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Adherence Amplified: Optimizing Topical Therapy for Psoriasis

Announcer:
You're listening to *On the Frontlines of Psoriasis* on ReachMD. And now, here's your host, Dr. Raj Chovatiya.

Dr. Chovatiya:
Welcome to *On the Frontlines of Psoriasis* on ReachMD. I'm Dr. Raj Chovatiya, Associate Professor at the Rosalind Franklin University Chicago Medical School and Founder and Director of the Center for Medical Dermatology and Immunology Research in Chicago. And joining me today to share his thoughts on strategies to improve adherence to topical agents among psoriasis patients is the inimitable Dr. Steve Feldman. He's a Professor of Dermatology, Pathology, Social Sciences, and Health Policy at the Wake Forest University School of Medicine in Winston-Salem, North Carolina.

Dr. Feldman, as always, it's great to have you here with us today.

Dr. Feldman:
The pleasure is mine.

Dr. Chovatiya:
Now for some background—and these are studies that you definitely know quite intimately, let's say—they actually show that only about 50 percent of psoriasis patients are adherent to topical medications by the end of an eight-week treatment period. Steve, what do you make of this finding based on what you've seen in your practice and your years of research? And what are some of the factors that you hypothesize contribute to nonadherence in the real world?

Dr. Feldman:
Yeah, I think that's an overestimate of how people are adhering. The studies that I'm familiar with show that 50 percent of people with psoriasis in research studies are adherent to their topicals, so they've been given the medicine, they're highly motivated research subjects, and even they're only using the medication about 50 percent of the time by the end of eight weeks. So I think the adherence of real-life patients is much lower. One of my favorite studies that was done was done in Denmark where they show that 50 percent of the psoriasis prescriptions weren't even filled, so you're starting with 50 percent not being filled and then in clinical trials, 50 percent not getting used. And then in real life, it's probably even less than that.

I think the biggest factors that contribute to poor adherence is the assumption that people will adhere if all other things were okay. I think the default assumption with human beings is that human beings are not going to do something unless you make them do it, and so I think our default assumption has been wrong all along.

Dr. Chovatiya:
Yeah, it's interesting. We look at it almost as a zero-sum equation, right? Where it's either zero, somebody doesn't adhere, or 100, like they adhere, without realizing there, in fact, is a very broad middle ground that probably exists in between those two.

Dr. Feldman:
Yes. There's such a wide range of adherence behavior from your obsessive-compulsive patients who bring you multicolored Excel spreadsheets and they work as certified public accountants who use the medicine religiously to those patients who almost never use the medicine but tell you that they do. In fact, it's even broader than that because you'll have some patients who have overuse of medicine. One of our studies where we told people to use the medicine twice a day saw patients using the medicine up to 14 times a day.

Dr. Chovatiya:

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That's incredible. I'd say that the adherence behavior is one part of it, but the real impact that nonadherence can have on patients' quality of life and the healthcare system is another one too. Maybe you can walk us through some of the multilevel impacts that nonadherence can have across some individuals' health and the population health and public health as a whole.

Dr. Feldman:
Sure. I mean, psoriasis and other skin diseases are horrible, and patients' quality of life is miserable. Then you give them effective therapy, and their quality of life remains miserable because they're not using the effective therapy. The dean of our medical school once said to me, "This is really surprising to me, Steve," because, you know, he was an internist. He took care of patients with what you would call "silent diseases," like hypertension, and he figured that adherence is bad then, but if you had a disease that was bothering you, like eczema or psoriasis, that you could see and feel, you would use your treatments, and I explained to him that the one thing I learned about adherence in medical school was that while you could in theory cure gonorrhea by taking an antibiotic pill twice a day for one week, we never treat gonorrhea that way. We treat it with injections, a one-time injection of penicillin because you cannot count on patients to take an antibiotic pill twice a day for one week.

The stuff we ask people to do with topical therapy chronically is much more difficult than oral treatment for gonorrhea, and we know you can't do that for gonorrhea, so we have to do more than just assume that because patients have a bad disease they're going to treat themselves. In fact, I think the few studies that have looked at this have found that the worse the quality of life associated with skin disease, the worse patients' adherence was.

Dr. Chovatiya:
For those of you just tuning in, you're listening to *On the Frontlines of Psoriasis* on ReachMD. I'm Raj Chovatiya, and I'm speaking with Dr. Steven Feldman about adherence to topical psoriasis treatments.

So, Dr. Feldman, now that we have a better understanding of the challenges that can contribute to nonadherence, let's focus on strategies to improve this issue. How can we work with our psoriasis patients to provide them with the best individualized treatment plan and outcomes? Is this a matter of, perhaps, coaching them and having better follow-up? Is this elevating people from topical to systemic therapy? Is this trying to come up with believable plans that they'll follow through? How do you think about this?

Dr. Feldman:
Yeah, I think about this in terms of piano lessons. When we create a plan for patients, no matter how good, no matter how simple it is, and we tell patients to come back in, I don't know, eight to 12 weeks, two to three months. I think we're just asking for disaster. It would be like a piano teacher saying, "Here's your sheet music. Practice every day. I'll see you in two or three months. Forget the weekly lessons." No, it's worse than that. It's like a piano teacher saying, "Here's a prescription for some sheet music. Take it to the sheet music store. I have no idea what it's going to cost. I want you to fill the prescription for the sheet music. I want you to practice every day. Practicing may cause rashes, diarrhea, possibly a serious infection, but I want you to practice every day. I'll see you in two or three months. And if the recital doesn't sound good, which it often doesn't, I'll give you a second, maybe a third musical instrument to practice at the same time." It's just crazy that we do that, you know?

