

AAD **ANNUAL MEETING 2025**

# AEDV

7 - 11  
MARZO  
ORLANDO

**highlights**



Una iniciativa de:



ACADEMIA ESPAÑOLA  
DE DERMATOLOGÍA  
Y VENEREOLÓGIA



ACADEMIA ESPAÑOLA  
DE DERMATOLOGÍA  
Y VENEREOLÓGIA

Con el patrocinio de:



# **| Dermatología Pediátrica**

## **| Parte I**

**Miguel Mansilla Polo**

Hospital Universitario y Politécnico La Fe, Valencia



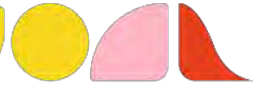
**@mig\_yec**



AAD **ANNUAL MEETING 2025**

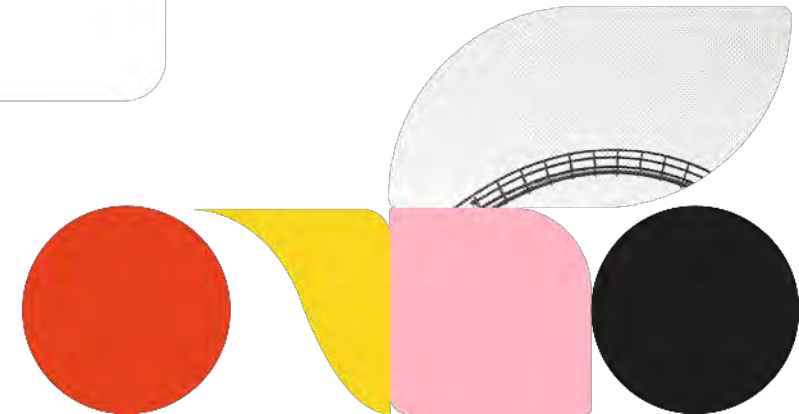
**AEDV** 7 - 11  
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*highlights*



**NO TENGO CONFLICTOS  
DE INTERÉS**

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## **Dermatología Pediátrica**

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

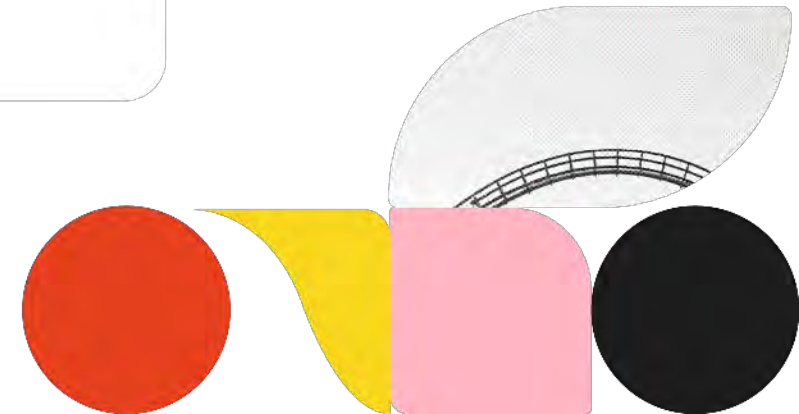


## PARTE I

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

## PARTE II

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

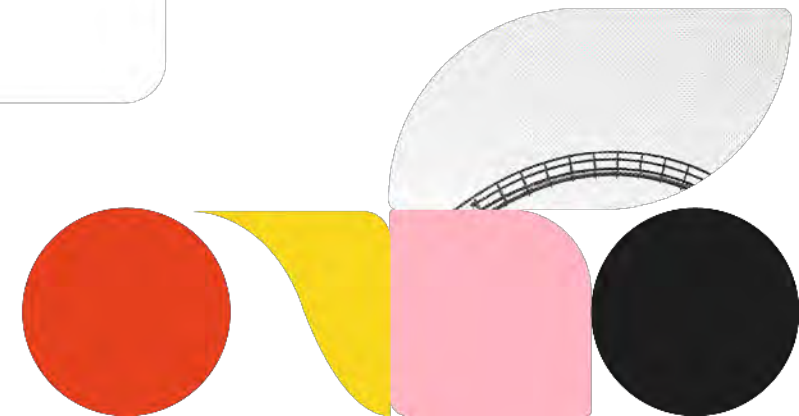


# DERMATITIS ATÓPICA



## **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%

Simpson EL, Eichenfield LF, Alonso-Llamazares J, Draelos ZD, Ferris LK, Forman SB, Gooderham M, Gonzalez ME, Hebert AA, Kirioik LH, Lomaga M, Moore A, Papp KA, Prajapati VH, Hanna D, Snyder S, 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 Trials. 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,<sup>1</sup> Lawrence F. Eichenfield,<sup>2</sup> Kim A. Papp,<sup>3,4</sup> Seth B. Forman,<sup>5</sup> Adelaide A. Hebert,<sup>1</sup> Mercedes E. Gonzalez,<sup>2</sup> Melinda J. Gooderham,<sup>1</sup> H. Chih-ho Hong,<sup>1</sup> Vimal H. Prajapati,<sup>1</sup> Emma Guttman-Yassky,<sup>1</sup> Jonathan I. Silverberg,<sup>1</sup> Melissa S. Seal,<sup>6</sup> David Krupa,<sup>7</sup> Erin Almaraz,<sup>8</sup> Diane Hanna,<sup>9</sup> Patrick Burnett,<sup>10</sup> Scott Snyder,<sup>11</sup> David H. Chu,<sup>12</sup> Robert C. Higham,<sup>13</sup> and David R. Berk<sup>14</sup>

