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www.reachmd.com
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(866) 423-7849

Recognizing When to Escalate Therapy in Atopic Dermatitis Care

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

Dr. Caudle:
This is *DermConsult* on ReachMD, and I'm your host, Dr. Jennifer Caudle. Joining me to share real-world insights on when we should consider escalating therapy in atopic dermatitis is Dr. Christopher Bunick. He's an Associate Professor of Dermatology at Yale School of Medicine in New Haven, Connecticut.

Dr. Bunick, welcome to the program.

Dr. Bunick:
Thank you so much. It's exciting to be here.

Dr. Caudle:
So, let's jump right in, Dr. Bunick. What are some limitations you've seen with standard scoring tools like the Eczema Area and Severity Index and Body Surface Area when it comes to guiding treatment escalation?

Dr. Bunick:
Yeah, let's start with the Eczema Area and Severity Index, or what's known as the EASI Score. This is a very complex scoring system, and when you're in the dermatology clinic and you're seeing 40 or 50 patients a day, it just may not be the most practical tool to use. It is really better suited for clinical trials. I don't think everyday practicing dermatologists are using the EASI score, but it's important to know about so you can understand clinical trial data.

Body Surface Area is a little bit more practical in the busy clinic, because it's something that you can sort of look at, estimate, and measure. If you want to follow the palm print algorithm for measuring, there's a lot of ways to do it very simply.

The problem is that both of these measures—whether it's the EASI or the BSA—can have limitations. They only measure what we can see—the inflammation of the skin that we can see. It doesn't capture the full day-to-day experience or challenges that patients face with their atopic dermatitis. This could be different types of patient-reported outcomes or patient-reported symptoms, which would include things like itch, pain, sleep disturbances, anxiety at work, or social anxieties. These are all important measures and things that can be affected by atopic dermatitis that could harm the patient's everyday quality of life.

The other aspect of both EASI and BSA scores is that sometimes they could underestimate the disease burden of the patient. For example, one of the emerging themes in dermatology has been emphasis on high impact or special sites, such as the scalp, the hands, the feet, and the genitalia. These are areas that, when they are involved—if those are the only areas involved on the person—it could lead to a high burden of disease because they are such special locations on the human body. Therefore, a low EASI score or a low BSA may not capture someone that has really severe atopic dermatitis on the hands, that has horrible itching, horrible pain, can't do handshakes, has social anxiety, can't lift at work, or can't hold a pencil at school. These measures may not capture the full burden of the patient, for example, with severe chronic atopic dermatitis—hand eczema.

Dr. Caudle:
That's very helpful. With those limitations in mind, how do you approach cases where traditional metrics show mild-to-moderate disease, but the patient is clearly struggling?

Dr. Bunick:

Well, I think the concept of mild, moderate, and severe is evolving in dermatology. And what I mean by that is, for me personally, when I'm in clinic, I don't like using mild because I think pretty much any patient that's coming to me in clinic is already at a moderate.

And for example, in psoriasis, we've already had—just in the last few months—the International Psoriasis Council define patients as topical eligible or systemic eligible and come out with a definition that a topical failure is two four-week consecutive treatments that don't achieve clear or almost clear skin. So we have, at least on the psoriasis side, this idea that if you try a couple topicals for four weeks and then another four weeks and you're not hitting clear or almost clear skin, you're systemic eligible.

And I think that we are evolving that way in atopic dermatitis, too, where we are going to see that patients that aren't meeting, early on, certain benchmarks—this clear or almost clear skin, or no itch or no improvement of quality of life—they are going to be systemic eligible. And I think that that's where we're headed in atopic dermatitis, is thinking about topical eligible or systemic eligible. And it may be that the EASI score and BSA aren't very high, but those patients are still eligible based on other factors, which are the patient-reported outcomes that give us a clue into the quality of life.

Dr. Caudle:
Thank you for that. And you kind of helped me segue into the next question. You started talking a little bit about these patient-reported outcomes. I would love for you to talk a little bit more about the role of these patient-reported outcomes in how you make decisions. Can you talk more about that?

Dr. Bunick:
So let me give an example. Three or four years ago, if a severe atopic dermatitis patient came into my clinic and I put them on a topical therapy or systemic therapy, if they had an itch score—we score itch between zero and 10 on that numerical rating scale—of eight out of 10, and I was able to get them to a four, I would pat myself on the back and say, "Why, Dr. Bunick, you did a really good job. You really helped this patient."

But what we have learned in more recent studies is that a drop from an eight to a four actually doesn't move the patient's quality of life as much as we think. There's data showing that if you have an itch score of zero or one, which is little or no itch, and that itch score goes from a zero or one up to say a two, a three, or even higher, you could have a drop in quality of life of 50, 60, sometimes 70 or more percent. And when I saw that data, it made me really rethink this idea about how important patient-reported outcomes are in understanding the full patient experience with atopic dermatitis.

Therefore, in clinic, I pay very much attention to itch now, and my goals are no longer, "Let's get some itch improvement." The goal is really to get patients to little or no itch. And that is really the game changer there: we maximize quality of life, whether it's itch, pain, sleep, social withdrawal, or other anxieties. We maximize the patient's quality of life when we optimize and hit minimal disease activity. And there's new research showing that, that when you achieve minimal disease activity, you do actually achieve higher quality of life for patients. And so for me, I think that is the biggest change, clinically, that I have seen. I've gone from, "Wow, it's not good enough to get this itch change," to "How do I achieve a minimal disease activity for my patients?" Because I know that that's going to give them the best likely chance to have a normal life.

