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A Personalized Approach to Complex Psoriasis Cases

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

Ryan Quigley:
This is *On the Frontlines of Psoriasis* on ReachMD. I'm Ryan Quigley, and today I'm joined by Dr. Jenny Murase, Founder and Chair of the American Academy of Dermatology Women's Health Expert Resource Group, as well as a Associate Clinical Professor at UCSF, Department of Dermatology and Deputy Chair of the Clinical Guidelines Committee for the American Academy of Dermatology. Together, we'll be exploring treatment strategies for patients with multiple forms of psoriasis.

Dr. Murase, thank you so much for doing this. Welcome to the program.

Dr. Murase:
Well, thank you so much for having me.

Ryan Quigley:
Absolutely. It's a pleasure. So let's dive right in, Dr. Murase. How common is it for patients to present with more than one subtype of psoriasis?

Dr. Murase:
I think that with the new therapeutics that we have to treat skin disease, our understanding of the types of psoriasis has changed over time. Originally, we based our descriptions primarily on morphology, which means the shape in the skin. Over time, what I'm seeing more and more—as well as many of my colleagues throughout the world—is that what our eyes were trained to recognize as dermatologists through looking at morphology is actually just a state where the patient is creating excess Th17-driven inflammation. That Th17-driven inflammation is what we visibly associate with psoriasis. And so we may have a patient who comes in with just classic chronic plaque psoriasis, or maybe classic guttate psoriasis. But more often than not, patients will present with these mixed morphologies, meaning that we're wondering, "Is this eczema? Is this psoriasis? I'm not sure."

Ryan Quigley:
When you see patients present with multiple subtypes, how do you approach building a personalized treatment plan for them?

Dr. Murase:
I think that it really speaks to this concept that I've been developing the past year in terms of how I'm rethinking not only psoriasis, but the different forms of dermatitis that we see. It feels, to some extent, that we're playing a trumpet—something that I refer to as the lymphocyte trumpet.

I don't know how much of their skin disease is either Th1, Th2, or Th17-driven. And so what I'm going to do is look at the clinical pattern and see how much it closely associates with a psoriasis type pattern. So if I'm seeing more of a papulosquamous plaque versus an eczematous, or if I'm seeing these key locations—the umbilicus, the gluteal cleft, the inguinal creases, the armpits, the back of the scalp, the elbows, or the knees, which is what we've always classically thought of as psoriasis, but also looking carefully at their nails with nail pitting—if I'm seeing a primarily Th17-dominant pattern, then I'm going to usually focus on using a Th17-based agent. So I'm playing my trumpet; I'm pushing down on the 17, and if they start to develop rashes other places—perhaps they start to develop it underneath their ear or opposite of their elbow in the antecubital fossa—then I know I've unmasked Th2, and maybe they need two different agents to suppress both Th2 or Th17.

We basically have our eyes to see what's happening in the skin, and then seeing hundreds if not thousands of patients over many years, to indicate what kind of pattern we think that they have. So we put them on an agent, we push it down, and then we see what happens.

Ryan Quigley:
How do you navigate care when different subtypes vary in severity or symptom burden?

Dr. Murase:
That's a really great question because it gets to the heart of what the patient cares about, which is the burden of their disease. And that can really vary from patient to patient, because I've had patients over the years who were covered from head to toe in psoriasis, with a very classic Th17-driven pattern, but there was a very minimal itch, and maybe they weren't particularly bothered by the cosmesis and just wanted to control their hands and face with a topical. I've had other patients where the psoriasis may have just been in the anogenital area, causing significant itching—10 out of 10 itching—and they were unable to focus on their work and unable to live a normal life. If they have psoriatic arthritis as well, then we're dealing with potential joint pain that can have a very significant impact on whether they can routinely do activities of daily living. And so I think what we try to put in the forefront of our mind is really what impact the skin disease is having on the patient.

For example, the onus is on us to make sure that we ask either in the intake the staff is doing for us, or we ask this question ourselves. I'm very dependent on my staff to ask these questions because I want to make sure I'm capturing it, and I have a limited amount of time. I try to focus on the assessment and plan. It's important to have an assessment of the itch: “On a scale of zero to 10, if 10 is the worst itch that you can imagine, what is your itch from your psoriasis in the past 24 hours?” And pain as well, because the skin and the joints can be painful.

I have my staff asking about the joints, and also asking about if they have been screened for cholesterol issues because I don't want to miss coronary artery disease. There's implications to not treating psoriasis because of the inflammation that's present in the body, which can have very significant effects on health. And so all of that has to be factored in in addition to looking at the skin and seeing how much of the skin has resolved from our therapeutic.

Ryan Quigley:
For those just tuning in, you are listening to *On the Frontlines of Psoriasis* on ReachMD. I'm Ryan Quigley, and I'm speaking with Dr. Jenny Murase about caring for patients with multiple types of psoriasis.

