

Una iniciativa de:



ACADEMIA ESPAÑOLA
DE DERMATOLOGÍA
Y VENEREOLÓGIA



FUNDACIÓN
AEDV
PIEL SANA
ACADEMIA ESPAÑOLA
DE DERMATOLOGÍA
Y VENEREOLÓGIA

Con el patrocinio de:



AEDV 35^a
edición

HIGHLIGHTS

Viena

30sep - 3oct
2026

AEDV 35ª edición

HIGHLIGHTS

Viena
30sep - 3oct
2026

MIRIAM FERNÁNDEZ PARRADO

Hospital Universitario de León y del Bierzo

Grupo Pedro Jaén (Madrid)

HospitalSan Juan de Dios (León)

Una iniciativa de:



Con el patrocinio de:



AEDV 35ª edición

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TRICOLOGIA Y PATOLOGÍA UNGUEAL

Una iniciativa de:



Con el patrocinio de:



AEDV 35ª edición

HIGHLIGHTS

Viena
30sep - 3oct
2026

MIRIAM FERNÁNDEZ PARRADO

HOSPITAL UNIVERSITARIO DE LEÓN Y DEL BIERZO
GRUPO PEDRO JAÉN (MADRID)
HOSPITAL SAN JUAN DE DIOS (LEÓN)

Una iniciativa de:



Con el patrocinio de:



AEDV 35ª edición

HIGHLIGHTS

Viena
30sep - 3oct
2026

INDIQUE SI TIENE ALGÚN CONFLICTO DE INTERÉS

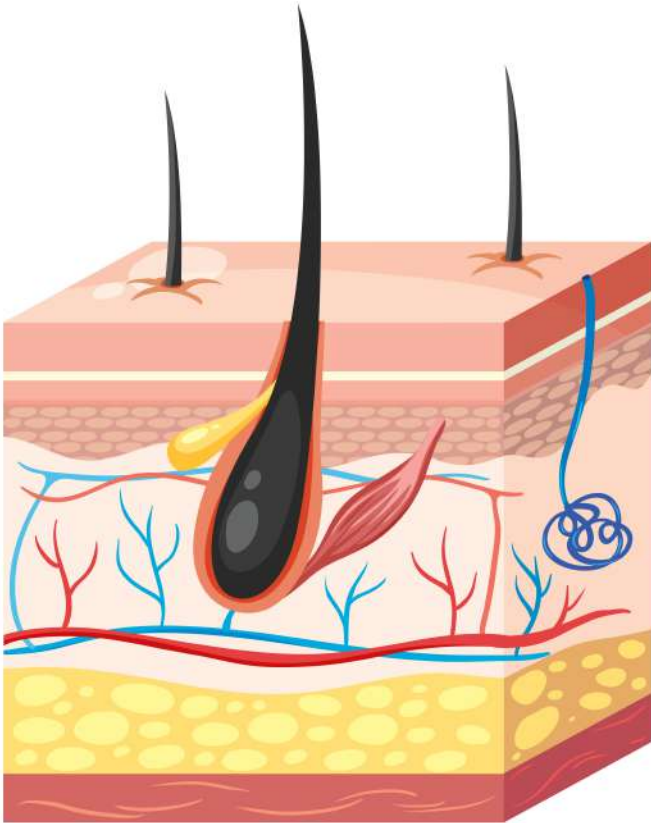
**NO TENGO CONFLICTOS
DE INTERÉS**

Una iniciativa de:



Con el patrocinio de:





TRICOLOGIA

ALOPECIAS NO CICATRICIALES

- ALOPECIA ANDROGÉNICA
- ALOPECIA AREATA
- EFLUVIO TELÓGENO

ALOPECIAS CICATRICIALES

- ALOPECIA FRONTAL FIBROSANTE
- FOLICULITIS DECALVANTE

ALOPECIA NO CICATRICIALES

ALOPECIA ANDROGÉNICA

ETIOPATOGENIA

Box 1 | Selected genes with androgenetic alopecia risk loci

Genome-wide association studies have identified >380 risk loci commonly associated with androgenetic alopecia. Selected genes linked to those risk loci are listed, categorized based on their primary role in androgen signalling, hair growth cycling and transcriptional regulation.

Androgen signalling

- AR Androgen receptor
- SRD5A2 5 alpha reductase type II
- TOP1
- FAM9B
- HDAC4
- PRKD1

Activities
of androgens

Hair cycling

- WNT10A
- FGF5
- EDA2R
- DKK2
- FZD10
- FAM53B
- RSP02
- WNT3
- WNT6
- GPR4

Regulation
of the hair follicle
growth cycle

WNT
signalling

Transcription factors

- EBF1
- TWIST1
- TWIST2
- TBX15
- RUNX3
- RUNX1
- IRF4
- PAX3
- SOX13
- PRRX1
- ZHX3
- TCF12

ALTERACIONES EN OTROS
GENES NO
RELACIONADOS CON LA
ACTIVIDAD
ANDROGÉNICA

En AGAS avanzadas también
hay adelgazamiento del
pelo en zona occipital,
No es posible la
comparación con zonas
andrógeno dependientes

- Polygenic inheritance
- More than 380 susceptibility loci
- Identified genes both on sex (X)(1) and autosomal (11) chromosomes

Park et al. J Am Acad Dermatol. 2025; 93: 1151-1153
Maas et al. J Am Acad Dermatol. 2026:S0190-9622 (26) 03035-5.

Clin Exp Dermatol 2026; 51:220-225
<https://doi.org/10.1093/ced/llaf361>
Advance access publication date: 1 August 2025

Clinical and Experimental Dermatology
Original Article

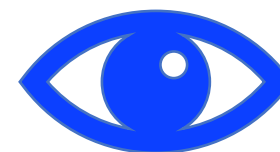
You cannot go bald without first losing your hair: telogen effluvium is a precursor to, prerequisite for and potentially an incitant to common baldness in men

Leila Asfour¹, Ulrike Blume-Peytavi², Laita Bokhari¹, Michal Kasprzak³, Matthias Seise⁴, Justyna Sicinska⁵ and Rodney D Sinclair^{1,6}

diameter (μm)	diameter (μm)	Anagen Duration (days)	Growth rate (μm/die)
> 80 μm	> 80 μm	580	355 μm
< 20 μm	70 μm	365	200
molto sottili	60 μm	200	< 100 μm

Igual no es un solo un efluvio...

...Si no el inicio de una AGA



Tratamiento con minoxidil previene



Uso de minoxidil off-label

Low-Dose Oral Minoxidil Initiation for Patients With Hair Loss: An International Modified Delphi Consensus Statement.

Akiska YM, Mirmirani P, Roseborough I, Mathes E, Bhutani T, Ambrosy A, Aguh C, Bergfeld W, Callender VD, Castelo-Soccio L, Cotsarelis G, Craiglow BG, Desai NS, Doche I, Duque-Estrada B, Elston DM, Goh C, Goldberg LJ, Grimalt R, Jabbari A, Jolliffe V, King BA, LaSenna C, Lenzy Y, Lester JC, Lortkipanidze N, Lo Sicco KI, McMichael A, Meah N, Mesinkovska N, Miteva M, Mostaghimi A, Ovcharenko Y, Piliang M, Piraccini BM, Rakowska A, Salkey KS, Schmidt A, Shapiro J, Sibbald C, Sinclair R, Suchonwanit P, Taylor S, Tosti A, Vañó-Galván S, Wall DR, Fu JM.

JAMA Dermatol. 2024 Nov 20. doi: 10.1001/jamadermatol.2024.4593. Online ahead of print.
PMID: 39565602

¿Qué hemos aprendido?

**Uso de
minoxidil
off-label**

No necesario monitorizar en pacientes sanos

¿Qué hemos
aprendido?

Uso de
minoxidil
off-label

No necesario monitorizar en pacientes sanos

Hipertrichosis: efecto 2º + frecuente

¿Qué hemos
aprendido?

Uso de minoxidil off-label

No necesario monitorizar en pacientes sanos

Hipertrichosis: efecto 2º + frecuente

Edema piernas: efecto 2º + incapacitante

¿Qué hemos aprendido?

> J Am Acad Dermatol. 2025 Jun;92(6):e197-e198. doi: 10.1016/j.jaad.2024.12.048. Epub 2025 Feb 13.

Spironolactone reduces the risk of low-dose oral minoxidil-induced edema in women with female pattern hair loss

Juan Jimenez-Cauhe ¹, Rocio Gil-Redondo ², David Saceda-Corrado ³, Adrian Imbernon-Moya ⁴, Angela Hermosa-Gelbard ³, Daniel Ortega-Quijano ³, Cristina Pindado-Ortega ³, Diego Buendia-Castaño ³, Sergio Vaño-Galvan ³

Akiska et al. JAMA Dermatol. 2025; 161: 87-95.



Uso de minoxidil off-label

No necesario monitorizar en pacientes sanos

Hipertrichosis: efecto 2º + frecuente

Edema piernas: efecto 2º + incapacitante

Poblaciones especiales

¿Qué hemos aprendido?

No fijarse solo en la edad cronológica

- Cardiovascular
- Renal / hepatic
- Thrombotic / cancer
- Polypharmacy
- Frailty / falls

ANCIANOS

> J Am Acad Dermatol. 2025 Sep;93(3):767-769. doi: 10.1016/j.jaad.2025.05.1363. Epub 2025 May 12.

