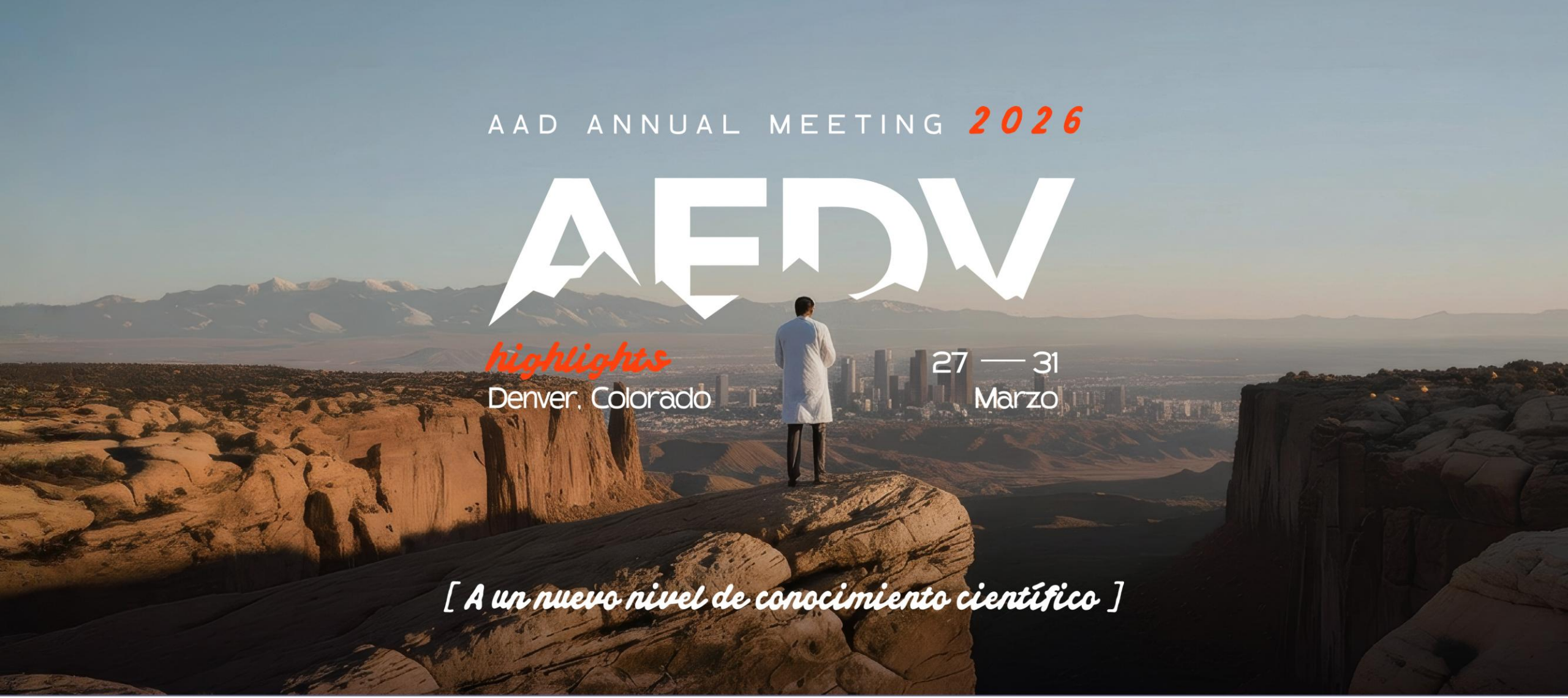


Una iniciativa de:

AEDV 1909 ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

FUNDACIÓN AEDV PIEL SANA ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

Con el patrocinio de:

ucb

Psoriasis

La llegada de los nuevos orales

Josep Riera Monroig

Hospital Clínic de Barcelona

@drjosepriera

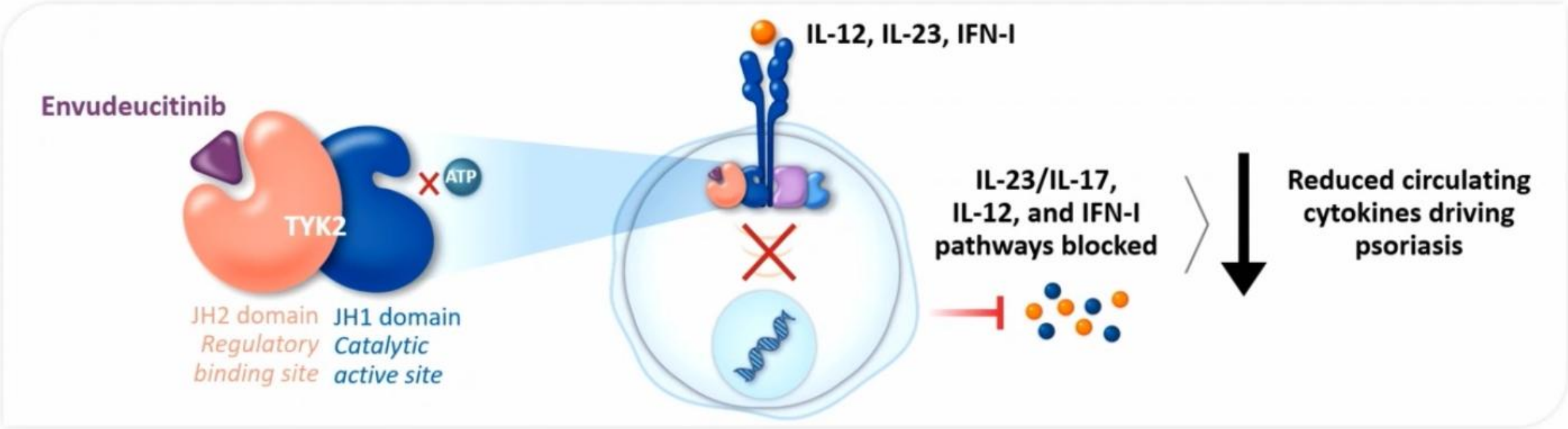
DECLARACIÓN DE CONFLICTOS DE INTERÉS

- He proporcionado asesoramiento científico/actuado como ponente/participado en ensayos clínicos de Abbvie, Almirall, Boheringuer Ingelheim, Chiesi, LeoPharma, Johnson&Johnson, KrystalBiotech, Novartis, Lilly, Loreal, Bristol Myers Squibb, UCB, Oruka Therapeutics, Takeda
- Este contenido está esponsorizado por UCB

