Y-GRAPPA members prepared this Newsletter. It highlights some of the very interesting abstracts on psoriatic disease that will be presented at the 2023 AAD meeting in New Orleans.

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**Contributors**

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TREATMENT

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• Research focus: Nail Psoriasis, Clinical Trials

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Cumulative clinical benefit over 52 weeks comparing initiation with deucravacitinib versus apremilast in patients with moderate to severe plaque psoriasis: a post hoc analysis of POETYK PSO-1 trial results stratified by prior treatment

April W. Armstrong
Poster presentation on Sunday, March 19
Poster ID: 43766

Disclosures: AWA: Research grants and personal fees: Bristol Myers Squibb, Eli Lilly, Janssen, Leo Pharma, and Novartis; Personal fees: Boehringer Ingelheim/Parexel, Celgene, Dermavant, Genentech, GlaxoSmithKline, Menlo Therapeutics, Merck, Modernizing Medicine, Ortho Dermatologics, Pfizer, Regeneron, Sanofi Genzyme, Science 37, Sun Pharma, and Valeant; and Grants: Dermira, Kyowa Hakko Kirin, and UCB, outside the submitted work, SHP, VP, PN, and MIC: Employees of and shareholders in Bristol Myers Squibb W-JW and VC: Employees of OPEN Health Evidence & Access, which received funding from Bristol Myers Squibb

POETYK PSO-1 evaluated the safety and efficacy of deucravacitinib compared with placebo and apremilast in adults with moderate-to-severe plaque psoriasis. In this post hoc analysis, the authors used patient-level data from the POETYK PSO-1 trial, including two arms: 1) Deucravacitinib arm: patients initiated with and continued on deucravacitinib. 2) Apremilast initiators arm: patients initiated with apremilast and at Week 24 responders continued with apremilast, while nonresponders crossed over to deucravacitinib. Over 52 weeks, patients who were initiated with deucravacitinib obtained greater cumulative PASI 75 benefit and sPGA 0/1, regardless of prior treatment, compared with patients who were initiated with apremilast.

WHY IMPORTANT?
Starting deucravacitinib as first-line therapy rather than switching to deucravacitinib as second-line therapy after apremilast response failure may improve clinical outcomes in patients.

POLLING QUESTION
Would you prefer using deucravacitinib as a first-line oral treatment in patients with moderate-to-severe plaque psoriasis?

A.
Among the 102 biologic-naive apremilast initiators, 57 patients achieved PASI 50 at Week 24 and continued receiving apremilast, and 27 did not achieve PASI 50 and crossed over to deucravacitinib.

Among the 66 biologic-experienced apremilast initiators, 30 patients achieved PASI 50 at Week 24 and continued receiving apremilast, and 27 did not achieve PASI 50 and crossed over to deucravacitinib.

B. Among the 59 systemic-naive apremilast initiators, 36 patients achieved PASI 50 at Week 24 and continued receiving apremilast, and 13 did not achieve PASI 50 and crossed over to deucravacitinib.

Among the 109 systemic experienced apremilast initiators, 51 patients achieved PASI 50 at Week 24 and continued receiving apremilast, and 48 did not achieve PASI 50 and crossed over to deucravacitinib.

AUC, area under the curve; AUC0–52wk, AUC over 52 weeks; PASI 50/75, ≥ 50%/75% improvement from baseline in Psoriasis Area and Severity Index score

Disclosures: AWA: Research grants and personal fees: Bristol Myers Squibb, Eli Lilly, Janssen, Leo Pharma, and Novartis; Personal fees: Boehringer Ingelheim/Parexel, Celgene, Dermavant, Genentech, GlaxoSmithKline, Menlo Therapeutics, Merck, Modernizing Medicine, Ortho Dermatologics, Pfizer, Regeneron, Sanofi Genzyme, Science 37, Sun Pharma, and Valeant; and Grants: Dermira, Kyowa Hakko Kirin, and UCB, outside the submitted work, SHP, VP, PN, and MIC: Employees of and shareholders in Bristol Myers Squibb W-JW and VC: Employees of OPEN Health Evidence & Access, which received funding from Bristol Myers Squibb

