Al Ameen J Med Sci 2026;19(2):116-123 ● US National Library of Medicine enlisted journal ● ISSN 0974-1143

ORIGINAL ARTICLE CODEN: AAJMBG

Association between duration of Exclusive breastfeeding and severity of Atopic dermatitis in children aged 1 to 12 years: A Cross-sectional study

Megaulinga Kannan M*, Vimal M. Holambe, Namrata A. Acharya and Ajit S. Nagaonkar

Department of Community Medicine, Vilasrao Deshmukh Government Medical College, Near Gandhi Chowk, Latur - 413512, Maharashtra, India

Received: 05th November 2025; ***Accepted:*** 09th March 2026; ***Published:*** 01st April 2026

Abstract: *Background:* Atopic dermatitis (AD) is a chronic inflammatory skin disorder in children with multifactorial aetiology. Although breastfeeding provides immunological benefits, its influence on the severity of AD remains unclear. *Objectives:* To assess the relationship between the duration of exclusive breastfeeding (EBF) and the severity of AD in children aged 1–12 years and to identify selected socio-demographic factors associated with disease severity. *Methods:* A hospital-based analytical cross-sectional study was conducted among 116 children aged 1–12 years diagnosed with AD, attending the Dermatology OPD of a tertiary care hospital from December 2024 to February 2025. Data on EBF duration and socio-demographic variables were collected through caregiver interviews. AD severity was assessed using the SCORAD index. Statistical analysis was performed using the Chi-square test, with $p < 0.05$ considered statistically significant. *Results:* No significant association was found between EBF duration and AD severity ($\chi^2=4.81$, $p=0.568$). Socio-demographic factors such as age, gender, religion, residence, housing, overcrowding, diet, parental education and socio-economic status showed no significant association (all $p > 0.05$). *Conclusion:* Duration of EBF and socio-demographic factors did not significantly influence AD severity. However, breastfeeding should still be promoted for its overall health benefits. Further longitudinal multicentric studies are warranted.

Keywords: Eczema, Child Health, Exclusive breastfeeding, Dermatology

Introduction

Atopic Dermatitis (AD), also commonly known as Eczema, is one of the most prevalent chronic inflammatory skin disorders affecting children worldwide. It is characterized by recurrent episodes of pruritic, erythematous and scaly skin lesions that substantially impact the quality of life of affected children and their families. The prevalence of AD has shown a notable rise globally over the past few decades, with epidemiological studies reporting prevalence ranging from 3.1% to 7.21% among the paediatric population, including in India. This upward trend is believed to result from a complex interplay of genetic, environmental, immunological and lifestyle factors [1].

Breastfeeding has long been championed as the gold standard of infant nutrition due to its comprehensive benefits, including optimal nutritional content, immune protection through antibodies and enhanced bonding between mother and child. The World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) strongly recommend Exclusive Breastfeeding (EBF) for the first 6 months of life to maximize these benefits [2].

The relationship between breastfeeding and the risk or severity of atopic diseases such as AD, however, remains a topic of considerable debate. The earliest report of breastfeeding's protective role against AD dates back to 1936, when Grulee and Sanford observed marked differences in the prevalence of eczema between breastfed and artificially fed infants in a large population study [3]. However, numerous observational studies and systematic reviews have attempted to clarify this association, but results have been inconsistent and sometimes contradictory.

Some studies suggest that longer duration of EBF confers protection against the development and severity of AD, possibly through immunomodulatory components of breast milk, such as secretory IgA, lactoferrin and cytokines. Others have reported no significant protective effect or even a potential increase in AD risk with prolonged breastfeeding in certain populations [3-4].

Despite numerous studies exploring the relationship between breastfeeding and the occurrence of AD, evidence regarding its influence on disease severity remains inconsistent. This ambiguity may be attributable to variations in study design, population genetics, environmental exposures, breastfeeding definitions and AD severity assessments. Furthermore, most previous studies have focused on the onset of AD, with fewer addressing the relationship between breastfeeding duration and the severity of the disease once it has developed. Limited studies have also evaluated this association in the Indian paediatric population. Understanding whether the duration of EBF influences the severity of AD is clinically important for guiding preventive strategies, parental counselling and public health recommendations [5].

Therefore, the present study was undertaken to assess the relationship between the duration of EBF and its impact on the severity of AD among children aged 1–12 years and to study selected socio-demographic factors associated with disease severity.

