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Enhancing Care in Moderate to Severe Psoriasis: Treatment Selection

Announcer:
Welcome to CME on ReachMD. This activity titled Enhancing Care in Moderate to Severe Psoriasis - Treatment Selection is provided by Clinical Care options LLC and the Partners for Advancing Clinical Education, PACE, and is supported by educational grants from Novartis. Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Ms. Kucera:
Hello, I'm Kristine Kucera. I'm a Physician Assistant at U.S. Dermatology Partners and the Clinical Associate Professor of PA Studies at UT Southwestern Medical Center in Dallas, Texas, and I will be your moderator. With that, I'm pleased to introduce our next two speakers, Dr. Steven Feldman and Melodie Young. Dr. Feldman is a Professor of Dermatology at Wake Forest University School of Medicine in Winston Salem, North Carolina. And Ms. Young is a Nurse Practitioner at Mindful Dermatology and Modern Research Associates in Dallas, Texas. And today they are here to teach us about enhancing care in moderate to severe psoriasis.

These are their disclosures.

And now we'll move to our learning objectives. Today we're going to describe the efficacy and safety profiles of current and emerging therapies for the treatment of moderate to severe psoriasis.

Okay, jumping into our case study. This is Jocelyn. She's a 36-year-old nurse practitioner and she has severe psoriasis. She has about a 30-year history of moderate to severe disease with various topical agents that she's used in the past. She has not seen a provider for several years due to a negative experience with the medical system, misdiagnosed as a child. She does have mild depression that's treated with an SSRI. And now she's learning about other treatment options in school and interested in finding a provider that will include her as a part of the team. We're going to move on and we're going to actually listen to a patient perspective video on the impact of uncontrolled psoriatic disease on quality of life.

Patient:
My name is Jocely Davenport. I was diagnosed with psoriasis 30 years ago when I was 6 years old. After being diagnosed with psoriasis, my psoriasis was very severe, it covered probably more than 90% of my body at the time. It was very difficult being a child with psoriasis. And they were little treatments. And it wasn't until I was age 35 that my psoriasis really became controlled.

Having uncontrolled psoriasis does impact the overall quality of life. Having spots on your skin that cover your complete body, from your scalp to your toes, was a big thing for me. I dealt a lot with bullying because people didn't know what it was. I was bullied about it often in the summer months. I will often want to wear turtlenecks and pants, and you know, my parents wouldn't want me to do that. But people staring at you doesn't make you feel more confident about it. Even as a preteen, I was very, very self-conscious about it. I did not want people looking at me. In my adult years, it mostly affected my legs and my elbows, so I would get jokes even as an adult when people say my elbows were ashy. So you know, trying to make sure that they stay moisturized. And the medications that they had me applying to my skin, it wasn't helping much, which is why in my adult years, I reached out to a different provider, and I went to see a dermatologist instead of having my primary care doctor look into treatments for me.

Ms. Kucera:
A very interesting video on how a patient actually perceives her quality of life with psoriatic disease. Now I'm going to go ahead and move the slide presentation to Melodie Young and she's going to take us forward from here. So welcome, Melodie.

Ms. Young:
Thank you. So I want to just present this one slide to you that helps you understand what patients feel and the experience they're having when they come into a clinic. So I have more than 30 years of experience of taking care of people, primarily focusing on psoriasis. And sometimes what we think their perspective is can be quite different from reality. And so, this is interesting to me as well. It's just how prevalent psoriasis is within the United States.

So there - this is a pie chart showing the data over between 2007 and 2012. And they found that 1.7 million people who have insurance, so this is from an insurance claim database, in the United States have moderate to severe psoriasis. And as the presentation goes on, we're going to talk a little bit more about what moderate to severe psoriasis is and how it's defined and what it looks like.

But what's also really, really interesting is if you look at the pie chart, almost half, 42% of patients with moderate to severe disease, so this is significant disease, are using topical therapies. And then a small piece, 3%, are using phototherapy, which is light treatment, primarily what we call narrowband UVB. And then about a third are using traditional oral systemic agents, things again that we'll talk about in more detail. And then a small portion, so 22%, are actually using a biologic agent. So, despite all these, all the advertisements you see on television and you hear about with biologics, only a small portion or a moderate portion, are using biologic agents.

And what's also interesting in this survey, 59% of people had not been treated within the past year. So during that period of time, again, a small portion of folks were actually being treated, only about 41% had had any kind of treatment in the last year. And then out of all those that had been treated, there were about half of patients were no longer continuing to get treatment. So let that kind of soak in. They're not likely to have been treated within the last year. And if they had been, half of those, so half of that 41%, are no longer under care. So again, no matter how you look at these treatment options, what they done, it's very unlikely that the patient that you see or presents to you is going to have been given therapy are going to continue to be on therapy.

Okay, so now I'm going to hand off - I'm going to click it over to the next slide, and Dr. Feldman is going to take it from here.

Dr. Feldman:
Yeah, Melodie, thanks so much. I'm Steve. Steve Feldman. I've been running a Psoriasis Treatment Center for about the last 30 years. And when I took over our Psoriasis Treatment Center, I was kind of lost because I had patients with bad psoriasis I'd been giving them to Michael to manage. So I needed a simple algorithm. And this is my simple approach. So I make the diagnosis of psoriasis. And then I remind myself to address patients' psychosocial needs, because it is not natural for me to do it. And so I need that reminder. And I found the Psoriasis Foundation has been a huge help to me for helping patients with their psychosocial needs.

The next thing I try to do is remember to ask all my patients about joint symptoms. And if they're having joint symptoms, morning stiffness, joint pain, or back pain, any of those, I want them to see a rheumatologist. Some people say, 'Steve, well, you could - you're - you know, you're a doctor, you can manage psoriatic arthritis.' I'm like, 'No, I'm a dermatologist. I need to send them to a rheumatologist.' I once asked a rheumatologist what screening I should do, and they recommended the morning stiffness, the back pain, and the joint pain. They also mentioned fatigue, which I wasn't going to ask because all of my patients are fatigued. And then I asked the rheumatologist, 'Well, what - if I identify any of those patients who are having symptoms, what physical exam should I do?' And they said, 'Oh, do a complete musculoskeletal examination, including range of motion and an evaluation of gait?' And I'm like, 'No, I'm not doing that. If that's the standard, I'm going to send them to y'all.'

