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Strategies for the Long-Term Control of Atopic Dermatitis

Announcer:
You're listening to *DermConsult* on ReachMD, and this episode is sponsored by LEO Pharma Inc. Your host is Dr. Raj Chovatiya.

Dr. Chovatiya:
Welcome to *DermConsult* on ReachMD. I'm Dr. Raj Chovatiya, and joining me to discuss strategies for the long-term control of atopic dermatitis is Dr. Melinda Gooderham. Dr. Gooderham is the Medical Director for the SKiN Center for Dermatology and the principal investigator for the SKiN Research Center in Peterborough, Ontario. Dr. Gooderham, it's always great to have you with us.

Dr. Gooderham:
Thanks so much. Appreciate the invitation.

Dr. Chovatiya:
Well, you're the right person to ask the series of questions I have for you because as far as atopic dermatitis goes, I know that your knowledge is top-notch, and I really want to start off with a little bit of background. Why should we be thinking about atopic dermatitis in our adult patients or even sort of our elderly patients? I know that historically we thought about this as a childhood and infancy kind of disease, but how has this thinking shifted a little bit?

Dr. Gooderham:
Yeah. When I even think back to residency, we used to think of this population a lot differently, and adult-onset AD was so rare, especially in the elderly. We blamed it on their medications and on all these other issues, like cirrhosis, and we just weren't thinking about atopic dermatitis as a diagnosis. And I think it is really important in taking a good history. And a lot of times in these patients, you can find out about childhood rashes or things that show their atopic predisposition.

Dr. Chovatiya:
So thinking about that in mind, what should we consider for our adults and older adults with atopic dermatitis as far as it relates to what might be the best therapeutic option for them when we're balancing safety and efficacy? Because I know that before, we didn't really have that many options, and we weren't really that keen on starting many of our immunosuppressive therapies in our older population.

Dr. Gooderham:
That's a great question because yeah, you're right. We were very reluctant, like cyclosporine to a 75-year-old, we just didn't want to do that. And so they just kept getting more and more tubs of topical steroid creams to slather on everywhere because not only are they often immune challenged, but they have other comorbidities and other medications we have to consider. So now that we have more targeted therapies, we don't have to rely on these conventional systemic agents that have off-target effects and organ toxicity. We can actually treat the type 2 inflammation that's causing the symptoms with some of these targeted therapies.

Dr. Chovatiya:
Maybe we can zoom in on some of those monoclonal antibodies or biologic therapies. How do you talk about this with your patients when it comes to thinking about this being an appropriate treatment choice, especially when we know in our populations that are kind of older, they might be on a variety of other medications, or they may not be so keen to start something else. How do you have that discussion?

Dr. Gooderham:
Well, a couple of things. Number one, I find in this day and age, patients are a lot more accepting of injectable medications as opposed to even 10 years ago just because not only in dermatology but in diabetes, in cancer treatments, in cholesterol management, all of

these other therapeutic areas use injectable biologic medications. So these patients often have spouses or family members who are getting a medication that is targeted and delivered by an injectable method. So patients I find are a lot more open to that discussion these days, and it is very reassuring to tell them that there will be no drug-drug interactions to worry about with their other medications. It's something that is not required on a daily basis. So it's convenient for them to have intermittent dosing and that they're going to have the efficacy along with the safety, so we don't have the end-organ toxicity and the off-target effects that they may have heard about in the past with other treatments or with the course of prednisone that they were given in the emergency department where they may have had some side effects.

Dr. Chovatiya:
Is there any special screening that you think about when you're starting a medication therapy like this in that kind of population?

Dr. Gooderham:
For an injectable monoclonal antibody for atopic dermatitis, there is no indicated workup on the labels of available agents. And so I'm usually starting this medication after the patients have been monitored for something else. Maybe they were on a conventional systemic before. So I don't typically have to do a workup or monitoring in these therapies unless it is indicated for some reason that the patient has a comorbidity or something, but a routine workup and monitoring is not required.

Dr. Chovatiya:
For those of you just tuning in, you're listening to *DermConsult* on ReachMD. I'm Dr. Raj Chovatiya, and I'm speaking with Dr. Melinda Gooderham about how we can ensure long-term control of atopic dermatitis.

So, Dr. Gooderham, now that we have a better understanding of some of the treatment options that we might be thinking about, maybe you can kind of take this to a more practical sense. How do you work with your patients to select a therapy? Knowing that we have a lot of different options in topical, oral, and injectable formats for our patients with atopic dermatitis, what are the principles that you really hinge that discussion on when it comes to different aspects of patient choice, safety, and efficacy?

