Management of moderate-to-severe psoriasis in patients with cancer: Guidance from the International Psoriasis Council

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To the Editor: The management of moderate-to-severe psoriasis in patients with cancer is challenging due to concerns that systemic treatments may adversely affect tumor behavior, increasing the risk of progression and/or recurrence. Evidence to guide decision-making remains limited because these patients are excluded from clinical trials, and available data are limited to observational studies.[1] Here, the International Psoriasis Council provides guidance on treatment selection for patients with psoriasis and cancer.

Therapeutic decisions are made collaboratively with the oncologist and are guided by the patient's overall clinical and oncologic status. Key considerations include the presence of treatment- or disease-related leukopenia or lymphopenia, the impact of systemic corticosteroids on immune function and psoriasis, and scenarios in which psoriasis either worsens or newly appears as an immune-related adverse event during oncologic immunotherapy.

The first decision for the dermatologist is whether and when to initiate systemic therapy for psoriasis in patients with current or prior malignancy. These criteria should be consistent with those established by the International Psoriasis Council (Table I).

There is no evidence that systemic therapies for moderate-to-severe psoriasis increase the risk of tumor progression or recurrence in patients with cancer, with the exception of cyclosporine, which is associated with increased risk of non−melanoma skin cancer (NMSC).[2] However, it is reasonable to preferentially select therapies with lower immunosuppressive potential (Fig 1).

Phototherapy is a safe option, except for patients with melanoma and NMSC history. Acitretin, methotrexate, dimethylfumarate, and apremilast could be considered, although their efficacy and tolerability/safety profiles are less favorable than those of biologics.

Regarding biologics, interleukin (IL) 12/23, IL-17, and IL-23 inhibitors have not been associated with increased risk of malignancy.[3] Mouse models provide circumstantial evidence that inhibition of IL-17 and IL-23 may reduce tumor progression and that IL-12 contributes to tumor immune surveillance. A slight increase in the risk of lymphoma and NMSC is associated with tumor necrosis factor inhibitors,

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Table I. Criteria for systemic psoriasis therapy in patients with cancer

According to the International Psoriasis Council, patients who meet one or more of the following criteria are candidates for systemic therapy:	
1	Psoriasis lesions on ≥10% of body surface
2	Psoriasis lesions on high-impact sites (ie, hands/feet, face, genitals, and scalp)
3	Topical therapy failed to control symptoms: inability to achieve clear/nearly clear skin (BSA ≤1%, PGA 0 or 1) after 2 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

The data in Table I were obtained from https://psoriasiscouncil.org/ipc-resources/disease-severity.

