Think Efficacy, Toxicity When Treating Psoriasis

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PARIS — Nonbiologic systemic drugs can be effective choices for the treatment of psoriasis if they are chosen properly, according to Dr. Jonathan Barker.

Traditional systemic drugs work but are not always effective, and are often associated with considerable toxicity, he said at the annual congress of the European Academy of Dermatology and Venereology.

"To optimize systemic therapy, we're talking about maximizing efficacy and minimizing toxicity," said Dr. Barker, head of the skin inflammation unit at St. John's Institute of Dermatology, King's College, London. He gave an overview of several standard systemic drugs:

▶ **Methotrexate.** The preferred drug for unrelenting disease that is likely to require long-term therapy, it also helps in psoriatic arthritis. The key to avoiding adverse events is to start with a low dose and increase it slowly. Dr. Barker said he and his colleagues begin psoriasis patients on 5 mg/week and then increase the dose by 5 mg/week up to 15 mg/week for the first 3 months. The maximum dose they use for psoriasis is 25 mg/week.

Most causes of death that are associated with methotrexate are attributable to bone marrow suppression, not hepatotoxicity. These deaths usually result from confusion over dosage, or from folic acid deficiency, he said. Bone marrow suppression is rare when patients are on folic acid supplementation.

Liver function can be monitored without routine liver biopsy by measuring serum levels of procollagen III aminopeptide (Br. J. Dermatol. 2005;152:444-50). Dr. Barker checks serum levels every 3 months for psoriasis patients on long-term methotrexate. "If this practice were to be widely adopted, then methotrexate would become a more acceptable option for many patients who are dissuaded from considering it because of the threat of repeated liver biopsy," he said.

▶ **Cyclosporine.** It is a fast-acting drug that "presents a different set of problems with respect to usage," Dr. Barker noted.

In patients receiving long-term methotrexate treatment, liver function can be monitored without routine liver biopsy by measuring serum levels of procollagen III aminopeptide.

"It's a very good drug for patients with intermittent disease, where they need a quick fix but you're hoping that the duration of therapy will be very short."

Glomerular sclerosis is extremely unlikely to occur in patients who are treated with cyclosporine for less than 12 months and in whom there is an insignificant rise in creatinine levels. Glomerular sclerosis is much more likely to occur when cyclosporine is used for more than a year.

Also, long-term cyclosporine A—the main form of this drug—is associated with an increased risk of nonmelanoma skin cancer. However, this risk can be minimized by limiting both dosage and duration of use (no longer than 1-2 years), Dr. Barker said. Cyclosporine use should be minimized in patients who have had significant phototherapy.

▶ **Acitretin.** It can be used "occasionally in moderate chronic plaque psoriasis, more so in palmo-plantar pustulosis," said Dr. Barker, who added that he starts with the lowest dosage (25 mg/day) and uses it with narrow-band UVB phototherapy.

But one should use extreme caution when treating women of child-bearing age with acitretin because it can cause major fetal abnormalities, he cautioned.

In addition, it is very helpful as an adjunctive treatment for patients with severe disease and multiple squamoproliferative lesions who have been on phototherapy in the past.

"This is not an immunosuppressive drug, and there is some evidence that it has chemoprotective activity for malignancy," he said.

Dr. Barker has consulted for several pharmaceutical companies making biologics but noted that none was relevant to his presentation. ■