Current Opinion of the Use of Biologics for Psoriasis in Finland

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Ostrobothnia Central Hospital is located in Seinäjoki town in the centre of Finland. In this area the prevalence and incidence of psoriasis is quite high, although we lack accurate statistical analysis. In our dermatology clinic we have used biological treatments for severe plaque-type psoriasis patients since 2005.

Infliximab

At first we used infliximab infusions (3 mg/kg, 8 patients; 7 males, 1 female) combined with peroral methotrexate, 5 mg/week, and folic acid, 5 mg/week. Initially the Psoriasis Area and Severity Index (PASI) scores for all patients were over 20 (i.e. very severe psoriasis). The short dermatology life quality index (DLQI) (our own index based on that of Finlay & Khan) was also used. After 4–6 infusions, PASI scores were reduced to 1–2. Life quality indexes also showed a good response.

During the treatments, one female patient showed mild urticaria symptoms. One week before the next infusions we started her on setirizin per os and continued the treatments. The psoriasis improved and arthralgias were relieved (C-reactive protein dropped from 98 to 12). After 5 infusions her infections (bacterial cystitis, streptococcal tonsillitis, etc) were constant. Now we are starting her on etanercept. One male patient had elevated liver enzymes and infusions were interrupted.

A further 5 male patients have tolerated infusions well and their psoriasis has shown remission for about 6–12 weeks. This year our last infliximab patient has had 3 infusions and has shown excellent results for skin and joints. Surprisingly, however, he attempted suicide and was admitted to the intensive care unit. He is now in the psychiatric department.

Efalizumab and etanercept

In 2006 we began to change most of our patient infliximab treatments to either efalizumab or etanercept treatments. Thus the results are not yet available or are very scant. One infliximab patient's psoriasis relapsed after 4 intramuscular efalizumab injections. Relapse was severe and he needed hospital admission. The patient was extremely dissatisfied and behaved almost aggressively. We plan to start infliximab again and later try etanercept treatment for him. On the other hand, 1 patient was very satisfied, almost euphoric, with the efalizumab treatment after 4 weeks, although the results were not so good.

Table I. *Infliximab treatment in 8 patients.*

Pat	DLQI (own) 10 = bad 1 = great	Continuation after infliximab	Observations
ML	10-4-2-1	etanercept	Slight guttata psoriasis
OO	4-4-0-2-2	efalizumab, etanercept	Artalagias, efalizumab shift etanercept
RR	5-3-1-1	efalizumab	Bad relapse, shift back to infliximab
HT	7-2-3-	efalizumab	
OA	6-6-3-1	etanercept	Head erysipelas
AK	8-7-2-	etanercept	Liver enzymes ad 180 with infliximab
HM	10-8-	etanercept	Urticaria, infections
JL	8-	infliximab	Exellent response, suicide attempt, psychiatric treatment

Observations

At present, treating patients with biological drugs – especially infliximab – is laborious. You need more time, nurses, space and money. The number of our patients treated with biologics is small, so it is difficult to draw any conclusions about long-lasting procedures, results and side-effects. Efalizumab and etanercept are administered by the patients themselves, but still require careful monitoring of infections and other side-effects, which takes costly time.

As we already know, biologics have many side-effects: infections, malignancies, hypersensitivity reactions, lupus-like or multiple sclerosis (MS)-like syndromes, etc. Tumour necrosis factor-alpha (TNF-α) regulates cytokine production in the body. Some scientists have also associated TNF-α with major depression. According to Tyring et al. (Lancet 2006, Jan 7), reducing the effects of the some cytokines in the brain may relieve depressive symptoms. Furthermore, we know that new effective antidepressive drugs may add to the suicidal feelings of some depressive patients, especially at the beginning of the treatment (BMJ 2005, May).

Psoriasis is a complex biopsychosocial condition. We need new safe treatments to improve quality of life of our psoriasis patients. In addition, we need more studies and information about the central nervous system (CNS) side-effects of biologics. Antidepressive side-effects are, of course, desirable for patients. Still, in my opinion, patients with severe long-lasting psoriasis require more careful monitoring for psychiatric disorders, especially at the start of biological treatments.

Clinical Experience with Biological Agents at the Department of Dermatology, Aarhus University Hospital

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To provide the best possible therapy for patients with severe psoriasis, we have tried to gain experience with all the available biological agents, even before they became licensed for this indication. This means that we have clinical experience with more than 100 patients, some of whom have been treated for more than 3 years.

Remicade® is used for severe and unstable psoriasis, including pustular psoriasis. Enbrel® is selected for severe psoriasis, particularly in patients with associated athropathy. Raptiva® is prescribed mainly for moderate to severe, stable plaque-type psoriasis without arthropathy. Humira®, which is still not approved for psoriasis, is given to patients who do not respond to the other biologicals. Screening for tuberculosis is mandatory for the anti-TNF-α antagonists. For Raptiva® only patients considered to be at risk of tuberculosis are screened.

Our experience is longest for Remicade® (infliximab), which is extremely effective early on. However, in a significant number of patients the effect is reduced over time. To avoid this loss of efficacy, we try to use Remicade® in combination with methotrexate. Infliximab is also effective in other immune-mediated inflammatory skin diseases. Thus, we have obtained excellent results in refractory cases of pityriasis rubra pilaris, Behcet's disease, pyoderma gangrenosum, vasculitis, dermatomyositis and sarcoidosis. Some patients have