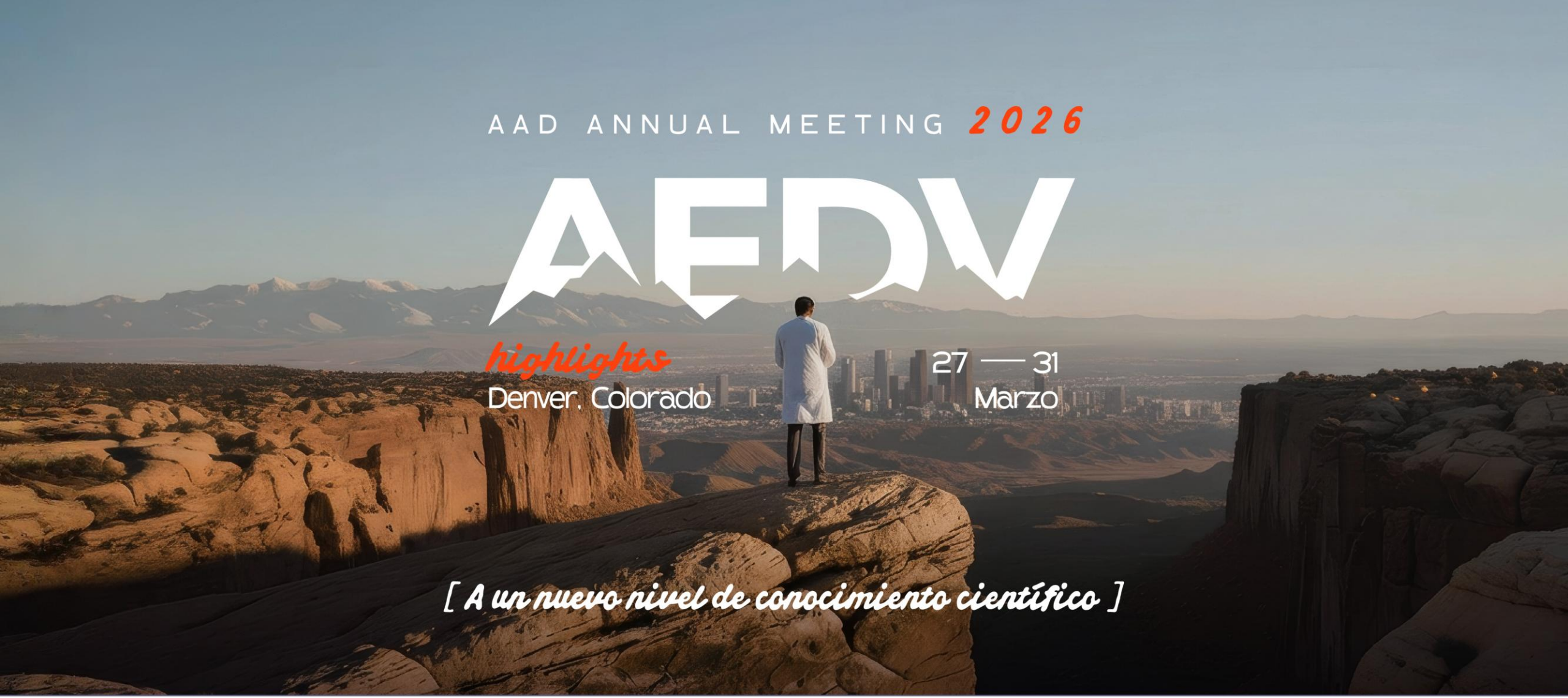

Una iniciativa de:

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AAD ANNUAL MEETING 2026

AEDV

highlights

Denver, Colorado

27 — 31 Marzo

HIDRADENITIS SUPURATIVA

Una nueva era para la HS: auge en nuevas terapias y optimización mediante tratamientos combinados

Aurora Fernández Galván

Hospital Universitario Fundación Jiménez Díaz

aurora.fgalvan@quironsalud.es

NO TENGO CONFLICTOS DE INTERÉS

highlights
Denver, Colorado

AAD ANNUAL MEETING 2026

27 — 31
Marzo

AEDV

12 sesiones 144 posters

Una iniciativa de:

ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

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#AEDVenAAD2026

Con el patrocinio de:

ucb

Innovación y avances en tratamientos biológicos e inhibidores de pequeñas moléculas

Monitorización

Terapias duales

Efectos adversos y paradójicos

Futuras dianas

U018 Innovative and Advanced Management of Biologics and Small Molecule Inhibitors in Hidradenitis Suppurativa and Beyond
Fri, Mar 27, 3:30 PM - 4:30 PM
S030 A New Paradigm in the Management of the Hidradenitis Suppurativa Disease Spectrum
Sat, Mar 28, 9:00 AM - 12:00 PM

Monitorización

Tumor Necrosis Factor-alpha Inhibitors

Potential Side Effect	Screening Test	Monitoring
Mild elevation in LFTs	CBC/CMP	Periodically (6-12 months)
Increased risk of TB	TB - PPD, IGRA	Annually, annually only if high risk, ROS annually
Increased risk of Hep B/C	Hepatitis B Panel Hepatitis C Ab	Repeat if high risk, symptomatic or elevated LFTs

Interleukin-17 Inhibitors

Potential Side Effect	Screening Test	Monitoring
Neutropenia	CBC/CMP	Periodically (6-12 months)
Low risk of TB	TB - PPD, IGRA	ROS annually
Low risk of Hep B/C	Hepatitis B Panel Hepatitis C Ab	Repeat if high risk, symptomatic or elevated LFTs

Janus Kinase Inhibitors

Potential Side Effect	Screening Test	Monitoring
Neutropenia, Anemia	CBC	CBC at 12 weeks and periodically
Drug-Induced Liver injury	LFTs	Periodically
Elevated total cholesterol, LDL/HDL	Consider lipid panel at baseline	Lipid panel at 12 weeks
Increased risk of TB	TB - PPD, IGRA	Annually, annually only if high risk, ROS annually
Increased risk of Hep B/C	Hepatitis B Panel Hepatitis C Ab	Repeat if high risk

Infectious risk and Lab monitoring in Advanced Biologics
Julia Mhlaba Riley, MD, FAAD. *Northwestern Feinberg*

Infecciones activas (TB/HB) → diferir biológico/SMI

TB

- **Conversión a TB latente durante tratamiento con biológicos:** Se puede iniciar tratamiento antituberculoso y continuar el biológico
- **TB previa (tratada)** considerar inhibidores de IL-17 en lugar de anti-TNF-alfa

Hepatitis B

- **Crónica/resuelta:** considerar (++inhibidores de IL-17) tras discusión con digestivo (monitorización/profilaxis)

Inmunización

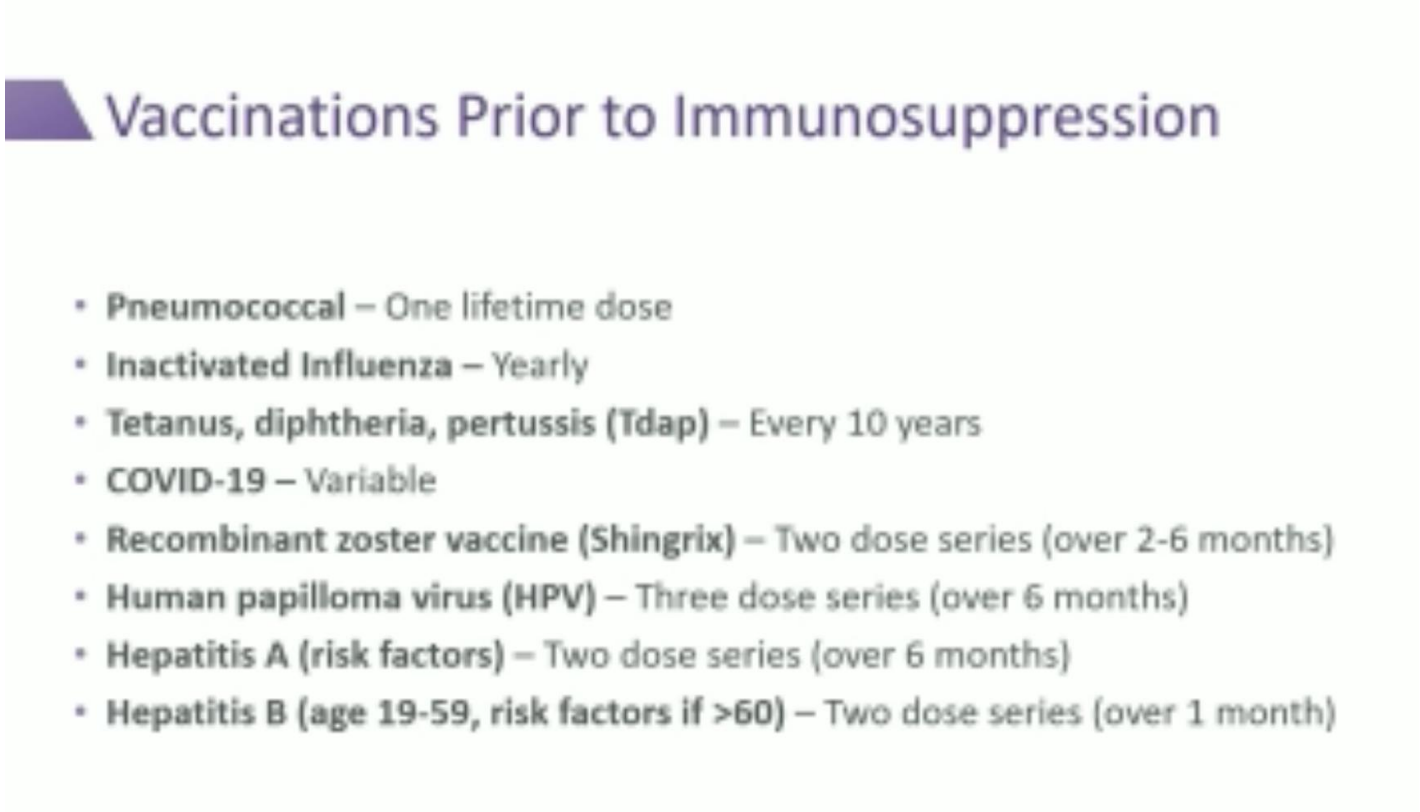
El inicio del tratamiento no debe posponerse en espera de alcanzar el estado de vacunación.

Vacunas inactivadas:

- Se deben completar al menos dos semanas antes de iniciar el biológico/SMI
- **Son seguras durante el tratamiento**

Vacunas vivas:

- Se deben completar al menos 4 semanas antes del inicio del tratamiento
- **SE DEBEN EVITAR DURANTE EL TRATAMIENTO**



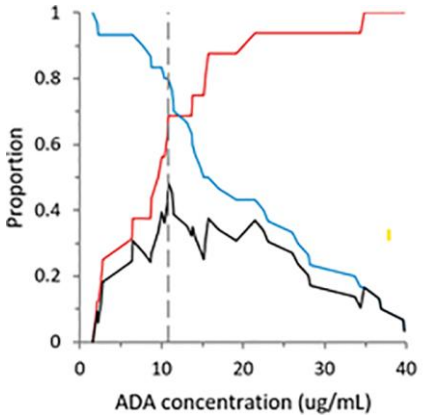
Infectious risk and Lab monitoring in Advanced Biologics
Julia Mhlaba Riley, MD, FAAD. *Northwestern Feinberg*

Monitorización terapéutica

Therapeutic drug monitoring of adalimumab in hidradenitis suppurativa: a prospective observational study

Stella X. Chen[1†], Bruna Galvao de O. Wafae[1*†], Sydney Look-Why[1], Tracey Otto[1], Corey Snyder[1], William Sweet[1], Nazrin Ashina[1], Ruby Gibson[1], Prerna Salian[1], Maneli Doroudian Tehrani[1], Thierry Dervieux[2], Alexa B. Kimball[1,3] and Martina L. Porter[1,3]

[1]Clinical Laboratory for Epidemiology and Applied Research in Skin (CLEARS), Beth Israel Deaconess Medical Center, Boston, MA, United States, [2]Prometheus Laboratories, San Diego, CA, United States, [3]Harvard Medical School, Boston, MA, United States



	All patients (n =46)	Low responders (n = 16)	Partial responders (n = 18)	High responders (n = 12)	P value
Treatment duration, median (IQR), months	13.3 [3.6, 30.2]	4.2 [2.3, 15.4]	14.1 [4.8, 30.2]	30.4 [18.8, 37.4]	0.007
IHS4 at ADA dosing					
Mild	20 (45.5)	3 (20.0)	8 (47.1)	9 (75.0)	0.003
Moderate	16 (36.4)	5 (33.3)	8 (47.1)	3 (25.0)	
Severe	8 (18.2)	7 (46.7)	1 (5.9)	0 (0.0)	
DLQI, median (IQR)	8.0 (3.0-17.0)	17.0 [8.5, 19.0]	6.0 [3.0, 9.0]	6.0 [3.5, 14.0]	0.056
Laboratory values					
ADA concentration (ug/mL), median (IQR)	13.7 [8.6, 22.9]	9.1 [2.7, 14.1]	14.2 [11.3, 22.6]	24.6 [11.2, 33.9]	0.014
ADA Clearance (L/day, median (IQR)	0.5 [0.3-1.0]	0.9 [0.6-1.8]	0.4 [0.3-1.1]	0.4 [0.3-0.5]	0.002
Antibodies, n(%)	10 (21.7)	6 (37.5)	3 (16.7)	1 (8.3)	0.144

- Nieves de **ADA de 10.7 µg/mL** con buena sensibilidad (ROC) para distinguir parcial/alta respuesta de baja respuesta (80% S 69%E)
- Nieves más elevados son necesarios para major respuesta (24.6 µg/mL)

Therapeutic Drug Monitoring in HS and Beyond.
Stella Chen, MD, FAAD

Practical recommendations for Adalimumab TDM

- Greater risk of subtherapeutic levels in patients with:
  - High CRP
  - High BMI
  - Low albumin
  - More severe disease (Hurley II/III)
- Greater risk of antidrug antibody development with:
  - Missed doses or insufficient dosing
  - Prior history of antibodies
  - HLA DQA1*05 (celiac genetic testing)
- Target at least adalimumab level of 10.7 ug/mL
  - Higher levels likely needed for high response (HiSCR75) – greater than 20 ug/mL
  - For primary nonresponders (high adalimumab level, no response) → switch medications, preferably switch classes
  - For partial responders with adalimumab levels <20 ug/mL, consider off-label adalimumab 80 mg weekly

Therapeutic Drug Monitoring in HS and Beyond.
Stella Chen, MD, FAAD

CRP and MCV as Predictors of Adalimumab Discontinuation in Hidradenitis Suppurativa

Batuhan Kerem Balan MD[1], Neslihan Akdogan MD[1], Ihsan Berkay Memisoglu MD[1], Leyla Huseynova Terzi MD[1], Duygu Gulseren MD[1], Sibel Dogan Gunaydin MD[1], Sibel Ersoy Evans MD[1]
[1] Hacettepe University , School of Medicine , Department of Dermatology and Venereology , **Ankara, Turkiye**
All authors report no relevant disclosures, and this study received no commercial support.

Background

- Hidradenitis suppurativa (HS) is a chronic, inflammatory, recurrent disease with substantial morbidity.
- Adalimumab is approved for moderate-to-severe HS, yet a considerable proportion discontinue due to inadequate efficacy[1,2]
- Readily available biomarkers predicting adalimumab drug survival could support personalized management

Objective

To evaluate clinical and baseline laboratory predictors of **adalimumab drug survival** in HS.

