AAD **ANNUAL** MEETING

AEDV highlights

SAN DIEGO

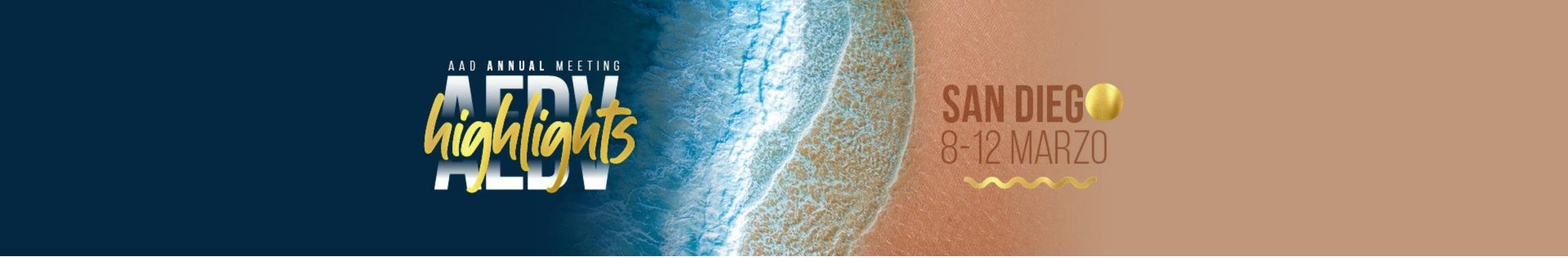
8-12 MARZO

ACADEMIA ESPAÑOLA
DE DERMATOLOGÍA
Y VENEREOLOGÍA

HIDRADENITIS SUPURATIVA

Aina Vila Payeras.
Dermatología, Hospital de Manacor (Islas Baleares)

ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA



NO TENGO CONFLICTOS DE INTERÉS

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HIDRADENITIS SUPURATIVA

- Índice de la presentación:
  - GENERALIDADES
  - HS EN ADULTOS
  - HS EN POBL. PEDIÁTRICA (pedHS)
  - CONCLUSIONES

- HS en el AAD 2024 San Diego: 7 sesiones. 20 Epósters

GENERALIDADES

PATOGENIA HS

- Unidad folicular→ site of earliest disease alterations
- Claves en patogenia:
  - Disfunción epitelial
  - Inflamación
  - Alteración inmunológica:
    - ↑ Citoquinas pro-inflamatorias (TNFalfa, IL17, IL12, IL23, IL36, IL1beta) y anti-inflamatorias como la IL-10.
    - Múltiples células: inmunes, estromales, queratinocitos, cels T, neutrófilos…
  - Factores genéticos (aprox 30% casos familiares)
  - Factores ambientales

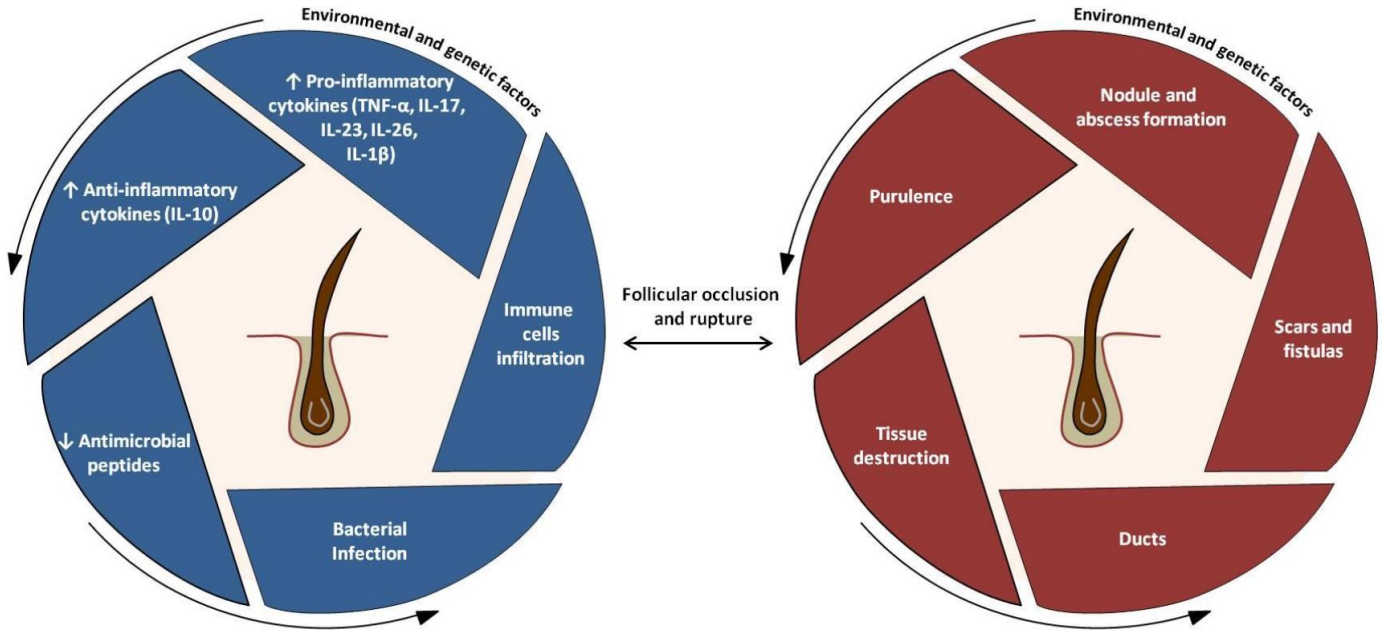


Figure 3. Pathophysiology of HS: a schematic overview.

PATOGENIA HS

Citoquinas implicadas:

Table 1. Cytokines associated with hidradenitis suppurativa and the reaction they induced.

Cytokine	Receptor	Activated Pathway	Induced Reaction
TNF-α	TNFR1 TNFR2	NFκB, MAPKS, Caspase8, MLKL NFκB, MAPKS, AKT	Cytotoxic and proinflammation Cell activation, migration, proliferation
IL-17	IL-17R A, C, D	NFκB MEK5	Inflammation Keratinocyte proliferation
IL-1β	IL-1R1 Co-receptor: IL-1RAcP	NFκB, JNK, p38 MAPK	Naïve T-cell and CD4+ memory T-cell expansion Keratinocyte proliferation
IL-12	IL-12R (IL-12Rβ1 + IL-12Rβ2)	TYK2, STAT4	Th1 proliferation and TFN-γ production
IL-23	IL-12Rβ1 + IL-23Rα	JAK, RTK, STAT, ROR-γt	Th17 release IL-17

MICROBIOLOGIA HS

- Aprox. 42-50% cultivos negativos
- Microbiología en HS:
  - Aumento de *Porphyromonas, Prevotella y Peptoniphilus*
  - Disminución de especies comensales como *Cutibacterium, Estafilococos CN*
- Posible aumento de Anaerobios en lesiones profundas, en ocasiones resistentes a ATB habituales.
- Concepto de ”HS AUTOINFECCIOSA”→disregulación inmune cutánea desencadenada por el propio microbioma del huésped.

MICROBIOLOGÍA HS

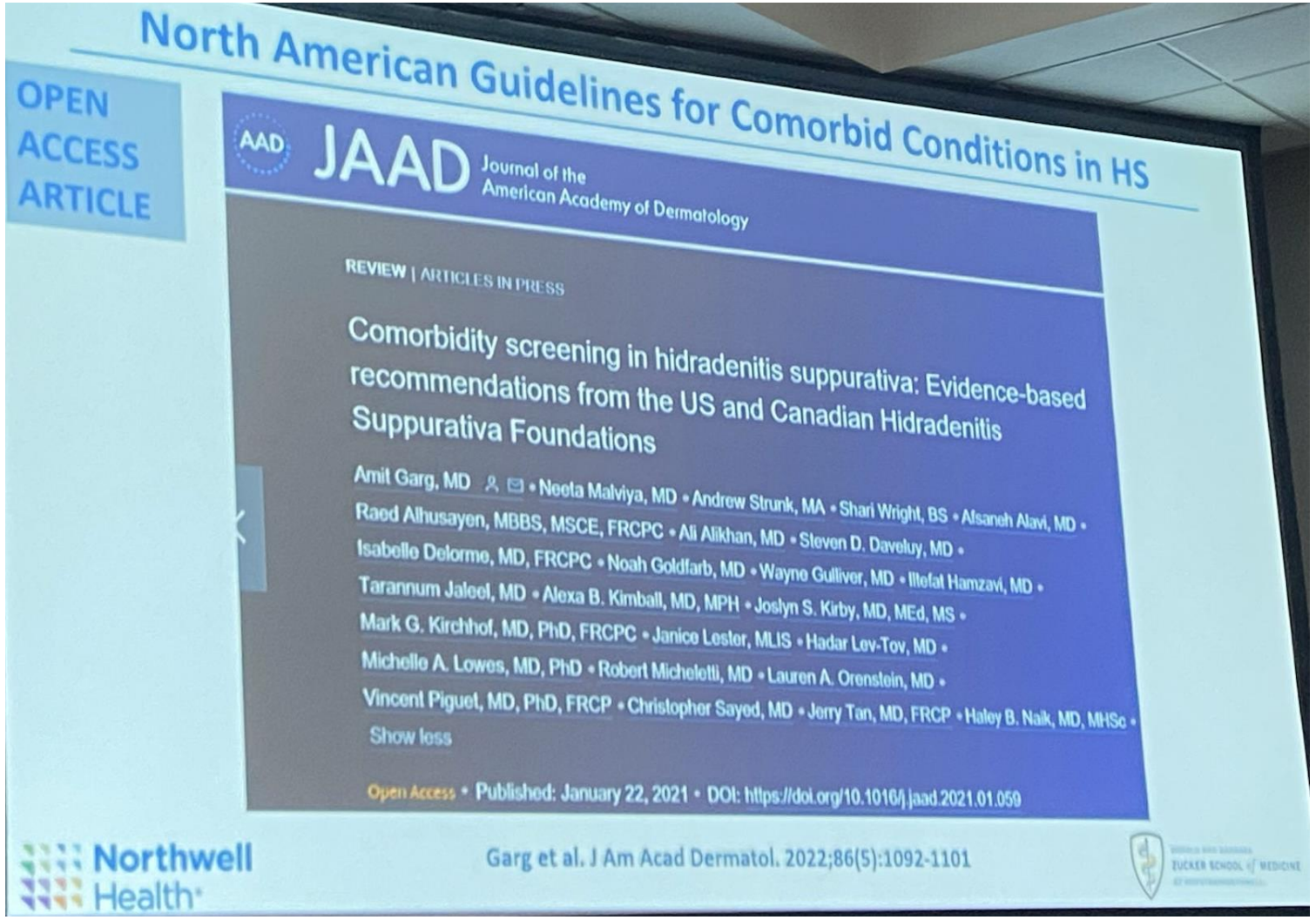
Causal relationship between gut microbiota and hidradenitis suppurativa: a two-sample Mendelian randomization study

