«Βιολογικοί παράγοντες σε ΑξΨΑ, Ψωρίαση και HS: μια θεραπεία, πολλαπλοί στόχοι;»

Ενδείξεις, δεδομένα πραγματικής ζωήςκαι επιλογή ασθενούς

«Αναστολείς IL-17 και IL-23 σε ψωρίαση και HS»

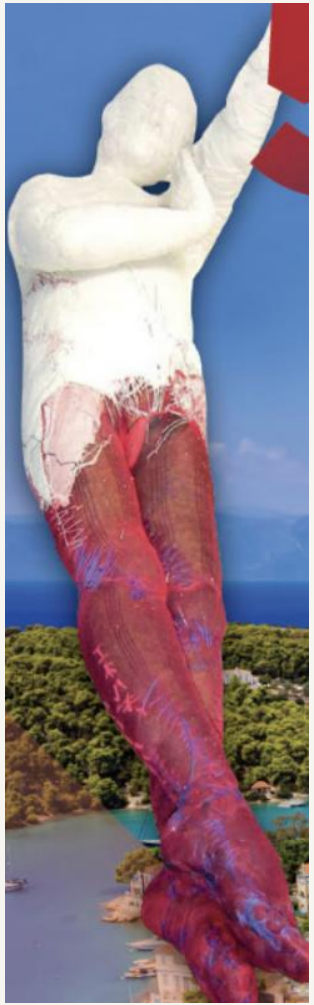
Μαρίνα Παπουτσάκη MD, PhD

Δερματολόγος-Αφροδισιολόγος

Διευθύντρια ΕΣΥ

Α΄ Κλινική Αφροδισίων και Δερματικών Νόσων Ε.Κ.Π.Α.,

Νοσοκομείο Αφροδισίων και Δερματικών Νόσων, «Ανδρέας Συγγρός»



Δήλωση σύγκρουσης συμφερόντων

- **Έχω λάβει αμοιβή για ομιλίες και συμβουλευτικές δραστηριότητες από :**

- Janssen, LEO, MSD, Genesis pharma, Pfizer, Novartis, Abbvie, UCB, Lilly

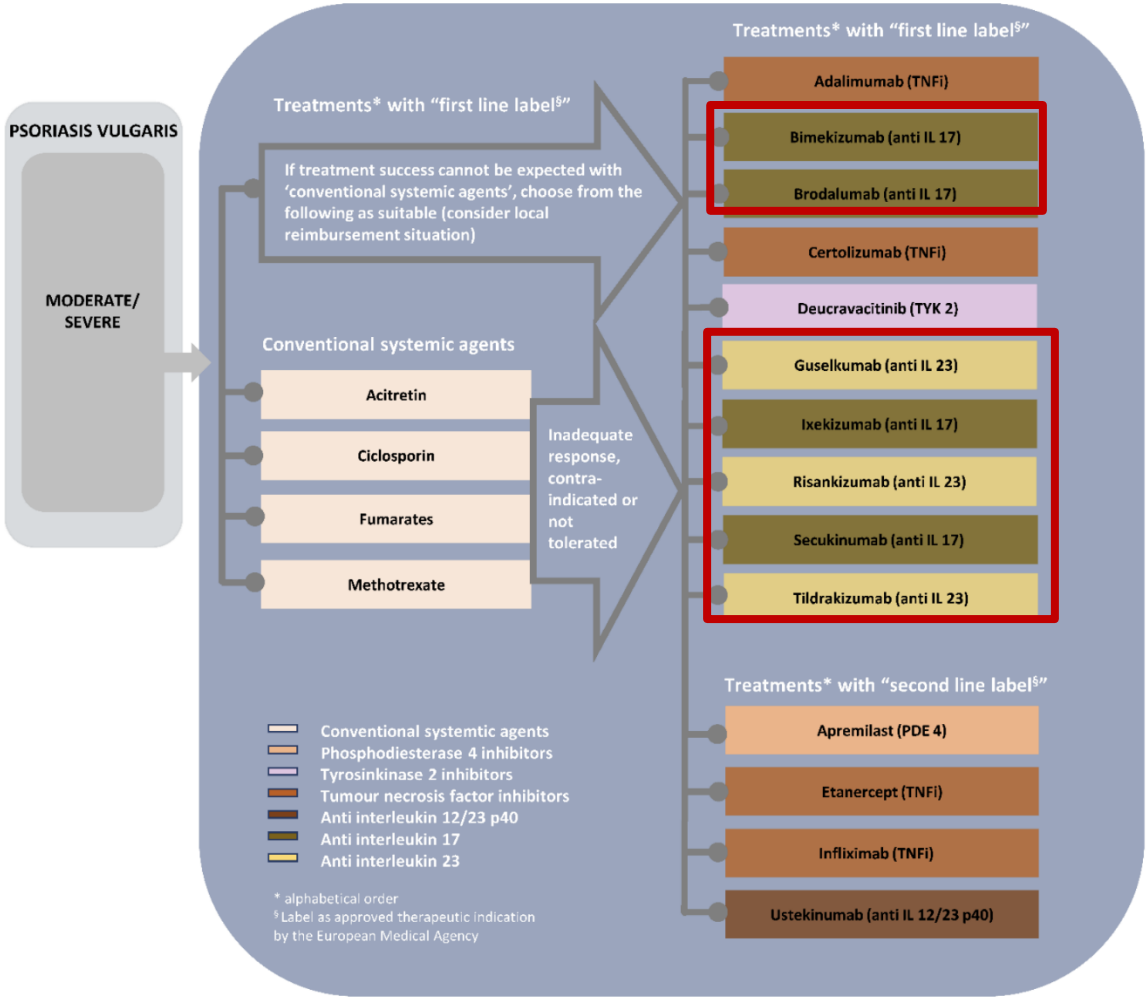
- **Ερευνήτρια σε κλινικές μελέτες για:**

- Janssen, Pfizer, Novartis, Abbvie, LEO

EUROPEAN CENTRE FOR GUIDELINES DEVELOPMENT

European Dermatology Forum

CHARITÉ d:EBM



EuroGuiDerm Guideline for the systemic treatment of Psoriasis vulgaris

September 2023, revised version March 2024 *

A Nast, PI Spuls, C Dressler, Z Bata-Csörgö, I Bogdanov, H Boonen, EMGJ De Jong, I Garcia-Doval, P Gisondi, D Kaur-Knudsen, S Mahil, T Mälkönen, JT Maul, S Mburu, L Mercieca, U Mrowietz, A Pennitz, E Remenyik, D Rigopoulos, PG Sator, M Schmitt-Egenolf, M Sikora, K Strömer, O Sundnes, I Vader, G Van Der Kraaij, N Yawalkar, C Zeyen, C Smith.

Therapy / Specific circumstances			TNF inhibitors				anti-IL12/23	anti-IL17				anti-IL23		
	Apremilast	Deucravacitinib	Etanercept	Infliximab	Adalimumab	Certolizumab	Ustekinumab	Secukinumab	Ixekizumab	Brodalumab	Bimekizumab	Guselkumab	Tildrakizumab	Risankizumab
Concomitant psoriatic arthritis	↑		↑↑								has been approved for PsA 06/23, evaluation pending	↑↑		↑↑
Chronic inflammatory bowel disease: Crohn's Disease				↑↑ 1st choice				↓				↑ 2nd choice if TNFi not suitable		
Chronic inflammatory bowel disease: Ulcerative colitis	↑ 2nd choice oral treatment			↑↑ 1st choice			↑↑ 1st choice	↓				↑ 2nd choice if TNFi not suitable		
Diabetes mel./ metabolic syndrome														
Dyslipidaemia														
Advanced heart failure	↑		↓↓					↑				↑		
Heart Disease: Ischemic heart disease			↑											
Concomitant latent / treated TB	↑		↓↓					↑				↑		
Pregnancy	↓	↓				↑ preferred choice biologic								

EUROGUIDERM GUIDELINE FOR THE SYSTEMIC TREATMENT OF PSORIASIS VULGARIS

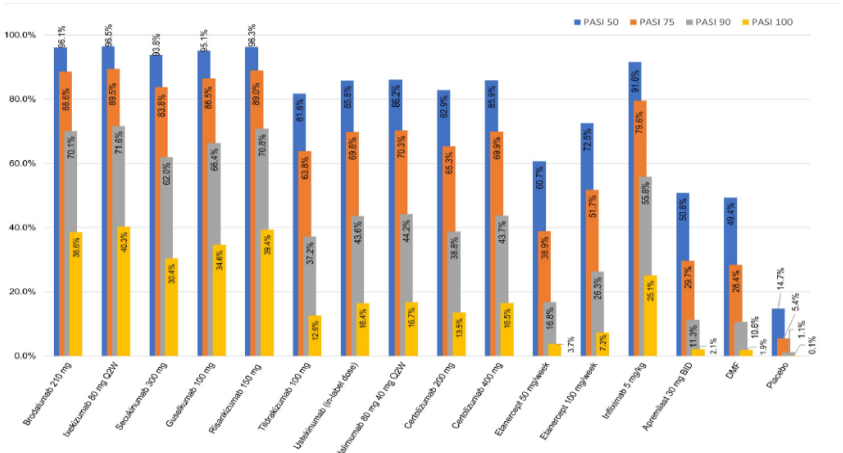
September 2023, revised version March 2024 *

A Nast, PI Spuls, C Dressler, Z Bata-Csörgö, I Bogdanov, H Boonen, EMGJ De Jong, I Garcia-Doval, P Gisondi, D Kaur-Knudsen, S Mahil, T Mäkikönen, JT Maul, S Mburu, L Mercieca, U Mrowietz, A Pennitz, E Remenyik, D Rigopoulos, PG Sator, M Schmitt-Egenolf, M Sikora, K Strömer, O Sundnes, I Vader, G Van Der Kraaij, N Yawalkar, C Zeyen, C Smith.

Assessing the relative efficacy of interleukin-17 and interleukin-23 targeted treatments for moderate-to-severe plaque psoriasis: A systematic review and network meta-analysis of PASI response

Laura M. Sawyer[1]*, Kinga Malottki[1], Celia Sabry-Grant[1], Najeeda Yasmeen[1], Emily Wright[1], Anne Sohrt[2], Emma Borg[2], Richard B. Warren[3]

1 Symmetron Limited, London, England, United Kingdom, 2 LEO Pharma A/S, Ballerup, Denmark, 3 Dermatology Centre, Salford Royal NHS Foundation Trust, Manchester NIHR Biomedical Research Centre, The University of Manchester, Manchester, England, United Kingdom



Sawyer LM, Malottki K, Sabry-Grant C, Yasmeen N, Wright E, Sohrt A, Borg E, Warren RB.. PLoS One. 2019 Aug 14;14(8):e0220868. doi: 10.1371/journal.pone.0220868. PMID: 31412060; PMCID: PMC6693782.

ORIGINAL RESEARCH

Cumulative Clinical Benefits of Biologics in the Treatment of Patients with Moderate-to-Severe Psoriasis over 1 Year: a Network Meta-Analysis

Andrew Blauvelt · Melinda Gooderham · Christopher E. M. Griffiths · April W. Armstrong · Baojin Zhu · Russel Burge · Gaia Gallo · Jiaying Guo · Alyssa Garrelts · Mark Lebwohl

Received: December 23, 2021 / Accepted: February 3, 2022 / Published online: February 23, 2022

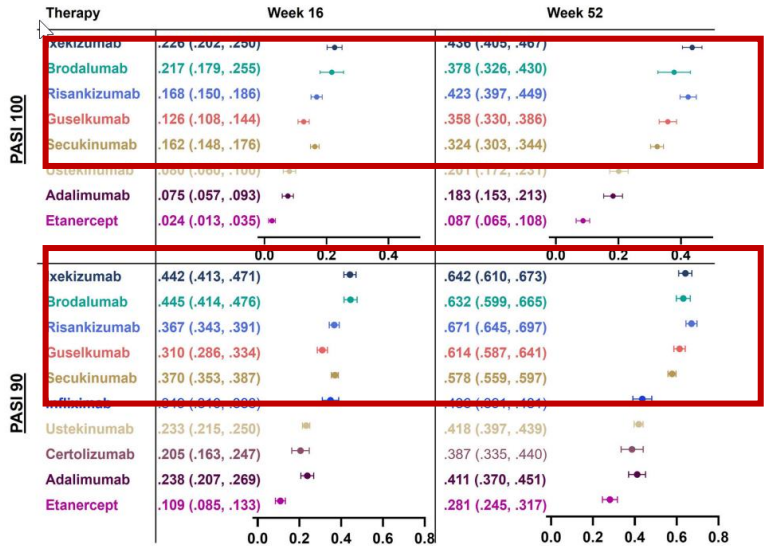


Fig. 1 Placebo-adjusted normalized maximum AUC for PASI 100 and PASI 90 at 16 and 52 Weeks. Data displayed as median (95% credible interval). *AUC* area under the curve, *PASI 100/90* 100% or ≥ 90% improvement in Psoriasis Area and Severity Index

Blauvelt A, Gooderham M, Griffiths CEM, Armstrong AW, Zhu B, Burge R, Gallo G, Guo J, Garrelts A, Lebwohl M. Dermatol Ther (Heidelb). 2022 Mar;12(3):727-740. doi: 10.1007/s13555-022-00690-5. Epub 2022 Feb 23. PMID: 35195887; PMCID: PMC8941028.

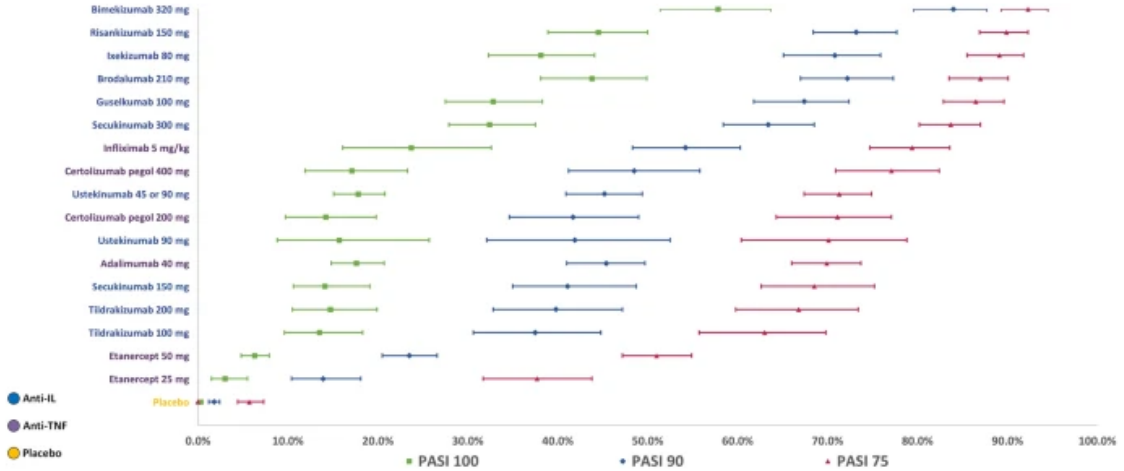
NMA, Armstrong(12-16 weeks), short-term efficacy

Efficacy of Bimekizumab and Other Biologics in Moderate to Severe Plaque Psoriasis: A Systematic Literature Review and a Network Meta-Analysis

April Armstrong Dermatol Ther (Heidelb)

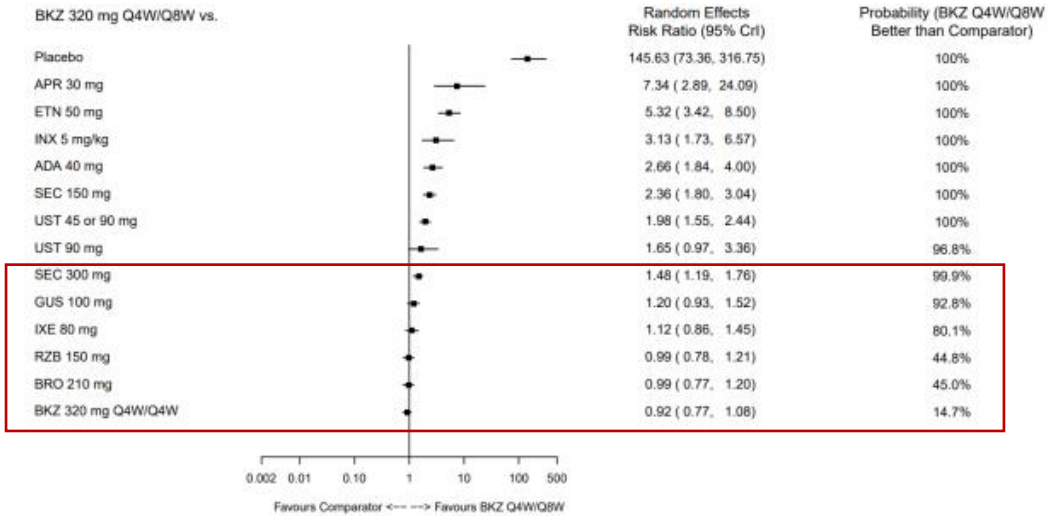
. 2022 Aug;12(8):1777-1792

Fig. 3



Probit probabilities (95% CrI) of achieving PASI outcomes (REZ, adjusted, random-effects multinomial model). Treatments are sorted by the highest to lowest probabilities of reaching PASI 75. *CrI* credible interval, *IL* interleukin, *PASI* Psoriasis Area and Severity Index, *TNF* tumour necrosis factor

