Congress Introduction

Congress Review

Review of the European Academy of Dermatology and Venereology (EADV) Congress 2026

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THE 35th European Academy of Dermatology and Venereology (EADV) Congress 2026 brought together dermatology and venereology specialists from around the world in Vienna, Austria, to share research, exchange knowledge, and strengthen international collaboration. Reflecting EADV's motto, 'Together for Better', the meeting highlighted the importance of professional education, scientific cooperation, and collective efforts to advance dermatological practice and improve patient care.

TOGETHER FOR BETTER: A GLOBAL DERMATOLOGY COMMUNITY

EADV President Branka Marinović welcomed delegates to Vienna, which had previously hosted the Congress in 2007 and 2016. Approximately 20,000 dermatology specialists from more than 139 countries gathered to connect and share research across the scientific programme. Marinović expressed her gratitude to everyone involved in organising the meeting and wished delegates a successful, inspiring, and memorable Congress.

Robert Müllegger, President of the Austrian Society of Dermatology and Venereology (ÖGDV), similarly highlighted the Congress as an opportunity for professional education, international networking, and scientific collaboration. These priorities reflected the wider spirit of 'Together for Better', bringing professionals together to exchange perspectives and advance knowledge across the specialty.

Key themes included inflammatory skin diseases, targeted therapies, personalised medicine, skin cancer, and advances in diagnosis. Sessions also explored sexually transmitted infections, AI, and emerging research, highlighting their implications for clinical practice and patient care.

The Congress also recognised excellence and contributions to the field through several prestigious awards. Christine Bodemer, Head of the Department of Dermatology, Hôpital Necker–Enfants Malades, Paris, France, received the EADV Scientific Achievement Award, while Mette Søndergaard Deleuran, Aarhus University Hospital, Denmark, was presented with

the EADV Distinguished Service Award. Antonio G. Massa, Porto, Portugal, received the Clinical Care Award, while Seemal R. Desai, The University of Texas Southwestern Medical Center, Dallas, USA; and Michele Ramien, University of Calgary, Canada, were jointly recognised with the EADV International Award.

VIENNA: A SETTING FOR SCIENTIFIC EXCHANGE

Situated at the crossroads of Central and Eastern Europe, Vienna provided a fitting setting for an international scientific gathering. Once the centre of the Habsburg Empire, the city is renowned for its imperial architecture, cultural heritage, music, and arts. Its extensive transport connections and international character also make it an attractive destination for congresses and professional meetings.

Austria's contribution to dermatology added further significance to the location. The country has a distinguished history of morphological classification of skin diseases, integrating clinical morphology with histopathology, and advancing dermatological education. Its reputation for clinical dermatology and research provided a relevant backdrop for discussions on modern challenges and developments in the specialty.

GLOBAL HEALTH CHALLENGES IN FOCUS

The opening plenary session extended beyond dermatology to consider broader threats to global health. Lidia Rudnicka, Chair of the Scientific Programme Committee, introduced keynote speaker Salim Abdool Karim of Durban, South Africa. His lecture addressed challenges facing current and future generations, including climate change, global inequality, war and conflict, pandemics, and the spread of misinformation, commonly described as the 'infodemic'.

Recognised internationally for his work on HIV, Abdool Karim highlighted the continuing burden of infection in sub-Saharan Africa, particularly among young women. Research from KwaZulu-Natal, South Africa, illustrated the scale of the challenge, reinforcing the importance of continued scientific investigation, effective public health strategies, and equitable access to healthcare.[1]

The opening discussions set the scene for a Congress centred on scientific exchange and shared learning. Through its international participation and broad scientific programme, EADV 2026 reflected the importance of collaboration in addressing challenges across healthcare and advancing better outcomes for patients.



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Dupilumab Not Associated with Increased Lymphoma Risk in Cohort Study

DUPILUMAB was not associated with an increased risk of cutaneous T cell lymphoma (CTCL) or several other lymphoid malignancies among patients with atopic dermatitis (AD) or other Type 2 inflammatory diseases (T2ID), according to a retrospective propensity-matched cohort study using real-world electronic health records presented at EADV 2026. The findings address ongoing concerns about malignancies reported during dupilumab treatment and suggest that underlying inflammatory disease may contribute to observed CTCL risk.[2]

Researchers used the TriNetX™ (TriNetX, LLC, Cambridge, Massachusetts, USA) database to compare patients receiving dupilumab with those receiving alternative systemic therapies, including corticosteroids, ciclosporin, methotrexate, azathioprine, and mycophenolate mofetil.