Chengling Liu[1†], Xingchen Liu[2†] and Xin Li[1*]

[1]Center of Burns and Plastic Surgery and Dermatology, The 924th Hospital of Joint Logistics Support Force of the PLA, Guilin, China, [2]Department of Pathology, Changhai Hospital, Naval Medical University, Shanghai, China

- Relación entre composición de la microbiota Intestinal e HS.
- *Clostridium innocuum* group and *Lachnospira* → **anti-protective effect**
- *Family XI* and Porphyromonadaceae→ **protective effect**
- HS enfermedad multifactoral, considerar también género, edad, genética, epigenética, entorno, dieta…
- Faltan estudios para establecer conclusiones

COMORBILIDADES HS



- COMORBILIDADES

→*Comorbidity screening in hidradenitis suppurativa: Evidence-based recommendations from the US and Canadian Hidradenitis Suppurativa Foundations (Garg et al)*

→J Am Acad Dermatol. 2022 May; 86(5): 1092–1101.

HS EN ADULTOS

(tratamiento): biológicos, pequeñas moléculas, antibióticos, hormonales, cirugía y otros

ANTIBIÓTICOS, TRATAMIENTO HORMONAL y DIETA

ANTIBIÓTICOS Y TRATAMIENTO METABÓLICO

- Antibióticos:
  - Doxicilina 100mg BID o Minociclina 100mg BID x 12 sem
  - Clindamicina 300mg BID ± Rifampicina 300mg BID x 12 sem
    - Equivalente respuesta HiSCR y reducción inflamación
    - Clindamicina monotx mayor reducción ”draining tunnels"
  - Otros ATB: Amoxicilina-clavulánico, Cefalexina, Septrin, Cefdinir.
  - Combinación casos graves:
    - **Rifampicina** 300mg BID + **moxifloxacino** 400mg/d + **metronidazol** 500mg BID x 12 sem (Metronidazol solo durante las 1as 6 semanas).
  - ERTAPENEM 1g/diario EV durante 6-12 sem en casos refractarios: ”puente” hasta tto definitivo (Cirugía/tto médico).
- Tratamiento “metabólico”:
  - Mujeres: espironolactona 50-200mg/d, ACOs
  - Hombres: Finasteride 5mg/D
  - Ambos: Metformina 500-1500mg/d (obesos, preDM o DM), ¿agonistas GLP-1?

ANTICONCEPTIVOS EN HS

Hormonal Birth Control:

- Progesterone only birth control can worsen HS
- Speak with your primary care doctor or OB/GYN about changing to a different form of birth control if you are on one of these medications. **These can be BAD for HS**:
  - Depo Provera shot, Nexplanon implant
  - **Progestin IUD** (Mirena, Skyla)
  - Progestin only pill **(norgestimate, norethindrone, levonorgestrel)**, Jolivette, Micronor.

  Most oral contraceptive pills (OCPs) are combination estrogen-progesterone, and they can be evaluated for their androgenicity, which is related to the progesterone component. High androgen OCPs can worsen HS.
- **Low androgen OCPs (typically GOOD for HS):**
  - **Ethinyl estradiol +drospirenone** (Yasmin, Yaz)
  - **Ethinyl estradiol +desogestrel** (Apri, Mircette, Desogen, Reclipsen, Kariva)
  - **Ethinyl estradiol +norgestimate** (Ortho Tri-Cyclen, Estarylla, Trinessa)
  - **Ethinyl estradiol + norethindrone** (Estrostep)

- EVITAR anticonceptivos que solo lleven progesterona
- ACOs combinados se clasifican según su "androgenicidad" que depende del progestágeno→ HS de elección los de "anti-androgénicos".

DIETA y HS

Diet:

- No specific diet has been shown to cure HS and further research is needed on how food choices affect the condition.
- There is no evidence for improvement with the paleo diet, avoidance of nightshades, vitamin supplementation, or turmeric supplementation.
- Limited evidence suggests that certain steps might be helpful:
  - **Eliminating dairy products**: Milk, cheese and other dairy products can raise insulin levels. This leads to the overproduction of hormones called androgens, which play a role in HS.
  - **Eating less sugar**: When combined with moderate exercise, limiting foods with added sugars and syrups, such as sodas, cereals and candy, might reduce your insulin levels and ease the symptoms of HS.
  - **Avoid whey protein** (powders, bars, protein shakes): If you desire protein supplementation, use soy

RECOMENDADOS: Dieta Mediterránea (fruta, verdura, carne blanca, pescado cereales)

→ ***Suplementos de Zinc:***

- Zinc inhibe la quimiotaxis de neutrófilos, modula TNF, IL6 y la producción de MMP
- Opciones:
  - Suplementos de Gluconato de Zinc 100-200mg/d
  - Gluconato de Zinc 90mg + Nicotinamida 30mg/d

TRATAMIENTOS BIOLÓGICOS

TRATAMIENTO BIOLÓGICO HS

- Desde 2015 único biológico aprobado **ADALIMUMAB (adultos y adolescentes >12ª)**
- JUNIO 2023 EMA→ aprobación **SECUKINUMAB** para el tto de la HS moderada/grave en ADULTOS (SUNRISE/SUNSHINE)*

Kimball, 2023	Randomized, placebo-controlled, double-blind phase 3 trials N = 541	– Significantly more patients in the secukinumab every 2 weeks group ($p = 0.015$) and the secukinumab every 4 weeks group ($p = 0.0022$) had a clinical response in the SUNRISE trial. – Significantly more patients in the secukinumab every 2 weeks group had a clinical response compared with the placebo group ($p = 0.0070$) in the SUNSHINE trial.

- **BIMEKIZUMAB**→ ¿próximo?→ datos de eficacia y seguridad presentados en AAD 2023 Nueva Orleans (BE HEARD I/II) (Kimball AB, Zouboulis CC, Sayed C, et al. Bimekizumab in patients with moderate-to-severe hidradenitis suppurativa: 48- week efficacy and safety from BE HEARD I & II, two phase 3, randomized, double-blind, placebo controlled, multicenter studies. Late-Breaking Platform Presentation at the 2023 Amer- ican Academy of Dermatology Annual Meeting

Fernandez-Crehuet P, Haselgruber S, Padial-Gomez A, Vasquez-Chinchay F, Fernandez-Ballesteros MD, López- Riquelme I, et al. Short-term effectiveness, safety, and potential predictors of response of secukinumab in patients with severe hidradenitis suppurativa refractory to biologic therapy: a multicenter observational retro- spective study. Dermatol Ther (Heidelb). 2023;13:1029-38, http://dx.doi.org/10.1007/s13555-023-00906-2.

