

AAD ANNUAL MEETING **2026**

AEDV

highlights
Denver, Colorado

27 — 31
Marzo

[A un nuevo nivel de conocimiento científico]

Una iniciativa de:



Con el patrocinio de:



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Dermatología Pediátrica

**Inflamación, infecciones y
precisión terapéutica**

Helena Iznardo Ruiz

Hospital de Dénia, Alicante

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**Sin conflictos de interés
para esta presentación**

Psoriasis

Balance the risk of side effects from interventions with the risks of undertreatment on development, overall health and wellbeing.



El riesgo cardiovascular empieza en la infancia

Screening comorbilidades

- Obesidad
- Síndrome metabólico
- PsA
- Trastornos psiquiátricos

JAMA Dermatology | Consensus Statement

Pediatric Psoriasis Comorbidity Screening Guidelines

Emily Osler, MD; Audrey S. Wang, MD; Megha M. Tollefson, MD; Kelly M. Cordoro, MD; Stephen R. Daniels, MD, PhD; Andrew Eichenfield, MD; Joel M. Gelfand, MD, MSCE; Alice B. Gottlieb, MD, PhD; Alexa B. Kimball, MD, MPH; Mark Lebwohl, MD; Nehal N. Mehta, MD, MSCE; Amy S. Paller, MD; Jeffrey B. Schwimmer, MD; Dennis M. Styne, MD; Abby S. Van Voorhees, MD; Wynnis L. Tom, MD; Lawrence F. Eichenfield, MD

Summary of guidelines:

- Evaluation of BMI after age 2
- Screening for elevated glucose every 3 years at 10 for obese children with risk factors for diabetes
- Lipids between 9-11 and 17-21 and more if high risk for cardiovascular disease
- Yearly BP starting at age 3
- ALT starting at age 9-11 if obese and risk factors for fatty liver
- Review of Systems and PE for Arthritis
- Screening for anxiety and depression at all ages
- Screening for substance abuse starting at age 11

JAMA Dermatol. 2017 Jul 1;153(7):698-704

Psoriasis

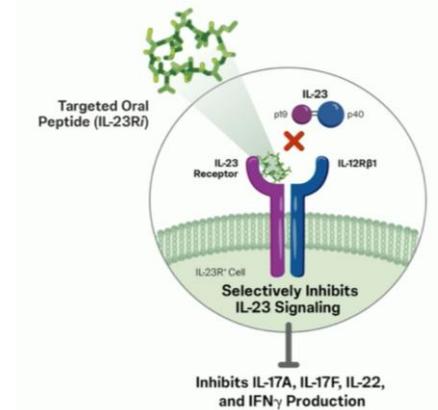
• Guselkumab

- Aprobado en ≥ 6 años
- Semana 16: 66% IGA 0/1, 56% PASI 90, 39% PASI 100
- Sin nuevas alertas de seguridad

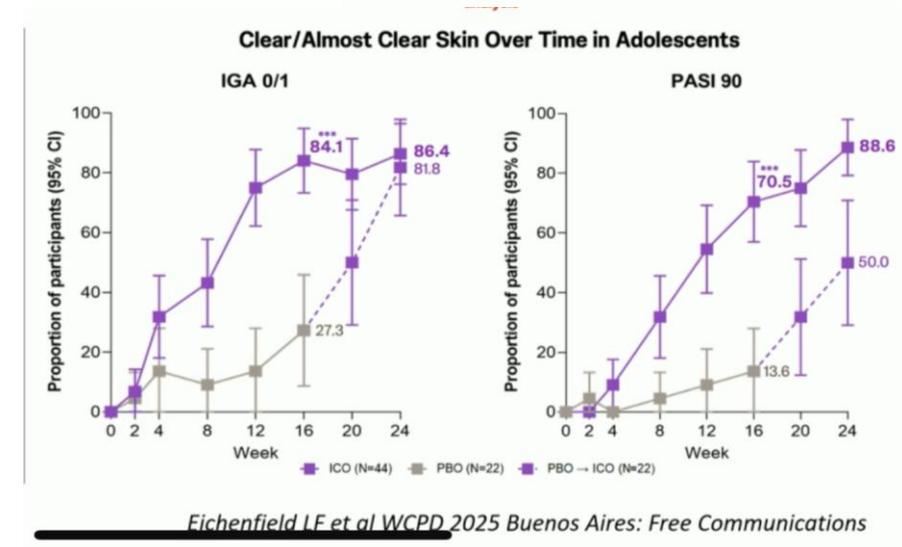
• Icotrokinra - Inhibidor IL-23 oral

- Aprobado en ≥ 12 años
- Una vez al día, al menos 30 minutos antes de ingesta
- Eficacia similar a biológicos anti IL-23
 - Semana 16: 84.1% IGA 0/1, 70.5% PASI 90
- Seguridad similar a placebo