Supplementary Figure 3. Multinomial NMA at Weeks 44–60 – Risk Ratios of Achieving PASI 100 (Sensitivity Analysis: Treat-though, with Placebo) between Bimekizumab 320 mg Q4W/Q8W* and Other Treatments

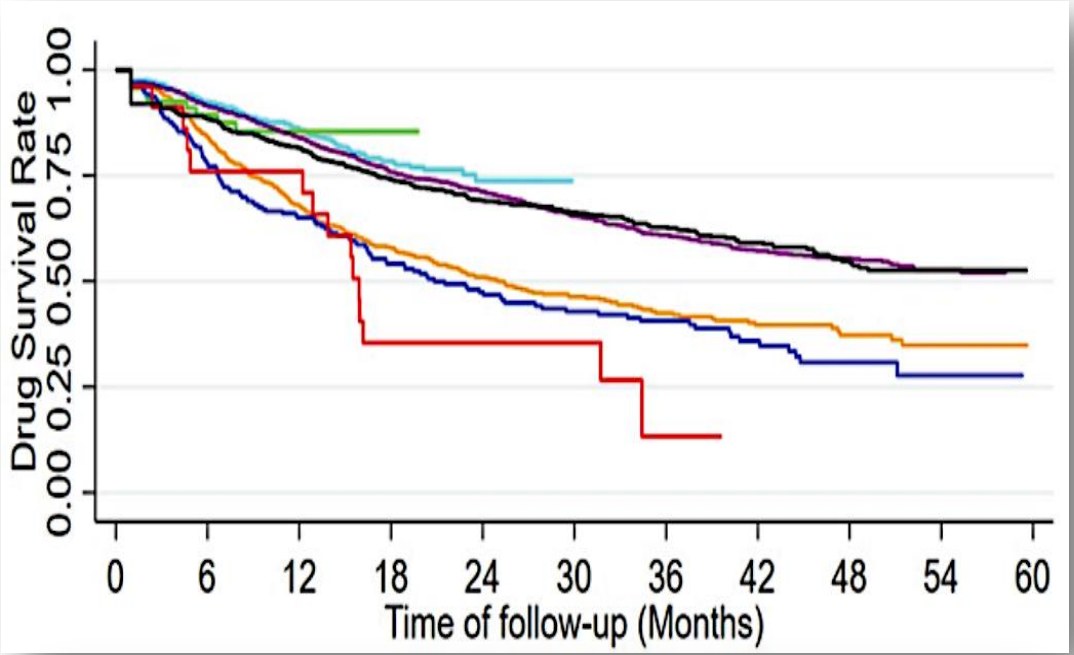


Model: Treat-through, with placebo; random effects, baseline-adjusted, REZ, multinomial NMA.

*Bimekizumab-treated patients were dosed 320 mg every 4 weeks through Week 16 and then switched to every 8 weeks dosing (Q4W/Q8W).

Abbreviations: ADA = adalimumab; APR = apremilast; BKZ = bimekizumab; BRO = brodalumab; CrI = credible interval; ETN = etanercept; GUS = guselkumab; INX = infliximab; IXE = ixekizumab; NMA = network meta-analysis; PASI 100 = achievement of 100% improvement from baseline in Psoriasis Area and Severity Index; Q4W = every 4 weeks; Q8W = every 8 weeks; REZ = random effects model combined with the parameter z; RZB = risankizumab; SEC = secukinumab; UST = ustekinumab.

8819 pts:
✓ 6772 bio-experienced
✓ 2047 bio-naive



Clin Exp Dermatol 2024; **00**:1–9
https://doi.org/10.1093/ced/llae240
Advance access publication date: 6 July 2024

CED
Clinical and Experimental Dermatology
Original Article

Drug survival of biologics in patients with psoriasis: real-world evidence for Greece during the period 2016–2020

Elizabeth Lazaridou,[1] Georgia Kourlaba,[2] Stylianos Ravanidis,[3] George Gounelas,[3] Garyfallia Stefanou,[3] Anastasios Tsolakidis,[4] Konstantinos Mathioudakis[4] and Zoe Apalla[1]

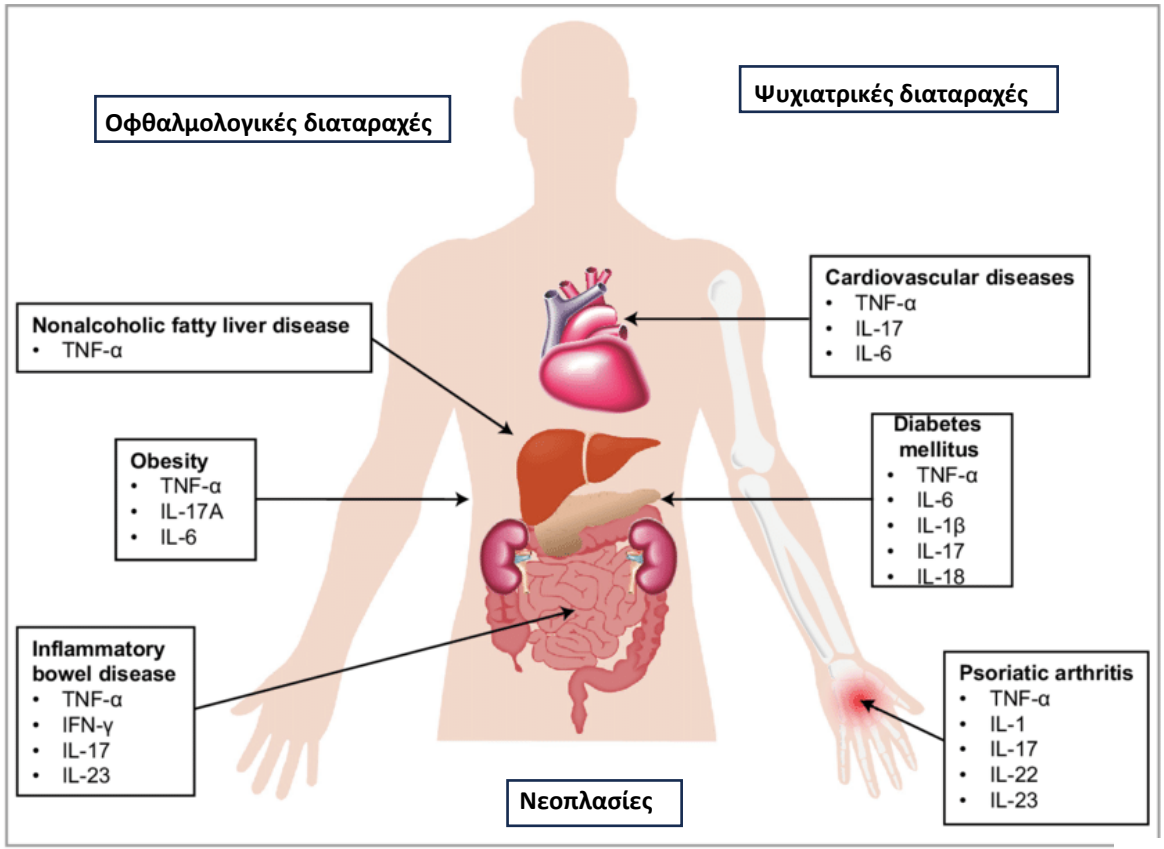
[1]Second Department of Dermatology, Aristotle University School of Medicine, Thessaloniki, Greece
[2]Department of Nursing, University of Peloponnese, Tripoli, Greece
[3]ECONCARE, Athens, Greece
[4]IDIKA SA – e-Government Center for Social Security Services, Athens, Greece
Correspondence: Elizabeth Lazaridou. Email: bethlaz@auth.gr
E.L. and G.K. are joint first authors.

- Επιβεβαιώνεται η σημασία των βιολογικών φαρμάκων 1ης γραμμής ειδικά σε ασθενείς με συνυπάρχουσα ΨΑ
- **Τα αντισώματα κατά της ιντερλευκίνης-17/23 φαίνεται να σχετίζονται με υψηλότερα ποσοστά επιβίωσης συγκριτικά με τους παραδοσιακούς βιολογικούς παράγοντες, όπως TNFi.**

Lazaridou E, Apalla Z. Clin Exp Dermatol. 2024 Jul 6:llae240. doi: 10.1093/ced/llae240.

Ψωρίαση

Συστηματική νόσος



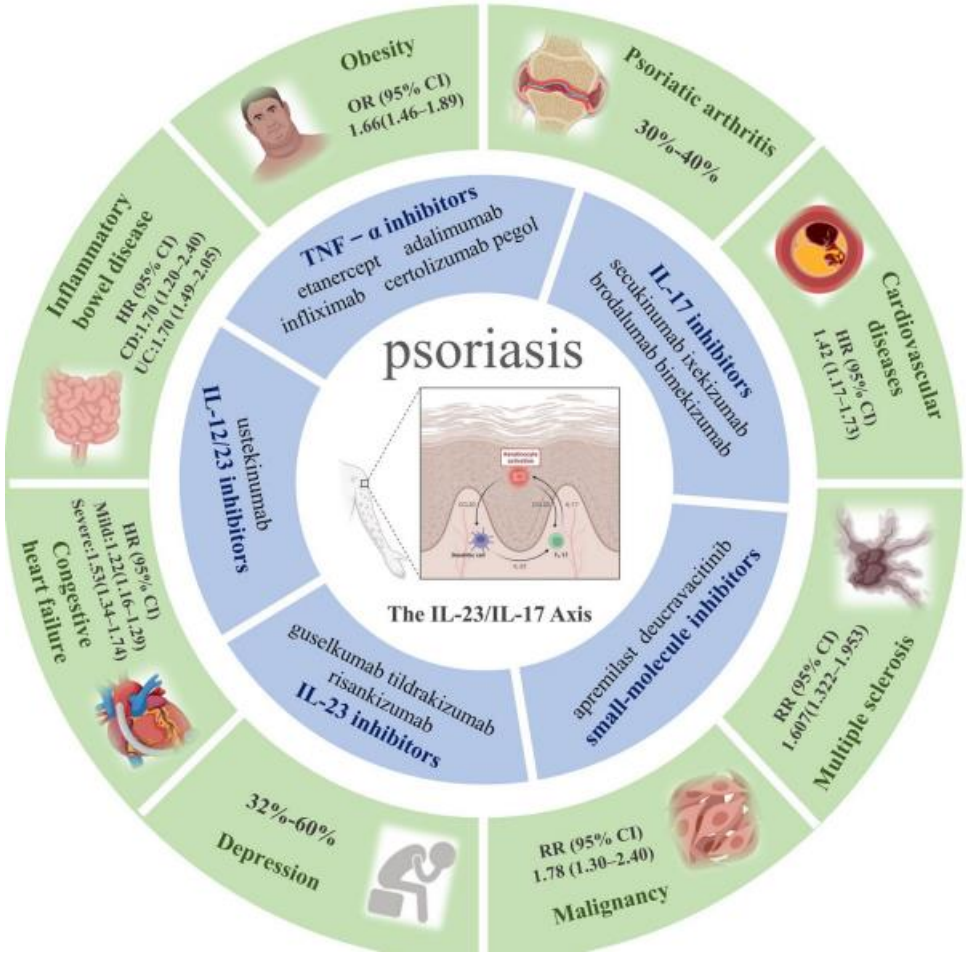
British Journal of Dermatology (2020) **182**, pp840–848

BioDrugs (2023) 37:35–55
https://doi.org/10.1007/s40259-022-00569-z

REVIEW ARTICLE

Biologic and Small-Molecule Therapies for Moderate-to-Severe Psoriasis: Focus on Psoriasis Comorbidities

Yuxiong Jiang[1,3] · Youdong Chen[1,3] · Qian Yu[2,3] · Yuling Shi[1,3]



Meta-Analysis > Front Immunol. 2022 Dec 1:13:1033844. doi: 10.3389/fimmu.2022.1033844. eCollection 2022.

Risk of psoriasis in people with hidradenitis suppurativa: A systematic review and meta-analysis

JAAD Journal of the American Academy of Dermatology

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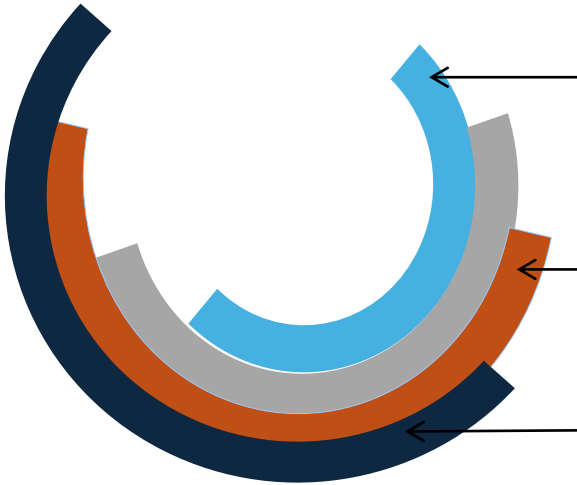
ORIGINAL ARTICLE · Volume 92, Issue 6, P1303-1311, June 2025 · *Open Access*

Patients with PSOriasis and Suppurative Hidradenitis (PSO-SH) share genetic risk factors and are at risk of increased morbidity

Antonia Wiala, MD [a] · Kareem G. Elhage, MD [b] · Andrea Leung, BA, MPH [b] · Albert T. Young, MD, MAS [c] · Mark Gregory, MS [c] · Indra Adrianto, PhD [c,d,e,f,g] · Li Zhou, MD, MS [c,e,f,g] · Qing-Sheng Mi, MD, PhD [c,e,f,g] · Sugandh Kumar, PhD [b] · Faye Orcales, BS [b] · Samuel Yeroushalmi, MD [b] · Kathryn Haran, BS [b] · Jared Liu, PhD [b] · Haley B. Naik, MD [b] · Wilson Liao, MD [b] · Christian Posch, MD, PhD [a,h,i,j]

Διαγνωστικά κριτήρια Δ.Ι.

Διαπυητική ιδρωταδενίτιδα (Δ.Ι.), χρόνια φλεγμονώδης, υποτροπιάζουσα δερματική νόσος[1,2]

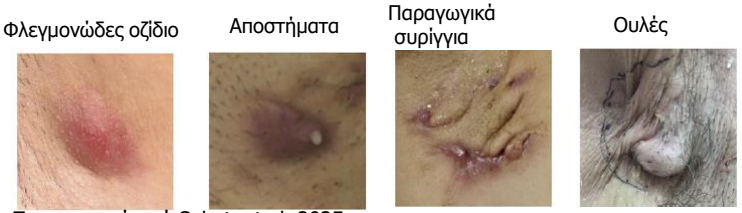


Τυπικές δερματικές βλάβες

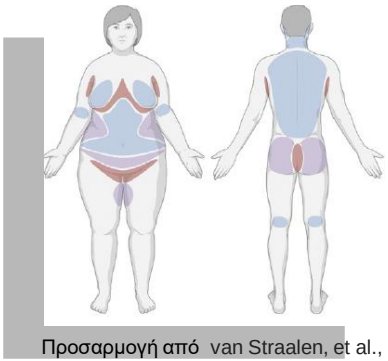
Τυπική εντόπιση

Τυπική πορεία

- **Επίμονη**:δερμ. βλάβες ≥ 6μήνες
- **Υποτροπιάζουσα:**
  >2 δερμ. βλάβες / 6 μήνες



