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Treating Atopic Dermatitis in Sensitive and High-Impact Areas

Announcer:
You're listening to *DermConsult* on ReachMD. This episode is sponsored by LEO Pharma. And now, here's your host, Dr. Alexandria May.

Dr. May:
This Is *DermConsult* on ReachMD. I'm Dr. Alexandria May, and joining me to share their perspectives on treating atopic dermatitis in sensitive and high-impact areas are Drs. Naiem Issa and Allison Truong.

Dr. Issa is an Assistant Professor in the Dr. Philip Frost Department of Dermatology and Cutaneous Surgery at the University of Miami Miller School of Medicine, and a Clinical Assistant Professor in the Department of Dermatology at the George Washington University School of Medicine and Health Sciences. He's also the Medical Director of Research and Academics at Forefront Dermatology in Vienna, Virginia.

Dr. Issa, welcome to the program.

Dr. Issa:
Thanks for having me, Dr. May.

Dr. May:
And Dr. Truong is the Associate Division Chief of Dermatology at Cedars-Sinai Medical Group in Beverly Hills, California. Dr. Truong, thanks so much for being here.

Dr. Truong:
Thank you for having me.

Dr. May:
To start us off, Dr. Truong, we know that atopic dermatitis affecting the face, neck, hands, or intertriginous areas can have a much greater impact than the extent of skin involvement might suggest. So what key considerations do you keep in mind when you're seeing patients with disease in those regions?

Dr. Truong:
I think a big burden that patients with atopic dermatitis experience is often related to quality-of-life measures. These patients, especially in areas that are cosmetic appearing—for example, the face patients do experience a greater disease burden given that it is a societal area that patients expose to the world. And so they do experience more stress related to their appearance as well as other factors such as itch at night, and during the day, things that they have to deal with on a regular basis. The hands offer a different type of burden in terms of quality of life as it is things that they use on a regular basis. And cracking of the hands and fissures in addition to itch. And pain is a big issue on the hands because we do have a lot of nerve endings in the hands. And then, just in general, body surface area of eczema does play a role when I think about patients in terms of where their involvement is, how much of their distribution of their body is involved, and key features of locations, specifically face, hands, genitals, et cetera, do provide a worsened burden and quality of life for our patients with eczema.

Dr. May:
So when it comes to treatment options for these patients, Dr. Issa, topical corticosteroids are typically where we start. How do you think about optimizing the use and duration of topical therapy in these sensitive areas, and what factors signal it might be time to consider

non-steroidal options or move beyond topical therapy altogether?

Dr. Issa:
We do start with topical corticosteroids, but we are now in an era of what we collectively like to call “steroid stewardship.” We started before with topical steroids, right? We’ve got your clobetasol, triamcinolone, hydrocortisones, you name it. The goal with steroids is to have an anti-inflammatory effect, and they do a pretty decent job, but it's kind of like a blanket way of doing them that's not precise. It's a general way of stopping inflammation—not very targeted, if you will.

And we also have baggage when it comes to topical steroids. Common adverse events include, let's say, skin thinning and atrophy, right? You can have increased bruising and telangiectasias, and you can also have systemic absorption for some patients as well. So we have to keep that in mind as we practice steroid stewardship.

Now, in the current era of dermatology and medicine, we have a slew of new non-steroidal agents as well. And we won't go into all those details, but the idea is that we should be moving from maybe short-term usage of topical steroids and moving them to these non-steroidal options so we can avoid adverse events, and especially when we have chronic relapsing remitting disease such as atopic dermatitis. And especially in high impact areas as we just discussed—head and neck, genitalia, so on and so forth—where we are really limited for how long we can use the topical steroids. So those are great options when we have non-steroidal topicals.