Safety and tolerability of low-dose oral minoxidil in patients aged 65 or older: A multicenter study of 321 patients

Juan Jimenez-Cauhe¹, María González-Ramos², Adrian Imbernon-Moya³, Valentina Balaguera-Orjuela⁴, Angela Hermosa-Gelbard⁵, Cristina Pindado-Ortega¹, Diego Buendia-Castaño¹, Rocio Gil-Redondo⁶, David Saceda-Corralo⁶, Sergio Vaño-Galvan¹

-Hipertrichosis
+Efectos adversos sistémicos
Taquicardia
Suspensión fármaco
Mejor dosis diaria



ORIGINAL

[Artículo traducido] Seguridad de minoxidil oral a dosis bajas en pacientes con hipertensión o arritmias: estudio multicéntrico de 264 pacientes

J. Jimenez-Cauhe^{1,2}, R. Pirmez¹, P. Müller-Ramos¹, D.F. Melo⁴, D. Ortega-Quijano^{1,2}, O.M. Moreno-Arroyos^{1,2}, D. Saceda-Corralo^{1,2,3}, R. Gil-Redondo^{1,2}, A. Hermosa-Gelbard^{1,2}, B. Dias-Sanabria¹, D. Restom¹, M.L. Porriño-Bustamante¹, C. Pindado-Ortega^{1,2}, E. Bernal-Rico¹, D. Fernandez-Nieto^{1,2}, M. Ramos¹, P. Jaen-Olasolo^{1,2} y S. Vaño-Galvan^{1,2}

Perfil de seguridad similar a población general pero con algunas consideraciones

HIPERTENSION

Precauciones especiales	Recomendaciones
Antecedentes personales de: - Hipotensión postural, síncope, hipertensión no controlada o arritmia. - Combinación de 3 o más fármacos antihipertensivos. - Tratamiento con Doxazosina	Considerar - Automedición de la presión arterial en los primeros días de la toma de MOBD - Realizar electrocardiograma basal - Consultar con el cardiólogo *
MOBD no recomendado^b Antecedentes personales de mayor riesgo de: - Infarto de miocardio (enfermedad coronaria) ^c - Insuficiencia cardíaca crónica con fracción de eyección reducida - Enfermedad valvular grave - Trastornos pericárdicos recientes - Enfermedad renal avanzada	Recomendaciones: - Consultar seriamente: - Consultar con el cardiólogo

ARRITMIAS

Poblaciones especiales

¿Qué hemos aprendido?



Bruno Halioua
Association between GLP-1 receptor agonists and scalp involvement: results from a multinational case-control study

Caída de pelo
+
signos
inflamatorios

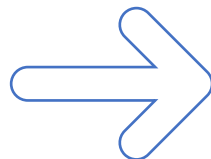
> Br J Dermatol. 2026 Jul 15:ljag280. doi: 10.1093/bjd/ljag280. Online ahead of print.

Increased Efficacy of Daytime Low-dose Oral Minoxidil Dosing for Androgenetic Alopecia: A Retrospective Study

Derek Maas ¹, Archie Spindler ¹, Isabella Zappi ^{1 2}, Margaret Cote ¹, Jolie Kantor ¹, Esha Patel ¹, Sarah Go ¹, Ian M Ahearn ¹, Ian W Tattersall ¹, Lynn Petukhova ¹, Jerry Shapiro ¹, Kristen I Lo Sicco ¹



329
MINOXIDIL

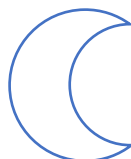


Más incremento de densidad en zona frontal

No aumento del calibre del pelo



Ritmo circadiano





Topical Minoxidil and Companion Animals



Topical minoxidil is effective and generally well tolerated in humans, but it can cause severe poisoning in dogs and cats after ingestion or contact. Exposure may occur indirectly through treated hands, hair, skin, pillows, surfaces or contaminated waste.



1. Why is it dangerous?

Cats and, to a lesser extent, dogs have limited glucuronidation capacity. Even small exposures may cause cardiovascular toxicity; cats tend to develop more severe reactions and have a higher mortality risk.



2. Clinical signs:

Symptoms may appear from 1 hour to 3 days after exposure. Early signs include weakness, vomiting, drooling, hypotension, hypothermia, tachycardia and lethargy. Severe cases may involve respiratory difficulty, pulmonary oedema and pleural effusion.



3. Prevention:

Ask about dogs and cats before prescribing. Apply minoxidil in a closed room, store it out of reach, wash hands, prevent contact with treated hair, skin, pillows and bedding, and dispose of applicators and tissues safely.



4. Suspected exposure:

Contact a veterinarian or emergency veterinary service immediately, even if the animal appears well.

Do not induce vomiting or give home remedies. Prevent licking and ask the veterinarian about decontamination.



Ma et al. *J Am Acad Dermatol.* 2026; McMullen et al. *J Am Acad Dermatol.* 2025; Tater et al. *J Am Anim Hosp Assoc.* 2021; Xiong et al, *Int J Dermatol.* 2026.





Precautions for Using Minoxidil in the Presence of Pets



- Applications and storage: Apply minoxidil lotion in a closed room that is inaccessible to the animal; close the bottle immediately and store it in a cabinet out of the animal's reach.



- Contact with the animal: Keep the animal away from treated hands, skin, and hair; do not allow it to lick the head or lie on a pillow or bedding that may be contaminated.



- Drying: Allow the product to dry completely before going to bed.



- Cleaning surfaces: Immediately collect any drops that have fallen and wash the surface with soap and water, rinsing thoroughly.



- Disposal: Throw applicators, tissues, and packaging into a bin that is out of the animal's reach.

Oral finasteride 1 mg for AGA in males

Safety

- **Sexual adverse events are the best-quantified risk.** In 11 placebo-controlled randomized trials (3,751 men), at least one sexual adverse event occurred in **5.3% with finasteride versus 3.1% with placebo** (RR 1.66, 95% CI 1.20–2.30); **erectile dysfunction occurred in 2.4% versus 1.0%**. This is an absolute excess of about 2.3 percentage points over the trials' follow-up, not an annual risk.
- **Long-term certainty is limited.** A five-year extension reported no new safety signal, but a review of 34 trials found that none reported adverse events adequately and 26 followed safety for one year or less. A 2026 review likewise describes sexual adverse events as generally uncommon in controlled trials, while calling for better long-term data. **The frequency of rare or persistent post-treatment effects therefore remains uncertain.**
- **Mood and suicidal ideation require explicit counseling.** Following its EU-wide review, EMA confirmed suicidal ideation as an adverse reaction to oral finasteride; its frequency is not known, and most reported cases involved 1 mg used for hair loss. Patients taking 1 mg should stop treatment and seek medical advice if depressed mood, depression, or suicidal thoughts occur; they should seek medical advice for sexual dysfunction and consider discontinuation. **The EU review concluded that benefits continue to outweigh risks for approved uses.**

Złotowska A, et al. *Front Med.* 2026;13:1787706. Zot26

EMA PRAC/CMDh and AIFA. *Finasteride and dutasteride: measures to minimise the risk of suicidal ideation.* 2025. EMA · AIFA

Antiandrogen therapy in female androgenetic alopecia

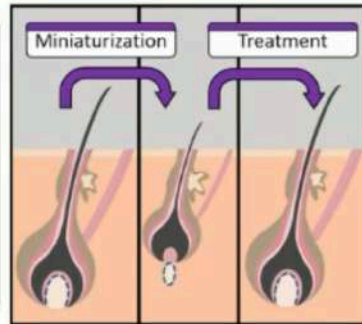
Drug	Dose	Pharmacologic Class	Female-specific evidence	Side effects
Bicalutamide	10-50 mg/day	Nonsteroidal androgen-receptor antagonist	Most clinical experience. In a 24-week pilot RCT, 100 mg/day added to topical minoxidil improved moderate-to-marked photographic response (38% vs 9%); between-group hair-count differences were not statistically significant.	risk of liver injury; periodic for transaminase monitoring required
Spironolactone	50-200 mg/day	Androgen-receptor antagonist; also an antimineralocorticoid	In a 24-week RCT (n=204), 50 mg/day improved trichoscopic density and shaft diameter more than spironolactone 100 mg/day; clinical endpoints did not differ significantly.	menstrual changes and dizziness: rare. Consider potassium and renal-function risks
Finasteride	2.5-5 mg/day	Type II 5 α -reductase inhibitor	In a placebo-controlled trial of 137 postmenopausal women, 1 mg/day for 12 months did not improve hair-count or global outcomes. Benefits reported at 2.5–5 mg/day come mainly from small or uncontrolled studies.	-
Dutasteride	0.15-0.5 mg/day	Type I and II 5 α -reductase inhibitor	A 3-year observational comparison in women used 0.15 mg/day; both dutasteride and finasteride groups improved hair thickness. A dutasteride advantage was reported only in the under-50 subgroup.	-

Contraception needed

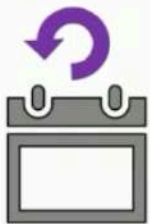
Topical Finasteride 0.25% Monotherapy for Female Pattern Hair Loss in Postmenopausal Women: A 52-Week Observational Study

Objective:

To assess the efficacy of topical finasteride 0.25% monotherapy in the treatment of female pattern hair loss (FPHL) in postmenopausal women over 52 weeks.



