Transcript Details
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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Practical Dermatology Roundtable: Generalized Pustular Psoriasis, Ch. 3

Dr. Neal Bhatia:
Laura, what would you say, not just getting into therapeutics, but what do patients need to know about first sign of flare? How critical it is to not only get treated, but to go get evaluated? Because they may not know what to recognize.

Dr. Laura Ferris:
Right, right. So I think patients, once they've had a few flares, interestingly, in my experience, they start to know this prodrome. They know that they have skin pain. They know that they get aches or chills or even fever sometimes. And then oftentimes that is a harbinger of a really bad flare that's about to start. But I think making sure that they do understand that you may not see anything on your skin, but you might start to feel the pain.

Again, I think the key thing is who do you call when that happens? Call your dermatologist. And then what do you need to do? You need to really get tied into care quickly because this is something that evolves so rapidly, unlike plaque-type psoriasis. This is something that can evolve over 24 hours and patients can become incredibly sick. So I think emphasizing not delaying care is important.

Dr. Neal Bhatia:
And Jason, you're exposed to that same environment. What would you add to that?

Dr. Jason Hawkes:
Yeah, and Laura brings up great points. And one other aspect, not only does the skin evolve rapidly and can evolve rapidly, but these patients also have secondary complications. So we see an increased mortality. This is rare. So there's been a number of studies showing maybe anywhere between 15 and 40%. So we know with erythrodermic psoriasis, it's approximately about 40%. So these are patients who get... They can get very sick. They can get secondary skin infections.

They can become septic. We start to see secondary organ failure, so high output cardiac failure. We see the skin breakdown. So all the protective functions we start to lose, thermoregulation, obviously the barrier effect. So these are patients that not only rapidly evolve, but they can really crash pretty quickly too from some of these other secondary complications. So to Laura's point, we need to not only recognize them quickly, but we need to initiate therapy.

And then I think the other aspect that is coming out, I think it's important to separate it from the flares versus those patients that actually have GPP. Because what's difficult, you could see a patient, this happened to me when we do the inpatient consults, that you'd see a patient for the first time, no prior history, has a single event. Those are difficult because you are thinking about HS and did they get any antibiotics in the hospital, and you're thinking about other aspects.

Could this really just be plaque psoriasis that flared from oral prednisone taper, which we used to see those in the ER quite a bit. But that's different from these patients who've had repeated episodes. I think the second, the third, the fourth episode starts to make this much more clear. Some plaque psoriasis patients may only have one flare, but these patients live with this recurrent episodic history, and that's what we need to recognize.

So intervening at the acute flares is one thing, but the recognition of these patients having disease that's ongoing even in between flares opens up that idea of acute treatment versus the maintenance of treatment to try to keep them under control and that immune response suppressed so that we're not letting them go back in these cycles because patients will tell you, this is traumatizing to have this widespread flare.

And then have to go to the hospital, and they're in the hospital for a few days or a week or two weeks. This is the kind of thing we want to eliminate for our patients by recognizing it early, treating it when it happens, but trying to look at preventative measures to keep their disease under control so they don't keep recurring and having these repeated flares.

Dr. Neal Bhatia:
I know we've each described it almost like a prison, right? I mean, they're in prison of their disease, and they really have to watch when's the next time they're going to be stuck. And they live in a fear of constant flare as well as their families, as well as their spouses. They're worried about could they travel and go away from hospitals for a longer time, or is there something that's going to set the next flare off at the worst possible time.

The quality of life between poor sleep, poor job functioning, and everything else is really... It cannot be underestimated for one. But for two, I think we talk about, again, the role of the dermatologist and the need to get the patients in to see the dermatologist. I mean, these are not patients that get seen by the emergency room and you say, "Go make your appointment."

I mean, we tell them, you see this, you call and get them over to us as fast as you can, or in an institution fortunately can get them evaluated very quickly. But I think too we really have to make a good case for the patients to look at this as something they cannot take lightly and it has to be intercepted very quickly.