Εξελίσσοντας τη διαχείριση της Ψωριασικής Νόσου μέσα από την εμπειρία των κοινών ιατρείων

RISN-GR-00342-E | April 2025

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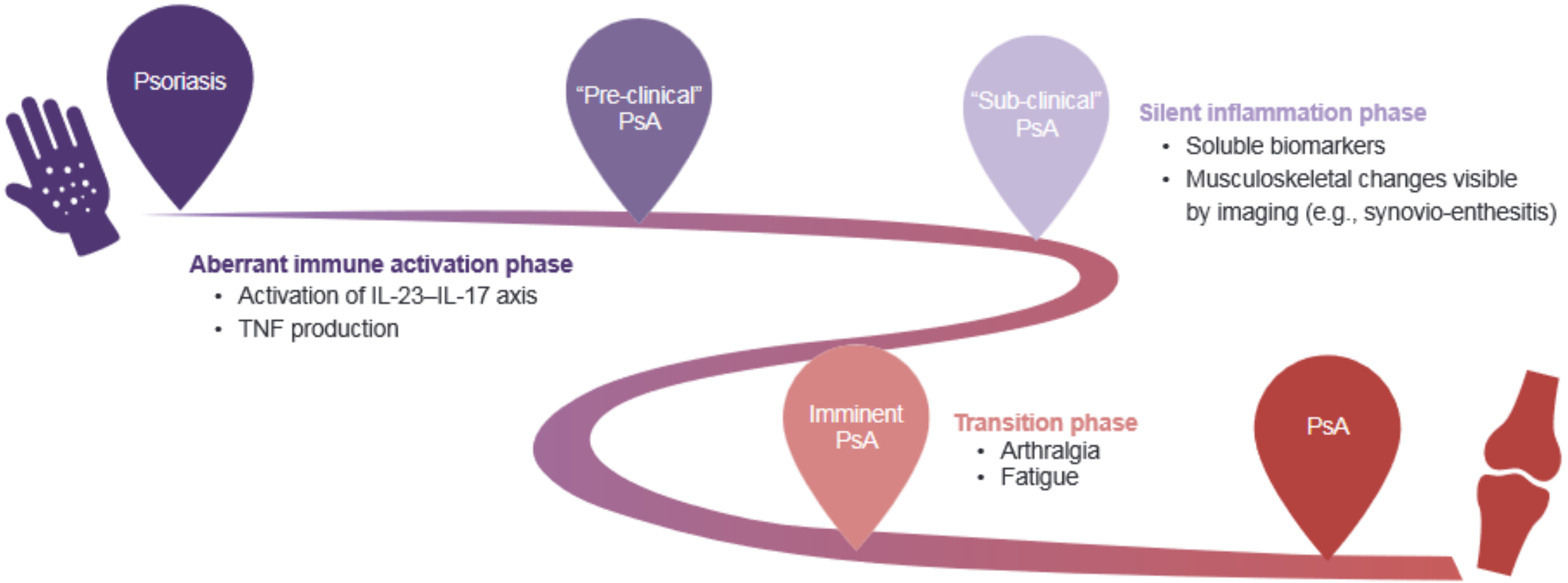
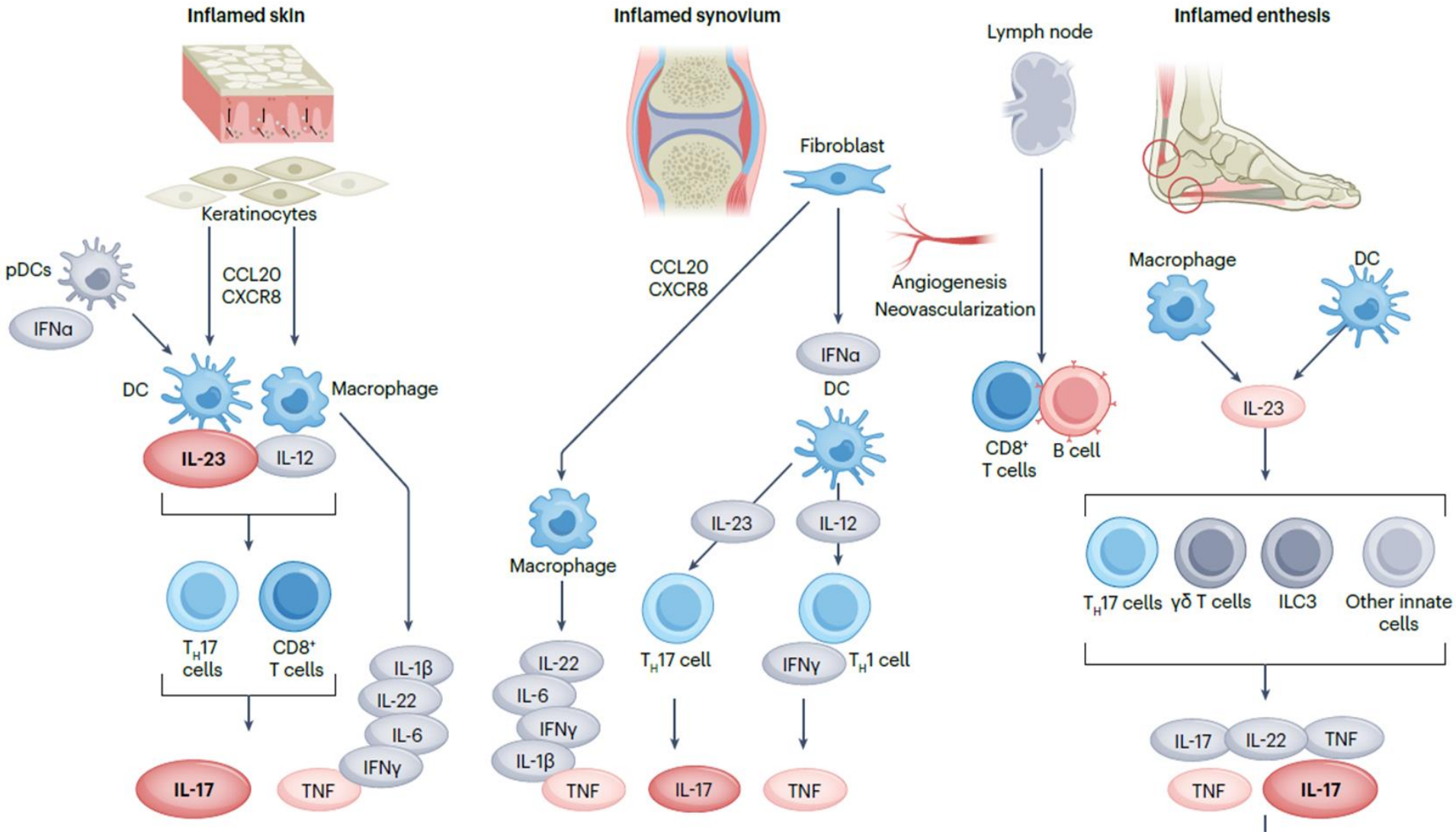


Christiansen, Sara Nysom et al. "Patient-reported outcomes in axial spondyloarthritis and psoriatic arthritis patients treated with secukinumab for 24 months in daily clinical practice." *Seminars in arthritis and rheumatism* vol. 65 (2024): 152388. doi:10.1016/j.semarthrit.2024.152388

Analyzing PsD from a mechanistic perspective

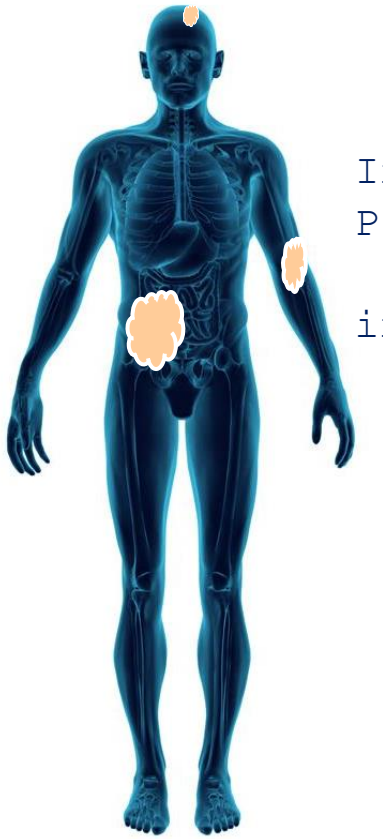


Schett G. et al., Nature Reviews 2022

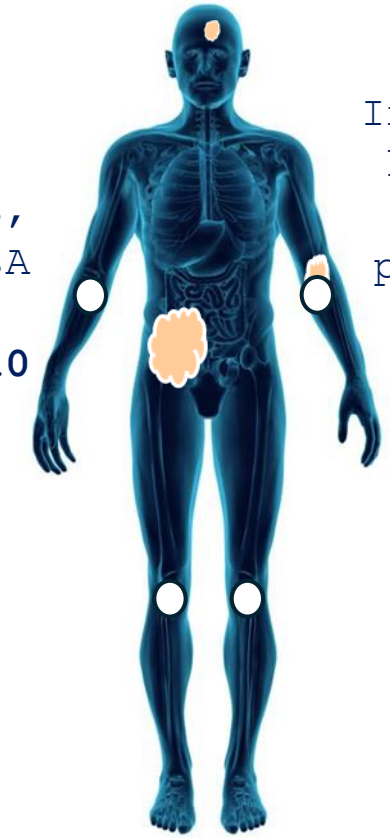
Patient with Psoriasis

PsA

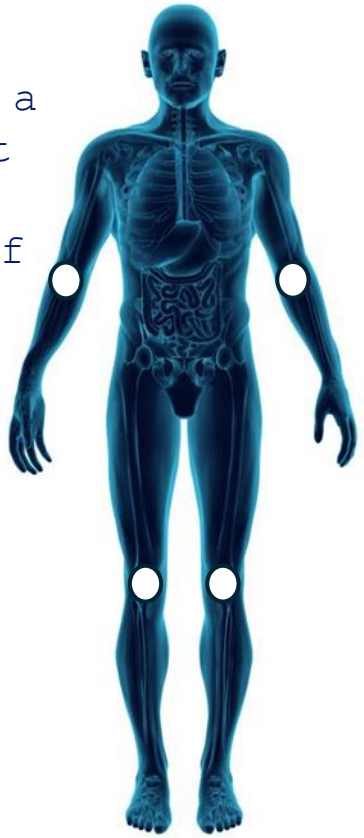
Patient with history if joint involvement



In **70%** of cases, Pso precedes PsA with a mean interval of **~ 10 years**



In **13%** of cases, a history of joint involvement preceded onset of skin symptoms, with a mean interval of **~ 4 years**

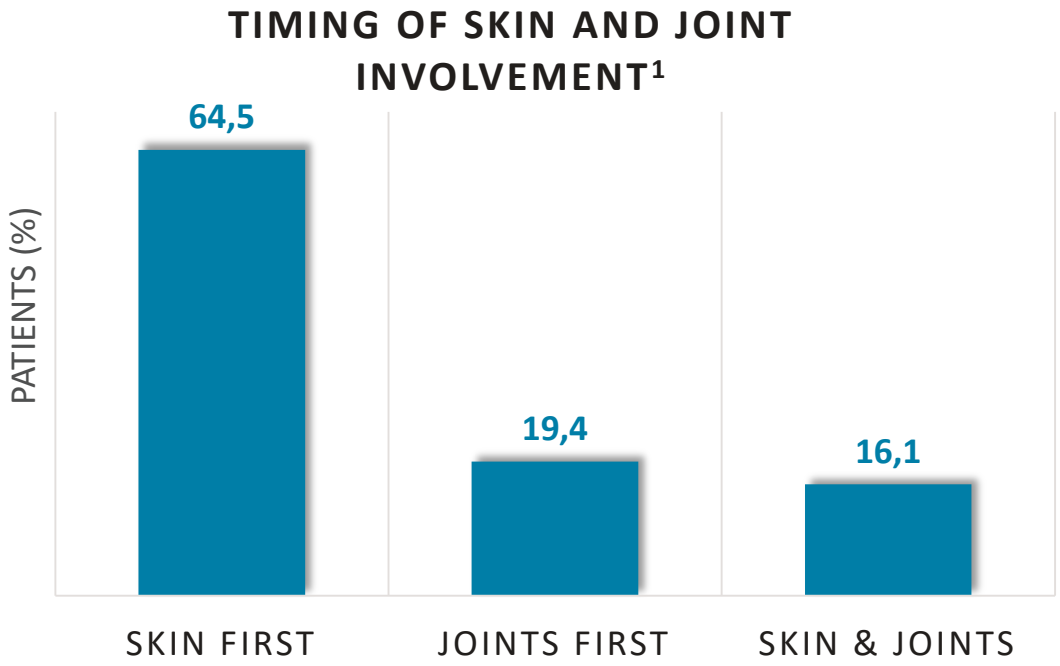


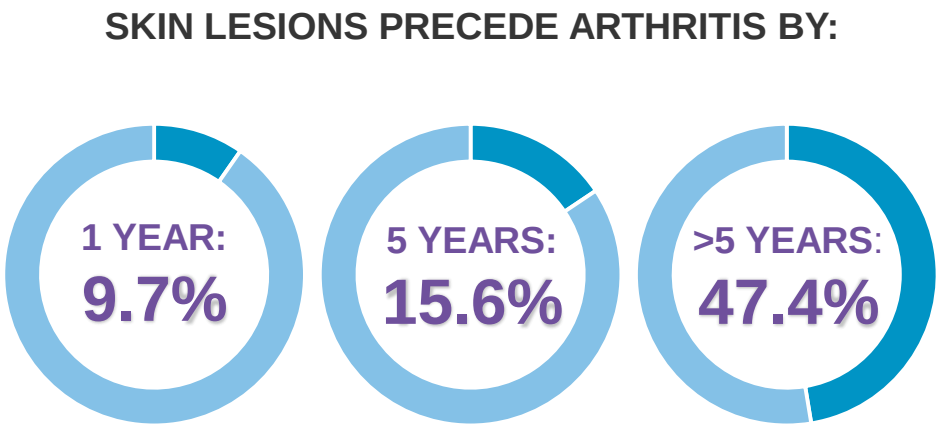
Parallel onset of skin and joint manifestations is seen in **16%** of cases

Approximately **15%** of patients with PsO who are under the care of dermatologists have an undiagnosed case of psoriatic arthritis

1. Lee, Leon Tsung-Ju et al. "Machine Learning Approaches for Predicting Psoriatic Arthritis Among Those Using Electronic Medical Records: Population-Based Study." Journal of medical Internet research vol. 25 e39972. 28 Mar. 2023, doi:10.2196/39972. 2. Stephen R. Pennington and Oliver FitzGerald, (2021) Front. Med. 8:723944.; 2. Lourdes M. Perez-Chada, Jose U. Scher et al. Nat Rev Rheumatol. 2021; 17(4): 238–243, 3. Kumar, Ramesh et al. "Prevalence and clinical patterns of psoriatic arthritis in Indian patients with psoriasis." Indian journal of dermatology, venereology and leprology vol. 80,1 (2014): 15-23. doi:10.4103/0378-6323.125472, 4. Tan, Minjia et al. "Concurrent onset of skin and joint symptoms correlates with higher psoriatic arthritis disease activity: A single-center retrospective study." Journal of the American Academy of Dermatology vol. 89,1 (2023): 173-175. doi:10.1016/j.jaad.2023.02.045

