

Patient journey leading to generalized pustular psoriasis (GPP)

Koremasa Hayama¹, Yahui Tian², Ryoko Iwasaki³, Hideki Fujita¹

¹Division of Cutaneous Science, Department of Dermatology, Nihon University School of Medicine, Tokyo, Japan; ²Boehringer Ingelheim (China) Investment Co., Ltd, Shanghai, China; ³Nippon Boehringer Ingelheim Co., Ltd, Tokyo, Japan



Our findings may help to facilitate early diagnosis and, therefore, promote timely treatment interventions for GPP

PURPOSE

We conducted a retrospective study using machine learning and data mining methods to define the patient journey (disease trajectory) before a confirmed diagnosis of GPP.

INTRODUCTION

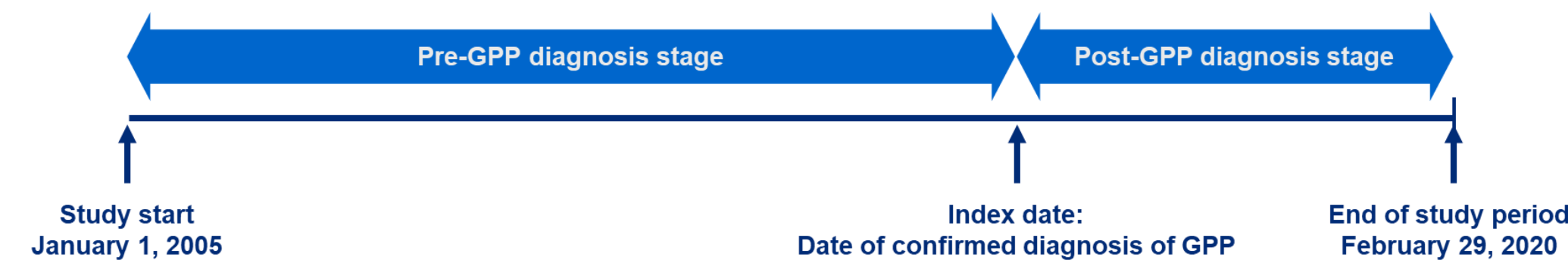
- The clinical course of GPP can be characterised as relapsing with recurrent flares or persistent with intermittent flares^{1,2}
- Case reports are available that describe the disease trajectory of individual patients prior to a diagnosis of GPP; 30–60% of patients have prior or concomitant PV²⁻⁷
 - However, no population-level information is available
- A better understanding of the patient journey is essential for improving disease awareness and facilitating early diagnosis of GPP

CONCLUSIONS

- This is the first real-world study of short- and long-term patient journeys before a confirmed diagnosis of GPP
- Patients with GPP often have prior or concomitant PV, which was identified in the network pattern analysis, supporting the validity of this method
- Diagnoses first made within 120 days of GPP diagnosis highlight several differential diagnoses that physicians should exclude in reaching a GPP diagnosis

METHODS

Study design



Eligibility criteria:

- Confirmed diagnosis of GPP (inpatient or outpatient claim ICD-10 code L40.1)
- ≥1 year of continuous insurance enrolment prior to GPP diagnosis

- Primary outcome:** Disease trajectory before confirmed diagnosis of GPP
 - Network analysis
 - Sequential pattern mining
- Secondary outcome:** Frequency of other disease diagnoses in pre-diagnosis stage
- Further outcomes:** Time to GPP diagnosis

