Treatment of erythrodermic psoriasis with apremilast

To the Editor: Apremilast is a phosphodiesterase 4 inhibitor that blocks proinflammatory effects and promotes anti-inflammatory effects of immunologic cells.[1] We were pleased to read about the success of Jeon et al[2] in using it for treating patients with multiple comorbidities for generalized pustular psoriasis. Similarly, we found meaningful results when patients with numerous comorbidities were treated with apremilast for erythrodermic psoriasis (EP), and we believe that many would find our cases worth reviewing.

There remains a paucity of data on the best treatment for EP. Historically, cyclosporine has been the first-line therapy, with methotrexate and acitretin as close seconds only because of their slower onset of action.[1,3] More recently, biologics such as infliximab and ustekinumab have been at the forefront of treatment for EP.[3] Although not currently recognized as a first-line agent, we found that the oral agent apremilast offers promise in the treatment of EP as well.

We followed up 2 patients with debilitating EP involving more than 95% of body surface area (BSA) in patient A (Fig 1) and 65% BSA in patient B. Patient A was a 34-year-old woman with a past medical history of psoriasis, presence of chronic surface antigen, presence of core antibody, noncirrhotic hepatitis B, bipolar disorder, morbid obesity, acute *Streptococcus agalactiae* and methicillin-resistant *Staphylococcus aureus* bacteremia, and pulmonary embolus initiated on anticoagulation therapy. Patient B was a 49-year-old woman with a past medical history of psoriasis, iron-deficiency anemia, uterine fibroids, and severe cervical dysplasia status after total abdominal hysterectomy, who was not compliant with an initial cyclosporine regimen. She was transitioned to methotrexate, which was quickly discontinued because of hematologic side effects. As illustrated above, each patient presented with multiple comorbidities, acute illnesses, and/or intolerance to other treatments, making them poor candidates for traditional therapies, including methotrexate, acitretin, cyclosporine, and biologic therapy. Consequently, each patient was started on apremilast in addition to topical triamcinolone ointment 0.1%, and we found excellent results. One month after the initiation of treatment, patient A's BSA involvement decreased to less than 15% (Fig 2), and patient B's BSA involvement decreased to merely 3% in that same timeframe.

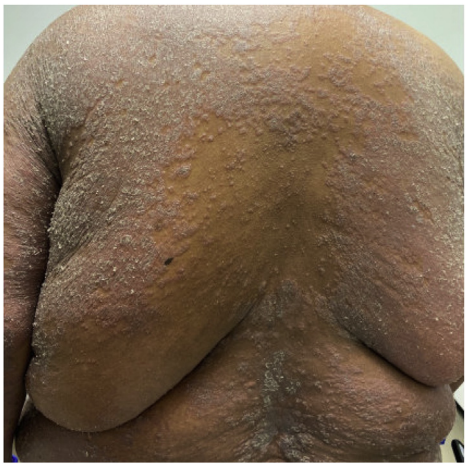

Fig 1. Extensive erythematous plaques with adherent scaling on the back of patient A.

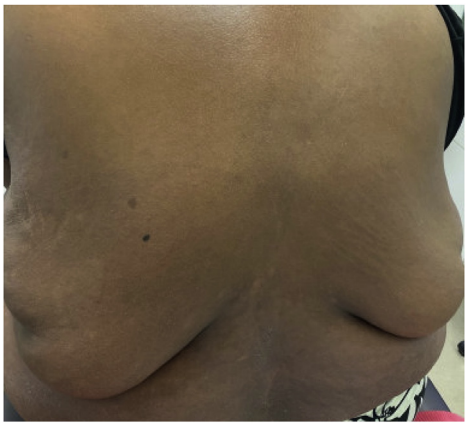

Fig 2. Clearance of erythrodermic psoriasis of patient A after 1 month of therapy.

To our knowledge, 3 case reports have been published, in which apremilast monotherapy was used for the treatment of EP.[1,2,4,5] Apremilast is well tolerated and offers a mild side-effect profile compared with biologics and immunosuppressants.[1]

In summary, we believe that apremilast shows promise for patients with multiple comorbidities and is unreliable in terms of follow-up for drug monitoring. However, further studies are required to confirm its efficacy to endorse its use as a recommended treatment for EP.

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Conflicts of interest

Dr Grieshaber is a speaker for Galderma. Dr Gioe, Author Savoie, and Dr Hilton have no conflicts of interest to declare.

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