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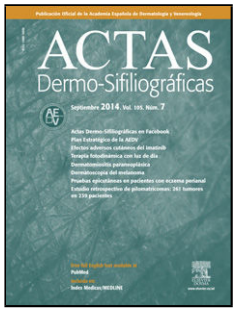

[[Translated article]]Research Priority Setting Partnerships in Dermatology: A Pending Imperative?

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PII: S0001-7310(25)00649-0

DOI: https://doi.org/doi:10.1016/j.ad.2025.10.002

Reference: AD 4469

To appear in: *Actas dermosifiliograficas*

Received Date: 14 November 2024

Accepted Date: 22 February 2025

Please cite this article as: Martin-Gorgojo A, Grau-Pérez M, García-Doval I, [[Translated article]]Research Priority Setting Partnerships in Dermatology: A Pending Imperative?, *Actas dermosifiliograficas* (2025), doi: https://doi.org/10.1016/j.ad.2025.10.002

Refers to AD_4438

ARTÍCULO DE OPINIÓN

Establecimiento de prioridades de investigación entre clínicos y pacientes en Dermatología: ¿una asignatura pendiente?

[[Translated article]]Research Priority Setting Partnerships in Dermatology: A Pending Imperative?

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Introduction

We believe that prioritizing research by establishing research priorities jointly with clinicians and patients—Priority Setting Partnerships (PSP)—should have growing importance and interest in our setting.

Alessandro Liberati, a prominent Italian physician–researcher and founder of the Cochrane Centre in Italy in 1994, died from multiple myeloma.[1] As a patient, but with the perspective of his prior experience as a researcher, he emphasized a troubling disconnect between what clinicians study and what patients need. He also highlighted the mismatch between research priorities driven by industry and academia and those that are truly relevant to patients.

Typically, those who set research priorities are those who fund it (research agencies and the pharmaceutical industry) and those who compete for that funding (investigators). On the one hand, this can favor research oriented toward generating results advantageous to the pharmaceutical industry—for example, promoting effectiveness studies of new drugs vs placebo, or single-arm effectiveness studies without a comparator, instead of more ambitious head-to-head comparative studies that could reveal that expensive new drugs are no better than older, lower-cost alternatives, when what clinicians and patients most want to know is which currently available drug is most safe and effective. On the other hand, it can tilt priorities toward basic and translational research over clinical and epidemiologic research, because many funding agencies and journals are more oriented to basic and translational work, which may be more readily publishable. However, this may be far from what patients most need for their disease and what clinicians most need when making decisions in our office.[1,2]

For these reasons, it could benefit everyone if priority research agendas were reevaluated and realigned with the actual needs of patients, caregivers, and health professionals. This approach seeks to optimize resource use by directing efforts toward areas that directly and meaningfully impact patients' health (which, ultimately, concerns us all).

PSP methodology: how is it done?

To set priorities through a PSP, one first explores areas of need in a given disease or topic with participation from a group representing clinicians, patients, and other stakeholders (such as family members and caregivers). The group then compiles uncertainties and examines the existing evidence about them: the questions must be ones that cannot be answered with current evidence and that matter to all groups. After generating a provisional list of priorities, the group holds a meeting to agree on a final list (usually a Top 10) of priorities considered essential for research in the area. Finally, periodic updates of the list and appropriate follow-up are required.

The methodology proposed by the James Lind Alliance (JLA) is summarized in Table 1.[3,4]

