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When Topicals Fail: The New IPC Consensus Every Clinician Should Know

Announcer:
Welcome to CE on ReachMD. This activity, titled “When Topicals Fail: The New International Psoriasis Council Consensus Every Clinician Should Know” is provided by Prova Education.

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Dr. Stein-Gold:
Today, we will discuss the 2025 International Psoriasis Council Consensus, promoting earlier evidence-based escalation to systemic therapy in psoriasis. This is CE on ReachMD, and I'm Dr. Linda Stein-Gold. I'm the Director of Dermatology Clinical Research at Henry Ford Health System in Detroit, Michigan, and I'm thrilled to be joined by my friend and colleague, Dr. Bruce Strober. Welcome, Bruce.

Dr. Strober:
Thank you, Linda. It's a pleasure to be here.

Dr. Stein-Gold:
Well, it's such an exciting time in psoriasis. We have some wonderful new topical, oral, and biologic treatment options. I feel like if somebody has very localized disease, we're pretty good at getting them under control. If somebody has very extensive disease, we're pretty good at getting them under control. But some of our patients seem to cycle on topicals and we don't tend to advance them. And I feel like there's kind of an unmet need on these patients who maybe don't have the most extensive disease, maybe have a little more localized disease, but really aren't getting better.

And I know that the IPC got together with a group of psoriasis enthusiasts and experts, and they put together new guidelines on how to figure out when to advance patients to appropriate systemic therapy. And Bruce, you were a lead author on this paper. Can you help us to understand who should advance to systemic therapy?

Dr. Strober:
Right. Well, it was all about an appropriate advancement for people who are on topical therapy or who already are severe enough to perhaps skip topical therapy. The ultimate consensus was that there's two categories of patients with psoriasis: those who are appropriate for topicals and those who are appropriate for systemic therapy or phototherapy.

Now, basically, to be appropriate for systemic therapy, you of course, need to either fail topical therapy or perhaps be inappropriate just at the get-go. You just look at the patient, you're like, they’re too severe, I need to go right to a systemic. But the other two criteria were very straightforward. You could be 10% or more of your BSA, and again, that's a person who should be on systemic therapy. Or a person who has high impact limited disease. Some people call it special site involvement; for example, the scalp, the hands, the feet,

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genitals, and nails. And those patients, of course,would be candidates for topical therapy right out of the gate. But on the other hand,many of them are deserving of systemic therapy, even though their BSA would be less than 10%.

So, the upshot is these are people who couldn't enroll in a clinical trial for a systemic therapy, or at least a registrational clinical trial, where you require BSA of 10% or more, or a POSI of 12. These are patients who wouldn't achieve those thresholds, but nevertheless could be on systemic therapy. And we've actually studied this in many different settings, but in particularly real world registries, a large percentage of patients in dermatology fall into those categories where they don't really have enough to be in a clinical trial but nevertheless are getting systemic therapy and/or phototherapy beyond just topical therapy.

Dr. Stein-Gold:
So, I really like that. I'm so thrilled with this new classification because people get so fixated on mild, moderate, or severe disease. But putting people in these two categories, either topical therapy or systemic-worthy, I think is great.

So, as I understand what the paper told us was, if you have 10% or more, you're systemic worthy. If you have a high impact site, as you described, or if you have failed topical therapy. So, I think that really what you're telling us is there are a lot of patients who should be advanced to systemic therapy who have really been stuck in a topical treatment regimen.

Dr. Strober:
Yeah, and the survey suggests that there's a – I want to make it clear, our specialty has gotten very good over the past two decades in terms of using systemic therapies, particularly biologics. We're very comfortable with biologics, but nevertheless, if you survey patients, there are still many by percentage who are undertreated. They're not being advanced beyond topicals. They are cycled through topical after topical, never, ever getting to a systemic. And that's what we're really addressing,the undertreatment of a certain subset of psoriasis patients. And by the way, when surveyed, express a lot of frustration with just the topical churn, as it's called, even though they know they're severe enough to be on a systemic therapy.

Dr. Stein-Gold:
So, let's talk a little bit more about that, Bruce, and it brings me to the second publication from the IPC. And that's where we talk about this group of topical failures, the IPC has actually put out a consensus paper helping us to understand, well, what does a topical failure actually mean. Can you elaborate on this?

Dr. Strober:
Well, I would see this as sort of the sequel to the first paper I just discussed. We got pushback because we didn't really define well enough what is a topical failure. And we did that on purpose because it's somewhat of a murky concept, what is a topical failure. But there is some congealing around a concept that people should not be continuously treated with topical medications if they're not achieving certain benchmarks.

So, in this update, so to speak, we say patients should be clear, almost clear, or 1% or less on their BSA to be deemed a success on a topical. Clear, almost clear, like an IGA-01 or 1% less BSA. And to get there, they could march through two 4-week consecutive trials of topicals, meaning you could try one topical for up to 4 weeks. And if that doesn't work, you can go to a second topical up to 4 weeks, just seeing whether you're getting anywhere with these specific regimens of whether it's corticosteroids or non-steroidal topicals. We have many, as you know, some new, some old. But the idea is now you have a definition of what it means to fail a topical.