With the exception of the limited data for deucravacitinib in the systemic naïve subpopulation, this analysis provides a comprehensive overview of the three arms in the POETYK PSO-1 trial and their relative comparisons. The findings are consistent with the primary efficacy endpoint and support the conclusion that deucravacitinib is a promising agent in the treatment of moderate to severe plaque psoriasis.
A. Among the 102 biologic-naive apremilast initiators, 57 patients achieved PASI 50 at Week 24 and continued receiving apremilast, and 27 did not achieve PASI 50 and crossed over to deucravacitinib. Among the 66 biologic-experienced apremilast initiators, 30 patients achieved PASI 50 at Week 24 and continued receiving apremilast, and 27 did not achieve PASI 50 and crossed over to deucravacitinib. B. Among the 59 systemic-naive apremilast initiators, 36 patients achieved PASI 50 at Week 24 and continued receiving apremilast, and 13 did not achieve PASI 50 and crossed over to deucravacitinib. Among the 109 systemic experienced apremilast initiators, 51 patients achieved PASI 50 at Week 24 and continued receiving apremilast, and 41 did not achieve PASI 50 and crossed over to deucravacitinib. AUC, area under the curve; AUC0–52wk, AUC over 52 weeks; PASI 50, ≥ 50% improvement from baseline in Psoriasis Area and Severity Index score; sPGA 0/1, static Physician Global Assessment score of 0 or 1.
Impact of Risankizumab on Nail Psoriasis and Enthesitis Among Psoriatic Arthritis Patients with High Nail Symptom Burden

Joseph F. Merola
Poster presentation on Sunday, March 19
Poster ID: 44094

KEEPsAKE 1 evaluated Risankizumab (RZB) for the treatment of adult patients with active PsA and plaque or nail psoriasis. This abstract presents the efficacy of RZB specifically on nail psoriasis and enthesitis in patients with PsA and moderate-to-severe nail psoriasis. Patients received RZB 150 mg at weeks 0, 4, 16, and every 12 weeks thereafter. Patients improved their mNAPSI score by 74.9% and their PGA-F score by 61.9% after 52 weeks of RZB treatment. After 52 weeks of RZB, 69.3% of patients had resolution of enthesitis.

WHY IMPORTANT?
There are no standardized treatment protocols for nail psoriasis and only a few trials focus on nail psoriasis and enthesitis. It is therefore important to show the efficacy of RZB specifically on nail psoriasis and enthesitis.

POLLING QUESTION
Would you choose RZB over other therapies in patients with extensive nail psoriasis?
Tapinarof Cream 1% Once Daily (QD) for Plaque Psoriasis: Psoriasis Area and Severity Index Score by Body Region for the PSOARING 1 and 2 Trials.

Linda Stein Gold

Poster presentation on Friday, March 17
Poster ID: 41574

PSOARING 1 and 2 are two 12-week, vehicle-controlled studies of Tapinarof in adults with mild to severe plaque psoriasis. Tapiranof is a first-in-class, non-steroidal, topical, aryl hydrocarbon receptor (AhR) modulator. This abstract reports a post hoc analysis of PASI by body region. At week 12, PASI scores were significantly improved in the Tapinarof group in all body regions, including head and neck, upper extremities, trunk, buttocks, genitalia, and lower extremities. Tapinarof cream 1% QD demonstrated consistent efficacy overall and across body regions as measured by PASI. This indicates suitability for use in patients with mild to severe plaque psoriasis, regardless of location, including difficult-to-treat regions such as intertriginous areas and genitalia.

WHY IMPORTANT?
This study showed efficacy of Tapiranof overall and across difficult-to-treat areas.

POLLING QUESTION
Would you consider using Tapinarof Cream for your patients who have psoriasis in difficult-to-treat areas including lower extremities, intertriginous areas and genitalia?

