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Abstract N°: 5

Idiopathic orbital inflammatory disease in psoriasis: presentation of two cases treated with anti-TNF agents.

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Introduction

Idiopathic orbital inflammatory disease (IOID) is a rare condition that is often difficult to diagnose due to the nonspecific nature of its clinical, radiological, and histological findings. It occurs more frequently in adults, and its presentation varies depending on the orbital tissue involved, such as the lacrimal gland, extraocular muscles, or orbital fat. Orbital myositis typically presents with pain during ocular movements and requires urgent evaluation. Although IOID may be associated with systemic diseases, its association with psoriasis is exceptional, likely occurring within the systemic inflammatory spectrum.

Case Presentation

We present two cases of plaque psoriasis that developed IOID with a sluggish course despite conventional treatment.1) A 32-year-old male presented with ocular pain, with CT and histology consistent with orbital myositis. He showed an insufficient response to systemic and periocular corticosteroids. After failure with methotrexate, infliximab was initiated, leading to improvement in both skin and ocular conditions, but it was discontinued due to an infusion reaction. He was later switched to adalimumab, which resulted in secondary failure of the cutaneous involvement despite intensification, with ocular stability maintained.2) A 68-year-old male presented with periorbital edema, CT revealing orbital fat infiltration, and histology that was nonspecific. He was treated with periocular corticosteroid injections. Due to worsening of his skin condition, methotrexate was replaced with adalimumab, leading to significant and lasting improvement in both skin and ocular involvement.

Conclusion

IOID associated with psoriasis is uncommon and recurrent in nature. Anti-TNF agents can provide long-term control when corticosteroids are insufficient. Coordination between dermatology and ophthalmology is essential to optimize management.

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Abstract N°: 10

Time from Psoriasis Onset to Systemic Treatment Initiation and Long-Term Outcomes: A Study from the British Association of Dermatologists Biologics and Immunomodulators Register (BADBIR)

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Introduction

Prolonged time from onset to systemic treatment initiation in moderate-to-severe psoriasis may contribute to greater cumulative life-course impairment, a higher burden of comorbidities, and reduced quality of life. Earlier systemic intervention may potentially modify disease progression, improve long-term disease control, and mitigate the development of chronic comorbidities.

Materials and Methods

This is a cohort study following the target trial emulation framework. We used data from the British Association of Dermatologists Biologics and Immunomodulators Register (BADBIR) to evaluate the long-term impact of short versus prolonged disease duration before initiation of systemic therapy on disease control in patients with moderate-to-severe psoriasis. We used data from September 2007 to December 2024. Eligible participants were adults (≥18 years) with moderate-to-severe psoriasis (baseline Psoriasis Area and Severity Index [PASI] ≥10) and no prior systemic therapy at registration. In the primary analysis, short disease duration was defined as initiating systemic conventional or biologic therapy within two years of psoriasis onset, while prolonged disease duration referred to initiation after two years. Long-term PASI trajectories over 5 years were assessed using mixed-effects repeated-measures models, adjusting for baseline and time-varying covariates. The probability of complete skin clearance (PASI = 0) was estimated using Cox proportional-hazards models with stabilised Inverse Probability Weighting (IPW) to adjust for confounding. In the secondary analysis, the time from psoriasis onset to systemic treatment initiation (i.e., disease duration) was evaluated as a continuous variable using a Super Learner ensemble of 12 survival models, with performance optimised via 10-fold cross-validation. Absolute risk differences in achieving PASI 0 were calculated annually (1–20 years) relative to a 1-year disease duration reference.

Results

A total of 3,702 patients were included: 451 initiated systemic therapy within two years of onset (short disease duration) and 3,251 initiated after two years (prolonged disease duration). After one year of treatment, the predicted mean PASI was significantly lower in the short disease duration group compared with the prolonged disease duration group (4.9, 95% CI 4.0–5.8 vs. 6.4, 95% CI 6.0–6.7). During follow-up, the cumulative rate of achieving PASI 0 was 38.7% in the short disease duration cohort, compared with 33.8% in the prolonged disease

duration cohort. Short disease duration before treatment initiation was associated with a higher probability of achieving PASI 0 (Hazard ratio [HR] 1.20, 95% CI 1.02–1.43). The Super Learner model indicated a nonlinear association between disease duration prior to systemic treatment initiation and the likelihood of achieving complete skin clearance. A steep decline in the cumulative rate of achieving PASI 0 was observed with increasing disease duration in the first five years, with increasing disease duration from 1 to 5 years before starting treatment associated with a reduction of 10.1% (6.1 - 13.5%) in the rate of achieving skin clearance, and the rate stabilised with longer durations.

Conclusions

The results suggest that a shorter time from psoriasis onset to systemic treatment initiation was associated with improved long-term disease control.

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Abstract N°: 26

TDRKH-mediated piRNA regulation sustains pro-inflammatory M1 macrophage polarization in psoriasis

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Introduction
Psoriasis is a chronic inflammatory skin disease with a strong genetic component, yet how susceptibility genes translate into cell-specific inflammatory programs remains incompletely understood.

Materials and Methods
To identify causal genes and downstream regulatory mechanisms, we integrated transcriptome-wide association analysis and summary-data-based Mendelian randomization. Long-read sequencing was used to characterize alternative splicing and alternative polyadenylation (APA) of candidate genes. Single-cell RNA sequencing was applied to resolve cell-type–specific expression patterns in psoriatic lesions. Functional validation was performed using in vitro M1 macrophage models focusing on piRNA-mediated regulation.

Results
Genetic analyses identified TDRKH as a robust psoriasis susceptibility gene across multiple tissue contexts. Long-read sequencing revealed pronounced APA changes of TDRKH, characterized by 3′UTR lengthening associated with increased mRNA stability in patients. Single-cell analysis demonstrated marked infiltration of pro-inflammatory M1 macrophages in psoriatic lesions, with high TDRKH expression in this subset and activation of the IL-23/IL-17 inflammatory axis. Functional experiments showed that TDRKH knockdown reshaped the piRNA landscape in M1 macrophages, leading to reduced expression of specific piRNAs targeting anti-inflammatory regulators, including STAT6 and PPARγ, thereby attenuating the pro-inflammatory phenotype.

Conclusions
Our study identifies TDRKH as a genetically driven regulator linking alternative polyadenylation to piRNA-mediated post-transcriptional control of macrophage polarization in psoriasis. These findings provide a mechanistic framework connecting genetic susceptibility to sustained inflammation and highlight the TDRKH–piRNA axis as a potential translational target in psoriasis.

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Abstract N°: 52

Beyond Symmetry: A Case of Strictly Unilateral Psoriasis in an 89-Year-Old Woman

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Introduction
Psoriasis is traditionally characterized by its symmetric, bilateral distribution. Strictly unilateral involvement is an exceptional variant that challenges our understanding of the disease's pathogenesis. It raises questions regarding cutaneous mosaicism and the role of localized triggers in a disease typically considered systemic.

Case Presentation
An 89-year-old woman presented with pruritic, erythematous plaques with silvery scales strictly localized to the left leg and left forearm. There was absolute sparing of the contralateral side, scalp, and nails, with no personal or family history of psoriasis. Notably, there were no neurological deficits or history of sensory loss to explain the unilateral distribution. Differential diagnoses included inflammatory linear verrucous epidermal nevus (ILVEN) and tinea corporis. Histopathological examination confirmed psoriasis, showing regular psoriasiform hyperplasia and parakeratosis. The patient achieved a rapid, marked improvement within four weeks using a combination of topical corticosteroid and vitamin D analogue, with sustained remission at follow-up.

Conclusion
This case highlights that psoriasis can deviate from its classic symmetric pattern, even in late-onset presentations. In the absence of neurological factors or Koebnerization, such presentations may reflect cutaneous mosaicism. Recognizing this rare variant is essential to ensure accurate diagnosis and avoid mismanagement of common mimics such as eczema or fungal infections.

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Psoriatic Arthritis as a Marker of Cardiometabolic Risk in a Caribbean Cohort

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Introduction
Psoriasis is a chronic systemic inflammatory disease associated with an increased burden of cardiometabolic comorbidities. Psoriatic arthritis (PsA), a major extracutaneous manifestation of psoriasis, has been increasingly linked to higher cardiovascular risk. However, data evaluating the relationship between PsA and cardiometabolic risk factors in Caribbean populations remain limited. Therefore, this study aimed to evaluate the association between PsA and major cardiometabolic risk factors, including hypertension, type 2 diabetes mellitus, and obesity, in patients with psoriasis.

Materials and Methods
A retrospective, cross-sectional study including 548 patients with dermatologist-confirmed psoriasis treated at a tertiary care center in the Dominican Republicwas conducted. Sociodemographic, clinical, and comorbidity data were extracted frommedical records.

Patients were stratified based on the presence or absence of PsA. Comparative analyses were performed using chi-square tests for categorical variables and Student's t-test forcontinuous variables. A multivariable logistic regression model was constructed to identifyindependent associations between PsA and cardiovascular risk factors, adjusting for ageand sex. Statistical significance was defined as $p < 0.05$.

Results
Among 548 patients, PsA was identified in 158 individuals and was associated witha markedly higher burden of cardiometabolic comorbidities. Patients with PsA demonstratedsignificantly higher prevalence of HTN (62.4% vs 41.8%, p=0.014), T2DM (38.7% vs 22.5%,p= 0.038) and obesity (55.1% vs 33.6%, p=0.009). Additionally, PsA patients were morelikely to present with active disease and require systemic or biologic therapy, reflecting amore severe inflammatory phenotype.

In multivariable logistic regression analysis, PsA remained independently associated with: HTN (OR 2.1; 95% CI 1.4–3.2; $p < 0.001$), obesity (OR 1.9; 95% CI 1.3–2.8; $p = 0.001$) and T2DM (OR 1.7; 95% CI 1.1–2.6; $p = 0.015$). These findings support a strong andindependent relationship between PsA and cardiometabolic risk factors beyond traditionalconfounders.

Conclusions
Psoriatic arthritis represents more than a joint manifestation of psoriasis; it's arobust clinical indicator of increased cardiometabolic risk. The strong association withhypertension, diabetes, and obesity reinforces the concept of psoriasis as a systemicinflammatory disorder with significant cardiovascular implications. The presence of PsAshould prompt early and aggressive cardiovascular risk assessment and management. Furthermore, early diagnosis and timely initiation of treatment, considering biologic therapiestargeting inflammatory processes,play a critical role in reducing the risk of major adversecardiovascular events.

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Abstract N°: 69

Patient Knowledge and Educational Priorities Among Biologic-Treated Psoriasis Patients

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Introduction
Psoriasis is a chronic inflammatory skin disease associated with multiple comorbidities, including obesity, diabetes, and cardiovascular disease. Adequate patient knowledge and targeted health education are critical for effective disease management, particularly among patients receiving biologic therapy. This study aimed to assess the awareness, understanding, and specific health education needs of patients with psoriasis in northern Taiwan.

Materials and Methods
A descriptive cross-sectional, self-administered survey was conducted from April to October 2025 at three medical centers in northern Taiwan. Eligible participants were adults diagnosed with psoriasis who were currently receiving biologic therapy and capable of independently completing the questionnaire. The questionnaire assessed patient knowledge of psoriasis, comorbidities, and health education needs, with the latter presented as multiple-choice items allowing respondents to select more than one topic of interest. Chi-square tests were used to examine associations between patient knowledge, disease duration, and biologic treatment experience.

Results
A total of 113 participants completed the survey. Regarding self-assessed psoriasis knowledge, 12.4% rated their understanding as poor, 48.7% as average, 32.7% as good, and 6.2% as excellent. Participants with experience using two or more biologics demonstrated significantly greater awareness of disease causes, risk factors, and associated comorbidities compared to those with experience using only one biologic ($p = 0.028$), whereas disease duration was not associated with knowledge. The most frequently identified health education needs were medication use and potential side effects (20.9%), managing triggering factors (20.6%), dietary plans (18.8%), exercise programs (15.6%), and skin care methods (13.8%). Stress management techniques were less frequently requested (10.3%). Of the 113 respondents indicating interest in patient support groups, 33.6% expressed willingness to participate.

Health Education Topic	Number of Respondents (n)	Percentage (%)
Medication use and potential side effects	71	20.9
Understanding and managing triggering factors	70	20.6
Dietary plans for psoriasis	64	18.8
Exercise programs suitable for psoriasis	53	15.6
Skin care methods	47	13.8
Stress management techniques	35	10.3

Specific Health Education Needs of Psoriasis Patients Receiving Biologic Therapy

Conclusions

Psoriasis patients on biologics show variable disease awareness, with greater biologic experience linked to better knowledge. Tailored educational interventions addressing medication, triggers, lifestyle, and self-management are recommended.

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Abstract N°: 81

Impact of Glucose Metabolism Disorders on the Effectiveness of Tumor Necrosis Factor-α Inhibitor Therapy (Adalimumab) in Patients with Psoriasis

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Introduction

Psoriasis is a chronic immune-mediated inflammatory skin disease frequently associated with metabolic comorbidities, including metabolic syndrome, which comprises obesity, hypertension, hypertriglyceridemia, reduced high-density lipoprotein (HDL) cholesterol, and impaired glucose metabolism. These comorbidities substantially increase the risk of cardiovascular complications and may contribute to premature mortality in patients with psoriasis, while also negatively influencing responses to biologic therapy. Previous studies have demonstrated that metabolic comorbidities may affect the effectiveness and persistence of biologic treatment in moderate-to-severe psoriasis. For example, a Danish nationwide cohort study reported that metabolic comorbidities were significant predictors of reduced biologic efficacy. Similarly, analyses of the CorEvitas Psoriasis Registry demonstrated that obesity and diabetes were independently associated with lower odds of achieving PASI75 and PASI90 responses and with higher rates of biologic discontinuation. The aim of this study is to investigate the impact of glucose metabolism disorders on the effectiveness of treatment with the tumor necrosis factor-α inhibitor (adalimumab) in patients with severe plaque psoriasis.

Materials and Methods

Thirty-two patients with severe plaque psoriasis (Psoriasis Area and Severity Index, PASI >12) received adalimumab therapy between August 2020 and November 2021. Treatment was initiated with an 80 mg loading dose followed by 40 mg administered subcutaneously every two weeks for 12 weeks. All patients received biologic therapy for the first time. Treatment effectiveness was defined as achieving a 75% reduction in PASI (PASI75) compared with baseline. Patients were divided into two groups according to glucose metabolism status. Group 1 included 16 patients with diabetes mellitus or impaired glucose tolerance, while Group 2 included 16 patients without glucose metabolism disorders. The groups were comparable in baseline characteristics. Mean age was 52 years (IQR 44–60) and 44.88 ± 6.62 years, respectively; sex distribution was 14 men and 2 women in each group. Mean body mass index was 33.69 ± 5.18 and 33.89 ± 4.62, PASI 31.05 (IQR 30.6–39.6) and 33.75 (IQR 31.5–44.1), and psoriasis duration 12 years (IQR 5.5–18.5) and 14 years (IQR 8.5–29) in Groups 1 and 2, respectively. Diabetes mellitus was diagnosed based on two fasting venous plasma glucose measurements >7 mmol/L and the presence of glycosuria. Impaired glucose tolerance was defined as fasting venous plasma glucose >5.5 mmol/L but <7 mmol/L. In Group 1, diabetes mellitus was newly diagnosed in 6 patients, and impaired glucose tolerance in 10 patients. Statistical analysis included calculation of the odds ratio (OR) for response to biologic therapy with a 95% confidence interval (CI).

Results

The mean blood glucose level in Group 1 was 6.78 ± 1.24 mmol/L compared with 4.29 ± 0.59 mmol/L in Group 2 ($p < 0.01$). After treatment, PASI75 was achieved in 37.5% of patients in Group 1 and in 87.5% of patients in Group 2. The calculated odds ratio was 5.00 (95% CI 1.30–19.30), indicating a significantly higher likelihood of non-response to adalimumab therapy among patients with glucose metabolism disorders compared with those without such disorders.

Conclusions

Disorders of glucose metabolism may represent an important factor associated with reduced effectiveness of tumor necrosis factor-α inhibitor therapy (adalimumab) in patients with severe plaque psoriasis. Further studies with larger patient populations are required to confirm these findings.

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Abstract N°: 82

Efficacy and safety of topical Lactobacillus paracasei MSMC 39-1 postbiotic solution compared with topical corticosteroid in the treatment of mild chronic plaque psoriasis: A pilot study

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Introduction

Despite advances in biologic therapies for psoriasis, a recent survey showed that 76% of respondents preferred topical treatment over pills or injections, and 80% wished for more alternatives to steroids.[1] The supernatant of *Lactobacillus paracasei* MSMC 39-1 can suppress TNF-α,[2] suggesting its potential in psoriasis treatment. However, clinical evidence for the efficacy of topical postbiotic therapy is lacking. We aimed to evaluate the efficacy, safety, and cytokine modulation of a topical *L. paracasei* MSMC 39-1 postbiotic solution compared with 0.1% triamcinolone acetonide (TA) milk lotion in patients with mild chronic plaque psoriasis.

Materials and Methods

This IRB-approved, randomized, double-blind, split-body controlled trial enrolled patients with mild chronic plaque psoriasis (PASI ≤ 10). The participants applied topical *L. paracasei* MSMC 39-1 postbiotic solution (postbiotic group) to lesions on one side and TA milk lotion (TA group) to the other side for 12 weeks. The treatment sides were randomized between the left and right. Follow-up visits were at weeks 4, 8, and 12. The primary outcome was clinical efficacy at week 12, assessed using the modified Psoriasis Area and Severity Index (mPASI). The secondary outcomes were pruritus assessed by a numeric rating scale (NRS), participant satisfaction using a visual analog scale (VAS), and cytokine levels in lesional skin. Biopsies were performed at baseline and week 12 to measure TNF-α, IFN-γ, IL-12, IL-17A, IL-17F, and IL-22 levels. Adverse events (burning, dryness, skin infection) were monitored.

Results

Thirty participants were recruited. All showed significant mPASI reduction in lesions treated with *L. paracasei* MSMC 39-1 postbiotic solution starting at week 4, continuing to decrease throughout the study, similar to TA group. No significant difference was observed in the mean mPASI reduction between groups (Fig 1). At week 12, more participants in the postbiotic group achieved mPASI75 than those in the TA group (22.22% vs. 7.41%, p = 0.13). Both treatments reduced pruritus significantly since week 4, with no significant difference between groups. Lesional cytokine analysis showed significant TNF-α and IFN-γ reductions in both groups at week 12. A significantly greater IL-17A reduction was observed in the postbiotic group than in the TA group (p = 0.014). Decreases in IL-12, IL-17F, and IL-22 were observed but not statistically significant. The postbiotic group was well tolerated, with mild transient erythema (4/30) and burning sensations (3/30) reported. No serious adverse events were observed. The mean participant satisfaction scores were significantly higher in the postbiotic group (8.44 ± 1.48) than in the TA group (7.19 ± 1.49) (p = 0.001).

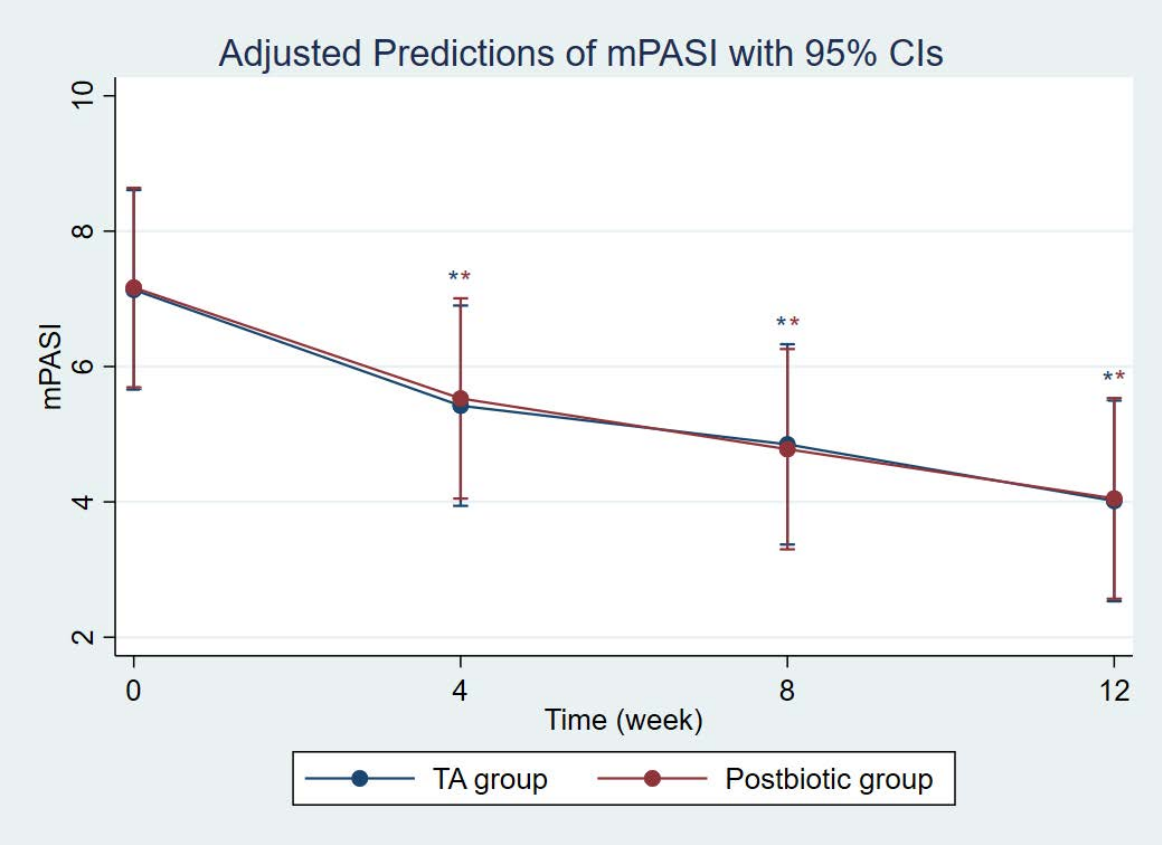

Fig 1. mPASI from baseline to week 12, comparing TA group (blue line) and postbiotic group (red line)

Conclusions

Topical *L. paracasei* MSMC 39-1 postbiotic solution showed clinical efficacy similar to 0.1% triamcinolone acetonide (TA) milk lotion in reducing mPASI scores in patients with mild chronic plaque psoriasis. The postbiotic solution significantly reduced the pro-inflammatory cytokines TNF-α, IFN-γ, and IL-17A, with a greater reduction in IL-17A than in TA milk lotion ($p = 0.014$), suggesting modulation of the IL-23/IL-17 inflammatory axis. The formulation was well tolerated, with high patient satisfaction. These findings support the use of a topical *L. paracasei* MSMC 39-1 postbiotic solution as a safe and effective steroid-sparing alternative for mild psoriasis. Further large-scale studies with longer follow-ups are needed to confirm the long-term efficacy and elucidate the underlying mechanisms.

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Abstract N°: 93

Clinical and Metabolic Factors Associated with Biologic Treatment Response in Psoriasis: A 20-Year Real-World Cohort

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Introduction
Biologic therapies have significantly improved treatment outcomes in patients with moderate-to-severe psoriasis. However, treatment response varies among individuals, and both clinical and metabolic factors may influence the likelihood of achieving optimal therapeutic outcomes in real-world practice.

Materials and Methods
This retrospective real-world cohort study included adult patients with moderate-to-severe plaque psoriasis who received biologic therapy for at least 16 weeks between January 2005 and March 2025 in a tertiary referral dermatology centre. Demographic and clinical characteristics, smoking status, disease duration, family history, nail involvement, psoriatic arthritis and comorbidities were recorded. Metabolic parameters including body mass index, waist circumference and HbA1c levels were analysed. Biologic agents were grouped according to their targeted pathways (TNF-α, IL-12/23, IL-17 and IL-23 inhibitors). Disease severity was assessed using the Psoriasis Area and Severity Index (PASI), and treatment response was evaluated based on PASI75, PASI90 and PASI100 outcomes. Associations between clinical and metabolic factors and treatment response were analysed using appropriate statistical tests and logistic regression models.

Results
Among 463 patients treated with biologic therapy, PASI75 response was achieved in 78.8% of patients. Smoking was associated with significantly lower PASI90 and PASI100 response rates compared with non-smokers (PASI90: 57.2% vs 68.4%, p=0.032; PASI100: 52.4% vs 63.8%, p=0.032). Older age was associated with reduced treatment response; patients aged ≥65 years had significantly lower PASI90 and PASI100 response rates compared with younger patients (PASI90: 48.4% vs 64.3%, p=0.017; PASI100: 45.2% vs 59.1%, p=0.040).Longer disease duration was associated with reduced likelihood of achieving PASI90 and PASI100 responses. Logistic regression analysis showed that each additional year of disease duration decreased the probability of achieving PASI90 (OR 0.980, p=0.017) and PASI100 (OR 0.982, p=0.032). Hypertension was associated with lower PASI90 response (p=0.016). Patients achieving PASI90 had significantly lower HbA1c levels compared with non-responders (5.94±1.21 vs 6.44±1.99, p=0.032). Nail involvement was associated with lower PASI100 response (p=0.042). A trend toward lower PASI75 response was observed in patients with higher waist circumference (105.0 vs 101.8 cm, p=0.054).

Conclusions
In this 20-year real-world cohort, biologic treatment response in psoriasis was associated with multiple clinical and metabolic factors. Older age, smoking, longer disease duration, hypertension and higher HbA1c levels were linked to reduced likelihood of achieving higher PASI response thresholds, highlighting the importance of addressing metabolic burden and disease chronicity in the management of psoriasis.

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Impact of Insulin Resistance on Biologic Treatment Response in Psoriasis: A 20-Year Real-World Cohort

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Introduction
Psoriasis is a chronic immune-mediated inflammatory disease increasingly recognised as a systemic disorder associated with cardiometabolic comorbidities such as obesity, diabetes mellitus, hypertension and dyslipidaemia. Biologic therapies targeting key inflammatory cytokines have substantially improved outcomes in moderate-to-severe psoriasis. However, metabolic dysfunction may influence treatment effectiveness in real-world clinical practice. While the impact of obesity and diabetes on biologic response has been widely investigated, data specifically addressing insulin resistance remain limited. This study aimed to evaluate the association between insulin resistance and biologic treatment response in patients with plaque psoriasis in a large real-world cohort.

Materials and Methods
This retrospective observational cross-sectional study included adult patients with moderate-to-severe plaque psoriasis followed in a tertiary referral psoriasis clinic between January 2005 and April 2025 who received biologic therapy. Patients with available baseline and 3–6-month follow-up clinical and laboratory data were included. Demographic, clinical and metabolic characteristics were recorded. Insulin resistance was assessed using HbA1c, HOMA-IR and triglyceride-glucose body mass index (TyG-BMI). Laboratory-defined insulin resistance was defined as HbA1c ≥5.7 and/or HOMA-IR ≥2.5, while a TyG-BMI cut-off of ≥249.54 was determined by ROC analysis. Treatment response was evaluated using PASI75, PASI90 and PASI100 outcomes. Associations between metabolic factors and treatment response were analysed using comparative statistics and logistic regression models.

Results
A total of 417 patients with plaque psoriasis receiving biologic therapy were included (mean age 46.7±15.5 years; 60.9% male). Laboratory-defined insulin resistance was present in 60.1% of patients, while TyG-BMI-defined insulin resistance was detected in 48.4%. In pooled analyses, insulin resistance was associated with a 21% lower likelihood of achieving PASI90 (OR 0.79, 95% CI 0.30–2.09; p=0.634) and a 32% lower likelihood of achieving PASI100 (OR 0.68, 95% CI 0.26–1.77; p=0.427). The most pronounced effect was observed with certolizumab pegol, where insulin resistance reduced PASI90 by 78% (OR 0.22, 95% CI 0.02–2.45) and PASI100 by 92% (OR 0.08, 95% CI 0.01–1.26; p=0.047).Abdominal obesity significantly affected treatment outcomes in some biologics. In adalimumab-treated patients, abdominal obesity reduced PASI90 by 78% (OR 0.22, 95% CI 0.06–0.80; p=0.021), while in ustekinumab-treated patients it reduced PASI90 by 76% (OR 0.24, 95% CI 0.07–0.78; p=0.018) and PASI100 by 71% (OR 0.29, 95% CI 0.09–0.94; p=0.039).Obesity (BMI ≥30 kg/m^2) showed a trend toward reduced response across biologics (PASI90 OR 0.78, 95% CI 0.52–1.19). Diabetes mellitus was associated with a 36% reduction in PASI90 response among TNF-α inhibitors (OR 0.64, 95% CI 0.26–1.56) and a 90% reduction with certolizumab pegol (OR 0.10, 95% CI 0.01–1.50; p=0.050). Patients achieving PASI90 had significantly lower HbA1c levels compared with non-responders (5.94±1.21 vs 6.44±1.99; p=0.032).In contrast, IL-17 and IL-23 inhibitors appeared to maintain treatment effectiveness despite adverse metabolic profiles, suggesting that these biologic classes may be less influenced by metabolic dysfunction compared with TNF-α and IL-12/23 inhibitors.

Conclusions

In this real-world cohort, metabolic burden—including insulin resistance, abdominal obesity, obesity and diabetes—was associated with reduced likelihood of achieving higher PASI responses, particularly among TNF-α and IL-12/23 inhibitors. In contrast, IL-17 and IL-23 inhibitors appeared to maintain treatment effectiveness despite metabolic dysfunction, suggesting potential resilience of these pathways to cardiometabolic factors. These findings highlight the importance of metabolic profiling when selecting biologic therapy and support a more personalised treatment approach in psoriasis.

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Abstract N°: 146

Efficacy and safety of SHR-1139, a novel anti-IL-23p19/IL-36R bispecific antibody, in patients with moderate-to-severe plaque psoriasis: interim results from a randomized, double-blind, placebo-controlled phase 2 trial

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Introduction

Plaque psoriasis is a chronic, immune-mediated inflammatory skin disease with a substantial disease burden. Key pathogenic pathways include the IL-23/Th17 signaling axis and the IL-36/IL-36R signaling axis. SHR-1139 is a novel, bispecific antibody targeting both IL-23p19 and IL-36R to synergistically suppress key pathogenic pathways, with Fc modification providing an extended half-life to reduce dosing frequency. This phase 2 study (NCT06875934) evaluated the efficacy and safety of SHR-1139 in patients with moderate-to-severe plaque psoriasis.

Materials and Methods

Eligible patients were aged ≥18 years and had moderate-to-severe plaque psoriasis for ≥6 months before randomization, with a psoriasis area and severity index (PASI) score ≥12, static Physician's Global Assessment (sPGA) score ≥3, and body surface area (BSA) involvement ≥10%. Patients were randomized (1:1:2:2:1) to five treatment arms (Figure 1): (1) SHR-1139 60 mg at week 0 and 30 mg at week 26; (2) SHR-1139 150 mg at week 0, 4, and 26; (3) SHR-1139 300 mg at week 0, then re-randomized (1:1) at week 26 to receive SHR-1139 150 mg or placebo; (4) SHR-1139 600 mg at week 0, then re-randomized (1:1) at week 26 to receive SHR-1139 300 mg or placebo; (5) placebo at week 0 and week 4, switching to SHR-1139 600 mg at week 26. Randomization was stratified by weight (<70 kg or ≥70 kg). The primary endpoint was the proportion of patients achieving ≥90% improvement from baseline in PASI score (PASI 90) at week 16. Key secondary endpoints included proportions achieving sPGA 0 (clear) or 1 (almost clear), PASI 75, PASI 100, and sPGA 0 at week 16. Patients who did not achieve PASI 50 at week 16 received a single dose of SHR-1139 600 mg as rescue treatment. Patients who received this rescue therapy were excluded from the week 26 dosing. This report presents prespecified 26-week interim analysis results.

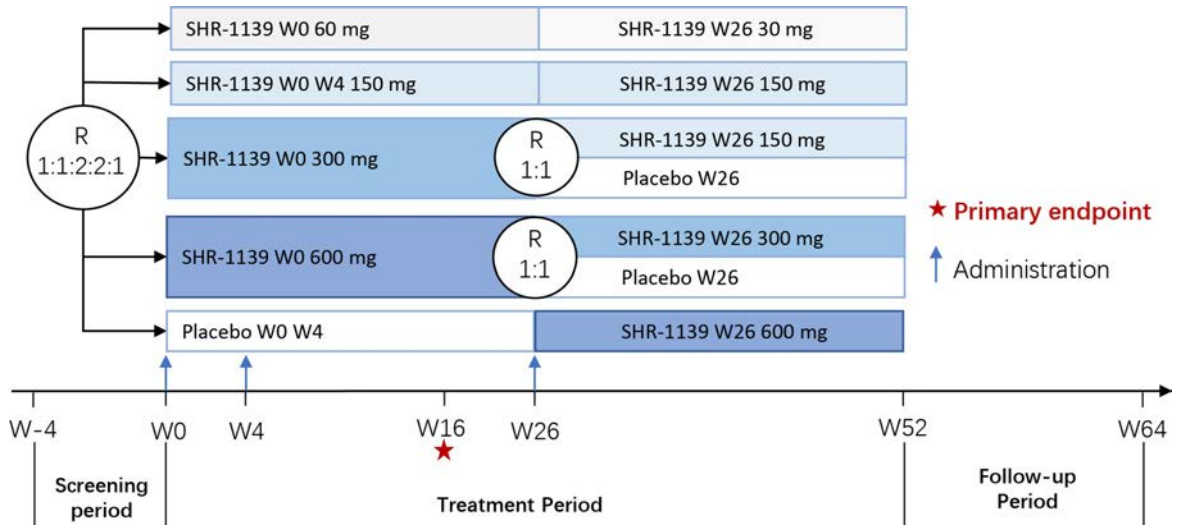

Figure 1. study design

Results

Between Apr 7, 2025 and Jun 20, 2025, 145 patients were randomized (SHR-1139 60 mg, n=22; SHR-1139 150 mg, n=19; SHR-1139 300 mg n=42; SHR-1139 600 mg, n=41; placebo, n=21). Mean (SD) age was 46.1 (14.1) years, 82.8% were male, mean (SD) duration of psoriasis was 12.8 (11.2) years, and 31.0% of patients received previous biologic therapy. The baseline mean (SD) PASI score was 22.7 (10.2), with 37.2% of patients having sPGA=3 and 62.8% having sPGA>3 at baseline. At the interim data cutoff of Dec 19, 2025, the prespecified interim analysis of 26 weeks was conducted. At week 16, all SHR-1139 groups exhibited significantly higher PASI 90 response rates

versus placebo (60 mg: 72.7% [95% CI 54.1%-91.3%]; 150 mg: 52.6% [30.2%-75.1%]; 300 mg: 81.0% [69.1%-92.8%]; 600 mg: 92.7% [84.7%-100.0%]; placebo: 0%; all p<0.0001; Figure 2). More patients in the SHR-1139 groups achieved sPGA 0/1 (60 mg: 68.2%; 150 mg: 57.9%; 300 mg: 76.2%; 600 mg: 90.2%; all p<0.0001) compared to placebo (0%). PASI 75 responses at week 16 were 95.5% (60 mg), 78.9% (150 mg), 95.2% (300 mg), and 95.1% (600 mg) versus 9.5% with placebo (all p<0.0001). PASI 100 responses were 22.7% (60 mg), 31.6% (150 mg), 38.1% (300 mg), and 43.9% (600 mg) versus 0% with placebo. sPGA 0 was achieved by 22.7% (60 mg), 31.6% (150 mg), 38.1% (300 mg), and 43.9% (600 mg), with no patients achieving this endpoint in the placebo group. Efficacy was maintained through week 26. By week 16, adverse events (AEs) were reported in 73.4% of patients receiving SHR-1139 and 71.4% in the placebo group, predominantly mild to moderate in severity. No AE led to treatment discontinuation, and no deaths were reported.

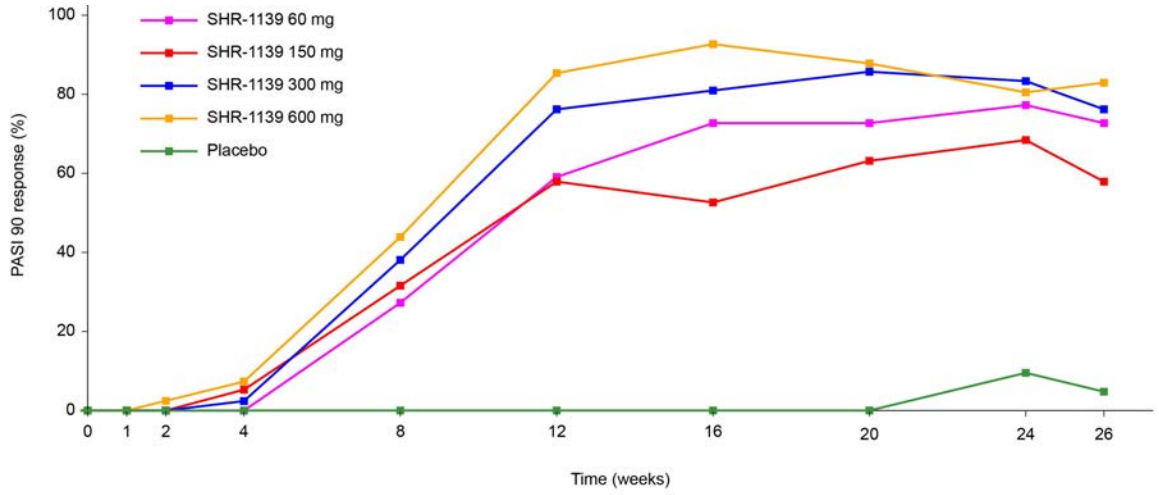

Figure 2. Proportion of patients achieving PASI 90

Conclusions

SHR-1139 demonstrated robust and sustained clinical response through week 26 after a single-dose, with a favorable safety profile. These interim findings support continued development of SHR-1139 with extended dose interval to every 6 months or every 12 months for moderate-to-severe plaque psoriasis.

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Comparing the clinical profile with immunohistochemistry in psoriasis treatment with interleukin 17RA inhibitor using survivin as a biomarker

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Introduction
Psoriasis is characterized by overproduction and reduced apoptosis of keratinocytes. Survivin an apoptosis inhibitor protein is overexpressed in psoriatic plaques. The objective of this study was to evaluate the effect of anti-IL17RA therapy (brodalumab) on clinical and immunohistochemical disease expression using survivin as a biomarker.

Materials and Methods
We obtained peripheral blood samples and skin biopsies from 16 bionaive patients with moderate to severe psoriasis (mean age 50.1) and 16 healthy control (mean age 47.9). Psoriatic patients were followed clinically using the Psoriasis Area and Severity Index (PASI), and serum survivin levels were measured at 0,3, and 12 months. Biopsies were conducted at 0 and 12 months from both lesional and normal skin areas. The control group, selected randomly, also underwent blood measurements for survivin in addition to skin biopsies

Results
Brodalumab produced a remarkable clinical response at 3 and 12 months compared to baseline with the median PASI score decreasing from 12.5 at baseline to 0.0 at 12 months. At 12 months, the psoriasis group showed a significant reduction in serum survivin levels, with mean serum levels of 13.1 (SD=7.3), marking a statistically significant decrease from the control group's baseline levels 29.4 (p=0.007). Additionally, by 12 months, tissue survivin levels in psoriatic skin decreased significantly reaching a mean of 0.037 (SD=0.01), which, while showing a reduction in the healthy skin in the psoriatic group, 0.041 (SD=0.01), still differed significantly from the baseline levels of healthy skin in the control group 0.072 (SD=0.05) (p=0.001)

Conclusions
This study represents the first systematic examination of the clinical and immunohistochemical improvement of psoriasis in patients receiving brodalumab treatment, in comparison to a control group, with a specific emphasis on the survivin biomarker associated with the disease. Our findings underscore the potential of survivin as a significant biomarker in the current landscape of psoriasis research.

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Efficacy and Safety of RSS0393 Ointment in Chronic Plaque Psoriasis: A Phase II Randomized Controlled Trial

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Introduction

RSS0393 is a highly potent, selective PDE-4 inhibitor in development for once-daily topical treatment of chronic plaque psoriasis (PsO). In phase I study, local dermal administration of RSS0393 showed acceptable safety and tolerance in healthy participants and potential efficacy in PsO patients. This study was objected to evaluate the efficacy and safety of RSS0393 ointment in larger scales of patients with PsO.

Materials and Methods

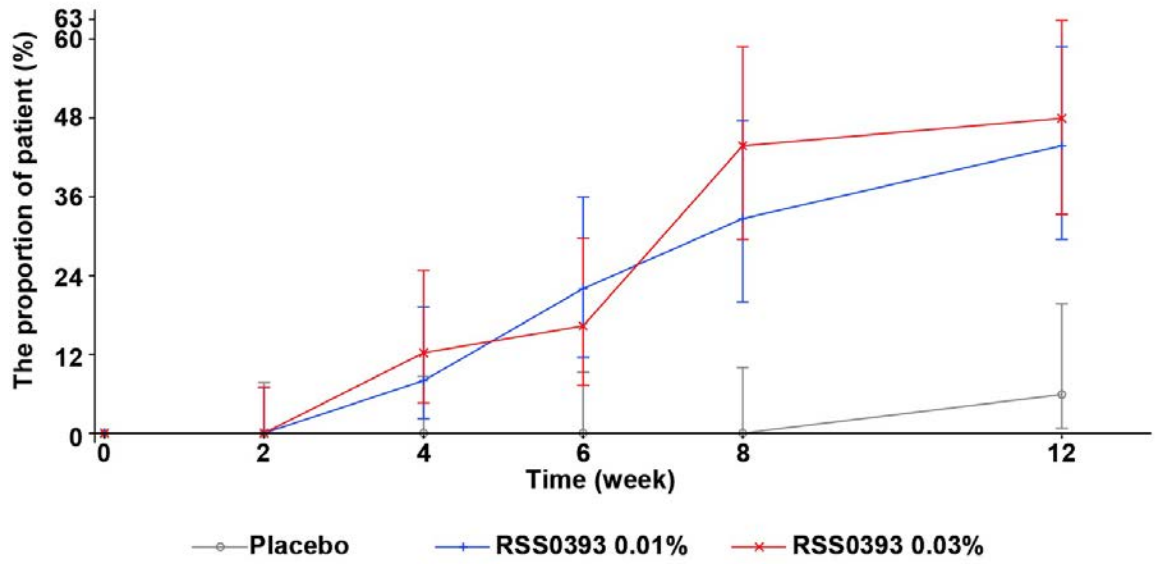
This multicenter, randomized, double-blind, vehicle-controlled phase II study (Clinicaltrials.gov, NCT06918743) included a 4-week screening period, a 12-week treatment period, and a 2-week follow-up period. Eligible adult patients with PsO involving 2–20% of body surface area, a psoriasis area and severity index (PASI) score ≥2 and a

Physician's Global Assessment (PGA) score ≥2, were randomized in a 1:1:1 ratio to RSS0393 0.01%, RSS0393 0.03%, or corresponding vehicle group, to apply treatment for 12 weeks once daily. The primary endpoint was the proportion of patients who achieved PGA response (defined as PGA score of 0/1 with an improvement of ≥2 from baseline) at Week 8. Other clinical response included the proportion of participants achieving ≥75% improvement in PASI score from baseline (PASI 75); the proportion of participants with a baseline Worst Itch Numeric Rating Scale (WI-NRS) score ≥4 achieving a ≥4-point reduction from baseline in the WI-NRS score; and the proportion of patients with baseline involvement of intertriginous areas achieving Intertriginous-PGA (I-PGA) response (defined as I-PGA score of 0/1 with an improvement of ≥2 from baseline). The safety and pharmacokinetic endpoints were also assessed.

Results

Overall, 155 patients (52 in each RSS0393 dosing groups and 51 in the vehicle group) were randomized and received at least one dose of treatment. Demographics and baseline characteristics were generally balanced among groups. At Week 8, the vehicle-corrected PGA response rates were 32.2% and 42.7% for RSS0393 0.01% and 0.03%, respectively (both Nominal p <0.0001). The vehicle-corrected PASI 75, WI-NRS score ≥4 achieving a ≥4-point reduction from baseline and I-PGA response rates were up to 49.8% (RSS0393 0.03% group), 35.6% (RSS0393 0.03% group) and 75.0% (RSS0393 0.01% group) at Week 8, respectively. The incidence of treatment-emergent adverse events (TEAEs) was 63.5%, 71.2% and 49.0% for RSS0393 0.01%, 0.03% and vehicle group, respectively. Most of TEAEs were mild or moderate. The most common TEAEs for RSS0393 were upper respiratory tract infection and hyperuricemia. Additionally, assessment of local dermal tolerability showed that RSS0393 was well tolerated, with predominantly no or mild irritation. Additionally, the systemic exposure to RSS0393 following topical application in patients with PsO was low.

Figure: The proportion of patient with PGA response over 12 weeks



Data are value (95% CI). PGA, physician's global assessment.

Conclusions

RSS0393 showed favorable safety and outstanding efficacy in patients with PsO, supporting further clinical development.

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MANAGING PSORIASIS IN THE ONCOLOGIC SETTING: THE ROLE OF TOPICAL CALCIPOTRIOL/BETAMETHASONE

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Introduction

Psoriasis and cancer share a complex bidirectional relationship based on common inflammatory, immunological, and proliferative mechanisms. Patients with psoriasis have an increased risk of certain malignancies, while oncologic treatments may improve or, conversely, induce or exacerbate psoriatic disease. This interaction creates specific therapeutic challenges and highlights the need for effective and safe treatment options for psoriasis in patients with neoplasms, particularly during concomitant cancer therapies.

Case Presentation

Case 1

A 31-year-old man with hypertension, obesity, and chronic hepatitis B, treated with entecavir, lisinopril, liraglutide, and testosterone gel. Family history was positive for psoriasis (father). He had a >10-year history of cutaneous psoriasis without psoriatic arthritis, previously treated with acitretin, phototherapy, methotrexate, and etanercept. In 2023, he was diagnosed with testicular cancer, leading to discontinuation of systemic therapy and a significant psoriasis flare. Topical calcipotriol/betamethasone cream was initiated as bridging therapy until completion of oncologic treatment and before restarting biologic therapy, achieving good clinical control.

Case 2

A 56-year-old woman with a history of right peripheral facial palsy (2019) with recurrence in 2023 and post-paralytic hemifacial spasm, treated with eslicarbazepine. In 2024, she was diagnosed with breast cancer and treated with surgery, radiotherapy, and trastuzumab. After oncologic treatment, she developed psoriasis with small pruritic plaques on the extremities and abdomen. Treatment with calcipotriol/betamethasone resulted in marked improvement of pruritus and skin lesions.

DISCUSSION

Chronic inflammation, impaired immune surveillance, and activation of pathways such as JAK/STAT, NF-κB, and MAPK explain both the increased cancer risk in psoriasis and the development or exacerbation of skin lesions induced by modern oncologic therapies. Tyrosine kinase inhibitors and immune checkpoint inhibitors are frequently associated with de novo psoriasis or flares of pre-existing disease, and effective management of these cutaneous toxicities is essential to avoid interruption of antineoplastic treatment.Clinical guidelines and expert experience support the use of topical corticosteroids combined with vitamin D analogues, such as calcipotriol, as first-line therapy for psoriasis induced or exacerbated by cancer treatments. These topical regimens allow adequate disease control in most cases without modifying oncologic therapy, avoiding systemic corticosteroids,

whose use is controversial in patients receiving immunotherapy.Although evidence is limited to case reports and small series, available data support the efficacy of calcipotriol/betamethasone in patients with solid and hematologic malignancies, including myeloproliferative neoplasms. Experimental studies have shown no increase in UV-induced photocarcinogenesis with calcipotriol or topical corticosteroids, reinforcing their favorable safety profile in oncologic patients.

Conclusion

Psoriasis and cancer share inflammatory and immunological mechanisms that complicate management. Calcipotriol/betamethasone is an effective and safe first-line topical option for psoriasis in oncologic patients, allowing maintenance of antineoplastic therapy without compromising cutaneous safety.

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Abstract N°: 184

High effectiveness of tildrakizumab in moderate-to-severe psoriasis regardless of prior biologic, lines of therapy, or disease duration: 28-week interim data from the PROCARE-T study

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Introduction

Both prior therapies and timing of biologic initiation may affect the treatment response in psoriasis (1,2). The objectives of this analysis were to evaluate the effectiveness of tildrakizumab in patients with moderate-to-severe psoriasis based on prior biologic therapy, line of treatment, and time since diagnosis.

Materials and Methods

PROCARE-T is an ambispective, observational, 12-month follow-up study in adults with moderate-to-severe plaque psoriasis treated with tildrakizumab in clinical practice. Effectiveness was assessed using the Psoriasis Area and Severity Index (PASI). Response was defined as achievement of absolute PASI ≤3 and PASI ≤1.The impact on

quality of life was measured using the Dermatology Life Quality Index (DLQI). Treatment satisfaction was evaluated using the Treatment Satisfaction Questionnaire for Medication (TSQM-9).Within-group changes from baseline to week (W) 28 were analysed with using paired parametric or non-parametric tests (paired t-test or Wilcoxon signed-rank test), as appropriate. Preliminary results at W28 are reported using observed cases.

Results

A total of 97 patients were included (50.5% male, mean±SD age 52.5±15.1 years).Of the 97 patients, 36 (37.1%) were biologic-naïve and received tildrakizumab as first-line biologic, while 61 (62.9%) had received prior biologic therapy. Among those with prior biologic exposure, the most recent agent was an anti-tumour necrosis factor (TNF) (78.7%), anti-interleukin (IL)-12/23 (6.6%), anti-IL-17 (11.5%), or anti-IL-23p19 (3.3%). Table 1 shows the evolution of PASI and DLQI scores according to prior biologic therapy, line of treatment, and disease duration. Response rates are reported throughout as PASI ≤3 / PASI ≤1 (%/%). According to prior therapy, 68.2/38.6, 25.0/25.0, 42.9/42.9, and 100/50.0 of patients in the anti-TNF, anti-IL-12/23, anti-IL-17, and anti-IL-23p19 groups achieved response at W28. According to lines of therapy, response rates were 76.5/50.0, 66.0/38.0, and 42.9/42.9 in first-, second-, and third-line groups. According to disease duration, response rates were 77.3/45.5, 65.2/43.5, 58.3/37.5, and 72.7/45.5 in patients with <5.1, 5.1–<12.5, 12.5–<23.5, and ≥23.5 years since diagnosis, respectively. At W28, TSQM-9 scores were consistently high across subgroups: effectiveness ranged 73.0–90.3, convenience 78.0–95.8, and global satisfaction 67.3–92.9. The safety profile was consistent with the known profile of tildrakizumab, with no new or serious treatment-related adverse events reported.

Table 1. Evolution of PASI and DLQI by prior biologic therapy, line of treatment, and disease duration

Classification	Subgroup	Scale	Baseline	Week 28	p-value
Prior therapy	Anti-TNF (n=48)	PASI	9.9 ± 7.7	3.1 ± 5.5	p<0.0001
		DLQI	6.9 ± 5.5	2.8 ± 3.5	p<0.0001
	Anti-IL-12/23 (n=4)	PASI	9.8 ± 6.7	2.7 ± 1.8	ns
		DLQI	1.5 ± 1.0	0.8 ± 0.5	ns
	Anti-IL-17 (n=7)	PASI	6.9 ± 6.7	3.8 ± 3.5	ns
		DLQI	7.6 ± 6.7	3.3 ± 5.3	ns
	Anti-IL-23p19 (n=2)	PASI	11.5 ± 9.1	0.9 ± 1.3	ns
		DLQI	9.0 ± 8.5	0.5 ± 0.7	ns
Line of therapy	First (n=36)	PASI	12.4 ± 8.8	2.2 ± 3.0	p<0.0001
		DLQI	9.1 ± 6.6	4.1 ± 5.5	p<0.0001
	Second (n=53)	PASI	9.6 ± 7.6	3.0 ± 5.2	p<0.0001
		DLQI	7.2 ± 5.7	2.8 ± 3.8	p<0.0001
	Third or higher (n=8)	PASI	9.4 ± 6.4	3.3 ± 3.0	p<0.05
		DLQI	3.5 ± 3.9	1.6 ± 1.4	ns
Time since diagnosis (years)	<5.1 (n=25)	PASI	7.9 ± 4.9	2.0 ± 1.9	p<0.0001
		DLQI	10.6 ± 7.5	5.2 ± 6.1	p<0.01
	5.1–<12.5 (n=24)	PASI	11.9 ± 7.4	2.7 ± 3.0	p<0.0001
		DLQI	6.3 ± 5.2	2.5 ± 3.8	p<0.01
	12.5–<23.5 (n=24)	PASI	10.9 ± 8.9	4.0 ± 7.2	p<0.001
		DLQI	7.8 ± 5.3	2.7 ± 3.2	p<0.001
	≥23.5 (n=24)	PASI	12.1 ± 10.1	2.1 ± 2.7	p<0.001
		DLQI	5.5 ± 4.9	2.2 ± 3.2	p<0.05

Data are shown as the mean ± SD. DLQI, Dermatology Life Quality Index; IL, interleukin; ns: non-significant; PASI, Psoriasis Area and Severity Index; SD, standard deviation; TNF, tumour necrosis factor.

Conclusions

Despite limited sample size in some groups,tildrakizumab improved PASI and DLQI at W28, with high treatment satisfaction regardless of prior biologic, lines of therapy, or disease duration, suggesting tildrakizumab is an

effective option both in biologic-naïve patients and after failure of previous biologic therapies, including anti-TNF and anti-IL-17.

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Abstract N°: 185

High effectiveness of tildrakizumab in moderate-to-severe psoriasis involving high-impact areas after failure of prior biologics: 28-week interim data from the PATH-T study

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Introduction

Psoriasis involving special or high-impact areas such as the scalp, nails, palms or soles, or genitals is associated with impaired quality of life, emphasizing the need for effective treatment to improve patient well-being (1, 2). The objective of this analysis was to assess the effectiveness of tildrakizumab in high-impact areas in patients with moderate-to-severe psoriasis with primary or secondary biologic treatment failure.

Materials and Methods

PATH-T is an observational, phase IV, 2-year follow-up study in adult patients with moderate-to-severe psoriasis and prior failure to biologic therapy treated with tildrakizumab according to clinical practice. Effectiveness assessments in this analysis included 5-point Physician's Global Assessment (PGA) scales (range 0-4, from clear to severe), overall and for the scalp, face, nails, palmoplantar areas, and genital involvement. We present preliminary results at week 28 using an observed cases approach

Results

A total of 153 patients were included (49.7% male, mean±SD age 48.8±14.4 years), of whom 90.5% were previously treated with anti-tumour necrosis factor, 10.8% with anti-interleukin (IL)-17, 9.5% with anti-IL-12/23, and 4.7% with anti-IL-23p19 agents. Patients with clear or almost clear skin (PGA 0-1) increased from 20.4% at baseline to 76.2% at week 28, while those with moderate-to-severe involvement (PGA 3-4) decreased from 43.4% to 7.6%. Patients with scalp-PGA 0-1 increased from 72.0% at baseline to 92.2% at week 28, while those with scalp-PGA 3-4 decreased from 12.7% to 3.9%. Patients with face-PGA 0-1 increased from 95.4% at baseline to 99.0% at week 28, while those with face-PGA 3-4 decreased from 1.3% to 1.0%. Patients with nail-PGA 0-1 increased from 88.1% at baseline to 93.1% at week 28, while those with nail-PGA 3-4 decreased from 6.0% to 2.0%. Patients with palmoplantar-PGA 0-1 increased from 85.4% at baseline to 96.1% at week 28, while those with palmoplantar-PGA 3-4 decreased from 7.3% to 2.9%. Patients with genital-PGA 0-1 increased from 92.0% at baseline to 98.0% at week 28, while those with genital-PGA 3-4 decreased from 4.7% to 0.0%. The safety profile was favourable, with no new or serious related adverse events reported.

Conclusions

Tildrakizumab showed high effectiveness in clinical practice, demonstrating excellent clearance rates in scalp, face, nails, palmoplantar, and genital regions at week 28, confirming its therapeutic value for patients with high-impact areas involved.

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Abstract N°: 187

Immune Checkpoint Gene Polymorphisms Influence Biologic Treatment Response in Psoriasis: PDCD1 and LAG3 Analysis

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Introduction

Psoriasis is a chronic immune-mediated inflammatory disease in which immune checkpoint pathways play a key role. PD-1 (PDCD1) and LAG-3 are inhibitory molecules that regulate T-cell activity. However, the clinical impact of their genetic polymorphisms, especially on treatment response, is not fully understood.

Materials and Methods

This study included 118 patients with psoriasis and 68 healthy controls. PDCD1 (rs10204525) and LAG3 (rs1922452) polymorphisms were analyzed using real-time PCR. Clinical data including disease duration, PASI score, clinical subtype, and treatment history were recorded. Statistical analysis was performed to evaluate associations between genotypes and clinical parameters, including biologic treatment response.

Results

No significant association was found between PDCD1 or LAG3 polymorphisms and psoriasis susceptibility ($p>0.05$).However, clinically relevant findings emerged. All patients carrying the PDCD1 SNP genotype required biologic therapy and demonstrated a favorable treatment response (PASI <3) ($p=0.021$).LAG3 polymorphisms were significantly associated with response to TNF-α inhibitors ($p=0.039$), with reduced efficacy observed in patients with the normal genotype.Additionally, a trend toward longer disease duration was observed in LAG3 variant carriers ($p=0.054$). Notably, normal genotypes of both PDCD1 and LAG3 were absent in patients with pustular psoriasis.No significant associations were identified between genotypes and PASI score, nail or joint involvement, or response to IL-17 and IL-23 inhibitors (all $p>0.3$).

Conclusions

PDCD1 and LAG3 polymorphisms were not associated with psoriasis susceptibility; however, they may influence disease course and treatment response.PDCD1 variants appear to be related to biologic treatment requirement and may predict a favorable response. In addition, LAG3 polymorphisms seem to affect the efficacy of TNF-α inhibitors.These findings suggest that immune checkpoint–related genetic variations could play a role in treatment stratification and support the development of more personalized therapeutic approaches in psoriasis.Further large-scale studies are needed to confirm these results.

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Abstract N°: 193

ERCIP-CHN: Construction of a novel efficacy-related comorbidity index for psoriasis in Chinese population

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Introduction

Psoriasis has been unequivocally linked to various comorbidities, and the presence of these comorbidities substantially impacts patients' prognosis and quality of life. However, existing comorbidity scores, such as the Charlson Comorbidity Index, are primarily designed for older populations and focus on mortality rather than being specific to psoriasis patients. Consequently, the objective of this study was to develop a straightforward indicator to evaluate the comorbid burden of psoriasis in Chinese patients, and to explore its association with efficacy.

Materials and Methods

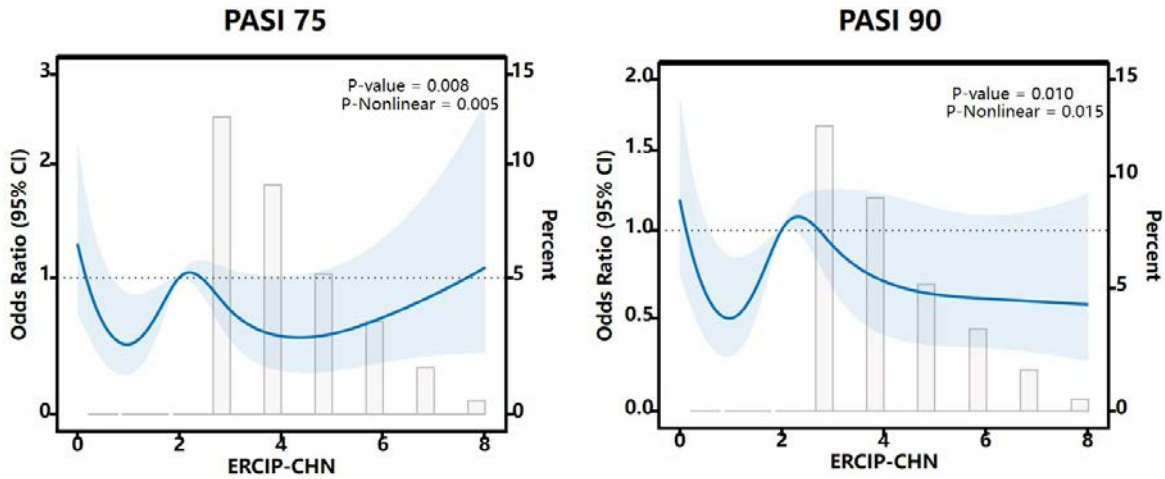
Based on the Shanghai Psoriasis Effectiveness Evaluation Cohort (SPEECH), we conducted a prospective cohort study. Patient comorbidities were assessed across 13 categories, including obesity, hypertension, diabetes, hyperlipidemia, hyperuricemia, non-alcoholic fatty liver disease, coronary heart disease, stroke, heart failure, inflammatory bowel disease, anxiety, depression, and psoriatic arthritis. The efficacy-related comorbidity index for psoriasis in Chinese population (ERCIP-CHN) is determined as follows: within the specified comorbidities, 0 points for no comorbidity, 1 point for an untreated comorbidity, and 2 points for a treated comorbidity. The scoring range is from 0 to 24. Subsequently, patients were administered biologic therapies with efficacy data being gathered at various time points.

	None	Untreated	Treated
Obesity	□	□	□
Hypertension	□	□	□
Diabetes	□	□	□
Hyperlipidemia	□	□	□
Hyperuricemia	□	□	□
NAFLD	□	□	□
Coronary heart disease	□	□	□
Stroke	□	□	□
Heart failure	□	□	□
IBD	□	□	□
Anxiety	□	□	□
Depression	□	□	□
PsA	□	□	□

The survey for comorbidities collection

Results

A total of 609 patients were included in the study, of whom only 168 (27.6%) had no comorbidities, while 141 (23.2%) had more than three comorbidities. Among these, the prevalence of metabolic diseases and psychiatric conditions was the highest, with depression affecting 26.1%, hypertension 25.0%, anxiety 22.4%, and obesity 22.2%. The ERCIP-CHN score was subsequently calculated for each patient, and 128 patients (21.0%) had a score of 4 or higher. Further analysis revealed that a higher ERCIP-CHN score was associated with a lower response rate for PASI 75, PASI 90, PASI 100, and PGA 0/1. Further analysis employing restricted cubic spline regression demonstrated a non-linear association between the ERCIP-CHN score and response rate of PASI75 and PASI90. Notably, at an ERCIP-CHN score of ≥ 2, a statistically significant inverse relationship was observed with both treatment response endpoints. This suggests that patients with either one treated comorbidity or two untreated comorbidities exhibit a substantially diminished likelihood of achieving PASI75 or PASI90.



Restricted cubic spline regression for ERCIP-CHN score and response rate of PASI75 and PASI90

Conclusions

The comorbidities burden of psoriasis patients in China is relatively heavy, and ERCIP-CHN can better reflect the comorbidities burden of patients, and is related to the efficacy of psoriasis.

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Abstract N°: 195

Real-world effectiveness of brodalumab in overweight and obese psoriasis patients: a French, ambispective, multicenter cohort.

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Introduction

Brodalumab is a recombinant fully human monoclonal immunoglobulin IgG2 antibody that binds with high affinity to human IL-17RA and blocks the biological activities of the pro-inflammatory cytokines IL-17A, IL-17F, IL-17A/F heterodimer, IL-17C and IL-17E, resulting in inhibition of the inflammation and clinical symptoms associated with moderate-to-severe plaque psoriasis. In clinical trials, brodalumab demonstrated significant efficacy with a favorable safety profile. However, data evaluating the effectiveness of brodalumab specifically in overweight and obese patients remain scarce. In this study, we aimed to evaluate the effectiveness of brodalumab in real-world settings in obese and overweight psoriasis patients.

Materials and Methods

We conducted an ambispective, multicenter study across two French dermatology centers. Adult patients with moderate-to-severe plaque psoriasis initiating brodalumab were enrolled between 2017 and February 2026. Patients were stratified into BMI groups: normal weight (<25 kg/m^2), overweight (25-29.9 kg/m^2), and obese (≥30 kg/m^2). Effectiveness was assessed using the Psoriasis Area and Severity Index (PASI), Physician Global Assessment (PGA), Dermatology Life Quality Index (DLQI) during a baseline visit (V0), when brodalumab was initiated, and at two follow-up visits: V1 (20±8 weeks) and V2 (52±4 weeks). Adverse events were collected throughout the observation period.

Results

Twenty-eight patients were included (58.6% (17/29) male; median age 50±15 years). At baseline, 51.7% (15/29) of patients had obesity, 27.6% (8/29) were overweight, and 20.7% (6/29) had a normal BMI. Metabolic syndrome was a comorbidity in 6/15 (40.0%) of patients with obesity and was not present in any other groups. The median duration of psoriasis was 13.5±9 years, with 55.2% (16/29) of patients presenting with diffuse plaque involvement across the entire body surface. Among all patients, 62.1% (18/29) had a medical history of cardiovascular risk factors and 34.5% (10/29) had a history of endocrine and metabolic disorders. Prior treatments were discontinued due to lack of efficacy in 79.3% (23/29). At baseline, the median PGA score was 3±1, the median PASI was 15.0±8 and the median DLQI was 14±3. There were no differences in PASI, PGA, DLQI scores between the BMI categories.

At V1 (median 21 weeks and 0 days), 24 patients were evaluated for BMI, PGA, PASI and DLQI. Among patients assessed, 76.2% presented a PGA score of 0/1 (16/21 for which PGA was recorded). The median PASI decreased from 15.0 to 3.6 (median decrease: -13.0). The median DLQI improved from 14 to 4 (-10). At V2 (median 54 weeks and 3 day), 24 patients were evaluated. Among patients assessed, 88.9% presented PGA 0 (16/18 for which PGA was recorded) and the remaining patients presented PGA 1. Overall, PASI improved, with 83.3% (15/18) of patients assessed with PASI 0, and only three patients assessed with PASI 1, 1.2 and 2.8 respectively. Over 64% of patients (9/14 for which the DLQI was recorded) reported DLQI 0. No clinical differences were observed in the effectiveness of brodalumab between across all BMI patients' categories during the study. Interestingly, mean

weight decreased by 3.6kg between V0 and V2 (evaluated for 14/29 patients) Brodalumab was well tolerated, with 86.2% (25/29) of patients reporting no adverse events.

Conclusions

In this real-world French cohort, brodalumab demonstrated rapid and sustained effectiveness in patients with moderate-to-severe plaque psoriasis, irrespective of BMI category with 100% of patients reaching a PGA 0/1 at 52 weeks. Brodalumab also improves quality of life in this population with a DLQI 0/1 reached by 64.3% of patients at 52 weeks. These findings support brodalumab as a clinically relevant therapeutic option for overweight and obese psoriasis patients. However, the small sample size (n=29) limits statistical significance, warranting confirmation in larger prospective real-world cohorts.

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Abstract N°: 196

CARD14 and HLA-Cw6 SNPs as Predictors of Response to IL-17 versus IL-23 Blockade: A Retrospective Real-World Study

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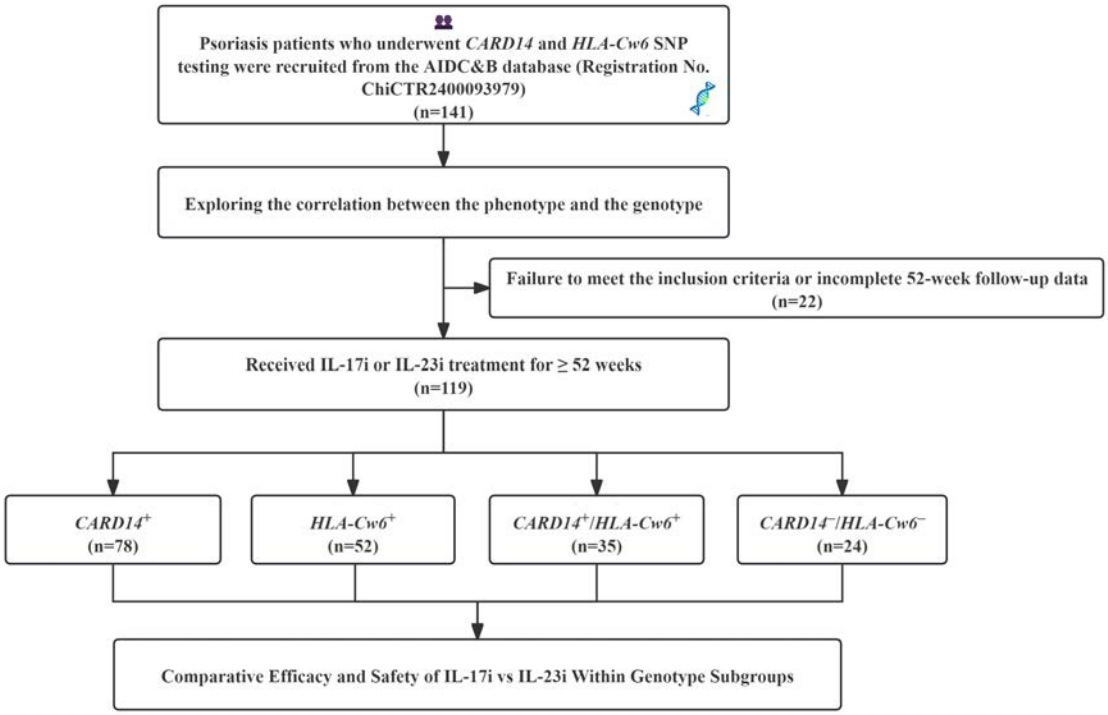
Introduction

Psoriasis is a common chronic inflammatory skin disorder characterized by persistent plaques, which not only impairs patients' physical appearance but also affects their mental health and quality of life. For moderate-to-severe psoriasis, interleukin-17 inhibitors (IL-17i) and interleukin-23 inhibitors (IL-23i) have become the mainstay of treatment in recent years, significantly improving clinical outcomes for most patients. However, clinical practice often encounters two major challenges: some patients experience secondary treatment failure after an initial response, and a subset develop paradoxical eczema during biologic therapy, which limits the long-term effectiveness of these drugs and brings additional burdens to patients.

Genetic factors play a crucial role in the pathogenesis and progression of psoriasis. HLA-Cw6 and CARD14 are well-recognized genetic susceptibility markers for the disease. Previous studies have confirmed that these two genes are closely associated with the occurrence and severity of psoriasis, but their specific role in guiding biologic treatment remains unclear. In particular, there is a lack of clear evidence on how HLA-Cw6 and CARD14 genotypes affect the therapeutic response to IL-17i versus IL-23i—including differences in short-term efficacy, long-term drug survival, and the risk of adverse events such as secondary failure and paradoxical eczema.

Clarifying the correlation between these genetic markers and biologic treatment response is of great clinical significance. It can help clinicians tailor personalized treatment strategies, select the most appropriate biologic agent for individual patients, reduce the risk of treatment failure and adverse reactions, and ultimately improve the long-term management effect of moderate-to-severe psoriasis. Therefore, this study aimed to explore the genotype-phenotype correlation of HLA-Cw6 and CARD14 in patients with moderate-to-severe plaque psoriasis, and further analyze the association between these genotypes and the therapeutic efficacy and safety of IL-17i and IL-23i.



A total of 141 patients with moderate-to-severe plaque psoriasis who underwent CARD14 (rs2066964, rs11652075) and HLA-Cw6 (C06:02) genotyping were initially identified from the electronic data capture database of a tertiary hospital in China between December 2023 and October 2025. Baseline clinical characteristics were analyzed in this initial cohort stratified by CARD14 and HLA-Cw6 genotype. After applying inclusion criteria (age ≥ 18 years, Received IL-17i or IL-23i treatment for ≥52 weeks) and exclusion criteria (incomplete 52-week follow-up data, n=22), 119 patients were included in the final analysis. Eligible patients were stratified into four genotypic subgroups based on the presence of at least one risk allele: CARD14+(n=78, 65.5%), HLA-Cw6+(n=52, 43.7%), CARD14+/HLA-Cw6+ (double-positive, n=35, 29.4%), and CARD14-/HLA-Cw6- (double-negative, n=24, 20.2%). Each subgroup was further divided by initial biologic class: IL-17 inhibitors (secukinumab, ixekizumab, vunakizumab) or IL-23 inhibitors (guselkumab, ustekinumab). For patients who switched to a different biological agent during the follow-up period, if they completed 52 weeks of treatment for each category, they would be assigned to two separate groups. At 52 weeks, efficacy, treatment persistence, and safety outcomes were evaluated in patients stratified by CARD14 and HLA-Cw6 genotype and treated with IL-17 inhibitors vs. IL-23 inhibitors. Drug retention probability was assessed using Kaplan-Meier curves.

Conclusion

This study demonstrates that genetic stratification based on HLA-Cw6 and CARD14 status serves as a powerful predictor of long-term therapeutic response to advanced biologics in psoriasis. These findings argue for a transition to a genotype-informed paradigm for biologic therapy selection. The integration of HLA-Cw6 and CARD14 testing into clinical decision-making, especially in patients with early-onset disease or relevant clinical histories, has the potential to guide more effective first-line biologic use, reduce empirical treatment approaches, and improve long-term clinical outcomes. Large-sample, prospective, randomized studies are warranted to validate the proposed treatment algorithm and to evaluate the cost-effectiveness of incorporating pretreatment genetic screening into the management pathway for moderate-to-severe psoriasis.

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Abstract N°: 206

Multiple biologic treatment failure in patients with psoriasis: A systematic review and meta-analysis

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Introduction
Psoriasis is a multi-system chronic autoimmune inflammatory disease with a genetic predisposition. Biologic therapies are more effective and better tolerated than older oral immunosuppressants such as methotrexate and cyclosporine. However, some patients fail to attain the expected therapeutic response, and a subgroup of these patients are resistant to multiple biological agents.A systematic review and meta-analysis was conducted to identify relevant patient and disease characteristics that may contribute to multiple biologic failure in psoriasis.

Materials and Methods
Medline, Embase, Scopus and Cochrane library were searched from their inception until June 2025. Studies describing patients who had failed multiple biological agents were included for review. The primary outcome was to identify risk factors associated with an ineffective response to multiple biologics. Two authors conducted screening of eligible studies and extracted the data independently from included studies. Data extracted from case series and single arm cohort studies were summarised using descriptive statistics. A meta-analysis was performed to pool data from comparative studies. Only high or moderately high-quality studies, as assessed by the Joanna Briggs Institute checklist, were included for analysis.

Results
Twelve studies were included for data extraction: six case series, one case-control study and five cohort studies. Four comparative studies with 427 multi-biologic failure (MBF) patients and 1925 control patients were included in the meta-analysis.Female sex (odds ratio (OR) 1.45; 95% confidence interval (CI) 1.14-1.83), higher body mass index (BMI) (mean difference 1.85; 95% CI 0.22-3.48), cardiovascular disease (OR 1.84; 95% CI 1.29-2.62), dyslipidaemia (OR 1.89; 95% CI 1.15-3.09) and erythrodermic psoriasis (OR 4.51; 95% CI 1.57-12.99) were associated with increased odds or mean difference of failing multiple biological agents.Four further variables demonstrated possible positive association with failing multiple biologics, however, pooled estimates were not statistically significant. These variables were psoriatic arthritis (OR 1.51, 95% CI 0.96-2.39), smoking status (OR 1.23, 95% CI 0.74-2.04), obesity (OR 1.23, 95% CI 0.85-1.77) and palmoplantar psoriasis (OR 1.73, 95% CI 0.79-3.82). 73 MBF patients were included from case series and non-comparative cohort studies. Amongst these patients, the mean age was 54.19 years and the male to female ratio was 1.80 to 1. The weighted mean number of failed biologics was 4.08 agents. Biologic failure was most commonly seen with tumour necrosis factor- α (TNFα) inhibitors, while interleukin-17 inhibitors demonstrated the highest effectiveness.

Conclusions
Of the variables examined, five were statistically significant in our meta-analysis: female sex, higher BMI, dyslipidaemia, cardiovascular disease and erythrodermic psoriasis. These findings are consistent with established risk factors for reduced biologic response. Knowledge of these variables can guide treatment decisions in MBF

patients, especially as this cohort increases with wider biologic use in psoriasis. Our review is limited by small sample size, missing data points and heterogenous data. Further cohort studies are required to increase the reliability of pooled data.

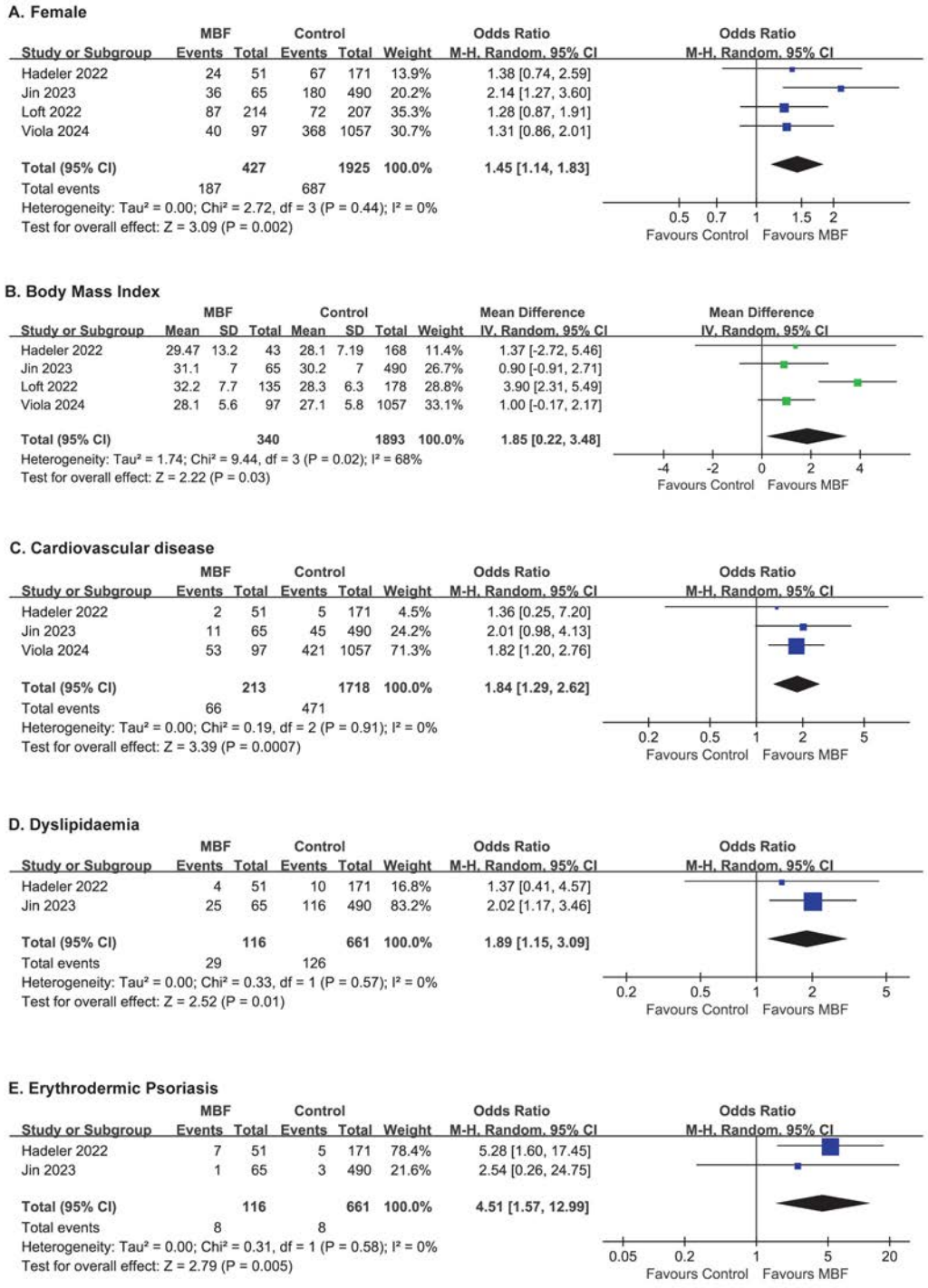

Figure 1: Statistically significant risk factors for multiple-biologic failure in patients with psoriasis

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Abstract N°: 241

Real-World Adherence to CAL/BDP PAD-Cream in Adults with Mild-to-Moderate Psoriasis: Results from the ADHER-TOP Study

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Introduction
Topical therapies remain the mainstay of management for patients with mild-to-moderate plaque psoriasis, with the fixed-dose combination of calcipotriol and betamethasone dipropionate (CAL/BDP) recommended as first-line therapy [1,2]. However, conventional CAL/BDP formulations may be associated with greasiness and stickiness, which may negatively impact adherence. A novel cream formulation based on the polyaphron dispersion (PAD) technology was developed to improve cosmetic acceptability and patient convenience [3]. This study aims to evaluate CAL/BDP PAD-cream adherence in patients with mild-to-moderate plaque psoriasis under real-world conditions.

Materials and Methods
ADHER-TOP was a real-world evidence, prospective, observational, single-arm, multicentre study including adults with mild-to-moderate plaque psoriasis treated with CAL/BDP PAD-cream in Spain. CAL/BDP PAD-cream was prescribed as monotherapy in routine clinical practice, according to the Summary of Product Characteristics, prior to study invitation. Eligible patients were consecutively enrolled without any influence on the prescribed treatment. Adherence was self-reported at Week 4 (W4) and Week 8 (W8) through the Questionnaire for Adherence to TOPical treatment (QATOP) and a Numerical Rating Scale (NRS) ranging from 0 (“no cream was applied”) to 10 (“the cream was applied once every day during the treatment period”). All data were collected as part of routine clinical practice, with no additional diagnostic or therapeutic procedures, consistent with the observational nature of the study. Analyses were conducted on the full analysis set (FAS; defined as all those patients in the safety population who had ≥1 post-baseline QATOP assessment at W4 or W8, total or partially completed) based on observed cases. No imputation for missing data was done.

Results
A total of 55 patients were included in the FAS, with a mean (standard deviation [SD]) age of 50.1 (15.4) years and most being males (65.5%). Mean (SD) body mass index was 26.1 (4.7) kg/m2. At baseline, 41.8% of patients had scalp involvement and none had concomitant psoriatic arthritis. In patients with available cream-use data (n=52), mean (SD) use was 1.8 (0.9) tubes (corresponding to 79.2 [58.4] g). The QATOP and the NRS for adherence were both completed by 55 patients at W4 and 48 patients at W8. Few patients reported having received pharmacy counselling (12.7% and 25.0% at W4 and W8) and in most cases treatment was applied by the patients themselves (96.4% and 95.8% at W4 and W8). Skincare products were used as a complement to CAL/BDP PAD-cream by 10.9% and 16.7% of patients at W4 and W8, respectively. CAL/BDP PAD-cream was applied for a mean

(SD) of 27.6 (8.2) days at W4 and 49.8 (10.5) days at W8. In addition, at W4 and W8, 65.5% and 58.3% of patients reported having "always" completed the prescribed treatment, and 94.5% and 91.7% reported applying it "always" or "many times". Main non-adherence reason was forgetting to apply the treatment both at W4 (29.1%) and W8 (20.0%). At W8, perceived treatment effectiveness was also reported (12.7%) as a reason for non-compliance, while all other non-adherence reasons at both timepoints were reported by only one or two patients. A mean (SD) NRS of adherence of 9.0 (1.3) and 8.8 (1.8) was reported at W4 and W8, respectively, with 89.1% and 87.5% of patients indicating high adherence (i.e., NRS≥8).

Conclusions

In a real-world setting, adults with mild-to-moderate plaque psoriasis demonstrated high self-reported adherence to CAL/BDP PAD-cream. Adherence, assessed using both QATOP and NRS instruments, was high at the primary assessment at W4 and remained consistent through the end of the treatment period at W8 in the ADHER-TOP study.

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Abstract N°: 245

Long-term Durability and Safety of the Targeted Oral Peptide Icotrokinra for High-Impact Site Psoriasis: 2-year Findings From the ICONIC-TOTAL Randomized Controlled Trial

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Introduction

Plaque psoriasis (PsO) involving high-impact sites, including the scalp, genitals, hands/feet, and nails, can substantially impair health-related quality of life and may be particularly challenging to treat. Icotrokinra (ICO) is a targeted oral peptide that precisely blocks the interleukin (IL)-23 receptor and inhibits IL-23 pathway signaling. Across phase 3 trials in participants (pts) with PsO, ICO demonstrated robust efficacy with favorable safety vs placebo (PBO) through Week (W)16, with consistent results through 1 year (Y).[1-4] Long-term data on durability of response and safety will help inform treatment decisions. Reported here are clinical response rates and safety of ICO through 2Y in ICONIC-TOTAL study pts with high-impact site plaque PsO.

Materials and Methods

ICONIC-TOTAL is an ongoing, phase 3, multicenter, randomized, double-blind, PBO-controlled trial in adult and adolescent pts (≥12 years of age) with Investigator's Global Assessment (IGA) score ≥2 and PsO body surface area ≥1%. Eligible pts had at least moderate involvement of ≥1 high-impact site, defined as a score ≥3 for scalp specific-IGA (ss-IGA), static Physician's Global Assessment of Genitalia (sPGA-G), or hand/foot PGA (hf-PGA). Pts

were randomized (2:1) to receive once-daily oral ICO 200 mg or PBO with transition to ICO at W16. Topical therapies were permitted after W52. Rates of achieving clear/almost clear (IGA 0/1 with ≥2-grade IGA improvement from baseline) or completely clear (IGA 0) skin overall and clear/almost clear (ss-IGA 0/1, sPGA-G 0/1, hf-PGA 0/1) or completely clear (ss-IGA 0, sPGA-G 0, hf-PGA 0) PsO at high-impact sites were reported through W112. For binary endpoints, non-responder imputation was applied through W52; after W52 multiple imputation was used for missing data. Nail PsO severity was assessed via percent improvement in modified Nail Psoriasis Severity Index (mNAPSI) through W112. Safety was reported as exposure-adjusted rates of pts with ≥1 adverse event (AE) per 100 patient-years (PY) through W112.

Results

Among 311 randomized pts (208 ICO, 103 PBO), 254 (82%) completed treatment through W112. Among ICO-randomized pts, achievement rates of IGA 0/1 increased from W16 (57%) through W24 (67%) and remained stable through W112 (70%; Fig 1A), with similar trends for IGA 0 (W16: 25%, W24: 45%, W112: 48%; Fig 1B). Rates of achieving clear/almost clear skin at high-impact sites increased through W24 and were maintained through W112 for scalp (ss-IGA 0/1; W16: 66%, W24: 78%, W112: 74%; Fig 1C) and genital PsO (sPGA-G 0/1; W16: 77%, W24: 90%, W112: 89%; Fig 1D). Rates increased through W52 for hand/foot PsO (hf-PGA 0/1; W16: 42%, W24: 54%, W52: 62%) and were maintained through W112 (68%; Fig 1E). At W112, high rates of complete skin clearance (score of 0) were reported for scalp (60%), genital (89%), and hand/foot (63%) PsO among ICO-randomized pts. Nail PsO improved progressively among ICO-randomized pts, with mNAPSI percent improvements increasing from 33% at W16 to 62% at W52 and 71% at W112 (Fig 1F), with comparable improvements among PBO-to-ICO pts. Exposure-adjusted incidence rates (95% confidence interval) of ICO-treated pts with ≥1 AE did not increase between W0-W52 (160 [138, 182]/100PY) and W0-W112 (122 [106, 137]/100PY) time periods, with similar trends for serious AEs (W0-W52: 2.7 [1.1, 5.6]/100PY; W0-W112: 2.7 [1.3, 4.1]/100PY). No deaths were reported.

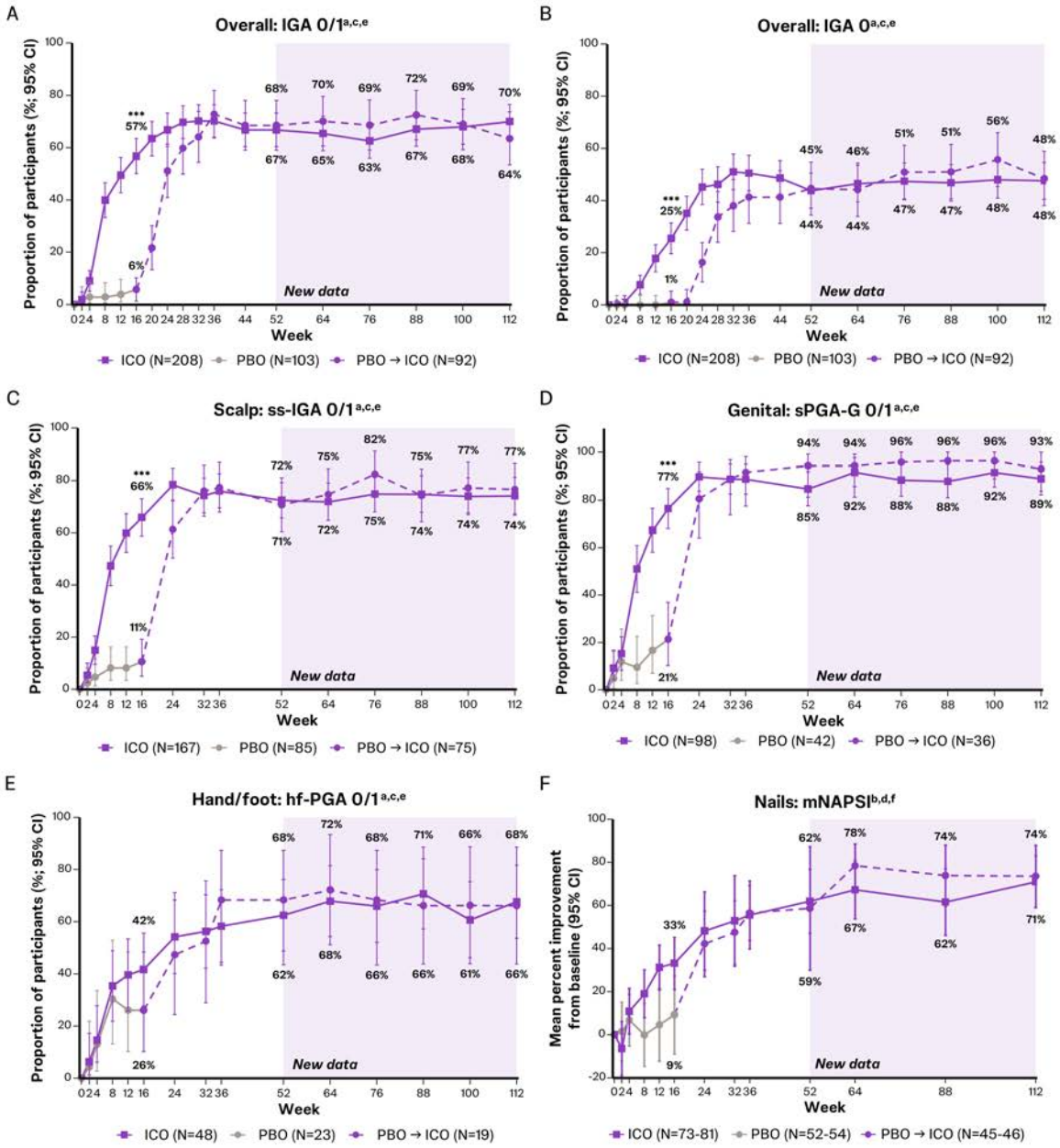
Figure 1. Proportion of pts achieving (A) overall IGA 0/1 with an improvement of ≥2 from baseline, (B) overall IGA 0, (C) ss-IGA 0/1, (D) sPGA-G 0/1, and (E) hf-PGA 0/1; (F) mNAPSI percent improvement through W112.

***Multiplicity-adjusted p <0.001 ICO vs PBO. [d]Through W52 nonresponder imputation / [b]0% improvement from baseline assigned after pts discontinued study drug due to a lack of efficacy or an AE of worsening PsO or initiated prohibited medication that could impact PsO; observed data were used for pts who discontinued study agent for other reasons. [c]After W52 nonresponder imputation / [d]0% improvement from baseline assigned after pts who discontinued study drug due to a lack of efficacy or an AE of worsening PsO. [e]After accounting for these intercurrent events: through W52, pts with missing data were considered nonresponders and, after W52, other missing data were imputed using multiple imputation. [f]The remaining missing data were not imputed. Through W52 CIs were based on the normal approximation or an exact method if the number of responders or number of non-responders was <10. After W52, confidence intervals were derived based on multiple imputations.

ss-IGA evaluated among pts with baseline ss-IGA score ≥3. sPGA-G evaluated among pts with baseline score ≥3. hf-PGA evaluated among pts with baseline score ≥3. mNAPSI evaluated among pts with baseline score >0.

IGA range: 0 (cleared); 1 (minimal); 2 (mild), 3 (moderate); 4 (severe). ss-IGA range: 0 (absent), 1 (very mild), 2 (mild), 3 (moderate), 4 (severe). sPGA-G range: 0 (clear), 1 (minimal), 2 (mild), 3 (moderate), 4 (severe), 5 (very severe). hf-PGA range: 0 (clear), 1 (almost clear), 2 (mild), 3 (moderate), 4 (severe). mNAPSI range: 0-130; higher scores indicate worse severity.

AE: adverse event, CI: confidence interval, hf-PGA: Physician's Global Assessment of the hands and/or feet, ICE: intercurrent event, ICO: icotrokinra, IGA: Investigator's Global Assessment, mNAPSI: modified Nail Psoriasis Severity Index, PBO: placebo, sPGA-G: static Physician's Global Assessment of Genitalia, ss-IGA: scalp specific-Investigator's Global Assessment.



Conclusion

ICO demonstrated high and durable rates of PsO clearance across high-impact sites through 2Y of treatment. Exposure-adjusted rates of pts with AEs and serious AEs remained stable with extended ICO treatment, with no new safety signals identified. The robust efficacy, favorable safety profile, and convenience of once-daily oral dosing support the use of ICO in pts with high-impact site PsO.

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From diagnosis to treatment optimization: a narrative review with meta-analytic estimates of racial and ethnic disparities across the psoriasis care continuum

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Introduction
Racial and ethnic disparities in psoriasis have been documented in isolated domains without integration across the full care continuum. European-relevant quantitative data remain exceptionally scarce. This study aimed to map racial and ethnic disparities across six sequential domains of psoriasis care: clinical diagnosis, biologic access, trial representation, treatment efficacy, quality of life and optimization, and hospitalization burden.

Materials and Methods
Structured narrative review of MEDLINE, Scopus, and EMBASE (inception–March 2026). Random-effects meta-analysis (DerSimonian–Laird) for biologic access in Black versus White patients (k=4 studies with adjusted biologic-specific odds ratios). Remaining domains synthesized descriptively. Total: k=34 studies, N>1.8 million patients.

Results
Disparities were identified across five of six domains, with a notable exception in treatment efficacy.

The most proximal barrier is diagnostic. In a nationwide survey of 129 dermatologists, correct visual identification of psoriasis in skin of color was achieved in only 30.3% of cases versus 88.8% in light skin (OR=18.14 [8.16–40.29]; p<0.001), with fewer than one in ten having received specific training. Erythema-based PASI scoring systematically underestimates severity in pigmented skin, preventing patients from reaching biologic eligibility thresholds.

Biologic access disparities were consistent across settings. Black patients had 35% lower odds of receiving biologic therapy (pooled OR=0.65 [0.50–0.85]; I^2=72.0%; p=0.013; k=4), and Hispanic patients showed the largest individual gap (adjusted OR=0.14 [0.04–0.46]) despite attending dermatology appointments more frequently than White patients — a prescription-level rather than access-level barrier. In the BADBIR registry (n=21,407; UK and Ireland, 2007–2024), ethnic minority enrollment rose only from 8.7% to 12.1% over 17 years, confirming the barrier extends to European universal coverage systems.

Trial representation remained severely skewed, with White patients comprising 84.3–85.8% of psoriasis trial participants and Black patients accounting for only 3.09% of Phase III enrollees.

Biologic treatment efficacy was equivalent across all groups (adjusted RR 0.91–1.03; all NS), confirmed by the first randomized trial designed exclusively for patients with skin of color. Lower real-world response rates in a European registry reflect accumulated pre-treatment barriers and PASI underestimation, not pharmacological differences.

Despite equivalent efficacy, minority patients reported significantly greater quality-of-life impact (adjusted OR 1.42–1.74 for DLQI≥2; n=10,107), and Black patients were 57% less likely to switch biologic when response was

inadequate (adjusted RR=0.43 [0.26–0.73]). Patient-level barriers are group-specific: unfamiliarity and injection hesitancy in Black biologic-naïve patients; structural and linguistic barriers in Latine patients. All non-White groups had significantly longer inpatient lengths of stay (IRR 1.14–1.24), and First Nations patients in a Canadian cohort had three times higher hospitalization rates alongside 40% fewer specialist visits.

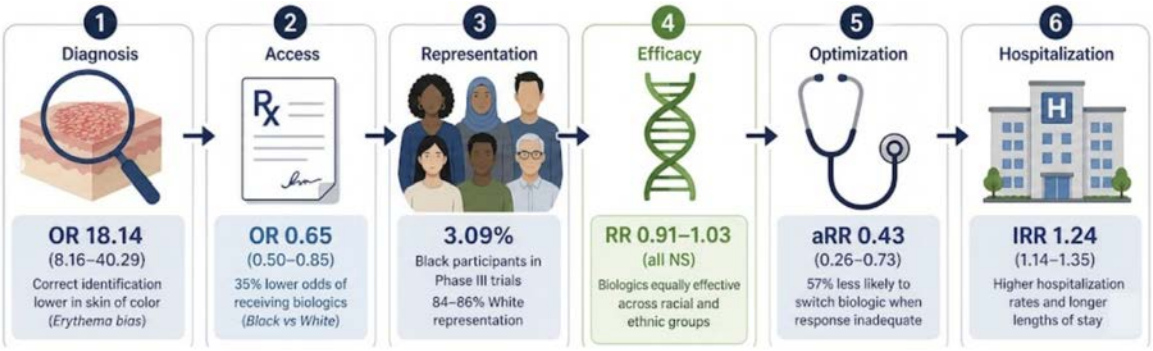

Figure 1. The Psoriasis Care Continuum: Cumulative Disparities. This diagram illustrates the sequential barriers and the efficacy paradox identified across six domains of psoriasis care. Abbreviations and Statistical Definitions: OR: Odds Ratio. RR: Relative Risk. aRR: Adjusted Relative Risk. IRR: Incidence Rate Ratio. 95% CI: 95% Confidence Interval (indicated in parentheses). NS: Not Statistically Significant. SOC: Skin of Color

Conclusions

Biologics perform equally across all racial and ethnic groups when prescribed; the gap lies in access, optimization, and downstream consequences. The diagnostic deficit among European dermatologists, the persistent prescription gap in European registry data, and PASI erythema bias in pigmented skin are immediate, addressable priorities. Mandatory skin-of-color training, removal of barriers to biologic prescription, group-specific patient education, and diversified trial recruitment are urgently needed.

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Efficacy of Apremilast in Patients with Moderate Psoriasis, Including High-impact Site Involvement: A Pooled Analysis of Six Trials

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Introduction
Plaque psoriasis can significantly impact quality of life, even in patients with limited skin involvement. High-impact site involvement (defined as lesions in scalp, nails, genital areas, visible locations, and/or palmoplantar areas) can also impact quality of life in patients with psoriasis. We assessed efficacy of apremilast in patients with psoriasis with limited skin involvement (affected body surface area [BSA] 3–10%), including some patients with high-impact site (HIS) involvement in scalp, nails, or genitals.

Materials and Methods
In this post hoc analysis, patients were pooled from five placebo-controlled trials (randomized to apremilast or placebo through Week 16, followed by open-label apremilast: ADVANCE [NCT03721172], DISCREET [NCT03777436], EMBRACE [NCT03774875], STYLE [NCT03123471], and UNVEIL [NCT02425826])[1–5] and one open-label, single-arm apremilast trial (PROMINENT [NCT03930186])[6]. Assessments at Weeks 16 and 32 included achievement of BSA ≤1% or ≤3%, 75% reduction from baseline BSA (BSA-75), Psoriasis Area and Severity Index (PASI) score <3, Static Physician's Global Assessment (sPGA) score 0/1, Dermatology Life Quality Index (DLQI) score 0/1, Scalp PGA (ScPGA) score 0/1 (in patients with ScPGA score ≥2 at baseline), percent change from baseline in Nail Psoriasis Severity Index (NAPSI; in patients with NAPSI score >1 at baseline), and sPGA-Genitalia (sPGA-G) score 0/1 (in patients with sPGA-G score ≥2 at baseline); nonresponder imputation was used for missing data.

Results
This analysis included 1,152 patients: 671 patients received apremilast and 481 received placebo, with HIS involvement: scalp, 62.5%; nails, 32.6%; genitals, 22.4%. Baseline characteristics were generally similar between treatment arms, including mean BSA (apremilast, 6.3%; placebo, 6.2%; Table 1). At Week 16, apremilast significantly improved skin clearance (as assessed by BSA ≤1%, BSA ≤3%, BSA-75, PASI <3, sPGA 0/1) and quality of life (as assessed by DLQI 0/1) vs placebo ($p<0.0001$ for all; Fig 1). At Week 32, efficacy was maintained or further improved with apremilast. Apremilast also resulted in improvements by HIS vs placebo at Week 16 ($p<0.01$ for ScPGA 0/1, NAPSI, and sPGA-G 0/1 in affected patients; Fig 2); improvements were maintained at Week 32.

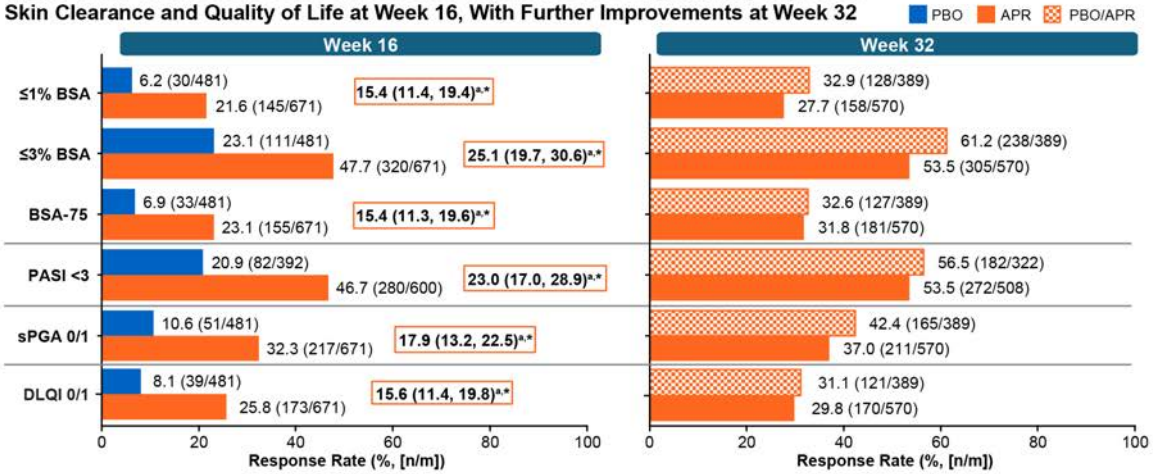
Table 1. Baseline Demographics and Disease Characteristics

Characteristic	PBO N=481	APR N=671	Total N=1,152
Age, years, mean (SD)	48.5 (14.4)	47.6 (14.6)	48.0 (14.5)
Sex, n (%)			
Female	207 (43.0)	293 (43.7)	500 (43.4)
Male	274 (57.0)	378 (56.3)	652 (56.6)
PsO disease duration, years, mean (SD)	15.3 (13.4)	15.5 (13.2)	15.4 (13.2)
BMI,[a] kg/m^2, mean (SD)	30.5 (6.6)	29.5 (7.0)	30.0 (6.8)
DLQI (0–30), mean (SD)	11.5 (6.6)	11.7 (7.0)	11.6 (6.9)
BSA, %, mean (SD)	6.2 (2.2)	6.3 (2.1)	6.3 (2.1)
PASI, mean (SD)	6.8 (2.8)	6.9 (3.0)	6.8 (2.9)
sPGA score (0–4), n (%)			
Clear (0)	15 (3.1)	25 (3.7)	40 (3.5)
Almost clear (1)	6 (1.2)	7 (1.0)	13 (1.1)
Mild (2)	90 (18.7)	138 (20.6)	228 (19.8)
Moderate (3)	355 (73.8)	480 (71.5)	835 (72.5)
Severe (4)	15 (3.1)	21 (3.1)	36 (3.1)
HIS involvement, n (%)			
Scalp (ScPGA ≥2)	273 (56.8)	477 (71.1)	720 (62.5)
Genital area (sPGA-G ≥2)	117 (24.3)	141 (21.0)	258 (22.4)
Nails (NAPSI >0)	137 (28.5)	238 (35.5)	375 (32.6)

[a]BMI is calculated as (body weight in kg)/(height in m^2). Baseline BMI is based on the last weight measurement taken on or prior to the first dose of investigational product and the height measurement taken at screening

Abbreviations: APR, apremilast; BMI, body mass index; BSA, body surface area; DLQI, Dermatology Life Quality Index; NAPSI, Nail Psoriasis Severity Index; PASI, Psoriasis Area and Severity Index; PBO, placebo; PsO, psoriasis; ScPGA, Scalp Physician's Global Assessment; sPGA, static Physician's Global Assessment; sPGA-G, sPGA of Genitalia.

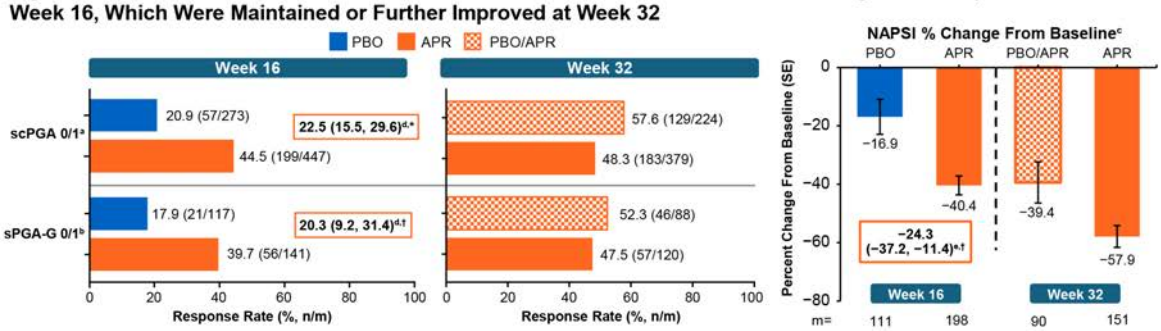
Figure 1. In Patients With BSA 3–10% at Baseline, APR vs PBO Significantly Improved Skin Clearance and Quality of Life at Week 16, With Further Improvements at Week 32



*P<0.0001. Nonresponder imputation. [a]Value represents the Δ (95% CI), where Δ is the adjusted difference (%) in proportions and the weighted average of the treatment differences across strata formed by trial ID as the stratification factor using Cochran-Mantel-Haenszel weights, and the two-sided 95% CI is based on a normal approximation to the weighted average.

Abbreviations: APR, apremilast; BSA, body surface area; BSA-75, a 75% reduction in BSA from baseline; n/m, number of patients with response/number of patients with a baseline and postbaseline value at the time point; PASI, Psoriasis Area and Severity Index; PBO, placebo; sPGA, static Physician's Global Assessment.

Figure 2. Patients With HIS Involvement Who Received APR vs PBO Demonstrated Significant Improvements at Week 16, Which Were Maintained or Further Improved at Week 32



*P<0.0001; †P<0.001. Nonresponder imputation. [a]Patients with baseline ScPGA ≥2. [b]Patients with baseline sPGA-G ≥2. [c]Patients with baseline NAPSI >0. [d]Value represents Δ (95% CI), where Δ is the adjusted difference (%) in proportions and the weighted average of the treatment differences across strata formed by trial ID as the stratification factor using Cochran-Mantel-Haenszel weights, and the two-sided 95% CI is based on a normal approximation to the weighted average. [e]Based on an MMRM of the percent change from baseline.

Abbreviations: APR, apremilast; HIS, high-impact site; MMRM, mixed-effects model for repeated measures; NAPSI, Nail Psoriasis Severity Index; n/m, number of patients with response/number of patients with a baseline and postbaseline value at the time point; PBO, placebo; ScPGA, Scalp Physician's Global Assessment; sPGA-G, static Physician's Global Assessment of Genitalia.

Conclusions

This post hoc analysis of pooled data from six apremilast trials demonstrates that apremilast improves skin clearance and quality of life in patients with moderate psoriasis, including those with HIS involvement.

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Paradoxical Psoriasis During Biologic Therapy: Successful Management with Calcipotriol/Betamethasone Cream

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Introduction
Background:Paradoxical psoriasis refers to the development of psoriasiform lesions in patients receiving biological therapies, most commonly TNF-α inhibitors, but also agents targeting IL-17 or IL-23. Although clinically indistinguishable from classical psoriasis, its management requires balancing control of the underlying immune-mediated disease with the severity of the paradoxical eruption.

Objectives:To describe the clinical profile of patients who may benefit from calcipotriol/betamethasone dipropionate (CAL/BDP) aqueous cream for the treatment of paradoxical psoriasis, and to present two real-world cases illustrating its effectiveness.

Case Presentation
Methods:
Two female patients with immune-mediated diseases (panuveitis and severe Crohn's disease) who developed paradoxical psoriasis while on biologic therapy were treated with CAL/BDP aqueous cream. Clinical evolution, therapeutic decisions, and outcomes were documented.

Results:
In Case 1, an 18-year-old woman on adalimumab developed scalp and umbilical psoriasiform lesions resistant to mometasone. Treatment with CAL/BDP cream achieved complete clearance, allowing continuation of adalimumab with extended dosing intervals.
In Case 2, a 33-year-old woman with severe Crohn's disease developed extensive psoriasiform alopecia shortly after switching to ustekinumab. CAL/BDP cream led to rapid improvement in erythema, scaling, pruritus, and inflammation, serving as a bridging therapy until risankizumab became effective. Complete hair regrowth was observed after two months.

Conclusion
Conclusions:
CAL/BDP aqueous cream was effective and well tolerated in both cases of paradoxical psoriasis, enabling either the continuation of the causative biologic or symptomatic control during the transition to alternative systemic

therapy. These findings support the use of CAL/BDP aqueous cream as a valuable therapeutic option in patients with paradoxical psoriasis requiring topical management

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The association of systemic immune-inflammation index with Th17/Treg imbalance, disease severity (PASI) and quality of life (DLQI/PLSI) in psoriasis vulgaris patients: a cross-sectional study

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Introduction

Psoriasis vulgaris (PV) is an immune-mediated, chronic, inflammatory skin disease driven by dysregulation of the Th17/Treg axis. This dysregulation is characterized by elevated levels of pro-inflammatory cytokines (e.g., IL-17, IL-22) and reduced levels of anti-inflammatory cytokines (e.g., IL-10, TGF-β1). The systemic immune-inflammation index (SII), a composite biomarker derived from routine peripheral blood test results, reflects systemic immune-inflammatory status by integrating neutrophil, lymphocyte and platelet counts. While previous studies have shown that SII correlates with disease severity and activity in psoriasis, its relationship with the underlying immune dysregulation in PV remains unclear. This cross-sectional observational study aimed to investigate the association of SII with Th17/Treg imbalance, disease severity, and quality of life in PV patients.

Materials and Methods

A total of 112 newly diagnosed PV patients and 112 age-/sex-matched healthy controls were enrolled. Peripheral blood samples were collected upon admission. SII was calculated as (platelet count × neutrophil count)/lymphocyte count. Peripheral blood Th17 ($CD3^+CD4^+IL\text{-}17A^+$) and Treg ($CD3^+CD4^+CD25^+FOXP3^+$) proportions were measured by flow cytometry. Serum levels of pro-inflammatory cytokines IL-17 and IL-22, as well as anti-inflammatory cytokines IL-10 and TGF-β1 were determined by ELISA. Psoriasis area and severity index (PASI) was used to assess disease severity, whereas the Dermatology Life Quality Index (DLQI) and Psoriasis Life Stress Inventory (PLSI) were used to reflect quality of life. Correlations of SII with Th17/Treg cells, cytokines (IL-17, IL-22, IL-10, and TGF-β1), PASI, DLQI and PLSI were analyzed by Spearman analysis. PV patients were classified into mild (MPV, n=76) or moderate-to-severe (MSPV, n=36) groups. Logistic regression was used to identify independent factors for disease severity.

Results

Compared with controls, PV patients showed significantly elevated SII and neutrophil counts (all $P<0.0001$), increased IL-17 and IL-22 levels (all $P<0.001$), and decreased IL-10 level ($P<0.001$) and lymphocyte count ($P<0.05$). The proportion of Th17 cells in PV patients was increased ($P < 0.001$), while the proportion of Treg cells was reduced ($P < 0.001$). SII was positively correlated with Th17, IL-17 and IL-22 ($r = 0.3387$, $r = 0.2367$, $r = 0.2259$, respectively, all $P < 0.05$), as well as PASI ($r=0.6190$, $P<0.0001$), DLQI ($r=0.6124$, $P<0.05$) and PLSI ($r=0.5219$, $P<0.001$). SII was negatively correlated with Treg, IL-10 and TGF-β1 ($r = -0.3846$, $r = -0.3735$, $r = -0.3823$, respectively, all $P < 0.0001$). Compared with MPV patients, MSPV patients had increased neutrophil count and SII level, their Th17/Treg ratio and IL-17/IL-22 levels were also significantly higher (all $P<0.05$). On the other hand, MSPV patients exhibited lower lymphocyte count, a reduced Treg proportion, and lower IL-10/TGF-β1 levels. Multivariate logistic regression identified elevated BMI, increased SII, a higher Th17 proportion and a lower Treg proportion (all $P<0.05$) as independent predictors of disease severity.

Conclusions

Elevated SII levels in PV patients at admission are significantly associated with Th17/Treg imbalance, greater disease severity (PASI) and poorer quality of life (DLQI/PLSI). SII may serve as a convenient “snapshot” biomarker of immuno-inflammatory status in PV, though its value for dynamic monitoring of disease activity and treatment response requires validation in future prospective cohort studies or longitudinal studies.

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Managing the Unknown: A Case Report of Generalized Pustular Psoriasis in the Absence of Established Guidelines

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Introduction

Generalized pustular psoriasis (GPP) is a rare, potentially life-threatening autoinflammatory disease characterized by a widespread eruption of sterile pustules on erythematous skin. Clinical manifestations may include fever, malaise, and arthralgias. Although many patients have a history of other forms of psoriasis, evidence suggests that GPP has a distinct genetic basis. No specific race or sex predilection has been observed, with the peak age of onset ranging between 40 and 60 years. The prevalence of GPP is unknown due to its rarity, making diagnosis and management challenging and largely based on limited case series and reports.

Case Presentation

We present the case of a 42-year-old female patient hospitalized for a severe acute pustular eruption. The current episode debuted in the inguinal folds 3 weeks prior to presentation, with subsequent extension to the trunk and upper limbs, characterized by small, superficial pustules on an erythematous background, coalescing into large erythematous-pustular plaques with superficial desquamation. Physical examination also revealed onychodystrophy of three fingernails. No fever or extracutaneous or subjective symptoms were present at the time of admission. Laboratory findings showed leukocytosis with neutrophilia and systemic inflammation.Her medical history revealed a similar episode in 2020, occurring 48 hours postpartum following cephalosporin exposure, initially suspected as acute generalized exanthematous pustulosis (AGEP). Skin biopsy showed overlapping features suggestive of both GPP and AGEP. The prolonged refractory course eventually supported GPP. Methotrexate was initiated but halted due to significant liver enzyme elevation. Systemic retinoids successfully induced complete remission, and no subsequent pustular episodes have occurred to date.It was debatable whether the current episode was GPP or AGEP, particularly given the reported onset soon after metronidazole intake. A new 4 mm punch biopsy revealed dense neutrophilic infiltration, subcorneal pustules, spongiosis, and no eosinophils or necrotic keratinocytes. While awaiting biopsy results, oral prednisone was initiated. Inflammation progressed, with lesions extending to involve the entire body surface and clinical deterioration. Adding cyclosporine led to a significant response within 48 hours. The patient was discharged on 5 mg/kg/day, tapered at follow-up visits, with close monitoring of renal function and blood pressure.After reducing cyclosporine to 2.5 mg/kg/day, new painful erythematous-pustular plaques appeared, along with leukocytosis, neutrophilia, and inflammatory syndrome. The dose was increased back to 5 mg/kg/day, but hypertension required initiation of amlodipine. Acitretin 20 mg/day, obtained from abroad due to lack of national availability, was added to enable cyclosporine tapering and maintain disease control.

Conclusion

Determining the optimal approach for GPP remains complicated, as available data is limited and therapeutic resources are also scarce in some countries. Systemic therapy is the primary mode of treatment for acute GPP. Cyclosporine offers the advantage of a rapid onset of action compared to methotrexate, while acitretin and other therapies are not universally accessible. Response to treatment is variable, and the course of GPP is also unpredictable, with periods of remission and flares, highlighting the need for individualized management

strategies and improved access to effective therapies. Nevertheless, differential diagnosis with AGEP is essential, as the prognosis of a patient with GPP depends on prompt recognition and appropriate therapy.

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Abstract N°: 309

Immediate biologic intervention in psoriasis: promoting rapid remission and optimizing patient quality of life

Ngoc Phat Trinh*[1, 2], Dinh Nguyen[1, 2]

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Introduction
Monoclonal antibodies are now a standard treatment for moderate-to-severe plaque psoriasis. Nonetheless, the concept of early intervention with biologic agents has only recently emerged. Contemporary evidence indicates that initiating biologic therapy early in the disease course leads to superior clinical outcomes, faster achievement of target Psoriasis Area and Severity Index (PASI) thresholds, and prolonged remission. Most studies define early intervention as treatment initiated within the first 1 to 2 years of disease onset.

Materials and Methods
We conducted a pilot study employing an even earlier treatment window, designated as "immediate intervention," defined as a disease duration of less than 6 months in patients with milder severity. Twelve patients with plaque psoriasis of varying severity received standard-dose guselkumab (an interleukin-23 blocker) and were followed every 4 weeks for 20 weeks.

Results
The mean patient age was 30.1±9.8 years. Mean disease duration was 3.6±1.0 months. Four patients were classified as moderate-to-severe and eight as mild. The mean baseline PASI score was 8.1±4.1. PASI75 was achieved by 91.7% at week 8 and 100.0% at week 12. PASI90 rates were 8.3%, 83.3%, and 100.0% at weeks 8, 12, and 16, respectively. PASI100 was reached by 16.7%, 75.0%, and 100.0% at weeks 12, 16, and 20. Baseline DLQI was 12.4±33, decreasing to 10.2±2.6 at week 4 compared to baseline ($p<0.05$), 7.2±1.5 at week 8 ($p<0.001$), 4.8±1.0 at week 12 ($p<0.001$), and 1.9±1.2 at week 16 ($p<0.001$), with 62.5% achieving DLQI ≤1. By week 20, DLQI decreased to 0.3±0.4 ($p<0.001$), with 100.0% achieving DLQI ≤1. No adverse events occurred. These outcomes were markedly superior to those reported in the VOYAGE 1 and VOYAGE 2 clinical trials.

Conclusions
Collectively, these findings suggest that very early initiation of biologic therapy enhances treatment efficacy, accelerates clinical response, and rapidly improves quality of life without a corresponding increase in adverse events.

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Abstract N°: 312

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Abstract N°: 312

Zasocitinib, a highly selective, once-daily oral TYK2 inhibitor, demonstrates superior skin clearance (PASI 100) versus an approved oral TYK2 inhibitor, deucravacitinib, and a consistent safety profile in moderate-to-severe plaque psoriasis: results from a randomized phase 3 intraclass head-to-head trial (LATITUDE Atlas)

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Introduction
Zasocitinib is an investigational, next-generation, highly selective, once-daily oral tyrosine kinase 2 (TYK2) inhibitor that maintains 24-hour inhibition of interleukin-23 plus other core disease-driving immune pathways. In two pivotal phase 3 placebo- and active- (apremilast) controlled trials in adults with moderate-to-severe plaque psoriasis (LATITUDE-PsO-3001 [NCT06088043] and -3002 [NCT06108544]), zasocitinib demonstrated rapid, durable and reproducible skin clearance with a consistent safety profile. Here, we evaluated the efficacy and safety of zasocitinib vs an approved oral TYK2 inhibitor, deucravacitinib, in adults with moderate-to-severe plaque psoriasis in a phase 3 head-to-head clinical trial (LATITUDE Atlas; NCT06973291).

Materials and Methods
This multicentre, international, randomized, double-blind, active comparator-controlled trial compared zasocitinib 30 mg once daily (QD) with deucravacitinib 6 mg QD. Eligible adults (Psoriasis Area and Severity Index [PASI] ≥12, static Physician's Global Assessment [sPGA] ≥3, body surface area involvement ≥10%) were randomized 1:1 to receive zasocitinib or deucravacitinib. The primary efficacy endpoint was PASI 100 response at Week 16. Key secondary efficacy endpoints were PASI 90, absolute PASI ≤2 and sPGA 0 responses at Week 16. Exploratory efficacy endpoints included the change from baseline (CfB) in Dermatology Life Quality Index (DLQI) and Itch Numerical Rating Scale (NRS) over time. Safety endpoints included the incidence of treatment-emergent adverse events (TEAEs), serious adverse events (SAEs), adverse events of special interest (AESIs) and laboratory parameters.

Results

Overall, 301 and 303 patients were randomized to receive zasocitinib and deucravacitinib. Baseline patient demographics and disease characteristics were generally balanced between groups. Among patients receiving zasocitinib and deucravacitinib, respectively, most were male (64.1% and 69.6%), mean (standard deviation [SD]) age was 46.1 (12.9) and 45.6 (13.8) years, mean (SD) weight was 87.6 (21.9) and 91.1 (24.6) kg, and overall mean (SD) PASI score was 19.7 (7.2) and 19.0 (6.4).

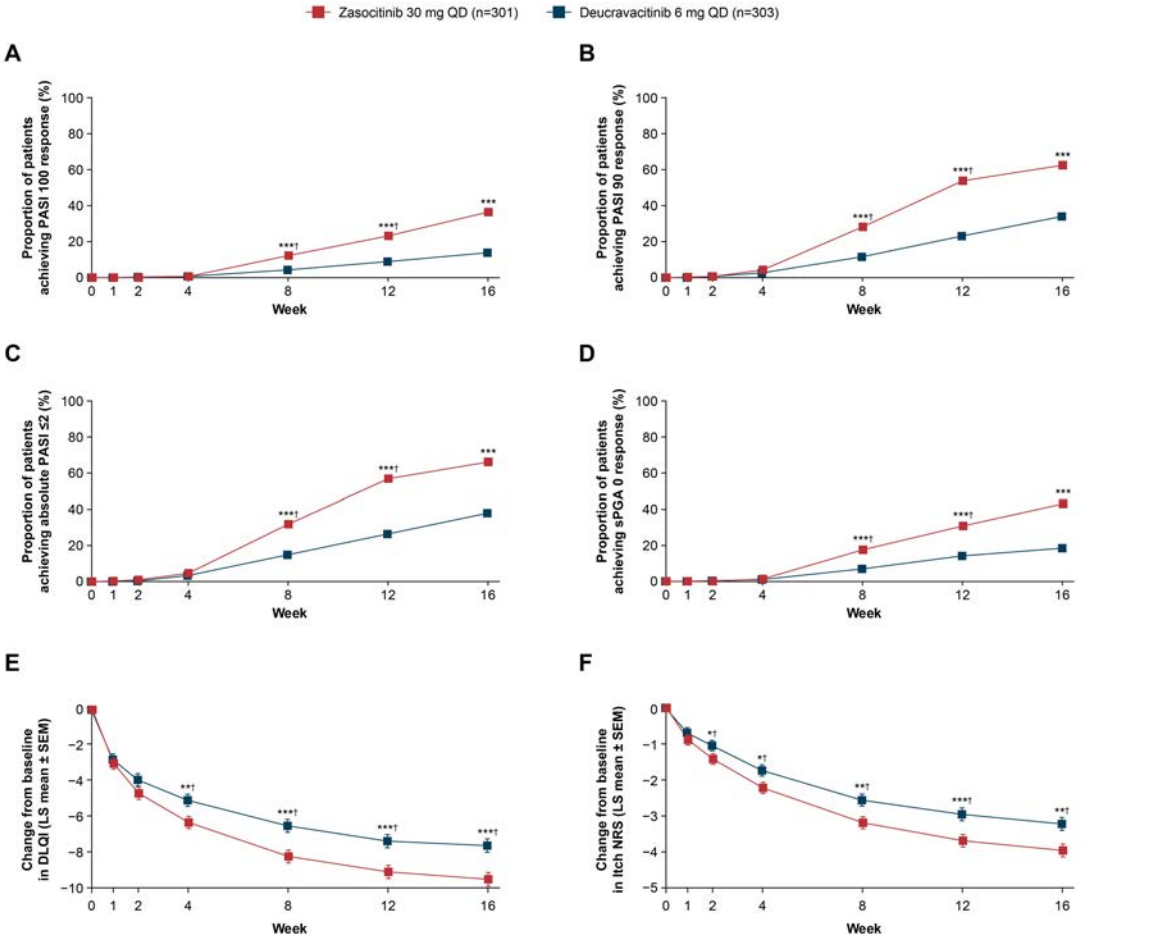
At Week 16, zasocitinib demonstrated a significantly greater PASI 100 response rate vs deucravacitinib (36.5% vs 13.9%; $p<0.001$; **Figure 1A**). Zasocitinib also demonstrated greater PASI 90, absolute PASI ≤2 and sPGA 0 response rates at Week 16 (62.5%, 66.1% and 43.2%, respectively) vs deucravacitinib (34.0%, 38.0% and 18.5%, respectively; all $p<0.001$; **Figure 1B–D**). Higher response rates with zasocitinib than deucravacitinib were observed for all of these outcomes as early as Week 8 (nominal $p<0.001$). In evaluable patients at Week 16, zasocitinib demonstrated a greater least-squares mean (standard error of the mean) CfB versus deucravacitinib in DLQI score (−9.5 [0.4] vs −7.6 [0.4]; nominal $p<0.001$; **Figure 1E**) and Itch NRS score (−4.0 [0.2] vs −3.2 [0.2]; nominal$p=0.001$; **Figure 1F**).

Rates of TEAEs, SAEs and treatment-related AESIs were generally similar between treatment groups. In total, TEAE rates were higher and SAE rates were lower with zasocitinib than deucravacitinib (TEAEs: 65.9% and 58.7%; SAEs: 1.3% and 2.3%; treatment-related AESIs: 2.0% and 2.3%). Consistent with previous trials, the most frequently occurring TEAEs in the zasocitinib group were nasopharyngitis (12.9%), upper respiratory tract infection (11.3%) and acne (7.3%). No treatment-related major adverse cardiovascular or venous thromboembolism events were observed in either group. No clinically meaningful trends in laboratory parameters were observed through Week 16 in either group.

Conclusion

In this phase 3 comparative trial, highly selective TYK2 inhibition with oral zasocitinib 30 mg QD showed superior skin clearance with multiple efficacy endpoints (including PASI 100, PASI 90, absolute PASI ≤2 and sPGA 0) versus the TYK2 inhibitor deucravacitinib at Week 16, with higher response rates from Week 8. The overall safety and tolerability profile of zasocitinib was consistent with previous trials.

Figure 1. Zasocitinib demonstrated significantly greater (A) PASI 100, (B) PASI 90, (C) absolute PASI ≤2 and (D) sPGA 0 response rates versus deucravacitinib as early as Week 8 and through Week 16, and greater changes from baseline in (E) DLQI score[a] as early as Week 4 and (F) Itch NRS score[b] as early as Week 2 versus deucravacitinib through Week 16.



***p<0.001; *†nominal p<0.05; **†nominal p<0.01; ***†nominal p<0.001.
[a]At baseline, n = 295 (zasocitinib) and n = 292 (deucravacitinib).
[b]At baseline, n = 297 (zasocitinib) and n = 293 (deucravacitinib).
For panels A–D, p values for comparison versus deucravacitinib 6 mg QD are based on the Mantel–Haenszel test, with geographic region and prior treatment with biologics as stratification factors. For panels E and F, p values for comparisons versus deucravacitinib 6 mg QD are from a mixed model for repeated measures including treatment, visit and treatment-by-visit interaction as fixed effects and geographic region, prior treatment with biologics and baseline score as covariates.
DLQI, Dermatology Life Quality Index; LS, least-squares; NRS, Numerical Rating Scale; PASI, Psoriasis Area and Severity Index; QD, once daily; SEM, standard error of the mean; sPGA, static Physician's Global Assessment.

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Abstract N°: 339

Secondary Failure to Secukinumab in Psoriasis: Real-World Outcomes and Cost Implications of Biologic Switching in a Public-Funded Setting

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Introduction

Biologics for psoriasis are typically administered after failure of conventional therapies, with affordability being an important factor in treatment decision. Since tuberculosis (TB) is endemic in India, IL-17mAbs are often preferred due to their favourable safety profile compared to TNFα inhibitors (TNFi). However, treatment failures with these agents do occur, raising concerns about their use in all patients with moderate-to-severe psoriasis. Our objective was to analyze the secondary failures to secukinumab in moderate to severe psoriasis patients. The secondary aim was to analyze the cost and efficacy of other biologics after secondary failure to secukinumab.

Materials and Methods

All patients with psoriasis who had failed conventional therapy were administered secukinumab. After the induction phase (defined as treatment till 16 weeks), secukinumab was continued if PASI 75 was achieved. Secondary failure was defined as the loss of response (PASI > 50% of initial value) in a patient who had previously achieved PASI 50 response at week 16. Intra- or inter- class switching of biologics was attempted in these patients and cost of therapy was calculated at end of 16 weeks.

Results

Out of 42 patients who were administered secukinumab, 14 experienced secondary failures at a mean duration of 7.5 months (33%). All these patients had received multiple oral conventional agents and 9/14 (64%) had received prior TNFα inhibitors (TNFi). While secukinumab was updosed (repeat loading dose given) in 3 patients, 6 were administered TNFi and 5 were administered ixekizumab. All the patients who were switched to other biologics achieved improvement in PASI(38.7 at secondary failure: 26.7 $p<0.001$) with a significantly lowered PASI in the etanercept and the ixekizumab group as compared to the secukinumab loading dose group (p-value 0.003) at the end of induction phase. On comparing the cost of 16 weeks treatment it was observed that the TNFi (ie, adalimumab and etanercept) have a lower cost per unit dose as well as overall treatment cost as compared to secukinumab loading dose (SLD) and ixekizumab. It was also observed that the percent reduction in the PASI scores was significant in the etanercept group as compared to adalimumab and SLD group. On comparing the cost per dose per unit improvement in PASI it was observed that the most cost-effective alternative among the four compounds was etanercept (111.11) followed by adalimumab (272.82) followed by ixekizumab (572.74) and lastly secukinumab loading dose (SLD) at (910.36).

Conclusions

Our data suggests that in case of secukinumab failures a cheaper option than ixekizumab is to administer adalimumab or etanercept. Long term (44–60 week) efficacy and side effect profile data (especially with respect to TB) is still needed. A major strength of our study is the elimination of adherence bias, as treatment costs were covered by the public health system which accounts for the switch to second line biologic and completion of 16 weeks in case of secondary failures. If the industry aligns prices, based on country specific needs & value-based

pricing is included in treatment algorithms, it would serve patients and the health system better than directly equating efficacy data amongst biologics, which are based on data on drug survivals which disregard the cost of therapy.

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Abstract N°: 369

Bimekizumab drug survival in psoriasis: Real-world outcomes from the British Association of Dermatologists Biologics and Immunomodulators Register

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Introduction

The chronic, relapsing nature of moderate to severe psoriasis often requires long-term, continuous treatment,[1] underscoring the value of real-world treatment durability. Drug survival due to effectiveness is a pragmatic real-world measure of continued treatment reflecting sustained therapeutic benefit in clinical practice.[2] It enables meaningful comparisons between systemic therapies to inform treatment selection, particularly in heterogeneous, complex populations that are often under-represented in clinical trials, e.g. patients with prior biologic exposure, high-impact area involvement and exclusionary comorbidities.[3,4]

Analyses using the British Association of Dermatologists Biologics and Immunomodulators Register (BADBIR) have reported drug survival due to sustained effectiveness across established interleukin (IL)-17 and IL-23 biologics, ranging from 80–95%/73–92% at 1/2 years (yrs),[5,6] providing an important benchmark for real-world treatment durability.

Bimekizumab (BKZ) is a humanised IgG1 monoclonal antibody that selectively inhibits IL-17A and IL-17F.[7] Here, we estimate BKZ drug survival in patients with moderate to severe plaque psoriasis using real-world registry data.

Materials and Methods

We analysed data from BADBIR, a prospective registry that assesses the long-term safety of biologics for moderate to severe psoriasis (United Kingdom/Republic of Ireland).[8]

Drug survival due to effectiveness was defined using discontinuation due to ineffectiveness as the event; other discontinuations were censored. Baseline characteristics and drug survival due to effectiveness at 1/2yrs are reported for adult patients who received BKZ from 08/2021–08/2025 and had >183 days of follow-up from BKZ initiation (eligibility criteria align with prior BADBIR publications[5,6]). Drug survival was estimated using unadjusted Kaplan-Meier analysis, overall and by prior biologic use.

To assess the impact of the restriction to >183 days of follow-up, a sensitivity analysis included all patients who

received BKZ, regardless of follow-up.

Results

Of 435 patients with >183 days of follow-up, the median (interquartile range [IQR]) age was 49.0 (39.0–58.0) yrs, 182 (41.8%) were female and the median follow-up was 1.5 (0.9–2.1) yrs. There were 74 (17.0%) biologic-naïve patients and 361 (83.0%) biologic-experienced patients, with 178 (40.9%) having had ≥3 prior treatments. Nail and scalp involvement were present in 227 (52.2%) and 311 (71.5%) patients, respectively. The median baseline PASI was 11.7 (6.4–17.7) and disease duration was 23.0 (14.0–34.0) yrs; 171 patients (39.3%) had psoriatic arthritis (PsA) and 132 (30.3%) had ≥3 prespecified comorbidities.

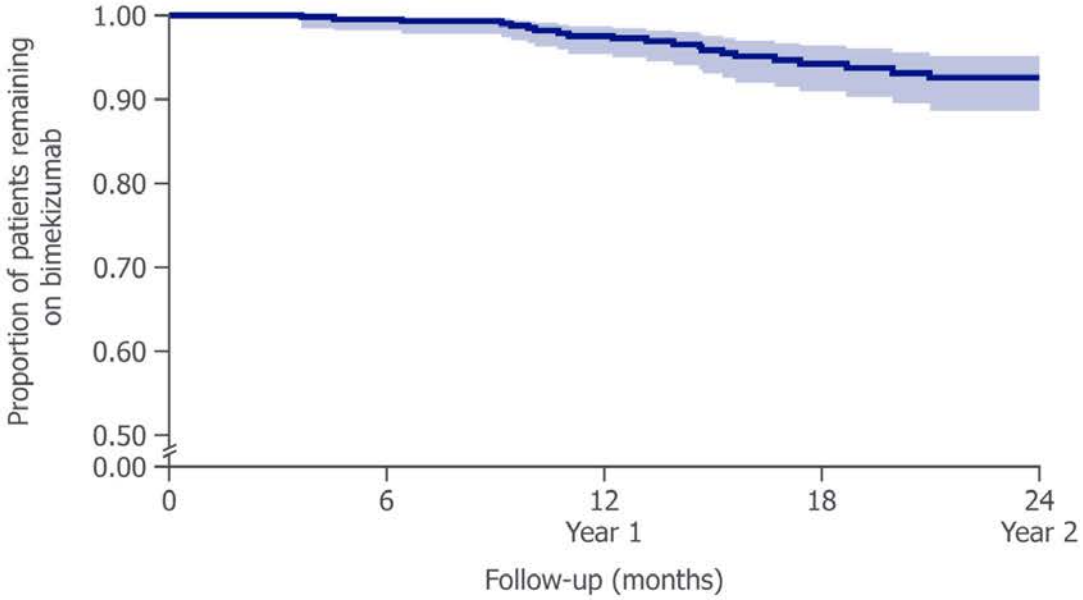
Drug survival due to effectiveness was 0.98 at 1yr (95% CI 0.95, 0.99) and 0.93 at 2yrs (95% CI 0.89, 0.95; **Figure 1A**).

A higher proportion of biologic-naïve vs biologic-experienced patients remained on BKZ at 1yr (1.00 vs 0.97 [95% CI 0.94, 0.98]) and at 2yrs (1.00 vs 0.91 [95% CI 0.86, 0.94]; **Figure 1B**).

The sensitivity analysis of all BKZ-treated patients, regardless of follow-up duration (N=545), yielded similar results.

Figure 1. Bimekizumab drug survival due to effectiveness

A) All patients

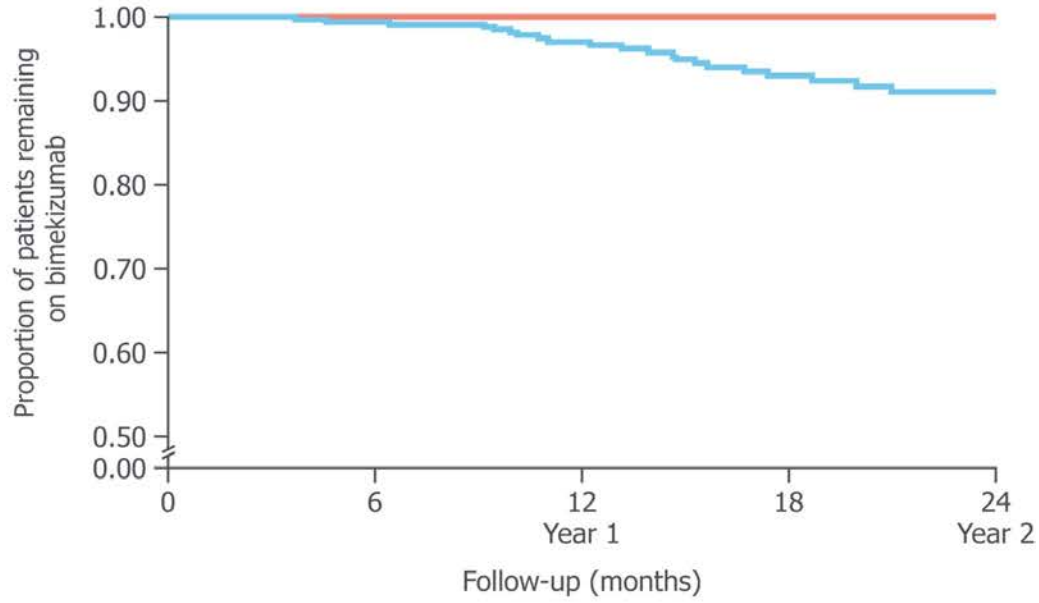


Number at risk

All patients	435	421	305	213	123

95% Confidence intervals — All patients

B) By prior biologic treatment



Number at risk

Biologic-naïve	74	73	57	42	19
Biologic-experienced	361	348	248	171	104

Biologic-naïve — Biologic-experienced

Patients who received BKZ between 24 August 2021 and 30 August 2025 and had >183 days of follow-up were included.

Conclusions

In this real-world cohort with substantial prior biologic exposure, high-impact area involvement and multiple comorbidities (including PsA), BKZ demonstrated a high drug survival due to effectiveness through 2 yrs.

Higher drug survival was observed in biologic-naïve vs biologic-experienced patients, suggesting early initiation of BKZ may be advantageous.

These findings provide real-world insight on continued treatment with BKZ in routine clinical practice across heterogeneous psoriasis populations.

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Abstract N°: 399

Rapid Response to Vunakizumab in an Elderly Patient with Generalized Pustular Psoriasis Masquerading as Acute Generalized Exanthematous Pustulosis: A Case Report

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Introduction

Generalized pustular psoriasis (GPP) is a rare, serious inflammatory skin disease driven by mutations in the IL-36RN gene. Acute generalized exanthematous pustulosis (AGEP), a severe drug-induced hypersensitivity reaction, shares overlapping clinical and histopathological features with GPP, making differentiation challenging. Here, we report an elderly patient with GPP, initially diagnosed as AGEP, carrying the c.115+6T>C variant in the IL36RN gene, who showed a rapid response to vunakizumab, an anti–IL-17A monoclonal antibody.

Case Presentation

A 73-year-old female presented in August 2025 with recurrent widespread erythema and pustules with fever over 3 years, recently exacerbated for 12 days. She had a history of multiple hospitalizations for similar episodes, previously diagnosed as AGEP. Notably, she had no personal or family history of plaque psoriasis.

On admission, she had high fever, diffuse erythema and pustules, and markedly elevated inflammatory markers. Skin biopsy revealed basket-weave hyperkeratosis with numerous subcorneal and upper epidermal spongiform pustules. At admission, genetic testing results were not yet available. She was initially diagnosed as AGEP due to clinical presentation, although GPP remained a differential consideration given the recurrent and severe pustular episodes. Disease severity assessment yielded a GPPASI of 40.2 and a GPPGA of 3.

Intravenous methylprednisolone 60 mg/day was initiated, along with supportive anti-infective therapy. However, her condition remained relapsing. AGEP is increasingly recognized as a drug-induced variant of GPP due to substantial overlap in their transcriptomic profiles. Hyperactivation of the IL-36 signaling pathway leads to excessive downstream IL-17 production, promoting neutrophil recruitment and sterile pustule formation, thereby providing a mechanistic rationale for IL-17A-targeted therapy, which may be effective even when clinical features resemble AGEP.

Vunakizumab 120 mg was administered subcutaneously, resulting in rapid clinical improvement within 3 days, with normalization of body temperature, near-complete pustule clearance (GPPASI 26.8, GPPGA 2), and marked reduction in inflammatory markers. A second dose was administered 7 days later, and by day 13, GPPASI had decreased to 7.8 and GPPGA to 1, with marked reduction in inflammatory markers and rapid clinical improvement. Subsequent whole-exome sequencing revealed a heterozygous c.115+6T>C pathogenic variant in the IL36RN gene. The absence of a personal or family history of psoriasis may have limited the initial consideration of GPP in the differential diagnosis. Combined with her clinical presentation and rapid response to targeted therapy, a final diagnosis of GPP was established.

Conclusion

Vunakizumab, a monoclonal antibody targeting IL-17A, demonstrated rapid clinical efficacy and good tolerability in an elderly patient with GPP prior to definitive diagnosis, enabling prompt tapering and discontinuation of systemic corticosteroids and minimizing steroid-related adverse effects. This report highlights the diagnostic challenges posed by the clinical overlap between GPP and AGEP, and to demonstrate the effectiveness of Vunakizumab in such complex clinical settings, reinforcing the importance of accurate diagnosis and timely intervention.

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Abstract N°: 406

Association Between Smoking Cessation, Post-cessation Weight change, and Cardiovascular Disease in Psoriasis

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Introduction

Psoriasis is a chronic immune-mediated disease that shares Th1/Th17-mediated inflammatory pathways with atherosclerosis which is associated with cardiovascular disease (CVD). CVD is a major comorbidity in patients with psoriasis. Smoking is prevalent in this population and worsens both CVD risk and psoriasis severity, making cessation imperative. However, post-cessation weight gain may adversely affect lipid profiles, blood pressure, and systemic inflammation, potentially counteracting the cardiovascular benefits of cessation. Whether such weight gain attenuates the CVD-protective effect of smoking cessation in psoriasis has not been elucidated. Using a nationwide database, we examined the association of smoking cessation and post-cessation weight changes with CVD development, including coronary heart disease (CHD) and stroke, in patients with psoriasis.

Materials and Methods

This study employed a nationwide longitudinal cohort design based on data derived from the Korean National Health Insurance Service database. From 2004 to 2018, 127,218 patients newly diagnosed with psoriasis who underwent consecutive biennial health screenings before and after diagnosis were enrolled. Smoking status and body mass index (BMI) were ascertained from questionnaires and physical examinations. Participants were classified into persistent smokers, smoking quitters with BMI gain >2 kg/m2, quitters with BMI gain of 0.1-2 kg/m2, quitters without BMI gain, and non-smokers. Cox proportional hazard regression models estimated adjusted hazard ratios (aHRs) with 95% confidence intervals (CIs) for CVD risk across the five groups categorized by changes in smoking and weight status, adjusting for various confounding factors. Interaction terms tested for effect modification by weight change category. Two supplemental cohorts were established for sensitivity analyses: one comprising individuals whose smoking status remained consistent at the end of follow-up or at CVD diagnosis, and another comprising those whose smoking and weight status remained unchanged through a subsequent third health examination.

Results

A total of 9,203 CVD events occurred during 990,774 person-years of follow-up. Compared with persistent smokers, quitters with BMI gain of 0.1–2 kg/m^2 (aHR 0.87; 95% CI 0.76–0.99) and quitters without BMI gain (aHR 0.86; 95% CI 0.74–0.99) had a significantly reduced risk of CVD. Quitters with BMI gain >2 kg/m^2 also showed a lower but non-significant reduction in CVD risk (aHR 0.88; 95% CI 0.67–1.15). For all quitters, a significant reduction in CVD risk was observed compared with persistent smokers (aHR 0.87; 95% CI 0.79–0.95). No significant effect modification by post-cessation weight gain was identified (P for interaction = 0.85), and BMI changes among quitters were not independently associated with CVD risk. For CHD and stroke, similar results and trends were observed. In subgroup analyses, the cardiovascular benefit of cessation was particularly pronounced in individuals without pre-existing hypertension, diabetes, or hypercholesterolemia. The results of sensitivity analyses considering dynamic changes in smoking habits and weight status after the index date were consistent with the main results.

Conclusions

In this large, population-based, nationwide study, we showed that post-cessation weight gain did not attenuate the cardiovascular protective effect of smoking cessation in patients with psoriasis. The benefit of quitting smoking on CVD risk was preserved regardless of the degree of post-cessation weight gain. Our findings support the need to actively promote smoking cessation in patients with psoriasis irrespective of concerns about accompanying weight gain.

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Abstract N°: 438

Topical Betamethasone/Calcipotriol creme as an Effective Add-On Therapy for Residual Psoriasis Plaques: Two Clinical Cases

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Introduction
A considerable proportion of patients with moderate-to-severe psoriasis achieve substantial clinical improvement with systemic or biologic therapies. However, residual localized plaques—particularly on the lower extremities—often persist and prevent complete skin clearance (PASI 100). Escalating systemic treatment may increase the risk of adverse events and healthcare costs. Topical therapy combining a corticosteroid and a vitamin D analogue offers a safe and effective alternative. This report presents two clinical cases in which betamethasone dipropionate/calcipotriol cream was used as an adjunct to systemic or biologic therapy to achieve full clearance.

Case Presentation
Case 1. A 35-year-old man with a 5-year history of plaque psoriasis and no comorbidities presented with severe disease (PASI 14, BSA 13, DLQI 8). He initiated oral methotrexate 15 mg weekly plus folic acid, achieving significant improvement after two months but with persistent residual plaques on the legs (BSA <2%). Adjunctive treatment with betamethasone dipropionate 50 mg/g + calcipotriol 50 µg/g cream once daily for 4 weeks resulted in complete clearance (BSA <1%) without adverse events.
Case 2, A 25-year-old woman with severe psoriasis of 10 years' duration and intolerance to methotrexate presented with PASI 8, BSA 14, and DLQI 12. After 16 weeks of secukinumab 300 mg monthly, she showed marked improvement but persistent plaques on the legs (BSA <3%). The same topical combination (betamethasone dipropionate + calcipotriol) was added once daily for 4 weeks, achieving complete clearance (BSA <1%) without adverse effects.

Conclusion
In both cases, systemic or biologic therapy provided substantial improvement, yet localized residual plaques persisted. Adding topical betamethasone/calcipotriol successfully resolved these lesions within a short timeframe, with excellent tolerability and without the need to intensify systemic treatment. This strategy helps optimize overall clinical response, reduce potential risks associated with systemic escalation, and avoid additional healthcare costs.
Topical betamethasone dipropionate/calcipotriol is an effective, safe, and cost-efficient adjunct therapy for managing residual psoriasis plaques in patients already receiving systemic or biologic treatment. Its use enables complete skin clearance without modifying systemic therapy, representing a valuable approach in routine dermatological practice.

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Abstract N°: 439

Hepatitis B Reactivation in Biologic-Treated Moderate-to-Severe Psoriasis: A Real-World Cohort Study With 534 Patient-Years of Follow-Up

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Introduction
Psoriasis vulgaris is a chronic immune-mediated inflammatory disease frequently requiring long-term biologic therapy. Although biologics targeting TNF-α and interleukin pathways have revolutionized disease management, they may disrupt antiviral immune surveillance and trigger hepatitis B virus (HBV) reactivation in individuals with prior HBV exposure. Data on the long-term safety of newer agents—particularly IL-17 and IL-23 inhibitors—in patients with prior HBV exposure remain limited. To evaluate longitudinal changes in HBV serological and virological markers and determine the frequency of HBV reactivation among patients with psoriasis vulgaris receiving biologic therapies in routine clinical practice.

Materials and Methods
This retrospective, single-center study included adult patients treated with biologics between December 2019 and January 2025. HBV serology (HBsAg, anti-HBs, and anti-HBc) and HBV-DNA were assessed at baseline and every 6 months, with 3-monthly monitoring for anti-HBc–positive patients from electronic hospital records.

Results
A total of 345 biologic treatment episodes in 311 patients, corresponding to 534.3 patient-years of exposure, were analyzed. Biologic therapies included secukinumab (33%), risankizumab (24.6%), guselkumab (17.7%), ixekizumab (15.4%), adalimumab (4.1%), certolizumab pegol (2.9%), and ustekinumab (1.7%). Anti-HBc positivity was identified in 42 treatment episodes (12.2%), of whom 93% received antiviral prophylaxis. Four HBV reactivation events (9.5%) were observed—two during ixekizumab, one during secukinumab, and one during risankizumab therapy—without progression to clinical hepatitis. The incidence of HBV reactivation among anti-HBc–positive patients was 5.42 per 100 patient-years.

Conclusions
In this real-world cohort, HBV reactivation occurred in a clinically meaningful proportion of patients with prior HBV exposure (9.5%), presenting exclusively virologic or serologic reactivation without clinical hepatitis despite widespread antiviral prophylaxis. These findings underscore the need for individualized risk assessment and continuous virologic monitoring during biologic therapy and highlight the importance of further prospective studies to inform future clinical guidelines.

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Abstract N°: 456

Machine Learning-Based Prediction of Biologic Target Selection in Psoriasis: A Real-World Retrospective Study

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Introduction

Psoriasis is a chronic, immune-mediated inflammatory disease. Although biologic agents are widely used in moderate-to-severe disease, treatment selection remains largely experience-based. We aimed to predict the most appropriate biologic agent group for individual patients using machine learning algorithms applied to real-world clinical data.

Materials and Methods

This retrospective study included 249 psoriasis patients based at our center for the period from January 2015 to December 2025, who were aged ≥18 years and received biologic therapy for ≥9 months with maintained PASI 75 response. Patients were treated with IL-17 inhibitors (ixekizumab, secukinumab, or bimekizumab; n=125), IL-23 inhibitors (guselkumab or risankizumab; n=89), or the IL-12/23 inhibitor (ustekinumab; n=35). Ethical approval was obtained from the local ethics committee. A total of 27 clinical variables were used as input features to predict the biologic target: age, sex, age at prescription, baseline PASI, current PASI, family history, psoriatic arthritis, neurological disease, cardiovascular disease, diabetes mellitus, renal disease, concomitant skin disease, malignancy history, other comorbidities, baseline and current genital involvement, baseline and current nail involvement, liver and renal function test abnormalities (within the last 9 months), biologic-naive status, hepatitis B carrier status, autoimmune thyroiditis, Sjogren's syndrome, hypertension, arrhythmia, and hyperlipidemia.

Six machine learning algorithms representing distinct algorithmic paradigms were compared: Linear Discriminant Analysis (LDA, statistical/linear), Light Gradient Boosting Machine (LightGBM, tree-based/boosting), Support Vector Machine (SVM, geometric/kernel-based), K-Nearest Neighbors (KNN, distance-based), Naive Bayes (probabilistic), and Ensemble Voting (soft voting combination of LDA and LightGBM). Model performance was evaluated using 5-fold stratified cross-validation with three metrics: weighted one-vs-rest Area Under the Receiver Operating Characteristic Curve (AUC-ROC), Accuracy, and Top-2 Accuracy.

Results

Among the six algorithms evaluated, LDA achieved the highest discrimination (AUC-ROC: 0.720, Accuracy: 60.7%, Top-2 Accuracy: 94.8%), followed by Ensemble Voting (0.677, 52.7%, 92.8%), Naive Bayes (0.662, 48.2%, 76.7%), SVM (0.603, 45.0%, 86.7%), LightGBM (0.585, 47.4%, 75.9%), and KNN (0.550, 47.8%, 84.3%).

LDA structure matrix analysis revealed distinct clinical predictors for each biologic target group (Table 1). Psoriatic arthritis, particularly with older age and biologic-naive status, was the strongest predictor of IL-17 inhibitor selection, with cardiovascular comorbidities and autoimmune thyroiditis as additional factors. IL-23 inhibitor

selection was most distinctly associated with nail involvement, younger age, absence of psoriatic arthritis, and biologic-experienced status, which may reflect their more frequent use in patients with prior biologic exposure due to their relatively later introduction into clinical practice. IL-12/23 inhibitor showed favorable and sustained long-term responses in older patients with renal and neurological comorbidities, and genital involvement, suggesting their preferential use in patients with complex comorbidity profiles.

Table 1. Key Clinical Predictors of Biologic Target Group Selection (LDA Structure Matrix)

Variable	Total (n=249)	IL-17 Inhibitor (n=125)	IL-23 Inhibitor (n=89)	IL-12/23 Inhibitor (n=35)
Age (years)	47.5 ± 14.1	48.8 ± 13.9	44.0 ± 14.3	51.6 ± 12.5
Age at prescription (years)	44.0 ± 13.9	45.5 ± 13.8	41.4 ± 14.5	45.2 ± 12.1
Baseline PASI	18.0 ± 9.3	18.3 ± 9.0	17.5 ± 10.7	17.9 ± 6.1
Psoriatic arthritis	67 (26.9%)	49 (39.2%)	14 (15.7%)	4 (11.4%)
Biologic-naive	152 (61.0%)	82 (65.6%)	45 (50.6%)	25 (71.4%)
Hepatitis B carrier	46 (18.5%)	20 (16.0%)	13 (14.6%)	13 (37.1%)
Cardiovascular disease	75 (30.1%)	44 (35.2%)	20 (22.5%)	11 (31.4%)
Hypertension	67 (26.9%)	39 (31.2%)	18 (20.2%)	10 (28.6%)
Neurological disease	11 (4.4%)	8 (6.4%)	2 (2.2%)	1 (2.9%)
Renal disease	13 (5.2%)	5 (4.0%)	4 (4.5%)	4 (11.4%)
Autoimmune thyroiditis	11 (4.4%)	7 (5.6%)	4 (4.5%)	0 (0.0%)
Genital improvement	83 (33.3%)	42 (33.6%)	24 (27.0%)	17 (48.6%)
Nail improvement	49 (19.7%)	22 (17.6%)	24 (27.0%)	3 (8.6%)

Data are presented as mean ± SD for continuous variables and n (%) for categorical variables.

Conclusions

This study demonstrates that machine learning can support biologic agent selection in psoriasis. The superior performance of LDA suggests a predominantly linear relationship between clinical features and prescribing patterns. Notably, the model narrowed treatment selection to two cytokine targets in 94.8% of cases, potentially reducing trial-and-error in clinical practice.

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Abstract N°: 461

CLINICAL RELEVANCE OF DRUG RELATED PSORIASIS.

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Introduction

Psoriasis is an autoimmune, chronic inflammatory skin disease. It is multifactorial. It is easy for an experienced dermatologist to pick up a diagnosis of psoriasis but often challenging to pinpoint the etiology. Many times, during history taking, patients fail to reveal medications taken for other diseases or conditions like depression, considering it to be an irrelevant part . Drugs are one of the causes for psoriasis. Psoriasis can be induced or exacerbated by drugs like Beta blockers, lithium, Hydroxychloroquine, interferon, terbinafine, tumor necrosis factor -alpha antagonist.This article also explains the need for dermatologist to collaborate with physicians and work closely.

Materials and Methods

Aim: Identify “Drug related Psoriasis”.
Material and Method:
1.Lithium:-Depression can either be associated with psoriasis or be a cause of psoriasis.Treatment for depression with lithium may exacerbate or destabilize psoriasis.
Mechanism of Action: Lithium→calcium release interference within keratinocytes→Proliferation→Psoriasis.
2. Beta blockers :- Beta blocker is widely used drug for various conditions worldwide. It can induce psoriasis. The lag time is variably long(upto 12 months) so the diagnosis of drug induced psoriasis is often missed.
Mechanism of action: Beta blocker→Decrease CAMP→ Increase epidermopoesis→Psoriasis.
3.Hydroxychloroquine(HCQs): Since 1955 it has been used as an antimalarial drug. Also main line of treatment for Systemic lupus Erythematosus, Rheumatoid arthritis. During COVID 19 it was used with purpose to decrease viral load.
Mechanism of action:HCQs→ inhibit epidermal transglutaminase activity→initial break in epidermal barrier→ in order to restore the barrier, induced hyperproliferation →Psoriasis.
HCQs→Produce IL-17, IL-23→ Increased keratinocyte growth.
HCQs→ interfere with cholesterol metabolism→disruption of structural and functional integrity of st.corneum.
4.Terbinafine: It is a widely used antifungal drug. It is known to induce as well as exacerbate existing psoriasis. It may give rise to inverse psoriasis.

Results

Result and Discussion:Psoriasis is a chronic disease. Exposure to certain medications can elicit an exacerbated psoriasis or induce psoriasis.It is important for a health care provider to identify the drugs inducing or exacerbating psoriasis. The clinical and histological portrait of drug induced psoriasis is different from the classical non drug related psoriasis. Example- b blocker induced psoriasis is less scaly, less erythromatous, rarely involving palms and soles. Histopathological features are evident- less tortuous papillary dermal capillaries, and suprapapillary epidermal thinning. Less munro micro abscesses and macrophages observed.
Drugs affecting psoriasis can act in various ways.
A) It can aggravate a pre-existing psoriatic lesion.
B) When the implicated drug is discontinued,the induced psoriatic lesion can either decrease
or

lesions may persist (drug aggravated psoriasis).
C)In a patient with a personal history of psoriasis, implicated drugs can lead to onset of new psoriatic lesions at clinically uninvolved sites.
D)Psoriasis de novo- The drug can provoke psoriasis in patients who do not have personal or family history of psoriasis.
Naranjo adverse drug reaction probability scale may help to assess the condition and help to find a probable drug association.
The scale consists of 10 questions and the scoring of these results in 4 categories- Definite, Probable,Possible and Doubtful.

Conclusions

In clinical practice, psoriasis inducing medication is often missed because of few reasons like
-inappropriate patient history,
-invariable lag time(time between giving the medication and onset of psoriasis) and
-even after cessation of the medication, the psoriasis may persist.
Awareness needs to be created for medication related causes of psoriasis. Early diagnosis and management will have good outcomes.
This article also opens the door for further research and collaboration on Drug related Psoriasis.

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Risk of cancer in psoriasis patients treated with biologic therapy: a BADBIR cohort study

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Introduction

There are concerns that biologic therapies for psoriasis may increase cancer risk due to their immunomodulatory effects. We compared the risks of incident cancer overall (excluding keratinocyte carcinoma [KC]) among patients with moderate-to-severe psoriasis across biologic classes and between biologic and non-biologic systemic (conventional or small-molecule) cohorts.

Materials and Methods

We analysed data from BADBIR, a large, multicentre register spanning the UK and Republic of Ireland, established to evaluate the long-term safety of systemic therapies for psoriasis. The dataset covers the period from September 2007 to November 2025 and is strengthened through linkage with external health databases, including National Health Service Digital, enabling comprehensive and enhanced ascertainment of cancer events. In a new-user cohort of biologic-naïve patients with chronic plaque psoriasis aged ≥16 years and no prior history of cancer, follow-up began at treatment initiation and ended at the first cancer diagnosis, switch to a different biologic class, or last recorded follow-up, whichever came first. Additionally, an intention-to-treat (ITT) analysis was conducted to compare cancer risk between biologic and non-biologic systemic (reference) cohorts. In pairwise comparisons, tumour necrosis factor inhibitors (TNFi) were used as the reference group and compared with interleukin (IL)-12/23 and IL-17 inhibitors (i). Cancers diagnosed within 12 months of treatment initiation were excluded as unlikely to be treatment-related. Crude incidence rates (IRs) were calculated as the number of incident cases divided by total person-years at risk and presented per 1,000 person-years. Hazard ratios (HR) with 95% confidence intervals (CI) were estimated using weighted flexible parametric survival models with propensity score adjustment and multiple imputation.

Results

Among 11,761 new-user biologic-treated patients, 7,794 (66%) received TNFi, 2,472 (21%) IL-12/23i, and 1,495

(13%) IL-17i. Crude incidence rates were comparable across biologic classes. For IL-12/23i versus TNFi, IRs were 6.05 (5.00–7.36) and 6.22 (5.52–7.01), respectively. For IL-17i versus TNFi, IRs were 5.14 (3.81–6.93) and 6.37 (5.71–7.10), respectively. Compared with TNFi, cancer risk did not significantly differ for IL-12/23i (HR 1.00, 95% CI 0.80–1.26) or IL-17i (HR 0.81, 95% CI 0.58–1.14). In the ITT analysis (n=18,941; 8,031 [42%] non-biologic systemic and 10,910 [58%] biologic users), IRs were 6.89 (6.06–7.82) for non-biologic systemic and 6.40 (5.83–7.02) for biologic cohorts. There was no increased cancer risk in biologic versus non-biologic systemic users (HR 0.94, 95% CI 0.78–1.12).

Conclusions

This study provides reassuring evidence that the risk of cancer overall (excluding KC) does not differ across biologic classes or compared with non-biologic systemic therapy. Further research with extended follow-up, particularly for newer biologics, is needed to better characterise long-term risk.

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Abstract N°: 479

Blaschko-linear Psoriasis Localized at the Right Arm, Hand, and Palm: A Documented Case

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Introduction

Blaschko-linear psoriasis is an exceptionally rare variant of psoriasis that follows the lines of Blaschko, reflecting an underlying genetic somatic mosaicism. Diagnosing this condition is clinically challenging due to its resemblance to other linear dermatoses, such as Inflammatory Linear Verrucous Epidermal Nevus (ILVEN). Dermoscopy serves as a vital, non-invasive diagnostic tool to quickly differentiate these conditions. We present a rare case of Blaschko-linear psoriasis strictly localized to the right upper extremity, uniquely involving the palmar surface.

Case Presentation

A 34-year-old male presented with a three-year history of mildly pruritic, erythematous, scaly plaques localized exclusively to his right upper limb. He had no personal or family history of psoriasis, nor any preceding trauma. Clinical examination revealed well-demarcated linear plaques following Blaschko's lines along the right forearm, dorsal hand, and palm. The palmar lesions exhibited notable hyperkeratosis and superficial fissuring.To rule out ILVEN, polarized contact dermoscopy was performed. The forearm and dorsal hand plaques displayed a specific psoriatic pattern: regularly distributed red dotted vessels on a light red background, covered by patchy white scales. Palmar dermoscopy showed thick hyperkeratosis with underlying pinpoint red dots visible upon manipulation (Auspitz sign). To provide a definitive diagnosis, a skin biopsy was performed; the histopathological findings confirmed the diagnosis of psoriasis. Given the extent of the lesions and their impact on the patient’s professional life as a dentist, systemic therapy with acitretin was initiated, resulting in significant clinical improvement..

Conclusion

This case highlights a rare phenotypic expression of psoriasis with extensive unilateral involvement extending into the palm—an anatomical site infrequently affected in linear variants. Distinguishing Blaschko-linear psoriasis from other linear inflammatory dermatoses is essential for appropriate therapeutic management.

This report emphasizes the significant value of dermoscopy in clinical practice. The detection of homogeneous red dotted vessels is highly specific for psoriasis, enabling clinicians to confidently confirm the diagnosis before resorting to invasive skin biopsies.

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Abstract N°: 481

Beyond Skin Severity: Sexual Quality of Life Impairment in Patients with Severe Psoriasis

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Introduction

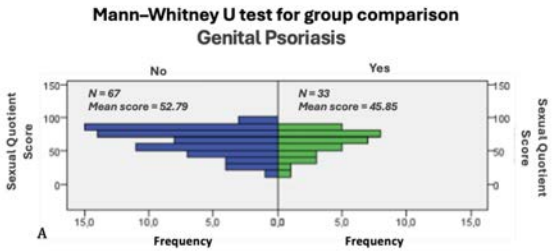
Psoriasis is a chronic systemic inflammatory disease associated with significant impairment in quality of life. Sexual health is an often-overlooked dimension, despite its major psychosocial relevance. Sexual dysfunction in psoriasis may be influenced by multiple factors, including psychological burden, lesion localization, and comorbid conditions such as psoriatic arthritis.However, data on sexual quality of life in patients with severe psoriasis remain limited, and the relationship between sexual dysfunction and disease severity is not fully established. Emerging evidence suggests that specific factors, such as genital involvement and psoriatic arthritis, may play a more relevant role than overall disease severity in determining sexual outcomes.This study aimed to evaluate sexual quality of life in patients with severe psoriasis compared with healthy controls, and to investigate its association with disease severity, genital involvement, and psoriatic arthritis.

Materials and Methods

An observational case–control study was conducted including 100 patients with severe psoriasis and 100 age- and sex- matched healthy controls. The study included sexually active individuals aged ≥18 years, of both sexes.The case group consisted of patients with a confirmed diagnosis of psoriasis, while the control group included individuals without psoriasis who were evaluated at a dermatology outpatient clinic during the same period. Data were collected during routine medical consultations through administration of the Sexual Quotient Questionnaire, using validated male and female versions according to the participant's sex, with scores ranging from 0 to 100 (higher scores indicating better sexual function). Psoriasis severity was evaluated using PASI and BSA. The presence of genital psoriasis and psoriatic arthritis (CASPAR criteria) was recorded.

Results

Patients with psoriasis had significantly lower Sexual Quotient scores compared to controls (mean 64 vs. 74; p = 0.001). Genital psoriasis was present in 33% and psoriatic arthritis in 28% of patients. No significant association was found between sexual dysfunction and disease severity measured by PASI or BSA.When comparing patients with genital psoriasis to participants without genital involvement (including both psoriasis patients without genital lesions and controls), those with genital psoriasis showed significantly lower Sexual Quotient scores (p = 0.004).Similarly, patients with psoriatic arthritis presented worse sexual quality of life compared to participants without arthritis (including both psoriasis patients without arthritis and controls), with a statistically significant difference (p = 0.019).Male patients showed slightly higher scores than females across all subgroups.



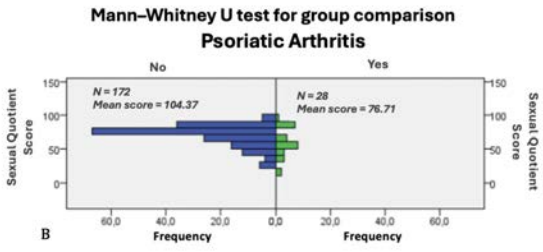


Figure 1. Distribution of Sexual Quotient (SQ) scores by genital psoriasis (A) and psoriatic arthritis (B). Both conditions are associated with lower sexual quality of life.

Conclusions

Severe psoriasis is associated with a significant impairment in sexual quality of life, independently of overall disease severity as measured by PASI and BSA. The findings of this study reinforce that sexual dysfunction in psoriasis is not solely driven by the extent of cutaneous involvement, but rather by specific clinical factors.Genital psoriasis and psoriatic arthritis emerged as key determinants of worse sexual outcomes, both being significantly associated with lower Sexual Quotient scores. These results highlight the importance of lesion localization and systemic involvement in shaping patients' sexual health.Overall, this study underscores the need for a more comprehensive and patient-centered approach in the management of psoriasis. Dermatologists should actively address sexual health in routine clinical practice, particularly in patients with genital involvement or psoriatic arthritis, in order to improve overall quality of life and optimize patient care.

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Vitamin D deficiency in psoriasis: correlation with disease severity and therapeutic implications

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Introduction
Psoriasis is a chronic immune-mediated inflammatory dermatosis characterized by abnormal keratinocyte proliferation. Emerging evidence suggests a link between vitamin D deficiency and psoriasis severity. This study aimed to evaluate the prevalence of vitamin D deficiency in patients with psoriasis and its correlation with disease severity, as well as its potential therapeutic implications.

Materials and Methods
A retrospective analytical study was conducted including patients with psoriasis who underwent serum 25(OH)D measurement. A control group of healthy individuals was included for comparison. Clinical severity was assessed using the Psoriasis Area and Severity Index (PASI). Quantitative variables were expressed as mean ± standard deviation and compared using Student's t-test, while qualitative variables were analyzed using the χ^2 test. Pearson correlation was used to assess the association between PASI and vitamin D levels. Statistical significance was set at $p < 0.05$.

Results
ur study included 263 participants, comprising 103 patients with psoriasis vulgaris and 160 healthy controls. The mean age of psoriatic patients was 43.3 ± 13.5 years compared to 42.8 ± 14.7 years in controls, with no significant difference ($p = 0.78$). The mean disease duration was 12.6 years (range: 1–37 years), with a mean age at onset of 30.7 years, and a family history reported in 13% of patients.The mean PASI score was 6.84 ± 2.72, with a predominance of moderate forms (57.3%), followed by mild (24.3%) and severe forms (18.4%). The most frequent sites of involvement were the elbows and knees (49%), followed by the scalp (35%) and palms/soles (15%). Inverse (4%) and genital (2%) involvement were rare.Mean vitamin D levels were significantly lower in psoriatic patients (21.9 ± 7.2 ng/mL) compared to controls (23.3 ± 6.0 ng/mL; $p = 0.04$). Vitamin D deficiency (< 20 ng/mL) was observed in 43.7% of psoriatic patients versus 15% of controls (OR = 4.33; 95% CI: 2.27–8.25; $p < 0.001$). Conversely, normal vitamin D status (> 30 ng/mL) was found in 17.5% of psoriatic patients compared to 51% of controls (OR = 0.18; 95% CI: 0.09–0.35; $p < 0.001$).A significant inverse correlation was found between PASI score and vitamin D levels ($r = -0.32$; $p = 0.02$). Patients with PASI ≥ 10 had lower vitamin D levels than those with PASI < 10 (18.5 ± 5.9 ng/mL vs 22.7 ± 6.4 ng/mL; OR = 2.11; 95% CI: 1.11–4.01; $p = 0.02$).In univariate analysis, psoriasis severity (PASI ≥ 10) (OR = 2.36; 95% CI: 1.20–4.63; $p = 0.01$) and lack of regular sun exposure (OR = 1.92; 95% CI: 1.01–3.64; $p = 0.04$) were associated with vitamin D deficiency, while female sex showed a non-significant trend (OR = 1.75; 95% CI: 0.95–3.21; $p = 0.07$). In multivariate analysis, only PASI ≥ 10 remained significantly associated with vitamin D deficiency (adjusted OR = 2.11; 95% CI: 1.05–4.24; $p = 0.03$), suggesting that clinical severity is the main independent predictor.Among the 103 psoriatic patients, 70 received vitamin D supplementation. The mean time to remission was significantly shorter in supplemented patients (3.0 ± 0.9 months) compared to non-supplemented patients (5.8 ± 1.9 months; $p < 0.001$). Supplemented patients were approximately 4.5 times more likely to achieve rapid remission (OR = 4.55; 95% CI: 1.88–11.1).

Conclusions

Vitamin D deficiency is common in psoriasis and is associated with greater disease severity, as shown by its inverse correlation with PASI score and independent link in multivariate analysis. Supplemented patients had shorter remission times, suggesting a beneficial role of vitamin D as an adjunctive therapy. These findings support routine assessment of vitamin D levels and consideration of supplementation, pending confirmation by prospective randomized studies.

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Abstract N°: 599

Computer-aided diagnosis of psoriasis based on a segmentation-guided multiple instance learning framework

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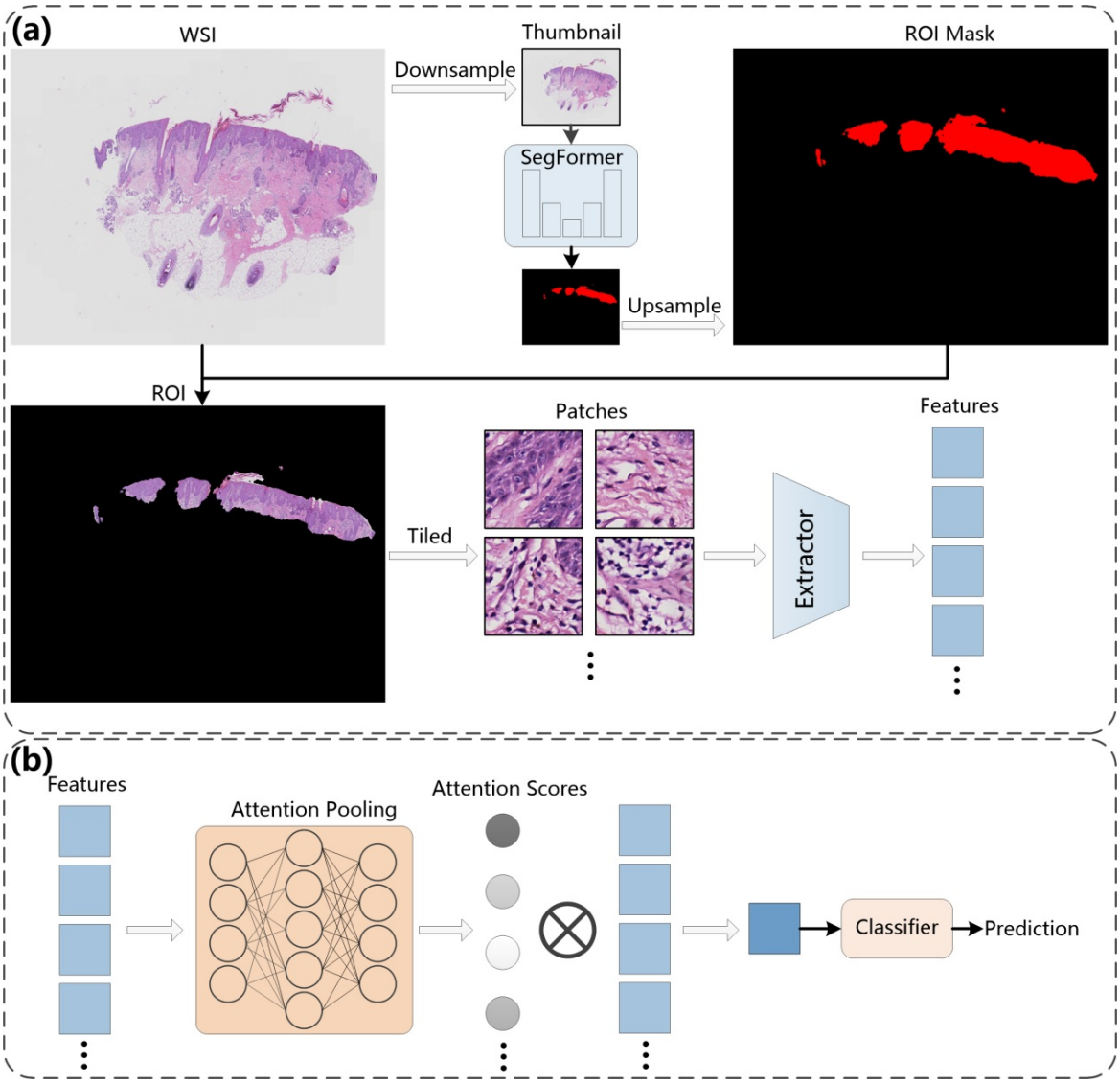
Introduction

To develop a machine learning-based diagnostic system for automated detection of psoriasis using histopathological image analysis.

Materials and Methods

We developed a multiple instance learning (MIL)-based diagnostic system using 2,148 whole slide images from 2,102 patients (1,402 psoriasis, 700 non-psoriatic) . Epidermis and upper dermis regions were segmented using a Segformer model trained on 50 expert-annotated cases, and 256×256-pixel patches were extracted for feature encoding with a LoRA-fine-tuned UNI foundation model. Psoriasis classification models were built using CLAM and TransMIL frameworks and evaluated via five-fold cross-validation.



Overview of the proposed method. (a) Illustrates the workflow for ROI segmentation. (b) Depicts the CLAM algorithm pipeline, starting from patch-level feature, followed by attention pooling to identify diagnostically relevant regions, and culminating in slide-level prediction.

Results

Using features from the LoRA-fine-tuned UNI model, the CLAM framework achieved a sensitivity of 0.952, a specificity of 0.799, an AUC of 0.947, and an overall accuracy of 0.901 for psoriasis diagnosis. The TransMIL framework achieved a sensitivity of 0.956, a specificity of 0.771, an AUC of 0.941, and an overall accuracy of 0.895. When using features from the original pre-trained UNI model without fine-tuning, CLAM obtained a sensitivity of 0.947, a specificity of 0.781, an AUC of 0.947, and an accuracy of 0.892, while TransMIL achieved a sensitivity of 0.949, a specificity of 0.754, an AUC of 0.934, and an accuracy of 0.884. Across both feature settings, CLAM demonstrated more balanced diagnostic performance with consistently higher specificity and accuracy.

Conclusions

The proposed machine learning framework demonstrates high sensitivity and robust performance in distinguishing psoriasis from non-psoriatic tissue, indicating its potential as an assistive tool for histopathological diagnosis.

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Abstract N°: 600

Line-field confocal optical coherence tomography for subclinical monitoring of psoriasis during treatment with biological agents: a pilot study

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Introduction

Line-field confocal optical coherence tomography (LC-OCT) is a novel non-invasive imaging technique that in plaque psoriasis allows the recognition of typical features, consisting of hyper-parakeratosis, acanthosis, and papillomatosis ("psoriatic" pattern), comparable to histopathology.The aim of the study was to evaluate the role of LC-OCT in the non-invasive assessment of the therapeutic response of psoriasis to different biologic agents over time.

Materials and Methods

Twenty consecutive patients affected by moderate to severe plaque psoriasis starting treatment with biologics were enrolled. For each patient, a target lesion was selected and monitored clinically (by assigning a Target Lesion Score) and by LC-OCT (evaluating the presence or absence of the psoriatic pattern) at baseline (T0) and at 4 (T1), 8 (T2), 12 (T3) and 24 (T4) weeks of treatment.

Results

A time-dependent improvement of both clinical and LC-OCT outcome parameters of the target lesions over time was observed: at T0, all target plaques showed the typical psoriatic aspects; at T1 no target plaque was rated as clear; at T2, clearing was clinically observed in 8 cases and at LC-OCT in 4; at T3, clearing was clinically observed in 14 cases and at LC-OCT in 10; finally, at T4 a complete clearing was observed in 18 cases both clinically and by LC-OCT. LC-OCT identified a cluster of patients that, despite the clinical assessment as clear, still demonstrated disease activity suggesting that clinical regression does not always match with complete microscopic remission.

Conclusions

Our study suggests that LC-OCT may be complementary to clinical evaluation in the monitoring of psoriasis treatment with biologic drugs by noninvasively revealing the subclinical plaque alterations and their changes over time.

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Abstract N°: 607

Rapid and Effective Management of Psoriasis in Difficult-to-Treat Areas Using Calcipotriol/Betamethasone PAD-Cream: A Four-Case Series

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Introduction
Psoriasis involving difficult-to-treat areas such as the scalp, palms, soles, hands, and nails represents a major therapeutic challenge, frequently associated with persistent symptoms, functional impairment, and reduced quality of life. In these locations, topical treatments often fail to achieve rapid and satisfactory disease control due to application difficulties and poor adherence.

Materials and Methods
Objective
To illustrate the real-world effectiveness and patient satisfaction of calcipotriol/betamethasone dipropionate (Cal/BDP) cream in psoriasis affecting difficult-to-treat anatomical areas.
Methods
We present a real-world case series of four adult patients with psoriasis involving challenging sites, including scalp, palmoplantar areas, hands, and nails. All patients received once-daily Cal/BDP cream, with occlusion applied when clinically appropriate. Clinical response, symptom relief, functional recovery, and patient-reported satisfaction were evaluated during follow-up. Patient characteristics and clinical outcomes are summarized in Table 1.

Results
Treatment with Cal/BDP cream resulted in a rapid and clinically meaningful improvement across all cases. Noticeable reduction of psoriatic plaques and associated symptoms, including pruritus, pain, and fissuring, was observed within 3 to 4 weeks of treatment initiation. Patients with palmoplantar and hand involvement experienced marked functional recovery, enabling resumption of daily activities, while scalp psoriasis showed visible clearance and substantial symptom relief. Overall patient satisfaction was consistently high, driven by rapid onset of action, good tolerability, and ease of use in cosmetically and functionally sensitive areas.

Patient	Age (years)	Difficult-to-Treat Area	Main Symptoms at Baseline	Treatment	Clinical Outcome
1	25	Scalp (including hairline)	Pruritus, visible plaques, social embarnassment	Cal/BDP cream once daily	Rapid and clinically meaningful improvement within 3 weeks
2	64	Soles (palmoplantar psoriesia)	Pain, fissuring, pruritus, walking dicomfort	Cal/BDP cream once daily under occlusion	Rapid improvement of lesions and symptoms
3	68	Hands (palmar and dorsal) and nails	Pain, functional impairment, reduced quality of life	Cal/BDP cream once daily under occlusion	Marked improvement after 1 month, with recovery of daily activities
4	55	Scalp	Pruritus, excoriations, hair loss due to scratching	Cal/BDP cream once daily	Marked symptom relief and visible improvement after 1 month

Clinical characteristics and response to once-daily calcipotriol/betamethasone dipropionate cream in difficult-to-treat psoriasis

Conclusions

In this real-world case series, once-daily Cal/BDP cream demonstrated rapid effectiveness and high patient satisfaction in psoriasis affecting difficult-to-treat areas. These findings support its role as a valuable topical treatment option for achieving fast disease control and improving patient experience in clinical practice.

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Abstract N°: 625

A Pivotal Multicenter, Randomized, Double-blind, Placebo-Controlled, Phase 3 Clinical Trial of SSGJ-608 in moderate-to-severe psoriasis.

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Introduction
SSGJ-608 is a recombinant humanized IgG1 monoclonal antibody that targets human IL-17A with high specificity and high affinity. This pivotal multicenter, randomized, double-blind, placebo-controlled, phase 3 clinical trial aims to evaluate the efficacy and safety of SSGJ-608 in patients with moderate-to-severe psoriasis.

Materials and Methods
Patients with moderate-to-severe plaque psoriasis were randomized (2:2:1) to receive placebo, SSGJ-608 80 mg Q2W (with a 160 mg loading dose at Week 0; 608A group), or SSGJ-608 160 mg Q4W (608B group). At Week 12, the 608A group switched to 80 mg Q4W, the 608B group to 160 mg Q8W, and the placebo group were re-randomized (1:1) to receive either the 608A or 608B maintenance regimen (with a 160 mg loading dose for those entering the 608A regimen). Treatment continued for all patients until Week 48. The co-primary efficacy endpoints were the achievement of Psoriasis Area and Severity Index score 75 (PASI75) and sPGA 0/1 at Week 12. Key secondary efficacy endpoints included the proportion of patients achieved PASI90, PASI100 and sPGA 0 at week 12. Other secondary efficacy endpoints included DLQI and itch-NRS changes; proportion of patients who experienced relapse during the double-blind maintenance period after receiving the SSGJ-608 during the induction period. Safety, pharmacokinetics, and immunogenicity were assessed.

Results
A total of 458 Chinese patients were enrolled（608A, n=184; 608B, n=183; placebo, n=91). PASI75 response was observed as early as week 2, and 48.4% and 44.3% of patients in the 608A and 608B groups, respectively, achieved PASI75 versus no patient in the placebo group ($P < 0.0001$) by week 4. Similarly, sPGA 0/1 response emerged at Week 2, with 26.6% (608A) and 21.3% (608B) of patients achieving this endpoint at Week 4, compared to none in the placebo group ($P < 0.0001$). At week 12, PASI75 was achieved by 95.1% (175/184, 608A) and 93.4% (171/183, 608B) vs. 8.8% (8/91, placebo); PASI90 by 80.4% (148/184, 608A) and 72.7% (133/183, 608B) vs. 1.1% (1/91, placebo); and PASI100 by 42.9% (79/184, 608A) and 33.9% (62/183, 608B) vs. 0%. sPGA 0/1 was achieved by 76.1% (140/184, 608A) and 67.2% (123/183, 608B) vs. 1.1% (1/91, placebo), with the rate of sPGA 0 matching that of PASI100. At week 12, among patients with baseline itch-NRS ≥4, ≥4-point reductions were achieved by 79.5% (608A) and 77.3% (608B) vs. 21.8% placebo ($P<0.0001$). Mean DLQI reductions were 72.3%, 67.8%, and 18.3%, respectively. At week 52, both SSGJ-608 groups maintained PASI75 (93.7% [164/175] vs. 93.6% [160/171]), sPGA 0/1 (89.3% [125/140] vs. 89.4% [110/123]), and PASI90 (92.6% [137/148] vs. 92.5% [123/133]). Through week 60, TEAEs occurred in 94.6% (608A) and 93.4% (608B); SAEs in 4.3% and 6.6%, with two (608B, pneumonia/abscess) possibly drug-related. In 608A and 608B groups, steady-state drug concentrations were generally achieved by week 8 and concentrations remained at a certain level and exhibited a trend toward steady state again around week 36. Treatment-induced ADA occurred in 2.7% (608A) and 1.6% (608B) of patients. Persistent ADA was observed in 0.5% (608A) and 1.6% (608B) of patients, and all tested negative for neutralizing antibodies. With continued treatment up to 52 weeks, among patients who achieved a PASI 75 response, the relapse rates were 0.6% (1/179) for the 608A group and 2.3% (4/173) for the 608B group, respectively.

Conclusions
SSGJ-608 demonstrated rapid, substantial, and durable skin clearance in Chinese patients with moderate-to-severe plaque psoriasis, and the efficacy was maintained for up to 52 weeks with higher levels of skin clearance and low one-year relapse rates even at an extended dosing interval of every 8 weeks during the maintenance treatment period. The safety profile was consistent with other IL-17 inhibitors, with no new safety signals identified. These findings support SSGJ-608 as a promising new treatment option for this patient population.

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Abstract N°: 671

Rapid Stabilization of Systemic Inflammatory Index (SII), Neutrophil-Lymphocyte Ratio (NLR), Platelet-Lymphocyte Ratio (PLR) and Monocyte HDL ratio (MHR) Outpaces Clinical PASI Reduction in Severe Psoriasis: A Case Study

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Introduction

Psoriasis is considered a systemic inflammatory disease for which there exists a correlation between skin manifestations of disease activity and risk factors for cardiovascular and metabolic diseases called psoriatic march. Although the Psoriasis Area and Severity Index (PASI) still represent the gold standard, it may not be enough for the early assessment of systemic anti-inflammatory effect after biologic treatments. This case report describes the dynamic changes in several advanced inflammation markers (SII, NLR, PLR and MHR) in patients under Ustekinumab treatment.

Case Presentation

A 59-year-old male patient , with a 34- year duration of Psoriasis Vulgaris, as well as hypertension, chronic psychiatric disorders and diabetes mellitus type 2 (HbA1c 6.5%), presented with a severe psoriasis flare. On the day of presentation, the patient's PASI score was 46.8. The laboratory test results showed high systemic inflammation: CRP 48.6 mg/L, SII 1,103.8, NLR 4.15, PLR 137.1 and MHR 0.035. The Patient received subcutaneous Ustekinumab 90m/ml. Re-assessment was conducted at Day 8 after injection. PASI score was reduced to 39.2 (a 16.2% decrease). Notably, systemic biomarkers revealed greater and faster normalization: NLR was decreased by 56.1% (4.15 to 1.82), falling to healthy reference levels. SII was decreased by 41.1% (1,103.8 to 650.3). PLR demonstrated a significant 41.9% reduction (137.1 to 79.6), reflecting a rapid decrease in platelet-mediated inflammatory signaling. MHR was decreased by 14.3% (0.035 to 0.030), indicating possible early prevention of oxidative stress due to monocytes.

Conclusion

These results show that biological therapy with Ustekinumab causes a much faster immune system stabilization compared to full skin clearance. For physicians and medical students, measurement of SII, NLR, PLR, MHR values serves as an inexpensive and immediate window to evaluate treatment effectiveness. This case study highlights the fact that managing severe psoriasis does not only mean achieving skin clearance but extinguishing the systemic inflammatory state.

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Abstract N°: 686

Combined Therapy with Low-Temperature Argon Plasma and Narrowband UVB-311 nm in Plaque Psoriasis: Clinical Efficacy and Cytokine Profile Dynamics

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Introduction
Psoriasis is one of the most prevalent chronic immune-inflammatory skin diseases. In the Russian Federation, its prevalence reached 243.7 cases per 100,000 population in 2021, with a continuing upward trend. Despite the well-established efficacy of narrowband UVB-311 nm phototherapy, a PASI-75 response is achieved in only 62–68% of patients, underscoring the need for approaches capable of augmenting the phototherapeutic effect. Low-temperature argon plasma (LTAP) possesses demonstrated anti-inflammatory, immunomodulatory, and anti-angiogenic properties; however, its combination with phototherapy has not previously been investigated in prospective clinical studies. The aim of this study was to evaluate clinical efficacy and cytokine profile dynamics following the addition of LTAP to standard narrowband UVB-311 nm therapy in patients with plaque psoriasis.