Okay, so I will screen for this psoriatic arthritis. And then I decide does the patient have limited disease or extensive disease? If they have limited disease, which I define as they can reasonably put topicals on all their spots, then I give them topicals. And I do my best to get them to use them, which is really tough because adherence to topical therapy is abysmal. I think half the prescriptions don't even get filled for topical therapy. And if they do get them, they tend not to use them very well. If it's more extensive disease where topicals aren't going to be effective, just aren't practical, then I think about phototherapy. I like biologics. If an insurer makes me, I would prescribe methotrexate.

But this is just my algorithm. It's not the only algorithm out there. One of the algorithms from the National Psoriasis Foundation looks more like this. You make the diagnosis of psoriasis and then the first step would be look for joint symptoms. And if they're having psoriatic arthritis, pick a treatment that works for both. If there's no psoriatic arthritis, then you can look for mild disease, which you could treat with topicals or targeted light treatment. Or if it's more extensive, then you do something that treats all the lesions at once, along maybe with some topicals to resistant lesions.

I don't particularly like this algorithm, because it's suggested if you have any skin disease and any joint symptoms you need - you ought

to be treating with one drug that works for both. And I'm thinking well, wait a minute, if somebody has mild psoriatic arthritis and the rheumatologist has evaluated, it's not destructive, there's no loss of range of motion, there's no joint destruction on x-ray films, and the rheumatologist decides, well this patient only needs ibuprofen for their psoriatic arthritis. And if all their skin involvement is just a spot on the elbow or knee and just needs a little topical therapy, I don't know that they need one treatment that works for both. But aside from that, I think this is - this algorithm is a very reasonable approach as well.

A lot of the most exciting research being done in dermatology today, I think, is on the comorbidities of the inflammatory skin diseases that we see. So, in addition to psoriatic arthritis, patients with psoriasis that are higher risk of cardiovascular disease and a host of other issues, as shown on this slide. And it's as though the inflammation affects pretty much every organ system in the body. And this is important. The cardiovascular impact of psoriasis is meaningful. If you have severe psoriasis, you die sooner. I don't know if it's all from the psoriasis. But after accounting for other factors, it looks like psoriasis is an independent cause of cardiovascular disease, an independent risk factor. And the young adults are especially at increased risk. If you look at a 60-year-old, the relative risk for severe psoriasis, what's like 40% higher; if you're 30, you might have like a threefold increased two- or threefold increased risk of having a heart attack. And that sounds really bad.

When you look across a whole array of comorbidities, you find higher relative risk for diabetes, lymphoma, and depression, cardiovascular disease, the melanoma risk was sixfold higher. But these are relative risks, and when you're thinking about comorbidities and risks and making treatment decisions, you should not base treatment decisions on relative risk, you need to make treatment decisions based on absolute risk.

When a study was done that looked at those relative risk levels and then calculated a sort of a measure of absolute risk. So take melanoma, yes, there was a sixfold increased risk of melanoma, but the study was done in Taiwan where almost nobody has melanoma. And that sixfold increased risk meant that you would have to see 20,000 patients with psoriasis before you would see 1 more melanoma due to the psoriasis. And so, you know, I like to keep that in mind when evaluating these issues of cardiovascular health. I think people should have a healthy diet, they should keep their cholesterol under control. But if a 30-year-old came to us with severe psoriasis, came to see me and said, ‘Oh my god, I just read that I'm at a threefold risk of having a heart attack because of psoriasis. I don't know what to do.’ I would tell them, ‘Ah, I don't pay that any mind,’ you know, because the likelihood the 30-year-old without psoriasis is going to have a heart attack is not zero, but it's pretty close to zero, and three times that is still pretty close to zero. So I would caution the person you know, get some regular exercise, watch your diet, your cholesterol is high, maybe talk to somebody about taking a statin. But we should keep these things in perspective. I personally have an elevated cardiovascular risk because of my cholesterol being so high, I'm in a 30% increased risk of having an MI, which means my baseline risk is 7%. If I took a statin and got my cholesterol under good control, it would drop 30% from 7% to 5%. Which, you know, is not a lot to write home about.

Okay, well we don't know if psoriasis treatments reduce cardiovascular risk of psoriasis, but assuming they did, if they completely eliminated it, if they were just as good as a statin for reducing the risk, yeah, it's probably still a small benefit. I think patients need these treatments because their psoriasis is so bad. And so, with that, let's switch to talking about these treatments. And to the - I'm going to give you back to Melodie. Thank you.

Ms. Young:
So these are the newer biologic agents that have been listed, as well as some new oral agents that are on the market and more things likely to come. We have TNF as a class. And then they're - the next sort of thing that happened was IL-12/23 inhibitor, which is ustekinumab. The two that we see as very psoriasis-specific classes are the IL-23 inhibitors and the IL-17 inhibitors for speed of onset, maintenance, and a little bit cleaner safety profiles, particularly than the TNF inhibitors. And then those small molecules that we mentioned with the JAK inhibitor of tofacitinib, and then apremilast, a PDE4 inhibitor.

And the treatment options for pediatric patients are also improving. And that's really exciting. So I have unfortunately seen a lot of damage to children from things that maybe we've considered to be safe. There has been significant damage from long-term use of corticosteroids, topically or systemically, with children. A lot of times they don't like calcineurin inhibitors because of their complaint that it stings and burns, and it's for real, and that will definitely affect their ability to do it. And then, of course, phototherapy we've used and it can be effective. But it's also problematic and cumbersome for families and kids in school and co-payments. And then with the IL-17 inhibitors with ixekizumab and secukinumab, being down to age 6. And these are weight based. And if you want to use them, you know, just check with whatever app you use to help you be familiar with weight-based dosing in children, because their effectiveness and their ease of use is really remarkable. And we do have good data to drive those decisions.

Okay, back off to Dr. Feldman.

Dr. Feldman:
Thanks so much, Melodie. These drugs are really remarkably safe in my opinion. We have TNF inhibitors, and they were revolutionary

to my practice, but I tend not to use them anymore, at least not to start patients on them anymore, because I have newer drugs that are more effective and safer. With TNF inhibitors, there is probably - there's certainly some increased risk of infection. I think the infection risk is double, which sounds bad. It goes from maybe 1% to 2%. Another way to look at that as you're going from 99 out of 100 and not getting a serious infection to 98 out of 100 not getting a serious infection. We also wouldn't use it in a patient with a history of demyelinating disease or congestive heart failure, bad congestive heart failure.

