Actualización en el manejo de la artropatía psoriásica: Nuevas Líneas de Tratamiento

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23 Febrero. XII Congreso AADEA

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REUMATOLOGÍA
HURS

AdEA

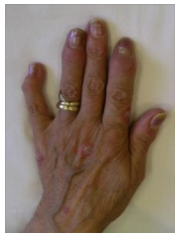
XII CONGRESO DE AADEA

Índice

Índice

Artritis Psoriásica

La PsA es una enfermedad compleja que afecta a múltiples dominios.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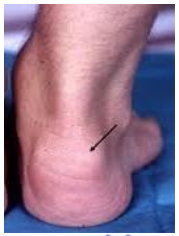
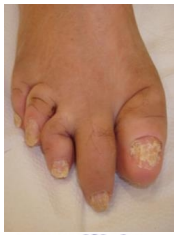
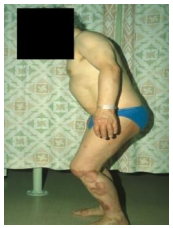

Entesitis


Dactilitis


Afectación axial

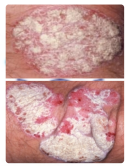
Fenotipos

HETEROGENEIDAD

Individualizar el tto.

Manifestaciones extraarticulares

- Uveitis
- EII
- Piel/uñas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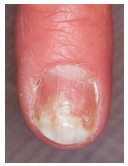

Ungueal

Comorbilidades

- CV
- DM2
- HTA
- OTP
- Ansiedad/depresión
- Úlcera gástrica….

↑ MORBILIDAD

↑ MORTALIDAD

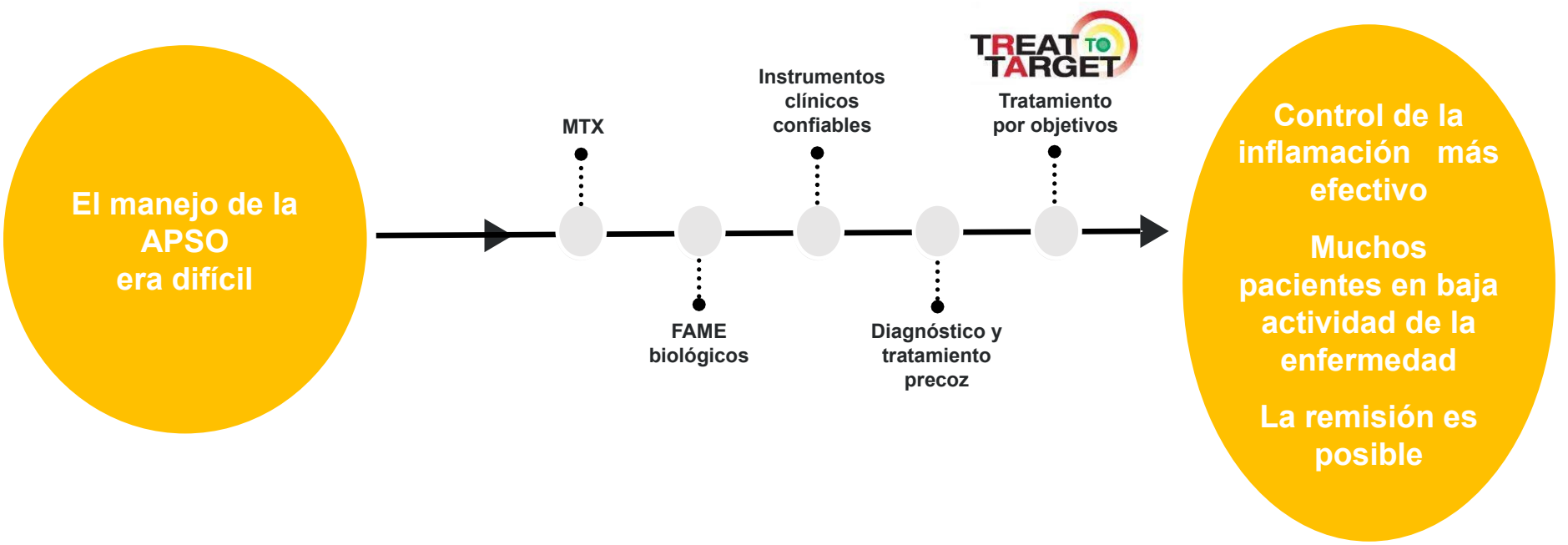
Mortalidad CV
Enfermedad metabólica

1 .Clin Med (Lond). 2017;17(1):65-70. 2. Arthritis Rheum. 2017;47(3):351-360. 3. Scriffignano S, et al. Clin Rheumatol. 2019 Jan; 38 (1): 3-10.

Índice

Objetivo terapéutico

El manejo de la Artritis Psoriásica ha cambiado dramáticamente en las últimas décadas

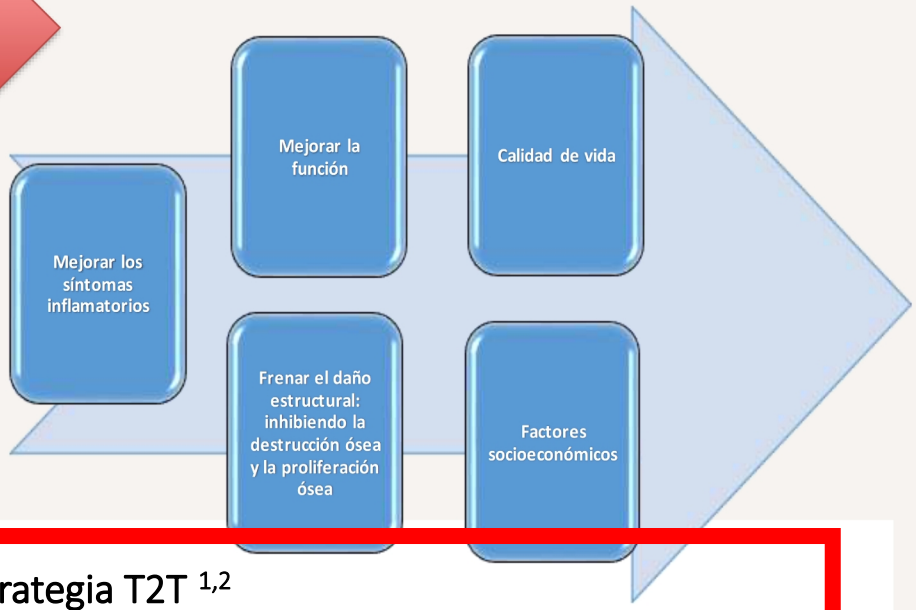


Van den Bosch F and Coates L. Lancet 2018;391:2285–94

• Objetivo terapéutico (T2T) en APs

Remisión clínica o Mínima/Baja actividad de la enfermedad

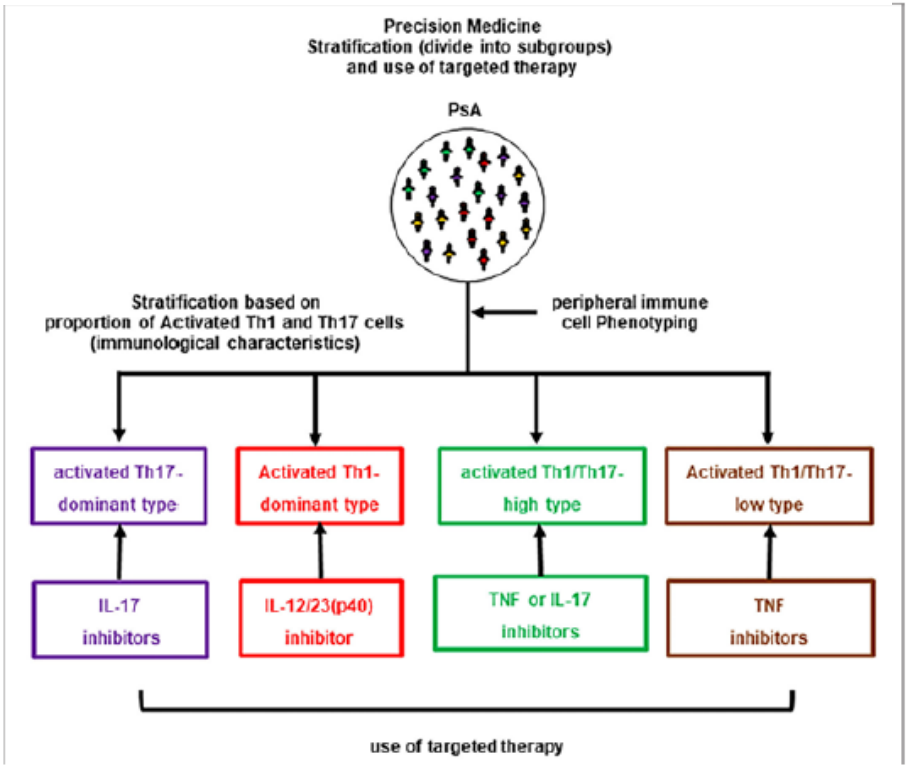
- Objetivo IDEAL: Remisión
- Objetivo ACEPTABLE: MDA/LDA



Las pautas de tratamiento de las guías apoyan la estrategia T2T [1,2]
El uso de PROS y escalas de Calidad de vida

Nuevos conceptos Medicina Precisión

PRECISION MEDICINE BASED ON PHENOTYPIC DIFFERENCES IN PERIPHERAL T HELPER CELLS IN PsA



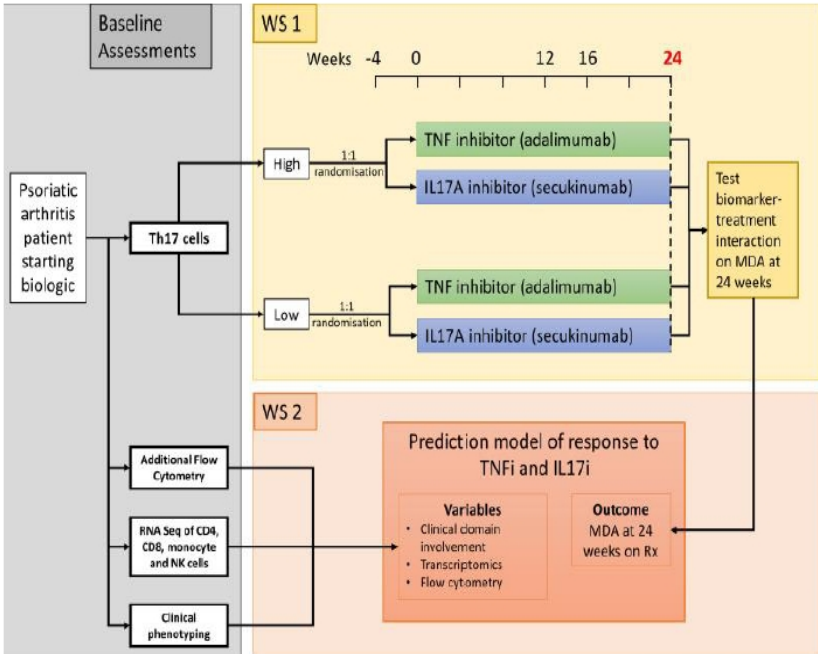
frontiers in Medicine

Pacientes en LDA (6 meses):
Grupo intervención: 92.3%
Grupo estándar: 55.2%

Open access Protocol
BMJ Open

Optimising psoriatic arthritis therapy with immunological methods to increase standard evaluation: the protocol of an open-label multicentre, parallel-group, two-arm randomised controlled study evaluation precision medicine approach in the treatment of psoriatic arthritis

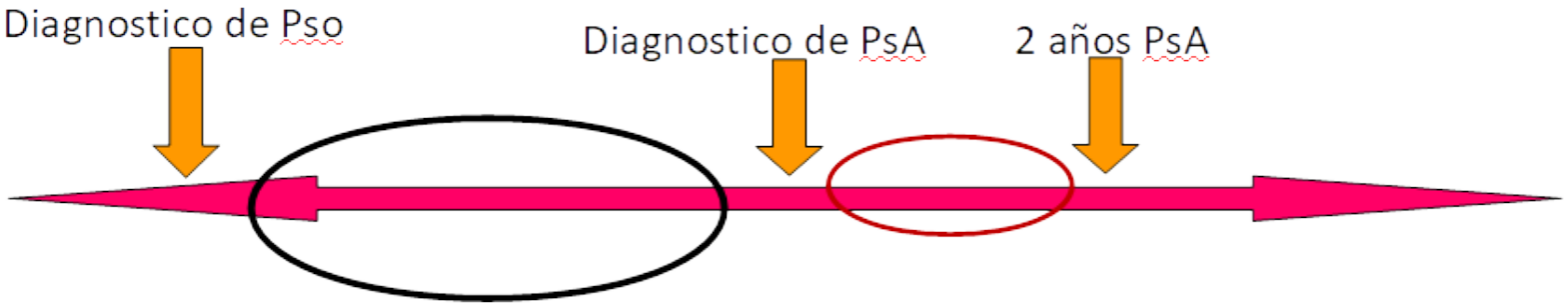
Alexander Ooms ,[1] Hussein Al-Mossawi,[1] Louise Bennett,[2] Mimi Bogale,[1] Paul Bowness,[3] Anne Francis,[1] Carl Goodyear,[2] Bruce W Kirkham,[3] Sylvine Lalnunhlimi,[4] Iain B McInnes,[5,6] Duncan Richards,[1] Stefan Siebert ,[4,7] Leonie S Taams,[4] Aysin Tulunay Virlan ,[2] Nicole Yager,[1] Laura C Coates [1]



