Canadian Dermatology Today 2026 Rising Stars in Dermatology Symposium

Event Summary

Toronto, ON • April 18, 2026

catalytic health
medical minds meet here

In This Report

Scientific Steering Committee

DR. ALIM R. DEVANI
DR. VIMAL H. PRAJAPATI
DR. MAXWELL B. SAUDER
DR. MIMI TRAN

Symposium Faculty

SONYA ABDULLA
JESSICA ASGARPOUR
KIM BLAKELY
GEORGE CHRISTODOULOU
SOPHIA COLANTONIO
DAVID CROITORU
ANDREW FERRIER
GENEVIEVE GAVIGAN
FIONA LOVEGROVE
ANASTASIYA MUNTYANU
IRINA OROZ
ASHLEY O'TOOLE
KIM PAPP
MICHELE RAMIEN
JULIEN RINGUET
STÉPHANIE TURMEL

Acronyms

AAAAI	AMERICAN ACADEMY OF ALLERGY, ASTHMA & IMMUNOLOGY
AAD	AMERICAN ACADEMY OF DERMATOLOGY
ACAAI	AMERICAN COLLEGE OF ALLERGY, ASTHMA & IMMUNOLOGY
AE	ADVERSE EVENT
AhR	ARYL HYDROCARBON RECEPTOR
BMI	BODY MASS INDEX
BSA	BODY SURFACE AREA
BTK	BRUTON TYROSINE KINASE
CRP	C-REACTIVE PROTEIN
CRSwNP	CHRONIC RHINOSINUSITIS WITH NASAL POLYPS
CSU	CHRONIC SPONTANEOUS URTICARIA
EASI	ECZEMA AREA AND SEVERITY INDEX
ESR	ERYTHROCYTE SEDIMENTATION RATE
F-VASI	FACIAL VITILIGO AREA SCORING INDEX
GP	GENERAL PRACTITIONER
HECSI	HAND ECZEMA SEVERITY INDEX
HiSCR50	HIDRADENITIS SUPPURATIVA CLINICAL RESPONSE 50
HIV	HUMAN IMMUNODEFICIENCY VIRUS
HS	HIDRADENITIS SUPPURATIVA
IBD	INFLAMMATORY BOWEL DISEASE
IGA	INVESTIGATOR GLOBAL ASSESSMENT
I-IGA	INTERTRIGINOUS INVESTIGATOR GLOBAL ASSESSMENT
IgE	IMMUNOGLOBULIN E
IgG	IMMUNOGLOBULIN G
IgM	IMMUNOGLOBULIN M
IPL	INTENSE PULSED LIGHT

Acronyms Continued

IL	INTERLEUKIN
JAK	JANUS KINASE
NRS	NUMERIC RATING SCALE
NSAID	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS
PASI	PSORIASIS AREA AND SEVERITY INDEX
PGA	PHYSICIAN'S GLOBAL ASSESSMENT
PDE4	PHOSPHODIESTERASE-4
PIH	POST-INFLAMMATORY HYPERPIGMENTATION
PN	PRURIGO NODULARIS
PsA	PSORIATIC ARTHRITIS
SALT	SEVERITY OF ALOPECIA TOOL
SNRI	SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITOR
SPF	SUN PROTECTION FACTOR
SSRI	SELECTIVE SEROTONIN REUPTAKE INHIBITOR
TNFα	TUMOR NECROSIS FACTOR-ALPHA
TPO	THYROID PEROXIDASE
TRM	TISSUE-RESIDENT MEMORY
T-VAS	TOTAL VITILIGO AREA SCORING INDEX
TYK2	TYROSINE KINASE 2
UAS7	URTICARIA ACTIVITY SCORE OVER 7 DAYS
UCT	URTICARIA CONTROL TEST
UVA	ULTRAVIOLET A
UVB	ULTRAVIOLET B
vIGA	VALIDATED INVESTIGATOR'S GLOBAL ASSESSMENT
WI-NRS	WORST ITCH NUMERIC RATING SCALE

Risen Star Plenary Lecture

DR. KIM PAPP

Dr. Papp discussed the concept of expertise, emphasizing that "expert" is not a fixed status but an evolving process of continuous self-improvement. He argued that experts may have a breadth of knowledge across a wide area or depth of knowledge in a more limited area, and encouraged the dermatologists in attendance to consider the focus of their learning and growth, recognizing that deep expertise in many conditions and treatment areas is not possible.

While acknowledging that circumstances play a role, Dr. Papp explained that a methodical, goal-oriented approach significantly increases the likelihood of success. He encouraged the attendees to define their goals, understand the steps required to reach them, and work consistently toward those objectives. He noted that feelings such as jealousy over a peer's success or discontent over being passed over for an opportunity can result in lost focus, and can ultimately be barriers to achieving one's goals. He encouraged young physicians to focus on areas within their control.

Motivation is a key determinant of how far an individual can progress. Dr. Papp warned against extrinsic motivators such as financial gain. Using personal examples, he explained that academic and scholarly pursuits are unlikely to yield substantial financial rewards. However, those driven primarily by money typically find this pursuit to be less fulfilling over time. Similarly, he cautioned against excessive reliance on recognition, as too much ego can hinder learning by preventing individuals from acknowledging gaps in their knowledge and result in individuals being overly influenced by the opinions of others.

Curiosity was also described as a key driver of professional growth. Dr. Papp emphasized the importance of continually asking "why." However, he emphasized that questioning alone is insufficient; meaningful progress requires pursuing answers through critical thinking, analysis, and reflection. Dr. Papp discussed a Harvard Business Review article (Ericsson et al, 2007) that identified a deliberate learning practice, deliberate thinking (including being critical about one's own assumptions and beliefs), relationships with coaches and mentors, and openness to feedback are common elements that build expertise. Dr. Papp stressed that, while there are no guarantees of reaching a particular level of recognition or achievement, deliberately honing one's expertise will ensure meaningful professional growth and a more fulfilling career trajectory.

The Making of an Expert
By KA Ericsson, MJ Prietula, and ET Cokely

Harvard Business Review, July-August 2007

Mostly taken from Developing Talent in Young People, Benjamin Bloom

Deliberate Practice
Deliberate Thinking
Coaches and Mentors
Feedback

2026 Canadian Dermatology Today Rising Stars in Dermatology Symposium

Cleanse, Moisturize, Protect: Building a Practical Foundation for Everyday Dermatology

Sponsored Breakfast Symposium: Kenvue

DR. SONYA ABDULLA

Dr. Abdulla began by revisiting the "brick and mortar" model of the skin barrier, underscoring the importance of the triple lipid layer (ceramides, fatty acids, and cholesterol) and the corneocytes (including keratins and natural moisturizing factors). She noted that skin care products are increasingly designed to support both the lipid biolayer and corneocytes.

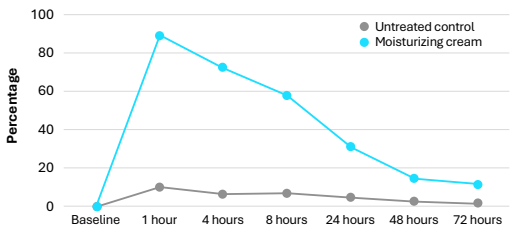
The Neutrogena® Hydro Boost portfolio includes cleanser, moisturizer, and sunscreen. Dr. Abdulla highlighted that the Hydro Boost cleanser includes hydrophobically modified polymer technology, which binds micelles to form polymers. The cleanser also uses Natrasurf® technology, derived from potato starch, to create a foaming texture and increase the size of micelles. The result is that micelles are less irritating to the lipid barrier. After 4 weeks of using the Neutrogena® Hydro Boost cleanser daily, overall skin appearance in patients with barrier-related skin disease improved by 30%.

The Hydro Boost Gel Cream Extra Dry contains hyaluronic acid, natural moisturizing factors and three essential lipids. Dr. Abdulla recommends this cream to patients who identify as having dry skin, patients using acne therapies, and perimenopausal and menopausal patients. An analysis of skin explants treated with Gel Cream Extra Dry over 3 days showed significant increases in hydration-relevant genes and proteins. A clinical study of 29 patients who identified as having extra dry skin demonstrated that a single application could increase skin hydration and reduce transepidermal water loss. After 4 weeks of daily use, dermatologist-graded results showed Gel Cream reduced stinging, burning, itching, tightness, redness, and overall sensitivity.

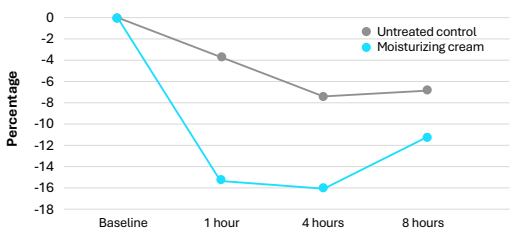
Kinetic moisturization study

Gel Cream Extra-Dry significantly increased skin hydration and decreased water loss compared with control

% Increase skin surface hydration (capacitance) vs. Baseline*



% Decrease skin surface water loss (TEWL) vs. Baseline*



Reference: Poster #50564 – Presented at the American Academy of Dermatology Annual Meeting, 17 Presented at the American Academy of Dermatology Annual Meeting, 8-12 March 2024

PKG-05

Neutrogena®

DR. SONYA ABDULLA

Addressing the longstanding question of how to sequence moisturizers with topical retinoids, Dr. Abdulla showed explant model data evaluating gene transcription markers of retinoid activity. The data demonstrated that applying moisturizer either before or after retinoid therapy does not compromise bioactivity. However, a "sandwich" approach – applying moisturizer both before and after retinoid therapy – was associated with reduced gene transcription, suggesting reduced retinoid activity. Dr. Abdulla noted that the sandwich approach can be used to improve tolerability during treatment initiation, with a transition to a single moisturizer application as patients become more tolerant of retinoid cream.

