Clinical Management Of Psoriasis Using 0.25% Niosomal Methotrexate Gel: A Placebo Controlled Double Blind Study

P Lakshmi, S Devi, S Bhaskaran, S Sacchidananda, Meenakshi

Citation


Abstract

In the formulation of topical dosage forms, more attention has been devoted to new structures, which can ensure either adequate localization of drug within the skin to enhance the local effect or can increase the penetration through the stratum corneum. For these purposes vesicular systems such as niosomes and liposomes have been investigated by several groups. Drug delivery systems using colloidal particulate carriers such as liposomes or niosomes have distinct advantages over conventional dosage forms because the particles can act as drug containing reservoirs. Methotrexate (MTX) is used in psoriasis as a systemic therapy with lot of adverse effects. A novel sustained release niosomal 0.25% MTX using a polymer chitosan administered once daily for 12 weeks. It was compared with placebo gel and plain MTX 0.25% gel for the treatment of different types of psoriasis, especially palmoplantar psoriasis.

30 patients were enrolled for study. They were divided randomly in to three groups of 10 patients for each formulation. The patients with 25% or less than 25% psoriatic lesions were included for the study. The results are calculated using PASI scoring. Changes in the disease signs and symptoms indicated that both agents have anti psoriatic activity but not with placebo gel. However lesions treated with Niosomal chitosan-MTX formulation showed marked improvement in comparison to plain MTX and placebo gel inspite of twice a day application. Few patients experienced mild adverse events. No clinically significant changes in blood or other lab parameters were seen.

The findings suggest that the 0.25% niosomal MTX in chitosan gel exhibited beneficial effect in psoriasis and did not exert any systemic toxicity.

BACKGROUND

Psoriasis is a common noninfectious chronic inflammatory skin disorder characterized by well defined, distinctive erythematous plaques that produce adherent silvery white scales which may cause bleeding points when removed (auspitz's sign). Psoriasis may flare up at any cutaneous surface but most frequent sites are the extensor surfaces of the elbows and knees, scalp and sacral areas. Methotrexate (MTX) is frequently used orally in the treatment for severe, recalcitrant psoriasis. Although effective, MTX has the potential to induce hepatotoxicity, bone marrow suppression, and other adverse effects, thus limiting its use for systemic therapy. To minimize the systemic exposure and toxicity associated with orally administered MTX, topical MTX formulations containing Azone (laurocapram), a skin penetration enhancer are being developed and evaluated.

Earlier study of MTX (0.1,0.5,and1%) in Azone formulation produces a 50% or greater improvement in psoriatic patients following 6 weeks twice daily application. Inorder to have better skin penetration and also sustained effect to improve the patient compliance a novel drug delivery using niosomal methotrexate incorporated in chitosan polymer in the form of gels were used as once daily application.

Niosomes or non-ionic surfactant vesicles are now widely studied as an alternative to liposomes and produces sustained release of drug topically. An increasing number of non-ionic surfactants have been found to form vesicles capable of entrapping hydrophobic and hydrophilic solutes. These non-ionic surfactant vesicles are regarded either as inexpensive alternatives, of non-biological origin, to liposomes, or perhaps in vivo as a carrier system to carry drug molecules like liposomes.
Chitosan, a natural polysaccharide, is being widely used as a pharmaceutical excipient. It is obtained by the partial deacetylation of chitin, the second most abundant natural polymer. The presence of a number of amino groups permit chitosan to chemically react with anionic systems, thereby resulting in alteration of physicochemical characteristics of such combinations. The polymer has also been investigated as a potential adjuvant for swellable controlled drug delivery systems. Chitosan exhibits myriad biological actions, namely hypocholesterolemic, antimicrobial and wound healing properties. Hence this property can be exploited for the treatment of psoriasis and controlled release topical formulation can be made using chitosan 6.