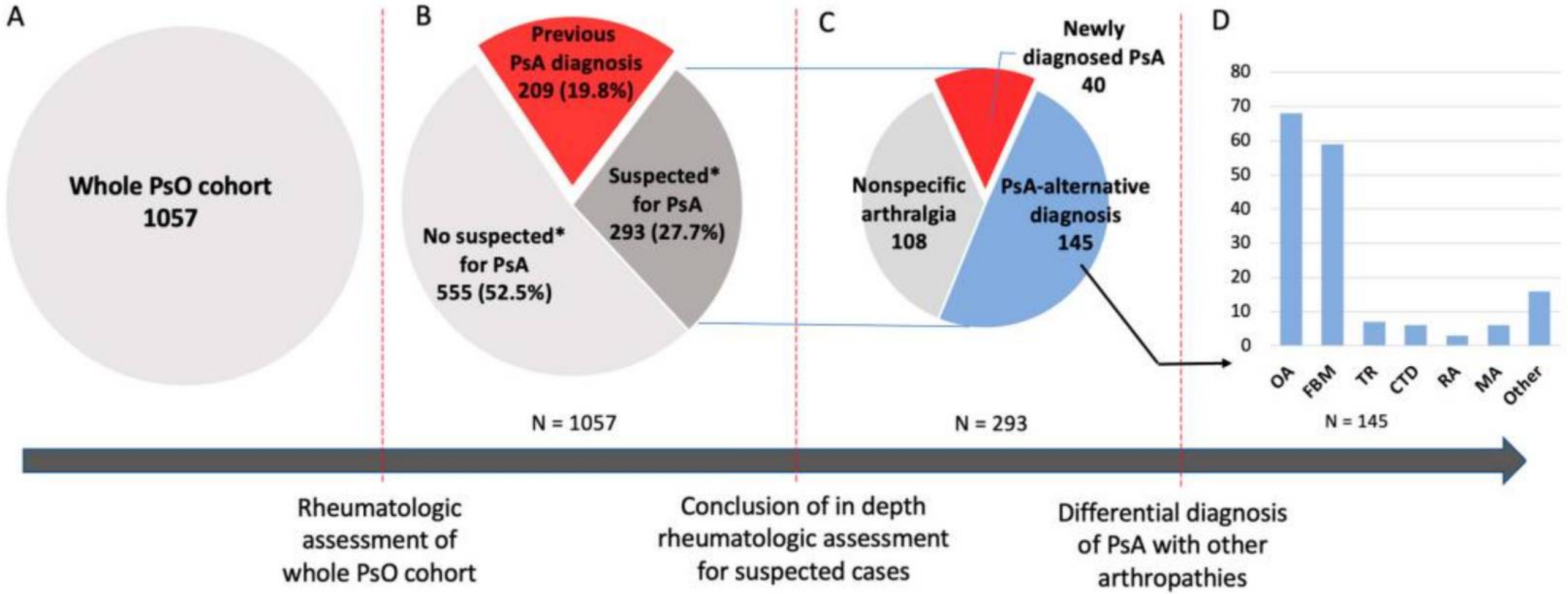
Psoriasis symptoms typically precede joint symptoms





1. Elmets CA, et al. *J Am Acad Dermatol.* 2019;80(4):1073–1113;

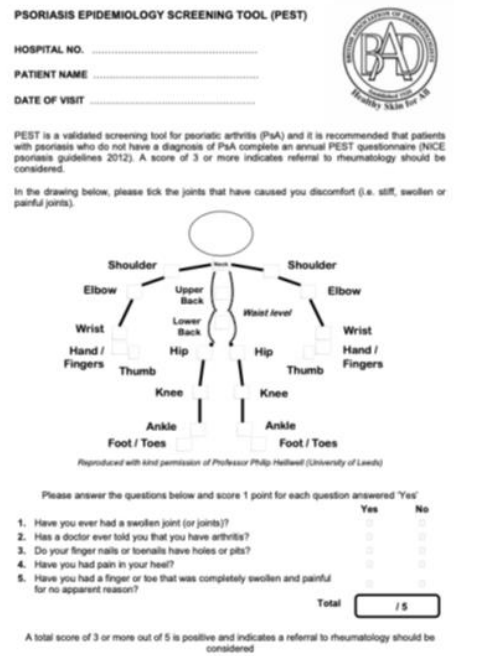
Differentiating PsA



Floris A, Mugheddu C, Sichi L, Dessì M, Anedda J, Frau A, Pau A, Lari SA, Sorgia J, Li Volsi L, Paladino MT, Congia M, Chessa E, Angioni MM, Ferreli C, Piga M, Atzori L, Cauli A. The Challenging Differentiation of Psoriatic Arthritis from Other Arthropathies and Nonspecific Arthralgias in Patients with Psoriasis: Results of a Cross-Sectional Rheumatologic Assessment of a Large Dermatologic Cohort. J Clin Med. 2023 Sep 21;12(18):6090. doi: 10.3390/jcm12186090. PMID: 37763030; PMCID: PMC10532027.

Κλινική Περίπτωση 1

- Νίκος, 54 ετών
- BMI 28, ΑΥ, δυσλιπιδαιμία
  Έκθεση εξανθημάτων από 6μηνου
- **1η εξέταση στα δερματολογικά Ε.Ι:** διάγνωση ψωρίασης κατά πλάκας στους 2 αγκώνες και στη ΔΕ κνήμη
- PEST score:0



PSORIASIS EPIDEMIOLOGY SCREENING TOOL (PEST)

HOSPITAL NO. .....

PATIENT NAME .....

DATE OF VISIT .....

PEST is a validated screening tool for psoriatic arthritis (PsA) and it is recommended that patients with psoriasis who do not have a diagnosis of PsA complete an annual PEST questionnaire (NICE psoriasis guidelines 2012). A score of 3 or more indicates referral to rheumatology should be considered.

In the drawing below, please tick the joints that have caused you discomfort (i.e. stiff, swollen or painful joints).

Shoulder Shoulder Elbow Elbow Upper Back Lower Back Waist level Wrist Wrist Hand / Fingers Hip Hip Hand / Fingers Thumb Thumb Knee Knee Ankle Ankle Foot / Toes Foot / Toes

Reproduced with kind permission of Professor Philip Helliwell (University of Leeds)

Please answer the questions below and score 1 point for each question answered 'Yes'

	Yes	No
1. Have you ever had a swollen joint (or joints)?	☐	☐
2. Has a doctor ever told you that you have arthritis?	☐	☐
3. Do your finger nails or toenails have holes or pits?	☐	☐
4. Have you had pain in your heel?	☐	☐
5. Have you had a finger or toe that was completely swollen and painful for no apparent reason?	☐	☐
Total	/ 5	

A total score of 3 or more out of 5 is positive and indicates a referral to rheumatology should be considered

Speaker's approach

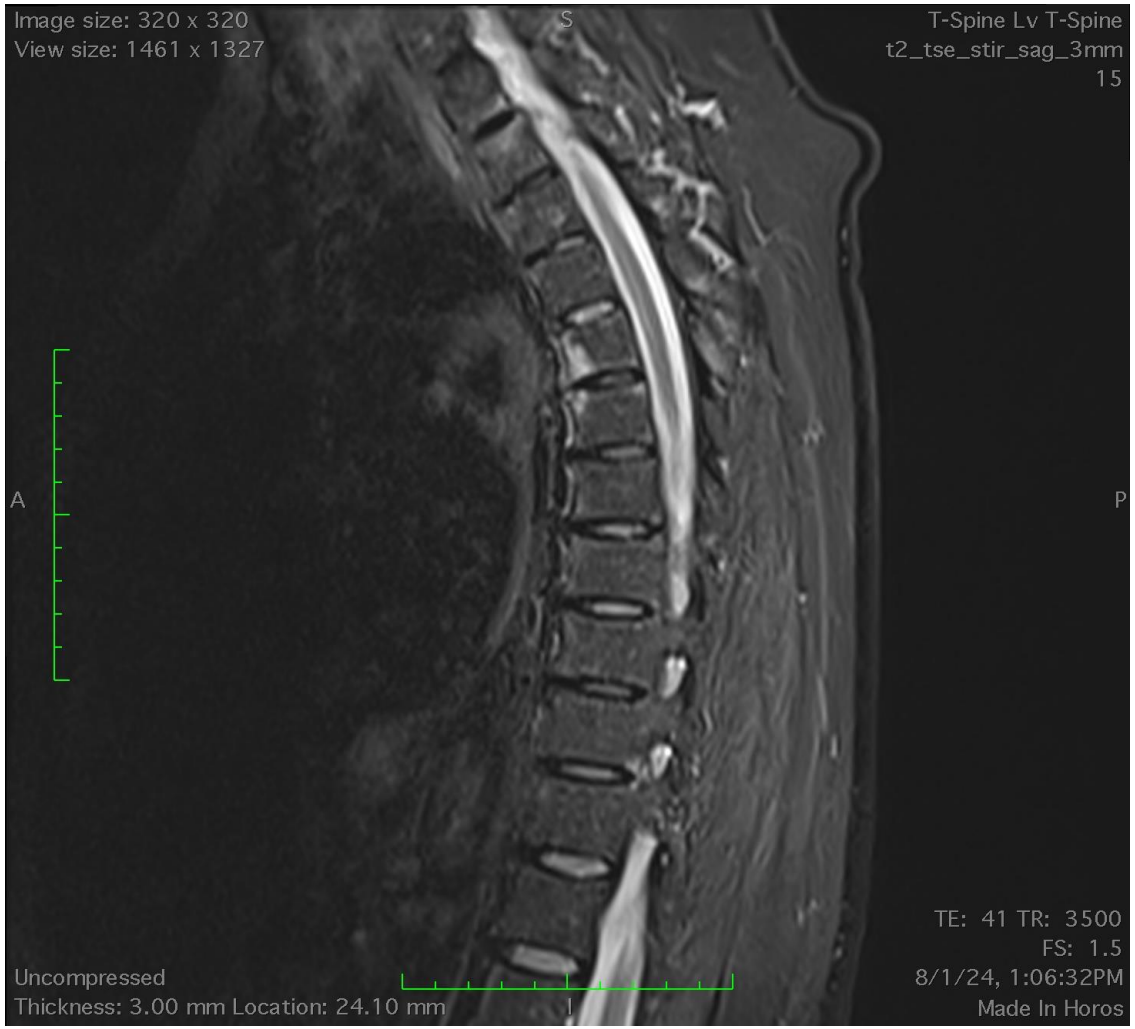
Κλινική Περίπτωση 1

Από το ιστορικό αναφερομένη χρόνια ραχιαλγία-επαγγελματική καταπόνηση και πρόσφατες συνεδρίες φυσιοθεραπειών χωρίς ιδιαίτερη βελτίωση

- Παραπομπή για εξέταση στο κοινό ιατρείο
- Χωρίς περιφερική αρθρίτιδα ή δακτυλίτιδα
- Ραχιαλγία με φλεγμονώδη χαρακτηριστικά

Αυξημένες απαιτήσεις και υποχρεώσεις στην καθημερινότητα του Νίκου

Speaker's approach



- CRP 73 mg/dl
- ΤΚΕ 60 mm Hg
- Λοιπός εργαστηριακός έλεγχος κ.φ.
- Ακτινογραφία ιερολαγονίων ετερόπλευρο στάδιο ΙΙ (NY criteria)

Speaker's approach

What options we have?

Target	Disease Domain					
	Arthritis (ACR 70)	Physical function (HAQ)	Skin (PASI 75)	Enthesitis*	Dactylitis*	Radiographic damage (PsA-mSvdHS)
TNF (ADA, CZP, ETN, IFX, GOL)						
IL-17A (IXE, SEC)						
IL-17A/F (BKZ)						
IL-12/23 (UST)						
IL-23-p19 (GUS, RIS)						GUS / RIS
JAK (TOFA, UPA)				TOFA / UPA	TOFA / UPA	TOFA / UPA
CD80/86 (ABA)						
PDE-4 (APR)						

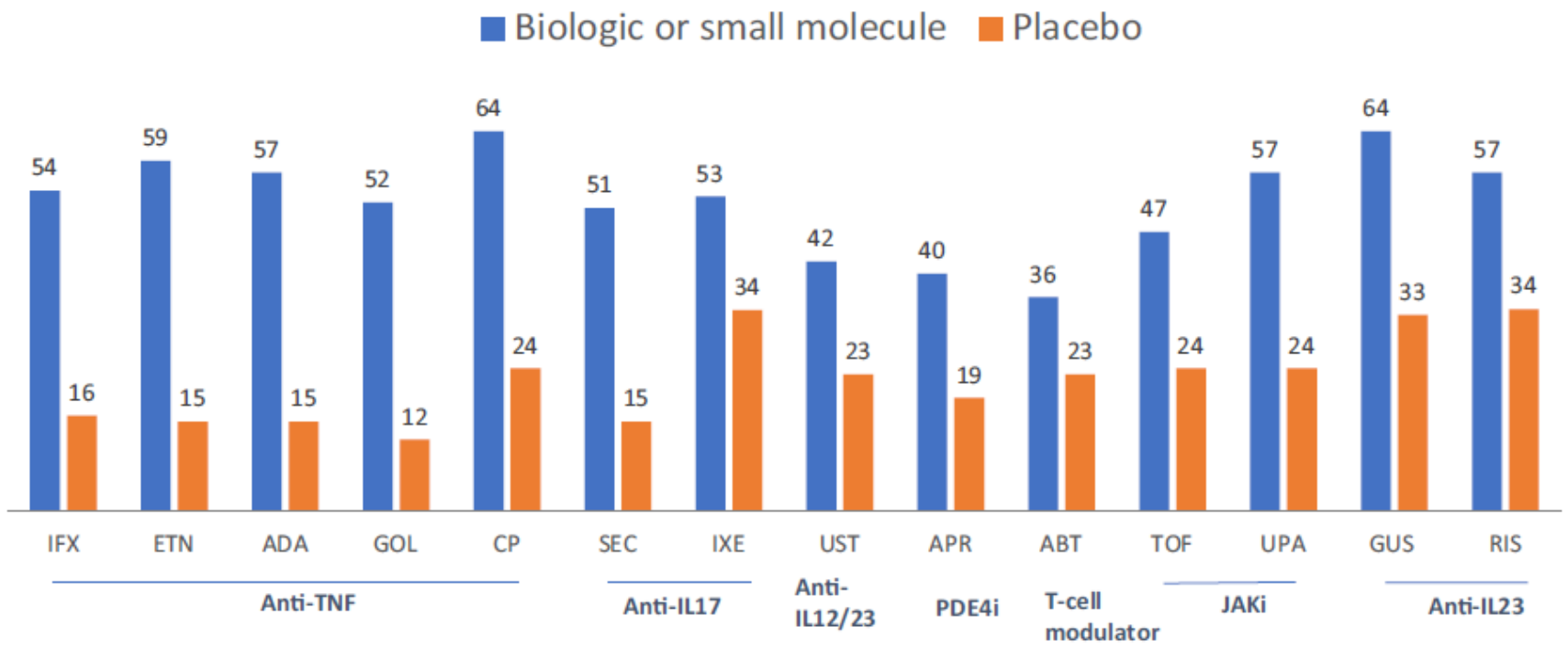
Statistically superior compared to placebo (primary or secondary endpoints)	No difference compared to placebo
Superior compared to placebo; pre-specified post-hoc analysis	Not evaluated / reported
Not statistically different compared to placebo; numerically better results	

There are many therapeutic options for PsA to treat our patients

Kerschbaumer, Andreas et al. *Annals of the rheumatic diseases* vol. 83,6 760-774. 15 May. 2024, doi:10.1136/ard-2024-225534

Biologic and Small-molecule Therapies for PsA: Efficacy Data from Registration Trials

Patients achieving ACR20% Response in Phase 3 PsA Trials

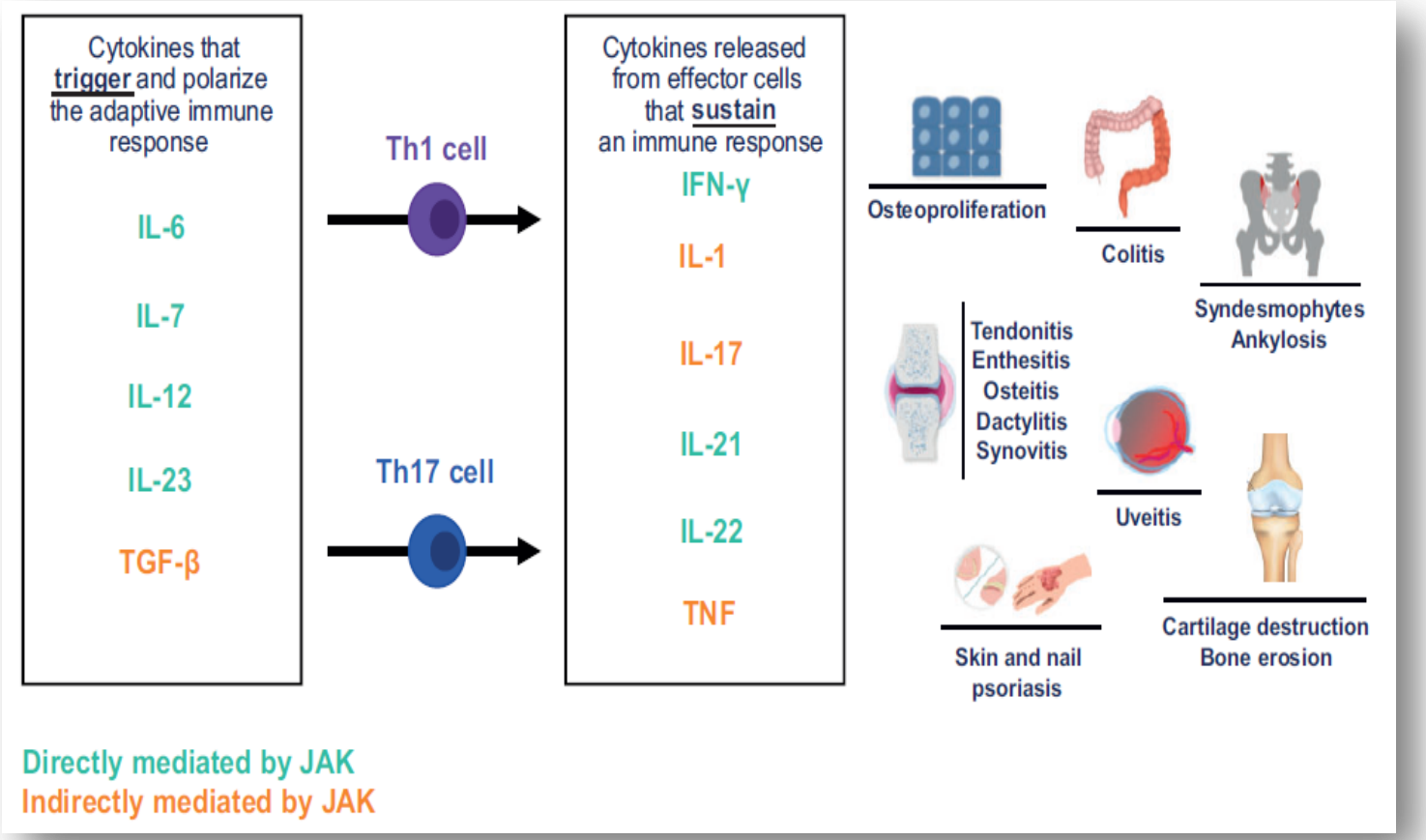


Note: Data are only presented for illustrative purposes and not for direct comparison.

