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Breaking the Cycle: Strategies to Reduce Biologic Switching in Atopic Dermatitis

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

Dr. McDonough:
Welcome to *DermConsult* on ReachMD. I'm Dr. Brian McDonough, and joining me to discuss biologic cycling in atopic dermatitis and strategies for maintaining treatment continuity is Dr. Brian Kim. He's the Vice Chair of Research and the Site Chair of Morningside and Mount Sinai West in New York City. He's also Director of the Mark Lebwohl Center for Neuroinflammation and Sensation and Lead of the Allen Discovery Center for Neuroimmune Interactions at the Icahn School of Medicine. Dr. Kim, thanks for being here today.

Dr. Kim:
Thank you for having me.

Dr. McDonough:
To kick things off, Dr. Kim, could you give us some background on what biologic cycling is and what its potential implications are for patients long-term outcomes?

Dr. Kim:
I think biologic cycling essentially means patients are trying to find the best drug for them. We have a number of different biologics now on the market, and what I often say to people is that the clinical trials are just really trying to see the difference in terms of the effect of a drug versus placebo. That doesn't really tell you what drug is best for that patient, because these trials are run individually. So it's really that cycling is trying to find what's best for you, and that decision is made between the provider and the patient.

Dr. McDonough:
With that being said, what are some of the common drivers that lead patients and providers to abandon or switch biologics early on?

Dr. Kim:
I think the number one is going to be, does the drug work? Simply, is the drug gonna work? Is it actually gonna improve their disease and accomplish what it needs to? But also, another common one is if you encounter a side effect or if you have an adverse event on the drug—that's obviously going to impact patients, particularly if it's not something that you can get around very easily.

And then another area is the ease of use. How easy is it? Does it require lab monitoring? Does it have other risks that are not necessarily adverse events or side effects? If you have certain theoretical risks of the drugs, that also would raise a lot of concerns for patients.

So I think all of those combinatorially impact the patient's decision. And what I find is it also really depends on the mindset of the patient and what their risk-benefit profile is. Is the patient a child? A challenging thing is actually, with children, when there's a difference of opinion between the child and the parent as to what they want to do.

Dr. McDonough:
Now, from my understanding, administration barriers can be another piece of the puzzle. So how do issues like prior authorization, delays, or pharmacy fulfillment gaps contribute to biologic cycling?

Dr. Kim:
Unfortunately, that's just a reality that we are dealing with, is that sometimes prior authorizations and step edits that patients have to go through do not necessarily, as we all know, follow medical logic, but have to do with different kinds of deals and health economics that

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have very little to do with the medical necessity or requirement. So this does impact us, unfortunately, quite a bit in the real world, of course.

Dr. McDonough:
So, really, it's not just the laboratory setting. We're dealing with the day-to-day real life frustrations at issues in trying to get this done and getting it done the right way.

For those just joining in, this is *DermConsult* on ReachMD. I'm Dr. Brian McDonough and I'm speaking with Dr. Brian Kim about the key drivers behind biologic cycling in atopic dermatitis.

So, Dr. Kim, now that we've established the challenges leading to biologic cycling, let's talk about how we can overcome them. What are some best practices, strategies, or tools that clinicians should use to reduce cycling risk and set patients up for long-term treatment?

Dr. Kim:
I think first and foremost, what you have to know is what the patient actually wants to achieve. What is it about their disease that is impacting them the most? As an example, in atopic dermatitis, it's often the fact that they itch or that they're up at night, but there are many components to diseases like that, where they don't want to use topical agents anymore. They're tired of using topicals, or they have burning and stinging. Or it's the fact that they can't wear a dress because of the disease, and all they want is to be able to wear a dress for the first time in their life.

I think knowing what they really want to achieve based on the therapy, first and foremost, is really important, rather than just plug and chug and say, "This is gonna be first line, this is gonna be second line, this is gonna be third line." And in reality—this discussion came up with another colleague of mine recently, where we said, "There's no such thing, in atopic dermatitis, as first line, second line, or third line," the way we think, say, with cardiology guidelines or something like that. We were kind of joking that everything's first line. The question is, what's best for the patient?

Dr. McDonough:
I would think too, being proactive must play an important role in the things you're doing, as far as all these protocols and addressing the various options.

Dr. Kim:
Yeah, absolutely. It's also warning them about what could happen and what may not happen. So one big cultural shift we've had in dermatology is that the expectation, for instance, for the improvement of itch has gone up considerably in terms of the time dimension. So, say 10 years ago, no one was really expecting their itch to improve, even within a matter of weeks.