TRATAMIENTO BIOLÓGICO HS

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	ADALIMUMAB	SECUKINUMAB
PHASE III Trials	PIONEER I and II 2016	SUNRISE/SUNSHINE 2023
Dosing	160 mg once then 80 the[illegible] weekly; Some pts w[illegible] increase to 80 weekly (not FDA approved)	300 mg weekly for 5 weeks followed by monthly OR every 2 weeks thereafter
ENDPOINT	12 weeks;	16 weeks;
OUTCOME	41%/58% of pts achieved HISCR at 12 weeks (All biologic naïve)	42/45% of pts achieved HISCR at 1[illegible] weeks (Not biologic naïve)

NOT HEAD TO HEAD

	ADALIMUMAB	SECUKINUMAB
Contraindications	**Absolute:** - Congestive Heart Failure - Demyelinating disorders **Relative:** Malignancy in past 5 yrs; SLE	**Relative:** - Inflammatory Bowel Disease (some pts with well controlled IBD were included in trials) - Recurrent Oropharyngeal Candidiasis
Comorbidities	**RA*; Uveitis*; IBD*** Seronegative spondyloarthropathy PSA/PSO	Seronegative spondyloarthropathy PSA/PSO
Speed of onset	Primary endpoint in PIONEER Trials was 12 weeks;	Primary endpoint in SUNRISE/SUNSHINE Trials was 16 weeks; → improvement to 52 weeks
Drug survival	IBD data suggests 20% per pt/year development of ADAs	SUNRISE/SUNSHINE Trials demonstrated minimal ADA development
Side Effects	**Immunosuppression; infection; paradoxical rashes**	**Mucocutaneous candidiasis (thrush primarily); New onset IBD (rare); Paradoxical rashes**
Pediatric considerations	**Approved for children >12 yo for HS** Approved for children >2 for JIA	**Only approved for adults** Approved for PSA in >2

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Sekukinumab (Cosentyx) (*IL-17A*):

- Two phase 3 studies (SUNRISE, SUNSHINE) demonstrated more treated patients (~44%) achieving $HiSCR_{50}$, compared to placebo (29%), at **week 16**, with sustained response to week 52

NOW FDA-APPROVED

Bimekizumab (*IL-17A and IL-17F*):

- In phase 3 trials (BE HEARD I and II), ~56% of treated patients achieved $HiSCR_{50}$ at **week 16**, compared with 33% on placebo
- ~35% achieved $HiSCR_{75}$, compared to 15% with placebo
- At week 48, ~80% maintained $HiSCR_{50}$ and 55% $HiSCR_{75}$

Lancet. 2023 Mar 4;401(10378):747-761.
JAMA Dermatol. 2021 Nov 1;157(11):1279-1288.
J Eur Acad Dermatol Venereol. 2021 Jul;35(7):e441-e442.
J Eur Acad Dermatol Venereol. 2020 Nov;34(11):e750-e751.

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Guselkumab (Tremfya) (*IL-23*): non-significant Phase 2 RCT

Risankizumab (Skyrizi) (*IL-23*): non-significant Phase 2 RCT

Vilobelimab (intravenous) (*C5a*): non-significant Phase 2 RCT

Avacopan (oral) (*C5a*): Phase 2 study, significant difference for Hurley III but not Hurley II patients, compared with placebo

Apremilast (Otezla) (*PDE-4*): small (20 patient) RCT showed efficacy for Hurley II versus placebo

- Mixed results for these agents; may be some patients or some situations where these agents are a good fit

J Am Acad Dermatol. 2019 Jan;80(1):80-88.

Clin Cosmet Investig Dermatol. 2023 Sep 18;16:2525-2536.

Results of Phase II AURORA Clinical Trial of Avacopan for HS

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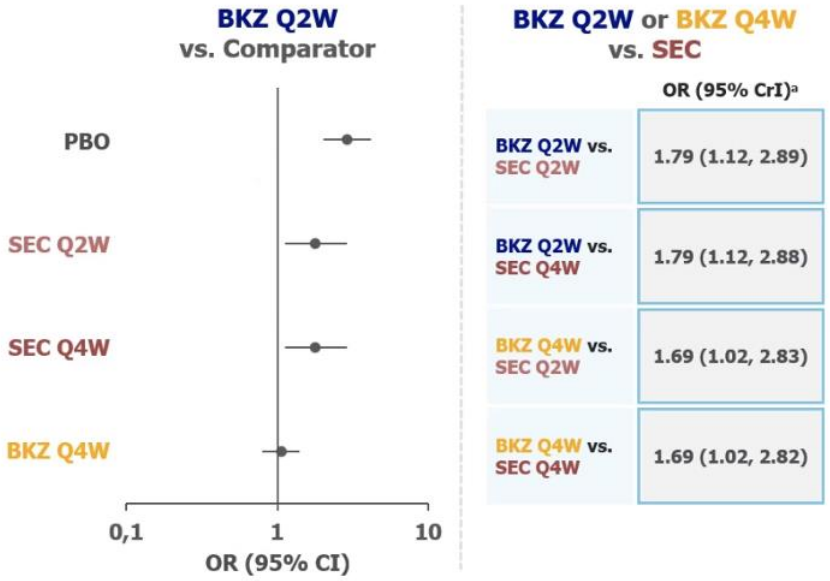
TRATAMIENTO BIOLÓGICO HS

Bimekizumab vs secukinumab: matching-adjusted indirect comparison (MAIC)

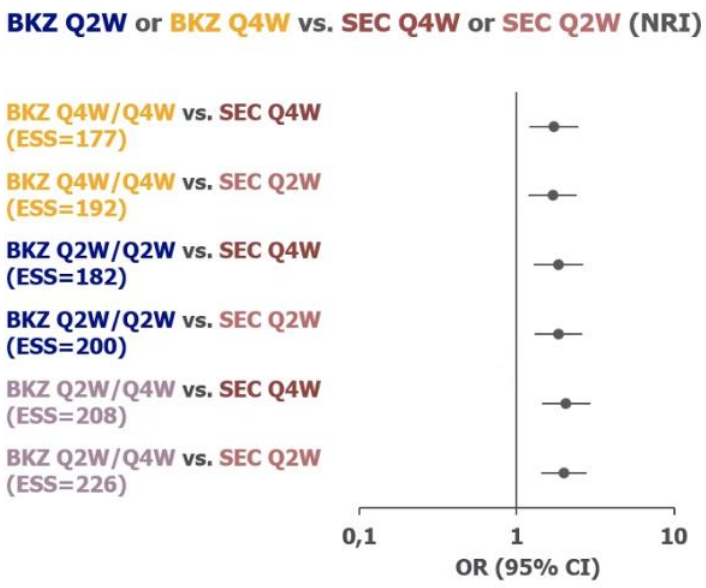
BKZ vs SEC: HiSCR50 week 16



BKZ Q2W or BKZ Q4W vs. SEC	OR (95% CrI)[a]
BKZ Q2W vs. SEC Q2W	1.79 (1.12, 2.89)
BKZ Q2W vs. SEC Q4W	1.79 (1.12, 2.88)
BKZ Q4W vs. SEC Q2W	1.69 (1.02, 2.83)
BKZ Q4W vs. SEC Q4W	1.69 (1.02, 2.82)

BKZ Q2W and Q4W showed **higher HiSCR50 responses** when indirectly compared with SEC.

