Evolving Issues and New Treatment Approaches to Psoriasis: What the PCP Needs to Know

Wednesday, April 8, 2015
2:00 pm – 3:15 pm
Anaheim, California
Session 5: Evolving Issues and New Treatment Approaches to Psoriasis: What the PCP Needs to Know

Learning Objectives
1. Incorporate therapeutic strategies that manage the systemic manifestations and comorbidities associated with psoriasis
2. Assess the risk-benefit profiles of conventional and emerging treatments for psoriasis to assist in therapeutic decision making
3. Recognize the physiological and psychological impacts of psoriasis, counsel patients accordingly, and incorporate care coordination and active patient engagement to improve outcomes in patients with psoriasis

Faculty

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Dr Sylvia Hsu graduated cum laude from Rice University in 1985 and Baylor College of Medicine in 1989. She did her internship at the University of Pennsylvania and her dermatology residency at Jefferson Medical College. After her training, she stayed at Jefferson as an assistant professor of dermatology. Dr Hsu moved back to Houston in 1997 to be on faculty in the department of dermatology at Baylor College of Medicine. Dr Hsu is professor of dermatology and chief of dermatology at Ben Taub General Hospital. She has a special interest in autoimmune bullous diseases, psoriasis, and acne. Dr Hsu was president of the Houston Dermatological Society in 2006. She was a member of the editorial board for the Journal of the Academy of Dermatology and the Medical Board of the National Psoriasis Foundation. She is also a member of the advisory board for Dermatology World.

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Dr Paul Yamauchi practices at the Dermatology Institute and Skin Care Center and is on staff at St. John's Hospital, Santa Monica and the Ronald Reagan Hospital at the UCLA Medical Center. He is a clinical assistant professor of medicine at the David Geffen School of Medicine at UCLA and adjunct associate professor at the John Wayne Cancer Institute. Dr Yamauchi serves as a principle investigator in several studies of psoriasis, skin cancer, rejuvenation, rosacea, eczema, and acne. He is a key opinion leader in psoriasis and speaks extensively on new advances in the treatment of psoriasis and other dermatologic conditions. He has written several articles on the use of botulinum toxins and fillers for rejuvenation and other indications as well as advances in laser treatment. Dr Yamauchi serves on the editorial board of the Scientific World Journal and has authored numerous publications. He has published extensively on new advances in the treatment of psoriasis as well as on topics of acne, eczema, skin manifestations associated with rheumatologic conditions, and hyperhidrosis.
Planning Committee and Faculty Financial Disclosure Statements

The planning committee reported the following:

**Alan Menter, MD:** **Advisory Board** for AbbVie, Allergan, Amgen, Boehringer Ingelheim, Genentech, Janssen Biotech, Inc., LEO Pharma and Pfizer, **Consultant** for AbbVie, Allergan, Amgen, Convoy Therapeutics, Inc., Eli-Lilly, Janssen Biotech, Inc., LEO Pharma, Novartis, Pfizer, Syntrix, Wyeth and XenoPort, **Investigator** for AbbVie, Allergan, Amgen, ApoPharma, Boehringer Ingelheim, Celgene, Convoy Therapeutics, Eli-Lilly, Genentech, Janssen Biotech, Inc., LEO Pharma, Merck, Novartis, Pfizer, Symbio/Maruhco, Syntrix and Wyeth and **Speaker** for AbbVie, Amgen, Janssen Biotech, Inc., LEO Pharma and Wyeth.

The presenting faculty reported the following:

**Dr Hsu:** No relevant financial relationships to disclose.

**Dr Yamauchi:** **Consultant** for AbbVie, Amgen, Baxter, Janssen-Ortho, Inc., Novartis and Pfizer, Inc., **Speaker** for AbbVie, Amgen, Galderma USA, Janssen-Ortho, Inc., Leo Pharma, Inc., Novartis Pharmaceuticals Corporation, **Investigator** for Amgen, Celgene Corporation, Galderma USA, Janssen-Ortho, Inc., Leo Pharma, Inc., Lilly ICOS, LLC, Pfizer, Inc. and **Advisory Board** for Lilly ICOS, LLC.

