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Advancements in Atopic Dermatitis Care: Targeting IL-31 with Nemolizumab

Announcer:
You're listening to *DermConsult* on ReachMD, and this episode is brought to you by Galderma Laboratories. And now, here's your host, Dr. Brian McDonough.

Dr. McDonough:
This is *DermConsult* on ReachMD, and I'm Dr. Brian McDonough. Joining me to discuss recent advancements in IL-31 targeted therapies for atopic dermatitis is Dr. Tina Bhutani. She's an Associate Adjunct Professor of Dermatology at the University of California San Francisco School of Medicine and the owner of Synergy Dermatology. Dr. Bhutani, thanks for being here today.

Dr. Bhutani:
Thank you for having me.

Dr. McDonough:
To start off, Dr. Bhutani, can you tell us about the latest therapeutic approaches to atopic dermatitis that target IL-31?

Dr. Bhutani:
Sure. It's a really exciting time for our patients with atopic dermatitis because we have lots of new treatment options that are already available or in the pipeline—particularly, the treatments that are targeting something called IL-31. We have a new treatment available called nemolizumab. It was approved earlier this year for the treatment of atopic dermatitis, and it's really providing a new mechanism of action for our patients. That's always good with a disease like atopic dermatitis, where it can be quite complex. So it's nice to have treatments with different mechanisms.

With the nemolizumab, which targets IL-31, what we're seeing is that patients not only do well as far as with their skin disease—it obviously improves—but so does their itch. And that's important because in atopic dermatitis, itch is one of the most troubling and debilitating symptoms that patients have. It causes them to not sleep and not be able to carry on with their daily activities. And so what we're seeing with nemolizumab is an improvement in both skin disease and itch. And we see this not only in the long term, which is important for a chronic disease like atopic dermatitis, but we're also starting to see it quickly as well. So within the first few weeks of starting therapy, patients are starting to notice an improvement in their symptoms, which is great.

Dr. McDonough:
So Dr. Bhutani, how do patient-specific factors like disease severity, comorbidities, and prior treatment play a role in deciding if an IL-31 targeted therapy is the right approach?

Dr. Bhutani:
Most systemic therapies for atopic dermatitis are indicated for patients with moderate to severe disease, so that means that they usually have a significant amount of their skin affected. But to me, I also think about moderate to severe disease as patients who have a significant impact on their quality of life. So I think it really needs to be a more holistic approach to how we define moderate to severe atopic dermatitis. So I always kind of take in both the patient factors, kind of what they're dealing with, as well as what I'm seeing on their skin.

And then, as we just mentioned, you want to definitely make sure that you're taking itch into account, because you can't see the itch on the skin, so it's really important to ask the patients what their itch levels are, how they're sleeping at night, how it's impacting their

everyday living.

As far as prior treatments and how they play a role, again, most of the time in order to get these drugs approved, most patients will have to have at least tried some topical therapies. Oftentimes, they might have had to try phototherapy or another systemic agent sometimes to get these drugs approved. But again, because our treatment options with atopic dermatitis are really still quite limited, although it's growing, we don't usually have too many problems getting access to these drugs, which is great.

Dr. McDonough:
For those just tuning in, you're listening to DermConsult on ReachMD. I'm Dr. Brian McDonough, and I'm speaking with Dr. Tina Bhutani about advancements in atopic dermatitis therapies that target IL-31 signaling.

And after we've determined a patient should receive an IL-31 targeted therapy, what are some best practices for incorporating it into a personalized care plan?

Dr. Bhutani:
So for the first few weeks of treatment, they want to be diligent with not only their new systemic treatment, but also with topicals. And so I usually will co-prescribe patients with topicals. And what I let them know is if they're really diligent with using the topicals in the very beginning, that helps to get that inflammation level to a more manageable place, and that will help that systemic therapy to start working a little bit faster. So in the beginning, I always co-prescribe a systemic agent with topical therapy.

Then I like to do some checkpoints with the patients. I usually like to see them about one or two months into starting therapy. And usually this is a visit where, first of all, we can see if they're having those quick results that we might expect. But if they're not having those quick results, which we sometimes see as well—for some patients, it just takes a little bit longer—this is also a great time to really just hand-hold and let them know that this is still within the normal limits and to continue with therapy. Because it's at this point where if patients aren't starting to see significant improvement, they might just give up on therapy. But I always let them know that some patients just take a little bit longer to respond, and so they should continue with it. But it's another touchpoint where, again, if they're not seeing that efficacy, I can have them be more diligent with their topicals during that point in time. And then I usually do another checkpoint at about three to six months, and that's when we're going to determine whether this is a sustainable therapy for them and if this is effective for them in the long term. Because by that point, we should know once they get their maximal effects for the treatment.

With atopic dermatitis, it's also important that with any treatment plan that we prescribe them, we also have our patients doing their regular, gentle skin care routine. So with atopic dermatitis, make sure that they're moisturizing, they're taking care of their skin, they're not taking super hot showers, and they're not using a lot of fragrances or things with preservatives. So they really want to focus on products that are made for sensitive skin. All of those things are really important to continue to educate our patients on. Just because we can get their disease much better with these medications, they still need to be taking care of their skin health.

Dr. McDonough:
Before we wrap up our program, Dr. Bhutani, do you have any final takeaways you'd like to leave with our audience regarding IL-31 targeted therapies for atopic dermatitis care?

Dr. Bhutani:
Yeah. So with the advent of these IL-31 therapies, like I said, we have a new mechanism of action for our patients. And because it works differently, we can try it for our patients who may have even tried and failed maybe multiple other therapies. They still have a reasonable chance of getting an effect with this medication because it works in a different way and it targets a new kind of neuroimmune access, which we know is important for our patients with atopic dermatitis, especially those patients who have significant amounts of itch. So again, you don't have to avoid this treatment because patients have tried and failed other things in the past. This is definitely something to try.

Dr. McDonough:
Well, with those key takeaways in mind, I want to thank my guest, Dr. Tina Bhutani, for joining me to discuss IL-31 targeted therapy for atopic dermatitis. Dr. Bhutani, it was great having you on the program.

Dr. Bhutani:
Thank you so much.

Announcer:
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