But now, it's not uncommon for patients to say within a week they think that the drug's not working if it doesn't improve their itch. That's a big shift, and that's largely due to the fact that we now do have therapeutics that improve itch on very short timescales now, like we've never seen.

Dr. McDonough:
I could see where the problem with pharmacies not having or being able to fulfill prescriptions of that, that'd be an issue as well, because people have their expectations, and now all of the sudden they're saying, "Wait a minute. I want that help. I want the relief."

Dr. Kim:
Yeah, absolutely. And people hear from other patients as well. They say, "Oh, I got on this drug, and it's changed my life," or, "I improved so quickly." So the word's out in terms of what drugs can do and how much people can improve. And, honestly, a lot of what I get through my clinic is word of mouth now.

Dr. McDonough:
A lot of that's patient education. Zeroing in on patient education for a moment, how important is it in minimizing unnecessary cycling, and are there any key messages that we should be emphasizing?

Dr. Kim:
There's appropriate cycling. So if you have inadequate response to the first drug that you go on, it's not satisfactory, and you're not meeting the endpoints that you initially had that great discussion about with the patient and about what their goals are, then cycling off makes sense.

If you have an adverse event that could be circumvented with another drug, cycling makes sense. But I think cycling sometimes happens because there's a misunderstanding, there were mismatched expectations, or there's lack of confidence. Therapeutic confidence is very important. I always tell my residency, you want to establish confidence with these patients upfront that, one way or

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another, you're going to get what's best for them in front of them. So I think from that standpoint, you really want to have clear communication, therapeutic confidence, and realistic expectations.

Every patient's different. So, for instance, I'm a scientist. I've done clinical trials and I look at aggregate data. We think about biology deeply, but I always tell my patients, "When you come into my clinic, all that data, all that biology, is entering into my decision making in a very different way." It's all being transfigured into intuition. It is no longer about just the data—it's really about a gut feeling that I'm getting in this patient as to what they need from that conversation and what I know.

I literally say that in my clinic, because I think it's very important for the patient to know that you wanna do what's best for them and that they're not just a mean data point in a clinical trial. And I think the therapeutics are lending that level of personalized granularity in terms of what we can do for these patients.

Dr. McDonough:
That's a great point, Dr. Kim. I know in training my residents, it's really about managing those expectations. Because if you don't, the patients might think you're not doing a good job, when in fact, you're doing a great job, but you didn't tell them what they should expect now. But I would think with something like atopic dermatitis where you have an itch, or you got these things, you want results.

And at least if you're, at the beginning, saying, "Hey, this may not give you complete relief, but some relief," or, "We're gonna take an amount of time to do this", that has to be helpful.

Dr. Kim:
It's critically important, and I think also about side effects. We've had drugs demonstrate certain kinds of AEs in the clinical trials, and sometimes, people are dismissive of it, but in the last five years, we've had experience with a lot of new drugs becoming FDA-approved for atopic dermatitis and other related conditions.

I think it's very important to know what the side effects are and let them know right away, because then they don't panic. And this literally happened this past week with me with a new drug that came to market. And they had a very unique side effect, and they didn't panic. They stayed on the drug and they just let me know, as I asked them to.

And I think holding their hand through both the highs and lows is critically important for avoiding cycling, for sure.

Dr. McDonough:
As we come to the end of our program, Dr. Kim, what takeaways would you like to leave with our audience today?

Dr. Kim:
The takeaway is that there are a lot of great drugs for atomic dermatitis right now, and not one single drug is gonna be best for everybody. And I think really understanding what the best drug is for that patient in front of you is really important—using everything you know about the drug and knowing it deeply, and also everything you know about the patient and their disease itself, but also their expectations of their disease, and making that best decision upfront.

And that includes comorbidities. There are certain comorbidities that patients may have—like asthma or even something like food allergies—that actually may make them more appropriate for one drug versus another. Or a patient might have a comorbid autoimmune condition that might make them more appropriate for one drug or another in terms of the arsenal drugs that we have.

So that would be my takeaway, is that we're not doing first line, second line, or third line. We're doing truly precision personalized medicine. What's the best drug for that patient?

Dr. McDonough:
With those key takeaways in mind, and I want to thank my guest, Dr. Brian Kim, for joining me to discuss how we can improve treatment continuity in patients with atopic dermatitis. Dr. Kim, it was great having you on the program.

Dr. Kim:
Thank you for having me.

Announcer:
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