Disclosures: Linda Stein Gold has served as a consultant, and/or has received payment for the development of educational presentations, and/or has received grants from Arcutis, Amgen, Bristol Myers Squibb, Dermavant Sciences, Inc., Eli Lilly, LEO Pharma, Ortho Dermatologic, and UCB Biopharma. Alexandra Golant has received consulting or speaking fees from AbbVie, Amgen, Arcutis, Dermavant Sciences, Inc., Eli Lilly, Evelo Biosciences, Incyte, Janssen, LEO Pharma, Regeneron, and Sanofi. Rocco Serrao has served as a consultant and/or has received payment for the development of educational presentations, and/or has received grants from Abbott, AbbVie, Arcutis, Bristol Myers Squibb, Dermavant, Eli Lilly, Incyte, Janssen, Pfizer, Regeneron, and Sanofi Genzyme. Anna M. Tallman and Philip M. Brown are employees of Dermavant Sciences, Inc. with stock options.

Change in PASI Score by Body Region at Week 12
PASI scores were significantly lower at Week 12 in the Tapinarof group versus vehicle for all body regions for patients in PSOARING 1 and 2 (P<0.0001 for all comparisons).
This work aimed to quantify switch rates, healthcare resource use, and treatment costs among patients with psoriasis by screening real-world data. IBM® MarketScan® databases were used to identify adults with ≥2 psoriasis diagnoses without other autoimmune conditions initiating a new biologic between 1/1/2018 and 3/31/2022. Patients had continuous enrollment for ≥6 months pre- and >12 months post-index date. Treatment switch rates at 12 months were compared for the overall population and individual biologics. Costs (adjusted to 2021 dollars) and healthcare resource use were compared among switchers and non-switchers. By 12 months, the switch rate was 15.5% across all biologics. Risankizumab had the lowest switch rate (4.9%, p< 0.01) compared with other biologics. Mean outpatient visits were higher for switchers versus non-switchers (16.4 vs. 12.0; P<0.0001), with similar trends for psoriasis-specific outpatient visits. Mean total costs of care over 12 months were higher for switchers compared with non-switchers, $93,217 (SD 43,787) versus $72,125 (SD 32,263), respectively, P<0.0001.

WHY IMPORTANT?
This real-world study provides important information about the rates and costs of switching biologics and indicates the biologic which required fewest switches over the studied period.

POLLING QUESTION
How much does the economic burden of drugs affect your treatment schedule when prescribing or switching between biologics in your daily practice?
These post hoc analyses of VOYAGE 1 and VOYAGE 2 aimed to assess changes in neutrophil-to-lymphocyte ratio (NLR) in patients with moderate—to-severe psoriasis treated with guselkumab and investigate the correlation of NLR with psoriasis disease severity and other baseline clinical parameters. Patients were initially randomized to either guselkumab or placebo in VOYAGE 1 and VOYAGE 2 and followed for 48 weeks (Figure 1). Mean and median NLR were analyzed through week 48, and Spearman correlation coefficients and 95% CI were calculated. In the VOYAGE 1 and VOYAGE 2 trials, NLR was lower at Week 16 in the guselkumab group than in the placebo group. A weak correlation was observed between NLR and PASI.

**WHY IMPORTANT?**

These results show that Guselkumab treatment was associated with a lower NLR, indicating reduced systemic inflammation.

**POLLING QUESTION**

Do you use the neutrophil-to-lymphocyte ratio when assessing patients with psoriasis?

**Disclosures:** B Kirby has received research support from/tis a principal investigator (clinical trials) for AbbVie, Almirall, Janssen, Merck Sharp & Dohme, MoonLake, Novartis, Pfizer and UCB; been a consultant for AbbVie, Almirall, Celgene, Janssen, Merck Sharp & Dohme, MoonLake, Novartis, Pfizer and UCB; and has been on scientific advisory boards for AbbVie, Almirall, Celgene, Janssen, Lilly, MoonLake, Novartis, Pfizer and UCB. N Kearney has received honoraria from AbbVie, Janssen and UC and has acted as a sub-investigator on clinical trials for AbbVie, MoonLake and UC. P Gorecki is an employee of Janssen-Cilag, High Wycombe, UK. J Buyze is an employee of Janssen Pharmaceutica NV, Beerse, Belgium. YW Yang is an employee of Global Medical Affairs, Janssen Pharmaceutical Companies of Johnson & Johnson, Horsham, PA, USA. JF Merola has received honoraria (consultant) at Celgene and grants/research funding (investigator) from Biogen, Incyte, Novartis, Pfizer and Sanofi.

