
# Canadian Dermatology Today 2025 Rising Stars in Dermatology Symposium

## Event Summary Report

Omni King Edward Hotel
Toronto, Ontario • April 5, 2025

catalytic health
medical minds meet here

# In This Report...

# Acronyms

| | |
|---|---|
| AAD | AMERICAN ACADEMY OF DERMATOLOGY |
| AD | ATOPIC DERMATITIS |
| BSA | BODY SURFACE AREA |
| CPK | CREATINE PHOSPHOKINASE |
| CR | COMPLETE RESPONSE |
| CRP | C-REACTIVE PROTEIN |
| CTCL | CUTANEOUS T-CELL LYMPHOMA |
| DLQI | DERMATOLOGY LIFE QUALITY INDEX |
| DMARD | DISEASE-MODIFYING ANTI-RHEUMATIC DRUG |
| EASI | ECZEMA AREA AND SEVERITY INDEX |
| FDA | FOOD AND DRUG ADMINISTRATION |
| F-VASI | FACIAL VITILIGO AREA SCORING INDEX |
| GRAPPA | GROUP FOR RESEARCH AND ASSESSMENT OF PSORIASIS AND PSORIATIC ARTHRITIS |
| HS | HIDRADENITIS SUPPURATIVA |
| IBD | INFLAMMATORY BOWEL DISEASE |
| IGA | INVESTIGATOR GLOBAL ASSESSMENT |
| iL12/23I | INTERLEUKIN-12/23 INHIBITOR |
| iL15I | INTERLEUKIN-15 INHIBITOR |
| iL17I | INTERLEUKIN-17 INHIBITOR |
| iL23I | INTERLEUKIN-23 INHIBITOR |
| ILK | INTRALESIONAL TRIAMCINOLONE ACETONIDE INJECTIONS |
| JAAD | JOURNAL OF THE AMERICAN ACADEMY OF DERMATOLOGY |
| JAMA | JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION |
| JAKi | JANUS KINASE INHIBITOR |
| MACE | MAJOR ADVERSE CARDIOVASCULAR EVENTS |

# Acronyms Continued

| | | |
|---|---|---|
| NB-UVB | | NARROWBAND ULTRAVIOLET B |
| NRS | | NUMERIC RATING SCALE |
| NSAID | | NON-STEROIDAL ANTI-INFLAMMATORY DRUG |
| PASI | | PSORIASIS AREA AND SEVERITY INDEX |
| PDE4 | | PHOSPHODIESTERASE-4 |
| PP-NRS | | PEAK PRURITUS NUMERIC RATING SCALE |
| PsA | | PSORIATIC ARTHRITIS |
| PSP | | PATIENT SUPPORT PROGRAM |
| RCT | | RANDOMIZED CONTROLLED TRIAL |
| SALT | | SEVERITY OF ALOPECIA TOOL |
| T-VASI | | TOTAL VITILIGO AREA SCORING INDEX |
| TCI | | TOPICAL CALCINEURIN INHIBITOR |
| TEAE | | TREATMENT-EMERGENT ADVERSE EVENT |
| TNFi | | TUMOUR NECROSIS FACTOR INHIBITOR |
| TYK2i | | TYROSINE KINASE 2 INHIBITOR |
| VAS | | VISUAL ANALOG SCALE |
| VASI | | VITILIGO AREA SCORING INDEX |
| VEXAS | | VACUOLES, E1 ENZYME, X-LINKED, AUTOINFLAMMATORY, SOMATIC |
| VRS | | VERBAL RATING SCALE |
| VTE | | VENOUS THROMBOEMBOLISM |

# Rise to the Challenge: Elevating Knowledge of Interleukin-13 Inhibitors in AD (Eli Lilly Sponsored Breakfast Symposium)

VIMAL H. PRAJAPATI, MD
GEORGE CHRISTODOULOU, MD

AD patients are often exasperated by the time they see a dermatologist. In one survey conducted by the Eczema Society of Canada, 43% of respondents reported trying 10 or more therapies to manage their symptoms. Around 50% of respondents were dissatisfied with their current therapy.

Dr. Christodoulou explained that dupilumab, lebrikizumab, and tralokinumab have all demonstrated statistically significant EASI-75 and itch improvement by week 16. A network meta-analysis published in *JAMA* in 2024 showed upadacitinib 30 mg and abrocitinib 200 mg were associated with superior EASI outcomes, compared to baricitinib, lower dose JAKi therapy, and biologic therapies. He added that tralokinumab and lebrikizumab can be dosed once monthly after the initial 16 weeks of therapy, unlike dupilumab. The dosing schedule may be important to some patients.

To evaluate and optimize therapy, Dr. Christodoulou recommended the Treat-to-Target tool published by Dr. Jensen Yeung et al in 2023. Another approach is the AHEAD approach, whereby the patient chooses one to three of their most problematic features, the clinician then selects appropriate moderate or optimal clinician-reported and patient-reported outcome(s), depending on patient's preferences. Treatment targets are approved every 3 to 6 months. If patients don't reach treatment goals, physicians should consider modifying or optimizing therapy.


VIMAL H. PRAJAPATI, MD
GEORGE CHRISTODOULOU, MD

Discussing the safety of biologics in AD, Dr. Christodoulou noted that conjunctivitis is a common adverse event associated with dupilumab, lebrikizumab, and tralokinumab. Mild conjunctivitis can be treated with topical mast cell stabilizers, antihistamines, or both. Patients with conjunctival scarring or swelling, watery discharge, pain, dryness, irritation, blepharitis, or light sensitivity should be referred to an eye care specialist. Patients with a decline in visual acuity, loss of clarity in the cornea, eyelid swelling or purulent discharge require an urgent referral to an eye care specialist.

In addition to conjunctivitis, retrospective observational studies demonstrate that 4% to 6% of patients treated with dupilumab develop arthritis, arthralgia, inflammatory enthesitis, or tenosynovitis. If dupilumab-associated arthritis is mild-to-moderate, Dr. Christodoulou recommended continuing or pausing dupilumab; while dupilumab should be discontinued in the case of moderate-to-severe arthritis. A NSAID and/or low-dose or intra-articular steroids may be appropriate for mild dupilumab-associated arthritis; while moderate arthritis may require DMARD therapy.

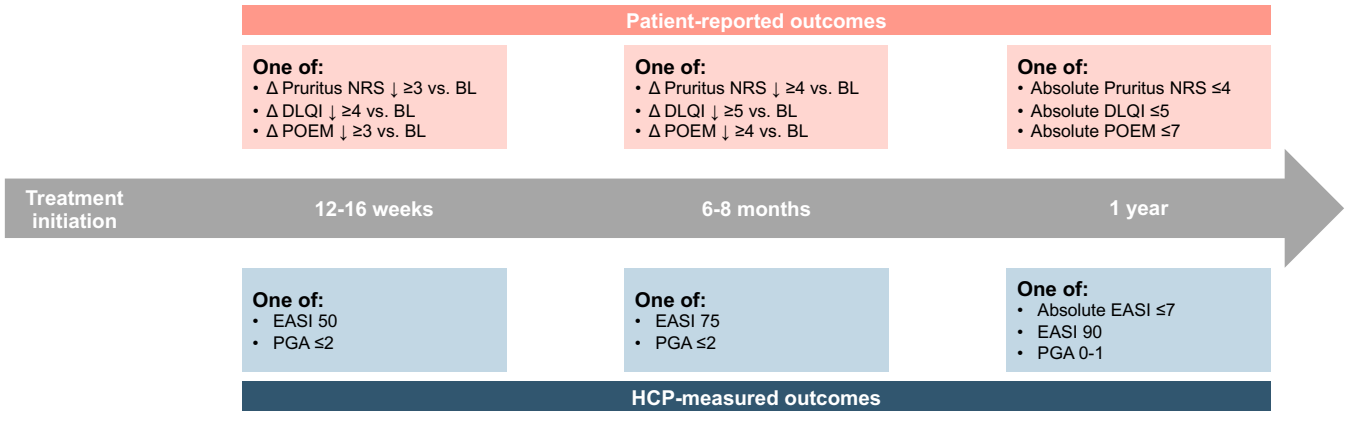
Observational studies also show that up to 10% of patients experience dupilumab-associated facial erythema, with histopathological features distinct from AD. He presented the flowchart below to guide the management of this adverse event.

There is a potential association between dupilumab use and the exacerbation of pre-existing CTCL or an increased susceptibility to its development. It is important for physicians to be aware of this possibility and refer patients for flow cytometry if they develop CTCL symptoms.

One option to address dupilumab-associated adverse events is to switch patients to another biologic or JAKi therapy. The ADapt study showed that, out of 10 patients who reported eye-related events, facial dermatitis, or inflammatory arthritis as the reason for prior dupilumab discontinuation, none reported similar events with lebrikizumab. A multi-centre retrospective study showed that 85% of patients who switched from dupilumab to JAKi therapy saw improvement or resolution of dupilumab-induced facial redness and 92% saw improvement or resolution of conjunctivitis. Among those switched to tralokinumab, improvement or resolution rates were 33% for facial redness and 72% for conjunctivitis.

## Treat-to-Target: Decision-Making Tool for Adjustment of Therapy in Moderate-to-Severe AD

Reminder: Topical therapies should be prescribed and optimized throughout the entire course of disease management. The T2T strategy described below applies only to the use of systemic therapies.

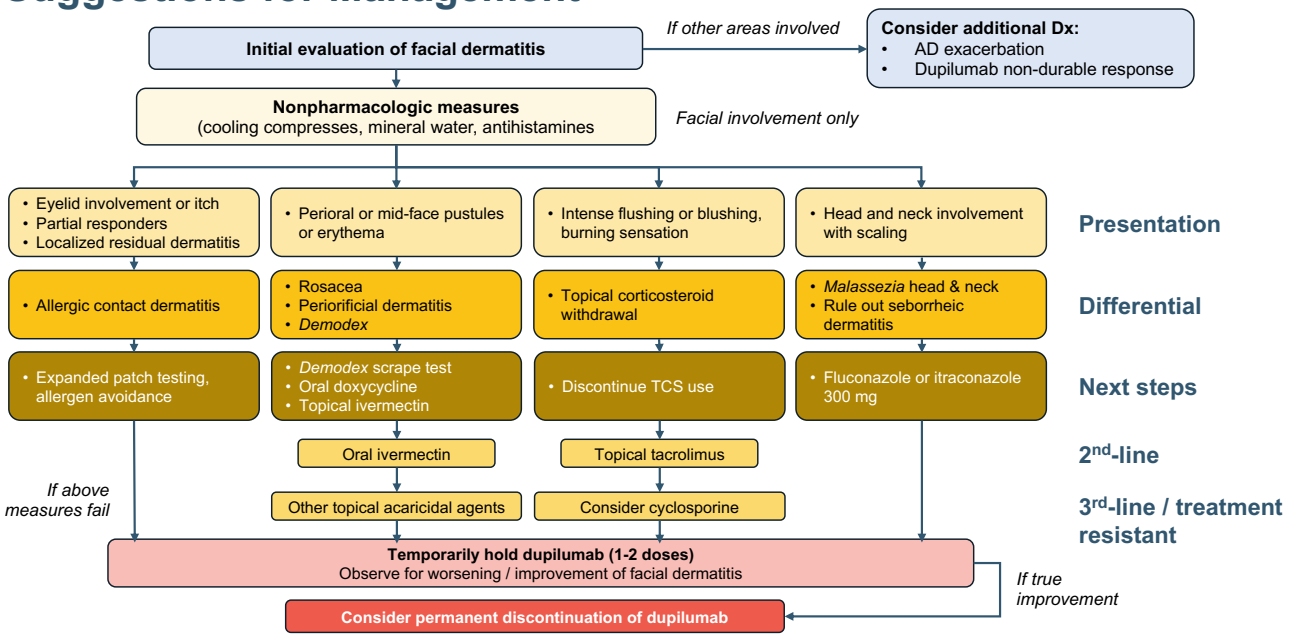



**If endpoints are not met at time of assessment, consider treatment optimization or modification**

*Clinical follow-up every 6-12 months thereafter using 1-year criteria
AD, atopic dermatitis; BL, baseline; DLQI, Dermatology Life Quality Index; EASI, Eczema Area and Severity Index; NRS, numerical rating scale; PGA, Physician Global Assessment; POEM, Patient Oriented Eczema Measure; T2T, treat to target
Adapted from Yeung J, et al. J Am Acad Dermatol. 2023;89(2):372–5.

