#WCD2019

AEDV HIGHLIGHTS

24th World Congress of Dermatology (WCD)

10-15 JUNIO 2019

Milàn

Patrocina:

janssen Immunology
PHARMACEUTICAL COMPANIES OF Johnson&Johnson

Organiza:

ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA
AEDV 1909

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24th World Congress of Dermatology (WCD)

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Milán

Enfermedades sistémicas y autoinmunes

Dra. Almudena Nuño González

Hospital Universitario La Paz. Madrid

Patrocina: Janssen Immunology, Pharmaceutical companies of Johnson & Johnson

Organiza: AEDV Academia Española de Dermatología y Venereología

Topical Jak inhibitors (Dr. Robert Bissonnette)

Treatment for:

- Atopic dermatitis +++++
- Chronic hand dermatitis +++
- Psoriasis ++
- Vitiligo +++
- Alopecia areata?

VITILIGO:

- Ruxolitinib 1,5% cream for vitíligo:
  - More effective on the face than the rest of the body
- Topical JAK inhibitors should be combined with phototherapy (tofacitinib and ruxolitinib)

ALOPECIA AREATA

- Ruxolitinib 1% cream vs tofacitinib 2% vs clobetasol 0,05% vs vehicle
- No more effective tan steroids

Tapiranof (topical AhR agonists) (Dr. Robert Bissonnette)

Aryl hydrocarbon receptor agonist (Tapiranof=benvitimod)