If you don't get clear, almost clear, and you don't do it within a certain specific timeframe, at that point, then you can kind of cassette that definition into the original IPC categorization. Now, you've called a person appropriately a topical failure with a real, valid measuring stick. Which we think is very practical. And there's a few extra comments within the paper about limiting the use of high-potency topical steroids, perhaps 2 weeks. But otherwise, the 4-week rule is a good one, and two consecutive 4-week intervals.

Dr. Stein-Gold:
I think this is just a wonderful guideline for us to help us to understand it. And it's important that you're not saying not to use topical therapy because as you mentioned, we do have topical steroids, but we have this wealth of new non-steroidal options that are also quite effective on their own. But I think this gives us some guidance to not do that topical churning, as you mentioned earlier. So, I appreciate this. Do you think that this is going to allow us to be a little more aggressive in our treatments?

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Dr. Strober:
Well, we hope it allows the providers in the dermatology universe some specific guidance because prior to this, what could be defined as a topical failure is very open-ended. And while these are not obviously hard and fast rules, it imparts a message to you know new and seasoned therapeuticians. Listen, you can try topicals, but you know move away from them once you see there's no success being achieved. And this is ultimately because patients deserve more given all of our systemic options.

Dr. Stein-Gold:
Bruce, let's now talk a little bit more about that systemic world. We talked about the fact that we have some wonderful new topicals. We have some fantastic biologic agents that are getting the majority of our patients to clear, almost clear. But we have an oral space that actually doesn't necessarily have the trio of great efficacy, great safety, and great tolerability. And we do have some newcomers on the horizon that are in clinical trials. Can you talk to us about what you're most excited about in the oral space?

Dr. Strober:
Well, I think we're on the precipice of a new era in oral therapeutics for psoriasis, mainly because the efficacy is going to jump to another level that may not quite hit our top rung modern biologic therapies, but really nip at the heels with regard to their efficacy. We have oral IL-23 receptor antagonism in the form of a molecule called icotrokinra, and we have some TYK2 inhibitors that are in the pipeline as well, that are built on the mechanism of action first introduced by deucravacitinib. But now these will probably be more efficacious for people with psoriasis.

I'm most excited by, I think, the oral IL-23 receptor blocker, icotrokinra, that's likely to be the first of these medicines to be approved. Only because it's going to be once daily, it's going to be of a mechanism of action, specifically IL-23 pathway inhibition, that we're familiar with, and I believe it'll have the same tolerability and safety profile that our biologic IL-23 inhibitors currently possess. So, there'll be a lot of comfort with this medicine. It's efficacy looks to be really strong. I can't overstate the importance of they're going to launch this medicine with an approval in patients 12 years of age and up, so it'll be an adolescent approval right at launch. We've never seen that before. And I think that'll go a long way into making it a very successful option.

Dr. Stein-Gold:
I agree with you. I think this is really an exciting time for the oral therapy landscape. I have done clinical trials with all of these new drugs. I'm also excited about this new peptide, the IL-23 receptor inhibitor. And I think we all want great efficacy, but we also worry about safety and tolerability. And I think with this drug, we actually see a drug that is going to provide us with – as you mentioned, we're getting close to the biologic type efficacy – but with a safety profile that's actually really quite good, and a tolerability profile that's quite good.

Do you see these drugs as kind of the first step towards systemic therapy, or do you see them used in potentially any type of a patient?

Dr. Strober:
Well, I think more the latter. You'll see them used in all types of psoriasis patients.

The issue will come down to whether the provider is biased towards infrequent injections, which we have, obviously, that work really well, versus a daily oral medication that also works well. And this is going to be a discussion between the provider and the patient regarding what are their expectations in a medication.

There are arguments on both sides regarding biologics versus orals, but only now will we really be able to say the orals are really close in the efficacy to the injectables, and therefore they become even a more valid choice for the patient.

Dr. Stein-Gold:
So, Bruce, we're just about out of time, but can you give us one final take-home message?

Dr. Strober:
Well, the take-home message is, and it harkens back to the disease recategorization, and systemic versus topicals. I think the important point is that you use, as a competent therapeutician, all at your fingertips. You use topicals, but increasingly use non-steroidal topicals. I'm really biased towards that. I try very hard not to prescribe topical steroids, even though they have a payer advantage in many instances.

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And then, I don't make patients languish on topicals. I think you need to set that expectation early with a patient, you put on a topical that, you know we're going to try this. We may try two, but ultimately I want you to consider internal medications, whether they're oral or injectable, as really, liberating. Ultimately, oral and systemic therapies are very liberating the patients because they're free from topical applications, and generally, they do better.

And then, finally, which is not written about enough, when we treat systemically, we often treat other tissues and organs that are negatively affected by psoriasis, because psoriasis needs to be viewed as as a systemic illness with the skin as its most outward facing manifestation. We have psoriatic arthritis, of course, but we have a lot of cardiovascular comorbiditythat probably is positively impacted by the use of systemic therapies. And so, think of the patient as a holistic approach that in many instances, topicals will not address.

Dr. Stein-Gold:
Well, Bruce, that was a wonderful take home message. And I hope that all of our listeners will learn more and really try to help get our patients under control.

That's all we have time for today. So, I want to thank our audience for listening and thank you, Bruce, for joining me and sharing your valuable insights. It was great speaking with you today.

Dr. Strober:
My pleasure. Thank you.

Dr. Stein-Gold:
Thanks so much.

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