Categorizing Psoriasis Severity
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Bruce Strober, MD, PhD, FAAD, interviewed by Flavia Fedeles, MD, FAAD

FLAVIA FEDELES, MD, FAAD: Hi, everybody. Welcome to another episode of *Dialogues in Dermatology* podcast. My name is Flavia Fedeles. I'm an Instructor in dermatology at Harvard Medical School, and a clinical dermatologist in the department of dermatology at Massachusetts General Hospital. Today, I have the privilege of welcoming Dr. Bruce Strober to our podcast. Dr. Strober is Clinical Professor of Dermatology at the Yale University School of Medicine. And he practices and does clinical research at Central Connecticut Dermatology in Connecticut.—

--He is a nationally and internationally recognized expert in psoriasis and clinical trials. And he is also the scientific co-director of the CorEvitas Psoriasis Registry, the Treasurer of the International Psoriasis Council, and the Editor-in-Chief of the *Journal of Psoriasis and Psoriatic Arthritis*. His main research interests center around the therapeutics of inflammatory skin diseases, such as psoriasis and atopic dermatitis. His goal in clinical practice is to help improve the care of patients with difficult-to-treat inflammatory skin diseases.—

--Today, we are going to be talking about Categorizing Psoriasis Severity. Thank you so, so much for joining me, Dr. Strober. I'm very excited about this conversation. This is a very important topic, so I'm very excited to talk about this. I was thinking to start first by just talking about why this is such an important topic: categorizing the severity of psoriasis and how that affects our clinical practice or our clinical decision making when we see psoriasis patients in our clinic.

BRUCE STROBER, MD, PhD, FAAD: Thank you for having me. The most important issue here is delivering care to patients with psoriasis that's appropriate to how the psoriasis affects them from quality of life standpoint. And importantly, why determining the patient's severity is going to

be part and parcel with regard to determining their correct therapy. So if you don't deliver therapy appropriately, you risk under-treating patients.—

--And that's really the concern I have mostly is the undertreatment of patients with psoriasis that can be occurring in general medical dermatology practice.

FLAVIA FEDELES, MD, FAAD: What are some of the current ways that we're categorizing severity that perhaps are not ideal to meeting some of the needs of some of the patients?

BRUCE STROBER, MD, PhD, FAAD: Well, we've all heard that psoriasis is either mild, moderate, or severe. And in most instances, it's moderate to severe that's the major classification for patients who could be on either systemic therapy or phototherapy. The problem is moderate to severe is often dictated by what kind of patients are enrolled in the clinical trials leading to approval of our therapeutics.—

--In almost every instance, a moderate to severe patient in a clinical trial has more than 10 percent of his or her body surface involved with psoriasis or a PASI score of 12 or worse. And for the most part, that is defining a patient who is very severe. In fact, the average patient in a clinical trial has a PASI score of 20. What happens to patients who, regardless of their ability to be in these trials, could nevertheless benefit from a systemic therapy or a biologic therapy?—

--You may understand that patients might not get into these studies. Perhaps they have a BSA of 8 percent or 7 percent, yet, they're not adequately treated with topical therapies. Or they have palms and soles involved only and they can't even get past 5 percent, but you couldn't control them with topicals. These patients would potentially be undertreated because they're not really that which is studied in the clinical studies.—

--They're too low in their BSA, yet they fail topicals. They're left in this intermediate zone that leaves them inadequately addressed with regard to how the disease truly affects them.

FLAVIA FEDELES, MD, FAAD: That's a very good point that unfortunately, some of these patients are not severe enough, sometimes they don't get aggressive treatment enough because they're not considered severe enough. So you talked about the BSA and the PASI. Are there any other tools that we can perhaps use in our practice as far as addressing their quality of life?

BRUCE STROBER, MD, PhD, FAAD: First of all, no one does a PASI score in the clinic. So we can throw that out, it's a purely research-focused metric. We do look at body surface area. And many providers appropriately look at the PGA, Physician's Global Assessment. Sometimes that's called an Investigator's Global Assessment, IGA. But regardless, we tend to look at both BSA and PGA.—

--And they're very different from each other but used in combination, those two outcome measures do summarize to some extent severity. But they nevertheless will fall down for people with special areas. When I say special areas, I'm really speaking to scalp, palms, soles, genitals, nails, perhaps inverse, intertriginous psoriasis. So we need to not be too focused on BSA for that reason.—

--Now, you did ask what are some quality of life instruments that could be utilized. They, too, have not been integrated very extensively into clinical practice. We have a few we use in clinical trials, for example the Dermatology Life Quality Index, the DLQI, which is a ten question survey of how one's dermatologic disease affects quality of life, it's not specific to psoriasis. In fact, it wasn't developed specifically for psoriasis.—

