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Antipruritic Therapeutics

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Anti-pruritic therapies – what's new?

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The first question to ask (although it may seem very logical) is – Is this pruritus?

What about pain?

Could it be neurogenic discomfort?

As a last resort, is there any component that could be behavioral?

**I consider patients pruritic until proven otherwise when considering behavioral problems as a component of the clinical presentation.

If this is pruritus - Why?

Secondary causes are exceedingly common and must be addressed in order to determine the primary cause of pruritus that remains, if any does remain.

- pyoderma
- demodicosis with secondary pyoderma
- yeast dermatitis
- dermatophytosis
- furunculosis – blood-tinged discharge
- otitis
- pododermatitis

Once the secondary causes have been identified, treated, and resolved, if pruritus remains a primary cause should be considered.

Primary causes

- Atopic dermatitis (environmental allergies)
- Cutaneous adverse reaction to food (food allergy)
- Flea allergic dermatitis
- Contact dermatitis - RARE

So… what is the approach?

History

- Is the pruritus seasonal?
- Is it non-seasonal?
- Is it steroid responsive?
- Is it mild, moderate, or severe?
- What is the distribution?

How do we rule in/rule out a diagnosis?

- Atopic dermatitis = rule out everything else!
- Cutaneous adverse reaction to food = elimination diet trial
- Flea allergic dermatitis = excellent flea control program

Once the diagnosis is confirmed – what are the options?

- Flea allergic dermatitis
  - Flea control
  - Steroid therapy
  - Topical therapy
- Cutaneous adverse reaction to food
  - Identify the offending food allergen
  - Avoid the offending food allergen
  - Topical therapy
- Atopic dermatitis - the challenge
  - Avoid the allergens…

- Manage the pruritus
  - Manage the side effects
  - Cost
  - Effectiveness
  - Safety

Therapeutic Options

- What's old?
  - Antihistamines
  - Fatty acid supplementation
  - Topical anesthetic agents, colloidal oatmeal
  - Steroid therapy
  - Syclosporine (Atopica®) tacrolimus (Protopic®)
  - Allergen specific immunostherapy (ASIT)
- What's new?
  - Antihistamines - 2nd generation
  - Fatty acid supplementation - topical barrier replacement
  - Reasons for using topical therapy
  - Cyclosporine (Atopica®) tacrolimus (Protopic®)
  - Sublingual immunotherapy (SLIT)
  - Oclacitinib (Apoquel®)
- Oldies but goodies
  - Antihistamines = hydroxyzine, clemastine, diphenhydramine – sedation
  - Fatty Acid supplementation = do we need them?
    180mg EPA/ 5kg body weight
    high potency formulations are available to achieve therapeutic doses with minimal side effects
  - Topical anesthetic agents, colloidal oatmeal = adjunct therapies
  - Steroid therapy
    - dexamethasone, triamcinolone, injectable steroids **are not recommended** for pruritus
- How should one choose a steroid?
  If you choose steroids…
  - Monitoring – what is realistic?
  - For me, PCV/TP, blood glucose, Alk Phos, ALT, Urine culture = non-negotiable, every 6 months if steroid therapy is administered consistently, year round.
  - The goal is to find the lowest dose that can be administered on an every other day schedule.
- Cyclosporine therapy = Atopica®, Protopic®
  - When to consider generic? Should we?
  - How about compounded products?
  - Seasonal administration?
  - Therapeutic drug monitoring?
- Oclacitinib - Apoquel®
  - It's quick!
  - It's affordable!
  - It works!
  - Is it safe?
  - The relationship between drug concentrations and cytokine inhibition – understand how the drug works to determine how best to utilize this option for pruritic patients.