Icotrokinra



N Engl J Med 2024;390:510-2



Infecciones bacterianas

- **Psoriasis pediátrica: 57% cultivo positivo** (estafilococo o estreptococo)
 - Psoriasis **guttata**: más frecuente en exudado **faríngeo** positivo
 - Psoriasis **inversa**: más frecuente en exudado **anogenital** positivo
- **Mycoplasma como imitador de DRESS**
 - Fiebre, rash morbiliforme,
 - Aumento transaminasas, linfocitos atípicos, eosinofilia
 - Uso reciente de atb
 - PCR Mycoplasma negativa, serologías positivas (IgM)

The Association of Psoriasis and Bacterial Infections in Pediatric Patients: A Retrospective Review

Manisha Ravi¹ | Kelly M. Cordero² | Kristen E. Holland¹ | Carmel Aghdasi² | Caden Ulschmid⁴ | Irene Lara-Corrales⁵ | Lucia Z. Diaz^{6,7} | Courtney N. Haller⁷ | Fabiana Castro Porto Silva Lopes⁷ | Lara Wine-Lee⁸ | Caroline Brailsford⁸ | Amy Buros-Stein⁹ | Esteban Fernandez Faith¹

Garritsen FM, et al. *Clin exp dermatol.* 2017.
Ravi M, et al. *Pediatr Dermatol.* 2025.



Lopes Almeida Gomes L, et al. *Pediatr Dermatol.* 2025.

Síndrome de shock tóxico estafilocócico: menos es más

- ¿Cultivos?
 - **No** hemocultivos
 - Cultivar **zonas de infección** y **periorificiales** en pacientes con mala respuesta a tratamiento

- **Antibióticos**
 - **Cefalosporinas** de elección (Cefazolina IV o cefalexina)
 - **Clindamicina no** modifica el pronóstico. Evitar

- **Vaselina** superior a antibiótico tópico

- No fluidoterapia de rutina

**Pediatric Staphylococcal Scalded Skin Syndrome:
A Systematic Review of the Literature to Inform Work-Up
and Management**

Laurel Gray¹ | Annika M. Hansen² | Sarah D. Cipriano¹

Gray L, et al. *Pediatr Dermatol.* 2025.

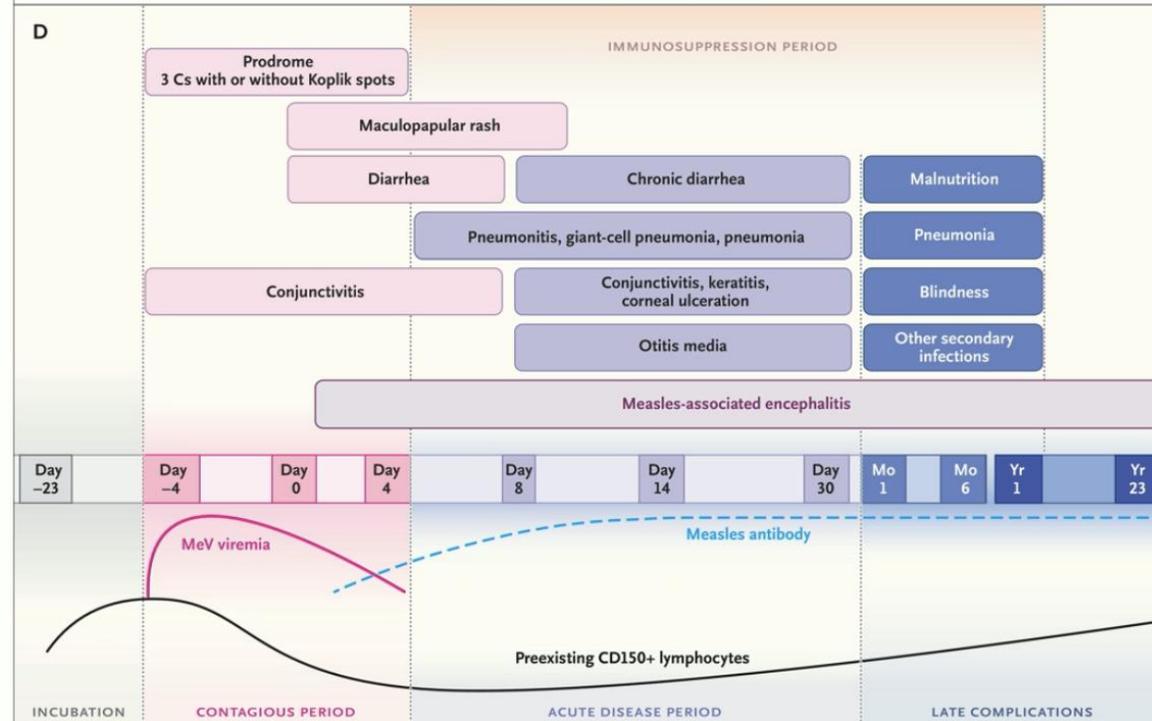
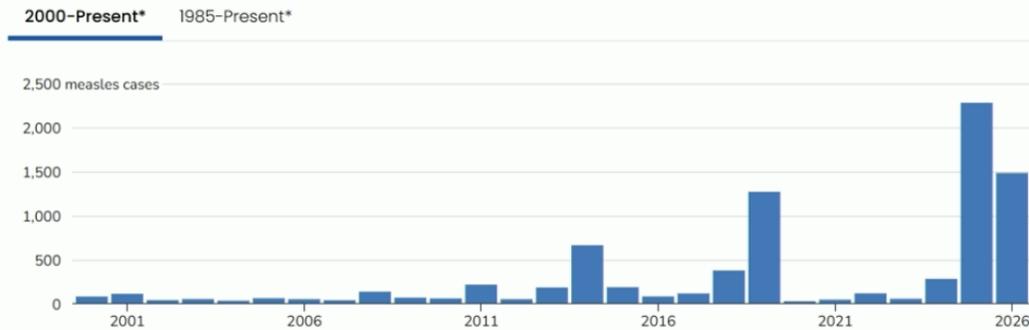
Infecciones emergentes

