lipid-enriched vehicles but also delineates the evidentiary gap. Physiological restoration of epidermal lipid organization is important in atopic dermatitis [3,9], and systematic reviews support moisturizer use as part of eczema care [6,7]. Yet goose fat differs in composition and manufacturing conditions from the physiologically balanced lipid formulations used in some controlled studies [8]. Claims about its barrier-repair activity therefore require direct measurements, such as transepidermal water loss, corneometry, controlled patch or irritation testing, stability and microbial quality of the product. Aloe vera has been assessed for wound healing, but results from wound trials should not be extrapolated without qualification to allergic dermatitis, a condition with distinct inflammatory mechanisms [15]. The earlier formulation-specific animal study [16] supports preclinical feasibility and not the establishment of comparative clinical efficacy in humans.

Several issues materially affect interpretation. First, the source describes 268 participants but provides baseline percentages that imply nonmatching denominators across the reported groups; therefore, precise group sizes and the number of patients who completed each visit remain uncertain. Second, the counts may represent patients with a given manifestation, lesions or another recording unit, and the distinction needs to be specified. Third, the unexpected rise in scratch marks in Group II deserves attention because it may indicate unresolved itch, medication effects or inconsistent recording; it cannot be assigned a reparative meaning without corroborating clinical measures. Fourth, statements of more rapid response by sex and age, longer remission and improved DLQI are not accompanied by enough stratified data or numerical scores to verify these comparisons. Finally, the source does not document the corticosteroid concentration, adjunct treatments, randomization, safety monitoring or histological outcomes. These gaps preclude robust conclusions about treatment superiority or long-term safety.

For a definitive assessment, future trials should establish the diagnosis of atopic dermatitis versus allergic contact dermatitis and specify relevant allergen testing and avoidance where indicated [12–14]. The study protocol should state eligibility criteria, exact group sizes, allocation method, product composition, pharmacological potency, dosing frequency, treatment adherence and concomitant therapy. Prospective evaluation should include validated severity instruments such as EASI, patient-reported itch scores, DLQI, objective barrier measures, treatment-emergent adverse events and a predefined follow-up period [17,18]. Statistical analysis should distinguish within-person repeated measures from independent between-group comparisons and report effect sizes with confidence intervals, rather than relying only on omnibus p-values. These measures would clarify whether any goose-fat-based formulation adds clinically meaningful benefit to established topical treatment.

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ISSN: 2230-7761
www.jadr.co.in

Volume 17, Issue 05 | Received 27.10.2026 | Accepted 1.11.2026 | Online 6.11.2026

CONCLUSION

In this clinical report, visible papular, vesicular and excoriated manifestations generally diminished across three topical treatment approaches over a three-month observation period. The direction of the reported changes justifies further research into modified goose-fat-containing preparations, but the available data do not demonstrate superiority to betamethasone or establish the isolated efficacy of goose fat or Aloe vera. The inconsistent reported group denominators, incomplete documentation of dosing and safety, and the need to recheck several statistical and descriptive statements must be resolved before definitive comparative claims can be made. Carefully designed clinical studies incorporating validated eczema severity, quality-of-life and barrier-function measures are required to determine the therapeutic value, tolerability and longer-term role of these formulations.

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