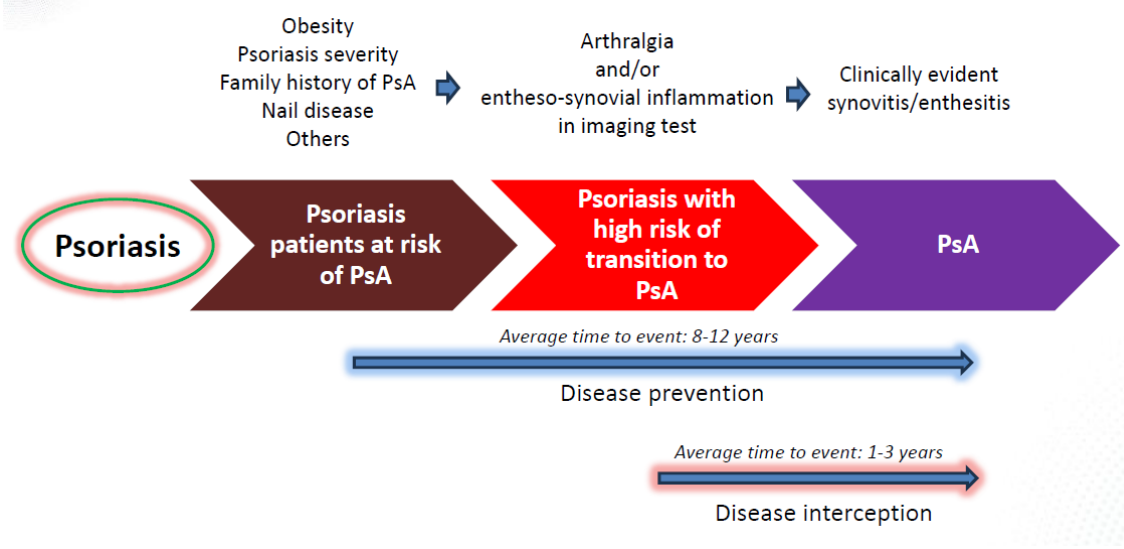
Nuevos conceptos

Ventana de Oportunidad

FASE PRECLÍNICA



- Hay un periodo critico para intervenir



EULAR pointsto considerforthedefinitionofclinicaland imagingfeaturessuspiciousforprogressionfrompsoriasis to psoriaticarthritis. Ann RheumDis. 2023 Sep;82(9):1162-1170. doi: 10.1136/ard-2023-224148.

Zabotti A et al. From Psoriasis to Psoriatic Arthritis: Insights from Imaging on the Transition to Psoriatic Arthritis and Implications for Arthritis Prevention. Curr Rheumatol Rep **22**, 24 (2020).
Alexis Ogdie, The pre-clinical phase of PsA: A challenge for the epidemiologist, Ann Rheum Dis 2017; 76:1481-1483

¿Podemos prevenir o detener la progresión de la enfermedad?

Prevención de enfermedad

Psoriasis en riesgo de APs

Intercepción de enfermedad

Psoriasis con alto riesgo de transición hacia APs


Open access Protocol

BMJ Open **Efficacy of guselkumab, a selective IL-23 inhibitor, in Preventing Arthritis in a Multicentre Psoriasis At-Risk cohort (PAMPA): protocol of a randomised, double-blind, placebo controlled multicentre trial**

Rebecca H Haberman, Katrina A MacFarlane, Sydney Catron, Jonathan Samuels, Rebecca B Blank, Michael Toprover, Zakwan Uddin, Jiyuan Hu, Rochelle Castillo, Cirity Gong, Kun Qian, Vincent Piguet, Francisco Tausk, Jensen Yeung, Andrea L Neimann, Wayne Gulliver, Ralf G Thiele, Joseph F Merola, Alexis Ogdie, Proton Rahman, Soumya D Chakravarty, Lihi Eder, C T Ritchlin, Jose U Scher

[1]TB vs fototerapia: aHR 0.27, IC95% 0.11–0.66

[2]TB vs tópicos: aHR 0.19, IC95% 0.05 to 0.81

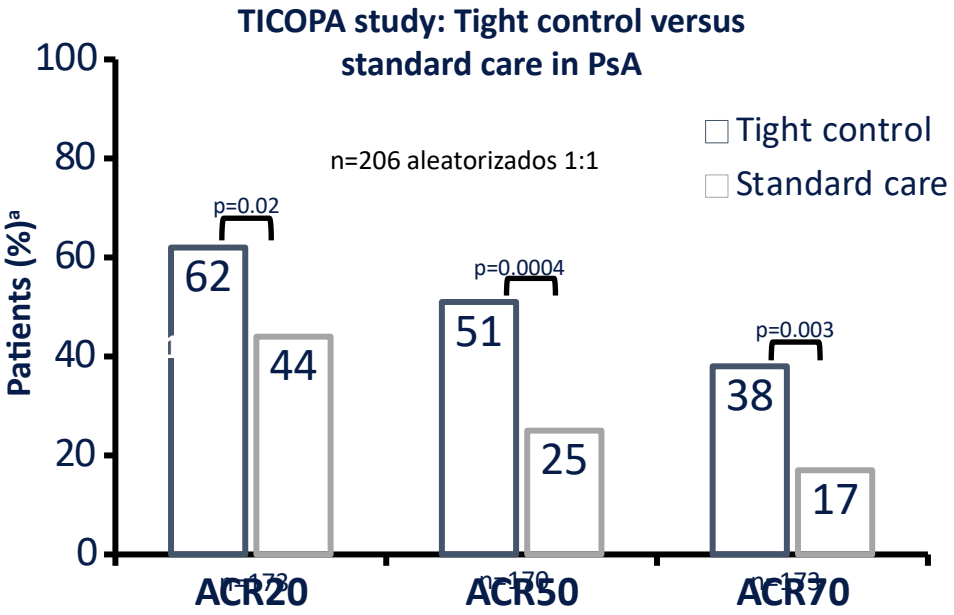
[3]No TB vs TB: aHR 1.39, IC95% 1.03–1.87

[4]Reducción de entesopatía subclínica con Ust

[5]Mejora de síntomas (artralgia) y scores de RM con Sec

[1]Ann Rheum Dis. 2022;81:68–73. [2]Ann Rheum Dis. 2022;81:74–79. [3]Arthritis Rheumatol. 2022 Feb;74(2):237-243.[4]Arthritis Rheumatol. 2019;71:626–631. [5]Arthritis Res Ther. 2019;21:178.

El T2T mejora los resultados de los pacientes en comparación con el Tto estándar en pacientes con PsA naive a Tto (<2 años)



Probabilidad de alcanzar ACR 20/50/70[b]

Outcome measure[c]	OR	Lower 95% CI	Upper 95% CI	p-value
ACR20	1.91	1.03	3.55	0.0392
ACR50	2.36	1.25	4.47	0.0081
ACR70	2.64	1.32	5.26	0.0058

Mayor probabilidad de alcanzar PASI 75 y mejoría en los PROs de función física y calidad de vida(Health Assessment Questionnaire, Psoriatic Arthritis QualityOf-Life index) en el grupo de tight control

Alcanzar los objetivos de remisión y LDA reduce la progresión de la enfermedad
Se asocia con mejores resultados funcionales y calidad de vida en pacientes con PsA

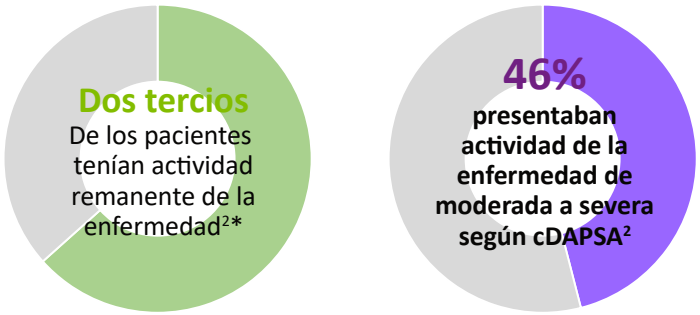
Ambos relacionados con menor daño estructural y mejor calidad de vida [1]

- [a]Evaluable population; [b]Intention-to-treat population (n=206) que fueron aleatorizados 1:1; [c]ACR20 requires at least a 20% improvement in tender and swollen joint counts with a 20% improvement in three out of five of the following outcomes: HAQ, patient global disease activity VAS, patient pain VAS, physician global disease activity VAS, and ESR or CRP. ACR50 and ACR70 are the same instruments with improvement levels defined as 50% and 70%, respectively, versus 20% for ACR20. ACR, 20/50/70, American College of Rheumatology 20%/50%/70% improvement score; CI, confidence interval; CRP, C-reactive protein; ECR, erythrocyte sedimentation rate; HAQ, Health Assessment Questionnaire; PsA, psoriatic arthritis; TICOPA, Tight Control of Psoriatic Arthritis; VAS, visual analogue scale.

Coates LC et al. Lancet 2015;386:2489–98.

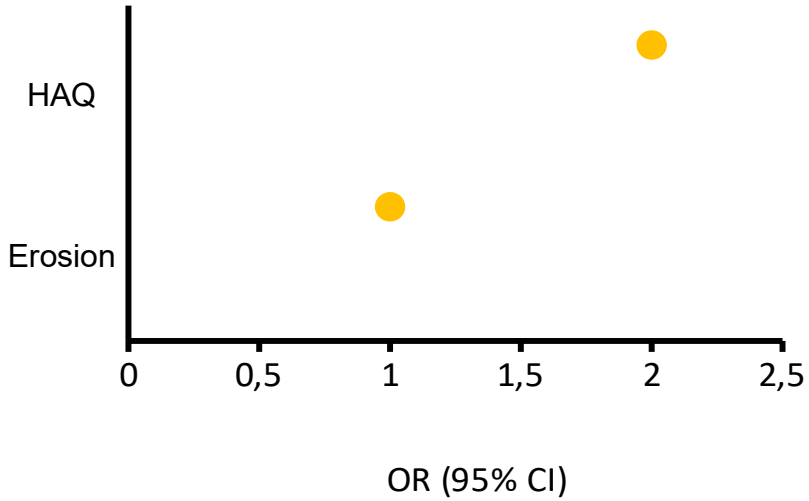
Sin embargo, un **% elevado** de pacientes con PsA **NO alcanzan los objetivos de remisión o MDA y EL Retraso en el diagnóstico y en el tto sigue existiendo,** TODO ELLO asociado con peores resultados (Peor HAQ y aumento de daño estructural)

– **En un estudio transversal de 142 pacientes con APs:**[2]



– En práctica clínica diaria solo un **5,7%** de los Pacientes con APs alcanzó los criterios de remisión y solo un **22,9%** alcanzó MDA[3]

>6 meses de retraso en el diagnóstico en PsA está asociado con un peor HAQ e incremento de erosiones[1]



CI, confidence interval; HAQ, Health Assessment Questionnaire; OR, odds ratio; TNF, tumor necrosis factor

- *According to the treating rheumatologist.
cDAPSA, clinical Disease Activity Index for Psoriatic Arthritis; MDA, minimal disease activity; PsA, psoriatic arthritis; VLDA, very low disease activity.

1. Haroon M, et al. Ann Rheum Dis 2015;74:1045–50;

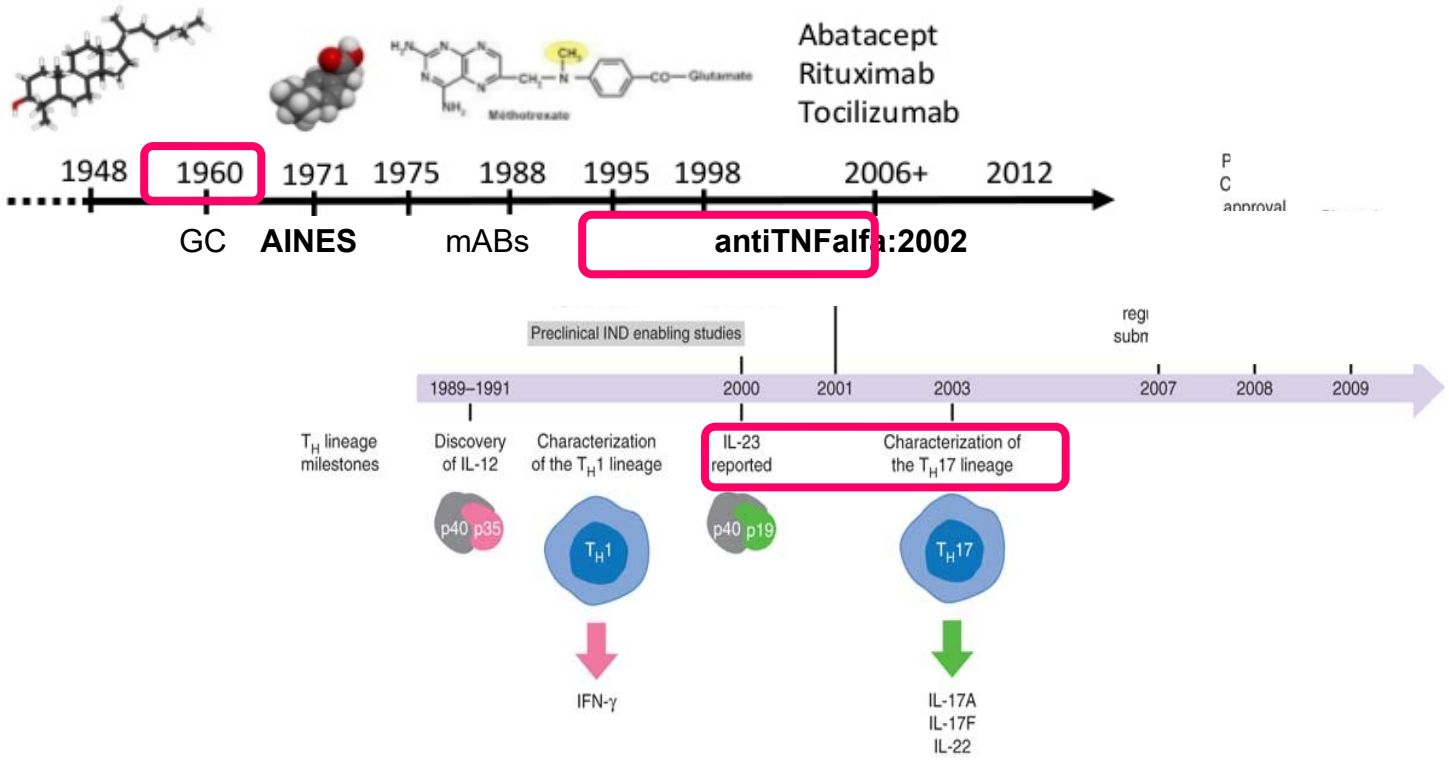
Índice

1. Introducción
2. Objetivo terapéutico. Nuevos conceptos en el manejo de la APSO
3. **Tratamiento disponible en APSO**
4. **Nuevas líneas de tratamiento:**

