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Personalized Biologic Care in Hidradenitis Suppurativa

Announcer:

This is *On the Frontlines of Hidradenitis Suppurativa* on ReachMD. Your host today is Dr. Mary Leuchars.

Dr. Leuchars:

You're listening to *On the Frontlines of Hidradenitis Suppurativa* on ReachMD, and I'm Dr. Mary Leuchars. Today, we're diving into a very interesting question: how do we choose a biologic for a patient with hidradenitis suppurativa, also known as HS? Here with me to share his insights is Dr. Luis Garza, who's a Professor of Dermatology at the Johns Hopkins University School of Medicine in Baltimore. Dr. Garza, thanks so much for joining us today.

Dr. Garza:

Thanks, Dr. L, for the invitation, and I look forward to our conversation.

Dr. Leuchars:

So to kick things off, Dr. Garza, when you start an HS patient on a biologic, what does success look like to you, and how do you make sure that lines up with what success means to the patient, like less pain and fewer flares?

Dr. Garza:

So I think it is important to align expectations to likelihood. The most critical one to explain to patients—and even sometimes some physicians don't realize this—is that the biologics do not cause the dismantling of existing tunnels. So part of HS is this progressively worsening condition, where you start off with less severe inflammation and move to much more severe inflammation that also involves these down growths of the top epidermis or the top layer of skin. And those down growths can lead to these sinus tracts or tunnels. And biologics do not touch those. So we'll come back to that.

It's important to tell patients that no biologic will ever completely cure them. It won't. If they're at that stage, they'll always have a tendency for flares. But the hope is that they'll have fewer flares, fewer new nodules, less pain, and less pus output. So those are the main goals of the therapy.

Dr. Leuchars:

So now that we have both TNF and IL-17 options, what patient and disease factors help you to decide which biologic someone starts on?

Dr. Garza:

Unfortunately, these days, a lot of what we do in the United States is really dictated by insurance companies. And a lot of insurance companies demand that we start with TNF inhibitors before we move to IL-17 inhibitors, because the TNF inhibitors are off patent, so there are biosimilar TNF inhibitors. And those biosimilars tend to be cheaper for insurance companies. Their efficacy tends to be not dramatically worse, and some people might say close to equal even, but certainly not dramatically worse. Because of that lower cost, a lot of insurance companies really require that we start with the TNF inhibitors. There are some disadvantages, where they might have slightly decreased efficacy. There might be patients have more failures. With time, they might have more burnout failures. So it's certainly common that we move on, and that we'll talk about in a second.

But typically, we'll start with TNF inhibitors. In some cases, we will only use TNF inhibitors, in terms of what's on the market currently. And those examples are patients that have inflammatory bowel disease, like Crohn's disease or ulcerative colitis. In those patients, it's

appreciated that IL-17 can actually be detrimental, and antibodies against IL-17 can worsen their bowel disease, so we avoid those drugs in those folks. And also, in the reverse, sometimes we can make some points to insurance companies and say, "Look, we can't start a TNF inhibitor because this patient has a history of, let's say, congestive heart failure," and it's known that TNF might make that worse. So there are some unique biological cases where doctors might move for one over the other. But really, most of the time, it's unfortunately dictated by insurance companies.

Dr. Leuchars:

So let's say your patient's three to four months into a biologic, and they've improved, but they're still having some flares and dealing with pain. How do you decide between intensifying the dose, adding a different therapy, or just giving the current regimen more time?

Dr. Garza:

It is true that three months is a minimum. So I think you really need to wait at least three months to give patients a fair shot. I tend to ask patients to give it more like four months before they make a decision. I think it's the case that, after six months, they know really well. So I don't think it's ever really worth hoping things are going to get better after six months on therapy. So there's that window between three and six months when patients can switch.

I think a lot of it is a conversation with a patient about what they prefer, and also what they've been on. It makes a lot of sense to move from a patient that's been on a TNF inhibitor to an IL-17 inhibitor if they're failing, because it's a different modality. There are several IL-17 inhibitors that are marketed right now, and, with those medications, maybe there are some differences where it looks like efficacy. There might be a slightly increased efficacy in bimekizumab based on the clinical trials. But you can imagine it's less of a value proposition to a patient to say, "I'm moving you from one IL-17 to another." But still, there is value there, and there is some evidence that it works better.

A lot of times, it's really talking to the patients and telling them about their options. The good news about switching from a TNF to an IL-17 is that there's less frequent dosing. So the TNF inhibitors are weekly dosing, whereas the IL-17 inhibitors are monthly dosing. So patients very much appreciate that. And they also appreciate that their outcomes might be better. And so I think it is the case that there's always the option of thinking about adjunctive therapies.