Examples of the clinical relevance of the PSP methodology

Applying PSP methodology has had tangible effects in dermatologic practice. One example is the work by Dávila-Seijo et al., who addressed prioritizing therapeutic uncertainties in dystrophic epidermolysis bullosa. By creating a PSP that included patients, caregivers, and health professionals, they produced a list of research questions considered most critical to improving clinical management of the disease.[5] Subsequently, it became clear that research at that time (more genetics-oriented) did not address the main priorities of patients and frontline clinicians,[2] which led to changes in international DEBRA (Dystrophic Epidermolysis Bullosa Research Association) funding calls, prioritizing research on how to relieve children's suffering during wound care. Another experience, led by Hernández-Martín, focused on ichthyosis and identified ten priority areas for research.[6] Recently, the Spanish Hidradenitis Suppurativa Registry of the Spanish Academy of Dermatology and Venereology[7] was developed to

address several of the questions JLA had designated as priorities (Table 2).[8] Another valuable account is from Amanda, the mother of a child with severe atopic dermatitis, who actively participated in the JLA eczema PSP, where she helped define and prioritize the most relevant research questions from the patient perspective.[9]

Beyond dermatology and research, these methodologies can aid the humanization of clinical practice. A paradigmatic example is the Patients Changing Things Together (PATCHATT) ethics pack, a tool created to support inclusive ethical decision-making that has enabled people with terminal illness to lead meaningful changes in community care planning.[10]

Conclusions and final reflections

Engaging patients from the earliest stages of projects and considering their input before launching them is essential to aligning research with the real needs of those affected.[11] Establishing future PSP initiatives within Spain's national health system will require creating collaborative platforms where these stakeholders identify and prioritize research areas together with clinicians and investigators, following models such as the JLA.

While including patients and clinicians in decision-making is unquestionably valuable, it is not without challenges. One is the potential interference of researchers' individual preferences and the pressure to deliver results.[12] As Liberati noted in 2011: "If we want more relevant information, a new governance strategy for research is needed. We cannot expect researchers alone to resolve the current mismatch. Researchers are trapped by their own internal interests—professional and academic—that compete with each other."[1] Ensuring adequate representation of patients' interests can also be difficult.

Another hurdle was seen in the epidermolysis bullosa study, where it was hard to assemble a representative participant group due to the disease's rarity and the need for international coordination.[5] Even so, examples like this suggest that, especially in rare diseases, conclusions are likely generalizable to other settings without replicating similar efforts in different geographic areas.

Once priorities are set, it is also worth reflecting on how research is executed. As Roberts points out, the medical literature contains a biased sample of trials, which means systematic reviews inherit those biases. Moreover, when trials are identified, selective outcome reporting undermines validity because the literature includes many limited-quality studies (single-center, small samples, etc.), which continue to be promoted and published.[13] In some cases, research may be poorly executed partly because investigators lack certain methodological skills. Added to this, institutions rarely provide adequate methodological support, leading to grant applications and studies that sometimes fail to produce meaningful results—wasting time and resources.

Using PSPs when designing studies, securing appropriate methodological support for planning and conducting research, and working in a coordinated fashion could further accelerate Spanish (and global) research in the coming years[2] and generate results with greater impact on patients' health and quality of life, while improving efficacy.

In conclusion, it is essential to raise awareness of this method, to encourage more dermatologists to use results from existing PSPs and participate in new ones, and to align research objectives as closely as possible with established priorities. Research within the PSP framework will help reduce wasted

research resources. As Hywel Williams recently emphasized in a British Journal of Dermatology editorial, what is needed is not "more research," as many studies often conclude, but "less, but better—prioritized, well conducted, and fully reported." Patients deserve no less (and recalling Liberati: we deserve no less).[14]

Conflict of Interest

None declared.

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Table 1. PSP Methodology Proposed by the James Lind Alliance (JLA)

