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American Academy of Dermatology 2026—Highlights with a Pediatric Dermatology Focus

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The 2026 annual meeting of the American Academy of Dermatology (AAD) was held in Denver, Colorado, from March 27–31. As expected, the meeting featured the presentation of new data and generated ongoing excitement about therapies and approaches aimed at optimizing our care of patients. This article summarizes several key takeaways, with a focus on those relevant to pediatric dermatology.

Atopic Dermatitis

Eric Simpson presented results from the COAST1, COAST2, and SHORE studies,[1,2] which investigated amlitelimab, a non-T-cell-depleting anti-OX40L antibody that blocks OX40L–OX40 interactions on activated T-cells. Dosing every 12 weeks demonstrated efficacy comparable to dosing every 4 weeks, with minimal adverse effects (**Table 1**). In the SHORE study, background topical corticosteroids or calcineurin inhibitors were allowed, which resulted in a 7–8% improvement across most measures at 24 weeks compared to outcomes observed in the COAST studies. Notably, discussion addressed the potential associated between OX40-targeted therapies and the risk of Kaposi's Sarcoma (KS), which has been linked to OX40 deficiency.[3] Further studies on rocatinlimab, a T-cell depleting OX-40 antibody, were put on hold recently due to several cases of KS reported in studies. Nevertheless, there may still be a role for targeting OX40 in select patients given its potential impact on memory T cells, especially for those recalcitrant or unable to receive other treatments. More data and research is clearly warranted, with consideration of potential baseline assessment and monitoring of serologic markers, as well as potential stratification by factors associated with higher incidence of KS (e.g., individuals from the

Netherlands or Turkey, men who have sex with men, and black Americans).[4]

Data were also presented for nemolizumab, a monoclonal antibody targeting interleukin (IL)-31, in children aged 2–11 years with atopic dermatitis (AD) (**Table 1**). After 16 weeks, clear or almost clear skin was achieved in 40.5–47.2% of patients. Rates of asthma (2.7%) and conjunctivitis (3.7%) were low. In addition to longer dosing intervals of 4 weeks in patients aged 6–11 years, which is not currently on-label for dupilumab in this age group, many providers have noted that the injections are well tolerated, with minimal associated pain. In a session focused on pruritus, Dr. Brian Kim shared his experience with new-onset cutaneous eruptions in patients receiving nemolizumab. He suggested that these eruptions could result from activation of the oncostatin M receptor beta (OSMR-B) receptor, which normally dimerizes with the IL-31 receptor. When the IL-31 receptor is blocked, the OSMR-B receptor is freed and can be activated, resulting in pro-inflammatory effects. In his clinical experience, these new-onset skin rashes were non-pruritic and either self-limited or responsive to topical medications.

Additional promising data in adults with AD were presented for several emerging systemic therapies, including MG-K10, a long-acting monoclonal antibody binding IL-4Rα, and blocking IL-4 and IL-13 signalling; zumilokibart, an extended half-life monoclonal antibody targeting IL-13, with dosing every 3 or 6 months; and KT-621, an oral signal transducer and activator of transcription 6 (STAT6) degrader that inhibits IL4 and 13, and is administered once daily.

With our growing armamentarium of topicals for pediatric AD, new data were presented for roflumilast 0.05% cream, applied once daily for infants aged 3 to 24 months. Results for the INTEGUMENT-INFANT study were presented by Dr Larry Eichenfield.[5] This phase 2 open label trial enrolled infants with mild to moderate AD, with 49% of participants achieving clear or almost clear scores at 4 weeks (**Table 1**). Dr. Eichenfield highlighted the high efficacy in scalp dermatitis and quick onset of itch relief (within hours).

