AAD **ANNUAL** MEETING **2025**

AEDV

7 - 11 MARZO

ORLANDO

highlights

Una iniciativa de:

ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

FUNDACIÓN AEDV PIEL SANA

ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

Con el patrocinio de:

ucb

Dermatología Pediátrica

Parte I

Miguel Mansilla Polo

Hospital Universitario y Politécnico La Fe, Valencia

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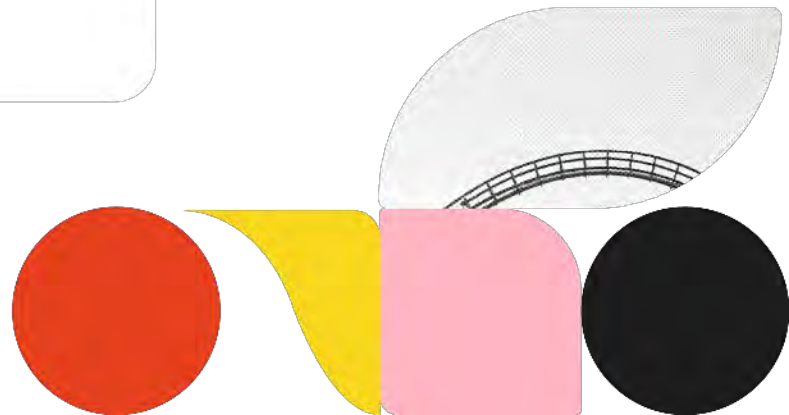
AAD **ANNUAL** MEETING **2025**

AEDV 7 - 11 MARZO ORLANDO

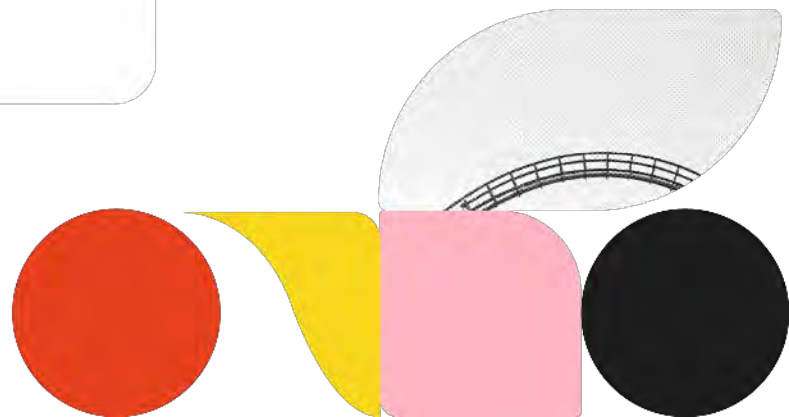
highlights

NO TENGO CONFLICTOS DE INTERÉS



Dermatología Pediátrica

- **18 charlas específicas** con >80 intervenciones
- **41 pósteres**

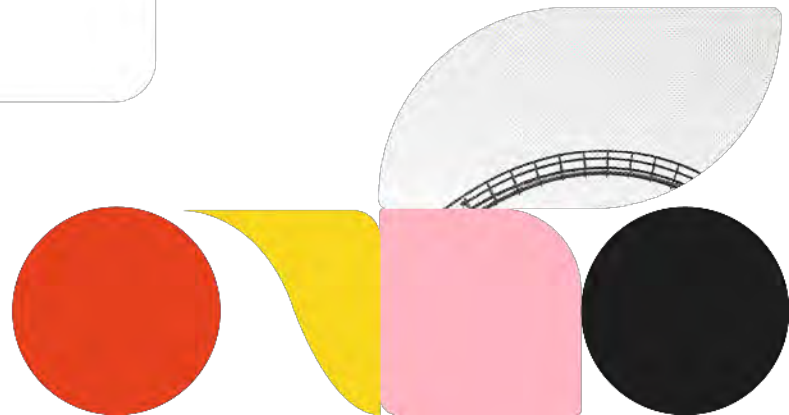


PARTE I

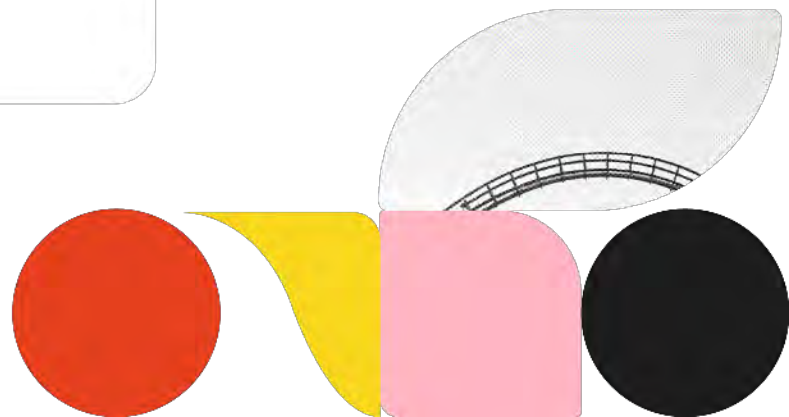
- Dermatitis atópica
- Acné e HS
- Lesiones pigmentadas:
  - Nevus y melanoma en la infancia
  - Vitíligo

PARTE II

- Hemangioma y malformaciones vasculares
- Alopecia areata
- Cosmeticorrexia
- Miscelánea



DERMATITIS ATÓPICA



DERMATITIS ATÓPICA

> Charlas presentan resultados recientes de nuevos fármacos tópicos y orales

DERMATITIS ATÓPICA. Roflumilast

Roflumilast 0.15% Cream

Potent PDE4 inhibitor

- FDA approved as 0.3% cream for psoriasis adults 2022
- FDA approved for AD ≥ 6y July 2024
  - 0.15% cream daily

INTEGUMENT-1/2

Phase 3 RCT 1337 children ≥ 6 y and adults mild-to-moderate AD 0.15% roflumilast cream x 4 weeks

- IGA 0/1: 32.0%/28.9% vs 15.2%/12.0%
- EASI-75 43.2%/42.0% vs 22%/19.7%
- Rapid improvement itch
- Application site pain 0.9/2.1%

mpson EL, Eichenfield LF, Alonso-Llamazares J, Draelos ZD, Ferris LK, Forman SB, Gooderham M, Gonzalez ME, Hebert AA, Kircik LH, Lomaga M, Moore A, Papp KA, Prajapati VH, Hanna D, Snyd
Krupa D, Burnett P, Almaraz E, Higham RC, Chu DH, Berk DR. Roflumilast Cream, 0.15%, for Atopic Dermatitis in Adults and Children: INTEGUMENT-1 and INTEGUMENT-2 Randomized Clinical
als. JAMA Dermatol. 2024 Nov 1;160(11):1161-1170. doi: 10.1001/jamadermatol.2024.3121. PMID: 39292443; PMCID: PMC11411450.

Long-Term Safety and Efficacy with Roflumilast Cream 0.15% in Patients Aged ≥6 Years with Atopic Dermatitis: A Phase 3 Open-Label Extension Trial

Eric L. Simpson,[a] Lawrence F. Eichenfield,[b] Kim A. Papp,[c,d] Seth B. Forman,[e] Adelaide A. Hebert,[f] Mercedes E. Gonzalez,[g] Melinda J. Gooderham,[h] H. Chih-ho Hong,[i] Vimal H. Prajapati,[j] Emma Guttman-Yassky,[k] Jonathan I. Silverberg,[l] Melissa S. Seal,[m] David Krupa,[m] Erin Almaraz,[m] Diane Hanna,[m] Patrick Burnett,[m] Scott Snyder,[m] David H. Chu,[m] Robert C. Higham,[m] and David R. Berk[m]

Dermatitis. 2025 Jan 10. Epub ahead of print.

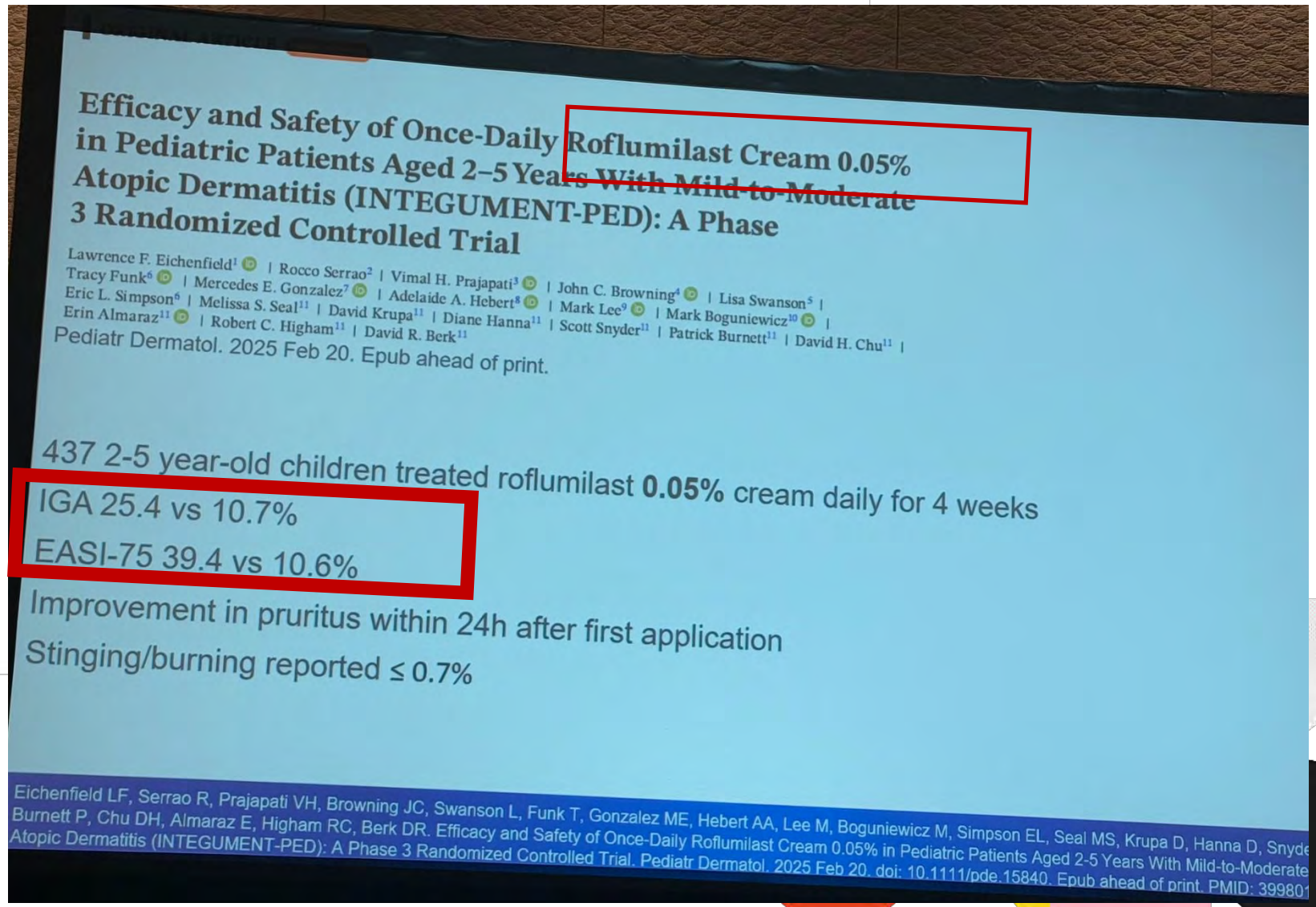
Open label extension 657 patients ≥6 years for up to 52 weeks

- Daily application for 4 weeks
- Proportion of pts with IGA 0/1, EASI-75, improvement in itch improved during trial
- Proactive BIW application if achieved IGA 0
  - Maintained improvement in AD for over 200 days
- TEAEs: COVID, URTI, nasopharyngitis, headache
  - 0.5% application site pain
  - 0.4-2.1% patients reported stinging/burning

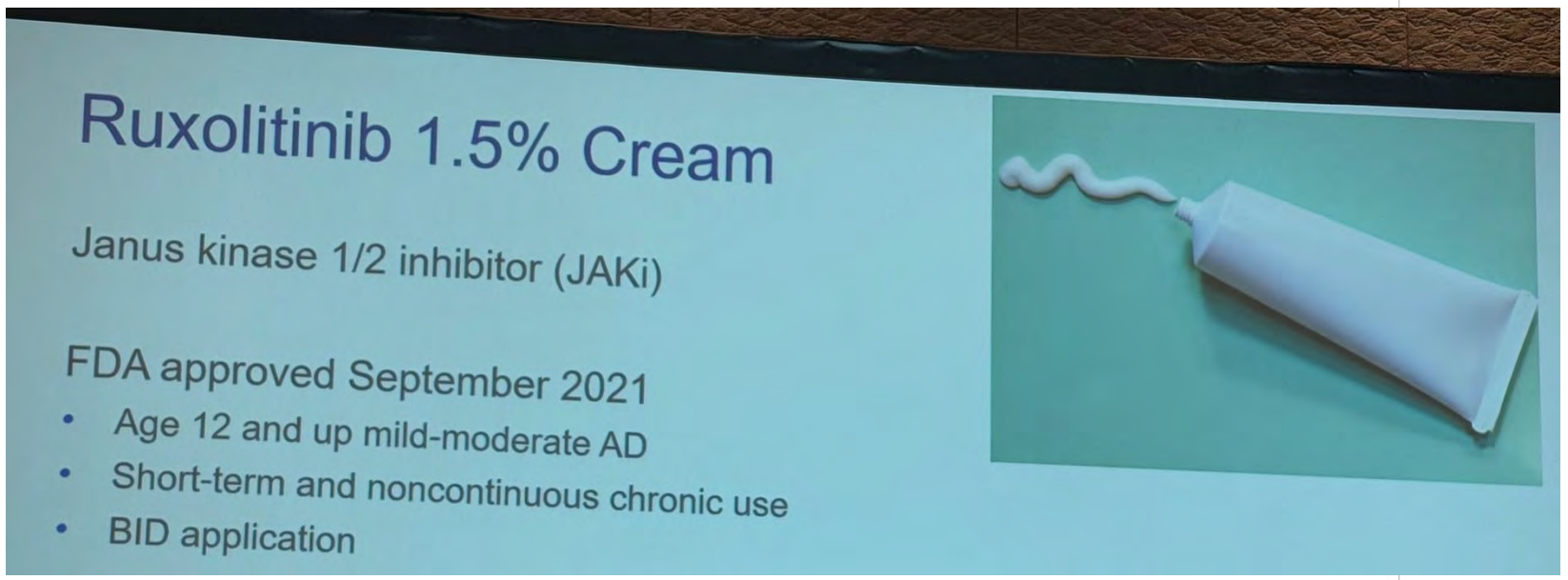
Simpson EL, Eichenfield LF, Papp KA, Forman SB, Hebert AA, Gonzalez ME, Gooderham MJ, Hong HC, Prajapati VH, Guttman-Yassky E, Silverberg JI, Seal MS, Krupa D, Almaraz E, Hanna D, Burnett P, Snyder S, Chu DH, Higham RC, Berk DR. Long-Term Safety and Efficacy with Roflumilast Cream 0.15% in Patients Aged ≥6 Years with Atopic Dermatitis: A Phase 3 Open-Label Extension Trial. Dermatitis. 2025 Jan 10. doi: 10.1089/derm.2024.0418. Epub ahead of print. PMID: 39792455