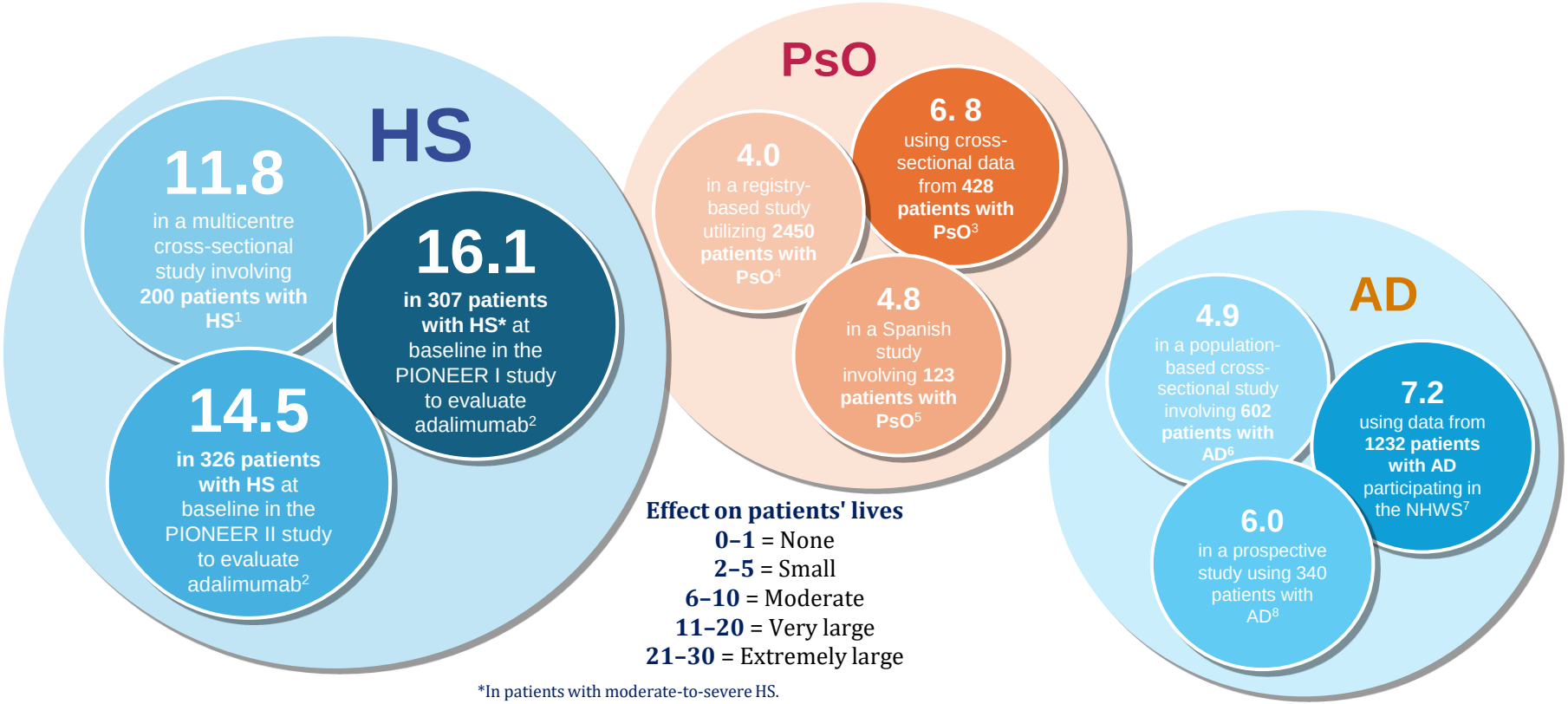
Προσαρμογή από Sabat, et al.,2025



Προσαρμογή από van Straalen, et al., 2022

1. van Straalen, Kelsey R et al. “Insights into hidradenitis suppurativa.” *The Journal of allergy and clinical immunology* vol. 149,4 (2022): 1150-1161. doi:10.1016/j.jaci.2022.02.003
2. Sabat, Robert et al. “Hidradenitis suppurativa.” *Lancet (London, England)* vol. 405,10476 (2025): 420-438. doi:10.1016/S0140-6736(24)02475-9

Οι βαθμολογίες DLQI είναι υψηλότερες στη Δ.Ι. σε σύγκριση με άλλες δερματολογικές παθήσεις

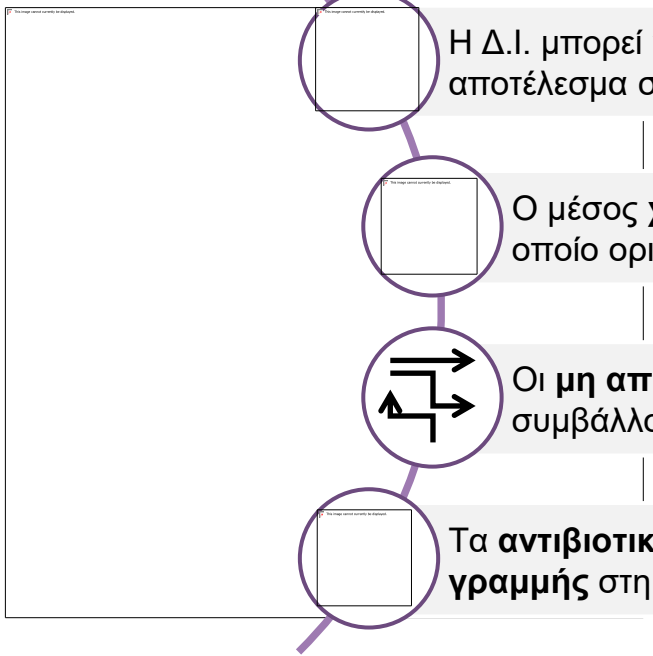


*In patients with moderate-to-severe HS.

AD, atopic dermatitis; NHWS, national health and wellness study; PSO, psoriasis.

1. Gergely et al. J Eur Acad Dermatol Venereol. 2020;34:2584–92. 2. Kimball et al. N Engl J Med 2016;375:422–34. 3. Rencz et al. Br J Dermatol. 2020;182:1167–75. 4. Norlin et al. Br J Dermatol 2012;166:797–802. 5. Badia et al. Br J Dermatol 1999;141:698–702. 6. Silverberg et al. Ann Allergy Asthma Immunol 2018;340–7. 7. Visbøll et al. Qual Life Res 2020;29:2529–2539. 8. Patel et al. Br J Dermatol 2019;180:1083–9.

Διαπυητική Ιδρωταδενίτιδα: Ανεκπλήρωτα κενά στη διαχείριση



Η Δ.Ι. μπορεί να οδηγήσει σε **προοδευτική και μόνιμη βλάβη των ιστών** με αποτέλεσμα σημαντική λειτουργική και ψυχοκοινωνική επιβάρυνση για τους ασθενείς.[1,2]

Ο μέσος **χρόνος μέχρι τη διάγνωση υπερβαίνει τα 7 έτη,** διάστημα κατά το οποίο ορισμένοι ασθενείς πιθανά έχουν ήδη εξελιχθεί σε μέτρια ή σοβαρή νόσο[3,4]

Οι **μη αποτελεσματικές διαδικασίες παραπομπής** στο σύστημα υγείας συμβάλλουν ουσιαστικά στην καθυστέρηση διάγνωσης της Δ.Ι.[3]

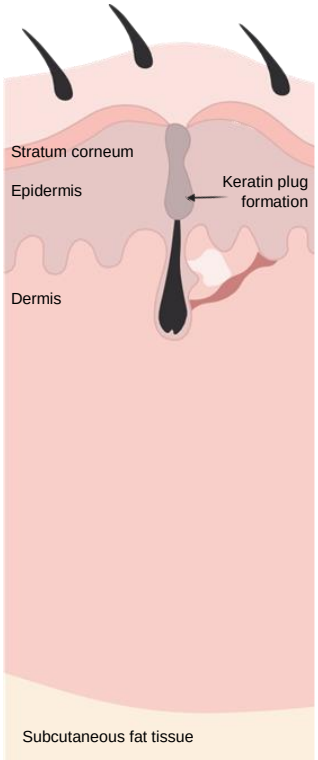
Τα **αντιβιοτικά εξακολουθούν να χρησιμοποιούνται ως θεραπεία πρώτης γραμμής** στη διαχείριση της Δ.Ι.[6]

HS, hidradenitis suppurativa.

1. Sabat et al. Nat Rev Dis Primers. 2020;6:18; 2. Garg et al. J Am Acad Dermatol. 2020;82:366–76; 3. Kearney et al. SHSA 2021 (P4.04); 4. Ingram et al. EADV 2021 (P0027); 5. Orenstein et al. J Am Acad Dermatol. 2021;84(5):1399–401; 6. Zouboulis et al. J Eur Acad Dermatol Venereol. 2019;33:19–31.

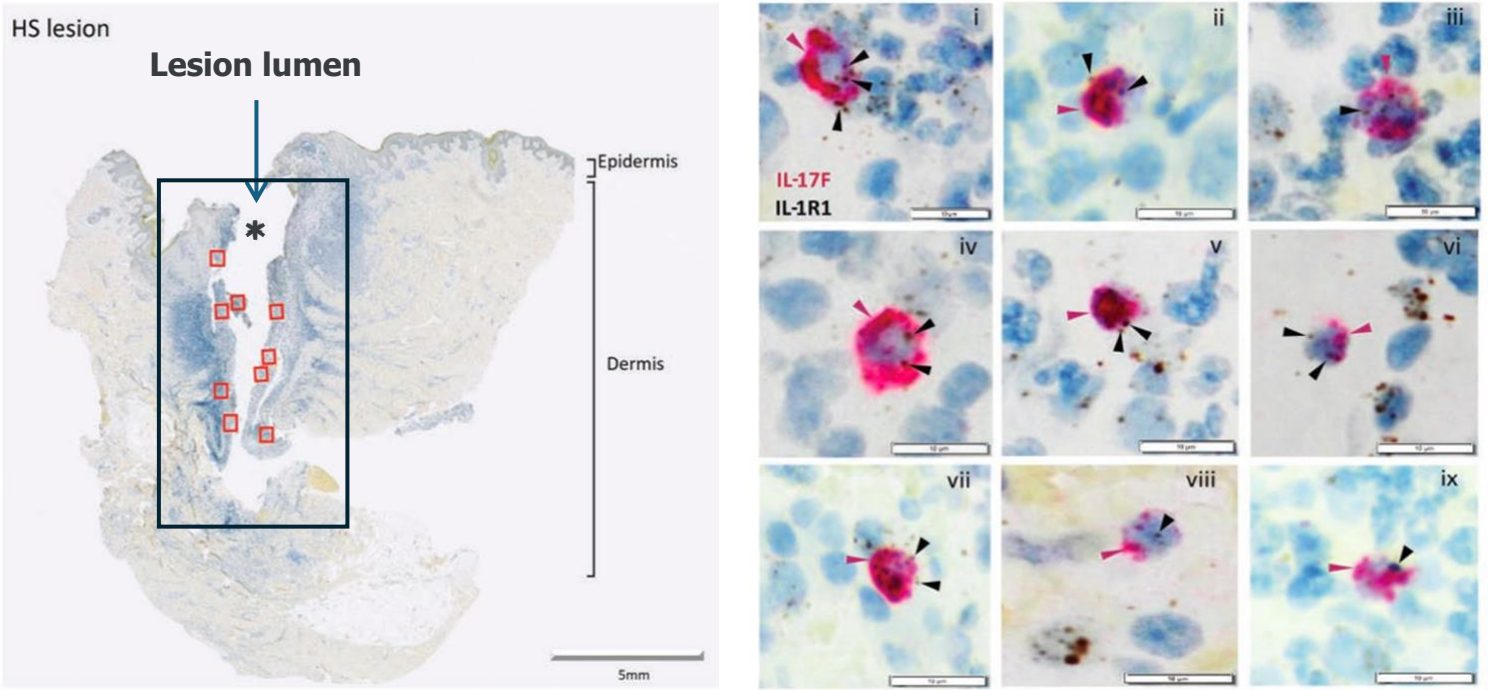
Ο ρόλος των IL-17F και IL-17A στην παθογένεια της Δ.Ι.

A. Follicular occlusion



CSF, colony-stimulating factor; CXCL, chemokine (C-X-C motif) ligand; HS, hidradenitis suppurativa; IFN, interferon; IL, interleukin, ILC3, type 3 innate lymphoid cells; MAIT, mucosal-associated invariant; Th17, T helper 17 cell; TNF, tumour necrosis factor; Trm, tissue-resident memory. Figure adapted from reference. Rastrick J, et al. Br J Dermatol. 2025;192:660–71.

Η χρώση RNAscope επιβεβαιώνει ότι η IL-17F εκφράζεται σε υψηλά επίπεδα στις βλάβες Δ.Ι. επιβεβαιώνοντας τον ρόλο της στη βαρύτητα της νόσου



RNAscope staining of HS lesion. Asterisks mark lesion lumen; red boxes are representative sample areas for the RNAscope staining.
HS, hidradenitis suppurativa; IL, interleukin; MAIT, mucosal-associated invariant T cell; RNA, ribonucleic acid.
Rastrick J, et al. Br J Dermatol. 2025;192(4):660–71.

Ο ρόλος της IL17A στην ψωρίαση και τη ΔΙ

ΠΡΟΚΛΗΣΗ ΧΡΟΝΙΑΣ ΦΛΕΓΜΟΝΗΣ

- ✓ IL-17A : η κύρια αιτία στη δυσλειτουργία των επιδερμικών κερατινοκυττάρων , προάγει την ανώμαλη διαφοροποίηση και πολλαπλασιασμό τους

ΥΨΗΛΑ ΕΠΙΠΕΔΑ IL17A ΣΤΟΝ ΟΡΟ ΚΑΙ ΙΣΤΟΥΣ ΑΣΘΕΝΩΝ ΜΕ ΔΙ

- ✓ Υψηλότερα επίπεδα σε ιστολογικά δείγματα ΔΙ με επιβεβαιωμένα συρίγγια vs χωρίς συρίγγια και κυρίως αυξημένα σε δείγματα με παραγωγικά συρίγγια vs μη παραγωγικά.
- ✓ Η παρουσία συριγγίων επηρεάζει σημαντικά τις πιθανότητες επίτευξης HiSCR και τον χρόνο επίτευξης του.

ΑΥΤΟΑΝΟΣΑ ΝΟΣΗΜΑΤΑ

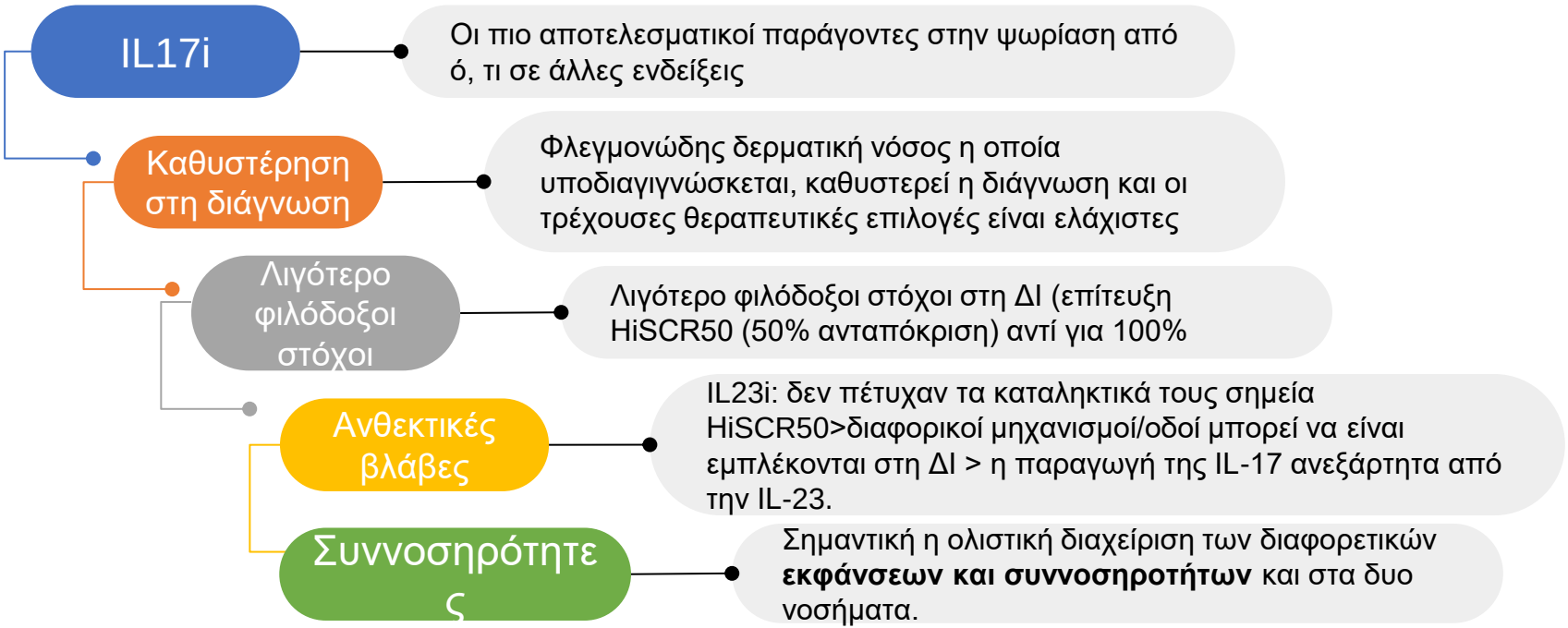
- ✓ Είναι ο πιο βιολογικά ενεργός υπότυπος

ΣΥΣΧΕΤΙΖΕΤΑΙ ΜΕ ΜΕΓΑΛΥΤΕΡΗΣ ΣΟΒΑΡΟΤΗΤΑΣ ΝΟΣΟ

- ✓ Ανοσοϊστοχημεία του δέρματος ασθενών με ΔΙ δείχνει ότι στις πιο σοβαρές βλάβες στο φλεγμονώδες διήθημα υπάρχουν πολλά μαστοκύτταρα, τα οποία είναι θετικά για IL-17A

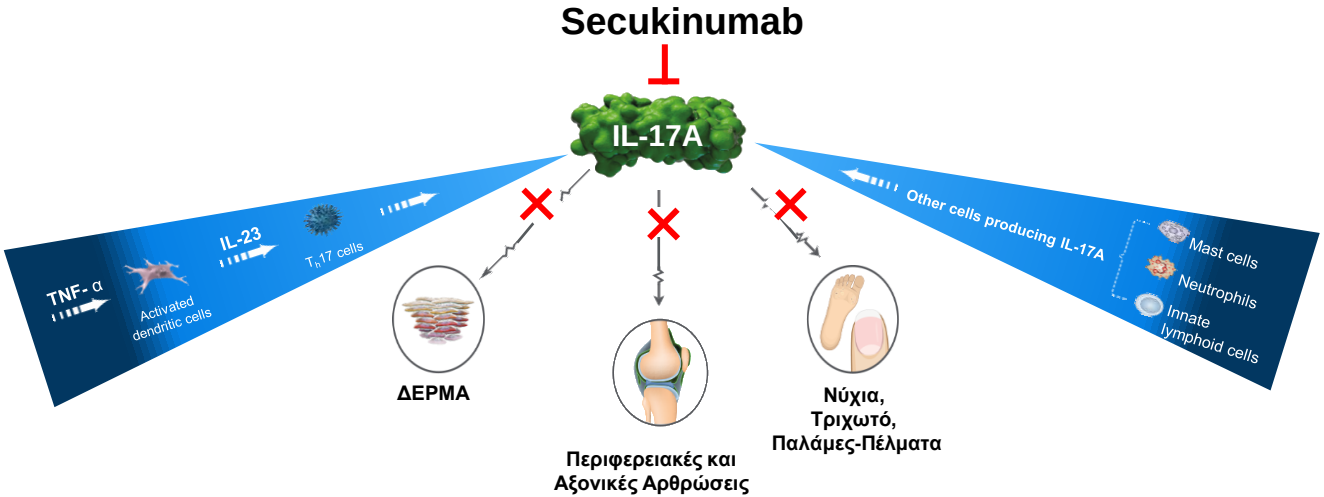
1. Malvaso, D et al.Pharmaceutics 2023, 15, 2450. https://doi.org/10.3390/pharmaceutics15102450 2. Sánchez-Rodríguez, G.; et al. Int. J. Mol. Sci. 2023, 24, 10305. 3. J. W. Frew, Clinical and Experimental Dermatology, Volume 46, Issue 2, 1 March 2021, Pages 306–313

Δανειζόμενοι την εμπειρία από την ψωρίαση...



