AAD 2023

DO NOT MISS HIGHLIGHTS IN PSORIATIC DISEASE

MARCH 2023

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.

Betul Macit

Anika M. Hartmann

Cemre B. Turk

NEWSLETTER

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Y-GRAPPiANs

Young Group for Research and Assessment of Psoriasis and Psoriatic Arthritis

TREATMENT

- Betul Macit, MD
- Clinical Trials Fellow at Brown Dermatology, Providence/USA
- Young Grappa Member, Participates in the Education Committee, Slide Library and Message to Young GRAPPiAns Projects
- 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

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.

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 MJC: 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

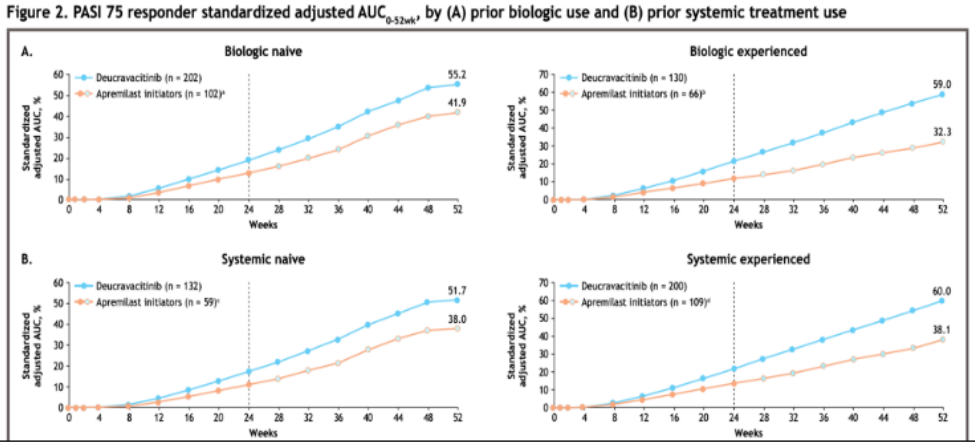
WHY IMPORTANT?

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

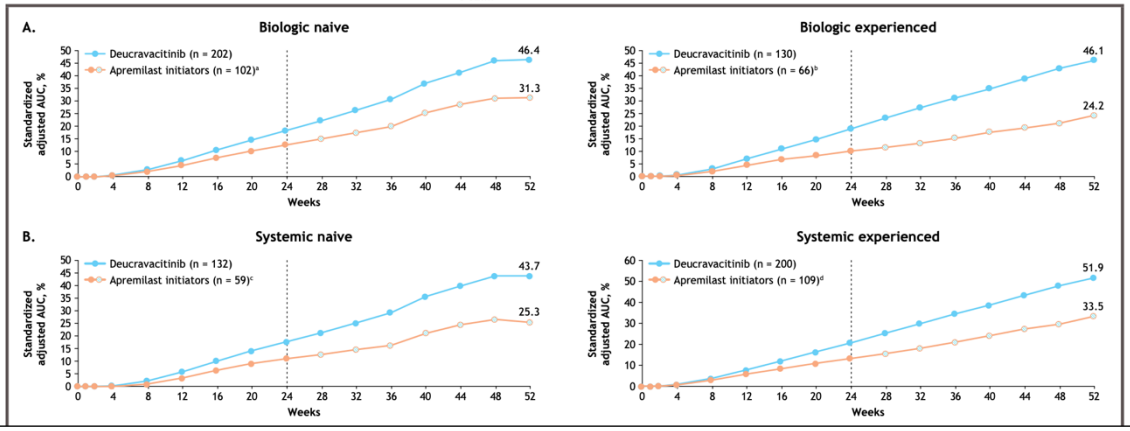
Would you prefer using deucravacitinib as a first-line oral treatment in patients with moderate-to-severe plaque psoriasis?

Figure 2. PASI 75 responder standardized adjusted $AUC_{0\text{-}52wk}$, by (A) prior biologic use and (B) prior systemic treatment use



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; $AUC_{0–52wk}$, AUC over 52 weeks; PASI 50/75, ≥ 50%/75% improvement from baseline in Psoriasis Area and Severity Index score

Figure 3. sPGA 0/1 responder standardized adjusted $AUC_{0\text{-}52wk}$, by (A) prior biologic use and (B) prior systemic treatment use



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.