Education Partner Financial Disclosure Statement

The content collaborators at Vindico Medical Education no relevant financial relationships to disclose.

Suggested Reading List


Management of Psoriasis Patients: What the PCP Needs to Know

Objectives

- Improve management of systemic manifestations of psoriasis and its comorbidities
- Learn about the risks and benefits of conventional and emerging psoriasis treatments
- Recognize the psychological impacts of psoriasis and incorporate care coordination to improve patient outcomes

Psoriasis (sō-rīˈə-sis) [Gr., an itching]

A common, genetically-determined dermatosis most commonly consisting of discrete erythematous plaques with a characteristic silvery scale.

An inflammatory arthritis is associated with psoriasis in approximately 30% of patients.
**Epidemiology**

- **Age of onset**
  - Bimodal – 1st peak – age 15-20 years, 2nd peak - age 55-60 years
  - Onset earlier than 15 years of age may indicate more severe disease

- **Family history**
  - Up to 33% patients report family history
  - HLA-Cw6, B13, B17, Bw57

**Psoriasis: Clinical Features**

- Chronic immune-mediated disease
- Psoriatic plaques
  - Erythema (redness)
  - Induration (thickening)
  - Desquamation (scaling)
- Affected areas of the body
  - Symmetric
  - Extensors (elbows, knees)
  - Scalp
  - Trunk
- No permanent cure

**Psoriasis: Differential Diagnosis**

- Plaque psoriasis
  - Well-demarcated, erythematous plaques with thick, silvery scale

**Psoriasis: Differential Diagnosis**

- Eczema
  - Pruritic dry skin with poorly defined erythematous patches, papules, and plaques, with fine scale

- Tinea Corporis
  - Flat, scaly patch with a raised, palpable border. Enlarges by advancing outer border, leaving a clear center

**Psoriasis: Differential Diagnosis**

- Contact Dermatitis
  - Erythematous, edematous plaques with linear or geometric patterns
Psoriasis: Differential Diagnosis

- Mycosis fungoides
- Scale is not thick
- More common on trunk and proximal extremities

Psoriasis: Differential Diagnosis

- Drug Eruptions
- Many presentations, but may be exanthematous, urticarial, blistering, or pustular.

Types of Psoriasis

- **Plaque Psoriasis**: Comprises 80% of all psoriasis cases.
- **DDx**: eczema, tinea corporis, mycosis fungoides

Types of Psoriasis

- **Guttate Psoriasis**: Small droplet lesions. Frequently first manifestation of psoriasis, can develop into plaque psoriasis. Often precipitated by streptococcus throat infection.
- **DDx**: pityriasis rosea, secondary syphilis, morbilliform drug eruption

Types of Psoriasis

- **Scalp Psoriasis**:
- **DDx**: seborrheic dermatitis, allergic contact dermatitis, dermatomyositis

Types of Psoriasis

- **Palmoplantar Psoriasis**: Scaly plaques on palms and soles.
- **DDx**: dyshidrosis, keratoderma
Types of Psoriasis

- **Pustular Psoriasis**: Sterile pustules. Can be precipitated by withdrawal of systemic steroids.

