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The Dermatologist's Guide to Improving Our Standards of Care for Psoriasis

Announcer:

Welcome to ReachMD. This medical industry feature titled, The Dermatologist's Guide to Improving Our Standards of Care for Psoriasis, is sponsored by AbbVie US Medical Affairs.

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Dr. Birnholz:

Despite a common shared goal of improving quality of life for patients with psoriasis, dermatologists and their patients sometimes struggle to align on treatment expectations, which can lead to missed opportunities in achieving even higher levels of skin clearance. On today's program, we'll explore some therapeutic and patient counseling strategies to help bridge that gap and improve our standards of care.

This is ReachMD, and I'm Dr. Matt Birnholz. Joining me are Dr. April Armstrong and Dr. Laura Ferris. Dr. Armstrong is a Professor of Dermatology and Associate Dean of Clinical Research at the Keck School of Medicine at USC in Los Angeles. Dr. Armstrong, thanks for being here today.

Dr. Armstrong:

Thank you so much for having me.

Dr. Birnholz:

And Dr. Laura Ferris is an Associate Professor and Director of Clinical Trials in the Department of Dermatology at the University of Pittsburgh Clinical and Translational Science Institute.

Dr. Ferris:

Thank you. It's great to be here.

Dr. Birnholz:

So, let's start with an overview of treatment expectations applied to psoriasis care, and what kinds of outcomes those expectations are built on. Dr. Armstrong, what are your initial thoughts on this?

Dr. Armstrong:

I start with acknowledging that there is a difference between completely clear skin and clear or almost clear skin, which put in another way recognizes a difference between PASI 75 and PASI 90 to 100. For patients, that difference is experienced in their health-related quality of life. And based on an increasing recognition of both the physical and psychosocial burdens of psoriasis, we know that our patients have a strong desire to attain completely clear skin, but they can sometimes be unaware that greater treatment expectations are possible or that complete clearance is possible. They could also be reluctant to verbalize this to us for a variety of reasons and may not proactively bring that up. Likewise, on our end, as clinicians, we might be reluctant to disrupt a treatment plan without an active complaint, or we might become passive to the expectation that our patients will speak up if they're truly dissatisfied with their therapy. So, our goal should not only be to improve their disease outcomes, but also to try to improve how they function in life, and that requires

clear and consistent communication from both sides.

Dr. Birnholz:

Excellent point, Dr. Armstrong, and staying with that line of thought, in your experience, are there any situations or manifestations of psoriasis where that line of communication seems more challenging up front?

Dr. Armstrong:

Sure. So, let's consider genital psoriasis. Typically, people are not willing to bring this up themselves, both because it involves a small body surface area and because of feeling self-conscious about drawing specific attention to it. But when we do a full skin check and the genital psoriasis is discovered and then treated adequately, over time, I'll notice that some patients will begin talking about new relationships and even bring their partners along to follow-up appointments, which may suggest a greater willingness or capability to form significant social relationships over time.

Dr. Birnholz:

Thanks, Dr. Armstrong. That's a really compelling example. And, Dr. Ferris, let me turn to you on this subject of treatment impact and how that changes communications and expectations. Do any memorable instances come to mind?

Dr. Ferris:

There are a few that come to mind. One of the things that strikes me is when patients say, "This is the first time I've ever..." alluding to their quality of life, examples like, "This is the first time I actually wore shorts in the summer." or, "This is the first time I wore a black shirt out because my scalp isn't flaking anymore." Another that I hear, related to Dr. Armstrong's experience, is when patients talk about the first time they went out on a date, and didn't feel self-conscious. Statements like that really highlight the improvements in quality of life when we reach for more than just being a little better off than before and actually strive for higher levels of skin clearance.

Dr. Birnholz:

Well, those are great comments to hear from our patients, Dr. Ferris, but practically speaking, with a limited amount of time that dermatologists have with their patients, how do you bring quality of life assessments into these brief visits just to keep tabs on how they're really feeling and really doing?

Dr. Ferris:

I often start with basic questions like, "how are you doing? Are you happy with your therapy? What changes have you noticed?" But, if I sense that patients aren't being direct or withholding for some reason, I'll ask more specifically about how their psoriasis is affecting their life at that point in time and what they would most want me to address going forward. I find that often leads to more direct answers about comorbidities, such as joint pain or issues connected to affected skin areas, such as itching and degree of visibility to others. But, like Dr. Armstrong said earlier, it's unlikely we'll arrive at those understandings if we're reluctant or too busy to ask more than one question on a review of systems. And we can't settle for checking assessments that don't yield much substance. So, I pay attention to social history and come back to that every time I can, since it's such an important way to evaluate quality of life for these patients.

Dr. Birnholz:

And Dr. Armstrong, let me pose the same question to you. What are some strategies that work for you to draw out the impacts that psoriasis is having on your patient's day-to-day lives?

Dr. Armstrong:

Well, as Dr. Ferris said, it's difficult to encapsulate the impact of psoriasis into one quality-of-life question. What I found to be helpful is to use my notes from previous conversations with my patients as a way to connect with them on the next visits. So, for example, they may say in one visit something like, "you know, I really want to go on a vacation overseas and think I'll do that soon." So then on our next visit, I will ask something like, "how was that vacation? Did you have a good time? Did you notice when you were or were not bothered by your skin?" and so on. And this provides some continuity to compare expectations around life events to actual experiences and then assess quality of life impacts from that. I also treat adolescents, so I will ask how they're doing at school and whether they're feeling distracted. But general questioning around something like school only gets us so far. So, I'll ask them more specific questions about what they would like to do in school but haven't felt able to do because of their psoriasis. And this helps set some benchmarks that we can follow to evaluate their clinical course over time.

