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Journal Club: Treating Itch and Lessons from the IL-4 and IL-13 Blockade

Dr. Neal Bhatia:
Hi, I'm Dr. Neal Bhatia. I'm Chief Medical Editor at Practical Dermatology. And this is another episode of Atopic Dermatitis Journal Club. I'm here with one of the architects of atopic dermatitis, Dr. Matt Zirwas from Ohio University, Associate Professor, and thanks, Matt for being with me.

Dr. Matt Zirwas:
Thrilled to be here and love that we've got so many great journal articles nowadays in the space of atopic dermatitis.

Dr. Neal Bhatia:
Itchy patient without a lot of rash, what's your algorithm for where you move forward from there, not just in testing but in the therapeutic approach?

Dr. Matt Zirwas:
Yeah. So I always think about patients. So there's the itchy patient who has little to no rash. And first, I will say, if mirtazapine doesn't work, the most effective drug for itch is butorphanol nasal spray. The challenge using that drug, it is a controlled substance. It's an opioid.

Now the other type of itch that I think about is the spongiotic dermatitis patient. And really, the way I approach spongiotic dermatitis now, first visit, I'm going through what products are you using, what larger products are you using. So I want to assume that it's contact dermatitis. But I don't patch test initially. I have them avoid the obvious allergens. Now if it's, "I changed shampoo, and my face broke out," then I might patch test them to see what in the shampoo.

But with just nonspecific dermatitis, I have them avoid things first. Have them come back in about 8 weeks. If they're better, OK, it was contact derm. Now we decide, do we want to patch test you to figure out what it was contact derm to, or do you just want to keep using hypoallergenic products?

Dr. Neal Bhatia:
Makes perfect sense, yeah.

Dr. Matt Zirwas:
If they're not better, then I treat them for atopic dermatitis using what I would call an atopic-specific drug. And what I mean there ... So I did an article recently called “Lessons Learned from IL-4, IL-13 Blockade.” And it's, for me, kind of the things that I took away from when dupi came on the scene, and having all of these patients with nonspecific dermatitis, that now we know, "Oh, my God, they had atopic derm the whole time, not contact derm." And so now, when people don't get better pretty quickly, when I address contact derm, and it is appropriate to do so, I call it atopic derm.

Dr. Neal Bhatia:
Atopic, exactly. Yeah.

Dr. Matt Zirwas:
And you treat them with dupi. If they get better, I've confirmed that it is atopic derm. I get about a 3-month trial. Usually, I use samples to do that because I don't want to do the prior auth until I know the drug is going to work.

Dr. Neal Bhatia:

Right.

Dr. Matt Zirwas:
If they get better, great, now I know it's atopic derm. If they didn't get better, then it's going back to the drawing board, saying, now this is somebody who might need comprehensive patch testing.

Dr. Neal Bhatia:
Yup.

Dr. Matt Zirwas:
Or maybe if it's somebody that, for whatever reason I can't patch test them, I'm going to go to a JAK inhibitor.

Dr. Neal Bhatia:
I was just going to say, because one of the pearls you gave here, I've heard you say in Maui, wherever we were using steroids, use a JAK inhibitor instead. It's a better outcome, works faster, and without all the drama.

Dr. Matt Zirwas:
And I've got patients who had... I think they had elements of primarily contact derm with some atopic, but for example, a woman who owned a nail salon, horribly allergic to acrylates on patch testing. But, literally, her family is going to have their home foreclosed on or repossessed if she stops doing nails. She's been doing this for 20 years. She's built this business. She can't stop doing it. I put her on a JAK inhibitor. She was able to keep working, keep her nail salon. So that's the big thing with JAKs.

The other things that have been really interesting lately, so there was one article that talked a little about dupilumab and CTCL. The takeaway from the article was dupilumab might increase your risk of CTCL. Totally wrong.

Dr. Neal Bhatia:
That's false.

Dr. Matt Zirwas:
Totally wrong.

Dr. Neal Bhatia:
If anything, what's happening is not being given a diagnosis.

Dr. Matt Zirwas:
Yes.

Dr. Neal Bhatia:
That's what increases your risk.

Dr. Matt Zirwas:
Yes. But the thing with that study was they just looked at people who went on dupi versus people who didn't. Well, the people who didn't go on dupi had milder atopic dermatitis. Worse atopic derm is more likely to be undiagnosed CTCL. And what I think happens is, when you get rid of the nonspecific reactive inflammatory lymphocytes, it gets easier for the dermpath to identify the malignant lymphocytes. And so I think dupi is actually a diagnostic aid in CTCL.

Dr. Neal Bhatia:
Yeah, that makes perfect sense. And we chase spongiotic dermatitis all the time to try to get to MF. And yet, finally, at the time you get it, maybe the therapeutic challenge is the answer.

Dr. Matt Zirwas:
Yeah. Really is.

Dr. Neal Bhatia:
So one last pearl about Bruton's tyrosine kinase. As you mentioned, we have remibrutinib. We mentioned about a couple others. Where are they sitting? We realize remibrutinib was studied for atopic. Where's the status of BTK?

Dr. Matt Zirwas:
BTK inhibitors … So far, they don't seem to be making a whole lot of progress at atopic derm. But the Phase III studies have been out for remibrutinib, and it is an incredibly effective drug. What's most impressive about it is how fast it is for chronic urticaria.

So CSU, these people get dramatic itch relief in the first week. And for anybody who is maybe an internist, who's also going on to treat

derm, or somebody who's done stuff outside of derm, BTK inhibitors have been around for a while in the onc world, and they're considered dangerous, risky drugs.

This is a totally different BTK inhibitor. It doesn't have the adverse events associated with the older drugs. The only thing seen in any of the trials was some mild petechiae. No bleeding events. Nothing. It's going to be a really nice drug. It's really going to change CSU.

Dr. Neal Bhatia:
Yeah. And we'd have to talk to our allergy colleagues to remind them that the petechia is not a big deal.

Dr. Matt Zirwas:
Yeah.

Dr. Neal Bhatia:
And it's very rare. But even more so, I mean, the flexibility of BTK is whether it be hidradenitis, be a bullous pemphigoid or what have you, the opportunity is never-ending.

Dr. Matt Zirwas:
Yeah.

Dr. Neal Bhatia:
It's just we have to get out of our own way to make sure we're not afraid to do the right thing.

Dr. Matt Zirwas:
Yeah. Well, it's like the JAK inhibitors, right? So the latest data in the rheumatology world, in their most recent meta-analyses, what they specifically say is, even Xeljanz, which is the one we always say, "Well, Xeljanz, that increases the risk." They say Xeljanz doesn't increase the risk. Xeljanz reduces the risk of MACE and VTE. It just doesn't reduce it as much as a TNF inhibitor.

Dr. Neal Bhatia:
Right.

Dr. Matt Zirwas:
And so now we're still stuck with the boxed warning. So we still have to talk to patients about it, and it still makes it challenging to use. But the data is, there is no risk of MACE or VTE associated with JAK inhibitors.

Dr. Neal Bhatia:
Boxed warning means just pay a little more attention. No one's going to take your prescription pad away. There's no Storm Troopers coming in to end your office. Just do the right thing for them.

Dr. Matt Zirwas:
Yeah.