Lubrano et al Rheum Ther 2023
Kumthekar et al Clin Rheum 2023

Targeting multiple pathways could lead to better results?

Η αποτελεσματικότητα των JAKi στηρίζεται στην ικανότητα τους να παρεμβαίνουν στη σηματοδότηση κυτταροκινών που εμπλέκονται με διαφορετικό τρόπο στην παθογένεια της νόσου



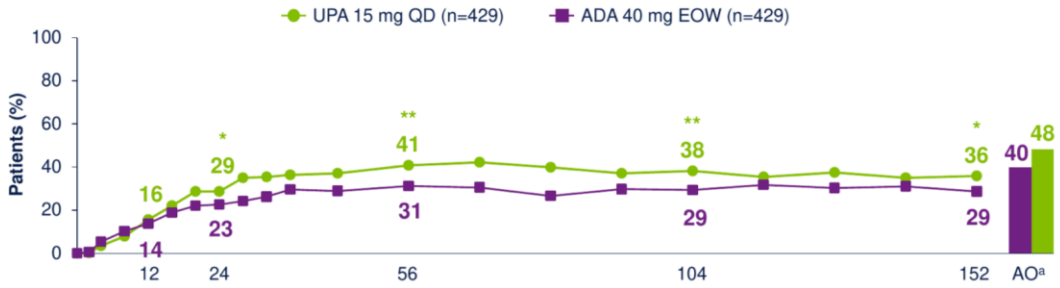
Bonelli M et al. Ann Rheum Dis. 2024
McInnes IB et al. Rheumatology (Oxford). 2022

Maintenance of responses through week 152

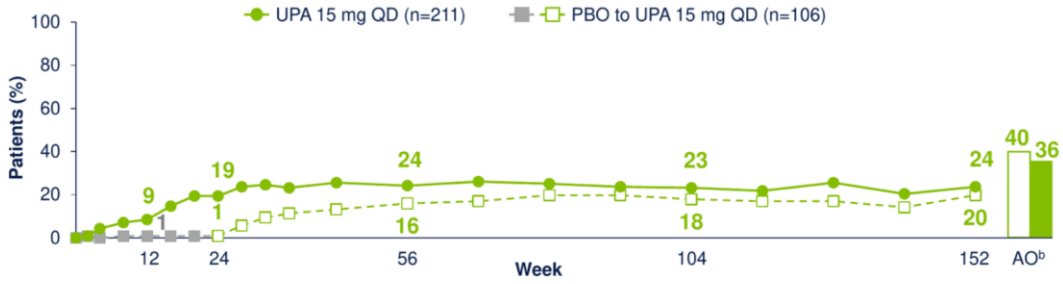
SELECT-PsA 1 SELECT-PsA 2

ACR70

SELECT-PsA 1
nbDMARD-IR
background +/- csDMARD(s)

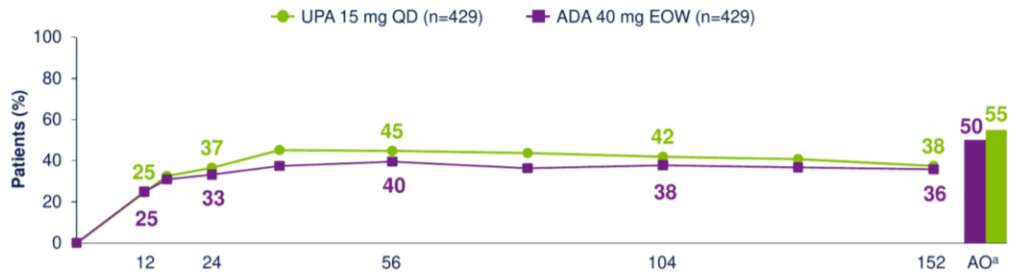


SELECT-PsA 2
bDMARD-IR
background +/- csDMARD(s)

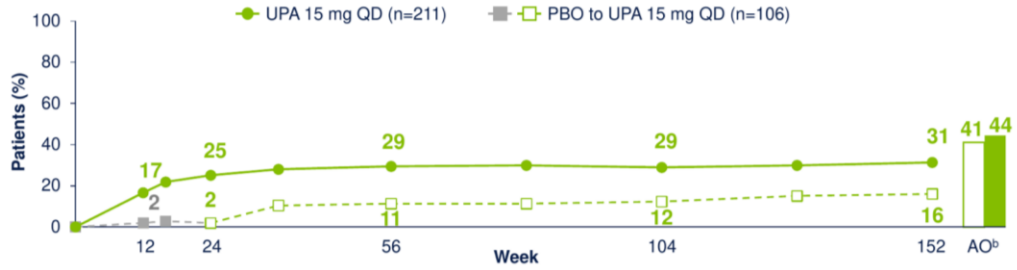


MDA

SELECT-PsA 1
nbDMARD-IR
background +/- csDMARD(s)



SELECT-PsA 2
bDMARD-IR
background +/- csDMARD(s)



[a]N=321 and 315 for UPA 15 mg QD and ADA 40 mg EOW, respectively; [b]N=56 and 144 for PBO to UPA 15 mg QD and UPA 15 mg QD, respectively. MDA (defined as defined as meeting ≥5/7 of the following criteria: SJC66 ≤1, TJC68 ≤1, PASI ≤1 or BSA-Ps ≤3%, pain ≤1.5 [0–10 NRS], PtGA ≤2 [0–10 NRS], HAQ-DI ≤0.5, and LEI ≤1) was analyzed using Cochran–Mantel–Haenszel tests with NRI and are shown as response rates. ADA=adalimumab; AO=as observed; b=biologic; BSA-Ps=body surface area with psoriasis; cs=conventional synthetic; DMARD=disease-modifying antirheumatic drug; EOW=every other week; HAQ-DI=health assessment questionnaire–disability index; IR=inadequate response; LEI=Leeds Enthesitis Index; MDA=minimal disease activity; nb=non-biologic; NRI=non-responder imputation; NRS=numeric rating scale; PASI=psoriasis activity and severity index; PBO=placebo; PtGA=patient global assessment of disease activity; QD=once daily; SJC66=swollen joint count in 66 joints; TJC68=tender joint count in 68 joints; UPA=upadacitinib.

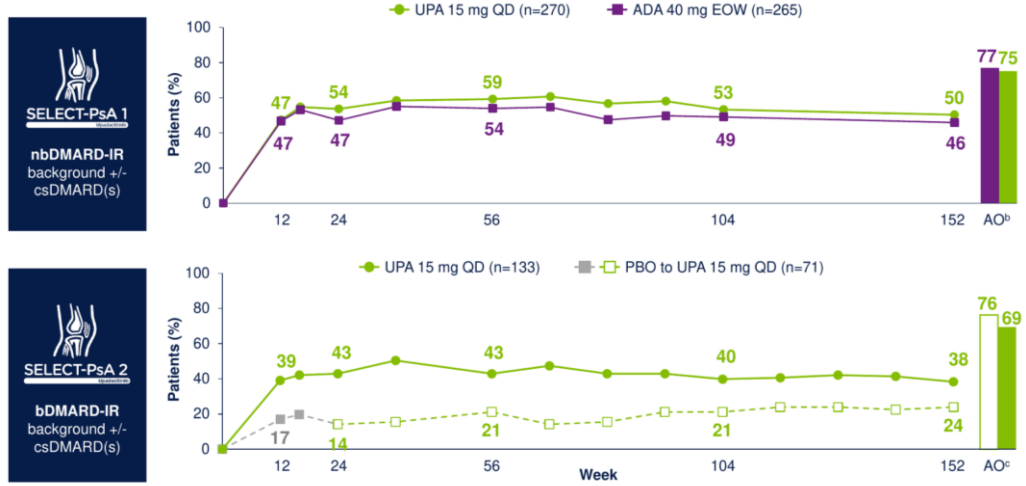
1. McInnes IB et al. *N Engl J Med*. 2021;384(4):1227-1239. 2. Mease PJ et al. *Ann Rheum Dis*. 2021;80:312-320. 3. McInnes IB et al. EULAR 2023. POS1541. 4. Mease PJ et al. *Clin Exp Rheumatol*. 2023;41(11):2286-2297.

N=305 and 304 for UPA 15 mg QD and ADA 40 mg EOW, respectively; [b]N=55 and 140 for PBO to UPA 15 mg QD and UPA 15 mg QD, respectively. Longitudinal data were analyzed using Cochran–Mantel–Haenszel tests with NRI and are shown as response rates. *P<0.05 and **P<0.01 for UPA vs ADA; nominal *P* values are shown and were not multiplicity controlled. ACR20/50/70=≥20/50/70% improvement in American College of Rheumatology response criteria; ADA=adalimumab; AO=as observed; b=biologic; cs=conventional synthetic; DMARD=disease-modifying antirheumatic drug; EOW=every other week; IR=inadequate response; nb=non-biologic; NRI=non-responder imputation; PBO=placebo; QD=once daily; UPA=upadacitinib.

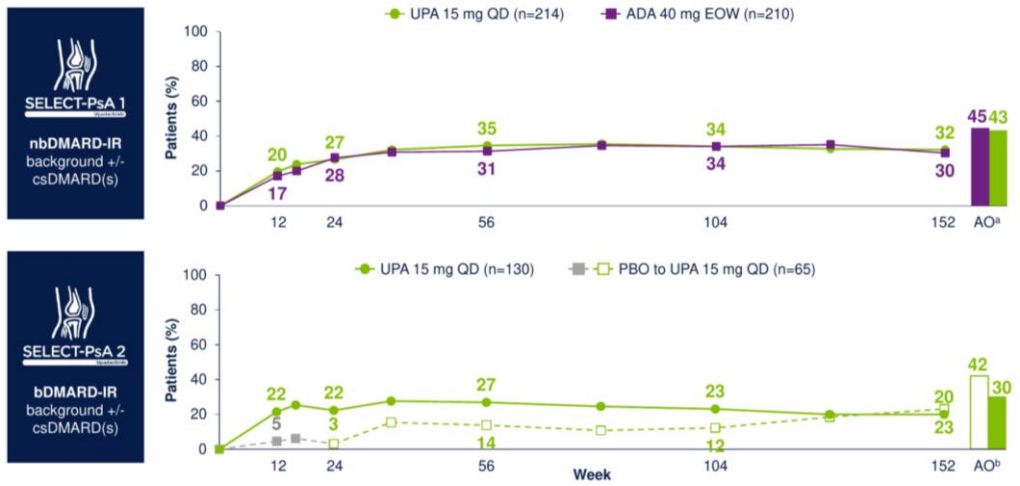
1. McInnes IB et al. *N Engl J Med*. 2021;384(4):1227-1239. 2. Mease PJ et al. *Ann Rheum Dis*. 2021;80:312-320. 3. McInnes IB et al. EULAR 2023. POS1541. 4. Mease PJ et al. *Clin Exp Rheumatol*. 2023;41(11):2286-2297.

Maintenance of responses through week 152

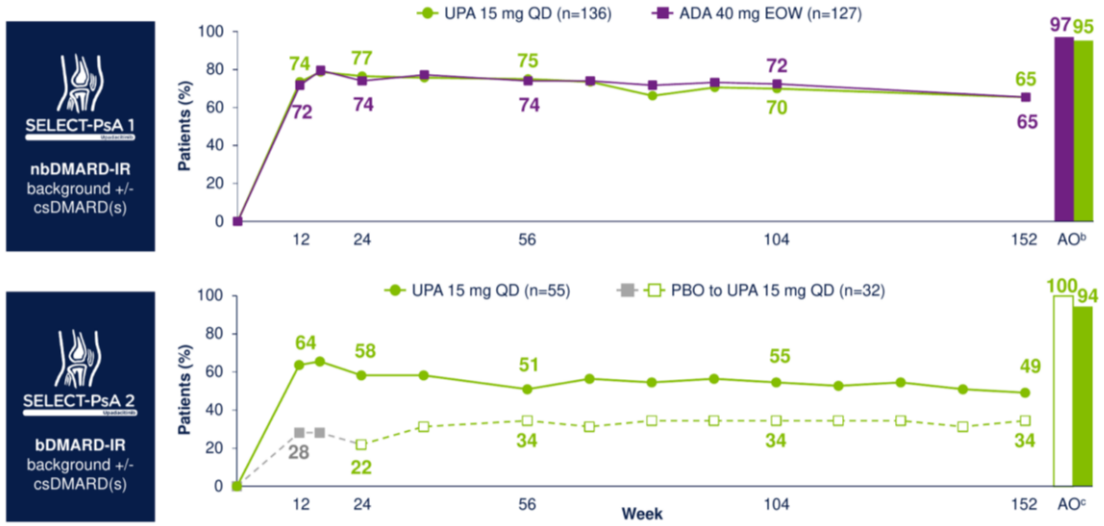
Enthesitis



PASI 100



Dactylitis



[a]For patients with LEI >0 at BL; [b]N=104 and 102 for UPA 15 mg QD and ADA 40 mg EOW, respectively; [c]N=18 and 36 for PBO to UPA 15 mg QD and UPA 15 mg QD, respectively. Data were analyzed using Cochran–Mantel–Haenszel tests with NRI and are shown as response rates. ADA=adalimumab; b=biologic; BL=baseline; cs=conventional synthetic; DMARD=disease-modifying antirheumatic drug; EOW=every other week; IR=inadequate response; LDI=Leeds dactylitis index; LEI=Leeds enthesitis index; nb=non-biologic; NRI=non-responder imputation; PBO=placebo; QD=once daily; UPA=upadacitinib.

1. McInnes IB et al. *N Engl J Med.* 2021;384(13):1227-1239. 2. Mease PJ et al. *Ann Rheum Dis.* 2021;80(3):312-320. 3. McInnes IB et al. *Rheumatol Ther.* 2023;10(1):275-292. 4. McInnes IB et al. EULAR 2023. POS1541. 5. Mease PJ et al. *Clin Exp Rheumatol.* 2023;41(11):2286-2297.

[a]For patients with LEI >0 at BL; [b]N=202 and 187 for UPA 15 mg QD and ADA 40 mg EOW, respectively; [c]N=38 and 88 for PBO to UPA 15 mg QD and UPA 15 mg QD, respectively. Data were analyzed using Cochran–Mantel–Haenszel tests with NRI and are shown as response rates. [*]$P<0.05$ for UPA vs ADA; nominal P-values are shown. ADA=adalimumab; b=biologic; BL=baseline; cs=conventional synthetic; DMARD=disease-modifying antirheumatic drug; EOW=every other week; IR=inadequate response; LDI=Leeds dactylitis index; LEI=Leeds enthesitis index; nb=non-biologic; NRI=non-responder imputation; PBO=placebo; QD=once daily; UPA=upadacitinib.

1. McInnes IB et al. *N Engl J Med.* 2021;384(4):1227-1239. 2. Mease PJ et al. *Ann Rheum Dis.* 2021;80:312-320. 3. McInnes IB et al. *Rheumatol Ther.* 2023;10(1):275-292. 4. McInnes IB et al. EULAR 2023. POS1541. 5. Mease PJ et al. *Clin Exp Rheumatol.* 2023;41(11):2286-2297.

