

PSOaring UPWARD™

The Patient Newsletter of the Corrona® Psoriasis Registry

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Examining Health Disparities and Psoriasis

Joe Doolen, National Psoriasis Foundation

NPF spoke with Junko Takeshita, M.D., Ph.D., about her research on psoriasis and its effect on different populations.

Dermatologist Junko Takeshita, M.D., Ph.D., is an assistant professor of dermatology and epidemiology at the University of Pennsylvania Perelman School of Medicine. She is the recipient of multiple NPF Dermatology Fellowships and an NPF Outstanding New Investigator Award.



We spoke with her about tackling health disparities among people with psoriasis in different racial and economic groups – and what can be done to close the gaps. Her answers have been edited for length and clarity.

Joe Doolen: How are low-income individuals disproportionately affected by psoriasis compared with those with higher incomes?

Junko Takeshita: There are a lot of effective new treatments for severe psoriasis, particularly biologics, and they are expensive. As a result, lower-income individuals have more difficulty affording treatment.

There are a few exceptions to this. For example, we performed a study of Medicare beneficiaries to identify factors associated with whether or not someone received biologic therapy. People who had the Part D Low-income Subsidy (also called “Extra Help”), which allows for low out-of-pocket payments for biologics, were more likely to get biologics than those who did not qualify for the subsidy.

I think the largest problem with access is that being financially disadvantaged is correlated with poor insurance coverage. In terms of psoriatic disease, more work needs to be done to discover the impact socioeconomic status has on disease activity itself. A couple of studies have looked at socioeconomic factors and psoriasis, and results indicate that socioeconomic status has an effect on the levels of undiagnosed psoriasis. This may be related to poor access to health care as well.

JD: How is access to care different between socioeconomic groups? Besides income, are awareness and culture also factors?

JT: There needs to be more research into this, but anecdotally I could share experiences I have had. First of all, in terms of disease awareness, psoriasis is more prevalent in people of a European background. While still a common skin disease among minorities, psoriasis is much less prevalent among these groups, in comparison. So psoriasis is much more well-known among white communities.

Certainly in textbooks and commercials, we mostly see white people with psoriasis. I have heard from patients, “Oh, I didn’t know that psoriasis could occur in non-white people,” so I suspect there is an awareness issue. This may relate to the findings we see where minorities tend to have more severe psoriasis (as a proportion of total cases). That may be biologically driven, but could also be due to under-diagnosis. But there is not a lot of data to robustly support this.

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JD: The lives of individuals with psoriatic disease are markedly better today than in generations past. Are some members of our society being left behind when it comes to the improvements we have seen in overall quality of life?

JT: We have more targeted therapies out there now that are just working better. Socioeconomics and insurance coverage can be huge access barriers. In our study, we tried to control for socioeconomic status, and the beauty of Medicare data is that everybody had some level of medical coverage, so we minimized those issues somewhat.

Independent of those, we did find race to be a factor in whether or not you receive a biologic; African-Americans in the study were less likely, for unknown reasons, to receive biologic treatment for severe psoriasis. Also (not in the study), geographically, access to dermatologists and psoriasis specialists can be more difficult in rural areas.

JD: Are there diseases associated with psoriasis that are also more prevalent among poorer populations? What about factors like environment and behavior?

JT: In terms of environmental and behavioral risk factors, the most well-established ones for psoriasis are obesity and smoking, which are more prevalent among the more socioeconomically disadvantaged. Also, psoriasis comorbidities like heart disease are also higher in these groups. So socioeconomic status can have an effect on psoriasis itself, conditions associated with psoriasis and risk factors that can trigger the disease.

JD: How can psoriatic disease researchers and advocates alleviate disparities in care?

JT: First, as researchers, we need to better identify and understand what disparities in care exist. Once we do this, we can start to develop methods to reduce those disparities. If we take financial and resource barriers to accessing medications as an example, I think NPF is doing an excellent job advocating for patients. NPF's Patient Navigation Center provides assistance of all sorts to patients with psoriatic disease, including tips on how to navigate the health care system to access treatments. Increasing awareness of disparities in care is critically important, and alleviating disparities requires more efforts like those of NPF.

For more content, visit psoriasis.org/advance.

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Fun Facts about Corrona and the National Psoriasis Foundation

*Stacey Hirata Holmgren & Deidre Sepavich,
Corrona, LLC*

- ✓ 4,300 patients are enrolled in the Corrona® Psoriasis Registry!
- ✓ 5,136 people were served by the NPF Patient Navigation Center last year.
- ✓ 4,300 Team NPF participants and volunteers led the way in 2017 to raise \$1.75 million.
- ✓ 166 dermatology practices from across 36 U.S. states and 2 Canadian provinces take part in the Corrona® Psoriasis Registry. And this number continues to grow!
- ✓ 212,000 people read the NPF award-winning Psoriasis Advance magazine.
- ✓ Nearly 400 dermatology providers and 500 research staff work with registry patients throughout the year to schedule and complete follow up visits.