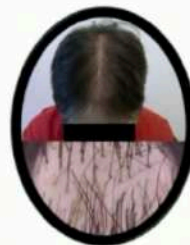
Methods



Retrospective
52 Weeks

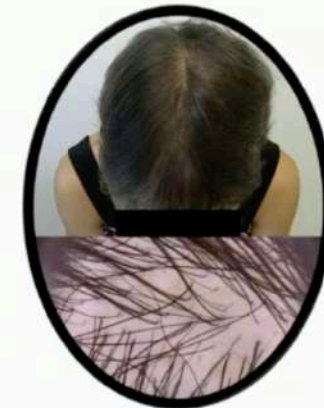


26
Postmenopausal
Women
with FPHL



Hair Density
Hair Thickness
Terminal-to-Vellus
Hair Ratio

Results



Hair Density: **+23.37 hairs/cm²***

Hair Thickness: **+10.62 μ m***

Terminal-to-Vellus: **+0.52*** * $p < 0.001$

Topical Finasteride 0.25% was a safe and effective in the treatment of FPHL in postmenopausal women over 52 weeks.

36/10

EFLUVIO TELÓGENO

NUTRICOSMÉTICOS

Oral Supplements for Hair Growth

A systematic review and meta-analysis of 14 trials

Who was studied

- 967 participants across 14 studies
- 12 RCTs and 2 prospective studies
- Ages 18 to 71 years
- Comparator was usually placebo; one trial used an active fish-extract comparator

What was tested

- Ceramosides, Nutrafol, Nourkrin, Lambdaplil-1SDIN, Viviscal, FortiS, GFM supplement, Cynatine HNS, and a fish/marine extract
- Dosing schedules varied by product
- Study duration: 12 weeks up to 12 months

Alanazi R, Alshammari S, Aldossari K, Alwatban R, Aljeribah D, Alanazi S, Alsahhi A, Alhumam A, Alajlan A. J Cosmet Dermatol 2026;25:e70817. doi:10.1111/jocd.70817

The two products compared

Bernárdez RCT

Amino acids
L-cysteine, L-methionine, L-arginine, L-lysine

Antioxidants
Vitamin E, resveratrol, anthocyanidins, astaxanthin

Adaptogen / postbiotics
Ashwagandha; L. reuteri, paracasei, plantarum

Micronutrients
Vitamin C, folic acid, biotin, zinc, selenium, iron

Anti-inflammatory
Curcuma longa, Nigella sativa

Plant extracts
Serenoa repens, Prunus africana, Cucurbita pepo

Piquero-Casals RCT

L-Cystine
Amino acid needed for keratin structure

Cucurbita pepo
Pumpkin seed; antioxidant, anti-inflammatory

B vitamins
Nicotinamide, pantothenic acid, pyridoxine, biotin

Serenoa repens & Pygeum
5-alpha reductase inhibitor extracts

Zinc sulfate
Trace element for protein synthesis

Equisetum arvense
Horsetail extract; anti-inflammatory, antioxidant

Dose: one 25 mL vial daily after breakfast or lunch, vs matched placebo

Dose: one capsule daily for 6 months, vs MCT placebo capsule

PRP

Seven publications (Dec 2023–Sept 2026) that report on PRP efficacy for telogen effluvium

Study	Design	PRP Verdict
Bedoui et al., 2026	RCT, diffuse TE	Positive — best when combined with PDT
Hogade et al., 2026	Comparative, AGA+TE	Positive — but outperformed by GFC
Rajar/Fahim et al., 2024	RCT, chronic TE	Positive — best when combined with serum
Yuan et al., 2024	SR/MA, AGA/TE/FPHL	Strongly positive — CTE = best responder
Anitua et al., 2025	SR/MA, pooled alopecias	Positive overall — not TE-specific
Koç Babayiğit et al., 2025	Comparative, AGA, TE	Positive — tangential population (AGA)
Gentile & Garcovich, 2023	SR, COVID-TE	Preliminary — low-certainty signal

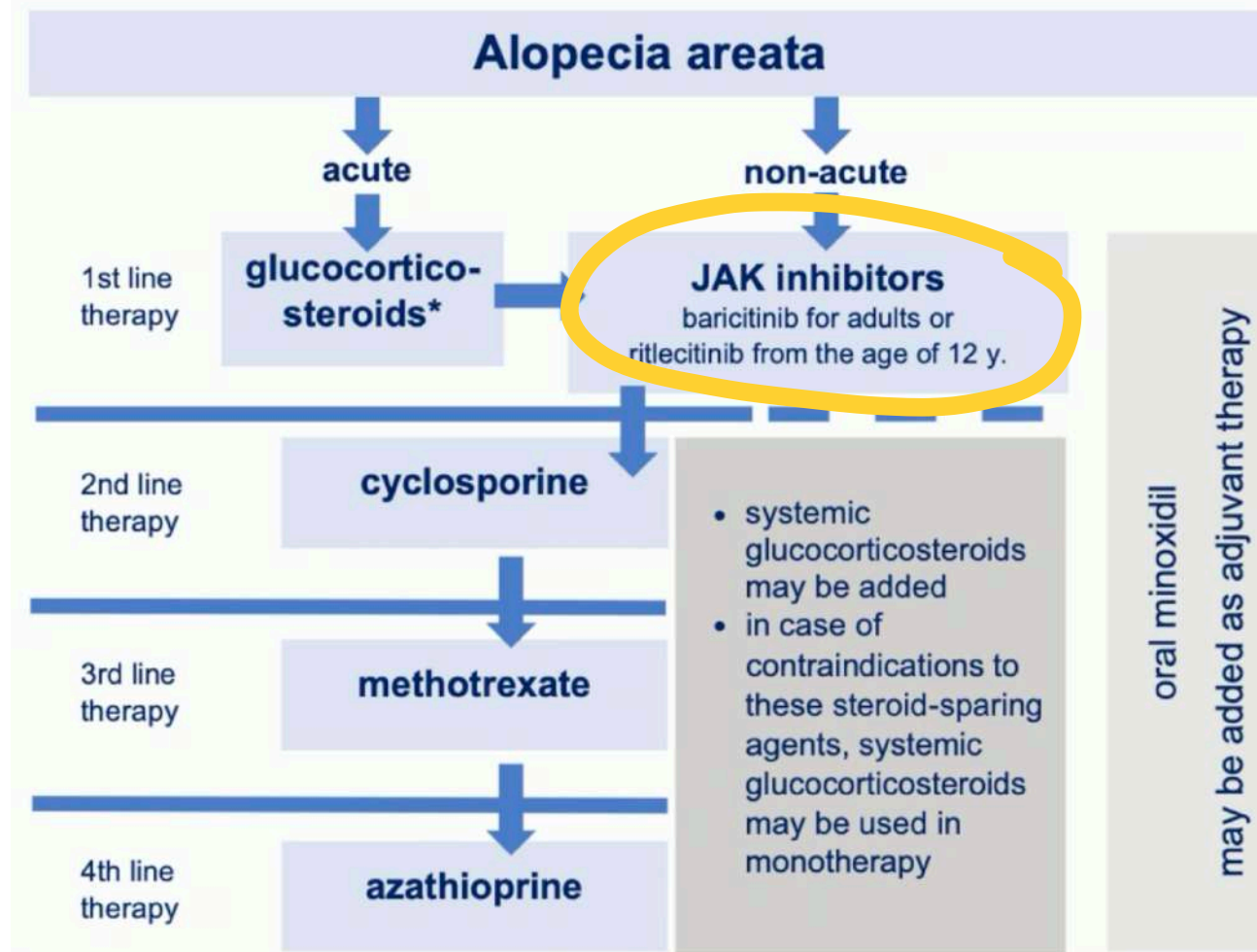
Pattern across all seven: every study reports PRP as biologically active and safe for TE

ALOPECIA AREATA

TRATAMIENTO

European expert consensus statement on the systemic treatment of alopecia areata

L. Rudnicka¹ | M. Arenbergerova² | R. Grimalt³ | D. Ioannides⁴ |
A. C. Katoulis⁵ | E. Lazaridou⁵ | M. Olszewska¹ | Y. S. Ovcharenko⁶ |
B. M. Piraccini^{7,8} | A. Prohic⁹ | A. Rakowska¹ | P. Reygagne¹⁰ | M. A. Richard¹¹ |
R. O. Soares¹² | M. Starace^{7,8} | S. Vaño-Galvan¹³ | A. Waskiel-Burnat¹



TRATAMIENTO

Dr. Vañó

BARICITINIB (JAKi 1/2):
FDA/EMA approved
(June 2022)

RITLECITINIB (JAKi 3):
FDA approved June 2023
EMA approved: Sept 2023



>12 años

Lilly

abbvie

UPADACITINIB (JAKi 1):
EMA approval: 2026

No solo eficaces, si no también buen perfil de seguridad

AEs Commonly Reported

Upper respiratory tract infection

Headache

Nasopharyngitis

Nausea

Acne

Black Box Warning

Serious infection

Major adverse cardiovascular events

Thromboembolic events

Malignancy

NOT OBSERVED MORE FREQUENTLY IN
ALOPECIA AREATA PATIENTS TREATED
WITH JAK INHIBITORS

Mantener tratamiento

Descender muy progresivamente

TRATAMIENTO

Dr. Vañó

BARICITINIB (JAKi 1/2):
FDA/EMA approved
(June 2022)

RITLECITINIB (JAKi 3):
FDA approved June 2023
EMA approved: Sept 2023



>12 años

Lilly

abbvie

UPADACITINIB (JAKi 1):
EMA approval: 2026

Efficacy of upadacitinib for the treatment alopecia areata: A systematic review and meta-analysis.

