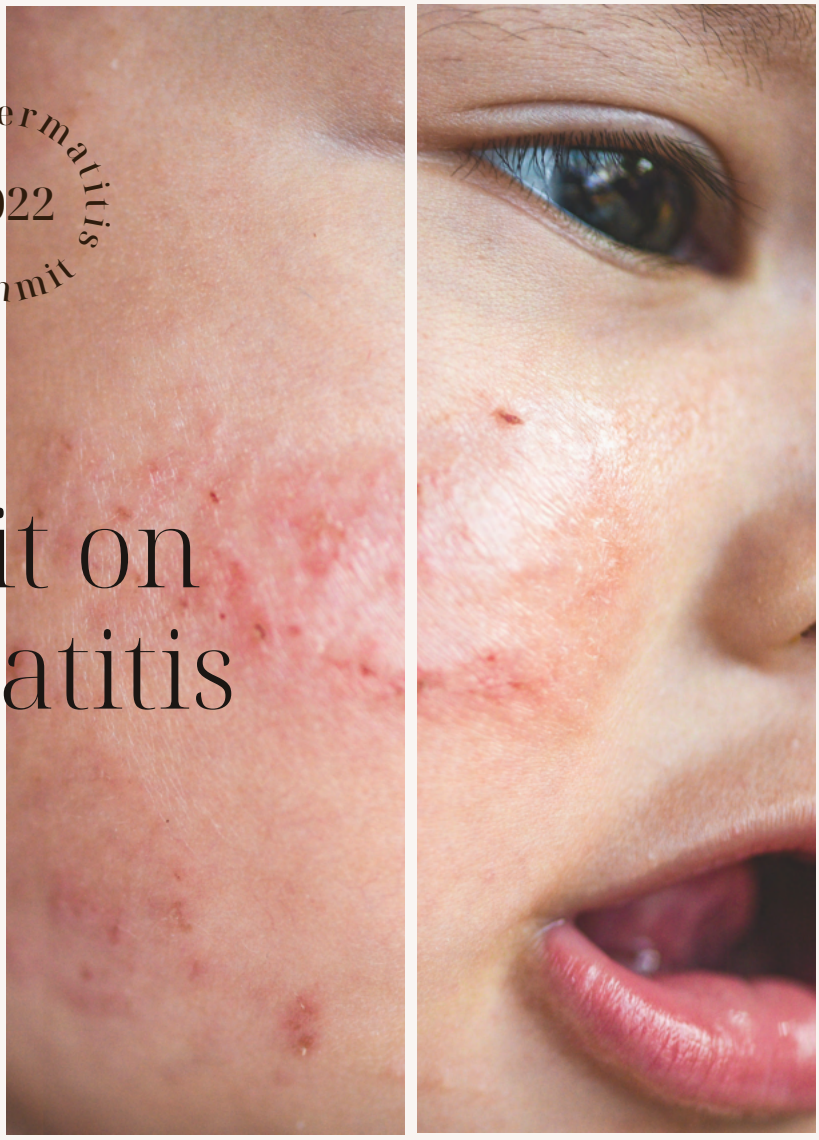
atopic dermatitis 2022 summit



advance briefing

2022 summit on atopic dermatitis

Saturday, April 23, 2022
10 am – 2 pm ET

what is atopic dermatitis?

Atopic dermatitis (AD) is the most common form of eczema, and can be found in patients of all ages and backgrounds, although it usually begins in children under five years of age. It often resolves before a child's 18th birthday, but may reoccur and can become a life-long chronic condition. There is no cure, but it is not contagious.

According to the Canadian Dermatology Association (CDA), up to 17% of Canadians will have AD at some point in their lives. And, according to the American Academy of Dermatology (AAD), one in 10 Americans has AD, and “research indicates that African American and Asian American children develop AD more often than white children.”

Atopic dermatitis usually appears inside the bend of elbows and knees, and can also appear on hands, feet, ankles, wrists, neck, upper chest and even on the eyelids. In infants, AD can appear on the face and scalp.

It is characterized by:

- Dry skin
- Red to brownish-grey patches of skin
- Severe, sometimes nearly unbearable pruritis, especially at night, which can lead to a severe disruption of sleep patterns
- Small raised bumps which can leak fluid and crust over when scratched
- Thickened and scaly skin, which can also be cracked
- Raw and swollen skin from scratching, which can lead to the skin splitting, leaving the patient vulnerable to infections

While allergies do not cause AD, children with AD also often develop asthma and/or hay fever and often have family members with those conditions.

While the exact cause of AD is unknown, there are triggers that can lead to flares of AD or can make the condition worse. These can include sweat, stress, obesity, perfumed soaps, detergents, cold and dry air, irritants and chemicals, rough materials like wool, colds or flu, swimming, dust and pollen. In infants and children, eating certain foods, including eggs, milk, soy and wheat, can lead to flares.

According to the Eczema Society of Canada, eczema can wax and wane, and can migrate around the body. This is the chronic nature of the disease, the Society says on their website. When the skin cycles back to inflammation, the patient experiences a flare.

