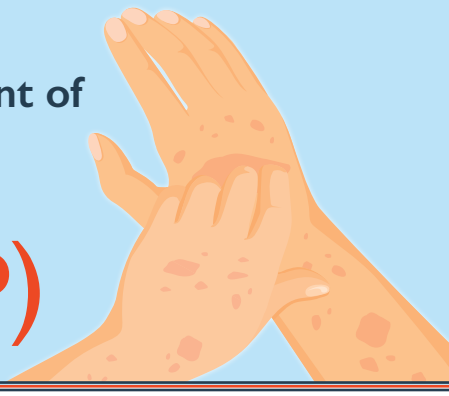
Improving the Understanding, Diagnosis, and Management of

Generalized Pustular Psoriasis (GPP)



Podcast Series: Episode 4

Adrian: Hello and welcome to "Improving the Understanding, Diagnosis, and Management of Generalized Pustular Psoriasis," a podcast series brought to you by the American Academy of Physician Associates and The France Foundation. This activity is supported by an independent educational grant from Boehringer Ingelheim. This is episode four of a five part series focused on generalized pustular psoriasis or GPP for short.

In this episode, we're going to discuss the current and emerging treatment for GPP. Keeping up to date with current research is important to every clinician. This episode will review the current research related to the therapeutic management of GPP, and we're also going to share the latest clinical research related to potential, current, and future options for the management of GPP.

The content is going to review clinical and safety profiles of current and potential options for the treatment of this disease. My name's Adrian Banning. I'm a PA and associate professor in the Delaware Valley University PA program in Doylestown, Pennsylvania.

I'm joined today by my fantastic colleagues, dermatology MP Leigh Ann Pansch and dermatology PA Terri Nagy, and we are going to discuss generalized pustular psoriasis. Terri and Leigh Ann, it's so great to be back here with you again for episode four. If you've listened to any of the other episodes, there is so much that's been shared already and I'm so glad to be back. Thank you both for being here. I'd love if you could tell us more about yourselves.

Terri: It's great to be back here with both you and Leigh Ann again Adrian. This is Terri Nagy. I am a physician assistant. I've been a PA for 25 years, working specifically in dermatology. For the last 20, I spent most of my time working in Akron and Cleveland, Ohio, but about three years ago relocated to Colorado and I'm working with a private practice here in Colorado Springs. And I'm grateful to be with both of you here today for this podcast.

Leigh Ann: Hello, I am Leigh Ann Pansch. I'm a nurse practitioner and I practice in the private practice setting in Cincinnati, Ohio. I've been in practice as a dermatology nurse practitioner for about just shy of 15 years, and I absolutely love treating patients with inflammatory skin disease.

Adrian: Two wonderful and enthusiastic experts, who could ask for anything more? In this episode, we're getting into one of my favorite topics, evidence-based medicine. Terri, what's going on in the current world of GPP management research? What are the evidence-backed current guideline recommendations, and are there any new modalities or changes we should be aware of? Let's just dig into it right away.

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Terri: I love it. I'm ready to dig into this. I have been a PA for 25 years and I'm going to tell you the changes I have seen in medicine have been astronomical. When I lecture for, I lecture at various other local and national conferences. And I talk about all types of different diagnoses, and when I'm talking to my audience about some of the common things out there, I say, "I predict in 10 years we're not going to be using topical corticosteroids first line for common skin disorders any longer," because there's so much new science and so many new medications out there. Part of this is due to an increased understanding about not only our immune system, but these disease states. And in the realm of GPP, we actually have two monoclonal antibodies coming to market. One has already received FDA approval and the second one is pending.

And I'm going to be honest here, I always slaughter the names of these drugs. For some reason, monoclonal antibodies get tongue-tied on my tongue, but we're going to do the best I can here. So the first one, spesolimab, is an IL-36 receptor blocker. It received FDA approval last September, September 2022. It's administered as an infusion over a 90-minute period, and if a second dose is needed, it's administered one week later.

Imsidolimab is also an IL-36 receptor blocker. It is still in clinical trials. It will also be administered as an infusion, but this is a really exciting time for patients who have GPP flares as prior, we had no FDA approved treatments and now we have one and a second one coming to market.

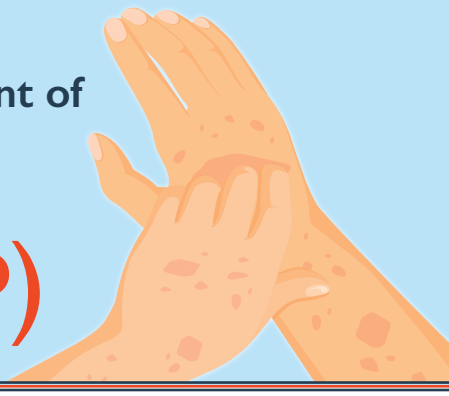
Adrian: That's really huge news. That's a big development in GPP.

Terri: It is. It's amazing what's going on right now.

Adrian: Follow-up question, since we didn't really have anything for a long time, I'm sure people were trying the best that they could, but are there any treatments that you see clinicians using that are not evidence-based or things that we should stop doing?