Disclosures: AbbVie funded this trial and participated in the trial design, research, analysis, data collection, interpretation of data, and the review and approval of the publication. All authors had access to relevant data and participated in the drafting, review, and approval of this publication. No honoraria or payments were made for authorship. The authors thank Christian Kauffman of AbbVie for his assistance with this publication. Medical writing support was provided by Trisha Rettig, PhD, of AbbVie. J.F. Merola is a consultant and/or investigator for Amgen, Biogen, BMS, AbbVie, Dermavant, Janssen, LEO, Lilly, Novartis, Pfizer, Regeneron, Sanofi, Sun, and UCB. B.E. Elewski has received clinical research support (research funding to her university) from and/or has served as a consultant (received honorarium) for AbbVie, Amgen, Anaptys-Bio, Arcutis, BI, BMS, Celgene, Incyte, LEO, Lilly, Merck, Menlo, Novartis, Pfizer, Regeneron, Sun, UCB, Valeant (Ortho Dermatology), and Vanda. P. Rich has received grant/research support from BI, BMS, Cellceutix, Centocor, Janssen, Kadmon, Lilly, Merck, Novartis, Pfizer, and UCB. A. Amin has received speaker or consulting fees from AbbVie, Amgen, BMS, Dermavant, Janssen, LEO, Lilly, Pfizer, Regeneron, Sanofi-Genzyme, and UCB. L. Savage has received grant/research support from, is a consultant, and/or speaker for AbbVie, Almirall, Amgen, Aspire, Biogen, BI, BMS, Celgene, Celltrion, Galderma, Janssen, LEO, Lilly, Novartis, Pfizer, Sanofi-Genzyme, and UCB. She is a committee member for the Group for Research and Assessment in Psoriasis and Psoriatic Arthritis (GRAPPA) and the British Society of Medical Dermatology (BSMD). K. Papp has received research funds from AbbVie, Amgen, Arcutis, Astellas, Bausch Health, Baxalta, Baxter, BI, BMS, Celgene, Coherus, Dermavant,

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?

Figure 1. Percent Improvement From Baseline in mNAPSI and PGA-F

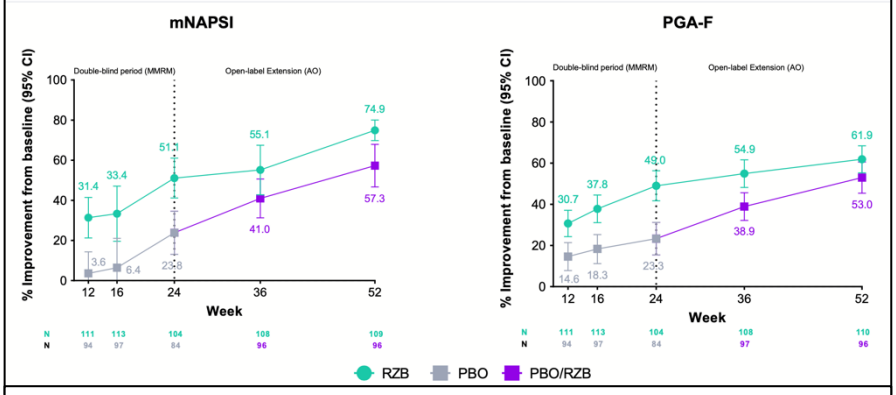
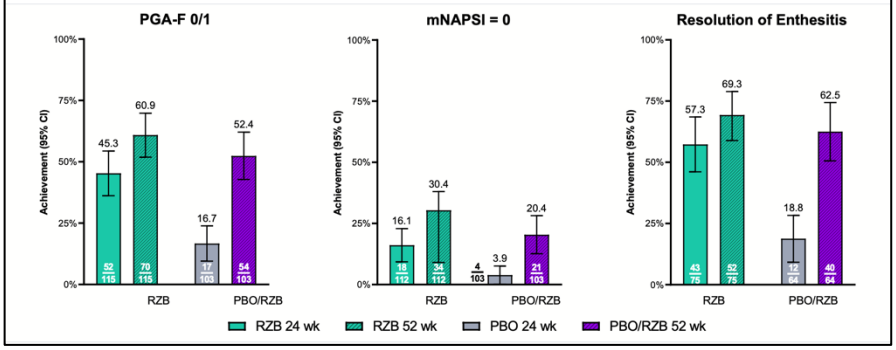


Figure 2. PGA-F 0/1, mNAPSI = 0 and Resolution of Enthesitis



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.

