HEALTH POLICY AND PRACTICE

Establishing consensus on defining failure of topical therapy in psoriasis: Recommendations from the International Psoriasis Council

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Early and effective treatment in psoriasis mitigates cumulative chronic disease burden and may prevent psoriatic arthritis and cardiovascular comorbidities. Consequently, achievement of clear or nearly clear skin has been adopted as a treatment target (Table I). However, patients with psoriasis who require systemic therapy are sometimes initiated on topical treatment, which often fails to bring them to the recommended treatment goals. The categorization of disease severity by the International Psoriasis Council guides topical therapy use, discouraging overuse by stating that patients are either candidates for topical treatment or systemic therapy, the latter meeting one of three criteria: (1) body surface area (BSA) >10%, or (2) psoriasis involving a high-impact site, or (3) failure to respond to topical treatment.[1]

Results from several surveys, such as the international UPLIFT study, illustrate the global undertreatment of psoriasis. Interestingly, over half of the patients in this survey with less than 3% BSA rated their disease as either moderate or severe, but received only topical or no treatment.[2] Patients on topical treatments reported a median therapy duration of 5 years.[3] Although national guidelines underscore the goal of achieving clear skin and cite topical treatment failure as a reason for transitioning to systemic therapy, they usually fail to clearly define what constitutes topical treatment failure (Table II). One recent attempt by an independent panel of 45 Japanese clinical experts defined topical treatment failure as: (1) persistent symptoms and plaques, (2) poor patient satisfaction, or (3) a need to increase medication quantity or application time after treatment with two topical treatments, each used for four consecutive weeks.[4]

The International Psoriasis Council's Disease Severity Working Group proposes the following guidance for topical treatment failure: inability to achieve

Abbreviation used:

BSA: body surface area

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Table I. Treatment targets according to national guidelines and expert groups [https://psoriasiscouncil.org/disease-severity-tables/]

	Outcome measure					Source		
Region Country	**% PASI**	**PASI (res)**	**BSA (res)**	**DLQI**	**PGA**	**National guideline**	**Expert group**	**Time frame**
Africa/Eastern Mediterranean								
Saudi Arabia	≤90	≤3			0/1		X	
Europe								
Denmark		≤3				DDS		
Europe	≤90-100	≤2		≤2	0/1	EDF		
France	≤90	≤3		0/1		FSD		
Germany*	≤90	≤3		≤2		DDG		
Italy	≤90	≤3					X	3-4 mo
Poland	≤90					PDS		
Portugal	≤90	≤2				SPVD		
Spain	≤90	≤3-5	Minimal	0/1	0/1	SADV		
Switzerland†	≤75			≤5		SSDV		
UK		≤2			0/1	BAD		
Latin America/Caribbean								
Argentina‡	≤90	≤3		0/1	0/1	SAD		
Brazil@	90-100	≤3	≤3	0/1	0/1	SBD		
Colombia	≤90	≤3				ACD		
	≤75§			≤5§		ACD		
North America								
Canada		≤3	≤1		0/1		X	
Canada	≤75					CDA		
USA			≤1			NPF		3 mo
Southeast Asia/Western Pacific								
Australia	≤90	≤3			0/1	ACD		
China	≤90-100				0/1	CSD		
Japan	≤90	≤2		0/1		JDA		
Malaysia			≤3	≤5		DSM		

ACD, Australian College of Dermatologists; *ACDD*, Asociación Colombiana de Dermatología y Cirugía Dermatológica; *BAD*, British Association of Dermatologists; *BSA*, body surface area; *BSA res*, residual BSA; *CDA*, Canadian Dermatology Association; *DDG*, Deutsche Dermatologische Gesellschaft; *DDS*, Danish Dermatological Association; *DLQI*, Dermatology Life Quality Index; *DSM*, Dermatologic Society of Malaysia; *EDF*, European Dermatology Forum; *FSD*, Frech Society of Dermatology; *JDA*, Japanese Dermatological Association; *NPF*, National Psoriasis Foundation; *PASI*, Psoriasis Area and Severity Index; *PASI res*, residual PASI; *PDS*, Polish Dermatological Society; *PGA*, Physician's Global Assessment; *SAD*, Sociedad Argentina de Dermatologia; *SADV*, Spanish Academy of Dermatology and Venereology; *SBD*, Sociedade Brasileira de Dermatologia; *SCD*, Chinese Society of Dermatology; *SPVD*, Portuguese Society of Dermatology and Venereology; *SSDV*, Swiss Society of Dermatology and Venereology.