DERMATITIS ATÓPICA. Roflumilast

2025, ensayo concentración menor
Mantiene eficacia

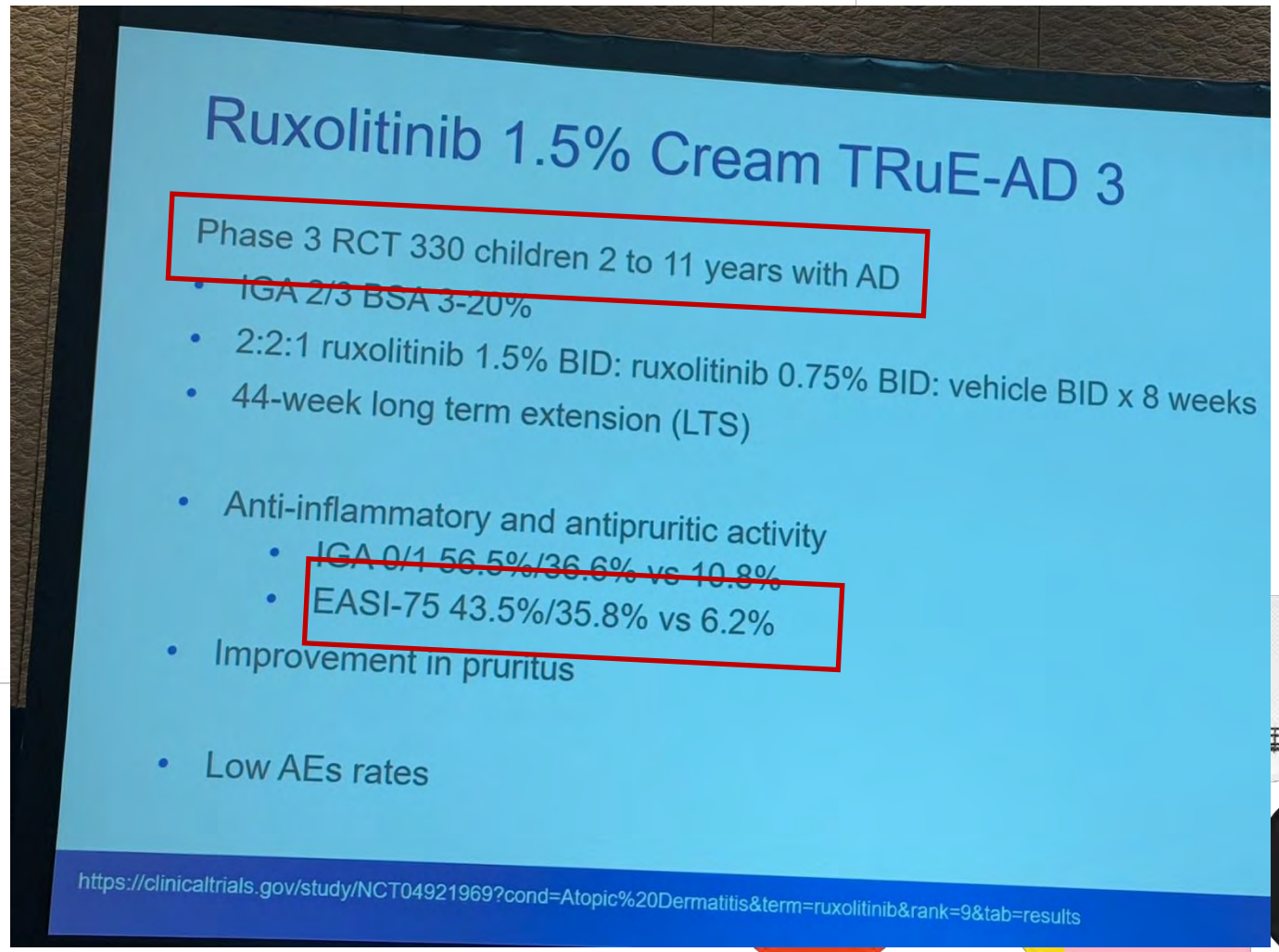


DERMATITIS ATÓPICA. Ruxolitinib tópico



DERMATITIS ATÓPICA. Ruxolitinib tópico

Fase 3 2025



DERMATITIS ATÓPICA. Delgocitinib crema

Delgocitinib Ointment

Pan JAKi

Approved in Japan as 0.25% and 0.5%

Mild to severe AD children ≥ 6 months and adults

Well-tolerated through week 56

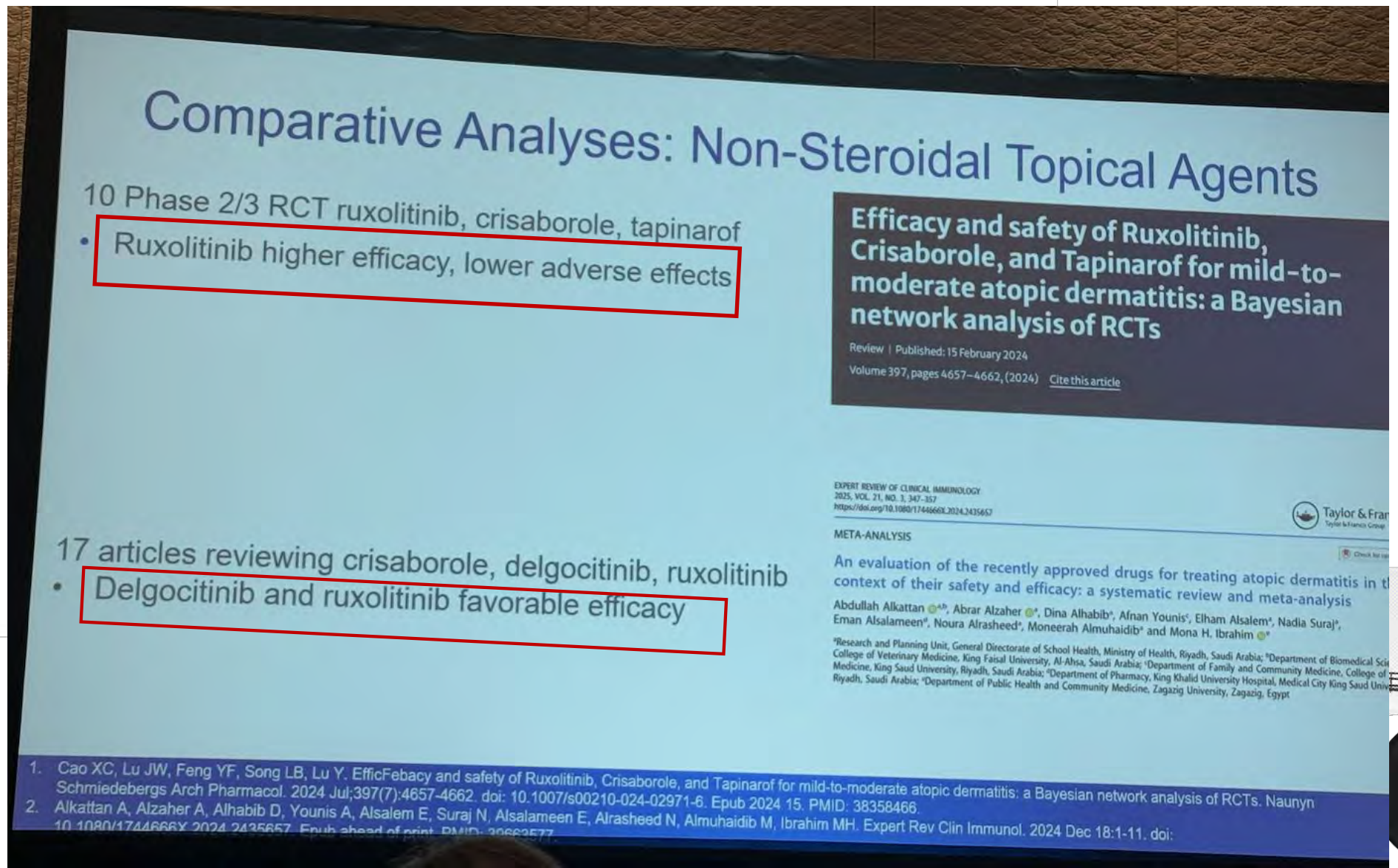
0.5% may be superior

NCT03826901: Phase 1 Age 2 and up Moderate to Severe AD

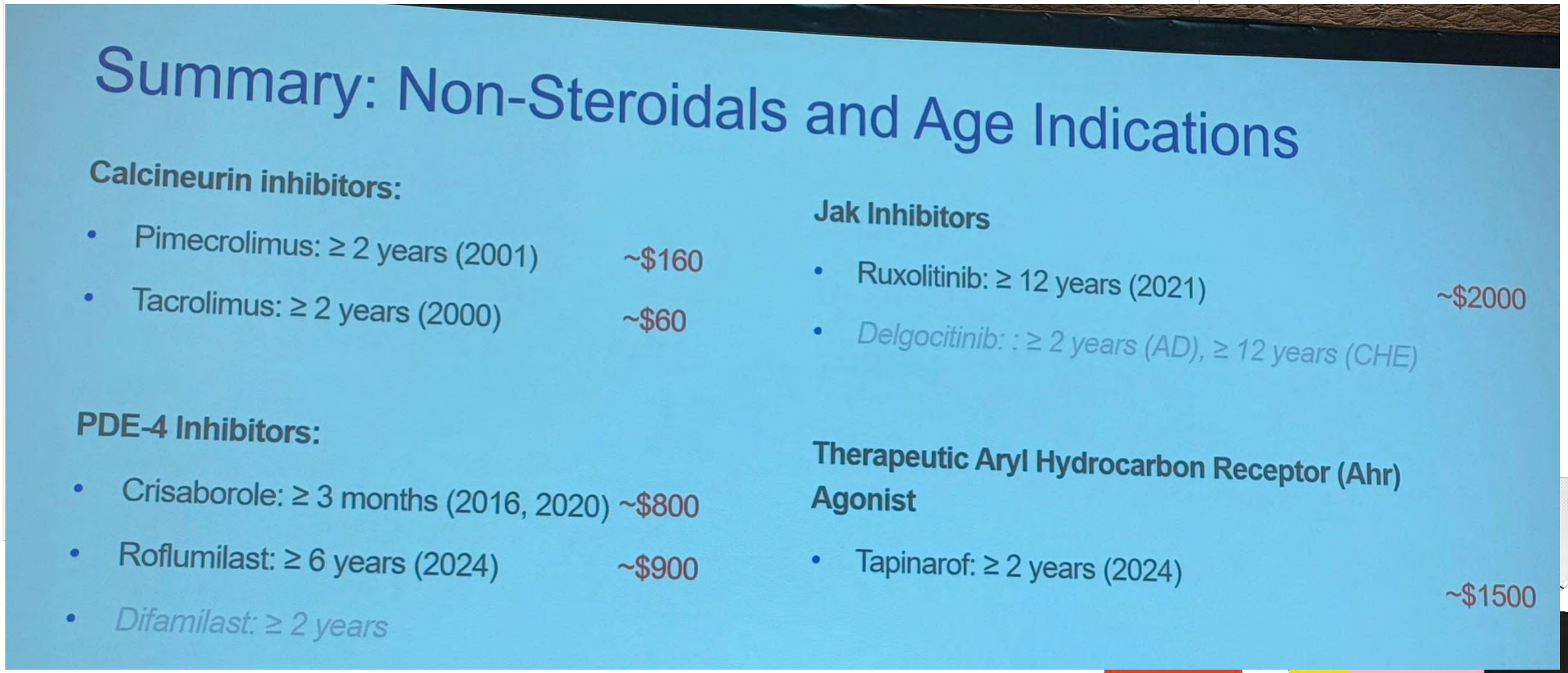
onnette R, Warren RB, Pinter A, Agner T, Gooderham M, Schuttelaar MLA, Crépy MN, Stingeni L, Serra-Baldrich E, Baranowski K, Korn S, Kurvits M, Plohberger U, Stran chliemann S; trial investigators. Efficacy and safety of delgocitinib cream in adults with moderate to severe chronic hand eczema (DELTA 1 and DELTA 2): results from icentre, randomised, controlled, double-blind, phase 3 trials. Lancet. 2024 Aug 3;404(10451):461-473. doi: 10.1016/S0140-6736(24)01027-4. Epub 2024 Jul 18. PMI

DERMATITIS ATÓPICA. Comparativa tópicos

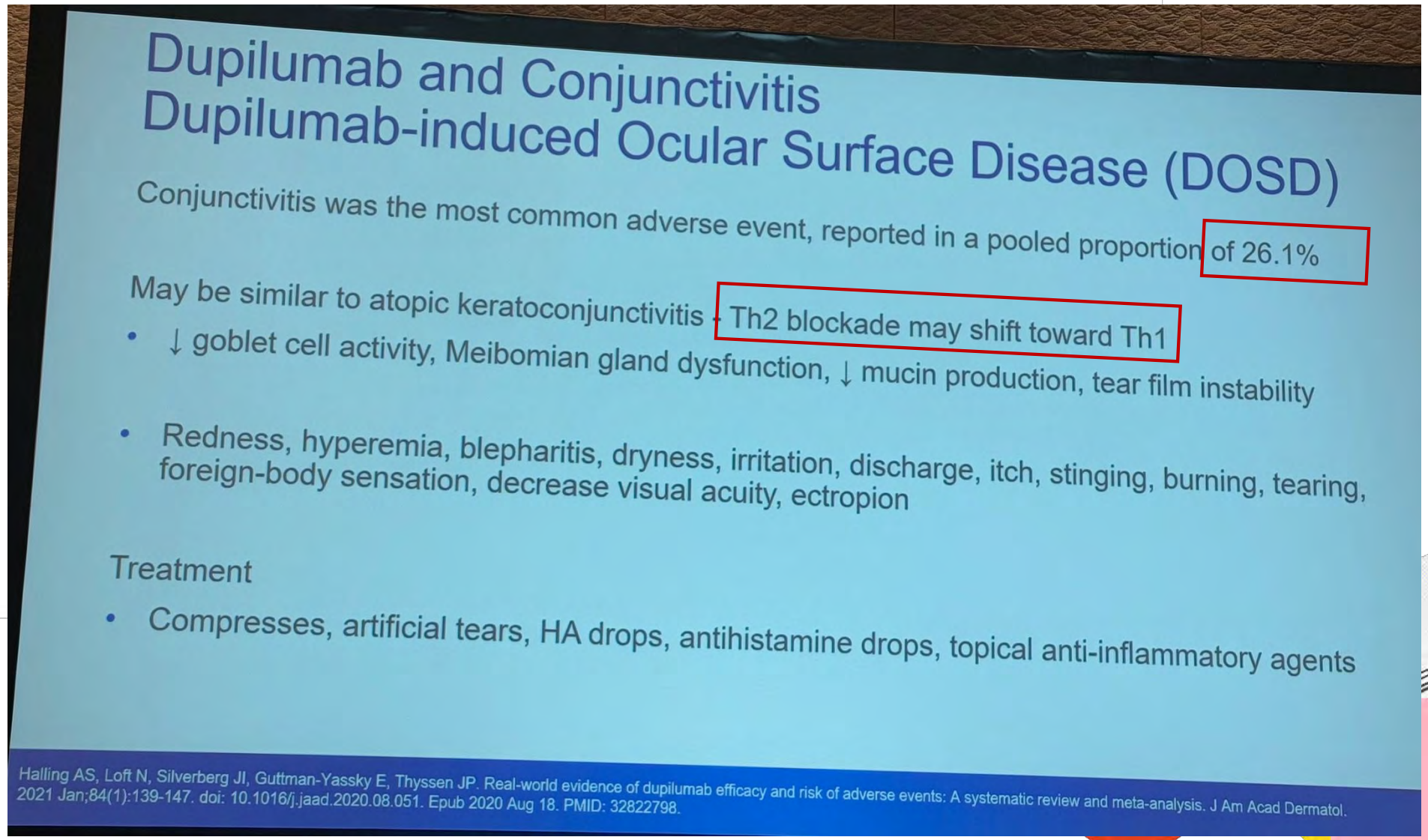
Delgo
Ruxo



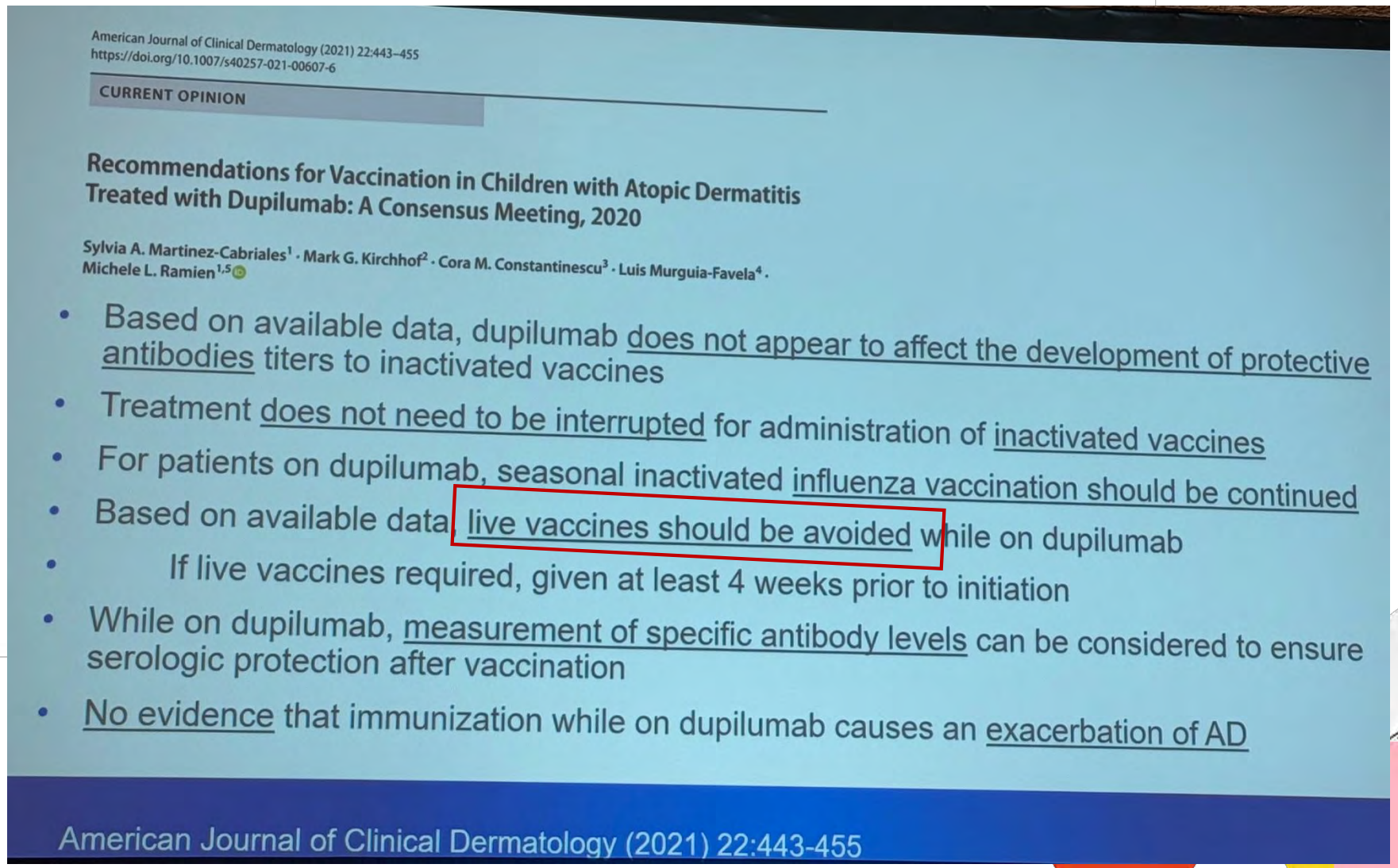
DERMATITIS ATÓPICA. Comparativa tópicos



DERMATITIS ATÓPICA. Sistémicos. Dupilumab



DERMATITIS ATÓPICA. Sistémicos. Dupilumab



American Journal of Clinical Dermatology (2021) 22:443–455
https://doi.org/10.1007/s40257-021-00607-6

CURRENT OPINION

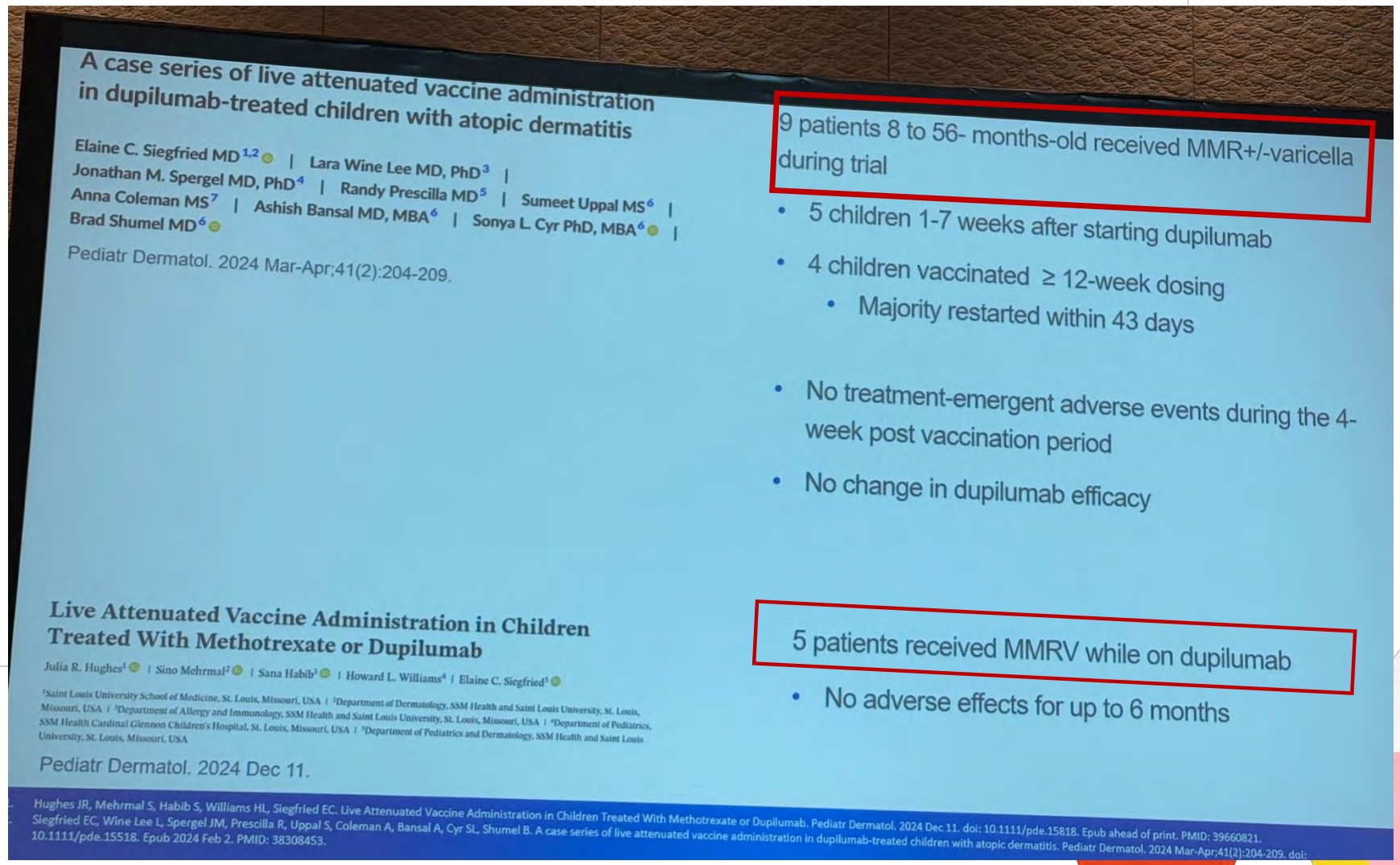
Recommendations for Vaccination in Children with Atopic Dermatitis Treated with Dupilumab: A Consensus Meeting, 2020

Sylvia A. Martinez-Cabriales[1] · Mark G. Kirchhof[2] · Cora M. Constantinescu[3] · Luis Murguia-Favela[4] · Michele L. Ramien[1,5]

- Based on available data, dupilumab does not appear to affect the development of protective antibodies titers to inactivated vaccines
- Treatment does not need to be interrupted for administration of inactivated vaccines
- For patients on dupilumab, seasonal inactivated influenza vaccination should be continued
- Based on available data, live vaccines should be avoided while on dupilumab
- If live vaccines required, given at least 4 weeks prior to initiation
- While on dupilumab, measurement of specific antibody levels can be considered to ensure serologic protection after vaccination
- No evidence that immunization while on dupilumab causes an exacerbation of AD

American Journal of Clinical Dermatology (2021) 22:443-455

DERMATITIS ATÓPICA. Sistémicos. Dupilumab



A case series of live attenuated vaccine administration in dupilumab-treated children with atopic dermatitis

Elaine C. Siegfried MD[1,2] | Lara Wine Lee MD, PhD[3] | Jonathan M. Spergel MD, PhD[4] | Randy Prescilla MD[5] | Sumeet Uppal MS[6] | Anna Coleman MS[7] | Ashish Bansal MD, MBA[6] | Sonya L. Cyr PhD, MBA[6] | Brad Shumel MD[6]

Pediatr Dermatol. 2024 Mar-Apr;41(2):204-209.