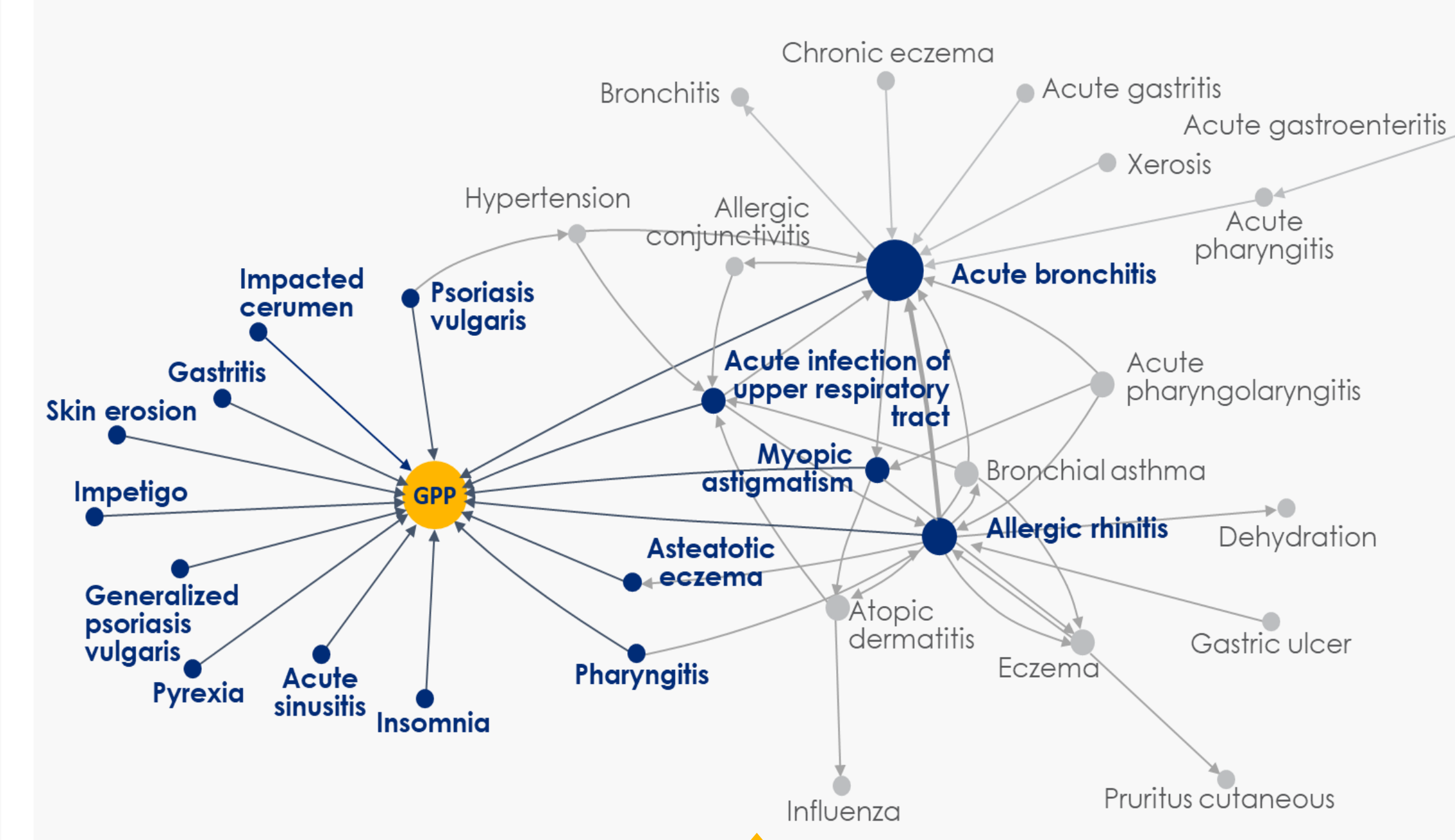
RESULTS

Demographics of the study cohort (N=189)

Characteristic	N=189
Sex, n (%)	
Male	108 (57.1)
Female	81 (42.9)
Age at index GPP diagnosis, years	
Median	39
Range	1–74
Age group in years at index GPP diagnosis, n (%)	
0–9	23 (12.2)
10–19	24 (12.7)
20–29	18 (9.5)
30–39	33 (17.5)
40–49	25 (13.2)
50–59	35 (18.5)
60–69	25 (13.2)
70–79	6 (3.2)

