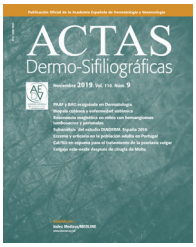
ACTAS Dermo-Sifiliográficas 113 (2022) 995–996

ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

ACTAS Dermo-Sifiliográficas

Full English text available at www.actasdermo.org



CASE AND RESEARCH LETTER

Two Track Biologic Therapy for Concurrent Chronic Spontaneous Urticaria and Psoriasis Vulgaris in One Patient

Terapia biológica de dos vías para urticaria espontánea crónica concurrente con psoriasis vulgar en un paciente

Dear Editor:

Chronic spontaneous urticaria (CSU) is a mast cell mediated disease for which therapeutic options are relatively limited. For those with refractory disease anti-IgE antibody therapy is indicated.[2] Psoriasis vulgaris is a common, chronic inflammatory T cell-mediated condition.[1] For patients with a moderate to severe form of the disease biologic therapies present a mainstay of treatment.

A 57-year-old Caucasian male had a long-standing history of severe psoriasis vulgaris, which was unsuccessfully treated with topical therapy, acitetin and methotrexate. Afterwards, biologic therapy was introduced 6 years ago in the following order adalimumab, etanercept, infliximab, secukinumab, ustekinumab and adalimumab again. Each was discontinued due to insignificant clinical improvement. Initial screening laboratory analysis was within reference ranges and included a complete blood cell count, comprehensive metabolic panel (including liver function tests), hepatitis B and C, and QuantiFERON-TB Gold. Due to insignificant clinical amelioration with other biologic therapies for psoriasis, guselkumab was finally introduced. Prior to initiation of guselkumab diffuse erythematosquamous plaques, involving >50% of the body surface area were present and pitting and dystrophic changes of multiple fingernails were noted, without joint swelling. Significant clearance of psoriatic plaques ensued within 5 months after initiating treatment with guselkumab and the BSA was reduced to >5%.

Nine years ago the patient started noticing hives and the diagnosis of CSU was established. First line therapy with an increasing dose of a second generation H1 AH-levocetirizin was introduced. Due to a lack of clinical response, he was subsequently approved and treated with omalizumab with no interruption of biologic therapy for psoriasis. Disease severity was assessed using the 7-day Urticaria Activity Score (UAS-7) at baseline (prior to omalizumab administration) and at every application. Prior to the administration of omalizumab UAS-7 was 17 with a threefold dose of a second generation AH. He had improved symptoms after the first dose of omalizumab within 4 weeks, with UAS7-0 and reported interruption of AH therapy. After the first 6 month cycle the treatment with omalizumab was stopped with a subsequent worsening of his condition (UAS7-31). He was therefore approved for the 2 cycle and later for the 3 and 4 cycle. Significant improvement of symptomatic dermographism and pressure urticaria was also noted during therapy with omalizumab.

While receiving treatment with omalizumab the patient continued receiving different biologic therapies for psoriasis. First he received concurrently ustekinumab for a period of three months followed by adalimumab also for a period of three months. Both were discontinued due to a lack of a clinical response. Lastly a treatment attempt with guselkumab was made, which led to significant clinical remission. The patient obtained a full response for CSU while receiving treatment with omalizumab. The patient received two track biologic therapy with guselkumab and omalizumab for a period of twenty-one months. Due to a lack of information about the administration of two track biologic therapies the patient was frequently monitored at our outpatient clinic. Two track antibody therapies were well tolerated by the patient, no clinically relevant adverse effects and drug interactions were registered. The patient is still receiving both therapies so an extended time is observed.

To the best of our knowledge this is the first case of one patient receiving concurrent biologic therapy with ustekinumab/adalimumab/guselkumab and omalizumab. Little is known about the concomitant use of different antibodies for psoriasis and CSU and their potential adverse effects. Therefore careful examination of the risks and benefits of administering two biological agents in the management of two separate conditions is mandatory prior to application, followed by regular clinical and laboratory monitoring of the patient. Our case shows that concomitant use of two biologic therapies for psoriasis and CSU appears to be well tolerated, without clinically significant side effects.

https://doi.org/10.1016/j.ad.2021.02.029

Conflicts of interest

Tomaz Lunder: participated in clinical trials sponsored by Abbvie, Janssen, Roche and Schering Plough/MSD.

Consultatnt/speaker for Abbott/Abbvie, Eli Lilly, Janssen, Pfizer, Schering Plough/MSD.

Speakers bureau/advisory board member of Abbott/Abbvie, Eli Lilly, Janssen, Pfizer, Roche, Schering Plough/MSD.

Maja Benko: consultant and speaker for Sanofi and Novartis.

Bor Hrvatin Stancic: has no conflicts of interest to declare.

References

1. Zuberbier T, Aberer W, Asero R, Abdul Latiff AH, Baker D, Ballmer-Weber B, et al. The EAACI/GA^{2}LEN/EDF/WAO guideline for the definition, classification, diagnosis and management of urticaria. Allergy. 2018;73:1393–414, http://dx.doi.org/10.1111/all.13397.
2. Boehncke W-H, Schön MP. Psoriasis. Lancet. 2015;386:983–94, http://dx.doi.org/10.1016/S0140-6736(14)61909-7.

M. Benko[a,*,1,◊], B. Hrvatin Stancic[a,1,◊], T. Lunder[a,b,1,◊]

[a] *Dermatovenerology Department, University Medical Centre Ljubljana, Slovenia*
[b] *Faculty of Medicine, University of Ljubljana, Slovenia*

* Corresponding author.
E-mail address: bor.hrvatin.stancic@kclj.si (M. Benko).
◊ The authors have equally contributed to the manuscript.
◊ All authors read and approved the final version of the manuscript.