Moving to the vital role of sun protection, Dr. Abdulla discussed the evolving understanding of the light spectrum, including the role of UVA and visible light in driving photodamage. The incorporation of iron oxides available in tinted sunscreens for people with Fitzpatrick skin type III to V provides broader-spectrum protection while improving cosmetic acceptability, a key determinant of patient adherence. In addition, Neutrogena has developed the highly stable and clear UVA filter HelioPlex® and, more recently, Purescreen+® Technology, a high SPF mineral active with up to three times more UVA protection versus competitors. Dr. Abdulla presented data showing that Neutrogena sunscreen with HelioPlex® technology maintains over 85% UVA protection after 5 hours.

Explaining that avoiding visible sun damage and preventing skin cancer are especially important for patients and physicians, Dr. Abdulla also presented comparative data demonstrating that SPF 100 formulations reduce UVB penetrance more effectively than SPF 50+ formulations, translating into lower rates of sunburn and reduced pigmentation. Neutrogena® Ultra Sheer Face & Body Lotion SPF 100 is now available to address patient demand for maximal UV defense.

Acne: New Paradigms in Assessment and Management

DR. IRINA OROZ

Dr. Oroz delivered a comprehensive overview of evolving paradigms in acne management. Beginning with recently approved therapies, Dr. Oroz described Cabtreo, a fixed-dose combination topical that integrates an antibiotic, a retinoid, and benzoyl peroxide into a single formulation; clascoterone 1% cream (Winlevi), a first-in-class topical androgen receptor inhibitor that reduces sebum production in the sebaceous gland; and Absorica, oral isotretinoin that is formulated with improved bioavailability and can be taken with or without food. Dr. Oroz recommended the latter for patients who have failed previous oral isotretinoin formulations.

Focusing on hormonal acne, Dr. Oroz reviewed how androgen binding drives sebum production, which promotes the proliferation of Cutibacterium acnes and stimulates follicular hyperkeratinization, resulting in obstruction. Clinical data demonstrate that the androgen receptor blocker, clascoterone, leads to meaningful reductions in both inflammatory and non-inflammatory lesion counts, as well as improvements in IGA scores. After 12 weeks, approximately 20% of patients achieved IGA success in the clascoterone arm, compared to less than 8% in the vehicle arm.

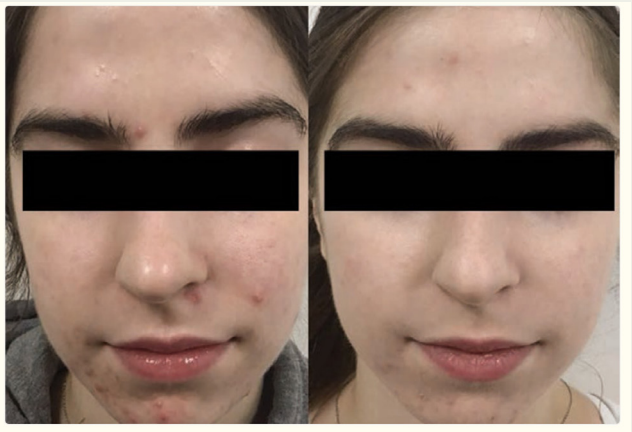
Importantly, a 16-week pilot study presented at the 2025 Fall Clinical Dermatology Conference demonstrated that the combination of clascoterone 1% cream and adapalene 0.3% gel reduced inflammatory and non-inflammatory lesions by 87%. Similarly, pairing clascoterone 1% with Cabtreo led to an improvement of approximately 60% at week 8 (Yu et al, 2025). Combining clascoterone and isotretinoin demonstrated a 92% rate of IGA 0/1 at week 24 versus 73% with isotretinoin alone. These findings reinforce the principle that targeting multiple pathways yields superior results.

Combination with triple therapy (Cabtreo + clascoterone)

A prospective pilot evaluation looked at:

- Clindamycin 1.2%/adapalene 0.15%/benzoyl peroxide 3.1% (Cabtreo) PLUS clascoterone 1%
- About **60% improvement** was seen at eight weeks → IGA not reported
- This approach targets all four pillars of acne pathogenesis simultaneously:
  - bacteria
  - inflammation
  - follicular hyperkeratinization
  - androgens/sebum

The study reported good efficacy and tolerability in acne patients.



Yu Z, Swenson K, Graber E. Prospective Pilot Evaluation of the Safety, Tolerability, and Efficacy of Clindamycin Phosphate 1.2%/Adapalene 0.15%/Benzoyl Peroxide 3.1% Gel plus Clascoterone 1% Cream in Adult Patients with Acne. J Clin Aesthet Dermatol. 2025 Jan;18(1):20-23. PMID: 39830821; PMCID: PMC11741171.

For patients with acne concerned about sebum levels despite acne clearance, Dr. Oroz drew attention to a study presented at the 2025 Fall Clinical Dermatology Conference by Dr. Draelos et al that evaluated the effect of clascoterone cream 1% on facial sebum production. The study demonstrated an overall 47% reduction in casual sebum levels from baseline to week 52, and a 79% decrease in facial oily appearance, with no safety or tolerability concerns.

Addressing procedural considerations, Dr. Oroz noted that the conventional philosophy of waiting 6 months to treat isotretinoin patients with laser therapy is based on historical case reports and may not be the best approach. A randomized controlled trial (Taleb et al, 2024) and systematic review (Xu et al, 2024) support the safety and efficacy of concurrent laser therapy. While the evidence supports the concurrent use of IPL, vascular lasers, and non-ablative fractional lasers and radiofrequency, Dr. Oroz recommended caution with aggressive ablative procedures.

To target PIH in patients with skin of colour, Dr. Oroz emphasized the need to address acne and PIH concurrently. Strategies include the early use of retinoids, the incorporation of anti-inflammatory agents that reduce melanosome transfer, azelaic acid, and anti-tyrosinase agents. The short-term use of hydroquinone can also be used for significant PIH. Strict photoprotection is critical. Dr. Oroz also underscored the importance of minimizing irritation, as treatment-induced inflammation can exacerbate pigmentation concerns.

Finally, Dr. Oroz reviewed emerging evidence on lifestyle factors, including diet and supplements. Low-glycemic-index diets have a modest, yet significant, effect on inflammation and acne lesion counts (Meixiong, 2022). Evidence supporting nutraceuticals is more limited. Research suggests vitamin D supplementation may improve acne in patients with vitamin D deficiency. Omega-3 fatty acids, probiotics, and green tea extract may also benefit patients when combined with standard acne therapies.

Hidradenitis Suppurativa: New Paradigms in Assessment and Management

DR. DAVID CROITORU

HS is a heterogeneous, chronic inflammatory disease that is more common in women and people of colour and is associated with significant physical and psychosocial burden. Dr. Croitoru noted that HS is likely underdiagnosed, particularly in its milder forms.

Reviewing the pivotal trials for adalimumab, secukinumab, and bimekizumab, Dr. Croitoru drew attention to the differing time points for evaluating outcomes, the high placebo rates, and the outcomes suggesting an efficacy ceiling. He contextualized this by explaining that HiSCR50 is a percentage reduction in active nodules, and this measure does not account for the challenges of resolving complex nodules that form within sinus tracts.

Dr. Croitoru cautioned against cross-trial comparisons, noting that BE HEARD included more biologic-exposed patients, and there were differences across trials regarding antimicrobial use. Dr. Croitoru also challenged the concept of a narrow "window of opportunity," noting that the crossover design in the adalimumab study demonstrated that while earlier treatment results in better outcomes, patients initiating therapy later in their disease course can still achieve substantial benefit. Importantly, longer-term data suggest that continued treatment with bimekizumab may yield deeper responses over time, with improvements in pain, lesion counts, and tunnel involvement. While IL-17 inhibitors have been scrutinized for potential IBD exacerbation, the pivotal trials for secukinumab and bimekizumab showed new-onset IBD occurred in 3 cases among 1,865 treated patients, suggesting that this concern may not be evidence-based. Dr. Croitoru also emphasized the clinical overlap between HS and cutaneous Crohn's disease, underscoring the importance of careful diagnostic evaluation in atypical presentations.

Emerging therapies include biologic, small molecule, and nanobody therapies as well as treatments with new targets. Dr. Croitoru presented promising data for ruxolitinib 1.5% cream, povorcitinib, and upadacitinib, before highlighting the compelling data for brivekimig, an OX40L-TNF bispecific molecule. Phase IIb trials showed an adjusted response rate differential of 29% at week 6 between brivekimig and placebo and impressive activity on draining tunnel count. Izokibep, a fully synthetic IL-17A inhibitor, also shows

HS Approved Agents: Pivotal Trials

Drug	Pivotal Phase 3 (n)	Design & dosing	Primary	Result at primary	Key secondary	Label Dosing
Humira; adalimumab [TNF-α]	PIONEER I: n=307 PIONEERII: n=326	RDBPC; 12 wks Day 1: 160 mg → Day 15: 80 mg → Day 29: 40 mg q wk	HiSCR50 @ Week 12	PIONEER I: 42% vs 26% PIONEER II: 58% vs 28%	Pain (NRS); DLQI; lesion counts (AN).	160 mg → 80 mg → 40 mg q wk
Cosentyx; secukinumab [IL-17A]	SUNSHINE: n=541 SUNRISE : n=543	RDBPC; 52 wks 300 mg weekly x5 wk → Q2W or Q4W.	HiSCR50 @ Week 16	SUNSHINE: 45% vs 29% SUNRISE: 43%* vs 26%	HiSCR75; IHS4-55; flare reduction; pain; DLQI.	300 mg SC q wk x 5 300 mg SC q 4wk
Bimzelx; bimekizumab-bkzx [IL-17A/F]	BE HEARD I: n=505 BEHEARD II: n=509	RDBPC; 48 wks 320 mg Q2W or Q4W.	HiSCR50 @ Week 16	BE HEARDI: 48% vs 29% BE HEARDII: 52% vs32%	HiSCR75/90/100; tunnel outcomes; comprehensive PRO.	320 mg q 2wk x 8 320 mg q 4wk

deep response data in phase 3 data. Similarly, sonelokimab, a nanobody IL-17A inhibitor, may penetrate deeper into the tissue, with 74% to 79% achieving HiSCR50 at week 40 and 62% achieving HiSCR75. Lutikizumab, an IL-1a/b inhibitor, is also promising, and may be especially efficacious for patients who have failed anti-TNFa medications.