Dr. Birnholz:

For those just joining us, this is ReachMD. I'm Dr. Matt Birnholz, and today I'm speaking with doctors April Armstrong and Laura Ferris about practical strategies to improve our standards of care for patients with psoriasis.

Well, these have clearly been excellent tips from you both to give us a more personalized understanding of disease impacts on patient quality of life. But why don't we consider how the current treatment landscape is also changing mindsets? And Dr. Ferris, starting with

you, how does this factor into practice in your case?

Dr. Ferris:

You know, since I started in dermatology, we have added so many more therapeutic options for psoriasis that are both effective and safe. And that takes on even more relevance as we've become increasingly aware of these quality-of-life distinctions between achieving clearer skin and achieving even higher levels of skin clearance, because it's now a lot easier to advocate for a higher standard of care and raise our treatment expectations when we have so many more therapeutic options we can offer. So for me, that translates into asking my patients, why would we keep using something that's not meeting their expectations when we can try something else that may be much more likely to work for them?

Dr. Birnholz:

And Dr. Ferris, have we seen this change in perspective manifesting in dermatology guidelines and recommendations as well?

Dr. Ferris:

Yes, we have. So, the expanded therapeutic options for psoriasis are based on identifying more clinical targets, and that paves the way to wider acceptance of clear or almost clear skin as an achievable outcome. One product of the sea of change is the modified NPF treat-to-target guidelines a few years ago, which recommended getting our patients down to ideally less than 1 percent body surface area affected. Additionally, the IPC guidelines are now looking beyond body surface area alone and including other important factors to guide systemic therapy initiations such as which areas are affected and whether patients have failed topical therapy before. Additionally, for the first time, PASI 100 responses have been mentioned in a guideline, and clear or almost clear skin is now a unifying target. So, the question we can ask ourselves now is, given all that we can do, are we doing enough?

Dr. Birnholz:

That's a great question, Dr. Ferris, and really a central one for us moving forward. Dr. Armstrong, any thoughts to add on that?

Dr. Armstrong:

Sure. As clinicians, our understanding of psoriasis immunology has increased. And as Dr. Ferris just said, the psoriasis treatment landscape has evolved. But I think sometimes we can get complacent with what we know. We need to challenge ourselves to get out of our comfort zone and learn about the changes happening in this therapeutic space, the new treatments, what they're targeting, how they're different, and whether they can elevate the level of clinical response for our patients. These are considerations I think we, as a collective specialty, need to make more often to raise the bar.

Dr. Birnholz:

And Dr. Armstrong, continuing on that line of thought, how often does the topic of switching therapies come up in your practice and who's usually bringing that into the conversation?

Dr. Armstrong:

Great question, Dr. Birnholz. In most instances, my patients bring up the topic of treatment switching. And it's usually prompted by changes in their expectations over time. I do bring up the idea of switching as well when it involves potential comorbidities or an extensive body surface area involvement. And like we talked about this before, one of the most important factors leading to changes in therapy is picking up on patient dissatisfaction and then talking about why they're dissatisfied. I start with addressing the topic of compliance or adherence just to make sure that the prescribed medication has been used as directed. If so, we'll talk through dose escalation, if that's an option. And if that doesn't help, then we talk about switching. I'll also remind patients that switching is not an irreversible step, that they can always switch back if a new treatment approach isn't right for them.

Dr. Birnholz:

Well, as we come to the end of our program today, why don't we turn to each of you for some final takeaway thoughts that you want to impart to our audience. And Dr. Ferris, starting with you, what resonates most strongly in your case?

Dr. Ferris:

For me, it starts with taking the time to assess with our patients how their psoriasis is most affecting their lives and bringing what we learn from those assessments directly into our care decisions. I think it's our responsibility to set the highest treatment expectations we can for psoriasis patients, and then to work through those times when patients, for whatever reason, may not think it's possible to attain even higher levels of skin clearance. And as Dr. Armstrong mentioned, we can only get there if we ourselves stay on top of the growing spectrum of therapeutic options available and update our patients, in turn.

Dr. Birnholz:

Thanks, Dr. Ferris, those are great insights. And coming back to you, Dr. Armstrong. The floor is yours. You get the final word.

Dr. Armstrong:

Yes, I completely agree with Dr. Ferris's comments. A couple of things for me to come back to. First of all, I think every person should be viewed as a candidate for achieving PASI 100. This is because data has shown that being clear is possible for the majority of our patients. And second, as clinicians, we have to appreciate that what may seem like small disease impacts based on limited measures such as low body surface area involvement, can actually have a disproportionate effect on our patients and their perspectives toward their skin. And when we lose sight of that, we risk settling in our treatment plants and missing opportunities to make more substantial impacts to patient's quality of life.

Dr. Bimholz:

Well, these have been excellent points from you both, and such a great way to round out our discussion today. I want to thank both of my guests for helping shine a light on ways to set and achieve higher treatment expectations with our psoriasis patients. Dr. Armstrong, Dr. Ferris, it's great speaking with you both today. Thanks so much for joining the program.

Dr. Ferris:

Thank you.

Dr. Armstrong:

Thanks for having us.

Announcer:

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