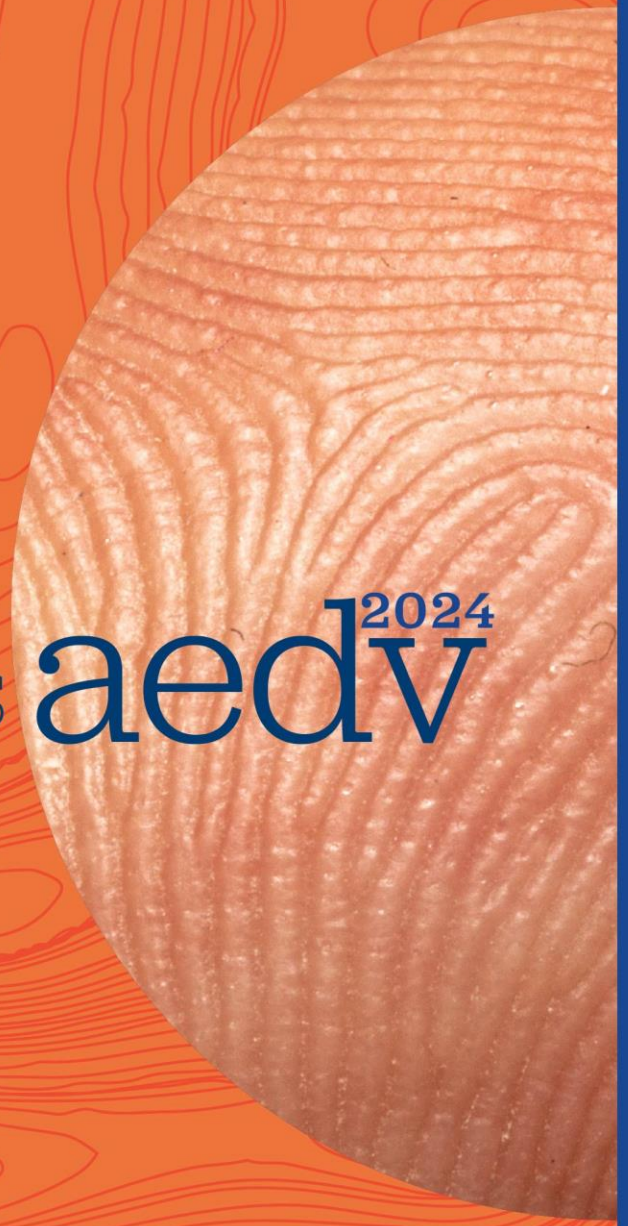
# Highlights aedv 2024



# 33 EDICIÓN
25-28 SEPT 2024
# AMSTERDAM

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# DERMATITIS ATÓPICA E INMUNOALERGIA CUTÁNEA


**José Mª Camino Salvador**

**R4 Hospital Universitario de Guadalajara**

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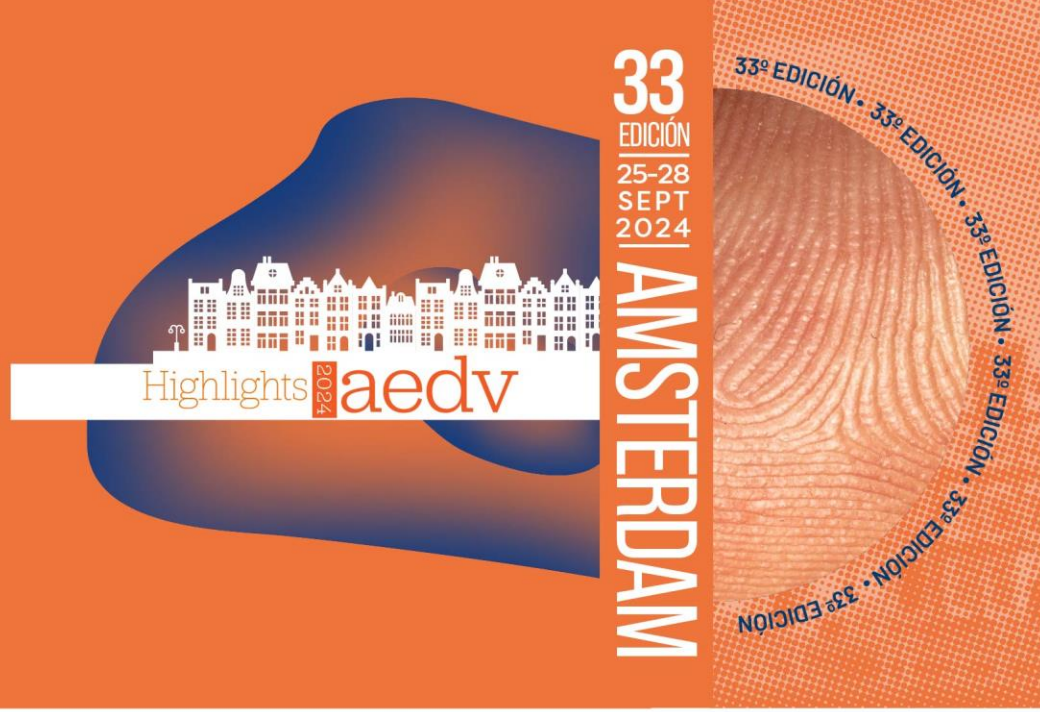
ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA








# NO TENGO CONFLICTOS DE INTERÉS PARA ESTA PRESENTACIÓN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# DERMATITIS ATÓPICA

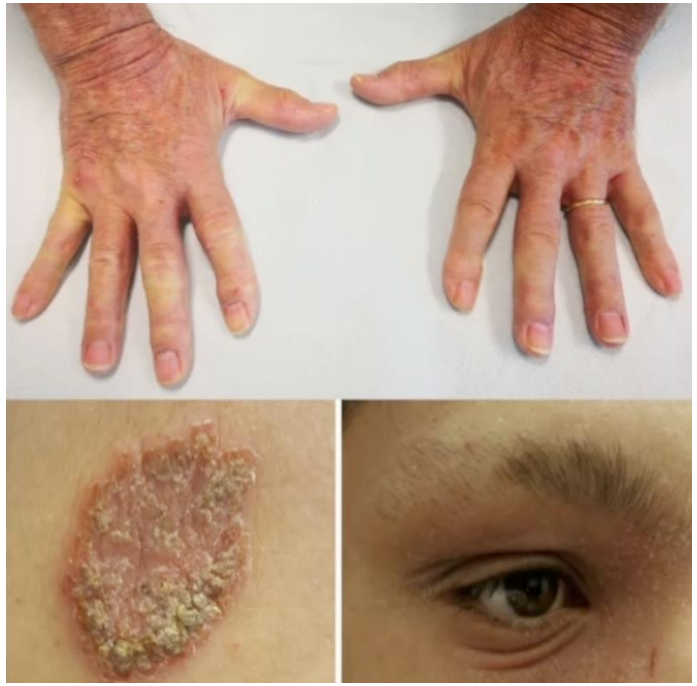
ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

# DA de inicio en el adulto (AOAD)

Prof. Emma Guttman-Yassky – Mount Sinai

## DA de inicio en el adulto (adult-onset AD, AOAD)

- Incidencia 5-18% de adultos en países desarrollados.
- Diferencias clínicas y epidemiológicas con DA de inicio pediátrico (POAD).
  - > 20 años.
  - ↑ **prurigo nodular**, **eccema numular** y **eccema periocular**.
  - Afectación de **cara y cuello**, **cuero cabelludo**, **manos y pies**.
  - ↑ asociación con **vesículas y nódulos**.
  - ↑ alopecia de la cola de la ceja (**signo de Hertogue**).




1. Bannister MJ, Freeman S. Adult-onset atopic dermatitis. Australas J Dermatol. 2000 Nov;41(4):225-8. doi: 10.1046/j.1440-0960.2000.00442.x. PMID: 11105366.
2. Silverberg JI. Adult-Onset Atopic Dermatitis. J Allergy Clin Immunol Pract. 2019 Jan;7(1):28-33. doi: 10.1016/j.jaip.2018.09.029. PMID: 30598180.
3. Lee HH. A systematic review and meta-analysis of the prevalence and phenotype of adult-onset atopic dermatitis. J Am Acad Dermatol. 2019.
4. Pesce G, et al. Adult eczema in Italy: prevalence and associations with environmental factors. J Eur Acad Dermatol Venereol. 2015 Jun;29(6):1180-7. doi: 10.1111/jdv.12784. Epub 2014 Nov.
5. Chiesa Fuxench ZC, et al. Atopic Dermatitis in America Study: A Cross-Sectional Study Examining the Prevalence and Disease Burden of Atopic Dermatitis in the US Adult Population. J Invest Dermatol. 2019 Mar;139(3):583-590. doi: 10.1016/j.jid.2018.08.028. Epub 2018 Oct 30. PMID: 30389491.

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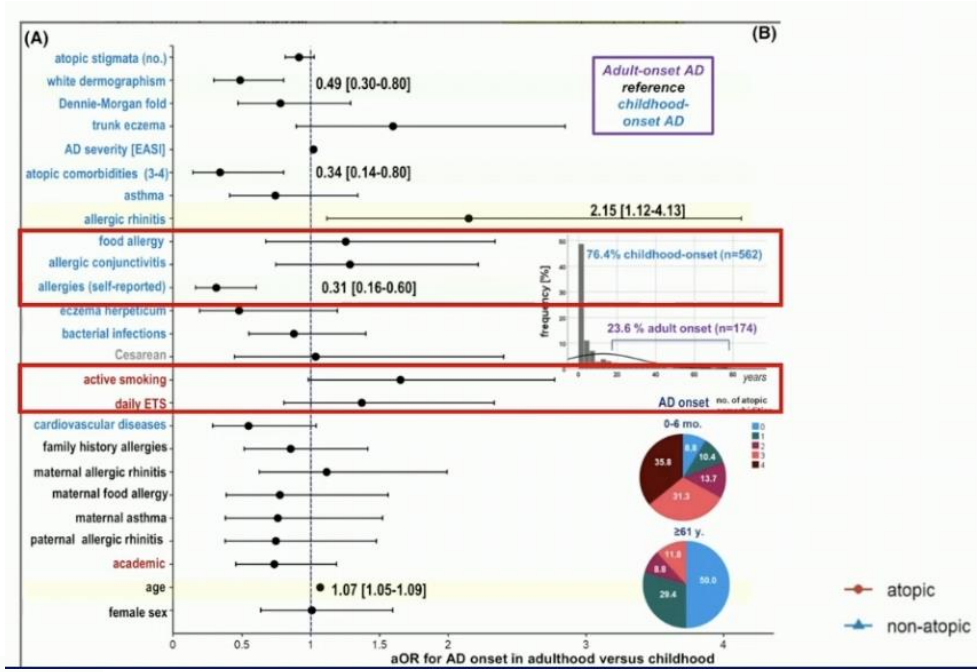
**PAPEL DEL EXPOSOMA** → AOAD posee mayor asociación a factores de riesgo como el **tabaquismo** (activo o pasivo) y menor a comorbilidades atópicas personales o familiares

- Diferencial importante → recomienda plantear **biopsia** (*"do not forget cutaneous T cell lymphomas")*

Prof. Emma Guttman-Yassky – Mount Sinai





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# DA de inicio en el adulto (AOAD)

DOI: 10.1111/all.15741

ORIGINAL ARTICLE

Atopic Dermatitis, Urticaria and Skin Disease

Allergy WILEY

## Age of onset defines two distinct profiles of atopic dermatitis in adults

Paola Facheris[1,2] | Joel Correa Da Rosa[1] | Angel D. Pagan[1,3] | Michael Angelov[1] | Ester Del Duca[1] | Grace Rabinowitz[1] | Pedro Jesús Gómez-Arias[1,4] | Camille Rothenberg-Lausell[1,5] | Yeriel D. Estrada[1] | Swaroop Bose[1] | Mashkura Chowdhury[1] | Avner Shemer[6] | Ana B. Pavel[1] | Emma Guttman-Yassky[1]

[1]Icahn School of Medicine at Mount Sinai, New York City, New York, USA

[2]Department of Biomedical Sciences, Humanitas University, Pieve Emanuele, Italy

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[4]Reina Sofia University Hospital, Maimonides Biomedical Research Institute of Cordoba (IMIBIC), Cordoba, Spain

[5]University of Puerto Rico, School of Medicine, San Juan, Puerto Rico

[6]Department of Dermatology, Tel Hashomer, Tel Aviv University, Tel Aviv, Israel

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Email: emma.guttman@mountsinai.org

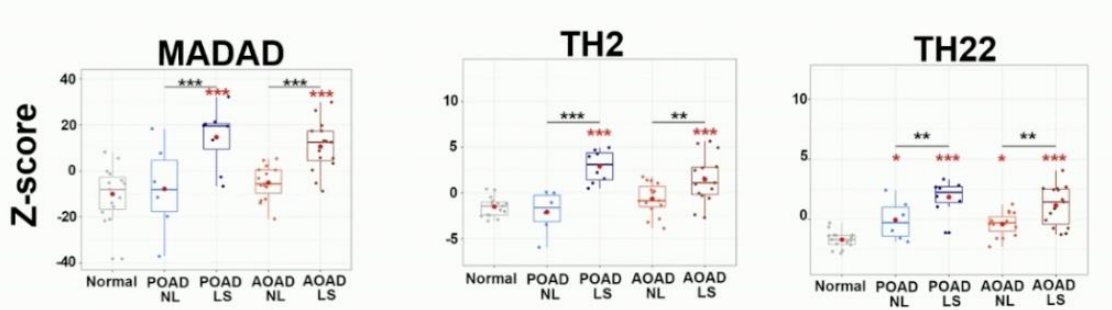
**Abstract**

**Background:** The incidence of adult-onset atopic dermatitis (AOAD) is increasing. However, the unique characteristics of AOAD compared to pediatric-onset AD persisting into adulthood (POAD) are underexplored, hampering the development of targeted-therapeutics for this growing population. We thus assessed the profile of AOAD in skin and blood compared to that of POAD.

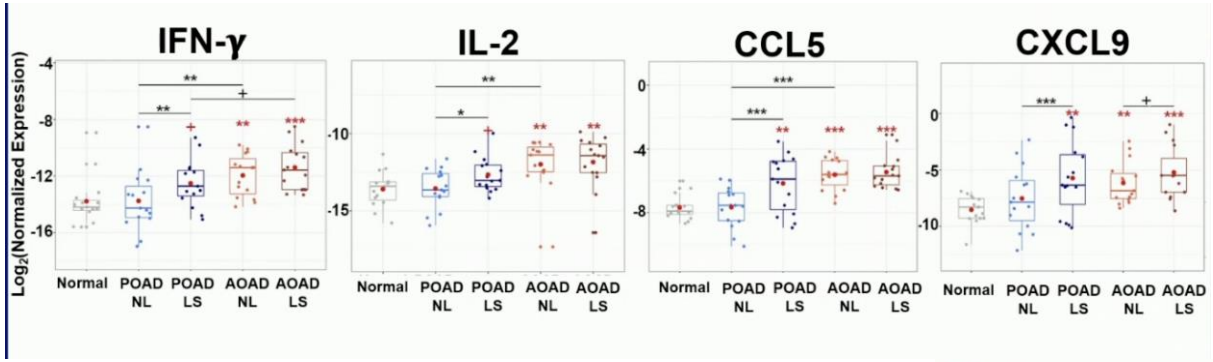
**Methods:** We collected skin biopsies and blood from adults with AOAD, POAD, and healthy controls ($n = 15$ in each group). Skin samples were analyzed by RNA sequencing, qRT-PCR, and immunohistochemistry, and Olink Proseek multiplex assay was used to identify the serum proteomic profile.