Novedades terapéuticas: inhibidores de TYK2

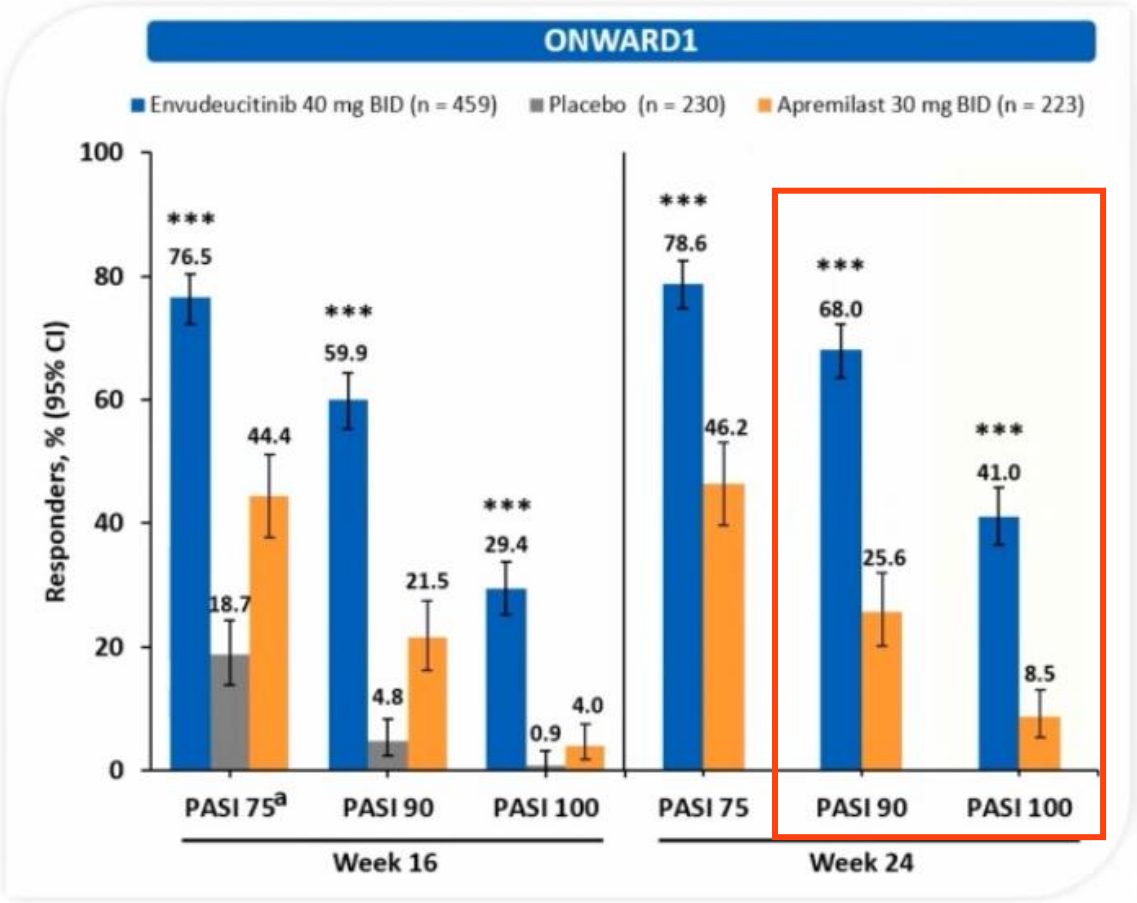
Envudeucitinib

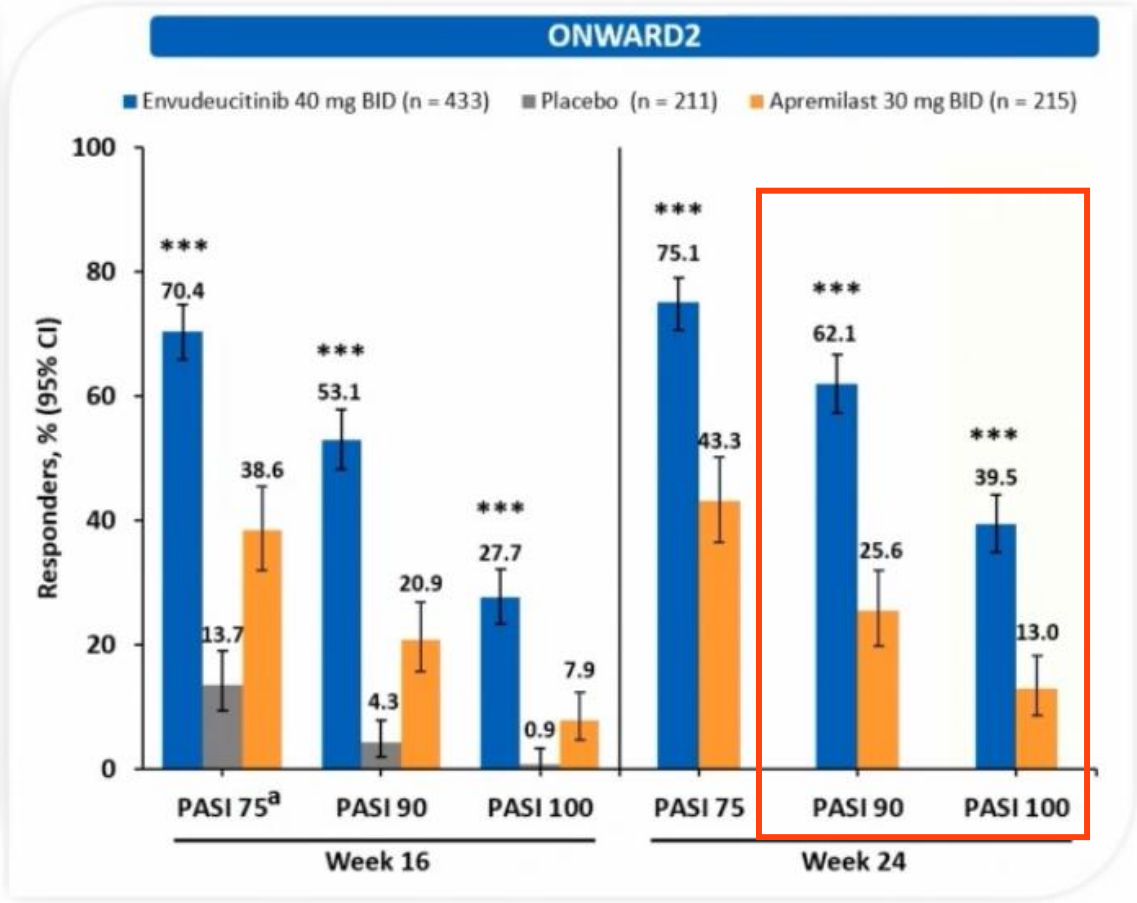
- Envudeucitinib, un inhibidor alostérico oral de TYK2 de nueva generación
- Bloqueo del eje IL-23/IL-17 pero también otras vías en menor medida



S023 Late-Breaking Research: Session 1 - Presentation: Envudeucitinib (ESK-001) in moderate-to-severe plaque psoriasis: 24-week results from the randomized, double-blind, active comparator- and placebo-controlled, Phase 3 ONWARD 1 and 2 studies (Blauvelt) – AAD, Denver 2026

Novedades terapéuticas: inhibidores de TYK2





Intention-to-treat population. The 95% CIs and *P*-values of the treatment differences were based on the Cochran-Mantel-Haenszel test adjusted for stratification factors. Nonresponder imputation was applied for missing data. [a]Coprimary endpoint: PASI 75 at Week 16 vs placebo. ***P <0.0001 vs placebo and apremilast.

BID, *bis in die* (twice daily); CI, confidence interval; PASI, Psoriasis Area and Severity Index; PASI 75/90/100, ≥75%/≥90%/100% improvement in PASI.

ONWARD1 and ONWARD2 Pooled Safety Through Weeks 16 and 24

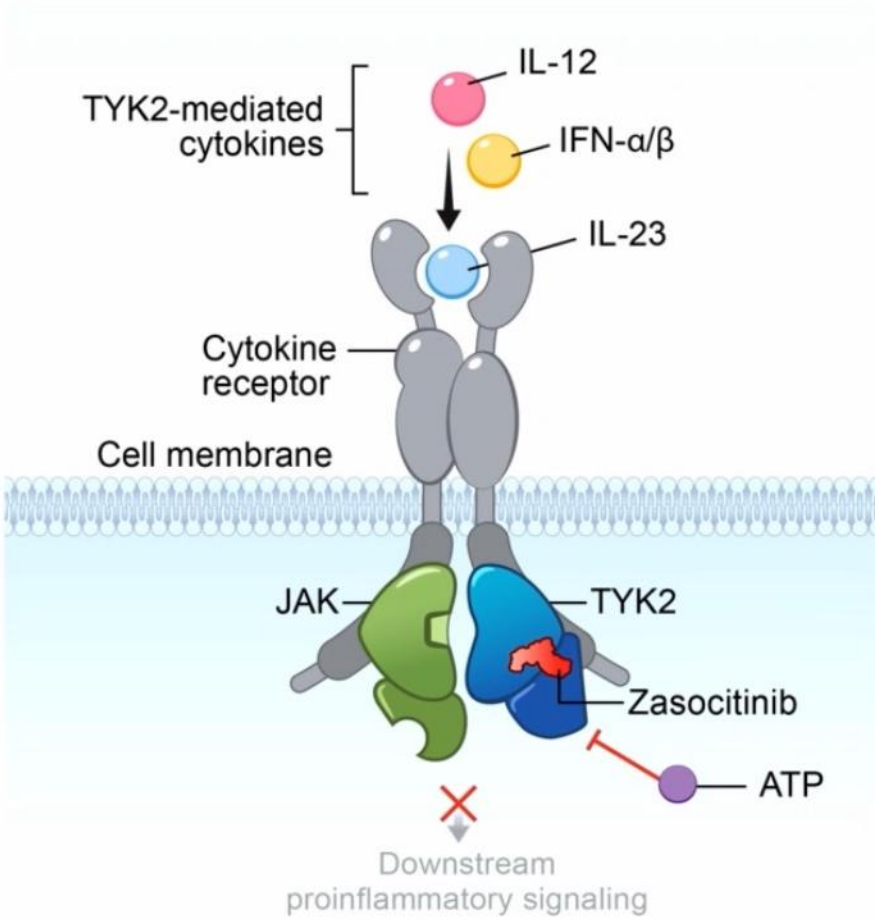
n (%)	Through Week 16: Envudeucitinib 40 mg BID n = 890	Through Week 16: Placebo n = 441	Through Week 16: Apremilast 30 mg BID n = 438	Through Week 24: Envudeucitinib 40 mg BID only n = 890	Through Week 24: Placebo to Envudeucitinib 40 mg BID n = 390	Through Week 24: Overall Envudeucitinib 40 mg BID n = 1280	Through Week 24: Apremilast 30 mg BID n = 438
≥1 TEAE	524 (58.9)	166 (37.6)	223 (50.9)	563 (63.3)	130 (33.3)	693 (54.1)	248 (56.6)
≥1 SAE	19 (2.1)	5 (1.1)	5 (1.1)	24 (2.7)	1 (0.3)	25 (2.0)	6 (1.4)
TEAE leading to treatment discontinuation	30 (3.4)	7 (1.6)	9 (2.1)	31 (3.5)	4 (1.0)	35 (2.7)	12 (2.7)
TEAE grade ≥3	42 (4.7)	14 (3.2)	18 (4.1)	48 (5.4)	7 (1.8)	55 (4.3)	23 (5.3)
Most-frequent TEAEs (≥5%)[a]							
Nasopharyngitis	64 (7.2)	21 (4.8)	16 (3.7)	92 (10.3)	18 (4.6)	110 (8.6)	26 (5.9)
Headache	92 (10.3)	11 (2.5)	40 (9.1)	97 (10.9)	11 (2.8)	108 (8.4)	42 (9.6)
Upper respiratory tract infection	43 (4.8)	7 (1.6)	16 (3.7)	57 (6.4)	2 (0.5)	59 (4.6)	21 (4.8)
Acne	53 (6.0)	3 (0.7)	3 (0.7)	60 (6.7)	17 (4.4)	77 (6.0)	3 (0.7)
Nausea	20 (2.2)	4 (0.9)	23 (5.3)	20 (2.2)	0	20 (1.6)	23 (5.3)
Diarrhea	14 (1.6)	11 (2.5)	36 (8.2)	16 (1.8)	1 (0.3)	17 (1.3)	36 (8.2)

- Envudeucitinib showed low rates of SAEs and AEs leading to discontinuation, with no clusters of events
  - No deaths; no MACE or cytopenia signals; no TB reactivation[b]
- No clinically significant laboratory abnormalities were observed across lipid, hematologic and chemistry panels, with comparable variability across treatment arms throughout the study
- At Week 24, low incidence of serious infections (0.7%) and malignancies (0.2%) observed in patients treated with envudeucitinib

S023 Late-Breaking Research: Session 1 - Presentation: Envudeucitinib (ESK-001) in moderate-to-severe plaque psoriasis: 24-week results from the randomized, double-blind, active comparator- and placebo-controlled, Phase 3 ONWARD 1 and 2 studies (Blauvelt) – AAD, Denver 2026