BKZ vs SEC: HiSCR50 1 year

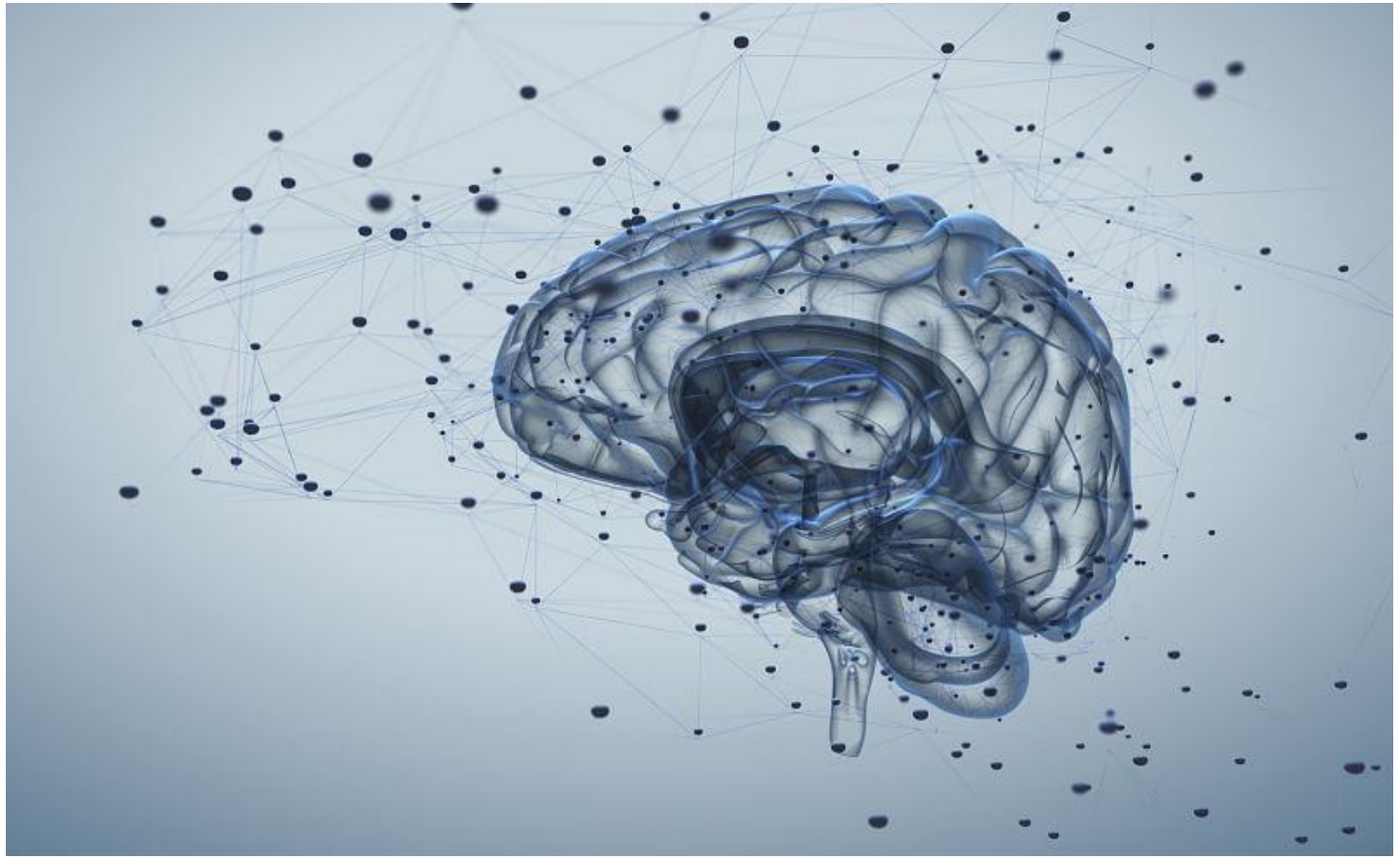


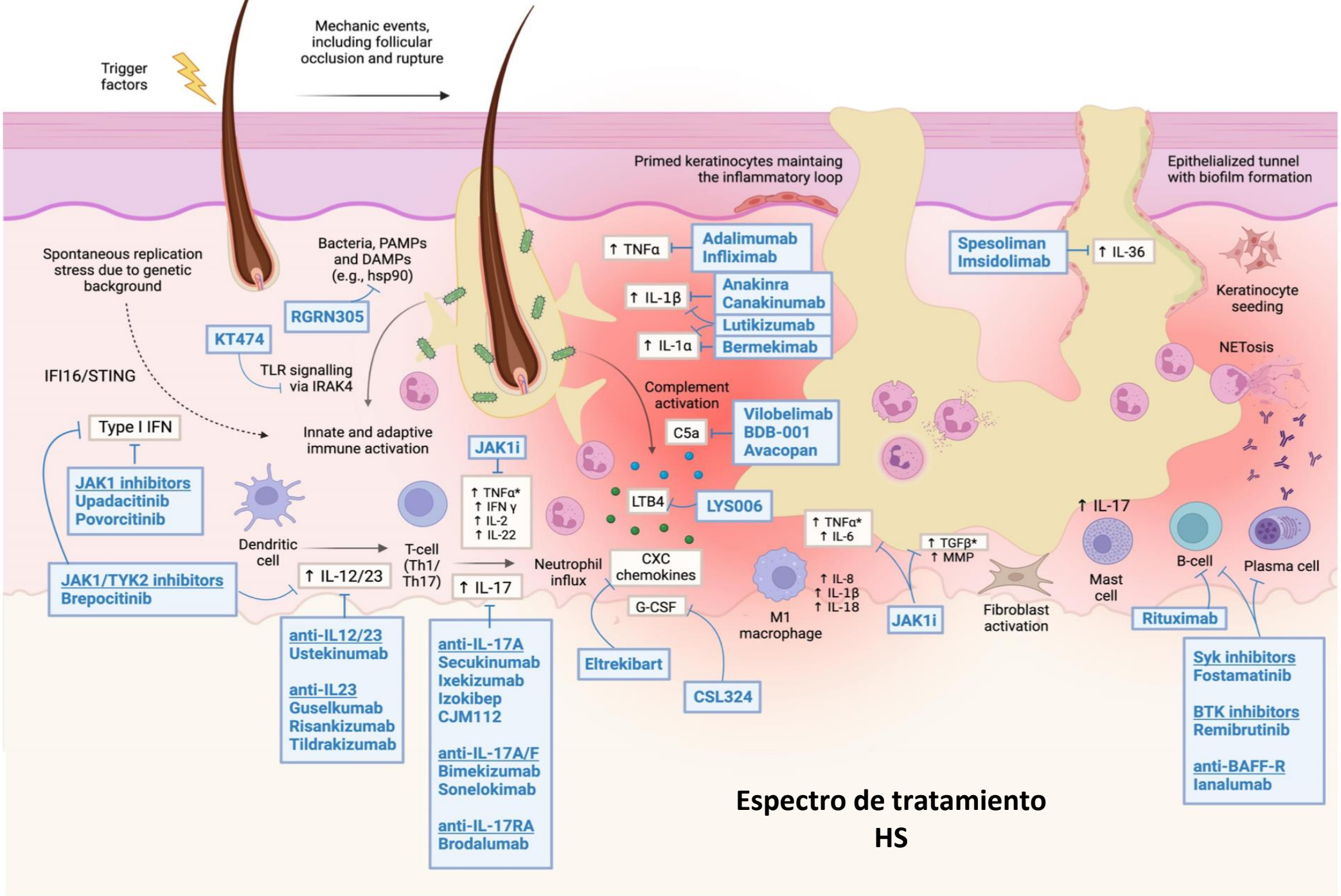
BKZ demonstrated **higher HiSCR50 responses** when compared with SEC in the MAIC analysis.

Bimekizumab demostró superioridad vs secukinumab en la respuesta HiSCR50, tanto en semana 16 como al año de tratamiento, independientemente de la pauta posológica utilizada.

TRATAMIENTO BIOLÓGICO HS

- El futuro en el tratamiento de la HS…





Espectro de tratamiento HS

TRATAMIENTO HS

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Table 1. Biologics and small molecules currently under investigation for the treatment of hidradenitis suppurativa.

Biologics	NCT identifier	Mechanism	Current phase of development	Notes (e.g., signals of effectiveness/safety)	Approved/ commerciall y available (e.g., for other indications)	References
CJM112	NCT02421172	Anti-IL-17A IgG1/κ mAb	Pre-clinical and phase II proof-of-concept completed	Higher HS-PGA but no difference in HiSCR at week 16	No	28
Izokibep (ABY 035)	NCT05355805 NCT05905783	Small therapeutic protein inhibitor of IL-17A	Double-blind, placebo-controlled Part B of the Phase 2b/3 trial ongoing	Izokibep 160 mg sc weekly in the open label Part A of the Phase 2b/3 program (30 participants) resulted in the following response rates at week 12: 71% HiSCR50, 57% HiSCR75, 38% HiSCR90 and 33% HiSCR100	No	29,30
Sonelokimab (M1095)	NCT05322473	Anti-IL-17 A/F nanobody	Phase 2 ongoing	The phase 2 trial met its primary endpoint with a significantly greater proportion of patients treated with both sonelokimab 120mg and 240mg achieving HiSCR75 compared to those on placebo at week 12	No	31
Bimekizumab	NCT04901195 NCT04242446 NCT04242498	Anti-IL-17A/F	Phase 3 open-label, parallel group extension	Active, not recruiting	Yes	32-34
Secukinumab	NCT04179175	Anti-IL-17A	Phase 3 randomized, triple-blind	Recruiting	Yes	35
Vilobelimab	NCT03487276	Anti-C5a	Phase 2 completed, failed but re-examined. Phase 3 initiated but currently on hold.	HiSCR50 at week12: IFX-1 800 mg once every 4 weeks, 51.5%; IFX-1 1,200 mg once every 2 weeks, 45.5%; IFX-1 400 mg one every 4 weeks, 40.0%; IFX-1 800 mg once every 2 weeks, 38.7%; placebo, 47.1%	Yes	36
BDB-001	NCT05103423 NCT05093855	Anti-C5a	Phase 2 ongoing	NA	No	37,38
Spesolimab	NCT04762277 NCT05819398 NCT04876391	Anti-IL-36R	Phase 2b/Phase 3 ongoing.	NCT04762277: Change from baseline in AN count at week 12: spesolimab 1,200 mg once every two weeks, –38.8%; placebo, –34.7%		39-41
Bermekimab (MABp1)	NCT04019041 NCT04988308	Anti-IL-1α	Phase 2 completed.	NCT04988308: Uselessness criteria met.	No	42,43
Lutikizumab (ABT-981)	NCT05139602	Anti-IL-1α/β	Phase 2	Recruiting	No	44
SAR442970	NCT05849922	Anti-TNFα /OX-40L nanobody	Proof-of-concept study	Recruiting	No	45

