Palmoplantar pustular Psoriasis induced in a patient treated with infliximab for Crohn’s disease

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History

- The Crohn was diagnosed in 1994 at the age of 23 Y.
- Initially on steroid. This stopped due to side effect.
- 18 inches resection of large bowel and illectomy after this.
- Fast recovery and Crohn disease was in remission.
- B12 injection and Questran(Colestyramine) were prescribed.
- Abscess in 2012 consequently an operation to remove and clean(fitted a Seton). Other small abscess developed later but they settled with Abs.
- The Croh’s consultant recommended Infliximab treatment in Sept 2013.
- Treatment commenced in March 2014.
- She got skin rash on her feet and hands after 4 sessions of infliximab. Hands involved first. 26th and 27th June 2014.
- Seen by her own GP and diagnosed with Hand,Foot and mouth disease.
- The emergency GP on 14th July gave her oral antibiotics (Flucloxacillin) 500mg 4 times a day for 7 days and an antibiotic cream (Fucidin) to rub.
- A week later her hands had cleared up considerably but feet were worse.
- The emergency GP on 19th July continued the above.
- Infected Contact Dermatitis 20/07/14 in A&E, fucibet given.
- Seen by me two weeks later and given clobetasol propionate:
- Reviewed in one week time and given active heal(hydrocolloid).
Skin presentation after treatment by ABS and fucidin followed by fucibet

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What is the specific therapeutic challenge in this patient?

- Patient already seen by other health professional and given medication and topical treatment which can change the initial clinical presentation.
- History taking and examination are paramount in diagnosis!
- Dilemma of therapeutic options as initial diagnosis of infliximab induced PPP. Paradoxical effect of anti-TNF!
- Question to be answered: should we stop the infliximab or choose a treatment to commence without discontinuation?
- This needs an MDT meeting?
- Which therapeutic option are available on this case? Topical? Systemic? With or without continuation of Anti-TNF?
- If topical< which topical to choose?
# Evidence for use of selected treatment

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Type of evidence e.g. RCT, guidelines</th>
<th>Details of study or publication</th>
<th>Key findings &amp; conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alan Menter et al</td>
<td>randomized 4-week comparative study</td>
<td>the efficacy and safety of clobetasol propionate 0.05% spray to calcipotriene 0.005%, betamethasone dipropionate 0.064%</td>
<td>75% clear by CT in comparison to C-BD 45%, Adverse events 31% for CP spray and 33% for C-BD ointment</td>
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<tr>
<td>Mason et al: Topical treatments for chronic plaque psoriasis (Review)</td>
<td>Cochrane review</td>
<td>Cochrane Database of Systematic Reviews 2013</td>
<td>Corticosteroids perform at least as well as vitamin D analogues</td>
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<tr>
<td>M. Sevrain et al 2014</td>
<td>Systemic review</td>
<td>evidence-based recommendations and expert opinion</td>
<td>potent or very potent topical corticosteroids with Occlusion (no PsA) With PsA (NSAID + topical corticosteroids) first line</td>
</tr>
<tr>
<td>Chalmers R et al: Interventions for chronic palmoplantar pustulosis (Review)</td>
<td>Cochrane review</td>
<td>Cochrane Database of Systematic Reviews 2009</td>
<td>combination of PUVA and retinoids is better than the individual treatments. The use of topical steroid under hydrocolloid occlusion is beneficial</td>
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<tr>
<td>NICE guidelines 2012, updated evidence 2014</td>
<td>Guidelines</td>
<td>guidelines</td>
<td>first-line topical therapies (such as potent corticosteroids with vitamin D analogues, dithranol and tar preparations). Very potent corticosteroid if the above fails</td>
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<tr>
<td>Cullen et al 2011</td>
<td>Retrospective review</td>
<td>Identification of anti-TNF-induced psoriasis in inflammatory bowel disease, management</td>
<td>41% of those who developed psoriasis while on anti-TNFs responded to topical therapy.</td>
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</table>
Review of evidence: clinical implications

• The use of very potent corticosteroid must be limited to 4 weeks and in specialist settings under careful supervision. (NICE guidelines)

• Use of topical treatment (mostly potent corticosteroid) with or without Anti-TNF continuation. Cullen et al 2011

• Risk of dermal atrophy. (Cochrane review). Need for a break after 4 weeks and using other topical like Vitamin D antagonist. (NICE guidelines)

• Any treatment decision should be made jointly by the gastroenterologist and the dermatologist. Cullet et al 2011

• Choice of long-term maintenance treatment, if response is clearance or nearly clear. (Cochrane review)

• The use of very potent corticosteroid under hydrocolloid occlusion. (Cochrane review)
Recommendations for clinical practice

- Topical corticosteroid (potent or very potent) can be chosen as first line of treatment for anti-TNF induced plantopalmar psoriasis or other cutaneous presentation.
- In case of extensive skin presentation, PUVA should be considered to avoid systemic absorption of corticosteroid.
- Use of this topical treatment limited for 4 weeks with break in which uses of other topical like vitamin D antagonist is recommended.
- The use of Anti-TNF may not stop based on response to the topical treatment.
- Topical corticosteroid usage under hydrocolloid occlusion deliver better outcome.
- Betamethasone + vitamin D antagonist is more efficient than Betamethasone itself. It can be used as first line of treatment.
- Close supervision is required in usage of very potent corticosteroid.
- Therapeutic approach need to be discussed in a MDT meeting.

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Reflection

- As the use of TNF antagonists has increased, new cutaneous reactions like psoriasis are being seen more in the practice. I am now aware of this.
- I watch closely any patients who suffer from rheumatoid arthritis, ankylosing spondylitis, psoriasis, Crohn’s disease, and rarely psoriatic arthritis on anti-TNF for any skin presentation like psoriasis (in this case PPPP).
- I inform my patients accordingly to look for signs and symptoms in their skin.
- I need to have close communication with rheumatologist, oncologist, and gastroenterologist in order to manage and treat the dermatological side effect of Anti-TNF treatment in primary care dermatology.
- NICE Guidelines and algorithms are very useful and practical in choosing appropriate treatment for different types of psoriasis. I need to update myself from time to time with the guidelines.
- A good history taking is very beneficial in diagnosis and consequently treatment of skin disorders induced by drugs.
- I am more aware of practicality and efficacy of potent corticosteroid treatment with occlusive dressing like hydrocolloid occlusion.
- My first topical treatment of choice would be combination of betamethasone and vitamin D antagonist. In case of no response I would choose very potent corticosteroid with close supervision for 4 weeks.
- I would refer these kind of patient for systemic therapy or PUVA if they fail first line of therapy namely topical treatment. (MDT meeting needed)
References