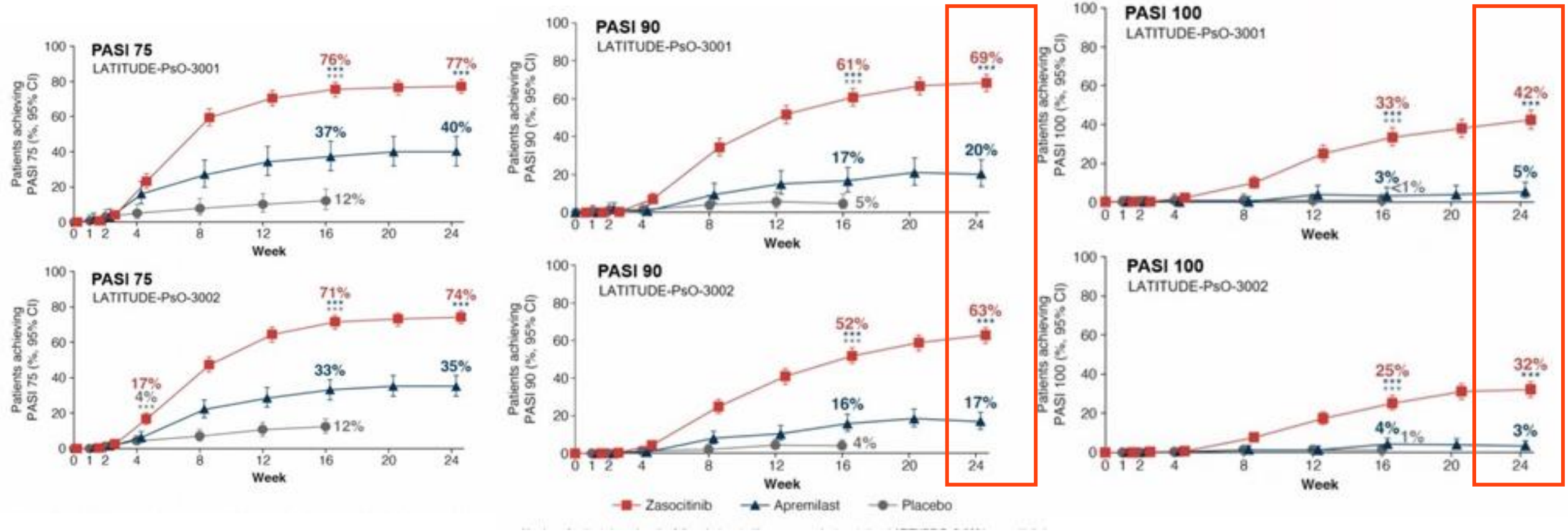
Novedades terapéuticas: zasocitinib

- Más de un millón de veces mayor selectividad de unión por TYK2 frente a JAK1, JAK2 y JAK3.
- Mantiene la inhibición durante 24 horas
- LATITUDE ensayos fase 3 vs placebo y vs apremilast en adultos con psoriasis en placas moderada-grave



Gooderham et al, S034 Late-Breaking Research: Session 2 – AAD Denver 2026

Novedades terapéuticas: zasocitinib



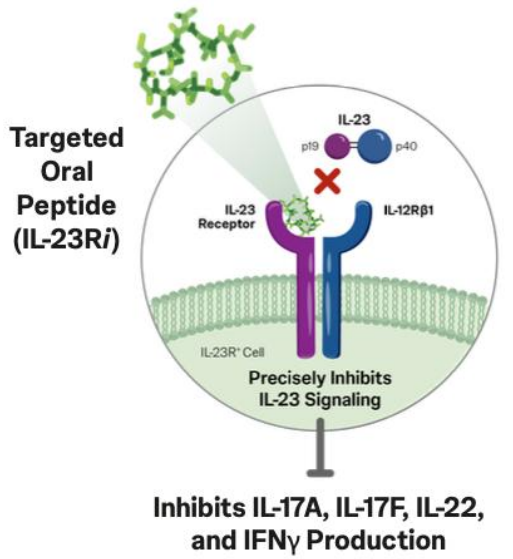
Gooderham et al, S034 Late-Breaking Research: Session 2 – AAD Denver 2026

Novedades terapéuticas: zasocitinib

TEAEs from LATITUDE-PsO-3001 and 3002[a]	Day 0 to Week 16						Day 0 to Week 24			
	Zasocitinib (n = 970)		Apremilast (n = 412)		Placebo (n = 417)		Zasocitinib (n = 970)		Apremilast (n = 412)	
	n	%[b] (95% CI)[c]	n	%[b] (95% CI)[c]	n	%[b] (95% CI)[c]	n	%[b] (95% CI)[c]	n	%[b] (95% CI)[c]
Any TEAE	605	**62.1** (59.0–65.1)	207	**50.5** (45.7–55.4)	196	**46.9** (42.0–51.7)	674	**69.3** (66.4–72.2)	232	**56.5** (51.7–61.4)
Leading to discontinuation	31	**3.2** (2.1–4.3)	11	**2.6** (1.1–4.2)	3	**< 1** (0.0–1.6)	36	**3.7** (2.5–4.9)	13	**1.3** (1.4–4.7)
SAE	29	**3.0** (1.9–4.1)	6	**1.5** (0.3–2.7)	2	**< 1** (0.1–1.7)	35	**3.6** (2.4–4.8)	7	**1.7** (0.5–3.0)
Death	1[d]	**< 1** (0.0–0.6)[d]	0	**0** (0.0–0.9)	0	**0** (0.0–0.9)	1[d]	**< 1** (0.0–0.6)[d]	0	**0** (0.0–0.9)
Most frequent TEAE (≥ 5%)[e]										
URTI	100	**10.1** (8.2–12.0)	24	**6.0** (3.7–8.3)	13	**3.2** (1.5–4.8)	123	**12.5** (10.4–14.6)	29	**7.4** (4.8–10.0)
Acne	62	**6.5** (5.0–8.1)	3	**< 1** (0.0–1.7)	1	**< 1** (0.0–1.3)	70	**7.3** (5.6–8.9)	3	**< 1** (0.0–1.7)
Nasopharyngitis	60	**6.2** (4.7–7.7)	23	**5.4** (3.2–7.5)	20	**4.7** (2.7–6.6)	80	**8.3** (6.5–10.0)	34	**7.9** (5.4–10.5)
Diarrhea	30	**3.1** (2.0–4.2)	33	**8.2** (5.5–10.9)	8	**1.8** (0.6–3.1)	36	**3.7** (2.5–4.9)	33	**8.2** (5.5–10.9)
Headache	27	**2.8** (1.8–3.9)	26	**6.3** (4.0–8.7)	8	**1.9** (0.6–3.2)	32	**3.3** (2.2–4.5)	28	**6.8** (4.4–9.3)
Nausea	20	**2.1** (1.2–3.0)	23	**5.5** (3.3–7.8)	5	**1.2** (0.1–2.2)	23	**2.4** (1.4–3.4)	24	**5.8** (3.5–8.1)

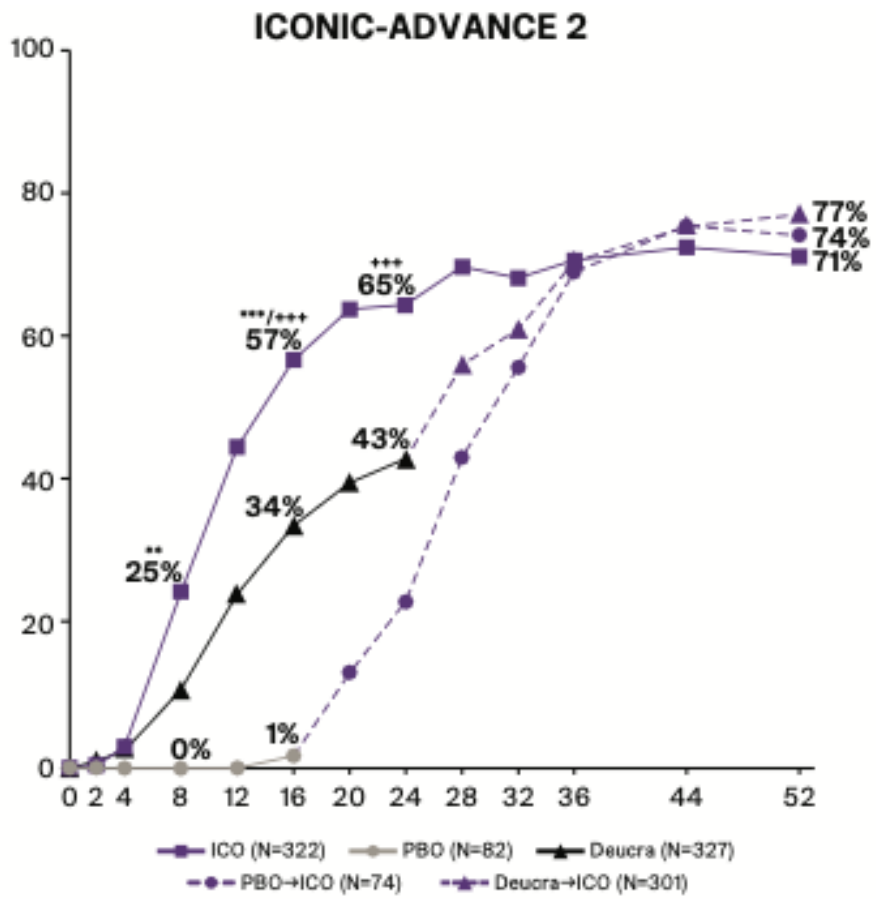
Gooderham et al, S034 Late-Breaking Research: Session 2 – AAD Denver 2026

Icotrokinra en adultos a 52 semanas

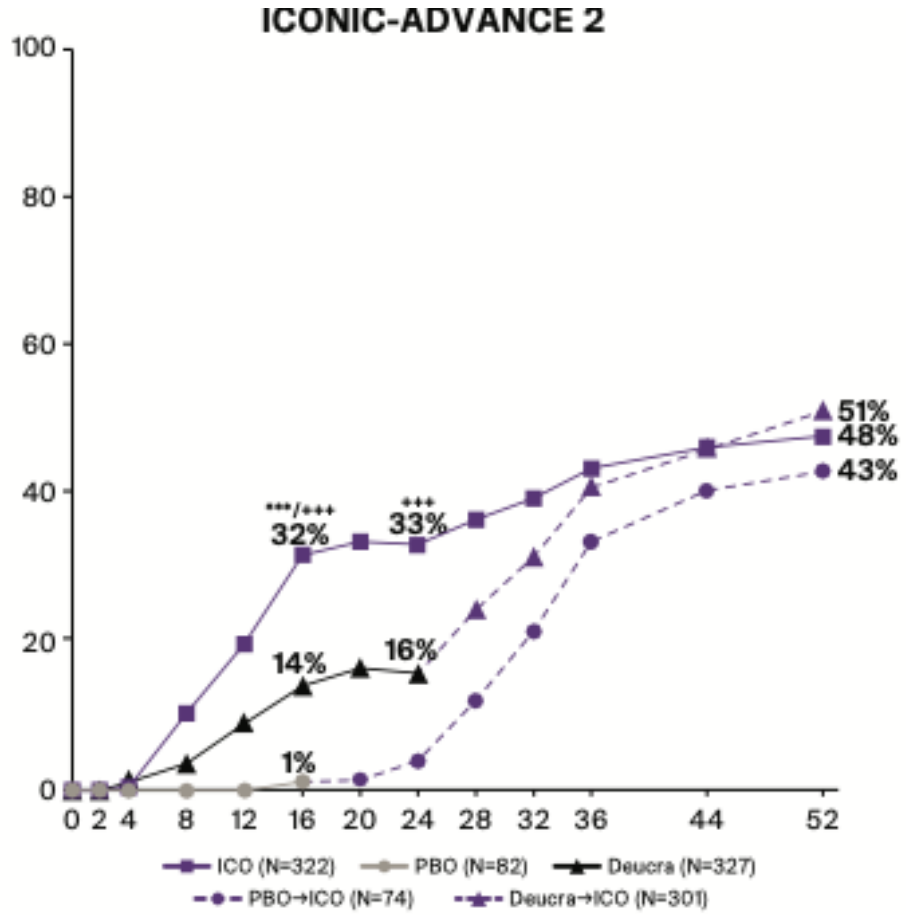


IFN=interferon, IL-12Rβ1=interleukin-12 receptor beta 1, IL-23Ri=interleukin-23 receptor inhibitor.