9 patients 8 to 56- months-old received MMR+/-varicella during trial

- 5 children 1-7 weeks after starting dupilumab
- 4 children vaccinated ≥ 12-week dosing
  - Majority restarted within 43 days
- No treatment-emergent adverse events during the 4-week post vaccination period
- No change in dupilumab efficacy

Live Attenuated Vaccine Administration in Children Treated With Methotrexate or Dupilumab

Julia R. Hughes[1] | Sino Mehrmal[2] | Sana Habib[3] | Howard L. Williams[4] | Elaine C. Siegfried[5]

[1]Saint Louis University School of Medicine, St. Louis, Missouri, USA | [2]Department of Dermatology, SSM Health and Saint Louis University, St. Louis, Missouri, USA | [3]Department of Allergy and Immunology, SSM Health and Saint Louis University, St. Louis, Missouri, USA | [4]Department of Pediatrics, SSM Health Cardinal Glennon Children's Hospital, St. Louis, Missouri, USA | [5]Department of Pediatrics and Dermatology, SSM Health and Saint Louis University, St. Louis, Missouri, USA

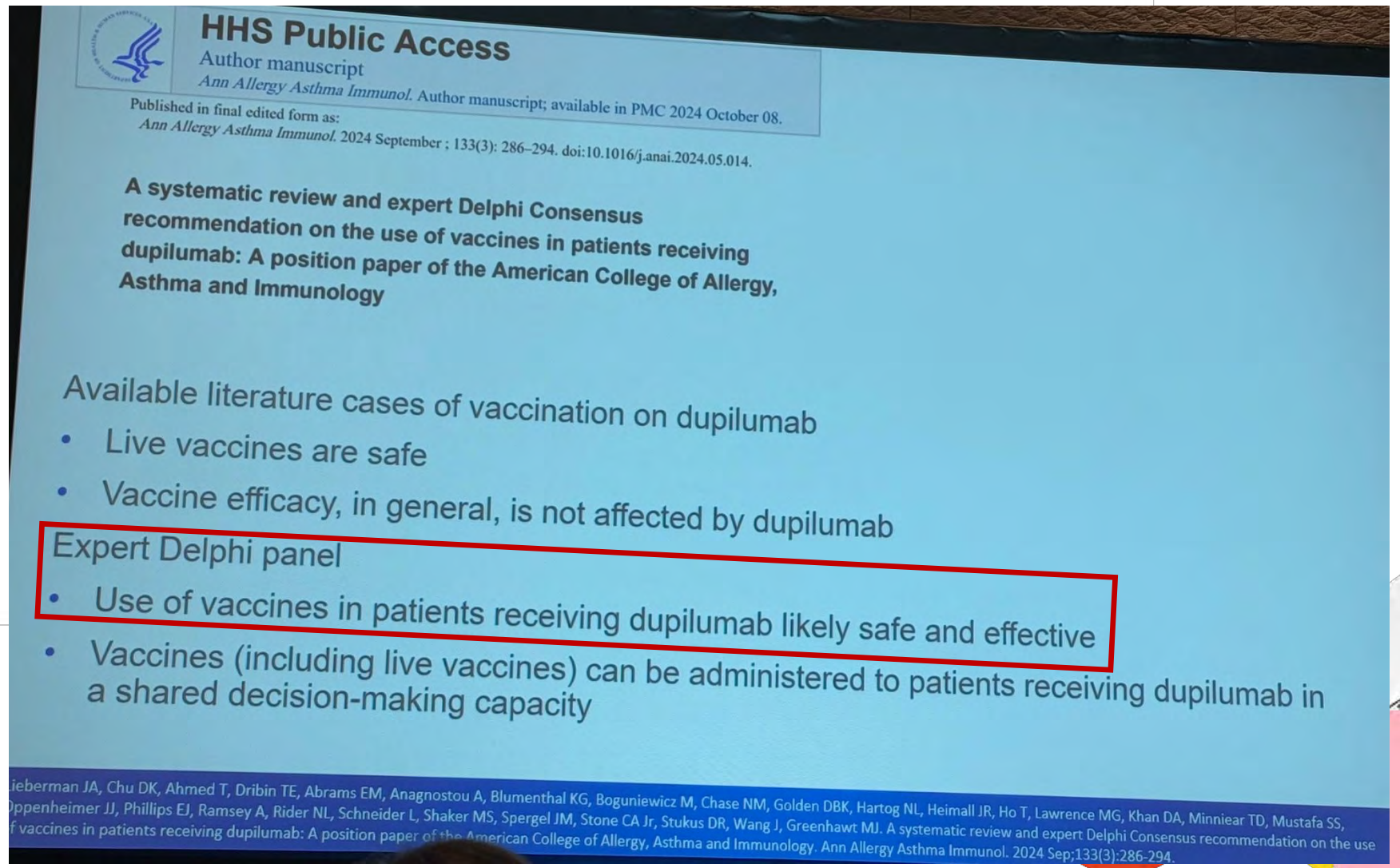
Pediatr Dermatol. 2024 Dec 11.

5 patients received MMRV while on dupilumab

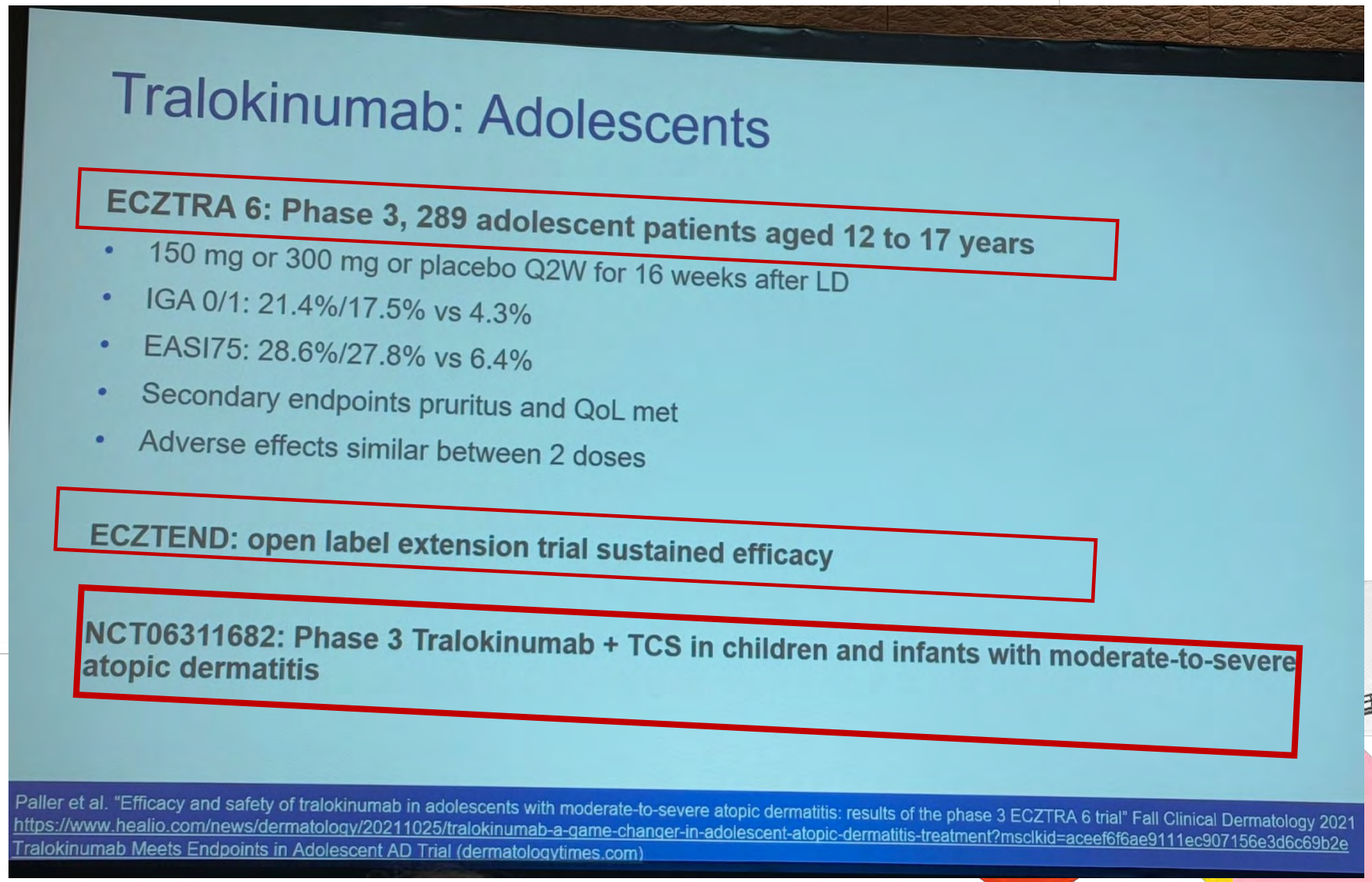
- No adverse effects for up to 6 months

Hughes JR, Mehrmal S, Habib S, Williams HL, Siegfried EC. Live Attenuated Vaccine Administration in Children Treated With Methotrexate or Dupilumab. Pediatr Dermatol. 2024 Dec 11. doi: 10.1111/pde.15818. Epub ahead of print. PMID: 39660821.
Siegfried EC, Wine Lee L, Spergel JM, Prescilla R, Uppal S, Coleman A, Bansal A, Cyr SL, Shumel B. A case series of live attenuated vaccine administration in dupilumab-treated children with atopic dermatitis. Pediatr Dermatol. 2024 Mar-Apr;41(2):204-209. doi: 10.1111/pde.15518. Epub 2024 Feb 2. PMID: 38308453.

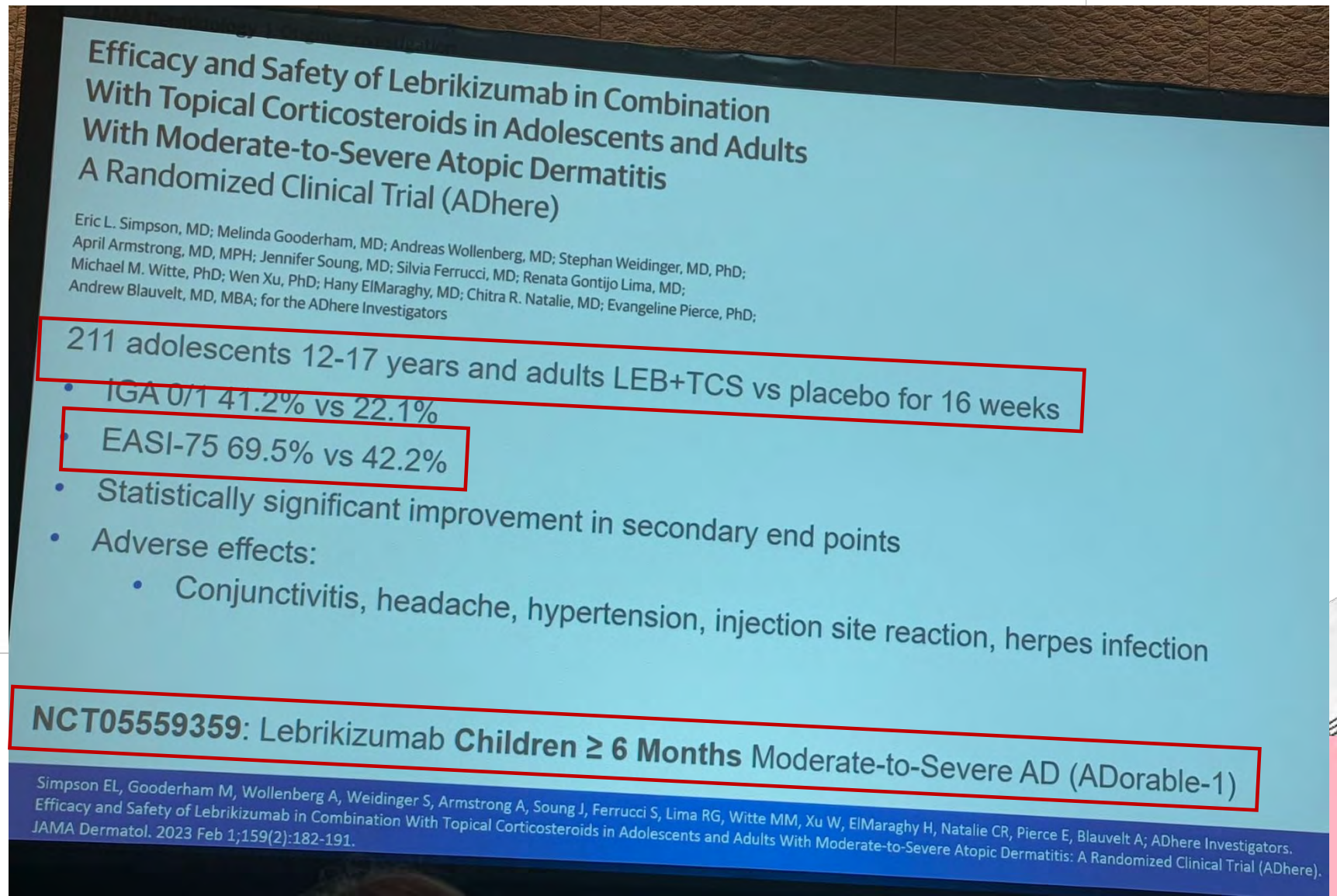
DERMATITIS ATÓPICA. Sistémicos. Dupilumab



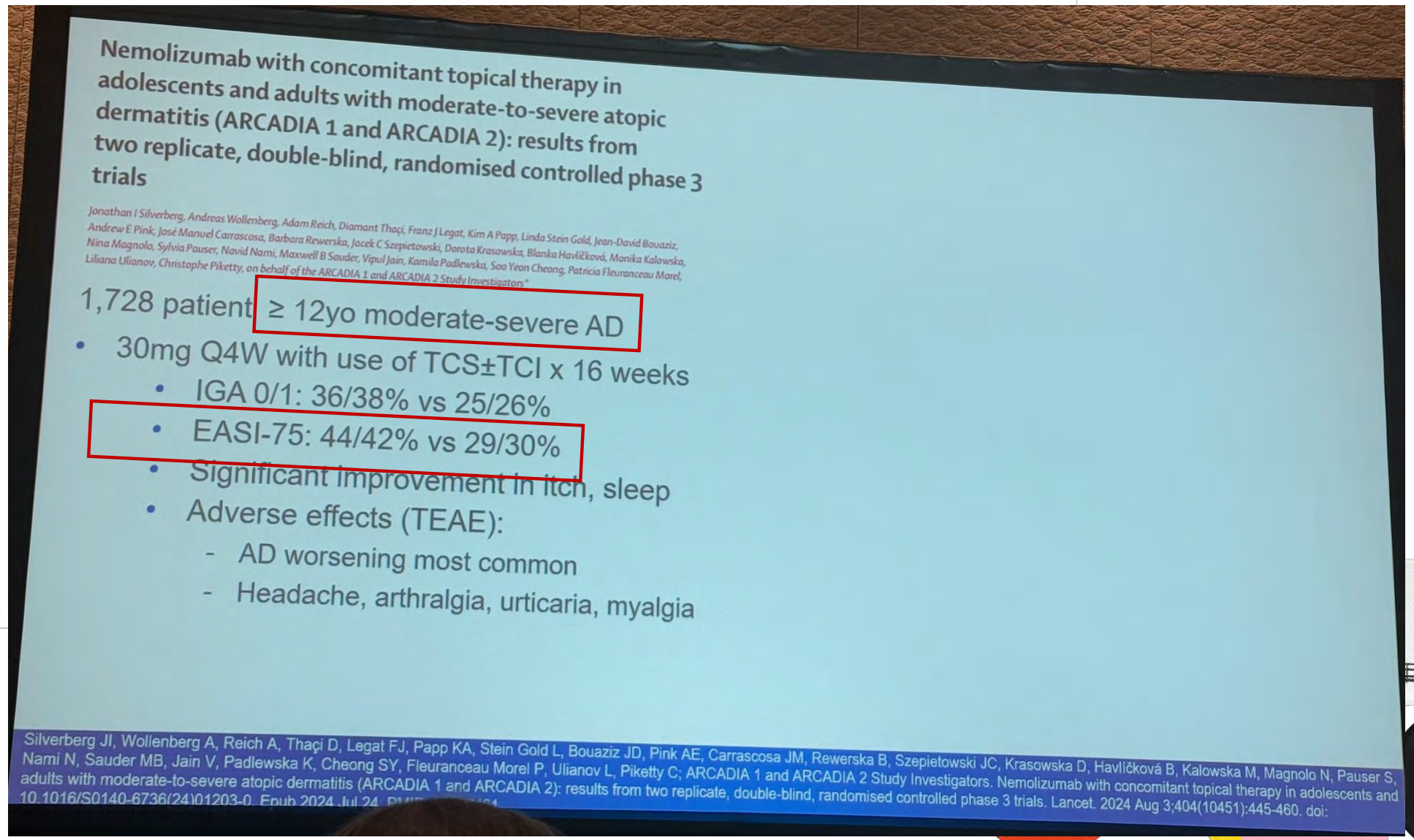
DERMATITIS ATÓPICA. Sistémicos. Tralokinumab