- **Erythrodermic Psoriasis**: Generalized erythema with scale. Can be precipitated by withdrawal of systemic steroids.
- **DDx**: pityriasis rubra pilaris, mycosis fungoides, drug eruption

Types of Psoriasis

- **Inverse Psoriasis**: Psoriasis in the flexural (intertriginous) areas
- **DDx**: Candidal intertrigo, dermatophytosis, erythrasma

Psoriasis-associated Comorbidities

1. Psoriatic arthritis
2. Obesity/metabolic syndrome
3. Cardiovascular disease
4. Cancer/lymphoma
5. Psychiatric diseases
6. Increased mortality

All statistically validated


Associated Comorbidities

- Personal behaviors, e.g. smoking
- Autoimmune diseases
- Nonalcoholic steatohepatitis (NASH)
- COPD
- Sleep apnea

All statistically validated

Risk of Cardiovascular Disease in Patients with More Severe Psoriasis

Clinical Significance:
1. Increased risk of MI, stroke, cardiovascular death, diabetes, chronic kidney disease
2. 5 years of life lost
3. 10-year risk of major CV event attributable to psoriasis = 6%
4. Risk of cardiovascular disease in patients with severe psoriasis similar to risk conferred by diabetes mellitus

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<tr>
<td>MACE</td>
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<td>Diabetes</td>
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<td>CKD</td>
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Comorbidities: Cardiovascular Disease

Psoriasis: An Opportunity to Identify Cardiovascular Risk

- Risk factor evaluation and interventions:
  - Obesity
  - Hypertension
  - Diabetes mellitus
  - Cardiovascular Disease

Comorbidities: Psoriatic Arthritis (PsA)

- An inflammatory arthritis in approx 30% of patients with psoriasis
- Temporal relationship between psoriasis and PsA
  - 70% have psoriasis prior to onset of PsA
  - 20% have PsA before psoriasis
  - 10%-15% report simultaneous onset
- Severity of psoriasis is not predictive of severity of PsA

Psoriasis: Unmet Needs and Undertreatment

Patient Satisfaction with Treatment

- National Psoriasis Foundation study
  - Physician unwillingness to prescribe systemic therapy was the 3rd most common reason why patients were on topical monotherapy (fewer adverse effects than other options, 2nd - psoriasis not severe enough)
- Netherlands study (N=1293)
  - Patients receiving biologic therapy were most satisfied and those receiving topical treatment were least satisfied of all groups

Case Presentation
Case

- A 45-year-old woman
- PMH: Type 2 diabetes mellitus, asthma
- Treatment History:
  - Recently completed a 7-day course of oral steroids for an acute asthma exacerbation.
  - She is taking metformin for her diabetes.
- HPI: She presents to your office with a 4-day history of erythematous patches, plaques, and multiple pustules over most of her body surface area.
- Vitals/Labs: Temperature: 99.5°F. BP: 124/84 mm HG bilaterally. CBC: normal.

Psoriasis is Not Simply a Skin Disease

Psoriasis is not just a cosmetic disfigurement or skin disease. Psoriasis significantly impacts QOL comparable to, if not more, than most other systemic diseases.

Summary: Psoriasis Treatment, Inflammation, and Comorbidities

- With inflammation as a common link, systemic treatment of psoriasis may also mitigate comorbidities
  - anti-TNF therapy may decrease CV morbidity and mortality
- Understanding risks of psoriasis \(\rightarrow\) better treatment decisions \(\rightarrow\) improved QOL and outcomes

Examining the Risk-Benefit Profiles of Current and Emerging Treatments

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Agenda

- Discuss:
  - Safety concerns with conventional systemic agents
  - Biologics and their place in management
  - Novel oral systemic agents
  - Development of biosimilars

Assessing Severity of Psoriasis

- Imagine 1 palm equal to 1% of your body surface area.
  - Mild: 1-3%
  - Moderate: 3-10%
  - Severe: More than 10%
- Location also determines severity
  - Scalp
  - Hands and feet
  - Groin and skin folds
Treatment Overview

- Topical agents
- Phototherapy
- Oral systemic agents
- Biologics
  - Anti-TNF agents
  - IL-12/23 antagonists
  - IL-17 antagonists
  - Biosimilars
- Novel oral systemic agents
  - JAK kinase inhibitors
  - IL-23 antagonists