Materials and Methods
This pilot prospective comparative cohort study enrolled 10 patients with confirmed moderate-to-severe plaque psoriasis. Group 1 (n=5) received UVB-311 nm combined with LTAP using the Plazmoran device (mode B2, 20 seconds per field, 20 sessions on alternate days); Group 2 (n=5) received UVB-311 nm alone. The observation period was 6 weeks. PASI, DLQI, and VAS (pruritus) were assessed, along with serum levels of IL-17A, IL-23, TNF-α, and VEGF by ELISA before and after treatment. Statistical analysis was performed using the Wilcoxon and Mann–Whitney tests, Pearson correlation analysis, and the Holm–Bonferroni correction.

Results
In Group 1, the PASI score decreased by 95.5% (from 26.5±2.3 to 1.2±1.0); a PASI-90 response was achieved in 100% of patients. In Group 2, PASI decreased by 54.5%, with no patient attaining a PASI-75 response. Suppression of IL-17A in Group 1 reached 84.9%, IL-23 — 77.9%, TNF-α — 83.8%, and VEGF — 64.3%, representing 1.9- to 3.5-fold greater reductions compared with Group 2 ($p<0.05$ for all parameters). Strong correlations were identified between PASI and IL-17A (r=0.84–0.95), erythema and TNF-α (r=0.86–0.88), and induration and VEGF (r=0.76–0.93). DLQI normalised to 1.4 points in Group 1 versus 8.2 points in Group 2. No adverse events were recorded.

Conclusions
Combined LTAP and UVB-311 nm therapy is pathogenetically justified, safe, and demonstrates significantly superior outcomes over phototherapy alone across both clinical and laboratory parameters. The findings are preliminary in nature and require confirmation in a randomised controlled trial with a larger patient cohort.

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Abstract N°: 695

Real-world efficacy and safety of vunakizumab in scalp psoriasis: a prospective cohort study

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Introduction

Scalp psoriasis is often treatment-resistant and significantly impairs the quality of life of patients. Vunakizumab, a recombinant anti-interleukin-17A monoclonal antibody, has demonstrated efficacy in plaque psoriasis; however, real-world data specifically in scalp psoriasis remain limited. This study evaluated the 12-week efficacy, onset of response, and safety of vunakizumab in a real-world cohort of patients with scalp psoriasis.

Materials and Methods

This prospective, observational, single-centre study enrolled adult patients with scalp psoriasis who received subcutaneous vunakizumab 240 mg at weeks 0, 2, 4, and every 4 weeks thereafter. Psoriasis Scalp Severity Index (PSSI), Psoriasis Area and Severity Index (PASI), Physician Global Assessment (PGA), Dermatology Life Quality Index (DLQI), and body surface area (BSA) were assessed at baseline and weeks 2, 4, 8, and 12 (as-observed analysis). Changes from baseline were evaluated using the Wilcoxon signed-rank test. The 95% confidence intervals for response rates were calculated using the Clopper-Pearson exact method.

Results

Eighteen patients (16 male, 2 female; mean age 34.7 ± 14.7 years) were enrolled. Mean baseline parameters were PSSI 11.56 ± 9.74, PASI 9.81 ± 5.85, DLQI 6.39 ± 4.37, and BSA 11.22 ± 8.94%. Clinically meaningful improvements occurred by week 2 and continued through week 12 across all metrics (all $P < 0.001$; Fig. A). At week 12, PSSI 90 and PSSI 100 response rates were 100% (18/18; 95% CI 81.5–100%) and 94.4% (17/18; 95% CI 72.7–99.9%), respectively (Fig. B). All patients achieved a PGA of 0 or 1 by week 8 and maintained this response through week 12. Mean BSA decreased by 96.5% to 0.39 ± 0.83%. Mean DLQI decreased by 99.1% to 0.06 ± 0.24, with all patients achieving a DLQI of 0 or 1 at week 12. Three patients (16.7%) experienced mild (Grade 1) adverse events: folliculitis (n = 1), acne (n = 1), and concurrent alopecia and arthralgia (n = 1). No severe adverse events or treatment discontinuations occurred.

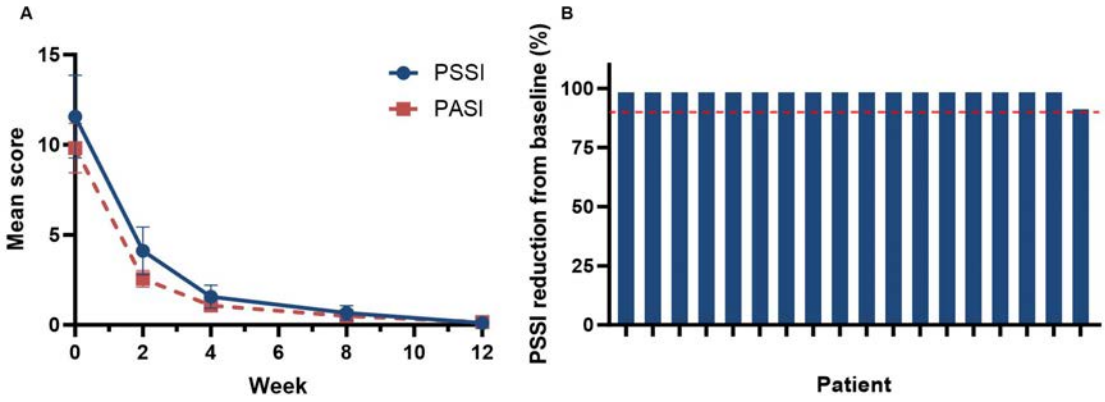

Figure 1. (A) Mean PSSI and PASI scores over 12 weeks of vunakizumab treatment (n = 18). Data are presented as mean ± SEM. Significant reductions from baseline were observed at all time points (Wilcoxon signed-rank test, all P = 0.0002). (B) Waterfall plot of individual PSSI reduction from baseline at week 12. The dashed line indicates the PSSI90 threshold (≥90% reduction from baseline). PSSI, Psoriasis Scalp Severity Index; PASI, Psoriasis Area and Severity Index; SEM, standard error of the mean.

Conclusions

Vunakizumab demonstrated rapid, high-rate scalp clearance with a favourable short-term safety profile in real-world practice. The complete resolution of quality-of-life impairment across the cohort supports vunakizumab as an effective and well-tolerated treatment option for scalp psoriasis.

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Abstract N°: 696

Real-world efficacy and safety of vunakizumab in patients with moderate-to-severe plaque psoriasis: a prospective cohort study analysing BMI as a predictor of response

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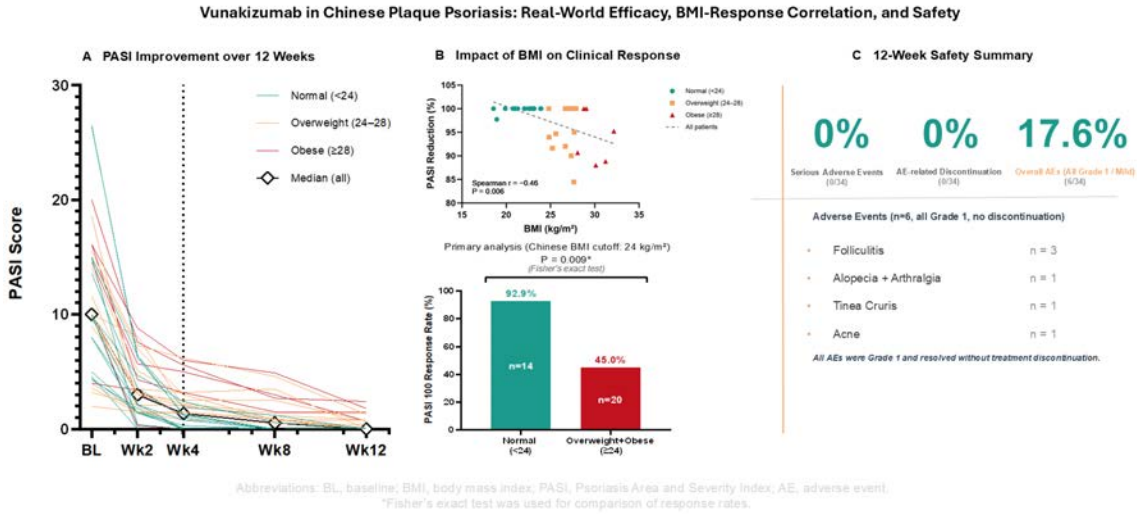
Introduction
Vunakizumab, a novel recombinant anti-interleukin-17A monoclonal antibody, demonstrated high response rates in phase III trials. However, real-world evidence in Chinese patients is limited, and baseline predictors of response depth remain unclear. Therefore, this study evaluated the 12-week efficacy (including rapidity of onset) and safety of vunakizumab in a real-world cohort, and identified body mass index (BMI) as a baseline predictor of complete skin clearance.

Materials and Methods
This prospective, observational, single-centre study enrolled adult patients with moderate-to-severe plaque psoriasis receiving subcutaneous vunakizumab 240 mg at weeks 0, 2, 4, and every 4 weeks thereafter. Psoriasis Area and Severity Index (PASI), Physician Global Assessment (PGA), and Dermatology Life Quality Index (DLQI) were assessed at baseline and weeks 2, 4, 8, and 12 (as-observed analysis). Patients were classified as normal weight (BMI <24 kg/m^2) or overweight/obese (BMI ≥24 kg/m^2) per Chinese criteria. Univariate logistic regression quantified the association between BMI and PASI 100 response.

Results
A total of 34 patients were enrolled, with a mean baseline PASI 11.10 ± 6.17. Clinically meaningful PASI reductions occurred by week 2, with continued improvement through week 12 (Fig. A). At week 12, PASI 75, 90, and 100 response rates were 100%, 91.2%, and 64.7%, respectively; all patients achieved a PGA of 0 or 1. Mean DLQI decreased from 8.38 ± 6.25 to 0.18 ± 0.46 (P<0.001). BMI was the sole significant baseline predictor of PASI 100 response: each 1 kg/m^2 increase reduced the odds of complete clearance by 26.5% (OR 0.735, 95% CI 0.562–0.962, P=0.025). The PASI 100 rate was 92.9% in normal-weight patients (n=14) versus 45.0% in overweight/obese patients (n=20; P=0.009). PASI 90 rates did not differ significantly (100% vs 85.0%; P=0.251), suggesting higher BMI impacts complete clearance (PASI 100) but not near-complete response (PASI 90; Fig. B). Six patients (17.6%) experienced mild (Grade 1) adverse events: folliculitis (n=3), concurrent alopecia and arthralgia (n=1), tinea cruris (n=1), and acne (n=1). No severe adverse events or treatment discontinuations occurred (Fig. C).



Conclusions

Vunakizumab demonstrated rapid, high-rate skin clearance with a favourable short-term safety profile in real-world practice. Normal-weight patients achieved PASI 100 at more than double the rate of overweight/obese patients, with no significant difference in PASI 90 attainment. Weight status is a critical factor when counselling patients on treatment expectations. Future studies should explore whether weight-adjusted dosing or weight management may help improve therapeutic efficacy.

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Abstract N°: 721

Matching-Adjusted Indirect Comparison of Risankizumab Versus Icotrokinra in Adult Patients With Moderate-to-Severe Plaque Psoriasis

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Introduction
This study uses matching-adjusted indirect comparison (MAIC) to compare the efficacy outcomes between risankizumab (RZB) 150 mg, an approved IL-23 inhibitor administered subcutaneously at week 0, 4, then every 12 weeks and daily oral icotrokinra (ICO) 200mg, an IL-23 receptor blocker under investigation for the treatment of adult patients with moderate-to-severe PsO.

Materials and Methods
Phase 3, randomized, double-blinded, placebo (PBO)-controlled trials of RZB and ICO in adults with moderate-to-severe PsO, eligible for systemic therapy and phototherapy, were included following independent review; only studies meeting prespecified inclusion and exclusion criteria were selected for analysis. Individual patient data from RZB trials (UltiMMa-1, UltiMMa-2, and IMMhance) and published aggregate data from ICO trials (ICONIC-LEAD [data from adult patients] and ICONIC-ADVANCE 1/2) were used. Individual patient data from RZB trials were weighted to match the pooled summary statistics of ICO trials on reported baseline characteristics, including age, sex, race, body mass index, static Physician's Global Assessment, Psoriasis Area and Severity Index (PASI), prior phototherapy, and prior biologic therapy. Risk differences between RZB and ICO were assessed for ≥ 75%, 90%, and 100% improvement in PASI (PASI 75, PASI 90, PASI 100), Investigator's Global Assessment (IGA) of 0/1 and 0 (IGA 0/1 and IGA 0) every 4 weeks. PBO-anchored results at week 16 are reported here. For each outcome, we present: (1) PBO-adjusted response rates, and (2) PBO-adjusted risk differences between RZB and ICO, along with confidence intervals and P values.

Results
This analysis included 1005 patients on RZB and 300 patients on PBO from RZB trials; 1045 patients on ICO and 444 on PBO from ICO trials. Baseline characteristics were balanced after matching (effective sample size: RZB = 749, PBO = 236). The average age (SD) was 46.0 (15.0) years; 68% and 77% of the patients were male and White, respectively. The mean baseline PASI (SD) was 18.7 (6.2), and 29% of patients had received prior biologic therapy.At 16 weeks of treatment, the PBO-adjusted response rates (RZB vs ICO) for PASI 75 were 80.6% vs 61.7%, with a risk difference (RD) of 18.9% (95% CI, 11.5%, 26.4%; P < .001). The PBO-adjusted response rates for PASI 90 were 71.4% vs 49.9% (RD RZB vs ICO 21.5% [95% CI, 15.6%, 27.4%; P < .001]). The PBO-adjusted response rates for PASI 100 were 42.3% vs 29.4% (RD RZB vs ICO 13.0% (95% CI, 7.9%, 18.0%; P < .001]). The PBO-adjusted

response rates for IGA 0/1 were 77.8% vs 58.4% (RD RZB vs ICO 19.4% [95% CI, 12.4%, 26.3%; P < .001]). The PBO-adjusted response rates of patients who achieved IGA 0 were 41.6% vs 33.9% (RD RZB vs ICO 7.7% [95% CI, 2.3%, 13.0%; P < .05]).

Conclusions

In this analysis, patients with moderate-to-severe psoriasis treated with RZB demonstrated higher response rates of achieving PASI 75/90/100, IGA 0/1, and IGA 0 at week 16 compared with patients treated with ICO.

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Abstract N°: 730

Clinical Psychological Discordance in Von Zumbusch Generalized Pustular Psoriasis: Implication of an Alexithymic Profile

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Introduction

Generalized pustular psoriasis of the Von Zumbusch type is a rare and severe form of psoriasis. It is classically associated with a significant psychological impact. Among patients with psoriasis, the prevalence of alexithymia is estimated to range between 25% and 30%[1], and is associated with a higher morbidity burden, increased levels of anxiety and depression. Through the observation of a patient with generalized pustular psoriasis showing a marked clinico-psychological discordance, we explore the hypothesis of an alexithymic profile and discuss its implications within a psychodermatological perspective.

Case Presentation

A 57-year-old patient with a psoriasis vulgaris since the age of 16, was hospitalized for the management of Von Zumbusch type generalized pustular psoriasis. The patient presented with diffuse erythematous, pustular, and crusted lesions involving the entire integument, evolving in a context of general condition deterioration and fever of 38.5 °C. Also a geographic tongue and peri-oral honey-colored crusts. The conjunctival and nasal mucosa showed the presence of purulent discharge. Examination of the fingernails revealed thimble-like pitting. The scalp showed scaly-crusted lesions.

Palpable axillary and inguinal lymphadenopathy. Facial and extremity edema.

Biological workup revealed a severe inflammatory syndrome: leukocytosis at 29,000 G/L with neutrophil predominance, inflammatory anemia with hemoglobin at 11.6 g/dL, and reactive thrombocytosis at 600,000/µL, reflecting the intensity of the inflammatory process. CRP was markedly elevated at 272 mg/L. Electrolyte disturbances included hyponatremia (128 mmol/L) and hyperkalemia (7 mmol/L), indicating significant fluid and electrolyte imbalance. Hypoalbuminemia at 28 g/L.

Also a cholestatic syndrome with hepatocellular injury evidenced by AST at 376 U/L and ALT at 157 U/L . Procalcitonin was 5 ng/mL.1 During hospitalization, the patient consistently reported improvement to the healthcare staff, minimizing any information suggestive of clinical deterioration. The Dermatology Life Quality Index (DLQI) assesses the subjective impact of the flare, which returned a score of 3/30, indicating a low impact. Alexithymia was evaluated using the self-administered 20- item Toronto Alexithymia Scale (TAS-20), was at 61. The patient was treated with Cefotaxime and Acyclovir for 10 days. Than Methotrexate was initiated at 15 mg weekly via injection, leading to progressive clinical with appropriate psychological support.

Conclusion

The clinical severity was corroborated by a massive biological inflammatory syndrome.This profile is consistent with the severe systemic forms of generalized pustular psoriasis described in the literature[2]. However, in the discrepancy between the clinical and biological severity and the patient's subjective perception, as he underestimated the seriousness of his condition. The skin, in particular, maintains a close relationship with the psyche, sharing a common embryonic origin: the ectoderm[3]. Several studies have shown an increased prevalence of alexithymic traits, especially in psoriatic patients[4], suggesting a link between emotional dysregulation and

chronic inflammation. In this context, alexithymia could not only modulate the subjective experience but also influence clinical progression through psycho- immunological mechanisms. Alexithymia can be assessed using clinician-administered scales or self-report questionnaires[5], which revealed a notable discrepancy: a DLQI score of 3/30 indicated a minimal perceived impact on quality of life, while a TAS-20 score was consistent with alexithymia. Our observation thus highlights the importance of a comprehensive approach combining dermatological, biological, and psychological assessment, particularly in severe forms of generalized pustular psoriasis. Screening for an alexithymic profile could represent a relevant factor in the overall evaluation of the patient and in optimizing therapeutic management.

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Abstract N°: 737

Safety and Efficacy of Risankizumab in Genital and Scalp Psoriasis in the UnlIMMited Phase 4 Randomized Clinical Trial at Week 52

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Introduction
Psoriasis (PsO) involving the genital or scalp regions is considered high impact and is associated with substantial impairment in patient quality of life (QoL) and increased disease burden. Patients with genital or scalp PsO may have limited overall body surface area involvement yet experience disproportionately high QoL impairment. Risankizumab (RZB), an interleukin-23 inhibitor approved for the treatment of moderate-to-severe PsO, has previously demonstrated efficacy in high-impact disease areas. Here, we present 52-week results from the first dedicated studies evaluating RZB in genital and scalp PsO from the UnlIMMited study.

Materials and Methods
UnlIMMited (NCT05969223) is a Phase 4, multicenter, randomized, double-blind, placebo-controlled study for adult patients with moderate-to-severe genital or scalp PsO. Patients were randomized within either Study-G (genital PsO) or Study-S (scalp PsO) at 1:1 to receive either 150 mg RZB or placebo (PBO) at weeks 0 and 4 (Period A). Beginning at week 16, all patients entered the open-label extension and received 150 mg RZB every 12 weeks (Period B). Efficacy outcomes are reported at the end of Period B (week 52). Endpoints for Study-G include achievement of static Physician's Global Assessment-Genital (sPGA-G) 0 and 0 or 1, achievement of Dermatology and Life Quality Index (DLQI) 0 or 1, improvement of ≥4 points from baseline Genital PsO Itch on a numerical rating scale (clinically meaningful change), and Genital Psoriasis – Sexual Frequency Questionnaire (GenPs-SFQ) item 2 score of 0 or 1 (minimal or no interference with sexual activity). Endpoints reported for Study-S are achievement of scalp Investigator Global Assessment (IGA) 0 or 1, achievement of a >75%/90%/100% improvement in Psoriasis Scalp Severity Index (PSSI) from baseline, change from baseline in Psoriasis Symptom Score (PSS), and achievement of PSS 0. Other additional efficacy endpoints and safety were assessed throughout the studies. Missing data was handled with non-responder imputation for categorical endpoints and MMRM for continuous endpoints.

Results
At week 52, a substantial proportion of patients in both Study-G and Study-S showed improvements in signs and symptoms of genital or scalp PsO (Table 1). In Study-G, the majority of patients (PBO/RZB 75.5%; RZB/RZB 81.5%) achieved sPGA-G 0/1. Approximately half of patients (PBO/RZB 50.9%; RZB/RZB 57.4%) reported little to no impact of PsO on their quality of life (DLQI 0/1). Clinically meaningful improvements in Genital PsO itch were reported by most patients (PBO/RZB 55.6%; RZB/RZB 80.5%). The majority of patients (PBO/RZB 84.4%, RZB/RZB

77.4%) also reported a GenPS-SFQ item 2 score of 0/1. At week 52 in Study-S, most patients (PBO/RZB 79.2%; RZB/RZB 72.5%) achieved scalp IGA 0/1. Marked improvements in PSSI were observed, with over 65% of patients (PBO/RZB 66.7%; RZB/RZB 64.7%) achieving complete clearance (PSSI 100) at week 52. Mean reductions from baseline in Psoriasis Scalp Severity (PSS) scores were approximately 7.5 points (PBO/RZB, 7.5; RZB/RZB, 7.7), with a subset of patients achieving PSS scores of 0 (PBO/RZB, 50.0%; RZB/RZB, 35.3%). Both Study G and S had a similar adverse event profile, and no new safety signals were identified.

Conclusions

This study provides the first long-term data from dedicated studies for RZB in patients with genital or scalp PsO. At week 52, patients demonstrated continued improvement in their genital and scalp PsO, and no new safety signals were identified. At week 52, the majority of patients with genital and scalp PsO achieved sPGA-G 0/1 and scalp IGA 0/1, respectively. Collectively, this analysis provides additional support for the use of RZB to treat high-impact areas of PsO.

Table 1. Efficacy of patients with genital or scalp psoriasis at week 52

% (95% CI)	PBO/RZB	RZB/RZB
Study G	**(N = 53)**	**(N = 54)**
sPGA-G 0/1	75.5 (63.9, 87.1)	81.5 (71.1, 91.8)
sPGA-G 0	54.7 (41.3, 68.1)	70.4 (58.2, 82.5)
DLQI 0/1	50.9 (37.5, 64.4)	57.4 (44.2, 70.6)
Clinically meaningful change from baseline in Genital PsO Itch[a]	55.6 (41.0, 70.1)	80.5 (68.4, 92.6)
GenPs-SFQ item 2 score 0/1[b]	84.4 (71.8, 97.0)	77.4 (62.7, 92.1)
Study S	**(N = 48)**	**(N = 51)**
Scalp IGA 0/1	79.2 (67.7, 90.7)	72.5 (60.3, 84.8)
PSSI 75	81.3 (70.2, 92.3)	86.3 (76.8, 95.7)
PSSI 90	75.0 (62.8, 87.2)	70.6 (58.1, 83.1)
PSSI 100	66.7 (53.3, 80.0)	64.7 (51.6, 77.8)
Change from baseline PSS[c]	-7.5 (-8.5, -6.5)	-7.7 (-8.7, -6.7)
PSS 0	50.0 (35.9, 64.1)	35.3 (22.2, 48.4)

[a]Defined as ≥4 point reduction from baseline for patients with a baseline score ≥4 (PBO/RZB N=45, RZB/RZB N=41).

[b]For patients with a baseline score ≥2 (PBO/RZB 32, RZB/RZB 31).

[c]PBO/RZB N=42, RZB/RZB N=43.

DLQI, Dermatology and Life Quality Index; GenPs-SFQ Item 2, Genital Psoriasis – Sexual Frequency Questionnaire item 2; IGA, Investigator Global Assessment; PBO, placebo; PSS, Psoriasis Symptom Score; PSSI, >75%/90%/100% improvement in baseline Psoriasis Scalp Severity Index; RZB, risankizumab; sPGA-G, static Physician's Global Assessment-Genital.

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Abstract N°: 761

High effectiveness of tildrakizumab 200 mg over 2 years in patients with severe psoriasis: a Belgian two-centre real-world study

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Introduction

Tildrakizumab (TIL), an interleukin-23p19 inhibitor for moderate-to-severe plaque psoriasis, offers two dosing options allowing individualised treatment. While the standard dose is 100 mg, the 200 mg dose may be appropriate for patients with high disease burden or body weight >90 kg (1). In Belgium, however, reimbursement for 200 mg is limited to patients with Psoriasis Area and Severity Index (PASI) ≥20 (indicative of severe psoriasis) and body weight >90 kg. Since there was no real-world data for the 200 mg dose use in Belgium, this study aimed to identify the characteristics of patients receiving TIL 200 mg in Belgium and to evaluate the effectiveness of TIL 200 mg in patients with severe psoriasis.

Materials and Methods

This was a 2-year real-world study in adults with psoriasis treated with TIL 200 mg according to reimbursement criteria in Belgium. Patients with severe psoriasis who were eligible for reimbursement of TIL 200 mg (PASI ≥20, body surface area [BSA] >10%, and body weight >90 kg) were included. Effectiveness was assessed using the PASI. Psychological well-being was assessed with the 5-item WHO Well-Being Index (WHO-5, range 0-100, from absence of well-being to maximal well-being; as a reference, the mean WHO-5 score in the general Belgian population is 65.0 [2]). The impact on quality of life (QoL) was measured using the Dermatology Life Quality Index (DLQI, range 0-30, where higher scores indicate greater QoL impairment). An itch-Numeric Rating Scale (NRS) was used to assess the intensity of itching (range 0-10, from no itch to worst itch imaginable). Physicians rated treatment satisfaction on a satisfaction-NRS (range 0-10, from absolutely not satisfied to absolutely satisfied). We report 2-year data based on observed cases.

Results

Fifteen patients (66.7% male; mean age 53.1 years [SD 15.2]; mean body weight 103.4 kg [SD 8.8]) were included. The median BSA affected was 21% (IQR 17-45) and the median time since diagnosis was 15.1 years (IQR 11.2-28.7). The most common comorbidities were obesity (73.3%), diabetes (40.0%), and hypertension (33.3%). The median PASI score decreased from 27 at baseline (BL) to 0 at months 6, 12, 18, and 24 ($p<0.01$, all). At month 6, 12, 18, and 24, 73.3%/53.3%, 83.3%/66.7%, 88.9%/88.9%, and 66.7%/55.6% of patients, respectively, achieved PASI 90/100. Similarly, 73.3%/53.3%, 83.3%/66.7%, 100%/88.9%, and 88.9%/55.6% of patients, achieved absolute PASI ≤3/≤1 at month 6, 12, 18, and 24, respectively. The median WHO-5 score increased from 40 at BL to 80 at months 6 and 12, and 100 at months 18 and 24 ($p<0.01$, all). The median DLQI score decreased from 15 at BL to 1 at month 6, and 0 at months 12, 18, and 24 ($p<0.05$, all). At month 6, 12, 18, and 24, 53.3%, 75.0%, 77.8%, and 77.8% of patients, respectively, had a DLQI score of 0 or 1. The median itch-NRS score decreased from 5 at BL to 0 at months 6, 12, 18, and 24 ($p<0.05$, all). At month 24, the median satisfaction-NRS score was 10. No adverse events were reported during the follow-up period.

Conclusions

Although the sample size was limited, this is the first study on long-term TIL 200 mg use in Belgium, where reimbursement criteria are stricter than those for the approved indication. In this study, patients with severe psoriasis treated with TIL 200 mg were predominantly middle-aged males with obesity. TIL 200 mg showed high effectiveness in patients with severe psoriasis significantly improving patients' psychological well-being, QoL, and itching, achieving a well-being status similar to the general Belgian population after 6 months, with improvement maintained over 2 years. Physicians reported high levels of satisfaction with the treatment. The safety profile was favourable and consistent with previous studies (3,4).

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Real-World Effectiveness of Calcipotriol/Betamethasone Dipropionate Cream (Wynzora®) in Mild-to-Moderate Psoriasis: A Four-Patient Case Series

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Introduction
Topical therapy remains the cornerstone of treatment for patients with mild-to-moderate psoriasis. However, disease involvement of visible, high-impact or difficult-to-treat areas—such as the scalp, palms and other functionally relevant sites—often compromises treatment adherence due to poor cosmetic acceptability of traditional topical formulations. Calcipotriol/betamethasone dipropionate cream formulated with Poly-Aphron Dispersion (PAD) technology (Wynzora®) has been developed to enhance drug delivery while improving sensory properties, with the potential to optimize both efficacy and patient adherence.
The objective is to describe the clinical outcomes, speed of response and patient-reported experience in four real-world patients with mild-to-moderate psoriasis treated with calcipotriol/betamethasone dipropionate cream in different anatomical locations.

Materials and Methods
Four adult patients with clinically diagnosed mild-to-moderate plaque psoriasis affecting different body areas (including scalp, palms and other localized regions) were treated once daily with calcipotriol/betamethasone dipropionate cream for periods ranging from 1 to 4 weeks. Clinical evolution was assessed based on improvements in erythema, scaling and plaque thickness, as well as functional and symptomatic impact. Patient-reported perception of the formulation, including texture, ease of application, cosmetic acceptability and adherence, was recorded during follow-up visits.

Results
All four patients demonstrated early and clinically meaningful improvement, with visible reduction of erythema and scaling typically observed within the first week of treatment, regardless of lesion location. Progressive thinning of plaques and symptomatic relief were documented across all cases. By the end of the observation period, three patients achieved near-complete clearance of treated lesions, while the fourth showed marked improvement with significant functional benefit.Across all cases, patients reported a high level of satisfaction with the treatment, highlighting the light, non-greasy texture, rapid absorption, and absence of residue of the cream. These organoleptic characteristics facilitated daily use, including application on visible or functionally active areas, and were consistently associated with good adherence. No local or systemic adverse events were reported.

Conclusions

In this real-world four-patient case series, calcipotriol/betamethasone dipropionate cream demonstrated rapid efficacy, good tolerability and high patient acceptance in the treatment of mild-to-moderate psoriasis across different anatomical locations. The favorable cosmetic profile of the PAD-cream formulation may contribute to improved adherence and effective disease control in daily clinical practice. These observations support the role of calcipotriol/betamethasone dipropionate cream as a first-line topical treatment option for localized psoriasis.

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Abstract N°: 835

Clinical and epidemiological profile of patients with psoriasis treated with risankizumab at a teaching hospital

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Introduction

Risankizumab, a humanised immunoglobulin G1 (IgG1) monoclonal antibody and selective inhibitor ofthe p19 subunit of interleukin 23 (IL-23), is approved for the treatment of moderate to severe plaquepsoriasis in adults.

Materials and Methods

This descriptive cross-sectional study analysed the baseline characteristics of patientswith psoriasis who were being monitored at the Psoriasis Unit of our Hospital and treated withrisankizumab. Fifty patients were included in the study, and the following variables were assessed:demographic factors (age, sex, family history, smoking status and body mass index); comorbidities(metabolic syndrome, arthritis and neoplasms, among others); and disease-related data (conditionduration, clinical presentation and involvement of difficult-to-manage areas). Previous treatment historywith systemic and biologic drugs was also recorded. The analysis involved calculating percentages forqualitative variables and means with standard deviation for quantitative variables.

Results

The mean age was 53years, 40% of patients were female, and 66% had a family history of psoriasis. 20% were smokers. Themost common comorbidities were diabetes (20%), dyslipidaemia (24%), metabolic syndrome (30%), fattyliver (20%), a history of neoplasia (8%) and latent tuberculosis infection (12%).The mean disease durationwas 21.4 years. The most common clinical form was plaque psoriasis (90%). In terms of location, scalpinvolvement was present in 94% of patients, inverse psoriasis in 62%, and palmoplantar psoriasis in 16%.Before starting risankizumab treatment, patients had previously undergone an average of two systemictreatments and 2.26 biologic treatments.

Conclusions

These results demonstrate a clinical-epidemiological profileconsistent with that reported in the international literature, thereby confirming the representativeness ofthe analysed cohort.

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Abstract N°: 840

Circulating semaphorins in psoriasis: unveiling their role as indicators of metabolic status

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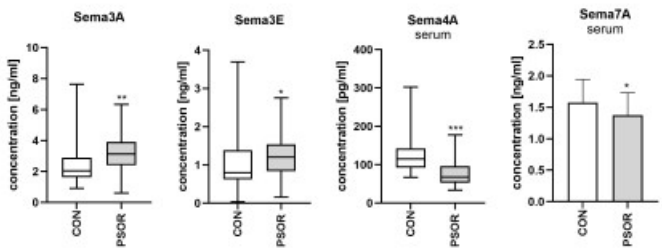
Introduction
Psoriasis is an autoimmune systemic inflammatory disease associated with numerous comorbidities, with metabolic complications contributing to increased cardiovascular risk and mortality. Semaphorins (Sema) are a group of transmembrane, cell surface-attached and secretory proteins that might play an important role in psoriasis due to their presence on keratinocytes and the ability to stimulate the proinflammatory cytokine production. The study aimed to assess the concentration of serum Sema3A, Sema3E, Sema4A, Sema4D and Sema7A of psoriatic patients and explore the correlation with disease activity and clinical and metabolic status.

Materials and Methods
Serum concentrations of selected semaphorins were assessed by ELISA in 60 patients with flared plaque psoriasis and 30 healthy volunteers matched for gender, age, and BMI. Psoriasis severity was assessed using Psoriasis Activity and Severity Index (PASI). The study group was subdived with regards to disease severity or weight. Laboratory analyses included C-reactive protein, complete blood count, fasting glucose, lipid profile and parameters reflecting renal and hepatic function.The study protocol received approval from the local Bioethics Committee.

Results
The mean serum Sema3A, Sema3E and Sema4D levels were significantly higher in patients with psoriasis than controls ($p<0.01$, $p<0.05$ and $p<0.05$, respectively). Contrarily, Sema4A and Sema7A were significantly lower ($p<0.001$ and $p<0.05$ respectively). Significant positive correlation between Sema3A and UREA was noted. Sema3A levels were significantly higher in moderately ill and overweight patients ($p<0.05$, $p<0.01$, respectively) and in patients with longer-lasting psoriasis and male patients compared to controls (both $p<0.05$). Sema3E significantly negatively correlated with HDL and glucose levels. Sema4A was significantly lower in moderately and severe psoriatic patients ($p<0.0001$, $p<0.01$, respectively). Sema7A was significantly higher in moderately ill and overweight patients ($p<0.05$, $p<0.01$, respectively) and significantly lower in male patients and in those with longer lasting disease than in controls. None of the semaphorins correlated with psoriasis severity, total BMI, psoriasis duration and age.



Serum semaphorins levels in patients with psoriasis in comparison to healthy volunteers.

Conclusions

Psoriatic patients exhibited significant alterations in circulating semaphorins. Specifically, levels of Sema3A, Sema3E, and Sema4D were elevated, while Sema4A and Sema7A were decreased in comparison to healthy individuals. Sema3E demonstrated a significant negative correlation with HDL cholesterol and glucose levels, suggesting it may serve as a potential marker for assessing metabolic complications associated with psoriasis. Sema4A also deserves further investigation, as it may play a role in the itch–scratch cycle seen in psoriasis and could be relevant for developing new therapeutic approaches. Overall, these findings highlight semaphorins as promising indicators of systemic dysregulation in psoriasis and offer insight into their connections with metabolic and clinical characteristics.

EA DV CONGRESS
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Abstract N°: 866

Guselkumab demonstrates superior effectiveness compared with secukinumab in overweight/obese psoriasis patients: results through 84 weeks from the non-interventional German G-REAL study

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Introduction

Guselkumab (GUS), an IL-23 inhibitor targeting its p19 subunit, demonstrated superior efficacy in psoriasis patients through 48 weeks compared with the IL-17A inhibitor secukinumab (SEC) in the phase 3 randomized, comparator-controlled ECLIPSE trial[1]. The prospective, non-interventional G-REAL study assessed the real-world effectiveness of GUS versus SEC in patients with moderate-to-severe psoriasis in routine clinical practice in Germany. Given the high prevalence of overweight and obese psoriasis patients[2], this analysis focused on the patient subgroup with body mass index (BMI) > 25 in G-REAL.

Materials and Methods

Patients received GUS or SEC dosed according to their respective labels. Shortly after study start, the SEC label was updated to allow for higher maintenance dosing in patients weighing ≥90 kg. Overweight/obese patients (BMI>25) were stratified by biologic treatment history: bio-naïve (bn) and ≥1 prior biologic therapy (≥1pbt). This analysis included 378 overweight/obese GUS patients (183 bn and 195 ≥1pbt) and 123 overweight/obese SEC patients (71 bn and 52 ≥1pbt). Current treatment targets of Psoriasis Area and Severity Index (PASI) <2 and Dermatology Life Quality Index (DLQI) 0/1, based on the German S3 guideline[3], were evaluated through week (W) 84. The Psoriasis Symptoms and Signs Diary (PSSD)[4] was used as an additional patient-reported outcome measure to assess treatment benefits. The "Pain" subscore ranging from 0 (no pain at all) to 10 (maximum pain), was evaluated in this analysis. Data were imputed using treatment failure rules (i.e. discontinuation of therapy due to lack/loss of effectiveness, adverse event of worsening psoriasis, or initiation of a new psoriasis therapy was imputed as non-response). Calculated p values at W84 were considered nominal.

Results

At W28, in the overall GUS vs SEC BMI>25 cohorts, PASI<2 was achieved by 75.8% vs 56.3% of patients, respectively (Figure 1). Corresponding response rates were 76.0% vs 66.7% in the bn subgroups and 75.6% vs

42.9% in the ≥1pbt subgroups, respectively.
At W84, PASI<2 response rates in the overall GUS vs SEC BMI>25 cohorts were 79.6% vs 53.2% (p<0.0001), 86.8% vs 67.4% in the bn subgroups (p<0.005), and 72.9% vs 35.3% in the ≥1pbt subgroups (p<0.0001, Figure 1).

At W28, DLQI 0/1, indicating no effect of skin disease on patients' quality of life, was achieved by 54.3% vs 44.2% of patients in the overall GUS vs SEC BMI>25 cohorts, respectively.
At W84, GUS vs SEC DLQI 0/1 response rates were 64.3% vs 46.5% (p<0.01) in the overall BMI>25 cohorts, 69.5% vs 61.5% in the bn subgroups (p=0.355), and 59.7% vs 28.1% in the ≥1pbt subgroups (p<0.002), respectively.

In the overall GUS vs SEC BMI>25 cohorts, combined treatment targets (both PASI<2 *and* DLQI 0/1) were achieved by 46.8% vs 32.5% of patients at W28 and by 53.5% vs 39.7% of patients at W84 (p<0.05), respectively.

At W28, in the overall GUS vs SEC BMI>25 cohorts, 59.7% vs 40.5% of patients were pain-free (PSSD pain score = 0), as were 63.9% vs 58.5% in the bn subgroups and 55.9% vs 18.2% in the ≥1pbt subgroups, respectively.
Corresponding response rates at W84 were 65.4% vs 45.1% in the overall cohorts (p<0.01), 73.5% vs 56.4% in the bn subgroups (p<0.05), and 58.3% vs 31.3% in the ≥1pbt subgroups (p<0.01), respectively.

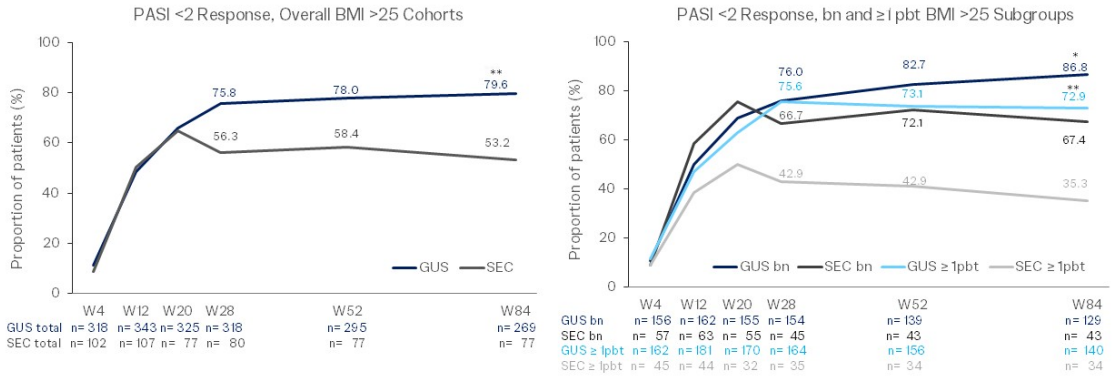

Figure 1: Proportion of patients achieving PASI <2 from W4 to W84 with GUS or SEC treatment in the overall BMI >25 cohorts, and in the bn and ≥ 1 pbt subgroups. Data were analyzed after applying treatment failure rules. p at W84: *p < 0.005; **p<0.0001 vs SEC. Abbreviations: bn, bio-naive; PASI, Psoriasis Area and Severity Index; pbt, prior biologic therapy; W, week

Conclusions

In the real-world G-REAL study, guselkumab (GUS), a p19-targeted IL-23 inhibitor, demonstrated significantly better long-term clinical effectiveness versus secukinumab (SEC), an IL-17A inhibitor, in overweight and obese patients (BMI>25) with moderate-to-severe psoriasis, including both bio-naïve and biologic-experienced patients. High quality of life and complete pain relief were achieved more frequently with GUS. These findings support the robust and durable real-world effectiveness of GUS in overweight and obese psoriasis patients.

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Abstract N°: 871

Risk Factor Clusters Associated With Progression From Oligoarticular to Polyarticular Psoriatic Arthritis: Apremilast Treatment Effect in the FOREMOST Study

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Introduction

Oligoarticular (oligo; ≤4 active [swollen and/or tender] joints) psoriatic arthritis (PsA) is common in early disease. Timely diagnosis and therapeutic intervention at the oligo stage could attenuate, delay, or prevent progression to polyarticular (poly; >4 active joints) disease. In the FOREMOST (NCT03747939) study of early oligo PsA (mean disease duration: 9.9 months), apremilast (APR) significantly reduced the odds of progressing from ≤4 active joints at baseline to >4 active joints at Week 16 (W16) by 58% (OR: 0.42) compared with placebo (PBO).[1] A previous post hoc analysis of patients receiving PBO identified female sex, swollen upper extremity small joints, 4 active joints at baseline, and presence of enthesitis as risk factors for progression, particularly when these risk factors present in clusters.[2] We report post hoc analyses of the association between these risk factors (individually and in clusters) and progression from oligo to poly PsA in the FOREMOST population, including APR treatment effect.

Materials and Methods

Univariate logistic regression was performed for each individual risk factor and each risk factor cluster. Odds ratios (OR) for progression at W16 were calculated for patients with vs without each risk factor or cluster, and for APR- vs PBO-treated patients.

Results

Among 268 patients with ≤4 active joints at baseline (overall population), the odds of disease progression at W16 were significantly higher in patients who were female (OR: 2.48) or who had 4 active joints (OR: 2.94), enthesitis

(OR: 2.59), or swollen upper extremity small joint involvement at baseline (OR: 2.50; **Figure 1A**). Compared with PBO, APR significantly reduced odds of progression in patients who were female or who had 4 active joints or swollen upper extremity small joints at baseline (OR: 0.37, 0.46, and 0.38, respectively; **Figure 1A**). All evaluated risk factor clusters significantly increased the odds of disease progression vs patients without each risk factor cluster (OR: 2.72–4.65; **Figure 1B;** overall population). The clusters most strongly associated with progression included: females with 4 active joints, enthesitis, and swollen upper extremity small joints (OR: 4.65); females with enthesitis and swollen upper extremity small joints (OR: 3.95); and females with enthesitis (OR: 3.54; **Figure 1B**). APR showed the greatest reduction in odds of progression vs PBO in the following clusters: females with enthesitis and swollen upper extremity small joints (OR: 0.21); females with swollen upper extremity small joints (OR: 0.22); and patients with 4 active joints, enthesitis, and swollen upper extremity small joints (OR: 0.23; **Figure 1B**). Progression from oligo to poly was generally less likely with APR vs PBO regardless of individual risk factors or risk factor clusters, with a trend toward greater reduction of odds of progression with APR in patients with risk factors vs those without (**Figures 1A & 1B**).

Conclusions

In the overall FOREMOST population, in addition to having more active joints, the presence of enthesitis or swollen upper extremity small joints, or being female, either as single risk factors or in clusters, was associated with higher odds of progression from oligo to poly PsA. APR reduced the odds of progression compared with PBO in patients with individual risk factors and risk factor clusters.

References:

1. Coates LC et al. Poster presented at: American College of Rheumatology 2025; October 24-29, 2025; Chicago, IL, USA.
2. Gossec L et al. European Alliance of Associations for Rheumatology Annual Meeting 2026; June 3–6, 2026; London, UK. Abstract 0696.

Funding:

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Odds ratios >1 indicate higher odds of disease progression. Odds ratios for Y vs N indicate odds of disease progression for patients with each risk factor compared with those without. Odds ratios for APR vs PBO indicate odds of disease progression in each subgroup with APR compared with PBO.

EADV CONGRESS
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Abstract N°: 888

Functional Impact of Palmoplantar Psoriasis on Hand Performance: A Cross-Sectional Study

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Introduction

Palmoplantar psoriasis (PP) affects functionally critical areas and may cause substantial impairment in daily activities due to pain, fissures, and hyperkeratosis. Despite its potential impact, the functional consequences of hand involvement remain poorly quantified in clinical practice. This study aimed to evaluate hand function in patients with palmoplantar psoriasis and to investigate its relationship with disease severity and quality of life.

Materials and Methods

A cross-sectional observational study was conducted at a tertiary dermatology outpatient clinic between November 2024 and October 2025. Adult patients (≥18 years) with clinical and/or histopathological diagnosis of palmoplantar psoriasis were included. Individuals with orthopedic, neurological, or rheumatologic conditions potentially affecting hand function were excluded.Sociodemographic and clinical data were collected, including disease duration, comorbidities, and involvement of nails, joints, and scalp. Disease severity was assessed using the Psoriasis Area Severity Index (PASI), and quality of life using the Dermatology Life Quality Index (DLQI).Hand function was evaluated using the Cochin Hand Functional Scale (CHFS), an 18-item validated questionnaire assessing daily manual activities, with scores ranging from 0 to 90, where higher scores indicate greater functional impairment.Statistical analysis was performed using SPSS v27. Descriptive statistics were calculated, and associations were evaluated using Fisher's exact test and Spearman's correlation coefficient. Statistical significance was defined as $p < 0.05$.

Results

Thirty patients with palmoplantar psoriasis were included. Most participants were female (73.3%), with a mean age of 57.9 years and a mean disease duration of 13.7 years. Isolated palmoplantar involvement was observed in 63.3% of patients, while 33.3% also presented plaque psoriasis. Nail involvement occurred in 30%, joint involvement in 16.7%, and scalp involvement in 16.7%.Disease severity was generally mild, with a mean PASI score of 1.9. The mean DLQI score was 4.4, indicating predominantly mild impact on quality of life. Most patients were receiving treatment, with 76.7% using topical therapy and 76.7% systemic therapy, including 40% receiving biologic agents.The mean CHFS score was 7.1, indicating overall preserved hand function, although some patients showed mild to moderate impairment. A significant positive correlation was observed between PASI and DLQI ($\rho = 0.689$; $p < 0.01$). Hand function impairment, measured by CHFS, demonstrated a moderate and significant correlation with DLQI ($\rho = 0.435$; $p = 0.01$). A positive but non-significant correlation was observed between CHFS and PASI ($\rho = 0.352$; $p = 0.057$).

Conclusions

Palmoplantar psoriasis may impair hand function even in patients with clinically mild disease. Functional limitation was significantly associated with reduced quality of life but showed only a weak association with PASI, suggesting that conventional severity indices may underestimate the functional burden of palmoplantar involvement. Incorporating functional assessment tools into clinical evaluation may provide a more comprehensive

understanding of disease impact and improve patient management.

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Abstract N°: 891

Effects of calcipotriene/betamethasone dipropionate foam combined with phototherapy in an imiquimod-induced mouse model of psoriasis

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Introduction

Psoriasis is a chronic inflammatory skin disease characterized by erythematous scaly plaques and dysregulated keratinocyte proliferation and differentiation. Calcipotriene/betamethasone dipropionate (Cal/BD) foam has demonstrated superior efficacy compared with ointment and gel formulations. However, monotherapy often fails to achieve complete clearance in clinical practice, necessitating combination strategies. Narrowband UVB (NB-UVB) phototherapy is widely used, and clinical studies comparing NB-UVB alone with NB-UVB combined with topical therapy have demonstrated improved clinical outcomes with combination regimens, including faster lesion clearance and reduced cumulative UVB exposure. However, previous clinical studies have primarily demonstrated the additive clinical benefit of combining topical therapy with phototherapy, while the underlying biological mechanisms remain largely undefined. Moreover, the biological impact of adding UVB to an already effective topical treatment has not been systematically investigated, either clinically or experimentally. Therefore, this study aimed to evaluate both the biological effects underlying combination therapy and the specific impact of adding UVB to Cal/BD foam, using an imiquimod (IMQ)-induced mouse model of psoriasis.

Materials and Methods

BALB/c mice (6–10 weeks old) received daily topical IMQ application (62.5 mg) for 6 consecutive days. Cal/BD foam (15 mg) or vehicle was applied every other day, and UVB irradiation (308 nm, 100 mJ/cm^2) was administered every other day (Figure 1A). Disease severity was evaluated daily using a modified Psoriasis Area and Severity Index–based clinical score, assessing erythema, scaling, and thickness (each graded 0–4; total score 0–12). Skin samples were collected on day 4 for quantitative PCR and on day 6 for histological analysis, including epidermal thickness and number of epidermal layers.

Results

Both Cal/BD foam monotherapy and combination therapy significantly improved clinical scores compared with vehicle (Figure 1B). However, no significant difference in total clinical score was observed between Cal/BD monotherapy and combination therapy. In contrast, histopathological analysis demonstrated that combination therapy significantly reduced the number of epidermal layers compared with monotherapy (Figure 1C). At the molecular level, both treatments reduced IL-17A, IL-23, and TNF expression compared with vehicle (Figure 1D). Notably, IL-17F and IL-22 were significantly suppressed only in the combination therapy group, whereas IL-6 reduction was more pronounced in the monotherapy group, and IL-10 expression showed no consistent change. In addition, comparison with UVB-treated groups showed that combination therapy resulted in greater histopathological improvements and differential modulation of selected inflammatory cytokines (Figure 1C, 1D). These findings indicate differential modulation of inflammatory pathways, particularly enhanced suppression of the Th17 axis with combination therapy.

Conclusions

Although the addition of UVB to Cal/BD foam did not further improve overall clinical scores in this model, it resulted in greater histopathological improvement and selective suppression of key inflammatory cytokines,

including IL-17F and IL-22. Importantly, by evaluating both the additive effects of topical therapy on phototherapy and the impact of adding UVB to effective topical treatment, this study demonstrates that UVB provides additional biological effects beyond those achieved with topical therapy alone. These findings highlight a dissociation between clinical and biological responses and provide a mechanistic rationale for combination therapy in clinical settings. Further investigation is warranted to clarify the translational relevance of these findings.

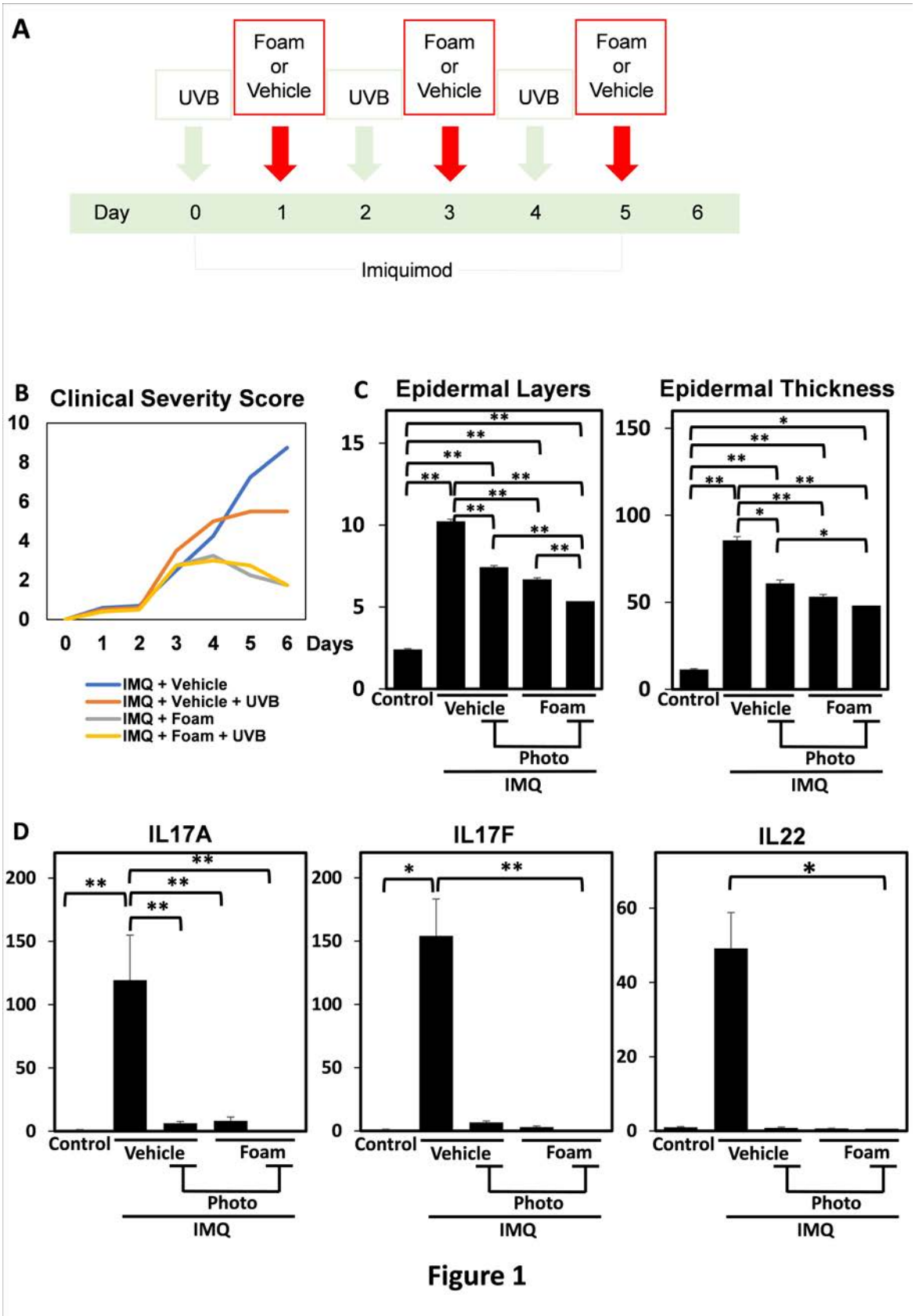

Figure 1

Figure 1. Effects of calcipotriene/betamethasone dipropionate (Cal/BD) foam and UVB combination therapy in an imiquimod (IMQ)-induced mouse model of psoriasis. (A) Experimental protocol. BALB/c mice were treated with topical IMQ daily for 6 days. Cal/BD foam or vehicle was applied every other day, with or without UVB irradiation (308 nm). (B) Clinical severity score over time. IMQ-induced skin

inflammation was significantly attenuated by both Cal/BD foam monotherapy and combination therapy compared with vehicle-treated controls. No significant difference was observed between monotherapy and combination therapy. (C) Histological analysis of epidermal layers and epidermal thickness on day 6. Combination therapy significantly reduced epidermal hyperplasia compared with both vehicle and Cal/BD monotherapy. (D) Relative mRNA expression levels of inflammatory cytokines in lesional skin on day 4. Expression of IL-17A, IL-17F, and IL-22 was significantly suppressed in the combination therapy group compared with controls, with selective enhancement of suppression for IL-17F and IL-22 compared with monotherapy. Data are presented as mean ± SEM. *$p < 0.05$, **$p < 0.01$.

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Abstract N°: 925

Long-term effectiveness and safety of risankizumab in psoriasis: a five-year real-world study

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Introduction
Risankizumab, a selective interleukin-23 p19 inhibitor, is approved for moderate-to-severe plaque psoriasis. Real-world long-term data remain limited. This study evaluates its effectiveness and safety over up to five years in routine clinical practice.

Materials and Methods
Retrospective observational study including 50 patients with plaque psoriasis treated with risankizumab according to approved prescribing information in a real-world clinical setting. Mean age was 49 years (range 18–80), with treatment duration between 12 and 96 months. Outcomes included Psoriasis Area and Severity Index (PASI), Body Surface Area (BSA), Physician Global Assessment (PGA), pruritus Visual Analogue Scale (VAS), and Dermatology Life Quality Index (DLQI), assessed at baseline, weeks 12–16, 12 months, and annually up to five years. Adverse events were recorded.

Results
Rapid and sustained improvements were observed across all outcomes. Mean PASI decreased from 13.28 (SD 6.37) at baseline to 0.54 (SD 0.99) at weeks 12–16 ($p<0.001$), remaining ≤ 0.4 thereafter. BSA decreased from 18.62% (SD 13.26) to 0.6% (SD 1.01), with values $\leq 0.5\%$ during follow-up. PGA improved from 3.58 (SD 0.70) to 0.44 (SD 0.50), remaining close to 0 over time. DLQI decreased from 12.76 (SD 5.87) to 1.06 (SD 1.74), and pruritus VAS from 7.10 (SD 2.73) to 0.56 (SD 0.97), with sustained responses through five years. No serious adverse events or treatment discontinuations due to safety were observed.

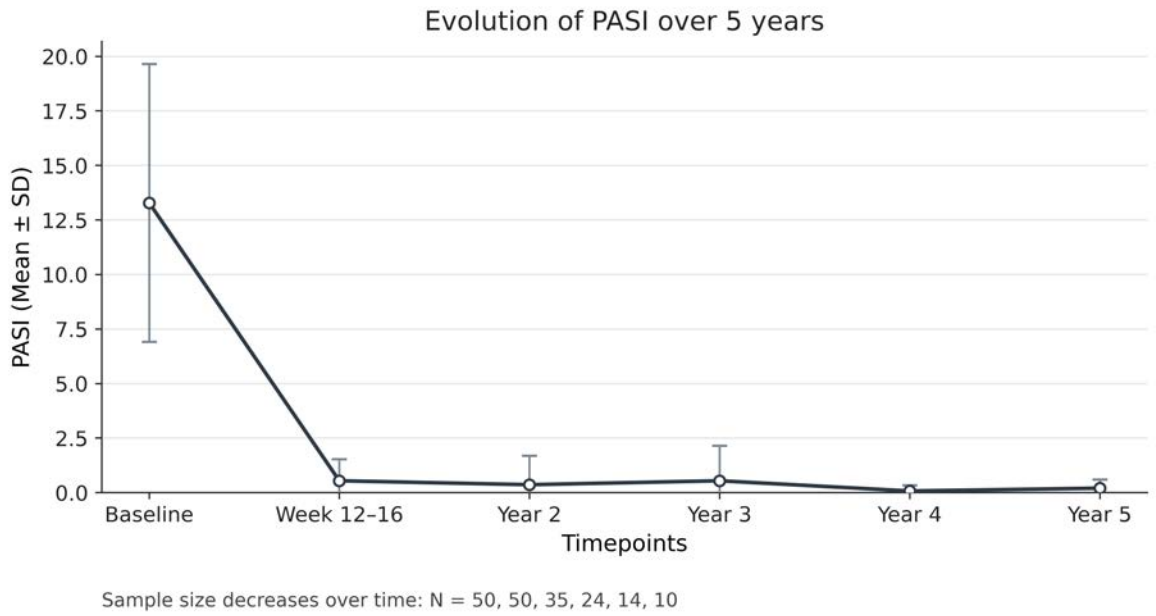

Figure 1. Evolution of mean PASI (±SD) from baseline to 5 years. A rapid reduction is observed at

weeks 12–16, followed by sustained low disease activity throughout long-term follow-up. The number of patients decreases over time due to varying follow-up duration.

Conclusions

Risankizumab provides rapid, deep, and durable clinical responses with a favorable safety profile in real-world practice, supporting its long-term use in psoriasis.

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Abstract N°: 927

Efficacy and Safety of Icotrokinra for Plaque Psoriasis: A Systematic Review and Meta-analysis

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Introduction

Parenteral administration for biologic therapies has been a considerable hurdle to treatment adherence and improvement of quality of life in psoriasis. Icotrokinra is a first-in-class oral peptide that selectively antagonizes the IL-23 receptor and has shown promising efficacy in phase 2 and phase 3 trials. However, a comprehensive synthesis of its efficacy and safety across these trials is warranted to provide a global overview. This systematic review and meta-analysis aimed to evaluate the efficacy and safety of Icotrokinra in adolescents and adults aged 12 years or older with moderate-to-severe plaque psoriasis.

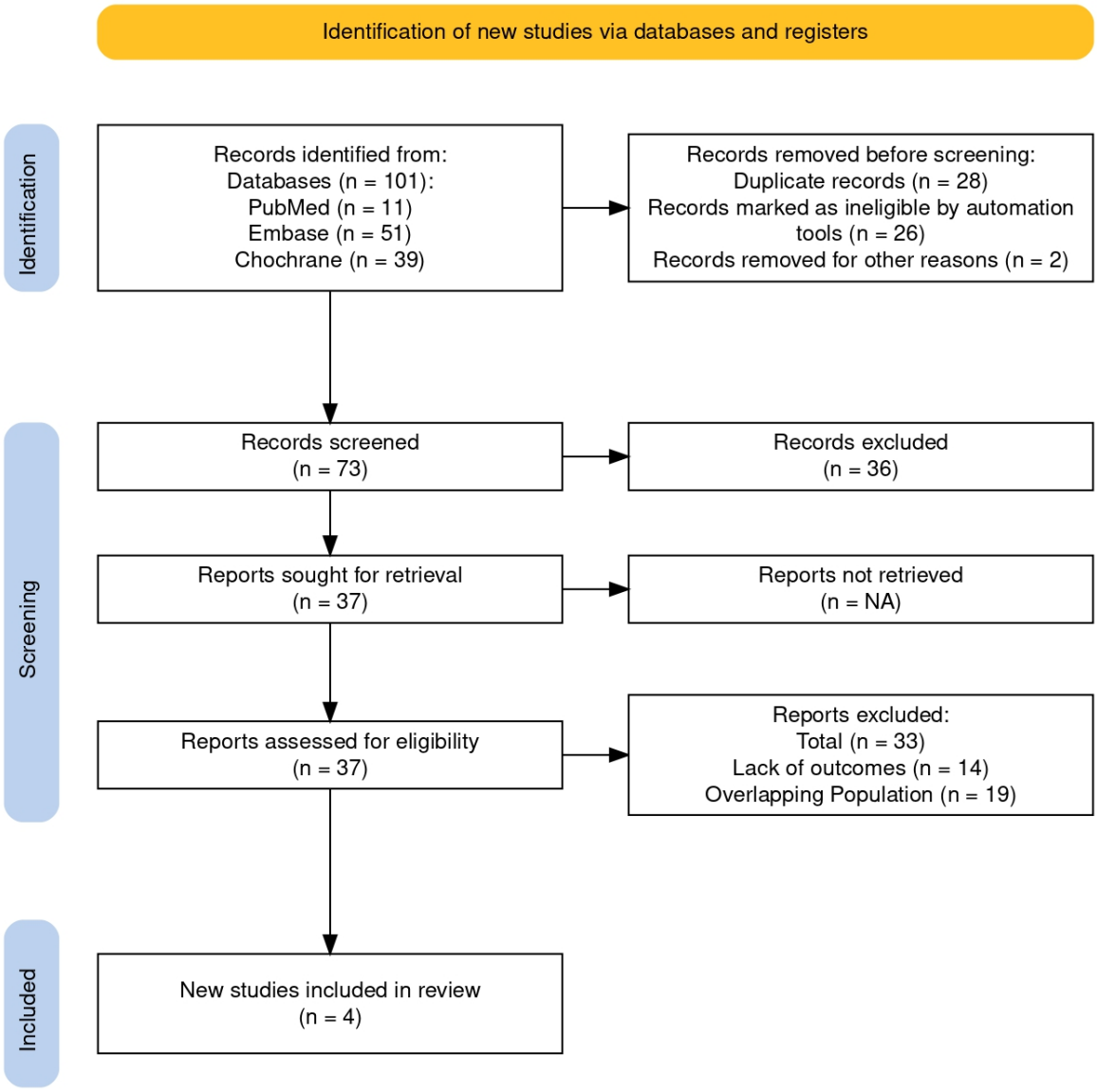

Figure 1: PRISMA flow diagram

Materials and Methods

PubMed, EMBASE, and the Cochrane Central Register of Controlled Trials were searched in December 2025. Randomized controlled trials (RCTs) enrolling patients aged 12 years or older with moderate-to-severe plaque psoriasis that compared icotrokinra with placebo and reported efficacy or safety outcomes were included. The primary outcome was achievement of an Investigator Global Assessment (IGA) score of 0 or 1 at week 16. Secondary outcomes included Psoriasis Area and Severity Index (PASI) 90. Safety outcomes included treatment-emergent and serious adverse events.

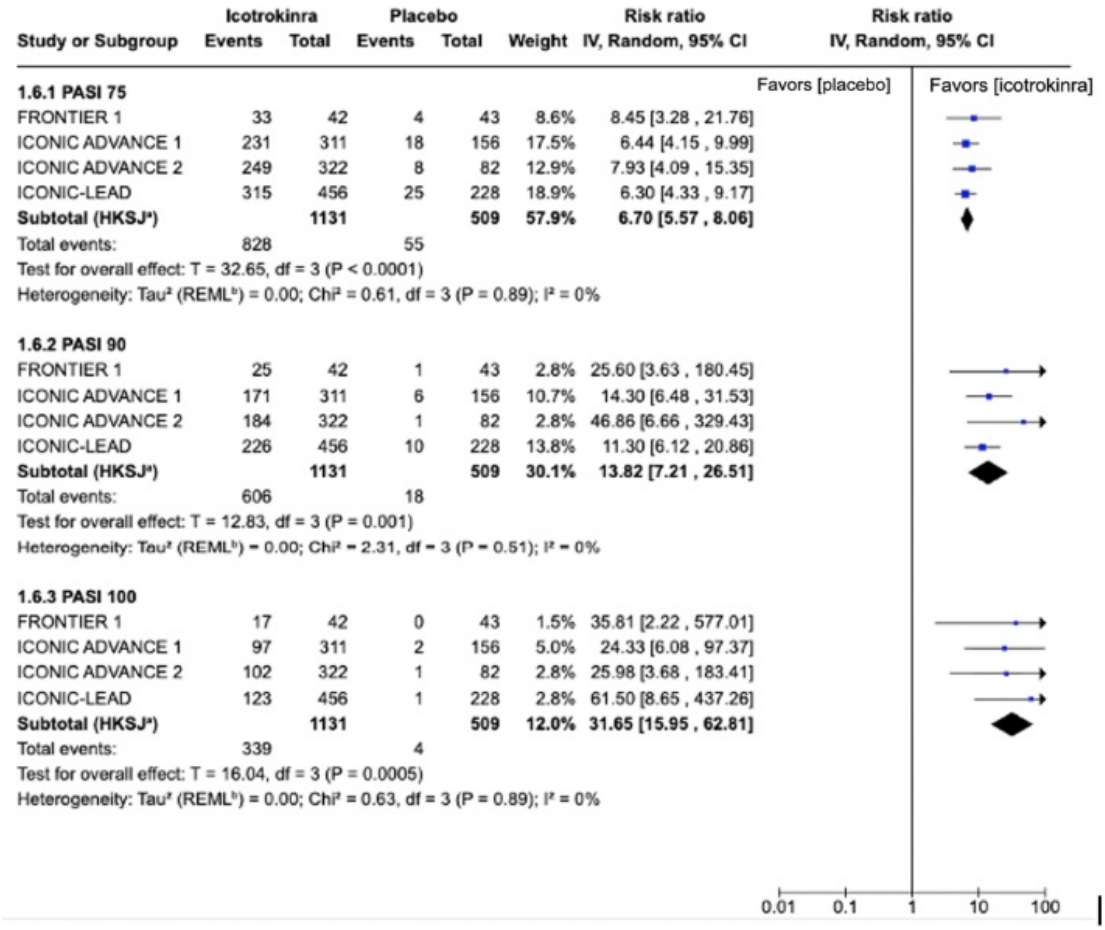

Figure 2: PASI 75, 90, 100 response rates were higher with Icotrokinra compared to placebo

Results

A systematic review and meta-analysis of five RCTs (one phase 2 and four phase 3) was conducted. Icotrokinra significantly increased the likelihood of achieving IGA 0/1 at week 16 (65.7% in the icotrokinra group vs 8.82% in the placebo group; RR, 7.27; 95% CI, 5.80–9.11), with no heterogeneity (I2=0%). High-level skin clearance assessed by PASI 90 was also significantly improved (53.6% in the icotrokinra group vs 3.54% in the placebo group; RR, 13.82; 95% CI, 7.21-26.51). Rates of treatment-emergent adverse events were comparable between icotrokinra and placebo (RR 0.98; 95% CI, 0.78–1.22). Similarly, the rates of serious adverse events (SAEs) were infrequent across all included trials and the pooled incidence of SAEs did not differ significantly between treatment groups (1.59% in the icotrokinra group vs 1.96% in the placebo group; RR, 0.63; 95% CI, 0.25–1.58; P=0.24). Discontinuations due to adverse events were low and balanced between groups, with no consistent safety signal identified during the 16-week induction period.

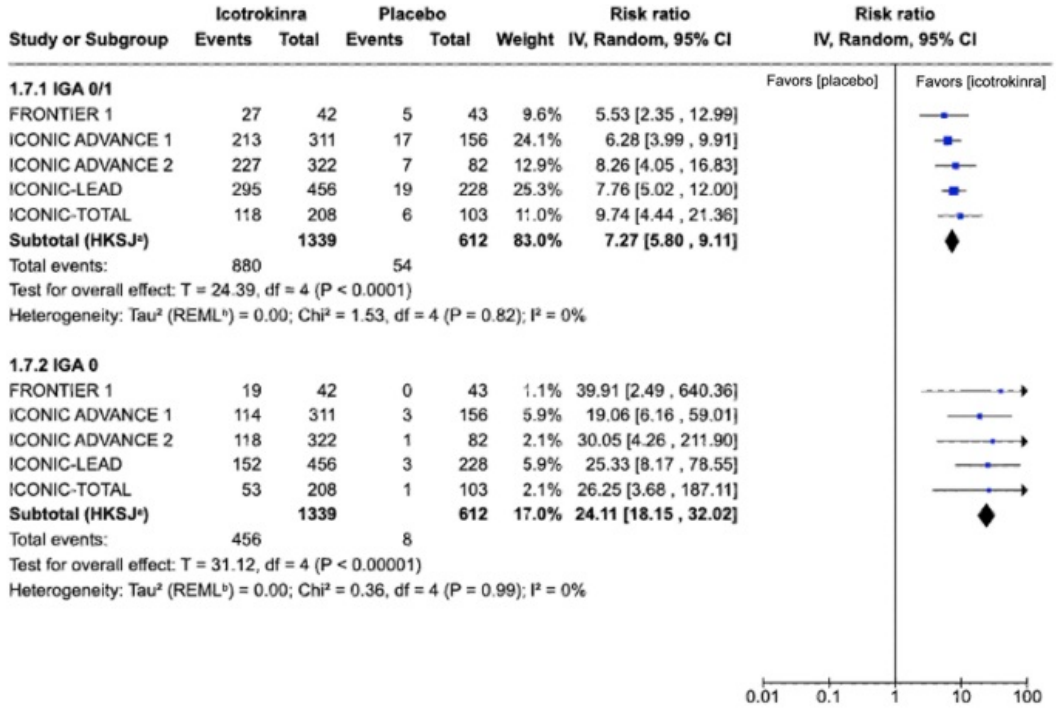

Figure 3: IGA 0/1 rates were higher in Icotrokinra group campared to placebo

Conclusions

Icotrokinra has shown short-term efficacy and favorable safety profile in patients with plaque psoriasis. Icotrokinra therefore represents an important advance in psoriasis therapy, combining biologic-level efficacy with ease of administration.

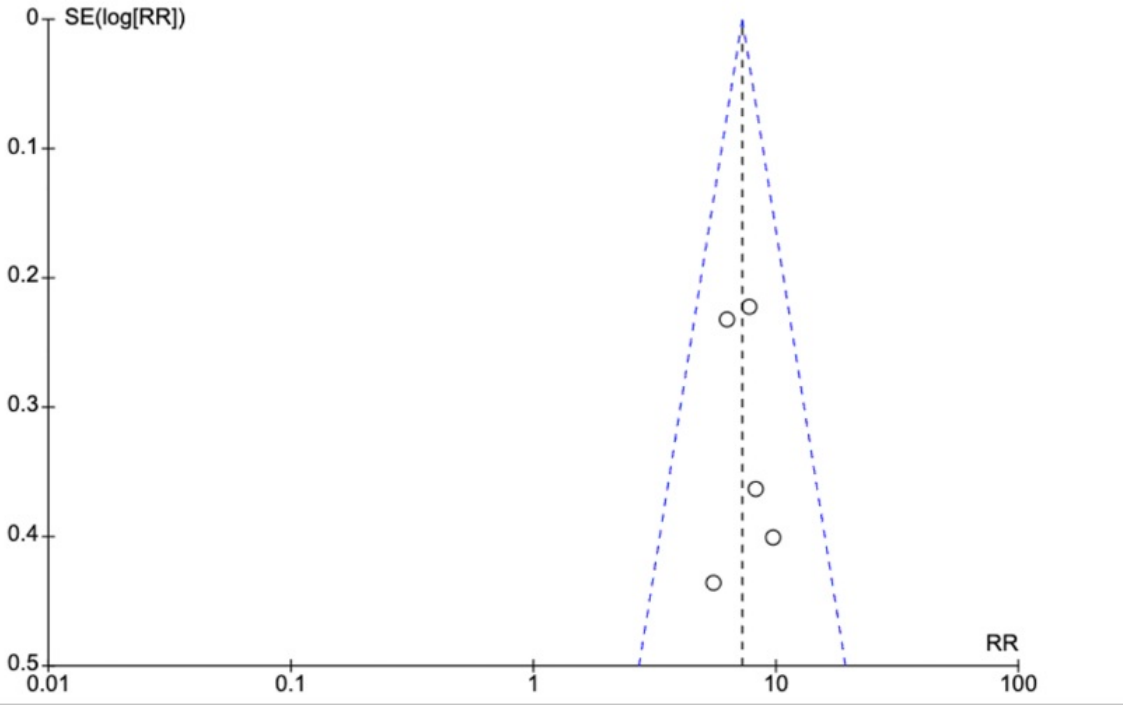

Figure 4: Funnel plot for IGA0/1 outcome

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30 SEP - 3 OCT 2026

Abstract N°: 938

A Multicenter, Randomized, Open-label, Phase 3 Study to Evaluate the Efficacy and Safety of SSGJ-608 in patients with moderate-to-severe plaque psoriasis

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Introduction
SSGJ-608 is an anti-interleukin-17A monoclonal antibody with high specificity and high affinity. This is a multicenter, randomized, open-label, phase 3 study with the primary objective of demonstrating efficacy and safety of SSGJ-608 in patients with moderate-to-severe plaque psoriasis, further validating the confirmatory phase 3 results (NCT05536726) in a large sample size.

Materials and Methods
This study composed of a 12-week open label treatment period and a 8-week safety follow-up period. Patients with moderate-to-severe plaque psoriasis were randomly assigned (1:1) to receive subcutaneous injections of 80mg of SSGJ-608 every two weeks (Q2W) after a starting dose of 160mg at week 0 (608A group), or 160mg of SSGJ-608 every four weeks (Q4W) (608 B group) for 12 weeks. Efficacy was assessed by ≥75% improvement from baseline in the Psoriasis Area and Severity Index score (PASI75) and a static Physicians Global Assessment score of 0/1 (sPGA 0/1) response rates at week 12 as co-primary endpoints, and proportion of patients who achieved PASI90, PASI100 or sPGA score of 0 at week 12, DLQI and itch-NRS changes as secondary endpoints. The safety profile was also evaluated.

Results
A total of 770 Chinese patients were enrolled and randomized to 608A group (n=385) or 608B group (n=385). At week12, PASI75 (92.7% [357/385, 608A] vs. 95.1% [366/385, 608B] and sPGA 0/1 (80.3% [309/385, 608A] vs. 79.0% [304/385, 608B]) were comparable between the two SSGJ-608 dose regimens; 81.0% (312/385, 608A) and 82.3% (317/385, 608B) of patients achieved PASI90; 49.4% and 47.5% in each group achieved PASI100, respectively;

49.4% and 47.3% of patients in each group achieved sPGA score of 0, respectively. The proportions of patients achieving sPGA 0 in the two groups (49.4% and 47.3%) were comparable to the PASI100 response rates, with both endpoints signifying complete skin clearance. Besides, of the patients who had a NRS score ≥4 at baseline, 82.3% of patients in the 608A group and 78.9% in the 608B group achieved a reduction in NRS score of ≥4 at week 12. At week 12, mean DLQI scores decreased by 79.6% (608A) and 75.5% (608B) from baseline; by week 20, reductions reached 83.6% and 76.5%, respectively. In the subgroup of patients who had received IL-17 targeted therapy before, 77.8% (42/54) of patients in the 608A group and 74.0% (37/50) in the 608B group achieved PASI90, respectively; 55.6% (30/54) and 44.0% (22/50) in each group achieved PASI100, respectively; sPGA 0 was achieved by 55.6% (30/54) and 44.0% (22/54) in each group, respectively. 64.2% (247/385) of patients in the 608A group and 62.8% (241/384) in the 608B group experienced TEAEs. SAEs were reported in 9(2.3%) patients in the 608A group and 5(1.3%) patients in the 608B group, and all these SAEs were assessed as definitely unrelated or possibly unrelated to the investigational drug. Both treatment groups demonstrated a favorable safety profile, with no increase in risk observed with longer drug exposure.

Conclusions

SSGJ-608 showed rapid, substantial, and durable levels of skin clearance in in a larger cohort of patients with moderate-to-severe psoriasis at both 80mg Q2W (with a 160mg starting dose at Week 0) and 160mg Q4W, yielding high complete clearance rates that aligned with the confirmatory phase 3 results. SSGJ-608 also achieved high clinical response rates in patients previously treated with anti-IL-17 therapy in both dosing schedules. Safety findings in this patient population were consistent with other same-target drugs, and no new risk signals were found for SSGJ-608. These findings suggest that SSGJ-608 has the potential to ensure long-term therapeutic success and improve patient quality of life, while also presenting a lower risk of certain significant complications. This study featured a larger sample size and sufficient exposure, further validating both the efficacy and safety profile of SSGJ-608.

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Correlation of PGA×BSA With PASI over 52 Weeks in a Danish Real-World Cohort of Adults With Plaque Psoriasis

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Introduction

The Psoriasis Area and Severity Index (PASI) and Physician's Global Assessment (PGA) remain the two most used instruments for psoriasis severity and are routinely used as co-primary endpoints in clinical trials. While PASI is considered the gold standard for measuring disease severity, limitations have been described e.g. it being time consuming, high inter-rater variability between experienced and less experienced physicians, and its clinical interpretability. For PGA, the main limitation is not accounting for the amount of body surface area (BSA) affected by psoriasis. Previous studies have proposed a composite score PGA×BSA, which combines PGA and BSA into a single score, aiming to provide a simpler and more practical instrument that is sensitive across all severities.
The objective of this study was to compare PGA×BSA scores with PASI throughout a 52-week follow-up period in a population-based psoriasis cohort study.

Materials and Methods

This analysis was based on the psoriasis cohort of a broader population-based observational study including adults with dermatological diseases in Denmark (Derma-001; NCT06319781). Participants were recruited via social media and were eligible if: >18 years of age and previous diagnosis of plaque psoriasis. Participants were followed for 52 weeks with four site visits (baseline, week 12, week 26, and week 52). Data collected included demographics and disease severity assessed using PASI, a 6-point static PGA, and BSA (palm method).
For the analysis, the PGA×BSA was calculated at each visit resulting in a scale of 0–500. At each study visit, the correlation between PASI and PGA×BSA was evaluated using Spearman's rank-order correlation coefficient, cross-sectionally at each visit and longitudinal using percentage change from baseline to each visit. Correlations were interpreted as weak (<0.40), moderate (0.4-0.69), strong (0.70-0.89), and very strong (≥0.90).

	N =88
Mean Age, years (SD), range	51.3 (12.5)
Mean BMI kg/m^2 (SD), range	31.2 (6.9)
SEX- Female, n (%)	46 (52.3%)
SEX- Male n (%)	42 (47.7%)
Fitzpatrick Skintype Type I, n (%)	2 (2.3%)
Fitzpatrick Skintype Type II, n (%)	20 (27.7%)
Fitzpatrick Skintype Type III, n (%)	51 (58%)
Fitzpatrick Skintype Type IV, n (%)	15 (17%)
Fitzpatrick Skintype Type V, n (%)	0
Fitzpatrick Skintype Type VI, n (%)	0
Mean PGA (SD)	2.2 (0.8)
PGA - Almost clear, n (%)	18 (18.8%)
PGA - Mild, n (%)	49 (51%)
PGA - Moderate, n (%)	25 (26%)
PGA - Moderate to Severe, n (%).	4 (4.2%)
PGA - Severe, n (%)	0
Mean PASI (SD)	4.6 (4.1)
PASI - Mild, n (%)	70 (72.9%)
PASI - Moderate, n (%)	17 (17.7%)
PASI - Severe, n (%)	9 (9.4%)
Mean BSA % (SD)	5.4 (11.2)
Mean PGAxBSA (SD)	13.3 (31.4)

Table 1 - Baseline characteristics

Results

A total of 88 participants were included in the analysis. At baseline, the mean age was 51.3 years; 52.3% were female, with a mean PASI of 4.6 and a mean PGA of 2.15. The main demographics are shown in Table 1. The correlation between PASI and PGA at baseline was Spearman's $\rho = 0.54$ ($p<0.001$).

The mean PGA×BSA was 13.3. At baseline, the correlation between this composite score and PASI was $\rho = 0.71$, $p<0.0001$, notably higher than the correlation between PGA alone. Similar results were observed when calculating the correlation between PASI and PGAxBSA at each subsequent visit: $\rho = 0.80$ at week 12, $\rho = 0.77$ at week 26, and $\rho = 0.74$ at week 52, all with $p<0.001$ (Figure 1).

When assessing longitudinal data with the mean percentage change between baseline and each visit, mean % change in PASI fluctuated during the study. At Visit 3 the change was minimal (-1.56% SD: 47.6), increased at Visit 4 (27.9%, SD:112.9), and again minimal by Visit 5 (0.84%, SD:56.7). The mean % change for PGA×BSA showed a similar pattern but with larger magnitude, increasing from Visit 3 (9.18%, SD:88.9) to Visit 4 (58.9%, SD: 229.3), and similar to Visit 3 again by Visit 5 (9.08%, SD:80.3). Across visits, PASI and PGA×BSA were weak and consistently positively associated, with Spearman correlations of $\rho=0.27$ ($p=0.02$) at Week 12, $\rho=0.39$ ($p=0.001$) at Week 26, and $\rho=0.26$ ($p=0.051$) at Week 52, indicating the two measures are related, but with a modest association and not statistically significant at week 52 (Figure 2). The correlation between PASI and PGA across visits, was weak to moderate across all visits $\rho=0.29$ ($p=0.012$) at Week 12, $\rho=0.50$ at Week 26, and $\rho=0.50$ at Week 52, last two with $p<0.001$.

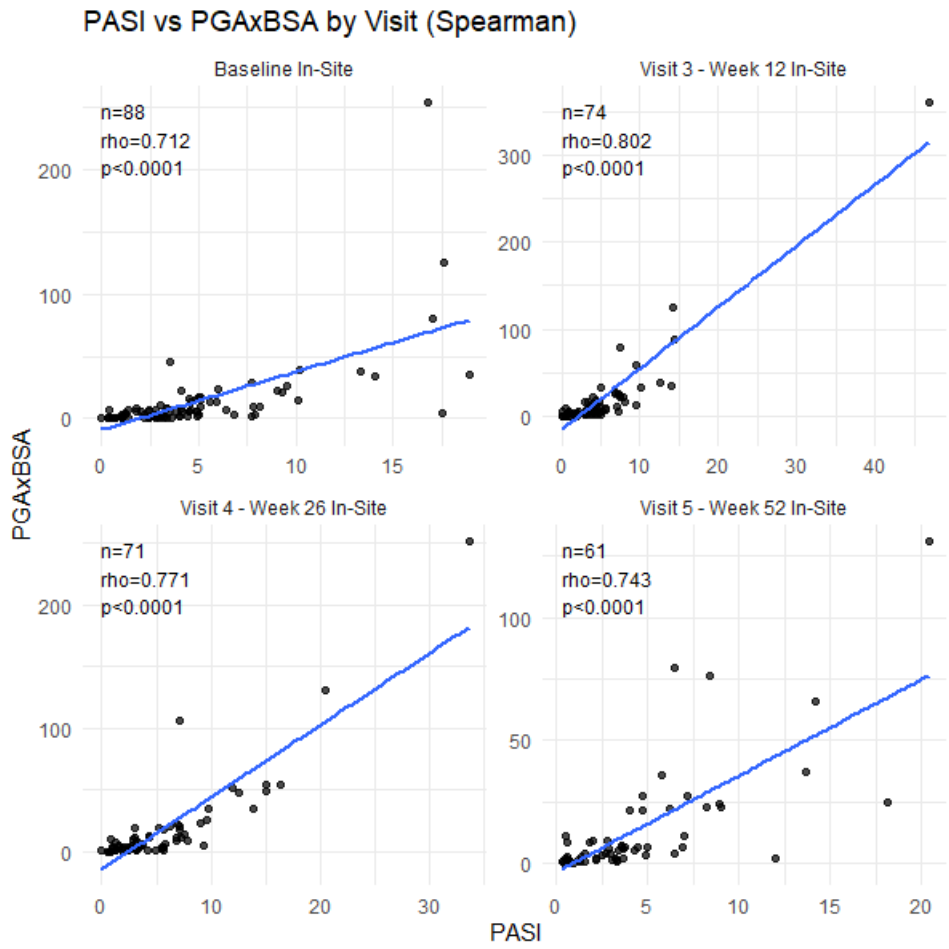
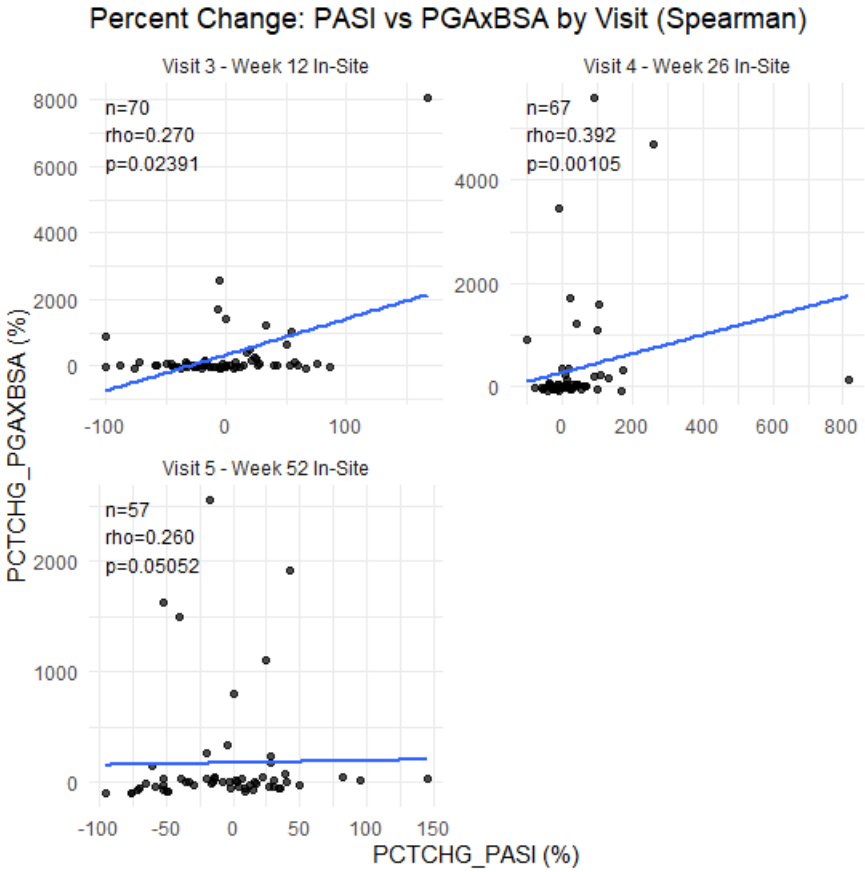


Figure 1 - Spearman correlation PASI-PGAxBSA at each visit

Conclusions

PGA×BSA demonstrated consistently strong cross-sectional with PASI across 52 weeks, and stronger than PGA alone. Associations between percentage change in PGA×BSA and PASI were consistently positive but modest, suggesting PGA×BSA may be better suited for point-in-time severity assessment than treatment response monitoring. PGAxBSA may represent a practical alternative to PASI in routine clinical care.



Spearman correlation %changePASI-%changePGAxBSA at each visit

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Peripheral blood eosinophilia in association with Generalized pustular psoriasis- A case report

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Introduction

Generalized pustular psoriasis (GPP) is a rare disease defined by the presence of primary sterile, visible pustules on skin. It is often relapsing and remitting, with acute flares of cutaneous inflammation and systemic symptoms. In the acute phase, the activity of inflammation is reflected in elevated C-reactive protein and ESR levels. There may be an absolute lymphopenia at the onset of Gpp followed by a polymorphonuclear leukocytosis with a left shift.

In recent studies, it has been documented that the eosinophil cells play active role in many kinds of inflammatory disorders such as psoriasis. Measurements of the mediators released by eosinophils and cell counts in serum and skin have provided some evidence indicating the role of eosinophils in psoriasis.

The association between psoriasis and peripheral blood eosinophilia is still a controversial issue. We report a patient with GPP and a very high peripheral blood eosinophilia.

Case Presentation

A 22-year-old man, known case of GPP with recent episode, and generalized pustular eruption developing over 3 days was referred to our department. He was febrile and clinical examination revealed generalized erythema and desquamation around the axillae, face, genitalia, extremities and trunk. Dozens of pustules were developing on these areas. Complete blood count showed anemia and leukocytosis with significant hypereosinophilia.Other laboratory tests revealed elevated C-reactive protein level, hypoproteinaemia, hypoalbuminemia, normal liver and renal function.

A skin biopsy showed parakeratosis, spongiosis, subepidermal blisters and spongiform pustules of Kogoj. In papillary dermis identified moderate infiltration of inflammatory cells such as lymphocyte and eosinophils up to 8/hpf. Peripheral blood smear showed severe eosinophilia (50% of 19×10^3 WBC). Aspiration of bone marrow showed hypereosinophilia. Lymph node biopsy showed follicular hyperplasia with sinus histiocytosis. The echocardiogram and Chest X-ray was normal.

The patient was treated with preparation of topical corticosteroids, emollient and cyclosporine (200 mg/day). After relative clinical improvement, dose of cyclosporine was gradually reduced, and adalimumab was added to the regimen.

Conclusion

GPP is one of the most serious variants of psoriasis, since it is usually not restricted to the skin and has variable systemic manifestations. There is increasing evidence, peripheral blood eosinophilia is found in psoriasis especially in severe forms such as GPP. Eosinophils contribute to inflammation through the release of cytotoxic proteins, including eosinophilic cationic protein and major basic protein, both of which activate immune cells and amplify the inflammatory cascade. Chemotactic factors such as platelet-activating factor and leukotriene B4, which are elevated in psoriatic lesions, may facilitate eosinophil recruitment. The presence of eosinophils in a substantial proportion of psoriasis cases suggests they are not merely a secondary phenomenon but may actively participate in disease pathology.

Eosinophils are cells that mainly reside in tissues. It is estimated that for every one blood eosinophil, there are 100 tissue eosinophils. Therefore, a high peripheral blood eosinophil count might be expected to correlate with a heavy tissue eosinophil infiltration in lesions of severe psoriasis. Eosinophils may be recruited in response to vascular and epidermal changes within psoriatic plaques. Spongiosis, a feature often linked to eczematous conditions, was also significantly correlated with eosinophil presence. These findings suggest a potential association between eosinophils and the pathological features of psoriasis, indicating their involvement in the disease process.

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Exercise Capacity in Patients with Psoriasis Assessed by Cardiopulmonary Exercise Testing: A Case–Control Study

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Introduction

Psoriasis is a systemic inflammatory disease associated with cardiovascular and metabolic comorbidities. Although reduced physical activity is frequently reported in these patients, objective data on physiological exercise capacity remain limited. This study aimed to evaluate exercise capacity in patients with psoriasis using cardiopulmonary exercise testing (CPET), the gold standard method, and to compare the results with those of healthy controls.

Materials and Methods

This cross-sectional study included 32 patients with psoriasis (off systemic therapy for ≥6 months) and 33 age and sex-matched healthy controls. Participants underwent symptom-limited CPET on a cycle ergometer. Disease severity was assessed using the Psoriasis Area and Severity Index (PASI), and Physician Global Assessment (PGA).

Results

Patients with psoriasis demonstrated significantly lower exercise capacity compared to controls. Peak VO_2, percentage of predicted peak VO_2, VO_2 at AT, and work rate were all significantly lower (all $p < 0.01$). Peak VO_2 showed significant negative correlations with BMI, PASI, and PGA (all $p \leq 0.001$). In multiple linear regression analysis, age ($\beta = -0.17$, $p = 0.017$), BMI ($\beta = -0.30$, $p = 0.007$), and PASI score ($\beta = -0.47$, $p = 0.001$) were identified as independent predictors of peak VO_2, explaining 63.4% of its variance ($R^2 = 0.634$, $p < 0.001$).

Table 1. Spearman correlations between clinical characteristics and cardiopulmonary exercise test parameters in patients with psoriasis

	Peak VO_2 (ml/kg/min)	Peak VO_2 (%)	VO_2 at AT (%)	Work Rate	O_2 Pulse	HRmax	VE/VCO_2 slope
Age	-0.31 (0.085)	-0.02 (0.93)	-0.02 (0.91)	-0.31 (0.087)	-0.26 (0.143)	-0.31 (0.086)	-0.07 (0.690)
BMI	-0.55 (0.001)	-0.25 (0.175)	-0.13 (0.463)	-0.15 (0.404)	0.45 (0.010)	-0.48 (0.005)	-0.44 (0.011)
Disease duration	-0.06 (0.754)	-0.06 (0.728)	0.39 (0.025)	-0.11 (0.565)	-0.14 (0.459)	-0.22 (0.227)	-0.06 (0.739)
PASI	-0.65 (<0.001)	-0.52 (0.002)	0.31 (0.089)	-0.46 (0.008)	-0.30 (0.092)	-0.13 (0.477)	0.16 (0.387)
PGA	-0.65 (<0.001)	-0.63 (<0.001)	0.10 (0.573)	-0.51 (0.003)	-0.02 (0.906)	-0.31 (0.083)	0.08 (0.661)
DLQI	-0.57 (<0.001)	-0.45 (0.010)	0.42 (0.017)	-0.68 (<0.001)	-0.42 (0.016)	-0.30 (0.098)	0.03 (0.866)
IPAQ	-0.20 (0.279)	0.15 (0.419)	-0.16 (0.377)	-0.35 (0.052)	-0.52 (0.002)	0.06 (0.763)	0.08 (0.656)

r (p) values are given

BMI, body mass index; PASI, Psoriasis area and severity index; PGA, Physician global assessment; DLQI, Dermatology life quality index; IPAQ, International physical activity questionnaire; HADS, Hospital anxiety and depression scale

Table 2. Multiple linear regression analysis identifying predictors of peak VO_2 in patients with psoriasis

Variable	Coefficient (β) (Std. Error)	P value	95% CI
Age	-0.17 (0.07)	0.017	-0.315 – -0.034
BMI	-0.30 (0.10)	0.007	-0.508 – -0.090
PASI	-0.47 (0.12)	0.001	-0.725 – -0.220
IPAQ score	-0.0002 (0.001)	0.841	-0.002 – 0.001

Model statistics: **$R^2 = 0.634$, Adjusted $R^2 = 0.579$, $F = 11.68$, $p < 0.001$**

Dependent variable: Peak VO_2 (ml/kg/min)

BMI, body mass index; PASI, Psoriasis area and severity index; IPAQ, International physical activity questionnaire;

The correlations between clinical characteristics and CPET parameters in patients with psoriasis, as well as the results of the multiple linear regression analysis identifying predictors of peak VO_2, are presented in Tables 1 and 2.

Conclusions

Patients with psoriasis exhibit reduced cardiorespiratory fitness that is independently associated with greater disease severity, indicating a measurable systemic functional burden and supporting the integration of objective exercise assessment and targeted physical interventions into multidisciplinary clinical management.

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Early clinical response predicts long-term outcomes in moderate-to-severe psoriasis: real-life effectiveness of bimekizumab across clinical, psychological and inflammatory domains

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Introduction
Psoriasis is a chronic systemic inflammatory disease associated with significant impairment in quality of life and psychological well-being. Bimekizumab, a dual IL-17A/F inhibitor, has demonstrated high efficacy in clinical trials; however, real-world data integrating clinical outcomes, psychological parameters, and adverse event profiles remain limited. In particular, predictors of treatment response and factors associated with adverse events such as mucocutaneous candidiasis are not well defined.

Materials and Methods
This real-life observational study included 65 patients with moderate-to-severe psoriasis treated with bimekizumab. Patients were followed prospectively for 24 weeks.
Demographic and clinical data including age, sex, body mass index (BMI), disease duration, presence of psoriatic arthritis, comorbidities, prior systemic and biologic treatments, and distribution of skin involvement were recorded.
Clinical severity (PASI), quality of life (DLQI), psychological status (HADS), and inflammatory markers (neutrophil-to-lymphocyte ratio [NLR], monocyte-to-lymphocyte ratio [MLR], and systemic immune-inflammation index [SIRI]) were assessed at baseline and at weeks 4, 16, and 24.
Short-term (0–4 weeks) and long-term (0–24 weeks) changes were analyzed. Correlation analyses were performed to evaluate relationships between clinical response, patient-reported outcomes, and inflammatory markers.
Adverse events, including mucocutaneous candidiasis and eczematous reactions, were recorded, and associated factors were investigated.

Results
Bimekizumab induced rapid and profound clinical responses, with PASI decreasing from 11.22±9.25 at baseline to 0.11±0.66 at week 24. Complete skin clearance (PASI 0) was achieved in 96.9% of patients. Significant reductions were also observed in DLQI and HADS scores ($p<0.001$), indicating marked improvements in both quality of life and psychological burden, particularly within the first 16 weeks.
Early clinical response was a strong predictor of long-term outcomes, with a very strong correlation between PASI improvement at week 4 and week 24 ($r=0.941$, $p<0.001$). Long-term PASI improvement was significantly associated with DLQI improvement ($r=0.370$, $p=0.003$), whereas no significant correlations were found with HADS or inflammatory markers. Despite marked clinical and psychological improvement, inflammatory markers (NLR, MLR, SIRI) did not show significant longitudinal changes, although significant inter-correlations were observed among these markers. Adverse events were mostly mild, with mucocutaneous candidiasis observed in 16.9% of patients and eczematous reactions in 3.1%. No significant associations were found between adverse events and demographic, clinical, or laboratory parameters. However, prior use of cyclosporine or acitretin was associated with a higher rate of adverse events ($p=0.037$). Treatment retention was high (96.9%), with a low discontinuation rate (3.1%).

Parameter	Baseline	Week 4	Week 16	Week 24	p-value
PASI	11.22 ± 9.25	1.31 ± 2.19	0.23 ± 1.12	0.11 ± 0.66	<0.001
DLQI	12.48 ± 8.10	2.59 ± 4.31	0.92 ± 3.19	0.39 ± 1.54	<0.001
HADS-A	7.40 ± 4.44	3.32 ± 4.08	1.43 ± 2.86	0.78 ± 2.47	<0.001
HADS-D	7.51 ± 4.45	3.32 ± 3.85	1.42 ± 2.89	0.49 ± 1.94	<0.001

PASI: Psoriasis Area and Severity Index; DLQI: Dermatology Life Quality Index; HADS-A: Hospital Anxiety and Depression Scale-Anxiety; HADS-D: Hospital Anxiety and Depression Scale-Depression.

Conclusions

Bimekizumab demonstrates rapid, sustained, and near-complete clinical efficacy in real-world practice, with significant improvements in quality of life and psychological outcomes. Early clinical response is a strong predictor of long-term treatment success. The absence of clear predictors for adverse events, except for prior systemic treatment exposure, and the lack of parallel changes in systemic inflammatory markers despite profound clinical improvement suggest that clinical remission may not fully reflect systemic inflammatory activity, highlighting the need for a more comprehensive understanding of disease dynamics.

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Brodalumab demonstrates rapid effectiveness in patients with moderate-to-severe plaque psoriasis: short-term results from the Greek REALITY-1 non-interventional study

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Introduction
Plaque psoriasis is a chronic inflammatory skin disease that substantially impairs patients' health-related quality of life (HRQoL). Brodalumab, a recombinant fully human monoclonal antibody targeting the interleukin-17 receptor A involved in the disease pathogenesis, is approved by the European Medical Agency for the treatment of moderate-to-severe plaque psoriasis in patients eligible for systemic therapy. While the long-term effectiveness of brodalumab is well documented, there is limited real-world evidence regarding its short-term effectiveness which positively correlated with improvements in HRQoL. The objective of this study was to evaluate the short-term effectiveness and safety of brodalumab in patients with moderate-to-severe plaque psoriasis treated in routine clinical practice in Greece.

Materials and Methods
REALITY-1 is a prospective observational study conducted at 24 sites across Greece. Adult patients with moderate-to-severe plaque psoriasis who initiated treatment with brodalumab were followed for up to 12 weeks. Effectiveness of brodalumab was evaluated at Weeks 4 and 12 by change in the Psoriasis Area Severity Index (PASI), including the percentage of patients achieving absolute PASI≤3 and those with 50%, 75%, 90%, and 100% improvement in the score (PASI 50/75/90/100, respectively). Changes in the Body Surface Area (BSA) affected were also recorded. The effect of brodalumab on the patient-reported outcomes (PROs) was assessed using the pruritus numerical rating scale (NRS) and the Dermatology Life Quality Index (DLQI). Safety of the treatment was assessed by evaluating the incidence and severity of adverse events (AEs) reported during the study period. Data reported as observed.

Results
A total of 120 patients were enrolled between 08 October 2022 and 28 July 2023 (data cut-off: 09 November 2023), of whom 118 completed the study. At baseline, the mean (standard deviation [SD]) age of patients was 49.0 (15.8). Most patients were male (62.7%; n=74). The mean (SD) absolute PASI was 19.4 (12.4), BSA was 19.8%

(13.5%), pruritus NRS was 6.0 (2.5), and DLQI was 14.1 (7.4). As shown in Table 1, at Week 4, 48.3% (95% confidence interval [CI]: 39.1%, 57.6%; n=57) of patients achieved an absolute PASI≤3, increasing to 81.4% (95% CI: 72.9%, 87.7%; n=96) at Week 12. PASI 50/75/90/100 responses at Week 4 were achieved by 81.7% (95% CI: 73.3%, 87.9%; n=98), 60.0% (95% CI: 50.6%, 68.7%; n=72), 38.3% (95% CI: 29.7%, 47.7%; n=46), and 25.8% (95% CI: 18.5%, 34.8%; n=31) of patients, respectively. These rates increased at Week 12 to 91.7% (95% CI: 84.8%, 95.7%; n=110), 84.2% (95% CI: 76.1%, 90.0%; n=101), 66.7% (95% CI: 57.4%, 74.9%; n=80), and 49.2% (95% CI: 40.0%, 58.4%; n=59), respectively. The least-square (LS) mean change from baseline in BSA affected was -13.8 points (95% CI: -14.5, -13.2, p<0.001) at Week 4, improving to -17.3 points (95% CI: -17.9, -16.7, p<0.001) at Week 12. Brodalumab also improved PROs (Table 1). The LS mean change from baseline in pruritus NRS was -3.9 points (95% CI: -4.2, -3.6, p<0.001) at Week 4, improving to -5.3 points (95% CI: -5.5, -5.0, p<0.001) at Week 12, indicating a clinically meaningful reduction in pruritus. The LS mean change from baseline in DLQI was -9.6 points (95% CI: -10.2, -9.0; p<0.001) at Week 4, improving to -13.0 points (95% CI: -13.6, -12.4; p<0.001) at Week 12. Brodalumab had a favourable safety profile. Overall, 2.5% of patients (n=3) reported at least one AE; all were non-serious, and only one was considered treatment-related (Table 1).

Effectiveness			
	Brodalumab SC (N=118)		
	Baseline	Week 4	Week 12
PASI, n (%)			
PASI≤3	–	57 (48.3)	96 (81.4)
PASI 50	–	98 (81.7)	110 (91.7)
PASI 75	–	72 (60.0)	101 (84.2)
PASI 90	–	46 (38.3)	80 (66.7)
PASI 100	–	31 (25.8)	59 (49.2)
BSA, mean (SD)			
Reported value	19.8 (13.5)	–	–
Change from baseline	–	-13.8[a,b]	-17.3[a,c]
Pruritus NRS, mean (SD)			
Reported value	6.0 (2.5)	–	–
Change from baseline	–	-3.9[a,b]	-5.3[a,c]
DLQI, mean (SD)			
Reported value	14.1 (7.4)	–	–
Change from baseline	–	-9.6[a,b]	-13.0[a,c]
Safety			
Overview of AEs			**N=118**
AE, n (%)			3 (2.5)
Serious AE, n (%)			0 (0.0)
AE related to study treatment, n (%)			1 (0.9)
AE leading to temporary drug discontinuation, n (%)			2 (1.7)
AE leading to death, n (%)			0 (0.0)
AEs by Primary System Organ Class and Preferred Term			
Injury, poisoning and procedural complications, n (%)			1 (0.9)
Infections and infestations, n (%)			1 (0.9)
Respiratory, thoracic and mediastinal disorders, n (%)			1 (0.9)

AE: Adverse Event; BSA: Body Surface Area; DLQI: Dermatology Life Quality Index; N: number of patients; n: number of patients in each category; NRS: Numerical Rating Scale; PASI: Psoriasis Area Severity Index; SD: Standard Deviation; %: percentage of patients in each category.
Note: [a] p<0.001 compared with baseline; [b] N=109; [c] N=110.

Table 1. Summary of the Greek REALITY-1 non-interventional study: effectiveness of brodalumab in patients with moderate-to-severe plaque psoriasis, based on the proportion achieving PASI thresholds (absolute PASI ≤ 3, PASI 50/75/90/100) and changes in BSA, pruritus NRS, and DLQI at baseline,

Week 4, and Week 12; and safety data summarizing AEs reported throughout the study period.

Conclusions

In real-world clinical practice in Greece, brodalumab demonstrated a quick onset of action and a favourable safety profile in patients with moderate-to-severe plaque psoriasis. Rapid improvements in disease severity, symptom burden, and HRQoL were evident by Week 4, with further improvements observed at Week 12. These findings reinforce the relevance of brodalumab as an effective treatment option in routine clinical practice.

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Real world response to Cal/BD aerosol foam long-term maintenance treatment in patients with plaque psoriasis: an observational, prospective study in Greek clinical setting (the STABILITY study)

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Introduction
Psoriasis is a chronic, relapsing, inflammatory disorder, primarily affecting the skin and joints of more than 125 million people worldwide (prevalence 0.14–1.99%). Plaque psoriasis accounts for up to 90% of all psoriasis cases. A foam formulation of calcipotriol and betamethasone dipropionate (Cal/BD) is approved for daily treatment of plaque psoriasis for up to four weeks. In a phase 3 PSO-LONG study (NCT02899962), Cal/BD foam was effective and safe when applied twice weekly as a proactive maintenance therapy.
Here we present real-world effectiveness and safety data from a 52-week-long Cal/BD foam maintenance treatment in patients with plaque psoriasis in Greece.

Materials and Methods
STABILITY was a multicentre, prospective, observational study of patients with mild to severe plaque psoriasis. Patients who achieved treatment success after four-week once-daily Cal/BD aerosol foam (Physician Global Assessment [PGA] score of “clear” or “almost clear”) initiated a twice-weekly Cal/BD maintenance therapy as part of routine clinical management of their psoriasis entered the study. Among 306 patients enrolled between Nov-2022 and Nov-2023, 304 completed at least one post-baseline assessment and were included in the full analysis set. Over the 52-week study period, patients were evaluated at routine clinical visits: at baseline and post-enrolment Visit 1 (Week 10–14), Visit 2 (Week 22–26), Visit 3 (Week 34–38), and Visit 4 (Week 50–54), or at unscheduled visits if they experienced a relapse. The primary endpoint was time to first relapse (at least “mild” according to PGA), secondary outcomes included frequency of adverse events (AEs).

Results
Patients included were 51.32% male and 48.68% female. At baseline, mean (standard deviation [SD]) age was 51.37 (14.58) years and median time from the initial psoriasis diagnosis was 2.33 years (range: 0.07–48.56). Before the study initiation, 39.14% of patients had received at least one psoriasis treatment prior to the four-week Cal/BD treatment: 36.18% topical therapy, 2.96% systemic treatments, and 1.97% biologics. Survival probability for remaining free of relapse was 70.53% (95% CI: 65.54%–75.90%) at Week 52. By day 252 (Week 36), 25% of patients experienced first relapse. The median time to first relapse was not reached as 50% of patients remained

relapse-free during the 52-week observational period. Overall, 28.95% of patients had at least one relapse (26.97% mild, 1.64% moderate, and 0.66% severe), while 71.05% experienced none. The mean (SD) number of relapses per patient was 0.33 (0.55), comprising 0.30 (0.53) for mild, 0.02 (0.16) for moderate, and 0.01 (0.08) for severe relapses. The incidence rate of relapses per year was 0.32 (95% CI: 0.26–0.39). On average, patients remained in remission for 368.19 days and spent a mean (SD) proportion of 0.97 (0.05) of study time in remission. Most (93.52%) patients complied with the study treatment and 94.74% achieved >75% adherence. The mean (SD) Dermatology Life Quality Index (DLQI) improved from 6.63 (6.35) points at baseline to 2.34 (2.67) at Week 52, with 55.59% and 91.60% of patients at baseline and Week 52, respectively, reporting no or a small effect on their health-related quality of life. Five patients (1.64%) experienced seven skin or subcutaneous tissue treatment-emergent adverse events (TEAE). Among these patients, four (1.32%) had at least one study treatment-related TEAE. No AE led to treatment discontinuation.

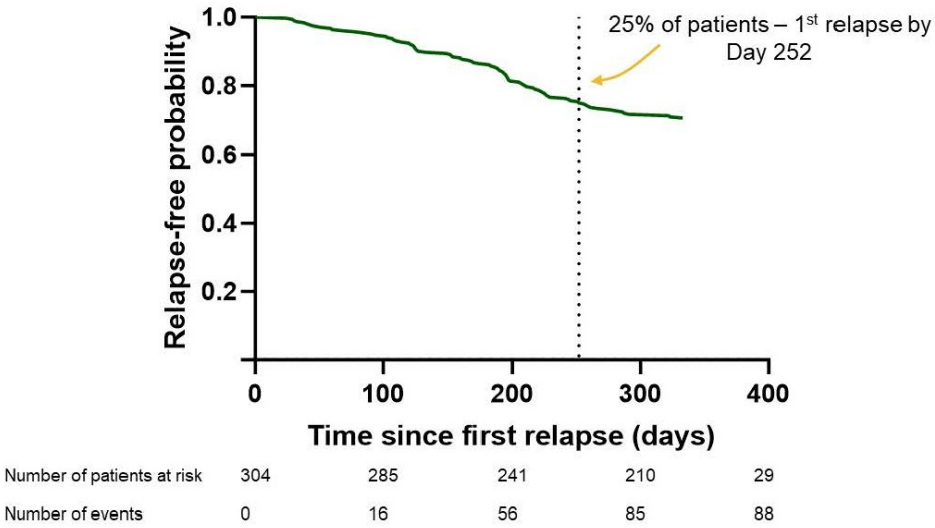

Figure 1. Kaplan-Meier curve of time to first relapse, FAS

Conclusions

This real-world study showed that Cal/BD aerosol foam was an effective and safe proactive maintenance therapy in patients with plaque psoriasis in Greece and may provide a potential long-term disease management option.

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Holistic Treatment Success with Tildrakizumab: Combined Evidence of WHO-5, PASI and DLQI Outcomes from the POSITIVE, BLUE, TiGER, TIL-TWO and TIL-Senior Studies

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Introduction

Plaque psoriasis (PsO) is a chronic, immune-mediated inflammatory disease which impairs overall patient (pt) well-being.[1] Pts with moderate-to-severe (mod-sev) PsO require systemic treatments that offer sustained effectiveness and alleviation of burdensome symptoms. Tildrakizumab (TIL) has demonstrated long-term efficacy and safety in PsO.[2,3] We report the effect of TIL on psychological well-being, disease severity and health-related quality of life (HRQoL) across five observational, real-world, European studies (POSITIVE, BLUE, TiGER, TIL-TWO and TIL-Senior) to Week (W) 28.

Materials and Methods

POSITIVE was a 104-week multinational European study in adults with mod-sev PsO treated with 100/200 mg TIL.[4] BLUE was a 52-week study in adults with mod-sev PsO treated with 100/200 mg TIL in Italy.[5] TiGER was a 52-week study in adults with mod-sev PsO with involvement of ≥1 high impact area (scalp, fingernails, palms/soles or genitals) receiving 100/200 mg TIL in Germany.[6] TIL-TWO is an ongoing 52-week, prospective, multicentre non-interventional study (NIS) in adults with mod-sev PsO treated with 200 mg TIL in Germany.[7] TIL-Senior is an ongoing 52-week, prospective, multicentre NIS in adults (<65 years vs ≥65 years) with mod-sev PsO treated with 100/200 mg TIL in Germany.[8] Endpoints analysed: patient-reported World Health Organisation-Five Well-Being Index (WHO-5; range 0–100; higher scores indicate better well-being; change of ≥10 considered clinically relevant),[9] Psoriasis Area and Severity Index (PASI; range 0-72; higher scores indicate greater severity),[4] and Dermatology Life Quality Index (DLQI; range 0–30; higher scores indicate greater impairment in HRQoL; 0-1.99: no effect on patient life; POSITIVE reported DLQI-Relevant scores [DLQI-R; adjusted for 'not relevant responses']).[10] We report final data from POSITIVE (Full Analysis Set [FAS]), BLUE (FAS) and TIGER (FAS), and interim results from TIL-TWO (Per Protocol Set [PP]) and TIL-Senior (PP) at W28 as observed cases.

Results

A total of 785, 102, 353, 180 and 145 pts were included in the POSITIVE, BLUE, TiGER, TIL-TWO and TIL-Senior studies, respectively. Percentage of male pts (%) and mean (standard deviation [SD]) age were: POSITIVE (64.5%, 46.9 [15.1] years), BLUE (60.8%, 52.5 [16.0] years), TiGER (63.2%, 46.5 [15.1] years), TIL-TWO (61.1%, 49.3 [15.6] years), TIL-Senior (<65 years: 60.4%, 45.7 [12.3] years; ≥65 years: 44.9%, 73.8 [6.7] years). Compared to baseline (BL), mean (SD) WHO-5 scores at W28 improved across all studies (**Figure**). Mean (SD) PASI scores at W28 decreased from BL: POSITIVE, 1.7 (2.7; n=621; mean change from BL [CfB]: −11.1); BLUE, 1.8 (2.6; n=102; mean CfB: −13.7); TiGER, 2.7 (3.7; n=278; mean CfB: −13.9); TIL-TWO, 3.4 (5.8; n=164; mean CfB: −14.9); TIL-Senior (<65 years), 2.4 (3.3; n=72; mean CfB: −12.4); TIL-Senior (≥65 years), 2.4 (3.6; n=37; mean CfB: −13.8). Mean (SD) DLQI scores at W28 declined accordingly: POSITIVE, 3.3 (4.7; n=481; mean CfB: −8.2); BLUE, 1.2 (1.9; n=101; mean CfB: −8.8); TiGER, 3.5 (4.2; n=279; mean CfB: −10.3); TIL-TWO, 4.5 (6.0; n=164; mean CfB: −9.9); TIL-Senior (<65 years), 3.2 (4.5; n=76; mean CfB: −9.9); TIL-Senior (≥65 years), 4.2 (6.2; n=34; mean CfB: −8.7).

Conclusions

Pts with mod-sev PsO treated with TIL demonstrated durable improvements in psychological well-being, disease severity and HRQoL at W28; further improvements could be expected with longer treatment duration. This was consistent in those with high impact area involvement and older pts in real-world practice.

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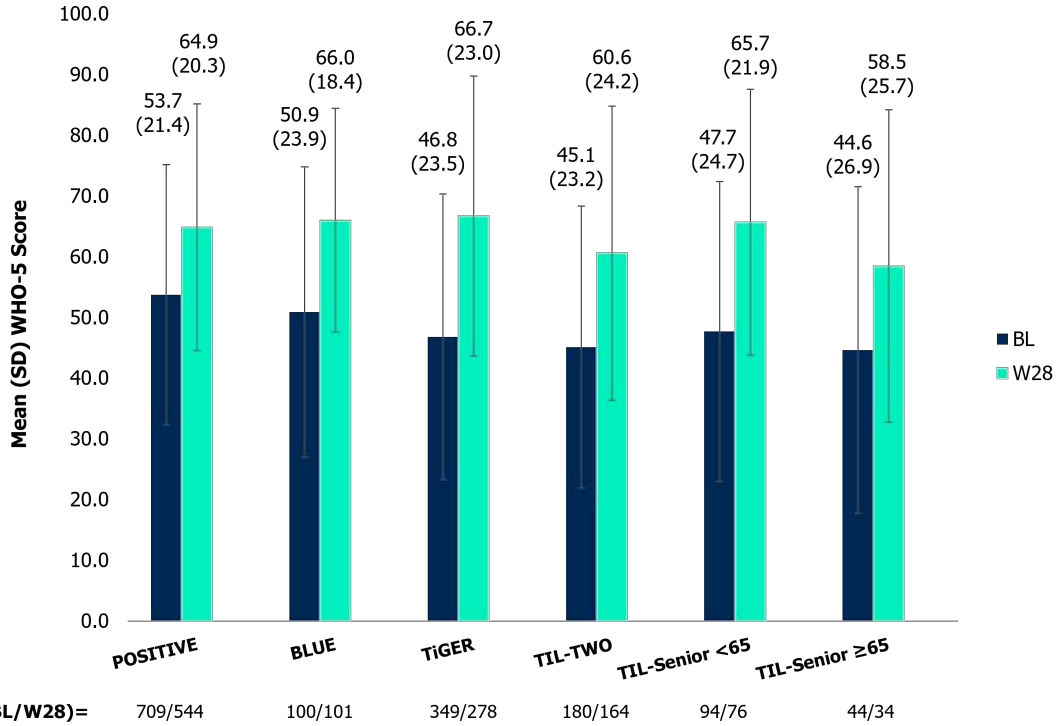
Figure. Multi-study WHO-5 scores at BL and W28 (OC).



WHO-5 scores at BL and W28 across the POSITIVE, BLUE, TiGER, TIL-TWO and TIL-Senior studies. BL: baseline; SD: standard deviation; W: week; WHO-5: World Health Organisation-Five Well-Being Index.

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Efficacy and safety of continuous picankibart treatment versus treatment withdrawal after achieving therapeutic response in patients with moderate-to-severe plaque psoriasis: a randomised, double-blind, placebo-controlled phase 3 CLEAR-2 trial

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Introduction
Plaque psoriasis is a chronic, immune-mediated inflammatory disease, characterized by recurrent flares and substantial impairment in quality of life, particularly in patients with moderate-to-severe disease. Accumulating evidence indicates that IL-23 inhibitors provide favourable safety profiles and durable responses in this population, highlighting the potential role of IL-23 inhibition for long-term disease control. However, evidence regarding their sustained effectiveness in Chinese patients remains limited. Picankibart, a novel anti-IL-23p19 monoclonal antibody, has demonstrated robust efficacy in skin clearance across multiple clinical trials. This phase 3 trial (NCT06049810) aims to evaluate the efficacy and safety of treatment maintenance versus treatment withdrawal in Chinese patients with moderate-to-severe plaque psoriasis.

Materials and Methods
This multicentre, randomised, double-blind, placebo-controlled phase 3 trial enrolled adults aged 18-75 years with moderate-to-severe plaque psoriasis. All participants initially received picankibart 200 mg at weeks 0, 4, and 8, then were randomized in a 1:1 ratio at week 20 to receive picankibart 100 mg or 200 mg every 12 weeks. Participants who achieved at least a 90% improvement from baseline in Psoriasis Area and Severity Index (PASI 90 responders) at week 32 underwent rerandomisation in a 1:1 ratio to either continue treatment with the dose assigned at week 20 or switch to placebo as treatment withdrawal. The primary endpoint was the PASI 90 response rate at week 56 in each dose group, comparing treatment maintenance with treatment withdrawal. Time to loss of PASI 90 response and other secondary efficacy endpoints were also evaluated. Safety was monitored throughout the study.

Results
A total of 566 participants were enrolled, of whom 554 were randomised at week 20 to picankibart 100 mg or 200 mg (n=277 in each group). Among these, 244 participants in the 100 mg group and 241 in the 200 mg group who achieved PASI 90 at week 32 were rerandomised. The primary endpoint was met: at week 56, a significantly greater proportion of participants who received continuous treatment achieved a PASI 90 response than those who switched to placebo (89.3% with continuous picankibart 100 mg vs 37.7% with placebo [difference 51.6%;

95% CI 41.4-61.8; P<0.0001]; 90.1% with continuous picankibart 200 mg vs 51.7% with placebo [difference 38.4%; 95% CI 28.0-48.8; P<0.0001]). Consistent with these findings, continued treatment markedly reduced the risk of losing PASI 90 response. Among those with treatment withdrawal, the median time to the loss of PASI 90 response was 20.4 weeks for the 100 mg group (95% CI 20.0, 23.7) and 24.6 weeks for the 200 mg group (23.7, 25.1). The hazard ratio for PASI 90 loss was 0.159 (95% CI, 0.094-0.270) for continuous picankibart 100 mg versus withdrawal and 0.235 (0.137-0.402) for continuous picankibart 200 mg versus withdrawal (both P<0.0001, log-rank test). All other secondary endpoints at week 56 were also met including the proportions of participants achieving PASI 75 (continuous therapy vs. withdrawal, 100 mg: 95.9% vs. 65.6%; 200 mg: 97.5% vs. 74.2%), PASI 100 (100 mg: 54.1% vs. 8.2%; 200 mg: 49.6% vs. 22.5%), static Physician's Global Assessments (sPGA) score of 0/1 (100 mg: 83.6% vs. 46.7%; 200 mg: 88.4% vs. 63.3%), sPGA score of 0 (100 mg: 57.4% vs. 11.5%; 200 mg: 52.1% vs. 24.2%), and Dermatology Life Quality Index of 0/1 (100 mg: 77.5% vs. 27.7%; 200 mg: 71.6% vs. 47.0%). Overall, the safety profile was comparable between the maintenance and withdrawal groups, with no new safety signals identified.

Conclusions

In this phase 3 trial, maintenance treatment with picankibart after achievement of PASI 90 provided long-term disease control in moderate-to-severe plaque psoriasis with a favourable safety profile. These findings indicate that picankibart treatment is an effective strategy for sustaining optimal clinical response in patients with moderate-to-severe plaque psoriasis.

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Systemic Treatment Choice Determines Psoriasis Control in Difficult-to-Treat Locations: Insights from the PsO Challenge Real-World Study

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Introduction

Psoriasis is a chronic inflammatory skin disease affecting 2-4% of the global population and 2.3% of the Spanish population. Involvement of specific anatomical sites —such as scalp, nails, palmoplantar areas and genital region— collectively referred to as difficult-to-treat locations (DTTL), presents unique and distinct therapeutic challenges due to their complexity and sensitivity. The Physician's Global Assessment (PGA) and the Patient Global Assessment (PtGA) are widely used standardized tools to evaluate disease severity in routine clinical practice. This real-world study aimed to assess the clinical relevance of these specific psoriasis manifestations, their evaluation, and their impact on patient burden. In a cohort of adult Spanish patients with psoriasis affecting DTTLs and receiving treatment for at least three months, global clinical control at the study visit (defined as global PGA≤1 and global PtGA≤1) was evaluated. The association between treatment type and psoriasis control was analyzed from both physician and patient perspectives, adjusting for relevant clinical covariates.

Materials and Methods

This was a non-interventional, cross-sectional, multicenter study, based on primary data collection, and focused on patients with psoriasis affecting at least one DTTL (i.e., scalp, nail, palmoplantar and/or genital psoriasis) who were currently receiving systemic treatment (biologic or/and non-biologic). The study consisted of a single face-to-face visit, during which patients completed the PtGA (global and site-specific), and physicians completed the PGA (global and site-specific). Sociodemographic and clinical variables were also collected.

Results

350 patients were included in the study. Their mean (SD) age was 52.5 (13.8) years old, and 54.6% were male. 227 (68,8%) patients were overweight or obese. The scalp was the most common DTTL, reported in 81.1% of patients, followed by nails (49.4%), the genital region (45.4%), and palmoplantar involvement (35.1%). Overall, 100 patients (28.6%) had psoriasis limited exclusively to DTTLs. The majority of patients (67.4%) had one or two DTTLs.

Based on the joint physician- and patient-reported assessment of global clinical control, among patients receiving biologic therapy (n=284), 172 (60.6%) achieved PGA≤1 and PtGA≤1. In contrast, among patients receiving systemic non-biologic therapy (n=44), 11 (25.0%) had PGA≤1 and PtGA≤1 based on the joint physician- and patient-reported assessment of global clinical control. The associated prevalence odds ratio (POR: 0.22) indicates that patients receiving non-biologic systemic therapy presented approximately 78% lower odds of achieving global clinical control compared with those receiving biologic therapy. A summary of global clinical control (PGA and PtGA ≤1) stratified by clinical covariates among patients treated for at least three months is presented in the Table.

Table. Global clinical control (PGA and PtGA) stratified by clinical covariates according to type of treatment and for patients treated for at least three months

Variable		Systemic non-biologic	Systemic biological	POR / p-value
Global clinical control according to physicians and patients' perspective jointly	PGA≤1 and PtGA≤1, n (%)	11 (25.0%)	172 (60.6%)	0.22 / <0.0001
	PGA>1 or PtGA>1, n (%)	33 (75.0%)	112 (39.4%)	
	Valid N	44	284	
Patients with <2 DTTL	PGA≤1 and PtGA≤1, n (%)	5 (22.7%)	55 (59.1%)	0.20 / 0.0037
	PGA>1 or PtGA>1, n (%)	17 (77.3%)	38 (40.9%)	
	Valid N	22	93	
Patients with ≥2 DTTL	PGA≤1 and PtGA≤1, n (%)	6 (27.3%)	117 (61.3%)	0.24 / 0.0028
	PGA>1 or PtGA>1, n (%)	16 (72.7%)	74 (38.7%)	
	Valid N	22	191	
No other body area affected	PGA≤1 and PtGA≤1, n (%)	6 (31.6%)	49 (62.0%)	0.28 / 0.0211
	PGA>1 or PtGA>1, n (%)	13 (68.4%)	30 (38.0%)	
	Valid N	19	79	
Other body area affected	PGA≤1 and PtGA≤1, n (%)	5 (20.0%)	123 (60.0%)	0.17 / 0.0002
	PGA>1 or PtGA>1, n (%)	20 (80.0%)	82 (40.0%)	
	Valid N	25	205	
BMI <25 kg/m²	PGA≤1 and PtGA≤1, n (%)	2 (15.4%)	56 (65.1%)	0.10 / 0.0014
	PGA>1 or PtGA>1, n (%)	11 (84.6%)	30 (34.9%)	
	Valid N	13	86	
BMI ≥25 kg/m²	PGA≤1 and PtGA≤1, n (%)	6 (24.0%)	108 (57.8%)	0.23 / 0.0022
	PGA>1 or PtGA>1, n (%)	19 (76.0%)	79 (42.2%)	
	Valid N	25	187	

BMI, body mass index; DTTL, difficult-to-treat locations; PGA, Physician's Global Assessment; POR, prevalence Odds Ratio; PtGA, Patient Global Assessment.

Conclusions

This study provides real-world evidence on the effectiveness of systemic therapies in patients with psoriasis involving DTTLs, addressing the existing gap in data regarding the concordance between physician-assessed disease control and patient-perceived disease burden. While the majority of patients achieved favorable clinical control, patient-reported symptoms and quality-of-life impact showed greater variability, highlighting the need to integrate both clinical and patient perspectives. Biologic therapies were associated with consistently better outcomes and higher levels of patient-reported satisfaction. Overall, these findings support the combined use of objective clinical measures and Patient-Reported-Outcomes in the evaluation of special-site psoriasis, enabling more informed treatment decisions and a more comprehensive, patient-centered approach to care.

EA DV CONGRESS
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30 SEP - 3 OCT 2026

Abstract N°: 1066

eGEPARD as a Digital Self-Screening Tool to Support Early Detection of Psoriatic Arthritis in Psoriasis Patients: A Prospective Study

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Introduction

Approximately 30% of patients with psoriasis (Pso) develop psoriatic arthritis (PsA) over the course of the disease. Despite medical care, PsA is often diagnosed too late. Diagnostic delay is associated with disease progression, irreversible joint damage, and significant impairments in quality of life. Digital self-screening tools may facilitate symptom awareness and timely physician contact. The aim of the project was to develop and evaluate a digital self-screening tool (eGEPARD) for the early detection of PsA in patients with psoriasis. The study examined the extent to which the tool can support disease awareness, contact with healthcare providers, and diagnostic evaluation in routine clinical practice.

Materials and Methods

An electronic version of the established German Psoriasis Arthritis Diagnostic Questionnaire (eGEPARD; score 0–13, ≥4 indicating a high probability of PsA) was developed and accessed by participants via an open digital platform. Between April 2024 and May 2025, participants were recruited via flyers, various patient organizations, an outpatient clinic, and Google Ads. Participants included individuals with psoriasis with or without a prior PsA diagnosis who accessed the open digital platform. They completed the eGEPARD and took part in an anonymous online survey at two time points: immediately after completion (T0) and five months later (T1). All variables were analyzed descriptively. Changes in awareness of PsA symptoms between T0 and T1 were assessed using the Wilcoxon signed-rank test. A non-responder analysis and subgroup comparisons were performed using chi-square tests and multivariate logistic regression.

Results

A total of N=217 patients participated (76.0% female, mean age 57.7±12.1 years, mean time since Pso diagnosis 22.4±17.7 years). 54.3% of all participants reported no known PsA diagnosis; the mean eGEPARD score was 8.7, and 94.0% had a score ≥4. Over 80.0% of participants were familiar with the clinical picture of PsA and their risk of developing the disease. The main reasons for taking the digital self-screening included joint pain (55.8%), followed by curiosity (30.4%) and diagnostic uncertainty (25.3%). Over 94.0% rated the eGEPARD as easy to use, user-friendly, and visually appealing. Even 5 months after using the eGEPARD (T1, N=115), 70.4% of participants reported continuing to pay closer attention to PsA symptoms, although this was significantly lower than initially intended (T0: 86.2%) ($p<.001$; N=115). At T1, over 80.0% had scheduled a physician appointment for PsA evaluation or planned to schedule one; of these, 22.5% and 41.7% did so based on their eGEPARD results. Since using eGEPARD, 46.1% of participants had been screened for PsA; of these, 66.0% were diagnosed with PsA. The non-responder analysis at T1 showed no significant differences. Few subgroup differences were observed: female sex was associated with higher odds of being aware of the clinical picture of PsA prior to visiting the digital platform (aOR 2.89, 95% CI 1.19-7.02). Participants aged >55 years were more likely to have actively sought information on early detection of PsA (aOR 2.76, 95% CI 1.47-5.06) and to have ever discussed PsA with a physician prior to visiting the digital platform (aOR 2.21, 95% CI 1.03-4.73).

Conclusions

The discrepancy between positive screening results and pre-existing PsA diagnoses highlights the need for structured early detection approaches in dermatological care. The eGEPARD proved to be an acceptable, low-threshold digital tool that empowers psoriasis patients in recognizing their symptoms and encourages physician contact. Only a few subgroup differences in awareness and health-seeking behavior were observed, suggesting that the eGEPARD may be broadly applicable and similarly beneficial across different patient groups. Overall, digital self-screening may contribute meaningfully to improving early PsA detection in routine dermatology care.

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Abstract N°: 1076

ERAP1 Q730E mutation reverses HaCaT cell status in psoriasis via promoting TNFR1 internalization and inhibiting caspase-8 activity

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Introduction

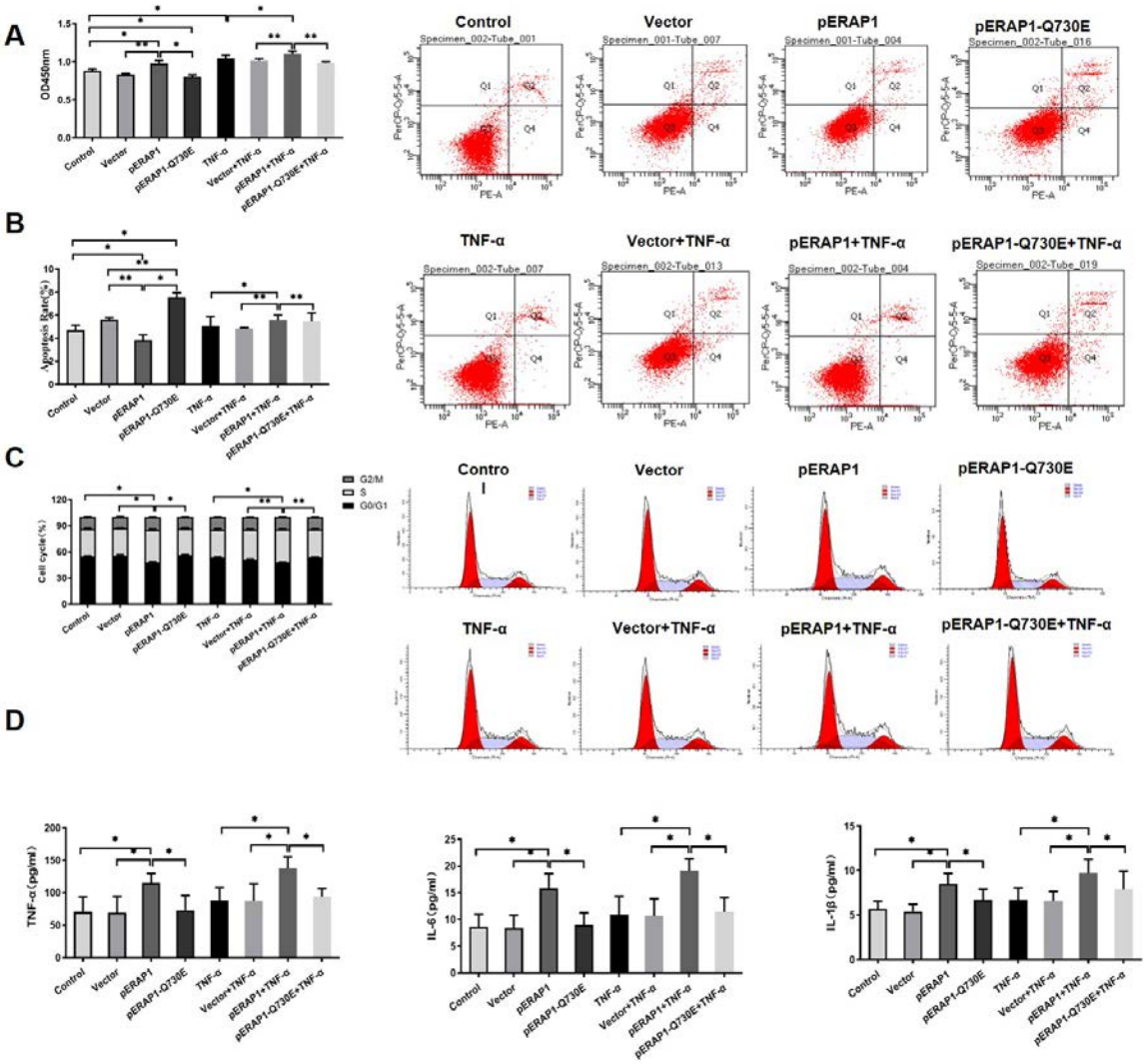
Psoriasis is a chronic immune-mediated inflammatory skin disorder characterized by hyperproliferation and abnormal differentiation of keratinocytes. The ERAP1 gene and its multiple single nucleotide polymorphisms are associated with psoriasis. However, their effects and regulatory mechanisms on keratinocytes remain incompletely elucidated.

Materials and Methods

We overexpressed ERAP1 and ERAP1-Q730E in HaCaT cells via gene transfection. The steady-state and partial inflammatory state of psoriasis were simulated by the presence or absence of TNF-α, respectively. The proliferation of HaCaT cells was detected using the CCK-8 assay. The cell cycle and apoptosis of HaCaT cells were analyzed by flow cytometry. The secretion of TNF-α, IL-6, and IL-1β by HaCaT cells was analyzed using an ELISA. The expression of TNFR1 and TNFR2 in HaCaT cells was detected by immunofluorescence. The expression of IKKs and caspase-8 was detected by Western blotting.

Results

ERAP1 significantly promoted the entry of HaCaT cells into the S and M phases, facilitated cell proliferation, inhibited apoptosis, and enhanced the secretion of TNF-α, IL-6, and IL-1β. Conversely, ERAP1-Q730E significantly reduced the number of HaCaT cells entering the S and M phases, inhibited cell proliferation, promoted apoptosis, and suppressed the secretion of TNF-α, IL-6, and IL-1β. ERAP1 inhibited the expression of TNFR1 in HaCaT cells without affecting TNFR2, whereas ERAP1-Q730E suppressed the expression of both TNFR1 and TNFR2 in cells and promoted receptor internalization. Both ERAP1 and ERAP1-Q730E inhibited the expression of IKKs and caspase-8.



ERAP1-Q730E inhibits the proliferation of HaCaT cells. ERAP1-Q730E promotes apoptosis of HaCaT cells. ERAP1-Q730E inhibits cell cycle progression in HaCaT cells. ERAP1-Q730E inhibits the expression of TNF-α, IL-6, and IL-1β in HaCaT cells.

Conclusions

ERAP1-Q730E reverses the effects of ERAP1 on the proliferation, apoptosis, and cytokine secretion of HaCaT cells by promoting TNFR1 internalization and inhibiting caspase-8 activity.

EADV CONGRESS
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30 SEP - 3 OCT 2026

Abstract N°: 1093

Bimekizumab patient-reported real-world impact in moderate to severe plaque psoriasis: Insights from a multi-country online survey

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Introduction

Given the variety of biologics available for psoriasis, the advancing treatment landscape, and rising patient expectations,[1,2] it is crucial to understand patients' perspectives on treatments and their efficacy to encourage shared decision-making. Despite the impact of moderate to severe psoriasis on quality of life (QoL),[3] there are limited real-world data on patients' perspectives of the effectiveness of biologic treatments, such as bimekizumab (BKZ).

Here, this multi-country patient survey explored patient experiences by evaluating the patient-reported burden of moderate to severe plaque psoriasis and the impact of BKZ on physical and emotional symptoms, and activities of daily living.

Materials and Methods

Adults aged 18–64 years with moderate to severe plaque psoriasis (physician-diagnosed ≥1 year prior) who had received BKZ for ≥3 months were invited to complete an anonymous online survey (conducted 20th April–30th July 2025). Participants from Australia, Canada, France, Germany, UK and US were recruited primarily via an online patient panel and secondarily via patient groups and patient support programmes.

Participants were asked to select their most impactful physical and emotional symptoms when their psoriasis was at its worst and self-reported improvement in these, and activities of daily living, after treatment with BKZ. Patients also rated statements regarding their overall experience with BKZ. Direct wording from survey questions are included in quotation marks.

Descriptive analyses were performed; missing data were recorded as "prefer not to answer".

Results

Among 207 participants (mean age of 42 years, 53% female), 15% were biologic naïve, while most had previously received 1 (43%) or ≥2 (42%) biologics. 44% had been treated with BKZ for ≥1 year.

Overall, more than 8 in 10 agreed that BKZ addressed their "most bothersome symptoms" (87%) and "hardest to treat areas" (85%), and "improved their QoL" (86%); a similar proportion were "surprised and delighted" with "the speed with which [BKZ] worked" (82%) and were "glad/wish [BKZ] had been their first treatment" (84%;

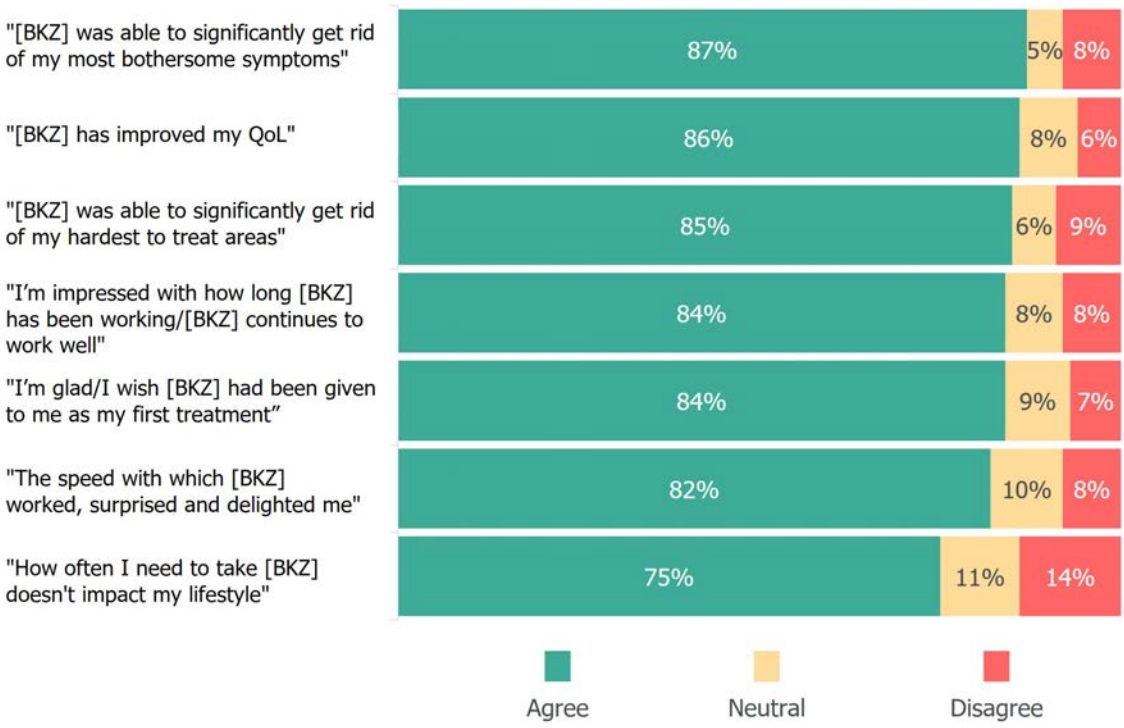
Figure). Participants were also pleased that "how often [BKZ] needs to be taken doesn't impact [my] lifestyle" (75%) and were "impressed with how long [BKZ] has been working/continues to work well" (84%).

After BKZ initiation, 72% of participants reported an improvement in the percentage of body surface area affected. Most participants also saw an improvement in their self-reported "most impactful" physical signs/symptoms, including plaques (90%), skin discolouration (89%), skin pain (86%), and skin itching/tightness (86%). 62–74% of participants reported improvements in each of these symptoms within one month of starting BKZ.

In most emotional domains, including those "most impactful" (anxiety that psoriasis will worsen, depression, social withdrawal/isolation, body consciousness), 42–55% noticed improvements in these symptoms within one month.

Overall, 79–88% of participants reported improvements following BKZ treatment in their "most impacted" activities of daily living (how skin felt, physical comfort, mental health, self-confidence, and clothing choice).

Figure. Participants' overall experience with bimekizumab



Participants (N=207) self-reported their experience with BKZ using a predefined list. Participants were asked, "we will now show you a list of statements about [BKZ] and would like to know the extent to which you agree or disagree with each." A 7-point Likert scale was used, 1–3 (disagreement), 4 (neutral), 5–7 (agreement). BKZ: bimekizumab; QoL: quality of life. Source: Ipsos.

Conclusions

This multi-country survey of adults with moderate to severe plaque psoriasis treated with bimekizumab for ≥3 months showed rapid, high-level improvements within 1 month across physical and emotional domains, and daily functioning. Many were "glad/wish" bimekizumab was their "first treatment".

These real-world findings highlight patient-reported benefits across key burden domains and may support clinician/patient decision-making and encourage earlier treatment with optimal therapies in a complex treatment landscape. However, the results of this self-reported survey may be subject to recall and selection bias.

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Abstract N°: 1094

Bimekizumab efficacy in patients with moderate to severe psoriasis classified as obese or overweight: 1-year results from four phase 3/3b studies

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Introduction

Patients with moderate to severe psoriasis often have a higher body weight and more weight-related comorbidities than the general population; increased weight is associated with heightened systemic inflammation.[1] Around 61% of US patients with psoriasis are classified as obese (body mass index [BMI] ≥30 kg/m^2) or overweight (BMI 27–29.9 kg/m^2) with ≥1 weight-related comorbidity.[2] As biologic treatments may be less efficacious in this population,[1] it is crucial to evaluate whether they can control inflammation irrespective of patients' weight.

A recent study found that patients with psoriasis classified as obese or overweight with weight-related comorbidities treated with ixekizumab (interleukin [IL]-17A inhibitor) combined with tirzepatide achieved higher PASI 100 (100% improvement from baseline in Psoriasis Area and Severity Index) responses at Week 36 than ixekizumab alone (40.6% versus 29.0%, respectively; $p<0.05$).[3]

Bimekizumab (BKZ) is a IgG1 monoclonal antibody that selectively inhibits both IL-17A and IL-17F from IL-23-dependent and independent sources.[4] In this post-hoc analysis, we assess BKZ's efficacy in patients with elevated baseline BMI with or without weight-related comorbidities through 1 year.

Materials and Methods

Data were pooled from the 56-week BE SURE (NCT03412747) and BE READY (NCT03410992), 52-week BE VIVID (NCT03370133) and 48-week BE RADIANT (NCT03536884) phase 3/3b trials.[5–8] Included patients had elevated BMI and received BKZ 320 mg every 4 weeks (Q4W) to Week 16, then Q4W or every 8 weeks (Q8W) to study end.

Proportions of patients achieving PASI 90 (≥90% improvement from baseline in PASI) and PASI 100 (near-complete/complete skin clearance, respectively) are reported through 48 weeks (1 year) in three subgroupsbaseline BMI: 27–29.9 kg/m^2 with ≥1 weight-related comorbidity; ≥30 kg/m^2; ≥35 kg/m^2 (subset of BMI ≥30 kg/m^2 subgroup). Comorbidities included hypertension, dyslipidaemia, sleep apnoea syndrome, cardiovascular disease and type 2 diabetes mellitus.

Data are reported for patients who received continuous BKZ, regardless of dosing regimen (BKZ Total). The subset who received BKZ Q4W to Week 16 then Q8W thereafter were also analysed (Q4W/Q8W; approved dosing regimen for most patients with psoriasis).[9] Missing data were imputed using non-responder imputation (NRI).

Results

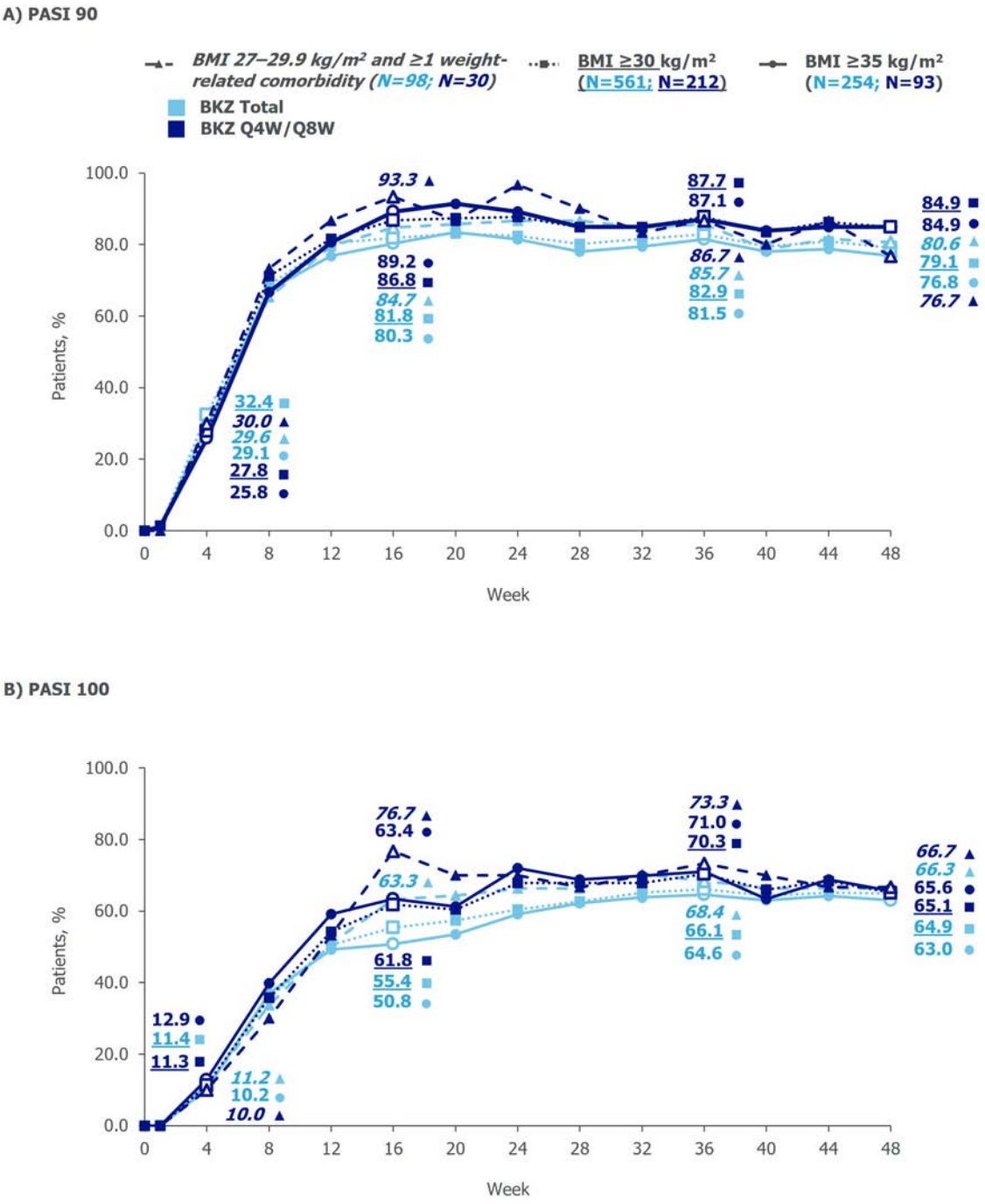
Overall, 98/561/254 patients had a baseline BMI of 27–29.9 with ≥1 weight-related comorbidity, BMI ≥30 or BMI ≥35, respectively; among patients who received BKZ Q4W/Q8W, these subgroups included 30/212/93 patients, respectively.

High levels of PASI 90 were observed at Week 16 and Week 36 in BKZ Total patients with BMI 27–29.9 with ≥1 weight-related comorbidity (84.7%/85.7%), BMI ≥30 (81.8%/82.9%) and BMI ≥35 (80.3%/81.5%), respectively (**Figure 1A**). Responses were maintained to Week 48.

PASI 100 responses increased to Week 16 and further improved at Week 36 across all subgroups: BMI 27–29.9 with ≥1 weight-related comorbidity (63.3%/68.4%), BMI ≥30 (55.4%/66.1%) and BMI ≥35 (50.8%/64.6%), respectively (**Figure 1B**). Responses were sustained through Week 48.

Similar PASI 90/100 results were seen in the BKZ Q4W/Q8W subgroup.

Figure 1. PASI 90/100 response rates through Week 48 in patients with baseline BMI 27–29.9 kg/m² with ≥1 weight-related comorbidity, BMI ≥30 kg/m² and BMI ≥35 kg/m² (NRI)



The BMI ≥35 kg/m2 group was a subset of the BMI ≥30 kg/m2 group. Weight-related comorbidities included hypertension, dyslipidaemia, sleep apnoea syndrome, cardiovascular disease and type 2 diabetes mellitus. BKZ: bimekizumab; BMI: body mass index; NRI: non-responder imputation; PASI: Psoriasis Area and Severity Index; PASI 90/100: ≥90%/100% improvement from baseline in PASI; Q4W: every 4 weeks; Q8W: every 8 weeks.

Conclusions

High levels of near-complete/complete skin clearance were achieved through 1 year of bimekizumab treatment in patients with psoriasis classified as obese or overweight with weight-related comorbidities. These data suggest deep control of underlying inflammatory pathways by targeting IL-17A and IL-17F with bimekizumab, irrespective of elevated baseline weight and/or comorbidities.

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Abstract N°: 1095

Successful Treatment of A 75-year-old Male with Severe Plaque Psoriasis Using Vunakizumab (antiIL-17)- A Case Report

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Introduction

Plaque psoriasis accounts for approximately 80% to 90% of psoriasis cases and is a chronic, recurrent inflammatory skin disease mediated by inflammatory factors such as IL-17, which seriously affects the physical and mental health of patients[1]. As a highly selective humanized anti-IL-17A monoclonal antibody, Vunakizumab has demonstrated good efficacy and safety in phase III studies (NCT04839016) for the treatment of moderate to severe plaque psoriasis in adults[2]. However, data on its efficacy and safety in the elderly population remain limited.

Case Presentation

A 75-year-old male with severe plaque psoriasis presented with intermittent erythematous plaques, scaling, and pruritus affecting the whole body for 21 years, which had exacerbated over the past 2 months. Previous treatments included Acitretin and phototherapy, both with suboptimal efficacy. Subsequently, the patient received Secukinumab therapy. Initial rash control was satisfactory; However, as treatment continued, erythematous plaques with scales developed on both lower legs. The patient self-discontinued the medication 3 months ago, leading to rapid recurrence of the lesions, which became generalized over the past month. After completing relevant laboratory investigations, a 10-day course of oral Acitretin 20 mg was administered with poor response. The patient was then switched to Vunakizumab therapy, administered as 240 mg subcutaneous injections at weeks 0, 2, and 4 during the induction phase, followed by maintenance dosing at the same dose every 4 weeks.

After 4 weeks of treatment, the patient’s Psoriasis Area and Severity Index(PASI) score decreased from 43.9 to 8.6, achieving PASI 75 improvement, while the Body Surface Area (BSA) involvement declined from 70% to 50%, with complete resolution of pruritus.By 12 weeks of treatment, the patient's PASI score further decreased from 8.6 to 0.6, reaching near-PASI100, with skin lesions nearly completely cleared.

Characteristics	Baseline	Week 4	Week 12
PASI score	43.9	8.6	0.6
BSA（%）	70	50	1



Figure1 assessment of efficacy

Conclusion

In this case of elderly patient with severe plaque psoriasis, the skin lesions showed significant improvement after 4 weeks of treatment with Vunakizumab, achieving complete clearance by week 12. No adverse events were observed during the treatment period. Further studies are warranted to provide additional evidence for the use of Vunakizumab in the treatment of psoriasis in the elderly population.

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EA DV CONGRESS
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Abstract N°: 1106

Envudeucitinib, an oral allosteric TYK2 inhibitor, suppresses inflammatory supraspinous keratinocyte states in psoriasis skin

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Introduction

Psoriasis is characterized by aberrant keratinocyte differentiation and expansion of inflammatory keratinocyte states that sustain epidermal hyperplasia and chronic inflammation. While TYK2 inhibition improves clinical disease, how modulation of this pathway affects keratinocytes within lesional skin remains unclear. Envudeucitinib (formerly ESK-001) is an oral, highly selective allosteric TYK2 inhibitor, currently under investigation, that demonstrated robust clinical efficacy in the Phase 2 STRIDE trial in patients with moderate-to-severe plaque psoriasis. Here, we leveraged bulk and spatial transcriptomics to determine whether envudeucitinib selectively modulates pathologic keratinocyte differentiation states in human psoriasis skin.

Materials and Methods

Skin punch biopsies were collected from lesional and non-lesional sites at baseline and Week 12 from patients receiving envudeucitinib 40 mg twice daily or placebo in the STRIDE trial. Biopsies were bisected for bulk RNA sequencing and spatial transcriptomic profiling. Spatial transcriptomics was performed using the 10x Genomics Visium HD platform and analyzed with Space Ranger. Cell-type resolved and pseudobulk analyses were conducted in R using the Seurat framework to characterize keratinocyte subtypes and differentiation states.

Results

Spatial transcriptomic profiling revealed distinct keratinocyte differentiation states in lesional skin at baseline, including an expanded population of supraspinous keratinocytes exhibiting high expression of psoriasis-associated inflammatory and stress-response genes such as IL36A, KRT16/17, SERPINB3/4, and members of the SPRR gene family. Following 12 weeks of envudeucitinib treatment, this inflammatory supraspinous keratinocyte population was markedly reduced compared with placebo, with transcriptional profiles shifting toward those observed in non-lesional skin. Bulk RNA-seq analysis of paired biopsies confirmed concordant suppression of keratinocyte inflammatory gene programs, supporting a focused, cell-state–specific effect rather than uniform epidermal inhibition.

Conclusions

Envudeucitinib suppresses a pathologic inflammatory supraspinous keratinocyte state associated with aberrant differentiation in psoriasis skin. These spatially resolved findings provide mechanistic insight into how allosteric TYK2 inhibition normalizes epidermal pathology and highlight keratinocyte cell-state modulation as a key component of therapeutic response in psoriasis.

EADV CONGRESS
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Abstract N°: 1112

Successful Treatment of a Patient with Severe Plaque Psoriasis Complicated by Pustular Psoriasis Using Vunakizumab

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Introduction

Pustular psoriasis (PP) is a rare, severe, and potentially life-threatening variant of psoriasis; however, standardized treatment guidelines remain lacking. Accumulating clinical evidence has demonstrated the efficacy of interleukin-17 (IL-17) inhibitors, such as secukinumab and ixekizumab, in the management of PP. Vunakizumab is an innovative Chinese-developed IL-17A inhibitor approved by the NMPA for the treatment of moderate to severe plaque psoriasis in adults. Nevertheless, its therapeutic efficacy in patients with PP remains largely unknown.

Case Presentation

Objective: To evaluate the efficacy and safety of vunakizumab in the treatment of patients with pustular psoriasis.

Methods: A patient with severe plaque psoriasis complicated by pustular psoriasis received treatment with vunakizumab for 2 months. The primary efficacy outcome was defined as the improvement in Psoriasis Area and Severity Index (PASI) score compared with baseline, while adverse events (AEs) were monitored and recorded for safety evaluation.

Conclusion

Results and Conclusions:

A 42-year-old male patient with a 10-year history of psoriasis presented with recurrent trunk and extremity rashes 5 months prior, without obvious precipitating factors. Oral administration of viaminate capsules and thymosin enteric-coated tablets failed to control the disease, instead exacerbating it and leading to generalized skin lesions. The patient developed generalized cutaneous erythema, swelling and pain in both lower extremities, and white pustules on the back; he was diagnosed with plaque psoriasis complicated by pustular psoriasis, with 90% BSA involvement, a PASI score of 64.8, and a DLQI score of 19.

Vunakizumab was administered on February 13, 2026. Two days after treatment initiation, skin lesions were effectively controlled and pruritus was significantly relieved. After 1 month of treatment, complete skin lesion clearance was achieved, with BSA, PASI score, and DLQI score all reduced to 0. No adverse events were reported during 2 months of follow-up.

This case indicates that Vunakizumab can rapidly relieve pruritus and achieve complete skin clearance (PASI 100) in patients with pustular psoriasis, with good safety. Its efficacy is consistent with other IL-17 inhibitors, suggesting that IL-17 inhibitors and vunakizumab are promising options for the management of severe pustular psoriasis.

EADV CONGRESS
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Abstract N°: 1125

Metabolic Comorbidities in Psoriasis: Differences Between Patients With and Without Psoriatic Arthritis in a Caribbean Cohort

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Introduction
Psoriasis is a chronic immune-mediated inflammatory disease associated with multiple systemic comorbidities, particularly cardiometabolic disorders. Psoriatic arthritis (PsA) represents a more severe phenotype of psoriatic disease and has been increasingly linked to an elevated cardiovascular risk profile. However, data from Caribbean populations remain limited, highlighting the need for regional studies evaluating these associations.

Materials and Methods
A retrospective cross-sectional study was conducted including 548 patients with dermatologist-confirmed psoriasis at a tertiary care center in the Dominican Republic. Patients were stratified according to the presence of psoriatic arthritis. Clinical variables and cardiometabolic comorbidities were collected. Multivariable logistic regression analysis was performed adjusting for age and sex to evaluate independent associations.

Results
Psoriatic arthritis was identified in 158 patients. It was significantly associated with a higher prevalence of hypertension (62.4% vs 41.8%, p=0.014), type 2 diabetes mellitus (38.7% vs 22.5%, p=0.038), and obesity (55.1% vs 33.6%, p=0.009). In multivariable analysis, PsA remained independently associated with hypertension (OR 2.1; 95% CI 1.4–3.2; p<0.001), obesity (OR 1.9; 95% CI 1.3–2.8; p=0.001), and diabetes mellitus (OR 1.7; 95% CI 1.1–2.6; p=0.015).

Conclusions
Psoriatic arthritis is an independent clinical marker of increased cardiometabolic risk in patients with psoriasis. These findings support the importance of early cardiovascular risk screening and comprehensive multidisciplinary management in patients with psoriatic disease, particularly in underrepresented populations.

EADV CONGRESS
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Abstract N°: 1185

The Effect of Oral Administration of Borage (Borago officinalis) and Flaxseed (Linum usitatissimum) Seed Oils on Treatment in an Imiquimod-Induced Murine Psoriasis Model

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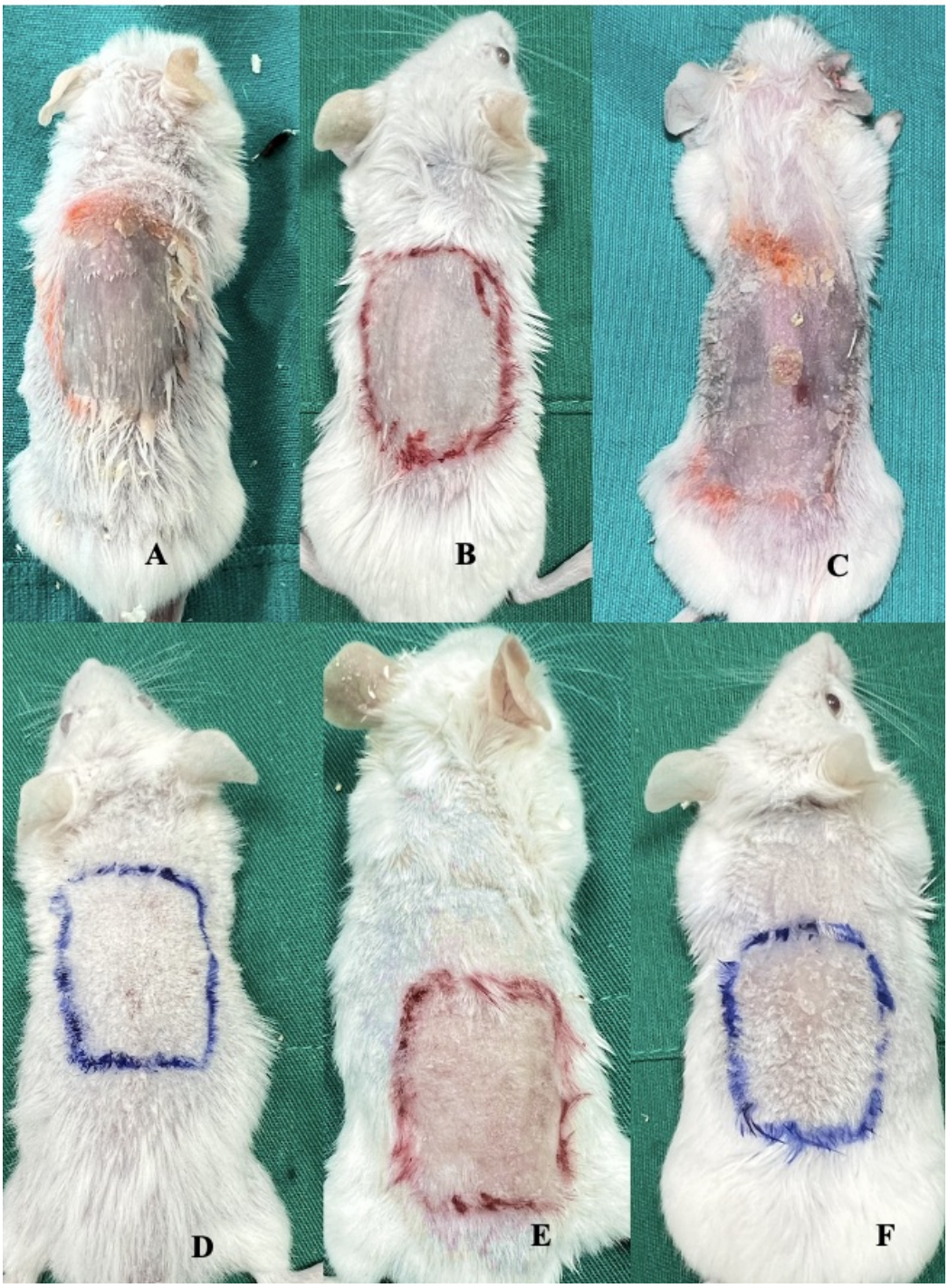
Introduction
Psoriasis is a chronic skin disease that is frequently encountered in the general population. In its etiology, the combined effect of genetic predisposition and environmental factors is implicated. Among the various treatment options are topical agents, phototherapy, conventional therapies, and systemic agents. Borage seed oil, rich in gamma-linolenic acid (GLA), and flaxseed oil, rich in alpha-linolenic acid (ALA), are essential fatty acids with anti-inflammatory properties. Their use in various inflammatory diseases has been demonstrated in numerous studies in the literature. The aim of this study was to investigate the effects of borage seed oil and flaxseed oil in a murine model of psoriasis.

Materials and Methods
A total of 56 Balb/c mice were used in the study. Each group consisted of 8 mice (4 males and 4 females), divided into 7 groups. The back and ears were chosen as the areas for imiquimod cream application. These areas were shaved, and 62.5 mg of 5% imiquimod cream was applied. The ear thicknesses of all mice were measured on the first day. During the first seven days, all groups except the control received only imiquimod cream. At the end of the seventh day, a modified Psoriasis Area Severity Index (PASI) scoring was performed. From day 7 onward, imiquimod application continued, and the treatment groups received oral gavage of 100 mg/kg and 200 mg/kg borage seed oil, 200 mg/kg and 500 mg/kg flaxseed oil, and 1 mg/kg methotrexate, respectively. At the end of day 14, all animals were anesthetized and euthanized; ear thickness was re-measured, and PASI scoring was repeated. Skin samples collected from all mice were evaluated for histopathological, immunohistochemical, and ELISA analyses.

Results
No significant difference was found in body weight between groups or between sexes. The percentage change in ear thickness between the first and last days was found to be favorable in the flaxseed and methotrexate groups. When the change in PASI scores between days 7 and 14 was evaluated, a significant decrease was observed in the high-dose flaxseed (500 mg/kg/day) and methotrexate (1 mg/kg/day) groups. Histopathologically, the lowest mean score was observed in the high-dose flaxseed seed oil group, while the methotrexate group had the highest mean score. In immunohistochemical analysis, the signal transducer and activator of transcription 3 (STAT3) levels were most effectively reduced in the high-dose flaxseed seed oil group. Regarding Ki-67, a marked effect was observed not only in the flaxseed seed oil groups but also in the low-dose borage seed oil (100 mg/kg/day) group. In the ELISA results, the methotrexate group demonstrated the greatest efficacy across all three cytokines: tumor necrosis factor-alpha (TNF-α), interleukin (IL)-17, and IL-23.



Erythema, scaling, and induration in the treatment groups on day 14. A: Group 2; B: Group 3; C: Group 4; D: Group 5; E: Group 6; F: Representative samples from Group 7.

Conclusions

The high-dose flaxseed seed oil group demonstrated significant therapeutic success across all clinical, histopathological, immunohistochemical, and ELISA parameters. However, the effect of the low-dose flaxseed seed oil group (200 mg/kg/day) remained limited compared to the high dose. The low-dose borage seed oil group was found to be more effective than the high-dose borage seed oil (200 mg/kg/day) group across all evaluated parameters. The methotrexate group exhibited the expected therapeutic effect in all parameters except for histopathological evaluation. These findings indicate that high-dose flaxseed seed oil may serve as an effective treatment option in the psoriasis model, while borage seed oil provides limited benefit at low doses and becomes ineffective at higher doses.

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Abstract N°: 1190

Rapid improvement of systemic inflammatory markers by spesolimab in generalized pustular psoriasis: a real-world daily time-course analysis

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Introduction

Generalized pustular psoriasis (GPP) is a rare, severe inflammatory disease associated with systemic inflammation, including fever, elevated white blood cell (WBC) and neutrophil counts, increased C-reactive protein (CRP), and decreased serum albumin. Rapid control of systemic inflammation is essential, as GPP can be life-threatening. Spesolimab, an interleukin (IL)-36 receptor antagonist, has demonstrated efficacy in GPP flares; however, detailed real-world data on the early temporal dynamics of systemic inflammatory markers remain limited. We evaluated day-to-day changes in these markers during the first 14 days following spesolimab initiation.

Materials and Methods

We retrospectively analyzed patients with GPP and systemic inflammation treated with spesolimab at our institution between February 2023 and August 2025. Systemic inflammation was defined according to Japanese guidelines based on the Japanese Dermatological Association (JDA) severity criteria. Body temperature was assessed daily, and laboratory data were analyzed using mean values over 2–3 consecutive days.

Results

Seven patients (four females and three males; mean age 53.1 years) were included. At baseline, mean body temperature was 37.7°C, WBC count 15.9 × 10^9 cells/L, neutrophil count 13.1 × 10^9 cells/L, CRP 15.1 mg/dL, and serum albumin 2.4 g/dL. Concomitant therapies included etretinate (n=6) and ixekizumab (n=5). Spesolimab was associated with rapid improvement in systemic inflammatory markers (Figure 1). CRP levels showed the earliest response, with significant reductions observed at days 2–3 (percentage change) and days 4–5 (absolute change). In contrast, WBC counts and neutrophil counts decreased later, reaching significance at days 10–11 and 12–14, respectively. Body temperature decreased over time, while serum albumin levels gradually increased without statistical significance.

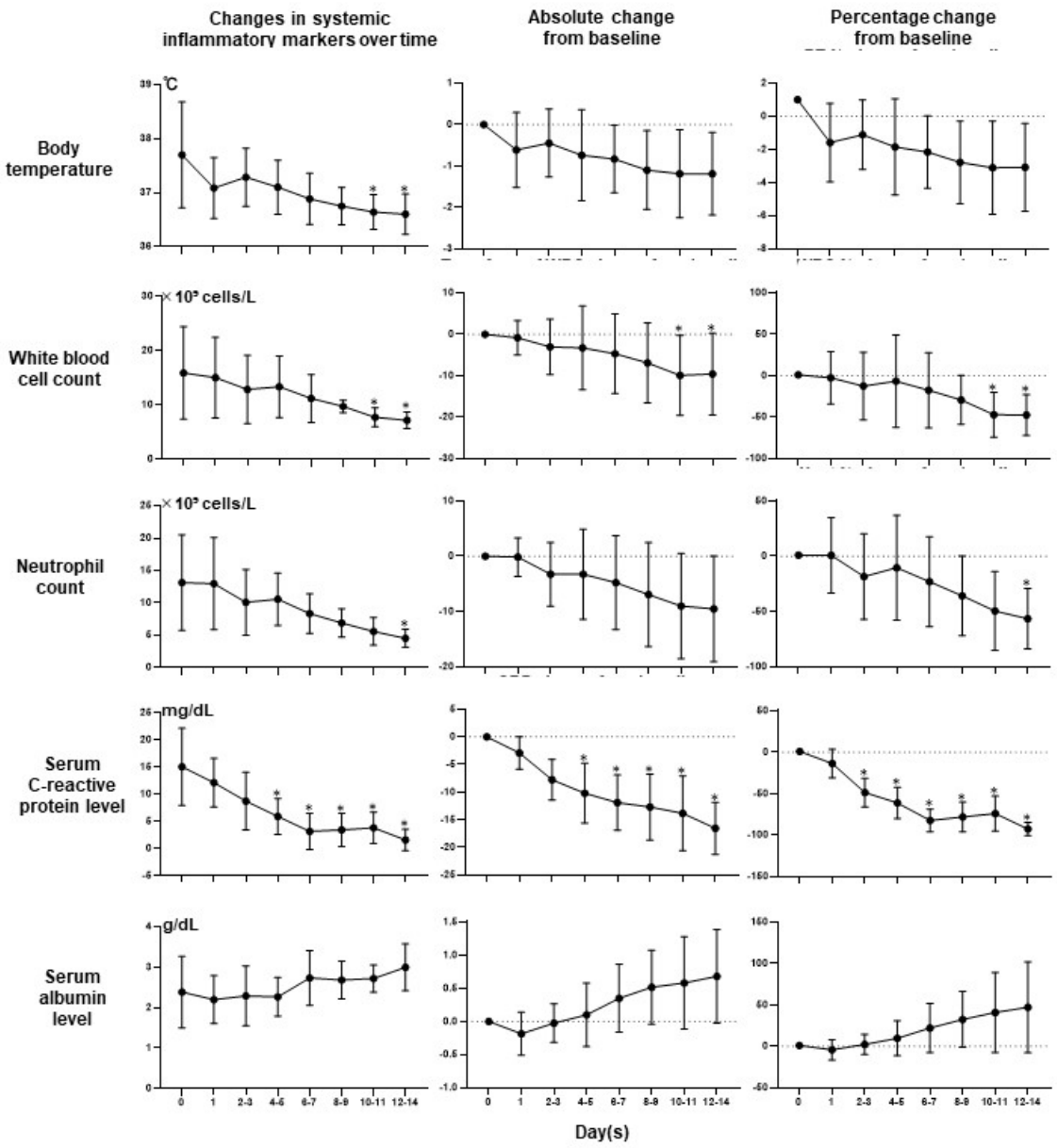

Figure 1

Changes in body temperature and laboratory parameters in seven patients with generalized pustular psoriasis accompanied by systemic inflammation before and after the first spesolimab treatment. Absolute and percentage changes from baseline are also shown. Values are expressed as mean ± standard deviation. Normality was assessed using the Shapiro–Wilk test, followed by Dunnett's multiple comparisons test to compare each time point with baseline. Statistical significance was defined as p-value < 0.05 (*p < 0.05).

Conclusions

These findings demonstrate that spesolimab rapidly improves systemic inflammation in GPP, as reflected by early

reductions in CRP, whereas leukocyte-related parameters normalize more gradually. CRP decreased as early as days 2–3, while WBC and neutrophil counts declined later, at days 10–14, indicating a temporal dissociation between biochemical and cellular inflammatory components. This may reflect differences in their dynamics, with CRP responding rapidly to cytokine-driven hepatic signaling, whereas circulating neutrophil counts are influenced by systemic regulatory mechanisms. This pattern is consistent with previous reports showing rapid improvement in cutaneous pustulation and reduced neutrophil infiltration in lesional skin, despite delayed normalization of peripheral neutrophil counts. Clinically, CRP may serve as an early marker of treatment response, while persistent leukocytosis in the early phase may not necessarily indicate inadequate response. This study is limited by its small sample size and concomitant therapies, but provides real-world insight into the early temporal dynamics of systemic inflammation following spesolimab treatment.

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Abstract N°: 1201

Psoriasis, obesity and eating disorders: is there a clinically relevant correlation?

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Introduction

Psoriasis is a chronic immune-mediated disease frequently associated with obesity, a comorbidity linked to psychological distress that may predispose to eating disorders (EDs); nonetheless, evidence in overweight and obese individuals with psoriasis remains limited and heterogeneous. The aim of this study was to investigate the prevalence of ED-related symptoms in a multicenter Italian cohort of psoriasis patients with body mass index (BMI) ≥25 kg/m², as well as to explore the relationship between BMI and ED-related scores.

Materials and Methods

A retrospective, multicenter, observational study was conducted at three Italian dermatology centers. Adult patients (18-75 years) with psoriasis and BMI ≥25 kg/m² were enrolled and stratified as overweight (25.0-29.9), obesity class I (30.0-34.9), II (35.0-39.9) or III (≥40.0 kg/m²). ED-related symptoms were assessed with the Binge Eating Scale (BES; positive cut-off ≥17) and the Eating Attitudes Test-26 (EAT-26; positive cut-off ≥20). Screening positivity, defined as a positive result on at least one of the two questionnaires, was compared across BMI groups using Fisher's exact and chi-square tests. Continuous BES/EAT-26 scores were compared between overweight and obese patients (BMI ≥30) and BMI was compared between ED-positive and ED-negative patients with Student's t-test. The relationship between BMI and BES/EAT-26 scores was further explored through Spearman's correlation. Further evaluation in a larger cohort is ongoing.

Results

A total of 104 patients were enrolled (mean age 49.8 ± 12.6 years). Thirteen patients (12.5%) were positive on at least one questionnaire: 5 (4.8%) on BES only, 6 (5.8%) on EAT-26 only, and 2 (1.9%) on both. Screening positivity across BMI categories was 16.7% (7/42), 9.1% (3/33), 9.1% (2/22) and 14.3% (1/7) in overweight, obesity class I, II and III, respectively, with no significant differences across the four groups (Fisher's exact, p=0.75) or between overweight and obese patients (16.7% vs. 9.7%; chi-square, p=0.31). Mean BES and EAT-26 scores did not differ between overweight and obese patients (BES: 6.3±6.1 vs. 7±6.5, p=0.57; EAT-26: 8.6±6.5 vs. 7.4±7.3, p=0.41), and mean BMI was comparable between ED-positive and ED-negative patients (31.2±3.6 vs. 32.2±4.4, p=0.43). Spearman's correlation showed no association between BMI and BES (ρ=0.03, p=0.75), but a weak yet significant negative correlation between BMI and EAT-26 (ρ=−0.21, p=0.032).

Conclusions

In our study, ED-related symptoms were detected in approximately 12% of patients. The prevalence of ED-related

symptoms did not significantly differ across BMI classes, suggesting that increasing obesity is not a reliable predictor of ED positivity in psoriasis. A weak but significant negative Spearman correlation between BMI and EAT-26 suggests that overweight, rather than obese, patients may carry greater restrictive/dysfunctional eating concerns. These findings support systematic screening for ED-related symptoms in all psoriasis patients with excess weight, and highlight the need for an integrated approach addressing both metabolic and psychological dimensions of the disease.

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Abstract N°: 1202

Rethinking Biologic Failure: Ixekizumab Rescues Secukinumab Secondary Failure Through Intra-Class IL-17A Inhibitors Switching

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Introduction

Monoclonal antibodies targeting IL-17A such as Secukinumab (SEC) and Ixekizumab (IXE) are established therapies for moderate-to-severe plaque psoriasis. Current clinical practice generally recommends switching to a different biologic class in cases of primary non-response. However, in secondary failure, either inter-class or intra-class switching may be considered. Secondary failure is defined as loss of efficacy (PASI >50% of the initial value) after a prior PASI 50 response achieved at weeks 12–16.

Case Presentation

We report a case series of nine patients with psoriasis, with clinical data extracted from institutional records. All patients initially received SEC 300 mg weekly for five weeks, followed by 300 mg monthly, achieving PASI ≥ 90 within 4–12 weeks. However, after 3–16 months, all patients experienced loss of response to maintenance therapy, qualifying as a secondary biologic failure. Patients were subsequently switched to IXE after informed consent, initiated at 160 mg, followed by 80 mg biweekly for three months and then monthly. Clinical improvement was observed as early as week 2, with consistent PASI reduction at each follow-up. Over 24 weeks, all patients achieved and maintained near-clear skin without significant adverse events. Mean PASI scores showed marked reduction post-switching, supporting the effectiveness of IXE in moderate-to-severe psoriasis. These data suggests that switching to IXE leads to significant clinical improvement in psoriasis severity across multiple parameters. Detailed clinical characteristics are summarized in Table 1.

Table 1. Characteristic of patients with switching biologic agents history

Case	Age,years/Sex	Diagnosis	Co-morbidity	Arthritis	Previous treatment/duration	Switching Reasons (PF/SF)	No
1	18/ M	Plaque psoriasis	Obesity	-	SEC for 9 months	SF	Ele LF
2	26/ M	Nail psoriasis	Obesity	-	SEC for >12 months	SF	Wo
3	38/ F	GPP	Obesity	-	SEC for >12 months	SF	Wo
4	30/ F	Plaque psoriasis	Thalassemia	-	SEC for 6 months	SF	Dif tre
5	64/ F	Plaque psoriasis	DM, DYS, HTN	+	SEC for 3 months	SF	Wo
6	21/ M	Plaque psoriasis	Obesity	-	SEC for 12 months	SF	Dif tre
7	35/ M	Plaque psoriasis	DYS, HTN	-	SEC for 12 months	SF	Wo
8	45/ M	Plaque psoriasis	DYS, HTN	-	SEC for 12 months	SF	Wo
9	22/ M	Plaque psoriasis	-	-	SEC for >12 months	SF	Dif tre

*SF: secondary failure; PF: primary failure; PASI: Psoriasis Area and Severity Index; GPP: General Pustular Psoriasis; DM: diabetes mellitus; DYS: dyslipidemia; HTN: hypertension.

Conclusion

Intra-class switching among IL-17A inhibitors may provide clinical benefit despite similar mechanisms of action, likely due to structural and epitope-binding differences. SEC and IXE both neutralize IL-17A homodimers and IL-17A/F heterodimers; however, IXE exhibits higher binding affinity to IL-17A, potentially resulting in more potent and sustained pathway inhibition. In this case series, patients with secondary loss of response to SEC frequently achieved remission after switching to IXE. Variations in molecular structure, pharmacokinetics, and dosing regimens may further enhance therapeutic consistency. Additionally, differences in receptor interactions may contribute to variable clinical responses. These findings support intra-class IL-17A inhibitor switching as a rational and effective strategy in patients with refractory psoriasis. The inclusion of nine patients reflects real-world

experience and aims to illustrate the clinical utility of intra-class switching in a defined subset of psoriasis cases. Limited biologic availability in certain settings and the relatively recent adoption of this strategy contribute to the scarcity of large-scale data. Although our findings are consistent with prior evidence supporting IL-17A inhibitor switching, larger, prospective studies are required to improve treatment guidelines.

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Abstract N°: 1223

Concomitant Treatment with Ixekizumab and Tirzepatide According to Demographics and Disease Characteristics for Patients with Psoriasis and Overweight or Obesity: Subgroup Analyses From the TOGETHER-PsO Randomized Trial

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Introduction

A high proportion of patients with moderate-to-severe psoriasis (PsO) fail to achieve complete skin clearance despite treatment with biologic therapies. A key barrier is comorbid overweight/obesity, present in up to 60-78% of patients. Both conditions share chronic, immune-mediated inflammatory pathways, and dermatological expert consensus recommends incorporating weight management into PsO care. The innovative TOGETHER-PsO clinical trial demonstrated a higher rate of complete skin clearance when patients with moderate-to-severe PsO and overweight/obesity were treated with ixekizumab (IXE) concomitantly with tirzepatide (TZP) versus IXE alone. Here, we report secondary analyses from the TOGETHER-PsO trial examining complete skin clearance and quality of life across clinically relevant subgroups.

Materials and Methods

TOGETHER-PsO (NCT06588283) is a Phase 3b, randomized, open-label, US-based, 52-week trial in adults with moderate-to-severe plaque PsO and either overweight (body mass index [BMI] ≥27 to <30 kg/m^2) with at least one weight-related comorbidity or obesity (BMI ≥30 kg/m^2). Eligible participants had a Psoriasis Area and Severity Index (PASI) ≥12, a static Physician Global Assessment (sPGA) ≥3, and a body surface area (BSA) ≥10%. Participants were randomized 1:1 to receive IXE or IXE+TZP at FDA-approved doses. Pre-specified subgroup analyses were performed for PASI 100 and DLQI (0,1) at Week (W) 36: sex (male/female) and baseline disease characteristics (disease duration [≤2 years versus >2 years, ≤10 years vs >10 years]; treatment history [naïve, conventional systemic experienced, and advanced therapy experienced]; disease severity [sPGA 3 "moderate" vs sPGA 4 "severe"], and baseline BMI (<35 vs ≥35-<40 vs ≥40). Missing PASI 100 and DLQI (0,1) values were handled using multiple imputation. G-computation based on logistic regression was performed by subgroup with treatment, screening BMI category, sex, and treatment history as factors in the logistic regression model.

Results

A total of 274 participants were randomized to IXE+TZP (n=138) and IXE treatment arms (n=136), of whom 231 (84.3%) completed treatment. The PASI 100 and DLQI (0,1) response rates at W36 were 40.6% (in IXE+TZP vs 29.0% in IXE alone; p<0.05) and 71.7% (in IXE+TZP vs 58.3% in IXE alone; p<0.05), respectively. No significant treatment-by-subgroup interactions were detected for any baseline characteristic, indicating that the incremental benefit of IXE+TZP relative to IXE alone in achieving PASI 100 was consistent across subgroups for both participant demographics and illness characteristics (Table 1). Similarly, there were no significant interactions between subgroups and treatment arms for DLQI (0,1), except for the sex subgroup: male participants achieved greater improvement in DLQI (0,1), while there was no difference between treatment arms among female participants.