On MTX, only few studies are available on topical formulation. The adverse effects of oral MTX can be avoided by using the topical preparations. The controlled release of niosomes will enhance the stay of the drug on the site and will provide better therapeutic effect. Topical formulation MTX will be a boon to the psoriasis patients. Polymers like Chitosan has been used which has anti-inflammatory effect and penetration enhancing effect so that better absorption can be obtained 8,9.

Topical drug delivery is important from the viewpoints of improvement of therapeutic effect and reduction of systemic side effects10. Hence niosomal MTX-chitosan gel is formulated and studied on psoriatic patients.

MATERIAL AND METHODS
HUMAN REPEATED INSULT PATCH TEST (HRRIPT)
STUDY PROCEDURE
This was performed on human volunteers to determine the irritation and/or allergic contact sensitization potential of a test article after repetitive patch applications to the skin of human subjects before subjecting formulations on patients 11. 10 human volunteers selected for the study. Approval was obtained from ethical clearance committee of the hospital to conduct human volunteer study. An informed consent from the human volunteer had been obtained before starting the study. Table 1 provides the sex and age distribution of the human volunteers.

Table 1: Demographic features of human volunteers

<table>
<thead>
<tr>
<th></th>
<th>Placebo</th>
<th>Plain MTX*</th>
<th>Niosomal MTX*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>F*</td>
<td>M**</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>31.08± 10.132</td>
<td>31.08± 10.132</td>
<td>31.08± 10.132</td>
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*Female; **Male

INDUCTION PHASE

Approximately 0.2 grams of each gel is applied to the subject's back, using occlusive patches. Semi-occlusive tape was applied. Twenty-four hour patch applications were made on a Monday, Wednesday, Friday schedule. Twenty-four hour rest periods follow Tuesday and Thursday removals and a 48-hour rest period follows the Saturday removal. The site was scored by a dermatologist just prior to the next patch application. This procedure was repeated until 9 inductions of the test article are made on the same skin site.

The area was scored with 0-5 point scale. If a subject develops a level 2 reaction or greater during the Induction phase, the patch was applied to an adjacent fresh site for the next application. If a 2 or greater reaction occurs on the new site, no further induction applications were made. However, any reactive subjects are subsequently patched with the test article on a virgin test site during the challenge phase of the study.

CHALLENGE PHASE

Approximately 2 weeks after application of the last induction patch, a challenge patch was applied to a previously unpatched (virgin) site, adjacent to the original induction patch site. The challenge site was scored 24 and 72 hours after application. The subjects were asked to report any delayed reactions, which might occur after the final challenge patch reading. The results are tabulated in Table 2.

Table 2: Frequency of dermal response in Human Repeated Insult Patch Test at each evaluation interval

<table>
<thead>
<tr>
<th></th>
<th>Induction Phase Readings (24 hr)</th>
<th>Challenge phase readings (24 hr)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Placebo</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Niosomal</td>
<td>0</td>
<td>0</td>
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</tbody>
</table>

Skin responses are scored according to the following 6-point scale:
1. (None) No evidence of any effect.
2. (Barely perceptible) Minimal, faint, uniform or spotty erythema.
3. (Mild) Pink, uniform erythema covering most of the contact site.
4. (Moderate) Pink-red erythema, uniform in the entire contact site.
5. (Marked) Bright red erythema with/without petechiae or papules.
6. (Severe) Deep red erythema with/without vesiculation or weeping.

None of human volunteers faced any irritation during induction and challenge phase. Hence results of level 2 to level 5 are not shown Table 2. These formulations were used for patient study.

**DOUBLE BLIND PLACEBO CONTROLLED PASI STUDY ON PSORIASIS PATIENTS**

The extent and severity was measured by Psoriasis Area and Severity Index (PASI). Global assessment was measured for efficacy, tolerability of the treatment, and the preference between the treatments administered. 

**PATIENT POPULATION**

30 patients between ages of 22 and 50 years having psoriasis from 2-8 years were chosen for inclusion in the study. Approval was obtained from ethical clearance committee of the hospital to conduct patient study. An informed consent from the patient had been obtained before starting the study. Patients were randomly assigned to study the treatments. All the patients were evaluated for the efficacy of the treatments. All the 30 patients completed the full study. Table 3 provides demographic features of patients participated in the study.