**Results:** Compared to healthy controls, both AOAD and POAD showed cutaneous immune and barrier dysregulations with a shared Th2/Th22 hyperactivation. Overall, POAD showed greater inflammation in lesional skin, with more prominent expression of Th2/Th17/Th22 markers (CCL17/22, S100A8/9, IL-36A, PI3/Elafin, DEFB4) in POAD compared to AOAD (p-value < .05). In contrast, higher Th1-(IFN-γ, IL-2, IL-15, CCL5) up-regulation and Th1-skewing were seen in AOAD. The epidermal barrier was also more

Tanto POAD como AOAD muestran ↑ activación **Th2/Th22**




AOAD muestra ↑ viraje **Th1/IFN-gamma**, mientras que POAD muestra ↑ viraje **Th17**




Red stars: significance versus healthy controls
**Black** stars: significance versus other group
***(p<0.001) **(p<0.01) *(p<0.05) +(p<0.1)

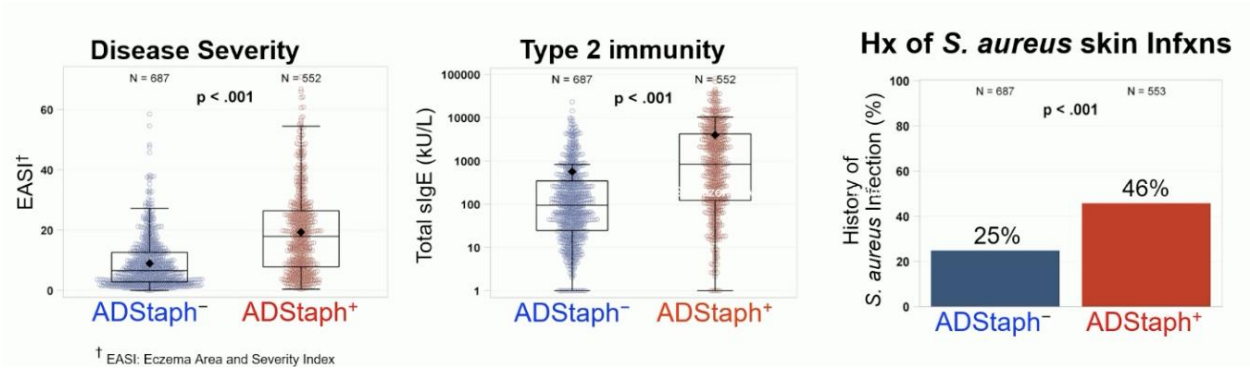
# The role of *S. aureus*

↑ S. *Aureus* ↔ Inflamación Th2, disrupción cutánea y ↑ severidad de DA

Prof. Lisa Beck – Rochester Medical Center

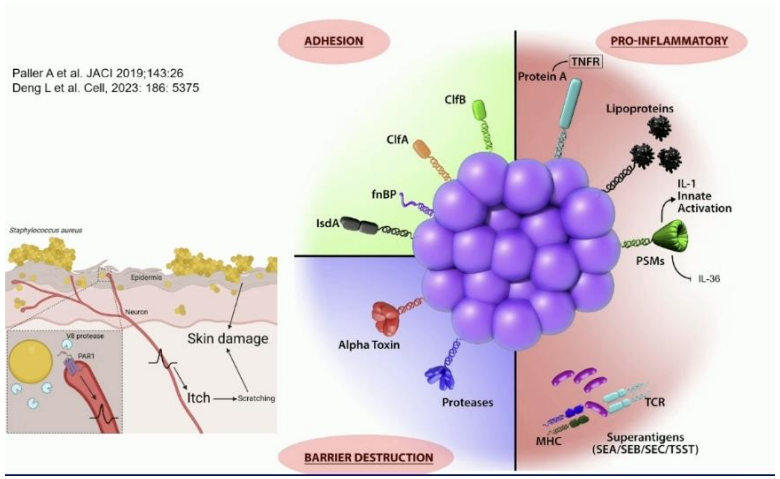
Los pacientes con DA colonizados por *S. aureus*:

- Poseen mayor **severidad** de los brotes.
- Mayor **polarización Th2**.
- Mayores **infecciones cutáneas**.
- Mayor disfunción de la **barrera epidérmica** (piel no lesional).




**Factores de virulencia de *S. aureus*:**

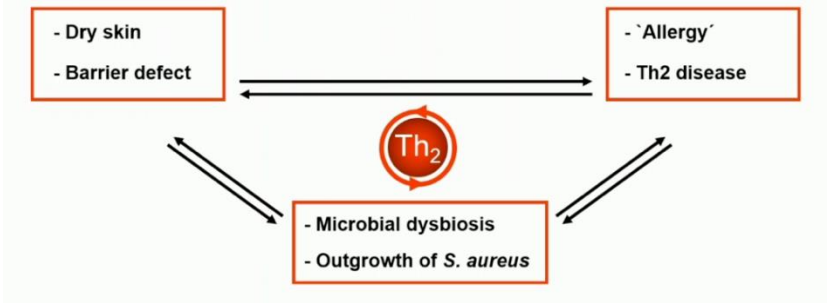
- Moléculas de adherencia (**MSCRAMMs**) → adhesión a **fibronetina** y otras proteínas del tejido conectivo expuesto (heridas).
- Toxinas y proteasas → muerte de queratinocitos y alteración de la barrera cutánea.
- **Proteasas** → prurito neuromediado (PAR1).

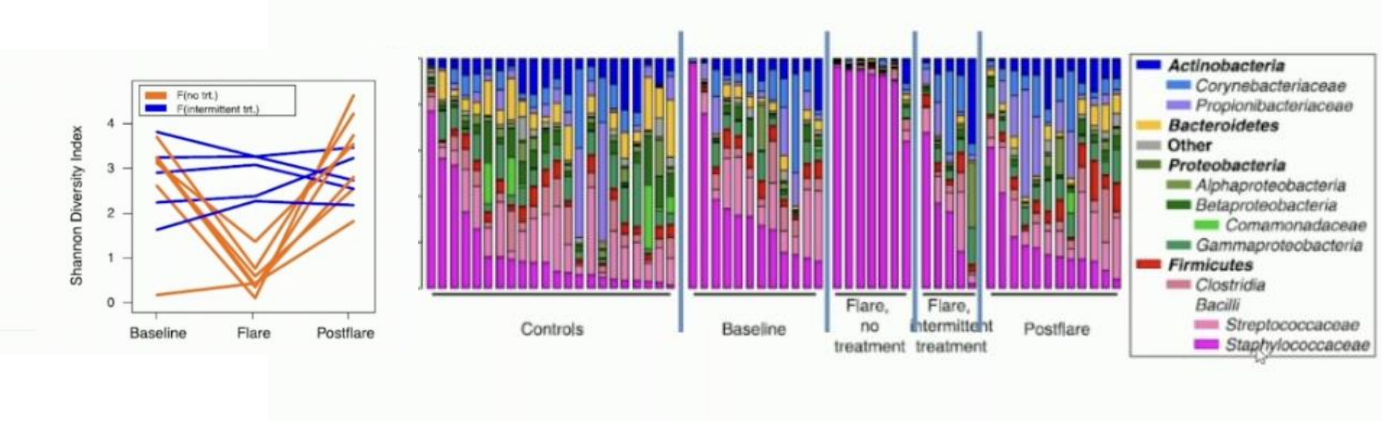


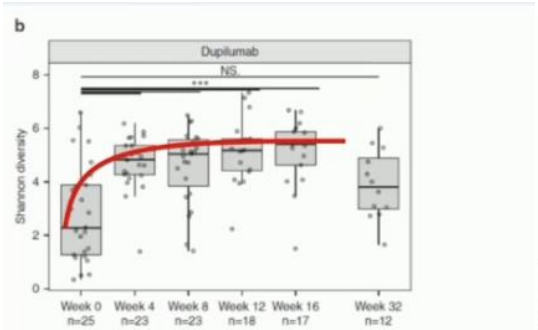
# Modulación del microbioma: ¿prevención o tratamiento de la DA?

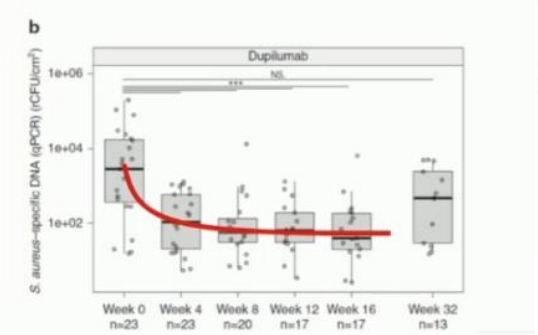
Dr. Tilo Bidermann - Munich

- Papel en la **patogenia**
  - **Disbiosis** → en **brotes de DA** se observa una disrupción profunda en la heterogeneidad del microbioma cutáneo (**↑↑ estreptococos y estafilococos**).
  - ↑ TEWL <-> ↑ *S. aureus*.
  - Las terapias biológicas han demostrado normalizar esta diversidad microbiana y ↑ la carga de *S. aureus*.

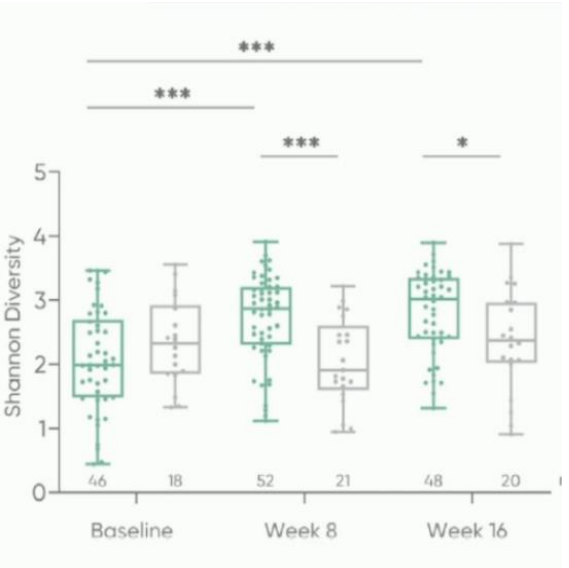



**Dupilumab**

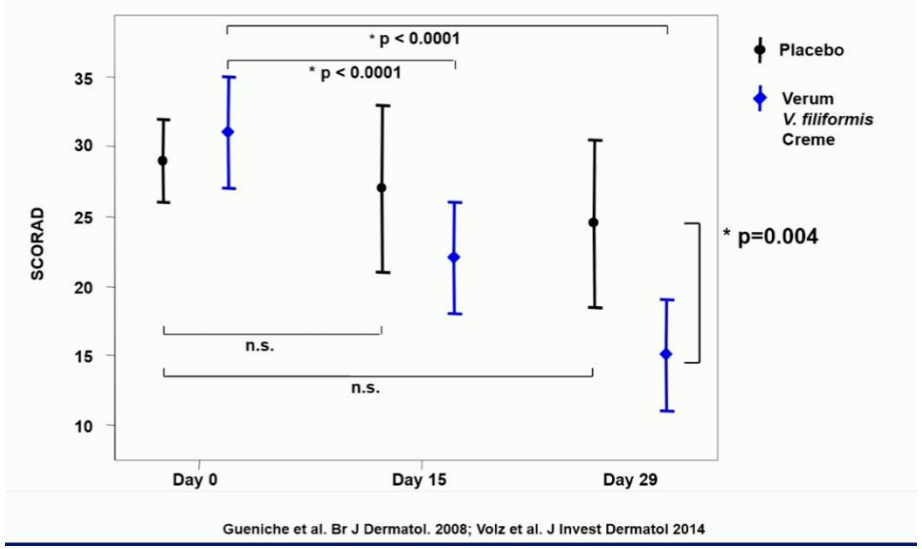



**Tralokinumab**

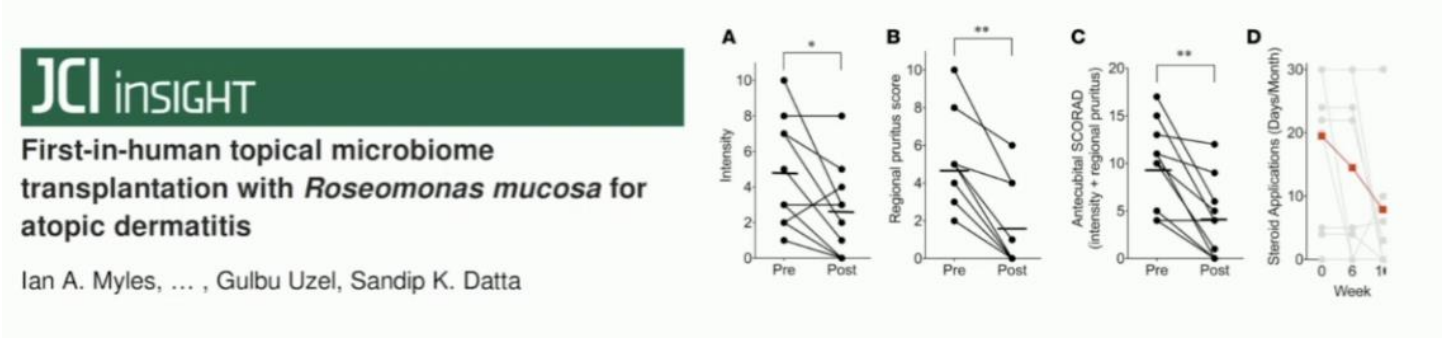
# Modulación del microbioma: ¿prevención o tratamiento de la DA?

- **Modulación** de la microbiota para el tratamiento y prevención
  - Estrategias: 1) Reemplazo de **pérdidas microbianas**. 2) Reducción del **sobrecrecimiento**. 3) Sustitución por **microbios 'balanceadores'**. 4) Introducción de **nutrientes** para los microbios.

  - ¿Emplear sustancias microbianas para reducir la **inflamación**? (inmunidad – tolerancia microbiana) → **BACTERIOTERAPIA**
    - ***Staphilococcus hominis A9*** (ShA9). UCSD Ph1 trial.
    - ***Verum filiformis*** en crema. *Gueniche et al*. (2008)
    - ***Roseomonas mucosa.*** *Myles et al. (2020)*



Gueniche et al. Br J Dermatol. 2008; Volz et al. J Invest Dermatol 2014



# Modulación del microbioma: ¿prevención o tratamiento de la DA?

TERMINATED

Failure of the Phase 2 study (protocol FB401-01) to meet its endpoint.