- ***Trychophyton indotinea***
 - Itraconazol de elección, tratamientos largos (≥ 8 semanas)
 - No identificable con cultivos convencionales
 - Resistencias a terbinafina en *Trycophyton*, en aumento
- **Leishmaniasis**
 - Aumento de casos en zonas no endémicas por cambio climático

Infecciones emergentes

- **Sarampión**

- Aumento exponencial por caída en vacunación
- Altamente contagioso, importante sospecha diagnóstica
- Notificar!!



Infecciones víricas

- **Solución salina saturada para verrugas víricas**
 - 2 cm de agua del grifo + sal refinada hasta saturación
 - Sumergir la zona afectada 30 minutos una vez al día

- **Moluscos contagiosos**

- Berdamizer 10.3%
- Cantaridina 0.7%

¿Tratar o no tratar?

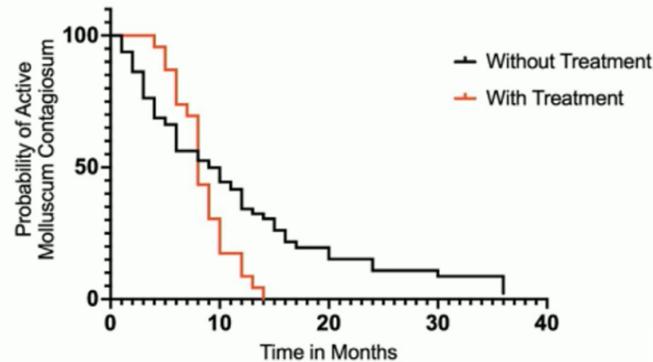
Duración media 8.5 m vs 9.9 m



Results after 5 weeks

Xu Y, et al. *J Am Acad Dermatol.* 2026.

Probability of Active Molluscum Contagiosum With Versus Without Treatment



Robin CY, et al. *JAAD int.* 2025.

- **Fundamental tratar la enfermedad de base en casos extensos (atopia, inmunodeficiencias...)**

Screening y vacunación

- Screening en **biológicos**
 - **Anti-TNF**
 - Quantiferon: basal y anual
 - Hepatitis B
 - **IL-17, IL-12/23, IL-23**
 - Innecesario el screening rutinario ni monitorización
 - IL-17: preguntar sobre candidiasis y síntomas gastrointestinales
- Vacunación en **dupilumab**
 - **Vacunas víricas: seguras y eficaces**
 - **Recomiendan vacunación con virus vivos**

To test or not to test? Revisiting the value of baseline screening and monitoring tests among biologic treatments for psoriasis using an evidence-based assessment

Jessica Q. Duong, BS,^a Dillon J. Razler, BS,^a Matthew L. Hrin, MD,^a William W. Huang, MD,^b and Steven R. Feldman, MD, PhD^a

Duong JQ, et al. *J Am Acad Dermatol.* 2026.