Interleukin 12-23 inhibitor, ustekinumab, also revolutionary when it came out because it was as effective as a TNF inhibitor, safer, and so few injections, and it also works for inflammatory bowel disease. That's great. I'm not sure it has much in the way of side effects, those TNF inhibitors, the issue of the box warnings.

The newer agents, the IL-17 drugs, highly effective. They work fast. One of them, brodalumab, is associated with a REMS program for suicidal ideation and behavior. The IL-17 drugs probably should be avoided in patients with inflammatory bowel disease unless absolutely needed, because there is a tendency for them to make inflammatory bowel disease worse.

The IL-23 drugs may not be as fast-acting as the IL-17 drugs, but they're very effective. And they don't seem to have that inflammatory bowel disease risk that the IL-17 drugs have. The oral agent, apremilast, it's not that well tolerated. There's associated nausea and diarrhea. But if patients can put up with it, you know, it's modestly effective.

Ms. Young:
This is just a summary slide that you might want to look at that really focuses on some of the things that he mentioned before as far as comorbidities. And really, I think all you have to - for the TNF inhibitors, if they have a history of a demyelinating disorder, you know, that's probably not the way you want to go. If they have a history of depression, they – you may or may not choose to use brodalumab, but it just means you have to monitor it the same for apremilast. And if they have a history of a diagnosed inflammatory bowel disease, like ulcerative colitis or Crohn's disease, you probably would not want to choose an IL-17 inhibitor. Fortunately, some of the other classes of drugs will work on multiple diseases. So you would probably choose the TNF inhibitor or the ustekinumab that we mentioned earlier. So, there are ways that you can treat these patients with other diseases, but also be able to avoid the problems that can come up.

Ms. Kucera:
And I will actually pass it to Dr. Feldman.

Dr. Feldman:
Kristine, thanks so much. So this slide is really lovely and you can see rates of getting high levels of success at 90% improvement in the PASI score. And the PDE4 inhibitor doesn't get a lot of people there. Etanercept, one of the TNF inhibitors, doesn't either. Now the other TNF inhibitors are pretty potent drugs. Some of those drugs that block IL-23 are very effective, and those IL-17 drugs, also very effective.

We have other drugs coming. I feel blessed that we have - so many times I thought I'm never going to see another quantum leap forward in psoriasis treatment again. And then, you know, I find that we do. There's an IL-17A/F receptor antagonist coming that, based on the data available so far, looks even more effective for the skin and joint. And so we have another IL-17 smaller molecule in development. The tyrosine kinase 2 inhibitors, so deucravacitinib now available for us to treat patients. I think it has an efficacy level in the short run similar to adalimumab. And then interleukin-36 inhibitor was recently approved earlier this month for generalized pustular psoriasis.

Alright, Kristine, I'm going to give it to you for a couple more questions.

Ms. Kucera:
Okay, thank you. We have gotten to the end of our time. Dr. Feldman, Melodie, you have enlightened us with so much information. We appreciate you so much being here. And thank you.

Hello, I'm Kristine Kucera. I'm a Physician Assistant at U.S. Dermatology Partners and a Clinical Associate Professor of PA studies at UT Southwestern Medical Center in Dallas, Texas, and I will be your moderator. With that, I'm pleased to introduce our next two speakers, Dr. Steven Feldman and Melodie Young Dr. Feldman is a Professor of Dermatology at Wake Forest University School of Medicine in Winston Salem, North Carolina. And Ms. Young is a Nurse Practitioner at Mindful Dermatology and Modern Research Associates in Dallas, Texas. And today, they are here to teach us about enhancing care and moderate to severe psoriasis.

These are their disclosures.

And now we'll move to our learning objectives. Develop treatment regimens for patients with moderate to severe psoriasis based on treatment characteristics and patient preferences.

Okay, jumping into our case study. This is Jocelyn. She's a 36-year-old nurse practitioner and she has severe psoriasis. She has about a 30-year history of moderate to severe disease with various topical agents that she's used in the past.

She has not seen a provider for several years due to a negative experience with the medical system, misdiagnosed as a child. She does have mild depression that's treated with an SSRI. And now she's learning about other treatment options in school and interested in finding a provider that will include her as a part of the team. We're going to move on and we're going to actually listen to a patient perspective video on the impact of optimal management on quality of life, a video.

Patient:
As promised, by the end of the 8 weeks, my skin was completely clear of the psoriasis. Doing the injections monthly, just trying to make sure that it stays away or it has not come back. But she did tell me that I have some discoloration where my psoriasis patches were. She told me that by continuing that medication, my skin will eventually even-tone. But it might take about a year to 2 years for that to happen. But I'm okay with that because it's better than walking around with a body full of sores and scaly patches on your skin.

Ms. Kucera:
Now I'm going to go ahead and move the slide presentation to Melodie Young and she's going to take us forward from here. So welcome, Melodie.

Ms. Young:
And the National Psoriasis Foundation but it's a really important group of volunteers that really help guide the NPF and guide all of their membership towards treatments and research. And one of the things that they came up with that is really interesting is sort of the treatment target. And so, all the things that we do, there seems to be a number that - a numbers game as far as tight control. We if we want to tightly control someone's LDL, their hemoglobin A1c, their blood pressure, we sort of know the numbers that we're shooting for. And the National Psoriasis Foundation came up with this goal. The Medical Advisory Board did have saying that the treatment target to have psoriatic disease, well controlled, is to mean they have less than 1% body surface area. So 1% body surface area is the hand, the entire hand, palm, fingers included. And a lot of times with these new therapies, what patients are left with is, you know, a collection of small spots rather than just, you know, one big spot. But the overall goal, that is the treatment target. So sometimes that requires a treatment-specific therapy that we need to do that has shown us what the efficacy rates are, and then also the reassessment through time and follow-up, and not just assuming that the patient is using the treatment the way we want, and then maintaining that level of clearance.

So there is an initiation phase, you know, they come in with bad disease, and over a period of 12, 16, 24 weeks, depending on what the data is when we should have the expectation of improvement, and then being able to put them into maintenance phase. And a lot of clinicians will see these folks in the treatment initiation piece to monitor not just for efficacy, but any sort of adverse event and as well as adherence, maybe every 3 months initially, and then be able to go every 6 months, or even longer, as long as that patient is stable.

