When BiDil (NitroMed) earned FDA approval this summer for cardiac symptoms in African-Americans, it became the first drug developed and marketed for a specific racial group. The approval of the drug, many observers suggest, may mark a new approach to therapeutic development, where the target is not simply a disease process, but a disease process in a particular group of people.

For dermatologists, the notion of targeting the specific needs of a particular group is nothing new, but when it comes to psoriasis management, there’s growing interest in better serving one sometimes overlooked subset of patients—those who are overweight. Even when dealing with the biologic therapies, some of which have a fixed dose, weight may be an important treatment consideration, new research suggests.

**Obesity and Psoriasis Links**

“A fair number of studies show that there is a clear link between obesity and psoriasis,” observes Mark Lebwohl, MD, Professor and Chair, Department of Dermatology, Mount Sinai School of Medicine, New York. Yet exactly how the two relate remains “very unclear,” he says. Hypotheses abound, and studies currently ongoing or anticipated in the near future seek to elucidate the link between psoriasis and obesity.

There are lingering questions about diet and psoriasis, with studies dating back at least 30 years seeking links between psoriasis and blood glucose levels. There are possible hormonal factors at play in patients with psoriasis. And there’s the simple fact that some psoriasis patients, bothered by the appearance of their skin, may be less likely to actively participate in group sports, workout at gyms, or otherwise be out and active, possibly contributing to obesity.

“Patients with psoriasis may stay at home, be less active,” Dr. Lebwohl notes. The relationship between obesity and psoriasis may be cyclical, as well. Research suggests that obesity, along with other “lifestyle” factors, may increase the morbidity of psoriasis.

Emotional stress, alcohol use, smoking, and obesity were all identified as possibly increasing the morbidity associated with psoriasis.

**Current Implications**

While the connection between obesity and psoriasis remains unclear, new research suggests that patient weight may be a key factor in therapeutic decision-making, particularly with the biologic agents. Of the biologic agents approved for psoriatic disease, alefacept (Amevive, Biogen-Idec), etanercept (Enbrel, Amgen/Wyeth), and adalimumab (Humira, Abbott) are all fixed dose agents, while efalizumab (Raptiva, Genentech) and infliximab (Remicade, Centocor) are provided using a weight-based dose.

To determine how a biologic agent supplied in a weight-based dose performed in overweight patients, Dr. Lebwohl and colleagues reviewed pooled data from phase III trials of efalizumab to determine the efficacy and safety of this therapy in patients weighing 100kg or more versus those weighing less than 100kg.

They found that efalizumab provided in a weight-based dose worked as well in obese patients as in normal weight patients.

**Efalizumab**

provided in a weight-based dose worked as well in obese patients as in normal weight patients.
 excerpt for placebo. PASI-75 response rates among treated patients were 25.1 percent for those 100kg or over and 29.4 percent in those under 100kg.

The incidence of adverse events was similar in both treatment groups. For those 100kg or over, adverse events were observed in 81.1 percent of treated patients versus 74.9 percent in the placebo group. In the under 100kg group, adverse events occurred in 85.3 percent of treated patients, versus 73.4 percent in the placebo group.

The findings suggest that weight-dependent agents may be logical in patients who are overweight. Further investigation may lead to alternative or increased dosing regimens of the standard dose agents for use in obese patients.

New in Your Practice

Sal On. Patients with localized hyperkeratosis or keratoses pilaris seem to like the efficacy and cosmetic acceptability of salicylic acid 6% cream or lotion (Salex, Coria Labs), according to a recent study presented at Academy ’05 in Chicago. Following a once-daily, four-week treatment, 72 percent and 90 percent of patients using the cream formulation demonstrated at least significant improvement in hyperkeratosis of the heels or elbows, respectively. Sixty percent of patients with keratoses pilaris of posterior-lateral arms who used the cream formulation and 50 percent who used the lotion formulation also demonstrated at least significant improvement.

Blind Promises. Interim Phase III data continues to show ISA247 holds promise for moderate to severe psoriasis patients, Isotechnika recently announced. Although blinded data of 369 patients treated for 12 weeks with one of three doses of ISA247 or placebo show a mean decrease in PASI of 38 percent, a study investigator notes a subgroup of patients have responded very well to ISA247, with many experiencing complete clearance after eight to 12 weeks of therapy. Isotechnika expects to release the final 24-week unblinded data early next year.

More Excuses. A recent study in Cancer Research (65:5470-79) may have your male patients finding another excuse to spend time in the sun. Based on a study of 905 men ages 40-79, the authors report that high sun exposure, as determined by reflectometry and high occupational outdoor activity, and vitamin D receptor polymorphisms, as determined by genotyping, reduces the risk of advanced prostate cancer.

Other Academy ’05 Highlights

Patients who switch from twice weekly injections of etanercept 25mg (Enbrel, Amgen/Wyeth) to once weekly injections of 50mg can expect to maintain similar efficacy while halving the frequency of self injections and potentially improving compliance, data show. For an extension study, 265 patients who had participated in initial phase III trials of etanercept at the 25mg twice-weekly dose switched to the 50mg weekly dose for 48 to 72 weeks and were assessed at week 12. PASI scores were not significantly different from baseline of the extension study through week 12. Scores documented sustained improvement of DSGAP “clear” or “almost clear” status as well as sustained improvement in DLQI. (P92; Elewski B, et al.) Additional reported data reveal that there are no consistent predictors of skin or joint response to etanercept. The phase 4 study looked at response in 1,122 patients but failed to uncover any consistent predictors of response across various joint and skin endpoints examined. (P135; Goffe B, et al.) Reported cases suggested benefit for etanercept outside of psoriasis, including treatment of dermatomyositis in a patient with a history of breast cancer (P47; Jackson JM) and subacute lupus erythematosus (P48; Jackson JM).

In phase III trials investigating infliximab (Remicade, Centocor) for the treatment of psoriasis, 80.4 percent of treated patients achieved PASI-75 and 57.1 percent achieved PASI-90 at week 10 (versus 2.6 percent and 1.3 percent respectively for placebo). At week 24, response rates among treated patients climbed to 82.2 percent for PASI-75 and 58.3 percent showed a PASI-90 (placebo was 3.9 percent and 1.3 percent respectively). The phase 4 study of adult patients with PsA found that those receiving 40mg adalimumab every other week demonstrated no change in erosion and a slight improvement in joint space narrowing, whereas untreated patients demonstrated worsening. Treated patients’ change in erosion was 0, versus 0.6 in placebo, and change in narrowing was –0.2, versus 0.4 in placebo. The differences between treated patients and placebo were statistically significant, regardless of whether patients received methotrexate concomitantly. (P95; Mease PJ, et al.)

Alefacept (Amgen, Biogen-Idec) may be safely combined with UVB phototherapy, data suggest, and may be more effective than alefacept plus other psoriasis therapies. Compared to patients receiving alefacept alone, mid- or high-potency topicalis plus alefacept, or retinoids plus alefacept, those who received concomitant light therapy had the most significant improvements in PGA. Twenty-six percent of patients in the alefacept plus UVB group achieved a PGA of clear or almost clear. Incidence of adverse events in the light combination group was similar to alefacept alone. (P90; Bagel J.)