Transcript Details
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Practical Dermatology Roundtable: Generalized Pustular Psoriasis, Ch. 5

Dr. Neal Bhatia:
Given the understanding of those pathways. I'll pose this to both of you. How do we get our colleagues to get out of the mindset that they can use conventional psoriasis treatments and think they'll get by? I mean, these are patients, and we'll talk about this in a second, about getting them introduced to IV therapy very quickly, putting out the fire with the dosage strategy, that's again, one week apart, and then trying to get them on some maintenance with the sub-Q dosage that's available. But the overall theme is that a lot of our colleagues will say, "Oh, these patients will do fine with a 23 blocker, or I can give them a 17 blocker and they'll do just fine." I mean, Laura, how would you address some of these misconceptions? Because clearly they're going down the wrong path.

Dr. Laura Ferris:
Yeah, I think it's getting at these are two different diseases and we know what drives GPP, but I also think it's emphasizing that this is a chronic disease and it needs a chronic treatment, and that we have an option that sort of treats both flares and the chronic aspects of the disease. So, I think, maybe in the past it might've been challenging because it was like, "I just have to get this patient through the flare. I just need something. I've got to get a patient through the flare and then I'll figure out maintenance."

But now we really have, one, we can target, with the same drug delivered differently, the flare. You've got a way to get the patient through the flare, but it's also equally important, one, that we're preventing that next flare, and two, that these patients don't go from flare to completely cleared. And so they really do need something to help with that lingering skin pain, some erythema, an occasional pustule, a little bit of scaling. So, I think it's getting at, this is its own disease, it's a chronic disease, you want the drug that targets this disease and that, we know, has data to back up, treats it in both the flare state, but also in that chronic state as well.

Dr. Neal Bhatia:
And Jason, how would you handle some of the same situations?

Dr. Jason Hawkes:
Yeah, it's difficult when we talk about the patients that have both diseases because I don't think it's as clear cut. If a patient came in and had generalized pustular psoriasis, and they'd had a history, and they never had plaques, then I think you lose your basis for saying, "Oh, I'm going to use a IL-23 or an IL-17," for example. It doesn't make a lot of sense for those patients. But I think what's been confusing to our counterparts has been those patients that have clear plaque psoriasis first, who then also start to develop features of GPP. We know that this is the minority of patients. Most patients with GPP don't have plaques, psoriasis. But I think when they do, there's been this thought, "Well, one drug to treat both," because I think it's difficult if you start to say, "Well, what if something works really well for plaque psoriasis, but it doesn't work for GPP," which we would expect. But you still have the problem that if we get the GPP under control, then we start, we still have to manage the plaque psoriasis.

And unfortunately, I don't think there have been good treatment guidelines there, but the recognition that these patients, we've already seen the studies, they don't respond really well, there wouldn't have been a need for developing spesolimab if these patients had gotten better just from, what do we have? 13 biologics down in psoriasis? So, there wouldn't have been a need. And I think the patients, if you look at the reports where they're really surveying these patients, they're getting patient reported metrics and outcomes, these patients are showing a high degree of persistent symptoms or recurrent symptoms. Even when they don't look severe in these flares, these patients are still describing the skin pain, the desquamation, the burning, the stinging. So, it's really educating, again, going back to what Laura said, to recognize that these patients are not a one-off event. They're not just GPP when they show up in the hospital, but they're GPP all the time.

And that disease can be at a simmer or it can be boiling, but we still need to manage that. So, I think if we watch those patients over time on the anti-plaque psoriasis therapies, and I think those clinicians would follow those patients closely, they would see that they were inadequately controlled. And the last point I'll make is we want to differentiate it from the localized disease, because I'll talk to some of my colleagues who are like, "Well, yeah, I have these patients that have pustules on the palms and the soles, and should I treat them?" It's like, well, that's a different disease, right?

So, palmoplantar pustulosis is by definition a localized form. Same with ACH, involving the fingers and the nail plates. That's not what we're talking about in GPP. So, we're really talking about widespread, and we're not talking about plaques that occasionally get pustules. I think the criteria for diagnosis is they need to have these monomorphic pustules outside of their regular plaques if they have concomitant and plaque psoriasis. So, we're really trying to differentiate them by classification, but as well as strategy. So, it's important to know what GPP is, but also what it's not.