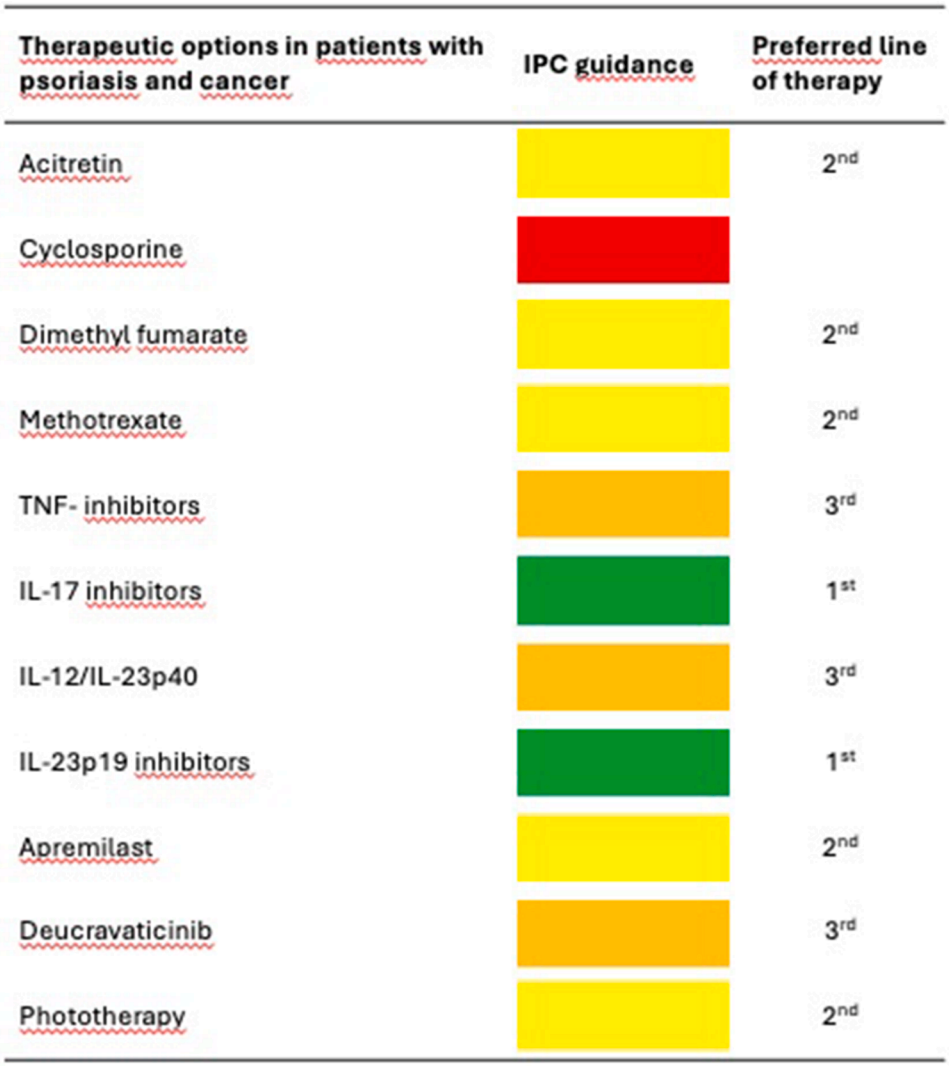

Fig 1. Therapeutic options in patients with psoriasis and active and/or history of cancer according to International Psoriasis Council guidance (https://psoriasiscouncil.org/therapeutic-options-for-cancer/). A *green* box indicates a first-line treatment option; a *yellow* box indicates a second-line treatment option; an *orange* box indicates a third-line treatment option; and a *red* box indicates a contraindication.

but this is possibly disease and not drug related.[3,4] Also, in randomized clinical trials, lymphoma and NMSC have been reported in patients treated with deucravacitinib (www.ema.europa.eu/en/documents/assessment-report/sotyktu-epar-public-assessment-report_en.pdf). According to the summary of product characteristics, active malignancy is not a contraindication to any biologic; cautious use is advised with tumor necrosis factor and IL-12/IL-23 inhibitors.

In our opinion, IL-17 and IL-23 inhibitors (including the oral peptide icotrokinra) should be considered as first-line treatment, although the recommendation for icotrokinra is based on its mechanism of action rather than on clinical evidence. With lower efficacy, acitretin, methotrexate, apremilast, and phototherapy may be considered, particularly if first-line treatments are unavailable. Ustekinumab and deucravacitinib may represent third-line treatment options owing to IL-12 inhibition and type 1 interferon impairment and the still-limited long-term data for deucravacitinib. A slight increase in NMSC and lymphoma have been reported in patients treated with tumor necrosis factor inhibitors.[3,4] Cyclosporine should be avoided because of its broad immunosuppressive effects. In a recent International Psoriasis Council survey, apremilast, IL-17 inhibitors, and IL-23 inhibitors were the preferred therapies in patients with active malignancy.[5]

In conclusion, dermatologists, aiming to improve diminished quality of life related to skin disease, play a critical role in caring for patients with cancer who require systemic therapy for their skin disease.

Declaration of Generative AI and AI-Assisted Technologies in the Writing Process

Not used.

Conflicts of interest

Dr Gisondi has received honoraria as consultant and/or speaker for AbbVie, Almirall, Bristol Myers Squibb, Eli Lilly, LEO Pharma, Janssen, Novartis, Pfizer, Takeda, and UCB. Dr Carrascosa has received consultancy/speaker's honoraria from and/or participated in clinical trials sponsored by AbbVie, Almirall, Amgen, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, J&J Innovative Medicine, Novartis, Pfizer, Galderma, Sanofi, LEO Pharma, Eli Lilly, Novartis, Pfizer, and UCB. Dr Jo has acted as an advisor, speaker, or consultant for and/or received research grants from AbbVie, Boehringer Ingelheim, Bristol Myers Squibb, Celltrion Healthcare, Daewoong, Eli Lilly, Green Cross Laboratories, Janssen, Kolon Pharma, LEO Pharma, Novartis, Pfizer, Sanofi, Takeda, UCB, and Yuhan. Dr Puig has received consultancy/speaker's honoraria from and/or participated in clinical trials sponsored by AbbVie, Almirall, Amgen, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, Fresenius-Kabi, Horizon (DSMB), J&J Innovative Medicine, LEO Pharma, Eli Lilly, Novartis, Pfizer, Samsung-Bioepis, STADA, Sun-Pharma, Takeda, and UCB. Dr Ryan has served as a consultant, advisor, or speaker for AbbVie, Allergan, Bristol Myers Squibb, UCB, FIDE, Janssen, Leo, and Eli Lilly. 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, J&J Innovative Medicine, LEO Pharma, Eli Lilly, MSD, Mylan, Novartis, Oruka, Pfizer, Samsung-Bioepis, Sanofi-Genzyme, Sandoz, STADA, Takeda, and UCB. Dr van de Kerkhof received fees for consultancy services or lectureships from Almirall, Eli Lilly, Novartis, Janssen Pharmaceutical, Bristol Myers Squibb, UCB, Boehringer Ingelheim, Celltrion, and Sandoz. Dr Vesely has received consulting fees from SunPharma and Priovant. Dr Maskin has received consultancy/speaker's honoraria from and/or participated in clinical trials sponsored by AbbVie, Amgen, Boehringer Ingelheim, Bristol Myers Squibb, MSD, Adium, L'Oreal, J&J Innovative Medicine, Eli Lilly, Pfizer, Cantabria Labs, Celldex, Takeda, and Sanofi.

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