Barnawi G, Lazarowitz R, Nukaly HY, Creighton R, Ridha Z, Aldein AS, Algaidi Y, Weiss E, Litvinov IV, Donovan J.

J Am Acad Dermatol 2026 Oct;95(4):1155-1158. doi: 10.1016/j.jaad.2026.06.013. Epub 2026 Jun 6. PMID: 42251939 **Free article.** No abstract available.

33 estudios, 136 pacientes

- ✓ SALT BASAL77,1
- ✓ REDUCCIÓN MEDIA DE SALT 68,5 EN SEMANA 24
- ✓ ADULTOS = NIÑOS
- ✓ 30MG = 15MG
- ✓ EFICACIA SIMILAR EN PACIENTES NAIVE O TRAS FALLO A iJACK previo

Alopecia areata: Emerging therapies and up-to-date management strategies.

Spindler A, Maas D, Zappi I, Brinks A, Kearney CA, Nohria A, Orlov S, Grant-Kels JM, Shapiro J, Lo Sicco KI.

J Am Acad Dermatol. 2026 Aug 17:S0190-9622(26)03323-2. doi: 10.1016/j.jaad.2026.07.132. Online ahead of print.

PMID: 42607954 Review.

Approved oral JAK options in the paper

- **Baricitinib:** JAK1/2; adult AA; SALT20 at week 36: **22.8% with 2 mg, 38.8% with 4 mg.** AREATA 2026 emerging therapies
- **Ritlecitinib:** JAK3/TEC; ≥12 years; SALT20 **14–31%** depending on dose/loading, with continued improvement to week 48. AREATA 2026 emerging therapies
- **Deuruxolitinib:** JAK1/2; adult AA; SALT20 at week 24 **29.6–33.0% with 8 mg BID and 38.41.5% with 12 mg daily.**

TRATAMIENTO

Dr. Vañó

BARICITINIB (JAKi 1/2):
FDA/EMA approved
(June 2022)

RITLECITINIB (JAKi 3):
FDA approved June 2023
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J Am Acad Dermatol. 2026 Aug 17:S0190-9622(26)03323-2. doi: 10.1016/j.jaad.2026.07.132. Online ahead of print.

PMID: 42607954 Review.

En caso de fallo, probar otro iJAK

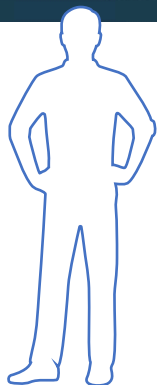
Después del 1er cambio 48,8% SALT < 20

Después del 2 cambio 52,4%

ORAL MINOXIDIL ENHANCES EARLY RESPONSE TO BARICITINIB IN MODERATE-TO-SEVERE ALOPECIA AREATA A RETROSPECTIVE STUDY OF 59 PATIENTS

Juan Jimenez-Cauhe, Diego Buendia-Castaño, David Saceda-Corralo, Daniel Ortega-Quijano, Cristina Pindado-Ortega, Sergio Vaño-Galvan, Angela Hermosa-Gelbard

Unidad de Tricología, Grupo Pedro Jaén; Servicio de Dermatología, Hospital Universitario Ramón y Cajal, IRYCIS, Madrid, Spain



Baricitinib 4mg

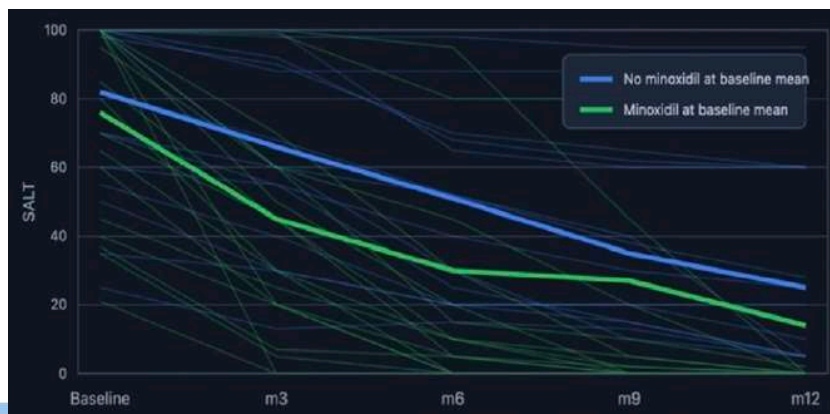
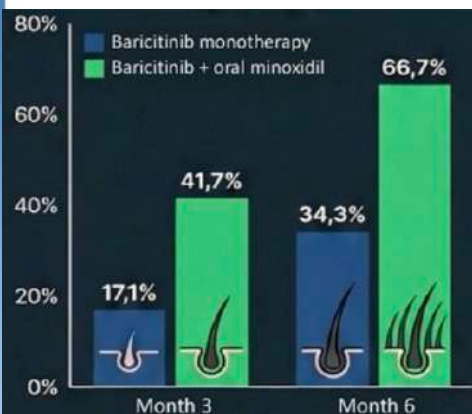
59 pacientes



Iniciado desde el principio

Iniciado a los 3 meses

Iniciado a los 6 meses



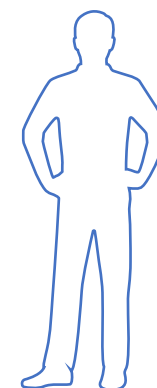
Combination of oral minoxidil and baricitinib for alopecia areata: A retrospective study of 77 patients.

Jimenez-Cauhe J, Buendia-Castaño D, Saceda-Corralo D, Ortega-Quijano D, Pindado-Ortega C, Vaño-Galvan S, Hermosa-Gelbard A.

J Am Acad Dermatol. 2026 Apr;94(4):e253-e254. doi: 10.1016/j.jaad.2025.10.157. Epub 2025 Dec 2. PMID: 41344450 No abstract available.

Mejoría del SALT

SALT 100	SALT 45	SALT30	SALT15	SALT5
Basal	9 meses	6 meses	9 meses	12 meses



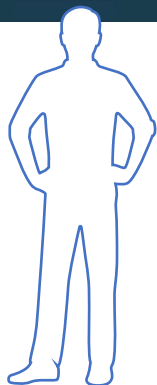
77 pacientes

Baricitinib 4mg
+
minoxidil oral 2mg/dia
(1-5mg)

ORAL MINOXIDIL ENHANCES EARLY RESPONSE TO BARICITINIB IN MODERATE-TO-SEVERE ALOPECIA AREATA A RETROSPECTIVE STUDY OF 59 PATIENTS

Juan Jimenez-Cauhe, Diego Buendia-Castaño, David Saceda-Corralo, Daniel Ortega-Quijano, Cristina Pindado-Ortega, Sergio Vaño-Galvan, Angela Hermosa-Gelbard

Unidad de Tricología, Grupo Pedro Jaén; Servicio de Dermatología, Hospital Universitario Ramón y Cajal, IRYCIS, Madrid, Spain



Baricitinib 4mg

59 pacientes



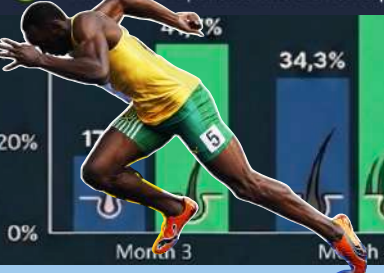
Iniciado desde el principio

Iniciado a los 3 meses

Iniciado a los 6 meses

1 Faster response in patients receiving OM since baricitinib initiation (Figures 2 and 3)
With no change in long-term response rate (no significant differences at 9 and 12 months), suggesting that OM primarily accelerates hair regrowth rather than modifying the long-term effectiveness of baricitinib.

2 Potential "booster" effect of OM in non-responders to baricitinib monotherapy
Adding OM in patients who did not respond to baricitinib monotherapy at month 3, increased the response rate at month 9.



Baricitinib + minoxidil puede acelerar la
respuesta terapéutica aunque no modifique
resultados a largo plazo
Actuar como en no respondedores

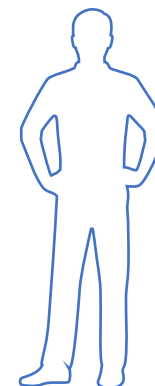
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Mejoría del SALT

SALT 100	SALT 45	SALT30	SALT15	SALT5
Basal	9 meses	6 meses	9 meses	12 meses



77 pacientes

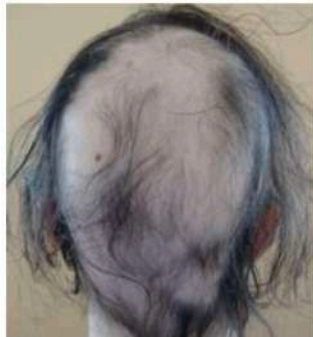
Baricitinib 4mg
+
minoxidil oral 2mg/dia
(1-5mg)

Dr. Vañó

PRACTICAL MANAGEMENT OF JAK INHIBITORS FOR ALOPECIA AREATA

PATIENT CANDIDATE FOR JAKi

(>12 years, SALT>50, quality of life impairment, no response to previous therapies)



CLINICAL MANAGEMENT

- Baricitinib** 4 mg daily (approved)
- Ritlecitinib** 50 mg daily (approved)
- Upadacitinib** 30 mg/ daily (EMA approved)
- Deureuxolitinib**: 8 mg BID(FDA approved)

- ☐ Evaluate every 3-6 months
- ☐ Wait 9 months without regrowth to classify a patient as non-responder

REQUIRED PREVIOUS TESTS (Blood cell count, complete metabolic panel, lipids, HIV, HCV, and HBV antibodies, tuberculosis screening: tuberculin skin test/IGRA)

+ VACCINE SCHEDULE UPDATE (including herpes zoster vaccine).