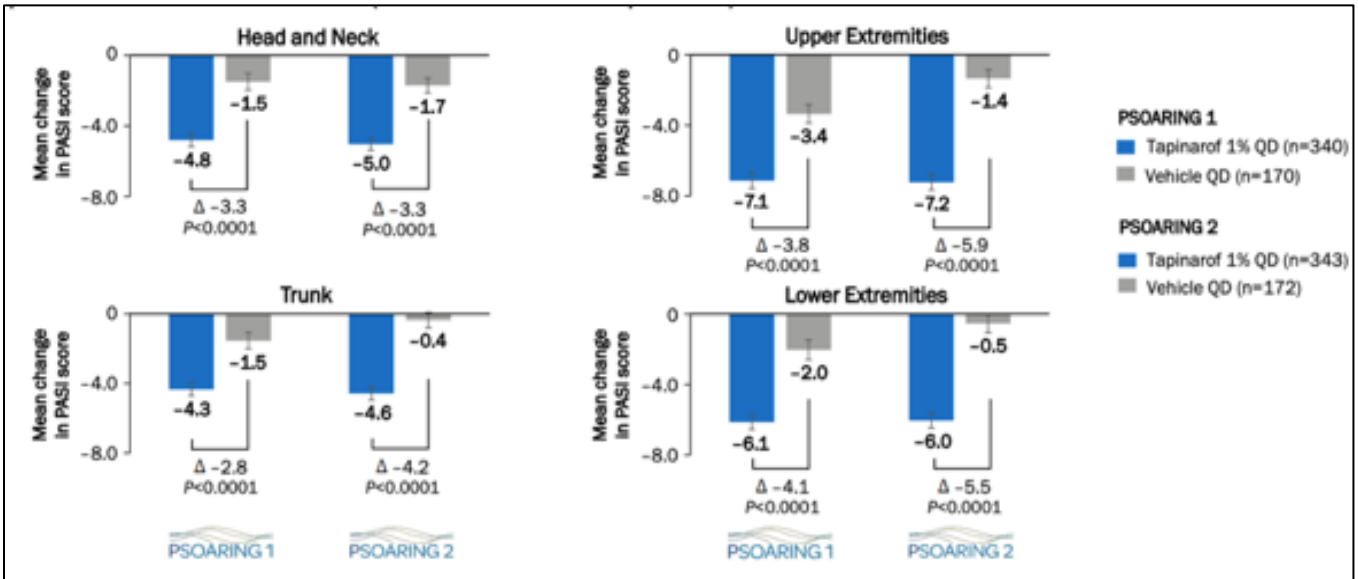
Disclosures: Linda Stein Gold has served as a consultant, and/or has received payment for the development of educational presentations, and/or has received grants from Arcutis, Amgen,Bristol Myers Squibb, Dermavant Sciences, Inc., Eli Lilly, LEO Pharma, Ortho Dermatologic, and UCB Biopharma. Alexandra 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.

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?



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).

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Real-World Switch Rates of Biologics and Associated Costs in Patients With Psoriasis

Jashin J. Wu

Poster presentation on

Sunday, March 19

Poster ID: 41279

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.

Disclosures: Medical writing services provided by Sarah Hodgkinson, PhD, of Fishawack Facilitate Ltd, part of Fishawack Health, and funded by AbbVie.Financial support for the study was provided by AbbVie. AbbVie participated in the study design, data acquisition and interpretation, and in the writing, review, and approval of the poster. All authors contributed to the development of the poster and maintained control over the final content. A.W. Armstrong has served as a research investigator and/or scientific advisor to AbbVie, Almirall, Arcutis, ASLAN, Beiersdorf, BI, BMS, Dermavant, Dermira, EPI, Incyte, Janssen, LEO, Lilly, Modmed, Nimbus, Novartis, Ortho Dermatologics, Pfizer, Sun, Sanofi, Regeneron, and UCB. M. Patel, C. Li, and V. Garg, are employees of AbbVie and may own AbbVie stock. M.R. Mandava is a research investigator at University of Illinois Chicago. J.J. Wu is or has been an investigator, consultant, and/or speaker for AbbVie, Almirall, Amgen, Arcutis, Aristea, Bausch Health, BI, BMS, Dermavant, DermTech, Dr. Reddy's Laboratories, EPI Health, Galderma, Janssen, LEO, Lilly, Mindera, Novartis, Pfizer, Regeneron, Samsung Bioepis, Sanofi-Genzyme, Solius, Sun, UCB, and Zerigo Health.

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?