Preparatory work	Advance preparation (read the PSP guide, send a preparatory questionnaire) Assign a facilitator/chair for the PSP
1) Create the working group	Composed in equal parts of patients, caregivers, and clinicians; this group agrees on the action plan ("protocol") and takes responsibility for the PSP
2) Gather uncertainties in the available evidence	Ask patients, caregivers, and clinicians (via a survey) what research questions they have, and search the literature for existing evidence gaps
3) Summarize collected responses	With support from an information specialist, the PSP categorizes all responses and produces a long list of synthesized questions
4) Check the available evidence	Cross-check the list against existing evidence to ensure the questions are truly unanswered; remove questions that have already been answered
5) Provisional priority setting	To shorten the list for discussion at a workshop, a broad group of patients, caregivers, and clinicians ranks the most important questions in an interim priority-setting survey (usually online)
6) Workshop	The top 25–30 questions from the interim survey are discussed at a workshop of patients, caregivers, and clinicians, who jointly agree the "Top 10" priorities
7) Publish and promote the 10 research priorities	The Top 10 are announced and posted on the JLA website and promoted to researchers and funders. The PSP works with researchers/funders to develop these priorities into specific research questions
Follow-up work	Possible publication(s) on PSP findings Ongoing, long-term promotion of the research priorities Long-term follow-up of PSP impact

Source: James Lind Alliance Priority Setting Partnerships.[3]

Table 2. The Top Research Questions per the James Lind Alliance in Dermatology Conditions/Areas

Dermatology condition/area	Top research questions (James Lind Alliance)
Acne (2014)	• What management strategy should be used to treat acne to optimize short- and long-term outcomes? • What is the correct way to use antibiotics in acne to achieve the best results with the lowest risk? • What is the best treatment for acne scarring? • What is the best way to prevent acne? • What is the correct way to use oral isotretinoin for acne to achieve the best results with the lowest risk of potentially serious adverse effects? • Which lifestyle factors most affect susceptibility to, or severity of, acne, and could diet be one of them? • What is the best way to manage acne in mature women, with or without underlying hormonal abnormalities? • What is the best topical product to treat acne? • Which physical therapies, including lasers and other light-based treatments, are safe and effective for acne? • How long do acne treatments take to work, and which act fastest?
Eczema (2012)	• What is the best and safest way to use topical steroids for eczema (frequency, potency, duration, alternating with other topicals, age limits)? • What is the long-term safety of applying topical steroids for eczema? • What role might food allergy testing play in eczema treatment? • Which emollient is most effective and safe for eczema? • What is the best psychological treatment for itch/scratching in eczema? • What is the best way for people with eczema to wash (frequency, water temperature, bath vs shower)? • Which natural products are safest and most effective to apply to the skin for eczema? • How helpful is avoidance of irritants and allergens for people with eczema? • What is the role of diet in eczema treatment (exclusion diets and nutritional supplements)? • What is most effective for managing eczema: education programs, primary-care-led care, nurse-led