So, Dr. Murase, if we look more closely at therapeutic approaches, how do you think about systemic options when managing mixed presentations?

Dr. Murase:
In general, with the advent of the biologic agents, these have been incredibly helpful at getting the burden of disease under much better control, not only for the visible psoriasis to improve, but also because of the impact that they will have on potential for psoriatic arthritis and the joint pain that can accompany. The risk of developing psoriatic arthritis never plateaus, so it's not like after five years or 10 years, you can stop asking the patient if they have joint pain or that it can happen at any point in time. So you’re controlling the joints and then also getting a reduction in the cardiovascular disease risk burden when you use the systemic therapeutics. And so I think that we're really starting to think of both psoriasis and dermatitis for that matter as conditions where the disease exists in the immune cells and not the skin per se. And that's why there can be such far reaching effects on the other organ systems.

I think that more and more, patients are electing to use systemic options as opposed to the topical, because the topical options, although they can be helpful as supplement, really don't get the disease under control in the way that most patients feel happy about long term. They're a good supplement when certain areas are flaring. But for the most part, I think most of my patients select to use the biologic options. There are patients that just prefer to do the pill a day. But I would estimate probably 85 to 90 percent prefer the systemic biologic agent over the oral agents.

Ryan Quigley:
What are some common pitfalls clinicians face when managing those overlapping psoriasis subtypes?

Dr. Murase:
I think that, first of all, we tend to get into old habits where we may have been trained, for example, on the TNF-Alpha class of medicine and residency, and then we get out into the real world, and the IL-12/23s are released and the 17s are released. But one pitfall, I would say, is not getting out of old prescribing habits and just doing something because that's what you've traditionally done. We’re really trying to stay on that cutting edge of the science and the knowledge that's available and the therapeutics that we have so that your patient's therapeutic regimen is optimized.

I do have to put my women's health hat on a bit because, particularly for lactating patients—for women who want to breastfeed after they've delivered—all of these agents for psoriasis are perfectly safe to be using during breastfeeding. It breaks my heart when a woman is not breastfeeding unnecessarily because the provider is unsure whether or not it's safe. And the same also goes for pregnancy, for that matter. It really isn't until that third trimester that the antibody is being transferred at any kind of substantial level to the fetus. So not using the therapeutic if a woman is really suffering in the first and second trimester just really is not in the patient's best interest. And we really did focus on that when developing the Delphi consensus guidelines to try to provide further reassurance to providers that may not be as familiar with the pregnancy safety data, to encourage them to treat through.

In and of itself, pregnancy can sometimes be therapeutic for the psoriasis, and they can go into remission during their pregnancy, so they may not need the biologic agents during pregnancy. But for those that do, restricting them and having their psoriasis and/or psoriatic arthritis flare is really not in the patient's best interest because in patients who do have moderate-to-severe psoriasis, there is the potential for increase in low birth weight infants, and we really want to try to keep the systemic inflammation down.

Ryan Quigley:
Now, Dr. Murase, before we close here, I want to look ahead. How do you see the field evolving in terms of managing psoriasis as a heterogeneous patient specific disease?

Dr. Murase:
I'm just hoping that one day, our lymphocyte trumpet will not depend on the eye of a clinician, and that we actually will have a diagnostic test that indicates exactly what therapeutic we should be using. Because I'm hoping within my lifetime, we will get more data to really give us very clear indication what therapeutic we should use and not have this trial-and-error approach.

One patient that comes to mind: a patient with psoriatic arthritis and psoriasis, both very classic looking. She also developed an eczema eruption on her hands where she really did have prominent Th2-disease. I did thorough patch testing and identified her allergens, and in spite of that, she had a mixed morphology—this sort of heterogeneous pattern. I put her on a pan-JAK inhibitor because she had the symptoms of arthritis—so that means that it's suppressing JAK 1, 2, and 3, and TYK2—and she would get stomach issues. She was very fatigued. It controlled both the Th2 pattern and the Th17 pattern fairly well, but it would still break through. Ultimately, I ended up giving her a Th2 agent and a Th17 agent, and now she's under beautiful control with those two therapeutics. No systemic symptoms. So she's not having any GI upset. She's not fatigued throughout the day. Her joint pain is under phenomenally good control. Her skin looks the best that it's ever looked.

So I think that moving forward, what we will do more and more is combine agents, or we will have therapeutics released that are combined agents of biologics we've had in the past, and that will allow us to really tailor our therapeutic regimen for that specific patient so that we're minimizing the effect on their cell mediated immunity to try to preserve that Th1, but then using the therapeutics that we need to get the skin disease and the joint disease under good control.

Ryan Quigley:
As those insights bring us to the end of our program, I want to thank my guest, Dr. Jenny Murase, for joining me to share her insights on treating patients who have multiple types of psoriasis.

Dr. Murase, thank you so much for doing this. It was a pleasure having you on the program.

Dr. Murase:
Thank you for having me, Ryan. I enjoyed speaking with you.

Announcer:
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