International Psoriasis Council psoriasis disease severity reclassification: Update on validity, acceptance, and implementation

Bruce E. Strober, MD, PhD,[a] Andrew Blauvelt, MD, PhD,[b] Peter CM. van de Kerkhof, MD, PhD,[c] Álvaro González-Cantero, MD, PhD,[d,e] Mona El-Kalioby, MSc, MD,[f] Cesar Gonzalez, MD,[g] Benjamin Hidalgo Matlock, MD,[h,i] Filip Rob, MD, PhD,[j] Pravit Asawanonda, MD, MSc, DSc,[k] Rudi Chandra, MD,[l] Julia-Tatjana Maul, MD,[m,n] Tiago Torres, MD, PhD,[o] and Lone Skov, MD, PhD[p]

Key words: high-impact sites; psoriasis; quality of life; severity classification; systemic therapy.

The International Psoriasis Council (IPC) psoriasis severity reclassification divides patients with psoriasis into 2 distinct groups: candidates for either topical treatment or systemic therapy. Systemic therapy candidates meet 1 of 3 criteria: (1) disease involving high-impact sites (eg, face, scalp, genital, palmoplantar, nails, intertriginous); (2) over 10% body surface area affected; or (3) failure to respond to topical therapy.[1] A wealth of real-world evidence supports the IPC definition for guiding treatment decisions. Data from the National Psoriasis Foundation's US patient survey highlight a connection between high-impact site involvement and significant quality of life deterioration, increased risk of depression, and diminished social engagement—even in cases with body surface area (BSA) <10%.[2] This challenges the conventional severity thresholds (Psoriasis Area Severity Index [PASI] ≥12, BSA ≥10%) for initiation of systemic therapy, suggesting these criteria may contribute to misclassification and potential undertreatment of patients

Abbreviations used:

BSA:	body surface area
GP:	genital psoriasis
hfPGA:	Hands and Feet Physician Global Assessment
IGA-scalp:	Investigator Global Assessment - Scalp
IPC:	International Psoriasis Council
PASI:	Psoriasis Area and Severity Index
ppIGA:	Palmoplantar Investigator Global Assessment
ppPASI:	Palmoplantar Psoriasis Psoriasis Area Severity Index
ScPGA:	Scalp Physician Global Assessment
sPGA-G:	Static Physician Global Assessment - Genitalia

From the Department of Dermatology, Yale University School of Medicine, New Haven, Connecticut[a]; Blauvelt Consulting LLC, Annapolis, Maryland[b]; Department of Dermatology, Radboud University Nijmegen Medical Centre, Nijmegen, Netherlands[c]; Department of Dermatology, Ramón y Cajal University Hospital, Madrid, Spain[d]; Faculty of Medicine, Department of Dermatology, Universidad Francisco de Vitoria, Pozuelo de Alarcón, Madrid, Spain[e]; Faculty of Medicine, Department of Dermatology, Kasr Al-Ainy Hospital, Cairo University, Cairo, Egypt, Egypt[f]; Department of Dermatology, Clinica Universitaria Colombia, Bogota, Colombia[g]; Department of Dermatology, Hospital Nacional de Niños, Universidad de Costa Rica, Universidad Latina de Costa Rica, San Jose, Costa Rica[h]; Skin Care Physicians of Costa Rica, San Jose, Costa Rica[i]; Second Faculty of Medicine, Department of Dermatology, Charles University, Prague, Czech Republic[j]; Department of Dermatology, Chulalongkorn University, Bangkok, Thailand[k]; Department of Dermatology, University of Prima, Medan, Indonesia[l]; Department of Dermatology, University Hospital Zurich, Zurich, Switzerland[m]; Faculty of Medicine, Department of Dermatology, University of Zurich, Zurich, Switzerland[n]; Department of Dermatology, Centro Hospitalar Universitário de Santo António, University of Porto, Porto, Portugal[o]; and Department of Dermatology, Herlev and Gentofte Hospital, University of Copenhagen, Copenhagen, Denmark.[p]

Funding sources: None.
Patient consent: Not applicable.
IRB approval status: Not applicable.
Accepted for publication May 19, 2025.

Correspondence to: Bruce E. Strober, MD, PhD, Yale University School of Medicine, 33 Cedar St, New Haven, CT 06510. E-mail: brucestrober30@me.com.