Method

Study design & setting

- Retrospective cohort, single center
- Period: December 2018 – December 2024

Participants

- HS patients treated with adalimumab
- Responders vs non-responders defined by **HiSCR**

Baseline variables (Pre-treatment)

- WBC, neutrophils, NLR, MCV, ESR, CRP

Statistics

- ROC → optimal cut-offs
- Kaplan–Meier + log-rank
- Multivariable Cox regression (covariates: age, sex, BMI, gluteal involvement, CRP, neutrophils, MCV)

Results and Discussion

Sixty-seven patients with HS were included (25 non-responders, 42 responders). ROC analysis identified cut-offs of CRP >14.3 mg/L and MCV <82.05 fL; Kaplan–Meier analysis showed shorter adalimumab drug survival in patients with higher inflammatory markers and low MCV. In multivariable Cox regression, only CRP >14.3 mg/L (HR 5.6; 95% CI 1.18–27.14; p=0.030) and MCV <82.05 fL (HR 4.3; 95% CI 1.49–12.84; p=0.007) independently predicted discontinuation due to lack of efficacy (Table 1). Overall, baseline CRP and MCV are practical, widely available biomarkers that may help identify patients at higher risk for early adalimumab failure in HS, supporting closer monitoring and earlier treatment optimization

Variable	HR (95% CI)	p-value
Age (years)	0.996 (0.960–1.034)	0.847
BMI (kg/m²)	0.897 (0.799–1.007)	0.065
Gluteal involvement	1.549 (0.576–4.162)	0.386
MCV <82.05 fL	4.383 (1.495–12.847)	0.007*
CRP >14.3 mg/L	5.668 (1.184–27.143)	0.030*
Female sex	2.063 (0.669–6.363)	0.208
Neutrophil count >7.45 ×10⁹/L	2.663 (0.674–10.520)	0.162

Table 1. Multivariate Cox proportional hazards regression analysis of factors associated with adalimumab discontinuation in patients with HS

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- 2- Rayner DG, Gea D, Olugundudu L, Khosravi-Hafshejani T, Dutz JP. Predictors of drug survival of biologics in hidradenitis suppurativa: A systematic review and meta-analysis. J Am Acad Dermatol. Sep 2025;93(3):854-857. doi:10.1016/j.jaad.2025.05.1418

Development of Anti-Adalimumab Antibodies in Patients with Hidradenitis Suppurativa: A Single-Center Retrospective Study

Tung Son Tran, M.D.[1,2,3], David Wetter, M.D.[3], Shannon Piche, Pharm.[3], Giang Huong Nguyen, M.D.[3]

[1]Department of Dermatology, Hanoi Medical University, [2]National Hospital of Dermatology and Venereology, Hanoi, Vietnam, [3]Department of Dermatology, Mayo Clinic, Rochester, MN, USA,

INTRODUCTION

Hidradenitis suppurativa (HS) is a chronic, inflammatory skin disorder characterized by painful nodules, abscesses, and sinus tract formation, predominantly affecting apocrine gland-bearing areas such as the axillae and groin. Adalimumab, a tumor necrosis factor-α (TNF-α) inhibitor, was the first biologic approved for moderate-to-severe HS, demonstrating substantial efficacy in reducing disease activity and improving quality of life. Mechanistically, therapeutic success of adalimumab may be compromised by several factors including the development of anti-adalimumab antibodies (AAA), which can neutralize drug activity and reduce serum trough levels, leading to suboptimal clinical response, as proved in several inflammatory diseases

OBJECTIVES

To evaluate the prevalence, timing, and associated factors of AAA development in HS patients receiving adalimumab therapy.

METHODS

STUDY DESIGN AND POPULATION

A retrospective cohort study on patients diagnosed with HS who received adalimumab treatment at our institution and were tested for adalimumab trough level and AAA. Clinical response was classified into three categories: optimal response – achieving significant improvement, primary suboptimal response – no achieving significant improvement from the start, and secondary suboptimal response – initially achieving improvement followed by substantial exacerbation.

ANTI-ADALIMUMAB ANTIBODY TESTING

The trough level of adalimumab was first measured prior to the administration of subsequent injection (LC-MS/MS). When the trough concentration remained within the therapeutic range, AAA were considered negative. Conversely, if the trough level fell below the therapeutic threshold, AAA testing was implemented to evaluate its immune activity (ELISA-based).

OUTCOMES

The primary outcome of observation in this study was the detection of AAA in HS patients. The secondary outcomes included the stretch of time from the start of adalimumab therapy to AAA formation and characterization of clinical response.

ETHICAL APPROVAL

The study received the Institutional Review Board approval and followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guidelines.

RESULTS 1

BASELINE CHARACTERISTICS

A total of 131 eligible patients were included in our study.

Male/Female: 45%/55%.

Age of HS onset: 20 [16-29]. Age of adalimumab start: 34 [26-34].

Hurley I: 6.1% - Hurley II: 39.1% - Hurley III: 54.8%.

Adalimumab dosing: 40mg Q2W (19%), 40mg QW (66.2%), 80mg Q2W (7.8%), 80mg QW (7%).

Duration from disease onset to adalimumab start: 36.6 [12.2-97.0] months.

Smoking: 43%. White/non-white: 75.6%/24.4%.

Comorbidities: IBD (32.1%), Arthritis (23.7%), Diabetes (16.8%), Hypertension (23.7%), Hyperlipidemia (20.6%).

No conflicts of interest to declare

RESULTS 2

DEVELOPMENT OF AAA

AAA formation was identified in 38.9% of HS patients, with a median duration of 15.3 months [IQR: 6-26] following initiation of adalimumab therapy. (Figure 1)

Patients with AAA demonstrated significantly lower adalimumab trough levels compared to those without AAA ($p < 0.001$). (Figure 2)

Stratification by clinical response revealed a significant difference in AAA development among the three response groups—optimal responders, secondary suboptimal responders, and primary suboptimal responders—based on the log-rank test. (Figure 3)

FIGURE 1. Development of AAA in HS patients

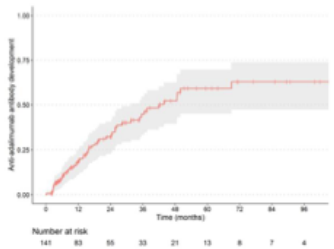


FIGURE 3. AAA in HS patients with different clinical response

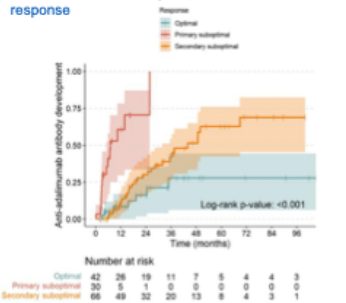
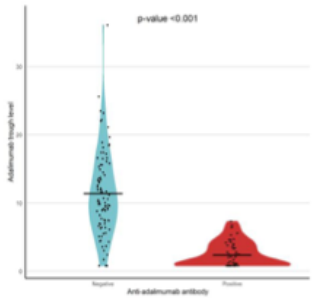


FIGURE 2. Trough levels of adalimumab in patients with and without AAA



The Table below summarizes the findings derived from Cox proportional analyses. Patients with elevated blood CRP, ferritin, HbA1c, neutrophil, neutrophil/lymphocyte ratio, decreased vitamin D, and normochromic anemia experienced a significantly greater risk of developing AAA.

Factors	AAA (-) (N=80)	AAA+ (N=51)	HR
Elevated CRP	40 (69.0)	35 (95.6)	**7.81 (1.87-32.62)**
Elevated ferritin	5 (8.6)	11 (28.95)	**2.25 (1.12-4.54)**
Decreased vitamin D	15 (23.8)	20 (54.1)	**2.63 (1.38-5.01)**
Elevated HbA1c	6 (10.7)	13 (31.7)	**2.05 (1.05-3.98)**
Elevated neutrophil	26 (33.8)	30 (63.8)	**1.96 (1.09-3.55)**
Decreased lymphocyte	5 (6.5)	6 (12.8)	**3.09 (1.29-7.42)**
Elevated NLR	23 (30.3)	33 (70.2)	**2.93 (1.57-5.47)**
Decreased albumin	5 (7.7)	9 (20.5)	1.23 (0.59-2.56)
Anemia			
Normochromic	13 (16.5)	22 (45.8)	**1.94 (1.11-3.56)**
Hypochromic	5 (6.3)	4 (8.3)	1.06 (0.37-3.08)

DISCUSSION

Our study found: AAA occurred in 38.9% of our cohort, with a median onset of 15.3 months. 68.6% of AAA-positive cases were detected within the first two years of adalimumab use, **indicating that the majority of immunogenic events occur relatively early in the treatment course.** Other studies: AAA rates in HS range 6.5% - 24% (Notes: Study design).

AAA – poor clinical response and decreased trough levels of adalimumab.

Some associated factors: inflammatory markers (CRP, neutrophil, NRL, ferritin), vitamin D, anemia, HbA1c. Larger cohort with validation is warranted.

Limitations: retrospective nature, single-center study, lacking a representative cohort with detailed characterization of laboratory, potential bias in conducting AAA testing.

CONCLUSIONS

- AAA: frequent occurrence in patients with hidradenitis suppurativa treated with adalimumab, often emerging within the first two years of therapy; associated with reduced drug levels and diminished treatment response.
- Early identification of patients at risk—based on clinical and laboratory markers— enables more personalized therapeutic strategies, including timely adjustments to biologic regimens or adjunctive immunomodulatory approaches.

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Tratamiento dual o combinado

Habitual en EII, psoriasis y Aps, con alta eficacia y útil en fallo de monoterapia.
En HS la evidencia es escasa: ausencia de ensayos clínicos, seguimiento corto de casos publicados

Biologic + JAK inhibitor

CASE REPORT

Dual immunomodulator therapy with adalimumab and upadacitinib to treat recalcitrant hidradenitis suppurativa

Zahidul Islam, BA,[a,b] Solbie Choi, BS,[a] Lucy Wang, BA,[b] Tyler M. Andriano, MD,[a] and Kristina Compton, MD[a]

Dermatol Ther (Heidelb). 2025 Oct 16. doi: 10.1007/s13555-025-01569-x. Online ahead of print.

Secukinumab Plus Upadacitinib for the Treatment of Severe Hidradenitis Suppurativa and Associated Immune-Mediated Comorbidities: A Case Series

Francisco Javier Melgosa Ramos [1], Esperanza Martínez Ruiz [2], Marta Galarreta Pascual [3], Virginia Sanz-Motilva [3], Antonio Martorell [2]

P-146 | **Refractory, severe hidradenitis suppurativa Hurley stage III shows positive response to a therapy with the combination of brodalumab (Il-17-receptor- inhibitor) and Upadacitinib (JAK - inhibitor). A case report**

Caroline Gewiss, Matthias Augustin, Natalia Kirsten
University Hospital Hamburg-Eppendorf, Health Care Research in Dermatology and Nursing, Hamburg, Germany

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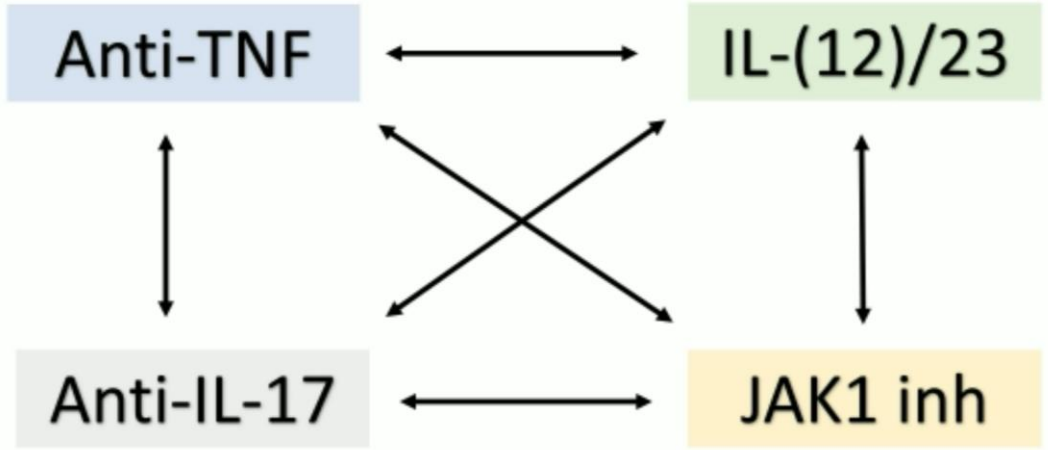
CASE REPORT

Dual immunomodulator therapy with upadacitinib and bimekizumab in severe hidradenitis suppurativa: A case report

Possible Combinations to Consider



Courtesy of Dr. Katrina Lee

Review > Dermatol Ther (Heidelb). 2026 Jan;16(1):231-245.
doi: 10.1007/s13555-025-01601-0. Epub 2025 Nov 24.

Dual Targeted Therapy for Hidradenitis Suppurativa: A Narrative Review

Kenan Kherallah [1], Claire S Chung [1], Raveena Ghanshani [1], Alexandra Charrow [2 3], Julia M Riley [4], Christopher J Sayed [5], Vivian Y Shi [6], Katrina H Lee [7], Jennifer L Hsiao [8]

Affiliations + expand

PMID: 41276757 PMCID: PMC12873004 DOI: 10.1007/s13555-025-01601-0

4 casos publicados
Secukinumab + Baricitinib
Adalimumab + Upadacitinib
Certolizumab + Anakinra
Adalimumab + Anakinra
TT (8 Semanas – 2 años)

SE RECOMIENDA PRECAUCION CON LA INHIBICIÓN DUAL TNF-α e IL1

La evidencia en otras enfermedades inflamatorias (por ejemplo, **AR**) muestra que la **combinación no mejoró eficacia** pero sí **aumentó la tasa de infecciones graves** (neumonía, celulitis, herpes zóster, neumonitis, pielonefritis)

<u>Resultados observados:</u>

- Menor carga inflamatoria y mayor calidad de vida.
- **Bien tolerada**: no se observaron problemas de seguridad importantes para ninguna combinación específica

- Combination therapy common/standard of care
  - RA, PsA, IBD, Cancer

- Present Day Combinations: Cytokine + Jak inhibitors
  - Adalimumab or infliximab + upacitinib or tofacitinib
  - Secukinumab or bimekizumab + upacitinib or tofacitinib

Garg et al. Br J Dermatol. 2022 Sep;187(3):414-415

Double Trouble… or Double Triumph? Dual Biologic Therapy in Refractory Hidradenitis Suppurativa

Nicole Vecin MD MPH[1], Guy Shaposhnik MD[1], Juliana Berk-Krauss MD[2], Jan Smogorzewski MD[1,3]

[1] Division of Dermatology, Harbor-UCLA Medical Center, Torrance, CA, [2]Department of Dermatology, Keck School of Medicine of USC, Los Angeles, CA, [3]Los Angeles General Medical Center, Los Angeles, CA

Background

- Systemic and topical therapies often fail to control severe hidradenitis suppurativa (HS).
- **Adalimumab, secukinumab, and bimekizumab** are currently FDA-approved for moderate-to-severe HS, with adalimumab demonstrating response rates of 42–59%.
- While dual biologic therapy has shown success in other inflammatory diseases, evidence in HS remains limited.

Case Report

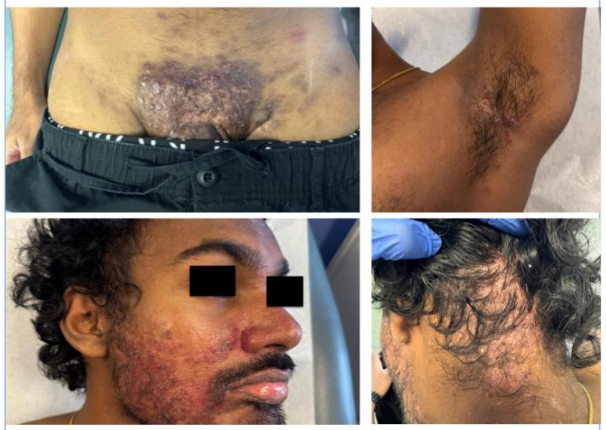
- A 21-year-old male with Hurley stage III HS, acne conglobata, pilonidal disease, and phlyctenular keratoconjunctivitis presented with debilitating disease requiring hospitalizations for pain and infection.
- He had minimal response to doxycycline, benzoyl peroxide wash, and clindamycin, and subsequently failed adalimumab, secukinumab, acitretin, dapsone, cefadroxil, prednisone, laser hair removal, and topical agents over two years.
- Given inadequate disease control, **infliximab** was added to ongoing **secukinumab**.