James G Krueger, et al. British Journal of Dermatology, Volume 190, Issue 2, February 2024, Pages 149–162, https://doi.org/10.1093/bjd/ljad345

Το Secukinumab είναι ένα πλήρως ανθρώπινο μονοκλωνικό αντίσωμα που μπλοκάρει την IL-17A ανεξαρτήτως προέλευσης[12,13]

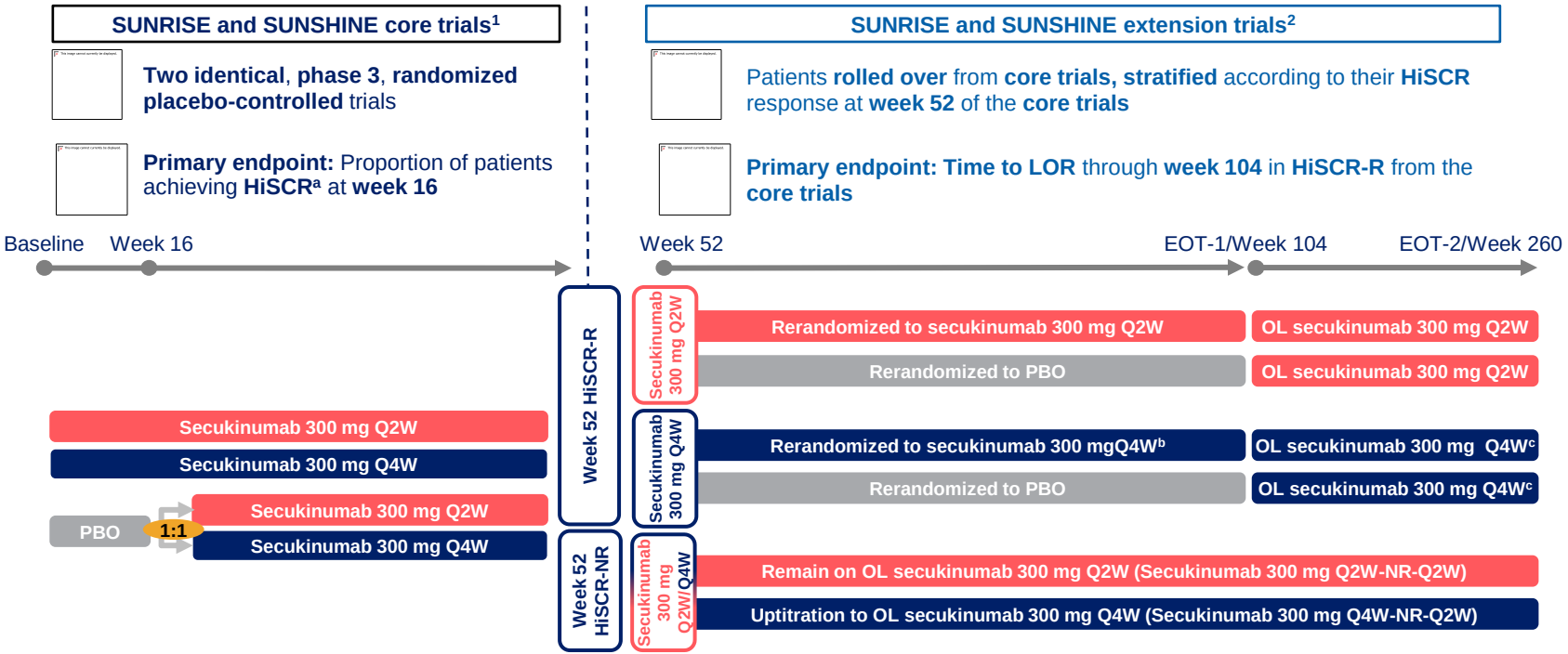


- Στο **δέρμα**, η IL-17A παράγεται κυρίως απο τα **Th17 κύτταρα, επαγώμενη** απο την IL-23[4]
- Στις **ειδικές εντοπίσεις** και στην **αξονική και περιφερική αρθρίτιδα** φαίνεται να παίζουν πιο σχετικό ρόλο τα κύτταρα **της φυσικής άμυνας** του οργανισμού. Αυτά κύτταρα του ανοσοποιητικού συστήματος ενεργοποιούνται απο διάφορες κυτοκίνες [9–11] και το μηχανικό στρες **ανεξάρτητα απο την IL-23**[1,3]

IL, interleukin; ILC3, Type 3 innate lymphoid cells; Th17, T helper 17 cells

1 Bissonette R et al. *JEADV* 2014;28:1298; 2. Lubberts E. *Nat Rev Rheumatol* 2015;11:415; 3. Schett G, et al. *Nat Rev Rheumatol* 2017;13:731; 4. De Marco G, et al. Rheumatology 2018;key199; 5. Abdelmaksoud A. *Clin Exp Dermatol* 2018;doi: 10.1111/ced.13644; 6. Rossini M, et al. *Rheumatol Int* 2016;36:469; 7. Appel H, et al. *Arthritis Res Ther* 2011;13:R95; 8. Kenna TJ, Brown MA. *Nat Rev Rheumatol* 2013;9:3759. Lowes MA, et al. *Trends Immunol* 2013;34;174; 10. Lin A, et al. *J Immunol* 2011;187:490; 11. Cai Y, et al. *Immunity* 2011;35:59612. Girolomoni G et al. *Br J Dermatol* 2012;167(4):717; 13. SmPC Secukinumab_16 October 2025

The SUNRISE and SUNSHINE trials represent the largest HS clinical development program to date, with up to 4 years of follow-up[1,2]



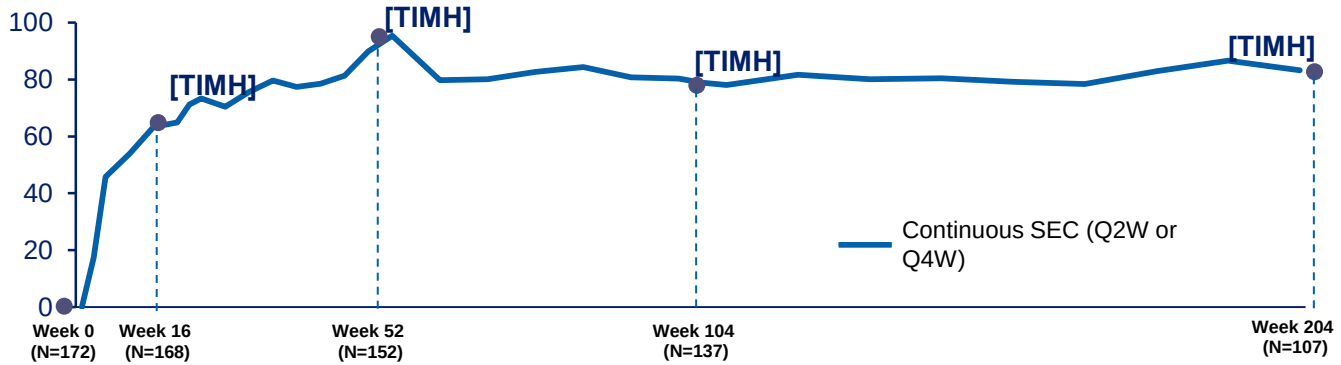
AN, abscesses and nodules; EOT-1/2, end of treatment period 1/2; FU, follow-up; HiSCR, Hidradenitis Suppurativa Clinical Response; HiSCR-NR, HiSCR non-responder at week 52 of the core trials; HiSCR-R, HiSCR responder at week 52 of the core trials; HS, hidradenitis suppurativa; LOR, loss of response; OL, open-label; PBO, placebo; Q2W, every 2 weeks; Q4W, every 4 weeks.

[a] HiSCR is defined as at least a 50% decrease in AN count with no increase in the number of abscesses and/or in the number of draining fistulae. [b] Switched to OL secukinumab 300 mg Q2W if LOR occurred before week 104. [c] May be uptitrated to the secukinumab 300 mg Q2W at the discretion of the principal investigator.

1. Kimball AB, et al. *Lancet*. 2023;401(10378):747-761; 2. Kimball AB, et al. *Br J Dermatol.* 2025;192(4):629-640; 3. Szepietowski JC, et al. Poster presented at: EHSF 2026; February 4-6, 2026; Valetta, Malta. Poster A-08-01.

Secukinumab was associated with sustained HiSCR50 for up to 4 years of treatment[1,2]

Proportion of patients (Week 52 HiSCR-R patients) achieving HiSCR50 with continuous[a] secukinumab treatment between baseline of core trials (Week 0)–Week 204



>80% of Week 52 HiSCR responders maintained HiSCR50 though Week 204, following treatment with continuous secukinumab 300 mg (Q2W or Q4W) from Week 0 to Week 204

Analysis of HiSCR-NR population demonstrated a similar trend.[2b]

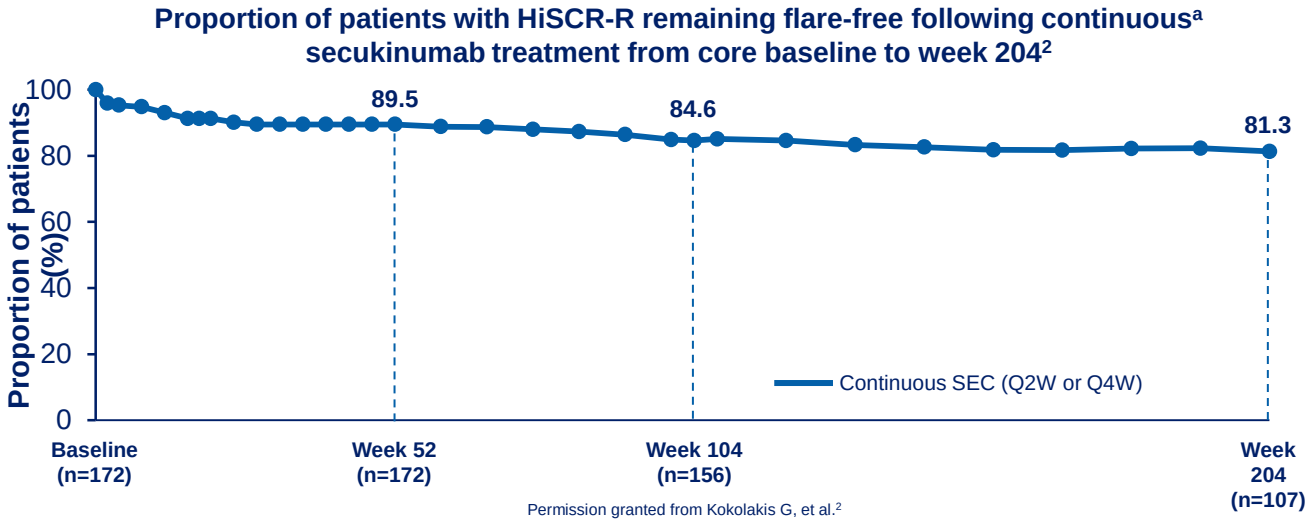
Statistical method used: Primary or secondary estimand up to week 16; data was presented as observed at weeks 52, 104 and 204.
[a]Visits across both randomized withdrawal and open-label periods were considered. [b]Post hoc analysis of Week 52 HiSCR-R/NR patients treated with continuous secukinumab 300 mg (Q2W or Q4W) from Week 0 to Week 204.

HiSCR, hidradenitis suppurativa clinical response; HiSCR-NR, HiSCR nonresponders at week 52 of the core trials; HiSCR-R, HiSCR-responders at week 52 of the core trials; IHS4, International Hidradenitis Suppurativa Severity Scoring System; PBO, placebo; Q2W, every 2 weeks; Q4W, every 4 weeks; SEC, secukinumab 300 mg. HiSCR75/90/100 was defined as a ≥75%/ ≥90%/100% reduction in abscess and inflammatory nodule count with no increase in the number of abscesses and/or draining tunnels versus core trials baseline.

1. Kimball AB, et al. *Lancet*. 2023;401(10378):747-761.

2. Abstracts of the 10th Annual Symposium on Hidradenitis Suppurativa Advances 2025. Dermatol Ther (Heidelb) (2025). https://doi.org/10.1007/s13555-025-01579-9

Secukinumab was associated with up to 4 years of flare-free status in patients receiving continuous treatment[1,2]



Permission granted from Kokolakis G, et al.[2]

According to the **GLOBAL VOICE** study, **>80%** of patients experience **flares** at least **once a month**[3b]

The proportion of **HiSCR-R** patients **remaining flare-free**[c] was **89.5%** at **week 52,** which was **sustained** up to **week 204 (81.3%)** following treatment with **continuous secukinumab 300 mg** (Q2W or Q4W)[2d]

Results are from a post-hoc analysis and should be interpreted with caution.

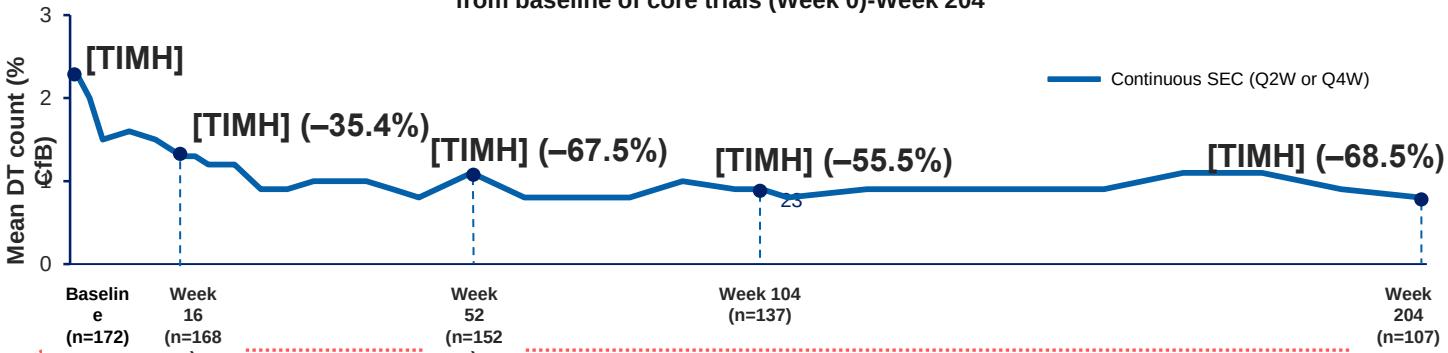
AN, abscesses and nodules; HiSCR, Hidradenitis Suppurativa Clinical Response; HiSCR-NR, HiSCR non-responder at week 52 of the core trials; HiSCR-R, HiSCR responder at week 52 of the core trials; HS, hidradenitis suppurativa; Q2W, every 2 weeks; Q4W, every 4 weeks; SEC, secukinumab 300 mg.

[a] Visits across both randomized withdrawal and open-label periods were considered. [b] The Global VOICE study was a prospective, multinational survey conducted between October 2017 and July 2018 in 1299 patients with HS. Among participants, 23.0% reported daily flares, 29.8% weekly flares, and 31.3% monthly flares.[3] [c] Flares were defined as a ≥25% increase in AN count with a minimum increase of 2 ANs compared with baseline.[1,2] [d] Post hoc analysis of week 52 HiSCR-R/NR patients treated with continuous secukinumab 300 mg (Q2W or Q4W) from week 0 to week 204.[2]

1. Kimball AB, et al. *Lancet*. 2023;401(10378):747-761; 2. Kokolakis G, et al. Oral presented at: EHSF 2026; February 4-6, 2026; Vialetta, Malta. Oral S-11-01;
3. Garg A, et al. *J Am Acad Dermatol.* 2020;82(2):366-376.