VIMAL H. PRAJAPATI, MD
GEORGE CHRISTODOULOU, MD

# Dupilumab-associated Facial, Head, and/or Neck Dermatitis: Suggestions for Management




*Therapies are off-label, with limited evidence

Adapted from Jaros J, et al. Dermatitis. 2020;31(3):169-77.

# Keynote: Pearls of Wisdom from My First 10 years in Practice

MELINDA GOODERHAM, MD

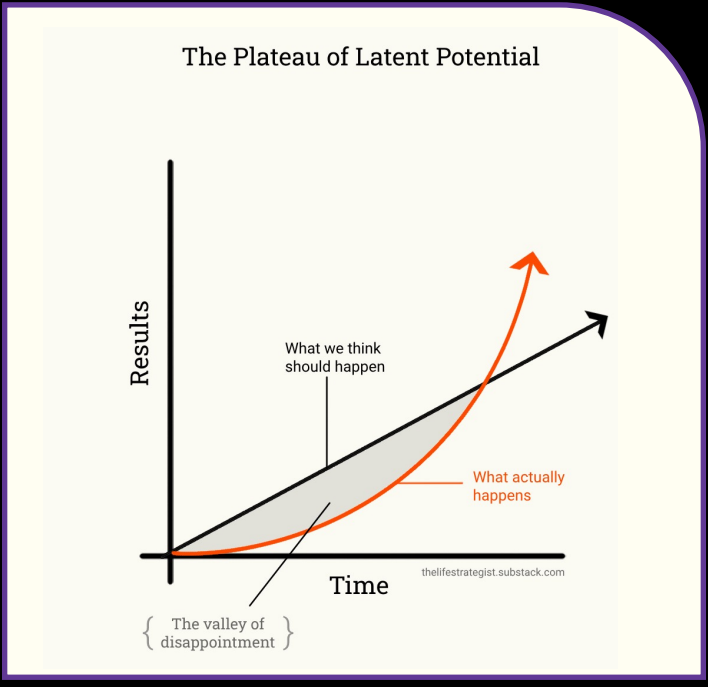
Dr. Gooderham began by describing the importance of mentors. Her first mentor in dermatology, Dr. Lyn Guenther from the University of Western Ontario, taught Dr. Gooderham the importance of honing presentation skills, including physical gestures and expressiveness, which helped her win a presentation award from the Canadian Professors of Dermatology. Another mentor, the late Dr. Stuart Maddin, emphasized the importance of finding a niche, which inspired Dr. Gooderham to focus on the medical management of skin cancer. A third mentor, Dr. Kim Papp, instilled in Dr. Gooderham the importance of staying focused. His advice made her realize she was over-extending herself, so she gave up the cosmetics aspect of her practice.

Another pearl of wisdom shared by Dr. Gooderham was the importance of saying yes. She encouraged new-to-practice dermatologists not to think about the short-term pay-off of an opportunity, but the long-term potential. She shared the saying, "you may not see the dollar if you're focused on the penny in front of the face." She encouraged the audience to say yes to publications, including chart reviews or a review article, to hone their expertise in a niche area. Conference organizers and members of the media will then come across one's name when seeking out an expert in a specific condition. While encouraging young dermatologists not to over-commit, which means knowing when to say "no," Dr. Gooderham also emphasized that the "yes to no ratio" should be higher in the first 5 years of practice.

Dr. Gooderham described the Plateau of Latent Potential, explaining that results happen along an exponential curve rather than a continuous upward trajectory. The results of one's efforts may not be perceptible initially. People may give up because they don't see immediate results, but Dr. Gooderham stressed that those who persist will not only see the outcomes they were hoping for, but the results will also exceed their expectations.

Finally, Dr. Gooderham advised attendees to invest in themselves. She has invested in three speaker coaches and numerous professional development books. She also subscribes to various tools and programs to create high-quality slides with compelling images. From a medical standpoint, Dr. Gooderham recommended creating systems to stay up to date on developments in one's interest areas. As an example, Google Scholar alerts allow users to be alerted to new publications regarding a specific molecule. She pointed out that new-to-practice dermatologists have a unique opportunity to be technology opinion leaders, by staying up to date on teledermatology, AI, and digital tools.

Dr. Gooderham left the audience with a quote from James Clear, author of Atomic Habits: "When you finally break through the Plateau of Latent Potential, people will call it an overnight success. The outside world only sees the most dramatic event rather than all that preceded it. But you know that it's the work you did long ago – when it seemed that you weren't making any progress – that makes the jump today possible."

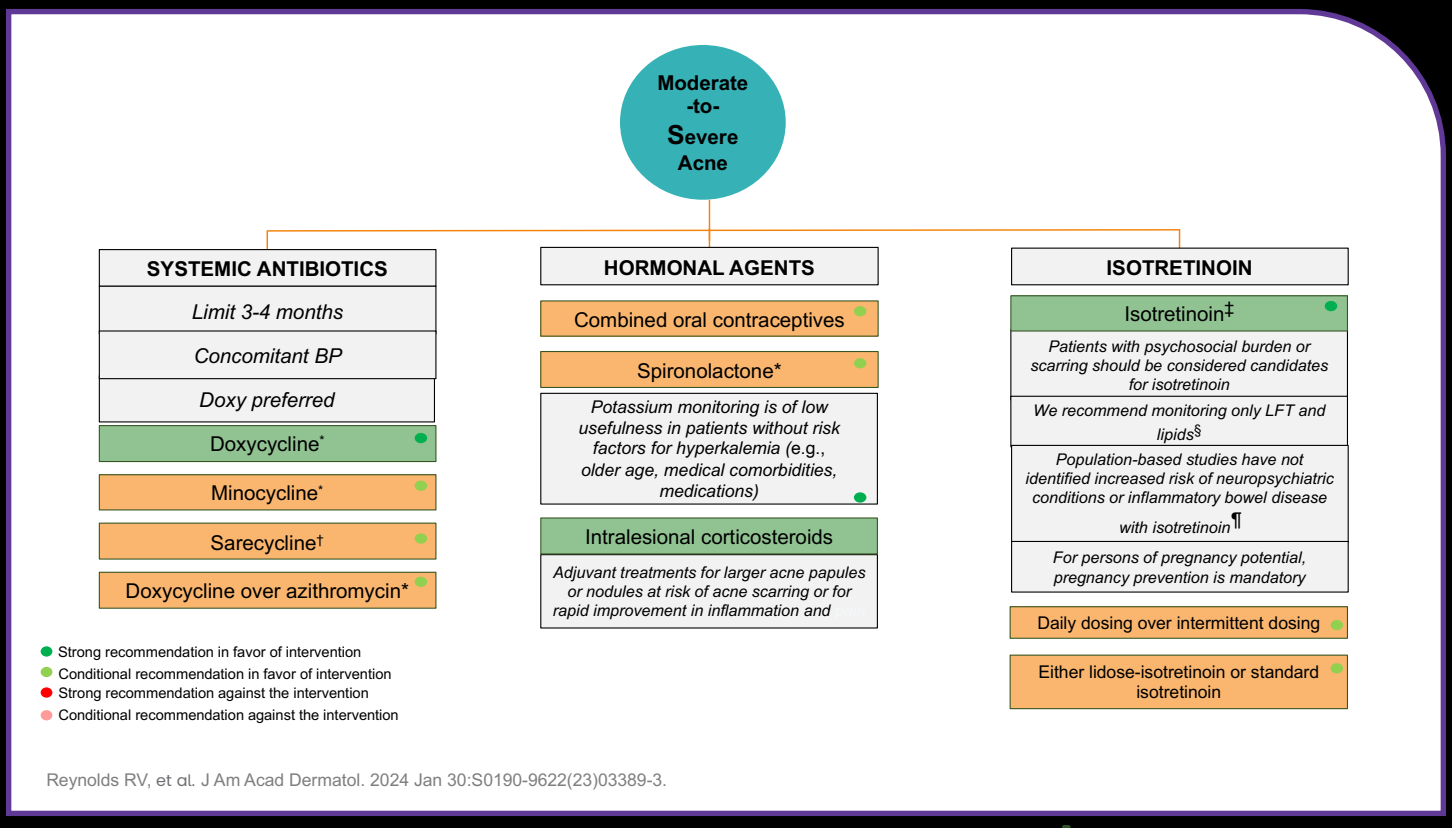


# Acne: New Paradigms in Assessment and Management

MIMI TRAN, MD

The AAD 2024 Guidelines for the management of acne vulgaris strongly recommend benzyl peroxide, retinoids, and topical antibiotics for mild acne. Combining multiple mechanisms of action increases effectiveness. Salicylic acid and azelaic acid were given conditional recommendations due to limited evidence. Despite strong evidence for its use, clascoterone was also given a conditional recommendation due to the cost of the product. Dr. Tran noted that the 1726 nanometer laser recently approved by the FDA was not included in the guidelines, due to the lack of an RCT supporting its use.

Discussing the management of moderate-to-severe acne, Dr. Tran pointed out that doxycycline was the only systemic antibiotic that received a strong recommendation; minocycline and sarecycline received conditional recommendations due to potential side effects and cost. The guidelines recommended that treaters prevent antibiotic resistance by limiting antibiotic use to 3 to 4 months and use antibiotic agents concurrently with benzyl peroxide. Combined oral contraceptives and spironolactone received conditional recommendations, given the moderate level of evidence behind these medications. Intralesional corticosteroids was strongly recommended as an adjuvant therapy, especially if patients are presenting with severe nodules, cystic acne, and the potential for scarring. Isotretinoin, along with




Reynolds RV, et al. J Am Acad Dermatol. 2024 Jan 30:S0190-9622(23)03389-3.

liver function tests and lipid monitoring, received a strong recommendation for severe acne that is refractory to multiple treatments. Patients on this treatment must be counselled to prevent pregnancy, if they are of child-bearing age.