Results

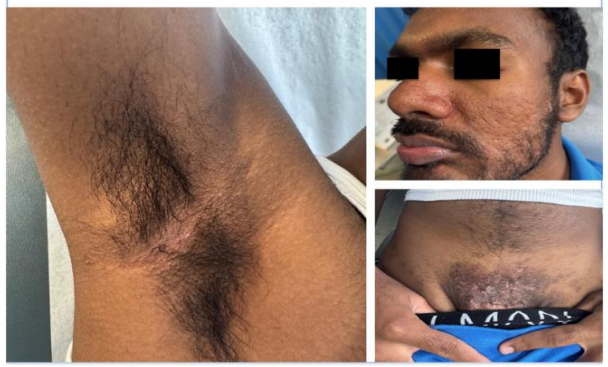
- After two infliximab infusions (weeks 0 and 2), his International Hidradenitis Suppurativa Severity Score (IHS4) decreased from 31 (severe) to 4 (moderate), and Dermatology Life Quality Index (DLQI) improved from 7 to 1.
- No infections occurred. Mild palmar and plantar desquamation was attributed to acitretin.
- Clinical and quality of life improvements remained stable with continued dual biologic therapy.

Results, cont.

Prior to Dual Biologic Initiation



S/p 4 Months of Dual Biologic Therapy



Discussion

- Hurley Stage III HS remains therapeutically challenging, with many patients failing FDA-approved biologics, including adalimumab and secukinumab.
- HS is driven by complex, overlapping inflammatory pathways, including TNF-α and IL-17 signaling, suggesting that single-cytokine blockade may be insufficient in severe disease.
- In this case, combined TNF-α (**infliximab**) and IL-17A (**secukinumab**) inhibition resulted in rapid and sustained improvement in both disease severity (**IHS4 31→4**) and quality of life (**DLQI 7→1**).
- The marked response following infliximab initiation raises the possibility of synergistic pathway suppression in refractory HS.
- No serious infections occurred, though careful monitoring is essential given the theoretical increased risk of immunosuppression.

Conclusions

- Dual biologic therapy may represent a promising option for patients with severe, refractory HS unresponsive to monotherapy with currently available systemic treatments, including FDA-approved biologics used individually.
- Larger studies are needed to clarify long-term efficacy and safety.

Disclosures

Drs. Vecin and Shaposhnik have no disclosures. Dr. Smogorzewski discloses affiliations with Incyte, Novartis, and UCB.

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#AEDVenAAD2026

Combination Biologic Therapy in Severe, Refractory Hidradenitis Suppurativa: Safety and Early Clinical Outcomes

University of California San Francisco

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Introduction

- While biologics have advanced hidradenitis suppurativa (HS) treatment, monotherapy is often insufficient for severe, refractory disease.[1-3]
- Combination biologic therapy targeting multiple dysregulated immune pathways may offer improved disease control.[4-6]
- We evaluated the safety and therapeutic responses of concomitant anti-TNF and anti-IL-17 therapy in patients with severe, treatment-refractory HS.

Methods

- Retrospective cohort study of patients with physician-confirmed treatment-refractory HS treated with concomitant anti-IL-17 and anti-TNF therapy between November 2022 and November 2025.
- Treatment-refractory HS was defined as development of new lesions in new locations despite maximum available dose of a given regimen for at least 4-6 months.
- Patients who completed fewer than 3 months of continuous dual therapy were excluded.
- Demographics, comorbidities, HS history, treatments, HS-Physician Global Assessment (HS-PGA) severity, patient- and physician-reported outcomes, and adverse events were obtained by chart review.
- We report descriptive statistics and comparisons using Wilcoxon signed-rank test.
- This study was approved by the University of California, San Francisco Institutional Review Board.

Results

Table 1. Patient Disease History and Treatment Course.
All had severe, longstanding disease. Two patients received dual therapy for over 1 and 2 years. Ten patients remained on dual therapy at most recent follow-up.

Total patients, n	11
Female sex, n (%)	8 (72.7%)
Age at onset, years (median, IQR)	19 (14-29)
Disease duration, years (median, IQR)	11 (5-16)
Hurley Stage 3, n (%)	10 (90.9)
History of Tobacco Smoking	4 (36.4%)
Prior Biologic monotherapy, n (%)	
Number of previous monotherapy trials (median, IQR)	3 (2-4)
Adalimumab	9 (81.8%)
Infliximab	11 (100%)
Secukinumab	3 (27.3%)
Other	2 (18.2%)
Concomitant Biologics Regimen, n (%)	
Infliximab + Secukinumab	8 (72.7%)
Infliximab + Bimekizumab	2 (18.2%)
Adalimumab + Secukinumab	1 (9.1%)
Age at dual therapy initiation, years (median, IQR)	34.0 (24.5-45.5)
BMI at dual therapy initiation, kg/m^2 (median, IQR)	31.0 (24.4-38.5)
Duration on dual biologics, months (median, IQR), n=10	6.2 (4.6-7.7)

Figure 2. HS-Physician Global Assessment (HS-PGA) scores improved significantly with dual biologic treatment.
HS-PGA scores were determined at baseline and endpoint visits.

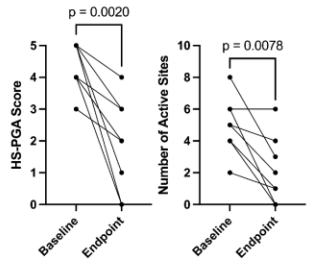


Figure 1. Patients on dual therapy exhibited reductions in disease activity.
Disease activity was measured by patient subjective report*, physical exam findings, clinical photographs, and clinician impression.
HS-PGA=Hidradenitis Suppurativa Physician Global Assessment Score.

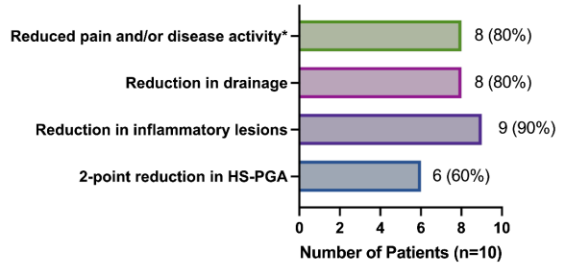
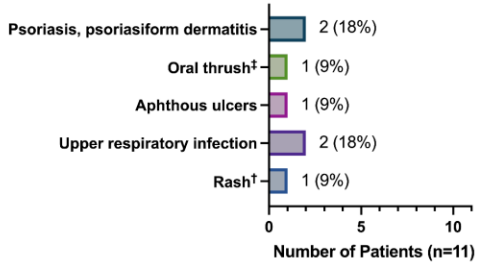


Figure 3. Mild, treatable adverse events occurred while on dual therapy.
Two patients developed suspected psoriasiform dermatitis, a paradoxical skin reaction that has been associated with anti-TNF and anti-IL-17 monotherapies. Reported infections included tonsillitis and recurrent sinus infections. These events were manageable with standard medical care and did not require treatment discontinuation. One patient discontinued dual therapy following development of generalized xerosis and eczematous eruption.



†Patient developed generalized xerosis and eczematous eruption, leading to discontinuation of dual therapy
‡ Recurrent oral thrush on chronic antibiotics for other medical condition

Strengths & Limitations

- This report represents the largest cohort of dual biologic therapy in HS to date and provides critical preliminary effectiveness and safety data.
- This study is limited by retrospective design, small sample size, limited follow-up time, and challenges inherent in evaluating a chronic, flaring disease, where isolated time points may not represent global outcomes.
- To address this, we incorporated both patient-reported symptoms and clinician assessments.

Conclusion

- Combination anti-TNF and anti-IL-17 therapy was safe, well-tolerated and associated with clinical and/or patient-reported improvement in refractory HS.
- These preliminary findings support further study of multi-pathway targeting to improve disease control.

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Authors Bastian, Bizuneh, and Amerson have no disclosures to report

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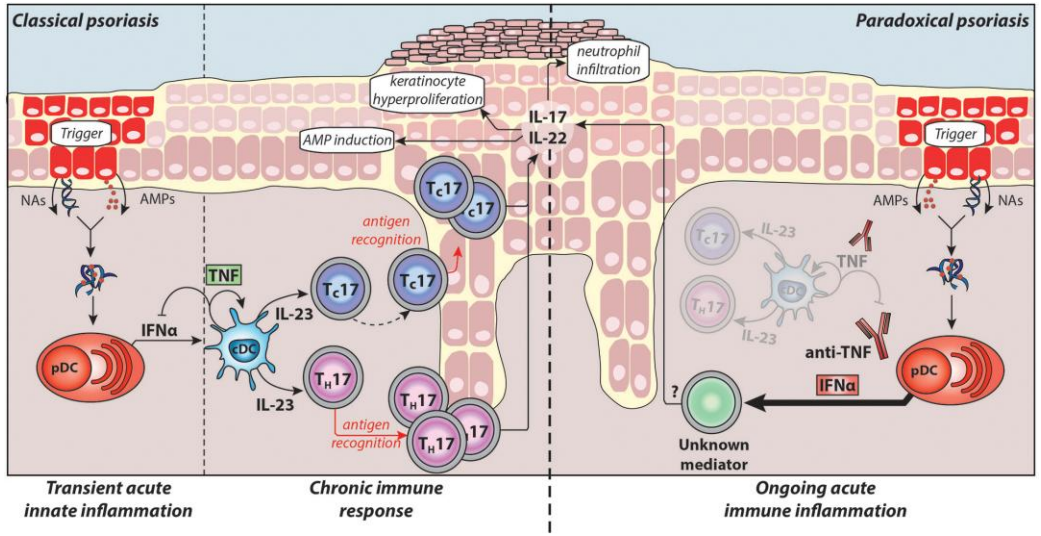

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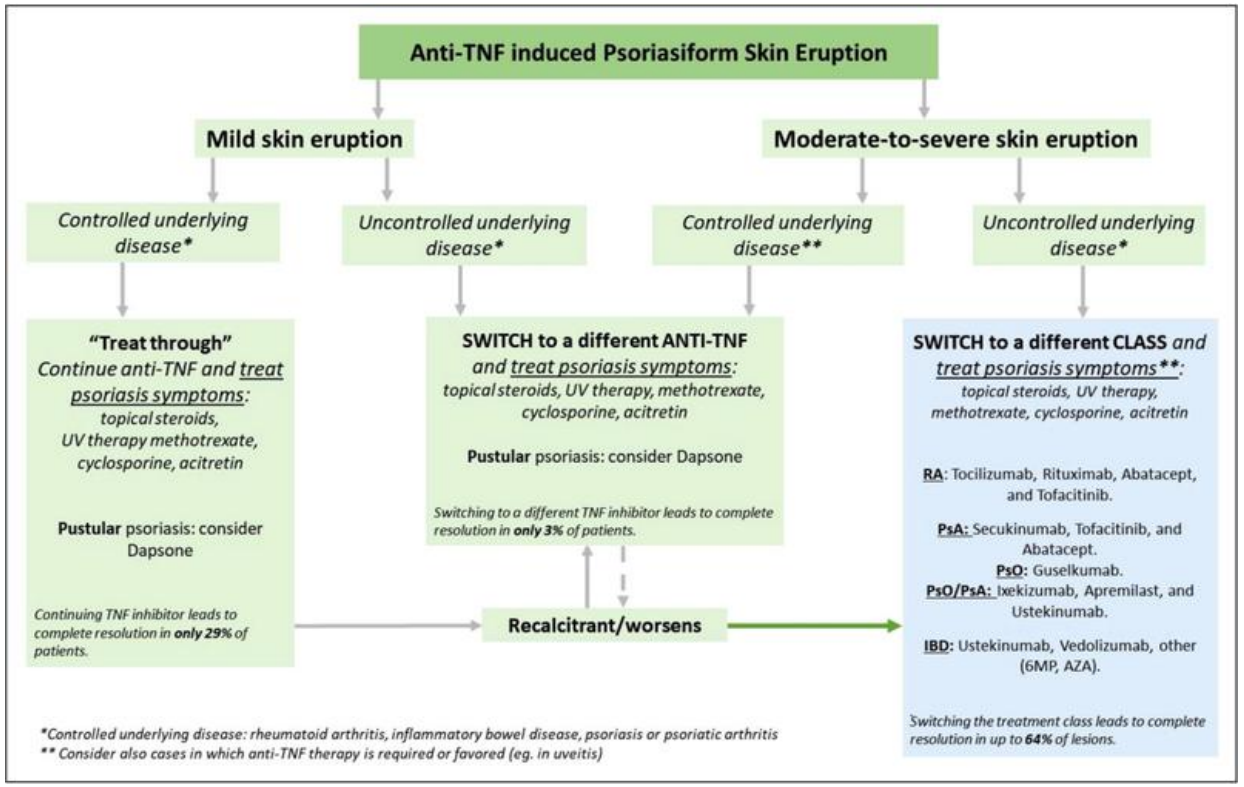

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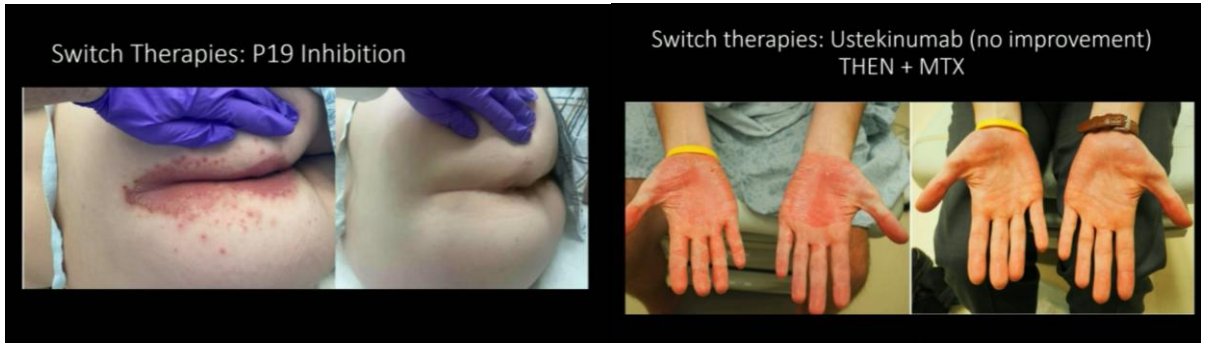

Paradoxical Rashes and 'JAKne' Risk factors and Management
Alexandra P. Charrow, MD, FAAD

Efectos adversos

- JAKNE

Figure 2. Summary of Janus Kinase Inhibitors and Associations With Acne

Drug	Meta-analyzed OR (95% CI)
Abrocitinib	13.47 (3.25-55.91)
Peficitinib	11.01 (0.56-215.62)
Baricitinib	4.96 (2.52-9.78)
Deucravacitinib	2.64 (1.44-4.86)
Delgocitinib	4.79 (0.59-38.55)
Deuruxolitinib	3.30 (1.22-8.93)
Ritlecitinib	2.06 (0.08-52.39)
Ruxolitinib	2.19 (0.88-5.48)
Tofacitinib	0.67 (0.11-4.06)
Upadacitinib	4.79 (3.61-6.37)
Random-effects model	3.83 (2.76-5.32)
Heterogeneity: $I^2 = 24.0\%$	