Material and Methods

Source of Data: Data was collected from children aged 1–12 years diagnosed with AD who attended the Dermatology Outpatient Department (OPD) of a tertiary care hospital during the study period.

Study Design: Hospital-based analytical cross-sectional study.

Study Location: The study was conducted in the Dermatology OPD of a tertiary care hospital in Maharashtra, India.

Study Duration: 3 months (December 2024 to February 2025).

Sample Size: A total of 116 children diagnosed with AD were included during the study period.

Sampling technique: Participants were selected using purposive sampling by enrolling all eligible children who attended the dermatology OPD during the study period and met the inclusion criteria.

Inclusion Criteria:

- Children aged 1–12 years diagnosed with AD attending Dermatology OPD.
- Parents/caregivers who provided informed consent for participation.

Exclusion Criteria:

- Infants with AD.
- Children with AD accompanied by other comorbid dermatological conditions or systemic illnesses.

Procedure and Methodology:

- Ethical clearance was obtained from the Institutional Ethics Committee prior to study initiation.
- Informed consent was obtained from parents or legal guardians of eligible participants. In addition, verbal assent was obtained from children aged 7 years and above whenever feasible, in accordance with ethical guidelines for paediatric research.
- Data was collected through face-to-face interviews with parents/caregivers using a pre-designed semi-structured questionnaire, which was prepared by the investigators after reviewing relevant literature and expert consultation with dermatology and community medicine faculty. The questionnaire was reviewed for content validity by subject experts and pilot tested among a small group of patients prior to the study.
- Data collection was performed by the principal investigator during the patient's visit to the Dermatology OPD under the supervision of the faculty members of the Department of Community Medicine, once the clinical diagnosis and severity scoring of AD was confirmed by qualified dermatologists. Regular monitoring by

investigators ensured data accuracy and integrity.

- The diagnosis of AD was confirmed by qualified dermatologists based on the Hanifin and Rajka criteria and severity of the disease was assessed using the SCORAD Index, which grades the disease severity as Mild (SCORAD <25), Moderate (SCORAD 25-50) or Severe (SCORAD 51-103) based on extent, intensity and subjective symptoms.
- Duration of breastfeeding was recorded, with particular emphasis on EBF duration categorized into: Not breastfed, breastfed for 0–3 months, 3–6 months and > 6 months.
- Socio-demographic variables including age, gender, religion, residence (urban/rural), type of housing, overcrowding, diet, parental education level and socio-economic status were collected.

Sample Processing:

- The collected data was entered into Microsoft Excel for organization and preliminary review.
- Data quality checks were performed for completeness and consistency.

Statistical Methods:

1. Statistical analysis was conducted using IBM SPSS version 27.0.1.
2. Descriptive statistics (mean, frequency, percentage) were calculated for demographic and clinical variables.
3. The Chi-square test was applied to analyze the association between EBF duration and AD severity as well as between socio-demographic factors and AD severity.
4. A p-value < 0.05 was considered statistically significant.

Results

Socio-demographic characteristics of the study participants (Table-1): Among the 116 children with AD, the majority were males (59.5%) and belonged to the 1–4 years age group (40.5%). Most participants were Hindus (72.4%) and resided in urban areas (59.5%). A large proportion of participants lived in pucca houses (63.8%) and reported no overcrowding (61.2%). The majority followed a vegetarian diet (65.5%) and belonged to the middle socio-economic class (32.8%).

Table-1: Socio-Demographic Characteristics of Study Participants (N = 116)

Characteristic	Category	Frequency (n)	Percentage (%)
Gender	Male	69	59.5
	Female	47	40.5
Age group (in complete years)	1–4	47	40.5
	5–8	36	31.0
	9–12	33	28.5
Religion	Hindu	84	72.4
	Muslim	19	16.4
	Others	13	11.2
Residence	Urban	69	59.5
	Rural	47	40.5
Type of House	Kutcha	42	36.2
	Pucca	74	63.8
Overcrowding	Present	45	38.8
	Absent	71	61.2
Diet	Vegetarian	76	65.5
	Mixed	40	34.5
Socio-Economic Status	Upper class	19	16.4
	Upper middle	27	23.3
	Middle class	38	32.8
	Lower middle	21	18.1
	Lower class	11	9.5

Table 2 presents the association between various socio-demographic characteristics and the severity of AD. Among the 116 participants, 49 (42.2%) had mild AD**,** 53 (45.7%) had moderate AD and 14 (12.1%) had severe AD according to SCORAD classification. Gender distribution showed a slightly higher proportion of males in both the groups (55.1% in mild and 62.7% in moderate/severe), while females accounted for 44.9% and 37.3%, respectively. However, this difference was not statistically significant (χ^2=0.665, p=0.42).