A new topical agent – fixed-dose clindamycin phosphate 1.2%, benzoyl peroxide 3.1%, and adapalene 0.15% gel – was studied in two phase 3 double-blinded RCTs. The trials enrolled 363 patients who were 9 years of age and above. By week 12, the mean improvement from baseline inflammatory lesion count was 76%, while the mean improvement from baseline non-inflammatory lesion count was 80%.

Clascoterone cream 1% remains the only topical androgen receptor inhibitor therapy available in Canada; a 2-week randomized, double-blinded, vehicle-controlled trial of 1,440 patients demonstrated that 20% of patients achieved clear or almost clear IGA scores by week 12, compared to 8% in the vehicle arm. Dr. Tran added that the IGA percentage increased in the long-term extension study. Dr. Tran said that she often combines clascoterone cream 1% with other agents and pointed to a study presented at the 2024 Fall Clinical Dermatology Conference that showed clascoterone doesn't degrade over an 8-hour period when combined with other treatments.

Discussing the controversy surrounding benzene and benzoyl peroxide, Dr. Tran noted that the study that sparked the concern was criticized for not mimicking real-world conditions, as products were incubated at 50°C. Last month, the FDA announced the findings from an independent study. The study demonstrated a much smaller number of products contained elevated levels of benzene contamination, compared to the initial study. Dr. Tran called for ongoing research to determine the true health impact of benzene exposure, and mitigation strategies in transportation and storage. She pointed out that Cabtreo is kept in cold-chain conditions, which is reassuring. Dr. Tran recommended advising patients to keep benzyl peroxide products refrigerated, discard expired products, and replace products every 3 to 6 months.

# HS: New Paradigms in Assessment and Management

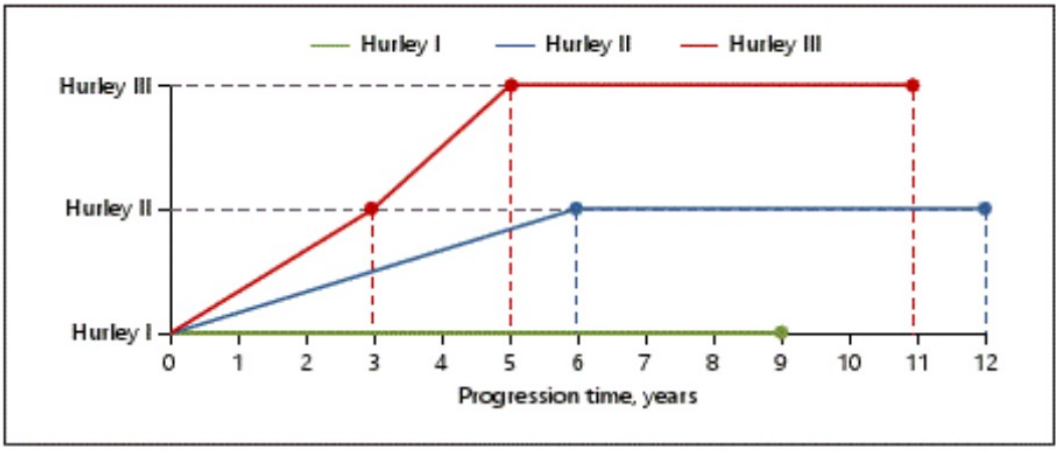
JESSICA ASGARPOUR, MD

HS is a chronic debilitating disease characterized by recurrent nodules, abscesses, sinus tracts, fistulas, and scarring within apocrine gland-bearing areas. The condition affects up to 4% of the Canadian population. It is more common among women and the Black population and typically begins in adolescence and early adulthood.
Dr. Asgarpour emphasized the importance of diagnosing and treating HS early, to prevent patients from progressing to sinus tract and fistula formation, which can only be treated with surgery.

Therapies for early-stage disease include lifestyle management (weight reduction, smoking cessation, dairy reduction, eating healthy, exercising, and decreasing stress) and topical treatment.
For patients who have HS stage 2, Dr. Asgarpour recommended biologic therapy. There are two Health Canada-approved biologics – secukinumab and adalimumab. To access coverage for adalimumab in Ontario, patients must have failed 90 days of antibiotic treatment, and must have lesions in more than two areas, as well as sinus tract formation. To access secukinumab, patients must first fail adalimumab. Dr. Asgarpour presented the BE HEARD trial results, showing slightly higher rates of response with bimekizumab, compared to currently available biologics. For patients who do not want biologic therapy, other options include immunosuppressants, hormonal therapy such as spironolactone or oral contraceptive medications, or oral retinoids, but these are not long-term options.

Discussing procedural treatment options, Dr. Asgarpour recommended light therapy and laser therapy as preventive treatment, incision and drainage or ILK for symptomatic relief, and excision (scalpel or CO2 ablation) or deroofing/

## HS is a progressive disease




Annika M.J.D. Vanlaerhoven, Christine B. Ardon, Kelsey R. van Straalen, Allard R.J.V. Vossen, Errol P. Prens, Hessel H. van der Zee; Hurley III Hidradenitis Suppurativa Has an Aggressive Disease Course. Dermatology 16 November 2018; 234 (5-6): 232–233.

skin-tissue sparing excision with electrosurgical peeling for the management of static lesions. Dr. Asgarpour highlighted that incision and drainage can provide rapid symptomatic relief for HS patients, but this is a temporary therapy. The use of ILK is controversial, due to some studies showing non-superiority to placebo, but Dr. Asgarpour said ILK can hasten resolution of lesions in her experience.

Dr. Asgarpour presented results from a Canadian study, published in *JAAD* in 2022, of 43 patients who underwent surgical deroofing. Out of 123 lesions deroofed, only nine (7%) recurred during the 3-month follow-up period. Post-surgery, 93% of patients had no discharge and patients reported that pain dramatically reduced from baseline.

A meta-analysis published in 2015 in *JAAD* found local incisions were associated with a 22% recurrence rate and wide excisions with a 13% recurrence rate. Primary closures had the highest rate of recurrence (15%) while grafting had the lowest rate (6%). Dr. Asgarpour prefers deroofing, as it is not associated with as many complications as excisions, and research shows that patient satisfaction scores are higher with deroofing, compared to excisions. She added that patients can continue biologics despite deroofing treatment, based on data from a RCT published in *JAMA Surgery* in 2021.

In summary, Dr. Asgarpour encouraged her colleagues to ensure patients are medically managed prior to surgery, as lesions are otherwise likely to recur. She explained that HS patients require a multimodal approach to optimizing patient care, and expressed hope that emerging therapies offered early in the course of the disease may prevent the progression of HS.

# Psoriasis: New Paradigms in Assessment and Management

ASHLEY O'TOOLE, MD

There are now 14 biologic and novel small molecule medications approved for psoriasis in Canada. Dr. O'Toole shared a Cochrane Database Systematic Review from 2023 that showed bimekizumab and risankizumab achieve the best combination of effectiveness and safety, compared to other available therapies. A network meta-analysis shows brodalumab and bimekizumab are associated with the fastest times to achieve a PASI-75 response, followed by ixekizumab and secukinumab. This may be important for a subset of patients who require rapid results.

Dr. O'Toole shared the Canadian Treat-to-Target Guidelines for assessing biologic treatment success, noting that major criteria include:

- Absolute PASI ≤2
- BSA of ≤2% without special site involvement

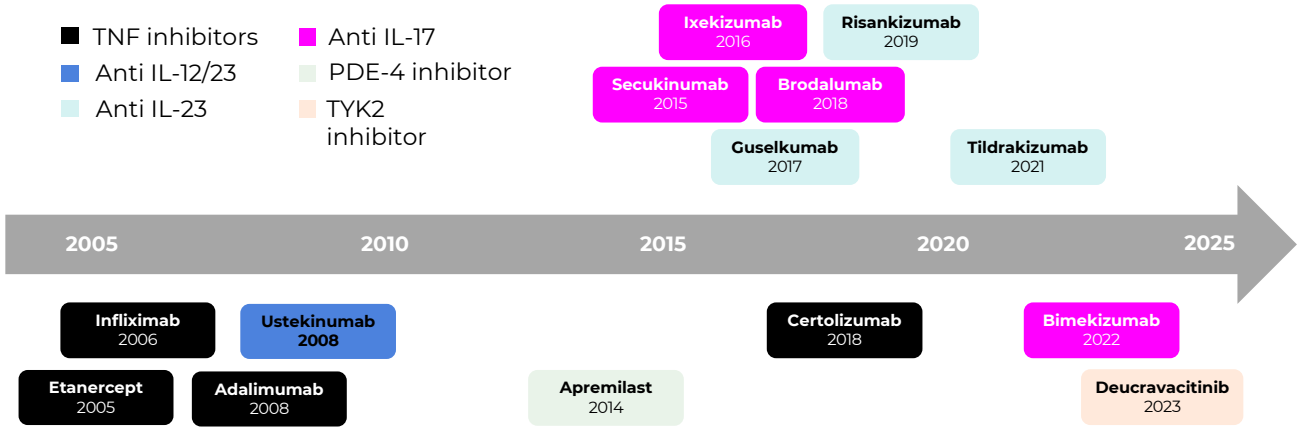
**Minor criteria include:**

- PGA 0/1 (special sites: face, genitals, palms, and soles)
- PGA 0/1 (overall)
- DLQI score of ≤5
- a PASI of 90

Patients who meet either both major criteria, or one major criteria and two or more of the minor criteria, are considered to meet the Canadian Treat-to-Target Guidelines. Patients should be assessed every 3 to 6 months after initiating a new medication, and then every 6 to 12 months thereafter, to determine whether they meet targets. Dr. O'Toole also recommended the 2021 GRAPPA guideline for managing PsA.

In addition to PsA, other comorbidities associated with psoriasis include obesity, axial

## Timeline of Biologic and Novel Small Molecule Approvals for Psoriasis in Canada




IL, interleukin; PDE, phosphodiesterase; TNF, tumor necrosis factor; TYK, tyrosine kinase. Adapted from Health Canada Notice of Compliance Database. https://health-products.canada.ca/noc-ac/index-eng.jsp. Accessed January 2025

spondylarthritis, cardiovascular disease, IBD, mood disorders, and HS. Dr. O'Toole pointed out that in the last few years, many biologic PSPs have begun to allow physicians to prescribe higher doses, based on weight. On cardiovascular disease, Dr. O'Toole pointed to the CANTOS study, which suggested that biologic treatment can reduce patients' risk of cardiovascular disease. For patients with a personal history of IBD, Dr. O'Toole noted that risankizumab is approved for the treatment of IBD. She recommended avoiding IL-17i in these patients. For patients with HS, Dr. O'Toole noted that TNFi and secukinumab are approved for the treatment of HS, and bimekizumab is expected to be approved for the treatment of HS in the coming months.