Dr. Gooderham:
I like to start by telling patients there are new options available that are not a steroid because I find even after five- or ten-minute conversations with patients, they'll still question, “Oh, so is this a steroid?” And “No, as I mentioned initially, there's no steroid in this.” People have a lot of fear of steroids. They may have been treated in the emergency department or by their primary care practitioner with repeated courses of steroids. So I like to put that upfront — that we have other options that are available. And then I like to tell them about the different formats: topical therapy, phototherapy, which we do offer in my clinic, and then oral and injectable. And I find that sometimes patients will just jump at first, like, “Oh, I want to take a pill.” And I say, “Okay, for sure. We'll keep that in mind, but let's talk about the different options available, the efficacy that can be provided, and then the safety that goes along with it. Are there any trade-offs for the treatment?” So I actually have a handout that's prepared in a table format for my patients to take home and think about if we don't come to a decision at that clinic visit so they can see the risks and the benefits of each of the options.

Dr. Chovatiya:
Now when we think about some of these approaches, I think one of those big buzzy words that we like to think about is long-term control. And we know that atopic dermatitis is a chronic disease, and there are a lot of different ways to think about what long-term control means. How do you talk about that with patients who have been dealing with a chronic issue and are looking for something that is going to chronically manage their symptoms and signs? Is that something that figures into your discussion when you're helping to choose a therapy?

Dr. Gooderham:
Yeah, because often patients will say, "How long do I have to take this for?” Or “At what point can I stop this? When I get clear?” So I like to have that conversation upfront. This is a chronic condition typically, and, especially with the adults, they have other chronic conditions that I can use as an example. And I'll say, “You’re on your hypertensive medication, and you'll stay on that. And so it's the same with managing the atopic dermatitis—the plan is to treat it for the long term.” Like you, I'm at a lot of conferences getting the updates so I can give them the information; “I was just at a conference where we talked about the four-year long-term efficacy and safety data of these different medications or the five year,” or I can use my own clinical trial patients as an example and say, “I've had patients from the phase two study. They've been taking some of these medications for eight and nine years, and really their lives have changed and they're living their best life in a very safe and effective manner, and they're continuing on the therapy.”

Dr. Chovatiya:
Yeah, sometimes the package insert data based on these endpoints of EASI-75 success doesn't resonate quite as much as some of those stories. And like you, I found dealing with my own research patients or my own clinic patients really tends to resonate with the patients when they're kind of on the fence about what might be the best choice of action. And in our last minute or two together before

we close, speaking about being on the fence, do you have any final thoughts that you might want to share for clinicians out there who may seem or feel overwhelmed with all the new therapeutic options they have and really sort of are struggling with how they present these options to their patients and figure out exactly how to match the right therapy with the right patient?

Dr. Gooderham:
I do recommend having some form of literature, whether you create your own one-pager table like I've done from my clinic or there's lots of stuff available online. I think there's little things you might forget to bring up. So I like having that. Some people do it like a checklist. Some people do it like an info sheet or a handout. I think that's a really good guide. So when you are about to start that conversation, you can pull out that piece of paper and go through it with the patient. I find that's easier. They can take it with them so that you don't get home trying to remember what you talked about. And then as far as you talked about the patient sitting on the fence and how do you get them to agree to try something new, talk beyond the EASI improvement or how clear their skin will look, and talk about how their lives can change, using suggestions such as patients might sleep better, they have less itch, they're able to concentrate more, and they're able to do things that they weren't able to do because of their atopic dermatitis. So putting it beyond the skin clearance and more about quality of life, sleep, and itch I find is what speaks to my patients anyway. They don't care so much about what their skin looks like. It's what it feels like.

So I guess my advice to somebody who doesn't know how to choose the right therapy is you have to understand it's going to be a decision with the patient. These patients really want to take a big part in their decision-making, and I find educating them, giving them a handout, bringing them back in, and having them think about it really goes a long way. That first visit might take a bit longer, but all subsequent visits will be much easier moving forward.

Dr. Chovatiya:
Love it. Couldn't have put it any better myself. Well, with those final thoughts in mind, I want to thank my guest, Dr. Melinda Gooderham, for sharing her insights on long-term management strategies for patients with atopic dermatitis. Dr. Gooderham, it was great having you on the program. Thanks so much.

Dr. Gooderham:
Thanks for having me. Always fun.

Announcer:
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