   (Fármacos recientemente aprobados y emergentes)

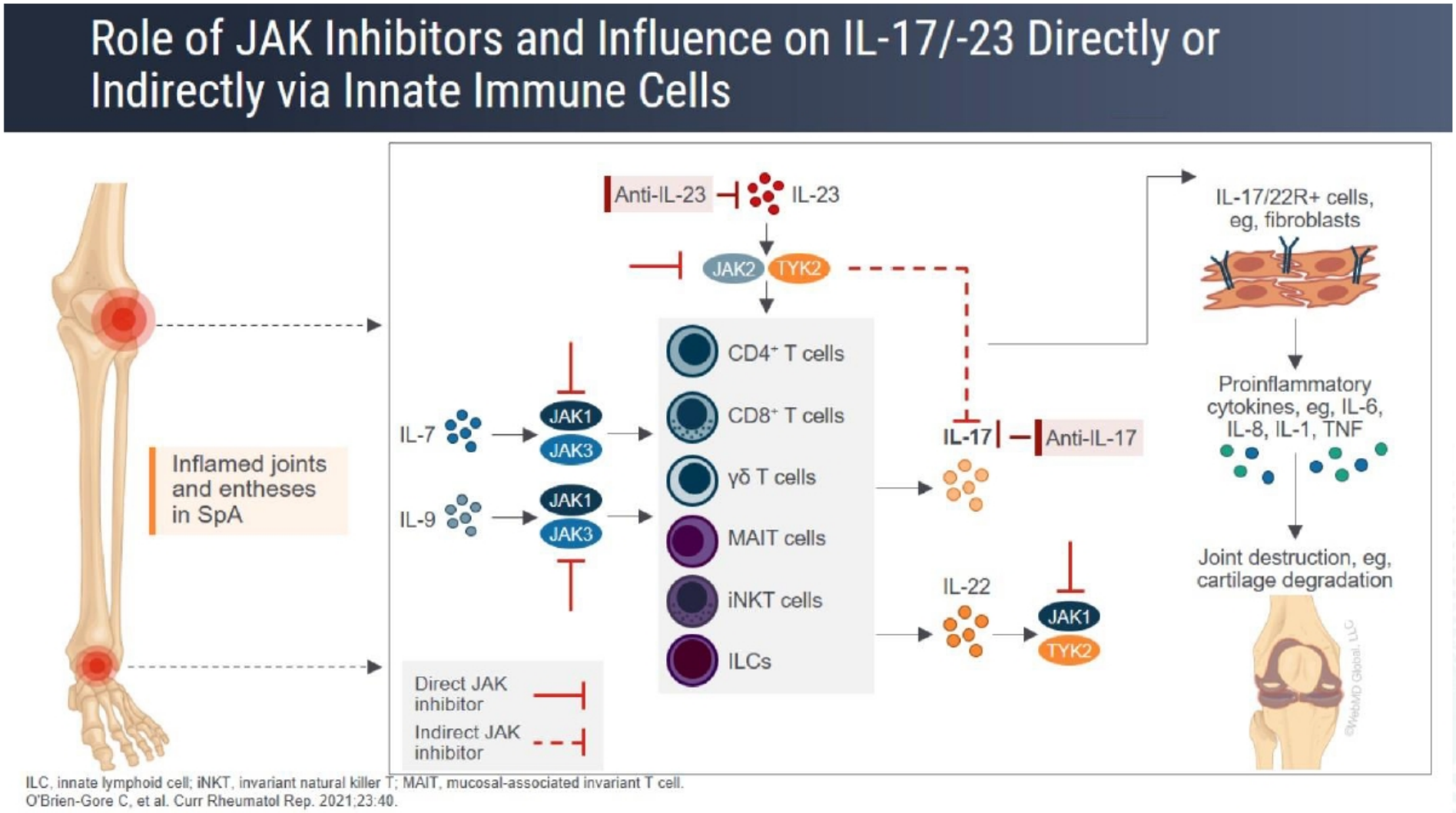
Las opciones de tratamiento en Espondiloartritis y Artritis psoriásica han sido limitadas…

Tratamientos venían derivados de la AR →investigación y desarrollo de nuevas dianas



Patogenia de la PsA

IL-17 IL-23 JAK

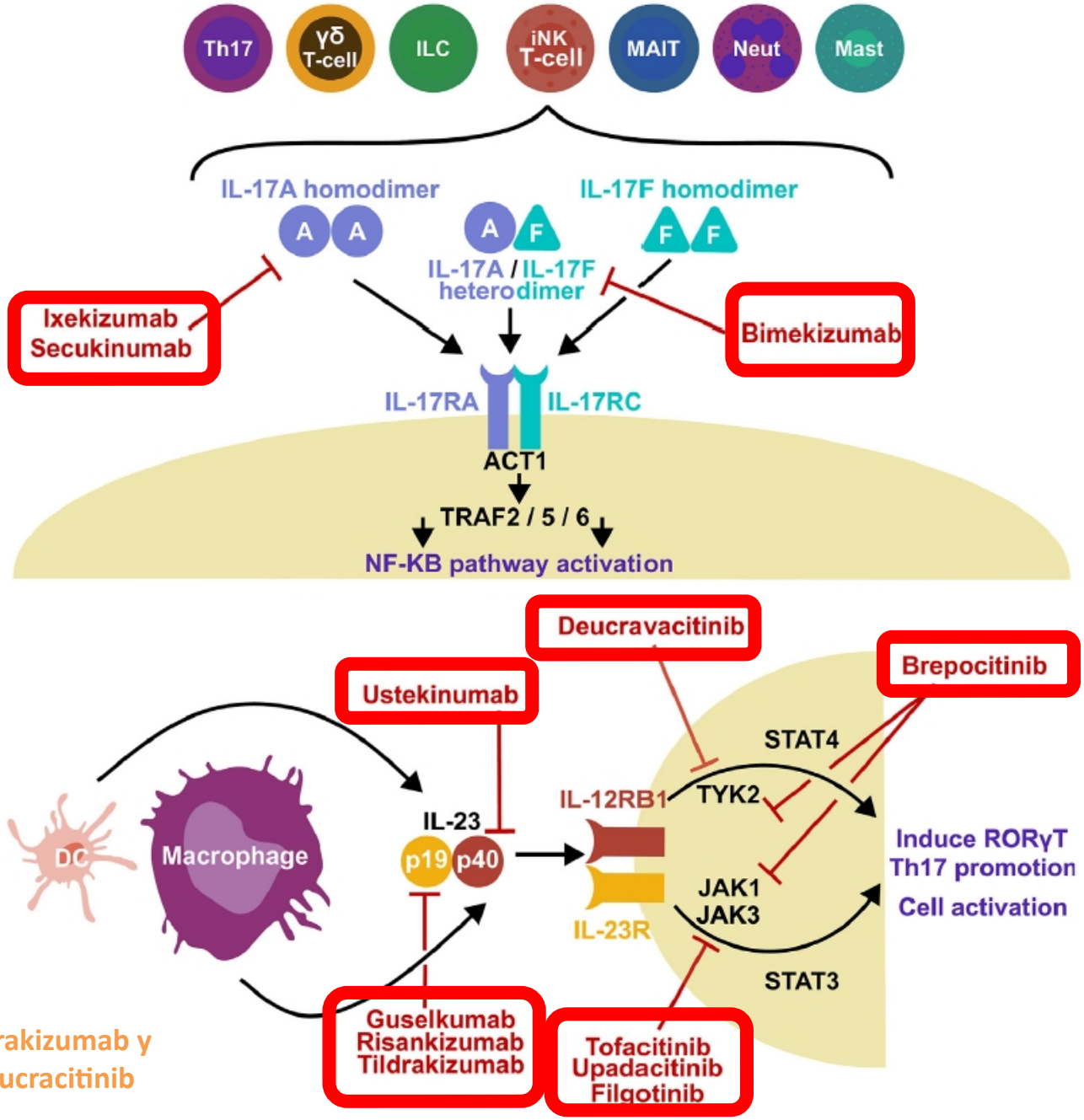


ILC, innate lymphoid cell; iNKT, invariant natural killer T; MAIT, mucosal-associated invariant T cell.
O'Brien-Gore C, et al. Curr Rheumatol Rep. 2021;23:40.

Tratamiento disponible en APSO

Adjunctive Therapies
Non-steroidal anti-inflammatory drugs (NSAIDs)
Glucocorticoids: oral, intra-articular, intra-muscular, topical routes
Conventional Synthetic DMARDs (csDMARDs)
Methotrexate
Leflunomide
Sulfasalazine
Cyclosporine
Biological DMARDs (bDMARDs)
TNF Inhibitors: etanercept[a], infliximab[a], adalimumab[a], golimumab, certolizumab
IL-12/IL-23 p40 Subunit Inhibitors: ustekinumab
IL-23 p19 Subunit Inhibitors: guselkumab, risankizumab[b], tildrakizumab[b]
IL-17 Inhibitors: secukinumab, ixekizumab, brodalumab[b]
T-cell Modulator: abatacept
Targeted Synthetic DMARDs
PDE4 Inhibitor: apremilast
JAK Inhibitors: tofacitinib, upadacitinib

Best Practice & Research Clinical Rheumatology 36 (2022)



bDMARD dirigidos a IL-17

INHIBIDORES DE IL-17A

SECUKINUMAB: ACPO Monoclonal totalmente humano IgG1K **dirigido frente a IL-17A.**

IXEKIZUMAB: ACPO Monoclonal humano IgG4K **dirigido frente a IL-17A**

INHIBIDORES DUALES IL-17A y F

BIMEKIZUMAB: ACPO Monoclonal humanizado IgG1 que **neutraliza tanto la IL-17A como la IL-17F.**

bDMARD dirigidos a IL-23

USTEKINUMAB: ACPO Monoclonal totalmente humano dirigido frente a la **subunidad P-40 compartida por la IL-12 y la IL-23** e inhibe la diferenciación de Th-17.

GUSELKUMAB: ACPO Monoclonal humano IgG1-Lambda dirigido frente a la **subunidad P-19 de la IL-23** e inhibe la señal de la IL-23.

RISANKIZUMAB: ACPO Monoclonal humano dirigido frente a la **subunidad P-19 de la IL-23** e inhibe la señal de la IL-23.

TILDRAKIZUMAB: ACPO Monoclonal humano IgG1-K dirigido frente a la **subunidad P-19 de la IL-23** e inhibe la señal de la IL-23con alta afinidad.