To identify PsA, Dr. O'Toole recommended using the PSA mnemonic (**P**ain, **S**welling, and **A**xial). She explained that joint pain is a key feature of PsA, and involved joints are often swollen. Joint stiffness after more than 30 minutes of inactivity or upon awakening in the morning is a classic feature of PsA. Another helpful tool is the patient-administered Psoriasis and Epidemiology Screening Tool, which include a short set of questions as well as an illustration to help patients identify the joints in which they experience stiffness, swelling, and pain.

A study published in *Rheumatology* in 2024 demonstrated patients on IL-17i had the lowest risk of developing PsA, at 2%, compared to the 26% risk among patients with psoriasis who were never treated with biologic medications. The risk of developing PsA was 6% in patients treated with IL-23i and/or IL-12/23i, and 9% in patients with TNFi. Dr. O'Toole added that bimekizumab and upadacitinib have recently been approved for the treatment of PsA.

Treatments on the horizon include Icotrokinra, which resulted in 65% of patients reaching an IGA score of 0 or 1 (clear or almost clear) by week 16, compared to 8% in placebo group in the ICONIC-LEAD trial. The medication is well-tolerated. Other oral small molecules are in the pipeline as well, including a TYK2i in development by Alumis, and the JAKi, zasocitinib. New topicals include roflumilast cream/foam, an effective and well-tolerated option for patients with mild-to-moderate psoriasis.

# Seborrheic Dermatitis: New Paradigms in Assessment and Management

DANIEL WONG, MD

Dr. Wong summarized the three main components in the pathophysiology of seborrheic dermatitis: *Malassezia* species, immunological susceptibility/skin barrier dysfunction, and increased sebaceous gland activity. Patients with seborrheic dermatitis have decreased biomarkers of skin integrity (stratum corneum lipids, human serum albumin, and keratins). While *Malassezia* plays an important role in seborrheic dermatitis, there is conflicting evidence on whether the quantity correlates with disease severity.

Strategies in the treatment of seborrheic dermatitis include modulating sebum production with isotretinoin, reducing *Malassezia* skin colonization with antifungal shampoos or topicals, or controlling inflammation and addressing skin barrier dysfunction, with topical steroids, topical PDE4 inhibitors or topical, off-label TCIs.

A new therapeutic for seborrheic dermatitis is roflumilast, approved in Canada in 2024 for the treatment of seborrheic dermatitis in patients 9 years of age and older. Emphasizing the importance of the vehicle for patient adherence, Dr. Wong explained that roflumilast is formulated without fragrances, propylene glycol, polyethylene glycol, isopropyl alcohol, nor ethanol. The formulation is adjusted to the stratum corneum pH and includes a mild emulsifier to maintain epidermal intercellular lipids.

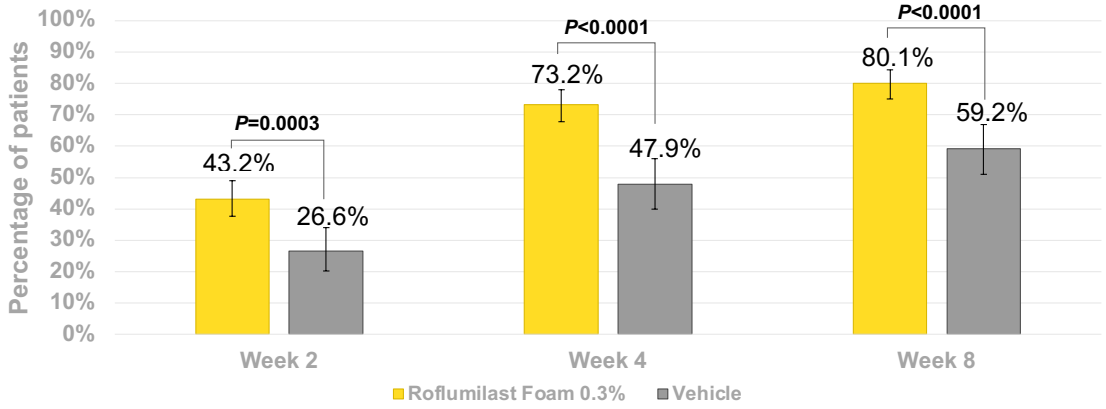
*Roflumilast Foam 0.3%: STRATUM Phase 3*

## Patients Achieving IGA Success (0 or 1 with ≥2-Grade Improvement)

IGA Scale

**Primary Endpoint:**

**80% of Patients Achieved IGA Success at Week 8**




IGA Success = Clear or Almost Clear with at least a 2-grade improvement from baseline. Intent-to-treat population; missing scores imputed using multiple imputations. Error bars represent 95% confidence interval. Statistical significance was concluded at the 1% significance level (2 sided). IGA, Investigator Global Assessment.

1. Blauvelt A, et al. J Am Acad Dermatol. 2024;90(5):986-993. 2. Blauvelt A, et al. Poster presented at: European Academy of Dermatology and Venereology (EADV) Congress; September 7-11, 2022; Milano, Italy.


The STRATUM phase 3 RCT randomized 457 patients 2:1 across the roflumilast foam and vehicle groups. The trial enrolled patients 9 years and above with at least moderate seborrheic dermatitis and a BSA >20%. The average age in the study was 43 years old; men and women were equally represented. Approximately 80% of patients in the roflumilast arm achieved the primary endpoint of IGA success (clear or almost clear). In the vehicle arm, 59% of patients reached the primary endpoint, which speaks to the quality of the vehicle and the role of skin barrier disruption in seborrheic dermatitis.

Discussing safety and tolerability results, Dr. Wong explained that >1% of patients in the treatment arm discontinued the study due to treatment-related adverse events and 98% of roflumilast-treated patients reported no sensation or a mild sensation with application.

Discussing the therapeutic pipeline for seborrheic dermatitis, Dr. Wong noted that Eutoplac, a probiotic-containing oily suspension, has demonstrated efficacy in phase 2 trials.

Over-the-counter shampoos can also be effective for seborrheic dermatitis. Dr. Wong explained that these options range in mechanisms of action and price, with costs anywhere from approximately $9.00 to $45.00.

Dr. Wong emphasized that seborrheic dermatitis is a very common condition, estimated to affect more than 5% of the population. Data shows the condition can have a significant impact on patients' quality of life, due to itching and cosmetic concerns. He described his approach for treating seborrheic dermatitis, noting that roflumilast foam has emerged as his treatment-of-choice for seborrheic dermatitis on the face and body. For patients who don't have insurance coverage, he recommended combination therapy of 2% hydrocortisone powder in Canesten cream or clotrimazole 1% powder in pimecrolimus cream. For the scalp, Dr. Wong recommended antidandruff shampoo along with roflumilast foam or a corticosteroid lotion. For severe cases, Dr. Wong recommended low-dose isotretinoin and oral itraconazole in the case of isotretinoin failure.

# AD: New Paradigms in Assessment and Management

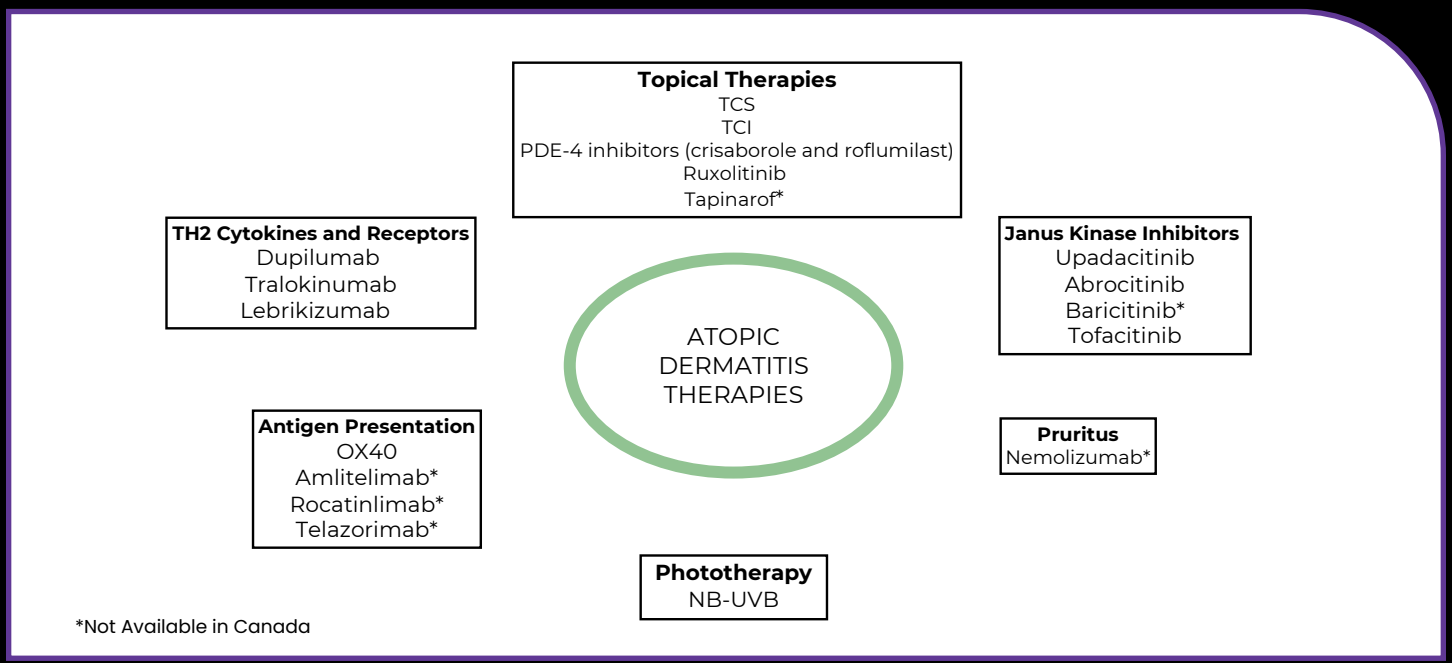
ANDREW FERRIER, MD

Approximately 10% to 15% of Canadian children suffer from AD. Indigenous communities have a much a higher prevalence of AD, with a study of children in grade 1 in Iqaluit finding a 35% rate of AD. Effective control of AD is crucial, due to the substantial quality-of-life impacts of the condition. Chronic itch leads to impaired sleep and, thus, impaired cognitive function, as well as psychosocial distress and relationship challenges. Children with AD have an increased susceptibility to cutaneous infections, such as *Staphylococcus aureus* and viral infections.

The field of AD therapeutics is undergoing a significant evolution, due to a greater understanding of the pathophysiology of AD. Dr. Ferrier described the 2024 AAD guidelines, noting significant changes since the 2014 guidelines. While baseline management strategies continue to involve emollients and topical corticosteroids, new topical options include roflumilast, topical ruxolitinib, and, in the near future, tapinarof. These non-steroidal alternatives fulfill an unmet need, especially for challenging-to-treat areas such as the head and neck. The 2024 guidelines strongly recommend systemic therapies, including biologics (i.e., dupilumab, tralokinumab) and JAKis (i.e., upadacitinib, abrocitinib, and baricitinib). Dr. Ferrier pointed out that lebrikizumab was not included in the guidelines because it wasn't available when the guidelines were developed.