**Continued Safety Evaluation of FB-401 in Children, Adolescents and Adults (2 Years and Older) With Mild to Moderate Atopic Dermatitis Previously Enrolled in the FB401-01 Study**

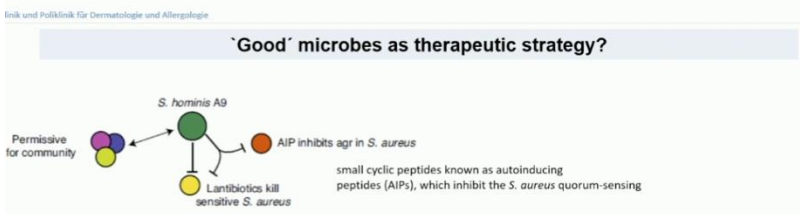
ClinicalTrials.gov ID NCT04936113

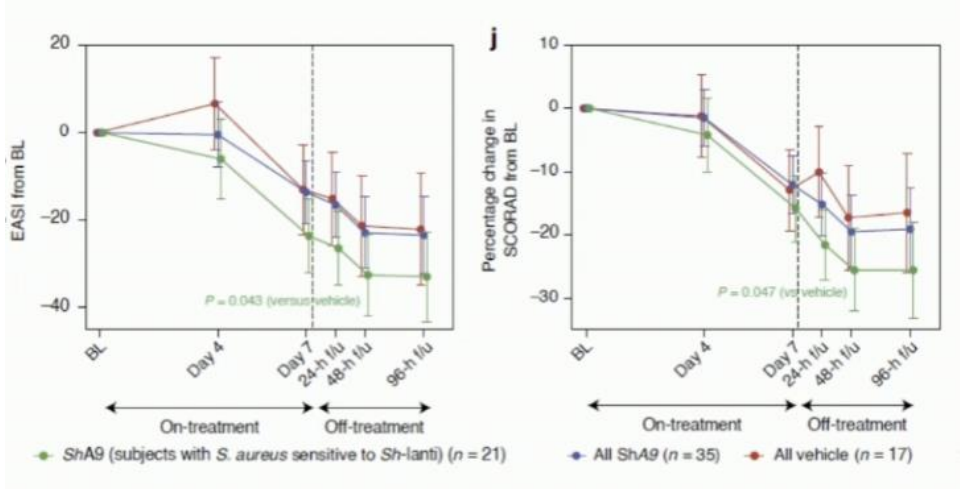
Sponsor Forte Biosciences, Inc.

Information provided by Forte Biosciences, Inc. (Responsible Party)

Last Update Posted 2021-10-28

EC fase II controlado con placebo que combinaba 3 cepas de *R. mucosa* (FB-401) **fue suspendido** por no demostrar diferencias significativas en pacientes para alcanzar el objetivo primario (EASI-50), pero **sí demostraron ↓ *S. aureus***

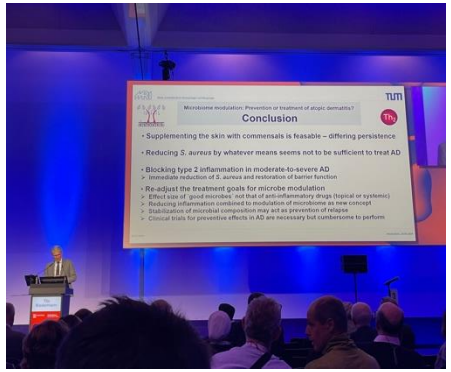



*S. Hominis* es un comensal que produce **lantibióticos**, asociados a ↑ AMPs (LL-37) y ↓ *S. aureus*

Conclusiones:

- La suplementación de la piel con **microbios comensales y bacteriocinas (lantibióticos)** pueden constituir una estrategia interesante (ej: emolientes ricos en microbiota).
- Sin embargo, reducir *S. aureus* como único objetivo **no es suficiente** para tratar la DA.
- Los microbios beneficiosos requieren de un **↓ en inflamación Th2** para controlar la DA.



# Suplementación materna prenatal con prebióticos para prevenir DA al año de edad

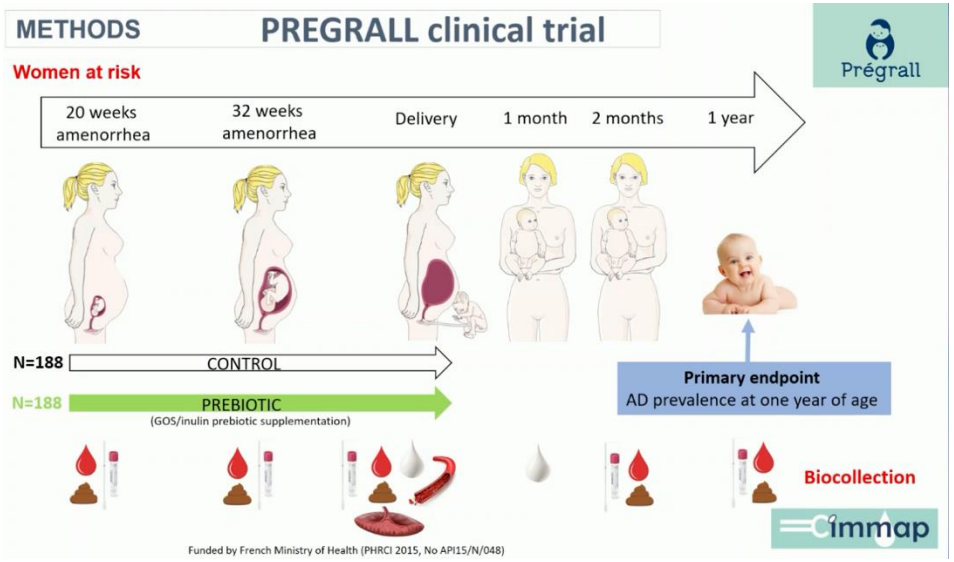
**The PREGRALL ramdomized controlled trial** (France)

Prof. Sébastien Barbarot

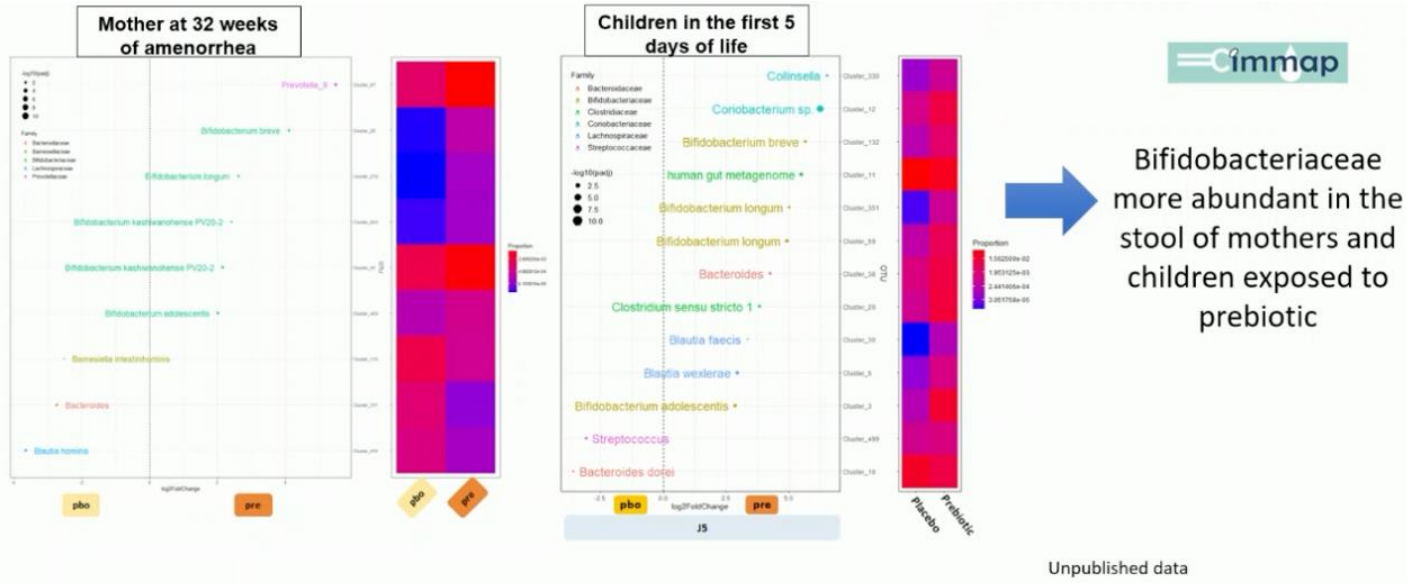
- N=376.
  - Placebo:188.
  - Prebiótico: 188.
- Prebiótico: galaco-oligosacárido(GOS)/inulina.

**Endpoint primario**
**Prevalencia de DA al año**
Placebo (n=188): 33 (20.25%)
Prebiótico (n=188): 34 (20.24%)

**Excluyen** un efecto clínico significativo de los PREBIÓTICOS PERINATALES en la prevención de DA al año




16 rRNA sequencing




**Conclusiones**

- La suplementación con GOS/Inulina prenatales **no alcanzó** el endpoint primario.
- Sin embargo, la suplementación con GOS/Inulina **modificó** la microbiota materna y del niño.
- Probablemente, sea **importante pero no suficiente** para prevenir DA.

La suplementación con PREBIÓTICOS **modificó** la microbiota intestinal materna, y esta modificación **fue transmitida** al niño

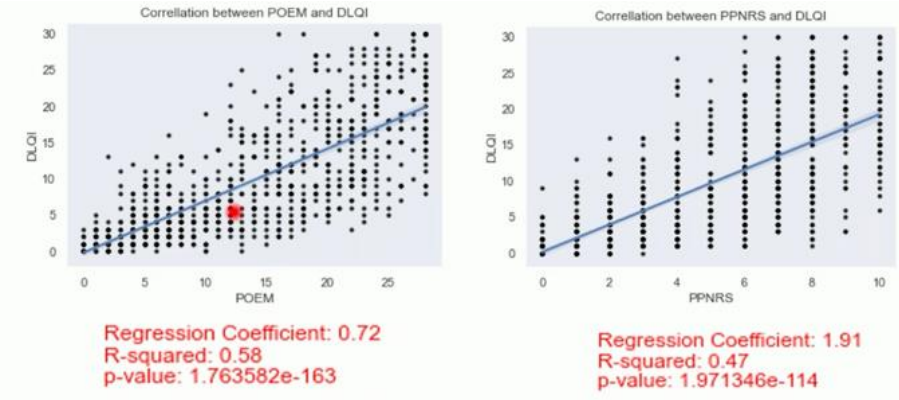
*Barbarot S. Maternal supplementation with prebiotics during pregnancy regulates colonization of the microbiota of high-risk children, but does not prevent atopic dermatitis at one year of age. The PREGRALL multicenter randomized control trial. Subspecialty speaker at: ETFAD - European Task Force of Atopic Dermatitis. Presented at: Subspecialty session, Room 7.2; 2023 Sep 25; 09:25-09:40 CEST*

# Variabilidad en el impacto sobre la calidad de vida del EASI en DA pediátrica y adulta

**A-STAR: Atopic Eczema Systemic Therapy Register** (UK-Ireland) Prof. Dr. Michael Arden-Jones – Southampton, UK

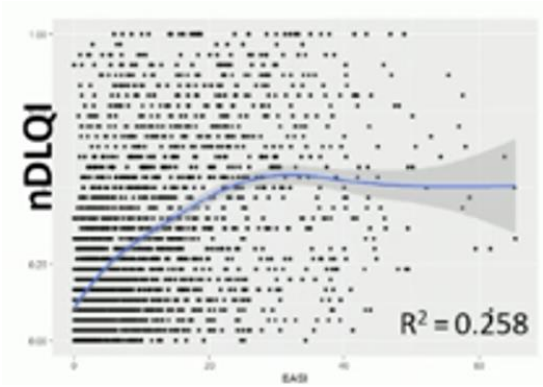
- N=898 pacientes. 50 ciuidades
- Registro prospectivo de EASI y PROMS (DLQI, POEMS, PPNRS)

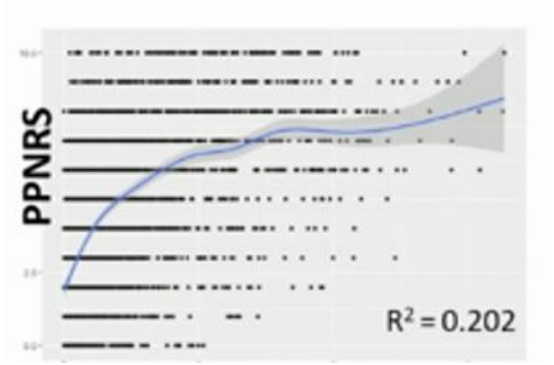
DLQI, POEM y PPNRS muestran una correlación adecuada entre sí

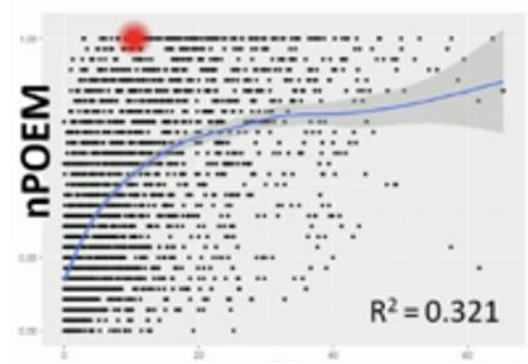



Correlación débil entre **DLQI y EASI** (**$R^2$=0,258**), DLQI y POEM ($R^2$=0.321), y DLQI y PPNRS ($R^2$=0.02)

El EASI solo explicaría el 25.8% del impacto del DLQI




*Ardern-Jones M. Variability in impact on quality of life from EASI score changes in paediatric and adult dermatitis: insights from the UK-Irish Atopic Eczema Systemic Therapy Register (A-STAR). Subspecialty speaker at: ETFAD - European Task Force of Atopic Dermatitis. Presented at: Subspecialty session, Room 7.2; 2023 Sep 25; 09:55-10:10 CEST.*

# Riesgo de infecciones en pacientes con DA en tratamiento biólogico o JAKi

**BIODAY REGISTER** (Netherlands) Dr. Marjolein de Bruin Weller

- Prospectivo, multicéntrico
- Pacientes con DA ≥ 12 años, tratados con biológicos y/o JAKi
- Inclusión oct 2017 – jul 2024
  - Dupilumab n = 1599
  - Tralokinumab n = 212
  - Abrocitinib n = 134
  - Baricitinib n = 97
  - Upadacitinib n = 237

## Treatment-emergent infections

| | Total (*n*) | Biologics | | | | JAK inhibitors | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Dupilumab | | Tralokinumab | | Abrocitinib | | Baricitinib | | Upadacitinib | |
| | | TEI (*n*) | Incidence per 1000PY | TEI (*n*) | Incidence per 1000PY | TEI (*n*) | Incidence per 1000PY | TEI (*n*) | Incidence per 1000PY | TEI (*n*) | Incidence per 1000PY |
| Abscess | 10 | 6 | 1.7 (0.7-3.7) | 0 | - | 1 | 8.6 (0.4-42.5) | 1 | 11.3 (0.6-55.9) | 2 | 7.2 (1.2-23.7) |
| Airway infection | 158 | 93 | 27.6 (22.4-33.7) | 14 | 71.5 (40.7-117.2) | 12 | 103.4 (56.0-175.7) | 13 | 147.4 (82.0-245.7) | 26 | 93.2 (62.2-134.6) |
| Ear infection | 12 | 10 | 3.0 (1.5-5.3) | 0 | - | 0 | - | 1 | 11.3 (0.6-55.9) | 1 | 3.6 (0.2-17.7) |
| Eye infection | 37 | 30 | 8.9 (6.1-12.6) | 1 | 5.1 (0.3-25.2) | 2 | 17.2 (2.9-56.9) | 3 | 34.0 (8.6-92.6) | 1 | 3.6 (0.2-17.7) |
| Influenza | 27 | 11 | 3.3 (1.7-5.7) | 1 | 5.1 (0.3-25.2) | 4 | 34.5 (11.0-83.1) | 2 | 22.7 (3.8-74.9) | 9 | 32.3 (15.7-59.2) |
| Skin and mucosal infection | 424 | 234 | 69.5 (61.0-78.9) | 23 | 117.5 (76.3-173.6) | 45 | 387.6 (286.1-514.0) | 21 | 238.1 (151.3-357.7) | 101 | 362.0 (296.4-438.0) |
| Urinary tract infection | 43 | 25 | 7.4 (4.9-10.8) | 2 | 10.2 (1.7-33.8) | 1 | 8.6 (0.4-42.5) | 9 | 102.0 (49.8-187.3) | 6 | 21.5 (8.7-44.7) |
| Other infection | 93 | 53 | 15.8 (11.9-20.4) | 2 | 10.2 (1.7-33.8) | 12 | 112.0 (62.3-186.7) | 7 | 79.4 (34.7-157.0) | 19 | 68.1 (42.2-104.4) |
| **Total** | **794** | *n=456* | **135.5** | *n=43* | **219.7** | *n=76* | **654.6** | *n=56* | **634.9** | *n=163* | **584.2** |

Incidence rates per 100PY are n (95% CI). Abbreviatons: TEI, treatment-emergent infection; PY, patient years; CI, confidence interval.

