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Navigating Systemic Therapy Eligibility and Treatment Goals in Psoriasis Care

Announcer:

Welcome to ReachMD. This medical industry feature, titled “Navigating Systemic Therapy Eligibility and Treatment Goals in Psoriasis Care,” is sponsored by AbbVie US Medical Affairs. Here’s your host, Dr. Charles Turck.

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Dr. Turck:

This is ReachMD, and I’m Dr. Charles Turck. Today, we’ll be exploring how we can navigate and assess a psoriasis patient’s eligibility for systemic therapy. Joining me are Dr. James Song and Ms. Lakshi Marie Aldredge. Dr. Song is a board-certified dermatologist serving as the Director of Clinical Research and Co-Chief Medical Officer at Frontier Dermatology in Mill Creek, Washington. He also serves as an international psoriasis counselor.

Dr. Song, welcome to the program.

Dr. Song:

Thank you for having me.

Dr. Turck:

Also with us is Ms. Aldredge. She’s an adult nurse practitioner at the VA Portland Healthcare System in the Dermatology Service in Portland, Oregon. She also serves as the Director of the Primary Care NP Residency Program. Ms. Aldredge, thank you for joining us today.

Ms. Aldredge:

It’s great to be here.

Dr. Turck:

To start us off, Dr. Song, could you provide an overview of the 2019 International Psoriasis Council consensus statement on patient eligibility for systemic therapy?

Dr. Song:

Absolutely. So back in 2019, the IPC introduced a consensus statement to expand the eligibility criteria for systemic treatment. Previously, systemic therapy was often reserved for patients with more extensive body surface area involvement.[1,2] However, the IPC consensus statement has simplified the “mild,” “moderate,” and “severe,” terminology to, “Are you a candidate for a systemic therapy or not?” And they defined a systemic therapy candidate as someone who meets one or more of the following criteria:

1. A body surface area greater than ten percent,
2. Disease involving special areas, including the genitals, palms, nails, soles of the feet, scalp, or face—irrespective of body surface area—or

3. Failure of topical therapy.[1]

Now I think a lot of us have already been using this criteria whether we realize it or not. But this shift reflects a broader recognition of the impact psoriasis can have on patients' lives, even in those with less extensive disease.[1–3] And what this recategorization of psoriasis severity allows us to do is really identify more patients eligible for systemic therapy, avoid treatment delays, and ultimately improve patients' quality of life.[1]

But it does, appear that we still have work to do. Because in my experience, many patients who should qualify for systemic therapy according to this consensus statement are still being told by their providers that their psoriasis isn't severe enough to escalate beyond topicals. And this, of course, leads to unnecessary delays in effective treatments and suboptimal disease control.[4]

Dr. Turck:
Thank you, Dr. Song. And turning to you now, Ms. Aldredge, what have you observed in your practice since the release of the 2019 IPC consensus statement, and how has it impacted patient outcomes?

Ms. Aldredge:
Yeah, from my vantage point, the goal to broaden the criteria for patient access to systemic therapy will always be admirable, but echoing Dr. Song's words, there's still room for improvement given the burden of psoriasis.[4,5]

In fact, we have real-world data on patient outcomes based on the National Psoriasis Foundation's treat-to-target goals in the U.S. This was a retrospective study from January 2021 to September 2022—meaning it was conducted after the release of the 2019 IPC consensus statement—and despite this study not requiring patients to meet IPC criteria, it still revealed some key findings on how we're doing in terms of patient outcomes.[4]

So to give you a little more background, the NPF treat-to-target goals are divided into acceptable or target responses. An acceptable response is defined as a BSA of three percent or less, or a 75 percent improvement in BSA from baseline after three months of treatment. A target response, on the other hand, is defined as a BSA of one percent or less after three months of treatment.[6]

And in terms of participants, this study included:

- 6,395 patients with psoriasis aged 18 years and older,
- with a mean age of 52.5 years,
- who had initiated advanced therapy, such as TNF, IL-12/23, IL-17, IL-23, or PDE-4 inhibitors, and had a minimum of one BSA assessment conducted at least 90 days after starting treatment.[4]

Finally, it was discovered that approximately 69 percent of patients achieved the acceptable goal, while only about 43 percent of patients—so less than half—reached the target goal.[4]

So to reinforce Dr. Song's earlier point, these findings highlight that patients are still not meeting treatment goals.[4] And, we may be able to help achieve better patient outcomes in those who are deemed eligible for systemic therapy by ensuring that treat-to-target goals are being considered when evaluating patients.