**Figure 1. Trial designs through Week 48 for (A) VOYAGE 1 and (B) VOYAGE 2**

*Patients re-initiated guselkumab upon loss of ≥50% of Week 28 PASI response. NLR, neutrophil-to-lymphocyte ratio; NR, non-responder (patient not achieving PASI90 at Week 28); PASI, Psoriasis Area and Severity Index, q2w, every 2 weeks; q4w, every 4 weeks; R, responder (patient achieving PASI90 at Week 28).
### Figure 2. Median NLR from baseline through Week 48 for patients in (A) VOYAGE 1 and (B) VOYAGE 2 by treatment subgroup

Data labels show date for Week 0, 12, 24, and 48. The y-axis are compressed and do not start at 0. This group includes 32 patients who were re-treated with guselkumab (due to loss of ≥ 50% of Week 28 PASI response) by Week 48. n=3 at Week 36, n=3 at Week 40, n=10 at Week 44 and n=6 at Week 48. This group includes 4 patients who were re-treated with guselkumab (due to loss of ≥ 50% of Week 28 PASI response) by Week 48. n=2 at Week 44 and n=2 at Week 48. GUS: guselkumab; NLR: neutrophil-to-lymphocyte ratio; NR: non-responder (patient not achieving PASI90 at Week 26), PASI: Psoriasis Area and Severity Index, PBO: placebo; R: responder (patient achieving PASI90 at Week 26).

### Table 3. Spearman correlation coefficients at baseline and Week 16

<table>
<thead>
<tr>
<th>Correlation variables</th>
<th>VOYAGE 1</th>
<th>VOYAGE 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GUS</td>
<td>PBO</td>
</tr>
<tr>
<td>Baseline NLR vs. PASI</td>
<td>n</td>
<td>326</td>
</tr>
<tr>
<td></td>
<td>r_s (95% CI)</td>
<td>-0.0468 to -0.1996</td>
</tr>
<tr>
<td>Baseline NLR vs. hs-CRP</td>
<td>n</td>
<td>326</td>
</tr>
<tr>
<td></td>
<td>r_s (95% CI)</td>
<td>-0.1024 to -0.1149</td>
</tr>
<tr>
<td>Obese patients* Baseline NLR vs. BMI</td>
<td>n</td>
<td>142</td>
</tr>
<tr>
<td></td>
<td>r_s (95% CI)</td>
<td>-0.0416 to -0.2830</td>
</tr>
<tr>
<td>Change from baseline to Week 16 NLR vs. PASI</td>
<td>n</td>
<td>317</td>
</tr>
<tr>
<td></td>
<td>r_s (95% CI)</td>
<td>0.14651 (0.0367 to 0.2524)</td>
</tr>
</tbody>
</table>

*These patients are defined as those with a BMI ≥ 30 kg/m².
BMI: body mass index; CI: confidence interval; GUS: guselkumab; hs-CRP: high-sensitivity C-reactive protein; NLR: neutrophil-to-lymphocyte ratio; PASI: Psoriasis Area and Severity Index, PBO: placebo; R: responder (patient achieving PASI90 at Week 26).
This work analysed data from the CorEvitar Psoriasis Registry with the aim to identify clinical features associated with multiple biologic failures (MBF). MBF was defined as failing ≥2 biologic classes (TNFi, IL12/23i, IL17i, IL23i) with ≥90 days of treatment. Good response (GR) was characterized as ≥24 months of continued use of the first biologic. Patients with plaque psoriasis who initiated their first biologic therapy during enrolment and had ≥2 years of follow-up (2015-2022) were included. Patients' personal and clinical features and patient-reported outcomes were assessed at the first biologic initiation. A multivariable logistic regression model was constructed to identify independent risk factors for MBF. The final model included a priori selected variables (age, sex, race, ethnicity, BMI) and others retaining statistical significance of P<0.10. Among the 1,039 biologic-naïve initiators, 65 (6%) were MBF and 490 (47%) were GR. Female sex, hyperlipidemia, Medicaid insurance, earlier year of biologic initiation, shorter psoriasis duration, and prior non-biologic systemic therapy use were associated with MBF.