--Now, there are more recently developed dermatology quality of life instruments that are geared towards psoriasis, for example, the Psoriasis Disease Inventory. These are questionnaires that were developed by the pharmaceutical industry at the behest of the FDA to look at specific aspects of psoriasis that affect patients. And by and large, their issues such as

pruritus, scale, skin pain, bleeding, issues such as symptoms that affect patients every day, and if you really narrow it down it's a basic few symptoms that we've all known about, like pruritus.—

--So if you ask about itch and you gather their BSA, and you gather their IGA, and importantly examine how they respond to topicals, then you have a sense of where they should be on the treatment ladder.

FLAVIA FEDELES, MD, FAAD: That's a wonderful point about the quality of life and the symptoms, the pruritus particularly which I guess in the past, we really didn't think psoriasis would be or could be so pruritic, but now we know that a lot of the patients have severe pruritus that really affects their quality of life. Now, I know there was some research done by the International Psoriasis Council looking at or assessing disease severity. Can you tell us a little bit about that?

BRUCE STROBER, MD, PhD, FAAD: It was an endeavor I led for the IPC that was basically about how do we talk about psoriasis with regard to does the patient deserve topicals or does the patient deserve systemic therapy and/or phototherapy. And it came down to an effort to survey about 70 experts in psoriasis therapy around the world, it's an international effort. And through a Delphi exercise, identify statements that best describe how you categorize patients.—

--And in the end, through many rounds of voting, all anonymous, online, and then a last session where there was a presentation done by the final top vote getters, because we actually were able to collect about 35 unique definitions. But in the end, we were able to vote down to one. And it was a statement, actually in retrospect we learned developed by Dr. Andy Blauvelt in Oregon, his statement won the day.—

--You can bring it down to this succinct definition of how we should treat psoriasis. Psoriasis patients can be either topically treated or systemically treated, and we include phototherapy into

systemic treatment, based on their ability to meet the following criteria. Are they a BSA of 10 percent or worse? Do they have special areas of involvement? And then finally, have they tried and failed topical therapy?—

--If they meet those criteria, and it can be any of them, they don't have to be 10 percent or worse, they could be special areas alone and deemed, look, this patient needs a systemic therapy, and they can be on a systemic therapy. So you could therefore gather patients who have 4 percent BSA but very severe refractory palmoplantar disease or 5 percent and very severe refractory scalp psoriasis, as we've all seen very severe scalp psoriasis that can't be managed with topical therapy. Then you are green-lighted conceptually for the use of a systemic therapy.—

--And I know, and all of us were very happy with this outcome winning, so to speak, all blind and anonymous but it won, because it's real. Essentially, if you treat a lot of psoriasis, you are guided by these basic rules. And, of course, you consider quality of life. Now, some people ask, "Why didn't you include a quality of life metric?" And the reason was in the United States, most payers don't recognize quality of life metrics as valid.—

--The FDA does, obviously they're incorporating DLQI into their studies as outcome measures. But often, DLQI doesn't make it into the label for these drugs. So we kept DLQI out because while, of course, it's highly relevant practically speaking, it's not relevant from an insurance payer standpoint. We wanted to keep things relevant such that we're using terminology that payers recognize, and BSA and PGA are those terms, and also failure of topical therapy.

FLAVIA FEDELES, MD, FAAD: That's wonderful to really try to address the very important area where patients are undertreated. And like you said, perhaps the payers are not really looking at the quality of life and they are looking at these other measures. What do you think are perhaps some barriers as far as why? Is it the way we are categorizing the severity that the

patients are undertreated? Or if we are talking about maybe implementing different ways of looking at the severity, what are some of the barriers of implementing this in a general dermatology clinical practice?

BRUCE STROBER, MD, PhD, FAAD: There's a few layers there. One, we don't do clinical trials with these kind of criteria for entry criteria. In other words, it's still being locked in at 10 percent BSA, 12 PASI. And that's starting to change. We're seeing companies with systemic therapeutics address this lower BSA population, doing more specific studies on palmoplantar disease and scalp disease, and therefore allowing lower BSA patients into the studies.—

--So that's helpful. Ultimately, we'd like to see regulatory agencies like the FDA truly allow studies for label indication that use these type of criteria. And then payers would be more amenable to covering expensive therapeutics for these types of patients. The second major issue is on the provider side, there are a lot of providers who are nevertheless reluctant to use systemic therapy in a patient who might only have 5 percent, who might only be localized to a part of the body that limits their BSA involvement but nevertheless it's a huge quality of life impact.—