Psoriasis

Considerable excitement surrounded the results of the Together-PsA study, presented by Dr. Merola during the late-breaking sessions, and recently published.[6] In this phase 3 study, adult patients with psoriatic arthritis, a body mass index (BMI) >39, and one obesity-related complication were randomized to receive ixekizumab alone or in combination with tirzepatide. At week 36, a greater proportion of patients in the combination group achieved an ACR50 response compared to those in the monotherapy group (33.5% vs 20.4%, $p<0.05$). A similar study conducted in adult patients with plaque psoriasis demonstrated superior Psoriasis Area and Severity Index responses with the combination approach, although these results have not yet been published. Dr. Merola noted that treatment differences appeared before weight loss, suggesting that the benefit of tirzepatide could be a result of anti-inflammatory effects in addition to weight changes. Although these studies were conducted in adult populations, it is notable that ixekizumab is approved in Canada for pediatric plaque psoriasis in children aged 6 years and older, and that other glucagon-like peptide-1 (GLP-1) receptor agonists (semaglutide and liraglutide) are approved for adolescents (12 years and older) with a BMI above the 95th percentile.

Equally exciting was the presentation and review of a new joint statement from the National Psoriasis Foundation and International Psoriasis council on tuberculosis (TB) screening, which advises that routine TB testing before and during treatment with IL-17 and IL-23 inhibitors is not required.[7] In his session dedicated to psoriasis, Dr. Anthony Fernandez reviewed the evidence underpinning these recommendations, emphasizing extensive and reassuring real-world data, including only a single reported case of latent TB reactivating in a patient receiving IL-17 inhibitors among hundreds of patients treated with IL-17 inhibitors and no reported cases of disseminated or extrapulmonary TB. Of note, this recommendation suggests screening could be continued for patients on concomitant immunosuppressive therapy and for those living in TB endemic areas.

Intervention	Population	Protocol	Results	Adverse Effects
Amlitelimab SC **Anti-OX40 Ligand Antibody**	**Patients with AD ≥12 years** **IGA: 3 or 4** **BSA: 10%+** **EASI: 16+** **NNRS**	COAST1+2 Randomized 2:1:1 • amlitelimab SC Q4W + LD • amlitelimab SC Q12W + LD • placebo 24 weeks	**COAST-1:** 24 weeks **vIGA-AD:** 0/1 Q4W: 21.1%, Q12W: 22.5% vs placebo: 9.2%; P < 0.01 **EASI-75:** 35.9%, 39.1% vs 19.1%; P < 0.001 **PP-NRS:** ≥4 22.5%, 24.5% vs 12.7%; P ≤ 0.02 **COAST-2:** N=589 **vIGA-AD:** 0/1: Q4W: 25.3%, Q12W: 25.7% vs **placebo:** 14.8%; P ≤ 0.025. **EASI-75:** 41.8%, 40.5% vs 24.2% **PP-NRS:** ≥4 26.8%, 27.2% vs 17.1%	**NP:** (7.3% vs 10.5%) **dermatitis:** (7.3% vs 22.4%) **URTI:** (5.3% vs 8.6%) **NP:** (5.9% vs 7.4%) **dermatitis:** (5.3% vs 2.7%) **URTI:** (4.8% vs 4.0%)
		SHORE: As per COAST but with background topical steroid or calcineurin inhibitor	**vIGA-AD:** 0/1 Q4W: 28.7%, Q12W: 32.3% vs placebo: 16.8%; P ≤ 0.01, **EASI-75:** 48.1%, 46.8% vs 32.3%; P ≤ 0.025 **PP-NRS≥4:** 38.2%, 33.3% vs 21.5%; P ≤ 0.025	**NP:** (9.5% vs 12.5%) **URTI:** (7.9% vs 4.4%) **dermatitis:** (2.7% vs 5.6%)
Rademikibart **Antibody to IL-4Rα epitope higher affinity than dupilumab**	**Patients with AD ≥12 years** **IGA: 3 or 4** **BSA: 10%+** **EASI: 16+** **NNRS**	RADIANT-AD Randomized 1:1 • rademikibart SC LD, then Q2W vs placebo 16 weeks then OLE x 36-week • rademikibart Q2W	259 patients 204 adults, 55 adolescents **Week 16:** **IGA 0/1 and ≥2-pt IGA reduction:** 47.7% vs. placebo 17.6% P < 0.0001 **EASI-75:** 74.2% vs. placebo 34.4% P < 0.0001 **EASI-90:** 43.0% vs. 14.5% P < 0.0001 ≥3-pt **Pruritus NRS reduction:** 54.7% vs. 27.5% P < 0.0001 **Week 52:** **IGA 0/1 and ≥2-point reduction:** 87.1% , **EASI-75:** 96.6% **EASI-90:** 85.3% , ≥3-pt Pruritus NRS reduction: 91.2% .	**Week 16** (R vs placebo) **SAE:** 2.3% vs 9% **DC:** 0.8% vs 0% **Week 52:** **SAE:** 5.5% **DC:** 0.8%