Table 1. Summary of results

Baseline demographics and disease characteristics[a]			
	Participants		
	Ixekizumab (n=136)	**Ixekizumab plus tirzepatide (n=138)**	**Total (N=274)**
Age, years, mean (SD)	45.7 (12.5)	45.6 (13.0)	45.6 (12.7)
Sex, n (%)			
Female	61 (44.9)	62 (44.9)	123 (44.9)
Male	75 (55.1)	76 (55.1)	151 (55.1)
Screening BMI, kg/m², mean (SD)	39.2 (7.9)	39.3 (10.2)	39.2 (9.1)
PASI 100 subgroup analysis	**Response Rate at Week 36 (% [95% CI])[b]**		
	Ixekizumab (n=136)	**Ixekizumab plus tirzepatide (n=138)**	**Interaction p-value[b]**
Sex			
Female, n=123 (44.9%)	29.7 (18.0, 41.5)	35.4 (23.3, 47.6)	0.377
Male, n=151 (55.1%)	28.4 (18.1, 38.7)	44.8 (33.4, 56.3)	
Disease duration			
≤2 years, n=35 (12.8%)	22.0 (-0.8, 44.9)	51.8 (29.2, 74.5)	0.293
>2 years, n=239 (87.2%)	29.8 (21.6, 38.0)	38.6 (29.6, 47.5)	
≤10 years, n=137 (50.0%)	31.8 (20.2, 43.3)	39.5 (28.1, 50.9)	0.491
>10 years, n=137 (50.0%)	26.2 (15.8, 36.6)	42.3 (30.1, 54.5)	
Treatment history			
Advanced therapy naïve, n=180 (65.7%)	32.4 (22.5, 42.4)	42.1 (31.9, 52.3)	0.600
Advanced therapy experienced, n=94 (34.3%)	23.1 (11.1, 35.1)	37.3 (22.7, 51.8)	
Systemic treatment naïve, n=154 (56.2%)	34.1 (23.4, 44.8)	41.5 (30.3, 52.7)	0.695
Conventional systemic experienced, n=26 (9.5%)	20.4 (-5.3, 46.0)	44.5 (17.7, 71.3)	
Advanced therapy experienced, n=94 (34.3%)	23.1 (11.1, 35.1)	37.3 (22.7, 51.8)	
Baseline BMI			
BMI <35, n=105 (38.3%)	25.0 (12.4, 37.5)	51.2 (37.9, 64.5)	0.139
BMI ≥35-<40, n=62 (22.6%)	36.3 (19.6, 53.1)	29.0 (11.8, 46.2)	
BMI ≥ 40, n=107 (39.1%)	30.5 (18.3, 42.7)	33.5 (20.1, 47.0)	
sPGA			
3 (moderate), n=181 (66.1%)	25.4 (16.2, 34.6)	41.0 (30.8, 51.1)	0.324
4 (severe), n=93 (33.9%)	35.6 (21.7, 49.5)	39.8 (25.2, 54.3)	
DLQI (0,1) subgroup analysis	**Response Rate at Week 36 (% [95% CI])[b]**		
	Ixekizumab (n=129)	**Ixekizumab plus tirzepatide (n=135)**	**Interaction p-value[b]**
Sex			
Female, n=121 (45.8%)	64.7 (51.3, 78.2)	60.6 (47.4, 73.7)	0.028
Male, n=143 (54.2%)	47.1 (35.0, 59.1)	71.8 (60.6, 83.0)	
Disease duration			
≤2 years, n=34 (12.9%)	26.6 (-0.83, 54.0)	66.4 (43.8, 89.0)	0.155
>2 years, n=230 (87.1%)	58.6 (49.2, 67.9)	66.7 (57.5, 76.0)	
≤10 years, n=131 (49.6%)	47.7 (34.0, 61.4)	70.1 (58.4, 81.7)	0.159
>10 years, n=133 (50.4%)	60.9 (48.7, 73.0)	64.0 (51.6, 76.4)	
Treatment history			
Advanced therapy naïve, n=175 (66.3%)	62.6 (51.4, 73.8)	67.6 (57.3, 78.0)	0.209
Advanced therapy experienced, n=89 (33.7%)	41.3 (26.3, 56.4)	65.3 (50.0, 80.7)	
Systemic treatment naïve, n=149 (56.4%)	66.6 (54.6, 78.6)	69.3 (58.0, 80.6)	

Conventional systemic experienced, n=26 (9.8%)	33.5 (-1.09, 68.1)	59.8 (32.9, 86.8)	0.340
Advanced therapy experienced, n=89 (33.7%)	41.3 (26.3, 56.4)	65.3 (50.0, 80.7)	
Baseline BMI			
BMI <35, n=100 (37.9%)	51.7 (35.8, 67.7)	66.3 (52.7, 80.0)	0.630
BMI ≥ 35-<40, n=59 (22.3%)	62.1 (43.1, 81.0)	62.3 (43.1, 81.5)	
BMI ≥ 40, n=105 (39.8%)	55.0 (40.6, 69.4)	69.3 (55.3, 83.3)	
sPGA			
3 (moderate), n=173 (65.5%)	53.7 (42.0, 65.3)	67.8 (57.0, 78.5)	0.586
4 (severe), n=91 (34.5%)	58.3 (43.2, 73.5)	64.4 (49.3, 79.5)	

[a]Data from modified intent-to-treat population. Subgroup analyses are exploratory; nominal p-values not adjusted for multiple comparisons. Adjusted response rates based on G-computation with treatment and prespecified covariates (sex, screening BMI category, and treatment history [advanced therapy naive vs experienced], excluding the subgroup variable) as factors in the logistic regression model. Hypothetical estimand evaluated treatment effects using data prior to discontinuation of trial drug or use of prohibited medication. Missing values were handled using multiple imputation for PASI 100 and DLQI (0,1). [b]p-value for treatment-by-subgroup interaction (Type 3 Wald test).
Abbreviations: BMI, body mass index; CI, confidence interval; DLQI, Dermatology Life Quality Index; N, number of participants in the modified intent-to-treat population; n, number of participants in the subgroup at baseline (DLQI (0,1) analysis includes only participants with baseline DLQI >1; PASI, Psoriasis Area and Severity Index; SD, standard deviation; SE, standard error; sPGA, static Physician Global Assessment.

aData from modified intent-to-treat population. Subgroup analyses are exploratory; nominal p-values not adjusted for multiple comparisons. Adjusted response rates based on G-computation with treatment and prespecified covariates (sex, screening BMI category, and treatment history [advanced therapy naive vs experienced], excluding the subgroup variable) as factors in the logistic regression model. Hypothetical estimand evaluated treatment effects using data prior to discontinuation of trial drug or use of prohibited medication. Missing values were handled using multiple imputation for PASI 100 and DLQI (0,1). bp-value for treatment-by-subgroup interaction (Type 3 Wald test). Abbreviations: BMI, body mass index; CI, confidence interval; DLQI, Dermatology Life Quality Index; N, number of participants in the modified intent-to-treat population; n, number of participants in the subgroup at baseline (DLQI (0,1) analysis includes only participants with baseline DLQI >1; PASI, Psoriasis Area and Severity Index; SD, standard deviation; SE, standard error; sPGA, static Physician Global Assessment.

Conclusions

In this exploratory subgroup analysis of the TOGETHER-PsO trial, participants treated with concomitant therapy for both their PsO and overweight/obesity demonstrated significantly better outcomes at W36 than those treated with IXE alone, regardless of demographics and baseline disease characteristics. Similarly, participants treated with concomitant therapy were more likely to report that their skin disease no longer had an impact on their quality of life than those receiving IXE alone. This advantage was consistent across different subgroups, with a numerically larger benefit observed in males. Overall, these subgroup analyses corroborate the primary findings that patients with PsO and overweight/obesity benefit with concomitant treatment relative to ixekizumab alone, thus demonstrating the benefit of addressing overweight/obesity within the care of psoriatic disease to optimize disease control and overall health.

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Abstract N°: 1238

Effectiveness and Patient-Reported Outcomes of CAL/BDP PAD-Cream in Adults with Mild-to-Moderate Psoriasis in a Real-World setting: Results from the ADHER-TOP Study

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Introduction
Topical therapies remain a cornerstone in psoriasis management. Fixed-dose combination of calcipotriol and betamethasone dipropionate (CAL/BDP) is recommended as first-line option for mild-to-moderate psoriasis. In phase 3 studies, CAL/BDP cream based on polyaphron dispersion (PAD) technology demonstrated superior efficacy, improved convenience and a more rapid onset of action compared with CAL/BDP gel. The ADHER-TOP study evaluated adherence as primary endpoint and assessed effectiveness and patient-reported outcomes (PROs) as secondary endpoints of CAL/BDP PAD-cream in patients with mild-to-moderate plaque psoriasis under real-world conditions. This analysis focuses on secondary assessments of effectiveness and PROs.

Materials and Methods
ADHER-TOP was a real-world evidence, prospective, observational, single-arm, multicentre study including adults with mild-to-moderate plaque psoriasis treated with CAL/BDP PAD-cream in Spain. CAL/BDP PAD-cream was prescribed as monotherapy in routine clinical practice, according to the Summary of Product Characteristics, prior to invitation to participate. Eligible patients were consecutively enrolled without any influence on the prescribed treatment. Effectiveness was evaluated at Week (W) 8 through the Physician Global Assessment (PGA), with evaluation of the scalp if affected (scalp-PGA), and the Psoriasis Area and Severity Index (PASI). PROs included Dermatology Life Quality Index (DLQI), Psoriasis Treatment Convenience Scale (PTCS), Patient Preference Questionnaire (PPQ) and Treatment Satisfaction Questionnaire for Medication Version 9 (TSQM-9). All data were collected per routine clinical practice, with no additional diagnostic or therapeutic procedures, consistent with the observational nature of the study. Analyses were conducted on the full analysis set (FAS) based on observed cases. No imputation for missing data was done.

Results
A total of 55 patients were included in the FAS, with a mean (standard deviation [SD]) age of 50.1 (15.4) years and the majority were male (65.5%). Mean (SD) body mass index was 26.1 (4.7) kg/m2. At baseline (BL), 41.8% of patients presented with scalp involvement and none had concomitant psoriatic arthritis. By W8, 80.8% of patients achieved controlled disease (PGA score 0–1), including 80.0% of those with scalp involvement (scalp-PGA score 0–1). Moreover, 61.5% achieved PGA success and 66.7% achieved scalp-PGA success (score 0–1 with ≥2-point improvement from BL). Significant reductions in mean (SD) PASI scores were observed from BL to W8 (3.4 [2.0] vs. 0.8 [1.1]; $p<0.001$). At W8, 90.4% of patients had a PASI score ≤2. Mean (SD) DLQI scores improved from 8.6 (5.2) at BL to 1.5 (3.3) at W8 (mean [SD] percentage change: -80.2% [30.6]; $p<0.001$). At W8, 70.8% of patients had a

DLQI score ≤1. Mean PTCS overall satisfaction scores (ranging from 0 to 10) at W1 and W8 were 7.9 and 8.7, indicating high convenience with CAL/BDP PAD-cream during the study. When patients compared CAL/BDP PAD-cream with their previous topical treatments through the PPQ at W8, most patients scored positive responses (i.e., 'agree' and 'strongly agree') indicating a preference for CAL/BDP PAD-cream (83.3%) and finding CAL/BDP PAD-cream easier to use (83.3%), more effective (79.2%) and with fewer side effects (62.5%). Overall satisfaction assessed by the TSQM-9 was high, with 89.4% of patients being satisfied, very satisfied or extremely satisfied at W8. CAL/BDP PAD-cream also demonstrated a favourable safety profile, with only one related adverse event (moderate desquamation) being reported.

Conclusions

In a real-world setting, CAL/BDP PAD-cream demonstrated high effectiveness and favourable PROs in adults with mild-to-moderate plaque psoriasis in the ADHER-TOP study. Patients reported high rates of disease control (including scalp) and reductions in psoriatic lesions after 8 weeks, as well as improved quality of life, treatment convenience, preference and satisfaction.

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Abstract N°: 1238

Breaking therapeutic barriers: rapid efficacy of calcipotriol/betamethasone cream (Wynzora®) in psoriasis patients unwilling to initiate systemic therapy

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Introduction

Psoriasis is a chronic inflammatory disease with a substantial psychological burden, frequently associated with anxiety and depression, affecting up to 32% of patients (Pujol et al, 2013). Despite the proven efficacy of systemic treatment, fear of adverse effects, comorbidities or previous oncologic history often lead to treatment refusal, creating a significant unmet clinical need. We report two cases of patients with moderate plaques psoriasis treated with topical calcipotriol/betamethasone cream (Wynzora®) who declined systemic or biologic therapies in order to highlight the effectiveness in this profile of patients.

Case Presentation

Case 1: A 57-year-old woman with multiple comorbidities (type 2 diabetes, obesity, prior bariatric surgery and anxiety-depressive disorder) presented with plaque psoriasis on elbows, abdomen, and knees, refractory to phototherapy and calcipotriol/betamethasone foam. The patient refused systemic or further phototherapy. Treatment with Wynzora® once daily for 20 days led to marked clinical improvement without need for systemic therapy.

Case 2: A 60-year-old woman with history of breast cancer, hypertension, and dyslipidemia had long-standing psoriasis previously controlled with secukinumab. After her oncologic diagnosis, she refused injectable or immunomodulatory treatments. Due to incompatibility with phototherapy, Wynzora® once daily for 30 days was initiated, achieving complete clearance.

Conclusion

Wynzora® cream demonstrated rapid and clinically meaningful efficacy in patients unwilling to initiate systemic treatments. These cases underscore the importance of flexible, patient-centered strategies and position optimized topical therapy as a valuable bridge or alternative in complex, high-concern populations.

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Abstract N°: 1268

Efficacy of upadacitinib in palmoplantar psoriasis: addressing a therapeutic challenge

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Introduction

Palmoplantar psoriasis (PPP) is a challenging localization to manage, particularly in the presence of atopic features or eczematized psoriasis.

Materials and Methods

We report an ongoing case series of six patients with moderate-to-severe PPP treated with upadacitinib offlabel in our department between 2024 and 2026.

Results

The mean PPP severity index (PP-PASI) was 24.85 (11.34), Dermatology Life Quality Index (DLQI) 17.17 (3.66), pruritus NRS 6.3 (2.66), and disease duration 16.17 years (12.25). Four patients exhibited eczema in other locations or atopic features. Patch testing was performed in three cases and yielded negative results. The mean number of prior systemic treatments was 6.5 (2.35), of which 3.7 (2.25) were biologics. The initial dose of upadacitinib was 30 mg daily in four patients (subsequently reduced to 15 mg) and 15 mg daily in two. Treatment was well tolerated, with one case of hypercholesterolemia and one of headache, and no treatment discontinuations. Mean follow-up was 42.33 weeks (12.67), and time to clinical improvement was 25.8 days (14.47). All patients achieved PP-PASI 0, with rapid improvement in pruritus (within 24–48 hours in one case), except for one patient with residual pruritus (NRS 3).

Conclusions

Palmoplantar psoriasis is a challenging subtype of psoriasis characterized by complex and life-altering disease presentations despite limited body surface area involvement. It is associated with significant morbidity, as painful fissures and marked hyperkeratosis lead to intense pruritus, functional impairment and social disability. Moreover, it represents one of the most treatment-refractory localizations, where topical therapies are frequently insufficient and the clinical course is often recalcitrant. In this setting, traditional systemic agents such as cyclosporine, methotrexate and retinoids, as well as emerging TYK2/JAK inhibitors, remain valuable therapeutic options.

Upadacitinib is a selective JAK1 inhibitor approved for multiple immune-mediated inflammatory diseases, including atopic dermatitis and psoriatic arthritis. Its broader mechanism of action may be beneficial in heterogeneous immunological profiles involving pathways such as IL-17C (pruritus) and IL-17E (Th2), emerging as a promising alternative in recalcitrant and/or eczematized PPP, with or without atopic features.

Four patients in our series displayed clinical features of eczematized psoriasis. This complex variant of plaque psoriasis—characterized by intense pruritus, spongiosis, and reduced response to otherwise effective biologics—accounts for 5–10% of cases and occurs particularly in palmoplantar locations. A total of 23 cases successfully treated with upadacitinib have been reported, most involving psoriasis–atopy overlap.

While our series included patients without eczematous features or atopic overlap, upadacitinib proved equally effective across the entire cohort. We observed a rapid and complete clinical response in less than one month, with a significant and early reduction in pruritus. Consequently, upadacitinib emerges as a highly effective therapeutic option for recalcitrant palmoplantar psoriasis, offering a rapid solution for patients with a high disease burden and poor quality of life.

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Abstract N°: 1271

Systemic Immune-Inflammation Index (SII) and systemic inflammation response index (SIRI) trend in psoriatic patients treated with brodalumab: a real-life pilot study

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Introduction
The Systemic Immune-Inflammation Index (SII) is a marker that can be used to assess systemic inflammation in psoriasis and potentially predict its severity. Less evidence is available for the systemic inflammation response index (SIRI). Data on changes in SII and SIRI during biological treatment are scarce. In this study, we investigate the trend of inflammation markers in patients with severe psoriasis treated with brodalumab.

Materials and Methods
204 patients with moderate-to-severe psoriasis treated with brodalumab were followed up for 2 years, and retrospective blood sample analysis was performed to calculate SII and SIRI at baseline, 1 year, and 2 years of treatment.

Results
Forty-five patients have retrievable data for SII and SIRI at baseline. SII decreases from 673.4 to 543.1 (19% of reduction), and SIRI from 2.6 to 1.3 (50%) at baseline and two years of treatment. No significant correlation among mean PASI, SII, and SIRI values at each time point was found. Bio-experienced patients and psoriatic arthritis patients showed a similar percentage of cut-off points exceeding those of their counterparts, also evaluating absolute value of the indices this patient presents a higher inflammatory status without reaching significant differences at each time points. Overweight and obese patients had higher SII and SIRI levels than normal weight patients at all time points

Conclusions
In general, in our population, a mean reduction of 50% of SIRI and almost 20% of SII index values during brodalumab treatment was observed in psoriatic patients. Prospective trials with larger samples are mandatory to better elucidate our observations.

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Abstract N°: 1273

Superior Clinical and Economic Value of IL-23 InhibitorsVersus Adalimumab Biosimilars in Plaque Psoriasis

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Introduction

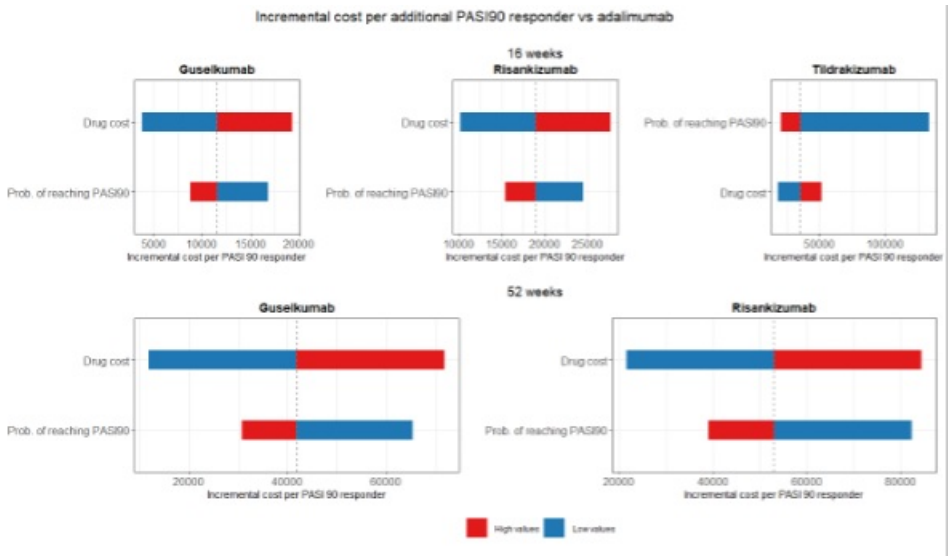
Interleukin (IL)-23 inhibitors have markedly improved the management of moderate-to-severe plaque psoriasis, enabling high rates of sustained skin clearance. Despite their increasing use, real-world data integrating both clinical effectiveness and economic impact compared with commonly prescribed first-line biologics, such as adalimumab biosimilars, remain limited.

Materials and Methods

We conducted a retrospective bicentric observational study including adult patients with moderate-to-severe psoriasis treated with IL-23 inhibitors (guselkumab, risankizumab, tildrakizumab) or adalimumab biosimilars for at least 16 weeks. Clinical effectiveness was assessed using Psoriasis Area and Severity Index (PASI)90 response rates and number needed to treat (NNT) at weeks 16 and 52, using an as-observed approach. Cost-effectiveness was evaluated by estimating incremental cost per PASI90 responder based on drug acquisition costs. Deterministic and probabilistic sensitivity analyses were performed to assess the robustness of the findings.

Results

A total of 616 patients were included (mean age 51.7±15.2 years; 50.3% female, 49.7% male). Overall, 200 patients received guselkumab, 176 risankizumab, 75 tildrakizumab, and 165 adalimumab biosimilars. PASI90 response rates at week 16 were 61.0% for guselkumab, 69.3% for risankizumab, 54.7% for tildrakizumab, and 39.4% for adalimumab biosimilars. At week 52, PASI90 was achieved by 82.4%, 84.1%, 77.6%, and 67.5% of patients, respectively. Risankizumab showed the lowest NNT at week 16 (3.34; 95% CI 2.50-5.04), maintained at week 52 (6.00; 95% CI 3.62-17.49). Guselkumab demonstrated an NNT of 4.63 at week 16 and 6.71 at week 52. All IL-23 inhibitors showed superior effectiveness compared with adalimumab biosimilars. In cost analyses, guselkumab was associated with the lowest incremental cost per PASI90 responder at both time points (€11,552.87 at week 16; €41,820.60 at week 52), whereas risankizumab showed higher incremental effectiveness but greater costs. Sensitivity analyses confirmed the robustness of these results.



Tornado diagram showing the variation in incremental cost per PASI90 responder with variation in the value of parameters. All treatments are compared against adalimumab as the reference comparator

Conclusions

IL-23 inhibitors demonstrate superior clinical effectiveness compared with adalimumab biosimilars in real-world practice. Among them, risankizumab shows the highest efficacy, while guselkumab provides the most favorable cost-effectiveness profile, supporting optimized treatment strategies in moderate-to-severe psoriasis.

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Abstract N°: 1279

Vunakizumab Achieve Complete Remission of Severe Plaque Psoriasis in a 25-Year-Old Male with HIV Infection: A Case Report

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Introduction

The management of severe plaque psoriasis is particularly challenging in patients co-infected with human immunodeficiency virus (HIV), due to conflicting treatment goals that may potentially lead to HIV reactivation. This article reports a case of severe plaque psoriasis with HIV co-infection successfully treated with vunakizumab, a monoclonal antibody targeting interleukin-17A (IL-17A).

Case Presentation

A 25-year-old male had extensive scaly erythema, papules, and plaques for 2 years, confirmed as psoriasis, with prior ineffective treatments. He was diagnosed with HIV 4 months earlier and was on antiretroviral therapy. 2 months prior, his HIV RNA was <20 copies/mL and CD4+ count was >300/μL. Dermoscopy supported severe plaque psoriasis. The physical exam showed well-demarcated plaques with thick scaling. Treatment was subcutaneous vunakizumab, initially 240 mg q2w for 4 weeks, then q4w. Antiretroviral therapy continued. Efficacy was assessed via Psoriasis Area and Severity Index (PASI), Body Surface Area (BSA), Investigator's Global Assessment (IGA), and Dermatology Life Quality Index (DLQI).

At baseline, the patient had a PASI score of 29.4, BSA of 51%, IGA of 4, and DLQI of 22, indicating severe disease and impaired quality of life. His CD4+ count was 356/μL, and HIV RNA was below 20 copies/mL. After two weeks, he achieved PASI 88, with a score of 3.4, BSA 9.9%, IGA 1, and DLQI 6. Significant clinical improvement was observed. By week 8, he reached PASI 100, with a score of 0, BSA 0%, IGA 0, and DLQI 1 as shown in Figure 1. No plaques or scales were visible. CD4+ increased to 482/μL, and HIV RNA stayed undetectable. No treatment-related adverse events occurred during the treatment period, and the HIV infection did not worsen.



Figure 1. Clinical photographs of psoriatic lesions at baseline (W0), Week 4, and Week 8. At W0, widespread erythematous, indurated, and scaly plaques were present across the scalp, trunk, and extremities. By W2, marked flattening and reduction of erythema were evident. By W8, complete skin clearance was achieved with only residual pigmentation, and no active lesions were present.

Conclusion

Vunakizumab led to PASI 100 in a patient with severe plaque psoriasis and HIV co-infection within eight weeks, while maintaining HIV stability and a favorable safety profile.As HIV-positive patients are often excluded from trials, real-world evidence like this case backs vunakizumab as a feasible, effective choice for this refractory group.

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Abstract N°: 1330

Early PASI Response Predicts Long-Term Complete Skin Clearance with Risankizumab: A Five-Year Real-World ROC Analysis

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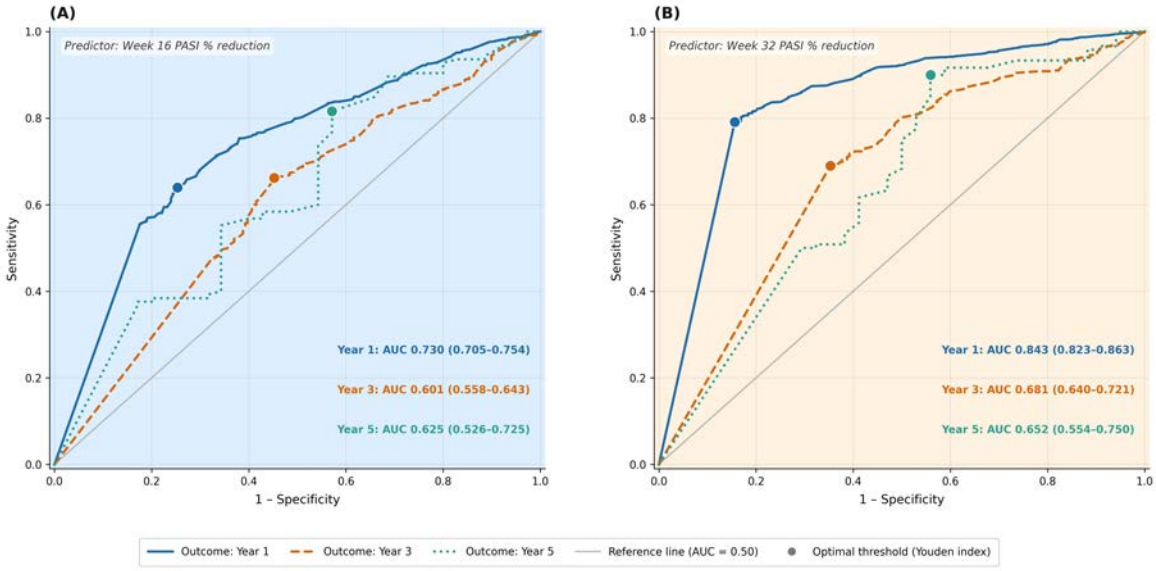
Introduction
Risankizumab, a selective Interleukin(IL)-23 inhibitor, has demonstrated sustained efficacy in moderate-to-severe plaque psoriasis. However, in everyday clinical practice, it is still unclear how well early improvements in terms of PASI (Psoriasis Area and Severity Index) at weeks 16 (W16) and 32 (W32) can predict who will achieve long-term complete skin clearance (PASI 100) at years 1, 3, and 5 (Y1, Y3, Y5).

Materials and Methods
We conducted a multicenter, retrospective, real-world cohort study enrolling 1883 adults with moderate-to-severe psoriasis treated with risankizumab at 15 Italian dermatology centers between April 2019 and December 2025. Receiver Operating Characteristic (ROC) analysis was used to evaluate how accurately PASI percentage reduction at W16 and W32 predicted PASI 100 at Y1, Y3 and Y5. Optimal cut-off values were identified using the Youden index. Pairwise comparisons of the AUC (Area Under the Curve) were carried out with the DeLong method for correlated ROC curves. In addition, we conducted a longitudinal stratified analysis of PASI 100 rates at each yearly time-point (Y1–Y5) according to four response groups defined by W16 PASI score: PASI 0, PASI 1-2, PASI 3-5, and PASI 6-10.

Results
PASI percentage reduction at W32 was a better predictor of PASI 100 at Y1 than W16. The AUC at W32 was 0.843 (95% CI 0.820–0.867) compared with 0.753 (95% CI 0.726–0.780) for W16 ($p < 0.001$). Complete skin clearance at W32 emerged as the optimal threshold (sensitivity 72.1%, specificity 84.2%). W32 PASI response also outperformed W16 for predicting PASI 100 at Y3 (AUC 0.681 vs. 0.621; $p < 0.001$), while at Y5 (N = 154), AUC values for W32 and W16 were closer and no longer significantly different (0.652 vs. 0.614; $p = 0.35$).
The longitudinal stratified analysis showed a progressive *catch-up phenomenon* over time. Patients with suboptimal W16 responses (PASI 3-5 and PASI 6-10) showed lower PASI 100 rates at Y1 (63.0% and 35.1%, respectively) but progressively improved with ongoing treatment. By Y5, their PASI 100

rates approached those of patients who had a near-complete response at W16.



ROC curves for W16 (A) and W32 (B) PASI percentage reduction as predictors of PASI 100 at Y1, Y3 and Y5. The optimal threshold (Youden index) is indicated by a filled circle on each curve. AUC values are shown within each panel. AUC: Area Under the Curve; CI: Confidence Interval; PASI: Psoriasis Area and Severity Index. Y1/Y3/Y5: Year 1/3/5; W16: Week 16; W32: Week 32

Conclusions

In our real-world multicenter study, PASI percentage reduction at W32 was the strongest predictor of complete skin clearance at Y1 and Y3 in patients treated with risankizumab. Achieving complete skin clearance at W32 represented the optimal predictive threshold. Importantly, many patients with only partial responses at W16 experienced progressive improvement and reached similar PASI 100 rates over long-term follow-up *(catch-up phenomenon*). These findings support continuing risankizumab beyond W16 in partial responders, rather than switching treatment prematurely.

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Abstract N°: 1335

Work productivity impairment in generalized pustular psoriasis: a real-world analysis of its association with quality of life and disease severity

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Introduction
Generalized pustular psoriasis (GPP) is a rare and severe inflammatory skin disease associated with substantial physical, psychological, and social burden. Although the impact of GPP on quality of life has been increasingly recognized, its effect on work productivity and daily activities remains insufficiently characterized. This study aimed to evaluate work productivity impairment in patients with GPP and to examine its associations with clinical severity and dermatology-specific quality of life in a real-world setting.

Materials and Methods
We retrospectively analyzed responses to questionnaire and clinical data from 65 patients with GPP and compared Work Productivity and Activity Impairment (WPAI) scores with those of 360 healthy controls. WPAI domains included absenteeism, presenteeism, overall work impairment, and activity impairment. Clinical severity was assessed using physician-reported skin severity indices, including total erythema extent, erythema with pustules, and edema. Quality of life was evaluated using the Dermatology Life Quality Index (DLQI). Comparisons between patients with GPP and healthy controls were performed using the Wilcoxon rank-sum test. Spearman's rank correlation coefficients were calculated to assess relationships between WPAI domains, clinical severity, and DLQI. Multivariate regression analyses were also performed to evaluate the independent association of clinical severity and DLQI with WPAI outcomes.

Results
A total of 65 patients with GPP (36 males and 29 females; mean age 51.97 ± 14.01 years) were included. Compared with healthy controls, patients with GPP showed significantly greater impairment in all four WPAI domains. Presenteeism was significantly higher in the GPP group than in healthy controls (median 20 vs 10, $p = 7.89 \times 10^{-7}$). Overall work impairment was also significantly higher in patients with GPP (median 20 vs 10, $p = 7.16 \times 10^{-7}$), and activity impairment showed the largest difference between the groups (median 30 vs 10, $p = 4.28 \times 10^{-11}$). Although the median absenteeism score was 0 in both groups, the difference remained statistically significant ($p = 5.74 \times 10^{-7}$), indicating a greater proportion of work absence in a subset of GPP patients.

Clinical severity indices did not show significant correlations with WPAI domains. In contrast, DLQI showed significant positive correlations with all WPAI domains, with the strongest association observed for activity impairment. In multivariate analyses adjusted for clinical severity, DLQI remained significantly associated with presenteeism ($\beta = 1.87$, $p = 0.00203$), overall work impairment ($\beta = 2.01$, $p = 0.00373$), and activity impairment ($\beta = 3.44$, $p = 3.36 \times 10^{-7}$), whereas clinical severity was not significantly associated with these outcomes. Although not significant ($\beta = 1.37$, $p = 0.056$), absenteeism showed a tend to be correlated with DLQI.

WPAI domain	GPP patients, median	Healthy controls, median	Difference	p value
Absenteeism	0	0	0	5.74 × 10^-7
Presenteeism	20	10	10	7.89 × 10^-7
Overall work impairment	20	10	10	7.16 × 10^-7
Activity impairment	30	10	20	4.28 × 10^-11

Table. Comparison of WPAI domains between patients with GPP and healthy controls: Values are shown as medians. WPAI, Work Productivity and Activity Impairment; GPP, generalized pustular psoriasis. Comparisons were performed using the Wilcoxon rank-sum test.

Conclusions

Patients with GPP experience substantial impairment in work productivity and daily activities compared with healthy controls. This burden appears to be more strongly associated with patient-reported quality of life than with physician-assessed clinical severity. These findings suggest that conventional clinical severity assessments alone may underestimate the real-world burden of GPP and support the importance of incorporating patient-reported outcomes into the comprehensive evaluation of disease impact.

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Abstract N°: 1338

Cutaneous adverse effects of Tumor necrosis factor-alpha inhibitor: a case series

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Introduction

Tumor necrosis factor-alpha (TNFα) inhibitors have significantly improved the management of immune-mediated inflammatory diseases. Generally, TNFα inhibitors are well tolerated. However, cutaneous adverse effects are among the most frequently observed complications.

We report four cases illustrating this clinical variability and its therapeutic implications.

Case Presentation

Case 1:

A 54-year-old woman with longstanding ileocolonic Crohn's disease was treated with infliximab (5 mg/kg) in combination with azathioprine. Following the second infusion, she developed an immediate hypersensitivity reaction characterized by generalized urticaria, an erythematous rash, and facial edema, without anaphylactic shock. The course was further complicated by acute pancreatitis, leading to discontinuation of both infliximab and azathioprine. The patient was switched to adalimumab combined with methotrexate, with a favorable outcome.

Cases 2 and 3:

Two males aged 34 and 46 years old, followed for axial spondyloarthritis and treated with adalimumab (40 mg every two weeks) and certolizumab pegol (200 mg every other week), respectively, with no personal or family history of psoriasis, developed erythematous, scaly, well-defined plaques after 18 and 20 weeks of treatment, respectively. Lesions predominantly involved the scalp and flexural areas, with associated palmoplantar involvement. The patients were managed with a topical traitement of combined calcipotriol and betamethasone dipropionate, resulting in favorable clinical outcomes, allowing continuation of the biologic treatment.

Case 4 :

A 54-year-old woman with Crohn's disease and extraintestinal manifestations (axial spondyloarthritis, ocular involvement, and erythema nodosum) was treated with infliximab (5 mg/kg). After the first infusion, she developed cutaneous leukocytoclastic vasculitis confirmed by histology. The immunological workup was unremarkable. The subsequent occurrence of a delayed hypersensitivity reaction after the third infusion led to permanent discontinuation of infliximab. Treatment was switched to adalimumab combined with azathioprine, with favorable evolution.

Discussion

Anti-TNFα agents may induce a broad spectrum of cutaneous adverse events. Our series highlights this

heterogeneity, including acute and delayed hypersensitivity reactions, leukocytoclastic vasculitis, and paradoxical psoriasis. Hypersensitivity reactions may be IgE-mediated or related to mast cell degranulation. Drug-induced vasculitis is rare and typically involves small vessels, resulting from immune complex deposition (TNF–anti-TNF), corresponding to a type III hypersensitivity reaction.

Psoriasis represents the most common paradoxical immune-mediated adverse effect. Clinically, lesions often involve the scalp, flexural areas, and palmoplantar regions, as observed in our patients.

In most cases, particularly in mild to moderate cases, topical treatment is sufficient. While only a few patients require systemic treatment, discontinuation of TNF-alpha inhibitors, or a switch to an alternative biologic agent.

Conclusion

Cutaneous adverse effects associated with anti-TNFα therapy are heterogeneous. Early recognition is essential to optimize therapeutic management and ensure treatment continuity.

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Abstract N°: 1340

Development and Validation of a Machine Learning Model for Early Detection of Psychiatric Comorbidities in Patients with Psoriasis Using Multi-Center Electronic Health Records

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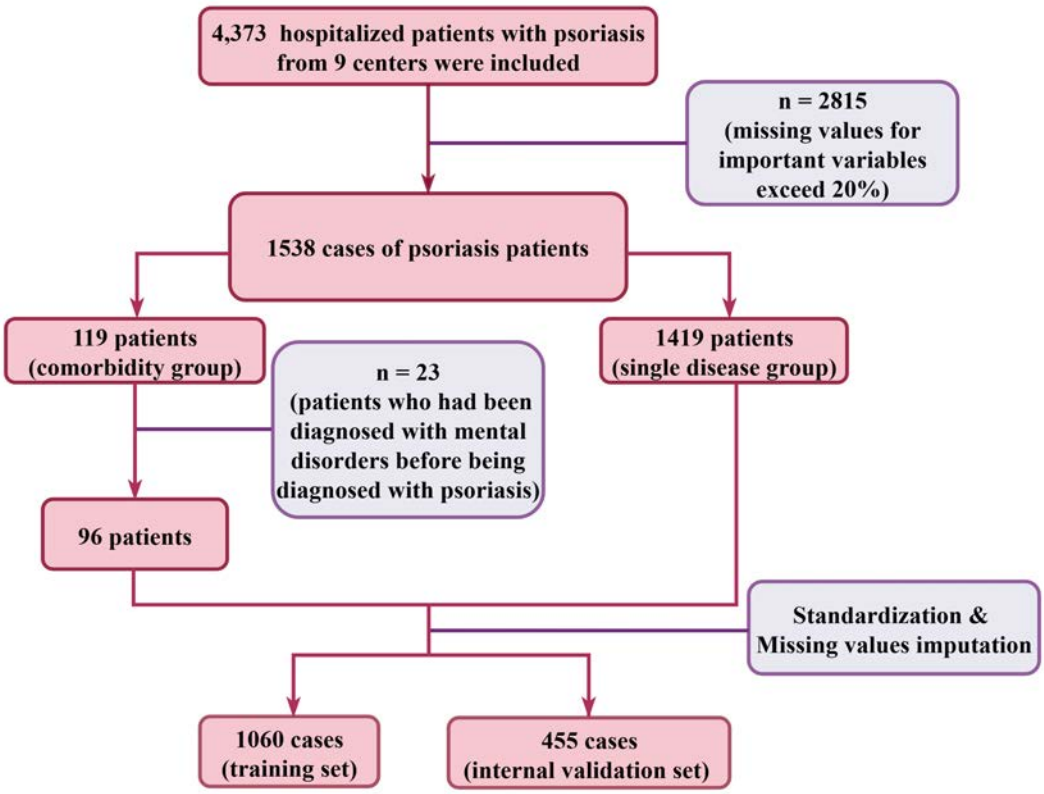
Introduction

Psoriasis is a chronic inflammatory skin disease frequently associated with a range of psychiatric comorbidities, which substantially impair patient quality of life. Currently, there is a lack of objective and efficient tools for the early identification of psychiatric disorders in individuals with psoriasis. This study aimed to leverage multi-center inpatient data to identify early diagnostic markers and to construct a machine learning-based prediction model for the early detection of psychiatric comorbidities in patients with psoriasis.

Materials and Methods

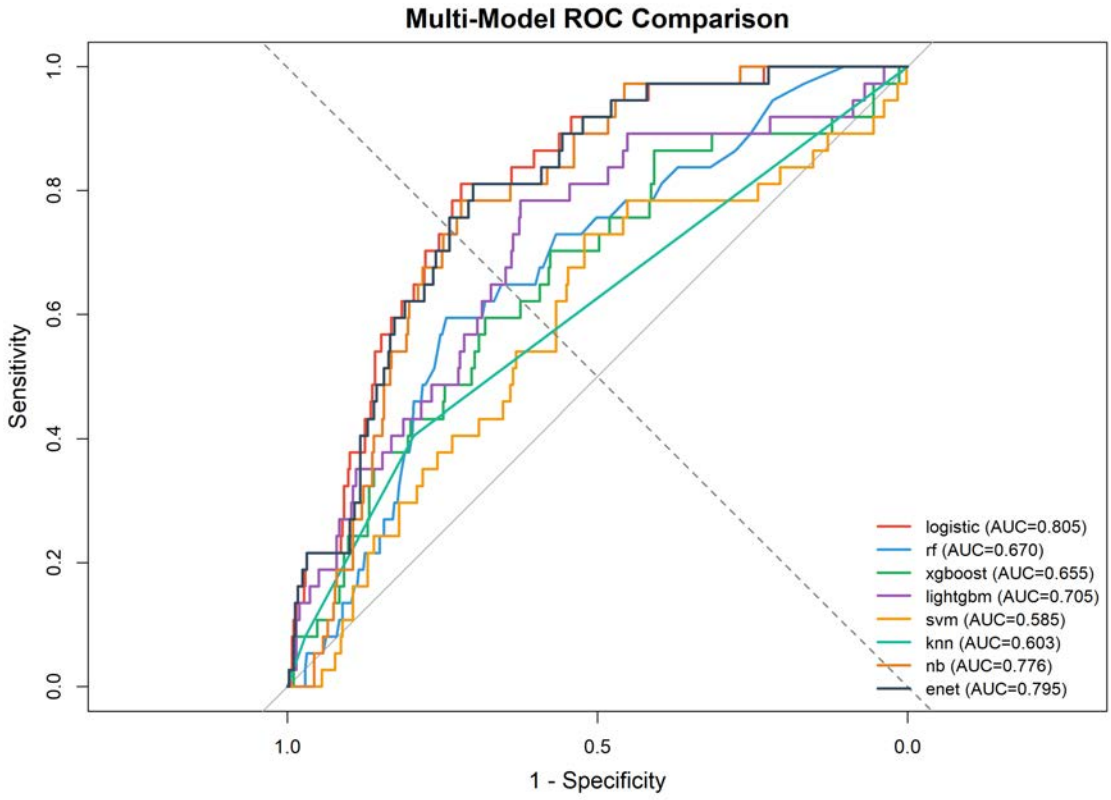
We retrospectively collected clinical data from psoriasis inpatients treated at 9 medical centers between January 1, 2013, and December 31, 2023. The study workflow is illustrated in Fig. 1. Based on the International Classification of Diseases, Tenth Revision (ICD-10) discharge codes, patients were stratified into two groups: a comorbid group (psoriasis, L40, with concomitant mental/behavioral disorders, F00–F99, or sleep disorders, G47) and a psoriasis-only group (L40 alone). Eligible patient data, including demographic characteristics, clinical parameters, and laboratory results, were extracted. Variable selection was performed using univariate analysis ($P < 0.05$) and least absolute shrinkage and selection operator (Lasso) regression. 8 machine learning algorithms were subsequently applied to construct the diagnostic model: logistic regression, random forest (RF), extreme gradient boosting (XGBoost), light gradient boosting machine (LightGBM), support vector machine (SVM), k-nearest neighbors (KNN), naive Bayes (NB), and elastic net. A fixed random seed (100) was used to split the dataset into training ($n = 1060$) and testing ($n = 455$) subsets in a 7:3 ratio. Model performance was internally validated using k-fold cross-validation and 200 bootstrap resamples. Evaluation metrics included the area under the receiver operating characteristic curve (AUC-ROC), calibration curves, and decision curve analysis (DCA).



Study Flowchart: Overview of patient selection, data preprocessing, and model development pipeline.

Results

A total of 1515 patients were included, comprising 1419 in the comorbid group and 96 in the psoriasis-only group. 14 candidate variables were initially considered: white blood cell count, neutrophil count, neutrophil-to-lymphocyte ratio (NLR), neutrophil-monocyte-lymphocyte ratio (NMLR), systemic inflammatory response index (SIRI), systemic immune-inflammation index (SII), lymphocyte count, monocyte-to-lymphocyte ratio (MLR), platelet count, derived neutrophil-to-lymphocyte ratio (dNLR), red blood cell count, sex, and age. After collinearity assessment (excluding variables with variance inflation factor > 5 or correlation coefficient > 0.7) and feature selection via univariate analysis and Lasso regression, 8 variables were retained for modeling: age, dNLR, lymphocyte count, NMLR, sex, SII, platelet count, and neutrophil count. The comparative performance of multiple models is presented in the ROC curves shown in Fig. 2. In the test set, the AUC values for the top-performing models were: logistic regression (0.805), elastic net (0.795), naive Bayes (0.776), and LightGBM (0.705). Bootstrap internal validation yielded a calibrated AUC of 0.7065. SHapley Additive exPlanations (SHAP) analysis identified neutrophil count, sex, NMLR, dNLR, age, platelet count, SII, and lymphocyte count as the most influential predictors.



Multi-Model ROC Comparison: Receiver Operating Characteristic curves of eight different machine learning algorithms evaluated on the test set.

Conclusions

This study successfully developed and validated a machine learning-based diagnostic model for psychiatric comorbidities in psoriasis using multi-center real-world data. The model demonstrated good discriminatory performance, with logistic regression and elastic net exhibiting the highest predictive accuracy. Key predictors included demographic and systemic inflammation markers. This tool may assist in the early identification of psychiatric comorbidities in psoriasis patients, facilitating integrated dermatological-psychiatric care. Further external validation in independent cohorts is warranted to confirm generalizability and clinical utility.

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Abstract N°: 1355

Three-Year Recurrent Cheilitis: Revealing Hidden Disease

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Introduction

Psoriatic involvement of the lips is rare, and sparesly reported. Due to its rarity, clinicians often have a low index of suspicion, and diagnostic delay is common, as lip psoriasis shares overlapping clinical features with other causes of chronic cheilitis. We report a case of persistent chelitis ultimately diagnosed as lip psoriasis following extra-labial biopsy.

Case Presentation

A young male presented with a three-year history of recurrent cheilitis characterized by persistent erythema, fissuring, and scaling of the upper lip involving the commissures. The condition was refractory to multiple topical therapies, with only partial improvement to corticosteroids and tacrolimus prescribed externally. Patch testing was negative.

A comprehensive skin and mucosal examination revealed previously intermittent well-demarcated erythramatous axillary plaques. The axillary lesion was biopsied. Histopathology demonstrated psoriasiform hyperplasia with parakeratosis, consistent with psoriasis. Clinicopathological correlation established the diagnosis of psoriatic cheilitis.

Given the chronicity, functional impact, and incomplete response to topical therapy, escalation to systemic treatment, including biologics, was considered; however, the patient opted to continue topical management.

Conclusion

This case highlights the importance of thorough skin and mucosal examination in patients with chronic or treatment-resistant cheilitis. Lip psoriasis may present in isolation, without obvious cutaneous involvement, making the diagnosis easy to miss. Recognizing this presentation may help reduce diagnostic delay and guide appropriate management.

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Abstract N°: 1387

Reduction of Skin CD8 TRMs in Icotrokinra-Treated Participants With Moderate-to-Severe Plaque Psoriasis: Phase 3 ICONIC-LEAD Results Through Week 52

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Introduction
Icotrokinra (ICO), a targeted oral peptide that selectively binds the interleukin (IL)-23 receptor, and precisely inhibits the IL-23 pathway, is being evaluated in ICONIC-LEAD (NCT06095115) in participants with moderate-to-severe plaque psoriasis (PsO). We report ICO pharmacodynamic (PD) effects on skin epidermal thickness and T cells (CD3+), including CD8 tissue resident memory T cells (TRMs; CD3+CD8+CD103+).

Materials and Methods
Participants from the ICONIC-LEAD study were randomized to once-daily ICO 200 mg or placebo (PBO; PBO→ICO at Week[W]16).[1] Adult ICO W24 responders were rerandomized to continue or withdraw from ICO through W52; participants rerandomized to PBO were excluded from W52 analyses. Optional skin biopsies were collected at W0/24/52. Skin blocks and digested skin cells were analyzed by histology and immunofluorescence (n=50) and flow cytometry (n=16).

Results
Baseline histology and immunofluorescence showed increased epidermal thickness and T cell densities (count/mm^2) in W0 lesional skin (LS) vs nonlesional skin (NLS; all $p<0.05$). ICO significantly reduced these PsO features, including CD8 TRMs, at W24 and W52 (vs W0 LS; both $p<0.05$), with levels approaching NLS at W52. Flow cytometry confirmed T cell and CD8 TRM results, with increased IL-17A+ and IL-17F+ T cell counts in W0 LS (vs NLS; $p<0.05$) significantly reduced by ICO at W24 and W52 (vs W0 LS; $p<0.05$). Similar PD effects were seen in the PBO→ICO cohort as early as 8W after starting ICO.

Conclusions
ICO robustly and durably reduced skin TRMs and IL-17+ T cells implicated in PsO pathogenesis.

Reference:

[1]Soung J. EADV; Sep17,2025; Paris, France.

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Abstract N°: 1400

Mild and moderate-to-severe psoriasis share lesional clinical and transcriptomic profiles during guselkumab induction

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Introduction
Psoriasis is a chronic inflammatory skin disease with heterogeneous clinical severity and complex immune dysregulation. Mild psoriasis is often underrepresented in molecular studies despite representing the majority of patients. this study characterizes local lesional clinical progression and transcriptomic profiles in mild psoriasis, compares these profiles with lesional features of moderate-to-severe disease, and evaluates the effects of guselkumab versus placebo on treatment efficacy and biomarker identification.

Materials and Methods
In this randomized, double-blind, placebo-controlled trial, 20 patients with mild psoriasis (PASI ≤5) were randomized 3:1 to receive placebo or guselkumab. Clinical outcomes were assessed over 24 weeks, and lesional skin biopsies were collected for RNA-sequencing analyses. In addition, a separate cohort of five patients with moderate-to-severe psoriasis (PASI ≥10) received open-label guselkumab 100 mg and was included as a reference control for molecular analyses.

Results
Guselkumab-treated mild and moderate-to-severe patients showed clinical improvement compared with baseline and placebo. Lesional skin from mild and moderate-to-severe psoriasis patients exhibited highly similar transcriptomic profiles relative to healthy controls and non-lesional skin, with shared psoriasis-associated gene expression patterns and minimal differences between severity groups during induction.

Conclusions
Guselkumab induction therapy resulted in comparable lesion-level clinical improvement and transcriptomic responses in patients with mild and moderate-to-severe psoriasis, indicating that mild psoriasis can exhibit a local clinical and molecular burden similar to more severe disease. These findings support further evaluation of biologic therapy, including guselkumab, for selected patients with mild psoriasis based on local disease characteristics and clinical impact rather than total body scores.

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Abstract N°: 1427

Successful Treatment of Severe Generalized Pustular Psoriasis With Concomitant Infection Using Vunakizumab in an 87-Year-Old Patient: A Case Report

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Introduction

Generalized pustular psoriasis (GPP) is a rare, potentially life-threatening inflammatory skin disorder. Elderly patients often present with multiple comorbidities and an increased susceptibility to infection, posing significant challenges to clinical management. IL-17A inhibitors have demonstrated rapid and robust efficacy in plaque psoriasis and recent studies suggest they may also be effective in GPP. Here, we report a case of an 87-year-old patient with severe GPP and concomitant infection treated with vunakizumab, an anti–IL-17A monoclonal antibody, who achieved rapid disease control with favorable tolerability, suggesting a potential therapeutic option for high-risk patients with GPP.

Case Presentation

An 87-year-old male with a 20-year history of erythematous scaly lesions associated with pruritus presented with a 3-day history of diffuse erythema, edema, and pustule formation. Twenty days prior to admission, the patient had received anti-infective therapy for pneumonia but continued to have recurrent fever. Three days before admission, the cutaneous condition rapidly worsened with marked expansion of lesions, accompanied by numerous pinhead-sized pustules and diffuse cutaneous edema. Past medical history included pulmonary tuberculosis (treated approximately 60 years previously) and chronic bronchiectasis for over 60 years. No relevant family history was reported.

Physical examination revealed extensive erythema, silvery-white scales (Auspitz sign positive) and dense pinhead-sized pustules involving the entire body, with GPPASI 67.6, GPPGA 4 and DLQI 14. The patient reported severe pruritus accompanied by fever. Laboratory tests showed significantly elevated white blood cell count (15.40×10^9/L), neutrophil count (12.55×10^9/L) and serum amyloid A (428.44 mg/L). Screening tests for hepatitis B virus, hepatitis C virus, syphilis, and human immunodeficiency virus were all negative. Pulmonology consultation confirmed bronchiectasis with concurrent infection. Based on clinical evaluation, history, and dermatopathology, a diagnosis of GPP with bronchiectasis-associated infection was established.

The patient received anti-infective therapy, including Tanreqing injection (20 mL, intravenously once daily for 11 days), levofloxacin (100 mL, intravenously once daily for 10 days), and oral carbocisteine (0.5 g twice daily for 10 days). By day 6, infection-related symptoms had significantly improved. Concurrently, treatment with vunakizumab was initiated (240 mg subcutaneously at weeks 0, 2, and 4, followed by maintenance every 4 weeks). A rapid clinical response was observed, with marked improvement in pustules and erythema as early as day 2 following the first injection. After 10 days of treatment, the patient was discharged in a stable condition, and antibiotic therapy was discontinued. One week after initiation, GPPASI decreased to 43.5, GPPGA to 2.7, and DLQI to 11. At 2 weeks, GPPASI further decreased to 22.6, GPPGA to 1.7, and DLQI to 7. Treatment was well tolerated, with no significant adverse events observed. During follow-up over 4 weeks, no recurrence or adverse events were reported.

Conclusion

This case demonstrates that vunakizumab achieved rapid disease control and was well tolerated in an ultra-elderly patient with GPP complicated by infection. It highlights the potential feasibility of initiating IL-17A inhibition in carefully selected elderly patients with GPP following adequate resolution of concomitant infection.

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Abstract N°: 1430

Bimekizumab quality of life and treatment satisfaction outcomes in patients with moderate to severe plaque psoriasis in routine clinical practice in Germany: 1-year results from the ELEVATE observational study

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Introduction

Bimekizumab (BKZ) selectively inhibits interleukin (IL)-17A and IL-17F and was approved in Europe in 2021 for the treatment of moderate to severe plaque psoriasis.[1] Psoriasis can impose a significant burden on patients' health-related quality of life (HRQoL).[2]

ELEVATE, a real-world study across France, Germany, Greece, Italy and the UK, describes treatment history and clinical and patient-reported outcomes (PROs) in adults with moderate to severe psoriasis receiving BKZ in routine practice.

Here, PROs stratified by previous systemic/biologic exposure are presented for patients enrolled in Germany through 52 weeks of BKZ treatment. Baseline characteristics and clinical outcomes are reported separately.

Materials and Methods

ELEVATE is an ongoing multicentre, prospective, observational study. Eligible patients were aged ≥18 years with moderate to severe psoriasis newly initiating BKZ per local label requirements. Patients completed PRO measures (Dermatology Life Quality Index [DLQI]; Psoriasis Symptoms and Impacts Measure [P-SIM]; Treatment Satisfaction Questionnaire for Medications-9 [TSQM-9]) via an app at Week 0 (baseline; before first BKZ dose) and approximately Weeks 2, 4, 8, 12, 26, 39 and 52.

Primary study objectives were to characterise the treatment history of patients initiating BKZ, and to assess the proportion of patients reporting no effect of skin disease on their life (DLQI 0/1) at Week 26.[3]

This analysis was performed once all enrolled German patients completed 52 weeks of follow-up. Observed case results are reported for all patients with a baseline and ≥1 post-baseline assessment (full analysis set), and by treatment history subgroup (systemic-naïve; systemic-experienced/biologic-naïve; biologic-experienced).

Results

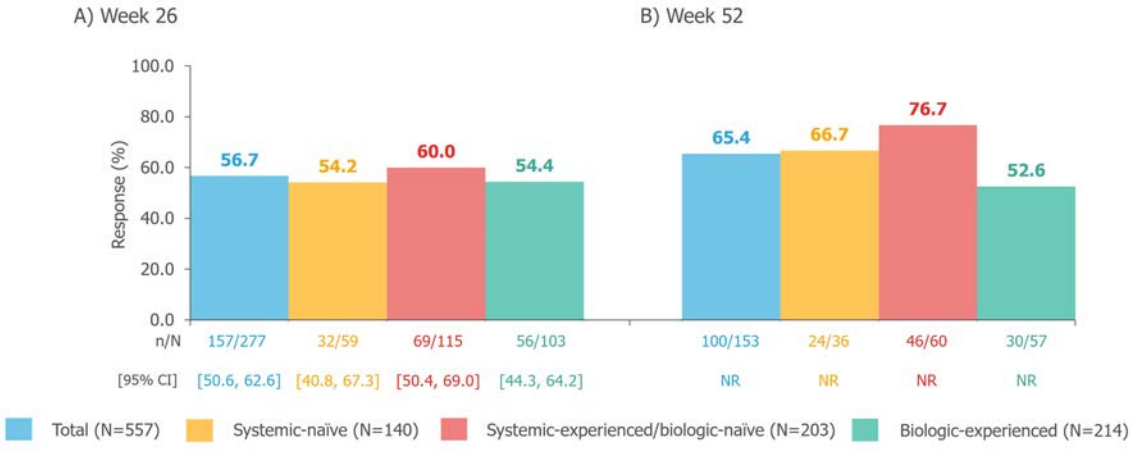
Overall, 557 patients were included (systemic-naïve: 140; systemic-experienced/biologic-naïve: 203; biologic-experienced: 214).

Over 50% of patients in all subgroups reported DLQI 0/1 at Week 26, with rates maintained or numerically increased at Week 52 (**Figure 1**). A clinically meaningful reduction (≥4 points) was observed in overall mean (standard deviation [SD]) DLQI score from baseline (14.1 [7.7]; N=502) to Week 52 (2.5 [4.1]; N=153), and in all subgroups.[3] Mean (SD) DLQI scores at Week 52 were numerically lower for systemic-naïve (2.3 [3.8]; N=36) and systemic-experienced/biologic-naïve (1.6 [2.9]; N=60) patients versus biologic-experienced patients (3.7 [5.1]; N=57).

Proportions of patients reporting no symptom/impact in the past 7 days (P-SIM=0) for all items, including itching, redness, pain and scaling, rapidly increased (by Week 2) in all subgroups (**Figure 2**); these proportions were generally maintained or further increased numerically from Week 26 to Week 52.

Mean (SD) TSQM-9 effectiveness scores increased from 69.3 (30.2) at Week 2 (N=325) to 79.9 (28.4) at Week 52 (N=159). Mean (SD) TSQM-9 convenience/global satisfaction scores remained high and numerically increased from Week 2 (76.8 [20.2]/76.6 [19.6] respectively; N=325) to Week 52 (81.9 [18.1]/84.4 [19.5] respectively; N=159).

Figure 1. Proportions of patients reporting DLQI 0/1 at Week 26 (primary endpoint) and Week 52 (OC)



The full analysis set was used, defined as all patients with a baseline and ≥1 post-baseline assessment. DLQI 0/1 indicates no effect of skin disease on a patient's life. CI: confidence interval; DLQI: Dermatology Life Quality Index; NR: not reported; OC: observed cases.

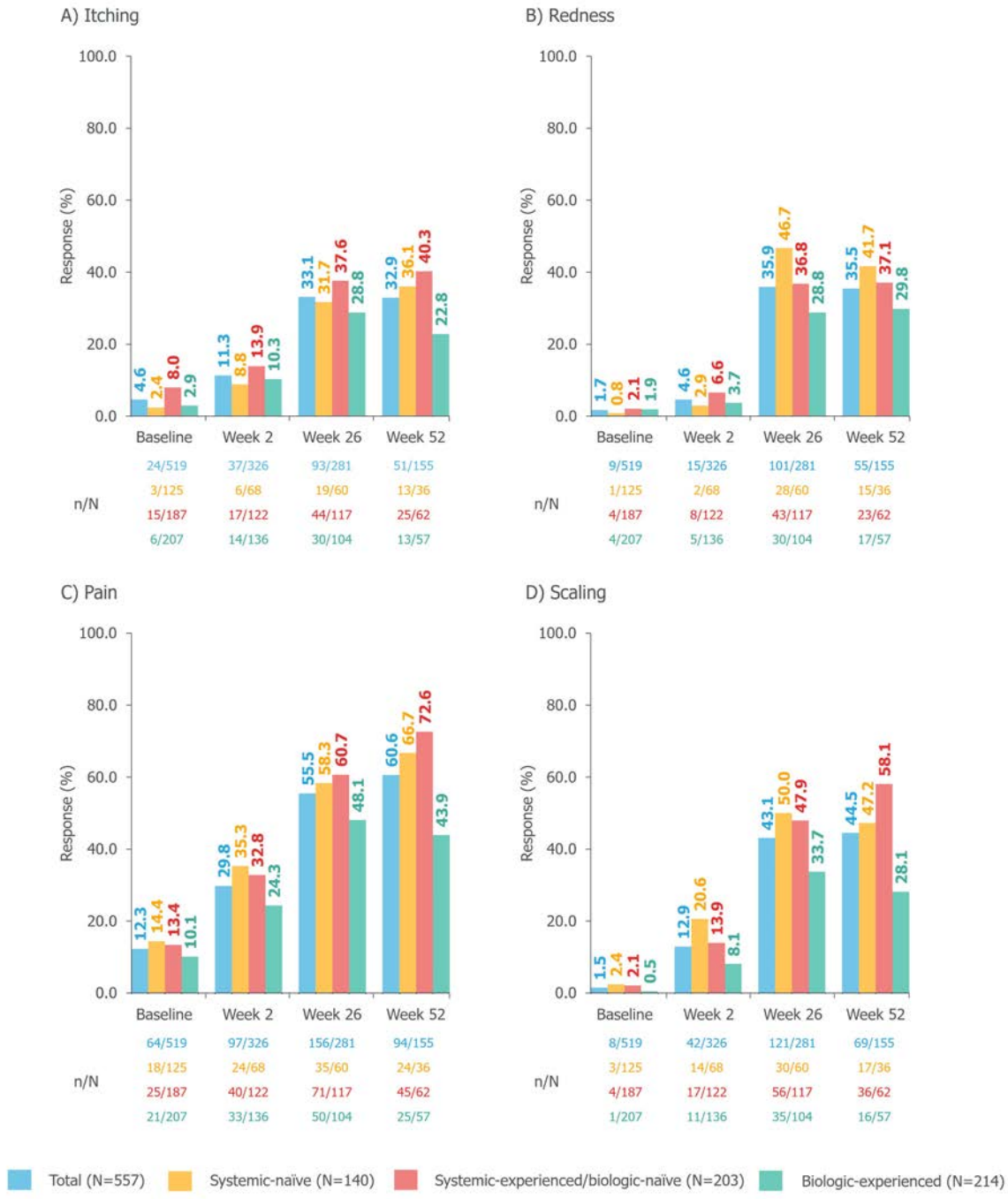
Conclusions

In these analyses of ELEVATE in patients from Germany, bimekizumab resulted in rapid and meaningful symptom improvement and high treatment satisfaction as early as Week 2, which were maintained or further increased from Week 26 to Week 52. This was associated with HRQoL improvements, with over half of patients reporting no impact of skin disease on their life at Weeks 26 and 52, and numerically higher responses in biologic-naïve patients. These real-world data reflect HRQoL results observed in clinical trials and support bimekizumab's ability to achieve rapid, meaningful benefits for patients.

References

1. European Medicines Agency. www.ema.europa.eu/en/medicines/human/EPAR/bimzelx. Accessed April 2026;**2.** Augustin M & Radtke MA. Expert Rev Pharmacoecon Outcomes Res 2014;14:559–68; **3.** Dermatology Life Quality Index. www.cardiff.ac.uk/medicine/resources/quality-of-life-questionnaires/dermatology-life-quality-index. Accessed April 2026.

Figure 2. Proportions of patients reporting P-SIM=0 in skin itching, redness, pain and scaling to Week 52 (OC)



The full analysis set was used, defined as all patients with a baseline and ≥1 post-baseline assessment. P-SIM=0 indicates symptom resolution of a specific domain in the last 7 days. OC: observed cases; P-SIM: Psoriasis Symptoms and Impacts Measure.

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Abstract N°: 1435

Unmet Needs and Disease Burden: Perspectives from Adults with Psoriasis and Clinicians Treating Psoriasis in Germany and the US

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Introduction
Despite therapeutic advances, psoriasis (PsO) continues to be associated with substantial unmet patient needs. This study (ENCOMPASS) aimed to compare adult patient characteristics, unmet needs, treatment preferences, and goals between the United States (US) and Germany (DE), representing distinct healthcare systems.

Materials and Methods
ENCOMPASS was a web-based, cross-sectional study of patients with PsO, eligible for systemic therapy (per IPC guidelines), and health care providers (HCPs). Surveys were conducted in the US (400 patients; 200 HCPs) and DE (250 patients; 101 HCPs). Data were analyzed separately by country to enable side-by-side comparison.

Results
Patient populations were comparable across countries, with similar age, gender distribution, disease duration, and self-reported body surface area involvement.

Disease burden was substantial and comparable in both countries. Psoriatic arthritis (PsA) was the most frequent self-reported comorbidity (US: 45%; DE: 34%), followed by depression (US: 41%; DE: 23%). Itch was the most commonly self-reported symptom, reported by 91% of patients in the US and 84% in Germany. Sleep disruption from itch (>=3 nights/month) were reported in 90% of US patients and 86% of German patients. More than half of patients in both countries (US: 55%; DE: 53%) reported a very large to extremely large impact on quality of life as measured by the Dermatology Life Quality Index (DLQI).

Current treatment patterns differed modestly between countries. Topical steroids were the most frequently

prescribed treatment (US: 46%; DE: 29%). Injectable treatments were used by 20% of US and 10% of German patients while oral systemic treatments were used by 29% and 22% of patients, respectively. 19% of patients in both countries remained untreated.

Treatment preferences were highly similar across both countries, with 51% of US patients and 56% of German patients preferring oral therapy overall. Among patients currently receiving injectables, willingness to switch to an equally effective and safe oral pill was expressed by 91% (n=83/91) of US patients and 72% (n=21/29) of German patients. HCPs exhibited similar preferences, with 48% in both countries favoring an oral treatment when efficacy, safety, and tolerability were equivalent.

Reasons for treatment discontinuation followed similar patterns. For injectables, side effects (US: 44%; DE: 36%) and insufficient symptom improvement (US: 41%; DE: 44%) were the leading causes in both countries. For oral drugs, insufficient symptom improvement was the primary discontinuation driver (US: 58%; DE: 54%), followed by side effects (US: 37%; DE: 47%). Needle aversion was the most frequently cited concern regarding injectable therapies by HCPs (US: 69%; DE: 58%).

Patient treatment goals showed similar priorities with nuanced differences. US patients prioritized achieving clear skin (73%), reducing itch (68%), and long-term disease control (46%). German patients ranked itch reduction highest (78%), followed by clear skin (50%), and long-term control (42%). HCPs in both countries reported effectiveness as their foremost consideration when selecting treatment (US: 85%; DE: 73%), with side effects (US: 52%; DE: 52%) and long-term safety (US: 49%; DE: 56%) representing secondary priorities in both settings.

Conclusions

Despite differences in healthcare systems and treatment patterns, patients with PsO in the United States and Germany experience similarly high disease burdens due to insufficient symptom control, treatment-related side effects, and substantial reductions in quality of life. The observed cross-national similarities indicate that existing therapeutic options do not adequately meet the fundamental needs of patients, regardless of healthcare system structure, highlighting a universal demand for safe and effective oral treatments in psoriasis management.

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Abstract N°: 1441

Health-Related Quality of Life, Work Productivity and Treatment Satisfaction with Tildrakizumab for Up to 2 Years in Patients with Moderate-to-Severe Psoriasis in the POSITIVE Study

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Introduction

Plaque psoriasis (PsO) is a chronic, immune-mediated inflammatory disease that profoundly impairs patients' social, psychological and physical functioning, impacting their overall well-being.[1] Tildrakizumab (TIL) is a high-affinity humanised IgG1κ monoclonal antibody that selectively inhibits the IL-23p19 subunit and has demonstrated sustained efficacy in Phase 3 clinical trials for PsO.[2,3] Here, we report the impact of TIL on health-related quality of life (HRQoL), work productivity, treatment satisfaction and achievement of patients' treatment goals in those with moderate-to-severe (mod-sev) PsO in routine clinical care through Week (W) 104 of the POSITIVE study (NCT04823247).

Materials and Methods

POSITIVE was a 104-week multinational European study in adults with mod-sev PsO treated with 100/200 mg TIL in a real-world setting.[4] Endpoints reported to W104 include: Dermatology Life Quality Index-Relevant score (DLQI-R; range 0–30; higher scores represent a greater impairment in HRQoL; 0-1.99: no effect on patient life),[5] Treatment Satisfaction Questionnaire for Medication score (TSQM-9: three domains [treatment effectiveness, convenience of use, overall satisfaction]; range 0–100; higher scores represent higher satisfaction),[6] Patient Benefit

Index (PBI; Patient Needs Questionnaire [PNQ] at baseline [BL] and Patient Benefit Questionnaire [PBQ] at follow-up visits; ranges between 0–4 with response categories of “not at all”, “somewhat”, “moderately”, “quite”, “very much” and “does not apply to me” [PBI ≥1: minimum clinically relevant benefit]),[7] and Work Productivity and Activity Impairment (WPAI) questionnaire scores across 4 domains (work time missed, impairment while working, overall work impairment, and activity impairment). Wilcoxon signed-rank tests were used to calculate p-values. Data are reported for the full analysis set (FAS) to W104 as observed cases.

Results

Overall, 785 patients were included in the FAS (64.5% male) with a mean (95% confidence interval [CI]) age of 46.9 (±1.1) years. Mean (95% CI) DLQI-R score decreased from 12.0 (±0.6) at BL (n=647) to 4.3 (±0.4) at W16 (n=530; mean change from BL [CfB]: −7.8; p<0.0001), and to 2.1 (±0.4) at W104 (n=261; mean CfB: −9.7; p<0.0001). At W16 (n=171)/W104 (n=137), 37.7% and 62.3% of patients who had a DLQI-R score >1.99 at BL had a DLQI-R score between 0–1.99. At W16 (n=526)/W104 (n=273), the mean (95% CI) scores on TSQM-9 domains were 69.7 (±2.3)/82.2 (±2.7) for effectiveness, 80.1 (±1.5)/84.2 (±2.0) for convenience, and 74.0 (±2.0)/83.1 (±2.2) for global satisfaction. When asked how treatment has helped them at W16 (n=377)/W104 (n=244), 69.2%/88.4% of patients reported that TIL helped them “to be healed of all skin defects” “quite” or “very much”. Additionally, at W16 (n=401)/W104 (n=256) 73.6%/92.8% of patients reported that TIL helped them “to regain control of the disease” “quite” or “very much”. At W16 (n=453)/W104 (n=243), 89.7%/98.4% of patients achieved a PBI score ≥1. All WPAI domain scores improved at W104 (e.g. mean [95% CI] percent overall work impairment score decreased from 25.7 [±2.7] at BL to 9.74 [±2.1] at W16 [mean CfB: −14.8] and to 7.1 [±2.4] at W104 [mean CfB: −17.2] [p<0.0001, both]).

Conclusions

In a real-world setting, TIL provided long-term improvements in HRQoL and work productivity with high rates of treatment satisfaction in patients with mod-sev PsO from W16, which were maintained through W104.

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Abstract N°: 1443

Crosstalk Between Selected Serum Proteins in the Pathogenesis of Psoriasis

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Introduction

Psoriasis is a chronic, immune-mediated inflammatory skin disease associated with complex metabolic and immunological pathways. This study aimed to evaluate the role and interrelationships of selected serum proteins —visfatin, chemerin, elafin, and zyxin—in the pathogenesis of psoriasis. We assessed their serum levels in patients with psoriasis compared to healthy controls and analysed associations with disease severity (PASI), biochemical and inflammatory parameters, and disease duration.

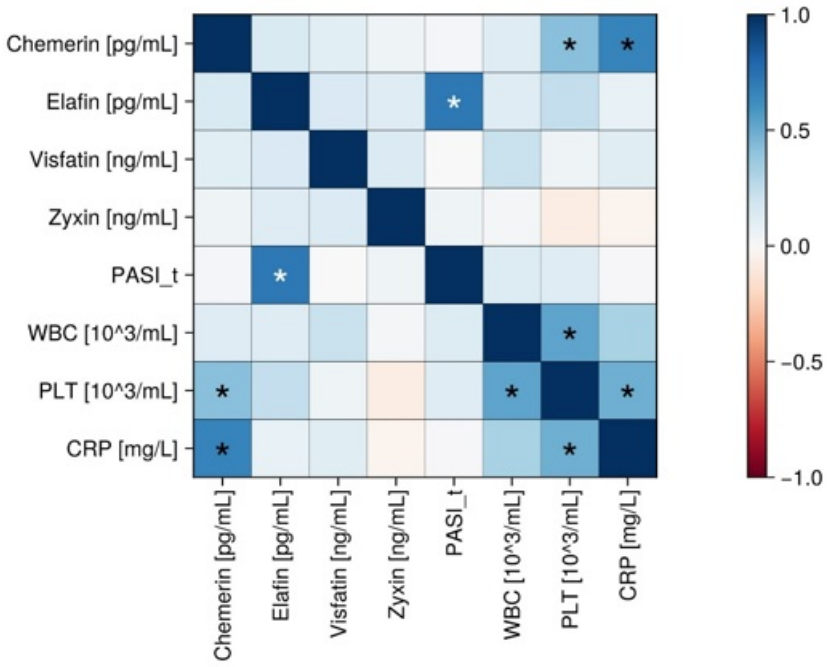
Materials and Methods

The study included 50 patients with plaque-type psoriasis and 28 healthy controls. Serum samples were collected after an overnight fast. Concentrations of visfatin, chemerin, elafin, and zyxin were measured using commercially available sandwich ELISA kits.

Results

Serum levels of visfatin, elafin, chemerin, and zyxin were significantly higher in patients with psoriasis compared to healthy controls. However, no significant correlations were observed among these proteins in psoriatic serum, nor with disease duration. In contrast, we demonstrated positive correlations between chemerin and C-reactive protein (CRP) as well as platelet count (PLT), and between elafin and PASI score. In the present analysis, elafin showed a strong positive correlation with disease severity (PASI) ($r = 0.94$, $p < 0.05$), while chemerin correlated with CRP ($r = 0.66$, $p < 0.05$) and PLT ($r = 0.42$, $p < 0.05$) (Figure 1).

Figure 1. Correlation matrix (heatmap) in the psoriatic group. Pearson correlation coefficients are depicted as the shades of blue (positive correlation) or red (negative correlation). WBC – white blood count, CRP – C-reactive protein, PLT—platelet count, PASI_t – Psoriasis Area Severity Index_total



Conclusions

Visfatin, chemerin, elafin, and zyxin have been implicated in psoriasis pathogenesis. Our findings confirm increased serum levels of these proteins in affected patients, supporting their involvement in systemic inflammation. However, no direct intercorrelations were observed, suggesting a complex and multifactorial regulatory network.

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Interstitial lung disease in psoriasis patients treated with biological drugs. Report of five cases.

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Introduction

Interstitial lung disease (ILD) has been associated with TNF-a inhibitor drugs, mainly in patients with rheumatoid arthritis and preexisting lung disease, although it has also been described in patients with psoriasis and with other treatments.
We report the cases of 5 patients with psoriasis who developed ILD during treatment with anti-TNFa, IL-17 and IL12/23 inhibitor drugs.

Case Presentation

Case 1: 50-year-old male with psoriasis and psoriatic arthritis treated with infliximab since 2009. In August 2020 he was admitted for moderate exertional dyspnea of several months' evolution. He did not present infectious symptoms and laboratory tests, including PCR for SARS-CoV-2, were negative. Chest CT and X-ray showed patchy parenchymal infiltrates of subsegmental distribution with ground-glass density. After excluding other causes, ILD related to infliximab was diagnosed, infliximab was discontinued, and prednisone was prescribed with resolution of respiratory symptoms.

Case 2: 57-year-old male with psoriasis. In 2014, he had been treated with etanercept, which was discontinued due to bilateral atypical pneumonia. Four months after starting brodalumab, he was admitted for minimal exertional dyspnea. A chest CT scan showed extensive consolidative pulmonary infiltrates with a ground-glass pattern distributed in a band. After excluding infectious causes, he was diagnosed with ILD and brodalumab was discontinued, with resolution of respiratory symptoms.

Case 3: 67-year-old male with psoriasis treated with secukinumab for 2 years. On follow-up chest X-ray, interstitial lung involvement was observed. Pulmonary function tests and chest CT showed a restrictive pattern and ground-glass pulmonary infiltrates. He was diagnosed with ILD and secukinumab was discontinued with improvement of respiratory function and pulmonary infiltrates.

Case 4: 50-year-old woman with plaque psoriasis treated with adalimumab since March 2023. In December 2025, she was admitted for dyspnea and persistent cough with sensation of obstruction at the upper respiratory tract. A chest CT scan showed geographic areas of ground-glass attenuation in both lungs, alternating with other hypoattenuating areas, forming a mosaic pattern. Infectious causes were ruled out; adalimumab was discontinued and treatment with oral corticosteroids were initiated with good evolution of the pulmonary infiltrates 3 months later.

Case 5: 71-year-old male treated with ustekinumab for more than 10 years. On follow-up chest X-ray, a slight interstitial involvement predominating in the left base, with some reticulation and mild ground-glass opacities, was observed. A chest CT was performed, showing chronic bilateral ILD with peripheral and basal distribution. Pulmonary function tests revealed moderate restrictive ventilatory impairment. Ustekinumab was discontinued, with stability of lung infiltrates on follow-up chest CT.

Conclusion

The exact mechanism of ILD induced by biological drugs in patients with psoriasis is unknown, although it is probably due to a multifactorial etiology that includes immunological, genetic causes and lung damage from previous treatment with methotrexate. Most cases are described in Japanese patients, with incidences in post-marketing studies of 0.25% with infliximab, followed by adalimumab (0.14%) and

ustekinumab (0.04%). There are isolated cases in patients treated with secukinumab and, more recently, cases have been reported in patients treated with IL17 and IL23 inhibitors.
Most patients have mild symptoms, and they usually recover when treatment is stopped, even without specific treatment for lung disease.
Although it is an uncommon entity, given the progressive increase in the number of patients treated with biological drugs, we must take this possible complication into account, especially when patients present with dyspnea or changes in imaging tests.

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Beyond Skin Clearance: Long Term Improvement of Psychological Well-Being and Health-Related Quality of Life in High-Impact Area Psoriasis Treated with Tildrakizumab (POSITIVE Study)

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Introduction

Plaque psoriasis (PsO) is a chronic, immune-mediated disease that commonly affects high-impact areas, such as the scalp, palms/soles or nails. These areas can be difficult to treat with topical/conventional systemic treatments, thus patients with PsO and high-impact area involvement incur a high disease burden.[1,2] Tildrakizumab (TIL) is a high-affinity humanised IgG1κ monoclonal antibody that selectively inhibits the IL-23p19 subunit and has demonstrated efficacy in Phase 3 clinicals trials for PsO.[3,4] Here, we report the effectiveness of TIL in high-impact areas, and improvements in psychological well-being and health-related quality of life (HRQoL) in patients with PsO and high-impact area involvement in routine care in the POSITIVE study (NCT04823247).

Materials and Methods

POSITIVE was a 104-week, phase 4, multinational European study in adults with moderate-to-severe PsO treated with 100/200 mg TIL.[5] Endpoints reported to Week (W)104 include the proportion of patients achieving Physician Global Assessment (PGA)=0/1 (clear/almost clear skin) in high-impact areas (scalp-, palmoplantar-, and nail-PGA) in the Full Analysis Set. We also report mean 5-item World Health Organisation Well-being Index score (WHO-5; range 0–100; higher scores indicate better well-being; change of ≥10 considered clinically relevant) and mean Dermatology Life Quality Index-Relevant score (DLQI; range 0–30; higher scores indicate greater impairment in

HRQoL; 0–1.99: no effect on patient life) in patients with PsO in high-impact areas at baseline (BL; defined as scalp-, palmoplantar-, and nail-PGA ≥1).[6,7] Data are reported as observed cases.

Results

At BL, 39.4% (304/771), 79.8% (615/771), and 76.5% (590/771) of patients had scalp-, palmoplantar-, and nail-PGA=0/1, respectively. At W104, 89.3% (250/280), 96.9% (94/97), and 90.3% (93/103) of patients achieved scalp-, palmoplantar-, and nail PGA=0/1, respectively. In patients who had PGA≥1 in all high-impact areas at BL (n=100), 80.0% achieved a global-PGA score 0/1 at W104 (n=44/55).

Patients with PsO and high-impact area involvement at BL had considerably worse WHO-5 and DLQI-R at BL compared with those without high-impact area involvement (**Table**). Improvements with TIL in both WHO-5 and DLQI-R in patients with scalp-, palmoplantar, and nail-PGA≥1 were seen as early as W16 and sustained to W104, and were generally similar to patients without high-impact area involvement (**Table**). In patients with scalp-PGA≥1 and 0 at BL, mean (±95% confidence interval [CI]) WHO-5 was 51.5 (±1.8) and 59.6 (±3.0) at BL and 70.1 (±2.7) and 71.9 (±4.2) at W104, respectively. In patients with scalp-PGA≥1 and 0 at BL, DLQI-R was 12.7 (±0.6) and 10.2 (±1.1) at BL, and 2.0 (±0.5) and 2.3 (±0.9) at W104, respectively. In patients with palmoplantar-PGA≥1 and 0 at BL, mean WHO-5 was 50.0 (±3.1) and 55.0 (±1.8) at BL, and 72.5 (±4.3) and 69.9 (±2.6) at W104, respectively. In patients with palmoplantar-PGA≥1 and 0 at BL, DLQI-R was 13.5 (±1.1) and 11.5 (±0.7) at BL, and 2.4 (±1.0) and 2.0 (±0.5) at W104, respectively. In patients with nail-PGA≥1 and 0 at BL, mean WHO-5 was 52.5 (±2.6) and 54.4 (±2.0) at BL, and 71.7(±3.5) and 69.8 (±3.0) at W104, respectively. In patients with nail-PGA≥1 and 0 at BL, DLQI-R was 13.3 (±0.9) and 11.2 (±0.7) at BL, and 1.8 (±0.5) and 2.3 (±0.6) at W104, respectively.

Conclusions

In a real-world setting, TIL demonstrated high effectiveness in high-impact areas at W104, and improved both overall psychological well-being and HRQoL in patients with PsO and high-impact area involvement, highlighting the potential of TIL in alleviating the multi-faceted burden of PsO in the long-term.

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Table. WHO-5 and DLQI-R scores in POSITIVE to W104

		Mean score (95% CI; n)			
		Baseline	W16	W52	W104
WHO-5					
Scalp-PGA	**≥1**	51.5 (49.6, 53.3; n=513)	61.8 (59.8, 63.7; n=438)	64.7 (62.5, 67.0; n=320)	70.1 (67.4, 72.9; n=222)
	0	59.6 (56.6, 62.5; n=187)	67.2 (64.0, 70.4; n=152)	69.8 (66.1, 73.6; n=109)	71.9 (67.7, 76.1; n=73)
Palmoplantar-PGA	**≥1**	50.0 (46.8, 53.1; n=188)	62.0 (58.7, 65.3; n=157)	67.3 (63.2, 71.3; n=100)	72.5 (67.8, 77.1; n=75)
	0	55.0 (53.2, 56.8; n=512)	63.6 (61.7, 65.5; n=433)	65.6 (63.4, 67.8; n=329)	69.9 (67.3, 72.6; n=220)
Nail-PGA	**≥1**	52.5 (49.9, 55.1; n=277)	62.3 (59.6, 64.9; n=229)	67.0 (64.0, 70.0; n=162)	71.7 (68.2, 75.2; n=114)
	0	54.4 (52.4, 56.4; n=423)	63.7 (61.6, 65.9; n=361)	65.4 (62.9, 68.0; n=267)	69.8 (66.8, 72.9; n=181)
DLQI-R					
Scalp-PGA	**≥1**	12.7 (12.1, 13.4; n=462)	4.3 (3.8, 4.8; n=386)	3.2 (2.6, 3.8; n=278)	2.0 (1.5, 2.5; n=192)
	0	10.2 (9.1, 11.4; n=178)	4.2 (3.4, 5.1; n=139)	2.8 (2.0, 3.6; n=100)	2.3 (1.4, 3.2; n=63)
Palmoplantar-PGA	**≥1**	13.5 (12.4, 14.6; n=175)	4.9 (4.1, 5.8; n=144)	3.6 (2.5, 4.6; n=95)	2.4 (1.3, 3.4; n=64)
	0	11.5 (10.8, 12.2; n=465)	4.0 (3.5, 4.5; n=381)	3.0 (2.4, 3.5; n=283)	2.0 (1.5, 2.4; n=191)
Nail-PGA	**≥1**	13.3 (12.3, 14.2; n=250)	5.0 (4.2, 5.8; n=203)	3.1 (2.4, 3.9; n=143)	1.8 (1.3, 2.4; n=100)
	0	11.2 (10.5, 12.0; n=390)	3.8 (3.3, 4.3; n=322)	3.1 (2.5, 3.7; n=235)	2.3 (1.7, 2.9; n=155)

CI: confidence interval; DLQI-R: Dermatology Life Quality Index-Relevant; n: number; PGA: Physician Global Assessment; W: week; WHO-5; 5-item World Health Organisation Well-being Index.

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Disentangling Treatment from Risk: Cardiovascular Disease in Psoriasis Is Driven by Traditional Factors—A French CPAM Causal Inference Study

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Introduction
Psoriasis confers excess cardiovascular disease (CVD) risk, yet the respective roles of systemic therapies and traditional cardiovascular risk factors (CVRFs) remain unclear in real-world settings due to confounding by indication. Leveraging the French SNDS/CPAM infrastructure, we aimed to disentangle treatment effects from underlying cardiometabolic (CV) risk.

Materials and Methods
We conducted a population-based cross-sectional pharmacoepidemiological study using CPAM Loire reimbursement data (August 2023–August 2025), covering approximately 730,000 insured individuals. Adults with treated psoriasis (n=10,331) were identified using validated treatment-based proxy algorithms adapted to the absence of systematic outpatient ICD-10 coding in French claims data. Patients were stratified by treatment intensity using a hierarchical approach (topical, non-biologic systemic, biologic therapy).

The primary outcome was prevalent CVD, defined using a composite algorithm combining chronic cardiovascular medication use and procedure-based proxies. Multivariable logistic regression models adjusted for age, sex, socioeconomic status (CMU-C/AME), and major CVRFs (hypertension, dyslipidaemia, diabetes, COPD). To address confounding by indication, inverse probability of treatment weighting (IPTW) based on propensity scores was applied among systemic therapy users. Robustness to unmeasured confounding was quantified using E-values.

Results
Overall CVD prevalence was 14.4%, consistent with international psoriasis cohorts. CVRF burden was substantial: hypertension (37.8%), dyslipidaemia (20.1%), diabetes (13.3%), and COPD (19.5%), exceeding general population estimates. Crude analyses suggested lower CVD prevalence among biologic-treated patients; however, this inverse gradient reflected strong channelling bias, with biologics preferentially prescribed to younger, healthier individuals.

After comprehensive adjustment, neither biologic therapy (aOR 1.08; 95% CI 0.93–1.27; p=0.31) nor non-biologic

systemic therapy (aOR 1.07; 95% CI 0.78–1.45; p=0.69) was associated with prevalent CVD compared with topical therapy. IPTW analysis confirmed these findings (OR 0.98; 95% CI 0.69–1.38; p=0.90), with excellent post-weighting covariate balance.

In contrast, traditional CVRFs emerged as the dominant determinants of CVD: dyslipidaemia (aOR 3.75; 95% CI 3.27–4.30), hypertension (aOR 3.20; 95% CI 2.71–3.78), and diabetes mellitus (aOR 1.95; 95% CI 1.68–2.27) (all p<0.001). These associations demonstrated strong robustness to unmeasured confounding (E-values >5 for dyslipidaemia and hypertension). Age was a major determinant (aOR 1.05 per year), while female sex was associated with lower CVD risk (aOR 0.58).

Notably, dyslipidaemia showed a markedly amplified association in patients <60 years (aOR 5.59 vs 3.35 in ≥60 years), suggesting accelerated cumulative atherosclerotic burden in younger psoriasis populations.

Conclusions

In this large real-world French study leveraging SNDS/CPAM data, cardiovascular burden in psoriasis is primarily driven by traditional risk factors rather than treatment modality. After rigorous causal adjustment, neither biologic nor non-biologic systemic therapies were associated with increased CVD prevalence, supporting their cardiovascular safety in routine practice.

These findings shift the clinical paradigm toward systematic and aggressive management of modifiable CVRFs—particularly dyslipidaemia and hypertension—irrespective of psoriasis treatment strategy. The pronounced impact of dyslipidaemia in younger patients highlights the importance of early cardiovascular risk identification and intervention. Prospective longitudinal studies are warranted to assess the effect of sustained treatment exposure on incident cardiovascular events.

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Global Health and Economic Impact of Expanding the WHO Essential Medicines List for Psoriasis: A Health Economic Modelling Study

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Introduction

Psoriasis affects at least 60 million people globally, yet access to biologic treatment remains highly unequal, particularly in low- and middle-income countries. In 2025, the World Health Organization (WHO) Essential Medicines List (EML) was expanded to include adalimumab and ustekinumab for moderate-to-severe psoriasis. This study models the incremental global health and economic impact of large-scale access expansion for adalimumab and ustekinumab biosimilars following their inclusion on the WHO EML for psoriasis, as recommended by the 25th WHO Expert Committee on Selection and Use of Essential Medicines.

Materials and Methods

An empirical decision-analytic health economic model was developed to estimate the incremental costs and quality-adjusted life-years (QALYs) over a five-year horizon, using a 3% discount rate. The target population was estimated by applying sequential epidemiological, conventional systemic-failure, and biologic-access filters to the global psoriasis population, with access estimates stratified by World Bank income group, yielding 8.9 million possible eligible adults with moderate-to-severe disease refractory to conventional systemic therapy globally. The model compared the current status quo with an expanded biosimilar-access following EML expansion scenario for

a target population of 8.9 million adults with moderate-to-severe psoriasis refractory to conventional systemic therapies and without meaningful access to biologics. Deterministic one-way and 10,000-iteration probabilistic sensitivity analyses were performed, with parameter uncertainty modelled using Normal, Beta, and Gamma distributions. Goodness-of-fit assessment supported the internal validity of model parameterization.

Results

Expanded biosimilar access under EML implementation was simulated to generate an incremental 0.625 QALYs per patient at an additional cost of $13,973 USD over five years. Extrapolated to the global target population, this policy could deliver a total health gain of 5.56 million QALYs, with an associated incremental budget impact of $124.35 billion USD over five years. One-way sensitivity analysis identified time horizon, target population size, and utility gain with Psoriasis Area Severity Index (PASI) response as the principal drivers of projected QALY gains. Probabilistic analysis estimated a mean gain of 5.67 million QALYs (95% Credible Interval 0.38 - 12.84 million). In a conservative scenario assuming 25% uptake, implementation still generated 1.39 million QALYs at an incremental cost of USD $31.1 billion.

Conclusions

Expansion of the WHO EML for psoriasis could deliver substantial global population health gains, but real-world impact will depend on affordability, procurement, and implementation capacity. These findings provide a quantitative framework for national planning and support regional monitoring of uptake, outcomes, equity, and budget impact during implementation.

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Abstract N°: 1477

Effectiveness of dose spacing of biologic therapies in psoriasis: a real-life experience up to 18-months

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Introduction
Biologic therapies have revolutionized the management of moderate-to-severe plaque psoriasis, enabling sustained disease control and high rates of skin clearance. However, long-term treatment optimization remains a clinical challenge. Dose spacing, defined as extension of dosing intervals in patients with stable remission, may represent a strategy to maintain effectiveness while reducing treatment burden and costs, although real-world evidence is limited.
The primary outcome of this study was to evaluate maintenance of clinical remission (PASI ≤1) throughout the 18-month follow-up. Secondary outcomes included the effectiveness, persistence and predictors of success of biologic dose spacing in a real-life cohort of patients with moderate-to-severe plaque psoriasis over an 18-months follow-up.

Materials and Methods
This retrospective, observational study included 261 adult patients with moderate-to-severe plaque psoriasis who achieved stable disease control on biologic therapy, defined as sustained PASI (Psoriasis Area and Severity Index) ≤1 after at least 1 year of continuous treatment, and subsequently underwent dose spacing. Four biologic agents were evaluated: secukinumab and brodalumab (anti–IL-17), guselkumab and risankizumab (anti–IL-23). Clinical outcomes included PASI 100, PASI 90, and PASI ≤1, assessed using observed case and modified non-responder imputation (mNRI) analyses. Persistence of dose spacing was analyzed using Kaplan–Meier curves and Cox regression models.

Results
PASI≤1 rates remained stable at 12 months (83.8% - 129/154) and 18 months (91.9% - 68/74) in patients under dose reduction; guselkumab emerges as the drug with the most consistent and lasting response in maintaining minimal levels of disease activity, followed by risankizumab, while secukinumab shows reduced effectiveness over time.
Overall persistence of dose reduction at 18 months was 74.4%. Persistence was significantly higher with IL-23 inhibitors compared with anti–IL-17 drugs (83.6% vs 63.1%; p=0.002). Guselkumab and risankizumab showed the highest 18-month persistence rates (85.5% and 83.0%, respectively). Multivariate analysis confirmed an independent advantage for IL-23 inhibitors.

Conclusions
In real-world practice, biologic dose spacing is an effective strategy for patients with moderate-to-severe plaque

psoriasis in stable remission. Anti–IL-23 inhibitors demonstrated superior persistence and durability, supporting their suitability for individualized de-escalation approaches.

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Inaugural generalized pustular psoriasis induced by disseminated cutaneous leishmaniasis in a patient with psoriasis vulgaris

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Introduction

Generalized pustular psoriasis (GPP) is a severe form of psoriasis. It may complicate psoriasis vulgaris, often following drug exposure or infection. We report the first case triggered by cutaneous leishmaniasis (CL).

Case Presentation

A 61-year-old man with a history of psoriasis vulgaris involving the elbows and knees was referred for management of disseminated CL evolving over 9 months, resistant to two 15-day courses of metronidazole and clarithromycin (1.5 g/day each), and one course of fluconazole (150 mg/day). Clinical examination revealed a patient in good general condition, with 10 ulcerocrusted lesions on the upper limb and forehead, as well as a mediofacial lupoid plaque. In addition, lesions suggestive of GPP were noted, consisting of widespread erythematous plaques covered with non-follicular, flat pustules on the trunk and upper limbs, sparing the folds. These appeared 6 months after the onset of CL and evolved with recurrent flares. An erythematous scaly scalp involvement was also observed. There was no history of recent drug intake or prior infection. Parasitological examination of the CL lesions revealed Leishmania bodies.

The diagnosis of inaugural GPP was retained based on the psoriatic background, typical clinical features, recurrence, chronicity of the pustular eruption (lasting more than 3 months), and supportive histology showing acanthotic and parakeratotic epidermis, subcorneal pustules with neutrophil exocytosis, and a superficial dermal perivascular neutrophilic inflammatory infiltrate.

During hospitalization, the patient received a 15-day course of intramuscular meglumine antimoniate (60 mg/kg/day of total product). For GPP, acitretin was indicated; however, due to the potential hepatotoxicity shared with antimoniate and the preserved general condition, this treatment was postponed until resolution of leishmaniasis. After 15 days of antimoniate, parasitological examination of the CL lesions became negative, although only partial clinical improvement was observed, justifying a second course after a 15-day interval. The patient continued to experience afebrile GPP flares while remaining in good general condition.



Midfacial angiolupoid plaque

Conclusion

According to the literature, the most common triggers of GPP are bacterial infections, certain medications (nonsteroidal anti-inflammatory drugs, lithium, antimalarials), and abrupt withdrawal of systemic corticosteroids.

Interleukin-1, particularly IL-1α and IL-1β, has been implicated in CL. IL-36, which is involved in GPP, belongs to the same interleukin family. Its role in CL has not been studied, but this observation suggests a potential link that could explain the onset of GPP.

To date, no documented cases have reported cutaneous leishmaniasis as a direct trigger of GPP, making this observation the first reported case.

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Abstract N°: 1506

Efficacy and Disease-Modifying Potential of GLP-1 Analogues in Psoriasis: A Cohort Study

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Introduction

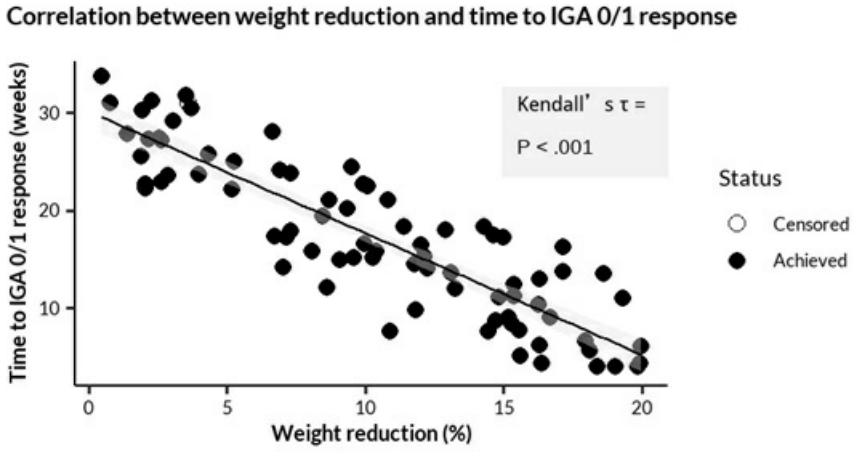
Obesity-related metabolic inflammation contributes to psoriasis pathogenesis and is associated with reduced therapeutic response. We aimed to investigate whether treatment with GLP-1 analogues improves skin disease in obese patients with psoriasis.

Materials and Methods

Consecutive patients with psoriasis eligible for GLP-1 analogue therapy (BMI ≥27) were enrolled. A comparator cohort comprised obese patients with psoriasis who did not receive GLP-1 therapy. The primary outcomes were the proportion of patients achieving an investigator's global assessment (IGA) score of 0/1, and the correlation between weight reduction and improvement in skin disease.

Results

An IGA 0/1 response was achieved by 16 of 36 patients (44.4%) in the GLP-1 group compared with 7 of 58 patients (12.1%) in the control group ($P < .001$). Greater weight loss correlated with a more rapid response ($\tau = -0.59$; $P < .001$). Among patients receiving biologic therapy, the addition of GLP-1 treatment was associated with superior response rates ($P = .029$).



Conclusions

GLP-1 receptor agonists demonstrated efficacy in obese patients with psoriasis and may represent a therapeutic

alternative for individuals in whom conventional systemic or biologic therapies are contraindicated, or in those who prefer a non-immunomodulatory approach.

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A Holistic View of Treatment Success in Psoriasis: Long-Term Real-World Improvements in Psychological Well-Being and Health-Related Quality of Life with Tildrakizumab in Patients with Psoriasis and Burdensome Symptoms (POSITIVE study)

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Introduction

Plaque psoriasis (PsO) is a chronic, immune-mediated disease that impacts patients' (pts') physical, psychological and social functioning.[1] Itch, skin pain, joint pain and fatigue can be some of the most burdensome symptoms associated with PsO; there is a need for effective treatments to address these.[2] Tildrakizumab (TIL) is a high-affinity humanised IgG1κ monoclonal antibody that selectively inhibits the IL-23p19 subunit and has demonstrated efficacy in Phase 3 clinicals trials for PsO.[3,4] Here, we report the effectiveness of TIL in treating burdensome symptoms, and improvements in psychological well-being and health-related quality of life (HRQoL) in pts with PsO and burdensome symptoms in routine care from the POSITIVE study (NCT04823247).

Materials and Methods

POSITIVE was a 104-week, phase 4, multinational European study in adult pts with moderate-to-severe PsO treated with TIL in a real-world setting.[5] Endpoints reported to Week (W)104 include the proportion of pts achieving ≥4-point reduction in the 11-point Itch-, Pain-, Joint Pain-, and Fatigue-Numeric Rating Scale (NRS; range 0–10 [0=no symptoms, 10=worst symptoms imaginable]) in the Full Analysis Set with NRS≥4 at baseline (BL). We also report mean 5-item World Health Organisation Well-being Index score (WHO-5; range 0–100;

higher scores indicate better well-being; change of ≥10 considered clinically relevant) and mean Dermatology Life Quality Index-Relevant score (DLQI; range 0–30; higher scores indicate greater impairment in HRQoL; 0–1.99: no effect on patient life) in pts with (Itch-, Pain-, Joint-, and Fatigue-NRS≥1) and without burdensome symptoms at BL.[6,7] Data are reported as observed cases.

Results

At BL, 72.3% (465/643), 48.7% (313/643), 29.9% (192/643) and 47.9% (308/643) of pts had Itch-, Pain-, Joint Pain-, and Fatigue-NRS≥4. Of these, at W104, 79.3% (146/184), 81.1% (90/111), 61.9% (39/63), and 72.5% (87/120) achieved NRS reduction≥4 from BL in Itch-, Pain-, Joint Pain-, and Fatigue-NRS.

Pts with burdensome symptoms had considerably worse WHO-5 and DLQI-R at BL compared with those without (**Table**). Improvements with TIL in both WHO-5 and DLQI-R in pts with burdensome symptoms were seen as early as W16 and sustained to W104 (**Table**). In pts with Itch-NRS≥1 and 0 at BL, mean (±95% confidence interval [CI]) WHO-5 was 53.2 (±1.7) and 67.7 (±6.2) at BL, and 69.8 (±2.5) and 74.8 (±11.9) at W104, respectively, and DLQI-R was 12.6 (±0.6) and 4.9 (±1.8) at BL, and 2.3 (±0.5) and 0.6 (±0.5) at W104. In pts with Pain-NRS≥1 and 0 at BL, mean WHO-5 was 51.9 (±1.8) and 61.1 (±3.4) at BL, and 69.5 (±2.9) and 71.8 (±4.4) at W104, respectively, and DLQI-R was 13.9 (±0.7) and 6.5 (±0.9) at BL, and 2.5 (±0.6) and 1.2 (±0.4) at W104. In pts with Joint Pain-NRS≥1 and 0 at BL, mean WHO-5 was 50.9 (±2.3) and 57.6 (±2.4) at BL and 66.6 (±3.8) and 73.1 (±3.1) at W104, respectively and DLQI-R was 14.3 (±0.8) and 9.8 (±0.8) at BL, and 2.6 (±0.8) and 1.8 (±0.5) at W104. In pts with Fatigue-NRS≥1 and 0 at BL, mean WHO-5 was 50.6 (±1.9) and 63.7 (±3.0) at BL, and 68.4 (±2.8) and 74.4 (±4.5) respectively, and DLQI-R was 13.7 (±0.7) and 7.7 (±1.1) at BL, and 2.3 (±0.5) and 1.8 (±0.7) at W104.

Conclusions

In a real-world setting, TIL demonstrated high effectiveness on burdensome symptoms to W104 and sustained improvements in WHO-5 and DLQI-R scores, demonstrating its holistic effect in alleviating the impact of burdensome symptoms in PsO on psychological well-being and HRQoL. Combining WHO-5 and DLQI-R provides a fuller picture of treatment impact.

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Table. WHO-5 and DLQI-R scores in POSITIVE to W104

		Mean score (95% CI; n)			
		Baseline	**W16**	**W52**	**W104**
WHO-5					
Itch-NRS	**≥1**	53.2 (51.5, 54.9; n=599)	62.3 (60.5, 64.1; n=502)	65.2 (63.1, 67.2; n=366)	69.8 (67.4, 72.3; n=253)
	0	67.7 (61.5, 74.0; n=43)	73.0 (66.4, 79.6; n=36)	73.0 (63.7, 82.2; n=25)	74.8 (63.0, 86.7; n=17)
Pain-NRS	**≥1**	51.9 (50.1, 53.8; n=485)	61.1 (59.1, 63.1; n=409)	63.9 (61.6, 66.3; n=298)	69.5 (66.7, 72.4; n=197)
	0	61.1 (57.7, 64.6; n=157)	69.0 (65.6, 72.4; n=129)	71.1 (67.1, 75.2; n=93)	71.8 (67.3, 76.2; n=73)
Joint pain-NRS	**≥1**	50.9 (48.6, 53.2; n=329)	58.7 (56.3, 61.2; n=274)	60.9 (57.9, 64.0; n=194)	66.6 (62.8, 70.4; n=123)
	0	57.6 (55.3, 60.0; n=313)	67.5 (65.1, 69.9; n=264)	70.3 (67.8, 72.9; n=197)	73.1 (70.1, 76.1; n=147)
Fatigue-NRS	**≥1**	50.6 (48.7, 52.5; n=467)	60.2 (58.2, 62.2; n=391)	62.5 (60.1, 64.8; n=284)	68.4 (65.6, 71.2; n=192)
	0	63.7 (60.7, 66.7; n=175)	70.4 (67.2, 73.6; n=147)	74.2 (70.5, 77.8; n=107)	74.4 (69.9, 78.9; n=78)
DLQI-R					
Itch-NRS	**≥1**	12.6 (12.0, 13.2; n=570)	4.4 (3.9, 4.9; n=456)	3.2 (2.7, 3.7; n=331)	2.3 (1.8, 2.8; n=224)
	0	4.9 (3.1, 6.8; n=42)	1.8 (0.6, 3.0; n=34)	0.7 (0.2, 1.1; n=23)	0.6 (–0.0, 1.1; n=15)
Pain-NRS	**≥1**	13.9 (13.2, 14.6; n=462)	4.8 (4.3, 5.3; n=373)	3.5 (2.9, 4.1; n=269)	2.5 (1.9, 3.1; n=177)
	0	6.5 (5.6, 7.5; n=150)	2.3 (1.7, 2.9; n=117)	1.7 (1.0, 2.3; n=85)	1.2 (0.8, 1.6; n=62)
Joint pain-NRS	**≥1**	14.3 (13.5, 15.1; n=310)	5.4 (4.7, 6.1; n=242)	3.6 (2.9, 4.4; n=169)	2.6 (1.8, 3.4; n=108)
	0	9.8 (9.0, 10.6; n=302)	3.1 (2.5, 3.6; n=248)	2.5 (1.9, 3.1; n=185)	1.8 (1.3, 2.3; n=131)
Fatigue-NRS	**≥1**	13.7 (13.1, 14.4; n=445)	4.9 (4.4, 5.5; n=359)	3.3 (2.8, 3.9; n=258)	2.3 (1.7, 2.9; n=172)
	0	7.7 (6.6, 8.8; n=167)	2.3 (1.7, 2.9; n=131)	2.2 (1.4, 3.1; n=96)	1.8 (1.1, 2.6; n=67)

CI: confidence interval; DLQI-R: Dermatology Life Quality Index-Relevant; n: number; NRS: Numeric Rating Scale; W: week; WHO-5; 5-item World Health Organisation Well-being Index.

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An AI G2-PASE scoring tool for Primary Care Providers to assess Psoriasis Severity and Generate A Meaningful Dermatological Referral

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Introduction

Psoriasis is a lifelong, immune-mediated inflammatory skin disease, affecting ~60 million people around the world. PCPs frequently refer patients with psoriasis to dermatologists, regardless of disease severity. This practice contributes to referral backlogs and prevents dermatologists from effectively prioritizing cases. To address this, we have developed an AI-powered image analytics tool to assist PCPs in assessing psoriasis severity, reducing unnecessary referrals. Additionally, dermatologists can review the AI's image analysis (via an AI-generated referral letter) to determine the need and urgency of an in-person consultation, enabling more efficient, priority-based patient management.

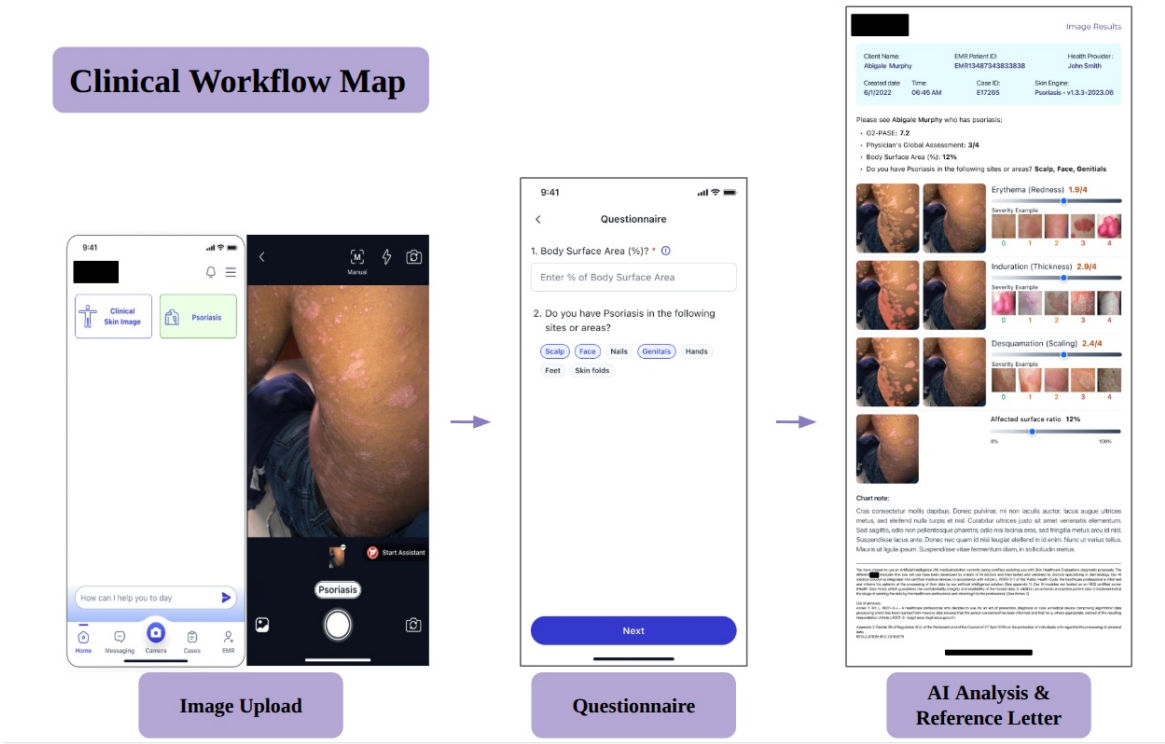
Our novel G2-PASE measurement tool requires only one target lesion to effectively and efficiently assess psoriasis severity. This is a significant improvement from previous work which has focused on the Psoriasis Area and Severity Index (PASI), which is a complex, time-consuming scoring task subject to inter-rater variability. Our objective is to validate the performance of our AI model capable of accurate, efficient, and consistent G2-PASE scoring through a comparison with expert scoring.

Materials and Methods

The G2-PASE is computed as follows:

G2-PASE = PGA×3×BSA score

Where BSA score is computed as BSA <10% = 1; BSA 10%–30% = 2; BSA >30% = 3Our model takes the BSA as an input from the clinician (see Fig. 1). To estimate the PGA score, our AI model completes three tasks. Firstly, the model performs skin segmentation in which it identifies and segments skin regions in the input image. Secondly, the model performs psoriasis segmentation, which discriminates between psoriasis-afflicted skin and general skin; this identifies the target lesion in the image. Finally, the PGA score is calculated based on the average degree (0-4) of redness, thickness, and scaling of the target lesion. Model performance was evaluated on a test set of 63 lesion images; AI scores were compared to gold standard dermatologist scores using Intraclass Correlation Coefficients (ICCs).



Results

The AI G2-PASE scoring model showed strong agreement with dermatologist G2-PASE scoring with an ICC of 0.86. This illustrates the accuracy of AI-powered PGA computation. Note: BSA values are constant between AI scores and physician scores as BSA is a clinician-determined input into the model.

Conclusions

The strong agreement between AI and dermatologist scores supports the integration of this AI model into primary care workflows. Our AI G2-PASE scoring tool can assist PCPs in distinguishing psoriasis cases that require dermatology referral from those that do not, enhancing diagnostic confidence. This aid will reduce unnecessary dermatological referrals, alleviate the workload burden of specialists, and enable faster prioritization of severe cases.

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Abstract N°: 1527

Thermographic Assessment in the Monitoring of Interleukin-17 and Interleukin-23Biologics for Psoriasis: Toward an Objective Alternative to Clinical Scoring Systems

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Introduction

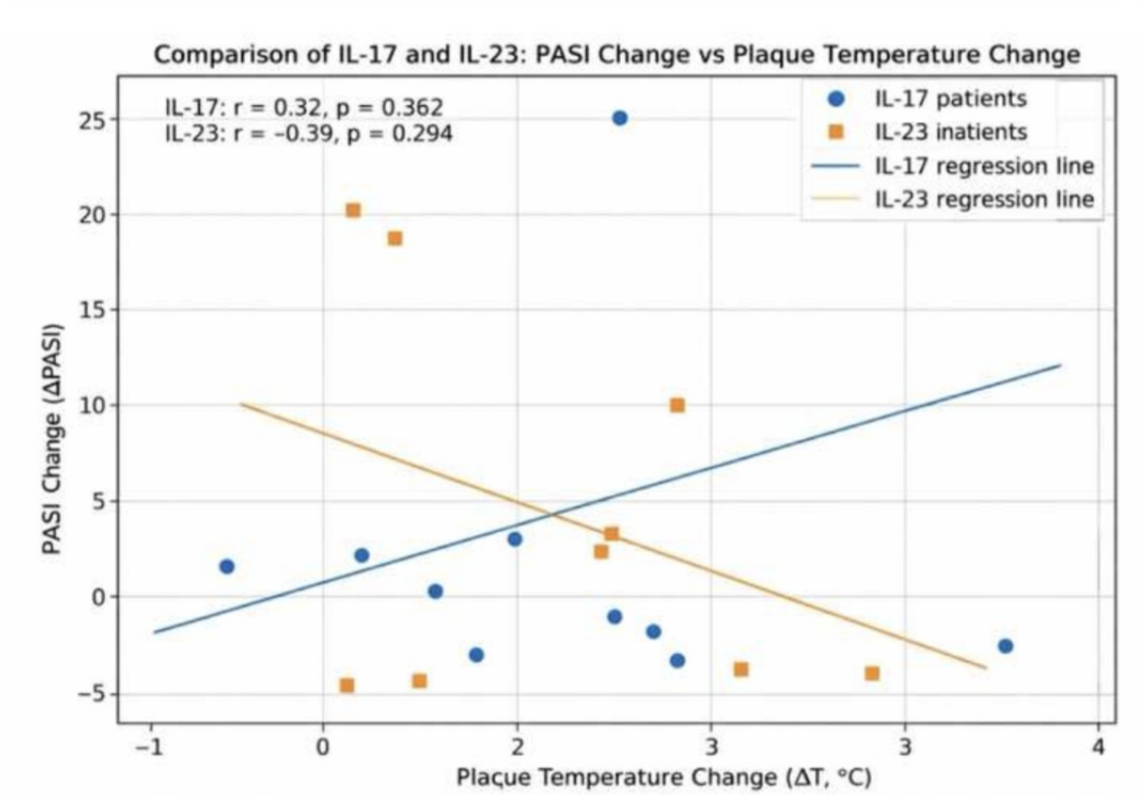
Psoriasis is a chronic immune-mediated inflammatory disease characterized by microvascular alterations and increased cutaneous blood flow. Biologic therapies targeting the IL-17/23 axis have significantly improved clinical outcomes; however, treatment response is still primarily assessed using clinical indices such as PASI, which are inherently subjective and may fail to reflect underlying inflammatory activity. Objective, quantitative tools capable of capturing real-time inflammatory dynamics remain an unmet need in psoriasis management.
Purpose of the present study is to evaluate infrared thermography as a non-invasive, objective method for monitoring treatment response and to explore its potential role in improving treatment stratification in patients receiving biologic therapy.

Materials and Methods

In this prospective longitudinal study, 49 biologic-naïve patients with plaque psoriasis were initially enrolled, of whom 19 completed the study after exclusions. Patients were allocated to IL-17 (n=10) or IL-23 (n=9) inhibitor therapy based on clinical evaluation. Clinical severity (PASI) and thermographic plaque temperatures were assessed at baseline and week 16 under standardized conditions. For each patient, three representative plaques were selected for thermographic evaluation to improve measurement reliability and reduce regional variability. Changes in PASI scores and plaque temperatures were analyzed, and their relationship was assessed using correlation analysis.

Results

Both treatment groups demonstrated significant clinical improvement, with marked reductions in PASI scores ($p<0.001$). Thermographic analysis showed a significant decrease in plaque temperatures in both groups, indicating reduced inflammatory activity (IL-17: $-0.89°C$, $p<0.01$; IL-23: $-1.24°C$, $p<0.05$) Although not statistically significant, a greater reduction in plaque temperature was observed in patients receiving IL-23 inhibitors, suggesting a potentially stronger effect on vascular and inflammatory pathways.
Importantly, no significant correlation was found between PASI improvement and thermographic changes, indicating that clinical and biophysical responses do not progress in parallel. In some patients, thermographic activity persisted despite clinical improvement, suggesting residual subclinical inflammation not captured by clinical scoring.
Thermography also revealed increased temperatures in perilesional and clinically unaffected skin, supporting the presence of subclinical inflammatory activity extending beyond visible plaques. These areas showed temperature normalization following treatment, indicating that thermography may detect early inflammatory changes and identify regions at risk for disease progression or recurrence.
Additionally, heterogeneous thermal responses were observed, including paradoxical temperature increases in certain plaques after treatment. This finding may be explained by the reduction of hyperkeratosis-related insulation, unmasking underlying vascular activity and emphasizing the complexity of interpreting clinical improvement.



Relationship between change in plaque temperature (ΔT, °C) and change in clinical severity (ΔPASI) in patients treated with IL-17 and IL-23 inhibitors.

Conclusions

Thermography provides objective, real-time insight into inflammatory activity in psoriasis and reveals disease dynamics beyond clinical assessment. The observed discordance between PASI and thermographic findings highlights the limitations of relying solely on clinical scoring systems. Incorporating thermographic evaluation into clinical practice may improve treatment monitoring, support personalized biologic selection, and enable earlier identification of patients with persistent inflammation, higher recurrence risk, or potential for long-term remission. These findings suggest that thermography may serve as a complementary biomarker in precision-based psoriasis management.

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Abstract N°: 1532

Successful Treatment of Psoriasis during Pregnancy and Lactation with Secukinumab: A Case Series Report

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Introduction

Psoriasis is a chronic inflammatory immune-mediated skin disease affecting 0.47% of the Chinese population. In 20%–40% of patients, the disease worsens during pregnancy due to immune fluctuations which pose significant risks of miscarriage, preterm birth, and fetal growth restriction. Certolizumab pegol (CZP) is the current preferred biologic for pregnant patients, but its efficacy is generally lower than that of IL-17A inhibitors. Given the scarcity of real-world data on secukinumab (SEC) in Chinese pregnant populations, this study of nine patients evaluates its efficacy and safety to optimize gestational management strategies.

Case Presentation

This single-center retrospective study analyzed nine Chinese patients with moderate-to-severe psoriasis exposed to SEC during preconception, pregnancy, or lactation. We evaluated longitudinal changes in skin lesions (PASI/BSA), treatment transitions, pregnancy outcomes, and neonatal health—including birth weight, development, and vaccination safety (Table 1).

Nine patients with moderate-to-severe psoriasis (median age 30 yrs; disease duration 4–22 yrs; median BSA 30%) were enrolled. Pre-pregnancy, eight patients treated with SEC achieved near-complete clearance (six BSA=0; two BSA≤1%). Obstetric history included primiparous (n=6), multiparous (n=3), and prior miscarriage (n=1). Of the eight patients who stopped SEC, three had no washout exposure and five discontinued during the washout or early pregnancy. All resulted in healthy live births; notably, one patient treated with CZP delivered a small-for-gestational-age (SGA) infant. A single patient received SEC (150 mg q4w) from week 16 through lactation (23 weeks in-utero; 750 mg total dose). Both mother and infant remained healthy, with sustained skin clearance and no adverse events, infections, or Koebner phenomenon reported. All patients who stopped SEC experienced flares, regardless of the degree of pre-pregnancy disease control. Conventional therapies (phototherapy/topical agents) were insufficient, and even switching to CZP failed to achieve complete clearance. These findings suggest that maintaining effective targeted anti-inflammatory treatment is critical for preventing relapses and optimizing pregnancy outcomes.

Postpartum biologic resumption (n=8; seven SEC, another IL-17A inhibitor) led to complete (BSA=0) or near-complete (PASI 90) clearance in most patients. Prompt re-initiation of IL-17A therapy effectively manages postpartum flares and enhances patient quality of life.

No.	Age	Psoriasis Course	Obstetric History	Baseline BSA	Pre-pregnancy Medication	Pre-pregnancy/Early Pregnancy Drug Exposure & Discontinuation Timing	Skin Lesions after Pre-pregnancy Treatment	Intrapregnancy Regimen	Disease Condition During Pregnancy	Delivery Gestation	Neonatal Outcome	Postpartum Treatment & Efficacy
1	33 years	4 years	1-0-0-1	6	Secukinumab	Discontinued 4 months before pregnancy; no gestational biologic exposure	BSA=1, PASI=0.4	No systematic treatment during pregnancy and postpartum	Mild relapse; BSA=2, PASI=1.0	39 weeks	Healthy fetus, 3.55 kg	No systematic treatment with mild persistent skin lesions
2	31 years	10 years	1-0-0-1	50	Secukinumab	Immediate discontinuation during pregnancy preparation; 0-day exposure	Complete skin clearance, BSA=0, PASI=0	Relapse at gestational month 2; phototherapy from GW 20–28; Certolizumab pegol 200mg q2w from GW 28–38	BSA decreased to 2 after phototherapy; BSA=0.5 after combination therapy	39 weeks	Small for gestational age, 2.83 kg	Switched back to secukinumab postpartum with complete skin clearance (BSA=0)
3	29 years	6 years	2-0-0-2	70	No biologic agent	No biologic exposure	—	Topical moisturizer (Yuze)	Spontaneous rash clearance, BSA=0, PASI=0	38 weeks	Healthy fetus, 3.65 kg	Relapse at 8 months postpartum; secukinumab 150mg q2w, achieved PASI 95
4	30 years	7 years	1-0-0-1	30	Secukinumab	Medication from 4 months pre-pregnancy to GW 1, discontinued at GW 1	Complete skin clearance, BSA=0, PASI=0	No systematic medication	Mild early pregnancy relapse; BSA=0.5, PASI=0.2	40 weeks	Healthy fetus, 3.50 kg	Postpartum relapse; sequentially treated with ixekizumab and guselkumab with sustained complete clearance
5	34 years	20 years	2-0-0-2	65	Secukinumab	Medication from 4 months pre-pregnancy to GW 4, discontinued at GW 4	Complete skin clearance, BSA=0, PASI=0	Topical glucocorticoid	Severe relapse with persistent BSA=65 throughout pregnancy	40 weeks	Healthy fetus, 3.80 kg	Reinitiated secukinumab postpartum with short-term clearance; gradual efficacy attenuation and new lesions after 3 years
6	30 years	22 years	2-0-0-2	Missing	Secukinumab	Medication from 4 months pre-pregnancy to GW 6, discontinued at GW 6	Data missing	Topical hydrocortisone butyrate combined with calcipotriol	BSA improved to 2 after treatment	39 weeks	Healthy fetus, 3.40 kg	Regular secukinumab 150mg q4w postpartum
7	37 years	6 years	1-0-0-1	20	Secukinumab	Medication from 4 months pre-pregnancy to GW 3, discontinued at GW 3	BSA=1, PASI=1.3	No systematic medication	Disease relapse 1 month after discontinuation, BSA=20	37+3 weeks	Healthy fetus, 4.35 kg	Switched to ixekizumab 80mg q4w postpartum; 90% lesion clearance and stable condition
8	29 years	15 years	1-0-1-1	5	Secukinumab	Discontinued for pregnancy planning; irregular re-initiation at GW 16	Complete skin clearance, BSA=0, PASI=0	Secukinumab 150mg q4w; total drug exposure for 23 weeks	Complete skin clearance	39+6 weeks	Healthy female infant, 3.50 kg; delayed BCG vaccination, other vaccines well-tolerated	Continuous secukinumab during lactation; 7-month breastfeeding, normal neonatal growth
9	30 years	15 years	1-0-0-1	6	Secukinumab	Discontinued 1.5 months before pregnancy after 4-month pre-pregnancy administration	Complete skin clearance, BSA=0, PASI=0	Topical Yuze moisturizer	No relapse during pregnancy, sustained lesion clearance	40 weeks	Healthy fetus, 3.50 kg	Relapse at 2 months postpartum; dose-escalated secukinumab achieved complete lesion clearance

Table 1 Clinical information of 9 pregnant patients with moderate to severe psoriasis

Conclusion

This study provides real-world evidence for SEC in managing moderate-to-severe gestational psoriasis. WHO pharmacovigilance data (1968–2024) and our findings confirm that SEC can effectively control severe flares during pregnancy and lactation without compromising neonatal development or immune safety. Discontinuation of SEC leads to flares that are refractory to conservative therapy. Given that systemic inflammation is a key driver of preterm birth and low birth weight, initiating effective systemic therapy at specific time points is critical to balance inflammation and pregnancy outcomes. Current international guidelines (BSR/EULAR 2024) confirm the safety of IL-17 inhibitors during pregnancy, recommending only the deferral of infant live vaccines if used after week 28. Based on current evidence, we present a "three-stage" stratified management strategy for gestational psoriasis.

Our proposed stratified pathway prioritizes fetal safety while maintaining maternal control. These findings identify SEC as a key option for severe late-gestational psoriasis. Further studies are needed to clarify long-term neonatal safety profile. Ultimately, gestational stratification ombined with enhanced perinatal monitoring is essential for optimising maternal and fetal outcomes (Table 2).

Stages	Time window	Recommendations
Phase 1	First trimester (0-14 weeks): critical period of organogenesis	During the critical period of fetal organ formation, non-pharmacological approaches can be attempted. For patients who were on secukinumab prior to pregnancy and have stable disease, continued use of the medication is acceptable. For those who did not use biologics before pregnancy, mild topical medications (such as Hydrocortisone Butyrate Cream, etc.) may be preferred for disease control.
Phase 2	Second trimester (14-28 weeks): an ideal treatment window	An ideal window for treatment. If the disease recurs, intensive interventions including secukinumab can be used to ensure that the mother is in a low-inflammatory state. If the drug discontinuation is scheduled at 28 weeks of gestation, this window period can be utilized to sustain disease control until delivery, thereby to reduce fetal drug exposure while preventing/diminishing severe relapse in the mother before delivery.
Phase 3	Third trimester (after 28 weeks) : aim to reduce fetal drug exposure	Aim to reduce fetal drug exposure. Discontinuation of biologics may be considered. For those with extremely severe conditions, maintain the original drug and enhance neonatal vaccine management, or alternatively switch to certolizumab pegol, which has a very low placental transport rate, along with other adjunctive therapies to achieve a balance between efficacy and reduced neonatal drug exposure.

Table 2 'Three-stage' stratified management pathway for gestational psoriasis

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Abstract N°: 1538

Spatial Multi-Omics Mapping Reveals Key Pathogenic Niche and Core Regulatory Transcription Factor MYBL2 Driving Psoriasis Severity

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Introduction
Psoriasis vulgaris is characterized by epidermal hyperproliferation and immune cell infiltration. However, the specific spatial tissue structures (niches) driving disease severity and their underlying molecular mechanisms remain unclear. This study aims to identify pathogenic niches significantly correlated with psoriasis severity (PASI score) and investigate the role of core transcription factors in regulating keratinocyte (KC) abnormal proliferation by integrating single-cell transcriptomics (scRNA-seq) and multi-platform spatial transcriptomics (ST).

Materials and Methods
Public scRNA-seq data were integrated to construct a single-cell atlas of psoriatic lesions and normal skin. The cell2location algorithm was applied to map cells onto 10X Visium spatial transcriptomic sections with PASI scores, and non-negative matrix factorization (NMF) was used to define spatial niches. In-house high-resolution Stereo-seq data (5 pairs of matched psoriatic lesions and perilesional normal skin) were employed for cross-platform validation. Gene regulatory networks were constructed using pySCENIC, and core transcription factors were functionally predicted with CellOracle. Cell–cell communication networks were analyzed using the CosMx spatial molecular imaging system, followed by deconvolution validation and clinical correlation analysis in a large bulk RNA-seq cohort.

Results
Spatial deconvolution identified a key pathogenic niche strongly positively correlated with PASI scores. High-resolution analysis revealed that this niche consists of proliferating keratinocytes, LAMP3+ dendritic cells (DCs), and the cDC2A subset. Stereo-seq analysis confirmed the stability of this multicellular co-localization structure, and neighborhood analysis further demonstrated significant expansion of this niche in lesions. Gene regulatory network analysis identified MYBL2 as the core transcription factor driving aberrant KC proliferation within the niche. In silico perturbation simulations showed that MYBL2 inhibition blocks cell-cycle progression and promotes differentiation toward a mature state. Spatial interaction analysis revealed active communication between LAMP3+ DC/cDC2A and KCs via the IL-23/CCL22 and MIF signaling axes. Validation in a bulk RNA-seq cohort confirmed that MYBL2 expression levels significantly correlate with disease severity.

Conclusions
This study spatially delineates for the first time a core pathogenic unit driving psoriasis severity—a specific niche composed of proliferating keratinocytes, LAMP3+ DCs, and the cDC2A subset—and identifies MYBL2 as the central transcriptional regulator within this niche. These findings elucidate a complete pathological cascade linking "spatial niche–core transcription factor–clinical phenotype," providing new targets and strategies for precisely intervening in this disease-driven spatial unit.

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Abstract N°: 1555

Risk Factors for Coronary Heart Disease in Patients with Psoriasis: A Multicenter Retrospective Case–Control Study

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Introduction

Psoriasis is increasingly recognized as a systemic inflammatory disorder. Among its associated comorbidities, cardiovascular disease has drawn significant attention due to its substantial disability and mortality rates. Although an association between psoriasis and Coronary Heart Disease (CHD) has been established, the specific risk factors contributing to CHD in patients with psoriasis remain incompletely understood.

Materials and Methods

We conducted a multicenter, hospital-based, retrospective case–control study across three hospitals. The study included 56 cases (psoriasis patients with CHD) and 112 age-matched controls (psoriasis patients without CHD). Data were obtained from a pre-established psoriasis-specific database that systematically recorded clinical information from patients seen at the participating hospitals between September 2023 and February 2025. Univariate and multivariate analyses were performed to compare differences between the groups and identify independent risk factors for CHD.Data were collected as follow: gender, age, age at onset, disease duration, Body Surface Area (BSA) score, rash distribution characteristics (including involvement of the scalp, external genitalia, and nails), psoriasis subtype (psoriasis vulgaris, erythrodermic psoriasis, pustular psoriasis, and psoriatic arthritis), and comorbidities—including CHD and Metabolic Syndrome (MetS) along with its components.

Results

1.**Cases and controls**

A total of 1114 psoriasis patients from the three hospitals met the inclusion criteria. After excluding 593 patients due to missing clinical data essential for the study, 521 eligible patients remained, comprising 60 in the case group and 461 in the control group. Using propensity score matching, cases and controls were matched at a 1:2 ratio based on age. Ultimately, 56 cases and 112 controls were successfully matched, the remaining 4 cases and 349 controls that could not be matched were excluded from the analysis (Figure 1).

2. **Comparison of demographic characteristics and risk factors between Cases and Controls. (Univariate analysis)**

A univariate analysis comparing demographic characteristics and risk factors between cases and controls is presented in Table 1. The prevalence of MetS and its components was significantly higher in cases than in controls (83.93% vs. 39.29%, $P < 0.001$). This difference was consistently observed across its components: hypertension (64.29% vs. 32.14%, $P < 0.001$), hyperglycemia (44.64% vs. 14.29%, $P < 0.001$), and dyslipidemia (50% vs. 11.61%, $P < 0.001$). Disease severity, assessed by median BSA score, was significantly higher in cases than in controls (15% vs. 6.5%, $P < 0.001$). No significant differences were observed between groups in gender, age at onset, disease duration, subtype of psoriasis, involvement of nails/scalp/external genitalia, and use of biologic therapy.

3.**Risk factors independently associated with CHD occurrence in psoriasis. Multivariate analysis**

Multivariate logistic regression analysis, incorporating potential risk factors identified in univariate analysis (including BSA, MetS and its components, and psoriasis subtype), revealed that BSA (OR = 1.023, 95% CI: 1.008–1.038, P = 0.002) and MetS and its components (OR = 7.656, 95% CI: 3.32–17.655, P< 0.001) remained independently associated with CHD occurrence in this hospital-based psoriasis population .

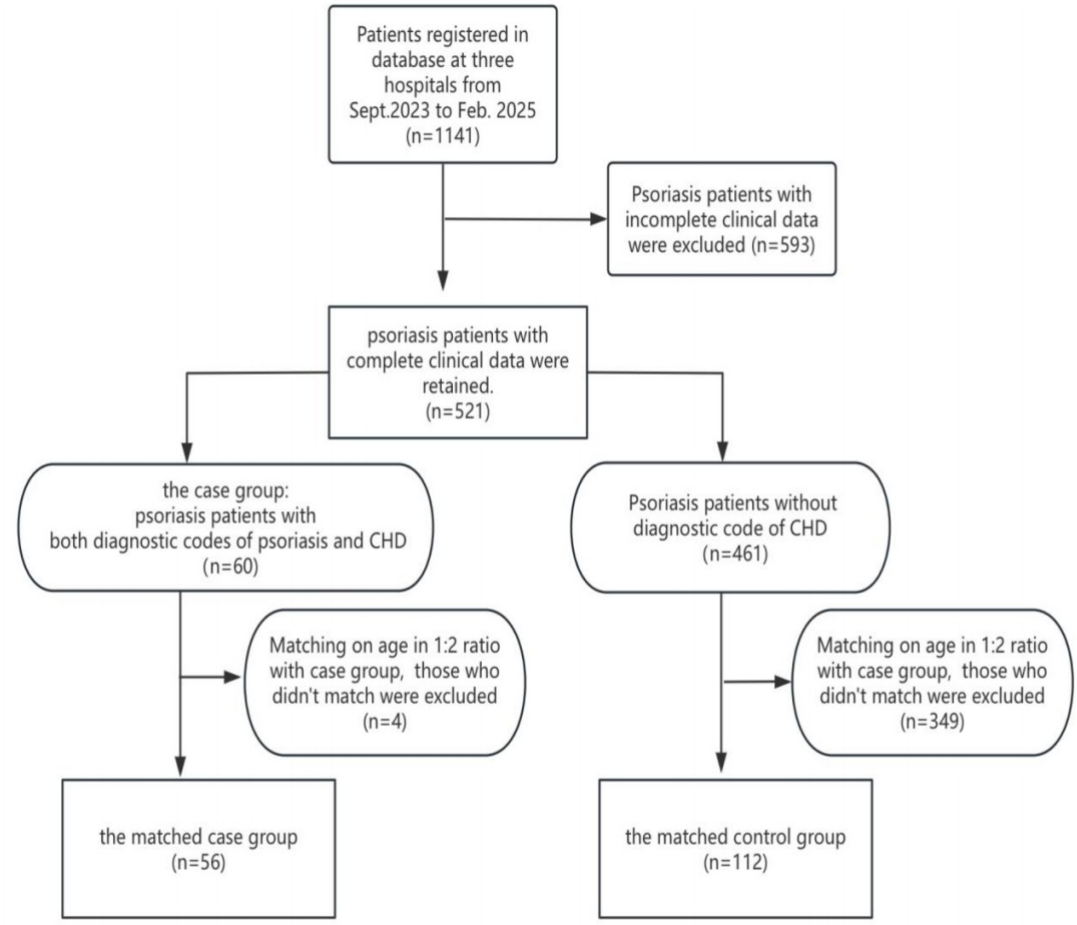

Figure 1: Study flow diagram. CHD: coronary heart disease

Figure 1: Study flow diagram. CHD: coronary heart disease

Conclusions

In summary, in this hospital-based Chinese cohort, extensive BSA involvement and the presence of MetS independently predicted CHD in psoriasis patients. Those with severe skin disease or multiple metabolic abnormalities warrant early and regular cardiovascular screening to reduce the risk of adverse cardiac events. Limitations include the small tertiary-center sample and reliance on ICD-10-CM coding, which may vary in accuracy between groups.

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Abstract N°: 1565

Assessment of a Cosmetic Shampoo formulated with encapsulated Salicylic Acid for Psoriasis-Prone Scalp: Preclinical and Clinical evaluation and Microbiome Compatibility

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Introduction

Psoriasis is a chronic inflammatory skin disease that frequently involves the scalp, causing erythema, scaling and pruritus, with a strong impact on quality of life and treatment adherence. A specialized cosmetic shampoo for psoriasis-prone scalp was developed, combining encapsulated salicylic acid, prebiotics and niacinamide intended to help relieve symptoms such as itching and erythema, while preserving microbiome balance. To comprehensively assess the efficacy and tolerability of this cosmetic shampoo in subjects with psoriasis-prone scalp, integrating preclinical and clinical data, volunteer self-assessments and microbiome compatibility in an *in vitro* model with representative scalp flora.

Materials and Methods

Preclinical evaluation was performed on human skin explants. Corneocyte layer reduction and cell viability were quantified to confirm keratolytic activity without cytotoxicity. The selected formulation was clinically tested in a 28-day, open-label study in adults aged 18–65 years (n = 34) with sensitive and moderate to severe psoriasis-prone scalps. Participants applied the shampoo 3–5 times weekly on wet scalp, left it for 2–3 minutes and rinsed. Assessments at baseline (D0) and D14 and D28 included instrumental measurements of scalp hydration (corneometry), erythema (colorimetry) and dandruff/flaking (standardized imaging), as well as investigator-rated scores for scaling, redness and itching. Volunteer self-assessments were also recorded. Microbiome compatibility was assessed *in vitro* co-culture model.

Results

Preclinical testing showed significant keratolytic activity with a 21% reduction in corneocyte layers by Day 4 ($p < 0.01$), while cell viability remained unchanged, confirming good local tolerance. In the clinical study, after 28 days, instrumental measurements show scalp hydration increased by 55.82% ($p < 0.0001$) and erythema decreased by 16.10% ($p = 0.0029$) and dandruff/scaling count was reduced by 47.12% ($p = 0.0052$) versus baseline. Volunteer self-assessments showed reductions of 76% in scaling, 91% in redness and 76% in itching. Consistently, 91% of participants reported visible redness reduction and 79% expressed overall satisfaction and improved scalp comfort. Microbiome in vitro testing concludes that the investigational product preserves the balance of the scalp microbiota.

Conclusions

These assessments demonstrate that the investigational product provides effective, well-tolerated relief of key subject's concerns related to psoriasis-prone scalp, significantly improving hydration and reducing scaling, erythema and itching, with high patient satisfaction. Preservation of

microbiome *in vitro* supports its use as a microbiome-friendly, adjunctive cosmetic option for individuals with sensitive psoriasis-prone scalps.

EADV CONGRESS
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Abstract N°: 1568

Predictors of Sustained PASI100 and Relapse in Biologic-Treated Psoriasis

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Introduction
Achieving complete skin clearance (PASI100) is now feasible in psoriasis, yet its long-term durability remains inconsistent. Identifying early and modifiable predictors of sustained remission and relapse is critical to guide treatment decisions and long-term disease control.

Materials and Methods
We conducted a retrospective real-world cohort study including 1141 adults with moderate-to-severe psoriasis treated with biologics for ≥24 months. Sustained PASI100 was defined as complete clearance maintained for ≥52 consecutive weeks. Early response was defined as PASI100 at week 16. Multivariable logistic and Cox regression models were used to identify predictors of sustained response and relapse. A week-24 landmark analysis was applied to reduce time-dependent bias.

Results
Sustained PASI100 was achieved in 45.4% of patients. Early PASI100 at week 16 emerged as the strongest predictor of durable remission (adjusted OR 2.98, 95% CI 2.25–3.94; adjusted HR 2.40, 95% CI 1.90–2.90), and was also associated with a significantly lower relapse risk (adjusted HR 0.62, 95% CI 0.41–0.93).
Higher BMI negatively impacted both the probability (adjusted OR 0.90 per unit increase, 95% CI 0.86–0.94) and speed (adjusted HR 0.78, 95% CI 0.60–0.99) of achieving sustained PASI100, while obesity more than doubled the risk of relapse (adjusted HR 2.46, 95% CI 1.54–3.94).
Notably, treatment class did not independently predict long-term outcomes after adjustment. In an obesity-focused analysis, IL-17 inhibitors showed higher effectiveness compared to other biologics (adjusted OR 2.6, 95% CI 1.1–6.0), although this finding should be interpreted cautiously.

Conclusions
In real-world practice, sustained complete clearance is achievable in nearly half of biologic-treated patients but remains unstable in a substantial proportion. Early PASI100 at week 16 is a key determinant of long-term remission and relapse risk, outperforming baseline clinical characteristics and treatment class. Obesity emerges as a major modifiable barrier to durable response, supporting a combined dermatologic and metabolic management approach. These findings reinforce the clinical value of early response–guided treatment strategies in psoriasis.

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Abstract N°: 1581

Bimekizumab clinical outcomes in patients with moderate to severe plaque psoriasis in routine clinical practice in Germany: 1-year results from the ELEVATE observational study

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Introduction

Bimekizumab (BKZ), which selectively inhibits interleukin (IL)-17F in addition to IL-17A, was approved in Europe in 2021 for the treatment of moderate to severe plaque psoriasis.[1]

ELEVATE is a real-world study describing clinical and patient-reported outcomes (PROs) in adults with moderate to severe psoriasis receiving BKZ in routine practice in France, Germany, Greece, Italy and the UK.

Here, clinical outcomes from the analysis of patients enrolled in Germany are presented up to Week 52, stratified by previous treatment exposure. Baseline characteristics and PROs are reported separately.

Materials and Methods

ELEVATE is an ongoing multicentre, prospective, observational study that enrolled adults (≥18 years) with moderate to severe psoriasis newly initiating BKZ per local label requirements. Clinical outcomes (Psoriasis Area and Severity Index [PASI] and high-impact area [scalp-/fingernail-/palmoplantar-] Physician's Global Assessment [sc-/f-/pp-PGA, respectively]) were assessed at Week 0 (baseline; before first BKZ dose) and approximately Weeks 12, 26, 39 and 52.

Primary study objectives were to characterise the previous treatment history of patients initiating BKZ, and to assess the proportion of patients reporting no effect of skin disease on a patient's life at Week 26. The secondary objective was to describe clinical measures of disease severity at different timepoints.

This analysis for German patients was performed once all patients completed approximately Week 52. Results are reported as observed cases for patients with a baseline and ≥1 post-baseline assessment (full analysis set), and by previous treatment exposure subgroups (systemic-naïve; systemic-experienced/biologic-naïve; biologic-experienced).

Treatment-emergent adverse events (TEAEs), collected via routine pharmacovigilance activities, are reported

descriptively for patients who received ≥1 BKZ dose (safety set).

Results

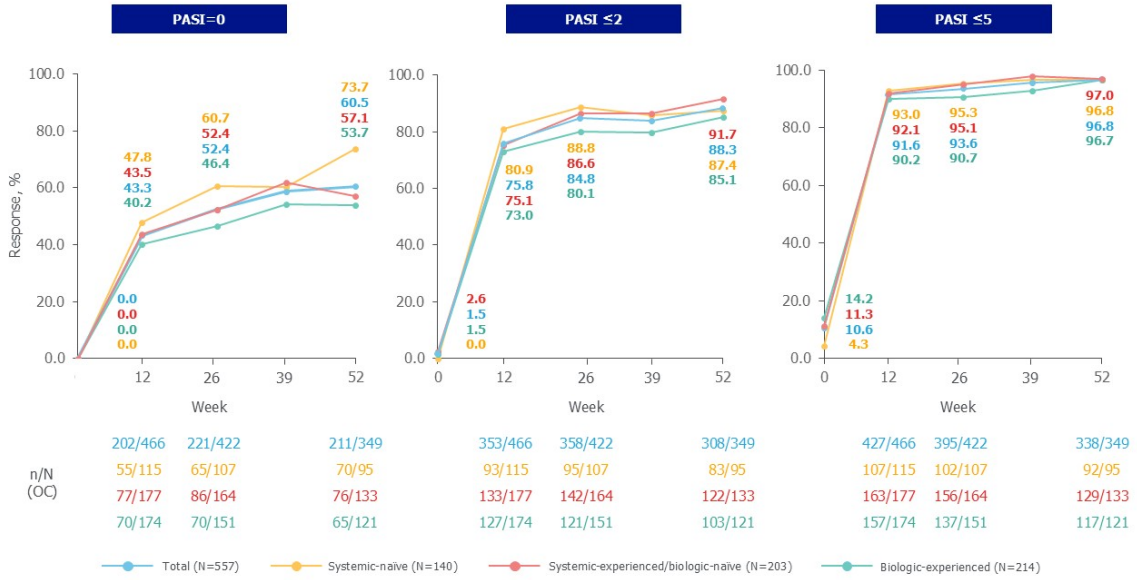
Overall, 557 patients were included (systemic-naïve: 140; systemic-experienced/biologic-naïve: 203; biologic-experienced: 214).

Among patients with baseline PASI >1, PASI=0/≤2/≤5 response rates increased to Week 12 and continued to improve to Week 52 (**Figure 1**). For PASI=0, the most stringent outcome, systemic-naïve patients generally showed slightly numerically higher response rates versus other subgroups. For the total population, mean [standard deviation] PASI decreased from baseline (14.5 [9.6]; N=537) to Week 12 (1.6 [3.1]; N=466) and Week 52 (0.8 [2.0]; N=349). PASI 75/90/100 (≥75/≥90/100% improvement from baseline in PASI) response rates [n/N] were 81.8% [381/466]/63.3% [295/466]/43.3% [202/466] by Week 12, respectively, and continued to improve to Week 52 (92.0% [321/349]/82.2% [287/349]/60.5% [211/349]).

At baseline, 92.3% of patients had any high-impact area involvement (sc-/f-/pp-PGA >0); 68.2% had meaningful involvement (sc-/f-/pp-PGA ≥3). At Week 52, >90% of all patients achieved PGA 0/1 (clear/almost clear) in these areas (sc-PGA: 92.6% [325/351]/f-PGA: 95.7% [337/352]/pp-PGA: 94.6% [331/350]; **Figure 2**).

Of 577 patients who received ≥1 BKZ dose, 51.0% reported a TEAE over 52 weeks. The most common TEAEs, by preferred term, were oral candidiasis, nasopharyngitis and *Candida* infection (not otherwise specified). No new safety signals for BKZ were identified.

Figure 1. PASI=0/≤2/≤5 response to Week 52 (OC)



The full analysis set was used, defined as all patients with a baseline and ≥1 post-baseline assessment. Only patients with PASI >1 at baseline were included in this analysis. OC: observed cases; PASI: Psoriasis Area and Severity Index.

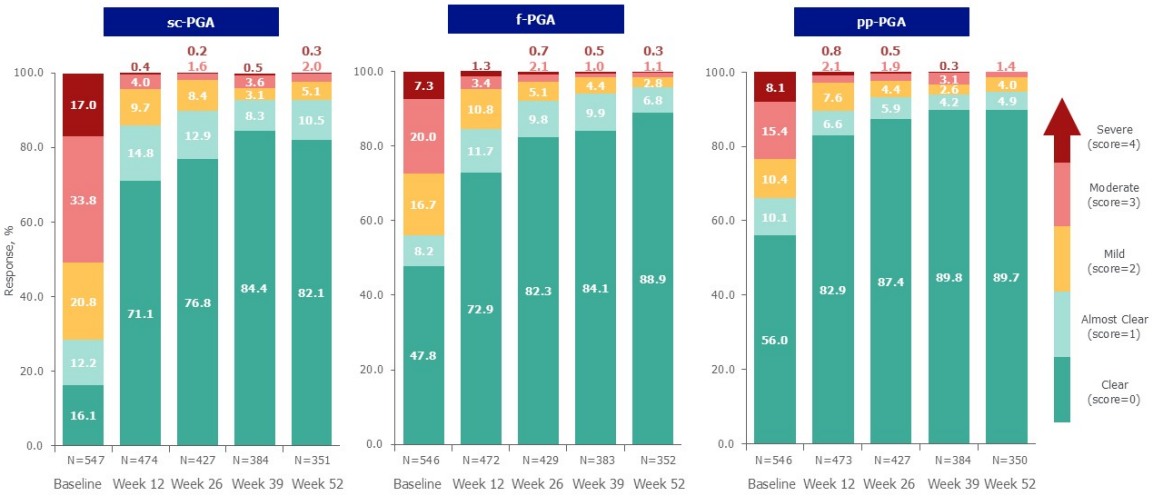
Conclusions

In these ELEVATE analyses for Germany, bimekizumab resulted in substantial improvements by the first post-initiation visit (Week 12), maintained through Week 52. Responses were consistent across treatment history subgroups, with slightly numerically higher responses for systemic-naïve patients in the most stringent outcome. Most patients achieved complete/near-complete skin and high-impact area clearance. These findings support bimekizumab as a highly effective and durable treatment option for moderate to severe plaque psoriasis across various patient populations in routine clinical practice.

References

1. European Medical Agency. www.ema.europa.eu/en/medicines/human/EPAR/bimzelx. [Accessed April 2026].

Figure 2. sc-/f-/pp-PGA category outcomes to Week 52 (OC)



The full analysis set was used, defined as all patients with a baseline and ≥1 post-baseline assessment. Only patients with any high impact area involvement (sc-/f-/pp-PGA >0) were included in this analysis. OC: observed cases; f-PGA: fingernail-Physician's Global Assessment; pp-PGA: palmoplantar-Physician's Global Assessment; sc-PGA: scalp-Physician's Global Assessment.

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Abstract N°: 1584

Use of Janus kinase inhibitors in psoriasis and psoriatic arthritis: clinical profile and cutaneous response in real-world practice. A multicentre retrospective observational study from the Spanish Psoriasis Group

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Introduction
Janus kinase inhibitors (JAKi), except deucravacitinib, are not approved for psoriasis but are increasingly used in real-world practice, particularly in patients with psoriatic arthritis (PsA) or difficult-to-treat disease. Data on their cutaneous effectiveness remain limited. This study aimed to describe the clinical characteristics of these patients and to evaluate their cutaneous effectiveness and safety.

Materials and Methods
Retrospective multicentre observational study. Adult patients with psoriasis, with or without PsA, treated with a JAK inhibitor were included. Demographic, clinical, effectiveness and safety data were collected. The primary outcome was the evolution of mean PASI over time. Secondary outcomes included PASI90, PASI ≤2, DAPSA evolution and subgroup analyses according to baseline disease severity.

Results
A total of 69 patients were included, predominantly female, with a mean age of 54 years; 74% had PsA. Patients presented a high prevalence of cardiometabolic comorbidities, including overweight or obesity, dyslipidaemia, hypertension and smoking, reflecting a complex real-world population. Overall, this was a highly pretreated

cohort, with a mean of 2 prior systemic therapies and 3 biologics. The main reason for treatment initiation was articular involvement, and upadacitinib was used in more than 80% of patients. Plaque psoriasis was the most frequent phenotype, followed by eczematous psoriasis. Special localisations were common, particularly palmoplantar and scalp involvement. Mean baseline PASI was 4, with a reduction of approximately 3 points at week 16, which was maintained and further improved at week 52. In subgroup analyses, patients with controlled baseline disease (PASI <3) had a mean PASI of 1.18 and maintained disease control. Patients with uncontrolled baseline disease (PASI ≥3) had a mean PASI of 6.8 and showed a reduction of around 3 points, maintained throughout follow-up. PASI90 was achieved by 55% of evaluable patients at week 16 and 75% at week 52, while 95% achieved PASI ≤2 at week 52. DAPSA showed a rapid and sustained improvement. Twelve patients discontinued treatment, mainly due to lack of articular efficacy (50% of discontinuations). Adverse events were reported in 16 patients, most commonly infections, including three cases of herpes zoster. One malignancy was observed. No thromboembolic or major cardiovascular events were reported.

Conclusions

In this real-world multicentre study, JAK inhibitors were associated with rapid, clinically meaningful and sustained cutaneous improvement in patients with psoriasis, including those with uncontrolled baseline disease. The safety profile was consistent with previous reports. These findings provide relevant real-world evidence supporting the use of JAK inhibitors in complex clinical scenarios.

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Abstract N°: 1636

Ccf-mtDNA as a potential biomarker for assessing treatment response and relapse in plaque psoriasis during Xeligekimab therapy

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Introduction
Circulating cell-free mtDNA (ccf-mtDNA) acts as a damage-associated molecular pattern and may contribute to inflammatory amplification in psoriasis. However, longitudinal changes in ccf-mtDNA during anti–IL-17A monoclonal antibody treatment remain unclear. This study aimed to explore the potential value of peripheral blood ccf-mtDNA as a biomarker for assessing treatment response and detecting relapse in patients with moderate-to-severe plaque psoriasis receiving an anti–IL-17A monoclonal antibody- Xeligekimab.

Materials and Methods
Five patients with moderate-to-severe plaque psoriasis (Psoriasis Area and Severity Index [PASI] ≥10) were enrolled. Patients who had received systemic immunosuppressive therapy or biologics within the previous 3 months were excluded. Peripheral blood samples were collected at baseline, 1 month, 4 months, and at relapse when applicable. Plasma ccf-mtDNA was quantified by real-time quantitative polymerase chain reaction(qPCR) in triplicate, with absolute quantification based on a standard curve. Longitudinal changes were assessed in relation to clinical disease activity.

Results
Clinical improvement was observed after 1 month of treatment, with mean PASI decreasing from 21.1 at baseline to 4.6. In parallel, ccf-mtDNA levels declined from approximately 1.5 × 10^8 to the 10^7 copies/mL range. In a representative patient with relapse after delayed dosing, ccf-mtDNA increased by more than 20-fold from 1.25 × 10^7 to 2.55 × 10^8 copies/mL, together with worsening of PASI from 2.2 to 18.5 and BSA from 3% to 25.0%. By contrast, patients with a lower baseline molecular burden showed relatively stable ccf-mtDNA levels together with sustained clinical remission.

Conclusions
In this pilot longitudinal study, peripheral blood ccf-mtDNA decreased during clinical improvement and increased at relapse in patients with plaque psoriasis receiving Xeligekimab therapy. These findings suggest that ccf-mtDNA may reflect inflammatory disease activity and may serve as a potential biomarker for therapeutic monitoring and relapse detection. Larger studies are needed to validate these preliminary observations

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Abstract N°: 1642

Analysis of the impact of dermatological diseases on patients' family members: application of the FDLQI

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Introduction

Chronic dermatological diseases, such as psoriasis and atopic dermatitis, significantly impact the quality of life (QoL) of patients and their family members, with emotional, social, and economic consequences. Evidence suggests that these conditions affect the entire family unit, with up to 30% of relatives experiencing relevant impairment in QoL. In this context, standardized instruments such as the Family Dermatology Life Quality Index (FDLQI) allow objective measurement of this impact; however, national studies exploring its application remain scarce.

Materials and Methods

To compare the impact of psoriasis and atopic dermatitis on the quality of life of patients and their family members.

This was an observational, cross-sectional, analytical study. Patients with psoriasis or atopic dermatitis and one cohabiting family member were included through convenience sampling. The Dermatology Life Quality Index (DLQI) was applied to patients, and the FDLQI to family members, both validated for Portuguese. Scores range from 0 to 30, with higher values indicating worse QoL. Categorical variables were described as frequencies and percentages, and quantitative variables as mean, standard deviation, median, and range. Comparisons were performed using the Mann–Whitney and Kruskal–Wallis tests, followed by Dunn's post hoc test with Bonferroni correction. Associations were assessed using the chi-square or Fisher's exact test, and the correlation between DLQI and FDLQI using Spearman's coefficient. A significance level of 5% ($\alpha=0.05$) was adopted.

Results

A total of 82 patients and 101 family members were evaluated. The mean DLQI score was 5.4±7.3, with no significant differences between sexes ($p=0.639$) or diagnoses ($p=0.112$). The distribution of QoL impairment categories was also similar between groups (mild: 58%, moderate: 31%, severe: 11%; $p>0.05$). Among family members, the mean FDLQI score was 7.5±7.9, with a significantly greater impact among relatives of patients with atopic dermatitis compared to psoriasis (10.6±8.9 vs. 6.2±7.1; $p=0.012$), as well as among parents compared to children ($p=0.048$). No differences were observed according to the sex of patients or family members. In the analysis of patient–family dyads ($n=81$), a direct, moderate, and significant correlation was observed between DLQI and FDLQI.

Conclusions

Chronic dermatological diseases negatively impact the quality of life of both patients and their family members, with greater burden observed in cases of atopic dermatitis. These findings highlight the importance of integrated, family-centered approaches.

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Abstract N°: 1647

Comparison of efficacy and drug survival between intra-class and inter-class biologic switching in psoriasis: a retrospective study

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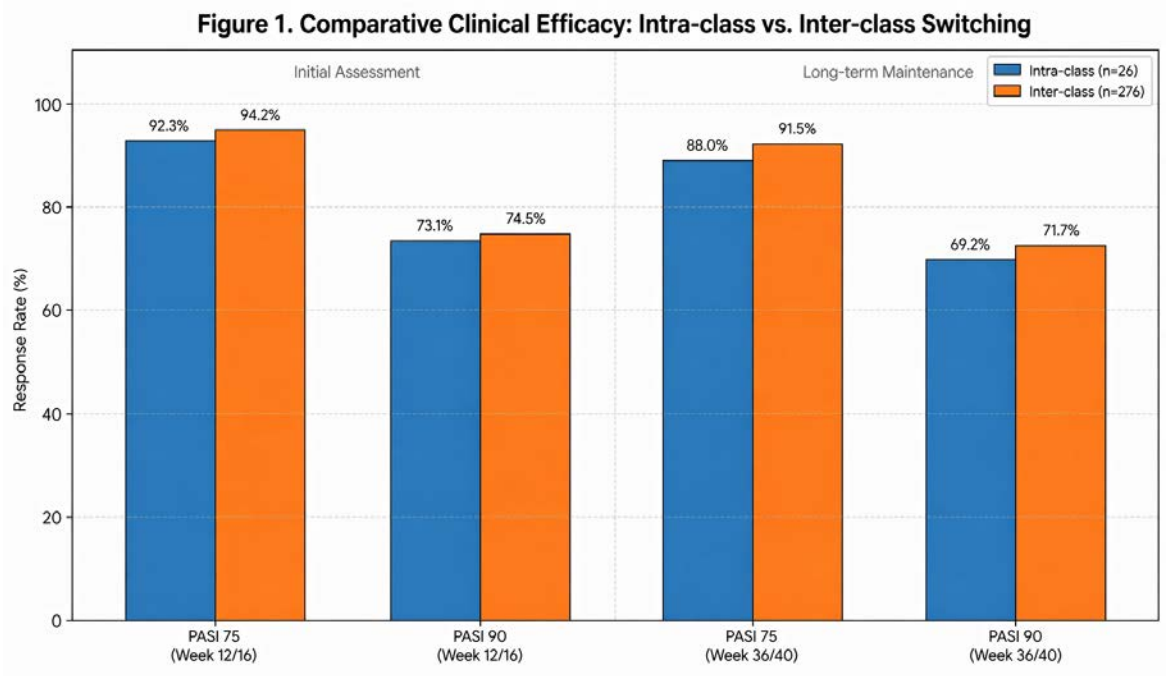
Introduction
Biologic switching is common in patients with psoriasis who experience primary or secondary treatment failure. Inter-class switching is generally preferred in clinical practice, but intra-class switching may preserve future therapeutic options while maintaining treatment response. We compared the real-world efficacy and drug survival of intra-class and inter-class biologic switching in patients with moderate-to-severe psoriasis.

Materials and Methods
We retrospectively reviewed biologic switching events in patients with moderate-to-severe psoriasis treated between January 2015 and September 2025. Among 876 patients treated with biologics, 302 switching events in 216 patients were analyzed. Intra-class switching was defined as switching within the same molecular class, including secukinumab↔ixekizumab and guselkumab↔risankizumab. Inter-class switching was defined as switching between biologics with different primary mechanisms of action. Primary outcomes were Psoriasis Area and Severity Index (PASI) 75 and PASI 90 responses at the initial evaluation point at weeks 12–16. Maintenance of response 24 weeks later was also assessed. Generalized estimating equations were used to account for repeated switching events within individual patients, and drug survival was analyzed using Kaplan–Meier methods.

Results
Among 302 switching events, 26 were intra-class and 276 were inter-class. Baseline demographic and disease characteristics were broadly comparable between the groups. At the initial assessment (weeks 12–16), PASI 75 and PASI 90 response rates were 92.3% and 73.1% in the intra-class group and 94.2% and 74.5% in the inter-class group, respectively. After adjustment for baseline PASI, body mass index, and prior biologic exposures, no significant difference in treatment response was observed between the two switching strategies. Response was maintained at follow-up assessment (weeks 36–40), with PASI 90 rates of 69.2% in the intra-class group and 71.7% in the inter-class group. Kaplan–Meier analysis also showed no significant difference in drug survival between the two strategies. Among individual biologics, 3-year drug survival was higher for risankizumab and ixekizumab than for adalimumab.



PASI 75 and PASI 90 response rates at the initial assessment (weeks 12–16) and follow-up assessment (weeks 36–40) in the intra-class and inter-class switching groups. PASI, Psoriasis Area and Severity Index.

Conclusions

In this real-world cohort, intra-class switching showed efficacy and drug survival comparable to those of inter-class switching. Although interpretation is limited by the small size of the intra-class group, intra-class switching may represent a practical treatment option in selected patients with psoriasis, particularly when preservation of future biologic classes is an important consideration.

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Abstract N°: 1673

Concomitant therapy with ixekizumab plus tirzepatide in adults with psoriatic arthritis and overweight or obesity demonstrated superior disease control compared to ixekizumab alone: results from the Ph3b TOGETHER-PsA trial

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Introduction

Overweight and obesity occurs in 72-82%[1,2] of patients with psoriatic arthritis (PsA) and is associated with worse clinical outcomes and increased comorbidities[3]. We evaluated efficacy and safety of ixekizumab and tirzepatide (IXE+TZP) compared to ixekizumab (IXE) in adults with active PsA and overweight (BMI≥27-<30 kg/m^2) with ≥1 weight-related comorbidity or obesity (BMI≥30 kg/m^2).

Type of Study

TOGETHER-PsA (NCT06588296) is a Phase 3b, randomized, 52-week trial.

Materials and Methods

Participants were randomized 1:1 to IXE+TZP or IXE (open-label) using FDA-approved doses. Primary outcome was week 36 simultaneous achievement of ACR50 and ≥10% weight reduction. Key secondaries included ACR50.

Results

Of participants on IXE+TZP (n=138) and IXE (n=133), mean age was 55.0 years, 69.7% were female, BMI was 37.6 kg/m^2, 71.6% had psoriasis, and 18.8% had failed ≥2 classes of advanced therapies.

31.7% participants achieved primary outcome with IXE+TZP versus 0.8% for IXE (p<0.001). A meaningful difference in ACR50 was observed in IXE+TZP (33.5%) versus IXE alone (20.4%) (multiplicity-controlled p=0.020) with a significant improvement (p<0.05) seen as early as week 4. Improvements were demonstrated in PASI

75/90/100 for IXE+TZP and IXE alone, with IXE+TZP demonstrating a significant difference in absolute PASI change from baseline ($p<0.01$). Significant improvements were observed in physical function (HAQ-DI; $p<0.001$), FACIT-fatigue ($p<0.01$), SF-36 MCS ($p<0.05$) and PCS ($p<0.001$).

Adverse events (AEs) aligned with established drug profiles. Treatment discontinuations due to AEs were comparable among treatment groups.

Conclusions

Significant comprehensive improvement in disease activity was demonstrated with IXE+TZP compared to IXE alone in active PsA, with no new safety concerns.

Previously presented at AAD 2026.

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Abstract N°: 1680

Perceptions of Living with and Managing Both Psoriatic Disease and Overweight/Obesity: A Qualitative Interview Study

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Introduction
Psoriasis vulgaris (PsO) and psoriatic arthritis (PsA), (together, psoriatic disease, PsD) are chronic inflammatory conditions that significantly impair quality of life (QoL). Obesity is a prevalent condition amongst people with PsD. Comorbid obesity and PsD can exacerbate each other. Recent expert consensus state that weight control is a vital component of improving health outcomes for patients with PsD. Weight control can be achieved through diet, exercise, medications, and surgery. The real-world experiences of individuals receiving advanced therapies for PsD and overweight/obesity, with the more recently approved incretin hormones remain largely unexplored.

Objective: The objective of this study was to qualitatively summarize the experiences of adults with PsD and overweight/obesity who are receiving concomitant treatment for both conditions.

Materials and Methods
Adults with PsD and overweight/obesity were invited to participate in a survey followed by virtual semi-structured interviews. Eligible participants self-reported taking a biologic or advanced therapy for PsD for ≥1 year, initiating an incretin hormone ≥3 months after PsO/PsA treatment, and using it for at least 6 months allowing for weight loss to occur, and no longer than 12 months to mitigate recall bias. Interview transcripts were coded for emergent concepts using NVivo v12.0, and thematic analysis was conducted to assess patterns across responses.

Results
Twenty U.S. adults (PsO and PsA: N=9; PsO only: N=6, PsA only: N=5) were recruited from market research panels (N=19) and the National Psoriasis Foundation (N=1). Participants (responses out of all participants (mean age: 50 ± 12.4; 60% female) discussed impaired QoL across physical health and social engagement (100%), daily functioning (90%), and mental health (90%) prior to initiating incretin hormone therapy. Joint pain (50%) and skin symptoms (35%) were cited as most distressing symptoms during interviews.

Participants primarily initiated incretin hormone therapy to lose weight (90%), with 20% seeking improvement in PsD symptoms. Following initiation, all reported physical health improvements, including weight loss (95%), PsO/PsA symptom relief (90%), and improved ability to exercise (80%). Participants discussed improvements in mental health, ability to perform daily activities such as chores and self-care, and social engagement and how this impacted their lives. Most participants (60%) initiated the conversations about weight-loss medications with their HCP; 40% recalled providers discussing the potential connection between PsD and weight. Many (80%) wished these discussions had occurred earlier, with 25% specifically wishing they had taken place at the time of PsO/PsA

diagnosis. Additionally, 30% expressed a desire for more information from providers about weight-loss treatment options.

Four key themes were identified: 1) Impact of living with PsD and overweight/obesity before weight-loss medications was largely negative; 2) weight-loss medications contributed to meaningful improvements in QoL, including physical and mental health 3) individuals wanted more interaction and information from providers of weight-loss medications and PsD and 4) individuals perceived a relationship between weight and health, but not always between weight and PsD.

Conclusions

Individuals with PsD and overweight/obesity reported physical health and quality of life improvement after incretin hormone therapy. Early and proactive provider engagement around PsD and weight management options may enhance health outcomes.

Previously presented at Fall CDC 2025.

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Abstract N°: 1690

Using social listening to understand experiences of incretin use among individuals with both obesity and psoriasis

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Introduction
Obesity is associated with various inflammatory disorders, including psoriasis, as excess adipose tissue promotes chronic inflammation. Incretin-based therapies for weight management may help control psoriasis in people with obesity. Patient perceptions of how incretins affect psoriasis remain unknown. A social listening approach provides insights into disease impact and therapeutic effects beyond what formal studies can capture by systematically analyzing patients' publicly shared conversations. We examined data on social media platforms (Reddit, X, Facebook, Instagram, YouTube, and patient forums) to elucidate the lived experiences of people with both overweight/obesity and psoriasis when using incretins.

Materials and Methods
Posts from people with self-reported overweight/obesity and psoriasis during June 2023–May 2025 were evaluated for disease burden and treatment experiences, including mention of incretins. The Quid Monitor social listening tool with patented natural language processing techniques was used for data analyses and net sentiment calculation. Trained analysts manually reviewed the dataset to correct misclassified mentions. Tagging methods were adapted to clarify emerging topics or themes. A neutral evaluator reviewed the content. The final dataset was cleaned, locked, and aggregated for analysis. Net sentiment was calculated as the ratio of positive to negative mentions; a score of +100 represents exclusively positive opinions.

Results
In total, 6101 posts (943 authors) discussed both psoriasis and obesity/weight reduction; of them, 927 posts (639 authors) mentioned incretin use (net sentiment score, +86). Most posts on symptom burden that did not mention incretin use focused on healthy eating, but weight reduction impact on psoriasis symptoms was mixed, with many people feeling stuck in a frustrating cycle of trial and error, adjusting or switching medications. Over half of the posts mentioning symptom burden with incretin use discussed incretins' positive effects on psoriasis. People highlighted clearer skin with fewer or no patches or lesions, absence of new patches, reduced flare frequency, improved inflammation control, and, in some cases, complete remission or a marked decrease in inflammation levels, after starting incretin medications. Some reported that their inflammation was reduced, noting being less inflamed and commenting on laboratory results. Around <5% of the posts on symptom burden with incretin use reported no improvements or even flare-ups or worsening. Some people mentioned experiencing side effects such as nausea, gastrointestinal discomfort, or increased skin sensitivity, although many felt these were manageable. Barriers to accessing incretin were a common theme and included insurance denials and high out-of-pocket costs. Interest was notable in ongoing and upcoming research and clinical trials in this space. Many

people actively sought information on incretins' effects in psoriasis and other autoimmune conditions. Some referenced emerging studies investigating the role of incretins in psoriasis, with a few noting that their doctors had mentioned these drugs could help reduce inflammation.

Conclusions

Social listening uncovers interest in incretins among people with both psoriasis and overweight/obesity. The findings warrant investigation into the therapeutic efficacy of incretins for this patient group and the strategies to improve their access to incretin medications.

Previously presented at the Maui Derm for Dermatologists - 22nd Annual Meeting, 2026.

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Abstract N°: 1734

Durability of Icotrokinra Effect in Participants With Moderate-to-Severe Plaque Psoriasis and Psoriatic Arthritis: Pooled Analysis of One-Year Outcomes From the Phase 3 ICONIC-ADVANCE 1 and ICONIC-ADVANCE 2 Trials

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Introduction

Icotrokinra (ICO) is a targeted oral peptide that precisely blocks the interleukin (IL)-23 receptor and inhibits IL-23 pathway signaling. In the phase 3 ICONIC-LEAD (NCT06095115), ADVANCE 1 (NCT06143878), and ADVANCE 2 (NCT06220604) studies of participants (pts) with moderate-to-severe plaque psoriasis (PsO), ICO met co-primary and key secondary endpoints at Week (W)16, supporting its recent FDA approval.[1] ICO is being studied in active psoriatic arthritis (PsA) in parallel phase 3 studies (NCT06878404; NCT06807424). In prior pooled analyses of PsO pts and a self-reported medical history of PsA (PsO w/PsA) across 3 ICONIC PsO studies through W16, ICO demonstrated substantial improvements in PsA patient-reported outcomes (PROs) and PsA-relevant PsO outcomes with safety similar to placebo (PBO).[2] This analysis assesses the durability of ICO effects in PsO w/PsA pts who received continuous ICO through W52 in ADVANCE 1 and 2.

Materials and Methods

Pts ≥18 years with moderate-to-severe PsO (body surface area≥10%; Psoriasis Area and Severity Index [PASI]≥12; Investigator's Global Assessment [IGA]≥3) were randomized (2:1 ADVANCE 1; 4:1 ADVANCE 2) to once daily oral ICO or PBO with transition to ICO at W16. In the pooled PsO w/PsA cohort, assessments and endpoints through W52 among pts with evaluable efficacy included: mean change from baseline (BL; least squares mean [LSM] change for ICO vs PBO at W16) and proportions achieving ≥50% improvement in Patient's Global Assessment (PtGA) of PsA disease activity and patient's assessment of PsA pain (PsA Patient Pain); mean/median percent PASI improvement; mean percent improvement in modified Nail Psoriasis Severity Index (mNAPSI) among those with BL score >0; proportions of pts achieving a Physician's Global Assessment of fingernails score of 0/1 (f-PGA 0/1) and a scalp-specific IGA score of 0/1 with ≥2-grade improvement (ss-IGA 0/1) among those with BL scores ≥2; and proportions achieving a Dermatology Life Quality Index score of 0/1 (DLQI 0/1) among those with BL score >1.

Results

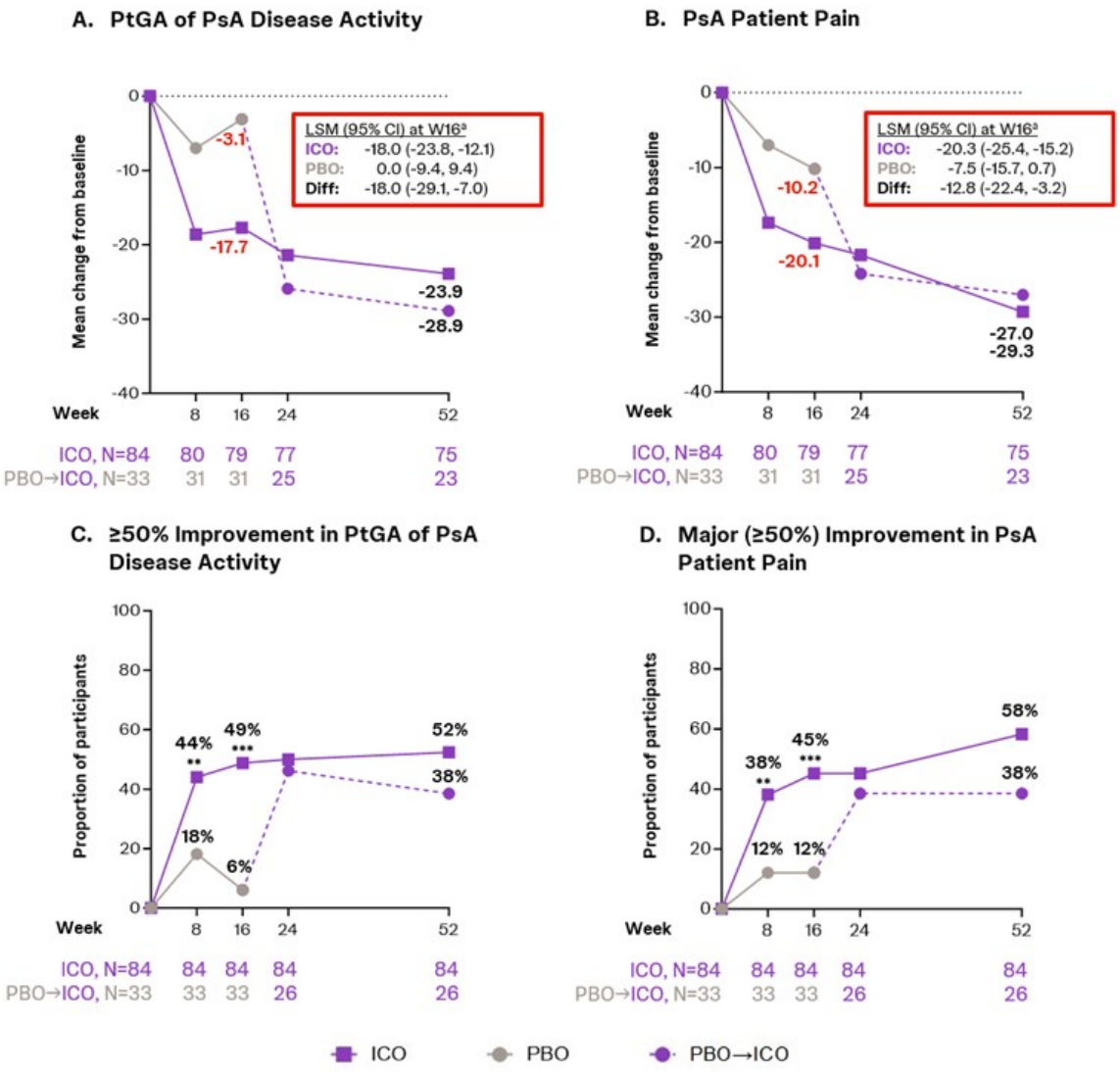
In total, 127 pts (ICO N=89; PBO N=38) comprised the PsO w/PsA cohort, representing 15% (127/871) of the ADVANCE 1 and 2 pooled population receiving ICO or PBO. BL characteristics were generally balanced between groups, with pts reporting moderate PsA disease activity (ICO 48.3; PBO 52.0) and pain (mean ICO 49.4; PBO 54.9). A majority of pts were male (63%), and 80%/20% had an IGA score of 3 (moderate)/4 (severe).
Among pts evaluable for efficacy (ICO N=87; PBO N=37), ICO-randomized pts reported greater reductions in PsA disease activity (LSM [95% CI]: -18.0 [-23.8, -12.1] vs 0.0 [-9.4, 9.4]; **Fig1A**) and PsA pain (-20.3 [-25.4, -15.2] vs -7.5 [-15.7, 0.7]; **Fig1B**) from baseline to W16. Higher proportions of ICO vs PBO pts reported ≥50% improvement in these PsA-specific PROs by W8 (**Fig1C, D**). PsA disease activity and pain scores continued to improve through 1 year, with 52% and 58% of ICO-randomized pts, respectively, reporting ≥50% improvement at W52.
Consistent with overall findings from ADVANCE 1 and 2, ICO demonstrated durable PsO improvements in the pooled PsO w/PsA cohort through 1 year. ICO-randomized pts had mean/median percent PASI improvements >80%/>90% during W16-52. At W52, mean mNAPSI improvement was 76%, 68% achieved f-PGA 0/1, 72% achieved ss-IGA 0/1, and 54% reported DLQI 0/1. The ICO AE profile in the pooled PsO w/PsA cohort was consistent with the known ICO safety profile.[1]

Conclusions

In adults with moderate-to-severe plaque PsO and a self-reported medical history of PsA, ICO demonstrated substantial improvements in PsA disease activity and pain, overall PsO, nail and scalp PsO, and HRQoL that were durable through 1 year, with no safety signals. These exploratory findings further support the potential of ICO as an advanced oral treatment option for active PsA.

References: 1. Janssen Biotech, Inc. ICOTYDE™ (icotrokinra) tablets. Revised 3/2026 (prescribing information). 2. McInnes IB. Presented: EULAR 2026; June 2026; London, England.

Figure 1. PsA-specific PROs from the pooled PsO w/PsA cohort through W52: mean change in disease activity (A) and pain (B) scores from BL and proportions achieving ≥50% improvement disease activity (C) and pain (D)



Nominal *p<0.05, **p<0.01, ***p<0.001 vs PBO[b]

No change from baseline (A, B) / nonresponder imputation (C, D) was assigned after pts discontinued study drug due to a lack of efficacy or an adverse event of worsening PsO, or initiated prohibited medication that could impact PsO; Observed data were used for pts who discontinued study drug for other reasons. The remaining missing data were not imputed (A, B). After accounting for the intercurrent events, pts with missing data were considered nonresponders (C, D). [a]LSMs/LSM differences at W16 based on the MMRM model that accounted for missing data, with treatment group, study, visit, treatment group by visit interaction, baseline PtGA PsA disease activity/pain scores, and baseline PtGA PsA disease activity/pain scores by visit interaction as covariates. [b]Nominal p-values based on Cochran-Mantel-Haenszel chi-square test stratified by study, baseline weight category (≤90 kg, >90 kg), and geographic region. BL, baseline; ICO, icotrokinra; LSM, least squares mean; MMRM=mixed-effect model for repeated measures; PBO, placebo; PROs, patient-reported outcomes; PsA, psoriatic arthritis; PsO, psoriasis; PtGA, Patient's Global Assessment; W, Week.

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Abstract N°: 1739

Durability of Systemic and Skin Pharmacodynamic Responses With Icotrokinra in Moderate-to-Severe Plaque Psoriasis: Phase 3 ICONIC-LEAD Week 52 Results

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Introduction

Icotrokinra (ICO) is the first and only targeted oral peptide that precisely blocks the IL-23 receptor (IL-23R) and inhibits IL-23 pathway signaling. ICO is being evaluated in the phase 3 ICONIC-LEAD study in adults and adolescents (≥12 years) with moderate-to-severe plaque psoriasis (PsO). Week (W)52 study results[1] showed high and durable rates of skin clearance with continued ICO, with 84% of W24 adult PASI90 responders rerandomized to continue ICO maintaining response. Pharmacodynamic (PD) effects of ICO through W52 were assessed via serum protein and skin transcriptomic analyses.

Materials and Methods

ICONIC-LEAD participants (pts) were randomized 2:1 to once-daily (QD) ICO 200 mg or placebo (PBO) with transition to ICO at W16.[1] At W24, adults receiving ICO who achieved PASI 75 or IGA 0/1 (W24 ICO responders) were rerandomized 1:1 to continue ICO (treatment maintenance) or to receive PBO (treatment withdrawal; retreated with ICO 200 mg QD upon loss of ≥50% W24 PASI improvement). Adolescents continued ICO 200 mg QD through W52.

W0, W4, W16, W24, and W52 serum samples (N=171) were analyzed for levels of IL-17A, IL-17F, IL-19, IL-22, BD-2, and IL-23; pts rerandomized to PBO at W24 were excluded from continuous ICO analysis. Analyses focused on the randomized-withdrawal period (W24-52) in adults also included W28 and W36 serum samples (N=90). Skin biopsies collected at W0, W24, and W52 from consenting pts of an optional sub-study (N=65) were analyzed for gene expression by RNA sequencing. Analyses used a linear mixed-effect model that included effects for W0 levels, treatment-over-time interaction, and pt random effects.

Results

In pts treated with ICO through W52, reductions in serum IL-17A, IL-17F, IL-19, IL-22, and BD-2 levels were observed as early as W4, with durable attenuation at subsequent time points through W52 (all $p<0.05$ vs W0).

Similar reductions were observed in pts initially randomized to PBO, 8 weeks after initiating ICO (all $p<0.05$ vs W0). Serum IL-23 levels were stable through W52. During the randomized-withdrawal period in adults, pts with continuous ICO exhibited durable serum biomarker attenuation. Among pts withdrawn from ICO, loss of PD effect was gradual and variable for IL-17A, IL-17F, IL-19 and BD-2; IL-22 and IL-23 levels were stable. Notably, serum biomarker attenuation was sustained in pts who withdrew from ICO and maintained PASI90 response at W52.

In lesional skin, ICO was associated with significant reductions in PsO-related gene set enrichment (MAD3, MAD5) and in the expression of key inflammatory genes, including *IL17A*, *IL17F*, *IL22*, *IL19*, *IL23A*, and *DEFB4A*, at W24 and W52 (all $p<0.05$ vs W0), when they approached levels in nonlesional skin. Similar reductions were observed in pts initially randomized to PBO 8 weeks after initiating ICO (all $p<0.05$ vs W0). Although based on a limited number of pts during the randomized-withdrawal period, attenuation of skin biomarkers was durable in both pts continuing ICO (N=10) and those rerandomized to PBO (N=6).

Conclusions

Consistent with its mechanism of precisely blocking the IL-23R and inhibiting IL-23 pathway signaling, ICO was associated with early and durable PD effects, with attenuation of serum and skin transcriptional biomarkers of IL-23 pathway activation and PsO disease severity. Among adult W24 ICO responders, continued ICO treatment was associated with better maintenance of systemic PD effects through W52. Notably, durable PD effects were also observed following ICO withdrawal at W24 among pts who maintained PASI90 at W52. Overall, these comprehensive PD findings demonstrate durable modulation of the IL-23 pathway at both the systemic and tissue levels, consistent with previously reported clinical findings[1] of high and durable skin clearance observed with this first and only IL-23R-targeted oral peptide.

[1]Soung J. EADV; Sep17,2025; Paris, France.

EADV CONGRESS
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30 SEP - 3 OCT 2026

Abstract N°: 1750

Evaluation of the prevalence of migraine in patients with psoriasis in a reference center in southern Brazil

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Introduction

Psoriasis is a systemic, inflammatory, and chronic disease that affects approximately 2% of the world's population and usually presents as erythematous and scaly skin plaques. It has no sex predilection and has a bimodal peak incidence, between 15-30 years and 55-60 years of age. Migraine, on the other hand, is a neurological condition characterized by perivascular dilation and inflammation that affects almost 10 to 20% of the world's population. Recent studies have raised the possibility that both diseases share pathophysiological mechanisms, given the association with cardiovascular risk factors observed in both psoriasis and migraine.

Materials and Methods

This was a cross-sectional observational study in which 200 patients of both genders, diagnosed with psoriasis for at least 6 months and over 18 years of age, who were followed up at an outpatient clinic of a teaching hospital in southern Brazil, were studied. Epidemiological data, clinical data, and disease activity and quality of life indices (PASI and DLQI, respectively) were collected. For the diagnosis of migraine, diagnostic criteria from the International Classification of Headache Disorders (ICHD – 3rd edition) were used.

Results

The prevalence of migraine was seen in 22% of psoriatic patients, with 16.5% presenting with aura. Visual aura was the most frequent symptom, occurring in 12.5% of migraine cases. The study population was slightly larger in terms of women (55.5%) compared to men (44.5%), with an average age of approximately 58 years. It is worth highlighting that patients with psoriatic arthritis were almost three times more likely to experience migraines, with statistical significance ($p<0.05$), demonstrating an important association between migraines in patients with more severe psoriasis and systemic involvement, such as joint inflammation. Similarly, it was observed that the greater the impairment of quality of life caused by the disease, the greater the likelihood of migraine occurrence, since 40.7% of patients with moderate LDLQI and 26.3% with severe LDLQI were associated with migraine episodes ($p<0.05$).

Conclusions

In summary, the current research shows a considerable prevalence of migraines in patients with psoriasis, as well as a strong association of this comorbidity in those with a higher level of systemic involvement from psoriasis, as is the case with individuals with psoriatic arthritis. In addition, the study shows that there is an increased probability of migraine being present in those with poorer quality of life indices, thus demonstrating the importance of screening for this comorbidity in the study population.

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Abstract N°: 1752

Drug survival of biologics in patients with psoriasis at a reference center in southern Brazil

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Introduction

Psoriasis is a chronic immune-mediated inflammatory disease, frequently associated with systemic comorbidities and a significant impact on quality of life. Severity is assessed using clinical instruments such as PASI, BSA, and DLQI. In moderate-to-severe cases, treatment involves biologics, developed based on the understanding of inflammatory pathways mediated by TNF-α and interleukins (IL-12, IL-17, and IL-23). In this context, drug survival is a fundamental indicator of long-term effectiveness, safety, and tolerability in clinical practice.

Materials and Methods

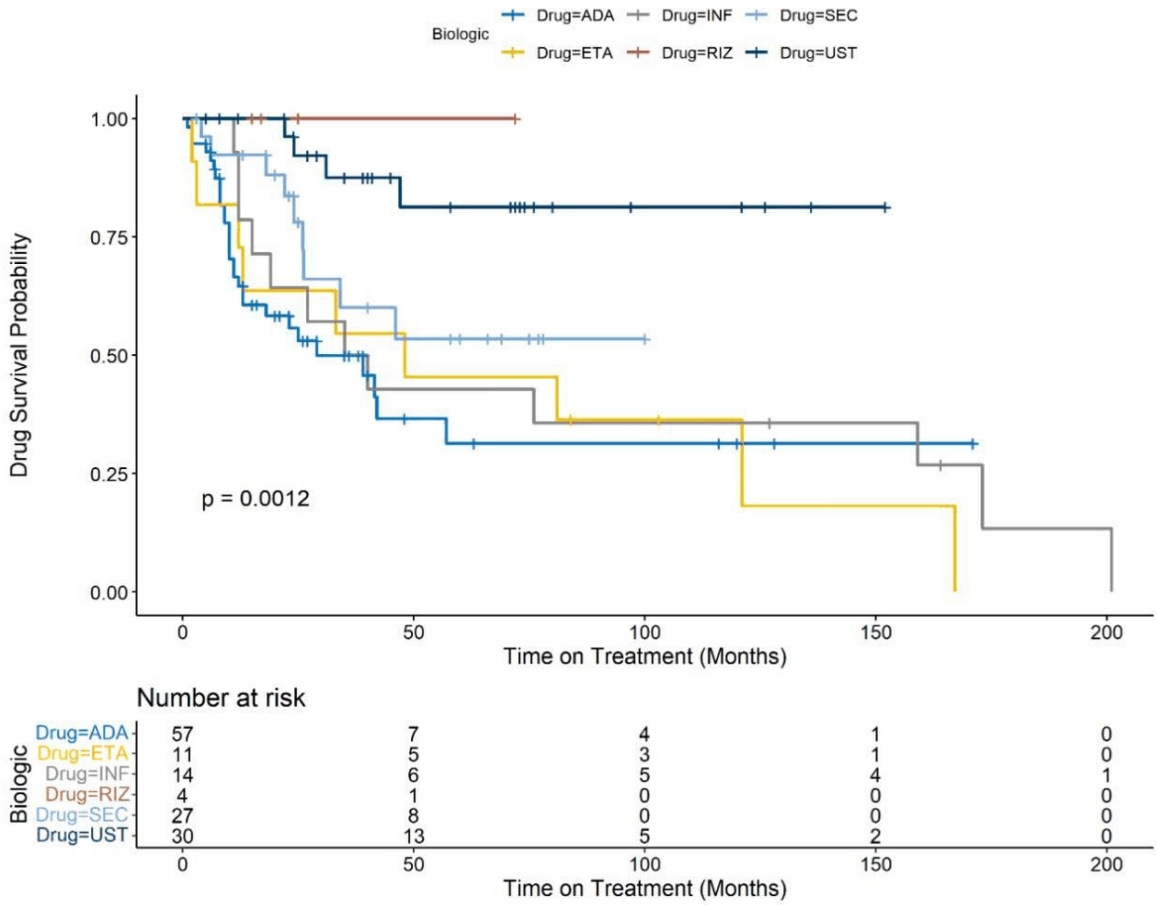
An observational, analytical, and retrospective cohort study was conducted, evaluating 143 medical records. The variables analyzed included: age at diagnosis, sex, type of biologic used, dose administered, duration of drug use in months, and reasons for treatment discontinuation or switch—classified as primary failure, secondary failure, adverse events, and other causes. Drug survival was estimated using the Kaplan-Meier method, and differences between the persistence curves of the various drugs were compared using the log-rank test. Discontinuation was defined as any cessation of treatment due to primary failure (lack of initial response), secondary failure (loss of efficacy over time), adverse events, or loss to follow-up. The level of statistical significance was set at $p < 0.05$.

Results

The sample consisted of 143 individuals, with a mean age of 50.5 years and a slight male predominance (55.2%). The mean follow-up time was 62 months. Regarding the first line of biological treatment, Adalimumab (ADA) was the most prescribed (39.9%), followed by Ustekinumab (UST, 21.0%) and Secukinumab (SEC, 18.9%). Other agents such as Etanercept (10.5%) and Infliximab (8.4%) were also recorded.

Kaplan-Meier analysis revealed statistically significant differences in drug survival ($p = 0.0012$). Ustekinumab demonstrated the highest long-term persistence rate, remaining stable with a survival rate exceeding 80% after 120 months of follow-up. Secukinumab showed the second-best performance, with excellent retention during the first 5 years. In contrast, anti-TNF agents presented the lowest survival rates, with Adalimumab and Etanercept exhibiting steeper decline curves, primarily due to secondary failure.

Of the patients who discontinued the first-line treatment (44.1% of the sample), the main reason was loss of efficacy (secondary failure) in 49.2% of cases, followed by adverse events (15.9%) and primary failure (12.7%). In the second-line analysis, Ustekinumab also maintained relative superiority in terms of treatment duration.



Drug survival probability

Conclusions

This study demonstrates that, in the Brazilian real-world clinical practice setting, IL-12/23 and IL-17 inhibitors show significantly higher drug survivability compared to traditional anti-TNFs in the treatment of psoriasis. Ustekinumab stood out for its remarkable stability and low discontinuation rate over a decade, suggesting it is a highly sustainable option. Loss of efficacy (secondary failure) remains the primary challenge for maintaining biologic therapy. In conclusion, the choice of immunobiologic should consider not only rapid efficacy but also the drug's potential for persistence, aiming for long-term disease control and the optimization of healthcare resources.