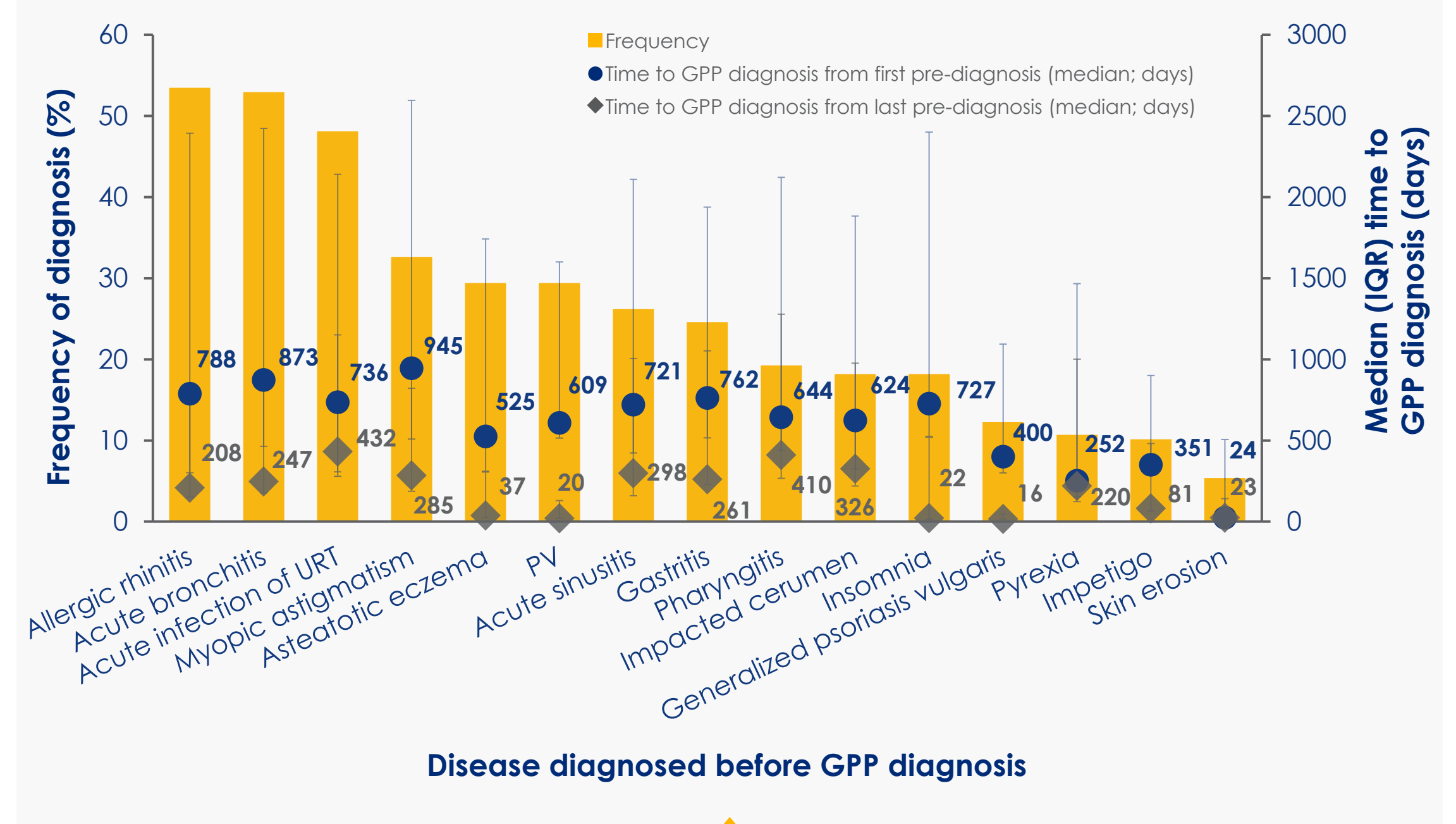
57.1% of patients were male and 42.9% of patients were female; median age at index GPP diagnosis was 39 years (range 1–74)