**Incidence per 1000 patient years 3-4x higher for JAKi**

van der Gang et al. Manuscript in preparation

ETFAD 2024

## Infecciones cutáneas 54.8%

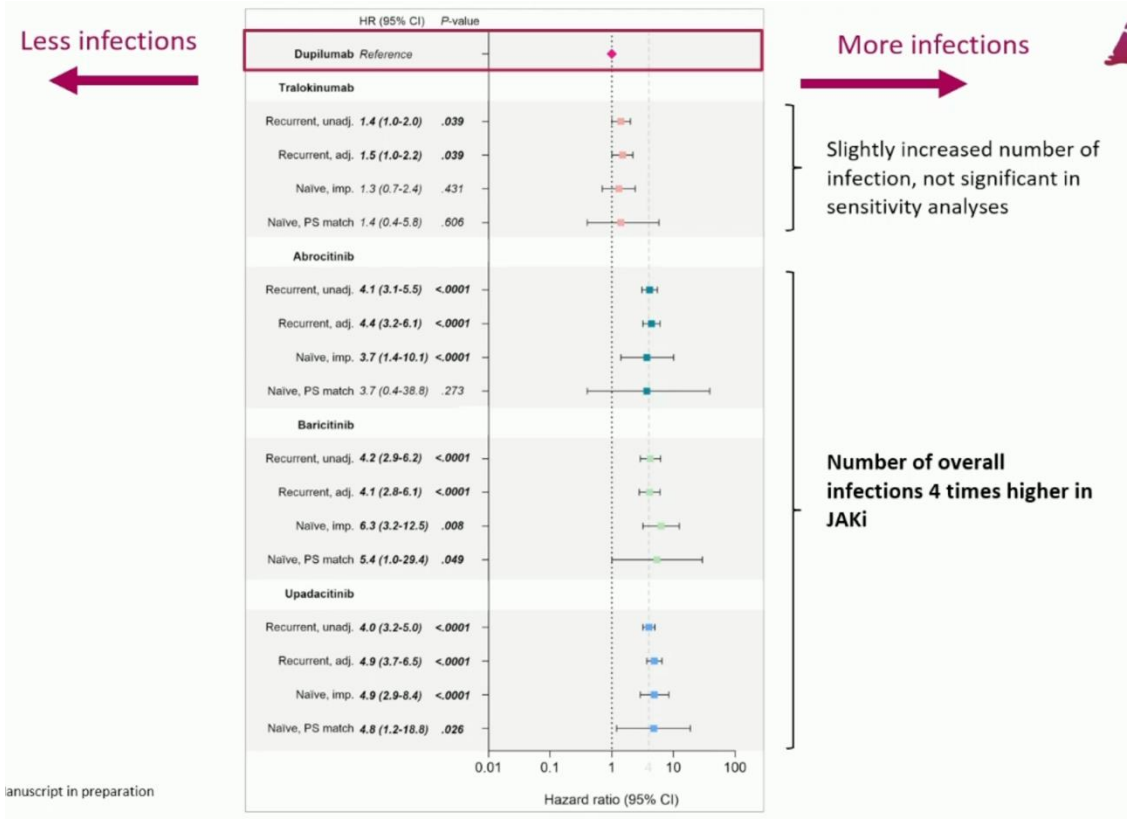
| | | Total (*n*) | Biologics | | | | JAK inhibitors | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Dupilumab | | Tralokinumab | | Abrocitinib | | Baricitinib | | Upadacitinib | |
| | | | TEI (*n*) | Incidence per 1000PY | TEI (*n*) | Incidence per 1000PY | TEI (*n*) | Incidence per 1000PY | TEI (*n*) | Incidence per 1000PY | TEI (*n*) | Incidence per 1000PY |
| Bacterial | Erysipelas/celulitis | 18 | 11 | 3.3 (1.7-5.7) | 3 | 15.3 (3.9-41.7) | 0 | - | 0 | - | 4 | 14.3 (4.6-34.6) |
| | Folliculitis | 27 | 15 | 4.5 (2.6-7.2) | 1 | 5.1 (0.3-25.2) | 6 | 51.7 (21.0-107.5) | 1 | 11.3 (0.6-55.9) | 4 | 14.3 (4.6-34.6) |
| | Furunculosis | 12 | 5 | 1.5 (0.5-3.3) | 0 | - | 4 | 34.5 (11.0-83.1) | 0 | - | 3 | 10.8 (2.7-29.30 |
| | Impetiginization | 49 | 26 | 7.7 (5.2-11.2) | 3 | 15.3 (3.9-41.7) | 3 | 25.8 (6.6-70.3) | 0 | - | 17 | 60.9 (36.7-95.6) |
| | Other/unknown | 19 | 13 | 3.9 (2.1-6.4) | 1 | 5.1 (0.3-25.2) | 3 | 25.8 (6.6-70.3) | 1 | 11.3 (0.6-55.9) | 1 | 3.6 (0.2-17.7) |
| Viral | **Herpes simplex** | **162** | **87** | **25.9 (20.8-31.7)** | **7** | **35.8 (15.6-70.8)** | **20** | **172.3 (108.2-261.3)** | **10** | **113.4 (57.6-202.1)** | **38** | **136.2 (97.8-185.0)** |
| | Herpes zoster | 33 | 15 | 4.5 (2.6-7.2) | 0 | - | 3 | 25.8 (6.6-70.3) | 2 | 22.7 (3.8-74.9) | 13 | 46.6 (25.9-77.7) |
| | Other/unknown* | 10 | 3 | 0.9 (0.2-2.4) | 0 | - | 3 | 25.8 (6.6-70.3) | 1 | 11.3 (0.6-55.9) | 3 | 10.8 (2.7-29.30 |
| Mycosis/yeast | Cutaneous† | 56 | 34 | 10.1 (7.1-14.0) | 5 | 25.6 (9.4-56.6) | 2 | 17.2 (2.9-56.9) | 4 | 45.4 (14.4-109.4) | 11 | 39.4 (20.7-68.5) |
| | Genital | 3 | 2 | 0.6 (0.1-2.0) | 1 | 5.1 (0.3-25.2) | 0 | - | 0 | - | 0 | - |
| | Onychomycosis | 11 | 8 | 2.4 (1.1-4.5) | 1 | 5.1 (0.3-25.2) | 0 | - | 0 | - | 2 | 7.2 (1.2-23.7) |
| | Other | 6 | 0 | - | 0 | - | 1 | 8.6 (0.4-42.5) | 0 | - | 5 | 17.9 (6.6-39.7) |
| Other | Scabies | 6 | 6 | 1.7 (0.7-3.7) | 0 | - | 0 | - | 0 | - | 0 | - |
| | Unknown | 12 | 9 | 2.7 (1.3-4.9) | 1 | 5.1 (0.3-25.2) | 0 | - | 2 | 22.7 (3.8-74.9) | 0 | - |
| **Total** | | 424 | 234 | 69.5 (61.0-78.9) | 23 | 117.5 (76.3-173.6) | 45 | 387.6 (286.1-514.0) | 21 | 238.1 (151.3-357.7) | 101 | 362.0 (296.4-438.0) |

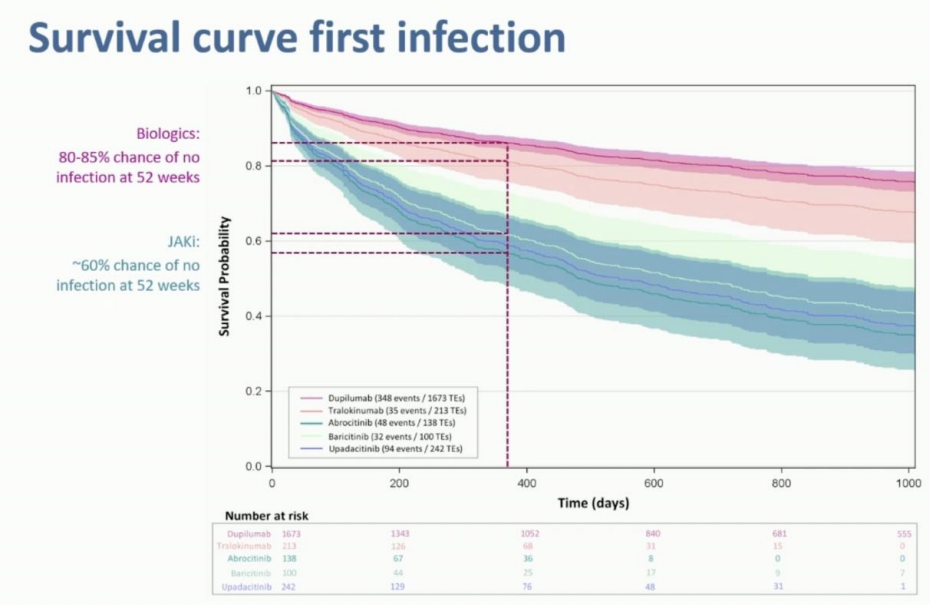
†Other comprised intertriginosa, pityriasis versicolor, tinea corporis, tinea pedis; *Other comprised: condylomata acuminata, mollusca contagiosa, verruca vulgaris. Abbreviatons: treatment-emergent infection, TEI; patient years, PY:

- La mayoría de infecciones fueron leves (30.5%) o moderadas (61.4%)
- La tasa de discontinuación permanente por infección fue baja:
  - Biológicos n = 7 (1.4%)
  - JAKi n = 24 (8.1%) -> **Herpes zóster**
  - Las infecciones cutáneas fueron la principal causa de discontinuación

# Riesgo de infecciones en pacientes con DA en tratamiento biólogico o JAKi

**BIODAY REGISTER** (Netherlands)




**Conclusiones**
En comparación con DUPI:

- Aumento del nº de infecciones con todos los JAKi
- Aumento ligero del nº de infecciones con TRALO

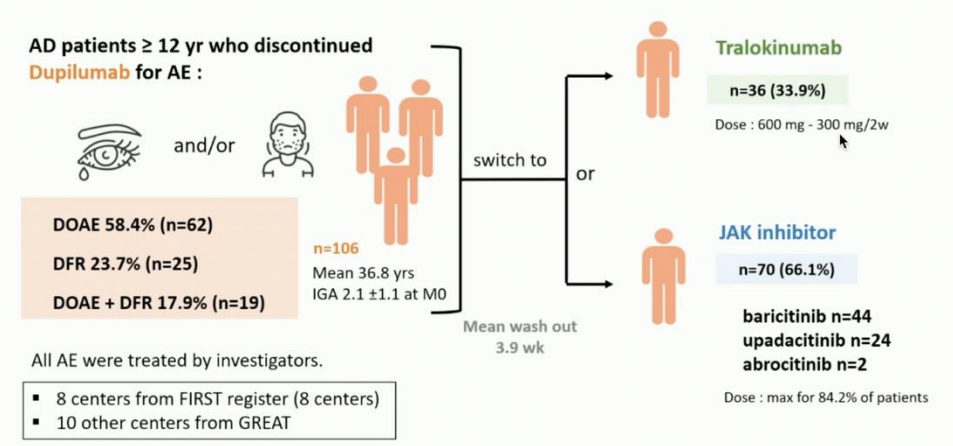
# Switch de Dupilumab a JAKi o Tralokinumab en caso de eventos adversos faciales u oculares

**DUPISWICH STUDY** (France) Prof. Delphine Staumont Salle

n=106. Retrospectivo, multicéntrico

DOAE: discontinuación por EA oculares

DFR: discontinuación por cara roja




Características basales sin diferencias (a elección del dermatólogo)

**% patients with resolution or improvement of DOAE and DFR at M3-M6**

| Drug / Outcome | 👁 👍 | 🧑 👍 |
|---|---|---|
| Tralokinumab | 72.4% (n=21/29) | 33.3% (n=5/15) |
| JAKi | 92.2% (n=47/51)* | 85.2% (n=23/27)** |

* JAKi vs tralo p=0,0244 * JAKi vs tralo p=0,0006

JAKi demostraron ser más efectivos que TRALO tanto en la resolución de **DOAE** como en la **DFR**

**% patients achieving IGA 0/1 and who discontinued treatment after switching**

| Drug / Outcome | % IGA 0/1 at M0 | % IGA 0/1 at M3-M6 | % discontinuation *mean ttt duration: 7.8 months* |
|---|---|---|---|
| Tralokinumab | 32.3% (n=10/31[a]) | 35.5% (n=11/31[a]) | 44.4% (16/36[a])<br>**Lack of efficacy** 56.2% (n=9/16)<br>**OAE** 37.5% (n=6/16)<br>**FR** 12.5% (n=2/16)<br>**Other** 12.5% (n=2/16) |
| JAKi | 21.9% (n=14/64[a]) | 42.2%* (n=27/64[a])<br>*p=0,0067 (M3-M6 *vs* M0) | 64.7% (n=44/64[a])<br>**Lack of efficacy** 68.1% (n=30/44)<br>**Acne** 4.5% (n=2/64, bari)<br>**OAE (corneal abscess)** n=1 (upada)<br>**Stroke** n=1 (upada)<br>**VZV reactivation** n=1 (upada) |

[a] Data available

**Upada** 59.1% (13/22)
**Bari** 34.1% (14/41)
**Abro** IGA=3 and 2 (n=2)

**Discontinuation for lack of efficacy:**
**Bari** 26/35
**Upada** 2/7
**Abro** 2/2

JAKi mostraron un aumento significativo, en comparación con TRALO(*p = 0.0067*), en el % de pacientes que alcanzaron un IGA 0/1 en los meses 3-6.