Dr. Turck:
Wonderful insights, Ms. Aldredge.

And what about you, Dr. Song? How have the changes in eligibility criteria influenced your clinical practice? And would you elaborate on your approach to using assessment tools for determining systemic therapy eligibility?

Dr. Song:
Well, we now have this consensus statement on the recategorization of psoriasis severity that allows us to escalate to systemic therapy much earlier.[1] And from an insurance coverage standpoint, this has helped with getting my treatment recommendations approved for my patients.

In terms of patient evaluation, I like to use simple, and objective assessments like a BSA and an IGA, and I incorporate some quality-of-life measures to truly understand how well a patient is doing. For example, I ask questions like, "How is your psoriasis impacting your work, or your relationships?". I've found that while the PASI score and DLQI they are important in clinical trials, they can be onerous and impractical since it may not uncover specific personal concerns many patients may have.

Simply asking about symptomatology, like pain, itching, and burning, is something that's easy to capture but also very meaningful, especially in those with special area involvement or in patients who have failed topicals.[5] Because even in my patients who have less than one percent BSA, some still feel like they're not at their goal because of persistent symptoms.[6]

Now that's my experience but, Ms. Aldredge, what's your perspective on how these changes in eligibility criteria impact comprehensive care?

Ms. Aldredge:

I agree with you, Dr. Song; this consensus statement absolutely gives us the ability to escalate patients to systemic therapy sooner.[1]

In fact, I had a patient who had been suffering for so many years, but since he had failed topical therapy, he was now eligible for systemic therapy based on IPC criteria. So we made the mutual decision to start him on systemic therapy, and when he came back for his follow-up, he had significantly improved, and he told me "I wish somebody had told me about this sooner - I wish I would have started earlier."

And that's really the take-home message here—to start early when clinically appropriate and make sure we're helping patients understand all their options.

I'd also like to add that patient reported outcomes, or PROs, are so important to understanding disease severity and quality of life - particularly for special area involvement which often has a substantial impact on quality of life despite impacting a lower BSA.[5]

Of course, conversation with the patient is the go-to form of getting PROs, but different tools may be used prior or during visits with their providers.[2,3,6]

Understanding the state of each patient's disease is essential to giving patients effective care. Psoriasis is a systemic, chronic inflammatory disease that runs deeper than what we see on the skin.[5,7] It can be associated with comorbidities, including psoriatic arthritis, cardiovascular diseases, diabetes, and many others, so not treating psoriasis properly can potentially have a downstream effect on the patient's overall health.[8]

In fact, comorbidities are one of the biggest arguments for systemic therapy. It may be advantageous to treat the underlying, systemic issue rather than just what's on the surface, and we want to do this as soon as appropriate rather than later so we can halt psoriasis progression and possibly help avoid the risk of developing comorbidities.[8]

Dr. Turck

For those just tuning in, you're listening to ReachMD. I'm Dr. Charles Turck and today I'm speaking with Dr. James Song and Ms. Lakshi Marie Aldredge about strategies and considerations for determining a psoriasis patient's eligibility for systemic therapy.

So now that we've discussed assessment tools for determining systemic therapy eligibility, let's shift our focus to how special area involvement affects quality of life and treatment decisions.

Dr. Song, how do you evaluate the impact of psoriasis in special areas when considering systemic therapy?