IMPORTANT:

*Withdraw if: lymphopenia < 500, neutropenia < 1000, Hb < 8
 *The lipid profile may worsen after 4 weeks (baricitinib)

→ Perform blood analysis pre and after 1 month (ritle) / 3 months (bari)



Evening Versus Morning Baricitinib Administration in Alopecia Areata: A Real-World Cohort Study

Luca Valtellini, MD^{1,2}, Chiara Prunerì^{1,2}, Mauro Barbareschi², Angelo V. Marzano^{1,2}, Andrea Sechi¹

¹Department of Pathophysiology and Transplantation, University of Milan, Milan, Italy.

²Dermatology Unit, Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Milan, Italy.

¿Cuándo?



	Morning	Evening	Overall
Sex; n (%):			
- Female	37 (64)	33 (66)	70 (65)
- Male	21 (36)	17 (34)	38 (35)
Age, years; median (IQR)	45 (35.25–52.75)	35.5 (25.25–50.75)	42 (30.75–52.25)
Duration of AA, years; median (IQR)	10 (3–19.5)	9 (3.25–19.75)	10 (3–20)
Current episode, months; median (IQR)	3 (1–8)	3 (1–7.5)	3 (1–8)
Severity of AA; n (%):			
- AU	37 (63.79)	27 (54)	64 (59.26)
- AT	6 (10.45)	8 (16)	14 (12.96)
- Severe Patchy alopecia	15 (25.86)	15 (30)	30 (27.78)
SALT score T0; median (IQR)	100 (86.25–100)	100 (70–100)	100 (83.75–100)
ClinRO score EB T0; median (IQR)	3 (2–3)	3 (1–3)	3 (1–3)
ClinRO score EL T0; median (IQR)	3 (1.25–3)	3 (1–3)	3 (1–3)
SALT score T48; median (IQR)	50 (10–80)	20 (0–78.75)	30 (5–80)
SALT ≤20 T48; n (%)	20 (34.5)	27 (54)	47 (43.52)
ClinRO score EB T48; median (IQR)	0.5 (0–2)	0 (0–2)	0 (0–2)
ClinRO score EL T48; median (IQR)	0.5 (0–2)	0 (0–1)	0 (0–2)

SEMANA 48

SALT MEDIO NOCHE 20

VS

SALT MEDIO MAÑANA 50

SALT <20NIGHT (54%)

VS

MAÑANA (34,5%)

RESULTADOS ESTADÍSTICAMENTE
SIGNIFICATIVOS BRUTOS Y
AJUSTADOS

Rezpegaldesleukin, a Novel Regulatory T Cell-Inducing Biologic, Demonstrates Efficacy and Safety in Severe-to-Very-Severe Alopecia Areata: 52-Week Results from the Phase 2b REZOLVE-AA Study

David Rosmarin¹, Benjamin Ungar², Natasha Mesinkovska³, Jonathan I. Silverberg⁴, Beata Imko-Walcuk⁵, Ewa Ring⁶, Tadeusz Debniak⁷, Hubert Arasiewicz⁸, Jacek Szepietowski⁹, Agnieszka Owczarczyk-Saczonek¹⁰, Wojciech Baran¹¹, Bartłomiej Kwiek¹², Michał Torz¹³, Jacek Zdybski¹⁴, Neil Sadick¹⁵, Evelyn Chinchilla¹⁶, Mary Veremis-Ley¹⁷, Edward Lain¹⁸, Lawrence Osman¹⁹, Lorne Albrecht²⁰, Charles Lynde²¹, Maria Hannaway²², Haq Nawaz²², Zachary Lee²², Soratree Charoenthongtrakul²², Christie Fanton²², Heng Xu²², Yi Liu²², Sohail Chaudhry²², Mary Tagliaferri²², Jonathan Zalevsky²², Brett King²³

Rezpegaldesleukin (REZPEG) is a novel, first-in-class biologic targeting regulatory T cells (Tregs)

- ✓ Administered as an active drug, with extended half-life¹
- ✓ Preferential binding to IL-2 receptor complex on Tregs compared to conventional T cells (Tcons)¹
- ✓ *In vivo* selectively expands and enhances the function of Tregs^{1,2}
- ✓ Previously demonstrated clinical activity in atopic dermatitis (AD), psoriasis, systemic lupus erythematosus²⁻⁵

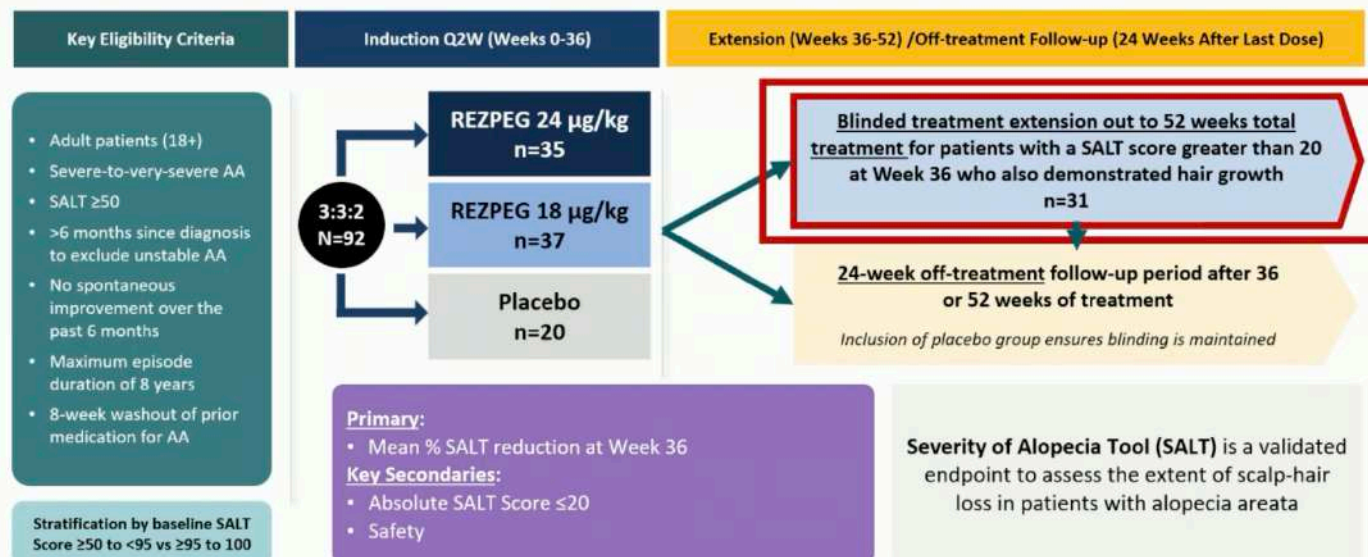
As a Treg agonist, Rezpegaldesleukin is differentiated from biologics currently approved and in development for dermatologic indications.

Resultados preliminares
Fase 3 2027

- ✓ No diferencia en eficacia entre AA > o < 4 años:
SALT < 20: 30%
- ✓ Persistencia de resultados al menos 6 meses tras suspender tratamiento

Phase 2b REZOLVE-AA Study Evaluating REZPEG for Alopecia Areata

Severe-to-Very-Severe Alopecia Areata (NCT06340360) - Granted Fast Track Designation in July 2025



Bempikibart: una nueva vía inmunológica en alopecia areata

Anticuerpo anti-IL-7Ra · alopecia areata grave/muy grave

¿QUÉ LO HACE DIFERENTE?

BEMPIKIBART



Bloqueo de IL-7Ra

↓ señalización de IL-7 + TSLP

Modula la inmunidad adaptativa sin actuar sobre JAK.

Objetivo: restaurar la homeostasis folicular

SEÑAL DE EFICACIA A 36 SEMANAS

35,3%

reducción media del SALT (mITT)

40%

alcanzó SALT ≤20 (mITT)

33

pacientes tratados (estudio abierto)

LO MÁS INTERESANTE: PERSISTENCIA SIN FÁRMACO

16 semanas sin tratamiento

En los 12 pacientes con crecimiento al finalizar el tratamiento:

100%
mantuvo

42%
profundizó

TAKE-HOME

No es un iJAK y la respuesta podría persistir tras suspenderlo.

ALOPECIAS CICATRICIALES

Dr. Dmitri Wall

Emerging JAKi case series

THERAPEUTIC HOTLINE: SHORT PAPER

WILEY

Tofacitinib for the treatment of lichen planopilaris: A case series

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¹Department of Dermatology, Columbia University Medical Center, New York, New York

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Abstract

Lichen planopilaris (LPP) is an inflammatory cicatricial alopecia for which many different therapies are attempted with varying success. The Janus kinase (JAK) inhibitor, tofacitinib, has been shown to be effective in treating the noncicatricial alopecia, alopecia areata. As in alopecia areata, upregulation of interferon and JAK signaling may play a role in LPP. We retrospectively reviewed the cases of 10 patients with recalcitrant LPP who were treated with oral tofacitinib. Patients received oral tofacitinib 5 mg twice or three times daily for 2–19 months as either monotherapy or adjunctive therapy to other ongoing treatments including intralesional triamcinolone, hydroxychloroquine, and tacrolimus ointment. Eight patients had clinical improvement in LPP with tofacitinib as either monotherapy (4/10) or adjunctive therapy (4/10). LPP Activity Index (LPPAI) before and after treatment was measured in seven patients and was significantly different (6.22 before treatment, 3.08 after treatment; p value = .0014). Reduction in LPPAI ranged from 30 to 94%. One patient complained of 10 pound (4.5 kg) weight gain after 12 months on tofacitinib. No other adverse effects were reported. Treatment with oral tofacitinib either as monotherapy or adjunctive therapy can lead to measurable improvement in recalcitrant LPP.