So as I just mentioned, 1% body surface area is that patient's hand. So if they're a little person or a big person, kind of look at what their hand is, and then look at the plaques and patches around their body and sort of place them on the hand and say that's about how much they have. Patients tend to overestimate how much they have, and clinicians who are experienced at calculating the BSA, you know, are going to be much more scientific. Again, this is a numbers game. So, we historically - if you decide if a patient has mild, moderate, or severe disease strictly based on body surface area, and that is one factor that we include, but not the only factor, 3% - less than 3% would be considered mild. And this could be small bits of psoriasis scattered about. A lot of times you're going to find it in in the locations at the back of the scalp or in around the ears, genital areas, gluteal cleft, knees, elbows, hands and feet, shins. Those are common areas that you need to look. So if a patient comes in and says I have this, you go, they have mild disease. Make sure you do a full exam and look all over because sometimes they're not showing you something or they don't even realize that they have more extensive disease. So once they hit the 3% mark from 3 to 10%, now that is considered moderate disease. If you're again, you're looking at BSA. And from 10% on, that is considered severe disease. So remember back to the slide I presented earlier that we know of insured through an insurance database, claim database, that 1.7 million Americans have this moderate to severe disease.

And then the areas that you often - that we mentioned before, that we would consider if they have mild disease, and sometimes moderate disease, or even if they have severe disease and they're mostly clear, but they have a little bit left, that's not fully cleared, you could have a biologic agent, for example, that cleared this patient, you know, 90%, 95%, but they could still be left with some disease. And so, a lot of times what we do dermatology loves topicals. That's - topicals are, you know, the one thing that we do that's different than most of the rest of medicine, and that is using topical therapies. And so we all sort of identify our - we all use corticosteroids for all these different inflammatory diseases and we find our favorites that we like, We make decisions based on the potency, you know, from a class 1 all the way down to a class 7, and then also what the base is. If you're doing a hair-bearing area, if you want a more sort of greasy or creamy type of treatment, we have all of those available now. And so, since the skin is different from one into the other, what

we historically had to do is they might have one therapy for their scalp, something different for their ear, or something different for their face and genitals, and something totally different for tougher areas like around the hands or knees. And so, it's - there's an art to it. And it's a lot to choreograph as a clinician and as a patient.

And then we also have some really exciting new topical therapies that have come into the marketplace and they're showing - they're now even looking at their PASI improvement scores with these topicals. So, we've all been very familiar with calcineurin inhibitors, which are not FDA approved to treat psoriasis, but there's a lot of data out there. And they have been used a lot of times in intertriginous areas if a patient can tolerate it. They are considered relatively safe and can have some help. And then the vitamin D analogues again, they can be sort of slow out of the gate if you're using them by themselves and not as widely utilized anymore. But these new ones are pretty impressive. The PDE4 inhibitor, roflumilast, just got its FDA approval down to age 12. And it has on the label for the first time ever for a topical that it can be used in what we would call delicate areas where you worry about skin damage from using steroids, including the intertriginous folds and creases, which is, you know, commonly seen in psoriatic patients. And then tapinarof also, which got in the label, now it's an adult-only therapy, but it also has some opportunity even for remission, or freedom of treatment once a patient gets cleared with it. So these new topical therapies, and especially the last 2 I mentioned, roflumilast and tapinarof, they don't have time limits like the steroids do, which may be just a couple of weeks, then you have to get off of them or take a break. So that's really exciting and something new that we're going to have to offer.

Methotrexate is, I don't even know if we should say it's mediocre drug, it's kind of I would say it's a, you know, if I were giving it a grade maybe a C+. Now I have some patients that do beautifully on it. But I have a whole lot of patients that may not be able to tolerate it. It can be something that, you know, they do have some PASI score data with it. But it's a third to up to 60% of people can, within 4 months achieving a PASI 75. And for most folks, that's not acceptable. And it's not likely to breach that treatment target of maintenance at 1%. And it is used a lot of times, especially in the rheumatology world, in combination with some biologics, particularly the TNF inhibitors, they seem to be enhanced by the use of methotrexate. And it's dosed weekly. It's tricky, you have to really watch liver, bone marrow function and liver enzymes, there's a lot of drug-drug interactions, it should not be used in males or females when conception is possible or likely. So it's not just a concern with the women. And there is concern about alcohol use. So it's not my favorite thing to be used in a young adult population. And in an older adult because of polypharmacy and bone marrow concerns, I don't particularly like it for that either.

Cyclosporine historically has been a fast-acting drug. It can kind of rescue a patient when they're in trouble. I remember when it became FDA approved back in the 90s. But it has a 1-year limit. And you have to do a lot of labs on this drug as well just like methotrexate because there can be some kidney impact. And you can see hypertension, you can also see pseudotumor cerebri with this, particularly in young women. A lot of drug-drug interaction, you cannot - they can't have grapefruit when they're on it. So it's tricky to use. But sometimes, I think most of the time, it's just been sort of to rescue a patient when they have a big exacerbation of disease.

And then acitretin, again, old drug, it has - is not necessarily an inexpensive drug, so for being generic, it's still a little costly. And there is a sweet spot for acitretin; you can overmedicate a person. And what I mean by that is it may not have any systemic effect, it may bump their cholesterol up a little bit. You stay on it for a longer period of time. You can also see some other concerns that will happen if they take high dose for long periods of time. But they will have mucocutaneous side effects. And so what we've learned in dermatology is to combine it and use low dose acitretin, or to maybe with phototherapy or just in sort of more moderate cases. And so, it has some efficacy, but it is also a drug that I would never use in a female that ever had the potential for childbearing because if it's longevity and staying in the body, and it has definitely been - it's a retinoid, it's a systemic retinoid. So it and methotrexate are 2 drugs you have to use with great caution related to reproduction.

So these are the newer biologic agents that have been listed as well as some new oral agents that are on the market, and more things likely to come. And particularly, the oral agents are used more by rheumatologists than in derm, with the exception of apremilast. We have TNF as a class. And there are things that patients can inject themselves or infliximab can be administered intravenously. It's got good coverage for Medicare. So, you know, sometimes we have to use that with the elderly population. And then there - the next sort of thing that happened was IL-12/23 inhibitor, which is ustekinumab, also used by gastroenterology, rheumatology, and dermatology. The 2 that we see as very psoriasis-specific classes are the IL-23 inhibitors and the IL-17 inhibitors for speed onset, maintenance, and a little bit cleaner safety profiles, particularly than the TNF inhibitors. And then those small molecules that we mentioned with the JAK inhibitor of tofacitinib, and then apremilast, and a PDE4 inhibitor.

Ms. Kucera:
We're going to go to a video now on the impact of effective therapy on disease burden.

