Psoriasis Case Discussions

INTERACTIVE

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Case History #1

- 58 year-old man with recent onset psoriasis (~1 year); 28% BSA affected
- No signs/symptoms PsA
- PMH and ROS entirely negative
- FHx: Positive for psoriasis (mother)
- Meds: None
- Height 5’10” Weight: 285lb BMI: 40.9  Waist 46.5 inches = Morbidly obese
- Prior Rx: Topical steroids
- What should you do?

Obesity and Psoriasis

- Obesity: a global epidemic
- Psoriasis patients are about twice as likely to be obese compared to general population
  - Dermatologica 172:298, 1989 – Sweden
  - J Invest Dermatol 125:61, 2005 – Italy
  - Arch Dermatol 141:1527, 2005 – USA (Utah)
- Mean weight in PsO trials > 90kg (200lb)
- Psoriasis lifestyle conducive to obesity (less physical activity, stress eating)
- PsO → Obesity; Question: PsO ↔ Obesity
- PsO patients with BMI > 30 are 50% more likely to have severe disease; Obesity →PsO Neumann: SID Poster 284, 2006

Metabolic Syndrome

- “Immuno-metabolic Syndrome”
- TNF-α and IL-6 produced and secreted from adipose tissue during obesity
- TNF-α central pro-inflammatory role and inducer of insulin resistance
- IL-6 (+TGF-β) stimulate production of Th-17 lymphocytes
- TNF-α and IL-6 and IL-17A,F, IL-22 and other cytokines are produced and secreted from TH17 lymphocytes in psoriasis

Therapeutic Options

- Topical agents
- PUVA
- UVB, NB-UVB
- Acitretin
- Methotrexate
- Cyclosporine
- Hydroxyurea
- 6-Thioguanine
- Adalimumab
- Alefacept
- Etanercept
- Infliximab
- Ustekinumab
Therapeutic Options

- Topical agents
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Adalimumab
Alefacept
Etanercept
Infliximab
Ustekinumab
TNF-alfa blockers have MS benefit

Case History #2

- 34 year-old man
- 10 year history of scaly, itchy elbows
- Eucerin® lotion kept the problem in reasonable control
- Seeks attention because it might be getting "a little worse"
- PMH, FHx, ROS negative
- SHx: Non-smoker; recreational EtOH
- BMI = 25 (normal)
- BP = 124/78

Pre-Treatment Case #2

How would you treat him?

Therapeutic Options

- Topical agents
- PUVA
- UVB, NB-UVB
- Acitretin
- Methotrexate
- Cyclosporine
- Hydroxyurea
- 6-Thioguanine

Adalimumab
Alefacept
Etanercept
Infliximab
Ustekinumab

Case #2

4 weeks Taclonex BID

WHAT WOULD YOU DO NOW?
Case History #3

- 68 year old African-American male
- Psoriasis since teenage years
- Current: BSA 85% No evidence of PsA
- PMHx, ROS: Hypertension, Prostate CA
- Meds: Amlodipine besylate 10 mg/day
- Height: 5’7” Weight 267lb BMI: 42
- In the past, given MTX: 3-5x elevation normal LFTs (discontinued); Twice!
- Depressed, even suicidal
- Labs: Normal; PPD and chest x-ray neg

Pre-Treatment Case #3

How would you treat him?

Therapeutic Options

- Topical agents
- PUVA
- UVB, NB-UVB
- Acitretin
- Methotrexate
- Cyclosporine
- Hydroxyurea
- 6-Thioguanine

- Adalimumab
- Alefacept
- Etanercept
- Infliximab
- Ustekinumab

Acitretin + nb-UVB

48 weeks of therapy
Case History #4

• 19 year-old female with PsO since age 16;
  Currently 40% BSA affected
• No evidence of PsA
• PMHx, ROS: negative
• FHx: Mother with mild and Father with severe
  psoriasis *(She was doomed!)*
• Meds: None
• Height: 5’8”  Weight: 240lb  BMI: 41
  (morbidly obese) and BP = 140/94
• Labs: Elevated triglycerides and LDL; FBS is
  OK; PPD and CXR negative

Pre-Treatment Case #4

Social History Important

• Can’t come for phototherapy due to school
  schedule
• Similarly, 3 hour infusions would be
  impractical for her lifestyle
• Sexually active with “intermittent” condom
  use as only contraceptive

How would you treat her?

Therapeutic Options

• Topical agents
• PUVA
• UVB, NB-UVB
• Acitretin
• Methotrexate
• Cyclosporine
• Hydroxyurea
• 6-Thioguanine
• Adalimumab
• Alefacept
• Etanercept
• Infliximab
• Ustekinumab
Pregnancy

- Alefacept B
- Cyclosporine C
- Etanercept B
- Adalimumab B
- Methotrexate X
- PUVA D
- Ustekinumab B
- Infliximab B
- Acitretin X

Post-Treatment

- Neomycin 5%
- Acyclovir 5%
- 2% Hydrocortisone

Case History #5

- 40 year-old Hispanic male; recent onset of psoriasis (60% BSA)
- No evidence of psoriatic arthritis
- PMHx and FHx unremarkable
- ROS: Abdominal cramping with increased frequency of watery, blood-tinged, stools
  Meds: Imodium
- BMI 28 (slightly overweight); BP = 130/80
- Labs: Anemia (Hb/Hct = 11.5/32%); LFTs, U/A normal; PPD and CXR negative