Dr. Song:

Well first, it's important to recognize that the involvement of special-site areas can have a disproportionately high impact on quality of life, sometimes it rivals what we see in patients with much more extensive skin disease. And so, while BSA is one component of disease severity, we must also factor in which areas are involved and the patient's perception of their disease severity.[2]

Take the 2020 UPLIFT survey, for example—it included about 700 patients with psoriasis in at least one special-site area. And among those with limited body surface area but also having special site area involvement, a majority reported that their psoriasis had at least a "moderate effect" on their quality of life.[5]

And I'll also add that, in my clinical experience, some topical treatments they just don't work all that well in these special areas probably because of limited penetration.[7]

So we must also consider the nuances in treating special site areas in patients of different racial and ethnic groups. For example, patients with darker skin tones may be more susceptible to hypopigmentation from topical corticosteroids and hyperpigmentation from phototherapy, which can be a limitation.[9]

Also, patients with afro-textured hair who have scalp psoriasis may have a harder time using certain topical medications due to the application method and frequency.[9,10] So, for these patients, I find myself having to escalate to systemic therapies as soon as it's clinically appropriate.

Based on this, we can see that treating psoriasis in special areas can be challenging.[7] So, we need to set realistic expectations with patients, as far as what it may take and how long it may take to reach their treatment goals.[5]

But I'm curious to hear Ms. Aldredge's input, as a nurse practitioner. Lakshi, do you have any thoughts about psoriasis in special areas and systemic therapy?

Ms. Aldredge:
Absolutely. Now we know that psoriasis looks different on different parts of the body, but a lot of patients don't know that. So patients may be unaware that what they have on their genitals is actually psoriasis and not a fungal infection.[7] And that's why it's important to have patients undress during their check-ups because psoriasis in these special areas can go unresolved and untreated if they're not caught.[11]

Additionally, psoriasis in these special areas can be associated with greater risk for certain comorbidities.[3] For example, patients with psoriasis in the nails have an increased risk of developing psoriatic arthritis.[12] And I'll say it again and again: psoriasis is an immune-mediated disease, so this is where systemic therapy can be very effective.[7]

Dr. Turck:
To close our discussion today, let's turn our attention to the role of patient communication in treatment planning. Dr. Song, how do you navigate the dialogue around treatment options and manage expectations with your patients after selecting a systemic therapy?

Dr. Song:
Yeah that's such a great question. Our goal as providers is to arrive at a treatment decision that's mutually agreed upon. And sometimes shared decision making means the patient may prefer a systemic therapy option that isn't our preferred treatment. But if it doesn't put the patient at harm's way, then I'm okay starting there because we can always change treatments in the future. And I think most importantly, we just need to know which medication they cannot receive based on their medical history and go from there.

Now, I do try to understand why a patient isn't interested in your preferred treatment choice and see if there are some misconceptions that you may be able to clarify. For example, in some instances, my preferred treatment may be an injectable. Some patients may be wary about self-injections, but in my experience, injections with certain devices can be done rather easily even in the most needle-phobic patients.

I also think it's important to avoid overly complicating things by giving our patients too many options or going into too much detail.

Analysis paralysis is real, so I prefer to give them a few options, avoid medical jargon, and speak in generalities.

Some of my patients prioritize efficacy and want to go straight to the most effective medication. Others are okay with lower efficacy as long as it's a pill. But at the end of the day, it has to be their decision, but I remind them that we have other options if the first one doesn't work.

Ultimately, earlier identification of patients who are candidates for systemic therapy may ensure that the benefits of the IPC consensus statement are fully realized in the real world, closing the gap between the NPF treat-to-target goal and actual clinical outcomes.[1,4] By doing so, we have the best chance of achieving maximum skin clearance and improving our patients' quality of life.[13,14]

Dr. Turck:
Thank you, these are great takeaways from our discussion.

And with those final thoughts in mind, I want to thank my guests, Dr. James Song and Ms. Lakshi Marie Aldredge, for sharing their clinical perspectives on optimizing psoriasis assessment and systemic therapy decisions. Dr. Song, Ms. Aldredge, it was great speaking with you both today.

Dr. Song
Thank you for having me.

Ms. Aldredge:
Thank you so much for including me – it was a pleasure.

Announcer:
This medical industry feature was sponsored by AbbVie US Medical Affairs. If you missed any part of this discussion, visit Industry Features on ReachMD.com, where you can Be Part of the Knowledge.

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ABBV-US-01849-MC Version 1.0 Approved December 2024