Patient:
When visiting with my new provider, she went through my treatment options. We discussed how the results from my topical therapy, the

remaining sores that I had, that was probably as good as my skin would get. And that because my psoriasis was so severe, even in my adult years, that we should try an injectable therapy. And so, we discussed different shots that I can take to control my psoriasis. And she also explained that most of them were just given once a month. And that made it a lot easier too, so it's no more rubbing and creams twice a day or laying in the sun for 30 minutes. And just give yourself a shot once a month. And you'll see the results within 8 weeks. She had me sold on that.

Ms. Kucera:
So, we will now move along. And we'll talk about this. And I will actually pass it to Dr. Feldman.

Dr. Feldman:
Kristine, thanks so much. So, this slide is really lovely. And you see at the top, the most effective agents being IL-17 and IL-23 inhibiting drugs, and an apremilast and etanercept holding up the rear.

Now that said, this slide looks at the quality of life improvement. And here you see that while we saw earlier that etanercept did not get high levels of clearing that we saw with some of the other drugs in very many people, you get a lot of the quality of life improvement with etanercept. And so, some of these biologics, even if they're not the most effective treatment, they get patients feeling much better.

Ms. Kucera:
And I will pass it along to Melodie, and she can chat with us about this in a little more detail.

Ms. Young:
Okay, so we're going to now to kind of move to that objective about, you know, what's - what are the barriers? We have all these fabulous drugs that we've mentioned, good safety profiles, but why are patients not getting their optimal care? And there are a lot of reasons for that. Some of that lies with the blame in dermatology, as some of it with healthcare in general, some, you know, could be issues associated with patients, that we'll mention. So that misdiagnosis occurs a lot, a lot more than it should. Patients may not know what they have, and how to get the help or have sought help and then, you know, don't know how to find somebody that really, really focuses on and specializes in this with that specialty care. And then were they properly examined? In the derm world, it's shocking how many times that we see patients who will say, 'Oh, I've never had a full skin check before,' even when they come in for psoriatic disease. And we need to do better with that.

And psoriasis can be a mimicker with some other dermatoses. And so, it can fool you sometimes. Of course, the care associated costs, we all want to be good stewards of healthcare. Not everyone has good - they may have insurance, but they could be underinsured or the insurance could have limitations of what we can do. People have had bad experiences with dermatology providers or healthcare in general. And then we maybe are not as good at thinking about being widely inclusive in the United States as far as the clinical trial information we need and what will make a patient happy regarding their satisfaction, etc.

And then also, here's an interesting chart that you need to look at and kind of reassess. I think that's part of the scientific process is to reassess and see where are we falling in the Caucasian and in the non-Caucasian populations and in your areas, as far as what could be a barrier to care and what we can do to improve that, because I do think there's room for improvement for every one of us.

So I grew up in rural Missouri, and it's about a minimum of 70 miles to find a dermatologist from where I live. Very, very limited. I currently live in Texas, and we have - more than half of the counties in Texas don't have any healthcare provider at all, much less specialty care. And if you really look at the United States, and there are hot pockets of dermatology providers and dermatology specialists, and even among those, a lot of times they may be more surgically oriented than medical dermatologists. So if you think about the spread of the counties that we have, that don't have good medical dermatology access, particularly with certain ethnic groups and skin, Fitzpatrick skin types, it can make a difference. There are, in my particular county in Texas, there is not a single dermatologist that takes Medicaid. So it's really a problem if, particularly when you have fewer Caucasians in the Medicaid population, and we're not doing a good job of taking care of those folks. And so again, that's something and access to barrier of care that I think is really important. And we are fortunate that NPs and PAs have taken great strides and are making great strides in the derm community of being able to get clinics into some of those less served areas.

And then the other burden has to be with the therapies that we're choosing. And looking at this chart, I hope you'll take a minute to look at it, and it also really talks about what are the issues. And the laboratory testing and the frequency of visits with general systemic therapies can be very cumbersome and an issue that affects patient's satisfaction or the burden of care. And then biologic agents again, sometimes it's the frequency of injections or whether or not it stings that can make a difference. So, this is something we need to think about that again, we can have an impact on.

Ms. Kucera:
I'm going to pass it back to Dr. Feldman.

Dr. Feldman:
Thank you. I could spend a lot of time talking about adherence, but let me just make one thing really clear. Patients are not fully adherent to their treatments. I know it's shocking. Adherence to topicals is abysmal. Adherence to orals is better than topicals, but not great. Adherence to biologics is better than adherence to orals, but still, it's not perfect. And if you have patients on self-injected biologic agents, I would encourage you to ask the patients if they're taking their medicine regularly, but don't phrase it that way. Because if you do, of course, they'll say, 'Yeah, I'm taking it regularly.' Instead, I like to ask patients, 'Are you keeping the extras that you've accumulated refrigerated like you're supposed to?' Because then they think I'm asking you about refrigeration. If they say, 'I don't know what you're talking about, I don't have any extras,' then I know they're taking it correctly. If they say anything else, then I'm not so sure.

One of the things that if you ask patients what bothers them about injections is taking an injection, and patients may prefer medications that require fewer injections. For example, ustekinumab or risankizumab, it's 4 shots a year over something like etanercept at 52 shots a year. But, and some patients don't want to take an injection at all. One of the things that I do is to use a technique called anchoring. I had my minions test this. They took 100 patients with psoriasis who've never been on an injection therapy they asked 50 of them how willing would you be to take an injection once a month for your psoriasis? And their average willingness was only 2 out of 10. The other 50 they asked how willing would you be to take a shot once a day for your psoriasis, and then they asked them the once a month question. Those patients were 7 out of 10 on average willing to take out an injection once a month. In the first group, they're comparing taking a shot to not taking a shot, they don't want to do it. The second group is comparing taking a shot every month to taking one every day, and they're happy to take it every month. So, you know, you could do what I do and tell patients, 'I've got a great medicine for you. It's given by injection every day,' - and did I just say every day? Having another senior moment. It's not every day. You only have taken once a month or every 3 months or whatever the schedule is. Or you could tell patients, but it has to be given like insulin. You know, diabetics take insulin shots 2 to 4 times a day, 'Oh, this isn't exactly like insulin, you don't have to take it 2 to 4 times a day, you know, once a month will do the trick.

Ms. Kucera:
We are going to go into a case study discussion. And I'm going to kick it back over to Dr. Feldman to take us through this case.