Beyond pharmacologic advances, Dr. Croitoru strongly emphasized the critical role of surgery in HS management. The SHARPS randomized controlled trial found that surgery was safe among patients receiving adalimumab, with no increase in postoperative complications. Deroofing and wide local excision can be highly effective. Dr. Croitoru highlighted that deroofing is an accessible technique for dermatologists that can be performed in outpatient settings, while wide local excision may offer advantages in healing time and cosmetic outcomes for select patients. Dr. Croitoru presented real-world data from Women's College Hospital demonstrating meaningful improvements in disease activity, pain, and drainage following surgical intervention, including in patients receiving systemic therapy. Dr. Croitoru emphasized that an approach that combines targeted medical therapy with appropriate surgical intervention offers the greatest potential to achieve meaningful and sustained disease control.

Psoriasis: New Paradigms in Assessment and Management

DR. FIONA LOVEGROVE

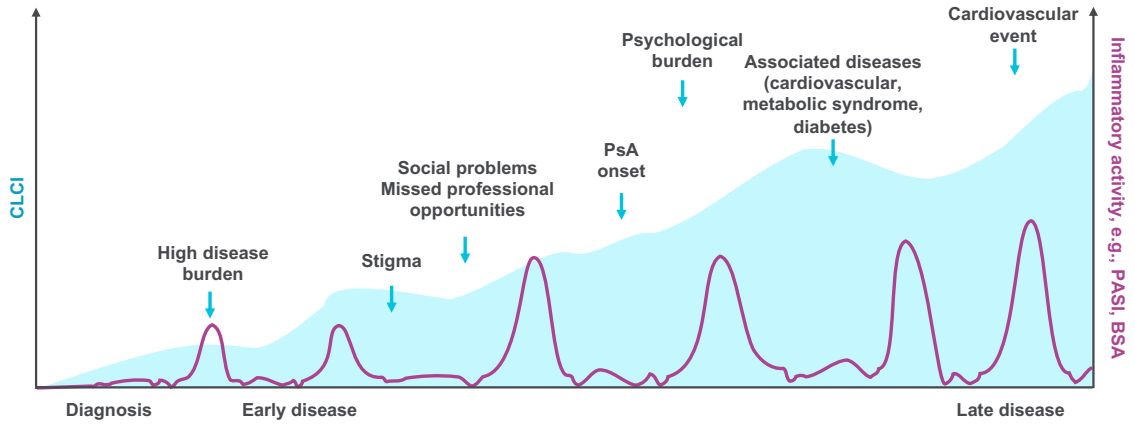
Dr. Lovegrove framed psoriasis management around increasingly ambitious treatment goals, emphasizing that the standard of care is now clear or almost clear skin, with an emerging focus on sustained clearance over at least 6 months (Armstrong et al, 2025). She underscored the importance of early and effective intervention to reduce the risk of social stigma as well as comorbidities, including PsA and cardiovascular events.

Early intervention with IL-23 inhibitors may have the potential to restore the Th17/T^{reg} balance to match that of healthy controls and control T^{RM} levels, possibly resulting in a disease-modifying therapeutic effect. Supporting this, clinical data published by Dr. Schäkel et al. in 2023 show that patients treated earlier in their disease course are more likely to achieve durable PASI 100 responses (or "super" response) than those treated later (43.7% versus 34.4%).

Dr. Lovegrove then reviewed the expanding therapeutic landscape, particularly the emergence of highly effective oral agents. She highlighted icotrokinra, a novel molecule targeting the IL-23 pathway that led to PASI 90 rates of 65% at week 24 and demonstrated robust long-term safety. A comparison of icotrokinra versus deucravacitinib demonstrated that IGA success occurred in approximately 70% of patients in the icotrokinra arm versus 50% in the deucravacitinib arm. Zasocitinib, an oral TYK2 inhibitor, also demonstrated very strong efficacy, with PGA success of approximately 70% at week 16 (versus 31% in the apremilast arm) and reassuring long-term safety outcomes. However, rates of acne were higher in the zasocitinib arm, while rates of diarrhea were higher in the apremilast control arm. Envudeucitinib was also highlighted as a next-generation oral TYK2 inhibitor with promising phase 2 efficacy and safety results. In addition, ORKA-001, a long-acting IL-23p19 antibody, may provide increased efficacy with a potential dosing frequency of every 6 months to once yearly.

Psoriasis Burden Accumulates Over Time

Potential negative impact of psoriasis over the life path[1–4]



BSA, body surface area; CLCI, cumulative life course impairment; PASI, Psoriasis Area and Severity Index; PsA, psoriatic arthritis.

1. Pariente B, et al. *Inflamm Bowel Dis*. 2011;17(6):1415–22; 2. Kimball AB, et al. *J Eur Acad Dermatol Venereol*. 2010;24(9):989–1004; 3. Ros S, et al. *Actas Dermosifiliogr*. 2014;105(2):128–34; 4. Linder MI *Derm Venereol*. 2016;96(217):102–8.

Despite these advances, several controversies remain in psoriasis care. One key question is whether early and aggressive treatment can prevent the development of PsA. An estimated one-third of patients develop joint involvement over time. Risk factors for PsA include nail disease, scalp involvement, arthralgia, higher BMI, and family history of arthritis. Observational data from the CorEvitas database suggest that patients who achieved a BSA of ≤1% within 15 months of starting biologic therapy had a 28% lower risk of psoriatic arthritis. In addition, a population-based cohort study found that IL-23 inhibitor use was associated with a lower risk of PsA compared to both IL-12/23 inhibition (HR 0.57) and IL-17 inhibition (HR 0.50). Additionally, IL-23 and IL-17 inhibition resulted in a greater risk reduction in PsA when compared to TNF-α inhibitors. However, findings across studies are inconsistent, with some studies not finding a link between biologic therapy and PsA-free survival. Patient selection plays a role with retrospective data, as patients with concomitant PsA or those at risk of developing PsA are more likely to be prescribed TNFa or IL-17 inhibitors compared with IL-12/23 or IL-23 inhibitors.

To apply the latest research clinically, Dr. Lovegrove advocated for aiming for clear or almost clear skin, initiating effective systemic therapy early when appropriate, and recognizing high-risk features for PsA development, including nail disease, obesity, and arthralgia. She also encouraged her colleagues to address comorbidities by ensuring that GPs and other specialists in the patient's circle of care are aware of the larger implications of psoriasis as a systemic inflammatory disease.

Novel Topicals (nonsteroidal): New Paradigms in Assessment and Management

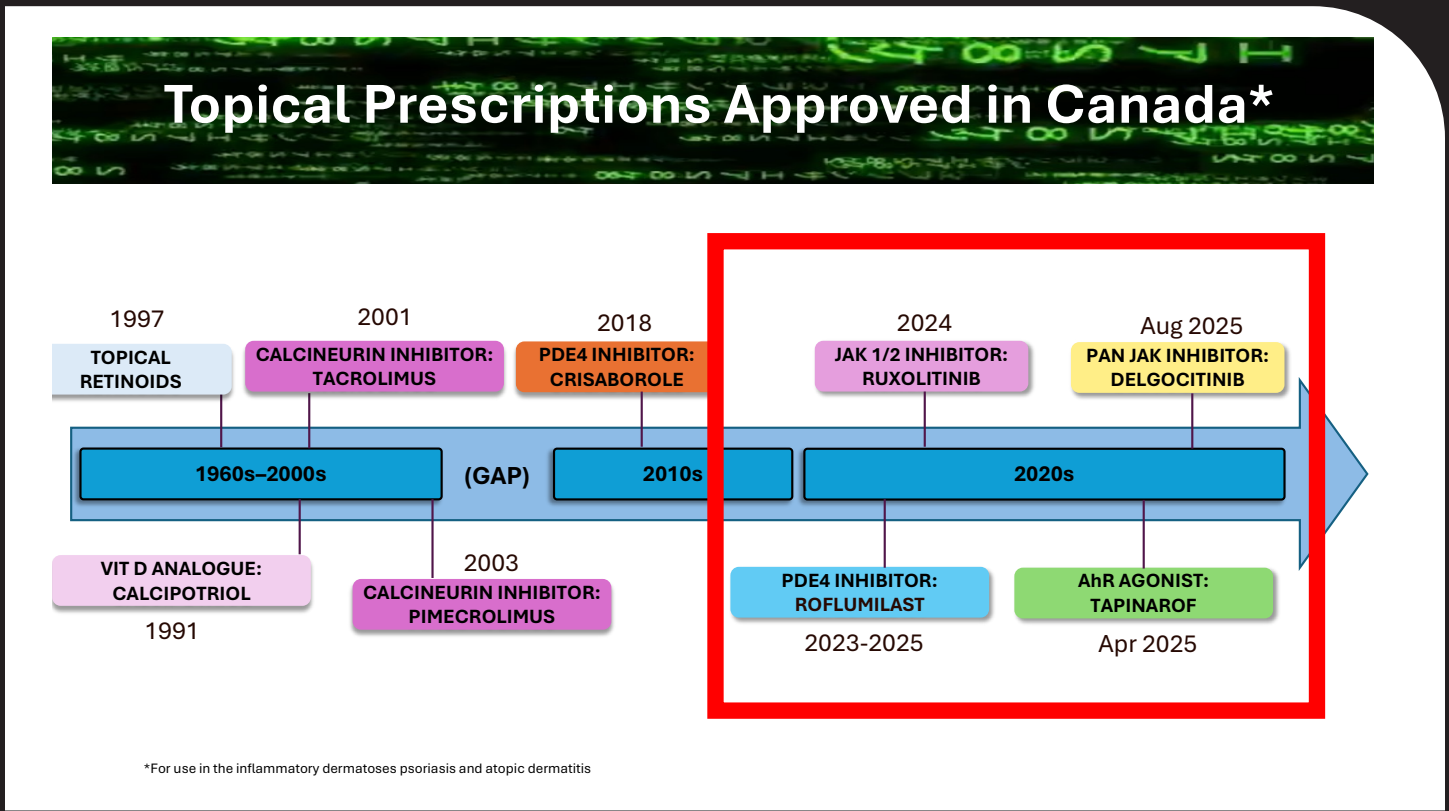
DR. KIM BLAKELY

Dr. Blakely opened with a familiar clinical scenario: patients arriving with a "bag of creams," reflecting patient confusion and poor guidance in topical prescribing.