IL-17: Interleukin-17, JAK: Janus Kinase, TNF: Tumor Necrosis Factor

AAD Recommendations: Psoriasis Management

Psoriasis +/- psoriatic arthritis

- Anti-TNF +/- MTX

UVB/PUVA

Topicals/targeted phototherapy

Limited disease

Extensive disease

Lack of effect

Topical Therapy

- High efficacy : safety ratio
- May be used as adjunctive therapy to ultraviolet, systemic, or biologic therapy
- Inappropriate candidates for topical monotherapy:
  - Extensive disease
  - Limited, recalcitrant disease

Topical Steroids

CLASS 1 – Superpotent
- Clobetasol propionate
- Diflucinhexone dipropionate
- Betamethasone dipropionate
- Halobetasol propionate

CLASS 2 – Potent
- Betamethasone dipropionate
- Mometasone furoate
- Fluocinonide
- Diflucinhexone dipropionate
- Desoximetasone

CLASS 3 - Upper Mid-Strength
- Triamcinolone acetonide
- Fluticasone propionate
- Betamethasone valerate
- Desoximetasone

CLASS 4 - Mid-Strength
- Triamcinolone acetonide
- Fluocinolone acetonide
- Mometasone furoate

CLASS 5 - Lower Mid-Strength
- Flurandrenolide
- Fluticasone propionate
- Prednicarbate
- Desonide
- Hydrocortisone butyrate
- Hydrocortisone sodium succinate
- Fluocinolone acetonide

CLASS 6 – Mild
- Desonide
- Alclometasone dipropionate

CLASS 7 - Least Potent
- Over the counter 0.5-1% Hydrocortisone cream

Topical Steroids: Adverse Events

- Tachyphylaxis
- Skin atrophy
- Telangiectasias
- Striae
- Discoloration
- HPA axis suppression

Phototherapy

- Phototherapy
  - Ultraviolet light B (UVB)
  - Broadband
  - Narrowband
  - PUVA (drug psoralens plus ultraviolet light A)
  - Home light boxes

Lillian W. Wong, BA, Faranak Kamangar, BSc, Tien V. Nguyen, BA, John Y.M. Koo, MD. *Skin Therapy Letter.* 2012;17(5).
Phototherapy

- Exposure to ultraviolet light
  - Continuous, intermittent therapy
- Meaningful response in 60% to 70% of patients
- Risks:
  - Burning
  - Skin cancer
  - Premature aging
- Does not treat psoriatic arthritis
- Labor intensive and usually impractical → requires frequent visits to office (3 visits per week), but can be self-administered at home by appropriate patient

When to Initiate Systemic or Biologic Therapy

Reasons for Systemic Treatment

- Poor or no response to topicals, UVB, PUVA therapy
- Received maximum “safe” cumulative PUVA dose
- Psoriasis covers > 10% BSA
- More inflammatory forms of psoriasis
- Localized/recalcitrant disease
- Physical restrictions
- Negative impact on QOL
- Status of disease
  - (PASI > 10, BSA > 10, DLQI > 10)

Traditional Oral Systemic Therapy

Methotrexate
Cyclosporine
Acitretin

Methotrexate: Efficacy/Safety

- Most commonly prescribed traditional systemic agent globally for psoriasis
  - Dramatically effective, even in the most severe cases
- Can be used in combination with all approved biologics for psoriasis, especially the anti-TNFs
  - Can be used to suppress anti-drug antibodies against adalimumab and infliximab

Safety

- Pregnancy issues
- Clinical efficacy relative to biologics
- Drug interactions
- Polymorphisms
- Liver biopsies and amino-terminal propeptide of type III collagen (PIIINP)
- Bone marrow suppression
- Lifetime dose restriction

Cyclosporine: Efficacy/Safety

- One of the most effective interventional therapies
- Rapid response in 80-90% of patients
- Induces rapid remission in patients with severe flares
- Can prevent rebound flares in patients discontinuing systemic steroids

Safety

- Irreversible nephrotoxicity/hypertension with continued usage
- Malignancy – rare
- Dyslipidemia and metabolic issues
- Infections, including TB – rare
- Use limited to 1 year in the U.S. due to nephrotoxicity