**WHY IMPORTANT?**
These results may help clinicians to identify psoriasis patients who may be more likely to experience multiple-biological failures and require more frequent follow-up visits.

**POLLING QUESTION**
What are the common characteristics of the patients you have observed multiple-biological failure with? From your experience, what do you recommend when managing these patients?

**Funding sources:** This study was funded by CorEvitas, LLC and supported through a partnership between CorEvitas and the National Psoriasis Foundation. The CorEvitas Psoriasis Registry was developed in collaboration with the National Psoriasis Foundation. CorEvitas has been supported through contracted subscriptions in the last two years by AbbVie, Amgen, Inc., Arena, Boehringer Ingelheim, Bristol Myers Squibb, Celgene, Chugai, Eli Lilly and Company, Genentech, Gilead Sciences, Inc., GlaxoSmithKline, Janssen Pharmaceuticals, Inc., LEO Pharma, Novartis, Ortho Dermatologics, Pfizer, Inc., Regeneron Pharmaceuticals, Inc., Sanofi, Sun Pharmaceutical Industries Ltd., and UCB S.A.
Figure 2: Multivariable adjusted odds ratios for associations of baseline characteristics with multiple biologic failure (MBF) vs. good response (GR). *Odds ratios for continuous variables are reported per standard deviation (SD) increase in that variable. Standard deviations were as follows: age (SD 15); BMI (SD 7.4); psoriatic duration (SD 12.5).
In this retrospective analysis, the incidence of PsA among patients with psoriasis after treatment with biologics was compared to those not taking biologics. The analysis was based on data from the US-American COVID-19 Research Database, which followed 352,115 patients diagnosed with psoriasis (ICD-10: L40) between 2017 and 2020. Two patient cohorts were formulated based on their psoriasis management: unknown biologics and IL-23 inhibitors. Two respective control groups (matched for age, sex, and psoriasis severity) were created for unknown biologics and IL-23 inhibitors. The incidence of PsA was similar in both groups (p-value=0.716). However, patients using IL-23i and IL-12/23i seemed to experience a delayed manifestation of PsA.

### Table: Average Days to PsA Development

<table>
<thead>
<tr>
<th>Biologics Groups</th>
<th>Treatment Arm: PsA Incidence</th>
<th>Control Arm: PsA Incidence</th>
<th>Treatment Arm: Average days to PsA</th>
<th>Control Arm: Average days to PsA</th>
</tr>
</thead>
<tbody>
<tr>
<td>TNFa</td>
<td>481/3421 (14.1%)</td>
<td>415/3421 (12.1%)</td>
<td>858</td>
<td>791</td>
</tr>
<tr>
<td>IL-23i</td>
<td>332/211 (15.6%)</td>
<td>322/11 (15.2%)</td>
<td>922</td>
<td>639</td>
</tr>
<tr>
<td>IL-12/23i</td>
<td>126/1287 (9.9%)</td>
<td>161/1287 (12.5%)</td>
<td>965</td>
<td>739</td>
</tr>
</tbody>
</table>

### WHY IMPORTANT?

The use of targeted therapy using monoclonal antibodies, especially IL-23i and IL-12/23i, might not prevent, but can possibly delay the onset of psoriatic arthritis in patients with psoriasis.
Intermittent fasting (IMF) is increasingly popular, but little is known about its effects on psoriasis and PsA. IMF offers, among several health benefits, anti-inflammatory effects, which might be beneficial for psoriasis and PsA. This systematic review analysed four articles on IMF in psoriasis and PsA.

For psoriasis, both a prospective observational study and an interventional study supported clinical benefit with IMF compared to regular diet or weight loss alone. In the PsA interventional study, clinical improvements were noted in disease activity in PsA (DAPSA) index and enthesis and dactylitis scoring systems. No serious health risks were reported.