Topical corticosteroids remain effective, accessible, and inexpensive, but are associated with AEs such as skin atrophy, telangiectasia, and striae, as well as growing concerns around topical steroid withdrawal. Topical calcineurin inhibitors offer steroid-sparing benefits and flexibility across sensitive body areas, but are less effective in more severe disease and are often poorly tolerated, with burning and stinging occurring more frequently in real-world use than initially reported in clinical trials.

Dr. Blakely emphasized that recent years have seen a significant expansion in the topical therapeutic landscape, with multiple new agents offering novel mechanisms of action, improved tolerability, and simplified regimens. Tapinarof, an AhR agonist, was approved in Canada in 2025 for adult psoriasis. In the phase 3 PSOARING 1 and 2 trials, patients with mild to severe psoriasis (mean BSA approximately 8%) were randomized 2:1 to tapinarof or vehicle. At week 12, 35% to 40% of patients achieved the primary endpoint of clear or almost clear skin with at least a 2-grade PGA improvement, compared to 6% with vehicle. In the PSOARING 3 extension study, patients achieving clearance were able to remain off therapy for an average of 115 to 130 days before disease flare (≥ PGA 2), suggesting a potential remittive effect.

Roflumilast, a topical PDE4 inhibitor, has also demonstrated strong efficacy across psoriasis and atopic dermatitis. In the DERMIS 1 and 2 trials



in psoriasis, up to 42% of patients in the roflumilast 0.15% arm achieved IGA success at week 8, with significant improvements seen as early as 4 weeks. In atopic dermatitis, the INTEGUMENT trials showed that approximately 30% of patients achieved vIGA success at week 4, with statistically significant improvements evident within 1 week. Notably, itch reduction was rapid, with measurable improvement within 24 hours. Long-term extension data showed that once-daily treatment followed by twice-weekly maintenance dosing could sustain disease control for an average of 281 days in patients aged 6 and older. Roflumilast 0.05% cream, under investigation, has demonstrated long-term disease control of approximately 238 days in children aged 2 to 5.

Ruxolitinib cream, a topical JAK1/2 inhibitor approved in Canada in 2024, has demonstrated robust efficacy in atopic dermatitis. In the TRuE-AD1 and TRuE-AD2 trials, significant improvements in IGA, EASI, and itch scores were observed by week 8 in patients treated topical ruxolitinib cream 1.5%. Itch reduction occurred rapidly, with meaningful improvement reported within 15 minutes of application. Patients maintained disease control through 52 weeks without evidence of tachyphylaxis. Dr. Blakely highlighted that ruxolitinib is being assessed for a wide range of conditions, including HS, lichen planus, and seborrheic dermatitis.

Delgocitinib, a pan-JAK inhibitor approved in Canada in 2025 for chronic hand eczema, is another newly approved nonsteroidal topical. In the DELTA 1 and 2 trials, twice-daily application for 16 weeks led to statistically significant improvements in IGA scores, HECSI 75 and 90 scores, and quality-of-life measures. Improvements in itch and pain were observed as early as 2 weeks. In a head-to-head trial, delgocitinib demonstrated superior efficacy to oral alitretinoin at 24 weeks, suggesting that effective topical therapy may reduce the need for systemic treatment in some patients.

Dr. Blakely concluded by emphasizing a shift in how clinicians approach topical therapy. Rather than reactive, episodic treatment, the focus is now on strategic, long-term disease control, with the potential for disease modification. Simplified regimens and improved tolerability allow clinicians to move away from complex, multi-product prescribing toward more streamlined, patient-centred care.

Rethinking Topical Therapy in Modern Dermatology Practice

Sponsored Lunch Symposium: Incyte

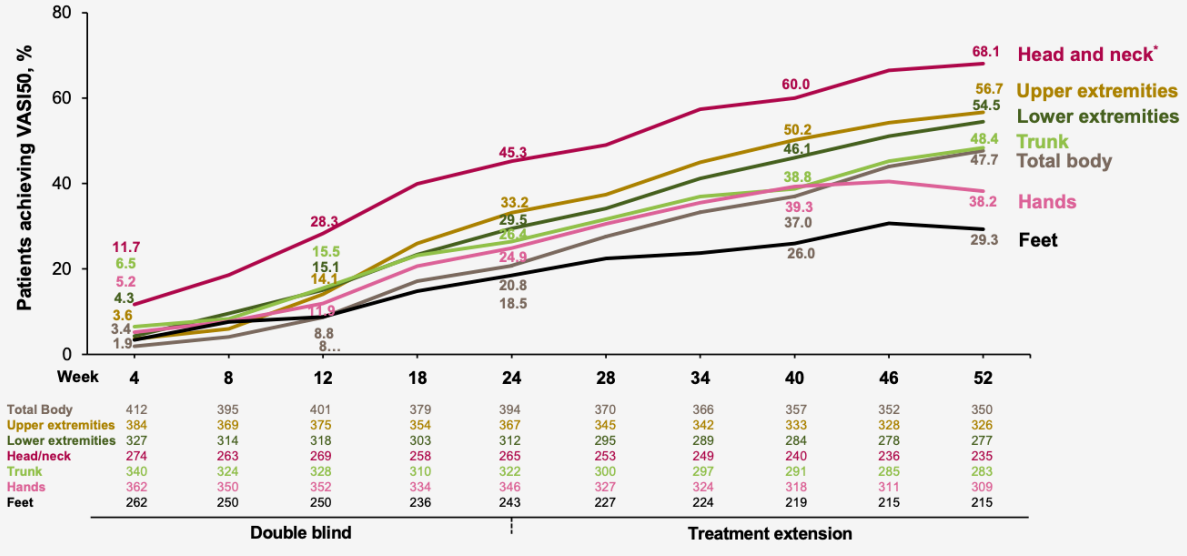
DR. GENEVIEVE GAVIGAN; DR. JESSICA ASGARPOUR; DR. ASHLEY O'TOOLE; DR. VIMAL PRAJAPATI (MODERATOR)

Drs. Gavigan, O'Toole and Asgarpour discussed the evidence for topical ruxolitinib therapy in atopic dermatitis, vitiligo, and HS. Beginning with atopic dermatitis, Dr. Gavigan presented a case of a 12-year-old boy with severe atopic dermatitis occurring with significant itch (NRS: 10/10), sleep disruption, school interference, and impaired quality of life. His treatment history included topical corticosteroids, topical calcineurin inhibitors, roflumilast and phototherapy, due to profound needle phobia. Treatment with topical ruxolitinib 1.5% cream twice daily led to a BSA improvement from 15% at baseline to 5% at 11 weeks, with significant reduction in itch. The patient and family reported high satisfaction.

Dr. Gavigan reviewed data from the TRuE-AD studies in children aged 2 to 11 years, which showed that ruxolitinib cream provides both rapid and sustained efficacy. Patients were randomized to ruxolitinib 1.5%, ruxolitinib 0.75% or vehicle. In each arm, they were instructed to use the cream twice per day until clearance, and then as needed. By week 52, the median time off therapy in the ruxolitinib 1.5% arm was about 50%. BSA involvement improved

Steady increase in VASI50 responses over time across all body regions

TRuE-V1 and TRuE-V2



*Excluding face.
VASI50, ≥50% improvement in Vitiligo Area Scoring Index
Passeron T, et al. Journal of the European Academy of Dermatology and Venereology. 2025;39(3):e251-e254.

DR. GENEVIEVE GAVIGAN; DR. JESSICA ASGARPOUR; DR. ASHLEY O'TOOLE; DR. VIMAL PRAJAPATI (MODERATOR)

rapidly and remained stable or continued to improve over time.

A meta-analysis showed ruxolitinib 1.5% cream was about twice as likely as roflumilast 0.15% to result in EASI 75 at week 4 (Gupta et al, 2025). Long-term safety data of ruxolitinib 1.5% cream are reassuring for children 2 to 17 years old, with exposure-adjusted incidence rates consistent with rates observed in adults and adolescents. There were two serious infections (mycoplasma pneumonia and eczema herpetica) and no observed major cardiovascular events, non-melanoma skin cancers and other malignancies or thromboembolic events.

Dr. O'Toole discussed the use of topical ruxolitinib for vitiligo. She described a 14-year-old patient with a 10-year history of vitiligo that involved significant psychosocial impact, including bullying. The patient had previously tried topical calcineurin inhibitors with little improvement. Noting that delayed diagnosis or ineffective treatment can lead to disease progression, stigma, and increased risk of anxiety and depression, Dr. O'Toole reviewed the TRuE-V1 and TRuE-V2 studies, assessing twice-daily topical ruxolitinib 1.5% in patients aged 12 and older with limited BSA involvement. At 24 weeks, approximately 32% of patients achieved F-VASI75, which increased to about 50% at 1 year. Disease duration didn't seem to negatively affect response rates. A long-term extension study demonstrated efficacy continues to improve, with 70% of patients achieving F-VASI75 at 2 years. Dr. O'Toole noted that facial areas respond best, while hands and feet had the slowest rates of response. She emphasized setting expectations, encouraging long-term treatment, and combining ruxolitinib cream with phototherapy to optimize outcomes. Treatment-related AEs included low rates of acne and pruritus (4% to 5%).

Moving to HS, Dr. Asgarpour highlighted the significant unmet need given the absence of Health Canada-approved topical therapies for this condition. Phase 2 trial data evaluated ruxolitinib 1.5% cream applied twice daily in adults with HS. The study population was diverse, with over 50% of participants in the vehicle arm identifying as Black. Baseline disease severity was moderate, with an average abscess and nodule count of approximately 5.

At week 16, there was a greater mean reduction in abscess and nodule count with ruxolitinib compared to vehicle (-3.61 versus -2.42). Clinical response rates were impressive, with 79.2% of patients achieving HiSCR50 at week 16 in the treatment arm. The treatment was well tolerated, with no new safety signals in comparison to the atopic dermatitis and vitiligo trials.