Inhibidores JAK y TYK2

TOFACITINIB: Inhibidor de **JAK 1 y JAK 3.**

UPADACITINIB: Inhibidor de **JAK 1**

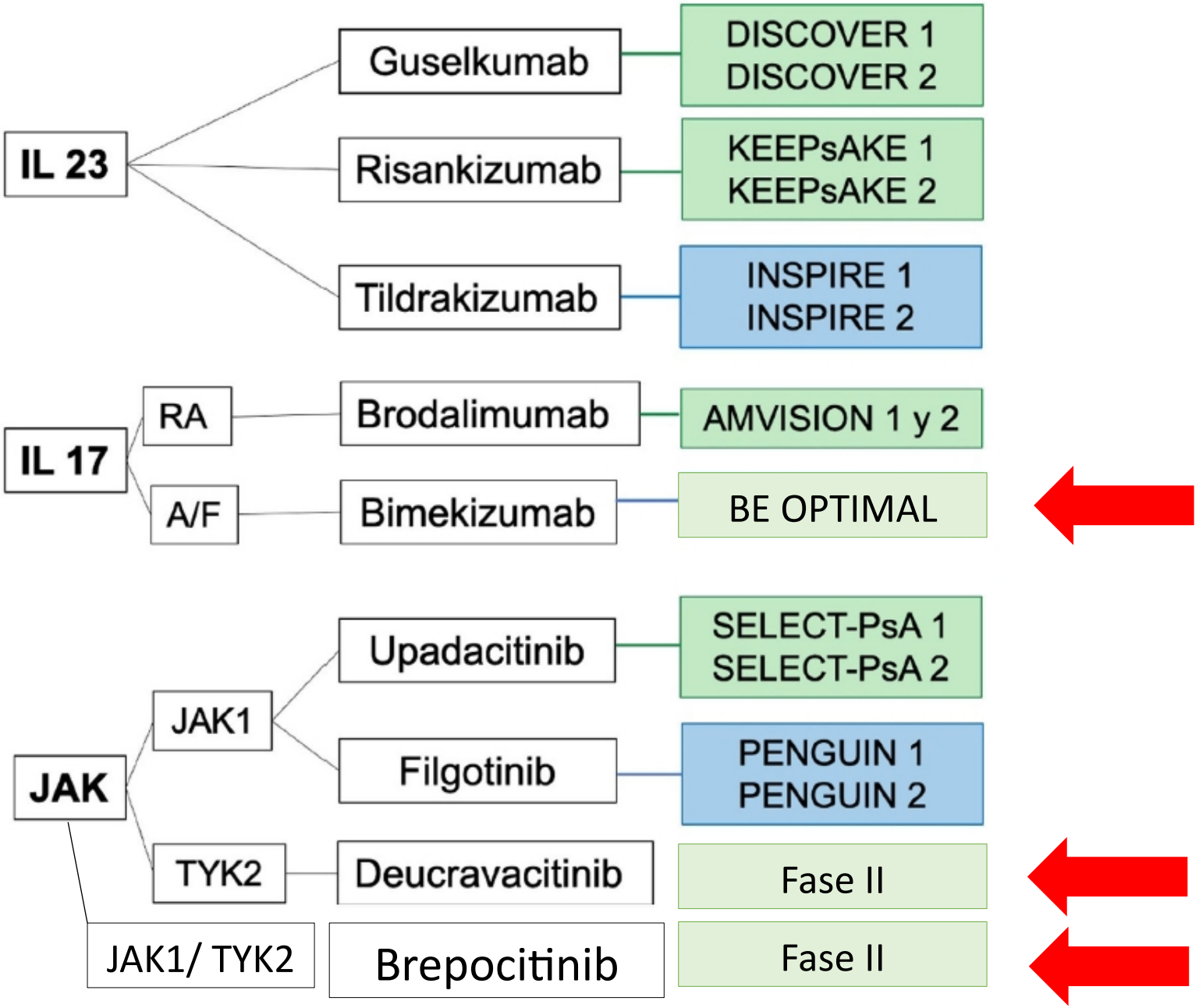
FILGOTINIB: Inhibidor de **JAK 1.**

DEUCRAVACITINIB: Inhibidor de **TYK2.**

BREPOCITINIB: Inhibidor dual de **JAK1 TYK2.**

Tildrakizumab y Deucracitinib

Fase III



Ensayos controlados aleatorios de fase 2 y 3 de nuevas moléculas para el tratamiento de la PsA, en verde los reportados actualmente y en azul los que están en desarrollo

Bimekizumab in patients with psoriatic arthritis, naive to biologic treatment: a randomised, double-blind, placebo-controlled, phase 3 trial (BE OPTIMAL)

Iain B McInnes, Akihiko Asahina, Laura C Coates, Robert Landewé, Joseph F Merola, Christopher T Ritchlin, Yoshiya Tanaka, Laure Gossec, Alice B Gottlieb, Richard B Warren, Barbara Ink, Deepak Assudani, Rajan Bajracharya, Vishwesh Shende, Jason Coarse, Philip J Mease

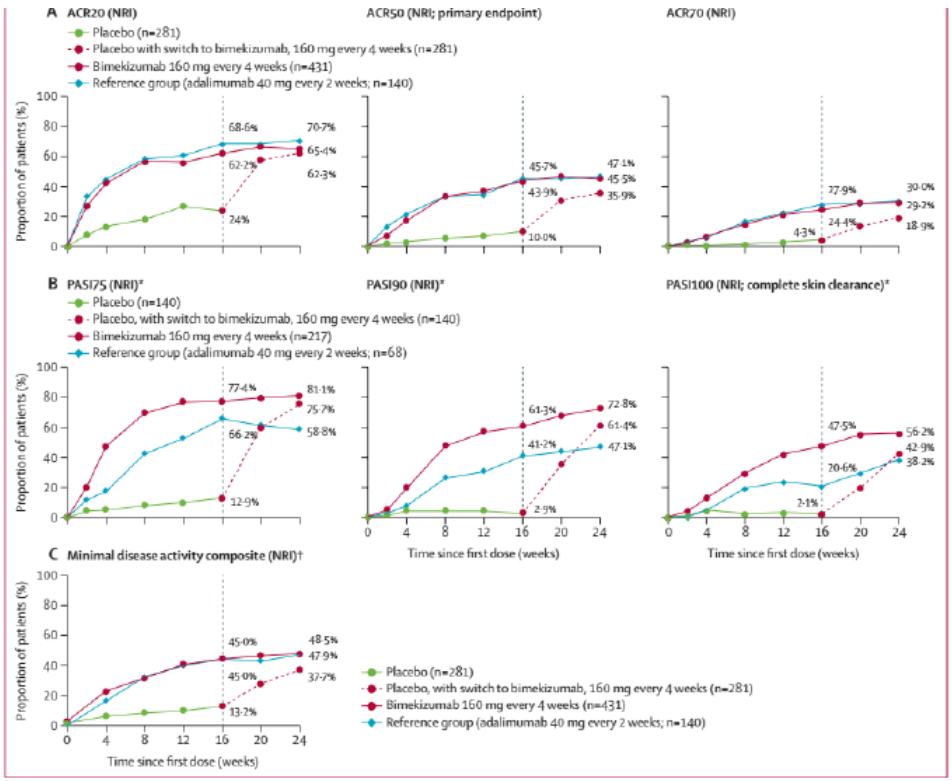


Figure 2: ACR (A), PASI (B), and minimal disease activity (C) data from weeks 0 to 24

	Week 0–16			Week 0–24		
	Placebo (n=281)	Bimekizumab 160 mg every 4 weeks (n=431)	Reference group (adalimumab 40 mg every 2 weeks; n=140)	Placebo to bimekizumab 160 mg every 4 weeks (week 16–24; n=271)*	Bimekizumab 160 mg every 4 weeks (n=431)	Reference group (adalimumab 40 mg every 2 weeks; n=140)
Any TEAE	139 (49%)	258 (60%)	83 (59%)	95 (35%)	300 (70%)	96 (69%)
Serious TEAE	3 (1%)	7 (2%)	2 (1%)	3 (1%)	17 (4%)	5 (4%)
Discontinuation due to TEAE	3 (1%)	8 (2%)	3 (2%)	0	12 (3%)	7 (5%)
Drug-related TEAE	35 (12%)	101 (23%)	34 (24%)	27 (10%)	122 (28%)	43 (31%)
Severe TEAE	0	4 (1%)	3 (2%)	1 (<1%)	9 (2%)	3 (2%)
Deaths	0	0	0	0	0	0
Fungal infections	4 (1%)	20 (5%)	1 (1%)	7 (3%)	33 (8%)	1 (1%)
Candida infections	2 (1%)	11 (3%)	0	4 (1%)	18 (4%)	0
Serious *Candida* infections	0	0	0	0	0	0
Systemic fungal infections	0	0	0	0	0	0
Candida infections leading to study discontinuation	0	1 (<1%)	0	0	1 (<1%)	0

Interpretation Bimekizumab treatment had superior improvements in joint, skin, and radiographic efficacy outcomes at week 16 compared with placebo in patients with psoriatic arthritis who were naive to biologic DMARDs. The safety profile of bimekizumab, including the occurrence of fungal infections, was consistent with previous phase 3 studies in patients with plaque psoriasis, and with IL-17A inhibitors.

Lancet 2023; 401: 25–37

Bimekizumab in patients with active psoriatic arthritis and previous inadequate response or intolerance to tumour necrosis factor-α inhibitors: a randomised, double-blind, placebo-controlled, phase 3 trial (BE COMPLETE)

Joseph F Merola, Robert Landewé, Iain B McInnes, Philip J Mease, Christopher T Ritchlin, Yoshiya Tanaka, Akihiko Asahina, Frank Behrens, Dafna D Gladman, Laure Gossec, Alice B Gottlieb, Diamant Thaçi, Richard B Warren, Barbara Ink, Deepak Assudani, Rajan Bajracharya, Vishvesh Shende, Jason Coarse, Laura C Coates

	Placebo (n=133)	Bimekizumab 160 mg every 4 weeks (n=267)	All patients (n=400)
Previous TNFα inhibitors			
Inadequate response to one TNFα inhibitor	103 (77%)	204 (76%)	307 (77%)
Inadequate response to two TNFα inhibitors	15 (11%)	29 (11%)	44 (11%)
Intolerance to TNFα inhibitors	15 (11%)	34 (13%)	49 (12%)

Interpretation Bimekizumab treatment led to superior improvements in joint and skin efficacy outcomes at week 16 compared with placebo in patients with psoriatic arthritis and inadequate response or intolerance to TNFα inhibitors. The safety profile of bimekizumab was consistent with previous phase 3 studies in patients with plaque psoriasis, and studies of IL-17A inhibitors.

Lancet 2023; 401: 38–48

Queiro R. Bimekizumab in psoriatic arthritis: a great leap forward? Lancet. 2023 Jan 7;401(10370):2-3. doi: 10.1016/S0140-6736(22)02423-0.

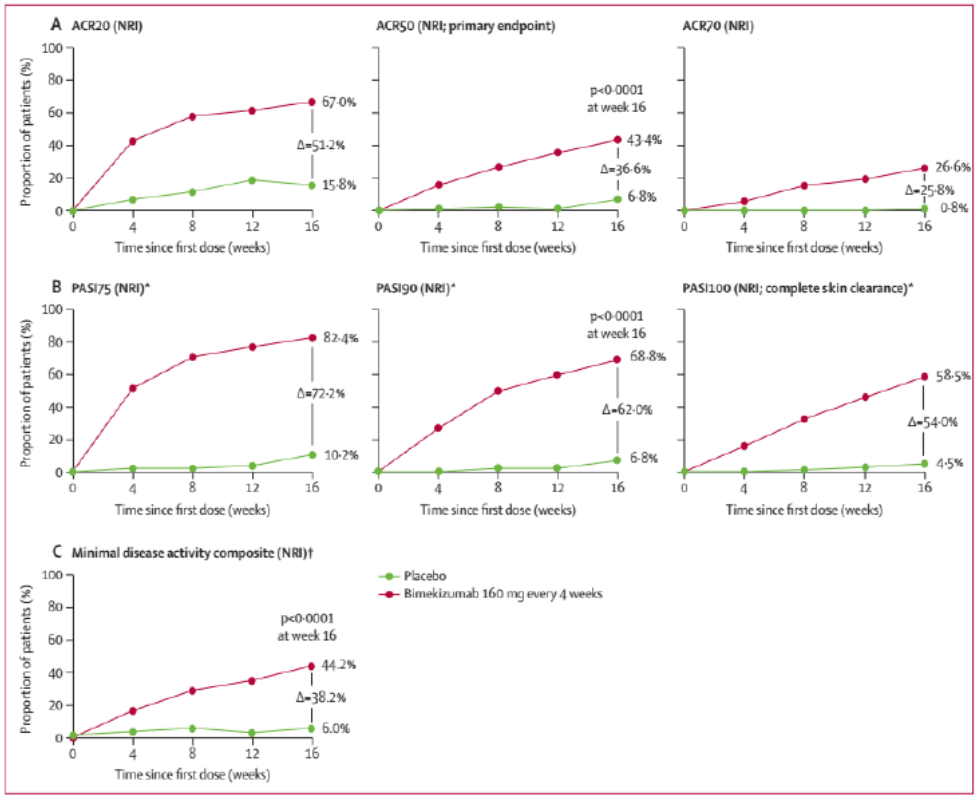


Figure 2: ACR (A), PASI (B), and minimal disease activity composite (C) responders from week 0 to week 16

CLINICAL SCIENCE

Efficacy and safety of selective TYK2 inhibitor, deucravacitinib, in a phase II trial in psoriatic arthritis

Philip J Mease ,[1] Atul A Deodhar ,[2] Désirée van der Heijde ,[3] Frank Behrens,[4] Alan J Kivitz,[5] Jeffrey Neal,[6] Jonghyeon Kim,[7] Shalabh Singhal,[7] Miroslawa Nowak,[7] Subhashis Banerjee[7]

Table 2 Efficacy endpoints at week 16

Endpoint	Placebo n=66	Deucravacitinib 6 mg once a day n=70	Deucravacitinib 12 mg once a day n=67
Primary endpoint			
ACR-20			
Response rate, % (95% CI)	31.8 (20.6 to 43.1)	52.9 (41.2 to 64.6)	62.7 (51.1 to 74.3)
Adjusted OR vs placebo (95% CI)		2.4 (1.2 to 4.8)	3.6 (1.8 to 7.4)
P value		0.0134*	0.0004*
Secondary endpoints			
HAQ-DI			
Adjusted mean change from baseline (95% CI)	−0.1 (−0.2 to 0.0)	−0.4 (−0.5 to −0.2)	−0.4 (−0.5 to −0.3)
Difference from placebo (95% CI)		−0.3 (−0.4 to −0.1)	−0.3 (−0.5 to −0.1)
P value		0.0020*	0.0008*
PASI-75			
Response rate, % (95% CI)	20.4 (9.6 to 31.1)	42.4 (29.8 to 55.0)	59.6 (46.3 to 73.0)
Adjusted OR vs placebo (95% CI)		2.9 (1.3 to 6.7)	5.8 (2.4 to 13.8)
P value		0.0136*	<0.0001*
SF-36 PCS			
Adjusted mean change from baseline (95% CI)	2.3 (0.4 to 4.2)	5.6 (3.8 to 7.5)	5.8 (3.9 to 7.7)
Difference from placebo (95% CI)		3.3 (0.9 to 5.7)	3.5 (1.1 to 5.9)
P value		0.0062*	0.0042*

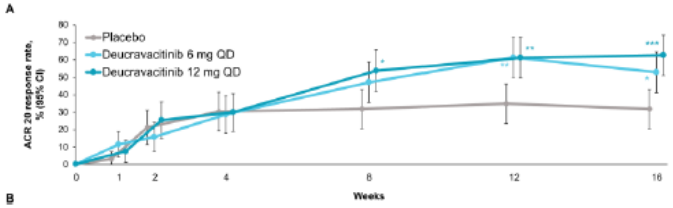


Table 1 Baseline demographic and clinical characteristics

	Total N=203	Placebo n=66	Deucravacitinib 6 mg once a day n=70	Deucravacitinib 12 mg once a day n=67
Demographics				
Age, years, mean (SD)	49.8 (13.5)	48.5 (13.2)	50.5 (13.7)	50.5 (13.8)
Female, n (%)	104 (51.2)	40 (60.6)	30 (42.9)	34 (50.7)
White, n (%)	199 (98.0)	65 (98.5)	67 (95.7)	67 (100.0)
Prior/concomitant medications				
Use of csDMARD, n (%)	132 (65.0)	44 (66.7)	45 (64.3)	43 (64.2)
Use of methotrexate, n (%)	111 (54.7)	39 (59.1)	35 (50.0)	37 (55.2)
Weekly dose, mg, mean (SD)	16.5 (4.7)	16.7 (4.8)	16.4 (4.9)	16.5 (4.6)
Prior TNFi use, n (%)				
1	31 (15.3)	11 (16.7)	12 (17.1)	8 (11.9)
2	1 (0.5)	0	0	1 (1.5)

What does this study add?