**WHY IMPORTANT?**

Intermittent fasting (IMF) is a low-cost and widely accessible option for adjuvant treatment in both psoriasis and PsA. It is believed to have additional beneficial effects in both psoriasis and PsA disease activity and quality of life due to mechanisms independent of weight loss alone.

**Polling Question**

Do your patients ask you for possible dietary adjustments to improve their disease activity and quality of life?

**Table 1. Studies Summary Table**

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Study Type</th>
<th>Country</th>
<th>Multicenter</th>
<th>Guideline</th>
<th>Energy/Fasting Type</th>
<th>Outcome</th>
<th>Number of Patients</th>
<th>Randomization</th>
<th>Controlled</th>
<th>Secondary Outcome Measures</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Gray</td>
<td>2012</td>
<td>Clinical Trial</td>
<td>United States</td>
<td>No</td>
<td>Psoriasis</td>
<td>Twice, 10 hour fast daily (7 week duration)</td>
<td>Yes</td>
<td>21</td>
<td>No</td>
<td>No</td>
<td>PASI</td>
<td>Pain, biomarker parameters.</td>
</tr>
<tr>
<td>A. Gray et al.</td>
<td>2019</td>
<td>Clinical Trial</td>
<td>Denmark</td>
<td>No</td>
<td>Psoriasis</td>
<td>Twice, 14 hour fast daily (4 week duration)</td>
<td>Yes</td>
<td>97</td>
<td>No</td>
<td>No</td>
<td>DAPSA, BMDA (U-550)</td>
<td>Biomarker parameters.</td>
</tr>
<tr>
<td>G. Rastam et al.</td>
<td>2019</td>
<td>Clinical Trial</td>
<td>Sweden</td>
<td>No</td>
<td>Psoriasis</td>
<td>Calorie energy deficit (12 week duration)</td>
<td>No</td>
<td>41</td>
<td>No</td>
<td>No</td>
<td>Percentage of patients reaching normal disease activity (DAPSA)</td>
<td>PASI and ACR response criteria.</td>
</tr>
<tr>
<td>T. Bright et al.</td>
<td>2019</td>
<td>Clinical Trial</td>
<td>Italy</td>
<td>Yes</td>
<td>Moderate-volunteers</td>
<td>Twice, 14 hour fast daily (4 week duration)</td>
<td>Yes</td>
<td>188</td>
<td>No</td>
<td>No</td>
<td>PASI</td>
<td>BMI</td>
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<tr>
<td>P. Hildreth et al.</td>
<td>2013</td>
<td>Clinical Trial</td>
<td>Denmark</td>
<td>No</td>
<td>Psoriasis</td>
<td>Calorie energy deficit (12 week duration)</td>
<td>No</td>
<td>60</td>
<td>Yes</td>
<td>Yes</td>
<td>PASI, DAPSA</td>
<td>BMI, ultrasound parameters.</td>
</tr>
<tr>
<td>H. Lillqvist et al.</td>
<td>1993</td>
<td>Observational Study</td>
<td>Sweden</td>
<td>No</td>
<td>Psoriasis</td>
<td>Calorie energy deficit (4 week duration)</td>
<td>No</td>
<td>14</td>
<td>No</td>
<td>No</td>
<td>DAS-28, patient quality of life measures</td>
<td>Study limitations on small scale, biomarker parameters.</td>
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<tr>
<td>J. A. K. et al.</td>
<td>2012</td>
<td>Observational Study</td>
<td>Denmark</td>
<td>No</td>
<td>Psoriasis</td>
<td>Twice, Modified intermittent fasting (12 week duration)</td>
<td>No</td>
<td>32</td>
<td>Yes</td>
<td>Yes</td>
<td>PASI, DAS-28</td>
<td>Biomarker parameters.</td>
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<tr>
<td>L. H. et al.</td>
<td>2012</td>
<td>Observational Study</td>
<td>Belgium</td>
<td>No</td>
<td>Psoriasis</td>
<td>Twice, Modified intermittent fasting (12 week duration)</td>
<td>No</td>
<td>24</td>
<td>Yes</td>
<td>Yes</td>
<td>PASI, DAS-28</td>
<td>Biomarker parameters.</td>
</tr>
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*Disclosures: The authors thank the National Psoriasis Foundation for funding this research fellowship and Ohio State Dermatology department and Prior Hall Health Sciences Library staff for additional support and collaboration.*
Advancing Diversity in Dermatology Research: The VISIBLE Study Experience