Because AD can affect a patient's appearance, it can have a detrimental effect on quality of life, leading to self-consciousness and affecting socialization. In severe cases, chronic AD can lead to serious depression.

Pfizer
Inflammation & Immunology

Break • through:

(noun)

An advance in knowledge as a result of research and perseverance

Areas of exploration include:

- Atopic Dermatitis
- Alopecia
- Vitiligo
- Psoriasis

It's what we strive for in our relentless pursuit of innovative research in chronic inflammatory skin diseases.

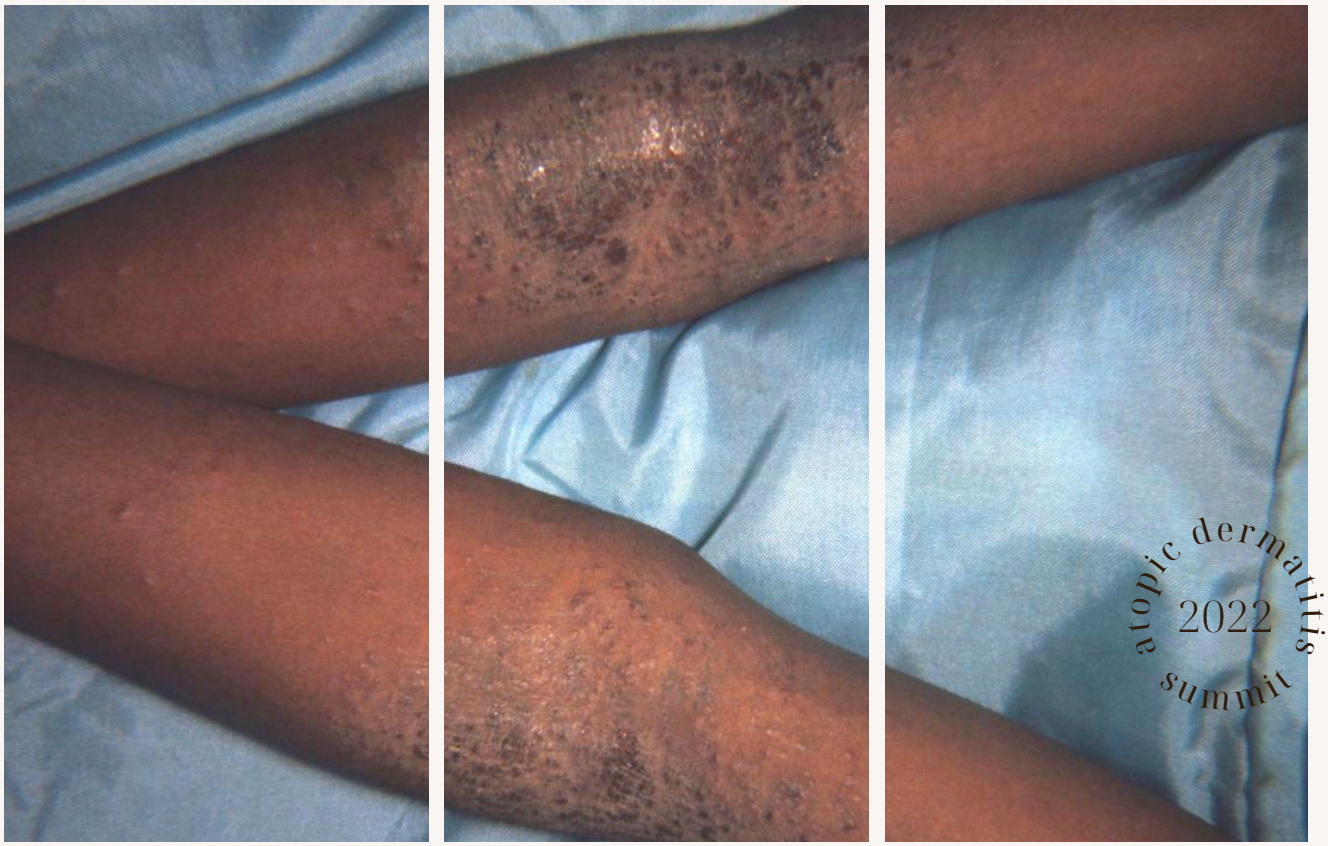
Pfizer Inflammation & Immunology's unwavering commitment to research in dermatology sees us building on our pioneering science and expertise as we work to better understand chronic inflammatory skin conditions.

diagnostic challenges in dark skin

Red patches tend to appear in patients with lightly pigmented skin. In darker-skinned patients, these patches can be harder to see. According to the AAD, “sometimes, the condition is missed altogether because it is less noticeable. In brown or black skin, [dermatologists] tend to see grey to violet-brown skin discolouration rather than red rashes.”

At the 7th Annual Skin Spectrum Summit in November 2021, Dr. Marissa Joseph told attendees that those differences in presentation can lead to delays in diagnosis for patients of colour.

“There are unmet needs in the management of atopic dermatitis in skin of colour, which can lead to a delay in diagnosis, late referral to a dermatologist, more severe disease at the treatment time of presentation and the referral not catching the severity of the disease with respect to triage,” she said.



causes of AD

The exact cause of AD is unknown, although it is often considered hereditary. Patients with asthma and/or hay fever, or with a family history of those conditions, are more likely to develop AD. According to the U.S.-based National Eczema Association (NEA), AD causes a disruption of the immune system for unknown reasons.