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Abstract N°: 1764

Methotrexate-Induced Sexual Dysfunction: An Underrecognized Complication

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Introduction
Methotrexate (MTX) is a widely used systemic therapy in dermatology. The most frequently reported adverse effects include nausea, fatigue, and stomatitis. We report a case of erectile dysfunction occurring in a patient treated with MTX for extensive psoriasis vulgaris.

Case Presentation
A 56-year-old man with a history of untreated hypertension and localized psoriasis vulgaris since the age of 27 presented with a one-month history of disease exacerbation and extension of cutaneous lesions.

Oral methotrexate was initiated at a dose of 10 mg/week, resulting in significant clinical improvement.

Six weeks after treatment initiation, the patient reported decreased libido associated with erectile dysfunction.

Urological examination and prostate–vesico–renal ultrasound revealed no abnormalities.

Given the favorable dermatological response, MTX was discontinued. Three weeks after treatment withdrawal, the patient reported full recovery of sexual function.

Conclusion

Methotrexate has been considered a first-line systemic treatment for moderate to severe psoriasis for nearly five decades. Commonly reported adverse effects include ulcerative stomatitis, nausea, abdominal pain, and leukopenia. In contrast, erectile dysfunction and decreased libido remain rarely described in the literature.
In our case, sexual dysfunction developed six weeks

after MTX initiation. This timeframe is consistent with the findings reported by Theodosiou et al., who observed that erectile dysfunction may occur within weeks of starting therapy and typically resolves within three to four weeks after discontinuation. Another case described sexual dysfunction occurring after nine months of MTX therapy in a patient treated for erythroderma, suggesting variable latency.

The exact pathophysiological mechanism underlying MTX-associated erectile dysfunction remains unclear. Proposed hypotheses include pituitary dysfunction secondary to interleukin-1 inhibition and impaired nitric oxide (NO) production, leading to reduced smooth muscle relaxation and compromised erectile function.

We report a case of methotrexate-induced erectile dysfunction in a patient with psoriasis. Although rare, this adverse effect warrants systematic assessment of sexual function during follow-up of patients receiving MTX therapy.

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Abstract N°: 1770

Generalized Pustular Psoriasis and Hypovitaminosis K: An Unusual Association

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Introduction

Generalized pustular psoriasis (GPP) is a rare and severe form of psoriasis. While the role of certain vitamins has been widely studied, that of vitamin K has been poorly explored. We report an association between GPP and hypovitaminosis K.

Case Presentation

A 3-year-old patient with a history of psoriasis vulgaris was hospitalized for GPP. Laboratory investigations revealed a decreased prothrombin time (PT) of 56%, which corrected after vitamin K administration, confirming hypovitaminosis K. An inflammatory syndrome was also noted (CRP: 16 mg/L; ESR: 34 mm in the first hour). The remainder of the laboratory workup was unremarkable.

The patient was treated with oral acitretin (Soriatane) at a dose of 0.3 mg/kg/day, with a favorable outcome of the GPP.

Conclusion

Psoriasis is a chronic systemic inflammatory dermatosis involving complex immune activation, including pro-inflammatory cytokines, oxidative stress, and endothelial dysfunction. While the role of certain vitamins, particularly vitamin D, has been extensively studied, the role of vitamin K in this condition remains poorly understood.
In a case–control study including 88 subjects (44 patients with psoriasis vulgaris and 44 controls), vitamin K status was evaluated and found to be reduced. This was demonstrated by decreased activation of vitamin K–dependent proteins, particularly coagulation factors, osteocalcin, and matrix Gla protein. No clear relationship was found between vitamin K status and psoriasis severity or the presence of metabolic syndrome. Intestinal inflammation and an altered microbiota may contribute to reduced vitamin K status, impacting vitamin K–dependent proteins.
In our patient, vitamin K deficiency could not be explained by inadequate intake or malabsorption. As suggested by some authors, this may be related to the emerging role of vitamin K in immune regulation, particularly through the reduction of IL-1, IL-6, and TNF-α expression, as well as decreased T-cell proliferation.

We report the first original observation of pediatric GPP associated with hypovitaminosis K. This association remains undocumented and therefore requires cautious interpretation and further investigation.

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Abstract N°: 1772

Correlation of Adalimumab Trough Concentrations and Anti-Drug Antibodies with Clinical Response in Moderate-to-Severe Plaque Psoriasis: A Prospective Cohort Study

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Introduction

Adalimumab is effective for moderate-to-severe plaque psoriasis, yet individual response varies, and secondary loss of efficacy remains a challenge. Therapeutic drug monitoring (TDM) and anti-drug antibody (ADA) assessment are established in inflammatory bowel disease but remain underexplored prospectively in psoriasis. This study evaluates the correlation between serum trough concentrations, anti-drug antibodies (ADA), and clinical outcomes to define a therapeutic threshold.

Materials and Methods

This 24-week prospective cohort study enrolled 78 patients with moderate-to-severe plaque psoriasis (inclusion: BSA ≥ 3% or PASI ≥ 3 or DLQI ≥ 6). Participants received standard adalimumab dosing (80 mg induction; 40 mg every other week). Serum trough concentrations and ADA were measured at weeks 5 and 13 using chemiluminescent immunoassay (detection limit: 0.2 μg/mL). Primary endpoints included the correlation between week-13 trough concentrations and PASI 75 response. Statistical analyses included Spearman/Pearson correlation, ROC analysis for threshold determination, and multivariate logistic regression to identify predictors of response.

Results

Baseline Characteristics: Of the 78 patients enrolled, 74 (94.87%) completed the 24-week follow-up. Among the 74 patients (median age 36.00 (*IQR*, 32.00-46.00) years, 68.92% male), the mean BMI was 24.60 ± 3.43 kg/m² and median disease duration was 15.00 (*IQR,* 8.00-23.00) years. Notably, 97.30% (72/74) were biologic-naïve, while 2.70% (2/74) had prior biologic exposure.

Clinical Efficacy: BSA, PASI, IGA, and DLQI significantly improved at all time points (*P* < 0.001; see Table 1A and Figure 1). At week 13, the response rates for PASI 75, PASI 90, and PASI 100 were 86.49%, 75.68%, and 39.19% (see Table 1B and Figure 1), respectively.

TDM and Correlation: The mean week 13 trough concentration was 5.61 ± 3.32 μg/mL. Concentrations correlated inversely with PASI scores (*r*=-0.280, *P*=0.021) and positively with PASI improvement (*r*=0.280, *P*=0.021). ROC analysis identified a trough concentration ≥ 4.95 μg/mL as the optimal threshold for achieving PASI75 (*AUC*=0.720*, 95% CI :* 0.547-0.892*, sensitivity* 58.3%*, specificity* 62.5%; see Figure 2A).

Immunogenicity: Among 68 patients with TDM data, 8 (11.76%) were ADA-positive at week 13, exhibiting significantly lower trough concentrations than ADA-negative patients (0.65 ± 0.63 vs. 6.26 ± 2.95 μg/mL*, P* < 0.001). Notably, 7 of 8 ADA-positive patients eventually required a treatment switch due to secondary loss of response.

Predictive Modeling: Based on univariate analysis (Table 2), baseline PASI, baseline IGA, and prior biologic exposure were statistically significant. Considering the established clinical relevance of drug exposure and immunogenicity, week-13 trough concentration and ADA status were also forced into the multivariate model. A

binary logistic regression model incorporating these five variables demonstrated excellent predictive performance for PASI75 response, yielding an AUC of 0.905 (95% CI: 0.798–1.000; Figure 2B).

Safety: The treatment was well-tolerated. Minor adverse events included upper respiratory infections (4.05%) and injection site reactions (1.35%). No serious adverse events (e.g., tuberculosis or malignancies) occurred.

Table 1. Clinical outcomes over time: (A) BSA, PASI, IGA, and DLQI scores; (B) PASI response and improvement rates.

Tab.1A The conditions of BSA,PASI, IGA and DLQI at different time points

	Baseline	Week 5	Z	Week 13	Z	Week 24	Z
BSA [M(P_{25}, P_{75})]	21.00 (12.50,31.00)	11.00 (4.5,18.63) *	-6.865	1.00 (0.00,2.70) *	-7.303	0.85 (0.00,2.00) *	-7.241
PASI [M(P_{25}, P_{75})]	16.30 (12.10,21.60)	5.05 (2.70,9.45) *	-7.304	0.60 (0.00,1.80) *	-7.329	0.70 (0.00,1.20) *	-7.284
IGA [M(P_{25}, P_{75})]	4.00 (3.00,4.00)	2.00 (2.00,3.00) *	-7.025	1.00 (0.00,2.00) *	-7.285	1.00 (0.00,1.00) *	-7.204
DLQI [M(P_{25}, P_{75})]	13.00 (8.00,19.25)	6.00 (4.00,11.25) *	-6.457	1.00 (0.00,5.25) *	-7.140	1.00 (0.00,4.25) *	-7.116

Note: * $P < 0.05$, Z refers to the results at weeks 5, 13 and 24 compared to baseline levels.

Tab.1B. Response rates and improvement rates of PASI50, PASI75, PASI90 and PASI100 at different time points

	Week 5	Week 13	Week 24
PASI50[n(%)]	57 (77.03)	69 (93.24)	67 (90.54)
PASI75[n(%)]	29 (39.19)	64 (86.49)	63 (85.14)
PASI90[n(%)]	10 (13.51)	56 (75.68)	56 (75.68)
PASI100[n(%)]	0 (0.00)	29 (39.19)	29 (39.19)
PASI improvement rate[M(P_{25}, P_{75}), %]	66.53 (50.67,84.45)	96.53 (89.47,100.00)	95.90 (89.88,100.00)
DLQI improvement rate[M(P_{25}, P_{75}), %]	45.75 (24.70,66.67)	94.44 (69.03,100.00)	90.45 (69.61,100.00)

Tab.2 Factors related to achieving a PASI 75 response in the 13th week

Research factors	Responders to PASI75(n=64)	Non-responders to PASI75(n=10)	P	OR
Age [M(P25, P75), Y]	35.00 (31.25,44.00)	46.00 (34.50,57.25)	0.394	/
Male [n(%)]	44 (68.75)	7 (70.00)	1.000	/
BMI($\bar{x} \pm s$)	24.58±3.38	24.72±3.95	0.667	/
disease duration[M(P_{25},P_{75}), Y]	14.00 (8.00,23.00)	20.00 (6.25,35.25)	0.373	/
Age of initial onset[M(P_{25}, P_{75}), Y]	20.00 (14.00,30.00)	22.00 (18.00,31.25)	0.394	/
Baseline DLQI($\bar{x} \pm s$)	13.55±8.17	13.50±6.64	0.398	/
Baseline PASI [M(P_{25}, P_{75})]	17.05 (12.75,22.13)	11.40 (9.25,13.58)	0.006	1.124
Baseline BSA[M(P_{25}, P_{75})]	21.50 (12.50,31.38)	19.00 (10.00,24.25)	0.223	/
Baseline IGA[M(P_{25}, P_{75})]	4.00 (3.00,4.00)	3.00 (3.00,4.00)	0.014	3.686
Week 13 Plasma Drug Concentration($\bar{x} \pm s$)	6.02±3.23	4.62±2.46	0.383	/
Week 13 ADA positive[n(%)]	5 (8.33)	3 (37.50)	0.069	/
Biologic-naive [n(%)]	64 (100.00)	8 (80.00)	0.017	0.000
Joint damage[n(%)]	10 (15.63)	3 (30.00)	0.507	/
Nail damage[n(%)]	25 (39.06)	2 (20.00)	0.417	/
Family history[n(%)]	16 (25.00)	1 (10.00)	0.519	/

Fig.1 Patient's PASI50/75/90/100 response rates, PASI improvement rates, and DLQI improvement rates at week 5, 13, and 24

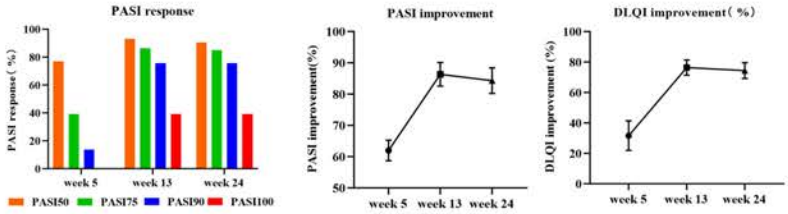
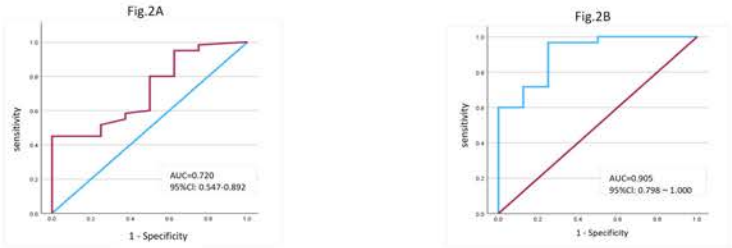


Fig.2 Receiver operating characteristic (ROC) curve analysis of (A) adalimumab trough concentration in predicting Week 13 PASI 75 response and (B) the multivariate logistic regression model for predicting PASI 75 response at Week 13



Tab.1–1 and Fig.1–2 are included in this file, with full titles within the image.

Conclusions

In this prospective cohort, adalimumab trough concentrations ≥ 4.95 µg/mL at week 13 predicted favorable response in moderate-to-severe plaque psoriasis. ADA positivity (11.8%) strongly diminished drug concentrations and preceded loss of efficacy. Routine monitoring of drug levels and immunogenicity offers a practical strategy for personalized management and cost-effective use of adalimumab in dermatology practice.

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Abstract N°: 1806

Modulation of leukemia inhibitory factor (LIF) pathway in patients treated with tildrakizumab, brodalumab and methotrexate: A potential marker of cardiovascular inflammation improvement under tildrakizumab treatment.

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Introduction

Atherosclerosis is a complex process mediated by different cytokines. There is recent evidence that Leukemia Inhibitory Factor (LIF) and its receptor (LIF-R) a IL-6/gp130 related cytokine, is produced in atherosclerotic plaques, and could be considered a marker of active vascular inflammation. The aim of this study was to explore the modification of LIF/ LIF-R in patients with severe psoriasis under systemic treatment.

Materials and Methods

A prospective study was conducted in patients with moderate-to-severe psoriasis treated with methotrexate, brodalumab, and tildrakizumab. Levels of LIF and LIF-R were measured at baseline and after 9 months of treatment as well as levels of other cytokines. Data on disease severity and comorbidities were also collected.

Results

A total of 34 patients were included in the study, with a mean age of 47.8 years, 63% of whom were male, and a baseline PASI score of 9.78. Of these, 17 received treatment with tildrakizumab, 9 with brodalumab, and 7 with methotrexate. After 9 months of treatment, PASI decreased significantly in all treatment groups ($p<0.05$). Levels of LIF and LIF-R showed a significant decrease after treatment in tildrakizumab group ($p<0,05$), whereas it was not found for methotrexate nor brodalumab group. LIF and LIF-R reduction correlated with TNF, IL-17A, IL-17C and erythrocyte sedimentation rate reduction in overall patients ($p<0,05$). No correlation was found between PASI reduction and LIF / LIF-R reduction.

Conclusions

The reduction in LIF and LIF-R levels after 9 months of tildrakizumab may reflect a decrease in systemic and vascular inflammatory burden. This interpretation is supported by evidence showing that LIF is induced in activated immune cells, is present in atherosclerotic plaques, and that LIF/LIFR signaling is associated with activated endothelium and immune cell infiltration within vascular lesions. Therefore, the observed decrease in LIF and LIF-R may represent an indirect signal of reduced vascular inflammation, supporting the hypothesis that effective IL-23 blockade could contribute to a more favorable cardiovascular inflammatory profile in patients with psoriasis.

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Abstract N°: 1823

Perceived impact and burden of patients living with generalised pustular psoriasis: a qualitative study

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Introduction

Generalized pustular psoriasis (GPP) is a severe, chronic inflammatory skin disease, characterized by relapsing-remitting flares with pustules that can cover the whole body. The evolving insights and changing treatment landscape of GPP increases the need for a deeper understanding of its disease burden and patients' needs and preferences within disease management. Therefore, the aim was to explore the disease burden and impact of GPP, in both the acute and chronic phase of the disease.

Materials and Methods

A cross-sectional qualitative study was performed consisting of semi-structured interviews. Patients were recruited through the Dutch Psoriasis Patient Federation and at the outpatient clinic of the Radboud University Medical Centre. Interviews were audio-recorded and transcribed verbatim. Interviews were analyzed by inductive thematic analysis using ATLAS.ti software.

Results

In total, 10 patients were interviewed, of which 6 females and 4 males with a median age of 64.5 years (range 32-75) at time of interview. Most patients were treated with a combination of topical and systemic treatments (90%). Three patients had received the IL36 inhibitor spesolimab. Seven main themes were identified, highlighting the significant impact of GPP on several domains of patients' lives (Figure 1). GPP substantially affected daily functioning, ranging from inabilities in household tasks to work-related tasks, often preventing patients from reaching their full life potential. The emotional burden of GPP was also frequently mentioned by patients, including feelings of shame and anxiety related to upcoming flares, largely due to the unpredictable disease course. In addition to its direct impact on the patient, GPP also had considerable effects on patients' social environment, particularly as patients frequently required support from those around them. Managing and coping with the disease emerged as a continuing and demanding process, often accompanied by treatment challenges characterized by a trial-and-error approach. With regard to healthcare practices, the need for a personalized healthcare approach emerged as an important theme among patients, including a positive patient-physician relationship and shared treatment decision-making processes. Overall, GPP was described as having a persistent impact, with the nature of the burden shifting across disease phases. During flares, patients emphasized acute, often disabling symptoms that necessitated substantial adjustments to daily life. In the chronic phase, the burden was predominantly characterized by the unpredictability of future flares and ongoing efforts to prevent recurrence. Across both phases, visible manifestations of the disease remained a consistent source of distress, contributing to

feelings of shame.

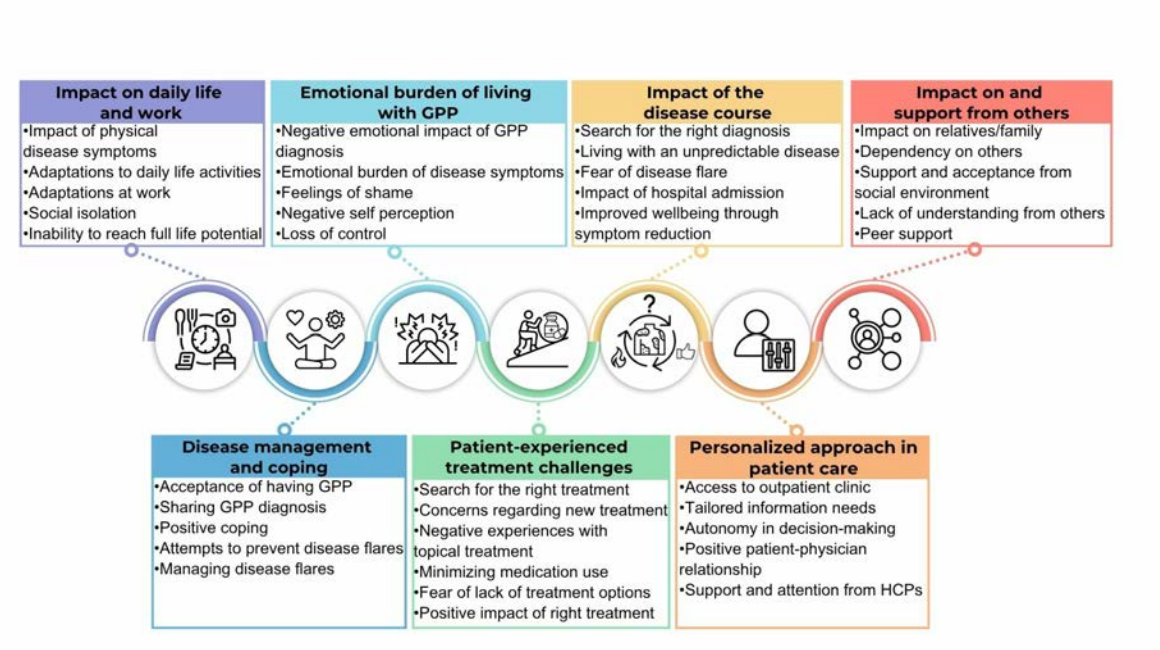

Figure 1. Overview of main themes and subthemes derived from interviews with patients with generalised pustular psoriasis (GPP)

Conclusions

The in-depth exploration of experiences from people living with GPP highlights the persistent and substantial impact on all aspects of patients' lives, both physical and psychological. The variability in disease course across patients further complicates disease management for both patients and physicians. Together, these findings emphasize the need for tailored treatment approaches, patient guidance, and attention to emotional well-being alongside symptom management.

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Abstract N°: 1829

Zasocitinib, a highly selective, once-daily oral TYK2 inhibitor, demonstrates durable efficacy for up to 60 weeks in adults with moderate-to-severe plaque psoriasis: results from two randomized phase 3 trials (LATITUDE-PsO-3001 and 3002)

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Introduction

Zasocitinib is an investigational, next-generation, highly selective, once-daily oral tyrosine kinase 2 (TYK2) inhibitor that maintains 24-hour inhibition of interleukin (IL)-23 plus other core disease-driving immune pathways. In two pivotal phase 3 trials in adults with moderate-to-severe plaque psoriasis (LATITUDE-PsO-3001 [NCT06088043] and LATITUDE-PsO-3002 [NCT06108544]), zasocitinib demonstrated rapid and reproducible skin clearance with a consistent safety profile. Here, we evaluated the durability of skin clearance improvements following treatment with zasocitinib in these trials.

Materials and Methods

Two phase 3 randomized, double-blind, international multicentre trials compared once-daily zasocitinib 30 mg with placebo or twice-daily apremilast 30 mg over 52 (LATITUDE-PsO-3001) or 60 weeks (LATITUDE-PsO-3002). Eligible adults (Psoriasis Area and Severity Index [PASI] ≥12, static Physician's Global Assessment [sPGA] ≥3, body surface area ≥10%) were randomized 3:1:1 (LATITUDE-PsO-3001) and 2:1:1 (LATITUDE-PsO-3002) to zasocitinib, apremilast or placebo.

In both trials, patients receiving zasocitinib or apremilast who achieved PASI 50 at Week 24 continued treatment through Week 40. In LATITUDE-PsO-3001, patients receiving zasocitinib or apremilast who achieved PASI 75 at Week 40 continued treatment through Week 52. LATITUDE-PsO-3002 included a randomized withdrawal and retreatment period from Week 40 through Week 60; patients originally randomized to zasocitinib who achieved PASI 75 at Week 40 were re-randomized 2:1 to zasocitinib or placebo. The proportion of patients maintaining sPGA 0/1, PASI 75, PASI 90 or PASI 100 responses from Week 24 to Week 52 or 60 are reported.

Results

In total, 693 and 1108 patients were randomized in LATITUDE-PsO-3001 and LATITUDE-PsO-3002, respectively. Baseline characteristics were comparable across groups in each trial; 69.7/67.0% were male, with a mean (standard deviation [SD]) age of 44.5 (13.5)/46.1 (13.3) years, mean bodyweight of 85.7 (22.5)/90.0 (22.2) kg and a mean (SD) PASI of 20.0 (7.8)/21.2 (8.9).

At Week 52 (LATITUDE-PsO-3001), maintenance rates across individual endpoints (sPGA 0/1, PASI 75, PASI 90 and PASI 100) among Week 24 responders ranged 85.8–93.0% for zasocitinib-treated patients and 57.1–76.4% for apremilast-treated patients (**Figure A**). At Week 40 (LATITUDE-PsO-3002), the proportion of Week 24 responders maintaining sPGA 0/1, PASI 75, PASI 90 or PASI 100 responses ranged 85.4–90.5% in the zasocitinib group and 66.7–86.6% in the apremilast group (**Figure B**).

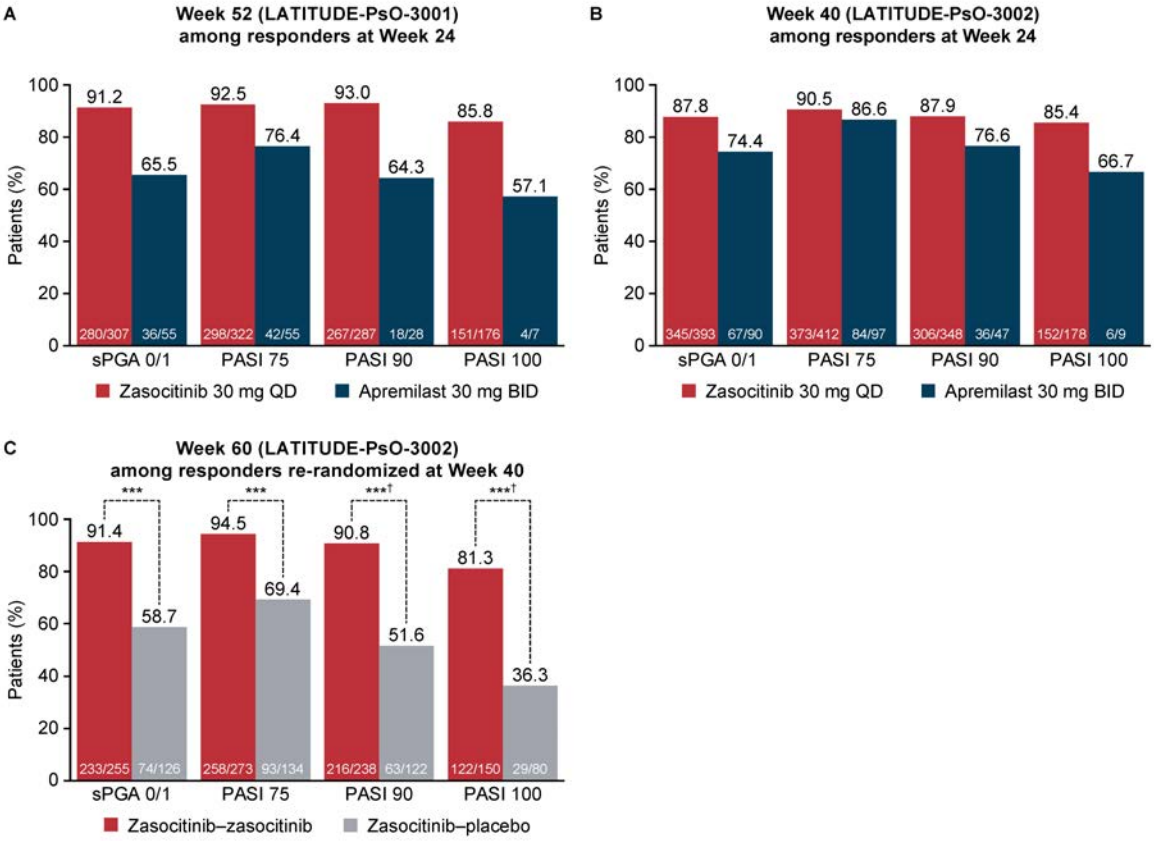
In LATITUDE-PsO-3002, 134 patients initially assigned to zasocitinib were re-randomized to placebo at Week 40, while 273 patients continued receiving zasocitinib. Between 51.6–69.4% of patients re-randomized from zasocitinib to placebo during the re-randomized withdrawal period maintained sPGA 0/1, PASI 75 or PASI 90 response through Week 60, compared with over 90% of patients who continued zasocitinib over the ~5-month period (**Figure C**). In addition, 81.3% who continued zasocitinib maintained PASI 100 response through Week 60.

Of note, at Week 44 (1-month post-re-randomization), 91.3% of patients who had switched to placebo maintained sPGA 0/1, compared with 92.9% of patients who continued zasocitinib.

Conclusions

Once-daily oral zasocitinib demonstrated durable skin clearance across two pivotal phase 3 trials, with over 90% of patients who continued zasocitinib during the re-randomized withdrawal period in the LATITUDE-PsO-3002 study maintaining sPGA 0/1, PASI 75 or PASI 90 response over a ~5-month period. The durability of efficacy responses are being further characterized in a 3-year, open-label, long-term extension study in adults with moderate-to-severe plaque psoriasis (NCT06550076).

Figure. Proportion of patients maintaining sPGA 0/1, PASI 75, PASI 90 or PASI 100 at (A) Week 52 (LATITUDE-PsO-3001) among responders at Week 24, (B) Week 40 (LATITUDE-PsO-3002) among responders at Week 24, or (C) Week 60 (LATITUDE-PsO-3002) among responders re-randomized at Week 40.



N numbers based on number of evaluable patients. Evaluable patients are those who achieved sPGA 0/1, PASI 75, PASI 90 or PASI 100 at Week 24 (A, B) or Week 40 (C).
P values for comparison versus apremilast 30 mg BID or zasocitinib–placebo based on a stratified Cochran–Mantel–Haenszel test: ***$p<0.001$; ***†nominal $p<0.001$.
BID, twice daily; PASI, Psoriasis Area and Severity Index; QD, once daily; sPGA, static Physician's Global Assessment.

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Abstract N°: 1831

Once-daily oral zasocitinib demonstrates rapid and reproducible skin clearance with a consistent safety profile in moderate-to-severe plaque psoriasis: results from two randomized phase 3 trials (LATITUDE-PsO-3001 and 3002)

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Introduction

Zasocitinib is a once-daily oral, allosteric, highly selective and potent tyrosine kinase 2 (TYK2) inhibitor in late-stage clinical development for the treatment of immune-mediated inflammatory diseases, including psoriasis. Here, the efficacy and safety of zasocitinib in adults with moderate-to-severe plaque psoriasis were evaluated in two pivotal trials (LATITUDE-PsO-3001 [NCT06088043], LATITUDE-PsO-3002 [NCT06108544]).

Materials and Methods

Two phase 3 randomized, double-blinded, global, multicentre trials compared zasocitinib 30 mg once daily with placebo or apremilast 30 mg twice daily over 52 (LATITUDE-PsO-3001) or 60 weeks (LATITUDE-PsO-3002). Eligible adults (Psoriasis Area and Severity Index [PASI] ≥ 12; static Physician's Global Assessment [sPGA] ≥ 3; body surface area [BSA] ≥ 10%) were randomized 3:1:1 (LATITUDE-PsO-3001) and 2:1:1 (LATITUDE-PsO-3002) to receive zasocitinib, placebo or apremilast, respectively. Co-primary endpoints were sPGA 0/1 (with a ≥ 2-point decrease from baseline) and PASI 75 response versus placebo (Week 16). Secondary endpoints included PASI 75, PASI 90 and PASI 100 responses versus comparators at Weeks 16 or 24.

Results

LATITUDE-PsO-3001 and LATITUDE-PsO-3002 enrolled 693 and 1108 participants, respectively. Baseline patient demographics and disease characteristics were generally balanced between treatment groups. Most participants were male (69.7% and 67.0%), mean (standard deviation; SD) age was 44.5 (13.50) and 46.1 (13.30) years, mean (SD) weight was 85.69 (22.50) and 89.99 (22.23) kg, and overall PASI score was 19.97 (7.82) and 21.24 (8.93), in LATITUDE-PsO-3001 and LATITUDE-PsO-3002 respectively.

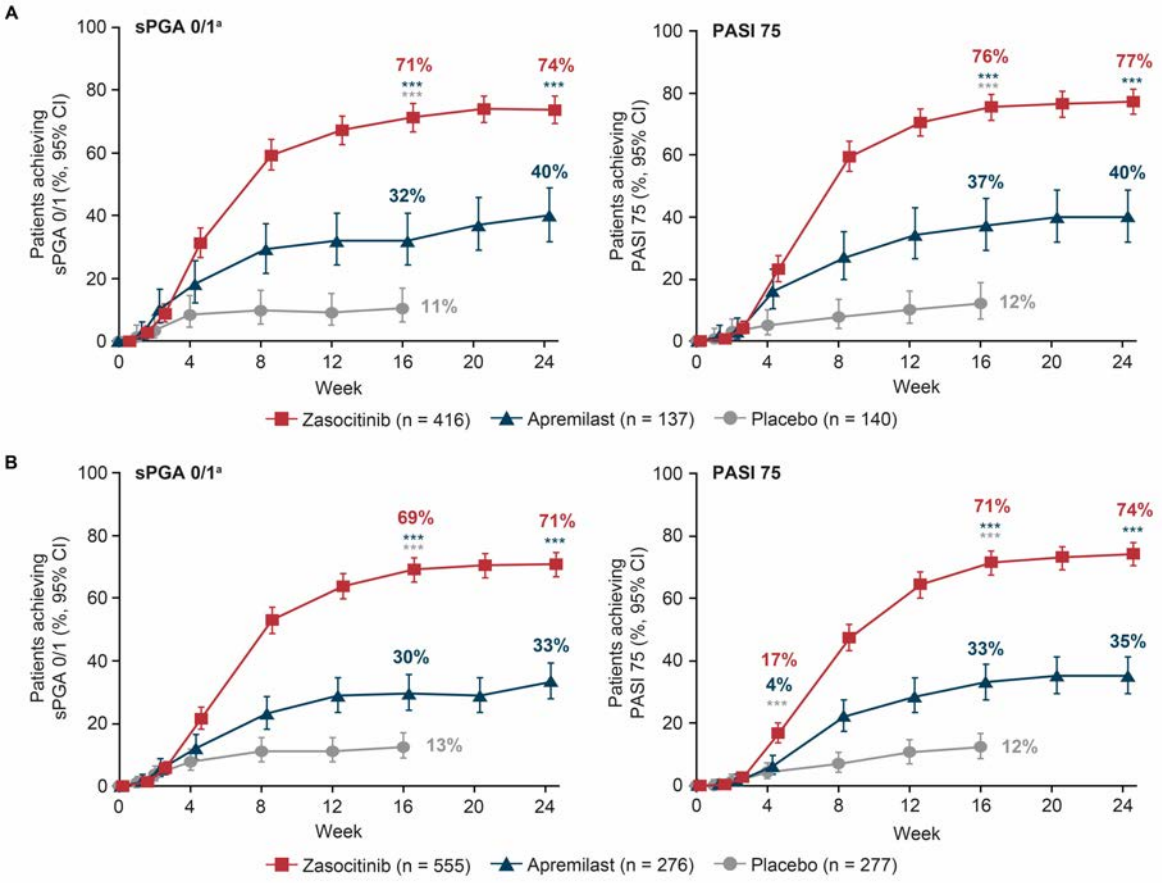
Both LATITUDE-PsO-3001 (**Figure 1A**) and LATITUDE-PsO-3002 (**Figure 1B**) met the co-primary endpoints. A significantly greater proportion of participants receiving zasocitinib achieved sPGA 0/1 or PASI 75 than those

receiving placebo at Week 16 (sPGA 0/1: 71.4%/69.2% versus 10.7%/12.6%, respectively [$p < 0.001$]; PASI 75: 75.7%/71.4% versus 12.1%/12.3%, respectively [$p < 0.001$]). Zasocitinib also demonstrated superiority over apremilast at Week 16 (sPGA 0/1: 32.1%/29.7% [$p < 0.001$]; PASI 75: 37.2%/33.0% [$p < 0.001$]), with progressive improvement observed through Week 24. In LATITUDE-PsO-3002, zasocitinib demonstrated superiority over placebo for PASI 75 as early as Week 4 (16.8% versus 4.3%, respectively; $p < 0.001$).

Superiority of zasocitinib over apremilast was also observed for PASI 90 and PASI 100 at Week 24 (PASI 90: 69.0%/62.7% versus 20.4%/17.0%, respectively [$p < 0.001$]; PASI 100: 42.3%/32.1% versus 5.1%/3.3%, respectively [$p < 0.001$]).

Zasocitinib was generally well tolerated, with no new safety signals identified. Treatment-emergent adverse events (TEAEs) to Week 16 were as follows: zasocitinib 66.1%/59.6%, placebo 45.0%/48.0%, apremilast 54.0%/48.4%. TEAEs to Week 24 were as follows: 72.4%/67.3%, apremilast 58.4%/55.3%.
The most frequently occurring adverse events (≥ 5%) observed with zasocitinib were upper respiratory tract infection, nasopharyngitis and acne.

Figure 1. Zasocitinib met the co-primary endpoints (sPGA 0/1 and PASI 75 at Week 16) in (A) LATITUDE-PsO-3001 and (B) LATITUDE-PsO-3002.



Number of patients based on full analysis set with nonresponder imputation. *p* values for comparison versus placebo (in grey) and versus apremilast (in blue) based on a stratified Cochran-Mantel-Haenszel test: ***$p < 0.001$.
[a]With a ≥ 2-point decrease from baseline.
CI, confidence interval; PASI, Psoriasis Area and Severity Index; sPGA, static Physician's Global Assessment.

Conclusions

Once-daily zasocitinib demonstrates rapid and reproducible skin clearance with a consistent safety profile across two pivotal phase 3 trials.

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Abstract N°: 1833

Zasocitinib, a once-daily oral TYK2 inhibitor, demonstrates efficacy at high impact sites in adults with moderate-to-severe plaque psoriasis: results from two randomized phase 3 trials (LATITUDE-PsO-3001 and 3002)

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Introduction

Zasocitinib is an investigational, next-generation, highly selective oral tyrosine kinase 2 (TYK2) inhibitor that maintains 24-hour inhibition of interleukin (IL)-23 plus other core disease-driving immune pathways. In two pivotal phase 3 trials in adults with moderate-to-severe plaque psoriasis (LATITUDE-PsO-3001 [NCT06088043] and 3002 [NCT06108544]), zasocitinib demonstrated rapid and reproducible skin clearance with a consistent safety profile. Here, the efficacy of zasocitinib for high impact sites was evaluated in adults enrolled in these trials.

Materials and Methods

Two phase 3 randomized, double-blind, international multicentre trials compared once-daily zasocitinib 30 mg with placebo or standard dosing apremilast over 52 (LATITUDE-PsO-3001) or 60 weeks (LATITUDE-PsO-3002). Eligible adults (Psoriasis Area and Severity Index [PASI] ≥12, static Physician's Global Assessment ≥3, body surface area ≥10%) were randomized 3:1:1 (LATITUDE-PsO-3001) and 2:1:1 (LATITUDE-PsO-3002) to receive zasocitinib, placebo or apremilast.

Secondary endpoints included the proportion of patients achieving scalp-specific PGA (ssPGA) response (defined

as clear [0] or almost clear [1] with ≥2-point decrease from baseline [in patients with baseline ssPGA ≥3, baseline psoriasis scalp severity index ≥12 and scalp surface area involvement ≥30%]), change from baseline (CfB) in Nail Psoriasis Severity Index (NAPSI) (in patients with nail involvement at baseline), and proportion of patients with PGA of the palmoplantar hands and/or feet (hfPGA) response (defined as clear [0] or almost clear [1] with ≥2-point decrease from baseline [in patients with baseline hfPGA ≥3]) at Week 16 (versus placebo and apremilast) and Week 24 (versus apremilast).

Results

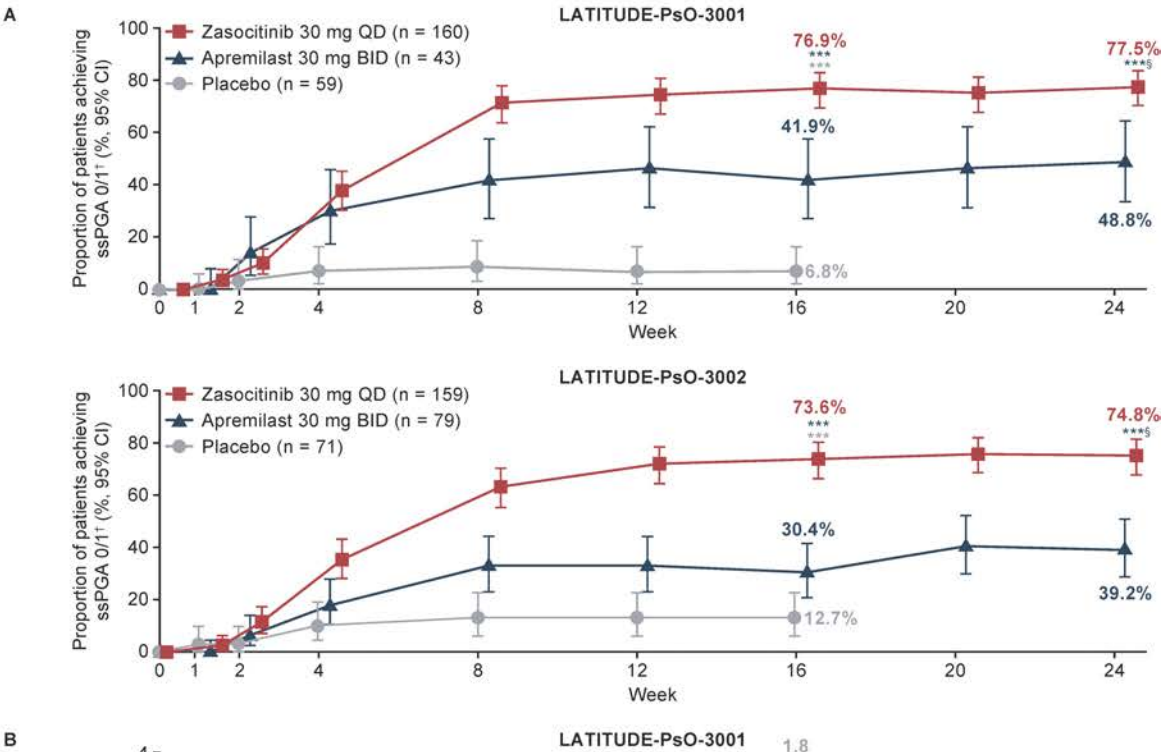
Overall, 693 and 1108 adults were randomized in LATITUDE-PsO-3001 and LATITUDE-PsO-3002, respectively. Baseline characteristics were generally comparable between the two trials; 69.7/67.0% were male, with a mean (standard deviation [SD]) age of 44.5 (13.5)/46.1 (13.3) years, mean (SD) weight of 85.7 (22.5)/90.0 (22.2) kg, and a mean (SD) PASI score of 20.0 (7.8)/21.2 (8.9). At baseline, 262 (37.8%)/309 (27.9%), 167 (24.1%)/240 (21.7%) and 254 (36.7%)/329 (29.7%) patients were evaluable for ssPGA response, hfPGA response and CfB in NAPSI, respectively, in LATITUDE-PsO-3001 and LATITUDE-PsO-3002.

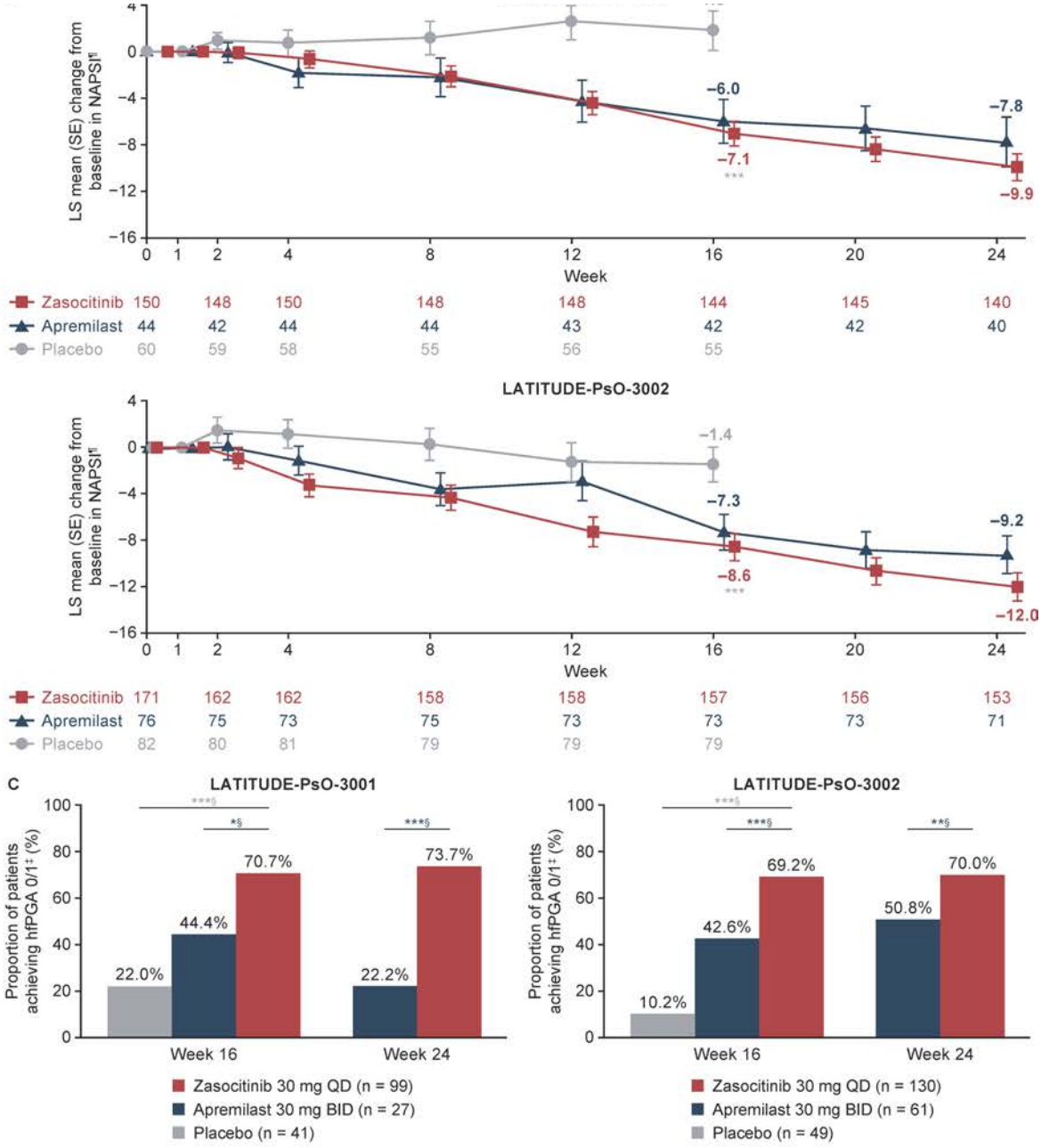
At Week 16, a significantly greater proportion of patients receiving zasocitinib had ssPGA response (76.9%/73.6%) versus placebo (6.8%; $p<0.001$/12.7%; $p<0.001$) and apremilast (41.9%; $p<0.001$/30.4%; $p<0.001$), which continued to Week 24 for zasocitinib (77.5%/74.8%) versus apremilast (48.8%; nominal $p<0.001$/39.2%; nominal $p<0.001$) (**Figure A**). Significant improvements (least-squares mean CfB [±standard error]) in NAPSI at Week 16 were observed in patients receiving zasocitinib versus placebo (−7.1 [±1.1] versus 1.8 [±1.7]; $p<0.001$/−8.6 [±1.2] versus −1.4 [±1.5]; $p<0.001$) (**Figure B**). A greater proportion of patients receiving zasocitinib had hfPGA response at Week 16 (70.7%/69.2%) versus those receiving placebo (22.0%; nominal $p<0.001$/10.2%; nominal $p<0.001$) or apremilast (44.4%; nominal $p=0.022$/42.6%; nominal $p<0.001$), which continued to Week 24 for zasocitinib (73.7%/70.0%) versus apremilast (22.2%; nominal $p<0.001$/50.8%; nominal $p=0.006$) (**Figure C**).

Conclusions

In adults with moderate-to-severe plaque psoriasis, once-daily oral zasocitinib demonstrates reproducible efficacy at high impact sites including the scalp, nails, palms and soles.

Figure. Zasocitinib demonstrated improvements versus placebo and apremilast in A) ssPGA 0/1 response, B) change from baseline in NAPSI and C) hfPGA 0/1 response.





(A) Patients achieving an ssPGA 0/1 response in LATITUDE-PsO-3001 and LATITUDE-PsO-3002. (B) LS mean change from baseline in NAPSI in LATITUDE-PsO-3001 and LATITUDE-PsO-3002. (C) Patients achieving a hfPGA 0/1 response in LATITUDE-PsO-3001 and LATITUDE-PsO-3002.
†Evaluable patients include those with an ssPGA ≥3, baseline PSSI ≥12, and SSA involvement ≥30%.
¶Evaluable patients include those with baseline nail involvement.
‡Evaluable patients include those with a baseline hfPGA score ≥3.
§nominal *p* value.
BID, twice daily; CI, confidence interval; hfPGA, Physician's Global Assessment of the hands and/or feet; LS, least-squares; NAPSI, Nail Psoriasis Severity Index; PGA, Physician's Global Assessment; PSSI, Psoriasis Scalp Severity Index; QD, once daily; SE, standard error; SSA, scalp surface area; ssPGA, scalp-specific Physician's Global Assessment.
*$p<0.05$, **$p<0.01$, ***$p<0.001$ versus placebo (in grey) and versus apremilast (in blue).

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Abstract N°: 1860

Combined nitrogen plasma method and special form plasma therapy (topical use) for palmoplantar psoriasis treatment.

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Introduction

Palmoplantar psoriasis is a chronic, recalcitrant variant of psoriasis that causes significant functional impairment and quality-of-life reduction, while often responding inadequately to conventional topical and systemic therapies. Nitrogen plasma method delivers controlled thermal energy via ionised nitrogen, inducing non-ablative epidermal and dermal remodeling with anti-inflammatory and regenerative effects. Special form plasma therapy (topical use) has demonstrated regenerative and anti-inflammatory properties in various dermatologic conditions and may enhance local control of hyperkeratotic and fissured plaques.

Case Presentation

Patient: A 15-year-old boy diagnosed with palmoplantar psoriasis (PPP), confirmed clinically and histologically. The disease has persisted for 5 years with periodic exacerbations, resistant to prior therapy with topical corticosteroids (class I-II) and keratolytics (salicylic acid 5-10%). Family history of psoriasis—present in his sister. No associated systemic manifestations (arthritis, obesity).

Disease History: First onset at age 10 with hyperkeratotic plaques on soles accompanied by itching and pain. Progression to moderate-severe form with hyperkeratosis,deep fissures, and functional impairment (pain on walking, limited physical activity). PPPASI (Palmoplantar Pustulosis Area and Severity Index) at presentation: 25.4.
Objective Status: On soles—hyperkeratotic plaques with yellowish scales (70% surface area), fissures up to 3 mm deep. No nail bed involvement or other localizations.
Treatment: Combined therapy with nitrogen plasma treatment (0.5 J low energy) and special plasma form as serum and a hormone-free cream for home use. Protocol: 5 sessions at 1-week intervals. Each session included:

- Disinfection.
- Nitrogen plasma therapy at 0.5 J low power.
- Application of special topical plasma form as serum and hormone-free cream with plasma for home use.Session duration: 20-30 minutes total. Patient followed home care regimen (serum with special plasma form and hormone-free cream). A total of 5 sessions were completed.

Results:

- After 3 sessions: PPPASI 12.1 (52% reduction), regression of inflammation, reduction in fissures.
- After 5 sessions: PPPASI 0 (complete clinical remission), normalized skin texture, absence of erythema and hyperkeratosis.
- 3-month follow-up: sustained remission without relapse, DLQI (Dermatology Life Quality Index) improved from 18 to 1.Adverse effects: none observed.



The result of five procedures of a combination of nitrogen plasma and topical plasma therapy

Conclusion

The combination of nitrogen plasma therapy and topical plasmotherapy demonstrates high efficacy and safety in adolescent palmoplantar psoriasis, achieving complete remission in 5 weeks without systemic agents. Suitable for cases resistant to standard topical therapy.

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Abstract N°: 1863

Association of Helicobacter pylori infection with the severity of psoriasis.

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Introduction
Psoriasis is a chronic, immune-mediated inflammatory disease, with a global prevalence ranging from 0.51% to 11.43%, and approximately 0.7% in Bangladesh. Helicobacter pylori (H. pylori), a Gram-negative bacterium with a high prevalence in Bangladesh, has been implicated not only in gastrointestinal diseases but also in several extraintestinal and dermatological conditions. The pathogenesis of psoriasis involves a complex interaction between genetic, immunological, and environmental factors, with Th17-mediated cytokines such as TNF-α, IL-17, IL-22, and IL-23 playing a central role. Environmental triggers, particularly infections, are known to influence disease onset and severity. Emerging evidence highlights the role of the gut-skin axis, suggesting that microbial agents like H. pylori may contribute to systemic inflammation and disease exacerbation. H. pylori infection may promote psoriasis through chronic immune activation, increased cytokine production, and release of inflammatory mediators. While some studies report a significant association, others show conflicting results. Therefore, this study aimed to evaluate the association between H. pylori infection and the severity of psoriasis

Materials and Methods
This cross-sectional comparative study was conducted in the Department of Dermatology and Venereology, Bangladesh Medical University (BMU), Dhaka, from May 2023 to March 2025. A total of 58 participants were enrolled using a consecutive sampling technique, including 29 clinically and histopathologically confirmed psoriasis patients (Group A) and 29 age- and sex-matched non-psoriatic controls (Group B). Patients with recent use of systemic immunosuppressants, proton pump inhibitors, or prior H. pylori eradication therapy were excluded. Individuals with dermatological conditions known to be associated with H. pylori infection were also excluded. Detailed demographic and clinical data were collected using a semi-structured questionnaire. Psoriasis severity was assessed using the Psoriasis Area and Severity Index (PASI). Detection of H. pylori infection was performed using a stool antigen test (CerTest), a rapid chromatographic immunoassay with high sensitivity and specificity. Data were analyzed using SPSS version 26. Quantitative variables were expressed as mean ± standard deviation, and qualitative variables as frequencies and percentages. Comparisons between groups were performed using the Chi-square test and Mann-Whitney U test as appropriate. A p-value <0.05 was considered statistically significant.

Results
A total of 58 participants were included, comprising 29 psoriasis patients and 29 controls. There were no significant differences between groups regarding age (31.3 ± 15.9 vs. 34.2 ± 15.4 years; $p=0.508$) or sex distribution ($p=0.597$). H. pylori stool antigen positivity was significantly higher in psoriasis patients compared to controls (31.0% vs. 6.9%; OR=6.07, 95% CI: 1.18–31.2; $p=0.019$). Among psoriasis patients, those with H. pylori infection had significantly higher disease severity. The mean PASI score was markedly elevated in H. pylori-positive patients compared to negative patients (21.7 ± 5.14 vs. 7.24 ± 7.13; $p<0.001$). All H. pylori-positive patients (100%) had severe psoriasis (PASI ≥10), whereas among H. pylori-negative patients, 45.0% had mild, 30.0% moderate, and 25.0% severe disease ($p<0.001$). No significant associations were found between psoriasis severity and demographic variables such as age, sex, or disease duration ($p>0.05$). Similarly, no significant differences in age, sex, or disease duration were observed between H. pylori-positive and negative psoriasis patients.

Conclusions

Helicobacter pylori infection was significantly associated with increased severity of psoriasis. Psoriasis patients with H. pylori showed markedly higher PASI scores and a predominance of severe disease. These findings suggest a potential role of H. pylori in disease exacerbation, possibly via systemic inflammatory and gut–skin axis mechanisms.

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Abstract N°: 1870

Real-world use of incretin-based therapies in patients with psoriasis and metabolic comorbidities: a case series

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Introduction

Psoriasis is a chronic immune-mediated disease associated with obesity and type 2 diabetes mellitus, contributing to increased systemic inflammation and cardiometabolic risk. Incretin-based therapies, including glucagon-like peptide-1 receptor agonists and dual incretin receptor agonists, are increasingly used for metabolic control, with emerging evidence suggesting anti-inflammatory and immunomodulatory effects beyond weight and glycaemic regulation, potentially relevant in inflammatory skin diseases.

This study aimed to describe real-world clinical outcomes of incretin-based therapies in patients with psoriasis and metabolic comorbidities, focusing on metabolic response and psoriasis evolution.

Materials and Methods

We conducted a retrospective case series of six patients with psoriasis and metabolic comorbidities treated with incretin-based therapies, including semaglutide, liraglutide and tirzepatide. Demographic data, comorbidities, prior and concomitant psoriasis treatments, and longitudinal outcomes were collected.

Results

Most patients presented with moderate-to-severe psoriasis and significant metabolic burden, including obesity and/or type 2 diabetes mellitus. Incretin-based therapy was consistently associated with clinically meaningful weight reduction across all patients. In those receiving concomitant biologic therapy, psoriasis remained clinically stable or improved during follow-up. One patient experienced disease worsening after discontinuation of systemic immunosuppressive treatment despite ongoing incretin-based therapy. No relevant adverse events leading to discontinuation were observed.

Conclusions

In this real-world case series, incretin-based therapy in patients with psoriasis and metabolic comorbidities was associated with favourable metabolic outcomes and a stable dermatological course when combined with standard antipsoriatic treatments. These findings align with emerging evidence suggesting systemic benefits of incretin-based therapies in this population beyond metabolic control. However, their direct impact on psoriasis activity remains uncertain, particularly in the absence of concomitant immunomodulatory therapy. Larger prospective studies are needed to clarify their role as adjunctive treatment in psoriasis management.

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Abstract N°: 1873

Envudeucitinib (ESK-001) in moderate-to-severe plaque psoriasis: 24-week results from the randomized, double-blind, active comparator- and placebo-controlled, Phase 3 ONWARD1 and 2 studies

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Introduction
Envudeucitinib, a novel oral tyrosine kinase 2 inhibitor, demonstrated a robust dose-dependent benefit/risk profile in the Phase 2 program. Here we assess efficacy and safety of envudeucitinib vs. placebo (16 weeks) and apremilast (24 weeks) in adults with moderate-to-severe psoriasis.

Materials and Methods
Patients were randomized 2:1:1 to envudeucitinib 40mg BID, placebo, or apremilast 30mg BID. At Wk16, patients on placebo received envudeucitinib. Co-primary endpoints were PASI-75 and sPGA-0/1 response rates vs. placebo at Wk16.

Results
ONWARD 1/2 randomized 912/859 patients to envudeucitinib (n=459/433), placebo (n=230/211), or apremilast (n=223/215), respectively. At Wk16, 76.5%/70.4% of patients achieved PASI-75 and 61.0%/57.3% achieved sPGA-0/1 with envudeucitinib vs. 18.7%/13.7% and 10.0%/5.7% with placebo (both $p<0.0001$).

At Wk24, 68.0%/62.1% of patients achieved PASI-90 and 41.0%/39.5% achieved PASI-100 with envudeucitinib vs. 25.6%/25.6% and 8.5%/13.0% with apremilast (both $p<0.0001$). sPGA-0 and PASI-100 responses were comparable.

At Wk16, itch NRS change from baseline (LS-mean (SE)) was -4.1(0.17)/-4.8(0.19) with envudeucitinib and -0.9(0.21)/-1.6(0.23) with placebo ($p<0.0001$). At Wk24, 77.4%/74.7% achieved scalp sPGA-0/1 with envudeucitinib vs. 48.7%/41.8% with apremilast ($p<0.0001$). All other secondary endpoints were met ($p<0.0001$).

Most treatment-emergent AEs in the envudeucitinib group were mild-moderate, transient, and/or responsive to standard therapy. No deaths or significant lab trends were observed. The incidence of serious AEs was low (2.7%) and mostly deemed unrelated.

At Wk24, the most common AEs with envudeucitinib were headache (10.9%), nasopharyngitis (10.3%), acne (6.7%), and URTI (6.4%).

Conclusions

Envudeucitinib achieved superior skin clearance and improvement in signs and symptoms of psoriasis compared with placebo and apremilast and was well-tolerated.

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Abstract N°: 1875

Clinical Outcomes and Relapse Patterns in Erythrodermic Psoriasis: A 204-Patient Cohort Study

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Introduction

Erythrodermic psoriasis (EP) is a rare, potentially life-threatening psoriasis phenotype often managed as an acute dermatologic emergency. Beyond initial disease control, its longitudinal course remains poorly characterized. Although evidence on systemic and biologic responses is increasing, data on remission durability, relapse patterns, and distinct trajectories between primary and secondary EP remain limited.

Materials and Methods

We conducted a retrospective longitudinal cohort study of204 patients with EP with up to10 years of follow-up. EP was classified as primary if erythroderma was the initial manifestation of psoriasis, and as secondary if it developed from pre-existing psoriasis (eg. plaque, pustular or guttate psoriasis). Clinical characteristics, precipitating factors, admission course, treatment patterns, remission, relapse, and outcomes were reviewed. Relapse-free survival (RFS) from remission to first relapse was assessed using Kaplan-Meier analysis and log-rank testing. Factors associated with earlier relapse were evaluated using Cox proportional hazards models.

Results

Among 204 patients, 36 (17.6%) had primary EP and 168 (82.4%) had secondary EP, predominantly from plaque psoriasis (70.6%), followed by pustular psoriasis (9.8%) and guttate psoriasis (2.0%). At presentation, secondary EP had higher severity index score than primary EP (37.4 vs 18.1, $p<0.001$) whereas primary EP had more systemic symptoms, particularly fever/chills. Precipitating factors differed by subtype. Primary EP was more often idiopathic (61.1%) or associated with drug or herbal use (27.8%), whereas secondary EP was more commonly associated with treatment interruption or loss to follow-up (43.5%) and emotional stress (10.1%).

Inpatient admission for erythroderma was reported in 50 patients. The proportion of admissions was higher in primary than secondary EP (30.6% vs 23.32%). The clinical characteristics in the first admission was analyzed. Concurrent infection during admission was documented in 67.4%, most commonly originating from the skin (75%). Sepsis (34.0%) and transaminitis (26.0%) were common, with no significant subtype differences; length of stay, major complications, and overall admission outcomes were comparable between groups.

At EP diagnosis, methotrexate (32.8%) and acitretin (27.5%) were the most common systemic therapies. Methotrexate was more commonly used in secondary than primary EP (36.3% vs 16.7%), whereas acitretin was more commonly used in primary than secondary EP (44.4% vs 23.8%); however, neither comparison remained statistically significant after Holm adjustment. Other initial treatments included topical therapy alone (11.3%), cyclosporine (10.3%), biologics (6.4%), and phototherapy (4.9%; equally NB-UVB and PUVA). Biologics were used exclusively in secondary EP.

Short-term outcomes were comparable between subtypes, with a median time to remission (defined as reduction in involvement to BSA <75%) of 6.1 weeks. However, long-term relapse burden was substantial: over a median follow-up of 41.9 months, 114 of 176 patients (64.8%) in the descriptive post-remission cohort had a documented

first relapse. Kaplan–Meier analysis showed significantly shorter relapse-free survival (RFS) in primary than in secondary EP (median 3.71 vs 19.73 months; log-rank p=0.038; Figure 1), with differences emerging within the first year. In multivariable analysis, primary EP remained independently associated with a higher risk of early relapse (adjusted HR 1.73, 95% CI 1.01–2.97; p=0.047).

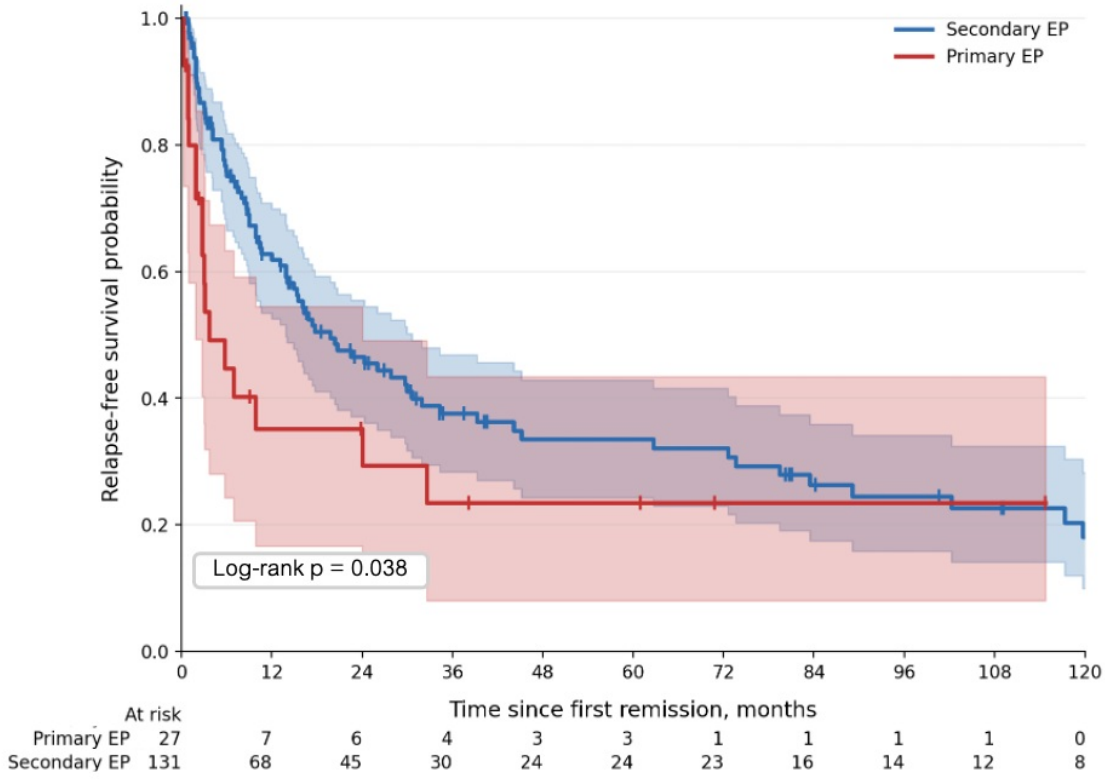

Figure 1. Kaplan–Meier relapse-free survival curves after first remission in primary and secondary erythrodermic psoriasis. Solid lines represent Kaplan–Meier estimates; shaded areas indicate 95% confidence intervals.

Conclusions

EP represents not only an acute dermatologic emergency but also a chronically relapsing disease with distinct subtype-specific trajectories. Primary EP showed greater systemic involvement and a substantially higher early relapse hazard after remission. These findings support phenotype-stratified long-term management, with targeted monitoring and early intervention to reduce relapse burden.

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Abstract N°: 1884

Effectiveness and Drug Survival of IL-23, IL-17, and IL-12/23 Inhibitors in Obese Patients With Psoriasis: A Real-World Monocentric Comparative Study

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Introduction

Obesity is a common comorbidity in psoriasis and may influence disease severity and response to systemic therapies. While biologics targeting IL-17 and IL-23 have demonstrated high efficacy in randomized clinical trials, real-world comparative data specifically focusing on obese patients remain limited. This study aimed to compare treatment effectiveness and drug survival among obese patients with moderate-to-severe plaque psoriasis receiving anti-IL-12/23, anti-IL-17, or anti-IL-23 biologics in a real-world setting and to identify clinical predictors of treatment discontinuation.

Materials and Methods

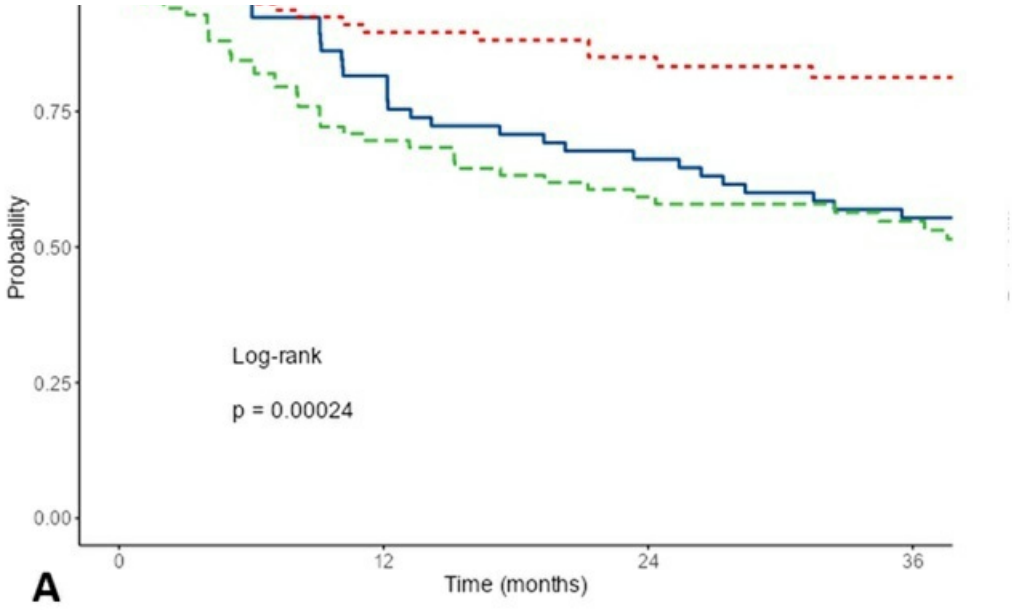
We conducted a retrospective observational monocentric study including adult patients with moderate-to-severe plaque psoriasis and obesity (body mass index [BMI] ≥30 kg/m^2) treated with anti-IL-12/23 (ustekinumab originator or biosimilar), anti-IL-17 (brodalumab, ixekizumab, secukinumab, bimekizumab), or anti-IL-23 agents (guselkumab, risankizumab, tildrakizumab) between April 2020 and January 2026. Disease severity was assessed using the Psoriasis Area and Severity Index (PASI) at baseline and after 12–16 weeks. Clinical effectiveness was defined as achievement of PASI90. Drug survival was defined as time from treatment initiation to discontinuation for any cause. Logistic regression models were used to evaluate predictors of PASI90, while Kaplan–Meier and Cox proportional hazards models were applied to assess treatment persistence and predictors of discontinuation.

Results

A total of 228 treatment cycles in 151 obese patients were included: 84 with anti-IL-17 agents, 79 with anti-IL-23 agents, and 65 with anti-IL-12/23 therapy. At week 12–16, PASI90 responses were achieved in 58.3% of patients receiving anti-IL-17 therapies, 53.2% with anti-IL-23 agents, and 41.5% with anti-IL-12/23. In multivariable logistic regression analysis, anti-IL-17 therapy was associated with significantly higher odds of achieving PASI90 compared with anti-IL-12/23 therapy (OR 2.18, p = 0.029), whereas no significant differences were observed between anti-IL-23 and the other classes.

Drug survival differed significantly across biologic classes (p = 0.00024), with anti-IL-23 therapies showing the highest persistence (1-year 89.6%, 2-year 85.0%, 3-year 81.3%), followed by anti-IL-12/23 and anti-IL-17 agents. In Cox regression analyses, anti-IL-23 therapy was associated with a significantly lower risk of discontinuation compared with anti-IL-12/23 (HR 0.31, p < 0.001). Psoriatic arthritis and higher BMI were independently associated with an increased risk of discontinuation, while older age showed a small protective effect. Drug survival due to ineffectiveness was also significantly higher with anti-IL-23 therapies compared with anti-IL-12/23 agents, whereas no treatment class was significantly associated with discontinuation due to adverse events.




Probability
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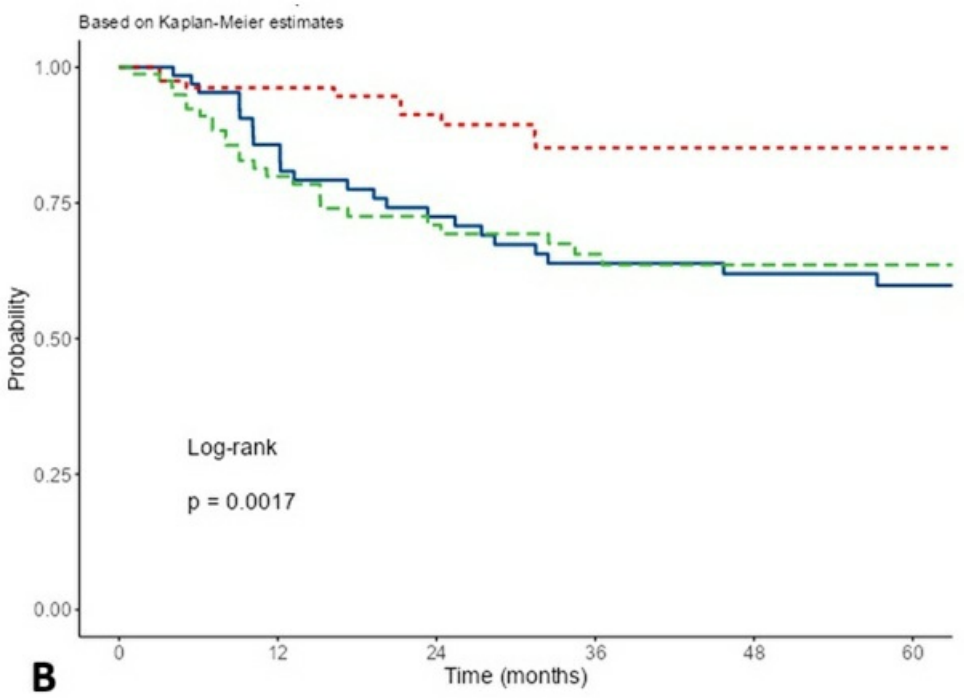
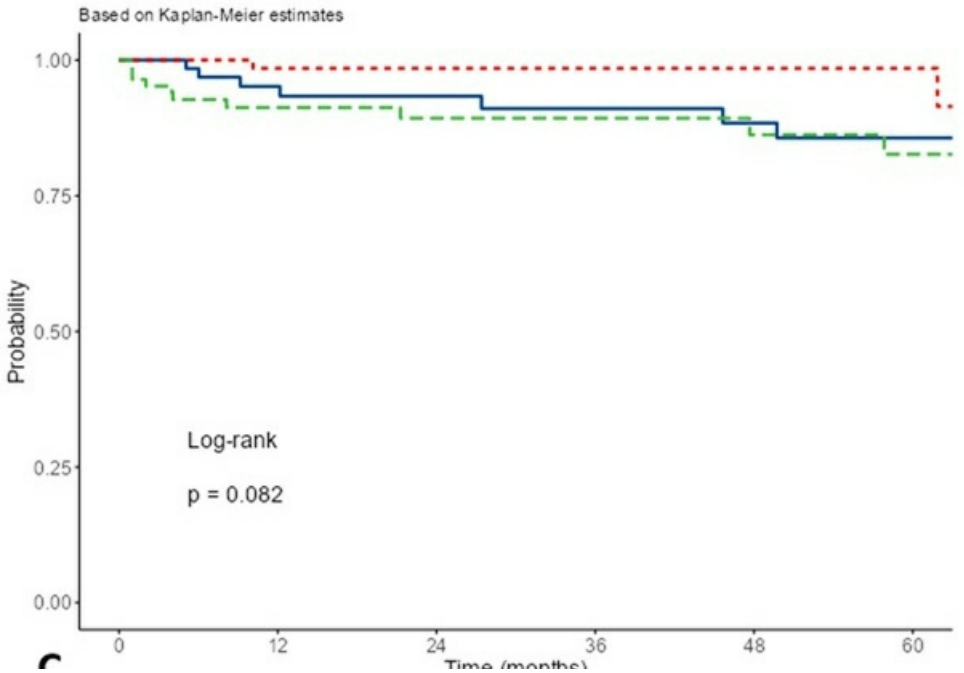
0.50
0.25
0.00
Log-rank
p = 0.00024
0
12
24
36
Time (months)

A


Based on Kaplan-Meier estimates
1.00
0.75
0.50
0.25
0.00
Probability
Log-rank
p = 0.0017
0
12
24
36
48
60
Time (months)

B


Based on Kaplan-Meier estimates
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0.50
0.25
0.00
Probability
Log-rank
p = 0.082
0
12
24
36
48
60

C

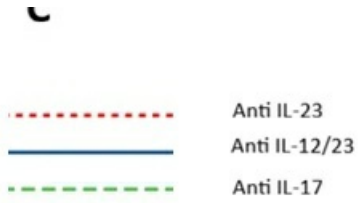

Figure 1. Overall drug survival (a), drug survival for discontinuations due to ineffectiveness (b) and adverse events (c), according to treatment class

Conclusions

In this real-world cohort of obese patients with moderate-to-severe psoriasis, biologic class significantly influenced treatment outcomes. Anti-IL-17 therapies were associated with higher short-term effectiveness compared with anti-IL-12/23, while anti-IL-23 agents demonstrated the most favorable long-term drug survival. These findings suggest that IL-17 and IL-23 inhibitors may represent the most effective therapeutic strategies in patients with psoriasis and obesity, supporting the importance of considering BMI as a clinically relevant factor in treatment selection.

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Abstract N°: 1904

Seropositive Rheumatoid Arthritis Associated with Pustular Psoriasis: A Diagnostic Challenge

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Introduction

Articular involvement in patients with psoriasis is commonly attributed to psoriatic arthritis. However, the coexistence of rheumatoid arthritis (RA) represents a rare but important diagnostic challenge, particularly in the presence of highly specific serological markers.

Case Presentation

We report the case of a 59-year-old man with a history of cutaneous psoriasis since 2020, admitted for a diffuse erythematous eruption with non-follicular pustules in a febrile context. Histopathological examination confirmed pustular psoriasis. The patient developed persistent inflammatory polyarthritis lasting more than six weeks, predominantly affecting the shoulders, wrists, metacarpophalangeal and proximal interphalangeal joints, with sparing of distal interphalangeal joints. Laboratory findings revealed a marked inflammatory syndrome, positive rheumatoid factor (twice the upper normal limit), and strongly positive anti-cyclic citrullinated peptide antibodies (>500 IU/mL). Radiographs showed proximal interphalangeal joint space narrowing and sacroiliitis. Methotrexate therapy was initiated in collaboration with rheumatologists, with progressive clinical improvement of both cutaneous and articular manifestations.
Differentiating psoriatic arthritis from concomitant RA can be challenging in psoriatic patients presenting with inflammatory polyarthritis. The high anti-CCP titer and the predominant involvement of metacarpophalangeal and proximal interphalangeal joints supported the diagnosis of seropositive RA rather than psoriatic arthritis.

Conclusion

This case highlights the importance of comprehensive clinical, radiological, and immunological evaluation in psoriatic patients with persistent polyarthritis to ensure accurate diagnosis and appropriate therapeutic management.

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Abstract N°: 1911

Generalized Pustular Psoriasis with Detectable HBV DNA: An Evidence-Based Relapse Prevention Strategy

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Introduction

Generalized pustular psoriasis (GPP) is a severe form of psoriasis characterized by generalized pustular eruptions accompanied by systemic symptoms such as fever, leukocytosis, and systemic inflammation. The disease is relapsing in nature and can be life-threatening, requiring prompt and well-structured management, and associated with dysregulation of the interleukin-36 signaling pathway and often requires systemic immunosuppressive or biologic therapy. Clinical challenges increase in patients with hepatitis B virus (HBV) infection, particularly when Hepatitis B Virus Deoxyribonucleic Acid (HBV DNA) is detectable, due to the risk of viral reactivation triggered by immunomodulatory therapy.

Case Presentation

A 35-year-old woman presented with generalized erythematous plaques accompanied by pustules for the past five days, preceded by fever, fatigue, pain, and pruritus. The lesions initially appeared on the abdomen and rapidly disseminated over almost the entire body. She had a history of similar episodes from 2021, with two relapses in 2024 and one in 2026. Physical examination revealed erythematous plaques with coalescing pustules forming a lake of pus, erosions, scales, and nail pitting. No mucosal involvement, joint abnormalities, or lymphadenopathy was observed. Laboratory findings showed leukocytosis (12,500/mm^3) with neutrophilia (77.6%), aspartate aminotransferase (AST) 20 U/L, alanine aminotransferase (ALT) 23 U/L, non-reactive VDRL and TPHA, reactive HBsAg, and detectable DNA HBV (1.54×10^2 IU/mL). The patient showed clinical improvement after systemic methylprednisolone, antihistamines, NaCl compresses for erosions, and topical 0,1% mometasone furoate. The relapse rate of GPP ranges from 32.3% to 61.4%, with infection being the most common trigger (15.2%). The patient had a history of recurrent episodes over five years, however, the precipitating factor could not be determined. Corticosteroid therapy may have contributed as a potential precipitating factor. Management of GPP depends on disease severity. First-line therapy includes biologic agents such as IL-17 or IL-36 inhibitors. However, systemic corticosteroids are often required as an alternate therapy approach due to limited accessibility. The patient received an initial intravenous dose of methylprednisolone 1 mg/kg body weight with gradual tapering, followed by oral and topical therapy, resulting in a positive response. Corticosteroids may be effective in the acute phase, and the initial high dose in this case was based on expected therapeutic response. Screening for HBV is essential prior to initiating immunosuppressive therapy due to the risk of viral reactivation. The patient was found to be HBsAg reactive with detectable HBV DNA. Therefore, baseline evaluation with serial monitoring of HBsAg, anti-HBs, and HBV DNA was recommended, along with consideration of antiviral prophylaxis. Although corticosteroids were administered at a high dose and tapered over less than two weeks, this regimen still places the patient in a high-risk category, warranting consideration of antiviral therapy to prevent future complications and possible GPP exacerbations. Overall, this case represents recurrent GPP with active HBV infection, requiring an individualized therapeutic approach that balances disease control and treatment safety.

Conclusion

Generalized pustular psoriasis is a severe inflammatory skin disease with a relapsing course that can be life-threatening. This case demonstrates recurrent GPP with a positive response to systemic corticosteroid therapy. Reactive HBsAg and detectable HBV DNA were identified, highlighting the importance of hepatitis B screening and monitoring prior to initiating immunosuppressive therapy to prevent viral reactivation. Management should be individualized, balancing disease control with treatment safety.

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Abstract N°: 1923

Real-world effectiveness and safety of deucravacitinib through 52 weeks of treatment for moderate to severe plaque psoriasis in Germany: results from the DELPHIN study (DELPHIN)

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Introduction

Deucravacitinib, an oral, selective tyrosine kinase 2 inhibitor, was approved in Germany in March 2023 for adults with moderate to severe plaque psoriasis (PsO). The ongoing, prospective, non-interventional study DELPHIN aims to generate real-world evidence in routine care. This interim analysis updates effectiveness outcomes through Week 52, with a focus on disease activity and involvement of high-impact areas.

Materials and Methods

DELPHIN is a Germany-wide, multicenter, prospective observational cohort study conducted in routine clinical practice. Adults (≥18 years) with physician-reported moderate-to-severe plaque PsO initiating deucravacitinib for the first time according to the approved Summary of Product Characteristics were eligible; treatment decisions were made prior to enrollment and independent of study participation. Patients are followed for up to 5 years. Outcomes included disease severity (absolute Psoriasis Area and Severity Index [aPASI]), relative responses (PASI75/90 among patients with baseline PASI >10), quality of life (Dermatology Life Quality Index [DLQI]), and effectiveness in high-impact areas assessed by Physician Global Assessment (PGA; scalp-specific [ss]-PGA, palmoplantar [pp]-PGA, genital and intertriginous PGA). Nail involvement was assessed using target Nail Psoriasis Severity Index (NAPSI).

Results

This analysis describes 552 patients treated with deucravacitinib, enrolled between April 2023 and February 2025, with a data cut-off occurring in October 2025. Due to the ongoing study status, the number of patients who had completed each post-baseline visit decreased over time: 541 at Week 4, 497 at Week 16, 449 at Week 24, and 311 at Week 52 (Table 1). At the time of data cut-off, not all patients had reached Week 52. Table 1 summarizes overall patient numbers and the availability of effectiveness measures of interest over the course of the study. Mean (standard deviation [SD]) age at baseline was 48.5 (15.2) years, 41.6% were female, and mean (SD) Body Mass Index [BMI] was 28.5 (5.6) kg/m^2. Mean (SD) PASI was 13.1 (8.4), mean DLQI (SD) 12.3 (7.4), and mean (SD) affected Body Surface Area [BSA] 19.7% (17.0); 42.8% had no prior systemic therapy.

The proportion of patients achieving aPASI ≤3 increased from 3.6% at baseline to 75.6% at Week 52; mean (SD) PASI decreased from 13.1 (8.4) to 2.4 (3.0) at Week 52. Mean (SD) DLQI decreased from 12.3 (7.4) at baseline to 3.3 (4.3) at Week 52. Among patients with baseline PASI >10, PASI75 and PASI90 response rates at Week 52 were 79.2% and 53.2%, respectively. For high-impact areas, Week 52 PGA 0/1 responses (patients with PGA ≥ 3 for the area of interest and with at least a 2-point improvement) were 77.7% for scalp, 60.0% for palmoplantar, 95.2% for genital, and 89.4% for intertriginous areas. Mean (SD) target NAPSI among patients with baseline target NAPSI ≥ 1 decreased from 4.1 (2.2) at baseline to 1.4 (2.1) at Week 52. The safety profile was consistent with clinical trials; no new safety findings were observed.

Table 1: Overall patient numbers and availability of effectiveness data at each time point

	Baseline	Week 4	Week 16	Week 24	Week 52
Overall patient number with completed visits	552	541	497	449	311
Non-missing data numbers					
PASI	551	506	404	269	258
DLQI	541	506	406	273	254
ss-PGA (scalp)	548	505	404	269	258
pp-PGA (palmoplantar)	548	504	404	269	258
PGA (genitals)	548	505	404	269	258
PGA (intertriginous)	547	505	404	269	258
Target NAPSI	541	498	398	268	251

Conclusions

In this ongoing prospective real-world study in Germany, patients initiating deucravacitinib in routine care showed improvements in PsO severity and quality of life through Week 52 in this interim analysis. Improvements were also observed in especially burdensome high-impact areas like the scalp, genitals, intertriginous and palmoplantar areas and the nails. These real-world data support the current clinical trial efficacy and safety profile of deucravacitinib for treating patients with moderate-to-severe plaque psoriasis.

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Abstract N°: 1924

Matching-Adjusted Indirect Comparison of the Efficacy and Safety of Brodalumab and Secukinumab in the treatment of Patients with Moderate-to-Severe Plaque Psoriasis Weighing 90 kg or More

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Introduction
Plaque psoriasis (PsO) is a chronic immune-mediated condition that has a profound impact on quality of life. Obesity is a common comorbidity of PsO and is known to reduce response to biologic therapies, a fact that is reflected in a more individualised approach to treatment. In patients weighing ≥90 kg, a recent randomised controlled trial (NCT03504852) showed secukinumab 300 mg every 2 weeks (SEC Q2W) to be superior to the standard regimen administered monthly, with a similar safety profile, and guidance for this more frequent dosing regimen is outlined in its label. Post-hoc analyses of AMAGINE-2/3 (NCT01708603; NCT01708629) confirmed that a standard dose of brodalumab (210 mg Q2W), another licensed biologic targeting the IL-17R pathway, delivers high skin clearance versus ustekinumab/placebo regardless of body mass index (BMI). However, there are no head-to-head trials comparing brodalumab to SEC Q2W in this population of patients.

Contemporary PsO treat-to-target recommendations now prioritise near-complete skin clearance (Psoriasis Area and Severity Index [PASI] 90/100, static Physician's Global Assessment [sPGA] 0/1) over PASI 75 for optimal patient outcomes. Accordingly, this study aims to compare the efficacy and safety of brodalumab versus SEC in overweight or obese patients with moderate-to-severe PsO, focusing on these clinically relevant outcomes.

Materials and Methods
An unanchored matching-adjusted indirect comparison (MAIC) was conducted to indirectly compare the efficacy and safety of brodalumab 210 mg Q2W versus SEC Q2W in moderate-to-severe PsO patients weighing ≥90 kg using individual patient data (IPD) from AMAGINE-2/3 and aggregate data from NCT03504852. IPD from the brodalumab 210 mg Q2W arm of the AMAGINE-2 and -3 trials were reweighted to match the following baseline characteristics of the SEC Q2W arm in NCT03504852: sex, ethnicity, disease duration, baseline PASI score and body surface area, prior biologic PsO treatment and psoriatic arthritis history. No clinically meaningful differences in eligibility criterias were identified between trials; therefore, no population restriction was applied. As this was an unanchored comparison, adjustment for all relevant prognostic factors and treatment effect modifiers was required. PASI-90, PASI-100, sPGA score of 0/1 and serious adverse events (SAEs) were compared at week 12, 16 and 52, where available.

Results
After matching, baseline characteristics were well balanced across the trials, with an effective sample size (ESS) of 111 (70.8% of the original sample of brodalumab patients from AMAGINE-2/3). The results of the MAIC analysis

displayed comparable efficacy and safety for brodalumab and SEC Q2W, with no statistically significant differences between treatment groups (see Table). The response rates across the evaluated efficacy outcomes, and the observed incidence of SAEs, were similar between brodalumab and SEC Q2W across all timepoints.

Table: Results of a MAIC comparing brodalumab 210 mg Q2W versus secukinumab 300 mg Q2W among PsO patients weighing ≥90 kg

Outcome	Odds ratio (95% confidence interval)		
	Week 12	Week 16	Week 52
sPGA 0/1	1.60 (0.94, 2.72)	1.35 (0.76, 2.38)	1.84 (0.91, 3.75)
PASI 90	0.96 (0.58, 1.59)	0.86 (0.50, 1.49)	0.97 (0.53, 1.78)
PASI 100	1.23 (0.73, 2.08)	1.01 (0.61, 1.67)	1.11 (0.67, 1.82)
SAE	0.33 (0.04, 2.84)	NA	0.84 (0.35, 2.05)

Conclusions

This MAIC demonstrates no statistically significant difference in efficacy between brodalumab and SEC Q2W in achieving key treat-to-target endpoints (PASI-90/100 and sPGA 0/1), with similar safety profiles, in overweight or obese patients with moderate-to-severe PsO. These findings indicate that brodalumab, using the standard Q2W dosing regimen, provides comparable responses to an escalated SEC Q2W regimen, which is recommended in higher-weight patients according to the label. This could have implications for optimizing treatment, as administering SEC every two weeks, rather than the standard schedule every month, may lead to higher treatment costs if no commercial agreements are in place.

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Abstract N°: 1932

Scalp Microbiome Compatibility and Rebalancing Trends of a Cosmetic Shampoo for Psoriasis-Prone Scalp: A 16S rRNA Metagenomic Analysis

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Introduction

In psoriasis, scalp dysbiosis is not a primary pathogenic driver but rather a consequence of immune dysregulation and impaired skin barrier function. Nevertheless, the dysbiotic profile, characterized by reduced commensal bacterial abundance and elevated *Malassezia* yeasts, can perpetuate local inflammation and compromise the scalp environment. For cosmetic interventions targeting psoriasis-prone scalps, demonstrating microbiome compatibility and the absence of product-induced disruption is therefore a clinically relevant objective. This study evaluated the impact of a specialized cosmetic shampoo, combining encapsulated salicylic acid, prebiotics and niacinamide, on the scalp microbiome of subjects with sensitive, moderate to severe psoriasis using 16S rRNA sequencing.

Materials and Methods

This 28-day, single-arm clinical study enrolled 34 adults with scalp psoriasis (21 moderate, 8 severe; 20 women, 9 men; median age 41 years). Scalp microbiome samples were collected at baseline (D0) and after 28 days of product use (D28). Sequencing was performed after quality control on 29 subjects. Microbial community structure was assessed by alpha diversity indices (richness and Shannon diversity) and beta diversity (PERMANOVA). Species-level compositional changes were evaluated by relative abundance analysis.

Results

At baseline, the scalp microbiome displayed a dysbiotic profile consistent with psoriasis: reduced commensal bacterial species (*Cutibacterium acnes*, *Staphylococcus capitis*, *Staphylococcus epidermidis*) and elevated *Malassezia restricta*. After 28 days of shampoo use, global microbiome structure remained stable: alpha diversity indices showed no statistically significant change, and PERMANOVA confirmed no significant shift in overall community composition demonstrating that the product does not disrupt the natural scalp microbiome. At the species level, positive trends consistent with microbial rebalancing were observed: a decrease in *M. restricta* and increases in commensal bacterial species including *S. capitis*, *S. epidermidis* and *C. acnes*. These trends were more pronounced in subgroups of female subjects and those with severe psoriasis.

Conclusions

This analysis demonstrates that the tested product is fully compatible with the scalp microbiome in subjects with psoriasis-prone scalp, inducing no disruption of microbial diversity or community structure. The observed species-level trends suggest a potential shift toward a more balanced microbial ecosystem, with reduced psoriasis-associated yeast and increased commensal bacteria. These findings complement clinical and preclinical efficacy data and support its use as a microbiome respectful cosmetic intervention for the management of psoriasis prone scalp conditions.

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VIENNA
30 SEP - 3 OCT 2026

Abstract N°: 1933

Zasocitinib, a highly selective once-daily TYK2 inhibitor, demonstrates consistent improvements in quality of life and PSSD-reported symptoms in adults with moderate-to-severe plaque psoriasis: results from two randomized phase 3 trials (LATITUDE-PsO-3001 and 3002)

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Introduction

Zasocitinib is an investigational, next-generation, highly selective once-daily oral tyrosine kinase 2 (TYK2) inhibitor that maintains 24-hour inhibition of interleukin (IL)-23 plus other core disease-driving immune pathways. In two pivotal phase 3 trials in adults with moderate-to-severe plaque psoriasis (LATITUDE-PsO-3001 [NCT06088043] and LATITUDE-PsO-3002 [NCT06108544]), zasocitinib showed rapid and reproducible skin clearance with a consistent safety profile. Here, we evaluated the effect of zasocitinib on patient-reported outcomes in these trials.

Materials and Methods

Two phase 3 randomized, double-blind, international multicentre trials compared once-daily zasocitinib 30 mg with placebo or twice-daily apremilast 30 mg over 52 (LATITUDE-PsO-3001) or 60 weeks (LATITUDE-PsO-3002). Eligible patients (Psoriasis Area and Severity Index [PASI] ≥12, static Physician Global Assessment [sPGA] ≥3, body surface area [BSA] ≥10%) were randomized 3:1:1 (LATITUDE-PsO-3001) and 2:1:1 (LATITUDE-PsO-3002) to zasocitinib, placebo or apremilast.

Ranked key secondary endpoints included: the proportions of patients achieving Dermatology Life Quality Index (DLQI) 0/1 (baseline ≥2) and a weekly mean Psoriasis Symptoms and Signs Diary (PSSD) symptom score 0 (baseline ≥1) at Week 16 vs placebo or apremilast; and change from baseline (CfB) in weekly mean PSSD symptom score at Week 16 vs apremilast. CfB in DLQI at Week 16 vs placebo and at Weeks 16 and 24 vs

apremilast, and improvement (≥4-point) in the weekly mean PSSD itch score at Week 16 vs placebo and at Week 24 vs apremilast were also assessed, with nominal *p* values reported.

Results

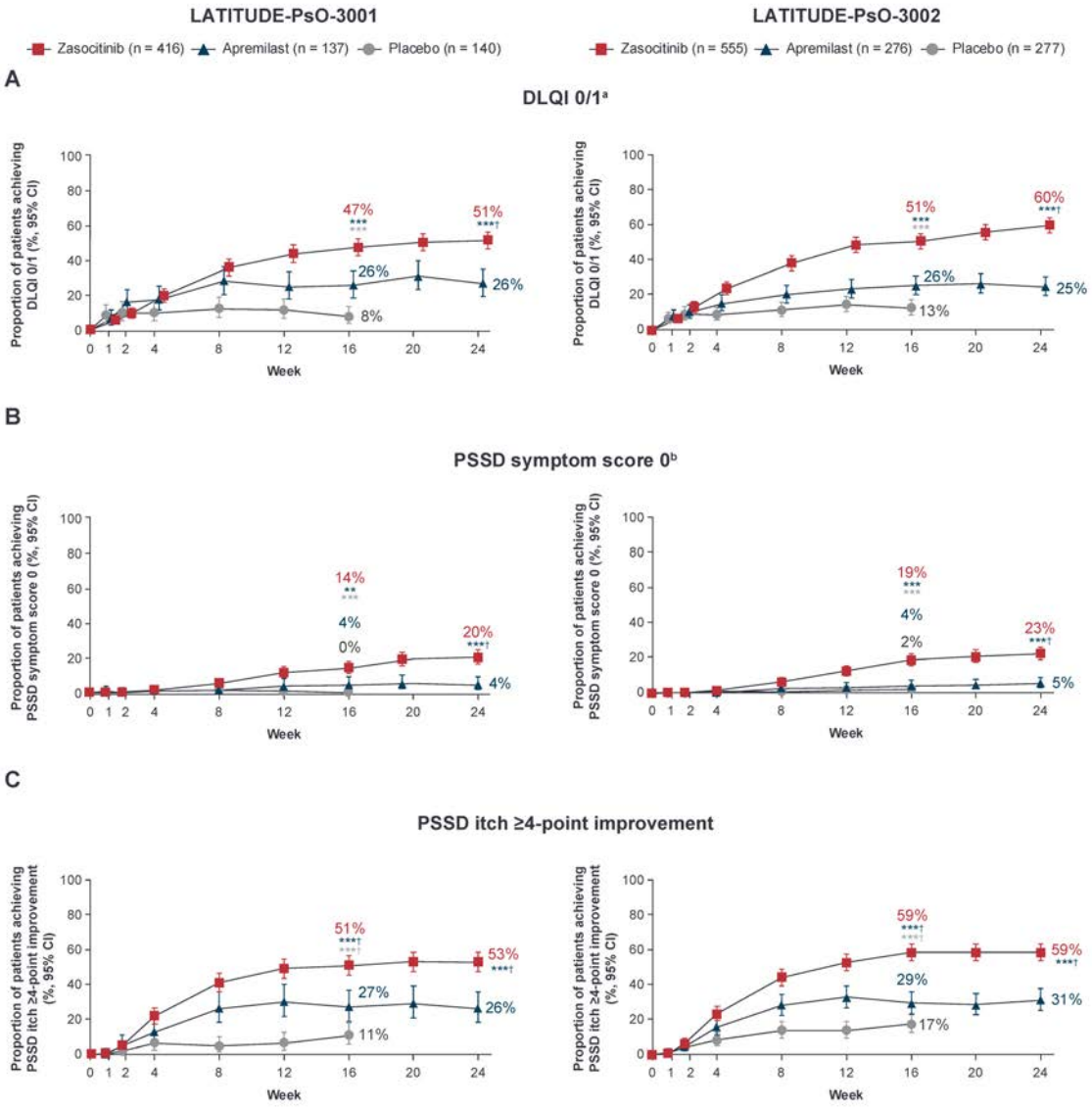
In LATITUDE-PsO-3001/LATITUDE-PsO-3002, 693 and 1108 patients were randomized, respectively. Patient baseline characteristics were comparable across zasocitinib, placebo and apremilast arms. Baseline mean (standard deviation) DLQI scores were 12.7 (7.23)/11.6 (7.23), 12.2 (7.29)/12.2 (7.40) and 11.1 (6.46)/11.5 (6.71), and baseline PSSD symptom scores were 50.9 (26.75)/52.2 (26.90), 56.5 (26.94)/55.7 (26.80) and 47.7 (25.83)/54.5 (26.24), respectively.

In both trials at Week 16, a greater proportion of patients receiving zasocitinib achieved DLQI 0/1 (47.3%/50.9%) vs placebo (7.5%/12.7%) and apremilast (25.6%/25.5%), with superiority over apremilast maintained at Week 24 (51.2% vs 26.3%; 60.2% vs 24.7%; all $p<0.001$; nominal at Week 24 vs apremilast; **Figure A**). Similarly, the proportion of patients attaining a weekly mean PSSD symptom score of 0 was greater with zasocitinib (14.1%/18.8%) vs placebo (0%/2.2%) and apremilast (4.4%/4.1%) at Week 16, and vs apremilast at Week 24 (20.1% vs 4.4%; 22.5% vs 5.2%; all $p<0.001$ [nominal at Week 24 vs apremilast], except Week 16 vs apremilast [$p<0.01$]; **Figure B**). A greater proportion of patients receiving zasocitinib vs placebo or apremilast achieved ≥4-point improvement in weekly mean PSSD itch score at Week 16 (LATITUDE-PsO-3001: 50.9% vs 10.7% vs 27.2%; LATITUDE-PsO-3002: 58.5% vs 17.3% vs 29.3%); and was observed through Week 24 (52.7%/58.5%; all nominal $p<0.001$; **Figure C**). These improvements reflected greater least-squares (LS) mean reductions in DLQI score from baseline at Week 16 with zasocitinib vs placebo (LATITUDE-PsO-3001: −8.80 vs −2.43; LS mean difference [Δ] −6.37; 95% confidence interval [CI] −7.444, −5.287; LATITUDE-PsO-3002: −8.88 vs −3.75; Δ −5.13; 95% CI −5.872, −4.381) and apremilast (LATITUDE-PsO-3001: −8.80 vs −5.24; Δ −3.55; 95% CI −4.645, −2.460; LATITUDE-PsO-3002: −8.88 vs −5.75; Δ −3.12; 95% CI −3.868, −2.382), with superiority over apremilast maintained through Week 24. A similar trend was observed in CfB in weekly mean PSSD symptom score up to Week 16 with zasocitinib vs apremilast.

Conclusions

Once-daily oral zasocitinib demonstrates consistent and meaningful improvements in patient quality of life and signs and symptoms of disease, including itch relief, in adults with moderate-to-severe plaque psoriasis.

Figure. Zasocitinib demonstrated superior improvements in the proportion of adults achieving (A) DLQI 0/1; (B) PSSD symptom score 0; and (C) PSSD itch ≥4-point improvement, compared with placebo or apremilast through Week 24.



[a]With a baseline DLQI score ≥2. [b]With a baseline PSSD symptom score ≥1.
Number of patients based on full analysis set. *P* values for comparison vs apremilast (in blue) and vs placebo (in grey) based on a stratified Cochran–Mantel–Haenszel test: ***p*<0.01; ****p*<0.001; ***† nominal *p*<0.001.
CI, confidence interval; DLQI, Dermatology Life Quality Index; PSSD, Psoriasis Symptoms and Signs Diary.

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30 SEP - 3 OCT 2026

Abstract N°: 1938

Zasocitinib, a highly selective, once-daily oral TYK2 inhibitor, was not associated with clinically meaningful laboratory parameter changes for up to 60 weeks in adults with moderate-to-severe plaque psoriasis: results from two randomized phase 3 trials (LATITUDE-PsO-3001 and 3002)

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Introduction

Zasocitinib is an investigational, next-generation, highly selective once-daily oral tyrosine kinase 2 (TYK2) inhibitor that maintains 24-hour inhibition of interleukin (IL)-23 plus other core disease-driving immune pathways. In two pivotal phase 3 trials in adults with moderate-to-severe plaque psoriasis (LATITUDE-PsO-3001 [NCT06088043] and LATITUDE-PsO-3002 [NCT06108544]), zasocitinib demonstrated rapid and reproducible skin clearance with a consistent safety profile. Here, we evaluated clinical laboratory parameters in patients receiving zasocitinib for up to 60 weeks in these trials.

Materials and Methods

Two phase 3 randomized, double-blind, international multicentre trials compared once-daily zasocitinib 30 mg with placebo or twice-daily apremilast 30 mg over 52 (LATITUDE-PsO-3001) or 60 weeks (LATITUDE-PsO-3002). Eligible adults (Psoriasis Area and Severity Index ≥12, static Physician's Global Assessment ≥3, body surface area ≥10%) were randomized 3:1:1 (LATITUDE-PsO-3001) and 2:1:1 (LATITUDE-PsO-3002) to zasocitinib, apremilast or placebo, respectively.

Laboratory parameters assessed throughout the trial included haematological (haemoglobin, lymphocytes, neutrophils, platelets), hepatic and renal (alanine aminotransferase, aspartate aminotransferase, bilirubin, creatinine) and lipid (total cholesterol, low-density lipoproteins, high-density lipoproteins, triglycerides) parameters, as well as creatine phosphokinase (CPK). Laboratory abnormalities of Grade ≥3 severity up to Week 16 and Week 24, according to the Common Terminology Criteria for Adverse Events (CTCAE; version 5.0), were

also evaluated. The safety analysis set included all participants who received ≥1 dose of the assigned study treatment.

Results

In total, the safety analysis set included 693 patients for LATITUDE-PsO-3001, and 1106 patients for LATITUDE-PsO-3002. Baseline demographics and disease characteristics were generally balanced between treatment groups. Most participants were male (69.7% and 66.9%), mean (standard deviation [SD]) age was 44.5 (13.50) and 46.0 (13.31) years, mean (SD) weight was 85.7 (22.50) and 90.0 (22.24) kg and overall PASI score was 19.97 (7.82) and 21.25 (8.94) in LATITUDE-PsO-3001 and LATITUDE-PsO-3002, respectively.

Changes in all laboratory parameters were generally similar in the zasocitinib, apremilast and placebo groups in both studies, and there were no clinically meaningful trends in any parameters observed in the assessed analyses periods.

Low rates of CTCAE Grade 3 or 4 events through Week 16 were reported for haematological, hepatic and renal and lipid parameters, which continued to Week 24. Grade 3 and 4 CPK elevations were observed in the zasocitinib group up to Week 24; however, these were transient and reversible. Patients remained asymptomatic and did not require medical intervention, and CPK elevations did not recur when zasocitinib was restarted. There were no cases of rhabdomyolysis or renal failure throughout the duration of the studies.

Conclusions

Treatment with once-daily zasocitinib generally did not result in clinically meaningful laboratory changes in haematological, hepatic, renal or lipid parameters for up to 60 weeks.

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Abstract N°: 1943

Once-daily oral zasocitinib, a highly selective TYK2 inhibitor, demonstrates rapid improvements in skin clearance, quality of life and psoriasis symptoms in adults with moderate-to-severe plaque psoriasis: results from two randomized phase 3 trials (LATITUDE-PsO-3001 and 3002)

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Introduction

In two pivotal phase 3 trials in adults with moderate-to-severe plaque psoriasis (LATITUDE-PsO-3001 [NCT06088043] and LATITUDE-PsO-3002 [NCT06108544]), zasocitinib met the co-primary endpoints of static Physician's Global Assessment (sPGA) 0/1 and Psoriasis Area and Severity Index (PASI) 75 response vs placebo at Week 16 and had a consistent safety profile. In addition, >90% of zasocitinib-treated patients with PASI 75 response at Week 40 who continued zasocitinib maintained sPGA 0/1, PASI 75 and PASI 90 at Week 60 in LATITUDE-PsO-3002. Here, we evaluated the rapidity of onset of response in patients receiving zasocitinib in these trials.

Materials and Methods

Two phase 3 randomized, double-blind, international multicentre trials compared once-daily zasocitinib 30mg with placebo or twice-daily apremilast 30mg over 52 (LATITUDE-PsO-3001) or 60 weeks (LATITUDE-PsO-3002). Eligible adults (PASI ≥12, sPGA ≥3, body surface area ≥10%) were randomized 3:1:1 (LATITUDE-PsO-3001) and 2:1:1 (LATITUDE-PsO-3002) to zasocitinib, placebo or apremilast. LATITUDE-PsO-3002 included a prespecified ranked secondary endpoint of PASI 75 vs placebo at Week 4. Rapidity of onset of response in additional outcomes including sPGA 0/1, sPGA 0, PASI 90, PASI 100, Dermatology Life Quality Index (DLQI) 0/1, and ≥4-point improvement in weekly mean PSSD itch score were assessed *post hoc*, with nominal *p* values reported.

Results

LATITUDE-PsO-3001 and LATITUDE-PsO-3002 enrolled 693 and 1108 participants, respectively. Baseline demographics and disease characteristics were generally balanced between treatment groups. Most participants were male (69.7% and 67.0%), mean (standard deviation [SD]) age was 44.5 (13.50) and 46.1 (13.30) years, mean (SD) weight was 85.7 (22.50) and 90.0 (22.23) kg, with an overall PASI score of 20.0 (7.82) and 21.2 (8.93) in LATITUDE-PsO-3001 and LATITUDE-PsO-3002, respectively.

Zasocitinib demonstrated rapid onset of efficacy, with significant differences in PASI 75 vs placebo or apremilast observed as early as Week 4 in LATITUDE-PsO-3002 ($p<0.001$ vs placebo; nominal $p<0.001$ vs apremilast; **Figure A**). In both studies, higher PASI 90 response rates were achieved with zasocitinib vs placebo or apremilast by Week 4 (nominal $p<0.05$ vs placebo; nominal $p<0.01$ vs apremilast; **Figure B**). Nominally significant improvements vs placebo in sPGA 0/1 were observed as early as Week 2 in LATITUDE-PsO-3001 (nominal $p<0.05$), from Week 4 vs apremilast in both studies (nominal $p<0.01$, LATITUDE-PsO-3001; nominal $p<0.001$, LATITUDE-PsO-3002; **Figure C**) and in PASI 100 or sPGA 0 by Week 8 (nominal $p<0.001$ vs placebo or apremilast).

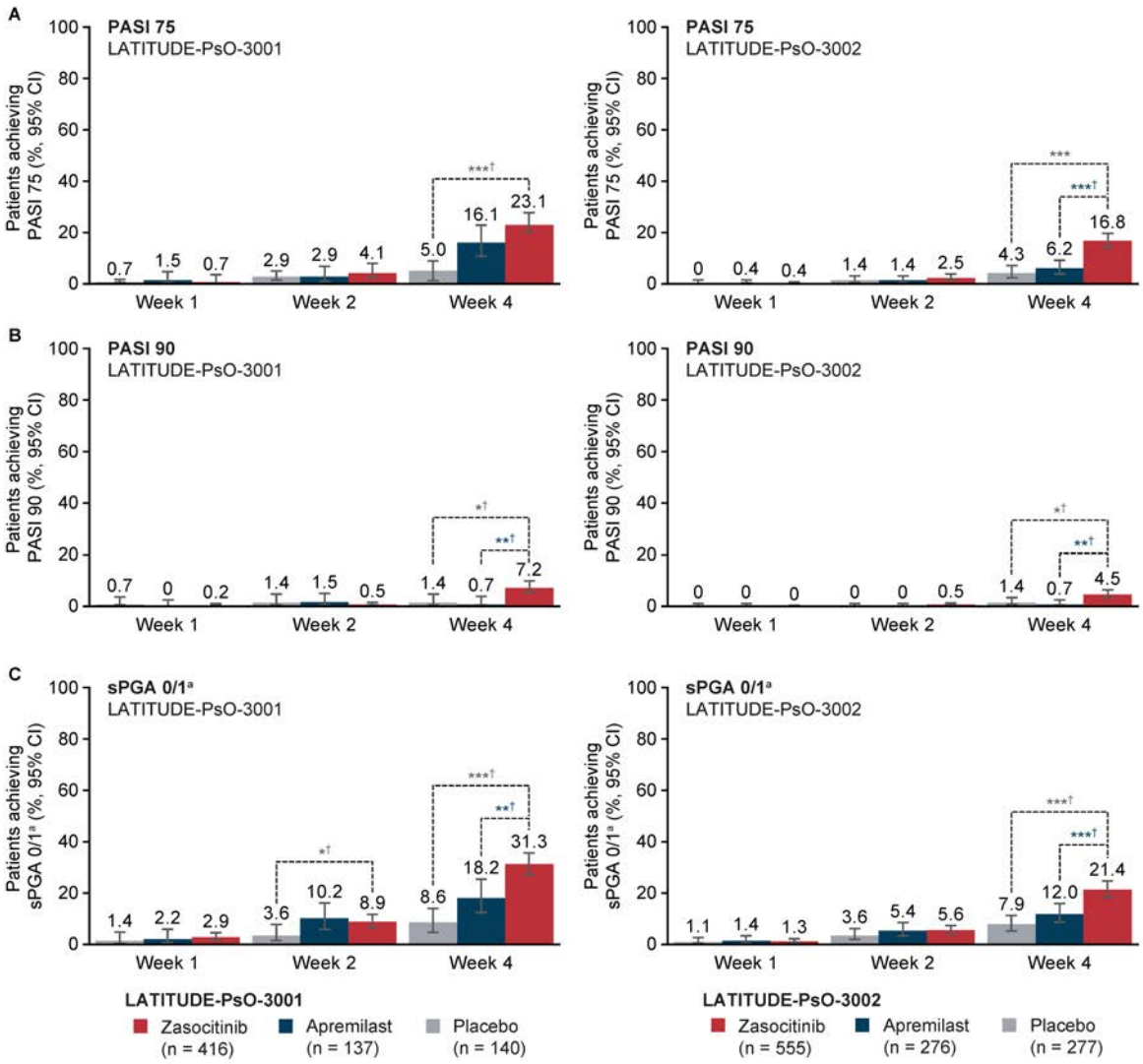
Significant improvements were also observed in patient-reported outcomes. A greater DLQI 0/1 response rate was achieved in zasocitinib-treated patients by Week 4 (nominal $p<0.01$ and $p<0.001$ vs placebo in LATITUDE-PsO-3001 and 3002, respectively; $p<0.01$ vs apremilast in LATITUDE-PsO-3002 only). Mean reduction from baseline in the weekly mean PSSD symptom score was greater with zasocitinib by Week 2 (nominal $p<0.001$ vs placebo; nominal $p<0.05$ vs apremilast in LATITUDE-PsO-3002 only). Among patients with a baseline weekly mean PSSD itch score ≥4, a greater proportion of zasocitinib-treated patients achieved an improvement of ≥4 points as early as Week 4 vs placebo or apremilast (nominal $p<0.001$ vs placebo; nominal $p<0.05$ vs apremilast for both studies).

Progressive improvements in PASI 75, sPGA 0/1, PASI 90, PASI 100, sPGA 0, DLQI 0/1, weekly mean PSSD symptom score and PSSD itch response rates were observed through Week 24 following treatment with zasocitinib.

Conclusions

Once-daily treatment with zasocitinib is associated with rapid skin improvement, improvement in patients' quality of life and reduction of symptoms and signs of disease, including itch, with early response evident within the first four weeks of treatment.

Figure. Zasocitinib led to greater proportions of patients achieving (A) PASI 75; (B) PASI 90; and (C) sPGA 0/1 than placebo or apremilast as early as Week 4.



[a]With a ≥2-point decrease from baseline.
Number of patients based on full analysis set with nonresponder imputation.
P values for comparison vs apremilast (in blue) and vs placebo (in grey) based on a stratified Cochran–Mantel–Haenszel test: ***$p<0.001$; *†nominal $p<0.05$; **†nominal $p<0.01$ ***†nominal $p<0.001$.
CI, confidence interval; PASI, Psoriasis Area and Severity Index; sPGA, static Physician's Global Assessment.

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Abstract N°: 1962

Audit on Deucravacitinib for treating moderate to severe plaque psoriasis against NICE Guidelines

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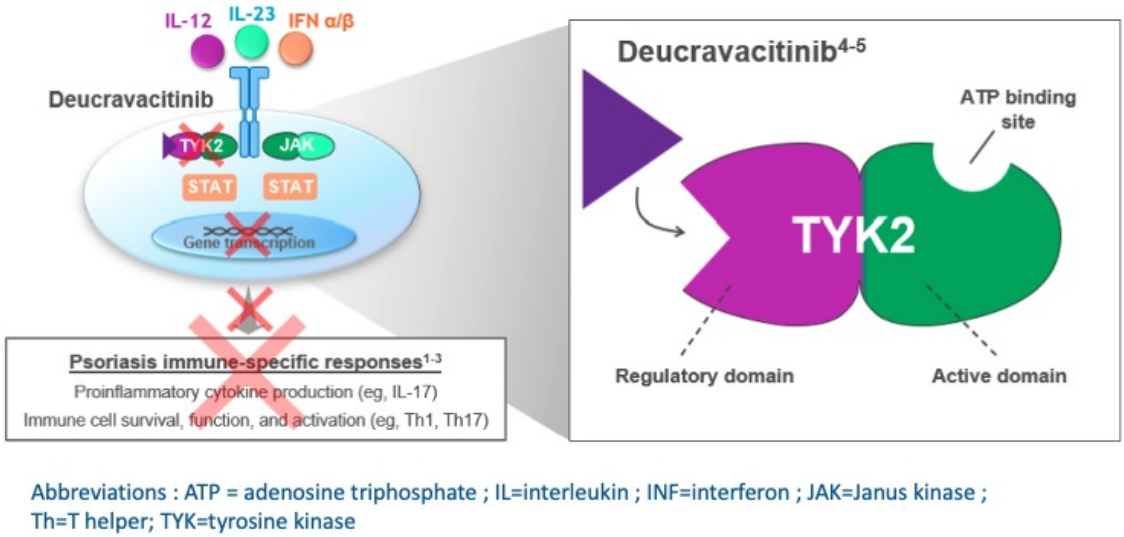
Introduction

Psoriasis is a chronic immune-mediated inflammatory skin disorder associated with significant impairment in quality of life and mental health. Its pathogenesis involves immune dysregulation, particularly the type I interferon and IL-23/IL-17 signalling pathways. Deucravacitinib is a selective allosteric TYK2 inhibitor that reduces downstream pro-inflammatory signalling from IL-23 and IL-12 receptors, thereby reducing psoriatic inflammation. This audit evaluated the use of deucravacitinib in a secondary care dermatology service and assessed compliance with National Institute for Health and Care Excellence guidance for moderate-to-severe plaque psoriasis.



Abbreviations : ATP = adenosine triphosphate ; IL=interleukin ; INF=interferon ; JAK=Janus kinase ; Th=T helper; TYK=tyrosine kinase

Mechanism of action of deucravacitinib

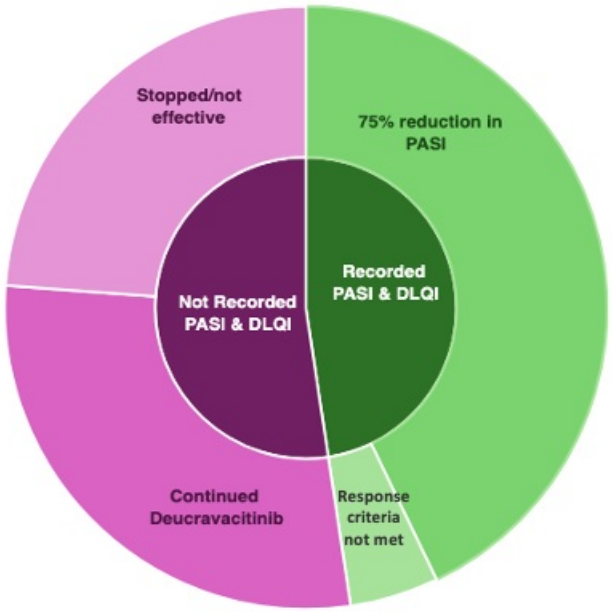
Materials and Methods

A retrospective audit was conducted for patients initiated on deucravacitinib between December 2024 and December 2025 (n=21). Data collected included demographics, co-morbidities, prior systemic therapies, treatment initiation and discontinuation dates and clinical outcomes. Compliance with guidance was assessed by reviewing documentation of baseline Psoriasis Area and Severity Index (PASI) and Dermatology Life Quality Index (DLQI) scores, eligibility criteria for treatment initiation (PASI and DLQI ≥10), completion of 16-week PASI and DLQI assessments and treatment response at 16 weeks. Response criteria required treatment discontinuation if PASI improvement was <75%, or if PASI improvement was <50% alongside a <5-point improvement in DLQI.

Results

Baseline PASI and DLQI scores were documented in 19/21 patients (91%), all of whom met eligibility criteria for treatment initiation. At 16 weeks, only 10/21 patients (48%) had documented PASI and DLQI follow-up assessments, while 11/21 (52%) had no recorded outcome data. Among patients with available follow-up data,

9/10 (90%) achieved PASI75. One patient failed to meet response criteria, demonstrating neither PASI75 nor a ≥5-point reduction in DLQI. Treatment discontinuation occurred in 5/21 patients: 3/21 (14%) due to adverse effects, including widespread rash with facial oedema, severe dizziness with nausea and gingival swelling or bleeding and severe genital blistering; and 2/21 (9.5%) due to lack of efficacy.



PASI and DLQI recorded at 16 weeks post deucravacitinib initiation

Conclusions

Initiation of deucravacitinib was largely compliant with national guidance, with appropriate baseline patient selection achieved in 91% of cases. However, significant deficiencies were identified in 16-week monitoring and documentation, with only 48% of patients having complete follow-up PASI and DLQI assessments. Among patients with documented outcomes, deucravacitinib demonstrated high short-term effectiveness, with 90% achieving PASI75 at 16 weeks. Improved structured follow-up pathways and documentation practices are required to ensure full compliance with guidance and accurate evaluation of treatment outcomes.

EADV CONGRESS
VIENNA
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Abstract N°: 1976

BADBIR Patient characteristics of biologic-experienced and biologic-naive patients with chronic plaque psoriasis receiving tildrakizumab

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Introduction

The British Association of Dermatologists Biologics and Immunomodulators Register (BADBIR) monitors the long-term safety of biologic treatments for psoriasis in the UK and Ireland. Tildrakizumab is a humanised monoclonal antibody targeting the p19 subunit of interleukin-23, approved for moderate-to-severe plaque psoriasis.

This study compared baseline characteristics of biologic-experienced and biologic-naive chronic plaque psoriasis patients treated with tildrakizumab in BADBIR.

Materials and Methods

The BADBIR tildrakizumab cohort included patients aged 18 years or older with chronic plaque psoriasis. For this analysis, patients were divided into two groups based on their prior biologic therapy exposure: the biologic-naive group comprised individuals who were starting tildrakizumab as their first biologic treatment, while the biologic-experienced group included those who had previously received at least one biologic therapy before initiating tildrakizumab. Characteristics analysed included age, sex, BMI, psoriatic arthritis, chronic comorbidities e.g. type 2 diabetes and depression, as well as disease duration, age of onset, baseline Psoriasis Area and Severity Index (PASI), Dermatology Life Quality Index (DLQI), presence of psoriatic arthritis (PsA), and high-impact site involvement.

Results

309 patients were included as of August 2025, comprising 75 biologic-naive and 234 biologic-experienced patients. Among the biologic-experienced group, the mean number of prior biologics was 2.1, with 49.6% having received three or more prior therapies.Comparing group characteristics, the biologic-naive group had a mean age of 50.6 years, whereas the experienced group averaged 46.7 years. Both groups shared a median disease duration of 19.0 years, though biologic-experienced patients had a younger age of onset (21.0 vs. 25.5 years). While baseline disease severity was high in both cohorts, biologic-naive patients reported higher baseline DLQI scores (mean 16.0 vs. 11.8) and a slightly higher mean PASI (13.2 vs. 11.9). High-impact site involvement was prevalent across the cohort but more frequent in biologic-experienced patients, such as scalp involvement in 64.5% experienced patients vs. 52.0% of naïve patients. Comorbidities were common, with psoriatic arthritis reported in 9.8% of the experienced group and 6.8% of the naive group.

Patient characteristics of biologic-experienced and biologic-naive patients with chronic plaque psoriasis treated with Tildrakizumab in BADBIR

Patient Characteristics	Biologic experienced	Biologic Naïve	P-value
Number of patients, n (%)	234 (75.2)	75 (24.7)	
Age (mean)	46.7 (13.7)	50.6 (15.1)	0.175
Male, n (%)	133 (56.8)	50 (66.7)	0.132
Disease duration (years)	22.8 (14.2)	21.5 (14.8)	1.000
Number of comorbidities	1.8 (1.5)	2.0 (1.5)	1.000
Age of psoriasis onset (years)	24.0 (14.4)	29.2 (16.1)	0.050
DLQI total score	11.8 (7.2)	16.0 (7.5)	0.005
Psoriatic arthritis, n (n%)	23 (9.8)	5 (6.8)	0.046
High impact site involvement			
Scalp, n (%)	151 (64.5)	39 (52.0)	0.052
Nail, n (%)	106 (45.3)	24 (32.0)	0.042
Number of patients on each dose			
Number of patients on 100mg dose	144 (61.5)	53 (70.7)	0.152
Number of patients on 200mg dose	90 (38.5)	22 (29.3)	
Increased from 100mg to 20mg	24 (10.3)	14 (18.7)	0.054
Decreased from 200mg to 100mg	5 (2.1)	2 (2.7)	0.788

Conclusions

The real-world data shows that biologic-experienced patients receiving tildrakizumab often present with a complex clinical profile, characterised by multiple prior treatment failures and a higher prevalence of high-impact site involvement, particularly scalp psoriasis. The substantial burden of scalp disease in this cohort reinforces the

growing evidence highlighting high impact areas as an important factor in decisions in psoriasis management. These difficult-to-treat areas may drive decisions for switching from one to a different therapeutic regardless the severity.

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Abstract N°: 1995

Psoriatic Scarring Alopecia in a Pediatric Patient: A Rare Manifestation of a Common Dermatosis

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Introduction

Psoriasis is a systemic inflammatory condition in which most manifestations involve the skin, nails, and scalp. Regarding the latter, approximately 50–80% of patients with psoriasis will develop scalp involvement, typically presenting with erythematous, scaly plaques and an increased incidence of telogen effluvium. It is important to emphasize that areas of alopecia and scarring manifestations, such as psoriatic scarring alopecia (PSA), are rare and occur in 50 up to 80% of patients with long-standing disease. Historically, the first definition of "psoriatic alopecia" dates back to 1972, when Shuster described the term "destructive alopecia" as an uncommon complication of scalp psoriasis. Although infrequent, its recognition is essential for timely evaluation and initiation of treatment, given its scarring and therefore permanent nature.

Case Presentation

We report the case of a 15-year-old Caucasian female with a nine-year history of palmoplantar and scalp psoriasis. During this period, she was treated with topical clobetasol 0.05% cream and petrolatum for palmoplantar fissures, with intermittent periods of adequate and inadequate disease control. At the age of 11, due to worsening dermatological symptoms and absence of articular involvement, oral acitretin (10 mg/day) was initiated and combined with topical therapy, resulting in good clinical response. At age 12, she developed marked hair thinning at the vertex, accompanied by mild pruritus. Dermatological examination revealed irregular widening of the midline part and reduced follicular density.

Trichoscopy demonstrated absence of follicular openings, perifollicular and interfollicular scaling. Histopathological examination revealed a perifollicular lymphocytic infiltrate in the dermis, decreased sebaceous glands, and mild fibroplasia, consistent with lymphocytic scarring alopecia with lichenoid interface damage. Notably, there were no histological features of psoriasis in the epidermis. A diagnosis of psoriatic scarring alopecia was established, and the patient was treated with adalimumab, achieving stabilization of both cutaneous and hair findings six months after therapy initiation. Histopathological examination of psoriatic scarring alopecia (PSA) typically lacks the classic features observed in cutaneous psoriasis. Studies indicate that the most common follicular alterations include infundibular dilation, followed by perifollicular fibrosis, perifollicular lymphocytic infiltrate, thinning of the follicular infundibulum, presence of fibrous tracts, and absence or atrophy of sebaceous glands, as observed in the present case.

Conclusion

Some studies suggest that T-cell infiltration and cytokine regulation—particularly involving interleukin-33 (IL-33)—play a role in promoting pathological changes in hair follicles in PSA and may represent potential therapeutic targets in scarring alopecias. IL-33 is primarily regulated in keratinocytes located in the outer root sheath of the hair follicle. The clinical and histopathological findings require exclusion of other forms of lymphocytic scarring alopecia, such as lichen planopilaris, pseudopelade of Brocq, lupus erythematosus, and central centrifugal cicatricial alopecia, which present distinct epidemiological characteristics (e.g., age and ethnicity) and are not typically associated with severe, long-standing scalp psoriasis. This case highlights the importance of careful

evaluation of patients with psoriasis, particularly those with scalp involvement, as psoriatic scarring alopecia is a potentially irreversible condition. Early diagnosis is crucial to prevent unfavorable outcomes.

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Abstract N°: 1998

Serum neopterin level in psoriatic patients treated with acitretin or narrowband ultraviolet B or both

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Introduction

A biological indicator of cellular immunity is neopterin. In certain studies, psoriasis patients had higher serum, and urine neopterin levels, which were reduced following therapy.
This work aims To evaluate the effect of acitretin versus narrowband ultraviolet B (NB-UVB) and combinations of them on psoriasis vulgaris and correlate it with neopterin level

Materials and Methods

In this case-control research, a total of 120 respondents (30 healthy volunteers) served as the control group, in addition to 90 psoriasis patients randomly allocated into three equal groups: group (I): 30 patients received Acitretin for 3 months. Group (II): 30 patients were treated with NB-UVB. Group (III): 30 patients received Acitretin and NB-UVB (3 sessions/week) for 3 months. Serum neopterin levels were measured pre- and post-treatment. All patients were clinically and photographically evaluated using the Psoriasis Area and Severity Index (PASI) score. The study was registered at clinicaltrial.com. Approval numbers: NCT05401006 and date of registration: 1/6/2022.

Results

In this study, statistically significant higher serum neopterin levels have been found in psoriatic patients than healthy controls. We found a significant decrease in PASI scores in all groups. The relative reduction percentage in the PASI score was substantially different between groups ($P<0.001$). The highest decrease percentage in PASI score was reported in group III compared with group II (NB- UVB) and group I (Acitretin group), ($P<0.001$). The median s. neopterin levels after treatment varied substantially among the three groups ($P<0.001$).

Conclusions

When compared with healthy controls, serum neopterin levels in psoriatic patients were substantially greater ($P<0.05$).

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Abstract N°: 2016

Moisturizers as Adjuvant Therapy to Secukinumab in Moderate-to-Severe Plaque Psoriasis: A Prospective, Multicenter, Randomized controlled, Cohort Study

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Introduction

Plaque psoriasis is a chronic, immune-mediated inflammatory disease characterized by reddening, thickening and scaling of the skin, as well as persistent skin barrier dysfunction. Some patients also experience itchiness. Biologics are now the primary treatment for moderate-to-severe plaque psoriasis. Although studies have shown that moisturizers can improve barrier function and relieve symptoms such as itchiness and dryness in people with mild-to-moderate psoriasis, their effectiveness in patients with moderate-to-severe plaque psoriasis is unclear, especially in relation to skin barrier function and their effectiveness alongside biologic therapy. This study aims to investigate the role of moisturisers as an adjunct to biologic therapy in patients with moderate-to-severe plaque psoriasis. The results will provide a scientific basis for skincare in these patients and help optimise comprehensive treatment strategies for psoriasis.

Materials and Methods

This was a prospective, multicenter, randomized controlled, cohort study. A total of 100 adult patients with moderate-to-severe plaque psoriasis (PASI≥5, BSA>3%) who were eligible for secukinumab treatment were enrolled. Patients were randomized at a ratio of 1:1 to receive secukinumab plus a moisturizing cream (twice daily, whole body) or secukinumab alone (no topical moisturizers), from week 0 (W0) to W4. From W4 to W12, the control group received no education or intervention regarding the use of moisturizers. From W12 to W16, both groups received the same intervention. The observation period was 16 weeks, with follow-up visits scheduled at weeks 0, 4, 8, 12, and 16.

The primary endpoint was the difference in stratum corneum (SC) hydration (measured by Corneometer CM825) or the clinical grading of skin dryness and smoothness between the two groups at W4. The secondary endpoints included differences in transepidermal water loss (TEWL, measured by Tewameter TM300) at weeks 4, 12 and 16; changes in PASI 75/90/100 improvement, sPGA 0/1 achievement, DLQI 0/1 achievement, and PP-NRS itch score from baseline to weeks 4, 8, 12 and 16; as well as patient and investigator satisfaction at W4 and W16.

Here we present the interim analysis results from the first 31 patients who completed the 4-week observation period.

Results

Baseline characteristics were comparable between the two groups (treatment group=17, vs control group=14,

P>0.05).

At W4, the primary endpoint showed that the change in SC hydration was higher (10.19±14.65 vs. -1.67±10.87, P=0.0553) in the treatment group than in the control group without significance. And intergroup comparison exhibited great significance before and after treatment in treatment group (P=0.0219). Clinical grading of skin dryness also favored the treatment group(4.36±2.24 vs. 6.25±1.76 , P=0.0265).

For secondary endpoints, TEWL at week 4 was reduced in the treatment group compared with the control group (0.34±9.96 vs. 0.43±15.86, P=0.9864) without significance.

The PP-NRS itch score showed a greater reduction from baseline at W4 in the treatment group compared with the control group. Patient and investigator satisfaction scores at W4 were also higher in the treatment group.

In terms of clinical efficacy, the improvement for PASI 75 in the treatment group compared to the control group at W4 were 4 (28.6%) vs. 1 (7.7%), compared with the control group. The treatment group achieved sPGA 0/1 and DLQI 0/1 were 3 (21.4%) and 4 (28.6%), with no statistically significant difference between the two groups.

No serious adverse events related to the moisturizer were reported during the 4-week observation period.

Table 1. Baseline characteristics

Baseline characteristics	treatment group N=17	control group N=14	P
Age (years), mean (SD)	41.53±9.86	45.64±11.71	0.5113
Male, n (%)	13 (76.5%)	6(42.9%)	0.0559
BMI (kg/m2), mean (SD)	24.26±4.01	26.69±3.41	0.0827
Psoriasis duration (years), mean (SD)	15.66±10.61	16.64±11.29	0.8043
SC hydration, mean (SD)	20.16±7.67	23.03±11.42	0.4108
Grading of skin dryness，mean (SD)	7.82±1.19	6.93±1.69	0.1416
TEWL, mean (SD)	19.09±7.74	22.41±12.49	0.6480
PP-NRS，mean (SD)	5.24±2.80	5.43±2.62	0.8413
BSA%, mean (SD)	19.09±15.90	10.43±6.94	0.0617
PASI score, mean (SD)	13.71±7.00	10.75±3.95	0.3207
sPGA, mean (SD)	3.53±0.51	3.36±0.50	0.3573
DLQI, mean (SD)	12.41±7.25	11.93±7.67	0.8584

SD, standard deviation

Table 2. Clinical outcomes from W0 to W4

Week 4	treatment group	control group	P
SC hydration, mean (SD)	28.98±13.17	20.29±8.77	0.0639
ΔSC hydration, mean (SD)	10.19±14.65	-1.67±10.87	0.0553
Intergroup P value of SC hydration at D0 and W4	0.0219**	0.5904	
Grading of skin dryness，mean (SD)	4.36±2.24	6.25±1.76	0.0265**
TEWL, mean (SD)	19.93±6.71	21.96±12.68	0.8977
ΔTEWL, mean (SD)	0.34±9.96	0.43±15.86	0.9864
Intergroup P value of TEWL at D0 and W4	0.8475	0.9197	
PP-NRS，mean (SD)	3.39±2.44	2.75±2.56	0.5186
PASI 75 improvement	4 (28.6%)	1 (7.7%)	0.3259
PASI 90/100 improvement	3 (21.4%)	0 (0.0%)	0.2222
sPGA（0/1）	3 (21.4%)	2 (15.4%)	1.0000
DLQI（0/1）	4 (28.6%)	6 (46.2%)	0.4401
Patient satisfaction, mean (SD)	22.14±3.76	21.50±3.78	0.6643
physician satisfaction, mean (SD)	21.93±2.87	20.00±2.13	0.0913

N, the number of patients with non-missing data; SD, standard deviation; **, P<0.05

Conclusions

This interim analysis of 31 patients suggests that the addition of a moisturizer to secukinumab therapy improves skin hydration, barrier function, and clinical symptoms in patients with moderate-to-severe plaque psoriasis at W4. The combination therapy was well tolerated, with no product-related safety concerns, and patient satisfaction with the treatment increased.

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Abstract N°: 2019

Risk Factors Associated with Creatinine Elevation in Psoriasis Patients Treated with Cyclosporine: A Real-World Study

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Introduction
Psoriasis is a chronic immune-mediated inflammatory disease that substantially impairs patients' quality of life. Cyclosporine is widely used as an effective systemic treatment for moderate-to-severe psoriasis because of its rapid onset of action and potent immunosuppressive effect. However, cyclosporine is associated with nephrotoxicity, which can limit its clinical use. Identifying factors associated with deterioration of renal function is therefore essential for safe treatment.

Materials and Methods
We conducted a retrospective analysis of patients with psoriasis treated with cyclosporine. Clinical and laboratory variables were collected, including age, body mass index (BMI), Psoriasis Area and Severity Index (PASI), comorbidities such as hypertension, diabetes, and dyslipidemia, treatment duration, and cumulative dose. The primary outcome was an increase in serum creatinine (SCr) level of at least 10% or 20% from baseline. Univariate and multivariate logistic, linear regression analyses were performed to identify factors associated with SCr elevation.

Results
A total of 486 patients were included in the analysis. Among them, 323 did not show an increase in SCr, whereas 163 exhibited an elevation of at least 10% and 77 an elevation of at least 20%. In univariate analyses, age, BMI, initial PASI score, hypertension, diabetes and dyslipidemia were significantly associated with SCr elevation in both groups. From multivariate logistic regression analysis, hypertension (aOR, 2.665; 95% CI, 1.439–4.933) and dyslipidemia (aOR, 2.726; 95% CI, 1.347–5.514) were identified as independent risk factors in the ≥10% elevation group, while hypertension (aOR, 2.772; 95% CI, 1.260–6.098) was the independent risk factor in the ≥20% elevation group. Multivariate linear regression analysis showed hypertension (p=0.006, p=0.019, respectively) and dyslipidemia (p=0.004, p=0.012, respectively) as independent contributing factors.

Conclusions
Although age, BMI, initial PASI score, hypertension, diabetes, and dyslipidemia were significantly associated with SCr elevation in univariate analyses, multivariate analyses identified hypertension and dyslipidemia as independent risk factors. In contrast, treatment dose and duration were not significantly associated with SCr elevation. These findings suggest that careful monitoring of renal function throughout cyclosporine treatment is warranted, particularly in relation to patients' metabolic comorbidities.

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Abstract N°: 2020

Xeligekimab Achieves Sustained Joint and Skin Improvement in Psoriatic Arthritis: A Real-World Subgroup Analysis from a Prospective, Multicenter, Observational Study in China (XP-Real)

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Introduction

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Psoriatic arthritis (PsA) affects approximately 14% of Asian patients with psoriasis, contributing to progressive joint damage and functional disability. The *interleukin (IL)-17A* pathway plays a central role in both cutaneous and articular inflammation. Xeligekimab is a domestically developed anti-IL-17A monoclonal antibody approved in China in 2024 for moderate-to-severe plaque psoriasis. However, its effects on joint outcomes in PsA patients have not been characterized in real-world settings. This prespecified subgroup analysis evaluated the effectiveness of xeligekimab on composite disease activity, joint counts, and patient-reported outcomes in PsA patients over 24 weeks.

Materials and Methods

This analysis was conducted within a prospective, multicenter, observational study across 45 dermatology centers in China (NCT06802848). Patients with concomitant PsA at baseline (n=19) were classified into active PsA (n=5;

not meeting Minimal Disease Activity [MDA] criteria) and non-active PsA (n=14). At baseline, the cohort had a mean age of 44.2 ± 14.3 years (68.4% male), mean PASI of 14.9 ± 13.0, mean tender joint count (TJC68) of 2.6 ± 2.8, and mean swollen joint count (SJC66) of 1.9 ± 2.7. Active PsA patients had higher baseline joint counts (TJC68: 5.4 ± 3.0; SJC66: 5.6 ± 2.9) versus non-active PsA (TJC68: 1.6 ± 1.9; SJC66: 0.6 ± 0.8) (**Table 1**). Disease activity was assessed using MDA criteria and American College of Rheumatology (ACR) 50 and 70 responses at Weeks 4, 12, and 24. Joint measures and patient-reported outcomes (pain and disease activity Visual Analogue Scale [VAS]) were evaluated at Weeks 4, 12, and 24. Missing data were handled by multiple imputation (m=40).

Table 1. Baseline Demographics and Disease Characteristics of Patients with Psoriatic Arthritis

Characteristic	All PsA (n=19)	Active PsA (n=5)	Non-active PsA (n=14)
Demographics			
Age (years), mean ± SD	44.2 ± 14.3	48.7 ± 9.4	42.6 ± 15.6
Male, n (%)	13 (68.4)	3 (60.0)	10 (71.4)
Disease duration (years), mean ± SD	7.0 ± 6.2	7.4 ± 3.6	6.9 ± 7.0
Skin severity			
PASI, mean ± SD	14.9 ± 13.0	18.1 ± 19.3	13.8 ± 10.7
Joint counts			
TJC68, mean ± SD	2.6 ± 2.8	5.4 ± 3.0	1.6 ± 1.9
SJC66, mean ± SD	1.9 ± 2.7	5.6 ± 2.9	0.6 ± 0.8
Patient-reported outcomes			
Patient pain VAS (mm), mean ± SD	22.5 ± 22.2	34.4 ± 26.8	18.2 ± 19.7
Patient disease activity VAS (mm), mean ± SD	30.3 ± 26.8	30.2 ± 29.9	30.4 ± 26.7
Physician disease activity VAS (mm), mean ± SD	32.7 ± 24.1	32.6 ± 25.0	32.7 ± 24.7

Active PsA was defined as not meeting Minimal Disease Activity (MDA) criteria at baseline. PASI, Psoriasis Area and Severity Index; TJC68, tender joint count (68 joints); SJC66, swollen joint count (66 joints); VAS, Visual Analogue Scale. SD, standard deviation.

Results

MDA achievement increased progressively from 48.2% (95% confidence interval [CI]: 24.8, 71.5) at Week 4 to 75.5% (95% CI: 55.3, 95.7) at Week 12 and 86.2% (95% CI: 69.1, 100.0) at Week 24 (**Table 2, Figure 1A**). At Week 24, ACR 50 was achieved by 53.7% (95% CI: 27.0, 80.4), and ACR 70 by 43.7% (95% CI: 17.5, 69.9) (**Table 2, Figure 1A**).

Mean TJC68 reached significance at Week 24 (−1.56; 95% CI: −2.91, −0.22) (**Table 2, Figure 1C**). Mean SJC66 decreased significantly at all time points, reaching −1.37 (95% CI: −2.61, −0.14) at Week 24 (**Table 2, Figure 1E**). Patient pain VAS decreased by −12.3 (95% CI: −22.6, −2.0) at Week 12 and −19.7 (95% CI: −30.0, −9.4) at Week 24 (Table 2, Figure 1B). Patient disease activity VAS showed consistent reductions, reaching −20.5 (95% CI: −35.5, −5.6) at Week 24 (**Table 2, Figure 1H**). Physician disease activity VAS showed a similar trend, with a mean reduction of −18.8 (95% CI: −33.6, −4.1) at Week 24 (**Table 2**).

In the active PsA subgroup (n=5), MDA achievement increased from 26.0% (95% CI: 0.0, 67.9) at Week 4 to 72.0% (95% CI: 28.8, 100.0) at Week 12 and 70.0% (95% CI: 24.5, 100.0) at Week 24. Mean SJC66 change was −2.72

(95% CI: −4.87, −0.57) at Week 4 and −4.74 (95% CI: −7.71, −1.76) at Week 24, with 95% CIs excluding zero at all time points. Mean TJC68 change reached −4.21 (95% CI: −7.53, −0.90) at Week 24 (**Table 2**). Meanwhile, in the non-active PsA subgroup (n=14), MDA achievement was 56.1% (95% CI: 29.6, 82.5) at Week 4 and 92.0% (95% CI: 77.0, 100.0) at Week 24. Mean changes in SJC66 and TJC68 were smaller in magnitude, with 95% CIs including zero at all time points (**Table 2**).

Table 2. Composite Disease Activity, Joint, Patient-Reported, and Functional Outcomes Over 24 Weeks in Patients with Psoriatic Arthritis

Endpoint	Week 4	Week 12	Week 24
All PsA (n=19)			
Response rates, % (95% CI)			
MDA achievement	48.2 (24.8, 71.5)	75.5 (55.3, 95.7)	86.2 (69.1, 100.0)
ACR 50	22.5 (3.2, 41.8)	47.1 (23.1, 71.1)	53.7 (27.0, 80.4)
ACR 70	11.7 (0.0, 26.8)	34.2 (11.9, 56.5)	43.7 (17.5, 69.9)
Joint counts, mean Δ (95% CI)			
TJC68	−0.35 (−1.28, 0.59)	−1.18 (−2.48, 0.12)	−1.56 (−2.91, −0.22)†
TJC28	−0.25 (−1.02, 0.53)	−0.86 (−1.89, 0.17)	−0.98 (−2.08, 0.12)
SJC66	−0.83 (−1.61, −0.04)†	−1.22 (−2.31, −0.13)†	−1.37 (−2.61, −0.14)†
SJC28	−0.54 (−1.06, −0.02)†	−0.96 (−1.76, −0.16)†	−1.06 (−2.00, −0.12)†
TJC6 (entheseal)	−0.27 (−0.66, 0.12)	−0.50 (−1.03, 0.03)	−0.55 (−1.13, 0.03)
Patient-reported outcomes, mean Δ (95% CI)			
Patient pain VAS (mm)	−6.1 (−14.8, 2.7)	−12.3 (−22.6, −2.0)†	−19.7 (−30.0, −9.4)†
Patient disease activity VAS (mm)	−8.9 (−17.6, −0.1)†	−16.7 (−27.5, −5.9)†	−20.5 (−35.5, −5.6)†
Physician disease activity VAS (mm)	−4.9 (−14.9, 5.0)	−17.1 (−27.7, −6.5)†	−18.8 (−33.6, −4.1)†
Active PsA (n=5)			
Response rates, % (95% CI)			
MDA achievement	26.0 (0.0, 67.9)	72.0 (28.8, 100.0)	70.0 (24.5, 100.0)
ACR 50	0.5 (0.0, 8.9)	33.5 (0.0, 82.4)	44.5 (0.0, 100.0)
ACR 70	0.5 (0.0, 8.9)	26.5 (0.0, 70.3)	30.5 (0.0, 83.5)
Joint counts, mean Δ (95% CI)			
TJC68	−2.14 (−4.43, 0.16)	−3.32 (−6.55, −0.08)†	−4.21 (−7.53, −0.90)†
TJC28	−1.41 (−3.02, 0.20)	−2.88 (−5.35, −0.41)†	−3.06 (−6.02, −0.10)†
SJC66	−2.72 (−4.87, −0.57)†	−3.94 (−6.93, −0.95)†	−4.74 (−7.71, −1.76)†
SJC28	−1.66 (−2.85, −0.46)†	−2.75 (−4.98, −0.52)†	−3.49 (−5.78, −1.19)†
TJC6 (entheseal)	−0.72 (−1.93, 0.50)	−1.13 (−2.87, 0.62)	−1.60 (−3.29, 0.10)
Patient-reported outcomes, mean Δ (95% CI)			
Patient pain VAS (mm)	−7.1 (−23.2, 9.0)	−19.4 (−48.1, 9.4)	−30.3 (−54.5, −6.0)†
Patient disease activity VAS (mm)	−1.4 (−20.6, 17.9)	−15.0 (−47.4, 17.3)	−20.5 (−62.0, 20.9)
Physician disease activity VAS (mm)	−3.3 (−24.5, 17.8)	−15.0 (−48.2, 18.2)	−17.2 (−55.2, 20.8)
Non-active PsA (n=14)			
Response rates, % (95% CI)			
MDA achievement	56.1 (29.6, 82.5)	76.8 (53.9, 99.7)	92.0 (77.0, 100.0)
ACR 50	30.4 (5.5, 55.2)	52.0 (25.1, 78.9)	57.0 (29.0, 85.0)
ACR 70	15.7 (0.0, 35.6)	37.0 (11.1, 62.8)	48.4 (20.5, 76.3)
Joint counts, mean Δ (95% CI)			
TJC68	0.30 (−0.48, 1.07)	−0.42 (−1.56, 0.72)	−0.62 (−1.71, 0.48)
TJC28	0.17 (−0.62, 0.96)	−0.14 (−0.98, 0.70)	−0.24 (−0.95, 0.46)

SJC66	−0.15 (−0.52, 0.22)	−0.25 (−0.66, 0.18)	−0.17 (−0.67, 0.33)
SJC28	−0.14 (−0.56, 0.28)	−0.33 (−0.77, 0.12)	−0.19 (−0.64, 0.26)
TJC6 (entheseal)	−0.11 (−0.40, 0.17)	−0.28 (−0.62, 0.07)	−0.17 (−0.57, 0.22)
Patient-reported outcomes, mean Δ (95% CI)			
Patient pain VAS (mm)	−5.7 (−16.2, 4.8)	−9.8 (−19.8, 0.2)	−16.0 (−26.9, −5.1)†
Patient disease activity VAS (mm)	−11.6 (−21.3, −1.8)†	−17.3 (−27.6, −7.0)†	−20.5 (−34.2, −6.9)†
Physician disease activity VAS (mm)	−5.5 (−16.9, 5.9)	−17.9 (−27.4, −8.3)†	−19.4 (−35.0, −3.9)†

Δ, change from baseline; MDA, Minimal Disease Activity; ACR, American College of Rheumatology; TJC68, tender joint count (68 joints); TJC28, tender joint count (28 joints); SJC66, swollen joint count (66 joints); SJC28, swollen joint count (28 joints); TJC6, entheseal tender joint count (6 sites); VAS, Visual Analogue Scale; CI, confidence interval. Active PsA was defined as not meeting MDA criteria at baseline. †95% CI excluding zero. Response rates and mean changes were estimated using multiple imputation (m=40).

Conclusions

Xeligekimab demonstrated progressive improvement in composite disease activity, joint inflammation, and patient-reported pain over 24 weeks. Over 85% achieved MDA and over 40% achieved ACR 70 by Week 24. Both subgroups showed sustained benefit, with active PsA patients exhibiting greater absolute joint count reductions. The small sample size (n=19) and observational design warrant confirmation in larger, dedicated PsA studies.

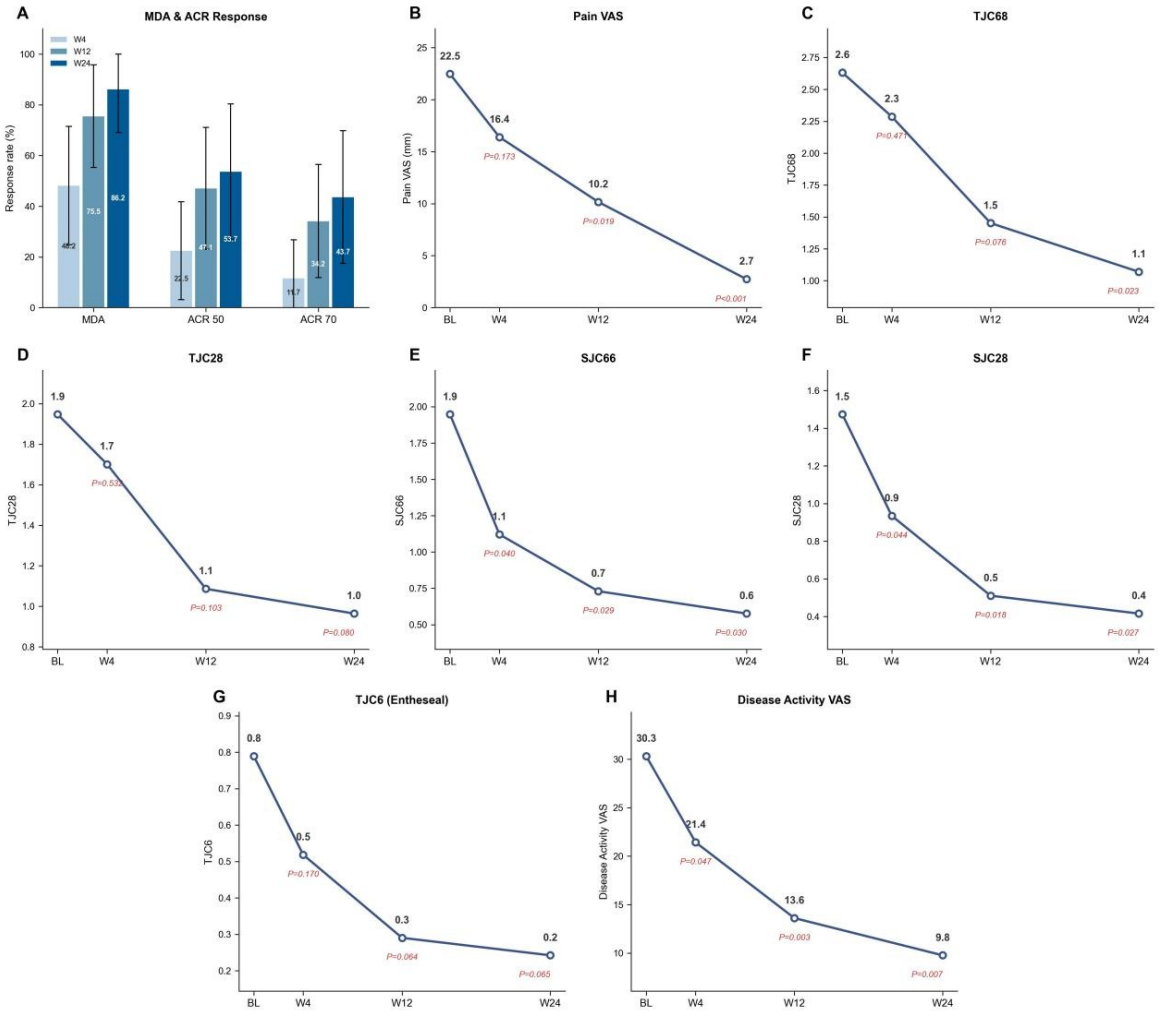

Figure 1. Disease Activity, Joint, Patient-Reported, and Functional Outcomes Over 24 Weeks in Patients with Psoriatic Arthritis (A)Minimal Disease Activity (MDA) achievement and American College of Rheumatology (ACR) 50/70 response rates at Weeks 4, 12, and 24 in the overall PsA cohort (n=19). (B) Mean change from baseline in patient pain Visual Analogue Scale (VAS). (C-G) Mean change from

baseline in joint counts over 24 weeks: (C) tender joint count (TJC68), (D) tender joint count (TJC28), (E) swollen joint count (SJC66), (F) swollen joint count (SJC28), (G) entheseal tender joint count (TJC6). (H) Mean change from baseline in patient disease activity VAS.

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Abstract N°: 2066

EARLY-ONSET PSORIASIS AS A RISK FACTOR FOR OSTEOPOROSIS: INSIGHTS FROM TWO YOUNG PATIENTS

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Introduction

Psoriasis is a chronic immune-mediated inflammatory disease associated with multiple systemic comorbidities. The IL-23/IL-17 axis, along with TNF-α and IL-6, plays a central role in psoriasis pathogenesis. These pro-inflammatory cytokines can promoting osteoclastogenesis, leading to a decrease in bone mineral density. Although several studies suggest a possible association between psoriasis and osteopenia/osteoporosis, the underlying mechanisms and clinical implications remain unclear. Notably, impaired bone health in patients without traditional risk factors such as obesity, immobility, or advanced age ma y indicate a direct effect of chronic inflammation. In this context, we present two patients with early-onset psoriasis who developed increased osteoporotic fracture risk at a young age in the absence of major risk factors. These cases aim to highlight osteoporosis as a potential comorbidity in psoriasis and emphasize the importance of evaluating bone metabolism in selected patients.

Case Presentation

Case 1, a 34-year-old male with a 21-year history of psoriasis had previously been treated with topical corticosteroids, methotrexate (1 year), adalimumab (1 year), and ixekizumab (3 years). Due to inadequate response and increased disease activity, bimekizumab therapy was initiated 3 months prior to presentation. Following the exclusion of rheumatologic conditions potentially associated with the patient's nonspecific pain, osteoporosis-related investigations were undertaken.Laboratory investigations were all within normal limits. BMD assessment revealed increased osteoporotic fracture risk. Major risk factors for osteoporosis, including obesity, family history, and advanced age, were absent. Additionally, there was no manifestation of psoriasis-associated arthritis.

Case 2, a 21-year-old female with a 7-year history of psoriasis had previously received methotrexate for 1 year and topical corticosteroids without sufficient response. She had been on secukinumab treatment for 9 months. After excluding accompanying rheumatologic disorders that might explain the patient's nonspecific pain, the patient was further investigated for osteoporosis. Laboratory investigations were all within normal limits. BMD assessment revealed increased osteoporotic fracture risk. Similar to the first patient, major osteoporosis risk factors and psoriatic arthritis were absent in this case.

Variables	Case 1	Case 2
Demography		
Age	34	21
Sex(female/male)	Male	Female
BMI	22	19
Alcohol	No	No
Smoking status	Nonsmoker	Nonsmoker
Clinical characteristics		
Disease age of onset	3 years	14 years
Disaease activity /PASI	20	13
Laboratuar		
ESR	9	9
CRP	3,78	0,92
Ca	8,93	8,99
P	2,98	4,07
Vitamin D	27,6	14,1
Evidence of athritis	without arthritis	without arthritis
Drugs		
Medication history/current medication	MTX,ADA,IXE/BKZ	MTX/SEC
BMD/T score		
L1	-2,0	-2,7
L2	-2,5	-2,3
L1-4	-1,9	-2,1
Femur total	-1,8	-1,4

(BMI: Body mass index; BMD: Bone mineral density; ESR: Erythrocyte sedimentation rate; CRP: C-reactive protein; PASI: Psoriasis Area and Severity Index; MTX: Methotrexate; ADA: Adalimumab; IXE: Ixekizumab; BKZ: Bimekizumab; SEC: Secukinumab)

Table 1: Clinical, laboratory, and densitometric characteristics of the patients

Conclusion

Remarkably, both young patients demonstrated an increased risk of osteoporotic fractures despite the absence of major risk factors such as advanced age, obesity, or systemic corticosteroid use, suggesting a potential association between early-onset psoriasis and premature bone loss. In recent years, proinflammatory cytokines associated with chronic inflammation, including TNF-α, IL-1, IL-6, and IL-17, have been shown to accelerate bone resorption by increasing osteoclast activity. Therefore, chronic inflammatory diseases have been associated with an increased risk of osteoporosis. Although the literature suggests that psoriasis-associated osteoporosis is more closely related to disease duration than disease severity, both of our cases presented with early-onset and severe psoriasis. Several factors are thought to contribute to the relationship between psoriasis and osteoporosis, including elevated inflammatory cytokine levels, long term use of topikal corticosteroids, vitamin D deficiency and immobilization due to pain in patients with psoriatic arthritis. The exact pathophysiology remains unclear, and further studies are needed to elucidate the underlying mechanisms. Early evaluation of bone health may be important in preventing irreversible skeletal complications. Furthermore, elucidation of shared pathogenic pathways may improve long-term biologic treatment strategies. Therefore, osteoporosis screening should be considered in patients with long-standing and severe psoriasis presenting with non-specific pain after exclusion of coexisting rheumatologic diseases.

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Psoriasis and risk of 26 cancers: pooled population-based cohort studies from Denmark, England, Israel and Taiwan

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Introduction

Psoriasis is a chronic inflammatory skin disease, and the risk of developing cancer has been postulated due to the presence of several plausible underlying mechanisms. Understanding the association between psoriasis and cancer is imperative to the provision of optimal psoriasis care. We sought to examine the risk of developing cancer in individuals with psoriasis.

Materials and Methods

Population-based cohort studies were conducted in Denmark, England, Israel and Taiwan through the use of linked electronic health records. Individuals aged at least 18 years with a diagnosis of psoriasis in the country-specific study period were matched with up to six comparators with no record of psoriasis prior to the index date. Country-specific hazard ratios for the risk of cancer development overall and for 26 site-specific cancers between individuals with and without psoriasis were calculated through Cox regression. Country-specific estimates were pooled using random effects modelling.

Results

We included 702,022 individuals with psoriasis and 4,185,342 matched comparators. In models implicitly controlled for age, sex and calendar time by matching, there was a small association between psoriasis and cancer overall [pooled HR (pHR) 1.08, 95% confidence interval (CI) 1.04-1.13; I2 = 92.4%]. Adjustment for potential confounding factors resulted in a slight attenuation of risk (pHR 1.05, 95% CI 1.01-1.09; I2 = 81.2%). When restricted to those with moderate-to-severe psoriasis, the risk of cancer overall was slightly higher (pHR 1.16, 95% CI 1.04-1.28; I2 = 92.8%) than in confounder-adjusted models (pHR 1.09, 95% CI 1.03-1.15; I2 = 60.6%). Associations with psoriasis were present for oral cavity (pHR 1.29, 95% CI 1.12-1.47; I2 = 55.4%), pharynx (pHR 1.30, 95% CI 1.07-1.58; I2 = 58.4%), oesophagus (pHR 1.17, 95% CI 1.03-1.33; I2 = 56.6%), liver (pHR 1.53, 95% CI 1.33-1.77; I2 = 75.1%), pancreas (pHR 1.09, 95% CI 1.02-1.17; I2 = 0.0%), kidney (pHR 1.19, 95% CI 1.11-1.27; I2 = 0.0%), bladder (pHR 1.13, 95% CI 1.06-1.20; I2 = 28.7%) and keratinocyte cancers (pHR 1.37, 95% CI 1.16-1.63; I2 = 97.5%), and Hodgkin lymphoma (pHR 1.56, 95% CI 1.16-2.11; I2 = 69.7%), non-Hodgkin lymphoma (pHR 1.16, 95% CI 1.07-1.26; I2 = 35.5%) and leukaemia (pHR 1.18, 95% CI 1.08-1.29; I2 = 41.9%). Site-specific associations generally persisted, with slight risk exacerbations and additional associations for lung and ovarian cancers, when limited to people with moderate-to-severe psoriasis.

Conclusions

Psoriasis was associated with an increased risk of developing 14 of 26 investigated site-specific cancers, including cancers with a poor prognosis, such as liver, lung and oesophageal cancer. Our findings can be used to reinforce cancer prevention strategies in psoriasis care.

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Abstract N°: 2100

Use of GLP-1 receptor agonists in patients with psoriasis: a retrospective observational study on safety and impact on comorbidities with TriNetX database

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Introduction

Glucagon-like peptide-1 (GLP-1) agonist are medications initially design for treatment of type 2 diabetes mellitus. However, aside from enhancing glycemic control, these drugs have demonstrated the ability to promote weight loss and improve cardiovascular outcomes, leading to an increase in prescription rates. Recently, the TOGETHER-PsA and TOGETHER-PsO trials are evaluating the efficacy of the combined treatment with GLP-1 and interleukin (IL)-17 inhibitors in patients with psoriatic arthritis and psoriasis.

Increase in the use of GLP-1 agonists has led to concerns about their safety, due to their potential association with pancreatitis, glaucoma, diabetic retinopathy, gastroesophageal reflux disease (GERD) or gastrointestinal intolerance. Because of these concerns, safety evaluations have been conducted among patients with diabetes mellitus, obesity and cardiovascular comorbidities; however, no study has evaluated the safety of these mediations in the population of patients with psoriasis.

Materials and Methods

We conducted a retrospective observational real-world study to evaluate the safety of GLP-1 agonists in patients with psoriasis, as well as preliminary efficacy data on cardiovascular and inflammatory outcomes. We used the Global Collaborative Network of the federated database TriNetX. We selected patients with Psoriasis, creating a cohort of patients under treatment with GLP-1 agonists for at least 6 months, and a cohort without exposure to these mediations. We further created a cohort of patients without psoriasis, both with and without exposure to these drugs. Exclusion criteria included the registration of outcomes of interest prior to the index date.

Propensity score matching was conducted to reduce residual confounding. Covariates adjusted for included age at index, gender, race, diabetes mellitus, kidney disease, cholelithiasis, cardiovascular disease, overweight/obesity, exposure to other antidiabetic medications. In the efficacy analysis, cohorts were also matched according to exposure to biologic therapies used in psoriasis.

Comorbidity outcomes included new-onset arthropathic psoriasis (PsA), acute myocardial infarction (AMI), transient cerebral ischemic attacks, stroke, heart failure and metabolic-associated liver disease. Safety outcomes included acute pancreatitis, acute cholecystitis, nausea and vomiting, GERD, visual disturbances, retinal vascular occlusions, glaucoma, major depressive disorder and suicidal ideation. Outcomes were evaluated from 1 month after treatment initiation up to 6 months, 1, 2 and 5 years. Patients with outcomes prior to the study window were excluded.

Results

Among patients with psoriasis, GLP-1 agonist reduced the risk of PsA (HR 0.69, 95%CI 0.57-0.84), AMI (HR 0.62,

95%CI 0.38-0.99) and heart failure (HR 0.67, 95%CI 0.48-0.93). No safety warning was detected, with no significant association with acute pancreatitis (p 0.51), acute cholecystitis (p 0.80), GERD (p 0.88), glaucoma (p 0.24), major depressive disorder (p 0.22) and suicidal ideation (p 0.24). Only nausea and vomiting were increased in patients under GLP-1 therapy (HR 1.30, 95%CI 1.13-1.49), while visual disturbances were significantly reduced (HR 0.71, 95%CI 0.57-0.89).

These results were further confirmed after comparing psoriasis patients with the control cohort, nor in the different time points evaluated.

	Outcome	Hazard Ratio (95%CI)	Log-rank test	Survival odds	Risk Ratio (95%CI)	Risk Difference
Psoriasis with GLP-1RA vs. Psoriasis without GLP-1RA AT 5 YEARS	Arthropatic psoriasis	0.69 (0.569,0.838)	0.0002	89.726% 88.812%	0.4 (0.333,0.481)	-5.155% (-6.132%,-4.178%)
	Acute myocardial infarction	0.618 (0.383,0.998)	0.0472	98.845% 97.803%	0.29 (0.182,0.46)	-1.061% (-1.431%,-0.691%)
	Transient cerebral ischemic attacks	0.456 (0.246,0.848)	0.0110	99.239% 98.619%	0.241 (0.132,0.441)	-0.768% (-1.067%,-0.469%)
	Cerebral infarction	0.779 (0.501,1.212)	0.2673	98.738% 97.943%	0.38 (0.248,0.581)	-0.883% (-1.256 %,-0.51%)
	Heart failure	0.667 (0.479,0.928)	0.0158	95.776% 95.572%	0.306 (0.223,0.421)	-2.122% (-2.657%,-1.588%)
	Fatty liver disease	0.993 (0.83,1.188)	0.9397	88.23% 88.834%	0.514 (0.434,0.608)	-4.017% (-4.994%,-3.039%)
	Acute pancreatitis	0.808 (0.428,1.529)	0.5122	98.956% 99.262%	0.4 (0.216,0.743)	-0.335% (-0.554%,-0.117%)
	Nausea and vomiting	1.302 (1.132,1.497)	0.0002	81.349% 85.915%	0.662 (0.581,0.753)	-3.52% (-4.597%,-2.443%)
	GERD or other esophagitis	0.989 (0.858,1.14)	0.8806	79.489% 79.65%	0.533 (0.468,0.607)	-7.166% (-8.571%,-5.762%)
	Visual disturbances and blindness	0.714 (0.573,0.89)	0.0026	93.528% 92.025%	0.356 (0.289,0.439)	-3.697% (-4.404%,-2.99%)
	Major depressive disorder, recurrent	1.131 (0.929,1.377)	0.2197	92.389% 92.652%	0.567 (0.471,0.683)	-2.303% (-3.039%,-1.567%)
	Suicidal ideations	0.832 (0.491,1.408)	0.4921	98.73% 98.853%	0.413 (0.249,0.686)	-0.48% (-0.745%,-0.214%)
	Glaucoma	0.819 (0.587,1.142)	0.2382	97.341% 97.073%	0.41 (0.298,0.565)	-1.248% (-1.68%,-0.816%)
	Acute cholecystitis	0.916 (0.462,1.816)	0.8010	99.408% 99.464%	0.501 (0.258,0.974)	-0.207% (-0.401%,-0.012%)

Table 1. Comorbidity and safety outcomes at 5 years of follow-up. Comparative analysis amongst the cohort of patients with psoriasis under treatment with GLP-1 agonists and the cohort of patients with psoriasis not exposed to GLP-1 agonists. Abbreviations: HR, hazard ratio; 95%CI, 95% confidence interval; GLP-1RA, glucagon-like peptide-1 receptor agonist; GERD, gastroesophageal reflux disease. Statistical significance when $p < 0.05$ or when the 95%CI does not include 1.

Conclusions

GLP-1 agonists have demonstrated a cardiovascular benefit in patients with psoriasis, with a possible protective effect on the development of PsA independent of the therapy for psoriasis. These benefits are achieved without significant side-effects. The results of the TOGETHER trials are expected to confirm these results and validate the use of these medications in psoriasis.

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Abstract N°: 2128

Navigating the Diagnostic Gray Zone: Concordance and Discrepancies of PsorX and IL-36γ Immunohistochemistry in Challenging Psoriasis vs. Atopic Eczema Cases

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Introduction

Differentiating between psoriasis and atopic eczema in clinically ambiguous cases is highly challenging, yet crucial due to the availability of highly targeted, disease-specific systemic therapies. While novel diagnostic tools, such as the PsorX real-time PCR classifier and Interleukin-36 gamma (IL-36γ) immunohistochemistry (IHC), offer new molecular and cellular insights, their comparative performance—especially in difficult-to-diagnose cases yielding conflicting results—remains under-investigated. Consequently, this study aims to evaluate the preliminary diagnostic concordance between PsorX and IL-36γ IHC in challenging clinical phenotypes and to outline a rigorously blinded methodological framework for determining their true diagnostic added value.

Materials and Methods

We conducted a retrospective analysis of 40 challenging clinical cases, including palmoplantar psoriasis, paradoxical immune switches under biologic therapy, pustular manifestations, therapy-resistant courses, and impetiginized or clinically ambiguous lesions. All cases underwent standard histopathological evaluation, IL-36γ IHC, and PsorX testing. To overcome incorporation bias (where novel test results inappropriately influence the final diagnosis), we designed a strict validation protocol: an independent expert panel will establish a clinical ground truth based on comprehensive anamnestic and photographic data, completely blinded to the IL-36γ and PsorX results.

Results

Preliminary data from the 40 analyzed cases revealed that PsorX classified 27 cases as "Psoriasis Probable". IL-36γ IHC indicated probable psoriasis in 23 cases (defined as focally ≥4 positive cell layers in the stratum spinosum). Notably, diagnostic discrepancy between the two novel methods was observed in 10 cases (25%). Specifically, in 7 cases, PsorX favored psoriasis while IL-36γ did not; conversely, in 3 cases, IL-36γ indicated psoriasis while PsorX did not (including one "undetermined" PsorX result).

Conclusions

The observed 25% discrepancy rate highlights the immense complexity of borderline cases and the likely existence of mixed pathogenetic phenotypes, underscoring the urgent need for advanced diagnostic triangulation. Our preliminary findings demonstrate that neither tool can be solely relied upon in highly challenging clinical scenarios. The ongoing establishment of a rigorously blinded expert ground truth will allow us to definitively calculate the independent diagnostic added value of each method. Final statistical concordance and performance metrics will be presented at the conference.

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Abstract N°: 2135

Eczematous component in psoriasis is possibly a negative prognostic factor for deucravacitinib treatment outcome

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Introduction

Eczematized psoriasis is a clinical variant of psoriasis characterized by overlapping features of both psoriasis and eczema. The diagnosis of eczematized psoriasis is currently based primarily on a combination of clinical, histological and immunological criteria, which are not uniformly standardized. Deucravacitinib is the first oral JAK inhibitor approved for the treatment of moderate to severe plaque psoriasis. The efficacy of standard psoriasis therapies might be reduced in eczematized psoriasis by the mixed pathophysiology, which differs from classic psoriasis by the activation of additional Th2/type 2 pathways. The aim of this study was to investigate and compare the efficacy of deucravacitinib in patients with classical and eczematized psoriasis in real world.

Materials and Methods

Patients with psoriasis who received deucravacitinib therapy in the dermatology department of two German University Medical Centers between 03/2023 and 03/2025 were included in this retrospective study. Treatment outcomes and drug survival of deucravacitinib was assessed with Kaplan-Meier analysis.

Results

A total of 38 patients were identified (19 with classical psoriasis, and 19 with eczematized psoriasis). Median drug survival of deucravacitinib was numerically higher in classical compared to eczematized psoriasis (21.0 vs. 6.0 months, $p = 0.056$). Partial or excellent response was more frequently observed in patients with classical psoriasis (68.4% vs. 47.4%). Relapses during treatment occurred significantly more frequently in eczematized than in classic psoriasis (57.9% vs. 26.3%, $p = 0.033$).

Conclusions

The presence of an eczematous component in patients with psoriasis could adversely affect the treatment response to deucravacitinib and should be further investigated.

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Abstract N°: 2150

Severe psoriatic disease after decades of neglect: Can we still treat-to-target?

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Introduction

Long disease duration in psoriasis has been strongly associated with poorer therapeutic outcomes and an increased likelihood of requiring multiple lines of therapy to achieve satisfactory disease control. We present a case that challenges this concept and highlights the potential benefits of timely biologic initiation even in medically and socially complex patients with longstanding untreated disease.

Case Presentation

We report the case of a 66-year-old female with plaque psoriasis diagnosed more than three decades earlier, who had never received topical or systemic treatment before presentation. At admission, the patient exhibited severe and extensive cutaneous and nail involvement, with PASI 28.6 and NAPSI 77. The patient came from a socioeconomically disadvantaged and difficult-to-access rural area and had not benefited from any medical care for more than a decade. Upon admission, multiple previously undiagnosed comorbidities were identified, including arterial hypertension, heart failure with cardiac insufficiency, Child–Pugh A alcoholic liver cirrhosis, and depressive syndrome. Due to these comorbidities, narrowband UVB phototherapy combined with topical therapy represented the only feasible conventional first-line therapeutic option, as methotrexate and cyclosporine were contraindicated; however, a satisfactory clinical response was not achieved.
Considering disease severity, comorbidity burden, and poor healthcare accessibility, we decided to initiate treatment with tildrakizumab because of its favorable safety profile and convenient administration schedule. A rapid and clinically meaningful response, corresponding to approximately 70% improvement in PASI score from baseline, was observed shortly after treatment initiation. Importantly, near treat-to-target disease control was sustained despite irregular follow-up, suboptimal adherence, and significantly prolonged dosing intervals related to the patient's difficulties in attending scheduled appointments. Furthermore, no adverse events were reported, with liver disease remaining clinically stable throughout follow-up, possibly associated with improvement in depressive symptoms and reduced alcohol consumption.

Conclusion

This case illustrates that substantial and sustained clinical improvement may still be achievable even in patients with long disease duration, major comorbidities, and challenging treatment adherence. In selected cases such as this, earlier access to biologic therapy may spare patients prolonged exposure to ineffective conventional therapies, particularly when comorbidities severely limit available treatment options. Moreover, IL-23 inhibitors with extended dosing intervals may represent a practical long-term strategy for socially vulnerable patients with questionable adherence, helping maintain therapeutic continuity and favorable clinical outcomes while minimizing additional healthcare system burden.

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Abstract N°: 2151

Dermoscopic Monitoring of Topical Therapy in Psoriasis – A Case Report

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Introduction

Dermoscopy is an increasingly valuable non-invasive tool in dermatology, not only for diagnosis but also for monitoring therapeutic response in inflammatory dermatoses such as psoriasis. It enables the assessment of vascular and structural changes that may precede clinical improvement or persist despite apparent remission.

Case Presentation

A 72-year-old male with a 5-year history of plaque psoriasis and accompanying joint pain, with a complex medical background, including cardiovascular disease and prior tuberculosis presented to the dermatology clinic in May 2025. The patient had been treated with methotrexate for two years with partial control of both cutaneous and joint symptoms.

At presentation, persistent psoriatic plaques were noted despite prior topical corticosteroid therapy. A short course of flumetasone with salicylic acid was initiated, followed by maintenance therapy with a fixed combination of betamethasone dipropionate and calcipotriol in foam formulation. Concurrently, the patient was diagnosed with psoriatic arthritis, and methotrexate therapy was optimized.

Clinical and dermoscopic follow-up over several months demonstrated gradual resolution of active lesions, with the appearance of post-inflammatory hypopigmentation. At baseline dermoscopy revealed typical dotted vessels on an erythematous background arranged in irregular circles or rings with a beaded capillary appearance, and white scaling, which is a very specific, but not so common, dermoscopic pattern in psoriasis. The persistence of vascular structures despite clinical improvement was noted after a couple weeks of topical therapy. During treatment, the hemorrhagic dots were spotted, which correlated with a favourable therapeutic response. Importantly, no features of steroid-induced skin atrophy, such as linear vessels, were observed during a long term proactive treatment.

Conclusion

This case highlights the role of dermoscopy as a supportive tool in evaluating treatment efficacy and safety in psoriasis. Persistent vascular patterns may indicate subclinical disease activity, while specific dermoscopic features, such as hemorrhagic dots, may serve as early markers of response. Additionally, dermoscopy allows for early detection of adverse effects related to topical corticosteroids.
Dermoscopy is a useful adjunct in both the diagnosis and longitudinal monitoring of psoriasis, providing valuable insights into treatment response beyond clinical assessment alone.

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Abstract N°: 2178

HIGH-DIMENSIONAL SINGLE-CELL ANALYSES REVEAL NEUTROPHIL HETEROGENEITY IN GUTTATE PSORIASIS

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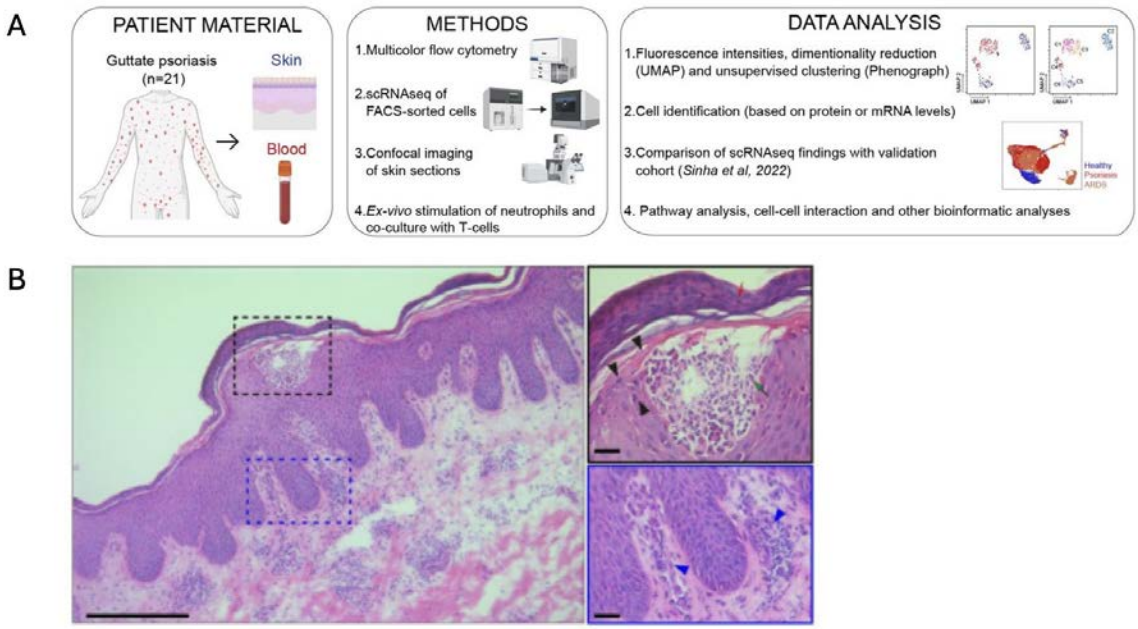
Introduction

Guttate psoriasis (GP) is associated with streptococcal throat infection. Neutrophils are the first immune cells to respond to Group A Streptococcal (GAS) infection. Despite recent advances in high-dimensional immune profiling, it remains unclear how neutrophil phenotypic and functional heterogeneity differs between the skin microenvironment and peripheral blood and how this shapes interactions between innate and adaptive immunity in GP pathogenesis. Thus, our study primarily focused on phenotyping the neutrophils located at the site of inflammation in GP skin and exploration of their specific contribution to the pathogenesis in the disease.



(A) Overview of the experimental and analytical workflow of the study performed on samples from GP lesional skin and blood. (B) Haematoxylin and eosin staining of lesional GP skin. Skin biopsy reveals infiltration of the epidermis by neutrophils (black box) and other immune cells (blue box and blue arrowheads). Neutrophil infiltration leads to the formation of neutrophilic vesicles (black arrowheads) and spongiform pustules of Kogoj (green arrow). Neutrophils were also present in the stratum corneum (Munro's microabscesses, red arrow). The scale bar indicates 250 µm; the zoomed-in panels indicate 50 µm.

Materials and Methods

Twenty one (n=21) patients with a dermatologist verified GP were included in the study (n=4 single-cell protein

and RNA analyses (*10x*), n=21 flow cytometry data). Punch biopsies (3 × 4 mm full thickness) were obtained from lesional, affected skin from the patients as well as PBMC/serum. We performed a comprehensive immunophenotypic and transcriptomic analysis of neutrophils from blood and inflamed GP skin using high-dimensional single-cell protein and RNA analyses. Ex vivo stimulation of neutrophils and co-culture with $CD4^+$ T cells was performed to validate the function of neutrophil subsets upon GAS stimulation.

Results

Our data uncovers high diversity of human neutrophils in GP, with enrichment of an immature subset in GP skin that exhibited antigen processing and presentation signature. A similar subset in healthy controls was observed only upon ex vivo stimulation of neutrophils with GAS bacteria. Additionally, the GAS-induced neutrophil subset was found to induce $CD4^+$ T cell proliferation mediated by HLA-DR. Other neutrophil subsets that expanded in GP were characterised by enrichment of genes related to neutrophil migration, formation of neutrophil extracellular traps and phagocytosis.

Conclusions

Our work provides the first detailed neutrophil characterisation in GP. The study depicts the landscape of neutrophils in GP skin and highlights HLA-DR^+ neutrophils with possible role in disease pathogenesis.

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Abstract N°: 2187

Efficacy of Picankibart among Different BMI and Body Weight in Adult Plaque Psoriasis: Subgroup Analyses of the Phase 3 CLEAR-2 Study

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Introduction

Obesity is an independent risk factor for psoriasis and one of its most common comorbidities. Prior studies have demonstrated that patients with psoriasis complicated by obesity exhibit suboptimal responses to systemic therapeutic regimens. This subgroup analysis aimed to evaluate the efficacy of picankibart, an anti-interleukin-23p19 monoclonal antibody, for the treatment of moderate-to-severe plaque psoriasis across patient populations stratified by varying body weights (BW) and body mass index (BMI).

Materials and Methods

The phase 3 CLEAR-2 study (NCT06049810) was a 56-week, randomized, double-blind, placebo-controlled trial with a randomized withdrawal and retreatment design, primarily assessing the maintenance of therapeutic efficacy of picankibart for moderate-to-severe plaque psoriasis. All Patients received 200mg of picankibart at weeks 0, 4, and 8, then were randomized in a 1:1 ratio at week 20 to receive either picankibart 200mg (200mg group) or 100mg (100mg group). At week 32, all patients were evaluated for achievement of a PASI 90 response. Responders were randomized in a 1:1 ratio to continue picankibart at their assigned dose or placebo every 12 weeks through week 44. Non-responders were administered with picankibart 200mg at week 32 and 44. Efficacy was assessed by PASI scores and the proportion of patients achieving sPGA 0/1 among different BMI (normal, 24 kg/m^2; overweight, ≥24 kg/m^2 and 28kg/m^2; obesity, ≥28kg/m^2) and BW (median, ≥median) subgroups.

Results

A total of 485 patients were enrolled in this study, with a baseline median body weight of 72.4 kg. At week 16, there were 87.1% (BW□72.4 kg) and 86.70% (BW ≥ 72.4 kg) patients achieved PASI 90 in the 100mg group, and 86.0% (BW□72.4 kg) and 81.3% (BW ≥ 72.4 kg) achieved PASI 90 in the 200mg group. A total of 93.5% (BW□72.4 kg) and 93.3% (BW ≥ 72.4 kg) patients achieved sPGA 0/1 in the 100mg group, and 94.7% (BW□72.4 kg) and 90.6% (BW ≥ 72.4 kg) achieved sPGA 0/1 in the 200mg group. For BMI, the PASI 90 responses were 94.3%, 83.1% and 85.7% for normal, overweight and obesity patients in the 100mg group; and 90.9%, 84.0% and 70.4% in the 200mg group. A total of 94.3%, 94.9% and 89.3% patients reached sPGA 0/1 in 100mg group, and 93.2%, 92.0% and 92.6% in the 200mg group. At week 56, there were 87.1% (BW□72.4 kg) and 91.7% (BW ≥ 72.4 kg) patients achieved PASI 90 in the 100mg group, and 91.2% (BW□72.4 kg) and 89.1% (BW ≥ 72.4 kg) achieved PASI 90 in the 200mg group. A total of 80.6% (BW□72.4 kg) and 86.7% (BW ≥ 72.4 kg) patients achieved sPGA 0/1 in the 100mg group, and 87.7% (BW□72.4 kg) and 89.1% (BW ≥ 72.4 kg) achieved sPGA 0/1 in the 200mg group. For BMI, the PASI 90 response rate were 91.4%, 89.8% and 85.7% for normal, overweight and obesity patients in the 100mg group, and 90.9%, 92.0% and 85.2% in the 200mg group. A total of 80.0%, 86.4% and 82.1% patients reached sPGA 0/1 in 100mg group, and 88.6%, 86.0% and 92.6% in the 200mg group.

Conclusions

Picankibart demonstrated rapid and sustained therapeutic efficacy across all BW and BMI subgroups of patients with moderate-to-severe plaque psoriasis. Psoriasis clearance rates were comparable between subgroups, further supporting the favorable clinical efficacy of this novel IL-23 inhibitor.

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Evaluation of the Efficacy of Picankibart in the Treatment of Moderate-to-Severe Plaque Psoriasis with Scalp Involvement: A Post-Hoc Analysis of the phase 3 CLEAR-2 Study

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Introduction

The scalp is one of the most commonly affected areas in psoriasis. Approximately 80% of patients with moderate to severe plaque psoriasis have scalp involvement, which is often accompanied by significant itching, scaling, and social distress, seriously impacting patient’s quality of life. The phase 3 clinical study CLEAR-1 (NCT05645627) has demonstrated rapid and potent therapeutic effects of picankibart in the overall skin lesions and high efficacy in patients with concomitant scalp psoriasis. This data further evaluated the efficacy of subcutaneous picankibart in patients with moderate to severe plaque psoriasis and scalp involvement from another phase 3 CLEAR-2 (NCT06049810) study, further supporting the clinical benefits of this drug in special affected areas.

Materials and Methods

The phase 3 CLEAR-2 study (NCT06049810) was a 56-week, randomized, double-blind, placebo-controlled trial with a randomized withdrawal and retreatment design, primarily assessing the maintenance of therapeutic efficacy of picankibart for moderate-to-severe plaque psoriasis.

A total of 566 patients received 200mg of picankibart at weeks 0, 4, and 8, then were randomized in a 1:1 ratio at week 20 to receive either picankibart 200mg (200mg group) or 100mg (100mg group). At week 32, all patients were evaluated for achievement of a PASI 90 response. Responders were randomized in a 1:1 ratio to continue picankibart at their assigned dose or placebo every 12 weeks through week 44.

In this post-hoc analysis, the Psoriasis Scalp Area and Severity Index (PSSI) was used as the core assessment index to observe scalp-related outcomes after treatment, including the percentage change in PSSI from baseline at different time points (0–56 weeks), mean PSSI scores and changes from baseline , week 16, and week 56, and different PSSI response rates on the scalp at week 16 and week 56 (PSSI 75, 90, and 100, i.e., the proportion of patients with 75%, 90%, and 100% improvement in scalp severity).

Results

Overall, 455 patients (455/485, 93.8%) were identified with psoriatic scalp involvement at baseline during the randomized double-blind response period, of whom 74% were male and 26% were female, with a mean age of 43.4 years, a mean disease duration of 10.62 years, and a mean BMI of 25.55 kg/m^2.

In this analysis, only patients with concomitant scalp psoriasis who entered the continued treatment period and completed the follow-up (a total of 233 patients, 117 in the 100 mg group and 116 in the 200 mg group) were included for efficacy evaluation:

- The baseline PSSI score was 25.56 in the maintenance treatment group (total group), 26.57 in the 100 mg group and 24.3 in the 200 mg group;
- At Week 16, compared with baseline, the mean PSSI decreased to 0.92 in the total group, 1.18 in the 100 mg group, and 0.42 in the 200 mg group; the percentage change in PSSI from baseline: −95.74% in the total group, −95.24% in the 100 mg group, and −96.25% in the 200 mg group;
- At Week 56, compared with baseline, the mean PSSI decreased to1.57 in the total group, 2.02 in the 100 mg group, and 0.88 in the 200 mg group; the percentage change in PSSI from baseline: −94.13% in the total group, −91.73% in the 100 mg group, and −96.55% in the 200 mg group;
- The proportion of patients who achieved PSSI 75/90/100 at Week 16 was 93.85%, 83.30%, and 76.04%, respectively;
- The proportions of patients who achieved PSSI 75/90/100 at Week 56 were 89.57%, 82.61%, and 77.39% in the 100 mg group, and 95.61%, 91.23%, and 80.70% in the 200 mg group.

Conclusions

In summary, results from the phase 3 CLEAR-2 study suggest that treatment of patients with moderate to severe plaque psoriasis and scalp involvement with picankibart can achieve profound improvement in scalp lesions and maintain stable efficacy during maintenance treatment for up to 56 weeks. These findings are consistent with the efficacy of scalp involvement in the CLEAR-1 study, further validating the therapeutic benefit of picankibart on scalp involvement in psoriasis.

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Once-daily oral zasocitinib demonstrates robust and consistent efficacy across subgroups of adults with moderate-to-severe plaque psoriasis, including difficult-to-treat populations: an integrated analysis of two randomized phase 3 trials (LATITUDE-PsO-3001 and 3002)

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Introduction

Zasocitinib is an investigational, next-generation, highly selective once-daily oral tyrosine kinase 2 (TYK2) inhibitor that maintains 24-hour inhibition of interleukin (IL)-23 plus other core disease-driving immune pathways. In two pivotal phase 3 trials in adults with moderate-to-severe plaque psoriasis (LATITUDE-PsO-3001 [NCT06088043] and LATITUDE-PsO-3002 [NCT06108544]), zasocitinib demonstrated rapid and reproducible skin clearance with a consistent safety profile.