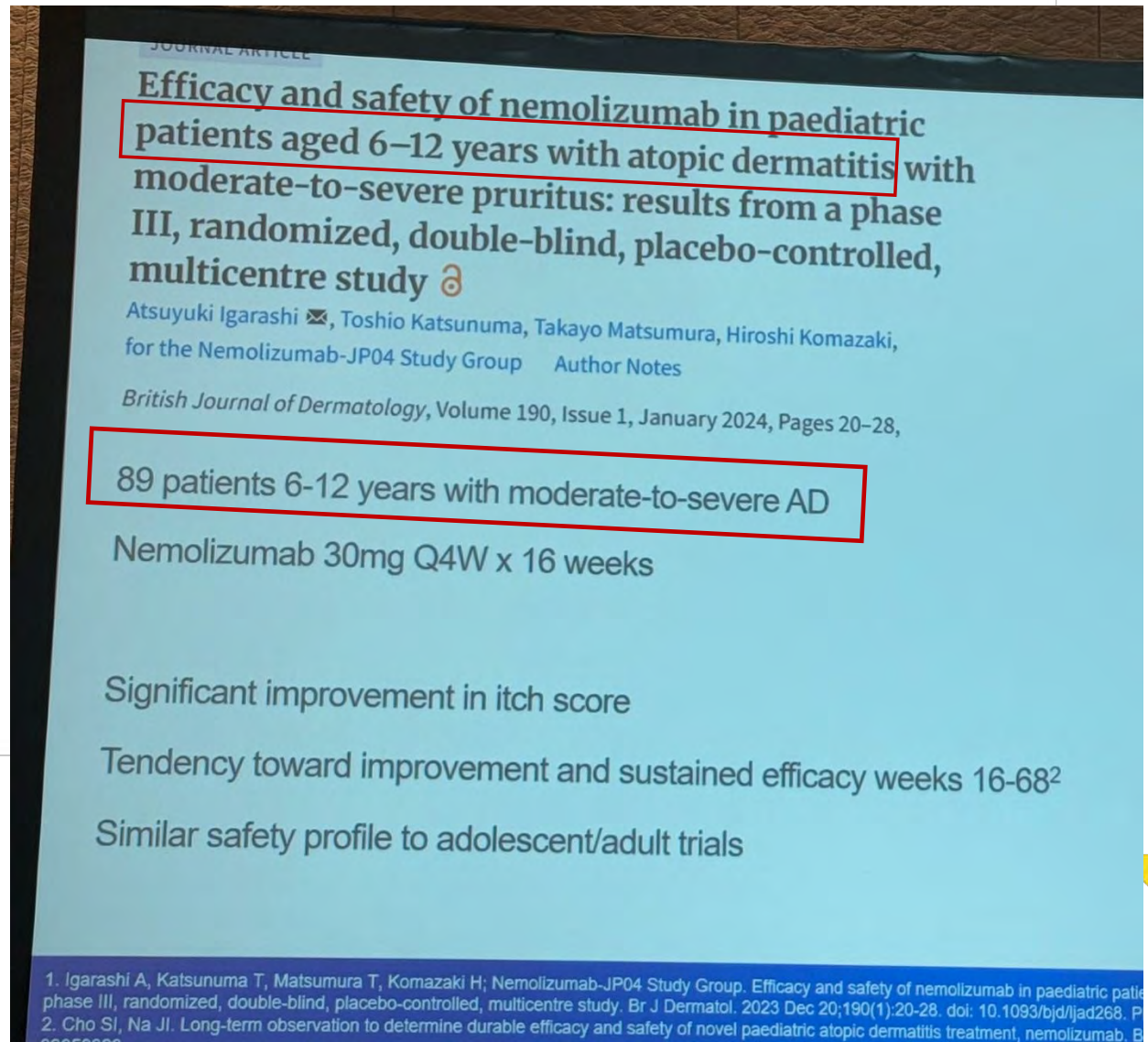
DERMATITIS ATÓPICA. Sistémicos. Lebrikizumab



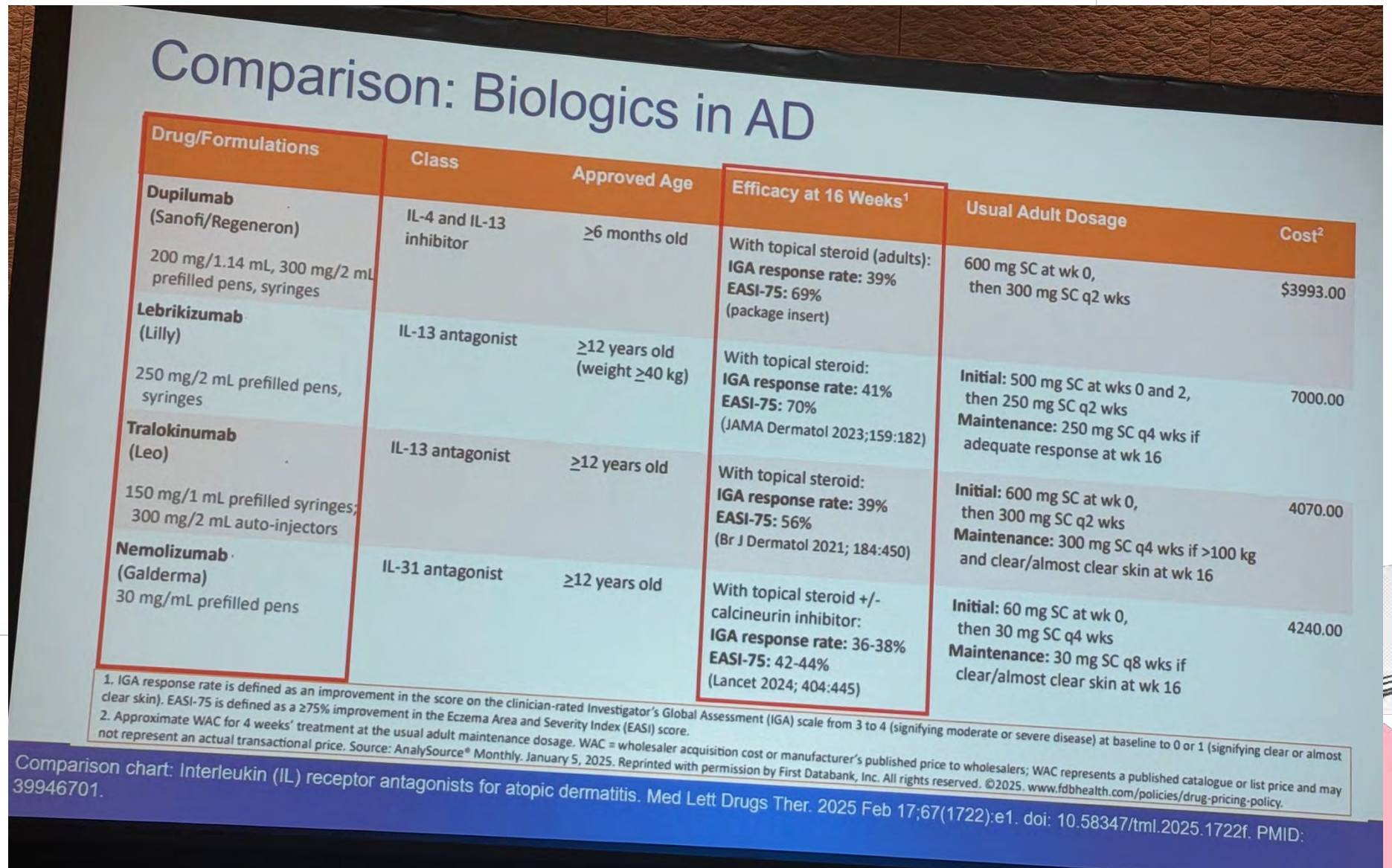
DERMATITIS ATÓPICA. Sistémicos. Nemolizumab



DERMATITIS ATÓPICA. Sistémicos. Nemolizumab



DERMATITIS ATÓPICA. Sistémicos. Comparativa biológicos



Comparison: Biologics in AD

Drug/Formulations	Class	Approved Age	Efficacy at 16 Weeks[1]	Usual Adult Dosage	Cost[2]
Dupilumab (Sanofi/Regeneron) 200 mg/1.14 mL, 300 mg/2 mL prefilled pens, syringes	IL-4 and IL-13 inhibitor	≥6 months old	With topical steroid (adults): **IGA response rate:** 39% **EASI-75:** 69% (package insert)	600 mg SC at wk 0, then 300 mg SC q2 wks	$3993.00
Lebrikizumab (Lilly) 250 mg/2 mL prefilled pens, syringes	IL-13 antagonist	≥12 years old (weight ≥40 kg)	With topical steroid: **IGA response rate:** 41% **EASI-75:** 70% (JAMA Dermatol 2023;159:182)	**Initial:** 500 mg SC at wks 0 and 2, then 250 mg SC q2 wks **Maintenance:** 250 mg SC q4 wks if adequate response at wk 16	7000.00
Tralokinumab (Leo) 150 mg/1 mL prefilled syringes; 300 mg/2 mL auto-injectors	IL-13 antagonist	≥12 years old	With topical steroid: **IGA response rate:** 39% **EASI-75:** 56% (Br J Dermatol 2021; 184:450)	**Initial:** 600 mg SC at wk 0, then 300 mg SC q2 wks **Maintenance:** 300 mg SC q4 wks if >100 kg and clear/almost clear skin at wk 16	4070.00
Nemolizumab (Galderma) 30 mg/mL prefilled pens	IL-31 antagonist	≥12 years old	With topical steroid +/- calcineurin inhibitor: **IGA response rate:** 36-38% **EASI-75:** 42-44% (Lancet 2024; 404:445)	**Initial:** 60 mg SC at wk 0, then 30 mg SC q4 wks **Maintenance:** 30 mg SC q8 wks if clear/almost clear skin at wk 16	4240.00

1. IGA response rate is defined as an improvement in the score on the clinician-rated Investigator's Global Assessment (IGA) scale from 3 to 4 (signifying moderate or severe disease) at baseline to 0 or 1 (signifying clear or almost clear skin). EASI-75 is defined as a ≥75% improvement in the Eczema Area and Severity Index (EASI) score.
2. Approximate WAC for 4 weeks' treatment at the usual adult maintenance dosage. WAC = wholesaler acquisition cost or manufacturer's published price to wholesalers; WAC represents a published catalogue or list price and may not represent an actual transactional price. Source: AnalySource® Monthly. January 5, 2025. Reprinted with permission by First Databank, Inc. All rights reserved. ©2025. www.fdbhealth.com/policies/drug-pricing-policy.

Comparison chart: Interleukin (IL) receptor antagonists for atopic dermatitis. Med Lett Drugs Ther. 2025 Feb 17;67(1722):e1. doi: 10.58347/tml.2025.1722f. PMID: 39946701.

DERMATITIS ATÓPICA. Sistémicos. JAKi: upadacitinib

Upadacitinib

Once-daily upadacitinib versus placebo in adolescents and adults with moderate-to-severe atopic dermatitis (Measure Up 1 and Measure Up 2): results from two replicate double-blind, randomised controlled phase 3 trials

Emma Guttman-Yassky, Henrique D Teixeira, Eric L Simpson, Kim A Papp, Aileen L Pangan, Andrew Blauvelt, Diamant Thaçi, Chia-Yu Chu, H Chih-ho Hong, Norito Katoh, Amy S Paller, Brian Calimlim, Yihua Gu, Xiaofei Hu, Meng Liu, Yang Yang, John Liu, Allan R Tenorio, Alvina D Chu, Alan D Irvine

Improvement by week 16, sustained @ week 52

EASI 75, EASI 90, vIGA, Itch

AEs: *acne 7-17%,* nasopharyngitis, CPK, URI, HSV, herpes zoster

ancet. 2021 Jun 5;397(10290):2151-2168.

Safety of upadacitinib in moderate-to-severe atopic dermatitis: An integrated analysis of phase 3 studies

Check for updates

Emma Guttman-Yassky, MD, PhD,[a] Jacob P. Thyssen, MD, PhD, DmSci,[b] Jonathan I. Silverberg, MD, PhD, MPH,[c] Kim A. Papp, MD, PhD,[d] Amy S. Paller, MD,[e] Stephan Weidinger, MD,[f] H. Chih-ho Hong, MD,[g] Barbara Hendrickson, MD,[h] Deanne Dilley, MPH,[h] Allan R. Tenorio, MD,[h] Barry Ladizinski, MD, MPH, MBA,[h] Alvina D. Chu, MD,[h] John Liu, MD, MS,[h] and Alan D. Irvine, MD, DSc[i]

New York, NY; Copenhagen, Denmark; Washington, DC; Waterloo, Ontario, and Vancouver and Surrey, British Columbia, Canada; Chicago and North Chicago, Ill; Kiel, Germany; and Dublin, Ireland

2485 patients (333 adolescents), 15 mg (n = 1239) or 30 mg (n = 1246) for average 1 year

- AEs more common in 30mg dosing
- Acne most common >10%
- No new important safety risks

DERMATITIS ATÓPICA. Sistémicos. Comparativa

JAKi Show Superior Efficacy to Dupilumab Head-to-Head Studies

Study	Drug	IGA 0/1 @ week 12	EASI-75 @ week 12	PP-NRS @ week 2	IGA 0/1 @ week 16	AEs
JADE Compare 26-week Phase 3 trial n=838	**Abrocitinib** 100mg daily n=238	36.6%	58.7%	31.8%	34.8%	Nausea, acne, headache, herpes zoster
	Abrocitinib 200mg daily n=226	48.4%	70.3%	49.1%	47.5%	Nausea, acne, headache and herpes zoster
	Dupilumab 300mg Q2W n=243	36.5%	58.1%	26.4%	38.8%	Conjunctivitis, nasopharyngitis and headache
	Placebo n=131	14.0%	27.1%	13.8%	12.9%	

Study	Drug	EASI-90 @ week 4	PP-NRS @ week 2	EASI-90 @ week 16	AEs
JADE DARE 26-week Phase 3 trial n=727	**Abrocitinib** 200mg daily n=362	29%	48%	54%	Nausea, acne, headache, folliculitis
	Dupilumab 300mg Q2W n=365	15%	26%	42%	Conjunctivitis, headache

Study	Drug	EASI-75 @ week 16	Change from baseline worst pruritus @ week 16	EASI-90 @ week 16	AEs
Heads Up 24-week Phase 3 trial n=692	**Upadacitinib** 30mg daily n=348	71.0%	66.9%	60.0%	Acne, headache, folliculitis, transaminitis, cytopenias, URTI
	Dupilumab 300mg Q2W n=344	61.1%	49%	38.7%	Conjunctivitis, headache, nasopharyngitis

DERMATITIS ATÓPICA. Sistémicos. Comparativa

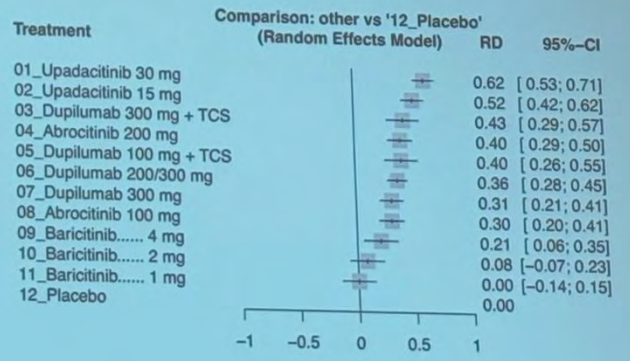
DOI: 10.1111/pai.70045

ORIGINAL ARTICLE

WILEY

Comparative efficacy of biologics and small molecule drugs in treating pediatric atopic dermatitis in patients aged 2–18 years: A 12–16 week network meta-analysis of randomized controlled trials

Su-Boon Yong[1] | Berne Ting[2] | Ikbal Andrian Malau[3,4] | Suet-Kei Wu[3,5] | Xin-Zhi Huang[6] | Jiu-Yao Wang[1,7] | Li Jingling[4] | Chang-Ching Wei[1,8]



8 RCTs children 2-18 y (primarily adolescents) through March 2024

Upadacitinib highest efficacy at 30mg and 15mg

Dupilumab with TCS, abrocitinib significant efficacy

Yong SB, Ting B, Malau IA, Wu SK, Huang XZ, Wang JY, Jingling L, Wei CC. Comparative efficacy of biologics and small molecule drugs in treating pediatric atopic dermatitis in patients aged 2-18 years: A 12-16 week network meta-analysis of randomized controlled trials. Pediatr Allergy Immunol. 2025 Feb;36(2):e70045. doi: 10.1111/pai.70045. PMID: 39936572

DERMATITIS ATÓPICA. Sistémicos. Comparativa

RESEARCH ARTICLE

Comparative efficacy and safety of dupilumab versus newly approved biologics and JAKi in pediatric atopic dermatitis: A systematic review and network meta-analysis

Qiwei Liao*, Hanwen Pan, Yixin Guo, Yuxiang Lan, Zhuo Huang, Peiyi Wu

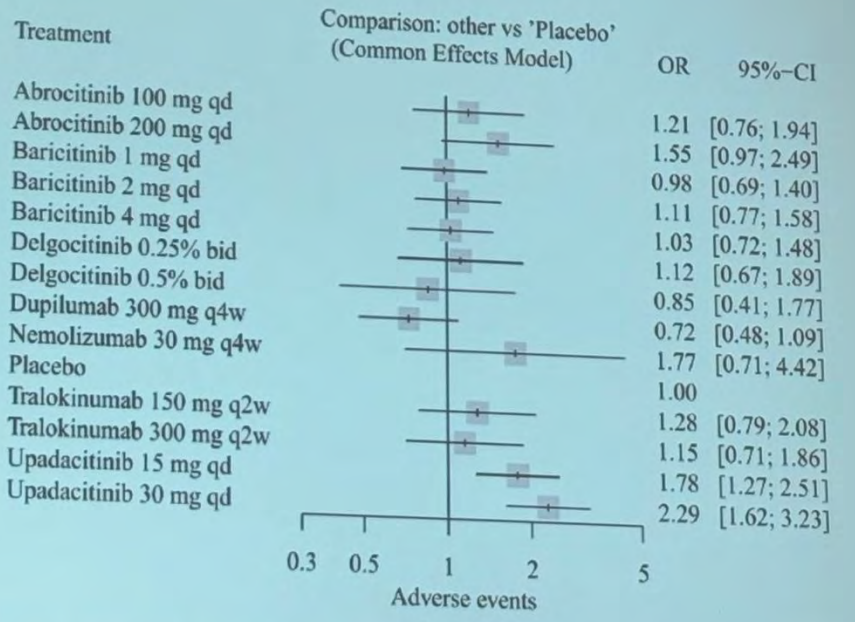
2,352 pediatric patients from 11 trials

Drug efficacy compared to dupilumab 300mg q4 weeks

- Upadacitinib 30mg best IGA 0/1, EASI-75, EASI-90
- Tralokinumab may be most effective for pruritus

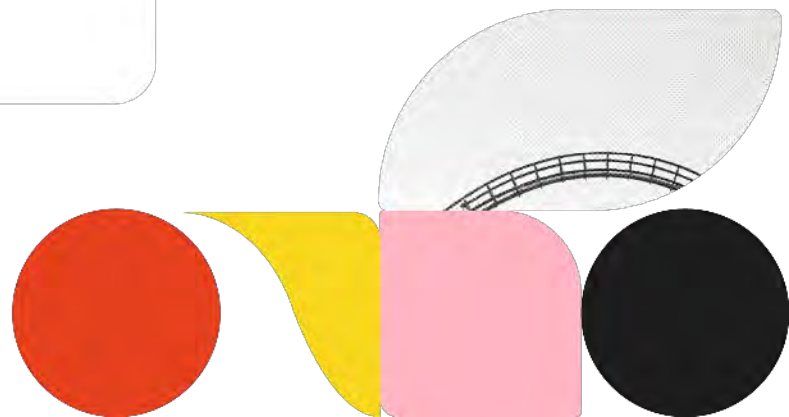
Adverse effects compared to placebo

- Upadacitinib highest AE
- Dupilumab nasopharyngitis
- URTI with baricitinib, tralokinumab