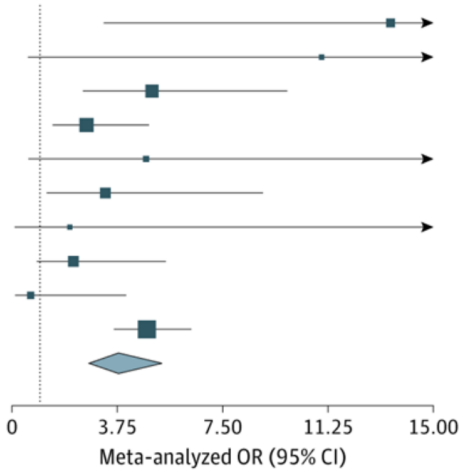

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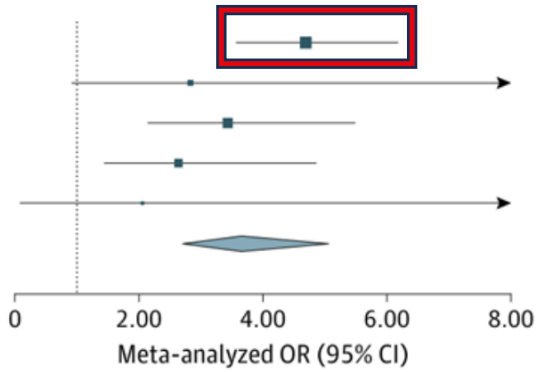
Figure 3. Subgroup Analysis by Janus Kinase (JAK) Inhibitor Specificity

Drug class	Meta-analyzed OR (95% CI)
Inhibitors of JAK1	4.69 (3.56-6.18)
Inhibitors of JAK1, JAK2, and JAK3	2.83 (0.92-8.74)
Inhibitors of JAK1 and JAK2	3.43 (2.14-5.49)
Inhibitors of TYK2	2.64 (1.44-4.86)
Inhibitors of JAK3	2.06 (0.08-52.39)
Random-effects model	3.71 (2.72-5.05)
Heterogeneity: $I^2 = 27.9\%$	



"JAKNE" Management Pearls

TABLE 1 Guidelines for the management of acne induced by JAK inhibitors

	Comedonal acne	Mild-to-moderate papulopustular acne	Severe papulopustular/ moderate nodular acne	Severe nodular/ conglobate acne
First line	Topical retinoid (Adapalene) or Adapalene + BPO	Adapalene + BPO or BPO + Clindamycin	Isotretinoin	
Second line	Benzoyl peroxide (PBO) or azelaic acid	Azelaic acid or Topical clindamycin + Tretinoin or Systemic Antibiotic (Doxycycline) + Adapalene or Azelaic acid or Adapalene + BPO	Systemic Antibiotic (Doxycycline) + Adapalene or Azelaic acid or Adapalene + BPO	

El futuro de la HS…

Most evidence behind:

- **Adalimumab** (FDA-approved)
- **Secukinumab** (FDA-approved)
- **Bimekizumab** (FDA-approved)
- **JAK inhibitor**
  - (e.g. Upadacitinib PO 30mg QD)
- **Infliximab**
  - 7.5-10mg/kg at week 0, 2, 6 then q4-6w (typical dose: 10mg/kg q4w)

Other medications to consider:

- Ustekinumab (90mg q4w)
- Other IL-17 (e.g. brodalumab)
- Other TNF-alpha (e.g. golimumab)
- Remibrutinib (25mg PO BID)
- *IL-1 inhibitor (Anakinra)*
- *IL-23 inhibitor (Guselkumab, Risankizumab, Tildrakizumab)*
- *PDE4 inhibitor (Apremilast/Roflumilast)*

P75099

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Four-year efficacy of continuous secukinumab in SUNSHINE/SUNRISE core and extension trials on hidradenitis suppurativa (HS) lesions

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CONCLUSIONS

- Continuous secukinumab over 4 years delivered sustained long term HS disease control, shown by substantial reductions in AN count and consistently high proportions of patients with no increase in draining tunnels.

Scan to obtain:
- Poster

This study was sponsored by Novartis Pharma AG, Basel, Switzerland.

Poster presented at American Academy of Dermatology (AAD) 2026; Mar 27–31, 2026; Denver, Colorado.

INTRODUCTION

- Hidradenitis suppurativa (HS) is a chronic, systemic, progressive inflammatory disease characterized by deep and painful dermal lesions, which can progress to irreversible tissue destruction and scarring[1,2]
- Sustained inflammation in the area contributes to the formation of abscesses and draining tunnels (DTs), and patients with DTs experience a greater disease burden and a greater negative impact of the disease compared to those without DTs[2,3]
- Hence, the counts of abscesses/inflammatory nodules (AN count) and DTs are important objective parameters in assessing the severity of HS and the response to treatment[4]
- Previous data from the SUNSHINE/SUNRISE core and extension trials highlighted the sustained clinical benefits (as measured by Hidradenitis Suppurativa Clinical Response [HiSCR] and International Hidradenitis Suppurativa Severity Scoring System [IHS4]) of continuous secukinumab treatment through 4 years in patients with moderate to severe HS[5-8]

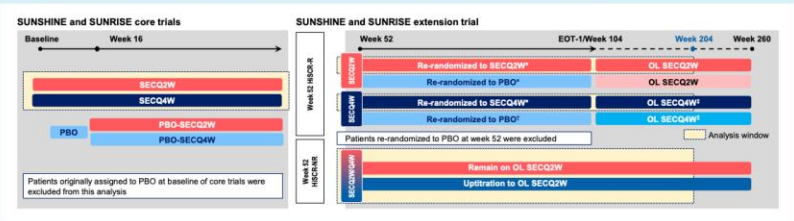
OBJECTIVE

- This post hoc analysis assessed the impact of secukinumab on AN count and DTs over 4 years in patients with moderate to severe HS who received continuous secukinumab treatment throughout the SUNSHINE and SUNRISE core and extension trials

METHODS

- Patients completing the core trials could enter a 4-year extension trial, whereby they were stratified according to their HS clinical response (HiSCR) status at week 52 (i.e., HiSCR responders [HiSCR-R]/non-responders [HiSCR-NR] (**Figure 1**)[8,9]
- Patients achieving HiSCR-r at week 52 (Figure 1 footnote for definition) of the core trials entered a randomized withdrawal period up to week 104 and received open-label treatment thereafter up to week 260
- HiSCR non-responders (HiSCR-NR) at week 52 of the core trials could also enter the extension trial directly on open-label secukinumab

Figure 1. Overview of the post hoc analysis from the SUNSHINE and SUNRISE core and extension trials



The complete study designs for the SUNSHINE and SUNRISE core[8] and extension[9] trials have been reported. Patients in the extension trial were stratified according to their HS clinical response at week 52 of the core trials (HiSCR-R/HiSCR-NR). The identification of HiSCR responders at week 52 was based on nominal visit week 52 and was computed with respect to the weighted average of lesions at core trial baseline and/or screening. HiSCR-R entered a randomized withdrawal period at week 52 until end-of-treatment-1 (EOT-1), defined as either week 104 or meeting the primary endpoint of time to loss of response (LOR). If a patient met LOR before or at week 104, they could remain in the trial by switching to open-label treatment (see symbols for treatment switching). From week 104, all treatment was open-label. This analysis reports outcomes from baseline of the core trials to week 204 only in patients receiving continuous secukinumab, including patients meeting LOR and switching from randomized treatment to open-label treatment. Patients originally assigned to placebo in the core trials and those re-randomized to receive placebo at week 52 were excluded.

HiSCR non-responders (HiSCR-NR) at week 52 of the core trials could also enter the extension trial on open-label. *Switched to OL SECQ2W if LOR occurred before or at week 104; †Switched to OL SECQ4W if LOR occurred before or at week 104; ‡May be up-titrated to the SECQ2W at the discretion of the principal investigator. EOT, end of treatment period; HiSCR, Hidradenitis Suppurativa Clinical Response; LOR, loss of response; HiSCR-NR, HiSCR non-responder at week 52 of the core trial; PBO, placebo; Q2W, every 2 weeks; Q4W, every 4 weeks; HiSCR-R responder at week 52 of the core trial; SEC, secukinumab 300 mg.

- This analysis was conducted in patients who received continuous secukinumab treatment from baseline of the core trials up to week 204 of the extension trial
- Outcomes were reported irrespective of secukinumab dosing regimen (Q2W or Q4W) or uptitration
- Patients originally assigned to placebo in the core trials and those re-randomized to receive placebo at week 52 were excluded
- Outcomes assessed included change from baseline (CFB) in AN count and proportion of patients reporting no increase in DTs over time
- Data from all visits through week 204 (independent of blinded or open-label treatment status) were considered and are reported as observed without formal hypothesis testing

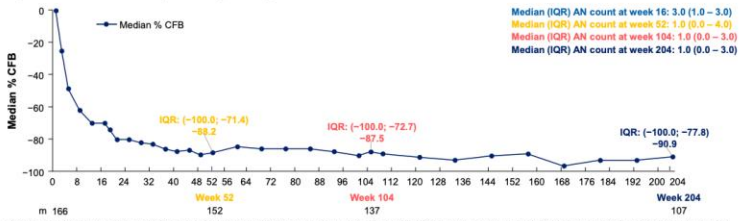
RESULTS

- In total, 391 patients were defined as HiSCR-R at week 52. Of these, 172 patients received continuous secukinumab from baseline through week 204 and were eligible for this analysis
- Similarly, 308 patients were defined as HiSCR-NR at week 52 and 200 of these patients were eligible for this analysis

Change in abscess and inflammatory nodule count (AN count) from baseline

- In the HiSCR-R group, reductions in median AN count were observed from baseline (median count: 11.0) to week 204 (median count: 1.0; % CFB: –90.9) in patients receiving continuous secukinumab (**Figure 2**)
- The median percentage CFB in AN count was –88.2%, –87.5%, and –90.9% at weeks 52, 104, and 204, respectively (**Figure 2**)

Figure 2. HiSCR-R: Median percentage change in AN count from baseline of core trials to week 204



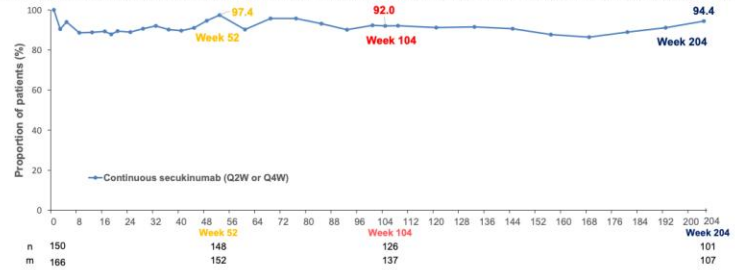
AN, abscess and inflammatory nodules count; CFB, change from baseline; HiSCR-R, responders at week 52 of the core trial; IQR, interquartile range; m, number of subjects with non-missing assessments at the associated visit; Q2W, every 2 weeks; Q4W, every 4 weeks.

- A sustained decrease in the median AN count was also seen in the HiSCR-NR group

Proportion of patients reporting no increase in draining tunnels (DTs) from baseline

- In the HiSCR-R group, the proportion of patients reporting no increase in DTs from baseline was 97.4% (148/152) at week 52 with the response sustained through week 204 at 94.4% (101/107) (**Figure 3**)

Figure 3. HiSCR-R: Proportion of patients reporting no increase in draining tunnel count from baseline of core trials to week 204



HiSCR-R, responder at week 52 of the core trial; n, number of patients with no increase in the number of tunnels from the baseline; m, number of patients with non-missing number of draining tunnels at the visit and the percentage is n/m; Q2W, every 2 weeks; Q4W, every 4 weeks.

- The proportion of patients reporting no increase in DTs was also sustained in most patients in the HiSCR-NR group

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Disclosures

Vivian Y. Shi is on the board of directors for the Hidradenitis Suppurativa Foundation (HSF), an advisor for the National Eczema Association, is a stock shareholder of Learn Health and has served as an advisory board member, investigator, speaker, and/or received research funding from Sanofi Genzyme, Regeneron, AbbVie, Genentech, Eli Lilly, Novartis, SUN Pharma, Oruka, Arcutis, Takeda, Immed, LEO Pharma, ZuraBio, Pfizer, Incyte, Dermavant, Apogee, MoonLake, Navigator Medicine, Boehringer Ingelheim, Almirall, Alumis, Aristea Therapeutics, Menlo Therapeutics, Dermira, Burt's Bees, Galderma, Kiniksa, UCB, Ceraclare, Bain Capital, Target-PharmaSolutions, Castle Bioscience, Altus Lab/cQuell, MYOR, Polyfins Technology, GpSkin and Skin Actives Scientific. **Jennifer L. Hsiao** is on the board of directors for the Hidradenitis Suppurativa Foundation, and has served as an advisor for AbbVie, Aclaris, Boehringer Ingelheim, Incyte, Novartis, UCB; as a speaker for AbbVie, Galderma, Novartis, Sanofi Regeneron, UCB; as an investigator for Amgen, Boehringer Ingelheim, and Incyte. **Pierre-Andre Becherel** reports consulting fees from Novartis, AbbVie, Pfizer, and UCB pharma; payment or honoraria from Novartis and AbbVie; support for attending meetings or travel from Novartis; and served on a Data Safety Monitoring Board or Advisory Board for Novartis. **Ziad Reguiai** has received honoraria for participation in advisory boards, in clinical trials, and/or as a speaker for AbbVie, Amgen, Almirall, Apogee, Boehringer-Ingelheim, Leo Pharma, Celltrion, Incyte, Pfizer, Eli Lilly, Janssen-Cilag, Novartis, UCB, Regeneron, and Sanofi; personal fees for attending meetings or for travel from AbbVie, Janssen-Cilag, Eli Lilly, Novartis, Pfizer, UCB, and Sanofi. **Pedro Mendes-Bastos** reports consulting fees from Alumis, AbbVie, Almirall, Apogee, Eli Lilly, Janssen, LEO Pharma, Novartis, Pfizer, and Sanofi; payment or honoraria from Alumis, AbbVie, Almirall, GSK, Janssen, LEO Pharma, Eli Lilly, Novartis, Organon, Pfizer, Sanofi, Takeda and Viatris; support for attending meetings or travel from AbbVie, Almirall, ISDIN, Janssen, LEO Pharma, Eli Lilly, Novartis, and Sanofi; and served on a data safety monitoring board or advisory board for Alumis, AbbVie, Almirall, Janssen, LEO Pharma, Eli Lilly, Novartis, Pfizer and Sanofi. **Haley B. Naik** received consulting fees from Abbvie, Medscape, Sonoma Biotherapeutics, UCB and Novartis; grant from UCB; and holds shares in Radera, Inc. She is on the JAMA Dermatology Editorial Board and Vice President of the Hidradenitis Suppurativa Foundation. **Falk G. Bechara** has received honoraria for participation in advisory boards, in clinical trials, and/or as a speaker for AbbVie Inc., AbbVie Deutschland GmbH & Co. KG, Acelyrin, Avalo, Boehringer Ingelheim Pharma GmbH & Co. KG, Celltrion, Incyte Corporation, Merck, Mölnlycke, Moonlake Immunotherapeutics, Novartis Pharma GmbH, Sitala, UCB, and Janssen-Cilag GmbH. **Valeria Jordan M and Bertrand Paguet** are employed by Novartis and own company stocks. **Vipin N** is employed by Novartis.

Full Title	Authors	Key Messages
Bimekizumab efficacy by patient subgroups in moderate to severe hidradenitis suppurativa: 3-year phase 3 results from BE HEARD EXT	Sayed CJ, Porter ML, Molina-Leyva A, Szepietowski JC, Ishitsuka Y, van Ree E, Crater C, Vaux T, Kokolakis G	Patients treated with bimekizumab demonstrated efficacy in all subgroups with improvements in clinical response maintained over 3 years
Bimekizumab leads to sustained flare-free status in moderate to severe hidradenitis suppurativa: 3-year data from BE HEARD EXT	Daveluy S, Naik HB, Reguiai Z, Yamaguchi S, Fernandez-Peñas P, Lukowski B, Crater C, Tilt N, Martorell A	The majority of patients with moderate to severe HS treated with bimekizumab who remained in the study at Year 3 remained flare-free at scheduled clinic visits through 3 years.
Bimekizumab efficacy by disease duration and severity in moderate to severe hidradenitis suppurativa: 3-year phase 3 results from BE HEARD EXT	Chovatiya R, Alavi A, Shi VY, van der Zee HH, Gooderham M, Miyagawa T, Zouboulis CC, Oh T, Crater C, Tilt N, Sabat R	Patients in both disease duration and severity subgroups demonstrated clinically meaningful efficacy with treatment at Year 1, with improvements at Year 3. Patients with shorter disease duration and moderate HS had higher achievement of each HiSCR threshold (HiSCR50/75/90/100) than those with longer duration and severe HS, especially at higher HiSCR thresholds.
Bimekizumab efficacy on IHS4 response levels and lesions by HS disease duration over 2 years: Data from BE HEARD EXT	Alavi A, Sayed CJ, Zouboulis CC, Dini V, Miyagawa T, Turchin I, Lukowski B, Crater C, Kavanagh S, Tzellos T	Both disease duration quartiles showed clinically meaningful improvements over 2 years. With bimekizumab treatment over 2 years, patients with shorter disease duration had better outcomes than those with longer disease duration, particularly at higher efficacy thresholds, emphasizing the impact of earlier treatment with bimekizumab upon diagnosis.