This disruption leads to disordered, overactive immune function in the skin and inflammation that weakens the skin's barrier function. These changes leave the skin dry and prone to itch, and can also result in changes to the skin colour—reds in lighter skin tones and purple, brown or greyish in darker skin types.

The NEA's website explains that mutations in genes that code for the protein filaggrin—which plays a role in maintenance of the skin barrier—are also found in the skin of patients with AD.

"Research shows that some people with eczema, especially atopic dermatitis, have a mutation of the gene responsible for creating filaggrin. Filaggrin is a protein that helps our bodies maintain a healthy, protective barrier on the very top layer of the skin. Without enough filaggrin to build a strong skin barrier, moisture can escape and bacteria, viruses and more can enter. This is why many people with AD have very dry and infection-prone skin."

As noted above, patients with AD can have various triggers which—although they do not cause AD—can lead to flares or recurrence after an absence of disease.

The first once-daily oral JAK inhibitor therapy indicated in AD*†

CHOOSE

RINVOQ®
upadacitinib

POWERFUL EFFICACY DEMONSTRATED in moderate to severe AD

RINVOQ is indicated for the treatment of adults and adolescents 12 years of age and older with refractory moderate to severe atopic dermatitis (AD) who are not adequately controlled with a systemic treatment (e.g., steroid or biologic) or when use of those therapies is inadvisable. RINVOQ can be used with or without topical corticosteroids.

Not a real patient, for illustrative purposes only.

In the Measure Up 1 study:‡

RINVOQ 15 mg demonstrated significant improvement in skin clearance (as measured by proportion of patients with EASI 75; co-primary endpoint & EASI 90; secondary endpoint) **vs.** placebo at Week 16[1,2]

- **EASI 75**: **69.6%** (n/N=196/281) **vs. 16.3%** (n/N=46/281) of patients achieved EASI 75 with **RINVOQ 15 mg vs. placebo** (p<0.0001, multiplicity-controlled).
- **EASI 90**: **53.1%** (n/N=149/281) **vs. 8.1%** (n/N=23/281) of patients achieved EASI 90 with **RINVOQ 15 mg vs. placebo** (p<0.0001, multiplicity-controlled).

A rapid improvement in skin clearance was achieved for RINVOQ 15 mg compared to placebo (defined as EASI 75 by Week 2; secondary endpoint)[1,2]

- **EASI 75**: **38.1%** (n/N=107/281) **vs. 3.6%** (n/N=10/281) of patients achieved EASI 75 at Week 2 with **RINVOQ 15 mg vs. placebo** (p<0.0001, multiplicity-controlled).

A greater proportion of patients treated with RINVOQ 15 mg achieved clinically meaningful itch reduction (≥4-point reduction in Worst Pruritus NRS; secondary endpoint) compared to placebo treatment group at Week 16

- **≥4-point reduction in Worst Pruritus NRS**: **52.2%** (n/N=143/274) **vs. 11.8%** (n/N=32/272) of patients achieved a ≥4-point reduction in Worst Pruritus NRS with **RINVOQ 15 mg vs. placebo** (p<0.0001, multiplicity-controlled).

At Week 16, a greater proportion of patients treated with RINVOQ 15 mg achieved clinically meaningful improvement in emotional state (ADerm-IS emotional state domain score improvement from baseline; secondary endpoint) compared to placebo group (RINVOQ 15 mg [n/N=142/227]: 62.6%; placebo [n/N=42/212]: 19.8%; p<0.0001, RINVOQ vs. placebo, multiplicity-controlled).

* Comparative clinical significance has not been established.
† Please see Product Monograph for additional dosing and administration information.
‡ Measure Up 1 was a 16-week, randomized, double-blind, multicentre, placebo-controlled study that included adolescent and adult patients with refractory moderate to severe atopic dermatitis not adequately controlled by topical medication(s). At baseline, patients had an vIGA-AD score ≥3 in the overall assessment of AD (erythema, induration/papulation, and oozing/crusting) on an increasing severity scale of 0 to 4, an EASI score ≥16 (composite score assessing extent and severity of erythema, edema/papulation, scratches and lichenification across 4 different body sites), a minimum BSA involvement of ≥10%, weekly average Worst Pruritus NRS ≥4, and a DLQI score of ≥4 (in patients aged ≥16). Patients received RINVOQ 15 mg or RINVOQ 30 mg once daily, or placebo.

ADerm-IS: Atopic Dermatitis Impact Scale; BSA: body surface area; DLQI: Dermatology Life Quality Index; EASI: Eczema Area and Severity Index; JAK: Janus kinase; NRS: Numerical Rating Scale; vIGA-AD: validated Investigator's Global Assessment for Atopic Dermatitis.

References: 1. RINVOQ Product Monograph. AbbVie Corporation. **2.** Guttman-Yassky E, Teixeira HD, Simpson EL, *et al.* Once-daily upadacitinib versus placebo in adolescents and adults with moderate-to-severe atopic dermatitis (Measure Up 1 and Measure Up 2): results from two replicate double-blind, randomised controlled phase 3 trials. *Lancet* 2021;397(10290):2151-68.

