WHO GETS WHAT:
CHALLENGES IN TREATING PSORIASIS WITH COMORBIDITIES

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DISCLOSURES

- Speaker, advisory board and/or investigator for the following companies:
- Abbott, Amgen, Braintree Laboratories, Celgene, Cipher Pharmaceuticals, Leo Pharma, Pfizer

COMORBIDITIES IN PSORIASIS PATIENTS

- Cardiovascular disease
- History of malignancy
- Psoriasis induced by anti-TNF treatment for RA or Crohn's disease
- Renal and hepatic disease
- Chronic and past infections

TREATMENT OPTIONS

- UVL (PUVA, BB, NB)
- Acitretin
- Methotrexate
- Cyclosporine
- Alefacept
- TNF inhibitors (Adalimumab, Etanercept, Infliximab)
- Ustekinumab
- Rare but sometimes useful: azathioprine, hydrea, sulfasalazine

CARDIOVASCULAR DISEASE

- 74 yo male with history of hypertension, hypercholesterolemia, MI>10 years ago, normal EF
  - Some evidence for protective effects: Methotrexate, TNF inhibitors
  - Relative contraindication: cyclosporine, acitretin, corticosteroids
  - My choice

  Methotrexate, note new recommendations of liver biopsy at 4 grams dosing (my dosing averages 1 g/year)
- 68 year old female with heart failure
  - Previously treated with etanercept → hospitalization due to CHF exacerbation
  - Oral ulcerations on MTX, nephrotoxicity with CSA
  - Failed UVL, acitretin and alefacept
  - No indication ustekinumab increases risk of MACE or CHF (single meta analysis, limited data)
  - BIG ISSUE – access for Medicare patients
  - My choice

  At the time, efalizumab and alefacept, now likely ustekinumab

HISTORY OF MALIGNANCY

- Breast cancer
  - 70 year old woman with a history of breast cancer >20 years ago
  - 53 year old woman with new onset severe psoriasis following chemotherapy (two of these!)
    - First choice: UVL, acitretin
    - Mixed evidence (very limited) : etanercept, methotrexate
    - Relative contraindication (but based on transplant literature with multiple immunosuppressants): CSA, anti-metabolites
    - Relative contraindication (based on basic science): ustekinumab
    - My choices:

    #1: Acitretin contraindicated (depression), unable to come for light, MTX → Inflximab

    #2: Acitretin+ light . When she failed that, methotrexate, now on etanercept.

MELANOMA

- 32 year old female with 0.7 mm SSM, excised 5 years ago, no aggressive features, no SNL
- 56 year old male with 0.5 mm SSM, excised 1year ago, no aggressive features, no SNL
- First choice: acitretin
- No great second choice!
- Is NB UVB safer than BB UVB?
  - Yes and no
  - NB UVB more tumorigenic but less overall exposure needed to same endpoints

Few case reports on melanoma recurrence and metastasis in pts on TNF therapy, not confirmed on meta-analyses (except one, RA)

Limited data: MTX, CSA

My choices:

1st patient:: NBUVB → MTX

2nd patient: Soriatane + NB UVB

TNF INDUCED PSORIASIS

- 28 year old woman with severe Crohn's disease, has failed all other modalities and has a history of pre-malignant polyps
- 50 year old male with colitis
- 70 year old female with RA
- All developed severe psoriasis while on treatment with adalimumab, etanercept or infliximab
- Changing to another anti TNF medication has resulted in recurrence in all my cases (12 patients so far)
- Treatments: ustekinumab (does not control inflammatory bowel disease at psoriasis dosing), cyclosporine, methotrexate, excimer laser, cessation of anti TNF therapy if possible (not always possible!)

MY CHOICES IN ANTI-TNF INDUCED PSORIASIS

- Cyclosporine initially (it is often severe) – treats both diseases
- Methotrexate or azathioprine – though my psoriasis patients show limited responses to azathioprine and mycophenolate mofetil
- When patients must remain on TNF inhibitors:
  - Add in methotrexate
  - Excimer laser
  - Prednisone

LOOK FOR NEW THINGS ON THE HORIZON