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

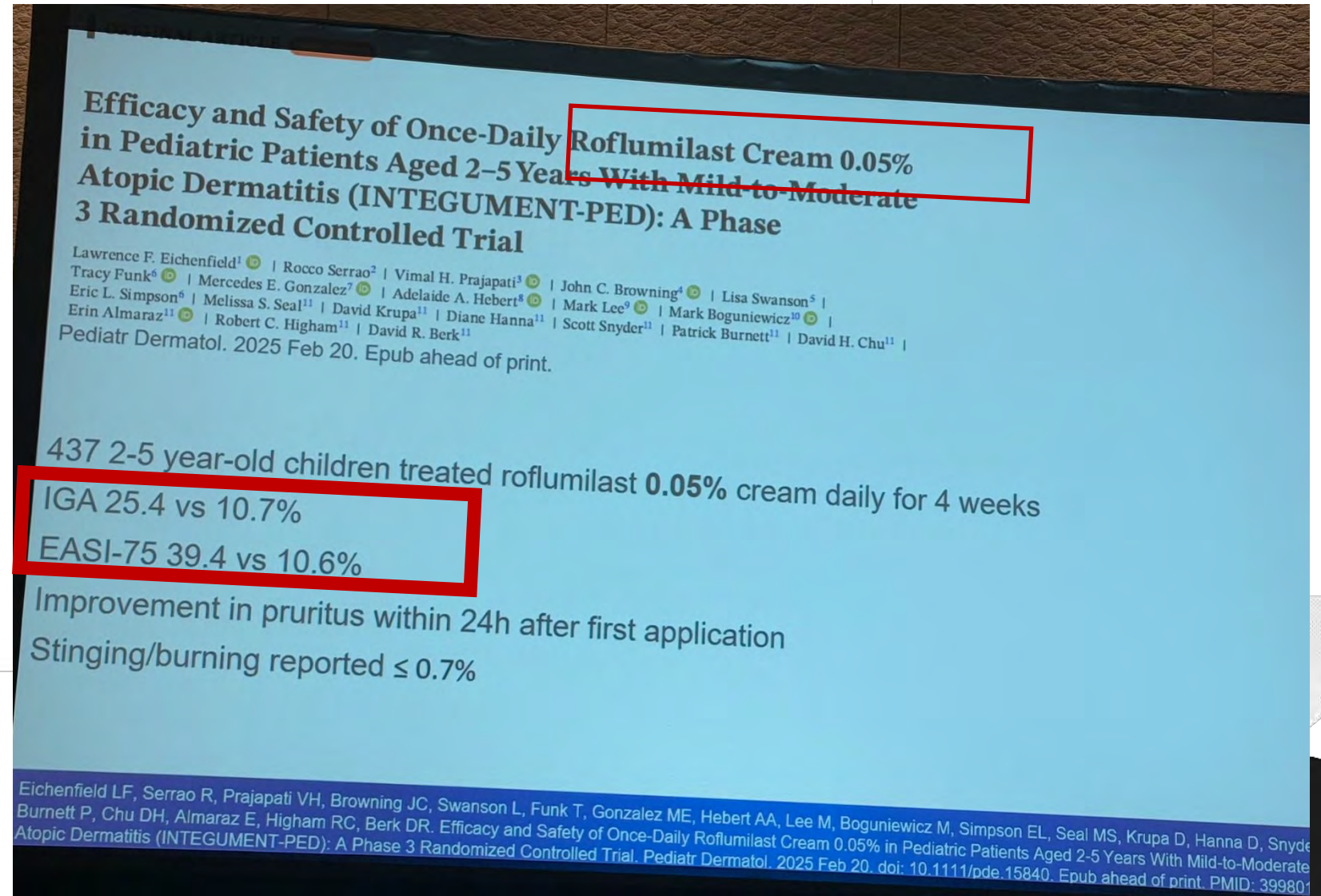
Simpson EL, Eichenfield LF, Papp KA, Forman SB, Hebert AA, Gonzalez ME, Gooderham MJ, Hong HC, Prajapati VH, Guttman-Yassky E, Silverberg JI, Seal MS, Krupa D, Almaraz E, Hanna D, Burnett P, Snyder S, Chu DH, Higham RC, Berk DR. Long-Term Safety and Efficacy with Roflumilast Cream 0.15% in Patients Aged ≥6 Years with Atopic Dermatitis: A Phase 3 Open-Label Extension Trial. Dermatitis. 2025 Jan 10; doi: 10.1090/derm.2024.0410. Epub ahead of print. PMID: 39792455





# DERMATITIS ATÓPICA. Roflumilast

2025, ensayo concentración  
menor  
Mantiene eficacia



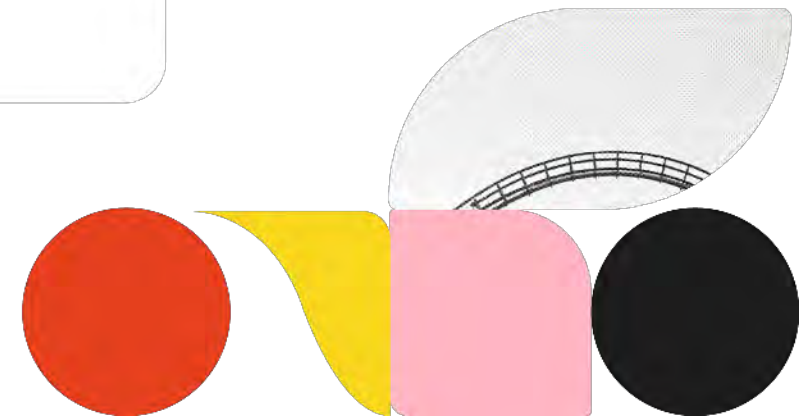
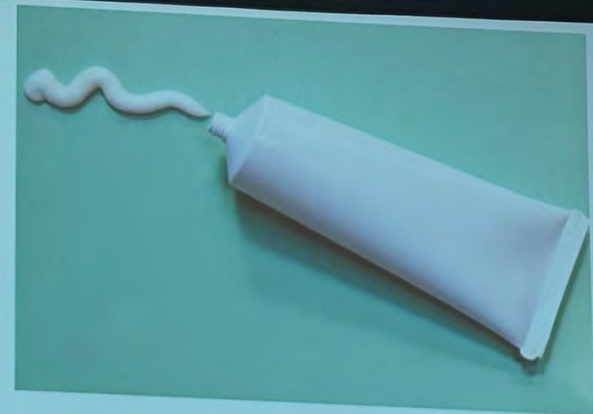
# DERMATITIS ATÓPICA. Ruxolitinib tópico

## Ruxolitinib 1.5% Cream

Janus kinase 1/2 inhibitor (JAKi)

FDA approved September 2021

- Age 12 and up mild-moderate AD
- Short-term and noncontinuous chronic use
- BID application



# DERMATITIS ATÓPICA. Ruxolitinib tópico

Fase 3 2025

## Ruxolitinib 1.5% Cream TRuE-AD 3

Phase 3 RCT 330 children 2 to 11 years with AD

- IGA 2/3 BSA 3-20%
- 2:2:1 ruxolitinib 1.5% BID: ruxolitinib 0.75% BID: vehicle BID x 8 weeks
- 44-week long term extension (LTS)
- Anti-inflammatory and antipruritic activity
  - IGA 0/1 56.5%/36.6% vs 10.8%
  - EASI-75 43.5%/35.8% vs 6.2%
- Improvement in pruritus
- Low AEs rates

# DERMATITIS ATÓPICA. Delgocitinib crema

## Delgocitinib Ointment

Pan JAKi

Approved in Japan as 0.25% and 0.5%

Mild to severe AD children  $\geq$  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



# DERMATITIS ATÓPICA. Comparativa tópicos

Delgo  
Ruxo

## Comparative Analyses: Non-Steroidal Topical Agents

- 10 Phase 2/3 RCT ruxolitinib, crisaborole, tapinarof
- Ruxolitinib higher efficacy, lower adverse effects

### Efficacy and safety of Ruxolitinib, Crisaborole, and Tapinarof for mild-to-moderate atopic dermatitis: a Bayesian network analysis of RCTs

Review | Published: 15 February 2024  
Volume 397, pages 4657–4662, (2024) [Cite this article](#)

EXPERT REVIEW OF CLINICAL IMMUNOLOGY  
2025, VOL. 21, NO. 3, 347–357  
<https://doi.org/10.1080/1744666X.2024.2435657>



#### META-ANALYSIS

An evaluation of the recently approved drugs for treating atopic dermatitis in the context of their safety and efficacy: a systematic review and meta-analysis

Abdullah Alkattan<sup>a,b</sup>, Abrar Alzahr<sup>c</sup>, Dina Alhabib<sup>d</sup>, Afnan Younis<sup>e</sup>, Elham Alsalem<sup>f</sup>, Nadia Suraj<sup>g</sup>, Eman Alsalam<sup>h</sup>, Noura Alrasheed<sup>i</sup>, Moneerah Almuhaideb<sup>j</sup> and Mona H. Ibrahim<sup>k</sup>

<sup>a</sup>Research and Planning Unit, General Directorate of School Health, Ministry of Health, Riyadh, Saudi Arabia; <sup>b</sup>Department of Biomedical Science, College of Veterinary Medicine, King Faisal University, Al-Husa, Saudi Arabia; <sup>c</sup>Department of Family and Community Medicine, College of Medicine, King Saud University, Riyadh, Saudi Arabia; <sup>d</sup>Department of Pharmacy, King Khalid University Hospital, Medical City King Saud University, Riyadh, Saudi Arabia; <sup>e</sup>Department of Public Health and Community Medicine, Zagazig University, Zagazig, Egypt

- 17 articles reviewing crisaborole, delgocitinib, ruxolitinib
- Delgocitinib and ruxolitinib favorable efficacy

1. Cao XC, Lu JW, Feng YF, Song LB, Lu Y. Efficacy and safety of Ruxolitinib, Crisaborole, and Tapinarof for mild-to-moderate atopic dermatitis: a Bayesian network analysis of RCTs. *Naunyn-Schmiedeberg's Arch Pharmacol.* 2024 Jul;397(7):4657-4662. doi: 10.1007/s00210-024-02971-6. Epub 2024 15. PMID: 38358466.
2. Alkattan A, Alzahr A, Alhabib D, Younis A, Alsalem E, Suraj N, Alsalameen E, Alrasheed N, Almuhaideb M, Ibrahim MH. Expert Rev Clin Immunol. 2024 Dec 18:1-11. doi: 10.1080/1744666X.2024.2435657. Epub ahead of print. PMID: 39662577.