Dr. Feldman:
Kristine, thank you so much. Alright, so we've got a 25-year-old who has psoriasis plaque-type psoriasis, covering 8% body surface area. That's pretty much psoriasis. But they're prescribed topical steroids, betamethasone dipropionate 60 grams, and it was not effective. I said they were prescribed topical steroids, I didn't say they filled the prescription. I don't know. I didn't say that if they did fill the prescription, if they put it on. And I'm not even sure 60 grams would get very far; 60 grams might cover the human body once or twice. That means it would cover 8% of the body maybe 12 times if the patient was supposed to use it twice a day, it might be only 6 days' worth of medicine. Not a particularly helpful approach for someone with 8% body surface area.

So light, ultraviolet light therapy was then recommended. The patient could not come to the office 3 times a week, so they tried a tanning bed. I think that's very reasonable. Some dermatologists find it horrible that I would suggest tanning bed has any redeeming social value. But I think they're a great treatment for psoriasis. Melodie earlier talked about how phototherapy can be very inconvenient. You can prescribe home phototherapy that makes it more convenient. Or if you can't find any other form of phototherapy, maybe a tanning bed's a good way to go. And this patient did find it temporarily effective. But gradually it stopped working. Often when things gradually stop working, it's because, well, they stopped doing the treatment.

Now the patient's up to 12% body surface area, the symptoms are getting worse. There's bad genital involvement. There might have been genital involvement earlier, I don't know. We might not have asked the patient. The scalp involvement is particularly bothersome to this patient. And there's joint stiffness. Now there's no diarrhea or other bowel symptoms to suggest any kind of inflammatory bowel disease is a problem for this patient. Patient drinks about a fifth of hard liquor and has elevated lipids.

What are the options for this patient? Well, there's a lot of options but methotrexate is probably not a good choice when you're drinking that much alcohol. Acitretin causes further elevation of lipids. If you wanted to use acitretin, you could, you just would need to use it with a lipid-lowering agent, but it's not going to help the joints. But there's plenty of biologic options that would be good for this patient's severe psoriasis, and their joint symptoms as well.

Now this particular patient was started on ixekizumab. And it didn't seem to help at first, it was associated with severe pain with each injection. The patient had come into the office, the office staff instructed the patient very carefully on how to use the medicine with those self-injectors. Taking an orange, the staff showed you stick the thing and you hold it tight against the surface, you push the button, you push the button, and push the button, and you wait for the click, and they sent the patient home. If the patient tried the treatment and it didn't work very well for them. Because again, because it was so painful. And they reported that the needle bent every time they gave themselves the injection. Well, it turned out that the patient, because their scalp symptoms were so severe, they had been injecting the

medicine in their scalp. Nobody had shown them that that's not how you're supposed to do it. So then they educated the patient further on doing subcutaneous injections in the abdomen and all. Their patient was were referred to rheumatology, who did a thorough examination, finding no joint destruction on radiologic testing, and the patient improved on the ixekizumab. They were also sent to primary care doctor for a cardiovascular evaluation.

I think this case illustrates some really cool issues that can come up in managing patients. This patient wanted to get better fast. Ixekizumab is a particularly good choice for that. These IL-17 drugs like secukinumab, ixekizumab, work even faster in the short run than are our best IL-23 inhibitors.

Melodie, did you want to comment on this case?

Ms. Young:
You know, no, well, yeah. There's just - yeah, there's a lot going on. And for people who are experienced and treat a lot of psoriasis, we can sort of - we have the algorithm in our head. And we can kind of start with the big bundle and zero it in pretty quickly to try to give that personalized care because at least this patient does have a lot of options, a lot of options. And I think, you know, trying to just move towards the decision is the skill that's required for providers at this point.

Ms. Kucera:
So, let's get into a few little questions here. So, Dr. Feldman, this is interesting. And I think a lot of people don't understand this. You did a quick calculation of a 60-gram tube in reference to how many applications a patient would get from this tube? Is there a good resource to help with this type of decision-making? How many grams? How many applications? How much do you get out of a tube of medication?

Dr. Feldman:
Yeah, when I want to figure it out, I use as a rule of thumb that it takes about 30 grams to cover the body one time. And so, if you've got 10% body surface area affected, 30 grams would be 10 applications. And then you can use that, you know, where palm is 1%, you can pretty much calculate anything you wanted. As a rule of thumb, I think for face to last a month, you need about a 45-gram tube, 30 to 60 grams. If they were to use it. Now, they're not going to use it. Adherence to topical therapy is absolutely miserable. For most patients who get a tube of medicine for their face, you know, it'll probably last an entire year. And so I think if we're giving face 45 grams, if you're dealing with anybody with an extensive rash, I'm prescribing big pound jars of triamcinolone.

Of course, that segues well into the question about the long-term use of triamcinolone. It can thin the skin out. I think it's very unusual for it to thin the skin out in most people, because most people don't put their topicals on very often, even when they - when the plaques are thick, they don't put them on. When the plaques thin out, I think they're even less likely. But that doesn't mean that none of them put it on. And if you do put the triamcinolone religiously, if you're taking care of patients who are architects, engineers, CPAs, and you tell them put this on twice a day and they do it regularly, yeah, it will thin the skin out.

Ms. Kucera:
Okay, we're winding down. We have a couple of minutes. There is one question here that I want to get to because I think it's important. The question is, are there triggers for psoriatic arthritis flares? But I'm going to bring it back to skin because a lot of patients will come in with a what they say flare, like a really bad episode of psoriasis. What kind of things do we need to ask those patients to see if we can find a trigger?

Ms. Young:
Infection. I had some weird flares after people have had COVID or even COVID vaccines. People have been stable for years, disease flaring up. Of course, strep throat or any sort of infection, even a UTI or upper respiratory infection can cause the disease to flare when they've been otherwise stable. I've had people say their disease was worse, and it turned out to be tinea. It wasn't psoriasis after all because they had steroid at home in the drawer. They drug it out started using on some little patch of rash that - and of course it's getting worse and they're calling saying you know, I need something else, this drug is no longer working. And I think the key to that is bringing them back in and having a look. And other - there are a lot of drugs that can cause psoriasis to flare. I see it with beta blockers. We'll see it with some of the psych drugs. I've seen it with blood thinners. So people that are doing well and they suddenly aren't, there's a reason for it. It's not likely that the drug that had been working really well, just suddenly stopped, if they're taking it as has been mentioned. If they're still on their therapy and haven't skipped a lot of dosages, there's got to be a reason.

Ms. Kucera:
Okay, thank you. We have gotten to the end of our time. Dr. Feldman, Melodie, you have enlightened us with so much information. We appreciate you so much being here. And thank you.