Consistent reductions in draining tunnels were observed in patients treated with secukinumab for up to 4 years[1]

Mean change from baseline in draining tunnels in Week 52 HiSCR-R patients treated with continuous[a] secukinumab from baseline of core trials (Week 0)-Week 204



The mean draining tunnel count **remained persistently low** in HiSCR-R patients through 4 years, following treatment with continuous secukinumab 300 mg (Q2W or Q4W) from Week 0 to Week 204 (mean count: 0.8; change from baseline: −68.5%)

Data are reported as observed and no formal hypothesis testing was performed

[a]Visits across both randomized withdrawal and open-label periods were considered.

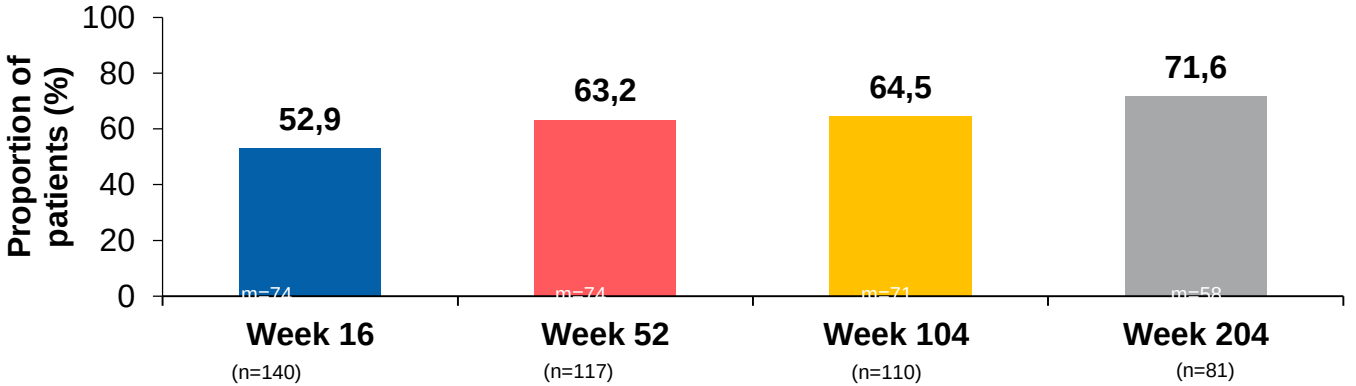
[b]Post hoc analysis of Week 52 HiSCR-R patients treated with continuous secukinumab 300 mg (Q2W or Q4W) from Week 0 to Week 204.

CfB, change from baseline; HiSCR, hidradenitis suppurativa clinical response; HiSCR-NR, HiSCR nonresponders at week 52 of the core trials; HiSCR-R, HiSCR-responders at week 52 of the core trials; HS, hidradenitis suppurativa; n, number of patients in the arm; Q2W, every 2 weeks; Q4W, every 4 weeks; SEC, secukinumab 300 mg.

1. Abstracts of the 10th Annual Symposium on Hidradenitis Suppurativa Advances 2025. Dermatol Ther (Heidelb) (2025). https://doi.org/10.1007/s13555-025-01579-9

Improvement in DLQI response was observed in patients treated with secukinumab for up to 4 years of treatment[1,2]

Proportion of HiSCR-R patients achieving DLQI response with continuous[a] secukinumab between baseline of core trials (Week 0) up to Week 204[2]



Improvements in DLQI response were observed in HiSCR-R patients through Week 204 following treatment with continuous secukinumab 300 mg (Q2W or Q4W) from Week 0 to Week 204[2b]

Data are reported as observed and no formal hypothesis testing was performed

[a]Visits across both randomized withdrawal and open-label periods were considered. [b]Post hoc analysis of Week 52 HiSCR-R patients treated with continuous secukinumab 300 mg (Q2W or Q4W) from Week 0 to Week 104.

DLQI response is defined as a decrease of ≥5 points on the DLQI total score.

DLQI, Dermatology Life Quality Index; HiSCR, hidradenitis suppurativa clinical response; HiSCR-R, HiSCR responders at week 52 of the core trials; HS, hidradenitis suppurativa; n, number of evaluable patients (non-missing and non-zero value at core trials baseline and non-missing value at the current visit); PBO, placebo; Q2W, every 2 weeks; Q4W, every 4 weeks; QoL, quality of life; SEC, secukinumab 300 mg.

1. Kimball AB, et al. *Lancet*. 2023;401(10378):747–61
2. Szepietowski JC, et al. Poster presented at the European Hidradenitis Suppurativa Foundation (EHSF), Valetta, Malta, 4th–6th February 2026 (PXXXX))
3. Kokolakis G, et al. *JEADV Clinical Practice*. 2025; 4:920–929

Η συνεχής θεραπεία με σεκουκινουμάμπη ήταν καλά ανεκτή για 4 έτη με τάση προς μείωση των EAIR

	Week 52: HiSCR-R and HiSCR-NR (N=372)*		Week 104: HiSCR-R and HiSCR-NR (N=372)*		Week 204: HiSCR-R and HiSCR-NR (N=372)*	
Patients with any AEs, n (%)	308 (82.8)		345 (92.7)		351 (94.4)	
Death†	0 (0.0)		0 (0.0)		2 (0.5)	
Non-fatal SAEs	21 (5.6)		65 (17.5)		79 (21.2)	
Discontinued study treatment due to any AEs	0 (0.0)		14 (3.8)		19 (5.1)	
Cumulative Exposure (weeks), median (IQR)	**52.3 (52.1, 53.3)**		**116.1 (114.3, 117.3)**		**215.1 (148.6, 217.0)**	
Most common TEAEs by preferred term‡	**EAIR**	**n / EX**	**EAIR**	**n / EX**	**EAIR**	**n / EX**
COVID-19	5.39	20 / 3.7	12.76	97 / 7.6	9.28	102 / 11.0
(Worsening of) hidradenitis	12.81	45 / 3.5	11.96	84 / 7.0	8.97	96 / 10.7
Headache	19.70	65 / 3.3	11.82	80 / 6.8	7.73	81 / 10.5
Nasopharyngitis	13.25	46 / 3.5	9.48	68 / 7.2	7.34	81 / 11.0
Upper respiratory tract infection	6.03	22 / 3.7	4.81	37 / 7.7	4.18	50 / 11.9
Diarrhea	7.84	28 / 3.6	4.68	35 / 7.5	3.13	37 / 11.8
Pyrexia	6.03	22 / 3.7	4.60	35 / 7.6	3.10	37 / 11.9

*Safety data are provided in a cumulative manner and includes all eligible patients through the associated timepoint and are inclusive of patients who may have discontinued treatment with secukinumab early; †Two deaths were reported and were both considered unrelated to treatment with secukinumab by the investigator. ‡Patients with multiple occurrences of a level under one treatment is counted only once for the same risk for that treatment. Furthermore, exposure time is censored at time of first event.

Porter ML, et al. Poster presented at the 10th Annual Symposium on Hidradenitis Suppurativa Advances (SHSA), Nashville, TN, USA October 31–November 02, 2025.

AE, adverse event; COVID-19, 2019 coronavirus disease; EAIR, exposure adjusted incidence rate; EX, exposure in 100 patient treatment years; HiSCR, Hidradenitis Suppurativa Clinical Response; HS, hidradenitis suppurativa; IQR, interquartile range; N, number of evaluable patients with non-missing and non-zero value at core trial baseline; n, number of patients with observed adverse event; NR, HiSCR non-responder at week 52 of the core trial;; R, HiSCR responder at week 52 of the core trial; SAE, serious adverse event; TEAE, treatment-emergent adverse event.

The use of secukinumab in the management of HS was evaluated over 2 years in routine clinical practice in Spain[1]

Retrospective, multicenter study including **263** patients with **HS** treated with **secukinumab** between 2020 and 2023[1]

Primary endpoint[1]:

- Proportion of patients achieving **HiSCR50** at week **104**

Secondary endpoints[1]:

- Achievement of **HiSCR75, IHS4-55, IHS4-75**
- Improvement in **DLQI**
- **Safety outcomes** including **AEs** and **drug discontinuation**

Baseline characteristics[1]:

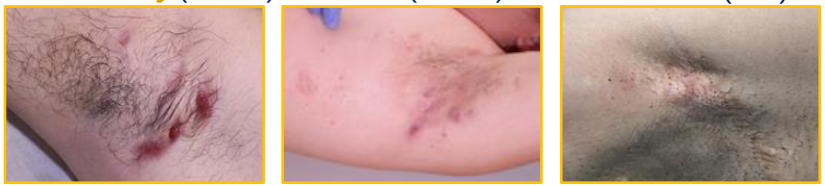
Women: n=130
Men: n=133

Mean age: 41.8 years

Mean DLQI: 15

HS phenotypes based on the Martorell classification

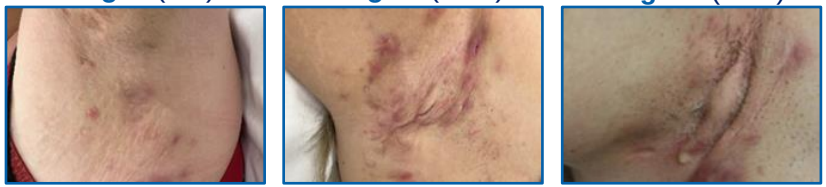
Inflammatory (n=126) **Mixed** (n=130) **Follicular** (n=7)



Permission granted from Martorell A, et al.[2]

HS phenotypes based on Hurley staging

Stage I (3%) **Stage II** (42%) **Stage III** (55%)



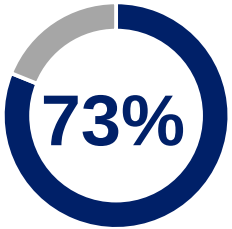
Adapted from Koerts NDK et al, with permission.[3]

AE, adverse event; DLQI, Dermatology Life Quality Index; HiSCR50, Hidradenitis Suppurativa Clinical Response 50; HiSCR575, Hidradenitis Suppurativa Clinical Response 75; HS, hidradenitis suppurativa; IHS4, International Hidradenitis Suppurativa Severity Score System; IHS4-55, International Hidradenitis Suppurativa Severity Score System 55; IHS4-75, International Hidradenitis Suppurativa Severity Score System 75; RWE, real-world evidence.

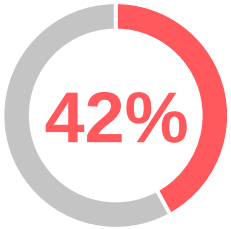
1. Martorell A, et al. Presented at EADV, September 17-20, 2025; Paris, France. Abstract 8217; 2. Martorell A, et al. *J Eur Acad Dermatol Venereol.* 2020;34(6):1309-1318;
3. Koerts NDK, et al. *Clin Dermatol*. 2023;41(5):601-610.

Secukinumab demonstrated sustained effectiveness through 2 years in routine clinical practice in Spain

IHS4 analysis:

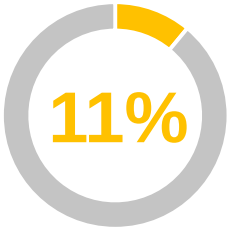


Of patients **reached IHS4-75** by **year 2**



Of patients who required **surgical interventions,** **77%** were **minor** (mainly **deroofing**)

Over 2 years:[a]



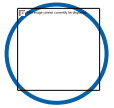
Required **antibiotics** or **systemic corticosteroids**, with an average of **0.7 flares/3 months**

DLQI: 2.2

Mean DLQI was **2.2** with a range of **1.0–3.2**

By **year 2,**

68% of patients who achieved **HiSCR75** at **week 16 continued treatment**



72% of patients required **biweekly dosing**

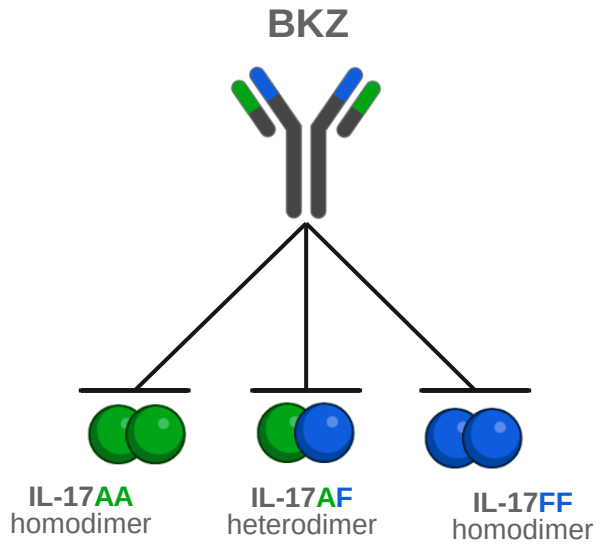
AE, adverse event; DLQI, Dermatology Life Quality Index; HiSCR, Hidradenitis Suppurativa Clinical Response; HS, hidradenitis suppurativa; IHS4, International Hidradenitis Suppurativa Severity Score System; IHS4-75, International Hidradenitis Suppurativa Severity Score System 75; RWE, real-world evidence.

[a] Number of patients who continued secukinumab 300 mg at week 104, n=76.

Martorell A, et al. Presented at EADV, September 17-20, 2025; Paris, France. Abstract 8217.

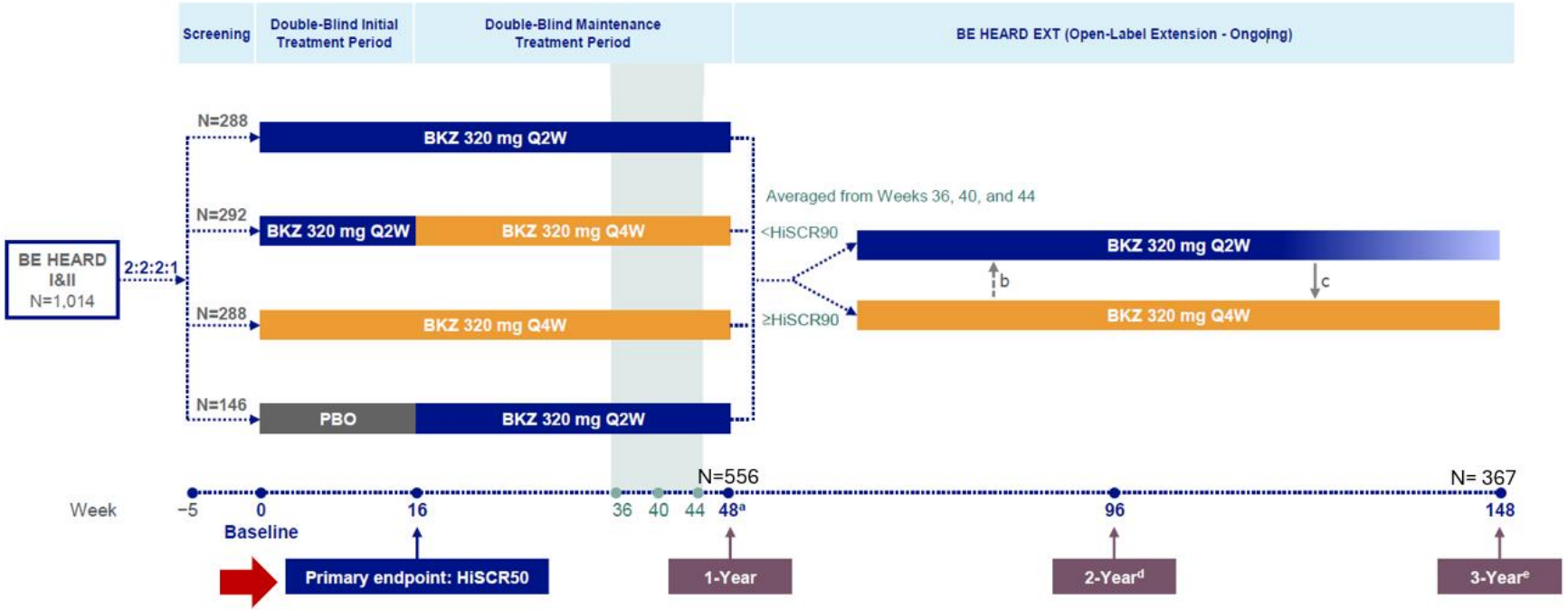
Μηχανισμός δράσης BKZ: Η διπλή εκλεκτική αναστολή της IL-17F και της IL-17A

- Το BKZ **αναστέλλει εκλεκτικά** τόσο την IL-17F όσο και την IL-17A.[1,2]
- Το BKZ **στοχεύει 3 διμερή**: IL-17A/A, IL-17A/F και IL-17F/F[2]
- Το BKZ **μειώνει την έκφραση προφλεγμονωδών γονιδίων** σε ασθενείς με Δ.Ι.[3,4]
- Τα αυξημένα επίπεδα IL-17F και IL-17A στον ιστό των βλαβών της Δ.Ι. **υποστηρίζουν την αξία της διπλής αναστολής**[3]



BKZ, bimekizumab; HS, hidradenitis suppurativa; IL, interleukin; PsO, psoriasis.
1. Glatt et al. Br J Clin Pharmacol. 2017;83:991–1001. 2. Adams et al. Frontiers Immunol. 2020;11:1894. 3. Rastrick et al. Br J Dermatol. 2024;ljae442. 4. Glatt et al. Ann Rheum Dis. 2018;77:523–32.