Original Article

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

Jay A. Lieberman, MD^{*}; Derek K. Chu, MD, PhD^{†‡}; Tasnuva Ahmed, MBBS, MPH, MSc[§]; Timothy E. Dribin, MD[¶]; Elissa M. Abrams, MD[¶]; Aikaterini Anagnostou, MD, MSc, PhD^{**}; Kimberly G. Blumenthal, MD, MSc[†]; Mark Boguniewicz, MD[†]; Nicole M. Chase, MD[†]; David B.K. Golden, MDCM[†]; Nicholas L. Hartog, MD[†]; Jennifer R. Heimal, MD^{†¶***}; Tina Ho, MD, PhD[†]; Monica G. Lawrence, MD[†]; David A. Khan, MD[†]; Timothy Dean Minniear, MD, MSc[†]; S. Shahzad Mustafa, MD[†]; John J. Oppenheimer, MD[†]; Elizabeth J. Phillips, MD[†]; Allison Ramsey, MD[†]; Nicholas L. Rider, DO[†]; Lynda Schneider, MD[†]; Marcus S. Shaker, MD, MS[†]; Jonathan M. Spergel, MD, PhD^{†¶***}; Cosby A. Stone, Jr, MD, MPH[†]; David R. Stukus, MD[†]; Julie Wang, MD[†]; Matthew J. Greenhawt, MD, MBA, MSc[†]

Lieberman JA, et al. *Ann Allergy, Asthma Immunol.* 2024.

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Síndrome ASH: acné fulminans + HS

- 14 pacientes, 100% varones
- 11/14 antecedentes familiares HS
- 14/14 ant. famil HS o acné severo
- Sin respuesta a tópicos, tetraciclina, rifa-clinda, cortis orales, isotretinoína, infliximab, adalimumab, ustekinumab
- Respuesta tras 7 meses de antibioterapia dirigida
- No se identificaron mutaciones en NCSTN, PSEN1, PSENEN, APH1B o PSTPIP1

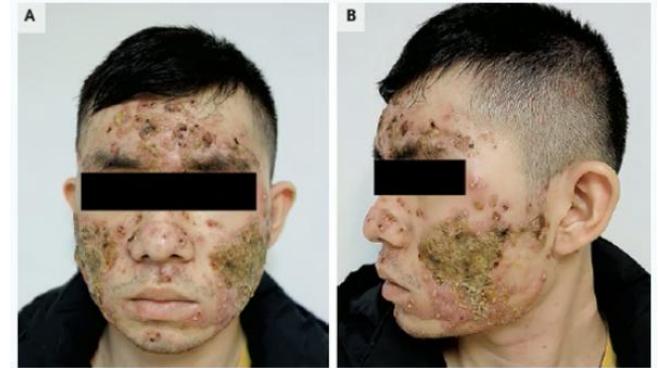


Table I. Characteristics of 14 patients presenting with AF + HS in our cohort of 1600 HS patients

Nº/Sex	Current age	Age at AF onset	Age at HS onset	Hurley stage at sampling	AF at sampling	Familial history of acne	Familial history of HS	Failed treatment
1/M	28	17	17	3	Chronic active	Yes (mC)	Yes (M, mA)	ISO, SS, Ada+RCC, IFX+RCC
2/M	30	15	10	3	Remission	Yes (pGF, F)	Yes (F, pC)	ISO, SS, IFX, RCC
3/M	39	16	16	1	Remission	Yes (F, M)	Yes (B = PNS, mGF?)	ISO, ILS
4/M	39	25	26	2	Remission	Yes* (B)	Yes (B)	ISO
5/M	28	15	17	2	Remission	Yes (F, M, pU, 2 mU)	Yes (pGU, pU = PNS)	ISO, SS, SPIRO, PRIST, RCC
6/M	31	14	13	2	Remission	Yes (F, M, S)	Yes (F, M, S)	ISO, Doxy
7/M	27	13	12	3	Remission	Yes (M, pGM, mGF, 4 mGU)	Yes (M, PNS = HB)	ISO, SS, RCC, Amoxi
8/M	38	24	24	2	Remission	Yes (mC, M)	Yes (B, mU = PNS)	ISO, RCC, Doxy
9/M	28	23	13	3	Remission	Yes (B, S)	Yes (B, mU = PNS)	ISO, SS, NSAIDs
10/M	25	15	16	2	Remission	Yes (F, mA)	Yes (M = PNS)	ISO, RCC, NSAIDs
11/M	25	14	15	2	Remission	Yes (2 pU, 1 pA, 1 mA)	Yes (M)	ISO, Doxy, SS
12/M	35	17	18	2	Remission	Yes (F, S, pGF, pA)	Yes (F, pGF, pA)	ISO, Doxy, SS
13/M	33	15	15	2	Remission	Yes (B, 2 S)	Yes (F, mU)	ISO, RCC, Doxy, ADA, SS
14/M	23	15	13	2	Remission	Yes (F, M)	No*	ISO, Doxy, SS, UST

Miskinyte S et al. JAAD 2025.

doi.org/10.1016/j.jaad.2024.07.1533.