# DERMATITIS ATÓPICA. Comparativa tópicos

## Summary: Non-Steroidals and Age Indications

### Calcineurin inhibitors:

- Pimecrolimus:  $\geq 2$  years (2001) ~\$160
- Tacrolimus:  $\geq 2$  years (2000) ~\$60

### PDE-4 Inhibitors:

- Crisaborole:  $\geq 3$  months (2016, 2020) ~\$800
- Roflumilast:  $\geq 6$  years (2024) ~\$900
- *Difamilast:  $\geq 2$  years*

### Jak Inhibitors

- Ruxolitinib:  $\geq 12$  years (2021) ~\$2000
- *Delgocitinib:  $\geq 2$  years (AD),  $\geq 12$  years (CHE)*

### Therapeutic Aryl Hydrocarbon Receptor (Ahr) Agonist

- Tapinarof:  $\geq 2$  years (2024) ~\$1500

# DERMATITIS ATÓPICA. Sistémicos. Dupilumab

## Dupilumab and Conjunctivitis Dupilumab-induced Ocular Surface Disease (DOSD)

Conjunctivitis was the most common adverse event, reported in a pooled proportion of 26.1%

May be similar to atopic keratoconjunctivitis - Th2 blockade may shift toward Th1

- ↓ goblet cell activity, Meibomian gland dysfunction, ↓ mucin production, tear film instability
- Redness, hyperemia, blepharitis, dryness, irritation, discharge, itch, stinging, burning, tearing, foreign-body sensation, decrease visual acuity, ectropion

### Treatment

- Compresses, artificial tears, HA drops, antihistamine drops, topical anti-inflammatory agents

# 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-Cabrales<sup>1</sup> · Mark G. Kirchof<sup>2</sup> · Cora M. Constantinescu<sup>3</sup> · Luis Murguía-Favela<sup>4</sup> · Michele L. Ramien<sup>1,5</sup>

- 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



# DERMATITIS ATÓPICA. Sistémicos. Dupilumab

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

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

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

## Live Attenuated Vaccine Administration in Children Treated With Methotrexate or Dupilumab

Julia R. Hughes<sup>1</sup> | Sino Mehrmal<sup>2</sup> | Sana Habib<sup>3</sup> | Howard L. Williams<sup>4</sup> | Elaine C. Siegfried<sup>5</sup>

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

Pediatr Dermatol. 2024 Dec 11.

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. 10.1111/pde.15518. Epub 2024 Feb 2. PMID: 38308453.

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

- 5 children 1-7 weeks after starting dupilumab
- 4 children vaccinated  $\geq$  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

5 patients received MMRV while on dupilumab

- No adverse effects for up to 6 months

# DERMATITIS ATÓPICA. Sistémicos. Dupilumab



## HHS Public Access

Author manuscript

*Ann Allergy Asthma Immunol.* Author manuscript; available in PMC 2024 October 08.

Published in final edited form as:

*Ann Allergy Asthma Immunol.* 2024 September ; 133(3): 286–294. doi:10.1016/j.anai.2024.05.014.

**A systematic review and expert Delphi Consensus recommendation on the use of vaccines in patients receiving dupilumab: A position paper of the American College of Allergy, Asthma and Immunology**

Available literature cases of vaccination on dupilumab

- Live vaccines are safe
- Vaccine efficacy, in general, is not affected by dupilumab

Expert Delphi panel

- Use of vaccines in patients receiving dupilumab likely safe and effective
- Vaccines (including live vaccines) can be administered to patients receiving dupilumab in a shared decision-making capacity

# DERMATITIS ATÓPICA. Sistémicos. Tralokinumab

## Tralokinumab: Adolescents

### ECZTRA 6: Phase 3, 289 adolescent patients aged 12 to 17 years

- 150 mg or 300 mg or placebo Q2W for 16 weeks after LD
- IGA 0/1: 21.4%/17.5% vs 4.3%
- EASI75: 28.6%/27.8% vs 6.4%
- Secondary endpoints pruritus and QoL met
- Adverse effects similar between 2 doses

### ECZTEND: open label extension trial sustained efficacy

### NCT06311682: Phase 3 Tralokinumab + TCS in children and infants with moderate-to-severe atopic dermatitis

# DERMATITIS ATÓPICA. Sistémicos. Lebrikizumab

## Efficacy and Safety of Lebrikizumab in Combination With Topical Corticosteroids in Adolescents and Adults With Moderate-to-Severe Atopic Dermatitis A Randomized Clinical Trial (ADhere)

Eric L. Simpson, MD; Melinda Gooderham, MD; Andreas Wollenberg, MD; Stephan Weidinger, MD, PhD; April Armstrong, MD, MPH; Jennifer Soung, MD; Silvia Ferrucci, MD; Renata Gontijo Lima, MD; Michael M. Witte, PhD; Wen Xu, PhD; Hany ElMaraghy, MD; Chitra R. Natalie, MD; Evangeline Pierce, PhD; Andrew Blauvelt, MD, MBA; for the ADhere Investigators

211 adolescents 12-17 years and adults LEB+TCS vs placebo for 16 weeks

- IGA 0/1 41.2% vs 22.1%
- EASI-75 69.5% vs 42.2%
- Statistically significant improvement in secondary end points
- Adverse effects:
  - Conjunctivitis, headache, hypertension, injection site reaction, herpes infection

**NCT05559359: Lebrikizumab Children ≥ 6 Months Moderate-to-Severe AD (ADorable-1)**

Simpson EL, Gooderham M, Wollenberg A, Weidinger S, Armstrong A, Soung J, Ferrucci S, Lima RG, Witte MM, Xu W, ElMaraghy H, Natalie CR, Pierce E, Blauvelt A; ADhere Investigators. Efficacy and Safety of Lebrikizumab in Combination With Topical Corticosteroids in Adolescents and Adults With Moderate-to-Severe Atopic Dermatitis: A Randomized Clinical Trial (ADhere). JAMA Dermatol. 2023 Feb 1;159(2):182-191.