*There is an ongoing discussion within DDG.

†A potential future goal of reaching PASI90 within 52 weeks after starting therapy seems achievable with newer therapies.

‡PASI 75 can be accepted as minimum treatment maintenance index if patient has no negative impact in quality of life.

§Combination required.

clear/nearly clear skin (BSA ≤1%, Physician's Global Assessment 0 or (1) after two consecutive 4-week topical therapy courses, per guidelines. Strong consideration should be given when a patient self-reports moderate or severe psoriasis, despite a provider's mild assessment, and experiences significant physical, psychological, or social impact. If effective and well-tolerated, topical treatments may be used for prolonged periods. However, potent corticosteroids should not be used continuously for more than 4 weeks, and superpotent ones should be limited to 2-4 weeks,[5] with failure in this period suggesting the need to transition the patient to either ultraviolet phototherapy or systemic therapy, and topicals continued as adjuvants for recalcitrant lesions.

This statement may guide treatment decisions, which should align with regional guidelines and be tailored to specific clinical scenarios, including age, comorbidities, presentation, and adherence. Also, when effective systemic therapies are inaccessible, continuing topical treatments, even if less effective, may be appropriate, provided they are customized to the patient's clinical profile and regional recommendations. In countries where the Psoriasis Area and

Table II. National guidelines and transitioning from topical to systemic treatment [https://psoriasiscouncil.org/disease-severity-tables/]

All guidelines emphasize topical failure as a key indicator for systemic escalation, but exact definitions vary:

- None specifies a minimum duration or number of topical treatments before deeming them inadequate.
- Terms like "inadequate control" or "failure" are interpreted in the context of extent, location, impact on quality of life, and response to previous therapies.

Country	Guidance (year)	When to switch to systemic treatment
United States	AAD-NPF guidelines (2018-2021)	Systemic therapy indicated if >5-10% BSA involved or if topical treatments fail to achieve control. Also, if psoriasis affects high-impact sites (hands, face, genitals, etc.) or causes significant life impact.
United Kingdom	NICE guideline (2012, updated)	If topicals are inadequate and disease has significant impact. e.g. >10% BSA or PASI >10, or localized severe sites (nails, scalp, etc. with functional impairment), or rapid relapse after other therapy.
Canada	CDA guidelines (2009 + 2016 addendum)	If topical agents no longer suffice to control disease.
Europe	EuroGuiDerm (2023, updated 2025)	Failure of topical treatments.
France	SFD psoriasis guidelines (2019)	Systemic therapy (incl. phototherapy) indicated if >10% BSA or PASI >10 or DLQI >10, or if significant physical/psychological impact, or if localized disease not controlled by topicals (e.g. severe nail, scalp, palmoplantar or genital psoriasis).
Denmark	DDS guidelines (2023)	Insufficient efficacy of topical treatment in adults is defined as insufficient efficacy of daily use of a class 3-4 topical steroid or a combination of topical steroid and calcipotriol for 4 wk, possibly extended to 8 wk after assessment.
Australia	ACD guidelines (2024)	Psoriasis worsens during topical treatments

AAD, American Academy of Dermatology; *ACD*, Australasian College of Dermatologists; *BSA*, body surface area; *CDA*, Canadian Dermatological Association; *DDS*, Danish Dermatological Association; *DLQI*, Dermatology Quality of Life Index; *NICE*, National Institute for Health and Care Excellence; *NPF*, National Psoriasis Association; *PASI*, Psoriasis Area and Severity Index; *SFD*, Société Française de Dermatologie.

Severity Index is used in routine practice, nearly clear skin can be defined per local recommendations related to this outcome measure. After an appropriate topical therapy trial, patients transitioning to either ultraviolet phototherapy or systemic therapy may more predictably achieve clear or nearly clear skin, reducing frustration and minimizing the lifelong burden of psoriasis.

