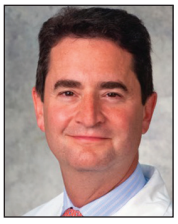
Bruce E. Strober, MD, PhD

The past, present and future of psoriasis treatment and management.



Bruce E. Strober, MD, PhD, is a professor of dermatology, the Chair and Director of Clinical Trials of the Department of Dermatology at UConn Health in Farmington, CT. He has devoted much of his already illustrious career toward finding better treatments for psoriasis and lessening the disease's impact on quality-of-life. Dr. Strober spoke with *Practical Dermatology*® about what's new and exciting in this field as well as what is still missing.

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What is the most exciting happening in psoriasis today?

Dr. Strober: We are about to receive a host of approvals of drugs that block interleukin-23 (IL-23) alone, and they show extremely high effectiveness in clearing psoriasis. These agents—all of which are injectable biologics—will likely grow to represent the best medications we have. These may be an advancement over Stelara (ustekinumab), which blocks both IL-12 and 23. IL-23 alone is a more precise target, and likely a linchpin molecule in psoriasis and maybe psoriatic arthritis as well.

Where does that leave anti-TNF drugs?

Dr. Strober: TNF blockers have shown an erosion of use, primarily because of the addition of IL-17 blockers and Stelara, which are as or more effective in treating psoriasis. The TNF blockers have seen the pinnacle of use in my opinion. They are still heavily prescribed because they are older, trusted, and more frequently covered by insurance.

What about the biosimilars?

Dr. Strober: We have every reason to believe that these are high-quality medications that do what their manufacturers report that they do. The totality of evidence in basic lab research and in healthy humans and individuals with diseases suggest that there are no clinically meaningful differences between biosimilars and their comparators. Questions remain regarding when they will be available due to patent disputes, contracts with payors, and there is debate over whether they will confer a significant cost savings to patients. For these reasons, the jury still is out on the future use of biosimilars to treat psoriasis in the US.

Is there a Holy Grail in psoriasis treatment?

Dr. Strober: Yes, the Holy Grail would be an oral medication that has the same efficacy as biologics. Pharma is still very active in investing in new psoriasis drugs, and over the next five to seven drugs, we likely will see better drugs of an oral nature.

What do you need to do your job better?

Dr. Strober: Biologics lose response in a lot of patients over time, and we need guidance on how to keep them effective for the long haul so that we can have confidence that the response that our patients are getting today and love will still occur in a year. One solution, switching, is easy medically but hard in other ways. Switching to another biologic costs everyone time and money. While it makes complete sense, it requires a lot of resources. We can also add on a second drug or topicals to increase efficacy, but we need clear guidance from well-designed studies (often pharma-funded) on how to proceed in an evidence-based manner.

Are dermatologists taking ownership of comorbidities in psoriasis patients?

Dr. Strober: The thought leaders are all on the same page. The data linking psoriasis to a host of other medical conditions is very convincing. That said, many medical-only dermatologists don't have the bandwidth to be internists, too. For this to happen, we will need incentives along with good epidemiologic data that firmly link specific degrees of skin clearance to a true reduction in morbidity and mortality. Until then, all stakeholders—patients, physicians, and payers—will continue to inaccurately see moderate to severe psoriasis as solely a quality of life disease, not also a marker for internal comorbidities that reduce life expectancy. ■