I think we should be telling every patient when we start a new medicine to let us know somewhere in the range of three to seven days how that medicine is working for you. I don't care what the treatment plan is or how simple or complicated it is. I think creating some kind of follow-up in three to seven days is the solution to getting people to use the medicine because people floss their teeth right before they go to the dentist; they use their medicines right before they come see us. That's why the acne patients will always tell us, "It's so frustrating. You always seem to catch it on a good day." I think driving their use of the medicine with a return visit is absolutely critical.

Dr. Chovatiya:
One of the big movements we've seen in the overall topical pharmaceutical industry is really trying to come up with better and more innovative nonsteroidal topical agents, and in addition to new mechanisms of action of the active product plus new formulations, it really tries to address something different than, perhaps, using the same old topical corticosteroids all over again, whether that be something that's pleasant to use, easily spreadable across different body sites, something that can be used either continuously, intermittently, and have good results. Have you seen a difference with any of these efforts? Do you think this is a reasonable direction that maybe gets us to better adherence, or is it still just going to be a drop in the bucket and it's not going to change people's base approach to adherence?

Dr. Feldman:
Yeah, I was initially very pessimistic about new topicals, and I think they do better than I thought. I think to the extent that you can do what you just said: pick one nonsteroidal that you can use on all the affected areas, including the face, genital, and scalp, to simplify the treatment, that could help adherence. But the reason I was so pessimistic is I figured the only patients who are going to get these new nonsteroidal treatments are patients who would have failed topical steroids first. And there's three reasons for failing topical steroids:

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#1 poor compliance, #2 poor compliance, and #3 poor compliance. So you would be selecting for patients who you know are nonadherent to topical therapy and then giving them another topical therapy. I thought that would be hopeless. You mentioned earlier switching people to some kind of systemic therapy. I think that's in theory a potentially more productive approach, but if you can get people to use the nonsteroid or if their big reason for failing topical steroids was that they weren't using them because they were afraid of steroids, then I think the nonsteroidal treatments could be a big advantage.

Dr. Chovatiya:
And just thinking along the lines of what have we not been doing that could be a difference, you know, the buzzword these days is talking all about disease modification or disease remission. Do you think maybe that is going to eventually be the only way that we get folks to really buy in where they don't have to use something chronically?

Dr. Feldman:
I think that's a great approach, although I don't think it's the only approach. If you give people a potent topical steroid or any other potent topical treatment, even if they failed other treatments, and you see them back in the office in three days, they will be dramatically better because they will have used the treatment. And once they see that it works really well, they will use that treatment intermittently as needed, I think many of them for a long time. You can get success with topicals in certainly, some subset of patients.

Look, patients would love a cure, and if you've got a cure, if you've got a disease-remittive therapy that is by far the best option, but I wouldn't give up on topicals because I believe that topicals are more effective than our strongest systemic drugs. If you look at the rate of clearing with topical clobetasol over two to four weeks, I think you'll see you get more clearing than you do with infliximab over eight to 12 weeks. It's just you're applying this super potent drug right to the site of inflammation. It should work great. If you get people to do it really well just for a few days, they'll see remarkable improvement. And they don't need to use it continuously. They just need to use it as needed, and I think they will do that.

If they fail that, if they're not improving with just three days of use, again, I would assume it's probably for one of the three major reasons. They're not using it, they're not using it, or they're not using it. And then I think ultraviolet light treatment is very effective because what you could do is you can bring the patient in daily for ultraviolet light treatment and apply the clobetasol to them before each treatment. And if you don't have a light box, you can just do this with a Wood's lamp, but the point being that if you apply the drug clobetasol to them, I think you would see remarkable improvement in a very short period of time.

Dr. Chovatiya:
Well, as we come to the end of our discussion today, Dr. Feldman, anything you want to leave our audience with? Any final takeaways about thinking about adherence as it relates to topical therapy and psoriasis?

Dr. Feldman:
I'm a one-trick pony. I think everything is about adherence. I'm biased that way. But I've seen patients who have told me, "None of these things work." I mean, they bring in bags of stuff. And you get them to use the topical for just a few days, and it works great. And telling people eight weeks, they won't use it really well for a couple of days, so I think the key is just give them a very, very simple regimen to do and for a very short period of time. If you want an alcoholic to quit alcohol, you just tell them, "You've got to quit for one day." You know, if you get people to do it daily for just three days, with the help of a friend to help assure that it gets done, I think you'll see remarkable benefit from topical therapies.

Dr. Chovatiya:
Keeping it simple. I like it. This has been a great discussion on an important treatment barrier we need to overcome with our psoriasis patients. I want to thank my guest, Dr. Steven Feldman, for sharing his insights. Dr. Feldman, it was wonderful speaking with you today.

Dr. Feldman:
Thank you so much.

Announcer:
You've been listening to *On the Frontlines of Psoriasis* on ReachMD. To access this and other episodes in our series, visit *On the Frontlines of Psoriasis* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.

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