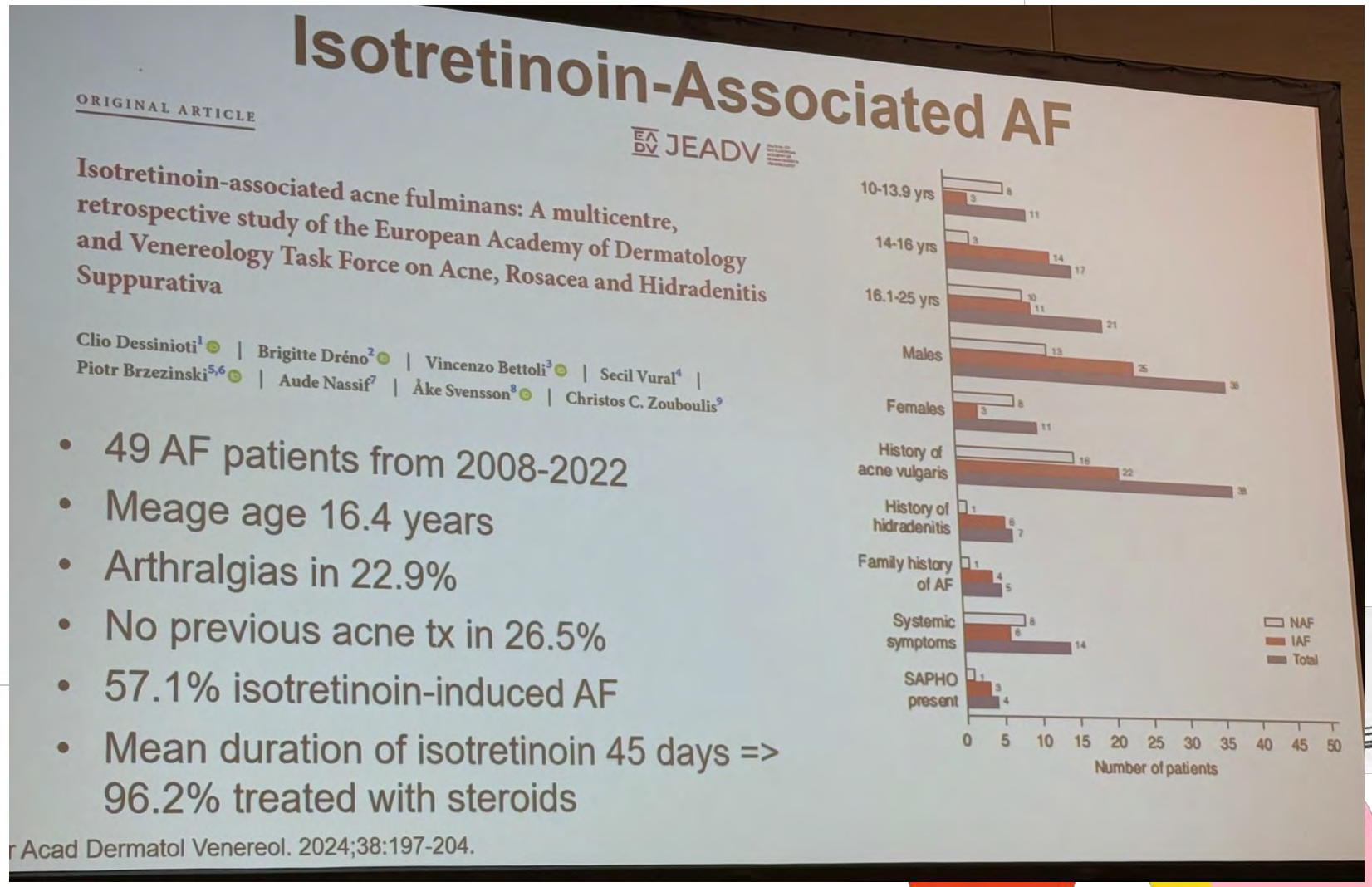


Liao Q, Pan H, Guo Y, Lan Y, Huang Z, Wu P. Comparative efficacy and safety of dupilumab versus newly approved biologics and JAKi in pediatric atopic dermatitis: A systematic review and network meta-analysis. PLoS One. 2025 Feb 24;20(2):e0319400. doi: 10.1371/journal.pone.0319400. PMID: 39992967; PMCID: PMC11849894.

ACNÉ E HS



ACNÉ. Acné *fulminans.* Clínica



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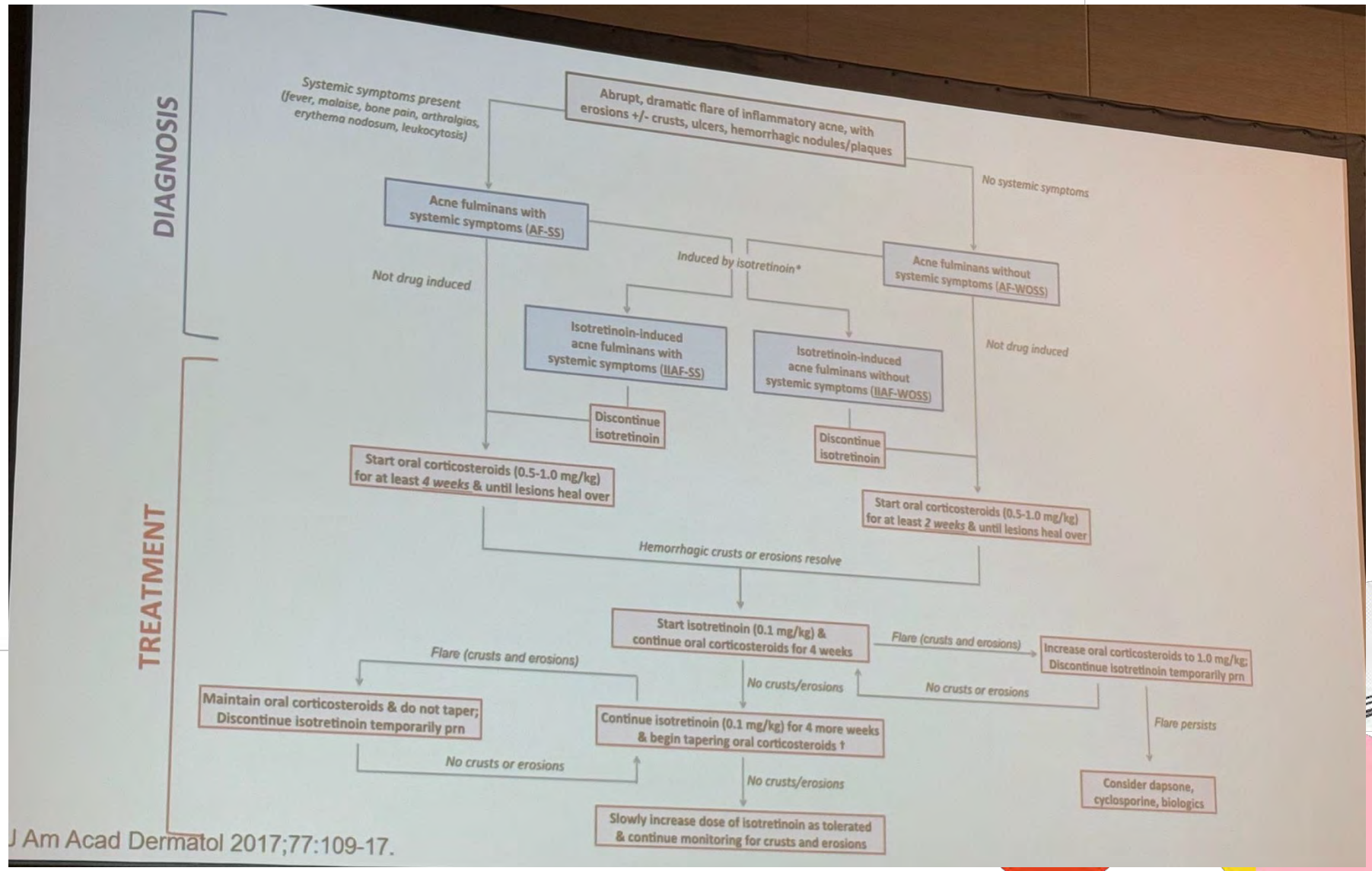
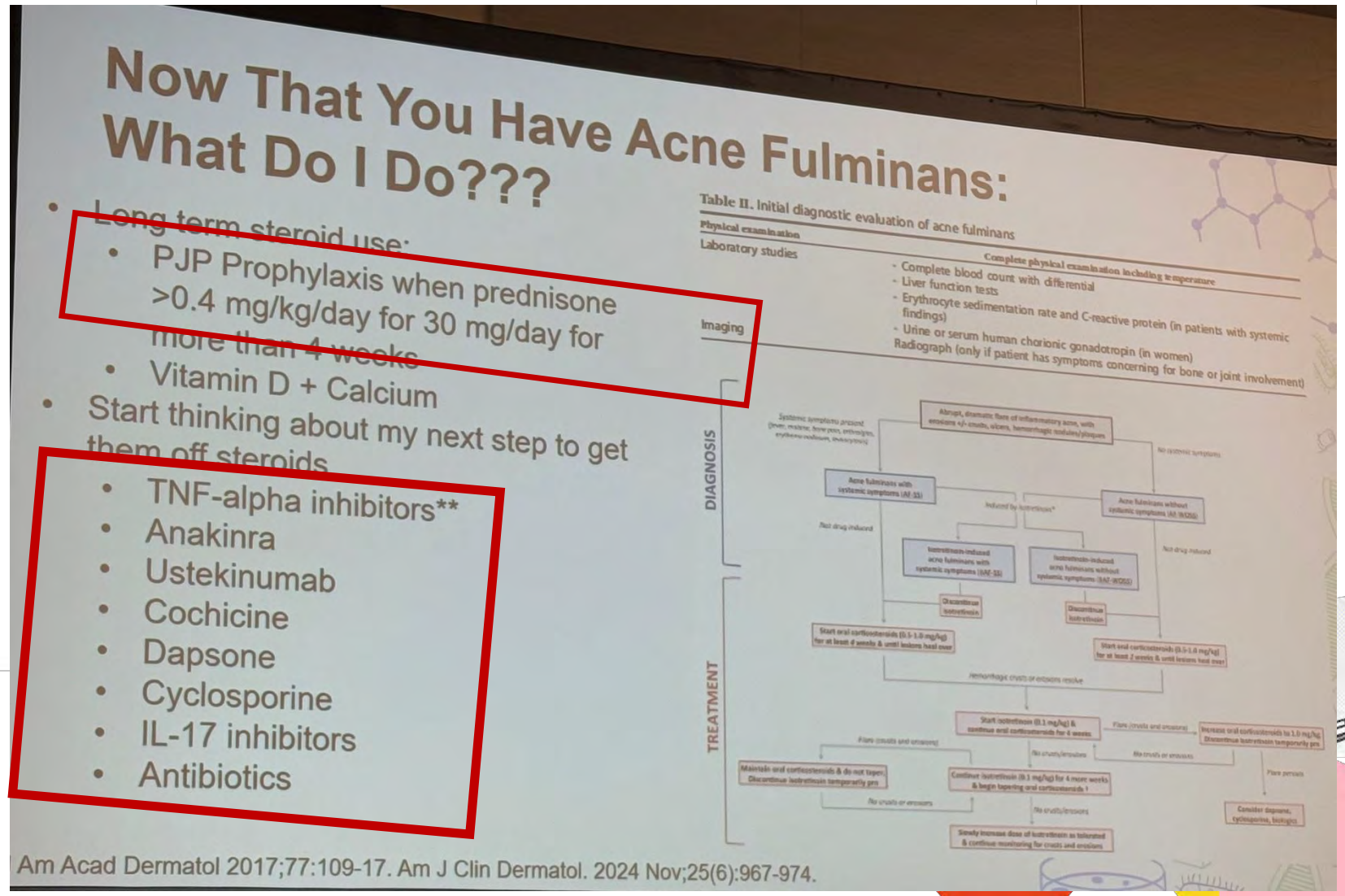


ACNÉ. Acné *fulminans.* Nuevas moléculas



ACNÉ. Acné *fulminans.* Nuevas moléculas

TNFis Effective in Treating Refractory Acne

- Systematic review of 53 studies on 64 patients who received TNFis for treatment of acne +/- other condition (47 for only acne)
- TNFis: adalimumab, infliximab, etanercept
- Mean age: 28.7 years
- 6 female patients
- 44/47 experienced partial improvement or clearance
- An alternative if isotretinoin fails!

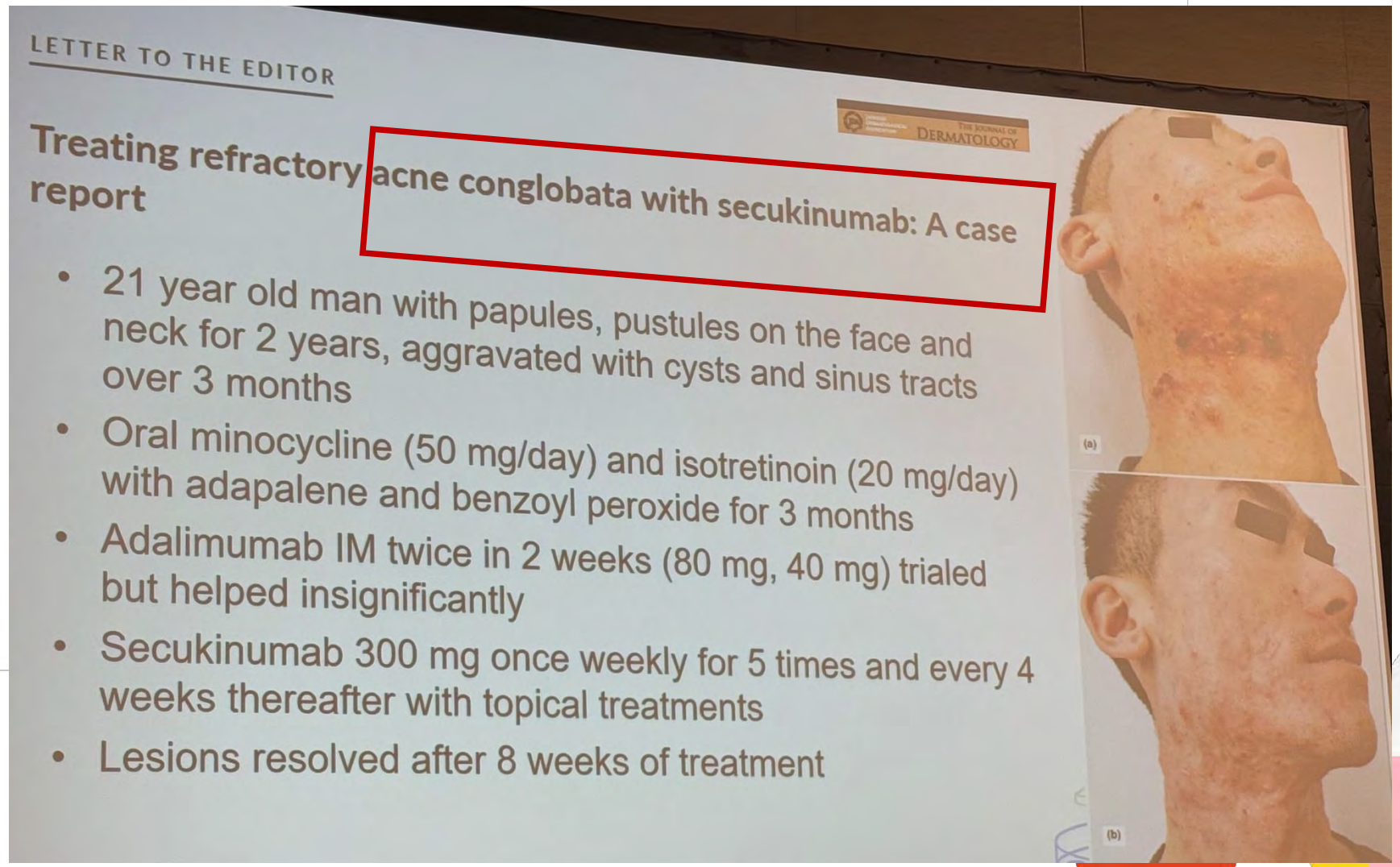
Table 2. Summary of Studies in Which Treatment With TNFis Was Followed by Acne Occurrence

Treatment	No. of patients (%) [sex, F/M]	Age, mean (range)	Involved areas	History of prior acne	Indication for which TNFi was used	Time to acne onset, mean (SD) [range], d	TNFi regimen altered	Notes
Totals	17 (100) [6/11]	36.6 (16-62)	Face: 11 (64.7); back: 9 (52.9); chest: 4 (23.5); neck: 2 (11.8); axillae: 1 (5.9); groin: 1 (5.9); arms: 1 (5.9); legs: 2 (11.8); abdomen: 1 (5.9); NR: 1 (5.9)	No: 9 (52.9); yes: 1 (5.9); NR: 7 (41.2)	Crohn disease: 9 (52.9); psoriasis: 6 (35.3); rheumatologic: 6 (35.3)	48.7 (37.4) [14-135]	Discontinued: 8 (47.1); continued with addition of medication: 5 (29.4); continued with change of frequency: 1 (5.9); no change: 1 (5.9); NR: 2 (11.8)	NA
Etanercept	1 (5.9) [0/1]	35 (NA)	Face: 1 (100)	NR: 1 (100)	Psoriasis: 1 (100)	30 (NA) [NA]	Discontinued: 1 (100)	1 Patient discontinued taking etanercept, reinitiated, then discontinued again due to recurrence of acne
Adalimumab	7 (41.2) [3/4]	45.4 (20-62)	Face: 5 (71.4); back: 4 (57.1); chest: 4 (57.1); axillae: 1 (14.3); groin: 1 (14.3); arms: 1 (14.3); legs: 1 (28.6); abdomen: 1 (14.3)	No: 3 (42.9); NR: 4 (57.1)	Crohn disease: 3 (42.9); psoriasis: 3 (42.9); rheumatologic: 3 (42.9)	60.1 (41.0) [15-135]	Discontinued: 4 (57.1); continued with addition of medication: 1 (14.3); no change: 1 (14.3); NR: 1 (14.3)	NA
Infliximab	9 (52.9) [3/6]	29.9 (16-44)	Face: 5 (55.6); back: 5 (55.6); neck: 2 (22.2)	No: 6 (66.7); yes: 1 (11.1); NR: 2 (22.2)	Crohn disease: 6 (66.7); psoriasis: 2 (22.2); rheumatologic: 3 (33.3)	41 (36.1) [14-120]	Discontinued: 3 (33.3); continued with addition of medication: 4 (44.4); continued with change of frequency: 1 (14.3); NR: 1 (14.3)	1 Patient discontinued taki infliximab then switched to adalimumab without recurre of acne

