Psoriasis Trends and Practice Gaps

Alice B. Gottlieb, MD, PhD*, Jacqueline E. Greb, BA, Ari M. Goldminz, MD

KEYWORDS

• Psoriasis • Psoriatic arthritis • Practice gaps • Treatment trends • Biologics • Resident education

KEY POINTS

- Psoriatic patients remain undertreated despite an increasing number of available systemic therapies, including biologics, with growing long-term safety data.
- Despite the established increased risk of cardiovascular disease risk factors and adverse outcomes among patients with psoriasis, routine screening and counseling is not a widespread practice.
- Although the importance of early psoriatic arthritis diagnosis is known, rates of detection remain less than the predicted incidence rates.
- Economic disincentives lead to limited adherence to standard of care in the treatment of psoriasis and psoriatic arthritis.
- Collaborative efforts can address the key deficiencies in psoriasis treatment, screening, and education.

INTRODUCTION

Psoriasis is a chronic, immune-mediated disorder that affects 2% to 3% of the global population. The most prevalent psoriatic disease phenotype is plaque-type, although other, less common subtypes include inverse, guttate, pustular, and erythrodermic. In addition to its cutaneous manifestations, psoriasis negatively impacts quality of life; is associated with rheumatologic, ophthalmologic, cardiac, and psychiatric comorbidities, and leads to economic burdens both for individual patients and society. The present article addresses several high-impact and clinically important practice gaps affecting the care of psoriatic patients. For each topic the authors review current practices, the gaps and barriers that prevent the delivery of optimal care, and recommendations to improve patient outcomes.

TREATMENT

Standards of Care

Selection of an appropriate treatment regimen is tailored to individual patients based on disease severity, measured by body surface area, disease location, presence of psoriatic arthritis, impact on quality of life, and previous responses or contraindications to psoriatic therapies. Specific psoriasis treatment algorithms have been developed by leaders in the field and are previously published.[1] Topical therapies are selected as a monotherapy

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Department of Dermatology, Tufts Medical Center, 800 Washington Street, Box 114, Boston, MA 02111, USA
* Corresponding author.
E-mail address: Agottlieb@tuftsmedicalcenter.org

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for localized disease but are not appropriate for more widespread cutaneous lesions, severe involvement of the palmoplantar surfaces, genitalia, scalp, or nails, and psoriatic arthritis. In these cases systemic treatments are required, such as cyclosporine, oral retinoids (in the absence of psoriatic arthritis), methotrexate, apremilast or biologic agents. Currently biologic agents are the gold standard for the systemic treatment of psoriasis and psoriatic arthritis with more rapid and complete control of disease signs and symptoms and a more favorable side effect profile.[2]

Current Practice

Despite the increasing number of highly efficacious and safe treatments for psoriasis, surveys demonstrate overall low treatment satisfaction and high noncompliance among psoriatic patients.[3,4] In a survey of 5604 patients with psoriasis or psoriatic arthritis, approximately 50% are reportedly dissatisfied with their current treatment.[5] Among patients with mild, moderate, and severe disease, one-half, one-third, and one-fifth remain untreated, respectively. Additionally, topical treatments alone were prescribed to 30% of patients with moderate disease and 21% of patients with severe disease.

Three hundred ninety-one dermatologists in North America and Europe surveyed in the Multinational Assessment of Psoriasis and Psoriatic Arthritis program demonstrated similar results.[6] Among patients with moderate to severe disease, topical monotherapy was prescribed to 54.0%, systemic therapy to 39.1%, and biologic therapy to 19.6%. Despite the US Food and Drug Administration approval of biologic agents for the treatment of psoriasis since 2003, a retrospective review of the US National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey demonstrated no increase in the use of systemic therapy for moderate to severe psoriasis between 1993 and 2010.[7] Similarly among private practitioners in Germany, systemic treatments for psoriasis were prescribed to 31% of patients with moderate to severe psoriasis and only 58% of patients with psoriatic arthritis.[8]

Gaps

Despite a growing number of systemic agents and increasing long-term safety data for these therapies, a large number of psoriatic patients remain undertreated. Additional considerations, such as the association between psoriasis and cardiovascular (CV) disease and the cardioprotective effects of several systemic therapies, add further importance to appropriate treatment selection. Provider- and patient-centered, clinically relevant, and adaptable outcome measures in psoriasis incorporating key domains comorbidities including CV risk and psoriatic arthritis are lacking.[9] These measures would provide more defined end points to assess treatment efficacy in clinical practice.

Barriers

In a survey conducted by dermatologists from both academic and private practice settings in Germany, self-reported confidence in prescribing systemic psoriasis treatments is low, with 76% of those polled noting that their own confidence in prescribing systemic agents limited their use.[10] Among physicians asked about the prescription of anti–tumor necrosis factor (TNF) agents, none were very confident, 9% were confident, 27% were relatively confident, 48% were uncertain, and 16% were very uncertain. Fewer than half of dermatologists reported that they were aware of the most recent guidelines 6 months after publication. Additional concerns over long-term safety, tolerability, and efficacy of systemic agents also influence prescription practices.[6]

Moreover, prescribing is influenced by the considerable time and overhead costs required for the prescription and management of systemic therapies. An example is the inefficient system of verbal and written interactions with insurance companies and pharmacies in order to obtain prior authorizations.[8] Further economic disincentives, including physician tiering, also negatively impact treatment patterns in psoriasis and other chronic conditions.[11] The cost and quality measures used to assign provider tiers fail to integrate important variables, such as disease severity, case complexity, and clearance of disease. Therefore, physicians receiving difficult referrals and treating refractory, chronic diseases that require expensive interventions are assigned worse tiers because of the higher costs of their practice. One consequence of receiving a worse tier is that patients require higher copays to see the doctor and the physician may be excluded from their tight networks. Finally, the lack of outcome measures useful in clinical practice that evaluate disease co-morbidities based on the input of both patient and provider prevents meaningful assessment of treatment effectiveness.

Recommendations for Improvement

The steps taken to address the treatment gaps in psoriasis are among the most important initiatives facing patients with psoriasis and the providers who deliver care. A group of academic and private