[a]For patients with BSA-Ps ≥3% at BL; [b]N=159 and 157 for UPA 15 mg QD and ADA 40 mg EOW, respectively; [c]N=38 and 89 for PBO to UPA 15 mg QD and UPA 15 mg QD, respectively. Data were analyzed using Cochran–Mantel–Haenszel tests with NRI. ADA=adalimumab; b=biologic; BL=baseline; BSA-Ps=body surface area with psoriasis; cs=conventional synthetic; DMARD=disease-modifying antirheumatic drug; EOW=every other week; IR=inadequate response; nb=non-biologic; NRI=non-responder imputation; PASI75/90/100=≥75/90/100% improvement in psoriasis area severity index; PBO=placebo; QD=once daily; UPA=upadacitinib.

1. McInnes IB et al. *N Engl J Med.* 2021;384(13):1227-1239. 2. Mease PJ et al. *Ann Rheum Dis.* 2021;80(3):312-320. 3. McInnes IB et al. EULAR 2023. POS1541. 4. Mease PJ et al. *Clin Exp Rheumatol.* 2023;41(11):2286-2297.

Κλινική Περίπτωση 1

» Έναρξη αγωγής με **Upadacitinib 15 mg**

»
- 3 μήνες αργότερα σε **πλήρη κλινική** (PASI:0 ASDAS: 1.2) **και εργαστηριακή ύφεση**
- Χωρίς ανεπιθύμητα συμβάματα

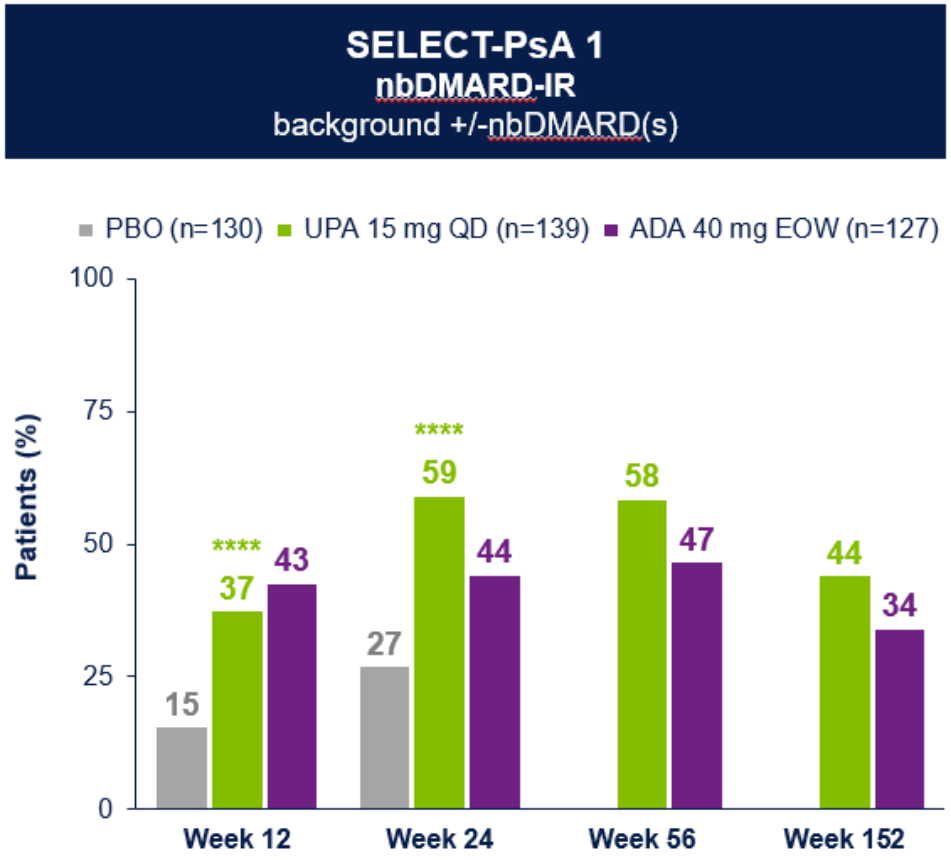
» **Διατήρηση της ύφεσης** μέχρι και την τελευταία επίσκεψη περίπου 1 έτος από την έναρξη της θεραπείας

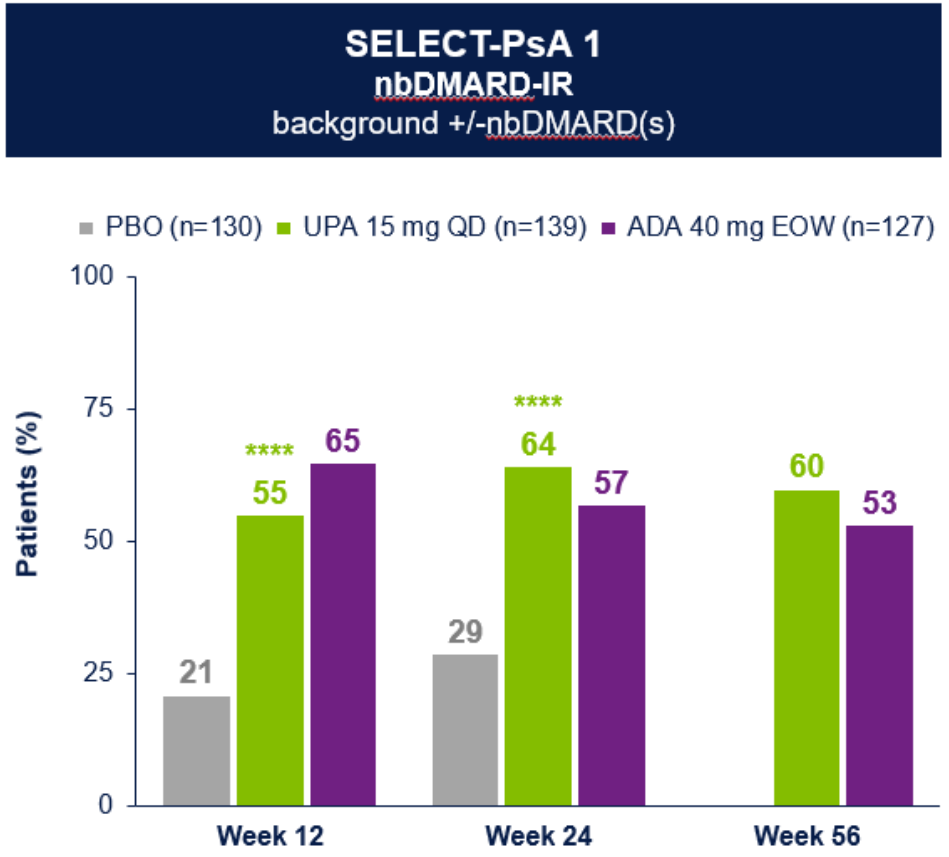
Ο Νίκος ανταπεξέρχεται πλέον στις απαιτήσεις και υποχρεώσεις της καθημερινότητας του

Speaker's approach

Patients with active PsA and axial involvement demonstrated significant improvements in their axial symptoms with upadacitinib[1-5]

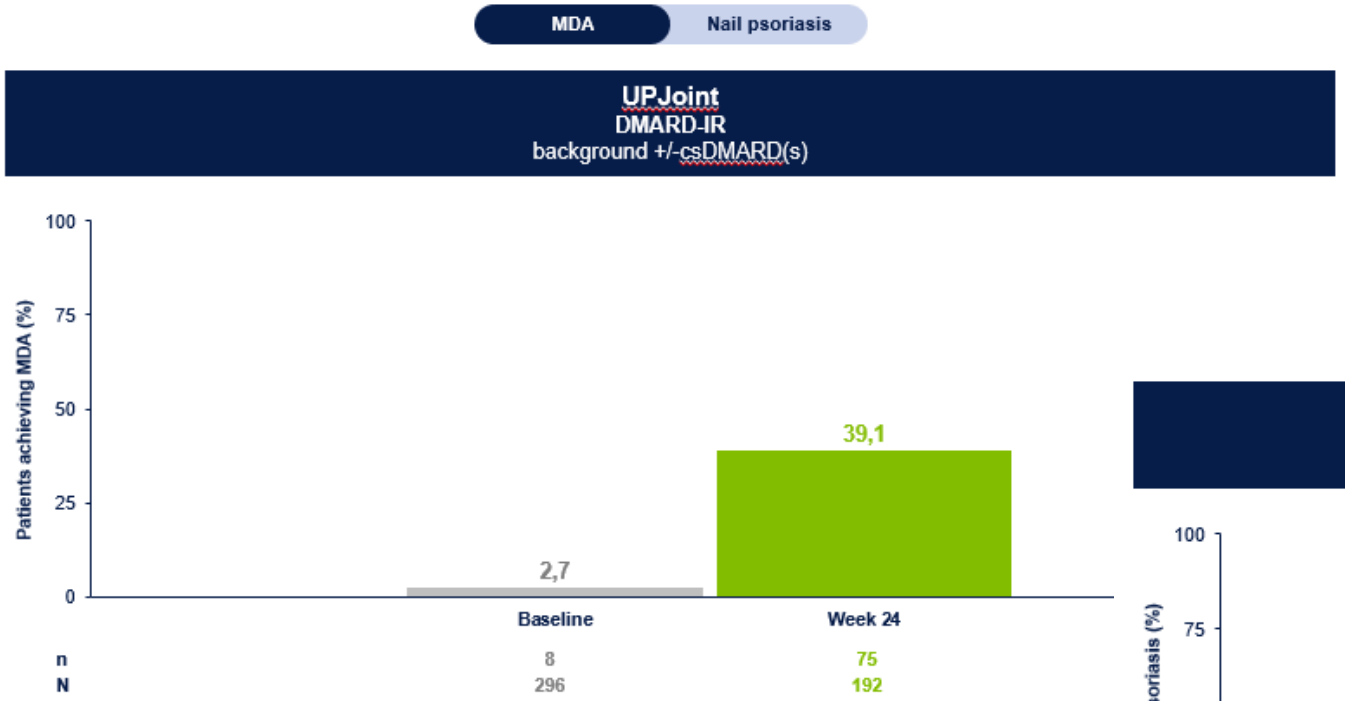
BASDAI50[a] | **ASDAS LDA[a]**

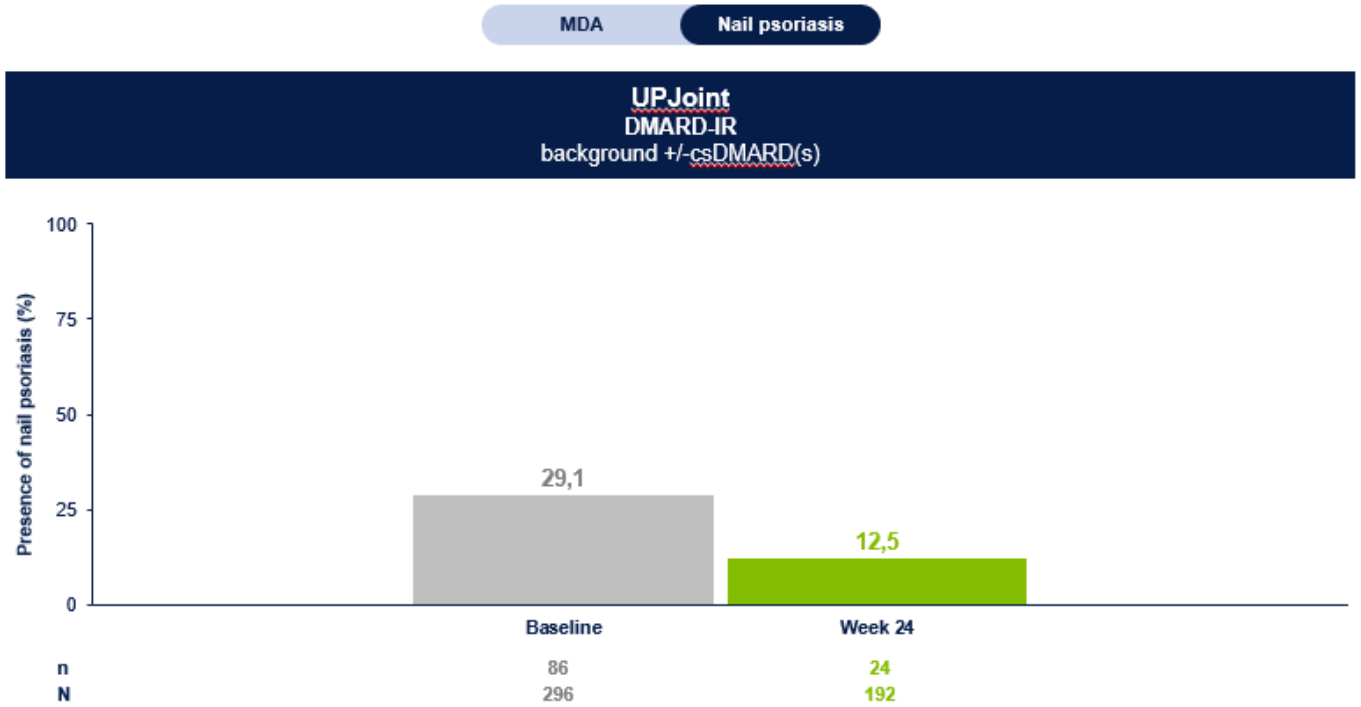




aFor patients with axial involvement at BL, as determined by the investigator. Data were analyzed using Cochran-Mantel-Haenszel tests with NRI and are shown as response rates.
****P<0.0001 for UPA 15 mg QD vs PBO; nominal P values are shown and were not multiplicity controlled. ADA=adalimumab; ASDAS=ankylosing spondylitis disease activity score; b=biologic; BASDAI=Bath Ankylosing Spondylitis Disease Activity Index; BASDAI50=≥50% improvement in the BASDAI; BL=baseline; DMARD=disease-modifying antirheumatic drug; EOW=every other week; IR=inadequate response; LDA=low disease activity; nb=non-biologic; PBO=placebo; PsA=psoriatic arthritis; QD=once daily; UPA=upadacitinib.

Real-world use of upadacitinib and impact on MDA and nail psoriasis in patients with PsA[1,2]





Data reported as observed. cs=conventional synthetic; DMARD=disease-modifying antirheumatic drug; IR=inadequate response; MDA=minimal disease activity; PsA=psoriatic arthritis.

Data reported as observed. MDA defined as meeting ≥5/7 of the following criteria: SJC66 ≤1, TJC68 ≤1, PASI ≤1 or BSA-Ps ≤3%, pain ≤1.5 (0–10 NRS), PtGA ≤2 (0–10 NRS), HAQ-DI ≤0.5, and LEI ≤1. BSA-Ps=body surface area with psoriasis; cs=conventional synthetic; DMARD=disease-modifying antirheumatic drug; HAQ-DI=health assessment questionnaire-disability index; IR=inadequate response; LEI=Leeds Enthesitis Index; MDA=minimal disease activity; NRS=numeric rating

1. Werner SG et al. Rheumatol Ther. 2023;10:1503-1518.
2. Werner SG et al. Rheumatol Ther. 2023;10:1503-1518.

The safety profile of upadacitinib has been established across 7 approved indications[1-3]

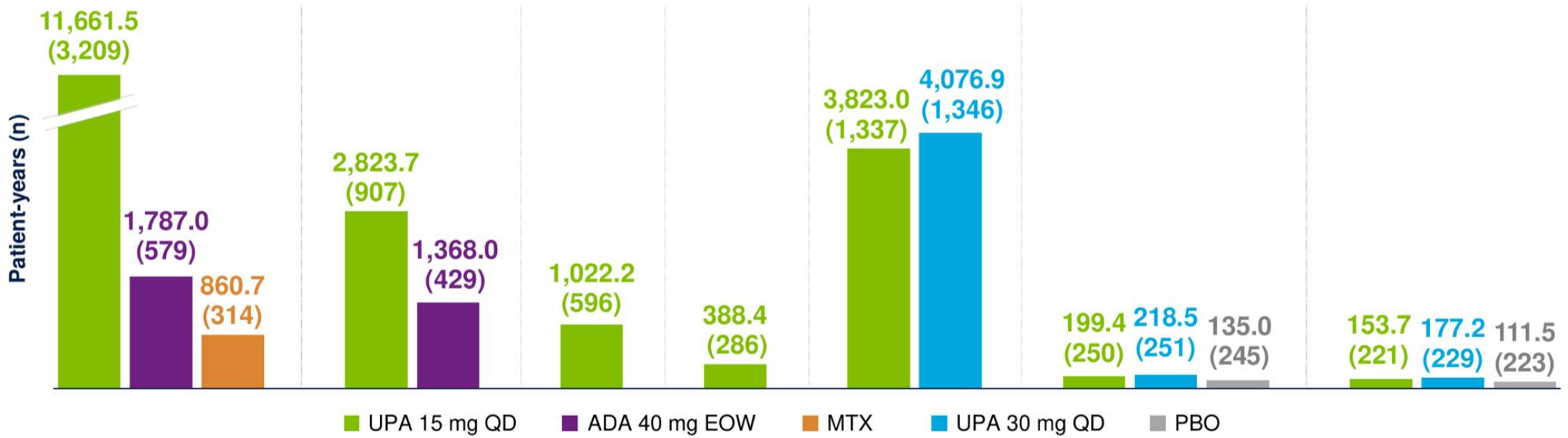
CONSISTING OF
16
CLINICAL TRIALS across RA, PsA, AS, nr-axSpA, AD, UC, and CD