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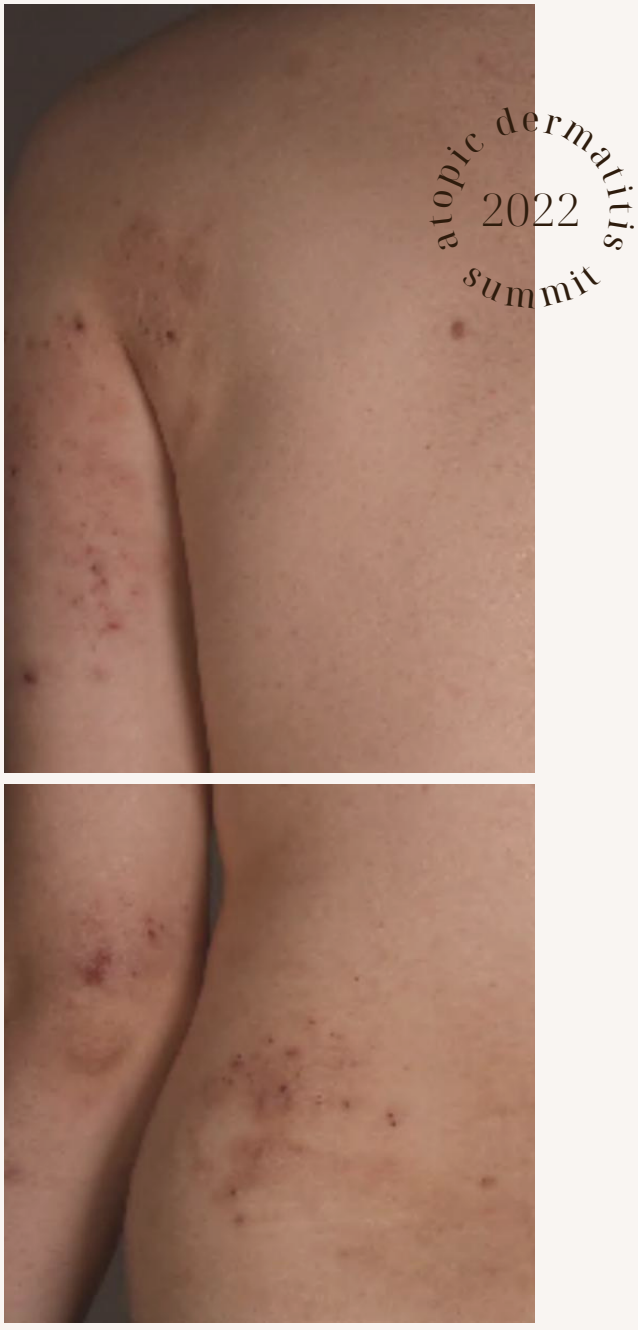
treatment of AD

Communicating with patients about treatment regimens and expected outcomes is crucial to effective treatment. According to the CDA, failure to follow treatment recommendations is the most significant barrier to successful management of eczema. They estimate that only 24% of patients with eczema properly follow the treatments recommended by their physician.

As well as avoiding triggers, skincare is crucial to controlling AD. Patients should moisturize two to three times a day, and should use fragrance- and alcohol-free products. Barrier repair creams containing ceramides may be recommended. Baths or showers should be as short as possible and patients should use gentle, fragrance-free soaps, and moisturize afterwards. A bleach bath, properly diluted, can kill bacteria on the skin, which can lead to a reduction in itching and visible irritation.



Anti-itch creams such as hydrocortisone cream or medications such as antihistamines will help with itching and lessen the need to scratch. Physicians may prescribe creams containing calcineurin inhibitors to help control skin reactions.

For infections caused by scratching or splitting, antibiotic creams can be used. If needed, oral antibiotics can also be prescribed. For short-term control of inflammation, physicians may prescribe oral corticosteroids such as prednisone.

For severe cases of AD, the use of biologics may be called for.

Other therapies such as wet dressings—wrapping the affected area with topical corticosteroids and wet bandages—and phototherapy—exposing the skin to ultraviolet light—may also be useful for more severe cases of AD.

recent studies

A recent study published in December in the *Journal of the American Medical Assocation (JAMA) Dermatology* concluded that the use of dupilumab to treat AD has been successful over a long-term period.

After a 12-month study of 699 patients, the authors concluded that, "This cohort study found that use of dupilumab for the treatment of atopic dermatitis was associated with early (one month) of patient-reported benefits that were maintained after 12 months of therapy."