Dr. Ferrier encouraged physicians to adopt a personalized medicine approach when managing AD. For example, Black Canadians are more likely to have a more TH22-skewed AD profile and may be better suited to JAKi therapy. While there aren't head-to-head trials, network meta-analyses show that JAKis are most effective when evaluating IGA and itch results to week 16. However, biologics also show strong efficacy, especially over time, and an improved safety profile. Novel non-steroidal anti-inflammatory topical therapies include roflumilast 0.15% cream and ruxolitinib 1.5% cream.

Dr. Ferrier recommended identifying at least one patient-reported outcome that is important to the patient, such as a PP-NRS or DLQI score. In addition, he recommended monitoring IGA and BSA improvement every 3 to 6 months. Canadian treat-to-target guidelines include a moderate target of



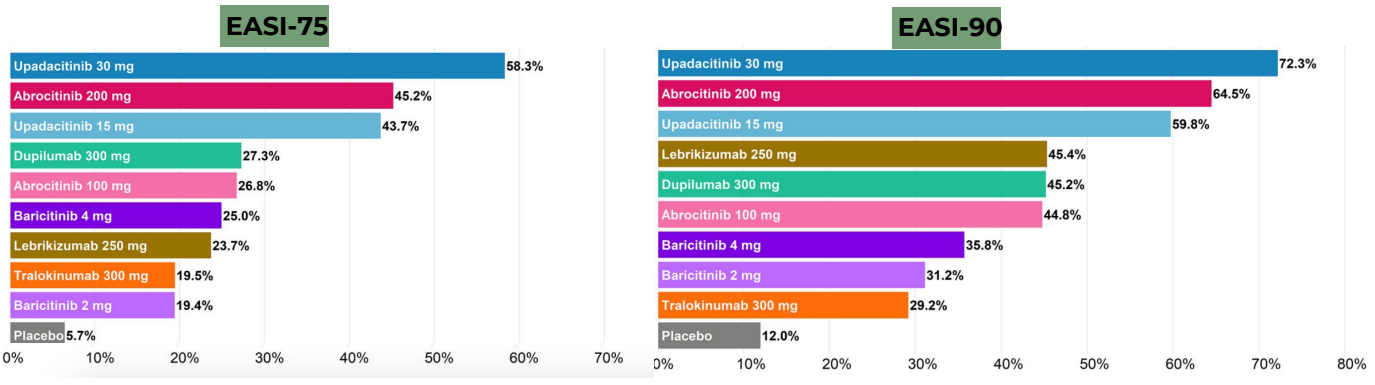
IGA ≤2 and 50% BSA improvement, and an optimal target of IGA 0/1 and BSA ≤2%. Given the challenges of treating AD, moderate targets may be adequate, in accordance with patient preference.

Finally, Dr. Ferrier discussed key emerging topics in AD treatment. He began by showing data on the association between dupilumab and CTCL and encouraged skin biopsies in patients with adult-onset AD who fail dupilumab and have atypical clinical features (such as nonclassical localizations). Flow cytometry and clonal analysis may be appropriate in patients with signs of more advanced disease.

Dr. Ferrier also discussed dupilumab-associated facial dermatitis, explaining the typical onset is approximately 6 months after dupilumab initiation and the majority of patients improve after dupilumab discontinuation. Dr. Ferrier noted that Asian patients may experience higher rates of head and neck erythema. Therapies for dupilumab-associated facial dermatitis include topical corticosteroids as well as topical TCIs, JAKis and, PDE4 inhibitors; antifungals if *Malassezia* is suspected, and doxycycline or isotretinoin for facial dermatitis with rosacea-like features.

Dr. Ferrier also discussed the safety profile of JAKis. He recommended that JAKis be avoided in patients over 65 who have risk factors for herpes zoster or lymphopenia. Finally, Dr. Ferrier highlighted ongoing research showing that OX40 is a promising target for durable, long-term disease control.

## Comparative Efficacy of Targeted Systemic Therapies for Moderate-to-Severe AD without Topical Corticosteroids: An Updated NMA 2023




Dermatol Ther (Heidelb) (2023) 13:2247–2264 https://doi.org/10.1007/s13555-023-01000-3

# JAKPARDY: Practical Use of JAK Inhibitors (Pfizer Canada Sponsored Lunch Symposium)

VIMAL H. PRAJAPATI, MD, BEZ TOOSI, MD,
JESSICA ASGARPOUR, MD, MARK KIRCHHOF, MD

The speakers shared information about the safety and efficacy of JAKis in an interactive question-and-answer format. In AD, Dr. Toosi shared data showing that 63% of previously systemic-naïve patients treated with abrocitinib 200mg achieved an IGA of 0 or 1. Similarly, the Measure Up 1 and 2 studies demonstrated that 49% to 63% of patients on upadacitinib 15 mg dose and 63% to 65.5% of patients on the upadacitinib 30 mg dose achieved a validated IGA score of 0 or 1.

Discussing itch scores, Dr. Toosi shared that 64% of biologic-exposed AD patients and 74% of systemic-naïve patients achieved a ≥4 improvement of PP-NRS after 112 weeks of abrocitinib treatment, with most patients reaching this endpoint within 4 weeks. The Measure Up 1 and 2 studies demonstrated a similarly rapid of onset and impressive itch results with upadacitinib.

Discussing safety of JAKi in AD, Dr. Asgarpour explained that rates of malignancy, VTE and MACE in clinical trials for abrocitinib and upadacitinib align with the rates of these events in the general moderate-to-severe AD population. The rate of serious infections, including herpes simplex and herpes zoster, were slightly higher in the JAKi trials compared to the general AD population rates (occurring at rates of 2% to 3%, compared to 1% in the moderate-to-severe AD population). Less than 1% of patients on JAKi therapy experienced pneumonia. Dr. Asgarpour highlighted that prior to initiating treatment with a JAK inhibitor, all patients should receive necessary immunizations, including prophylactic herpes zoster vaccinations.

Dr. Kirchhof discussed the currently available JAKis in Canada and their indications, noting that there are many JAKis in the pipeline for the treatment of immune-mediated skin diseases.

## JAK inhibitors have a wide variety of indications, and their use is increasing

In Canada:

**Atopic dermatitis**
- Abrocitinib[1]
- Upadacitinib[2]
- Ruxolitinib (topical)[3]

**Alopecia areata**
- Baricitinib[4]
- Ritlecitinib[5]

**Vitiligo**
- Ruxolitinib (topical)[3]

**Off-label uses in dermatology**
- Lupus
- Dermatomyositis
- Lichen planus
- Granuloma annulare

**IBD**
- Tofacitinib[6]
- Upadacitinib[2]

**PsA**
- Tofacitinib[6]
- Upadacitinib[2]

**RA**
- Baricitinib[4]
- Tofacitinib[6]
- Upadacitinib[2]

IBD, inflammatory bowel disease, PsA, psoriatic arthritis; RA, rheumatoid arthritis.
1. CIBINQO® (abrocitinib). Product monograph. Pfizer Canada ULC. November 2024. 2. RINVOQ® (upadacitinib). Product monograph. AbbVie Corporation. February 2025. 3. OPZELURA ® (ruxolitinib). Product monograph. Incyte Corporation. October 2024. 4. Olumiant ® (baricitinib). Product monograph. Eli Lilly Canada Inc. January 2024. 5. LITFULO ® (ritlecitinib). Product monograph. Pfizer Canada ULC. January 2025. 6. XELJANZ ® (tofacitinib). Product monograph. Pfizer Canada ULC. April 2024.

MARK KIRCHHOF, MD, BEZ TOOSI, MD,

JESSICA ASGARPOUR, MD, VIMAL H. PRAJAPATI, MD

# Prurigo Nodularis: New Paradigms in Assessment and Management

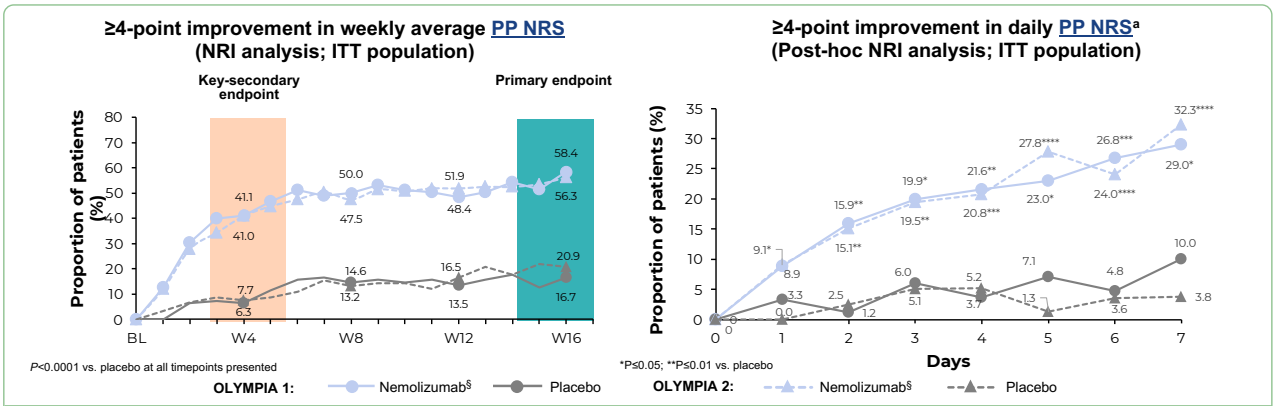
MAXWELL SAUDER, MD

Prurigo nodularis is a rare condition that is more common in women and people of colour. The clinical symptoms of prurigo nodularis are itch lasting greater than 6 weeks and a history of repeated scratching, picking, or rubbing. The itch may be accompanied by burning, stinging, and pain. Clinical signs include the presence of multiple pruriginous lesions and signs of lichenification from repeated scratching. Prurigo nodularis usually spares the face, palms, soles, scale, genitals, and back.

Prurigo nodularis is extremely itchy, with an average itch intensity slightly higher than scabies. Patient surveys show that relief in itch is of utmost priority for patients, before improvement in visible lesions. Dr. Sauder recommended incorporating tools to assess itch in patients, such as the NRS, VAS, or VRS. Dr. Sauder employs the NRS in his practice, asking patients to rank their average itch over the last three days. He also asks patients about how much their skin has affected their sleep over the past few days. For prurigo nodularis, an NRS reduction of 3 is considered clinically meaningful.