IN
8,632
PATIENTS who received UPA **15 mg** or **30 mg**

REPRESENTING
>24,000
PATIENT-YEARS of combined exposure to UPA **15 mg** and **30 mg**

RA[a]	PsA[a]	AS[a]	nr-axSpA[a]	AD[b]	UC[c]	CD[c]

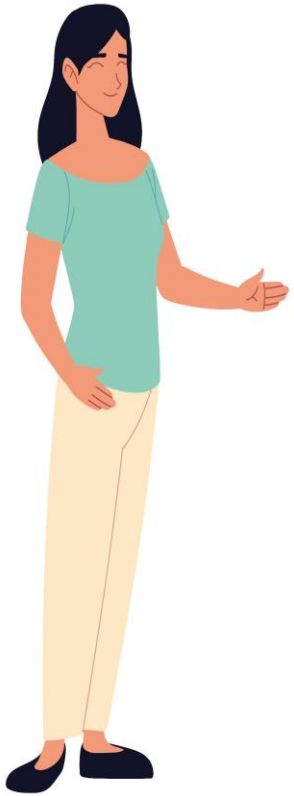
4 Rheumatology indications including 4,998 patients representing 15,895.8 patient-years



[a]Safety data (cutoff date: 15 August 2023) from 11 Phase 3 UPA trials were compiled for RA (6), PsA (2), AS (2; one phase 2/3), and nr-axSpA (1) for this analysis; [b]Long-term safety for up to 5 years of UPA 15 mg and 30 mg use in adolescents and adults with moderate-to-severe AD, based on the results of integrated data from three ongoing global pivotal Phase 3 studies; [c]Assessed among patients who responded to an induction dose of UPA 45 mg QD through Week 8 (UC) or Week 12 (CD) and then received ≥1 dose of PBO, UPA 15 mg or UPA 30 mg QD in U-ACHIEVE, and U-ENDURE during the 52-week PBO-controlled randomized maintenance period. Data were integrated comprising patients from both studies. AD=atopic dermatitis; ADA=adalimumab; AS=ankylosing spondylitis; CD=Crohn's disease; CV=cardiovascular; MTX=methotrexate; nr-axSpA=non-radiographic axial spondyloarthritis; PBO=placebo; PsA=psoriatic arthritis; QD=once daily; RA=rheumatoid arthritis; UC=ulcerative colitis; UPA=upadacitinib.

1. Burmester G et al. EULAR 2024. POS0894. **2.** Bunick C et al. RAD 2023. Poster 533. **3.** Panaccione R et al. ACG 2023. P3631.

Κλινική Περίπτωση 2

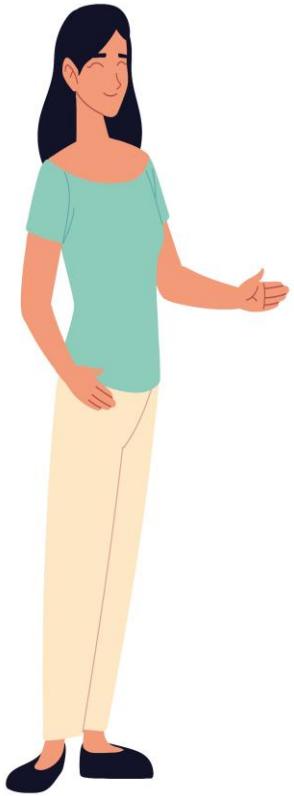


- Μαρία 49 ετών, Καπνιστρια 20 p/y, BMI 26,5 Hashimoto,δυσλιπιδαιμία, πιθανό θετικό οικογενειακό ιστορικό για φλεγμονώδη αρθρίτιδα
- Πρόσφατη διάγνωση οροαρνητικής RA (πολυαρθρίτιδα, αρνητικά αυτοαντισώματα, αυξημένη CRP)
- Έναρξη MTX 15 mg/week και κορτικοστεροειδή σε χαμηλές δόσεις
- Υποτροπή των συμπτωμάτων με τη διακοπή των στεροειδών

Αυξημένες απαιτήσεις και υποχρεώσεις στην καθημερινότητα της Μαρίας

Speaker’s approach

Κλινική Περίπτωση 2

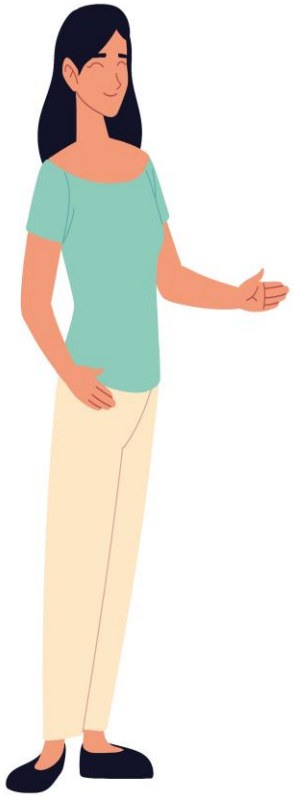


- Νέα στεροειδή και αύξηση MTX 20 mg/week
- • Αύξηση ηπατικών ενζύμων x3, αύξηση και ΣΒ από τη χρήση των κορτικοστεροειδών
  • Απόφαση για έναρξη βιολογικής θεραπείας
- Λήψη αντιμυκητισιακής αγωγής για βλάβες νυχιών χεριών χωρίς βελτίωση
- Παραπομπή στο κοινό ιατρείο ψωριασικής νόσου

Αυξημένες απαιτήσεις και υποχρεώσεις στην καθημερινότητα της Μαρίας

Speaker's approach

Κλινική Περίπτωση 2



- Διάγνωση ψωριασικής ονυχίας
- Έναρξη αγωγής με **Risankizumab**

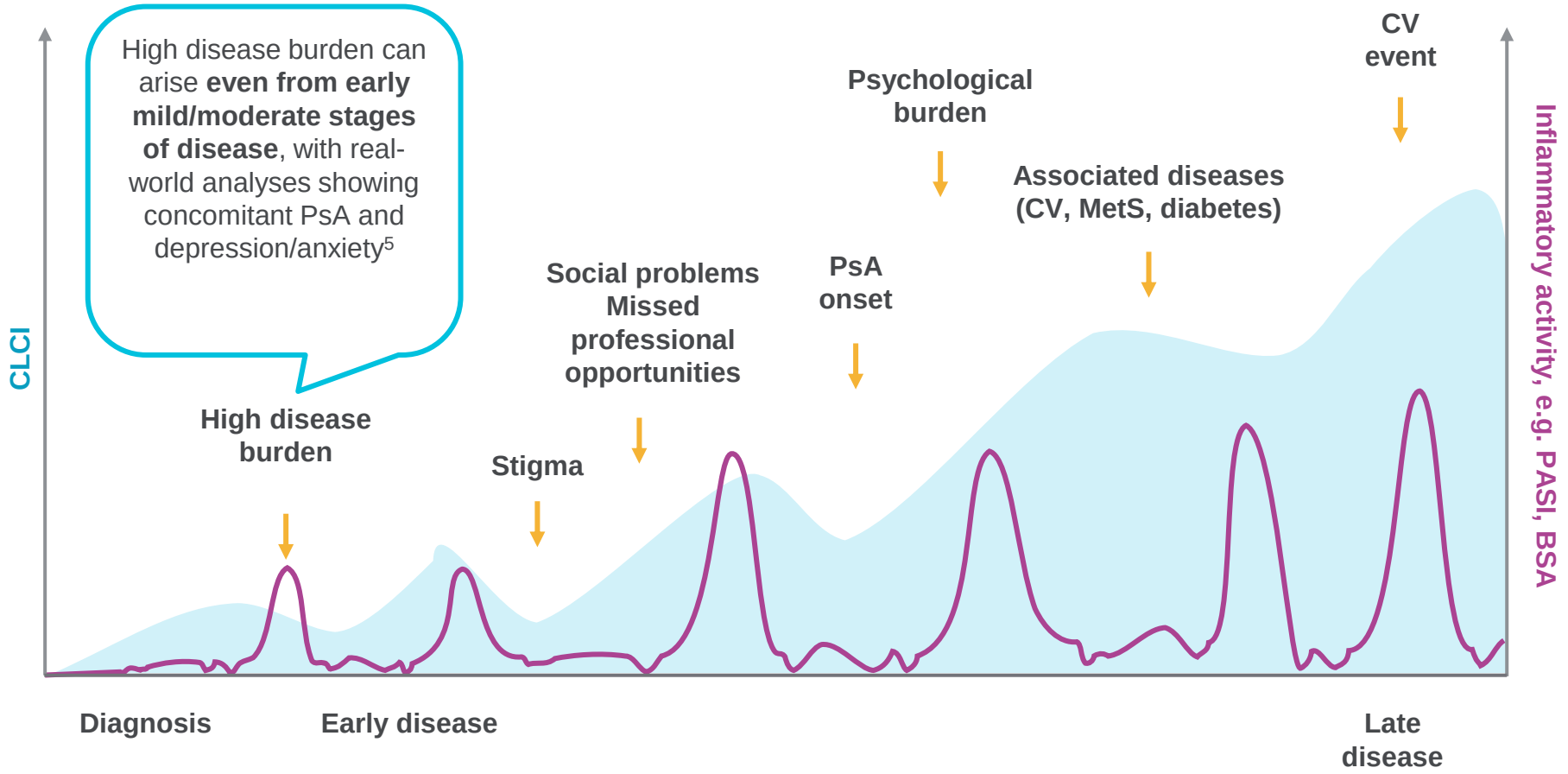
Αυξημένες απαιτήσεις και υποχρεώσεις στην καθημερινότητα της Μαρίας

Speaker’s approach

CLCI describes the potential cumulative negative impact of a patient's disease over their lifetime

- **CLCI** is a useful model in understanding the impact of chronic inflammatory diseases
- It describes the **compounding impact on a patient's life path**,[1–4] including on their physical health, mental health, comorbidities, daily activities, and social interaction

The potential negative impact of psoriasis over the life path[1–3]



BSA, body surface area; CLCI, Cumulative Life Course Impairment; CV, cardiovascular; MetS, metabolic syndrome; PASI, Psoriasis Area and Severity Index; PsA, psoriatic arthritis.
Adapted from: Pariente B, et al. *Inflamm Bowel Dis*. 2011;17:1415–22. For illustrative purposes only, not intended to represent a definitive linear disease progression for every patient.

1. Kimball AB, et al. *J Eur Acad Dermatol Venereol.* 2010;24(9):989–1004; 2. Ros S, et al. *Actas Dermosifiliogr.* 2014;105:128–34; 3. Linder MD, et al. *Acta Derm Venereol.* 2016;96:102–8; 4. Marzano AV, et al. *Br J Dermatol.* 2021;184:133–40;

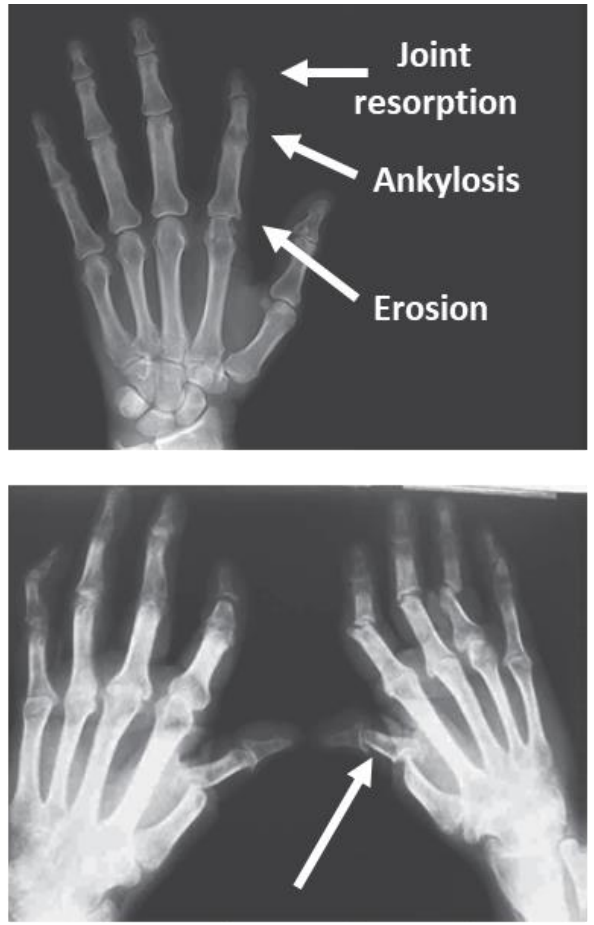
The burden of undiagnosed PsA

- A **diagnostic delay of even 6 months** has been shown to lead to significantly more radiographic damage and worse long-term physical function[1,2]

- Significantly **less common drug-free remission and more common arthritis mutilans** were noted among patients presenting >**1 year after symptom onset**[1]

- **Clinical and radiological damage** was higher among patients presenting later than **2 years of symptom onset**[1,2]
  - Almost half of patients exhibit structural damage and functional impairment within 2 years of developing symptoms

Early intervention in the PsA disease process can inhibit or delay structural joint damage, and patients are more likely to experience improvements in pain, fatigue, depression and QoL[3]