#AEDVenAAD2026

Síndrome de Stevens Johnson y NET

- Uso de **iJAKs** y **antiTNF** (vía IFN-JAK implicada en fisiopatogenia)
- Fundamental **manejo multidisciplinar**
- Revisión sistemática de 10 guías: poco consenso

- 90% highlight multidisp care
- **90% describe wound care: no debridement**
- 40% support systemic corticosteroids
- **50% support IVIg, generally 2g/kg 3-4 days**
- 40% support CsA
- **10% support TNFi (newer)**

Creighton R, Gupta S, Langille C, Sutherland A. Diagnosis and Management of Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis in Pediatric Patients: A Systematic Review of Clinical Guidelines and Consensus Statements. *Pediatr Dermatol.* 2026 Feb 16. doi: 10.1111/pde.70149.

- Ensayos clínicos ¡¡!!

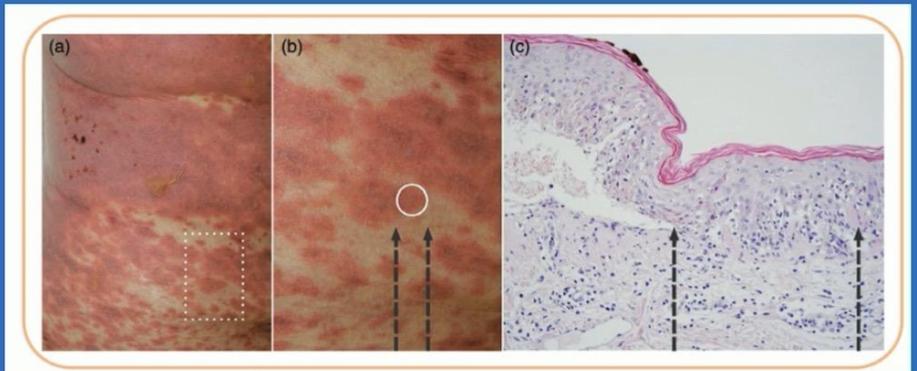
1. **CARE-SCAR Study:** delphi exercise for SCAR in children
A. More clear nomenclature, multidisp consults
2. **NCT06119490:** methylpred+abro or tofacitinib
3. **NCT06474078:** tofacitinib monotherapy (complete)
4. **NATIENS (>18yoa):** CsA vs ETN vs supportive (complete)