⇒ Deucravacitinib at 6 mg and 12 mg doses once a day demonstrated greater efficacy versus placebo at week 16, with improvements observed across all American College of Rheumatology domains, enthesitis endpoints, and multiple patient-reported, psoriasis-related and composite outcomes in patients with active psoriatic arthritis.

⇒ Treatment with deucravacitinib was generally well tolerated, and the safety and laboratory parameter profile of deucravacitinib was consistent with its selective mechanism of action and with that observed in an earlier phase II psoriasis trial and recently reported phase III trials in psoriasis.

Mease PJ, *et al*. *Ann Rheum Dis* 2022;**81**:815–822. doi:10.1136/annrheumdis-2021-221664

Efficacy and Safety of the TYK2/JAK1 Inhibitor Brepocitinib for Active Psoriatic Arthritis: A Phase IIb Randomized Controlled Trial

Philip Mease,[1] Philip Helliwell,[2] Paula Silwinska-Stanczyk,[3] Malgorzata Miakisz,[4] Andrew Ostor,[5] Elena Peeva,[6] Michael S. Vincent,[6] Qiankun Sun,[6] Vanja Sikirica,[7] Randall Winnette,[8] Ruolun Qiu,[6] Gang Li,[7] Gang Feng,[6] Jean S. Beebe,[6] and David A. Martin[6]

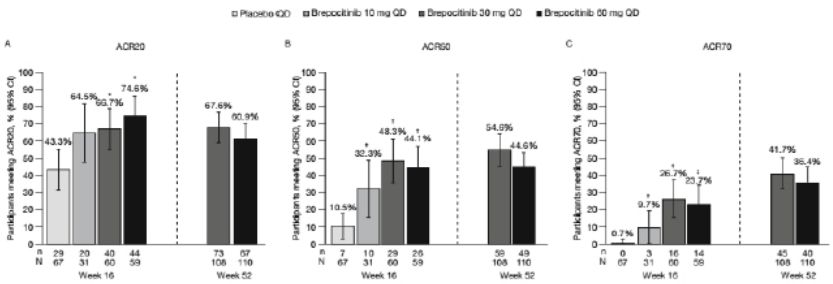
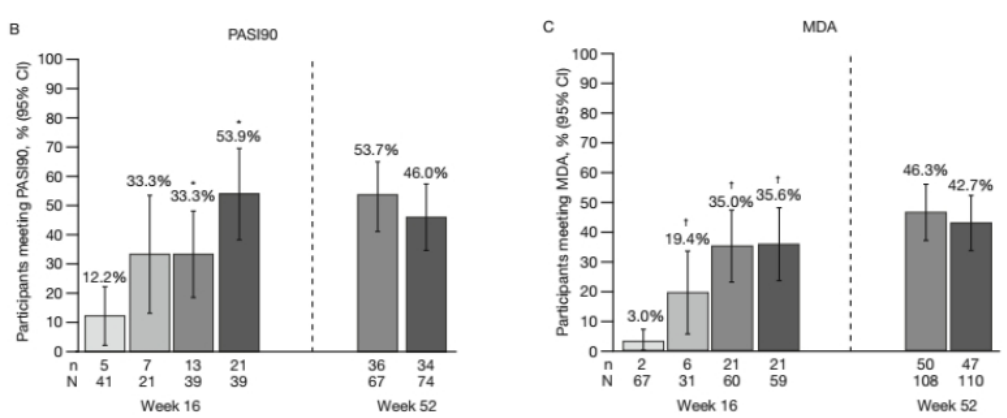


Table 1. Participant baseline demographics and disease characteristics*

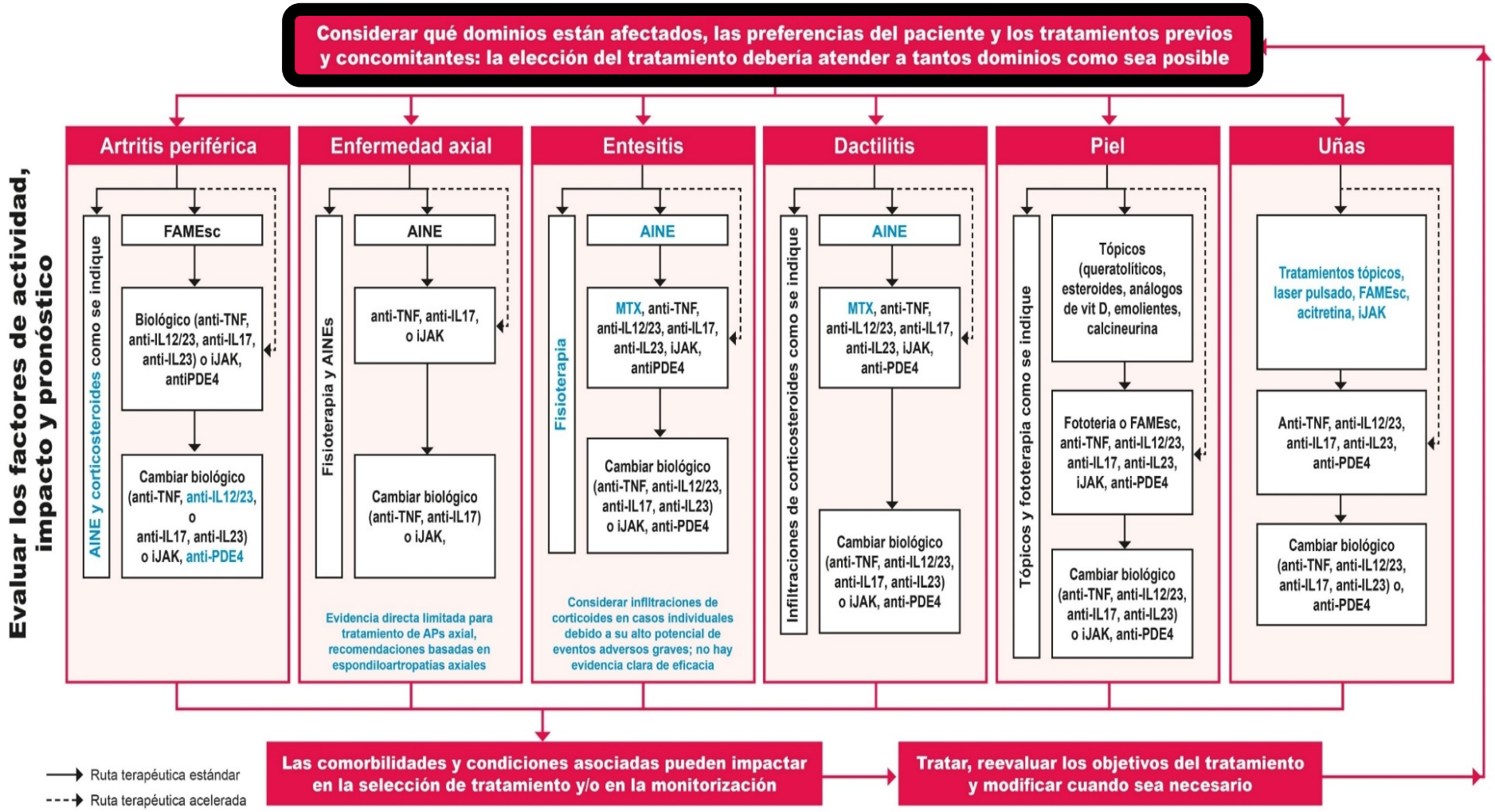
	Placebo (N = 67)	Brepocitinib 10 mg QD (N = 31)	Brepocitinib 30 mg QD (N = 60)	Brepocitinib 60 mg QD (N = 60)	Total (N = 218)
Age, mean (SD) years	48.2 (12.1)	47.8 (13.4)	45.9 (10.2)	48.7 (11.5)	47.6 (11.6)
Male, n (%)	31 (46.3)	17 (54.8)	28 (46.7)	26 (43.3)	102 (46.8)
Prior TNFi exposure, n (%)	7 (10.4)	3 (9.7)	4 (6.7)	4 (6.7)	18 (8.3)
Medication use at baseline, n (%)					
csDMARDs	49 (73.1)	23 (74.2)	40 (66.7)	50 (83.3)	162 (74.3)
Methotrexate	48 (71.6)	21 (67.7)	38 (63.3)	46 (76.7)	153 (70.2)



	Week 0–16 (initial dose)				
		Brepocitinib			
	Placebo (N = 67)	10 mg QD (N = 31)	30 mg QD (N = 60)	60 mg QD (N = 60)	Total (N = 151)
Number of TEAEs	61	24	68	104	196
Number of treatment-related TEAEs	11	8	19	27	54
Number (%) of participants					
Any TEAEs	32 (47.8)	14 (45.2)	33 (55.0)	40 (66.7)	87 (57.6)
Treatment-related TEAEs	9 (13.4)	6 (19.4)	12 (20.0)	15 (25.0)	33 (21.9)
SAEs	1 (1.5)	0 (0.0)	3 (5.0)	1 (1.7)	4 (2.6)
Severe AEs	1 (1.5)	0 (0.0)	2 (3.3)	1 (1.7)	3 (2.0)
TEAEs leading to discontinuation of study drug	3 (4.5)	0 (0.0)	2 (3.3)	3 (5.0)	5 (3.3)

Arthritis & Rheumatology
Vol. 75, No. 8, August 2023, pp 1370–1380

Algoritmo de GRAPPA 2021 para el tratamiento de la APs activa

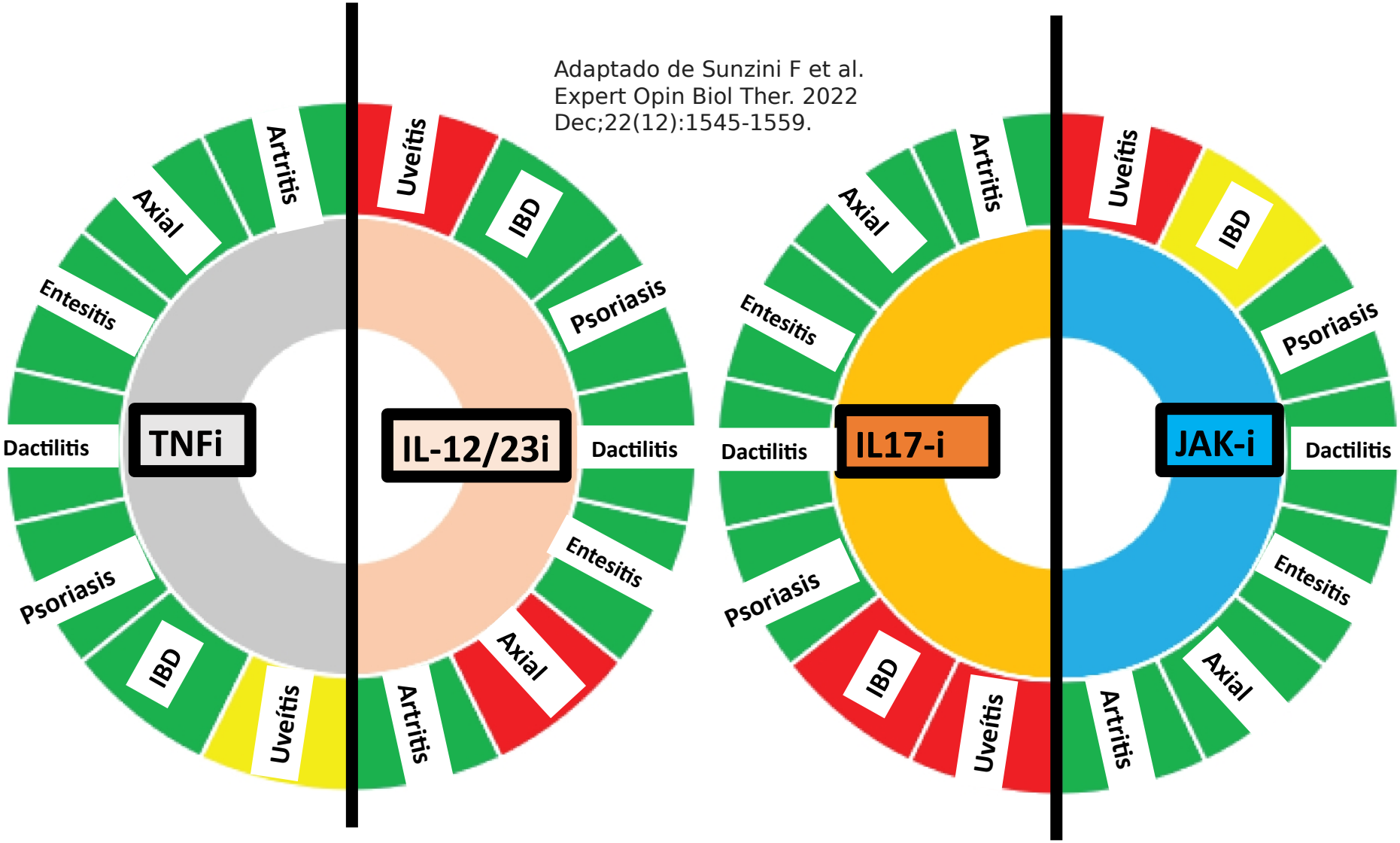


El texto en azul identifica las recomendaciones condicionales para fármacos sin aprobación actual o por aprobación basada en abstracts.
Extraído de Coates LC, et al. Arthritis Rheum 2021.