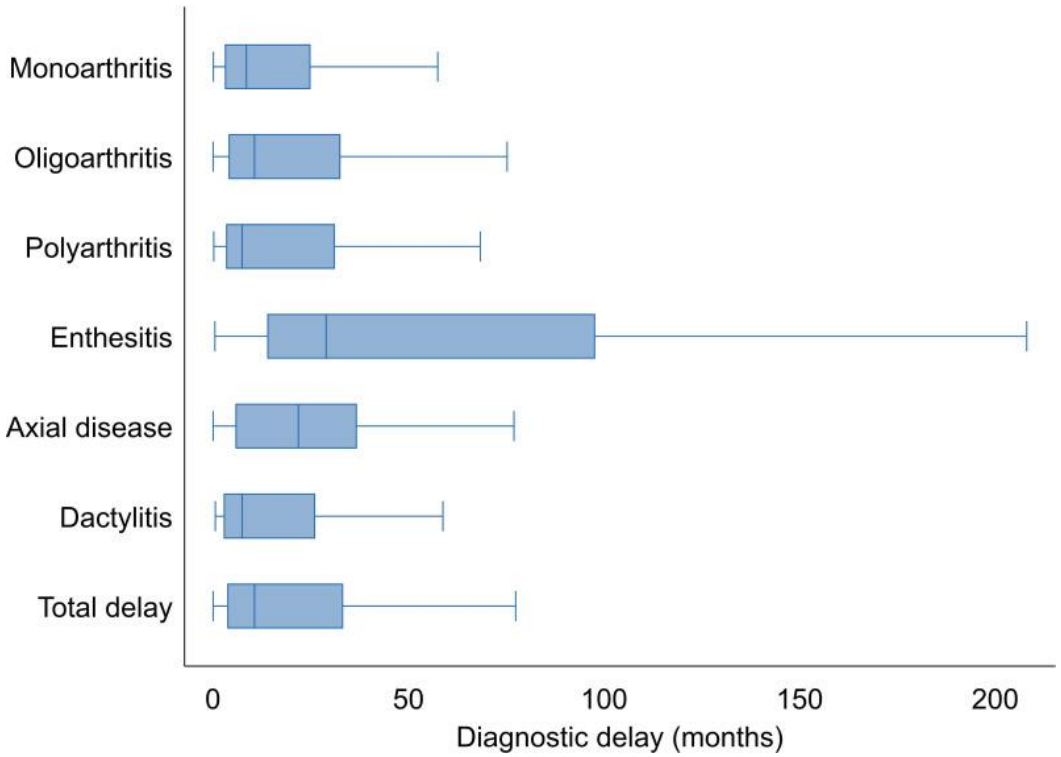


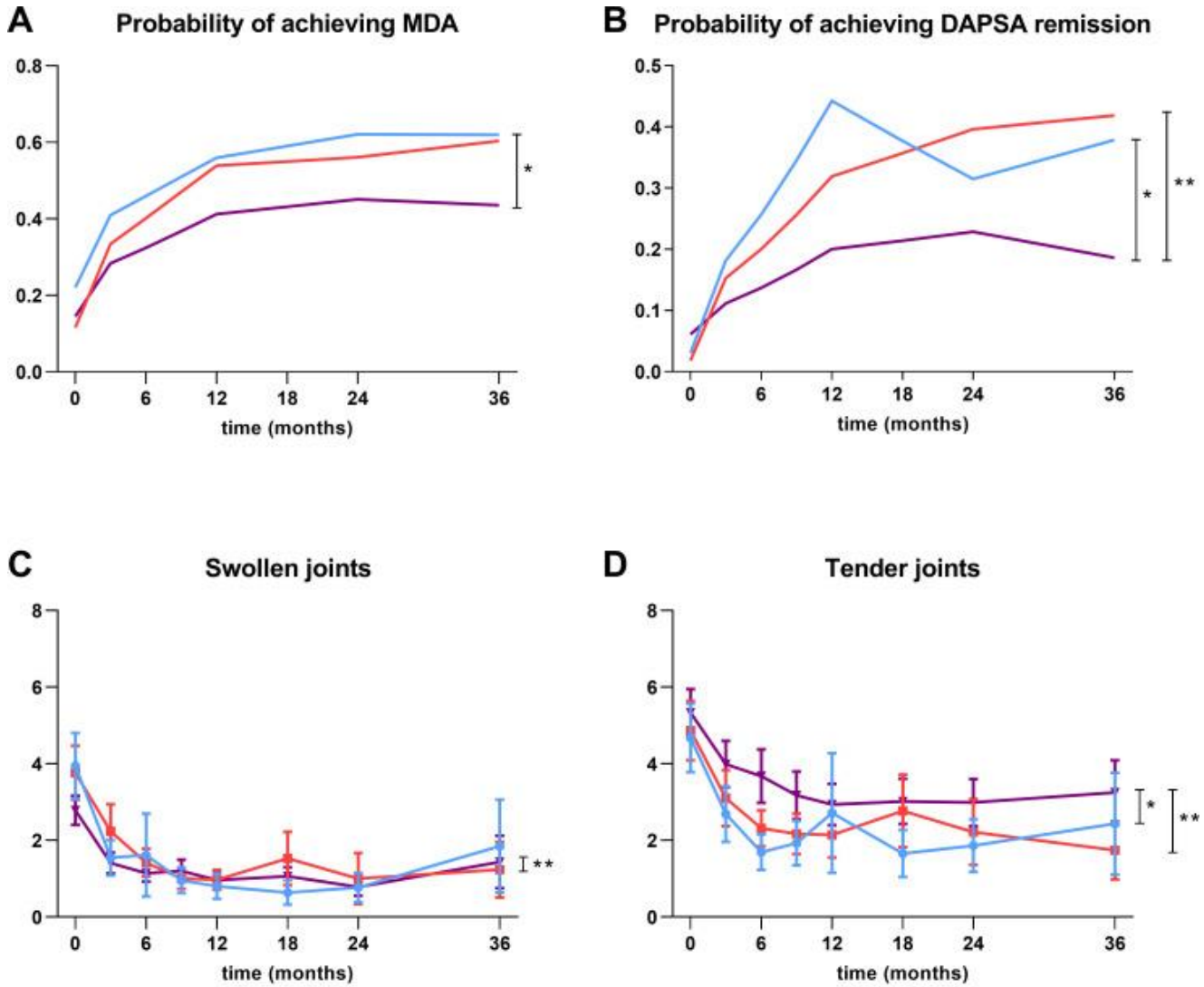
Arthritis mutilans, with pencil-in-cup deformities (arrow)[4]

PsA, psoriatic arthritis; QoL, quality of life.

1. Haroon M, et al. *Ann Rheum Dis.* 2015;74:1045–50; 2. van der Heijde, et al. *Arthritis Res Ther*. 2020;22:18; 3. Mease PJ, Armstrong AW. *Drugs.* 2014;74:423–41; 4. Images adapted from Ritchlin CT, et al. *N Engl J Med*. 2017;376:957–70.

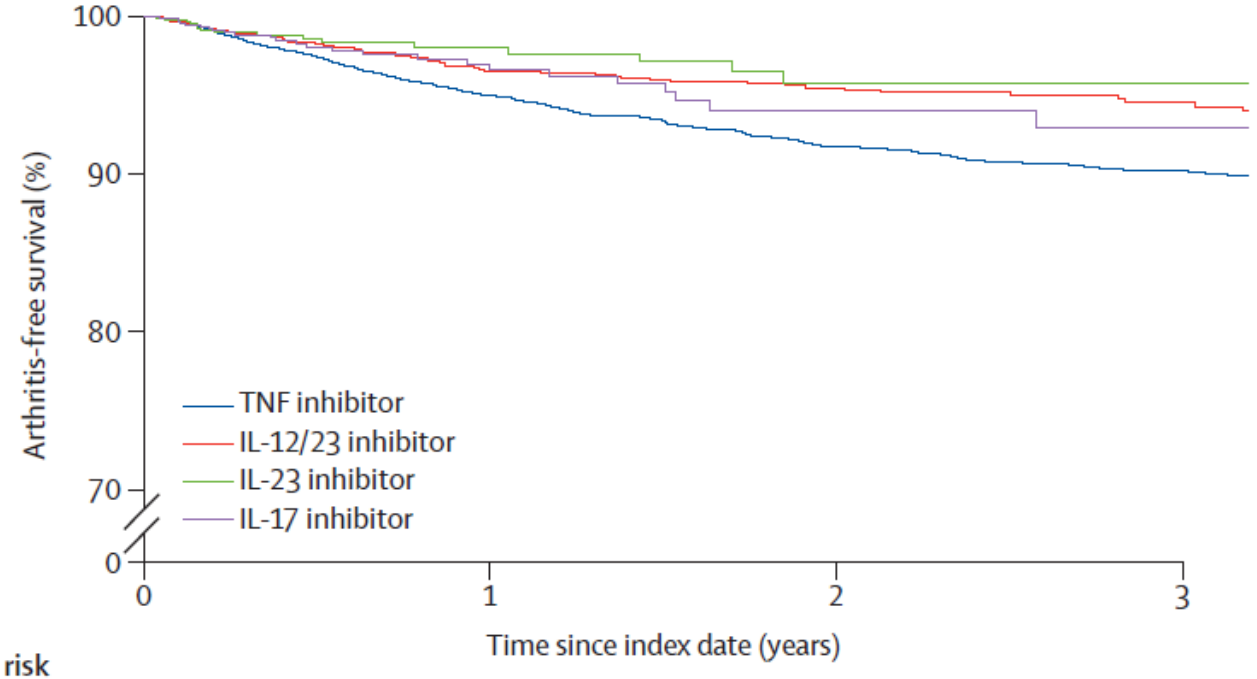
Window of opportunity in psoriatic arthritis: the earlier the better





Snoeck Henkemans, Selinde V J et al. *RMD open* vol. 10,1 e004062. 27 Feb. 2024, doi:10.1136/rmdopen-2023-004062

IL-23 therapy is associated with lower risk of developing inflammatory arthritis, including PsA



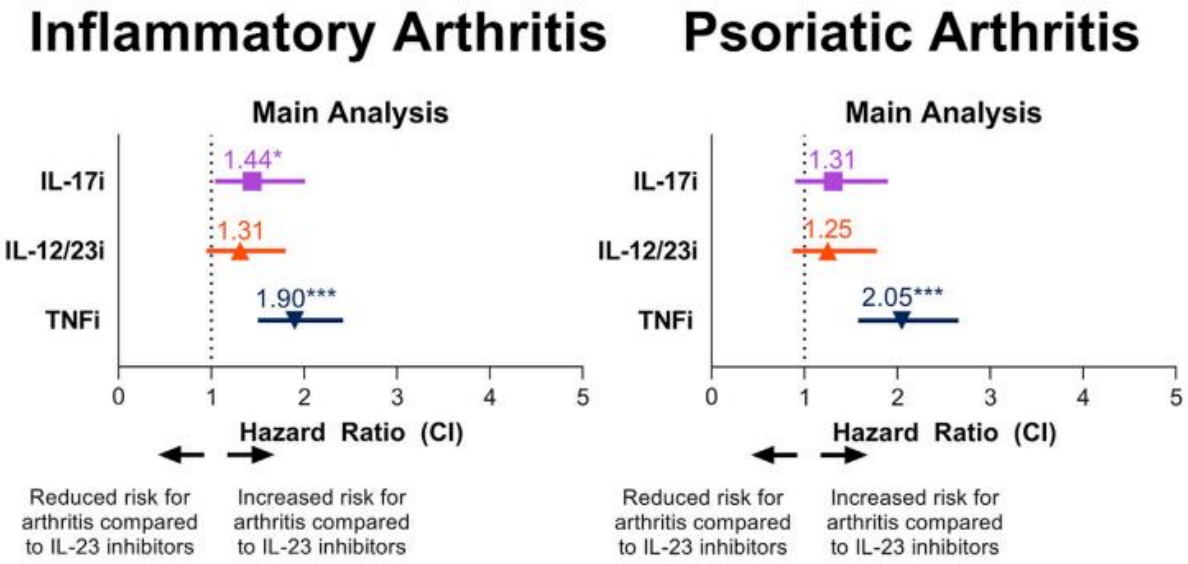
Number at risk (number censored)							
TNF inhibitor	9874 (522)	5342 (4518)	3904 (5829)	2919 (6760)	2244 (7389)	1716 (7889)	1330 (8268)
IL-12/23 inhibitor	2873 (132)	1415 (1466)	1088 (1768)	843 (2008)	658 (2190)	515 (2329)	397 (2445)
IL-23 inhibitor	1114 (130)	409 (729)	287 (849)	181 (954)	119 (1013)	76 (1056)	42 (1092)
IL-17 inhibitor	1355 (194)	468 (917)	284 (1098)	180 (1199)	130 (1246)	91 (1284)	57 (1317)

Figure 2: **Time to inflammatory arthritis among patients initiating biological therapies for psoriasis (n=15 501)**
TNF=tumour necrosis factor. IL=interleukin.

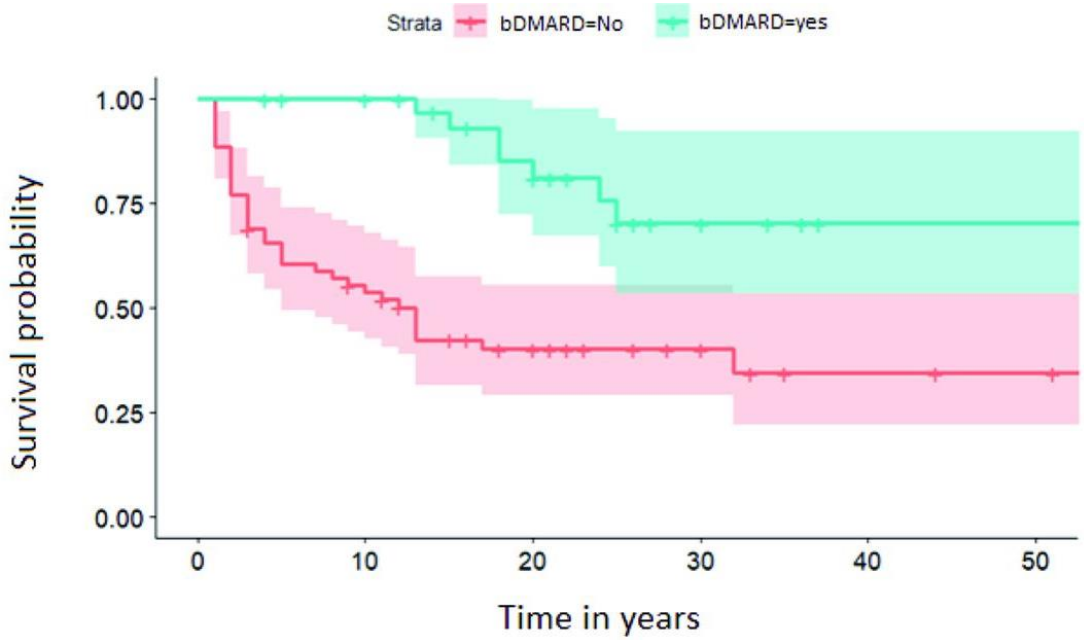
In a retrospective non-randomized study in 15.501 patients with psoriasis, **risk of developing inflammatory arthritis (including PsA)** is reduced among patients who have started anti-IL12/23 or anti-IL23 therapy3

Singla et al., Lancet Rheumatol March 6, 2023
https://doi.org/10.1016/ S2665-9913(23)00034-6

Patients receiving IL-17, IL-12/23, or TNF inhibitors have higher incidence rates than patients receiving IL-23



Survival curves for PsA development for different treatment groups (bDMARD yes/no)

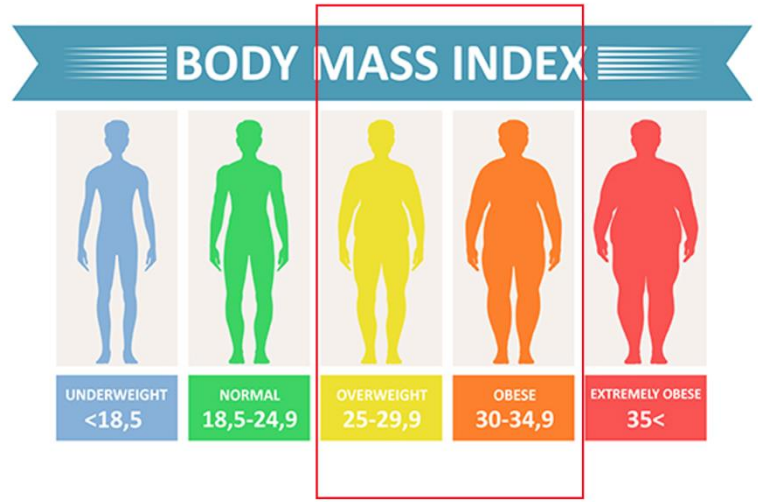


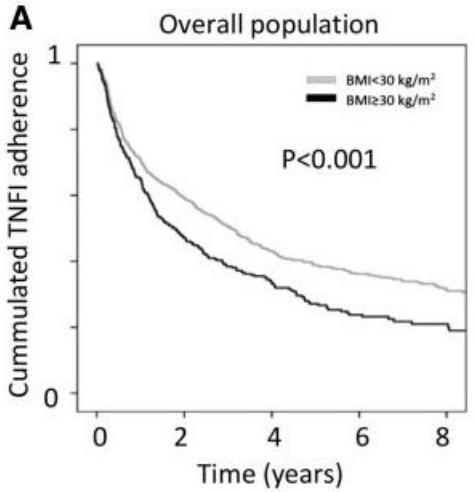
Risk of developing inflammatory arthritis in patients with psoriasis initiating treatment with biologics: A population-based analysis, Strober, Bruce et al. Journal of the American Academy of Dermatology, Volume 91, Issue 6, 1143 - 1149

Azevedo SF, *et al*, POS0988 *Annals of the Rheumatic Diseases* 2024;**83:**717.