Published online June 6, 2025.
J Am Acad Dermatol 2025;93:1154-7.
0190-9622

https://doi.org/10.1016/j.jaad.2025.05.1445

Table I. Clinical trials on small molecules and biologics for patients with psoriasis on high-impact sites (psoriasiscouncil.org/disease-severity-tables/)

Study	Drug and study population	Results
IXORA-Q	Ixekizumab in patients with moderate-to-severe genital psoriasis	73% of patients on ixekizumab reached sPGA-G 0 or 1 vs 8% of patients on placebo at wk 16
DISCREET	Apremilast in patients with moderate-to-severe genital psoriasis	39.6% of patients on apremilast reached a modified sPGA-G 0 or 1 and a reduction ≥2 points of modified sPGA-G vs 19.5% of patients on placebo at wk 16
G-PLUS	Guselkumab in nonpustular palmolantar psoriasis	35.9% of patients on guselkumab reached ppPASI75 vs 28.2% of patients on placebo at wk 16
REACH	Adalimumab in patients with moderate to chronic plaque psoriasis of hands and feet	31% of patients on adalimumab reached hfPGA75 vs 4% of patients on placebo at wk 16
GESTURE	Secukinumab in palmoplantar psoriasis	33.3% of patients on secukinumab 300 mg reached ppIGA 0/1 and a reduction of ≥2 points in ppIGA vs 22.1% of patients on secukinumab 150 mg vs 1.5% of patients on placebo at wk 16
IMMprint	Risankizumab in patients with moderate-to-severe plaque psoriasis with nonpustular palmoplantar involvement	33.3% of patients on risankizumab 150 mg reached ppIGA 0/1 and a reduction of ≥2 points in ppIGA vs 16.1% of patients on placebo at wk 16
STYLE	Apremilast in patients with moderate to severe plaque psoriasis of the scalp	43% of patients on apremilast reached ScPGA score 0 or 1 with ≥2-point reduction from baseline vs 13.7% of patients on placebo at wk 16
Secukinumab in patients with scalp psoriasis	Secukinumab in patients with moderate to severe scalp psoriasis	57% of patients on secukinumab reached IGA-scalp score of 0 or 1 vs 6% of patients on placebo at wk 12
PSORIATYK SCALP	Deucravacitinib in patients with scalp psoriasis	57.6% of patients reached sPGA 0 or 1 in vs 57.6% vs 5,3% on placebo at wk 24.
SPECTREM	Guselkumab in patients with low BSA and involvement of high-impact sites	74% of patients on guselkumab reached IGA score of 0 or 1 vs 12% in the placebo group at wk 16
GULLIVER	Guselkumab in patients with facial (FP) and genital psoriasis (GP)	83.3% of FP patients achieving a facial sPGA score of 0 or 1 at wk 12; 76.5% of GP patients achieving a facial sPGA score of 0 (clear) or 1 (almost clear) at wk 12

BSA, Body surface area; *hfPGA*, Global Assessment of Hands and/or Feet; *IGA*, Investigator Global Assessment; *modified sPGA-G*, Modified Static Physician Global Assessment of Genitalia; *ppIGA*, Palmoplantar Investigator's Global Assessment; *ppPASI*, Palmoplantar Psoriasis Area and Severity Index; *ScPGA*, Scalp Physician Global Assessment; *sPGA*, Static Physician Global Assessment.

whose disease burden is not fully reflected by these metrics. The Understanding Psoriatic Disease Leveraging Insight for Treatment (UPLIFT) survey, spanning North America, Europe, and Japan, further confirms the substantial quality of life impact when high-impact sites are affected, even with minimal BSA (≤3%).[3] Furthermore, data from the North America-based CorEvitas psoriasis registry, which includes only psoriasis patients initiating systemic therapies, underscore a real-world adoption of the IPC's reclassification: nearly half of the enrolled patients starting systemic treatment had BSA ≤10%, accompanied by either high-impact site involvement or prior failure to topical therapy.[4] These data also demonstrate that involvement of high-impact sites is associated with increased pruritus, skin pain, fatigue, and more significant limitations on daily activities.[5]

Consequently, numerous recent clinical trials, guided by real-world evidence, have adopted inclusion criteria aligned with the IPC's reclassification—low BSA paired with topical treatment failure and high-impact site involvement (Table I). Ideally, this shift toward more pragmatic and clinically relevant trial designs will become the standard in