Coates LC, Soriano E, Corp N, et al. OP0229 The group for research and assessment of psoriasis and psoriatic arthritis (GRAPPA) treatment recommendations 2021 Annals of the Rheumatic Diseases 2021; 80: 139-140.

Recomendaciones para el tratamiento de PsA según el grupo GRAPPA

Adaptado de Sunzini F et al. Expert Opin Biol Ther. 2022 Dec;22(12):1545-1559.



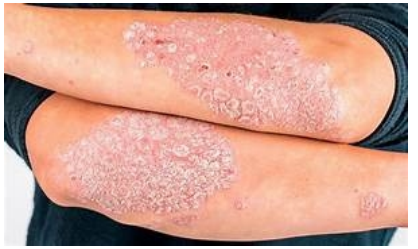
Muy recomendado

Recomendado condicionalmente

NO recomendado

Eficacia de fármacos biológicos en dominio cutáneo (CORTO plazo)

Risan
Ixe
Broda
Gusel
Secu

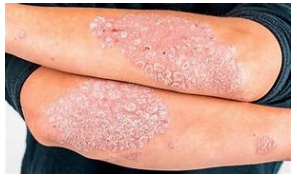


Respuesta Cutánea

	PASI 75			PASI 90			PASI 100		
	Response Rate (95% CrI), %	Fewer Needed to Treat to Achieve PASI 75	More Needed to Treat to Achieve PASI 75	Response Rate (95% CrI), %	Fewer Needed to Treat to Achieve PASI 90	More Needed to Treat to Achieve PASI 90	Response Rate (95% CrI), %	Fewer Needed to Treat to Achieve PASI 100	More Needed to Treat to Achieve PASI 100
Risankizumab-rzaa 150 mg	1.19 (1.16-1.23)			1.42 (1.35-1.51)			2.48 (2.23-2.79)		
Ixekizumab 80 mg	1.20 (1.17-1.23)			1.43 (1.36-1.52)			2.54 (2.28-2.85)		
Brodalumab 210 mg	1.20 (1.17-1.23)			1.44 (1.36-1.52)			2.56 (2.28-2.85)		
Guselkumab 100 mg	1.23 (1.19-1.27)			1.51 (1.41-1.63)			2.81 (2.46-3.25)		
Secukinumab 300 mg	1.29 (1.24-1.34)			1.66 (1.55-1.78)			3.36 (2.96-3.82)		
Infliximab 5 mg/kg	1.33 (1.27-1.40)			1.78 (1.62-1.96)			3.79 (3.21-4.50)		
Certolizumab pegol 400 mg	1.52 (1.41-1.66)			2.25 (1.96-2.62)			5.68 (4.50-7.30)		
Ustekinumab 45 mg ≤100 kg 90 mg > 100 kg	1.55 (1.48-1.64)			2.34 (2.14-2.56)			6.02 (5.21-6.99)		
Adalimumab 40 mg	1.56 (1.49-1.64)			2.35 (2.16-2.57)			6.10 (5.29-7.09)		
Certolizumab pegol 200 mg	1.64 (1.49-1.84)			2.56 (2.17-3.09)			6.99 (5.35-9.43)		
Tildrakizumab-asmn 200 mg	1.68 (1.54-1.85)			2.65 (2.30-3.11)			7.41 (5.88-9.52)		
Tildrakizumab-asmn 100 mg	1.74 (1.58-1.92)			2.80 (2.42-3.30)			8.06 (6.37-10.42)		
Etanercept 25 mg twice weekly, 50 mg once weekly	2.87 (2.52-3.32)			5.95 (4.93-7.25)			24.39 (18.87-32.26)		
Apremilast 30 mg	3.92 (3.37-4.63)			9.09 (7.41-11.36)			43.48 (33.33-58.82)		
Dimethyl fumarate	4.12 (3.03-5.99)			9.71 (6.41-15.63)			47.62 (27.03-90.91)		
		1 2 4 8			1 2 5 10 20			1 5 10 50 100	
		Number Needed to Treat			Number Needed to Treat			Number Needed to Treat	

Armstrong AW. JAMA Dermatol. 2020 Mar 1;156(3):258-269

LARGO plazo



Therapy	Response Rate (95% CI), %	PASI 75	Response Rate (95% CI), %	PASI 90	Response Rate (95% CI), %	PASI 100
Risankizumab-rzaa 150 mg at week 0, 4, then every 12 wk						
IMMvent[21] (N = 301)	86.7 (8.24-90.1)		75.7 (70.6-80.3)		52.8 (47.2-58.4)	
UltIMMa1[15] (N = 104)	91.8 (88.1-94.4)		81.9 (77.2-85.8)		56.3 (50.6-61.7)	
UltIMMa2[15] (N = 294)	91.5 (87.7-94.2)		80.6 (75.7-84.7)		59.5 (53.8-65.0)	
Overall	90.1 (86.3-92.9)		79.4 (75.5-82.9)		56.2 (52.4-59.9)	
Guselkumab 100 mg at week 0, 4, then every 8 wk						
Ohtsuki 2018[61] (N = 63)	90.5 (80.4-95.7)		77.8 (65.9-86.4)		47.6 (35.7-59.8)	
VOYAGE 1[17] (N = 329)	87.8 (83.8-91.0)		76.3 (71.4-80.6)		47.4 (42.1-52.8)	
Overall	88.2 (84.6-91.1)		76.5 (72.1-80.5)		47.4 (42.5-52.4)	
Brodalumab 210 mg at week 0, 1, 2, then every 2 wk						
AMAGINE-2[70] (N = 189)	80.0 (73.7-85.1)		75.0 (68.3-80.7)		56.0 (48.8-62.9)	
AMAGINE-3[70] (N = 194)	80.0 (73.8-85.0)		73.0 (66.3-78.8)		53.0 (46.0-59.9)	
Overall	80.0 (75.7-83.7)		74.0 (69.3-78.1)		54.5 (49.5-59.4)	
bekizumab 160 mg at week 0, 80 mg every 2 wk until week 12, then 80 mg every 4 wk						
00RA-S[16] (N = 136)	88.2 (81.6-92.6)		76.5 (68.7-82.9)		52.2 (43.8-60.5)	
UNCOVER 3[48] (N = 385)	83.0 (78.9-86.4)		73.0 (68.3-77.2)		55.0 (50.0-59.9)	
Overall	85.0 (79.2-89.4)		73.9 (69.9-77.5)		54.3 (50.0-58.5)	
Secukinumab 300 mg at week 0, 1, 2, and 3, then every 4 wk						
CLEAR[13] (N = 334)	91.6 (88.1-94.1)		74.9 (69.9-79.2)		44.9 (39.7-50.3)	
Pooled analysis of four trials (ERASURE,[50] FEATURE,[51] FIXTURE,[50] and JUNCTURE[52]) (N = 686)	85.2 (82.3-87.7)		68.1 (64.5-7.15)		40.8 (37.2-44.5)	
Overall	88.6 (80.6-93.6)		71.3 (64.2-77.5)		42.4 (38.5-46.4)	
Ustekinumab 45 mg or 90 mg at week 0, 4, then every 12 wk						
AMAGINE-2[70] (N = 300)	62.0 (56.4-67.3)		48.0 (42.4-53.7)		30.0 (25.1-35.4)	
AMAGINE-3[70] (N = 313)	63.0 (57.5-68.2)		50.0 (44.5-55.5)		29.0 (24.2-34.3)	
CLEAR[13] (N = 335)	78.2 (73.5-82.3)		60.6 (55.3-65.7)		36.7 (31.7-42.0)	
00RA-S[16] (N = 166)	75.9 (68.8-81.8)		59.0 (51.4-66.3)		35.5 (28.6-43.1)	
PSTELLAR[84] (N = 69)	82.6 (71.8-89.8)		–		–	
UltIMMa1[15] (N = 100)	70.0 (60.3-78.2)		44.0 (34.6-53.8)		21.0 (14.1-30.1)	
UltIMMa2[15] (N = 99)	76.8 (67.5-84.0)		50.5 (40.8-60.2)		30.3 (22.1-40.0)	
Overall	72.5 (65.9-78.2)		52.4 (4.71-57.7)		31.0 (27.2-35.2)	
Adalimumab 80 mg at week 0, then 40 mg every 2 wk						
ADACCESS[69] (N = 115)	79.6 (71.3-86.0)		51.0 (41.9-60.0)		29.6 (22.0-38.6)	
Gordon 2006[14] (N = 45)	56.0 (41.4-69.6)		33.0 (20.9-47.8)		16.0 (7.9-29.7)	
VOYAGE 1[17] (N = 334)	62.6 (57.3-67.6)		47.9 (42.6-53.3)		23.4 (19.1-28.2)	
Overall	67.1 (52.9-78.7)		46.2 (38.6-53.9)		24.2 (18.8-30.7)	
Infliximab 5 mg/kg at week 0, 2, and 6, then every 8 wk						
EXPRESS[41] (N = 281)	60.5 (54.7-66.0)		45.2 (39.5-51.1)		–	
EXPRESS II[42] (N = 134)	54.5 (46.0-62.7)		34.3 (26.8-42.7)			
Overall	58.3 (52.5-63.8)		40.1 (30.0-51.1)			
Etanercept 50 mg until week 12, then once weekly						
FIXTURE[50] (N = 323)	55.5 (50.1-60.9)		33.4 (28.5-38.7)			
Overall	55.5 (50.1-60.9)		33.4 (28.5-38.7)			
Apremilast 30 mg twice daily						
LIBERATE[19] (N = 74)	52.7 (41.4-63.8)		17.6 (10.5-27.9)			
Ohtsuki 2017[74] (N = 65)	40.0 (30.2-50.7)		–			
PSOR-005[73]/PSOR-006[58] (N = 58)	36.2 (24.9-49.2)		13.8 (7.1-25.2)			
Overall	43.2 (33.8-53.0)		16.0 (10.7-23.3)			