--They are under the belief that we only use these agents in very severely affected patients. They need to walk in the door with 15 to 25 percent or more of their body covered with psoriasis, not just the scalp-only patients. So it comes down to payer regulatory issues but also just providers who, while they know, I think every provider knows this is inherently the right way to go, that of course you try topical therapies for a month or two.—

--And we have multiple ones from which to choose, and some of them are very good, and some of them are nonsteroidal, the newer ones. And they should be tried, no doubt. But we should quickly move to systemic therapies for the sake of the patient, because often systemic therapies are the only approach that effectively clear special areas of involvement and bring around a

normalization of quality of life. So I would like to say it's just as much the provider side of the equation that needs to be worked on.

FLAVIA FEDELES, MD, FAAD: So how do you think that things will evolve in the future? Or do you see that we are going to move more and more towards including the quality of life in our assessments and including some of the patients with lower BSA in our clinical trials? Do you see a movement towards that in the future?

BRUCE STROBER, MD, PhD, FAAD: I do. It's probably it's still going to be a payer issue. There's a cost prohibitive aspect to using biologic therapies or even newer small molecules that are approved for psoriasis. That said, there is a strong movement within pharma to study special areas, to do formal active-control or placebo-control, placebo-comparator clinical trials in people who have special area of involvement.—

--Greatest focus is now on scalp and palmoplantar, as I've told you. There are some studies in genital psoriasis that are very good. And we even have indication for one drug, apremilast, for mild to moderate disease, that's actually in the label. You can just treat psoriasis, it doesn't have to be moderate to severe psoriasis with apremilast. I envision more and more movement towards that type of indication. Of course, you're going to have to get the blessings of the FDA to allow that and that might not always occur.—

--But nevertheless, you could see biologic therapies which, in my opinion, are very safe. We have some very safe modern biologic therapies, in my opinion every bit as safe as apremilast that work better and therefore should be given the opportunity to be studied in these lower BSA patients who need systemic therapy. So there's the future. I think it's going to happen. It's going to be slow. I actually think we're doing it already in clinical practice, a large number of us, so the movement is afoot.—

--Now we just need the blessing of regulatory agencies that say, “Yes, you can do this, as long as the patient meets these criteria that are somewhat in line with the IPC definition, doesn’t have to be exact, but somewhat in line.”

FLAVIA FEDELES, MD, FAAD: That’s great to hear. I think, like you said, we are already doing that in clinical practice. It’s just a matter of things catching up with what we’re actually doing in clinical practice and getting this treatment to some of these patients that are mild to moderate, as opposed to moderate to severe. We’re getting close to the end here. Is there anything that you would like our listeners to, kind of like the key points for this conversation? I know we talked about how we hope things to go in the future. Are there any sort of takeaway points from this?

BRUCE STROBER, MD, PhD, FAAD: I have a major takeaway point which is everyone out there listening, move away from the mild, moderate, and severe approach to your categorization. Just think, is this a topical-appropriate patient or is this a systemic, phototherapy-appropriate patient? It’s really that kind of delineation that helps you determine what type of treatment you should bring to bear for that patient. Because it’s easy, right? We all love topicals. Topicals define us as dermatologists, we’re experts in them.—

--But in the end, you need to know when to move away from topical-only therapy for a patient who needs more. They’re not doing well on topicals. They need to be treated, as I always say to the patient, from the inside out with the systemics. And that doesn’t mean you abandon the topical, because it can be also as an add-on to patients with systemic therapy. But the key point is abandon this moderate to severe concept, go into systemic-appropriate, that’s the term you should think about, a systemic-appropriate.—

--And we all know how to define that. And think about what the patient needs. If they’re in your office, they’re making their visits, they’re fairly adherent, you know they want to get better. So give them the tools to get better. They rely on you to explain to them all that’s available for the

treatment of their psoriasis and so that it's controlled in a way that's normalizing of their quality of life.

FLAVIA FEDELES, MD, FAAD: Thank you so much for the insights. I think, as you said, it is important to know when to move on from the topicals and to really individualize treatment for every patient that's in front of you in clinic. I think we're pretty much out of time. So I just want to thank you so much for joining us today for the *Dialogues in Dermatology* podcast. I'm sure our listeners are also very happy to hear about this topic. And again, this is Dr. Fedeles interviewing Dr. Bruce Strober from Yale University School of Medicine. Thank you so much for taking the time today to talk to us.

BRUCE STROBER, MD, PhD, FAAD: It's been my pleasure, thank you.