that larger studies should be considered to evaluate how DPCP might play a role in treatment algorithms for a subset of patients with cutaneous melanoma.

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Guselkumab dosing interval optimization in adult patients with psoriasis: A retrospective, multicenter case series

To the Editor: The currently approved dosing schedule for guselkumab in Canada is 100 mg subcutaneous injection at week 0 and week 4, followed by maintenance dosing every 8 weeks thereafter.[1] Three randomized controlled trials have shown that guselkumab has a favorable efficacy and safety profile.[2-4] Currently, to our knowledge, there are no published data on the off-label regimens for guselkumab. This case series aims to investigate the effectiveness and safety of guselkumab dosing interval optimization.

A retrospective chart review was conducted at 2 academic hospitals and 1 community dermatology clinic in Ontario, Canada. Responders were defined

Table I. Demographics, efficacy outcomes, and safety outcomes of patients using regimens with increased guselkumab frequency

Variable*	Value
Sex, n (%)	
Male	16 (59.3)
Female	11 (40.7)
Age, y, mean ± SD	54.7 ± 12.3
Number of previously failed treatments, mean ± SD	
Systemics	1.4 ± 1.1
Biologics	2.1 ± 1.9
Standard dosing	
Baseline PASI, mean ± SD (n)	11.9 ± 5.2 (16)
Treatment duration before shortening the dosing interval, wk, mean ± SD	32.2 ± 24.7
Off-label shortened dosing interval regiment	
PASI before frequency escalation, mean ± SD (n)	7.1 ± 6.4 (18)
PGA scores before frequency escalation, n	0
1	1
2	4
3	3
4	1
Dosing regimen, n (%)	
100 mg every 6 weeks	6 (22.2)
100 mg every 4 weeks	21 (77.8)
Follow-up time, wk, mean ± SD	19.0 ± 6.7
Patients achieving efficacy, n (%)	20 (74.1)
PGA 0	6.0 (22.2)
PGA 1	14.0 (51.9)
Nonresponders to shortened-interval regimen, n (%)	7.0 (25.9)
Concomitant systemic agents, n (%)	2.0 (7.4)
Methotrexate	1.0 (3.7)
Cyclosporine	1.0 (3.7)
Reported adverse events, n (%)	3.0 (11.1)
Common cold	1.0 (3.7)
Gastrointestinal symptoms	1.0 (3.7)
Headache and dizziness	1.0 (3.7)

PASI, Psoriasis Area and Severity Index; *PGA,* Physician Global Assessment.
*n indicates the number of individuals meeting criteria.

as having a 75% reduction in Psoriasis Area and Severity Index (PASI) score 3 to 6 months after dose optimization when compared to the PASI score immediately before dose optimization of guselkumab or a Physician Global Assessment (PGA) score of 0 or 1. Safety was assessed by recording the reported adverse events (AEs) after the dosage frequency increase.

Of the 27 patients in our study, 6 (22.2%) patients increased their dosing frequency to 100 mg every 6 weeks, and 21 (77.8%) patients increased to 100 mg every 4 weeks (Table I). At the time of shortening the dosing interval, the mean PASI was 7.1 ± 6.4 for the 18 of 27 patients who had PASI scores available. The remaining patients had PGA scores of 1 (n = 1), 2 (n = 4), 3 (n = 3), and 4 (n = 1).

Six (22.2%) patients achieved PGA 0, and 14 (51.9%) patients achieved PGA 1 after shortening the dosing frequency. Overall, 20 of 27 (74.1%) patients achieved clinically significant clearance of psoriasis from guselkumab after they switched to a shortened dosing interval based on our study endpoints.

Seven patients (25.9%) were nonresponders to a shortened-interval dosing regimen with guselkumab. Of these 7 patients, 1 was switched to ustekinumab, 3 switched to risankizumab, and 3 continued with their shortened-interval regimen because of patient/physician preference or to maintain the improvement they had.

There were 3 (11.1%) reported AEs, including 1 case of common cold in 1 individual and 1 case of gastrointestinal-related symptoms (nausea, vomiting), headache, and dizziness in the same individual. Our study failed to show that the shortened interval resulted in greater AEs than the standard regimen based on phase 3 trials.[2-4]

Limitations to this study include the retrospective nature of the study and the relatively small sample size. This study was a retrospective analysis, and therefore, during their assessment, dermatologists did not record all outcomes (eg, PASI) at each visit. This led to incomplete data documentation for some of the patients in our study. Moreover, there were 2 different increased shortened-interval dosing regimens: 100 mg every 6 weeks and 100 mg every 4 weeks. This may have contributed to the diversity of the values obtained.

Further larger studies are needed to determine if a shortened dosing interval can be useful for patients who do not respond to the standard dosing regimen of guselkumab.

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