25 50 75 100
Response Rate, %

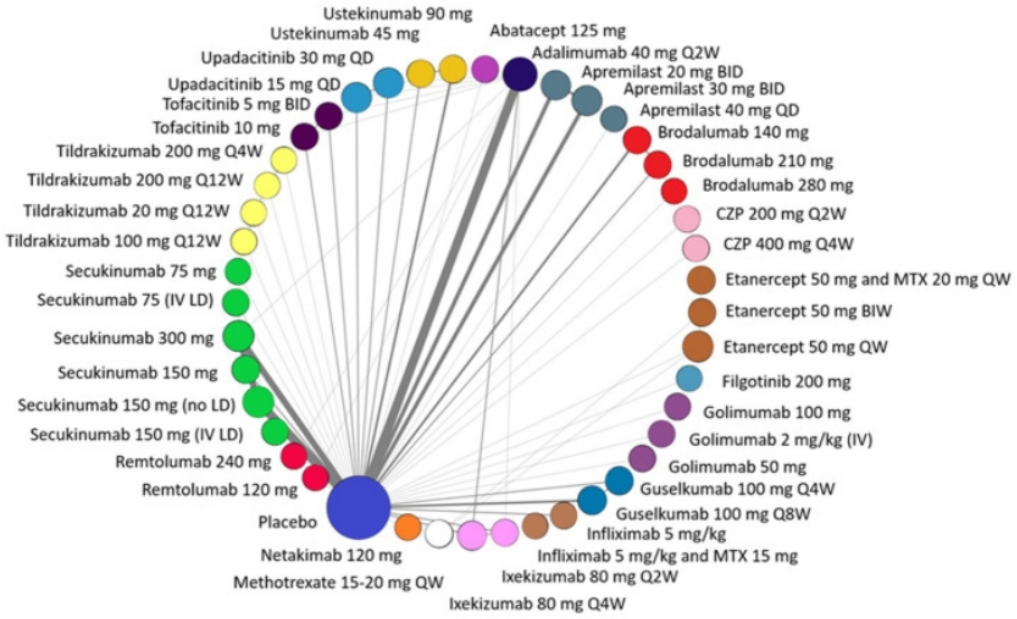
0 25 50
Response Rate

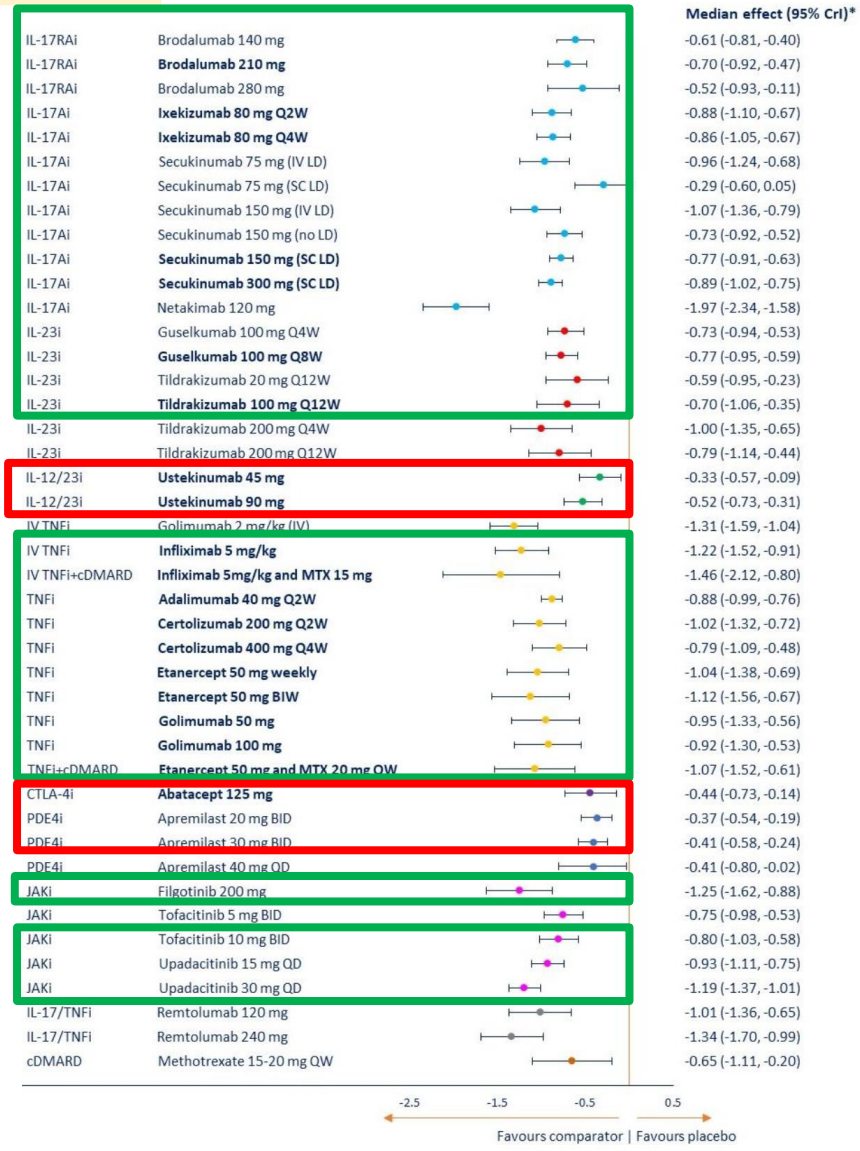
Armstrong AW. JAMA Dermatol. 2020 Mar 1;156(3):258-269

Targeted systemic therapies for psoriaticarthritis: a systematic Review and comparative synthesis of short-term articular, dermatological, entesitis and dactilitis outcomes

Respuesta articular(ACR)

46 ECA

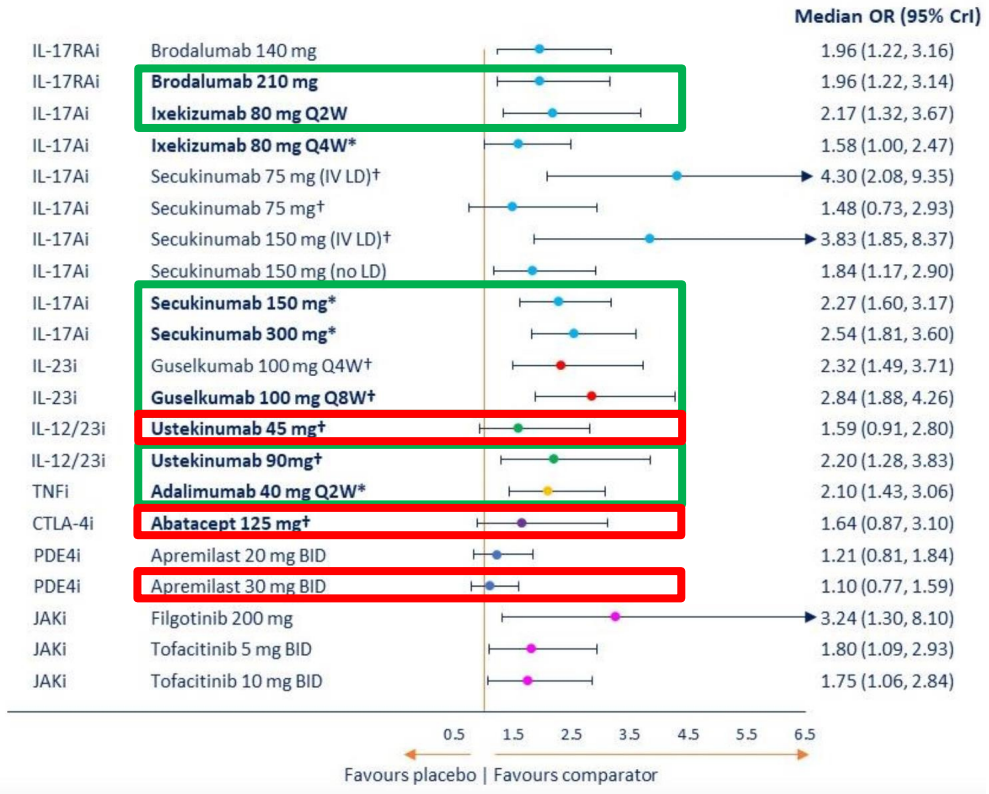




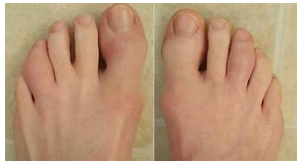
McInnesIB, SawyerLM, MarkusK, etal. RMD Open 2022;8:e002074 (matsupl)

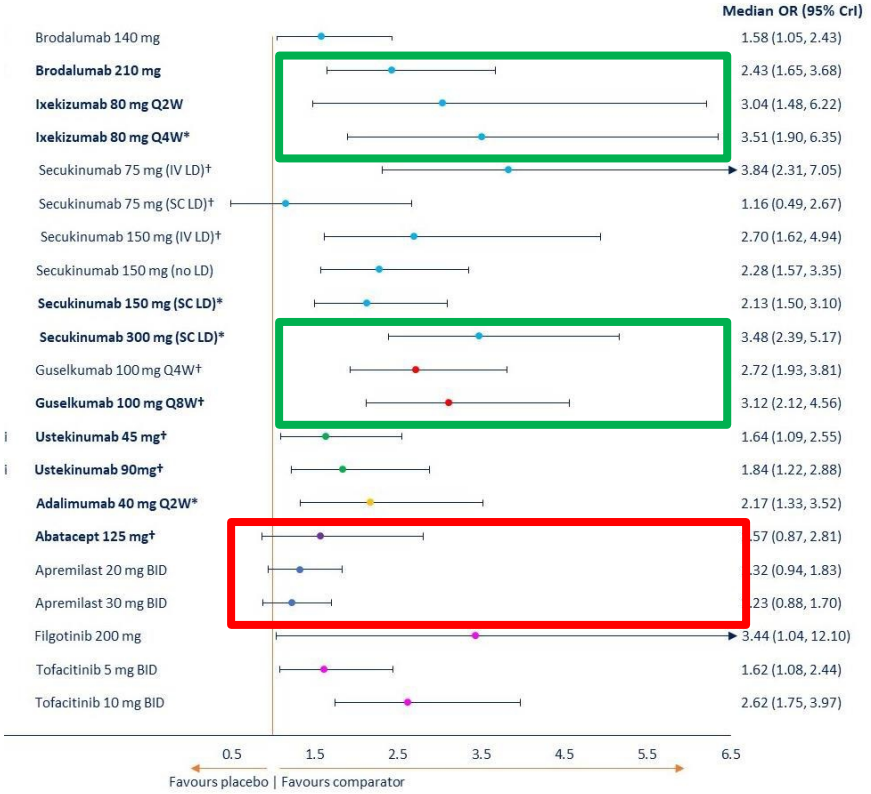
Targeted systemic therapies for psoriaticarthritis: a systematic Review and comparative synthesis of short-term articular, dermatological, entesitis and dactilitis outcomes

Entesitis



Dactilitis





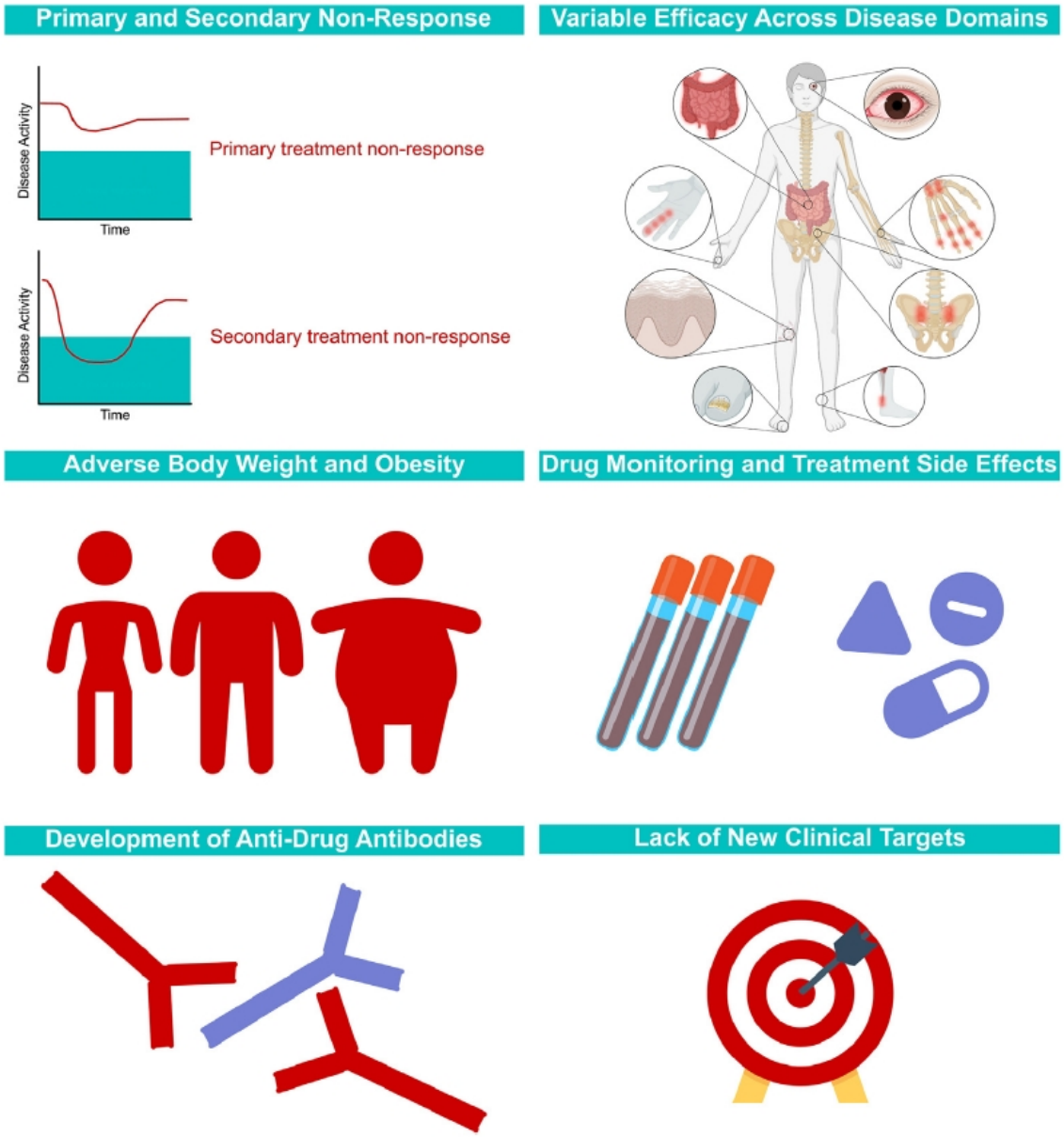
McInnesIB, SawyerLM, MarkusK, etal. RMD Open 2022;8:e002074