Andrew Alexis

Poster presentation on Sunday, March 19

Poster ID: 42193

The VISIBLE study focuses on the management of people with skin of colour (SOC) and psoriasis. Its goals are to generate data to help address care gaps and inform future best practices in diversity research in dermatology. VISIBLE will evaluate guselkumab efficacy, safety, and impact on quality of life in approximately 200 people with SOC with moderate-to-severe plaque psoriasis over 2 years. Outcomes include a combination of objective (colorimetry to determine Fitzpatrick skin type) and self-reported (non-white racial/ethnic origins) parameters to broaden inclusion of patients with SOC.

WHY IMPORTANT?

Diverse representation in clinical trials has been limited and the subject of pending FDA guidance. In dermatologic conditions, this applies especially to psoriasis, which varies in presentation and disease burden based on skin tone/racial/ethnic differences. Therefore, proper diagnosis and treatment data in this patient group is necessary.

In your practice, do you encounter difficulties in successful diagnosis and treatment of patients with skin of color?

Disclosures: A. Alexis has received grants (funds to institution) and/or served as an advisor/consultant and/or speaker for Abbvie, Allergan, Amgen, Aricuts, Bausch Health, Beiersdorf, Bristol-Myers Squibb, Care, Castle, Cetera, Dermavant, Eli Lilly, EPI, Galderma, Janssen, Leo, L'Oreal, Novartis, Ortho, Pfizer, Regeneron, Sandia-Gerzyme, Sandia-Regeneron, Sol-Cel, Seoul American, UCS, Valeant (Bausch Health), VisualDx, and Vysis royalties; Springer, Wiley-Blackwell, Wolters Kluwer Health. S.R. Desai serves as a consultant and/or investigator for a variety of different organizations including Janssen, Galderma, Pfizer, Incyte, Eli Lilly, L'Oreal and others. He also serves in numerous leadership capacities within Dermatology. B. Taylor has received honoraria/stock options serving as an advisor/consultant and/or speaker for Abbvie, Aricuts, Biotherapeutics, Inc., Amos Scientific, Avila Medical, Beiersdorf, Inc., Blane, Inc., Bristol-Myers Squibb, Cara Therapeutics, Dori, Eli Lilly, EPI Health, Evius, Inc., Galderma Laboratories, L.P., Galderma, Hugel America, Inc., Janssen, Johnson & Johnson Consumer Products Company, L'Oreal USA, Medscape/Wiley, MUH-LiSciences, Piction Health, Regeneron/Sand, Science US, UCB, Vichy Laboratories; Mercer Strategies (Honorary/Board of Directors); McGraw-Hill (author/royalties), editorial board; Practical Dermatology, Cutis, Archives in Dermatologic Research; British Journal of Dermatology (peer reviewer); Investigator: Concert Pharmaceuticals, Cortex-Pharma, Eli Lilly, Pfizer. O. Choi, D. Chan, and T. Alkousakis are employees of Janssen Scientific Affairs, LLC, and D. Breeher is an employee of Janssen Research & Development, LLC; employees may own stock/stock options in Johnson & Johnson, of which Janssen is a subsidiary.
Late-Breaking Research Session:1

Saturday, March 18, 11.50 AM

Efficacy and safety results from the randomized, double-blind, placebo-controlled phase 2b trial of TYK2 inhibitor NDI-034858 in moderate-to-severe psoriasis. April W. Armstrong, MD, MPH, FAAD

Late-Breaking Research Session:2

Saturday, March 18, 1.50 PM

Efficacy and safety of orismilast in patients with moderate-to-severe psoriasis: results from the phase IIb IASOS trial. Lars French, MD, IFAAD