Εγκριτικές μελέτες φάσης 3 BE HEARD I/II & μελέτη ανοικτής επέκτασης BE HEARD EXT



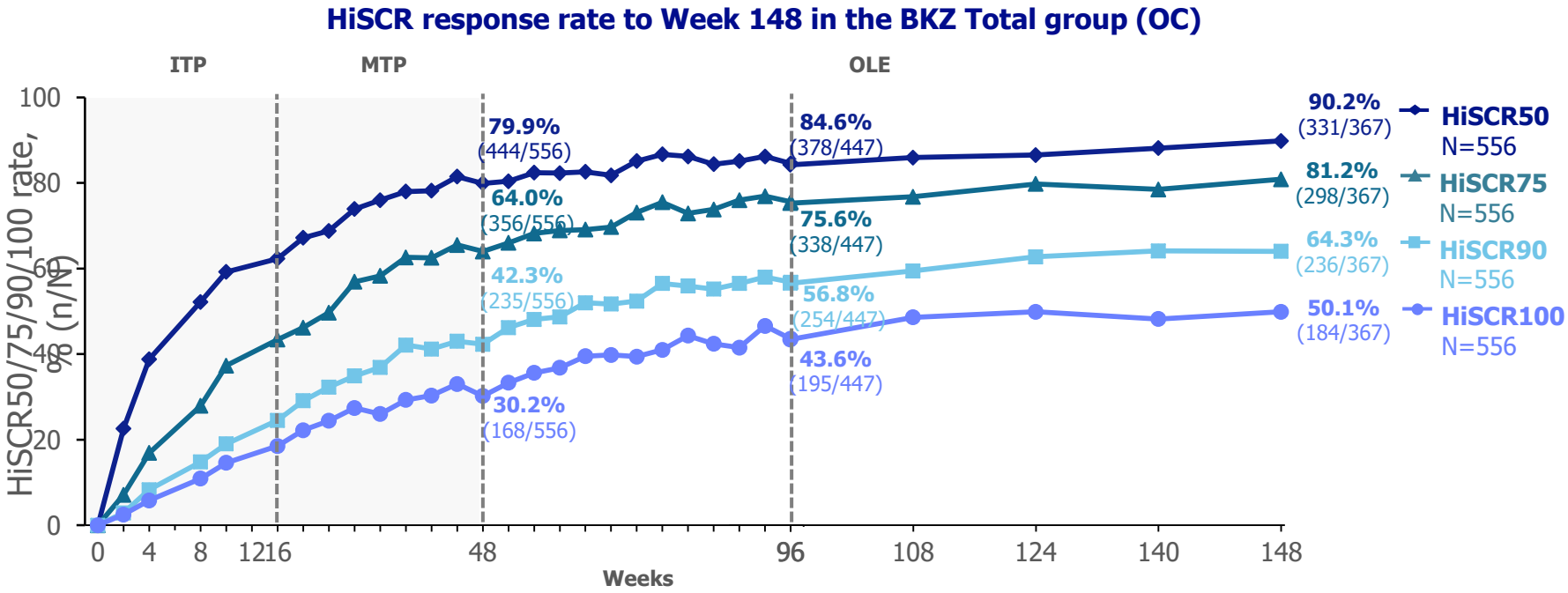
Οι κλινικές μελέτες του BKZ περιλαμβάνουν θεραπευτικά σκέλη εντός και εκτός ενδείξεων.
Ανατρέξτε στην τοπική ΠχΠ για την εγκεκριμένη δοσολογία.

Εγκεκριμένο δοσολογικό σχήμα BKZ 320mg Q2W μέχρι W16 και κατόπιν κάθε Q4W

**[a] Οι ασθενείς που ολοκλήρωσαν την 48η εβδομάδα των μελετών BE HEARD I & II μπορούσαν να ενταχθούν στη μελέτη BE HEARD EXT και να λάβουν με ανοιχτή επισήμανση(open label) BKZ κάθε 2 εβδομάδες (Q2W) ή κάθε 4 εβδομάδες (Q4W), με βάση την ανταπόκριση HiSCR90, χρησιμοποιώντας τον μέσο αριθμό βλαβών από τις Εβδομάδες 36, 40 και 44 των BE HEARD I & II. [b] Οι ασθενείς που λάμβαναν bimekizumab 320 mg κάθε 4 εβδομάδες (Q4W) στη BE HEARD EXT και δεν μπορούσαν να διατηρήσουν μέση βελτίωση >90% από την αρχική τιμή στον αριθμό AN σε οποιαδήποτε περίοδο 8 εβδομάδων ή να επιτύχουν >75% βελτίωση από την αρχική τιμή στον αριθμό AN σε οποιαδήποτε επίσκεψη, μπορούσαν να αυξήσουν τη δόση σε Q2W κατά την κρίση του ερευνητή. [c] Μετά την έγκριση τροποποίησης του πρωτοκόλλου στο τρίτο έτος, όλοι οι ασθενείς της BE HEARD EXT έπρεπε να λαμβάνουν BKZ Q4W. [d] Συγκεντρωτικά δεδομένα 2 ετών (48 εβδομάδες στις BE HEARD I & II και 48 εβδομάδες στη BE HEARD EXT). [e] Συγκεντρωτικά δεδομένα 3 ετών (48 εβδομάδες στις BE HEARD I & II και 96 εβδομάδες στη BE HEARD EXT).

1.Kimball AB et al. Lancet 2024;403:2504–19 (NCT04242446, NCT04242498);2. BE HEARD EXT: https://clinicaltrials.gov/study/NCT04901195. AN: αποστήματα και φλεγμονώδεις όζοι BKZ: bimekizumab, HiSCR50/90: ≥50%/90% μείωση από την αρχική τιμή στον συνολικό αριθμό AN χωρίς αύξηση από την αρχική τιμή στον αριθμό αποστημάτων ή συριγγίων με παροχέτευση, PBO: εικονικό φάρμακοQ2W: κάθε δύο εβδομάδεςQ4W: κάθε τέσσερις εβδομάδες . Προσαρμογή από από Ingram JR et al. EADV 2025. Παρουσίαση D1T01.2E

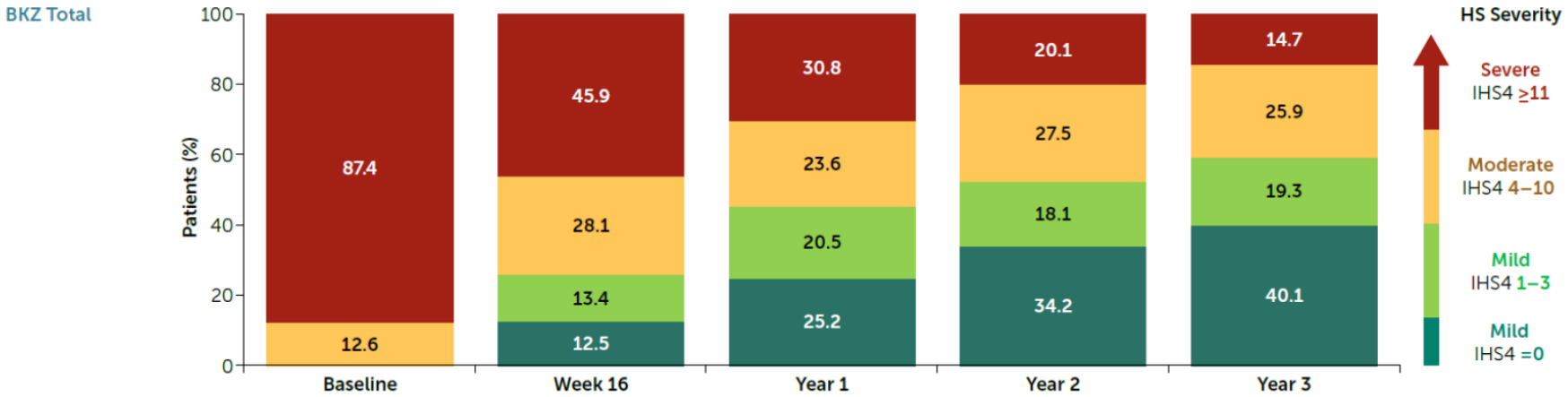
Το BKZ έδειξε κλινικά σημαντικές βελτιώσεις, οι οποίες διατηρήθηκαν έως τα 3 χρόνια για τα HiSCR50/75/90/100



Οι κλινικές μελέτες του BKZ περιλαμβάνουν θεραπευτικά σκέλη εντός και εκτός ενδείξεων. Ανατρέξτε στην τοπική ΠχΠ για την εγκεκριμένη δοσολογία.

OLE set. Data for patients in BKZ Total are presented. BKZ Total comprised patients randomised to BKZ from baseline in BE HEARD I&II who entered BE HEARD EXT. OC, n/N: denominator represents number of patients with a lesion assessment in the given week, and percentages are calculated accordingly (i.e., where data recorded after an intercurrent event are included as recorded). BKZ, bimekizumab; HiSCR, Hidradenitis Suppurativa Clinical Response; HiSCR50/75/90/100: ≥50%/75%/90%/100% reduction from baseline in the total abscess and inflammatory nodule count with no increase from baseline in abscess or draining tunnel count; ITP, initial treatment period; MTP, maintenance treatment period; OC, observed case; OLE, open-label extension; Q2W, every 2 weeks; Q4W, every 4 weeks; SmPC, Summary of Product Characteristics. 1. Ingram JR, et al. 2025. EADV. Presentation D1T01.2E.

Σταδιακή και διατηρούμενη βελτίωση της IHS4 βαρύτητας: Αυξανόμενα ποσοστά ασθενών με IHS4=0 έως τα 3 έτη



		Baseline	Week 16	Year 1	Year 2	Year 3
Severe	n/N (OC)	486/556	253/551	171/556	90/447	54/367
Moderate	n/N (OC)	70/556	155/551	131/556	123/447	95/367
Mild (IHS4 1–3)	n/N (OC)	0/556	74/551	114/556	81/447	71/367
Mild (IHS4 =0)	n/N (OC)	0/556	69/551	140/556	153/447	147/367

IHS4:

Number of **nodules** x1 + Number of **abscesses** x2 + Number of **draining tunnels** x4

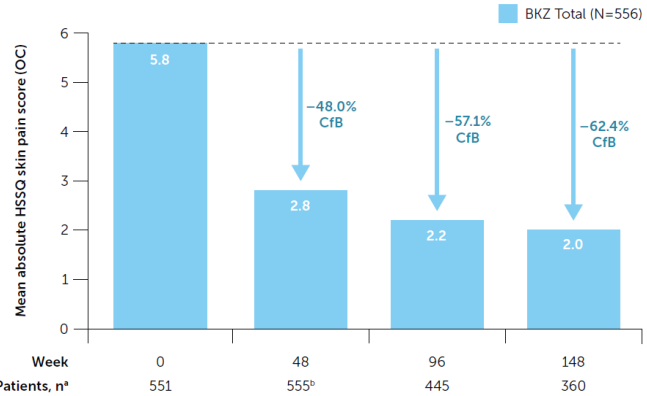
Παρόμοιες τάσεις παρατηρήθηκαν τόσο στα δεδομένα OC όσο και στα δεδομένα mNRI.

Οι κλινικές μελέτες του BKZ περιλαμβάνουν θεραπευτικά σκέλη εντός και εκτός ενδείξεων. ανατρέξτε στην τοπική ΠχΠ για την εγκεκριμένη δοσολογία.

OC, N represents the number of participants with non-missing data at the given week, and percentages are calculated accordingly. Percentages may not sum to 100 due to rounding. BKZ: bimekizumab; HS: hidradenitis suppurativa; IHS4: International Hidradenitis Suppurativa Severity Score System; OC: observed case. All content on this slide is from Zouboulis CC et al. EHSF 2026. Poster A-08-28.

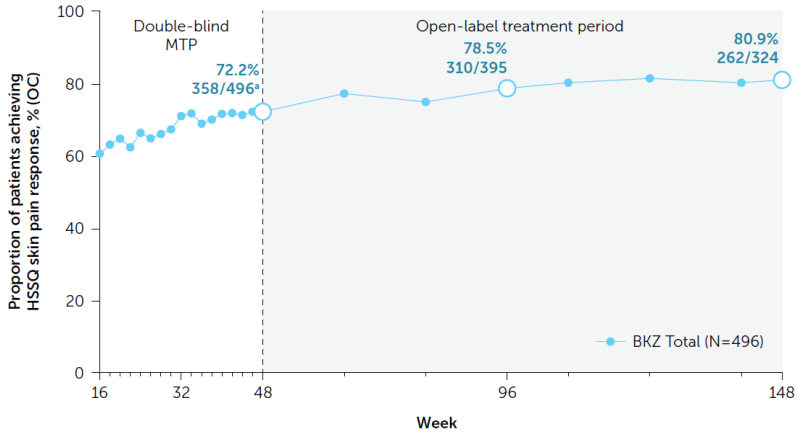
Μεταβολή και ανταπόκριση (HSSQ) πόνου στο δέρμα σε διάστημα 3 ετών

Απόλυτη & Ποσοστιαία Μεταβολή HSSQ



Week	0	48	96	148
Mean absolute HSSQ skin pain score (**MI**)[c]	5.8	2.8	2.4	2.2
Mean percentage CfB in HSSQ skin pain score, % (**MI**)[d]	N/A	−48.1%	−55.1%	−57.5%

Ανταπόκριση πόνου στο δέρμα (HSSQ)



Week	48	96	148
Proportion of patients, % (**mNRI**)[b]	72.2%	72.1%	71.1%

Οι κλινικές μελέτες του BKZ περιλαμβάνουν θεραπευτικά σκέλη εντός και εκτός ενδείξεων. Ανατρέξτε στην τοπική ΠχΠ για την εγκεκριμένη δοσολογία.

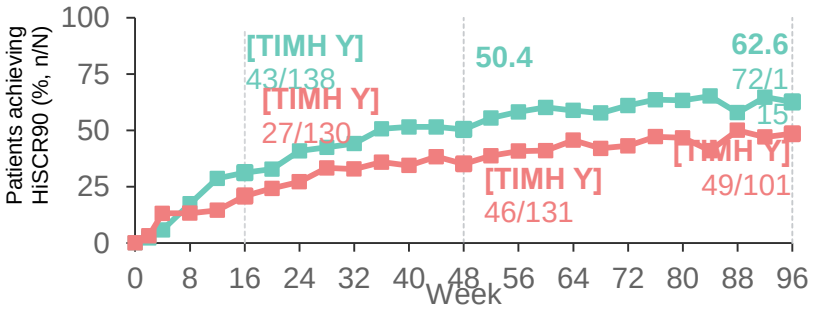
Fig 1 [a] For OC, n numbers are reported for mean absolute HSSQ skin pain score in the given week. Mean percentage CfB in HSSQ skin pain scores, n: Week 48, 543; Week 96, 436; Week 148, 354. **[b]** The requirement of a visit at Week 48 to enter the OLE resulted in an increase in n number at Week 48. **[c]** For MI, N=555 for mean absolute HSSQ skin pain score. **[d]** For MI, N=547 for percentage CfB in HSSQ skin pain score. BKZ: bimekizumab; CfB: change from baseline; HSSQ: Hidradenitis Suppurativa Symptom Questionnaire; MI: multiple imputation; OC: observed case; OLE: open-label extension; SD: standard deviation. Fig 2 OC, n/N: n represents patients achieving skin pain response at the given week, defined as a 30% reduction and ≥1-point reduction in patients with a baseline score of ≥3; N represents the total number of patients reporting on skin pain at the given week. [a] The requirement of a visit at Week 48 to enter the OLE resulted in an increase in N number at Week 48. [b] For mNRI, N=496 mNRI: modified non-responder imputation; MTP: maintenance treatment period; Προσαρμογή από Lev-Tov H et al. SHSA 2025. Poster 3000490.

Οι ασθενείς που έλαβαν θεραπεία με BKZ νωρίτερα στην πορεία της νόσου (<2.38 years) είχαν καλύτερα αποτελέσματα σε σύγκριση με ασθενείς που έλαβαν θεραπεία αργότερα (≥10.74 years)

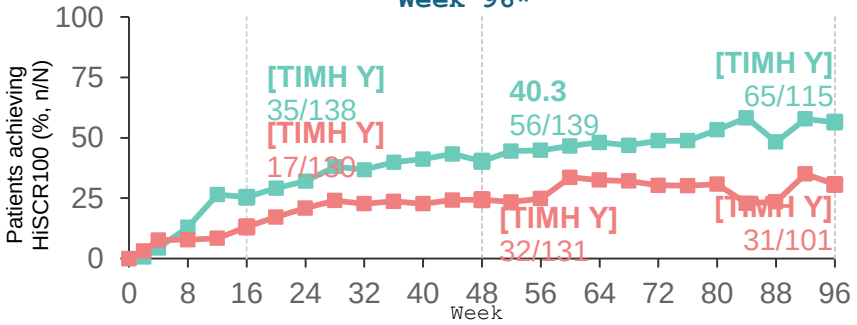
Pooled BE HEARD I and II data (OC)

Pooled data of all patients on BKZ 320 mg at baseline. The approved dosing regimen is 320 mg Q2W up to Week 16, and Q4W thereafter. The OLE included on-label and off-label dosing.