Intervention	Population	Protocol	Results	Adverse Effects
Roflumilast **Topical PDE4 inhibitor**	**Infants 3–24 months** **vIGA: 2–3** **BSA: 3%+**	INTEGUMENT-INFANT Phase 2 Open label study Roflumilast 0.05% cream once daily x 4 weeks	101 patients **Week 4:** **vIGA 0/1:** 49% **EASI-75:** 58.3% **WSI-NRS:** 60.6%	**Diarrhea:** 12.9% **Nasopharyngitis:** 8.9% **URTI:** 5.9%
Nemolizumab (anti-IL-31R Antibody)	**Children 2–11 years moderate–severe AD (EASI 16+)**	Open label Nemolizumab SC Q4W with topicals 52 weeks	**Week 16:** **EASI-75:** 64–73% **IGA success:** 40.5-47.2% Pruritis response up to 72% (sustained to Week 52)	**Asthma:** 2.7% **Conjunctivitis:** 3.7% **Bronchitis:** 10%
Dersimelagon (oral MC1R agonist)	**≥12 years** **Erythropoietic Porphyria /X-Linked Porphyria**	Phase 3 RCT (INSPIRE) 200 mg or 100 mg vs placebo 16 weeks	Improved sunlight tolerance (TTP +23 min) **Patient Global Impression of Change:** -1.83, P < 0.001 Reduction of total pain events: 39%, P = 0.004	Hyperpigmentation benign nevi headache GI (mostly mild)
Upadacitinib (oral JAK1 inhibitor)	**≥12 years** **non-segmental vitiligo (F-VASI ≥0.5, T-VASI ≥5)**	Phase 3 RCT (Viti-Up1+2) 15 mg daily vs placebo (2:1) 48 weeks	Viti-Up1 (n=205+101), Viti-Up2 (n=205+101) (phase 3 trials of upadacitinib) T-VASI50 ~19–21% vs 5.9% F-VASI75 ~23–25% vs ~6%	**URTI:** 10-14% vs 8-11% **Acne:** 11% vs 3-5% **NP:** 10-17% vs 8-14% No MACE or VTE

Table 1. Select late-breaking treatments for inflammatory dermatoses in pediatric populations; *courtesy of Cathryn Sibbald, MD.*

Abbreviations: AD: atopic dermatitis; **BSA:** Body surface area; **DC:** discontinuation; **EASI:** eczema area and severity index; **GI:** gastrointestinal; **IGA:** Investigator Global Assessment; **IL:** interleukin; **JAK1:** Janus kinase 1 inhibitor; **LD:** loading dose; **MACE:** major adverse cardiac events; **MC1R:** melanocortin 1 receptor, **vIGA:** validated IGA; **NNRS:** Numeric/Numerical Rating Scale (for pruritis); **NP:** Nasopharyngitis; **OLE:** Open Label extension, **PDE:** phosphodiesterase; **PP-NRS:** Peak Pruritis Rating Scale; **Q2W:** every 2 weeks; **Q4W:** every 4 weeks; **Q12W:** every 12 weeks; **RCT:** randomized controlled trial; **SAE:** serious adverse event; **SC:** subcutaneous; **VASI:** vitiligo assessment severity Index (**T:** Total, **F:** Facial); **URTI:** Upper Respiratory Tract Infection; **VTE:** venous thromboembolism; **WSI-NRS:** Worst Scratch/Itch Numeric Rating Scale

	Age and Weight	Dosing
Adalimumab	12–17 years, ≥30 kg	80 mg Week 0, 40 mg week 1 then q2W
Secukinumab	12–17 years, ≥30 kg to <90 kg	150 mg Weeks 0, 1, 2, 3, 4 then q4W
	12–17 years ≥90 kg	300 mg Weeks 0, 1, 2, 3, 4 then q4W