Acitretin: Efficacy/Safety

- Least effective as monotherapy
- Often used with UVB or PUVA phototherapy
- Acitretin may be effective in patients with palm-sole psoriasis
- Not immunosuppressive and can be used in combination with biologics

Safety

- Teratogenicity
  - Limits use
- High doses associated with mucocutaneous effects, including hair loss
- Hyperlipidemia
**Conventional Agents: End-Organ Toxicity**

- End-organ toxicity is a major concern common to conventional systemic therapy.
- Toxicities of individual agents can be decreased by rotating from one conventional agent to another.
- Biologics have decreased the incidence of end-organ toxicity.
  - Use of biologics has decreased the need for rotational therapy.


**Newer Oral Agent: Apremilast: Efficacy/Safety**

**Efficacy**
- Inhibits PDE4 (phosphodiesterase-4) and increases cAMP levels intracellularly.
- Indirectly immunomodulates production of inflammatory cytokines.
- Approved for psoriasis and psoriatic arthritis.

**Safety**
- No lab monitoring required.
- Diarrhea.
- Headache.
- Weight loss.
- Depression/suicide.


**Current and Emerging Biologics**

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<th>Drug Class</th>
<th>Agent</th>
<th>Indication (Psoriasis, PsA)</th>
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<td>Anti-TNF</td>
<td>Etanercept</td>
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<td>Infliximab</td>
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<td>Adalimumab</td>
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<td>IL-12/23 antagonist</td>
<td>Ustekinumab</td>
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<td>IL-17 antagonist</td>
<td>Secukinumab</td>
<td>Psoriasis, in Phase III for PsA</td>
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<td></td>
<td>Brodalumab</td>
<td>In Phase III for Psoriasis and PsA</td>
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<tr>
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<td>Ixekizumab</td>
<td>In Phase III for Psoriasis and PsA</td>
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**Trends in Biologic Use in Psoriasis in the United States**

- "Step therapy"  
  - Phototherapy
  - Then oral systemics
  - Then biologics

Both AAD and NPF support the use of biologic as a first-line agent for moderate to severe patients.


**Biologic Agents: Safety Profile Considerations in Psoriasis**

- **Key considerations**
  - Infections: Bacterial, viral, mycobacterial
  - Malignancy (Solid tumors and non-melanoma skin cancer)

- **Other considerations**
  - Infusion/injection-site reactions
  - Contraindications/cautions
    - Tuberculosis
    - Hepatitis B (TNF inhibitors)
    - Demyelinating diseases (TNF inhibitors)
    - Congestive heart failure (TNF inhibitors)


**When a Patient is on a Biologic Agent**

- Avoid administering live vaccines
  - Intranasal flu vaccine, herpes zoster, varicella, measles/mumps/rubella, oral polio, rotavirus, yellow fever, rabies, BCG, typhoid
- Inactivated or subunit vaccines are generally considered safe but efficacy may be compromised
- Monitor for signs or symptoms of infection
  - Opportunistic fungal infections
  - Reactivation of latent TB, underlying hepatitis B/C, shingles
- What if a patient becomes pregnant?
- Surgery

*BCG: Bacillus Calmette-Guérin, HBV: Hepatitis B Virus, HCV: Hepatitis C Virus, HIV: Herpes Zoster Virus, TB: Tuberculosis*
Prior to Initiating an Anti-TNF-α Biologic Agent

• Ensure patient is up-to-date on all vaccinations
• Verify negative TB test
• Assess underlying cancer risk
• Verify absence of demyelinating disease
• Verify absence of current infection
• Screen for Hepatitis B and C viral infections
• Use caution in patients with active CHF

Current and Emerging Oral Therapies

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<tr>
<td></td>
<td>LY3009104</td>
<td>Phase IIb: Psoriasis</td>
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TB: Tuberculosis, CHF: Congestive Heart Failure