Innovation in Psoriasis Care: Novel Non-Steroidal Topical Therapies

Sponsored Lunch Symposium: Organon

DR. FIONA LOVEGROVE; DR. ANDREW FERRIER; DR. VIMAL PRAJAPATI (MODERATOR)

Dr. Ferrier began by contextualizing that two-thirds of patients with psoriasis have mild disease (BSA <3%), and largely rely on topical management. Traditional options such as corticosteroids and calcineurin inhibitors are effective but are limited by tolerability and safety concerns as well as complexity of use.

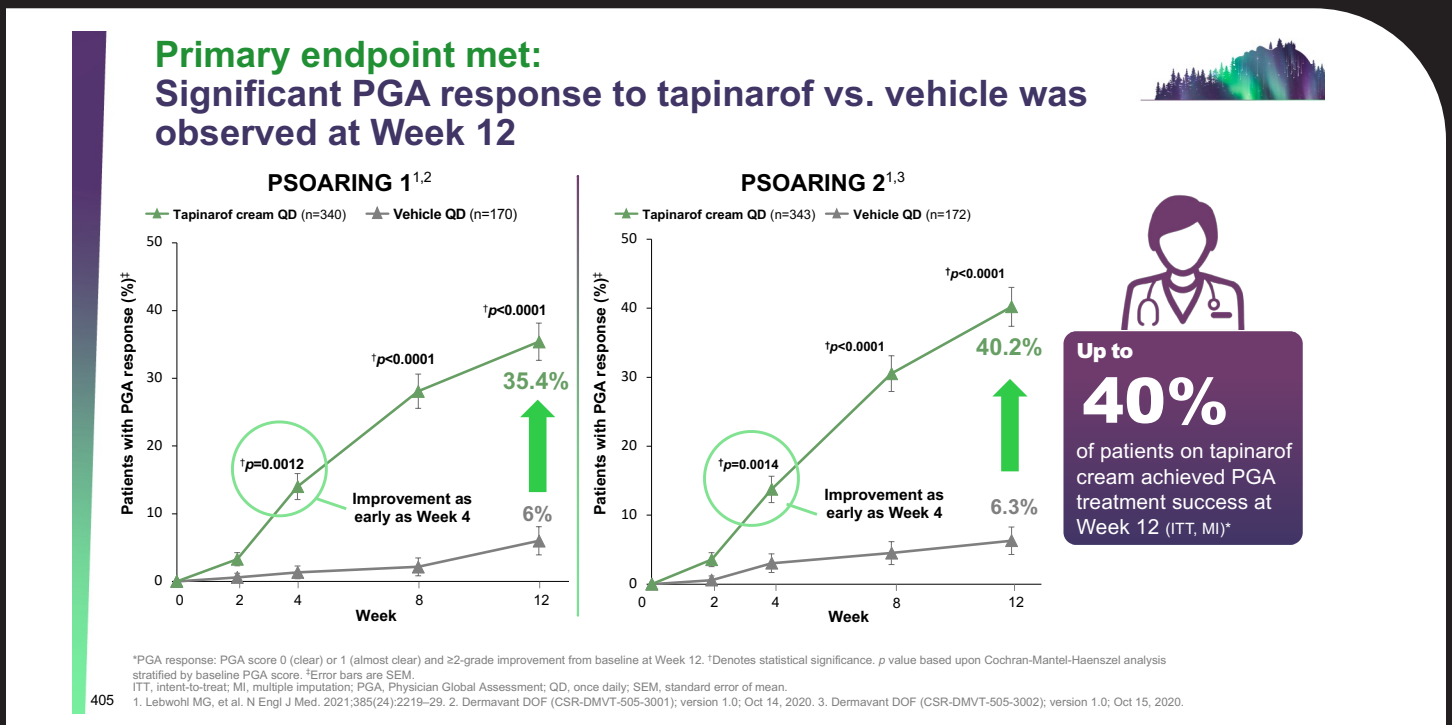
Reviewing the unique mechanism of tapinarof, Dr. Ferrier explained that tapinarof modulates inflammatory pathways by reducing Th17 cytokines, increasing antioxidant activity, and enhancing expression of structural skin proteins such as filaggrin, loricrin, and involucrin.

These multiple effects on AhR-mediated gene expression reduce inflammation and oxidative stress while supporting skin barrier homeostasis.

Dr. Lovegrove described the clinical efficacy and safety of tapinarof, including robust skin clearance and itch reduction results.

Dr. Lovegrove then compared the efficacy and safety of tapinarof with roflumilast, evaluated in the DERMIS 1 and 2 trials. Both agents showed comparable efficacy and excellent tolerability, with minimal irritation even in sensitive areas. Tapinarof was associated with mild follicular reactions, while roflumilast had very low rates of systemic side effects, including diarrhea.

In addition, both roflumilast and tapinarof demonstrated strong performance in sensitive sites in pivotal trials. Tapinarof achieved clear or almost clear skin in approximately 83% of patients with intertriginous psoriasis and 88.5% of patients with



*PGA response: PGA score 0 (clear) or 1 (almost clear) and ≥2-grade improvement from baseline at Week 12. †Denotes statistical significance. *p* value based upon Cochran-Mantel-Haenszel analysis stratified by baseline PGA score. ‡Error bars are SEM.
ITT, intent-to-treat; MI, multiple imputation; PGA, Physician Global Assessment; QD, once daily; SEM, standard error of mean.
1. Lebwohl MG, et al. N Engl J Med. 2021;385(24):2219–29. 2. Dermavant DOF (CSR-DMVT-505-3001); version 1.0; Oct 14, 2020. 3. Dermavant DOF (CSR-DMVT-505-3002); version 1.0; Oct 15, 2020.

DR. FIONA LOVEGROVE; DR. ANDREW FERRIER; DR. VIMAL PRAJAPATI (MODERATOR)

head, neck, and scalp plaque psoriasis. Roflumilast demonstrated efficacy across intertriginous, facial, and scalp regions, with I-IGA success rates ranging from 68 to 71% in the DERMIS-1 and DERMIS-2 trials, versus 14% to 18.5% in the vehicle arm.

Dr. Lovegrove also highlighted the potential for remission off therapy. In a long-term extension study, patients who achieved complete clearance with tapinarof were able to remain off therapy for a median of approximately 4 months before relapse.

Providing advice on counselling patients about novel non-steroidal topicals, Dr. Lovegrove recommended explaining that the therapies are effective for mild-to-severe plaque psoriasis and can be used on any part of the body, but that it is important to complete a full course of treatment before evaluating response. Setting expectations regarding speed of onset is especially important for patients with corticosteroid experience.

Dr. Lovegrove noted that it is reasonable to counsel patients that if they achieve clearance on tapinarof cream, they may be able to stop using the topical for several months and only resume if lesions return. She recommended advising patients to temporarily hold tapinarof therapy if acne-like bumps occur. Based on the evidence, she also recommended advising patients on roflumilast that if they experience gastrointestinal effects, these side effects will usually resolve on their own.

2026 Canadian Dermatology Today Rising Stars in Dermatology Symposium

Atopic Dermatitis: New Paradigms in Assessment and Management

DR. SOPHIA COLANTONIO

Dr. Colantonio began by presenting the AAD's guidelines for moderate-to-severe atopic dermatitis, noting they strongly favor biologics and JAK inhibitors and conditionally recommend conventional systemic agents such as methotrexate, azathioprine, and cyclosporine. Systemic corticosteroids are no longer supported. In contrast, AAAAI/ACAAI 2023 guidelines strongly favour biologics but conditionally favour JAK inhibitors, reflecting differences in prescribing comfort across specialties.

She emphasized that atopic dermatitis is characterized by immune dysregulation, skin barrier dysfunction, and an altered microbiome. The disease disproportionately affects youth, people of colour, and Indigenous people in Canada. When overactive, the type 2 inflammatory response causes atopic dermatitis, prurigo nodularis, allergic rhinitis, asthma, CRSwNP, eosinophilic esophagitis and food allergy. Key cytokines involved are IL-4, IL-5, IL-13, and IL-31, many of which are the targets of advanced biologics.

Dr. Colantonio discussed the clinical data for roflumilast 0.15% cream, noting the strength for atopic dermatitis is lower than that indicated for psoriasis (0.3%), due to the younger age groups and higher BSA involvement seen in atopic dermatitis. Approximately 30% of patients achieved vIGA-AD success at week 4 in the INTEGUMENT-1 and -2 trials. Dr. Colantonio noted that ruxolitinib cream showed even greater efficacy in atopic dermatitis, with around 71% improvement in EASI scores compared to baseline, along with rapid itch relief. Dr. Colantonio explained she doesn't counsel patients about side effects for either topical, as both agents are well tolerated, with rare and minimal systemic AEs.

Practical Pearls

	Mild	Mild-to-Moderate	Moderate-to-Severe
Maintenance Treatment	**Basic Management** • Frequent and liberal emollient use • Daily warm bath/shower with fragrance-free soap or soapless cleanser • Avoid known allergens and common irritants • Treat comorbidities	**Basic Management PLUS:** Lower strength TCS or TCI, PDE4i*, JAKi* up to 2x/daily **If localized recurrence: Proactive application of topical therapies to flare prone areas:** • Medium potency TCS: 2-3x/week (lower strength for face, groin) • TCI: 2-3x/week	**Basic Management PLUS and:** **Biologics:** • Dupilumab**, tralokinumab, lebrikizumab, nemolizumab **Oral JAK inhibitors:** • Upadacitinib, abrocitinib, baricitinib (not FDA approved) **Systemic immunosuppression:** • Cyclosporine, methotrexate, mycophenolate mofetil, azathioprine **Phototherapy** **Wet wrap therapy**
Flare Treatment	Apply medium-to-high potency TCS 1-2x/day, continue for 3-7 days beyond skin clearance Consider as adjunct: • TCI, PDE4i*, JAKi*, tapinarof	Apply medium-to-high potency TCS 1-2x/day, continue for 3-7 days beyond skin clearance Consider as adjunct: • TCI, PDE4i*, JAKi*, tapinarof	

If flare is not resolving in 7 days, consider:

- Challenges with adherence
- Superimposed infection
- Misdiagnosis
- Contact allergy to medication
- Environmental triggers

* PDE4i = PDE4 inhibitor; JAKi = JAK inhibitor
**First-line for systemic therapy

DR. SOPHIA COLANTONIO

Dr. Colantonio also introduced nemolizumab, a newly approved IL-31 inhibitor. In the ARCADIA-1 and -2 trials, approximately 50% of nemolizumab patients achieved EASI-75 at week 16 versus 16% of placebo patients. The medication was well tolerated; low rates of headache can be managed with over-the-counter pain relievers and arthralgia, urticaria, and myalgia were uncommon.
Dr. Colantonio suggested that there is an important role for nemolizumab for patients who have failed dupilumab or other biologics.

Beyond skin symptoms, Dr. Colantonio underscored the systemic nature of atopic dermatitis, including associations with inflammatory diseases like asthma (with increased severity of atopic dermatitis associated with a higher risk of developing asthma), cardiovascular disease, mood disorders, and reduced bone mineral density. Dr. Colantonio emphasized the concept of cumulative life course impairment, illustrating how delayed or inadequate treatment can affect education, relationships, overall health, and career opportunities. The LIBERTY AD pediatric long-term extension study found that 29% of children with severe atopic dermatitis treated with dupilumab for at least 52 weeks achieved clinical remission, which may reduce progression of atopic comorbidities. A meta-analysis (Geba et al., 2023) showed that dupilumab treatment reduced the risk of new/worsening allergies by 34%.

Addressing topical steroid hesitancy and concerns about topical steroid withdrawal, Dr. Colantonio explained that the condition is rare, and is associated with long-term, inappropriate use of high-potency topical corticosteroids, mainly on the face. She stressed that discussing the condition with patients if they raise it, rather than dismissing it, builds trust. Dr. Colantonio reviewed photos showing topical steroid withdrawal signs, and noted that the condition causes burning pain, skin redness, and edema. Offering non-steroidal alternatives, when appropriate, can address patient fears about topical steroid withdrawal.

Overall, Dr. Colantonio highlighted a paradigm shift toward earlier, more targeted, and patient-centered care, supported by a rapidly expanding range of safe and effective therapies.

Urticaria: New Paradigms in Assessment and Management

DR. STÉPHANIE TURMEL

Dr. Turmel provided a comprehensive overview of CSU, describing its pathophysiology, as well as diagnosis, treatment approaches and investigational therapies. CSU is defined as urticaria persisting for more than 6 weeks without an identifiable trigger. It accounts for 80% to 90% of chronic urticaria cases.

There are two major endotypes of CSU. Type I (autoallergic) CSU presents in about 58% of patients and is characterized by high serum IgE levels. Type IIb (autoimmune) CSU accounts for approximately 8% of cases and is more common in females. The latter is driven by IgG or IgM autoantibodies, and presents with lower serum IgE levels, low eosinophil and basophil counts and high anti-TPO antibodies.

Assessment tools are essential for monitoring disease activity and control. While the UAS7 remains widely used, the UCT offers a practical alternative for the busy clinic setting. Dr. Turmel also highlighted the CRUSE app, a digital health app that can facilitate real-world tracking of symptoms and quality of life.

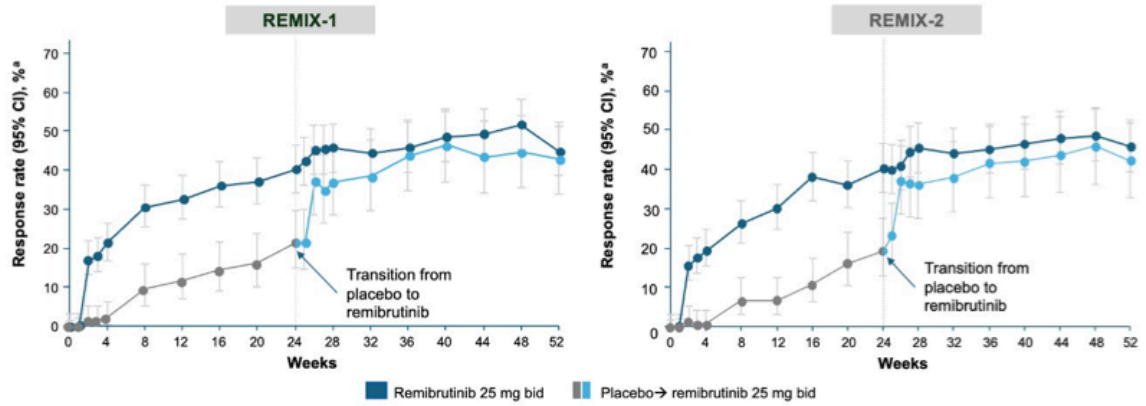
Dr. Turmel emphasized a streamlined diagnostic approach based on updated European Academy of Allergy and Clinical Immunology guidelines. Routine investigations should be limited to a differential blood count and CRP and/or ESR and specialist testing of total IgE and anti-TPO antibodies. Further diagnostic measures should be guided by patient history and examination.

Common exacerbating factors include NSAIDs, which worsen symptoms in up to 25% of patients, as well as stress, which worsens CSU in approximately one-third of patients. Dr. Turmel emphasized that physicians should routinely ask about NSAID use and stress, and encourage stress reduction strategies. Food allergy is rarely a cause of CSU, though non-allergic food reactions may contribute to CSU in some cases. Dr. Turmel recommended short diagnostic diets of 2 to 3 weeks if food intolerance or allergy is suspected.

The international CSU treatment algorithm follows a stepwise approach aimed at complete symptom control. First-line therapy is second-generation antihistamines, with dose escalation up to fourfold above the standard dose if needed.

BTK INHIBITOR · REMIBRUTINIB · PHASE 3 RESULTS

Complete responses (UAS7=0) with remibrutinib: observed early, sustained to week 52



Real-world data (Bernstein et al., 2025) suggest that approximately 74% of patients require updosing, yet only 16% achieve complete control after updosing, supporting escalation to second-line therapy after 2 to 4 weeks. In patients who respond inadequately, biologics such as omalizumab, as well as newer agents including dupilumab and remibrutinib, can be initiated as an add-on therapy to antihistamines. Once complete control is achieved, antihistamines can be stopped abruptly or tapered. Cyclosporine is a conditionally supported a third-line or adjunctive option. Topical corticosteroids are not effective in CSU, and systemic corticosteroids are reserved for short-term use only (10 days maximum) while depot formulations should be avoided.

Omalizumab achieves complete control in up to 60% of patients, with responses typically occurring within 1 to 4 weeks in approximately 65% of patients. Approximately 15% to 20% of patients are slow responders, who gradually improve over 3 to 6 months and 5% to 10% are non-responders. Dr. Turmel recommended considering updosing when there is no response following 3 injections or partial response after 6 weeks. Those with a higher BMI, lower IgE, lower UCT, older age, and prior cyclosporine use are more likely to require updosing.

Dupilumab, targeting IL-4 and IL-13 pathways, has demonstrated complete responses in approximately 30% of patients at 24 weeks. The treatment may be particularly useful in patients with type 2 comorbidities such as asthma, CRSwNP, or atopic dermatitis. Patients with type IIb disease tend to have a reduced response to omalizumab, and respond better to dupilumab, remibrutinib, or cyclosporine A.

Emerging therapies are further expanding options. Remibrutinib, an oral BTK inhibitor, has shown rapid and sustained improvements in urticaria activity scores, with complete responses in approximately half of patients by 1 year. Nasopharyngitis, headache, and petechiae were common side effects, occurring in approximately 7%, 6%, and 4% of patients respectively. Barzolvolimab, an anti-KIT therapy, is also in development, with early data showing promising efficacy.

Prurigo Nodularis: New Paradigms in Assessment and Management

DR. GEORGE CHRISTODOULOU

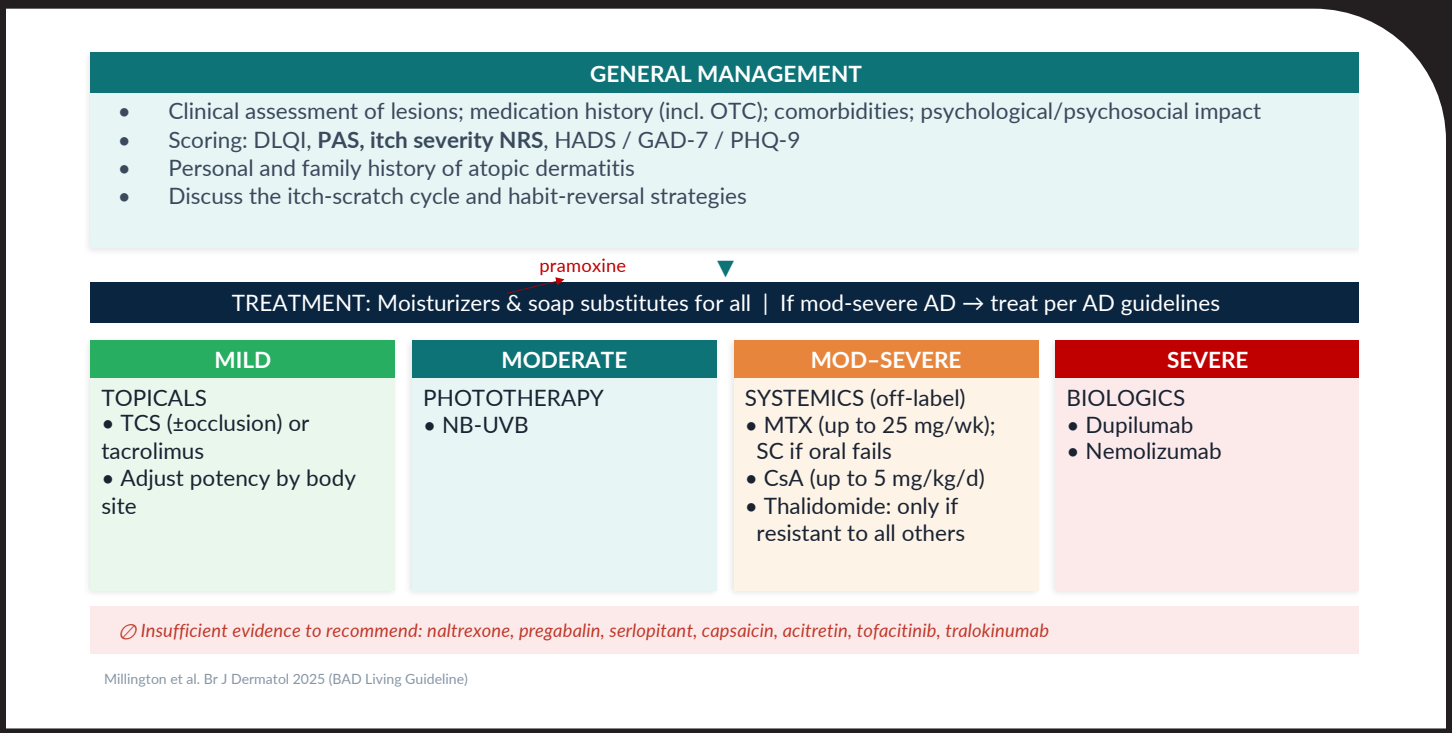
Dr. Christodoulou began by describing the significant disease burden and complex pathophysiology of PN. PN is a chronic inflammatory skin disease with intensely pruritic, hyperkeratotic nodules driven by a persistent itch-scratch cycle. Patients typically present with symmetrically distributed nodules, often sparing areas that patients cannot reach on the upper back ("butterfly sign"). Diagnosis remains clinical, with biopsy rarely required.

Describing the profound burden of disease, Dr. Christodoulou emphasized that patients report a mean itch score approaching 8.7/10, which is higher than scores associated with uremic pruritus, scabies, and atopic dermatitis. Over 80% experience sleep disruption. The psychosocial impact is substantial, with high rates of anxiety, depression, and even suicidal ideation in severe cases.

Atopic conditions commonly co-occur in patients with PN, including atopic dermatitis (occurring in 65% of patients with PN) and allergic rhinitis (present in 70% of patients with PN). Systemic comorbidities include chronic kidney disease, diabetes, viral infections, and, in select cases, underlying malignancy. Clinicians should consider malignancy as a possibility in those with acute-onset pruritus of less than a year.

Dr. Christodoulou explained that evaluation should include complete blood count, liver and renal function tests, medication reviews and targeted testing guided by clinical suspicion (such as glucose testing and HIV or hepatitis B/C screening).

Therapy for mild PN includes topical corticosteroids, often with occlusion, alongside emollients and behavioral strategies to disrupt the itch-scratch cycle. For moderate disease, phototherapy remains underutilized but is highly effective in practice. For moderate to severe disease, systemic methotrexate, cyclosporine, and biologic therapies play a central role. Dr. Christodoulou highlighted that co-therapies that can be added at any stage include topical therapy, neuropathic agents, SSRIs/SNRIs, non-sedating or sedating antihistamines at the lowest effective dose for a short period. Individual lesions can be frozen with liquid nitrogen or injected with intralesional Kenalog. Dr. Christodoulou also recommended self-help resources and patient support groups for patients



with mild distress and cognitive behavioural therapy or psychiatric referral for patients with more severe psychological distress.

Two biologics are currently approved in Canada. Dupilumab demonstrates consistent efficacy across studies. In the LIBERTY-PN trials, approximately 60% of patients achieved WI-NRS reduction of 4 points or greater (versus 19% on placebo) and 46% reached clear or almost clear skin at 24 weeks (versus 17% in the placebo arm). Its efficacy appears independent of atopic status, and no new safety signals were observed in the PN trial, which saw lower rates of conjunctivitis compared to atopic dermatitis trials.

Nemolizumab, targeting the IL-31 receptor, also demonstrated meaningful itch reduction in approximately 60% of patients, with separation from placebo as early as day 2. However, differences in trial design limit direct comparisons with dupilumab. Adverse events included headache in 7% of patients, new or worsening atopic dermatitis in 5.5% of patients and facial edema in 3% of patients.

Dr. Christodoulou cited a review article (Robertson and Rohan, 2026) that suggested nemolizumab may be particularly useful in patients with itch-predominant disease, while dupilumab may be better for patients with extensive, long-standing nodular disease.

Dr. Christodoulou also reviewed emerging therapies, noting that povorcitinib and vixarelimab show promising early efficacy with rapid reductions in itch scores. In closing, Dr. Christodoulou reinforced that PN requires a multimodal, individualized approach, and that screening for comorbidities and considering the need for psychosocial supports are essential.

Vitiligo: New Paradigms in Assessment and Management

DR. JULIEN RINGUET

Dr. Ringuet provided a comprehensive and clinically grounded overview of vitiligo, a condition that affects between 0.5% and 2% of the population across all skin types. He framed vitiligo as a historically undertreated condition, noting that only recently have clinicians gained access to therapies capable of both stabilizing disease and inducing repigmentation.

Vitiligo can be associated with substantial psychosocial burden, with younger age, larger BSA involvement, and Fitzpatrick type IV-VI skin types more likely to experience significant distress. Misconceptions, stigma, and social isolation continue to affect many patients.

Dr. Ringuet highlighted the importance of recognizing disease activity, including the Koebner phenomenon, trichrome lesions, and confetti-like depigmentation. Inflammatory vitiligo is also a rare sign of activity and occurs with lesions that have redness at the borders of lesions and itchiness. Accurate assessment is important, especially as access to advanced therapies increasingly depends on standardized scoring. Tools to assist with calculation include vasi.app and vitiligo-calculator.com.

Therapeutic management requires shared decision-making and careful expectation setting. Dr. Ringuet strongly emphasized the importance of taking photographs at clinical visits to monitor disease progression and treatment response. After confirming the diagnosis, specialists should offer lifestyle management strategies, including specialized cosmetic products for vitiligo, if desired, and the importance of minimizing skin trauma and using sun protection.

Determining a patient's goals is a necessary first step, as patients may prioritize stabilization, repigmentation, or, in very rare cases, depigmentation. Dr. Ringuet stressed that repigmentation is inherently slow, often requiring 8 to 12 months for meaningful results. Early treatment is critical, as active disease can progress rapidly. Dr. Ringuet also recommended explaining to patients that their skin will go through a freckling

1. Bergqvist C et Ezzedine K. *Dermatology.* 2020; 236:571-92. 2. Zhang Y, *et al. Chin Med J* (Engl). 2023;20;136(4):502-504. 3. Photo tirée Feng J, *et al. Ann Dermatol.* 2014;26(1):139-40 (rognée), utilisée en accord avec les dispositions du site https://creativecommons.org/licenses/by-nc-sa/3.0/legalcode. 4. Hann SK, *et al. J Am Acad Dermatol.* 2000 Apr;42(4):589-96. 5. Sosa JJ, Currimbhoy SD, *et al. J Am Acad Dermatol.* 2015;73(2):272-5. 6. Rodrigues M, *et al. J Am Acad Dermatol.* 2017;77:1-13. 7. Ezzedine K, *et al. Pigment Cell Melanoma Res.* 2012;25(3):E1-13.

process as repigmentation occurs. Not everyone responds to repigmentation therapy.

Topical corticosteroids and calcineurin inhibitors remain commonly used first-line options, due to ease of access, though their use is often limited by tolerability and long-term safety concerns. Common approaches to topical corticosteroids include using the therapy on weekends, or using topical corticosteroids for 2 weeks or 2 months, followed by 2 weeks or 2 months off therapy. Tacrolimus can also be used for patients with limited involvement, but it is associated with burning/stinging and not publicly covered in all regions.

Ruxolitinib cream represents a major advance as the only approved treatment for repigmentation, with clinical trial data demonstrating that approximately 50% of patients achieve 75% facial repigmentation at 1 year. On the body, approximately 50% of patients achieve 50% repigmentation. Two-year follow-up data show that outcomes further improve, including in patients with suboptimal early response.

Dr. Ringuet also emphasized the importance of maintenance therapy. Data suggest that approximately 65% of patients maintain repigmentation 1 year after discontinuation of topical ruxolitinib. For those who experienced recurrence, the median time to occurrence was approximately 4 months after therapy. Tacrolimus ointment two times per week reduces the risk of depigmentation.

For patients with large BSA involvement, systemic options remain limited but are evolving. Short-term methotrexate, cyclosporine, or pulse corticosteroids may be used off-label. Oral JAK inhibitors have demonstrated promising results. Approximately 50% of patients taking povorcitinib achieved F-VASI75 at week 52, and approximately 40% of patients achieved T-VASI50 at week 52 (Pandya et al., 2025). Similarly, 45% to 55% of patients taking upadacitinib achieved F-VASI75 at week 48 (Passeron et al., 2026) and mean F-VASI improvement in patients on ritlecitinib was approximately 65% after 48 weeks in a phase 2b trial. (Ezzedine et al., 2023).

Recent data shows that while phototherapy alone yields modest results, when combined with baricitinib (Hu et al., 2024) or ritlecitinib (Yamaguchi et al., 2024), both the speed and magnitude of repigmentation improve substantially, reinforcing the value of multimodal treatment strategies. Looking ahead, Dr. Ringuet highlighted IL-15 as a particularly promising target, given its role in maintaining resident memory T cells. Therapies targeting this pathway may offer the potential for longer-term disease control or modification.

