Transcript Details
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Practical Dermatology Roundtable: Generalized Pustular Psoriasis, Ch. 6

Dr. Neal Bhatia:
So Laura, in the time we have left, let's say the next hour, your residents call you and they say, "Oh, we've got a GPP patient in the emergency room." How do you walk us through from triage to IV dose, getting them on Sub-Q maintenance, your talking points in your strategy? Just give us a synopsis.

Dr. Laura Ferris:
Yeah, I mean, one, the first thing I'm going to do is go over and see that patient and make sure that this is truly GPP, right? I think bring our expertise once we say, yes, this is GPP and this person's maybe had flares before. You work with your hospital to say, we have an FDA approved drug, and we want to dose this patient with Spevigo. It's going to involve, it's not put it into Epic and walk away and it's going to happen. It's going to involve discussion and conversation with the pharmacy, but getting patients, being able to dose them in the hospital, and then in many cases this is going to mean that that patient can go home. They're not going to be back. They're not going to still be there in a week because we know most patients will actually clear their pustules.

So then making sure that we coordinate the care. It's that one, that patient has to come back to be evaluated a week later to know, do they need another dose? Most will not, but some will. So having a relationship with an infusion center where we can send the patient to get that second dose if they need it, and then from there working, knowing that after that in a month, I'm going to want to start them on Sub-Q formulation of Spevigo. So we're starting that process soon so that they can transition and we can prevent that next flare and really taking control of your skin.

Dr. Neal Bhatia:
It buys you a little time too to get the biopsies done, to get the TB test done, any other lab monitoring done. And I mentioned before, I think that's something that I would probably make sure they have a copy of their biopsy report because that's something, if they get seen somewhere else, they just say, "Look, I mean this is what I have." Because they're not going to have a bracelet like I said, or anything else and to the unexposed eye, that's going to be real important. But is there a timeline, and Jason, you can chime in on this as well. Is there a timeline that you have to say, "Well, maybe this patient deserves a night in the hospital to tune them up." Or maybe like you said, if they're walking, talking and they respond to the dose, we can let them go. I guess it's a multidisciplinary approach to it also, but it's something the dermatologist has to drive.

Dr. Jason Hawkes:
Yeah. I mean, when these patients would come into the hospital, I think what Laura said, we want to see them right away. These are not the ones that … residents should not be curbsiding these or looking at photos coming through the EHR. These are patients that need to be seen in person. They certainly need to be seen with the attending or an experienced dermatologist. I think one, we want to confirm the diagnosis, really get that history. But also I think from my standpoint, it's evaluating that they're not hemodynamically unstable. Do these people have .. are their creatinine elevated? Do they have a high white count? Are there any signs of infection? So these are patients we also may not get therapy in right away. We're going to push for that, but we need to also be managing these patients. So getting to your point from whether they go in the hospital, I think it depends on a lot of aspects.

We want to make sure these patients don't have an infection. We want to make sure that the other secondary organs are okay, that they're hydrated. So that might trigger that triage on whether they would stay in the hospital. Certainly in the case of acute flares, probably getting treatments, particularly medical treatments is probably easier in the hospital than if they were to come out, depending on the infrastructure that's available. But it also depends on follow-up, right?

If we can get somebody and see that they're under control, and we can see them the next day in the clinic for example, then that might be appropriate for the right patient. But I think we need to triage these patients just as we would anytime we would do consults and internal medicine where our internships, where we'd see those patients and you're always deciding, is this someone that can go home or someone that needs to stay overnight? We need to be thinking about that with these patients as well, and make sure that we have a clear plan, as Laura mentioned.

Dr. Neal Bhatia:
And that ties into the safety of the therapy too. We know that it's targeted against the receptor, and it's not a anti-cellular therapy or it's not cytotoxic by any means. It's not going to suppress the activity of dendritic cells. And it really shows the importance of a targeted treatment for this kind of condition, where the rest of the immune system can still function. And you'll provide some … rest of the support that those immune surveillance cells need. But from a safety standpoint, talking to the patients, we tell them, "This is just looking at stopping the process of your disease state and not affecting the rest of your immune system." So that's going to bring some alleviation to the patients as well as the families as well. So just to wrap up the two of you, any last comments about GPP and how to keep the dermatologist in the loop?

Dr. Laura Ferris:
Yeah. I think it's a great time in dermatology to really marry science with drug development. And it's great to have options for these patients, and it's a reminder that we do treat very serious skin disease. We have to treat the whole patient, and it's important that we continue to own this disease and make sure that we provide the best care that we can for these patients.

Dr. Neal Bhatia:
Yeah. Jason, I'll leave it with you.

Dr. Jason Hawkes:
Yeah, no, I totally agree. We've talked about it for a long time, but personalized medicine, this is it, right? The one size fits all therapeutic approach is bad for patients. It's bad for science. But here it's the opposite. We've teased out some of these key pathways, driving different variants, look different, they act different, they respond differently. So it's really about recognizing these patients, and I think to our colleagues, if you're not comfortable treating these patients, just find somebody who is, right?

Develop those relationships. There's very few therapies we talk about in dermatology that are truly life-saving. And I think this is one of those that if you can just recognize it and get them to therapy, even if you're not going to manage it, this can save a patient's life. And I think developing those relationships, if you're not comfortable, but knowing that there's a very effective target therapy, this is a slam dunk to give these patients back their life. And they deserve to be treated, and we therefore need to be educated. Even though we might not see these patients very often, we need to be ready to pull that trigger when we see them.

Dr. Neal Bhatia:
Yeah. Actually, you said it better. These are patients we don't want to see very often. We want to hope that they're doing well, that they're not having to come back too often. So with the treatments we have now with what's been study-proven with the Sub-Q maintenance as well as the IV that puts out the fire, hopefully we can keep it that way. Well, Dr. Laura Farris, Dr. Jason Hawkes. Thank you guys very much. This was really very informative, but also it's a good reminder of keeping some ownership of these severe diseases in derm, and making sure we're the ones driving the ship. So with that, this is Dr. Neal Bhatia, and this was another episode of the *Practical Dermatology* Roundtable, and we'll see you next time.