Biosimilars

• Not to be interchanged with the term “generics”
• They are not exact protein copies of the originators (the branded biologic)
• Although the mechanism of action is similar to the originator, they are manufactured by a different cell line.
• TNF inhibitors being considered first

Case Presentation

Case: Overview

• 51 year-old male
• Height: 5 ft 11 in, Weight: 245 lbs
• BMI = 33.2 kg/m²
• History of psoriasis since age 22 yrs
• Occupation – college professor
• Family history of psoriasis
  – Father
• Family history of cancer
  – Leukemia: Mother
  – Colon cancer: Father
• Social history
  – Social drinker (1 glass wine per day with dinner)
  – Smoking - 1 pack per day

• Past medical history
  – Hypertension
  – Hyperlipidemia
• Medications
  – Atorvastatin
  – Hydrochlorothiazide
• Prior therapies for psoriasis
  – Topical steroids
  – Phototherapy
• Physical exam
  – Psoriatic plaques on scalp, elbows, arms, knees, legs
  – 40% body surface area
  – No evidence of dactylitis,
  – No tender or swollen joints
  – No signs of enthesitis
Case: Laboratory Values

• Quantiferon Gold: Negative
• CBC – WNL
• LFTs – 1.5x higher than upper limit of normal
• Hepatitis B panel – Negative
• Hepatitis C panel – Negative
• Total cholesterol – 202 mg/dL
• Triglycerides – 175 mg/dL

Summary

• Conventional systemic agents can be effective in managing psoriasis and inducing remission, but their use is limited by teratogenicity and toxicity.
• Psoriasis treatment strategies are moving away from step therapy and more towards first-line use of biologics in patients with moderate to severe disease.
• Patients on biologics are immunosuppressed which must be taken into consideration when administering vaccines and monitoring for infections and possible malignancy.

Incorporating Shared Decision Making With Patients

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Agenda

• Review the psychosocial impacts of psoriasis
• Identify adherence-improving methods
• Discuss the importance of the coordination of care and referrals

Psoriasis and Quality of Life (QOL)

• Nearly half of patients with psoriasis prefer a different serious medical condition (e.g. hypertension, asthma)
• 83% need to hide their psoriasis
• 74% with lowered self confidence
• 46% chronically depressed
• 83% avoid sports activities (swimming)
• 35% inhibited in sexual relationships
• 23% affected choice of career
• 10% between the ages of 18-34 years contemplated suicide

What Role Do Quality-of-Life Issues Play in the Decision-making Process before Initiating a Plan of Treatment?
**Current Systemic Treatments For Psoriasis**

- **Quality-of-Life Issues**
  - How frequently do primary care physicians do QOL estimations in clinical practice?
  - Does the inability to wear a black jacket or shorts/short sleeves make systemic treatment more feasible?
  - Do problems with loved ones/peers make systemic treatment logical?
  - Do co-existent PsA make systemic treatment essential?

**Patient Perception of Treatment**

- Frustrated With Treatment: 78%
- Only Somewhat / Not at All Satisfied With Treatment: 49%
- Treatment Not Aggressive Enough: 32%

**Emotional Impact of Psoriasis**

1. Concern That Disease Would Worsen: 88%
2. Feelings of Embarrassment: 91%
3. Feelings of Unattractiveness: 79%
4. Depression: 54%
5. Contemplation of Suicide: 10%

5.5% of psoriasis population have reported suicidal ideation (up to 10% in patients < 35 years). In the general medical patient population, this figure is at 2.4% - 3.3%.

**Social Impact of Psoriasis**

- Adults with severe psoriasis were more likely to become romantically involved with patients with psoriasis.
- Adults with severe psoriasis reported that their health negatively impacted their work.

**Psoriasis Affects Employment**

- Adults without psoriasis were not likely to become romantically involved with patients with psoriasis.
- Adults with severe psoriasis reported that they have lost a job because of their health condition.