KEYWORDS

alopecia, frontal fibrosing alopecia, JAK inhibitors, lichen planopilaris, scarring alopecia, tofacitinib

LETTER

RESEARCH LETTER

Tofacitinib in the treatment of lichen planopilaris: A retrospective review

To the Editor: Tofacitinib is a Janus kinase inhibitor currently approved for the treatment of rheumatoid arthritis, psoriatic arthritis, and ulcerative colitis.¹ Topical and systemic forms have also been used off label to treat a variety of dermatologic conditions, including psoriasis and vitiligo.^{2–5} Lichen planopilaris is an immunomediated cicatricial alopecia that is often treatment refractory, but limited evidence supports the therapeutic potential of oral tofacitinib.^{6,7} The aim of this study is to further investigate the efficacy of both topical and oral tofacitinib in the treatment of recalcitrant lichen planopilaris.

A retrospective review was conducted with approval of the institutional review board at the Medical University of South Carolina. From May 2012 through March 2020, 9 patients treated with

tofacitinib for lichen planopilaris were identified (Table 1). All patients were white and had failed extensive therapies.

Tofacitinib was used adjunctively in all patients (Table 1). In both topical and oral forms, the median time to initial treatment response was 3 months. Through use of patient-reported symptoms and physical examination findings (affected area, erythema, and presence of follicular spines), treatment response was graded relative to baseline disease severity at the initiation of tofacitinib therapy. Three of 4 patients receiving topical therapy achieved a positive initial response, and 2 patients exhibited sustained clinical improvement. Patient 9 exhibited a negative clinical response to topical therapy and was converted to systemic therapy after 1 month. All patients receiving systemic therapy demonstrated a favorable initial response, and this was maintained in all but 1 patient. In patients 6 and 7, oral dosing was increased to 3 times

Table 1. Disease history before initiation of tofacitinib therapy

Patient no.	Sex	Age at diagnosis, years	Disease variant	Diagnostic method	Previous treatment duration, years	Previous therapies
1	F	61	FFA, classic LPP	Biopsy	1	Doxycycline, dutasteride, HCQ, pioglitazone, tacrolimus ointment, topical steroids
2	F	69	Classic LPP	Biopsy	9	Doxycycline, dutasteride, finasteride, HCQ, ILK, laser cap, minoxidil, pimecrolimus cream, topical steroids
3	F	63	FFA	Clinical	1	Finasteride, minoxidil, MPA, topical steroids
4	F	49	Classic LPP	Biopsy	3	HCQ, ILK, naltrexone, pimecrolimus cream, topical steroids
5	F	63	FFA, classic LPP	Clinical	2.5	Dutasteride, finasteride, HCQ, ILK, naltrexone, pimecrolimus cream, pioglitazone, topical steroids
6	M	33	Classic LPP	Biopsy	2	HCQ, ILK, laser cap, naltrexone, pimecrolimus cream, pioglitazone, topical steroids
7	F	67	FFA	Clinical	1	Dutasteride, naltrexone, pimecrolimus cream, pioglitazone, topical steroids
8	F	61	FFA, classic LPP	Clinical	2.5	Dutasteride, excimer laser, HCQ, naltrexone, pimecrolimus cream, pioglitazone, prednisone
9	F	59	FFA, classic LPP	Biopsy	6	Cyclosporine, dutasteride, excimer laser, HCQ, ILK, ketoconazole cream and shampoo, laser cap, leflunomide, MPA, naltrexone, pimecrolimus cream, prednisone, tacrolimus ointment, topical steroids

F, Female patient; FFA, frontal fibrosing alopecia; HCQ, hydroxychloroquine; ILK, intralesional triamcinolone; LPP, lichen planopilaris; M, male; MPA, mycophenolic acid.

use. *J Am Acad Dermatol.* 2021;84(1):199–200. <https://doi.org/10.1016/j.jaad.2020.04.101>

<https://doi.org/10.1016/j.jaad.2022.02.018>

Treatment of lichen planopilaris with baricitinib: A retrospective study

To the Editor: Lichen planopilaris (LPP) is a primary lymphocytic cicatricial alopecia.¹ Frontal fibrosing alopecia (FFA) is considered a clinical variant of LPP. Limited evidence supports the therapeutic potential of tofacitinib, a Janus kinase (JAK)-1/3 inhibitor, in the treatment of recalcitrant LPP.² The aim of our study was to evaluate the efficacy of baricitinib, JAK-1/2 inhibitor, for the treatment of LPP.³

We retrospectively reviewed the records of 2 patients with LPP treated with baricitinib for ≥ 3 months between January 2019 and December 2021. Disease activity was assessed using the Lichen Planopilaris Activity Index (LPPAI), where a score of 0 indicates no disease activity and a score of 1 indicates maximal disease activity.⁴ Data analysis was performed using SPSS V28.0 (International Business Machines Corporation). The Wilcoxon signed rank test was used to compare pre- and post-treatment LPPAI scores.

Twelve patients with recalcitrant LPP were identified; 7 patients had classical LPP and 5 had FF (Table 1). The median age at diagnosis was 43 years

ALOPECIA FRONTAL FIBROSANTE

EADV CONGRESS 2026

Dr. Dmitri Wall

Clinical trials in FFA and cicatricial alopecia



#	Study / intervention	Disease	Design / sample	Status / headline result
1	Delgocitinib 20 mg/g cream	FFA	Phase 2 open-label, n=30	Almost complete recruiting
2	Delgocitinib cream (molecular-signature trial)	FFA	Phase 2a randomized vehicle-controlled 1:1 n=30	↓ FFASS/LPPAI + ↓ Th1 (CXCL9) / JAK biomarkers
3	Brepocitinib (ALPINE)	LPP	Phase 2/3 randomized placebo-controlled, n=342	Recruiting
4	Ritlecitinib	CCCA; LPP; FFA	Phase 2 open-label pilot, n=50 (FFA=15)	Unpublished: 48/52 FFASI 41%↓ CCL5 ↓
5	Baricitinib	FFA	Pilot interventional study, n=15	Active, not recruiting
6	Tofacitinib	Recalcitrant FFA	Pilot open-label, n=11	↓ FFASI, FFASS & LPPAI
7	Hydroxychloroquine vs methotrexate	FFA	Patient-preference comparative trial	? recruiting

1. NCT07671157



2. NCT05332366



3. NCT07532603



4. NCT05549934



5. NCT06240351



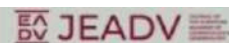
6. NCT06202560



7. NCT07190534



ORIGINAL ARTICLE



Statement from the frontal fibrosing alopecia international expert alliance: SOFFIA 2024

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 Maria Hordinsky³⁶ | Alan D. Irvine³⁷ | Victoria Jolliffe³⁸ | Spartak Kaiumov³⁹ |
 Brett King⁴⁰ | Steven Kossard⁴¹ | Joyce Lee⁴² | Won-Soo Lee⁴³ |
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 Andrew Messenger⁴⁷ | Paradi Mirmirani⁴⁸ | Elise Olsen⁴⁹ | Seth J. Orlow^{50,51} |
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Funding information
 National and International Skin Registry
 solutions (NISRS), Australasian Hair & Wool
 Research Society, Grant/Award Number:
 eDelphi software

Abstract

Background: As the incidence of frontal fibrosing alopecia (FFA) continues there is a need for an optimal treatment algorithm for FFA.

Objective: To produce an international consensus statement on the treatment modalities and prognostic indicators of FFA.

Methods: Sixty-nine hair experts from six continents were invited to participate in a three-round Delphi process. The final stage was held as a virtual meeting face via Zoom. The consensus threshold was set at ≥66%.