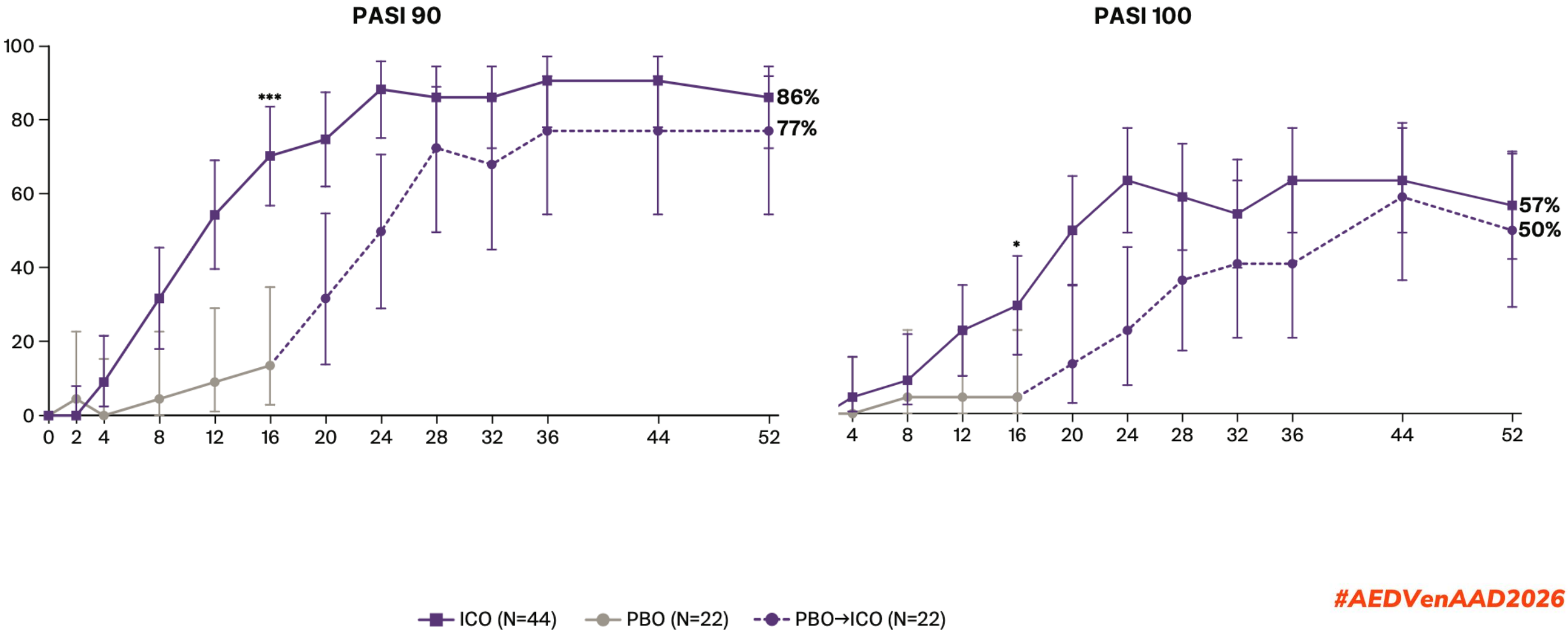
PASI 90



PASI 100



Icotrokinra en adolescentes > 12 años

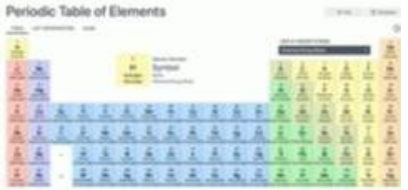


The ICO AE profile in adolescents was similar to PBO through W16, and consistent between W16 & W52

AEs Through W52: Adolescents[a]	PBO-Controlled (Through W16)		Through W52
	PBO (N=22)	ICO (N=44)	ICO Combined (N=66)[a]
Mean weeks / total PY of follow-up	16.2 / 6.8	16.2 / 13.7	46.3 / 58.6
Any AE	16 (73%)	22 (50%)	46 (70%)
Incidence/100 PY (95% CI)[b,c]	521 (266, 776)	238 (139, 338)	164 (117, 212)
Serious AE	0	2 (5%)	4 (6%)
Incidence/100 PY (95% CI)[b,d]	0 (0, 44)	15 (2, 54)	7 (2, 18)
AE leading to discontinuation	0	0	0
Incidence/100 PY (95% CI)[b,d]	0 (0, 44)	0 (0, 22)	0 (0, 5)
Infection	6 (27%)	14 (32%)	31 (47%)
Incidence/100 PY (95% CI)[b,c]	116 (23, 209)	130 (62, 198)	78 (50, 105)
Serious infection	0	0	0
Incidence/100 PY (95% CI)[b,d]	0 (0, 44)	0 (0, 22)	0 (0, 5)
Gastrointestinal AE	1 (5%)	2 (5%)	5 (8%)
Incidence/100 PY (95% CI)[b,d]	15 (<1, 85)	15 (2, 53)	9 (3, 21)
Malignancy	0	0	0
Incidence/100 PY (95% CI)[b,d]	0 (0, 44)	0 (0, 22)	0 (0, 5)

Data shown are n (%), unless otherwise noted. Safety analysis set included all randomized and treated pts. [a]Includes pts receiving ICO through W52 and data after W16 for pts receiving PBO who transitioned to ICO. [b]Incidence/100 PY: (number of pts with AEs/total PY at risk) × 100. [c]CIs were based on a Wald statistic using the normal assumption. [d]CIs were based on an exact method assuming that the observed number of events follows a Poisson distribution.

What therapies can work for PPP?



There's no green light here…

topicals

- **Cs** — broadband-ultraviolet-b
- **D** — vitamin D analog
- **A** — vitamin A analog
- **Cs-D** — Corticosteroid-vitamin D
- **Cs-A** — Corticosteroid-vitamin A
- **Rf** — Roflumilast, PDE-4 inhibitor
- **Tf** — tapinarof, Aryl hydrocarbon receptor (AhR) agonist

^{1}Pu Psoralen + Ultraviolet-A	^{2}Bb broadband-ultraviolet-b	^{3}Nb narrowband ultraviolet-b	^{4}Exc excimer 308nm ultraviolet-b	^{5}Hh handheld/home ultraviolet-b	
^{6}Mtx methotrexate, antimetabolite	^{7}Aci acitretin, retinoid	^{8}Cya cyclosporine, calcineurin inhibitor	^{16}Apr apremilast, phosphodiesterase-4 inhibitor	^{22}Deu Deucravacitinib, TYK2 inhibitor	^{23}Upa Upadacitinib, JAK inhibitor (AD, PsA)
^{9}Etn etanercept, TNF-a inhibitor	^{10}Ada adalimumab, TNF-a inhibitor	^{11}Cer certolizumab pegol, TNF-a inhibitor	^{12}Inf infliximab, TNF-a inhibitor	^{13} Gol golimumab, TNF-a inhibitor	
^{14}Ust ustekinumab, interleukin 12/23 inhibitor	^{21}Til tildrakizumab, interleukin-23 inhibitor	^{18} Gus guselkumab, interleukin-23 inhibitor	^{20} Ris risankizumab, interleukin-23 inhibitor	^{26}Ico Icotrokinra, Oral interleukin-23 receptor antagonist	
^{15}Sec Secukinumab, interleukin-17 inhibitor	^{17}Ixe Ixekizumab, interleukin-17 inhibitor	^{19}Bro brodalumab, interleukin-17 receptor inhibitor	^{25}Bim bimekizumab, interleukin-17 inhibitor		
^{24}Spe Spesolimab, IL36RA antagonist	Ana Anakinra, IL1 antagonist				

Uso de iJAK en PPP

FIGURE 1

Complete Pustule Clearance at Week 2

P = 0.003

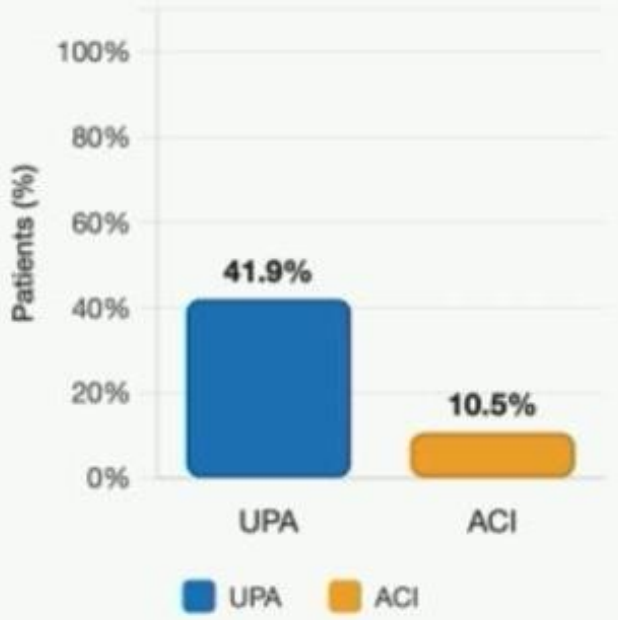
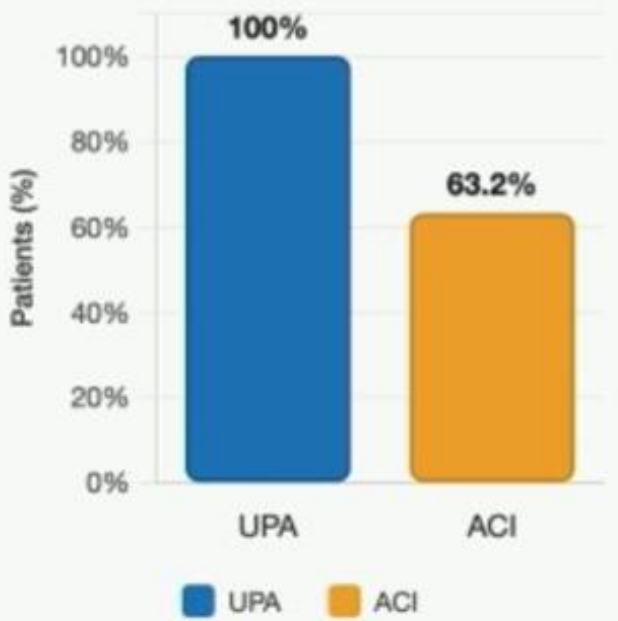