Bimekizumab leads to sustained flare-free status in moderate to severe hidradenitis suppurativa: 3-year data from BE HEARD EXT

Steven Daveluy,[1] Haley B. Naik,[2] Ziad Reguiai,[3,4] Sayaka Yamaguchi,[5] Pablo Fernandez-Peñas,[6] Bartosz Lukowski,[7] Christina Crater,[8] Nicola Tilt,[9] Antonio Martorell[4,10]

[1]Department of Dermatology, Wayne State University School of Medicine, Detroit, MI, USA; [2]Department of Dermatology, University of California, San Francisco, CA, USA; [3]Dermatology Department, Polyclinique Courlancy-Bezannes, Reims, France; [4]European Hidradenitis Suppurativa Foundation (EHSF) e.V., Dessau, Germany; [5]Department of Dermatology, University of the Ryukyus Graduate School of Medicine, Okinawa, Japan; [6]Department of Dermatology, Westmead Hospital, University of Sydney, Westmead, New South Wales, Australia; [7]Vedim/UCB, Warsaw, Poland; [8]UCB, Morrisville, NC, USA; [9]UCB, Slough, UK; [10]Department of Dermatology, Hospital de Manises, Valencia, Spain.

Presentation Number: 73493

Objectives

To assess **flare outcomes**[a,b] in all, or baseline Hurley stage II or III patients, with moderate to severe **hidradenitis suppurativa** (HS) treated with **bimekizumab** (BKZ) over 3 years (148 weeks).

Background

- **HS** is characterized by nodules, abscesses, and draining tunnels, with acute exacerbations of symptoms known as "**flares**".[1,2]
- Timely, effective **disease management** is important to reduce the frequency of flares.[1]
- **BKZ** is a humanized IgG1 monoclonal antibody that selectively inhibits interleukin (IL)-17A and IL-17F.[3]

Methods

- Data were pooled from BE HEARD I&II and their open-label extension BE HEARD EXT.[4,5]
- Patients randomized to receive **BKZ 320 mg** from baseline in BE HEARD I&II who entered BE HEARD EXT were included (**BKZ Total group**); data also reported by baseline **Hurley stage**.
- Flare data were collected at scheduled clinic visits. Data are reported as observed case (OC).

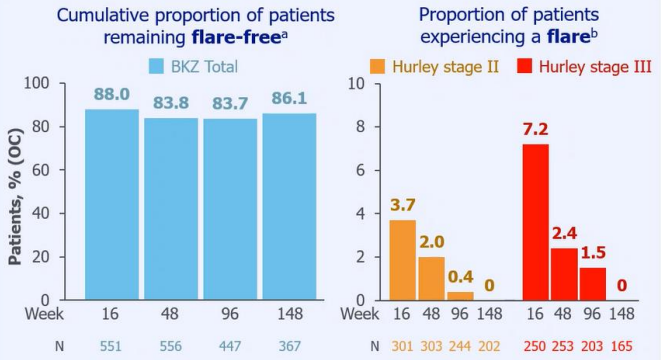
Flare: ≥25% increase in abscess and inflammatory nodule (AN) count versus baseline with an absolute increase in AN count of ≥2.

Flare outcomes reported to **Year 3**:

- The cumulative proportion of patients who **remained flare-free**.[a]
- The proportion of patients with a **flare** at a given visit.[b]

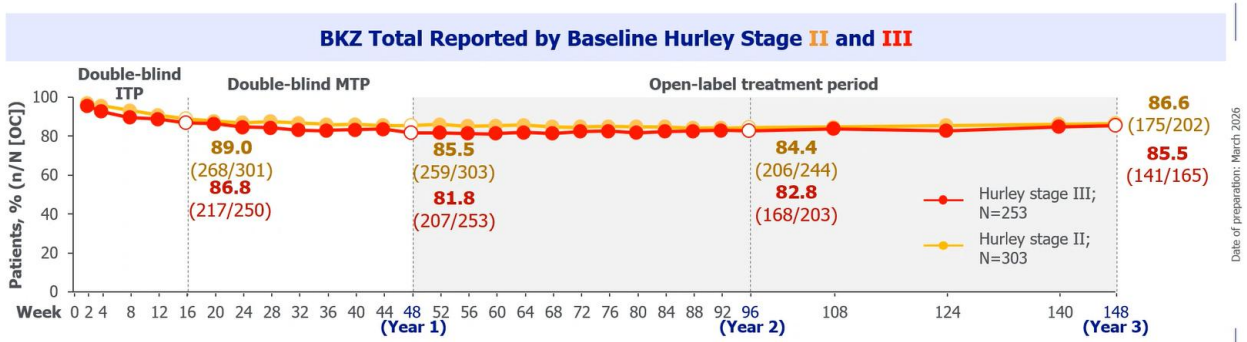
Date of preparation: March 2026

Flare outcomes were assessed in patients with **moderate to severe HS** treated with **bimekizumab** over 3 years.



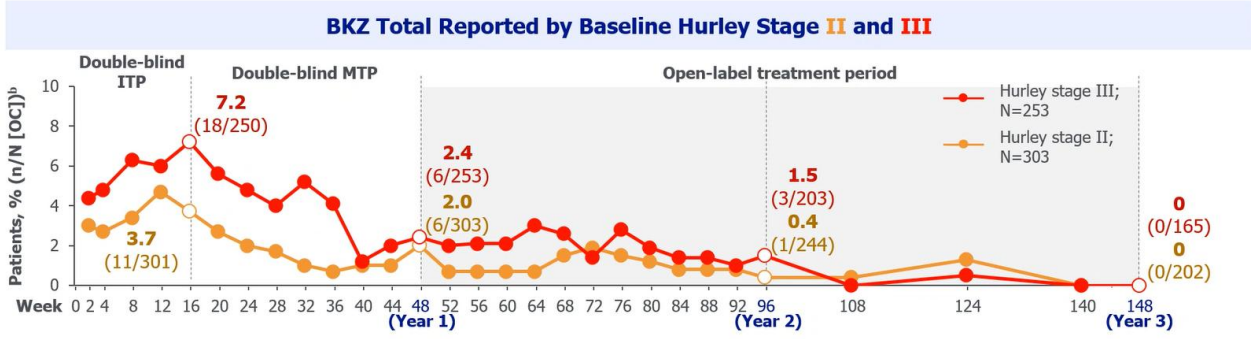
Most **bimekizumab-treated** patients **remained flare-free** at scheduled clinic visits through 3 years and **did not experience a flare** at Year 3, regardless of baseline Hurley stage.

The Cumulative Proportion of Patients Remaining Flare-Free Was High Through 3 Years[a]



Date of preparation: March 2026

The Proportion of Patients Experiencing a Flare at a Given Visit Remained Low to Year 3[a]



#AEDVenAAD2026

Bimekizumab efficacy by disease duration and severity in moderate to severe hidradenitis suppurativa: 3-year phase 3 results from BE HEARD EXT

Raj Chovatiya,[1,2] Afsaneh Alavi,[3,4] Vivian Y. Shi,[5] Hessel H. van der Zee,[3,6] Melinda Gooderham,[7,8] Takuya Miyagawa,[9] Christos C. Zouboulis,[3,10] Tae Oh,[11] Christina Crater,[12] Nicola Tilt,[13] Robert Sabat[3,14]

[1]Rosalind Franklin University of Medicine and Science Chicago Medical School, North Chicago, IL, USA; [2]Center for Medical Dermatology + Immunology Research, Chicago, IL, USA; [3]European Hidradenitis Suppurativa Foundation (EHSF) e.V., Dessau, Germany; [4]Department of Dermatology, Mayo Clinic College of Medicine and Science, Rochester, MN, USA; [5]Department of Dermatology, University of Washington, Seattle, USA; [6]Erasmus Medical Center, Rotterdam, The Netherlands; [7]SKIN Centre for Dermatology, Probity Medical Research, Peterborough, ON, Canada; [8]Queen's University, Kingston, ON, Canada; [9]Department of Dermatology, University of Tokyo Graduate School of Medicine, Tokyo, Japan; [10]Brandenburg Medical School Theodor Fontane and Faculty of Health Sciences Brandenburg, Neuruppin, Germany; [11]UCB, Smyrna, GA, USA; [12]UCB, Morrisville, NC, USA; [13]UCB, Slough, UK; [14]Translational Skin Inflammation Research and Former Psoriasis Research and Treatment Center, Charité-Universitätsmedizin Berlin, Corporate Member of Freie Universität Berlin and Humboldt-Universität zu Berlin, Berlin, Germany

Presentation Number: 7349

Objective

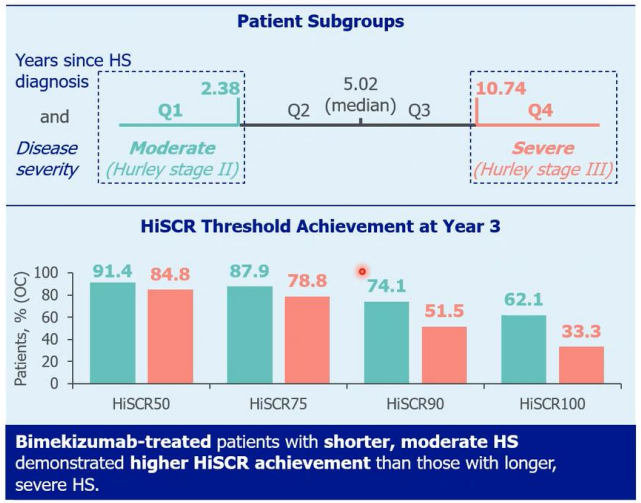
- To assess the achievement of HiSCR50/75/90/100 with bimekizumab (BKZ) treatment across selected disease duration and disease severity subgroups, for patients with moderate to severe hidradenitis suppurativa (HS) from BE HEARD I&II and BE HEARD EXT, over 3 years.

Background

- **Delayed diagnosis** is common for patients with **HS** and may delay treatment; earlier therapeutic intervention may limit disease progression.[1,2]
- Effective treatment within the '**window of opportunity**', when inflammation may be most effectively controlled, is crucial for management of HS.[3,4]
- **BKZ** is a humanized IgG1 monoclonal antibody that selectively inhibits interleukin (IL)-17F in addition to IL-17A.[5]

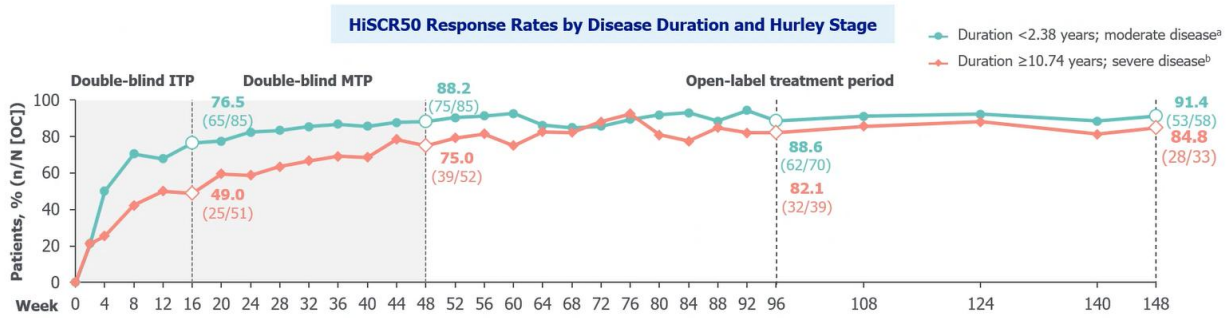
Methods

- Data were pooled from the phase 3 **BE HEARD I&II** trials and their open-label extension, **BE HEARD EXT**, for patients with **moderate to severe HS**.[6,7]
- Patients randomized to receive **BKZ 320 mg** from baseline in BE HEARD I&II who entered BE HEARD EXT were included (**BKZ Total group**).
- Proportions of patients reaching **HiSCR50/75/90/100** up to **Year 3** (Week 148) are reported by:
  - **Lowest disease duration quartile** with **moderate (Hurley stage II) baseline disease severity**;
  - **Highest disease duration quartile** with **severe (Hurley stage III) baseline disease severity**.
- Data are reported as observed case (OC).

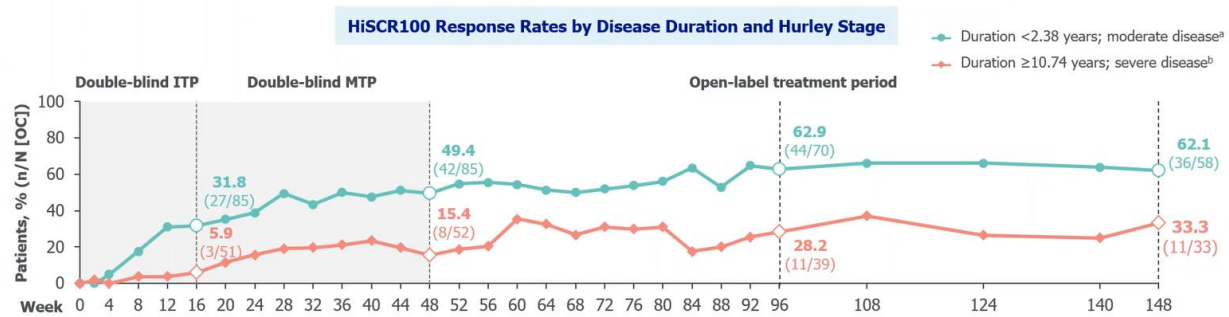


Bimekizumab-treated patients with **shorter, moderate HS** demonstrated **higher HiSCR achievement** than those with longer, severe HS.