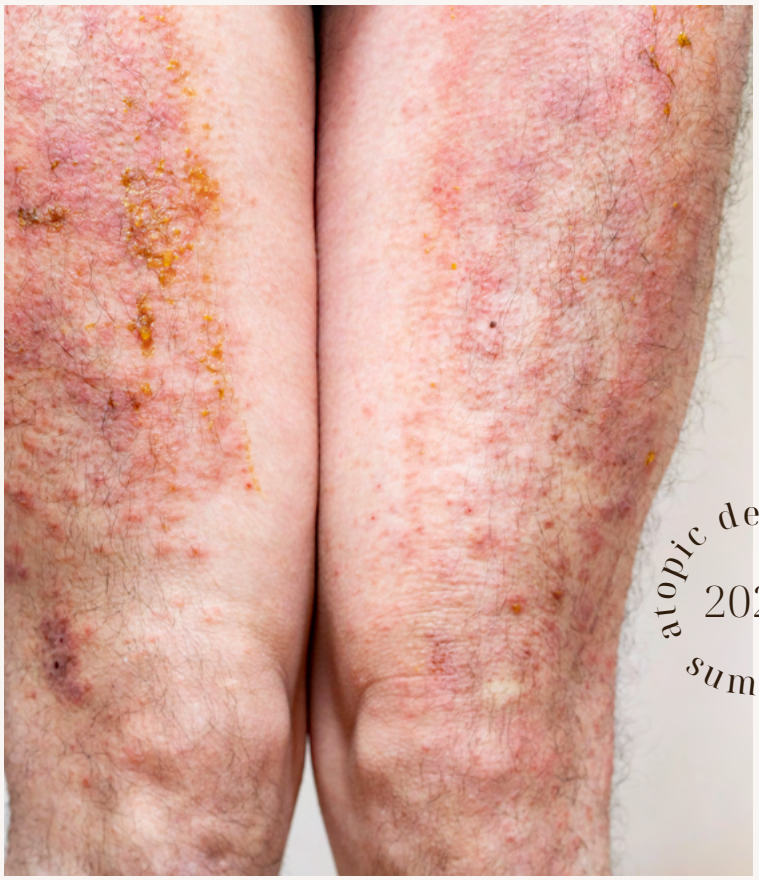
Another promising class of treatments for AD going forward is Janus Kinase (JAK) inhibitors.

Research indicates that immune system messengers called cytokines may play a role in causing abnormal immune system responses that can lead to AD and other immune-related diseases like rheumatoid arthritis, psoriatic arthritis and ulcerative colitis. Cytokines transmit their messages through a pathway in cells called the JAK-STAT pathway (Janus Kinase-Signal transducer and activators of transcription). JAK inhibitors are able to shut down those overactive pathways.

According to an article published last year on the website of the National Eczema Association, JAK inhibitors could be highly effective.

“JAK inhibitors block nerve itch signals, are anti-inflammatory, and they work quickly,” Dr. Eric Simpson, professor of dermatology at Oregon Health and Science University, told the Association.

“Similar to biologics, JAK inhibitors can help combat AD at the immune system level and, according to Dr. Simpson, they may be able to do so more broadly than a targeted biologic can, given their ability to inhibit the effects of several cytokines,” the article reports.



In January of this year, the U.S. Food and Drug Administration approved the use of the JAK inhibitors upadacitinib and abrocitinib to treat AD. Health Canada approved the use of upadacitinib in October of last year.

An article published last year in the *International Journal of Dermatology* reviewed the existing literature around the use of JAK inhibitors to treat AD. The article concluded that the literature indicates great promise for the treatment, but there is a lack of long-term data.

Dr. Melinda Gooderham, the medical director at the SKiN Centre for Dermatology and the principal investigator for the SKiN Research Centre in Peterborough, Ont. was the senior author of the study. She told *The Chronicle of Skin & Allergy* that the literature shows the side-effects of JAK inhibitors to be limited and predictable.

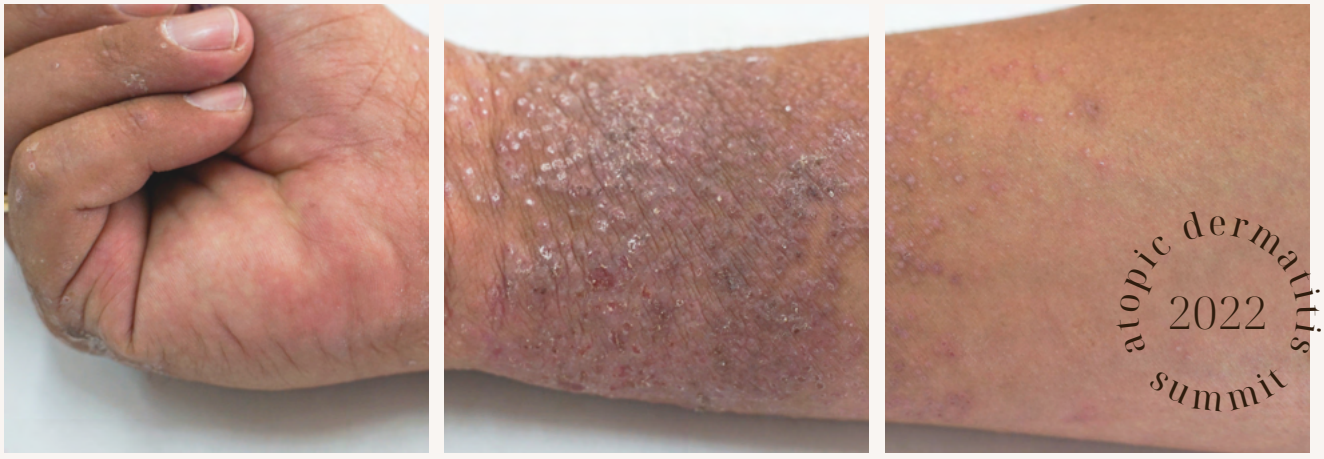
“When you look at the data and the doses that are used [in the evaluated trials], we can provide that reassurance for patients,” she said. “That we can improve their disease, their quality of life without creating too many issues.”