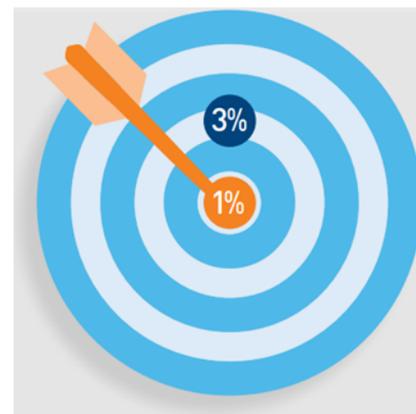
Your Data in the Spotlight

Stacey Hirata Holmgren, Corrona, LLC

The Corrona® Psoriasis Registry has enrolled over 4,000 people and counting! Each and every one of you contributed important information, helping psoriasis researchers learn more about safety and effectiveness of psoriasis treatments. New findings from the registry were presented at the largest dermatology medical conference of the year, the American Academy of Dermatology, held in San Diego, California, February 16-20, 2018. Here are some highlights:

How many patients are being treated to target? One study conducted by researchers affiliated with the National Psoriasis Foundation (NPF) assessed how many patients in the registry met the NPF's Treat-to-Target guidelines of achieving a Body Surface Area (BSA) \leq 1% as a target response after 6 months; and a BSA \leq 3% as an acceptable response after 6 months.

Among the 2,808 people included in this analysis, 43% of all patients receiving systemic treatment reached the target BSA \leq 1% after 6 months, and 65% of patients who received a biologic for the first time reached the target BSA \leq 1% after 6 months. Researchers also found that 64% of all patients receiving systemic treatment and 76% of patients who received a biologic for the first time reached a BSA \leq 3% after 6 months of follow up. Patients who achieved the BSA targets had better quality of life, less itch, and better productivity at work.



Greater BSA reduction, better quality of life. A separate analysis noted that improvements in BSA at 6 months and 12 months correlated with improvements in quality of life (as measured by the Dermatology Life Quality Index). The patients with greater the reduction in BSA (down to 0% or 1%) were more likely to have greater improvements in quality of life compared to those with less reduction in BSA. Patients with greater BSA improvement also had greater improvements in pain and itch at 12 months.

What type of patients are taking the IL-17 inhibitor biologics? Another study noted patients receiving an IL-17 inhibitor drug (Taltz or Cosentyx) were more likely to be older, have a longer disease duration, be overweight or obese, and have psoriatic arthritis than patients taking the other biologic medications (Enbrel, Humira, Stelara, Remicade). People taking IL-17 inhibitor medications were more likely to have received a biologic before, and 40% of these people had tried at least 3 biologic treatments. It appears dermatology providers are prescribing these newer biologic drugs to patients with more active disease that did not have a good response to other oral and biologic treatments.

Scalp psoriasis vs. no scalp psoriasis. A third of the people in the registry were affected by scalp psoriasis, and these patients tended to have more severe disease, itch problems, and poorer health status compared to patients without scalp psoriasis. Patients with scalp psoriasis were more likely to report also having psoriasis on their nails, palms/soles, and in areas of skin folds (e.g., armpits, genitals, buttocks, under breasts) compared to patients that did not have scalp involvement. A separate study by the same researchers noted patients with nail psoriasis reported higher itch, pain, anxiety, and impaired health status compared to patients without nail psoriasis.

Who is more likely to respond to a TNF-inhibitor drug? Another group of researchers compared patients whose psoriasis responded to one of the TNF-inhibitor drugs (Enbrel, Humira, Remicade) and patients whose disease did not respond to these drugs to see if there were any differences. About half (51.7%) of patients did see an improvement in their psoriasis after the first follow up visit. The patients who did not see an improvement in their disease were more likely to be overweight or obese, have tried a biologic medication before, and reported lower quality of life at their enrollment visit.

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Sudoku Puzzle Challenge

To solve the puzzle, simply fill in the grid so that every row, every column and every 3 by 3 box contains the digits 1 through 9, without repeating any. Simple enough, right?

No math is involved. The grid has to contain the numbers 1-9, but nothing has to add up to anything else. Good luck, and have fun!

4		6		8			5	9
8		7	5		9			
	9		3	6		7	8	4
2	6	5	9		4	1		8
	7			2	6	4	9	
		4	7					3
		9			3			1
6	4		1		8	5		7
	5	8	4	7			3	6

Answer:

6	3	9	2	7	4	8	5	1
7	2	5	8	9	1	3	4	6
1	4	8	3	5	6	9	2	7
3	9	2	5	1	7	4	8	9
5	9	4	6	2	8	1	7	3
8	7	1	4	3	9	5	6	2
4	8	7	1	6	3	2	9	5
2	1	6	9	4	5	7	3	8
9	5	3	7	8	2	6	1	4

To solve the puzzle, simply fill in the grid so that every row, every column and every 2 by 2 box contains the words, without repeating any. The grid has to contain the four words. Good luck!

The words that are used in the puzzle:

treatment skin follow-up registry

		skin	
skin			treatment
	skin		registry
registry		follow-up	

Answer:

skin	follow-up	treatment	registry
registry	treatment	skin	follow-up
treatment	registry	follow-up	skin
follow-up	skin	registry	treatment