The first international guideline for the management of prurigo nodularis, published in 2020, recommends a multimodal therapeutic approach to control itch and treat the pruriginous lesions. Dr. Sauder described a step-wise approach, beginning with topical steroids, TCIs, and antihistamines. The second line of therapy includes the addition of phototherapy, as well as higher-dose topical steroids, intralesional topical steroids, and topical capsaicin. If these approaches don't work, the international guidelines recommend differentiating whether patients have neuropathic or neuropsychiatric disease. To differentiate patients, Dr. Sauder recommended triamcinolone, 40 to 60mg, injected in the gluteal muscle. Patients

## OLYMPIA 1&2 Primary and Key secondary endpoints: ≥4-point improvement in PP NRS and Rapid onset of action in itch




**A significantly higher proportion of patients in nemolizumab group than in placebo group achieved ≥4-point improvement in PP NRS in both trials with onset of action as early as 2 days**

BL, baseline; IGA, ITT, intention-to-treat; NRI, nonresponder imputation; PP NRS, Peak Pruritus Numerical Rating Scale; W, week.
Baseline was defined as the last non-missing weekly value before the first dose of study drug. If a patient received any rescue therapy, composite variable strategy was applied, the underlying data at/after receipt of rescue therapy was set as worst possible value, and the response was derived from underlying data value. Patients with missing results are considered as nonresponders. Strata-adjusted P values for between-group comparisons are presented which are derived from the Cochran-Mantel-Haenszel test using the randomized stratification variables (analysis center and body weight at randomization [<90 kg, ≥90 kg]). [a]Mean daily itch scores using the PP NRS (range 0–10) were recorded, with the BL value defined as the weekly average PP NRS score at BL
§Galderma has received approval for nemolizumab for the treatment of prurigo nodularis in adults in the United States only and has not received approval for any other indication or in any other jurisdiction
1.Sonja et al. European Academy of Dermatology and Venereology. October 11-14, 2023. Berlin, Germany. NCT04501666. 2. Galderma. Data on file. Table adhoc 2.

who respond to this treatment can be considered to have immunologic disease, and can be treated with biologics, JAKis, or traditional immunosuppressants. Patients who don't respond to prednisone can be treated with gabapentinoids or antidepressants and should be referred for a psychiatric consult.

In Canada, dupilumab is the only medication approved for prurigo nodularis. However, nemolizumab, povorcitinib, and ruxolitinib are under phase 3 investigation for the treatment of prurigo nodularis. Dr. Sauder shared the results from the PRIME and PRIME2 studies of dupilumab, which enrolled patients with at least 20 prurigo nodularis lesions over the previous 3 months and a weekly average of PP-NRS of ≥7. At week 24, about 60% of paitents in the dupilumab arm saw a ≥4-point PP-NRS improvement and 46% of patients achieved an IGA score of 0 or 1.

Dr. Sauder described the OLYMPIA 1 & 2 trials for nemolizumab, a novel IL-31RA antibody. The trials enrolled over 500 patients. The inclusion criteria were aligned with the PRIME trials, but lesions needed to be present for 6 months. Approximately 57% of patients in the nemolizumab arm achieved a ≥4-point improvement in PP-NRS at week 16, while approximately 30% of patients achieved IGA success. By week 16, about a third of patients achieved an itch-free or nearly itch-free state (PP-NRS <2).

Dr. Sauder described two phase 3 RCTs of ruxolitinib cream in prurigo nodularis. The eligibility criteria included at least six prurigo nodularis lesions on two different body sites, symmetrically distributed. At week 12, 45% of patients in the ruxolitinib arm achieved a ≥4-point improvement in PP-NRS compared to 21% of patients in the placebo arm. The phase 3 data for povorcitinib showed that at 16 weeks, 36%, 44% and 54% of patients reached the primary endpoint (≥4-point improvement in PP-NRS) in the 15 mg, 45 mg, and 75 mg active treatment arms.

Dr. Sauder summarized that biologics, JAKis, and other emerging therapies are reshaping how prurigo nodularis is treated, offering meaningful relief for patients with previously refractory itch.

# Vitiligo: New Paradigms in Assessment and Management

MARISA PONZO, MD

The clinical assessment of vitiligo begins with a Wood's lamp examination. A vitiligo plaque presents with a blue-white glow, whereas certain differential diagnoses, including ash leaf macule, pityriasis alba, progressive macular hypomelanosis, tinea versicolor, and nevus anemicus will not present with a blue-white glow.

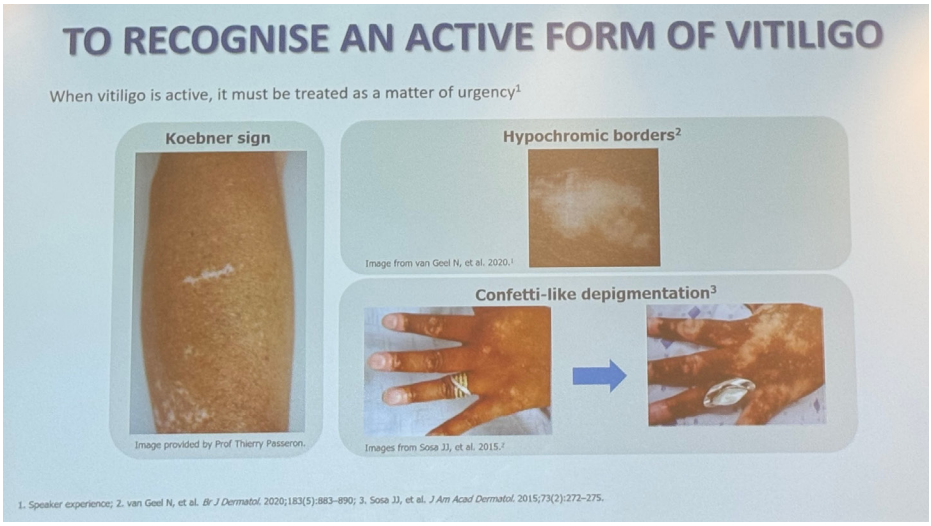
Dr. Ponzo encouraged her colleagues to recognize active vitiligo and treat it urgently. Signs of vitiligo that can progress very quickly (within weeks) include the Koebner sign, hypochromic borders, and confetti-like depigmentation.

Vitiligo is associated with more than 65 conditions including Addison's disease, autoimmune thyroid disease, type 1 diabetes, systemic lupus erythematosus, pernicious anemia, celiac disease, and cochlear dysfunction causing hearing loss. Dr. Ponzo recommended collaborating with family physicians to assess patients for comorbidities of vitiligo.

In the fall of 2024, ruxolitinib cream 1.5% was approved for the treatment of vitiligo. Dr. Ponzo provided an overview of the phase 3, randomized TRuE-V studies. After 2 years of treatment, 71% of patients reached F-VASI75, 42% reached F-VASI90, and 67% reached T-VASI50 in the treatment arm. Dr. Ponzo stressed that in general, patients require an improvement in F-VASI above 90% to be satisfied. She noted that vitiligo on the body is more difficult to treat than vitiligo on the face. Ruxolitinib cream was well-tolerated, with no serious safety signals; the most common treatment-emergent adverse event was application site acne, experienced by 5% of patients.

Novel systemic treatments for vitiligo include the oral JAKis ritlecitinib, povorcitinib, and upadacitinib. At the highest dose in the phase 2 trial, ritlecitinib reached clinical significance with a 12% F-VASI75 improvement compared to placebo; the medication did not reach significance for the T-VASI endpoint at week 24, however. Povorcitinib demonstrated a 61% F-VASI50 improvement and a 34% T-VASI50 improvement at week 52. A dose-finding phase 2 trial revealed that 65% of patients receiving upadacitinib 11 mg achieved F-VASI75 improvement of at week 52. Dr. Ponzo emphasized that there were

## Clinical assessment



no concerning safety signals with the JAKi therapies in the treatment of vitiligo.

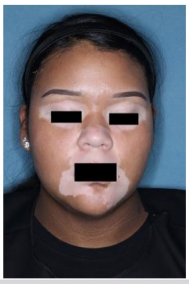
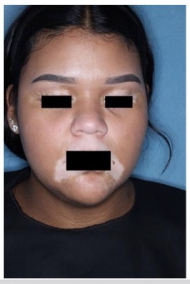
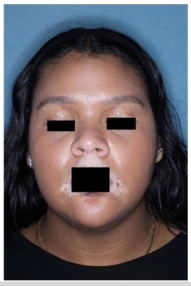
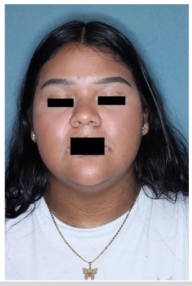
Dr. Ponzo summarized that highly effective topical and systemic agents for vitiligo are bringing new hope for patients. Ongoing, global studies suggest combining these therapies with NB-UVB can increase efficacy. Given that over half of the vitiligo population are children, Dr. Ponzo highlighted that there is a need for treatment that offers longer-lasting results, and IL15is are promising in this regard.


## Clinical Images of a Patient Who Achieved F-VASI90 Response at Week 24

*RUX 1.5% bid*

**14-year-old female with a vitiligo diagnosis for 10 years and Fitzpatrick skin type IV**

**RUX 1.5% bid**

| Baseline | Week 12 | Week 24 | Week 52 |
|---|---|---|---|
|  |  |  |  |
| **F-VASI 1.00** | **F-VASI 0.3**<br>70% change in F-VASI from baseline (F-VASI50) | **F-VASI 0.1**<br>90% change in F-VASI from baseline (F-VASI90) | **F-VASI 0.01**<br>99% change in F-VASI from baseline (F-VASI90) |

bid, twice daily; F-VASI, Facial Vitiligo Area Scoring Index; F-VASI90, ≥90% improvement in F-VASI; RUX, ruxolitinib cream.
Data on file, Incyte Corporation.

# Alopecia Areata: New Paradigms in Assessment and Management

JULIEN RINGUET, MD

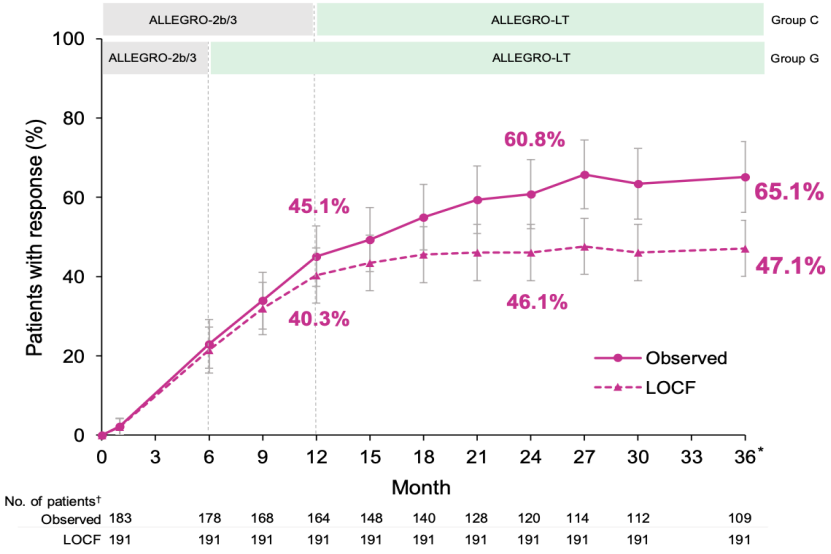
The stigmatization associated with alopecia areata can have a major impact on work and relationships. Dr. Ringuet highlighted the importance of assessing for autoimmune, dermatological, psychiatric, cardiovascular, and gastrointestinal comorbidities when considering therapies. Common comorbidities include thyroid disease, diabetes mellitus, allergic rhinitis, asthma, AD, contact dermatitis, depression or anxiety, vitamin D deficiency, hyperlipidemia, hypertension, anemia, and gastroesophageal reflux disease.