Hello, I'm Kristine Kucera. I'm a Physician Assistant at U.S. Dermatology Partners, and a Clinical Associate Professor of PA Studies at

UT Southwestern Medical Center in Dallas, Texas, and I will be your moderator. With that, I'm pleased to introduce our next two speakers, Dr. Steven Feldman and Melodie Young. Dr. Feldman is a Professor of Dermatology at Wake Forest University School of Medicine in Winston Salem, North Carolina. And Ms. Young is a Nurse Practitioner at Mindful Dermatology and Modern Research Associates in Dallas, Texas. And today, they are here to teach us about enhancing care and moderate to severe psoriasis.

These are their disclosures.

And now we'll move to our learning objectives. We're going to demonstrate cultural competence in addressing patient-specific needs in patients with psoriasis and skin of color.

Okay, jumping into our case study, this is Jocelyn. She's a 36-year-old nurse practitioner and she has severe psoriasis. She has about a 30-year history of moderate to severe disease with various topical agents that she's used in the past. She has not seen a provider for several years due to a negative experience with the medical system, misdiagnosed as a child. She does have mild depression that's treated with an SSRI. And now she's learning about other treatment options in school and interested in finding a provider that will include her as a part of the team. She has reviewed the current treatment options beyond topical therapy, and she expresses concerns about systemic therapy. We're going to move now into patient perspective and watch the importance of accurate recognition of psoriasis on all colors of skin.

Patient:
I was originally misdiagnosed at my pediatrician's office. They just thought that I had chicken pox all over again. But as the weeks went on, these chicken pox weren't going away, they were getting worse, they were getting bigger, they were getting redder, they started to scale. And it wasn't until that moment where my parents decided to take me to see an actual dermatologist. And that's when I was diagnosed with the psoriasis.

Psoriasis does look different on people of darker skin. It's important to kind of recognize different disease states in different ethnicities. My patches were more brown colored than it was red, so it didn't look as inflamed as it would in someone with fair skin. So while I was misdiagnosed for a while, I could have been receiving the proper treatment. The kids growing up won't have to deal with the bullying and the stares from their peers as well as adults. But it's important to treat each person individually. So just giving a one-therapy-fits-all approach as far as giving a steroid cream, might not work for some people, and it will be beneficial to look into other therapies for everybody.

Ms. Young:
Thanks. So, we all sort of have preconceived ideas about different ethnic groups or cultural or even regional areas, what we think patients are going to want versus what they won't want. And I think we have to be careful with that. But we also have to be skilled in our ability to do clinical exams with patients of differing skin color. And one of the things that, you know, the redness just does not show in a non-Caucasian and you can miss it. It can be much more severe than it's presented if you're judging all patients and all skin types the same. The non-Caucasians are much more likely to have either hypo or hyperpigmentation changes after they clear, which is why I say get them clear early before that damage has happened, don't let it sit around for years. And they're plaque can be thicker. Sometimes phototherapy can help correct those pigment changes, sometimes it won't. And they also can require more phototherapy, higher doses of it. And if you're not skilled at phototherapy, it would be a great addition to your clinic because there's some tricks for it. You do have to think about hair-bearing areas. You have to think about intertriginous areas, and then also the outcomes.

So, there's some data that you can look at with different drugs that show what, you know, what works best in different populations of people. A lot of these drugs are tested all over the world. But there is much less data, except for in the, you know, we have more in the white population than we do in the non-whites. So it is interesting to ask them about their preferences and to pitch it to them and say, I've got ointments, I've got foams, I've got shots, I've got pills, and really just let them kind of participate in the decision-making. And some of this is even showing some data based in Asia and Japan. And I think that we don't just assume that all patients are going to respond the same to what we have to offer.

And age groups. There's even differences. There's differences in race, ethnicity, religion, rural areas, age groups, they have different needs than what an older person might find to be valuable. Particularly, you know, the older folks want to sleep well and don't want to have to go to doctor's offices all the time. Younger people want quality of life issues that help them to keep working, help them to have their sexual relationships that are important to them. I think this is a great slide. Slide 55 is a great one to spend some time looking at.

And then also differences by gender, the male versus females, their needs are different. And I think we just have to ask them. I work with the physician who's fabulous about asking them what is the most important thing to you, speed of onset, ability to wear what you want to wear, to not itch; those things are all things that we take into account as opposed to just looking at body surface area when coming up with the plan.

And then this healthcare disparity piece that we mentioned before, it's really shocking and painful that black patients are 70% less likely to be offered these premium biologic therapies as compared with whites. So we really need to make sure that we offer it to all of our psoriasis patients. And they may not know that it's even an option for them, they may have fear of it, they may not be aware that it's out there, may not be as plugged in to the psoriasis community, and that their access also can decrease with age. So make sure that you offer it to all of your patients or have the same discussions across the board.

And that shared decision-making is incredibly important. They're more likely to adhere to the therapy if they've had some options, and you've run through the pros and cons, and don't just steer them away from something. Really, really try to say I can offer you phototherapy, but here's the pros and cons. I can offer you systemics, but here's the pros and cons, topicals etc. And their satisfaction levels will improve. And their adherence will improve. And I think that's the same across the board with all of healthcare. So keep that in mind.

Ms. Kucera:
So moving from questions, we are going to go into a case study discussion. Melodie, do you want to start with this?

Ms. Young:
Sure. So childhood psoriasis is something that we are going to commonly see. And they tend to have a lot on their scalp and face. Sometimes they also will have a guttate eruption that will happen after infection. So this is something that you're going to see. And this is a 9-year-old young lady who had come in with a rash, scaly scalp, and complaining of itching. And I'm sure the way it looked, the way it felt, causing them some consternation, some concern, not a lot of family history because they were adopted. And of course, upon exam, if you just examine the scalp, you're going to notice that there's plaque, usually it's behind the ears and posterior. And if you look around the ears, it was seen there too, and also signs of picking, which is very, very common. They - patients really, really do tend to pull at it. And I've had people describe it to me as feeling like dried oatmeal on their head. Or if you put Elmer's glue on your hand and let it dry, how you just can't help it pick it off. So we tell him not to do that because of the Koebner phenomenon and making it worse, but it's pretty miserable, and particularly for a child.

