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Tackling Atopic Dermatitis in Difficult-to-Treat Areas

Announcer:
You're listening to *DermConsult* on ReachMD, and this episode is sponsored by Pfizer. Here's your host, Dr. Charles Turck.

Dr. Turck:
This is *DermConsult* on ReachMD, and I'm Dr. Charles Turck. Joining me to discuss atopic dermatitis management in difficult-to-treat areas, like the face, neck and hands, is Dr. Linda Stein Gold. She's the Director of Dermatology Clinical Research at Henry Ford Health System in Detroit, as well as the Division Head of Dermatology at Henry Ford Health System in West Bloomfield, Michigan. Dr. Stein Gold, welcome to the program.

Dr. Stein Gold:
Thank you for having me.

Dr. Turck:
Well, if we get started off with the bigger picture, Dr. Stein Gold, what makes areas like the face, neck, and hands, especially difficult to manage in atopic dermatitis from both a treatment standpoint and a patient's day-to-day experience?

Dr. Stein Gold:
These areas are visible. So you can imagine for a patient, especially those who have moderate or more severe disease, you can't hide them. So while patients are suffering with the pain and the itch and the rash, when they walk out in public, they're actually judged by the way they look as well. So they have that stigma attached to them. It has a tremendous emotional toll that it takes on our patients, so this is something that, really, we strive to get under control as quickly as possible. These areas, especially in the face, can also be a challenge to treat because they're more sensitive, so we have to really be very careful in our treatment options.

Dr. Turck:
So, with this context in mind, how do you go about selecting topical therapies for those areas?

Dr. Stein Gold:
Well, topical therapy is really a great place to start. And traditionally, we think about using topical corticosteroids as kind of the mainstay of therapy for atopic dermatitis. But I think of topical corticosteroids, really, as a short-term solution to a long-term problem. They're a Band-Aid, and we certainly use them, but they're not a long-term solution. And when we're talking about those sensitive areas, especially the face and around the eyes, we have to be exceptionally careful about the treatments that we choose.

Unfortunately, we can't use potent topical steroids because of side effects. We know we can get thinning of the skin, and this can occur anywhere: face, neck, hands, or anywhere else on the body. So, especially for the face, we have to use more low-potency topical corticosteroids.

When we think about the nonsteroidal options that we've had for atopic dermatitis, for topical therapy, these have been helpful, but one of the issues is they weren't well tolerated. They tended to sting and burn. And if you think about putting something that stings and burns on a face or on a neck or on hands that might have some fissures, it can be challenging. And fortunately, when we look at the treatment landscape for topical therapy today, we have some wonderful new nonsteroidal options that actually help to get the disease under control and keep it under control. And fortunately, the tolerability profile is much better than what we've seen for the nonsteroidals in the past. So these are the new nonsteroidals we can use on the face and eyelids, and I consider them more like one stop shopping; you can use it on the face, you can also use it on other areas, you can use it on the hands, and it helps to simplify the treatment regimen for our

patients.

Dr. Turck:
Now, as we know, not all patients respond as we might hope to treatments, and you also mentioned tolerability. When topical therapy is producing a suboptimal response or the patient can't tolerate it, when do you consider systemic therapy and what clinical criteria help guide your decision?

Dr. Stein Gold:
That's such an important point, because I think we kind of let treatment inertia take over for a lot of our patients, and we don't necessarily strive for clear, or even almost clear, for these patients. And with all the challenges that we have for treating these special areas, a lot of the time, our patients really aren't at an acceptable efficacy outcome.

So there are a number of factors that I really take into consideration. How miserable is the patient? I like to ask the patient, how often do you think about your atopic dermatitis? How often do you think about your skin? And I know I'm not doing a really great job when they tell me they're always thinking about their skin. They wake up, they got to use their hands, they have to wash up, they have to wash dishes. Their hands might be hurting and cracking, even with the most simple things. Are they missing school or work because of their condition? How much emotional distress are they having?

Traditionally, we would try to categorize disease as mild, moderate, or severe, but that's not really practical. One patient might be mild one day and severe another day. It's much more practical to really divide patients by "Are you a topical candidate or are you a systemic candidate?" And for some patients, when they have more extensive body surface area, they're certainly a systemic candidate. For some patients who have these really important areas, like the face, the hands, or other high-impact areas, they certainly should be considered for systemic therapy. And for those patients who have tried and failed topical therapy, we really should think about advancing and thinking about systemic options for these patients, and really helping them to live a more normal life and not let their disease rule them.

Dr. Turck:
For those just joining us, this is *DermConsult* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Linda Stein Gold about strategies for effectively treating atopic dermatitis in challenging areas, like the face, neck, and hands.

So, continuing our conversation about systemic therapies, Dr. Stein Gold, which ones have proven most useful for patients with disease in the difficult spots we've been discussing?

Dr. Stein Gold:
When we determine that a patient needs systemic therapy, very frequently we might reach for a biologic drug as our first step to systemic therapy. We have a number of biologic drugs—dupilumab, tralokinumab, pertuzumab and nemolizumab—and these target some of the important proinflammatory cytokines that are really essential in the rash and the itch of atopic dermatitis.

One interesting thing though is, for instance, with dupilumab, we found that there happens to be an exacerbation of facial dermatitis in some patients. We didn't see this so much initially, but as this drug is used more and more, we do find that there is a small population of patients who do have this facial dermatitis that tends to get exacerbated while on the drug. The good news is, if you switch to another biologic drug, sometimes that rash will go away and they won't have it anymore.