Treatment benefit can be influenced by multiple factors including patient age and sex. Additionally, patients with plaque psoriasis and high bodyweight or prior biologic treatment have shown lower response rates in previous clinical trials for systemic treatment of psoriasis, and patients with more severe disease (static Physician's Global Assessment[sPGA]=4) may require systemic treatment in addition to topical treatments. Here, we evaluated the efficacy of zasocitinib in these specific patient subgroups.

Materials and Methods

In these two phase 3, randomized, international, multicentre, double-blind, placebo (PBO)- and active-comparator-controlled trials, adults with moderate-to-severe plaque psoriasis (Psoriasis Area and Severity Index [PASI] ≥12, sPGA ≥3, body surface area ≥10%) were randomized 3:1:1 (LATITUDE-PsO-3001) or 2:1:1 (LATITUDE-PsO-3002) to receive zasocitinib 30 mg once daily, PBO or apremilast twice daily. In this integrated analysis of these trials, the efficacy of zasocitinib was assessed according to age (<65/≥65 years), sex (male/female), bodyweight (<90 kg/≥90 kg), prior treatment with biologics (yes/no) or baseline sPGA (<4/4).

Results

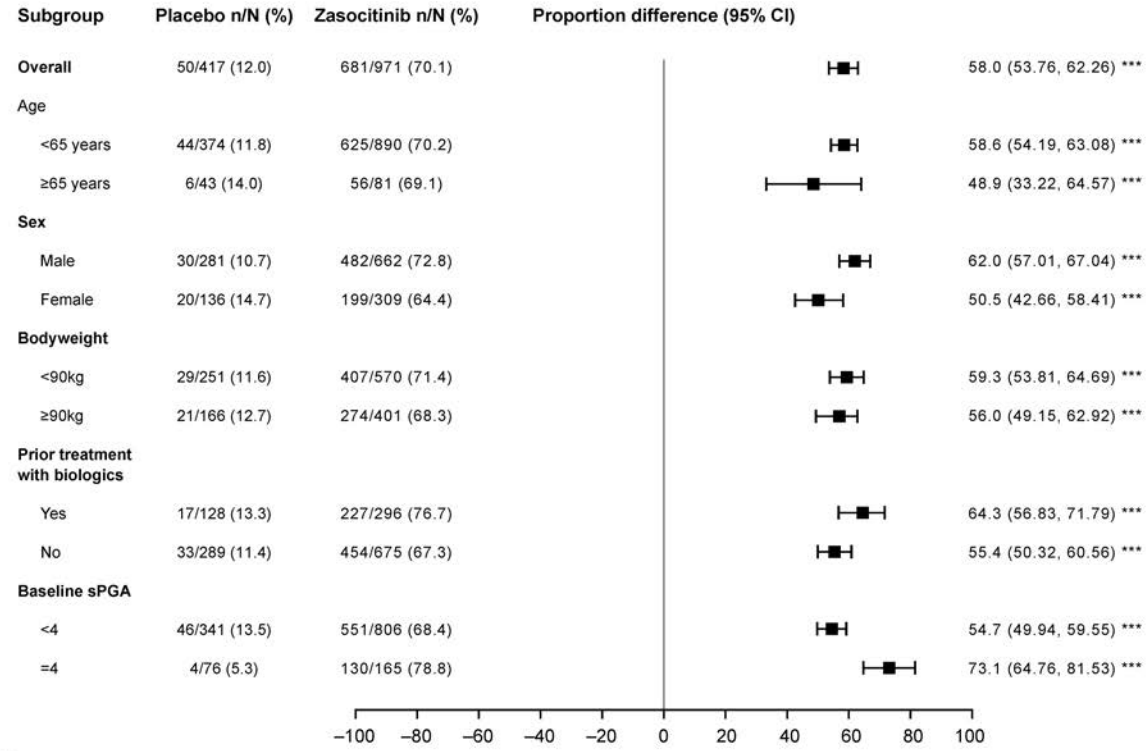
Overall, zasocitinib had higher sPGA 0/1 response rates versus PBO at Week 16 regardless of **age** (<65 years: zasocitinib, 70.2%; PBO, 11.8%; ≥65 years: zasocitinib, 69.1%; PBO, 14.0%), **sex** (male: zasocitinib, 72.8%; PBO, 10.7%; female: zasocitinib, 64.4%; PBO, 14.7%), **bodyweight** (<90kg: zasocitinib, 71.4%; PBO, 11.6%; ≥90kg: zasocitinib, 68.3%; PBO, 12.7%), **prior treatment with biologics** (yes: zasocitinib, 76.7%; PBO, 13.3%; no: zasocitinib, 67.3%; PBO, 11.4%) or **baseline sPGA** (<4: zasocitinib, 68.4%; PBO, 13.5%; 4: zasocitinib, 78.8%; PBO, 5.3%) (**Figure A,** each nominal $p<0.001$). Consistent with the results observed for sPGA 0/1, zasocitinib also had higher PASI 90 response rates versus PBO at Week 16 regardless of **age** (<65 years: zasocitinib, 56.9%; PBO, 3.7%; ≥65 years: zasocitinib, 45.7%; PBO, 9.3%), **sex** (male: zasocitinib, 55.9%; PBO, 3.9%; female: zasocitinib, 56.0%; PBO, 5.1%), **bodyweight** (<90kg: zasocitinib, 57.7%; PBO, 4.4%; ≥90kg: zasocitinib, 53.4%; PBO, 4.2%), **prior treatment with biologics** (yes: zasocitinib, 60.5%; PBO, 4.7%; no: zasocitinib, 53.9%; PBO, 4.2%) or **baseline sPGA** (<4: zasocitinib, 54.2%; PBO, 5.0%; 4: zasocitinib, 64.2%; PBO, 1.3%) (**Figure B,** each nominal $p<0.001$). Similar trends were also observed for PASI 75, PASI 100 and Dermatology Life Quality Index (DQLI) 0/1 responses versus placebo. In addition, zasocitinib achieved generally higher sPGA 0/1, PASI 75/90/100 and DLQI 0/1 response rates than apremilast across these patient subgroups at Week 16.

Conclusions

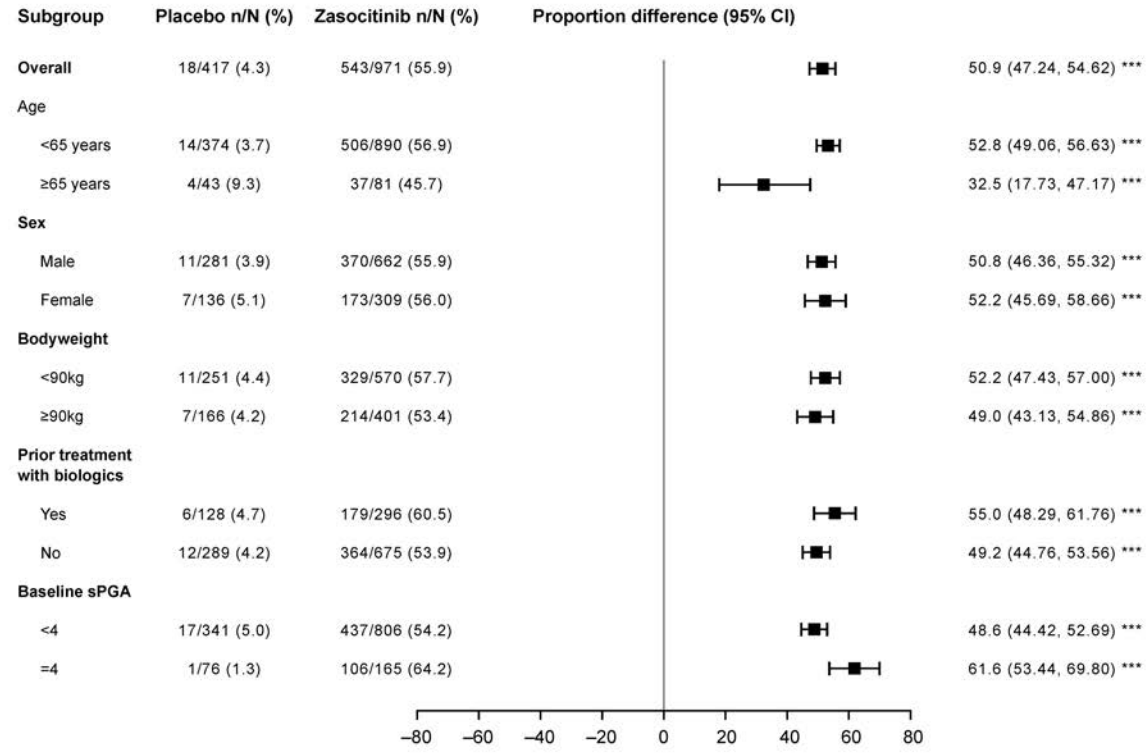
Once-daily oral zasocitinib consistently showed higher response rates versus PBO or apremilast across patient subgroups, including those who are traditionally difficult to treat (e.g. high bodyweight, prior biologic treatment or severe disease). Similar response rates were observed between the age and weight subgroups in patients receiving zasocitinib. These results further support the efficacy of zasocitinib across broad populations of adults with moderate-to-severe plaque psoriasis.

Figure. Zasocitinib demonstrated consistently greater (A) sPGA 0/1 and (B) PASI 90 response rates versus placebo at Week 16 in subgroups of patients with moderate-to-severe plaque psoriasis.

A



B



CI, confidence interval; PASI, Psoriasis Area and Severity Index; sPGA, static Physician Global Assessment.
***nominal $p<0.001$

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Evaluation of the Efficacy of Picankibart in the Treatment of Patients with Moderate-to-Severe Plaque Psoriasis and Nail Involvement: A Post-Hoc Analysis of a Phase 3 CLEAR-2 Study

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Introduction

Nail involvement is one of the common refractory manifestations of psoriasis, occurring in a considerable proportion of patients with plaque psoriasis, and is known to be an independent predictor of disease progression and the development of psoriatic arthritis. The phase 3 CLEAR-1 (NCT05645627) study has demonstrated rapid and potent therapeutic effects of picankibart on the overall psoriatic skin lesions, as well as good efficacy in patients with concomitant nail psoriasis. This data further evaluates the efficacy of subcutaneous injection of picankibart in patients with moderate to severe plaque psoriasis and nail involvement from the phase 3 CLEAR-2 (NCT06049810) study, to further supporting the clinical benefits of picankibart in special affected areas.

Materials and Methods

The phase 3 CLEAR-2 study (NCT06049810) was a 56-week, randomized, double-blind, placebo-controlled trial with a randomized withdrawal and retreatment design, primarily assessing the maintenance of therapeutic efficacy of picankibart for moderate-to-severe plaque psoriasis.

A total of 566 patients received 200mg of picankibart at weeks 0, 4, and 8, then were randomized in a 1:1 ratio at week 20 to receive either picankibart 200mg (200mg group) or 100mg (100mg group). At week 32, all patients were evaluated for achievement of a PASI 90 response. Responders were randomized in a 1:1 ratio to continue picankibart at their assigned dose or placebo every 12 weeks through week 44.

In this post-hoc analysis ,the nail psoriasis severity index (NAPSI) was used as the core assessment index to observe the improvement of nail involvement after treatment, including the percentage change in NAPSI from baseline at different time points (0–56 weeks), the mean NAPSI score at baseline, week 16, and week 56, and the change from baseline.

Results

Overall, 202 patients (202/485, 41.6%) were identified with psoriatic nail involvement at baseline in the randomized double-blind response period, of whom 80% were male and 20% were female, with a mean age of 45.4 years, a mean disease duration of 10.51 years, and a mean BMI of 25.68 kg/m2.

In this analysis, only patients with concomitant nail psoriasis who entered the maintenance treatment period and completed the follow-up (a total of 100 patients, 45 in the 100 mg group and 55 in the 200 mg group) were included for efficacy evaluation:

- The baseline NAPSI score was 25.7 in the maintenance treatment group (total group), 24.75 in the 100 mg group and 26.47 in the 200 mg group;
- At Week 16, compared with baseline, the mean NAPSI decreased to: 17.59 in the total group, 16.64 in the 100 mg group, and 18.42 in the 200 mg group; the percentage change from baseline in NAPSI was: -31.83% in the total group, -34.36% in the 100 mg group, and -29.75% in the 200 mg group;
- At Week 56, the mean NAPSI decreased from baseline to: 5.57 in the total group, 5.53 in the 100 mg group, and 5.6 in the 200 mg group; the percentage change from baseline in NAPSI was: -73.43% in the total group, -71.34% in the 100 mg group, and -75.13% in the 200 mg group;

Conclusions

In summary, the results of the phase 3 CLEAR-2 study suggested that picankibart provided robust and sustained efficacy in treating nail psoriasis, with particularly notable improvements observed at longer follow-up time points. These findings were consistent with the results from the nail involvement subgroup of the CLEAR-1 study, further validating the therapeutic effect of picankibart on nail involvement in psoriasis.

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Efficacy evaluation of treatment of patients with moderate to severe plaque psoriasis combined with palm and sole involvement with Picankibart: a Post-Hoc analysis of the phase 3 CLEAR-2 Study

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Introduction

Palmoplantar psoriasis (PP) often presents with keratinization thickening, pain, and function impairment, making clinical intervention challenging. Compared with skin lesions at other body sites, patients with palmoplantar involvement experience more severe persistent symptoms and greater impairment in quality of life. This study is based on the efficacy of a phase 3 CLEAR-2 (NCT06049810) study, in which a subcutaneous injection of picankibart is used for treating patients with moderate to severe plaque psoriasis combined with palm and sole involvement, and provides evidence-based support for the clinical benefit of the drug at this critical refractory site.

Materials and Methods

The phase 3 CLEAR-2 study (NCT06049810) was a 56-week, randomized, double-blind, placebo-controlled trial with a randomized withdrawal and retreatment design, primarily assessing the maintenance of therapeutic efficacy of picankibart for moderate-to-severe plaque psoriasis.

A total of 566 patients received 200mg of picankibart at weeks 0, 4, and 8, then were randomized in a 1:1 ratio at week 20 to receive either picankibart 200mg (200mg group) or 100mg (100mg group). At week 32, all patients were evaluated for achievement of a PASI 90 response. Responders were randomized in a 1:1 ratio to continue picankibart at their assigned dose or placebo every 12 weeks through week 44.

In this post-hoc analysis, the palmoplantar psoriasis area and severity index (PPASI) was used as a core evaluation index to observe the improvement of the palmoplantar involvement after treatment, including the percentage of change in PPASI from baseline, mean PPASI scores and changes from baseline as well as different PPASI response (PPASI 75,90,and 100 responses,defined as the proportion of patients achieving 75%, 90%, and 100% improvement in the area and severity of palmoplantar lesions, respectively at Week 16 and Week 56.

Results

Overall, 58 patients (58/485, 12.0%) were identified at baseline with palmoplantar psoriasis in the randomized, double-blind response phase, with 83% male and 17% female, a mean age of 45.48 years, a mean disease duration of 12.39 years, and a mean BMI of 25.94 kg/m^2.

Only patients with palmoplantar psoriasis who entered the continued treatment phase and completed the follow-up (a total of 31 patients, 14 in the 100 mg group and 17 in the 200 mg group) were included in this analysis for efficacy evaluation:

The baseline PPASI score was 10.24 in the total group, specifically, 9.13 in the 100 mg group and 11.15 in the 200 mg group;

At Week 16, compared with baseline, the mean PPASI decreased to 0.95 in the total group, 1.14 in the 100 mg group, and 0.79 in the 200 mg group; the percentage change from baseline in PPASI was -92.25% in the total group, -92.47% in the 100 mg group, and -92.06% in the 200 mg group;

At Week 56, compared with baseline, the mean PPASI decreased to 0.2 in the total group, 0 in the100 mg group, and 0.35 in the 200 mg group; the percentage change from baseline in PPASI was -98.51% in the total group, -100% in the 100 mg group, and -97.27% in the 200 mg group;

The proportion of patients who achieved PASI 75/90/100 at Week 16 was 82.76%, 74.14%, and 68.97%, respectively;

The proportions of patients who achieved PASI 75/90/100 at Week 56 were 100% of patients in the 100 mg group,and 954.12%, 94.12%, and 88.24% of patients in the 200 mg group.

Conclusions

In summary, the post-hoc analysis results of the phase 3 CLEAR-2 study show that picankibart can rapidly and significantly ameliorate skin lesions in patients with moderate to severe plaque psoriasis combined with palmoplantar involvement, and the efficacy continues to be stable during maintenance therapy for up to 56 weeks, with nearly complete clearance of the palmoplantar skin lesions being achieved in most patients. Both the 100 mg and 200 mg maintenance doses showed excellent long-term efficacy, with the 100 mg group being more likely to achieve complete clearance later due to a relatively low PASI score at baseline.

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safety and efficacy of apremilast in the treatment of moderate to severe plaque psoriasis

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Introduction
Plaque psoriasis is a chronic, immune mediated skin disease associated with significant physical, psychological, and social burden. Conventional treatments often have limited efficacy and compliance issues. Apremilast, an oral phosphodiesterase 4 (PDE4) inhibitor, offers a novel therapeutic approach by modulating inflammatory pathways, thereby reducing disease activity. While its safety and efficacy have been reported in Western and Indian populations, data from Pakistan remain limited.

Objective: To determine the safety and efficacy of Apremilast in patients with moderate to severe plaque psoriasis.

Case Presentation
This study was conducted in the tertiary care hospital of Lahore, Pakistan over six months. Sixty-five adult patients (18–70 years) with moderate to severe plaque psoriasis, defined by psoriasis area severity index (PASI) and body surface area (BSA), were recruited via non probability consecutive sampling. Apremilast was administered orally at 30 mg twice daily for 16 weeks following a six day titration. Efficacy defined as achievement of PASI-75 (≥75% reduction in PASI score) at week 16, and safety based on the absence of serious adverse events leading to treatment withdrawal. Data was entered and analyzed using SPSS version 26.0. Quantitative variables such as age, duration of disease, baseline PASI score, post treatment PASI score and percentage reduction in PASI score were presented as mean ± standard deviation. Categorical variables such as gender, disease severity, efficacy, safety and adverse effects were presented as frequencies and percentages. Chi-square test is used after stratification to assess association between categorical variables such as gender, disease severity and efficacy. A p-value < 0.05 was considered to be significant.

Results: Out of 65 enrolled patients, 4 patients were lost to follow up, and data from 61 patients were analyzed. The mean age of the patients was 37.69 ± 15.14 years, while the mean duration of disease was 17.03 ± 5.52 years. Among them, 40 (65.6%) were male and 21 (34.4%) were female. At baseline, 48 (78.7%) patients had moderate psoriasis and 13 (21.3%) had severe psoriasis which was defined on PASI. The mean baseline PASI score was 16.20 ± 3.89, which decreased to 4.59 ± 2.04 after 16 weeks of treatment, with a mean PASI reduction of 71.08 ± 13.00%.

Treatment efficacy, defined as achievement of PASI-75 at week 16, was observed in 32 (52.5%) patients, while 29 (47.5%) did not achieve PASI-75. Safety was observed in 56 (91.8%) patients, whereas 5 (8.2%) patients experienced adverse effects affecting safety outcome. Reported adverse effects included nausea in 02 (3.3%), vomiting in 02 (3.3%), headache in 02 (3.3%), and diarrhea in 01 (1.6%) patient.

Post stratification analysis showed that efficacy was achieved in 20/40 (50%) male patients and 12/21 (57.1%) female patients, with no statistically significant association between gender and efficacy ($p = 0.79$). According to disease severity, efficacy was achieved in 22/48 (45.8%) patients with moderate psoriasis and 10/13 (76.9%) patients with severe psoriasis, which was also not statistically significant ($p = 0.093$).

Conclusion

Apremilast is an effective and well tolerated oral treatment for moderate to severe plaque psoriasis in the Pakistani population

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Abstract N°: 2202

Efficacy analysis of switching patients with plaque psoriasis who have had an inadequate response to prior biologics to treatment with Picankibart: stratified analysis based on primary endpoint response status at week 16 - post-hoc analysis of a phase II clinical study

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Introduction

Based on the subgroup evidence from the phase II study of picankibart in patients with plaque psoriasis (NCT05970978), this study aimed to evaluate skin lesion clearance and quality of life improvement following treatment in patients with poor response to prior therapy (poor response is defined as sPGA ≥ 2 or BSA ≥ 3%). Additionally, the study explored stratified efficacy differences according to whether the primary endpoint was

reached at Week 16, in order to support the association between early clinical response and long-term t outcomes.

Materials and Methods

This study was based on the subgroup data analysis from a multi-center, open-label, phase II clinical study (NCT05970978) of picankibart. The main study included 152 patients with plaque psoriasis, of whom 83 were poor responders who switched treatment. Poor response was defined as sPGA ≥ 2 or BSA ≥ 3%, following treatment with 200 mg of subcutaneous picankibart at Weeks 0, 4, and 8, then maintenance dosing every 12 weeks until Week 32 with follow-up continuing until Week 44.

Patients were divided into two groups based on whether they achieved the primary endpoint (sPGA 0/1 and BSA < 3%) at Week 16: the group achieving the primary endpoint at Week 16 (n = 40) and the group not achieving the primary endpoint at Week 16 (n = 43). The following outcomes were assessed at various time points from week 0 to Week 44: the proportions of patients achieving sPGA 0/1 and BSA < 3%, sPGA 0/1, BSA ≤ 3% and ≤ 1%, and PASI ≤ 3 and ≤ 1. Additionally, the proportions of patients with a Dermatology Life Quality Index (DLQI) 0/1 was evaluated at baseline, week 16, and week 44.

Results

Baseline characteristics: The baseline demographic and disease characteristics of the two groups were generally similar and similar to the overall population with poor response to previous biological agents in the main study

Demographic characteristics: The mean age of the overall population with poor response to previous biological agents was 42.6 years old, 78.3% were male, the mean weight was 77.74 kg, and the BMI was 26.47 kg/m^2. There was no significant difference in the distribution of smoking and drinking history.

Disease characteristics: The overall population with poor response to previous biological agents has a mean psoriasis duration of 14.98 years, with a baseline PASI score of 7.90, baseline BSA of 9.83%, sPGA of 2–3, and DLQI of 8.4. Skin lesions were mostly commonly located on the limbs, trunk, and head.

Efficacy results: This analysis included 83 patients with poor response to previous biological agents, of whom 40 achieved the primary endpoint at Week 16, resulting in a response rate of 48.2%. Patients who achieved the primary endpoint (sPGA 0/1 and BSA < 3%) at Week 16 maintained a higher response rate of skin lesions and more significant improvements in quality of life during subsequent follow-ups:

The proportions of patients in the primary endpoint groups who achieved sPGA 0/1 and BSA < 3%, sPGA 0/1, BSA ≤ 3% and ≤1%, and PASI ≤ 3 and ≤1 at Week 4, Week 16, and Week 44 at Week 16 are shown as below:

sPGA 0/1 and BSA < 3%: 50%, 100%, and 80%, respectively;

sPGA 0/1: 77.5%, 100%, and 95%, respectively;

BSA ≤ 3% and ≤1%: 55% and 40%, 100% and 75%, and 100% and 85%, respectively;

PASI ≤ 3 and ≤ 1: 52.5% and 47.5%, 100% and 70%, and 100% and 60%, respectively;

DLQI achievement: 15%, 60%, and 75%, respectively;

Conclusions

In a plaque psoriasis population with poor response to prior biological agents who were switched to picankibart, patients who achieved the primary endpoint early after treatment were more likely to achieve a higher level of disease control and improvement in quality of life during the follow-up phase

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Abstract N°: 2210

Limited long-term persistence of conventional systemic therapies in psoriasis: a real-world comparison of methotrexate and dimethyl fumarate

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Introduction
Despite the rapid expansion of highly effective targeted therapies, conventional systemic treatments remain widely used in routine care for moderate-to-severe psoriasis. However, their long-term effectiveness under real-world conditions remains uncertain.

The objective of this study was to evaluate and compare drug survival of methotrexate and dimethyl fumarate and to assess their long-term treatment persistence in routine clinical practice.

Materials and Methods
This retrospective observational study included patients with moderate-to-severe psoriasis initiating methotrexate or dimethyl fumarate between 2017 and 2022. Drug survival was defined as time to treatment discontinuation. Kaplan–Meier analysis with log-rank testing was performed in an unselected real-world population.

Results
A total of 582 patients were included (72.2% dimethyl fumarate, 27.8% methotrexate). Baseline disease severity (PASI and DLQI) was comparable between groups. Prior systemic therapy was markedly more frequent in the methotrexate cohort (77.8%) compared with dimethyl fumarate (37.3%), indicating a more pretreated population.

Drug survival was significantly longer for methotrexate compared with dimethyl fumarate (log-rank $p < 0.001$). Median drug survival was 267 days for methotrexate and 141 days for dimethyl fumarate.

Overall treatment persistence was low in both groups. After 12 months, only 39.7% of patients receiving methotrexate and 25.4% receiving dimethyl fumarate remained on therapy. At 24 months, persistence further declined to 20.5% and 12.1%, respectively.

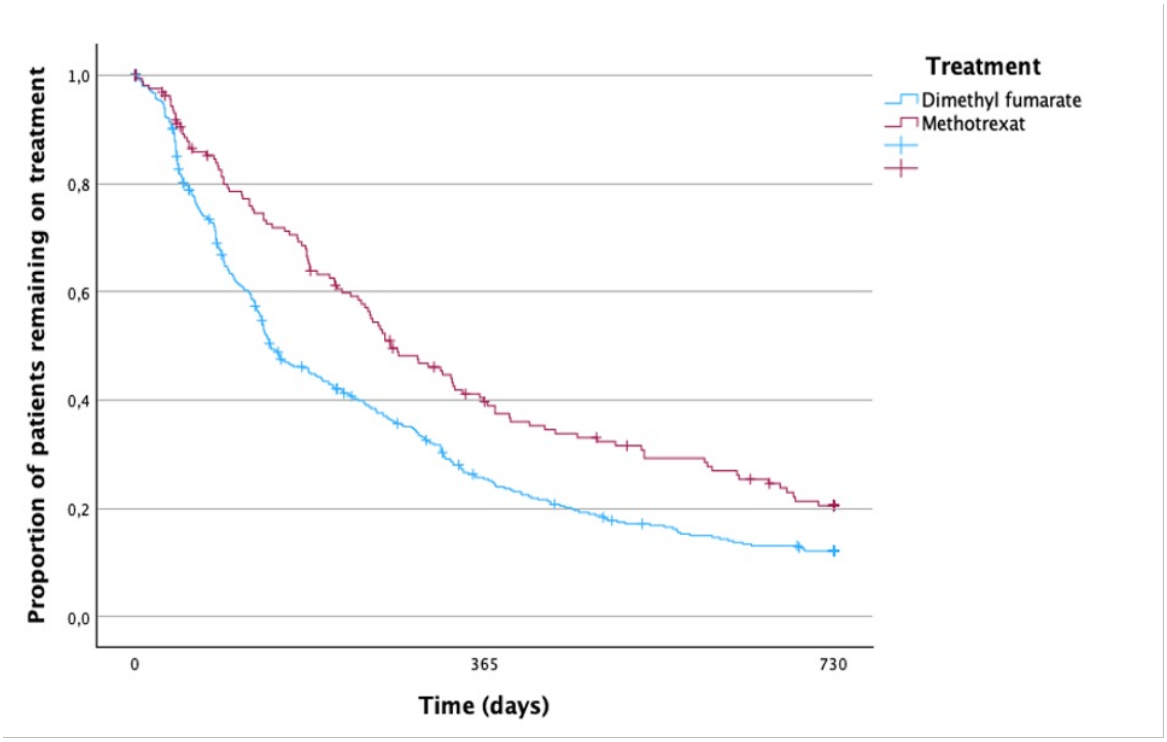
More than two-thirds of patients discontinued therapy within the first year, likely reflecting limitations in tolerability and/or effectiveness and indicating limited real-world sustainability.

A proportion of patients were lost to follow-up (14.8% for dimethyl fumarate and 13.6% for methotrexate), which may have led to an underestimation of true discontinuation rates.

Conclusions
In this real-world cohort, both methotrexate and dimethyl fumarate demonstrated limited long-term drug survival, with high discontinuation rates within the first year of treatment.

Notably, methotrexate showed longer persistence despite being used in a more heavily pretreated population, suggesting that differences in drug survival are unlikely to be solely explained by baseline characteristics.

These findings highlight the limited real-world sustainability of conventional systemic therapies and raise questions regarding their role in the current therapeutic landscape, where more effective and better tolerated treatment options are available.



Kaplan–Meier curves showing drug survival (time to treatment discontinuation) of dimethyl fumarate (blue) and methotrexate (red) in 582 patients with moderate-to-severe psoriasis. Methotrexate demonstrated significantly longer drug survival compared with dimethyl fumarate (log-rank $p < 0.001$). Censored observations are indicated by tick marks.

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Abstract N°: 2211

Vaccination in Psoriatic Disease: Knowledges, Attitudes, and Perceptions from Adult Patients with Psoriasis (Ps) and Psoriasis arthritis (PsA) and Dermatologists in Spain

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Introduction
Adults with psoriatic diseases, especially on systemic immunosuppressants, have higher risk of vaccine-preventable diseases. Inactivated vaccines show a positive risk–benefit profile and are recommended (1–4). This study assessed vaccination knowledge, attitudes and barriers among patients with Ps/PsA and dermatologists in Spain.

Materials and Methods
A non-interventional, cross-sectional study was conducted from June to October 2025 using 2 anonymous online, close-ended surveys for dermatologists and Ps/PsA patients ≥18 years. The protocol was Ethics Committee–approved, with participation supported by the Spanish Academy of Dermatology (AEDV) and Acción Psoriasis.

Results
A total of 78 dermatologists (≈4% of AEDV members) and 628 patients (~7% of Accion Psoriasis members; Ps: n=355; PsA: n=169; both [Ps+PsA]: n=169) participated. Of dermatologists, 47.7% had >20 years' experience, 85.9% worked in public hospitals, and 35.9% belonged to immune-dermatology units. Among patients, 63.7% are women, 63.6% are ≥50 years, and 53.5% have a university degree. 80.0% have lived with Ps for >10 years; Plaque and Scalp psoriasis are the most common. For PsA, 44.2% reported >10 years disease. About 50% of patients report moderate disease. Biologics (anti-TNF; anti-IL12/23, anti-IL17, anti-IL23) and topical therapies (corticosteroids, immunomodulators, vitamin A/D derivatives) were most frequently reported.

Vaccination perception was positive: 94.9% of dermatologists rated it important/very important. Most patients considered vaccines effective and necessary due to perceived risk from the underlying disease (86.0% and 69.9%, respectively) Dermatologists and Ps patients identify dermatologists (85.9%, 62.8%) and primary care physicians (73.1%, 55.5%) accountable for providing vaccine information. ≈70% PsA and Ps+PsA patients also cited rheumatologists. Only 57.7% of dermatologists felt well-trained to advise on vaccines. A subset of patients did not know recommended vaccines for them beyond COVID-19 (62.3% Ps, 41.4% PsA, 36.1% both). Overall, >80% of patients were indecisive or had insufficient knowledge to decide on vaccination. Dermatologists and patients agreed that patients are not proactive in asking for vaccine information.

Dermatologists most often recommended shingles (76.9%), flu (75.6%) and pneumococcal (70.5%) vaccines. Patient-reported vaccination status in the last year: ≈20% for shingles, ≈60% for flu and ≈35% for pneumococcal. Notably, ≈25% were unwilling to receive a COVID-19 vaccine. Active refusal was ≈10% for flu and <10% for other

vaccines, with no differences across groups.49.7% of dermatologists were unaware of their patients' vaccination status. Dermatologists estimated past year vaccination coverage at 33.0%. Patients on biologics or JAKi had higher uptakes than those on other therapies.

Main patient-reported barriers were lack of dermatologist (63.8%)/ rheumatologist (61.3%) recommendation, fear of side effects, flares or treatment interactions. Dermatologists (42.3%) cited limited time during visits, and 43.6% perceived patient reluctance, although only 18.3% of patients reported ever rejecting a recommended vaccine.

Dermatologists identified opportunities for improvement, including vaccine training, enhanced hospital/primary care vaccination pathways, and greater involvement of dermatology nurses and hospital pharmacists. The survey was considered useful by ≈80% of patients and 53.3% of dermatologists.

Conclusions

Dermatologists and patients with psoriatic diseases show high trust in vaccines yet, a mismatch on perceived importance, knowledge and actual uptake was found. Limited patient proactiveness, insufficient specialist recommendation and safety concerns are key modifiable barriers. Dermatologist proactiveness is essential, but time constraints and limited vaccine training mean recommendations often rely on individual initiative or patient proactivity, creating inequities in access.

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Abstract N°: 2218

Efficacy Analysis of Patients With Plaque Psoriasis Who Have Had an Inadequate Response to Prior Biologic Agents and Who Switched to Treatment With Picankibart (Grouped by Baseline sPGA Score) - a Post-Hoc Analysis of a Phase 2 Clinical Study

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Introduction

Patients with plaque psoriasis who had a poor response to prior biologic agents tend to present a higher baseline disease burden and are less likely to achieve complete skin clearance. To further evaluate the efficacy of picankibart in this population, this subgroup analysis stratified patients by baseline static physician global assessment score (sPGA). The analysis compared d the efficacy in poor responders who switched therapy, and

evaluated the treatment outcomes of the two groups of patients with sPGA 2 and sPGA 3–5 at Week 16 and beyond, aiming to provide a treatment reference for poor responders with varying disease severity.

Materials and Methods

This study was based on the subgroup data analysis of a multi-center, open-label, phase II clinical study(NCT05970978) of picankibart, and the main study included 152 patients with plaque psoriasis, of which 83 were patients with poor response who switched drugs. Patients with poor response were defined as those with sPGA ≥ 2 or BSA ≥ 3%, who were treated with 200 mg of picankibart via subcutaneous injection at Weeks 0, 4, and 8, followed by maintenance administration every 12 weeks until Week 32, and followed up after the last dose until Week 44.

Based on the baseline sPGA score, patients were divided into 2 groups: sPGA 2 (n = 32) and sPGA 3-5 (n = 43). To evaluate the proportion of patients who achieve sPGA 0/1 with BSA < 3% (primary efficacy endpoint), sPGA 0/1, BSA ≤ 1%, and PASI ≤ 1 at different time points (0–44 weeks) and the proportion of patients with Dermatology Life Quality Index (DLQI) 0/1 at baseline, Week 16, and Week 44.

Results

Baseline characteristics: The baseline demographic characteristics of the two groups were similar, basically the same as the overall population characteristics with poor response to prior biologic agents in the main study

Demographic characteristics: The mean age of the overall population with poor response to previous biological agents was 42.6 years old, 78.3% were male, the mean weight was 77.74 kg, and the BMI was 26.47 kg/m2. There was no significant difference in the distribution of smoking and drinking history.

Disease characteristics: Compared with the baseline sPGA 2 group, the baseline sPGA 3-5 group had a longer mean disease duration (10, 5 vs. 5.1 years), higher baseline BSA (body surface area affected by psoriasis) (11.8% vs. 7.2%), and higher baseline DLQI (Dermatology Life Quality Index) score (9 vs. 7.5).

Efficacy results: Overall, in terms of all efficacy endpoints, the improvement in efficacy was observed in both groups at Week 4, and the response increased faster in the early stage in the sPGA 2 group, while similar benefits were also achieved in the sPGA 3–5 groups with the extension of treatment duration.

Response rates of sPGA 0/1 and BSA < 3%: 18.8% and 7%, 50% and 51.2%, and 59.4% and 48.8% for sPGA 2 and sPGA 3-5 at weeks 4, 16, and 44, respectively;

sPGA 0/1 response rates: 50% and 7%, 65.6% and 65.1%, and 81.2% and 58.1% for sPGA 2 and sPGA 3-5 at Weeks 4, 16, and 44, respectively;

Response rate of BSA ≤ 1%: 12.5% and 7%, 40.6% and 46.5%, and 56.2% and 53.5% for sPGA 2 and sPGA 3-5 at Weeks 4, 16, and 44, respectively;

Response rate of PASI ≤ 1: 12.5% and 9.3%, 37.5% and 37.2%, and 34.4% and 39.5% for sPGA 2 and sPGA 3-5 at weeks 4, 16, and 44, respectively;

DLQI ≤ 1 response rate: 15.6% and 16.3%, 43.8% and 46.5%, and 53.1% and 55.8% in sPGA 2 and sPGA 3-5 at Weeks 4, 16, and 44, respectively;

Conclusions

In patients who had a poor response to prior biologics and were switched to picankibart, subgroup analysis by baseline sPGA (sPGA 2 vs sPGA 3–5) showed rapid and sustained improvement in skin lesions and improvement in quality of life in both groups.

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Abstract N°: 2233

Validation of the Diagnostic Performance of the Chinese Version of the Psoriasis Epidemiology Screening Tool (PEST) for Psoriatic Arthritis: A Cross-Sectional Study.

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Introduction

To validate the diagnostic efficacy of the Chinese version of the Psoriasis Epidemiology Screening Tool (PEST) for psoriatic arthritis (PsA) in Chinese psoriasis patients, optimize its clinical cutoff value, and provide localized evidence for the early screening of PsA in this population.

Materials and Methods

A single-center cross-sectional study was conducted, enrolling 877 psoriasis patients treated at the First Affiliated Hospital of University of Science and Technology of China from September 2024 to February 2026. Patients were classified into the PsA group (n=115) and non-PsA group (n=762) per the Classification Criteria for Psoriatic Arthritis (CASPAR). Clinical baseline data and Chinese version PEST scores were collected, and statistical analyses (including ROC curve construction and diagnostic efficacy index calculation) were performed using IBM SPSS 26. Intergroup comparisons of PEST item positive rates and baseline indicators were conducted with appropriate statistical tests.

Results

The PsA group had significantly higher positive rates of all PEST items and baseline indicator scores (PASI, DLQI, PHQ-9) than the non-PsA group (all $P<0.05$), with nail pitting (Q3) showing the highest positive rate (31.4%) in the total population. The PEST had an AUC of 0.966 (95% CI: 0.947 to 0.985) for PsA screening. A cutoff value of ≥2 points yielded optimal efficacy, with 87.0% sensitivity, 97.8% specificity and a Youden's index of 84.7%. Joint swelling (Q1), nail pitting (Q3) and dactylitis (Q5) were identified as the core discriminatory items for PsA.

Conclusions

The Chinese version of PEST exhibits excellent diagnostic efficacy for PsA screening in Chinese psoriasis patients, with ≥2 points as the appropriate clinical cutoff value. Q1, Q3 and Q5 are the core screening items of this tool. This study provides localized evidence-based evidence for early PsA screening in Chinese psoriasis patients and supplements non-European and American population data for the global application of PEST.

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Abstract N°: 2234

Psoriasis-Like Disorders: Two Challenging Mimics

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Introduction

Targeted therapies have increased interest in psoriasis management. However, its broad spectrum (nails, joints, folds and intertriginous areas) requires careful differential diagnosis. We describe two cases mimicking psoriasis - amicrobial pustulosis of the folds (APF) and acrylate-induced onychodystrophy - focusing on their diagnosis and management.

Case Presentation

The first patient was a 24-year-old woman presented with a 6-month history of pruritic, erythematous, scaly plaques and pustules involving the scalp, neck, trunk, and intertriginous areas, including axillary and inguinal folds, intergluteal cleft, and suprapubic region. Psoriasis (vulgar and pustular forms) or HTLV-1-associated infective dermatitis were initially suspected. Systemic features included recurrent fever, polyarthralgia affecting both large and small joints, purulent otorrhea, and a 3 kg weight loss. Laboratory investigations showed non-reactive HTLV serology, positive antinuclear antibodies, and positive anti-dsDNA and anti-Sm antibodies. Histopathological examination revealed spongiotic and psoriasiform dermatitis with intraepidermal pustules and a neutrophilic infiltrate. Given the predominant involvement of intertriginous areas, the presence of autoantibodies, and supportive histopathological findings, a diagnosis of APF was established. Initial improvement was obtained with prednisone but relapsed when tapered below 20 mg/day. Multiple steroid-sparing agents were used over time, including cyclosporine, methotrexate (MTX), doxycycline, hydroxychloroquine, azathioprine and ustekinumab, with limited response. Dapsone was contraindicated due to allergy. Upadacitinib (15 mg/day) was initiated, leading to significant disease control and successful prednisone withdrawal. The second case involves a woman in her 30s who presented with a 9-month history of distal onycholysis, subungual hyperkeratosis, and painful paronychia of the right fourth finger, following gel nail application. Multiple prior treatments, including topical ciclopirox, fusidic acid, corticosteroids, and oral terbinafine, were ineffective. Based on persistent nail changes with distal phalanx erythema and swelling, along with Power Doppler ultrasound findings suggestive of extensor peritendinitis and nail bed thickening, psoriatic arthritis was diagnosed, and MTX was initiated prior to admission. In the absence of nail pitting, personal or family history of psoriasis, and given the unusual presentation in a single nail, acrylate-induced psoriasiform onychodystrophy was suspected. Magnetic resonance imaging showed no joint or tendon involvement, leading to MTX discontinuation and initiation of topical calcipotriol/betamethasone under occlusion, with marked improvement within the first month. Nail culture grew *Candida parapsilosis*, consistent with secondary onychomycosis. The combination was subsequently reduced to alternate nights for one additional month, and itraconazole pulse therapy was initiated, resulting in complete clinical resolution after five cycles.

Conclusion

Amicrobial pustulosis of the folds is a rare autoinflammatory condition with incompletely understood pathogenesis but established diagnostic criteria. Predominant involvement of intertriginous areas with

psoriasiform and pustular lesions in women with positive autoantibodies, along with poor response to conventional psoriasis therapies, should raise suspicion for this entity. Upadacitinib may represent a promising therapeutic alternative. Acrylate-induced contact dermatitis is the most common adverse event associated with gel nails and may take months of exposure to develop sensitization. Active inquiry about gel nail use is essential in patients with suspected nail psoriasis, as onycholysis, subungual hyperkeratosis, and painful paronychia may mimic psoriatic disease. Isolated nail psoriasis is uncommon, particularly when limited to a single nail and in the absence of pitting.

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Abstract N°: 2239

Beyond Classical Psoriasis Genetics: Familial CongenitalHyperkeratotic Psoriasis Associated with a Shared ATP7B p.Ile1230ValVariant: Coincidence, Modifier, or Pathogenic Clue?

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Introduction

Congenital and early-onset psoriasis are rare and incompletely characterized,particularly when presenting as severe generalized hyperkeratotic disease. A 2008 literature review[1] found only nine biopsy-proven congenital psoriasis cases andemphasized the need for additional reports with long-term follow-up. Recent studies increasingly link copper metabolism to psoriasis biology: human studies report altered copper/zinc balance in psoriasis, and a 2025 case-control study of 301 psoriasis patients and 301 matched controls found significantly higher blood and serum copper in psoriasis, with positive correlation between copper levels and PASI. Although ATP7B is classically associated with autosomal recessive Wilson disease, emerging data suggest that copper homeostasis, oxidative stress, and cuproptosis-related pathways may contribute to psoriasis pathogenesis.
Objective: To describe a mother–daughter case series of severe familial hyperkeratotic psoriasis associated with shared heterozygous ATP7B p.Ile1230Val variant and to discuss its possible role as a copper-homeostasis modifier.
Methods: Clinical examination, photographic documentation, histopathological assessment, liver enzymes, ceruloplasmin, 24-hour urinary copper, and whole-exome sequencing were performed in two related female patients, aged 54 and 14 years, with congenital-onset severe generalized hyperkeratotic psoriasiform disease beginning shortly after birth.

Case Presentation

Two related female patients, a 54-year-old mother and her 14-year-old daughter, presented with longstanding severe generalized hyperkeratotic psoriasiform disease. Lesions were diffuse, involving the trunk, back, neck, face/auricular region, and extremities, with thick scaling, erythema, post-inflammatory hyperpigmentation, and prominent linear/verrucous hyperkeratotic plaques suggestive of marked Koebnerization. PASI >50 for both patients. A male maternal cousin reportedly had a similar phenotype. The mother had previously shown clinical response to acitretin, with relapse after treatment discontinuation.

Histopathology: Skin biopsy showed classical psoriasiform changes: hyperkeratosis with focal parakeratosis, neutrophils in parakeratotic keratin, regular acanthosis with elongated rete ridges, thinning of the granular layer, dilated papillary dermal vessels, and superficial perivascular lymphocytic infiltrate, supporting the diagnosis of psoriasis.
Genetic and biochemical findings: Whole-exome sequencing in both patients detected heterozygous ATP7B NM_000053.4:c.3688A>G, p.(Ile1230Val), rs200911496, classified in the provided report as likely pathogenic. Liver enzymes were normal in both patients. Ceruloplasmin was mildly elevated in the mother and normal in the daughter; 24-hour urinary copper was within the provided reference range in both. This supports ATP7B carrier status rather than clinically overt Wilson disease.
Interpretation: The literature review found no published report directly linking ATP7B, Wilson disease, or specifically p.Ile1230Val/rs200911496 to congenital psoriasis,
ichthyosis, ichthyosiform dermatosis, or keratoderma. It identified only weaker links: Wilson disease–psoriasis co-occurrence case reports, Wilson disease cohorts with xerosis/ichthyosis-like scaling, and newer ATP7B/cuproptosis-related psoriasis studies. ATP7B is a copper-transporting ATPase, and psoriasis studies now implicate copper imbalance, oxidative stress, keratinocyte activation, and cuproptosis-related pathways. A 2023 psoriasis bioinformatics study found altered cuproptosis-related genes including ATP7B, while preclinical work showed that the copper chelator tetrathiomolybdate reduced imiquimod-induced psoriasiform inflammation, epidermal thickness, Ki-67 expression, cytokine levels, and ERK/STAT3 activation in mice.

Conclusion

These findings suggest that ATP7B and copper-homeostasis pathways may act as disease modifiers in selected severe familial psoriasiform keratinization phenotypes.

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Abstract N°: 2242

The RNA demethylase ALKBH5 regulates the pathological process of psoriatic keratinocytes by facilitating the expression of FUT8 in a YTHDF2 m6A modificationdependent manner.

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Introduction
The α-ketoglutarate-dependent dioxygenase ALKBH5 is a critical demethylase that has been established to play a pivotal role in biological processes associated with various diseases, notably cellular proliferation and inflammation. Excessive keratinocyte proliferation and systemic inflammation are hallmark pathological characteristics of psoriasis. This study aims to explore the important role ALKBH5 may play in the pathogenesis of psoriasis.

Materials and Methods
In this study, we observed elevated expression levels of ALKBH5 in both skin lesions from psoriatic patients and in animal models of psoriasis. Knockdown of ALKBH5 was performed in a psoriasis cell model. RNA immunoprecipitation (RIP) and methylated RNA immunoprecipitation (MeRIP) assays were conducted to investigate ALKBH5 binding to FUT8 transcripts. A dual-luciferase reporter assay was used to identify the specific binding site of ALKBH5 on FUT8 mRNA. Transcriptional repression assays were performed to assess FUT8 mRNA degradation rate.

Results
Knockdown of ALKBH5 markedly ameliorated the pathology of the psoriasis cell model, concomitantly leading to a substantial reduction in FUT8 expression. Furthermore, ALKBH5 knockdown inhibited the proliferation and migration of HaCaT cells while promoting their apoptosis, alongside the downregulation of proinflammatory cytokines and the upregulation of differentiation markers involucrin (IVL) and keratin 1 (KRT1). RIP and MeRIP assays revealed that ALKBH5 binds to FUT8 transcripts and modulates FUT8 expression through mRNA demethylation. The specific binding site of ALKBH5 on FUT8 mRNA was identified via dual-luciferase reporter assay. Additionally, we discovered that knockdown of the reader protein YTHDF2 led to an increase in FUT8 protein expression, whereas knockdown of ALKBH5 significantly diminished FUT8 protein expression and the activation of its downstream EGFR pathway. Transcriptional repression assays confirmed that the degradation rate of FUT8 mRNA was slowed in YTHDF2 knockdown cells.

Conclusions
ALKBH5 may facilitate keratinocyte proliferation via the FUT8/EGFR axis by enhancing YTHDF2-mediated FUT8 expression.

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Abstract N°: 2253

Unmet Needs Along the Psoriasis Care Pathway: Comparing Traditional and Patient-Driven AI-Enabled Real-World Research across different Continents

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Introduction

Psoriasis is a chronic inflammatory disease associated with substantial physical symptoms, psychosocial burden, and cumulative life course impairment. While clinical outcomes, disease severity, and treatment efficacy are well described, real-world evidence capturing how patients experience psoriasis during the full care pathway across different regions remains limited. Traditional research approaches often rely on predefined questionnaires or interviewer-led designs, which may overlook personalized concerns and unmet needs. In addition, regional differences in access, care delivery, and patient experience are not fully characterized.

This study was conducted to generate large-scale patient-reported insights on symptoms, diagnostic pathways, treatment experiences, psychosocial impact, and unmet needs across the psoriasis care pathway, and to compare insights derived from traditional patient journey research with those obtained through a patient-driven research approach.

Materials and Methods

Adults living with psoriasis participated in either traditional patient journey research or patient-driven AI-enabled interviews conducted via text and audio. Traditional research used predefined questions and structured domains, while patient-driven interviews were exploratory and open-ended, enabling participants to freely describe experiences, concerns, and priorities without predefined response options or interviewer influence. The overall dataset included more than 1,000 patients from Germany, the United States, and Japan by the end of April, 2026.

Patient narratives were anonymized, transformed into structured data, and aggregated across key journey dimensions, including symptoms, diagnostic and referral pathways, treatments, quality of life, mental health, comorbidities, and region. Analyses were descriptive.

Results

Across regions, both research approaches consistently identified a substantial and persistent burden throughout the psoriasis care pathway. Core symptoms—including itching, scaling, plaques, dryness, and erythema—were commonly reported and represented major contributors to impaired sleep, reduced daily functioning, and diminished quality of life. Traditional research quantified symptom prevalence and relative impact, while patient-driven AI-enabled interviews provided additional context regarding symptom fluctuation, cumulative life course impairments, and perceived triggers.

Structured research highlighted prolonged time to diagnosis and delayed specialist access, while patient-driven data provided further insight into repeated consultations and prolonged diagnostic uncertainty. Regional variation was observed: patients in the United

States reported comparatively faster specialist access accompanied by insurance-related barriers; patients in Japan described more standardized diagnostic pathways; and patients in Germany reported substantial delays associated with referral systems and specialist availability. In Germany, 34.9% of patients waited more than six months for their first dermatology visit, and 36.0% reported diagnostic timelines exceeding two years.

Traditional research demonstrated high levels of dissatisfaction with treatment effectiveness and durability. Patient-driven interviews further clarified drivers of suboptimal treatment use, including limited long-term efficacy, treatment burden, formulation challenges, and concerns related to adverse effects. Traditional methods captured substantial cumulative life course impairments, while patient-driven analyses provided insight into how psychosocial burden evolves across the care pathway.

Conclusions

Traditional patient journey research provides standardized and comparable insights across predefined domains, while patient-driven AI-enabled approaches captured patient-prioritized concerns and nuanced lived experiences that may be underrepresented in structured tools. Integrating both approaches enables a more comprehensive understanding of unmet needs along the psoriasis care pathway.

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Abstract N°: 2270

Vunakizumab in the Treatment of Severe Erythrodermic Psoriasis with Multiple Organ Dysfunction: A Case Report

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Introduction

Erythrodermic psoriasis (EP) is a rare and severe psoriasis type, marked by widespread scaling and redness over 75% of the body. It can cause systemic issues like swollen lymph nodes, joint pain, fever, fatigue, dehydration, electrolyte imbalances, and rapid heartbeat, making it potentially life-threatening. Currently, there are no established guidelines or standardized treatments for EP. This article discusses a case study on using Vunakizumab to treat severe EP with multiple organ dysfunction.

Case Presentation

We present the case of a 71-year-old male patient with a 20-year history of psoriasis, who was admitted with exacerbated generalized erythema, scaling, fever, and septic shock. The patient had multiple comorbidities, including atrial fibrillation, coronary heart disease, heart failure, diabetes mellitus, and multiple organ dysfunction. Dermatological examination revealed diffuse erythema, swelling, and extensive furfuraceous scales covering more than 90% of the body surface area. Laboratory investigations demonstrated severe systemic inflammation, hypoalbuminemia, and liver and kidney dysfunction. Histopathological analysis of the skin confirmed erythrodermic psoriasis. Following stabilization through intensive care, anti-infective treatment, and supportive therapy, the patient received a subcutaneous injection of vunakizumab (an Interleukin-17 inhibitor) at a dose of 240 mg. Significant improvement in skin lesions was observed two days post-treatment, characterized by rapid regression of erythema, edema, and scaling, along with a gradual decrease in inflammatory markers. No serious adverse events were reported.

Conclusion

This case indicates that vunakizumab exhibits rapid efficacy and a favorable safety profile in the treatment of severe erythrodermic psoriasis accompanied by multiple organ dysfunctions, thereby offering a novel therapeutic option for critically ill patients with limited conventional treatment alternatives.

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Abstract N°: 2273

Psoriatic cheilitis versus other cheilitides: key role of dermoscopy in differentiation

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Introduction

Cheilitis is a common reason for dermatological consultation, encompassing a wide range of etiologies, including inflammatory, autoimmune, and precancerous conditions. Its diagnosis can be challenging due to overlapping clinical presentations. Dermoscopy, as a non-invasive tool, allows better characterization of vascular structures, scaling, and other specific features. However, dermoscopic criteria for each type of cheilitis remain insufficiently defined and standardized.

Materials and Methods

A retro-prospective descriptive and analytical study was conducted . Patients presenting with lip involvement in the context of psoriasis, lichen planus, or actinic cheilitis were included from January 2024 to March 2026. All patients underwent standardized clinical and dermoscopic examinations. Images were evaluated independently by two clinicians. In doubtful cases, histopathological confirmation was performed.

Results

70 patients with cheilitis were included: 40 cases of psoriatic cheilitis, 15 actinic cheilitis, and 15 lichen planus-related cheilitis. The mean age was 43 years (range: 4–80), with no sex predominance (36 females, 34 males).

Clinically, the dry form of cheilitis predominated in all groups: 60% of psoriatic, 66.7% of lichenoid, and 80% of actinic cheilitis. In psoriatic cheilitis, it was followed by angular (20%), fissured (5%), and erosive forms. In lichen planus, the erosive form accounted for 33.3% of cases. In actinic cheilitis, fissured, erosive, and angular forms were each observed in 6.7% of cases.Dermoscopy revealed dotted vessels in 100% of psoriatic cases ($p = 0.002$), with a sensitivity of 100% and a specificity of 23%. Linear vessels were observed in 40% of cases ($p = 0.001$), with a sensitivity of 40% and a specificity of 20%, while no hairpin vessels were observed. Vascular distribution was homogeneous in all psoriatic cases ($p < 0.001$). In lichen planus, dotted, linear, and hairpin vessels were observed in 66.7% ($p = 0.004$), 80% ($p = 0.044$), and 53.3% ($p = 0.001$) of cases, respectively. Vascular distribution was homogeneous in 53% and radial in 47% of cases. In actinic cheilitis, a polymorphic vascular pattern was observed. Dotted vessels were present in 86.7% of patients ($p = 0.637$), linear vessels in 80% ($p = 0.044$), and hairpin vessels in 33.3% ($p = 0.133$). A predominantly radial vascular distribution was noted in 53% of cases ($p = 0.002$). Regarding scaling, it was predominantly white in psoriatic cheilitis, with a homogeneous distribution in 82.4% of cases ($p < 0.001$; sensitivity 82%, specificity 76%). In lichen planus, with scales was present in 73% of patients, mainly with a peripheral distribution. In actinic cheilitis, scales were white in 60%

and yellowish in 40% of cases, with exclusively peripheral distribution ($p < 0.001$). Regarding associated structures, structureless white areas were observed in 5% of psoriatic cases, 13% of lichen planus cases, and 100% of actinic cheilitis cases ($p < 0.001$). Wickham striae were exclusively observed in lichen planus ($p < 0.001$). Ulcerations were observed in 5% of psoriatic cases ($p = 0.066$), 33% of lichen planus cases ($p = 0.009$), and 6.7% of actinic cheilitis cases ($p = 1.000$).

Conclusions

Dermoscopy is a valuable tool in the differential diagnosis of cheilitis, revealing characteristic patterns according to etiology. It allows the identification of distinctive features of psoriatic, lichenoid, and actinic cheilitis, thereby improving diagnostic orientation.

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Abstract N°: 2297

Heterogeneity of the association between body mass index and skin clearance in real-world ustekinumab-treated patients with psoriasis in China

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Introduction

Elevated body mass index (BMI) has been associated with reduced response to biologic therapies in moderate to severe psoriasis according to published information [1]. Our study aimed to examine whether the association between BMI and real-world ustekinumab response varied by patient characteristics in moderate to severe psoriasis.

Materials and Methods

The study cohort was derived from the Shanghai Psoriasis Effectiveness Evaluation Cohort (SPEECH), a prospective multicenter observational study conducted between November 2022 and March 2024 [2]. Adults with moderate to severe plaque psoriasis who initiated ustekinumab were included.

Treatment response was assessed using time to achievement of PASI75, PASI90, PASI100, and Physician's Global Assessment (PGA) ≤1. In addition, improvement in PASI from baseline at week 16 was analyzed as a continuous outcome.

To investigate heterogeneity in treatment response associated with BMI, multivariable Cox proportional hazards models were applied to assess interactions between BMI and predefined demographic and clinical characteristics (Table 1). Interaction terms were tested using Wald chi-square statistics. For statistically significant interactions, predicted hazard ratios (HRs) were visualized using interaction plots to illustrate how the association between BMI and outcomes varied across subgroups. For the continuous outcome, scatter plots with smoothed curves were generated and stratified by the corresponding interacting variables.

All analyses were adjusted for relevant covariates. Statistical significance was defined as a two-sided p value <0.05.

Results

Among 132 patients included in the study, the mean age was 45.8 years, 79.6% were male, and the median disease duration was 10 years (Table 1). The median BMI was 24.5 kg/m^2, 32.6% had metabolic comorbidities, and the median baseline PASI was 12.5. Median times to PASI75, PASI90, PASI100, and PGA ≤1 were 16.4 (N=97), 17.0 (N=62), 24.0 (N=29), and 16.0 (N=91) weeks, respectively.

Multivariable Cox proportional hazards models identified disease duration as the patient characteristic that significantly modified the association between BMI and treatment response for time to PASI75 and PGA ≤1 (Table

2; P for interaction <0.05 for both outcomes). No other demographic or clinical variables showed significant interactions.

Interaction plots (Figure 1) showed that among patients with shorter disease duration (approximately <15 years), higher BMI was associated with slower achievement of PASI75, with estimated hazard ratios consistently below 1.0. In contrast, this association was progressively attenuated and no longer evident among patients with longer disease duration, indicating modification of the BMI effect by disease duration. Based on this pattern, subsequent subgroup analyses were conducted using 15 years as the stratification cutoff.

In patients with disease duration <15 years, higher BMI was associated with delayed achievement of PASI75 (HR=0.88, p<0.05) and PGA ≤1 (HR=0.88, p<0.05), whereas no significant association was observed in those with disease duration ≥15 years (PASI75: HR=1.06, p=0.37; PGA ≤1: HR=1.02, p=0.80). Most patients received 45 mg ustekinumab, with only three patients treated with the 90 mg dose, all of whom had disease duration <15 years.

Consistent with these time-to-event analyses, descriptive analysis of PASI improvement at week 16 showed lower PASI improvement with increasing BMI among patients with disease duration <15 years, but no clear association in those with longer disease duration (Figure 2).

Table 1. Baseline demographic and clinical characteristics of the study population (N = 132).

	Total N=132
Age (years)	
Mean (std)	47.4 (15.1)
Median (Q1-Q3)	45.8 (35.1-60.3)
Min-Max	47.4-89.6
Gender n (%)	
Female	27 (20.5%)
Male	105 (79.5%)
BMI	
Mean (std)	24.9 (3.6)
Median (Q1-Q3)	24.5 (22.6-27.3)
Min-Max	17.0-39.2
Dosage n (%)	
45 mg ustekinumab	129 (97.7%)
90 mg ustekinumab	3 (2.3%)
Baseline PASI score	
Mean (std)	14.4 (7.2)
Median (Q1-Q3)	12.5 (10.2-16.7)
Min-Max	3.4-46.4
Baseline HADS-A	
Mean (std)	5.4 (4.4)
Median (Q1-Q3)	5 (1-8)
Min-Max	0-18
Duration of psoriasis diagnosis (years)	
Mean (std)	13.1 (11.4)
Median (Q1-Q3)	10 (5.5-19)
Min-Max	1-58
Type 2 diabetes n (%)	19 (14.4%)
Hypertension n (%)	32 (24.2%)
Prior systemic therapy n (%)	62 (47.0%)
Prior biologics therapy n (%)	24 (18.2%)

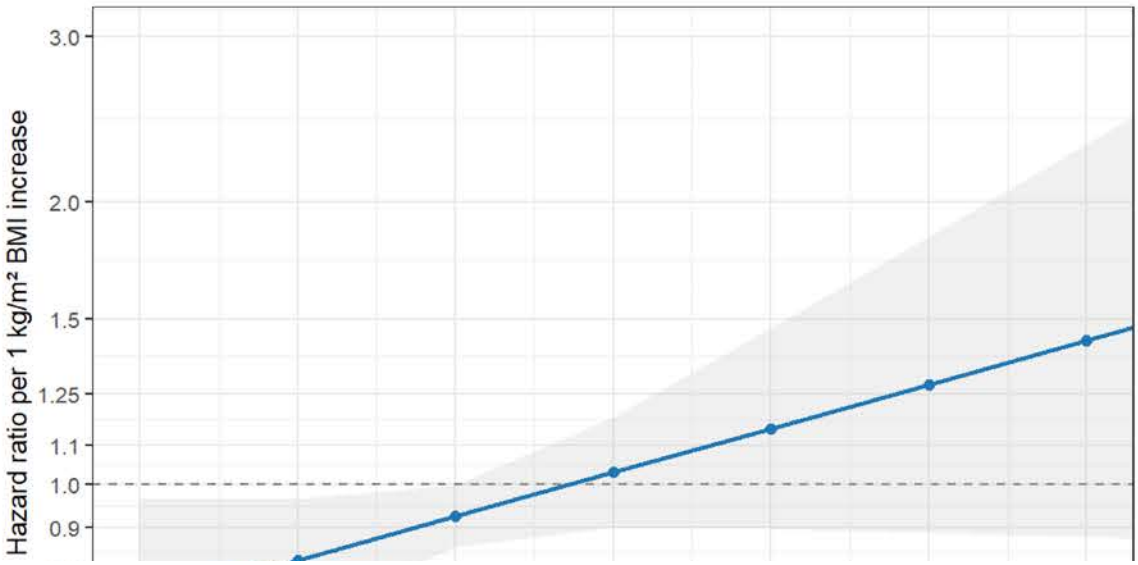
Prior topical therapy n (%)	116 (87.9%)
Family history of psoriasis n (%)	24 (18.2%)
Drinking history n (%)	35 (26.5%)
Smoking history n (%)	67 (50.8%)
Education (bachelor's degree or above) n (%)	44 (33.3%)

Table 2. Interaction between BMI and patient characteristics in multivariable Cox proportional hazards models for PASI75 and PGA ≤ 1 (N=132).

Interaction variable	P-value for PASI75 (N=97)	P-value for PGA ≤1 (N=91)
Duration of psoriasis diagnosis	**0.0141**	**0.0164**
Age	0.2914	0.7617
Gender	0.8012	0.1091
Baseline PASI score	0.0882	0.1072
Baseline HADS-A	0.4625	0.8263
Type 2 diabetes	0.1578	0.7889
Hypertension	0.1985	0.1525
Prior systemic therapy	0.6970	0.6799
Prior biologics therapy	0.0616	0.0893
Prior topical therapy	0.9637	0.5360
Family history	0.2681	0.2989
Drinking history	0.7630	0.5031
Smoking history	0.4127	0.2019
Education level	0.1397	0.8000

Figure 1. Disease duration–dependent association between BMI and PASI75 response to ustekinumab.

Hazard ratios (solid line) and 95% confidence intervals (shaded area) represent the estimated effect of a 1 kg/m² increase in BMI across disease duration, with BMI referenced to the median value of the study population, derived from an adjusted Cox proportional hazards model. Estimates beyond 30 years were not shown owing to limited sample size.



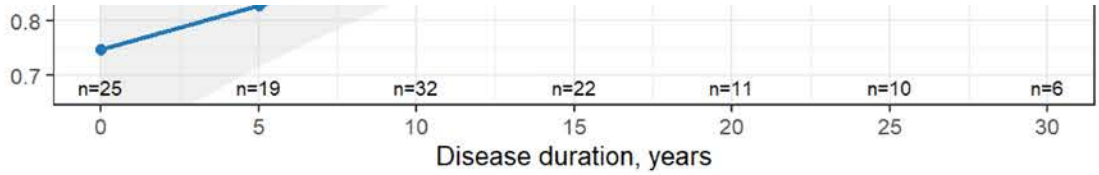
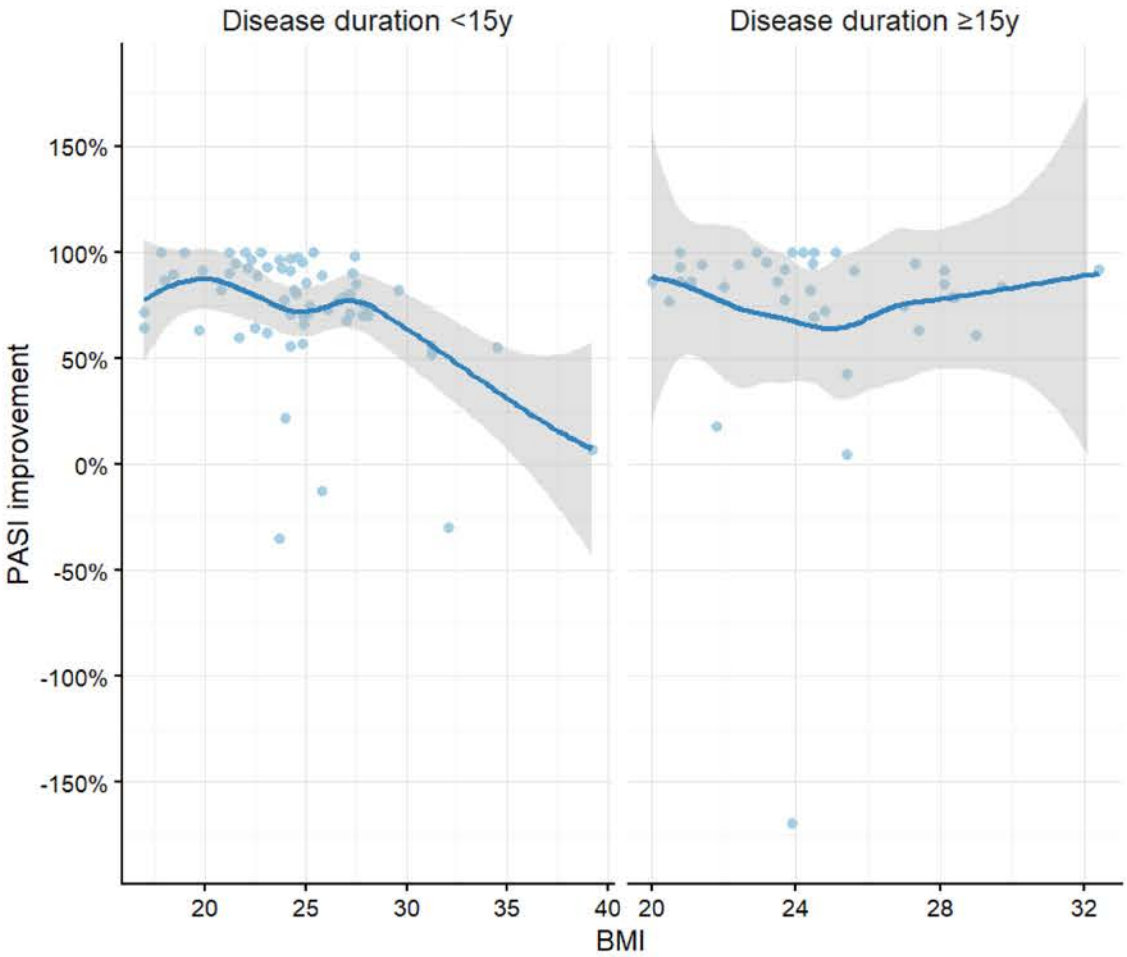


Figure 2. Percentage of PASI improvement at week 16, stratified by disease duration (<15 years vs ≥15 years).

The BMI range differs between groups due to the underlying distribution of observed data.



Conclusions

The findings of this study suggest that the association between elevated BMI and ustekinumab effectiveness is modified by disease duration after adjustment for covariates. These results warrant further investigation in larger studies with longer follow-up.

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Abstract N°: 2301

Isolated Paradoxical Nail Psoriasis Induced by Anti–TNF-α Therapy : First Reported Case

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Introduction

Paradoxical psoriasis (PP), defined as the development of psoriatic lesions, in previously unaffected individuals is well known under tumor necrosis factor-alpha (TNF-α) inhibitors and shows a broad spectum of phenotypic presentations. In our case, it manifested as isolated nail psoriasis. We herein report the first case in the literature of a paradoxical nail limited psoriasis with a high intrinsic drug causality. We also emphasize the value of dermoscopy as a practical and reliable tool that helped us establish the diagnosis.

Case Presentation

49-year-old female patient, diagnosed with refractory granulomatous uveitis with no identifiable underlying cause. She was treated with corticosteroids, Cyclophosphamide, and Azathioprine without satisfactory response.She was started on Infliximab and 6 months later, she developed painful paronychia and onychodystrophy affecting both fingernails and toenails. She didn't have any personal or family history of psoriasis and denied any joint pain, or any erythematous or scaly plaques on body or scalp. Dermoscopy of the finger-nails revealed: diffuse nail pitting (>10 per nail), fuzzy and mottled lunula, with red spots on it, alternating longitudinal erythema and pallor of the nail bed, dilated nail bed capillaries surrounded by white halos and periungual homogenous dotted vessels. Dermoscopy of toe-nails revealed: fuzzy lunula, Beau's lines, leukonychia, salmon patches, red spots in the nail bed, distal onycholysis with an erythematous border, scales and onycholysis.The diagnostis of nail psoriasis was established and no histopathological examination was made since dermoscopy showed highly specifc dermoscopic features. Fungal superinfection was ruled out in fingernails by negative direct microscopic examination and culture. However, it was detected in toenails and was treated accordingly with no improvement of nail dystrophy. No discontinuation of Infliximab was made, as it was a precious treatment option for the patient's ocular condition which was much more debilitating that her nail disorder. We treated the nail psoriasis with topical Calcipotriol/Betamethasone with mild improvement.

Conclusion

Induction or worsening or changing in the pattern of psoriasis has been noted in patients treated with anti-TNF inhibitors. Nail involvement has been described, but never as an isolated finding. The latency period (6 months) between the start of anti-TNF and the development of nail lesions in our patient is consistent with previous reports, and the fact that lesions did not resolve under topical corticosteroids as long as the medication was continued, was strongly suggestive of paradoxical nail psoriasis. Dermoscopy may serve as the gold-standard diagnostic tool for nail psoriasis, excluding the necessity of histopathological examination when detecting highly specific findings that form pathognomic patterns. Because a significant component of the pathogenesis of psoriasis is driven through increased inflammatory angiogenesis and microvascular dilation, findings related to nail-bed are the most characterizing features. Longitudinal erythema of the nail bed, fuzzy lunula, mottled lunula,

dilated nail bed capillaries surrounded by white halos, dilated hyponychial capillaries, salmon patches, red spots in the nail bed or lunula are unique and characteristic dermoscopic features of nail psoriasis. Distal onycholysis with an erythematous border is a specific finding, even if other nail-bed related findings are not detected. Nail pitting is one of the most common findings although not specific, but 10 pits in one nail is considered proof of psoriasis.Treatment may lead to complete or partial resolution, but psoriasis remains active in most patients maintained on anti-TNFs agents. Their withdrawal is often required. However, it may result in major flare of the underlying disease, which in many cases is more debilitating than psoriasis. Switching to another anti-TNF agent may be associated with persistence or recurrence of the rash.

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Abstract N°: 2306

Clinical effectiveness of risankizumab in moderate to severe genital psoriasis stratified by baseline PASI: interim results from a real-world study

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Introduction

Genital psoriasis (GenPso) is associated with substantial impairment in quality of life (QoL) including sexual burden and avoidance of sexual activity. The decision criteria for systemic antipsoriatic therapy specified in the updated German AWMF guideline in 2025, as well as the more ambitious therapeutic goals defined therein for patients with moderate to severe GenPso, are examined. In clinical practice, patients with high Psoriasis Area and Severity Index (PASI) scores are more likely to receive systemic therapy. The objective of this interim analysis is to evaluate the impact of Risankizumab (anti-IL23) (RZB) on QoL after 40 weeks with respect to baseline PASI.

Materials and Methods

The German Psoriasis registry PsoBest observes adult patients with moderate to severe plaque-type psoriasis starting systemic therapy. The GPS-Best study is a nested non-interventional cohort study within the PsoBest registry and aims to evaluate the effectiveness of RZB, as well as its effects on QoL and sexual impairment. Patients with moderate to severe GenPso (static physician's global assessment of genitalia (sPGA-G ≥ 3)), are treated with RZB at the discretion of the treating physician.

This analysis evaluates the sPGA-G, PASI and the Dermatology Life Quality Index (DLQI) at week 40 and baseline. It compares patients with lower (LOSI) vs. higher (HOSI) overall skin involvement (baseline PASI≤ 10 vs. PASI> 10). Differences were analysed using Kruskal-Wallis test (α= 0.05).

Results

These analyses comprise data of 87 patients who completed week 40 under RZB treatment (60.9% male, n= 53; 39.1% females, n= 34). Mean age was 46.2 years and the mean duration of psoriasis was 17.5 years (44.8% nail psoriasis, 20.7% psoriatic arthritis). Mean baseline PASI and DLQI were 15.5 and 14.1, respectively, indicating marked disease severity. The majority of patients were assigned to the HOSI subgroup (PASI> 10, n= 59, 67.8%; n= 23, 26.4% with LOSI, PASI≤ 10). Although mean PASI differed between subgroups (6.5 in LOSI vs. 19.1 in HOSI), DLQI was comparable (14.7 and 13.8).

At week 40, mean PASI decreased to 0.7, mean DLQI to 1.6. PASI-90 was achieved in 82.9%, PASI< 2 in 87.0%. 73.6% achieved DLQI 0-1 i.e., no or mild impairment. 83.9% of patients achieved sPGA-G 0/1 and 66.7% showed total clearance of GenPso (sPGA-G= 0). The response in HOSI was comparable to the response in LOSI: 87.3 vs. 85.7% PASI< 2; 69.5 vs. 65.2% sPGA-G= 0 (not significant). There was a higher rate of patients with no or mild impairment of QoL (DLQI 0-1) in LOSI (78.3 vs. 72.9%, p> 0.05). Also, the mean DLQI reduction from week 0 to 40 was numerically higher in LOSI (13.4 vs. 12.2). Patients with a duration of psoriasis ≤ 5 years showed higher response rates in PASI <2 (100 vs. 81.8%, p= 0.054) and in sPGA-G 0/1 (100 vs. 77.4%, p= 0.016) compared to

patients with shorter disease duration.

Conclusions

RZB demonstrated substantial improvement of GenPso symptoms, with benefits reflected in objective and patient reported scores. The findings show that upgrade criteria like genital involvement are highly important for treatment considerations. PASI does not appear to drive DLQI in patients with GenPso. The greater reduction in DLQI observed in the LOSI subgroup suggests a trend in QoL development, reflecting a combination of GenPso severity and skin involvement. Overall, this data shows that LOSI and HOSI patients benefit from an early and effective therapy with RZB and may support a shift towards therapeutic decisions that are based less on overall scores like PASI and more on special area specific scores (sPGA-G), emphasizing GenPso as a dominant factor in QoL impairment.

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Super-Responders in Patients with Plaque Psoriasis Treated with Picankibart Treatment: Results from the Phase 3 CLEAR-1 Study

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Introduction

As a novel selective anti-IL23p19 monoclonal antibody, picankibart has demonstrated favorable efficacy and safety profiles in clinical trials for moderate-to-severe plaque psoriasis. However, data characterizing the profile and treatment outcomes of super-responders to this agent remain limited. Therefore, we conducted a post-hoc analysis to define the demographic, clinical, and disease-related profile of super-responders to picankibart, and the long-term treatment outcomes.

Materials and Methods

The analysis was conducted with data from a randomized, double-masked, placebo-controlled phase 3 study of picankibart (CLEAR-1, NCT05645627). Adult patients with moderate-to- severe plaque psoriasis were randomized with a ratio of 2:2:1 to the picankibart 100mg group (administrated with 3 doses of 200mg picankibart every 4 weeks [Q4W], then switch to 100mg Q12W tile week 52), picankibart 200mg group (administrated with 3 doses of 200mg picankibart every 4 weeks [Q4W], then with extended dosing frequency of Q12W tile week 52), or placebo group (administrated with placebo with the same dosing frequency). A super-responder was defined as a patient who achieved a rapid and robust treatment response, defined as two consecutive PASI 100 scores at week 20 and week 28. Baseline demographic characteristics, medical and disease history, disease features, and maintenance of treatment response were summarized.

Results

Among 500 enrolled patients, a total of 37.0% participants (n=185) fulfill the definition of super-responder, with the vast majority (n=182, 98.4%) distributed across the two active treatment groups: 87 patients in the 100 mg arm and 95 patients in the 200 mg arm. Baseline demographic characteristics were broadly comparable between

super-responders and non-super-responders: mean age (standard deviation [SD]) 41.2 (11.73) vs. 42.3 (12.15) years, male sex 72.4% vs. 79.4%, and mean body weight (SD) 73.87 (13.615) kg vs. 75.83 (14.509) kg. The proportions of patients with no history of tobacco use (57.8% vs. 53.7%) or alcohol consumption (71.4% vs. 74.6%) were also similar between groups. Super-responders exhibited numerically lower rates of comorbid psoriatic arthritis (1.1% vs. 5.1%), as well as lower frequencies of cutaneous involvement at specific anatomical sites: scalp psoriasis (90.3% vs. 92.4%), nail psoriasis (39.5% vs. 45.5%), palmoplantar psoriasis (5.4% vs. 10.2%), and genital psoriasis (8.1% vs. 13.3%). A smaller proportion of super-responders had prior exposure to IL-17-targeted biologics (9.7% vs. 16.8%). At week 52, 74.7% of super-responders maintained a PASI 100 response. The rates of PASI 90 response were 94.5% and the proportion of patients achieving DLQI 0/1 at week 52 was 85.5%.

Conclusions

Approximately one-third of patients achieved consecutive PASI 100 responses at weeks 20 and 28 following initiation of picankibart treatment. Baseline demographic characteristics were largely similar between super-responders and non-super-responders. Patients with lower baseline rates of psoriatic arthritis comorbidity and localized cutaneous psoriatic involvement, as well as those who were treatment-naïve to IL-17-targeted biologics, were more likely to meet super-responder criteria. Super-responders maintained significantly superior treatment outcomes, including PASI 90, PASI 100, and health-related quality of life metrics, through week 52 follow-up. These data suggest that patients who achieve early, sustained PASI 100 response during picankibart treatment exhibit stable, long-term maintenance of therapeutic efficacy.

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Bimekizumab in routine clinical practice: Understanding baseline characteristics of patients with moderate to severe plaque psoriasis across five European countries from the ELEVATE observational study

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Introduction

Bimekizumab (BKZ), a humanised IgG1 monoclonal antibody that selectively inhibits interleukin (IL)-17F in addition to IL-17A, was approved in Europe in 2021 for the treatment of moderate to severe plaque psoriasis.[1]

ELEVATE is a real-world study of adults with moderate to severe plaque psoriasis receiving BKZ in routine clinical practice across France, Germany, Greece, Italy and the UK, describing treatment history and other baseline (BL) patient characteristics, as well as clinical outcomes and patient-reported outcomes (PROs). Investigating patient characteristics helps to understand which patient populations are being prescribed BKZ and to assess differences in treatment patterns.

ELEVATE enrolled patients during the first ~2.5 years of BKZ availability in the included countries. Here, we present treatment history and BL characteristics of all enrolled patients.

Materials and Methods

ELEVATE is an ongoing, multicentre, prospective, observational study. Eligible patients were aged ≥18 years with moderate to severe plaque psoriasis, newly initiating BKZ in line with local label requirements. Clinical assessments at BL included Psoriasis Area and Severity Index (PASI), high-impact area (fingernail, scalp and palmoplantar) Physician's Global Assessment (PGA) and affected body surface area. PROs at BL were captured from patients directly via an app, including Dermatology Life Quality Index (DLQI) and all 14 items of the Psoriasis Symptoms and Impacts Measure (P-SIM) (range: 0 [none]–10 [very severe]).

This analysis was performed once enrolment was completed across all countries (data cut-off: 17th September 2025). Data are reported for the safety set, defined as all patients who received ≥1 BKZ dose.

Results

A total of 1,337 patients were enrolled (France: 167; Germany: 577; Greece: 222; Italy: 220; UK: 151). At BL, overall, 61.3% were male, and mean age and disease duration (standard deviation [SD]) were 47.6 (13.8) and 16.7 (13.5) years, respectively (**Table**). Mean (SD) PASI and DLQI scores were 14.5 (9.7) and 13.7 (7.7), respectively. All mean P-SIM item scores were ≥5; the items with the highest severity were skin dryness, redness and lesions. Among all patients, 84.1% had psoriasis in ≥1 high-impact area (fingernail, scalp and palmoplantar), and 68.5% were at high risk (≥2 risk factors) of psoriatic arthritis (PsA).

Demographics and BL characteristics were generally similar between countries, with some differences compared with the overall population (**Table**). Greek patients had a shorter mean disease duration (11.8 vs 16.7 years), and German/Greek patients had the highest rates of high-impact area involvement (91.5%/89.2% vs 84.1%). The proportion of patients at high risk of PsA ranged from 48.3–77.0% across countries.

Overall, 74.3% (993/1,337) of patients had a treatment history of systemic therapy, of which 54.2% (538/993) had previous biologic therapy (**Table**). Over half of all enrolled patients were biologic-naïve (59.5%; 796/1,337), making BKZ the first biologic therapy for most patients. The proportion of biologic-naïve patients was similarly high across German, French, Italian and Greek patients (range: 55.9–66.5%), with a lower rate in UK patients (44.4%).

Table. Baseline characteristics for patients in ELEVATE across European countries

	France N=167	Germany N=577	Greece N=222	Italy N=220	UK N=151	Overall N=1,337
Age (years), mean (SD)	47.4 (12.4)	46.0 (14.5)	52.6 (13.8)	47.6 (13.3)	46.8 (12.1)	47.6 (13.8)
Sex, male, n (%)	90 (53.9)	375 (65.0)	131 (59.0)	132 (60.0)	91 (60.3)	819 (61.3)
Weight (kg), mean (SD)[a]	85.4 (19.4)	91.2 (22.2)	86.1 (17.5)	80.1 (18.8)	94.7 (23.9)	88.2 (21.3)
BMI (kg/m^2), mean (SD)[b]	29.2 (5.9)	29.4 (6.5)	28.9 (5.9)	27.0 (5.6)	31.6 (7.1)	29.1 (6.4)
Disease duration (years), mean (SD)[c]	20.6 (13.8)	17.2 (13.9)	11.8 (12.3)	14.8 (12.8)	20.2 (12.0)	16.7 (13.5)
PASI score, mean (SD)[d]	13.3 (10.6)	14.3 (9.8)	14.4 (9.1)	15.6 (9.1)	15.3 (9.6)	14.5 (9.7)
≥10, n (%)	86 (51.5)	359 (62.2)	160 (72.1)	167 (75.9)	89 (58.9)	861 (64.4)
Missing, n (%)	7 (4.2)	12 (2.1)	1 (0.5)	3 (1.4)	21 (13.9)	44 (3.3)
BSA, n (%)						
0–<10%	54 (32.3)	137 (23.7)	35 (15.8)	36 (16.4)	18 (11.9)	280 (20.9)
≥10–<30%	70 (41.9)	279 (48.4)	131 (59.0)	92 (41.8)	64 (42.4)	636 (47.6)
≥30%	35 (21.0)	149 (25.8)	55 (24.8)	89 (40.5)	48 (31.8)	376 (28.1)
Missing	8 (4.8)	12 (2.1)	1 (0.5)	3 (1.4)	21 (13.9)	45 (3.4)
DLQI total score, mean (SD)[e]	12.0 (7.5)	14.1 (7.7)	13.9 (7.3)	11.9 (7.3)	16.8 (8.3)	13.7 (7.7)
>10 (very/extremely large effect on patient life), n (%)	81 (48.5)	334 (57.9)	134 (60.4)	116 (52.7)	95 (62.9)	760 (56.8)
Missing, n (%)	15 (9.0)	62 (10.7)	18 (8.1)	7 (3.2)	21 (13.9)	123 (9.2)
P-SIM score, mean (SD)[f]						
Skin redness	6.4 (2.7)	7.1 (2.5)	6.4 (2.3)	6.7 (2.6)	7.8 (2.1)	6.9 (2.5)
Skin lesions	6.6 (2.5)	6.7 (2.8)	6.7 (2.3)	7.1 (2.4)	7.8 (2.3)	6.9 (2.6)
Skin dryness	6.7 (2.7)	7.1 (2.4)	6.5 (2.4)	7.2 (2.4)	8.1 (1.9)	7.1 (2.4)
High-impact psoriasis, n (%)[g]	118 (70.7)	528 (91.5)	198 (89.2)	170 (77.3)	111 (73.5)	1,125 (84.1)
High-impact area PGA score ≥3 (moderate to severe severity), n (%)						
f-PGA	29 (17.4)	151 (26.2)	80 (36.0)	42 (19.1)	26 (17.2)	328 (24.5)
sc-PGA	54 (32.3)	287 (49.7)	132 (59.5)	79 (35.9)	54 (35.8)	606 (45.3)
pp-PGA	28 (16.8)	131 (22.7)	65 (29.3)	44 (20.0)	27 (17.9)	295 (22.1)
Comorbidities, n (%)[h]						
Suspected/confirmed PsA and/or spondyloarthritis	9 (5.4)	47 (8.1)	8 (3.6)	15 (6.8)	23 (15.2)	102 (7.6)
Anxiety or depression	13 (7.8)	42 (7.3)	16 (7.2)	12 (5.5)	26 (17.2)	109 (8.2)
Major adverse cardiac event	6 (3.6)	34 (5.9)	11 (5.0)	5 (2.3)	8 (5.3)	64 (4.8)
Metabolic syndrome	2 (1.2)	37 (6.4)	27 (12.2)	5 (2.3)	12 (7.9)	83 (6.2)
At high risk of PsA, n (%)[i]	106 (63.5)	426 (73.8)	171 (77.0)	140 (63.6)	73 (48.3)	916 (68.5)
Treatment history, n (%)						
Systemic-experienced	123 (73.7)	433 (75.0)	132 (59.5)	167 (75.9)	138 (91.4)	993 (74.3)
Systemic-naïve	44 (26.3)	144 (25.0)	90 (40.5)	50 (22.7)	13 (8.6)	341 (25.5)
Biologic-experienced	56 (33.5)	224 (38.8)	80 (36.0)	94 (42.7)	84 (55.6)	538 (40.2)
Biologic-naïve	111 (66.5)	353 (61.2)	142 (64.0)	123 (55.9)	67 (44.4)	796 (59.5)
Biologic-naïve, systemic-experienced	67 (40.1)	209 (36.2)	52 (23.4)	73 (33.2)	54 (35.8)	455 (34.0)
Missing	0 (0.0)	0 (0.0)	0 (0.0)	3 (1.4)	0 (0.0)	3 (0.2)

[a] France: N=157, Germany: N=566, Greece: N=222, Italy: N=216, UK: N=149; Overall: N=1,310; [b] France: N=151, Germany: N=566, Greece: N=222, Italy: N=215, UK: N=148; Overall: N=1,302; [c] France: N=166, Germany: N=573, Greece: N=222, Italy: N=220, UK: N=147, Overall: N=1,328; [d] France: N=160, Germany: N=565, Greece: N=221, Italy: N=217, UK: N=130, Overall: N=1,293; [e] France: N=152, Germany: N=515, Greece: N=204, Italy, N=213, UK: N=130, Overall: N=1,214; [f] P-SIM items with highest mean severity score at baseline in the overall patient group; France: N=153, Germany: N=534, Greece: N=207, Italy: N=214, UK: N=129, Overall: N=1,237; [g] Presence of psoriasis in ≥1 high-impact area (fingernail, scalp and palmoplantar) with a PGA score >0; [h] Based on any previous and ongoing medical conditions that occurred prior to first BKZ dose; [i] Patients with ≥2 selected risk factors for PsA, including: BMI >30 kg/m2; f-PGA ≥2; sc-PGA ≥2; PASI >20 or ≥3 regions involved in PASI score; excludes patients with reported psoriatic arthropathy, ankylosing spondylitis, rheumatoid arthritis or polyarthritis. BL: baseline; BMI: body mass index; BSA: body surface area; DLQI: Dermatology Life Quality Index; f-PGA: fingernail-specific PGA; PASI: Psoriasis Area and Severity Index; PGA: Physician's Global Assessment; pp-PGA: palmoplantar-specific PGA; PsA: psoriatic arthritis; P-SIM: Psoriasis Symptoms and Impacts Measure; sc-PGA: scalp-specific PGA; SD: standard deviation; UK: United Kingdom.

Conclusions

BL characteristics of patients receiving bimekizumab in routine clinical practice were broadly similar across countries and representative of moderate to severe plaque psoriasis, with some differences in disease duration, high-impact area involvement and risk of PsA. Although differences between countries might be influenced by individual countries' healthcare system specifications, overall, the majority of patients in ELEVATE were biologic-naïve prior to initiating bimekizumab treatment, reflecting the real-life readiness for positioning bimekizumab early in the treatment pathway.

References

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Abstract N°: 2340

Methotrexate-Induced Sexual Dysfunction: An Underrecognized Complication

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Introduction

Methotrexate (MTX) is a widely used systemic therapy in dermatology. The most frequently reported adverse effects include nausea, fatigue, and stomatitis. We report a case of erectile dysfunction occurring in a patient treated with MTX for extensive psoriasis vulgaris.

Materials and Methods

A 56-year-old man with a history of untreated hypertension and localized psoriasis vulgaris since the age of 27 presented with a one-month history of disease exacerbation and extension of cutaneous lesions.
Oral methotrexate was initiated at a dose of 10 mg/week, resulting in significant clinical improvement.
Six weeks after treatment initiation, the patient reported decreased libido associated with erectile dysfunction.
Urological examination and prostate–vesico–renal ultrasound revealed no abnormalities.
Given the favorable dermatological response, MTX was discontinued. Three weeks after treatment withdrawal, the patient reported full recovery of sexual function.

Results

Methotrexate has been considered a first-line systemic treatment for moderate to severe psoriasis for nearly five decades. Commonly reported adverse effects include ulcerative stomatitis, nausea, abdominal pain, and leukopenia. In contrast, erectile dysfunction and decreased libido remain rarely described in the literature.
In our case, sexual dysfunction developed six weeks after MTX initiation. This timeframe is consistent with the findings reported by Theodosiou et al., who observed that erectile dysfunction may occur within weeks of starting therapy and typically resolves within three to four weeks after discontinuation. Another case described sexual dysfunction occurring after nine months of MTX therapy in a patient treated for erythroderma, suggesting variable latency.
The exact pathophysiological mechanism underlying MTX-associated erectile dysfunction remains unclear. Proposed hypotheses include pituitary dysfunction secondary to interleukin-1 inhibition and impaired nitric oxide (NO) production, leading to reduced smooth muscle relaxation and compromised erectile function.

Conclusions

We report a case of methotrexate-induced erectile dysfunction in a patient with psoriasis. Although rare, this adverse effect warrants systematic assessment of sexual

function during follow-up of patients receiving MTX therapy.

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Rupioid psoriasis in a patient with chronic kidney disease: a rare clinical presentation with multifactorial aetiology

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Introduction

Rupioid psoriasis is a rare variant of chronic plaque psoriasis characterised by conical lesions covered with thick, adherent, lamellated crusts resembling oyster shells. We report the case of a patient presenting with this unusual clinical pattern in the context of chronic kidney disease.

Case Presentation

A 64-year-old woman with a history of arterial hypertension treated with an angiotensin-converting enzyme inhibitor and chronic kidney disease, and with no personal or family history of psoriasis, presented with the abrupt onset—three months earlier—of two well-demarcated, conical psoriasiform plaques located on the back and the thigh. These lesions were covered with thick, dark, adherent, lamellated crusts, giving a characteristic rupioid "oyster-shell" appearance. In addition, erythematous scaly drop-like lesions were observed on the limbs. There was no palmoplantar keratoderma, nail involvement, or psoriatic arthritis.

Serological tests for HIV and syphilis were negative. Skin histology revealed psoriasiform epidermal hyperplasia with elongation of rete ridges, thinning of the suprapapillary plates, compact parakeratosis, and Munro–Sabouraud microabscesses. The dermis showed a lymphocytic infiltrate with dilated and tortuous vessels. These histopathological findings were consistent with chronic plaque psoriasis.

Conclusion

This case highlights a rare and atypical presentation of psoriasis, in which the rupioid morphology necessitates a broad differential diagnosis, including secondary syphilis, crusted scabies, and deep fungal infections. The pathophysiology of this unusual presentation appears to be multifactorial.

First, chronic kidney disease may induce a state of immunosuppression that facilitates the emergence or phenotypic transformation of inflammatory dermatoses such as psoriasis. This hypothesis is supported by similar cases reported in immunocompromised patients, particularly those with HIV infection or receiving immunosuppressive therapies such as anti-PD-1 agents.

Second, several studies have suggested an independent association between reduced glomerular filtration rate, proteinuria, and the occurrence of psoriasis, indicating a potential direct pathophysiological link between renal impairment and cutaneous inflammation.

Finally, certain antihypertensive medications—particularly β-blockers and angiotensin-converting enzyme inhibitors, both prescribed in this patient—are well documented as potential triggers or exacerbating factors for psoriasis.

This atypical presentation should prompt clinicians to investigate the presence of an immunocompromised state

such as CKD, exposure to psoriasis-inducing medications, or the coexistence of both factors.

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Diagnostic performance of liver fibrosis markers in patients with psoriasis treated with methotrexate.

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Introduction

Methotrexate (MTX) remains a cornerstone treatment for psoriasis, but concerns persist regarding liver fibrosis. Non-invasive biomarkers are widely used for screening for fibrosis or cirrhosis; however, their diagnostic performance in this population is uncertain. We therefore conducted a cross-sectional study evaluating the performance of Fib-4 and P3NP, individually and in combination, for detecting advanced liver fibrosis and cirrhosis in MTX-treated patients with psoriasis.

Materials and Methods

In 2024, we measured P3NP and Fib-4 semi-annually in all MTX-treated patients with psoriasis at a hospital outpatient clinic. Patients with Fib-4 >1.3 underwent Enhanced Liver Fibrosis (ELF) testing, and those with elevated ELF were referred to transient elastography (FibroScan). One author (TSP) reviewed the patients' medical records for patient characterization and captured test results in REDCap v16.1.4. We calculated the diagnostic performance (sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV)) for Fib-4 (>2.67), P3NP (>10 µg/L), and combined "OR" (either positive) and "AND" (both positive) criteria. We used advanced fibrosis/cirrhosis confirmed by FibroScan as the gold standard. We performed analyses using STATA v18.

Results

We initially assessed 342 MTX-treated psoriasis patients. 184 were excluded, mainly due to missing Fib-4 and/or P3NP data (n=180) or alternative diagnoses (n=4).

The final study population comprised 158 patients with complete Fib-4 and P3NP measurements**.** Among these, 134 patients did not undergo FibroScan evaluation. Within this group, 131 (97.8%) patients had normal Fib-4 and P3NP levels, while two patients had elevated biomarkers but did not undergo FibroScan due to advanced age (>90 years). One patient was already diagnosed with cirrhosis. A total of 24 patients underwent FibroScan assessment. Of these, 15 patients had normal liver findings, whereas nine patients were found to have liver fibrosis or cirrhosis.

The study population had a median age of 52 year and consisted of 48.7% female. Those who underwent FibroScan (n=24) consisted of 58.3% females and the majority were in the age range of 61-80 years (66.7%). Overall, obesity (BMI ≥30) was present in 41.7%, 8.3% reported alcohol intake >10 units/week, and 37.5% were former or current smokers. Common comorbidities included hypertension (35.4%), dyslipidemia (66.7%), and type 2 diabetes (25.0%). Advanced fibrosis/cirrhosis was identified in 9/24 (37,5%) patients, indicating a low-prevalence setting.

Fib-4 showed low sensitivity (22.2%) and moderate specificity (80%). P3NP had higher sensitivity (55.6%) but low specificity (33.3%). The presence of P3NP>10 ug/L *OR* Fib-4 >2.67 improved sensitivity to 66.7% but reduced specificity to 26.7%, whereas the presence of P3NP>10 ug/L *AND* Fib-4 >2.67 improved specificity (86.7%) but markedly reduced sensitivity (11.1%). As expected in a low-prevalence population, PPV were low across all strategies (table 1).

Table 1. Diagnostic performance of Fib-4 and P3NP among 25 patients with elevated ELF test referred to FibroScan (reference standard)

Marker	TP	FP	FN	TN	Sensitivity	Specificity	PPV	NPV
Fib-4 >2.67	2	3	7	12	22.2%	80.0%	40.0%	63.2%
P3NP >10 ug/L	5	10	4	5	55.6%	33.3%	33.3%	55.6%
P3NP>10 ug/L *OR* Fib-4 >2.67	6	11	3	4	66.7%	26.7%	35.3%	57.1%
P3NP>10 ug/L *AND* Fib-4 >2.67	1	2	8	13	11.1%	86.7%	33.3%	61.9%

ELF, Enhanced Liver Fibrosis; Fib-4, Fibrosis-4; FN, false negative; FP, false positive; NPV, negative predictive value P3NP, procollagen type III N-terminal peptide; PPV, positive predictive value; TN, true negative; TP true positive.

Conclusions

Fib-4 and P3NP show limited diagnostic performance for detecting advanced liver fibrosis in MTX-treated psoriasis patients. Although the presence of P3NP>10 ug/L *OR* Fib-4 >2.67 improves sensitivity, it still misses approximately 30% of cases, which is suboptimal for screening purposes, and it generates a high false-positive rate. The presence of P3NP>10 ug/L *AND* Fib-4 >2.67 increased specificity but is unsuitable for screening due to very low sensitivity.

These findings question the clinical utility of these biomarkers as standalone screening tools for routine MTX monitoring. Interpretation is limited by the sequential testing strategy with partial verification by FibroScan, which may overestimate sensitivity, and by inclusion of prevalent MTX users, potentially introducing selection and healthy-adherer bias. Larger studies including MTX initiators, data on treatment duration, and systematic fibrosis assessment are warranted.

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Abstract N°: 2371

Comparative Effectiveness of Biologic Therapies for Moderate-to-Severe Plaque Psoriasis: A Network Meta-Analysis Including Bimekizumab

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Introduction
Moderate-to-severe plaque psoriasis affects approximately 2–3% of the global population, characterized by red, scaly plaques covering more than 10% of body surface area, causing substantial impairment in quality of life. Multiple biologic agents targeting tumor necrosis factor-alpha, interleukin-12/23, interleukin-17, and interleukin-23 pathways are available. Most prior network meta-analyses predate bimekizumab approval and lack head-to-head comparisons incorporating this agent alongside contemporary biologic therapies. This study aimed to compare the relative efficacy of bimekizumab, secukinumab, risankizumab, guselkumab, adalimumab, and ustekinumab and establish a current treatment efficacy hierarchy.

Materials and Methods
A systematic review and frequentist random-effects network meta-analysis was conducted following PRISMA 2020 guidelines and registered with PROSPERO (CRD420251148352). PubMed and ClinicalTrials.gov were searched to identify phase III randomized controlled trials in adults with moderate-to-severe plaque psoriasis. The primary outcome was PASI 90 — a 90% or greater reduction in Psoriasis Area and Severity Index from baseline — at week 16. Odds ratios with 95% confidence intervals and P-scores were calculated using the netmeta package in R. Risk of bias was assessed using the Cochrane Risk of Bias 2 tool. Consistency between direct and indirect evidence was evaluated using the SIDE approach.

Results
Eleven phase III RCTs (10 datasets, 6,657 patients) were included, all demonstrating low risk of bias. All active treatments demonstrated significant superiority over placebo. The efficacy hierarchy was: bimekizumab (OR 170.04, 95% CI 104.33–277.14, P-score 0.00), risankizumab (OR 95.40, 95% CI 59.97–151.74, P-score 0.21), guselkumab (OR 82.25, 95% CI 51.23–132.03, P-score 0.35), secukinumab (OR 75.01, 95% CI 45.37–124.02, P-score 0.44), adalimumab (OR 30.07, 95% CI 19.16–47.18, P-score 0.71), and ustekinumab (OR 26.68, 95% CI 16.48–43.20, P-score 0.79). Bimekizumab demonstrated statistically significant superiority over all active comparators. Risankizumab and guselkumab showed comparable efficacy to each other (OR 1.16, 95% CI 0.81–1.64). Global network heterogeneity was very low (I^2=0.0%), and no significant inconsistency was detected in any comparison.

Conclusions
Bimekizumab achieves the highest PASI 90 efficacy among currently available biologic therapies. Risankizumab, guselkumab, and secukinumab form a cluster of highly effective treatments substantially superior to adalimumab and ustekinumab. The exceptionally low heterogeneity and absence of inconsistency strengthen confidence in these findings. Treatment selection should integrate efficacy with dosing convenience, safety profiles, and

individual patient circumstances including comorbidities.

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Abstract N°: 2375

Quality of life shifts over 15 years in 20,178 patients enrolled in the German psoriasis registry PsoBest

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Introduction

The German psoriasis registry PsoBest has been systematically collecting long-term real-world data on treatment effectiveness, safety, and patient-reported outcomes since 2008. The Dermatology Life Quality Index (DLQI) is routinely assessed as a key indicator of health-related quality of life (HRQoL) in over 2,000 studies worldwide. The objectives of this study are to examine temporal effects in DLQI outcomes between 2008 and 2023, to explore demographic and clinical determinants of HRQoL (shifts), and to evaluate the implications of methodological refinements such as the DLQI-R scoring system.

Materials and Methods

All patients with psoriasis enrolled in PsoBest from 2008 to 2023 were included. DLQI total and item-level scores were analyzed overall and within subgroups stratified by age, gender, disease duration, psoriatic arthritis, and treatment experience. In addition, the DLQI-R was calculated, which corrects the standard DLQI for potential underestimation due to “not relevant” responses.

Results

A total of 20,178 patients were observed, including 42% female, with a mean age of 48 ± 15 years, disease duration 17 ± 15 years, PASI 15.2 ± 10.3, DLQI 11.9 ± 7.3, EQ-VAS 58 ± 22, and psoriatic arthritis in 21%. Mean total DLQI at baseline increased from 11.4 in 2008 to 13.0 in 2023. Items 1 (Symptoms) and 2 (Feelings) contributed most significantly to the total DLQI score: 66% and 56% with “high impairment”. Higher DLQI values were observed among younger and female participants. A notable proportion (up to 20%) of participants used the possibility to rate items 3–10 as “not relevant”, with higher rates in female patients. The mean DLQI-R in the overall population was 9.2% higher than the standard DLQI.

Conclusions

Fifteen years of PsoBest data highlight evolving patterns of HRQoL in psoriasis and underscore the need to employ additional instruments for comprehensive disease burden measurement. The importance of accounting for “not relevant” responses to ensure the validity of DLQI is reinforced.

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Abstract N°: 2394

Acrodermatitis continua of Hallopeau: a rapid response to IL-17A/F inhibition

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Introduction

Acrodermatitis continua of Hallopeau (ACH) is a rare, chronic variant of pustular psoriasis characterized by sterile pustules affecting the nail apparatus, often leading to progressive nail dystrophy and possible irreversible destruction of the nail matrix. Due to its clinical resemblance to bacterial or fungal infection, ACH is frequently misdiagnosed, resulting in delayed initiation of appropriate therapy. We report a case of ACH with severe nail involvement and delayed diagnosis, successfully treated with bimekizumab.

Case Presentation

A 63-year-old woman presented with a 1.5-year history of progressive nail dystrophy predominantly affecting the great toenails, associated with erythema, hyperkeratosis, and purulent discharge. The condition had initially been misdiagnosed as an infection by her primary physician, leading to repeated surgical nail avulsions and multiple courses of antibiotic therapy without clinical improvement, followed by further deterioration.

Dermatological examination revealed marked involvement of the great toenails with nail plate dystrophy and inflammation of the hyponychium (Figure 1). Additional findings included psoriatic plaques on the scalp and lower legs, as well as fingernail involvement with onycholysis and splinter hemorrhages. Mycological testing and bacterial cultures were negative. Although overall skin involvement was limited (BSA ≈ 3%), the disease had a significant functional and psychological impact (NAPSI > 10, DLQI 27).

Given the severity of nail involvement, the risk of irreversible nail matrix damage, and the anticipated poor and delayed response to conventional systemic therapies, treatment with the IL-17A/F inhibitor bimekizumab was initiated. After three months, marked clinical improvement was observed, with resolution of inflammation and purulent discharge (Figure 2). The great toenails remained thickened and distally brittle at the first follow-up visit, but without signs of active inflammation. The fifth toenails were still thickened. Overall, there was substantial recovery of the affected nails.

Discussion

ACH represents a severe and potentially destructive form of pustular psoriasis involving the nail unit and is considered an “onychopathic emergency”. Delayed recognition and treatment may lead to complete destruction of the nail matrix and, in advanced cases, even osteolysis of the affected distal phalanx. Management remains challenging due to the rarity of the condition and the absence of standardized treatment guidelines. Conventional therapies, including retinoids and methotrexate, are commonly used but show delayed and often limited efficacy. Recent evidence highlights the central role of the IL-17 pathway in pustular psoriasis variants. Bimekizumab, a monoclonal antibody targeting both IL-17A and IL-17F, provides dual inhibition of this pathway and represents a novel therapeutic option with rapid onset of action, high efficacy, and a favorable safety profile. This is further supported by our case, which demonstrates a marked and rapid clinical response in a difficult-to-treat location

such as the nail apparatus.



Figure 1: Marked involvement of the great toenails with nail plate dystrophy, pustules and severe inflammation of the hyponychium and paronychia.

Conclusion

Early recognition of ACH is essential to avoid unnecessary procedures and prevent irreversible damage to the nail unit. This case supports bimekizumab as an effective and well-tolerated therapeutic option, capable of inducing rapid and clinically meaningful improvement in severe nail involvement.

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Abstract N°: 2412

Incident psoriasis in atopic dermatitis: A large-scale cohort study of disease- and treatment-associated risks

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Introduction

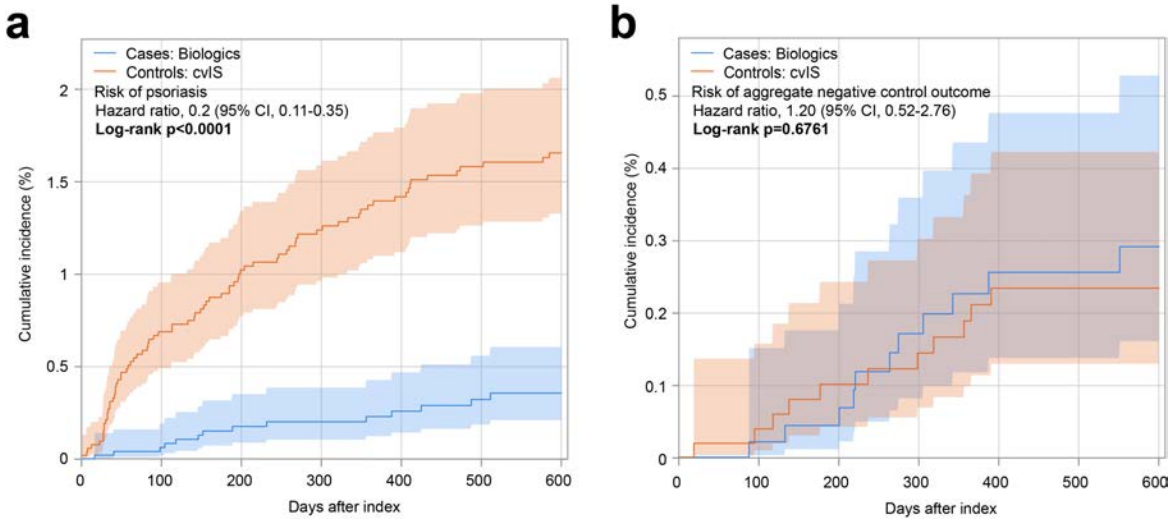
Clinical and genetic evidence on the association between atopic dermatitis (AD) and subsequent psoriasis remains conflicting, and it is unclear whether this risk is modified by systemic treatments. Recent reports suggest type 2-targeted biologics may unmask psoriasis in AD patients, but data are limited. We thus aimed to assess whether AD is associated with incident psoriasis and whether this risk differs by systemic treatment, particularly biologics versus conventional systemic immunosuppressants (cvIS).

Materials and Methods

Scoping analyses informed a locked analytic design, preregistration at OSF, and confirmatory execution. Propensity score–matched analyses compared AD with non-AD controls and biologics with cvIS. Sensitivity analyses, Cox model triangulation, and control outcomes assessed robustness.

Results

Among ~300,000 matched pairs, AD was associated with increased psoriasis risk (primary HR 3.81, 95% CI 3.35-4.34), consistent across all 8 sensitivity analyses and model triangulation. Biologic treatment was associated with reduced psoriasis risk versus cvIS (primary HR 0.20, 95% CI 0.11–0.35), consistent across 6 of 7 evaluable sensitivity analyses and Cox triangulation. Positive and negative control outcomes showed expected directional patterns.



Kaplan-Meier analyses of psoriasis vulgaris and aggregate negative control outcomes in patients with atopic dermatitis (AD) treated with biologics versus conventional systemic immunosuppressants (cvIS). (a) Cumulative incidence of psoriasis vulgaris. Biologic therapy was associated with a lower cumulative incidence of psoriasis vulgaris than cvIS (HR, 0.20; 95% CI, 0.11–0.35; log-rank p<0.0001). (b) Cumulative incidence of the aggregate negative control outcome. No association was observed between treatment group and the aggregate negative control outcome (HR, 1.20; 95% CI, 0.52–2.76; log-rank p=0.6761). Shaded areas indicate 95% confidence intervals. Curves are displayed according to Kaplan-Meier convention, with the last observed survival probability carried forward until the next event or censoring.

Conclusions

Acknowledging limitations including residual confounding and coding misclassification, AD was associated with increased psoriasis risk and biologics with lower psoriasis risk than cvIS.

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Abstract N°: 2426

zPASI: A novel and improved version of the PASI score

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Introduction

Psoriasis Area and Severity Index (PASI) is the gold standard for quantifying disease activity in patients with plaque psoriasis. The calculation of PASI is dependent on the rater's subjective assessment of area involvement, scaling, erythema and induration (of head/neck, torso, arms and legs). Area involvement is encoded into an ordinal scale (0-6). In cases where area score lies on the border between two values in the ordinal scale inter-rater variability is a concern. PASI score will not be sensitive to small area changes within the range of an ordinal area score. To address these problems we have developed a modified PASI score, zPASI.

zPASI recodes area scores into continuous variables similar to the PASI-HD score but encompassing the whole PASI range 0-72. We aimed to investigate if zPASI would provide smaller inter-rater disease assessment variability. A secondary aim was to investigate if patients themselves can assess disease activity reliably using a digital tool.

Materials and Methods

In this ongoing international multicenter study, 63 patients have been recruited in psoriasis clinics so far (between February and March 2026). An open-source digital tool, PsoCalc, was developed which assesses PASI, zPASI, and Body Surface Area (BSA). The patients were shown an instruction video on how to assess their disease activity with PsoCalc. The patient, as well as two independent healthcare professionals (nurses, medical doctors, or medical students) assessed the patient's disease activity using PsoCalc. The raters were blinded to each other's assessments. The affected area score was estimated using the palmar method where the palm, excluding the digits, is considered to correspond to 0.5% of the total BSA. For zPASI calculations the conventional 0-6 area score was replaced by a value derived from an equation (Table 1).

PASI calculation		zPASI calculation	
Affected area of body site (a%)	**Area score of affected body site**	**Affected area of body site (a%)**	**Area score of affected body site**
0%	0	0%	0
1-9%	1	1-9%	(1/9 x a%)
10-29%	2	10-29%	1 + (1/20 x (a% - 9))
30-49%	3	30-49%	2 + (1/20 x (a% -29))
50-69%	4	50-69%	3 + (1/20 x (a% - 49))
70-89%	5	70-89%	4 + (1/20 x (a% - 69))
90-100%	6	90-100%	4 + (1/20 x (a% - 69))

Table 1. Calculation of area score of affected body site for PASI (left) and zPASI (right), where a% corresponds to the body surface area affected by psoriasis vulgaris for a particular body region

Results

Inter-rater variability assessment healthcare professionals PASI vs zPASI

Data was collected from 63 patients. Approximately 75% of patients (n=47) had scores of 5 or lower in PASI according to all 3 raters. Data is presented as mean ± standard deviation [95% confidence interval]. There was a statistically significant difference between the Δassessment of healthcare professionals for ΔPASI 0.81±0.78 [0.61-1.00] and ΔzPASI 0.48±0.66 [0.31-0.64] ($p<0.001$) (Figure 1).

Patients' self-assessments vs Healthcare professionals

For PASI there was a statistically significant intraclass correlation of 0.73 [95% confidence interval 0.59-0.83], $p<0.001$, Cronbach's alpha 0.85.

For zPASI there was a statistically significant intraclass correlation of 0.70 [95% confidence interval 0.53-0.80], $p<0.001$, Cronbach's alpha 0.82.

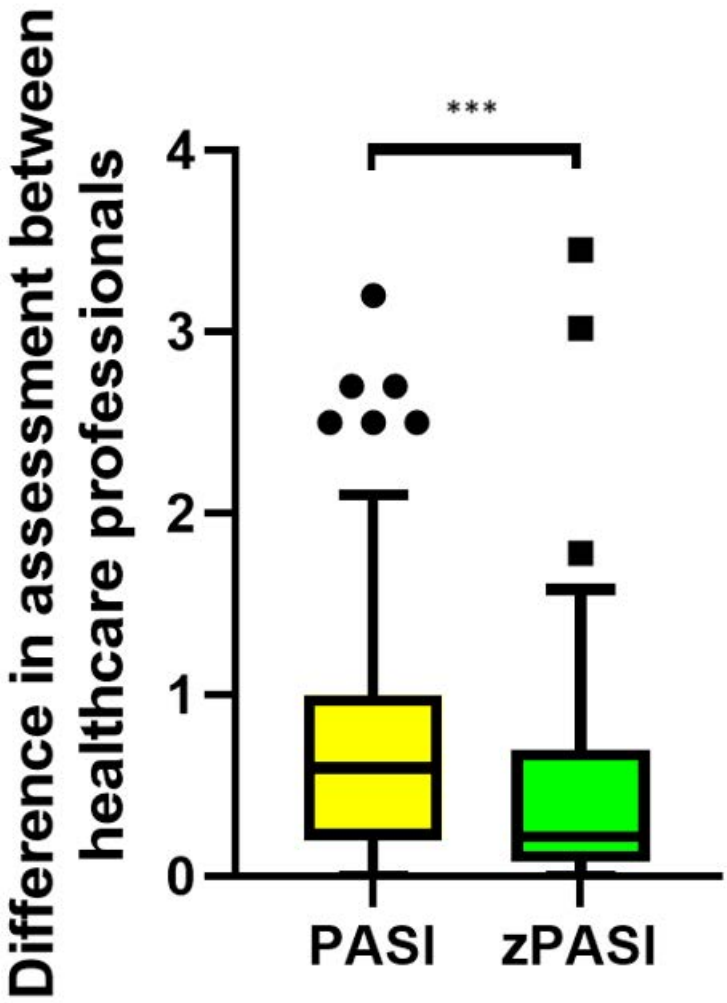

Figure 1. Box plot of the absolute difference in assessment between two healthcare professionals when assessing PASI (left) and zPASI (right). (***t-test, p<0.001).

Conclusions

Our findings suggest that there is a lower inter-rater variability between healthcare professionals when using zPASI to assess patients' disease activity compared to PASI. The main limitation of this study is the relatively small sample size which will be improved given that the current data are preliminary from an ongoing study. Given the generally low PASI scores in this cohort, our findings suggest that zPASI may provide more reliable results than PASI in patients with low disease activity. Furthermore, patients' self assessment with PASI and zPASI show similar results. Patients' self-assessments have a good correlation with healthcare professionals' assessments and "moderate" to "good" inter-rater reliability with PASI showing marginally higher intraclass correlation.

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Abstract N°: 2446

Successful Treatment of Psoriasis with Guselkumab in a Patient after Allogeneic Haematopoietic Stem Cell Transplantation

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Introduction

A 37-year-old male patient was diagnosed with acute lymphoblastic leukemia (ALL) in 2005, and underwent allogeneic hematopoietic stem cell transplantation (HSCT) from an unrelated donor the following year. The clinical course was subsequently complicated by graft-versus-host disease (GvHD), hypergonadotropic hypogonadism, and the development of chronic lymphocytic thyroiditis.



At initial presentation

Case Presentation

Since 2006, the patient had been receiving systemic methotrexate (MTX) therapy for haemato-oncological indication. In 2018, he developed psoriasis and psoriatic arthritis despite negative family history of psoriasis disease. MTX therapy was continued; however, resulted in hepatopathy and toxic renal impairment. MTX was therefore discontinued in March 2024, followed by significant exacerbation of both - psoriasis and joint pain.

Phototherapy was not considered an optimal treatment option because of poor tolerance related to the patient's skin phototype I and the increased risk of cutaneous malignancies associated with prior ALL and HSCT.

At our initial examination in May 2024, the patient presented with disseminated nummular to geographic erythematous plaques on the trunk and extremities, markedly infiltrated and covered with scales (Fig. 1). Diffuse

erythema with desquamation was also present on the scalp (PASI 13.8, DLQI 15).

Following consultation with hematologists and rheumatologists regarding the initiation of biologic therapy, agents from the IL-17 and IL-23 inhibitor classes were considered the most appropriate therapeutic options, therefore the patient was started on guselkumab. A significant improvement of psoriatic lesions (Fig. 2) as well as joint symptoms was observed already after the second administration and four months following guselkumab initiation, complete skin clearance (Fig. 3) and resolution of joint pain were achieved. To date, treatment remains effective and well tolerated, with no reported adverse effects.



After second dose of guselkumab

Conclusion

To the best of our knowledge, this is the first reported case of successful guselkumab therapy in a patient with psoriasis and history of allogeneic HSCT for ALL. This case report therefore represents an important contribution

to the therapeutic management of patients with a haemato-oncological history.



Four months after guselkumab introduction

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Abstract N°: 2460

The German Psoriasis Register PsoBest: Current status, patient characteristics and implications for healthcare

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Introduction

The German psoriasis registry PsoBest is a prospective, standardised, protocol-driven collection of patient data from routine care. The aim is to generate long-term real-world evidence on the effectiveness, safety, and patient-related outcomes of systemic therapies, as well as on the quality of drug utilisation for patients with psoriasis in Germany in a real-world setting.

Materials and Methods

Since 2008, PsoBest enrolles adult patients (≥18 years) with a confirmed diagnosis of psoriasis vulgaris, with or without psoriatic arthritis, who are initiating a systemic therapy and have provided written informed consent. Patients are enrolled according to predefined inclusion and exclusion criteria and with appropriate ethical approval. Patients are prospectively followed for up to ten years. Data collection includes clinical parameters such as the Psoriasis Area and Severity Index (PASI) and patient-reported outcomes such as the Dermatology Life Quality Index (DLQI), as well as comorbidities, concomitant medications and detailed treatment information. Comprehensive pharmacovigilance data are recorded, including both serious and non-serious adverse events, as well as events of special interest. Treatment switches, interruptions, and combination therapies are documented throughout the observation period, enabling longitudinal analyses under real-world conditions.

Results

By March 2026, a total of 26,783 patients had been enrolled at 1,208 sites across Germany, reflecting the widespread availability of dermatological care. The majority of sites were dermatological practices (93.0 %), while outpatient hospital clinics accounted for the remaining 7.0 % of sites and 15.0 % of initial patient enrolments, indicating the contribution of specialised care settings. As of 30 June 2025, quality-assured data was available for 21,110 patients. The mean age was 47.5 years, with 58.5 % of patients being male. At baseline, the mean disease duration was 17.0 years, with joint involvement in 21.2 % of patients and nail psoriasis in 46.3 %, underlining the chronic and multifaceted nature of the disease. The disease burden was high, as reflected by a mean PASI score of 15.2 and a mean DLQI score of 12.0. A clinically relevant impairment in quality of life (DLQI score >5) was shown

by 77% of patients. While patients are allowed to switch treatments, a total of 25,655 patient-years were documented for biologics and biosimilars, and 27,250 for non-biologic therapies, demonstrating the wide range of systemic treatment strategies employed in routine care. A total of 27,090 non-serious adverse events were reported in 7,865 (37.3%) patients. Additionally, 14,414 serious adverse events, including medical procedures, were reported in 2,815 (13.3%) patients. The observed safety profile was consistent with that reported in clinical trials, and no new safety signals were identified. PASI and DLQI values decreased over time, indicating sustained effectiveness in a real-world setting. Registry data are widely used to inform healthcare research, as well as regulatory and clinical decision-making.

Conclusions

PsoBest is the largest dermatological registry in Germany and continues to grow steadily. It provides comprehensive and robust real-world evidence on the effectiveness, safety, and patient benefits of systemic psoriasis therapies. The registry enables detailed analyses of healthcare provision, both independently and in collaboration with other national and international registries, and supports decision-making in the areas of clinical practice, regulation and health policy. PsoBest makes a substantial contribution to the quality assurance and continuous optimisation of psoriasis care in Germany. The registry's success is based on the long-standing commitment of the project group, continuous support from funding partners, the engagement of participating centres, and sustained patient willingness to contribute data.

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Abstract N°: 2472

Neuro-metabolic-inflammatory crosstalk in psoriasis: correlations between leptin/depression and visfatin/anxiety, and changes of psychological and molecular parameters under biological therapy.

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Introduction

Psoriasis is an immune-mediated inflammatory skin disease, frequently associated with metabolic and psychiatric comorbidities. This study aimed to evaluate psychological, metabolic, and molecular parameters in adult patients with psoriasis before starting biologic therapy and to examine the impact of 16 weeks (W16) of biologic treatment on these parameters.

Materials and Methods

An observational, longitudinal study was conducted, recruiting 47 adult patients with psoriasis. At baseline (T0) and after W16 of biologic therapy (anti-IL-17/23), the following data were collected clinical as severity assessed by Psoriasis Area and Severity Index (PASI) and body composition evaluated by Bioelectrical Impedance Analysis (BIA); Psychological assessment, including the Perceived Stress Scale (PSS-10), Hospital Anxiety and Depression Scale (HADS-A/D), Body Perception Questionnaire—Short Form (BPQ-SF), Body Weight, Image and Self-Esteem Evaluation Questionnaire (B-WISE), Personality Inventory, and Dermatology Life Quality Index (DLQI); Molecular parameters, serum levels of adipokines as visfatin, leptin, adiponectin and pro-inflammatory cytokines as TNF-alpha, INF-γ, IL-6, IL-1β, IL-(17) and IL-(23).

Results

The 57.4% of patients were overweight/obese (BMI ≥25), 61.7% had a severe impact on quality of life (QoL) (DLQI ≥10), and there was a high prevalence of anxiety symptoms (HADS-A ≥8), depression symptoms (HADS-D ≥8), and perceived stress (PSS 27-40 scores). The higher HADS-D scores showed significantly increased BMI and markedly higher leptin levels, solidifying the connection between depression and metabolic dysregulation. Furthermore, higher HADS-A scores were associated with significantly lower visfatin (eNAMPT) levels, an adipokine with a known pro-inflammatory role and strong implications for modulating brain functions and NAD+/NADH metabolism. Also, High anxiety scores are associated with higher somatic reactivity, suggesting that increased anxiety symptoms may deplete or down-regulate this adipokine involved in the NAD+/SIRT1 pathway. High levels of stress were associated with markedly higher IL-6 levels, and a moderate positive correlation was found between the personality trait Neuroticism and IL-6 levels, confirming the link between vulnerability to stress and systemic inflammatory activation. Greater subdiaphragmatic reactivity (e.g., digestive symptoms/bloating)

was positively correlated with TNF-α levels, suggesting a psychosomatic-inflammatory link. Biological treatment resulted in highly significant improvements in clinical, psychological, and molecular parameters. High baseline leptin levels predicted a lack of complete clinical response (PASI 100) at 16 weeks (94.1 vs 31.4 ng/mL, p=0.027).

Conclusions

This study showed the significant association between psoriasis, systemic inflammation, metabolic changes, and significant psychological implications. The association between elevated anxiety and reduced visfatin and between depression and hyperleptinemia highlights the neuro-metabolic-inflammatory cross-talk. This study suggests the need for increased translational research studies for an integrated therapeutic approach that takes into account the inflammatory and psychological components in psoriatic patients based on a specific clinical subgroup, “Psycho-Metabolic Phenotype”, high leptin levels and BMI identify a specific clinical subgroup, linking metabolic resistance to depression in psoriasis; Visfatin-Anxiety Axis; Stress and systemic IL-6 as an inflammatory driver that predicts a more aggressive immune profile, mediated by TNF-α. Psoriasis, as a complex immune-metabolic and multidimensional network disorder, should be managed through pharmacological synergy, integrated care, and biomarker-driven personalized medicine, in which the skin, brain, and adipose tissue are considered as a single interconnected therapeutic target.

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Abstract N°: 2493

Impact of Psoriasis as a Variable on Valvular Immune Cell Infiltration in Patients with Hypertension

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Introduction

Psoriasis (PSO) is a chronic systemic inflammatory disease associated with an increased risk of cardiovascular disorders, including aortic valve disease. Previous studies suggest that psoriasis may promote valvular inflammation and fibrosis through immune-mediated mechanisms. However, the specific impact of psoriasis, as a variable, on immune cell infiltration in the aortic valves of patients with hypertension (HT) remains unclear. This study utilized single-cell RNA sequencing (scRNA-seq) to compare cellular heterogeneity in aortic valve tissues between patients with psoriasis-associated aortic valve disease and those with hypertension alone, with a focus on the effects of psoriasis on immune cell infiltration and subtype characteristics.

Materials and Methods

A total of six aortic valve tissue samples were included, comprising three from patients with psoriasis and three from patients with hypertension. Single cells were captured using the BD Rhapsody platform and sequenced on the NovaSeq system, yielding approximately 27,795 cells (15,236 from the psoriasis group and 12,559 from the hypertension group). Dimensionality reduction and clustering were performed using Uniform Manifold Approximation and Projection (UMAP). Major cell types were identified, including valvular interstitial cells (VICs), endothelial cells, macrophages, T cells, mast cells, and neutrophils. Expression patterns of chemokines and receptors such as CCL20 and CCR6 were further analyzed across groups, and differentially expressed marker genes were visualized using heatmaps.

Results

Single-cell transcriptomic analysis revealed differences in the distribution of major cell types in aortic valves between the psoriasis and hypertension groups. Cell clusters with high CCL20 expression were more prominent in the psoriasis group, while CCR6-related signaling appeared to enhance the recruitment of specific immune cells (e.g., T cells or macrophages). Within VIC subpopulations, the psoriasis group exhibited alterations in the proportions of myofibroblasts and specific VIC clusters (VIC1–3), accompanied by upregulation of inflammation- and fibrosis-related genes such as COL1A1 and ACTA2. In terms of immune infiltration, the psoriasis group showed increased infiltration of adaptive immune cells (e.g., T cells) and certain innate immune subsets. The CCL20–CCR6 axis may contribute to shaping the local inflammatory microenvironment of the valve. Despite the small sample size, baseline clinical characteristics (e.g., age, blood pressure, ejection fraction, and aortic valve area) were generally comparable between the two groups.

Conclusions

Psoriasis, as an independent variable, significantly influences immune cell infiltration patterns in the aortic valves of patients with hypertension. This effect may be mediated through pathways such as the CCL20–CCR6 axis, enhancing local inflammatory responses and modulating VIC activation, thereby exacerbating pathological valvular remodeling. These findings provide single-cell-level evidence for the immunological mechanisms underlying psoriasis-related cardiovascular comorbidities and may offer new insights for targeted therapeutic strategies, such as modulation of chemokine axes.

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Abstract N°: 2496

Cardiovascular risk in patients with psoriasis: prevalence of risk factors and need for multidisciplinary screening in routine practice

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Introduction

Psoriasis is a chronic immune-mediated inflammatory disease associated not only with skin and joint involvement but also with increased cardiovascular (CV) morbidity and mortality. Recent studies demonstrate a higher prevalence of traditional CV risk factors (arterial hypertension, dyslipidemia, diabetes mellitus and others) and major adverse CV events in patients with moderate-to-severe psoriasis compared with the general population. However, CV risk is still frequently underestimated in daily dermatology practice, especially in younger patients and those without established CV disease.

To assess the presence of CV risk factors and the estimated 10-year CV risk in adult patients with psoriasis in routine clinical practice of dermatologist.

Materials and Methods

We performed case-control, single-center study with participation of 32 adult patients (older than 40 years old) with clinically confirmed psoriasis that formed a main group. All of them attended a dermatology outpatient clinic over 12 months. Main antropometric and clinical data (age, gender, duration of psoriasis, phenotype,PASI (Psoriasis Area and Severity Index), body mass index (BMI), smoking status, family history of CV diseases) were collected. Standard laboratory methods included lipid profile and glucose. For the ten-years CV risk estimation we used SCORE2/SCORE2-OP adapted to patients' age. Patients were stratified into low, moderate, high and very-high risk categories.

Results

All the patients were from very high CV risk region. At least one traditional CV risk factor was present in 30 (94%) of patients, while ≥3 risk factors were revealed in 14 (44%) of those with moderate-to-severe psoriasis. The most prevalent factors were arterial hypertension (22 (69%)), dyslipidemia (19 (59%)), and active smoking (15 (47%)). According to SCORE2/SCORE2-OP, only 2 (6%) of patients were at low 10-year CV risk, whereas 11 (35%) and 19 (59%) were classified as high and very-high risk, respectively. Higher PASI scores and longer psoriasis duration were significantly associated with higher CV risk categories ($p<0.01$). In most of the cases, the patients before were not examined by cardiologist and did not take the proper treatment (antihypertensive, lipid-lowering therapy etc.).

Conclusions

In routine dermatology practice, the majority of adults with psoriasis have multiple CV risk factors, and a substantial proportion fall into high or very-high 10-year CV risk categories, particularly those with more severe and long-standing disease. These findings support systematic CV risk assessment in all psoriasis patients and highlight the need for close collaboration between dermatologists, cardiologists and primary care physicians to implement early preventive strategies.

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Abstract N°: 2504

Follicular Psoriasis Successfully Treated with Vunakizumab: A Case Report

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Introduction

Follicular psoriasis is a rare phenotypic variant of psoriasis, characterized by follicularly centered papules with scale, often leading to diagnostic confusion with dermatoses such as seborrheic dermatitis, lichen planus, or keratosis pilaris. It predominantly affects the lower limbs in adult women and is frequently underdiagnosed due to its atypical presentation. There are relatively few reports and related studies on this type. We report a case of follicular psoriasis that was confirmed by biopsy and responded well to treatment with vunakizumab, with almost complete regression of the skin lesions.

Case Presentation

A 55-year-old man presented with a 2-year history of symmetrical, scaly follicular papules on both lower legs and eczema-like hand lesions with mild pruritus. Physical examination showed pale-red follicular papules on the lower extremities, hyperkeratosis with scales on the right thumb, a scaly erythematous patch on the left thumb, and nail fold deformities. Histopathology of biopsied leg papules indicated follicular psoriasis, a rare variant often misdiagnosed as seborrheic dermatitis, lichen planus, or keratosis pilaris. The patient used to be misdiagnosed as eczema or allergic purpura led to ineffective treatments including oral compound glycyrrhizin, levocetirizine, dipyridamole, and topical fluticasone propionate. Initial therapy with oral acitretin (25 mg/day) and topical calcipotriol was discontinued due to intolerable xerostomia. Subcutaneous vunakizumab (IL-17A inhibitor) 240 mg was administered with a repeat dose at 2 weeks.

At the three-week follow-up, clinical evaluation revealed near-complete clearance of the papules on the lower legs, with only residual hyperpigmentation. The hand lesions also improved significantly, though mild scaling persisted. Nail changes remained unchanged. The patient reported no adverse events after using vunakizumab.

Conclusion

We report a case of follicular psoriasis, a rare type of psoriasis that exhibited the remarkable efficacy of the vunakizumab that an IL-17A inhibitor following 3 week. The pathogenesis of FP is still unclear, some researchers suggested that hair follicle immune cells or keratin 17(K17) may be involved the pathogenesis. While further studies are needed, we speculate that in this case, the treatment with vunakizumab precisely blocked the upstream driving signal of this loop (IL-17A), achieving significant results.

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Abstract N°: 2512

Efficacy of Risankizumab in Patients with Scalp Psoriasis: A Subgroup Analysis by Affected Body Surface Area

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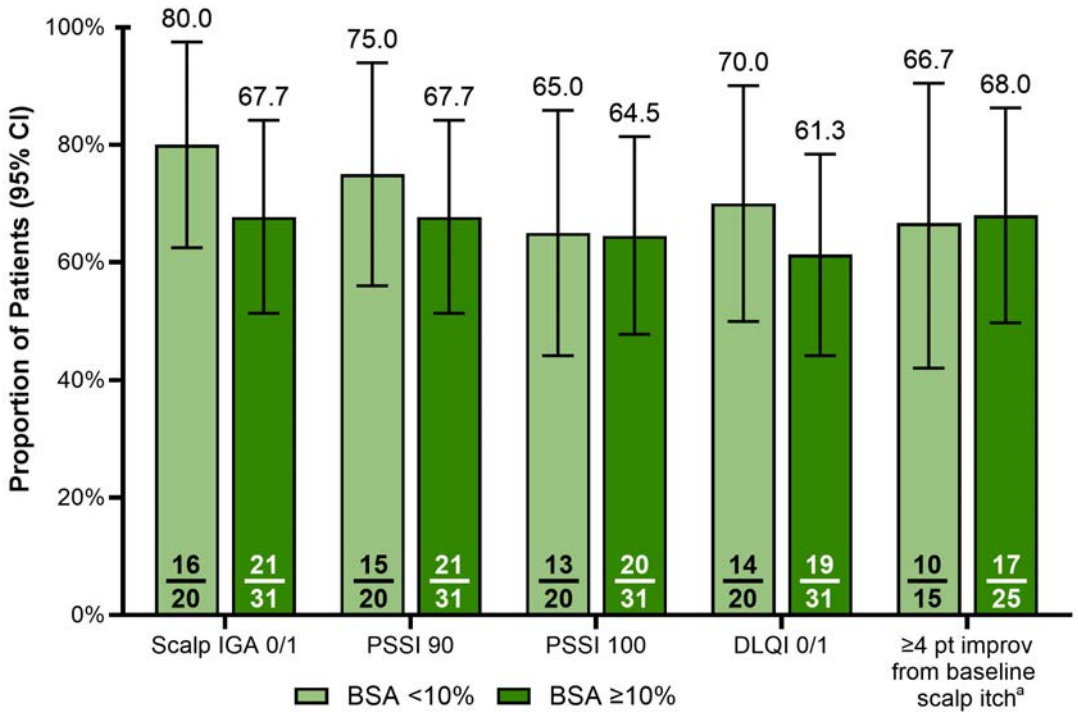
Introduction
Psoriasis (PsO) involving the scalp is considered a high impact site and qualifies patients for systemic treatment. Patients with scalp PsO often have decreased quality of life and increased disease burden despite, sometimes, having a lower overall affected body surface area (BSA). The UnlIMMited clinical trial assesses efficacy and safety of risankizumab (RZB), an IL-23 inhibitor, in patients with genital or scalp PsO. Here we present efficacy results for patients with scalp PsO in the UnlIMMited study stratified by baseline affected BSA.

Materials and Methods
UnlIMMited (NCT05969223) is a Phase 4, multicenter, randomized, double-blind, placebo-controlled study for adult patients with moderate-to-severe genital or scalp PsO. This analysis included patients with scalp PsO (Study-S) who were originally randomized during the double-blind placebo-controlled period to receive 150 mg RZB at weeks 0 and 4. Beginning at week 16, patients entered the open-label extension and received 150 mg RZB every 12 weeks. Patients were stratified by baseline affected BSA (<10% or ≥10%) and efficacy outcomes are reported at week 52. Safety was not assessed in this analysis and has been previously reported. Efficacy is reported using achievement of scalp Investigator Global Assessment (IGA) 0 or 1, achievement of a ≥90%/100% improvement in Psoriasis Scalp Severity Index (PSSI) from baseline, achievement of Dermatology and Life Quality Index (DLQI) 0/1 (no effect on the patient's life), and ≥4 point improvement from baseline scalp itch. Missing data was handled with non-responder imputation.

Results
A total of 51 (20 <10% baseline BSA; 31 ≥10% baseline BSA) patients originally receiving RZB in Study-S were included in this analysis. At week 52, regardless of baseline BSA, most patients achieved scalp IGA 0/1, PSSI 90/100, DLQI 0/1 and ≥4 point improvement from baseline scalp itch **(Figure 1)**. Scalp IGA 0/1 was achieved by 80.0% of patients with baseline BSA <10% and 67.7% of patients with baseline BSA ≥10%. PSSI 90 was achieved by 75.0% and 67.7% of patients with baseline BSA <10%, and BSA ≥10% at baseline, respectively. Similar results were reported for PSSI 100 (complete clearance) for both baseline groups (BSA <10% - 65.0%; BSA ≥10% - 64.5%). DLQI 0/1 was reported by 70.0% of patients with baseline BSA <10% and 61.3% of patients with baseline BSA ≥10%. Approximately 2/3 of patients (BSA <10% - 66.7%%; BSA ≥10% - 68.0%) achieved a ≥4 point improvement from baseline scalp itch.

Figure 1. Efficacy at Week 52 by Baseline BSA



[a]Reported for patients with a baseline score ≥4 at baseline.
BSA, body surface area; DLQI, Dermatology Life Quality Index; IGA, Investigator Global Assessment; PSSI, Psoriasis Scalp Severity Index.

Conclusions

After 52 weeks of treatment with risankizumab, most patients, regardless of their baseline affected BSA, reported reduced signs and symptoms of their scalp PsO. Most patients reported complete clearance of their PsO, no effect of PsO on their quality of life, and improvements in scalp itch. These results support the efficacy of RZB for use in the treatment of the high impact sites such as the scalp, including in patients with low baseline affected BSA.

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Abstract N°: 2521

A Case-control study of psoriasis severity and its correlation with Carotid-intimal-medial-thickness: A surrogate marker of cardiovascular disease

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Introduction

Psoriasis, an autoimmune skin disorder is frequently associated with metabolic syndrome (MS) and MS is a known risk factor for cardiovascular disease e.g. hypertension, diabetes, obesity, dyslipidemia, subclinical atherosclerosis etc. Carotid artery ultrasound with psoriasis have greater carotid intima-media thickness compared to healthy controls, indicating carotid atherosclerosis. Increased Carotid-intimal-medial-thickness (CIMT) is a well-established marker for cardiovascular morbidity. Every 0.1 mm increase in the CIMT increases the risk of myocardial infarction by 10% to 15% and of stroke by 13% to 18%.

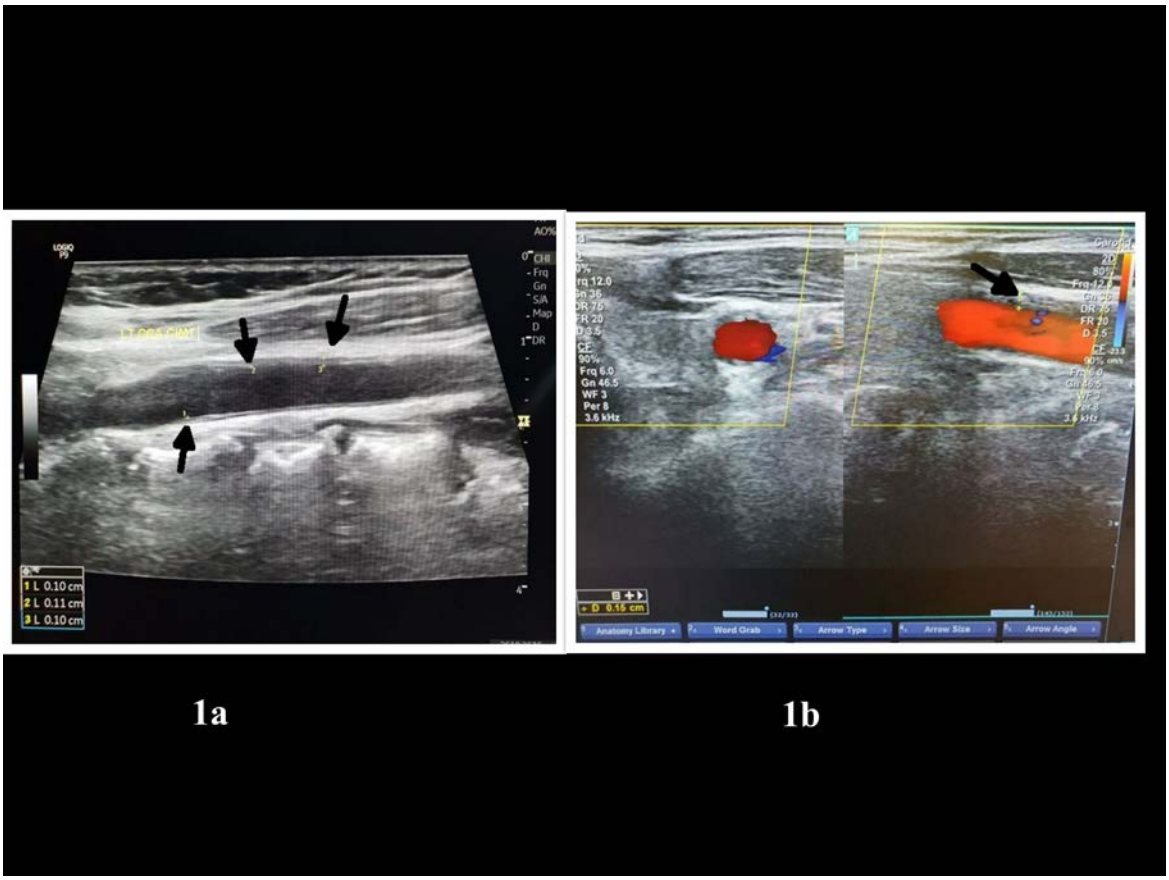
Materials and Methods

An institution-based case-control study with 50 patients of chronic plaque psoriasis above 12 years of age without metabolic syndrome (to rule out confounding factors) and 50 healthy controls (both age and sex matched) were recruited after informed consent. Detailed clinical history regarding age, sex, duration, age of onset, progression, family history, systemic complaints, and treatment history were taken. Cutaneous examination including Psoriasis area Severity Index (PASI) score was done. Blood Lipid profile, Fasting Blood sugar, Post-prandial blood sugar were measured.

High-resolution B-mode ultrasonography with a linear array transducer was performed by a radiologist to measure the CIMT of the distal Common Carotid Artery (CCA) and the presence of atherosclerotic plaques. The CIMT was determined in the following positions on both sides in the CCA, 1 cm inferior to the carotid sinus in both groups.

According to the European Society of Cardiology/European Society of Hypertension (ESC/ESH) 2003 guidelines, CIMT < 0.9 mm is classified as normal, and CIMT between 0.9 and 1.5 mm is classified as an increase in the intima-media thickness.The presence of an atherosclerotic plaque was defined as CIMT > 50% of the thickness of the nearby artery and protruding > 0.5 mm into the inner layer of the artery or CIMT ≥ 1.5 mm.

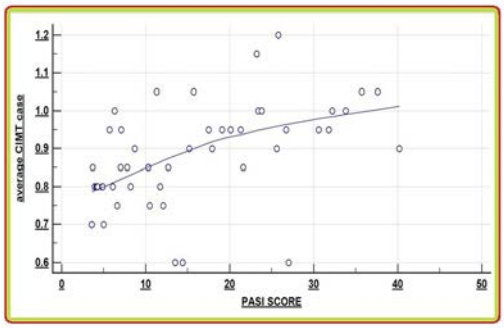
Data were analysed as median and interquartile range (skewed data) in Medcalc V15.8. Wilcoxon test was used to compare right and left CMT values (skewed data). The Mann-Whitney U test was used to compare average CMT values between case and control. Spearman's rank correlation coefficient was used to explore association between CIMT and PASI; gender and CIMT; age vs CIMT. A p-value<0.05 was considered statistically significant.



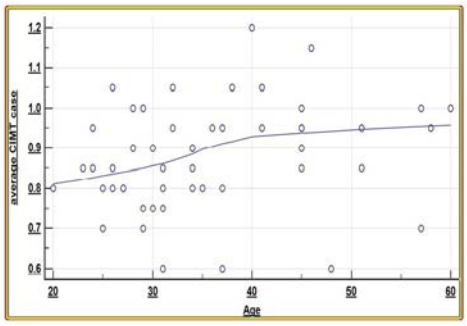
1a) CIMT of Left Distal CCA 0.10,0.11, 0.10cm. 1b) CIMT of Right Distal CCA 0.15cm

Results

Out of 50 patients, 62%(n=31) were male and 38% (n=19) was female. Median age was 34 years. Median PASI was 12.4. Of note, no significant difference was found between right and CIMT values of cases and control both (Wilcoxon match test, p= 0.15 & p= 0.84 respectively). So for further calculation, average CIMT values of both cases and controls were taken into account. **No statistically significant difference** was found between CIMT values of two genders (Mann -whitney test, p=0.856). **Median CIMT** values of psoriasis patients was **significantly higher** than that of controls [0.87 mm (interquartile range 0.8-0.95) vs. 0.75mm (interquartile range 0.6-0.8), respectively; **p=0.001**(Mann-Whitney test), **odd's-ratio=1.07**, confidence-interval=1.64-3.11]. **Positive correlation** was found between CIMT and PASI **[**Spearman correlation coefficient (r)=0.585; p=0.002)]. **No correlation** was found between age and CIMT [Spearman correlation coefficient (r)=0.23; p=0.09]



2a



2b

2a: Positive correlation was found between CIMT and PASI [Spearman correlation coefficient (r)=0.585; p=0.002)]. 2b: No correlation was found between age and CIMT [Spearman correlation coefficient (r)=0.23; p=0.09]

Conclusions

Psoriasis, irrespective of age, sex and presence of metabolic syndrome **is associated with cardiovascular morbidity.** Thus, in every psoriasis patient with **higher PASI score,** CIMT should be measured. So, CIMT can be used as an early, non-invasive, inexpensive and independent marker for **early prediction of cardiovascular disease** and can replace invasive and expensive carotid angiography.

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Abstract N°: 2531

Systemic therapies and well-being in psoriasis: superiority of IL-23 inhibitors in a WHO-5 analysis

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Introduction

Psoriatic disease is a chronic inflammatory skin condition that not only affects the skin and other organ systems but also substantially impairs patients' subjective well-being. Modern systemic therapies, particularly IL-17 and IL-23 inhibitors, have led to significant improvements in both clinical parameters (PASI, BSA) and patient-reported outcomes (DLQI).

The WHO-5 Well-Being Index is a validated tool assessing psychological well-being and has been applied to psoriasis, including the POSITIVE study. However, real-world data comparing its performance across different systemic therapy classes remain limited.

Materials and Methods

In this retrospective, single-center study, changes in well-being were analyzed using the WHO-5 in patients with moderate-to-severe psoriasis receiving different systemic therapies. Assessments were performed at three defined time points: baseline (t1; week 0), early follow-up (t2; 8–18 weeks), and follow-up (t3; up to 2.5 years). Demographic data, clinical parameters (PASI, BSA), and DLQI were also collected.

Results

A total of 319 patients were included (TNF inhibitors: n=40, IL-17 inhibitors: n=101, IL-23 inhibitors: n=110, conventional therapies: n=68).

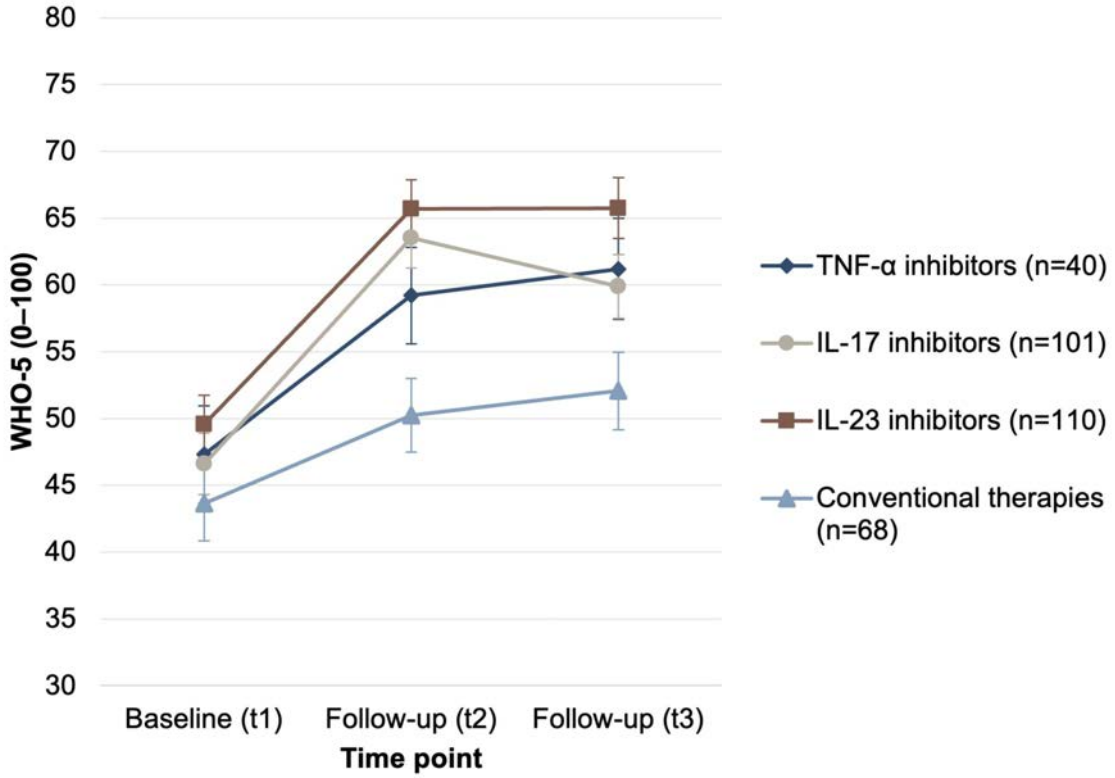
At baseline, WHO-5 scores were markedly reduced compared to the general German population (mean 67.56), with values of 47.30 (TNF inhibitors), 46.61 (IL-17 inhibitors), 49.56 (IL-23 inhibitors), and 43.65 (conventional therapies), resulting in an overall mean of 47.08 (± 23.11).

A significant improvement in WHO-5 scores over time was observed across all treatment groups ($p < 0.001$), with more pronounced and sustained effects particularly in patients receiving IL-23 inhibitors (65.71 at t2; 65.75 at follow-up), compared to IL-17 inhibitors (63.52; 59.88), TNF inhibitors (59.20; 61.20), and conventional therapies (50.24; 52.06).

Differences between IL-23 inhibitors and conventional therapies were significant at both follow-up time points (t2: $p < 0.001$; t3: $p = 0.001$). IL-17 inhibitors demonstrated a transient benefit compared to conventional therapies at t2 (8–18 weeks) only ($p = 0.001$; t3: $p = 0.223$), whereas TNF inhibitors showed less pronounced improvements and no significant differences compared to conventional therapies. WHO-5 scores correlated with DLQI and, to a lesser extent, with PASI and BSA.

Conclusions

These findings suggest that the WHO-5 Well-Being Index is a sensitive and easily applicable outcome measure in patients with psoriasis. Biologic therapies, particularly IL-23 inhibitors, appear to provide greater and more sustained improvements in well-being compared to conventional therapies. The inclusion of WHO-5 as a patient-reported endpoint is therefore recommended for both clinical trials and routine clinical practice.



Mean WHO-5 well-being scores at baseline (t1), early follow-up (t2; 8–18 weeks), and follow-up (t3; up to 2.5 years) in patients with psoriasis stratified by systemic therapy group (TNF-α inhibitors, IL-17 inhibitors, IL-23 inhibitors, and conventional therapies). Error bars represent the standard error of the mean. WHO-5 = World Health Organization-Five Well-Being Index; higher scores indicate better well-being.

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Abstract N°: 2566

Pro-inflammatory cytokine reduction in psoriasis patients treated withtildrakizumab, brodalumab and methotrexate: A prospective study.

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Introduction
Various cytokines have been linked to the pathophysiology of psoriasis and, in some cases, to its severity. Among the cytokines involved in psoriatic disease, Interleukin 17A and C (IL-17A, IL-17C) and Tumor Necrosis Factor alpha (TNF) stand out as well-known therapeutic targets. The objective of this study was to evaluate changes in circulating cytokine levels in a group of patients with moderate-to-severe
psoriasis undergoing various treatments and to attempt to correlate these changes with clinical improvement in the patients.

Materials and Methods
A prospective study was conducted in patients with moderate-to-severe psoriasis treated with methotrexate, brodalumab, and tildrakizumab. Levels of IL-17A, IL-17C, and TNF were measured at baseline and after 9 months of treatment. Data on disease severity and comorbidities were also collected.

Results
A total of 34 patients were included in the study, with a mean age of 47.8 years, 63% of whom were male, and a baseline PASI score of 9.78. Of these, 17 received treatment with tildrakizumab, 9 with brodalumab, and 7 with methotrexate. After 9 months of treatment, PASI decreased significantly in all treatment groups ($p<0.05$). IL-17A levels decreased after treatment in the tildrakizumab group ($p<0.05$)
and the methotrexate group ($p=0.33$), but not in the brodalumab group. IL-17C levels decreased only in the tildrakizumab group ($p<0.05$). TNF levels decreased in all treatment groups (tildrakizumab $p=0.05$; brodalumab $p=0.15$; methotrexate $p=0.39$). No correlation was found between changes in circulating cytokine levels and clinical improvement (PASI) ($p=0.30$).

Conclusions
Treatment of moderate-to-severe psoriasis appears to lead to a decrease in levels of IL-17A, IL-17C, and TNF, the extent of which varies depending on the drug used. However, there does not appear to be a correlation between clinical improvement and changes in blood cytokine levels.

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Abstract N°: 2573

Drug survival of bimekizumab, guselkumab and risankizumab after secondary IL-17 inhibitor failure: a real-world, retrospective study

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Introduction
The available evidence regarding intraclass (e.g. interleukin (IL)-17 to IL-17 inhibitor) versus interclass (e.g. IL-17 to IL-23 inhibitor) biologic switching remains contradictory, with few small sample studies and limited follow-up periods available. Moreover, analyses including the more recently approved IL-17A/F inhibitor bimekizumab are lacking and strong surrogate outcomes, depicting successful long-term psoriasis management, such as drug survival, have not been used to evaluate switching strategies. Therefore, we aimed to evaluate and compare the drug survival of bimekizumab (IL-17A/F inhibitor), guselkumab and risankizumab (IL-23 inhibitors) in patients who had experienced secondary failure to an IL-17 inhibitor.

Materials and Methods
We retrospectively included all psoriasis patients who discontinued an IL-17 inhibitor due to secondary failure (loss of effectiveness after an initial treatment response) and were directly switched to bimekizumab (intraclass switch) or to an IL-23 (interclass switch) inhibitor. Descriptives were used as appropriate. Differences in baseline characteristics were assessed using the Fisher's exact and the Wilcoxon rank-sum tests. Drug survival was estimated using the Kaplan-Meier method and differences were assessed with log-rank test. Univariable and multivariable Cox proportional hazards models were utilized to identify independent predictors of drug discontinuation.

Results
In total, 127 patients were identified and included with 38, 26 and 63 switching to bimekizumab, guselkumab and risankizumab respectively, with IL-23 inhibitors grouped and analysed together. No significant differences were observed between the two groups regarding baseline psoriasis area severity index (PASI), age, gender, body mass index (BMI), comorbidities or the presence of psoriatic arthritis. A higher proportion of patients in the bimekizumab group had received an IL-17 inhibitor as the only previous biologic (p=0.044). No significant differences were observed after switching to bimekizumab or an IL-23 inhibitor both in the short- and long-term drug survival (log-rank test; p=0.51). Estimated drug survival rates were 94.4% (95%, CI: 87.1–100) versus 92.1% (95%, CI: 86.6–97.9) at 12 months and 82.1% (95%, CI: 70.0–96.3) versus 88.6% (95%, CI: 82.2–95.5) at 24 months. After 36 months of treatment, drug survival estimates were 76.9 (95%, CI: 62.8–94.3) for bimekizumab compared to 80.5% (95%, CI: 72.3–89.6) for the IL-23 inhibitors. Neither univariate nor multivariate COX regression analyses identified any prognostic factors for treatment discontinuation. Regarding reasons for treatment discontinuation, 7 patients discontinued bimekizumab (1 due to recurrent fungal infection and 6 due to secondary skin failure) while 22 patients discontinued IL-23 inhibitors (3 due to primary skin failure, 3 due to exacerbation of psoriatic arthritis,

and 13 due to secondary skin failure).

Conclusions

Altogether, our findings suggest that bimekizumab may be an effective option, potentially comparable to IL-23 inhibitors, for patients who have experienced a previous IL-17 inhibitor failure. Larger, prospective studies are warranted to validate our findings.

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Abstract N°: 2579

Facial psoriasis succesfully treated with tildrakizumab

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Introduction

Psoriasis is a chronic inflammatory skin disease characterized by erythematous-scaly plaques with the potential to involve any cutaneous surface, including the face.

Facial psoriasis is a relatively uncommon variant in which well-demarcated erythematous-scaly plaques appear on the face, often requiring careful differentiation from seborrheic dermatitis. It represents a therapeutic challenge due to the risk of cutaneous atrophy from prolonged topical corticosteroid use and the limited efficacy of topical calcineurin inhibitors and requires effective treatment due to the visual impact and daily life impairment.

We present the first case reported in the literature of facial psoriasis successfully treated with tildrakizumab.

Case Presentation

A 44-year-old man, with no past relevant medical history and on pre-exposure prophylaxis with tenofovir disoproxil fumarate and emtricitabine, who suffered from psoriasis since the age of 33. Previous treatments received included dimethyl fumarate, methotrexate, and adalimumab. He presented with predominant involvement of the face, scalp, ears, and cervical region, with well-defined erythematous-scaly plaques. There was no nail, palmoplantar, or inverted involvement. Baseline scores were PASI 7, BSA 3, general PGA 3, and facial PGA 4.

Neither dimethyl fumarate nor methotrexate achieved adequate disease control. Adalimumab 40 mg every two weeks was initiated, but the facial component remained insufficiently controlled. Therefore treatment was switched to tildrakizumab with standard induction dose of 100mg at week 0 and 4. At week 16, the patient achieved complete clearance of both plaque and facial psoriasis: PASI 0, BSA 0, general PGA 0, and facial PGA 0, with excellent tolerability and no reported adverse events.

Conclusion

Psoriasis significantly impairs patients' quality of life, particularly when special or difficult-to-treat areas are involved. Facial involvement has a particular psychosocial impact due to the constant visibility of lesions. This case demonstrates that tildrakizumab is an effective and safe therapeutic option for psoriasis affecting difficult-to-treat areas, including the face, which is a rare presentation of psoriasis. The rapid and complete improvement observed provides novel clinical evidence supporting IL-23p19 blockade effectiveness in patients with prominent facial involvement. This case represents the first reported case in the literature of facial psoriasis succesfully treated with tildrakizumab.

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Abstract N°: 2600

Psoriasis, Work, and Unemployment in a Low-Resource Setting: A National Survey Highlighting Global Health Inequities in the Philippines

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Introduction
Psoriasis is a chronic immune-mediated disease associated with substantial physical, psychological, and socioeconomic burden. While global data emphasize clinical severity, the impact on employment and productivity in low- and middle-income countries (LMICs) remains underexplored. In the Philippines, limited access to dermatological care and high out-of-pocket costs may disproportionately affect patients' ability to work. This study aimed to evaluate the relationship between psoriasis, employment status, and quality of life, and examine potential health disparities.

Materials and Methods
A cross-sectional online survey was conducted in 2024 among Filipino adults with dermatologist-diagnosed psoriasis. Participants were recruited via national patient organisations. Data collected included demographic information, employment status, disease severity (self-assessed Simplified Psoriasis Index; saSPI, score 0 [clear/minor] to 40 [widespread]), treatment use, comorbidities, and validated outcome measures: EQ-5D-5L (EuroQoL 5-Dimension 5-Level) for quality of life and ICECAP-A (ICEpop CAPability measure for Adults) for capability, with scores of 1 representing full health/capability. Statistical analyses included descriptive statistics, Spearman's correlation, and multivariable linear regression to identify predictors of impaired quality of life and capability.

Results
A total of 480 participants (mean age 40.7 ± 12.16 years; 65% female) were included. Most were employed full-time (46%), 15% were unemployed, and 31% reported difficulty obtaining employment due to psoriasis. Approximately 21% worked less than 10 hours per week, reflecting reduced work participation.

Despite the majority having limited disease severity (66%; mean saSPI 8.42 ± 9.34), overall disease burden was substantial. Mean quality of life score was 0.66 ± 0.29, and mean capability score was 0.52 ± 0.25. Pain/discomfort and anxiety/depression were reported in 73% of participants.

Nearly half (46%) reported at least one comorbidity, with 79% perceiving these as more burdensome than psoriasis itself. Employment status significantly influenced outcomes: unemployment and long-term sickness were among the strongest predictors of poorer quality of life.

Regression analyses found that unemployment, greater disease severity, and visible psoriasis (particularly scalp and exposed areas) were associated with reduced quality of life. Similarly, reduced capability was associated with disease severity and functional impairment of hands, fingers, and nails—areas critical for occupational tasks.

Treatment disparities were evident: while 74% used topical therapy, only 12% were able to access biologics, despite markedly higher effectiveness (96% reported benefit). This treatment gap reflects financial and structural barriers, contributing to persistent disease activity and work impairment.

Conclusions

Psoriasis in the Philippines represents a significant health issue where employment and economic participation are profoundly affected, even among patients with clinically mild disease. Unemployment and reduced work capacity emerge as critical but under-recognized consequences, driven by visible disease, comorbidities, and limited access to effective therapies.

These findings highlight that in LMIC settings, the burden of psoriasis extends beyond clinical severity to include economic vulnerability and workforce exclusion. Addressing these inequities requires improved access to advanced therapies, expansion of dermatology services, and integration of occupational and psychosocial support into care models.

Targeted policy interventions are essential to reduce the cycle of disease, unemployment, and financial burden, ultimately improving both health and economic outcomes for patients with psoriasis in resource-limited settings.

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Abstract N°: 2616

Refractory Palmoplantar Psoriasis Successfully Treated With Apremilast After Failure of Multiple Systemic and Biologic Therapies – A Case Report

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Introduction

Palmoplantar psoriasis is a particularly challenging clinical subtype of psoriasis that may cause severe functional impairment and substantial reduction in quality of life despite limited body surface area involvement. Management is often difficult due to inadequate response, intolerance to systemic therapies, and limited evidence regarding therapeutic sequencing after biologic failure. We present a case of refractory palmoplantar psoriasis successfully treated with apremilast following failure of multiple conventional systemic and biologic therapies.

Case Presentation

We present the case of a 61-year-old woman with plaque psoriasis and palmoplantar involvement since 2018. Previous treatment with methotrexate, acitretin, and cyclosporine had been discontinued due to adverse effects and poor tolerability. Despite limited skin involvement (PASI 5.6; BSA 7%), the patient presented with severe quality-of-life impairment (DLQI 19) and significant palmoplantar disease burden (PPASI 12), resulting in painful hand lesions that substantially impaired occupational functioning. The patient subsequently underwent biologic therapy with ixekizumab followed by risankizumab; however, both treatments failed to achieve satisfactory clinical improvement. Following discontinuation of biologic therapy, apremilast treatment was initiated.

Marked clinical improvement was observed as early as week 4 following apremilast initiation, with significant reduction of erythema, scaling, fissuring, and palmoplantar inflammation. Further improvement was achieved by week 16, resulting in near- complete remission of palmar lesions, reduction of pain, and restoration of hand function, significantly improving the patient’s quality of life and ability to work. No significant adverse effects were observed during treatment.

Conclusion

Palmoplantar psoriasis may result in disproportionate functional impairment and quality-of-life reduction despite relatively low PASI and BSA scores. Failure of sequential biologic therapies does not preclude clinical response to phosphodiesterase-4 inhibition. Our case highlights apremilast as a potentially effective and well-tolerated therapeutic option in difficult-to-treat palmoplantar psoriasis, particularly in patients with inadequate response or intolerance to conventional systemic and biologic therapies.

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Abstract N°: 2638

Effect of Risankizumab Compared With Deucravacitinib on Health-Related Quality of Life and Treatment Satisfaction Among Patients With Moderate Plaque Psoriasis: Results From the Phase 4 IMMpactful Trial

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Introduction

Patients with plaque psoriasis (PsO) often experience negative impacts on their health-related quality of life (HRQoL). Risankizumab (RZB) is a humanized monoclonal antibody that inhibits the p19 subunit of interleukin-23 and is approved for use in patients with moderate-to-severe PsO. This post hoc analysis investigates the impact of treatment with RZB compared with deucravacitinib (DEU) on HRQoL and treatment satisfaction in patients with moderate PsO.

Materials and Methods

Data were from the global Phase 4, multicenter, randomised, open-label, assessor-blinded, active comparator IMMpactful study (NCT06333860), which compared the impact of RZB versus DEU in patients with moderate PsO. Eligible patients were aged ≥18 years, candidates for systemic therapy, biologic-naïve, and had moderate psoriasis (body surface area 10–15%, Psoriasis Area and Severity Index [PASI] ≥12, and Static Physician Global Assessment score = 3 [moderate; scale 0 to 4]). During Period A, patients were stratified by baseline weight (≤100 kg or >100kg) and then randomised 1:2 to receive subcutaneous RZB (150 mg single subcutaneous injection at baseline and Week 4) or oral DEU (6 mg once daily) for 16 weeks. In Period B (Week 16 to 52), all DEU-treated patients who failed to achieve PASI 90 were re-randomised 1:1 to RZB (DEU/RZB) or DEU (DEU/DEU) at Week 16.

At Week 52, the percentage of patients achieving Psoriasis Symptoms Scale (PSS) 0, PSS 0/1, and Dermatology Life Quality Index (DLQI) 0/1, 4-point improvement in DLQI, and mean Treatment Satisfaction Questionnaire for Medication version 9 (TSQM-9) and Work Productivity and Activity Impairment scores were assessed. Nonresponder imputation incorporating multiple imputations was used to handle missing data for binary endpoints. Least squares (LS) mean changes from baseline or entry into Period B to Week 52 were compared between DEU/RZB versus DEU/DEU by mixed-effects repeated regression modeling for continuous endpoints.

Results

Of 183 patients treated with DEU and re-randomised to RZB (n=90) or DEU (n=93), 33.3% were female, mean (standard deviation [SD]) body mass index was 29.6 (7.2) kg/m^2, mean (SD) PASI score was 15.3 (3.4), and mean (SD) age was 44.5 (13.3) years at baseline. At Week 52, a greater proportion of patients treated with DEU/RZB compared with those treated with DEU/DEU achieved PSS 0 (44.4%, 95% confidence interval (CI): 34.2%–54.7% vs 11.8%, 95% CI: 5.3%–18.4%; nominal p<0.0001), and PSS 0/1 (60.0%, 95% CI: 49.9%–70.1% vs 12.9%, 95% CI: 6.1%–19.7%; nominal p<0.0001; **Table**). A greater proportion of patients treated with DEU/RZB versus DEU/DEU also achieved DLQI 0/1 (70.0%, 95% CI: 60.5%–79.5% vs 18.3%, 95% CI: 10.4%–26.1%; nominal p<0.0001), and ≥4 points improvement in DLQI (minimally clinically important difference; 81.5%, 95% CI: 73.0%–89.9% vs 36.4%, 95% CI: 25.6%–47.1%; nominal p<0.0001) at Week 52. Treatment satisfaction at Week 52 was higher in patients treated with DEU/RZB versus DEU/DEU, including overall satisfaction (LS mean between group difference [Δ], 19.9; 95% CI, 13.4–26.4; nominal p<0.0001), satisfaction with effectiveness (Δ, 17.0; 95% CI, 8.7–25.3; nominal p<0.0001), and satisfaction with convenience domains (Δ, 6.6; 95% CI, 0.9–12.4; nominal p=0.0245). At Week 52, improvement from baseline in work activity impairment was greater in patients with PsO treated with RZB compared with those treated with DEU, but overall work impairment was similar between treatment groups.

Conclusions

Switching to RZB from once daily oral DEU compared with continuing treatment with DEU was associated with greater HRQoL outcomes and treatment satisfaction, including treatment convenience, in patients with moderate PsO who failed to achieve PASI 90 after 16 weeks of treatment. These results suggest that RZB may be an effective treatment option to improve the HRQoL and overall treatment experience of patients with moderate PsO, compared with once daily oral DEU.

Table. Summary of PSS, DLQI, and TSQM-9 results at Week 52 in IMMpactful

	DEU/RZB[a] n = 90	DEU/DEU[b] n = 93	Difference (95% CI)	Nominal p value
PSS 0, n (%) [95% CI]	40 (44.4) [34.2–54.7]	11 (11.8) [5.3–18.4]	32.6 (20.4–44.8)	<0.0001
PSS 0/1, n (%) [95% CI]	54 (60.0) [49.9–70.1]	12 (12.9) [6.1–19.7]	47.1 (34.9–59.3)	<0.0001
DLQI 0/1, n (%) [95% CI]	63 (70.0) [60.5–79.5]	17 (18.3) [10.4–26.1]	51.7 (39.4–64.0)	<0.0001
Minimally clinically important difference (≥4 points improvement) in DLQI from Week 16,[c] n (%) [95% CI]	66 (81.5) [73.0–89.9]	28 (36.4) [25.6–47.1]	45.1 (31.4–58.8)	<0.0001
	DEU/RZB[a] n = 78	**DEU/DEU[b] n = 34**	**Between group difference, Week 16 to 52 LS mean (95% CI)**	**Nominal p value**
TSQM-9 Global Satisfaction, mean	88.2	73.3	19.9 (13.4–26.4)	<0.0001
TSQM-9 Effectiveness, mean	85.0	72.1	17.0 (8.7–25.3)	<0.0001
TSQM-9 Convenience, mean	88.1	78.4	6.6 (0.9–12.4)	0.0245
Change from baseline to Week 52, LS mean (95% CI)			**Between group difference, LS mean (95% CI)**	
WPAI Overall Work Impairment[d]	−18.2 (−23.7 to −12.6)	−13.1 (−21.9 to −4.4)	−5.0 (−15.4 to 5.4)	0.3369
WPAI Activity Impairment[e]	−29.3 (−31.8 to −26.8)	−22.6 (−26.3 to −18.9)	−6.7 (−11.2 to −2.2)	0.0037

[a]Patients randomised to DEU in Period A who failed to achieve PASI 90 at Week 16 and were re-randomised to RZB. [b]Patients randomised to DEU in Period A who failed to achieve PASI 90 at Week 16 and were re-randomised to DEU. [c]DEU/RZB, n = 81; DEU/DEU, n = 77. [d]DEU/RZB, n = 49; DEU/DEU, n = 20. [e]DEU/RZB, n = 75; DEU/DEU, n = 34. For binary endpoints, nonresponder imputation incorporating multiple imputations was used to handle missing data. For continuous endpoints, LS mean changes were compared between DEU/RZB versus DEU/DEU by mixed-effects model repeated measurement.

CI, confidence interval; DEU, deucravacitinib; DLQI, Dermatology Life Quality Index; LS, least squares; PASI, Psoriasis Area and Severity Index; PSS, Psoriasis Symptoms Scale; RZB, risankizumab; TSQM-9, Treatment Satisfaction Questionnaire for Medication version 9; WPAI, Work Productivity and Activity Impairment.

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Abstract N°: 2662

Severe Plantar Psoriasis in an Elderly Patient on Long-Term Hydroxycarbamide: A 16-Year Clinical Course

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Introduction

Plantar psoriasis (psoriasis vulgaris) can be challenging to manage when complicated by secondary bacterial infection and long-term cytostatic therapy. We report a 75-year-old male with plantar psoriasis exacerbated by 16 years of hydroxycarbamide therapy for erythremia.



Case Presentation

A 75-year-old male presented with extensive erythematous, scaly plaques on both lower limbs. Lesions were well-demarcated, thick, and covered with silvery-white scales. Secondary changes included fissures, yellow crusting, and purulent discharge. The patient reported psoriasis onset 6 years after starting hydroxycarbamide (total duration 16 years). Initial lesions were small vesicles. A 3-year "light" period was followed by progressive worsening after 13 years. The patient was recently switched from hydroxycarbamide to ruxolitinib for erythremia and started a biologic (interleukin-23 or -17 inhibitor). The clinical appearance of "necrosis" was due to thick psoriatic crusting, secondary impetiginization, and topical brilliant green antiseptic application. No deep punched-out ulcers were present. Laboratory findings showed leukocytosis (WBC 18.9 $\times 10^9$/L) with neutrophilia (58%), elevated LDH (512–542 U/L), acute kidney injury (creatinine 205.7 μmol/L, urea 14.2–21.4 mmol/L), mild coagulopathy (INR 1.33, APTT 40.9 sec), and low total protein (65.0 g/L). CRP was negative.

Interventions: Antibiotic therapy included ofloxacin (200 mg twice daily), ceftriaxone (2.0 g intramuscular once daily), and levomycetin (0.5 mg four times daily, later discontinued). Fluconazole (150 mg once daily) was given for fungal superinfection and discontinued after one month. Topical brilliant green was replaced with modern dressings. Ruxolitinib and biologic therapy were continued. Hydration and discontinuation of nephrotoxic medications improved renal function.



COMPARISION WHEN PATIENT WAS ADMITTED AND AFTER STARTING TREATMENT

Conclusion

Severe plantar psoriasis in elderly patients on long-term hydroxycarbamide can mimic necrotic lower limb disease due to thick crusting, secondary infection, and topical dyes. Accurate diagnosis relies on recognizing typical psoriatic morphology. A combination of systemic antibiotics and antifungal therapy effectively managed secondary infection. Switching from hydroxycarbamide to ruxolitinib for erythremia is beneficial for both hematologic and cutaneous outcomes. This case highlights the need for interdisciplinary care between dermatology and hematology.

"Plantar psoriasis with secondary infection and topical dye application can resemble necrotic ulcers in patients on chronic hydroxycarbamide therapy. Clinical recognition of psoriatic plaques prevents misdiagnosis."



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Abstract N°: 2663

Real-World Effectiveness of Risankizumab Versus Other Biologic Therapies After 3 Years of Treatment in Adults With Moderate-To-Severe Plaque Psoriasis With High-Impact Area Involvement

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Introduction

Psoriasis (PsO) in high-impact areas (HIAs [nails, scalp, genitals, palm/soles]) negatively impacts quality of life (QoL). The International PsO Council classifies patients with HIA involvement, body surface area (BSA) >10%, or failure of topical therapy as eligible for systemic therapies, including biologics. Risankizumab (RZB) is an interleukin-23 inhibitor approved for adults with moderate-to-severe PsO with durable efficacy in HIAs. This post hoc analysis evaluated the real-world effectiveness of RZB versus other approved biologics (OtherBios) in PsO with HIA involvement.

Materials and Methods

VALUE (NCT03982394) was a multi-country, prospective, post-marketing observational study in adults with moderate-to-severe PsO receiving RZB or OtherBios. The full analysis set (FAS) included patients treated with ≥1 dose before Month 37. Outcomes (PsO Area and Severity Index [PASI] 90/100 [90%/100% skin clearance] and Dermatology Life Quality Index [DLQI] 0/1 [score range 0–30, 0/1: no effect, >21: large effect]) were evaluated at Month 13, 25, and 37 in patients with PsO in the nail, scalp, genital, and/or palmoplantar regions treated with RZB or OtherBios; agents with <50 treated patients were excluded from individual comparisons. Outcomes were stratified by baseline BSA (<10% or ≥10%). Results were reported by modified non-responder imputation (patients who switched or discontinued the initiated biologic due to ineffectiveness or intolerability were considered treatment failures for subsequent visits). Propensity score matching (PSM) was used to account for differences in characteristics. Chi-square analysis was used for statistical comparisons, and all *P* values were nominal.

Results

The FAS included 2787 patients (RZB: n=1856; OtherBios: n=931). Baseline characteristics were generally comparable between patients treated with RZB or OtherBios (mean PASI: 14.9 or 14.0; mean DLQI: 12.3 or 12.7; mean BSA: 22.3 or 21.0, respectively). HIA involvement (excluding patients with missing data) included the scalp (70.5%; 1955/2772), nails (40.7%; 1128/2770), genitals (23.3%; 647/2772), and palmoplantar (20.3%; 563/2772) regions.

In patients with HIA involvement, treatment with RZB compared with OtherBios resulted in significantly higher rates of achievement of PASI 90 (Month 13 [73.4% vs 56.6%], 25 [71.0% vs 51.1%], and 37 [72.3% vs 53.9%]), PASI 100 (Month 13 [53.8% vs 38.5%], 25 [53.1% vs 38.1%], and 37 [56.7% vs 40.9%]), and DLQI 0/1 (Month 13 [68.9% vs 53.2%], 25 [70.7% vs 52.0%], and 37 [70.3% vs 51.4%]); all $P<0.001$ **(Figure 1A)**.

In patients with BSA <10%, treatment with RZB compared with OtherBios resulted in significantly higher rates of achievement of PASI 90 (Month 13 [63.7% vs 49.3%], 25 [63.6% vs 40.2%], and 37 [68.4% vs 46.4%]), PASI 100 (Month 13 [52.7% vs 37.7%], 25 [55.1% vs 34.3%], and 37 [60.5% vs 40.7%]), and DLQI 0/1 (Month 13 [66.1% vs 50.4%], 25 [68.6% vs 52.3%], and 37 [70.9% vs 54.1%]); all $P<0.01$ **(Figure 1B)**.

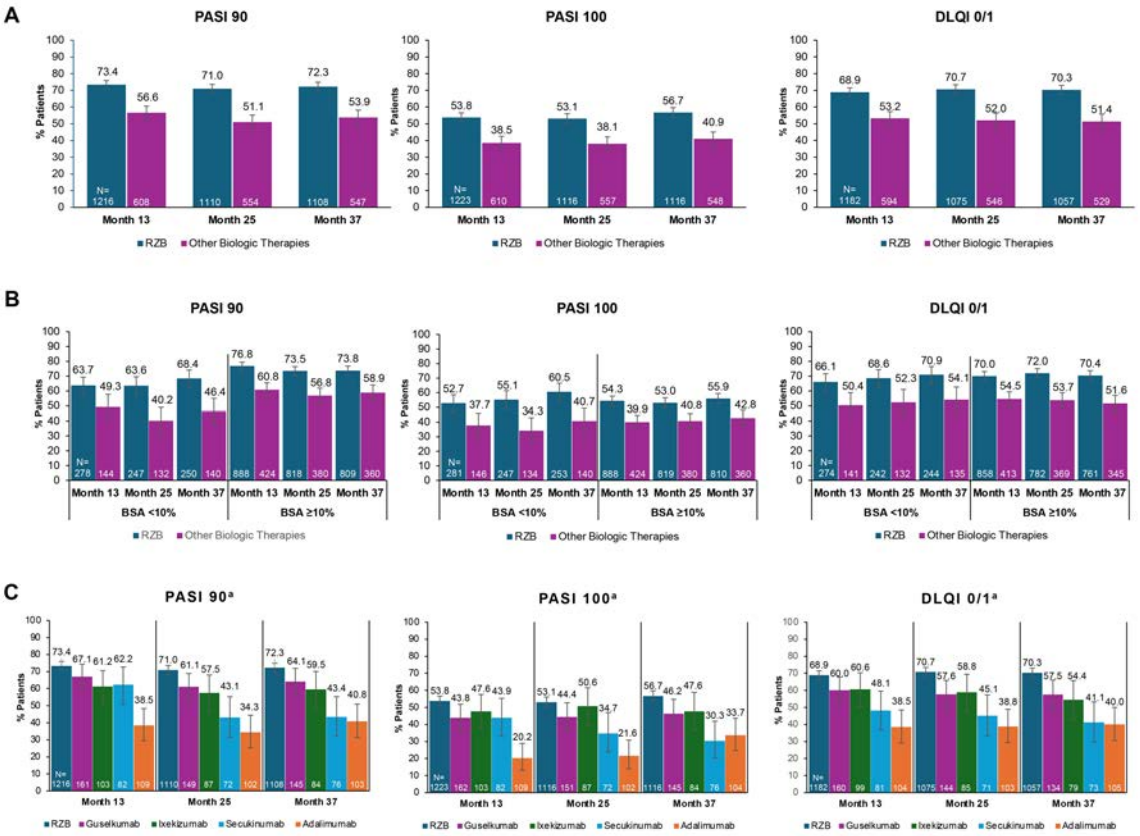
In patients with BSA ≥10%, treatment with RZB compared with OtherBios resulted in significantly higher rates of achievement of PASI 90 (Month 13 [76.8% vs 60.8%], 25 [73.5% vs 56.8%], and 37 [73.8% vs 58.9%]), PASI 100 (Month 13 [54.3% vs 39.9%], 25 [53.0% vs 40.8%], and 37 [55.9% vs 42.8%]), and DLQI 0/1 (Month 13 [70.0% vs 54.5%], 25 [72.0% vs 53.7%], and 37 [70.4% vs 51.6%]); all $P<0.001$ **(Figure 1B)**.

Similar trends were observed when comparing patients treated with RZB with individual agents (adalimumab, ixekizumab, secukinumab, or guselkumab; **Figure 1C**). Comparable results were observed with PSM (data not shown).

Conclusions

RZB led to significantly higher rates of skin clearance (PASI 90/100) and improved QoL (DLQI 0/1) compared with OtherBios in moderate-to-severe PsO with HIA involvement, regardless of baseline BSA (<10% or ≥10%). These findings demonstrate the sustained real-world effectiveness of RZB in patients with HIA involvement and are consistent with clinical trial results.

Figure 1. Achievement of PASI 90, PASI 100, and DLQI 0/1 at Months 13, 25, and 37 in patients with PsO in HIAs treated with RZB versus treatment with **A)** OtherBios,[a] **B)** OtherBios stratified by BSA <10% and ≥10%, **C)** individual agents



[a]Analyses excluded therapies which treated <50 patients.
HIAs, high-impact areas; DLQI, dermatology life quality index; OtherBios, all other biologic therapies; PASI, psoriasis area and severity index; RZB, risankizumab.

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Abstract N°: 2666

Real-World Effectiveness, Safety, and Drug Survival of Biologic Agents in Patients with Plaque Psoriasis: Retrospective Cohort Study

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Introduction
The aim of this study was to compare the real-world effectiveness, safety, and long-term drug survival of adalimumab, infliximab, ustekinumab, secukinumab, ixekizumab, guselkumab, and risankizumab in the treatment of moderate-to-severe plaque psoriasis, and to identify clinical predictors influencing drug survival.

Materials and Methods
This study included adult patients with moderate-to-severe plaque psoriasis who were followed at a single tertiary center between January 2014, and February 2025. Patients who received at least one biologic agent for a minimum of one month were included. A total of 649 biologic treatment courses from 393 patients were analyzed. Clinical and demographic data were extracted from patient records. Treatment effectiveness was evaluated using absolute (PASI ≤1, and 0) and relative (PASI90, and 100) PASI responses at the week 12 and week 52. Factors associated with treatment response were analyzed using logistic regression models. Reasons for treatment discontinuation were categorized. Cumulative drug survival were estimated using the Kaplan–Meier method, and clinical predictors for drug survival were evaluated using Cox proportional hazards regression analysis.

Results
Of 649 courses, 45.6% of the patients were biologic-experienced. At week 12, PASI90 response rates were observed as follows: ixekizumab 75.5%, risankizumab 70.2%, guselkumab 55.1%, secukinumab 52.9%, ustekinumab 51.4%, adalimumab 39.4%, and infliximab 30%. At week 12, the PASI100 response rate was highest in the ixekizumab group at 51.8%. At week 52, risankizumab achieved the highest response rates, with PASI90 at 84.3% and PASI100 at 51%. Psychiatric disease, hypertension, prior biologic therapy, and palmoplantar involvement were identified as independent factors negatively affecting PASI90 response at week 12. Treatment discontinuation due to primary failure was observed in 2.2% of cases, with the highest rate was in the infliximab group (6.7%). This was followed by adalimumab (4.2%) and ustekinumab (3.2%). No primary failure was observed in the ixekizumab and risankizumab groups. Discontinuation due to secondary failure was observed in 20.2% of cases, with the highest rate in the ustekinumab group (41.9%), while the lowest rate in the guselkumab group (6%). Discontinuation due to adverse events was observed in 6.9% of cases, most frequently in the adalimumab group (16.9%), followed by infliximab (11.1%).The most common adverse events were suspected malignancy (2%) and hepatotoxicity (1.7%). Of the 13 cases with suspected malignancy, 9 were confirmed to be malignant during follow-up. At the end of year 2, cumulative drug survival was highest in the guselkumab (57.8%) and risankizumab (54.8%) groups (Figure 1). In terms of ineffectiveness-related drug survival, guselkumab had the highest rate (84.4%), while secukinumab had the highest safety-related drug survival (95.5%). Presence of psoriatic arthritis, chronic obstructive lung disease, palmoplantar involvement, the use of concurrent methotrexate therapy, and a history of prior biologic therapy were found to be associated with decreased drug survival. A history of prior biologic therapy was found to independently increase the risk of treatment discontinuation (HR: 1.256; 95% CI: 1.023–1.542; p=0.029).

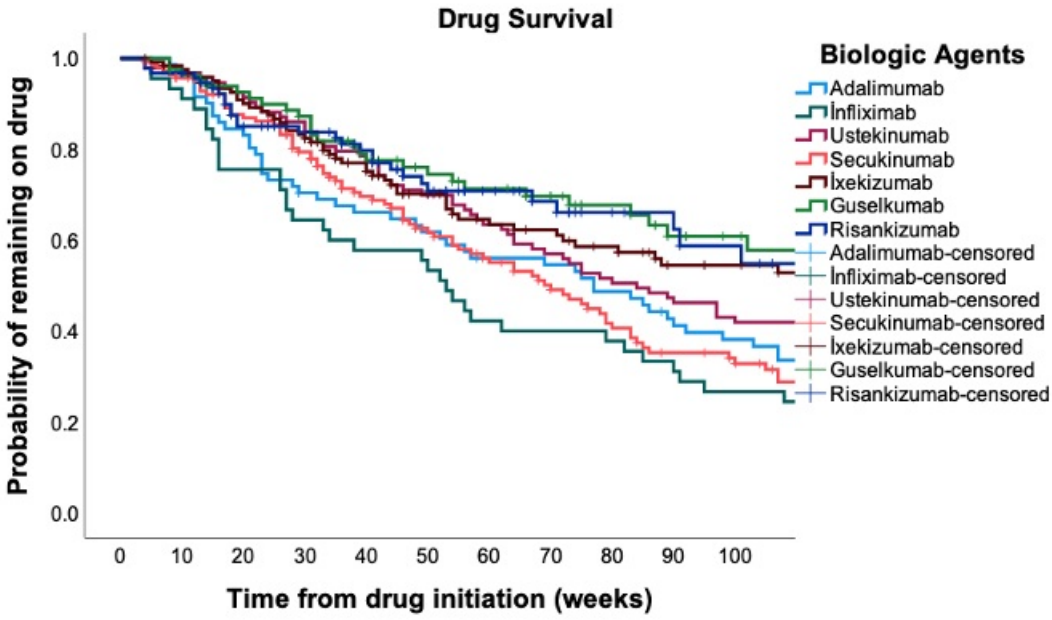

Figure 1. Overall drug survival: Kaplan–Meier survival curves over 2 years

Conclusions

In this real-world cohort, IL-17 and IL-23 inhibitors demonstrated superior effectiveness and drug survival compared to TNF-α and IL-12/23 inhibitors. Ixekizumab provided the fastest response, while risankizumab and guselkumab achieved the highest long-term responses and lowest inefficacy-related discontinuation rates. Secukinumab showed the most favorable safety-related drug survival profile. Prior biologic exposure was the strongest independent predictor of treatment discontinuation, underscoring the importance of early biologic optimization and careful treatment sequencing in long-term psoriasis management.

