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What's New in Dermatology: Key Updates on Emerging Therapies

Dr. Turck:
Welcome to *DermConsult* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss what's new in the world of dermatology treatment is Dr. James Del Rosso. He's the Research Director at JDR Dermatology Research, an Adjunct Clinical Professor of Dermatology at the Touro University Nevada, and a practicing dermatologist in Las Vegas, Nevada. He also presented this topic at the 2025 Fall Clinical Dermatology Conference for Physician Assistants and Nurse Practitioners. Dr. Del Rosso, it's a pleasure to have you on the program.

Dr. Del Rosso:
It's great to be on, Charles. Just call me Jim. Thank you very much.

Dr. Turck:
Absolutely. So what's new in the world of dermatology? If we look at the newest therapeutic developments, Jim, what stands out most to you?

Dr. Del Rosso:
So there's a variety of different things that we discuss, and I'm part of the group that puts on this meeting for years, and we really enjoy doing it. The dermatology physician assistants and nurse practitioners are an integral part of dermatology practice—and a very important one—so we like having these interactions and being collegial and collaborative with them.

But there are a lot of different therapies, too numerous to even stay on top of in many ways. So one of the areas that I'd like to address—because for most of my career, I did not have most of the therapies we have more recently that could actually get people a lot better with many disease states. We had things that didn't really work all that well for diseases like severe atopic dermatitis, more severe psoriasis, hidradenitis suppurativa, severe cases of alopecia areata, even moderate cases, vitiligo. You'd feel like you didn't have much to offer. Now we have so much to offer. But just because we have a therapy that's effective doesn't mean we're always going to be able to get it to the patient because there are these people in the middle that then look at whether they're going to approve a treatment for a patient that the clinician feels the patient definitely needs, but there's barriers in terms of coverage, prior authorizations, and things of that nature.

So one area where we had a big advance that I really was happy to be able to address at this meeting is for severe alopecia areata. And as I'm sure you know, Charles, with alopecia areata, people lose different amounts of hair, but we're talking about patients who lose a lot of hair on their scalp. They may have certain comorbid diseases, autoimmune diseases with that. In some cases they could lose eyelashes—very psychologically stressful. It can happen very quick, and it's challenging to get regrowth. So we actually have three FDA-approved oral agents that are Janus kinase inhibitors. And there's three of them that have been approved for some time. One of them is baricitinib. There's two different doses—a lower dose to start, and then you can progress to a higher dose. That's approved for severe alopecia areata in adults. Then there's ritlecitinib. That's approved in adolescents and adults, so they have to be at least 12 years of age. Adults are 18 years of age and older, once a day, 50 milligrams once a day. A different Janus kinase inhibition and also another kinase—a Tec kinase, also very effective.

And we've learned from these drugs that they have considerations, some box warnings and considerations in terms of doing some laboratory testing that you monitor and things that you need to watch with the patient, but by and large, most of the patients do extremely well. And it takes time, but they can grow back a significant amount of hair, sometimes even get complete regrowth.

And then we have a newer agent that is FDA approved that's just getting into the marketplace, and that's deuruxolitinib. And

deuruxolitinib is also a Janus kinase inhibitor, and it's an 8 milligram oral agent given twice a day—also very effective, also has the warnings that you have to monitor—but it has an additional warning that's different than the others. They require that you do a blood test to test a particular metabolic enzyme, cytochrome 2C9, that the company is agreeing to pay for, but it's required to be sure the patient's not a slow metabolizer. You don't want them on any drugs that can significantly affect that enzyme because that can make it harder to metabolize the drug. But once you get past that, that's another choice that you have.

Moving forward with that, the way the studies were done, the patient had to have at least 50 percent of their scalp hair loss gone in order to get into the study, And they had to, by the end of the study period, whatever number of weeks or months it was in the study—and it takes some time—you're typically going to be looking at 24 weeks or beyond that, and the patients still continue on after you evaluate the endpoint—they had to get to less than 20 percent hair loss. And there's a score to evaluate the scalp hair loss. It's called the SALT score.

What happens sometimes is the insurance company or the third party would say, "Well, to be severe, they have to have 50 percent scalp hair loss." Well, the indication doesn't say that number specifically when you read the indication, but they pull that out from the studies. The bottom line is, a way to consider that is when you're in the room with the patient who comes in and has lost a significant amount of their hair, now they have eyelashes and eyebrows that are missing or partially missing; they're under a lot of psychological stress. The clinician's in the room with the patient. The package insert is not. The person that's discussing the prior authorization is not. The textbook is not. The journals are not. These people have other factors that could make it severe, and there's actually a publication that was written by Brett King and others that addresses this, and it points out that if you have a patient—let's say they fall in the moderate category, so they had about 21 percent to 49 percent diffuse scalp hair loss or that much involvement lost. They're moderate. And if the insurance company or whoever is saying, "Oh, you're not covered," they then list other criteria that you as the clinician are capturing. And this is a big deal.

If we just talk about nothing else, this is really what needs to be brought forward to make a difference in treating patients in the real world that you have in front of you, that have a bona fide significant problem. This is not just something minor that's being blown out of proportion if they have significant psychological distress and depression; they're explaining to you that they're extremely anxious about it; maybe they have other considerations about it that they're not going to work certain days; and they don't know what to do. Significant psychological effects. And anyone sitting in that seat would likely have that if they had that problem. It's easy to be in an office somewhere and say, "No, no, this doesn't meet the criteria," if you or a loved one does not have the problem. Take it one step beyond that. If there's eyelash or eyebrow loss, that's a factor. If you do a light pull diffusely on the scalp and hairs are coming out very easily, which they shouldn't, or if you tried other things for at least six months, each of those raises the severity one level, so it would go from moderate to severe. So your designation is that this is a severe case because of the following criteria, not just looking at a pigeonhole assessment.

