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Editorial

Biologics for psoriasis-the evolving scenario

Psoriasis is an immune-mediated, inflammatory condition that has been described since antiquity and affects 125 million people worldwide.[1] If extensive, it can lead to significant distress and impair quality of life. Without an understanding of its pathogenesis, there have been many unusual treatments over the ages (e.g. topical application of mercury, sulphur). It was not until the 1960s that it was investigated as an autoimmune condition which led to treatments based on clinical efficacy becoming available since the 1970s. With advances in the pathogenesis of psoriasis, the first generation of biologics, the tumour necrosis factor α (TNFα) inhibitors, etanercept and infliximab became available for the treatment of psoriasis. This was followed by the interleukin 12/23 inhibitors, such as ustekinumab. With further research, the third generation of biologics has now become available. These new biologics have been able to achieve higher PASI clearances (PASI 90, PASI 100) than the older agents.[2] Over the past decade, with increasing experience and data in the use of biologics, their use has expanded. For example, the TNFα and IL 12/23 inhibitors have been approved for paediatric patients.[3,4] We also have more experience in the use of biologics in special scenarios such as hepatitis infection or before surgery. However, we are well aware that the response to treatment is variable both in terms of efficacy and side effects. A prime example of this being reports of paradoxical flare of psoriasis with TNFα inhibitors.[5] In addition to the different subtypes of psoriasis, there is also variation in response. Therefore with accumulating experience and a better understanding of the pathogenesis of psoriasis, better treatment choices and development of better medications for psoriasis will be possible.

Faced with the plethora of biologics currently available, the clinician would welcome information on the efficacy of these treatments when faced with a particular type of psoriasis. In the current review, Aw et al discuss the clinical data of various treatment options for different subgroups of psoriasis patients. This enables a more personalised approach to achieve a maximum therapeutic benefit.

In real life, cost is a major factor as well as careful exclusion of contra-indications such as infection that need to be considered before use. Furthermore, the high cost of biologics means that, in the public sector generally speaking, they will be reserved for resistant cases. There is also a need to monitor for any unexpected side effects for both the older and newer biologics. All in all however, the availability of the newer biologics provides an extra treatment option for psoriasis management. However, one must not forget simple measures such as cessation of smoking and alcohol and to continue to emphasise the importance of good compliance with topical medications. After all, although being effective suppressive therapy, biologics still do not cure psoriasis and cannot replace basic management measures. In addition, it has been recognised that there is an association between psoriasis and metabolic syndrome.[6] This is exemplified by the lipid

abnormalities commonly detected during the routine work-up for treatments such as acitretin. As such, patients should also be encouraged to maintain a healthy lifestyle to achieve optimum therapeutic effect. One must also not underestimate the psychological stress due to psoriasis which may not be in proportion to the extent of psoriasis. These aspects should not be neglected in order to achieve holistic care of the psoriasis patient. At the same time, continued research into the pathogenesis of psoriasis will provide further insight into the factors determining treatment response as well as new therapeutic agents.

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