The SALT score is an easy-to-use tool that allows for comparison to clinical trials and is appropriate for both adults and children. Dr. Ringuet recommended using an online tool to calculate the SALT score.

The most recent guidelines for alopecia areata were published by the British Association of Dermatologists in early 2025. The guidelines recommend assessing the psychosocial impacts of the disease and referring patients for psychological intervention and support if needed. For mild-to-moderate disease, the guidelines recommend a potent/very potent topical corticosteroid once daily for 3 to 6 months (with 6-week breaks at 6-week cycles to reduce side effects) and ILK (in adults). Moderate-to-severe disease recommendations include diphenylcyclopropenone, a JAKi, and an oral corticosteroid, which can be combined with azathioprine, methotrexate, or ciclosporin monotherapy. For rapidly progressive disease, the guidelines suggest an oral corticosteroid.

Physicians should always advise patients that responses are variable; some patients respond much better to the same treatment than others. Negative prognostic factors include a younger age of onset (before age 12 and especially before age 6), a duration of episodes over more than 7 years,

## Ritlecitinib : SALT<20
### up to month 36 (3 years)




LOCF, last observation carried forward; SALT, Severity of Alopecia Tool.
Interim results are subject to change as additional data are collected and analyzed in the ongoing study.

a positive family history for alopecia areata or other organ-specific autoimmune disease, and severe clinical presentations.

Discussing treatment options, Dr. Ringuet presented a study published in 2022 that showed significant improvement in the SALT score over a year-long period among patients receiving dexamethasone mini-pulse therapy. However, there was only slight improvement in patients diagnosed with alopecia areata before age 15.

Health Canada-approved JAKis for the treatment of alopecia areata include ritlecitinib (in patients 12 years and older) and baricitinib (in adult patients). Deuruxolitinib has demonstrated efficacy in phase 3 trials while upadacitinib and ivarmacitinib are currently under investigation in phase 3 trials. Dr. Ringuet noted that growth of hair takes 6 to 8 weeks on JAKi therapy; short mature hair growth typically takes around 3 months.

At week 24, 23% of patients taking ritlecitinib 50 mg achieved a SALT score of ≤20; by week 48, this percentage was 43%. The Étude BRAVE studies demonstrated that approximately 36% to 39% of patients in the baricitinib 4 mg arm achieved SALT scores ≤20 by week 36. The JAKis are similarly effective in eyebrows as in the scalp. Noting the follow-up differences in the studies, Dr. Ringuet explained the three medications have similar efficacy. Data shows responses of JAKis to be durable for more than 90% of alopecia areata patients.

Based on 2-year follow-up results for baricitinib, adverse events include a 6% rate of acne and very low rates of nausea, headaches, urinary tract infections, and increased CPK. Three-year safety data shows ritlecitinib is associated with diarrhea (9% versus 4% in the placebo group) and acne (6% versus 5% in the placebo group) and low rates (>5%) of folliculitis, urticaria, cutaneous eruption, herpes zoster, dizziness and increased CPK. There are no signals suggesting increased rates of malignancies, MACE, nor infections.

Dr. Ringuet encouraged his colleagues to communicate the importance of effective therapies for alopecia areata with payers, to improve access for patients.

# Practical Management of Treatment for Immune-mediated Inflammatory Disease with Systemic JAKi

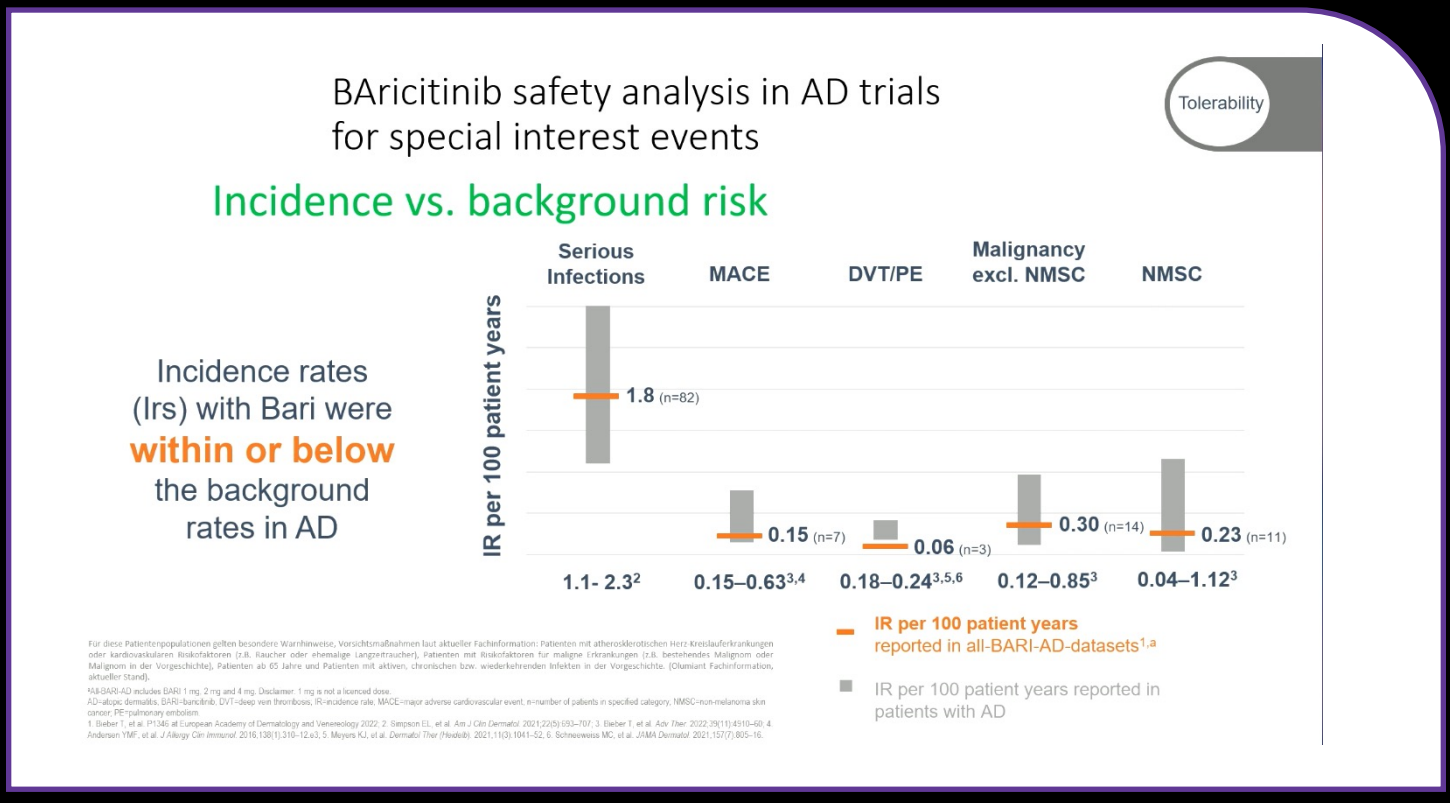
MARK KIRCHHOF, MD

The black box warning on JAKis pertains to serious infections, malignancy, thrombosis, and MACE. Dr. Kirchhof provided context to the black box warning by sharing black box warnings for acetaminophen, ciprofloxacin, methotrexate, and other commonly used medications.

The black box warning was motivated by a study of tofacitinib compared to TNFi in patients with rheumatoid arthritis, which found higher incidences of MACE, malignancies and VTE in patients treated with tofacitinib. Dr. Kirchhof showed data demonstrating that the risks of malignancies, MACE, and VTE in patients taking baricitinib and abrocitinib aligns with the background risk for these events. He also presented a pooled analysis showing there was no additional risk of MACE, malignancies, nor VTE among alopecia areata patients, including older alopecia areata patients with risk factors; the increased risk was concentrated in rheumatoid arthritis patients with one or more risk factors.

In addition, the rates of VTE, malignancy, and MACE differ according to the molecule. For example, the rates are much lower with abrocitinib (0.18 to 0.26 incidence rate/100 patient years), compared to tofacitinib (0.51 to 1.13 incidence rate /100 patient years). Additionally, three systematic reviews conclude there is no risk of MACE, VTE, nor malignancy associated with JAKis in the treatment of AD patients. Abrocitinib and baricitinib are, however, associated with an increased risk of herpes zoster infections.

Dr. Kirchhof shared clinical research data to



inform his monitoring approach to patients on JAKi. He noted that he hasn't had to discontinue JAKi due to elevated lipids, though in about 5% of patients, he encourages patients' family doctors to treat elevated cholesterol or triglycerides. Similarly, he has not encountered changes in neutrophil, lymphocyte, nor platelet counts that required a therapeutic switch. This is backed by data showing that hematologic changes observed with JAKi in patients with AD were generally mild and/or not clinically meaningful. Dr. Kirchhof has discontinued JAKis for elevated liver enzymes, usually in patients with comorbidities and possibly due to drug-drug interactions. While increased CPK was the most common laboratory-related adverse event, clinical studies show CPK increases occurred early during treatment and were transient, asymptomatic, and rarely led to treatment discontinuation.

Monitoring recommendations from Dr. Kirchhof's 2024 *Dermatologic Therapy* publication include that:

- Routine assessment and monitoring of CPK levels in patients with AD receiving oral JAKi treatment is not recommended.
- Unless observed changes in laboratory values between baseline and weeks 8 and 12 are clinically meaningful, ongoing laboratory monitoring of patients with AD receiving oral JAKi treatment is generally unnecessary.
- Dose reduction or switching oral JAKi treatment for patients with AD in response to meaningfully altered lipid levels may result in improvement in lipid levels.
- In patients with AD receiving oral JAKi treatment, profound changes in laboratory parameters that reverse upon treatment discontinuation are likely to recur on treatment re-initiation; therefore, alternative treatment options, including an oral JAKi that does not result in the same risk profile or treatments other than oral JAKi, might be considered.

Regarding vaccination, Dr. Kirchhof presented data showing there are no safety nor immunogenicity concerns with continuing JAKi therapy at the time of the first and second Shingles vaccine. The single greatest risk factor for developing Shingles on a JAKi is a prior history of Shingles. Dr. Kirchhof noted that vaccination may not prevent herpes zoster, and physicians should inform patients of this risk, especially patients who have a history of Shingles infection.