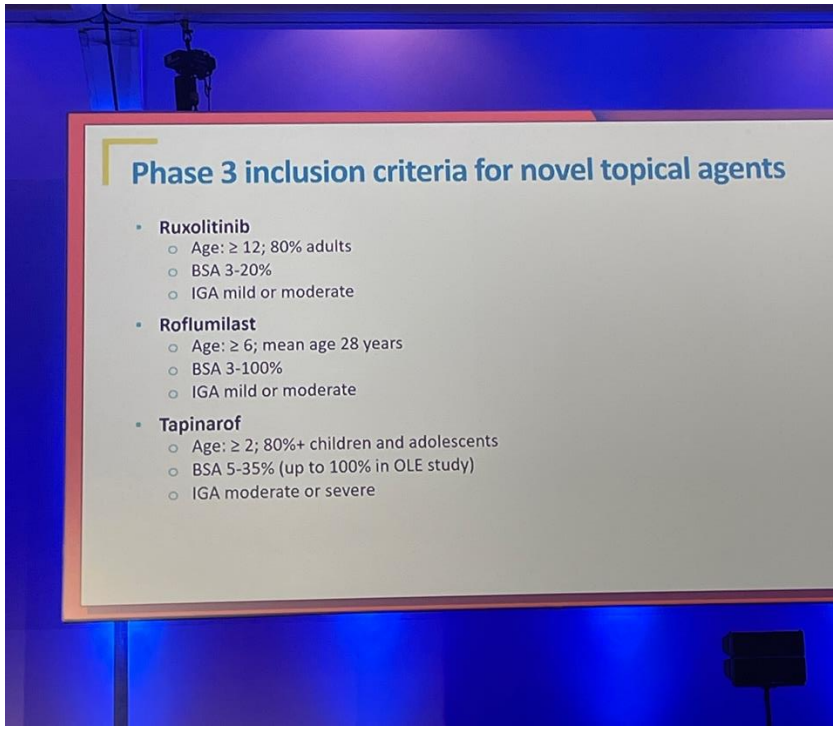
Sin embargo, **mayor tasa de discontinuación** con JAKi*

***BARI** = 26/35 JAKi

**Conclusiones**

- Switch a **JAKi obtuvo mejores resultados** cuando DUPI es discontinuado por DOAE y/o DRF.
- TRALO es una opción en pacientes con FR para JAKi.
- Sin embargo, el switch a TRALO o JAKi no siempre es suficiente para controlar la DA en esta población.

# Terapias tópicas y sistémicas

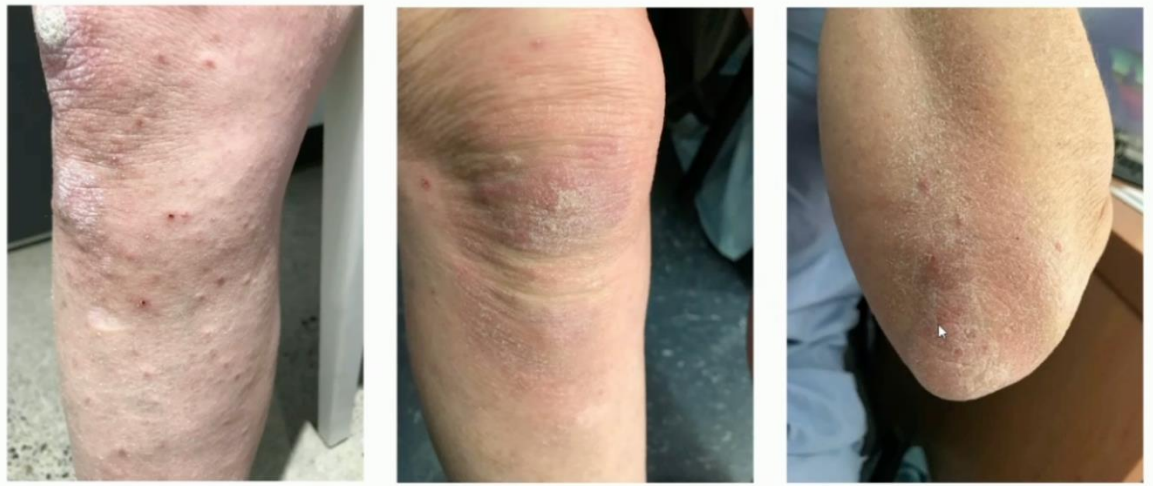



## Tapinarof Safety - Atopic Dermatitis

| Characteristic | ADORING 1 | | ADORING 2 | |
|---|---|---|---|---|
| Patients, n (%) | Tapinarof 1% QD (n = 270) | Vehicle QD (n = 137) | Tapinarof 1% QD (n = 271) | Vehicle QD (n = 133) |
| Any adverse event | 123 (45.6) | 35 (25.5) | 100 (36.9) | 28 (21.1) |
| Serious adverse event† | 3 (1.1) | 0 | 2 (0.7) | 0 |
| TEAE leading to trial discontinuation | 5 (1.9) | 5 (3.6) | 4 (1.5) | 4 (3.0) |
| Treatment-related TEAEs | | | | |
| Any | 34 (12.6) | 9 (6.6) | 32 (11.8) | 9 (6.8) |
| Serious | 0 | 0 | 0 | 0 |
| Adverse events of special interest‡ | | | | |
| Contact dermatitis | 4 (1.5) | 3 (2.2) | 3 (1.1) | 2 (1.5) |
| Grade 3 | 0 | 0 | 0 | 0 |
| Led to trial discontinuation | 2 (0.7) | 2 (1.5) | 0 | 1 (0.8) |
| Follicular event | 27 (10.0) | 1 (0.7) | 24 (8.9) | 2 (1.5) |
| Grade 3 | 0 | 0 | 0 | 0 |
| Led to trial discontinuation | 1 (0.4) | 0 | 0 | 0 |
| Headache | 19 (7.0) | 3 (2.2) | 4 (1.5) | 0 |
| Grade 3 | 1 (0.4) | 0 | 0 | 0 |
| Led to trial discontinuation | 1 (0.4) | 1 (0.7) | 0 | 0 |

Silverberg et al J Am Acad Dermatol 91: 457; 2024

Dr. Robert Bissonnette. Montreal, Canada



Reacción folicular a Tapinarof en paciente con PsO

*Bissonnette R. New topical and systemic treatments. Presentation at the Updates session on Atopic Dermatitis; 26 Sep 2024; Elicium, Montreal, Canada.*

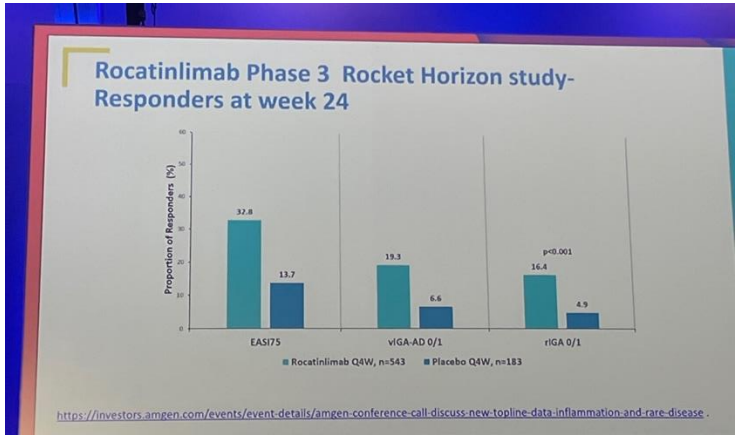
# Terapias tópicas y sistémicas

**NEMOLIZUMAB** (anti-IL31R)

**Nemolizumab long-term safety and efficacy up to 56 weeks in ARCADIA open-label extension study in adolescents and adults with moderate-to-severe atopic dermatitis**

Diamant Thaçi[1], Carle Paul[2], Kim A. Papp[3, 4], Marjolein de Bruin-weller[5], Matthias Augustin[6], Ketty Peris[7], Sébastien Barbarot[8], Andrew F. Alexis[9], Cheong Soo Yeon[10], Liliana Ulianov[11], Christophe Piketty[11]

- Aprobado en EEEUU para PN.
- El EC fase 3 fue diferente al resto de nuevas terapias por es el único que se ha realizado en combinación con GC tópicos.
- RAM característico: **edema periférico** (piernas, facial, bilateral).



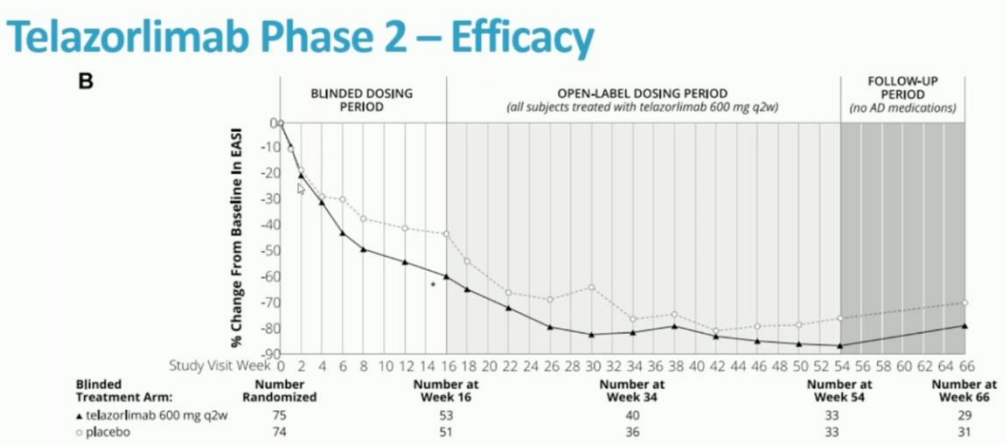

Dr. Robert Bissonnette. Montreal, Canada

**ROCANTILIMAB** (anti-OX40)

- EASI-75 37.8% (latencia > 16 semanas).
- RAM característico: pirexia, escalofríos y **aftas**.

**TELAZORLIMAB** (anti-OX40)

- Similar a ROCANTILIMAB (inicio lento).




Rewerska et al J All Clin Immunol 3: 100195; 2024

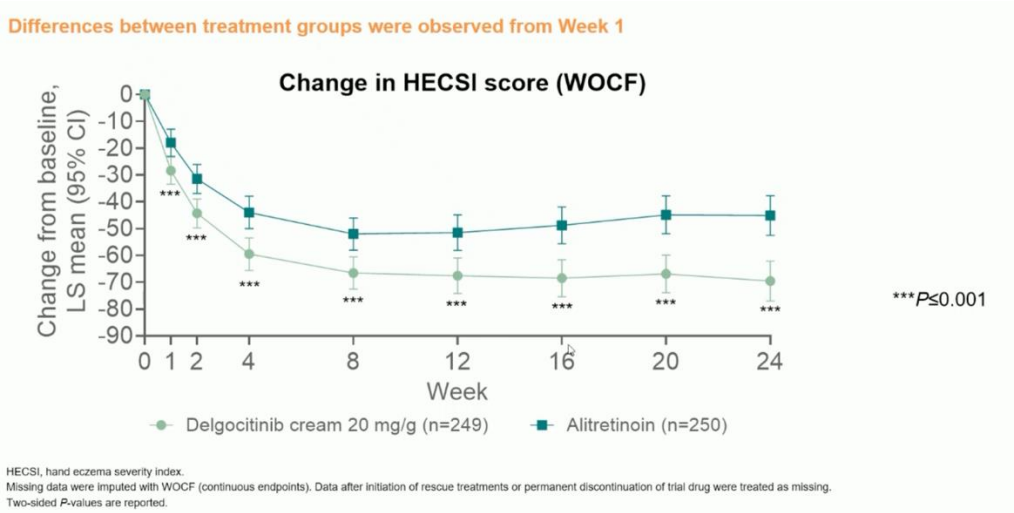
**AMLITINIMAB** (anti-OX40L)

*Bissonnette R. New topical and systemic treatments. Presentation at the Updates session on Atopic Dermatitis; 26 Sep 2024; Elicium, Montreal, Canada.*

# Delgocitinib – DELTA FORCE trial

**DELTA-FORCE TRIAL** Prof. Dr. Giménez-Arnáu – Hospital del Mar Research Institute, Barcelona


- Head-to-head activo-controlado multicéntrico.
- Eccema crónico de manos (ECH) **severo** con IGA ≥ 4.
- **DELGOCITINIB 20 mg/g** en crema dos veces en semana (n = 254) vs. **ALITRETINOÍNA** oral (n = 259) a **24 semanas**.




En semana 12, una mayor proporción de pacientes tratados con delgocitinib crema alcanzaron un **HECSI-90** (38.6% vs 26.0%, *p=0.003*).

**HECSI**: Hand Eczema Severity Index.

## Delgocitinib cream was well-tolerated and showed a favourable safety profile versus alitretinoin

| | Delgocitinib 20 mg/g (N=253, PYO=120.9) | | | Alitretinoin (N=247, PYO=104.0) | | |
|---|---|---|---|---|---|---|
| | n (%) | E | R | n (%) | E | R |
| **All AEs** | 125 (49.4) | 280 | 231.5 | 188 (76.1) | 620 | 596.1 |
| **Serious AEs** | 5 (2.0) | 5 | 4.1 | 12 (4.9) | 12 | 11.5 |
| **Severity** | | | | | | |
| Mild | 92 (36.4) | 168 | 138.9 | 151 (61.1) | 397 | 381.7 |
| Moderate | 68 (26.9) | 108 | 89.3 | 104 (42.1) | 198 | 190.4 |
| Severe | 4 (1.6) | 4 | 3.3 | 14 (5.7) | 25 | 24.0 |
| **AEs probably or possibly related to trial drug** | 24 (9.5) | 30 | 24.8 | 134 (54.3) | 311 | 299.0 |
| **AEs leading to permanent discontinuation of trial drug** | 3 (1.2) | 4 | 3.3 | 25 (10.1) | 44 | 42.3 |
| **AEs of special interest** | | | | | | |
| Eczema Herpeticum | 0 | 0 | 0 | 0 | 0 | 0 |
| Deep Vein Thrombosis | 0 | 0 | 0 | 1 (0.4) | 1 | 1.0 |
| Pulmonary Embolism | 0 | 0 | 0 | 0 | 0 | 0 |
| **Frequent AEs (≥5% in any treatment group)** | | | | | | |
| Headache | 10 (4.0) | 19 | 15.7 | 80 (32.4) | 114 | 109.6 |
| Nasopharyngitis | 30 (11.9) | 38 | 31.4 | 34 (13.8) | 46 | 44.2 |
| Nausea | 1 (0.4) | 1 | 0.8 | 14 (5.7) | 15 | 14.4 |

AEs starting or worsening in severity after first trial drug dose and reported on or before Week 26 were reported. Relation to trial drug was based on investigator's assessment.
AEs were coded using MedDRA Version 24.0 dictionary.