Infliximab biosimilar	NCT05663268	Anti-TNFα/infliximab biosimilar	Phase 1 open-label	Active, not recruiting	Yes	46
Eltrekibart (LY3041658)	NCT04493502	Neutralizing pan-ELR$^+$CXC chemokine monoclonal antibody	Phase 2 completed	In the phase 2 trial (67 patients, mean age, 36.8 years; age range, 18-65 years; 70% women) eltrekibart 600 mg iv every 2 weeks led to a statistically higher HiSCR response rate at week 16 than placebo (65.6% vs 41.4%)	No	47
Anumigilimab (CSL324)	NCT03972280	Anti-G-CSFR	Open-label, 2-regimen, Repeat-dose Study completed	NA	No	48
Iscalimab (CFZ533)	NCT03827798	Anti-CD40	Phase 2	Recruiting	No	49
MAS825	NCT03827798	Bispecific mAb against IL-1β and IL-18	Phase 2	Recruiting	No	49
Ianalumab (VAY736)	NCT03827798	Anti-BAFF-R	Phase 2	Rectuiting	No	49
PTM-001	NCT05020730	Anti-P2X7R	Phase 2 randomized, double-blind, placebo-controlled	Recruiting	No	50
Small molecules						
Povorcitinib	NCT05620823	JAK1 inhibitor	Phase 3 randomized, double-blind, placebo-controlled	Recruiting	No	196
Upadacitinib	NCT04430855	JAK1 inhibitor	Phase 2 randomized, double-blind, placebo-controlled completed	38.3% achieved HiSCR in treatment group and 23.8% in placebo group at week 12	Yes	197
Brepocitinib (PF 06700841)	NCT04092452	TYK2/JAK1 inhibitor	Phase 2 randomized, double-blind, placebo-controlled completed	HiSCR50 at week16: brepocitinib 45 mg once a day, 51.9%; placebo, 33.3%	No	204
Tofacitinib	NCT04246372	JAK1-3 inhibitor	Phase 2 open-label	Recruiting	Yes	213
Fostamatinib	NCT05040698	SYK inhibitor	Phase 2 exploratory, proof-of-concept completed	NA	Yes	214
LYS006	NCT03827798	LTA4H inhibitor	Phase 2 randomized, double-blind, placebo-controlled	Recruiting	No	49
Remibrutinib (LOU064)	NCT03827798	BTK inhibitor	Phase 2 randomized, double-blind, placebo-controlled	Recruiting	No	49
KT-474	NCT04772885	IRAK4 degrader	Phase 1 randomized, placebo-controlled completed	NA	No	215
Orismilast	NCT04982432	PDE-4 inhibitor	Phase 2 open-label	Clinically relevant improvements announced in HS for patients who completed the planned 16 weeks	No	216
RGRN-305	NCT05286567	HSP90 inhibitor	Phase 1 randomized, double-blind, placebo-controlled completed	NA	No	217

PEQUEÑAS MOLÉCULAS

Pequeñas moléculas en HS

- **JAAD 2024**
- **Povorcitinib (fase 2): INH SELECTIVO JAK 1 oral.**
- Datos de eficacia ya presentados en AAD 2023
- Datos a 52 semanas:
  - HiSCR50 59.3-66.7%
  - HiSCR100 22.2-29.4%
- 15, 45, 75mg o placebo durante 16 semanas
- Objetivo: Eficacia y seguridad semana 16.
- Conclusión: **Povorcitinib demonstrated efficacy in HS, with no evidence of increased incidence of adverse events among doses.**

Efficacy and safety of the oral Janus kinase 1 inhibitor povorcitinib (INCB054707) in patients with hidradenitis suppurativa in a phase 2, randomized, double-blind, dose-ranging, placebo-controlled study

Joslyn S. Kirby, MD, MS, MEd,[a] Martin M. Okun, MD, PhD,[b] Afsaneh Alavi, MD,[c] Falk G. Bechara, MD,[d] Christos C. Zouboulis, MD, PhD,[e] Kurt Brown, MD,[f] Leandro L. Santos, MS,[f] Annie Wang, PhD,[f] Kristen B. Bibeau, PhD, MSPH,[f] Alexa B. Kimball, MD,[g] and Martina L. Porter, MD[g]

INHIBIDORES JAK EN HS

Povorcitinib

- Phase 2 RCT with ~45% achieving HiSCR50 at week 16 versus ~29% of those receiving placebo
- Extension to 52 weeks → ~29% of patients meeting HiSCR100

Upadacitinib

- Retrospective cohort study of 20 patients showed high rates of HiSCR50 (100%) and HiSCR75 (95%) at week 12

Tofacitinib

- Case reports showing efficacy

➢ There is excitement about these drugs but limited access to them for HS at this time

JAK inhibitors: requirement for higher doses in HS due to increased inflammatory burden limit the therapeutic window of small molecules

JAAD Case Rep. 2020 Jan 20;6(2):99-102.
J Am Acad Dermatol. 2024 Mar;90(3):521-529.
J Am Acad Dermatol. 2022 Dec;87(6):1440-1442.

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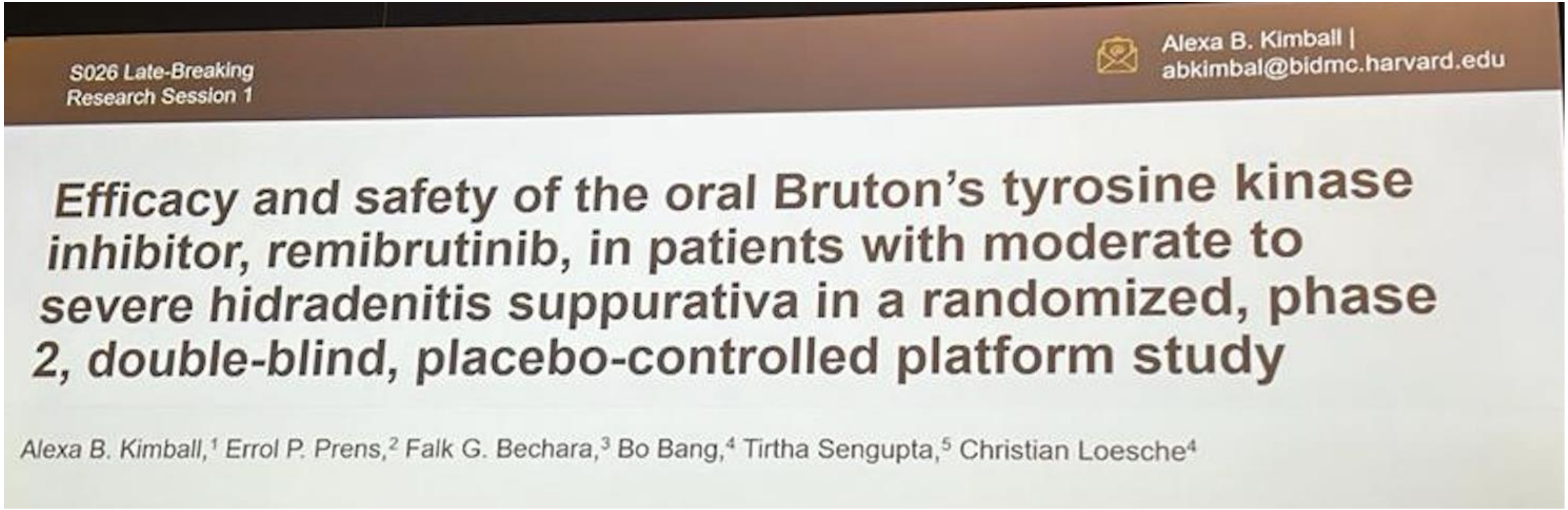
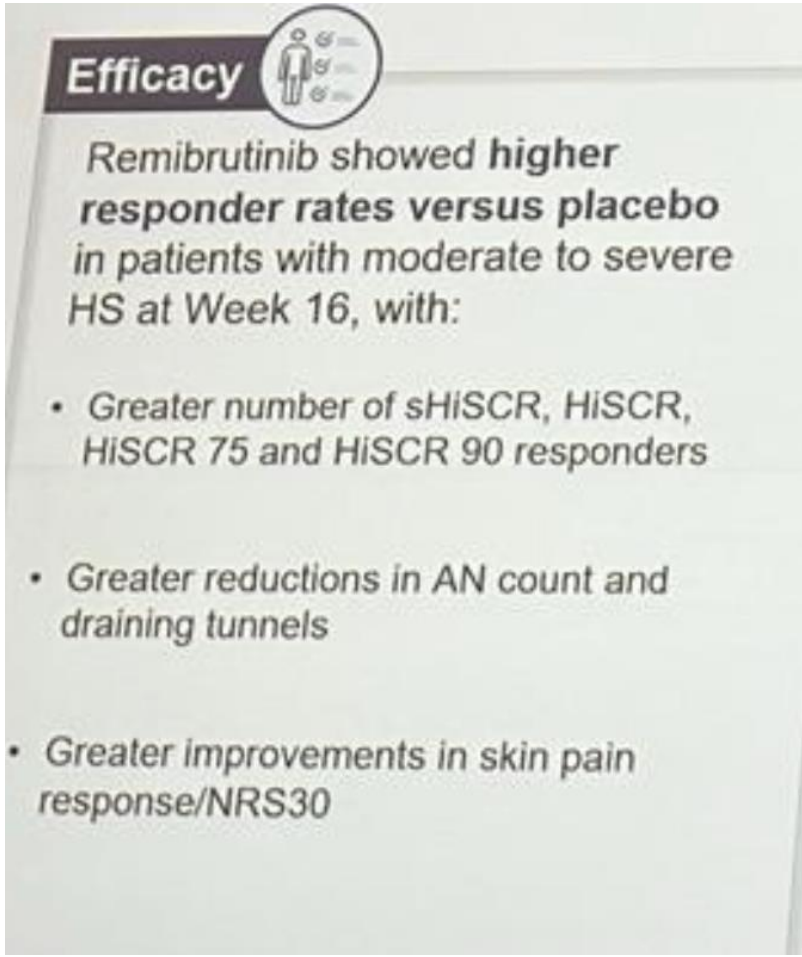
REMIBRUTINIB EN HS



