Editorial

Learning Curve

Jeffrey M. Weinberg, MD

As continued progress occurs in the treatment of psoriasis, dermatologists are faced by an array of new challenges. Suddenly the management of psoriasis is becoming a significantly more complex arena. With all of the new therapies and terminology, it is as if we have to learn a new language. The terminology is invading our space. PASI, PsA, DLQI, OLS, PGA, TNF, -umab, -ximab, -cept. What do these mean? What do they tell us about how a particular new treatment fits into our therapeutic ladder?

I am writing this piece not to espouse any or all of the new therapies but to encourage physicians to become educated consumers. Biologic therapy is a constantly evolving story, with an ever increasing, and often overwhelming, amount of information. The challenge most commonly faced is how to put these new therapies in context of one another, and in context with traditional therapies. Dermatologists want answers to the following questions.

Question 1: Which of the new therapies should I use? Do I use these prior to or following conventional systemic therapies?

All of the new drugs are promising. They have different profiles in terms of efficacy, side effects, and monitoring requirements. Over the next year, each respective manufacturer will be extolling the virtues of their compound, emphasizing the advantages they have over the competition. Thought leaders will be championing one or more therapies. How then is one to decide? My recommendation is to become your own expert—do not rely on the opinions of others. Read the literature thoroughly and critically. Learn to decipher the terminology and understand how results are interpreted. Test the claims against the realities. Then, you can arrange your personal algorithm based on which therapies are appropriate for your patients and your practice.

Question 2: Should I be treating psoriatic arthritis?

Because several of the new therapies have efficacy in the treatment of psoriatic arthritis (PsA), there recently has been a major emphasis on this concept. Psoriatic arthritis can start slowly with mild symptoms, or it can develop quickly. It is very important to have as early and accurate a diagnosis as possible. Left untreated, psoriatic arthritis can be a progressively disabling disease. In fact, half of those with psoriatic arthritis already have bone loss by the time the disease is diagnosed.[1] There are 5 types of psoriatic arthritis: symmetric, asymmetric, distal interphalangeal predominant (DIP), spondylitis, and arthritis mutilans. Many dermatologists seem to be unsure of their role in this disease. Should I treat it, or should I refer to a rheumatologist? The answer depends on one's personal comfort with this disease. At a minimum, however, it is important for us to recognize the condition. We should learn to ask the right questions and recognize the signs and symptoms. We know that psoriasis usually precedes PsA and that with early treatment, joint destruction can be inhibited. We should therefore be vigilant for its development and manage or refer the patient if this should occur.

Question 3: Will managed care pay for the new therapies?

That is the $100,000 question, literally. Probably not without a fight.

REFERENCE

1. National Psoriasis Foundation. Psoriatic arthritis. Available at: http://www.psoriasis.org/facts/psa. Accessed October 2, 2003.