Network pattern of disease trajectory before GPP diagnosis



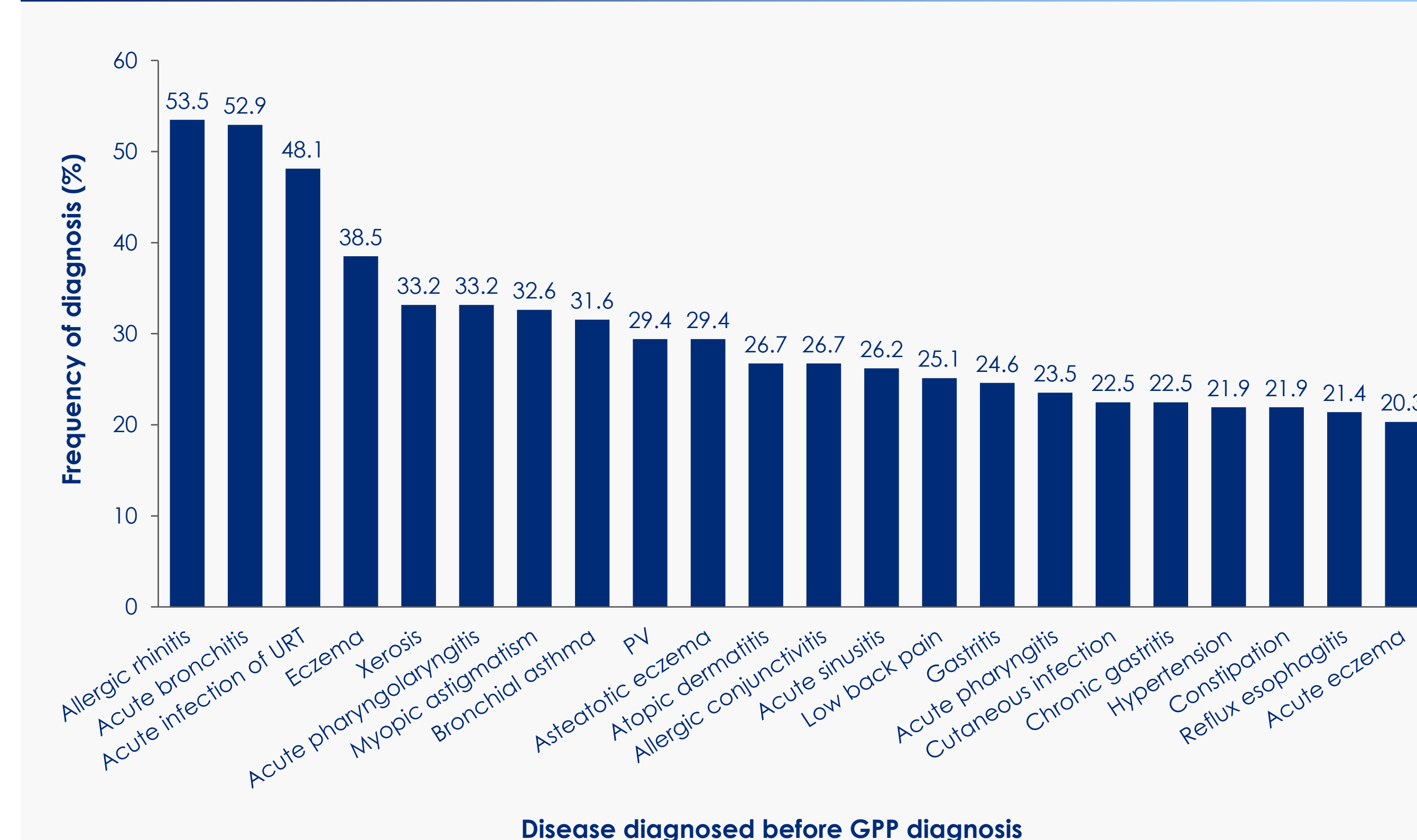
Of the diseases diagnosed prior to GPP, 31 appeared in the network pattern and 15 appeared in the direct network node

Time to GPP diagnosis for the 15 diseases connected to GPP



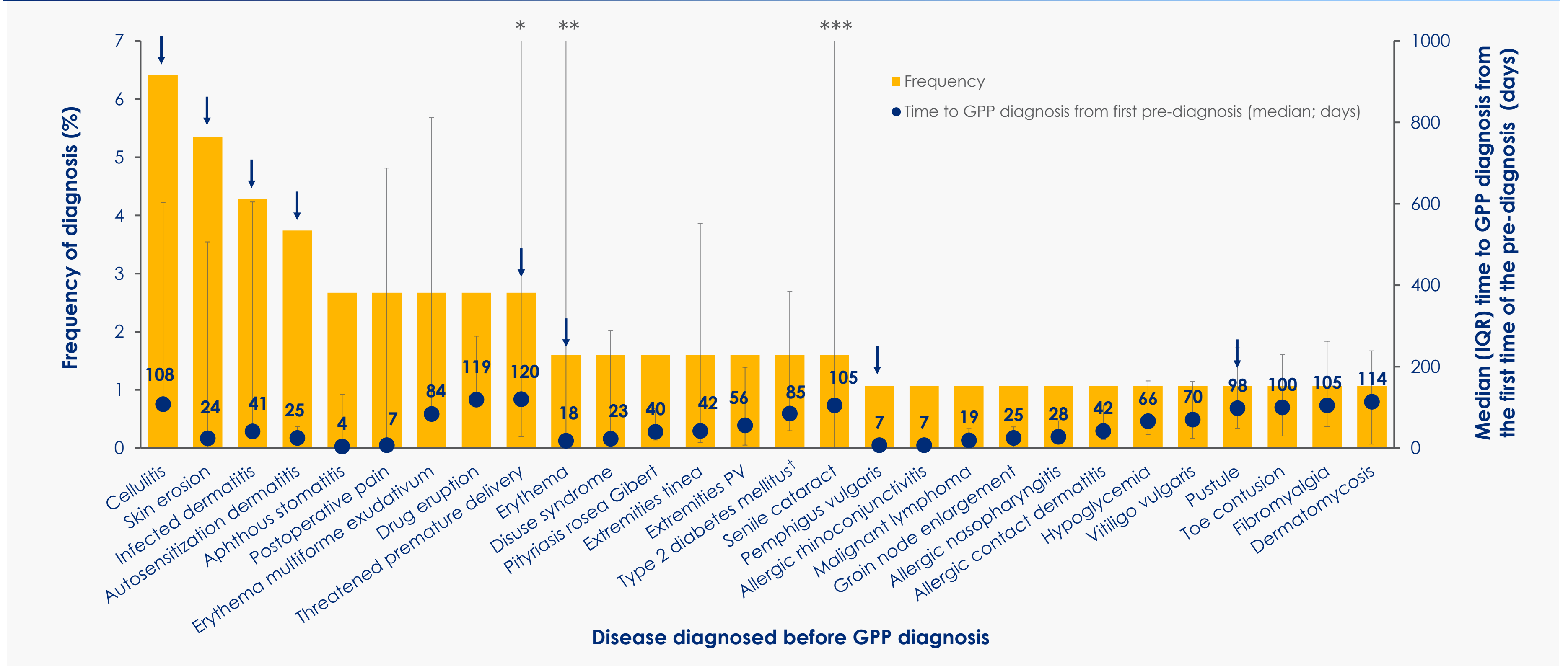
Median time to a GPP diagnosis for the 15 diseases directly connected to GPP on the network pattern ranged from 16 to 432 days (from last pre-diagnosis) and 24 to 945 days (from first pre-diagnosis)