# DERMATITIS ATÓPICA. Sistémicos. Nemolizumab

## Nemolizumab with concomitant topical therapy in adolescents and adults with moderate-to-severe atopic dermatitis (ARCADIA 1 and ARCADIA 2): results from two replicate, double-blind, randomised controlled phase 3 trials

Jonathan I Silverberg, Andreas Wollenberg, Adam Reich, Diamant Thaçi, Franz J Legat, Kim A Papp, Linda Stein Gold, Jean-David Bouaziz, Andrew E Pink, José Manuel Carrascosa, Barbara Rewerska, Jacek C Szepietowski, Dorota Krasowska, Blanka Havlíčková, Monika Kalowska, Nina Magnolo, Sylvia Pauser, Navid Nami, Maxwell B Sauder, Vipul Jain, Kamila Padlewska, Soo Yeon Cheong, Patricia Fleuranceau Morel, Liliana Ulianov, Christophe Picketty, on behalf of the ARCADIA 1 and ARCADIA 2 Study Investigators\*


1,728 patient  $\geq 12$ yo moderate-severe AD

- 30mg Q4W with use of TCS $\pm$ TCl x 16 weeks
  - IGA 0/1: 36/38% vs 25/26%
  - EASI-75: 44/42% vs 29/30%
  - Significant improvement in itch, sleep
  - Adverse effects (TEAE):
    - AD worsening most common
    - Headache, arthralgia, urticaria, myalgia

Silverberg JI, Wollenberg A, Reich A, Thaçi D, Legat FJ, Papp KA, Stein Gold L, Bouaziz JD, Pink AE, Carrascosa JM, Rewerska B, Szepietowski JC, Krasowska D, Havlíčková B, Kalowska M, Magnolo N, Pauser S, Nami N, Sauder MB, Jain V, Padlewska K, Cheong SY, Fleuranceau Morel P, Ulianov L, Picketty C; ARCADIA 1 and ARCADIA 2 Study Investigators. Nemolizumab with concomitant topical therapy in adolescents and adults with moderate-to-severe atopic dermatitis (ARCADIA 1 and ARCADIA 2): results from two replicate, double-blind, randomised controlled phase 3 trials. *Lancet*. 2024 Aug 3;404(10451):445-460. doi: 10.1016/S0140-6736(24)01203-0. Epub 2024 Jul 24. PMID: 39111614

# DERMATITIS ATÓPICA. Sistémicos. Nemolizumab

## Efficacy and safety of nemolizumab in paediatric patients aged 6–12 years with atopic dermatitis with moderate-to-severe pruritus: results from a phase III, randomized, double-blind, placebo-controlled, multicentre study

Atsuyuki Igarashi , Toshio Katsunuma, Takayo Matsumura, Hiroshi Komazaki, for the Nemolizumab-JP04 Study Group [Author Notes](#)

*British Journal of Dermatology*, Volume 190, Issue 1, January 2024, Pages 20–28,

89 patients 6-12 years with moderate-to-severe AD

Nemolizumab 30mg Q4W x 16 weeks

Significant improvement in itch score

Tendency toward improvement and sustained efficacy weeks 16-68<sup>2</sup>

Similar safety profile to adolescent/adult trials

1. Igarashi A, Katsunuma T, Matsumura T, Komazaki H; Nemolizumab-JP04 Study Group. Efficacy and safety of nemolizumab in paediatric patients with moderate-to-severe pruritus: results from a phase III, randomized, double-blind, placebo-controlled, multicentre study. *Br J Dermatol*. 2023 Dec 20;190(1):20-28. doi: 10.1093/bjd/ljad268. P 2. Cho SJ, Na JI. Long-term observation to determine durable efficacy and safety of novel paediatric atopic dermatitis treatment, nemolizumab. *Br J Dermatol*. 2023 Dec 20;190(1):20-28. doi: 10.1093/bjd/ljad268. P

# DERMATITIS ATÓPICA. Sistémicos. Comparativa biológicos

## Comparison: Biologics in AD

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

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



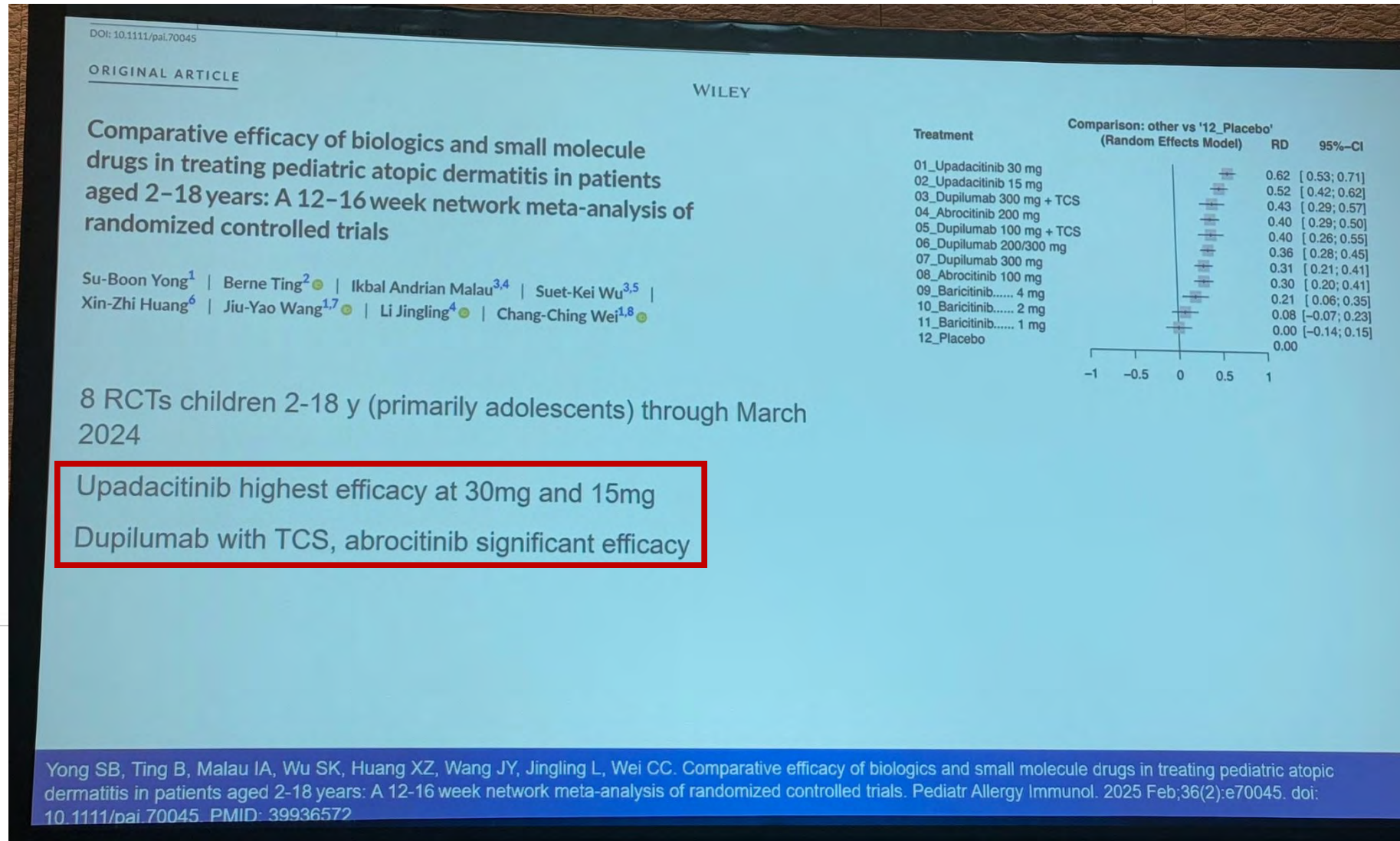


# DERMATITIS ATÓPICA. Sistémicos. Comparativa

## 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
<b>JADE Compare</b> 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	
<b>JADE DARE</b> 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	
<b>Heads Up</b> 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