Table 2. FDA approved biologics for adolescents with hidradenitis suppurativa; *courtesy of Cathryn Sibbald, MD.*

Abbreviations: FDA: U.S. Food and Drug Administration; **Q2W:** every 2 weeks; **Q4W:** every 4 weeks

Systemic treatment options for pediatric psoriasis continue to expand, with recent phase 3 studies for guselkumab, risankizumab, and icotrokinra. The U.S. Food and Drug Administration (FDA) has approved guselkumab for children aged 6 years and older with plaque psoriasis, as well as icotrokinra for adolescents aged 12 years and older. Icotrokinra is a targeted oral peptide that blocks the IL-23 receptor. One-year results from the ICONIC-LEAD study were highlighted in poster format.[8] Sixty-six participants aged 12–17 years with psoriasis (body surface area ≥10%, a Psoriasis Assessment Severity Index response of 12, and Investigator Global Assessment ≥3) were randomized to icotrokinra once daily (n=44) or placebo (n=22) for 16 weeks followed by an open label extension in which all participants received icotrokinra. By week 24, >80% of those receiving icotrokinra had clear/almost clear skin, and >90% of those maintained that response through week 52. Minimal adverse effects were reported for all participants until week 52, with the most common being infections (n=31, 44%) with no serious infections and no adverse effects leading to discontinuation. The requirement to take icotrokinra on an empty stomach may be more of a deterrent for adult patients compared to adolescents, who are likely to be excited about avoiding needles and bloodwork monitoring.

Hidradenitis Suppurativa

Multiple speakers highlighted the recent FDA approval of secukinumab for adolescents aged 12 years or older with hidradenitis suppurativa, bringing the total number of biologics approved for hidradenitis suppurativa in this population to two (**Table 2**). Dosing recommendations were based on a model-informed drug development approach, resulting in tiered dosing recommendations that differ from pediatric dosing in psoriasis.

Trisomy 21

At the pre-AAD meeting for the Society of Pediatric Dermatology, novel insights were presented from several years of research into the key role of interferon signalling in trisomy 21.[9] Building on this background, an interventional study for Janus kinase (JAK) inhibitors was conducted in patients with trisomy 21 and at least one immune-mediated cutaneous condition (alopecia areata, psoriasis, hidradenitis suppurativa, vitiligo, and AD).[10] More than 40 participants completed 16 weeks of systemic JAK inhibitor therapy. Across 27.7 patient-years of observation, a single adverse event of thromboembolism was reported, occurring in a participant who was concurrently taking oral contraceptives. Clearly, additional data will help to define which patients with trisomy 21 would benefit most from oral JAK inhibitor treatments and how this treatment should be positioned in management plans.

Polycystic Ovarian Syndrome

An update on the approach and treatment of adolescents with polycystic ovarian syndrome (PCOS) was also presented at the pre-AAD meeting. Predictably, there is interest in the benefits of GLP1 agonists for this population. An ongoing interventional study is evaluating semaglutide administered over 10 months for restoration of ovulation in adolescents and adults with PCOS.[11] The results of the first eight participants were presented, with a median weight loss of 16.5% and median free testosterone

decrease of 51.8%. Six participants experienced an increase in menses frequency, one reported no change, and one reported a decrease in menses.

Chronic Spontaneous Urticaria

Guidelines now position dupilumab and remibrutinib alongside omalizumab as first line advanced therapies for chronic spontaneous urticaria (CSU) after the failure of antihistamines at up to four times the approved dose.[9] Unfortunately, only omalizumab remains approved in Canada for CSU in pediatric populations. Safety results for dupilumab in children aged 2–11 years with CSU were presented in poster format and are also available online (NCT05526521).[12] In this study, dupilumab at doses used for AD for 24 weeks was well tolerated in the 15 participants, with a follow-up interval of 36 weeks. Only a single injection site reaction was reported. Ongoing studies including this population will be essential to support the availability of targeted treatments for children with CSU.

