Transcript Details
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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Psoriasis Update 2025: Dr. Gelfand

Dr. Joel Gelfand:
I'm Dr. Joel Gelfand. I'm a professor of dermatology and epidemiology at the University of Pennsylvania in Philadelphia. And here we're at Maui Derm, an amazing educational meeting, and we just covered the psoriasis session. I want to talk about a couple of pearls that we've talked about in that session. So, one thing I'm sure you've seen in your clinical practice if you've been managing people with psoriasis is, patient has Crohn's disease, they come in, and now have psoriasis from their TNF inhibitor, and their Crohn's is doing well, and their GI doctor does not want you to stop that medication. What do you do in that circumstance? And so, one of our panelists talked about the VEGA study. It's a clinical trial using guselkumab plus golimumab, which is a, first, one's IL-23, golimumab is TNF and for the treatment of ulcerative colitis.

And what they found was that there was no impact on safety of combining an IL-23 with a TNF inhibitor. And actually the patients had much better clinical outcomes in their gut when they had a combination approach to those two different biologics. This is a new way to think about it for us as dermatologists. Usually what I say is, "Oh, you really should stop that TNF inhibitor. Why don't we try an IL-23 inhibitor or ustekinumab, for example, but it has to be done at dosing for the GI perspective." But now this data suggests that it's actually safe enough to add a 23 to a TNF, and maybe the right thing to do is say, "You know what? Stay on your 23. Your bowel's doing really well, and why don't we try adding dermatologic dosing of an IL-23 inhibitor?" This is some solid data of safety of combining those approaches.

Speaking of safety, what's more safe than ultraviolet light? Here we are in Maui. We think about sunlight as being medicinal in a lot of ways. Patients think about it being a healthy way to treat their disease. And I want to talk about phototherapy, home phototherapy, that is. In a recent study we just published from JAMA Dermatology of home versus office phototherapy, the treatment of psoriasis, both plaque or guttate. And what we found in a study of over 783 patients treated at 42 dermatology sites around the country, that patients randomized to get treatment at home with phototherapy do just as well as people being randomized to the office and have a very safe response. None of the patients randomized to home treatment had to stop phototherapy because of side effects or problems in the machinery or anything like that. And the absolute response rates are actually quite outstanding.

This is a real-world study embedded in routine clinical practice, and what we found is that about 40 percent of patients previously used oral medication or systemic therapies like biologics for psoriasis. 12 percent were currently taking those medications. And by adding on phototherapy, whether at home or the office, patients achieve very high rates of skin clearance akin to what you can get with some of the more modern oral or biologic therapies. That's a new thing to keep in mind, the LITE study, and check out the article in JAMA Derm, December 2024.

Last pearl that came out in the session was comorbidity and obesity. Well, now, you've sure heard about GLP-1 agonists, these incredible drugs like semaglutide, for example, or tirzepatide, cause profound weight loss in patients who are obese or overweight. And there's hints of signs out there that using these drugs in psoriasis would lower the severity of their psoriatic disease. These drugs are also very good for fatty liver disease, treating insulin resistance and diabetes, and even in a population of patients without diabetes, lowered all-cause mortality compared to placebo.

So, it's pretty exciting, and a lot of dermatologists now are starting to think about, well, I should always educate my patient, see if they're considering going on a GLP-1 agonist, maybe reaffirm their primary doctor for this if their BMI is elevated or if they're in the obese range, a BMI of 30 or higher. Often, what I'll do with my patients, I'll check a hemoglobin A1C, and if that hemoglobin A1C is in the pre-diabetic range or diabetic range, that's sort of another piece of data for that patient to say, "You know what? Maybe treating your heavier body weight with a GLP-1 drug, and your insulin resistance will help not only these important medical problems, but also improve your

psoriasis."