Figure 1. Real-world Biologic Switch Rates Over 12 Months

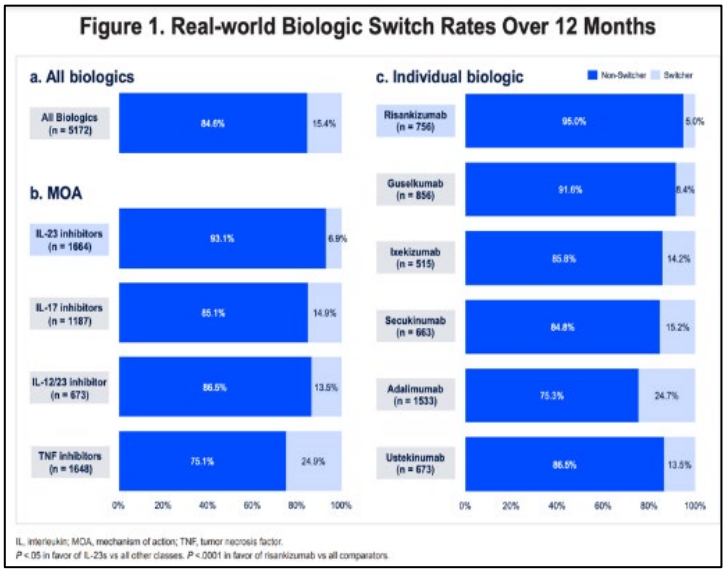
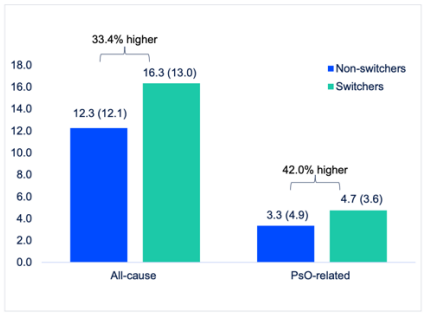


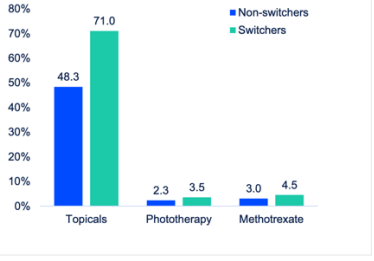
Figure 2. Mean Outpatient Visits Were Significantly Higher for Switchers vs Non-switchers Over 12 Months



PsO, psoriasis.
P < .05 for all cause and PsO-related outpatient visits.
Data are mean (SD).

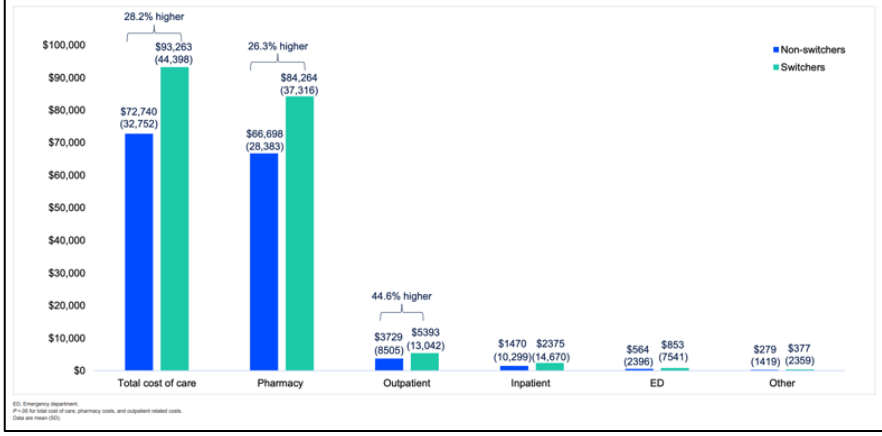
- All-cause emergency department (N = 760, 14.7%) and inpatient visits were low in this population (N = 301, 5.8%) over 12 months
- Similar rates of emergency department visits (14.5% vs 16.0%) and inpatient visits (5.6% vs 7.3%) were seen across switchers and non-switchers

Figure 3. PsO Supportive Care Use of Topicals Were Higher for Switchers vs Non-switchers (71.0% vs 48.3%; 2.9 vs 1.5 Claims)



P < .0001 for topical use.

Figure 4. Overall Costs of Care Were 28.2% Higher Among Patients Who Switched vs Those Who Did Not Switch Over 12 Months



ED, Emergency department.
P < .05 for total cost of care, pharmacy costs, and outpatient related costs.
Data are mean (SD).

TRANSLATIONAL

Mean Neutrophil-to-lymphocyte Ratio Improved Over Time With Guselkumab Treatment In The Voyage 1 and Voyage 2 Clinical Trial

Brian Kirby

e-Poster

Poster ID: 40858

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.