Dr. Gooderham said the literature also indicates that, unlike some existing treatments for AD, JAK inhibitors show no signs of causing long-term organ damage.

“There does not seem to be a cumulative impairment of any organs with JAK inhibitors,” according to Dr. Gooderham.

While more data is certainly needed, Dr. Gooderham said her article was intended to alert physicians to the possibilities of JAK inhibitors.

“I think the rates [of side effects] are low and they are manageable if physicians know what they are looking for,” she said. “The purpose [of the article] is to make people comfortable with a new treatment option that will help our patients.”



MILD TO MODERATE ATOPIC DERMATITIS

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ELIDEL® THAT ITCH

In a study in patients aged 3 to 23 months, more Elidel® patients (72.4%) had absent or mild pruritus than vehicle treated patients (33.3%) at 6 weeks (p<0.001) (secondary endpoint).‡

In a pooled analysis of two studies in pediatric patients aged 2-18 years, more Elidel® patients (57%) had mild or no pruritus than vehicle treated patients (34%) at 6 weeks (p<0.001).§

Indicated for second-line therapy for short term and intermittent long-term therapy of mild to moderate atopic dermatitis in non-immunocompromised patients 3 months of age and older, in whom the use of alternative, conventional therapies is deemed inadvisable because of potential risks, or in the treatment of patients who are not adequately responsive to or intolerant of alternative, conventional therapies.

CLINICAL USE:

Geriatrics (>65 years of age): Clinical studies of ELIDEL® did not include sufficient numbers of patients aged 65 and older to establish efficacy and safety of the drug in geriatric patients.

CONTRAINDICATIONS:

Known or suspected hypersensitivity to pimecrolimus or any of the cream components.

RELEVANT WARNINGS AND PRECAUTIONS:

- Active cutaneous viral infections
- Clinically infected atopic dermatitis
- Varicella zoster or herpes simplex virus infection, eczema herpeticum
- Skin bacterial infections
- Lymphadenopathy
- Skin papilloma or warts
- Exposure to natural or artificial sunlight
- Malignancies, including cutaneous and other types of lymphoma and skin cancers
- Immunocompromised patients
- Ophthalmic use
- Netherton's syndrome
- Skin burning
- Pregnant or nursing women
- Contact with nose, eyes and mouth

FOR MORE INFORMATION:

Please see Product Monograph at https://health-products.canada.ca/dpd-bdpp/index-eng.jsp for important information on adverse reactions, drug interactions and dosing not discussed in this piece. Product Monograph is also available by calling 1-800-361-4261.

† Comparative clinical significance is unknown.

‡ Based on a 6-week, double-blind, randomized, vehicle-controlled, multicentre trial in 186 patients aged between 3 and 23 months with mild to moderate atopic dermatitis (Elidel®, n=123; vehicle, n=63). The intensity of overall itching/scratching in the 24 hours before a visit was assessed using values ranging from 0 (no itching/scratching) to 3 (itching/scratching that disturbs sleep).

§ Based on two identical 6-week, randomized, vehicle-controlled, multicentre, phase III trials in 403 patients 2-18 years old with mild to moderate atopic dermatitis (Elidel®, n=267; vehicle, n=136). The mean body surface area (BSA) affected was 26%. About 75% of patients had atopic dermatitis affecting the face and/or neck region.

REFERENCES: 1. ELIDEL® Product Monograph, Bausch Health Canada Inc. January 2020.
2. Ho VC, Gupta A, Kaufmann R, et al. Safety and efficacy of nonsteroid pimecrolimus cream 1% in the treatment of atopic dermatitis in infants. *The Journal of Pediatrics*. 2003;142(2):155–62.

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conference chairs

Dr. Marissa Joseph

Dr. Marissa Joseph is a board-certified pediatrician and dermatologist in Canada and the U.S. and is full-time academic faculty at the University of Toronto. She has received and has been nominated for teaching awards in both undergraduate and postgraduate medical education. She has also completed an MSc in Community Health at the Dalla Lana School of Public Health.

Dr. Joseph is the Medical Director of the Ricky Kanee Schachter Dermatology Centre at Women's College Hospital. She also works at the Hospital For Sick Children where she manages children with complex dermatologic disease in outpatient and inpatient settings, as well as a pediatric laser treatment program.

Dr. Joseph enjoys her diverse practice in general adult, pediatric, and surgical dermatology. Her clinical and research interests include inflammatory skin disorders such as psoriasis, atopic dermatitis, and hidradenitis suppurativa; genodermatoses; and equity, diversity and inclusivity.

