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Closing Knowledge Gaps in Pediatric Psoriasis

ReachMD Announcer Intro:
Welcome to ReachMD. This medical-industry feature is sponsored by Novartis Pharmaceuticals Corporation and the information and views presented in this educational podcast are those of the health care professional who was interviewed. The views expressed herein do not necessarily reflect the views or position of Novartis. This program is intended for healthcare professionals. Our host, Jane Mast, is a PA by background and is currently an employee of Novartis Pharmaceuticals Corporation. She will be interviewing PA Doug DiRuggiero, who is a certified PA and the founding president of the Georgia Dermatology Physician Assistant Society. Doug DiRuggiero has served as an advisory board member of and/or on the speaker bureau for Novartis, Amgen, Incyte, Lilly, Regeneron, Sanofi, Sun Pharma, and UCB Pharma.

Jane Mast:
Hi everyone. I am Jane Mast and I will be your host for today's Dermatology Expert Podcast episode, "Closing Knowledge Gaps in Pediatric Psoriasis."

Today I am here with our special guest, PA Doug DiRuggiero, to discuss clinical presentation, comorbidities, and management of pediatric psoriasis.

Hi, Doug, thank you for joining me today. I'm looking forward to a great discussion.

Doug DiRuggiero:
Thank you, it's an honor to be here.

Jane Mast:
So let's get started. I would love if you could describe for us some of the key clinical features of psoriasis in children and adolescent patients and how the clinical presentation can differ from our adult patients.

Doug DiRuggiero:
I think that psoriasis in the pediatric population is likely underdiagnosed, misdiagnosed, whichever way you want to say it, because it can have a slightly different nuance to it.

When you get into the pediatric population it more often presents in the scalp than it does in adults. I'm talking about initial presentation here. Scalp psoriasis looks a little bit different than your classic what you tend to see in adults. It's not that thick, silvery scale with excoriations. It's more of a thinner scale. It may have a sebopsoriasis or a plaque-like subderm appearance, but it's not yellow and greasy. It still has an erythematous appearance to it; it's just thinner. Also, kids can have facial involvement more often than adults.

And then let me say this too, Jane. When I first got into dermatology 22 years ago, kids are going to present with guttate psoriasis, those small, little plaques it looks like drops of water dropped on them everywhere all over the body. And that's how kids presented, and adults rarely ever did that, but the fact is that that's not the case.

Jane Mast:
Yeah, you make a good point that pediatric psoriasis oftentimes presents differently, right, than our adult patients. When we talk about pediatric patients, we have really, you know, two sets of patients, right? We have the child and then we have the parents. So how do you effectively communicate with parents about their child's psoriasis?

Doug DiRuggiero:
I always lead with questions. I find that diseases like psoriasis, patients could walk in with a lot of baggage already and parents, and

they sometimes even hide their family history or their own personal history because they don't want it to sway your diagnostic considerations. I've had this happen recently when I went in and saw a teenager who had what I considered a classic presentation of psoriasis. The mother is there, and they had denied a history of psoriasis to the nurse because the nurse had some clues that maybe this is psoriasis. "Do you have any history of eczema?" they asked. "Do you have any history of psoriasis?" "No, no, no, no, no."

I come in and look at it and ask them questions and look all over and get some presentation. Said, "We can do a biopsy if we need to, but this is a clinical presentation of a condition called psoriasis. Have you ever heard of psoriasis?" That's what I always ask. And then mother immediately breaks down and cries because she watched her mother kind of suffer with debilitating joint and skin disease all of her life. And so for her it was like a lot of baggage was attached to this diagnosis.

So I edge into this by saying, "There is an inflammatory condition called psoriasis. Do you know what that is? Have you ever heard of it?" And then if it's yes or no. And, again, if they say, "Yes," then I say "Well then, what do you know about it? Tell me what you know." And I kind of want them to participate in the initial presentation and following education on what it is.

Jane Mast:
I think the great thing now is probably when her mother was suffering, we didn't have as many options. And that brings us really into, like, what are the comorbidities you often see in your pediatric patients with psoriasis?

Doug DiRuggiero:
So, initially, my first comorbidity that I always ask about and the only one that I will tend to focus on in the first visit, is simply ask them how it makes them feel because we know that this condition is a very visual condition. It impacts how people see them, how people react to them. So that is the number one initial comorbidity.

I had a kid just a few weeks ago that I'm managing for psoriasis tell me that he wished the coronavirus would not go away. Now he didn't really want people to be getting the disease and dying from it, but what he was saying, he said, "I didn't want school to restart. I wanted to stay home because when I go to school, kids make comments about my skin." And he was wishing that "school would stay this way forever," quote/unquote, to him as a 10-year-old boy. And so that just shows how much of that emotional load, that mental load really is there at a young age.

Jane Mast:
Yeah. And you really point out just leading with empathy, right, and trying to understand their experience.

So when you talk about the psychosocial impact of psoriasis, how do you evaluate that? Like what questions do you ask to assess that?

Doug DiRuggiero:
Well, again, open-ended starts off your conversation and then it becomes more focused based on response. But my opening question is always, "How does your psoriasis make you feel?" And sometimes they say, "Well, I feel fine. My skin doesn't hurt." I leave it open-ended. I know that they may interpret that as maybe just how do I feel, do I feel sick or not? And if they answer that way, I say, "Okay, well that's good. Psoriasis doesn't typically make your tummy hurt or give you a headache or cause any problems like that. But inside your mind how does it make you feel?