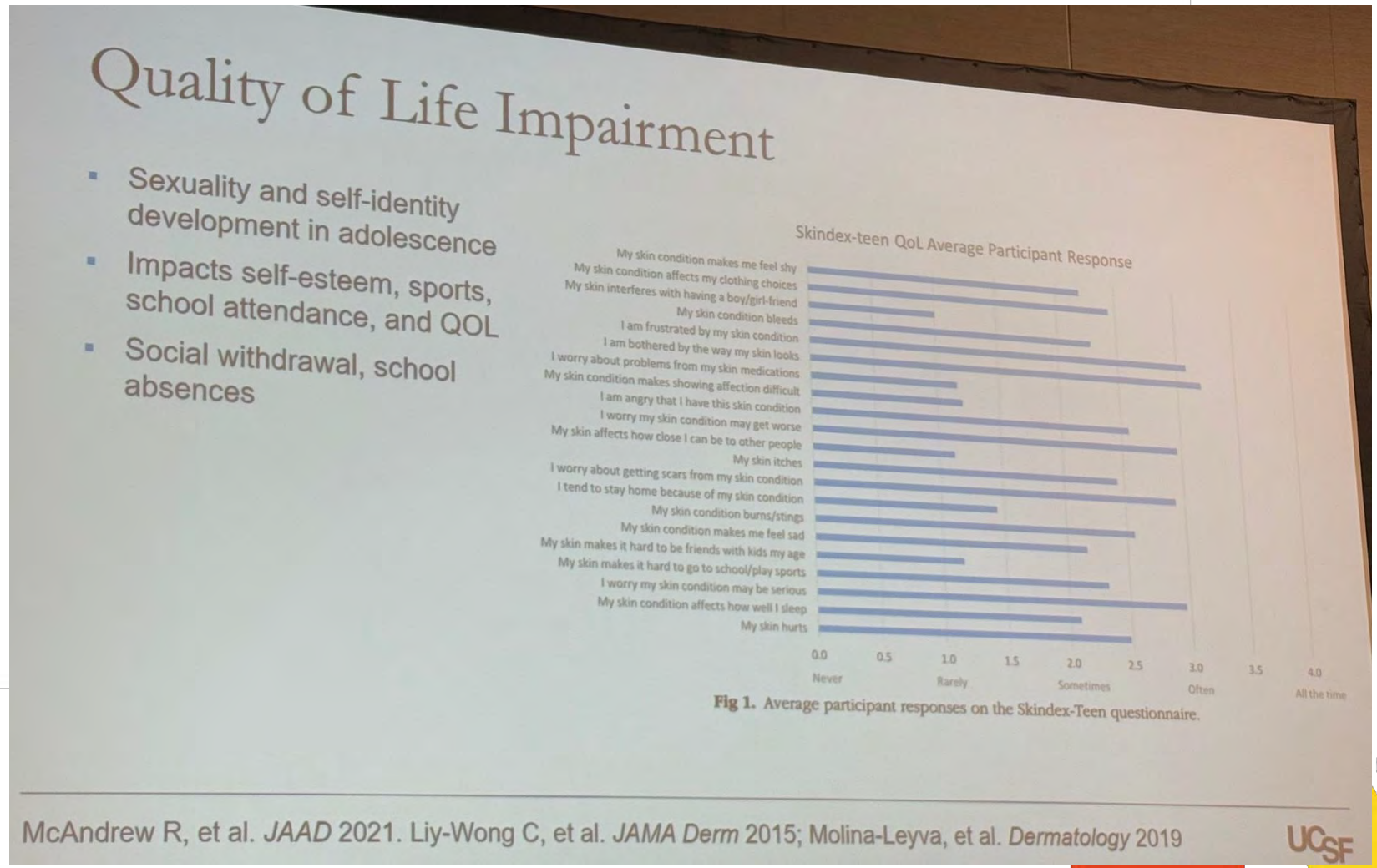
Abbreviations: F, female; M, male; NA, not applicable; NR, not reported; TNFi, tumor necrosis factor-α inhibitor.

JAMA Dermatol. 2023 May 1;159(5):504-509. doi: 10.1001/jamadermatol.2023.0269.

ACNÉ. Perla acné conglobata



Hidradenitis supurativa. Carga



Hidradenitis supurativa. Carga

UPMC
LIFE CHANGING MEDICINE

Incidence of Psychiatric Diagnoses in a Pediatric Hidradenitis Suppurativa Population in Western PA

Sydney DeVore BS, Ellen Koch MD

University of Pittsburgh Medical Center, Pittsburgh PA

**No disclosures to report

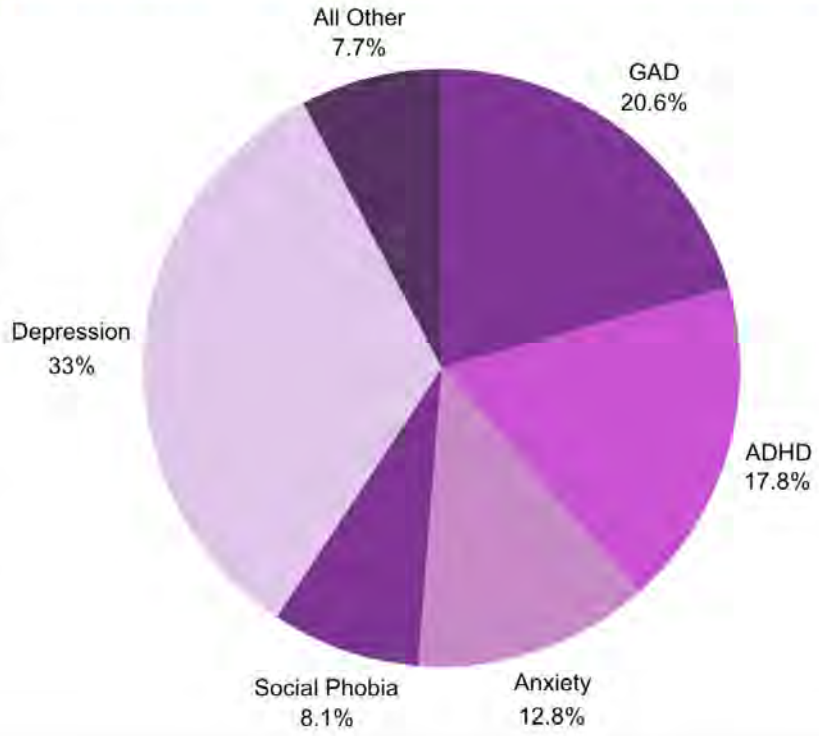
Introduction

- Hidradenitis Suppurativa (HS) is an inflammatory skin disorder characterized by follicular occlusion and inflammation
- Symptoms include pain, scarring, and draining abscesses in the axilla, buttocks or groin, leading patients to report poor mental health
- A growing number of cases are occurring in children
- This study analyzes the psychosocial burden of hidradenitis suppurativa in children, as measured by the incidence of different psychiatric disorders such as anxiety, depression, and social phobias.

Methodology

- We conducted a retrospective cohort study of 1139 pediatric HS patients within the UPMC system
- 492 patients additionally had a psychiatric comorbidity
- We recorded demographic information, BMI, race, sex, and ethnicity for each patient, as well as any psychiatric diagnoses

Figure 1: Percentages of Psychiatric Disorders within our 492 patient HS + Psych Cohort



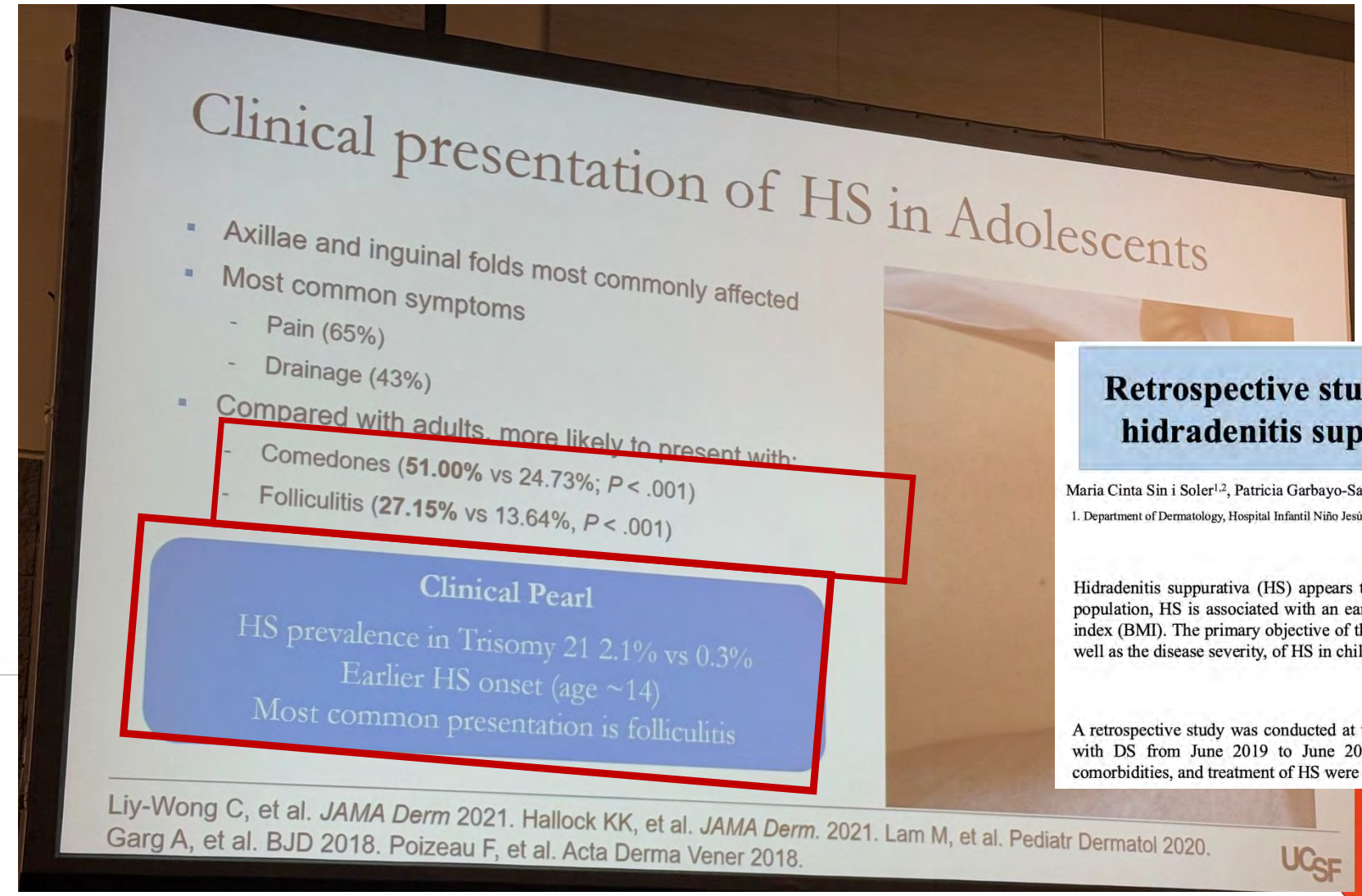
Results

- HS patients with a psychiatric diagnosis had a significantly higher average BMI than patients without a psychiatric diagnosis (p=0.035)
- Female patients without our pediatric HS-psychiatric cohort were significantly more likely than male patients to have a psychiatric diagnosis (p=0.0005, 95%CI=1.2767 to 2.5059, OR=1.7526)
- Black female HS patients were significantly more likely to have a diagnosis of anxiety than HS patients of any other race or gender (p=0.0341, 95%CI=0.1413-0.9264, OR=0.3618)

Conclusion

- Our study suggests that psychiatric patients have greater risks associated with HS, namely higher average BMI
- It also ultimately suggests that female and black female patients have a higher psychiatric burden from the disease
- Future work will analyze other factors associated with pediatric HS patients including insurance type, age at HS diagnosis, and specialty of diagnostic provider

Hidradenitis supurativa. Clínica



Retrospective study of 32 pediatric patients with hidradenitis suppurativa and Down syndrome

Maria Cinta Sin i Soler[1,2], Patricia Garbayo-Salmons[2], Antonio Torrelo[1], Angela Hernández-Martín[1], Lucero Noguera-Morel[1].

1. Department of Dermatology, Hospital Infantil Niño Jesús, Madrid, Spain. 2. Department of Dermatology, Parc Taulí Hospital Universitari, Sabadell, Spain.

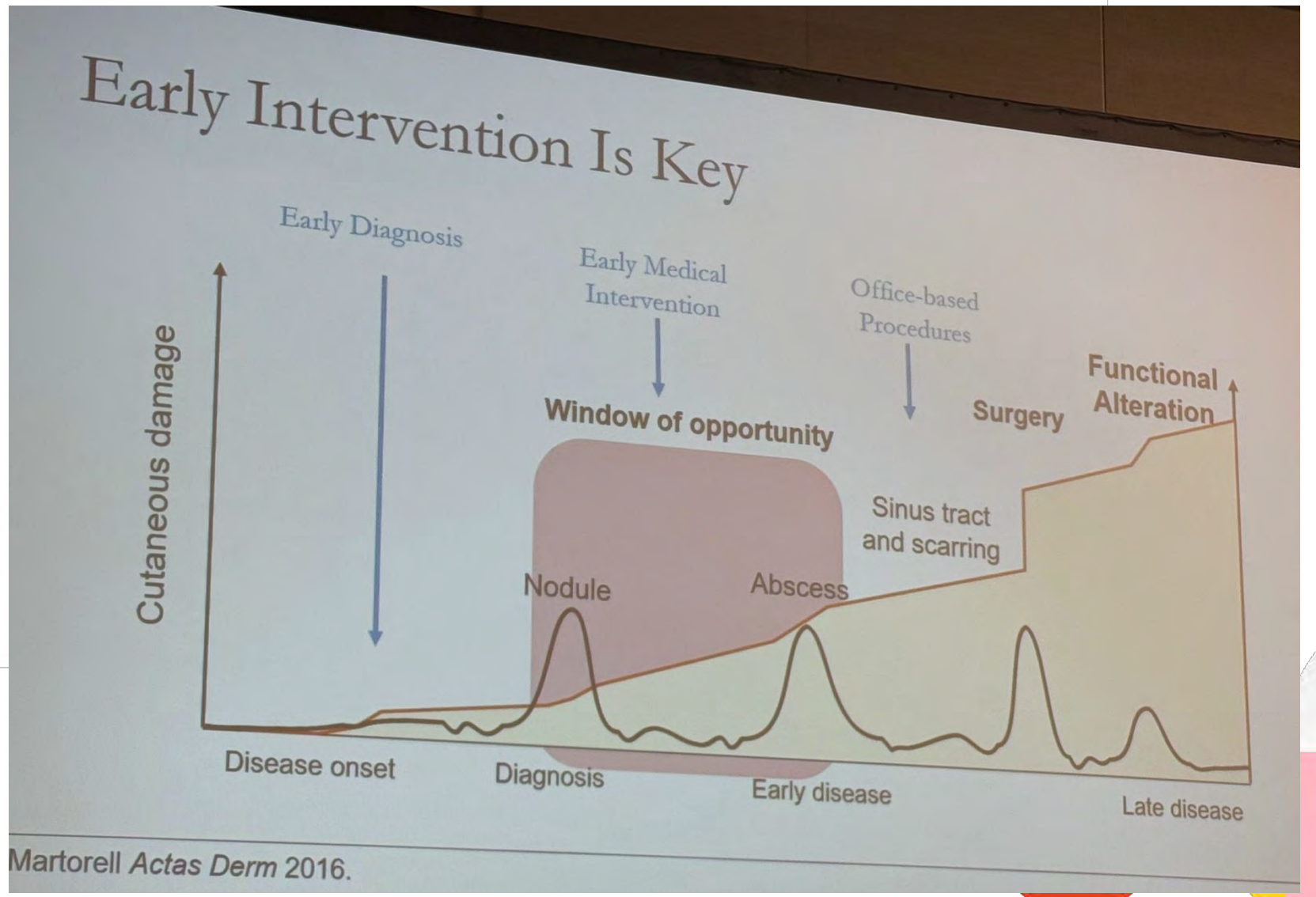
Introduction:

Hidradenitis suppurativa (HS) appears to be more prevalent in patients with Down syndrome (DS). In this population, HS is associated with an earlier onset, a higher incidence in females, and an elevated body mass index (BMI). The primary objective of this study is to describe the demographic and clinical characteristics, as well as the disease severity, of HS in children with DS.

Methods:

A retrospective study was conducted at the Hospital Infantil Universitario Niño Jesús, involving 118 children with DS from June 2019 to June 2024. Data on demographics and frequency, clinical characteristics, comorbidities, and treatment of HS were collected and analyzed.

Hidradenitis supurativa. Tratamiento

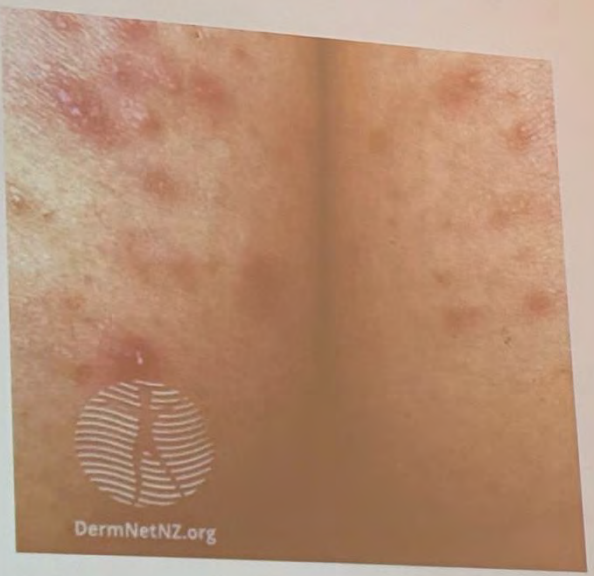


Hidradenitis supurativa. Tratamiento

Anti-androgens in Adolescents

SUGGEST

- Spironolactone
- Oral contraceptives, ↑estrogen:progesterone
  - AVOID progestin-only contraception**
- Finasteride, esp for male patients
- Metformin, esp in setting of insulin resistance



16 Alhusayen R, et al. Management of HS in Special Populations. *JAAD* 2025

Hidradenitis supurativa. Tratamiento

A Retrospective Analysis of Spironolactone Efficacy and Predictors of Isotretinoin Transition in Pediatric Acne Vulgaris

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*Koral Cohen, BA and Carli D. Needle, BA are co-first authors on poster

Conflicts of Interest: None. Commercial Support: None.