Conflicts of interest

Dr Strober is a consultant (honoraria) for AbbVie, Alumis, Almirall, Amgen, Apogee, Arcutis, Boehringer Ingelheim, Bristol-Myers-Squibb, Capital One, CorEvitas, Dermavant, Immunovant, Janssen, Leo, Eli Lilly, Maruho, Oruka, Meiji Seika Pharma, Protagonist, Takeda, Novartis, Pfizer, UCB Pharma, Rapt, Regeneron, Sanofi-Genzyme, and Union Therapeutics. Owns stock options in Connect Biopharma and Mindera Health. They are a speaker for AbbVie, Arcutis, Dermavant, Eli Lilly, Incyte, Janssen, Regeneron, Sanofi-Genzyme. Receives consulting fees as a Scientific Co-Director from CorEvitas Psoriasis Registry. They are an Investigator for CorEvitas Psoriasis Registry. There are an Editor-in-Chief (honorarium) for the Journal of Psoriasis and Psoriatic Arthritis.

Dr Blauvelt has served as a speaker (received honoraria) for Eli Lilly and Company, UCB, and Almirall, has served as a scientific adviser (received honoraria) for AbbVie, Almirall, Alumis, Amgen, Anaptysbio, Apogee, Arcutis, Astria, Boehringer Ingelheim, Bristol Myers Squibb, Celltrion, Corvus, Dermavant, Eli Lilly and Company, Galderma, GlaxoSmithKline, Immunovant, Incyte, IQVIA, Janssen, Leo, Lipidio, Merck, Novartis, Oruka, Paragon, Pfizer, Rani Therapeutics, Regeneron, Sanofi, Spherix Global Insights, Sun Pharma, Syncona, Takeda, UCB, Union, and Zai Lab, has acted as a clinical study investigator (institution has received clinical study funds) for AbbVie, Acelyrin, Almirall, Alumis, Amgen, Arcutis, Boehringer Ingelheim, Bristol-Myers Squibb, Dermavant, Eli Lilly and Company, Galderma, Incyte, Janssen, Leo, Merck, Novartis, Pfizer, Regeneron, Sanofi, Sun Pharma, Takeda, and UCB, and owns stock in Lipidio and Oruka.

Dr Kerkhof has received fees for consultancy services or lectureships from Almirall, Eli Lilly, Novartis, Janssen Pharmaceutical, Bristol-Myers Squibb, UCB, Boehringer Ingelheim, Centrion, and Sandoz.

Dr Asawanonda has received honoraria as a speaker from Boehringer Ingelheim, Eli Lilly, Novartis, Janssen, LEO Pharma, Pfizer, Sanofi, Kyowa Kirin, Beiersdorf, and LaRoche Posay. For consultancy or advisory board from

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Dr Chandra has no conflicts of interest to declare.

Dr González-Cantero has served as a consultant for and received speaker fees from AbbVie, Janssen, Amgen, Novartis, Almirall, Boehringer Ingelheim, Celgene, BMS, UCB, L'Oreal, MSD, and Leo Pharma.

Dr Gonzalez has served as a consultant for and received speaker fees from AbbVie, Janssen, Novartis, Eli Lilly, L'Oreal, and Boehringer Ingelheim.

Dr Matlock has served as a consultant for and received speaker fees from AbbVie, Janssen, Novartis, Pfizer, L'Oreal, Leo Pharma, Merck Sharp and Dome, Glaxo Wellcome, SmithKline Beecham, and Sanofi.

Dr Maul has served as advisor and/or received speaking fees and/or participated in clinical trials sponsored by AbbVie, Almirall, Amgen, BMS, Celgene, Eli Lilly, Incyte, Janssen-Cilag, LEO Pharma, MSD, Novartis, Pfizer, Pierre Fabre, Roche, Sanofi, Takeda, and UCB.

Dr Rob has received honoraria as a speaker and/or consultant for AbbVie, Almirall, Amgen, Boehringer Ingelheim, Bristol Myers Squibb, Eli Lilly, Johnson and Johnson, Leo Pharma, Novartis, MSD, Pfizer, Sanofi Genzyme, and UCB.

Dr Torres has received consultancy and/or speaker's honoraria from and/or participated in clinical trials sponsored by AbbVie, Amgen, Almirall, Apogee Therapeutics, Arena Pharmaceuticals, Biocad, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, Celgene, Fresenius-Kabi, Johnson & Johnson Innovative Medicine, LEO Pharma, Eli Lilly, MSD, Mylan, Novartis, Pfizer, Samsung-Bioepis, Sanofi-Genzyme, Sandoz, STADA, and UCB.

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