# 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

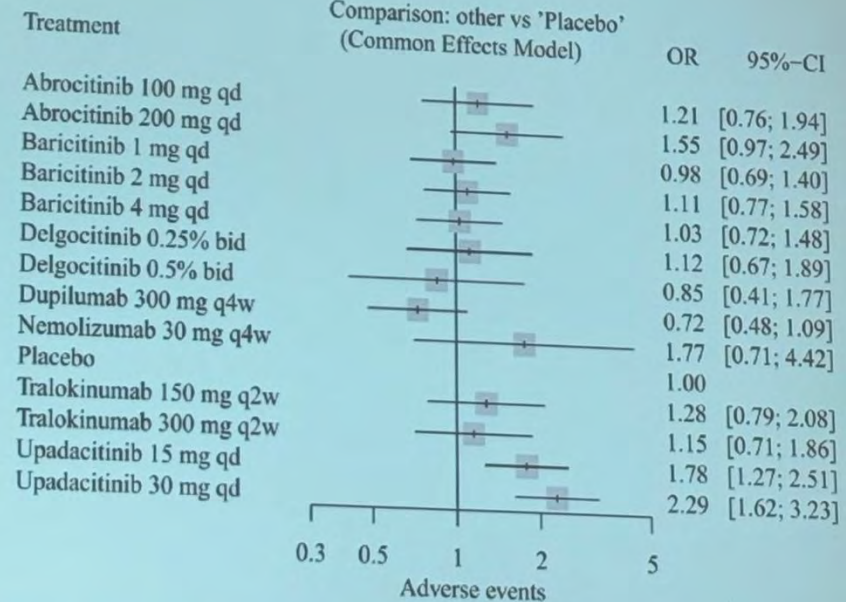
2,352 pediatric patients from 11 trials

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

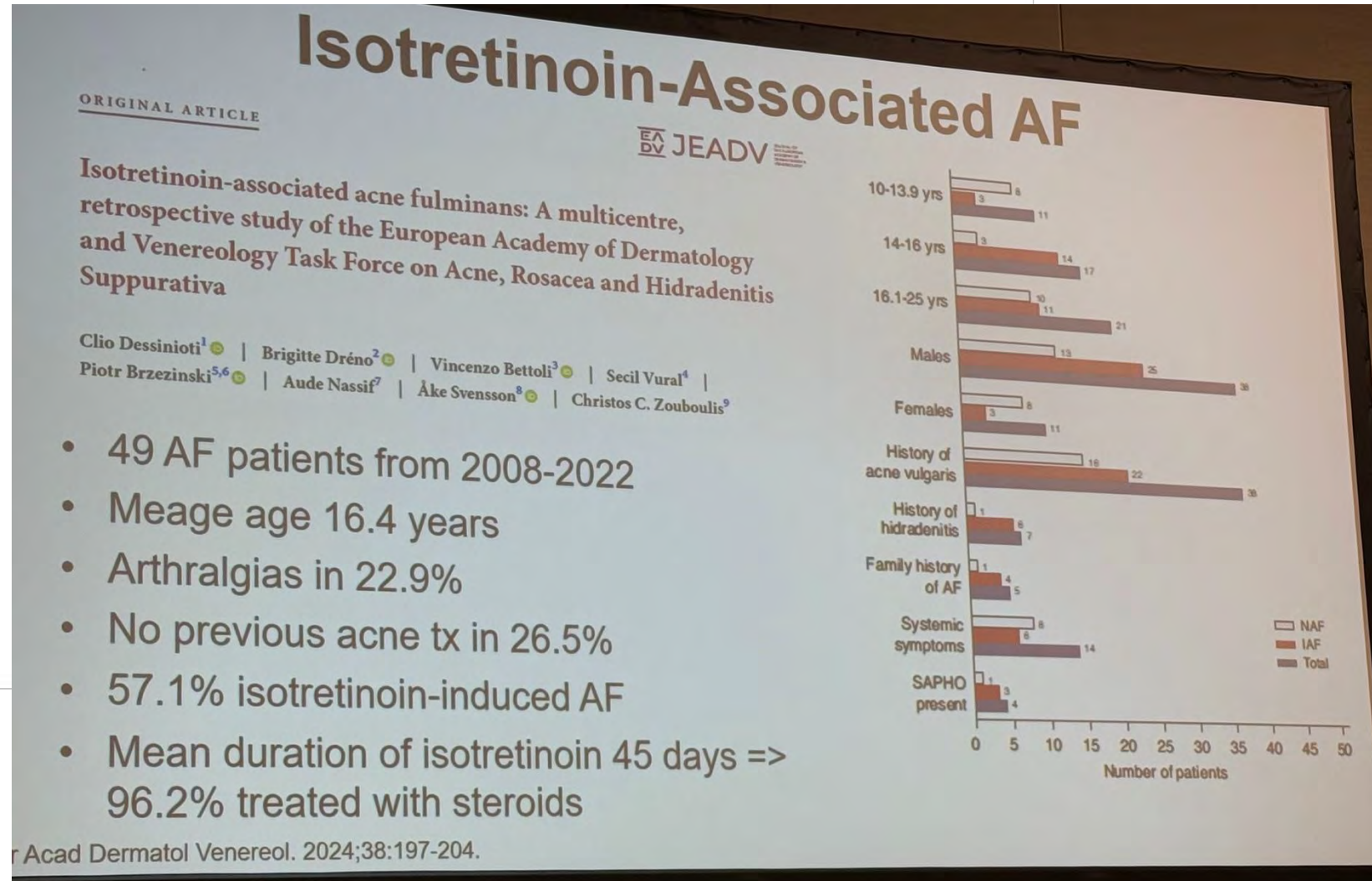
- Upadacitinib highest AE
- Dupilumab nasopharyngitis
- URTI with baricitinib, tralokinumab