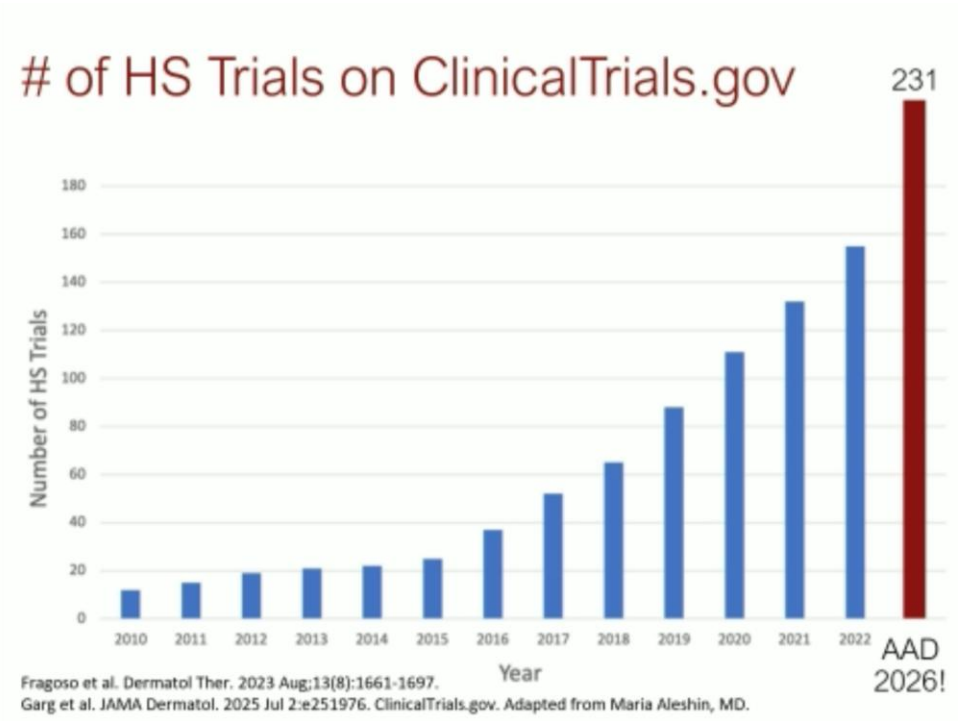
Patients in Both Subgroups Achieved High Rates of HiSCR50 Response Over 3 Years



Higher Proportions of Patients With Shorter, Moderate Disease Achieved HiSCR100 Versus Patients With Longer, Severe Disease Over 3 Years

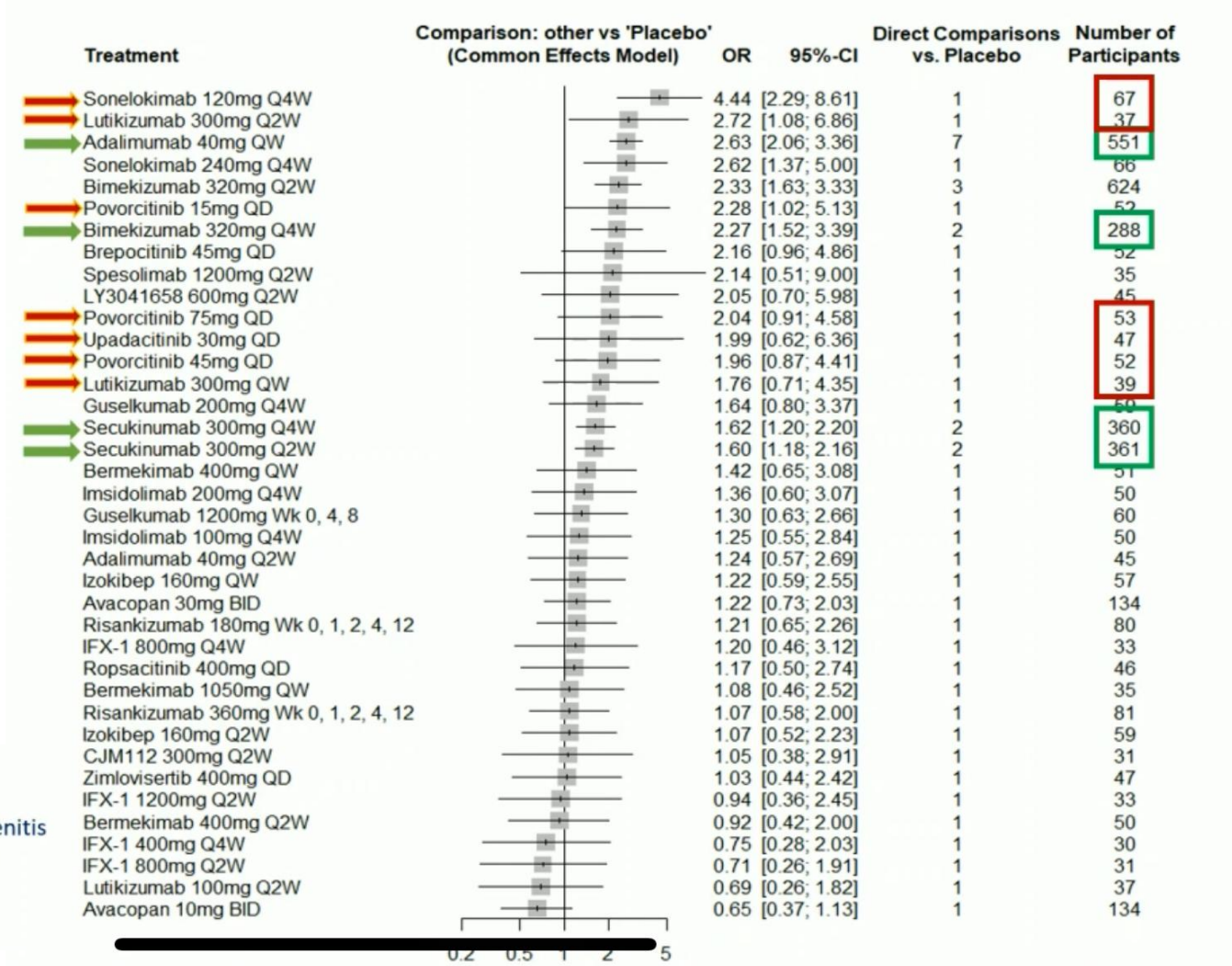



IL-17 inhibitors
TNF-α inhibitors
JAK inhibitors
HSP90 inhibitors
IL-1 inhibitors
PDE4 inhibitors
C5a inhibitors
IRAK4 inhibitors and degraders
BTK inhibitors
IL-36 inhibitors
…and more!
HS Super Heroes



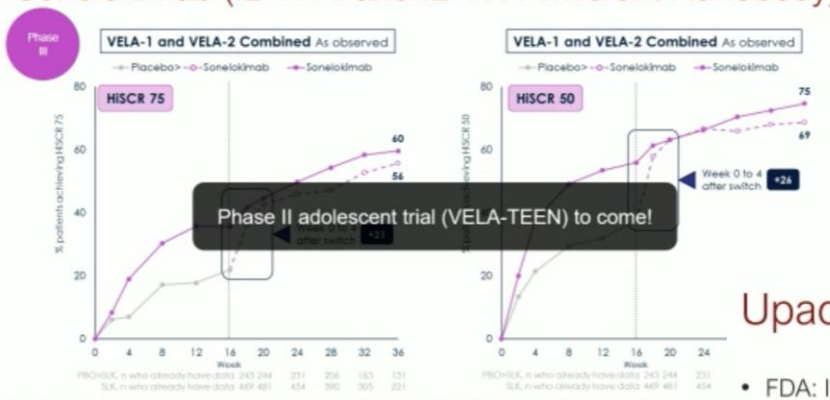
Fragoso et al. Dermatol Ther. 2023 Aug;13(8):1661-1697.
Garg et al. JAMA Dermatol. 2025 Jul 2:e251976. ClinicalTrials.gov. Adapted from Maria Aleshin, MD.

Network meta-analysis results for HiSCR-50:



Garg A et al. Efficacy and Safety of Medical Interventions for Moderate to Severe Hidradenitis Suppurativa: A Living Systematic Review and Network Meta-Analysis. JAMA Dermatol. 2025;161(9):931-940

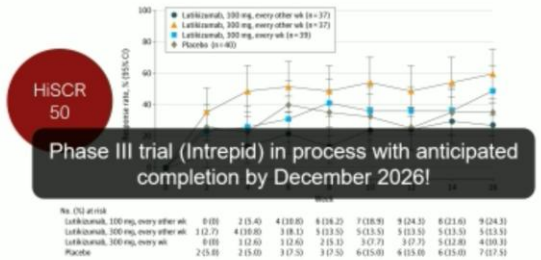
Sonelokimab (IL-17Ai and IL-17Fi Trivalent Nanobody)



Preliminary data for subjects who have already reached post-16 visits, subject to Week 52 database lock. Data are descriptive. Preliminary, pre-specified analysis suggests continued improvement beyond Week 16, subject to Week 52 database lock. Post-Week 16 ns reflect incomplete data due to patients not yet reaching these visits at data cut-off on Oct 20 2025, but who may do so in the future in these ongoing trials. Individual trials had similar results consistent with these combined data.

Lutikizumab (dual IL-1α/β inhibitor)

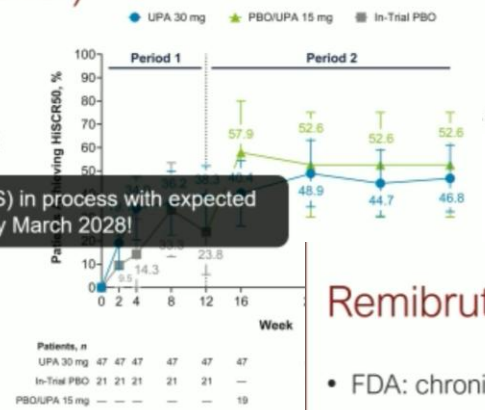
Published Phase II Data



2026 Mar 18:e260155.

Upadacitinib (JAK1 inhibitor)

- FDA: IBD, RA, AD, psoriatic arthritis, AS, non-rad axial SA
- Phase 2, UPA 30mg daily vs placebo
  - HiSCR50: 38.3% vs 25.0%, P=.018[2]
  - Maintained through week 40
- Currently in Phase 3 (Step-UP HS)
  - Adults and adolescents (12yo+)
  - Must have failed anti-TNF therapy and/or one approved non-anti-TNF treatment
  - HiSCR 50 at week 16



Phase III trial (Step-UP HS) in process with expected completion by March 2028!

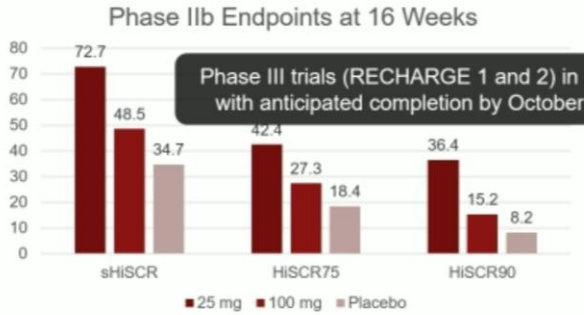
Ackerman et al. J Am Acad Dermatol. 2025 Jun;92(6):1252-1260. Adapted from Maria Aleshin, MD.

Povorcitinib (JAK1 inhibitor)

https://investor.incyte.com/news-releases/news-release-details/incyte-announces-positive-topline-results-two-phase-3-clinical/

Remibrutinib (highly selective BTK inhibitor)

- FDA: chronic spontaneous urticaria



*Simplified HiSCR (sHiSCR): 50% reduction in abscess and inflammatory nodule [AN] count, with no increase in draining tunnels

Gudjonsson JE et al. Journal of Investigative Dermatology. 2024;144(12):S244. (Abstract)

Manejo de la HS en determinadas poblaciones

Poblacion anciana

Población pediátrica

Síndrome de Down

Población en tratamiento hormonal

U043 Management and Special Considerations in Unique Hidradenitis Suppurativa Populations: A Focus on Down Syndrome, Exogenous Hormone Use, and the Elderly
Sat, Mar 28, 7:30 AM - 8:30 AM
S029 Treating Severe Skin Diseases in Children
Sat, Mar 28, 9:00 AM - 12:00 PM

Población envejecida

Pharmacologic Interactions & Considerations

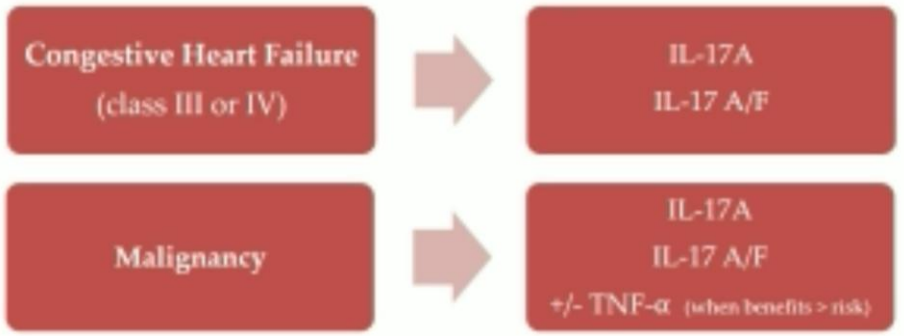
- Limit **rifampin** use (potent CYP3A4 inducer)
  - may reduce effectiveness (warfarin, apixaban, statin, etc.)
  - monotherapy clindamycin may be as effective
- Use **clindamycin** and **fluoroquinolones** cautiously in elderly on concurrent PPIs
  - 2.2 OR of clostridium difficile infection
- Consider prolonged QT risk with **fluroquinolones** and **macrolides**
- Counsel on **doxycycline** and chelation interactions
  - calcium, iron, magnesium, zinc
- **Spironolactone** (50-200 mg) → monitor K+
  - Hyperkalemia risk higher in ≥ 45 yo (10.1%, avg age 60.3)
  - ≥ 65 yo (15.4% risk)
  - ≥ 65 yo + ≥ predisposing comorbidity (28.1% risk)
- **Metformin** (500-1500 mg)
  - GFR < 30: contraindicated; GFR 30-44: avoid initiation

Biológicos

Meta-análisis del uso en otras patologías
4719 pacientes con tto biológico (>60yo)

Infecciones
OR 2.28 de infecciones en comparacion con población jóven
OR 3.6 comparado con población anciana sin biológico

Malignidad
No diferencias respecto a población anciana sin biológico



- Shared therapeutic decision-making approach essential
- Dose adjustment for biologics (anti-TNF, IL-17) *not required* in CKD (proteolytic catabolism)

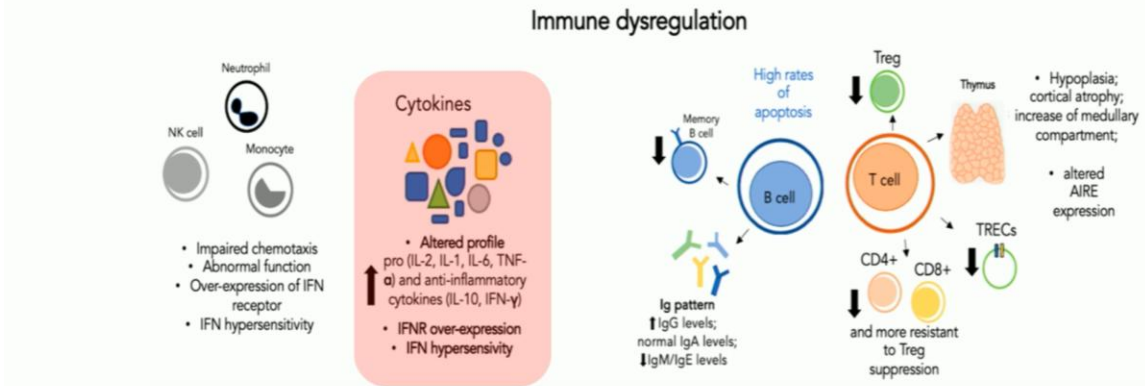
Síndrome de Down

Study Population
DS = 11,936
Without DS = 16,813,290

Hidradenitis Suppurativa
DS = 2.1%
Without DS = 0.3%
(p<0.001)

Adults with Down syndrome were over 5 times more likely to have HS
(Adjusted OR 5.24, 95% CI 4.62-5.94)

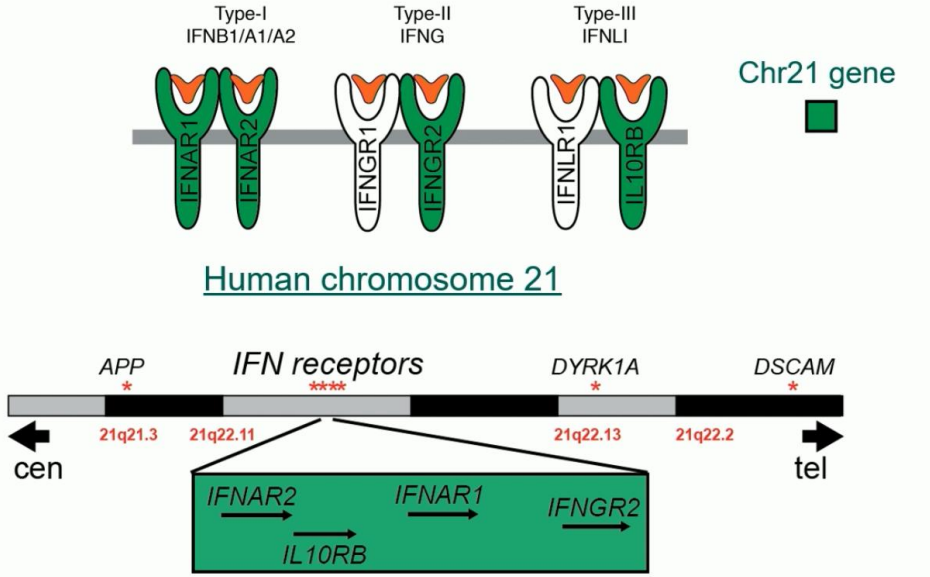
Immune dysregulation in Down syndrome is complex