Disclosures: B Kirby has received research support from/is 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; has received honoraria from AbbVie, Almirall, Celgene, Janssen, Lilly, 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 UCB and has acted as a sub-investigator on clinical trials for AbbVie, MoonLake and UCB. 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.

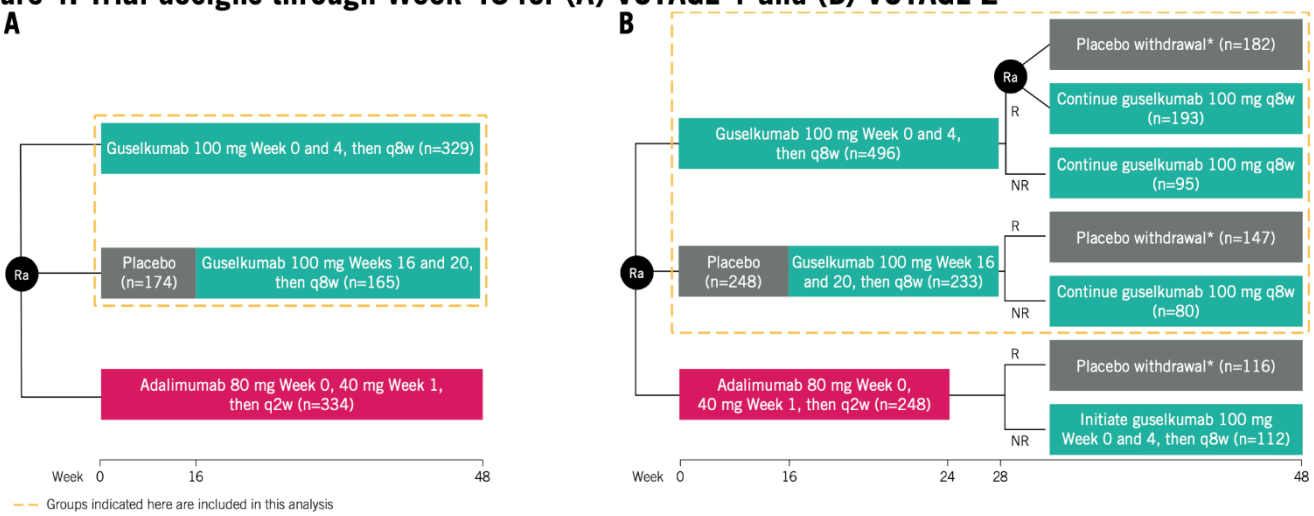
WHY IMPORTANT?

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

POLLING QUESTION

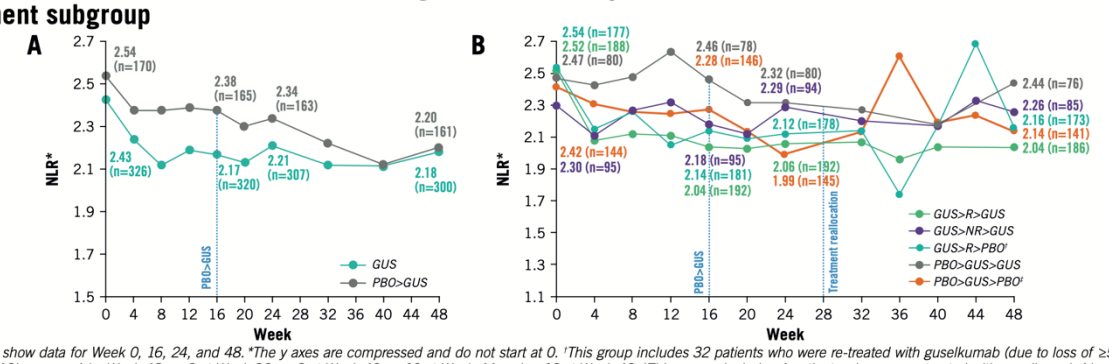
Do you use the neutrophil-to-lymphocyte ratio when assessing patients with psoriasis?