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Pustular Koebner phenomenon in a patient with generalized pustular psoriasis

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Introduction

The isomorphic response, known as the Koebner phenomenon (KP), is defined as the appearance of typical lesions at sites of even trivial injuries. In psoriasis, this characteristic feature accounts for the appearance of typical psoriatic patches on scars and at sites of scratches, tattoos, and burns, among others. On the other hand, the occurrence of a pustular KP occurring in the setting of generalized pustular psoriasis (GPP) has rarely been reported. We herein report a case of pustular KP occurring along excoriated areas during a severe flare of pustular lesions in a patient with diagnosis of GPP.

Case Presentation

A 69-year-old woman presented with an acute episode of a widespread pustular eruption associated with fever, malaise, and fatigue, preceded by an upper respiratory tract infection. Family history consisted of a sister with plaque psoriasis. Physical examination revealed multiple superficial, non-follicular pustules on an erythematous and edematous base, affecting trunk and limbs, palms and soles, associated with a pruritic and stinging sensation. New isolated and sometimes confluent pustular lesions progressively developed in a disseminated manner over the trunk and limbs during the next days, in addition to multiple, well-defined, linear erythematous patches studded with pustules over her abdomen and lower back at sites of previous excoriations, consistent with a KP. Biopsy of the lower back evidenced features of GPP, including subcorneal and intraepidermal pustules rich in neutrophils (pustules of Kogoj), psoriasiform epidermal hyperplasia, parakeratosis, hypogranulosis, thinning of the suprapapillary plates, and a superficial dermal inflammatory infiltrate with neutrophilic predominance. Treatment with acitretin 40mg/day led to progressive regression of the pustular outbreak after a two-week period, followed by the development of typical psoriatic patches when acitretin was tapered. Guselkumab 100mg was then initiated, leading to complete regression of psoriatic patches and no recurrence of pustular outbreaks after eight months of continuous treatment.

Conclusion

In 1878, Heinrich Koebner originally described the development of psoriatic lesions in the uninvolved skin of psoriatic patients as a consequence of trauma at tattoo sites. The reported frequency of a positive KP in psoriasis ranges 24-54%, depending on the population and criteria evaluated. It has been described in many other diseases, such as lichen planus, lichen nitidus, vitiligo, and nummular eczema. KP usually appears within 1-2 weeks but can also occur, ranging from 3 days to 2 years. This wide variation reflects the degree of sensitivity for the development of the KP, which may be a distinctive characteristic of the patients. By contrast, a pustular isomorphic response appears to be distinctly uncommon. Handa et al originally reported on a 44-year-old woman, who was known to have acrodermatitis continua of Hallopeau, presenting with a flare of her disease over her hands and a 2-month history of development of pustular lesions over keloids located on her presternal area.

In the presented case, a combination of intense pruritus, repeated excoriation, and subsequent lesion development on injured skin supports mechanical trauma as a relevant local trigger of the pustular KP in a susceptible individual. Subsequent evolution to plaque psoriasis is also clinically meaningful. Although GPP is currently regarded as a distinct inflammatory entity, increasing evidence supports phenotypic overlap with plaque psoriasis, and transitions between pustular and plaque forms may occur during the disease course. Recognition of this overlap is important because it may influence diagnostic reasoning, longitudinal assessment, and therapeutic planning.

In conclusion, this case adds to the uncommonly described pustular KP in a patient with GPP and highlights an unusual pustular expression of trauma-induced psoriasis. It also reinforces that scratching and skin injury may amplify disease expression.

EADV CONGRESS
VIENNA
30 SEP - 3 OCT 2026

Abstract N°: 2669

GENERALIZED PUSTULAR PSORIASIS: BEYOND CUTANEOUS INVOLVEMENT

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Introduction

Generalized pustular psoriasis (GPP) is a rare, heterogeneous, and potentially life-threatening neutrophilic dermatosis. Beyond cutaneous involvement, it may be accompanied by severe extracutaneous manifestations. The objective of this work is to illustrate, through a complex clinical observation, the systemic dimension of GPP and the importance of recognizing visceral involvement (pulmonary, hepatic, and articular) that dictates the vital prognosis.

Case Presentation

Materials and Methods

We report the case of a 41-year-old patient with a history of psoriasis vulgaris hospitalized for acute generalized pustulosis associated with febrile systemic impairment. The diagnostic approach included a skin biopsy, which confirmed the diagnosis of generalized pustular psoriasis, as well as an exhaustive exploration of vital functions: chest imaging (CT scan), pleural fluid aspiration, a complete liver function test, and biliary imaging (MRCP). An immunological workup (ANA, anti-M2, LKM1, anti-mitochondrial antibodies) and infectious screening (ADA, Tuberculin Skin Test, and viral serology) were performed to exclude classical etiologies.

Results

Upon questioning, the skin eruption did not appear to be triggered by drug intake.The clinical presentation revealed severe multi-organ involvement:

1. **Pulmonary: Respiratory distress related to interstitial syndrome and sterile transudative pleural effusion.**
2. **Articular: Inflammatory arthralgia with total functional impairment.**
3. **Hepatic: Jaundice with cytolysis and cholestasis. Imaging showed hepatomegaly and dilation of the intrahepatic bile ducts without evidence of obstruction.**

After excluding infectious and autoimmune causes, the diagnosis of neutrophilic cholangitis and psoriatic interstitial lung disease was established. Given the hepatic dysfunction and the decline in general health, systemic corticosteroid therapy (0.5 mg/kg) was initiated, leading to the concomitant regression of both cutaneous and visceral signs.

Discussion

The ERASPEN consensus defines GPP by primary sterile pustules, with or without systemic inflammation, which can lead to specific extracutaneous involvement: hepatic, pulmonary, renal, and articular. The role of cytokines, particularly IL-36, is central: studies link elevated levels of IL-36α and γ to interstitial lung diseases, the incidence of which is high during GPP. The hepatic involvements described in reported cases are neutrophilic cholangitis and non-alcoholic steatohepatitis (NASH), resulting from systemic inflammation mediated by IL-36 and IL-17. These complications manifest as major biological abnormalities (jaundice, cholestasis, cytolysis) and histological or radiological signs mimicking sclerosing cholangitis,

typically normalizing during cutaneous remission. First-line treatment for GPP now relies on anti-IL-36 antibodies. However, in cases of contraindication or unavailability, conventional systemic treatments (acitretin, cyclosporine, methotrexate) are used. In our case, the hepatic dysfunction and systemic severity necessitated the use of corticosteroids.

Conclusion

Although rare, the extracutaneous manifestations of GPP define the prognosis of the disease. Their recognition is paramount, as they transform this neutrophilic dermatosis into a true multi-organ failure. Early and appropriate management is vital to prevent a fatal outcome.

EADV CONGRESS
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Abstract N°: 2670

Association of Helicobacter pylori Infection with Disease Severity in Psoriasis: A Cross-Sectional Comparative Study.

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Introduction
Psoriasis is a chronic inflammatory, immune-mediated disorder with multifactorial etiopathogenesis. Infectious agents, including Helicobacter pylori, have been proposed as potential triggers influencing disease activity. However, the relationship between H. pylori infection and psoriasis severity remains inconclusive. This study aimed to evaluate this association in bangladeshi population.

Materials and Methods
This cross-sectional comparative study was conducted in the Department of Dermatology and Venereology at Bangladesh Medical University from May 2023 to March 2025. A total of 58 participants were enrolled, including 29 patients with clinically and histopathological diagnosed psoriasis (Group A) and 29 age- and sex-matched healthy controls (Group B), based on predefined inclusion and exclusion criteria. Psoriasis severity was assessed using the Psoriasis Area and Severity Index. Detection of H. pylori infection was performed using stool antigen testing. Statistical analysis was conducted using SPSS version 26.0, with a p-value <0.05 considered statistically significant.

Results
No significant differences were observed between groups in terms of age (p=0.480) or sex (p=0.597). Among psoriasis patients, the mean disease duration was 4.76 ± 4.78 years, with 79.3% having disease duration <10 years. A significantly higher prevalence of H. pylori infection was observed in psoriasis patients compared to controls (31.0% vs. 6.9%, p=0.019). Mean PASI score was significantly higher in H. pylori-positive patients (21.7 ± 5.14) compared to H. pylori-negative patients (7.24 ± 7.13, p<0.001). All H. pylori-positive psoriasis patients (100%) had severe disease (PASI ≥10). In contrast, among H. pylori-negative patients, 45.0% had mild, 30.0% moderate, and 25.0% severe disease (p<0.001). No significant association was found between psoriasis severity and age, sex, or disease duration.

Conclusions
Helicobacter pylori infection is significantly associated with increased severity of psoriasis. These findings suggest a potential contributory role of bacterial infection in exacerbating immune-mediated skin disease. Screening for H. pylori infection using stool antigen testing may be considered in psoriasis patients with high PASI scores, potentially guiding adjunctive management strategies.

EADV CONGRESS
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Abstract N°: 2675

Tumor Necrosis Factor-α Inhibitor Therapy and Risk of Dementia and Neurologic Outcomes in Psoriasis

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Introduction

Psoriasis is a chronic inflammatory disease associated with systemic comorbidities, including potential neurodegenerative and cerebrovascular risk. Tumor necrosis factor-α (TNF-α) inhibitors are widely used systemic therapies, but their impact on neurologic outcomes remains unclear. We sought to evaluate the association between TNF-α inhibitor therapy and the risk of dementia and related neurologic outcomes in patients with psoriasis.

Materials and Methods

A retrospective cohort study was conducted using the TriNetX federated research network, including 109 healthcare organizations. Patients with psoriasis treated with TNF-α inhibitors (n=42,264) were compared to psoriasis patients without TNF-α inhibitor exposure (n=581,166). Propensity score matching yielded balanced cohorts of 22,879 patients each. Outcomes included Alzheimer's disease, mild cognitive impairment, Parkinson's disease, vascular dementia, unspecified dementia, stroke, and related neurologic conditions. Analyses excluded patients with prior outcomes, and Kaplan-Meier survival analyses were performed.

Results

TNF-α inhibitor use was not associated with a significant difference in risk of Alzheimer's disease (RR 0.89, p=0.436), mild cognitive impairment (RR 1.09, p=0.353), Parkinson's disease (RR 1.02, p=0.889), vascular dementia (RR 0.81, p=0.234), multiple sclerosis, hydrocephalus, or stroke. A modest reduction was observed in unspecified dementia (hazard ratio 0.84, p=0.026) and composite neurologic outcomes (RR 0.94, p=0.031). Survival analyses showed small but statistically significant differences for select outcomes.

Conclusions

In this large real-world cohort, TNF-α inhibitor therapy in psoriasis was not associated with significant reductions in most dementia-related outcomes, with only modest effects observed in select endpoints. These findings suggest a differential impact of targeted inflammatory pathways on neurocognitive risk and highlight the need for further mechanistic and prospective studies.

EA DV CONGRESS
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30 SEP - 3 OCT 2026

Abstract N°: 2703

Dual Efficacy of Secukinumab in Plaque Psoriasis and Porokeratosis: A Case Report with Mechanistic Insights

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Introduction

Porokeratosis (PK) is a rare disorder of epidermal keratinization, presenting as circular or linear hyperkeratotic plaques with raised borders(1). It can be inherited or acquired, often triggered by UV exposure, viral infections, or immunosuppression. Long-standing PK carries a risk of malignant transformation(2). Current therapies are limited in efficacy. Secukinumab, a fully human IL-17A monoclonal antibody approved for first-line biologic therapy in moderate-to-severe plaque psoriasis, blocks IL-17A signaling, reducing keratinocyte proliferation and T-cell infiltration.(3,4). Given that psoriasis and PK share features of abnormal keratinization and inflammation, overlapping therapeutic mechanisms may exist. This is the first reported case demonstrating significant improvement in both psoriasis and PK following secukinumab therapy.

Case Presentation

A 40-year-old man with a 30-year history of psoriasis presented with worsened psoriatic lesions and new annular hyperpigmented plaques on the trunk. Previous therapies, including topical corticosteroids, antihistamines, and calcipotriol with UVB phototherapy, provided temporary improvement but relapsed. Family history was notable for psoriasis in the father and aunt, and PK in the mother and maternal uncle. Physical examination revealed multiple annular, well-defined, hyperpigmented macules predominantly on sun-exposed limbs, alongside classic psoriatic plaques on the limbs and trunk. For further diagnosis, a biopsy was obtained from a characteristic psoriatic plaque, with histopathological examination confirming the diagnosis of psoriasis(Figure 1A). Additionally, a biopsy of a annular hyperpigmented plaque revealed epidermal hyperkeratosis with parakeratotic columns in the stratum corneum, accompanied by loss of the granular layer and scattered dyskeratotic cells(Figure 1B). Based on these histopathological features, the patient was diagnosed with plaque psoriasis combined with porokeratosis(PK). After discontinuing phototherapy, he was started on regular treatment with secukinumab (300 mg once weekly for 5 weeks, followed by monthly doses). One month later, significant improvement was noted in the psoriatic skin lesions, with lesions becoming thinner and itching subsiding. After 3 months of sustained treatment, the psoriasis lesions had completely disappeared without recurrence. Moreover, the pigmentation of PK plaques diminished, and both the number and size of PK dermatologic plaques were reduced. No side effects were observed in this patient.

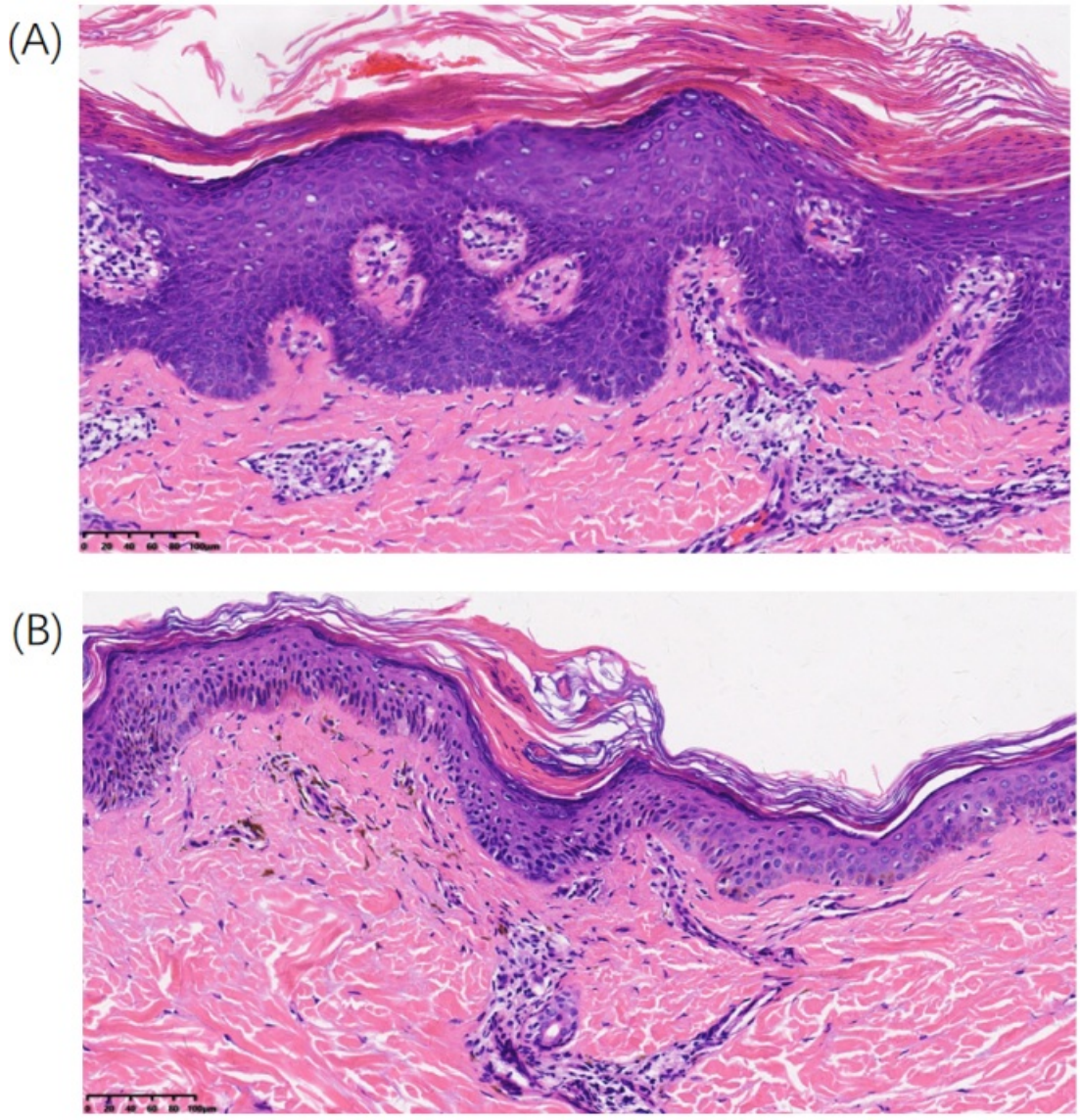

Figure 1. Histopathology of plaque psoriasis and porokeratosis. (A) Psoriatic plaque showing hyperkeratosis with parakeratosis, Munro microabscesses, acanthosis, dermal necrosis, and superficial dermal lymphocytic infiltration (H&E, ×200). (B) Biopsy of a hyperpigmented annular lesion showing characteristic features of porokeratosis: (1) epidermal hyperkeratosis with parakeratotic columns in the stratum corneum; (2) thinning and loss of the granular layer beneath hyperkeratotic columns with scattered dyskeratotic cells; (3) superficial dermal lymphocytic infiltration (H&E, ×200).

Conclusion

Dysregulation of IL-17 signaling drives immunoinflammatory skin diseases, including psoriasis, hidradenitis suppurativa, and cutaneous squamous cell carcinoma (4,5). IL-17 induces keratinocytes to produce cytokines, antimicrobial peptides, and chemokines, promoting epidermal hyperplasia, keratinocyte proliferation, leukocyte recruitment, and inflammation (6,7). To explore mechanisms of secukinumab in porokeratosis (PK), DEGs from PK lesions were compared with psoriasis lesions using Zhang et al.'s dataset (8). Seventeen overlapping upregulated genes, including K16, K6A, K6B, and K17, were identified, suggesting shared pathogenic processes (Fig. 2A). GO analysis revealed enrichment in skin development, leukocyte migration, plasma membrane components, cytokine activity, and receptor binding; KEGG analysis highlighted cytokine-cytokine receptor interaction, chemokine signaling, viral protein-cytokine interactions, and IL-17 signaling (Fig. 2B).This is the first case to demonstrate the dual efficacy of secukinumab in psoriasis and PK, providing new insights into the shared pathophysiology of these conditions. However, more cases and clinical trials are required to further investigate the underlying mechanisms.

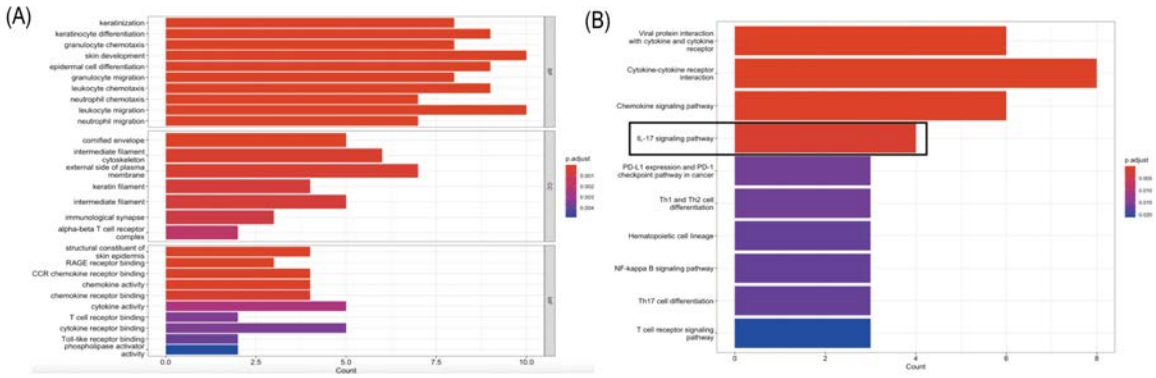

Figure 2. Functional enrichment of differentially expressed genes (DEGs) in porokeratosis (PK). (A) Gene Ontology (GO) enrichment analysis of all DEGs reported by Zhang et al.'s dataset (B) KEGG pathway enrichment analysis of 40 PK DEGs reported by Zhang et al.'s dataset Reference: 1. Abramovits W, Oquendo M. Introduction to autoinflammatory syndromes and diseases. Dermatol Clin. 2013;31(3):363-85. 2. Schamroth JM, Zlotogorski A, Gilead L. Porokeratosis of Mibelli. Overview and review of the literature. Acta Derm Venereol. 1997;77(3):207-13. 3. Pietkiewicz P, Korecka K, Salwowska N, Kohut I, Adhikari A, Bowszyc-Dmochowska M, et al. Porokeratoses-A Comprehensive Review on the Genetics and Metabolomics, Imaging Methods and Management of Common Clinical Variants. Metabolites. 2023;13(12). 4. Goerttler EA, Jung EG. Porokeratosis [correction of Parakeratosis] Mibelli and skin carcinoma: a critical review. Humangenetik. 1975;26(4):291-6. 5. Otsuka F, Someya T, Ishibashi Y. Porokeratosis and malignant skin tumors. J Cancer Res Clin Oncol. 1991;117(1):55-60. 6. Krueger JG, Fretzin S, Suarez-Farinas M, Haslett PA, Phipps KM, Cameron GS, et al. IL-17A is essential for cell activation and inflammatory gene circuits in subjects with psoriasis. J Allergy Clin Immunol. 2012;130(1):145-54 e9. 7. Krueger JG, Wharton KA Jr, Schlitt T, Suprun M, Torene RI, Jiang X, Wang CQ, Fuentes-Duculan J, Hartmann N, Peters T, Koroleva I, Hillenbrand R, Letzkus M, Yu X, Li Y, Glueck A, Hasselberg A, Flannery B, Suárez-Fariñas M, Hueber W. IL-17A inhibition by secukinumab induces early clinical, histopathologic, and molecular resolution of psoriasis. J Allergy Clin Immunol. 2019 Sep;144(3):750-763. 8. Zhang ZH, Wang ZM, Crosby ME, Wang HF, Xiang LH, Luan J, et al. Gene expression profiling of porokeratosis. J Cutan Pathol. 2008;35(11):1058-62.

EA DV CONGRESS
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30 SEP - 3 OCT 2026

Abstract N°: 2776

Association Between Psoriasis Duration and Maintenance of Control (PASI ≤2) after Tildrakizumab Withdrawal: Post Hoc Analyses from reSURFACE 1

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Introduction

Plaque psoriasis is a chronic, immune-mediated inflammatory disease characterised by immune dysregulation and pro-inflammatory cytokine signalling. Timely intervention in psoriasis may influence long-term disease control by enabling deeper and more durable suppression of disease activity. Tildrakizumab (TIL) is a high-affinity, humanised IgG1κ monoclonal antibody that selectively inhibits the IL-23p19 subunit and has demonstrated sustained efficacy in pivotal Phase 3 clinical trials for psoriasis.[1-3] Despite this, the impact of disease duration on the maintenance of disease control, particularly following treatment withdrawal, has not been fully explored. Here, we assess the impact of disease duration on the maintenance of disease control (Psoriasis Area and Severity Index [PASI] ≤2) up to Week (W) 64 of reSURFACE 1, during treatment with TIL and following treatment withdrawal.

Materials and Methods

reSURFACE 1 (NCT01722331) was a 64-week, Phase 3, randomised, double-blind, placebo-controlled trial that investigated the safety and efficacy of TIL in patients aged ≥18 years with moderate-to-severe chronic plaque psoriasis. Eligible patients were randomised to receive 2:2:1 100 mg TIL: 200 mg TIL: placebo at W0, W4, and W16. Patients who achieved ≥75% improvement from baseline in PASI (PASI-75) at W28 were re-randomised 1:1 to continue the same TIL dose (continued treatment) or to receive placebo every 12 weeks (withdrawal arm) through W64. In this analysis, two patient subgroups were assessed; those with short disease duration (SDD; ≤2 years since disease onset) or long disease duration (LDD; >5 years since disease onset). We report the percentage of patients with SDD and LDD who maintained PASI ≤2 between W28 and W64, in both the withdrawal arm and patients continuing the same TIL dose (a pooled dose analysis was also performed). Missing values were imputed using non-responder imputation.

Results

This post hoc analysis included 468 patients; of these, 47 had SDD and 354 had LDD. Baseline characteristics were generally similar between the SDD and LDD groups, with slightly higher proportions of patients with severe psoriasis (mean [standard deviation; SD] PASI 21.4 [7.8] vs 19.8 [7.6]) and biologic-naïve patients (93.6% [n=44] vs 76.0% [n=269]) in the SDD group. At W28, 114 patients (100 mg TIL) and 119 patients (200 mg TIL) were re-randomised to placebo (withdrawal arm) following 16 weeks of treatment. During continued treatment (W28 onwards), more patients with SDD than LDD maintained PASI ≤2 at W64 with 100 mg TIL (91.7% [n=12] vs 55.7%

[n=88]) and 200 mg TIL (90.0% [n=10] vs 49.2% [n=128]). This trend was reflected in the pooled dose analysis (**Figure**). Following withdrawal, a higher proportion of patients with SDD than LDD achieved PASI ≤2 at W40 with both 100 mg TIL (75.0% [n=12] vs 43.0% [n=86]) and 200 mg TIL (76.9% [n=13] vs 52.7% [n=91]); this trend persisted at W64 (100 mg: 33.3% [n=12] vs 32.6% [n=86]; 200 mg: 30.8% [n=13] vs 24.2% n=91]). Results in the pooled dose analysis were consistent with the dose-specific findings (**Figure**).

Conclusions

Although the sample size for patients with SDD in this study was low, these patients showed more sustained maintenance of PASI ≤2 over time than patients with LDD during continued TIL treatment and following treatment withdrawal to placebo. These trends were consistent across patients regardless of TIL dose. This suggests that early intervention in psoriasis may influence long-term disease control by enabling deeper and more durable suppression of disease activity.

References:

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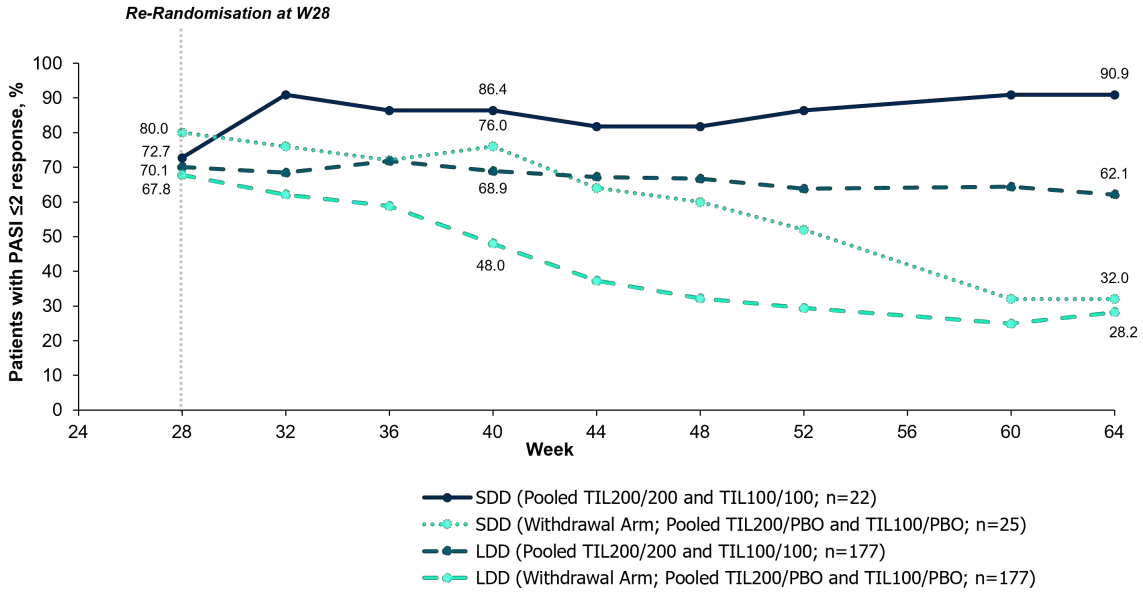
Figure. Proportions of patients with PASI ≤2 response in the pooled dose analysis group (NRI)



In the pooled TIL200/PBO and TIL100/PBO groups (withdrawal arm), the last dose of TIL was at W16; patients were re-randomised at W28. LDD, long disease duration; n, number of patients; NRI, non-responder imputation; PASI, psoriasis area and severity index; PBO, placebo; SDD, short disease duration; TIL: tildrakizumab.

EA DV CONGRESS
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Abstract N°: 2781

Evaluating Risankizumab's Long-Term Effects in Psoriasis Using Optical Coherence Tomography - Lesional vs. Perilesional Analysis

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Introduction

Risankizumab (RZB), an interleukin (IL)-23 inhibitor, has demonstrated rapid and sustained clinical efficacy in moderate-to-severe plaque type psoriasis. Its effect on persistent subclinical inflammation is less understood. Optical coherence tomography (OCT) is an innovative non-invasive, high-resolution imaging technique that enables visualization of structural and vascular changes in the skin, providing valuable insights beyond the visible manifestations.

Materials and Methods

This sub-analysis of a prospective, single-center exploratory study included 21 patients with moderate-to-severe plaque type psoriasis treated with RZB. Treatment decisions were made at the discretion of the patients' physician independently of and prior to study enrolment. Clinical assessments (PASI, IGA) were conducted at baseline and weeks 2, 4, 16, 28, 40, and 52. OCT imaging were performed at baseline and weeks 4, 16, and 52, measuring epidermal thickness vessel density, vessel diameter and plexus depth in both lesional and perilesional, clinically uninvolved skin of a representative plaque. Quantitative vascular parameters were derived from exported dynamic OCT data using a custom algorithm. Vessel density and vessel diameter were sampled at 0.05 mm intervals over 2 mm tissue depth and integrated as AUC. This external analysis differs from the manufacturer's slab-based output. Plexus depth was measured as the depth of the top of the superficial plexus, at which vessel density reaches 50% of its maximum.

Primary results from this cohort have been published elsewhere.[1,2] For this sub-analysis, analyzed data were expressed as the difference between lesional and perilesional skin to evaluate normalization. Wilcoxon signed-rank test was used to compare baseline with week 52.

Results

At baseline mean (SD) PASI score was 16.1 (10.8), mean (SD) IGA score was 3.2 (0.6) and mean (SD) DLQI was 13.3 (7.6). At week 52 PASI 75, PASI 90, and PASI 100 responses were achieved by 85.7%, 78.6%, and 43.0% of patients, respectively, while 92.3% achieved IGA 0/1 and 75% reached DLQI of 0/1.

OCT parameters of lesional skin showed convergence towards perilesional levels from baseline to week 52: mean (+/-95% CI) epidermal thickness decreased from 320,1 µm (+/- 70.8) to 34.4 µm (+/-32.9) ($p<0.0001$), plexus depth shifted from 98.1 µm (+/-31.8) to 19.0 µm (+/- 7.2) ($p<0.0002$), vessel diameter decreased from 15.4 µm (+/- 5.0) to 0.5 µm (+/- 0.2) ($p=0.0709$), vessel density reduced from 3.8 % (+/- 1.3) to 2.2 % (+/- 0.9) ($p=0.4061$),

here absolute values declined in lesional (from week0 AUC = 7.7 (+/- 2.5) to week52 AUC = 4.8 (+/- 1.9) (p<0.0001)) and perilesional skin (from AUC = week0 4.3 (+/- 1.4) to week52 AUC = 2.6 (+/- 1.1) (p=0.0232)) (Figure 1).

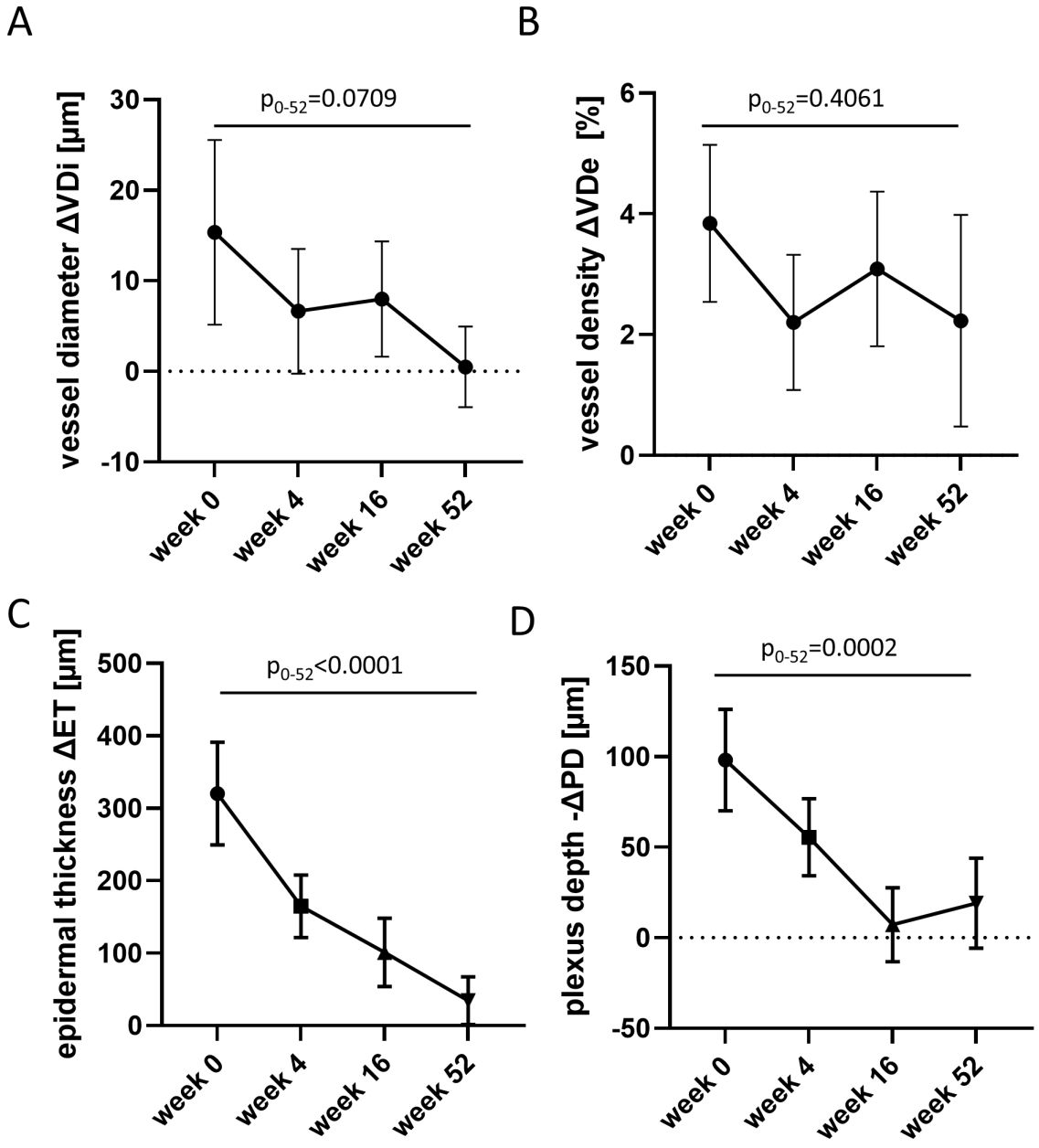

Figure 1: OCT parameters measured as the difference between lesional and perilesional skin (=delta, Δ) presented as mean +/- 95% CI for (A) vessel diameter (B) vessel density (C) epidermal thickness, and (D) plexus depth. CI, confidence interval; ET, epidermal thickness; OCT, optical coherence tomography; PD, plexus depth, VDe, vessel density; VDi, vessel diameter; Δ, delta

Conclusions

Risankizumab therapy showed normalization of the most OCT parameters over 52 weeks emphasizing the importance of long-term treatment with benefits extending beyond visible improvement. Furthermore, persistence of a similar delta in vessel density alongside reduced absolute values underscores the systemic nature of psoriasis. OCT emerged as a valuable tool for assessing deep (vascular) treatment response, thereby supporting a more comprehensive understanding of the therapeutic outcomes in psoriasis.

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Abstract N°: 2791

Systemic inflammation mediated the effect of obesity on progression from psoriasis to psoriatic arthritis: Results from two observational data sources in psoriasis

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Introduction
Obesity is a well-recognized comorbidity in psoriasis (PsO) and has been associated with an increased risk of progression to psoriatic arthritis (PsA). Although the precise causal mechanisms underlying this transition remain incompletely understood, systemic inflammation, amplified by adipose tissue dysfunction in obesity, is hypothesized to be a key driver.

Objective

To evaluate the association between overweight and obesity and the risk of PsA development in adults with PsO, and to assess whether this association was mediated by systemic inflammation, as determined by high-sensitivity C-reactive protein (hsCRP).

Materials and Methods
Two Swedish observational data sources were used: one is a prospective inception cohort study that enrolled participants within 1 year of first onset of PsO; and the other is a systemic treatment register for patients with PsO. Both studies collected data on different aspects of PsO, including obesity, musculoskeletal symptoms, and PsA. This analysis excluded patients with a prior PsA diagnosis.

Age, sex, smoking, Psoriasis Area and Severity Index (PASI), Body Mass Index (BMI, kg/m^2), and (hsCRP, only available in the inception cohort study) were measured at enrolment in the inception cohort study and at the first recorded measurement of both BMI and a PsO screening tool (Psoriatic Arthritis Screening and Evaluation Scale) in the PsO treatment register. The outcome, a specialist PsA diagnosis from the linked National Patient Register, was evaluated prospectively.

The cumulative incidence of PsA by BMI category (normal weight [BMI<25], overweight [25≤BMI<30], and obesity [BMI≥30]) was estimated using the Kaplan-Meier product limit estimator. The association between BMI and development of PsA was assessed using Cox proportional hazards models that adjusted for age, sex, PASI, and smoking. We performed these analyses separately in each study and in both studies combined.

Causal mediation analysis, conducted in the inception cohort study, examined whether systemic inflammation, measured as ln(hsCRP), mediated the BMI–PsA association. Missing data were handled using multiple imputation.

Results

A total of 628 individuals from the inception cohort study (mean age 41 years, 45% male, mean BMI 25.2, median [interquartile range] hsCRP 1.6 [0.7–3.6] mg/L) and 488 individuals from the PsO treatment register (mean age 49 years, 64% male, mean BMI 27.7) were included. Across both data sources, overweight and obesity showed numerically higher risks of PsA development versus normal weight. After adjustment, each 5-unit increase in BMI was associated with a 17–20% higher risk of PsA development (inception cohort study: hazard ratio [HR] 1.18, p=0.04; PsO treatment register: HR 1.17, p=0.045; combined: HR 1.20, p=0.001). Elevated ln(hsCRP) was independently associated with PsA development (HR 1.47 per standard deviation increase [SD=1.3], p<0.001). Causal mediation analysis modeling a BMI reduction from 30 to 22 demonstrated that hsCRP significantly mediated the BMI–PsA association (indirect effect HR 0.75 [95% CI: 0.64–0.84; p<0.001]; total effect HR 0.70 [95% CI: 0.53-0.94; p=0.02), while the direct effect was attenuated and non-significant (HR 0.79 [95% CI: 0.57-1.08; p=0.18]).

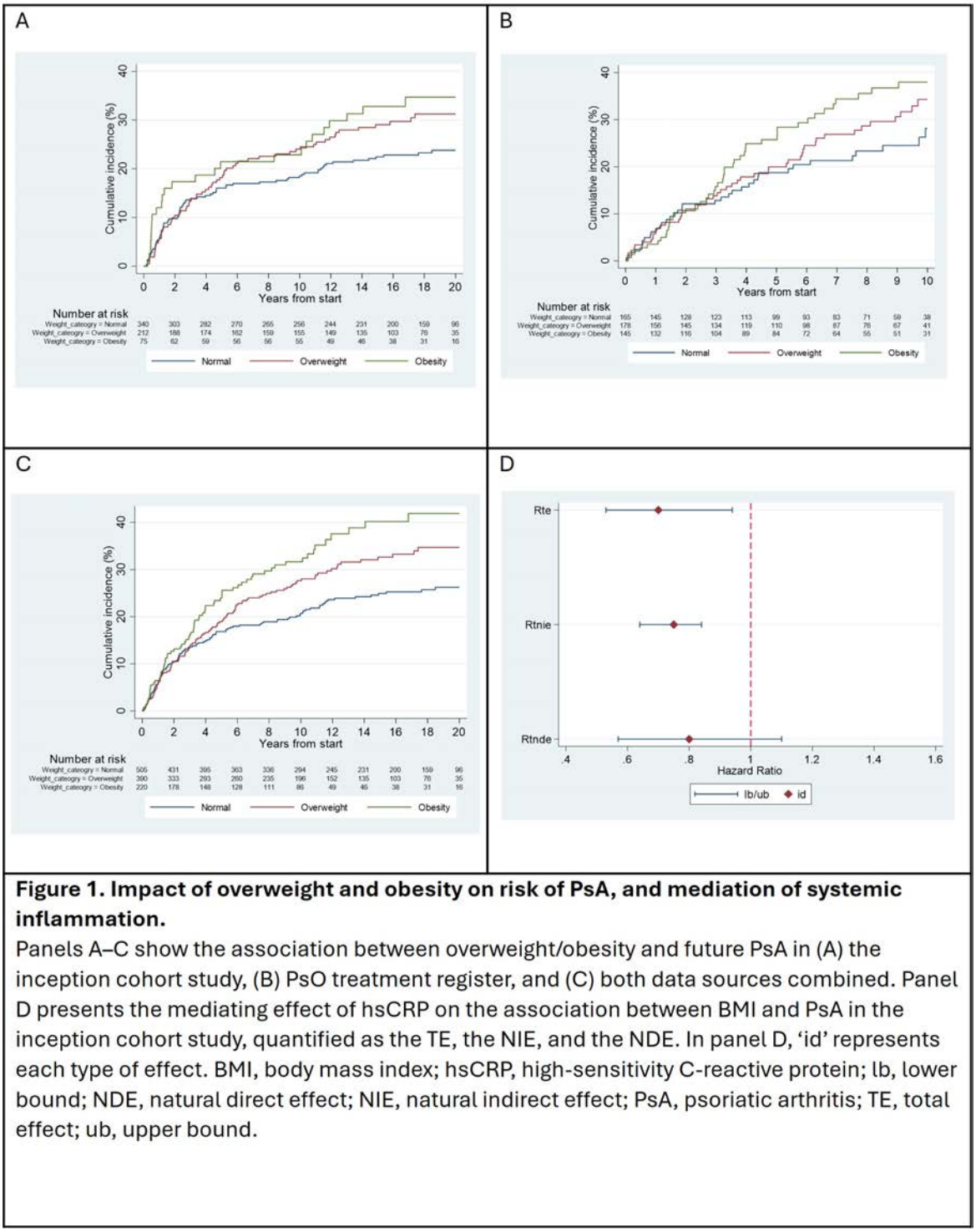

Figure 1. Impact of overweight and obesity on risk of PsA, and mediation of systemic inflammation.

Panels A–C show the association between overweight/obesity and future PsA in (A) the inception cohort study, (B) PsO treatment register, and (C) both data sources combined. Panel D presents the mediating effect of hsCRP on the association between BMI and PsA in the inception cohort study, quantified as the TE, the NIE, and the NDE. In panel D, 'id' represents each type of effect. BMI, body mass index; hsCRP, high-sensitivity C-reactive protein; lb, lower bound; NDE, natural direct effect; NIE, natural indirect effect; PsA, psoriatic arthritis; TE, total effect; ub, upper bound.

Conclusions

In our analysis, obesity was associated with an increased risk of PsA development in patients with PsO and this association was mediated through a surrogate marker of systemic inflammation, as measured by hsCRP. These findings further support a potential causal role for obesity in PsA development and, for the first time, also associated this risk with systemic inflammation, as measured by hsCRP. Thus, the inflammatory consequences of excess adiposity may be a proximal driver of PsA development. Taken together, these results highlight the importance of integrated weight management alongside standard PsO treatment as a potential strategy for PsA prevention.

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Abstract N°: 2805

Long-term effectiveness and safety of tildrakizumab in a patient with severe psoriasis and metabolic comorbidities

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Introduction

Severe psoriasis in patients with metabolic and hepatic comorbidities represents a therapeutic challenge, as conventional systemic treatments may be contraindicated or poorly tolerated. IL-23 inhibitors provide an effective and targeted treatment option in this setting. We report a case of severe, extensive psoriasis successfully managed with tildrakizumab, with sustained long-term response.

Case Presentation

A 44-year-old male with a 5-year history of psoriasis vulgaris, presented with progressive disease that became generalized over the past year. Skin involvement included the trunk, lower limbs, scalp, nails, palms, genital and intergluteal areas. Comorbidities included mixed dyslipidemia and mixed-etiology liver disease (alcohol-related and metabolic), with associated hepatic steatosis. Family history was positive for psoriasis.

Clinical examination revealed multiple erythematous-squamous plaques with fine scaling and positive Auspitz sign. Nail involvement included onycholysis and onychodystrophy. Baseline disease severity was high (PASI 27.7, NAPSI 101, PSSI 51, ESIF 14/48).

Laboratory findings showed severe hypertriglyceridemia, elevated liver enzymes, and dyslipidemia. Viral hepatitis markers were negative, while QuantiFERON-TB Gold Plus was positive. Methotrexate was contraindicated due to hepatic involvement. Following pneumological evaluation and isoniazid prophylaxis, tildrakizumab was initiated (100 mg at weeks 0 and 4, then every 12 weeks).

At 3 months, a marked clinical improvement was observed, with a reduction in PASI from 27.7 to 2.6 and resolution of scalp, palmoplantar, and genital involvement.

DLQI improved to 0. Residual lesions were minimal and mainly limited to nail involvement (NAPSI 45).

Transient elevations in liver enzymes and LDL cholesterol were observed and managed without treatment discontinuation.

At 6 months, complete skin clearance (PASI 0) was achieved, with normalization of metabolic and hepatic parameters under appropriate treatment. Nail psoriasis showed gradual improvement (NAPSI 38).

At 1 and 2 years, remission was maintained (PASI 0, PSSI 0, ESIF 0), with DLQI 0. Nail involvement persisted but continued to improve (NAPSI 33). No disease flares, serious adverse events, or infectious complications were observed.

Conclusion

Tildrakizumab demonstrated high efficacy and a favorable safety profile in this patient with severe psoriasis and significant metabolic and hepatic comorbidities. The treatment induced rapid clinical improvement and sustained complete remission over a 2-year period, including clearance of difficult to treat areas. These findings highlight the potential of IL-23 inhibition as an effective therapeutic.

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Abstract N°: 2812

Comparison of In-Person, Virtual, and Artificial Intelligence-Augmented Assessments of Psoriasis Disease Severity

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Introduction
The Psoriasis Area and Severity Index (PASI) is widely used to assess psoriasis severity and treatment response. However, PASI scoring is subject to inter- and intra-rater variability, particularly for the estimation of body surface area (BSA) involvement, where minor inaccuracies can contribute disproportionally to overall variability. Total body photography (TBP), used alone or in combination with artificial intelligence (AI), may offer more objective and consistent measurements.

Materials and Methods
This study evaluated the reliability of digital photography, used alone or in combination with AI, for remote assessment of psoriasis severity compared to in-person evaluations. Thirty-three patients with psoriasis (BSA: 0.5%-52.5%) first underwent in-person assessments by a dermatologist using a modified PASI (mPASI) that excluded the scalp and genital regions. Two additional dermatologists independently performed remote mPASI evaluations of the same patients twice, using 23 images captured with a TBP system. Percentage psoriasis involvement was quantified using the Psoriasis Grading Tool (PGT), a convolutional neural network, and converted to a continuous 0–6 area score for mPASI calculation.

Results
Agreement between conventional in-person mPASI scoring and remote assessments was excellent, with an intraclass correlation coefficient (ICC) of 0.90 and 0.91 for remote assessors 1 and 2, respectively, in their first evaluation. Incorporating PGT-derived area measurements improved in-person against remote agreement and narrowed mean differences (MDs) in a Bland-Altman analysis (Fig. 1a-b). The agreement between in-person assessments and mPASI derived using PGT-measured area was also excellent, with an ICC of 0.97 (Fig. 1c). Bland-Altman analysis demonstrated a small MD of 0.49 mPASI units between the two approaches, with 95% limits of agreement (LoA) from -2.47 to 3.45 (Fig. 1d). Inter-rater reliability between the 2 remote assessors across evaluation rounds ranged between 0.80 and 0.87, which improved to 0.89 and 0.91 with the incorporation of PGT-derived area measurements along with narrowed MDs (Fig. 1e-f). Intra-rater agreement across the two remote

evaluation rounds was excellent, with ICC values of 0.92 and 0.93 for remote assessors 1 and 2, respectively, and MDs of 0.09 and -1.33 (95% LoA: ±5.43 to ±5.96; Fig. 1g). Incorporating PGT-detected area further improved reliability, increasing ICC values to 0.98 and 0.95, respectively, and improved MDs to -0.69 (95% LoA: ±3.28 to ±4.48; Fig. 1h), indicating improved consistency across repeated evaluations.

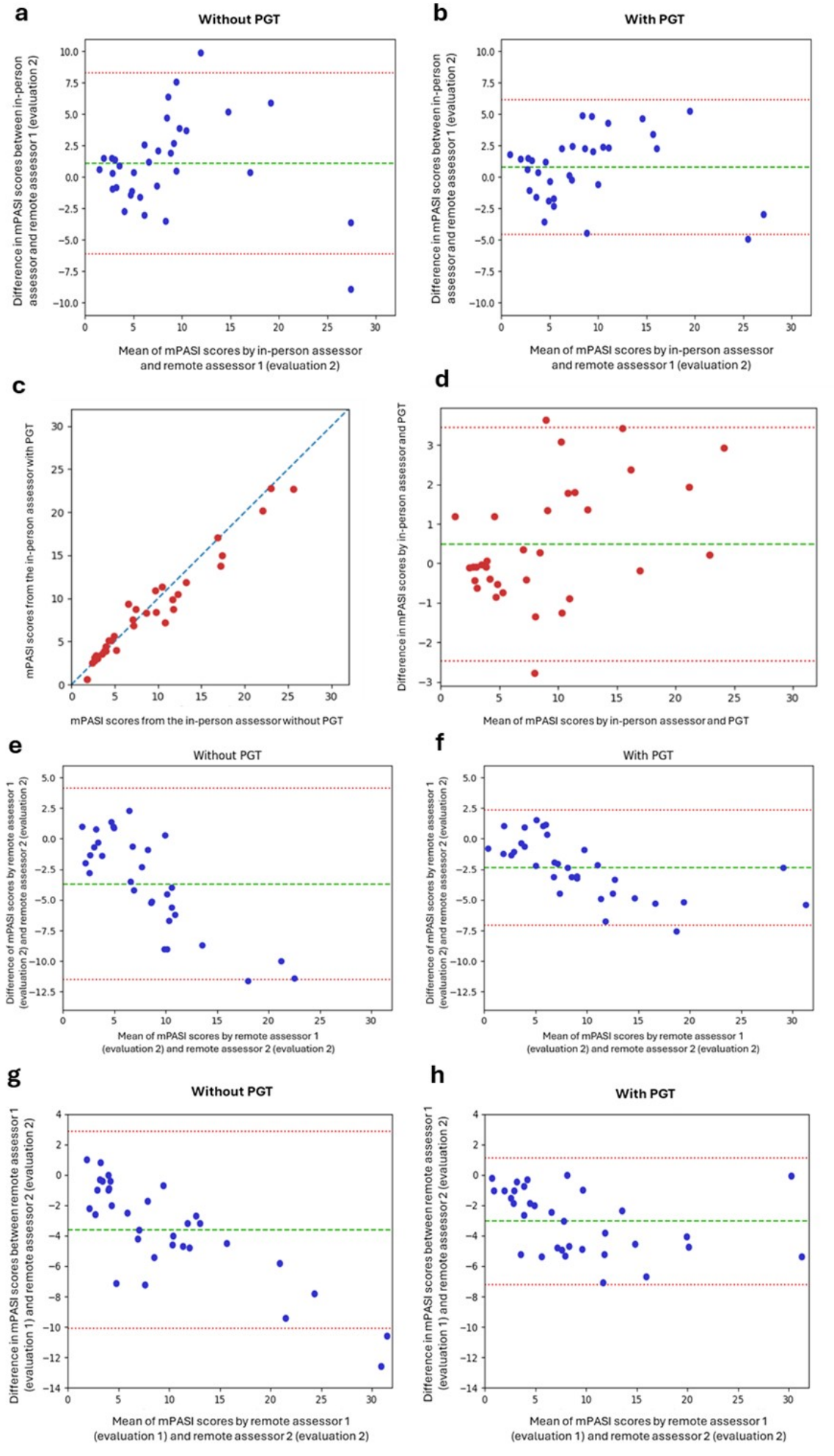

Figure 1 . PGT Area Detection Improves Agreement Across Comparisons. (a-b) Representative Bland-Altman plot comparing mPASI scores from remote assessor 1 (evaluation 2) with those from the in-

person assessor, without (a) or with (b) PGT-derived area replacing the evaluator-assigned area score. (c) Scatter plot illustrating the relationship between the mPASI scores determined by the in-person assessor and the corresponding mPASI scores calculated using the PGT automatic area detection ($r^2=0.97$), where the dotted blue line represents the ideal 1:1 relationship. (d) Bland-Altman plot depicting the agreement between in-person mPASI scores and mPASI scores incorporating PGT-derived area measurements. (e-f) Bland-Altman analysis of mPASI scores from remote assessor 1 (evaluation 1) compared to remote assessor 2 (evaluation 2), without (e) and with (f) PGT-derived area measurement. (g-h) Bland-Altman analysis of mPASI scores from remote assessor 1 (evaluation 1) compared to remote assessor 2 (evaluation 2), without PGT (g) and with (h) PGT-derived area measurement. In all panels (except c), the green line represents the MD, and the red lines represent the 95% LoAs.

Conclusions

In-person and remote mPASI assessments demonstrated strong concordance, and AI-assisted TBP consistently improved agreement across comparisons. This approach may help overcome challenges in area estimation within mPASI scoring, improve reproducibility, and support remote assessments in clinical practice and multicenter trials.

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Abstract N°: 2838

Effectiveness and safety of guselkumab through 28 weeks: a multicentre real-world study in Chinese patients with moderate-to-severe plaque psoriasis

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Introduction

Psoriasis is a chronic immune-mediated inflammatory disease associated with substantial disease burden and impaired quality of life. Guselkumab, a selective interleukin-23p19 subunit monoclonal antibody, has demonstrated high efficacy and a favourable safety profile in randomized controlled trials and real-world studies. However, large-scale real-world data in Chinese patients remain limited.

Leveraging data from the Chinese Psoriasis Biologic Registry Database, this study represents the largest real-world investigation of guselkumab conducted in China to date (ChiCTR2400089608). The objective of this study was to evaluate the 28-week real-world effectiveness and safety of guselkumab in Chinese patients with moderate-to-severe plaque psoriasis and to identify clinical predictors associated with achieving complete skin clearance (PASI 100) at Week 28.

Materials and Methods

This multicentre, observational, single-arm, hybrid-cohort real-world study enrolled adult patients with moderate-to-severe plaque psoriasis treated with guselkumab at 13 hospitals across China between April 2024 and February 2026, using data from the Chinese Psoriasis Biologic Registry Database. Effectiveness outcomes included Psoriasis Area and Severity Index (PASI), body surface area (BSA) involvement, and Dermatology Life Quality Index (DLQI). Analyses were conducted using as-observed methodology. Subgroup analyses and multivariable logistic regression were performed to explore associations between baseline characteristics

(including body mass index [BMI], disease duration, disease severity, joint involvement, special-site involvement, comorbidities, and prior biologic exposure) and achievement of complete skin clearance (PASI 100) at Week 28.

Results

Of 825 eligible patients, 763 who received at least two consecutive doses of guselkumab were included in the full analysis set. The mean age was 46.3 years, 69.9% were male, and the mean BMI was 25.1 kg/m^2. At baseline, disease duration was >5 years for 81.6% of patients, mean PASI score was 14.0, mean BSA involvement was 17.9%, and mean DLQI score was 11.6. Joint involvement was present in 6.3% of patients, 34.6% had comorbidities or other diseases, and 23.1% had prior biologic exposure.

At Week 28, PASI 75, PASI 90, and PASI 100 responses rates were 86.2%, 70.5%, and 47.9%, respectively, respectively (Figure 1A). Mean PASI score improved to 1.4, mean BSA to 2.0%, and mean DLQI to 1.8 (Figure 1B). Adverse events were reported in 1.4% (11/763) of patients; five adverse events were considered drug-related, including one serious adverse drug reaction (Generalized eczema), with no new safety signals identified.

Higher PASI 100 response rates were observed in patients with BMI <24 kg/m^2 compared with ≥24 kg/m^2 (59.3% vs. 39.8%; P<0.001), in patients without versus with comorbidities or other diseases (51.7% vs. 39.9%; P=0.007), in patients without versus with joint involvement (49.0% vs. 31.6%; P=0.037), and in biologic-naïve versus biologic-experienced patients (53.6% vs. 29.3%; P<0.001)(Figure 1C). Multivariable logistic regression identified BMI <24 kg/m^2, absence of joint involvement, and biologic-naïve status as independent predictors of achieving PASI 100 at Week 28 (Figure 1D).

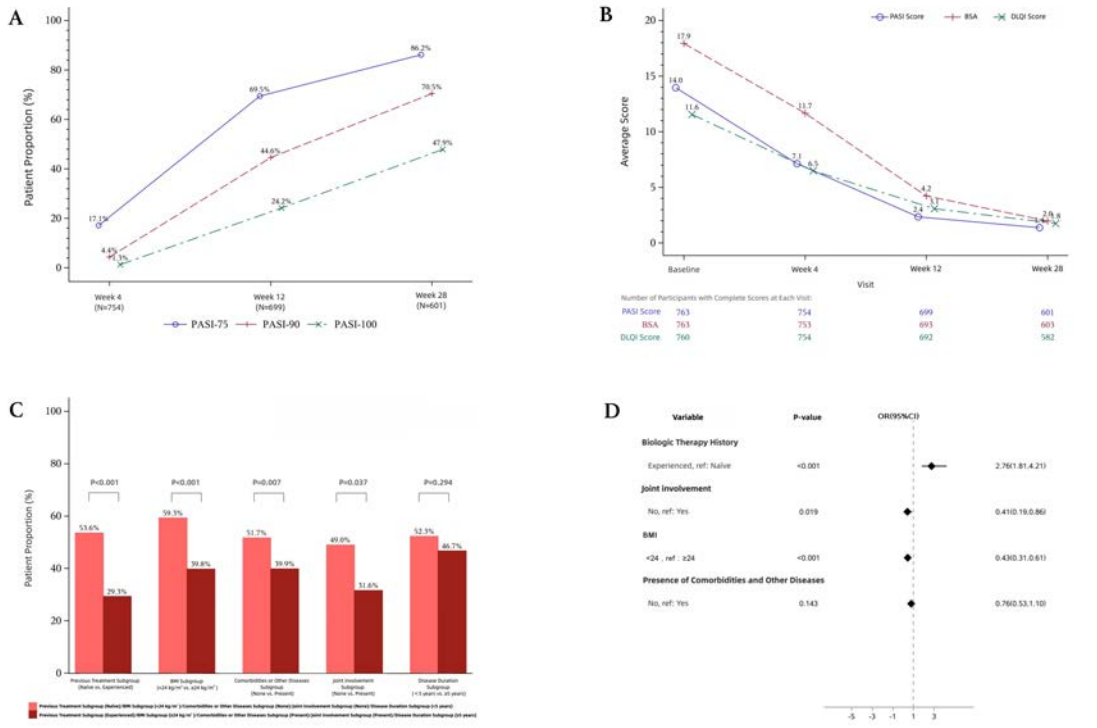

Figure 1: Effectiveness outcomes in patients treated with guselkumab: A. proportions of patients achieving PASI 75/90/100 at Weeks 4, 12, and 28; B. mean PASI score, BSA, and DLQI at baseline and Weeks 4, 12, and 28; C. PASI 100 response rates at Week 28 across subgroups by prior biologic exposure, BMI, comorbidity status, and disease duration; D. multivariable logistic regression analysis of predictors of PASI 100 at Week 28

Conclusions

Guselkumab demonstrated robust effectiveness and an excellent safety profile over 28 weeks in the largest real-world cohort of Chinese patients with moderate-to-severe plaque psoriasis to date, with nearly half achieving complete skin clearance. Lower BMI, absence of joint involvement, and biologic-naïve status were strong

independent predictors of optimal response. These results support the utility of guselkumab as a robust therapeutic option in routine clinical practice for the Chinese population. Further long-term studies are planned to confirm sustained benefits and safety.

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Abstract N°: 2842

Guselkumab in the Management of Psoriasis in a Patient with a History of Renal Transplantation: A Case Report

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Introduction

Psoriasis vulgaris is a chronic inflammatory skin disease that presents with well demarcated, red plaques with silvery scale. While topical treatments and phototherapy are effective for mild to moderate psoriasis, they may be insufficient for moderate to severe disease. Biologic agents offer high benefit risk ratio and are valuable treatment options for this group (1). Since the immune system plays a central role in how the disease develops, it directly influences the treatment approach. This creates clinical challenges in organ transplant patients who are receiving immunosuppressive therapy. As a consequence immunosuppression, psoriasis often clears acutely in immediate posttransplantation period. However, thereafter when patients are transitioned to a maintenance dose of immunosuppression, psoriasis may flare (2). In transplant patients, potential risks of combining immunosuppressants with biological agents in psoriasis are not fully known. Although case reports on biological agents following renal transplantation exist in literature, there is no published data regarding the use of guselkumab. The aim of this case report is to present the clinical response to guselkumab after multiple biological agents in a moderate to severe psoriasis patient with a history of renal transplantation.

Case Presentation

44 years old male patient had been followed for psoriasis since age of 17. As he didn’t respond to topical treatments, adalimumab was initiated at the age of 18, and he continued this treatment for 18 years. The patient doesn’t have comorbidities other than hypertension. During follow-up, proteinuria was detected, and treatment was switched to ustekinumab. However, because no clinical benefit was achieved, adalimumab was restarted, and after another two years of treatment, the patient developed a progressive increase in creatinine levels. Renal biopsy was performed and was found to be consistent with IgA nephropathy. After 8 month period of hemodialysis, he underwent renal transplantation in 2022. Following transplantation, immunosuppressive regimen consisting of mycophenolate mofetil, tacrolimus, and prednisolone was initiated, and regression of psoriasis lesions was observed.

During follow-up, due to increase in creatinine levels, kidney biopsy was performed and showed BK virus positivity. Mycophenolate mofetil was discontinued, while tacrolimus and prednisolone were continued. In the last month before admission to our clinic, patient developed a flare of psoriasis lesions, and didn’t respond to topical treatments. At presentation, there was widespread involvement of arms, legs, and scalp. Nail involvement was absent, psoriatic arthritis was present, and PASI score was 8.5. After multidisciplinary evaluation, ixekizumab treatment was initiated. Ixekizumab was continued for one year; however, due to an increase in his complaints, the treatment was switched to guselkumab. At week 36 of guselkumab treatment, PASI score decreased to 1.5, and a significant improvement was achieved in clinical findings and symptoms (Figure1).

Conclusion

Each psoriasis patient should be treated individually based on history, severity, and risk factors. In solid organ transplant patients, treatment decisions should be made with transplant team. In our case, guselkumab treatment provided a good clinical response during 36 weeks of follow-up under ongoing immunosuppressive therapy with tacrolimus and prednisolone, and no complications were reported. This case suggests that guselkumab may be effective treatment option in selected psoriasis patients with history of renal transplantation.

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Abstract N°: 2846

Effectiveness of guselkumab through 28 weeks in Chinese patients with moderate-to-severe plaque psoriasis involving special body sites: subgroup analyses from a multicentre real-world study

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Introduction

Psoriasis affecting special body sites, including the scalp, hands and feet, genital area, nails, and lower legs, is often associated with greater disease burden, functional impairment, and reduced quality of life, and remains challenging to manage in routine practice. Guselkumab, a selective interleukin-23p19 subunit monoclonal antibody, has demonstrated robust efficacy in randomized controlled trials; however, real-world evidence focusing on special body site involvement in Chinese patients is limited.

Using data from the Chinese Psoriasis Biologic Registry Database, subgroup analyses were performed to evaluate the 28-week effectiveness of guselkumab in Chinese adults with moderate-to-severe plaque psoriasis involving special body sites.

Materials and Methods

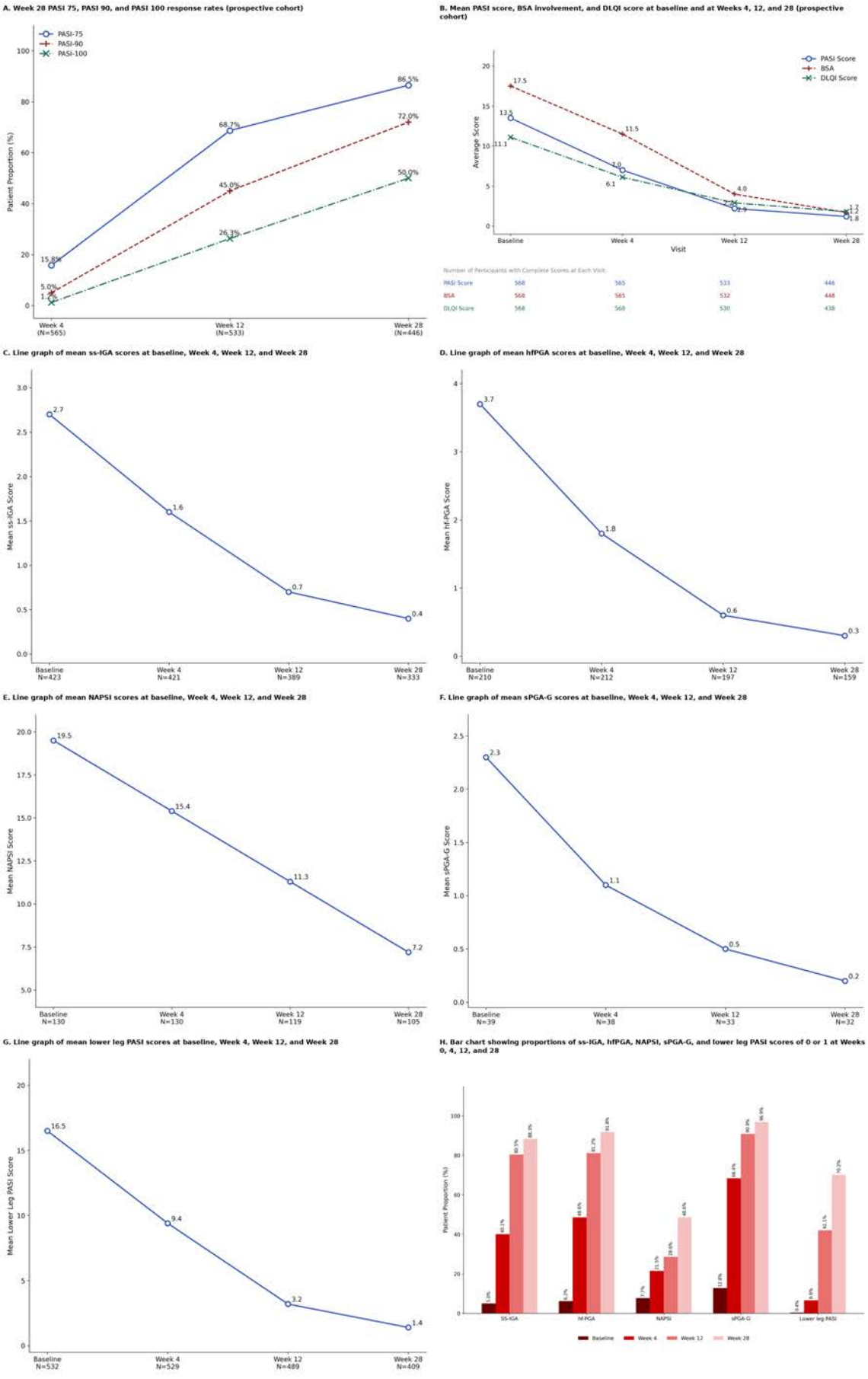
This multicentre, observational, single-arm, hybrid-cohort real-world study enrolled adult patients with moderate-to-severe plaque psoriasis treated with guselkumab at 13 hospitals across China between April 2024 and February 2026 (data collection was completed as of April 15, 2026.). Subgroup analyses for special body sites were conducted in the prospective cohort. PASI, BSA, DLQI, and site-specific measures, including ss-IGA (scalp), hfPGA (hands and feet), NAPSI (nails), sPGA-G (genital area), and lower leg PASI (lower leg region bounded superiorly by the knee joint and inferiorly by the ankle joint) were assessed at baseline, Week 12, and Week 28. Analyses were conducted using as-observed methodology.

Results

The prospective study cohort included 568 patients, of whom 99.1% had involvement of at least one special body site or the lower legs at baseline. Mean age was 46.4 years, mean BMI was 24.9 kg/m^2, 68.5% of the patients were male, 20.2% had prior biologic exposure, and 81.7% had a disease duration of ≥5 years.

Considerable effectiveness for improvements in overall disease severity and quality of life were observed. At Week 28, PASI 75, PASI 90, and PASI 100 response rates were 86.5%, 72.0%, and 50.0%, respectively. Mean PASI improved from 13.5 at baseline to 2.2 at Week 12 and 1.2 at Week 28; mean BSA improved from 17.5% to 4.0% and 1.7%; and mean DLQI improved from 11.1 to 2.9 and 1.8, respectively. (Figure A and B).

Substantial improvements were observed across all special body sites. From baseline to Week 28, mean ssIGA decreased from 2.7 to 0.4, mean hfPGA decreased from 3.7 to 0.3, mean NAPSI decreased from 19.5 to 7.2, and mean sPGAG decreased from 2.3 to 0.2 (Figures C–F). At Week 28, 88.3% of patients achieved ssIGA 0/1, 91.8% achieved hfPGA 0/1, 48.6% achieved NAPSI 0/1, and 96.9% achieved sPGAG 0/1 (Figure H). Notably, this is the first Chinese realworld study to include the lower leg as a specific assessment site; mean lower leg PASI decreased from 16.5 to 1.4, and 70.2% of patients achieved lower leg PASI <1 at Week 28 (Figure G).



Conclusions

In this large multicentre real-world study, guselkumab demonstrated considerable and consistent effectiveness across multiple special body sites through 28 weeks in Chinese patients with moderate-to-severe plaque psoriasis. Clinically meaningful improvements were observed in overall disease severity, quality of life, and difficult-to-treat

areas, with continuous improvements from Week 12 to Week 28. These real-world findings support the use of guselkumab as a robust treatment option for psoriasis involving special body sites in routine clinical practice in China.

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Abstract N°: 2852

Psoriasis Disease Severity and Obesity as Drivers of Cardiovascular Events: Results from Pooled Analyses of Two Prospective Studies

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Introduction
Psoriasis (PsO) is a systemic inflammatory disease that frequently coexists with obesity. Both skin disease severity and excess adiposity are linked to cardiometabolic dysfunction and accelerated atherosclerosis. In patients with PsO, systemic inflammation often clusters with obesity, insulin resistance, and endothelial dysfunction, all of which may contribute to cardiovascular (CV) risk. Understanding the independent contributions of PsO disease severity and body mass index (BMI) to the risk of CV disease (CVD) is relevant for dermatologists.

Objective

To estimate the independent associations of PsO skin severity and BMI with future CV events in patients with PsO.

Materials and Methods
We analyzed data from two Swedish observational data sources: a prospective inception cohort study that enrolled patients within 1 year of first onset of PsO under any treatment and a register for patients with PsO under systemic treatment. Both studies collected data on different aspects of PsO, including obesity.

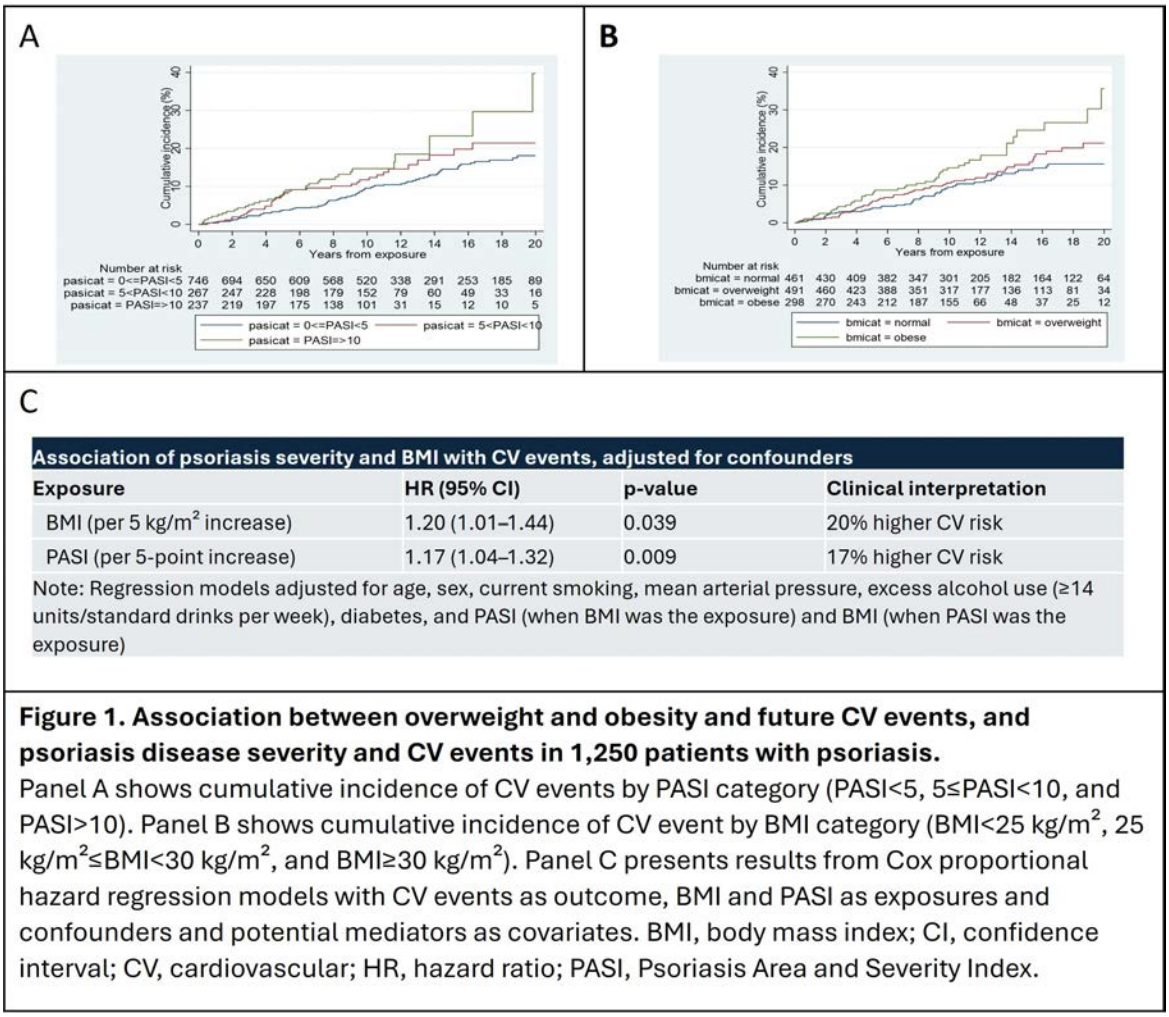
We obtained data on the main exposures of interest – Body Mass Index (BMI, kg/m^2) and the Psoriasis Area and Severity Index (PASI) – and covariates from the baseline examination in the cohort study, and at first contact where either PASI or BMI was available in the PsO register. CV events were obtained from health care registers with population-based coverage. The definition of CV event was consistent with the 10-year Framingham CVD risk score.

We included patients with plaque PsO and excluded individuals below 18 years of age, those with underweight (BMI<18.5), and those with prior CVD. We followed remaining patients from exposure measurement to the first of: CV event, death from other cause, or end of data availability (January 1, 2022).

We estimated the cumulative incidence of CV events across exposure groups. We also fit Cox Proportional Hazard models to estimate the confounder- and mediator-adjusted associations between exposures and CV events. Given that obesity is associated with more severe PsO we evaluated the mediating effect of PASI on the association between BMI and future CV events. To address missing data, we implemented multiple imputation using chained equations for multivariable analysis.

Results

After 44 exclusions for age and BMI, 1250 individuals were included (461 from cohort study, 789 from PsO register). Mean age was 47.5 years (SD 14.5), 57% were men, 19% had psoriatic arthritis. During a median follow-up of 11.2 years, 160 CV events occurred. Higher PASI and BMI were each associated with shorter time to first CV event in unadjusted analyses (Figure 1, A and B). In multivariable models adjusted for confounders, when a patient's PASI score is 5 points higher, there is a 17% higher risk of future CV event; and when a patient's BMI is 5 points higher, there is a 20% higher risk of future CV event (Figure 1, C). When modelling a decrease of BMI from 30 to 22 for the causal mediation analysis, the total natural effect hazard ratio (HR) was 0.71 (95% confidence interval [CI]: 0.52–0.97), the total natural direct effect HR was 0.73 (95% CI: 0.54–1.00), and the total natural indirect effect HR was 0.96 (95% CI: 0.89–1.01). The indirect effect, representing mediation via PASI, did not reach statistical significance, though its direction indicates a small amount of mediation.



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Association of psoriasis severity and BMI with CV events, adjusted for confounders			
Exposure	**HR (95% CI)**	**p-value**	**Clinical interpretation**
BMI (per 5 kg/m^2 increase)	1.20 (1.01–1.44)	0.039	20% higher CV risk
PASI (per 5-point increase)	1.17 (1.04–1.32)	0.009	17% higher CV risk

Note: Regression models adjusted for age, sex, current smoking, mean arterial pressure, excess alcohol use (≥14 units/standard drinks per week), diabetes, and PASI (when BMI was the exposure) and BMI (when PASI was the exposure)

Figure 1. Association between overweight and obesity and future CV events, and psoriasis disease severity and CV events in 1,250 patients with psoriasis.
Panel A shows cumulative incidence of CV events by PASI category (PASI<5, 5≤PASI<10, and PASI>10). Panel B shows cumulative incidence of CV event by BMI category (BMI<25 kg/m^2, 25 kg/m^2≤BMI<30 kg/m^2, and BMI≥30 kg/m^2). Panel C presents results from Cox proportional hazard regression models with CV events as outcome, BMI and PASI as exposures and confounders and potential mediators as covariates. BMI, body mass index; CI, confidence interval; CV, cardiovascular; HR, hazard ratio; PASI, Psoriasis Area and Severity Index.

Conclusions

In patients with PsO, both skin disease severity and obesity are independently associated with future CV events; these findings remained after mutual adjustment. The findings suggest a potential, albeit minimal, mediating role of skin disease severity in the association between obesity and CV events; part of the relationship between BMI and CV risk may be attributed to PASI. For dermatologists caring for patients with psoriatic disease, these findings underscore the importance of managing skin inflammation and weight simultaneously for prevention of CV events in patients with PsO.

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Abstract N°: 2853

AI-based automated PASI scoring: development and validation of a computer-aided system for psoriasis severity assessment

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Introduction

Psoriasis is a chronic inflammatory skin disease with significant global burden. Although clinical recognition is straightforward, objective and reproducible severity assessment remains challenging due to interobserver variability, particularly in clinical trials. Standardized and automated approaches are needed to improve consistency and reliability in PASI scoring.

Materials and Methods

We developed a computer-aided diagnosis (CAD) system for automated Psoriasis Area and Severity Index (PASI) assessment using deep learning. The system performs lesion segmentation and classification of key clinical signs (erythema, induration, and desquamation) from clinical images.

The model was trained and validated on a dataset of 2,857 clinical images annotated by three expert dermatologists. Multiple deep learning architectures were evaluated, and performance was assessed using segmentation metrics and classification accuracy compared with expert annotations.

Results

The proposed system achieved performance comparable to expert dermatologists in the assessment of PASI components. Classification accuracy reached 60.6% for erythema, 54.3% for induration, and 61.8% for desquamation, within the range of interobserver variability. Lesion segmentation achieved a high level of agreement, with an intersection-over-union (IoU) of 0.75, supporting robust lesion delineation.

Overall, the model demonstrated consistent performance across tasks, approaching expert-level agreement in both segmentation and severity grading. Detailed results across architectures are presented in Table 1, and representative confusion matrices are shown in Figure 1.

Encode the Annotator	Erythema		Induration		Peeling	
	Accuracy	RMSE	Accuracy	RMSE	Accuracy	RMSE
Annotators (one-vs-all)	0.649	0.627	0.63	0.654	0.685	0.615
Annotators (one-vs-rest)	0.525	0.795	0.516	0.820	0.590	0.762
EfficientNet-b2-clf	0.588	0.788	0.477	0.963	0.594	0.909
EfficientNet-b3-clf	0.551	0.88	0.509	0.947	0.599	0.874
Inceptionv4-clf	0.574	0.825	0.504	0.934	0.594	0.862
MiT_b1-clf	0.591	0.76	0.515	0.868	0.615	0.816
MiT_b2-clf	0.606	0.748	0.543	0.856	0.618	0.81
MiT_b3-clf	0.6	0.761	0.507	0.908	0.609	0.812
ResNet18-clf	0.558	0.915	0.472	1.07	0.573	0.921
ResNet34-clf	0.555	0.924	0.452	1.03	0.571	0.894
SE_ResNeXt101_32x4d-clf	0.567	0.841	0.504	0.946	0.601	0.856
SE_ResNeXt50_32x4d-clf	0.586	0.837	0.479	0.967	0.579	0.896
Xception-clf	0.567	0.843	0.442	0.978	0.57	0.898

Table 1: Results of the classification of the intensity of visual signs. Results of the classification of the intensity of PASI visual signs obtained by the models and the annotators.

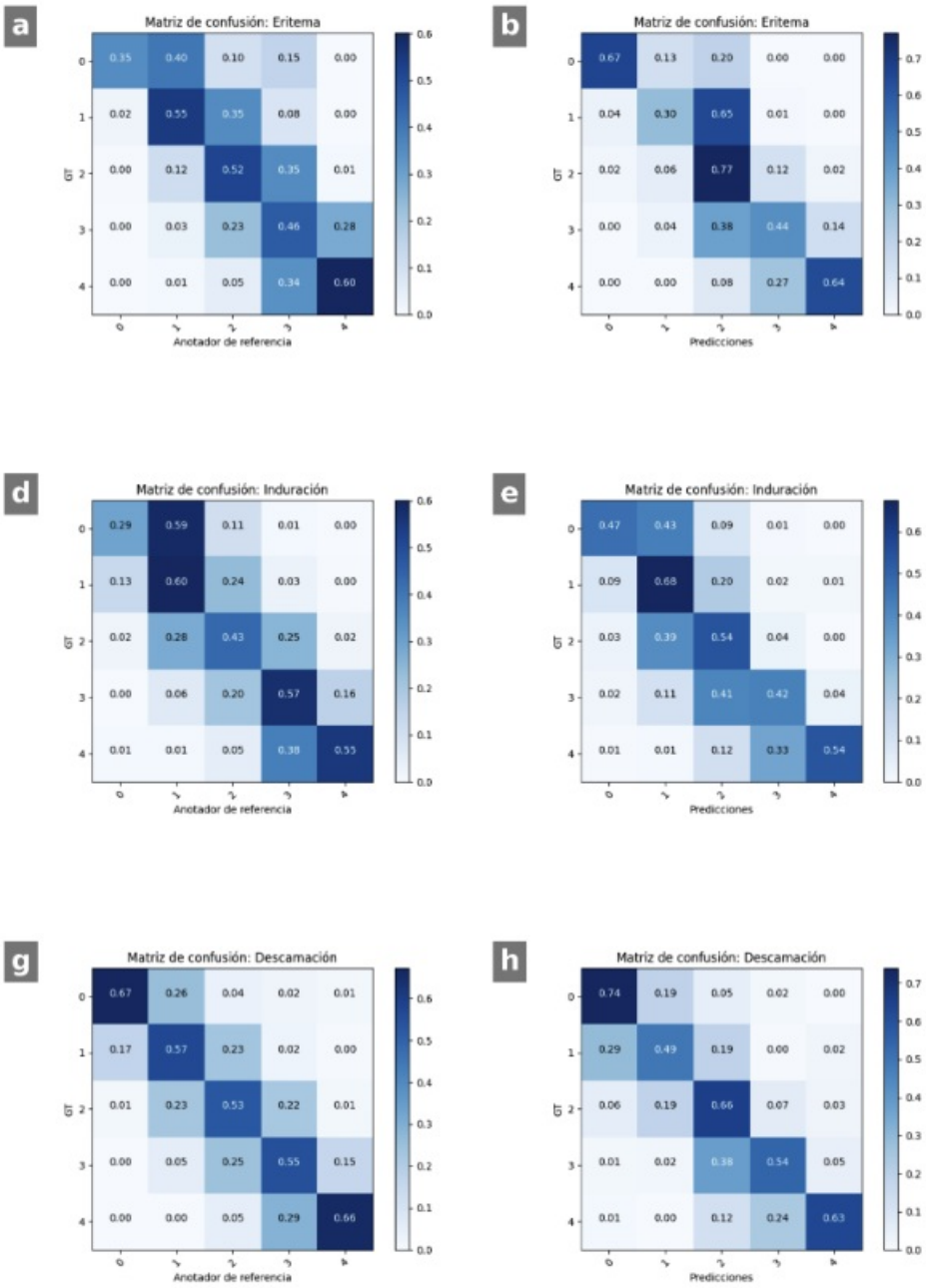

Figure 1: Confusion matrices for the classification of the intensity of visual signs. The left column shows the average confusion matrices of the annotators (one-vs-rest). The right column shows the results of the best performing model, MiT_b2.

Conclusions

This study demonstrates that AI-based systems can achieve dermatologist-level performance in automated PASI scoring. By providing rapid, objective, and standardized assessments, this approach has the potential to reduce interobserver variability and support both clinical practice and research. Integration into digital tools may enhance disease monitoring and facilitate more consistent outcome measurement in clinical trials.

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Abstract N°: 2861

Single cell transcriptomics of human psoriasis and epidermal specific Ube2l3 deficiency mouse highlighting CXCL16/CXCR6 mediating the development of psoriasis

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Introduction

Psoriasis is a chronic immune-mediated inflammatory disease driven by complex interactions among keratinocytes, dendritic cells, and T cells. Increasing evidence highlights the pivotal role of the epidermal immune microenvironment in disease initiation and progression. Ubiquitin Conjugating Enzyme E2 L3 (UBE2L3) regulates IL-1β turnover via ubiquitination, and its reduced expression has been associated with enhanced epidermal IL-1β production in psoriasis. However, the mechanistic role of epidermal UBE2L3 in modulating IL-17–mediated inflammation remains unclear. In addition, IL-17–producing γδT17 cells and $CD8^{+}$IL-17^{+} T (Tc17) cells are key contributors to psoriatic inflammation, yet their regulation within the epidermis is not fully understood. The CXCL16–CXCR6 axis has been implicated in the recruitment and differentiation of IL-17–producing T cells, but its functional role in epidermal immunity requires further investigation.

Materials and Methods

We generated an epidermis-specific Ube2l3 conditional knockout mouse model to investigate its role in psoriasis pathogenesis. Multi-level analyses were performed, including bulk RNA sequencing, single-cell RNA sequencing (scRNA-seq), and protein-level validation. Comparative analyses between mutant mice and human psoriatic skin samples were conducted to assess translational relevance.

Results

Epidermal Ube2l3 deficiency resulted in a phenotype closely resembling human psoriasis, characterized by enhanced inflammatory responses and increased IL-17 production. Single-cell transcriptomic analysis revealed expansion and activation of IL-17–producing $Vγ2^{+}$ γδT cells in mice and $CD8^{+}$ T (Tc17) cells in human psoriatic skin. Mechanistically, loss of UBE2L3 led to elevated IL-1β levels and upregulation of CXCL16 in the epidermis, which promoted recruitment and activation of CXCR6-expressing T cells. This CXCL16/CXCR6 signaling axis was identified as a key pathway linking keratinocyte-intrinsic UBE2L3 deficiency to amplified IL-17–driven inflammation.

Conclusions

UBE2L3 acts as a keratinocyte-intrinsic negative regulator of epidermal IL-17 responses by modulating the CXCL16/CXCR6 axis. Its deficiency promotes IL-1β–dependent inflammatory signaling and enhances recruitment and activation of IL-17–producing γδT and $CD8^{+}$ T cells, thereby driving psoriasis-like pathology. These findings establish a mechanistic link between ubiquitination, epidermal immune regulation, and IL-17–mediated inflammation, and highlight UBE2L3 as a potential therapeutic target in psoriasis.

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Abstract N°: 2871

Comparative Efficacy of Oral Icotrokinra versus Injectable IL-23 Inhibitors for Moderate-to-Severe Plaque Psoriasis: A Network Meta-Analysis

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Introduction

Psoriasis is a chronic immune-mediated disease with substantial physical and psychosocial burden. Therapeutic advances targeting the interleukin (IL)-23/Th17 axis have led to the introduction of effective biologics, including guselkumab, risankizumab and tildrakizumab. More recently, icotrokinra, a first-in-class oral peptide that selectively inhibits the IL-23 receptor, has emerged as a potential oral alternative to injectable biologics. Herein, this meta-analysis aimed to compare the efficacy of icotrokinra with injectable IL-23 inhibitors in patients with moderate-to-severe plaque psoriasis.

Materials and Methods

Four databases were searched in March 2026 with keywords related to “psoriasis,” “icotrokinra” and “interleukin-23.” Randomized placebo-controlled trials enrolling psoriasis patients (≥12 years) were included if they evaluated icotrokinra or injectable IL-23 inhibitors (guselkumab, risankizumab, tildrakizumab) at approved dosages. Single-arm or phase 1 trials and studies focusing on psoriasis of a single anatomic site were excluded. Primary outcomes included proportion of patients achieving 75-100% improvement in Psoriasis Area and Severity Index (PASI) and an Investigator’s or Physician Global Assessment (IGA/PGA) score of 0/1 at week 12 or 16. Random-effects frequentist network meta-analyses were performed (R v4.5.1) to determine the relative efficacy of icotrokinra against IL-23 inhibitors, reported as odds ratios (ORs) and 95% confidence intervals (CIs). As per Cochrane RoB2, 71% of included trials had low risk of bias and 29% moderate.

Results

Twenty-one trials comprising 6683 participants were included (31.0% female; mean age 45.6 years). At baseline, participants had a mean PASI score of 20.33, with 21.6% (n=1233/5703) reporting severe psoriasis. Icotrokinra was the most frequently administered IL-23 inhibitor (19.4%, n=1297/6683). All IL-23 inhibitors demonstrated substantial efficacy across outcomes, with icotrokinra showing generally comparable effects. Compared with placebo, odds of achieving PASI-75 were highest with risankizumab (OR 90.61; 95% CI 54.25-151.35), whereas icotrokinra demonstrated the lowest, though still substantial, odds (OR 22.15; 95% CI 14.00-35.07). Notably, icotrokinra demonstrated greater efficacy versus placebo at higher response thresholds, surpassing tildrakizumab for PASI-90 (OR 31.36; 95% CI, 12.98-75.73) and ranking second among IL-23 inhibitors for PASI-100 (OR 38.06; 95% CI, 15.60-92.84) behind risankizumab. Odds of achieving IGA/PGA scores of 0/1 was highest in risankizumab (OR 62.65; 95% CI 39.35-99.74), followed by guselkumab (OR 50.96; 95% CI 34.11-76.15) and icotrokinra (OR

20.47; 95% CI 13.50-31.05).

Table I. Efficacy outcomes summarized as odds ratios (OR) and 95% confidence intervals (CI) from random-effects network meta-analysis.

	OR (95% CI)			
Outcome	**ICO [200mg QD]**	**GUS [100mg Q8W]**	**RZB [150mg Q12W]**	**TIL [100mg Q12W]**
IGA/PGA 0/1	20.47 (13.50-31.05)	50.96 (34.11-76.15)	62.65 (39.35-99.74)	19.84 (12.09-32.56)
PASI-75	22.15 (14.00-35.07)	89.12 (54.89-144.70)	90.61 (54.25-151.35)	22.76 (13.96-37.08)
PASI-90	31.36 (12.98-75.73)	55.25 (27.56-110.74)	60.15 (28.50-126.96)	25.05 (10.39-60.37)
PASI-100	38.06 (15.60-92.84)	36.14 (17.72-73.71)	41.51 (18.16-94.89)	16.18 (5.51-47.55)

Abbreviations: CI: confidence interval; GUS: guselkumab; ICO: Icotrokinra; IGA: Investigator's Global Assessment; PASI: Psoriasis Area and Severity Index; PGA: Physician's Global Assessment; QD: once a day; Q8W: once every 8 weeks; Q12W: once every 12 weeks; RR: risk ratio; RZB: risankizumab; TIL: tildrakizumab

Conclusions

This meta-analysis suggests that icotrokinra is comparable to currently available IL-23 inhibitors in moderate-to-severe plaque psoriasis. While risankizumab remained superior across all outcomes, icotrokinra often performed similarly to tildrakizumab and was particularly effective in achieving near complete or complete skin clearance. This may be attributed to icotrokinra's pharmacologic properties. Peptide therapies exhibit greater tissue penetration and target selectivity, possibly enabling more precise modulation of IL-23 signaling than monoclonal antibodies. Limitations of this review include methodological heterogeneity and potential duplicate participants. Ultimately, icotrokinra represents a promising therapeutic option. Its oral formulation may help overcome barriers associated with injectable therapies, including injection-site discomfort and logistical constraints, subsequently improving treatment adherence. Further head-to-head trials with age-stratified outcomes and safety analyses are needed to elucidate icotrokinra's role in psoriasis.

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Abstract N°: 2940

Psoriasis: periodontitis as a risk factor

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Introduction

Patients with psoriasis have an increased risk for inflammatory periodontal disease, however, data are sparse. Inflammatory disorders are well known to trigger psoriasis. In order to gain further insight we examined the periodontal status in 50 patients with psoriasis compared to 25 healthy control individuals.

Materials and Methods

We examined whether there is (1) an enhanced periodontal risk, (2) increased IL-1 mediated inflammation, (3) increased bacterial load, (4) sufficient oral hygiene, an (5) an enhanced risk for tooth decay in psoriasis. Patients with psoriasis (19 female, 31 male) had a median age of 56 years, controls (17 female, 8 male) of 40 years. Individuals were given a questionnaire about diabetes mellitus, hematological disease, HIV-infection, osteoporosis, smoking status, dental history, family dental history. Tooth- and periodontal status were ascertained (perio-tools®), CA Ramseier, Univ. Berne, Switzerland). The DMFT-index (decayed, missing, filled teeth), BOP (bleeding on probing), PSI-index (periodontal screening) were measured. Bacterial analyses from gingival pockets were done by micro-Ident® (Hain Lifescience) which measures 5 periodontal species by PCR. IL-1 gene variants were determined from buccal swabs (Hain Lifescience). Statistical analyses,

1. e. t-test, U-test, Chi-square, Fisher's exact test was done by SPSS 23 software.

Results

We found the following results: Psoriasis patients were smokers in 40% vs.

12% in controls (p<0.03). There was no difference in general disease status between the two groups. Interdental tooth cleaning was done in 30% of patients but in 80% of controls (p<0.001). There was no difference in cariogenic nutrition. Regular dentist visits were less frequent in psoriasis (64% vs. 96%). Gingivitis, tooth migration, tooth loss after loosening gingival treatment did not differ. Missing, decayed or carious teeth were more frequent in psoriasis (10.3 vs. 6.4, p<0.013). DMFT-index did not differ. Gingival pockets (>3.5 mm) were more frequent in psoriasis (85.4% vs. 60%, p<0.021). BOP did not differ. Bacterial growth occurred in 95.8% in psoriasis vs. 72% in controls (p<0.006), specifically of Tannerella forsythia -species (p<0.05). IL-1 genotype did not differ. Periodontal risk was significantly higher in psoriasis (48% vs. 25%), p<0.029).

Conclusions

Given that inflammatory foci are known to trigger psoriasis, our data indicate that periodontitis is to be considered as a risk factor for psoriasis.

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Abstract N°: 2948

Some aspects of the immune complex nature of psoriasis pathogenesis.

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Introduction

The effect of changes in cytokine profile is admitted to be an integral pathogenic mechanism of psoriasis. In this case, we believe that it makes sense to study the levels IL-4, IL-10, IL-8 and TNFα. The first two have an anti-inflammatory effect. IL-4 suppresses cytokine synthesis and shows an apparent antiproliferative potential. IL-10 also does some inhibitory activity towards cytokines, but at the same time it is an immunosuppressive agent. IL-8 belongs to the main chemokines. TNFα is a part of a group of anti-inflammatory cytokines and shows cytolitic and antineoplastic effects.

Endocrine disorders hold the leading position in pathogenesis of psoriasis. In particular, there has been observed lately an increase in the level of thyreopaties, which is considered to beconnected with environmental deterioration. Thyroiddisorders, associated with both its suppression and functional improvement are characterized with the appearance of autoimmune reactions, and circulatory antibodies to thyroglobulin (Tg). In this aspect, we consider it to be prospective, to examine the antibodies to thyroidperoxidase (TPO) and Tg in the patients with psoriasis.

Materials and Methods

The study group consisted of 58 patients with psoriasis (36 men and 22 women) aged 19 to 65 years. The disease duration ranged from 6 months to 23 years. The progressive psoriasis was stated in 37 patients, and stationary one – 21. Formed the control group 26 healthy subjects of comparable age and sex. The levels of IL-4, IL-8, IL-10, TNFα and autoantibodies to thyroid peroxidase (TPO) and thyroglobulin (Tg) were determined.

Results

Unidirectional nature of the cytokine changes, owning different spectrum was discovered, indicating the accent and systemic immunological disorders in psoriasis and their dependence on the clinical course characterizes some specificity of the violations. In order to further investigation of revealed immunological changes we studied the contents of autoantibodies to TPO and Tg. The accented dependence content of autoantibodies to TPO and Tg on the clinical course of psoriasis prompted us to consider the correlation relationship between it and cytokine activity, resulting into a recorded close relationship between the content of cytokines and autoantibodies to Tg.

Conclusions

1. As a result of the study, it is shown that the increase in blood IL-4, IL-8, IL-10 and TNFα and changing levels of autoantibodies to TPO, Tg, reflecting a associativity with the clinical course of psoriasis, and is most accentuated in the presence of erythroderma, arthropathy and progressive stage dermatosis.
2. The close correlation between the content of the association of cytokines and autoantibodies to content TPO

and Tg, which ranges from r = +0,27 to r = +0,76, shows the concordance of immunological disorders and confirms the assumptions regarding, immune complex character pathogenesis of psoriatic disease.

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Abstract N°: 2966

Real-World Effectiveness, Drug Survival and Laboratory Changes in Patients with Plaque Psoriasis Treated with Apremilast

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Introduction
Apremilast, an oral phosphodiesterase-4 inhibitor, is widely used in plaque psoriasis; however, real-world data regarding its long-term effectiveness, drug survival, and effects on inflammatory and metabolic parameters remain limited. This study aimed to evaluate clinical response, treatment persistence, discontinuation patterns, and laboratory changes in patients with plaque psoriasis treated with apremilast.

Materials and Methods
Thirty-one patients with plaque psoriasis receiving apremilast were retrospectively analyzed. Demographic and clinical characteristics, Psoriasis Area and Severity Index (PASI) responses at weeks 16 and 52, prior systemic or biologic treatment exposure, drug survival, and reasons for treatment discontinuation were evaluated. Laboratory parameters included low-density lipoprotein (LDL), neutrophil-to-lymphocyte ratio (NLR), monocyte-to-lymphocyte ratio (MLR), platelet-to-lymphocyte ratio (PLR), monocyte-to-high-density lipoprotein ratio (MHR), systemic immune-inflammation index (SII), systemic inflammation response index (SIRI), C-reactive protein (CRP), and erythrocyte sedimentation rate (ESR). The association between baseline PASI score and treatment response, as well as the impact of special site involvement, were also analyzed.

Results
The mean age was 52.4±14.5 years, and 19 patients (61.3%) were female. Median disease duration was 14 years (IQR:13). At week 16, PASI50, PASI75, PASI90, and PASI100 responses were achieved in 14 (45.2%), 8 (25.8%), 8 (25.8%), and 6 (19.4%) patients, respectively. At week 52, response rates declined to 4 (12.9%), 2 (6.5%), 2 (6.5%), and 2 (6.5%) patients, respectively.
Drug survival duration was longer in treatment-naive patients (median 7 vs 4 months), although the difference was not statistically significant (p=0.163). Treatment continuation rates were comparable between treatment-naive and previously treated patients (57.9% vs 41.7%, p=0.379).
LDL levels showed no significant change over time (p=0.475). NLR significantly decreased at month 3 (median 1.85 vs 1.80, p=0.049). No significant changes were observed in MLR (p=0.829), PLR (p=0.350), MHR (p=0.148), SII (p=0.165), SIRI (p=0.186), CRP (p=0.258), or ESR (p=0.468), although most inflammatory indices numerically decreased by month 6.
Baseline PASI scores were not associated with PASI75 or PASI90 responses at week 16 (p>0.999 for both).
Psoriatic arthritis was present in 13 patients, with a response rate of 46.2% (n=6/13).
Treatment discontinuation occurred in 16 patients (51.6%), most commonly due to lack of efficacy (62.5%), followed by adverse events (25%). Special site involvement was not associated with PASI90 response or treatment continuation. Patients achieving PASI50 at week 16 had higher continuation rates compared to non-responders (71.4% vs 30.8%, p=0.057).

Conclusions

In this real-world cohort, apremilast demonstrated moderate short-term effectiveness with declining response rates over time. Drug survival was not significantly influenced by prior treatment exposure or special site involvement. Although only NLR showed a statistically significant reduction, several inflammatory indices demonstrated a numerical downward trend, suggesting a potential modulatory effect of apremilast on systemic inflammation. Metabolic parameters remained stable during follow-up, and early clinical response may be associated with improved treatment persistence.

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Abstract N°: 2998

Guselkumab every 4 weeks as a real-world therapeutic option for psoriatic arthritis patients at high risk of joint damage

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Introduction

Psoriatic arthritis (PsA) is a chronic inflammatory disease affecting approximately 20–30% of patients with psoriasis. It is characterized by heterogeneous clinical manifestations, including peripheral joint inflammation, enthesitis, and inflammatory axial involvement.
The disease burden can be significant, as some patients may develop disabling forms of arthritis characterized by multiple bone erosions with consequent severe functional impairment and reduced quality of life.

Early diagnosis and prompt treatment are crucial, as even short diagnostic delays may result in irreversible joint damage and reduced therapeutic response.

Guselkumab, a selective IL-23 inhibitor, has demonstrated sustained efficacy and safety in both psoriasis and PsA.

In PsA, guselkumab is typically administered subcutaneously every eight weeks as maintenance therapy. However, in Europe, a four-week dosing regimen is also approved for patients at high risk of joint damage progression.

Although several real-world studies have investigated the efficacy of the standard eight-week schedule, data on the four-week regimen are still limited. The aim of the present study was to evaluate the efficacy of guselkumab administered subcutaneously every four weeks in patients with PsA in a real-world setting, assessing both the skin and joint domains.

Materials and Methods

This retrospective observational study was conducted across two psoriasis referral centers. Eighteen patients were included; all were initially managed for chronic plaque psoriasis and, during routine outpatient follow-up, developed inflammatory joint symptoms consistent with psoriatic arthritis. Owing to inadequate response to previous conventional therapies and the presence of a high risk of disease progression and joint damage, treatment escalation was deemed necessary. In agreement with the consulting rheumatologist, all patients were initiated on guselkumab administered every four weeks.

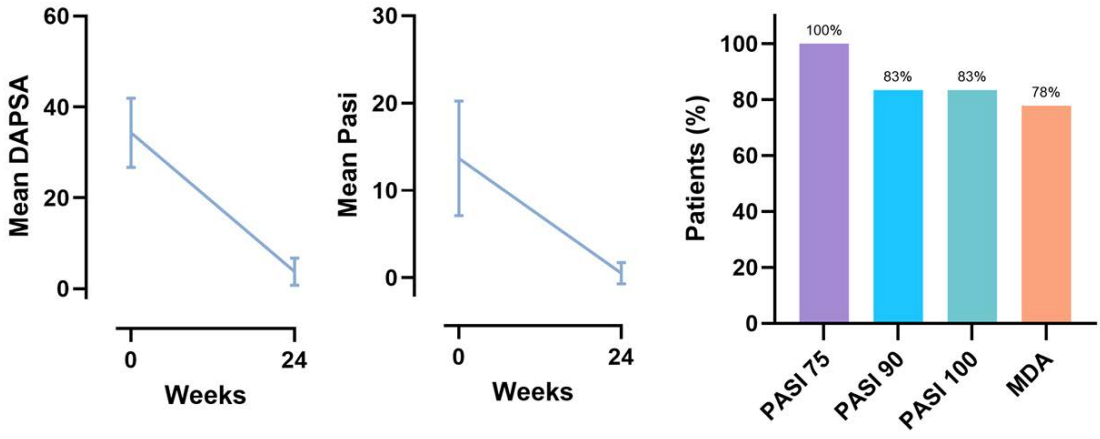
The cohort included 8 males and 10 females, with a mean age of 54.7 years and mean disease duration of 12.2 years. Peripheral arthritis was present in 72.2% of patients, axial involvement in 27.8%, enthesitis in 61.1% and

dactylitis in 38.9%. Cardiometabolic comorbidities were identified in 15 patients (83.3%). All patients had failed at least one prior biologic therapy, and 50% had failed multiple biologics.

Dermatologic and rheumatologic assessments routinely performed in clinical practice at baseline (T0) and after 24 weeks of treatment were retrospectively collected from medical records. Outcomes included DAPSA, Minimal Disease Activity (MDA), pain Visual Analogue Scale (VAS), Dermatology Life Quality Index (DLQI), and Psoriasis Area and Severity Index (PASI).

Results

After 24 weeks of treatment with guselkumab administered every four weeks, improvements were observed across all clinical and patient-reported outcomes. Mean DAPSA decreased from 34.3 ± 7.6 to 3.7 ± 3.0 ($p < 0.0001$), with 55.6% of patients achieving DAPSA remission and the remaining 44.4% achieving low disease activity. MDA was achieved by 77.8% of patients. Mean pain VAS improved from 5.89 ± 1.28 to 0.56 ± 0.62 ($p < 0.0001$), while DLQI decreased from 15.94 ± 7.41 to 1.50 ± 1.50 ($p < 0.0001$), indicating marked quality-of-life improvement. Mean PASI decreased from 13.67 ± 6.59 to 0.50 ± 1.20 ($p < 0.0001$). At Week 24, PASI 75 was achieved by 100% of patients, while PASI 90 and PASI 100 were achieved by 83.3%. No severe safety issues were observed during follow-up.



Changes in articular and cutaneous disease outcomes from baseline to Week 24 in patients treated with guselkumab administered every four weeks. Significant reductions in mean DAPSA and PASI scores were observed, together with high rates of PASI 75/90/100 and Minimal Disease Activity (MDA) achievement at Week 24.

Conclusions

Our findings reinforce guselkumab as a reliable therapeutic option with multidomain efficacy, excellent tolerability, and a consistent safety profile, in line with current clinical and real-world evidence supporting its role in controlling both articular and cutaneous inflammation. Furthermore, our real-world experience suggests that the Q4W regimen may represent an effective therapeutic option in selected patients with concomitant psoriasis and psoriatic arthritis at high risk of disease progression.

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Abstract N°: 3004

Line field confocal optical coherence tomography in scalp psoriasis: preliminary results of a descriptive study.

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Introduction

Scalp psoriasis affects up to 80% of patients with psoriasis and possesses a significant challenge as a difficult-to-treat area. Furthermore, scalp involvement can be the only manifestation of the disease and might be misdiagnosed as seborrheic dermatitis. Non-invasive skin imagine techniques can be helpful in differential diagnosis. Upon dermoscopy, psoriasis represents evenly distributed dotted vessels and silver scale. Nonetheless in challenging cases, punch-biopsy can be performed to confirm the diagnosis. Line-field confocal optical coherence tomography (LC-OCT) is a novel imaging technique that enables real-time visualization of the skin. By combining the advantages of reflectance confocal microscopy and optical coherence tomography, LC-OCT allows detailed assessment of epidermal and superficial dermal structures in vivo. The aim of this study was to describe characteristic LC-OCT features of scalp psoriasis using histopathology as a reference and compare obtained results to healthy scalp.

Materials and Methods

In our preliminary study, we included 15 patients with confirmed by histopathology scalp psoriasis and 5 healthy controls. Only lesions located on the vertex of the scalp in both groups were included in the study. Acquired images were retrospectively assessed by two independent investigators with at least 3 years in LC-OCT imaging, for typical features of psoriasis. Furthermore, both investigators measured the thickness of the epidermis and stratum corneum twice, then the mean for each modality used for further analysis. The obtained results were analyzed using STATA software. Results with $P<0,05$ were considered statistically significant.

Results

The study included 15 patients with confirmed scalp psoriasis (7 males, 8 females) the mean age 41.33 (SD +/- 17.94) and 5 healthy controls (all female, mean age 28.6 SD+/- 1.14). The age difference was not statistically significant. In patients with psoriasis, LC-OCT revealed: psoriasiform epidermal hyperplasia with parakeratosis (100%), elongated rete rigdes (93%), dilated blood vessels (80%), papillomatous appearance (73%) and bright hyper-reflective cells corresponding to the presence of neutrophils in the stratum corneum (60%). The LC-OCT images correlated None of the abovementioned features were present in healthy scalp. Mean thickness of the epidermis in psoriasis patients was 277.0 (SD +/- 44.5), stratum corneum 37.0 (SD +/- 18.2), when in healthy subjects 139.2 (SD +/- 4.7) and 10.6 (SD +/- 1.6). Additionally, we assessed stratum corneum to epidermis ratio, in psoriasis patients 0.13 (SD +/- 0.048) in healthy subjects 0.076 (SD +/- 0.011). All results were statistically significant when assessed by Mann-Whitney test.

Conclusions

These findings support the utility of LC-OCT as a reliable diagnostic tool for objective assessment of scalp psoriasis. The potential use of LC-OCT may reduce the number of invasive procedures (scalp biopsies) and furthermore might support the treatment monitoring.

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HLA-C*06:02 and Anti-TNFα Treatment Response in Psoriasis: Evidence from a Latin American Cohort

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Introduction
Psoriasis is a chronic disease affecting 0.5–11.5% of the population, with a significant impact on quality of life. Biologics have revolutionized treatment, but no biomarkers are currently used in clinical practice to predict drug response. The HLA-C*06:02 allele — the most important genetic marker in psoriasis — has been linked in some studies to poor response to anti-TNFα agents, though results remain inconsistent. SNP rs4406273 has been proposed as a surrogate marker in strong linkage disequilibrium with HLA-C*06:02, offering a simpler genotyping alternative. This study evaluated the relationship between HLA-C*06:02 and anti-TNFα response, and the utility of SNP rs4406273 as a surrogate marker, in patients from a university dermatology unit.

Materials and Methods
This was an analytical, observational, longitudinal, prospective single-cohort, including retrospective clinical records routinely gathered at the unit. The target population comprised all patients with moderate-to-severe plaque psoriasis receiving anti-TNFα treatment between May 2021 and May 2025 at a university hospital dermatology unit. A convenience sample of 24 patients was calculated (95% confidence level, 5% margin of error). Inclusion criteria: patients over 18 years old with moderate-to-severe cutaneous psoriasis who began anti-TNFα treatment between May 2021 and May 2025. Exclusion criteria: patients with a family relationship to other participants and those with clinical forms other than vulgaris. The study was approved by the institutional Ethics Committee; informed consent was obtained from all participants. The primary outcome was PASI 75 at week 12 up to week 48; BSA and DLQI were secondary variables assessed every 12 weeks up to week 48. PASI 75 at week 12 was used to define treatment responders. HLA-C*06:02 carrier status was determined via SNP rs4406273 detection, PCR-SSO and NGS confirmation. Statistical analysis was performed using the chi-square test.

Results
32 patients with plaque psoriasis starting adalimumab between May 2021 and May 2025 were followed. Mean age was 52 ± 12 years (range 25–70); 22 were male and 10 female. Mean baseline PASI was 18.2 ± 7.4 (range 6.6–33.5). Of these, 7 carried HLA-C*06:02 and 25 did not. PASI 75 at week 12 was achieved by 2 of 7 allele-positive patients versus 17 of 25 allele-negative patients (Fisher's Exact Test, $p = 0.09$). One patient was lost to follow-up since he changed healthcare provider. Allele frequency was 21.8%, consistent with published literature. SNP rs4406273 strongly correlated with HLA-C*06:02 carrier status (Fisher's Exact Test, $p = 0.0059$).

Conclusions
The HLA-C*06:02 allele has been associated with a differential response to anti-TNFα therapies, the most extensively studied treatments in this context. Upon reviewing the literature, inconsistent results were observed,

though several studies report a trend toward better response among HLA-C*06:02-negative patients — a trend also reflected in our study, although not statistically significant. In our cohort, SNP rs4406273 showed a strong correlation with HLA-C*06:02 carrier status (Fisher's Exact Test, p = 0.0059), supporting its potential as a reliable and accessible surrogate marker. Although not statistically significant, a trend towards better response was observed among HLA-C*06:02-negative patients (68% vs 28,6% response rate in non-carriers vs carriers) (Fisher's Exact Test, p = 0.0059). Larger studies with long-term data are needed to draw definitive conclusions regarding the use of HLA-C*06:02 and SNP rs4406273 as biomarkers in patients undergoing anti-TNFα therapy.

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Real-World Effectiveness and Patient-Reported Outcomes of Xeligekimab in Moderate-to-Severe Plaque Psoriasis With Challenging Clinical Profiles: A Prospective, Multicenter, Observational Study in China (XP-Real)

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Introduction

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Xeligekimab is a domestically developed anti-*interleukin (IL)-17A* monoclonal antibody approved in China in 2024 for moderate-to-severe plaque psoriasis. While phase III trials demonstrated robust efficacy, real-world evidence remains limited. This prospective, multicenter study evaluated the real-world effectiveness, patient-reported outcomes (PROs), and safety of xeligekimab over 24 weeks in Chinese patients with moderate-to-severe plaque psoriasis.

Materials and Methods

Patients initiating xeligekimab were prospectively enrolled across 45 dermatology centers in China (NCT06802848, first patient in: March 21, 2025). The full analysis set (FAS) comprised 392 patients with documented baseline data. The cohort had a mean age of 43.1±14.2 years (73.0% male), mean disease duration of 9.6±9.5 years, and 47.4% had severe disease. Challenging clinical profiles showed that 58.7% had scalp, 24.5% had nail, 5.4% had genital, and 3.6% had palmoplantar involvement, while 4.8% had concomitant psoriatic arthritis and 29.6% had prior biologic/targeted therapy exposure, most commonly *IL-17A* inhibitors (21.9%) (**Table 1**). Patients were stratified by prior biologic/targeted therapy exposure for prespecified subgroup analyses.

Primary endpoints included PASI 75/90/100 and PGA 0/1 rates at Weeks 4, 12, and 24. Secondary endpoints included mean percentage change from baseline in PASI, PGA, DLQI, PP-NRS, PHQ-9, and GAD-7, and DLQI 0/1 rate. Safety was monitored in all treated patients (N=392).

Table 1. Baseline Demographics and Disease Characteristics by Biologic/Targeted Therapy Subgroup

	Overall (N=392)	Bio/Target-experienced (N=116)	Bio/Target-naive (N=276)
Demographics			
Age (years), Mean ± SD	43.1 ± 14.2	43.1 ± 13.7	43.1 ± 14.5
Male, n (%)	286 (73.0)	84 (72.4)	202 (73.2)
Female, n (%)	106 (27.0)	32 (27.6)	74 (26.8)
Disease Characteristics			
Disease duration (years), Mean ± SD	9.6 ± 9.5	8.9 ± 7.8	9.9 ± 10.2
Severity			
Moderate, n (%)	205 (52.3)	68 (58.6)	137 (49.6)
Severe, n (%)	186 (47.4)	48 (41.4)	138 (50.0)
Concomitant PsA, n (%)	19 (4.8)	10 (8.6)	9 (3.3)
Difficult-to-treat area involvement			
Scalp, n (%)	230 (58.7)	54 (46.6)	176 (63.8)
Nails, n (%)	96 (24.5)	25 (21.6)	71 (25.7)
Genitalia, n (%)	21 (5.4)	7 (6.0)	14 (5.1)
Palms/Soles, n (%)	14 (3.6)	7 (6.0)	7 (2.5)
Prior Biologic/Targeted Therapy			
Total	116 (29.6)	116 (100.0)	0 (0.0)
IL-17A inhibitors, n (%)	86 (21.9)	86 (74.1)	0 (0.0)
IL-23 inhibitors, n (%)	17 (4.3)	17 (14.7)	0 (0.0)
IL-12/23 inhibitors, n (%)	9 (2.3)	9 (7.8)	0 (0.0)
TNF-α inhibitors, n (%)	7 (1.8)	7 (6.0)	0 (0.0)
JAK inhibitors, n (%)	5 (1.3)	5 (4.3)	0 (0.0)
TYK2 inhibitors, n (%)	5 (1.3)	5 (4.3)	0 (0.0)
PDE4 inhibitors, n (%)	16 (4.1)	16 (13.8)	0 (0.0)
Disease Severity and Quality of Life			
PASI, Mean ± SD	12.2 ± 9.0	10.6 ± 8.3	12.9 ± 9.2
PGA, Mean ± SD	3.3 ± 0.8	3.1 ± 0.8	3.3 ± 0.7
DLQI, Mean ± SD	11.5 ± 7.0	11.8 ± 7.0	11.3 ± 7.0
Peak Pruritus NRS, Mean ± SD	5.1 ± 2.7	4.9 ± 2.8	5.1 ± 2.7
Psychological Assessments			
PHQ-9, Mean ± SD	6.2 ± 5.8	6.8 ± 5.8	5.9 ± 5.7
GAD-7, Mean ± SD	4.8 ± 5.1	5.0 ± 5.1	4.6 ± 5.2

Abbreviations: PASI, Psoriasis Area and Severity Index; PGA, Physician's Global Assessment; DLQI, Dermatology Life Quality Index; NRS, Numerical Rating Scale; PHQ-9, Patient Health Questionnaire-9; GAD-7, Generalized Anxiety Disorder-7; SD, standard deviation.

Results

Skin clearance outcomes and PROs across the 24-week observation period are presented in Table 2 and Figure 1. Rapid skin clearance was evident as early as Week 4, with PASI 75 and PASI 90 response rates of 38.8% and 17.3%, respectively. Responses continued to increase through Week 12 (PASI 75: 78.6%; PASI 90: 62.9%; PASI 100: 40.5%)

and Week 24 (PASI 75: 84.8%; PASI 90: 73.1%; PASI 100: 55.7%). PGA 0/1 rates followed a similar trajectory, rising from 28.3% at Week 4 to 71.8% at Week 12 and 76.6% at Week 24. Mean PASI decreased by 61.4% at Week 4 and 88.1% at Week 24 (**Figure 1A, 1B**).

Biologic-naive patients consistently achieved numerically higher response rates than biologic-experienced patients across all timepoints (PASI 90 at Week 24: 80.3% vs. 55.9%; PASI 100: 62.6% vs. 39.3%). Nonetheless, biologic-experienced patients still demonstrated clinically meaningful responses, with PASI 75 reaching 73.1% and PGA 0/1 reaching 62.8% at Week 24 (**Table 2**).

Quality-of-life improvements paralleled skin clearance. DLQI 0/1 rates increased from 26.8% at Week 4 to 55.6% at Week 12 and 62.7% at Week 24, with mean reductions of 42.6% and 72.7% at Weeks 4 and 24, respectively (Figure 1C). PP-NRS decreased by 47.7% at Week 4 and 70.9% at Week 24, indicating rapid and sustained itch relief (**Figure 1D**).

PHQ-9 scores decreased by 27.8%, 53.2%, and 74.7% at Weeks 4, 12, and 24, respectively; GAD-7 scores showed corresponding reductions of 38.8%, 64.4%, and 76.8% (**Figure 1E, 1F**). Improvements were consistent across both subgroups (Table 2).

Regarding safety, 16.6% of patients experienced ≥1 AE, most commonly upper respiratory infection (2.0%). Drug-related AEs occurred in 7.7%, SAEs in 0.8%, and injection site reactions in 2.0%. One patient (0.3%) discontinued due to an AE.

Table 2. Effectiveness Outcomes Over 24 Weeks by Biologic/Targeted Therapy Subgroup

	Overall (N=392)	Bio/Target-experienced (N=116)	Bio/Target-naive (N=276)
Response rates, % (95% CI)			
PASI 75			
W4	38.8 (33.8, 43.7)	26.4 (18.0, 34.7)	43.9 (37.9, 49.9)
W12	78.6 (74.3, 82.9)	65.8 (56.5, 75.1)	84.0 (79.5, 88.5)
W24	84.8 (80.4, 89.2)	73.1 (63.1, 83.1)	89.7 (85.2, 94.2)
PASI 90			
W4	17.3 (13.5, 21.2)	10.1 (4.3, 15.9)	20.3 (15.4, 25.2)
W12	62.9 (57.9, 68.0)	45.1 (35.1, 55.1)	70.4 (64.8, 76.0)
W24	73.1 (67.7, 78.6)	55.9 (44.3, 67.4)	80.3 (74.5, 86.2)
PASI 100			
W4	9.5 (6.5, 12.6)	5.3 (0.9, 9.7)	11.3 (7.4, 15.2)
W12	40.5 (35.3, 45.7)	26.9 (17.8, 36.0)	46.2 (40.0, 52.4)
W24	55.7 (49.4, 62.0)	39.3 (28.0, 50.6)	62.6 (55.3, 69.8)
PGA 0/1			
W4	28.3 (23.7, 32.9)	23.0 (15.1, 30.9)	30.5 (24.9, 36.1)
W12	71.8 (67.0, 76.5)	57.4 (47.9, 67.0)	77.8 (72.6, 83.0)
W24	76.6 (71.8, 81.4)	62.8 (52.7, 72.9)	82.4 (77.3, 87.5)
DLQI 0/1			
W4	26.8 (22.3, 31.3)	23.2 (15.4, 31.1)	28.3 (22.9, 33.7)
W12	55.6 (50.4, 60.8)	43.5 (34.0, 52.9)	60.7 (54.7, 66.7)
W24	62.7 (56.8, 68.7)	53.8 (43.4, 64.2)	66.5 (59.6, 73.4)
Mean % change from baseline (95% CI)			
PASI			
W4	−61.4 (−64.6, −58.2)	−49.4 (−56.0, −42.8)	−66.5 (−69.9, −63.0)
W12	−84.8 (−87.6, −82.1)	−74.4 (−81.6, −67.3)	−89.1 (−91.4, −86.9)

W24	−88.1 (−92.8, −83.4)	−77.9 (−92.7, −63.1)	−92.4 (−95.4, −89.4)
PGA			
W4	−37.5 (−40.6, −34.3)	−28.4 (−34.2, −22.6)	−41.3 (−44.9, −37.6)
W12	−68.7 (−72.1, −65.3)	−55.5 (−62.5, −48.5)	−74.2 (−77.8, −70.6)
W24	−76.1 (−79.8, −72.4)	−62.2 (−70.8, −53.5)	−81.9 (−85.7, −78.2)
DLQI			
W4	−42.6 (−50.0, −35.2)	−31.0 (−51.2, −10.7)	−47.4 (−53.7, −41.2)
W12	−66.7 (−73.8, −59.6)	−58.8 (−75.4, −42.2)	−70.0 (−77.2, −62.9)
W24	−72.7 (−80.4, −65.0)	−64.9 (−82.8, −47.1)	−75.9 (−83.8, −68.0)
PP-NRS			
W4	−47.7 (−52.8, −42.6)	−41.1 (−51.2, −30.9)	−50.4 (−56.2, −44.6)
W12	−64.0 (−70.8, −57.2)	−55.2 (−69.1, −41.2)	−67.6 (−75.0, −60.1)
W24	−70.9 (−78.1, −63.6)	−58.3 (−73.7, −42.8)	−76.0 (−83.7, −68.4)
PHQ-9			
W4	−27.8 (−41.3, −14.2)	−27.7 (−51.4, −4.1)	−27.8 (−44.4, −11.2)
W12	−53.2 (−65.3, −41.0)	−55.0 (−73.2, −36.7)	−52.4 (−68.0, −36.8)
W24	−74.7 (−83.3, −66.1)	−68.5 (−80.2, −56.8)	−77.4 (−88.6, −66.2)
GAD-7			
W4	−38.8 (−49.7, −27.9)	−42.3 (−59.3, −25.2)	−37.3 (−51.1, −23.5)
W12	−64.4 (−73.7, −55.0)	−57.9 (−73.8, −42.1)	−67.2 (−78.7, −55.6)
W24	−76.8 (−86.8, −66.8)	−69.2 (−82.2, −56.1)	−80.1 (−93.1, −67.1)

PASI, Psoriasis Area and Severity Index; PGA, Physician's Global Assessment; DLQI, Dermatology Life Quality Index; PP-NRS, Peak Pruritus Numerical Rating Scale; PHQ-9, Patient Health Questionnaire-9; GAD-7, Generalized Anxiety Disorder 7-item scale; CI, confidence interval. Bio-experienced was defined as patients with prior exposure to ≥1 biologic agent; bio-naive denotes no prior biologic use. Response rates and mean percentage changes from baseline were estimated using multiple imputation (MI; m=40).

Conclusions

In this real-world study of 392 Chinese patients with challenging clinical profiles, including nearly 30% with prior biologic exposure, xeligekimab demonstrated rapid onset and sustained effectiveness through Week 24. High skin clearance (PASI 90: 73.1%; PASI 100: 55.7%) was accompanied by meaningful improvements in quality of life, pruritus, depression, and anxiety in both subgroups, with a favorable safety profile. These findings complement phase III evidence and support the comprehensive benefits of xeligekimab in routine clinical practice.

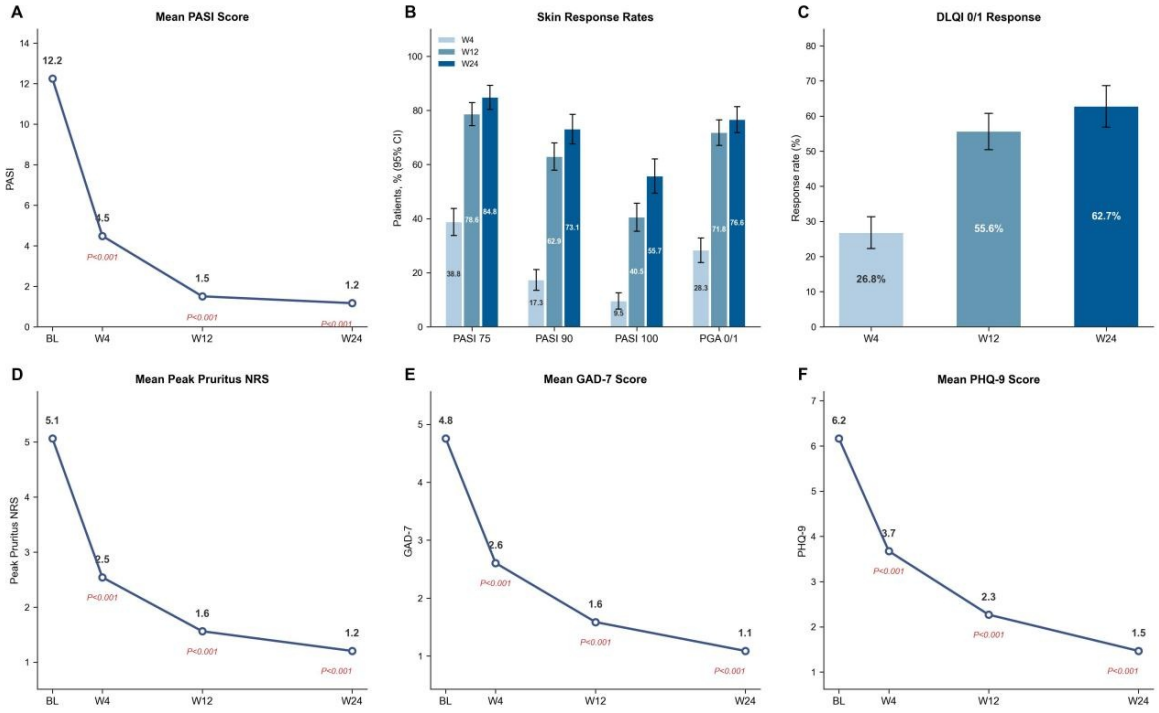

Figure 1. Effectiveness and Patient-Reported Outcomes Over 24 Weeks (A) Mean PASI score from baseline to Week 24. (B) PASI 75, PASI 90, PASI 100, and PGA 0/1 response rates at Weeks 4, 12, and 24. (C) DLQI 0/1 response rate at Weeks 4, 12, and 24. (D) Mean Peak Pruritus NRS score from baseline to Week 24. (E) Mean GAD-7 score from baseline to Week 24. (F) Mean PHQ-9 score from baseline to Week 24. Missing data were handled using multiple imputation (MI; m=40). PASI, Psoriasis Area and Se·verity Index; PGA, Physician's Global Assessment; DLQI, Dermatology Life Quality Index; NRS, Numerical Rating Scale; PHQ-9, Patient Health Questionnaire-9; GAD-7, Generalized Anxiety Disorder 7-item scale.

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Effectiveness and Safety of Vunakizumab in Patients with Moderate-to-Severe Plaque Psoriasis: A Preliminary Analysis of a Real-World Prospective Study

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Introduction

Vunakizumab has demonstrated robust clinical response and a favorable safety profile through week 52 in a randomized phase 3 trial for moderate-to-severe plaque psoriasis.[1] Real-world evidence is needed to confirm these outcomes in routine practice with heterogeneous patients. We therefore initiated an ongoing, large-scale, multicenter, prospective phase 4 observational study across >60 centers in China, aiming to enroll >1,000 biologic-naïve adults with moderate-to-severe plaque psoriasis (NCT06696417).

Materials and Methods

This report presents a preliminary analysis from the ongoing study. Biologic-naïve adults with moderate-to-severe plaque psoriasis, defined by a Body Surface Area (BSA) ≥3%, Psoriasis Area and Severity Index (PASI) ≥3, or Dermatology Life Quality Index (DLQI) ≥6 at baseline, were enrolled. Patients received subcutaneous vunakizumab 240 mg at weeks 0, 2, and 4, followed by 240 mg every 4 weeks through week 48. The primary endpoints were the proportions of patients achieving PASI 90 and static Physician's Global Assessment (sPGA) 0/1 at week 12. The present report focuses on prespecified secondary endpoints, including PASI 75/100, sPGA 0, safety, and patient-reported outcomes (PROs). Quality of life and itch were assessed via the Dermatology Life Quality Index (DLQI, 0–30) and Pruritus Numeric Rating Scale (NRS, 0–10), where lower scores indicate improvement. Treatment satisfaction was measured using the Treatment Satisfaction Questionnaire for Medication (TSQM-II, 0–100); higher scores represent greater satisfaction (higher Side Effects scores denote better tolerability).

Results

As of December 31, 2025 (data cut-off), 628 patients were screened for the study. Of these, 555 received at least one dose of the investigational drug (the treated population), and 311 completed the 12-week treatment period or discontinued prior to week 12, comprising the week 12 analysis set. Among the treated patients, baseline characteristics showed a majority of male patients (69.5%) and a high proportion with BMI ≥24 kg/m^2 (66.5%). Common medical history and comorbidities included metabolism/nutrition disorders (27.7%) and vascular disorders (16.9%). Baseline characteristics in the treated population were generally comparable to those in the week 12 analysis set (Table 1).

In the week 12 analysis set, the treatment demonstrated high efficacy at week 12. PASI 75, 90, and 100 response rates were 93.9%, 82.3%, and 50.8%, respectively. A total of 88.1% of patients achieved sPGA 0/1, with 60.5% achieving sPGA 0 (Table 2). Patient-reported outcomes improved, with the mean DLQI score decreasing from 12.8 to 3.0 (Least Squares [LS] mean change: –9.4) and the NRS score falling from 5.6 to 1.1 (LS mean change: –4.5). TSQM scores indicated high satisfaction with effectiveness (mean [SD], 83.4 [19.60]), convenience (82.8 [18.25]), and overall satisfaction (83.7 [17.83]), and a high side-effects domain score consistent with favorable tolerability (98.3 [7.92]) (Tables 3–4).

In the treated population, 211 patients (38.0%) had treatment-emergent adverse events (TEAEs) (mild: 21.3%; moderate: 14.4%). In the week 12 analysis set, 155 (49.8%) experienced TEAEs (mild: 27.0%; moderate: 20.3%) and 84 (27.0%) had TRAEs. Common TEAEs included upper respiratory tract infection (7.7%), eczema (3.5%), and increased ALT (2.6%). TEAEs led to treatment discontinuation in 1.3% and interruption in 1.9% of patients. No deaths occurred (Table 5).

Table 1. Baseline characteristics

Characteristics	Treated population (n=555)	Week 12 analysis set (n=311)
Age (years)		
Mean (SD)	43.8 (14.93)	42.9 (14.90)
Median (Range)	42 (18, 86)	40 (18, 86)
Age Group, n (%)		
< 65	508 (91.5)	287 (92.3)
≥ 65	47 (8.5)	24 (7.7)
Sex (Male), n (%)	386 (69.5)	205 (65.9)
BMI (kg/m²)		
Mean (SD)	25.676 (4.3405)	25.747 (4.2343)
Median (Range)	25.352 (12.63, 46.09)	25.687 (12.63, 42.29)
BMI Group, n (%)		
< 24 kg/m²	183 (33.0)	103 (33.1)
≥ 24 kg/m²	369 (66.5)	206 (66.2)
Medical History and Comorbidities, n (%)	366 (65.9%)	208 (66.9%)
Confirmed PsA Diagnosis, n (%)	35 (6.3)	17 (5.5)
Baseline sPGA		
Mean (SD)	3.3 (0.76)	3.2 (0.70)
Median (Range)	3 (0, 5)	3 (1, 5)
Baseline PASI		
Mean (SD)	18.36 (11.240)	18.06 (9.706)
Median (Range)	15.15 (0.6, 72.0)	15.25 (2.8, 72.0)

The treated population included all patients who received ≥1 dose of study drug. The week 12 analysis set included patients who completed the 12-week treatment period or discontinued before week 12.

BMI, body mass index; PASI, Psoriasis Area and Severity Index; PsA, psoriatic arthritis; SD, standard deviation; sPGA, static Physician's Global Assessment.

Table 2. Clinical response rates at week 12 (Week 12 analysis set)

Endpoint	Responders, n	Response rate, % (95% CI)
PASI 75	292	93.9 (90.6, 96.3)
PASI 90	256	82.3 (77.6, 86.4)
PASI 100	158	50.8 (45.1, 56.5)
sPGA 0/1	274	88.1 (84.0, 91.5)

sPGA 0	188	60.5 (54.8, 65.9)

The week 12 analysis set included patients who completed the 12-week treatment period or discontinued before week 12.

CI, confidence interval; PASI, Psoriasis Area and Severity Index; sPGA, static Physician's Global Assessment.

Table 3. Improvement in quality of life and itch (Week 12 analysis set)

Endpoint	Baseline, Mean (SD)	Week 12, Mean (SD)	LS Mean Change (SE)
DLQI	12.8 (8.1)	3.0 (4.9)	-9.4 (0.3)
Itch NRS	5.6 (2.5)	1.1 (1.7)	-4.5 (0.1)

The week 12 analysis set included patients who completed the 12-week treatment period or discontinued before week 12.

DLQI, Dermatology Life Quality Index; LS, least squares; NRS, Numeric Rating Scale; SD, standard deviation; SE, standard error.

Table 4. Treatment satisfaction (Week 12 analysis set)

TSQM	Patients with available data, n	Score at week 12, mean (SD)
Effectiveness	301	83.4 (19.60)
Side effects	267	98.3 (7.92)
Convenience	302	82.8 (18.25)
Overall satisfaction	302	83.7 (17.83)

The week 12 analysis set included patients who completed the 12-week treatment period or discontinued before week 12.

TSQM, Treatment Satisfaction Questionnaire for Medication; SD, standard deviation.

Table 5. TEAEs

TEAE	Treated population (n=555)	Week 12 analysis set (n=311)
Any TEAE, n (%)	211 (38.0)	155 (49.8)
Any TESAE, n (%)	20 (3.6)	15 (4.8)
TEAE leading to discontinuation, n (%)	7 (1.3)	4 (1.3)
TEAE leading to interruption, n (%)	8 (1.4)	6 (1.9)
Severity, n (%)		
Mild	118 (21.3)	84 (27.0)
Moderate	80 (14.4)	63 (20.3)
Severe	13 (2.3)	8 (2.6)

The treated population included all patients who received ≥1 dose of study drug. The week 12 analysis set included patients who completed the 12-week treatment period or discontinued before week 12.

TEAE, treatment-emergent adverse event; TESAE, Treatment-emergent serious adverse event.

Conclusions

In this real-world setting, vunakizumab demonstrated rapid and high levels of clinical clearance and significant improvements in quality of life and itch among biologic-naïve patients during the 12-week treatment. The safety profile was consistent with previous phase 3 findings, confirming vunakizumab as an effective and well-tolerated option for moderate-to-severe plaque psoriasis.

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EADV CONGRESS
VIENNA
30 SEP - 3 OCT 2026

Abstract N°: 3037

Secukinumab reduces residual systemic inflammation in biologic-naïve patients with moderate to severe psoriasis: Post hoc pooled analysis of phase III trials

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Introduction

Psoriasis is a chronic immune-mediated disease characterised by persistent systemic inflammation and frequent cardiometabolic comorbidities.[1] High-sensitivity C-reactive protein (hsCRP) is an established biomarker of low-grade systemic inflammation and an independent predictor of adverse cardiovascular outcomes.[2,3] Residual inflammation (RI), commonly defined as hsCRP ≥2 mg/L despite optimal skin clearance (Psoriasis Area and Severity Index [PASI] ≤2), has been reported in a substantial proportion of biologic-treated patients and may reflect ongoing inflammatory burden beyond the skin.[4] This analysis evaluated the prevalence and resolution of residual systemic inflammation after 52 weeks of continuous stable secukinumab therapy in biologic-naïve patients with moderate to severe psoriasis achieving optimal skin response (PASI ≤2).

Materials and Methods

This post hoc pooled analysis included biologic-naïve patients with moderate to severe plaque psoriasis (baseline PASI ≥10) from six phase III trials (ERASURE, FIXTURE, SCULPTURE, FEATURE, JUNCTURE, PROSE).[5-9] Secukinumab 150 or 300 mg was administered per protocol. RI was defined as hsCRP ≥2 mg/L. RI status at Week 52 was assessed among patients achieving PASI ≤2 with paired baseline and Week 52 hsCRP values. Baseline demographics and inflammatory comorbidities were summarized descriptively by RI status. The analysis focused on medians and categorical shifts to ensure robustness to outliers.

Results

The pooled cohort comprised 2836 biologic-naïve patients, of whom 1872 (66%) achieved PASI ≤2 at Week 52. Among patients with paired hsCRP measurements (n=1,594), 57.6% had no RI (hsCRP <2 mg/L), while 42.4% remained with RI at Week 52 (**Table 1**). Among the 787 patients with hsCRP ≥2 mg/L at baseline (49.4%), 35.3% transitioned below the RI threshold by Week 52, indicating resolution of residual systemic inflammation. Patients with RI at Week 52 had a higher baseline prevalence of inflammatory comorbidities compared with those without RI, including diabetes mellitus (8.9% vs 4.1%), hypertension (27.7% vs 15.8%), and psoriatic arthritis (13.0% vs 10.7%). Median-based analyses demonstrated sustained control of systemic inflammation.

Conclusions

In biologic-naïve patients with moderate to severe psoriasis, secukinumab substantially reduces residual systemic inflammation after 52 weeks of continuous therapy. In patients achieving optimal skin responses, more than half no longer met criteria for RI, and over one third of those with elevated hsCRP at baseline achieved resolution of residual inflammation. These findings demonstrate that secukinumab delivers clinically meaningful control beyond the skin, addressing persistent systemic inflammation in a substantial proportion of patients and supporting a multidimensional treatment goal integrating skin clearance with systemic inflammatory control in psoriasis.

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Table 1. Shift of hsCRP categories from baseline to Week 52 (patients achieving PASI score ≤2)

	Baseline hsCRP		Postbaseline hsCRP categories	
	Categories	n (%)	<2 mg/L, n (%)	≥2 mg/L, n (%)
Secukinumab 150/300 mg Q4W (n=1594)	<2 mg/L	807 (50.6%)	640 (79.3%)	167 (20.7%)
	≥2 mg/L	787 (49.4%)	278 (35.3%)	509 (64.7%)
	Total	1594 (100%)	918 (57.6%)	676 (42.4%)

This shift table shows data among patients with hsCRP available at baseline and at Week 52 (n=1594). A total of 1872 patients achieved PASI ≤2 at Week 52, but 278 (14.8%) had hsCRP missing at Week 52. hsCRP, high-sensitivity C-reactive protein; PASI, Psoriasis Area and Severity Index; Q4W, every 4 weeks.

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Abstract N°: 3048

Using 589 nm Solid-State Laser as an Adjuvant for the Treatment of Psoriasis

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Introduction

Psoriasis is a chronic autoimmune disease of multifactorial etiology, with cutaneous and articular involvement. Its clinical manifestations include erythematous and scaly lesions, frequently associated with pruritus and discomfort, which can compromise patients' physical and psychological quality of life. Treatment varies according to disease severity and extent, encompassing phototherapy, topical treatments such as corticosteroids and vitamin D analogues, and systemic therapies including immunosuppressants and biological agents. In addition to conventional approaches, the use of lasers — such as the excimer laser (308 nm), CO_2, pulsed dye laser (585–595 nm), and 589 nm solid-state laser — has been investigated as an alternative therapy, particularly in refractory patients or those with contraindications to conventional treatments. These devices aim to modulate the local inflammatory response and promote remission of psoriatic lesions.

Case Presentation

Patient C.R.S.M. was diagnosed with psoriasis in 2005, initially with involvement of the extensor areas of upper limbs and scalp. The condition remained stable until 2012, when the previously affected areas expanded, evolving to palmoplantar psoriasis and involvement of the elbows and scalp. In 2016, the patient reported worsening of the condition associated with stress, culminating in the development of psoriatic arthritis in 2018. The patient had previously used methotrexate but discontinued it due to adverse effects; ustekinumab (IL-12/IL-23 inhibitor) was then introduced between 2020 and 2022, which the patient independently discontinued.

The patient presented to our service in June 2024 without joint symptoms, expressing an initial preference for non-invasive treatments. At that time, she presented with lesions on the hands, elbows, and postsurgical breast scars. Monotherapy with a 589 nm solid-state laser in the right hemibody was proposed to assess clinical response while the left hemibody was kept without treatment, serving as the control.

Between June and August 2024, the patient showed continuous improvement in erythema, induration, and scaling when compared with the left hemibody. The most significant improvement was observed in the upper limbs treated with the laser. The Dermatology Life Quality Index score decreased from 13 to 6, and the regional Psoriasis Area and Severity Index score from 4 to 2 over this period. However, in August, the DLQI worsened (from 6 to 10) and the regional PASI slightly increased (from 2 to 3), due to an allergic reaction managed with corticosteroids and antihistamines.

Conclusion

The 589 nm solid-state laser has a cutaneous penetration depth of approximately 1 mm, with oxyhemoglobin as its primary chromophore. It has been shown to be safe and effective in reducing inflammatory processes. Given that the treated condition is multifactorial in nature, various factors may influence its exacerbation or remission, even in the context of effective topical or systemic therapies.

The availability of a therapeutic option with a high safety profile, without significant side effects, and with rapid and sustained response, provides a valuable tool in the management of difficult-to-treat cases. Furthermore, it

may serve as an adjuvant treatment during the initial phase of oral therapies with delayed onset of action, allowing for better clinical control.

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Abstract N°: 3049

From skin to systemic health: Potential of secukinumab for cardiovascular risk mitigation in patients with moderate to severe psoriasis

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Introduction

Psoriasis is a known independent cardiovascular (CV) risk factor, increasing the risk of heart attack and stroke. Patients with severe psoriasis (PsO) have an additional increased risk of CV mortality which is independent of the traditional CV risk factors.[1] A possible explanation is that the chronic inflammation in PsO elevates the high-sensitivity C-reactive protein (hsCRP) levels, associated with increased disease severity and a higher risk of CV events.[2,3] Cardiologists have reported CV risk groups classification based on hsCRP levels: (a) low risk: <1 mg/L, (b) moderate risk: ≥1 to <3 mg/L, and high risk: ≥3 mg/L.[3] This analysis aimed to determine the impact of secukinumab on the distribution of CV risk groups, defined by hsCRP[3], in moderate to severe patients with PsO who achieve clinically adequate skin control of their skin (Psoriasis Area and Severity Index, PASI ≤3) after 52 weeks of treatment.

Materials and Methods

This analysis is based on a pooled analysis of six studies including patients with PsO (ERASURE, FIXTURE, SCULPTURE, FEATURE, JUNCTURE and PROSE studies)[4-8]. All patients were biologic-naïve patients with moderate to severe psoriasis, defined as having a baseline PASI score of ≥10 who were assigned to 150 mg or 300 mg monthly treatment with secukinumab. For changes in the CV risk analysis, we included only patients with hsCRP data at baseline. We evaluated the change in CV risk categories by hsCRP levels at Week 52 on secukinumab treatment in patients with a PASI score of ≤3.

Results

The pooled data set included a total of 2836 patients with moderate to severe PsO, naïve to biologic treatment. Of these, 74% (2096/2836) achieved optimal disease control (PASI ≤3) after 52 weeks of secukinumab treatment. The mean±SD age was 43.5±13.54 years and 67.4% were male. The median (Q1-Q3) weight was 80.7 (68.8–94.1) kg and 33.2% of patients weighed ≥90 kg. Median (Q1-Q3) duration of PsO was 13.7 (6.4–22.5) years. The total PASI score (mean±SD) at baseline was 21.0±8.43. At baseline, 12.3%, 7% and 21.5% patients had psoriatic

arthritis, diabetes mellitus, and hypertension, respectively. In the total population, median hsCRP decreased from 2.3 mg/L at baseline to 1.6 mg/L at Week 12 and remained stable until Week 52. Among patients with hsCRP measurements available at both baseline and Week 52 for shift analysis of risk categories, 1787 patients were included (hsCRP levels at Week 52 were missing for 309 patients). At baseline 22.3% were categorized as low CV risk, 41.7% moderate CV risk and 36.0% high CV risk. At Week 52 the risk categories were 28.0%, 43.6% and 28.4%, respectively. 23% of patients experienced a shift from moderate to low CV risk category, and 45% from high to moderate or low CV risk category. Almost 70% of patients classified as low CV risk at baseline remained in this category after 52 weeks of secukinumab treatment, while 26.3% shifted to the moderate risk category (**Table**). Overall, 26.1% (467/1787) patients shifted to a better CV risk category, while 14.5% (260/1787) patients moved to a worse CV risk category.

Conclusions

Secukinumab was associated with fast and sustained reduction in serum hsCRP levels in patients with moderate to severe PsO. In patients achieving good skin control within 52 weeks (PASI ≤3), secukinumab treatment shifted 26.1% of patients into a lower CV risk category compared to baseline. This finding highlights the potential positive impact of secukinumab on CV risk in this patient population.

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Table. Shift of hsCRP categories from baseline to Week 52 in patients achieving PASI score ≤3

	Baseline hsCRP		Postbaseline hsCRP categories		
	Categories	n (%)	<1 mg/L n (%)	1 to <3 mg/L n (%)	≥3 mg/L n (%)
Secukinumab 150/300 mg Q4W (n=1787)	<1 mg/L	399 (22.3%)	274 (68.7%)	105 (26.3%)	20 (5%)
	1 to <3 mg/L	745 (41.7%)	176 (23.6%)	434 (58.3%)	135 (18.1%)
	≥3 mg/L	643 (36%)	51 (7.9%)	240 (37.3%)	352 (54.7%)
	Total	1787 (100%)	501 (28%)	779 (43.6%)	507 (28.4%)

This shift table shows data among patients with hsCRP available at baseline and at Week 52 (n=1787). A total of 2096 patients achieved PASI ≤3 at Week 52, but 309 (14.8%) had hsCRP data missing at Week 52.

hsCRP, high-sensitivity C-reactive protein; PASI, Psoriasis Area and Severity Index; Q4W, every 4 weeks.

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30 SEP - 3 OCT 2026

Abstract N°: 3058

Ultra High-Frequency Ultrasound (UHFUS) as a diagnostic and monitoring tool in nail psoriasis: structural assessment from healthy controls to ixekizumab treatment response – Prelinary results of a prospective observational study

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Introduction

Nail psoriasis is a frequent and disabling manifestation of psoriasis, affecting up to 80% of patients over their lifetime and associated with reduced quality of life and an increased risk of psoriatic arthritis. Ultra High-frequency Ultrasound (UHFUS) is an emerging, non-invasive tool for the objective assessment of structural and vascular alterations of the nail unit [1]. This study pursued two aims: first, to characterise UHFUS differences between patients with psoriatic onychopathy and healthy subjects; second, to evaluate the longitudinal course of ultrasound and clinical parameters in psoriatic patients initiating ixekizumab [2], an anti-IL-17A monoclonal antibody, comparing those with and without nail involvement.

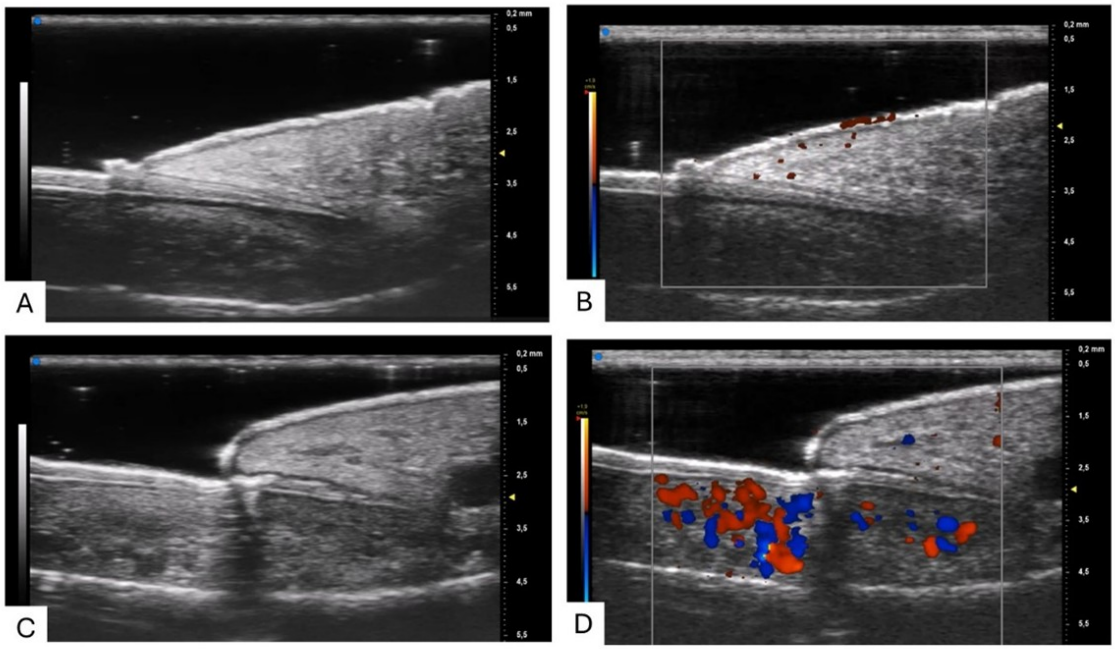
Materials and Methods

The study included two phases. In the first phase, 40 participants were enrolled: 20 healthy subjects (Group 0) and 20 patients with psoriatic onychopathy (Group 1), and UHFUS parameters were compared at baseline. In the second phase, 30 new psoriatic patients initiating ixekizumab were followed prospectively: 15 with nail psoriasis and 15 without. Six UHFUS parameters were assessed at Baseline, Week 4 (W4), Week 12 (W12) and Week 24 (W24): nail plate thickness (A), nail bed thickness (B), length of nail plate insertion (C), matrix length (D), matrix thickness (E), and Color Doppler signal (CD), scored on a semi-quantitative scale from 0 to 3, on fingers I, II and worst finger. Clinical parameters included PASI and DLQI for both groups; NAPSI, mNAPSI, FPGA and NPQ10 were additionally assessed in the nail psoriasis group. The Friedman test was used for longitudinal comparisons; the Mann-Whitney U test for between-group comparisons. Data are expressed as median (interquartile range).

Results

UHFUS revealed significant differences between healthy subjects and patients with nail psoriasis across most parameters at both fingers (all $p<0.001$), including nail plate thickness (A: 0.31 vs. 0.52 mm at finger I; 0.34 vs. 0.57 mm at finger II), nail bed thickness (B: 1.91 vs. 2.64 mm at finger I; 1.82 vs. 2.54 mm at finger II), matrix thickness (E: 0.41 vs. 0.67 mm at finger I; 0.56 vs. 0.81 mm at finger II, $p=0.015$), and Color Doppler signal (CD: 0.83 vs. 2.05 at finger I; 0.88 vs. 2.00 at finger II) (Figure 1). In the treatment cohort, patients with nail psoriasis showed significantly higher nail plate thickness (A: 0.58 vs. 0.45 mm, $p=0.025$), matrix thickness (E: 0.71 vs. 0.52 mm, $p=0.018$) and power Doppler signal at finger II (CD: 2.0 vs. 1.0, $p=0.022$) compared to those without nail involvement. All clinical parameters improved significantly under ixekizumab in both groups (all $p<0.001$), with clinically meaningful reductions observed from as early as W4; in the nail psoriasis group, NAPSI decreased from 56.0 to 16.0 and DLQI from 6.0 to 0.0 at W24. UHFUS parameters of the worst finger also showed significant longitudinal reductions (A: from 0.6 to 0.4 mm, $p=0.001$; E: from 0.9 to 0.7 mm, $p<0.001$; CD: from 1.0 to 1.0,

p=0.001).



Longitudinal section of the index fingernail using Ultra-High Frequency Ultrasound (UHFUS) in B-MODE and C-MODE in a healthy patient (A, B) and in a patient with psoriatic onychopathy (C, D). Alteration in nail apparatus and increased nail bed Doppler signal are detectable in C and D.

Conclusions

UHFUS effectively discriminates psoriatic onychopathy from healthy nails and detects subclinical differences between psoriatic patients with and without nail involvement. It also provides objective, quantitative monitoring of response to ixekizumab, supporting its role as a reliable outcome measure in both clinical research and practice.

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Abstract N°: 3062

Psoriatic onychopathy and bimekizumab (Anti-IL-17A/F): clinical and Ultra High-Frequency Ultrasound (UHFUS) outcomes up to Week 52 — Preliminary results of prospective observational study

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Introduction

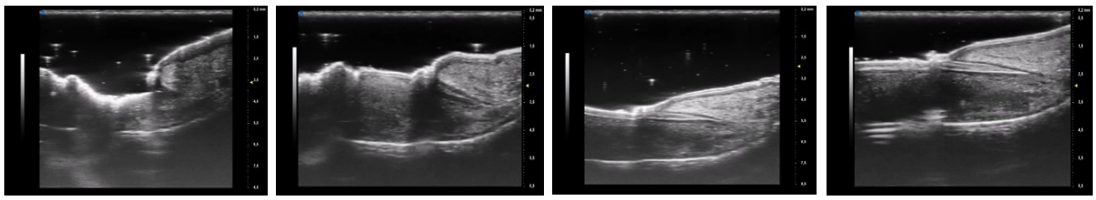
Nail psoriasis is a frequent and disabling manifestation of psoriasis, affecting quality of life and representing an early marker of progression to psoriatic arthritis (PsA). Ultra high-frequency ultrasound (UHFUS) allows objective, non-invasive assessment of structural and vascular changes of the nail unit [1]. Bimekizumab, a monoclonal antibody targeting both IL-17A and IL-17F, has demonstrated high efficacy in moderate-to-severe psoriasis and PsA [2,3]. This study aimed to evaluate the longitudinal course of UHFUS and clinical parameters in patients with psoriatic onychopathy initiating bimekizumab, and to compare treatment response between biologic-naive and non-naive patients.

Materials and Methods

Prospective observational study including 28 patients with psoriatic onychopathy (15 M, 13 F; median age 51 years; median BMI 25.6 kg/m^2; median disease duration 13.5 years), of whom 15 were biologic-naive and 13 non-naive. Although no patients had a diagnosis of PsA at baseline nor reported musculoskeletal symptoms attributable to PsA, several presented risk factors for its development, including elevated BMI, scalp and inverse psoriasis involvement. Clinical parameters — PASI, NAPSI, mNAPSI, FPGA, DLQI and NPQ10 — were assessed at Baseline, Week 4 (W4), Week 12 (W12) and Week 52 (W52). UHFUS parameters — nail plate thickness (A), nail bed thickness (B), length of nail plate insertion (C), matrix length (D), matrix thickness (E) and Color Doppler signal (CD, 0–3) — were assessed on fingers I, II and worst finger at each timepoint. The Friedman test was used for longitudinal comparisons; the Wilcoxon signed-rank test for paired timepoint comparisons; the Mann-Whitney U test for between-group comparisons of treatment response.

Results

All clinical parameters improved significantly over the follow-up period (all $p<0.001$). Among the 14 patients who completed the full 52-week follow-up, median NAPSI decreased from 31.0 at baseline to 0.0 at W52 ($p<0.001$), with significant improvement already at W4 ($p=0.005$). DLQI and NPQ10 reached a median of 0.0 at W52 (both $p<0.001$). UHFUS parameters of the worst finger showed significant longitudinal changes, with reductions in nail plate thickness (A: from 0.5 to 0.4 mm, $p=0.002$), nail bed thickness (B: from 2.5 to 2.0 mm, $p=0.004$), matrix thickness (E: from 0.7 to 0.5 mm, $p<0.001$) and Color Doppler signal (CD: from 2.0 to 1.2, $p=0.001$) (Figure 1). No statistically significant differences in clinical or UHFUS improvement were observed between naive and non-naive patients at W52 (all $p>0.05$), though the limited sample size warrants caution in interpretation.



Longitudinal section of the thumbnail in a patient with psoriatic onychopathy, using Ultra-High Frequency Ultrasound (UHFUS), evaluated at baseline (A), after 4 weeks (B), after 12 weeks (C) and after 52 weeks (D) from the initiation of biological therapy.

Conclusions

Bimekizumab induces significant and early clinical and ultrasonographic improvement in patients with psoriatic onychopathy at risk of developing PsA, with reductions across all clinical scores and key UHFUS structural and vascular parameters already detectable at W4. UHFUS emerges as a powerful objective outcome measure in this setting, capturing subclinical structural and vascular changes within the nail unit that precede and extend beyond what is detectable by clinical assessment alone — demonstrating that bimekizumab exerts its anti-inflammatory effect at the tissue level before visible nail improvement becomes clinically apparent

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Abstract N°: 3064

Towards an international consensus on a patient-centred outcome set for psoriasis: a Delphi study

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Introduction
Healthcare systems are increasingly shifting towards value-based healthcare, emphasising the measurement of outcomes that matter most to patients. Although a preliminary patient-centred outcomes set for psoriasis has been proposed, no formal international consensus has been established. Therefore, this study aims to develop and achieve international consensus on a patient-centred outcomes set for psoriasis.

Materials and Methods
A multi-phase Delphi study was conducted as the third stage of a broader project. An international expert panel of patients and dermatologists participated in three survey rounds and four consensus meetings. Items were rated using a 9-point Likert scale or yes/no voting, with consensus defined as ≥80% agreement. Following consensus, the proposed outcome set was externally validated by an independent and international reference group of patients and dermatologists.

Results
The expert panel (N = 43), including 13 (30%) patient representatives and 30 (70%) dermatologists, reached consensus on a set of 16 patient-relevant outcomes across domains including clinical outcomes, life impact, patient experiences, resource use, and adverse events. Key refinements included merging overlapping outcomes and distinguishing psoriatic arthritis control as a separate outcome. Consensus was also achieved on a set of outcome measurement instruments combining validated instruments with pragmatic measures such as numeric rating scales and binary items. A set of case-mix variables was defined to enable fair comparisons across populations. Additionally, a primary and secondary outcome set was established to enhance feasibility, alongside recommendations for annual measurement with optional intermediate assessments. External validation (N = 121; 46 countries) supported most elements, although some discrepancies emerged. Nevertheless, all components were retained to preserve a comprehensive and integrated perspective on psoriasis management.

Conclusions
This study establishes the first international consensus on a patient-centred outcome set for psoriasis, and supports value-based healthcare by facilitating patient-centred care, benchmarking, and quality improvement. Future work should focus on implementation and ongoing refinement, as this outcome set is intended to evolve alongside emerging evidence.

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Abstract N°: 3075

Short-Term Efficacy Observation and Medication Analysis of Vunakizumab in the Treatment of Moderate-to-Severe Plaque Psoriasis

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Introduction

Vunakizumab has been approved in China for the indication of moderate-to-severe plaque psoriasis. Results from Phase 3 studies have demonstrated that vunakizumab exhibits a rapid onset of action and significant therapeutic efficacy. This study retrospectively included patients with moderate-to-severe plaque psoriasis who were admitted to the hospital from March 2025 to March 2026 and subjected to treatment with vunakizumab. The objective was to analyze the short-term efficacy and medication patterns of vunakizumab in a real-world setting.

Materials and Methods

Patients with moderate-to-severe plaque psoriasis who had previously shown inadequate response to conventional therapies or biologics were enrolled. They received vunakizumab at a dose of 240 mg per administration at Weeks 0, 2, and 4, followed by a maintenance dose every 4 weeks. Efficacy was assessed using the Psoriasis Area and Severity Index (PASI), Body Surface Area (BSA) involvement, and the Investigator's Global Assessment (IGA). Adverse events during the treatment period were also recorded.

Results

A total of 17 patients were included, comprising 2 adolescents and 15 adults. The baseline body mass index (BMI) of the entire cohort was 22.74 ± 2.63 kg/m^2, and the baseline PASI score was 9.41 ± 5.82. The cohort included 6 patients with moderate and 11 with severe plaque psoriasis. All patients completed at least three doses of vunakizumab, with a maximum follow-up duration of 8 months. After treatment, the PASI 50 response rate at Week 2 was 82.3%, and the PASI 75 response rate was 17.6%. At Week 4, all patients achieved PASI 75, with PASI 90 and PASI 100 response rates of 57.1% and 35.7%, respectively. Compared with baseline, BSA involvement was significantly reduced (4.82% ± 2.56% vs. 1.93% ± 2.67%, *P* = 0.0046). Furthermore, all patients achieved an IGA score of 0/1 at Week 4. Of the 17 patients, 82.4% (14/17) received the first three injections on schedule, while the remaining 3 patients experienced varying degrees of delay. After the third dose, 8 patients chose to discontinue treatment, while the others continued maintenance therapy with a dosing interval of 2–3 months. Among the patients who discontinued, 3 experienced relapse after 5 months, with post-relapse PASI scores all below 3. The primary reasons for treatment discontinuation or delay were significant clinical improvement and decreased medication adherence. No serious adverse events occurred during the treatment period, indicating a favorable safety profile.

Conclusions

Phase 3 studies of vunakizumab have reported a median time to PASI 75 response of only 4.3 weeks. The findings of the present study corroborate the rapid onset of action of vunakizumab, with all patients achieving PASI 75 and

IGA 0/1 at Week 4. Moreover, the drug demonstrated sustained long-term efficacy and a prolonged relapse-free interval. Psoriasis is a chronic, recurrent, inflammatory dermatosis that requires long-term management. However, in real-world practice, some patients voluntarily discontinued treatment due to the pronounced initial efficacy, leading to poor adherence. Therefore, it is imperative to strengthen patient education and optimize disease management throughout the entire course of treatment. As a single-center, retrospective nature with a small sample size and short follow-up period, this study lacks long-term efficacy data. Larger prospective studies are warranted to further validate the real-world efficacy of vunakizumab.

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Abstract N°: 3090

Low Prevalence of Celiac Seropositivity in Psoriasis Patients: Evaluating Routine Screening and Gluten-Free Diets

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Introduction

Psoriasis is a chronic immune-mediated inflammatory disease associated with several autoimmune comorbidities, including celiac disease. In clinical practice, patients with psoriasis often ask about the potential benefits of a gluten-free diet, and some report subjective improvement in skin symptoms after eliminating gluten. Gluten is recognized as a potentially proinflammatory dietary component, which has increased interest in its role in chronic inflammatory diseases such as psoriasis. However, despite the proposed association between psoriasis and celiac disease, the clinical relevance and value of routine serological screening for celiac disease in patients with psoriasis remain uncertain. Therefore, we conducted a study evaluating celiac disease serology in 80 patients with well-controlled psoriasis to assess the prevalence of serological markers suggestive of celiac disease in this population.

Materials and Methods

This cross-sectional study included 80 patients with psoriasis (54 men, 26 women) aged 30–45 years. All participants were consecutively recruited from the University Medical Centre Ljubljana, Department of Dermatovenerology.

Psoriasis patients had been receiving stable and effective treatment for at least six months, either with topical therapy (n = 21) or systemic therapy, including methotrexate (n = 11), adalimumab (n = 14), secukinumab (n = 14), or guselkumab (n = 20). Treatment efficacy was assessed using the Psoriasis Area and Severity Index (PASI). Overall, 87.5% of patients achieved excellent disease control (PASI < 3), including 46% who reached complete skin clearance (PASI = 0), while 12.5% showed a good response (PASI 5–7).

All participants underwent serological screening for celiac disease. Serum anti-endomysial antibodies (anti-EMA) and tissue transglutaminase IgA antibodies (tTG-IgA) were measured to evaluate the presence of celiac disease-associated autoimmunity.

Results

Positive celiac disease serology was found in 1 of 80 psoriasis patients (1.25%). The patient was asymptomatic and had no gastrointestinal complaints. Further diagnostic evaluation with gastroscopy showed normal findings and no evidence of active celiac disease. However, HLA typing revealed HLA-DQ2 positivity, indicating genetic susceptibility to celiac disease. These findings may suggest a potential risk for future development of celiac disease rather than active disease at the time of evaluation. The patient will remain under follow-up, with repeat serological testing planned.

Conclusions

Although psoriasis patients often ask about the potential benefits of a gluten-free diet and psoriasis has been linked to autoimmune diseases such as celiac disease, our findings indicate that celiac autoimmunity is rare in

patients with well-controlled psoriasis. In this cohort, only one asymptomatic patient showed positive celiac serology, without endoscopic evidence of active disease.
These results call into question the clinical value of routine celiac disease screening and empirical gluten-free diets in asymptomatic psoriasis patients. Instead of universal screening, a targeted approach may be more appropriate, especially for patients with gastrointestinal symptoms, suggestive clinical features, or a family history of celiac disease. Further studies are needed to better identify which subgroups of psoriasis patients may benefit from celiac disease evaluation or dietary interventions.

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Abstract N°: 3107

Liver Steatosis and Obeisty Linked to a Higher Risk of Liver Fibrosis in Patients with Severe Plaque Psoriasis

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Introduction

Psoriasis (PsO) is a chronic immune-mediated inflammatory skin disease affecting approximately 2-4% of adults worldwide and is associated with metabolic comorbidities such as obesity, insulin resistance, type 2 diabetes, and dyslipidemia. These comorbidities are closely linked to metabolic dysfunction-associated steatotic liver disease (MASLD), defined as hepatic steatosis with metabolic risk factors.

PsO is considered an independent risk factor for MASLD, though the burden of liver disease in dermatology populations remains incompletely characterized. Concerns persist regarding potential hepatotoxicity from methotrexate (MTX), although metabolic risk factors may play a larger role in the development of liver fibrosis. Non-invasive examinations such as transient elastography (FibroScan) can facilitate the assessment of hepatic steatosis and fibrosis (liver stiffness) in psoriasis.

In this study, we aimed to determine the prevalence of liver steatosis and fibrosis in patients with severe PsO. As secondary aim we wanted to map the association of liver steatosis and fibrosis to metabolic and treatment related factors.

Materials and Methods

This was a cross-sectional observational study condutcted during two periods (January-February 2024, February- Mars 2026) and included adults with psoriasis receiving systemic treatment. Patients underwent transient elastography (FibroScan 430 Mini+). Steatosis and fibrosis were assessed using established cut-offs. Fibrosis was defined by liver stiffness measurements (LSM) as <8.0 kPa , 8-15 kPa and ≥15 kPa. Steatosis were defined as S1 ≥248 dB/m, S2 ≥268 dB/m and S3 ≥280 dB/m. Patients with unreliable measurements or known chronic liver disease were excluded.

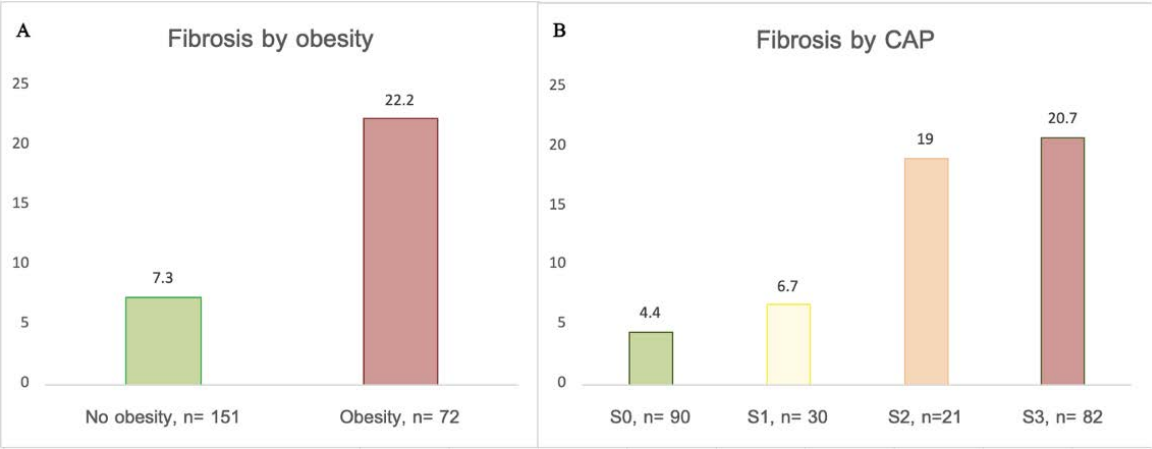
Results

A total of 224 patients were included (mean age 52.5 years, 59.3% men). Obesity BMI ≥30 kg/m 2 was present in 32.6%. Steatosis (CAP ≥248dB/m) was detected in 59.9% of patients, with 37.1% having severe steatosis (CAP ≥280 dB/m). Clinically significant fibrosis (≥8kPa) was present in12.1% and was similar in both sexes (men 12.8%, women 12.1%). Patients with fibrosis were older and had higher CAP and FIB-4 values.

Steatosis severity increased across BMI categories, supporting the link between obesity and hepatic fat accumulation. In univariable logistic regression, (obesity (OR 3.55, 95% CI 1.55-8.11, p= 0.003) and steatosis (OR

3.43, 95% CI 1.49-7.90, p= 0.002) were significantly associated with fibrosis. Fibrosis prevalence increased across CAP categories, from 4.4% in patients without steatosis to 20.7% in those with severe steatosis, suggesting a dose-response relationship (Figure 1B).

Regarding treatments, methotrexate exposure, including treatment duration, was not associated with liver fibrosis (OR 1.04, 95% CI 0.95-1.14, p = 0.417). Similarly, biologic treatment (including anti-TNF and interleukin inhibitors) was not significantyl associated with fibrosis (OR 0.54 95% CI 0.24–1.24, p = 0.144). In contrast, hypertension (2.97, 95% CI 1.31–6.74, p=0.009) and diabetes (OR 4.17, 95% CI 1.66–10.45, p=0.002) were significantly associated with increased odds of fibrosis. Lipid lowering drugs however were not associated with fibrosis (OR 1.12 (95% CI 0.40–3.18, p = 0.828).



Cut-off values adapted from the European association for the study of the liver (EASL) NAFLD guidelines in 2018. Fibrosis was defined as liver stiffness measurements (LSM) ≥ 8kPa. Steatosis categroies were defined by CAP: S1 ≥248 dB/m, S2 ≥268 dB/m, S3 ≥280 dB/m. Obesity was defined as BMI ≥ 30kg/m2. (A) Fibrosis prevalence by obesity status and (B) CAP category.

Conclusions

Hepatic steatosis is highly prevalent in patients with psoriasis receiving systemic treatment, while clinically significant fibrosis is less prevalent. Liver fibrosis appears predominantly metabolically driven rather than related to methotrexate. The strong association between obesity, severe steatosis and fibrosis supports integrating metabolic risk assessment and non-invasive liver screening in routine management in psoriasis practice. FibroScan is a simple, user-friendly, non-invaisve technique that can identify liver comorbidity i patients with severe psoriasis. Further studies need to determine if addressing liver steatosis in individuals with psoriasis can reduce the risk of liver fibrosis development.

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Abstract N°: 3130

Efficacy and Acceptability of Deucravacitinib in Moderate-to-Severe Psoriasis with Comorbidities Resistant to Conventional Therapy: A Real-World Study

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Introduction

Moderate-to-severe psoriasis is frequently associated with comorbid conditions including psoriatic arthritis, metabolic syndrome, and mood disorders, complicating management and often resulting in suboptimal response to conventional systemic therapies. Deucravacitinib, a selective tyrosine kinase 2 inhibitor, represents a novel oral therapeutic option; however, real-world evidence in patients with significant comorbidity burden remains limited.

Objectives:

To evaluate the clinical characteristics, comorbidities, tolerability, and patient-reported acceptability of deucravacitinib in patients with moderate-to-severe psoriasis previously resistant to standard systemic therapy.

Materials and Methods

A cross-sectional observational study was conducted among 50 adult patients with moderate-to-severe psoriasis and at least one documented comorbidity, who were receiving deucravacitinib following inadequate response or intolerance to prior systemic treatments. Data collected included demographic characteristics, disease duration, prior treatment history, baseline Psoriasis Area and Severity Index (PASI), comorbid conditions, adverse events, and patient-reported treatment acceptability.

Results

The cohort included an equal distribution of male and female patients, with a mean age of 39.4 ± 9.2 years and mean body weight of 77.3 ± 11.5 kg. Mean disease duration was 5.3 ± 2.2 years, with a mean duration of treatment resistance of 13.3 ± 6.2 months. The mean baseline PASI score was 9.6 ± 2.3. All patients had previously received multiple conventional therapies, most commonly topical corticosteroids, vitamin D analogues, methotrexate, and acitretin.

The most prevalent comorbidities were psoriatic arthritis (24%), anxiety or depression (24%), metabolic syndrome (16%), diabetes mellitus (14%), and cardiovascular disease (8%). Adverse events were reported in 18% of patients and included folliculitis, acneiform eruption, upper respiratory tract infections, and abnormalities in liver function tests; 14% required additional medical management. No treatment discontinuations due to adverse events were recorded.

All patients expressed willingness to continue deucravacitinib therapy, with 62% reporting high satisfaction (“very motivated and happy”) and 38% reporting positive acceptance (“motivated”).

Conclusions

In patients with moderate-to-severe psoriasis, significant comorbidity burden, and prior treatment resistance, deucravacitinib demonstrated favorable tolerability and high patient acceptability in a real-world setting. Adverse events were relatively infrequent and manageable. These findings support the role of deucravacitinib as a viable oral therapeutic option in complex psoriasis populations. Longitudinal studies with serial PASI assessments are warranted to further quantify clinical efficacy.

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Abstract N°: 3157

Psychometric and electrophysiological assessment of cognitive function in patients with chronic plaque psoriasis and matched controls: a case–control study

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Introduction

Psoriasis is a chronic immune mediated inflammatory disorder increasingly recognized as multisystem disease with significant extracutaneous features. Persistent systemic inflammation driven by TNF-α, IL-17, IL-23, Th1/Th17 immune pathways has been implicated in cardiovascular, metabolic, psychiatric and neurocognitive comorbidities.Chronic neuroinflammation, endothelial dysfunction, microglial activation, reduced BDNF levels and shared genetic susceptibility contribute to cognitive dysfunction in psoriasis. However, existing literature relies predominantly on psychometric assessment while objective electrophysiological evaluation remains limited.This study aimed to evaluate cognitive functions in chronic plaque psoriasis patients and matched controls using psychometric and electrophysiological measures and to assess its association with disease severity, duration, and nail involvement.

Materials and Methods

This hospital-based matched case–control study included 51 patients with chronic plaque psoriasis and 51 age, sex and education matched healthy controls aged 18–50 years. Individuals with psychiatric or neurological disorders, diabetes, hypertension, hearing impairment, head trauma, substance abuse, or medications affecting cognition were excluded. Anxiety and depression were screened using GAD-7 and PHQ-9.Clinical assessment included disease duration, Psoriasis Area and Severity Index (PASI) and nail involvement. Psychometric assessement was done using Montreal Cognitive Assessment (MoCA). Electrophysiological evaluation used auditory event related potential P300 testing with standard oddball paradigm at Cz and Fz electrodes. P300 latency and amplitude were compared between groups.Associations of cognitive dysfunction with disease severity, duration and nail involvement were analysed using appropriate statistical methods and multivariable linear regression, with $p<0.05$ considered statistically significant.

Results

Mean age was comparable between psoriasis patients and controls (38.12±10.41 vs 37.54±9.86 years;) with no significant differences in sex or education. Mean MoCA scores were significantly lower in psoriasis patients than controls (24.71±2.95 vs 25.98±2.45; $p=0.015$). MoCA defined cognitive impairment (score <26) was observed in 56.9% of psoriasis patients versus 35.3% of controls ($p=0.029$), with higher odds of cognitive dysfunction (OR 2.42; 95% CI: 1.09–5.37). Multivariable regression identified psoriasis as an independent predictor of cognitive impairment ($\beta=-1.23$, $p=0.007$). P300 latencies were prolonged in all electrodes in psoriasis patients ($p<0.001$) indicating delayed cortical processing (Table 1). Psoriasis remained an independent predictor of prolonged P300 latency after adjustment for demographic variables and education. However, P300 amplitude did not differ significantly. Higher PASI (>10) was associated with lower MoCA scores, indicating poor cognitive performance in severe disease (Table 2), although no significant association was seen on P300 assessment. Disease duration showed no significant association with cognitive functions. Nail involvement showed higher mean P300 latency, with significant prolongation at A12 (Cz-A+) electrode, suggesting nail disease may represent a marker of more

neurocognitive involvement (Table 3).

Table 1: Mean latencies in cases and control

	Latency in milliseconds(ms)		
Electrodes	**Cases** **Mean ± SD**	**Control** **Mean ± SD**	**P value**
A11 (Cz-A+)	357.84 ± 39.20	324.80 ± 27.69	**<0.001[1]**
A21 (Fz-A+)	359.47 ± 46.88	325.76 ± 28.44	**<0.001[2]**
A22 (Fz-A+)	361.73 ± 39.57	334.27 ± 30.38	**<0.001[1]**
A12 (Cz-A+)	364.20 ± 40.38	332.63 ± 31.91	**<0.001[1]**

1: Wilcoxon-Mann-Whitney U Test, 2: t test

Table 2: Comparison of MoCA score among PASI category

	PASI Category			
	<5 **Mild disease**	**5 to 10** **Moderate disease**	**>10** **Severe disease**	**P value** **(Kruskal Wallis Test)**
MoCA Mean ±SD	25.00 ±2.66	25.33 ±3.09	22.38 ±2.72	**0.040**

Table 3: Mean latency in p300 in patients with nail changes and without nail changes

	Nail Changes		**Wilcoxon-Mann-Whitney U Test**	
	Yes	**No**	**W**	**p value**
Latency: A11 (Cz-A+) Mean (SD)	363.00 (28.51)	355.03 (44.12)	348.000	0.319
Latency: A12 (Cz-A+) Mean (SD)	373.78 (32.59)	358.97 (43.63)	397.500	**0.049**
Latency: A21 (Fz-A+)	367.33 (36.90)	355.18 (51.55)	349.500	0.305
Latency: A22 (Fz-A+) Mean (SD)	366.72 (30.07)	359.00 (44.10)	373.000	0.137

Conclusions

Patients with chronic plaque psoriasis demonstrated significant psychometric and electrophysiological evidence of subclinical cognitive dysfunction compared with matched controls, reflected by lower MoCA scores and prolonged P300 latencies. Higher disease severity showed inverse association with cognitive performance. Nail involvement showed prolonged P300 latency, suggesting greater systemic or neurological involvement. However, disease duration showed no association with cognitive parameters. These findings highlight cognitive dysfunction as an important psoriasis comorbidity and support incorporating cognitive assessment, particularly in severe

disease or nail involvement, into routine dermatologic care.

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Abstract N°: 3162

Influence of prior biologic exposure on bimekizumab outcomes: a real-world study of PASI and regional PGA responses

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Introduction
Bimekizumab, a dual IL-17A/IL-17F inhibitor, has shown rapid and profound skin clearance in clinical trials. Real-world comparative data on its performance in biologic-naïve versus biologic-experienced patients, and the impact of multiple prior biologics, remain limited. This study evaluated longitudinal PASI and site-specific PGA responses in patients treated with bimekizumab, stratified by treatment history.

Materials and Methods
We retrospectively analyzed 98 adults with moderate-to-severe plaque psoriasis (75 experienced; 23 naïve). Baseline demographics were comparable, except for higher PASI in naïve patients (18.04 vs 13.29; p=0.021). PASI and PGA for scalp, face/neck, genital, palmoplantar and pretibial areas were assessed at weeks 4, 16, 24, 52, 104, and 156. Experienced patients were further stratified by number of prior biologics (1, 2, ≥3).

Results
Naïve patients demonstrated a markedly faster early response. At week 4, PASI90 and PASI100 rates were significantly higher in naïve patients (50.0% vs 13.3% and 50.0% vs 11.7%; both p=0.001), with greater PASI reduction (85.5% vs 62.5%; p<0.001). This advantage persisted at week 16 (PASI90: 95.5% vs 63.0%, p=0.008; PASI100: 86.4% vs 37.0%, p<0.001). By week 24, differences were no longer significant, with PASI90 achieved in 100% of naïve and 86.8% of experienced patients. At week 52, responses converged completely (PASI90: 100% vs 95.9%; PASI100: 93.8% vs 83.7%). Long-term follow-up confirmed sustained control, with PASI90 >95% at week 104 and complete clearance in all evaluable patients at week 156. Site-specific PGA mirrored PASI trajectories. Naïve patients showed faster improvement in difficult areas at week 4 (e.g., scalp PGA 0/1: 82.6% vs 66.7%), but differences disappeared by week 24, when PGA 0/1 exceeded 90% across all sites in both groups. At weeks 52 and 104, clearance remained consistently high, with PGA 0/1 rates above 90% in all regions. Among experienced patients, the number of prior biologics did not influence outcomes. PASI90 at week 24 was similar across subgroups (82.4%, 85.7%, and 100%; p=0.275), and no significant differences emerged at weeks 52 or 104. PGA responses were likewise comparable, with all subgroups achieving high clearance rates over time.

Conclusions
In this real-world cohort, bimekizumab demonstrated rapid, profound, and durable clinical effectiveness. Naïve patients achieved faster early responses, but experienced patients reached comparable outcomes by 24–52 weeks. Importantly, the number of prior biologics did not diminish treatment performance, supporting bimekizumab as

an effective option even in heavily pre-treated patients. Site-specific PGA confirmed consistent improvement across difficult-to-treat areas, reinforcing the broad utility of IL-17A/F inhibition in routine clinical practice.

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Abstract N°: 3177

Real-world treatment patterns of oral therapies for psoriasis in Japan

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Introduction

Psoriasis is a chronic immune-mediated inflammatory skin disease that may require systemic therapy when topical treatments or phototherapy are inadequate. Advanced oral therapies (AOTs), including the phosphodiesterase-4 inhibitor (PDE4i) apremilast and the tyrosine kinase 2 inhibitor (TYK2i) deucravacitinib, became available in Japan in March 2017 and December 2022, respectively; the latter is subject to prescribing restrictions from the relevant specialty society. However, real-world treatment patterns of currently available oral therapies in Japanese psoriasis care remain incompletely characterized.

The study objectives are to describe real-world use, persistence, and subsequent treatment patterns of currently available oral therapies for psoriasis in Japan following the introduction of AOTs, and to assess associated healthcare resource utilization (HCRU).

Materials and Methods

This retrospective cohort study used the Japan Medical Data Center (JMDC) claims database from 2005 through June 2025. Adult patients with psoriasis who initiated an oral treatment (ciclosporin, dimethyl fumarate, etretinate, methotrexate, PDE4i, or TYK2i) on or after 1 March 2017, corresponding to the first observed AOT prescription in JMDC, were identified. The index date was defined as initiation of the first oral treatment. Persistence was defined as the time from the index date to treatment discontinuation (≥90-day gap) or modification, including switching to another systemic therapy or escalation with the addition of another oral therapy or biologic. Time to initiation of any subsequent treatment after discontinuation or modification was assessed, representing the duration patients remained free of any treatment (topical therapy, phototherapy, oral therapy, or biologic therapy). Patients were classified as having long-term persistence (≥180 days) or short-term persistence (<180 days). On-treatment HCRU was evaluated during continuous index therapy, and post-index HCRU was assessed over a fixed 12-month follow-up period.

Results

A total of 6,019 patients initiating oral therapy were included; treatments were apremilast (56.8%), ciclosporin

(24.7%), etretinate (11.4%), methotrexate (6.3%), and deucravacitinib (0.8%). Mean age was 48.6 ± 11.2 years, and 69.5% were male. Disease duration had a median of 1.3 year and a mean of 2.2 years. Common comorbidities included hypertension (23.5%), hyperlipidaemia (23.0%), diabetes (7.5%), depression (5.1%), and psoriatic arthritis (4.2%). Most patients were treated in small clinics (0–19 beds: 65.8%). Median and mean follow-up were 41.3 and 45.6 months, respectively. Persistence rates were 49.9% at 6 months and 36.0% at 12 months, with a median persistence of 6.0 months. Among 4,837 patients who discontinued or modified treatment, median post-discontinuation follow-up was 35.2 months. Following treatment discontinuation or modification, 20.5% and 12.1% of patients remained treatment-free at 6 and 12 months, respectively; median treatment free time was 1.3 months. During the on-treatment period, patients with short-term persistence had higher psoriasis-related healthcare utilization than those with long-term persistence, with 1.87-, 1.77-, and 1.69-fold higher rates of psoriasis-related hospitalizations, psoriasis-related bed-days, and cumulative incidence of psoriasis-related hospitalization. Over the fixed 12-month post-index period, HCRU remained higher among patients with short-term persistence, with corresponding differences of 1.35-, 1.83-, and 1.29-fold, respectively.

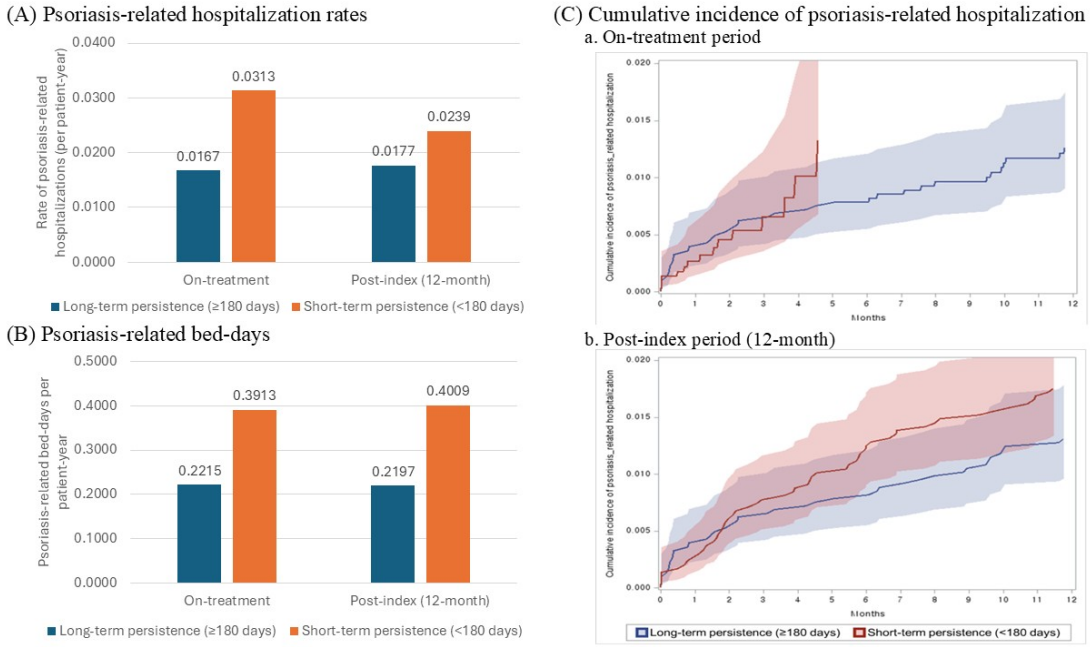

Figure. Psoriasis-Related Healthcare Resource Utilization by Persistence Status and Study Period

Conclusions

In real-world clinical practice in Japan, persistence with currently available oral therapies for psoriasis was modest, and early treatment discontinuation or modification was associated with higher psoriasis-related healthcare utilization during treatment and over subsequent follow-up. These findings highlight limitations of current oral treatments and an unmet need for more effective and safe oral options offering sustained disease control.