But what we haven't touched upon just yet is that the nature of atopic dermatitis goes well beyond the skin, right? We have the nerve aspect to it, as we just briefly mentioned, but we also have the systemic inflammatory nature. You have this spillage and circulation of cytokines and chemokines that is going to be affecting multiple organ systems. We have these studies that came out of California and especially the Kaiser cohort system before; we have patients who have moderate-to-severe disease where they have potentially links to other adverse events, such as cardiovascular problems or even obesity and so on and so forth. So we have this longitudinal data that is quite interesting for these systemic patients. So the idea here is that atopic dermatitis—yes, it's beyond the skin. It goes within, if you will. And we should be moving from topicals to systemics when we have identified what is called the “moderate” or “severe” patient, and especially for patients who have not responded in the way that we would like them to respond on topical treatments.

Dr. May:
And Dr. Issa, clinical trials and real-world studies have given us meaningful data on outcomes with systemic therapy among patients with difficult-to-treat atopic dermatitis. How have recent findings related to itch, pain, skin clearance, and IgA response influenced the way you think about systemic therapy in these patients?

Dr. Issa:
We have been involved with clinical trials, and we know that is a completely different framework, right? These are patients who we are looking at very deeply. They're coming in, they're being adherent to their therapies and so on and so forth, and this may not reflect the real-world patient. So we do lean a lot on these real-world studies and these ad hoc analyses and so on because these patients are a petri dish, if you will. They don't necessarily fit into a nice, decent category. So to see that these real-world patients with high-impact site involvement such as head and neck and so on and so forth, have that clearance outcomes that we're hoping for, those deep clearances such as global assessment scores of getting a clear or almost clear or even an EASI 75—or rather, if you're looking at specific sites, just the EASI subset scores for eczema area and severity and so on and so forth—and especially when it comes to patient-reported outcomes, right? Quality of life and even other endpoints such as itch and pain, as we just mentioned. It is nice to see that, again, the real-world patient is going to have that outcome that is clinically relevant to all of us as clinicians for those patients who we will be treating in our clinics.

Dr. May:
For those just joining us, this is DermConsult on ReachMD. I'm Dr. Alexandria May, and I'm speaking with Dr. Naiem Issa and Dr. Allison Truong about treating atopic dermatitis in sensitive and high-impact areas.

So with this growing body of evidence in mind, I'd like to hear your perspectives on treatment decision-making in these patients. If we start with you, Dr. Truong, how do you approach systemic therapy selection and what patient-specific factors most influence your thinking?

Dr. Truong:
I think for patients who have significant distribution, body surface area, and quality of life measures being severely affected, I do jump more to systemic agents as a first line. I also use a lot of patient factors: whether or not they want to be involved straight into a systemic agent versus trial of either natural therapies, holistic therapies, or topical agents—both a short course of topical steroids or a non-steroidal agent. Speaking of steroid stewardship, absolutely. I think it really is a patient-physician discussion whether or not they agree to which benefits and risks that patients would like to start with as we proceed into our treatment algorithm for them.

I do try to let my patients know that our therapies are really amazing nowadays, whether we start with a topical or an oral, or a systemic or a biologic systemic. So with my patients, I like to start with shared decision-making, where we both listen and go over options, whether it's a topical agent, light therapy, oral systemic agent, or biologic injectable. And we discuss the risks and benefits of each and which they would like to start with. Our agents are highly effective and very rapid, and they quickly can reduce itch symptoms within days, often. And so patients do experience relief as soon as they start therapy.

The other consideration, which we don't love to talk about in medicine yet is a big burden on physicians, is whether or not their insurance will cover some of these therapies that albeit are amazing and highly effective and quick-acting, yet insurance does give us some decisions on whether or not which therapy is first versus not. Not all insurances require step therapy, but some do, and that does play a role in my decision-making with patients.

Dr. May:
And how about you, Dr. Issa? What factors do you weigh when selecting systemic therapy in this setting?