Terri: That's a great question, Adrian. I think it's important to remember up until recently, we had no FDA approved treatments for GPP. So even dermatology providers were doing the best they could with the limited therapeutics. There were a lot of great drugs out there which controlled some disease states previously uncontrolled and debilitating for patients. Therefore, avoiding a TNF alpha inhibitor in your patient who has rheumatoid arthritis because you're afraid of causing a flare, GPP doesn't make therapeutic sense. If I had to pick one piece of wisdom to offer, it would be to avoid short bursts of oral prednisone in all patients with any type of dermatitis.

Adrian: That's huge. That's a really big piece of advice and so important. I think that's something that people keep in their back pocket. "Oh, something's flaring. If it's erythematous, let's just settle it down with oral prednisone." But that's not a good idea here. Really important. Thank you so much. Leigh Ann, with existing and new treatments, we always want to know about safety. Will you break down the clinical and safety profiles of the current treatment options and those of future treatment choices, if you know about them, that are currently being investigated?



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Leigh Ann: I sure will. I think first and most importantly, we've got to rule out serious infections, and we can do this by asking our patients about prior history of serious infections. But in general, we like to check for things like hepatitis, tuberculosis, and HIV, and in regions of the country where other infections are common that warrants further investigation. For instance, I live in the Ohio Valley and there are very high rates of histoplasmosis here. So I generally ask a few additional screening questions geared toward lung function prior to initiating any systemic biologic medication. I may also consider adding a chest x-ray, PA (post anterior), and lateral to my workup.

And when I look at the most common side effects for the approved and to be approved systemic therapies, I'm going to sum it up by saying common things are common. So, what I mean by that is that these common adverse events for these medications include things like nausea, vomiting, headache, upper respiratory infections, and fatigue, and thankfully we can usually manage those very common adverse events.

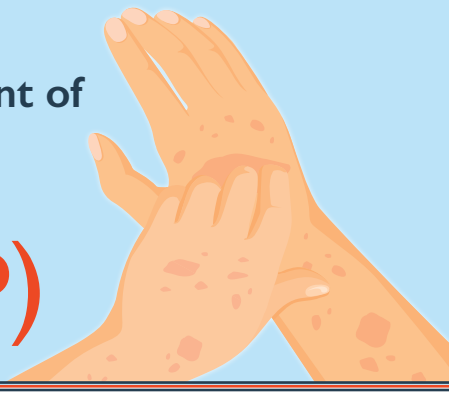
Adrian: That's so important and also such an important tip for when you see, say Ohio River Valley on a test question or histoplasmosis on a test question. Those two things go together so much, so I'm so glad that you reminded us of that. Even getting off the topic of GPP for a second, but going back when you talked about lung symptoms and doing an X-ray, would you do a chest x-ray for everyone even if they didn't have symptoms?

Leigh Ann: No. I would ask some screening questions about recent, ongoing, especially recurrent coughing or pneumonias.

Adrian: Okay. Okay. So when we're talking about the treatments that are currently available, Leigh Ann, are these options available to most people? Can anyone get them? And then to piggyback off of that, are they affordable?

Leigh Ann: These are such great questions. I think we've established that these medications work and I think we've established that they're really pretty safe, but if we can't get them in the hands of our patients, what good are they? And so in general, most of these pharmaceutical companies have patient assistance programs and most of our commercially insured patients have access with a prior approval. I think my one counsel for spesolimab is that it's the only current FDA approved therapy for generalized pustular psoriasis.

And a little note, if you're going to attempt to get this approved, make sure you're getting the first two doses approved, because, as Terri mentioned, the second dose should be administered a week later if they still have symptoms and pustules. And so it makes so much sense to actually get the two doses approved in advance to make for sure that patients have access to both doses if they're needed.



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Adrian: It sounds like you're speaking from experience. Yeah, that's such great advice because I can imagine maybe if this is the first time you're using it or that your office is, I can imagine being asked that question like what dose or how many doses? And if you just say, "One, I just want the one treatment," thinking ahead that you might need two, maybe you won't, but you might need two, and to have them approved ahead of time is so important. Great tip.

Leigh Ann, Terri, as usual, it's been a pleasure learning from you today. If you had to list just a few each, what would you say are the key takeaways about evidence-based emerging treatments? Terri, let's start with you.

Terri: Adrian, I think we live in a very exciting time in regard to new and emerging therapies. The treatments we now have and the treatments which are coming to market are what we call targeted therapies, meaning they work by targeting the underlying etiology of certain disease states. These therapies have been and will continue to be life changers for millions of our patients.

Leigh Ann: This is such an exciting time in the world of dermatology for our patients with these inflammatory skin diseases, we no longer have to look at sort of "band aiding" our therapy for these patients. We can choose individualized care that actually have a wealth of data supporting complete clearance for these patients.

Adrian: I have never met two individuals so excited about inflammatory skin diseases, and it's making me excited. I am so glad to be here with both of you today. I think our listeners are probably feeling the same way. I feel so much more informed on the latest evidence surrounding GPP. Thank you so much. And to our audience, thank you for listening to this episode of "Improving the Understanding, Diagnosis and Management of Generalized Pustular Psoriasis."

Please tune into the other podcast episodes in this series where we talk through the pathophysiology of GPP, the diagnostic challenges, steps of treatment, and implications for patient's quality of life related to GPP. You can find the full list of podcast episodes in the AAPA's Learning Central catalog at cme.aapa.org.