The study included 7,840 patients with AD and 16,926 patients with other T2IDs treated with dupilumab. Propensity-score matching accounted for demographic characteristics, comorbidities, and previous treatment exposure. The researchers assessed multiple malignancy outcomes using time-to-event analyses.

Among patients with AD, dupilumab was not associated with an increased risk of CTCL (hazard ratio [HR]: 1.04; 95% CI: 0.62–1.73). No increased risk was observed for CTCL excluding Sézary syndrome or T/natural killer cell lymphoma.

Similarly, among patients with other T2IDs, dupilumab was not associated with an increased CTCL risk (HR: 0.36; 95% CI: 0.14–1.03) or an increased risk of T/natural killer cell lymphoma. The CIs for these CTCL estimates included 1, meaning the findings did not demonstrate a statistically significant increase in risk.

Dupilumab exposure was also associated with lower observed risks of selected malignancies. In patients with AD, the risks of myeloproliferative neoplasms and multiple myeloma were lower. Among patients with other T2IDs, lower risks were observed for non-Hodgkin lymphoma, myeloproliferative neoplasms, and multiple myeloma. These associations do not establish that dupilumab directly reduces malignancy risk.

Regardless of treatment, AD was independently associated with increased CTCL risk (HR: 9.46; 95% CI: 7.28–12.28), as were other T2IDs (HR: 1.38; 95% CI: 1.27–1.50).

The authors suggested that CTCL cases reported during dupilumab treatment may reflect underlying disease-related risk or early CTCL initially misclassified as inflammatory skin disease, rather than a causal drug effect.

As a retrospective observational study, the analysis cannot establish causality or exclude all potential risks. Nevertheless, the findings provide reassurance that dupilumab was not associated with an increased risk of CTCL or other assessed lymphoid malignancies in these cohorts.



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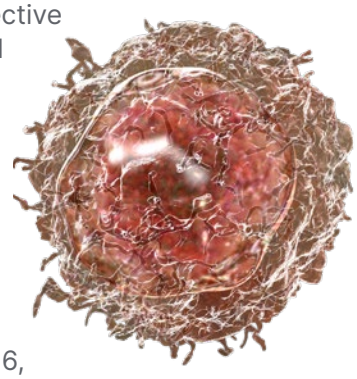
> **These associations do not establish that dupilumab directly reduces malignancy risk**



Immune Status Shapes Merkel Cell Carcinoma Outcomes

MERKEL cell carcinoma is a rare neuroendocrine tumour associated with aggressive behaviour and poor prognosis. While immunosuppression is a recognised risk factor, the impact of different types of immune dysfunction on survival has remained poorly understood.[3]

Researchers conducted a retrospective analysis of patients diagnosed and treated for Merkel cell carcinoma at a tertiary medical centre between 2000–2024. Data were collected on demographics, clinical characteristics, treatment approaches, and outcomes.



The study, presented at EADV 2026, included 156 patients with Merkel cell carcinoma. Of these, 132 patients were immunocompetent, 10 were solid organ transplant recipients, and 14 had a haematological malignancy. The solid organ transplant recipient group had a lower mean age at diagnosis compared with the other groups, at 66 years versus 74 years.

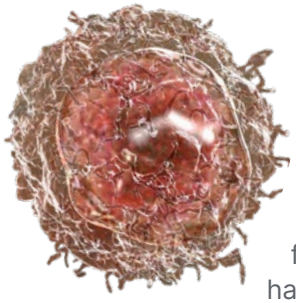
They also experienced a significantly longer interval between the start of immunosuppression and Merkel cell carcinoma diagnosis than patients with haematological malignancies, at 13 years versus 4 years (p=0.0052).

Multivariate Cox regression analysis identified several factors independently associated with increased overall mortality and Merkel cell carcinoma-related mortality. These included older age, male sex, advanced tumour stage at diagnosis, and a history of solid organ transplantation. In contrast, the presence of a haematological malignancy was not independently associated with poorer outcomes.

These findings suggest that not all forms of immunosuppression carry the same prognostic implications in Merkel cell carcinoma. The results highlight the particularly high risk faced by patients who have undergone solid organ transplantation and may help inform risk stratification and clinical management decisions.

Immune checkpoint inhibitors were incorporated into treatment regimens for 30% of solid organ transplant recipients and 50% of patients with haematological malignancies. Durable partial or complete responses were observed in 33% and 57% of treated patients, respectively.