FIGURE 2

Pustule Count <30 at Week 4



- Zheng Y, et al. Clinical efficacy and safety of upadacitinib in the treatment of palmoplantar pustulosis:. A single-center retrospective study. Indian J Dermatol Venereol Leprol. 2024. PMID: 39635802.
- Huang D, Jiang X, Yang N, Wang Y, Li Y, Yi X, Guo C, Gao Y, Shi Y. Upadacitinib Versus Acitretin for the Resolution of Pustules in Palmoplantar Pustulosis During Acute Phase: A Single-Center, Open-Label Prospective Cohort Study. Am J Clin Dermatol. 2025 Sep;26(5):843-850. doi: 10.1007/s40257-025-00971-7. Epub 2025 Jul 23. PMID: 40702395.
- Rahbar Kooybaran N, et al. Response of palmoplantar pustulosis to upadacitinib: A case series of five patients. J Dtsch Dermatol Ges. 2023 Nov;21(11):1387-1392. doi: 10.1111/ddg.15176. Epub 2023 Aug 21. PMID: 37605445.
- Xu Q, et al. Refractory Palmoplantar Pustulosis Successfully Treated with JAK Inhibitor Tofacitinib: A Case Series. Infect Drug Resist. 2023 Aug 9;16:5165-5172. PMID: 37581169

highlights
Denver, Colorado

AAD ANNUAL MEETING 2026

27 — 31
Marzo

Comorbilidades

Una iniciativa de:

ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

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ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

#AEDVenAAD2026

Con el patrocinio de:

ucb

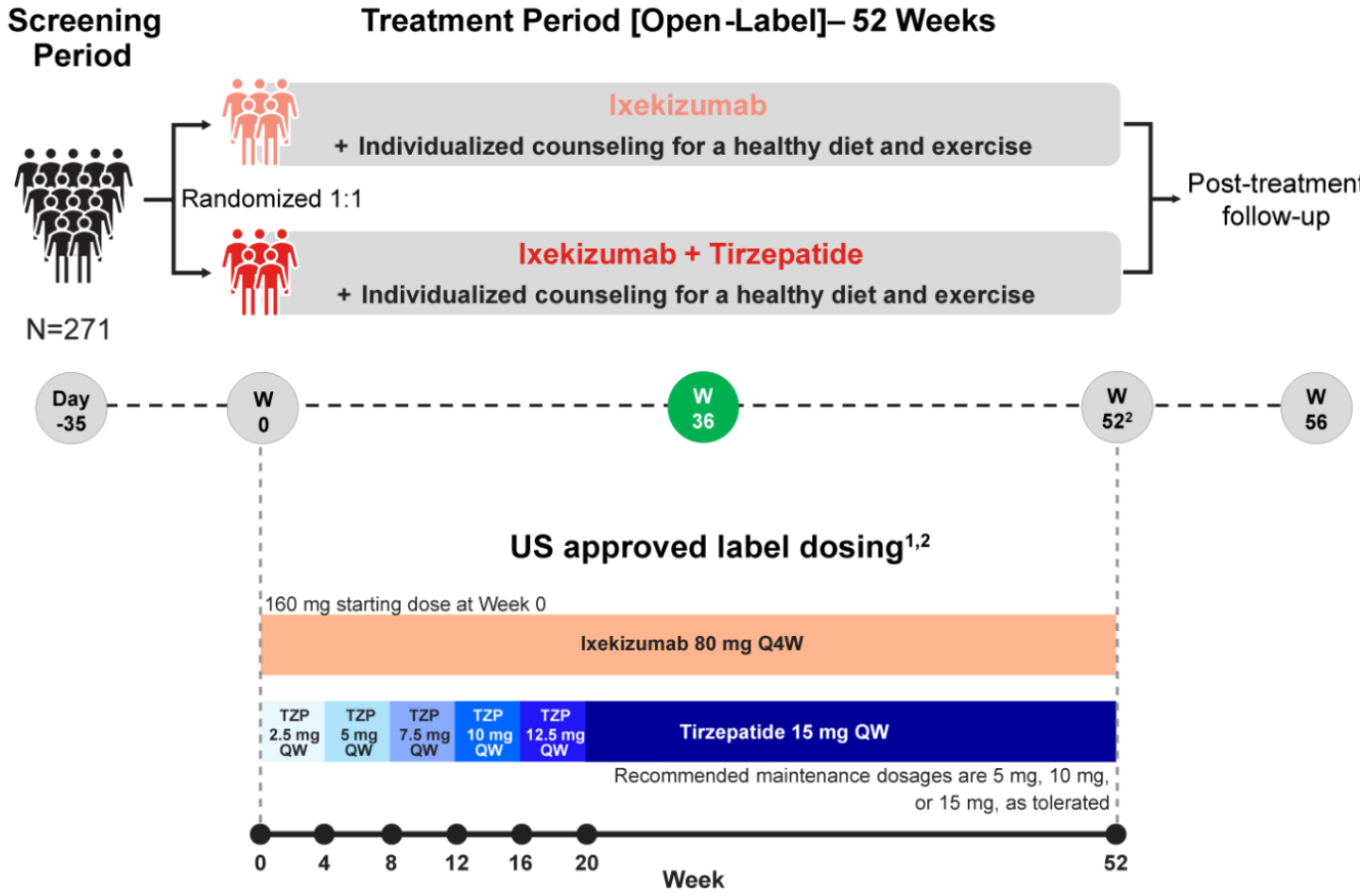
Tratamiento combinado: PsA y obesidad

El sobrepeso y la obesidad son comorbilidades frecuentes en PsO y PsA

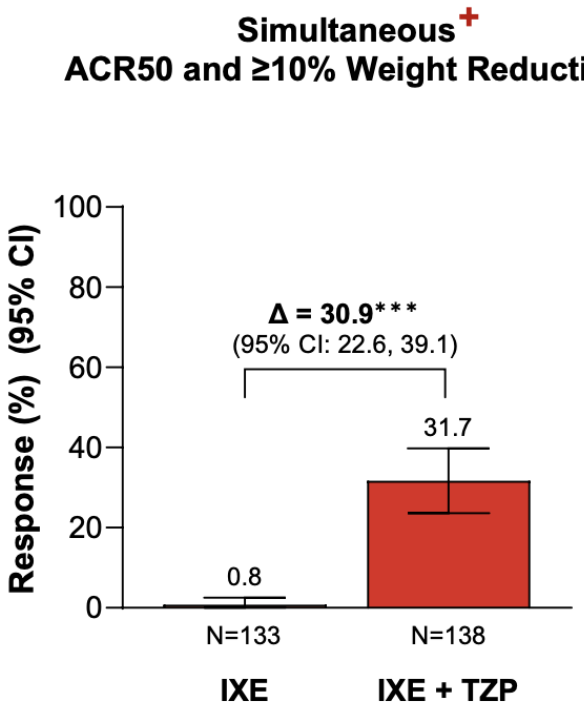
La obesidad se asocia a peor respuesta y a eventos cardiovasculares

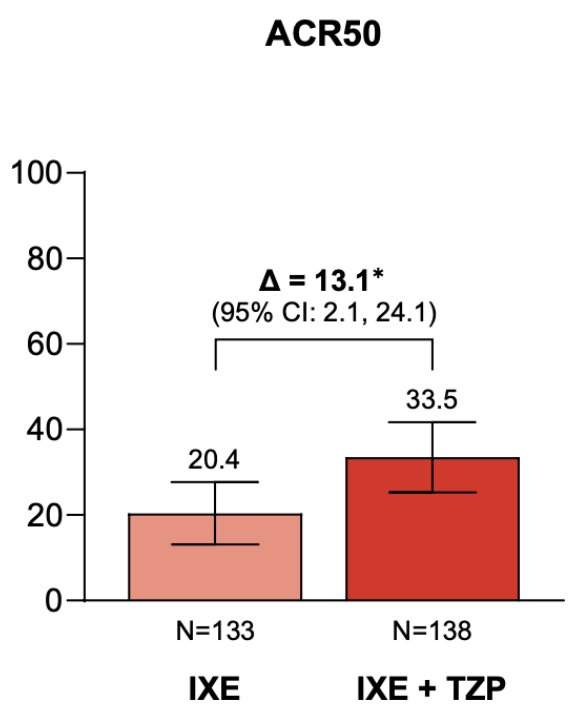
TOGETHER PsO / PsA

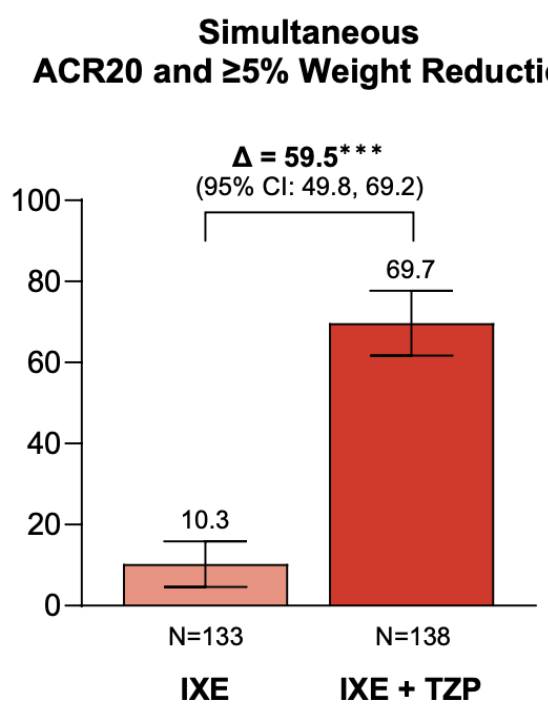
Estudia el impacto de ixekizumab vs ixekizumab tirzepatida

