Psoriasis is one of the most common chronic inflammatory skin diseases, the management of which has been revolutionized over the past decade by the development of biotherapies (1, 2). Symptoms occur in 20–30% of patients before the age of 18 years (3). When considered mild, psoriasis in children and adolescents may be managed with topical treatments. For moderate-to-severe psoriasis, guidelines are rare and poorly applied, and management is frequently delayed (4–6).

Therapeutic inertia is the failure to initiate or intensify treatment in a patient even when recommended (7, 8). Already evaluated in chronic diseases (e.g., diabetes, multiple sclerosis, hypertension), this phenomenon is rarely considered in dermatology (9, 10). The aim of this study was to investigate therapeutic inertia among dermatologists treating moderate-to-severe plaque psoriasis in adolescents.

MATERIALS AND METHODS

This study was performed using a survey sent by e-mail to the 2,500 dermatologists who were members of the Fédération Française de Formation Continue et d’Evaluation en Dermatologie-Vénérologie (FFFCEDV) (www.fffcedv.org). FFFCEDV is a French association dedicated to medical education with over 83 local associations. A 3-part survey was sent out in November 2019, followed by 2 weekly reminder emails. The first part of the survey investigated the demographics and clinical practice of physicians, their medical education regarding psoriasis over the past year, and the number of adolescents seen per trimester. Only practitioners treating adolescents with psoriasis could access the next part of the survey, evaluating therapeutic inertia among dermatologists treating moderate-to-severe plaque psoriasis in adolescents.

DISCUSSION

Therapeutic inertia is a complex phenomenon influencing the daily management of patients with chronic pathologies (7). This study evaluated therapeutic inertia in the management of adolescents with uncontrolled moderate-to-severe plaque psoriasis. The study found that the origin of therapeutic inertia in the management of these adolescents was multifactorial. In particular, the following elements that contributed to the development of therapeutic inertia were identified: disease evaluation by the practitioner, type of treatment in place, parental aspects, and concerns raised by the adolescent or their healthcare system delays during usual practice, and concerns raised by the adolescent or their healthcare system delays during usual practice.

Table I. Reasons given to justify therapeutic inertia

| Reasons given by the dermatologists to justify therapeutic inertia | Table I |
|---------------------------------------------------------------|--------|
| Medical practice                                              | Yes n (%) |
| I need time before reassessing treatment                      | 88 (66.7) |
| Disease evaluation                                            |         |
| Favourable evolution of plaque psoriasis                      | 106 (80.3) |
| Psoriasis was too localized                                    | 82 (62.1) |
| Adolescent status                                             |         |
| The adolescent refused                                       | 109 (82.6) |
| Reluctance of the adolescent or their parents to start a new treatment | 93 (70.5) |
| The adolescent is satisfied with their current treatment, although this differs from your assessment of effectiveness | 91 (68.9) |
| Lack of motivation from the adolescent                         | 73 (55.3) |
| A recent change in treatment                                   | 73 (55.3) |
| Concomitant acute disease                                     | 73 (55.3) |
| The adolescent was unavailable (due to holidays, consultation hours, etc.) | 69 (52.3) |
| Parental aspects                                               |         |
| Refusal by the parents                                         | 93 (70.5) |
| A request from the parents exclusively                        | 73 (55.3) |
| Healthcare system                                             |         |
| The drugs are not licensed for adolescents                     | 80 (60.6) |

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Therapeutic Inertia in the Management of Moderate-to-Severe Plaque Psoriasis in Adolescents

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Dermatologists also feel comfortable informing adolescents about their disease (86.4%) and treatments (74.2%), distinguishing adolescents’ and parents’ requests (68.2%), and starting new treatment if necessary (51.5%); including phototherapy (77.3%), acitretin (68.2%) and methotrexate (63.6%). However, less than half felt comfortable prescribing other treatments or optimizing treatment when needed (Tables SII and SVI).

The dermatologists’ responses (positive response rate ≥ 50%) to the explanations for therapeutic inertia are detailed in Table I (all items in Table SVI). Responses for elements that could reduce therapeutic inertia (positive response rate ≥ 50%) are seen in Table II.
Finally, a discrepancy in the responses of dermatologists was noted: while dermatologists clearly expressed their desire for additional training and guidance in the management of these patients, such elements were not considered factors in therapeutic inertia. However, it is possible that better information from doctors regarding possible treatments, their effects and side-effects could play a role in the unwillingness of parents and adolescents to change medication. In the same way, information given by patients’ associations could play this role.

The main limitation of this study was the low response rate despite national dissemination to dermatologists, a relatively short questionnaire, follow-up contact, guaranteed confidentiality and academic sponsorship. Several factors may account for this low response rate: (i) most dermatologists, especially those in private practice, rarely see patients with childhood psoriasis (12); (ii) the high frequency of surveys offered to dermatologists may have discouraged potential respondents. This potential bias may explain why rates of therapeutic inertia attributed to the physician and the healthcare system were lower in this study than reported previously. These initial results could serve as a pilot for larger international studies, as the question regarding treatment inertia in adolescence with psoriasis is “universal”.

Additional studies on therapeutic inertia in adolescents with psoriasis, as well as in the young population with chronic dermatological diseases, are necessary to allow strategies to be disseminated. Guidelines for the management of adolescent patients with moderate-to-severe psoriasis should include information supporting specific education and training, in order to minimize therapeutic inertia.

Conflicts of interest. FC is a consultant and has received speaker remuneration from Celgene and Novartis. CN, RM and BH are consultants for Celgene. EM is a consultant, has been an investigator, and has received speaker remuneration from Novartis, AbbVie, Janssen Cilag, Lilly, Leo Pharma, Celgene, and Amgen. The other authors have no conflicts of interest to declare.

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Table II. Responses for elements that could reduce therapeutic inertiaa

| Elements that could reduce therapeutic inertia | Yes | n (%) |
|----------------------------------------------|-----|-------|
| Medical training and information             |     |       |
| Specific medical training on new treatments  | 123 | (93.2)|
| Specific medical training on adolescent psoriasis | 121 | (91.7)|
| Personal experience with other adolescents   | 119 | (90.2)|
| Guidelines for the management of plaque psoriasis in adults | 115 | (87.1)|
| Positive feedback from colleagues or patients | 108 | (81.8)|
| Adverse effects of treatments                | 102 | (77.7)|
| Adolescents and their family                |     |       |
| The adolescent’s dissatisfaction with his/her treatment | 117 | (88.6)|
| The adolescent’s insistence on changing treatment | 105 | (79.5)|
| The adolescent experiencing a major non-dermatological aggravation of symptoms | 97 | (73.5)|
| The presence of comorbidities                | 97  | (73.5)|
| The patient’s therapy is changing to often from treatment to treatment | 95  | (72.0)|
| Parent dissatisfaction with their child’s treatment | 79  | (59.8)|
| Parent insistence on changing treatment      | 73  | (55.3)|
| Healthcare system                           |     |       |
| Access to a multidisciplinary consultation meeting to make the decision | 99  | (75.0)|
| Access to primary prescriptions (rather than access being restricted to hospital dermatologists) | 77  | (58.3)|

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