Results: Of 365 questions, expert consensus was achieved in 204 (56%) questions following completion of the three rounds. Three additional questions were in

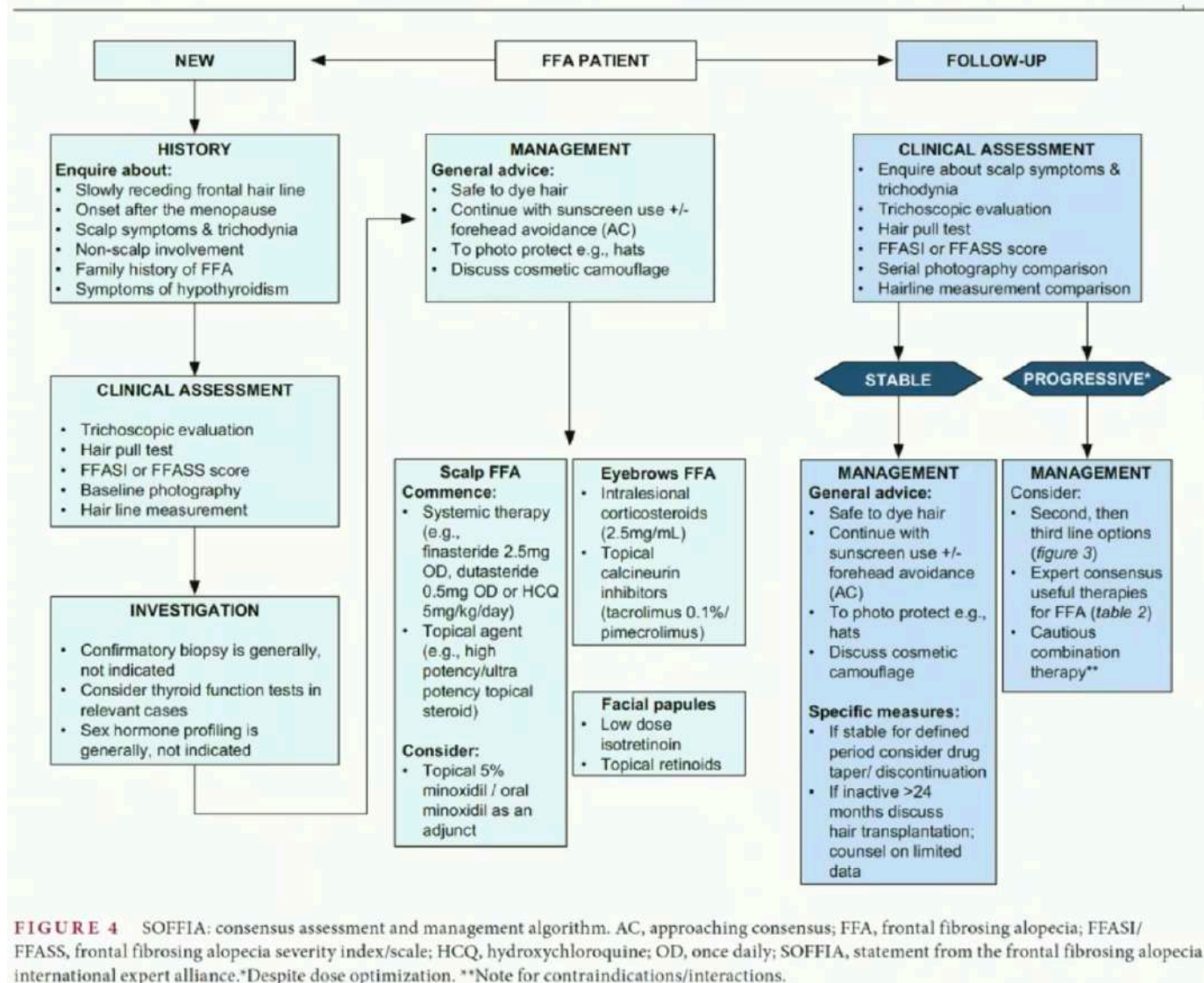


FIGURE 4 SOFFIA: consensus assessment and management algorithm. AC, approaching consensus; FFA, frontal fibrosing alopecia; FFASI/FFASS, frontal fibrosing alopecia severity index/scale; HCQ, hydroxychloroquine; OD, once daily; SOFFIA, statement from the frontal fibrosing alopecia international expert alliance.*Despite dose optimization. **Note for contraindications/interactions.

Dr. Dmitri Wall

Two parts of the modern backbone

Anti-androgen for progression + minoxidil for coverage

5 α -reductase inhibition

Why it earns a central role:

- Stronger observational signal than many traditional systemic agents
- Dutasteride repeatedly associated with stabilisation
- Mechanism may extend beyond simple treatment of concomitant AGA

Caveat: heterogeneous endpoints and mostly non-randomised data.

Low-dose oral minoxidil

What it adds:

- Improves density in retained / miniaturised follicles
- Can improve visual coverage at the hairline and eyebrows
- Particularly useful when AGA/FPHL co-exists

Important: coverage is not the same as proof that scarring progression has stopped.

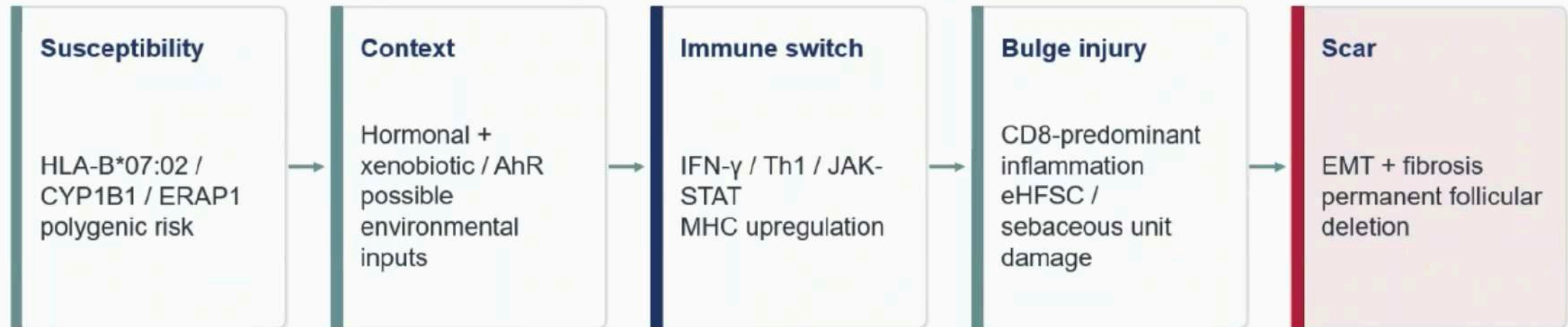
- Morais Silva, DH, [...], Donati, A. Low-Dose Oral Minoxidil Improves Hairline and Eyebrow Coverage in FFA: A Prospective Study. *Dermatol Ther (Heidelb)* 2026; **16**:2569-73
 - N=11 LDOM 1mg/day (6 co-therapy: MTX/dut/HCCQ/Clobetasol/Top minoxidil)
 - 9/10 – increased coverage anterior hairline
 - 4/8 – eyebrow improvement
- Pindado-Ortega C, [...], Vaño-Galván, S. [Translated article] Low-dose Oral Minoxidil for Frontal Fibrosing Alopecia: A 122-patient Case Series. *Actas Dermosifiliogr* 2025; **116**:T407-11.
 - N=122 (92% women); Stable Rx: LDOM 0.25-5mg/day (mean 1.3mg); mean dur 6/12
 - Improvement: interparietal midline (57%); Frontotemporal hairline (45%); Eyebrows (25%)
 - AEs 33.6% (hypertrichosis 24%)
- Baranjape, M, [...], Sinclair, R. A retrospective analysis of the use of minoxidil and androgen directed therapy in FFA
 - N=663 (253 FFA; 359 FFA + FPHL)
 - Treatment response: LDOM + bicalutamide (72%); LDOM + dut (60%); LDOM (70%)



Combination makes clinical sense because the goals are different.

Pathogenesis

Genetically primed follicle + external/hormonal context + immune privilege collapse



**Broad antinflammatory/
immunomodulatory therapy**

HCQ

doxycycline

MTX

ILK / steroids

Druggable biology

SARI

JAKi

Calcineurin

PPAR-γ

The bulge is the battlefield; fibrosis is the irreversible endpoint from epidermal-mesenchymal transition.

Dr. Dmitri Wall

Treatment impact



- Brinks AL, [...], Shapiro, J. Topical Tacrolimus, Clobetasol, and Minoxidil for Primary Cicatricial Alopecias: A Retrospective Analysis of Clinical Outcomes and Safety. *Skin Appendage Disord* 2025; **12**:1–5
 - “Shapirovote” (tacro 0.3%; clobetasol 0.05%; minoxidil 5%) OD->BD
 - N=82 (2009-2025)
 - Provider assessed disease stabilization or improvement 76.9%
 - Skin atrophy 3.7%
- Ezzat RZ, [...], Senna, M. Long-term stability of hairline landmarks in treated FFA: A retrospective cohort study. *JAAD Int* 2026; **26**:34–6.
 - N=37; Mean follow-up 4.78 years – measurement of standardized landmarks
 - Therapy (commonly topical immunomodulators; HCQ; minoxidil) achieved stabilization



Frontal Fibrosing Alopecia in men

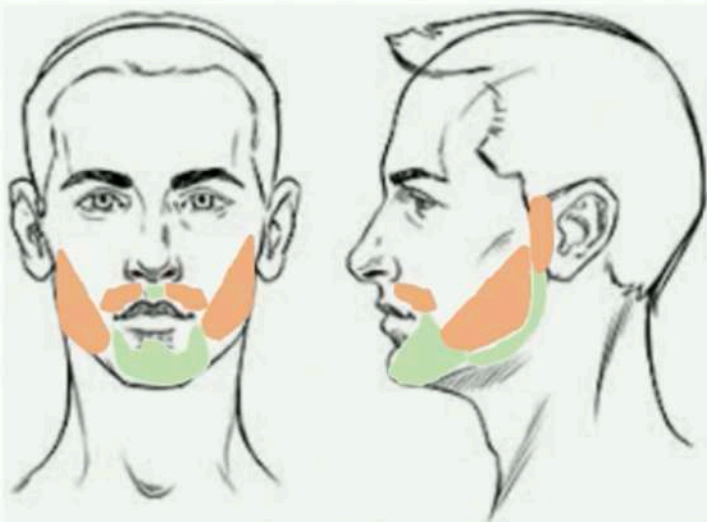


Fig 2. Beard involvement in FFA. Areas in orange are those frequently affected—90% of cases or more (lateral cheek, lateral moustache, and sideburns) with either partial or complete hair loss. Areas in green are those that will be less or later affected—less than 60% of cases (chin and central moustache).