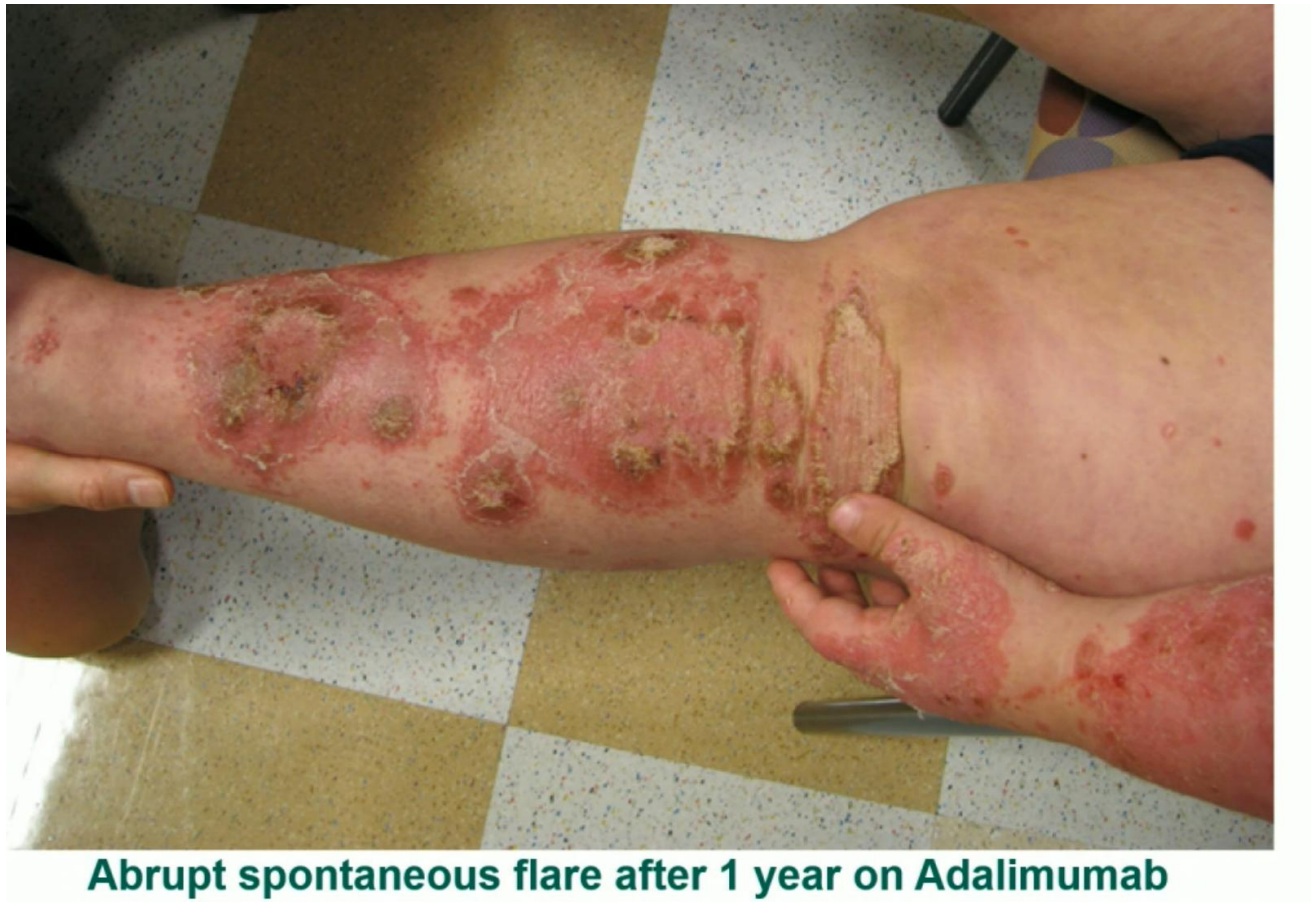
Genes (Basel). 2021 Feb 13;12(2):268.

Trisomia 21 produce aumento de señalización de la vía del interferón, produciendo inflamación crónica y sistémica (Dr. Joaquin Espinosa)

4 of the 6 IFN receptors Are encoded on Chromosome 21



Síndrome de Down

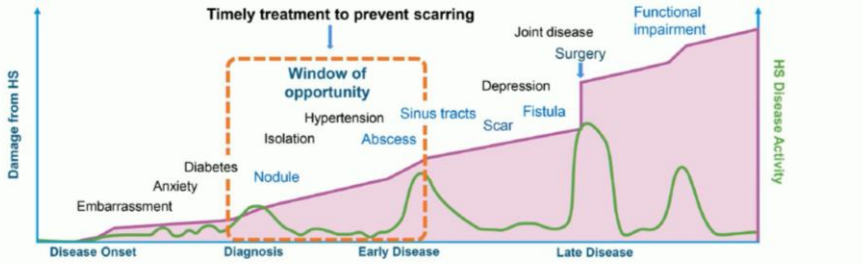


Abrupt spontaneous flare after 1 year on Adalimumab

Alta tasa de ineficacia y/o psoriasis paradójica en anti-TNF?

Población pediátrica

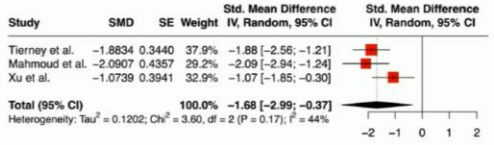
Treat BEFORE scars and fistulas develop



Bechara et al. Dermatol Ther (Heidelb) 15, 2317 (2025)

Propose early Laser Hair Removal

- Adult data (NdYag hair removal):
  - 4RCTs (n=99) monthly, 31-72% improvement
  - Prevention: Hurley 1, n=27, 10tx
    - decrease #/severity flares (NRS 6.4->3.6)
  - NA Guidelines: strength B, level II
- HSC pilot:
  - Monthly x 6-8 sessions
  - Ideally Hurley 1
  - All want numbing prior



Lasers Surg Med. 2024;56:425–436

Current Trials including patients <18y

Study / Drug	Mechanism	Age Range	Phase	Status
Bimekizumab NCT06921850	IL-17A + IL-17F monoclonal antibody	9–17 yrs	Phase 3	Recruiting
Upadacitinib NCT05889182	Selective JAK1 inhibitor	≥12 yrs (*failed TNFa)	Phase 2	Recruiting / Ongoing
INCB054707 (Povorcitinib)	Oral JAK1 inhibitor	≥12 yrs	Phase 3	Recruiting / ongoing
Topical JAKi therapy (INCB018424-112)	JAK pathway topical inhibitor	≥12 yrs	Phase 2	Recruiting
HB0043 NCT06895499	Bispecific antibody (IL-17A + IL-36R)	Adults (?pediatric expansion)	Phase 1/2	Recruiting
Vilobelimab (IFX-1)	Anti-C5a complement inhibitor	Adolescents planned in future cohorts	Phase 2	Planned / extension

Población en tratamiento hormonal

Gender-affirming hormone therapy

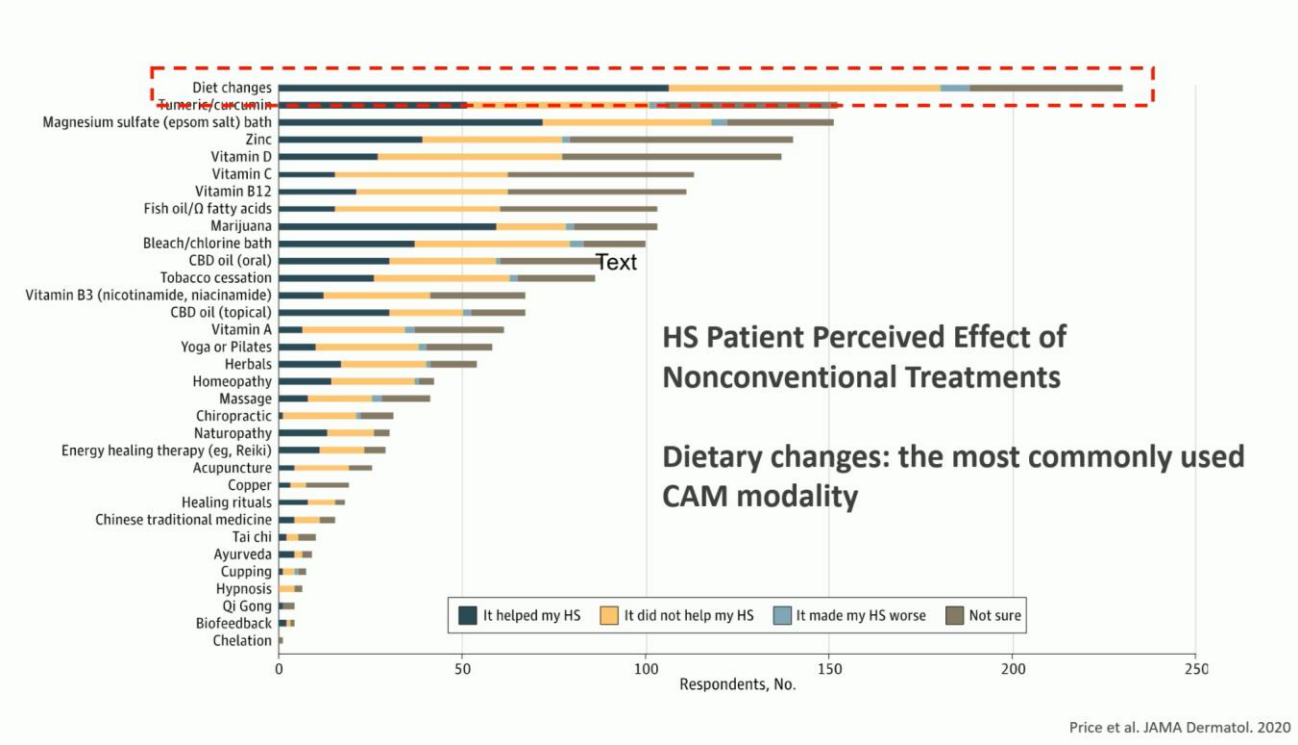
- May unmask or worsen hidradenitis
- Mechanism: ↑ androgens + underlying insulin resistance
- **Clinical approach:**
  - Don't stop gender-affirming therapy reflexively
  - Add:
    - Consider anti-androgen strategies (eg, 5 alpha reductase inhibitor spironolactone in selected patients)
      - Timing relative to testosterone initiation should be individualized
    - Metformin and GLP1s
    - Dermatologic therapy (biologics if needed)

Management approach in trans patients

- **Progestin-only methods:**
  - Can worsen HS (androgenic effect depending on progestin)
- **Combined OCPs:**
  - Anti-androgenic options may help (drospirenone, etc.)
- **Clinical approach:**
  - Choose **low-androgenicity formulations**
  - Avoid reflexive use of progestin-only in HS patients unless necessary

Dieta y suplementación en HS

- Mas del 89% de los pacientes utilizan medicinas alternativas y complementarias (CAM), productos “naturales”



F039 Dietary Triggers and Modifications of Common Dermatologic Conditions: An Evidence Based Approach
Sat, Mar 28, 1:00 PM - 3:00 PM

Dieta mediterranea

High Mediterranean Diet Adherence ~ Low HS severity

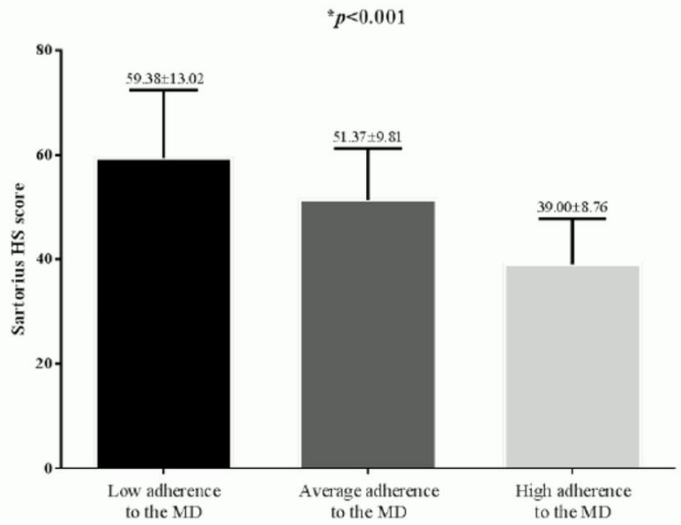


Figure 3. Differences in HS Sartorius scores across the PREDIMED categories. Higher HS Sartorius scores were evidenced in low adherers compared with average-higher adherers ($p < 0.001$).

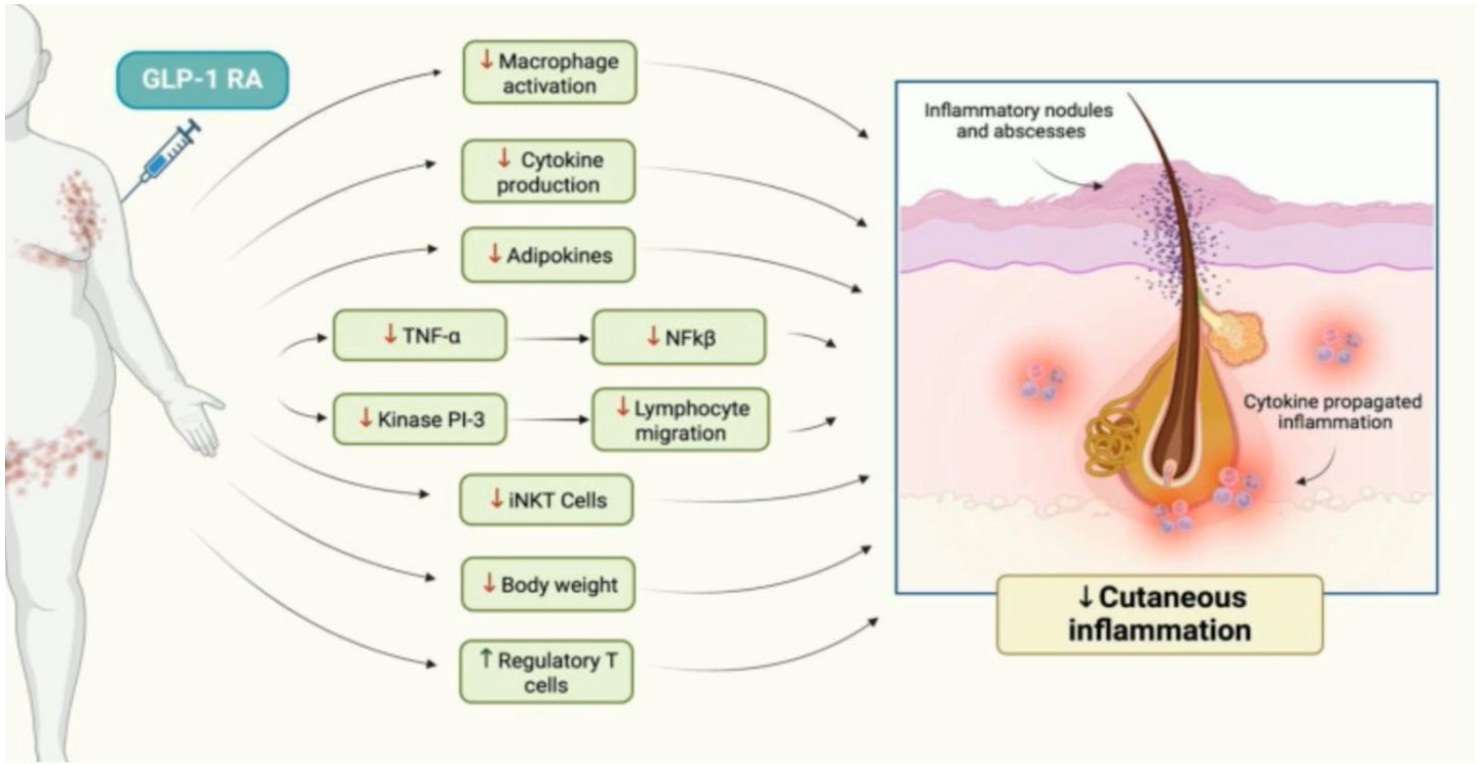
Recommended	Limit
Mediterranean Diet	Standard American Diet: high-fat foods, high-calorie foods, processed foods
Vegetables, fresh fruits	Insulinotropic foods: dairy and sweets
Corn-based cereals	Leucine-rich foods such as cheese
White meat, fish	Brewer's yeast-containing foods: alcohol, beer, baked goods, fermented cheese, mushrooms

B

Manejo del peso

Improves HS through:

- Decreased friction in skin folds
- Reduced humidity and microbial growth
- Reduced insulinemia and comorbidity of metabolic syndrome
- Reduced adipocyte inflammatory mediators (such as TNF-a, IL-1, etc.)