Dr. Neil Shear

Dr. Neil Shear was Head of Dermatology at Sunnybrook Health Sciences Centre and is Professor Emeritus at the University of Toronto. He retired from active practice in June 2021 and continues to provide mentorship and education in dermatology. His primary academic research was in drug safety, including basic mechanisms that lead to increased risk for drug-induced harm.

Dr. Shear's practice was considered advanced medical dermatology, with diseases of focus include atopic dermatitis, psoriasis, auto-immune blistering disease, drug-induced diseases, hidradenitis suppurativa, cutaneous lymphomas and auto-immune skin disease.

Past positions Dr. Shear has held include: President of the Canadian Dermatology Association, President of the Canadian Society of Clinical Pharmacology, President of the Canadian Professors of Dermatology, President of the Canadian Dermatology Foundation and Head of Dermatology at University of Toronto.

conference faculty

Dr. Michele Ramien

Dr. Michele Ramien is a hospital-based academic pediatric dermatologist at the University of Calgary. Her clinical practice is focused on clinical care of medically or dermatologically complex children. She is active in the university-based clinics as well as in resident teaching, in particular as a co-chair for the national exam preparation program for dermatology residents.

Dr. Ramien's main research interests are atopic dermatitis education and severe cutaneous adverse reactions (SCARs) in children. She leads a North American multicenter pediatric retrospective cohort study on SCARs and recently started a collaborative prospective study on patients who experience recurrent SCARs with US collaborators. She is also interested in quality improvement and resident education and mentorship.

Dr. Zainab Abdurrahman

Dr. Zainab Abdurrahman is a graduate of the University of Toronto Medical School and completed both her Pediatrics training and subspecialty training in Clinical Immunology and Allergy at McMaster University. She is an assistant clinical professor adjunct in the Department of Pediatrics at McMaster University and works primarily at Q & A Allergy in Mississauga.

At McMaster she is the allergy lead in the Special Immunization Clinic focusing on vaccine allergy and is an active member of the clinical immunology and allergy specialty training program. Dr. Abdurrahman is a member of the Black Scientists Taskforce on Covid-19 Vaccination Equity, the Black Health & Vaccine Initiative in association with BPAO (Black Physicians of Ontario) as well as a past member of the OMA Civility, Diversity, and Inclusion Committee. On a national level, she is also the co-supervisor of the Fellow in Training (FIT) curriculum at the Canadian Society of Allergy and Clinical Immunology (CSACI).

Dr. Danielle Marcoux

Dr. Danielle Marcoux is a dermatologist at CHU Sainte-Justine and Associate Professor in the Department of Pediatrics, University of Montreal. She completed her medical degree at the Université de Montréal and residency at Stanford Medical Center, University of California and University of Montréal.

Dr. Marcoux is the past President of the Canadian Dermatology Association, of the Montreal Dermatology Society, and of the Camp Liberté Society, a camp for children with dermatologic disorders, for which she was awarded the L'Oréal International Prize for Caring to Inspire Skin Confidence and the SKINPACT award from Galderma.

Dr. Rachel Asiniwasis

Dr. Rachel Netahe Asiniwasis is a board-certified dermatologist currently operating her own practicing in her hometown of Regina, and seeing a wide base of patients in southern Saskatchewan. Since 2015, she and her small team have expanded to service several remote and northern First Nations communities around Saskatchewan through a mixture of in-person and teledermatology clinics.

She is passionate about addressing health care challenges in remote and First Nations populations and developing proactive approaches to these challenges through a Truth and Reconciliation framework. She is the founder of Origins Dermatology Centre based in Regina.

Dr. Gurbir Dhadwal

Dr. Gurbir Dhadwal is an associate dermatologist at SkinfitMD. He attended Simon Fraser University before studying medicine at the University of British Columbia, where he graduated with honours. He then completed his dermatology residency at the University of British Columbia before joining the dermatology practice of Dr. Chih-ho Hong and SkinfitMD.

Dr. Dhadwal has lectured nationally to other physicians on dermatology topics and has served as an international examiner for dermatology qualification examinations in the Middle East.

Dr. Jaggi Rao

Dr. Jaggi Rao is a board-certified dermatologist licensed in both Canada and the United States. He is a certified cosmetic and laser surgeon, having completed an accredited fellowship in 2004 with the American Academy of Cosmetic Surgery in southern California. Dr. Rao has a very busy and popular practice in the Alberta DermaSurgery Centre in Edmonton. He specializes in medical, aesthetic, surgical and research dermatology.

Dr. Rao serves as a Clinical Professor of Medicine and was a previous Dermatology Residency Program Director at the University of Alberta. He is an accomplished author, peer reviewer and associate editor for a number of prominent medical journals, and has won numerous clinical, leadership and academic awards.

As an active researcher in the field of dermatology and pharmaceutical testing, Dr. Rao currently conducts over 15 industry-sponsored and investigator-initiated clinical trials.

Dr. Melinda Gooderham

Dr. Melinda Gooderham is a dermatologist and serves as Medical Director at the SKiN Centre for Dermatology in Peterborough, Ont. and the Principal Investigator for the SKiN Research Centre.

Currently, Dr. Gooderham is an Assistant Professor at Queens University, and also works as a Consultant Physician at the Peterborough Regional Health Centre (PRHC). She is a fellow of the Royal College of Physicians and Surgeons of Canada and Vice President of the Dermatology Association of Ontario. Actively involved in teaching, Dr. Gooderham provides medical students, medical residents, nurse practitioners, and physicians with both didactic lectures and hands-on clinical training.

atopic dermatitis 2022 summit

meeting agenda

April 23, 2022
10:00am–2:00pm EDT

Time	Topic	Duration	Faculty
10:00 AM*	Welcome & Learning Objectives	5 mins	Dr. Neil Shear
10:05 AM	Introduction to Atopic Dermatitis	20 mins	Dr. Neil Shear
10:25 AM	Differential diagnosis in AD	15 mins	Dr. Michele Ramien
10:40 AM	Diagnosis in dark skin tones	15 mins	Dr. Marissa Joseph
10:55 AM	Food allergies, allergy testing, and AD	15 mins	Dr. Zainab Abdurrahman
11:10 AM	Discussion Period	15 mins	Panel
11:25 AM	Treating pediatric cases	15 mins	Dr. Danielle Marcoux
11:40 AM	Treating adult (chronic) AD	15 mins	Dr. Jaggi Rao
11:55 AM	Challenging cases in AD	15 mins	Dr. Rachel Asiniwasis
12:10 PM	Procuring patient & caregiver resources	10 mins	Amanda Cresswell-Melville
12:25 PM	Patient experience of living with AD	10 mins	Tanya Mohan
12:30 PM	Discussion Period	15 mins	Panel
12:45 PM	Program Break	10 mins	Break
12:55 PM	Clear Horizons: Atopic Dermatitis **Sponsored by AbbVie**	20 mins	Dr. Gurbir Dhadwal
1:15 PM	JAK Inhibitors in Moderate-to-Severe AD: How Could the New Data Affect Your Practice? **Sponsored by Pfizer**	20 mins	Dr. Melinda Gooderham
1:35 PM	Discussion Period	10 mins	Panel
1:45 PM	Conclusion	5 mins	Dr. Marissa Joseph
*All times provided in EDT		**Total time**: 3 hrs 50 mins	

atopic dermatitis 2022 summit

Clinical use not mentioned elsewhere in the piece

RINVOQ should not be used in combination with other Janus kinase (JAK) inhibitors, immunomodulating biologics (e.g., biologic DMARDs), or with potent immunosuppressants such as azathioprine and cyclosporine.

The safety and efficacy of RINVOQ in adolescents weighing <40 kg and in children aged 0 to less than 12 years with atopic dermatitis have not yet been established.

Caution should be used when treating geriatric patients with RINVOQ.

Most serious warnings and precautions

Serious infections: Patients treated with RINVOQ are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids. If a serious infection develops, interrupt RINVOQ until the infection is controlled. Reported infections include active tuberculosis (TB), which may present with pulmonary or extrapulmonary disease; invasive fungal infections, including cryptococcosis and pneumocystosis; and bacterial, viral (including herpes zoster), and other infections due to opportunistic pathogens. Test patients for latent TB before RINVOQ use and during therapy. Consider treatment for latent infection prior to RINVOQ use. Do not initiate treatment in patients with active infections including chronic or localized infections. Carefully consider the risks and benefits of treatment prior to initiating therapy in patients with chronic or recurrent infections. Closely monitor patients for signs and symptoms of infection during and after treatment, including the possible development of TB in patients who tested negative for latent infection prior to initiating therapy.

Malignancies: Lymphoma and other malignancies have been observed in patients treated with RINVOQ.

Thrombosis: Thrombosis, including deep venous thrombosis, pulmonary embolism, and arterial thrombosis, have occurred in patients treated with JAK inhibitors, including RINVOQ, for inflammatory conditions. Many of these adverse events were serious and some resulted in death. Consider the risks and benefits prior to treating patients who may be at increased risk. Patients with symptoms of thrombosis should discontinue RINVOQ treatment and should be promptly evaluated and treated appropriately.

Other relevant warnings and precautions

- Increases in lipid parameters, including total, low-density lipoprotein, and high-density lipoprotein cholesterol
- Gastrointestinal perforations
- Hematologic events
- Liver enzyme elevation
- Patients with active hepatitis B or C infection
- Patients with severe hepatic impairment
- Concomitant use with other potent immunosuppressants, biologic DMARDs, or other JAK inhibitors
- Immunizations
- Viral reactivation, including herpes (e.g., herpes zoster) and hepatitis B
- Malignancies
- Increases in creatine phosphokinase
- Monitoring and laboratory tests
- Pregnant women
- Reproductive health
- Breast-feeding
- Geriatrics (≥65 years of age)
- Pediatrics (<12 years of age)
- Asian patients

For more information

Please consult the Product Monograph at rinvoq.ca/pm for important information relating to adverse reactions, drug interactions, and dosing information which have not been discussed in this piece. The Product Monograph is also available by calling us at 1-888-704-8271.

RINVOQ® upadacitinib

atopic dermatitis 2022 summit

see you soon!

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