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; q8w, every 8 weeks; Ra, randomisation; 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 data for Week 0, 16, 24, and 48. *The y axes 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=16 at Week 48. ‡This groups 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 28); PASI, Psoriasis Area and Severity Index; PBO, placebo; R, responder (patient achieving PASI90 at Week 28).*

Table 3. Spearman correlation coefficients at baseline and Week 16

Correlation variables		VOYAGE 1		VOYAGE 2	
		GUS	*PBO*	*GUS*	*PBO*
Baseline NLR vs. PASI	n	326	170	483	243
	r_s (95% CI)	0.0622 (–0.0468–0.1696)	0.1470 (–0.0041–0.2907)	0.1363 (0.0475–0.2227)	0.1599 (0.0344–0.2798)
Baseline NLR vs. hs-CRP	n	326	170	483	243
	r_s (95% CI)	0.0063 (–0.1024–0.1149)	–0.0611 (–0.2097–0.0902)	0.0454 (–0.0440–0.1341)	0.1056 (–0.0205–0.2284)
Obese patients:* Baseline NLR vs. BMI	n	142	63	199	98
	r_s (95% CI)	0.1240 (–0.0416–0.2830)	–0.0641 (–0.3069–0.1867)	0.0561 (–0.0838–0.1935)	0.0918 (–0.1091–0.2846)
Change from baseline to Week 16 NLR vs. PASI	n	317	161	469	226
	r_s (95% CI)	0.14651 (0.0367–0.2524)	0.1804 (0.0259–0.3254)	0.1455 (0.0555–0.2328)	0.0900 (–0.0412–0.2177)

**Obese 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; rs, Spearman's rho.

CLINICAL

Identification of Demographic and Clinical Features Associated with Multi-Biologic Failure in the CorEvitas Psoriasis Registry

Samuel Yeroushalmi

Poster presentation on Sunday, March 19

Poster ID: 41261

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.

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?

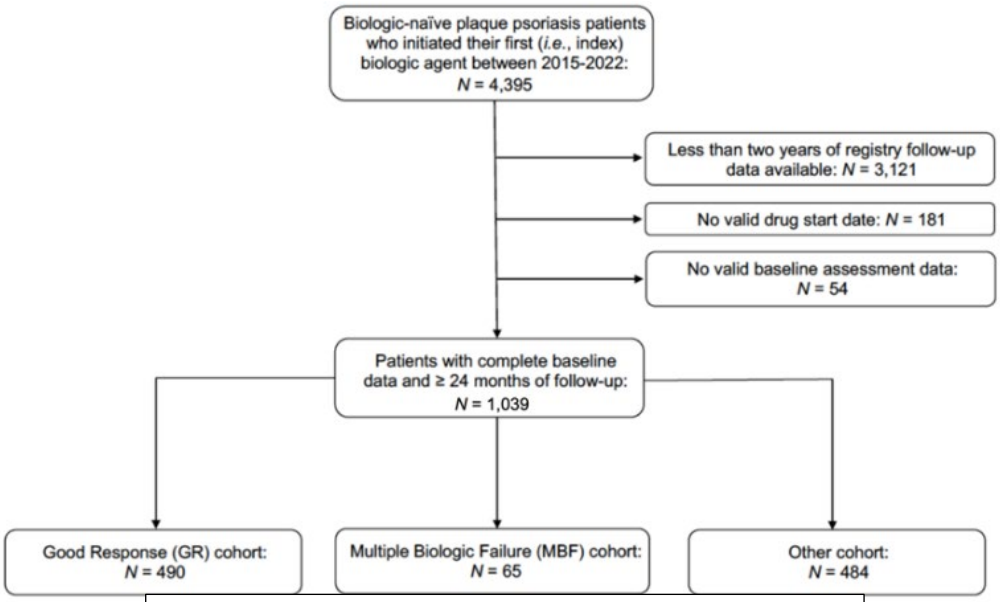


Figure 1: Patient numbers in different groups and study flow.

Independent Variable (Total N = 512; MBF n = 62; GR n = 450)	OR* [95% CI]	P-value
Age (per SD increase in years)	0.89 [0.61, 1.32]	0.58
Sex (female at birth vs. male at birth)	**2.29 [1.11, 4.72]**	**0.03**
Race and ethnicity (White and non-Hispanic vs. All others)	1.14 [0.49, 2.65]	0.77
BMI (per SD increase in kg/m^2)	0.93 [0.61, 1.40]	0.72
Year of index biologic initiation (per one year later)	**0.37 [0.27, 0.52]**	**<0.001**
Medicaid insurance (vs. any other coverage)	**4.53 [1.40, 14.60]**	**0.01**
History of hyperlipidemia	**3.14 [1.35, 7.30]**	**0.01**
Psoriasis duration (per SD increase in years)	**0.60 [0.38, 0.94]**	**0.03**
Prior non-biologic systemic therapy	**2.47 [1.16, 5.25]**	**0.02**

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); psoriasis duration (SD 12.5).