HiSCR90 response by lowest and highest disease duration quartiles over time, to Week 96*



HiSCR100 response by lowest and highest disease duration quartiles over time, to Week 96*



Disease duration <2.38 years (BKZ 320 mg Total N=139)

Disease duration ≥10.74 years (BKZ 320 mg Total N=131)

Οι κλινικές μελέτες του BKZ περιλαμβάνουν θεραπευτικά σκέλη εντός και εκτός ενδείξεων. Ανατρέξτε στην τοπική ΠχΠ για την εγκεκριμένη δοσολογία.

*The disease duration (years) was calculated using the date of randomisation and the date of HS diagnosis; the lowest and the highest disease duration quartiles were chosen for the analyses. OLE set; only included patients who entered BE HEARD EXT at Week 48. BKZ Total (N=556) comprised patients randomized to BKZ from baseline in BE HEARD I and II who entered BE HEARD EXT and continued to receive BKZ. OC, n/N: denominator represents number of patients with a non-missing lesion count assessment in the given week, and percentages are calculated accordingly. BKZ, bimekizumab; HiSCR, HS Clinical Response; HiSCR90/100, ≥90/100% reduction in the total abscess and inflammatory nodule count from baseline with no increase from baseline in abscess or draining tunnel count; HS, hidradenitis suppurativa; OC, observed case; OLE, open-label extension. Figures adapted from reference. Chovatiya et al. 2025. AAD. Presentation 61888.

Συχνότητα TEAEs ανά 100 έτη ασθενών- BE HEARD I, II & BE HEARD EXT

EAIR/100 PY (95% CI)	Patients with ≥1 dose BKZ N=995			
	Year 1 (Week 0–48) Total exposure: 7.8 per 100 PY	Year 2 (Week >48–96) Total exposure: 5.9 per 100 PY	Year 3 (Week >96–144) Total exposure: 4.7 per 100 PY	Up to 3 Years (Week 0–144) Total exposure: 18.4 per 100 PY
Any TEAE	261.9 (244.5, 280.3)	237.2 (218.3, 257.2)	168.3 (152.2, 185.6)	226.8 (212.4, 242.0)
Serious TEAEs	8.2 (6.3, 10.5)	7.9 (5.7, 10.5)	7.9 (5.5, 10.9)	7.2 (6.0, 8.6)
Severe TEAEs	10.4 (8.2, 12.9)	7.2 (5.2, 9.8)	7.0 (4.8, 9.9)	7.7 (6.4, 9.1)
TEAEs leading to discontinuation	8.7 (6.8, 11.1)	4.8 (3.2, 7.0)	3.0 (1.7, 5.1)	6.0 (5.0, 7.3)
Any TEAE leading to death[a]	0.1 (0.0, 0.7)	0.3 (0.0, 1.2)	0	0.2 (0.0, 0.5)
Most common TEAEs[b]				
Hidradenitis	25.5 (21.9, 29.5)	27.4 (23.1, 32.2)	18.2 (14.4, 22.7)	20.7 (18.5, 23.2)
Coronavirus infection	13.6 (11.1, 16.5)	23.7 (19.7, 28.2)	7.5 (5.2, 10.5)	15.3 (13.4, 17.4)
Oral candidiasis	15.2 (12.5, 18.2)	12.3 (9.5, 15.6)	10.3 (7.5, 13.8)	10.4 (8.9, 12.1)
Serious infections	1.9 (1.1, 3.2)	1.7 (0.8, 3.2)	3.2 (1.8, 5.3)	2.0 (1.4, 2.8)
Fungal infections	34.8 (30.5, 39.6)	25.0 (20.9, 29.7)	22.3 (18.0, 27.2)	24.4 (21.9, 27.1)
Any malignancies	0.5 (0.1, 1.3)	1.0 (0.4, 2.2)	0.6 (0.1, 1.9)	0.7 (0.4, 1.2)
Any hepatic events	6.0 (4.4, 8.0)	5.8 (4.0, 8.2)	4.6 (2.8, 7.0)	4.7 (3.8, 5.9)
Adjudicated suicidal ideation and behaviour[c]	0.8 (0.3, 1.7)	0.9 (0.3, 2.0)	0.4 (0.1, 1.6)	0.7 (0.4, 1.2)
Definite or probable adjudicated IBD[d]	0.9 (0.4, 1.8)	0.5 (0.1, 1.5)	0.2 (0.0, 1.2)	0.5 (0.3, 1.0)

Οι κλινικές μελέτες του BKZ περιλαμβάνουν θεραπευτικά σκέλη εντός και εκτός ενδείξεων. Ανατρέξτε στην τοπική ΠχΠ για την εγκεκριμένη δοσολογία.

Τα δεδομένα που παρουσιάζονται αφορούν την αρχική θεραπευτική περίοδο και την περίοδο συντήρησης των μελετών BE HEARD I & II, καθώς και την ανοικτή επέκταση BE HEARD EXT (συνολική διάρκεια 3 ετών). Τα ανεπιθύμητα συμβάντα που εμφανίστηκαν κατά τη διάρκεια της θεραπείας (TEAEs) κωδικοποιήθηκαν με χρήση του MedDRA v19.0 και αναφέρθηκαν για διάστημα έως και 3 ετών θεραπείας με BKZ (bimekizumab), χρησιμοποιώντας EAIRs (ρυθμοί επίπτωσης προσαρμοσμένοι στην έκθεση) ανά 100 ασθενή-έτη.[a] Μέχρι και τα 3 έτη, τρεις ασθενείς απεβίωσαν: Ένας ασθενής με σημαντικό καρδιαγγειακό ιστορικό απεβίωσε λόγω καρδιακής ανεπάρκειας, ένας ασθενής απεβίωσε λόγω πιθανής λοίμωξης του κεντρικού νευρικού συστήματος, στο πλαίσιο επιδεινούμενης Δ.Ι, ένας ασθενής με ιστορικό γυναικολογικού καρκίνου απεβίωσε από λειομυοσάρκωμα. [b] Οι τρεις πιο συχνές ανεπιθύμητες ενέργειες (TEAEs) παρουσιάζονται κατά φθίνουσα σειρά βάσει των δεδομένων έως και 3 ετών. [c] Δεν καταγράφηκαν περιστατικά ολοκληρωμένης αυτοκτονίας. [d] Από τους οκτώ ασθενείς με ιστορικό φλεγμονώδους νόσου του εντέρου (IBD), δύο παρουσίασαν εξάρσεις εντός των 3 ετών. BKZ: bimekizumab, CI: διάστημα εμπιστοσύνης (confidence interval)EAIR: ρυθμός επίπτωσης προσαρμοσμένος στην έκθεση (exposure-adjusted incidence rate) Δ.Ι.,: Διαπυητική ιδρωταδενίτιδα (hidradenitis suppurativa)IBD: φλεγμονώδης νόσος του εντέρου (inflammatory bowel disease)MedDRA: Ιατρικό Λεξικό για Ρυθμιστικές Δραστηριότητες (Medical Dictionary for Regulatory Activities)PY: ασθενή-έτη (patient-years)TEAEs: ανεπιθύμητες ενέργειες που εμφανίστηκαν κατά τη διάρκεια της θεραπείας (treatment-emergent adverse events) Προσαρμογή από Ingram JR et al. EADV 2025. Presentation D1T01.2E.

Abstract

Introduction: This second part of the S2k guidelines is an update of the 2015 S1 European guidelines.

Objective: These guidelines aim to provide an accepted decision aid for the selection, implementation and assessment of appropriate and sufficient therapy for patients with hidradenitis suppurativa/acne inversa (HS).

Methods: The chapters have been selected after a Delphi procedure among the experts/authors. Certain passages have been adopted without changes from the previous version. Potential treatment complications are not included, being beyond the scope of these guidelines.

Results: Since the S1 guidelines publication, validation of new therapeutic approaches has almost completely overhauled the knowledge in the field of HS treatment. Inflammatory nodules/abscesses/draining tunnels are the primary lesions, which enable the classification of the disease severity by new validated tools. In relation to the degree of detectable inflammation, HS is classified into the inflammatory and the predominantly non-inflammatory forms. While the intensity of the inflammatory form can be subdivided by the IHS4 classification in mild, moderate and severe HS and is treated by medication accordingly, the decision on surgical treatment of the predominantly non-inflammatory form is based on the Hurley stage of the affected localization. The effectiveness of oral tetracyclines as an alternative to the oral combination of clindamycin/rifampicin should be noted. The duration of systemic antibiotic therapy can be shortened by a 5-day intravenous clindamycin treatment. Adalimumab, secukinumab and bimekizumab subcutaneous administration has been approved by the EMA for the treatment of moderate-to-severe HS. Various surgical procedures are available for the predominantly non-inflammatory form of the disease. The combination of a medical therapy to reduce inflammation with a surgical procedure to remove irreversible tissue damage is currently considered a holistic therapeutic approach.

Conclusions: Suitable therapeutic options while considering HS severity in the therapeutic algorithm according to standardized criteria are aimed at ensuring a proper therapy.

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GUIDELINES

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European S2k guidelines for hidradenitis suppurativa/acne inversa part 2: Treatment

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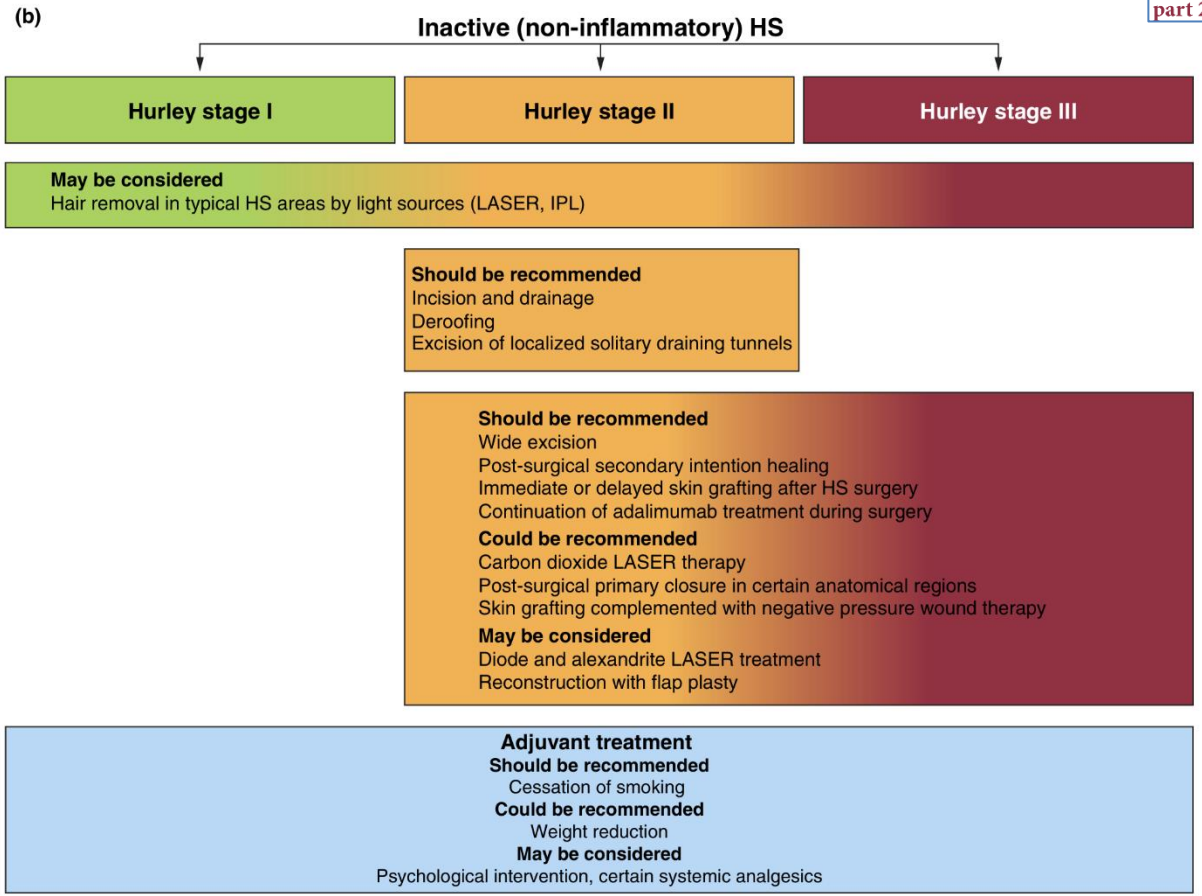

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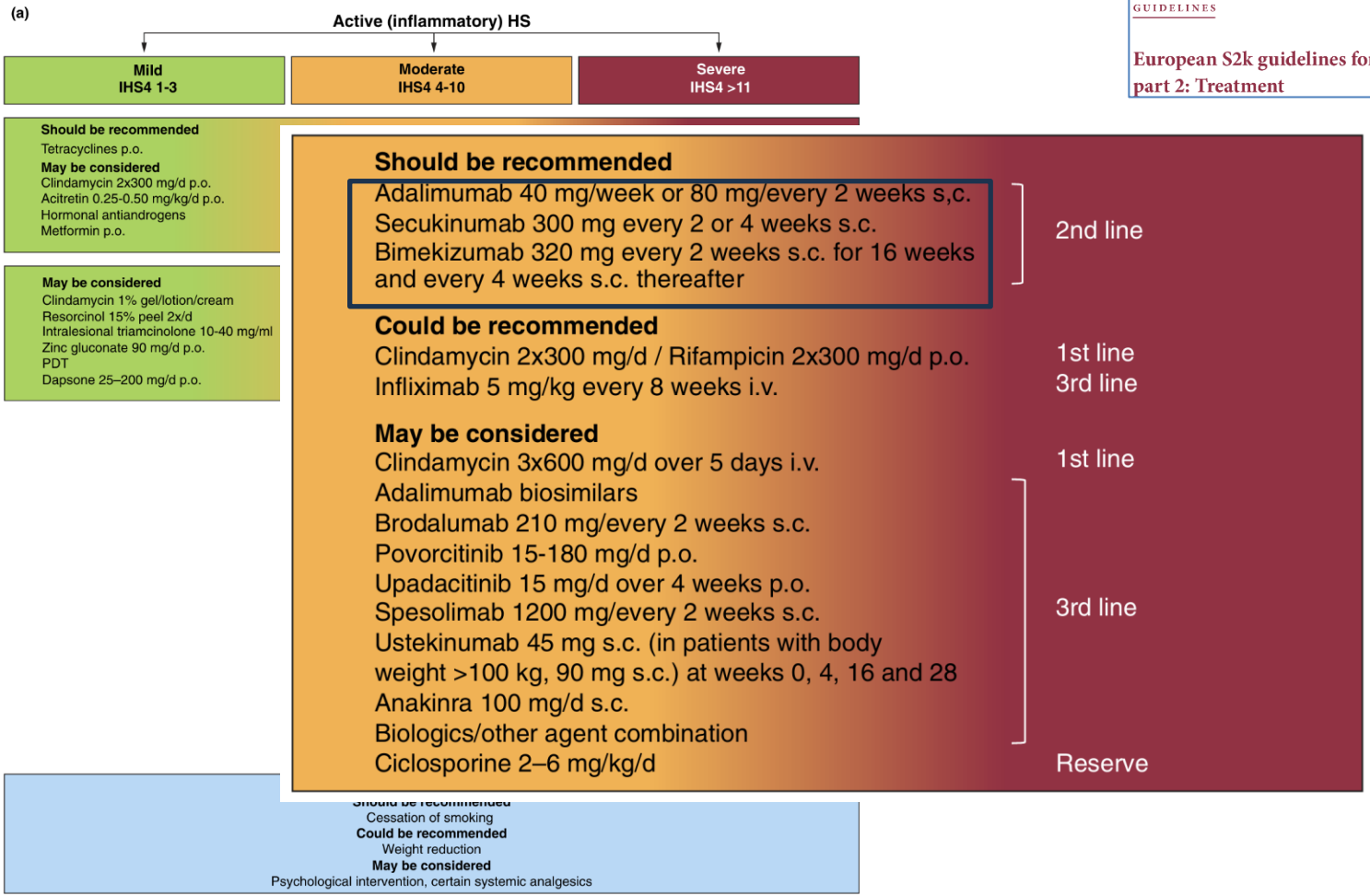

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European S2k guidelines for hidradenitis suppurativa/acne inversa part 2: Treatment

TABLE 2 Eligibility criteria for biologics and advanced molecules.