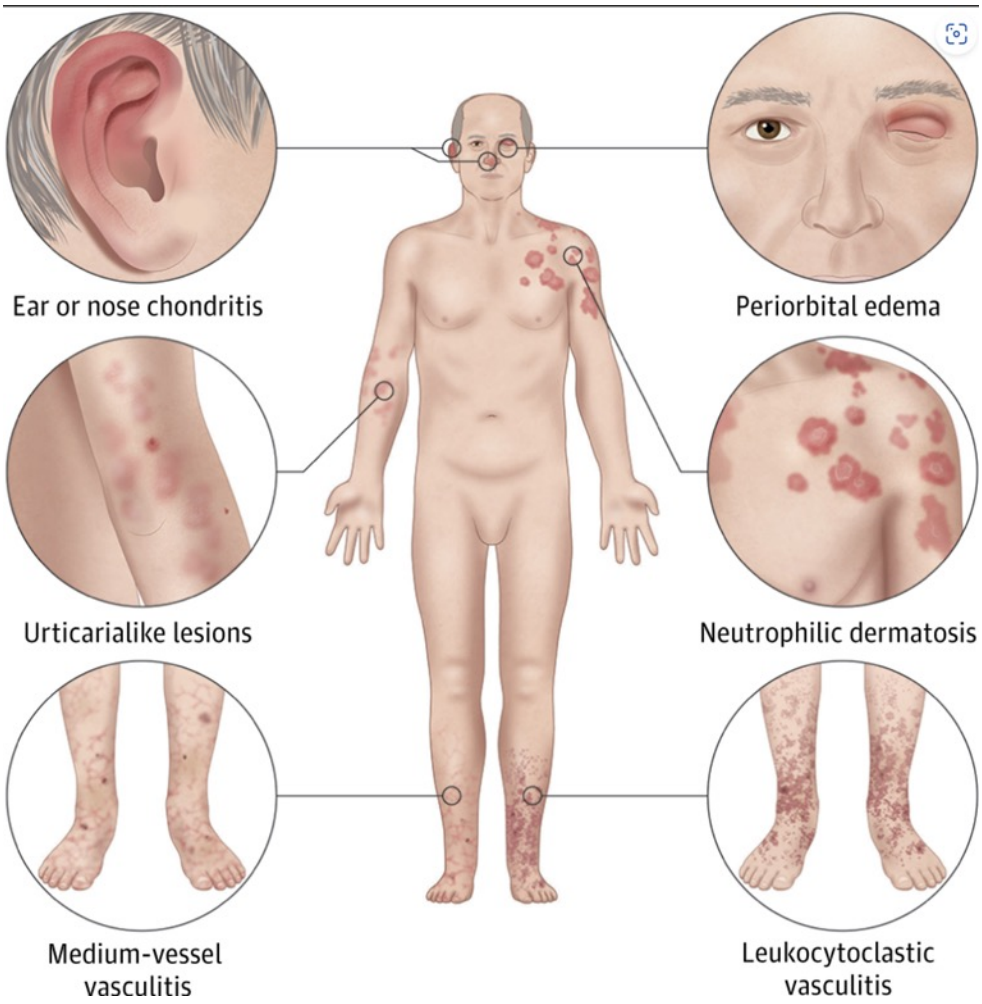
# Best of Dermatology Literature 2024/25

## ELENA NETCHIPOROUK, MD

Dr. Netchiporouk shared important studies in dermatology from the last year, beginning with a 7-year follow-up study of 83 patients with pemphigus that was published in 2024 in *JAMA* Dermatology. The study found a disease-free survival rate of 72% among patients treated with first-line rituximab plus a short course of prednisone, compared to 35% among patients treated with prednisone alone. The rituximab group also experienced fewer side effects than patients in the prednisone group.

For pemphigus patients who have failed rituximab, a study published by Dr. Jing Mao et al in March of 2025 showed ofatumumab may be an effective, steroid-sparing, fast-acting anti-CD20 therapy. However, a large RCT is needed to confirm efficacy and safety.

Discussing bullous pemphigoid, Dr. Netchiporouk discussed the phase 3 LIBERTY-BP trial,




Tan IJ et al. Skin Manifestations of VEXAS Syndrome and Associated Genotypes. JAMA Dermatol. 2024 Aug 1;160(8):822-829.

which was presented at the AAD 2025 annual meeting. In the dupilumab arm, 20% of patients achieved sustained disease remission at week 36, compared to 4% of placebo-treated patients. However, the real-world evidence is more promising; a study of 103 European patients with bullous pemphigoid across 34 hospitals showed that 53% achieved CR within 4 weeks and 96% achieved CR by 52 weeks. Another study from China that followed 146 patients with bullous pemphigoid found that 87% achieved disease control within 4 weeks. Dr. Netchiporouk explained that she has observed impressive results in her practice with dupilumab for severe, blistering bullous pemphigoid. She typically tapers systemic steroids within 4 weeks in patients treated with dupilumab and prescribes topical corticosteroids or TCIs alongside dupilumab.

For patients with immune checkpoint-induced bullous pemphigoid, a study from Mass General Brigham and the Dana Farber Cancer Institute found that biologics did not affect patients' responses to cancer therapy nor OS.

In chronic urticaria, a 2025 study published in the *New England Journal of Medicine* demonstrated rapid and sustained improvement with remibrutinib versus placebo in both autoimmune and autoallergic chronic spontaneous urticaria. The incidence of adverse events was comparable between the treatment and placebo groups, aside from increased petechiae in the treatment arm (3.8% versus 0.3).

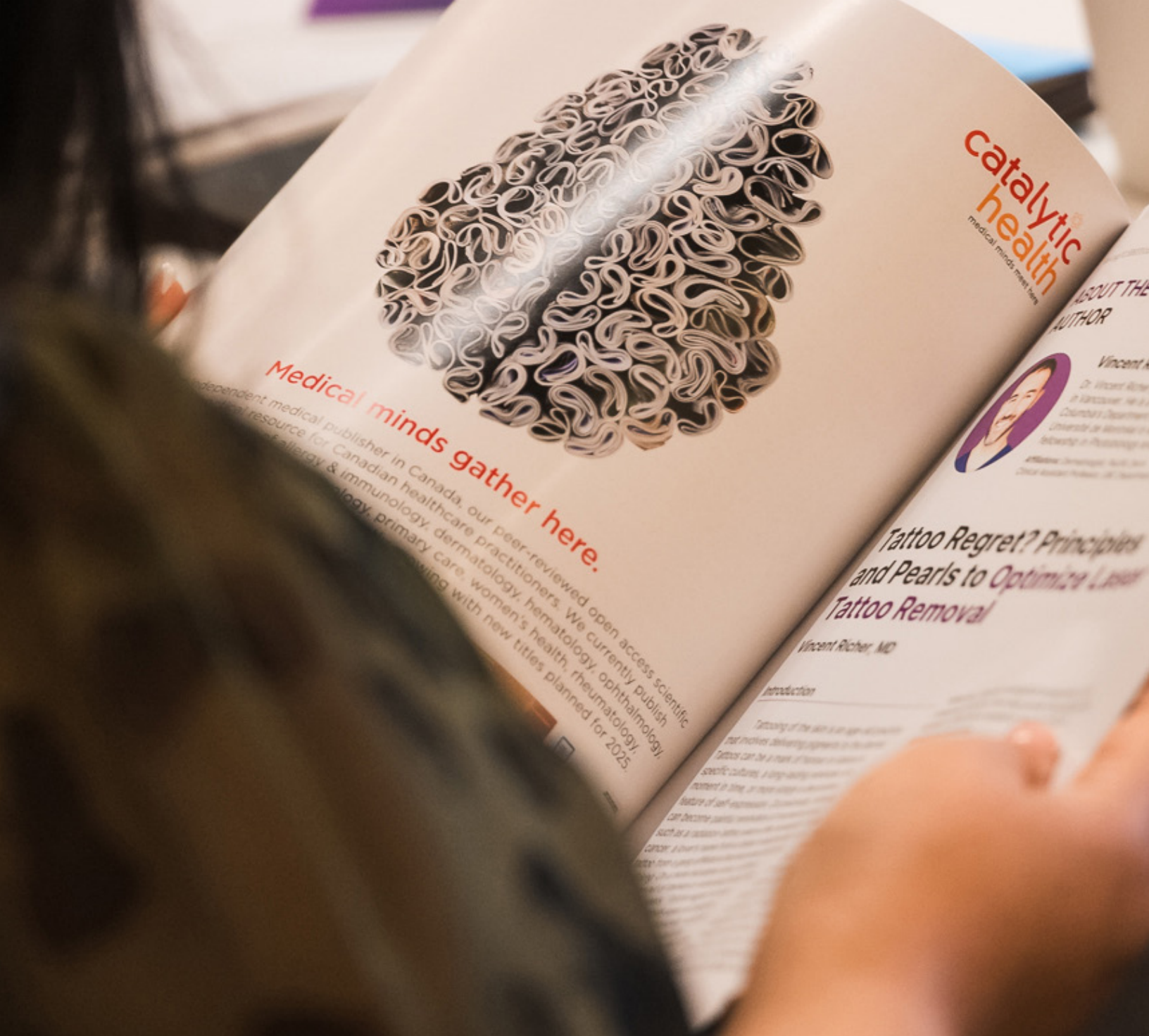
Another study published in *Dermatologic Therapy* showed that dupilumab (currently only approved for the treatment of chronic urticaria in Japan), reduced the mean urticaria activity score by approximately 17% from baseline at week 12, and the improvement occurred across patients with low and high levels of baseline serum total IgE. Additionally, a study presented at the European Academy of Dermatology and Venerology 2024 conference showed that barzolvolimab is effective in the treatment of chronic urticaria, regardless of whether patients are omalizumab-naïve, -exposed, or -refractory.

A systematic review and meta-analysis published in *Autoimmune Reviews* in February 2025 demonstrated the superior efficacy and safety of deucravacitinib, even when compared to anifrolumab.

A *JAMA* Dermatology article published in 2024 described the various skin manifestations of VEXAS syndrome, which was first described in the literature in 2020. Dr. Netchiporouk explained that VEXAS syndrome is a multi-system condition, caused by a mutation in the bone marrow cells. VEXAS syndrome primarily affects males aged 50 years and above, as it is an X-linked condition. Common symptoms include fever and fatigue. Patients may also experience weight loss and night sweats. Dr. Netchiporouk noted that patients with VEXAS syndrome in the study commonly had thromboembolic disease (43%), eye disease (54%), ear and nose chondritis (54%) and pulmonary disease (81%). All patients in the study had an elevated erythrocyte sedimentation rate and elevated CRP levels. She encouraged her colleagues to consider VEXAS syndrome in patients with similar clinical signs and laboratory markers.

# Closing Remarks and Adjournment

On behalf of the Scientific Steering Committee of the 2025 Rising Stars in Dermatology Symposium, Dr. Devani thanked all the attendees, sponsors, and faculty for their time and energy towards this inaugural symposium. He asked everyone to hold their calendars for next year's event from April 17th to 19th, 2026.

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