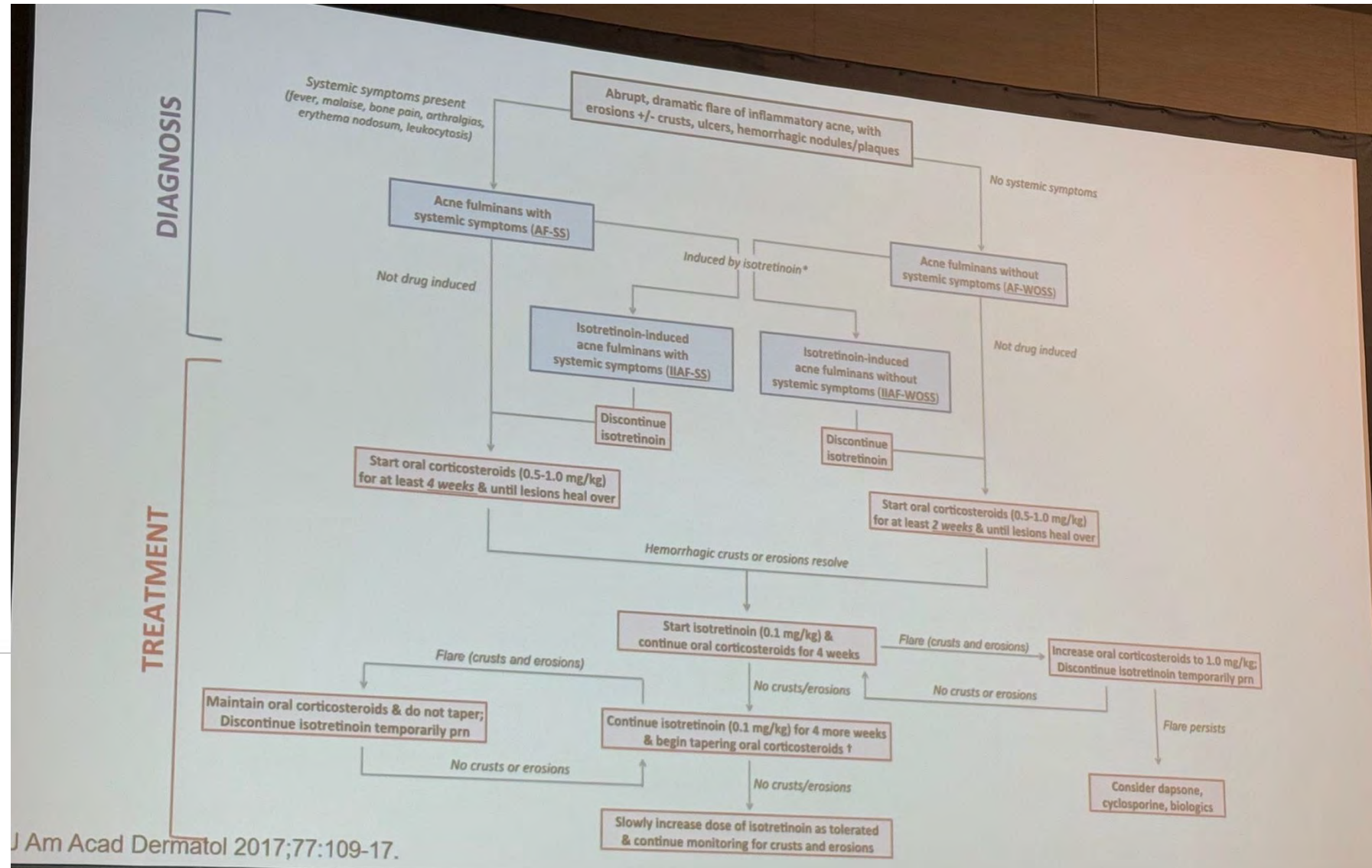
# ACNÉ E HS



# ACNÉ. Acné fulminans. Clínica



# ACNÉ. Acné fulminans. Algoritmo manejo



# ACNÉ. Acné fulminans. Nuevas moléculas

## Now That You Have Acne Fulminans: What Do I Do???

- Long term steroid use:
  - PJP Prophylaxis when prednisone >0.4 mg/kg/day for 30 mg/day for more than 4 weeks
  - Vitamin D + Calcium
- Start thinking about my next step to get them off steroids

- TNF-alpha inhibitors\*\*
- Anakinra
- Ustekinumab
- Cochicine
- Dapsone
- Cyclosporine
- IL-17 inhibitors
- Antibiotics

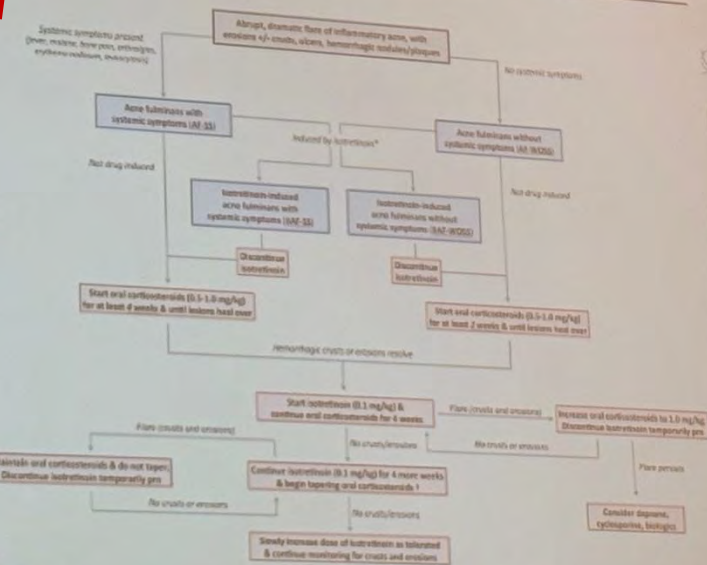
Table II. Initial diagnostic evaluation of acne fulminans

Physical examination	Laboratory studies
	Complete physical examination including temperature
	- Complete blood count with differential
	- Liver function tests
	- Erythrocyte sedimentation rate and C-reactive protein (in patients with systemic findings)
	- Urine or serum human chorionic gonadotropin (in women)
	Radiograph (only if patient has symptoms concerning for bone or joint involvement)

Imaging

DIAGNOSIS

TREATMENT



# 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, reintiated, 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 taking infliximab then switched to adalimumab without recurrence of acne

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



# ACNÉ. Perla acné conglobata

LETTER TO THE EDITOR

## Treating refractory acne conglobata with secukinumab: A case report

- 21 year old man with papules, pustules on the face and neck for 2 years, aggravated with cysts and sinus tracts over 3 months
- Oral minocycline (50 mg/day) and isotretinoin (20 mg/day) with adapalene and benzoyl peroxide for 3 months
- Adalimumab IM twice in 2 weeks (80 mg, 40 mg) trialed but helped insignificantly
- Secukinumab 300 mg once weekly for 5 times and every 4 weeks thereafter with topical treatments
- Lesions resolved after 8 weeks of treatment



# Hidradenitis suppurativa. Carga

## Quality of Life Impairment

- Sexuality and self-identity development in adolescence
- Impacts self-esteem, sports, school attendance, and QOL
- Social withdrawal, school absences

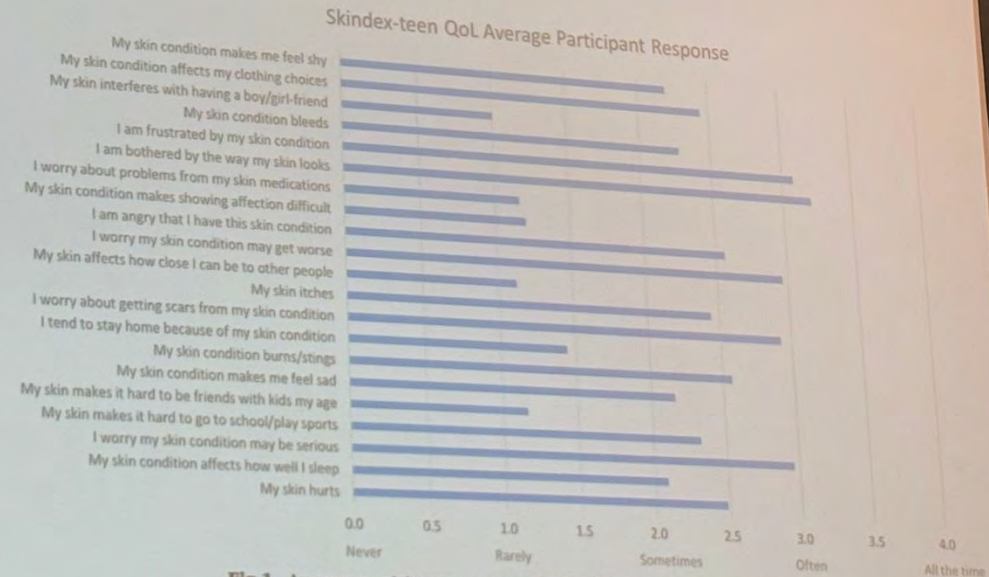


Fig 1. Average participant responses on the Skindex-Teen questionnaire.