Los pacientes tratados con delgocitinib reportaron **menos EA** que los tratados con alitretinoína (280 en 125 [49.4%] pacientes vs 620 in 188 [76.1%] pacientes)

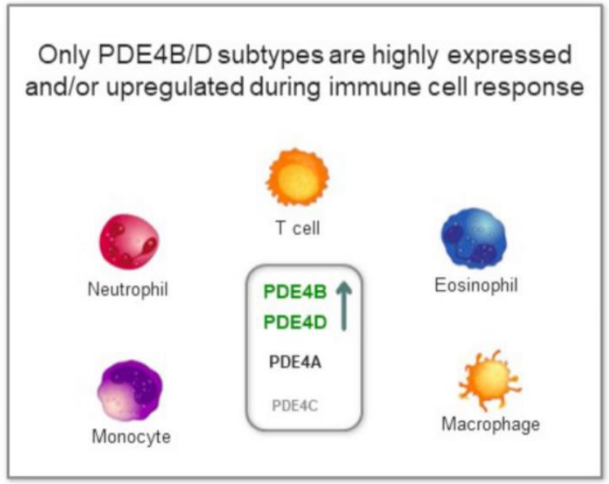
*Giménez-Arnau A. DELTA FORCE trial: A 24-week head-to-head phase 3 trial comparing the efficacy and safety of topical delgocitinib cream with oral alitretinoin capsules in adults with severe chronic hand eczema. Presentation ID D1T01.1F at the Updates session; 25 Sep 2024; Auditorium, Barcelona, Spain.*

# Orismilast – Phase 2b ADESOS trial

## Late breaking abstracts

Prof. Dr. Eric Simpson - Portland

ADESOS es un EC fase 2b a 16 semanas.
N = 233 pacientes (EASI medio basal 23).




**Orismilast** es un inhibidor de nueva generación de alta potencia (x39 veces Apremilast) y **selectivo** contra **PDE4 B/D**

- **Reducción precoz** del prurito con todas las dosis (semana 1).
- % de reducción de IGA 0/1 en **semana 16** mayor que placebo ($p < 0.05$):
  - 20 mg (n = 58): 26.3%
  - 30 mg (n = 61): 24.3%
  - 40 mg (n = 59): 30.9%
- Porcentajes de cambio de EASI en semana 16:
  - 20 mg: reducción **55.1%**
  - 30 mg: reducción **52.2%**
  - 40 mg: reducción **61.4%**
- Ausencia de RAM reseñables más allá de **diarrea**, **náuseas** y **cefalea** en el primer mes.

- Orismilast demonstrated rapid itch reduction, significant for all doses at Week 1
- Early improvements were also demonstrated for pain and patient global impression of change
- Statistically significant efficacy versus placebo at Week 16 as measured by IGA 0/1
- The high EASI placebo rate seen in this trial was decreased in severe patients, and the 20 mg dose separated from placebo for EASI75 and EASI90 measurements, consistent with the overall findings as measured by IGA 0/1, patient-reported efficacy, and objective biomarkers
- No new safety signals were identified, and the profile was aligned with the well-established experience from the PDE4 inhibitor class; most frequent TEAEs were gastrointestinal-related and headache, generally mild and seen within the first four weeks
- These data confirm the clinical relevance of oral high potency PDE4B/D selective inhibition with orismilast in patients with atopic dermatitis

D1T01.1 Orismilast efficacy in adults with moderate-to-severe atopic dermatitis in a phase 2b trial: early impact on itch and patient-reported Outcomes. Prof. Dr. Eric Simpson, Professor of Dermatology, School of Medicine, Frances J. Storrs, M.D. Medical Dermatology Professor, Dermatology, School of Medicine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# URTICARIA

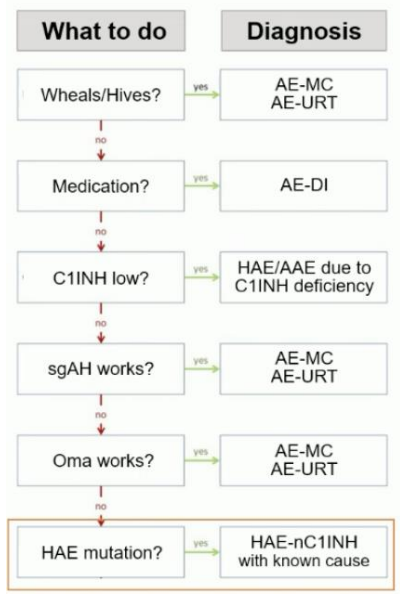
ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

# Tipos de Angioedema

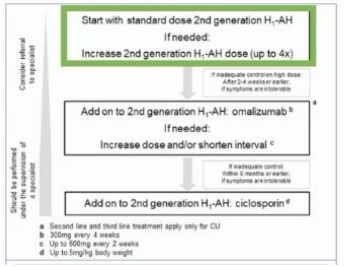
Prof .Thomas Buttgereit

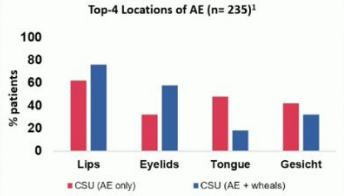
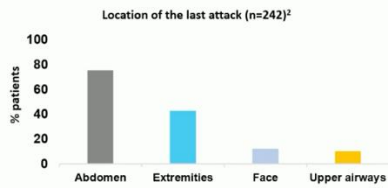
## DANCE Classification of angioedema

| | Endotype/subtype | Mechanism | Name/acronym |
|---|---|---|---|
| 3 Endotypes | AE-MC Mast-cell mediated | Mast cell degranulation | AE-URT |
| | | | AE-ANA |
| | AE-BK Bradykinin mediated | Hereditary C1INH deficiency | HAE-C1INH (Type 1,2) |
| | | Acquired C1INH deficiency | AAE-C1INH |
| | | KKS pathway mutations | HAE-FXII, HAE-PLG, HAE-KNG, HAE-UNK |
| | AE-VE Vascular endothelium | Intrinsic vascular endothelium dysfunction | HAE-ANGPT, HAE-MYOF, HAE-HSST, SCLS, HAE-UNK |
| 2 Subtypes | AE-DI Drug induced | Drug adverse reactions (various mechanisms) | AE-ACEI, AE-tPA, AE-DPP4, AE-NSAID, etc. |
| | AE-UNK Unknown | Unknown aetiology/mechanism | AE-UNK, HAE-UNK, EAE |




## Start with AH standard dose/ and increase up to 4-fold




| | AE-MC | HAE-C1INH |
|---|---|---|
| Location of AE: |  |  |
| Duration of AE: | ~ 24h | Days |
| Onset of disease: | Every age | Childhood/Adolecsence |





### Should sartans be used as replacement medication after AE-ACEI?

Data on 1 106 024 patients taking ACE inhibitors from Danish health registers

**0,5% (n=5507) AE-ACEI**

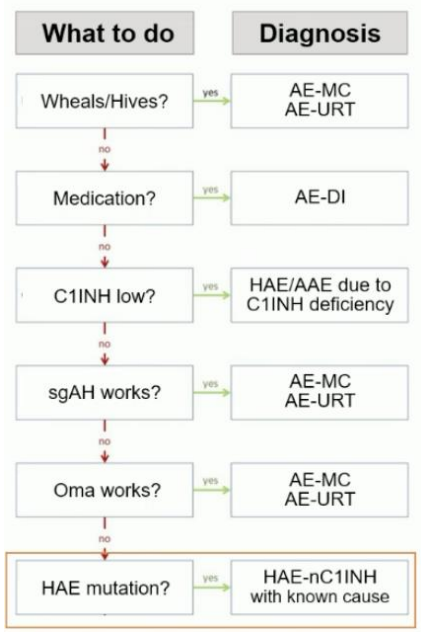
| Drug | HR (crude) | HR (adjusted) |
|---|---|---|
| ACEIs | 1.61 (1.34–1.94) | 1.45 (1.19–1.78) |
| AT2s | 0.49 (0.38–0.63) | 0.39 (0.30–0.51) |
| Beta-adrenergic blockers | 0.93 (0.79–1.10) | 0.77 (0.63–0.94) |
| Calcium channel blockers | 1.18 (1.03–1.35) | 0.97 (0.83–1.14) |
| Thiazides and analogues | 1.05 (0.90–1.22) | 0.87 (0.73–1.04) |

**Conclusion:**
"Compared with other antihypertensive drugs, AT2s do not increase the incidence of angioedema in patients with previous ACEi-related angioedema"

*Buttgereit T. Recognising different types of angioedema. Presentation ID D2T05.3D at the Updates session; 26 Sep 2024; Room 7.1.*

# Tipos de Angioedema

Prof .Thomas Buttgereit




## AAE-C1INH (acquired angioedema due to C1INH deficiency)

- Rare disease with an estimated **prevalence of 1 : 100,000 to 1 : 600,000**
- Manifestation usually **after the age of 40**
- C4 ↓, C1INH Protein ↓ and C1INH function ↓ C1q ↓ (in ca. 70% of cases)
- **Presumed pathogenesis:**
  a) Increased consumption of C1INH by neoplastic lymphoid tissue
  b) Anti-C1INH autoantibodies
- There is often a connection with lymphoproliferative diseases, MGUS, infections or autoimmune diseases

**Diagnostic Workup**

## 8 types of HAE-nC1INH

- **HAE-FXII:** Due to FXII mutation
- **HAE-PLG:** Due to plasminogen mutation
- **HAE-KNG1:** Due to kininogen-1 mutation

→ AE-BK

- **HAE-ANGPT1:** Due to angiopoietin-1 mutation
- **HAE-MYOF:** Due to myoferlin mutation
- **HAE-HS3ST6:** Due to heparan sulfate-glucosamine 3-O-sulfotransferase 6 mutation

→ AE-VE

- **HAE-CPN:** Due to Carboxypepdidase mutation → AE-MC/AE-BK?
- **HAE-DAB2IP** → AE-VE?

*Buttgereit T. Recognising different types of angioedema. Presentation ID D2T05.3D at the Updates session; 26 Sep 2024; Room 7.1.*

# Modelos pronósticos en CSU a partir de machine learning

Prof .Giménez-Arnau– Hospital del Mar Research Institute, Barcelona

n = 39 pacientes

**Input**

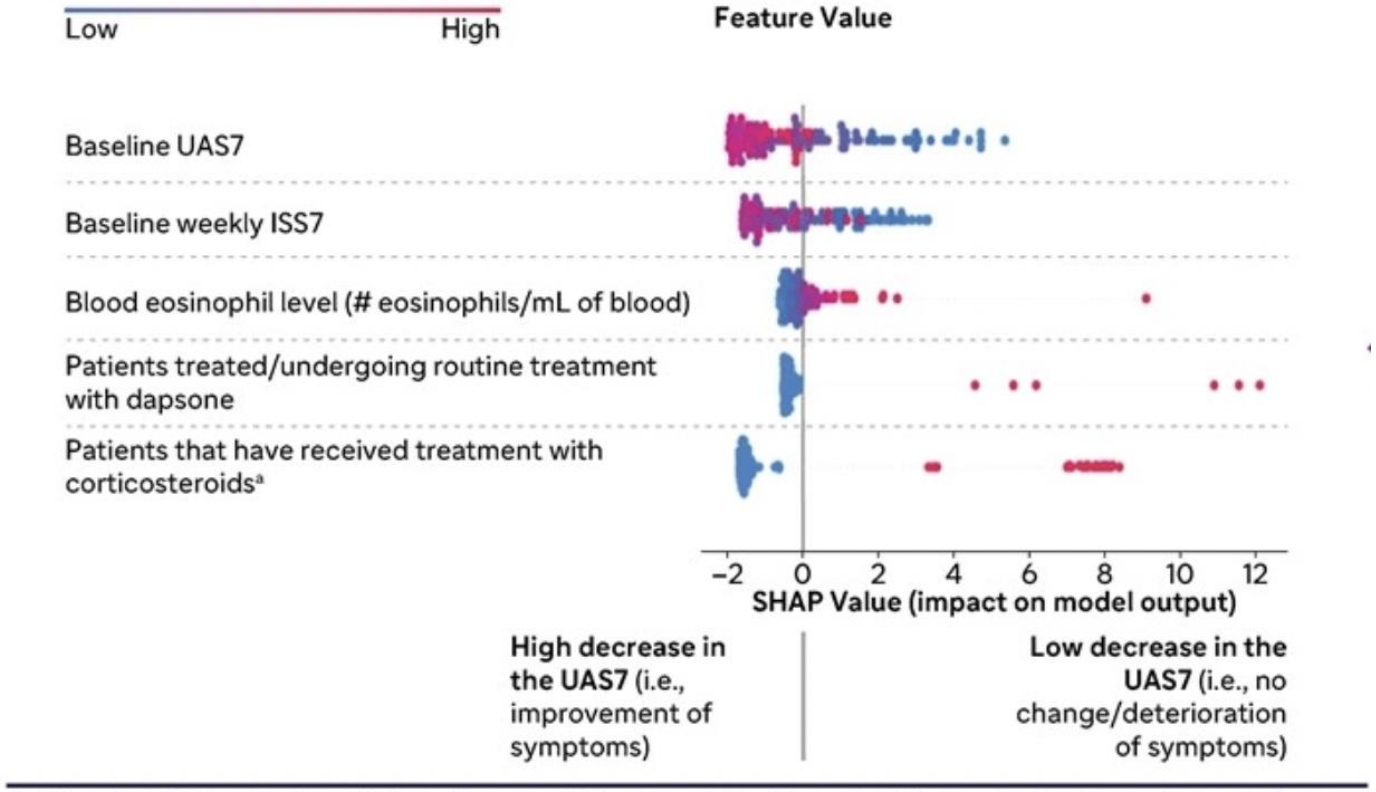
- Pacientes tratados con placebo en ASTERIA I, GLACIAL y RILECSU.
- **UAS7** como endpoint y recogida de variables como progresión de CSU, comorbilidades, UAS7 basal y uso de medicación, entre otras.
- Evaluación de los modelos de machine learning.

**Table 2.** Model performance of 5 machine learning models

| Model Tested | Mean Absolute Error[a] |
|---|---|
| Support Vector Regression | 8.82 |
| Ridge (linear model) | 9.23 |
| LASSO (linear model) | 9.31 |
| Decision Tree | 9.57 |
| Random Forest | 9.65 |
| *Constant prediction equal to population evolution average* | 9.90 |

El modelo ***Support Vector Regression*** mostró la mejor predicción de **progresión de UAS7 en 12 semanas** (mean absolute error 8.82 vs. 9.90)

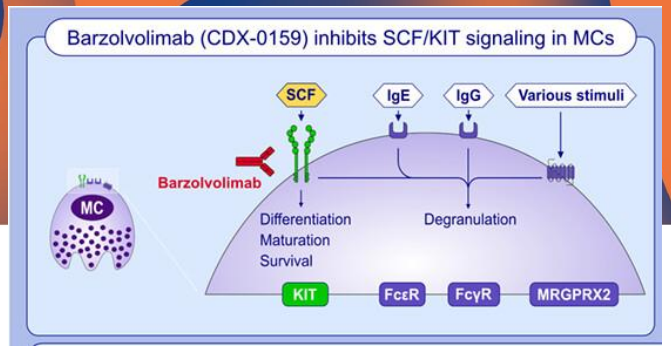
**Output**




[a]Includes patients that have been treated with prednisone, prednisolone, or methylprednisolone (oral). Treatment not ongoing; routine course of treatment stopped before initiating trial.