And so they were diagnosed with psoriasis. And the options were discussed, including an ultra-potent steroid, which is clobetasol, which can be available as a shampoo, to try to use that for a couple of weeks to see if you can move them into that - from the clearance phase into the maintenance phase of just using it once or twice a week and checking what the efficacy could be. Now this said return to clinic in 3 months. Even that might be something that you're going to know pretty fast, number 1, can you clear them, and number 2, can you keep them clear on a maintenance, and whether or not you know to when to bring them.

So when you look at this, at this young lady, she was not having results, she was getting worse. And she was starting to have what some who will call psoriatic alopecia where the hair will thin down from all the inflammation, it's almost as if the scale and inflammation is choking out the hair follicles. And that can be a very temporary issue if you get that scalp clear. And of course, the exam, if you're looking at the scalp, is noticing that the scale may be less. And if they're not having a lot of itch, to sort of reassess the diagnosis. Could the – is the diagnosis correct or not? So in the follow-up, and then of course, doing a KOH or doing a scraping or biopsy or whatever that needs to be done. And then somebody looking to see, do you agree that this is more psoriasiform than some other diagnosis? And then also if whether or not if this child has trichotillomania, again, not just scratching, but literally pulling and picking it the hair.

So the patient was returned, because there was a biopsy that was done. The patient did say that they are pulling it the hair, they're having some anxiety. Again, the psychosocial aspect that's been mentioned a lot, particularly in a child at this age, they are going to be mistreated and bullied, they're going to be flaky, they're going to be itchy, people are going to notice. It's going to impact their life. And even though you might consider it to be mild disease, and I'm sure the clinician did a total skin check and looked at all the other high likelihood places for seeing disease to know it truly this is the only place that this child has it or is it more widespread. But even if not, even if it were scalp only, I think it was very wise that this child was prescribed ustekinumab. Excellent safety profile that's used in children all the time for GI disorders and at higher doses. And this is a person - this clinician treated this patient the way the NPF recommends, which is to get them clear and are less than 1% body surface area remaining and put them on a maintenance program to keep them clear.

And so, this is a kid who literally has had 5 injections or less within a 12-month period of time. And the scalp was clear, the itching was gone. I would place bets that the anxiety and the bullying related to this disease is also gone from this life. And I always think that for a 9-year-old, for us to say oh, let's wait 6 months or 9 months or a year, that is forever for a 9-year-old. We need to do things that work quickly and that we don't have to wait or it's not going to take a lot of time and parental involvement. And with no more injections of what this kid had to take, I think this was a great option. And following up thereafter, keeping them on the treatment, and they're not having any issues at this point. And their definitely quality of life would be considerably better.

Ms. Kucera:

So, let's get into a few little questions here. What strategies do you recommend for avoiding misdiagnosis of psoriasis, particularly in patients with darker skin? Does it clinically appear different?

Ms. Young:
Yeah. In that slide we mentioned before particularly the erythema, there are some skills tests that you can take. There are a lot of continuing education offerings as well, help you see what erythema looks like in different skin tones. And I think a refresher course on it is wise for clinicians. I think you're going to miss the extent of it. So one of, you know, one of the simple things that I think about is again, white people are worried about skin cancer. And for a lot of non-whites, they don't think that they are at risk of skin cancer. It's very rare. I would say less than 10% of patients who come in for a skin check are something besides Caucasian. And when they do, you know, it's because they'd heard of, you know, a relative or someone that developed a skin cancer that they're worried about and say I just want to get a skin screening. So then with that, are they seem dermatologists very often? And then are they - are you looking at them? So are we as skilled in doing the exams and knowing how to look and getting them into a gown and really looking at them all over? And I think that that's one of the really important things that we do, is total body skin checks. The first time you see a person, if they say have psoriasis, 'Look, I need to get you in a gown, I've got to see how widespread this is.' And then really looking for plaque, scale, erythema, and sort of the way we write from a 1 to 3 on each of those factors. But the redness just may not be as prevalent. And sometimes you can get a gauze, get it wet, and kind of rub it over the plaque, and you can kind of see a difference of the redness versus the rest of the skin, make it show up. And then touching it. I have to touch. I'm very visual, but also very tactile. When I am touching the skin, and I'll see a feel in elevation in that plaque, that's going to tell me that, you know the induration is there, and that the disease can be more severe.

And then I think there's a lot of good subjective information as far as disease severity that we need to listen more, we need to ask more questions. And again, asking, 'How much is this bothering you? Is it itchy? Is it painful?' We didn't think psoriasis hurt but it does. People will complain about, you know, the pain that they feel, they sometimes describe it as itching, burning, stinging, tender. And if they scrub and pick or pull at it, it'll bleed. So really asking them, you know, 'How does it feel? Does it bother you? Would it be significant, would it affect your life if I could make this go away for you? And with the drugs that we have now, you know, there's a really high expectation that I can get you cleared or almost clear.' And that's the first thing I say when I meet a person is, 'Yeah, you have psoriasis, this is a disease that we can almost always get you either clear to almost clear, we just have to figure out what, you know, what the next path is going to be.' And a lot of times, the first thing we do is the perfect therapy. Sometimes it's not, you have to you know, say, 'Okay, well don't give up on me. If we have to go for, you know, more than one thing,' but so many options.

And I think as clinicians, doing thorough exams, really customizing the care to the patient, and then getting them involved in helping make decisions about, you know, do they want to, if they want to do topicals and phototherapy and they understand how much, you know, time and investment they've got to make associated with that? Or do they want to look at a oral agent, biologic agent? And kind of just - you can pull that that conversation together pretty quickly. And again, even if you're not sure that the patient's disease, in your mind, is severe enough. You're like, oh, they have 3 to 4% BSA, they're kind of in that moderate category, again, just to ask them and see what they want to do. And then use your skills to kind of guide them towards the best therapy.

Dr. Feldman:
Melodie raises an important principle when she mentioned that people might come in for their skin exam because they heard of a family member or friend who had a skin cancer.

One anecdote is a big driver for human behavior. And if you wanted to encourage a patient to take a particular medicine, rather than tell them all the data, you might just tell them, 'You know, I had another patient, you remind me of them. Their disease was so similar, they did really well on,' and then you name the drug. That one anecdote can be a very powerful tool.

Ms. Young:
That's really important. People like to know that you have taken care of folks that are very similar to them, either in race or age or whatever thing. I think that's comforting. They don't want to think that you're, you know, that they're an anomaly. I think that's important.

Ms. Kucera:
Okay, thank you. We have gotten to the end of our time. Dr. Feldman, Melodie, you have enlightened us with so much information. We appreciate you so much being here. And thank you.

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