Effect of comorbidities on treatment outcomes/decisions: the obesity paradigm

- ⇧ risk of PsA Development in patients with Psoriasis Or in healthy individuals
- ⇧ risk of not reaching outcomes
- ⇧ risk of not maintaining favorable outcomes





Outcome at ≤12 months unless otherwise specified	sample size, n	n (%) events	OR (95% CI)	ORadj (95% CI)	ORadj (95% CI)
MDA					
Normal weight	306	66 (21.6)	1 (ref.)	1 (ref.)	
Overweight	285	40 (14.0)	0.59 (0.38-0.91)	0.63 (0.39-1.03)	
Obese	183	19 (10.4)	0.43 (0.25-0.74)	0.45 (0.24-0.82)	
DAPSA-remission					
Normal weight	306	51 (16.7)	1 (ref.)	1 (ref.)	
Overweight	285	20 (7.0)	0.38 (0.22-0.66)	0.44 (0.24-0.79)	
Obese	183	12 (6.6)	0.36 (0.19-0.70)	0.42 (0.21-0.85)	

Drug category	RA	PsA	AxSpA
Abatacept			
JAK inhibitors			
IL-17 inhibitors			
IL-23 inhibitors			
IL-6R inhibitors			
Rituximab			
TNF inhibitors			

Højgaard et al, Rheumatology 2016;55:2191-2199 Yague et al, BMJ Open 2022;12:e061474

Gialouri C, et al Autoimmun Rev. 2023;22:103357

PsA
Data from Greece

923 patients (55% females)
median (IQR) age of 57 (48-65) years

MEDITERRANEAN JOURNAL OF RHEUMATOLOGY | 34 4 2023

ORIGINAL PAPER

Disease Profile and Achievement of Therapeutic Goals in a Modern, Nationwide Cohort of 923 Patients with Psoriatic Arthritis

George E. Fragoulis[1*], Charalampos Papagoras[2*], Sousana Gazi[3], Evangelia Mole[3], Michael Krikelis[3], Paraskevi V. Voulgari[4], Evripidis Kaltsonoudis[4], Nikolaos Koletsos[4], Pelagia Katsimpri[5], Dimitrios Boumpas[5], Dimitrios Katsifis[5], Nikolaos Kougkas[6], Theodoros Dimitroulas[6], Petros P. Sfikakis[1], Maria G. Tektonidou[1], Chrysoula Gialouri[1], Dimitrios P. Bogdanos[7], Theodora Simopoulou[7], Christos Koutsianas[8], Eugenia Mavrea[8], Gkikas Katsifis[9], Konstantinos Kottas[9], Maria Konsta[10], Matthoula Tziafalia[10], Evangelia Kataxaki[11], Eleni Kalavri[12], Kalliopi Klavdianou[12], Eleftheria P. Grika[13], Charalampos Sfontouris[13], Dimitrios Daoussis[14], George Iliopoulos[14], Ilias Bournazos[15], Dimitrios Karokis[15], Konstantinos Georganas[15], Dimos Patrikos[15], Dimitrios Vassilopoulos[8]

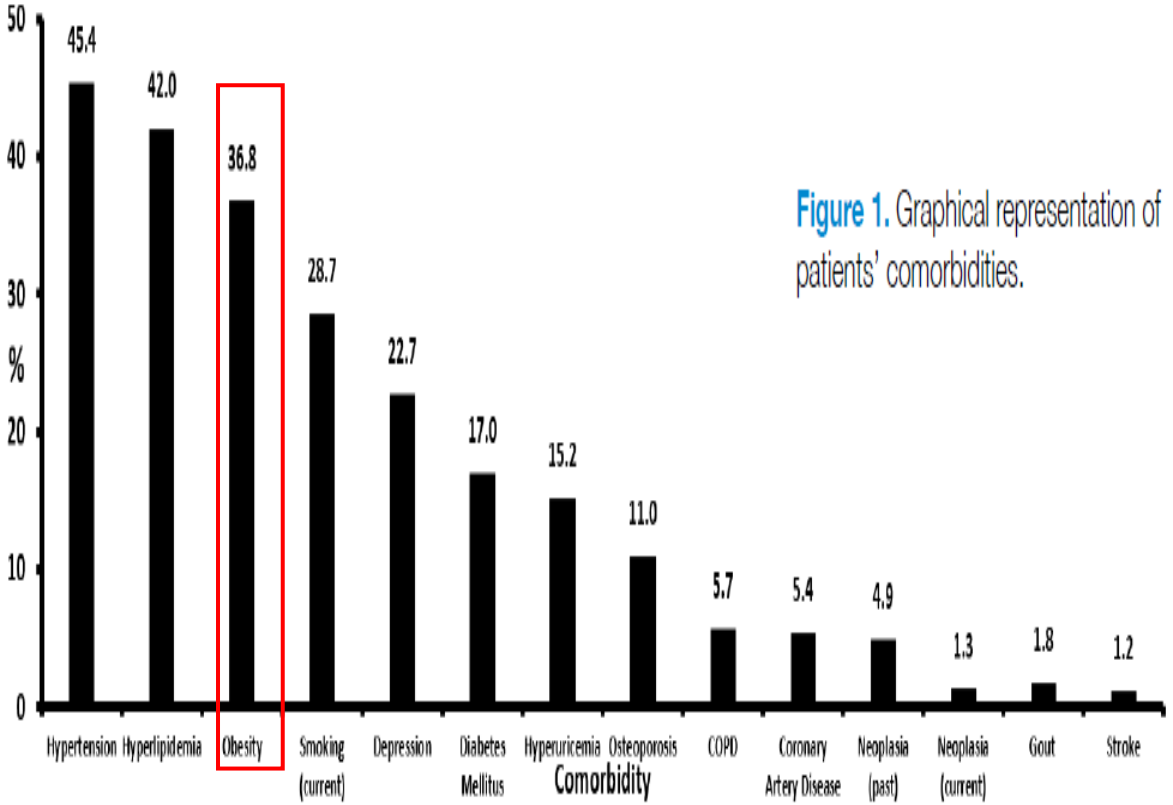
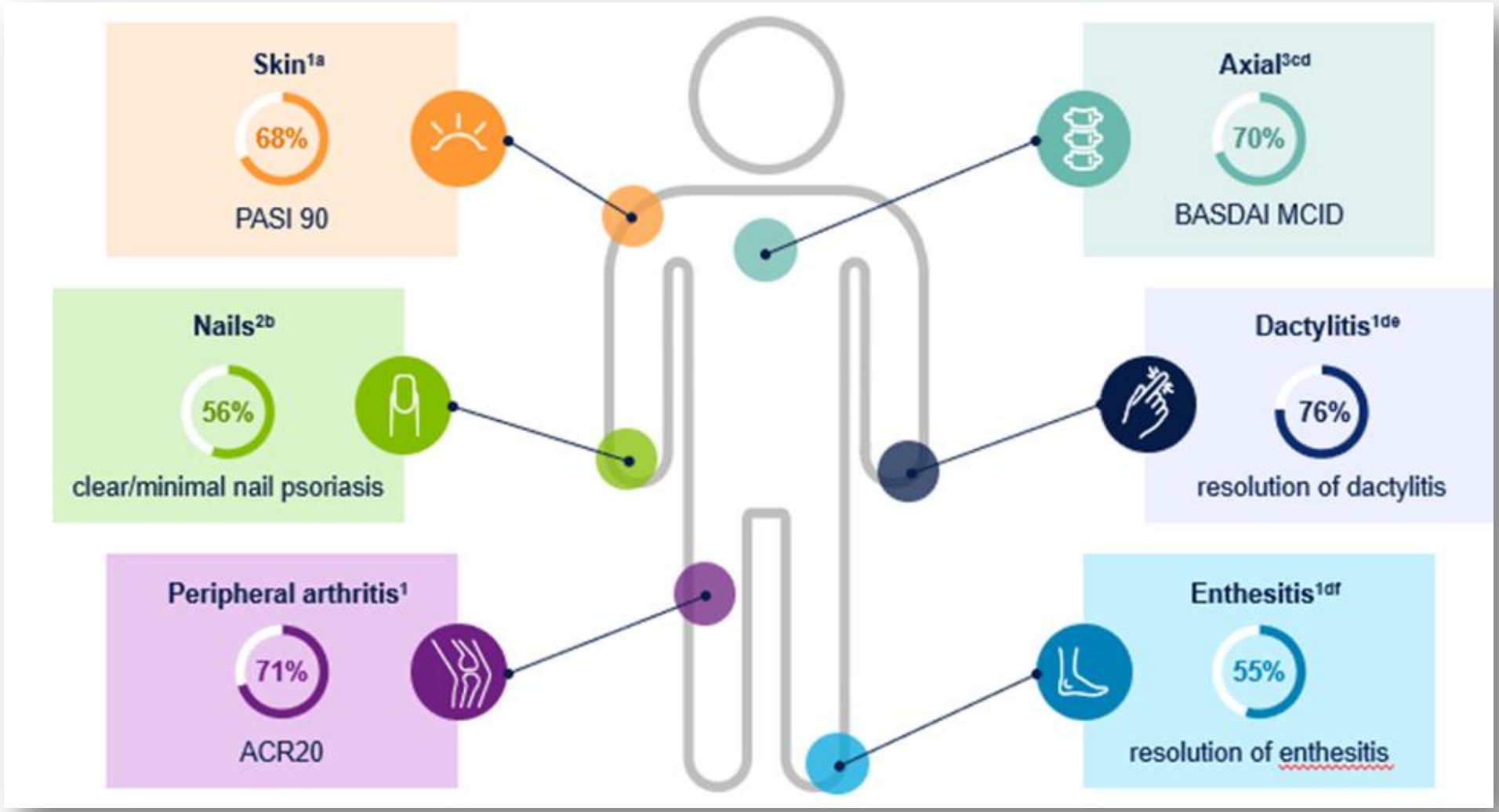


Figure 1. Graphical representation of patients' comorbidities.

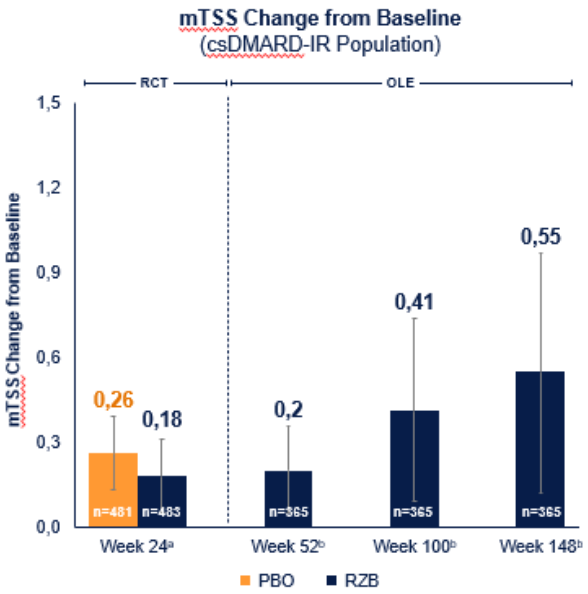
Risankizumab: efficacy across all domains

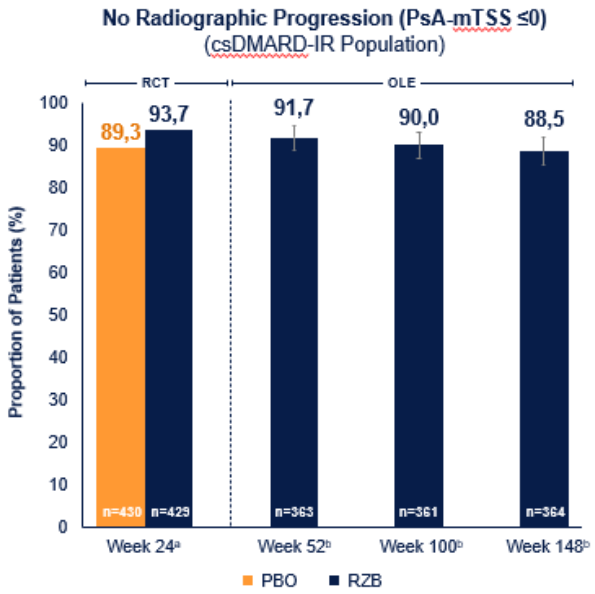


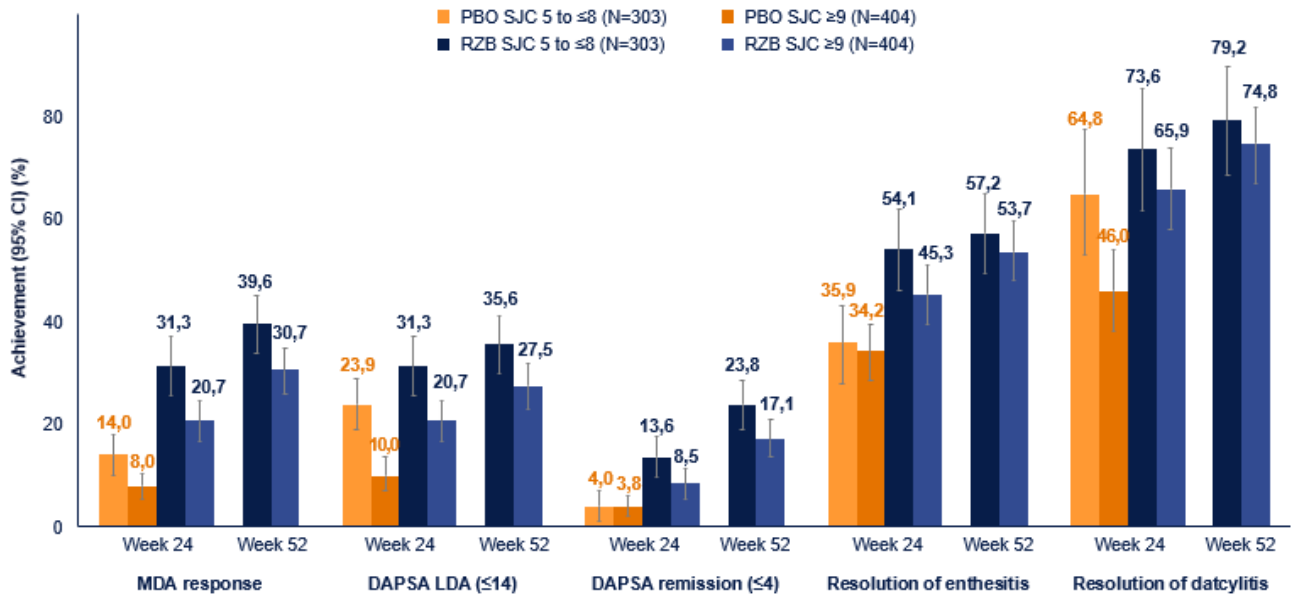
Kristensen LE et al. Rheumatology (Oxford). 2023
Kristensen LE et al. J Eur Acad Dermatol Venereol. 2022
Kristensen LE et al. Ann Rheum Dis. 2023 Volume 82, Supplement 1

High, durable responses can be achieved with IL-23 inhibition[1,2]

KEEPsAKE 1 KEEPsAKE 2







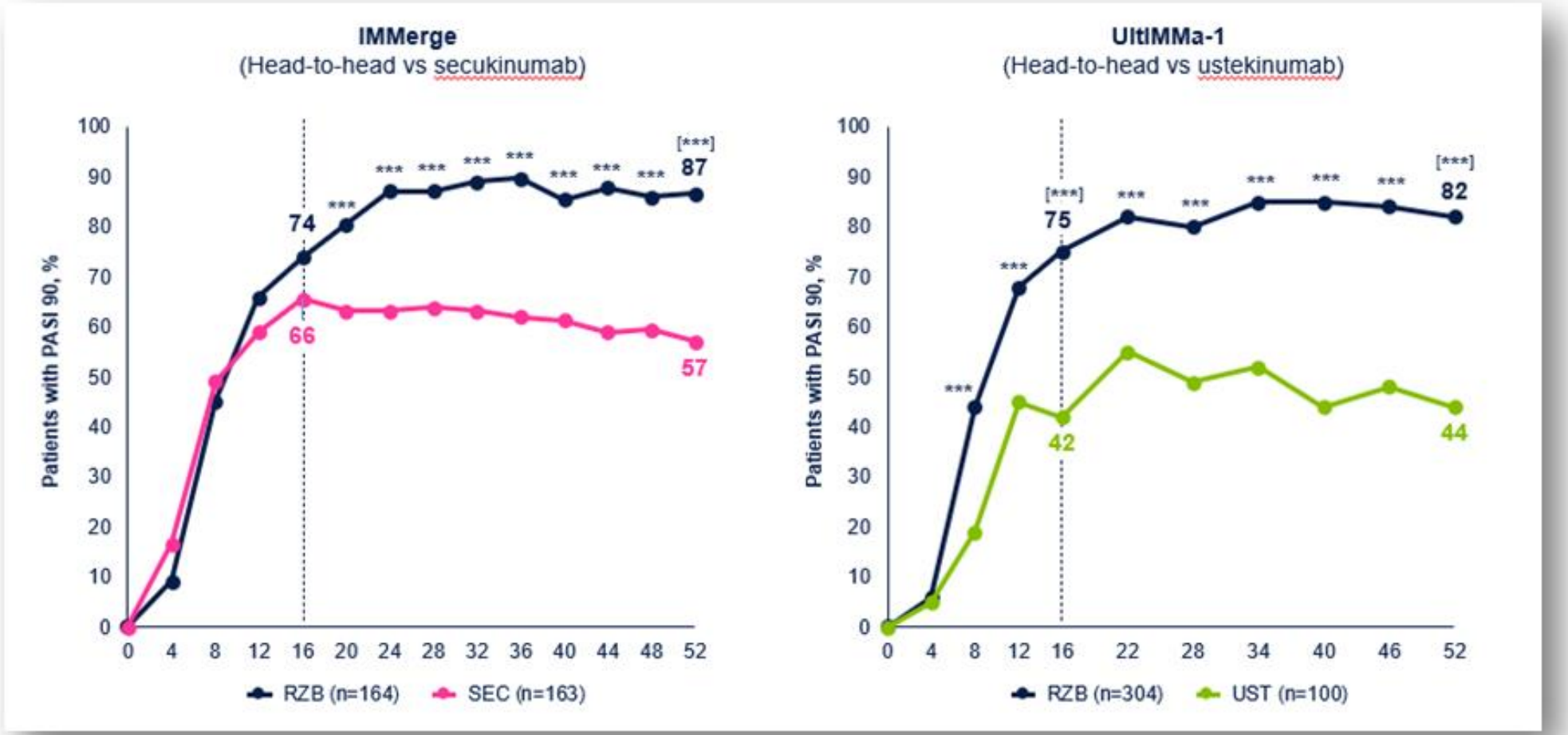
*p≤0.05 vs PBO; [a]Based on full analysis set, NRI-C. [b]Based on full analysis set, NRI (as observed with imputation, except those missing due to COVID-19) was used for missing data. Vertical dashed line represents the point at which all PBO patients were switched to RZB 150 mg. csDMARD-IR=inadequate response to conventional synthetic disease-modifying antirheumatic drugs; mTSS=modified total sharp score; OLE=open label extension; PBO=placebo; PsA=; RCT=randomized controlled trial; RZB=risankizumab.