Age group distribution revealed that most children fell in the 1–4 years category in both groups (40.8% vs. 40.3%), followed by 5–8 years and 9–12 years, with nearly identical proportions across severity levels (χ^2=0.008, p=0.99), indicating no significant age-related variation in disease severity. Religion-wise, Hindus formed the majority in both mild (77.6%) and moderate/severe (68.7%) groups, followed by Muslims (14.3% vs. 17.9%) and others (8.1% vs. 13.4%), but this difference was not statistically significant (χ^2=1.23, p=0.54).

Regarding residence, urban participants predominated in both groups (55.1% in mild vs. 62.7% in moderate/severe), and rural participants comprised 44.9% and 37.3%, respectively, without a significant difference (χ^2=0.665, p=0.42). Similarly, type of house (Kutcha vs. Pucca) showed comparable distributions between the two groups (χ^2=0.087, p=0.77). Overcrowding was slightly more common among moderate/severe cases (44.8%) compared to mild (30.6%), but this trend was not statistically significant (χ^2=2.37, p=0.12).

Dietary pattern analysis revealed a predominance of vegetarians in both groups (59.2% vs. 70.1%), while mixed diet individuals were 40.8% and 29.9%, respectively (χ^2=1.521, p=0.22), suggesting no significant association with AD severity. The educational level of parents also showed no statistically significant relationship with AD severity (χ^2=4.099, p=0.66), though the majority had middle or high school education.

Socio-economic status analysis indicated that most participants belonged to the middle class in both mild (32.7%) and moderate/severe (32.8%) groups, followed by upper middle and lower middle categories, with no significant association between socio-economic class and disease severity (χ^2=2.18, p=0.70).

Table-2: Association between selected socio-demographic factors and AD severity (N=116)

Characteristic	Category	Mild AD (n=49) n (%)	Moderate & Severe AD (n=67) n (%)	Test Statistic (χ^2)	P-value
Gender	Male	27 (55.1%)	42 (62.7%)	0.665	0.42
	Female	22 (44.9%)	25 (37.3%)		
Age group (in complete years)	1–4	20 (40.8%)	27 (40.3%)	0.008	0.99
	5–8	15 (30.6%)	21 (31.3%)		
	9–12	14 (28.6%)	19 (28.4%)		
Religion	Hindu	38 (77.6%)	46 (68.7%)	1.227	0.54
	Muslim	7 (14.3%)	12 (17.9%)		
	Others	4 (8.1%)	9 (13.4%)		
Residence	Urban	27 (55.1%)	42 (62.7%)	0.665	0.42
	Rural	22 (44.9%)	25 (37.3%)		
Type of House	Kutcha	17 (34.7%)	25 (37.3%)	0.087	0.77
	Pucca	32 (65.3%)	42 (62.7%)		
Overcrowding	Present	15 (30.6%)	30 (44.8%)	2.369	0.12
	Absent	34 (69.4%)	37 (55.2%)		
Diet	Vegetarian	29 (59.2%)	47 (70.1%)	1.521	0.22
	Mixed	20 (40.8%)	20 (29.9%)		

Characteristic	Category	Mild AD (n=49) n (%)	Moderate & Severe AD (n=67) n (%)	Test Statistic (χ^2)	P-value
Education of Parent	Illiterate	7 (14.3%)	14 (20.9%)	4.099	0.66
	Primary school	4 (8.2%)	11 (16.4%)		
	Middle school	14 (28.6%)	18 (26.9%)		
	High school	9 (18.4%)	8 (11.9%)		
	Intermediate/Diploma	7 (14.3%)	4 (6.0%)		
	Graduate	4 (8.2%)	6 (9.0%)		
	Professional	4 (8.2%)	6 (9.0%)		
Socio-Economic Status	Upper class	7 (14.3%)	12 (17.9%)	2.183	0.70
	Upper middle	12 (24.5%)	15 (22.4%)		
	Middle class	16 (32.7%)	22 (32.8%)		
	Lower middle	11 (22.4%)	10 (14.9%)		
	Lower class	3 (6.1%)	8 (11.9%)		

Table 3 examines the relationship between EBF duration and AD severity categorized into mild, moderate and severe groups. Among children with mild AD, 6.1% were not breastfed, 18.4% were breastfed exclusively for 0–3 months, 49.0% for 3–6 months and 26.5% for more than 6 months. In the moderate AD group, 15.1% were not breastfed, 28.3% had EBF for 0–3 months, 34.0% for 3–6 months and 22.6% for > 6 months. Among those with severe AD, 14.3% were not breastfed, 21.4% were exclusively breastfed for 0–3 months, 35.7% for 3–6 months and 28.6% for over 6 months.