El bajo UAS7 basal, así como ↑ **niveles de eosinófilos** y **tratamientos previos con corticoides** sistémicos y/o dapsona se asociaron a una **limitación en la progresión de la CSU**

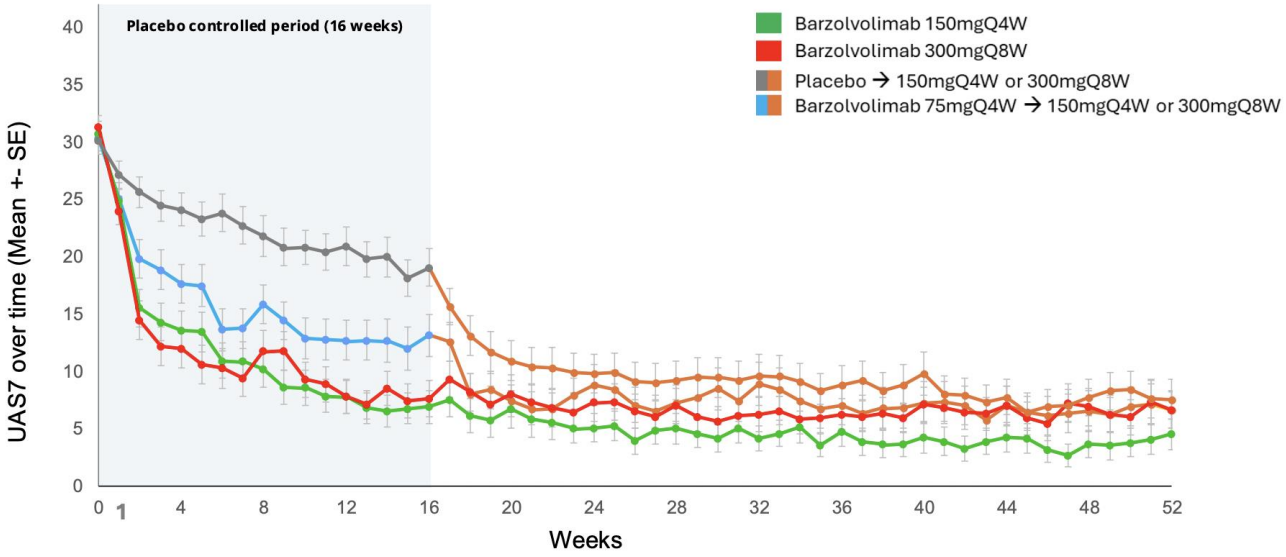
# Barzolvolimab – Phase 2



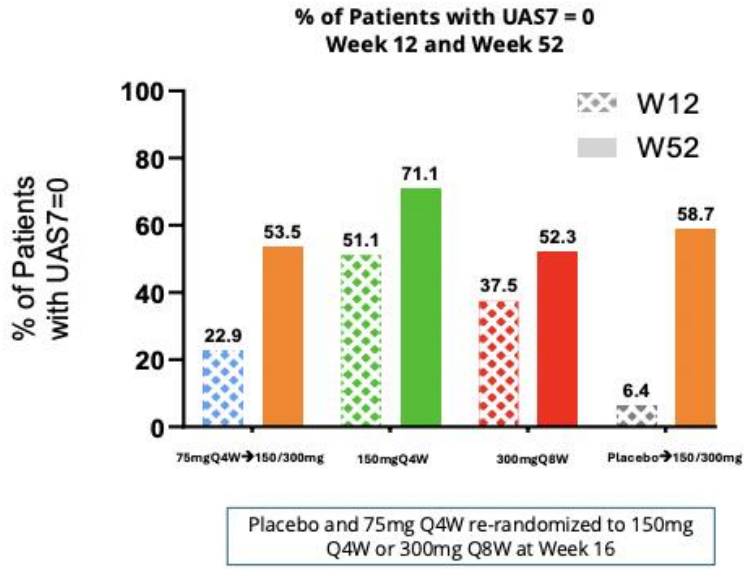

## Late breaking abstracts

Prof .Martin Metz – Institute of Allergology, Berlin

EC fase 2 controlado con placebo, doble ciego con Barzolvolimab 75 mg Q4W, 150 Q4W y 300mg Q8W
N = 208 pacientes (UAS7 medio 30.1-31.3).




Mejorías en UAS7 **desde semana 1** y mantenidas a semana 52




Un **71%** de pacientes alcanzaron **UAS7=0** a la semana 52

- Barzolvolimab demostró mejorías **rápidas**, **profundas** y **duraderas** en UAS7, con mejorías adicionales a semana 52.
- Adecuado perfil de tolerancia a 52 semanas.

*Metz M. Barzolvolimab shows profound efficacy and favorable safety over 52 weeks in patients with chronic spontaneous urticaria. Oral Presentation at the Late breaking news session; 25 Sep 2024; Auditorium, Amsterdam. Netherlands. EADV Congress 2024.*

# Remibrutinib – Phase 3 REMIX-1 y REMIX-2 a semana 52

Prof. Dr. Gimenez Arnau, Hospital del Mar Research Institute, Barcelona

**Remibrutinib 25 mg** dos veces al día.
N = 313/300 pacientes vs. 157/155 placebos.

Mejoría significativa en la proporción de pacientes en alcanzar **UAS7≤6** desde la **semana 1**.

La proporción de pacientes UAS7=0 y UAS7 ≤6 aumentaron hasta la **semana 24** y continuaron hasta **semana 52**.

Sin diferencias en las tasas de EA y EA graves ajustadas durante todo el periodo de tratamiento.

**Table: Key efficacy outcomes in REMIX-1 and REMIX-2 studies (*Full Analysis Set*)**

| | | REMIX-1 | | REMIX-2 | |
|---|---|---|---|---|---|
| Time point | Efficacy outcomes | Remibrutinib 25 mg | Placebo | Remibrutinib 25 mg | Placebo |
| Baseline | UAS7 mean ± SD | 30.8 ± 7.70 | 29.8 ± 7.61 | 30.3 ± 7.94 | 29.5 ± 7.55 |
| Week 1 | CFB-UAS7 LS mean ± SE[a] | -11.28±0.601 | -4.04±0.806 | -11.26±0.544 | -2.90±0.719 |
| | UAS7≤6 (%)[a] | 12.6 | 0.7 | 10.8 | 0.7 |
| | UAS7=0 (%)[a] | 0.3 | 0.0 | 0.3 | 0.0 |
| Week 2 | UAS7≤6 (%) | 33.7 | 3.3 | 30.0 | 5.9 |
| Week 12 | CFB-UAS7 LS mean ± SE | -20.0 ± 0.72 | -13.8 ± 0.98 | -19.4 ± 0.70 | -11.7 ± 0.95 |
| | UAS7≤6 (%) | 49.8 | 24.8 | 46.8 | 19.6 |
| | UAS7=0 (%) | 31.1 | 10.5 | 27.9 | 6.5 |
| Week 24 | CFB-UAS7 LS mean ± SE | -20.7 ± 0.72 | -16.0 ± 0.98 | -20.4 ± 0.74 | -13.7 ± 1.01 |
| | UAS7≤6 (%) | 54.7 | 35.3 | 51.9 | 27.5 |
| | UAS7=0 (%) | 35.6 | 19.6 | 35.7 | 15.7 |
| | | Remibrutinib 25 mg | Placebo-remibrutinib 25 mg[b] | Remibrutinib 25 mg | Placebo-remibrutinib 25 mg[b] |
| Week 52 | CFB-UAS7 Mean ± SD | -23.2 ± 12.46 | -23.0 ± 12.24 | -23.0 ± 11.60 | -22.4 ± 11.67 |
| | UAS7≤6 (%) | 62.9 | 64.1 | 62.2 | 62.4 |
| | UAS7=0 (%) | 44.8 | 42.7 | 45.9 | 42.2 |

[a]Post-hoc analysis.
[b]Patients who transitioned from placebo in the double-blind treatment period to open-label remibrutinib 25 mg b.i.d. at Week 24.
LS mean and percentage (%) presented for responder rate (UAS7=0; UAS7≤6) upto Week 24 are based on imputed data; mean and percentage (%) presented for responder rate (UAS7=0; UAS7≤6) at Week 52 are based on observed data.
CFB, change from baseline; LS, least squares; SD, standard deviation; SE, standard error; UAS7, weekly Urticaria Activity Score.

*Giménez-Arnau A, Metz M, Hide M, Jain V, Khemis A, Lebwohl M, Palumbo M, Saini S, Şavk E, Sussman G, Szalewski R, Walecka Herniczek I, Windom H, Yang B, Haemmerle S, Lheritier K, MacHado PGP, Martzloff E, Seko N, Wang P, Zharkov A, Maurer M. Early and long-term efficacy and safety of remibrutinib in patients with chronic spontaneous urticaria: 52-week data from the Phase 3 REMIX-1 and REMIX-2 studies. Abstract N°: 5727. Presented at: EADV Congress; 25-28 Sep 2024; Amsterdam.*

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# DERMATITIS DE CONTACTO

ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

# Nuevos alérgenos de contacto en 2024

Prof. Jeanne Duus Johansen (Hellerup, Denmark)

## Batería Estándar Europea

- Alérgenos relevantes:
  - HEMA al 2% in pet.
  - Metabisulfito sódico al 1% en pet.
  - Benzisotiazolinona al 0.1% en pet.

Received: 5 September 2022 | Revised: 9 November 2022 | Accepted: 23 November 2022
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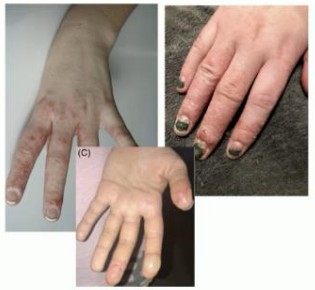
REVIEW

CONTACT DERMATITIS WILEY

**The European baseline series and recommended additions: 2023**

S. Mark Wilkinson[1] | Margarida Gonçalo[2] | Olivier Aerts[3] | Sonia Badulici[4,5] | Heinrich Dickel[6] | Rosella Gallo[7] | Jose L. Garcia-Abujeta[8] | Ana M. Giménez-Arnau[9] | Curt Hamman[10] | Marcos Hervella[11] | Marléne Isaksson[12] | Jeanne D. Johansen[13] | Vera Mahler[14] | Bo Niklasson[15] | Paolo Pigatto[16] | Gyorgyi Ponyai[17] | Thomas Rustemeyer[18] | Marie L. A. Schuttelaar[19] | Radoslaw Spiewak[20] | Luca Stingeni[21] | Jacob P. Thyssen[22] | Wolfgang Uter[23]

## HEMA and artificial nails/polish



2-hydroxyethyl methacrylate (HEMA) 2% pet.
Since 2019 in European Baseline Series
Increasing problems:

- Children
- Consumers
- Occupational nail technicians

Contact allergy to (meth)acrylates in gel nail polish in a child: An emerging risk for children

The bitter side of nail art: A teenage girl's encounter with (meth)acrylate-induced allergic contact dermatitis from nail glue

ORIGINAL ARTICLE

CONTACT DERMATITIS WILEY

**Acrylates in artificial nails—Results of product analyses and glove penetration studies**

Katri Suuronen[1] | Katriina Ylinen[2] | Jaakko Heikkilä[2] | Erja Mäkelä[3] | Raija Vastapuu[2] | Kristiina Aalto-Korte[1] | Maria Pesonen[1]

Chemical analysis of 37 gel nails and acrylic nail products
32 products contained (meth)acrylates.

| Substance | labelled | detected |
|---|---|---|
| HEMA | 12 | 20 |
| HPMA | 5 | 9 |
| IBOA | 1 | 9 |

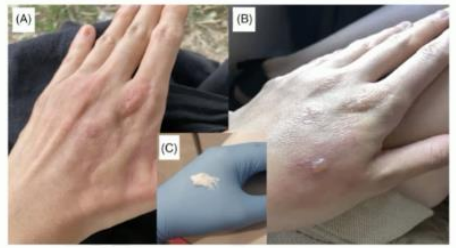
In all of them:
discrepancy between the listed (meth)acrylates and those discovered in the analysis.

Contact Dermatitis. 2024;90:266–272.

**Occupational hand dermatitis secondary to methacrylates—The 'manual tray' sign**

Sarah Francesca Ryan[1] | Felicity J. Ferguson[2] | Louise Cunningham[2] | Ian R. White[2] | John P. McFadden[2]

Manual tray sign



Penetration time (nitrile): 5 mins

Contact Dermatitis. 2023;1–7.

**Signo de la bandeja manual**

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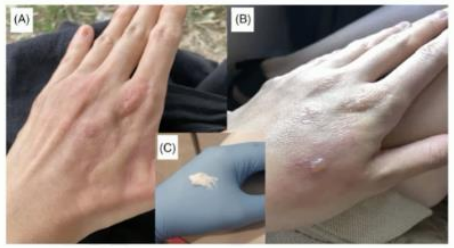



Penetration time (nitrile): 5 mins

Contact Dermatitis. 2023;1–7.

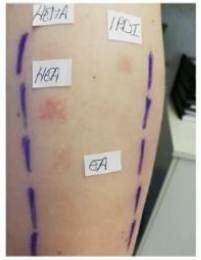
Signo de la bandeja manual

CONTACT POINT

CONTACT DERMATITIS WILEY

**Allergic contact dermatitis mimicking angioedema of the lips and eyelids from a vegan 'HEMA-free' gel nail polish containing acrylates and isocyanates**

Ella Dendooven[1] | Alessandro Toscano[2] | Vito Sabato[2] | Didier G. Ebo[2] | Olivier Aerts[1]




Nail products explicitly advertised as 'vegan' and 'hypoallergenic' (i.e., 'HEMA-free'),

Presence of other cross-reactive acrylates and isocyanate (IPDI)

DAC angioedema-like a **acrilatos e isocianatos** en productos HEMA-free

*Duus Johansen J. New allergens in 2024. Presentation at the Updates session on Contact Eczema; 26 Sep 2024; Room 7.1, EADV Congresss 2024, Amsterdam, Netherlands.*

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## Sodium metabisulfite

CONTACT ALLERGEN OF THE YEAR

Sulfites: Allergen of the Year 2024

Samuel F. Ekstein, MS[1,†] and Erin M. Warshaw, MD, MS[*,†,§]

Sulfites are ubiquitous preservatives, occurs naturally
Present in:
- foods, beverages (wine, dried fruit)
- Pharmaceuticals e.g. topical steroids
- Personal care products
- Occupational products, eg in latex gloves

Sulfites:
Sodium disulfite =sodium metabisulfite= sodium pyrosulfite

Ausencia de **relevancia clínica** frecuente

**TABLE 2** Recent Reports of Routine Patch Testing to Sodium Disulfite

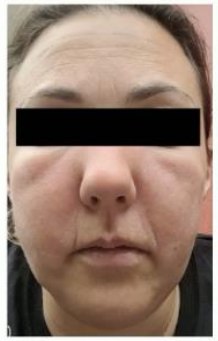
| First Author, Year Published, Location | Time Period of Testing | Patch Test Concentration | Total No. of Patients Tested | No. of Positive Reactions (%) |
|---|---|---|---|---|
| Morin (2020),[16] Canada | 2005–2019 | 2% Pet | 2323 Patients tested to a customized AVC series which included sodium metabisulfite. | 45 (1.9) |
| Hernández-Fernández (2021),[15] Spain | 2019–2020 | 1% Pet | 1850 Patients tested to a series of emerging allergens to determine potential inclusion into the Spanish standard series. | 35 (1.9) |
| Uter (2022),[17] 12 European Countries (ESSCA) | 2019–2020 | 1% Pet | 6819 Patients tested to audit allergens that included sodium metabisulfite. | 256 (3.8) |

Advocate for sulfite inclusion in the next ACDS Core Allergen Series.