I think that's extremely important that any clinician be able to access the information. It's very important. The patient-reported outcomes are not always what gets a drug approved, but what the patient's going through is what the clinician is dealing with realistically every day in their office.

Dr. Turck:
For those just tuning in, you're listening to *DermConsult* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. James Del Rosso about novel treatment options showing promise in the world of dermatology.

So, Jim, in your presentation, What's New in the Medicine Chest, what else did you cover?

Dr. Del Rosso:
I wanted to make sure that the clinicians there knew that there were things beyond these inflammatory skin diseases, biologics, Janus kinase inhibitors, etc. Actinic keratosis, which are extremely common and are the first visible sign on somebody's skin that you're seeing progression to a skin cancer, they've been labeled pre-cancers. They're typically on sun-exposed—they can be more commonly on fair-skinned individuals, but anybody can have them. We've had a variety of different topical treatments to treat the field involved. You can use liquid nitrogen cryotherapy to treat the ones that you can see, which is akin to pulling weeds out of your lawn, but you also have topical therapies you could use on the field to treat what you can see but also address the subclinical lesions, like the weeds that haven't come up yet. But if you only pull the weeds that you see, you're going to have weeds a week later because there are some that are under the ground, and that's what you're doing with the field treatment for actinic keratosis.

We have a therapy called topical tirbanibulin, which is a 1 percent topical formulation that comes in a packet that's put on in the thin layer once a day for five days. You evaluate it over time, usually at about two months. You see basically what the final effect of that therapy is going to be. It has a very low grade of inflammation the first to the second week, unlike a lot of the other therapies that we had

that had a lot of brisk crusting—people didn't want to go outdoors and sometimes were painful or itchy. Tirbanibulin is less, and it's for a shorter period of time, so it compresses that. And it's a new mechanism of action, but it's actually recently been approved for treating an entire field—the 100 square centimeter area. Most of these drugs, the vast majority, were approved in a 5x5 square centimeter area, which is very small. This is approved by the FDA for field treatment for an entire area—the field that you're treating on the scalp and/or the face—so that's available now. It is FDA approved. There's a larger packet size to be able to cover the larger area. So it's important that people know that it's FDA approved and available to their patients.

Another area that I discuss is the different biologics that we have for atopic dermatitis. And we've had dupilumab for—really, we're running into eight years now. It has seven indications. It has indications in dermatology, but it has indications for asthma, chronic obstructive pulmonary disease, and chronic rhinosinusitis with nasal polyps. It has seven indications. It's probably going to get past that with some of the things that are coming along. But it's FDA approved for some time in atopic dermatitis down to the age of six months, so it's approved to a very low pediatric age group. It encompasses many of the patients that have atopic dermatitis, and it's been around for a long time, and it has very well-substantiated efficacy. So we have data out seven years. And we show that most patients do extremely well in all the different age groups. There can be some that don't respond or occasionally get some adverse events. That can certainly happen. There are some that are listed in the package insert that you need to be aware of so you can choose other options. We also have data on retreatment, where if a patient has to stop and restart, the majority of them are going to pick up where they left off and have improvement.

So there's a lot more data. We don't have time to cover all of it, but there are a couple of new biologic agents. We have two agents that inhibit interleukin-13. That's just one cytokine. And dupilumab is interleukin-4 and interleukin-13. So we have dupilumab, we have tralokinumab, and we have, more recently, lebrikizumab. Both of these are very effective for atopic dermatitis. And after the patient gets to a point of improvement at about 12 to 16 weeks, you can actually extend them out from every two weeks to every four weeks, where dupilumab is always based on every two weeks, except in the very young age group where it's once a month. And then the more recent agent we have is anti-IL-31, which is nemolizumab—a different mechanism, very potent against itch but also effective for atopic dermatitis—and it doesn't carry, at least thus far, the risk of potential conjunctivitis, which dupilumab and the anti-IL-13s can have.

These drugs are all different, even if they look the same. Even the two anti-IL-13s have different bindings and different characteristics, so what's happening with one may not happen with the other. So we do have data. If someone gets conjunctivitis or ocular surface disease severe enough with dupilumab, there have been several cases that they can go on tralokinumab. Their atopic dermatitis is controlled well, but they don't get the conjunctivitis they got with the dupilumab, so that's also important. And it's also likely the same with lebrikizumab. We have some examples of that. Nemolizumab did not have any conjunctivitis higher in the active group than the placebo group. So it's nice to have these different options.

A lot more was covered. I get very excited about all of this because 90 percent of my career I didn't have this sort of stuff, so I'm happy to have this stuff right now.

Dr. Turck:
Well, with those observations and insights in mind, I want to thank my guest, Dr. James Del Rosso, for joining me to discuss new developments in dermatology. Jim, it was so great having you on the program.

Dr. Del Rosso:
It was a pleasure, and hopefully, we'll get to do it again. Thanks a lot.

Dr. Turck:
For ReachMD, I'm Dr. Charles Turck. To access this and other episodes in our series, visit *DermConsult* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.