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INTRODUCTION

- Acne vulgaris (AV) impacts **over 90% of adolescents**, often causing psychosocial distress and cosmetic disfigurement
- **Spironolactone**, with its anti-androgenic properties, is a **promising treatment for acne** in female patients
- There is a lack of prospective, randomized controlled trials assessing the efficacy of spironolactone in adolescent females
- **Objective**: To evaluate treatment failure rates and factors leading to isotretinoin transition in pediatric patients treated with spironolactone for AV

METHODS

- **Study Type**: Retrospective, single-center, IRB-approved
- **Study Population** (N=160): Females, age ≤18 years, treated with spironolactone for AV at NYU Langone Health (2015-2023)
- **Transition Group** (N=5): Required to be on spironolactone for ≥3 months before transitioning to isotretinoin
- **Exclusion Criteria**:
  - Fewer than 2 follow-up visits for spironolactone prescribed for AV
  - Spironolactone prescribed primarily for non-acne conditions such as congenital adrenal hyperplasia, even with co-morbid AV
  - Less than 3 months on spironolactone before isotretinoin transition
- **Data Collected**: Demographics, treatment duration, clinical outcomes, hormonal factors, isotretinoin transition, comorbidities
- **Analysis**: Barnard's Exact Test; p<0.05 considered significant

FIGURES AND TABLES

Figure 1: *Treatment Pathway for Pediatric Acne Patients*

Table 1: *Patient Demographics and Baseline Characteristics*

Characteristics	Overall (N=160)	Non-Transition Group (N=155)	Transition Group (N=5)
Age			
Mean (years)	13.66	13.62	10.40
Range (years)	8 to 18	9 to 18	8 to 12
Race/Ethnicity			
White	70 (43.75%)	67 (43.23%)	3 (60%)
Black or African American	11 (6.88%)	9 (5.81%)	2 (40%)
Hispanic or Latino	16 (9.25%)	16 (9.45%)	0 (0%)
Asian	9 (5.63%)	9 (5.81%)	0 (0%)
Other/mixed	45 (28.13%)	45 (29.03%)	0 (0%)
Not reported/unknown	15 (9.38%)	15 (9.68%)	0 (0%)
Body Mass Index (BMI)*			
Underweight	22 (13.75%)	21 (13.55%)	1 (20%)
Normal Range	67 (64.38%)	64 (54.19%)	3 (60%)
Overweight	47 (29.38%)	46 (29.68%)	1 (20%)
Obese	4 (2.50%)	4 (2.58%)	0 (0%)
Acne Severity (N=77)**			
Mild	23 (29.87%)	23 (30.56%)	0 (0%)
Moderate	37 (48.05%)	36 (47.22%)	1 (50%)
Severe	16 (23.38%)	16 (22.22%)	1 (50%)
Spironolactone Treatment Duration			
Mean (months)	15.83	15.77	8.95
Range	3 weeks - 4.5 years	3 weeks - 4.5 years	3 weeks - 1.75 years

*BMI Categories: *Underweight (<18.5), Normal (18.5-24.9), Overweight (25-29.9), Obese (≥30)*
**Acne Severity: *Determined based on physician documentation in chart note assessment*

Table 2: *Barnard's Exact Test for Isotretinoin Transition Factors*

Factor	Non-Transition Group (N=155)	Transition Group (N=5)	p-value
Younger Age (<14 years)	74/155 (47.7%)	4/5 (80%)	0.002
Severe Acne	16/155 (10.3%)	2/5 (40%)	0.0046
Prior OCP Use	56/155 (36.1%)	2/5 (40%)	0.0134
Black or African American	9/155 (5.81%)	2/5 (40%)	0.0143
Shorter Treatment Duration (≤15.53 months)	77/155 (49.7%)	5/5 (100%)	0.0143
Absence of Menstrual Flares	101/155 (65.2%)	5/5 (100%)	0.0404
Scarring Present	35/155 (22.6%)	3/5 (60%)	0.0824
PCOS	23/155 (14.8%)	1/5 (20%)	0.5751
Prior Oral Antibiotic Use	60/155 (61.6%)	3/5 (60%)	0.5751

Table 3: *Breakdown of Spironolactone Prescribers*

Prescriber	Overall (N=160)
Dermatologist	132 (82.5%)
Pediatrician	22 (13.8%)
Pediatric Endocrinologist	7 (4.4%)
OBGYN	5 (3.1%)
Unknown	3 (1.9%)

RESULTS

- Improvement was reported in **89.1%** of patients treated with spironolactone
- Patients had a mean spironolactone treatment duration of **15.5 months**
- Spironolactone was prescribed by a dermatologist in **82.5%** of cases
- The isotretinoin transition rate was **3.7%**, with a mean spironolactone duration of **8.95 months** before switching medications
- Potential predictors of isotretinoin transition included:
  - **Younger age** (p=0.002)
  - **Severe acne** (p=0.0046)
  - **Prior OCP use** (p=0.0134)
  - **Black race** (p=0.0143)
  - **Short treatment duration** (p=0.0143)
  - **No menstrual flares** (p=0.0404)
- **Limitations**: While there were associations with p<0.05, the small number of patients in the transition group (N=5) limits the reliability and generalizability of these results

CONCLUSIONS

- **Spironolactone is a highly effective treatment for pediatric AV**, particularly in cases of hormonally-driven acne
- Certain factors such as **younger age, severe acne, and absence of menstrual flares** may be associated with a higher likelihood of transitioning to isotretinoin
- Our findings emphasize the need for **individualized treatment strategies**, taking into account age, severity, and menstrual patterns to optimize therapeutic outcomes
- **Future Directions**: Continue chart review with expansion of the cohort up to age 21, allowing for a larger transition group and more balanced comparisons

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Hidradenitis supurativa. Tratamiento

Drug Survival of Biologics in Pediatric Patients with Hidradenitis Suppurativa seen at Duke, MGH, and UMass Memorial Health

Robyn Guo, BS[1], Joyce Xia, BS[2], Tarannum Jaleel, MD[3], Amy Buros Stein, PhD[4], Jessica St. John, MD[2], Anna Cristina Garza-Mayers, MD PhD[5], Daniela Kroshinsky, MD MPH[3]

[1]Duke University School of Medicine [2]UMass Memorial Health [3]Duke University Department of Dermatology [4]Pediatric Dermatology Research Alliance [5]Mass General for Children

Objectives

1. Determine the drug survival of adalimumab and infliximab in pediatric patients with HS
2. Determine whether patient comorbidities, HS lesion location and concomitant HS therapies are associated with length of biologic survival in pediatric HS patients

Methods

- **Inclusion Criteria:** HS patients who initiated biologic therapy at the age of 21 years old or under and were seen between January 1st, 2013 and December 31st, 2023
- **Exclusion Criteria:** Patients who initiated biologic therapy less than 24 months prior to the study end date
- Patients who failed adalimumab and subsequently started infliximab and vice versa were included in both cohorts
- **Definition of biologic survival:** Length of time until discontinuation of biologic therapy for any reason
- **Kaplan-Meier survival curves** were used to calculate biologic survival at 12 and 24 months following biologic initiation.
- Potential factors associated with adalimumab survival were analyzed using **Cox Proportional Hazards Regression**

Disclosures

- Dr. Jaleel has received funding from UCB, NIH, Skin of Color Society, Dermatology Foundation; Consultation: Novartis, Eli Lilly; Investigator for UCB, Eli Lilly, AbbVie, Sonoma; Received support for attending meetings and/or travel: Skin of Color Society, IDEOM; Received payment or honoraria for lectures, speaker, and presentation: PeerView; Leadership or fiduciary role: Skin of Color Society
- Dr. St. John has received honoraria and funding from AbbVie
- All other authors have no relationships to disclose

Results

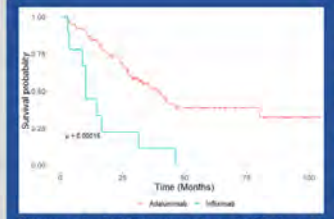

Figure 1. Adalimumab v. infliximab survival

Hurley Stage at Diagnosis	adalimumab (n = 77)	infliximab (n = 13)
Stage I	15 (19%)	2 (15%)
Stage II	32 (42%)	3 (23%)
Stage III	24 (31%)	8 (62%)
Unknown	6 (8%)	0 (0%)

Table 1. Hurley stage distribution of adalimumab and infliximab cohorts

Adalimumab survival at 12 and 24 months was **90.6%** (95% CI: 83.0%, 98.8%) and **78.3%** (95% CI: 67.7%, 90.6%). **Infliximab** survival at 12 and 24 months was **54.5%** (95% CI: 31.8%, 93.6%) and **36.4%** (95% CI: 16.6%, 79.5%)

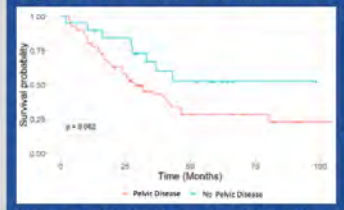

Figure 2. Biologic survival in patients with pelvic* v. no pelvic disease
*suprapubic, perianal, perineal, gluteal, groin, inguinal, inner thigh HS lesions

- Biologic survival at 12 and 24 months for those with **pelvic disease** was **78.8%** (95% CI: 69.5%, 89.3%) and **59.8%** (95% CI: 48.9%, 73.1) compared to **89.5%** (95% CI: 76.7, 100) and **83.9%** (95% CI: 68.7, 100) for those with **no pelvic disease.**
- **Median/mean Hurley stage** for those with and without pelvic disease were **2/2.2** and **2/2.1,** respectively

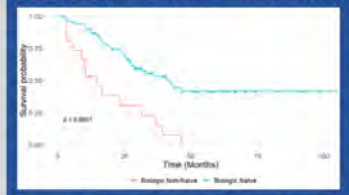

Figure 3. Biologic survival in biologic naïve v. biologic non-naïve patients

Biologic survival at 12 and 24 months for **biologic naïve** patients was **88.1%** (80.6, 96.2) and **72.7%** (62.6, 84.3) compared to **53.3%** (33.2, 85.6) and **30.5%** (13.7, 67.6) for **biologic non-naïve** patients

Variables	Unadjusted Analysis		Adjusted** Analysis	
	Hazard Ratio (95% CI)	P-value	Hazard Ratio (95% CI)	P-value
Age at HS Diagnosis	**1.11 (1.01, 1.23)**	**0.041**	**1.12 (1.01, 1.25)**	**0.048**
BMI	0.99 (0.96, 1.03)	0.577	0.99 (0.96, 1.03)	0.630
Past Medical History				
Prediabetes	0.51 (0.12, 2.13)	0.356	0.48 (0.11, 2.12)	0.333
DM	1.51 (0.46, 4.96)	0.497	1.18 (0.27, 5.10)	0.822
Obesity	0.69 (0.37, 1.28)	0.240	0.56 (0.30, 1.06)	0.073
PCOS	1.23 (0.54, 2.79)	0.621	1.11 (0.48, 2.58)	0.812
Crohn's Disease	0.64 (0.09, 4.70)	0.661	0.53 (0.07, 4.05)	0.544
Ulcerative Colitis	1.74 (0.41, 7.30)	0.451	1.66 (0.39, 7.14)	0.496
Depression	0.75 (0.37, 1.49)	0.409	0.73 (0.35, 1.52)	0.396
Anxiety	0.49 (0.24, 1.02)	0.055	0.55 (0.26, 1.14)	0.108
Substance Use (any)	1.46 (0.79, 2.71)	0.224	1.74 (0.87, 3.48)	0.120
Smoker	0.81 (0.32, 2.07)	0.656	0.80 (0.31, 2.11)	0.655
Other Substance Use	1.09 (0.50, 2.37)	0.823	1.22 (0.47, 3.18)	0.680
HS Lesion location				
Groin	1.35 (0.71, 2.55)	0.363	1.17 (0.61, 2.24)	0.638
Axillae	1.58 (0.70, 3.59)	0.271	1.66 (0.70, 3.97)	0.253
Abdomen	0.51 (0.12, 2.14)	0.360	0.24 (0.03, 1.77)	0.161
Back	0.92 (0.22, 3.83)	0.911	0.91 (0.21, 3.83)	0.894
Inguinal	1.58 (0.79, 3.16)	0.196	1.43 (0.69, 2.96)	0.332
Inner Thighs	0.60 (0.25, 1.43)	0.248	0.54 (0.22, 1.33)	0.183
Suprapubic	1.16 (0.41, 3.26)	0.780	0.96 (0.31, 2.92)	0.937
Perineal	1.51 (0.46, 4.94)	0.500	1.27 (0.35, 4.69)	0.715
Perianal	0.88 (0.12, 6.55)	0.903	0.70 (0.09, 5.52)	0.735
Gluteal	**2.50 (1.34, 4.66)**	**0.004**	**2.87 (1.40, 5.85)**	**0.004**
Inframammary	1.09 (0.55, 2.13)	0.809	0.97 (0.46, 2.03)	0.931
Neck	0.94 (0.33, 2.64)	0.907	0.78 (0.26, 2.35)	0.663
Concomitant Medications				
Topical antibiotics	1.23 (0.48, 3.14)	0.665	0.89 (0.34, 2.36)	0.813
Systemic antibiotics	1.64 (0.69, 3.91)	0.264	1.30 (0.53, 3.17)	0.568
Topical steroids	0.75 (0.40, 1.39)	0.355	0.66 (0.35, 1.26)	0.209
Systemic steroids	**2.27 (1.18, 4.36)**	**0.014**	**2.18 (1.07, 4.44)**	**0.031**
Cleansers	**2.76 (1.34, 5.68)**	**0.006**	**2.54 (1.19, 5.40)**	**0.016**
Medication Dosing				
40 mg Weekly	[Reference]		[Reference]	
Other Dose	0.94 (0.48, 1.84)	0.847	0.81 (0.39, 1.72)	0.590

Table 2. Cox Regression (adalimumab cohort) **Analysis was adjusted by baseline Hurley stage and smoking status

Conclusion

- Adalimumab survival in pediatric HS patients is higher than infliximab survival (confounding variables: higher disease severity and variability of dosing in infliximab cohort)
- Biologic survival is higher in pediatric HS patients with no pelvic disease compared to those with pelvic disease
- Biologic survival is higher in biologic naïve pediatric HS patients compared to those who are biologic non-naïve
- Age at HS diagnosis, gluteal HS lesions, and use of systemic steroids and cleansers may be associated with adalimumab survival
- Limitations: small sample size and there were patients in both cohorts who were not biologic naïve

Hidradenitis supurativa. Tratamiento

Conclusion

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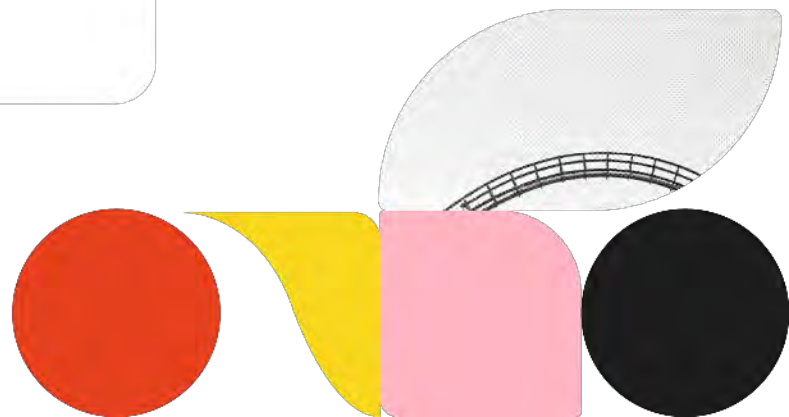
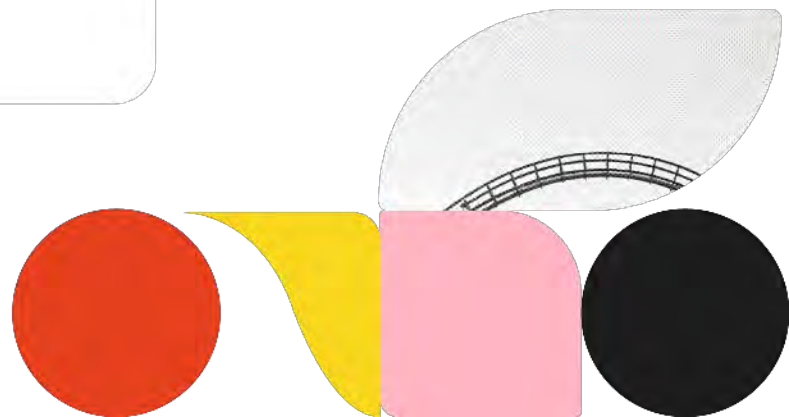
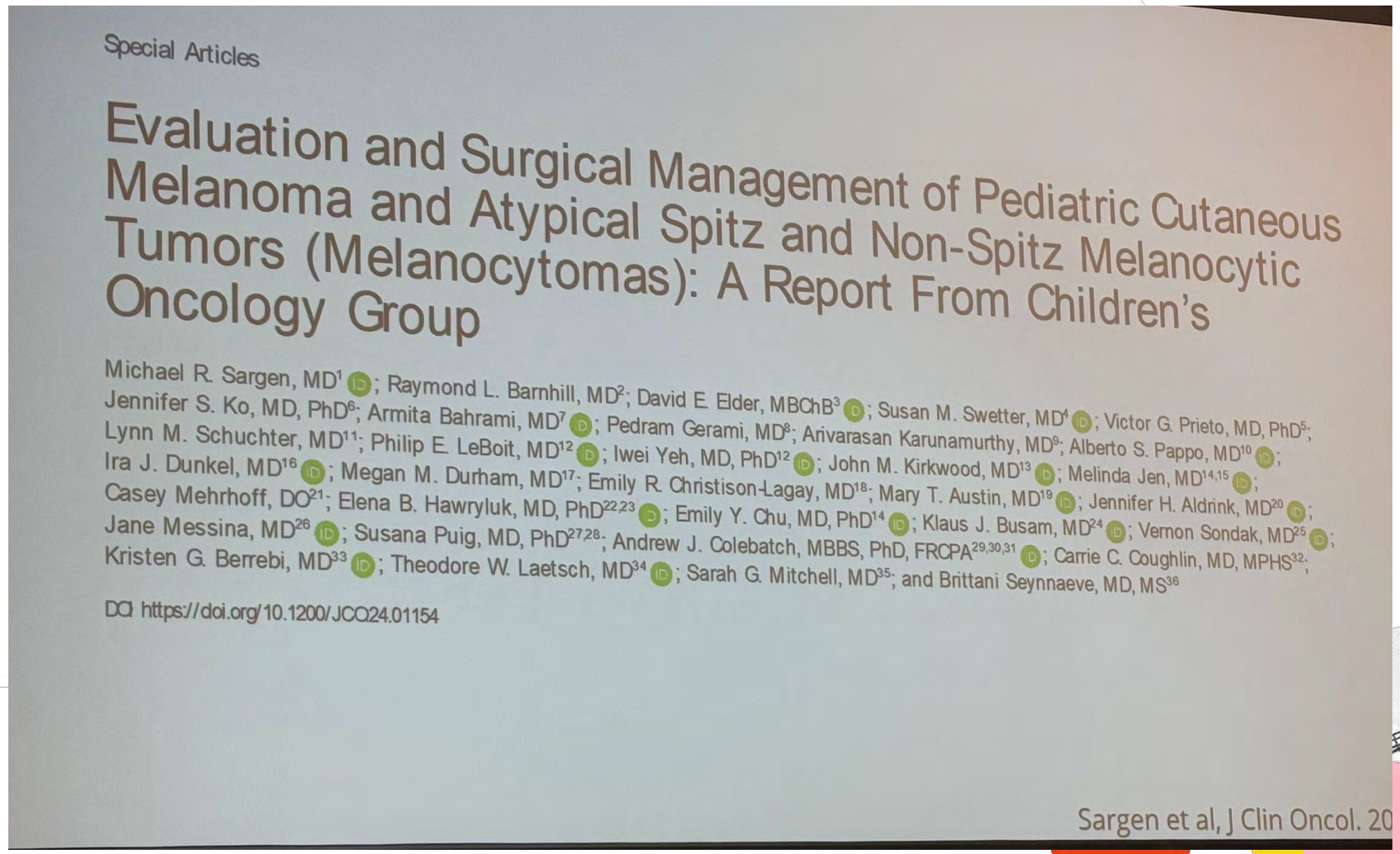