- **Cuidado con cirugía bariátrica:** riesgo de deficiancia de micronutrientes (zinc) y empeoramiento de HS

- **Uso de metformina y analogos de GLP-1**

Beyond Biologics: Monotherapy With GLP-1 Agonists in the Management of Hidradenitis Suppurativa: A Literature Review

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BACKGROUND

Hidradenitis suppurativa (HS) is a chronic inflammatory skin disorder affecting 1-4% of the population with recurrent painful nodules, abscesses, and draining sinus tracts. Current FDA-approved biologics (i.e. adalimumab, secukinumab, and bimekizumab) achieve only 42-59% HiSCR50 response at 12-16 weeks.

HS is strongly associated with metabolic comorbidities: obesity (OR 1.71), type 2 diabetes, and metabolic syndrome. Adipocyte-mediated inflammation drives pro-inflammatory cytokine production and insulin resistance, with weight gain recognized as both a predisposing and exacerbating factor.

GLP-1 receptor agonists (GLP-1 RAs) demonstrate dual metabolic and anti-inflammatory effects through suppression of TNF-α, IL-17, NF-κB pathways, and Toll-like receptor–mediated inflammation, positioning them as potentially valuable therapeutic agents for HS.

OBJECTIVE

To evaluate whether GLP-1 RA monotherapy is associated with clinically meaningful improvement in HS disease activity.

METHODS

Design: Systematic literature review following PRISMA 2020 guidelines

Search: PubMed and Google Scholar (January 2015 - December 2025) using terms: ("hidradenitis suppurativa" OR "acne inversa") AND ("GLP-1" OR "GLP-1 receptor agonist" OR "liraglutide" OR "semaglutide" OR "dulaglutide" OR "tirzepatide")

Inclusion: Studies of HS patients treated with GLP-1 RAs reporting HS-specific clinical outcomes

Screening: Seven independent reviewers using Rayyan software with three-phase screening and conflict resolution

Data Extracted: Study characteristics, patient demographics, HS severity, GLP-1 RA agent/regimen, treatment duration, outcomes (HiSCR, HS-PGA, DLQI, pain scores), adverse events

RESULTS

Study Selection: 95 records identified → 18 studies included in qualitative synthesis → 4 studies with primary clinical outcome data used for efficacy analysis

Study	Design	GLP-1 Agent(s)	N	Duration	Key Baseline Characteristics
Gouvrion et al.[26]	Retrospective Cohort	Semaglutide (n=48), Dulaglutide (n=13), Liraglutide (n=5)	66	18.5 months (median)	Median BMI 39.4; 86% diabetes; 53% concurrent HS treatment
Acosta-Madiedo et al.[27]	Open-Label Trial	Tirzepatide	20	24 weeks + 8-week washout	Mean BMI 38.9; moderate-severe HS (PGA ≥3)
Nicolau et al.[21]	Prospective Cohort	Liraglutide 3 mg	14	3 months	HS with obesity
Rames et al.[12]	Case Series	Various	Multiple	Variable	Real-world evidence

Table 1. Studies with Primary Clinical Outcome Data

Study	Treatment Approach	Primary Outcome	Response Rate	Secondary Outcomes
Acosta-Madiedo et al.	Tirzepatide monotherapy	HiSCR at week 24	80% (16/20)	Significant DLQI, VAS pain, PGA improvements; benefits persisted post-washout
Nicolau et al.	Liraglutide monotherapy	Hurley stage, DLQI	Improvements observed	DLQI reduction 5.5 points; weight loss 8.2 kg
Gouvrion et al.	53% adjunctive, 47% monotherapy	HS-PGA reduction	54% (≥1-point); 12% (≥2-point)	60% flare reduction; 52% pain reduction; 50% DLQI improvement

Table 2. Monotherapy Outcomes

Outcome Measure	Baseline Mean (SD)	6 Months Mean (SD)	P-value
HS-PGA	3.2 (0.8)	2.6 (1.0)	0.002
Flare frequency (per month)	2.1 (1.4)	1.2 (1.1)	0.008
NRS-Pain	5.8 (2.3)	3.9 (2.5)	0.001
NRS-Suppuration	4.9 (2.6)	3.1 (2.4)	0.003
DLQI	14.2 (6.8)	9.7 (6.2)	0.001

Table 3. Outcomes in Patients with Stable HS Treatment (Gouvrion et al.)

Clinical Efficacy: Tirzepatide monotherapy achieved **80% HiSCR at week 24** (P0.00001). In the Gouvrion cohort, 54% achieved ≥1-point HS-PGA reduction and 60% experienced flare reductions at 6 months.

Safety: Well-tolerated; common AEs included transient GI symptoms. Rare serious AEs: pancreatitis, gallbladder disease. High adherence in tirzepatide trial.

DISCUSSION

Principal Findings:

1. **GLP-1 RA monotherapy achieves high response rates:** Tirzepatide demonstrated 80% HiSCR at 24 weeks, exceeding FDA-approved biologics (42-59% at 12-16 weeks)
2. **Adjunct benefit for HS and metabolic comorbidities:** GLP-1 RAs simultaneously target disease activity and underlying metabolic dysfunction highly prevalent in HS patients

Clinical Implications: GLP-1 RAs may be particularly beneficial in HS patients with BMI ≥27 kg/m², type 2 diabetes or prediabetes, metabolic syndrome, mild-to-moderate HS (Hurley I-II) as monotherapy, and moderate-to-severe HS with suboptimal biologic response as adjunctive therapy.

Limitation include the absence of randomized control trials, small sample sizes, heterogeneous study designs and outcome measures, short follow-up, difficulty isolating GLP-1 RA effects in adjunctive therapy studies, and potential publication bias.

CONCLUSION

- GLP-1 receptor agonists are associated with **clinically meaningful improvements** in HS disease activity, pain, quality of life, and metabolic parameters.
- Tirzepatide monotherapy demonstrated **80% HiSCR at 24 weeks**, exceeding reported response rates of FDA-approved biologics.
- Dual mechanism addresses both **inflammatory pathways and metabolic dysfunction**, aligning with the systemic nature of HS.
- **Favorable safety profile** consistent with established use in metabolic populations

These findings support consideration of GLP-1 RAs as a therapeutic option for HS, particularly in patients with metabolic comorbidities. The high response rates with tirzepatide monotherapy are encouraging and warrant confirmation in larger controlled trials.

Future Directions: Prospective randomized controlled trials are needed to establish optimal patient selection, dosing strategies, treatment duration, and comparative effectiveness relative to established HS therapies.

ACKNOWLEDGEMENTS AND DISCLOSURES

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REFERENCES

Suplementación

ZINC

Hay formulaciones con mayor absorción y menores efectos GI

- Zinc picolinate
- Zinc glycinate/bisglycinate
- Zinc gluconate

Añadir cobre (10:1) para aportar equilibrio mineral

- Zinc 90mg PO daily
- Pilot study: 22 patients with HS (11 Hurley Stage I, 10 Hurley Stage II, 1 Hurley Stage III)
  - 8/22 (36%) had a complete remission (disappearance of cutaneous lesions or no new lesions during 6 months or more) – most were Hurley Stage I
  - 14/22 (63.6%) had partial remission (reduction of 50% or more of the number of nodules and/or a shorter cycle of each inflammatory lesion)

ZINC + NICOTINAMIDA

- Zinc gluconate 90mg daily + nicotinamide 30mg daily for 90 days
- 92 patients (52% Hurley 1 and 48% Hurley 2) who had all previously been treated with minocycline 100mg daily for 12 weeks with benefit
- After 90 and 180 days, the treated (n=47) versus control (n=45) group had reduction in number and mean duration of acute flares
- Zinc and nicotinamide may be beneficial as a maintenance treatment after treatment with other drugs such as oral antibiotics

Efficacy of oral zinc and nicotinamide as maintenance therapy for mild/moderate hidradenitis suppurativa: A controlled retrospective clinical study. April 2020 JAAD DOI:10.1016/j.jaad.2020.04.092

Suplementación

VITAMINA D

- 2020 Italian study
- 31/40 (77.5%) patients with vitamin D deficiency (<20ng/ml) and 5/40 (12.5%) patients with insufficiency (21-29ng/ml)
- Correlation between vitamin D deficiency and HS clinical severity
- In 27/36 (75%) patients who received oral supplementation of vit D, there was a significant improvement of clinical response to prescribed therapies corresponding to the increase in vitamin D levels

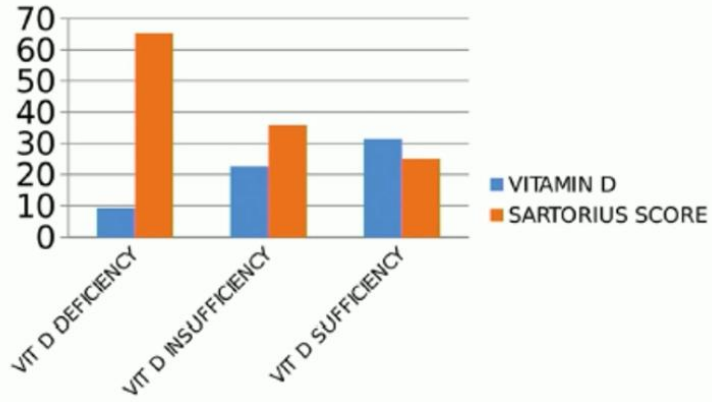

Figure 2. Reduction of Sartorius score after Vitamin D supplementation.

N-ACETILCISTEINA

- **Mechanism:**
  ↑ glutathione -> ↓ oxidative stress -> ↓ NF-kB signaling → ↓ inflammation
- **Evidence:** Small studies show **reduced lesion counts and pain in HS**
- **Typical dosing:** 600 mg BID → up to 1200 mg BID
- **Clinical pearl:**
  Particularly helpful in patients with metabolic features

Longitudinal Use and Perceived Helpfulness of Complementary and Alternative Medicine in Patients with Hidradenitis Suppurativa in Minnesota

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Introduction

- Hidradenitis suppurativa (HS) is a painful, chronic inflammatory skin disease with limited effective treatments, leading many patients to seek complementary and alternative medicine (CAM) therapies[1].
- Existing data are cross-sectional and lack longitudinal follow-up.

Objective

- To evaluate the prevalence of CAM use, characterize longitudinal patterns of persistence and perceived helpfulness, and assess associations with demographic characteristics within CAM users.

Methods

- Retrospective review of patient-reported survey data from a Minnesota HS Registry (n=154), collected at baseline and longitudinal follow-up visits at 6-month intervals out to 24-months.
- CAMs included turmeric/curcumin, zinc, magnesium sulfate, marijuana, and cannabidiol (CBD) oil.
- Continuation was defined as use at baseline and at least one follow-up visit.
- Perceived helpfulness was based on patient-reported symptom improvement (Yes/No), excluding "Unknown" responses.
- Associations between CAM use (within CAM users) and demographic variables (sex, age, ethnicity, race, marital status) were evaluated using chi-square or Fisher's exact tests with Benjamini-Hochberg adjustment (α=0.05).

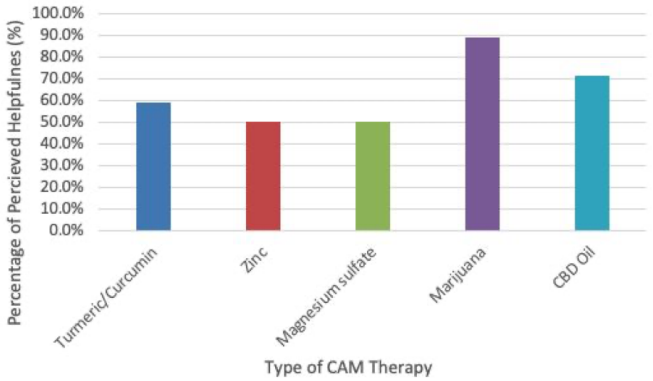

Figure 1. Perceived effectiveness of CAM Use Among Patients with HS. Percentage of patients reporting a therapy as helpful among those who used each CAM therapy.

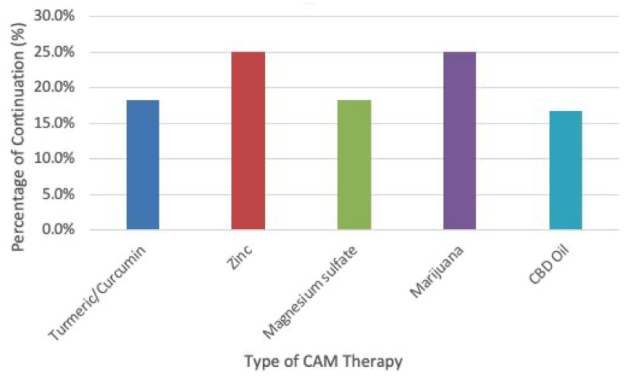

Figure 2. Continuous Use of CAM Among Patients with HS. Percentage of users with continuous use for each CAM therapy.

Results

- CAM use: n=45 (29.2%); turmeric was most common (n= 23; 51.1%), followed by marijuana (n= 18; 40.0%), zinc and magnesium sulfate (n= 16; 35.6%), and CBD oil (n= 7; 15.6%).
- Perceived helpfulness: Marijuana (88.9%) and CBD oil (71.4%), turmeric (59.1%), and zinc/magnesium sulfate (50.0%) **(Fig 1).**
- Continuation ranged from 16.7%–25.5%, with the highest for marijuana & zinc **(Fig 2).**
- Within CAM users, no demographic associations remained significant after Benjamini–Hochberg correction.

Conclusion

- CAM use is common with nearly one-third of patients in our registry reporting use, though lower than prior survey-based estimates[1].
- Cannabinoid-based therapies were most often perceived as helpful, though sustained use remained modest overall.
- Limitations include single-center study, small sample size, and self-reported measures.

References:
1. Price KN, Thompson AM, Rizvi O, et al. Complementary and Alternative Medicine Use in Patients With Hidradenitis Suppurativa. JAMA Dermatol. 2020;156(3):345.doi:10.1001/jamadermatol.2019.4595

Disclosures:
N. Goldfarb has participated in clinical trials with AbbVie, Pfizer, ChemoCentryx, and DeepX Health; and served on advisory boards and consulted for Novartis and Boehringer Ingelheim. J. Meisenheimer is an associate editor of JMIR dermatology.

CONCLUSIONES

- La **monitorización** de fármaco y anticuerpos anti-fármaco permite optimizar la dosis, la respuesta y guiar cambios terapéuticos en pacientes con hidradenitis.

- Las **terapias duales (biológico + JAKi)** parecen ser altamente eficaces en HS refractaria a monoterapia, con precaución en la combinación antii-TNF-α + IIL-1.

- **Futuras terapias** apuntan a tratamientos más precisos y personalizados de la HS, con eficacia igual o superior a las actuales.

- El manejo del peso con **agonistas de GLP-1** muestran eficacia en el control de la enfermedad aportando beneficio metabolic, mientras que la **suplementación** (zinc, magnesio, cúrcuma o CBD) tienen aun evidencia limitada.

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