1. Kristensen LE et al. *Ann Rheum Dis*. 2021;80:1315-1316. 2. Kristensen LE et al. P2383; presented at EADV 2023.

Resolution of enthesitis for patients with LEI ≥1 at baseline: SJC 5 to ≤8 PBO N=167, RZB N=159; SJC ≥9 PBO N=281, RZB N=285. Resolution of dactylitis LEI ≥1 at baseline: SJC 5 to ≤8 PBO N=54, RZB N=53; SJC ≥9 PBO N=150, RZB N=135. Week 24 results reported by non-responder imputation with multiple imputations accounting for COVID-19. Week 52 results reported by as observed with imputation. CI=confidence interval; DAPSA=Disease Activity Index for Psoriatic Arthritis; LDA=low disease activity; LEI=Leeds Enthesitis Index; MDA=minimal disease activity; PBO=placebo; RZB=risankizumab; SJC=swollen joint count.

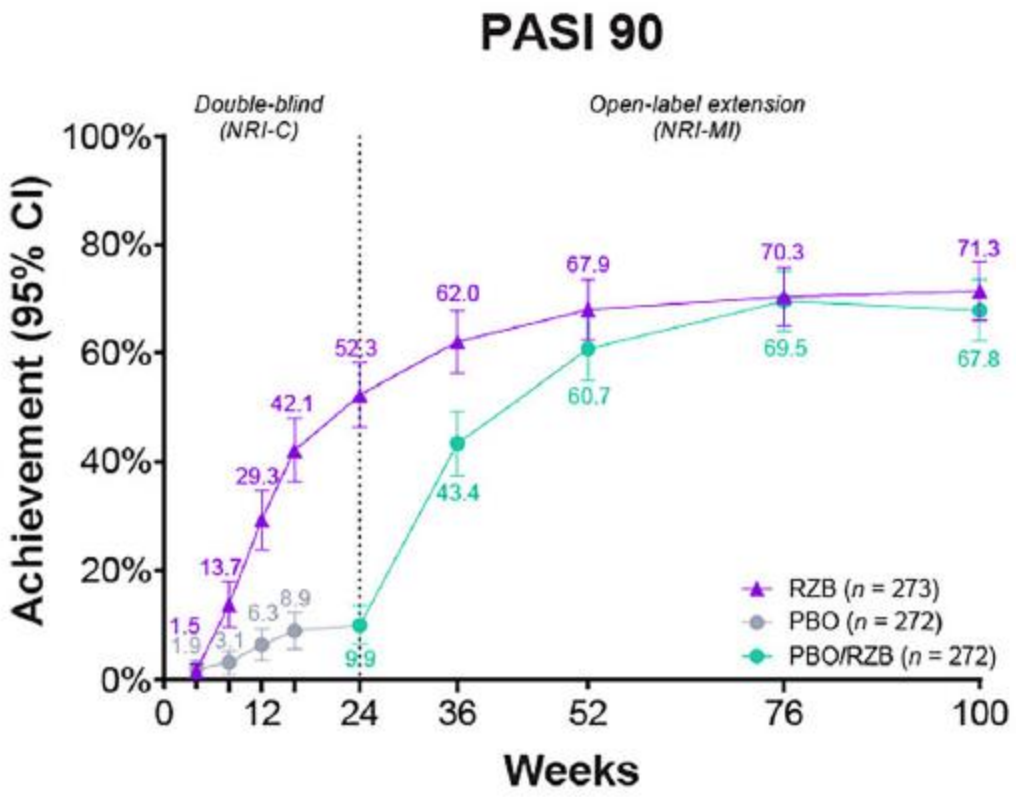
2. Coates M et al. Poster 1010 presented at ACR 2022.

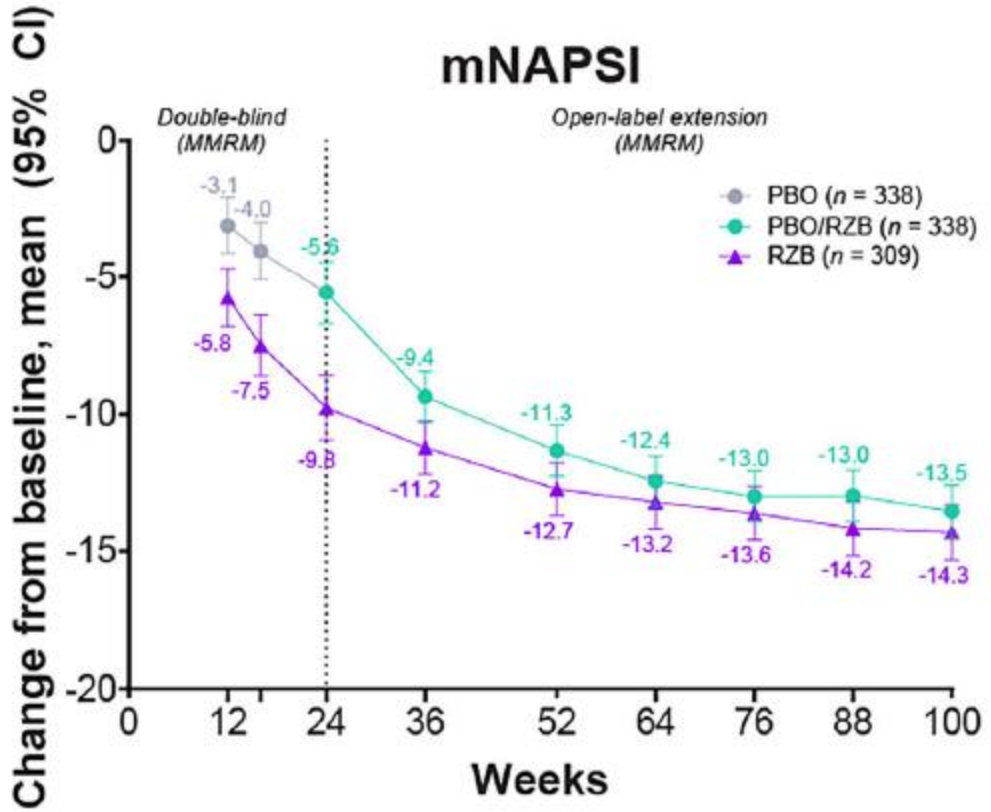
Superiority of Risankizumab vs Secukinumab and Ustekinumab



Gordon KB et al. Lancet. 2018
Warren RB. et a. Br J Dermatol. 2021

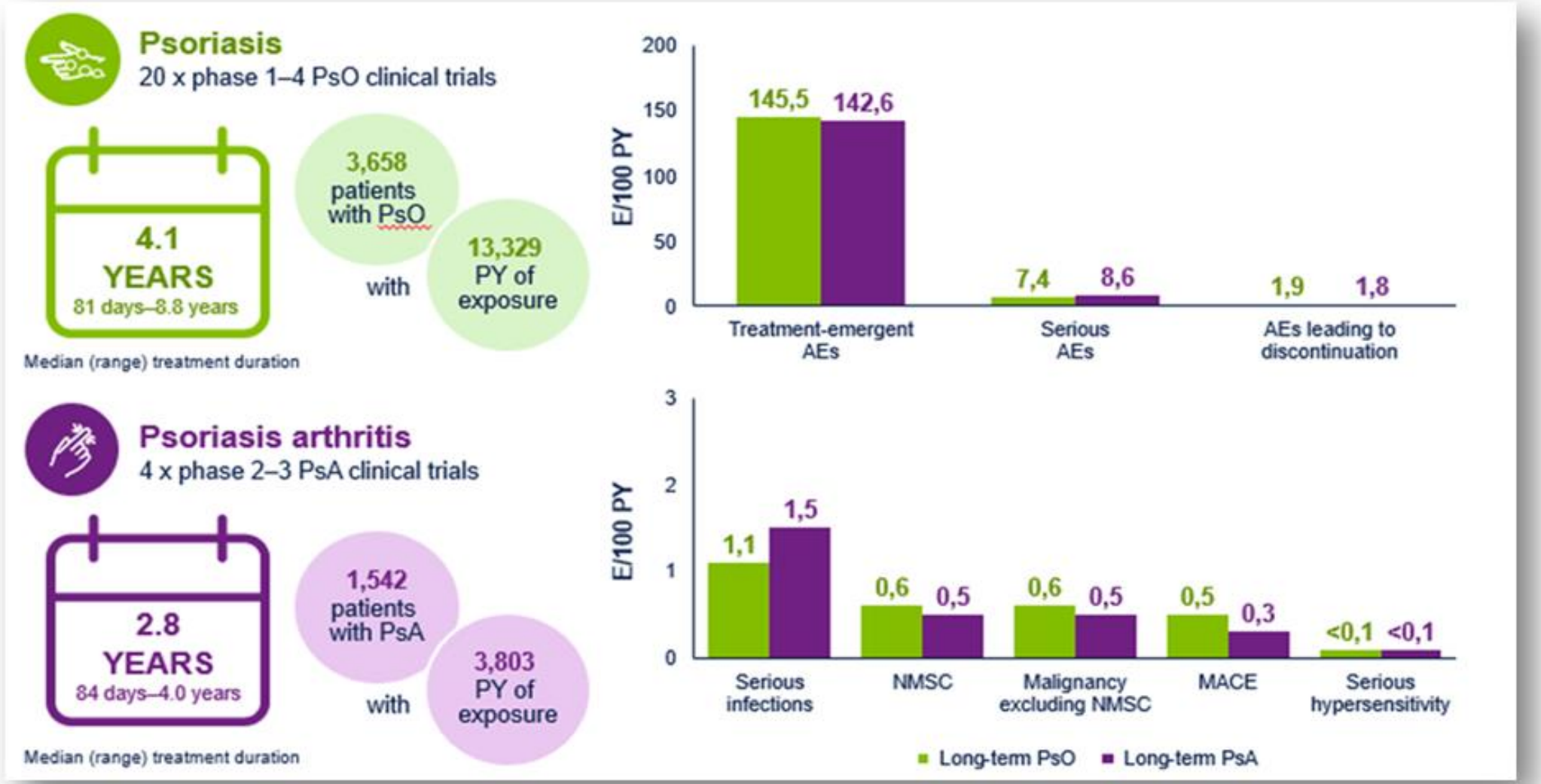
High, durable responses can be achieved with IL-23 inhibition





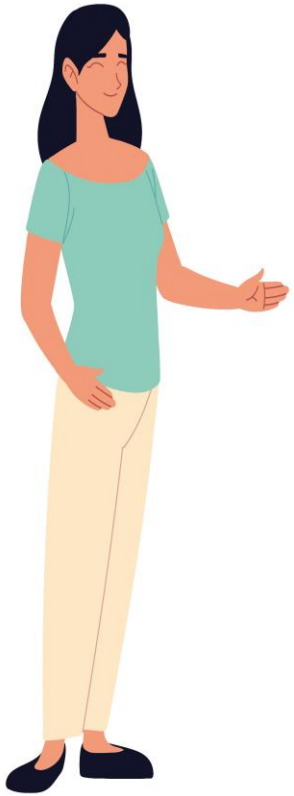
Kristensen et al., Rheumatol Ther (2024) 11:617–632
https://doi.org/10.1007/s40744-024-00654-5

Risankizumab: safety



Gordon KB et al. PP2616; presented at EADV 2023.

Κλινική Περίπτωση 2



- 6 μήνες αργότερα **πλήρης ύφεση** της ονυχίας και της αρθρίτιδας
- Φυσιολογικές τιμές ηπατικών ενζύμων και αρνητικοί δείκτες φλεγμονής

Η Μαρία συνεχίζει την καθημερινότητά της έχοντας επαναφέρει το βιοτικό της επίπεδο στο βέλτιστο

Speaker's approach

Psoriatic disease – Multidisciplinary treatment approach: Where do we stand, where do we need to go?

New directions in the management of patients with psoriatic disease

Multidisciplinary collaboration

Improve management of patients with PsO & PsA

Facilitate early diagnosis of PsA

Identify early abnormalities not limited to skin & joints

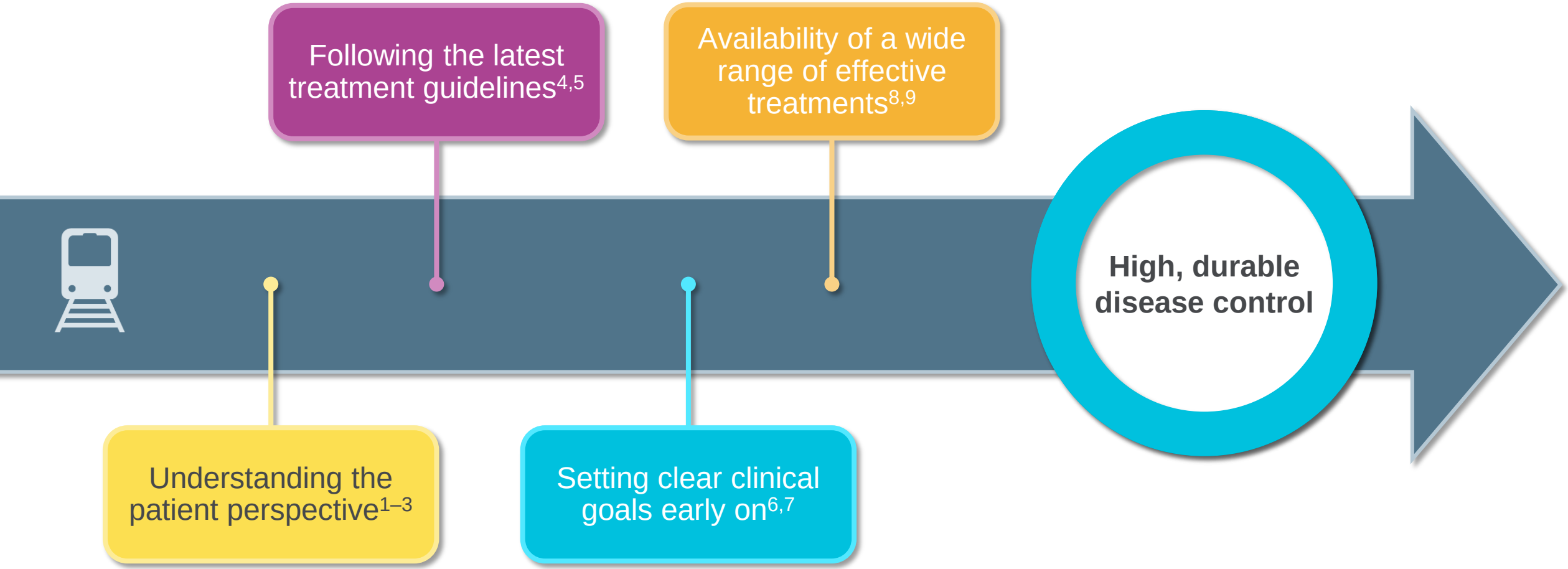
Train physicians in the global vision of psoriatic disease

↓

Models of multidisciplinary collaboration?

Speaker's opinion

We have many means to help us reach our destination of high, durable disease control



1. Kouwenhoven TA, et al. *J Dermatolog Treat.* 2020;31(1):13–7; 2. Armstrong A, et al. *J Eur Acad Dermatol Venereol.* 2018;32(12):2200–7; 3. Korman NJ, et al. *J Dermatolog Treat.* 2022;33(2):733–9; 4. Nast A, et al. EuroGuiDerm guideline for the systemic treatment of psoriasis vulgaris. www.guidelines.edf.one//uploads/attachments/clrf2t72k3ttodtjrokdem0cy-0-euroguiderm-pso-gl-draft-2024.pdf. September 2023. Accessed 23 April 2024; 5. Foley P, et al. *Australas J Dermatol.* 2023;64(4):476–87; 6. Strober BE, et al. *Dermatol Ther (Heidelb).* 2019;9(1):5–18; 7. Romero IB, et al. *Annals of Medicine.* 2021;53(1):1727–36; 8. Sawyer LM, et al. *PLoS One*. 2019;14(8):e0220868; 9. Armstrong AW, et al. *Dermatol Ther (Heidelb).* 2022;12:167–84.