Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/dermconsult/advances-in-pediatric-eczema-care-emerging-biologics-jak-inhibitors-and-beyond/35500/

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Advances in Pediatric Eczema Care: Emerging Biologics, JAK Inhibitors, and Beyond

Announcer:
This is *DermConsult* on ReachMD. On this episode, we'll hear from Dr. Peter Lio, who's a Clinical Assistant Professor of Dermatology and Pediatrics at Northwestern University Feinberg School of Medicine and a dermatologist at Medical Dermatology Associates of Chicago. He'll be discussing emerging therapies for pediatric eczema. Let's hear from Dr. Lio now.

Dr. Lio:
I think we're so lucky that in my career now—more than 20 years—I went from zero FDA-approved systemic therapies to now four biologics, two oral JAK inhibitors, and an exciting pipeline. So we have an incredible number of things that are now available to us, which is just so exciting, and I can't tell you how many things that are in the pipeline that sound like they're potentially even more game-changing. One of the things that's come up recently is that there are now some technologies to extend the life of antibodies, meaning that for some of the biologic drugs that we're using—maybe they need injection every two or four weeks—there's a potential that they might only need to be injected once or twice per year. Now, from a pediatric standpoint, that would change the game. That would be unbelievable because a lot of kids hate shots. It's a huge burden for families and patients. It's also a huge expense to get all these things shipped and move things around. So could you imagine just being able to do it once or twice a year, maybe even in the doctor's office to make it very simple and to keep kids under control with, again, known things that have already been out? So they're not necessarily a new molecule, beyond the fact that it can stay in the body longer, which is really exciting.

There's also a whole bunch of different new pathways that people are looking at. And obviously, these are still things in development, so we don't know, but the promise here is that we are going to be able to modify the disease to potentially push back and make it so that patients don't need treatment for a long time or for life; they could potentially be better and better, and then be able to stop the medication or reduce the medication so that they are actually improved. And there's also some discussion that this could affect the comorbid conditions—things like asthma, food allergy, and hay fever—all these other things that by affecting the immune system in a positive way and sort of unbending this bend towards allergy, we can straighten things out and get them in a much better place so that instead of just treating stuff all the time, we're actually heading towards a cure. So this is all very exciting.

In the short term though, I think most of the clinicians I'm talking with are still trying to get their feet wet in terms of the things that we now have. We, of course, have dupilumab, tralokinumab, lebrikizumab, and nemolizumab as our biologics. We have abrocitinib and upadacitinib. And all of them are approved down to at least 12 years. Dupilumab goes all the way down to six months of age. And I'm really excited to have some of these other ones that will hopefully be approved for lower ages very soon. In fact, it seems like we're going to have some options for younger patients, which is where we really need some more help as well, but this would be a game-changer to have some more of these options for patients who need it and who are under the age of 12. But already just having them is an amazing magical thing—in some ways a miracle—because just a few short years ago, we were stuck with old-fashioned immunosuppressants. That definitely helped. There's no doubt. I'm grateful that we had something, but boy, was there a price to pay for those, and the calculation for these new agents, while they're not perfect—no one would ever say they're perfect, and no one would ever say they don't have side effects because they do; all medicines do—the calculation is heck of a lot more favorable, and that means it's more open to so many people more than ever before.

With some of our treatments, one of the things I've published about a fair amount is this idea of a remittive effect. People go into a remission, and I feel like I am able to decrease the dose. And in fact, the three newer biologics—tralokinumab, lebrikizumab, and nemolizumab—they have an increased interval between dosing, which automatically, to some degree, tells you that there is some

improvement that is different than just responding to the medicine at the key dose. So all of these pieces I think come together, and I think we realized that we have these tools in our toolbox, and we can use them in ways that we've never used them before and we're able to do so. That also means we're now finding that the threshold for using more powerful medicines goes down.

Announcer:
That was Dr. Peter Lio talking about the evolving treatment landscape for pediatric eczema. To access this and other episodes in our series, visit *DermConsult* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!