And I think it's important for providers to keep in mind that, even though we have patients on biologics, we can't forget the roles of all the parts of medicine, including lifestyle modifications. Every visit, even for my folks on biologics, I go over the importance of being careful about what they eat and avoiding processed foods, because we think there's chemicals in food packaging that might make HS worse. We go over the importance of not smoking. We go over the importance of using Hibiclens soap regularly, especially after working out or sweating.

And then there's also, certainly, pills that can modify therapy. We know the drugs that help with diabetes, especially in our obese patients, might help. So metformin can help in those folks. Also, we're using a lot of GLP-1 agonists in our obese patients that have HS. And for women that have flares during their cycle, they can consider spironolactone. So there's a lot of adjunctive therapy and approaches we can also use.

But pretty much, after a patient's not doing well over three to six months, I'll recommend switching. And then there's several other things we could talk about when it comes to ways to switch and things to switch to.

Dr. Leuchars:

For those just joining us, you're listening to *On the Frontlines of Hidradenitis Suppurativa* on ReachMD. I'm Dr. Mary Leuchars, and I'm speaking with Dr. Luis Garza about personalizing biologic treatment in HS.

So, Dr. Garza, I'm curious about where surgery fits into the picture. How do you decide when to refer, and does being on a biologic change that decision or the timing at all?

Dr. Garza:

The important thing to realize is, in HS, if you press on one part of your skin and pus comes out of a different part of your skin, then you know you have one of these fistula connections. It's these tunnels that are underneath your skin that connect two distant places. And once those tunnels form, no biologic will take them down. So that's why I believe it's really important to start biologics early to prevent those tunnels, because surgery is the only way to take care of them.

Pretty much every single patient I start on biologics, I'll tell them about having a consult with our local plastic surgeons who are here at Hopkins, who are fantastic. And we work together. I think the plastic surgeons really actually prefer when our patients are very well managed medically and are on biologics, because they tend to have a better post-op course.

We're always trying to optimize the disease with biologics, and we're always trying to use surgery as an adjunctive therapy, and they're

never really competing. And I don't think they really change each other too much. Basically, for surgery, any time a patient has signs of fistula or scarring, I think it's really good to bring in our plastic surgery colleagues to help.

Dr. Leuchars:

So looking ahead with the new therapies in development, including oral options, how do you see treatment selection in HS changing over the next few years?

Dr. Garza:

We'll probably have our first JAK in the market pretty soon, after FDA approval. The first one will probably be pacritinib. It's going to be a great addition. It'll be the first oral. A lot of dermatologists have a lot of experience with JAK inhibitors, so they're very used to prescribing that. And it can be a new modality. So up to now, it's really been TNF inhibitors or IL-17 inhibitors. Now, we'll have this new modality of a JAK inhibitor, so that's going to be really exciting, because some of our patients really don't want injections at all. And some of them have some of these complicating conditions like I mentioned, like inflammatory bowel disease, and they can't use the IL-17s. JAK inhibitors are actually already approved for bowel disease, so it'll just be easier for docs to give therapies that can treat our whole patient with those. So that's going to be exciting.

I think we're going to see some new IL-17 inhibitors, and so that'll be useful, too, to have. Then, finally, there's going to be new IL-1 beta inhibitors that will be approved, relatively in the short term. I think that's going to be fantastic also, because this is going to be a new treatment modality. At that point, we'll have TNFs, IL-17s, JAKs, and IL-1, so we'll have four different options. And we'll be able to move to different biological players for our patients.

I think it's going to be the case that none of these medications treat the fundamental pathogenesis of HS, so none of them are going to be curative. They're all downstream from the upstream thing that causes HS. But there's still going to be a lot of movement, I think, between these medications, and different ones will be good for different patients. It'll be great to have new options to help all the folks coming into our clinic.

Dr. Leuchars:

So before we close, Dr. Garza, what's the one change you'd most like to see in how clinicians use biologics for HS?

Dr. Garza:

Probably, like I mentioned, using them earlier to prevent those tunnels forming, because it's a burden for the patients to have to go to plastic surgery. Those surgeries can be disfiguring, especially in the groin area. They can reduce mobility in the axilla. There is dehiscence, meaning sometimes the wound doesn't close or opens up afterwards. There are a lot of experienced surgeons who do fantastic work, and there are very few complications. But the less patients have to resort to that, the better. So I think using biologics early is probably the thing that will help our patient population the most.

Dr. Leuchars:

Those are very helpful recommendations for us to keep in mind. A big thanks to my guest, Dr. Luis Garza, for joining me to discuss the use of biologics in hidradenitis suppurativa. Dr. Garza, we appreciate you being here today.

Dr. Garza:

It's my pleasure, Dr. L. Thanks for the invite, and good luck to all of our patients suffering from this disease.

Announcer:

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