Efficacy and safety of the oral BrutonÂ's tyrosine kinase inhibitor, remibrutinib, in patients with moderate to severe hidradenitis suppurativa in a randomized, phase 2, double-blind, placebo-controlled platform study/ Alexandra Boer Kimball, MD, MPH, FAAD

- **Introduction: Remibrutinib, oral BrutonÂ's tyrosine kinase inhibitor**
- **Results:** Patients treated with remibrutinib reported greater sHiSCR at week 16 (remibrutinib 25mg, 72.7% [probability=0.999]; 100mg, 48.5% [probability=0.896]) versus placebo (34.7%), with separation between remibrutinib and placebo observed from week 2. Responder rates at week 16 were higher in remibrutinib 25mg and 100mg treatment arms versus placebo (HiSCR: 69.7%, 48.5%, versus 32.7%; HiSCR75: 42.4%, 27.3% versus 18.4%; HiSCR90: 36.4%, 15.2% versus 8.2%). Remibrutinib was well tolerated; adverse event (AE) frequencies were comparable between treatment arms, with three serious AEs reported (N=1 per arm).
- **Conclusion: Remibrutinib showed superior clinical efficacy versus placebo in patients with moderate to severe HS. BTK inhibition may emerge as a promising therapeutic intervention in HS.**



LUTIKIZUMAB EN HS

A Phase 2 Multicenter, Randomized, Double-Blind Placebo-Controlled Study to Evaluate the Safety and Efficacy of Lutikizumab in Adult Patients With Moderate to Severe Hidradenitis Suppurativa Who Have Failed Anti-TNF Therapy

Alexa B Kimball,[1] Lindsay Ackerman,[2] Hermenio Lima,[3] Tianyu Zhan,[4] Leonidas Drogaris,[4] Ronea Chambers,[4] Mona Akbari,[4] David Williams,[4] Falk G Bechara[5]

[1]Harvard Medical School and Clinical Laboratory for Epidemiology and Applied Research in Skin, Department of Dermatology, Beth Israel Deaconess Medical Center, Boston, MA, USA; [2]Medical Dermatology Specialists, Phoenix, AZ, USA; [3]LEADER Research, Director and Associate Professor, McMaster University, Medicine Department Div. of Clinical Immunology and Allergy & Div. of Dermatology Hamilton, ON, Canada; [4]AbbVie Inc., North Chicago, Illinois, United States; [5]Department of Dermatology, Venereology and Allergology, International Centre for Hidradenitis Suppurativa/Acne Inversa (ICH), Ruhr-University Bochum, Bochum, Germany

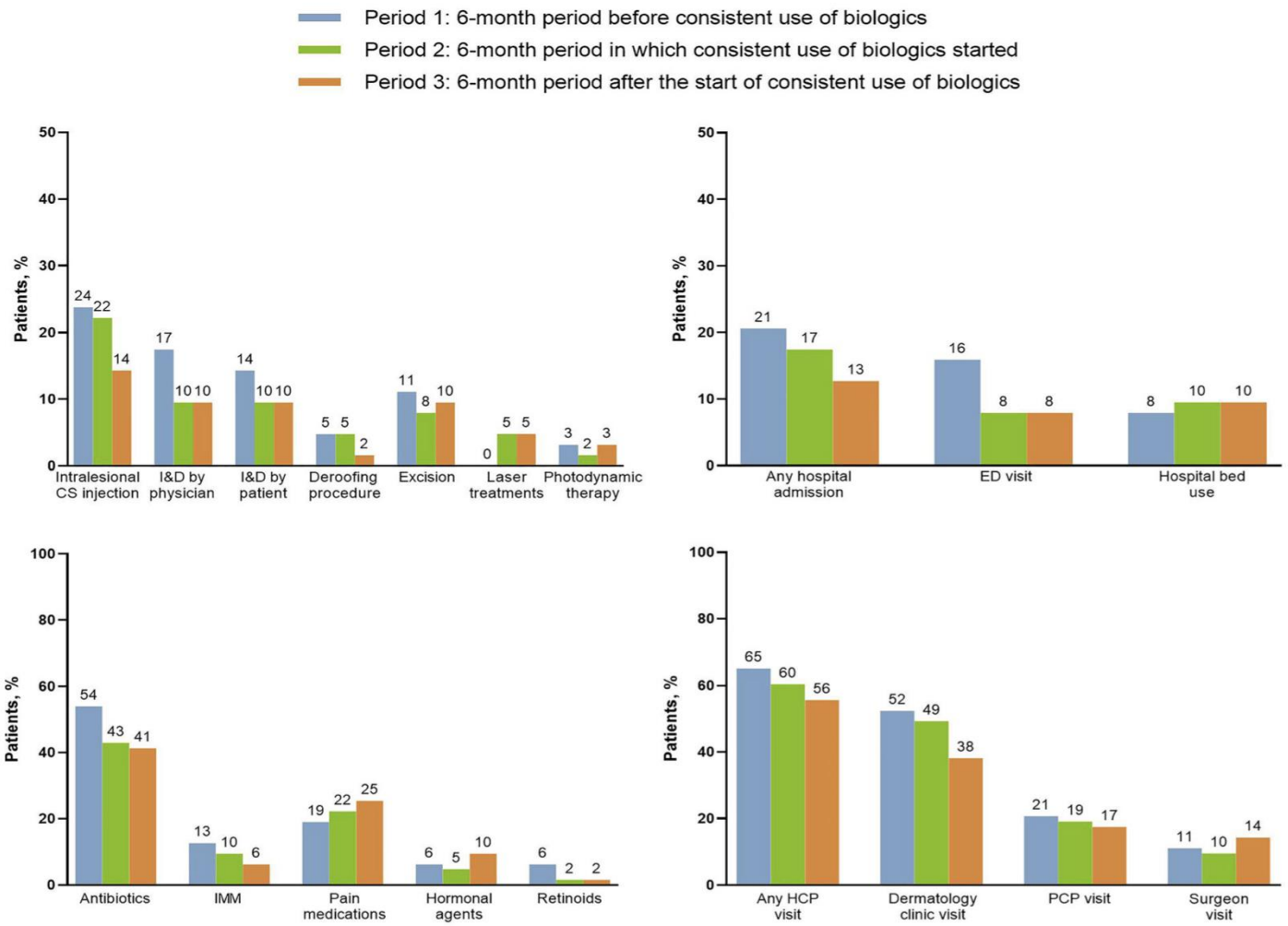
A Phase 2 Multicenter, Randomized, Double-Blind Placebo-Controlled Study to Evaluate the Safety and Efficacy of Lutikizumab in Adult Patients with Moderate to Severe Hidradenitis Suppurativa Who Have Failed Anti-TNF Therapy/Falk G. Bechara

This study evaluates lutikizumab, a dual-variable-domain interleukin (IL) 1α/1β antagonist, in adult patients with moderate to severe HS who have failed anti-TNF therapy.

- *Patients treated with lutikizumab 300 mg EOW and 300 mg EW experience higher response rates in the primary endpoint of HiSCR 50 and the secondary endpoint of skin pain NRS30 at week 16 than those treated with placebo*
- *Patients treated with lutikizumab 300 mg EOW and 300 mg EW experience higher response rates in HiSCR 75 and greater improvement in draining fistula count at week 16 than those treated with placebo*
- *All doses of lutikizumab in this small study were generally safe and well tolerated*
- *In the hard-to-treat moderate-to-severe HS patient population that has failed anti-TNF therapy, treatment with lutikizumab 300 mg EOW and 300 mg EW demonstrates higher efficacy than placebo in this phase 2 study*

Scan QR code

¿IMPLEMENTACION TEMPRANA DE BIOLÓGICOS?



Dermatol Ther (Heidelb) (2023) 13:1577–1585

Tras >12 semanas de tratamiento con biológicos reducción en:

- Tratamientos sistémicos e intralesionales
- Antibioterapia
- Procedimientos “agudos”
- Hospitalizaciones
- Visitas especialista (Dermatología, Cirugía) y servicios de urgencias

Plantea implementación de biológicos como estrategia temprana de tto en pacientes con HS moderada/grave.