Dermatology condition/area	Top research questions (James Lind Alliance)
	care, dermatologist-led care, or multidisciplinary care? • Which is safer and more effective for eczema: steroids or calcineurin inhibitors? • How effective are interventions to reduce skin infections in eczema care? • When treating eczema, what should be applied first—emollients or topical steroids? • What is the best and safest way to use systemic immunosuppressants when treating eczema?
Alopecia areata (2015)	1) What causes alopecia areata (eg, drugs, medical problems, lifestyle, vaccinations)? 2) Are immunosuppressive therapies (eg, methotrexate, mycophenolate mofetil) better than placebo for alopecia areata? 3) In alopecia areata, are biologics (including JAK inhibitors and anti-cytokine therapies) more effective than placebo for hair regrowth? 4) Are psychological interventions helpful for alopecia areata? 5) Can early diagnosis and treatment prevent progression of alopecia areata? 6) Do certain foods, vitamins, or supplements improve hair growth in alopecia areata? 7) What can be learned about alopecia areata from other autoimmune conditions? 8) In whom does hair loss progress in alopecia areata, and why? 9) Do any treatments have long-term benefit for alopecia areata? 10) How effective are alternative therapies for alopecia areata?
Other hair disorders (2015)	1) What is the most effective treatment for frontal fibrosing alopecia? 2) What causes frontal fibrosing alopecia (eg, diet, genetics, autoimmunity, skin-care products, drugs, hormones, environment, vaccines, infections)? 3) What causes female pattern hair loss (eg, genetics, hormones and childbirth, autoimmunity, diet, comorbid conditions, environmental factors)? 4) Across all hair-loss types, are psychological therapies effective for improving patient outcomes? 5) Across all hair-loss types, which outcome measures should be used to assess severity, progression, and impact on the individual? 6) Is spironolactone useful for female pattern hair loss? 7) Across all hair-loss types, does raising ferritin/replacing iron improve hair growth, and what is the optimal ferritin level? 8) What is the most effective treatment for lichen planopilaris? 9) Across all hair-loss types, do certain diets or supplements (eg, vitamin D) prevent or improve hair loss? 10) In female pattern hair loss, does hormone replacement therapy halt progression vs placebo?
Hidradenitis suppurativa (2013)	1) Which group of oral treatments is most effective and safe (eg, antibiotics, hormonal therapies, retinoids, immunosuppressants, metformin, steroids)? 2) What is the best management of an acute flare? 3) What is the impact of hidradenitis and its treatments (physical, psychological, economic, social, quality of life)? 4) How effective are biologics (etanercept, adalimumab, infliximab, ustekinumab)? 5) Do early diagnosis and intensive treatment influence disease course? 6) What is the best surgical procedure (eg, incision and drainage, local excision, wide excision)? 7) Which factors help determine prognosis (disease progression)? 8) What is the best wound-care method after surgery or for active disease (eg, skin grafts, secondary intention, dressings)? 9) To what extent is hidradenitis caused by genetic factors? 10) What is the best way to manage hidradenitis-associated pain?
Hyperhidrosis (2017)	1) Are there safe and effective permanent solutions for hyperhidrosis? 2) Which oral drug is most safe and effective? 3) What are the most effective and safe ways to reduce sweating in specific areas (hands, feet, axillae, face, scalp, etc)? 4) How does hyperhidrosis affect quality of life? 5) Are combinations of treatments more effective than single-modality approaches? 6) What is the safest and most effective treatment for mild–moderate hyperhidrosis? 7) Could targeted therapies or biologics (eg, antibodies, hormones, stem cells) be effective? 8) What is the most effective severity scale for determining eligibility for treatment? 9) What is the safest and most effective surgery for hyperhidrosis? 10) How safe are hyperhidrosis treatments across life stages (childhood, pregnancy, breastfeeding)?
Lichen sclerosus (2018)	1) What is the best way to prevent and manage anatomic changes caused by lichen sclerosus (eg, fusion, altered genital shape, scarring)?