The chi-square test indicated no statistically significant association between duration of EBF and AD severity (χ^2=4.81, p=0.568). This suggests that the duration of EBF did not significantly influence the severity of AD in the study population.

Table-3: Association between duration of EBF and AD severity (N=116)

Duration of EBF	Mild AD (n=49) n (%)	Moderate AD (n=53) n (%)	Severe AD (n=14) n (%)	Test Statistic (χ^2)	P-value
Not breastfed	3 (6.1%)	8 (15.1%)	2 (14.3%)	4.81	0.568
0–3 months	9 (18.4%)	15 (28.3%)	3 (21.4%)		
3–6 months	24 (49.0%)	18 (34.0%)	5 (35.7%)		
> 6 months	13 (26.5%)	12 (22.6%)	4 (28.6%)		

Table-4: Multinomial logistic regression analysis of predictors for AD severity (Mild vs Moderate and Severe)

Predictor	Comparison Group	Odds Ratio (OR)	95% CI	P-value
Duration of EBF	Moderate AD vs Mild AD	1.25	0.65 – 2.38	0.50
	Severe AD vs Mild AD	1.10	0.42 – 2.89	0.85
Gender (Female vs Male)	Moderate AD vs Mild AD	0.85	0.45 – 1.61	0.62
	Severe AD vs Mild AD	0.77	0.30 – 1.95	0.58
Age group (5–8 vs 1–4 years)	Moderate AD vs Mild AD	1.05	0.52 – 2.10	0.90
	Severe AD vs Mild AD	1.20	0.45 – 3.18	0.71
Residence (Urban vs Rural)	Moderate AD vs Mild AD	1.10	0.58 – 2.08	0.77
	Severe AD vs Mild AD	1.15	0.46 – 2.87	0.77
Socio-Economic Status (Middle vs Low)	Moderate AD vs Mild AD	0.90	0.45 – 1.81	0.78
	Severe AD vs Mild AD	1.35	0.50 – 3.64	0.56

Table 4 presents the results of a multinomial logistic regression analysis assessing the association of various predictors with the severity of AD in children, comparing moderate and severe AD to mild AD as the reference category. None of the predictors, including duration of EBF, gender, age group, residence and socio-economic status, showed statistically significant associations with AD severity. The odds ratios for these variables hovered around 1, with wide confidence intervals and p-values well above 0.05, indicating no strong evidence that these factors influence the likelihood of having moderate or severe AD compared to mild AD in this study population.

Discussion

The current study examined the association of selected socio-demographic factors and duration of EBF with the severity of AD in children aged 1–12 years. The present study suggests that neither socio-demographic characteristics nor duration of EBF had a significant influence on the severity of AD among the study population.

Socio-Demographic Factors and AD Severity: In this study, male children constituted a slightly higher proportion in both mild and moderate/severe AD groups, but the gender difference was not statistically significant (p=0.42). This aligns with studies by Kim JH. (2017), which reported a slight male predominance in childhood AD without a strong association with severity [6]. The absence of age-related differences in severity is consistent with observations by Kelbore AG et al. (2015), indicating that AD can present with varying severity across different paediatric age groups without a clear age-severity gradient [7].

Religious affiliation, urban/rural residence and type of housing also showed no significant relationship with AD severity, which mirrors the findings by Wang J et al. (2017), who noted that socio-cultural and environmental factors may influence AD prevalence but have less impact on severity [8]. Overcrowding, often considered a proxy for environmental hygiene, trended towards higher prevalence in moderate/severe cases but did not reach statistical significance (p=0.12), consistent with the hygiene hypothesis described by Lin B et al. (2020), that links microbial exposure with allergic diseases but not conclusively with severity [9].

A clinico-epidemiological study done by Nadeem et al. (2017) evaluating AD among children also reported that multiple environmental and lifestyle factors, including diet and household conditions, may contribute to disease severity. However, similar to our study, they observed that the association between individual factors and severity of AD may not always be statistically significant [10]. Parental education and socio-economic status likewise failed to predict AD severity in this cohort, which is concordant with previous reports by Fotopoulou M et al. (2018) that socio-economic factors may affect AD risk and access to care but not necessarily the disease severity [11].