Alopecia Areata: New Paradigms in Assessment and Management

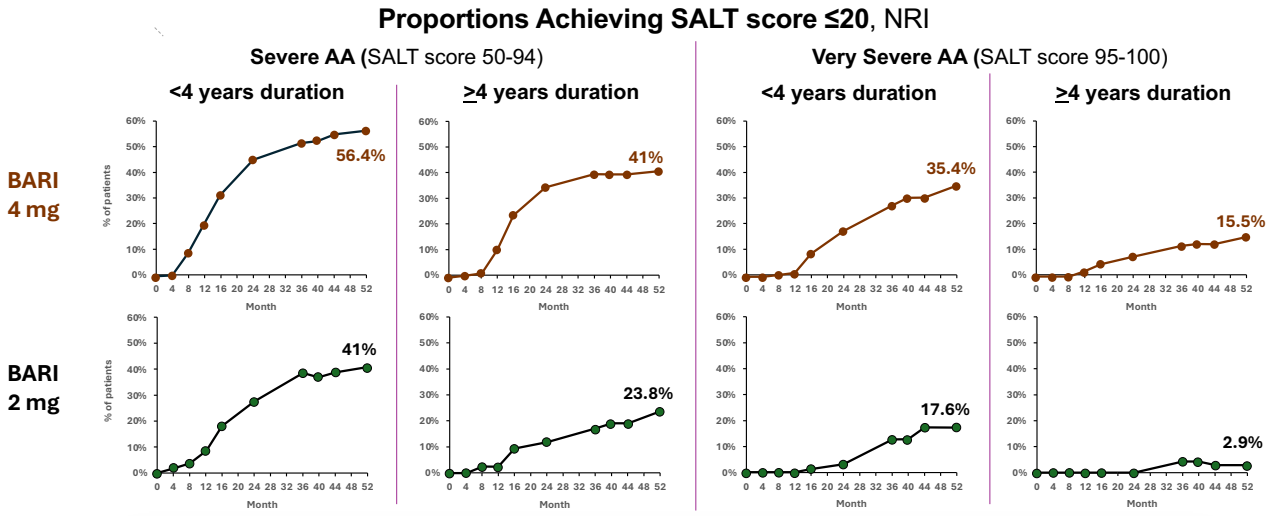
DR. ANASTASIYA MUNTYANU

Alopecia areata is not simply a cosmetic problem. Dr. Muntyanu explained that, for many, hair is a fundamental part of identity. Alopecia areata affects up to 4% of individuals over a lifetime, with 40% of cases occurring before age 20 and an estimated 85% occurring before age 40. Clinical presentations range from patchy hair loss to more extensive forms such as alopecia totalis and alopecia universalis, which occur in approximately 15–25% of patients. Nail involvement is seen in about 30% of patients and is associated with poorer prognosis.

Dr. Muntyanu highlighted the high burden of comorbidities, including autoimmune diseases such as thyroid disease and type 1 diabetes, atopic conditions, dermatologic conditions such as vitiligo and psoriasis, and psychiatric disorders. There are also emerging associations with cardiometabolic disease. The psychosocial impact is substantial, with 62% of patients reporting that major life decisions have been influenced by their disease. Children experience stigma, bullying, and social isolation. Patients affected by the disease are often perceived as being ill or unattractive, and are more likely to experience depression, anxiety, and absenteeism from work. Dr. Muntyanu explained that treatment is not simply about regrowing hair but improving quality of life and restoring the patient's sense of identity.

Diagnosis typically relies on bedside tools such as the hair pull test (considered positive if more than 10% of hairs are extracted) and/or trichoscopy. Routine laboratory investigations are generally unnecessary except to evaluate alternative diagnoses. The SALT score is used to assess severity based on the amount of hair loss. The Alopecia Areata Scale can also be used to account for additional features of severity, including negative

Baseline Characteristics and Treatment Response



The best responders were those with severe AA (SALT score 50-94), shorter duration of the current AA episode, and treated with the higher baricitinib dose

King B, et al. Presented at WCD 2023; Poster #1565.

impact on psychosocial function, eyebrow or eyelash involvement, or rapidly progressing disease.

Management begins with patient education, psychosocial screening, and supportive measures such as camouflage techniques. For limited disease, intralesional Kenalog and topical corticosteroids can be trialled. Dr. Muntyanu explained that systemic corticosteroids are the first-line approach for rapidly progressive disease while JAK inhibitors are the first-line therapy for non-acute disease. A randomized controlled trial published in JAMA in 2023 demonstrated that 20% to 31% of patients prescribed methotrexate and systemic corticosteroids in combination achieved SALT scores below 10 by 6 to 12 months.

Second and third-line therapies include cyclosporine and methotrexate, respectively. Minoxidil can be added as an adjunctive therapy at any stage. Dr. Muntyanu emphasized the importance of counselling patients on the shedding side effect with oral minoxidil, which typically peaks at 1 month and resolves around 3 months post-initiation. Dr. Muntyanu also advised counselling patients on hypertrichosis, edema, and orthostasis, and described mitigation measures.

JAK inhibitors have transformed the treatment landscape for moderate-to-severe alopecia areata. Baricitinib and ritlecitinib are now approved in Canada. The BRAVE-AA trials demonstrated that approximately 34% of patients in the baricitinib 4 mg arms achieved a SALT score <20 by 36 weeks. The ALLEGRO trial of ritlecitinib, in which patients were evaluated at week 24, demonstrated a 23% rate of SALT scores <20. Responses continued to improve beyond 1 year. Shorter disease duration and higher dose predict better outcomes, while patients with more very severe disease (SALT scores of 95 to 100) tend to have lower response rates.

Newer JAK inhibitors under investigation, deuruxolitinib and upadacitinib, demonstrate rapid onset of action and promising efficacy. Dr. Muntyanu also highlighted novel mechanisms of action being investigated. Early-phase data for bempikibart, a monoclonal antibody targeting IL-7Rα, suggest that patients maintain response or continue to improve after treatment discontinuation, raising the possibility of longer-term remission.

Currently, however, alopecia areata requires long-term management, with relapse rates as high as 85%. Clinicians should continue therapy for at least 6 to 12 months after achieving regrowth before considering dose reduction or discontinuation and routine monitoring.

Vaccines in Immune-Mediated Inflammatory Diseases (IMiDs)

DR. MICHELE RAMIEN

Dr. Ramien provided an overview of vaccination in patients receiving biologic and targeted therapies. She emphasized that live vaccines replicate within the host to induce immunity and therefore pose a potential risk in immunosuppressed patients, while inactivated vaccines are generally safe but may not stimulate robust immune responses in patients receiving immunomodulatory therapies. She highlighted that the incubation period of viruses also plays a role, noting that the long incubation time of hepatitis B allows low antibody levels to be protective, while the short incubation time of *Haemophilus influenzae* type b means that low antibody levels are not likely to rise above the protective threshold within the incubation period.

Vaccination is increasingly relevant in dermatology practice, particularly as vaccine-preventable diseases re-emerge and patient populations become increasingly under-vaccinated. When integrating vaccines with targeted therapies, two primary concerns arise: safety and efficacy. Safety considerations include the risk of vaccine-derived infection or disease flare, while efficacy relates to whether patients mount an adequate immune response. Mechanistically, therapies targeting specific immune pathways may impair responses to vaccination, particularly those affecting T-cell or B-cell function.

Dr. Ramien summarized guideline-based recommendations for vaccination timing. Ideally, patients should be brought up to date on vaccinations prior to initiating immunomodulating or immunosuppressive therapy. Inactivated vaccines should be administered 2 weeks prior to starting biologics to ensure an optimal response; live attenuated vaccines should be administered 4 weeks prior to biologic therapy.

During biologic therapy, inactivated vaccines can be administered safely during treatment, though response may be suboptimal. Live vaccines

Relevance to clinical practice

1. **Take a vaccine history as part of your intake.**
2. **Check titres if unsure and know which ones matter.**
3. **Give vaccines to optimize pre-biologic/targeted therapy (we usually need baseline testing and some other treatment to meet criteria anyways).**
4. **Consider optimizing immunizations in all patients with moderate-severe IMIDs of the skin. Starting any systemic therapy is like a gateway to other therapies that might be more immunosuppressive/modulatory.**
5. **Ask about pregnancy and refer moms to special immunization clinics.**

Screening

- ❑ Vaccine history
- ❑ Traveller?
- ❑ Check titres

+MMR +/- HBV
+Varicella

Pre-Tx Vx

- ❑ Zoster ≥12yo
- ❑ HBV
- ❑ Meningococcal
- ❑ MMR-V prn
- ❑ Travel Vx prn

LAVs + ↑response

On-Tx Routine Vx

- ❑ Pneumococcal vaccine
- ❑ Influenza vaccine (sc)
- ❑ COVID-19
- ❑ Tdap

*Do not give any vaccines on rituximab

On-Tx LAVs

Usual:
Stop x2wks → Vx → wait 2-4wks
Dupi/Aprem/Omaliz: Don't stop
Anti-TNFs: Don't stop if benefit>risk
Rituximab: No LAVs for 6-12mo

are not recommended for patients on anti-TNFα medications but booster doses are safe and efficacious. For patients on anti-IL-4/13 medications, anti-IgE medications and PDE4 inhibitors, the consensus recommendations are to provide live vaccines without interrupting therapy. Patients on anti-CD20 medications should receive no inactivated vaccines for 6 to 12 months after their last dose and no live vaccines until B-cell counts are normal and at least 6 months has elapsed since the last dose (Dorscheid et al, 2022; Martire et al, 2022). Babies of mothers on biologics can generally receive all vaccines, except for the Bacillus Calmette-Guérin vaccine (provided in Northern regions of Canada at 1 month of age).

If necessary, treatment should be paused for two to three half-lives prior to vaccination and restarted 2 to 4 weeks afterward to allow adequate immune response. Evolving data suggests that certain live vaccines may be safe in patients on dupilumab, though evidence remains limited.

Dr. Ramien emphasized incorporating vaccination assessment into routine clinical workflows. Early screening for immunization status, proactive planning, and coordination with primary care or specialized immunization clinics can help optimize outcomes. She also highlighted the importance of shared decision-making, balancing disease control with infection prevention, and tailoring strategies based on individual patient risk and community epidemiology.

About the Organizer

Founded in 2009, Catalytic Health is one of Canada's largest medical education agencies and reaches over 50,000 Canadian clinicians a year with its educational programs, services, and platforms.

As the largest independent medical publisher in Canada, our peer-reviewed open access scientific journals are a practical resource for Canadian healthcare practitioners, providing insights based on real-world experience.

Learn more about us at catalytichealth.com

catalytic health

medical minds meet here