# Hidradenitis suppurativa. Carga



## 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

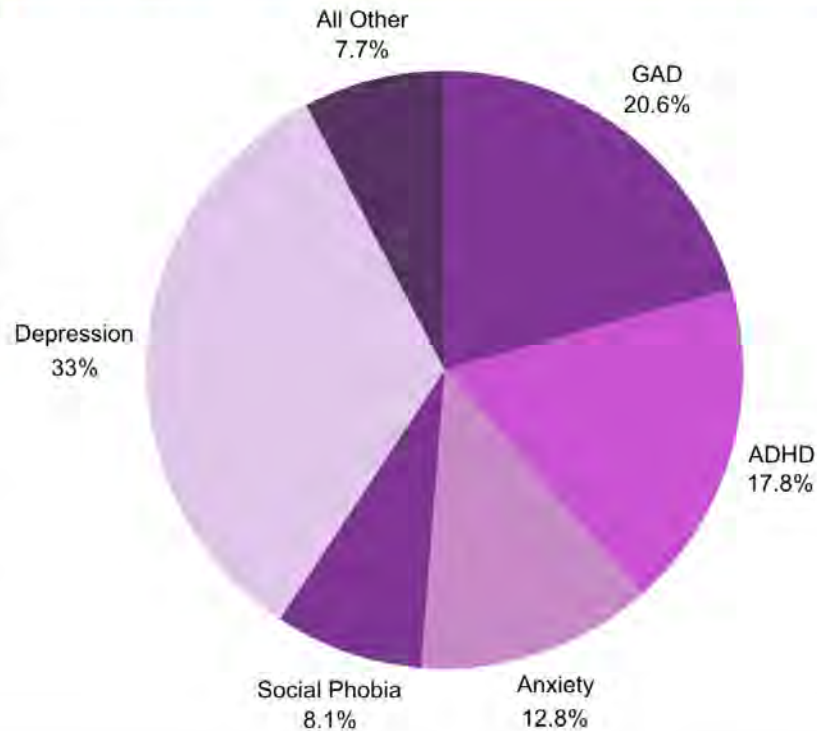
### Introduction

- 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 suppurativa. Clínica

## Clinical presentation of HS in Adolescents

- Axillae and inguinal folds most commonly affected
- Most common symptoms
  - Pain (65%)
  - Drainage (43%)
- Compared with adults, more likely to present with:
  - Comedones (51.00% vs 24.73%;  $P < .001$ )
  - Folliculitis (27.15% vs 13.64%,  $P < .001$ )

### Clinical Pearl

HS prevalence in Trisomy 21 2.1% vs 0.3%  
Earlier HS onset (age ~14)  
Most common presentation is folliculitis

Liy-Wong C, et al. *JAMA Derm* 2021. Hallock KK, et al. *JAMA Derm*. 2021. Lam M, et al. *Pediatr Dermatol* 2020.  
Garg A, et al. *BJD* 2018. Poizeau F, et al. *Acta Derma Vener* 2018.

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

Maria Cinta Sin i Soler<sup>1,2</sup>, Patricia Garbayo-Salmons<sup>2</sup>, Antonio Torrelo<sup>1</sup>, Angela Hernández-Martin<sup>1</sup>, Lucero Noguera-Morel<sup>1</sup>.  
1. Department of Dermatology, Hospital Infantil Niño Jesús, Madrid, Spain. 2. Department of Dermatology, Parc Taulí Hospital Universitari, Sabadell, Spain.

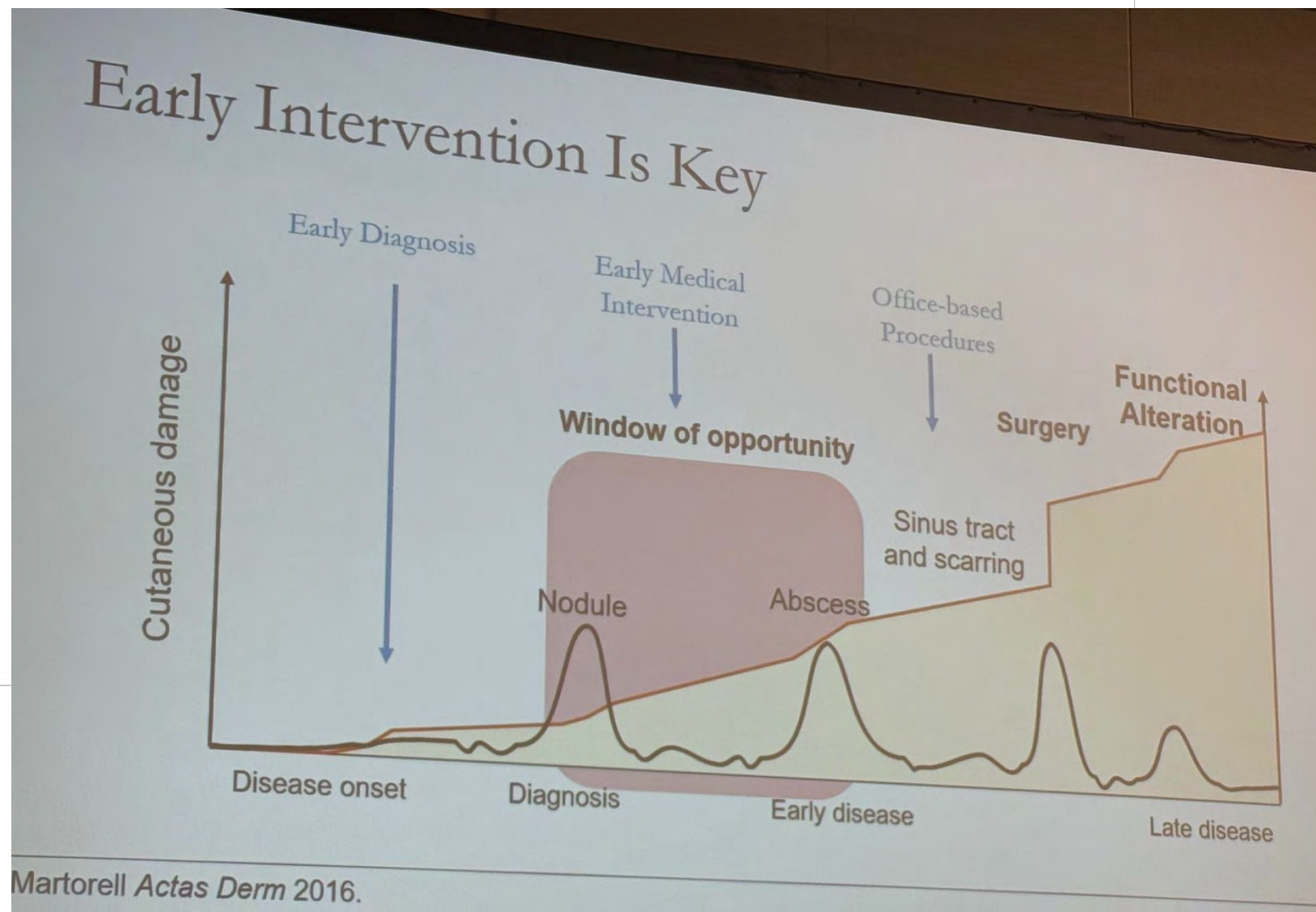
### Introduction:

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 suppurativa. Tratamiento



# Hidradenitis suppurativa. 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



# Hidradenitis suppurativa. Tratamiento

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

Koral Cohen, BA<sup>1\*</sup>, Carl D. Needle, BA<sup>2\*</sup>, Seth J. Orlow, MD, PhD<sup>3</sup>, Vikash S. Oza, MD<sup>3</sup>

<sup>1</sup>New York University Grossman Long Island School of Medicine

<sup>2</sup>New York University Grossman School of Medicine

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

Conflicts of Interest: None. Commercial Support: None.