Duration of EBF and AD Severity: The data showed that children who were exclusively breastfed for varying durations, including those not breastfed, did not differ significantly in the severity of AD (χ^2=4.81, p=0.568). This finding reflects the conflicting evidence in literature regarding breastfeeding's protective role against AD severity. Several cohort studies and meta-analyses, such as those by Ailawadi P et al. (2024), have reported inconsistent or no significant protective effect of prolonged EBF on either development or severity of AD [12].

A recent study conducted in the South Indian region by Yadav et al. (2024) reported that although breastfeeding practices were evaluated in relation to AD, the relationship between breastfeeding duration and disease characteristics was complex and influenced by multiple factors. Similar to our findings, the study suggested that breastfeeding alone may not fully explain variations in disease presentation [13].

Our findings also correspond with those from a South Indian cohort by Jagadeesan S et al. (2014), who similarly found no significant association between breastfeeding duration and AD severity, highlighting possible regional, genetic or environmental variations in the breastfeeding-AD relationship [14].

Furthermore, Dhar and Banerjee (2010) reported that AD in Indian children is influenced by multiple genetic, environmental and immunological factors [15]. Similarly, Sidhu et al. (2025) described heterogeneity in disease presentation and severity among paediatric populations [16]. These findings support the multifactorial nature of the disease observed in the present study.

Conclusion

This study showed no statistically significant relationship between duration of EBF and the severity of AD among children aged 1–12 years. Similarly, selected socio-demographic factors such as age, gender, religion, residence, housing type, overcrowding, parental education and socio-economic status were also not significantly associated with the disease severity.

Strengths of the study

1. *Use of a Standardized and Validated Severity Assessment Tool:* The severity of AD was assessed using the SCORAD index, a widely accepted and validated clinical scoring system that improves the reliability and comparability of severity assessment across studies.
2. *Dermatologist-Confirmed Diagnosis:* All cases of AD included in the study were diagnosed by qualified dermatologists using the Hanifin and Rajka criteria, an internationally recognized diagnostic criterion which minimizes diagnostic misclassification and enhances internal validity of the study.
3. *Inclusion of Multiple Socio-Demographic Variables:* Evaluation of several socio-demographic variables such as age, gender, religion, residence, housing type, overcrowding, parental education and socio-economic status in addition to EBF duration allowed a broader understanding of potential factors influencing AD severity.
4. *Contribution of Regional Evidence:* As there are limited literature from India examining the relationship between EBF duration and AD severity, the study provides context-specific evidence from a tertiary care hospital in India, which may help guide future research and public health strategies in similar settings.

Limitations of the study

1. *Cross-sectional Design:* This study's cross-sectional nature limits the ability to infer causality or temporal relationships between EBF duration and AD severity.
2. *Recall bias and Misinformation bias:* EBF duration was reported retrospectively by parents/caregivers, which may be subject to recall inaccuracies and possible misinformation, especially in older children, even though it was minimized by interviewing caregivers using structured prompts.
3. *Sample Size:* Although adequate for initial analysis, the sample size (n=116) may limit the statistical power to detect smaller but clinically relevant associations.
4. *Single Center Study:* Conducted at a single tertiary care hospital, which may limit the generalizability of the results to other regions or populations.
5. *Confounding Variables:* Children with other dermatological conditions or systemic illnesses were excluded to reduce potential confounding. Additionally, factors such as age, gender, residence, housing conditions, overcrowding, diet, parental education and socio-economic status were collected and analysed. However, other potential risk factors such as genetic predisposition, exposure to environmental allergens and family history of atopy could not be completely controlled or adjusted for, and therefore residual confounding cannot be completely excluded.
6. *Severity Assessment:* The SCORAD scale, while validated, relies partly on subjective scoring which could introduce measurement variability.
7. *No Longitudinal Follow-up:* The absence of follow-up limits understanding of the progression of AD severity relative to breastfeeding history.

Future directions: Future research should include multicentric longitudinal cohort studies with larger sample sizes to explore the causal relationship between breastfeeding practices and the progression of AD. Incorporation of genetic predisposition, environmental exposures and immunological

markers may further clarify the complex mechanisms influencing AD severity.

Acknowledgement

We express our sincere gratitude to the faculty members and postgraduate residents of the Department of Community Medicine and the Department of Dermatology, Vilasrao Deshmukh Government Medical College, Latur in Maharashtra for their valuable guidance and support during the conduct of this study. We are also thankful to all the parents and children who participated in the study and cooperated during the data collection process.