Dermatology condition/area	Top research questions (James Lind Alliance)
	2) What is the best way to diagnose lichen sclerosus (diagnostic criteria)—eg, clinical features, biopsy, tests (including severity indicators), and the need for, and adverse effects of, biopsy? 3) Which surgical treatments should be offered (eg, laser, platelet-rich plasma, lipofilling) and when; what are long-term outcomes? 4) Are there effective topical treatments besides topical steroids (eg, topical calcineurin inhibitors such as tacrolimus and pimecrolimus), and what to do when steroids fail? 5) What is the risk of cancer in lichen sclerosus—who is at higher risk, and do certain treatments increase or reduce risk? 6) Which aspects should be measured to assess treatment response? 7) Can onset be prevented and what are triggers (eg, irritation from clothing/chemicals/urine, trauma, environmental factors, drugs/drugs)? 8) Is ongoing treatment needed in asymptomatic/inactive disease, and what follow-up (how often, how long, and by whom)? 9) What is the impact on quality of life (daily life, psychological health, sexual relationships), and how can psychological/social support be used best? 10) Does disease course differ between children and adults, males and females, and can it fully remit?
Psoriasis (2018)	1) Do lifestyle factors (diet, supplements, alcohol, smoking, weight loss, exercise) play a role in psoriasis treatment? 2) Does early/proactive treatment reduce severity, increase chances of remission, or prevent comorbidities? 3) Which factors predict treatment response? 4) What is the best way to treat symptoms (itch, burning, redness, scaling)? 5) How effective are psychological and educational interventions for adults/children with psoriasis? 6) Does treating psoriasis improve other conditions (psoriatic arthritis, cardiovascular disease, metabolic syndrome, stress)? 7) Why do treatments stop working well, and what is the best way to regain control? 8) To what extent is psoriasis caused by genes vs other factors (stress, gut health, water quality, climate/temperature changes)? 9) Are people with psoriasis more likely to develop other health problems (from the disease or treatments), and which ones? 10) What is the best way to treat sudden flares?
Vitiligo (2012)	1) How effective are systemic immunosuppressants for vitiligo? 2) How helpful are psychological interventions for people with vitiligo? 3) Which is more effective for vitiligo: phototherapy or calcineurin inhibitors (eg, tacrolimus, pimecrolimus)? 4) How effective is UVB phototherapy when combined with creams/ointments for vitiligo? 5) How effective are hormones/hormone-related agents that stimulate pigment cells (MSH analogues, afamelanotide)? 6) Which is more effective: calcineurin inhibitors or topical steroids? 7) Which is more effective: topical steroids or phototherapy? (A BJD trial partly addresses this.) 8) Which is more effective: topical steroids or phototherapy? (duplicate as listed in source.) 9) How effective is adding psychological interventions for patients using camouflage to improve quality of life? 10) How effective is pseudocatalase cream (with brief UVB exposure) for vitiligo?
Skin cancer surgery (2022)	1) What are the effects of delays in skin cancer surgery on patient outcomes? 2) What is the most effective way to determine skin cancer margins preoperatively? 3) What are the best ways to ensure patients feel fully informed about their surgery (eg, scar outcomes, alternatives)? 4) What is the best treatment for incompletely or narrowly excised keratinocyte cancers (basal cell and squamous cell carcinomas)? 5) What are the psychological support needs after surgery and the best ways to meet them (eg, for depression/anxiety)? 6) Which factors influence post-surgical recurrence of skin cancer? 7) What is the role of sentinel lymph node biopsy (eg, melanoma, Merkel cell carcinoma, SCC)? 8) Which excision margins best balance scarring and cure for each cancer type, and what is the role of wide local excision for melanoma/lentigo maligna in reducing recurrence? 9) What are the best ways to measure outcomes after skin cancer surgery (eg, scar appearance, patient experience, pain)? 10) How does Mohs surgery compare with standard excision with immediate or delayed repair?

Dermatology condition/area	Top research questions (James Lind Alliance)
Pemphigus and pemphigoid (2023)	1) How effective, safe, and cost-effective is rituximab (or similar biologics) vs standard steroids/immunosuppressants for pemphigus vulgaris, mucous membrane pemphigoid, or bullous pemphigoid? When should it be started—first-line? 2) Are outcomes better if treatment starts earlier and with "stronger" therapies (immunosuppressant/biologic) rather than stepping up from "milder" options? 3) What is the best way to treat persistent oral lesions in pemphigus vulgaris and mucous membrane pemphigoid? 4) What is the best treatment to prevent/repair scarring in mucous membrane pemphigoid (medical and surgical)? 5) Can we identify drugs that block disease-specific immune pathways rather than using broad immunosuppressants? 6) What are the risks and benefits of the various oral and injectable treatments (eg, azathioprine, mycophenolate mofetil, methotrexate, cyclophosphamide, chlorambucil, nicotinamide, dapsone, IVIG, plasmapheresis)? 7) Which factors predict relapses; how can relapse risk be reduced, and what is the best way to treat relapses? 9) What is the best/most effective steroid tablet dose to prescribe (including starting dose), how quickly should it be tapered, and when should it be stopped? 9) Can we predict treatment response and what factors influence it? 10) What is the best way to manage skin wounds—including washing, treating blisters/erosions, and whether care varies by body site?

Source: James Lind Alliance Priority Setting Partnerships.[15]