

Recently, I had a 14-year-old boy that came in, in a pretty bad state. They had about 75% body surface area. Their IGA score would be 4, severe-- lots of open, oozing, and, frankly, infected areas of skin. The patient was not sleeping. The patient was actually missing tons of school.

And they already had a 504 plan to get specialized educational needs met because of the lack of sleep and inability to concentrate at school, but now, at this point, missing school just because he felt terrible. And it was tough because the family had seen a number of different physicians and got told over and over, you just need to use more steroids.

But one of the hard parts was they were already using, to me, an alarming amount. They were going through a 1-pound jar of triamcinolone every week. And it was not enough. They had even used stronger potency ones in the past, fluocinonide and clotrimazole. But even that was not giving him full relief. He'd get a little better and then would flare right back up again.

So I felt this was tough. Now, another provider had started him on methotrexate, but he had a lot of GI upset. And the family, frankly, was really concerned about immunosuppressant.

So when I have a patient like this, I feel that already, I'm thinking we need to do something systemically, even something like a hospitalization for this patient. That might help temporarily, but I'm worried wet wrapping is not going to be enough alone to get them under control. Plus, I really want to give him a topical corticosteroid holiday, or at least, thinking about how we can do that.

So prednisone is out. We don't want to do that in this case. We could think about cyclosporine for sure, but the family's already expressing misgivings about immunosuppressants. So this is a situation where we know dupilumab is approved from a just 12 and up. For this situation, this is clearly a patient who has refractory disease.

And I would start talking to them immediately about using dupilumab and being very honest, though, that might not be the end of the story. They're still going to need good topical care, and they still may need some other things that might not fix them perfectly.

And, in fact, we know, even in the studies, about 80% of the patients did significantly better. And you can define that maybe as an easy 75 type of experience, so 75% or more improvement on one of the scales. But certainly, that's not 100%. And this may vary from population to population.

So I'm very sober about it. And I say this is what I think we should do next. But if that were not possible for this family, due to a number of reasons, if insurance is definitely going to be a problem, if the patient has needle phobia, then we need to think other directions. And this might be a situation where I would say we need to do some kind of decolonization, especially if there are frequent infections.

Here, both systemic antibiotics, as well as some topical approaches, can potentially decrease the amount of staph on the skin, which we know can be driving it. And we might use something like phototherapy if it's possible. Sometimes for families, it's simply not doable, given the family structure with their location and in cost. It's often covered by insurance, but can have a copay burden every single time, which gets expensive very, very quickly for families.

And these are the kinds of patients I see all of the time. For this particular patient that I have in mind, they were amenable to starting dupilumab. We were able to get that covered by insurance very quickly. I wrote a strong letter. I actually sent some photographs along. I wanted to be very clear that they understood.

And when I listed the things that he failed-- all the different topical corticosteroids, the topical calcineurin inhibitors, and a systemic immunosuppressant-- I think the company realized, well, this is the absolutely appropriate patient for this type of medicine. And I'm very excited that we finally have that in our armamentarium.