**Factors Involved in Treatment Decisions**

- Co-morbidities
- Psoriasis
- Social
- Disease Severity

Treatment is designed to meet the patient’s individual needs.
Summary: Psoriasis Challenges and Quality-of-Life Issues

- We have many challenges!
- We must consider QOL issues at each visit.
- We owe it to our psoriasis patients and our colleagues to use systemic therapies appropriately!
- We must consider the full list of comorbidities at each visit, including PsA evaluation.

Adherence and Adherence Improving Methods

The Problem of Non-adherence

- Maintenance therapy is required for long-term treatment success.
- Discontinuation rates for conventional systemic and phototherapy range from 15%-25%.
- First-year attrition rates for biologics range from 10%-15%.
- Patients most likely to be non-adherent tend to be: Men, unmarried patients, those who are unemployed, patients who drink or smoke, and patients with more severe disease.


The Most Common Reasons Cited for Discontinuation

- Loss of efficacy
- Lack of initial response
- Adverse events
- Inconvenient administration

Practical Strategies to Improve Adherence

- Schedule a follow-up visit shortly after treatment initiation
- Ask patients about preferred vehicle for topical therapy
  - Gels and creams vs ointments
- Build patient trust by:
  - Being empathetic, listening to the patient, physically examining their skin, practicing good communication skills
- Clarify treatment goals in the context of patient expectations
- Provide cues to medication administration (e.g., setting a phone reminder, environmental cues, behavioral cues)


Practical Strategies to Improve Adherence

- Educate patients about psoriasis as a disease state
- Provide information about diagnosis, drug dosing, and treatment duration
- Provide an in-office demonstration showing how to properly apply/administer the prescribed medication
- Assure patient understanding by asking them to repeat back treatment instructions
- Provide information about alternative treatment options

Coordination of Care

- Involve other healthcare providers in the education, follow-up, and long-term care of patients
- Study was conducted on patients with psoriasis or eczema
  - Patients randomized to standard of care or receiving an additional session with a dermatology specialist nurse immediately after their physician consultation
  - At 6 weeks:
    - Both groups showed similar improvement in QOL
    - Patients who saw the nurse:
      - Had significantly more knowledge about treatment duration*
      - Knew how to obtain a repeat prescription*
      - Knew who to contact for support**

*P<0.01
**P<0.001

When to Refer to a Dermatologist

- Defined treatment goals are not met
- Patient dissatisfaction with treatment outcomes
- Discomfort with treating moderate to severe disease
- Psoriasis patients with multiple comorbidities

Case Presentation

Case: Palmoplantar Psoriasis

- 66-year-old male
- History of psoriasis since age 51 years
- Comorbidities:
  - Depression
  - Hyperlipidemia
- Physical Exam:
  - Significant involvement of palms and soles
  - 40% of both palmar and plantar aspects affected
  - Face, scalp, genitalia, groin
  - Significant impact on patient’s quality of life, i.e., pain when walking and limitation of the use of his hands

Treatment

Prior Therapies
- Scalp and genital area responded well to topical agents:
  - Corticosteroids
  - Tacrolimus

Treatment Decision:
- Acitretin was initiated at dose of 25 mg daily; moderate degree mucocutaneous side effects noted
- Acitretin dose reduced to 25 mg on alternate days: Improvement maintained with reduction in cheilitis
- Palmoplantar areas were recalcitrant to topicals and photochemotherapy. Examples of agents tried:
  - Corticosteroids
  - Vitamin D₃
  - Combination topical treatment, including occlusion
  - Topical PUVA

Summary

- Psoriasis is a systemic inflammatory disease often requiring systemic treatment
- Conventional systemic agents are limited by safety concerns such as teratogenicity and end-organ toxicity
- New oral and biologic agents are safe and effective treatment options
- Biologics may be used first-line in moderate-severe psoriasis
- Psychosocial concerns must be taken into account when determining treatment regimens
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<th>Brand</th>
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