Sequential Therapy Is Way to Go in Psoriasis

After the combo achieves good control, the plan should downshift, eliminating the more toxic agent.

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

NEW ORLEANS — Sequential therapy is a great way to get quick, effective control of chronic psoriasis while keeping costs down and minimizing the patient's exposure to potentially toxic systemic agents, John Koo, M.D., said at the annual meeting of the American Academy of Dermatology.

"You can start with a fast-acting agent like cyclosporine, then add a biologic and try to taper the cyclosporine," said Dr. Koo of the University of California, San Francisco. It's important to maintain the initial systemic treatment for at least 3 months, he stressed, because any biologic will take that long to kick in.

"It's not a good idea to stop the prebiologic agent when starting the biologic because the biologic takes at least 3 months to build efficacy and the prebiologic's efficacy will fade within 1 month," setting the stage for a flare, Dr. Koo said.

After the combination achieves good control, the plan should downshift, eliminating the more toxic systemic agent in favor of some form of maintenance therapy. This could be the biologic alone (with the temporary addition of a systemic if flare occurs), a biologic plus UVB or oral retinoid, or another safe and effective long-term regimen.

Unfortunately, some older therapies are falling by the wayside as the heavily promoted biologics take center stage. But focusing so heavily on these new drugs shortchanges patients who need access to the entire arsenal of treatment. "For optimal care, these patients need the full range, whether it's being promoted or not. PUVA isn't heavily promoted anymore, but it still works," he said.

When one looks at overall efficacy, "biologics are in the less effective range. They aren't always adequate as monotherapy, even with optimized topical therapy, especially if the patient is large or if it's during the winter," Dr. Koo said.

As a rough comparison of effectiveness, he said, retinoid plus psoralen and UVA will effect an improvement of 75% in the Psoriasis Area and Severity Index (PASI 75) in 100% of patients by 3 months. This is slightly better than the best biologic, infliximab (PASI 75 in about 90% by 3 months), but it's a lot cheaper and doesn't carry infliximab's risk of infection. The other biologics fall far behind this efficacy level: PASI 75 improvement by 3 months in 21% for alefacept, 28% for efalizumab, 34% for etanercept 25 mg biweekly, and 49% for etanercept 50 mg biweekly.

'You can start with a fast-acting agent like cyclosporine, then add a biologic and try to taper the cyclosporine.' Maintain the initial systemic therapy at least 3 months.

In contrast, PASI 75 by 3 months is seen in about 90% of patients on PUVA plus calcipotriene; 80% of those on moderate-dose cyclosporine; 71% of those on PUVA alone; 60% of those on methotrexate; and 55% of those on narrowband UVB phototherapy. The downside of these older treatments is that they're not as convenient as simply taking a pill, Dr. Koo said. They involve multiple office visits, which can be a problem in areas of limited medical access, or with noncompliant patients. And some carry a risk of organ damage.

This risk is one reason why some have shunned older systemic agents and embraced the biologics, Dr. Koo noted. "A third of U.S. dermatologists don't feel comfortable prescribing methotrexate or cyclosporine. Another third will only use them when 'pushed to the wall.' The remaining third account for more than 95% of all prebiologic systemic therapy prescribed in the United States."

Cost should be another consideration, Dr. Koo said. The biologics are considerably more expensive than prebiologic treatments. Approximate annual cost of alefacept approaches $20,000; infliximab, $18,000; and etanercept, $17,000. In contrast, a year of cyclosporine runs about $10,000; acitretin, $5,000; PUVA and UVB, about $2,500; and methotrexate, about $1,500. ■

Pimecrolimus Thorough and Fast for Inverse Psoriasis

BY SHERRY BOSCHERT
San Francisco Bureau

KOHALA COAST, HAWAII — Pimecrolimus cream 1% did a better and faster job of clearing inverse psoriasis in a randomized, double-blind, vehicle-controlled study of 57 patients, according to Mark Lebwohl, M.D.

The patients applied either the topical immunomodulator pimecrolimus cream 1% or a vehicle cream of identical appearance twice a day for 8 weeks. There were no significant differences at baseline in the two groups. All patients were adults with moderate to severe inverse psoriasis, a T-cell–mediated inflammatory skin disease involving intertriginous areas such as the groin, axilla, and skin folds or creases of the breasts and buttocks, he said in a poster presentation at a conference on clinical dermatology sponsored by the Center for Bio-Medical Communication Inc.

Skin in these areas is very susceptible to the cutaneous side effects of more common topical treatments for psoriasis such as corticosteroids, which can cause irritation or corticosteroid-induced atrophy and striae, wrote Dr. Lebwohl, professor and chairman of dermatology at the Mount Sinai School of Medicine, New York.

Previous data have shown pimecrolimus cream 1%, a nonsteroid topical calcineurin inhibitor, to be effective in treating psoriasis when used under occlusion. It is not approved by the Food and Drug Administration for this indication.

Investigators in the current study rated disease severity on a four-point Global Assessment Scale from 0 (clear) to 4 (severe disease). They selected a target area on each patient and rated erythema, induration, and scaling on a scale of 0 (absent) to 3 (severe); the sum of those three scores comprised the Target Area Score.

At week 8, 20 of 28 patients in the pimecrolimus group had an Investigator Global Assessment score of 0-1 (clear or almost clear), compared with 6 of 29 patients in the vehicle group, Dr. Lebwohl wrote.

Four patients in the pimecrolimus group and none in the vehicle group achieved a global assessment score of 0-1 by the third day of applying the cream.

The Target Area Scores (TAS) were significantly better in the pimecrolimus group than in the vehicle group at each assessment date: days 3 and 7, and weeks 2, 4, 6, and 8 of treatment. The TAS declined from 5.2 at baseline to 1.1 at the end of the study in the pimecrolimus group, and from 5.5 at baseline to 2.9 in the vehicle group.

The pimecrolimus cream was well tolerated, Dr. Lebwohl and his associates wrote. No serious adverse events were reported, and no patient in either group discontinued the cream because of adverse events.

Overall, two patients in the pimecrolimus group reported adverse events: One developed paresthesia at the application site, and the other developed shaving folliculitis, which was thought to be unrelated to the cream. Of the 10 adverse events reported in the vehicle group, only 1 was considered to be related to application of the vehicle cream: tenderness in the target area. ■