- Facial papules
 - 33–70% males³⁻⁵
 - (13% women)
- Beard (& sideburn) involvement
 - Patterns
 - Plaque alopecia (AA-like)
 - Diffuse
 - Beard (14-74%)^{4,6}
 - Cheeks (100%)
 - Sideburns (90%)
 - Moustache (55.6%) – lateral predo central sparing
 - Sideburn (13-90%)^{4,6}

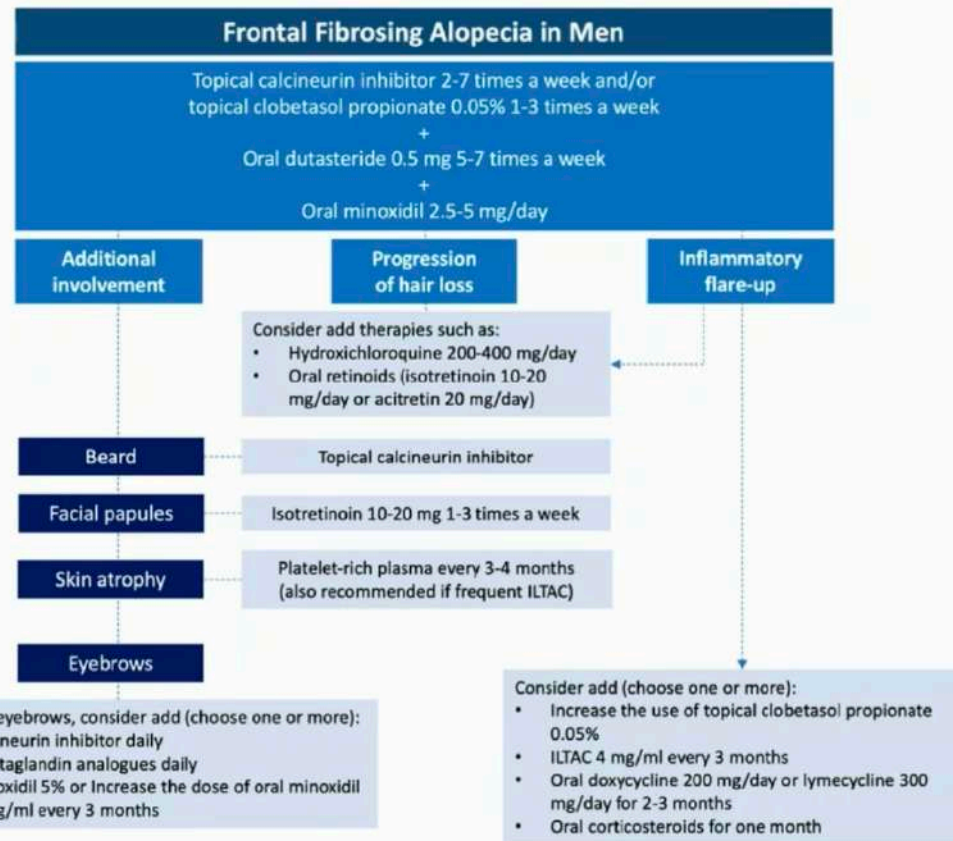
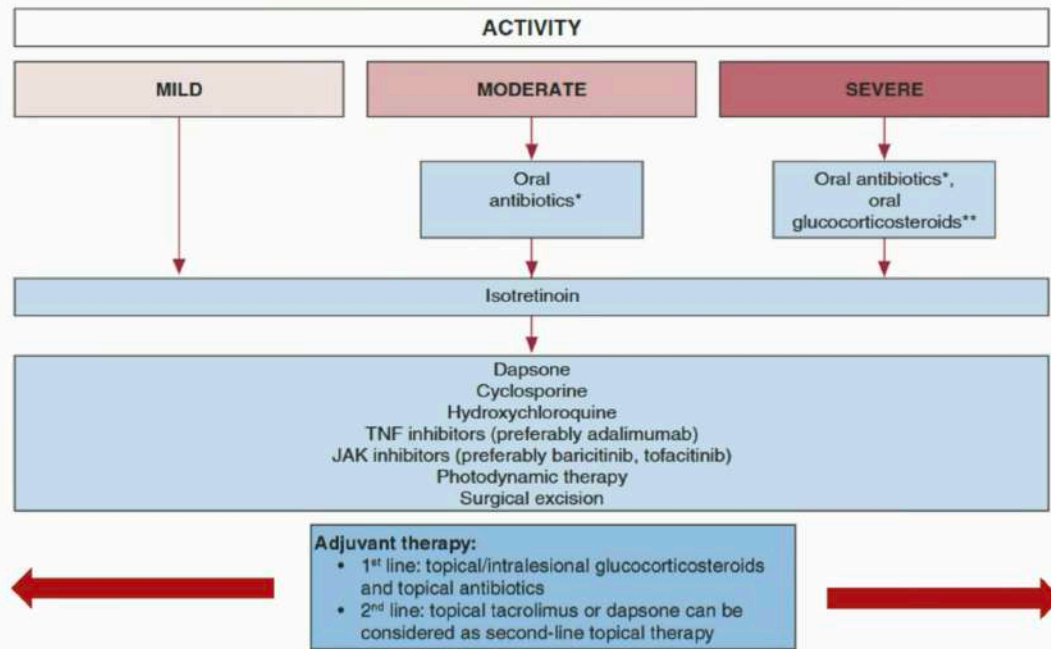


Figure 12. Therapeutic algorithm for male FFA proposed by the authors.

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FOLICULITIS DECALVANTE



Anti-TNFα:

- **Adalimumab** (23/23 clinical response observed within the first month)
 - 52% marked clinical improvement
 - 35% moderate improvement
 - 13% mild improvement
 - Regimen 160 mg (day 0) → 80 mg (day 14) → 80 mg q2w - [Iorizzo et al, 2022](#)
- **Infliximab**: (5 mg / kg, q4-8w) → effective in combination with topical therapy– [Dupont et al, 2023](#)
- **Certolizumab pegol**: Considered safe during pregnancy and breastfeeding – [Hoy et al, 2022](#)

Anti-IL17A: **Ixekizumab**, **Secukinumab** – [Lobato-Berezo et al, 2022](#); [Ismail et al, 2020](#)

NEW & EMERGING THERAPIES: JAK INHIBITORS

- **Baricitinib**: 3.4–6.8 mg/day x5-15mo → complete clinical response in all patients (4/4), with relapse in 2/4 – [Moussa et al., 2022](#)
- **Tofacitinib**: 2.5–5 mg/day x10-16mo → complete clinical response in all patients (3/3) - [Jerjen et al, 2020](#)
- Relapse occurred in all patients after treatment discontinuation
- All cases received other therapies concurrently
- **Early and long-term therapy for prevention and disease control is the goal**

CONGRESS
2026

HYDROXYCHLOROQUINE

Dosage: ≤ 5 mg/ kg/ day, most often 200 mg daily

Clinical improvement in 6 months – maximum benefit in 12 months

- **Mechanism of action:**
 - ↓ expression of MHC II → ↓ antigen presentation → ↓ Th1 reactivity
- **AE:** anorexia, nausea, myalgia, hyperpigmentation, haematological and eye complications
- Ophthalmologic examination: before and once per year
- Complete blood counts + hepatic chemistry every 3-6 months

JOURNAL ARTICLE

Hydroxychloroquine may be beneficial as an adjuvant therapy for folliculitis decalvans: a 5-year retrospective study with 49 patients [Get access](#)

[Isabella Doche](#) ✉, [Mirian N Sotto](#), [Maria K Hordinsky](#), [Isabela P Melhado](#), [Paula Gerlero](#), [Maria Cecilia Rivitti-Machado](#)

Clinical and Experimental Dermatology, Volume 50, Issue 2, February 2025, Pages 404–407, <https://doi.org/10.1093/ced/llae394>

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EFICACIOUS ESPECIALLY IN FD-LPP PHENOTYPIC SPECTRUM

Bald and Bold: Female Characters with Alopecia and Buzzcuts in Film and TV

Nicolas Kluger^{1, 2}, Lidiya Todorova³

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25 Películas 1928-2025

Results

- 85% main characters vs 15% secondary characters
- Can be a trait from the start, or acquired during the story
- Rarely the main plot focus



- Common causes shown:
 -  Chemotherapy (cancer)
 -  Warrior/fighter identity
 -  Aliens/superhumans
 -  Imprisonment, escape, poverty
 -  Personal transformation

1.

Diagnosticar el tipo de alopecia es definir el tipo de objetivo: repoblar, conservar el pelo o aliviar síntomas

2.

Sea cual sea la alopecia, minoxidil siempre en tu estrategia

3.

Fallo de un iJAK $\neq$ Fallo de los iJAK: un cambio de molécula puede cambiar la respuesta

AEDV 35ª edición

HIGHLIGHTS

Viena

30sep - 3oct
2026

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Con el patrocinio de:



La Academia Española de Dermatología y Venereología expresa su agradecimiento al patrocinador UCB, por su especial apoyo y contribución con la actividad formativa Highlights 2026.

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GRACIAS