Among patients with Stage IV Merkel cell carcinoma, immune checkpoint inhibitor treatment was associated with a 72% reduction in overall mortality and an 81% reduction in Merkel cell carcinoma-related mortality (p<0.03). For patients diagnosed with Stage IV disease from 2017 onwards, relative overall survival at 2 and 4 years was 43% and 31%, respectively, while Merkel cell carcinoma-related survival reached 59% and 52%.



The researchers concluded that solid organ transplantation appears to be an independent adverse prognostic factor in Merkel cell carcinoma, whereas haematological malignancy does not. The findings also support the selective use of immune checkpoint inhibitors in advanced Merkel cell carcinoma, including among immunocompromised patient populations.

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Early Response Predicts Sustained Skin Clearance with Risankizumab

EARLY improvements in psoriasis severity may help predict long-term complete skin clearance with risankizumab, according to a multicentre real-world study presented at EADV 2026. However, patients with partial responses at Week 16 continued to improve over time, suggesting that an incomplete early response does not necessarily indicate poor long-term outcomes.[4]

Risankizumab, a selective IL-23 inhibitor, has demonstrated sustained efficacy in moderate-to-severe plaque psoriasis. To investigate the predictive value of early treatment responses, Luciano Ibba, IRCCS Humanitas Research Hospital, Milan, Italy, and colleagues retrospectively analysed 1,883 adults treated at 15 Italian dermatology centres between April 2019–December 2025.

The researchers used receiver operating characteristic analyses to assess how accurately percentage reductions in Psoriasis Area and Severity Index (PASI) scores at Weeks 16 and 32 predicted complete skin clearance, defined as PASI 100, at Years 1, 3, and 5. They also examined yearly clearance rates according to absolute PASI scores at Week 16.

Week 32 responses predicted PASI 100 at Year 1 more accurately than Week 16 responses. The area under the curve (AUC) was 0.843 (95% CI: 0.820–0.867) at Week 32, compared with 0.753 (95% CI: 0.726–0.780) at Week 16 ($p<0.001$). Complete clearance at Week 32 was the optimal predictive threshold, with 72.1% sensitivity and 84.2% specificity.

Week 32 responses also provided greater predictive accuracy for Year 3 clearance than Week 16 responses (AUC: 0.681 versus 0.621; $p<0.001$). By Year 5, predictive performance was more modest, and the difference was no longer statistically significant (AUC: 0.652 versus 0.614; $p=0.35$).

The longitudinal analysis revealed a 'catch-up' pattern among patients with slower initial responses. Those with absolute PASI scores of 3–5 and 6–10 at Week 16 achieved Year 1 PASI 100 rates of 63.0% and 35.1%, respectively. With continued treatment, these rates improved, approaching those of patients with near-complete early responses by Year 5.

These findings suggest that Week 32 may provide a more informative assessment of future clearance than Week 16, while supporting the consideration of continued treatment in partial responders. However, the retrospective design and smaller Year 5 sample of 154 patients warrant caution: the results do not establish that continuing risankizumab is superior to switching treatment.

> **"Week 32 responses predicted PASI 100 at Year 1 more accurately than Week 16 responses"**



Vision Transformer AI Outperforms Dermatologists in Dermoscopy

AT EADV 2026, a key study was presented comparing the diagnostic performance of an AI model, based on the Vision Transformer (ViT) architecture, against a large cohort of expert dermatologists.[5]

Researchers developed a ViT-based AI model using the publicly available International Skin Imaging Collaboration (ISIC) 2019 dataset. Its architecture combined patch embedding, multi-head self-attention, and efficient channel attention to extract image features, with a logistic regression meta-model generating the final classification.

The evaluation involved 223 participants, including 71 dermatology specialists and 152 residents, who classified a set of 80 dermoscopic images. Performance was assessed using balanced accuracy (BACC), sensitivity (SEN), specificity (SPE), and macro-averaged F1 score (Macro-F1). Researchers also examined differences according to clinical experience and medical institution type.

The comparison covered both eight-class dermoscopic classification and differentiation between malignant and benign lesions.

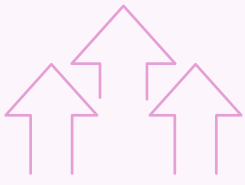
For malignant–benign differentiation, the AI model achieved consistent performance across the test (n=1,580) and quiz (n=80) datasets, with a BACC of 88.4% and 85.3%, an SEN of 83.9% and 82.1%, an SPE of 92.8% and 88.5%, and a Macro-F1 of 88.6% and 85.0%, respectively. In comparison, the 223 participants achieved an average BACC of 63.8% (range: 49.7–81.5); an SEN of 60.3% (range: 21.4–89.3); an SPE of 67.2% (range: 36.5–94.2); and a Macro-F1 of 62.9% (range: 47.2–80.1).