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30 SEP - 3 OCT 2026

Abstract N°: 3184

Efficacy and Safety of Gumokimab, a novel IL-17A mAb, in Patients with Moderate to Severe Plaque Psoriasis: A Randomized, Double-blind, Placebo-controlled, Multicenter Phase III Clinical Study

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Introduction

Interleukin 17A(IL-17A) is considered to play a key role in the pathogenesis of psoriasis. We evaluated the efficacy and safety of gumokimab, a novel anti-IL-17A monoclonal antibody, in patients with moderate-to-severe plaque psoriasis.

Materials and Methods

351 eligible participants were randomly assigned to receive subcutaneous (SC) injections of gumokimab at a dose of 150 mg□300 mg or placebo in a ratio of 3:3:1. Investigational Product was administered once weekly for 4 weeks, then every 4 weeks (Q4W) from week 4 though until week 48. And then there's an 8-week post treatment follow-up until week 56. At week 12, participants in the placebo group were switched to recieve gumokimab of 300 mg Q4W. Co-primary end points were the percentage of participant who had a 75% or greater reduction from baseline in Psoriasis Area and Severity Index (PASI 75) and or a score on the sPGA of 0 or 1 on the Static Physician Global Assessment (sPGA 0/1) at week 12.

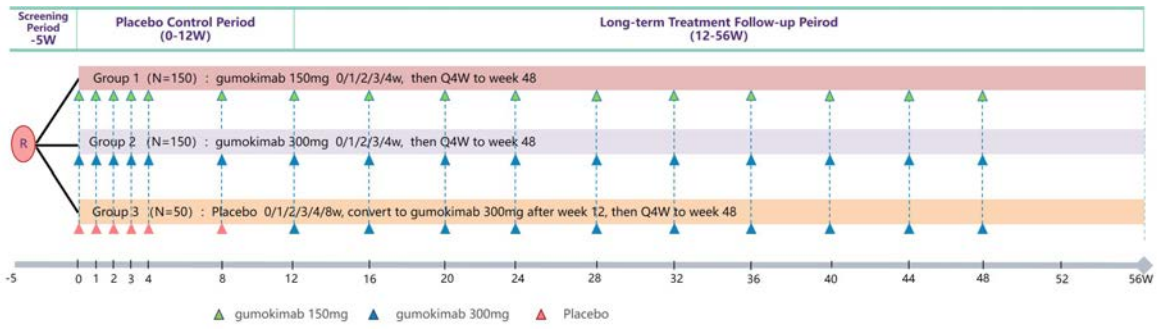

Figure 1 Study design

Results

Efficacy: At week 12 each gumokimab dose group had significantly higher PASI 75 response rates than the placebo group. The rates were 94.6% with 150 mg of gumokimab, 94.0% with 300 mg of gumokimab, and 17.6% with placebo. The participants in the gumokimab groups also had superior sPGA 0/1 response rates than in the placebo group (89.3%, 88.1% vs. 11.8%). During the long-term treatment period, the PASI 75 and sPGA 0/1 responses rates of the gumokimab groups were maintained and increased further. The PASI 90 response rates of the 2 gumokimab groups at week 12 were 81.8% (150mg group) and 82.0% (300mg group), which were further improved to 89.9% (150mg group) and 94.4% (300mg group) at week 52. Same trend also was found in PASI 100 response rates in gumokimab groups with 48.0% (150mg group) and 52.0% (300mg group) at week 12; and 68.9% (150mg group) and 74.8% (300mg group) at week 52. The placebo group showed a similar trend of efficacy with the gumokimab groups following the switch to gumokimab treatment.

Safety: During the 12-week placebo-controlled phase, adverse event rates were comparable between the gumokimab groups and the placebo group. The most commonly reported adverse events in the gumokimab group during entire study period included elevated alanine aminotransferase, upper respiratory tract infection, hyperuricemia, hypertriglyceridemia, hyperlipidemia, hypercholesterolemia and eczema.

Conclusions

The humanized monoclonal antibody Gumokimab was demonstrated to be highly and sustainbly efficacious and showed a good efficacy by improved PASI and sPGA0/1 response, and was generally safe and tolerable for the treatment of in treating with moderate-to-severe psoriasis in Chinese participants.

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Efficacy and safety of dual targeted therapy using biologics and small molecules for psoriasis and comorbidities: A systematic review

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Introduction

Psoriasis is a chronic T-helper (Th)-17-driven inflammatory disease that frequently coexists with other immune-mediated conditions, creating significant therapeutic challenges in patients with refractory disease or overlapping inflammatory phenotypes. Although biologics and small molecules targeting distinct immune pathways have transformed psoriasis management, evidence guiding dual targeted therapy remains limited. This systematic review evaluated the efficacy and safety of combined biologic and small molecule therapy for psoriasis and associated comorbidities.

Materials and Methods

Following PRISMA guidelines, MEDLINE and Embase were searched from inception for studies investigating evaluating dual targeted therapy in patients with psoriasis. Two reviewers independently screened studies and extracted data. Quality of evidence was assessed using the Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence. Demographic characteristics, treatment regimens, clinical outcomes, and adverse events were extracted and synthesized descriptively.

Results

Thirty-nine articles comprising 125 patients were included. Mean age was 48.6 years (range: 17-78 years), with 59.6% male patients. Of the 125 patients, 72.8% (91/125) received dual targeted therapy for psoriasis only, 16.0% (20/125) for psoriasis with atopic dermatitis, 3.2% (4/125) for psoriasis with psoriatic arthritis, 2.4% (3/125) for psoriasis with bullous pemphigoid, 1.6% (2/125) for psoriasis with prurigo nodularis, 1.6% (2/125) for psoriasis with asthma, 0.8% (1/125) for psoriasis with multiple sclerosis, 0.8% (1/125) for psoriasis with chronic spontaneous urticaria, and 0.8% (1/125) for psoriasis with ulcerative colitis. Mean follow-up duration was 11.7 months (range: 1.5-132.9).

Among 91 patients with only psoriasis, the most commonly reported dual targeted therapies included apremilast with ustekinumab (33.0%, 30/91) and apremilast with secukinumab (8.8%, 20/91). Clinical improvement was observed in 97.8% of patients, with the greatest Psoriasis Area and Severity Index (PASI) reductions achieved by apremilast with infliximab (-96.6%; 24.0 weeks) and apremilast with secukinumab (-91.4%; 29.0 weeks).

Among 20 patients with psoriasis and atopic dermatitis, the most common dual targeted therapies included dupilumab with guselkumab (60.0%, 12/20) and dupilumab with risankizumab (20.0%, 4/20). All patients achieved improvement except one (5.0%) patient receiving dupilumab with guselkumab. The greatest reductions in PASI

were achieved by dupilumab with risankizumab (-100%; 66.5 weeks) and dupilumab with secukinumab (-80.0%, 40.0 weeks). The greatest reduction in Eczema Area and Severity Index was achieved by dupilumab with risankizumab (-100%, 66.5 weeks).

Overall, adverse events occurred in 23.2% (29/125) of patients and were predominantly mild, most commonly diarrhea (27.6%; 8/29) and nausea (20.7%; 6/29). Only 2.4% of patients discontinued therapy because of treatment-related adverse events. Importantly, no serious infections were reported despite concurrent targeting of distinct immune pathways, including Th17 and Th2 signaling axes.

Conclusions

Dual targeted therapy using biologics and small molecules demonstrated promising efficacy and safety profiles in patients with refractory psoriasis and complex inflammatory comorbidities. These findings highlight the potential of precision combination immunotherapy to address complex immune dysregulation in patients with refractory psoriasis and inflammatory comorbidities. Given the increasing clinical use of combination targeted therapy and the absence of robust guidance in this area, large prospective studies are urgently needed to better define optimal patient selection, long-term safety, and therapeutic durability.

EADV CONGRESS
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Abstract N°: 3192

The impact of immunogenicity on the efficacy and safety of vunakizumab in moderate-to-severe chronic plaque psoriasis: a post hoc analysis of a phase 3 trial

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Introduction
Vunakizumab, a novel humanized IgG1/k monoclonal antibody targeting IL-17A, has demonstrated robust efficacy and favorable tolerability in patients with moderate-to-severe chronic plaque psoriasis. Anti-drug antibodies (ADAs) may develop during treatment with humanized biologics. Although ADAs are often clinically benign, in some patients they may affect drug efficacy or safety. We evaluated the impact of ADAs on the efficacy and safety of vunakizumab in patients with moderate-to-severe chronic plaque psoriasis.

Materials and Methods
This post-hoc analysis used data from a randomized, double-blind, phase 3 trial (NCT04839016) of vunakizumab in moderate-to-severe chronic plaque psoriasis. The study comprised a 12-week treatment period followed by a 40-week maintenance treatment period and a 16-week safety follow-up period. Eligible patients had chronic plaque psoriasis ≥6 months, a Psoriasis Area and Severity Index (PASI) score ≥12, a static physician's global assessment (sPGA) score ≥3, and psoriasis affecting ≥10% body surface area. Patients were randomized 2:1 to receive subcutaneous vunakizumab 240 mg or placebo at weeks 0, 2, 4, and 8. At week 12, patients initially assigned to placebo switched to vunakizumab 240 mg at weeks 12, 14, 16, and every 4 weeks thereafter, and other patients continued vunakizumab every 4 weeks through week 52. The co-primary endpoints were the proportion of patients with ≥90% reduction from baseline in PASI score (PASI 90) and a sPGA score of 0 or 1 (clear or almost clear; sPGA 0/1) at week 12. ADAs were assessed through 68 weeks (including the safety follow-up period). Confirmed ADA positive (ADA+) samples, which defined as at least one positive ADA signal detected in post-treatment samples, were further tested for neutralizing antibodies (NAbs). Efficacy and safety were evaluated based on ADA and NAb status in all vunakizumab-treated patients.

Results
Among 460 vunakizumab-treated patients, 437 (95.0%) were ADA negative (ADA-), 23 (5.0%) were ADA+, and 11 (2.4%) were NAb positive (NAb+). The development of ADAs or NAbs had no impact on serum vunakizumab concentrations through 52 weeks. At week 12, PASI 90 response rate was 76.7% (95% CI, 72.4%-80.5%) in ADA- patients, 73.9% (95% CI, 51.6%-89.8%) in ADA+ patients, and 81.8% (95% CI, 48.2%-97.7%) in NAb+ patients. The corresponding sPGA 0/1 response rate was 71.9% (95% CI, 67.4%-76.0%), 69.6% (95% CI, 47.1%-86.8%), and 90.9% (95% CI, 58.7%-99.8%), respectively. Responses for PASI 75, PASI 100, and sPGA 0 were observed across the ADA-, ADA+, and NAb+ subgroups and were consistent with those in the overall population (Table 1). A rapid onset of response and durable efficacy through 52 weeks reported in the overall population were also observed across these three subgroups. During the induction treatment period, treatment-emergent adverse events occurred in 69.1% (302/437), 69.6% (16/23), and 63.6% (7/11) of ADA-, ADA+, and NAb+ patients, respectively; the incidence of infections or infestations was 18.1% (79/437), 13.0% (3/23), and 18.2% (2/11), respectively. No new safety signals were identified during the extension period across the three subgroups. Overall, vunakizumab

was well tolerated, and the safety profile was generally comparable across the ADA-, ADA+, and NAb+ subgroups.

Table 1. Clinical outcomes of vunakizumab at week 12 by immunogenicity status

	ADA- (n=437)	ADA+ (n=23)	NAb+ (n=11)
Primary endpoints			
PASI 90 response, %	76.7 (95% CI, 72.4-80.5)	73.9 (95% CI, 51.6-89.8)	81.8 (95% CI, 48.2-97.7)
sPGA 0/1 response, %	71.9 (95% CI, 67.4-76.0)	69.6 (95% CI, 47.1-86.8)	90.9 (95% CI, 58.7-99.8)
Key secondary endpoints			
PASI 75 response, %	94.1 (95% CI, 91.4-96.1)	82.6 (95% CI, 61.2-95.0)	100.0 (95% CI, 71.5-100.0)
PASI 100 response, %	36.2 (95% CI, 31.6-40.9)	43.5 (95% CI, 23.2-65.5)	54.5 (95% CI, 23.4-83.3)
sPGA 0 response, %	37.8 (95% CI, 33.2-42.5)	43.5 (95% CI, 23.2-65.5)	54.5 (95% CI, 23.4-83.3)

Missing data were imputed using non-responder imputation. 95% CIs were calculated using the Clopper-Pearson method. PASI 75, ≥75% improvement in PASI score; PASI 90, ≥90% improvement in PASI score; PASI 100, 100% improvement in PASI score; sPGA 0/1, sPGA score of 0 or 1; sPGA 0, sPGA score of 0; ADA, anti-drug antibody; NAb, neutralizing antibody; CI, confidence interval.

Conclusions

In patients with moderate-to-severe chronic plaque psoriasis, ADA development with vunakizumab was infrequent. ADA or NAb positivity did not appear to reduce the efficacy or raise safety concerns of vunakizumab, with results consistent with those in the overall population.

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Abstract N°: 3232

Associations between circulating metabolites and psoriasis risk in the UK Biobank, Estonian Biobank, and HUNT Study

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Introduction

Psoriasis management is increasingly shifting toward preventative approaches. Given the link between psoriasis and systemic metabolic dysregulation, circulating metabolites may serve as susceptibility markers, supporting earlier prevention. Here, we aimed to identify circulating metabolites associated with psoriasis risk, using three large population-based cohorts: the UK Biobank, Estonian Biobank, and HUNT.

Materials and Methods

The three cohorts comprise 8,672 incident psoriasis cases among 643,817 participants of White ethnicity/European ancestry (n UK Biobank = 4,558/443,041; n Estonian Biobank = 3,329/184,877; n HUNT = 785/15,899). Psoriasis cases were identified using cohort-specific sources: self-reports and linked health records in the UK Biobank and HUNT, and national electronic health records in the Estonian Biobank. In all cohorts, metabolite levels were quantified using Nuclear Magnetic Resonance spectroscopy (Nightingale Health), covering 168 metabolite measures. For each metabolite, we performed Cox proportional hazards regression and meta-analyzed results across cohorts.

Results

The effect estimates of the metabolites were largely consistent across all three cohorts, with a trend of weaker effects in the UK Biobank. The meta-analysis identified 43 metabolites associated with the risk of developing psoriasis, including metabolites related to inflammation and fluid balance, as well as amino acids, ketone bodies, fatty acids, and various lipid compositions in lipoprotein fractions and subfractions. Triglycerides across multiple lipoprotein fractions and subfractions were the most prominent category, accounting for 32.5% of the associated metabolites. Glycoprotein acetyls, a marker of chronic low-grade inflammation, showed the strongest association (HR [95% CI]: 1.14 [1.09 - 1.19]), followed by triglyceride levels in small high-density lipoprotein (HR [95% CI]: 1.08 [1.03 - 1.14]) and in low-density lipoprotein (HR [95% CI]: 1.08 [1.03 - 1.13]).

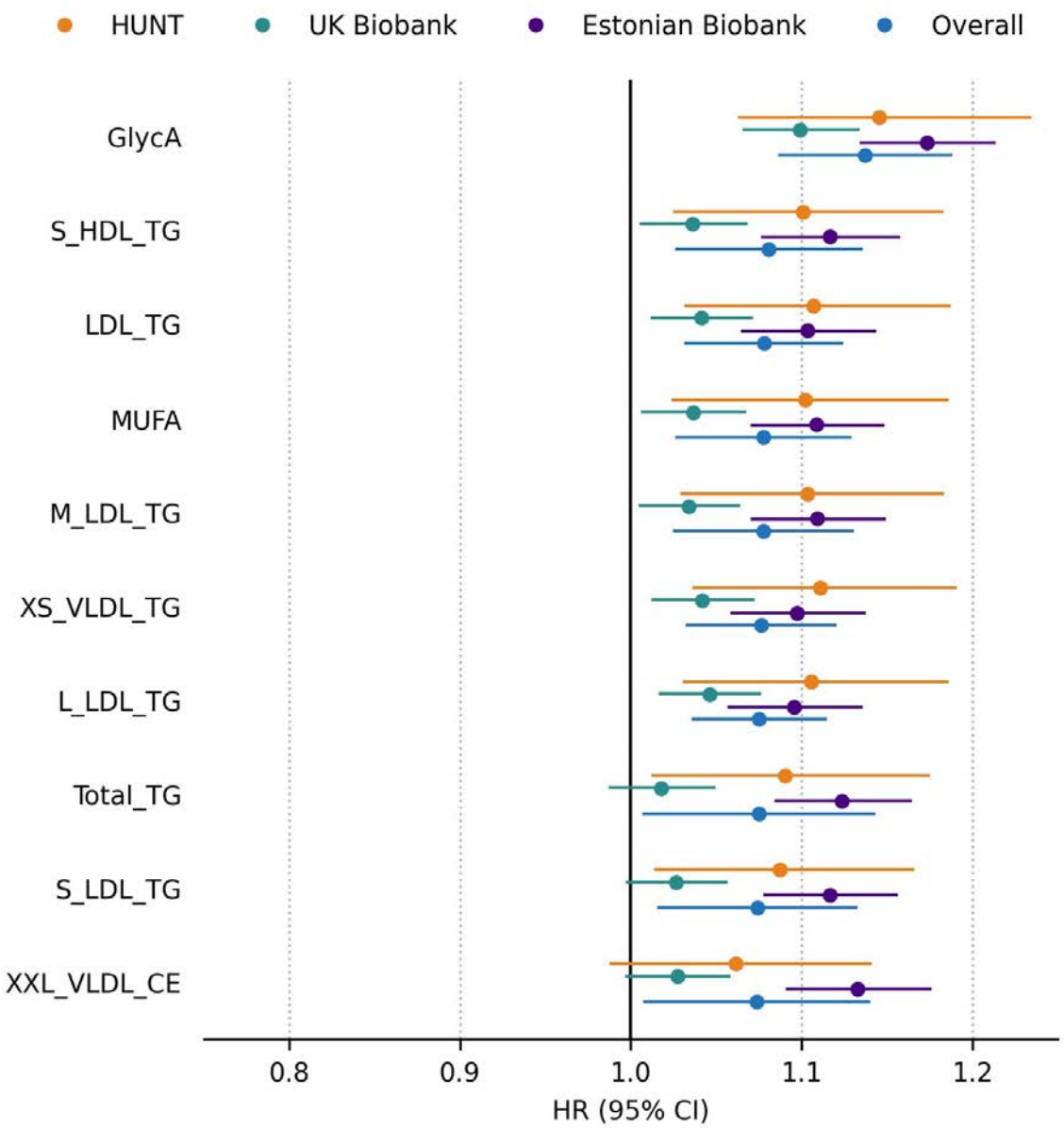

Figure 1: Forest plot showing the ten strongest metabolite associations with psoriasis risk in the UK Biobank, Estonian Biobank, HUNT, and the meta-analyzed estimates (overall). HR: Hazard Ratio, CI: Confidence Interval, GlycA: Glycoprotein Acetyls, S-HDL-TG: Triglycerides in Small HDL, LDL-TG: Triglycerides in LDL, MUFA: Monounsaturated Fatty Acids, M-LDL-TG: Triglycerides in Medium LDL, XS-VLDL-TG: Triglycerides in Very Small VLDL, L-LDL-TG: Triglycerides in Large LDL, Total-TG: Total Triglycerides, S-LDL-TG: Triglycerides in Small LDL, XXL-VLDL-CE: Cholesteryl Esters in Extremely Large VLDL.

Conclusions

In conclusion, we identified circulating metabolites that may help identify individuals at higher risk of developing psoriasis, potentially improving risk prediction within a multi-omics framework. Further studies are needed to assess causality and evaluate their potential for disease prediction.

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Abstract N°: 3238

Efficacy and Safety of TQH3906 in Patients with Plaque Psoriasis: 12-week Results From a Phase 2, Randomized, Placebo-controlled Study

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Introduction

TQH3906 is a novel, highly selective allosteric inhibitor targeting TYK2/JAK1 kinases, currently under clinical development for immune-mediated inflammatory disorders including plaque psoriasis (PsO), psoriatic arthritis (PsA), and ulcerative colitis (UC). This multicenter, randomized, double-blind, placebo-controlled Phase 2 clinical trial (NCT06542614) aims to assess the efficacy and safety of TQH3906 in patients with moderate-to-severe chronic plaque psoriasis (PsO).

Materials and Methods

Eligibility criteria required patients with chronic plaque psoriasis (PsO) for ≥6 months duration, involving ≥10% body surface area (BSA), accompanied by a Psoriasis Area and Severity Index (PASI) score ≥12 and static Physician's Global Assessment (sPGA) score ≥3 at both screening and baseline visits. The primary efficacy endpoint was defined as the proportion of patients achieving ≥75% improvement in PASI (PASI 75) at week 12, while secondary endpoints included PASI 90 response rate, sPGA 0/1 (clear/almost clear) achievement rate, and incidence of treatment-emergent adverse events (TEAEs). The study employed a two-part adaptive design (Figure 1). Part 1 featured a randomized, double-blind, placebo-controlled parallel-group comparison of TQH3906 at doses of 6 mg, 12 mg, and 18 mg versus placebo (1:1:1:1 allocation), administered as once-daily oral capsules for 12 weeks. Part 2 added higher doses (24 mg and 32 mg) with a 1:1:1 randomization against placebo, maintaining identical administration protocol and treatment duration.

Figure 1. Study design and Enrollment

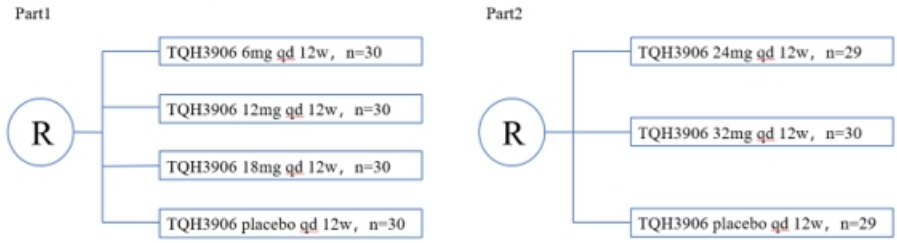
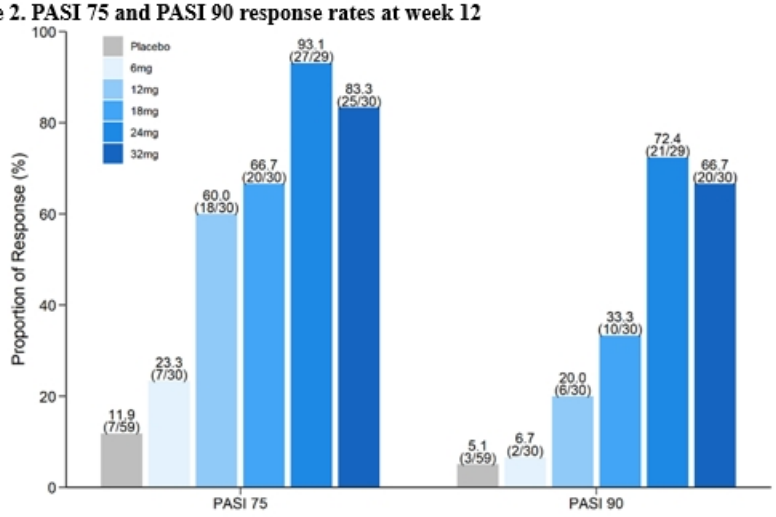


Figure 2. PASI 75 and PASI 90 response rates at week 12



Results

A total of 208 subjects participated in the study. Demographic and baseline disease characteristics were well balanced across groups. Mean baseline PASI scores ranged from 22.50 to 25.86, and mean affected BSA ranged from 29.6% to 38.8%. (Table 1). A dose-dependent efficacy was observed for the primary endpoint, with at week-12 PASI 75 response rates ranged from 22.3% in the lowest dose group (6 mg) to 93.1% in the 24 mg group, compared to 11.9%(7/59) for placebo.(Figure 2). The 24 mg once-daily regimen demonstrated optimal efficacy, achieving: PASI 75: 93.1%, sPGA 0/1: 86.2% and PASI 90: 72.4%. The safety profile was favorable, with similar TEAE incidence between treatment and placebo groups. Treatment-emergent adverse events occurred for 40 patients (67.8%) receiving placebo and 18 (60.0%) to 25 (85.3%) patients receiving the 5 different doses of TQH3906. Most TEAEs were mild to moderate in severity; hyperlipidemia and headache were the most commonly reported treatment-related adverse events. (Table 2).

Table 1. Demographic, Baseline Characteristics, and 12-Week Clinical Response of TQH3906 Capsules

	Placebo in Part1	Placebo in Part2	6mg qd	12mg qd	18mg qd	24mg qd	32mg qd
Baseline, n	30	29	30	30	30	29	30
Male, n(%)	24(80.0)	25(86.2)	24(80.0)	24(80.0)	27(90.0)	24(82.8)	28(93.3)
Age, year(SD)	44.8(13.47)	42.2(11.04)	47.9(13.46)	43.8(15.64)	42.5(10.48)	45.8(12.01)	45.4(13.63)
PASI, mean(SD)	24.43(7.48)	25.18(11.99)	23.45(10.48)	24.60(8.87)	22.50(7.49)	25.86(10.41)	25.54(13.17)
BSA%, mean(SD)	32.1(17.4)	33.0%(18.2)	32.8(17.6)	38.8(16.2)	29.6(13.8)	35.4(19.4)	33.7(21.9)
12-Week clinical response							
PASI 75, n(%)	4(13.3)	3(10.3)	7(22.3)	18(60.0)	20(66.7)	27(93.1)	25(83.3)
sPGA 0/1, n(%)	4(13.3)	4(13.8)	10(33.3)	20(66.7)	20(66.7)	25(86.2)	25(83.3)
PASI 90, n(%)	2(6.7)	1(3.5)	2(6.7)	6(20.0)	10(33.3)	21(72.4)	20(66.7)

Table 2. Treatment-emergent adverse events

TEAE, n(%)	Placebo in Part1	Placebo in Part2	6mg qd	12mg qd	18mg qd	24mg qd	32mg qd
N	30	29	30	30	30	29	30
Any TEAEs	17(56.7)	23(79.3)	18(60.0)	19(63.3)	25(83.3)	21(72.4)	24(80.0)
TEAEs related to the study drug	7(23.3)	17(58.6)	9(30.0)	7(23.3)	16(53.3)	16(55.2)	18(60.0)
SAEs	1(3.3)	1(3.5)	0	1(3.3)	0	0	0
SAEs related to the study drug	1(3.3)	0	0	0	0	0	0
TEAEs leading to study interruption	0	1(3.5)	0	0	2(6.7)	0	2(6.7)
TRAEs occurring in ⩾5% of any TQH3906 group and more frequent than placebo group*							
Hypertriglyceridemia	0	2(6.9)	0	1(3.3)	1(3.3)	5(17.2)	6(20.0)
Headache	0	0	1(3.3)	0	1(3.3)	3(10.3)	3(10.0)
Fever	0	0	0	1(3.3)	0	0	2(6.7)
Influenza-like illness	0		0	1(3.3)	2(6.7)		
Upper respiratory tract infection	1(3.3)	1(3.5)	2(6.7)	0	0	1(3.5)	
Herpes simplex infection	0	0	0	0	0	2(6.9)	0
Hyperuricemia	0	4(13.8)	0	0	2(6.7)	0	2(6.7)
Hypercholesterolemia	0	2(6.9)	2(6.7)	1(3.3)	0	0	0
ALT increased	0	1(3.5)	1(3.3)	1(3.3)	0	2(6.9)	2(6.7)
Blood urea increased	0	1(3.5)	0	0	1(3.3)	0	2(6.7)
Low density lipoprotein increased	0	0	0	0	0	0	2(6.7)

* In the studies of Part 1 and Part 2, meeting either one is sufficient.

Conclusions

TQH3906 demonstrated robust clinical efficacy and a favorable safety profile in patients with moderate-to-severe plaque psoriasis (PsO) across multiple dose cohorts. The compelling benefit-risk ratio, particularly at the optimal 24 mg once-daily dosage, supports advancement to pivotal Phase III evaluation. A randomized, active-controlled, double-blind, double-dummy, multicenter trial has been designed to directly compare TQH3906 (24 mg QD) versus deucravacitinib (6 mg QD) in PsO patients, with co-primary endpoints of PASI 90 and sPGA 0/1 at week 16.

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Abstract N°: 3238

Deucravacitinib: dual efficacy in alopecia areata and difficult-to-treat areas of psoriasis

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Introduction

Alopecia areata (AA) is an autoimmune form of non-scarring hair loss associated with the collapse of the immune privilege in the hair follicle. This process is thought to promote the recognition of follicular autoantigens by autoreactive cytotoxic $CD8^+$ T cells, which play a central role in disease development. Although AA and psoriasis have distinct immune phenotypes, both conditions are characterized by dysregulated T-cell responses and share certain pathogenic mechanisms, including the JAK-STAT signaling pathway. Indeed, their co-occurrence in the same patient is often observed in clinical practice, thus requiring a personalized therapeutic approach. However, no traditional agent, biologic, or small molecule is approved so far to treat either psoriasis and AA.

Case Presentation

We report the case of an 18-year-old male with concomitant chronic plaque psoriasis and patchy alopecia areata (AA), successfully treated with deucravacitinib. At baseline, the patient presented erythematous-scaly plaques involving the scalp, ears, elbows, trunk, and face (Physician Global Assessment, PGA=3; Fig.1a,b), together with a large occipital–nuchal alopecic patch (Severity of Alopecia Tool, SALT=8; Fig.2a,b). Both conditions had been present for three years and were refractory to topical calcipotriol/betamethasone for psoriasis and clobetasol plus minoxidil for AA. No family history of psoriasis, AA, or other immune-mediated diseases was reported.The coexistence of AA and psoriasis in sensitive and visible areas had a significant impact on the patient's quality of life (DLQI=23), influencing life decisions related to education, work, and personal relationships. To improve therapeutic adherence, oral treatment was initiated, and the patient started deucravacitinib 6 mg once daily as first-line systemic therapy. At week 4, psoriasis showed marked improvement (PGA=2; DLQI=15; Fig.1c,d), associated with initial hair regrowth in the alopecic area (SALT=3; Fig.2c,d). At week 16, near-complete resolution of both psoriasis (PGA=1; Fig.1e,f) and AA (SALT=1; Fig.2e,f) was documented, with significant improvement in quality of life (DLQI=5). Complete clearance of psoriasis and full hair regrowth were achieved at week 24 (PGA=0; SALT=0; DLQI=4), without adverse events. Deucravacitinib was therefore continued as maintenance treatment. Deucravacitinib is an oral, selective allosteric inhibitor of tyrosine kinase 2 (TYK2), currently approved for the treatment of moderate-to-severe plaque psoriasis. Phase III studies and real-world evidence case reports suggest its clinical efficacy in difficult-to-treat areas, including scalp, nails, and genital region, with optimal results maintained ≥52 weeks of treatment.





Figure legends Figure 1. Efficacy of deucravacitinib in facial and scalp psoriasis. a, b) Baseline clinical images showing erythematous and scaly plaques involving the head and neck region (PGA=3); c, d) Marked reduction of psoriatic lesions at week 4 of treatment (PGA= 2); e, f) Near-complete resolution of psoriasis at week 16 of therapy (PGA= 1). Figure 2. Efficacy of deucravacitinib in patchy alopecia areata (AA). a, b) Baseline clinical and dermoscopic images showing patchy AA of the occipito-nuchal region (SALT= 8), associated with well-demarcated erythematous and scaly psoriatic plaques; c, d) Clinical and dermoscopic images showing marked reduction of erythema within the alopecic patch at week 4 of treatment (SALT= 3); e, f) Almost complete clinical and dermoscopic evidence of hair regrowth at week 16 of therapy (SALT= 1).

Conclusion

This case adds further clinical evidence supporting the effectiveness of deucravacitinib in achieving rapid and sustained control of psoriasis in high-impact and visible areas, such as the scalp and face, even in patients with overall mild disease severity but a disproportionate disease burden. Moreover, the concomitant and progressive hair regrowth observed in our patient suggests a potential therapeutic effect of TYK2 inhibition in AA. These findings are consistent with emerging case-based literature reporting significant or complete hair regrowth in patients with AA, including severe forms such as alopecia universalis. Some of these reports describe concomitant improvement of psoriasis and AA during treatment, supporting the hypothesis that partially overlapping immune-mediated pathways, particularly those involving Th1 and interferon signaling, may be modulated through TYK2 inhibition. Recent narrative reviews have summarized these findings and proposed deucravacitinib as a promising off-label therapeutic option for AA. Nevertheless, current evidence remains limited to case reports and small case series, and larger prospective studies are needed to better define the role of TYK2 inhibition in AA.

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Efficacy and Safety of Retinoic Acid–Related Orphan Receptor Gamma Thymus (RORγt) Inverse Agonists for Psoriasis: A Systematic Review and Meta-analysis of Placebo-Controlled Randomized Trials

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Introduction
Psoriasis is a chronic immune-mediated inflammatory disease affecting approximately 100 million people worldwide, with the global burden expected to rise. Dendritic cells, T-helper 17 (Th17) cells, and keratinocytes form a key pathogenic triad in psoriasis, driven by dysregulation of the interleukin-23 (IL-23)/Th17 axis, supporting the use of biologic therapies targeting interleukin-17 (IL-17) and IL-23. While highly effective, these injectable biologics are associated with limitations in cost, access, and long-term adherence, underscoring the need for effective oral alternatives. Retinoic acid–related orphan receptor gamma thymus (RORγt), the central transcription factor regulating Th17 differentiation and IL-17 synthesis, has emerged as a promising upstream therapeutic target, with several small-molecule inhibitors under investigation. To evaluate the efficacy and safety of RORγt inverse agonists compared with placebo in psoriasis, we conducted a systematic review and meta-analysis of randomized controlled trials (RCTs).

Materials and Methods
PubMed, Embase, and Cochrane databases were systematically searched for RCTs comparing RORγt inverse agonists with placebo in patients with psoriasis. Primary outcomes included Psoriasis Area and Severity Index (PASI) 75 at week 12 and treatment-related adverse events (TRAEs). Secondary outcomes included static Physician's Global Assessment (sPGA) 0/1 responses, patient-reported outcomes (PROs), including the Psoriasis Symptom Scale (PSS) and Self-Assessment of Psoriasis Symptoms (SAPS), all-cause mortality, infections and infestations, pruritus, gastrointestinal adverse events (GI AEs), adverse events (AEs) leading to treatment discontinuation, and hepatic enzyme elevations. Continuous outcomes were pooled as mean differences (MDs) and dichotomous outcomes as risk ratios (RRs), both with 95% confidence intervals (CIs). Statistical analyses were performed using a random-effects model with restricted maximum likelihood (REML) in RStudio (2025.09.2+418). Risk of bias was assessed using ROB 2.

Results
Six RCTs (502 patients) were included; one trial consisted of two parts with separate, non-overlapping patient populations. Included studies evaluated different RORγt inverse agonists (cedirogant, BI 730357, PF-06763809, and AGN-242428), with variability in dosing regimens and routes of administration. Mean baseline PASI score was 18.4 ± 7.2, and mean age was 46.4 ± 13.3 years. Patients receiving RORγt inverse agonists were significantly more

likely to achieve PASI 75 at week 12 than those receiving placebo (RR 7.45; 95% CI 1.51–36.61; p=0.013; I^2=0%). Risk of TRAEs did not significantly differ between both groups (RR 1.34; 95% CI 0.77–2.33; p=0.305; I^2=0%). Among patients receiving RORγt inverse agonists, the likelihood of achieving sPGA 0/1 was significantly higher compared with placebo (RR 7.27; 95% CI 1.48–35.77; p=0.015; I^2=0%). Reduction in total PSS score from baseline at week 12 was significantly greater with RORγt inverse agonists (MD 2.41; 95% CI 0.81–4.01; p<0.01; I^2=0%). In Mohamed et al., the mean percentage change in SAPS score at day 28 was 2.0% in the placebo group and −46.5% in the cedirogant group. All-cause mortality was zero events in both the intervention and control groups across all included studies, and a forest plot was not estimable. Risk of infections and infestations (RR 0.70; 95% CI 0.07–6.60; p=0.651; I^2=48.0%), pruritus (RR 0.83; 95% CI 0.18–3.88; p=0.816; I^2=0%), GI AEs (RR 1.15; 95% CI 0.48–2.75; p=0.750; I^2=0%), AEs leading to treatment discontinuation (RR 0.74; 95% CI 0.01–53.73; p=0.793; I^2=54.7%), and hepatic enzyme elevation (RR 1.46; 95% CI 0.02–115.49; p=0.744; I^2=38.4%) did not differ significantly between groups.

Study, Trial Phase	RORγt Inverse Agonists	Total Participants, n	ROA + Dosage	Follow-up (weeks)	Psoriasis Severity	Baseline PASI [a]	Age, years [a]
NCT03339999 – 2018 Phase II	AGN-242428	24	Oral low, medium, and high dose QD	12	moderate to severe	16.9 (5.0)	48.5 (12.4)
Berstein – 2020 Phase I	PF-06763809	18	Topical 2.3%, 0.8%, and 0.23% QD*	7	mild to moderate	NR	52.3 (12.0)
Mohamed – 2023 (Study 2B) Phase I	Cedirogant	30	Oral 375 mg QD	4	moderate to severe	18.0 (6.5)	45.1 (14.6)
Tyring – 2024 Phase II	Cedirogant	156	Oral 75, 150, and 375 mg QD	20	moderate to severe	19.7 (8.8)	46.6 (12.1)
Gooderham Part 1 – 2025 Phase II	BI 730357	178	Oral 25, 50, 100, and 200 mg QD (Fasted Conditions)	28	moderate to severe	17.7 (5.8)	46.4 (14.1)
Gooderham Part 2 – 2025 Phase II	BI 730357	96	Oral 400 mg QD and 200 mg BID (Fed Conditions)	28	moderate to severe	18.3 (7.0)	44.7 (13.6)

Outcomes	Studies, n	Patients†, n RORγt inverse agonists/Placebo	Pooled Estimate (95% CI)	I^2 (%)	P-value
PASI75 (week 12)	3	361 / 69	RR 7.45 (1.51–36.61)	0	0.013
TRAEs	6	414 / 105	RR 1.34 (0.77–2.33)	0	0.305
sPGA 0/1	3	361 / 69	RR 7.27 (1.48–35.77)	0	0.015
PSS change from baseline (week 12)	2	244 / 30	MD 2.41 (0.81–4.01)	0	< 0.01
Infections & infestations	5	396 / 87	RR 0.70 (0.07–6.60)	48	0.651
Pruritus	4	139 / 46	RR 0.83 (0.18–3.88)	0	0.816
Gastrointestinal AEs	5	396 / 87	RR 1.15 (0.48–2.75)	0	0.750
AEs leading to treatment discontinuation	5	396 / 87	RR 0.74 (0.01–53.73)	54.7	0.793
Elevations in hepatic enzymes	3	152 / 57	RR 1.46 (0.02–115.49)	38.4	0.744

Table 1. Baseline characteristics of included studies. Abbreviations: BID: twice daily; NR: not reported; PASI: Psoriasis Area and Severity Index; QD: once daily; RORγt: Retinoic Acid–Related Orphan Receptor Gamma Thymus; ROA: route of administration. * Each participant received 180 µL of each treatment; a mean (SD). Table 2. Summary of pooled efficacy and safety outcomes. Interpretation of heterogeneity: 0% to <25%: low; 25% to 50%: moderate; 50% to 75%: substantial; >75%: considerable; † Participant numbers reflect those included in outcome-specific analyses, not total trial enrollment. Where applicable, multiple dose arms of RORγt inverse agonists were pooled to form a single intervention group per study. Abbreviations: AEs: adverse events; CI: confidence interval; MD: mean difference; PASI: Psoriasis Area and Severity Index; PSS: Psoriasis Symptom Scale; RR: risk ratio; RORγt: retinoic acid–related orphan receptor gamma thymus; sPGA: static Physician's Global Assessment; TRAEs: treatment-related adverse events.

Conclusions

RORγt inverse agonists may demonstrate short-term efficacy in psoriasis without new major safety signals compared with placebo. Further studies are needed to define their longer-term risk–benefit profile.

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Beyond the skin: Mucosal psoriasis and its clinicodermoscopic and therapeutic profile.

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Introduction

Psoriasis is a chronic inflammatory skin disease of multifactorial origin. Cutaneous forms are the most common, mucosal involvement remains underrecognized and poorly described, often leading to delayed diagnosis and inadequate management. Although rare, these forms can significantly impair quality of life particularly when associated with articular, ocular, or genital involvement.

Materials and Methods

We conducted a retrospective-prospective descriptive and analytical study, including psoriatic patients with mucosal involvement between January 2011 and June 2025. Clinical photographs were reviewed by two clinicians, and histological confirmation was obtained in doubtful cases.

Results

Among 930 patients followed for psoriasis, 50 presented with mucosal involvement (29 men and 21 women), with a mean age of 34 years (range: 5–70 years). Two patients had associated autoimmune diseases. Mucosal involvement was isolated in 5 cases and associated with cutaneous psoriasis in 45 patients: plaque psoriasis (33 patients), pustular and inverse psoriasis (4 cases each), and guttate psoriasis (2 cases). Involvement of at least two mucosal sites was observed in 6 patients. The oral cavity was the most frequent site, affecting 29 patients. Findings included fissured tongue (9 cases) and geographic tongue (8 cases). Cheilitis was observed in 21 patients: dry cheilitis (16 cases), fissured (3 cases), and erosive (2 cases). Dermoscopy revealed dotted vessels in all patients and linear vessels in 9 cases. Vascular distribution was homogeneous in 18 patients, peripheral in 2, and annular in 1. Scales were present in all cases of cheilitis. Angular cheilitis was noted in 9 patients, and perioral plaques in 5 patients, all showing homogeneously distributed dotted vessels and whitish scales. Genital involvement was observed in 19 patients (4 isolated, 3 associated with inverse psoriasis). In women (n = 3), erythematous vulvo-clitoral plaques with homogeneously distributed dotted vessels and whitish scales were noted. In men (n = 16), involvement affected the glans (13 cases), penis (9 cases), and scrotum (7 cases). Dermoscopy showed homogeneously distributed dotted vessels in 15 patients and linear vessels in 1 case. Scales were present in 10 patients, whitish in 9 cases and yellowish in 1 case. Anal involvement was found in 3 patients, all presenting an erythematous background with homogeneously distributed linear dotted vessels. Ocular involvement was present in 5 patients, including 3 cases of uveitis, 2 cases involving the external canthus, and 1 case of blepharitis. Therapeutically, 39 patients received topical treatment (topical corticosteroids in 36 cases and mouthwashes in 3 cases), with good outcomes in 75% of cases at 3 and 6 months. All patients maintained this improvement after more than one year of follow-up. Ten patients received systemic treatment (7 on methotrexate and 3 on acitretin), and 2 patients received biologic therapy due to severe cutaneous involvement, with good improvement in both cutaneous and mucosal lesions. Metabolic syndrome was present in 7 cases, psoriatic arthritis in 8 cases, PASI was severe in 8 patients and mild in 42 patients, and DLQI was impaired in 9 cases and preserved in 41 patients.

Analytical study did not demonstrate any significant association between mucosal psoriasis and metabolic syndrome, psoriatic arthritis, PASI, or DLQI.

Conclusions

Mucosal psoriasis is a rare and long underrecognized form of psoriasis, sometimes occurring in isolated presentations. Oral involvement has been found to be the most frequent location. Dermoscopy is an essential tool that helps confirm the diagnosis through specific features: regularly distributed dotted vessels and whitish scales.Response to topical treatment is generally favorable, although systemic therapy may be required in severe cases. Statistical analysis did not show any significant association with metabolic syndrome, psoriatic arthritis, PASI, or DLQI.

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Risankizumab Versus Deucravacitinib in Adult Patients With Moderate Plaque Psoriasis: 52-Week Results From IMMpactful, a Phase 4 Multicenter, Randomized, Study

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Introduction

Risankizumab (RZB), an IL-23 inhibitor, and deucravacitinib (DEU), a TYK2 inhibitor, are both approved for moderate-to-severe psoriasis (PSO), but their use in moderate patients (pts) has not been evaluated, though many providers consider DEU a first-line option with expected comparable efficacy over time in this group. IMMpactful is a 2-part (period A and B) phase 4 study investigating the efficacy and safety of RZB compared with DEU in the treatment of moderate PsO. In period A, significantly higher proportions of pts with moderate PsO treated with RZB achieved ≥ 90% improvement in Psoriasis Area and Severity Index (PASI 90; 57.3% vs 22.9%; $P < .001$) and static Physician Global Assessment of 0 or 1 (sPGA 0/1; 80.2% vs 39.7%;$P < .001$) than pts on DEU (Magnolo et al. *J of Skin.* 2025;9(6):s631). Here, we report results from pts treated with DEU in period A who failed to achieve PASI 90 at week 16 (PASI 90 nonresponders) and were rerandomized to RZB or DEU in period B, as well as the efficacy of continuous RZB and DEU over 52 weeks.

Materials and Methods

This phase 4 IMMpactful (NCT06333860) study investigated the safety and efficacy of RZB vs DEU in adult pts with moderate PsO and no prior biologic exposure. Pts (≥ 18 years) eligible for systemic treatment with body surface area 10% - ≤ 15%, PASI ≥ 12, and sPGA = 3 (moderate) were enrolled. In period B (weeks 16–52), PASI 90 nonresponders were rerandomized 1:1 to subcutaneous RZB 150 mg (DEU/RZB) every 12 weeks or oral DEU 6 mg (DEU/DEU) once daily. The primary endpoint of period B was the achievement of PASI 90, and ranked secondary endpoints included the achievement of PASI 100 and sPGA 0 with at least a 2-grade improvement from baseline at

week 52 among PASI 90 nonresponders. Nonresponder imputation incorporating multiple imputations was used to handle missing data.

Results

Among PASI 90 nonresponders, 90 pts (mean age [SD]: 44.8 [13.8] years) were rerandomized to RZB (DEU/RZB), and 93 pts (mean age [SD]: 44.2 [12.9] years) to DEU (DEU/DEU). Baseline mean PASI (SD) was similar between the DEU/RZB (15.5 [4.0]) and DEU/DEU (15.0 [2.8]) groups.

A significantly higher proportion of pts in the DEU/RZB group achieved PASI 90 (82.2% vs 20.4%, *P* < .0001), PASI 100 (60.0% vs 10.8%, *P* < .0001), and sPGA 0 (62.2% vs 9.7%, *P* < .0001), compared with pts in the DEU/DEU group (Table). A higher proportion of pts achieved PASI 90, PASI 100, and sPGA 0 in the continuous RZB group than in the continuous DEU group over the entire 52-week period.

Among all pts treated with DEU in period A who were treated in period B, the proportion of pts with treatment-emergent adverse events was 46.6% (DEU/RZB) and 37.5% (DEU/DEU). The proportion of pts with adverse events related to study drug was 8.5% (DEU/RZB) and 5.8% (DEU/DEU). Four resolved serious adverse events (angina pectoris, 2 events of appendicitis, and cerebrovascular accident) occurred in the DEU/RZB group, and there were no deaths reported in period B.

Table. Clinical responses of patients with moderate psoriasis at week 52.

Endpoints (NRI-MI)	Week 52					
	DEU/RZB n = 90	DEU/DEU n = 93	*P* value	[a]RZB n = 131	[b]DEU n = 131	*P* value
PASI 90, % (95% CI)	82.2 (74.3, 90.1)	20.4 (12.2, 28.6)	< .0001	77.1 (69.9, 84.3)	29.0 (21.2, 36.8)	< .0001
PASI 100, % (95% CI)	60.0 (49.9, 70.1)	10.8 (4.5, 17.0)	< .0001	61.8 (53.5, 70.2)	18.3 (11.7, 24.9)	< .0001
sPGA 0, % (95% CI)	62.2 (52.2, 72.2)	9.7 (3.7, 15.7)	< .0001	61.1 (52.7, 69.4)	17.6 (11.0, 24.1)	< .0001

DEU deucravacitinib,; DEU/DEU, patients who were randomized to deucravacitinib in period A, failed to achieve PASI 90 at week 16 and were rerandomized to deucravacitinib; DEU/RZB, patients who were randomized to deucravacitinib in period A, failed to achieve PASI 90 at week 16 and were rerandomized to risankizumab; PASI 90, 90% improvement in Psoriasis Area and Severity Index; PASI 100, 100% improvement in PASI; RZB, risankizumab ; sPGA 0, static Physician's Global Assessment of 0; NRI-MI, Nonresponder Imputation incorporating Multiple Imputation to handle any missing data that can be reasonably assumed to be missing at random. aPatients who were treated with continuous risankizumab. bPatients who were treated with deucravacitinib in period A and continued with deucravacitinib in period B, including half of the patients treated with deucravacitinib at baseline and prematurely discontinued from the study before entering period B

Conclusions

Among PASI 90 nonresponders, pts who switched from DEU to RZB demonstrated greater clinical improvement at week 52 than pts who remained on DEU. The switch resulted in significantly higher achievement of clear or almost

clear skin (PASI 90/100 and sPGA 0). Pts on continuous RZB also had greater clinical response compared with pts on continuous DEU. No new safety concerns were reported. These results emphasize a critical opportunity to improve outcomes in biologic-naïve pts with moderate PsO who are candidates for their first systemic therapy.

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Abstract N°: 3326

Genome-wide association study in 1,179 Polish patients with psoriasis: results from the Polish Psoriasis Consortium

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Introduction

Psoriasis is a chronic immune-mediated inflammatory skin disease with a strong genetic background. Although multiple susceptibility loci have been identified, population-specific genetic profiles remain insufficiently characterized. The aim of this multicentre study conducted by the Polish Psoriasis Consortium was to investigate the genetic architecture of psoriasis and identify susceptibility loci in a large cohort of Polish patients using genome-wide association study (GWAS) analysis.

Materials and Methods

A GWAS analysis was performed in 1,179 patients with psoriasis, including 1,032 patients with type I psoriasis and 147 patients with type II psoriasis, and compared with 5,885 healthy controls. Genotyping was conducted using the Infinium CoreExome microarray (Illumina). Among 558,231 analysed single nucleotide polymorphisms (SNPs), 233,644 passed quality control and were included in the final comparative analysis.

Results

A significant association between type I psoriasis and 260 SNPs located primarily on chromosome 6, together with one locus on chromosome 15, was identified. The strongest associations were observed within established psoriasis susceptibility regions, including *PSORS1*, *PSORS2*, and *PSORS3*. Significant associations were also confirmed for genes involved in antigen recognition and presentation, including *HLA-C*, *HLA-DQA*, *HLA-DQB*, *HLA-DRB*, and *TAP2*. Additional associated loci included genes related to complement activation (*C2*), immune regulation (*NOTCH4*, *RNF5*, *TCF19*, *ATF6B*, *POU5F1*, *NFKBIL1*), epidermal structure and differentiation (*CDSN*, *MUC22*, *RPTN*, *TNXB*), cellular signaling (*DXO*, *STK19*), and immune cell activation (*MICA*, *MICB*).

Importantly, a novel strong association was identified between type I psoriasis and the *USP8* gene on chromosome 15, encoding ubiquitin-specific protease 8.

Conclusions

This study defines the SNP profile of Polish patients with psoriasis and provides additional insight into the genetic architecture of the disease. The identification of a novel association involving *USP8* may contribute to a better understanding of psoriasis pathogenesis and warrants further functional investigations.

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Abstract N°: 3330

BALANCING IMMUNOMODULATION AND INFECTION CONTROL: SUCCESSFUL USE OF IL-23 INHIBITION IN A PATIENT WITH PSORIASIS AND CUTANEOUS LEISHMANIASIS

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Introduction

Psoriasis is a chronic immune-mediated inflammatory disease requiring long-term immunomodulatory therapy. However, management becomes particularly challenging in the presence of active infectious diseases, especially those dependent on cellular immunity, such as leishmaniasis. [1-2]

Leishmaniasis is a granulomatous parasitic infection in which Th1-mediated immunity plays a central role in parasite control. Conventional immunosuppressive therapies, particularly anti-TNF agents and methotrexate, have been associated with increased risk of infection, reactivation, and atypical presentations. [3–5]

Here we present a case that aims to describe the clinical course of a patient with long-standing psoriasis and cutaneous leishmaniasis, to highlight the clinical decision-making process regarding immunosuppression and discuss the potential role of IL-23 inhibition as a targeted and safer strategy after infection control.

Case Presentation

A 52-year-old male with a 30-year history of chronic plaque psoriasis (PASI 11.3; DLQI 27) using methotrexate 10-25mg/week for the last 15 years and comorbidities including hypertension, prediabetes, obesity, and chronic venous insufficiency was evaluated due to a large ulcer (15x10 cm) on the left lower limb (Figure 1), following incomplete treatment of suspected leishmaniasis with subtherapeutic meglumine antimoniate (~4 mg/kg/day).

Histopathology demonstrated a plasma cell–rich granulomatous inflammatory infiltrate with rare amastigotes and PCR for *Leishmania* was positive. Methotrexate was discontinued upon initial presentation, and the patient was treated with meglumine antimoniate 15 mg/kg/day for 20 days.

After clinical improvement and infection control, guselkumab (IL-23 inhibitor) was initiated using standard dosing (week 0, 4, then every 8 weeks). Following appropriate antiparasitic therapy, the ulcer showed progressive healing with no evidence of active infection (Figure 2).

After initiation of guselkumab, PASI improved from 11.3 to 3.6 (within 3 months) and 1.8 (within 5 months). DLQI improved from 27 to 1 and no recurrence of leishmaniasis was observed during follow-up (within 9 months). These findings suggest that targeted IL-23 inhibition achieved effective psoriasis control without compromising infectious outcomes.

Conclusion

This case highlights the complexity of managing psoriasis in the setting of active granulomatous infection. Available literature supports increased risk of leishmaniasis under immunosuppression, particularly anti-TNF therapy. [2-4] and the need to suspend immunosuppressive agents during active infection and reintroduce them

after control. [5]

IL-23 inhibition represents a more selective immunomodulatory approach, potentially preserving host defense mechanisms against intracellular pathogens while effectively controlling psoriatic inflammation. However, current evidence does not support their use during active infection, and treatment interruption is recommended in clinically significant infections. [6]

Prioritizing the treatment and complete control of leishmaniasis, with temporary withdrawal of immunosuppressive therapy, was essential to achieving a favorable clinical outcome. Following infection resolution, initiation of IL-23 inhibition resulted in sustained and effective psoriasis control without evidence of infectious relapse.

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Abstract N°: 3345

Safety of Risankizumab in Patients With Psoriatic Disease: Integrated Analysis of Long-Term Clinical Trial Data

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Introduction

Risankizumab (RZB) is an IL-23 inhibitor approved for the treatment of psoriasis (PsO) and psoriatic arthritis (PsA) with a favorable benefit-risk profile in long-term safety data. Here, we report updated safety data from patients with PsO and PsA receiving RZB.

Materials and Methods

Data were integrated from 29 clinical trials, comprised of 23 trials spanning phases 1-4 in PsO and 6 spanning phases 2-3 in PsA. The data cutoff date was March 25, 2026. Treatment-emergent adverse events (TEAEs) and AEs of special interest are reported for patients who received at least one dose of RZB. Exposure-adjusted event rates are reported as events per 100 patient-years (E/100 PY).

Results

This integrated analysis comprised 1616 patients with PsA (6617.8 PY exposure) and 4358 patients with PsO (14545.0 PY exposure). Median treatment duration (range) was 5.98 years (14 days-6.44 years) for PsA and 2.15 years (28 days-9.11 years) for PsO.

Rates of TEAEs and serious AEs were 132.8 E/100 PY and 8.3 E/100 PY in PsA and 143.3 E/100 PY and 7.1 E/100 PY in PsO, respectively. The rate of AEs leading to study drug discontinuation or death was 1.8 E/100 PY and 0.3 E/100 PY in PsA and 1.8 E/100 PY and 0.3 E/100 PY in PsO, respectively (**Table**).

The overall rate of infection was 39.5 E/100 PY for PsA and 46.4 E/100 PY in PsO (**Table**). The most common infections in PsA were nasopharyngitis (5.7 E/100 PY), upper respiratory tract infection (4.7 E/100 PY) and urinary tract infection (1.9 E/100 PY); the most common infections in PsO were nasopharyngitis (12.6 E/100 PY), upper respiratory tract infection (6.4 E/100 PY), and influenza (1.7 E/100 PY). Rates of serious infections were low in both groups, 1.5 E/100 PY in PsA and 1.2 E/100 PY in PsO, and within PSOLAR PsA/PsO population reference ranges[1, 2]. Commonly reported serious infections in PsO included cellulitis, sepsis, and pneumonia, each <0.1 E/100 PY, and in PsA included pneumonia (0.2 E/100 PY), cellulitis (<0.1 E/100 PY) and diverticulitis (<0.1 E/100 PY).

The rate of opportunistic infections excluding tuberculosis and herpes zoster was low and similar across both

populations, <0.1 E/100 PY in both PsA and PsO. There was one case of active tuberculosis in PsO, which was previously reported. This occurred in a 52-year-old Taiwanese patient who tested positive at screening, was adequately treated with isoniazid prophylaxis, and developed active disease 4 years later. Opportunistic infections including herpes zoster and candida were low in both PsA (0.3 E/100 PY and 0.5 E/100 PY, respectively) and PsO (0.5 E/100 PY and 0.5 E/100 PY, respectively) (**Table**). No cases of serious or systemic candidiasis were seen.

Rates of adjudicated major adverse cardiovascular events were 0.4 E/100 PY for PsA and 0.5 E/100 PY for PsO, which is within epidemiological reference benchmarks[3,4]. The rates of non-melanoma skin cancer (NMSC) were 0.4 E/100 PY in PsA, 0.6 E/100 PY in PsO. The rates of malignancy excluding NMSC were 0.6 E/100 PY both in PsA and PsO, which is within the PSOLAR PsO reference range[3] and within the reference benchmark for PsA[5] (**Table**). Of note, prostate and breast cancer are among the most common malignancies in the general population.

Table 1: Treatment-Emergent Adverse Events in Patients With Psoriasis and Psoriatic Arthritis

	Psoriasis (N = 4358, PY = 14545.0) Events (E/100 PY) [95% CI]	Psoriatic Arthritis (N = 1616, PY = 6617.8) Events (E/100 PY) [95% CI]
AEs	20843 (143.3) [141.36, 145.26]	8790 (132.8) [130.06, 135.63]
Serious AEs	1034 (7.1) [6.68, 7.56]	550 (8.3) [7.63, 9.04]
AEs leading to discontinuation	260 (1.8) [1.58, 2.02]	118 (1.8) [1.48, 2.14]
AEs leading to death	38 (0.3) [0.18, 0.36]	19 (0.3) [0.17, 0.45]
Infection	6752 (46.4)	2616 (39.5)
Most common infections		
Nasopharyngitis	1830 (12.6)	376 (5.7)
Upper respiratory tract infection	925 (6.4)	312 (4.7)
Influenza	246 (1.7)	69 (1.0)
Urinary tract infection	234 (1.6)	123 (1.9)
Serious infection	175 (1.2) [1.03, 1.40]	102 (1.5) [1.26, 1.87]
Sepsis	14 (<0.1)	3 (<0.1)
Cellulitis	14 (<0.1)	6 (<0.1)
Pneumonia	13 (<0.1)	11 (0.2)
Active tuberculosis	1 (<0.1) [0.00, 0.04]	0
Herpes zoster	72 (0.5) [0.39, 0.62]	21 (0.3) [0.20,0.49]
Opportunistic infections excluding tuberculosis and herpes zoster[a]	13 (<0.1) [0.05, 0.15]	4 (<0.1) [0.02, 0.15]
Candida infections	72 (0.5) [0.39, 0.62]	30 (0.5) [0.31, 0.65]
Malignant tumors	169 (1.2) [0.99, 1.35]	66 (1.0) [0.77, 1.27]
Non-melanoma skin cancer (NMSC)	81 (0.6) [0.44, 0.69]	29 (0.4) [0.29, 0.63]
Basal cell carcinoma	51 (0.4)	22 (0.3)
Squamous cell carcinoma of skin	20 (0.1)	3 (<0.1)
Malignant tumors excluding NMSC	88 (0.6) [0.49, 0.75]	37 (0.6) [0.39, 0.77]
Prostate cancer	12 (<0.1) [0.04, 0.14]	5 (<0.1) [0.02, 0.18]
Breast cancer	13 (<0.1) [0.05, 0.15]	7 (0.1) [0.04, 0.22]
Pancreatic carcinoma	5 (<0.1) [0.01, 0.08]	0
Adjudicated MACE	77 (0.5) [0.42, 0.66]	26 (0.4) [0.26, 0.58]
Serious hypersensitivity[b]	11 (<0.1) [0.04, 0.14]	5 (<0.1) [0.02, 0.18]
Injection site reactions	377 (2.6) [2.34, 2.87]	37 (0.6) [0.39, 0.77]
Depression	79 (0.5)	45 (0.7)
Suicidal ideation and behavior	12 (<0.1) [0.04, 0.14]	7 (0.1) [0.04, 0.22]
Inflammatory bowel disease[c]	1 (<0.1)	4 (<0.1)

Data cutoff date for this integrated safety analysis was March 25, 2026. Events are defined as those that begin either on or after the first dose of Risankizumab and up to 140 days after the last dose.
AE, adverse events; E, event; MACE, major adverse cardiovascular event; PY, patient-years; TEAEs, treatment-emergent adverse events.
[a]Opportunistic infections excluding tuberculosis and herpes zoster (E [E/100 PY]) included oesophageal candidiasis 7 (<0.1), balanitis candida 2 (<0.1), oropharyngeal candidiasis 2 (<0.1), candida urethritis 1 (<0.1), and gastrointestinal candidiasis 1 (<0.1) for PsO and clostridial sepsis 1 (<0.1), oesophageal candidiasis 1 (<0.1), oral fungal infection 1 (<0.1), and oropharyngeal candidiasis 1 (<0.1) for PsA.
[b]Serious hypersensitivity: PsO: eczema 2 (<0.1), Stevens-Johnson Syndrome 2 (<0.1), urticaria 2 (<0.1), angioedema 1 (<0.1), atopic dermatitis 1 (<0.1), drug hypersensitivity 1 (<0.1), erythema multiforme 1 (<0.1), hypersensitivity 1 (<0.1, each); PsA: anaphylactic reaction 1 (<0.1), dermatitis bullous 1 (<0.1), immune thrombocytopenia 1 (<0.1), swollen tongue 1 (<0.1).
[c]There was one case of ulcerative colitis each in PsO and PsA (1 [<0.1]) and 3 cases of Crohn's disease (3 [<0.1]) in PsA.4 of these 5 patients had a history of IBD.

Conclusions

In this extended dataset encompassing 29 clinical trials, rates of AEs remained generally low for PsO and PsA long-term. These data provide additional context on the long-term safety profile for RZB in patients with psoriatic disease.

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Dual inhibition of TYK2 and JAK1 for plaque psoriasis: A systematic review and meta-analysis

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Introduction

Plaque psoriasis is a chronic inflammatory skin disease characterized by erythematous and scaly plaques. Dual inhibitors of tyrosine kinase 2 (TYK2) and Janus kinase 1 (JAK1) are emerging therapies targeting key cytokine pathways. We aim to conduct a systematic review and meta-analysis to evaluate the safety and efficacy of combining TYK2 and JAK1 inhibitors for plaque psoriasis.

Materials and Methods

PubMed, Embase, and the Cochrane Library were searched for randomized controlled trials (RCTs) comparing TYK2/JAK1 inhibitors with placebo in patients with plaque psoriasis. Primary outcomes included Psoriasis Area and Severity Index (PASI) 75/90 and PASI change from baseline at week 12, Physician's Global Assessment (PGA) 0/1, and treatment-emergent adverse events (TEAEs). A random-effects model using inverse-variance (IV) weighting and restricted maximum likelihood (REML) estimation was applied, with Hartung-Knapp-Sidik-Jonkman (HKSJ) correction when $Tau^2 > 0$, and a Wald-type approach otherwise. Statistical analyses were performed using RStudio.

Results

Five RCTs, including 876 patients, were analyzed. Mean age was 47.6 ± 13.23 years, and baseline PASI score was 13.38 ± 9.73. Four RCTs evaluated Brepocitinib, one of which used a topical formulation and the remaining three oral formulations. The fifth RCT investigated a different TYK2/JAK1 inhibitor, the oral agent TLL-018. TYK2/JAK1 inhibitors significantly improved PASI 90 response rates at week 12 compared with placebo (RR, 6.42; 95% CI, 2.27–18.16; p<0.001), while PASI 75 responses were numerically higher but did not reach statistical significance in the overall pooled analysis driven by heterogeneity from the topical formulation (RR, 2.17; 95% CI, 0.74–6.38; p=0.106). The 60 mg subgroup demonstrated a statistically significant improvement in PASI75 (RR 4.83; 95% CI 1.62–14.41; p=0.005), while lower doses (10-40 mg) did not reach statistical significance. Improvement in PASI from baseline was significantly greater in the TYK2/JAK1 inhibitor group (SMD, −0.58; 95% CI, −1.00 to −0.15; p<0.01). No significant differences were observed in PGA 0/1 response rates (RR, 3.48; 95% CI, 0.77–15.70; p=0.078) or TEAEs (RR, 1.11; 95% CI, 0.94–1.31; p=0.199). Similarly, no significant differences were observed between TYK2/JAK1 inhibitors

and placebo for either SAEs (RR 0.71; 95% CI 0.23–2.20; p=0.557) or infections and infestations (RR 1.08; 95% CI 0.50–2.33; p=0.800).

Study	Trial Phase	Dual TYK2/JAK1 Inhibitors (administration)	No. of patients per dose vs placebo, n	Psoriasis Severity	Males, n (%)	Age, years, mean ± SD	Disease duration, years, mean ± SD	PASI, mean ± SD	Follow-up, weeks
Chen 2025	Ib	TLL-018 (oral)	10 mg BID: 20 20mg BID: 21 30 mg BID: 21 Placebo BID: 11	moderate-to-severe	52 (71.2)	43 ± 13.1	13 ± 8.9	24 ± 10.8	12
Mease 2023	IIb	Brepocitinib (oral)	10 mg QD: 31 30 mg QD: 60 60 mg QD: 60 Placebo QD: 67	moderate-to-severe	102 (46.8)	48 ± 11.6	6 ± 6.6*	11 ± 9.0**	52
Landis 2023	IIb	Brepocitinib (topical)	0.1% QD: 37 0.3% QD: 37 1.0% QD: 36 3.0% QD: 37 Vehicle QD: 37 0.3% BID: 36 1.0% BID: 36 3.0% BID: 38 Vehicle BID: 49	mild-to-moderate	241 (70.3)	50 ± 13.7	16 ± 12.6	7 ± 3.2	12
Forman 2020	IIa	Brepocitinib (oral)	Induction to maintenance dose 60 to 30 mg QD: 25 60 to 10 mg QD: 29 60 mg QD to 100 mg QW: 26 60 mg QD to placebo: 25 30 mg QD: 29 30 to 10 mg QD: 25 30 mg QD to 100 mg QW: 30 Placebo: 23	moderate-to-severe	148 (69.8)	46 ± 13.0	18 ± 13.0	21 ± 7.7	12
NCT02310750 2017	I	Brepocitinib (oral)	30 mg QD: 14 100 mg QD: 7 Placebo QD: 9	moderate-to-severe	27 (90.0)	40 ± 14.4	N/A	24 ± 8.0	8

Table 1. Baseline characteristics of patients in the included studies. Abbreviations: BID: twice daily; JAK1: Janus kinase 1; N/A, not available; PASI: Psoriasis Area and Severity Index; **reported for participants with body surface area ≥3% and PASI >0 at baseline; PsA: psoriatic arthritis; *PsA duration; QD: once daily; QW: once weekly; TYK2: tyrosine kinase 2.

Conclusions

In conclusion, our study indicates that TYK2 and JAK1 inhibitors are effective for treating plaque psoriasis. These inhibitors significantly improved PASI scores, particularly at week 12 and with higher doses, with some differences observed between oral and topical administration. No significant differences were observed for TEAEs, including SAEs and infections, and infestations. Further research is needed to clarify long-term outcomes, optimize dosing and administration routes, and identify patient subgroups most likely to benefit.

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Abstract N°: 3381

Real-world data assessing the efficacy and tolerability of deucravacitinib and apremilast: A retrospective, single-centre observational study

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Introduction

Apremilast and deucravacitinib are oral systemic therapies for moderate-to-severe psoriasis. Apremilast is a phosphodiesterase 4 inhibitor (PDE4) and deucravacitinib is a tyrosine kinase 2 (TYK2) inhibitor. These drugs are typically prescribed to patients after the failure or contraindication of topical treatments, UV therapy, and methotrexate. The patient may not meet the criteria for biologic therapy, or may prefer an oral medication. While randomised controlled trials have demonstrated the efficacy and safety profiles of both drugs, real-world treatment outcomes may differ due to variations in patient populations, comorbidities, and prior treatments. We conducted a single-centre observational study to assess the safety and efficacy of apremilast and deucravacitinib in a real-world cohort.

Materials and Methods

In this retrospective, single-centre observational study, appointment records and clinical letters from 2015 to 2026 were searched systematically. Records were identified by searching for ‘apremilast’, ‘deucravacitinib’ and respective brand names.

Data were extracted for two years from treatment initiation or until the cessation of treatment if earlier. The primary outcome extracted was treatment efficacy assessed as the change in Psoriasis Area and Severity Index (PASI) score at 6, 12, 18, and 24 months. Tolerability was assessed by recording the time on medicine and reported side effects. Patient characteristics were recorded and analysed to identify predictors of response to apremilast treatment.

Results

53 patients who had taken apremilast were identified. Of these, 13 subsequently received deucravacitinib. The mean duration of apremilast treatment was 14.0 months. 28 patients (52.8%) were female, and the mean age was 53.5 years. Most patients were of North West European ethnicity (52.8%), with other represented ethnicities being South and Central Asian (20.8%), Southern and Eastern European (15.1%), South East Asian (7.5%), North East Asian (1.9%), and Peoples of the Americas (1.9%).

The mean baseline PASI score in the cohort was 10.3. After six months of apremilast treatment, 23 patients (52.3%) achieved PASI 50 and of these 8 (18.2%) achieved PASI75. 29 patients reported side-effects, the majority (79%) of these being gastrointestinal. After two years, 18 patients (34.0%) remained on apremilast whilst 35 (66.0%) had switched to another medication. The most frequently cited reasons for stopping treatment

were side-effects (57.1%), lack of efficacy (57.1%) and financial difficulty (5.7%). Patients who remained on the drug after two years were significantly younger than those who switched (mean age 44.8 vs 53.5 years, p=0.0404, t-test) and more frequently female (66.7% vs 45.7%, $\chi 2=2.09$, p=0.148).

Conclusions

In our real-world cohort, apremilast showed moderate efficacy in the treatment of moderate-to-severe psoriasis. This cohort differed substantially from the ESTEEM trial population: our patients were more likely to be non-white and female, were older on average and had a lower baseline PASI score. Despite these differences, a similar proportion of patients achieved a 50% reduction in PASI score within six months. This supports the use of apremilast in broad patient cohorts.

Around one-third of patients remained on apremilast after two years whilst other patients switched drugs mostly due to side effects and lack of efficacy. We identified that younger patients are more likely to remain on treatment after two years. Further data in larger cohorts may identify further factors that predict patient responses to apremilast treatment and inform clinical decision making.

As the cohort size was insufficient to assess the long-term effectiveness and tolerability of deucravacitinib in routine clinical practice, further follow-up is required. Overall, this study supports the use of apremilast as an oral, systemic, non-biologic therapy for patients who are unsuitable or ineligible for biologic therapy.

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Follow - up of patients with plaque psoriasis and chronic kidney disease in stage 5 during secukinumab therapy

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Introduction

Plaque psoriasis is one of the most common skin diseases, while chronic kindney disease is common comorbility. There is an intensive development of new psoriasis therapies, especially in the field of biological therapies and small molecules. Biological drugs are relatively new drugs, taking into account the experience with classic therapies such as methotrexate, acitretin or cyclosporine. Due to the increasing frequency of using biological therapies, the probability of encountering difficult clinical situations is also higher. In this paper we will discuss 4 cases of patients with chronic kindey disease in stage 5 treated with secukinumab. Two patient was after kidney transplant and two patients were on dialysis. There are not many reports in the literature about patients diagnosed with end-stage renal disease during biological therapy. Such cases should be described to spread knowledge.

Case Presentation

In this paper, we will present the cases of 4 patients treated with secukinumab for plaque psoriasis who were diagnosed with chronic kidney disease in stage 5. In one patient, biologic therapy was initiated after kidney transplantation, and in another, the transplantation was performed during secukinumab therapy. The remaining patients are on dialysis, one of whom started dialysis before biologic therapy and the other patient during biologic treatment. Patients were 50 - 63 years old at the time of start biologic treatment. There were 3 males and 1 female. The observation period up to the time of writing this paper was 7 - 58 months. Patients remained under nephrological and dermatological care. The efficacy and safety of secukinumab therapy were monitored.

In all cases, secukinumab was highly effective in reducing psoriatic lesions. In patients who started renal replacement therapy while on biologic therapy, a gradual deterioration of renal function was observed until dialysis or kidney transplantation was required. Patients undergoing renal replacement therapy at the time of initiation of biological therapy were in a stable condition during dermatological treatment. One patient after renal transplant died during secukinumab. The cause of death could not be clearly identified.

Conclusion

Based on the presented cases, secukinumab is highly effective in the treatment of psoriasis in patients on dialysis and after kidney transplantation. Due to the small number of patients with end-stage renal disease, prognosis regarding the safety of the therapy should be cautious

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Abstract N°: 3385

Psoriasis with Superimposed Mosaicism: Unveiling a Rare Phenotypic Presentation

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Introduction

Psoriasis is a chronic immune-mediated inflammatory dermatosis with a strong genetic background. Rare cases showing a pronounced linear arrangement along Blaschko's lines have been interpreted through the concept of cutaneous mosaicism. Superimposed mosaicism refers to accentuated segmental lesions arising on a background of more generalized non-segmental disease. We report an uncommon presentation of plaque psoriasis with striking Blaschko-linear involvement and associated psoriatic arthritis.

Case Presentation

A 40-year-old man presented with a 6-month history of erythematous scaly plaques over the upper limbs. The lesions had initially appeared in a linear pattern over both arms and progressively extended from the upper arms to the fingers. He also complained of pain and stiffness affecting the involved fingers. There was no relevant family history of psoriasis or autoimmune disease. Prior treatment with methotrexate, apremilast, ciclosporin and potent topical corticosteroids had produced unsatisfactory control.

Cutaneous examination revealed well-defined erythematous scaly plaques distributed linearly along Blaschko's lines on both upper limbs, with the segmental lesions being more prominent than the scattered typical psoriatic plaques present over the trunk and lower limbs. The affected fingers showed swelling, tenderness and restricted movements. Routine hematological and biochemical investigations were within normal limits. Rheumatoid factor and anti-cyclic citrullinated peptide antibodies were negative, while inflammatory markers were mildly elevated. Histopathological examination of a linear plaque demonstrated hyperkeratosis, parakeratosis, acanthosis and Munro microabscesses, consistent with psoriasis.

Based on the coexistence of generalized plaque psoriasis with markedly accentuated Blaschko-linear lesions, a diagnosis of psoriasis with superimposed mosaicism was made. The associated inflammatory small-joint symptoms were clinically consistent with psoriatic arthritis. The patient was started on oral tofacitinib 5 mg twice daily, along with adjunctive topical calcipotriol and clobetasol propionate, non-steroidal anti-inflammatory drugs and physiotherapy. At 3 months, there was clear improvement in both cutaneous disease and joint symptoms, with partial regression of the linear plaques.

Conclusion

Psoriasis exhibiting superimposed mosaicism is rarely described. The present case illustrates how a postzygotic event in genetically susceptible skin may produce segmental lesions that are more pronounced than the background non-segmental disease. Recognition of this pattern is clinically relevant, as Blaschko-linear psoriasis may be mistaken for other linear inflammatory dermatoses such as inflammatory linear verrucous epidermal nevus or linear lichen planus. The concurrence of segmental cutaneous disease and psoriatic arthritis further adds to the distinctiveness of this presentation. This case underscores the value of careful pattern recognition, clinicopathological correlation and individualized therapeutic planning in atypical psoriasis.

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Abstract N°: 3386

Vitamin D Receptor Variants in Psoriasis Vulgaris Susceptibility and Clinical Phenotype: Data from a Greek cohort

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Introduction

Psoriasis vulgaris (PsV) is a complex immune-mediated disease with a polygenic background. Common variants in the vitamin D receptor (*VDR*) gene have been investigated in psoriasis, but findings remain inconsistent and Greek-specific data are scarce. This study aimed to explore potential associations of the *VDR* FokI (rs2228570), BsmI (rs1544410) and TaqI (rs731236) variants with PsV susceptibility and clinical phenotype in a Caucasian Greek cohort.

Materials and Methods

This observational cross-sectional study included 1015 unrelated Greek subjects, comprising 203 PsV cases and 812 age-, sex- and ethnicity-matched controls (case-control ratio 1:4). Genotyping of the selected *VDR* variants was performed by real-time PCR (melting-curve analysis). Statistical analyses were conducted under dominant, recessive, overdominant and allelic genetic models to calculate odds ratios (ORs) with 95% confidence intervals (CIs), while false discovery rate (FDR) correction was applied to adjust for multiple testing.

Results

After FDR correction, the BsmI variant remained significantly associated with PsV susceptibility in both the recessive (AA vs. GA + GG: OR 0.577; 95% CI 0.386-0.861; adjusted p=0.028) and allelic (A vs. G: OR 0.765; 95% CI 0.614-0.953; adjusted p=0.032) models. The AA genotype and A allele of BsmI were less common in PsV cases compared with controls (16.75% vs. 25.86% and 43.10% vs. 49.75%, respectively), suggesting a protective effect against PsV. No impact on PsV risk was observed for FokI or TaqI. Intra-patient analyses based on clinical traits indicated phenotype-specific associations: FokI correlated with early-onset and familial disease, TaqI with psoriatic arthritis, and both BsmI and TaqI with nail involvement.

Conclusions

To our knowledge, this is the first study to investigate *VDR* FokI (rs2228570), BsmI (rs1544410) and TaqI (rs731236) in relation to PsV in a Greek population. Our findings suggest that BsmI may contribute to disease susceptibility, while the studied variants may influence major clinical traits, including age at onset, nail or joint involvement and familial clustering of PsV. Thus, the *VDR* locus may warrant further evaluation as a population-

specific biomarker for tailored risk stratification and clinical profiling in PsV. Further large-scale studies in ethnically diverse cohorts are needed.

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Abstract N°: 3388

Balancing Biologic Therapy and Tuberculosis Prophylaxis in Psoriasis: A Case of Suspected Ixekizumab–Isoniazid Cross-Reaction

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Introduction

Familial type II psoriasis vulgaris is a chronic immune-mediated inflammatory skin disease characterized by late onset and a strong genetic predisposition. Biologic agents targeting the IL-17 pathway have demonstrated high efficacy, leading to their increasing use in the management of moderate-to-severe psoriasis; however, concomitant therapies and infectious disease prophylaxis may increase the risk of adverse drug reactions. This report describes a patient with psoriasis who developed suspected cross-reactivity between ixekizumab and isoniazid during tuberculosis prophylaxis.

Case Presentation

We present the case of a 68-year-old Caucasian female, active smoker, diagnosed with familial type II psoriasis vulgaris, with disease onset 20+ years prior to presentation. The patient had no articular involvement and had previously received multiple topical therapies with insufficient response and rebound following discontinuation. Clinical examination revealed moderate-to-severe psoriasis with generalized guttate and nummular lesions, inverse psoriasis lesions, and severe scalp involvement. Screening prior to biologic therapy revealed a positive QuantiFERON-TB Gold test, necessitating prophylactic treatment with isoniazid before initiation of biologic therapy. The patient was biologic-naïve prior to ixekizumab initiation. Additional investigations showed positive HBsAg with undetectable HBV-DNA viral load, and gastroenterology clearance was obtained for biologic therapy initiation under periodic laboratory monitoring. The patient was also receiving chronic treatment with perindopril/indapamide, sibutramine, and acetylsalicylic acid as part of her cardiovascular management.

Treatment with ixekizumab was initiated with a loading dose of 160 mg. Within 24 hours, the patient developed an eczematous eruption involving the anterior and posterior thorax, suggestive of an allergic drug reaction associated with concomitant ixekizumab and isoniazid administration. Following multidisciplinary evaluation involving a pulmonologist, ixekizumab was temporarily discontinued for three months pending completion of isoniazid treatment. Despite receiving only the initial dose, the patient achieved approximately 70% remission of psoriatic lesions. After completion of tuberculosis prophylaxis, ixekizumab therapy was successfully reintroduced without recurrence of adverse reactions. At reevaluation, the patient demonstrated approximately 90% remission of cutaneous lesions, with good tolerability and no further adverse events reported.

Conclusion

This case highlights the therapeutic challenges associated with biologic treatment in patients requiring concomitant tuberculosis prophylaxis. The occurrence of a suspected ixekizumab–isoniazid cross-reaction emphasizes the importance of close monitoring, particularly in the first hours following biologic initiation, multidisciplinary management and individualized therapeutic decision-making in patients with psoriasis. Reintroduction of ixekizumab after discontinuation of isoniazid proved safe and effective, leading to sustained

clinical improvement.

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Abstract N°: 3400

Biologic Therapy in Psoriasis Patients with Concomitant Malignancy: A Brazilian Tertiary Care Center Observational Study

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Introduction

Psoriasis is a chronic immune-mediated disease driven by TNF-α, IL-17, and IL-23 pathways. Although biologic agents targeting these cytokines have transformed treatment, their oncologic safety remains uncertain because of their role in antitumor surveillance (1,2,4). Given the increasing use of biologics and limited long-term evidence, further research on malignancy risk is needed.

Materials and Methods

We conducted a retrospective observational study including adult patients followed at a tertiary dermatology center between 2004 and 2026 who developed cancer while receiving biologic therapy or initiated biologic treatment during active cancer. Data were collected from medical records.

Results

We observed five male patients. Four were already receiving biologic therapy at the time of malignancy diagnosis, whereas one initiated biologic treatment during oncological care. Patient 1 had prostate cancer, patient 2 had non-melanoma skin cancer, patient 3 had colon cancer, patient 4 had soft-tissue sarcoma, and patient 5 had hepatocellular carcinoma. The mean age at cancer diagnosis was 61.8 years, and the mean time since psoriasis diagnosis was 14.8 years.

Patients 2 and 4 had prior phototherapy, and all five had previously used systemic immunosuppressants before their current biologic. At cancer diagnosis, patients 1 and 2 were receiving ustekinumab (anti-IL-12/23), patients 3 and 4 were receiving anti-TNF agents (adalimumab and infliximab, respectively), and patient 5 initiated secukinumab (anti-IL-17) during active cancer. Management varied across cases: patients 1 and 3 discontinued biologic therapy, with patient 1 resuming treatment one year later; patients 2 and 4 maintained treatment; and patient 5 continued biologic therapy throughout oncologic care.

Patient ID	Age at Cancer	Psoriasis to Cancer (Years)	Phototherapy	Biological Agent	Previous Treatments
Patient 1	62	9	No	Ustekinumab	Infliximab, Acitretin, Methotrexate
Patient 2	59	19	Yes	Ustekinumab	Acitretin
Patient 3	62	27	No	Adalimumab	Acitretin, Methotrexate
Patient 4	56	15	Yes	Infliximab	Methotrexate
Patient 5	70	4	No	Secukinumab	Methotrexate

Table 1 Cancer diagnosis in Psoriasis Patients Under Biological Therapy

Conclusions

The relationship between psoriasis and malignancy remains uncertain. Psoriasis is associated with a chronic systemic inflammatory state driven by TNF-α, IL-17, and IL-23 pathways, and the potential for these cytokines to modulate antitumor immune surveillance has raised safety concerns about long-term biologic use. In our case series, the mean age at cancer diagnosis and the tumor spectrum observed were consistent with hospital-based cohorts of psoriasis patients, in which malignancies are more frequent in older patients and commonly include skin, colorectal, lung, and other solid tumors (1,3).

A key finding was the history of previous systemic immunosuppression and phototherapy in all five patients. This is relevant because NMSC risk in psoriasis has been linked to cumulative exposure to phototherapy and conventional immunosuppressants rather than to biologic agents alone (6,1). Systematic reviews and meta-analyses, including Vaengebjerg et al. (2020) (8), have shown that biologic therapies do not independently increase the risk of overall malignancy compared with conventional treatments, supporting their long-term clinical use.

Our findings also reflect the challenges of managing biologics during cancer treatment. Although guidelines recommend case-by-case evaluation rather than absolute contraindications, our cases underscore the lack of standardized protocols. Outcomes varied from treatment maintenance to discontinuation, illustrating a shift toward patient-centered decision making (5).

The role of IL-17 and IL-23 inhibition in tumor physiology remains conflicting, as the IL-17 axis may contribute to both pro-tumorigenic mechanisms and antitumor responses (4). Our study also highlights the limitations of randomized clinical trials, which often exclude patients with active or pre-existing neoplasms, leaving an important gap in safety data (7). Although the small sample size precludes statistical inference, these real-world data are valuable for filling this gap. Future longitudinal studies with larger cohorts are needed to validate these findings and provide clearer clinical guidance for psoriatic patients with malignant conditions.

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Abstract N°: 3422

Real-World Outcomes of Bimekizumab in Severe Chronic Plaque Psoriasis: Drug Survival, Treatment Switching and Adverse Events

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Introduction

Chronic Plaque Psoriasis (CPP) is a chronic inflammatory skin disease associated with substantial patient and healthcare burden. Bimekizumab, a dual interleukin-17A/17F inhibitor recently listed on the Australian Pharmaceutical Benefits Scheme (PBS) in 2023 for CPP management, has demonstrated high efficacy in moderate-to-severe disease. However, evidence of its long-term real-world effectiveness remains limited. Although a small number of international studies exist, none have been conducted in Australia. This study aimed to investigate drug survival of Bimekizumab and identify predictors of survival rates in patients with severe CPP.

Materials and Methods

This retrospective observational study included adult patients with severe CPP who initiated Bimekizumab in a tertiary dermatology outpatient clinic in Australia. Data was collected from electronic medical records. Drug survival was analysed using Kaplan-Meier estimates, with reasons for discontinuation examined. Univariable and multivariable Cox proportional hazards regression analyses were performed to identify predictors of treatment discontinuation.

Results

A total of 43 with patients were included (53% male; mean age 50.1, SD 13.7). At baseline, the median PASI score was 20.4 (IQR 16.8-29.0), and 65% of patients had concomitant psoriatic arthritis (PsA). Estimated drug survival rates at 26, 52, and 104 weeks were 91.7%, 84.6%, and 80.4%, respectively. Overall, six patients discontinued treatment, primarily due to lack of efficacy (n=3) and candidiasis-related adverse events (n=2) (Figure 1). At data lock, 91% of patients remained on Bimekizumab therapy. Treatment line, PsA, age, sex, and baseline PASI were not significantly associated with treatment discontinuation.

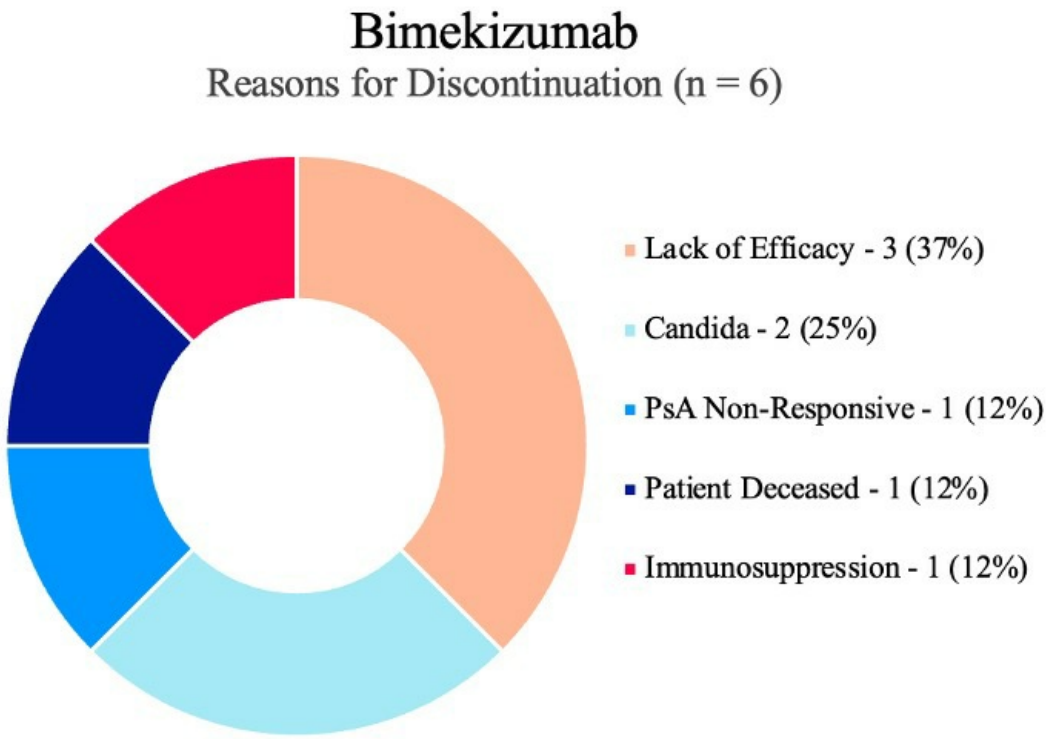

Figure 1: Reasons for Bimekizumab discontinuation

Conclusions

Bimekizumab demonstrated high drug survival rates in this Australian real-world cohort of patients with severe CPP (Figure 2). These findings provide important insights into treatment persistence and barriers to sustained therapy in routine clinical practice. Larger longitudinal studies are required to validate these findings and further identify predictors of treatment discontinuation, helping optimise biologic selection and long-term disease management.

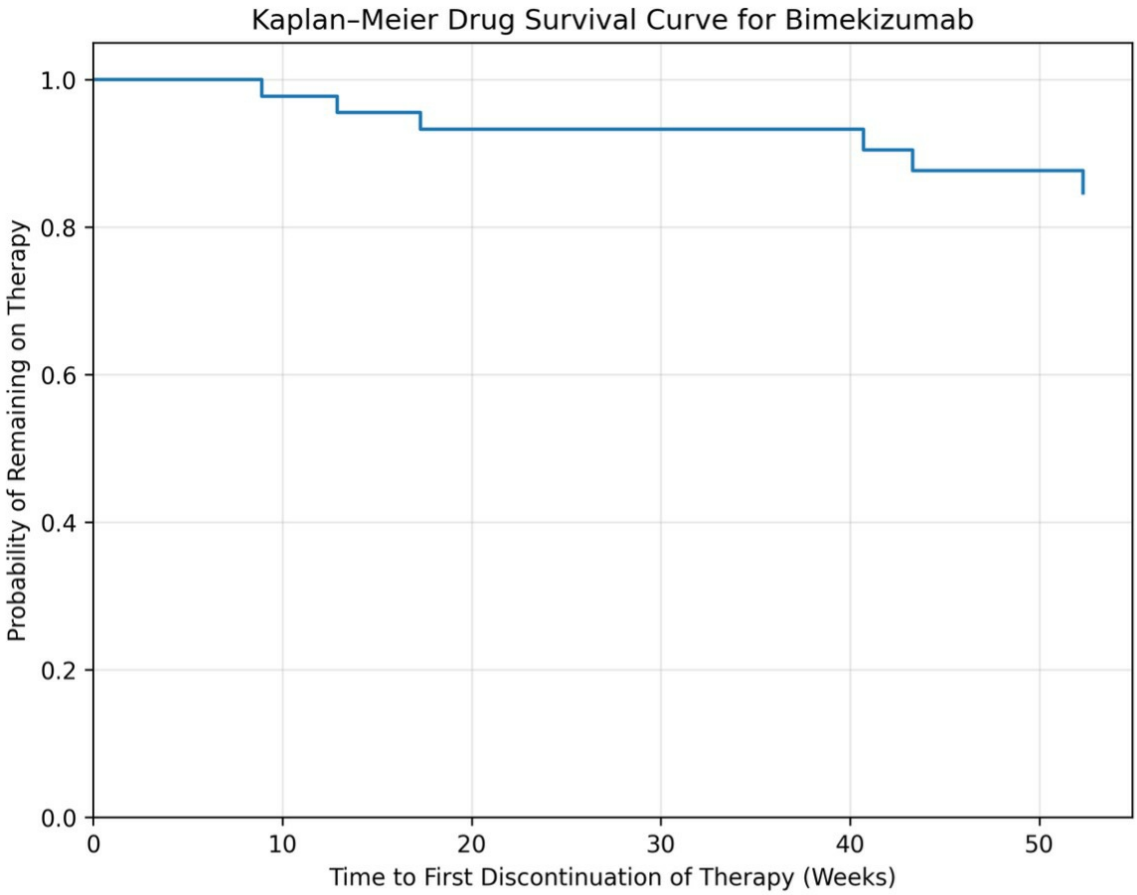

Figure 2: Kaplan-Meier drug survival curve for Bimekizumab

EADV CONGRESS
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Abstract N°: 3423

Psoriasis Induced by Immune Checkpoint Inhibitors: Lessons Learned from Our Clinical Practice

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Introduction

Immune checkpoint inhibitors (ICIs) have significantly improved survival across multiple malignancies, but their immune-activating mechanism predisposes patients to immune-related adverse events (irAEs), which may impair quality of life and require treatment modification or discontinuation. Among these, psoriasis and psoriatic arthritis are increasingly recognized, occurring either de novo or as exacerbations of pre-existing disease during ICI therapy. Their management remains challenging, as treatment strategies must effectively control inflammation while preserving antitumor efficacy. This study reviews current evidence regarding ICI-induced or exacerbated psoriasis, presents our institutional experience, and discusses pathogenic mechanisms and therapeutic approaches.

Case Presentation

We report five patients who developed psoriasis during ICI therapy: three cases of de novo psoriasis and two cases representing exacerbation of prior disease. All patients required systemic treatment because of extensive or symptomatic disease. Oral acitretin achieved satisfactory control of cutaneous manifestations in three patients, allowing continuation of immunotherapy without apparent oncologic compromise.

To contextualize our findings, we performed a structured review of the literature using PubMed, Medline, and Google Scholar. Eighty publications comprising 1,102 patients with psoriasis and/or psoriatic arthritis associated with ICIs were identified. Extracted variables included malignancy type, ICI agent, psoriasis phenotype, articular involvement, personal or familial history, demographics, latency to onset, therapeutic interventions, ICI interruption, and clinical outcomes. The available data demonstrate considerable heterogeneity in presentation and management, while highlighting the increasing incidence of these complications in routine oncologic practice.

Conclusion

The growing number of reported cases underscores the importance of early recognition and prompt dermatologic intervention in patients receiving ICIs. In the absence of standardized guidelines, individualized therapeutic strategies that control psoriatic disease while maintaining antitumor immunity are essential in order to minimize unnecessary discontinuation of immunotherapy and preserve oncologic prognosis. Close multidisciplinary collaboration between oncologists and dermatologists is critical to balance risks and benefits, monitor toxicity, optimize adherence, and improve both survival and quality of life in these complex patients.

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Abstract N°: 3426

Assessment of IL-23/Th17 Pathway Activity and Its Association with Ustekinumab Treatment Response in Patients with Psoriasis: A 52-Week Prospective Study

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Introduction

Psoriasis is a chronic immune-mediated inflammatory disease in which the IL-23/Th17 pathway has a central role in disease development and persistence. Activation of this pathway promotes Th17-cell differentiation and increases the production of pro-inflammatory cytokines, particularly IL-17A, contributing to epidermal hyperproliferation and the formation of psoriatic plaques. Ustekinumab targets the shared p40 subunit of IL-12 and IL-23 and is used for the treatment of moderate-to-severe plaque psoriasis. This study aimed to assess the association between changes in IL-23/Th17 pathway activity and clinical response to ustekinumab therapy over 52 weeks.

Materials and Methods

This prospective study included 20 patients with moderate-to-severe plaque psoriasis. The cohort consisted of 14 men and 6 women, aged 21–58 years, with a mean age of 36.8 ± 9.4 years. All patients received ustekinumab according to the standard dosing schedule: at week 0, week 4, and then every 12 weeks. Disease severity was assessed using the Psoriasis Area and Severity Index at baseline and at weeks 13, 26, and 52. Serum IL-23 and IL-17A concentrations were measured using enzyme-linked immunosorbent assay. PASI75 and PASI90 response rates were calculated, and the relationship between cytokine changes and PASI improvement was evaluated using correlation analysis.

Results

The baseline mean PASI score was 18.4 ± 4.2, indicating moderate-to-severe disease activity. During ustekinumab therapy, PASI scores decreased progressively to 9.6 ± 3.1 at week 13, 5.1 ± 2.4 at week 26, and 2.7 ± 1.8 at week 52. PASI75 response was achieved by 55% of patients at week 13, 70% at week 26, and 85% at week 52. At the end of follow-up, 40% of patients achieved PASI90. Reductions in serum IL-23 and IL-17A levels showed a moderate positive correlation with PASI improvement ($r = 0.62$; $p < 0.05$).

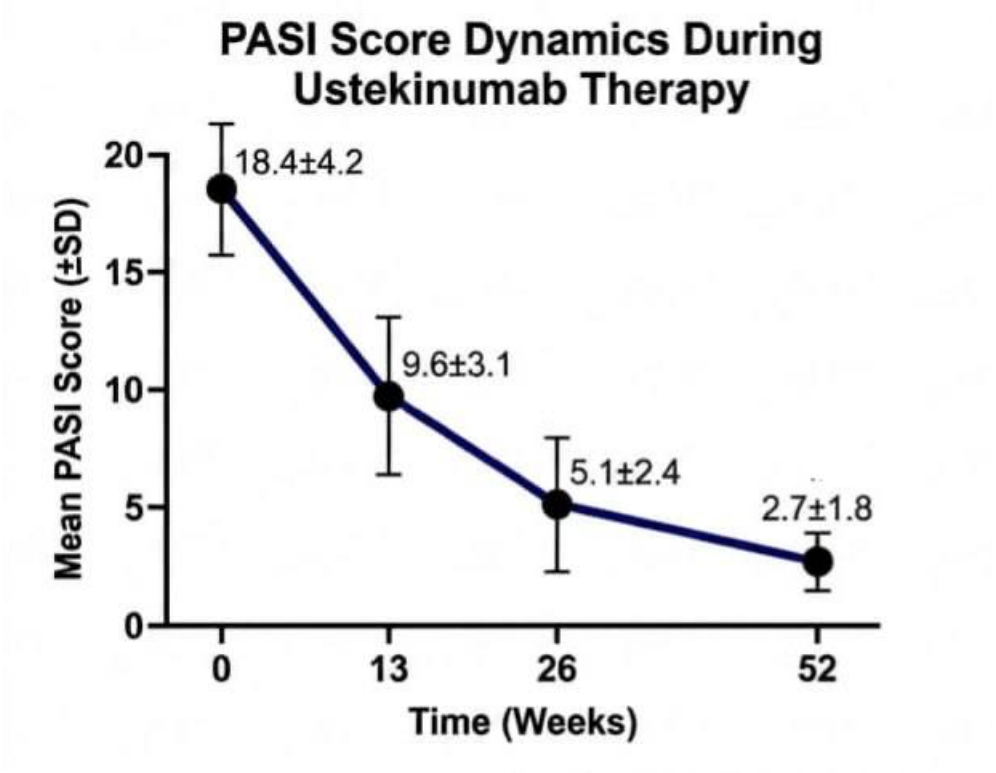

Figure A. PASI score dynamics during 52 weeks of ustekinumab therapy. Data are presented as mean ± SD. $p < 0.05$ versus baseline. Statistical analysis was performed using repeated-measures ANOVA with Dunnett's post hoc test.

Conclusions

Ustekinumab therapy was associated with a sustained reduction in disease activity in patients with moderate-to-severe plaque psoriasis over 52 weeks. The parallel decrease in IL-23 and IL-17A levels and PASI scores supports the clinical relevance of the IL-23/Th17 pathway in psoriasis. These cytokines may be useful biomarkers for monitoring treatment response and may help improve individualized assessment of biologic therapy effectiveness.

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Abstract N°: 3442

Cross-regional comparison of dermatologist perceptions of psoriasis treatment, emerging pipeline therapies, and unmet needs in Europe and the United States.

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Introduction

The treatment landscape for moderate-to-severe psoriasis (PsO) continues to evolve with expanding biologic options and emerging oral therapies. Understanding regional differences in physician perspectives is critical to future adoption.

Objectives: This study evaluated cross-regional differences in dermatologist perceptions of treatment drivers, unmet needs, and emerging pipeline therapies, including the oral IL-23R targeted oral peptide icotrokinra, across Europe and the United States.

Materials and Methods

Cross-sectional surveys of dermatologists were conducted in the EU5 (France, Germany, Italy, Spain, UK; n=250) and in the United States (n=101) between January and March 2026. Eligible physicians managed ≥50 PsO patients and prescribed advanced systemic therapies. The surveys assessed treatment preferences, prescribing drivers, and perceptions of emerging pipeline therapies.

Results

Across both regions, the psoriasis treatment landscape is increasingly dominated by IL-23 inhibitors, with risankizumab emerging as the leading biologic, largely at the expense of adalimumab and ustekinumab. In the US, risankizumab leads across all lines of therapy, whereas in the EU5 later-line use remains more distributed, with bimekizumab approaching risankizumab in third-line share (14% vs 15%). Bimekizumab is gaining momentum in both regions, accounting for 6% and 9% of adult biologic-treated patients in the US and EU5, respectively, with further growth anticipated.

Regarding oral therapies, deucravacitinib garners slightly greater share in Europe; however, 20% of EU5 physicians cite efficacy as a barrier to its use, a figure that has increased. Approximately two-thirds of US dermatologists report gaps in current treatment options, particularly for efficacious oral therapies, highlighting a greater unmet need.

Awareness of emerging therapies is high in both regions, with 76% and 63% of EU and US dermatologists reporting awareness of pipeline agents. Although now approved in the US following data collection, icotrokinra is consistently identified as the leading pipeline agent, with the highest levels of familiarity, interest, and likelihood to prescribe. Perceptions are stronger in the US, where 65% of dermatologists rank it as the top agent for approval compared with 46% in Europe, likely reflecting its earlier approval. EU physicians anticipate positioning icotrokinra primarily as a second-line therapy, preferred over apremilast and deucravacitinib, with approximately half of dermatologists indicating intent to initiate within the first three months of availability. Additional oral therapies are in late-stage development, with simepdekinra (oral IL-17 inhibitor) ranking second to icotrokinra on interest, likelihood to prescribe, and approval preference across regions.

Conclusions

While dermatologists' perceptions of psoriasis treatment are broadly aligned across Europe and the US, with IL-23 inhibitors dominating treatment paradigms and continued growth of bimekizumab, notable regional differences remain. Risankizumab is more dominant across treatment lines in the US, while later-line treatment in Europe is more competitive. Unmet need for oral therapies is also greater in the US. Across regions, icotrokinra is viewed as the leading emerging oral therapy, reflecting demand for more efficacious non-injectable options and a potential shift in treatment paradigms.

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Abstract N°: 3464

Refractory Palmoplantar Keratoderma with Lichenoid Epidermotropism: Unmasking Beta-Blocker–Induced Resistance

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Introduction

Palmoplantar keratoderma (PPK) can be chronic, treatment-resistant, and multifactorial. Drug-induced exacerbations are often under-recognized. This case illustrates a rare overlap of psoriatic and lichenoid histopathology, complicated by topical beta-blocker therapy for glaucoma.

Case Presentation

A 74-year-old patient with a 6-year history of gaucoma treated with beta-blockers presented with diffuse and fissured palmoplantar keratoderma that had been evolving for 7 years, resistant to topical corticosteroids and balneotherapy. The condition progressed to the development of pruritic erythematosquamous lesions, infiltrated in places on the trunk, back, and limbs (BSA < 5%). Multiple skin biopsies were performed to establish a diagnosis. The plantar fragment was consistent with psoriatic palmoplantar keratoderma, while all the body fragments were consistent with lichenoid dermatitis with epitheliotropism. Immunohistochemical analysis was negative on all fragments.

Initial management consisted of a preparation based on topical corticosteroids and keratolytics applied using wet-wrapping, with discontinuation of balneotherapy. The two-day follow-up was spectacular, with a marked regression of clinical signs. Pharmacological investigation implicated beta-blocker eye drops as a factor in treatment resistance; these were switched to another antiglaucoma medication by the ophthalmologists. Given the severity of this form of psoriasis and the presence of epidermotropism in the histopathological examination of the lesions suggestive of an early mycosis fongoides, methotrexate (MTX) was initiated.

Conclusion

Our case report shows that refractory PPK may be induced by topical drugs, especially beta-blockers. Histopathological evaluation can reveal overlapping disease processes requiring tailored therapy. Wet-wrapping dressings must be considered to improve the clinical discomfort in PPK. Multidisciplinary care and prompt modification of contributing medications can result in dramatic clinical improvement.

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Abstract N°: 3472

Real-World Effectiveness of Guselkumab in Psoriasis: Impact of Previous Anti-IL-17 Exposure

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Introduction
The efficacy and safety of guselkumab have been demonstrated in patients with moderate-to-severe plaque psoriasis.

Materials and Methods
This single-center retrospective study aimed to evaluate the effectiveness and safety of guselkumab treatment in real-world clinical practice among patients with moderate-to-severe plaque psoriasis.

Results
A total of 135 adult psoriasis patients were included in the study. Nail involvement was present in 33 patients (24.4%), psoriatic arthritis in 36 patients (26.7%), and at least one difficult-to-treat area involvement in 89 patients (65.9%). Eighty-five patients (63.0%) had a history of at least one biologic agent, while 27 patients (20.0%) had used ≥2 biologic agents previously. Prior history of anti-TNF agents was reported in 27 patients (20.0%), anti-IL-17 agents in 32 patients (23.7%), and anti-IL-23 agents in 4 patients (3.0%). The mean baseline PASI score was 11.5 ± 7.9. Mean PASI scores after treatment were 1.3 ± 2.0 at week 12, 0.67 ± 1.6 at week 28, 0.68 ± 2.0 at week 52, 0.16 ± 0.53 at week 76, and 0.23 ± 0.74 at week 100.

Comparisons performed using the Wilcoxon Signed-Rank test demonstrated a statistically significant reduction in PASI scores from baseline starting at week 12 ($p<0.001$). This improvement remained significant at weeks 28, 52, 76, and 100 (all $p<0.001$). While no significant differences were observed between weeks 12 and 28 or between weeks 28 and 52 ($p>0.05$), additional reductions in PASI scores were noted from week 28 to weeks 76 and 100 ($p=0.001$ and $p=0.013$, respectively). No significant difference was observed between weeks 76 and 100 ($p>0.05$).

At week 28, PASI75, PASI90, and PASI100 responses were achieved in 110 patients (88.7%), 98 patients (72.6%), and 93 patients (75.0%), respectively. The proportion of bio-naïve patients achieving PASI100 response (81.4%) was significantly higher than that of bio-experienced patients (62.7%) ($p=0.022$). Similarly, patients without prior anti-IL-17 exposure had significantly higher PASI100 response rates compared with those previously treated with anti-IL-17 agents (81.1% vs. 55.1%; $p=0.005$). In contrast, previous exposure to anti-TNF or anti-IL-23 agents did not result in a statistically significant difference ($p>0.05$).

Additionally, PASI100 response rates at week 28 were significantly higher in patients without diabetes mellitus (79.1% vs. 60.7%; $p=0.047$) and without hypertension (78.6% vs. 57.1%; $p=0.038$). The most common adverse events were upper respiratory tract infections (6.6%), candidiasis (4.4%), and herpes infections (4.4%). No statistically significant association was found between adverse event development and patients' sociodemographic or clinical characteristics.

Conclusions
Guselkumab is an effective and safe long-term biologic treatment for moderate-to-severe plaque psoriasis. Treatment response was found to be higher in bio-naïve patients and in those without previous anti-IL-17

exposure. This may be explained by the absence of biologic-induced alterations in the immune system, lack of residual inflammation within the IL-23/Th17 axis, and the possibility that patients previously treated with anti-IL-17 agents may have more treatment-resistant disease and cytokine imbalance, potentially reducing therapeutic response.

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Abstract N°: 3482

Bimekizumab Reduces Systemic Inflammatory Burden in Moderate-to-Severe Psoriasis: Real-World 52-Week Data from the Italian Landscape PSO Cohort

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Introduction
Psoriasis is increasingly recognized as a systemic inflammatory disease associated with cardiometabolic comorbidities and increased cardiovascular (CV) risk. The IL-17/23 axis plays a pivotal role not only in cutaneous inflammation but also in the development of endothelial dysfunction, atherosclerosis, and metabolic alterations. The systemic immune-inflammation index (SII), calculated from neutrophil, platelet, and lymphocyte counts, has emerged as a promising biomarker of systemic inflammatory burden and CV risk. However, real-world longitudinal data evaluating the impact of biologic therapies on SII in psoriasis remain limited. This study aimed to evaluate the effect of bimekizumab on systemic inflammatory burden over 52 weeks in patients with moderate-to-severe psoriasis.

Materials and Methods
We conducted a multicenter retrospective real-world study within the Italian Landscape PSO network including patients with moderate-to-severe plaque psoriasis treated with bimekizumab. Demographic and clinical characteristics, psoriasis severity indices, cardiometabolic comorbidities, and laboratory parameters were collected at baseline and during follow-up visits. SII was calculated using the formula: platelet count × neutrophil count / lymphocyte count. Mean SII values were assessed at baseline and Weeks 4, 16, 36, and 52. Subgroup analyses were performed according to the presence or absence of cardiometabolic comorbidities (CMDs). Correlations between baseline PASI and SII were also evaluated.

Number of Patients	**111**
	Mean ± SD
Age, years	51.78 ± 13.00
Disease duration, years	15.23 ± 12.71
BMI, kg/m²	25.41 ± 4.23
Baseline PASI	14.32 ± 7.87
	N (%)
Male	72 (64.86)
PsA	16 (14.41)
Difficult-to-treat areas	45 (40.54)
At least 1 CMD	50 (45.05)
Hypertension	37 (33.33)
Hyperlipidemia	26 (23.42)
Diabetes	15 (13.51)
MACE	7 (6.31)
Bio-naïve	40 (36.04)

Table 1. Baseline demographic and clinical characteristics of patients with moderate-to-severe psoriasis treated with bimekizumab in the Italian Landscape PSO real-world cohort.

Results

A total of 111 patients were included (mean age 51.8±13.0 years; 64.9% male). Mean disease duration was 15.2±12.7 years, mean baseline PASI was 14.3±7.9, and 45.0% of patients presented at least one cardiometabolic comorbidity. Psoriatic arthritis was reported in 14.4% of cases.

Bimekizumab induced rapid and sustained clinical improvement throughout the 52-week period, with mean PASI decreasing from 14.32 at baseline to 3.8 at Week 4, 1.25 at Week 16, and 0.69 at Week 52.

A progressive reduction in systemic inflammatory burden was also observed. Mean SII decreased from 511.7 at baseline to 466.3 at Week 4, 437.6 at Week 16, 436.0 at Week 36, and 410.9 at Week 52. Similar trends were observed both in patients without CMDs (baseline: 483.8; Week 52: 407.9) and in patients with CMDs (baseline: 520.9; Week 52: 413.9), suggesting a sustained reduction in systemic inflammation irrespective of baseline cardiometabolic status.

Interestingly, no significant correlation was observed between baseline PASI and SII, supporting the concept that cutaneous severity alone may not fully reflect systemic inflammatory burden in psoriasis.

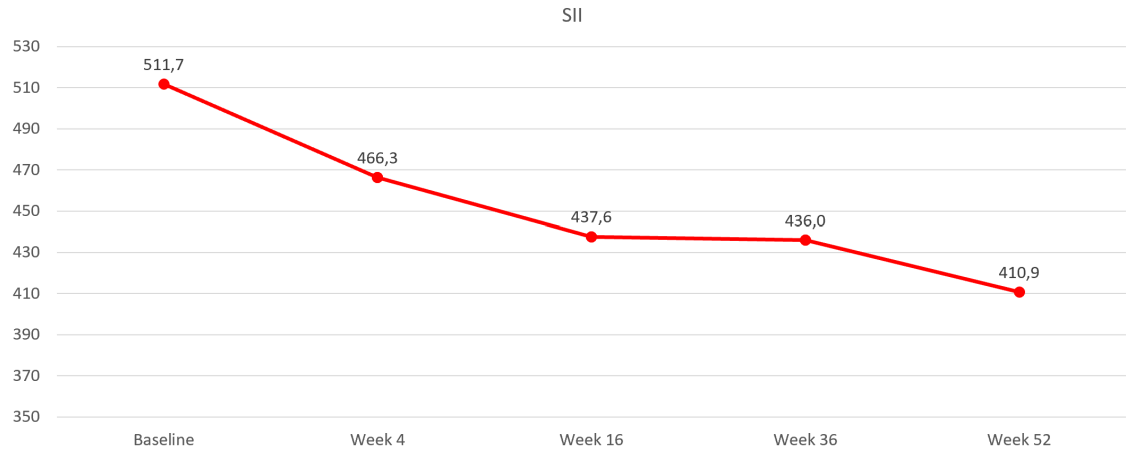

Figure 1. Progressive reduction in systemic immune-inflammation index (SII) during 52 weeks of bimekizumab treatment, suggesting a sustained decrease in systemic inflammatory burden.

Conclusions

In this real-world multicenter cohort, bimekizumab demonstrated rapid and sustained effectiveness in moderate-to-severe psoriasis together with a progressive reduction in systemic inflammatory burden as assessed by SII. These findings further support the concept of psoriasis as a systemic inflammatory disease and suggest that dual IL-17A/F inhibition may positively modulate inflammatory pathways potentially linked to cardiovascular risk. The absence of correlation between PASI and SII highlights the importance of integrating systemic inflammatory biomarkers into psoriasis assessment. Larger prospective studies are warranted to clarify the long-term impact of IL-17A/F inhibition on cardiovascular outcomes and systemic inflammation.

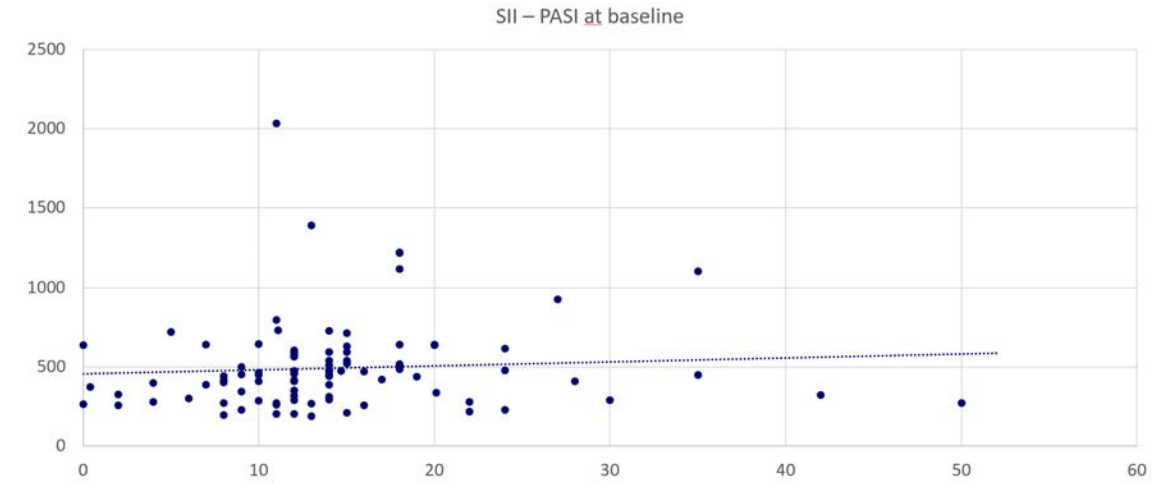

Figure 2. Correlation analysis between baseline PASI and SII values. No significant association was observed, supporting the concept that cutaneous severity may not fully reflect systemic inflammatory burden in psoriasis.

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Abstract N°: 3488

Real-World Treatment Patterns of Advanced Systemic Therapies in Psoriasis: A Spanish Multicentre Cohort (2020–2025)

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Introduction

Real-world data (RWD) provide important insights into how advanced systemic therapies (AST) are used in routine clinical practice. We aimed to describe patient characteristics, healthcare utilisation, and treatment patterns of ASTs in psoriasis using RWD from a Spanish hospital network applying the LOGEX EU Imune Mediated Inflammatory Diseases (IMID)-Observatory.

Materials and Methods

A retrospective observational study was conducted using routinely collected data from electronic health records, pharmacy records, and administrative databases across 8 Spanish hospitals, mapped to the OMOP common data model. Adult patients with a diagnosis of psoriasis who initiated any AST between 1 January 2020 and 1 July 2025 were included. Patients <18 years or receiving combination ASTs were excluded. Baseline characteristics were described per AST class (TNF-α, PDE-4, IL-12/23, IL-17, IL-23, TYK-2 inhibitors), including sex, age, socioeconomic status, body weight, treatment start year, and baseline Psoriasis Area and Severity Index(PASI). During-treatment hospital-related visits to dermatology, rheumatology, and gastroenterology departments were assessed.

Results

Among 11,103 psoriasis patients, 5,584 (50.3%) had ≥1 AST exposure; 3,930 initiated AST for the first time since 2020. The most frequently used AST classes were TNF-α inhibitors (n=1,784), IL-17 inhibitors (n=1,020), and IL-23 inhibitors (n=900). Year over year increase of IL-17 inhibitors and a decrease of TNF- α inhibitors is seen. See Figure 1. Mean age at treatment initiation ranged from 49 to 56 years, and from the patients with known sex 47.1% of patients were female. Mean body weight was comparable across classes (≈81–86 kg). Baseline PASI scores indicated mainly moderate disease (overall mean 9.8). From 2020 to 2025, the relative use of IL-12/23 inhibitors declined slightly (13% to 11%), while IL-17 and IL-23 inhibitors together accounted for approximately half of all AST starts in later years. Treatment sequence analyses showed frequent class switching, most commonly

from TNF-α inhibitors to IL-17 or IL-23 inhibitors. During treatment, rheumatology visits were common (20–34% across classes), dermatology visits occurred in 50–77% of patients, and gastroenterology visits in 11–20%.

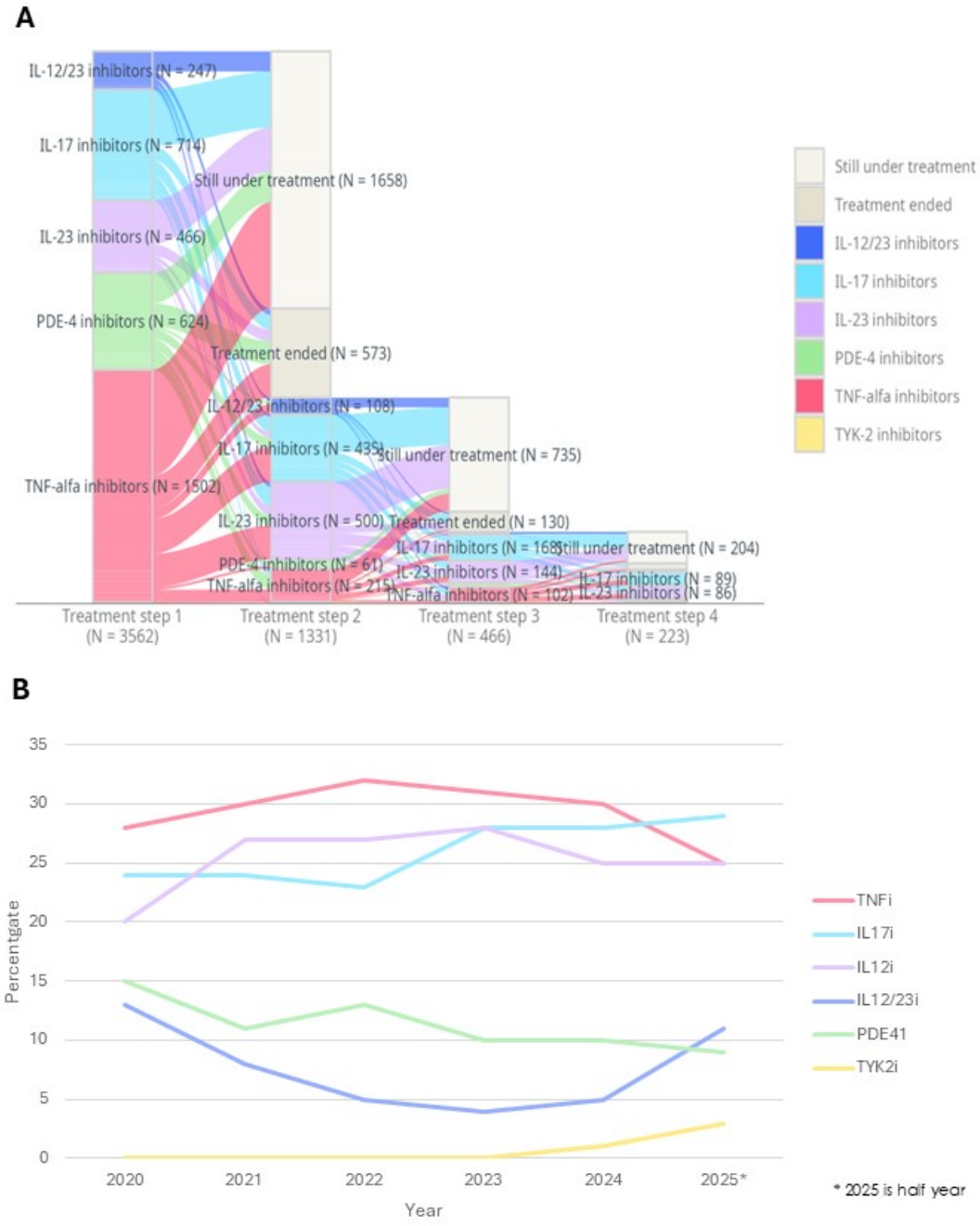

Figure 1: **A:** Advanced systemic therapy treatment sequence in PsO. **B:** Year-over-Year advanced systemic therapy initiation in PsO

Figure 1: A: Advanced systemic therapy treatment sequence in PsO. B: Year-over-Year advanced systemic therapy initiation in PsO

Conclusions

In this large multicentre real-world cohort from Spain, advanced systemic therapy use in psoriasis demonstrated a clear temporal shift towards increased initiation of IL-17 and IL-23 inhibitors, accompanied by declining use of TNF-α inhibitors. Treatment pathways were highly dynamic, with frequent switching between biologic classes, predominantly transitioning from TNF-α inhibitors to IL-17 or IL-23 inhibitors, reflecting evolving clinical decision-making and treatment optimisation. Patients receiving ASTs had comparable demographic and clinical profiles across classes, with predominantly moderate disease severity at initiation. Specialist healthcare utilisation remained substantial during treatment, particularly within dermatology and rheumatology services, indicating ongoing multidisciplinary disease management needs. Collectively, these findings provide quantitative evidence of changing prescribing patterns and care utilisation in routine clinical practice, supporting the need for continuous monitoring of real-world treatment strategies and their impact on patient outcomes.

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Spatial dynamics of regulatory T cells and tissue-resident memory T cells during IL-23 inhibition with tildrakizumab in psoriasis

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Introduction

Psoriasis is a chronic immune-mediated skin disease driven by dysregulation of the IL-17/IL-23 axis and characterized by complex interactions between resident skin cells (keratinocytes) and infiltrating immune cells. While IL-23 inhibitors (IL-23i) demonstrate high clinical efficacy, the spatial and temporal dynamics of regulatory T cells (Tregs) and tissue-resident memory T cells (TRM) within lesional skin during treatment with IL-23i remain poorly defined. To address this gap, we employed high-resolution spatial transcriptomics to map cellular remodeling at tissue-scale resolution during IL-23 inhibition.

Materials and Methods

We applied high-resolution spatial transcriptomics (Visium HD, 10x Genomics) and whole-slide immunofluorescence imaging to longitudinal skin biopsies from three patients with moderate-to-severe plaque psoriasis treated with the IL-23p19 inhibitor tildrakizumab. Two responders achieved early clinical benefit: PASI 50 by week 2 (57.7% and 75.6% reduction), PASI 75 by week 16 (57.7% and 75.6% reduction), and sustained PASI 90 response by week 28 (88.2% and 68.7% reduction, respectively). One patient demonstrated delayed response, failing to achieve PASI 50 at week 16 (14.1% worsening) but reaching PASI 75 by week 52 (24.4% reduction).

Biopsies were obtained from baseline non-lesional and lesional skin, and lesional skin at weeks 2 and 16 post-treatment. Spatial transcriptomic data were processed using Space Ranger followed by quality control and integration using the Seurat R package. A total of 284,212 high-quality spatial bins at 8 µm resolution were analyzed. Cell populations were identified through deconvolution using an in-house single-cell atlas, and changes in key populations including Tregs and TRMs were validated by immunofluorescence staining.

Results

Spatial transcriptomic analysis identified multiple keratinocyte subsets (BKC, SPKC, GKC, CKC), fibroblast populations (reticular, papillary, inflammatory), immune cells, endothelial cells, and other skin-resident populations. At baseline, lesional skin exhibited characteristic psoriatic features including expanded BKC, SPKC, and CKC with marked GKC depletion. By week 16, responders showed near-complete GKC restoration and normalization of SPKC and CKC proportions, while non-responder demonstrated delayed GKC recovery. Dermal fibroblasts showed baseline overexpression of COL1A2, COL3A1, SPARC, and VCAN with suppressed DCN and CTSK. Fibroblast markers progressively normalized by week 16 in responders, with early COL3A1 and SPARC decline at week 2.

At baseline, more than thirty-fold induction in Treg events was observed in lesional compared to non-lesional skin as determined by HDST and validated by IF. In clinical responders, Treg abundance progressively declined, with up to a five-fold reduction by week 16. In contrast, the non-responder exhibited an early seven-fold decrease followed by re-accumulation at week 16, suggesting ongoing inflammation.

Similarly, TRM populations showed 17-28-fold enrichment in lesional skin compared to non-lesional skin at

baseline. Responders demonstrated progressive TRM reduction (3.5-5.6-fold decrease by week 16), whereas the non-responder exhibited early decline (4.1-fold at week 2) followed by stabilization. These cellular dynamics paralleled clinical outcomes, with responders achieving PASI 75-90 while the non-responder exhibited persistent disease activity.

Conclusions

Overall, IL-23 inhibition induces coordinated remodeling of the cutaneous T-cell compartment. The progressive reduction of Treg and TRM in responders reflects restoration of immune homeostasis, while persistence or rebound of these populations in non-responders highlights their potential role in treatment resistance and disease chronicity. These findings provide spatially resolved quantitative insights into immune mechanisms underlying therapeutic response in psoriasis and may inform future strategies for patient stratification and targeted intervention.

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Abstract N°: 3500

Association between Hemoglobin-Albumin-Lymphocyte-Platelet (HALP) Score, Systemic Immune-Inflammation Index (SII), Pan-Immune Inflammation Value (PIV) and Psoriasis Vulgaris: A Case-Control Study

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Introduction

Psoriasis is a chronic, immune-mediated skin disease associated with systemic inflammation. In recent years, hematological indices such as Hemoglobin-Albumin-Lymphocyte-Platelet (HALP) score, Systemic Immune-Inflammation Index (SII), and Pan-Immune Inflammation Value (PIV) have emerged as potential markers in various inflammatory conditions. This study aimed to compare HALP, SII, and PIV levels between psoriasis patients and healthy controls, evaluate their diagnostic performance, and investigate their relationships with disease severity (PASI), nail and joint involvement.

Materials and Methods

In this retrospective case-control study, a total of 143 subjects were evaluated: 74 psoriasis patients and 69 age- and gender-matched healthy controls. Demographic data, complete blood count, and biochemical parameters were recorded. Disease severity was assessed using PASI; nail and joint involvement were documented. HALP (Hemoglobin × Albumin × Lymphocyte / Platelet), SII (Neutrophil × Platelet / Lymphocyte), and PIV (Neutrophil × Platelet × Monocyte / Lymphocyte) were calculated using standard formulas. Mann-Whitney U test was used for group comparisons; ROC curve analysis was performed for diagnostic evaluation. Cut-off values were determined by Youden index; positive predictive value (PPV), negative predictive value (NPV), and likelihood ratios (LR) were calculated. $p<0.05$ was considered statistically significant.

Results

The groups were comparable in terms of age ($p=0.522$). Albumin levels were significantly lower in the patient group compared to controls (41.87±3.42 vs 43.99±2.77 g/L; $p<0.001$). HALP score was significantly lower in psoriasis patients compared to controls (5.21±1.76 vs 6.14±2.24; $p=0.036$), consistent with hypoalbuminemia and thrombocytosis observed in psoriasis. SII (536.87±250.93 vs 469.00±204.21; $p=0.068$) and PIV (330.10±226.13 vs 272.82±149.94; $p=0.055$) were numerically higher in patients but did not reach statistical significance. PASI score was significantly higher in patients with nail involvement (n=13) compared to those without (12.25±9.42 vs 7.40±6.33; $p=0.027$). No significant differences were observed regarding joint involvement (n=9). In ROC analysis, only HALP showed a statistically significant AUC (0.602; $p=0.032$). At a cut-off of ≤3.83, HALP achieved 32.43% sensitivity, 92.75% specificity, 82.8% PPV, and a positive likelihood ratio of 4.47. No significant differences were found between the diagnostic performances of the three indices (DeLong, all $p>0.05$).

Table 1. Comparison of demographic and laboratory parameters between the patient and control groups.

Parameter	Control Group (n=69) Mean±SD	Patient Group (n=74) Mean±SD	p
Age (years)	45,33±15,75	46,78±15,17	0,522
Albumin (g/L)	43,99±2,77	41,87±3,42	**<0,001**
Hemoglobin (g/dL)	14,26±1,50	13,87±1,56	0,124
Lymphocyte (×10³/L)	2,36±0,67	2,39±0,79	0,837
Neutrophil (×10³/L)	4,21±1,34	4,45±1,62	0,553
Platelet (×10³/L)	250,71±59,24	276,08±71,34	0,067
Leukocyte (×10³/L)	7,33±1,75	7,71±2,25	0,561
HALP Score	6,14±2,24	5,21±1,76	**0,036**
SII	469,00±204,21	536,87±250,93	0,068
PIV	272,82±149,94	330,10±226,13	0,055

*Mann–Whitney U test. Mean: average; SD: standard deviation. p<0.05.
HALP score: Hemoglobin, Albumin, Lymphocyte, and Platelet score
SII: Systemic Immune-Inflammation Index PIV: Pan-Immune-Inflammation Value

Table 2. ROC Curve Analysis Results of HALP, SII, and PIV Indices in Predicting Psoriasis Parameter

Parameter	AUC	%95 CI	Cut-off	Sensitivity (%)	Specificity (%)	PPV (%)	NPV (%)	LR+	LR−	p
HALP	0,602	0,517–0,683	≤3,83	32,43	92,75	82,8	56,1	4,47	0,73	0,032*
SII	0,588	0,503–0,670	>418,63	72,97	49,28	60,7	63,0	1,44	0,55	0,066
PIV	0,593	0,508–0,674	>210,79	72,97	47,83	60,0	62,3	1,40	0,57	0,053

AUC: Area under the curve; CI: Confidence interval; PPV: Positive predictive value; NPV: Negative predictive value; LR+: Positive likelihood ratio; LR−: Negative likelihood ratio. Cut-off values were determined using the Youden index. PPV and NPV were calculated according to the study prevalence (51.75%). *p<0.05.

Conclusions

HALP score was significantly lower in psoriasis patients, reflecting the hypoalbuminemia and thrombocytosis associated with chronic inflammation. At a low cut-off value, HALP demonstrated high specificity (92.75%) and PPV (82.8%), with a clinically meaningful positive likelihood ratio (LR+=4.47), indicating that a positive test result substantially increases the probability of psoriasis. SII and PIV showed marginal results requiring validation in larger cohorts. The significant association between PASI and nail involvement suggests that nail disease reflects more severe psoriasis. HALP, SII, and PIV are easily calculable, low-cost parameters with potential as complementary markers in the clinical evaluation of psoriasis.

Figure 1. Receiver operating characteristic (ROC) curve analysis of the HALP index for predicting psoriasis (AUC=0.602, p=0.032)

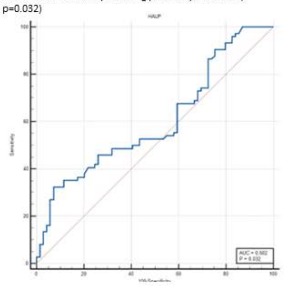


Figure 2. Receiver operating characteristic (ROC) curve analysis of the SII index for predicting psoriasis (AUC=0.588, p=0.066).

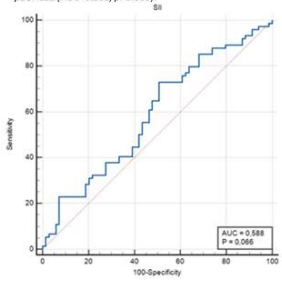


Figure 3. Receiver operating characteristic (ROC) curve analysis of the PIV index for predicting psoriasis (AUC=0.593, p=0.053).

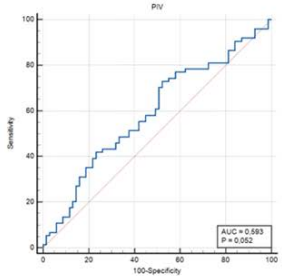
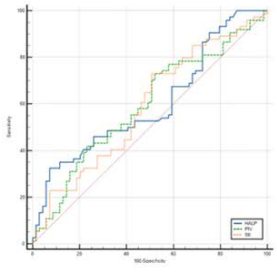


Figure 4. Comparison of receiver operating characteristic (ROC) curves of HALP, SII, and PIV indices for predicting psoriasis.



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Abstract N°: 3508

Real world data on secukinumab therapy for patients with moderate to severe psoriasis from the Czech BIOREP registry: 7 years follow up

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Introduction

Real-world evidence on long-term outcomes of biologic therapies remains essential for optimizing psoriasis management. This study evaluated the effectiveness, durability, and treatment persistence of secukinumab using data from the Czech BIOREP Registry.

Materials and Methods

BIOREP is a nationwide registry capturing patients with psoriasis receiving targeted therapies. We analyzed patients who initiated secukinumab between January 2015 and August 2024.

Results

A total of 837 patients were included, with a predominance of males (58.3%). Metabolic and endocrine comorbidities were present in 40.1% of patients and cardiovascular conditions in 38.9%, most commonly hypertension (36.5%), dyslipidemia (24.9%), and diabetes mellitus (11.5%). Overweight and obesity were documented in 37.2% and 39.8% of patients, respectively. Psoriatic arthritis was observed in 51%, and 52% of patients were biologic-naïve at treatment initiation.

Baseline disease severity, assessed by PASI, averaged 16.7 (SD ± 8.0) and decreased to 1.7 at week 16 and 1.2 at week 52. During long-term follow-up up to 7 years, PASI values remained stable, ranging between 1.3 and 1.7. Response rates for PASI 75 reached 86.5% and 91.0% at weeks 16 and 52, respectively, and were maintained between 88.7% and 93.4% over time. PASI 90 responses ranged from 66.5% to 73.8% in the early phase and from 65.3% to 71.7% long-term. Complete clearance (PASI 100) was achieved in 43.4% and 49.1% of patients at weeks 16 and 52, decreasing to 38.8% by year 7. Quality of life, measured by DLQI, improved markedly from 15.4 at baseline to 2.3 at week 16 and 1.4 at week 52, remaining consistently low thereafter. Drug survival rates were

97.2% at 3 months and 85.9% at 1 year, with gradual decline to 75.7%, 66.6%, 60.1%, 53.4%, and 46.8% at years 2–6, and 43.6% at year 7. Factors associated with treatment discontinuation included obesity, treatment line, and the presence of psoriatic arthritis.

Conclusions

These real-world data demonstrate sustained clinical effectiveness, long-term treatment persistence, and substantial quality-of-life improvement in patients with moderate-to-severe psoriasis treated with secukinumab.

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Abstract N°: 3517

Dimensions of patient needs in moderate to severe psoriasis

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Introduction

The Patient Benefit Index (PBI) was developed to provide a standardized measure of patient-reported achievement of individual treatment goals, which are highly relevant in clinical and health services research. Previous analyses of the scale structure were conducted using the 23-item version with small, sometimes diagnostically heterogeneous samples. This study aims to examine and validate the subscale structure, focusing on patients with moderate to severe psoriasis, using real-world data and the 25-item version of the Patient Needs Questionnaire to assess individual treatment goals.

Materials and Methods

The data are drawn from the non-interventional German Psoriasis Registry (PsoBest), which prospectively follows adult participants with moderate to severe psoriasis for up to 10 years starting from the initiation of a new systemic therapy. Confirmatory factor analyses were performed on the 23- and 25-item versions of the PBI, along with Bartlett's test for sphericity and reliability analyses (Cronbach's alpha).

Results

The analysis was based on data from n = 20,198 participants (49.2% female, average age 48 years, included 2008–2024). The 23-item version of the PBI revealed 5 factors with minor deviations from the original subscale structure: reduction in impairment in daily life and social life, in relationships, impairment due to therapy, physical impairment, and confidence in recovery. Cronbach's alpha ranged from $\alpha = 0.69$ to $\alpha = 0.91$, indicating acceptable to excellent reliability. The additional items in the 25-item version of the PBI loaded significantly on the "confidence in recovery" factor. The factors demonstrated reliability comparable to that of the 23-item version (Cronbach's alpha between $\alpha = 0.69$ and $\alpha = 0.91$).

Conclusions

The results confirm the stability and validity of the PBI subscale structure in a large, real-world cohort. Patient-relevant treatment goals can be assessed multidimensionally using the PBI, including psychosocial aspects. The use of the PBI in health services research and clinical trials is recommended; for studies on psoriasis, the 25-item version is preferred.

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Abstract N°: 3534

How have patient needs evolved over the past 15 years? Data from the German national psoriasis registry PsoBest

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Introduction

The needs of patients with psoriasis have been extensively studied in cross-sectional studies. However, it remains unclear how these needs have changed over the long term across the various phases of systemic therapy, including the introduction of biologics. Since 2008, the German national psoriasis registry PsoBest has been recording patients' treatment goals using the Patient Needs Questionnaire (PNQ). This analysis examines the temporal trends and subgroup-specific patterns of patient-reported treatment goals between 2008 and 2023, as well as their relationship to disease severity and quality of life.

Materials and Methods

The PNQ data for all participants registered through December 2023 were analyzed descriptively at the baseline of the registry. The PNQ consists of 25 individual items divided into five validated dimensions. Response options range from "not at all important" (0) to "very important" (4) and "does not apply to me" (0). Subgroup analyses were performed by gender, age, presence of psoriatic arthritis (PsA), and treatment history. The correlations between the PNQ scales, the PASI, the DLQI, and the EQ-VAS were examined.

Results

Among n = 20,178 participants (41.5% female, mean age 47.5 years, mean PASI 15.25 ± 10.25, DLQI 11.92 ± 7.3), the mean total PNQ scores ranged from 2.80 to 2.92 over time. The items with the highest overall agreement (≥90% "somewhat" + "very important") were "Healed of all" (94.7%), "Better skin quickly" (94.1%), "Regaining disease control" (92.7%), and "Confidence in therapy" (92.0%). Women reported a slightly higher need than men for almost all items (Δ -0.11 to 0.45). The differences in needs with respect to age were minimal; items concerning impairments in the relationship ("Dare to show," "More social contact" and "Sex life") decreased significantly with increasing age. The PNQ total score correlates strongly with the PNQ subscales (r = 0.61–0.93) and moderately with the DLQI (r ≈ 0.53), but only weakly with the PASI (r ≈ 0.11).

Between 2008/09 and 2022/23, the most significant increases were observed in “No burning” (+0.46), “Pain free” (+0.38), “Sleep better” (+0.28), and “No itching” (+0.24), while significant decreases were observed in “Fewer out-of-pocket costs” (−0.65), “Normal leisure activities” (−0.22), “Progression fear” (−0.19), and “Dependent” (−0.19).

Conclusions

Over the 15-year period analyzed, the needs of patients with psoriasis have shifted from concerns related to treatment and cost toward a greater emphasis on immediate symptom relief and the ability to function in daily life. These findings highlight the increased confidence in treatments as well as changing patient priorities regarding the management of psoriasis.

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Abstract N°: 3536

Improvement of patient reported outcomes with risankizumab in genital psoriasis: real-world evidence from the nested GPS-Best study within the german PsoBest registry

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Introduction

Genital psoriasis (GenPso) is associated with substantial impairment in quality of life (QoL) including sexual burden and avoidance of sexual activity. Its impact on disease severity and burden can be measured by the static physician's global assessment of genitalia (sPGA-G) or the patient reported Genital Psoriasis Symptoms Scale (GPSS). This study evaluates the effectiveness of the IL-23 inhibitor Risankizumab (RZB) in GenPso, assesses the interrater agreement, and examines associations between improvements in effectiveness parameters.

Materials and Methods

The German Psoriasis registry PsoBest observes adult patients with moderate to severe plaque psoriasis. GPS-Best, a nested non-interventional cohort study within PsoBest, evaluates the effectiveness of RZB in patients with GenPso, including its impact on QoL and sexual impairment. This interim analysis includes patients with moderate to severe GenPso (sPGA-G≥ 3) treated with RZB with focus on week 40 outcomes. Weighted Cohen's kappa assessed interrater agreement between patient and physician severity rating, and correlations were analysed using Pearson coefficient.

Results

Analyses comprise data of 87 patients (60.9%, n= 53 males, 39.1%, n= 34 females, mean age 46.2 years, mean duration of psoriasis 17.5 years, 44.8% nail psoriasis, 20.7% joint involvement). Mean PASI, DLQI, GPSS and sPGA-G at baseline were 15.5, 14.1, 42.0 and 3.8, respectively, showing a remarkable severity of the disease. At baseline, 22.4% (*Stinging*) to 57.6% (*Redness*) of GPSS items were rated as severe (GPSS 7-10). The items*Itch* (85.9%), *Redness* (83.5%) and *Discomfort* (83.1%) were most frequently rated as at least moderate (GPSS≥ 6).*Itch* was rated as severe (7-10) in 50.6% of patients.

At week 40, mean PASI, DLQI and sPGA-G were 0.7, 1.6 and 0.5, respectively. Mean total GPSS decreased to 5.9, which was a reduction of 86.0%. The improvement in GPSS and sPGA-G showed a significant correlation (R= 0.32, p= 0.005) while the weighted Cohen's κ indicated poor agreement (week 0: κ= 0.003, 95% CI -0.002 – 0.008; week 40: κ= 0.134, 95% CI -0.095 – 0.173) between physician and patient severity ratings of GenPso. Itemwise GPSS analyses revealed that physicians rate overall severity (sPGA-G) higher than patients rated their individual symptoms in 34.1 to 67.1% of cases at week 0 decreasing to 6.0 to 17.6% at week 40. Such physician-higher ratings occurred mainly for *Itch* and *Redness*, whereas the opposite pattern (higher patient ratings than sPGA-G) was most pronounced for *Pain* and *Stinging*.

The items *Itch*, *Redness* and *Discomfort* were still the items rated most frequently as at least moderate, but rates decreased to 10.5% each. When focusing on patients with at least moderate impairment in QoL (DLQI≥ 6, n=11)

left, the items changed to *Redness* (60.0%), *Itch*, *Pain* and *Discomfort* (each 54.5%) and *Stinging* (45.5%). Absolute GPSS itch improvement ≥ 4 was achieved in 71.4% of patients. DLQI improvement was correlated with improvement of GPSS (R= 0.38, p< 0.001), but not with improvement of PASI (R= 0.19, p= 0.092).

Conclusions

The symptoms *Itch*, *Discomfort* and *Redness* were the most severe items in GenPso. RZB demonstrated high effectiveness in reducing GenPso symptoms, as shown in sPGA-G, GPSS and DLQI, including *Itch*. For patients with DLQI≥ 6 at week 40, *Itch*, *Pain*, *Discomfort* and *Redness* were more pronounced. The reduction in genital symptoms was evident in both clinical and patient-reported endpoints, which correlated well with each other. PASI does not seem to be the most appropriate score to assess therapy outcomes in this special group of psoriasis patients and specific scores are highly relevant to adequately assess disease burden. Discrepancies in the assessment of severity across different symptoms underline the importance of open communication between physicians and patients about the symptoms and limitations of GenPso in order to establish a common understanding.

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Abstract N°: 3537

Stir Up the Sun Therapy: Topical PUVASOL Therapy in Palmoplantar Psoriasis

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Introduction

Palmoplantar psoriasis is a variant of psoriasis localized to palms and soles and is usually resistant to conventional topical therapy owing to the anatomical variations. Topical psoralen therapy was widely practiced during olden times due to less systemic side effects and sunlight was used as a source of UVA in developing countries due to its cost-effectiveness

Case Presentation

After obtaining informed consent, 30 patients with palmoplantar psoriasis were asked to apply a diluted solution of psoralen (1 part of 8-methoxypsoralen was diluted with 10 parts of tap water) over the lesions. They were told to stay indoors for 30 min and exposed to sun for a maximum of 2 min on alternate days for 6 weeks.
Palmoplantar psoriasis area and severity index was calculated at the beginning of the study and at the end of 6 weeks. Percentage improvement was calculated based on pre- and post-treatment scores and was categorized as minimal improvement (up to 25%), moderate improvement (26%–50%), marked improvement (51%–75%), and total/near total improvement (76%–100%).
Three patients (10.34%) showed mild improvement, 6 patients (20.68%) showed moderate improvement, 8 patients (27.58%) showed marked improvement, and 12 patients (41.37%) showed total or near total improvement. One patient reported phototoxicity and was excluded from the study. There was also a statistically significant correlation between smoking and alcohol with reduced response to therapy.

Conclusion

Topical Psoralen plus Ultraviolet A obtained by solar light (PUVASOL) can be reintroduced as a cost-effective alternative to other conventional and newer topical therapies. The chances of side effects due to systemic drugs can also be reduced with this.

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Abstract N°: 3574

Long-term safety of risankizumab in psoriatic patients with chronic infective comorbidities: results from a prospective multicenter study

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Introduction

Patients with moderate-to-severe psoriasis and chronic infectious comorbidities, such as tuberculosis (TB), hepatitis B and C virus infections (HBV/HCV), and human immunodeficiency virus (HIV), are often underrepresented in clinical trials, leading to limited evidence regarding the safety of biologic therapies in these populations. Risankizumab, an IL-23 inhibitor, has demonstrated high efficacy and a favorable safety profile in the treatment of psoriasis; however, real-world data in patients with chronic infections remain scarce. This study aimed to evaluate the long-term safety and clinical outcomes of risankizumab in patients with moderate-to-severe psoriasis and concomitant chronic infectious diseases.

Materials and Methods

In this multicenter prospective real-world study conducted across several dermatology centers in Tuscany, Italy, we evaluated the clinical outcomes of chronic infectious comorbidities in patients with moderate-to-severe psoriasis treated with risankizumab. All patients underwent regular clinical and laboratory monitoring during treatment, with a follow-up period ranging from 1 to 5 years. TB monitoring consisted of additional diagnostic investigations only in the presence of new clinical symptoms suggestive of TB reactivation. In patients with HBV infection, HBsAg and HBV DNA levels were assessed every 3 months during the first year and every 6 months thereafter. Similarly, in patients with HCV infection, HCV RNA levels were monitored with the same schedule. For both HBV- and HCV-infected patients, liver function tests, including AST, ALT, and GGT, were performed at the same time intervals, together with annual abdominal ultrasonography. In patients with HIV infection, HIV RNA levels were also monitored every 3 months during the first year and every 6 months thereafter.

Results

A total of 213 patients treated with risankizumab for moderate-to-severe psoriasis were included in the analysis. Infectious comorbidities were recorded in 49 (36 males; 13 females; mean age±SD 62.6±13 years) patients, including latent or previous TB in 35/213, HBV infection in 15, HCV infection in 6 and HIV infection in 4. Multiple infectious comorbidities were observed in 10 patients. Specifically, 1 patient presented with all four infectious comorbidities (TB, HBV, HCV, and HIV); 3 had concomitant TB and HIV infection; 2 had concomitant TB, HBV, and HCV infection; 1 had both HBV and HCV infection; and 3 had concomitant TB and HBV infection. Among the 35 patients with latent or previous TB infection, 29 underwent TB prophylaxis. Of these, 23 had already received prophylactic treatment in the past independently of risankizumab prescription, whereas 6 started prophylaxis specifically prior to risankizumab initiation. Among the 15 patients with HBV infection, 4 had chronic HBV infection with undetectable viral load under concomitant antiviral treatment (lamivudine or entecavir), whereas 11 had occult HBV infection. All 6 patients with HCV infection had achieved viral eradication before starting risankizumab treatment. Likewise, all 4 patients with HIV infection had an undetectable viral load at baseline. All 49 patients with infectious comorbidities completed at least 1 year of follow-up, with a mean follow-up duration of 2.37±1.38 years. Throughout the entire observation period, no cases of infectious reactivation were documented.

Conclusions

In our study, risankizumab demonstrated a favorable long-term safety profile in patients with psoriasis and concomitant chronic infectious comorbidities. No cases of viral or TB reactivation were observed throughout follow-up, even in patients with multiple infectious comorbidities. Notably, no TB reactivation occurred even among patients who did not receive TB prophylaxis. These findings support the safety of risankizumab in carefully monitored patients with chronic infections and provide further real-world evidence for its use in this challenging clinical setting.

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Abstract N°: 3575

Risankizumab in Acrodermatitis Continua of Hallopeau With Severe Nail Involvement: Sustained Clinical Response Through 36 Weeks

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Introduction

Acrodermatitis continua of Hallopeau (ACH) is a rare and difficult-to-treat variant of pustular psoriasis predominantly affecting the distal digits and nail apparatus. The disease is characterized by sterile pustules, painful periungual inflammation, chronic paronychia, onycholysis, subungual hyperkeratosis, and progressive nail dystrophy that may ultimately result in anonychia or functional impairment. Due to its rarity and overlapping clinical features with fungal infections, chronic paronychia, eczema, and nail psoriasis, diagnosis is frequently delayed. Conventional therapeutic options often provide limited and inconsistent responses. Although biologic therapies targeting the IL-17 and IL-23 pathways have shown promising results in pustular psoriasis spectrum disorders, evidence in ACH remains scarce, largely limited to case reports and small case series. We report a case of severe ACH with extensive nail involvement successfully treated with risankizumab, demonstrating sustained improvement through 36 weeks of follow-up.

Case Presentation

A 47-year-old female developed inflammatory nail disease in early 2024, initially presenting with distal onycholysis of the left thumbnail, followed by progressive involvement of multiple fingernails. The condition was initially misdiagnosed as onychomycosis, and repeated antifungal treatments failed to achieve clinical improvement. Microbiological investigations for fungal infection were negative.

By May 2025, the patient developed severe periungual inflammation, chronic paronychia, painful palmoplantar pustular lesions, marked subungual hyperkeratosis, and extensive nail dystrophy, consistent with ACH within the pustular psoriasis spectrum. The disease significantly impaired daily activities and hand function.

Topical calcipotriol/betamethasone dipropionate formulations were administered from June 2025 to February 2026 with partial disease control. Oral acitretin was initiated in June 2025 at 0.2 mg/kg/day without satisfactory response. Due to persistent active disease, risankizumab was initiated in August 2025.

Serial clinical and photographic follow-up demonstrated progressive reduction of acral inflammation and palmoplantar pustulation, followed by gradual restoration of nail plate architecture. By May 2026, near-complete clearance of palmoplantar lesions and marked improvement of nail morphology were observed.

Importantly, all concomitant topical and systemic non-biologic therapies were discontinued in February 2026, while clinical response remained sustained under risankizumab monotherapy through Week 36.

Conclusion

Published evidence regarding risankizumab in ACH remains limited and mainly involves elderly patients. Although favorable responses have also been described with TNF-α, IL-17, and other IL-23 inhibitors, evidence is still

restricted to isolated reports and small case series. This case further expands the available evidence by demonstrating sustained clinical improvement in a 47-year-old patient with severe nail and palmoplantar involvement refractory to conventional therapies. Risankizumab was associated with durable improvement through 36 weeks despite discontinuation of all concomitant therapies, further supporting the potential role of IL-23 inhibition in ACH and related pustular psoriasis spectrum disorders.

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Benefits of concomitant treatment with ixekizumab and tirzepatide for patients with psoriatic disease and overweight/obesity: An overview of results from the TOGETHER trials

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Introduction

Psoriasis (PsO) and psoriatic arthritis (PsA) share an immunopathology and a high global prevalence (60%-69%) of comorbid overweight/obesity, with weight management recommended as part of patient care [1-4]. TOGETHER-PsO (NCT06588283) and -PsA (NCT06588296) are open-label Phase 3b clinical trials that evaluated the efficacy and safety of concomitant ixekizumab and tirzepatide (IXE+TZP) compared to IXE-alone in adults with moderate-to-severe PsO or active PsA and comorbid overweight/obesity. This analysis presents an overview of clinical and patient-reported outcomes (PROs) across the two trials to examine the therapeutic impact of concomitant IXE+TZP.

Materials and Methods

Participants were aged ≥18 years, with either moderate-to-severe plaque PsO or active PsA and had either comorbid overweight (BMI ≥27kg/m2 to <30kg/m2) with at least 1 weight-related comorbid condition or obesity (BMI ≥30kg/m2). Participants were randomized 1:1 to receive concomitant IXE+TZP or IXE monotherapy for 52 weeks and also received individualised counselling for a healthy diet and exercise.

Key primary endpoints at week 36 were the simultaneous achievement of complete PsO clearance (PASI100) and ≥10% weight reduction (WR) in TOGETHER-PsO and simultaneous American College of Rheumatology 50% improvement (ACR50) and ≥10% WR in TOGETHER-PsA. Key secondary endpoints were PASI100 (PsO), ACR50 (PsA), ≥10% WR outcomes, simultaneous achievement of PASI75 and ≥5% WR (PsO), and ACR20 and ≥5% WR (PsA) at week 36. PRO measures included Dermatology Life Quality Index (DLQI; 0,1) and ≥4-point improvement in itch Numerical Rating Scale (NRS) in PsO, and Functional Assessment of Chronic Illness Therapy (FACIT)-Fatigue, 12 item Psoriatic Arthritis Impact of Disease (PsAID-12) total score, Health Assessment Questionnaire-Disability Index (HAQ-DI), and the short-form 36 (SF-36) mental component score (MCS) and physical component score (PCS) in PsA. Cardiometabolic (CM) measures included blood pressure, lipids, and glucose. Key outcomes were controlled for multiplicity, while other outcomes were exploratory with p-

values reported nominally.

Results

At baseline for PsO (N=274) and PsA (N=271), respectively, participants had a mean BMI of 39 and 38kg/m^2, 45% and 70% were female, and 34 and 63% were advanced therapy experienced. At week 36 (Table 1), participants achieved clinically meaningful incremental improvement in the primary endpoint of simultaneous disease control and weight loss with concomitant IXE+TZP therapy (treatment difference [Δ] for PsO: 21.2%; Δ for PsA: 30.9%). Consistently, concomitant IXE+TZP reported higher response rates than IXE-alone for key secondary outcomes, including PASI100 (40.6% versus (vs) 29.0%; Δ:11.6%) for PsO and ACR50 (33.5% vs 20.4%; Δ:13.1%) for PsA. Across both trials, the IXE+TZP group reported greater improvement vs IXE-alone in achievement of ≥10% WR (Δ for PsO: 60.0%; Δ for PsA: 80.0%) and several CM parameters.

Concomitant IXE+TZP demonstrated greater improvement in select quality-of-life (QoL) measures vs IXE alone. For TOGETHER-PsO, DLQI (0,1) was 71.7% for IXE+TZP vs 58.3% for IXE-alone, while no significant difference was reported for itch. For TOGETHER-PsA, the IXE+TZP group reported greater change from baseline than IXE-alone for FACIT-Fatigue score (8.6 vs 4.8), PsAID total score (-2.7 vs -2.0), HAQ-DI (-0.5 vs -0.3), SF-36 MCS (3.1 vs 0.4), and SF-36 PCS (9.7 vs 6.2).

Table 1: Key endpoints and patient-reported outcomes in TOGETHER-PsO and TOGETHER-PsA

Endpoints[1]	IXE, PsO/PsA N=136/133	IXE+TZP PsO/PsA N=138/138	PsO (N=274) Δ (95% CI)[2], p-value	PsA (N=271) Δ (95% CI)[2], p-value
Disease severity and weight reduction, response rate (%)				
Simult. PASI100 and ≥10% WR[3]/ Simult. ACR50 and ≥10% WR[3]	5.8/ 0.8	27.1/ 31.7	21.2 (12.8, 29.7), <0.001	30.9 (22.6, 39.1), <0.001
PASI100[4]/ ACR50[4]	29.0/ 20.4	40.6/ 33.5	11.6 (0.3, 22.9), 0.044	13.1 (2.1, 24.1), 0.020
Simult. PASI75 and ≥5% WR[4]/ Simult. ACR20 and ≥5% WR[4]	17.9/ 10.3	79.9/ 69.7	62.0 (51.7, 72.2), <0.001	59.5 (49.8, 69.2), <0.001
Weight reduction alone, response rate (%)				
≥10% WR[4]	9.1/ 4.5	69.2/ 84.5	60.0 (50.4, 69.7), <0.001	80.0 (72.2, 87.9), <0.001
PROs				
DLQI (0,1), %	58.3/ NA	71.7/ NA	13.3 (2.0, 24.7), 0.021	NA
≥4-point improvement in itch NRS, %	80.6/ NA	81.8/ NA	1.2 (-8.3, 10.8) 0.800	NA
FACIT-Fatigue, CFB	NA/ 4.8	NA/ 8.6	NA	3.8 (1.4, 6.1), 0.002
PsAID-12 total score, CFB	NA/ -2.0	NA/ -2.7	NA	-0.7 (-1.2, -0.2), 0.005
HAQ-DI, CFB	NA/ -0.3	NA/ -0.5	NA	-0.2 (-0.3, -0.1), <0.001
SF-36 MCS, CFB	NA/ 0.4	NA/ 3.1	NA	2.7 (0.1, 5.2), 0.041
SF-36 PCS, CFB	NA/ 6.2	NA/ 9.7	NA	3.5 (1.5, 5.6), <0.001
Cardiometabolic endpoints				
Systolic blood pressure, mmHg	-1.4/ -3.9	-9.9/ -10.8	-8.5 (-11.6, -5.3), <0.001	-6.9 (-10.3, -3.5), <0.001
Diastolic blood pressure, mmHg	0.3/ -2.8	-3.6/ -4.7	-3.9 (-6.1, -1.6), <0.001	-1.9 (-4.2, 0.5), 0.114
Total cholesterol, mg/dL	-1.3/ -0.8	-10.0/ -11.0	-8.7 (-16.2, -1.2), 0.022	-10.2 (-19.0, -1.5), 0.021
Triglycerides, mg/dL	-0.2/ 2.5	-32.2/ -36.2	-31.9 (-47.5, -16.4), <0.001	-38.8 (-51.8, -25.7), <0.001
HbA1c, %	0.1/ 0.1	-0.5/ -0.6	-0.6 (-0.7, -0.5), <0.001	-0.7 (-0.9, -0.5), <0.001

[1]Key primary and secondary endpoints were controlled for multiplicity. P-values for cardiometabolic and PRO endpoints were nominally reported.
[2]95% confidence intervals were calculated using Wald method.
[3]Key primary endpoints.
[4]Key secondary endpoints.

Abbreviations: ACR = American College of Rheumatology; CFB = change from baseline; DLQI = Dermatology Life Quality Index; FACIT = Functional Assessment of Chronic Illness Therapy; HAQ-DI = Health Assessment Questionnaire-Disability Index; HbA1c = haemoglobin A1c; IXE = ixekizumab; NRS = Numerical Rating Score; MCS =Mental Component Score; NA = not applicable; PASI = Psoriasis Area Severity Index; PCS = Physical Component Score; PsAID-12 = Psoriatic Arthritis Impact of Disease 12-item ; PROs = Patient-Reported Outcomes; Simult = simultaneous; SF-36 = 36-item short form health survey 36; TZP = tirzepatide; WR = weight reduction; 95% CI = 95% confidence intervals; Δ = treatment difference

Conclusions

TOGETHER-PsO and -PsA trials demonstrated that the concomitant administration of IXE+TZP enabled a greater proportion of improvements across multiple domains of psoriatic disease and supports a comprehensive approach to the treatment. These findings suggest a potential benefit for addressing obesity within the care of psoriatic disease.

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Abstract N°: 3598

Steroid-refractory impetigo herpetiformis with postpartum exacerbation after emergency caesarean section, successfully treated with adalimumab

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Introduction

Impetigo herpetiformis (IH) is a rare pregnancy-associated pustular dermatosis. It is now widely regarded as a pregnancy-triggered form of generalised pustular psoriasis. The condition usually manifests in the third trimester and is expected to remit after delivery. First-line therapy consists of systemic corticosteroids and ciclosporin. Reports on biologic therapy in the postpartum setting remain limited.

Case Presentation

A 32-year-old G3P2 patient with no prior history of psoriasis presented at 34 weeks of gestation. She showed widespread pustules on an erythematous base. In her two previous pregnancies, pustular lesions had been present but had remained restricted to a single finger. On admission, she was febrile with chills. Laboratory findings included a CRP of 163.4 mg/L, a leucocyte count of 31 G/L, IL-6 of 139 pg/mL, hypoalbuminaemia (21 g/L) and hypocalcaemia (total serum calcium 1.99 mmol/L). Skin biopsy showed a subcorneal pustulosis consistent with IH. Skin swabs grew *Staphylococcus aureus*, *Klebsiella pneumoniae*, *Escherichia coli* and *Proteus mirabilis*. IL36RN sequencing was not performed. Antepartum treatment consisted of intravenous prednisolone (200 mg/d), topical corticosteroids and intravenous piperacillin/tazobactam.

Because of further maternal deterioration with persistent fever and chills, emergency caesarean section was performed eight days after admission, at 34 weeks of gestation. The preterm newborn was transferred to neonatal intensive care.

Three days postpartum, the cutaneous findings worsened, now also involving the face. Prednisolone was increased to 300 mg/d intravenously and adalimumab was added (80 mg loading dose, then 40 mg every two weeks). Under this combined regimen, the skin lesions regressed. Prednisolone was switched to oral administration and tapered. After 21 days of in-patient care and two doses of adalimumab, the patient was discharged with almost complete clearing of the eruption. Further outpatient management was continued elsewhere.

Conclusion

This case adds to the few published reports of TNF-alpha inhibition in postpartum IH. It shows that IH does not always remit after delivery: in our patient, the disease worsened despite preterm caesarean section and high-dose systemic corticosteroids. The progression from pustular lesions limited to a single finger in two previous pregnancies to a generalised eruption with marked systemic inflammation also illustrates the heterogeneous severity of pregnancy-triggered pustular psoriasis within the same patient. While current attention in generalised pustular psoriasis is shifting towards interleukin-36 receptor blockade, adalimumab still has the most extensive pregnancy and lactation safety data among biologic agents and was therefore preferred. Postpartum exacerbation of IH may occur even after preterm delivery and high-dose systemic steroids; in this case, adalimumab provided effective disease control after corticosteroid-refractory disease.

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Skin-specific artificial intelligence-guided cellular spatial mapping in psoriasis

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Introduction
Psoriasis is a chronic inflammatory skin disease characterized by recurrent lesional inflammation resistant to targeted biologic therapies. Spatial transcriptomics allows the mapping and quantification of gene expression in tissue using cell-boundary agnostic bins. Accurate characterization of the genes active in psoriasis relies on precise segmentation of cell boundaries in psoriatic skin. However complex, overlapping, and inflamed extracellular structures limit boundary detection in existing models when applied to H&E-stained skin. We aim to develop a skin-specific artificial intelligence (AI) model for single-cell segmentation in H&E and integrate it with high-definition spatial transcriptomics to characterize immune cell proliferation and transcriptional dynamics in psoriasis throughout treatment.

Materials and Methods
Longitudinal skin biopsies from patients with moderate-to-severe plaque psoriasis obtained before and during treatment were analyzed. A deep learning-based segmentation model was trained on annotated hematoxylin and eosin-stained psoriasis sections allowing us to optimize specifically for skin architecture. The model focuses on improved cell boundary detection in tissue regions affected by extracellular matrix interference and heterogeneous morphology. Segmentation outputs were integrated with high-definition spatial transcriptomics to generate reliable single-cell boundaries on archived histological sections enabling downstream spatial gene expression analysis of immune associated cellular populations within inflamed skin.

Results
Our skin-specific AI model creates robust single-cell segmentation in psoriasis tissue and outperformed generic approaches (CPSAM) with intersect and overlap accuracy going from 39.3% to 74.4% and F1 score from 0.42 to 0.66. Integration with high-definition spatial transcriptomics improved assignment of transcriptional signals to individual cells and supported spatially resolved identification of immune cell associated compartments within lesional skin. This framework can provide a reproducible basis for analyzing longitudinal changes in cell-type distribution and gene expression during treatment, with the potential to identify early spatial correlates of therapeutic response.

Conclusions
Skin-adapted AI-based segmentation can substantially improve the spatial resolution of transcriptomic analysis in psoriasis. By combining morphology-aware deep learning with high-definition spatial transcriptomics, this approach enables single-cell interrogation of tissue organization in intact tissue and establishes a scalable platform for precision monitoring of inflammatory skin disease.

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Abstract N°: 3637

Clinical and Therapeutic Differences Between Early-Onset and Long-Standing Psoriasis: Experience from BIOBADADERM (Spanish National Registry)

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Introduction

The management of psoriasis has undergone a remarkable shift with the introduction of biological agents and their biosimilars. Recent studies (STEPin, GUIDE etc.), suggest that early intervention with biological therapies may be associated with more sustained responses over time, particularly in patients with shorter disease duration and no prior exposure to these treatments. However, the translation of this evidence into clinical practice remains limited, especially in early-onset psoriasis. The aim of this study was to describe the clinical characteristics and analyse prescribing trends in early-onset versus long-standing psoriasis in a real-world clinical practice setting. As a secondary objective, the impact of biosimilar introduction on clinical prescribing following their availability in Spain in 2015 was assessed.

Materials and Methods

An observational study was conducted using data from BIOBADADERM (Spain), a national prospective multicentre registry including patients with psoriasis initiating a new systemic treatment. Two groups were defined: patients with early-onset psoriasis of less than 2 years' duration (Pso<2) and patients with long-standing psoriasis of more than 10 years' duration (Pso>10). Baseline clinical characteristics, comorbidities, treatments used — stratified by enrolment period (<2015 vs ≥2015) — and reasons for treatment discontinuation were collected. Chi-squared tests, Mann–Whitney U tests, and survival analysis were performed.

Results

A total of 4,521 patients were included: 869 in the Pso<2 group and 3,652 in the Pso>10 group. Patients in the Pso<2 group were more frequently female, younger, had a lower mean baseline PASI, and a lower prevalence of psoriatic arthritis. No relevant differences in cardiometabolic comorbidities were observed between the two groups. The Pso<2 group had less prior exposure to biological agents. Regarding the first prescribed treatment, conventional systemic drugs were the most frequent initial option in both groups. After 2015, biological agents became the first-line treatment in Pso>10, while in Pso<2 more than half of patients continued to initiate treatment with conventional drugs. The main reason for treatment discontinuation in both groups was lack of efficacy. The remission rate with the first treatment was higher in the Pso<2 group in the unadjusted analysis (22% vs 14%; crude HR=0.80; 95% CI: 0.73–0.87); however, this difference lost statistical significance after adjustment (adjusted HR=1.05; 95% CI: 0.95–1.15). Treatments initiated from 2015 onwards showed a lower rate of discontinuation due to adverse events or lack of efficacy; however, a lower probability of discontinuation due to disease remission was also observed.

Conclusions

Despite the inherent limitations of an observational study, these findings provide relevant insights into the management of psoriasis in its early stages within a Spanish cohort. Although therapeutic strategies for psoriasis have evolved considerably, our data show that, in clinical practice, patients with early-onset psoriasis continue to be treated predominantly with conventional drugs, even after the availability of biosimilars. The low remission rate observed in this group may be related to the underuse of biological therapies in the early stages of the disease. Given that early intervention with high-efficacy therapies has been shown to improve both outcomes and the future course of psoriasis, these data would support more proactive and intensive treatment strategies during the first years of the disease.

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Selective TYK2 Inhibition in Plaque Psoriasis: A Systematic Review of Deucravacitinib with Clinical Perspective

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Introduction

Psoriasis is a chronic immune-mediated inflammatory dermatosis associated with significant physical, psychosocial, and systemic morbidity. Although biologic therapies targeting TNF-α, IL-17, and IL-23 pathways have transformed disease outcomes, their widespread use remains limited in many low- and middle-income countries because of high cost, injection-related barriers, cold-chain requirements, and restricted reimbursement systems. In India, conventional systemic agents such as methotrexate, cyclosporine, and acitretin continue to be widely used; however, their long-term use is constrained by organ toxicity, laboratory monitoring burden, and tolerability issues. Oral small-molecule therapies with improved efficacy and acceptable safety profiles therefore represent an important unmet need in psoriasis management.

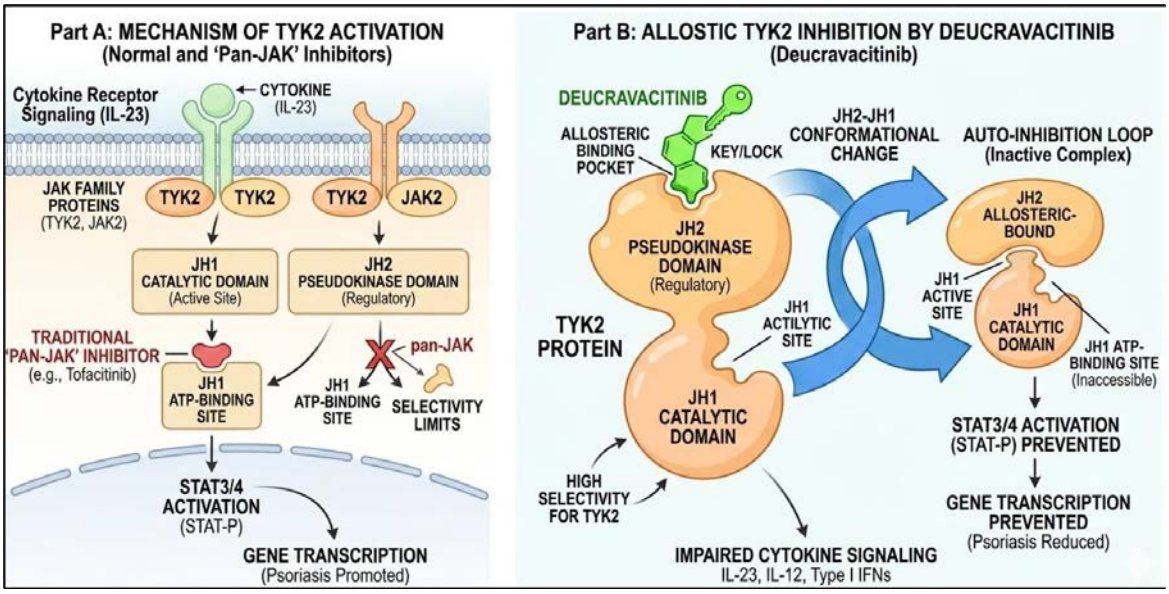

Figure 1: Molecular Mechanism of Selective allosteric TYK 2 inhibition

Materials and Methods

A structured literature review was conducted using PubMed/MEDLINE, Scopus, and Google Scholar to identify studies published between January 2015 and March 2026 that evaluated deucravacitinib in plaque psoriasis. Search terms included "deucravacitinib," "TYK2 inhibitor," "plaque psoriasis," "POETYK trials," and "TYK2 inhibition in dermatology." Randomized controlled trials, pooled analyses, long-term extension studies, real-world observational studies, pharmacoeconomic analyses, and relevant reviews were included. Conference abstracts lacking adequate methodological detail and studies unrelated to dermatologic indications were excluded. Twenty-six studies met inclusion criteria and were narratively synthesized with focus on efficacy outcomes, safety, durability of response, and practical applicability in real-world dermatology settings.

Results

Deucravacitinib is a first-in-class oral selective TYK2 inhibitor that binds allosterically to the TYK2 regulatory pseudokinase (JH2) domain, selectively inhibiting IL-12, IL-23, and type I interferon signaling while sparing JAK1/2/3 pathways. This selective mechanism contributes to its differentiated safety profile compared with conventional JAK inhibitors.

The phase 3 POETYK PSO-1 and PSO-2 trials demonstrated significantly greater efficacy of deucravacitinib versus placebo and apremilast in moderate-to-severe plaque psoriasis, with higher PASI 75, PASI 90, and sPGA 0/1 response rates at Weeks 16 and 52. Improvements in quality of life and patient-reported outcomes were also superior and remained durable in long-term extension studies extending up to 3–4 years.

The most common adverse events included nasopharyngitis, headache, upper respiratory infections, diarrhea, and nausea, which were generally mild to moderate. Unlike broader JAK inhibitors, major cardiovascular events, venous thromboembolism, serious opportunistic infections, and significant cytopenias have not been prominently observed in psoriasis trials to date.

Comparative analyses suggest that deucravacitinib provides substantially greater efficacy than apremilast and may bridge the therapeutic gap between conventional oral systemic agents and injectable biologics. Once-daily oral dosing, limited laboratory monitoring, and favorable tolerability may enhance its practical utility, although long-term real-world and pharmacoeconomic data remain necessary to define its precise role in psoriasis treatment algorithms.

Trial	Design & Population	Intervention	Primary Endpoints	Key Efficacy Results	Duration	Notes
POETYK PSO-1	Phase 3, multicenter, double-blind RCT; adults with moderate-to-severe plaque psoriasis (PASI ≥ 12, sPGA ≥ 3, BSA ≥ 10%)	Deucravacitinib 6 mg OD vs placebo vs apremilast 30 mg BD	PASI 75 & sPGA 0/1 at Week 16	Deucravacitinib superior to placebo & apremilast for PASI 75, PASI 90 and sPGA 0/1; improvements sustained to Week 52 [12,14]	52 weeks (placebo crossover from Week 16)	Robust improvement in DLQI and PROs; consistent across subgroups
POETYK PSO-2	Phase 3, multicenter, double-blind RCT; similar eligibility to PSO-1	Deucravacitinib 6 mg OD vs placebo vs apremilast 30 mg BD	PASI 75 & sPGA 0/1 at Week 16	Confirmed superiority vs placebo and apremilast at Week 16 & Week 52 [12,14]	52 weeks (placebo crossover from Week 16)	Withdrawal/re-treatment arm confirmed durability and recapture
Integrated Pooled Analyses	Pooled PSO-1 + PSO-2 populations	Deucravacitinib 6 mg OD	Long-term safety & efficacy	Sustained PASI 75/90, stable AE profile through ≥2–3 years [14,15]	Up to 3 years	No new late safety signals
Long-Term Extension (LTE)	Open-label extension of PSO-1/PSO-2 completers	Deucravacitinib 6 mg OD	Durability & safety	Durable responses to 3–4 years; low discontinuation for AEs [14,21]	Ongoing (≥4 years reported)	Reinforces long-term tolerability

Table 1. Major Clinical Trials Evaluating Deucravacitinib in Moderate-to-Severe Plaque Psoriasis (Abbreviations: AE = adverse event; BSA = body surface area; DLQI = Dermatology Life Quality Index; LTE = long-term extension; OD = once daily; PASI = Psoriasis Area and Severity Index; PRO = patient-reported outcome; RCT = randomized controlled trial; sPGA = static Physician's Global Assessment.)

Conclusions

Deucravacitinib represents a major advancement in oral targeted therapy for moderate-to-severe plaque psoriasis. Its selective allosteric inhibition of TYK2, robust efficacy, durable long-term responses, and favorable safety profile distinguish it from conventional JAK inhibitors and other oral systemic therapies. In resource-constrained settings, deucravacitinib has the potential to bridge an important therapeutic gap between traditional systemic agents and biologics, although broader accessibility, cost-effectiveness, and real-world evidence will determine its future role in routine clinical practice.

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Abstract N°: 3650

BMI and Treatment Efficacy and Persistence in Patients With Psoriasis and Psoriatic Arthritis: Real-World Evidence From Multi-country PSoHO and PRO-SPIRIT Cohorts

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Introduction

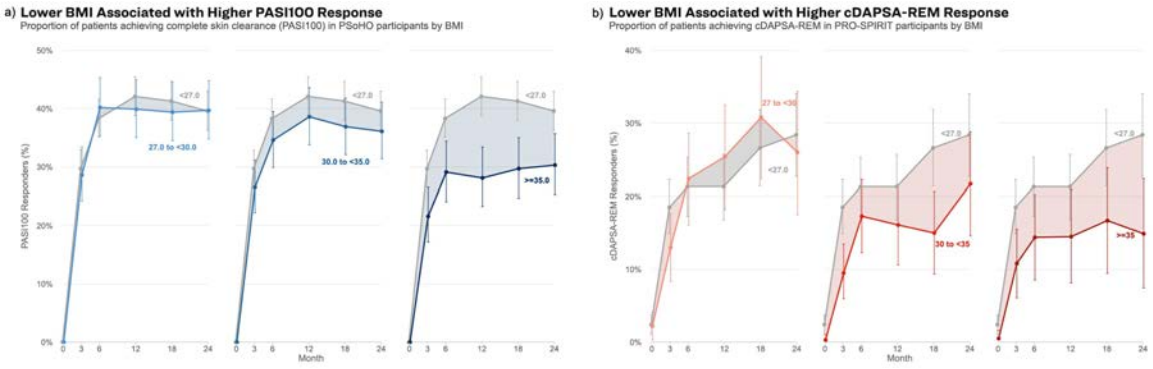
Body mass index (BMI) is an established factor affecting outcomes in patients with Psoriasis (PsO) and Psoriatic Arthritis (PsA) [1]. Combining the outcomes from two large, international, real-world studies: The Psoriasis Study of Health Outcomes (PSoHO; EUPAS24207) and the Psoriatic Arthritis (PsA) Observational Study of Persistence of Treatment (PRO-SPIRIT; EUPAS31174), this post-hoc analysis assesses the effect of baseline BMI on treatment efficacy and persistence rates.

Materials and Methods

Patients with baseline BMI data were stratified into four categories: < 27 kg/m^2, 27 to < 30 kg/m^2, 30 to < 35 kg/m^2, and ≥ 35 kg/m^2, analyses were descriptive, with data from all treatments pooled to focus on the overall BMI effect, regardless of the type of advanced systemic therapy. Patients were treated with TNF-α, IL-12/23, IL-17, and IL-23 inhibitors (PsO and PsA), and JAK and PDE-4 inhibitors (PsA). Efficacy was assessed up to 24 months by PASI100 response for patients with PsO, and by cDAPSA remission for patients with PsA. Treatment persistence was evaluated using Kaplan-Meier analysis for all-cause and ineffectiveness-related discontinuation. Analyses were descriptive only. Baseline distribution of treatments and further inclusion/exclusion criteria for PSoHO and PRO-SPIRIT have been previously described [2-3]. For PASI100, non-responder imputation was performed, and for cDAPSA, continuous components were imputed using multiple imputation where applicable.

Results

High BMI was generally associated with an inability to achieve complete skin clearance for PsO and poorer response in PsA. Among patients with PsO and BMI ≥ 35 kg/m² 29.1 % (95% CI, 24.1-34.4) had PASI100 response across biologics at 6 months and 30.3% (95% CI, 25.3-35.7) showed PASI100 response at 24 months while those with BMI < 27 kg/m² had a PASI100 response of 38.3% (95% CI, 35.1-41.7), and 39.6% (95% CI, 36.3-43.0), respectively, with separation becoming more pronounced from month 3 onwards. In PsA across advanced systemics, the cDAPSA remission at 6 months was 14.4 % (95% CI, 8.6-20.2) in patients with BMI ≥ 35 kg/m², and a response rate of 14.9% (95% CI, 7.5-22.4) at 24 months, while those with BMI < 27 kg/m² had a cDAPSA remission rate of 21.3% (95% CI, 17.3-25.3), and 28.4% (95% CI, 22.7-34.1), respectively. Higher BMI was also associated with decreased treatment persistence. By month 24, 21.3% of patients with PsO and BMI ≥ 35kg/m² had discontinued across biologics due to ineffectiveness, compared with 9.5% of patients with BMI < 27 kg/m². In PsA, 42.1% of patients with BMI 30-35 kg/m² discontinued across advanced systemics due to ineffectiveness by month 24, compared with 25.9% in patients with BMI < 27 kg/m². A similar trend was observed for all-cause discontinuation.



Baseline BMI–stratified efficacy outcomes, with each BMI category evaluated relative to the BMI < 27 group. (a) PASI100 responses in patients with PsO from PSoHO over 24 months; (b) cDAPSA remission in patients with PsA from PRO-SPIRIT over 24 months.

Conclusions

Across both PSoHO (PsO) and PRO-SPIRIT (PsA) cohorts, patients with higher BMI were less likely to achieve high disease control, most notably in patients with BMI ≥ 35 kg/m². Given the association between elevated BMI and increased difficulty in achieving high disease control and reduced persistence, these data reinforce the value of considering BMI in comprehensive psoriatic disease management, and suggest the potential benefit of exploring the incorporation of weight management strategies early into routine psoriatic disease treatment [4].

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Abstract N°: 3656

Efficacy of glucagon-like peptide-1 receptor agonists on psoriasis severity: a Bayesian meta-analysis

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Introduction

Psoriasis is a chronic inflammatory disease frequently associated with obesity and metabolic comorbidities. Glucagon-like peptide-1 receptor agonists (GLP-1 RAs), primarily used for type 2 diabetes and obesity, have demonstrated anti-inflammatory properties that may benefit psoriatic skin disease. Previous meta-analyses pooling a limited number of studies suggested a favourable effect of GLP-1 RAs on psoriasis severity. We aimed to provide an updated and methodologically robust assessment using a Bayesian framework, incorporating evidence from all available studies reporting Psoriasis Area and Severity Index (PASI) outcomes before and after GLP-1 RA treatment.

Materials and Methods

A systematic review was conducted across PubMed, Embase and Cochrane Library through March 2026. Studies evaluating GLP-1 RAs in patients with psoriasis and reporting PASI scores at baseline and follow-up were included. The primary outcome was the mean difference (MD) in PASI between pre- and post-intervention. Pre- and post-treatment data were pooled using a Bayesian random-effects model (bayesmeta package, R) with a vague prior for the overall effect [Normal(0, 10^2)] and a weakly informative Half-Normal(0, 5) prior for between-study heterogeneity (τ). Sensitivity analyses were performed using Half-Normal(0, 2.5) and Half-Normal(0, 8) priors for τ. Posterior probabilities for clinically relevant thresholds were computed.

Results

Nine studies (n = 167 patients treated with GLP-1 RAs; mean age: 50.2 years) were included, evaluating liraglutide (7 studies) and semaglutide (2 studies) over follow-up periods of 8 to 24 weeks. The Bayesian pooled MD in PASI was −6.49 (95% credible interval: −8.84 to −4.16), with a posterior probability of 99.99% that GLP-1 RAs reduce PASI scores ($P[MD < 0] = 99.99\%$). The probability of achieving at least a 3-point PASI reduction was 99.5% ($P[MD \leq -3] = 99.5\%$), and the probability of at least a 5-point reduction was 91.4% ($P[MD \leq -5] = 91.4\%$). Between-study heterogeneity was low ($\tau = 1.75$; 95% CrI: 0 to 4.63). The Bayesian 95% prediction interval (−12.24 to −0.79) indicated a 98.3% probability that a future study would show PASI improvement. Results were robust across all sensitivity analyses: MD −6.48 (95% CrI: −8.56 to −4.42) with Half-Normal(0, 2.5) and MD −6.49 (95% CrI: −8.95 to −4.06) with Half-Normal(0, 8).

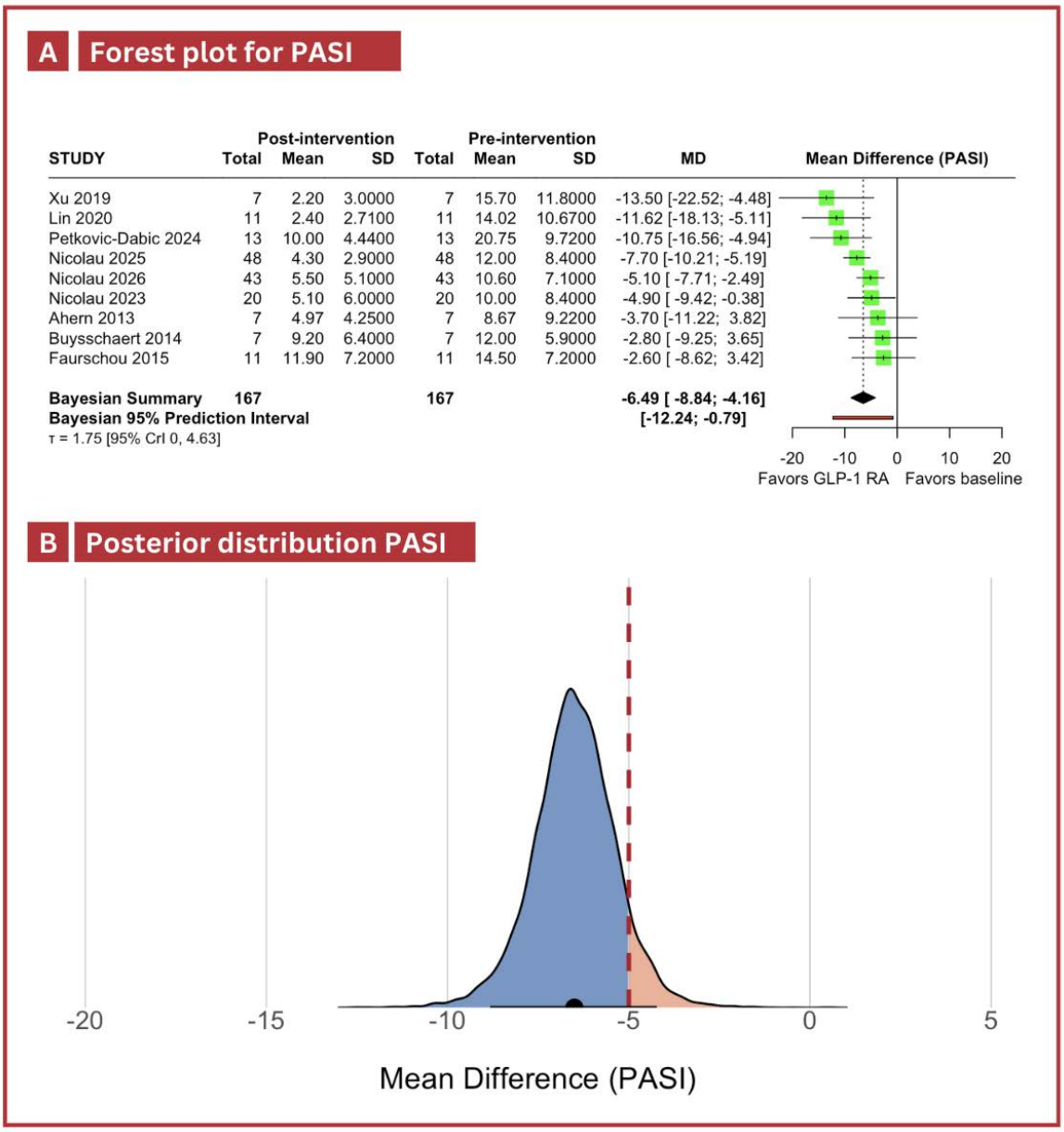

Figure 1. Bayesian random-effects forest plot for the association between GLP-1 receptor agonist therapy and PASI reduction in patients with psoriasis (Panel A). The diamond represents the pooled mean difference with 95% credible interval, and the red bar represents the 95% prediction interval. τ = between-study heterogeneity standard deviation; CrI = credible interval. Panel B shows the posterior distribution of the mean difference in PASI. The shaded areas represent the probability that the true mean difference lies below (blue) or above (salmon) a clinically relevant threshold of MD = −5 (vertical dashed line). The blue-colored area indicates that 91.4% of the total probability lies below MD = −5, consistent with a high likelihood of a clinically meaningful reduction in psoriasis severity.

Conclusions

This Bayesian meta-analysis provides strong evidence that GLP-1 RA therapy is associated with a clinically meaningful reduction in psoriasis severity, with a near-certain posterior probability of benefit. These findings support the potential role of GLP-1 RAs as an adjunctive therapeutic strategy in patients with psoriasis, particularly those with metabolic comorbidities. Randomized controlled trials with larger sample sizes are warranted to confirm these findings and to elucidate the mechanisms underlying the dermatological benefits of GLP-1 RAs.

