Proven Efficacy of Tacrolimus for Facial and Intertriginous Psoriasis

We are writing in response to Bigby’s article in this issue of the Archives. Additional data for our original study separating facial and intertriginous psoriasis are provided herein in the Table. If you compare the active drug group with the placebo group for number of patients with only facial psoriasis whose total score was 0 for disease signs and symptoms for the target lesion at the end of the study, it is clear that tacrolimus treatment showed a statistically significant benefit: the lesions on 19 (42%) of 45 patients receiving active treatment cleared compared with those of only 1 (6%) of 17 vehicle-treated patients (P=.006). There was also a statistically significant benefit for intertriginous areas only: the lesions on 32 (48%) of 67 tacrolimus-treated patients cleared compared with those on only 5 (14%) of 37 vehicle-treated patients (P<.001).

See also page 1152

Dermatologists have long recognized the similarities of facial and intertriginous sites in their response to treatment and therefore treat those sites with the same medications, which are very different from the medications used to treat the trunk, scalp, and extremities. The prediction of the face and intertriginous sites for adverse effects of topical medications like corticosteroids or calcipotriene and the similarities of the face and intertriginous sites in responding more easily and quickly to psoriasis medications have been known for years. Substantial published literature going back more than 50 years has reported the similarities between facial and intertriginous skin. The areas are similar in penetration of topical medications, absorption of topical medications, and clinical response to therapies, in terms of both adverse and therapeutic effects. This is corroborated by many studies, including several cowritten by the author who designed the most recent study (M.L.).

We likewise disagree that the physician’s global assessment in our study was “not defined enough to be clinically interpretable.” The physician’s global assessment not only reliably distinguished between the active drug and placebo but also correlated perfectly with the static severity score. The severity score used in the tacrolimus trials has been used in dozens if not hundreds of clinical psoriasis studies. The data are presented with simple numerical scales that should be easily interpreted. Certainly, the information provided in the Table herein, showing an end point at which all signs and symptoms are clear, should be understandable to anyone and supports the results reported in the original article.

We hope the information presented here eliminates any questions about the efficacy of tacrolimus for facial and/or intertriginous psoriasis.

Mark Lebwohl, MD
Amy Freeman, MD
M. Shane Chapman, MD
Steven Feldman, MD, PhD
Jennifer Hartle, MPH
Alice Henning, MS

Correspondence: Dr Lebwohl, 5 E
98th St, 5th Floor, Box 1048, New
York, NY 10029 (Lebwohl@aol.com).

Financial Disclosure: None.

REFERENCES


Table. Patients Who Scored 0* for Disease Signs and Symptoms at the End of the Study†

<table>
<thead>
<tr>
<th>Area of Interest</th>
<th>Protopic</th>
<th>Vehicle</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All target lesions</td>
<td>51/112 (46)</td>
<td>6/54 (11)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Face only</td>
<td>19/45 (42)</td>
<td>1/17 (6)</td>
<td>.01</td>
</tr>
<tr>
<td>Intertriginous areas only</td>
<td>32/67 (48)</td>
<td>5/37 (14)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

* A score of 0 means clear.
† Data are reported as number of patients with a score of 0/total number of patients (percentage).