UCSF

Figure 2: Multivariable adjusted odds ratios for associations of baseline characteristics with MBF and GR.

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- Young Grappa Member
- Research focus: Inflammatory diseases, diet, fasting, gut microbiome

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Protective Effects of Biologics against Psoriatic Arthritis in Patients with Psoriasis

Shahin Shahsavari

Poster presentation on
Sunday, March 19
Poster ID: 43356

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.

Disclosures: Dr. Wu is or has been an investigator, consultant, or speaker for AbbVie, Almirall, Amgen, Arcutis, Aristea Therapeutics, Bausch Health, Bayer, Boehringer Ingelheim, Bristol-Myers Squibb, Codex Labs, Dermavant, DermTech, Dr. Reddy's Laboratories, Eli Lilly, EPI Health, Galderma, Incyte, Janssen, LEO Pharma, Mindera, Novartis, Pfizer, Regeneron, Samsung Bioepis, Sanofi Genzyme, Solius, Sun Pharmaceutical, UCB, and Zerigo Health. Authors Shahsavari, Smith and Engel have no conflicts of interest to disclose.

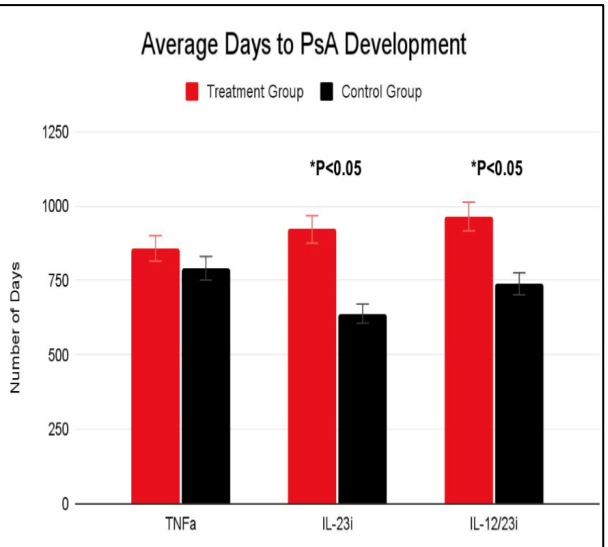
WHY IMPORTANT?

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.

POLLING QUESTION

Do your patients with psoriasis experience less frequent, or later onset of PsA, when treated with IL23i and IL-12/23i?

Biologics Groups	Treatment Arm: PsA Incidence	Control Arm: PsA Incident	Treatment Arm: Average days to PsA	Control Arm: Average days to PsA
TNFa	481/3421 (14.1%)	415/3421 (12.1%)	858	791
IL-23i	33/211 (15.6%)	32/211 (15.2%)	922	639
IL-12/23i	126/1287 (9.9%)	161/1287 (12.5%)	965	739



Systematic Review of Intermittent Fasting in Psoriasis and Psoriatic Arthritis

Ashley Gray

Poster presentation on Sunday, March 19

Poster ID: 43497

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 enthesitis and dactylitis scoring systems. No serious health risks were reported.

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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

Author	Year	Study Type	Country	Multicenter	Condition	Energy Restriction Type	Ramadan	Number of patients	Randomized	Controlled	Primary Outcome Measure	Secondary Outcome Measure
N. Almutairi et al.	2022	Clinical Trial	Kuwait	No	Plaque Psoriasis	Time: 14 hour fast daily (1 month duration)	Yes	121	No	No	PASI	Weight, biochemical parameters
M. Adawi et al.	2019	Clinical Trial	Israel; International	Yes	PsA	Time: 17 hour daily fast (1 month duration)	Yes	37	No	No	DAPSA, BASDAI, LEI, DSS	Biochemical parameters
E. Klingberg et al.	2019	Clinical Trial	Sweden	No	PsA	Calories: very low energy diet (12-16 week duration), followed by gradual reintroduction of energy-restriction (12 week duration)	No	41	No	No	Percentage of patients reaching minimal disease activity (MDA)	PsARC and ACR response criteria
G. Damiani et al.	2019	Clinical Trial	Italy	Yes	Moderate-to-severe plaque psoriasis	Time: 17 hour daily fast (1 month duration)	Yes	108	No	No	PASI	BMI
P. Jensen et al.	2013	Clinical Trial	Denmark	No	Plaque Psoriasis	Calories: low energy diet (64 week duration)	No	60	Yes	Yes	PASI	DLQI
H. Lithell et al.	1983	Clinical Trial	Sweden	No	PsA; palmopiantar pustulosis (PPP)	Calories/food type: low energy diet (2 weeks duration), followed by vegan diet (1 week duration)	No	14	No	No	Dermatologic exam (similar to PASI), number/size lesions for PPP	Subjective improvement on 5-point scale; biochemical parameters
Gray et al.	2022	Protocol	United States	No	Psoriasis; PsA	Time: 16 hour fast daily (12 week duration), crossed over to regular diet (12 week duration)	No	60	Yes	Yes	PASI, PsARC	DLQI, BSA, PGA, enthesitis, dactylitis assessments, NAPSI, biometric measurements
P. Jensen et al.	2016	Observational Study	Denmark	No	Plaque Psoriasis	Calories: low energy diet (64 week duration)	No	32	Yes	Yes	PASI	DLQI
L. Grine et al.	2022	Protocol	Belgium	No	Psoriasis	Time: modified intermittent fasting (12 week duration) crossing over to regular diet (12 week duration)	No	24	Yes	Yes	PASI	Biometric measurements, biochemical parameters, satisfaction scores
M. Haugen et al.	1991	Survey	Norway	No	Psoriatic arthropathy	N/a	No	51	No	No	Subjective disease aggravation	Pain, stiffness, joint swelling