But we also know with the JAK inhibitors, these are pills. And the JAK inhibitors target a more broad array of those proinflammatory cytokines. They don't get just the IL-4 or the IL-13 or the IL-31, but they get a number of these type two cytokines, and they can really get the disease under control much more rapidly and also get the itch under control much more quickly. So, with an oral JAK inhibitor, we might see itch calm down within even the first few days and a really nice depth of response. We don't tend to see the exacerbation of facial dermatitis on oral JAK inhibitors.

I know we did a subanalysis with abrocitinib and found that this was effective even for dermatitis that was on the face or the head. So I think these are also a very good option. For hand atopic dermatitis, dupilumab was looked at for atopic dermatitis of the hands, and that was also found to be effective. But I think all of these systemic agents do work, whether it's a biologic or JAK inhibitor, and work well for atopic dermatitis in these sensitive areas.

We know if we do choose to use an oral JAK inhibitor, we do appropriate blood monitoring. I find that patients are not concerned about that—we talk about the box label, but as long as it's explained, I think patients actually appreciate having some blood monitoring done. They think I'm keeping a closer eye on them when I check their blood, but I've had good success, and I think one of the problems is we need to think about using the systemic agents a little bit faster.

Dr. Turck:
I'd like to jump back to the patient perspective for just a moment. How do you incorporate quality of life metrics or patient-reported

outcomes into your treatment planning?

Dr. Stein Gold:
It's so important to understand the patient's perspective. And we're all busy, and you see a patient in your office, and we have to realize that's just a snapshot. They have this very long journey, and their journey might have started when they were an infant and continues even into adulthood. So we have to try to take a minute or two to understand, first of all, what does your journey look like? Just because I see you today and you might look great doesn't mean that last week you weren't home from school or work because the disease was so bad that you were bleeding and flaking and just having a really hard time.

So getting an understanding of what that patient's journey looks like, I think, is critically important. The question I like to ask them is, what are you not doing because of your atopic dermatitis? What do you wish you could do if you didn't have this disease? And that means maybe, "I wish I could go to the swimming pool and put on a bathing suit and not feel humiliated." Does that mean, "I wish when I'm shopping for a wedding dress, I could get something that kind of has a lower front and a lower back and shows off my skin, as opposed to having to cover up so nobody sees me"? Asking about their overall quality of life—how does this disease impact all aspects of their lives? And we have to remember to ask about the itch and the sleep. We feel like, ugh, I can't ask so many questions, I've got five people waiting, I got a surgery on the table. Here's a patient, they have a bad disease, but there are simple questions that you can ask, and it just helps the patient to understand that you get it, you get what their journey has been like. I always ask every patient, itch, zero to 10? 10 being the worst. How have you been not just today, but the past few days? How are you doing on average? Did you sleep? Did you sleep last night? How often do you sleep? How often don't you sleep? How often are you waking up in the middle of the night? So these are questions that can actually be asked very quickly, and a lot of times I'm asking my questions as I'm doing my physical. So I try to be very productive with my time, but I think I get a really good feel for the overall impact. Some patients say, "You know what? I do everything I want to do, and I'm fine. The rash comes up, I'm treated, I'm good. You're seeing me on a bad day. Overall, I'm great." And for some patients, they might say, "You know what? This has been devastating for me. I feel like an outsider. I'm not able to do what I want to do. I wish that I could live one day with normal skin."

Dr. Turck:
Now, before we bring things to a close, Dr. Stein Gold, let's briefly look ahead. Are there any emerging strategies you're excited about that could improve management in these difficult-to-treat anatomical areas?

Dr. Stein Gold:
There are. The good news is, I run clinical trials, so I know what's on the horizon, and that's one of the fun things that I get to do. I get to see what's on the horizon. Not everything makes it, unfortunately—sometimes we have some really amazing ideas of what's going to do well, and maybe it did well in phase 2, and then it gets to phase 3 with a lot of patients and a lot of different sites, and the drug doesn't work. So I understand that it is tremendous to get a drug from conception to FDA approval; that's a very, very high bar. In terms of topical therapy, I don't see much more on the horizon at this point that I'm excited about. We have some wonderful options now. We have three great nonsteroidal options that are changing the way we treat atopic dermatitis, so I think that's wonderful.

When I look at the other things on the horizon, we have new pathways that we are hitting. We have OX40 drugs—two different drugs that target different aspects of that OX40 pathway that's a little higher up in the treatments pathway. In theory, this is a pathway that might, more holistically, get this heterogeneous atopic dermatitis population under control. And there's a possibility that we might actually see a remission off drug with some of these newer drugs that are still in clinical trials. We have some clinical trials that are going on where we're taking different types of drugs and putting some of them together, so we're targeting more and more of those proinflammatory cytokines—again, maybe more holistically, getting patients under control.

So there's still a lot of research, and I think that's wonderful, because we're not where we need to be yet. Still, with any one drug in particular, I'm not getting the majority of my patients clear or almost clear, so I think we still have a ways to go. But I think we do have tools, especially with the systemic agents, with our biologic drugs, and the IL-13, the IL-4/13, the IL-31. The oral JAK inhibitors, I think, get the disease under control much faster than anything else. We see a reduction of itch that occurs really in just a few days. So that's quite exciting.

But overall, I'm hopeful. I'm hopeful that we continue to see more and more investment in research and development, and my goal is really to try to get every patient to a place where they're not thinking about their disease.

Dr. Turck:
Such great comments for us to consider as we come to the end of today's program. And I want to thank my guest, Dr. Linda Stein Gold, for joining me to discuss how we can improve atopic dermatitis management in hard-to-treat areas. Dr. Stein Gold, it was great having you on the program.

Dr. Stein Gold:
It's a pleasure. Thank you so much for having me.

Announcer:
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