Perfil de pacientes candidatos a diferentes dianas

1. Fenotipos/Dominios
2. Manifestaciones extraarticulares
3. Comorbilidades

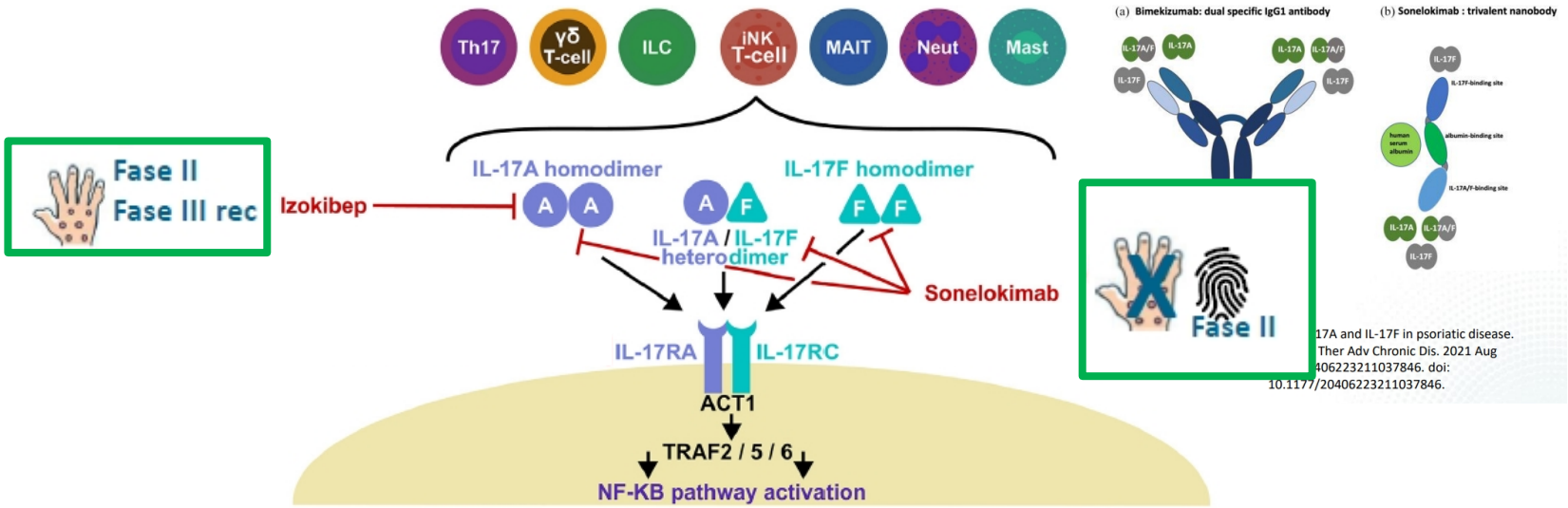
Ningún tratamiento logra consistentemente una respuesta ACR20 en más del 60% de los pacientes, y aproximadamente el 50% de los pacientes tienen daño radiológico los 2 años posteriores al inicio

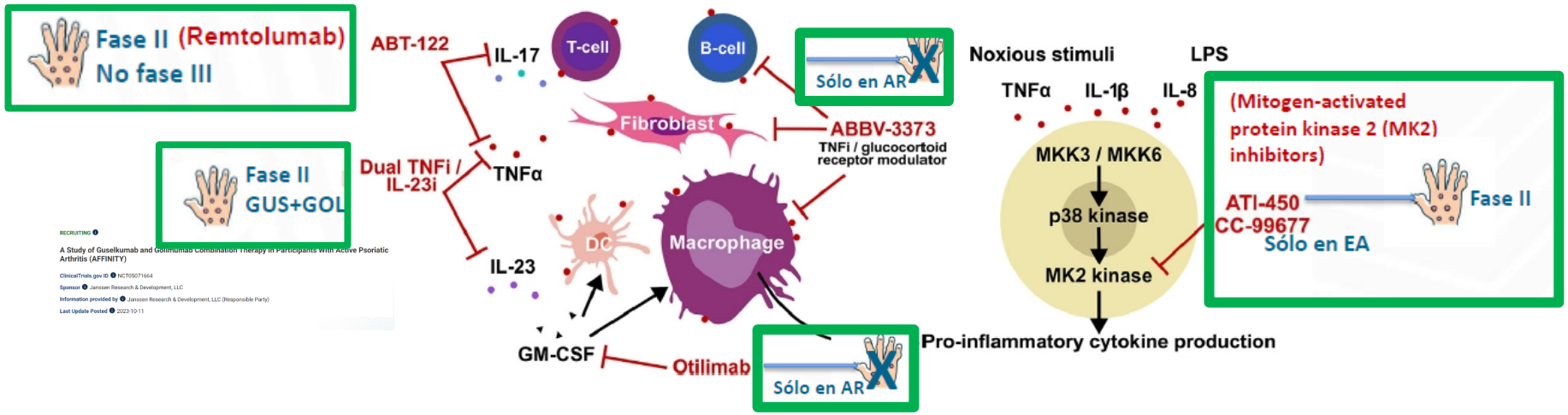
Motivos del fracaso terapéutico en la PsA



Best Practice & Research Clinical Rheumatology 36 (2022)

Horizon scan: State-of-the-art therapeutics for psoriatic arthritis

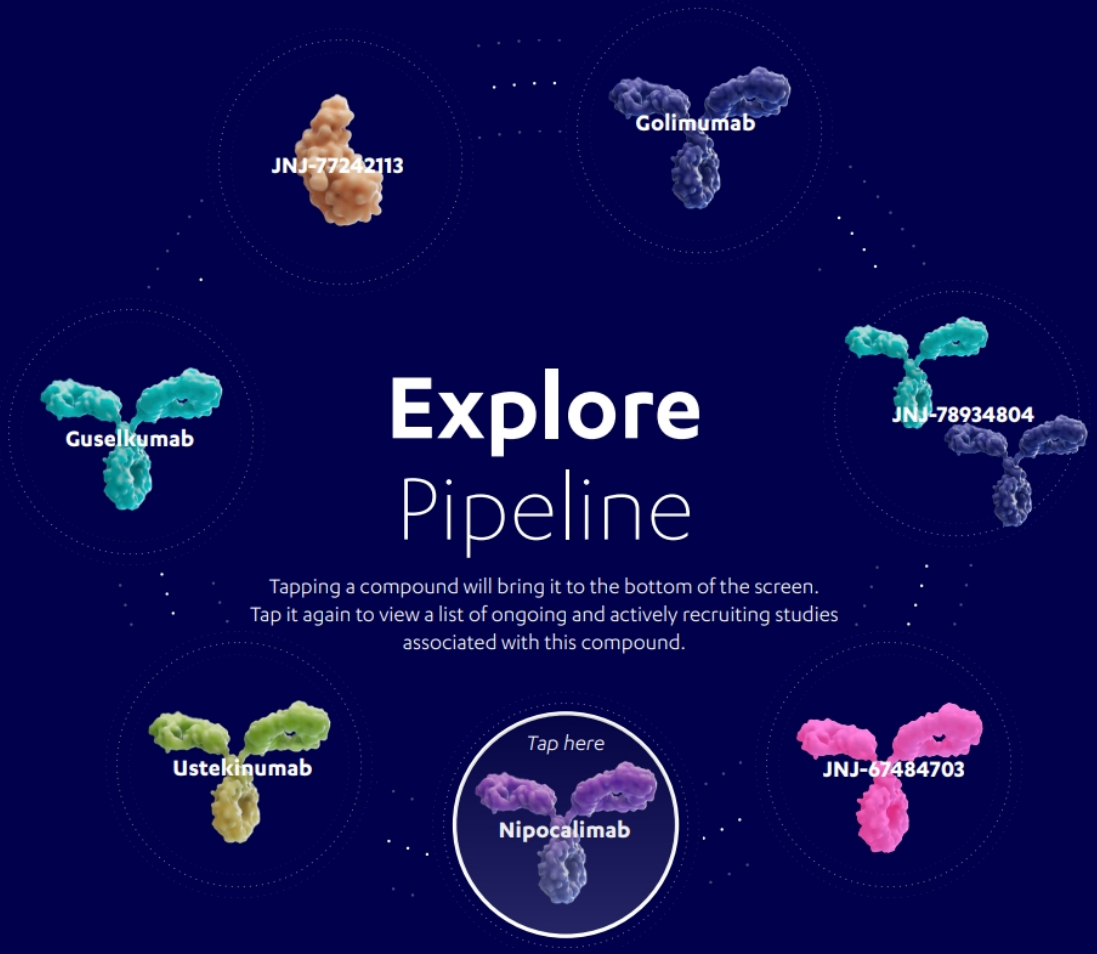




J. Hutton, P. Mease and D. JadonBestPractRes Clin Rheumatol. 2022 Dec23:101809

The Future of
Immunology

janssen Immunology



Explore Pipeline

Tapping a compound will bring it to the bottom of the screen.
Tap it again to view a list of ongoing and actively recruiting studies associated with this compound.

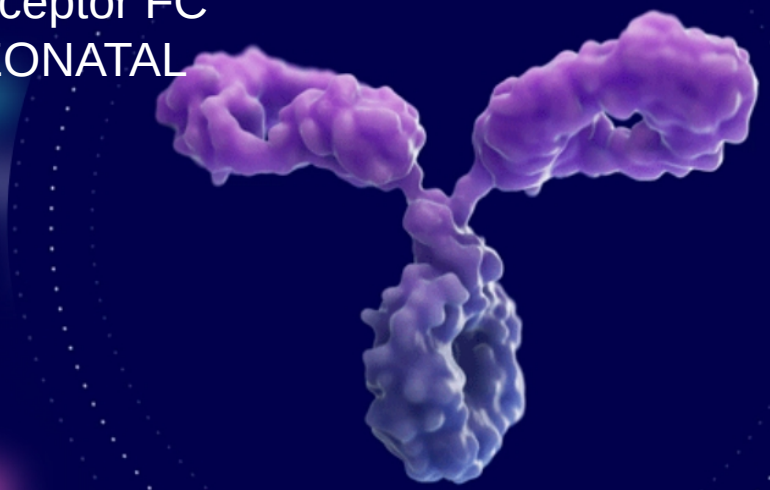
The Future of
Immunology

Janssen Immunology

4/7

Nipocalimab

(Anticuerpo anti-FcRn)
Receptor FC
NEONATAL



Tap a (trial) below to learn more

TRIAL	PHASE	THERAPY AREA	NCT CODE
-	●●○○	pSS	NCT04968912
JASMINE	●●○○	SLE	NCT04882878
SPIREA	●●○○	IIM	NCT05379634
MARIGOLD	●●/●○	BP	-
ENERGY	●●/●○	wAIHA	NCT04119050

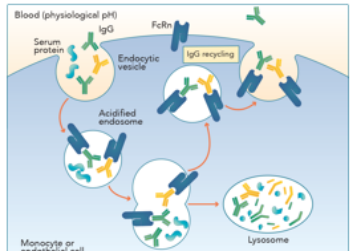
Color Key:
● Rheumatology ● Dermatology ● wAIHA

BP, bullous pemphigoid; IIM, idiopathic inflammatory myopathies; pSS, primary Sjö
SLE, systemic lupus erythematosus; wAIHA, warm autoimmune hemolytic anemia.

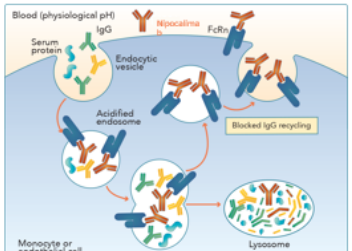
Nipocalimab: A fully human mAb blocking FcRn

Nipocalimab is a fully human, aglycosylated IgG1 monoclonal antibody designed to selectively bind, saturate and block the IgG-binding site on the endogenous FcRn

FcRn function



Nipocalimab blockade



The Future of
Immunology

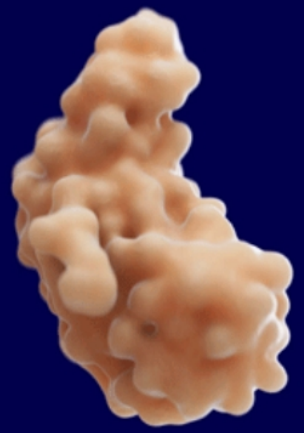
janssen Immunology

5/7

JNJ-77242113 (IL-23 oral)

Tap a (trial) below to learn more

TRIAL	PHASE	THERAPY AREA	NCT CODE
FRONTIER-2*	●●○○	Plaque PsO	NCT05364554
SUMMIT*	●●○○	Plaque PsO	NCT05357755
Oral anti IL-23 CD	●●○○	CD	-
Oral anti IL-23 UC	●●○○	UC	-



Color Key:
● Dermatology ● Gastroenterology

CD, Crohn's disease; IL, interleukin; PsO, psoriasis; UC, ulcerative colitis.

*Study is ongoing and no longer recruiting.

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Conclusiones

- ✓ La PsA es una **enfermedad heterogénea,** con múltiples **manifestaciones clínicas y comorbilidades** asociadas.

- ✓ Nuevos conceptos en el manejo: **Medicina de la precisión** (Basada en tejido e inmunofenotipos séricos) **y posibilidad de Intercepción de la enfermedad** (ventana oportunidad)

- ✓ Aunque existen tratamientos eficaces, **un alto % de pacientes →respuesta insuficiente al tratamiento o pierden la eficacia**, provocando dolor, daño estructural y discapacidad POR LO QUE **SIGUE SIENDO NECESARIO NUEVAS OPCIONES DE TRATAMIENTO**

- ✓ Las terapias aprobadas recientemente incluyen **inhib de IL-17A/IL-17F**, **inhib de la subunidad p19 de IL-23** e **Inhib JAK. (**han mostrado seguridad y eficacia)

- ✓ Varias terapias prometedoras están en el horizonte, incluidos **inhibidores de TYK2, inhibidores de MK2, nanoinhibidores de IL-17, nanoAnticuerpos duales IL-17 A/IL17-F y otras terapias duales.**

MUCHAS GRACIAS