Table II. National and regional guidelines reflecting components of the IPC definition (psoriasiscouncil.org/disease-severity-tables/)

Guideline year	Guideline country
2011 (updated 2024)	Germany
2012 (updated 2017)	Europe (NICE)
2016	Spain
2017	Italy
2018 (updated 2022)	Colombia
2019	France
2019	United States
2020	Brazil
2020	Chile
2020	Saudi Arabia
2020	United Kingdom
2021 (updated 2025)	Europe (EDF)
2021	Mexico
2022	Thailand
2023	Denmark
2023	Korea
2023	Australia
2024	Finland
2024	Japan

EDF, European Dermatology Forum; *IPC*, International Psoriasis Council; *NICE*, National Institute for Health and Care Excellence.

future phase 3 studies of emerging psoriasis therapies. Significantly, the IPC definition is reflected in an increasing number of national dermatology associations and countries (Table II), as well as by the International Federation of Psoriasis Associations and the National Psoriasis Foundation. Its incorporation into national guidelines and treatment recommendations reflects increasing global acceptance and endorsement of the IPC framework.

Collectively, this trend not only drives the design of clinical trials that more accurately reflect real-world patient experiences—especially by including those with low BSA and high-impact sites—but also influences drug labeling and reimbursement processes for systemic therapies. By prioritizing disease impact over BSA, the IPC criteria help reshape treatment management to align with real-world practices. Finally, although the concept may benefit from further clarification, topical treatment failure should be determined at a time point that prevents "topical churn"—the prolonged, ineffective use of multiple topicals that undermines good disease control and patient quality of life.

Conflicts of interest

Dr Strober is a consultant who has received honoraria from AbbVie, Alumis, Almirall, Amgen, Apogee, Arcutis, Boehringer Ingelheim, Bristol Myers Squibb, Capital One, CorEvitas, Dermavant, Immunovant, Janssen, Leo, Eli Lilly, Maruho, Oruka, Meiji Seika Pharma, Protagonist, Takeda, Novartis, Pfizer, UCB Pharma, Rapt, Regeneron, Sanofi Genzyme, and Union Therapeutics; holds stock options in Connect Biopharma, Mindera Health; has served as a speaker for AbbVie, Arcutis, Dermavant, Eli Lilly, Incyte, Janssen, Regeneron, and Sanofi Genzyme; as a scientific co-director (consulting fee) for CorEvitas Psoriasis Registry; as an investigator for CorEvitas Psoriasis Registry and is the Editor-in-Chief (honorarium) of *Journal of Psoriasis and Psoriatic Arthritis*. Dr Blauvelt has served as a speaker (received honoraria) for Eli Lilly and Company, UCB, and Almirall, has served as a scientific adviser (received honoraria) for AbbVie, Almirall, Alumis, Amgen, Anaptysbio, Apogee, Arcutis, Boehringer Ingelheim, Bristol Myers Squibb, Celltrion, Corvus, Dermavant, Eli Lilly and Company, Galderma, GlaxoSmithKline, Immunovant, Incyte, IQVIA, Janssen, Leo, Lipidio, Merck, Novartis, Oruka, Paragon, Pfizer, Regeneron, Sanofi, Spherix Global Insights, Sun Pharma, Syncona, Takeda, UCB, and Union, has acted as a clinical study investigator (institution has received clinical study funds) for AbbVie, Acelyrin, Almirall, Alumis, Amgen, Arcutis, Boehringer Ingelheim, Bristol Myers Squibb, Dermavant, Eli Lilly and Company, Galderma, Incyte, Janssen, Leo, Merck, Novartis, Pfizer, Regeneron, Sanofi, Sun Pharma, Takeda, and UCB, and owns stock in Lipidio and Oruka. Dr van de Kerkhof received fees for consultancy services or lectureships from Almirall, Eli Lilly, Novartis, Janssen Pharmaceutical, Bristol Myers Squibb, UCB, Boehringer Ingelheim, Centrion, and Sandoz. Dr González-Cantero has served as a consultant for and received speaker fees from AbbVie, Janssen, Novartis, Almirall, Celgene, BMS, UCB, L'Oreal, MSD, and Leo Pharma. Dr El-Kalioby received fees for speaker honoraria from Janssen, Novartis, and Boehringer Ingelheim. Dr Matlock has served as a consultant for and received speaker fees from AbbVie, Janssen, Novartis, Pfizer, L'Oreal, Leo Pharma, Merck Sharp and Dome, Glaxo Wellcome and SmithKline Beecham, Sanofi. Dr Rob has received honoraria as a speaker and/or consultant for AbbVie, Almirall, BMS, Eli Lilly, Johnson & Johnson, Leo Pharma, Novartis, Pfizer, Sanofi Genzyme, and UCB. Dr Asawanonda has received honorarium as a speaker for Boehringer Ingelheim, Eli Lilly, Novartis, Janssen, LEO Pharma, Pfizer, Sanofi, Kyowa Kirin. Beiersdorf, and LaRoche Posay; as a consultancy or advisory board for Boehringer Ingelheim, Eli Lilly, Novartis, Janssen, LEO Pharma, Pfizer, Sanofi, Kyowa Kirin. Beiersdorf, and LaRoche Posay; and as an investigator consultant for Boehringer Ingelheim, Eli Lilly, Novartis, LEO Pharma, Kyowa Kirin, GSK, and Beiersdorf. Dr Maul has served as advisor and/or received speaking fees and/or participated in clinical trials sponsored by AbbVie, Almirall, Amgen, BMS, Celgene, Eli Lilly, Incyte, Janssen-Cilag, LEO Pharma, MSD, Novartis, Pfizer, Pierre Fabre, Roche, Sanofi, Takeda, and UCB. Dr Torres has received consultancy and/or speaker's honoraria from and/or participated in clinical trials sponsored by AbbVie, Amgen, Almirall, Amgen, Apogee Therapeutics, Arena Pharmaceuticals, Biocad,

Biogen, Boehringer Ingelheim, Bristol Myers Squibb, Celgene, Fresenius-Kabi, Johnson & Johnson Innovative Medicine, LEO Pharma, Eli Lilly, MSD, Mylan, Novartis, Pfizer, Samsung-Bioepis, Sanofi-Genzyme, Sandoz, STADA, and UCB. Dr Skov has received research funding from Almirall, UCB, Sanofi, Bristol Myers Squibb, Janssen, the Danish National Psoriasis Foundation, the LEO Foundation, and the Kgl. Hofbundtmager Aage Bang Foundation and honoraria as consultant and/or speaker for AbbVie, Eli Lilly, Novartis, Pfizer, LEO Pharma, Bristol Myers Squibb, Janssen, UCB, Almirall, Galderma, Bristol Myers Squibb, Takeda, Stada, and Sanofi. Drs Gonzalez and Chandra have no conflicts of interest to declare.

REFERENCES

1. Strober B, Ryan C, van de Kerkhof P, et al, International Psoriasis Council Board Members and Councilors. Recategorization of psoriasis severity: Delphi consensus from the International Psoriasis Council. *J Am Acad Dermatol*. 2020;82(1):117-122. https://doi.org/10.1016/j.jaad.2019.08.026
2. Blauvelt A, Gondo GC, Bell S, et al. Psoriasis involving special areas is associated with worse quality of life, depression, and limitations in the ability to participate in social roles and activities. *J Psoriasis Psoriatic Arthritis*. 2023;8(3):100-106. https://doi.org/10.1177/24755303231160683
3. Lebwohl M, Langley RG, Paul C, et al. Evolution of patient perceptions of psoriatic disease: results from the Understanding Psoriatic Disease Leveraging Insights for Treatment (UPLIFT) survey. *Dermatol Ther (Heidelb)*. 2022;12:61-78. https://doi.org/10.1007/s13555-021-00635-4
4. Strober B, Zhong Y, Beegy A, et al. Criteria for identifying candidates for systemic psoriasis treatment in the real world: application of the International Psoriasis Council guidelines in patients in North America. *J Psoriasis Psoriatic Arthritis*. 2025;10(1):22-27. https://doi.org/10.1177/24755303241302070
5. Strober B, Duffin KC, Lebwohl M, et al. Impact of psoriasis disease severity and special area involvement on patient-reported outcomes in the real world: an analysis from the CorEvitas psoriasis registry. *J Dermatolog Treat*. 2024;35(1):2287401. https://doi.org/10.1080/09546634.2023.2287401