Dr. Issa:
So in addition to everything that Dr. Truong just said, which is very important and very practical, I find in addition that some of our patients think that they live in the world that I like to call the “Amazon Prime effect,” where they want a result yesterday and to magically appear in their house or onto their skin or within. And so actually, speed of onset of efficacy actually is quite important. And granted, we did mention before clinical trials and how that may not be reflective of real world. Some of the real-world data that I do implement is day-to-day itch reduction and, in addition, early skin clearance response. So we do have some great data on both biologics as well as oral systemics that could help achieve those early endpoints. And I use that to be able to help my patients move from topicals to the systemic world.

But there's also one more piece, I think as we are moving into this new milestone with the new data that has come out with recent studies. What happens when patients stop their systemic therapy? Can they maintain that efficacy as well as that itch reduction and that quality of life? I found before we had all these great options, when patients asked me, "Well, how long do I stay on X, Y, or Z medication?" I used to say, "Well, we just keep using it until you want to try to get off of it, and we'll see what happens." But that answer has actually changed and has become more data driven. Now, especially in the world of biologics, we have a few where we do have withdrawal arms after treatment success in those trials. And then those values for efficacies off drug helps me with that conversation with the patient or the patient's parents to say, "Look, I understand that you're afraid of a concept of a “forever drug,” but let me give you some probabilities here based on the clinical trials, and then you make your decision after that."

Dr. May:
Now, once a patient is on systemic therapy, how do you both define and monitor treatment success, especially in areas like the face or hands where clearance can look different than on the trunk? We'll start with you, Dr. Issa.

Dr. Issa:
What we as clinicians like to see is skin clearance, right? You want those patches and plaques and scaling and lichenification and so on and so forth to go away, and you want to also be able to see the hyperpigmentation, hypopigmentation, or pigmentary alteration revert back toward the normal skin. That's what we care about, and yes, we do align with patients in a sense as well. But studies have shown time and time again that we are also sometimes missing the mark as clinicians. Our patients are wanting more, and they want more of their patient-reported outcomes. They want their itch to be under control. They want the color to go back to normal, and they want to be able to have their skin just look back to normal as well. So we have to start thinking along the lines of, “What do the patients want?” Not just, “What do I want?” or “What does Dr. Truong want?” And so we have to have that alignment with that shared decision-making.

And ultimately, we should be asking our patients at every visit, "Are you satisfied?" Just that simple question is binary, zero or one. “Are you satisfied or not satisfied?” Because sometimes the patient will tell you, "Look, I do have a little bit of scale,” or “I still have a little bit of erythema or redness," or whatever they want to call it, "But I'm happy, and I didn't think that I was going to be able to live," let's say, "without itch or nearly without itch after having a disease for 20 or 25 years. I'm good. Let me just not rock the boat." And we should listen to the patient.

Dr. May:
As we wrap up for today, Dr. Truong, I'd love to hear your perspective on this as well. How do you monitor patients with atopic dermatitis in those sensitive and high-impact areas and evaluate treatment success?

Dr. Truong:
I agree wholeheartedly with everything that Dr. Issa said. As physicians and providers, we definitely are looking for clinical measures of improvement, whether that be redness, itch, dry, or scales, and for patients, some of the time, all they want is to go back to their regular

life. And I think that's really important for us to listen to what we see, but also listen to what patients have to say.

Nowadays, the world of biologics has allowed us to experience numerous options for atopic dermatitis for patients in these high-impact areas.

And furthermore, we have a whole world of oral JAK stats as well as our traditional therapies. So I think we are gifted in this day and age with lots of options. Lots of options means, sometimes, difficulty in deciding which options are best for patients, and that does come along the lines of a longer discussion during shared decision-making. But at the end of the day, I think we want our patients to be happy and to live fulfilled lives so that they can go out and be able to take care of people that they love and bring joy and happiness to the world as well.

Dr. May:
That's a great way to round out our discussion on this topic. And I want to thank my guests, Drs. Naiem Issa and Allison Truong, for joining me to share their approach to atopic dermatitis in sensitive and high-impact areas.

Dr. Issa, Dr. Truong, it was great having you both on the program.

Dr. Issa:
Our pleasure. Thank you.

Dr. Truong:
Thank you for having me.

Announcer:
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