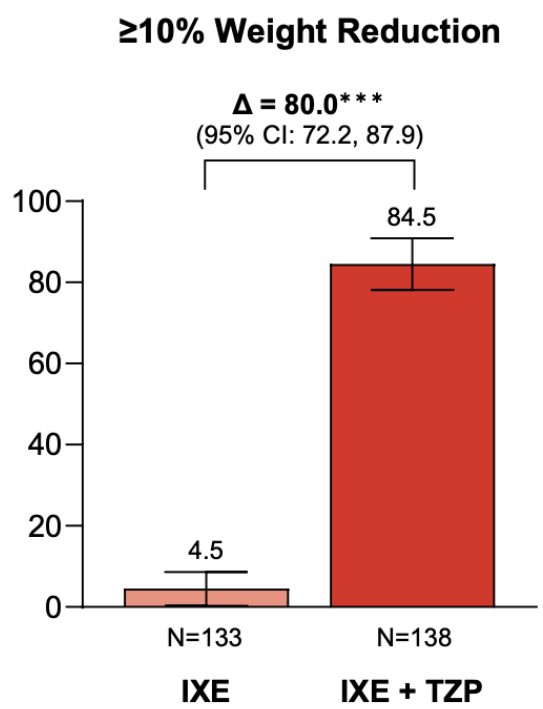


Merala et al, Late-breaker Presentation – 79178, AAD Denver 26-30 March 2026

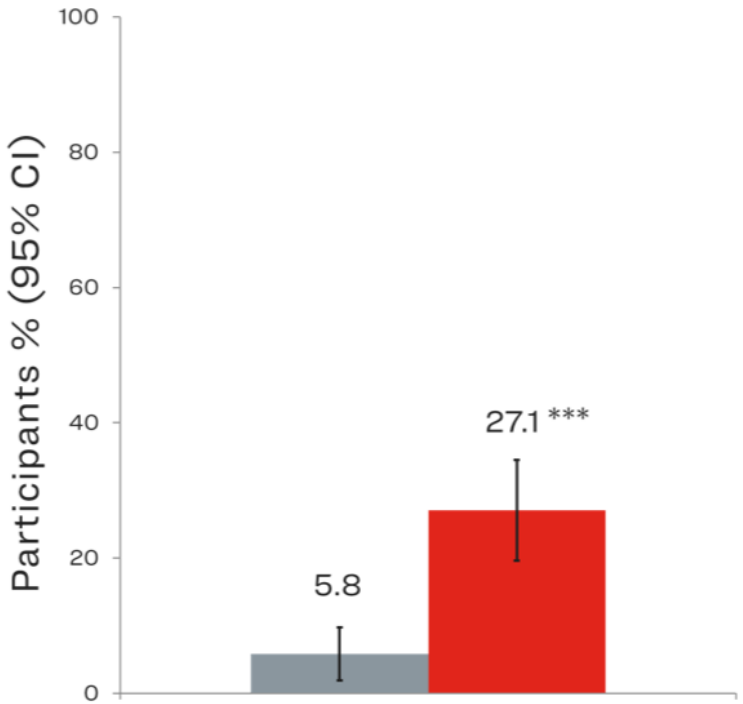

Simultaneous+
ACR50 and ≥10% Weight Reduction
Response (%) (95% CI)
100
80
60
40
20
0
Δ = 30.9***
(95% CI: 22.6, 39.1)
31.7
0.8
N=133
N=138
IXE
IXE + TZP


ACR50
100
80
60
40
20
0
Δ = 13.1*
(95% CI: 2.1, 24.1)
33.5
20.4
N=133
N=138
IXE
IXE + TZP


Simultaneous
ACR20 and ≥5% Weight Reduction
100
80
60
40
20
0
Δ = 59.5***
(95% CI: 49.8, 69.2)
69.7
10.3
N=133
N=138
IXE
IXE + TZP

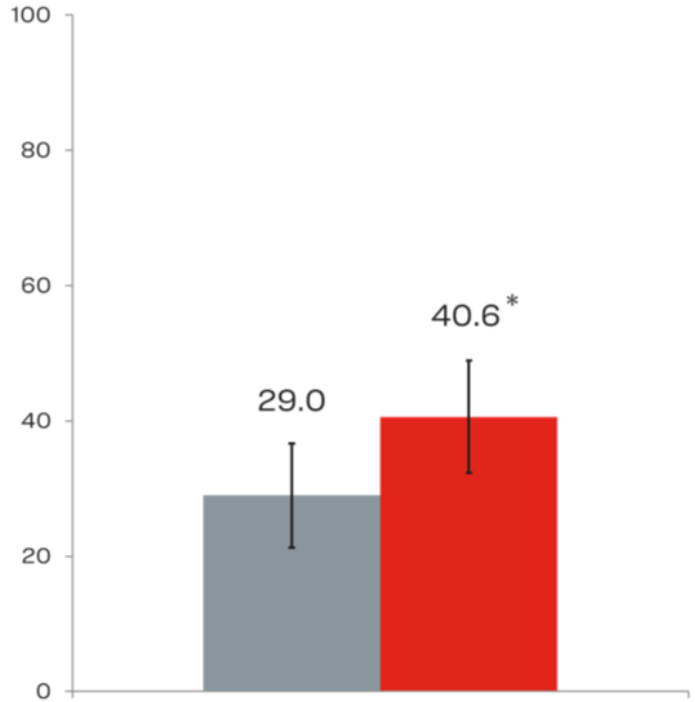

≥10% Weight Reduction
100
80
60
40
20
0
Δ = 80.0***
(95% CI: 72.2, 87.9)
84.5
4.5
N=133
N=138
IXE
IXE + TZP

Simultaneous PASI 100 and ≥10% Weight Reduction



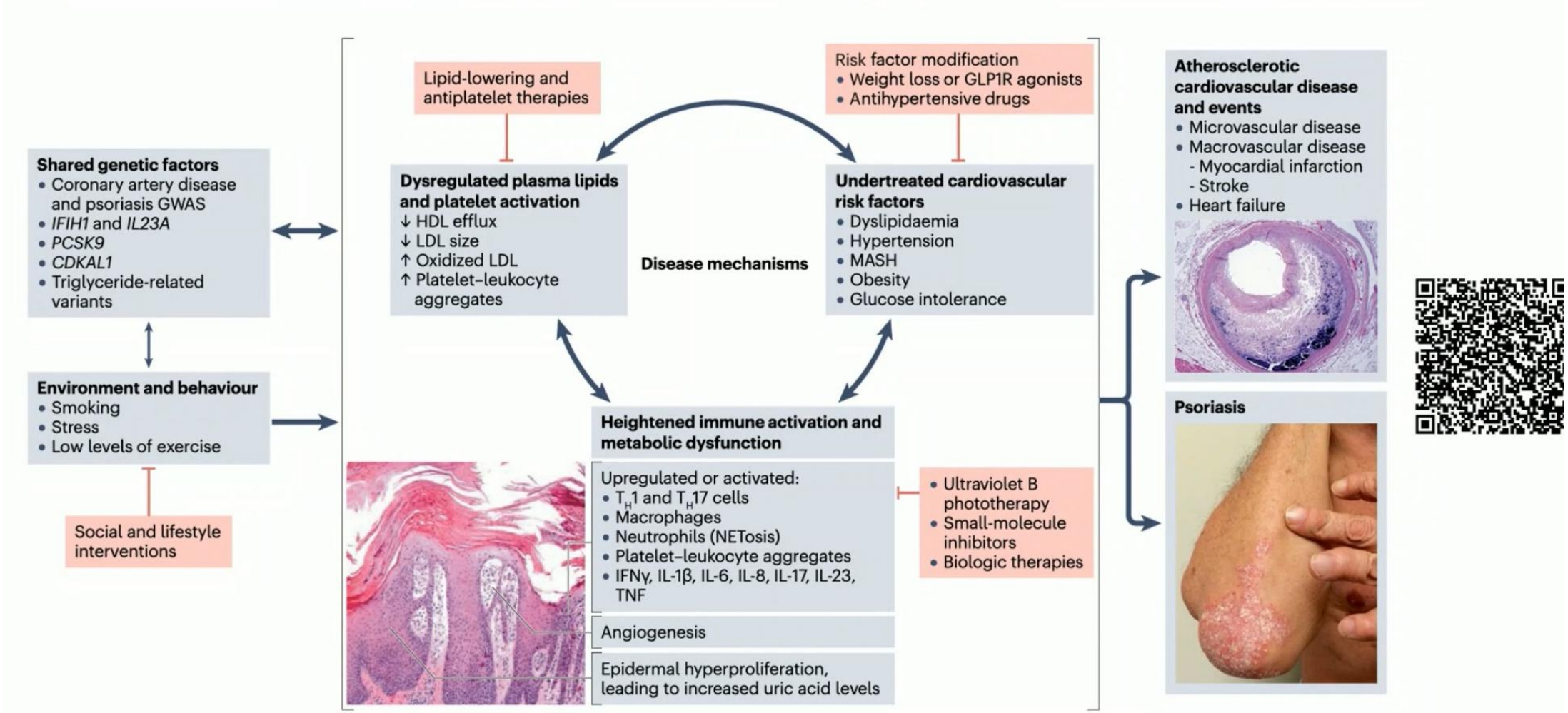
Primary Endpoint

PASI 100



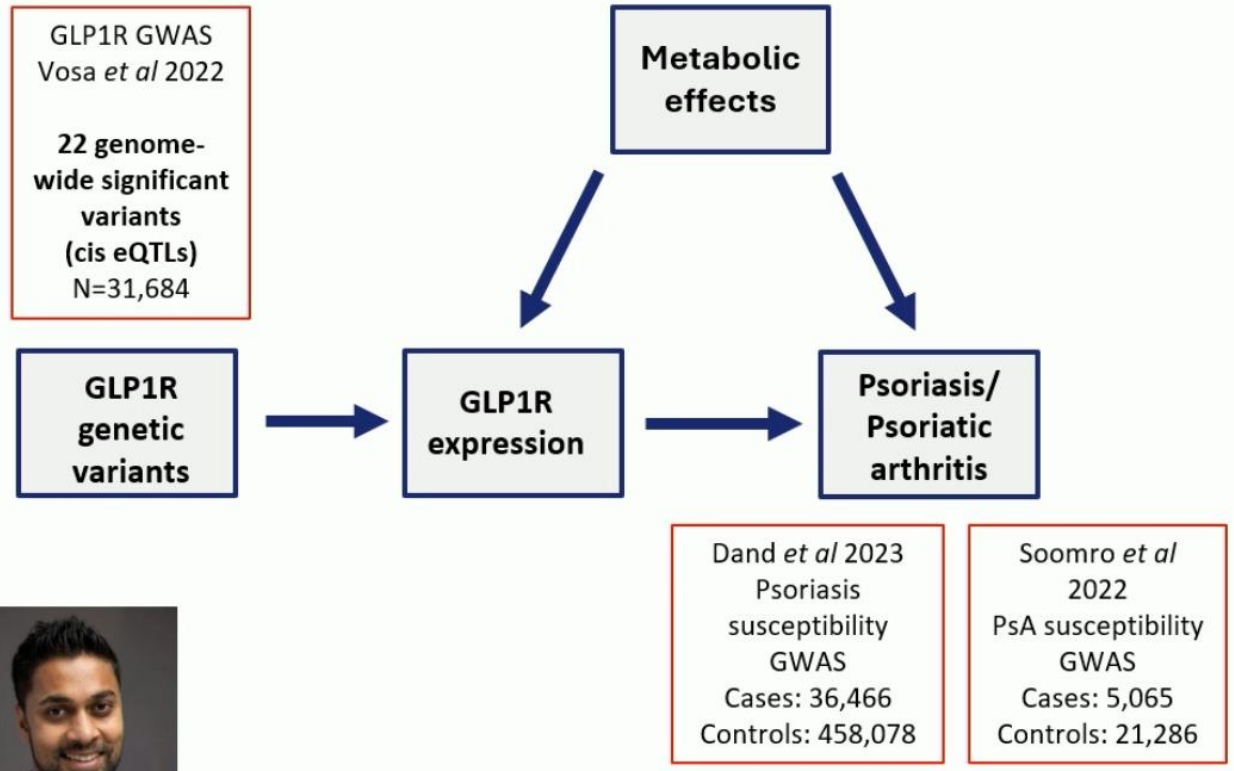
Key Secondary Endpoint

Riesgo cardiovascular



Gelfand JM, Song WB, Langan SM, Garshick MS. Cardiodermatology: the heart of the connection between the skin and cardiovascular disease. Nat Rev Cardiol. 2024 Nov 13.

