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Severity of psoriasis: time to disentangle severity from symptom control

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Dear Editor, The concept of severity in psoriasis is complex and has been subject to many divergent perspectives. Definitions of severity are important to patient wellbeing because they play a central role in framing treatment goals and determining eligibility for systemic treatment.

State of the art in psoriasis

The popular 'rule of 10s' classifies psoriasis as currently severe if patients present with body surface area (BSA) > 10% or Psoriasis Area and Severity Index score (PASI) > 10 or Dermatology Life Quality Index (DLQI) > 10.[1] As highlighted by Finlay in the original 2005 article, the rule of 10s does not account for the 'long-term severity' of psoriasis. In 2011, a European Delphi consensus process determined that moderate-to-severe psoriasis should be defined as (BSA > 10 or PASI > 10) and DLQI > 10.[2] Jointly, the American Academy of Dermatology (AAD) and National Psoriasis Foundation (NPF) defined moderate psoriasis as BSA between 3% and 10% and severe psoriasis as BSA > 10% or when special areas or emotional consequences are present.[3] In 2020, a consensus statement from the International Psoriasis Council (IPC) stated that patients should be dichotomized by their eligibility for systemic therapy, based on whether they present with BSA > 10% or have psoriasis in special areas or experience topical treatment failure.[4] The AAD-NPF and IPC formulations incorporate a temporal aspect of treatment history and recognize that threshold-based approaches are insufficient for categorizing 'mild' psoriasis in sensitive locations on the body. Most recently, German guidelines note that absolute thresholds of PASI ≤ 3 or DLQI ≤ 2 should be considered to define successful treatment.[5]

The importance of language: a conceptual issue

Today, many patients with moderate-to-severe psoriasis have a high likelihood of almost full skin clearance after initiating systemic therapy. This is a great accomplishment – but the language we use has not kept pace with the disruptive speed of therapeutic innovation.

If a patient experiences complete resolution of his or her severe symptoms, using current definitions, how should we classify this patient's psoriasis severity? How do we differentiate the long-term aspects of a systemic disease like psoriasis from short-term features such as treatment response and exacerbations? Conceptually and practically, there is a need to distinguish between current skin involvement and underlying phenotypic disease.

In asthma, patients are usually assessed in terms of both control and severity: The former relates to the degree that symptoms have been acceptably managed and the latter to the treatment intensity required to achieve control, impacted by the underlying disease activity and phenotype.[6] We advocate for a parallel approach to be used in psoriasis.

Clearly, well-controlled psoriasis is not synonymous with mild psoriasis. An extension of the language used to describe patients' disease activity and presentation is an important step in framing psoriasis and its treatment, ultimately empowering patients, payers and society.

Differentiating disease severity from symptom control

We propose the following approach to differentiate severity from control:

- **Moderate-to-severe psoriasis**: current or historical psoriasis signs and symptoms inadequately controlled by topical therapy.
- **Inadequate psoriasis control** (the patient meets at least one of the following criteria):
  - Currently presents with at least one of the following: BSA > 3%, PASI >3, DLQI >2.
  - Currently presents with psoriasis lesions on one or more special areas (e.g. hands, feet, scalp, face and genitals).
  - Currently presents with psoriasis that has a serious impact on the patient's psychosocial wellbeing.

This conceptualization incorporates recent consensus thinking in psoriasis with further subdivision into severity and control. The proposed criteria for control do not include relative improvement in symptoms (e.g. PASI 75), as baseline disease activity is usually unknown and because those with high pretreatment disease activity may not achieve an acceptable level of control despite achieving a relative improvement endpoint.[7] The proposed approach expands the precision with which physicians, decision-makers and patients can disentangle underlying disease severity from current skin involvement.

Application in the real world

Using the differentiated language of severity and control, physicians can improve the clarity when discussing patients' understanding of their disease and decisions around interventions. Consider a patient treated with a biologic presenting with low

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skin involvement (well-controlled psoriasis) on a given day, but with a history of high comorbidity burden relating to disease phenotype and systemic inflammation (moderate-to-severe psoriasis). Here, a treating physician might highlight the success of treatment by referring to the well-controlled skin lesions, while simultaneously communicating the importance of lifestyle interventions to reduce the risk of comorbidities given the patient's severe underlying disease. In this example, the physician can apply clear, differentiated language to help the patient understand their clinical situation.

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Conflicts of interest: K.G. is an employee, board member, and stock option holder in Quantify Research AB. M.S.-E. is responsible for dermatology in the project management for the national guidelines for psoriasis at the Swedish Board of Health and Welfare.

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