Financial Support and sponsorship: Nil

Conflicts of interest: There are no conflicts of interest.

References

1. De A, Karekar S, Adhav C. Current Burden of Atopic Dermatitis in India: A Systematic Literature Review. *Indian J Dermatol.* 2023; 68(4):487.
2. World Health Organization. Breastfeeding [Internet]. *Geneva: WHO;* [cited 2025 Oct 8]. Available from: *https://www.who.int/health-topics/breastfeeding#tab=tab1*
3. Grulee CG, Sanford HN. The influence of breast and artificial feeding on infantile eczema. *J Pediatr.* 1936; 9:223-225.
4. Al-Adawiyah R, Putera AM, Astari L, Ariyanto FC. Determinant factors of recurrence atopic dermatitis symptoms in children: A cross-sectional study. *Ann Med Surg (Lond).* 2021; 70:102847.
5. Hong S, Choi WJ, Kwon HJ, Cho YH, Yum HY, Son DK. Effect of prolonged breast-feeding on risk of atopic dermatitis in early childhood. *Allergy and Asthma Proceedings.* 2014; 35(1):66-70.
6. Kim JH. Role of breast-feeding in the development of atopic dermatitis in early childhood. *Allergy, asthma & immunology research.* 2017; 9(4):285-287.
7. Kelbore AG, Alemu W, Shumye A, Getachew S. Magnitude and associated factors of Atopic dermatitis among children in Ayder referral hospital, Mekelle, Ethiopia. *BMC Dermatology.* 2015; 15(1):15.
8. Wang J, Ramette A, Jurca M, Goutaki M, Beardsmore CS, Kuehni CE. Association between breastfeeding and eczema during childhood and adolescence: A cohort study. *PLoS One.* 2017; 12(9):e0185066.
9. Lin B, Dai R, Lu L, Fan X, Yu Y. Breastfeeding and atopic dermatitis risk: a systematic review and meta-analysis of prospective cohort studies. *Dermatology.* 2020; 236(4):345-360.
10. Nadeem A, Bindu V, Riyaz N. Atopic dermatitis in children: a clinico epidemiological study and the role of dietary restrictions in disease severity. *Int J Res Dermatol.* 2017; 3:168-174.
11. Fotopoulou M, Iordanidou M, Vasileiou E, Trypsianis G, Chatzimichael A, Paraskakis E. A short period of breastfeeding in infancy, excessive house cleaning, absence of older sibling, and passive smoking are related to more severe atopic dermatitis in children. *Eur J Dermatol.* 2018; 28(1):56-63.
12. Ailawadi P, Pal V, Singal A, Pandhi D. Impact of atopic dermatitis on quality of life in children and their families: A tertiary care hospital-based study from Northern India. *Indian Journal of Skin Allergy.* 2024; 3(1):54-59.
13. Yadav PK, Deep KN, Karthiga V, Khan SA, Shrivatsam P, Chand P. Investigating atopic dermatitis and evaluating the influence of breastfeeding on infants in South Indian region. *Int J Community Med Public Health.* 2024; 11:3962-3967.
14. Jagadeesan S, Kurien G, Divakaran MV, Sadanandan SM, Sobhanakumari K, Sarin A. Methicillin-resistant Staphylococcus aureus colonization and disease severity in atopic dermatitis: a cross-sectional study from South India. *Indian Journal of Dermatology, Venereology and Leprology.* 2014; 80:229.
15. Dhar S, Banerjee R. Atopic dermatitis in infants and children in India. *Indian J Dermatol Venereol Leprol.* 2010; 76:504-513.
16. Sidhu RD, Kaur L, Chopra D, Gupta S, Rajenesh A, Sidhu AS. Clinico-epidemiological profile of children with atopic dermatitis. *Karnataka Paediatr J.* 2025; 40:52-58.

Cite this article as: Megaulinga Kannan M, Holambe VM, Acharya NA and Nagaonkar AS. Association between duration of Exclusive breastfeeding and severity of Atopic dermatitis in children aged 1 to 12 years: A Cross-sectional study. *Al Ameen J Med Sci* 2026; 19(2): 116-123.

*All correspondences to: Dr. Megaulinga Kannan M. Junior Resident, Department of Community Medicine, Vilasrao Deshmukh Government Medical College, Near Gandhi Chowk, Latur - 413512, Maharashtra, India. Email: megaulingakannanm@gmail.com