Diagnoses (n=22) prior to GPP diagnosis occurring in ≥20% of patients



The most frequent diagnoses prior to GPP diagnosis were allergic rhinitis (53.5%), acute bronchitis (52.9%), acute infection of the URT (48.1%) and eczema (38.5%); a diagnosis of PV preceded GPP in 29.4% of patients with a GPP diagnosis

Diagnoses made within 120 days prior to GPP



Diagnoses made ≤120 days before a GPP diagnosis included skin diseases and symptoms, e.g., skin erosion; differential diagnoses such as infected dermatitis, autosensitization dermatitis, and pemphigus vulgaris; potential triggers of GPP, including cellulitis and pregnancy (threatened premature delivery); and symptoms observed at GPP onset, e.g., erythema and pustules

Abbreviations
GPP, generalized pustular psoriasis; ICD-10, International Classification of Diseases, Tenth Revision; IQR, interquartile range; JMDIC, Japan Medical Data Center; PV, psoriasis vulgaris; Q, quartile; URT, upper respiratory tract.

References
1. Zheng M, et al. *Am J Clin Dermatol*. 2022;23(Suppl 1):5–12; 2. Gooderham MJ, et al. *Expert Rev Clin Immunol*. 2019;15(9):907–919; 3. Choon SE, et al. *Int J Dermatol*. 2014;53(6):676–684; 4. Borges-Costa J, et al. *Am J Clin Dermatol*. 2011;12(4):271–276; 5. Ohkawara A, et al. *Acta Derm Venereol*. 1996;76(1):68–71; 6. Chata C, et al. *J Dermatol*. 2022;49:142–150; 7. Fujita H, et al. *J Dermatol*. 2018;45:1235–1270.

Disclosures & Acknowledgements
The study was supported and funded by Boehringer Ingelheim. KH declares grants and/or personal fees from AbbVie, Boehringer Ingelheim, Eisai, Janssen Pharmaceuticals, Maruho, Mitsubishi Tanabe Pharma, Novartis, Sun Pharmaceutical Industries and Taiho Pharmaceutical. YF and H are employees of Boehringer Ingelheim. HF declares receiving honoraria or fees for serving on advisory boards, as a speaker and as a consultant, as well as grants as an investigator from AbbVie, Amgen, Boehringer Ingelheim, Eisai, Eli Lilly, Janssen Pharmaceuticals, JMEC, Japan Blood Products Organization, Kaken, Kyowa Kirin, LEO Pharma, Maruho, Mitsubishi Tanabe Pharma, Nihon Pharmaceutical, Novartis, Sanofi, Sun Pharmaceutical Industries, Taiho Pharmaceutical, UCB and Ushio. The authors met criteria for authorship as recommended by the International Committee of Medical Journal Editors (ICMJE). The authors did not receive payment related to the development of the poster. Boehringer Ingelheim was given the opportunity to review the poster for medical and scientific accuracy, as well as intellectual property considerations. The authors would like to thank Christina Raabe, Vivek Jha, and Sumana Nagendrakumar for their contributions to the data analysis in this study. Isabella Goldborough, PhD, of OPEN Health Communications (London, UK) provided writing, editorial, and formatting support, which was contracted and funded by Boehringer Ingelheim.



Scan QR code for an interactive, electronic, device-friendly copy of the poster
<https://bit.ly/3psT20R>

Click the icon to access an interactive microsite for this Smart poster