So I begin to ask very pointed questions about, "Do you go to the pool? Do you feel comfortable in the pool in a bathing suit with it or not?" So I will keep going into some of these questions and becoming more and more specific if their responses are more vague.

In the pediatric population I don't ask them, "Do you have depression, or do you have anxiety?" They don't know what those terms are. I'm looking for clues to indicate social phobias which indicate the anxiety. And then I can, if they open the door, say, "Well, does this make you feel down? Do you feel like this disease doesn't really make you want to go to school, want to be at home, want to be around your family?"

Jane Mast:
I think you make a great point in how do we really ask pointed questions and questions that a kid would understand, right, to their level? So that's great.

Also, when we talk about pediatric psoriasis, we want to talk a little bit about the management, right, because it's not like it was 20 years ago. We have different tools in our toolbox. So what are some of the key considerations when thinking about starting a pediatric patient on systemic therapy and what factors really guide your treatment plan?

Doug DiRuggiero:
So we certainly still classify the classic BSA presentation of if it's less than 3%, it's considered mild; if it's between 3 and 10, it's moderate; if it's greater than 10% body surface area, then it would be considered severe. And so, if it's moderate to severe, greater than

3%, then certainly it's justifiable to consider systemic therapy. And then you have your investigator global assessment or physician or provider global assessment that's got from 0 to 4. So these are all what we talk about when we're in conferences.

But I personally like what's come out recently in the International Psoriasis Council, the IPC, this consortium of over 100 dermatologists across the globe saying that, look, either they have mild disease which justifies topical treatment and a variety of topicals, or they have a disease that topicals can't control. And once they get beyond anything topical, we should be considering systemic therapies.

You want to take into consideration if a child has 1% or 2% body surface area, but it's their entire scalp or it's on their face, that's a significant impact on the quality of their life. That would be considered a severe case not by BSA considerations but by impact on life. So that may be the person that's outside of BSA, but it's the impact on quality of life. And multiple treatment failures topically will move you towards systemic therapy, which is going to include your traditional DMARDs, your phototherapy, and now the newer biologics that are out there.

So I think it's an important thing to kind of begin to introduce the idea of having a systemic therapy because this skin disease is coming from the inside and is being driven by this immune system dysfunction.

Jane Mast:
And how do you then talk about starting a biologic with the parents as opposed to the child?

Doug DiRuggiero:
When I'm looking at the parent, if we're dealing with a truly pediatric patient under the age of 12, I don't use the word needle first off. I use the word injection, that these are injectables, that phrase. I lead with the efficacy as my presentation. "If we could get your child 75% to 90% better, and we have a therapy that does that, would you be interested in it?" And once they kind of say, "Yeah, I would be very interested in that."

"Well, I want you to know that this medicine is an injectable medication, but these injections are very superficial." I emphasize the word superficial. "They're not daily." And they're just kind of like, "Oh gosh." "But we may have to work at having your son or daughter be open to having this therapy initiated."

Then I introduce how it's administered. And then we move into what do you think is going to be the impact on the recipient. And sometimes some kids are paying attention, some aren't, some are smarter, some aren't, and they clue right in and start asking questions themselves.

Jane Mast:
Do you have any tips to help pediatric patients be more adherent to treatment?

Doug DiRuggiero:
The key is getting them to have the first injection and bringing them into the office and really having a great staff that's going to be there.

So adherence is you've got to get them past the first injection. And so I talk to them about that this is not the same as receiving a vaccine or having your blood drawn because this medication just needs to go in the outermost layer of the skin. I kind of take a little pinch of my own belly roll, and I say, "Just in this belly roll, I've got to go just right underneath the surface, barely underneath the surface." I say, "Four or five hairs kind of tied together is about how thick it is, and it's very, very short. So short that it just goes right underneath the surface of the skin." So I'm describing these things to them.

The adherence is when the medicines begin to work. I've had now probably more than 10 stories of parents who've told me that their child reminds them or asks them, "Is this my week to get my shot, mommy, because I don't want to miss it," because when their skin clears, they want it to remain clear.

So, you know, all the standard stuff – an ice pack on the surface of the skin to make it cold, distractionary techniques you would use if you had to do a biopsy. You can vibrate on the skin. You know, those little vibrating tools. So all of that can be things where they don't even feel the shots. So it's the same protocol of getting a biopsy off a pediatric patient in terms of leading them into the first shot so they realize it doesn't hurt, and you can show the parent how to do those things, but eventually they don't even need that once it gets rolling and they realize that this is not going into my muscle, it's not deep.

Jane Mast:
So as we wrap up our time together, Doug, is there anything else you would like to mention to our audience regarding this topic before we conclude?

Doug DiRuggiero:
I think if we can go back to the beginning, you know, make the right diagnosis. Have your clinical suspicion, your feelers pretty high.

Don't always assume that something's nummular eczema or seborrheic dermatitis or atopic dermatitis. You know, realize that psoriasis in kids can have a very thin plaque-like appearance. It almost looks like excoriated AD. Don't miss the diagnosis and leave someone with it. Secondly, get comfortable with the treatments that are available.

Jane Mast:
Thank you so much, Doug, for sharing your experience today. I've really enjoyed talking to you, and I hope our listeners have gained some valuable insights on this important topic. Thanks again.

Doug DiRuggiero:
Thank you so much for the opportunity. It was an honor.

ReachMD Announcer Close:
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