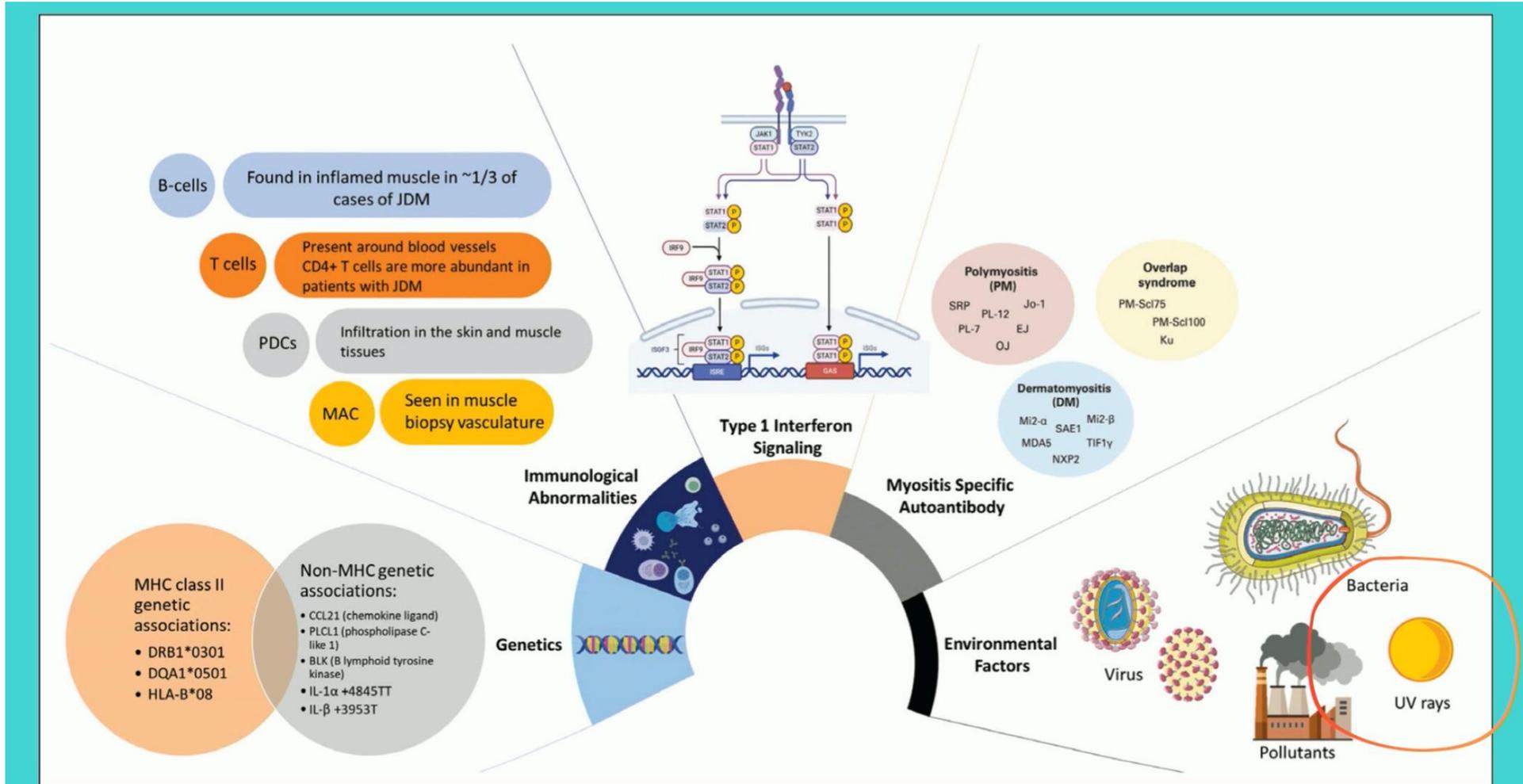
GUIDELINE

S3 guideline: Diagnosis and treatment of epidermal necrolysis (Stevens-Johnson syndrome and toxic epidermal necrolysis) – Part 1: Diagnosis, initial management, and immunomodulating systemic therapy

Ruben Heuer¹ | Maren Paulmann² | Thorsten Anneck³ | Björn Behr^{4,5} | Katharina Boch⁶ | Anja M. Boos⁷ | Knut Brockow⁸ | Lars E. French⁹ | Jochen Gille¹⁰ | Verena Gundlach¹¹ | Bernd Hartmann¹² | Peter Höger¹³ | Silke C. Hofmann¹⁴ | Tobias Klein¹⁵ | Marcus Lehnhardt⁴ | Yvonne Liß¹⁶ | Philip Maier¹⁷ | Philipp Mandel¹⁸ | Nicos Marathovouniotis¹⁵ | Finnja Marlok¹⁹ | Hans Mittelviehhaus⁹ | Uwe Pleyer^{20,21} | Marie Pradeau¹ | Katharina Rall²² | Siegbert Rieg²³ | Heike Rittner²⁴ | Frank Sander¹² | Stefan Schnitzler²⁵ | Christina Schut²⁶ | Annette Stolle²⁷ | Artem Vorobyev⁶ | Bettina Wedi²⁸ | Johannes Weiss²⁹ | Maximilian Zepp³⁰ | Mirjana Ziemer³¹ | Maja Mockenhaupt² | Alexander Nast¹



