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A Talk on Topical Therapy: Dermatologists' Experiences in Practice

Dr. Greenberg:
Welcome to *DermConsult* on ReachMD. I'm Dr. Michael Greenberg and joining me today to share his experiences with topical therapy in clinical practice is one of my fellow hosts for this series, Dr. Matthew Keller. Matt, would you like to introduce yourself for our audience?

Dr. Keller:
Sure. My name's Dr. Matthew Keller, and I'm an Associate Professor at Thomas Jefferson University in Philadelphia. I also run a psoriasis and complex medical dermatology center there, and I'm happy to be with you today, Mike.

Dr. Greenberg:
And he's one of our fantastic hosts here on ReachMD, along with me. So let's dive right in. Let's talk about eczema, the bread-and-butter diagnosis- of my practice and a lot of clinical practices. Focusing on biologics, how's dupilumab changed the landscape for you?

Dr. Keller:
It absolutely has changed things. I got into dermatology shortly after etanercept and adalimumab hit the market. So, I don't remember what it was like to practice before that, but I certainly know what it was like to try to take care of severe eczematous dermatitis patients without any real FDA-approved therapy. We were constantly using off-label therapies that had significant side effects. And for me, the dupilumab has been a homerun. No doubles, singles, or triples, it's all been homeruns, for the most part. It's really an amazing medicine. And it's unbelievable to think about how I took care of these patients prior to having that. So, it really has changed the landscape with the fact that it's such a safe medicine as most of the biologics are. The patients respond so well to it, and I really haven't had as much issue with some of the eye side effects as has been reported in the literature. And much of that is thanks to my ophthalmology colleagues that have really done a great job with helping me out with these patients.

Dr. Greenberg:
That's great. Do you find a population of patients that it just isn't working as well as I want? I see like 95% of patients do great. And then I get these patients who come along and it's just not working. Do you ever see that?

Dr. Keller:
Yeah, I run into that once in a while. I sometimes wonder exactly what I'm treating there sometimes. Is it truly atopic dermatitis? Is there another component to it? Could it be chronic contact? Could there be something else going on there? I certainly see patients and clinically, it appears they have atopic derm but there's something different about those patients. I've also had a lot of luck with it in patients with bad chronic nummular dermatitis, as well as prurigo. I see quite a few patients either from Hep C or HIV or other underlying medical conditions that have developed prurigo. And it really has been not quite as effective as it is for the bread-and-butter atopic derm patients, but it's really been a homerun for a lot of these patients who are just so miserable.

The issue we run into is dupilumab does not affect the skin barrier. It really just makes up for and compensates for the immune system reaction that happens to that impaired barrier. So a lot of my patients still get dry, they still get irritated; the difference is they're not excruciatingly itchy. They don't stay up all night. They don't come in with big dark circles around their eyes. It really doesn't affect their daily life quite as much. And for me and for many of those patients, if I focus on the anti-itch aspect of it. That's where the homerun comes in. But you're absolutely right. I see patients who come in and they are still needing to use a little topical steroid, still needing to use a lot of emollient, still getting dry in the wintertime.

Dr. Greenberg:

You know, one of the secrets of treating eczema that I learned because I'm an old guy is the micro infections that occur in atopics and a long time ago, in the old days, we used to stick people in bleach baths, which my patients would hate, they do it three times maybe. First time they would be okay. And the second time they either ruined a towel or did something and their house smells like a swimming pool. So a product that I found is called CLN, which has eliminated this need. Have you ever used that product?

Dr. Keller:
No, actually I haven't. I'd like to hear a little more about that.

Dr. Greenberg:
CLN is a product developed, actually a dermatologist owns a company and it takes the place of a bleach bath. It's a body scrub that you put on everyday, you put a tablespoon full on a wet washcloth, lather it over your skin that's affected, let it sit for a minute or two, and then go in the shower it off. It's elegant, and it doesn't smell. It's relatively cost-effective and it takes the place of a bleach bath, which I think a lot of primary care doctors have forgotten to use over time and some of our colleagues too. You've got to get that bacteria down.

Dr. Keller:
Yeah, absolutely. I mean, that's an interesting product, I'll have to look a little further into that because it was something I've never actually used. I never used bleach baths that often; once in a while among pediatric patients just because they're so prone to impetigo and other issues like that. I do, however, use sometimes Hibiclens or benzoyl peroxide wash minimally in patients in order to sort of help keep any other type of antibiotics that they're using efficacious.

I think the other thing that we've realized is that when you get these areas where you have that staph coverage, you don't necessarily have to use antibiotics as frequently as we once did. Really topical steroids will reduce the staph carriage. And I think there's been a couple of papers that have come out related to actually putting steroid on skin that had significant amount of staph colonization and actually seeing a reduction in the staph. And that's because you change the inflammatory milieu to a more antimicrobial sort of presentation, which we know that's something from a basic science standpoint that happens in atopic dermatitis skin that doesn't really happen in many other conditions.

Dr. Greenberg:
I don't know if you've noticed this, but during the pandemic, especially lately, I have noticed more people showing up with rather severe atopic dermatitis who claim they never had it before in their life. And that's what it is. I think it's kind of like the stress levels put people over the edge. Am I the only one noticing this? Or have you seen this too?

Dr. Keller:
Yeah, I definitely see that as far as things go. I think two things are happening. So one, I think there's a lot of patients who are living a very different lifestyle and environment, they're showering more frequently, because they're home from work. They're not doing some of the things that they would normally do, going to the gym, and other things like that. But I think the microbial flora has changed.

I think the other thing that's happened, and I don't know if you've run into this as well, but I've noticed a lot of people who have gotten their COVID shot, and then after that, whether it's Moderna, Pfizer, or Johnson and Johnson, they develop a rip-roaring rash. That rash is not always atopic derm, it could be a number of different morphologies. But what is really important is that these rashes, I've seen it now maybe 20 times, will come up somewhere between few hours and a few days after the rash breaks out.

Dr. Greenberg:
For those of you just tuning in, you're listening to *DermConsult* on ReachMD. I'm Dr. Michael Greenberg, and today I'm having the absolute pleasure of speaking with my fellow *DermConsult* host, Dr. Matthew Keller, about our experiences using topical therapy to treat a variety of dermatological conditions.

So let's move on from eczema. Let's talk about warts and molluscum. Any ideas on this, especially when treating small kids who you don't want to traumatize with physical modalities like nitrous oxide? What do you do for this?

Dr. Keller:
So there's a number of different things that I'll do for a lot of my wart patients. So first thing is I love cantharidin with salicylic acid and podophyllin. I think the Spanish blister beetle juice, essentially, it used to be something that you could get commercially available. And now unfortunately, you need to get it compounded because of a lack of safety data, one of these old rules kind of made them pull it off the market from a commercial standpoint, but it's awesome for molluscum. It's great for warts because it doesn't hurt like liquid nitrogen does. I use it for adults as well. And also, not only does it blister off the wart in a very controlled and consistent fashion, but the podophyllin also, in many cases, will act as an immune stimulant. And when you combine that along with other types of therapy, it really can be significant.

Dr. Greenberg:
Are you having any luck with imiquimod?

Dr. Keller:
Not with imiquimod. And it's actually interesting that you bring that up because in the package insert for imiquimod, there actually were two trials that were done and that data is in there, the FDA made them put it in that shows actually inefficacy. You know, no efficacy whatsoever. In fact, in the one trial, placebo wasn't statistically significant, it was actually more efficacious as far as numbers goes. So really, imiquimod plays no part essentially in the treatment of molluscum, and I've had no luck and I sort of stick with that.

I do have some luck with imiquimod and verruca. Obviously, sometimes you have to push it much more frequently than you normally would. And what I'll do is in the genital area, I'll start three nights a week and have them go to five nights a week, after a couple three weeks, if they haven't had a significant reaction, and then to seven nights a week. Obviously, some people get significant reactions. And when we use this for superficial basal cell and other things, you see a really vigorous reaction. But a lot of times these wart patients, you're selecting for people that have inferior toll-like receptor expression. So you're really kind of ringing a bell that's broken already. I do use the medicine, but I have a little less luck with it than some of the other things we do.

Dr. Greenberg:
So, Matt, let's get away from clinical issues for a moment and discuss patient expectations these days. Do you think that the media and especially social media has worsened the concept of perfection with our patients? I'm experiencing that. And if so, how do you handle it?

Dr. Keller:
So it can be very challenging. I see a lot of psoriasis patients, and what I will tell you is direct-to-consumer marketing is definitely a big thing that's going on. There is some benefit to it in that patients can be self-advocates, especially if they have a dermatologist who maybe isn't as aware or up on some of the newer medicines and data. The one issue that I am running into is exactly what you're speaking about, is controlling patient expectations. With these different forums as well as the mainstream media, you see these people on these medicines that are getting 100% clearance. And I think the companies are trying to set that as a bar. And I understand where they're going, you know, let's not let patients have a significant amount of breakout when we know there might be a more successful therapy. But I think there are patients where it's worth chasing a little bit better improvement. But then there's also the aspect of great being the of detriment of the good, right? So you're sort of pushing forward, you end up getting something worse than what you had to begin with. I think the really important thing with biologic medicines, and something I try to stress with my patients so they understand my reluctance sometimes to switch, is one, there's no guarantee the next medicine will work better. And two, there's no guarantee if we go to another medicine, it doesn't work as well, if we come back to the original medicine, that it's going to work well, because it very well could end up not working for you anymore. And that is an aspect of biologic medicines that are different than these chemical medicines.

So I build a relationship with my patients. I talk with them a lot about it. I also try to give them an understanding of how bad they were. I try to ask them to take pictures. I talk to them about joint disease and how if we have a little skin, there are some things we can do to help out with that. But really, if you have a significant joint disease, and we're doing really great with the joints on the medicine, let's not throw the baby out with the bathwater, so to speak. Let's recognize that we're gonna have to work a little harder.

I also start with talking about topical therapy; I think it's really important for patients to understand that what we get out of topical therapy we don't need to get from other systemic treatment. So the harder you work with that, and the more you sort of embrace that, the better you're going to get as far as your skin goes. Also, the more efficacious we're going to be able to be as far as side effect profile goes. As far as maintenance of improvement that they've had.

Dr. Greenberg:
Right, one of the key things I think, too, that I always have to emphasize and find I have a problem when patients come in from certain other doctors who don't spend a lot of time with them is I have to define for a patient that their problem is chronic. I'm not going to fix it, I'm only going to make it better. And I use the analogy of like going to your dentist and asking them for a tube of toothpaste that you can use for a week and never brush your teeth again, because patients expect when they get better on a medication and they stop it, that they were cured. And they get sometimes get angry when they come back if I don't emphasize that with them. And I usually have to say it three or four times before it sinks in. This is not a cure.

Dr. Keller:
Yeah, absolutely. And I like to tell them it's kind of like if you have high blood pressure, right? The majority people have high blood pressure, once they end up on medicine, they're always going to be on medicine, unless there was some underlying reason why they had the hypertension that could be fixed. So I tell them just like we need to control your high blood pressure, we need also to control your psoriasis. And it's one of those things that could be lifelong therapy. And they always ask me, 'How long will I be on this?' And I say until

we have something different for you to do that's better or it's a cure, right?

Dr. Greenberg:
Well that's all the time we have for today. I want to thank my fellow host for joining me to discuss clinical experiences and best practices for topical therapy. Matt, it was great speaking with you today, and let's continue this dialogue.

Dr. Keller:
Thank you so much, Mike.

Dr. Greenberg:
For ReachMD, I'm Dr. Michael Greenberg. To hear more from myself and Matt Keller, visit ReachMD.com/DermConsult, where you can Be Part of the Knowledge. And thank you for listening.