Pre-Treatment Case #5

Case History #5

- 40 year-old Hispanic male; recent onset of psoriasis (60% BSA)
- No evidence of psoriatic arthritis
- PMHx and FHx unremarkable
- ROS: Abdominal cramping with increased frequency of watery, blood-tinged, stools
  Meds: Imodium
- BMI 28 (slightly overweight); BP = 130/80
- Labs: Anemia (Hb/Hct = 11.5/32%); LFTs, U/A normal; PPD and CXR negative
- What would you do first?
Case History #5

- Pan-gastrointestinal endoscopy w/biopsies: Crohn's disease involving distal small bowel and proximal (ascending and transverse) colon

Psoriasis + Crohn's Disease

- Meta-analysis of case control studies PsO in Crohn’s 8.9% PsO in controls 1.4% Hum Molc Genet 16:1349, 1997
- Review of 8072 patients: given either IBD or PsO, what is risk of developing the other? 1.5-1.7x baseline Gastroenterol 129:827, 2005

Therapeutic Options

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<thead>
<tr>
<th>Psoriasis</th>
<th>Crohn's Dis</th>
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<tbody>
<tr>
<td>Infliximab</td>
<td>Effective, FDA+</td>
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Therapeutic Options

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| Adalimumab |
| Alefacept |
| Etanercept |
| Infliximab |
| Ustekinumab |

Case #5

Infliximab Infusions 0, 2 and 6 Weeks
Case History #6

- 36 year-old female with recent onset generalized skin eruption; 18% BSA
- ROS: negative for joint symptoms
- PMHx and SHx: remarkable for extensive prior IVDU; hysterectomy
- Meds: Fexofenadine 60mg BID (allergic rhinitis)
- Height: 5’4” Weight: 143 BMI = 25
- Laboratory evaluation: CBC, LFT: normal; PPD and CXR negative
  HBV and HCV serologies negative

WHAT ELSE SHOULD BE CHECKED?

HIV Positive….Now what?

- ELISA and Western Blot positive
- CD4 count 425 (nl = 500-1500)
- HIV viral load 52,500 copies/mm³
- Referral to HIV ID-specialist
  - No Rx unless CD4 < 350
  - No Rx unless VL > 100,000/mm³
  - No Rx unless symptomatic
- OK to treat psoriasis; ID to monitor viral disease closely
**HIV-Associated Psoriasis**

**Treatment Algorithm**

(Anitretroiral Treatment)

- Adbretin + calcipotriene or tazarotene
- UVB + calcipotriene or tazarotene or UVB±
  - aclretin or Goeckerman or hydroxyurea
- PUVA + calcipotriene or PUVA + tazarotene

**Anti-TNF Therapy in HIV**

- Eight patient study of anti-TNF therapy in the management of rheumatic dis
- RA, PsA (3), Ankylosing spondylitis
- Patients on/off HAART and….. CD4 count > 200
  - HIV load < 60,000/mm³
- Etanercept: 8
  - Infliximab: 4
  - Adalimumab: 3
- All achieved response; One patient (no HAART) had rise in HIV RNA

**Case #6**

Etanercept 50mg BIW x 12 weeks; Then 50mg weekly

About one year Rx

HIV status remains unchanged; CD4 & viral load same

**Case History #7**

- 28 year-old female
- New onset psoriasis; initially mild now 45-50% BSA
- 104 lb; 5’2” = BMI 19 (normal)
- No evidence PsA
- Father/Brother have PsO
- PMH, SHx, ROS: negative
- BP = 115/67 and All labs OK
- PPD negative; Chest x-ray ok
- Wedding in in 3 weeks; she wants to look good for this event
- Consistent user OCP + spermicide
Case History #7

- 28 year-old female
- New onset psoriasis; initially mild now 45-50% BSA
- 104 lb; 5'2" = BMI 19 (normal)
- No evidence PsA
- Father/Brother have PsO
- PMH, SHx, ROS: negative
- BP = 115/67 and All labs OK
- PPD negative; Chest x-ray ok
- Wedding in in 4 weeks; she wants to look good for this event
- Consistent user OCP + spermicide

How would you treat her?

Therapeutic Options

- Topical agents
- PUVA
- UVB, NB-UVB
- Acitretin
- Methotrexate
- Cyclosporine
- Hydroxyurea
- 6-Thioguanine

- Adalimumab
- Alefacept
- Etanercept
- Infliximab
- Ustekinumab

Therapeutic Options FAST

- Topical agents
- PUVA
- UVB, NB-UVB
- Acitretin
- Methotrexate
- Cyclosporine
- Hydroxyurea
- 6-Thioguanine

- Adalimumab +
- Alefacept
- Etanercept
- Infliximab
- Ustekinumab
Case #7

- Repeated BUN/Cr = stable
- Repeated BP = stable
- Moral to the story: there’s nothing quicker than Cyc-A
- But.....we are limited to 1 year use and then are advised to transition to another agent to avoid renal impairment
- Dose is also limited to 4mg/kg/d

Psoriasis Rx

- INDIVIDUALIZE
- One size does not fit all!
- Take into account other medical problems, social factors, patient’s needs
- Be prepared to change Rx if your first try doesn’t work