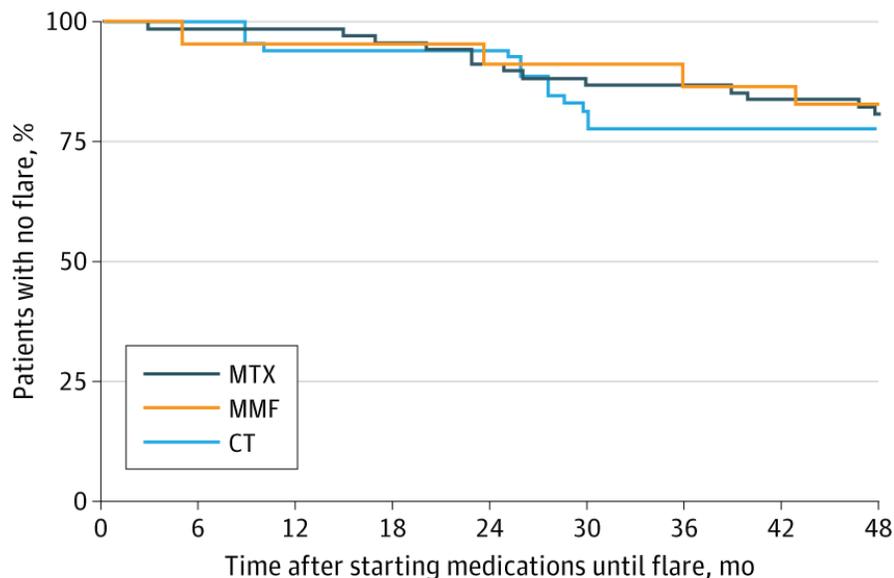
Dermatomyositis juvenil: fisiopatogenia



Esclerodermia localizada juvenil

- **Micofenolato de mofetilo**

- Respuesta similar a MTX con mejor tolerancia (menos náuseas y astenia)



No. at risk	0	6	12	18	24	30	36	42	48
MTX	68	67	67	65	62	59	59	57	55
MMF	28	27	27	27	26	25	25	25	24
CT	18	18	17	17	17	15	14	14	14

Table 3. Medication Adverse Effects

Characteristic	No. (%)			P value (MTX/MMF) ^a
	MTX	MMF	CT	
Symptom^b				
Nausea	41 (60.3)	2 (7.1)	10 (55.6)	<.001
Fatigue	32 (47.1)	3 (10.7)	4 (22.2)	.001
Anxiety	20 (29.4)	2 (7.1)	1 (5.6)	.02
Anticipatory vomiting	12 (17.7)	0	2 (11.1)	.02
Alopecia	10 (14.7)	0	0	.03
Mouth ulcers	8 (11.8)	2 (7.1)	0	.72
Increased LFTs	3 (4.4)	1 (3.6)	2 (11.1)	>.99
Vomiting	2 (3.0)	0	2 (11.1)	>.99
No. of symptoms in 1 patient				
0	9 (13.2)	19 (67.9)	4 (22.2)	<.001
1	16 (23.5)	6 (21.4)	7 (38.9)	>.99
2	28 (41.2)	2 (7.1)	7 (38.9)	.001
≥3	15 (22.1)	0	0	.046

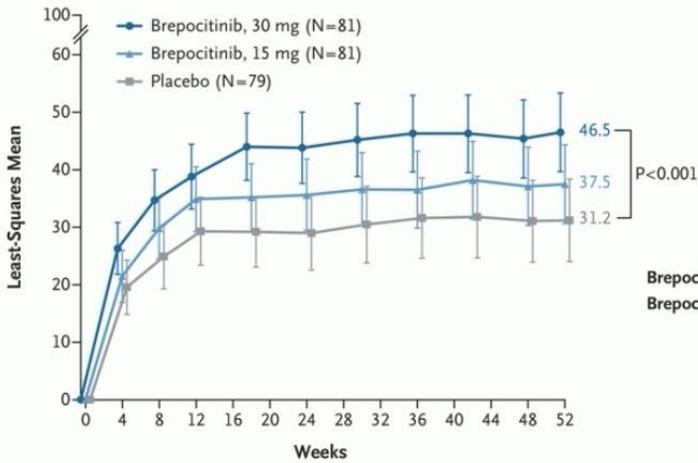
Abbreviations: CT, combination therapy; LFT, liver function test; MMF, mycophenolate mofetil therapy; MTX, methotrexate therapy.

de Rosas et al. JAMA 2026

Dermatomyositis

- **Brepocitinib** (inhibidor TYK2/JAK1)

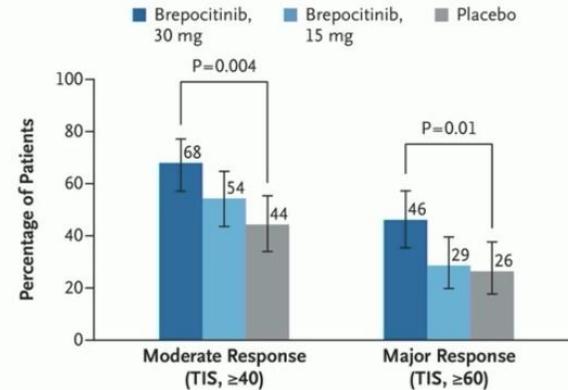
A Total Improvement Score (TIS) and Glucocorticoid Reduction