Genetically proxied GLP1 receptor signaling is protective of psoriasis & psoriatic arthritis but not selected inflammatory diseases

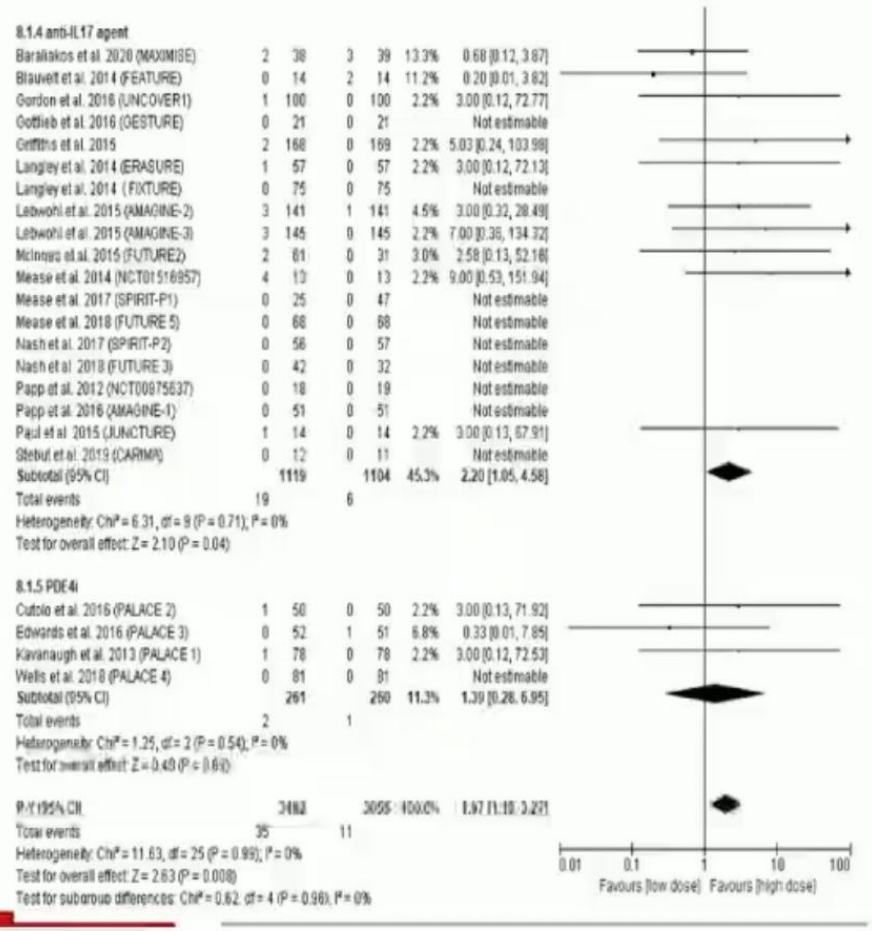


Outcome	OR (95% CI)	P-value
Psoriasis	**0.72 (0.68-0.77)**	**1.08×10^{-22}**
Psoriatic arthritis	**0.48 (0.40-0.58)**	**5.33×10^{-15}**
Acne	1.04 (0.96–1.13)	0.379
Asthma	1.03 (0.99–1.07)	0.187
Atopic dermatitis	1.01 (0.96–1.05)	0.835
Crohn's disease	1.24 (1.11–1.40)	**2.35×10^{-4}**
Multiple sclerosis	0.89 (0.80–1.00)	0.056
Rheumatoid arthritis	1.50 (1.35–1.67)	**1.36×10^{-13}**
Ulcerative colitis	1.01 (0.96–1.05)	0.835

Meta-analysis RCTs of targeted therapies and CV events in psoriasis or PsA: No overall benefit

- 88 RCTs 10,521 person years of psoriasis or psoriatic arthritis evaluating all CV events*
- TNFi RR = 1.26, 95% CI 0.66-2.41
- JAKi RR = 1.07, 95% CI 0.37-3.11
- anti-IL-12/23 RR = 0.92, 95% CI 0.48-1.74
- anti-IL-17 RR = 1.13, 95% CI 0.62-2.07
- PDE4i RR = 0.71, 95% CI 0.23-2.18
- Results confirmed in a 2025 meta-analysis of psoriasis only RCTs

*angina pectoris, MI, congestive heart failure, carotid artery disease, aortic aneurysm, stroke, transient ischemic attack, cardiovascular death, and arrhythmia.



Cai R, et al. Int J Rheum Dis. 2023 Apr;26(4):625-637
Mangkorntongsakul V, et al. Dermatol Ther (Heidelb). 2025 Dec;15(12):3547-3560.

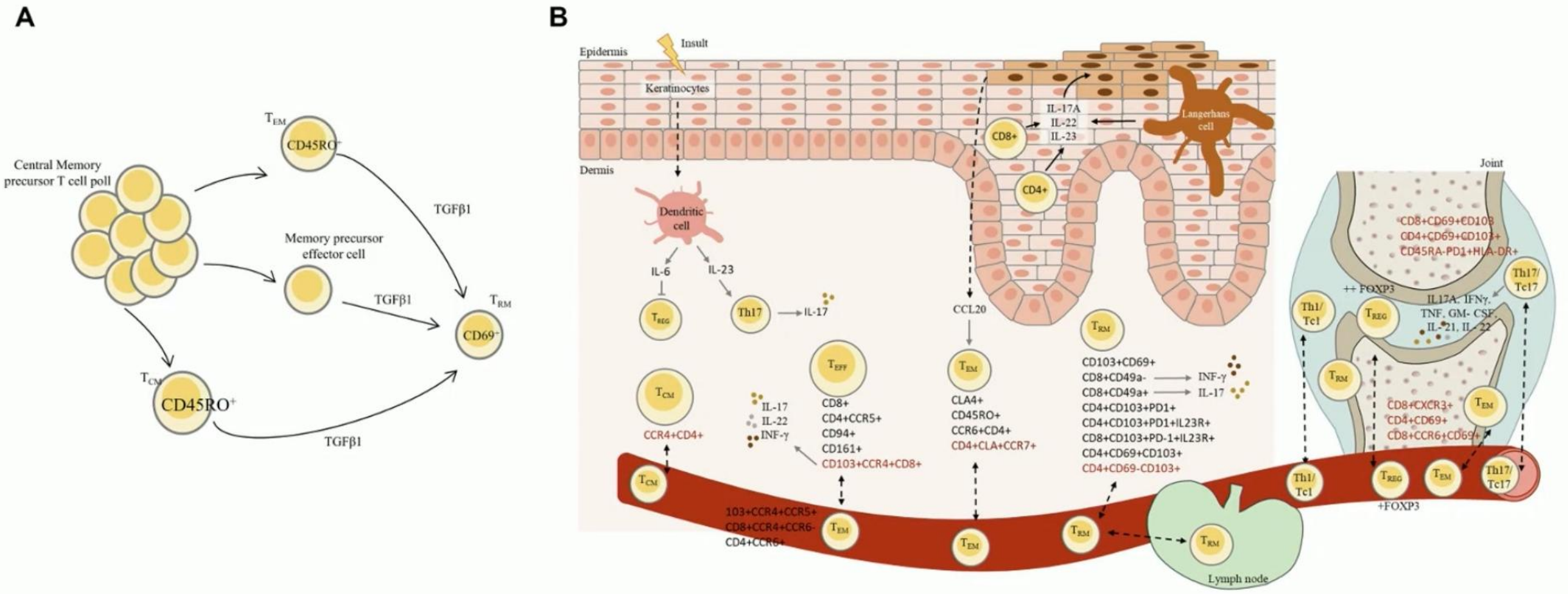
Artritis psoriásica

Limitaciones de los enfoques observacionales actuales

- Medición incompleta de variables de confusión, incluidas la BSA, la obesidad y la depresión
- Sesgo de selección
  - **Protopático**: el fármaco se prescribe para una manifestación precoz del desenlace que aún no ha sido detectada
  - **Confusión por indicación**: la indicación del tratamiento influye en el riesgo del desenlace
- **Sesgo colisionador**: una exposición y un desenlace influyen cada uno en una tercera variable común, y esa variable, o colisionador, se controla mediante el diseño del estudio o en el análisis (p. ej., la paradoja del tabaquismo en la APs)
- Sesgo de observación
- A menudo no hay estratificación según el mecanismo de acción del biológico

Conclusión: Algunas preguntas no se adaptan bien a los métodos observacionales. ¡Necesitamos ECA!