**INCLUSION CRITERIA**

Patients with stable plaque psoriasis involving <25% of the body surface area and palmoplantar psoriasis.

**EXCLUSION CRITERIA**

Patients with psoriatic lesions on face and or scalp, administration of other systemic therapy or intralvesional therapy or UV radiation for atleast 2 months prior to inclusion in the study, children, pregnant and lactating mothers, Patients with above 25% lesions were excluded from the study.

**METHOD**

Extent and severity as measured by psoriasis and severity index (PASI) using a method described by Lynda Sutton BS et al., . Global assessment was measured for efficacy and tolerability of the treatment, preference between the treatments administered. The global assessment was done on a 0-5 ordinal scale ranging from completely clear to worse. The severity of the erythema, infiltration, desquamation and overall severity was assessed presence of lesion on the trunk, upper arm or lower arm. The PASI score was calculated as the sum of severity of main symptoms multiplied by the numerical value of the areas involved with various percentages of the 3 main body areas. The scoring was done depends on the area of the lesion.

**FREQUENCY OF THE CLINICAL EVALUATION**

The efficacy of the treatment was evaluated as baseline (time 0) and subsequently for every 2 weeks for 12 weeks.

**Figure 3**

Table 3: Demographic features of patients participated in double blind placebo controlled PASI study

![Table 3](image)

**PATIENT STUDY PROCEDURE**

The study is a single center, double blind placebo controlled, comparison of treatments.

Patients were given placebo and plain gel twice-daily application. Niosomal MTX gel was given once a day application and placebo gel was given to this niosomal group to apply at night to avoid the bias between the placebo and plain gel groups. The body surface area treated ranged from and the formulations were applied in quantities of approximately 50g/m2. Treated lesions were a maximum of 25% of the body surface area.

**RESULTS**

The gels were subjected for HRIPT test on human volunteers to study the irritation on the skin. None of the formulations
selected for the patient study had produced irritation. The patient study also revealed that only few patients had experienced mild adverse events, which were of local in nature such as burning irritation. There were no clinically significant changes in hematologic or clinical laboratory features in any patient.

**DISCUSSION**

Complete patient compliance was achieved with the study medication. The Placebo, plain, niosomal gel preparations was well tolerated by all the patients and there were no dropouts. All 30 patients completed 12 weeks study. There was reduction in erythema followed by slight reduction in infiltration and desquamation leading to moderate to excellent improvement seen. There was substantial reduction in PASI score from the initial level.

Demographically all the three groups patients were comparable in age sex, presence of less than 25% of the psoriasis and the duration of psoriasis. Patients of stable plaque psoriasis with less than 25% and palmoplantar psoriasis were included for the study to avoid the use of this anticancer drug and to avoid more area exposed to this medication available for systemic absorption. Periodic
routine laboratory tests including complete blood count, urine analysis, liver chemistry (SGOT and SGPT) and serum creatinine were within normal limits.

Consistent with previous studies the results of this study indicate that niosomal MTX formulated with chitosan applied topically is effective in treating psoriasis. Especially palmoplantar psoriasis. The study on human volunteers also reveals that it does not produce any skin irritation and MTX can exert local therapeutic effect. Further various percentages of MTX has to be optimized for more clinical effectiveness.

The major findings of the study reveals that the niosomal MTX (0.25%) in a chitosan gel used as a topical agent significantly resolved psoriatic lesions and was shown to be quite effective in treating patients without any side effects. This gel was used once a day regime in comparison to plain preparation, which is, used twice a daily.

Most of the current treatment either topical or systemic involves suppression of diseases with lot of side effects and patient compliance is questionable. In this case the niosomal MTX in chitosan gel provides once a day application for patients by improving adherence to treatment.

This regimen can be an alternative treatment modality for treatment of psoriasis.

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