(QoL) tools such as the Dermatology Life Quality Index (DLQI) have been used in HS studies.[2] These are widely available, easy to administer and allow for comparison with other skin diseases.[3] Nonetheless, these tools have major limitations.

Dermatology generic QoL tools have not been properly validated for use in HS. There are also concerns the psychometric properties are not in keeping with current standards for the development of QoL tools.[4] More importantly, HS has unique symptoms such as pain and malodorous discharge not necessarily appropriately captured by generic tools. Recently, an international panel of patients and healthcare providers made a recommendation for pain to be one of five domains measured in future hidradenitis suppurativa clinical trials.[5]

Pain scores such as a pain visual analogue scale have been used in several HS studies.[2] These tools have been thoroughly validated in chronic musculoskeletal pain and provide a quick method to document pain numerically and compare pain over time and between patients. However, there are gaps in understanding the characteristics and factors influencing pain perception in HS.

The current article by Nielsen *et al.* is a step in the right direction. The pain characterization will hopefully inform the development of a disease-specific QoL tool. Another important finding is that patients with HS who have psychiatric comorbidities had more intense pain. Dermatologists should consider psychiatric comorbidity in patients with HS where there is a discrepancy between disease activity/severity and reported pain intensity. Another implication is an adjustment for psychiatric comorbidity might be needed in assessing improvement in pain scores in future clinical trials.

Conflicts of interest

None to declare.

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Secukinumab without the initial loading dose in the treatment of plaque-type psoriasis – a simplified dosing regimen at the expense of efficacy?

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Linked Article: Gisondi *et al.* Br J Dermatol 2020; **182**:175–179.

Treatment of psoriasis vulgaris, a chronic and as yet incurable disease, has been revolutionized by the introduction of biological therapies in the early 2000s.[1] Newer biologics such as the interleukin (IL)-17 or IL-17RA antagonists or IL-23p19 inhibitors allow for Psoriasis Area and Severity Index (PASI) 90 response rates of up to 80% after 52 weeks.[2,3] Most biologics have an induction phase in which the treatment is given in shorter time intervals and/or at increased doses to accelerate the therapeutic response and thus to enhance patients' adherence to treatment. Whereas many studies present data on the short-term outcome only, long-term results such as PASI or Physician Global Assessment at week 48 or later are in general of much greater relevance for patients and physicians given the chronicity of the disease.

Secukinumab is a first-in-class fully human monoclonal antibody against IL-17A for chronic plaque psoriasis administered by subcutaneous injections at the labelled dose of 300 mg at weeks 0, 1, 2, 3, 4 (loading dose) and every 4 weeks thereafter (maintenance dose).[4]

In this issue of the BJD, Gisondi *et al.* report on a retrospective observational study from Italy on the efficacy of secukinumab with or without an initial loading dose in individuals with chronic plaque-type psoriasis.[5] The study comprised 156 subjects who were alternately assigned to one of these two regimens. The two groups of patients were well matched with respect to psoriasis severity as well as age, sex, weight and duration of psoriasis. Of note, almost 50% of the participants had concomitant psoriatic arthritis and half of the patients had previously been treated with an antitumour necrosis factor-α blocking agent and/or ustekinumab. Patients not receiving the loading dose had a significantly lower response at weeks 8 and 12 and discontinued treatment significantly more often by week 8 because of lack of efficacy compared with patients treated according to the labelled dose (25% vs. 13%). Interestingly, lack of response was significantly associated with a

higher body weight. However, when looking at later time points, the difference in efficacy between the two treatment groups levelled off and was insignificant from week 16 onwards until week 48.[5]

Due to the uncontrolled retrospective study design and the particular characteristics of the study cohort the findings of this study need to be interpreted with caution but might nevertheless have a significant bearing on the future treatment of patients with psoriasis with secukinumab. A simplified administration schedule that omits the loading dose not only is much more comfortable for the patients but also associated with significant costs savings. These advantages are counterweighed by a slower onset of the therapeutic response and a higher rate of premature discontinuation of treatment. However, in the latter context it is important to point out that Gisondi *et al.* treated a selected group of severely affected patients with long-standing disease. It is thus conceivable that the therapeutic advantage of an initial loading dose will be much lower or even negligible in biological-naïve patients, patients without associated psoriatic arthritis and, in particular, patients of normal weight. A prospective randomized, controlled trial is required to confirm the findings of this study and to better delineate which patients are candidates for secukinumab without the initial loading dose.

Conflicts of interest

None to declare.

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How I learned to stop worrying about antidrug antibodies

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Since the first approval of etanercept for psoriasis in 2004, ten additional biologics have entered this therapeutic area, six of which have been introduced within the past 3 years. In this crowded market it is increasingly difficult to differentiate between the competing drugs. Recent biologics share common targets [interleukin (IL)-23 or interleukin-17 pathways], differences in efficacy are very small and safety is excellent. However, even the most efficacious biologics fail to achieve ≥ 90% improvement in the Psoriasis Area and Severity Index (PASI 90) in approximately 30% of patients and an additional 20–30% will lose efficacy long term.[1,2] Predictive biomarkers forecasting individual response to the therapy or long-term success would be an important differentiator, enabling cost- and time-savings through the personalized approach.

Therapeutic drug monitoring involving measurements of drug levels and antidrug antibodies might constitute such a biomarker and has already been adopted to optimize therapy for inflammatory bowel disease with anti-tumour necrosis factor-α agents.[3,4] This issue of the *BJD* includes an important article by Kimball *et al.*[5] that examines the impact of therapeutic drug monitoring of tildrakizumab, the most recently approved therapeutic antibody neutralizing the p19 subunit of IL-23. The authors have reviewed pharmacokinetic data and the presence of neutralizing antidrug antibodies (nADA) in 1400 participants from three randomized clinical trials. Their results document that the occurrence of nADA is a very rare phenomenon. Only eight patients (0.6%) developed nADA short term (up to week 16), which increased to a mere 2.8% (22/780) during long-term observation beyond week 52 of treatment. Patients with nADA tended to have lower blood concentrations of tildrakizumab and also lower clinical efficacy measured by an absolute reduction in PASI (~75% reduction in patients without nADA vs. 38% and 62% reductions in patients with nADA treated with 200 mg and 100 mg tildrakizumab, respectively).

The reassuring conclusion from this study is that incidence of nADA in patients treated with tildrakizumab is very low and is not a limiting factor that one should worry about in clinical practice. These results question the clinical usefulness of nADA assays for tildrakizumab. It is easily proven by a Bayesian approach that even the 99% specific and sensitive test for nADA would have a low prognostic value, as any positive result is likely to be false.[6] Assuming true 0.6% prevalence of nADA, the probability that a patient who tested positively actually developed nADA is only 34%, which is inferior to a random coin toss. In other words, ordering the test to 1000