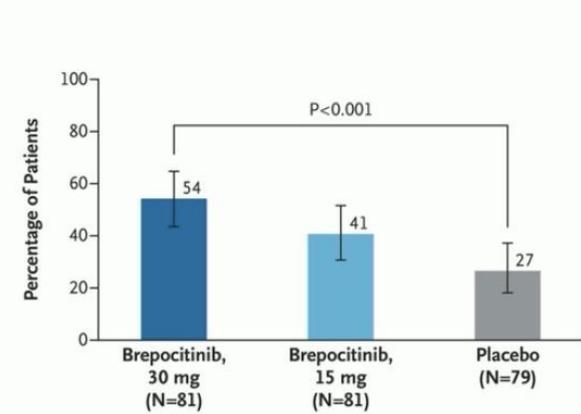
Glucocorticoid Reduction Outcomes
(prednisone-equivalent dose)

	No. of patients at baseline	Dose at baseline mg/day (\pm SD)	Percentage with	
			≤ 2.5 mg/day by weeks 48–52	0 mg/day by weeks 48–52
Brepocitinib, 30 mg	60	12.2 \pm 5.7	62	42
Brepocitinib, 15 mg	58	10.7 \pm 6.2	41	31
Placebo	64	11.3 \pm 5.9	34	23

B Patients with Moderate Response (TIS, ≥ 40) and Major Response (TIS, ≥ 60) at Week 52



C Patients with Moderate Response (TIS, ≥ 40) with Minimal-to-No Systemic Glucocorticoid Use at Week 52



Vleugels et al. NEJM Mar 2026

- **Anifrolumab** en DMJ refractaria



Barrutia-Etxebarria A et al. Pediatr Derm 2026

Identificación de perfiles de respuesta a biológicos/JAKi

- Non-invasive tissue sample: to *extract RNA for RNA-Seq analysis*
- 487-gene expression panel to define immune pathways
- 49 sites; Patients 12+ with AD (and Pso) about to start systemic therapy
- Standard outcomes measures (EASI, v-IGA, BSA; PROs)

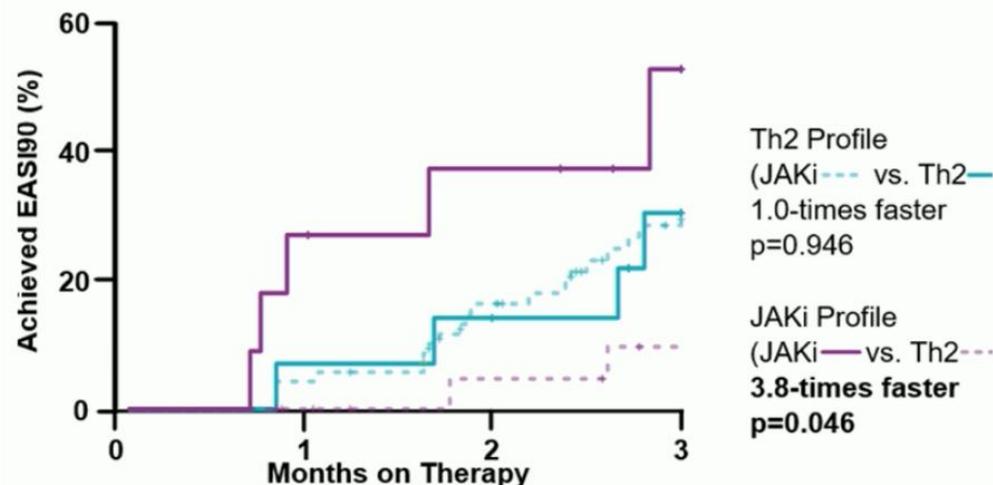


- Determined JAKi-Responder profile vs. Th-2 Molecular Profile

JAKi Profile: Determined higher likelihood to

- ↑ % achieving EASI90/vIGA by 3 months
- Faster time to achieving EASI90
- ↓ itch
- ↓ flares

Silverberg JI et al. JAAD 2026
doi: 10.1016/j.jaad.2026.02.034.



Weibull accelerated failure time (AFT) comparing differences in time to achieve EASI90 between groups.

Conclusiones

- **La dermatología pediátrica puede ser sistémica y potencialmente grave:** evitar infratratamiento si está justificado
- **Las terapias dirigidas están cambiando el manejo**
- **Cambios en infecciones:** resistencias, reemergencia y menor intervencionismo
- **El manejo multidisciplinar sigue siendo clave,** especialmente en enfermedades complejas

*A un nuevo nivel de
conocimiento científico*



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Y VENEREOLOGÍA



FUNDACIÓN
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Con el patrocinio de:



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