CIRUGÍA DE LA HS

CIRUGÍA DE LA HS

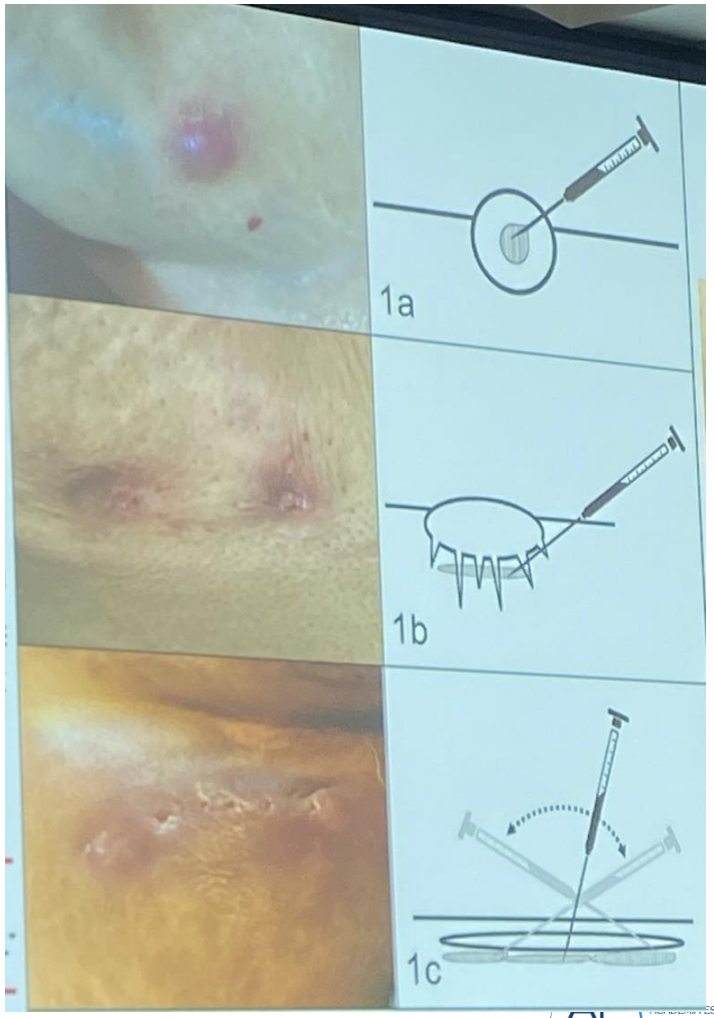
- Recomendación esperar 4-6 semanas tras el brote.
- Evitar actuar sobre lesiones muy inflamatorias.
- Preparación pre-operatoria →Pruebas de imagen →ECOGRAFÍA más usada
- Importante manejo del dolor postIQ con AINEs y reposo.
- ALERTA a complicaciones: sangrado primeras 72h!!
  - Dolor, infección, hipergranulación, neuralgia postoperatoria de la axila…

CIRUGÍA /LÁSER/ OTROS TRATAMIENTOS

1. ***Deroofing***: lesional parcial/completo, regional parcial/completo y punch
2. Escisión: completa o parcial regional/lesional
3. Láseres:
    1. "Láser Hair Removal": Nd:YAG, Alexandrita
    2. Láser fraccional ablativo: Er:YAG, CO2 láser- láser escisión, marsupialización, destrucción de túneles.
4. Inyecciones de toxina botulínica
5. Otros: "radiation-based treatments, seton placement, sclerotherapy"…

DEROOFING QUIRÚRGICO

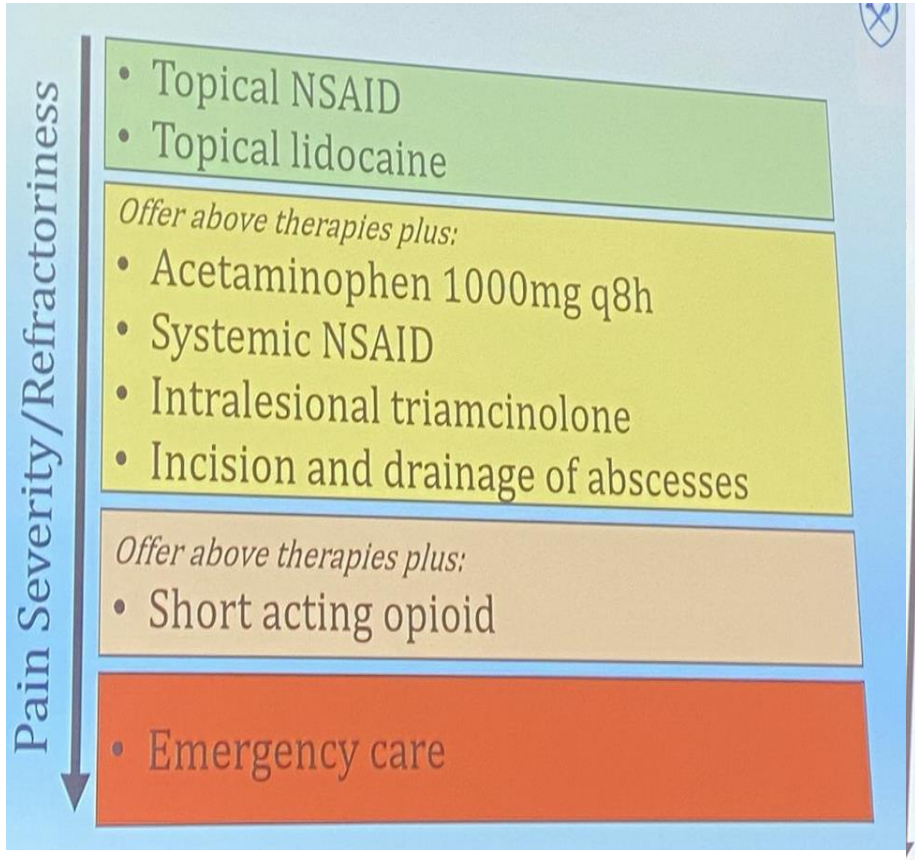
- Seleccionar al paciente actuando en:
  - Tunnel: misma lesión con rebrotes recurrentes
  - Absceso agudo, nódulo→Punch deroofing
- Puede realizarse con bisturí/tijeras, láser Co2 o electrocirugía.
- Escisión local vrs **deroofing:**
  - Recurrencia: 30 vrs **14,5%**
  - Complicaciones: 26% vrs **12,5%**
- Ravi et al.: cohorte restrospectivo con 194 deroofings:
  - 76% pacientes satisfechos
  - Media de ”missed days work/school” 2 días
  - 65% referían que el dolor durante el rebrote de HS era peor que durante la recuperación del deroofing.



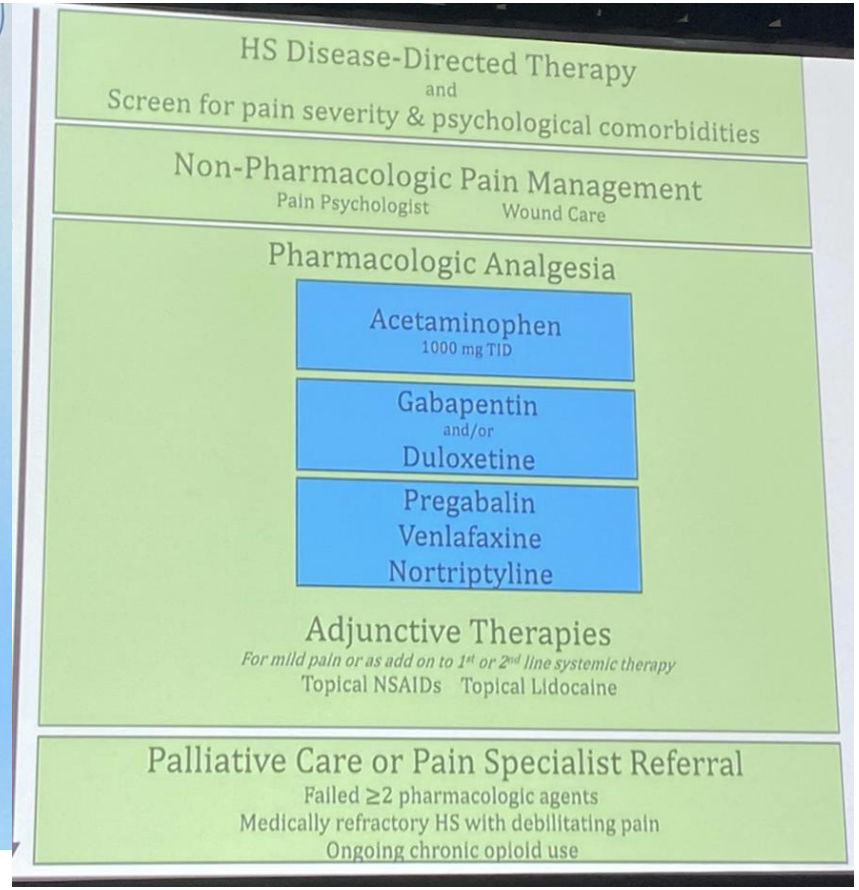
Ravi et al. JAMA Dermatol. 2022.

MANEJO DEL DOLOR

- Síntoma con mayor impacto en HS
- Nódulos inflamados/Abscesos lesión más dolorosas.
- Mecanismos de dolor:
  - Nociceptivo (40%): acute tissue injury
  - Neuropático (30%): peripheral nerve changes
  - Nociplástico*(36%): chronic systemic inflammation



Dolor agudo



Dolor crónico

Orenstein LAV, Salame N et al. Br J Dermatol. 2023;188(1):41-51.