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Abstract N°: 3663

Risankizumab Versus Deucravacitinib in Adults With Moderate Plaque Psoriasis: Week 52 Subgroup Results From the IMMpactful Study

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Introduction

Comparative efficacy and safety data for available plaque psoriasis (PsO) treatment options help inform systemic therapy selection for patients with varied demographics and disease characteristics. Risankizumab (RZB) and deucravacitinib (DEU) are 2 advanced therapies available for the treatment of adults with moderate-to-severe PsO. RZB is an injectable humanized IgG1 monoclonal antibody that inhibits interleukin 23; DEU is an oral TYK2 inhibitor. In a head-to-head trial of RZB and DEU (IMMpactful [NCT06333860]), a higher proportion of patients treated with RZB than DEU achieved the coprimary efficacy endpoints (≥ 90% improvement from baseline in Psoriasis Area and Severity Index [PASI; PASI 90] and static Physician's Global Assessment [sPGA] score of clear/almost clear [sPGA 0/1]) at week 16, with consistent efficacy observed across demographic and baseline characteristic subgroups. We evaluated efficacy outcomes by patient subgroup at week 52 of IMMpactful among patients who did not respond to DEU at week 16 and either continued DEU or switched to RZB.

Materials and Methods

IMMpactful is a phase 4, multicenter, randomized, open-label, efficacy assessor-blinded study. In period A, biologic-naive adults with moderate PsO (affected body surface area 10%–15%, PASI ≥ 12, sPGA = 3) were randomized (1:2) to receive subcutaneous (SC) RZB (150 mg at week 0 and 4) or oral DEU (6 mg once daily [QD] for 16 weeks). Period B of the study started at week 16, during which patients initially randomized to DEU were rerandomized (1:1) to receive SC RZB 150 mg at weeks 16, 20, 32, and 44 or oral DEU 6 mg QD up to week 52. At week 52, the period B primary endpoint (PASI 90) and ranked secondary endpoints (100% improvement from baseline in PASI [PASI 100]; sPGA of clear [sPGA 0]) were analyzed among patients initially randomized to receive DEU who did not achieve PASI 90 at week 16 and were rerandomized. Safety was assessed throughout the study.

Results

A total of 183 patients who were randomized to receive DEU in period A but did not achieve PASI 90 at week 16

were rerandomized in period B to receive SC RZB 150 mg (DEU/RZB; n = 90) or continue oral DEU 6 mg QD (DEU/DEU; n = 93). At week 52, PASI 90, PASI 100, and sPGA 0 were achieved by 82.2%, 60.0%, and 62.2% of patients who switched to RZB and by 20.4%, 10.8%, and 9.7% of patients who continued DEU. DEU/RZB vs DEU/DEU efficacy patterns were consistent across baseline subgroups (PASI 90 responses by body mass index [BMI]: < 25 kg/m^2, 94.7% vs 21.7%; ≥ 25 to < 30 kg/m^2, 84.8% vs 24.2%; ≥ 30 kg/m^2, 73.7% vs 16.2%; PASI 100 responses by BMI: < 25 kg/m^2, 57.9% vs 13.0%, ≥ 25 to < 30 kg/m^2, 66.7% vs 15.2%; ≥ 30 kg/m^2, 55.3% vs 5.4%; sPGA 0 responses by BMI: < 25 kg/m^2, 63.2% vs 8.7%; ≥ 25 to < 30 kg/m^2, 69.7% vs 15.2%; ≥ 30 kg/m^2, 55.3% vs 5.4%). DEU/RZB vs DEU/DEU responses by baseline PASI score (at or below vs above the median of 14.4) were PASI 90: ≤ median PASI, 82.6% vs 21.6%; > median PASI, 81.8% vs 19.0%; PASI 100: ≤ median PASI, 60.9% vs 9.8%; > median PASI, 59.1% vs 11.9%; sPGA 0: ≤ median PASI, 63.0% vs 9.8%; > median PASI, 61.4% vs 9.5%. Safety profiles remained generally consistent with the known profiles of both treatments.

Conclusions

Week 52 results showed consistent clinical benefit across patient subgroups for switching to RZB vs continuing DEU treatment in biologic-naive adults with moderate PsO who did not respond to 16 weeks of DEU treatment; the RZB safety profile was consistent with previous RZB studies.

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Abstract N°: 3675

Risankizumab as Early Systemic Intervention in Moderate Plaque Psoriasis: Long-Term Real-Life Effectiveness and Safety up to 156 Weeks

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Introduction

The traditional mild/moderate/severe classification of plaque psoriasis may not fully reflect treatment needs in clinical practice. The International Psoriasis Council (IPC) proposed a pragmatic reclassification distinguishing patients eligible for topical therapy from those requiring systemic treatment, based on BSA >10%, involvement of special areas or inadequate control with topical therapy. This approach moves beyond the previous definition of "moderate" psoriasis and supports earlier systemic intervention in selected patients who may otherwise remain undertreated with ineffective topical regimens. Early biologic treatment may reduce cumulative inflammatory burden, improve long-term disease control and potentially contribute to disease modification. We aimed to assess the long-term effectiveness and safety of risankizumab in bio-naïve patients with moderate plaque psoriasis without severe involvement of sensitive areas.

Materials and Methods

We conducted a monocentric, retrospective, real-life study including adult bio-naïve patients with plaque psoriasis treated with risankizumab in routine clinical practice. Patients had a moderate disease phenotype according to baseline PASI and no severe sensitive-area involvement as the main indication for systemic treatment. Effectiveness was evaluated up to 156 weeks using PASI and PGA responses. The proportions of patients achieving PASI 75, PASI 90, PASI 100, absolute PASI <2 and PGA 0/1 were assessed at weeks 16, 32, 40, 52, 104 and 156. Safety was evaluated by recording adverse events (AEs), severe AEs and AEs leading to treatment discontinuation. Continuous variables are reported as mean ± standard deviation and categorical variables as n (%).

Number of Patients	**177**
	Mean ± SD
Age, years	52,46(16,4)
Disease duration, years	18,49 (14,24)
BMI, Kg/m2	25,84 (4,50)
PASI at baseline	7,54 (2,38)
	N (%)
Male	99 (55,9)
PsA	15 (11,8)
Scalp/Face involvement	115 (65,0)
Genitalia involvement	47 (26,6)
Fingernails involvement	44 (24,9)
Palmoplantar involvement	29 (16,4)
At least one cardiometabolic comorbidity	86 (48,6)
Chronic infections	22 (12,4)
Neoplasm	14 (7,9)

Table 1. Demographic and clinical characteristics of the study population at baseline. Data are reported as mean ± standard deviation (SD) for continuous variables and as number and percentage, n (%), for

categorical variables. BMI, body mass index; PASI, Psoriasis Area and Severity Index; PsA, psoriatic arthritis.

Results

A total of 177 patients were included (Table1). Ninety-nine patients were male (55.9%). Mean age was 52.46 ± 16.4 years, mean disease duration 18.49 ± 14.24 years, mean BMI 25.84 ± 4.50 kg/m² and mean baseline PASI 7.54 ± 2.38. Psoriatic arthritis was reported in 15 patients (11.8%). Limited sensitive-area involvement was recorded, including scalp/face in 115 patients (65.0%), genital involvement in 47 (26.6%), fingernails in 44 (24.9%) and palmoplantar involvement in 29 (16.4%). At least one cardiometabolic comorbidity was present in 86 patients (48.6%), chronic infections in 22 (12.4%) and previous neoplasms in 14 (7.9%).

At week 16, PASI 75, PASI 90 and PASI 100 were achieved by 51.4%, 32.1% and 22.1% of patients, respectively; absolute PASI <2 and PGA 0/1 were reached by 47.9% and 60.0%. Responses progressively increased over time (Figure1). At week 52, PASI 75, PASI 90, PASI 100, absolute PASI <2 and PGA 0/1 were achieved by 90.2%, 74.8%, 61.2%, 87.4% and 92.2%, respectively. Long-term effectiveness was maintained up to week 156, with PASI 75, PASI 90 and PASI 100 achieved by 97.9%, 89.4% and 87.2% of patients; absolute PASI <2 and PGA 0/1 were both achieved by 97.9%.

Overall, 6 patients (3.4%) experienced at least one AE. Upper respiratory tract infections occurred in 4 patients (2.3%), while headache and herpes zoster were reported in 1 patient each (0.6%). No severe AEs and no AE-related treatment discontinuations were observed.

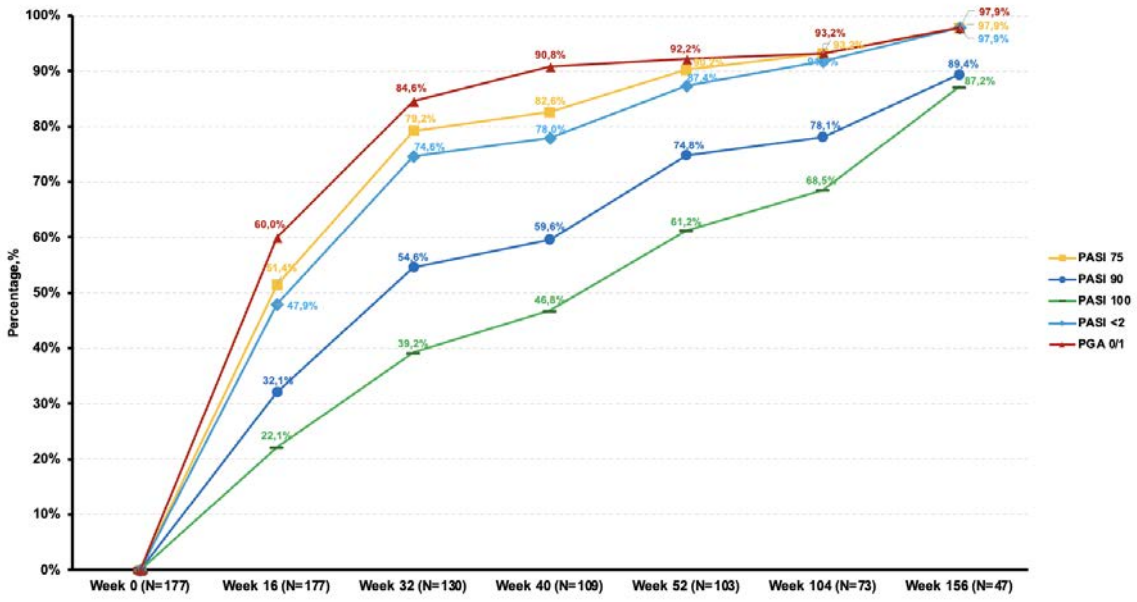

Figure 1. Long-term effectiveness of risankizumab in patients with moderate plaque psoriasis. Proportion of patients achieving PASI 75, PASI 90, PASI 100, absolute PASI <2 and PGA 0/1 from baseline to week 156. Effectiveness outcomes were assessed at weeks 16, 32, 40, 52, 104 and 156. Data are reported as percentages of patients achieving each endpoint at the corresponding time point. PASI, Psoriasis Area and Severity Index; PGA, Physician's Global Assessment.

Conclusions

In this monocentric real-life cohort, risankizumab showed rapid, progressive and sustained effectiveness in bio-naïve patients with moderate plaque psoriasis followed for up to 156 weeks. In line with the IPC reclassification, these findings support moving beyond rigid PASI-based severity categories and considering early systemic treatment for selected "moderate" patients inadequately controlled with topical therapy. Early intervention may reduce undertreatment, limit persistent systemic inflammation and potentially influence the development of psoriasis-associated comorbidities. The low AE rate, absence of severe events and absence of discontinuations

confirm the highly favorable safety profile of risankizumab in this clinical setting.

EADV CONGRESS
VIENNA
30 SEP - 3 OCT 2026

Abstract N°: 3675

Circinate Annular Pustular Psoriasis in an Adolescent Mimicking Dermatophytosis: A Diagnostic Challenge

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Introduction

Annular pustular psoriasis is a rare clinical variant of generalized pustular psoriasis characterized by annular or polycyclic erythematous plaques with peripheral sterile pustules. Its clinical resemblance to dermatophytosis and other annular dermatoses may delay diagnosis and management.

Case Presentation

We report the case of a 16-year-old boy with psoriasis since the age of two years and a family history of psoriasis, admitted for an acute febrile generalized eruption. The patient was being treated with weekly methotrexate injections following an episode of psoriatic erythroderma. Three days before admission, he developed a rapidly progressive pruritic erythematosquamous eruption associated with fever, asthenia, and inflammatory arthralgia.

Dermatological examination revealed extensive annular and polycyclic erythematous-squamous plaques with centrifugal extension and peripheral non-follicular pustules. Auspitz sign and candle grease sign were positive. Target-like lesions were also observed on the limbs further complicating the clinical picture by mimicking acute generalized exanthematous pustulosis (AGEP or erythema multiforme). Body surface area involvement was estimated at 45% with a PASI (*Psoriasis Area and Severity Index*) score of 22.

Dermoscopy showed homogeneous dotted vessels. Mycological examination and bacteriological cultures from pustular lesions were negative.
The diagnosis of circinate annular pustular psoriasis was retained based on a bundle of clinical arguments: sterile peripheral pustules, typical psoriatic scales, and the exclusion of mimics through negative mycological exams.
The condition was successful managed, highlighting the importance of early and accurate diagnosis to initiate appropriate therapy and avoid the complications associated with this entity.

Conclusion

Circinate annular pustular psoriasis is an uncommon and potentially misleading variant of generalized psoriasis. Systematic mycological examination is essential in annular eruptions to exclude fungal infection. Acute onset and peripheral sterile pustules are key diagnostic clues favoring pustular psoriasis.

EADV CONGRESS
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Abstract N°: 3679

Complex Management of a Generalized Pustular Psoriasis Exacerbation Triggered by Corticosteroid Withdrawal in an Oncologic Patient with Multiple Comorbidities

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Introduction

Systemic corticosteroids administered for concurrent acute illnesses can trigger severe rebound flares of generalized pustular psoriasis (GPP) upon withdrawal. Managing such flares becomes exceptionally challenging when the patient presents with active malignancy and severe pulmonary compromise, which limits conventional systemic therapy options.

Case Presentation

We present the case of a 58-year-old female with a known history of plaque and pustular psoriasis, admitted for generalized pustular psoriasis triggered by systemic corticosteroid withdrawal. Her concurrent active cervical cancer significantly restricted her dermatological treatment options. The patient is a long-term heavy smoker (40 pack-year history) with a significant medical background, including Grade III hypertension and Stage IV (GOLD) chronic obstructive pulmonary disease. Pulmonary function tests revealed a severe obstructive pattern, with a FEV1 of 24% of predicted, complicated by chronic respiratory failure necessitating long-term oxygen therapy via a Portable Oxygen Concentrator (POC). Additionally, the patient has a history of cervical cancer treated with radiotherapy. Regarding her psoriasis, initial treatment with tildrakizumab and methotrexate was discontinued following the oncological diagnosis. Upon admission the patient presented with an eruption that consisted in a generalized pustular and erythematous-squamous eruption. The flare occurred upon tapering and discontinuation of methylprednisolone, which had been administered for a recent respiratory exacerbation. Clinical evaluation revealed a GPPGA score of 3.33. Laboratory investigations showed marked systemic inflammation (elevated CRP and ESR) alongside normochromic normocytic anemia. Following oncological clearance, the dermatological management focused on continuing weekly methotrexate (15 mg), supplemented with folic acid 48 hours post-administration, alongside topical therapy. The clinical course was highly favorable; the pustules completely resolved, and the erythematous-squamous lesions significantly improved without compromising her complex cardiopulmonary or oncological status.

Conclusion

Systemic corticosteroids used for concurrent acute illnesses can trigger severe rebound flares of pustular psoriasis upon withdrawal. This case highlights that generalized pustular psoriazis management in patients with Stage IV COPD and active malignancy requires a delicate balance; however, through rigorous multidisciplinary coordination, traditional agents like methotrexate can be safely and effectively utilized even in critical patients with complex multiorgan pathology.

EA DV CONGRESS
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Abstract N°: 3683

Cutaneous Adverse Events of Allosteric TYK2 Inhibitors in Plaque Psoriasis: A Systematic Review and Meta-Analysis

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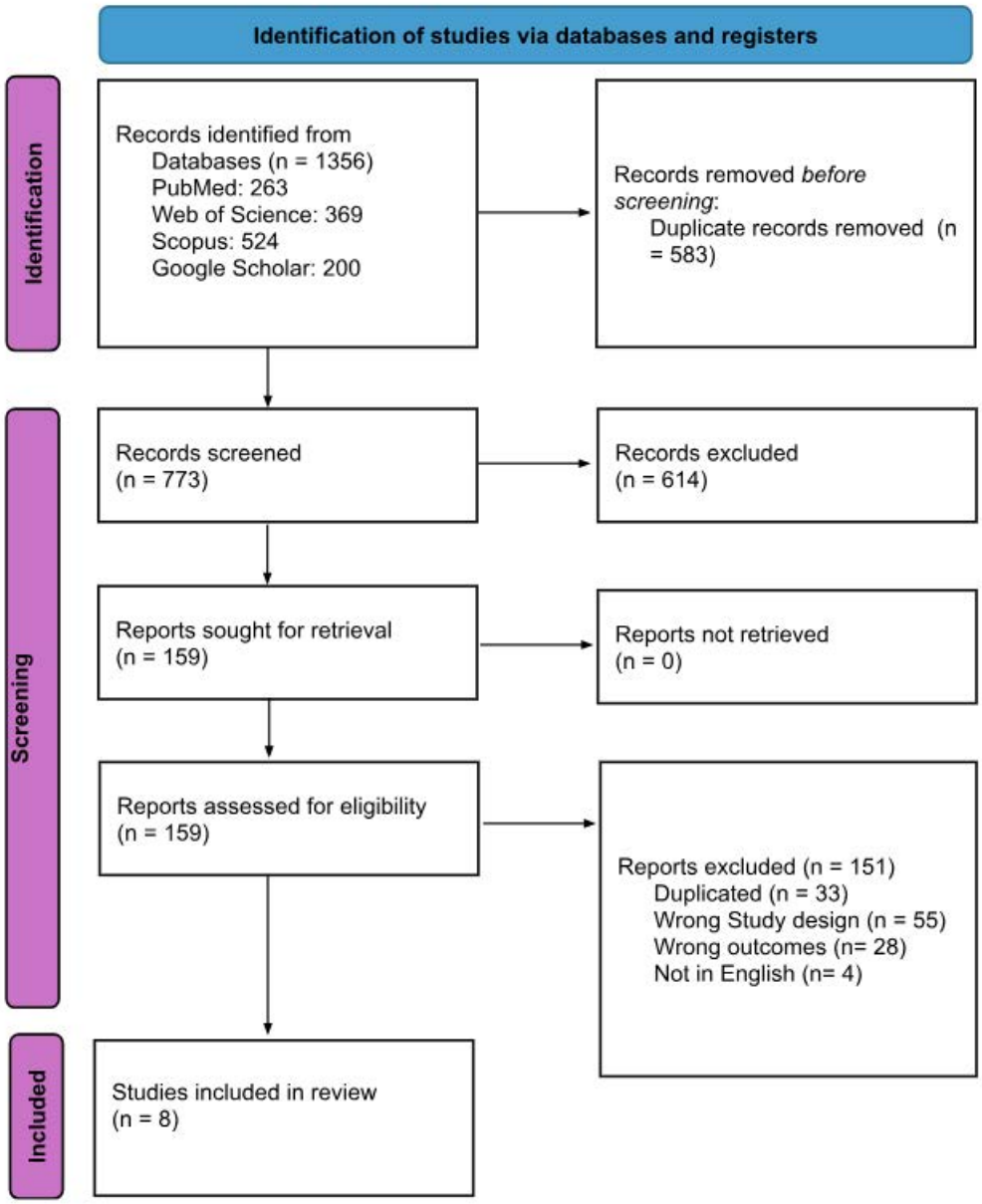
Introduction

Psoriasis is a chronic immune-mediated skin disease that significantly impairs quality of life, particularly in patients with moderate-to-severe disease. Allosteric tyrosine kinase 2 (TYK2) inhibitors are a novel class of oral small-molecule therapies targeting TYK2, an enzyme of the Janus kinase family, and have demonstrated substantial efficacy in clinical trials. However, given the recent emergence of several TYK2 inhibitors, no systematic review has comprehensively evaluated the safety profile of all available agents. Furthermore, although dermatologic adverse events have been frequently reported, cutaneous adverse events as a distinct subgroup have not been specifically analyzed. We conducted a systematic review and meta-analysis to evaluate the safety of deucravacitinib, zasocitinib, ESK-001, and D-2570 in moderate-to-severe plaque psoriasis, with an emphasis on cutaneous adverse events.

Materials and Methods

This systematic review and meta-analysis were conducted in accordance with PRISMA guidelines and registered in PROSPERO. A comprehensive search of PubMed, Scopus, Web of Science, and Google Scholar was performed for studies published from database inception until May 1, 2026. Randomized controlled trials (RCTs) were screened according to predefined inclusion and exclusion criteria. Eligible studies were required to report at least one predefined safety outcome, including acne, folliculitis, or herpes zoster. Meta-analyses were performed using random-effects models to calculate pooled risk differences (RDs) for acne and folliculitis. For rare events, specifically herpes zoster, Peto odds ratios (ORs) with a common-effect model were utilized. Subgroup analyses were conducted to evaluate potential differences across drug types, dosages, and treatment durations.



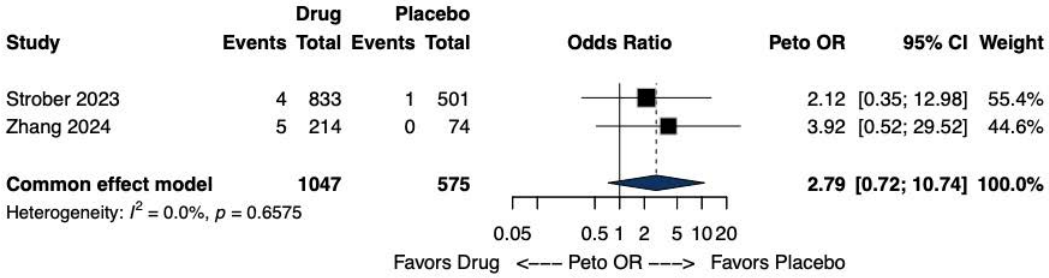
PRISMA

Results

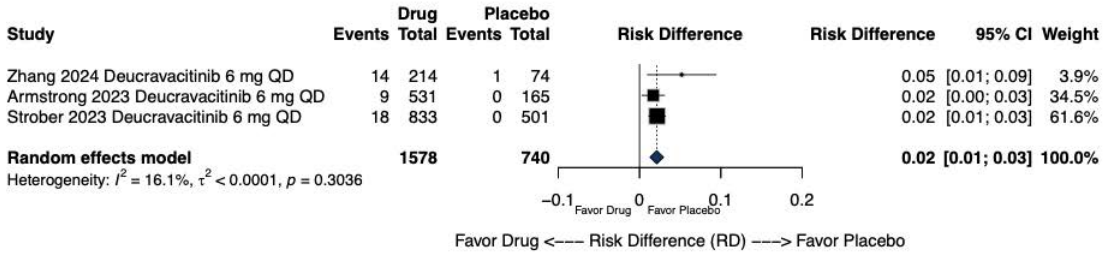
The meta-analysis included 8 clinical trials evaluating allosteric TYK2 inhibitors. Long-term analysis of folliculitis (3 studies, n=2,318) showed a statistically significant absolute risk increase (RD 0.02 [95% CI: 0.01, 0.03]). Despite minor clinical variations, statistical heterogeneity was low (I^2=16.1%), indicating high consistency across long-term trials. Regarding viral reactivation, long-term herpes zoster (2 studies, n=1,622) demonstrated an increased risk trend with a pooled Peto odds Ratio of 2.79 [95% CI: 0.72, 10.74] and no heterogeneity (I^2=0%).

For acne (n=526), the pooled risk difference was 0.03 [95% CI: -0.01, 0.07] with I^2=0%. Subgroup analyses revealed no significant differences between drug types (deucravacitinib vs. zasocitinib, p=0.87), suggesting a class-wide effect.

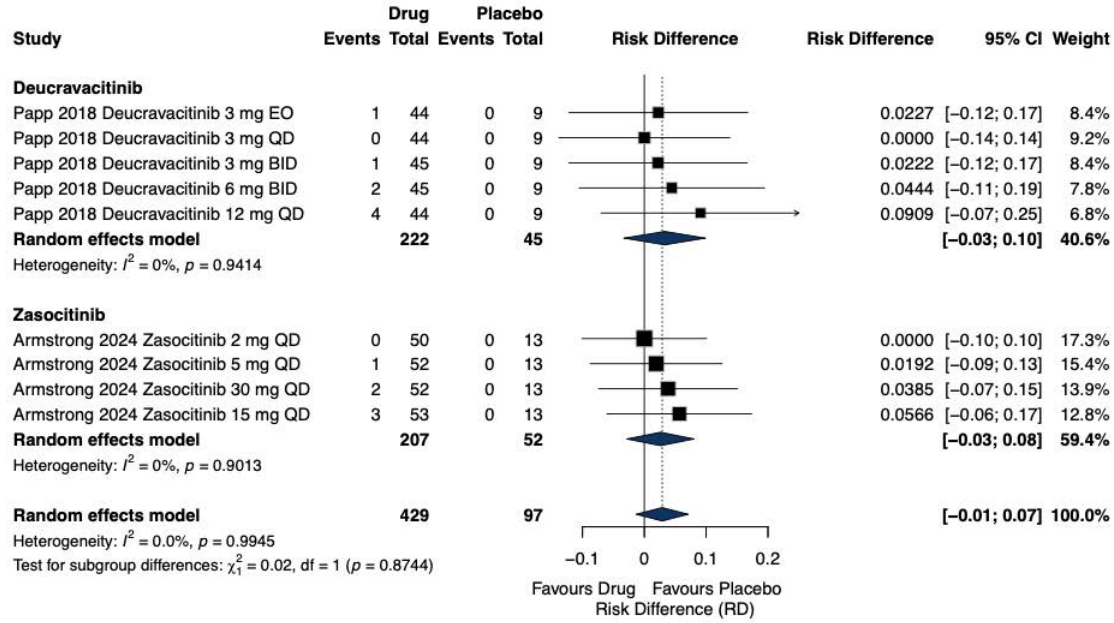
Herpes Zoster



Folliculitis



Acne



Forest Plot

Conclusions

TYK2 inhibitors are associated with a statistically significant increase in long-term folliculitis risk and a notable trend toward increased herpes zoster reactivation. The consistently low heterogeneity across outcomes strengthens the evidence that these cutaneous events represent reproducible class-wide adverse-event patterns.

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Abstract N°: 3721

Treatment with semaglutide lowers the risk of developing psoriasis compared to liraglutide: A Danish nationwide cohort study

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Introduction

Glucagon-like peptide-1 (GLP)-1 receptor agonists (RA) are used for treatment of type 2 diabetes (T2D) and/or weight loss, but smaller studies have shown that GLP-1RA may also improve psoriasis severity. In Denmark, the most used GLP-1RA are liraglutide and semaglutide. Although both work by mimicking GLP-1, semaglutide shows greater potency. Notably, semaglutide injections demonstrate almost three-fold greater weight reductions with better glycemic control than liraglutide. While GLP-1RA might work in psoriasis, little is known about the potential protective role of GLP-1RA in developing psoriasis. The aim of this study was to assess the risk of incident psoriasis in patients treated with liraglutide and semaglutide.

Materials and Methods

We conducted an active comparator, new-user, nationwide, register-based cohort study comparing the risk of incident psoriasis between all Danish patients treated with liraglutide or semaglutide injections between 2007 and 2023. Intention-to-treat analysis was performed, and patients could only be included once. Patients were followed for up to five years, and psoriasis diagnosis was according to ICD10 or two filled prescriptions of calcipotriol, as previously validated. Patients with history of psoriasis were excluded. Cox proportional hazards models were used to calculate hazard ratios adjusted for age, sex, ever-smokers, ever-alcohol abuse, ischemic heart disease (IHD), and dyslipidemia (aHR). Analyses were conducted for all and based on indication (T2D or weight loss). To address off-label use of GLP-1RA, additional analyses were performed for the T2D indication, including only patients previously treated with metformin.

Results

In total, 183,487 were treated with an GLP-1RA: 64,692 patients were treated with liraglutide (TD2: 37,827 patients and weight loss: 26,865 patients) contributing 238,336 patient years (PY) and 11,8795 patients were treated with semaglutide (T2D: 46,050 patients and weight loss: 72,745 patients) contributing 135,484 PY. Compared to the semaglutide group, patients treated with liraglutide were slightly older (53 vs. 56 years) and more often had dyslipidemia (57 vs 36%) and IHD (14 vs 8%).

Among patients treated with liraglutide, 467 patients developed psoriasis (incidence rate [IR]: 1.96 / 1000 PY) and 185 developed psoriasis (IR: 1.37 / 1000 PY) in the semaglutide group (Figure 1). Consequently, the risk of developing psoriasis was higher among liraglutide treated than semaglutide treated (aHR: 1.41, 95% confidence interval (CI): 1.18-1.70, p=0.0002). When restricting the analyses to only include T2D drugs (aHR: 1.41, 95% CI: 1.14-1.73, p=0.0013) and patients with prior metformin use (aHR: 1.43, 95% CI: 1.13-1.79, p=0.0026) similar risks were observed. For the weight loss indication, a non-statistically significant increased risk of psoriasis was observed (aHR: 1.52, 95% CI, 0.97-2.39, p=0.068).

The lower psoriasis risk observed with semaglutide compared with liraglutide may reflect the greater potency with

larger weight reductions and glycemic control, potentially influencing psoriasis risk through reduced metabolic inflammation.

Importantly, patients treated with liraglutide were older with more comorbidities, suggesting possible confounding by indication. However, the association was similar in analyses restricted to T2D and in those with prior metformin use, where baseline comorbidities were similar, supporting the robustness of the findings. An important limitation was the lack of body mass index, preventing assessment of whether weight reduction mediated the observed association. The non-significant result for the weight loss indication may reflect fewer events and shorter follow-up.

Conclusions

Semaglutide was associated with a lower risk of incident psoriasis compared with liraglutide. These findings support the growing evidence linking metabolic improvement with reduced psoriasis risk.

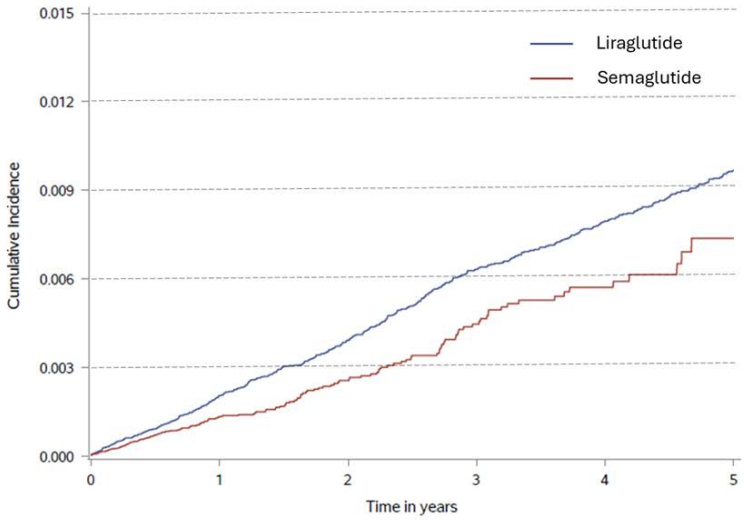

Figure 1. Cumulative incidence of incident psoriasis following treatment with liraglutide or semaglutide.

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Abstract N°: 3726

Real-World Effectiveness of Risankizumab Compared With Other Biologics in Patients With Moderate-to-Severe Psoriasis up to 37 Months

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[8] Hospital Aleman Capital Federal, Buenos Aires, Argentina
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Introduction

VALUE is a long-term post-marketing observational study (PMOS) assessing the real-world effectiveness of RZB compared with other approved biologics (OtherBios) for the management of psoriasis. All patients (pts) are followed up to 37 months, and the final results are reported.

Materials and Methods

Pts (≥18 years) with psoriasis receiving RZB or OtherBios (2:1 ratio), independent of this study and per local label, were enrolled in VALUE (NCT03982394). Effectiveness endpoints reported here include mean absolute Psoriasis Area and Severity Index (PASI) and Dermatology Life Quality Index (DLQI), proportions of pts achieving ≥ 90% improvement in PASI (PASI 90) and PASI 100, and Treatment Satisfaction Questionnaire for Medication (TSQM) global satisfaction scores at 37 months (data cut: 09 December 2025). Treatment results were compared as RZB vs OtherBios and RZB vs TNF α inhibitor (TNFi) vs Other IL-23i (OtherIL-23i) vs IL-17i. Modified Non-Responder Imputation (mNRI) was used to handle treatment change, with pts who switched or discontinued the initiated biologic due to ineffectiveness or intolerability considered treatment failures for subsequent visits. Propensity score matching (PSM) was used to address pt imbalance in baseline characteristics. Nominal *P* values are reported.

Results

Of 2805 pts who enrolled in VALUE, 1856 (mean age [SD]: 49.1 [14.7] years) and 931 (mean age [SD]: 47.9 [14.5] years) received RZB and OtherBios, respectively. Baseline mean (SD) PASI (RZB vs OtherBios) was 14.9 (9.0) vs 14.0 (9.1).

A higher proportion of pts (RZB vs OtherBios) achieved PASI 90 (72.4% vs 53.5%, $P < .0001$), and PASI 100 (57.4% vs 40.6%, $P < .0001$) in the RZB group compared with the OtherBios group (Table). Mean absolute PASI (1.3 vs 2.6, $P < .0001$) and mean absolute DLQI (1.9 vs 3.9,$P < .0001$) were lower in the RZB group compared with the OtherBios group. TSQM global satisfaction score (85.1 vs 77.6, $P < .0001$) was higher in the RZB group compared with the OtherBios group. Consistent results were observed in the PSM population.

When effectiveness was assessed in RZB compared with OtherBios by mechanism of action, the proportion of pts who achieved PASI 90 was higher in the RZB group (72.4%) compared with the TNFi (38.4%, $P < .001$), and IL-17i (50.9%, $P < .001$) groups but similar to the OtherIL-23i group (67.9%, $P = .159$) (Table). The proportion of pts who achieved PASI 100 was higher in the RZB group (57.4%) compared with the TNFi (31.7%, $P < .001$), and IL-17i (38.8%, $P < .001$) groups but similar to the OtherIL-23i group (51.3%, $P = .091$). Mean absolute PASI was lower in the RZB group (1.3) compared with the TNFi (3.9, $P < .001$) and the IL-17i groups (3.6, $P < .001$) but similar to the OtherIL-23 group (1.5, $P = .441$). Mean absolute DLQI was lower in the RZB group (1.9) compared with the TNFi (6.1, $P < .001$), OtherIL-23 (2.5, $P = .042$), and the IL-17i (3.6, $P < .001$) groups. TSQM global satisfaction score was higher in the RZB group (85.1) compared with the TNFi (71.0, $P < .001$), OtherIL-23i (82.0, $P = .035$), and IL-17i (77.9, $P < .001$) groups. Consistent results were observed in the PSM population.No new safety concerns were identified.

Table. Patient responses at month 37 in the VALUE PMOS effectiveness study.

Response (mNRI)	RZB	OtherBios	TNFi	OtherIL-23i	IL-17i
PASI 90					
% (95% CI)	72.4 (69.9, 74.8)	53.5 (49.6, 57.4)***	38.4 (30.8, 46.4)**	67.9 (61.3, 73.9)	50.9 (44.1, 57.6)**
n/N	949/1310	352/658	61/159	152/224	114/224
PASI 100					
% (95% CI)	57.4 (54.7, 60.1)	40.6 (36.8, 44.5)***	31.7 (24.6, 39.5)**	51.3 (44.6, 58.1)	38.8 (32.4, 45.6)**
n/N	757/1319	268/660	51/161	115/224	87/224
Absolute PASI					
Mean (95% CI)	1.3 (1.2, 1.5)	2.6 (2.2, 2.9)***	3.9 (3.1, 4.8)**	1.5 (1.0, 2.0)	2.6 (2.0, 3.2)**
n	1318	660	161	224	224
Absolute DLQI					
Mean (95% CI)	1.9 (1.7, 2.1)	3.9 (3.5, 4.4)***	6.1 (4.9, 7.4)**	2.5 (1.9, 3.2)*	3.6 (2.9, 4.4)**
n	1249	635	158	213	211
TSQM global					
Mean (95% CI)	85.1 (84.0, 86.2)	77.6 (75.7, 79.5)***	71.0 (66.6, 75.4)**	82.0 (79.1, 84.9)*	77.9 (74.9, 80.9)**
n	1215	617	152	207	209

DLQI, Dermatology Life Quality Index; IL-17i, interleukin 17 inhibitor; OtherIL-23i, other interleukin 23 inhibitor; mNRI, modified Non-Responder Imputation; PASI, Psoriasis Area and Severity Index; PASI 90, ≥ 90% improvement in PASI; PASI 100, 100% improvement in PASI; RZB, Risankizumab; TNFi, Tumor Necrosis Factor-alpha inhibitor; TSQM, Treatment Satisfaction Questionnaire for Medication (global satisfaction score);*P < .05 ; **P < .001 ***P < .0001 statistical difference between RZB and each treatment group.

Conclusions

In this final 37-month VALUE analysis, pts treated with RZB consistently achieved considerably higher clinical responses, better quality of life, and treatment satisfaction in real-world practice compared with OtherBios, including TNFi, and IL-17i.

EA DV CONGRESS
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Abstract N°: 3735

Safety Profile of Secukinumab in Plaque Psoriasis: Clinical Implications and Long-term Outcomes

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Introduction

Plaque psoriasis is a chronic immune-mediated inflammatory disease, affecting 2-3% of the global population. It is associated with significant physical and psychosocial burden, as well as comorbidities like psoriatic arthritis and cardiovascular disease. Interleukin-17A plays a key role in keratinocyte activation and inflammatory pathways involved in plaque formation, making it a key therapeutic target. Secukinumab, a monoclonal antibody targeting IL-17A, has demonstrated high efficacy in moderate-to-severe plaque psoriasis. Given the need for long-term therapy, evaluating its safety and clinical implications is essential.

Materials and Methods

A literature search was conducted using PubMed and Google Scholar for studies published between 2020 and 2026. Keywords included ‘secukinumab’, ‘plaque psoriasis’, ‘safety’, and ‘long-term outcomes’. A total of 106 studies were identified, of which 86 were excluded after screening for clinical relevance and duplicate removal using Rayyan. 20 studies, including randomized controlled trials, observational studies, and systematic reviews reporting safety outcomes, were included in the review.

Results

Phase III trials and long-term extensions show sustained efficacy of secukinumab with high PASI-75 response rates exceeding 75% at week 12 and maintained over follow-up periods of up to 5 years, without new safety concerns. The most commonly reported adverse events (AEs) were nasopharyngitis (33.7%) and upper respiratory tract infections (13%), both generally mild to moderate. Mucocutaneous candidiasis was observed in 2-3% of patients and was generally manageable without discontinuation of treatment. Serious AEs, including serious infections, myocardial infarction, stroke, heart failure and malignancies such as basal-cell carcinoma, demonstrated consistently low incidence rates across both clinical trials and real-world studies.

Although Crohn's disease and ulcerative colitis have been reported, occurrence rates remained low in long-term studies, with Crohn's disease reported in approximately 0.05-0.4 and Ulcerative colitis in 0.13-0.2 cases per 100 patient-years. Real-world data further support these findings, demonstrating sustained effectiveness and long-term treatment persistence with approximately 60% patients remaining on therapy at 5 years. However, studies have shown that prior exposure to biologic therapies may impact treatment response. These findings align with previously reported safety profiles of biologics used in plaque psoriasis and highlight the importance of individualized risk assessment and targeted monitoring, particularly in patients with underlying risk factors.

Conclusions

Secukinumab demonstrates a favorable and consistent safety profile in plaque psoriasis, supported by long-term and real-world evidence. While most adverse effects are mild and manageable, careful patient selection and targeted monitoring for infections and comorbid conditions are essential to optimize treatment outcomes. These

findings support its use as a reliable long-term therapeutic option in clinical practice.

EA DV CONGRESS
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30 SEP - 3 OCT 2026

Abstract N°: 3742

From Cement to Psoriasis: Unmasking a Koebner Phenomenon in an Adolescent

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Introduction
Psoriasis is a chronic immune-mediated inflammatory skin disease in which clinical expression can be influenced by a variety of environmental triggers, including cutaneous trauma through the Koebner phenomenon. Cement is a well-recognized chemical irritant frequently associated with irritant or allergic contact dermatitis; however, its role as a trigger of de novo psoriasis remains exceptionally reported. This overlap in clinical presentation may represent an early diagnostic pitfall, as initial psoriatic lesions can closely mimic contact dermatitis at exposed sites. Increased clinical awareness is therefore essential for prompt recognition and appropriate management of such atypical presentations.

Case Presentation
We report the case of a 17-year-old adolescent with no personal or family history of psoriasis, who developed a pruritic erythematous and scaly eruption three days after occupational exposure to cement. The eruption initially appeared on exposed contact areas of the hands and feet before rapidly extending over the following days to become generalized, involving the trunk and limbs.

Clinical examination revealed multiple well-demarcated erythematous plaques covered with thick silvery-white scales, with a clear predominance at sites of cement exposure where mild lichenification was also present. The Auspitz sign and candle grease sign were positive. The body surface area involvement was estimated at approximately 40%, with no mucosal or nail involvement.

Dermoscopy showed a homogeneous erythematous background with regularly distributed dotted and glomerular vessels associated with diffuse white scaling, a pattern consistent with psoriasis vulgaris.

Skin biopsy confirmed the diagnosis of psoriasis.

Overall, the temporal relationship with cement exposure, the site-restricted onset followed by rapid dissemination, and the clinico-histopathological correlation support a diagnosis of de novo psoriasis likely induced by a Koebner phenomenon. This case illustrates how a common occupational exposure can abruptly reveal an underlying psoriatic tendency in an otherwise healthy adolescent.

Conclusion
This case underscores that occupational cement exposure may act as a potent trigger of de novo psoriasis through the Koebner phenomenon, reflecting an underlying cutaneous susceptibility to environmental injury. Its initial presentation can closely mimic irritant or allergic contact dermatitis, making early clinical recognition particularly challenging.

This highlights the importance of including psoriasis in the differential diagnosis of acute eczematous or psoriasiform eruptions in exposed individuals, in order to avoid diagnostic delay and ensure appropriate

management, especially in young patients with occupational exposure.

EADV CONGRESS
VIENNA
30 SEP - 3 OCT 2026

Abstract N°: 3747

The Evolving Burden of Psoriasis in South Asia: A 33-Year Analysis of Age-Standardized DALYs, Prevalence, and Incidence (1990–2023) from the Global Burden of Disease Study

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Introduction

Psoriasis is a chronic, immune-mediated, multisystem inflammatory disorder characterized by keratinocyte hyperproliferation, scaly plaques, pruritus, and significant psychosocial burden. While global prevalence is estimated at 2–3%, substantial regional variations exist due to genetic, environmental, lifestyle, and healthcare access differences. Comprehensive country-level epidemiological data on psoriasis burden in South Asia remain limited. This study aimed to evaluate the burden of psoriasis across Bhutan, Nepal, Bangladesh, Pakistan, India, and the South Asia region by analysing age-standardized DALYs, prevalence, and incidence rates and their annual percentage changes (APC) from 1990 to 2023 using the Global Burden of Disease (GBD) study.

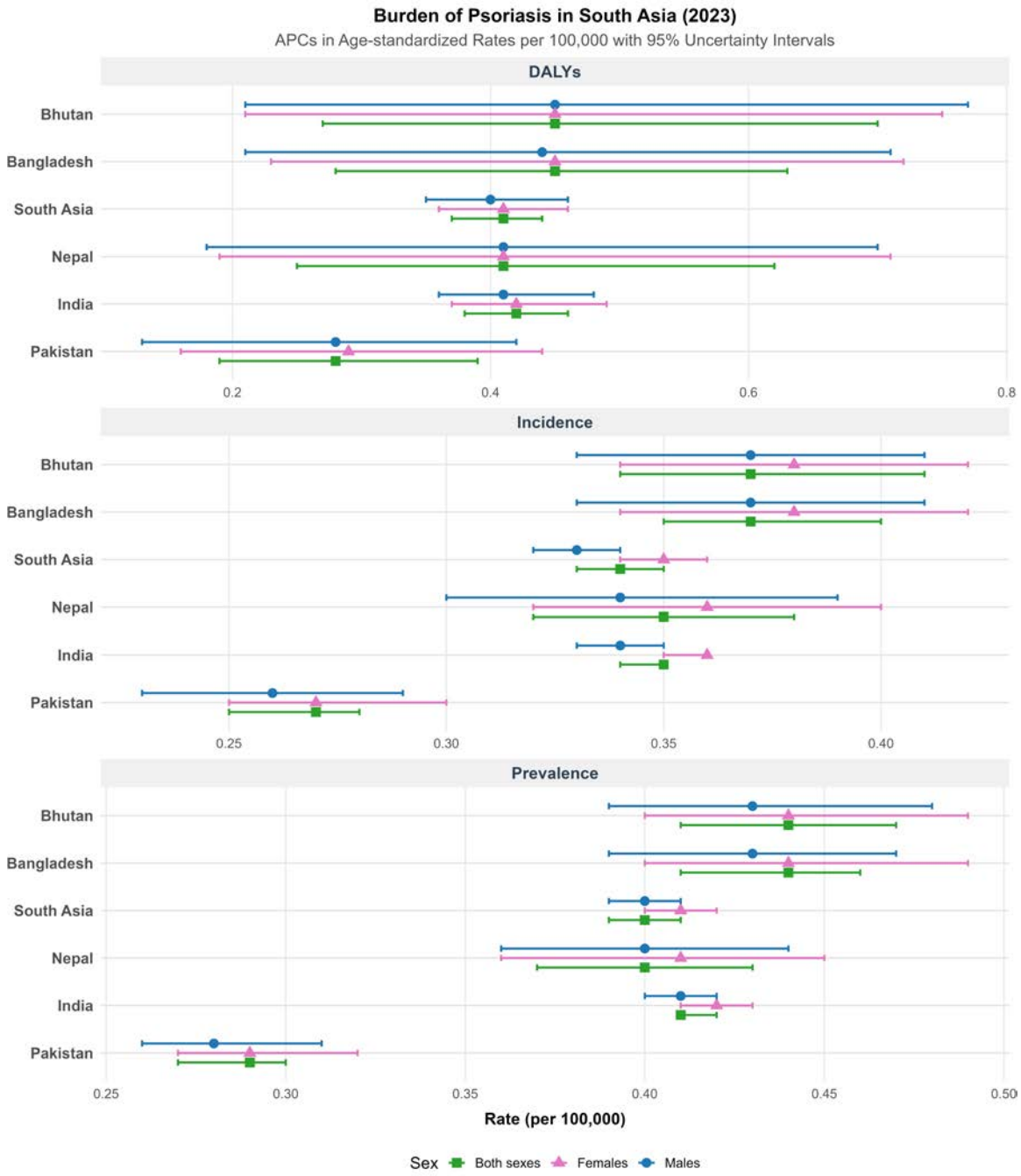
Materials and Methods

Data were systematically extracted from the Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 database. Age-standardized rates (per 100,000 population) for DALYs, prevalence, and incidence were retrieved for psoriasis (ICD-10 code L40). Metrics were stratified by sex (males, females, and both sexes) and location. The analysis focused on age-standardized estimates to allow fair comparison across countries with differing population age structures. Annual Percentage Changes (APC) were calculated to assess temporal trends over the 33-year period (1990–2023). Uncertainty intervals (95% UI) were incorporated to assess estimate robustness.

Results

From 1990 to 2023, APC in age-standardized DALYs rates remained relatively low yet persistent across South Asia. Bhutan and Bangladesh recorded the highest burden: Bhutan (males 0.45 [95% UI 0.21–0.77], females 0.45 [95% UI 0.21–0.75], both sexes 0.45 [95% UI 0.27–0.70]); Bangladesh (males 0.44 [95% UI 0.21–0.71], females 0.45 [95% UI 0.23–0.72], both sexes 0.45 [95% UI 0.28–0.63]). Nepal reported both-sexes DALYs of 0.41 (95% UI 0.25–0.62), India 0.42 (95% UI 0.38–0.46), and the South Asia region 0.41 (95% UI 0.37–0.44). Pakistan consistently showed the lowest DALYs rate (both sexes 0.28 [95% UI 0.19–0.39]). Age-standardized prevalence rates displayed remarkable consistency. The highest APCs were observed in Bhutan and Bangladesh (both sexes 0.44 [95% UI 0.41–0.47]), followed by India (0.41 [95% UI 0.41–0.42]), Nepal (0.40 [95% UI 0.37–0.43]), and South Asia overall (0.40 [95% UI 0.39–0.41]). Pakistan had the lowest prevalence (both sexes 0.29 [95% UI 0.27–0.30]). Age-standardized incidence patterns mirrored prevalence and DALYs. Bhutan and Bangladesh again led APCs with both-sexes rates of 0.37 (Bhutan: 95% UI 0.34–0.41; Bangladesh: 95% UI 0.35–0.40). India recorded 0.35 (95% UI 0.34–0.35), Nepal 0.35 (95% UI 0.32–0.38), South Asia 0.34 (95% UI 0.33–0.35), and Pakistan the lowest at 0.27 (95% UI 0.25–0.28). Minimal sex differences were noted across all countries and metrics, with male and female rates closely aligned. Over the 33-year period from 1990 to 2023, age-standardized DALYs, prevalence, and

incidence rates demonstrated notable stability with only modest fluctuations. Bhutan and Bangladesh consistently ranked highest across all three indicators, while Pakistan maintained the lowest burden throughout the study period.



APCs in Age-standardized Rates per 100,000 with 95% Uncertainty Intervals

Conclusions

This detailed 33-year analysis reveals a modest but persistent burden of psoriasis across South Asia, characterized by clear country-level heterogeneity. Higher rates in Bhutan and Bangladesh compared to Pakistan may reflect underlying differences in genetic predisposition, environmental exposures, healthcare-seeking behaviour, and diagnostic capacity. The remarkable stability of age-standardized metrics over three decades highlights the chronic nature of the disease and the limited impact of current control measures. Strengthening dermatological infrastructure, and conducting further research into local risk factors and socioeconomic determinants are essential to reduce long-term disability and improve quality of life for patients in South Asia.

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Abstract N°: 3773

The Effect of Methotrexate Treatment on Peripheral T Lymphocyte Subsets and Circulating Tissue-Resident Memory T Cells in Psoriasis Patients

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Introduction

Psoriasis is a chronic inflammatory skin disease, characterized by erythematous plaques with silvery scales. Treg, Th17 and tissue resident memory T (TRM) cells are among the major T cell subsets involved in the psoriasis pathogenesis. Several studies investigated Treg and Th17 cells in psoriasis, but conflicting results have been reported.

TRM cells have been shown to play an important role in psoriasis pathogenesis and associated with disease chronicity and recurrence. Although TRM cells are traditionally considered as non circulating, recent studies have suggested that they can enter the peripheral circulation following the loss of CD69 expression.

Therefore, this study aimed to investigate the characteristics of T cell subsets, possible role of circulating TRM-like T cells (cTRM) in pathogenesis and effect of the methotrexate treatment on these cell populations.

Materials and Methods

This prospective real-world study included psoriasis patients who were scheduled systemic methotrexate treatment. Patients with any other autoimmune disease, those who had received biologic agents any time, and those who had received conventional treatment within the previous month were excluded. Clinical assessments and peripheral blood flow cytometric analysis of T cell subsets were performed at baseline and month 4. Age and sex similar individuals without any inflammatory disease, were included as healthy controls.

Results

27 psoriasis patients and 27 healthy controls were included. The mean age was 39.59 years in the patient group and 39.41 years in the control group. The female/male distribution was 17/10 and 15/12, respectively. Mean body mass index was 28.08 kg/m^2 and 26.39 kg/m^2, respectively. There were no statistically significant differences between the groups.

In the patient group, the mean disease duration was 140.85 months, and the mean baseline PASI score was 10.59. Nail involvement was present in 77.78% of patients, and 51.85% had a history of psoriatic arthritis.

After 4 months of methotrexate treatment, PASI 50, PASI 75, and PASI 90 responses were achieved in 84.6% (n=22), 61.5% (n=16), and 34.6% (n=9) of patients, respectively.

At baseline, Treg levels were lower, whereas Th17, CD4 cTRM, and CD8 cTRM levels were higher in patients than in controls. Significant differences were also observed between baseline and month 4 after methotrexate treatment for all evaluated subsets (median baseline, month 4, and controls: Treg, 2.38% vs. 3.56% vs. 5.68%; Th17, 2.32% vs. 1.36% vs. 1.23%; CD4 cTRM, 0.64% vs. 0.21% vs. 0.22%; CD8 cTRM, 0.59% vs. 0.23% vs. 0.18%; all $p<0.001$ for baseline-control and baseline-month 4 comparisons).

When patients were classified according to the presence of psoriatic arthritis, CD4 cTRM levels were significantly higher in the PsA+ group than in the PsA− group (median 0.74% vs. 0.36%, $p<0.05$). Although median Treg, Th17, and CD8 cTRM levels were numerically higher in the PsA+ group, the differences were not statistically significant (Treg: 2.40% vs. 2.05%; Th17: 2.74% vs. 1.70%; CD8 cTRM: 0.75% vs. 0.47%, all $p>0.05$). No significant differences were observed in any of the evaluated T cell subsets according to the presence of nail involvement; all p values were >0.05.

Conclusions

cTRM cells, first described by Klicznik et al., have been suggested to enter the circulation and potentially differentiate into other memory T cell subsets. Allograft models have shown that, after entering the circulation, these cells may migrate to distant skin sites and reacquire tissue-resident memory features. cTRM cells have been implicated in the pathogenesis of GVHD and ankylosing spondylitis.

Our study provides further insight into the role of Treg and Th17 cells in psoriasis pathogenesis, for which conflicting findings have been reported in the literature, and highlights the potential involvement of cTRM cells in psoriasis. Further studies are needed to better clarify the role of cTRM cells in the immunopathogenesis of psoriasis.

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Abstract N°: 3773

Adrenal Insufficiency Induced by Topical Corticosteroids: A Case Report in a Child with Psoriasis

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Introduction

Corticosteroids are widely used in dermatology for the treatment of various inflammatory dermatoses in both adults and children, either topically or systemically. Their use, particularly at high doses and over prolonged periods, may lead to undesirable adverse effects. We report a case of topical corticosteroid-induced adrenal insufficiency in a child with psoriasis.

Case Presentation

A 7-year-old child, followed in dermatology for extensive and severe plaque psoriasis (PASI 17), had been treated with high-potency topical corticosteroids applied daily over a large body surface area for a prolonged period. However, the development of a cushingoid facies and hypertrichosis prompted pediatric evaluation. Investigation of the hypothalamic–pituitary–adrenal axis revealed corticosteroid-induced adrenal insufficiency, with low urinary cortisol and ACTH levels. Topical corticosteroids were discontinued and oral corticosteroid therapy was initiated. Treatment with acitretin at a dose of 10 mg every other day resulted in improvement of psoriasis lesions.
DISCUSSION
Topical corticosteroid-induced adrenal insufficiency in children is a complication mainly reported in atopic dermatitis, but less frequently in psoriasis. Several factors influence its occurrence, including the use of high-potency corticosteroids, prolonged treatment duration, and the extent of treated skin surfaces. In addition, the occlusive effect and cutaneous inflammation may enhance corticosteroid penetration, promoting systemic absorption. Clinical monitoring is essential, while dynamic evaluation of the hypothalamic–pituitary–adrenal axis should only be performed in the presence of clinical signs suggestive of adrenal insufficiency or systemic corticosteroid exposure. These investigations help confirm adrenal dysfunction and guide therapeutic management accordingly.

Conclusion

Through this observation, we highlight the importance of carefully adapted use of topical corticosteroids in order to minimize the risk of adverse effects.

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Abstract N°: 3775

Early change in neutrophil-to-lymphocyte ratio after guselkumab in moderate-to-severe plaque psoriasis: a four-patient real-world case series

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Introduction
The neutrophil-to-lymphocyte ratio (NLR) is an accessible marker of systemic inflammation derived from the complete blood count. Post hoc analyses of phase 3 psoriasis trials reported early reductions in NLR with guselkumab.

Materials and Methods
Observational case series of four consecutive adults with moderate-to-severe plaque psoriasis initiating guselkumab (100 mg subcutaneously at weeks 0 and 4, then every 8 weeks). Absolute neutrophil and lymphocyte counts from routine complete blood counts were collected at baseline (week 0) and week 12; NLR was calculated as neutrophils/lymphocytes. Intercurrent infections and systemic corticosteroid use around sampling were assessed.

Results
NLR decreased at week 12 in 3/4 patients. Baseline NLR values were 1.06, 3.96, 3.04 and 4.18; week 12 values were 1.31, 1.46, 1.72 and 1.44, respectively. Median NLR decreased from 3.50 to 1.46 (median change −2.04; approximately −58%); relative changes ranged from −65.6% to +23.5%. No intercurrent infections or systemic corticosteroid use were reported around the laboratory assessments.

Conclusions
In this small real-world case series, guselkumab was associated with an early reduction in NLR in most patients. Larger controlled cohorts are needed to clarify the clinical utility of NLR monitoring.

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Abstract N°: 3801

Supply-driven Biologic Switching in Psoriasis: Real-World Evidence From A Tertiary Referral Cohort in Sri Lanka

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Introduction

Real-world evidence on the use of biologics for psoriasis from publicly funded dermatology systems in low- and middle-income settings remains limited. Beyond clinical efficacy, continuity of access may shape biologic treatment pathways, particularly where advanced therapies are supplied through centralized government provision. We aim to characterize real-world biologic use, patient-reported therapeutic response, and drivers of biologic switching among patients with psoriasis receiving government-funded biologic therapy through a tertiary referral dermatology service in Sri Lanka, with particular focus on medication unavailability.

Materials and Methods

We conducted a descriptive cross-sectional review of patients with psoriasis who received biologic therapy between February and May 2026 at a single tertiary dermatology service. Data collected included age, current biologic agent, number of treatment cycles, treatment duration, patient-reported efficacy of the current biologic, prior biologic exposure, reason for biologic change where applicable, reported efficacy of the previous biologic, concurrent psoriasis medication, and adverse effects. Descriptive statistics were used to summarize treatment patterns and reasons for switching.

Results

Thirty-seven patients were identified. Current biologic therapy comprised infliximab (n=16), secukinumab (n=11), adalimumab (n=8), ixekizumab (n=1), and rituximab (n=1). Current efficacy data were available for 33 patients. Median patient-reported improvement on the current biologic was 90%; 21/33 patients (63.6%) reported ≥90% improvement, and 10/33 (30.3%) reported 100% improvement. Prior biologic exposure was documented in 12 patients. Among 10 patients with a recorded reason for biologic change, medication unavailability/out-of-stock supply was the most frequent reason (6/10, 60.0%), followed by allergic or adverse reactions (3/10, 30.0%) and poor response (1/10, 10.0%). In all six supply-driven switches, the previous biologic had been reported as highly effective (95–100% improvement). Five of these six patients reported lower efficacy with the current replacement biologic; the mean efficacy decreased from 98.3% on the previous biologic to 79.2% on the current biologic in this subgroup. Reported adverse effects on current therapy were uncommon in the dataset, with isolated entries including hair fall and an allergic respiratory reaction.biologic therapy comprised infliximab (n=16), secukinumab (n=11), adalimumab (n=8), ixekizumab (n=1), and rituximab (n=1).

Conclusions

Biologic therapy was associated with high overall patient-reported effectiveness. However, medication unavailability emerged as the leading documented driver of biologic switching, and several patients were switched away from therapies associated with excellent prior response. The lower reported efficacy observed after supply-driven switching raises concern that continuity of biologic access may be an underrecognized determinant of sustained psoriasis control in publicly funded, resource-constrained settings. These findings support the need for more systematic evaluation of biologic supply stability and treatment continuity as components of equitable psoriasis care.

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Abstract N°: 3802

The Efficacy and Safety of Oral Biologics and Small Molecule Inhibitors for Moderate to Severe Plaque Psoriasis: A Systematic Review and Network Meta-Analysis

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Introduction

Systemic options for moderate-to-severe plaque psoriasis have expanded with the development of oral small molecule inhibitors, including PDE4 inhibitors (apremilast, orismilast, roflumilast), TYK2 inhibitors (deucravacitinib, zasocitinib, envudeucitinib, ropsacitinib), and the first-in-class oral IL-23 receptor inhibitor icotrokinra. These agents offer advantages over injectable biologics, including oral administration, absence of immunogenicity, and no routine laboratory monitoring. However, no head-to-head trials have compared all available oral agents simultaneously. We performed a network meta-analysis (NMA) to synthesise direct and indirect evidence and provide comparative rankings.

Materials and Methods

A systematic search of MEDLINE, Embase, Web of Science, and ClinicalTrials.gov was conducted through April 2026, following PRISMA-NMA guidance (PROSPERO CRD420261394330). We included phase 2 and above randomised controlled trials of adults with moderate-to-severe plaque psoriasis receiving oral systemic therapy. Outcomes were the proportions of patients achieving PASI75, PASI90, and ≥1 adverse event. A frequentist random-effects NMA was performed using the netmeta package, with treatments ranked by P-scores.

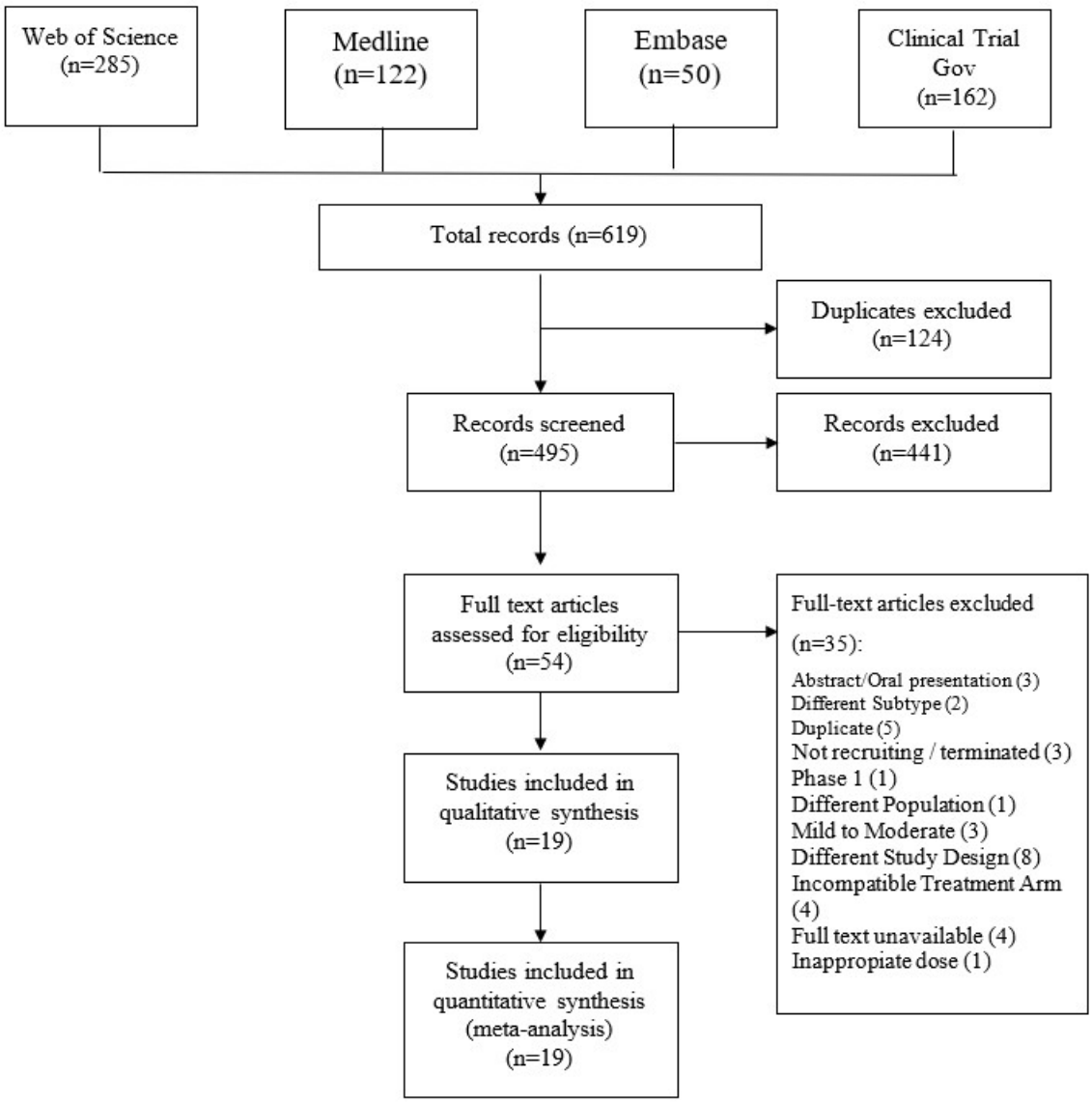
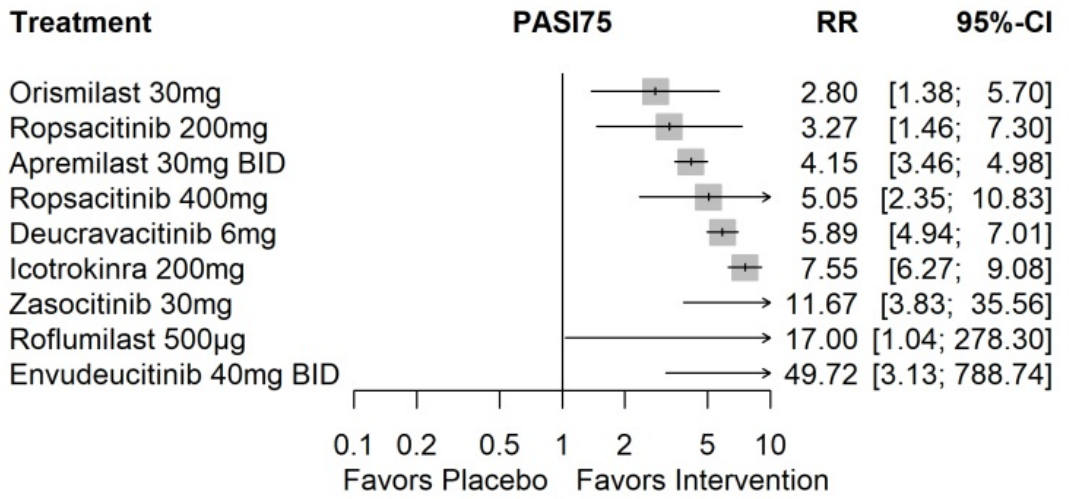
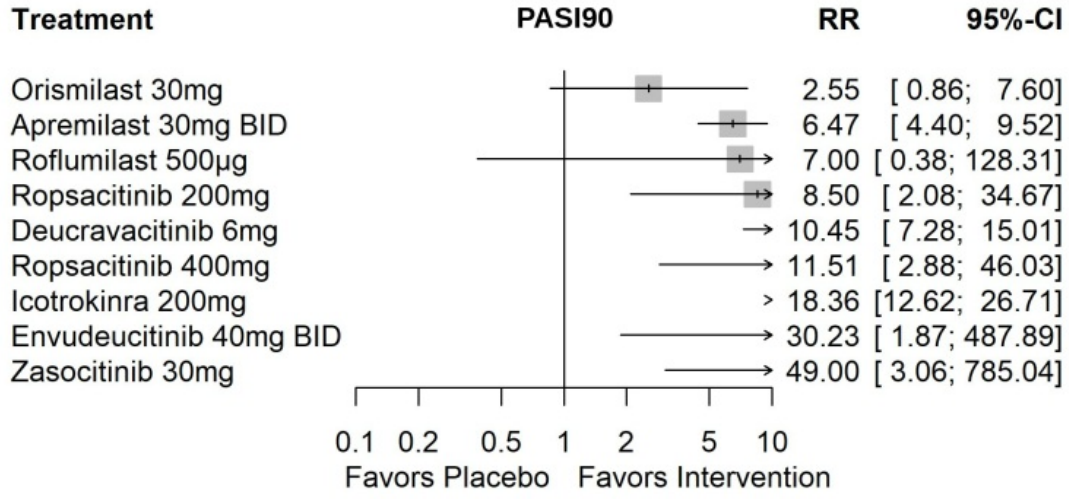


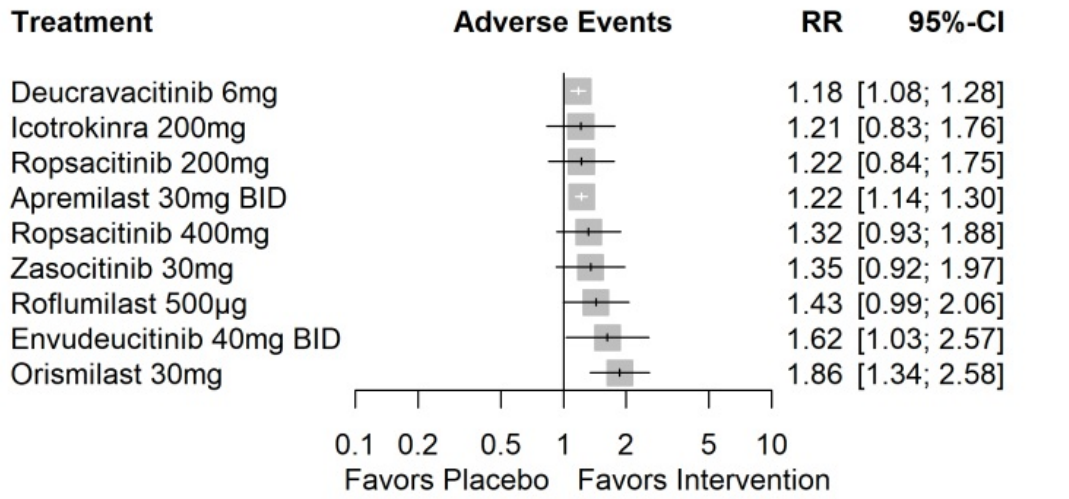
Figure 1. PRISMA Flow Diagram

Results

Nineteen RCTs enrolling 6,215 participants were included. No heterogeneity was detected across any network (I^2 = 0%), and no inconsistency or small-study effects were observed. For PASI75, envudeucitinib 40 mg BID ranked highest (P = 0.91; RR = 49.72, 95% CI 3.13–788.74), followed by zasocitinib 30 mg (P = 0.78), roflumilast 500 µg (P = 0.75), and icotrokinra 200 mg (P = 0.71). All active treatments were superior to placebo, with icotrokinra providing the most precise estimate (RR = 7.55, 95% CI 6.27–9.08). For PASI90, zasocitinib 30 mg ranked highest (P = 0.85; RR = 49.00, 95% CI 3.06–785.04), followed by icotrokinra (P = 0.77) and envudeucitinib (P = 0.77); icotrokinra had the most precise estimate (RR = 18.36, 95% CI 12.62–26.71). For adverse events, placebo ranked safest (P = 0.95), followed by deucravacitinib 6 mg (P = 0.69) and icotrokinra (P = 0.60). The greatest adverse event risk versus placebo was with orismilast 30 mg (RR = 1.86, 95% CI 1.34–2.58) and envudeucitinib 40 mg BID (RR = 1.62, 95% CI 1.03–2.57).







Forest Plot for PASI75, PASI90, and Adverse Events

Conclusions

Envudeucitinib, zasocitinib, and roflumilast ranked highest in efficacy for PASI75 and PASI90 but were each supported by only a single small trial, producing very wide confidence intervals that limit interpretation. Among interventions with a more robust evidence base, icotrokinra 200 mg/day and deucravacitinib 6 mg/day demonstrated substantially greater efficacy than apremilast with comparable safety. Larger head-to-head trials

and longer follow-up are needed to confirm the standing of the newer oral treatments.

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Abstract N°: 3845

Systemic Inflammation and Liver Fibrosis in Patients with Psoriasis Treated with Biologic Therapy: A Retrospective Study

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Introduction
Psoriasis is associated with persistent systemic inflammation and multiple cardiometabolic comorbidities, which may contribute to an increased risk of liver fibrosis. The aim of this study was to evaluate the trajectory of FIB-4 and the monocyte-to-lymphocyte ratio (MLR) in patients with psoriasis who initiated/switched biological therapy.

Materials and Methods
Retrospective, single-center study, which included all patients with psoriasis who initiated/switched biological therapy at a Dermatology department from a tertiary hospital between January 2023 and December 2025. Demographic, clinical, and laboratory data were analyzed, with calculation of FIB-4 and MLR at baseline, after six months, and after one year of therapy.

Results
A total of 226 patients were included: 121 treated with anti-TNF agents, 49 with anti-IL-23, 39 with anti-IL-17, and 17 with anti-IL-12/23. At six months, FIB-4 increased significantly in the anti-TNF group ($\Delta=+0.109$; $p=0.003$) and decreased significantly in the anti-IL-12/23 group ($\Delta=-0.070$; $p=0.032$). MLR decreased significantly in the anti-TNF group at both six months ($\Delta=-0.057$, $p<0.001$) and one year ($\Delta=-0.054$, $p=0.002$). A positive association between FIB-4 and MLR was observed at all time points (baseline, six months, and one year).

Conclusions
The positive association between FIB-4 and MLR suggests an interplay between systemic inflammation and the risk of liver fibrosis. In this study, divergent trajectories were observed in the anti-TNF group, with an increase in FIB-4 and a decrease in MLR, preventing the conclusion that improvement in systemic inflammation is necessarily associated with improvement in liver fibrosis indicators. Conversely, anti-IL-12/23 therapy was associated with a reduction in FIB-4, suggesting a possible favorable effect in this context. These findings highlight the importance of integrated monitoring of inflammatory and liver fibrosis markers in this population, particularly in patients with cardiometabolic comorbidities.

EA DV CONGRESS
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Abstract N°: 3877

Association of psoriasis severity with metabolic dysfunction, systemic inflammation and diagnostic delay in newly diagnosed treatment-naïve patients

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Introduction

Psoriasis is a chronic immune-mediated inflammatory disease increasingly recognized as a systemic disorder associated with metabolic dysfunction and obesity. Although the association between psoriasis and cardiometabolic comorbidities has been widely studied, evidence regarding these relationships in newly diagnosed, treatment-naïve patients remains limited. The aim of this study was to evaluate the relationship between psoriasis severity, metabolic and inflammatory parameters, and diagnostic delay in newly diagnosed treatment-naïve patients with psoriasis.

Materials and Methods

This cross-sectional observational study included 97 newly diagnosed patients with psoriasis without prior topical or systemic therapy who attended a specialized dermatology center from October 2025 to April 2026. Patients with previously diagnosed psoriasis, prior systemic therapy, severe concomitant inflammatory or autoimmune diseases, or acute infections were excluded. Clinical assessment included Psoriasis Area and Severity Index (PASI), Body Surface Area (BSA). Metabolic and inflammatory parameters included body mass index (BMI), serum glucose, total cholesterol, low-density lipoprotein (LDL) cholesterol, high-density lipoprotein (HDL) cholesterol, triglyceride levels and C-reactive protein (CRP). Patients were stratified into two groups according to disease severity measured by PASI: mild psoriasis (PASI<10) and moderate-to-severe psoriasis (PASI^{3}10). Time from symptom onset to confirmed diagnosis was also evaluated. Data were analyzed using IBM SPSS Statistics version 27.0 ($p<0.05$).

Results

Based on PASI-defined severity, 37 patients were classified as mild psoriasis (group 1), whereas 60 patients had moderate-to-severe psoriasis (group 2). Median age was significantly higher in group 2 than in group 1 (39.51 [IQR 27] vs 26.00 [IQR 15] years; Mann–Whitney U = 1647.5; $p < 0.001$). Median BSA values were markedly elevated in group 2 compared with group 1 (30.5 [IQR 19] vs 6.61 [IQR 8] %; Mann–Whitney U = 2190.0; $p < 0.001$). Median serum glucose levels were significantly higher in group 2 than in group 1 (7.15 [IQR 2] vs 4.22 [IQR 1] mmol/L; Mann-Whitney U = 2009.5; $p < 0.001$). Also, median total cholesterol levels were elevated in group 2 compared with group 1 (6.54 [IQR 3] vs 4.32 [IQR 2] mmol/L; Mann–Whitney U = 1859.0; $p < 0.001$). Median LDL cholesterol was significantly higher in group 2 than in group 1 (4.87 [IQR 2] vs 2.05 [IQR 2] mmol/L; Mann–Whitney U = 1997.0; $p < 0.001$). Median triglyceride levels were markedly increased in group 2 than in group 1 (2.81 [IQR 4] vs 1.10 [IQR 1] mmol/L; Mann–Whitney U = 1849.5; $p < 0.001$). Median HDL cholesterol levels did not differ significantly between groups (1.44 [IQR 1]

mmol/L in group 1 vs and 1.60 [IQR 1] mmol/L in group 2; Mann–Whitney U = 1030.5; p = 0.554). Median BMI was significantly higher in group 2 (26.70 [IQR 11] vs 18.50 [IQR 2] kg/m^2 ; Mann–Whitney U = 1947.0; p < 0.001). Median CRP levels, reflecting inflammatory activity, were significantly higher in group 2 than in group 1 (17.56 [IQR 13] vs 0.62 [IQR 5] mg/L; Mann–Whitney U = 1991.5; p < 0.001). Finally, patients with moderate-to-severe psoriasis demonstrated a significantly longer diagnostic delay than patients with mild psoriasis (1 [IQR 2] vs 0.6 [IQR 1] years; Mann–Whitney U = 1601.5; p < 0.001).

Conclusions

Moderate-to-severe psoriasis in treatment-naïve patients was significantly associated with systemic inflammation and metabolic dysfunction. Elevated glucose levels, atherogenic lipid profiles, BMI, and CRP levels indicate an increased cardiometabolic risk burden in these patients. Longer diagnostic delay and older age were also associated with greater disease severity, suggesting that prolonged untreated disease may contribute to cumulative systemic inflammatory and metabolic burden over time. These findings highlighted the importance of early diagnosis and comprehensive metabolic assessment in patients with psoriasis.

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Abstract N°: 3878

Risankizumab Treatment Is Associated With Lower Risk of Developing Psoriatic Arthritis in Patients With Psoriasis Compared to Other Targeted Immunomodulators

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Introduction
Patients with moderate-to-severe plaque psoriasis (PsO) often develop psoriatic arthritis (PsA). This real-world study compares PsA risk in patients with PsO receiving risankizumab (RZB) compared with other targeted immunomodulators (TIMs).

Materials and Methods
This retrospective study used the Merative Marketscan® database (Jan/2014–July/2025) to assess patients aged 18 years, with 2 PsO diagnoses, continuous enrollment for 6 months pre-PsO index (diagnosis) and 2 weeks post-index treatment, and no prior use of advanced treatments/methotrexate, history of inflammatory arthritis, or rheumatologist visits. Patients were stratified by initial biologic treatment (RZB, guselkumab, ixekizumab, secukinumab, adalimumab, ustekinumab, or apremilast) and followed for 3 years or until PsA onset (defined as 1 International Classification of Diseases [ICD]-9 [696.0]/ICD-10 [L40.5x] diagnosis code for PsA). PsA risk was measured using crude incidence rates (events/100 person-years), compared using Kaplan-Meier analysis, and a multivariate Cox proportional hazards model (reference=RZB) starting 2 weeks post-index treatment. Sensitivity analyses assessed risk after 3, 6, and 12 months post-index treatment.

Results
Overall, 20,511 patients were included. Crude PsA incidence rates (events/100 person-years) were lowest for RZB (3.89), versus guselkumab (5.37), ustekinumab (5.37), apremilast (6.20), ixekizumab (6.65), secukinumab (7.68), and adalimumab (9.04). Compared to RZB, adjusted hazard ratios (aHR) were significantly ($p<0.05$) higher for ustekinumab (aHR [95% confidence interval]: 1.40 [1.04, 1.87]), guselkumab (1.40 [1.08, 1.80]), apremilast (1.45 [1.20, 1.76]), ixekizumab (1.74 [1.32, 2.30]), secukinumab (1.92 [1.41, 2.61]), and adalimumab (2.25 [1.85, 2.75]). All sensitivity analyses showed consistent results.

Conclusions
RZB-treated patients showed lower 3-year incidence and risk of developing PsA compared with other TIMs.

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Abstract N°: 3957

Development and Validation of a Disease-Specific Screening Questionnaire for Inflammatory Bowel Disease in Patients with Psoriasis and/or Psoriatic Arthritis (IBD-Screen)

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Introduction

Psoriasis is a chronic inflammatory skin disease affecting approximately 2.5 % of the general population. Autoimmune processes are involved in its pathogenesis, with autoreactive T lymphocytes proinflammatory cytokines such as interleukin (IL)-17, which underscores the IL-23/Th17 axis as a shared core mechanism in both diseases.

Psoriasis is associated with systemic inflammation-related comorbidities, including psoriatic arthritis, cardiovascular diseases and metabolic syndrome. Patients with psoriasis have a two- to three-fold higher risk of chronic-inflammatory bowel disease (IBD) than the general population. The diagnosis of IBD is mainly a clinical suspect followed by laboratory investigation, physical examination and endoscopy with biopsies.

Recent publications and clinical guidelines emphasize the need to detect comorbidities like IBD early in patients to choose and adapt treatment to this modality and to treat the patient effectively for both. The choice of systemic medication must consider the systemic inflammation targeting various organs like skin and bowel.

So far, there is no screening questionnaire for the detection of IBD in patients with psoriasis, nor any validated tool that reliably distinguishes between irritable bowel syndrome and chronic inflammatory bowel disease. Therefore, there is a clear need for a simple and validated screening tool suitable for routine clinical practice. Apart from psoriasis, an IBD screening tool is helpful in identifying patients at risk.

The purpose of this study is to develop and validate a concise disease-specific screening questionnaire for the identification of inflammatory bowel disease in patients with psoriasis and/or psoriatic arthritis and to assess its feasibility in routine dermatological practice.

Materials and Methods

The study has been conducted since November 2025, with ongoing patient recruitment and data collection, which are anticipated to be completed by June 2026.

An 11-item screening questionnaire, based on characteristic gastrointestinal symptoms and established clinical indicators of IBD, was developed for single-use use during routine outpatient visits.

A prospective multicenter diagnostic validation study was conducted including three consecutive cohorts:
(1) patients with psoriasis and/or psoriatic arthritis with clinical or anamnestic suspicion of IBD,
(2) patients with psoriasis and/or psoriatic arthritis without suspicion of IBD, and
(3) patients with confirmed IBD with or without concomitant psoriatic disease.

Participants completed the questionnaire once during routine care. Data were pseudonymized and compared with

the clinical reference diagnosis (IBD confirmed or excluded). In cases of suspected IBD, diagnosis was established by gastroenterological assessment including endoscopy and histopathology. Statistical analyses will include reliability (two Cronbach's alpha, test-retest stability) as well as criterion and construct validity (including correlations and factor analysis).

Results

A total of 114 participants have been enrolled to date. Cohort (1) includes 16 patients with psoriasis and/or psoriatic arthritis and suspected inflammatory bowel disease, while cohort (2) comprises 48 patients without suspicion of IBD. The remaining participants belong to cohort (3) with confirmed IBD, with/without concomitant psoriatic disease. Recruitment and data collection are ongoing, and diagnostic performance analyses will be conducted after study completion. Preliminary findings indicate high patient acceptance and good feasibility within routine dermatological care.

Conclusions

The IBD-Screen was developed as a concise and feasible instrument for detecting inflammatory bowel disease in patients with psoriatic disease. Its integration into dermatological routine care may enable structured comorbidity screening and strengthen interdisciplinary management. Final diagnostic performance data will determine its potential role in standardized clinical pathways.

EA DV CONGRESS
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Abstract N°: 3989

Real-world response outcomes of secukinumab versus other biologics in psoriasis affecting difficult-to-treat areas: a systematic literature review

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Introduction
Psoriasis in difficult-to-treat areas (scalp, nails, palmoplantar) is associated with substantial functional impairment and reduced quality of life, while real-world evidence (RWE) describing response outcomes in these manifestations remains limited. This systematic literature review evaluated RWE studies reporting response outcomes with biologics in difficult-to-treat psoriasis areas, with a focus on secukinumab studies.

Materials and Methods
Following PRISMA guidance, PubMed, Embase, and Web of Science (2015–2025) were searched for RWE studies in adults with moderate-to-severe psoriasis. Eligible studies included ≥25 treated patients and evaluated IL-17, IL-23, IL-12/23, and TNF inhibitors.

Results
Seven studies were included (Figure 1).

Nail psoriasis data were reported across five studies (N=886). Across studies, secukinumab demonstrated progressive and sustained nail improvement across long-term follow-up, achieving sustained NAPSI improvement of 87.09% at week 156.[1] At week 24, nail matrix improvement was 65.9% for secukinumab, 60.5% for ixekizumab and 51.5% for guselkumab.[2] In patients with baseline mNAPSI ≥20, mean baseline mNAPSI values were 44.1 for secukinumab, 47.7 for ixekizumab, 37.5 for guselkumab, 39.5 for risankizumab, and 35.9 for adalimumab, with corresponding absolute reductions at week 48 of −35.5, −38.7, −21.5, −28.1, and −28.9, respectively.[3] Complete nail clearance (NAPSI 0) was evaluated in two studies. In a prospective study, secukinumab achieved numerically higher clearance rates (64.3%) at week 12 than ustekinumab (55.6%), guselkumab (40.0%), risankizumab (50.0%), and adalimumab (51.4%), with similar results to ixekizumab (66.5%).[4] However, in a retrospective study, secukinumab showed numerically higher clearance than ixekizumab (47.8% vs 40.7%).[5]

Scalp psoriasis data were reported in five studies (N=1822). Secukinumab studies showed rapid onset and sustained response outcomes across follow-up periods. Progressive PSSI improvement up to 83.79% at week 156 was reported.[1] Mean baseline PSSI values were 17.1 for secukinumab, 16.7 for ixekizumab, 18.6 for brodalumab,

17.4 for guselkumab, 25.0 for risankizumab, and 10.0 for tildrakizumab, with corresponding values at week 52 of 0.7, 1.2, 1.1, 1.3, 3.4, and 0.0, respectively.[6] For physician-reported outcomes, rapid responses were observed, with Scalp PGA 0/1 of 70.8% at week 4, numerically higher than ixekizumab (65.5%), brodalumab (33.3%), guselkumab (53.8%), risankizumab (34.3%) and tildrakizumab (14.2%), reaching 100% at weeks 16–48,[7] and with numerically higher week 12 responses versus ixekizumab (72.7% vs 47.1%).[5] For complete clearance, secukinumab reached 61.9% at week 12.[4]

Palmoplantar psoriasis data was reported across three studies (N=534). Across studies, secukinumab demonstrated sustained improvement in ppPASI outcomes through long-term follow-up, with ppPASI reduction reaching 71.23% at week 156, exceeding ixekizumab (55.72%) and risankizumab (45.37%), and similar to guselkumab (73.29%), while ustekinumab showed minimal change (21.11%).[1] Mean baseline ppPASI values were 27.6 for secukinumab, 24.0 for ixekizumab, 21.2 for brodalumab, 18.0 for guselkumab, 24.0 for risankizumab, and 18.3 for tildrakizumab, with corresponding values at week 52 of 5.4, 6.0, 1.4, 5.8, 5.6, and 6.6, respectively.[6] For complete clearance at week 12, secukinumab reached 74.4%, similar to ixekizumab (73.3%), numerically higher than guselkumab (64.6%), risankizumab (70.7%), and adalimumab (65.4%), but slightly below ustekinumab (78.9%).[4]

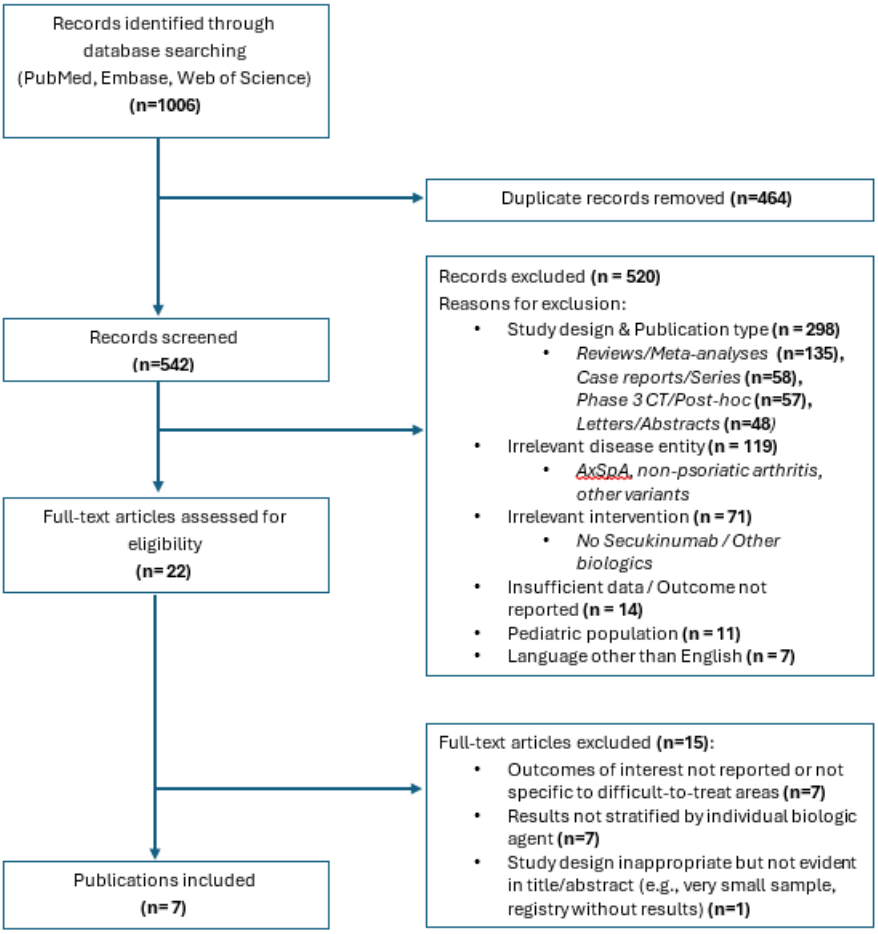

Figure 1. PRISMA flow diagram of study identification, screening, eligibility, and inclusion in the systematic review.

Conclusions

This systematic literature review of real-world evidence supports the consistent and sustained clinical benefit of secukinumab across nail, scalp, and palmoplantar psoriasis studies, with rapid and sustained responses particularly observed in scalp and nail disease. IL-23 and TNF inhibitors generally showed a more gradual response pattern, potentially related to differences in mechanism of action.

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EA DV CONGRESS
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Abstract N°: 3999

Effect of secukinumab on patient-reported outcomes in patients with moderate to severe plaque psoriasis: Pooled analysis from Phase 3 trials

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Introduction
Psoriasis (PsO) is a chronic, immune-mediated disease that can substantially impair quality of life (QoL), with symptoms affecting daily activities, work, relationships, and emotional wellbeing.[1] Although biologic therapies have improved clinical outcomes,[1] long-term data confirming the durability of improvements in patient-reported outcomes (PROs) are needed. Secukinumab (SEC) has demonstrated robust efficacy in randomized controlled trials;[2] however, sustained improvements in PROs over extended treatment periods are particularly relevant to treatment evaluation.

Objectives
To evaluate the long-term impact of SEC treatment on PROs, as assessed bythe Dermatology Life Quality Index (DLQI), and skin responses in patients with moderate to severe PsO for up to week (wk) 208 (4 years).

Materials and Methods
This post-hoc pooled analysis included patients with moderate to severe PsO (total Psoriasis Area and Severity Index [PASI] ≥12 at baseline) from the Phase 3 trials ERASURE, FIXTURE, SCULPTURE and their extension studies.[3-6] Analysis sets included: set 1 (baseline PASI ≥12 randomized to SEC 150 or 300 mg at core study initiation, followed up to wk 52) and set 2 (subset of set 1 comprising patients who were re-randomized to SEC in the extension study, followed up to wk 208). Changes from baseline in DLQI total and subdomain scores, DLQI 0 or 1, and PASI 75/90/100 were assessed up to wk 208. Achievement of minimal clinically important difference (MCID, ≥4-point reduction from baseline in the total DLQI score) was evaluated (including a time-to-event analysis through wk 52 using Kaplan-Meier estimate in patients with baseline DLQI ≥4 in set 1). Data were analyzed descriptively.

Results
A total of 2109 and 1229 patients were included in sets 1 and 2, respectively. Baseline characteristics were similar across both sets. Mean (SD) baseline PASI was 23.39 (9.98) in set 1 and 23.03 (9.48) in set 2; DLQI total score was 13.5 (7.2) in both sets. At wk 12, mean (SD) DLQI total score improved markedly from baseline (−10.7 and −11.2 in sets 1 and 2, respectively; SD 6.8) and was sustained in set 2 through wk 208 (−10.8 [6.9]). DLQI 0 or 1 was achieved by 1116/1985 (56.2%, 95% CI: 54.0–58.4) patients in set 1 at wk 12 and 537/896 (59.9%, 95% CI: 56.6–

63.2) in set 2 at wk 208. Improvement was observed across all subdomains, with the greatest mean changes at wk 12 in symptoms and feelings (−3.0 [1.7] and −3.1 [1.6] in sets 1 and 2) and daily activities (−2.3 in both sets, SD 1.8 and 1.7). Over 52 wks, 1831/1897 patients in set 1 (96.5%) attained MCID in DLQI (median time 4.1 wks, **Figure**). At wk 12, MCID was achieved by 1653/1800 (91.8%, 95% CI: 90.5–93.0) in set 1 and 1024/1083 (94.6%, 95% CI: 93.0–95.8) patients in set 2. At wk 208, 763/815 (93.6%, 95% CI: 91.7–95.2) patients in set 2 met the MCID threshold.

Skin responses were observed early, with PASI 75 achieved by wk 12 in 83.8% (95% CI: 82.1–85.4) patients in set 1 and 90.6% (95% CI: 88.7–92.1) in set 2. In set 2, PASI responses remained substantial through wk 208, with PASI 75/90/100 achieved by 82.6% (95% CI: 80.0–85.0), 57.1% (95% CI: 53.8–60.4) and 28.5% (95% CI: 25.6–31.6) patients, respectively.

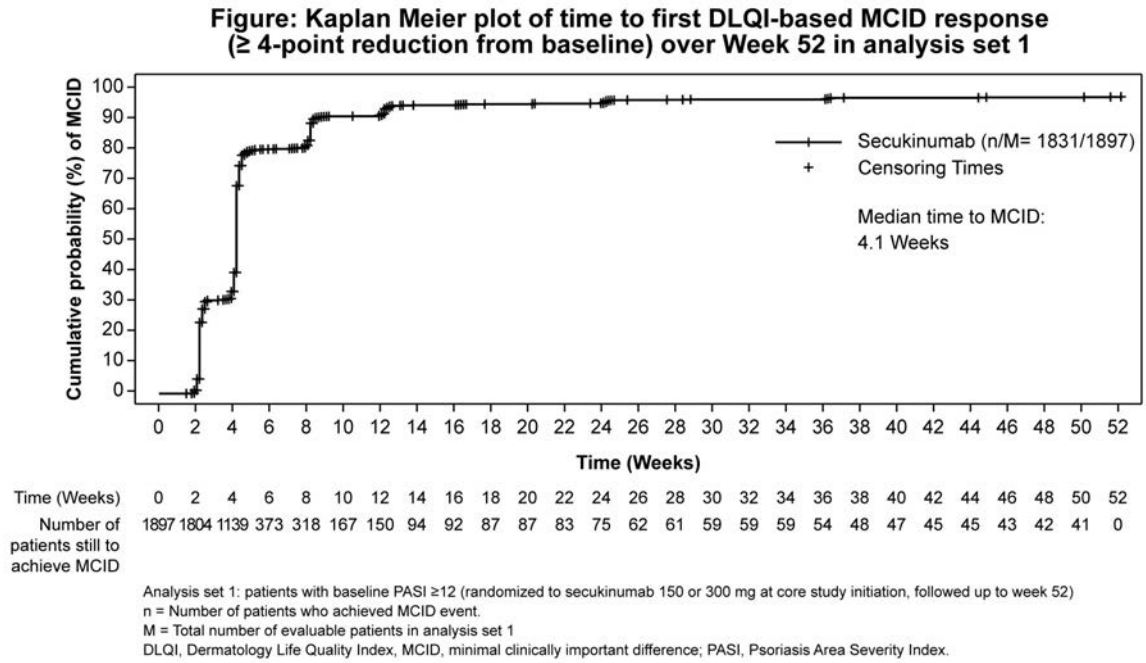

Figure: Kaplan Meier plot of time to first DLQI-based MCID response (≥ 4-point reduction from baseline) over Week 52 in analysis set 1

Conclusions

SEC delivered rapid, substantial, and sustained improvements across multiple dimensions of dermatology-related QoL in patients with moderate to severe PsO, including a reduction in overall DLQI burden, achievement of clinically meaningful improvement, and attainment of minimal or no residual QoL impact, together with durable skin responses through long-term follow-up.

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Abstract N°: 4030

Biologic dose reduction in well-controlled plaque psoriasis: preserved PASI75 but reduced PASI90/100 responses

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Introduction

Biologic therapies can achieve sustained disease control in plaque psoriasis, raising the question of whether treatment intensity can be reduced after stabilization. However, the comparative consequences of biologic dose reduction versus continued standard dosing remain insufficiently defined. To evaluate the efficacy and safety of biologic dose reduction compared with continued standard dosing in patients with well-controlled plaque psoriasis.

Materials and Methods

We performed a systematic review and meta-analysis of comparative studies including patients with well-controlled plaque psoriasis who underwent biologic dose reduction or continued standard dosing. Dose reduction was defined as a planned reduction in biologic treatment intensity after disease stabilization, most commonly through dosing-interval extension. Primary efficacy analyses were restricted to randomized controlled trials and assessed PASI75, PASI90, and PASI100 responses. Safety outcomes included adverse events, serious adverse events, and infections.

Results

Ten comparative studies involving 3,246 patients were included, comprising four randomized controlled trials and six observational studies. Dose reduction was generally introduced after sustained high-level disease control and was most often implemented by extending dosing intervals. In randomized trial analyses, PASI75 responses were largely maintained with dose reduction compared with standard dosing (risk ratio [RR] 0.97, 95% confidence interval [CI] 0.90–1.06). In contrast, deeper responses were less consistently maintained, with lower PASI90 (RR 0.89, 95% CI 0.81–0.98) and PASI100 responses (RR 0.80, 95% CI 0.68–0.95). No significant differences were observed in adverse events, serious adverse events, or infections, including in analyses restricted to randomized trials.

Conclusions

In selected patients with well-controlled plaque psoriasis, biologic dose reduction may preserve acceptable disease control but appears less reliable for maintaining near-complete or complete clearance. These findings suggest that dose reduction should be considered a treatment-target-dependent maintenance strategy rather than a universally equivalent substitute for standard dosing.

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Abstract N°: 4037

Psoriasis With Coexisting COPD: A Single-Center Descriptive Study

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Introduction

Psoriasis and chronic obstructive pulmonary disease (COPD) are both associated with chronic systemic inflammation and share tobacco smoking as a common risk factor. While epidemiologic data linking psoriasis and COPD are growing, the clinical phenotype, treatment patterns, and multimorbidity burden of patients with both diseases remain largely unexamined.

Materials and Methods

We conducted a retrospective, single-center descriptive study of 20 patients with concurrent psoriasis and COPD who were evaluated between 2020 and 2025. Demographic, clinical, treatment, and comorbidity data were extracted from medical records. Psoriasis severity was assessed using the Psoriasis Area and Severity Index (PASI) at baseline and at the most recent visit. GOLD spirometric grades (1–4) were assigned from post-bronchodilator FEV1 percent predicted, and COPD risk was classified using the GOLD 2026 ABE assessment tool, with Group E defined as ≥1 documented exacerbation or ≥1 hospitalization for COPD in the preceding year. Pulmonary outcomes were ascertained from clinical documentation. Paired PASI change was assessed by Wilcoxon signed-rank test. Continuous variables are reported as median and interquartile range (Q1, Q3).

Results

The cohort was predominantly male (14/20, 70%), with a median age of 73 years (69, 80). Smoking exposure was high: 18/20 (90%) were ever-smokers, with 8 (40%) current and 10 (50%) former smokers, with a median exposure of 40 pack-years (18, 50). Plaque psoriasis predominated (19/20, 95%); median disease duration was 10 years (6, 17). Psoriatic arthritis was present in 5 patients (25%). Baseline median PASI was 8.1 (4.1, 12.4; n=19); 6/19 patients (32%) had moderate-to-severe disease (PASI ≥10), whereas 13/19 (68%) had mild disease (PASI <10). PASI decreased significantly from 8.1 (4.1, 12.4) at baseline to 1.55 (0.00, 4.20) at the most recent visit (paired n=17, Wilcoxon signed-rank p<0.001). Current treatment included topical therapies (10/20, 50%), biologics (4/20, 20%), methotrexate (1/20, 5%), and Janus kinase (JAK) inhibitors (2/20, 10%; prescribed for concomitant atopic dermatitis and psoriasis). By GOLD spirometric grade, COPD was mild-to-moderate: GOLD 1 in 6/15 (40%) and GOLD 2 in 9/15 (60%); no patient had GOLD 3–4 disease. Median FEV1 was 75% predicted (71, 91) and median FEV1/FVC ratio was 67% (64, 71). 8/20 patients (40%) met GOLD 2026 Group E criteria; 7 of these 8 had at least one hospitalized exacerbation in the preceding year. Pulmonary hypertension was present in 3 (15%) and concurrent asthma in 1 (5%). Cardiometabolic comorbidities were frequent, including hypertension in 15 patients (75%), cardiovascular disease in 8 (40%), hyperlipidemia in 6 (30%), and diabetes in 5 (25%).

Malignancy was documented in 4 patients (20%), including 2 lung cancers.

Conclusions

Among older, heavily smoke-exposed patients with coexisting psoriasis and COPD, dermatologic treatment was associated with significant improvement in skin disease activity. Despite this, pulmonary and cardiometabolic multimorbidity remained substantial. Notably, 40% of patients met GOLD 2026 Group E criteria despite predominantly mild-to-moderate airflow limitation. This identifies a clinically important subset at elevated risk for future exacerbations, hospitalization, cardiovascular events, and mortality. Spirometric grade alone is insufficient for risk assessment in this population; structured smoking cessation, cardiovascular risk screening, and coordinated dermatology–pulmonology care are warranted even in the presence of preserved or mildly reduced FEV1.

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Abstract N°: 4046

Drug Survival of Risankizumab in Psoriasis: Real-World Australian Registry Data

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Introduction

Psoriasis is a chronic inflammatory skin disease associated with substantial physical, psychosocial, and economic burden. Although biologic therapies have significantly improved disease outcomes, Australian real-world data on long-term Risankizumab drug survival remain limited. This study aimed to evaluate the drug survival of Risankizumab in psoriasis management within the Australian Pharmaceutical Benefits Scheme (PBS) setting and identify factors associated with treatment discontinuation.

Materials and Methods

This retrospective observational study included 89 patients with psoriasis enrolled in an Australian psoriasis registry. Data were collected from de-identified electronic medical records and included demographics, comorbidities, smoking status, Psoriasis Area and Severity Index (PASI), Dermatology Life Quality Index (DLQI), prior therapies, and treatment outcomes. Drug survival was analysed using Kaplan–Meier estimates, while Cox proportional hazards regression was performed to identify predictors of discontinuation.

Results

Among 89 patients, 46.1% were female, with a mean age of 53.9 years (SD 14.1). Psoriatic arthritis was present in 43.8% of patients. Median baseline PASI was 23.4 (IQR 16.6–25.4) and median DLQI was 4.3 (IQR 0–7). Chronic comorbidities were present in 62.9% of patients, anxiety and/or depression in 39.3%, and metabolic risk factors in 60.7%. Prior biologic exposure occurred in 55.1% of patients, with Risankizumab most commonly prescribed as second-line therapy (29.2%). Drug survival was 98.8% at 26 weeks, 97.4% at 52 weeks, 94.3% at 104 weeks, and 90.1% at 208 weeks. Overall, 13.5% (n=12) of patients discontinued treatment due to lack of efficacy (6.7%), adverse effects (6.7%), and/or secondary loss of efficacy (2.2%). Reported adverse effects included headaches, arthralgia, arthritis, myalgia, and pustulosis. Median treatment duration was 81.9 weeks (IQR 73.9–117.3) among patients who discontinued therapy compared with 159.1 weeks (IQR 134.5–222.7) in patients remaining on treatment. Cox regression analysis identified no significant predictors of discontinuation.

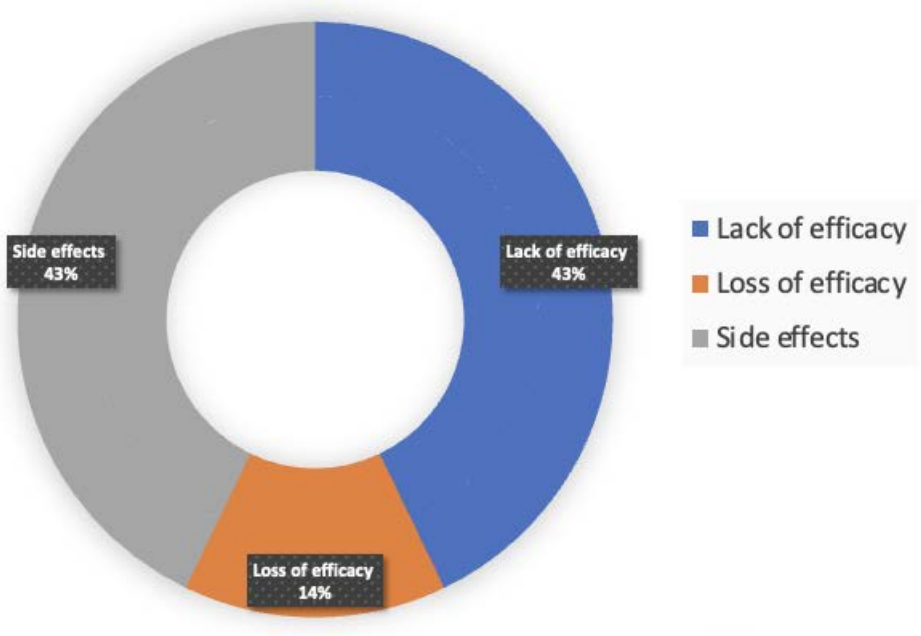

FIGURE 1 | Risankizumab reasons for discontinuation.

Conclusions

Risankizumab demonstrated high long-term drug survival and durable treatment retention in real-world psoriasis management. These findings support its effectiveness in routine clinical practice and contribute important Australian real-world evidence regarding biologic therapy outcomes. Overall, this is one of the largest drug survival studies within an Australian cohort for Risankizumab with the drug survival comparable to international studies.

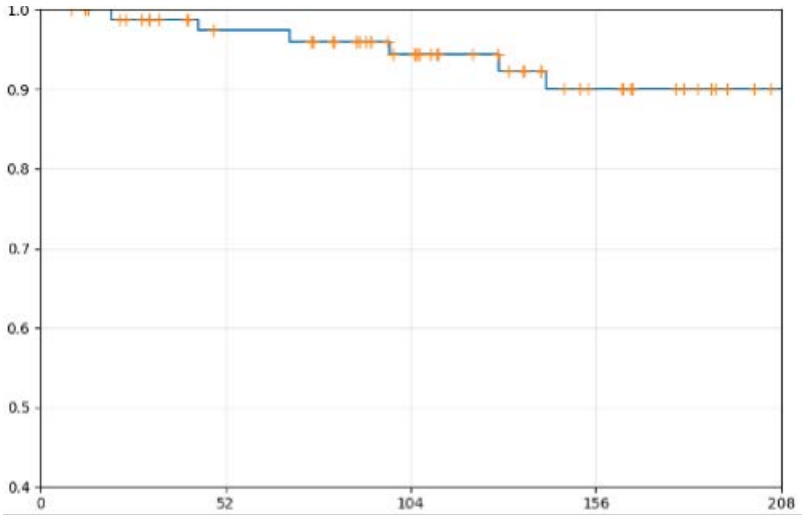

Figure 2 | Kaplan-Meier Survival Curve for Patients Treated with Risankizumab (x axis = time (weeks), y axis = survival probability).

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Abstract N°: 4048

A patient with Psoriatic Arthritis and Fibromyalgia in real clinical practice

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Introduction

Fibromyalgia (FM) is a chronic syndrome characterized by pain, fatigue, and other somatic symptoms. FM has a significant impact on the quality of life of patients with rheumatic diseases and often prevents them from achieving remission.

The aim of the study is to assess the frequency of FM in real clinical practice among patients with a confirmed diagnosis of psoriatic arthritis (PsA) and its impact on key indicators.

Materials and Methods

Research materials: the study included 34 patients with PsA. The 2016 American College of Rheumatology criteria (ACR2016) were applied to all patients. To diagnose fibromyalgia, it was necessary to have a pain syndrome lasting more than 3 months, a generalized pain syndrome, a widespread pain index (WPI) of ≥ 7 or WPI of 4–6, and a symptom severity scale (SSS) of ≥ 5 or SSS of ≥ 9. The patients' education level, marital status, employment status, and the relationship between the onset of the disease and a stressful situation (according to the patient) were also assessed. The CSI scale was used to measure central sensitization.

Results

Result: The main characteristics of the patients included in the study are presented in the table 1.

The use of the 2016 diagnostic criteria for FM revealed that 20.5% (n=7) of PsA patients had FM. Moreover, patients with FM had a more pronounced pain syndrome according to the VAS, a significantly higher number of painful joints, and more severe functional impairments in terms of disease activity, despite the absence of inflammatory activity in their blood tests. It was also found that patients with FM were less likely to be in a relationship, had a lower level of education, and were more likely to change their occupation or quit their job due to their illness. Patients with FM were more likely to attribute their illness to previous stress.

Table 1. Characteristics of patients included in the study with FM (FM+PsA) and without FM (FM-PsA).

Parameters	FM+PsA (n=7)	FM-PsA (n=27)	p
Age, years	49.0[46.0;58.0]	43.0[39.0;53.0]	0.2
BMI	34.8[24.7;37.1]	27.7[24.2;29.1]	0.2
Duration of illness, years	11.0[5.0;26.0]	6.0[4.0;11.0]	0.2
VAS	7.0[5.0;8.0]	4.0[3.0;6.0]	**0.01**
ESR, mmol/l	12.0[10.0;37.0]	10.0[7.0;22.0]	0.4
CRP mg/l	3.0[1.2;9.5]	5.8[3.0;11.4]	0.2
DAPSA	34.2[24.0;44.9]	28.0[17.5;36.0]	0.4
BASFI	5.3[3.5;4.3]	1.2[0.7;3.6]	**0.003**
BASDAI	7.0[5.8;8.1]	4.3[3.0;6.3]	**0.003**
ASDAS	3.5[3.4;4.3]	2.8[2.1;3.6]	**0.007**
MASES	7.0[5.0;13.0]	0.0[0.0;2.0]	**0.001**
SJC(0-66)	2.0[0.0;4.0]	2.0[1.0;6.0]	0.2
TJC66 (0-66)	19.0[8.0;30.0]	5.0[2.0;12.0]	**0.006**
CSI	54.0[45.0;59.0]	29.0[22.0;43.0]	**0.003**

Conclusions

Conclusion. A patient with FM is not only characterized by the presence of chronic generalized pain syndrome, higher rates of activity of the underlying disease, and a lower quality of life, but also has a specific "portrait." This patient is more likely to be single, have a lower level of education, be prone to changing careers or quitting their jobs, and have a higher level of anxiety.

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Abstract N°: 4051

Five-year real-world drug survival of risankizumab in moderate-to-severeplaque psoriasis: a multicenter Italian cohort study

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Introduction
Risankizumab is a humanized monoclonal antibody that specifically targets and blocks interleukin-23. It is approved for the treatment of moderate to severe plaque psoriasis and has demonstrated both efficacy and safety in clinical trials as well as in everyday clinical practice. This study was designed to assess the long-term effectiveness, safety, and treatment persistence of risankizumab in a real-world context.

Materials and Methods
Adult patients with moderate to severe plaque psoriasis treated with risankizumab 150 mg according to the approved regimen between 2020 and 2026 were retrospectively enrolled. Of the 211 patients screened across participating institutions, 72 were excluded due to the absence of complete 5-year follow-up data. Consequently, 139 patients were included in the final analysis. Treatment survival was estimated using the Kaplan-Meier method, and cumulative incidence was evaluated utilizing competing risks analysis. Discontinuations of therapy were categorized as clinical—attributable to reasons such as lack of efficacy, adverse events, or pregnancy—or nonclinical, including loss to follow-up, patient preference, or voluntary withdrawal.

Results
During a median follow-up period of 1,567 days, drug survival rates were 93.5% at 12 months, 92.6% at 24 months, 90.5% at 36 months, and 88.1% at both 48 and 60 months. Treatment discontinuation was observed in 15 patients (10.8%), with one discontinuation due to secondary inefficacy. The remaining 14 discontinuations were attributed to nonclinical reasons, including four voluntary therapy changes, four patient decisions (two patients discontinued due to perceived remission following prolonged treatment, and two switched to oral therapy owing to preference for the route of administration), three administrative reasons, and three cases of loss to follow-up. No discontinuations were reported due to adverse events, infections, malignancy, or pregnancy. The cumulative incidence of discontinuation at 5 years was 1.04% (95% CI, 0.09–5.08) for clinical causes and 10.88% (95% CI, 5.88–17.63) for nonclinical causes. At week 16, 66.2% of patients achieved a PASI 90 response, and 94.3% of those who responded by week 52 maintained this response at year 2. Drug survival at 60 months was lower in patients with psoriatic arthritis (hazard ratio [HR] 1.77), genital involvement (HR

1.54), and prior exposure to IL-17 inhibitors (HR 1.34). Survival rates at 60 months were 89.8% in biologic-naive patients, 93.0% in patients with one prior biologic treatment, and 75.4% in patients with two or more prior biologic treatments.

Conclusions

By selectively inhibiting the IL-23 p19 subunit and consequently modulating the downstream Th17/IL-17 pathway, risankizumab demonstrated durable treatment persistence over five years in our cohort. Notably, only one out of 139 patients discontinued therapy for clinical reasons. In the context of a chronic lifelong disease, this finding is particularly significant, as treatment continuation was rarely interrupted due to lack of efficacy or safety concerns once initiated. This study supports the long-term effectiveness and safety of risankizumab in a real-world setting.

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Abstract N°: 4072

Incidence, clinical phenotypes, and biologic class–specific risk of paradoxical psoriasis: a systematic review and meta-analysis

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Introduction

Paradoxical psoriasis is an increasingly recognized adverse effect of biologic therapies in chronic inflammatory diseases; however, its true incidence, clinical phenotypes, and biologic class-specific risks remain incompletely defined. This study aims to determine incidence, characterize phenotypes, and evaluate class-specific risk through a systematic review and meta-analysis, excluding case reports, reviews, non-human studies, duplicates, and studies lacking full text or extractable data.

Materials and Methods

A PRISMA 2020-compliant systematic review and meta-analysis was conducted. PubMed (n=406), Scopus (n=188), and Cochrane Library (n=50) were searched from inception to March 2026, yielding 644 records, using keywords including “paradoxical psoriasis,” “biologic therapy,” “TNF-α inhibitors,” “IL-17 inhibitors,” “IL-23 inhibitors,” “incidence,” and “adverse effects.” After removal of 101 studies (92 duplicates, 9 without full text), titles and abstracts were screened followed by full-text assessment. Eight studies met inclusion criteria. Case reports, reviews, non-human studies, duplicates, and studies lacking full text or extractable data were excluded. Eligible studies included randomized controlled trials and observational studies reporting incidence or risk of paradoxical psoriasis in patients receiving biologics. Data extraction was performed independently by two reviewers. Risk of bias was calculated using Newcastle-Ottawa Scale and Cochrane Risk of Bias-2. Random-effects meta-analysis was used to estimate pooled incidence and relative risks (RRs), with subgroup analyses by biologic class. Heterogeneity was assessed using I^2 statistics.

Results

Eight studies comprising 21,374 patients were included. The pooled incidence of paradoxical psoriasis was 2.9% (95% CI: 2.1-3.8), with moderate heterogeneity (I^2 = 62%). TNF-α inhibitors were associated with the highest risk (reference group), while IL-17 inhibitors demonstrated significantly reduced risk (RR 0.61, 95% CI: 0.39-0.94), followed by IL-23 inhibitors (RR 0.46, 95% CI: 0.27-0.77). IL-12/23 inhibitors showed a modest reduction in risk (RR 0.71, 95% CI: 0.52-0.98). The most frequently reported phenotypes were palmoplantar pustulosis (36%) and plaque psoriasis (31%), with less frequent presentations including scalp and guttate psoriasis. Median time to onset ranged from 4 to 7 months. Most studies showed moderate quality, with observational studies scoring 6–8 on the NOS and RCTs demonstrating overall low risk of bias on the Cochrane Risk of Bias tool, with minor concerns in blinding. Subgroup analysis suggested a higher incidence among patients with inflammatory bowel disease compared to other indications. Sensitivity analyses confirmed consistency of findings.

Conclusions

Paradoxical psoriasis represents a clinically significant complication of biologic therapy, with incidence approaching 3% and notable variation across biologic classes. TNF-α inhibitors confer the highest risk, whereas IL-17 and IL-23 inhibitors appear comparatively safer. The findings are derived from methodologically sound approaches, with appropriate statistical analyses supporting the validity and relevance of results. Data are presented in a clear, structured manner, and conclusions are justified by the evidence. This study provides important and clinically meaningful insights to support personalized biologic selection and improved patient care.

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Abstract N°: 4079

Cardiovascular Risk Awareness and Preventive Practices Among Patients with Psoriasis: A Questionnaire-Based Cross-Sectional Study from India

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Introduction

Psoriasis is increasingly recognized as a systemic inflammatory disorder associated with elevated cardiovascular (CV) morbidity and major adverse cardiovascular events. Patients with psoriasis are at increased risk of hypertension, obesity, metabolic syndrome, and atherosclerotic disease due to shared inflammatory pathways involving chronic immune dysregulation and systemic inflammation. Cardiovascular comorbidities contribute significantly to long-term disease burden and reduced quality of life among affected individuals. Despite growing evidence supporting this association, awareness regarding psoriasis-associated cardiovascular risk and adoption of preventive health behaviours remain poorly studied, particularly in Indian populations.

Materials and Methods

This cross-sectional questionnaire-based study included adult patients with clinically diagnosed psoriasis attending a tertiary care dermatology centre. Demographic and clinical parameters including Psoriasis Area and Severity Index (PASI), body mass index (BMI), blood pressure, smoking status, and comorbidities were recorded.

A structured interviewer-administered questionnaire was developed following literature review and expert content validation. Internal consistency reliability assessment demonstrated good reliability (Cronbach's alpha = 0.809). The questionnaire was administered in English or Tamil and assessed awareness of psoriasis as a systemic disease, cardiovascular risk perception, preventive screening behaviours, lifestyle modification practices, medication adherence, and healthcare-related barriers. Composite Likert-scale-based Knowledge, Attitude, and Practice (KAP) scores were calculated using predefined scoring criteria. Statistical analysis was performed using SPSS software, including Spearman correlation analysis.

Results

The study included 50 patients (27 females, 23 males) with a mean age of 43.8 ± 12.2 years. Psoriasis vulgaris was the predominant subtype (58%). Obesity (BMI ≥30 kg/m^2) was present in 64% of participants, while hypertension and diabetes mellitus were identified in 16% and 4%, respectively. Current smoking was reported by 12% of participants. Despite substantial cardiometabolic risk burden, awareness regarding psoriasis-associated cardiovascular disease remained limited. Mean Knowledge, Attitude, and Practice scores were 14.4 ± 6.8/36, 21.5 ± 5.1/36, and 42.3 ± 10.3/68, respectively, with a mean total KAP score of 78.2 ± 18.1/140.

Low cardiovascular risk-related knowledge was observed in 70% of participants, whereas only 4% demonstrated high knowledge levels. Neutral attitudes predominated (70%), while positive attitudes were observed in only 14%. Practice scores were moderate in 60%, poor in 18%, and good in 22% of participants. Older participants demonstrated comparatively lower cardiovascular risk awareness and poorer preventive practice scores.

Conclusions

Patients with psoriasis demonstrated substantial gaps in cardiovascular risk awareness despite a considerable burden of cardiometabolic risk factors. A high prevalence of obesity was observed within the study population, further emphasizing the importance of cardiovascular risk assessment in psoriasis care. Older participants demonstrated comparatively lower awareness and poorer preventive practices, highlighting the need for targeted patient education, structured cardiovascular counselling, and integrated preventive screening as part of routine psoriasis management.

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Clinical Markers Associated With Subclinical Cardiovascular Involvement in Psoriatic Patients: A Medical Imaging-Based Study

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Introduction

Patients with psoriasis have an increased burden of cardiovascular disease, emphasizing the need for clinically applicable tools to improve cardiovascular risk recognition in dermatological practice. Coronary artery calcium score (CACS), assessed by cardiac computed tomography, is an objective imaging marker of coronary atherosclerosis. The presence of coronary calcification indicates cardiovascular involvement, whereas a CACS of zero is considered a favourable prognostic marker in relation to future major adverse cardiovascular events. Our objective was to identify routinely available clinical and laboratory markers that may help dermatologists recognize psoriatic patients without cardiovascular symptoms who may have subclinical cardiovascular involvement.

Materials and Methods

In this cross-sectional single-centre study, 101 patients with psoriasis underwent coronary computed tomography for CACS assessment. Patients were classified into CACS = 0 and CACS > 0 groups. Demographic, clinical and laboratory parameters were analysed using univariate comparisons and multivariable predictive modelling. Variable importance was assessed using regularized logistic regression and random forest classification models.

Results

Patients with CACS>0 were significantly older than those with CACS = 0 (56.8 ± 11.2 vs. 43.2 ± 8.8 years, $p < 0.001$). Among routinely available clinical and laboratory parameters, glucose and aspartate aminotransferase (AST/GOT) showed the highest importance for predicting non-zero CACS. The random forest model demonstrated high discriminatory performance for identifying patients with coronary calcification. Increasing age, glucose and AST/GOT levels were associated with a progressively lower probability of zero CACS.

Conclusions

Age, glucose and AST/GOT were the strongest routine markers associated with subclinical atherosclerosis in psoriatic patients without cardiovascular symptoms. These markers should be further explored for potential

integration into cardiovascular risk screening strategies to improve the identification of psoriatic patients with subclinical cardiovascular involvement. Successful implementation may improve recognition of these patients and contribute to the prevention of future cardiovascular events.

EADV CONGRESS
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Abstract N°: 4137

Fibromyalgia among Patients with Psoriasis Treated with Biological Therapy

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Introduction
Psoriasis (PsO) is a chronic inflammatory, primarily cutaneous disease often accompanied by several comorbidities, including musculoskeletal disorders. While its association with psoriatic arthritis (PsA) has been widely addressed in the literature, several studies suggest a possible association with fibromyalgia (FM), a syndrome characterized by chronic widespread pain accompanied by fatigue, cognitive dysfunction, sleep disturbances, and autonomic and psychiatric disorders. Due to overlapping symptoms of PsA and FM, differentiation between the two conditions may be challenging, and it is unclear how much of the treatment failure in PsA patients is attributed to concurrent FM. This study aimed to evaluate the prevalence of fibromyalgia among patients with psoriasis and its association with different clinical presentations and comorbidities.

Materials and Methods
This observational cross-sectional study included 99 patients with PsO receiving biological therapy. The presence of FM was assessed according to the 2016 American College of Rheumatology (ACR) criteria. Demographic, clinical, and laboratory data were collected, together with the results of standardized questionnaires and scores, including PASI, BSA, DLQI, the Early Arthritis for Psoriatic Patients (EARP) questionnaire, and the Beck Depression Inventory (BDI). Statistical analysis included descriptive statistics, appropriate comparative tests, and univariate logistic regression.

Results
Eleven patients (11.1%) met the criteria for fibromyalgia. No significant differences were found in the severity of skin disease between the groups. Patients with FM had a significantly higher prevalence of psoriatic arthritis (63.6% comapred with 29.5% in patients without FM) and higher EARP score values. Although no difference in the frequency of depression was observed between the groups, Beck Depression Inventory scores were significantly higher and anxiety was more frequent among patients with FM.

Conclusions
Fibromyalgia is relatively common among patients with psoriasis. Its presence is associated with more pronounced musculoskeletal and psychological symptoms, but not with the objective severity of the skin disease. Recognition of fibromyalgia in clinical practice is important for accurate assessment of disease activity, evaluation of therapy response, and individualized therapeutic management.

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Epidemiological Analysis of Patients with Plaque Psoriasis Receiving Ustekinumab or Secukinumab Therapy

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Introduction
Psoriasis is a chronic, immune-mediated, inflammatory, and recurrent skin disease with an estimated global prevalence of approximately 2%, varying according to the population studied. Beyond cutaneous manifestations, psoriasis is currently recognized as a systemic inflammatory disorder associated with significant impairment in quality of life and multiple cardiometabolic comorbidities, including obesity, hypertension, diabetes mellitus, dyslipidemia, and psychiatric disorders. The chronic inflammatory burden and delayed access to effective therapies may contribute to disease progression, cumulative psychosocial impact, and reduced therapeutic response over time. With advances in the understanding of psoriasis immunopathogenesis, immunobiologic therapies targeting specific inflammatory pathways, such as Ustekinumab (anti–IL-12/23) and Secukinumab (anti–IL-17A), have become essential therapeutic options for moderate to severe plaque psoriasis, demonstrating high efficacy and favorable safety profiles. The present study aimed to analyze the epidemiological and clinical profile of patients with plaque psoriasis undergoing treatment with immunobiologic agents, with emphasis on associated comorbidities, previous therapeutic history, disease duration, and clinical factors potentially related to therapeutic failure or loss of response.

Materials and Methods
A retrospective epidemiological analysis of 56 medical records was conducted, including patients evaluated between June and August 2025, with data reviewed from August to November 2025. Variables analyzed included sex, age, comorbidities, smoking and alcohol consumption history, previous topical and systemic treatments, time from symptom onset to initiation of biologic therapy, and therapeutic outcomes. Disease severity and impact on quality of life were assessed through PASI (Psoriasis Area and Severity Index) and DLQI (Dermatology Life Quality Index) scores documented in medical records. Patients who developed therapeutic failure or secondary loss of response during biologic therapy were also individually analyzed.

Results
The results demonstrated a high prevalence of cardiometabolic comorbidities, particularly obesity and systemic arterial hypertension, reinforcing the systemic inflammatory nature of psoriasis. Most patients had previously undergone topical and systemic therapies before initiation of immunobiologic treatment, reflecting the therapeutic complexity of moderate to severe disease. A prolonged interval between disease onset and initiation of biologic therapy was observed, with a median duration of approximately 14.66 years. Patients who developed therapeutic failure or loss of response tended to present longer disease duration, greater comorbidity burden, and more extensive previous therapeutic exposure. These findings suggest that chronic systemic inflammation and delayed therapeutic optimization may negatively influence long-term treatment outcomes.

Conclusions
This study highlights the importance of early recognition of severe psoriasis, comprehensive evaluation of associated comorbidities, and timely access to advanced therapies. The findings reinforce psoriasis as a multisystemic inflammatory disease requiring an integrated and individualized therapeutic approach. Furthermore,

understanding epidemiological and clinical factors associated with therapeutic response may contribute to improved patient stratification and optimization of long-term management strategies in patients receiving immunobiologic therapy.

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Abstract N°: 4173

Spatiotemporal nanodrug delivery microneedles targeting pathogenic COX2-positive endothelial cell-mediated glycocalyx degradation to ameliorate psoriatic inflammation

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Introduction

Psoriasis is a chronic, immune-mediated inflammatory skin disorder. The vascular endothelium serves as the final barrier preventing circulating immune cells from entering inflamed skin. Dysregulation of this barrier, specifically the degradation of the endothelial glycocalyx, significantly facilitates excessive immune cell infiltration. Through single-cell RNA sequencing, we identified a pathogenic subpopulation of COX2-high endothelial cells in psoriatic lesions that drives this glycocalyx degradation via a sustained ROS-COX2-MMP9 signaling axis. To develop a vascular-targeted, mechanism-driven transdermal microneedle platform capable of selectively inhibiting endothelial COX2, preserving glycocalyx integrity, and ameliorating psoriatic inflammation without systemic side effects.

Materials and Methods

Public single-cell transcriptomic datasets and lesional skin specimens were analyzed to characterize endothelial subpopulations and glycocalyx status. An oxidative stress-induced endothelial injury model and an imiquimod-induced psoriasiform model were used to validate the ROS-COX2-MMP9 axis. Mebendazole was selected by computational repurposing and experimental validation as a COX2-suppressing agent. A P-selectin-targeted, carrier-free nanoparticle was generated by self-assembly of mebendazole with a PSGL-1 ligand and incorporated into an MMP9-responsive GelMA microneedle matrix to form P@Meb-MNs. Therapeutic efficacy, endothelial glycocalyx preservation, immune infiltration, and transcriptomic remodeling were evaluated by molecular assays, immunostaining, transmission electron microscopy, histology, and RNA sequencing.

Results

Single-cell analysis identified an expanded COX2-high endothelial subpopulation in psoriatic lesions, characterized by elevated oxidative phosphorylation, P-selectin expression, MMP9 activity, and reduced glycocalyx biosynthesis. Hyaluronic acid coverage was markedly reduced around COX2-positive vessels and remained impaired in lesions treated with anti-IL-17A biologics, indicating a persistent vascular defect. In endothelial cells, oxidative stress activated COX2, NF-κB, P-selectin, and MMP9, whereas PTGS2 silencing reduced ROS accumulation and preserved hyaluronic acid coverage. P@Meb nanoparticles were uniformly nanosized, preferentially taken up by activated endothelial cells, and retained the COX2-inhibitory and antioxidant activity of mebendazole. After transdermal application, P@Meb-MNs penetrated the hyperkeratotic epidermal barrier and released nanoparticles in response to elevated MMP9. In vivo, P@Meb-MNs produced the strongest improvement in erythema, scaling, epidermal thickening, CD3-positive T-cell infiltration, and Ki67-positive keratinocyte hyperproliferation. Ultrastructural

analysis showed restoration of endothelial glycocalyx coverage from 11.91 ± 4.09% in untreated psoriasiform lesions to 87.5 ± 8.7% after P@Meb-MNs treatment. This was accompanied by reduced endothelial COX2 and ICAM-1 expression, decreased neutrophil and macrophage infiltration, suppression of IL-17 signaling and cell-cycle pathways, enhanced extracellular matrix repair signatures, and improved perivascular collagen I deposition. Biosafety assessment showed favorable cytocompatibility, hemocompatibility, and no overt histological injury in major organs.

Conclusions

By directly targeting endothelial glycocalyx degradation rather than traditional downstream cytokine signaling, this biologically guided, MMP9-responsive microneedle platform achieves spatiotemporally controlled suppression of immune cell extravasation. This strategy establishes a highly effective, vascular-targeted therapeutic paradigm for psoriasis and offers a conceptual framework for treating other inflammatory diseases characterized by endothelial dysfunction.

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Abstract N°: 4182

Incidentally Reported Coronary Artery Calcium Identifies Cardiovascular Prevention Gaps in Psoriatic Disease: The STRATIFY-PsD Study

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Introduction

Psoriatic disease (PsD) is associated with excess cardiovascular (CV) risk, yet standardized CV risk assessment in dermatology remains limited. Coronary artery calcium (CAC), a measure of atherosclerotic burden, is frequently identified incidentally on non-gated chest computed tomography (CT) performed for non-cardiac indications. However, these findings are not systemically captured or used to guide CV risk assessment or preventative care in patients with PsD. The PREVENT equations estimate the 10-year risk of total CV disease (CVD), atherosclerotic cardiovascular disease (ASCVD), and heart failure (HF) in individuals without known CVD.

Materials and Methods

STRATIFY-PsD is an ongoing study within a cardio-dermatology program evaluating CV risk among adults with PsD seen in a large academic medical center since 2020 to identify a contemporary, actionable cohort. Patients with a prior chest CT were identified through the electronic health record (EHR). Qualitative CAC was abstracted from radiology reports and classified as none, minimal/small, moderate, large. CV risk factors, ASCVD events, medications and systemic PsD therapy exposure were extracted from the EHR. Among patients without prior ASCVD, PREVENT 10-year risk estimates were calculated when complete risk factor data was available. CAC burden, statin use, ASCVD event prevalent and PREVENT risk were compared across CAC categories using chi-square tests and Kruskal-Wallis tests, as appropriate.

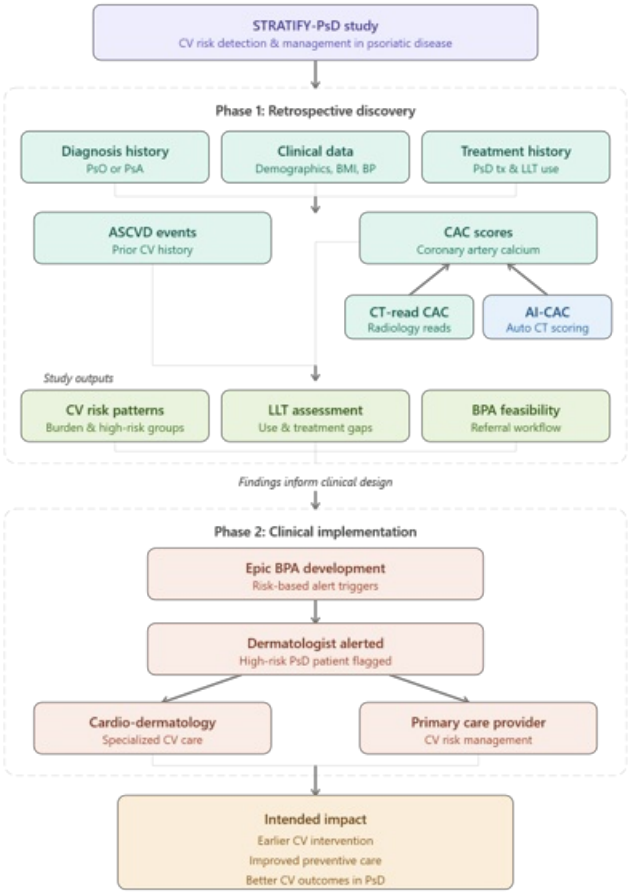

Figure 1. Overview of the STRATIFY-PsD study, a two-phase initiative in which retrospective EMR data are analyzed to characterize cardiovascular risk burden, assess treatment gaps, and evaluate the feasibility of an Epic-based best practice alert designed to notify dermatologists of high-risk psoriatic disease patients for referral to cardio-dermatology or primary care.

Results

Among 4,291 adults with PsD, 1,382 had chest CT imaging available in the EHR; of these, 610 had non-contrast chest CT performed from 2020 onward and were evaluable for qualitative CAC, and 379 (62%) had CAC>0. Of 610 patients with evaluable non-contrast chest CTs, 606 had qualitative CAC categories available for this analysis: no CAC, n=231; small CAC, n=181; moderate CAC, n=103; and large CAC, n=91. Four patients were excluded from this comparison because they had minimal or undefined amounts of CAC. Compared with patients with CAC=0, those with CAC>0 had higher prevalence of documented ASCVD events (39.3% vs. 27.7%, $p<0.001$) and higher prevalence of hypertension, dyslipidemia, smoking history, and chronic kidney disease (all $p<0.05$). Of the 230 patients with CAC>0 and no prior ASCVD event, 172 (75%) were not receiving statin therapy. Among patients without prior ASCVD and with risk factor data (n=175), PREVENT estimates increased significantly across CAC categories (p for trend <0.001). However, despite 75 patients (42.9%) having moderate or large CAC, only 6 (3.4%) were classified as high ASCVD risk (≥20%) by PREVENT ASCVD. Among 127 patients not receiving statin therapy, 51 (40.2%) had moderate/large CAC, yet only 4 were classified as high risk. Systemic PsD therapy exposure did not differ by CAC category by ever use ($p = 0.220$) or current use ($p = 0.907$).

Variable	CAC = 0 (n=231)	Minimal/Small CAC (n=181)	Moderate CAC (n=103)	Large CAC (n=91)	p-value
Sex					
Female	181 (78.4%)	105 (58.0%)	42 (40.8%)	34 (37.4%)	<0.001 *
Male	50 (21.6%)	76 (42.0%)	61 (59.2%)	57 (62.6%)	
Age					
Mean ± SD, years	57.3 ± 15.9	68.6 ± 12.5	74.2 ± 8.6	75.6 ± 9.4	<0.001 †
Race					
White	158 (68.4%)	149 (82.3%)	83 (80.6%)	75 (82.4%)	0.029 *
Black	39 (16.9%)	14 (7.7%)	14 (13.6%)	9 (9.9%)	
Asian	4 (1.7%)	1 (0.6%)	0 (0.0%)	1 (1.1%)	
Other/Unspecified	30 (13.0%)	17 (9.4%)	6 (5.8%)	6 (6.6%)	
Ethnicity					
Hispanic	30 (13.0%)	21 (11.6%)	7 (6.8%)	11 (12.1%)	0.387 *
Non-Hispanic	196 (84.8%)	157 (86.7%)	96 (93.2%)	76 (83.5%)	
Declined/Unknown	5 (2.2%)	3 (1.7%)	0 (0.0%)	4 (4.4%)	
Laboratory Values					
LDL, median (IQR), mg/dL	98 (70–128)	83 (61–104)	76 (63–101)	70 (54–89)	<0.001 †
HbA1c, median (IQR), %	5.6 (5.2–6.1)	5.8 (5.4–6.1)	5.9 (5.4–6.6)	5.8 (5.5–6.4)	<0.001 †
ASCVD Risk Factors					
≥1 ASCVD Risk Factor	191 (89.7%)	172 (95.0%)	102 (99.0%)	91 (100%)	<0.001 ‡
Hypertension	86 (37.2%)	110 (60.8%)	67 (65.0%)	74 (81.3%)	<0.001 ‡
Diabetes mellitus	83 (35.9%)	71 (39.2%)	45 (43.7%)	49 (53.8%)	0.003 ‡
Dyslipidemia	155 (67.1%)	153 (84.5%)	94 (91.3%)	88 (96.7%)	<0.001 ‡
Smoking history	90 (39.0%)	111 (61.3%)	77 (74.8%)	67 (73.6%)	<0.001 ‡
CKD	40 (17.3%)	58 (32.0%)	40 (38.8%)	41 (45.1%)	<0.001 ‡
Documented ASCVD Events					
≥1 ASCVD Event	64 (27.7%)	58 (32.0%)	37 (35.9%)	52 (57.1%)	<0.001 ‡
MI	20 (8.7%)	23 (12.7%)	19 (18.4%)	23 (25.3%)	<0.001 ‡
PCI	9 (3.9%)	8 (4.4%)	15 (14.6%)	20 (22.0%)	<0.001 ‡
CABG	12 (5.2%)	5 (2.8%)	14 (13.6%)	19 (20.9%)	<0.001 ‡
CVA/Stroke	40 (17.3%)	36 (19.9%)	17 (16.5%)	27 (29.7%)	0.053 ‡
Statin Status					
Statin-naïve	143 (61.9%)	66 (36.5%)	33 (32.0%)	19 (20.9%)	<0.001 *
Former statin	64 (27.7%)	69 (38.1%)	42 (40.8%)	43 (47.3%)	
Current statin	24 (10.4%)	46 (25.4%)	28 (27.2%)	29 (31.9%)	
Low–moderate intensity	14 (58.3%)	22 (47.8%)	13 (46.4%)	21 (72.4%)	0.281 *
High-intensity statin	10 (41.7%)	24 (52.2%)	15 (53.6%)	8 (27.6%)	
Systemic PsD Therapy Exposure**					
Ever on systemic therapy	78 (33.8%)	44 (24.3%)	30 (29.1%)	26 (28.6%)	0.220
Currently on systemic therapy	42 (18.2%)	28 (15.5%)	18 (17.5%)	16 (17.6%)	0.907

Table 1. Characteristics of adults with psoriatic disease with evaluable non-contrast chest CT, stratified by qualitative CAC category. Footer: P-values reflect comparisons across all four CAC categories. * Chi-square test for overall distribution across groups. Statin-naïve was defined as no statin prescription in prior five years. † Kruskal-Wallis test for continuous variables across groups. ‡ Chi-square test for trend across ordered CAC categories. **Current systemic therapy was defined as any active systemic PsD medication with a start date on or after January 1, 2025. Of 776 patients with extractable CAC data, 744 had a quantified CAC amount documented (CAC > 0, n = 495; CAC = 0, n = 249); 32 had prior evidence of coronary artery disease (CAD) or intervention for CAD and were, therefore, excluded from this table. LDL available for 487/610 patients (79.8%). HbA1c available for 451/606 patients (74.4%). Statin use was identified from electronic health record data capturing all statin prescriptions within the five years preceding the data pull. Patients were classified as current statin users if they had active statin use at the time of data extraction or an end date within six months prior to the data pull. Abbreviations: ASCVD, atherosclerotic cardiovascular disease; CABG, coronary artery bypass grafting; CAC, coronary artery calcium; CKD, chronic kidney disease; CVA, cerebrovascular accident; DM, diabetes mellitus; HbA1c, hemoglobin A1c; IQR, interquartile range; LDL, low-density lipoprotein cholesterol; MI, myocardial infarction; PCI, percutaneous coronary intervention; PsD, psoriatic disease; SD, standard deviation.

Conclusions

In this cardio-dermatology cohort, incidentally reported CAC identified significant coronary atherosclerotic burden and preventive treatment gaps among patients with PsD. Statin use was low despite prevalent CAC and PREVENT ASCVD risk classification was frequently discordant with CAC burden, suggesting it may not fully capture CV risk in

this population. These findings support prospective evaluation of systematic CAC capture and CAC-informed clinical decision support within dermatology workflows to improve guideline-directed CV prevention in PsD.

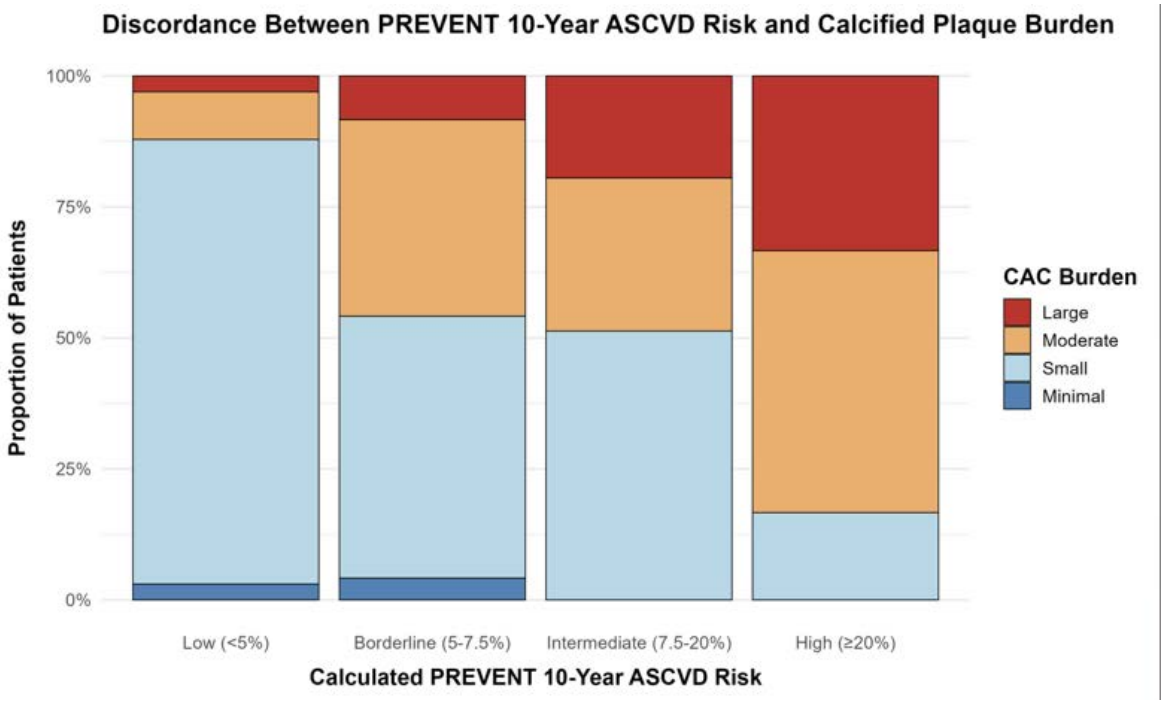

Figure 2. Discordance between PREVENT 10-year ASCVD risk and coronary artery calcium (CAC) burden. Stacked bar chart demonstrating the distribution of CAC burden (minimal, small, moderate, large) across PREVENT 10-year ASCVD risk tiers. Abbreviations: ASCVD, atherosclerotic cardiovascular disease; CAC, Coronary Artery Calcium

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Abstract N°: 4187

Fear of Transmitting Psoriasis to Offspring: An Underrecognized Psychosocial and Reproductive Burden

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Introduction

Psoriasis is a chronic inflammatory skin disease with a multifactorial etiology involving genetic predisposition and environmental triggers, and it significantly impairs quality of life and psychosocial well being.[1] Given its genetic component, some patients may experience concerns about transmitting psoriasis to their children. However, the potential impact of these concerns on reproductive decision making and parenthood perceptions remains poorly understood. This study aimed to investigate hereditary transmission concerns in psoriasis and their impact on psychological burden and reproductive decision making.

Materials and Methods

This crosssectional study included 200 patients with psoriasis who attended the dermatology outpatient clinic of a tertiary referral center. Demographic and clinical characteristics, including disease duration, family history, parenthood status, future childbearing intentions, treatment history, PASI scores, and psoriasis localization, were recorded. Transmission anxiety was assessed using an 8 item questionnaire informed by concepts of health anxiety by proxy and parental concern, covering hereditary transmission, guilt perception, future related anxiety, and family planning.[2] General future related anxiety and guilt perception were assessed using visual analogue scales (VAS), and quality of life was evaluated using the Dermatology Life Quality Index (DLQI).[3] Correlation and multivariable linear regression analyses were performed to identify factors associated with transmission anxiety scores.

Results

The mean age was 43.74±15.73 years; 54.5% were female, 69.5% had children, and 52.0% were receiving biologic therapy. The mean transmission anxiety score was 10.72±8.97 on a 0–32 scale, and 33.5% of patients demonstrated moderate to high transmission anxiety (score ≥16/32). Approximately 30% of patients reported that hereditary concerns affected family planning decisions, while 26.5% reported hesitation regarding childbearing because of psoriasis. Patients without children demonstrated significantly higher transmission anxiety scores compared with patients with children (12.38±9.82 vs 9.99±8.50, $p=0.043$). Patients with a family history of psoriasis also had significantly higher transmission anxiety scores than those without a family history (12.21±9.41 vs 9.90±8.64, $p=0.041$). Transmission anxiety scores showed significant positive correlations with DLQI scores ($r=0.471$, $p<0.01$), future related anxiety VAS scores ($r=0.609$, $p<0.01$), and guilt perception VAS scores ($r=0.623$, $p<0.01$). Higher DLQI scores were also significantly associated with both future related anxiety ($r=0.484$, $p<0.01$) and guilt perception ($r=0.528$, $p<0.01$). In multivariable linear regression analysis, future related anxiety ($\beta=0.341$, $p<0.001$) and guilt perception ($\beta=0.350$, $p<0.001$) were independently associated with higher transmission anxiety scores. Methotrexate use ($\beta=0.232$, $p=0.001$) also showed an independent association. The regression model explained 50.6% of the variance in transmission anxiety scores ($R^2=0.506$). Correlation and regression analyses are summarized in Table 1.

Table 1. Factors associated with transmission anxiety scores in patients with psoriasis

Variable	Analysis	Statistic	p value
DLQI	Correlation	r=0.471	<0.01
Future related anxiety VAS	Correlation	r=0.609	<0.01
Guilt perception VAS	Correlation	r=0.623	<0.01
Future-related anxiety VAS	Regression	β=0.341	<0.001
Guilt perception VAS	Regression	β=0.350	<0.001
Methotrexate use	Regression	β=0.232	0.001
Overall model	Regression	R^2=0.506	<0.001

DLQI: Dermatology Life Quality Index; VAS: visual analogue scale.
β values are standardized coefficients from multivariable linear regression analysis.
Transmission anxiety score was used as the dependent variable in regression analysis.

Conclusions

Fear of transmitting psoriasis to offspring represents an underrecognized psychosocial and reproductive burden, closely associated with impaired quality of life, future related anxiety, and guilt perception. These concerns may influence reproductive decision making. Therefore, patient centered psoriasis care should include education and counseling to address the emotional impact of hereditary transmission concerns.

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Abstract N°: 4257

Wearable and Passive Remote Monitoring Technologies for Psoriasis, Atopic Dermatitis, and Hidradenitis Suppurativa in the MENA Region: A Scoping Review

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Introduction

Chronic inflammatory skin diseases, for example psoriasis, atopic dermatitis, and hidradenitis suppurativa, necessitate long-term disease monitoring owing to their relapsing nature, detrimental impact on quality of life (QoL) , and requirement of constant therapeutic adjustment. Recent advancements led to the introduction of wearable and passive digital monitoring technologies has provided interesting new possibilities for monitoring diseases in real time, symptom monitoring, treatment adherence evaluation and remote patient management. Despite the rapid globalization of digital dermatology, the coverage, accessibility, and clinical applicability of digital in the Middle East and North Africa (MENA) is not well described. To conduct a systematic mapping and synthesis of evidence on wearable and passive digital monitoring technologies available for chronic inflammatory skin diseases in the MENA region, with a focus on clinical application, patient outcomes, technological feasibility and regional challenges in implementation.

Materials and Methods

A scoping review was conducted following PRISMA-ScR guidelines. Five major electronic databases (PubMed/MEDLINE, Scopus, Embase, Web of Science, and Cochrane CENTRAL) were searched for publications from January 2015 to March 2026. Eligible studies included randomized controlled trials, cohort studies, observational studies, pilot digital health research, teledermatology research and technology validation studies of wearable or passive monitoring technologies for patients with psoriasis, atopic dermatitis or hidradenitis suppurativa. Devices that included were wearable biosensors, smartwatches, mobile health applications, nocturnal scratching monitors, activity trackers, AI-assisted monitoring systems and passive symptom-tracking platforms. Outcomes assessed included disease severity monitoring, flare prediction and treatment adherence, patient-reported outcomes, sleep quality, QoL measures, and healthcare access. The search yielded 1,384 records. After removing duplicate articles, title/abstract screening, and final screening, 96 full-text articles were assessed for eligibility, and 27 studies met inclusion criteria for synthesis.

Results

Among the 27 studies, wearable and passive monitoring technologies have emerged as promising tools in enhancing longitudinal patient-level disease evaluations, remote symptom evaluation, and patient involvement across diverse chronic inflammatory dermatoses. Mobile health platforms and wearables are the most commonly used tools for data collection in atopic dermatitis and psoriasis populations, for evaluation of pruritus severity, sleep disturbances, adherence to therapy, and the variation of disease activity. Reported benefits included better patient-reported outcomes, better compliance with treatment, and improved access to dermatologic intervention based on remote monitoring solutions. Nighttime scratching sensors and sleep-monitoring wearables showed strong effectiveness in managing atopic dermatitis, while smartphone-based image and symptom-tracking apps

demonstrated promise for psoriasis assessment and flare prediction. Key barriers included inconsistent digital infrastructure, limited validation across diverse skin types, privacy concerns, unequal technology access, lack of standardized outcomes, and significant heterogeneity in study design and follow-up.

Conclusions

Wearable and passive digital monitoring tools present a novel and hopeful approach to the control of chronic inflammatory skin diseases. Available evidence has indicated potential advantages to disease monitoring, patient engagement, and remote dermatological care; however, implementation and validation among MENA populations poses considerable gaps. Future research can include region-specific validation studies, implementation of standardized digital outcome measures, and integration of culturally and technologically accessible remote monitoring systems to provide optimum digital dermatology care across the MENA region.

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Abstract N°: 4266

Severity of psoriasis in Tunisia: Results of the National PsoTReg Registry

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Introduction
Psoriasis is a chronic, inflammatory disease affecting up to 5% of the population. It significantly impacts patients' quality of life. In the African continent, data on disease severity remain limited. The aim of this study was to evaluate the prevalence of severe psoriasis among Tunisian patients and to identify factors associated with disease severity and quality of life impairment.

Materials and Methods
Results from the Tunisian National Psoriasis registry (PsoTreg) were analyzed (ClinicalTrials.gov IDNCT05258838). A total of 1,100 patients with psoriasis were included between July 12, 2022, and November 15, 2024. Disease severity and quality of life impairment were assessed using the Simplified Psoriasis Index (SPI). Demographic, clinical, and lifestyle data were analyzed to identify factors associated with disease severity and quality of life impairment.

Results
Moderate to severe psoriasis affected 31.9% of patients. Disease severity was associated with male gender ($p=0.001$), age ($p=0.024$), late disease onset ($p=0.042$), psoriatic arthritis ($p<0.001$), positive family history ($p=0.037$), anxiety ($p<0.001$), depression ($p=0.001$), alcohol intake ($p<0.001$), smoking in men ($p<0.001$) and obesity in women ($p<0.001$). Quality of life impairment, affecting 38.3% of the cohort, was significantly associated with obesity ($p=0.004$), musculoskeletal involvement ($p<0.001$), smoking ($p=0.005$), alcohol intake ($p=0.001$), anxiety and depression ($p<0.001$).

Conclusions
This study, the first multicenter psoriasis registry in North Africa, highlighted the frequency of moderate to severe psoriasis (31.9%). It emphasized a high proportion of patients with quality-of-life impairment (38.3%). Notably, psoriasis severity was strongly associated with smoking in men and obesity in women, underlining gender-specific risks.

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Abstract N°: 4270

From Metabolic to Dermatologic Disease: GLP-1 Receptor Agonists as Emerging Therapies for Psoriasis and Hidradenitis Suppurativa

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Introduction
Glucagon-like peptide-1 (GLP-1) receptor agonists may affect psoriasis and hidradenitis suppurativa by immunometabolic pathways involving adipose inflammation, keratinocyte signaling, and IL-23/Th17 pathway regulation.

Materials and Methods
PubMed-indexed studies and MDPI publications published through 2026 evaluating semaglutide and liraglutide in psoriasis and/or hidradenitis suppurativa were reviewed, prioritizing mechanistic studies, randomized trials, cohort studies, and case series reporting PASI, Hurley stage, flare frequency, inflammatory biomarkers, quality-of-life outcomes, and confounding variables.

Results
Psoriasis findings were heterogeneous but generally favorable following early negative studies in glucose-tolerant obesity. Studies involving liraglutide and semaglutide in patients with obesity and/or type 2 diabetes demonstrated PASI improvement, CRP reductions and lesional IL-17, IL-23, and TNF-α expression, and improved DLQI scores. Six-month liraglutide cohorts demonstrated PASI reductions from 12.0 to 4.3, while semaglutide studies reported approximately 48% PASI improvement alongside metabolic benefit. Regression analyses suggested that clinical improvement was not fully explained by BMI reduction alone. Evidence in hidradenitis suppurativa remains early-stage but promising, with liraglutide associated with improved Hurley stage and DLQI scores and semaglutide cohorts demonstrating reductions in flare frequency, pain, and quality-of-life impairment. Concurrent therapies and metabolic indications remained important confounders across studies.

Conclusions
GLP-1 agonists are increasingly indicated as an adjunctive immunometabolic treatment of psoriasis and hidradenitis suppurativa in patients with metabolic diseases, including obesity and/or diabetes. Findings support biologic plausibility and early symptomatic improvement, suggesting a broader role for immunometabolic modulation in dermatologic inflammation. However, small, heterogeneous, and largely uncontrolled studies continue to limit definitive conclusions regarding disease-specific efficacy.

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Abstract N°: 4330

Artificial Intelligence and Machine Learning for Prognostic Biomarkers in Psoriatic Disease: A Systematic Review

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Introduction
Psoriasis is a chronic, immune-mediated systemic disease. Traditionally, diagnosis, progression and severity assessment relied on clinical tools like Psoriasis Area and Severity Index (PASI). However, the focus has shifted to molecular biomarkers such as HLA-C*06:02, CRP and other inflammatory indices. These biomarkers lack sensitivity and provide only a snapshot of the current disease state. The integration of artificial intelligence (AI) and machine learning (ML) marks a paradigm shift, enabling the synthesis of genomic, proteomic and imaging data to discover biomarker signatures predicting disease progression and severity. However, a notable evidence gap exists regarding clinical readiness, accuracy and reproducibility of these models. This systematic review aims to bridge this gap by summarizing AI/ML tools used to predict prognostic biomarkers in psoriatic disease.

Materials and Methods
We searched PubMed and Scopus from inception to May 2026 for English-language human studies using MeSH and title/abstract terms for “psoriasis”, “psoriatic arthritis”, “biomarkers”, “disease progression”, “severity”, “artificial intelligence”, “machine learning”. Eligible studies included psoriasis patients with AI/ML-analyzed biomarkers (gene/protein/blood/imaging) predicting disease progression or treatment response. Eligible study designs were randomized controlled trials (RCTs), clinical trials and observational studies using real patient data. Two reviewers independently screened titles/abstracts and full texts with discrepancies resolved by a third reviewer. Initial search yielded 66 records. The study selection process is summarized in a Prisma flow diagram.

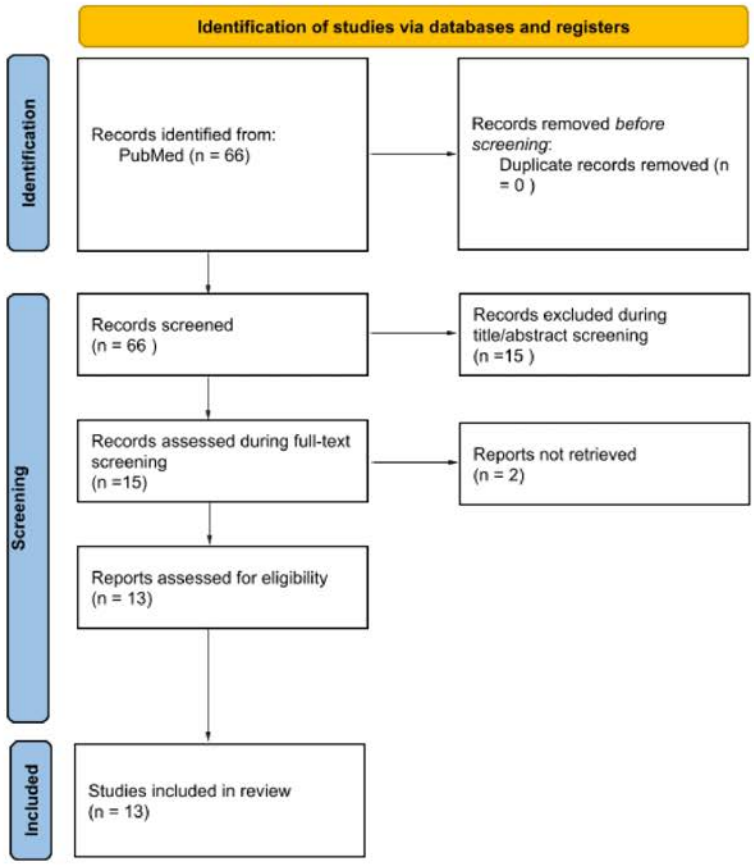

Figure 1: PRISMA Flow Diagram for Study Selection

Figure 1: PRISMA Flow Diagram for Study Selection

Results

Thirteen studies met our inclusion criteria (cohorts=7, case-control=5, clinical trial=1). All used ML; random forest (n=6) or LASSO (n=5) were most common; support vector machines, neural networks, conditional inference forest and shrinkage discriminant analysis appeared less frequently. For predicting psoriatic arthritis (PsA) in psoriasis patients, two large cohorts achieved an area under the curve (AUC=0.82) and identified a top-risk subset with >90% precision using genetic markers. For treatment response, the IL-18/IL-13 ratio predicted secukinumab super-response (PASI=0 at week 12) with AUC=0.86, while a neural network identified fast responders (PASI75 at

week 4) with 92% accuracy. Another study using penalized regression linked a monocyte gene signature to apremilast response at week 16. Five studies found serum or transcriptomic markers (e.g., PI3, GJB2, CXCL8, ANGPTL4, EMCN) tied to disease progression (AUC up to 1.0). Deep learning analysis of optoacoustic images extracted dermal microvascular features tracking with psoriasis severity over time.

Conclusions

AI/ML applied to clinical datasets shows promise for predicting disease progression and PsA development. Models using genetic markers achieved high predictive precision in identifying patients at risk of PsA as well as biologic "super responders." However, current evidence is limited by lack of standardization, small and localised cohorts and heterogeneity in ML architecture, making reproducibility difficult and generalizability uncertain. Future research should focus on prospective clinical trials and the integration of multi-omic datasets. Greater algorithmic transparency will be essential to validate these prognostic tools for routine dermatological practice.

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Abstract N°: 4365

Sex-Related Differences in Psoriatic Erythroderma: A retrospective study from Tajikistan

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Introduction
Erythrodermic psoriasis is a severe and potentially life-threatening form of psoriasis characterized by generalized erythema and extensive inflammation of the skin. Common clinical manifestations include pruritus, fever, warm skin, lymphadenopathy, edema, pain, and diffuse scaling. The condition may lead to serious systemic complications and often requires hospitalization and intensive management.

Materials and Methods
A retrospective study was conducted between January 2024 and April 2026 in Tajikistan. Medical records of 20 hospitalized patients diagnosed with erythrodermic psoriasis were reviewed. Data regarding sex distribution, mean age, hospitalization duration, clinical manifestations, hereditary predisposition, disease severity, and triggering factors were analyzed.

Results
A total of 20 patients with erythrodermic psoriasis were identified. Female patients predominated, accounting for 60% of cases, while males represented 40%. The mean age was 58.8 years among female patients and 47 years among male patients, while pediatric patients had a mean age of 7.5 years.

Despite lower prevalence, male patients demonstrated a more severe clinical course. The average duration of hospitalization was longer in men (26 days) compared to women (23 days). Several patients required repeated hospital admissions during the same year, mainly associated with treatment withdrawal syndrome.

The majority of patients presented with pain, edema, pruritus, and diffuse scaling. Approximately 90% of patients associated disease onset or exacerbation with psychological stress. A positive hereditary predisposition was identified only in a minority of patients. One fatal case was registered in a patient admitted in extremely severe condition.

Conclusions
Erythrodermic psoriasis remains a severe dermatological condition associated with prolonged hospitalization, recurrent admissions, and significant morbidity. In our cohort, women predominated; however, male patients demonstrated a more severe disease course. Psychological stress appeared to be the most commonly reported triggering factor. Early recognition and adequate management are essential to reduce complications and improve outcomes in patients with erythrodermic psoriasis.

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Abstract N°: 4399

Multimodal Large Language Models for Psoriasis Evaluation from Clinical Photographs

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Introduction

Psoriasis is a chronic immune-mediated inflammatory skin disease associated with substantial physical and psychosocial burden. Diagnosis and early severity assessment may be delayed because of heterogeneous clinical presentation and overlap with common mimicking dermatoses such as eczema, seborrheic dermatitis, and tinea. Multimodal large language models (LLMs), capable of jointly analyzing images and text, have emerged as accessible artificial intelligence tools with potential utility in dermatologic triage and decision support. We aimed to evaluate web-based multimodal LLMs for psoriasis identification, Physician Global Assessment (PGA) scoring, and treatment recommendation quality using standardized clinical photographs.

Materials and Methods

We retrospectively analyzed 303 standardized clinical photographs from 160 patients treated at Semmelweis University between May 2022 and January 2025, including 163 psoriasis lesions and 140 psoriasis mimickers. Images were captured under standardized conditions using DSLR photography. Reference diagnoses and PGA scores were independently assigned by two board-certified dermatologists, with adjudication by a third expert in cases of disagreement. Treatment recommendations generated by the models were categorized as appropriate, partially appropriate, or inappropriate according to current clinical guidelines and lesion severity. Four multimodal LLMs were evaluated: ChatGPT-5, ChatGPT-4o, Gemini 2.5 Flash, and Claude Sonnet 4.5. Each image was assessed individually using identical prompts across all models. Models first received the prompt “Can you guess the most likely diagnosis?” If psoriasis was identified, a second prompt requested PGA estimation and treatment recommendation. Sessions were periodically reset to minimize carry-over effects. Primary endpoints included diagnostic accuracy, PGA scoring accuracy among correctly identified psoriasis cases, and treatment recommendation appropriateness. A 30-case subset was additionally used to evaluate test–retest agreement.

Results

ChatGPT-5 demonstrated the highest diagnostic performance, achieving 93.1% accuracy (95% CI: 89.7–95.4), followed by ChatGPT-4o (90.1%), Claude Sonnet 4.5 (83.6%), and Gemini 2.5 Flash (61.5%). Gemini showed markedly lower sensitivity despite relatively preserved specificity. Among correctly classified psoriasis cases, PGA scoring accuracy was highest for ChatGPT-5 (93.3%) and ChatGPT-4o (92.9%), compared with 82.7% for Gemini and 78.1% for Claude. Appropriate treatment recommendations were generated most frequently by ChatGPT-5

(83.7%) and ChatGPT-4o (82.1%), followed by Claude (75.0%) and Gemini (53.2%). In the repeatability subset, composite test–retest agreement was highest for ChatGPT-5 (96.7%) and ChatGPT-4o (95.0%). All three blinded dermatologists achieved 100% diagnostic accuracy on the same dataset.

Conclusions

Under standardized conditions, general-purpose multimodal LLMs, particularly ChatGPT-5 and ChatGPT-4o, demonstrated strong performance for psoriasis recognition together with high PGA scoring accuracy and generally appropriate treatment recommendations. These findings suggest that multimodal LLMs may have potential as clinician-supervised supportive tools for psoriasis assessment and triage, particularly in settings with limited access to dermatologic expertise. Further validation in external and real-world datasets is warranted before broader clinical implementation.

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Abstract N°: 4408

Rapid and Sustained Effectiveness of Bimekizumab in Severe Palmoplantar Psoriasis: Real-World Outcomes Through 104 Weeks

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Introduction

Palmoplantar psoriasis (PP), including palmoplantar pustulosis (PPP), hyperkeratotic palmoplantar psoriasis (HKPP), and mixed phenotypes, is a difficult-to-treat form of psoriasis associated with pain, functional impairment, and substantial quality-of-life burden. Evidence regarding biologic therapies in PP remains limited, particularly in long-term real-world settings. Bimekizumab, a dual IL-17A and IL-17F inhibitor, has demonstrated high efficacy in plaque psoriasis; however, long-term real-world data in severe palmoplantar disease remain scarce. The aim of this study was to evaluate the short- and long-term effectiveness and safety of bimekizumab in severe PP through 104 weeks of follow-up.

Materials and Methods

We conducted a single-centre retrospective real-world extension study including 17 adult patients with severe palmoplantar psoriasis treated with bimekizumab at a tertiary dermatology referral centre. Patients initiated treatment between March 2023 and May 2024 and were followed through May 2026. Endpoints included modified Palmoplantar Psoriasis Area and Severity Index (m-PPPASI), Dermatology Life Quality Index (DLQI), Pruritus Visual Analogue Scale (PR-VAS), and Pain Visual Analogue Scale (P-VAS) assessed at baseline, Weeks 4 and 12, and throughout follow-up up to Week 104.

Results

A total of 17 patients (mean [range] age, 55 [40–69] years; 11 females) were included. Ten patients (58.8%) had HKPP, while seven (41.2%) had overlapping HKPP/PPP phenotypes. Thirteen patients (76.5%) were current smokers, and almost all patients had at least one psoriasis-related comorbidity. Nine patients (52.9%) had prior biologic failure, whereas eight (47.1%) were biologic naïve.

Rapid clinical improvement was observed early during treatment. Complete clearance (m-PPPASI=0) was achieved in 8/17 patients (47.1%) at Week 4 and in 11/12 patients (91.7%) who reached Week 24. Mean DLQI, PR-VAS, and P-VAS were reduced by 11.4, 5.3, and 4.7 points, respectively, by Week 4.

At Week 52, 14 patients remained on treatment, while three discontinued therapy due to exacerbation of pre-existing atopic dermatitis with conjunctivitis (n=1), primary inefficacy (n=1), and secondary loss of response (n=1). Complete clearance (m-PPPASI=0) was achieved in 13/14 evaluable patients (92.9%), while the remaining patient achieved m-PPPASI=2. The mean DLQI and PR-VAS were 0.21 and 0.36, respectively, and all evaluable patients achieved complete pain resolution.

Responses remained sustained through Week 104. Complete clearance (m-PPPASI=0) was maintained in 13/14 evaluable patients (92.9%), while the remaining patient maintained m-PPPASI=2. Mean DLQI and PR-VAS at Week 104 were 0.14 and 0.5, respectively, while complete pain resolution was maintained in all evaluable patients.

Three patients (17.6%) also presented with acrodermatitis continua of Hallopeau, associated with nail involvement, and demonstrated substantial improvement during long-term treatment.

Oropharyngeal candidiasis occurred in 6/17 patients (35.3%) and was successfully managed without permanent discontinuation of treatment. Additional non-serious adverse events included soft tissue infections (11.8%), tonsillitis (11.8%), otitis media (5.9%), vaginitis (5.9%), mild salpingitis (5.9%), Helicobacter pylori-associated gastritis (5.9%), and hair thinning (5.9%). One patient experienced an acute myocardial infarction requiring coronary angioplasty; treatment was continued following cardiologic evaluation.

Conclusions

Bimekizumab demonstrated rapid and sustained effectiveness in severe palmoplantar psoriasis, including hyperkeratotic and overlapping pustular phenotypes, with responses maintained through 104 weeks. Meaningful improvement in quality of life, pruritus, and pain was observed alongside a manageable long-term safety profile. Further prospective controlled studies are warranted.

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Abstract N°: 4454

Deucravacitinib in the treatment of genital psoriasis: real-world evidence from an italian multicentric study

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Introduction

Plaque psoriasis is a chronic, immune-mediated, inflammatory skin disease affecting 2–3% of the global population; up to 63% of adult patients with psoriasis experience genital involvement during their lifetime. Genital psoriasis is often accompanied by symptoms such as intense itching, pain, burning, and dyspareunia, resulting in a significant psychological burden and impaired quality of life. Deucravacitinib is an oral, first-in-class, allosteric inhibitor of tyrosine kinase 2 (TYK2), a key intracellular enzyme mediating signalling of multiple pro-inflammatory cytokines, including interleukin (IL)-12, IL-23, and type I interferons. The two phase 3 POETYK PSO-1 and POETYK PSO-2 and the subsequent long-term extension (LTE) trials demonstrated a consistent safety profile and durable efficacy through 5 years of treatment in patients with moderate to severe plaque psoriasis. However, to date, no clinical trials have been conducted to specifically assess the efficacy of deucravacitinib in genital psoriasis, and only limited real-world experience have been published.

Materials and Methods

We conducted a retrospective, multicentric, observational study involving nine italian dermatology centers to assess the effectiveness of deucravacitinib in the treatment of genital psoriasis. Adult patients (≥18 years) with a diagnosis of plaque psoriasis and genital involvement, eligible for systemic therapy with deucravacitinib 6 mg according to standard practice, with a genital sPGA (sPGA-G) ≥2 and inadequate symptom control with topical therapies were included. Follow-up visits were performed 4, 12, 24 and 48 weeks after the start of the treatment. The primary endpoint was the percentage of patients who achieved sPGA-G response of 0 (clear) or 1 (almost clear) at weeks 4, 12, 24, and 48 of treatment. The secondary endpoints were the following: i. improvement in quality of life, as assessed using the Dermatology Life Quality Index (DLQI), with specific attention to question 9

(DLQI Q-9; “Over the last week, how much has your skin caused any sexual difficulties?”); ii. improvement of Psoriasis Area and Severity Index (PASI) score; iii. reduction of subjective symptoms associated with genital psoriasis, as measured using the Numerical Rating Scale (NRS) Pruritus (range 0-10).

Results

35 patients were included. A sPGA-G score of 0/1 was reached by 20% (7/35) of patients at week 4, 64.5% (20/31) at week 12, 86.9% (20/23) at week 24, and 85.7% (12/14) at week 48. Mean baseline DLQI score was 13.8 and reduced to 7 at week 4, to 3.1 at week 12, to 1.3 at week 24, and to 1 at week 48. Mean baseline DLQI-Q9 score was 1.9, decreasing to 1.2 at week 4, to 0.9 at week 12, to 0.4 at week 24, and to 0.2 at week 48. Mean PASI score decreased from 8.3 at baseline to 5.2 at week 4, 2.4 at week 12, 1.3 at week 24 and 1.1 at week 48. Mean genital NRS pruritus dropped from baseline 6.8, to 3.9 after 4 weeks, to 1.3 after 12 weeks, to 0.4 after 24 weeks, and to 0.3 after 48 weeks. 3/33 patients (9%) had to discontinue treatment due to adverse events, of which two consisted of acneiform rash occurring after 4 weeks of treatment, and one due to upper respiratory infection after 12 weeks of treatment.

Conclusions

Genital psoriasis significantly impacts quality of life, as demonstrated by a mean baseline DLQI score of 13.8, despite moderate plaque psoriasis (mean baseline PASI 8.3). Deucravacitinib proved to be a valid therapeutic option for the treatment of genital psoriasis, leading to rapid improvement in patients’ symptoms and quality of life and resulting in a significant therapeutic outcome. A larger number of studies, particularly in a real-world setting, would be desirable to further support this evidence.

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Abstract N°: 4471

Beyond the Skin: Nail Involvement as a Potential Early Indicator of Psoriatic Arthritis in Pediatric Psoriasis

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Introduction

Pediatric psoriasis is increasingly recognized as a systemic inflammatory disease rather than an isolated cutaneous condition. Nail involvement is relatively common in children and adolescents with psoriasis and has been associated with greater disease severity and possible musculoskeletal involvement. However, the relationship between nail disease and early psoriatic arthritis features in pediatric patients remains incompletely understood.

Materials and Methods

A scoping review was performed using PubMed, Scopus, and Google Scholar to identify English-language studies published between January 2010 and March 2026 evaluating nail manifestations in pediatric psoriasis. Search terms included “pediatric psoriasis,” “nail psoriasis,” “psoriatic arthritis,” “children,” “adolescents,” and “musculoskeletal involvement.” Observational studies, cohort studies, case series, and relevant review articles examining associations between nail disease and inflammatory or musculoskeletal outcomes were included. Data regarding prevalence, clinical manifestations, disease severity, joint symptoms, psychosocial impact, and treatment response were qualitatively reviewed and synthesized.

Results

A total of 24 studies met inclusion criteria, consisting primarily of observational cohorts and case series. Reported prevalence of nail involvement in pediatric psoriasis ranged from approximately 15% to 32% across studies. Common manifestations included nail pitting, onycholysis, subungual hyperkeratosis, and nail dystrophy. Multiple studies described associations between nail disease and scalp involvement, higher psoriasis severity scores, enthesitis, arthralgia, and early psoriatic arthritis features. In one cohort of 313 pediatric patients, nail involvement was identified in 32.3% of cases and demonstrated significant association with psoriatic arthritis. Several studies also noted increased psychosocial and functional burden among children with nail involvement. Although biologic therapies showed improvement in both cutaneous and nail symptoms, pediatric longitudinal outcome data remained limited.

Conclusions

Nail involvement in pediatric psoriasis may represent more than an isolated cosmetic manifestation and could help identify patients with increased inflammatory and musculoskeletal disease burden. Greater recognition of nail disease during pediatric evaluation may support earlier monitoring and multidisciplinary management in higher-risk patients. Further prospective studies are needed to clarify the prognostic significance of nail involvement and its relationship to psoriatic arthritis development in children and adolescents.

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Abstract N°: 4489

Durable 104-Week Effectiveness and Drug Survival of Risankizumab in Moderate-to-Severe Psoriasis: A Multicenter Real-World Study Including IL-17-Experienced Patients

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Introduction
Long-term real-world evidence regarding the durability of risankizumab effectiveness and treatment persistence in biologic-experienced patients and difficult-to-treat psoriasis phenotypes remains limited. We aimed to evaluate the 104-week real-world effectiveness, drug survival, and safety profile of risankizumab in patients with moderate-to-severe psoriasis treated in routine clinical practice.

Materials and Methods
This multicenter retrospective cohort study included adult patients with moderate-to-severe psoriasis treated with risankizumab across seven tertiary referral centers. Clinical outcomes were assessed through week 104 using relative and absolute PASI responses. Drug survival was evaluated using Kaplan–Meier analysis. Subgroup analyses were performed according to prior IL-17 inhibitor exposure, biologic experience, psoriatic arthritis (PsA), and special area involvement including scalp, nail, genital, and palmoplantar psoriasis. Safety outcomes were collected from routine follow-up records.

Results
A total of 431 patients were included, with a mean age of 45.8 ± 13.2 years and mean BMI of 27.6 ± 4.4 kg/m^2. Mean baseline PASI was 12.2 ± 9.2. At week 104, median PASI decreased to 0.0. PASI90 and PASI100 responses were achieved in 84.9% and 63.2% of patients, respectively, while absolute PASI ≤1 and ≤3 were observed in 88.7% and 96.6% of patients.

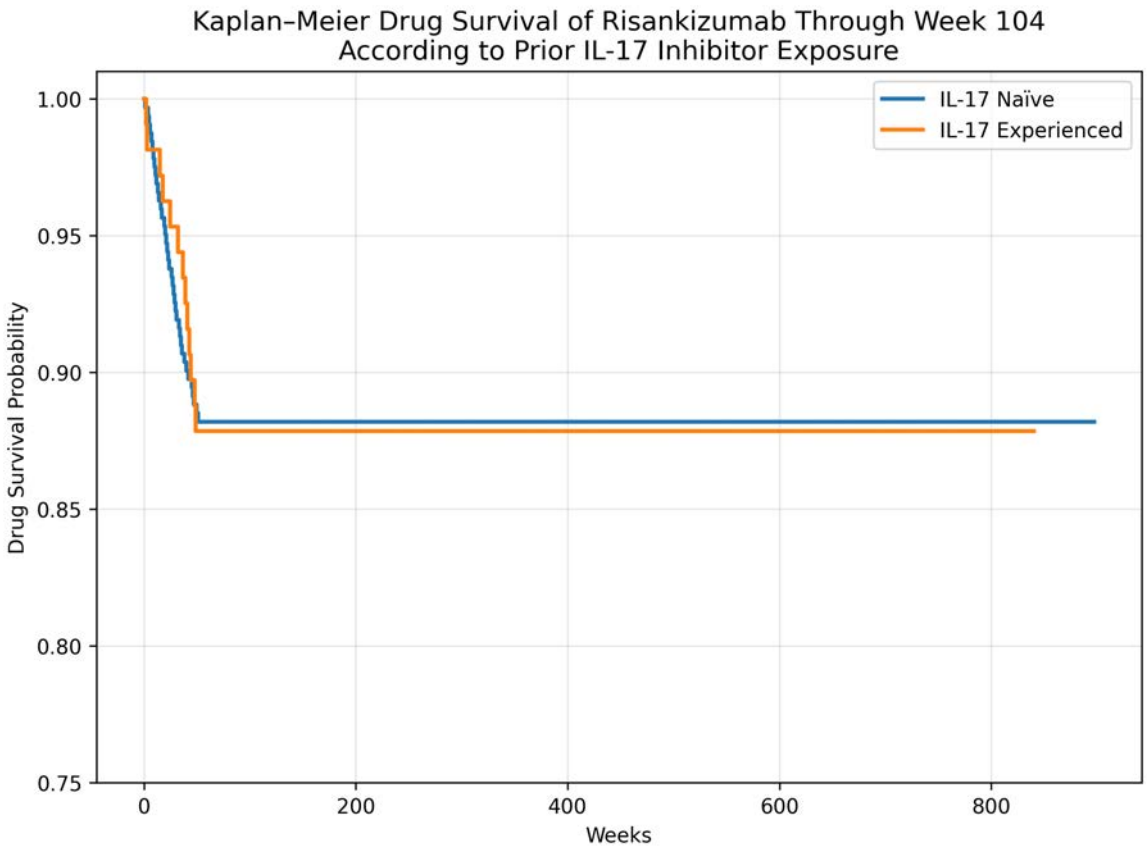
High week-104 responses were maintained across clinically challenging subgroups. PASI90 and PASI100 responses were achieved in 87.4% and 68.1% of biologic-naïve patients compared with 82.9% and 59.4% of biologic-experienced patients, respectively. Prior IL-17 inhibitor exposure did not substantially impair long-term effectiveness, with PASI90 and PASI100 responses achieved in 81.9% and 55.2% of IL-17-experienced patients, respectively. Patients with concomitant PsA also maintained robust responses through week 104, with PASI90 and PASI100 achieved in 89.2% and 50.0% of cases, respectively.

Special area involvement was frequent, including scalp involvement in 42.2%, nail involvement in 27.4%, genital involvement in 25.5%, and palmoplantar involvement in 16.7% of patients. Despite these difficult-to-treat

phenotypes, high rates of complete skin clearance were maintained through week 104. PASI100 responses were achieved in 71.3% of patients with scalp involvement, 62.9% with nail involvement, 49.5% with genital involvement, and 51.4% with palmoplantar involvement.

Overall 104-week drug survival was 91.0% in the primary Kaplan–Meier analysis. Drug survival remained high and comparable regardless of prior IL-17 inhibitor exposure (90.4% vs 92.6%, p=0.502), supporting the long-term durability of risankizumab in biologically challenging patient populations (**Figure 1)**. Drug survival also remained high among biologic-experienced patients.

Risankizumab demonstrated a favorable long-term safety profile. No treatment-emergent major adverse cardiovascular event was observed during follow-up. Serious infections, tuberculosis reactivation, hepatitis B reactivation, and malignancies were infrequent. One patient developed basal cell carcinoma and one patient was diagnosed with gastric adenocarcinoma during follow-up.



Kaplan–Meier analysis demonstrating 104-week risankizumab drug survival stratified according to prior IL-17 inhibitor exposure. Treatment persistence remained high and comparable between IL-17-experienced and IL-17-naive patients throughout follow-up, supporting the durable long-term effectiveness of risankizumab in biologically challenging psoriasis populations. Log-rank p=0.502.

Conclusions

In this large multicenter real-world cohort, risankizumab demonstrated remarkably durable 104-week effectiveness, high treatment persistence, and favorable long-term safety, including in biologic-experienced patients and difficult-to-treat psoriasis phenotypes. Prior IL-17 inhibitor exposure did not adversely affect long-term outcomes, supporting the sustained effectiveness of IL-23 inhibition in routine clinical practice and across biologically challenging psoriasis subgroups.

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TYK2 Inhibition and IL-12/23 Blockade in Moderate-to-Severe Plaque Psoriasis: A 52-Week Prospective Comparative Study of Deucravacitinib and Ustekinumab

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Introduction
Psoriasis is a chronic immune-mediated skin disease. The IL-23/Th17 pathway has an important role in plaque formation and persistent inflammation. Deucravacitinib is an oral selective TYK2 inhibitor. It modulates IL-12 and IL-23 signalling. Ustekinumab is a monoclonal antibody that blocks the shared p40 subunit of IL-12 and IL-23. Both drugs affect the same inflammatory axis, but through different mechanisms. This study compared clinical response, quality of life, cytokine changes and safety outcomes in patients with moderate-to-severe plaque psoriasis treated with deucravacitinib or ustekinumab over 52 weeks.

Materials and Methods
This prospective comparative study included 55 patients with moderate-to-severe plaque psoriasis. Thirty-five patients received deucravacitinib 6 mg once daily. Twenty patients received ustekinumab at week 0, week 4 and every 12 weeks thereafter. PASI and DLQI were assessed at baseline and at weeks 13, 26 and 52. Serum IL-23 and IL-17A levels were measured by enzyme-linked immunosorbent assay. PASI75 and PASI90 response rates were calculated. Safety assessment included treatment-emergent adverse events, serious infections, clinically significant laboratory abnormalities and treatment discontinuation. Within-group and between-group changes were analysed. Correlations between cytokine reduction and PASI improvement were also assessed. A p value <0.05 was considered statistically significant.

Results
Baseline characteristics were comparable between the two groups. Mean baseline PASI was 17.9 ± 4.6 in the deucravacitinib group and 18.4 ± 4.2 in the ustekinumab group. In patients receiving deucravacitinib, PASI decreased to 10.2 ± 3.4 at week 13, 5.8 ± 2.6 at week 26 and 3.1 ± 2.0 at week 52. PASI75 was achieved in 48.6% of patients at week 13, 65.7% at week 26 and 80.0% at week 52. PASI90 was achieved in 42.9% of patients at week 52. DLQI improved from 14.3 ± 3.7 at baseline to 4.0 ± 2.4 at week 52.

In the ustekinumab group, PASI decreased from 18.4 ± 4.2 at baseline to 9.6 ± 3.1 at week 13, 5.1 ± 2.4 at week 26 and 2.7 ± 1.8 at week 52. PASI75 was achieved in 55.0% of patients at week 13, 70.0% at week 26 and 85.0% at week 52. PASI90 was achieved in 40.0% of patients at week 52. DLQI improved from 14.6 ± 4.1 to 3.5 ± 2.0.

Both treatments reduced serum IL-23 and IL-17A levels during follow-up. Cytokine reduction showed a moderate positive correlation with PASI improvement in the deucravacitinib group ($r=0.59$; $p<0.01$) and in the ustekinumab group ($r=0.62$; $p<0.05$). At week 52, PASI75 response was numerically higher with ustekinumab, while PASI90 response was comparable between groups. The differences between groups were not statistically significant. Treatment-emergent adverse events were reported in 31.4% of patients receiving deucravacitinib and in 35.0% receiving ustekinumab. Most events were mild. The most common events were upper respiratory tract infection, headache and nasopharyngitis. Injection-site reactions were observed only in the ustekinumab group. No serious treatment-related adverse events, serious infections or treatment discontinuations were recorded.

Conclusions

Deucravacitinib and ustekinumab both provided sustained clinical improvement and better quality of life over 52 weeks in patients with moderate-to-severe plaque psoriasis. Both treatments also reduced IL-23/Th17 pathway activity. Ustekinumab showed a slightly higher PASI75 response, while deucravacitinib demonstrated comparable PASI90 improvement and good tolerability as an oral TYK2-targeted treatment. Monitoring IL-23 and IL-17A may help assess biological response and support more personalised treatment decisions in plaque psoriasis.

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Abstract N°: 4526

Analysis of the relationship between genital psoriasis and sexual function inadult patients

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Introduction

Psoriasis is a chronic inflammatory disease of immune-mediated etiology that may affect the genital region in a significant proportion of patients, with directimpact on quality of life (QoL) and sexual function. Although genital involvement is common, it remains underdiagnosed and frequently underestimated in clinical practice.

Evidence suggests that genital psoriasis is associated with impaired body image, dyspareunia, reduced sexual desire, avoidance of intimacy, and negative effects onemotional and relational well-being. In this context, standardized instruments such as the *Dermatology Life Quality Index* (DLQI), *Sexual Functioning Questionnaire* (SFQ), *Dyadic Interaction Scale* (DIS), and *Psoriasis Area and Severity Index* (PASI) allow objective assessment of the multidimensional burden of the disease.

Materials and Methods

This was an observational, cross-sectional, analytical study conducted in a specialized psoriasis outpatient clinic. A total of 109 adult patients with plaque psoriasis were included. Sociodemographic and clinical variables were collected, including sex, age, disease duration, sexual activity, and presence of current or previous genital lesions. The following instruments were applied: PASI, DLQI, SFQ, and DIS. Continuous variables were described as medians and interquartile ranges (IQR), and categorical variables as frequencies and percentages. Correlations between quantitative variables were assessed using Spearman's correlation coefficient, and comparisons between groups were performed using the Mann–Whitney test. A significance level of 5% ($p < 0.05$) was adopted.

Results

The sample showed predominance of females (52.3%), with a median age of 57.5 years and median disease duration of 20 years. Current or previous genital lesions were identified in 39.4% of participants and were more frequent among younger patients (median age 53.5 vs. 59.5 years; $p = 0.042$). The median PASI score was 1.2, indicating predominantly mild disease at the time of assessment. The median DLQI score was 0; however, 37.6% of participants presented clinically relevant impairment (DLQI > 1), and 12.8% showed severe or extremely severe impact (DLQI ≥ 11). A moderate and significant positive correlation was observed between DLQI and PASI ($r = 0.51$; $p < 0.001$), as well as between DLQI and DIS ($r = 0.40$; $p < 0.001$). The median SFQ score was 11.5 and differed significantly between sexes, with lower median values among women compared to men (8.5 vs. 14; $p < 0.001$). Significant differences were also observed between sexually active and non-active participants (12 vs. 0; $p < 0.001$).

Conclusions

Genital involvement in psoriasis is frequent and clinically relevant, being associated with younger age and significant impairment in quality of life and sexual function. The correlations observed between DLQI, PASI, and DIS reinforce the multidimensional burden of psoriasis, extending beyond

cutaneous manifestations to emotional, sexual, and relational domains. These findings highlight the importance of routinely assessing genital involvement and sexual health in patients with psoriasis, contributing to a more comprehensive and patient-centered clinical management.