

Light in the Distance

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Is there anything new? This is a frequently asked question from patients with psoriasis. They are looking for something better, something easier, or something safer. They want something that will finally defeat their nemesis.

Treating the patient with moderate-to-severe psoriasis is often a challenge. Topical medications usually will not suffice, and ultraviolet therapy is often inconvenient for many, not to mention the increased risk of squamous cell carcinoma with psoralen plus UVA (PUVA). The systemic medications, including methotrexate, acitretin, and cyclosporine, are often effective, but their utility is limited by a myriad of systemic side effects.

It is rewarding that we now have some good news to tell these patients. New therapies are available, and others are on the way. We can now happily tell patients that, over the next few years, they potentially will have a new array of treatments that are highly effective without major systemic side effects. In this issue of *Cutis*[®], 3 major new types of therapy are reviewed: immunotherapies, narrowband UVB therapy, and the 308-nm excimer laser.

Infliximab, *etanercept*, *efalizumab*, and *alefacept* are 4 words that most clinicians are not familiar with at this time—but that may change very soon. These are some of the most promising new drugs for the treatment of psoriasis. These new agents represent the development of novel, long-term biological therapies that have a much better side-effect profile than our current systemic therapies. Many patients in clinical trials have had positive clinical responses with sustained remissions. Most notably, no major systemic toxicities have been noted in extensive early trials of these drugs. (In this issue, some of earlier immunotherapies are

discussed: anti-CD4 antibody, anti-TAC, and peptide T. The second part of the same article will appear in the next issue of *Cutis* and will address these 4 newer therapies.)

An advance in UVB-based phototherapy has been the introduction of fluorescent lightbulbs (Philips TL-01) that deliver monochromatic light at 311-nm UVB, a narrowband wavelength that seems to maximize clearing of plaques relative to its erythrogenic potential. Narrowband UVB phototherapy has considerable advantages over traditional treatment options such as broadband UVB and PUVA. It is clearly more effective than broadband UVB, safer than PUVA, and well tolerated by patients at suberythemogenic doses. Because of these factors, the use of narrowband UVB phototherapy has been increasing.

The 308-nm excimer laser is a second new modality for the treatment of psoriasis. With the 308-nm UVB radiation generated by this laser, it is possible to clear psoriasis with as little as one treatment and to have a moderately long remission. In contrast to traditional phototherapy techniques, this handheld excimer laser UVB therapy is selectively directed toward lesional skin, thus sparing the surrounding normal skin from unnecessary radiation exposure. This modality may offer a new alternative in the treatment of limited psoriasis and other inflammatory diseases.

It is truly a time for optimism for us and our patients. We recommend that clinicians become familiar with the new therapies currently available and keep abreast of the others in development. Most importantly, we must encourage our patients with the fact that new treatments are here and many more are on the way.