							Aim	Key Findings
S. Zanesco et al.	2022	Systematic Review	United Kingdon		Plaque Psoriasis		Explore mechanisms by which time-restricted eating may be protective in psoriasis (part of Diet and Psoriasis Project- DIEPP)	• Time-restricted eating leads to weight loss and reduced inflammation. Consideration should be given towards meal timing, duration, and quality of diet. • Effectiveness of small-scale studies are promising, but interventional, large-scale studies are needed.
Y. Jiang et al.	2021	Systematic Review	United States		Psoriasis; PsA		Further develop evidence-based dietary recommendations for psoriasis and other immune-mediated, inflammatory diseases.	• Low-calorie diets demonstrate improved quality of life and disease activity. • Both short-term and long-term benefits were observed in calorie-restriction and fasting studies.
M. Wolters	2006	Systematic Review	Germany		Psoriasis		Review importance of diet and associated factors (i.e. fasting periods) in psoriasis.	• Fasting can improve inflammatory disease symptoms, reduce ROS production, and reduce epidermal cell proliferation rate. • Promising results demonstrated by energy-restricted diet and fasting studies.

Abbreviations: PASI (Psoriasis Area Severity Index), DAPSA (Disease Activity in PsA Score), BASDAI (Bath Ankylosing Spondylitis Disease Activity Index), LEI (Leeds Enthesitis Index), DSS (Dactylitis Severity Score), PsARC (PsA Response Criteria), ACR (American College of Rheumatology), DLQI (Dermatology Life Quality Index), BSA (Body Surface Area), PGA (Physician's Global Assessment), NAPSI (Nail Psoriasis Severity Index)

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.

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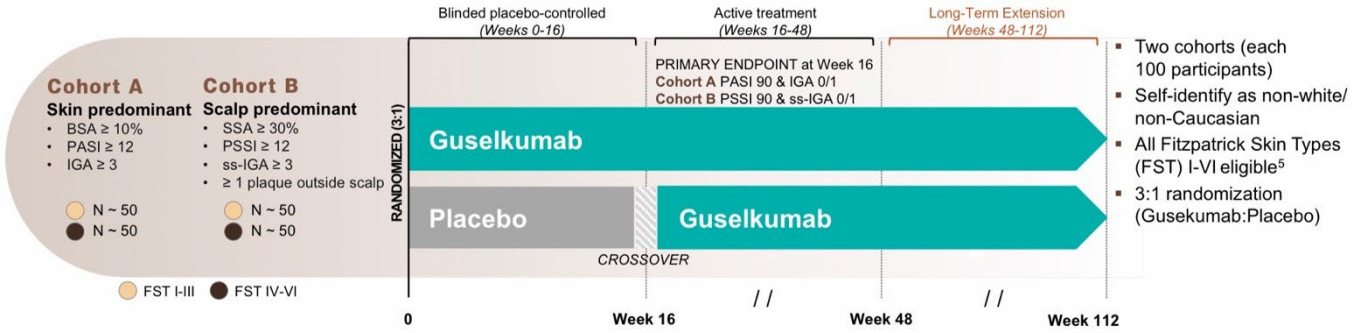
WHY IMPORTANT?

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.

POLLING QUESTION

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



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*