Spitzoid Tumours

Dr. Elena Hawlryluk provided an update on spitzoid tumours in children, emphasizing that melanomas arising in spitzoid-appearing lesions are uncommon in children. Among adolescents, melanoma was identified in 13.3% of cases (51 of 384 lesions), compared to adults (50% risk if aged >50 years).[13] High risk clinicopathologic features of spitzoid tumours in pediatric and adolescent melanomas include age at diagnosis >10 years, clinical tumour diameter >1 cm, ulceration, involvement of subcutaneous fat, a mitotic rate of 6 mm^2 or more, high-grade cytologic atypia, and the presence of an expansile dermal nodule.[9] She also reviewed recommended margins for excision spitzoid tumours.[9] In pediatric populations with atypical spitz tumours or non-spitzoid melanocytomas excised with positive margins, the recommendation is to re-excise with 1-3 mm margins without the need for sentinel node biopsy. If the tumour does not extend to the biopsy margins, no further excision is recommended. Sentinel lymph node biopsies are not recommended in either of these clinical scenarios.

Acne

During the hot topics session, Dr. Amy Flischel presented data from two recent studies with particular relevance to adolescent patients with acne. The first was an open label study evaluating an LED mask delivering combined 415-nm and 633-nm phototherapy (Omnilux Clear), which reported a mean decrease of inflammatory counts of 13.07 (standard deviation [SD] 7.29) and non-inflammatory counts of 14.73 (SD 10.86) after 7 weeks, with investigators noting improvements in erythema in 66% of patients.[14] Although interpretation is limited by the inherent biases of an open label study design, this data is helpful in providing some safety information for patients who are interested in these devices. Dr Flischel also reviewed findings from a large database study of over 20,000 patients, which reported a significantly increased risk of acne associated with hormonal intrauterine devices compared to copper devices, with incidence rates following insertion of 1.5% at 1 year, 2.8% at 3 years, and 3.6% at 5 years.[15]

Juvenile Dermatomyositis

Dr. Leslie Castelo-Soccio presented new insights into the pathogenesis and treatment of juvenile dermatomyositis (JDM). She reviewed recent data that reported on unique cytokine profiles according to antibody positivity.[16] In patients with anti–melanoma differentiation-associated protein 5 (MDA5) associated JDM, elevated levels of interferon-α (IFN-α), IL-18, and CXCL9 were observed and were associated with lung involvement. In contrast, anti–nuclear matrix protein 2 (NXP2) disease was characterized by elevated soluble tumour necrosis factor receptor II (sTNF-RII) and IL-6 levels, correlating with muscle injury. Patients with anti–transcriptional intermediary factor 1 gamma (TIF1γ) demonstrated only modest cytokine elevations, suggesting a distinct inflammatory profile.

Dr. Castelo-Soccio also highlighted the utility of examining capillary dropout in nails using dermoscopy as well as visual assessment of gingival capillaries with the naked eye to

monitor disease activity. Finally, she reviewed a growing amount of evidence supporting targeted treatments in JDM, including over 100 reports of successful systemic JAK inhibitor treatments (most commonly with ruxolitinib or baricitinib). Additional emerging data included treatment of refractory adolescents treated with anifrolimab, an interferon targeted therapy, and reports of children with refractory anti-TIF1γ disease treated with dazukibart, a monoclonal antibody targeting interferon beta.

Vitiligo

Speakers in the vitiligo sessions presented data demonstrating improvement in repigmentation outcomes with the addition of phototherapy to multiple emerging targeted therapies, including topical ruxolitinib and systemic ritlecitinib.[17,18] Practical tips on the use of topical ruxolitinib in clinical practice were discussed. While participants in clinical trials were asked to wait up to 2 hours before applying makeup or creams, in real-world settings, 30 minutes was recommended to allow for optimized morning applications. Resources to support patients and providers using home phototherapy, including treatment instructions and tracking logs, are available through the Global Vitiligo Foundation (**globalvitiligofoundation.org**).

Numerous other high-yield and engaging sessions, along with valuable opportunities to meet and connect with colleagues, contributed to an overall excellent meeting experience. Next year's meeting will be in San Francisco from March 19-23, 2027.

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