Subgroup analyses showed that specialists with 1–2 years of experience achieved the highest BACC (68.3%) and Macro-F1 (67.4%), while specialists with less than 1 year of experience recorded the highest SEN (65.7%). Among residents, those with 4–5 years of experience achieved the highest SPE (71.6%). Although performance improved throughout training, results peaked among early-career specialists, with an inverse trend observed among those with more than 10 years of practice.

Institution-based analyses showed that specialists at state hospitals performed best in eight-class classification, whereas those at university-affiliated centres performed better in malignant–benign differentiation. Actinic keratosis was the most challenging diagnosis for both the AI model and human participants.

The findings suggested that ViT-based AI could serve as a decision-support tool for dermatologists interpreting dermoscopic images. Differences in performance across experience levels and institution types also highlighted the complexity of human diagnostic assessment.

Although the model outperformed participants in the reported classification tasks, the findings did not establish its effectiveness in routine clinical practice. Further evaluation would be needed to determine how AI-assisted classification could complement clinical expertise and support diagnostic workflows.



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Hidradenitis Suppurativa Trials Show Substantial Placebo Effect

PLACEBO response in hidradenitis suppurativa (HS) clinical trials remained substantial across randomised controlled studies, according to a systematic review and meta-analysis presented at EADV 2026 that evaluated immunomodulatory therapies in patients with the disease.[6]

The findings suggest that placebo effects may significantly influence trial outcomes and should be carefully considered during study design.

HS is a chronic inflammatory skin disorder that often requires multiple treatment approaches. Although placebo responses have been frequently reported in trials of immunomodulatory therapies, their overall magnitude had not previously been systematically quantified.

To address this, researchers conducted a systematic review and meta-analysis of placebo controlled RCTs assessing immunomodulatory treatments in HS. The analysis included 39 trials involving 6,867 participants. Of these, 4,649 received active treatment and 2,218 received placebo.

Researchers assessed outcomes including Hidradenitis Suppurativa Clinical Response (HiSCR), the International Hidradenitis Suppurativa Severity Score System (IHS4), and the Dermatology Life Quality Index (DLQI), and pain reduction was measured using the Numeric Rating Scale 30 (NRS30).

Across studies, the pooled placebo response rate for HiSCR at Weeks 8–24 was 34% (95% CI: 31–36%). In comparison, the pooled response rate among participants receiving active treatment was 47% (95% CI: 44–50%). The pooled risk ratio for active treatment versus placebo was 1.31 (95% CI: 1.20–1.43).

Meaningful improvements were also observed among placebo recipients in other disease measures. For IHS4, the pooled mean change from baseline was −5.69 (95% CI: −7.26–−4.13). The difference in change between active treatment and placebo was −5.77 (95% CI: −8.37–−3.16). Quality of life also improved, with a pooled DLQI change from baseline of −2.37 (95% CI: −2.59–−2.16) among placebo recipients. The mean difference between active treatment and placebo was −1.91 (95% CI: −2.57–−1.26).

Pain outcomes showed a similar pattern. Placebo recipients achieved a pooled NRS30 response rate of 26.45% (95% CI: 22.80–30.45%), while active treatment was associated with higher odds of response: (odds ratio: 1.61; 95% CI: 1.27–2.05).

Meta regression analyses identified a significant association between a more recent publication year and an increased placebo HiSCR response: (β=0.063 per year; 95% CI: 0.031–0.095; p=0.0003). No significant associations were observed between placebo response and trial phase, drug class, age, sex, race, BMI, or baseline disease severity.

The researchers concluded that a substantial placebo response exists across immunomodulatory therapy trials in HS. They suggested that future studies should account for this effect when determining sample sizes, selecting endpoints, and planning study duration to ensure accurate assessment of treatment benefits.

> **The researchers concluded that a substantial placebo response exists across immunomodulatory therapy trials in HS**



Elevated Intestinal Barrier Biomarkers Found in Rosacea

PATIENTS with rosacea had elevated levels of three intestinal barrier biomarkers with D-lactate independently associated with rosacea, according to a new prospective case–control study presented at EADV 2026. These findings suggest that gastrointestinal comorbidities may represent a potential complementary disease dimension associated with rosacea.[7]

Researchers wanted to investigate whether gastrointestinal comorbidities often associated with rosacea are accompanied by measurable changes in intestinal barrier function.