Phase 2 completed in AD and psoriasis

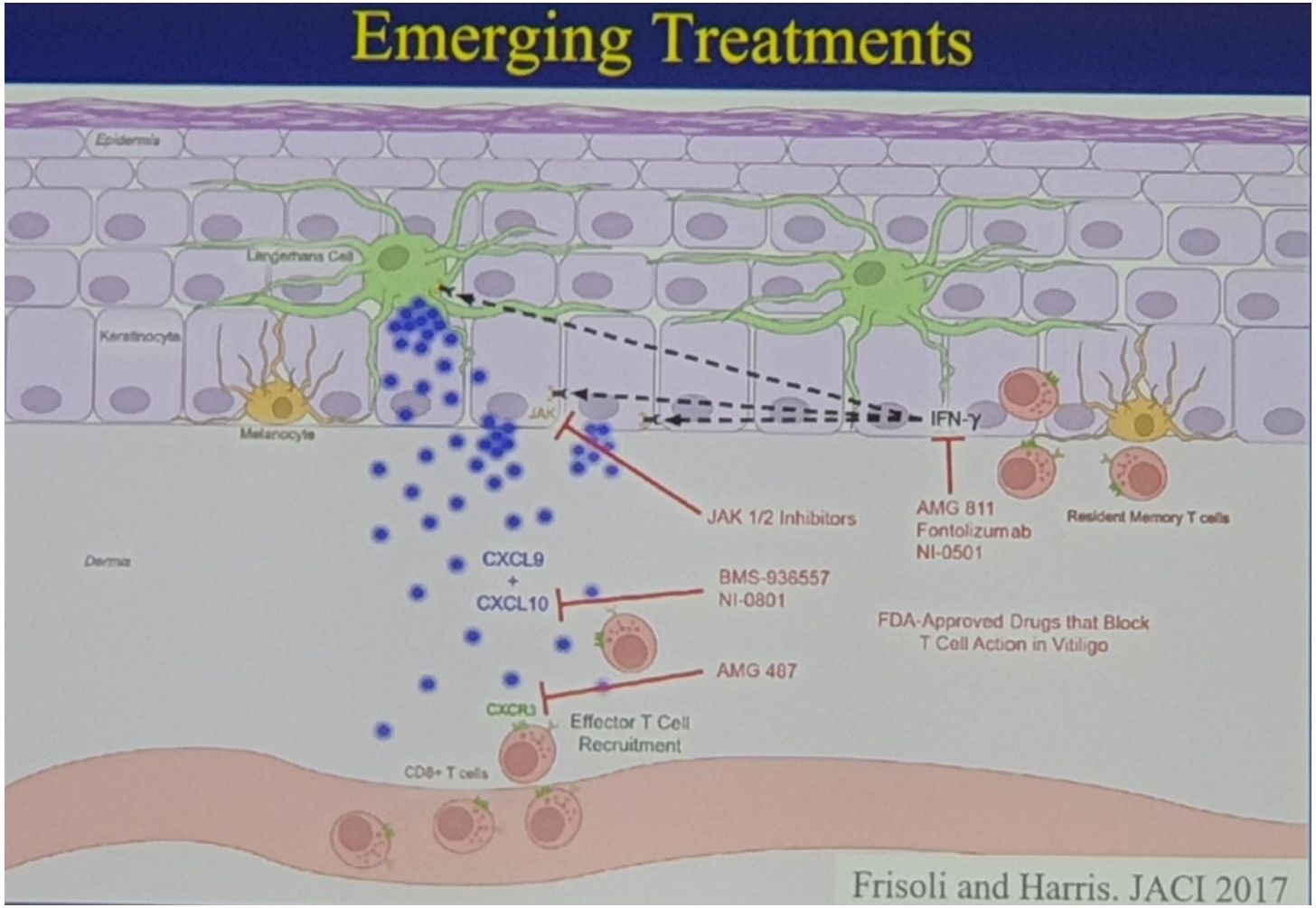
Tapiranof decreases IL-17

Tapiranof adverse events:

- Folliculitis
- Headache
- Application site pruritus, oedema, erythema or pain

Tapiranof controls inflammation but also causes hyperpigmentation: future research as topical drug for vitíligo.

Vitiligo (Dr. John Harris)



Vitiligo (Dr. John Harris)

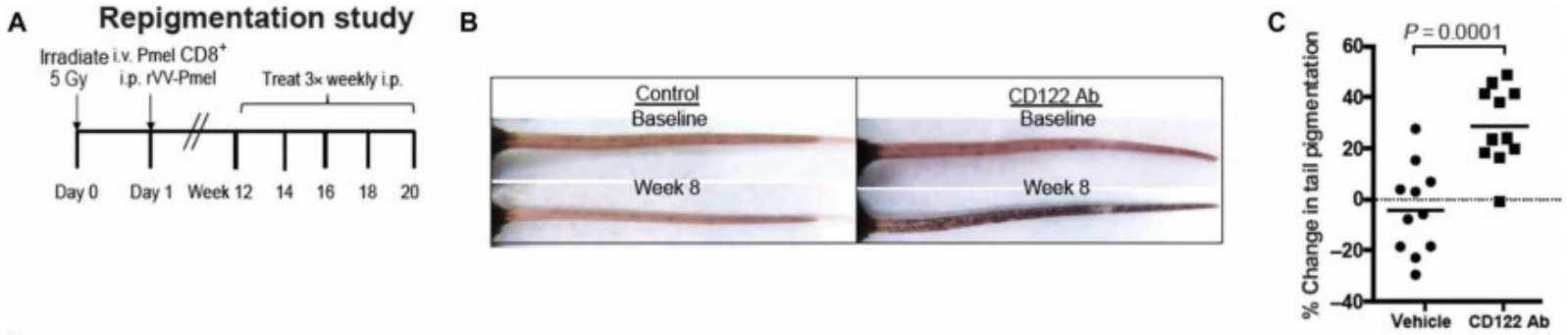
Vitiligo (Dr. John Harris)

SCIENCE TRANSLATIONAL MEDICINE | RESEARCH ARTICLE

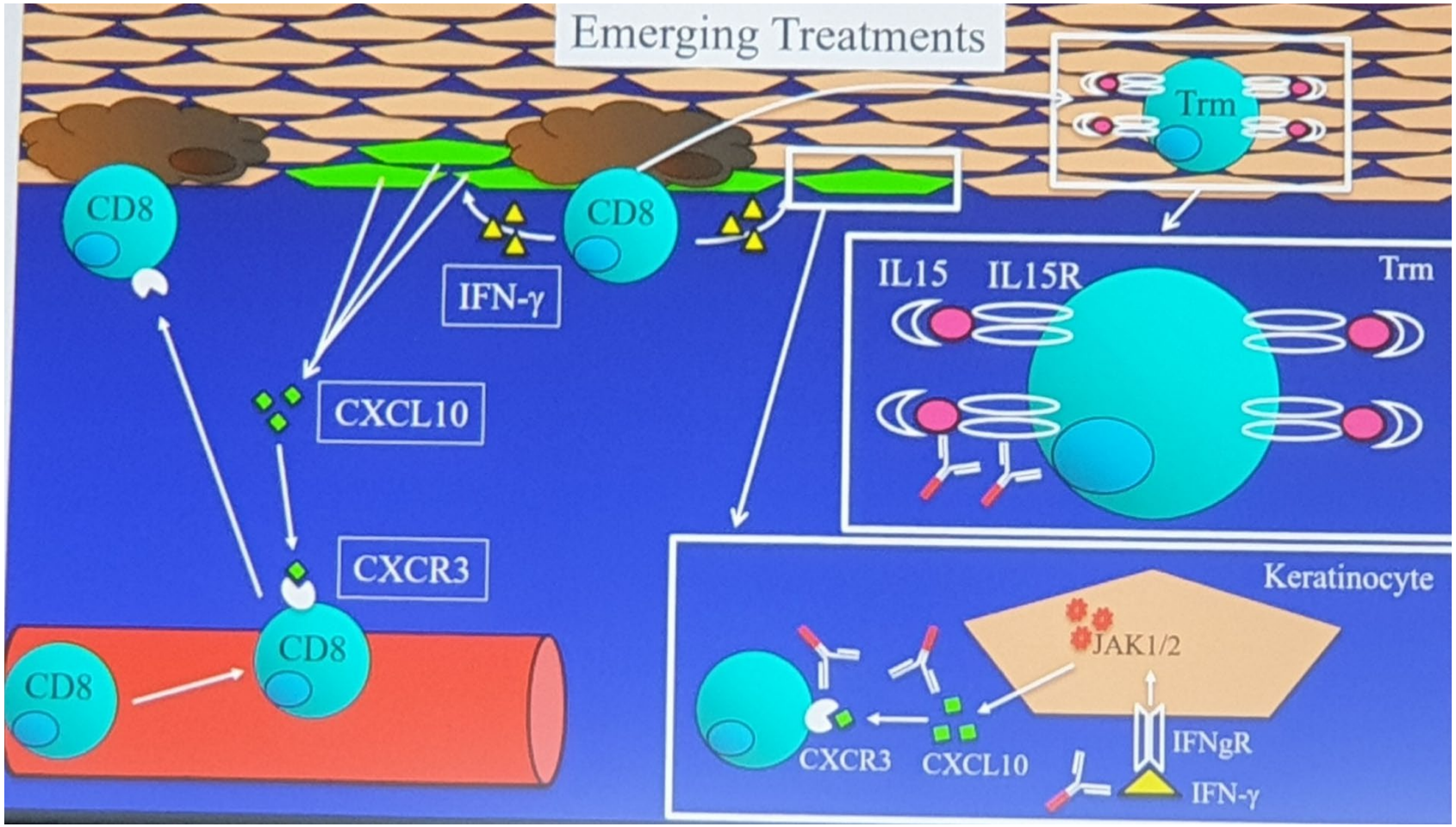
AUTOIMMUNITY

Antibody blockade of IL-15 signaling has the potential to durably reverse vitiligo

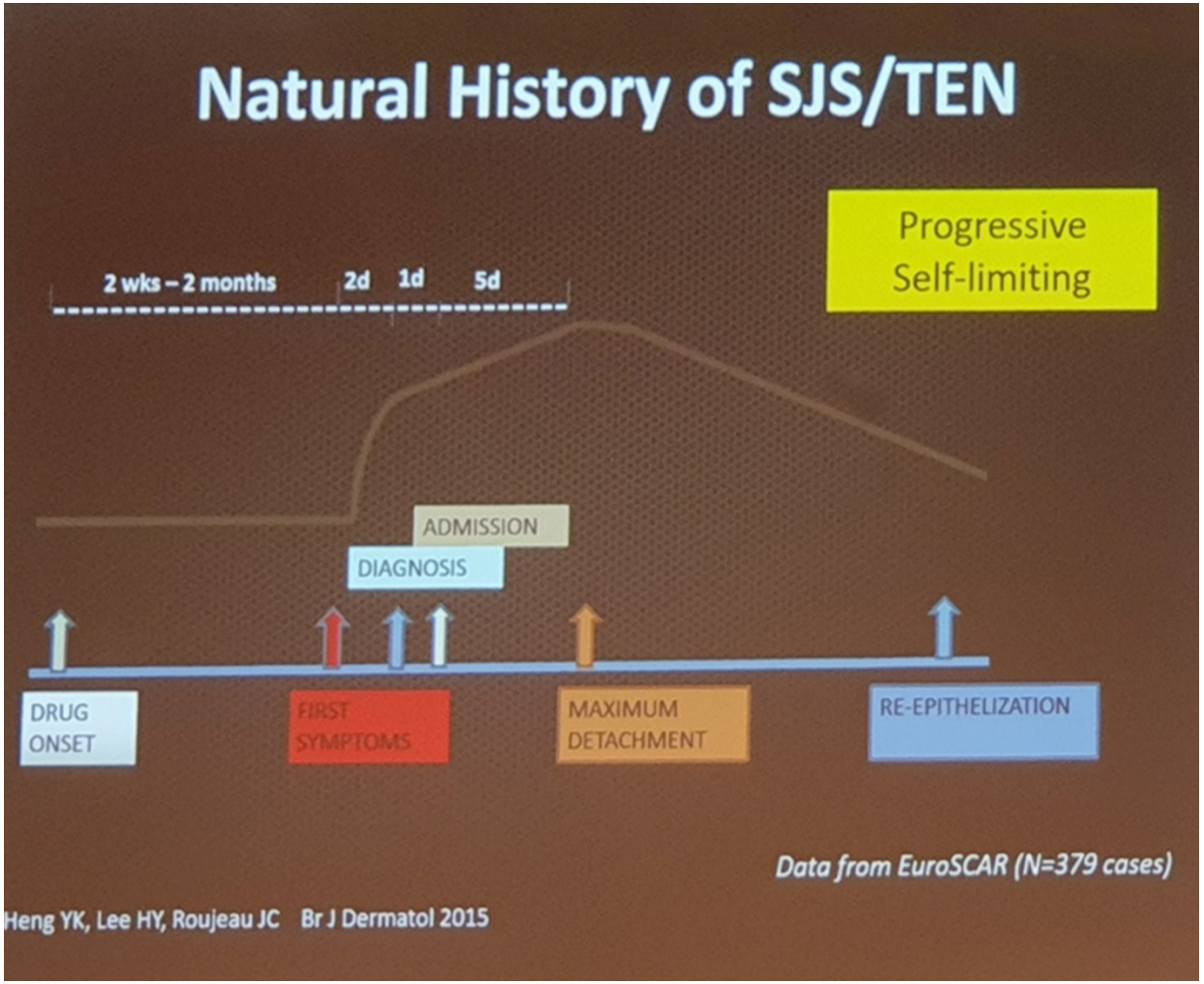
Jillian M. Richmond[1], James P. Strassner[1], Lucio Zapata Jr.[1], Madhuri Garg[1], Rebecca L. Riding[1], Maggi A. Refat[1], Xueli Fan[1], Vincent Azzolino[1], Andrea Tovar-Garza[2], Naoya Tsurushita[3], Amit G. Pandya[2], J. Yun Tso[3], John E. Harris[1]*



Vitiligo (Dr. John Harris)



SSJ- TEN (Dr. Haur Yueh Lee)



SSJ- TEN (Dr. Haur Yueh Lee)

New Evidence Supporting Cyclosporine Efficacy in Epidermal Necrolysis

Jean-Claude Roujeau[1], Maja Mockenhaupt[2], Jean-Claude Guillaume[3] and Jean Revuz[4]

Sixty years after its original description by Sir Alan Lyell, epidermal necrolysis (from Stevens-Johnson syndrome to toxic epidermal necrolysis) seems finally amenable to a specific treatment in addition to essential symptomatic measures in specialized settings. A recently published systematic review and an article by Gonzales-Herrada et al. strongly suggest that cyclosporine is effective in reducing the risk of death.

Journal of Investigative Dermatology (2017) **137,** 2047–2049. doi:10.1016/j.jid.2017.07.828

ORIGINAL ARTICLE

Cyclosporine for Epidermal Necrolysis: Absence of Beneficial Effect in a Retrospective Cohort of 174 Patients—Exposed/Unexposed and Propensity Score-Matched Analyses

Florence Poizeau[1,5], Olivier Gaudin[1,5], Laurence Le Cleach[1,2], Tu-Anh Duong[1], Camille Hua[1], Claire Hotz[1], Saskia Ingen-Housz-Oro[1,2], Emilie Sbidian[1,2], Ouidad Zehou[1], Audrey Colin[1], Nicolas de Prost[3], Bénédicte Lebrun-Vignes[2,4], Olivier Chosidow[1,2], Pierre Wolkenstein[1,2] and Laurence Fardet[1,2]

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SSJ- TEN (Dr. Haur Yueh Lee)

The Journal of Clinical Investigation

CLINICAL MEDICINE

Randomized, controlled trial of TNF-α antagonist in CTL-mediated severe cutaneous adverse reactions

Chuang-Wei Wang,[1,2] Lan-Yan Yang,[3] Chun-Bing Chen,[1] Hsin-Chun Ho,[1,4] Shuen-Iu Hung,[5] Chih-Hsun Yang,[1,4] Chee-Jen Chang,[6,7] Shih-Chi Su,[1,8] Rosaline Chung-Yee Hui,[1,4] See-Wen Chin,[1] Li-Fang Huang,[3] Yang Yu-Wei Lin,[1] Wei-Yang Chang,[3] Wen-Lang Fan,[8] Chin-Yi Yang,[1] Ji-Chen Ho,[4,9] Ya-Ching Chang,[1,4] Chun-Wei Lu,[1,4] Wen-Hung Chung,[1,2,4,8] and the Taiwan Severe Cutaneous Adverse Reaction (TSCAR) Consortium[10]

Table 8. Clinical characteristics as additional risk factors for mortality among patients treated with etanercept or corticosteroids compared with retrospective data on CTL-mediated SCAR patients treated with supportive care

	Supportive care[A] (retrospective data)	Etanercept	Corticosteroid
Age, yr, mean ± SD	56.00 ± 24.65	52.73 ± 16.78, $P = 0.444$	59.84 ± 24.20, $P = 0.503$
Heart rate, /min, mean ± SD	96.81 ± 11.99	95.33 ± 16.52, $P = 0.644$	91.23 ± 13.75, $P = 0.177$
BUN, mg/dl, mean ± SD	24.75 ± 16.31	20.38 ± 18.33, $P = 0.285$	32.33 ± 36.57, $P = 0.197$
$HCO3^-$, mEq/l, mean ± SD	21.38 ± 4.11	23.09 ± 4.25, $P = 0.082$	22.34 ± 3.84, $P = 0.244$
Glucose, mg/dl, mean ± SD	157.06 ± 59.77	137.6 ± 73.59, $P = 0.297$	153.86 ± 78.56, $P = 0.790$
SCORTEN, mean ± SD	1.97 ± 1.29	1.85 ± 1.29, $P = 0.100$	1.95 ± 1.36, $P = 0.209$

[A]Reference group. All *P* values were calculated by Student's *t* test.

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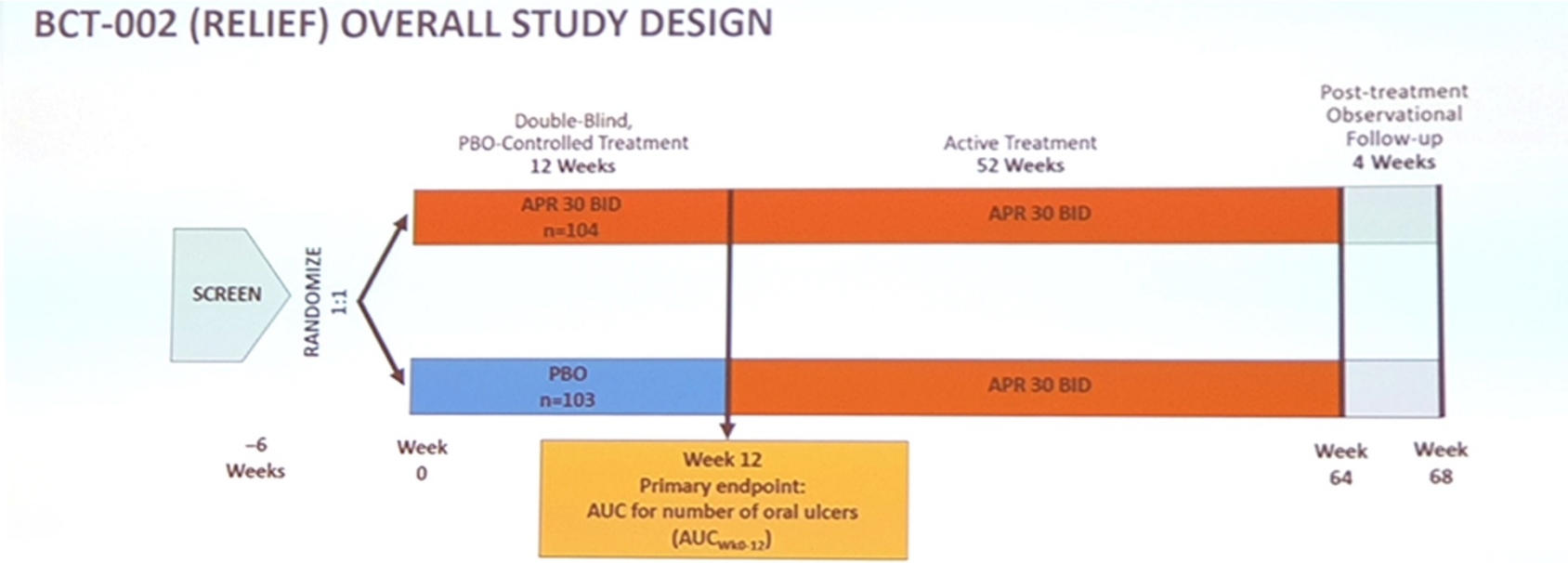
RISK FACTOR FOR SEPSIS IN SJS/ TEN	On admission:	Age
		BSA more tan 10% OR 14,3 (13,4-15,2)
		Haemoglobin less tan 10 g/dl OR 2,4 (2,2-2,6)
		Cardiovascular OR 2,1 (2.0-2.3)
	Parameters that predict positive cultures:	Procalcitonin more tan 1 µgr OR 2,4 (1,1-4,8)
		Hypothermia OR 2,4 (1,1-5,3)
		Negative predictive value of skin cultures.

Apremilast phase III for Behçet disease (Dr. A. Mahr)

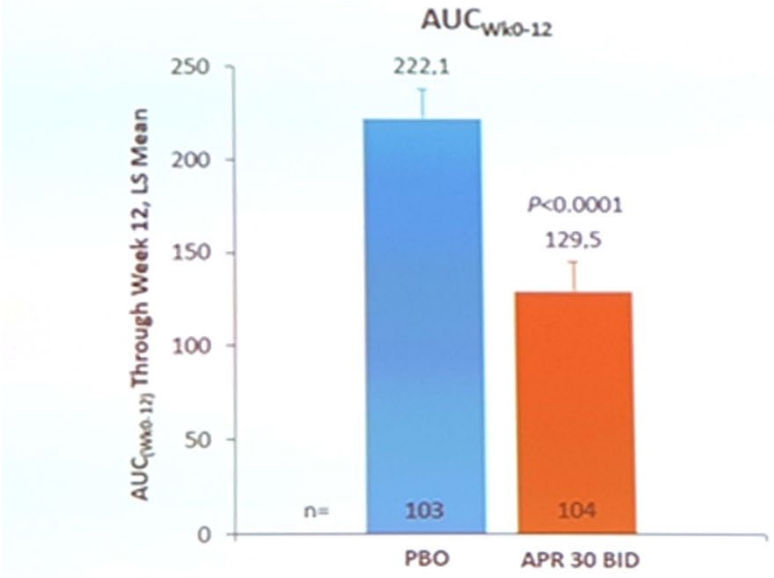


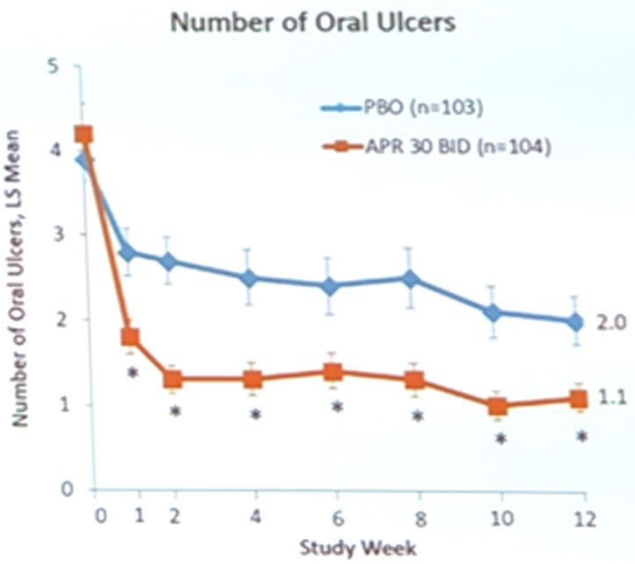
AUC_{Wk0-12}=number of oral ulcers from baseline over 12 weeks.

- Patients were stratified by gender, history of uveitis, and region (Japan and other)
- Dose titration occurred over the first week

Apremilast phase III

PRIMARY ENDPOINT: AUC_{Wk0-12}, AND NUMBER OF ORAL ULCERS (WEEKS 0 TO 12)





ITT population. Error bars represent standard error. Multiple imputation used for imputing missing data.

*$P \leq 0.0015$ vs. PBO (nominal P value).

LS=least-squares; ITT=intent-to-treat.

Improves QoL of patients

Adverse events: diarrhea, nausea, headache, abdominal pain

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