LESIONES PIGMENTADAS





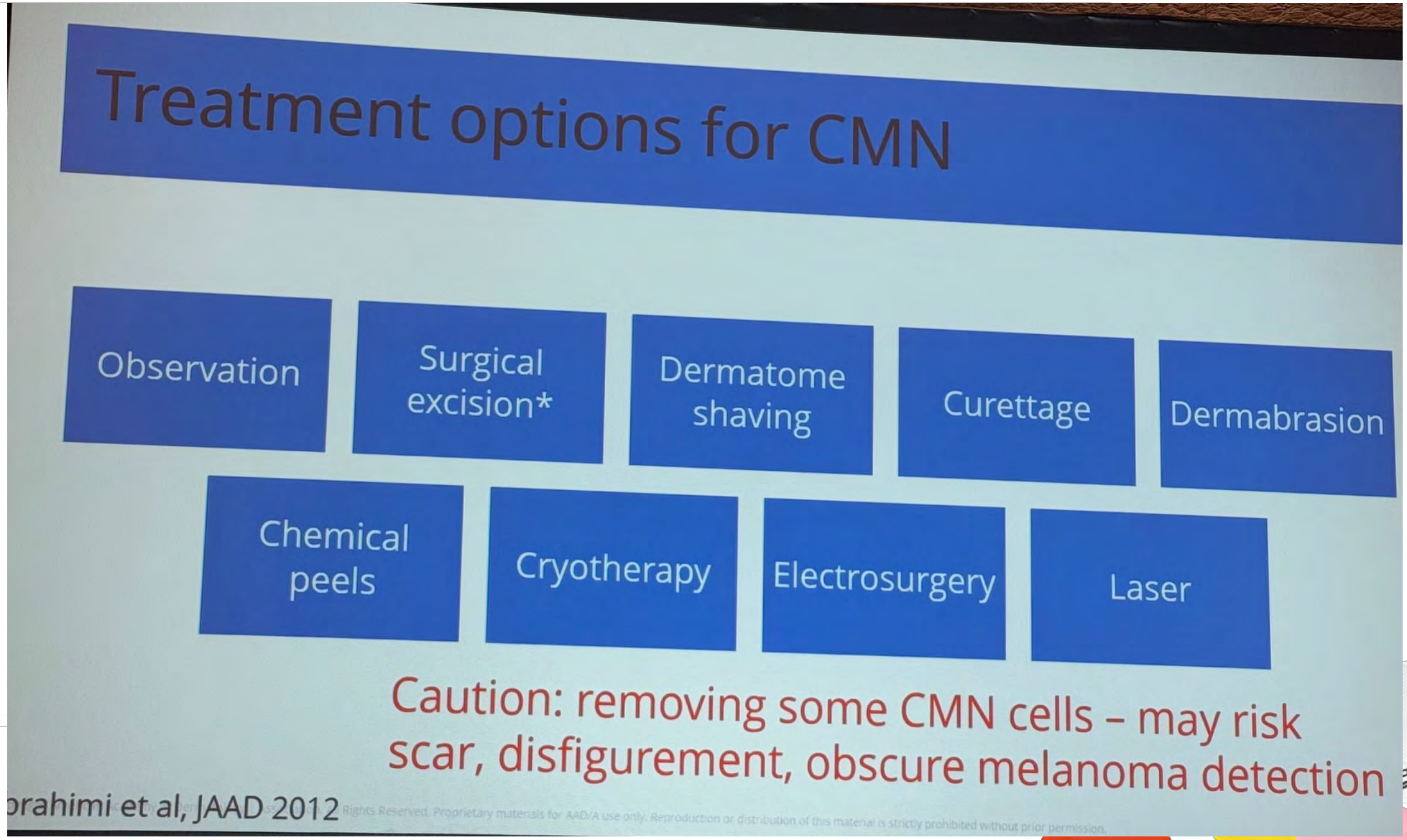
Special Articles

Evaluation and Surgical Management of Pediatric Cutaneous Melanoma and Atypical Spitz and Non-Spitz Melanocytic Tumors (Melanocytomas): A Report From Children's Oncology Group

Michael R. Sargen, MD[1]; Raymond L. Barnhill, MD[2]; David E. Elder, MBChB[3]; Susan M. Swetter, MD[4]; Victor G. Prieto, MD, PhD[5]; Jennifer S. Ko, MD, PhD[6]; Armita Bahrami, MD[7]; Pedram Gerami, MD[8]; Arivarasan Karunamurthy, MD[9]; Alberto S. Pappo, MD[10]; Lynn M. Schuchter, MD[11]; Philip E. LeBoit, MD[12]; Iwei Yeh, MD, PhD[12]; John M. Kirkwood, MD[13]; Melinda Jen, MD[14,15]; Ira J. Dunkel, MD[16]; Megan M. Durham, MD[17]; Emily R. Christison-Lagay, MD[18]; Mary T. Austin, MD[19]; Jennifer H. Aldrink, MD[20]; Casey Mehrhoff, DO[21]; Elena B. Hawryluk, MD, PhD[22,23]; Emily Y. Chu, MD, PhD[14]; Klaus J. Busam, MD[24]; Vernon Sondak, MD[25]; Jane Messina, MD[26]; Susana Puig, MD, PhD[27,28]; Andrew J. Colebatch, MBBS, PhD, FRCPA[29,30,31]; Carrie C. Coughlin, MD, MPHS[32]; Kristen G. Berrebi, MD[33]; Theodore W. Laetsch, MD[34]; Sarah G. Mitchell, MD[35]; and Brittani Seynnaeve, MD, MS[36]

DOI https://doi.org/10.1200/JCO.24.01154

Sargen et al, J Clin Oncol. 20


Treatment options for CMN
Observation
Surgical excision*
Dermatome shaving
Curettage
Dermabrasion
Chemical peels
Cryotherapy
Electrosurgery
Laser
Caution: removing some CMN cells – may risk scar, disfigurement, obscure melanoma detection
brahimi et al, JAAD 2012
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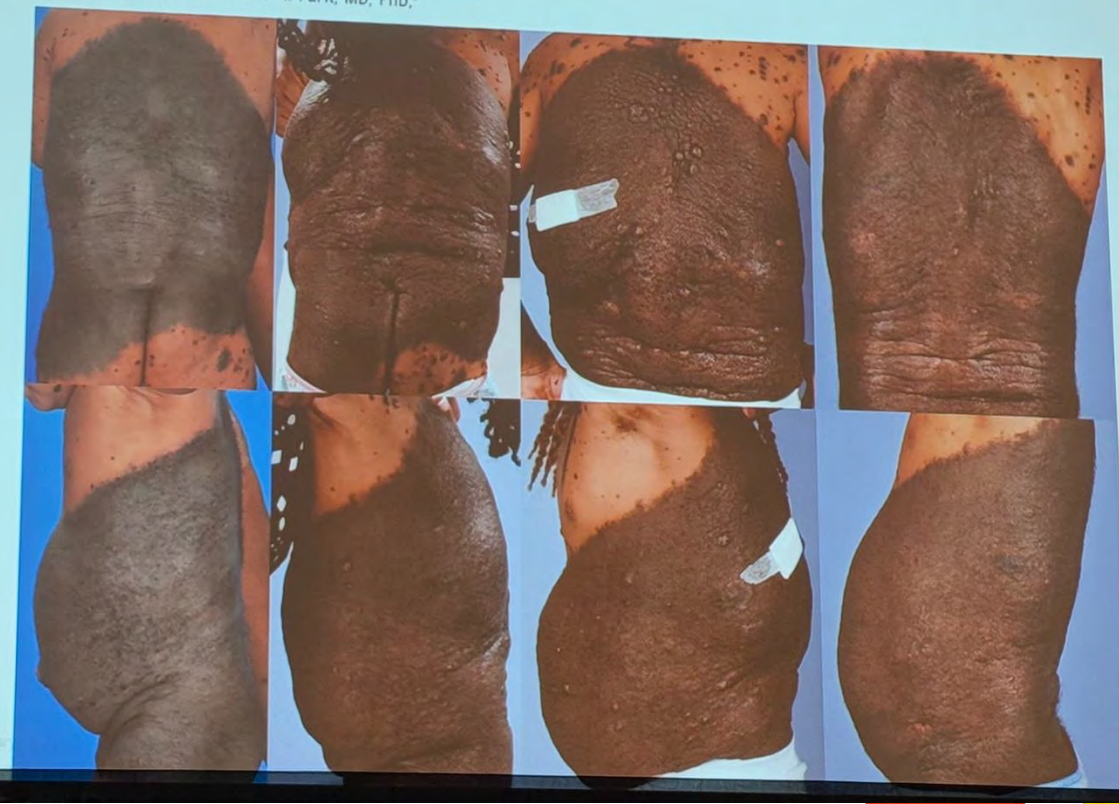
Giant Congenital Melanocytic Nevus Treated With Trametinib

Adnan Mir, MD, PhD,[a] Nnenna G. Agim, MD,[a] Alex A. Kane, MD,[b] Shellie C. Josephs, MD,[c] Jason Y. Park, MD, PhD,[d] Kathleen Ludwig, MD[e]



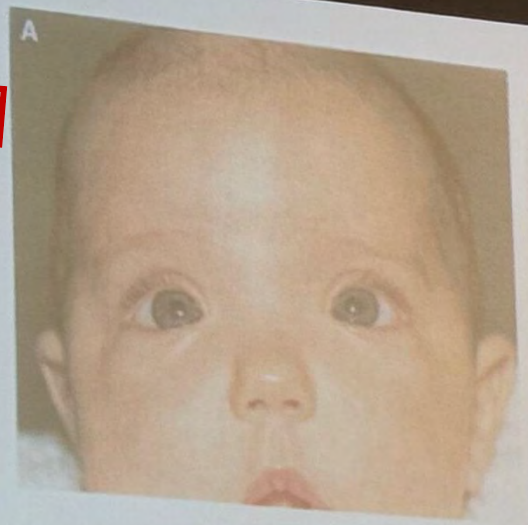
Pediatrics, 2019

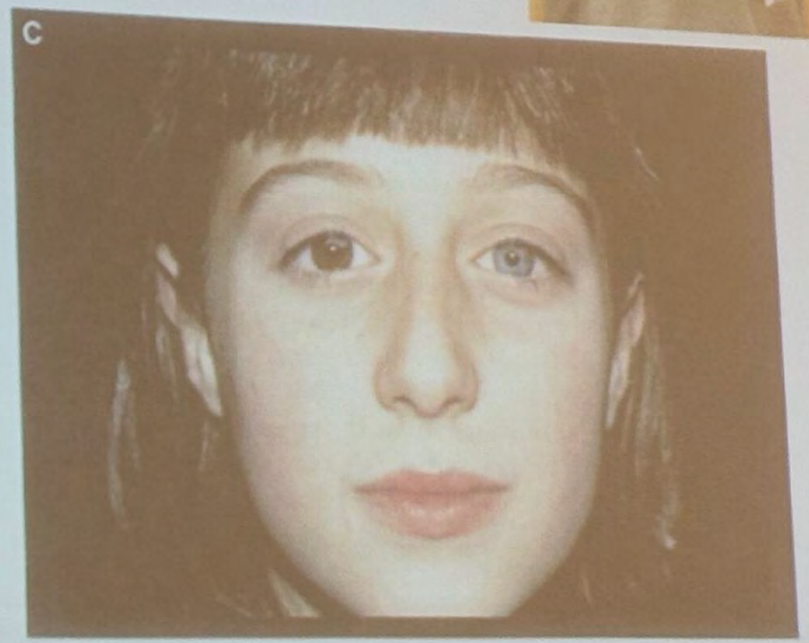
Non-segmental vitiligo

Differential diagnosis,

genodermatoses

Hypomelanosis of Ito

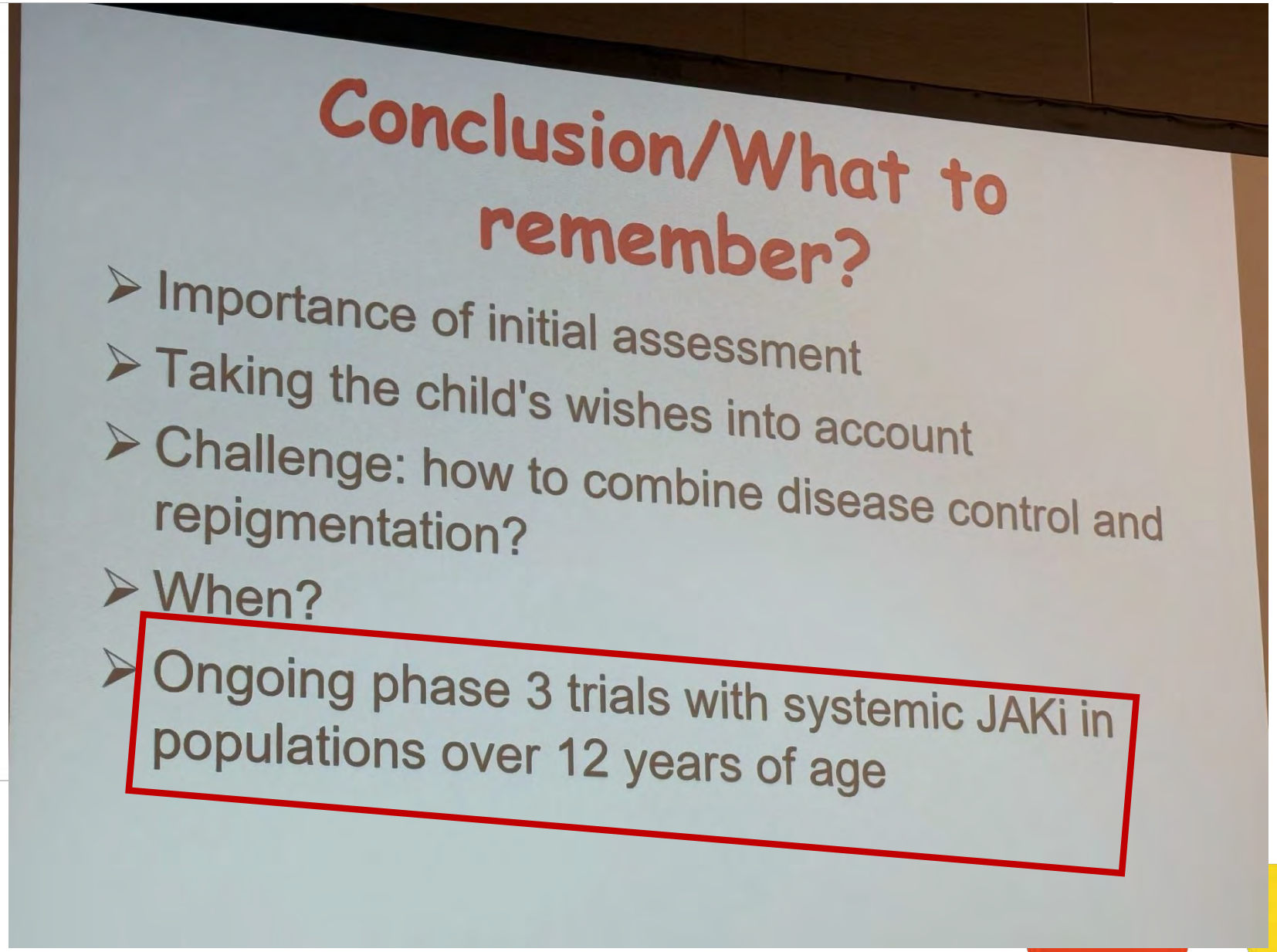




J Med Genet. 1997 Aug;34(8):656-65.

Waardenburg syndrome.

Read AP[1], Newton VE.


Conclusion/What to remember?
Importance of initial assessment
Taking the child's wishes into account
Challenge: how to combine disease control and repigmentation?
When?
Ongoing phase 3 trials with systemic JAKi in populations over 12 years of age

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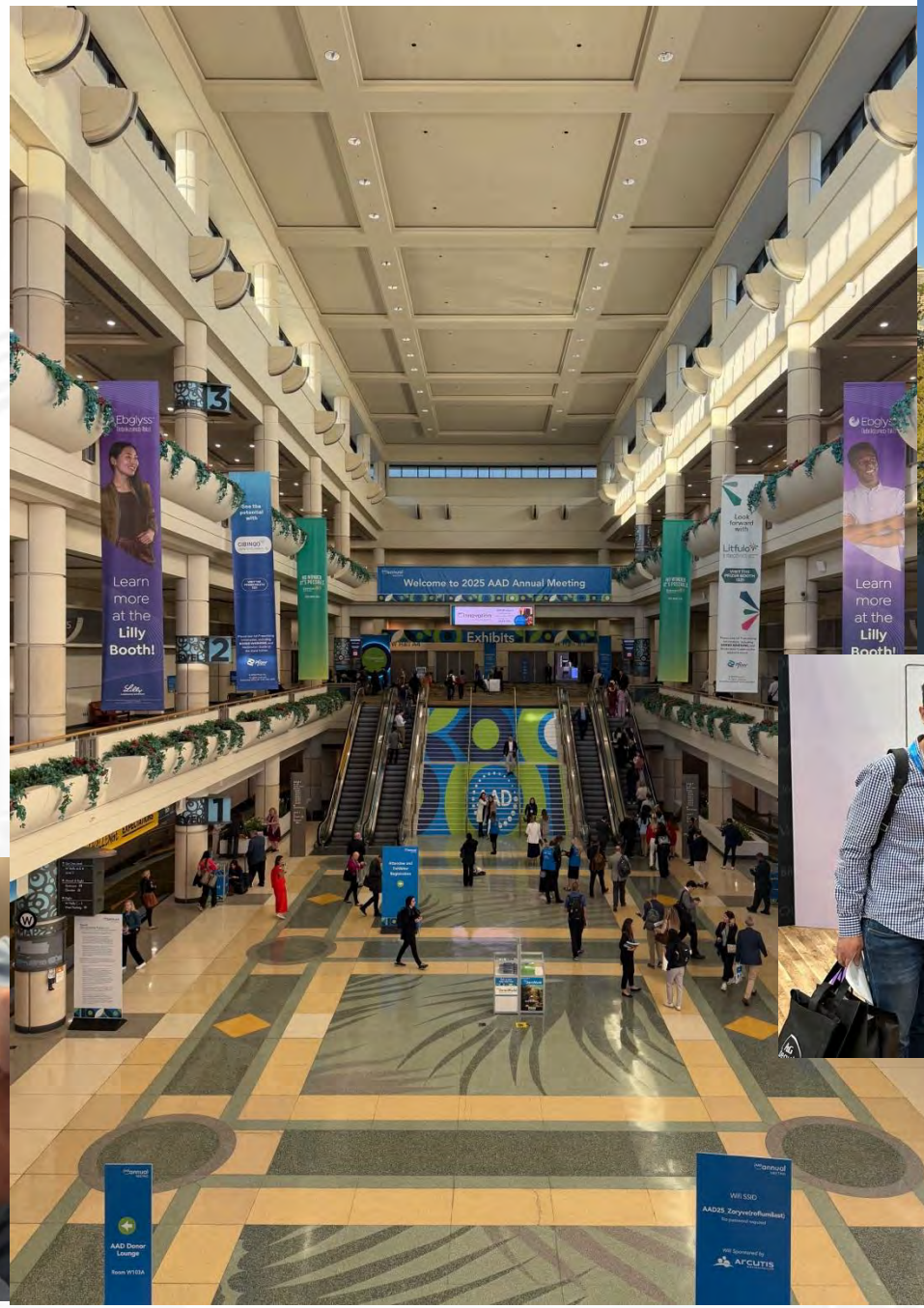
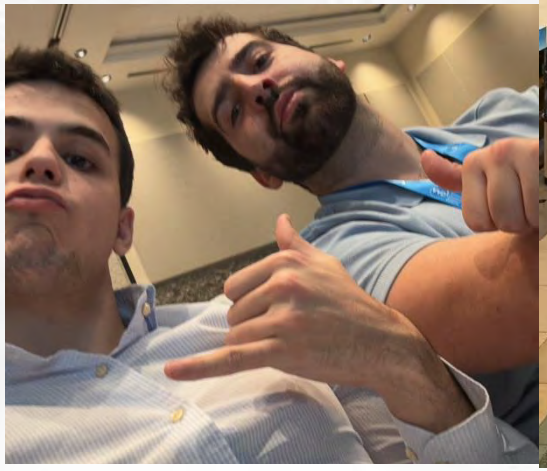
highlights





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