Criteria	Value	References
Moderate-to-severe objective disease severity	IHS4 ≥4 or HS-PGA ≥3 (moderate) or Refined Hurley: IC, IIB, IIC, III or Increase in Hurley stage	[4,6,113,151]
Significant impairment of quality of life	DLQI >10 or HS-QoL >20	[152,153]
Clinical signs of unstable/progressive disease	Several outbreaks per year or Rapidly progressive disease or Extensive disease	[154]
Special clinical scenarios	Special locations: genital area, face, scalp, neck or Signs of local complications: lymphedema	[155]

Anti-TNFα και AI

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GUIDELINES

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European S2k guidelines for hidradenitis suppurativa/acne inversa part 2: Treatment

Adalimumab as a first line treatment for patients (>12 years) with moderate-to-severe HS and an inadequate response to conventional systemic HS therapy			
Strength		**Agreement**	
↑↑	Should be recommended	Strong consensus	34/34 (100%)

Adalimumab for pediatric patients (>12 years) with moderate-to-severe HS and an inadequate response to conventional systemic HS therapy			
Strength		**Agreement**	
↑↑	Should be recommended	Strong consensus	34/34 (100%)

Infliximab as a second line biologic treatment in patients with moderate-to-severe HS if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↑	Could be recommended	Majority agreement	17/34 (50%)* *Chairman's vote

Certolizumab pegol in the treatment of moderate-to-severe HS as a second line biologic treatment if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↓	Is not recommended	Strong consensus	28/29 (97%)

Etanercept in the treatment of moderate-to-severe HS as a second line biologic treatment if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↓	Is not recommended	Consensus	28/34 (82%)

Intra-class switching to other anti-TNF agents in secondary non-responders			
Strength		**Agreement**	
↔	May be considered	Strong consensus	29/29 (100%)

5;39:899–941.

Anti-IL17 και ΔΙ

Secukinumab as a first line biologic treatment in patients with moderate-to-severe HS and an inadequate response to conventional systemic HS therapy			
Strength		**Agreement**	
↑↑	Should be recommended	Consensus	32/35 (91%)

Bimekizumab as a first line biologic treatment in patients with moderate-to-severe HS and an inadequate response to conventional systemic HS therapy			
Strength		**Agreement**	
↑↑	Should be recommended	Consensus	32/35 (91%)

Brodalumab as a second line biologic treatment in patients with moderate-to-severe HS if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↔	May be considered	Consensus	32/34 (94%)

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GUIDELINES

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Anti-IL1 και ΔΙ

Anakinra as a second line biologic treatment in patients with moderate-to-severe HS if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↔	May be considered	Majority agreement	20/34 (59%)

Bermekimab as a second line biologic treatment in patients with moderate-to-severe HS if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↓	Is not recommended	Majority agreement	23/34 (68%)

Anti-IL36 και ΔΙ

Spesolimab as a second line biologic treatment in patients with moderate-to-severe HS with draining tunnels if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↔	May be considered	Majority agreement	22/35 (63%)

Anti-IL12/23, anti-IL23 και ΔΙ

Ustekinumab as a second line biologic treatment in patients with moderate-to-severe HS if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↔	May be	Majority	20/32

Guselkumab as a second line biologic treatment in patients with moderate-to-severe HS if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↓	Is not recommended	Majority agreement	16/32 (50%)

Risankizumab as a second line biologic treatment in patients with moderate-to-severe HS if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↓	Is not recommended	Strong consensus	29/29 (100%)

Jak αναστολείς

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GUIDELINES

JEADV

European S2k guidelines for hidradenitis suppurativa/acne inversa part 2: Treatment

Povorcitinib as a second line biologic treatment in patients with moderate-to-severe HS if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↔	May be considered	Consensus	31/34 (91%)

Upadacitinib as a second line biologic treatment in patients with moderate-to-severe HS if the result of first-line biologic treatment is unsatisfactory			
Strength		**Agreement**	
↔	May be considered	Majority agreement	22/35 (63%)

J Eur Acad Dermatol Venereol. 2025;39:899–941.

Table 1. Demographic Characteristics of Our Patients at Baseline.

Total Patients	41 N (%)
Female	28 (68.3)
At least one cardiometabolic comorbidity	23 (56.1)
Smokers	23 (56.1)
Previously treated with adalimumab	35 (85.4)
Hurley II	17 (41.5)
Hurley III	24 (58.5)
Obese	13 (31.7)
Current biological drug	
Secukinumab	27 (65.9)
Brodalumab	1 (2.4)
Ixekizumab	5 (12.2)
Bimekizumab	2 (4.9)
Risankizumab	1 (2.4)
Guselkumab	5 (12.2)
	Mean (SD)
Age, years	40.59 (15)
BMI	27.94 (4.65)
IHS4 at baseline	29.49 (21.93)
DLQI at baseline	20.88 (7.08)

Abbreviations: BMI: body mass index; IHS4: International Hidradenitis Suppurativa Severity Scoring System 4; DLQI: Dermatology Life Quality Index; SD: standard deviation.

Dermatology Practical & Conceptual

Anti-IL-17/23 Drugs for the Treatment of Moderate-to-Severe Hidradenitis Suppurativa in Patients With Concomitant Psoriasis: A Multicenter Retrospective Study

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ABSTRACT

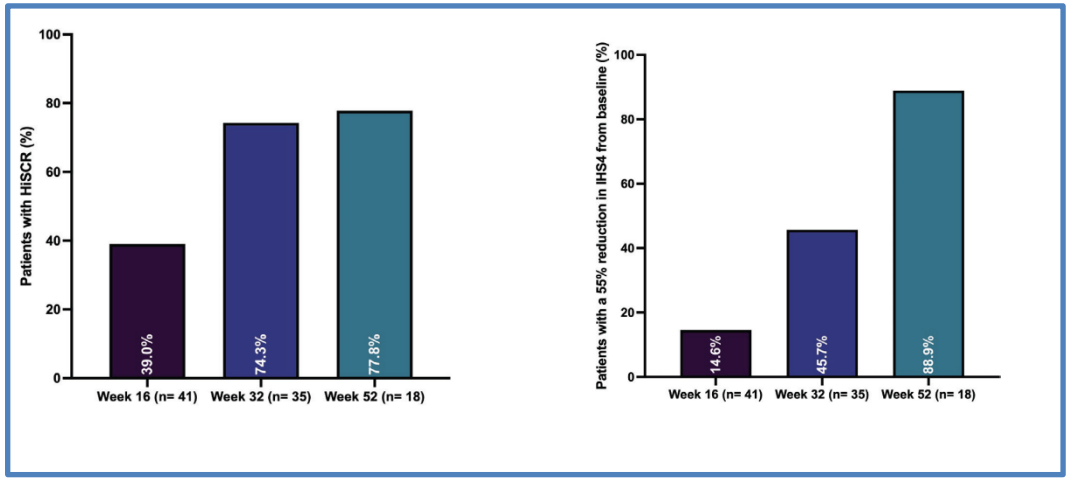
Introduction: Psoriasis and hidradenitis suppurativa (HS) are chronic inflammatory diseases with significant overlap in their immunologic pathways, which involve cytokines such as tumor necrosis factor-alfa, interleukin (IL)-17, and IL-23. Current treatment options for HS are limited, as only adalimumab and secukinumab are approved for severe cases. Given the overlapping pathogenetic features between HS and psoriasis, anti-IL-17 and anti-IL-23 drugs could represent valuable treatments for the management of HS.

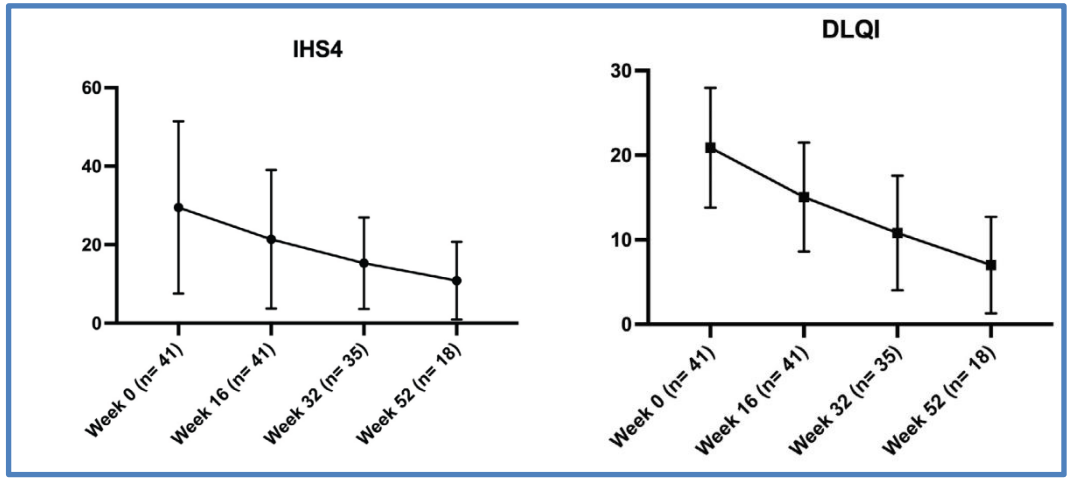
Objectives: We sought to evaluate the effectiveness and safety of anti-IL-17 and anti-IL-23 drugs in patients with HS and concomitant moderate-to-severe plaque psoriasis.

Methods: We conducted a multicenter retrospective study in 11 Italian Dermatology Units. The effectiveness of the drugs was evaluated by assessing the percentage of patients achieving HS Clinical Response (HiSCR) each week.

Results: We enrolled 41 patients with at least 16 weeks of follow-up, with 17 of them completing 52 weeks of treatment. The most commonly prescribed anti-IL drug was secukinumab (27 patients), followed by ixekizumab (5) and guselkumab (5). The HiSCR was achieved by 39%, 74.3%, and 77.8% of patients after 16, 32, and 52 weeks, respectively. No severe adverse events (AEs) or AEs leading to discontinuation were observed during the study. The most common AE was nasopharyngitis (four patients).

Conclusion: In this real-world study, we highlight the effectiveness of anti-IL-23 and anti-IL-17 drugs in the treatment of concomitant plaque psoriasis and severe HS. Longer and larger studies are needed to further evaluate the long-term effectiveness and safety of these treatments in patients affected by HS.





Dermatology Practical & Conceptual

Anti-IL-17/23 Drugs for the Treatment of Moderate-to-Severe Hidradenitis Suppurativa in Patients With Concomitant Psoriasis: A Multicenter Retrospective Study

Luigi Gargiulo[1,2], Luciano Ibba[1,2], Alessandra Narcisi[1], Silvia Giordano[3], Carlo A. Maronese[4,5], Fabrizio Martora[6], Federica Repetto[3], Giovanni Paolino[7], Anna Balato[8], Martina Burlando[9], Paolo Dapavo[3], Valentina Dini[10], Claudio Guarneri[11], Angelo V. Marzano[4,5], Matteo Megna[6], Santo R. Mercuri[7], Antonio Costanzo[1,2], Mario Valenti[1,2]

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SHORT COMMUNICATION

Efficacy and Safety of Risankizumab in Hidradenitis Suppurativa: A Case Series

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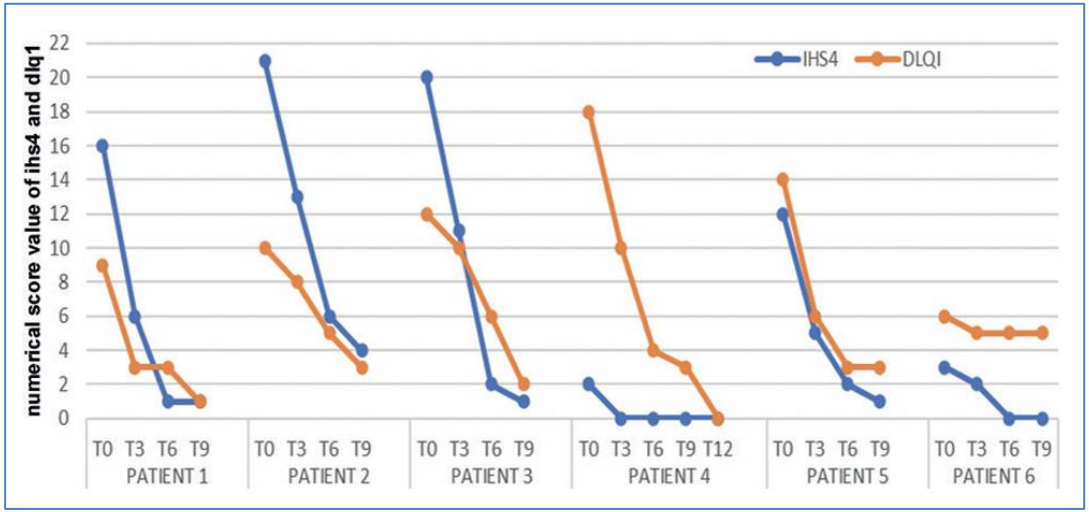
Table I. Observed clinical response to risankizumab in group 1 (patients 1-2-3) and group 2 (patients 4-5-6) at follow-up every 3 months

	Patient 1				Patient 2				Patient 3				Patient 4					Patient 5				Patient 6			
	T0	T3	T6	T9	T0	T3	T6	T9	T0	T3	T6	T9	T0	T3	T6	T9	T12	T0	T3	T6	T9	T0	T3	T6	T9
Hurley stage	II	II	II	II	III	III	III	III	III	III	III	III	II	II	II	II	II	III	III	III	III	III	III	III	III
Inflammatory nodule	4	2	1	1	5	5	2	0	8	5	2	1	0	0	0	0	0	2	1	2	1	0	0	0	0
Non inflammatory nodule	0	0	0	0	1	1	1	1	2	5	6	7	7	3	3	2	1	4	3	3	2	3	3	2	1
Abscess count	2	0	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	1	0	0	0	1	1	0	0
Draining fistulas count	2	1	0	0	4	2	1	2	2	1	0	0	0	0	0	0	0	2	1	0	0	0	0	0	0
IHS4	16	6	1	1	22	14	7	9	22	16	8	8	7	3	3	2	1	16	8	5	3	5	5	2	1
HiscR		1	1	1		0	1	1		0	1	1		1	1	1	1		1	1	1		0	1	1
DLQI	9	3	3	1	10	10	8	7	2	2	1	1	18	10	4	3	0	14	6	3	3	6	5	5	5
PASI													14	8	0	0	0	16	4	0	0	7	3	0	0

IHS4: Hidradenitis Suppurativa Severity Score System; HiscR: Hidradenitis Suppurativa Clinical Response (achieved=1, non-achieved=0); DLQI: Dermatology Quality of Life Index; PASI: Psoriasis Area Severity Index. The shaded area in the table refers to the fact that patients 1-2-3 belong to group 1, in which risankizumab therapy was set after approval by rare diseases and not due to onset of paradoxical psoriasis. Not having paradoxical psoriasis, no PASI values were expressed.



Hidradenitis suppurativa (HS) is a chronic, recurrent, inflammatory skin disease of the apocrine gland-bearing areas, characterized by painful nodules, abscesses, fistulas and scarring. The pathophysiology has not been clearly defined, but HS is considered a multifactorial disease with the involvement of several immunological factors.

An upregulation of various cytokines, such as tumour necrosis factor (TNF)-α, interleukin (IL)-1, IL-17, IL-23 contribute to the genesis of the inflammatory component characteristic of the disease (1). Adalimumab, a TNF-α inhibitor, is the only US Food and Drug Administration (FDA) approved biologic agent for moderate-to-severe HS (2), but new therapeutic options are being studied, targeting different specific cytokines involved in HS pathogenesis. The aim of this study is to provide an overview of the efficacy and safety of risankizumab, an anti-IL-23 agent, in the treatment of HS.

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Hidradenitis suppurativa and psoriasis: the odd couple

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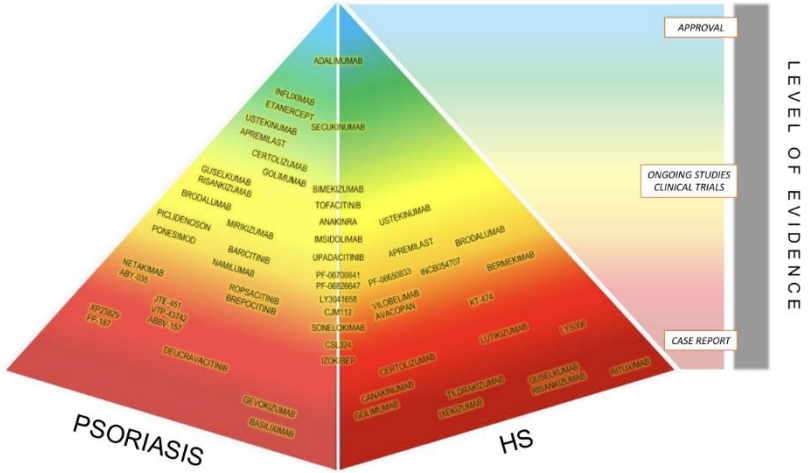

FIGURE 1
Approved and on-going studied biologic treatments for HS and psoriasis.

Psoriasis and hidradenitis suppurativa are chronic inflammatory skin diseases that can develop together, negatively impacting on the patient's quality of life. We aimed to review the most up-to-date information regarding the epidemiology, pathogenesis, clinical presentation and possible therapeutical choices in patients with both psoriasis and hidradenitis suppurativa, thus linking these two autoimmune and autoinflammatory conditions. A narrative review of articles dating from 2017 to 2022 has been performed using the PubMed database. We analyzed the case reports and case series found in the literature regarding patients who suffered from both psoriasis and HS. Psoriasis arose before hidradenitis suppurativa in the majority of cases, while only a minority of them had hidradenitis suppurativa before psoriasis. Interestingly, some patients suffered from paradoxical hidradenitis suppurativa following biological therapy administered to treat the already present psoriasis. Lastly, new biological drugs have been marketed with great success for the outcome of psoriasis, but similar progress did not happen for hidradenitis. Novel therapeutic approaches and lines of research are needed for the treatment of these pathologies, even if concomitant, in order to improve patient's quality of life.

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Σας ευχαριστώ