

Pushing the Limits: Developing a New Standard of Care for Psoriasis

Jeffrey M. Weinberg, MD

We are now in the midst of a second revolution in the care of patients with psoriasis. Since biologic therapies for psoriasis were first introduced in 2003 with the approval of alefacept, the psoriasis treatment paradigm has shifted and continues to evolve. Interestingly, the first 2 biologic agents approved for psoriasis, alefacept and efalizumab, are no longer on the market in the United States.

We certainly have made progress since the early days of psoriasis treatment. Over the years, we have come to understand the nature of psoriasis as a systemic inflammatory condition rather than as simply a skin disease. With this knowledge, we have continued to identify systemic comorbidities associated with psoriasis, including cardiovascular risk, diabetes, and metabolic syndrome. It is therefore the role of the dermatologist to serve as the gatekeeper for these individuals and help to screen for comorbidities of psoriasis, as well as provide appropriate counseling and referral.

Additionally, psoriasis therapies have been approved for new segments of the population. In 2016, the US Food and Drug Administration approved a supplemental biologics license application for use of etanercept in children aged 4 years and older with chronic moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. Last year, the US Food and Drug Administration also approved an expanded indication for ustekinumab for the treatment of adolescents (aged 12 years and older) with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

Another treatment development included the approval of apremilast as a new oral therapeutic option for psoriasis patients. This agent, which is approved for both psoriasis and psoriatic arthritis, has become an attractive therapy for many patients who are new to systemic treatment. Many patients prefer an oral medication and like the fact that no routine laboratory monitoring is required. Often patients leave their dermatologist's office with 2- to 4-weeks' worth of samples and can begin their course immediately.

A treat-to-target approach also has been established for psoriasis. In 2016, the Medical Board of the National

Psoriasis Foundation¹ created specific treatment goals in order to make achieving clear or almost clear skin the new standard of care. A consensus-building study conducted among 25 psoriasis experts revealed that the most preferred instrument for evaluating disease severity was body surface area (BSA). The time at which most participants preferred to evaluate patient response after starting a new psoriasis therapy was 3 months, and an acceptable response at this timepoint was considered to be either BSA involvement of 3% or less or improvement in BSA involvement of 75% or more compared to baseline. The target response at 3 months after starting treatment was BSA involvement of 1% or less. During the maintenance period, evaluation every 6 months was most preferred, and the target response at every 6-month follow-up evaluation was BSA involvement of 1% or less.¹ These standards enable and encourage both clinicians and patients to maximize their treatment success.

Over the past several years, a variety of new biologic agents also have come to the market, including 3 IL-17 inhibitors (ixekizumab, brodalumab, and secukinumab) and one IL-23 inhibitor (guselkumab). All of these agents have added new options to the armamentarium for psoriasis treatment and are highly effective. Overall, the clinical improvement and safety profiles for these agents are promising, and these new drugs may be equal to or more efficacious than the currently available therapeutic options for psoriasis treatment; however, long-term studies are still needed to further establish the safety and efficacy profiles for these biologic agents. Even more novel therapies are in development, as will be discussed by Lee et al² in this issue.

It is the purpose of this special issue to review new standards of care for psoriasis in 2018. We hope that you find this issue enjoyable and informative.

REFERENCES

1. Armstrong AW, Siegel MP, Bagel J, et al. From the Medical Board of the National Psoriasis Foundation: treatment targets for plaque psoriasis [published online November 28, 2016]. *J Am Acad Dermatol*. 2017;76:290-298.
2. Lee EB, Amin M, Bhutani T, et al. Emerging therapies in psoriasis: a systematic review. *Cutis*. 2018;101(suppl 3):5-9.

From the Icahn School of Medicine at Mount Sinai, New York, New York.

Dr. Weinberg is a speaker for and has received research grants from AbbVie Inc, Amgen Inc, Celgene Corporation, and Novartis. He also is a speaker for Eli Lilly and Company.

Correspondence: Jeffrey M. Weinberg, MD, 10 Union Square E, Ste 3C, New York, NY 10003 (jmw27@columbia.edu).