TRM & Treg en PsA



Labao B et al. Frontiers, 2024

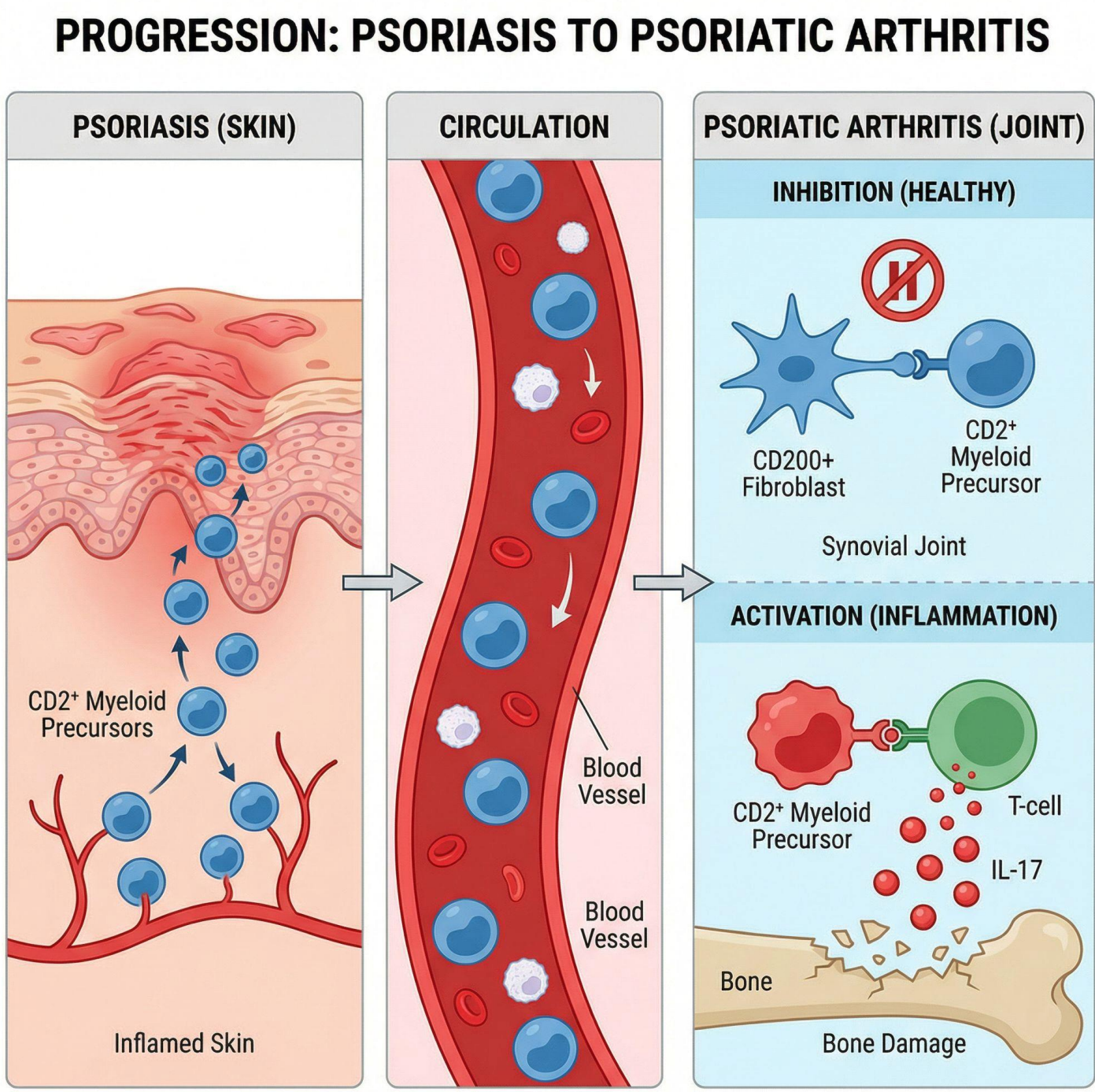
Skin-derived myeloid precursors and joint-resident fibroblasts spread psoriatic disease from skin to joints

nature immunology

Precursores precursores mieloides $CD2^{+}MHC-II^{+}CCR2^{+}$ se originan en la piel psoriásica

Que haya artritis o no depende de las células locales de la articulación. En personas sanas, los **fibroblastos** $CD200^{+}$ frenan a estas células invasoras. Sin embargo, en quienes desarrollan artritis, estos fibroblastos protectores desaparecen.

El daño final: Al no tener freno, los precursores mieloides se activan y ordenan a los linfocitos T que produzcan grandes cantidades de **IL-17**, la molécula que finalmente destruye el hueso y el cartílago.



Raimondo MG, et al. Nat Immunol. 2026 Jan;27(1):35-47.

highlights
Denver, Colorado

AAD ANNUAL MEETING 2026

27 — 31
Marzo

Pitiriasis rubra pilaris

Una iniciativa de:

ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

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ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

#AEDVenAAD2026

Con el patrocinio de:

ucb

Deucravacitinib tiriasis rubra pilaris

Ensayo clínico abierto, fase 2

Adultos con PRP con confirmación histológica

Deucravacitinib 6mg c/12h

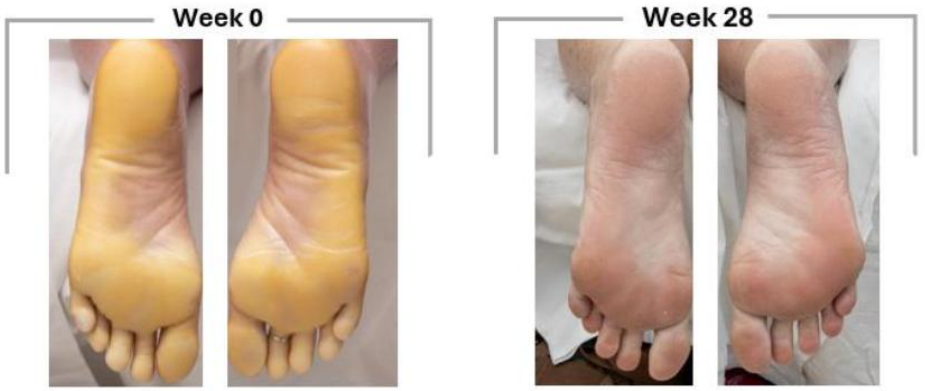
Endpoint a las 24 semanas
Medidas. PGA, PASI, BSA, DLQI, NRS-Itch, Skindex-16

Patients Enrolled	7
Patients Completed Study	6
Age (mean (SD)), years	59.0 (9.5)
Sex	
Female	1 (16.7%)
Male	5 (83.3%)
Race	
White (W)	5 (83.3%)
Black or African American (B)	1 (16.7%)

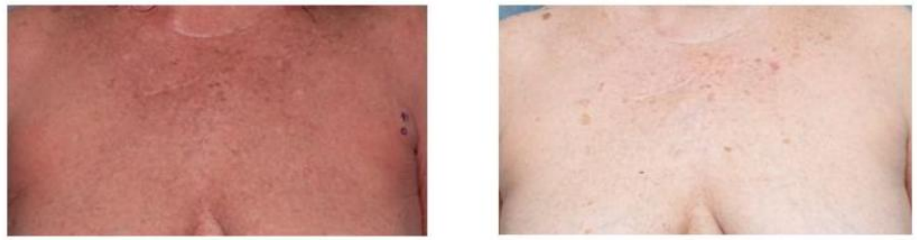
Roberts et al, Poster AAD Denver

RESULTS

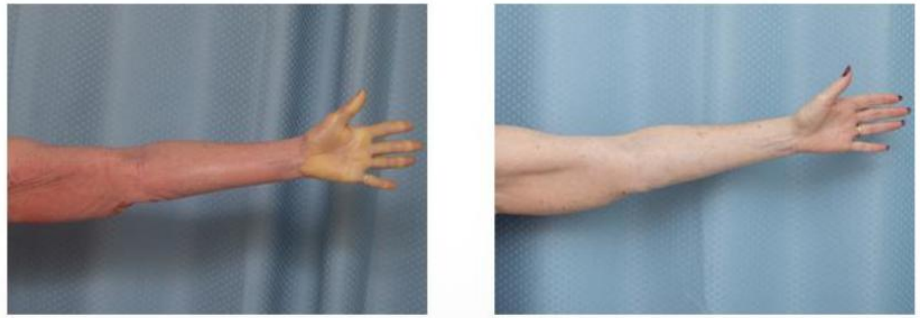
A.



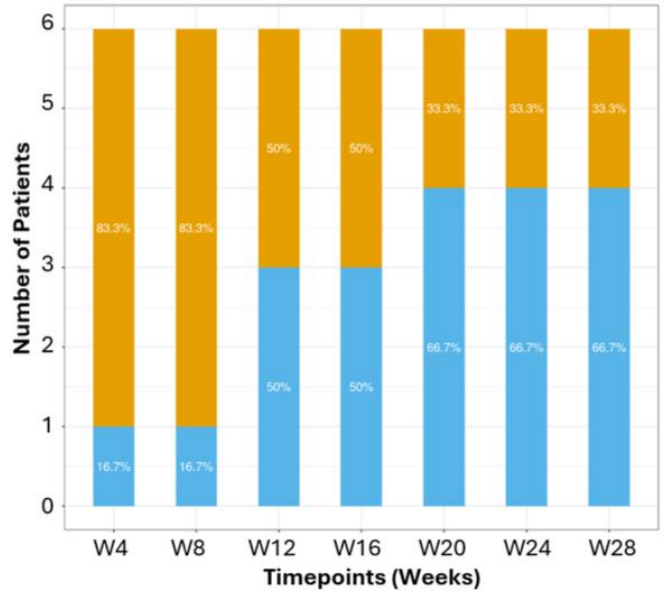
B.



C.



D. PGA Percentage by Timepoints



PGA Group: Non-responsive (grade 4 to 6) | Responsive (grade 0 to 3)

		Baseline*(n=6) Mean (SD)	Week 24 (n=6) Mean (SD)	Difference (SD)	P-value
Primary Endpoint	PGA	4.7 (0.8)	2.7 (1.9)	-2.0 (1.9)	0.098[2]
Secondary Endpoints	PASI	35.3 (11.1)	13.2 (15.8)	-22.2 (12.9)	**0.031[1]**
	NRS-Itch	8.0 (1.3)	4.8 (3.4)	-3.2 (2.9)	0.098[2]
	BSA	89.4 (8.2)	37.9 (35.1)	-51.5 (36.1)	0.063[1]
	Head	8.8 (0.3)	4.2 (4.1)	-4.7 (4.1)	0.106[2]
	Upper Limbs	16.8 (1.3)	7.7 (7.4)	-9.1 (8.1)	0.106[2]
	Trunk	29.7 (4.9)	14.0 (13.0)	-15.6 (14.4)	0.106[2]
	Lower Limbs	34.2 (2.5)	12.0 (13.6)	-22.2 (12.3)	0.059[2]
	Skindex-16	83.2 (6.9)	47.0 (25.5)	-36.2 (29.4)	0.063[1]
	DLQI	21.3 (9.2)	8.7 (6.2)	-12.7 (10.0)	0.063[1]

1. Wilcoxon signed rank exact test. 2. Wilcoxon signed rank test with continuity correction

** PGA baseline assessed at Week 4*

A un nuevo nivel de conocimiento científico

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