Contact dermatitis experts should be aware of this important, often missed, allergen

**Acute allergic contact dermatitis caused by sulphites in a cosmetic and a pharmaceutical cream**

Valérie Beaulieu[1,2] | Ilaria Matei[1] | Nancy Hajjar[1] | Saskia Ingen-Housz-Oro[1,3] | Haudrey Assier[1,3]



**Symmetric drug-related intertriginous and flexural exanthema elicited by lidocaine cum adrenaline in a patient allergic to sodium metabisulfite**

Emilia Dik | Elisabeth Bjorvatn | Jesper Elberling

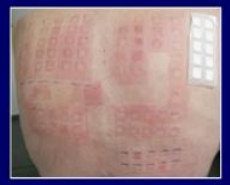
**SDRIFE:** after exposure to local anaesthesia in surgeries or dental treatments less than 24 h prior.

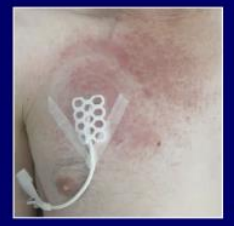
El metabisulfito sódico es un conservante presente en la mayoría de **soluciones de adrenalina**

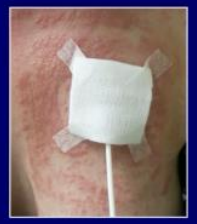
# Nuevos alérgenos de contacto en 2024

## Allergens in medical adhesive tapes

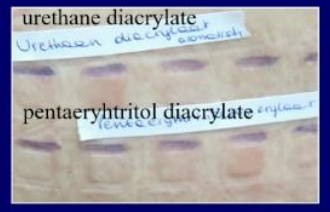
- Synthetic tackifying agents
  - (meth)acrylates











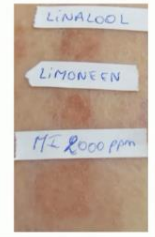
*Mestach L, et al. ACD caused by acrylic-based medical dressings and adhesives. Contact Dermatitis 2018; 79: 81-4*
*Spencer A, et al. Acrylate and methacrylate contact allergy and allergic contact disease: a 13-year review. CD 2016; 3: 157*

EADV CONGRESS

## Allergens in medical adhesive tapes

- Additives
  - lanolin
  - benzoyl peroxide
  - sulfites
  - isothiazolinones
  - salicylates, …

- Linalool HP +
- Limonene HP +
- MI 0.05% +, 0.2% ++



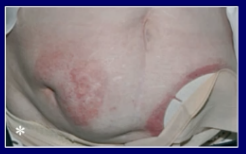


- MI/MCI +

** Dendooven E. Contact allergy caused by natural and synthetic components in medical devices, adhesives, in particular. Doctoral thesis Universiteit Antwerpen, 2021.*

## Allergens in peristomal adhesives

- Colophonium and modified colophonium
- (Meth)acrylates (e.g., 2-HEMA and ethyl acrylate)

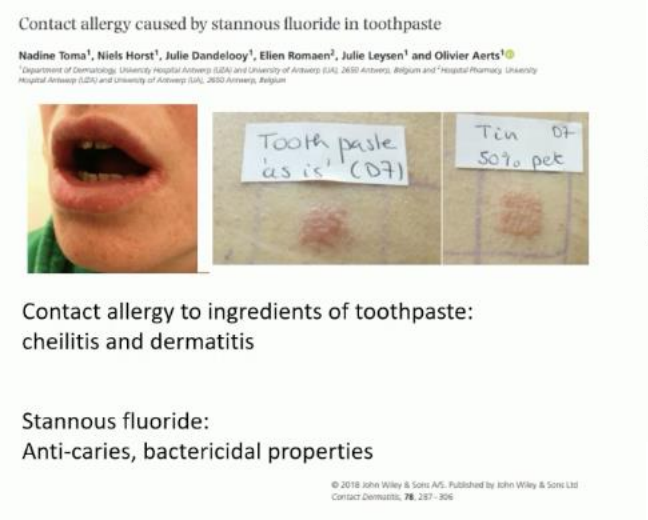


- Gantrez-ES™ derivatives: N-butyl, ethyl or isopropyl esters of polymethylvinyl/maleic acid (« PMV/MA ») copolymers in adhesive pastes (= most important allergens)

**Al-Niaimi F, et al. The relevance of patch testing in peristomal dermatitis. Br J Derm 2012; 167: 103–109.*

# Nuevos alérgenos de contacto en 2024

- **FLORURO DE ESTAÑO**
  - Propiedades bactericidas, uso como **anti-caries**.
  - DAC a ingredientes de pastas de dientes.
  - Queilitis y dermatitis perioral.
  - Patch test: ‘as is’, estaño al 50% en pet.


Contact allergy caused by stannous fluoride in toothpaste

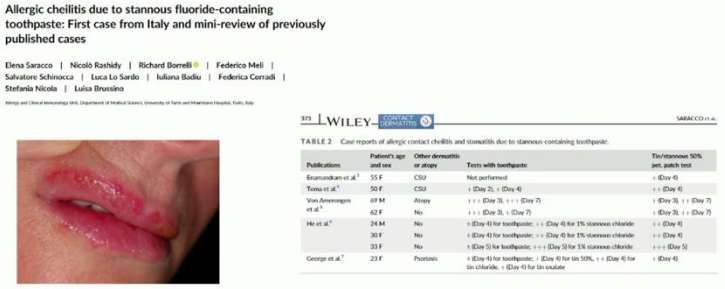
Nadine Toma[1], Niels Horst[1], Julie Dandelooy[1], Elien Romaen[2], Julie Leysen[1] and Olivier Aerts[1]



Contact allergy to ingredients of toothpaste: cheilitis and dermatitis

Stannous fluoride: Anti-caries, bactericidal properties




Allergic cheilitis due to stannous fluoride-containing toothpaste: First case from Italy and mini-review of previously published cases

Elena Saracco | Nicolò Raxidy | Richard Borrelli | Federico Meli | Salvatore Schinocca | Luca Lo Sardo | Iuliana Badiu | Federica Corradi | Stefania Nicola | Luisa Brussino



- **AURICULARES INALÁMBRICOS**
  - Pueden poseer cobertura interna con **isotiazolinonas (MI, MC-MI).**
  - **Isocianatos** como MDA 0.5% en pet.


Wireless over-ear headphones: A new source of allergic contact dermatitis to isothiazolinones

Elena Sofia Caroppo[1] | Luca Stingeni[1] | Laura Goracci[2] | Simone Moretti[2] | Rossella Marietti[1] | Leonardo Bianchi[1] | Marta Tramontana[1] | Katharina Hansel[1]




MDA (0.5% pet)

*Duus Johansen J. New allergens in 2024. Presentation at the Updates session on Contact Eczema; 26 Sep 2024; Room 7.1, EADV Congresss 2024, Amsterdam, Netherlands.*

# Nuevos alérgenos de contacto en 2024

- **VITAMINA K1** (fitomenadiona, filoquinona)
  - Presencia en **cosméticos** con propiedades **despigmentantes** (8%).
  - Puede producir reacciones severas similares a una anafilaxia (iv. o im).
  - Dermatitis de contacto alérgica (**eccema periocular**).
  - **Fue prohibida en 2009**, pero se ha comenzado a emplear **VITAMINA K1 OXIDADA** (fitonadiona epóxido).
  - El GEIDAC recomienda parchear al 5% en pet.


## New: Oxidised Vitamin K1

Introduced instead of Vit. K1
Phytonadione epoxide (PE)

20 cases
Women
Eyelid eczema

At least 12 had used the same creme from Isdin

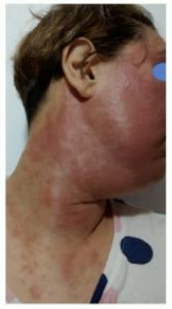
Patch testing recommended: 5% PE in pet

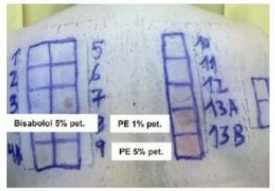
Ban considered in cosmetics (but may take years)

.

An emerging epidemic of allergic contact dermatitis due to phytonadione epoxide (oxidised vitamin K1)

**Severe allergic contact dermatitis to bisabolol and phytonadione epoxide found in a moisturizing and strengthening facial cream**






Sensitive Vitamin K Ox Cream (Chantelet SA, Madrid)
Whitening effect

Bisabolol (INCI): sesquiterpene alcohol

Whitening effect, claimed anti-inflammatory

Active ingredient in German chamomile

Tested in 5% pet.

El **BISABOLOL** es un alcohol despigmentante que puede asociarse a clínica de DCA de forma similar a vitamina K1 oxidada

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# Nuevos alérgenos de contacto en 2024

- **METOXIPROPILAMINO CICLOHEXENILIDENO (MCE)**
  - Es un nuevo **filtro solar UVA-1** con un pico de absorción en 385 nm.

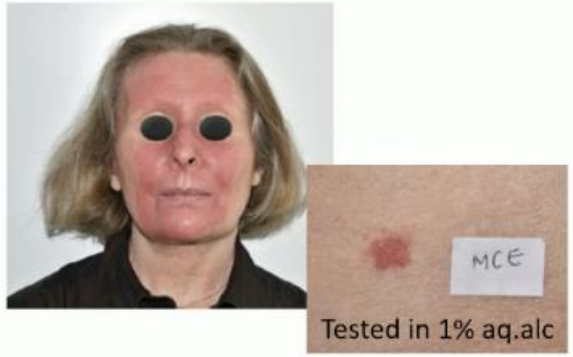
## First case

CONTACT POINT

WILEY

Severe allergic contact dermatitis caused by methoxypropylamino cyclohexenylidene ethoxyethylcyanoacetate

Audrey Loretan | Federica Bertone | Sebastien Menzinger | Pierre Piletta | Yassaman Alipour Tehrany




MCE is a new UVA1 filter absorption peak at 385.

Approved in 2020, the European Commission approved the use of MCE in 3% (safe)

We anticipate additional cases will be documented in the future.

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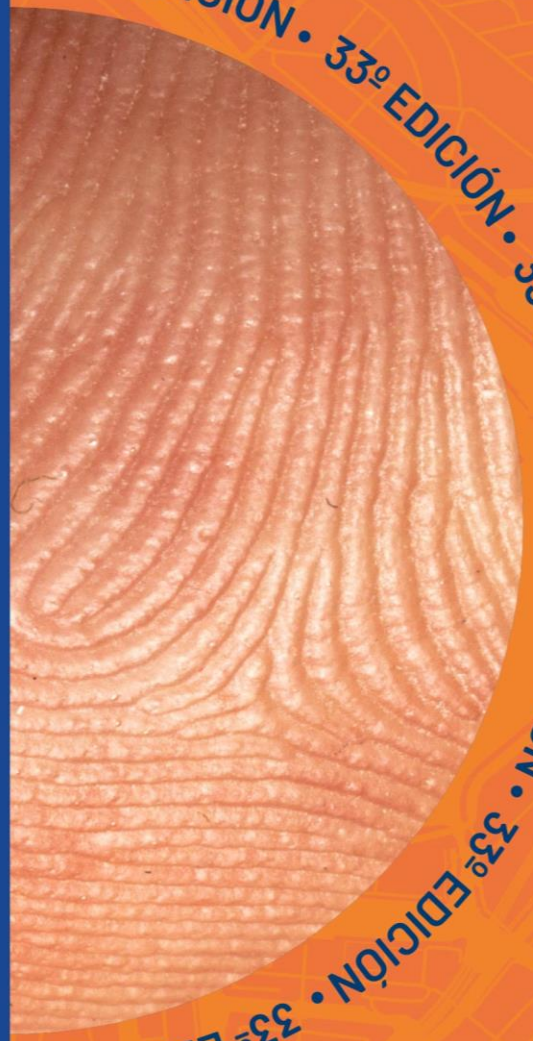

La Academia Española de Dermatología y Venereología expresa su agradecimiento al patrocinador UCB, por su especial apoyo y contribución con la actividad formativa Highlights 2024.

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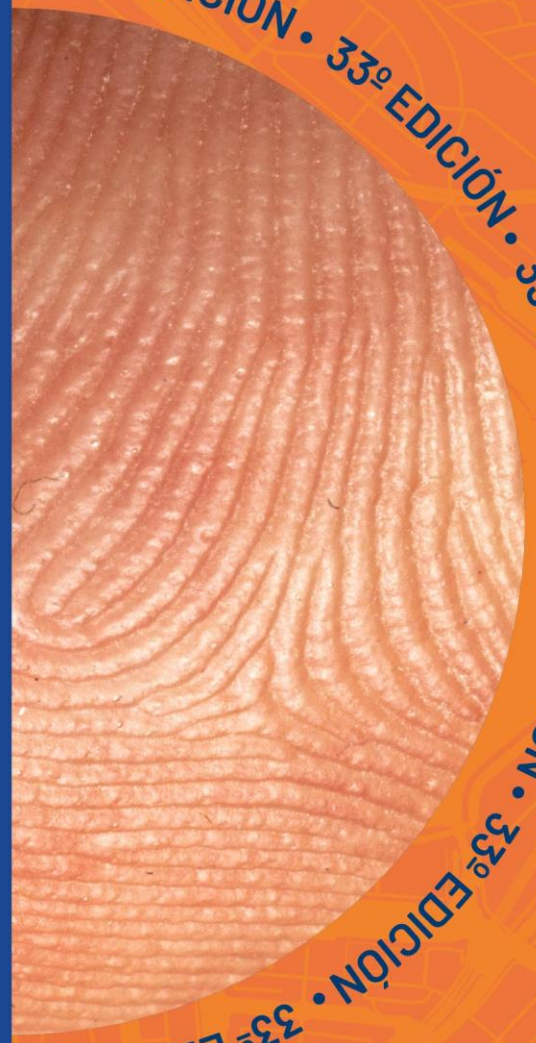

# GRACIAS

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