Dr. Caudle:
For those of you who are just tuning in, this is *DermConsult* on ReachMD. I'm your host, Dr. Jennifer Caudle, and I'm speaking with Dr. Christopher Bunick about the real-world burden of atopic dermatitis and how it can guide treatment escalation.

So, Dr. Bunick, let's shift gears for a moment and talk about systemic therapy. What are some red flags or tipping points that may prompt you to consider a step-up?

Dr. Bunick:
One of the things that I like to do when I talk to patients—so, first of all, that's actually the number one most important thing. Talk to your patient. Start there. As a clinician, it's important to talk to your patient. What I try to do is, I gauge the frustration level of the patient. There are some patients that come in, and they have skin involvement, they have atopic dermatitis, and they just aren't bothered by it. And then there's some patients that come in and they are tremendously frustrated by it.

But what we've been talking about through these series of questions is that reality that atopic dermatitis goes beyond the skin. It affects multiple aspects of the patient experience. We talk about the itch, the pain, the sleep, the social anxieties, et cetera. And an important point for me is that I will go to a systemic therapy if a patient's quality of life is out of proportion to their skin. I may treat a patient based on their quality of life being very low, even if their skin may not meet certain metrics.

We also see in patients, topical fatigue. Something that I'm very aware of is that many patients, when they've tried one, two, or three topicals, they are just a little bit tired of using topicals. And this makes compliance with therapy difficult. I do think that going to advanced

systemic therapy can be the right step if it improves patient compliance. And I think that this is incredibly important.

And then I'll add one last point here. I think it's been made a lot more on the psoriasis side of inflammatory skin diseases. And that is the burden of moderate-to-severe atopic dermatitis on the entire human body inside. So what I'm getting at is the cardiovascular impact of systemic inflammation. There's been some new literature out looking at how atopic dermatitis patients that are moderate to severe actually have subclinical atherosclerosis at levels similar to psoriasis patients or just under where psoriasis is. It's closer to psoriasis than it is to healthy patients. And I think that this goes to show, when I'm interacting with my patients, I'm also thinking in my mind, “What do I need to do to optimize the healthcare of this patient, not only externally, but internally?”

Dr. Caudle:
So interesting. Thank you for sharing that. Pulling all of this into practice—and you've given a lot of great real-world advice, examples, and suggestions—can you share, in addition, a real-world example where maybe one of your patients' symptoms didn't match the objective severity scores, and how that affected your approach to systemic therapy initiation in that case? Can you maybe talk about a case?

Dr. Bunick:
Yeah, I'd love to. There's one case that's always stuck with me for a number of years now. I had a roughly 30-year-old gentleman that came into my clinic. He was coming from out-of-state, actually, for guidance and for help. And he was very miserable. And I'll tell you how in just a second. When he came into clinic, his skin exam was not overly impressive, meaning that I had seen far worse atopic dermatitis patients. He may have had some patches and plaques on the trunk a little bit—maybe a body surface area between five and ten percent. And for some people, that's certainly in the moderate range. But compared to a lot of the severe patients that I saw, it didn't seem as bad as what one might expect. But his quality of life was significantly low because this was a gentleman who was a swimmer.

He was a swimmer and every single time he went into the pool, his skin felt pain. It was burning and stinging, which falls under skin pain. And he also did have itch. But he basically said, “I swim, I'm a swimmer, and I'm in pain every single time I go into the pool.” And when I heard that, it was just, “How do I help this person?” It doesn't matter how much skin involvement they have. What I'm hearing is that this quality of life and his passion for swimming—his exercise, which is important for overall health too—is being harmed by the patient-reported outcome measure—in this case, a combination of skin pain and itch. And I started him on an advanced systemic therapy—a biologic therapy—and he remains, actually, on that therapy to this day, and is doing phenomenal. And he is very thankful for that intervention.

Dr. Caudle:
Wow, that's a very powerful story. I really appreciate you sharing that. I know it's going to stay with so many of us. And before we come to the end of our conversation today, do you have any final thoughts you'd like to leave with our audience?

Dr. Bunick:
Well, what I would say is that atopic dermatitis is a very important and serious systemic inflammatory skin disease. And as we talked about, there can be internal systemic complications. I think that the quality of life of patients with atopic dermatitis is harmed maybe more than we think, and so I think that there are a few practical things that we can do in clinic. The first is, if you need a simple measure of what to do in clinic, if it's not body surface area, it could be just an IGA score—an investigator or physician PGA. That's Physician Global Assessment score, where you're just looking at clear, almost clear, mild, moderate, or severe. And our goal is to get the patient to clear or almost clear—IGA score of zero or one. That's an optimal treatment target.

When it comes to patient-reported outcomes, if you can't remember all of them, then the three to focus on the most would be itch, pain, and sleep. And when it comes to itch, again, you can simply measure the itch zero to ten. Our goal is to hit the optimal treatment target: itch zero or one.

If you want to strive for where the recommendations are going, you put those two together. How do I achieve clear or almost clear skin and little or no itch or pain plus optimal sleep? You put those together and try to achieve both, that is minimal disease activity, and that's where the data says our patients are the happiest and have the greatest quality of life improvement.

And that's what I'm doing in practice. I'm a big believer in elevating the standard of care for patients. And I think this does that for atopic dermatitis patients.

Dr. Caudle:
Thank you so much. As these final comments bring us to the end of today's program, I'd like to thank my guest, Dr. Christopher Bunick, for joining me to discuss when and how to recognize the need for systemic therapy in atopic dermatitis. Dr. Bunick, it was great having you on the program.

Dr. Bunick:
No, thank you so much for having me.

Announcer:
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