Dermatology Practical & Conceptual

Palmoplantar Psoriasis Resistant to Adalimumab Successfully Treated with Bimekizumab

Emanuele Trovato[1], Martina Dragotto[1], Eugenio Capalbo[1], Pietro Rubegni[1]

1 Unit of Dermatology, Department of Medical, Surgical and Neurosciences, University of Siena, Siena, Italy

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Corresponding Author: Emanuele Trovato, MD, Unit of Dermatology, Department of Medical, Surgical and Neurosciences, University of Siena, Siena, Italy. Phone: +39-0577 585428. Fax: +39 0577 44238 E-mail: emanuele.trovato@unisi.it

Introduction

Palmoplantar psoriasis (PPP) can significantly impair a patient's quality of life, and it also tends to be resistant to conventional therapies [1]. This condition is therefore often difficult to diagnose and treat. Often a misdiagnosis of allergic contact dermatitis or keratoderma leads the patient to long courses of local and systemic steroid therapy, with no benefit. To date, several real-life experiences of PPP treated with biologic and systemic drugs have been reported. However, data with bimekizumab are still lacking.

Case Presentation

We report the case of a 68-year-old man with plantar and palmar hyperkeratosis that had been present for about a month despite therapy with biosimilar adalimumab started in 2021. The patient has a history of diabetes mellitus, hypercholesterolemia, and arterial hypertension. Psoriasis was diagnosed about 20 years earlier, and he had already been treated with cyclosporine and acitretin. In addition, the patient was already applying local therapy with 10% salicylic acid in occlusion, without benefit. The patient was very concerned about the worsening of his condition despite therapy with adalimumab and frustrated about the invalidation of his daily activities. On dermatological examination, the patient had significant palmar and plantar hyperkeratosis, nail involvement with the presence of distal subungual hyperkeratosis, pitting, and splinter hemorrhages (Psoriasis Area and Severity Index [PASI] 9; moderate PP-PGA; Nail Psoriasis Severity Index [NAPSI] 85; Dermatology Life Quality Index [DLQI] 24) (Figure 1). The patient reported intense associated painful and itchy symptoms. A microscopic examination ruled out possible concomitant mycosis. In agreement with the patient, we started therapy with bimekizumab 320 mg according to the induction and maintenance dosage

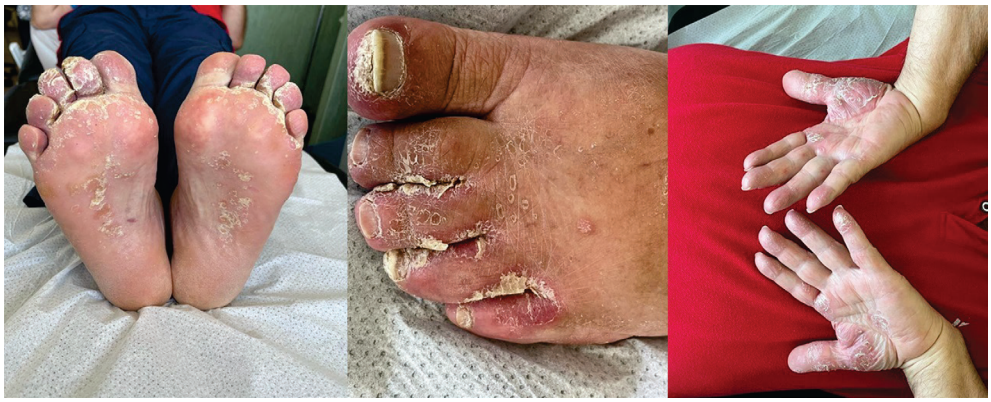

Figure 1. Palmar and plantar hyperkeratosis, nail involvement with the presence of distal subungual hyperkeratosis, pitting, and splinter hemorrhages (PASI 9; moderate PP-PGA; NAPSI 85).

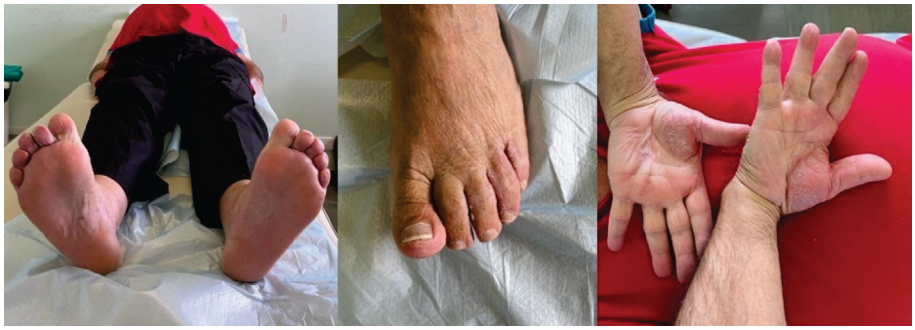

Figure 2. Almost complete resolution of skin manifestations with persistence of mild hyperkeratosis on the right foot and the left palm (PASI 2; mild PP-PGA; NAPSI 68).

schedule. The patient was prescribed topical emollients to reduce painful symptoms. Eight weeks later, we noted a marked improvement with almost complete resolution of skin manifestations, with persistence of mild hyperkeratosis on the right foot and the left palm (Figure 2). Given the short follow-up, it was possible to show just a mild improvement on nails (PASI 2; mild PP-PGA; NAPSI 68; DLQI 2). The patient also reported that he had not applied local emollients and that he had already noticed a progressive clinical improvement in the first two weeks. The patient is still in therapy with complete resolution at last follow-up visit.

Conclusion

Bimekizumab is a humanized IgG1 monoclonal antibody directed against IL-17A and IL-17F. Data from phase III clinical trials evaluated and assessed its safety and effectiveness in moderate-to-severe psoriasis. Real-life data on patients with psoriasis in particular sites or severe forms treated with bimekizumab are reported in the literature [2-6]. Within this cohort, patients with psoriasis at particular sites were also involved, although post-hoc analyses only on these patients were not performed. In our case, it is interesting to emphasize the rapidity with which the response was achieved, resulting in a fully satisfactory outcome for both patient and physician and limiting the use of local therapies. It is also crucial to emphasize the impact on patient quality of life, with a fairly complete reduction in DLQI in eight weeks. Undoubtedly, further studies and data are needed to confirm the efficacy and safety of bimekizumab in real life, especially in patients with PPP.

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