Treat to Target for Psoriasis and Psoriatic Arthritis

Junko Takeshita, MD, PhD, MSCE
Assistant Professor of Dermatology and Epidemiology
Senior Scholar, Center for Clinical Epidemiology and Biostatistics
University of Pennsylvania

Treat to target: what is it?

- Treat a disease until a prespecified clinically relevant measure is achieved
  - Ideally treatments have proven efficacy and safety data from randomized controlled trials
- Well-established in cardiovascular medicine
  - E.g., blood pressure, glucose targets
- Goal: Improve patient outcomes

Psoriasis treatment targets vary

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Treatment Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Psoriasis Foundation Medical Board (2017)⁴</td>
<td>BSA &lt; 1%</td>
</tr>
<tr>
<td>AAD Guidelines (2008-2011)²</td>
<td>None</td>
</tr>
</tbody>
</table>
| Canadian Position Paper (2017)³                              | 1. Clear/almost clear (PASI < 3, BSA < 1%, PGA < 1)
| European Consensus Programme (2011)⁴                        | 2. DLQI ≤ 6                           |
| Australian Psoriasis Treatment Goals (2013)²                  | 1. PASI 75                             |

Clinical trials: greater psoriasis clearance is associated with improved quality of life

25 psoriasis experts participated in Delphi process
- Recommended treatment target: BSA ≤ 1%
  - 3 months after treatment initiation and then 6 months
- Acceptable treatment target at 3 months after initiation: BSA ≤ 3% OR BSA reduction ≥ 75%
- Treatment targets should NOT be used by payers to deny access to therapies if targets aren’t met

From the Medical Board of the National Psoriasis Foundation: Treatment targets for plaque psoriasis

Disclosures

- Some of the presented work was supported by an unrestricted grant from Eli Lilly.
- I receive grant funding from Pfizer for work that is unrelated to this presentation.
Clinical practice: 20% of almost clear patients meet criteria for treatment change

<table>
<thead>
<tr>
<th>DLQI</th>
<th>Clear N=97</th>
<th>Almost Clear N=441</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 (moderate effect)</td>
<td>2 (2)</td>
<td>85 (20)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>


PsA: treatment target recommendations are similar but little agreement on disease activity measure

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Treatment Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>European League Against Rheumatism (EULAR) (2016)¹</td>
<td>1. Remission 2. Low/minimal disease activity</td>
</tr>
</tbody>
</table>


Summary

• Psoriasis: lower disease activity associated with improvements in quality of life.
• PsA: treat to target associated with improved clinical response, more adverse events.
• Expert agreement that regularly monitoring disease activity and discussing treatment targets with patients is important.
• More data needed to support specific treatment targets and cost-effectiveness of treat to target approach.

Effect of tight control of inflammation in early psoriatic arthritis (TICOPA): a UK multicentre, open-label, randomised controlled trial

Lancet. 2015; 386:2489-96.

• 206 patients with early psoriatic arthritis (PsA)
• Tight control with step up treatment regimen targeting minimal disease activity vs. standard care
• Results
  - Tight control group more likely to achieve American College of Rheumatology 20% (ACR20) endpoint: OR 1.91 (95% CI 1.03-3.55) (NNT = 6)
  - AEs and SAEs higher in tight control group; none were unexpected