HS en pacientes PEDIÁTRICOS (pedHS)

PED-HS: GENERALIDADES

- Epidemiología:
  - Ratio M:H 4:1.
  - Edad media: 12,5± 2.9a
  - >60% post puberal
    - Prepuberal: 7% antes de los 13ª y 2% antes de los 11 (antecedentes familiares)
  - Importante influencia hormonal: predominio en mujeres adolescentes con "premenstrual flares".
- Clínica niños similar adultos.
  - Quistes/abscesos (48%) y "tenderness/pain" (25%) sx más frecuentes.
  - Repercusión psicológica niños!!

PED-HS: COMORBILIDADES

- COMORBILIDADES→Muy frecuentes en niños: 34-93%*
  1. Metabólicas (obesidad, sd metabólico)
  2. **Psiquiátricas:** gran impacto calidad de vida (frustración, vergüenza, ansiedad, depresión…)
  3. Endocrinas (aunque asociación a pubertad precoz o adrenarquia prematura solo <5%)
     1. DM más frecuentes en pedHS
     2. SOP, Hirsutismo.
  4. Cutáneas (acné, psoriasis, pioderma gangrenoso).
  5. Síndrome de Down y otras alteraciones genéticas.
  6. Otras: EII, Síndromes PASH, PAPASH, PASS, PsAPASH

PED-HS: TRATAMIENTO

AAD ANNUAL MEETING AEDV highlights SAN DIEGO 8-12 MARZO

Efficacy of medical treatments for pediatric hidradenitis suppurativa: A systematic review

Rahul Masson BS[1] | Elaine Ma BS[1] | Neha Parvathala BS[1] | Terri Shih BS[2] | Swetha Atluri BS[3] | Marcia Hogeling MD[4] | Meagan Hughes MD[5,6] | Christopher J. Sayed MD[7] | Vivian Y. Shi MD[8] | Jennifer L. Hsiao MD[5]

- En general similar a adultos, salvo tratamientos sin indicación o contraindicados*
- ATB orales: Tetraciclinas más usado (ciclos de 12 o más semanas).
- ATB ev: casos aislados de Ertapenem ev.
- Tto hormonal: ACO, espironolactona, finasteride, metformina.
- Terapia biológica:
  - **ADALIMUMAB** único aprobado en pacientes >12años con HS moderada/severa.
  - Limitada evidencia uso biológicos en pedHS (media 15a, 54% mujeres y con comorbilidades).
- Cirugía: poca diferencia con adultos → tratamientos más conservadores, láser, TFD…

Hidradenitis Suppurativa in Pediatric Patients

Colleen H. Cotton, MD,[a,b] Stella X. Chen, MD,[c] Sadaf H. Hussain, MD,[c] Irene Lara-Corrales, MD, MSc,[d] Andrea L. Zaenglein, MD[e]

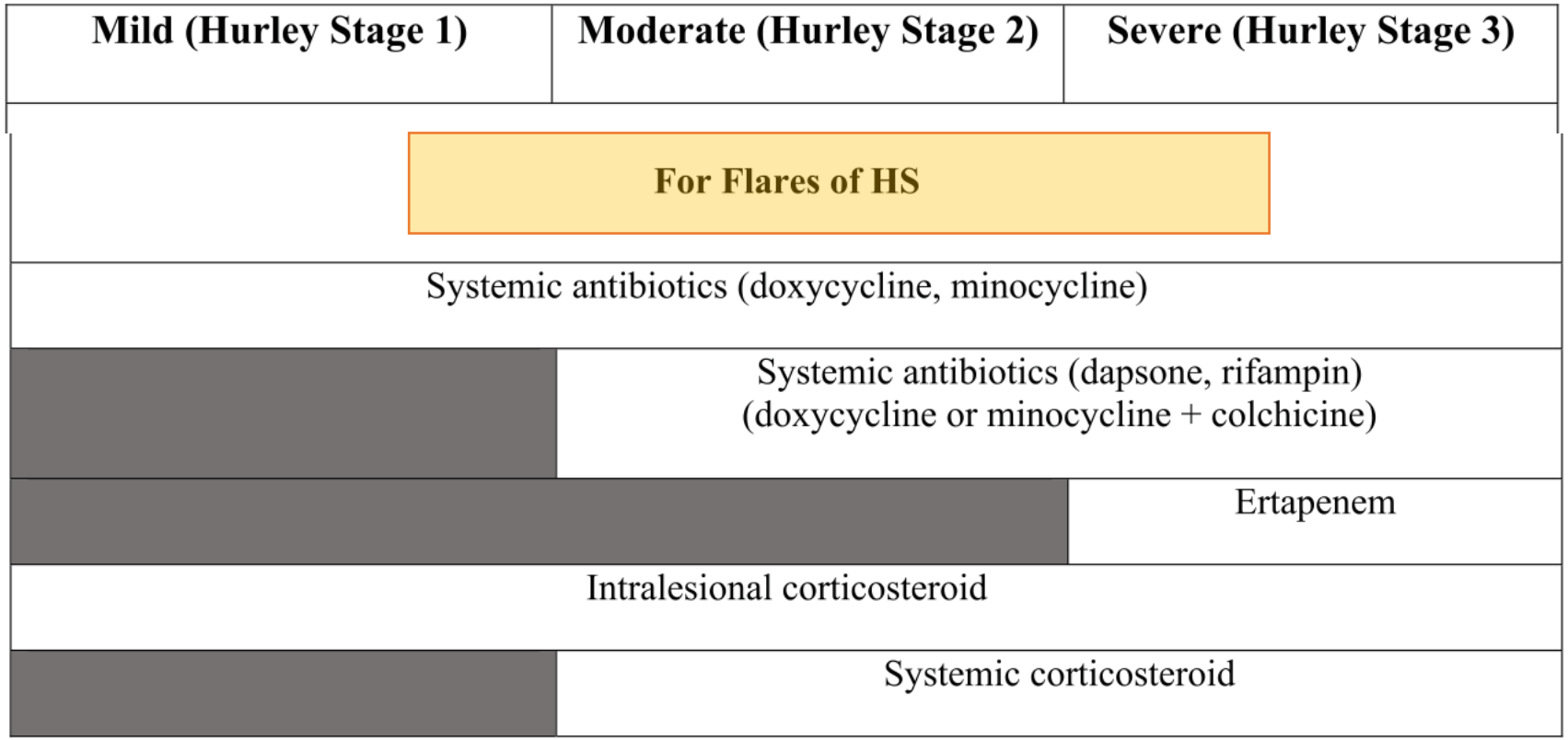
PEDIATRICS Volume 151, number 5, May 2023

PED-HS: TRATAMIENTO

Mild (Hurley Stage 1)	Moderate (Hurley Stage 2)	Severe (Hurley Stage 3)
Maintenance of HS		
Topical antimicrobials (clindamycin, benzoyl peroxide, chlorhexidine, resorcinol)		
Systemic retinoid (isotretinoin, acitretin)		
	Biologic agents (adalimumab, infliximab, other)	
Combined oral contraceptive, spironolactone (for female patients)		
	Finasteride	
	Metformin	
	Cyclosporine	
Laser hair removal Botulinum toxin A		
	Surgical deroofing, wide local excision	

PEDIATRICS Volume 151, number 5, May 2023

PED-HS: TRATAMIENTO



PEDIATRICS Volume 151, number 5, May 2023

PED-HS: TRATAMIENTO

- FUTUROS TRATAMIENTOS en pedHS:
  - Inhibidores IL17: Secukinumab, Bimekizumab, ixekizumab
  - Inhibidores IL23: Guselkumab, Risankizumab,
  - Anti IL36: Spesolisumab
  - Inh JAK: Upadacitinib, Porvorcitinib, Ruxolitinib (tópico)
  - Inh TYK2
  - Crema clascosterona 1% (tto acné asociado HS)
  - Agonistas GLP1
  - Agonistas AHR tópico: tapiranof.

CONCLUSIONES

CONCLUSIONES

AAD ANNUAL MEETING AEDV highlights SAN DIEGO 8-12 MARZO

1. Patogenia: factores genéticos, epigenéticos, microbiota (cutánea/intestinal) y disregulación inmune
2. Adalimumab (>12años) y Secukinumab (Adultos) únicos biológicos aprobados en HS
   - Próximo Bimekizumab?
3. Nuevas dianas y pequeñas moléculas en desarrollo
   - ➢ Vía JAK, TYK, inh complemento c5a, inh BTK, inh PDE…
4. Manejo de comorbilidades e impacto psicológico en HS pediátrica.
5. Futuro→ evolución a tratamiento personalizado en función del FENOTIPO (patrón genético/inmunológico) de HS?

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AAD **ANNUAL** MEETING

AEDV highlights

SAN DIEGO
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GRACIAS

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AEDV highlights

SAN DIEGO
8-12 MARZO

La Academia Española de Dermatología y Venereología expresa su agradecimiento al patrocinador UCB, por su especial apoyo y contribución con la actividad formativa Highlights 2024.

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