**NYU Grossman School of Medicine**

Ronald O. Perelman Department of Dermatology  
New York University Grossman School of Medicine  
New York, NY

### 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  $\leq 18$  years, treated with spironolactone for AV at NYU Langone Health (2015-2023)
- Transition Group (N=5):** Required to be on spironolactone for  $\geq 3$  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

Characteristic	Overall (N=160)	Non-Transition Group (N=155)	Transition Group (N=5)
<b>Age</b>			
Mean (years)	13.66	13.82	10.40
Range (years)	9 to 18	9 to 18	9 to 12
<b>Race/Ethnicity</b>			
White	70 (43.75%)	67 (43.2%)	3 (60%)
Black or African American	11 (6.88%)	9 (5.81%)	2 (40%)
Hispanic or Latino	15 (9.38%)	15 (9.65%)	0 (0%)
Asian	9 (5.63%)	9 (5.81%)	0 (0%)
Other	45 (28.13%)	45 (29.03%)	0 (0%)
Not reported/unknown	15 (9.38%)	15 (9.65%)	0 (0%)
<b>Body Mass Index (BMI)*</b>			
Underweight	22 (13.75%)	21 (13.55%)	1 (20%)
Normal Range	87 (54.38%)	84 (54.19%)	3 (60%)
Overweight	47 (29.38%)	46 (29.68%)	1 (20%)
Obese	4 (2.50%)	4 (2.58%)	0 (0%)
<b>Acne Severity (N=77)**</b>			
Mild	29 (37.7%)	27 (33.8%)	2 (25%)
Moderate	37 (48.0%)	34 (42.2%)	3 (38%)
Severe	16 (20.8%)	16 (20.2%)	0 (0%)
<b>Spironolactone Treatment Duration</b>			
Mean (months)	15.33	15.77	6.92
Range	3 to 48.5 years	3 to 48.5 years	3 to 17.5 years

\*BMI Categories: Underweight (<18.5), Normal (18.5-24.9), Overweight (25-29.9), Obese ( $\geq 30$ )  
\*\*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 ( $\leq 14$ years)	74/195 (47.7%)	4/5 (80%)	0.002
Severe Acne	16/100 (16.3%)	2/5 (40%)	0.008
Prior OCP Use	68/195 (34.9%)	2/5 (40%)	0.0134
Black or African American	9/100 (9.0%)	2/5 (40%)	0.0143
Shorter Treatment Duration ( $\leq 15.53$ months)	77/155 (49.7%)	5/5 (100%)	0.0160
Absence of Menstrual Flares	101/105 (96.2%)	5/5 (100%)	0.0004
Scarring Present	38/195 (19.5%)	3/5 (60%)	0.0034
PCOS	23/100 (23.0%)	1/5 (20%)	0.0751
Prior Oral Antibiotic Use	80/155 (51.6%)	3/5 (60%)	0.0751

Table 3. Breakdown of Spironolactone Prescribers

Prescriber	Overall (N=160)
Dermatologist	132 (82.5%)
Pediatrician	22 (13.8%)
Pediatric Endocrinologist	7 (4.4%)
OB/GYN	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 suppurativa. Tratamiento



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

Robyn Guo, BS<sup>1</sup>, Joyce Xia, BS<sup>2</sup>, Tarannum Jaleel, MD<sup>3</sup>, Amy Buros Stein, PhD<sup>4</sup>, Jessica St. John, MD<sup>5</sup>, Anna Cristina Garza-Mayers, MD PhD<sup>6</sup>, Daniela Kroshinsky, MD MPH<sup>3</sup>  
<sup>1</sup>Duke University School of Medicine <sup>2</sup>UMass Memorial Health <sup>3</sup>Duke University Department of Dermatology <sup>4</sup>Pediatric Dermatology Research Alliance <sup>5</sup>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 1<sup>st</sup>, 2013 and December 31<sup>st</sup>, 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; Sponsor: Received support for attending meetings and/or travel; Skin of Color Society, IDEQM; 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

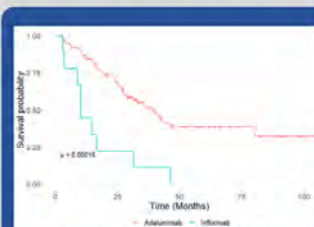


Figure 1. Adalimumab v. infliximab survival

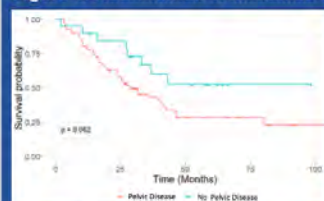


Figure 2. Biologic survival in patients with pelvic\* v. no pelvic disease  
 \*suprapubic, perianal, perineal, gluteal, groin, inguinal, inner thigh HS lesions

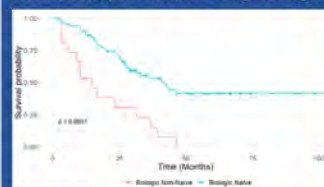


Figure 3. Biologic survival in biologic naïve v. biologic non-naïve patients

Hurley Stage at Diagnose	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%)

### Results

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%)**

- 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

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
<b>Age at HS Diagnosis</b>	<b>1.11 (1.01, 1.23)</b>	<b>0.041</b>	<b>1.12 (1.01, 1.25)</b>	<b>0.048</b>
BMI	0.99 (0.96, 1.03)	0.577	0.99 (0.96, 1.03)	0.630
<b>Past Medical History</b>				
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
<b>Substance Use (any)</b>	<b>1.46 (0.79, 2.71)</b>	<b>0.224</b>	<b>1.74 (0.87, 3.48)</b>	<b>0.120</b>
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
<b>HS Lesion location</b>				
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
<b>Gluteal</b>	<b>2.50 (1.34, 4.66)</b>	<b>0.004</b>	<b>2.87 (1.40, 5.85)</b>	<b>0.004</b>
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
<b>Concomitant Medications</b>				
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
<b>Systemic steroids</b>	<b>2.27 (1.18, 4.36)</b>	<b>0.014</b>	<b>2.18 (1.07, 4.44)</b>	<b>0.031</b>
Cleansers	2.76 (1.34, 5.68)	0.006	2.54 (1.19, 5.40)	0.016
<b>Medication Dosing</b>				
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



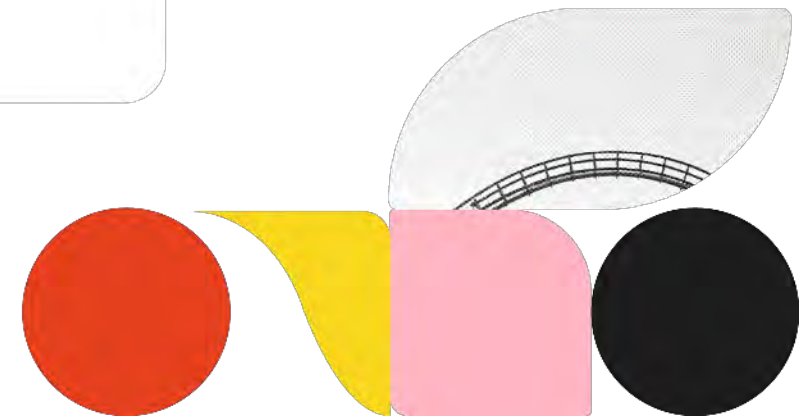
# Hidradenitis suppurativa. Tratamiento

## Conclusion





















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- Limitations: small sample size and there were patients in both cohorts who were not biologic naïve



# LESIONES PIGMENTADAS



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

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DOI <https://doi.org/10.1200/JCO.2014.011154>

# 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

# Giant Congenital Melanocytic Nevus Treated With Trametinib

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Kathleen Ludwig, MD<sup>e</sup>



Pediatrics, 2019

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**Non-segmental vitiligo**  
Differential diagnosis,  
genodermatoses  
Hypomelanosis of Ito



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

**Waardenburg syndrome.**

Read AP<sup>1</sup>, 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

AAD ANNUAL MEETING 2025

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highlights



Una iniciativa de:



Con el patrocinio de:

