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Trifarotene 50 μg/g cream: An effective and safe treatment for moderate facial and truncal acne

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Introduction: While ~50% of patients with facial acne have truncal acne, data concerning treatment of truncal acne has been lacking. Three recent studies evaluated the efficacy and safety of a new retinoid, trifarotene 50 μg/g cream (trifarotene), for facial and truncal acne.

Methods: Two multicenter, randomized, double-blind, vehicle controlled, 12-week phase 3 studies ("Perfect" 1+2) and 1 multicenter, open-label, non-comparative 52-week study ("Satisfy") investigated trifarotene once-daily in moderate facial and truncal acne. Efficacy end points included the Investigator's Global Assessment (IGA 0-4, face), the Physician Global Assessment (PGA 0-4, trunk), and the change in facial/truncal inflammatory and noninflammatory lesions. Safety assessments included adverse events and local tolerance (erythema, scaling, dryness and stinging/burning).

Results: The "Perfect" studies recruited 2420 subjects, and 1214 were treated with trifarotene. "Satisfy" enrolled 455 subjects, and 348 (76.5%) completed the 52-week study. All three studies met all efficacy end points, and both IGA and PGA successes (score 0-1, and 2-grade improvement) continued to increase throughout the full 52 weeks of the "Satisfy" study. There was a 29.4% IGA success rate with trifarotene compared with 19.5% for vehicle in "Perfect 1," and 42.3% trifarotene IGA success rate compared with 25.7% for vehicle in "Perfect 2." Signs/symptoms of local tolerability were mostly mild/moderate. Local irritation increased during week 1 on the face, up to week 2-4 on the trunk, decreasing thereafter, and was managed with moisturizers and/or regimen (application frequency) adjustment. Summary: Trifarotene was effective and safe in 3 phase 3 studies of moderate facial and truncal acne.

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Maintenance of response through 136 weeks of long-term continuous risankizumab treatment: An analysis of patients from UltIMMa-1 and UltIMMa-2

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Introduction: Risankizumab is a humanized immunoglobulin G1 monoclonal antibody that binds to the p19 subunit and selectively inhibits interleukin-23, a cytokine that plays a key role in the development and maintenance of psoriatic lesions. LIMMitless is a phase 3, single-arm, multicenter, open-label extension (OLE) study to assess the safety and efficacy of risankizumab for maintenance in moderate to severe plaque psoriasis (NCT03047395). This analysis evaluated the proportion of patients who maintained high levels of response (90% improvement in Psoriasis Area and Severity Index [PASI 90]) on risankizumab through 136 weeks of treatment.

Methods: Patients who had received risankizumab for 52 weeks during 2 previous phase 3 studies (UltIMMa-1 [NCT02684370] and UltIMMa-2 [NCT02684357]) were eligible for OLE and received 150 mg risankizumab subcutaneously every 12 weeks for 156 weeks. This interim analysis assesses the proportion of patients who entered the OLE with PASI 90 and received risankizumab for 84 weeks (total of 136 weeks). Missing data were imputed using modified nonresponder imputation (nonresponse imputed only for patients with worsening psoriasis).

Results: Of 525 patients who entered the OLE after receiving risankizumab for 52 weeks in the UltIMMa studies, 449 (85.5%) had a PASI 90. Of these 449 patients, 94.7% maintained PASI 90 after 84 weeks of the OLE (a total of 136 weeks of risankizumab).

Conclusions: Most patients who entered the OLE with PASI 90 maintained their response through 136 weeks of risankizumab. These data demonstrate that patients can expect to maintain a high level of response when on long-term risankizumab therapy.

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Cutaneous toxicities in lung cancer patients on immune checkpoint inhibitor therapy

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Introduction: Immune checkpoint inhibitors (ICIs) have revolutionized cancer treatment. They were FDA approved for metastatic melanoma and are now used for a variety of cancers. Cutaneous toxicities are the earliest-appearing and most prevalent toxicity from the ICIs. While there have been numerous descriptions of the cutaneous toxicities from ICIs in melanoma patients, there are no such studies in non-small cell lung cancer (NSCLC).

Methods: A retrospective chart review was performed with a board-certified dermatologist and a board-certified oncologist to analyze all institutional patients with diagnoses of NSCLC and a dermatologic condition between 1/1/2017 and 12/31/18. The institutional electronic medical record was queried using ICD10 codes for a combination of NSCLC and various dermatologic diagnoses.

Results: Sixty-four patients were reviewed with a median rash time-to-onset of three months and duration of four months. Eczematous, morbilliform, and acneiform rashes were most prevalent. There were 28 patients who had previous dermatologic conditions and only four of them had related cutaneous toxicities. Most patients' (70%) rashes improved or resolved after treatment with oral antihistamines and topical steroids. Eight (13%) of them had a dose impact to their cancer treatment due to their rash, with four (6%) patients discontinuing their ICIs.

Conclusions: Five patients had to discontinue their cancer treatment due to immune related adverse events, four of which were rashes. With the high incidence of cutaneous toxicities seen in the clinical trials (18%) and the potential for dose impact among these patients, cutaneous toxicities from ICIs in NSCLC patients is important to describe.

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Dupilumab for the treatment of dyshidrotic eczema: A multi-institution experience of 15 consecutive patients

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Dupilumab is a human monoclonal antibody that is approved for the treatment of atopic dermatitis. Several case reports and small case series (≤3 patients) have reported using dupilumab in the treatment of dyshidrotic eczema; however, data supporting dupilumab's use in this condition is still limited. To highlight the role of dupilumab in dyshidrotic eczema we present a series of 15 consecutive patients from three institutions treated with dupilumab for dyshidrosis. Patients with eczema only on hands and/or feet were included. All patients initially received atopic dermatitis dosing of dupilumab. Demographics are as follows: 10 males, 5 females, average age 56 (range 32-76). All patients had previously failed topical corticosteroids and 11/15 patients had previously failed at least one oral immunosuppressive and/or phototherapy. All patients demonstrated at least partial response to dupilumab with 6 patients clearing. 14/15 patients started on dupilumab for dyshidrotic eczema are still on dupilumab with an average treatment duration of 12.5 months. 7 patients have been on dupilumab for more than one year. The one patient in our cohort who stopped dupilumab was responding appropriately but decided to discontinue because she was concerned about possible side-effects. Dupilumab was well tolerated in our cohort with only 3 reported adverse events. One patient developed conjunctivitis that is being managed satisfactorily with artificial tears. Two patients developed dupilumab facial redness that was refractory to treatment with topical corticosteroids, topical azoles, and topical calcineurin inhibitors. Our series suggests that dupilumab is a generally well tolerated and frequently effective treatment for dyshidrotic eczema.

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