In total, 44 patients with rosacea and 44 age- and sex-matched healthy controls were enrolled to evaluate four serum biomarkers and their relationship with cutaneous severity, gastrointestinal symptom burden, and quality of life.

The biomarkers D-lactate, claudin-3, intestinal fatty acid–binding protein (I-FABP), and zonulin family peptides (ZFP) were selected as they represent distinct aspects of intestinal barrier function.

Patients with rosacea had higher serum levels of D-lactate, claudin-3, and ZFPs than healthy controls. Median D-lactate concentrations were 0.85 mmol/L in patients with rosacea compared with 0.36 mmol/L in controls ($p<0.001$). Claudin-3 levels were 6.02 versus 3.94 ng/mL ($p<0.001$), while ZFP levels were 18.19 versus 10.59 ng/mL ($p=0.013$).

D-lactate showed the strongest association with rosacea. In a multivariable logistic regression analysis, it was the only biomarker independently associated with rosacea (odds ratio: 4.93; 95% CI: 1.35–18.08; $p=0.016$).

The researchers found no significant correlations between biomarker levels and Investigator Global Assessment (IGA) or Rosacea Symptom Score (RSS), and no significant differences were observed across severity groups.

Within the rosacea group, ZFP levels were associated with gastrointestinal symptom burden and quality of life: higher ZFP levels correlated with greater gastrointestinal symptoms (Spearman correlation coefficient: 0.35; $p=0.018$) and higher Rosacea-specific Quality of Life (RosaQoL) total scores (Spearman correlation coefficient: 0.36; $p=0.016$). D-lactate and claudin-3 were not associated with either measure.

I-FABP levels did not differ significantly between patients with rosacea and healthy controls ($p=0.078$).

Overall, the findings revealed that patients with rosacea had a severity-independent pattern of intestinal barrier alteration. D-lactate was the only biomarker that was independently associated with rosacea, and ZFP levels were linked to gastrointestinal symptoms and quality of life. Researchers also reported limited statistical power for I-FABP, meaning that the finding did not resolve the question of histological enterocyte injury.

This study highlights changes in intestinal barrier-related biomarkers that reveal a potential complementary disease dimension associated with rosacea. The authors explained that longitudinal and mechanistic investigations should be undertaken to further investigate these findings.

> **“Overall, the findings revealed that patients with rosacea had a severity-independent pattern of intestinal barrier alteration”**

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Fingertip Sweat and Plasma May Predict Melanoma Immunotherapy Response

IDENTIFYING biomarkers that distinguish patients who respond to immunotherapy from those who do not remains a challenge in metastatic melanoma. Research presented at EADV 2026 investigated whether combining plasma omics profiling with non-invasive fingertip sweat analysis could help characterise treatment responses to immune checkpoint inhibitors and support more individualised patient stratification.[8]



Plasma proteomics identified increased Igs and GLIPR2 in responders, whereas non-responders showed elevated SPINK1

Anti-programmed cell death protein 1 (PD-1) and cytotoxic T-lymphocyte associated protein 4 (CTLA-4) therapies, including nivolumab and ipilimumab, are used to treat metastatic melanoma, but reliable biomarkers for predicting and monitoring treatment efficacy remain limited. Understanding the biological differences between responders and non-responders could help inform treatment decisions and identify patients who may be less likely to benefit from immunotherapy. The study examined metabolic and protein changes across plasma and fingertip sweat, with particular attention to pathways associated with immune activity and the gut microbiome.

In a pilot study, fingertip sweat samples were collected from patients receiving nivolumab immediately before and after treatment. A longitudinal cohort provided fingertip sweat and plasma samples at baseline, 3 weeks, and 3 months after starting ipilimumab and nivolumab. Sweat metabolomics was performed using liquid chromatography–mass spectrometry, while plasma metabolomics and proteomics were analysed using established analytical platforms.



Initial sweat findings showed elevated kynurenine, p-cresol sulfate, and markers of mitochondrial stress in non-responders. In contrast, indole-3-acetic acid increased over time in responders. Plasma proteomics identified increased Igs and glioma pathogenesis-related protein 2 (GLIPR2) in responders, whereas non-responders showed elevated serine protease inhibitor Kazal-type 1 (SPINK1), a protein associated with epithelial–mesenchymal transition and treatment resistance.

Plasma metabolomics also revealed higher kynurenine, triglycerides, and putrescine in non-responders, while phosphoenolpyruvate and phosphatidylcholine were associated with responders. Principal component analysis demonstrated partial separation between the groups, with triglycerides contributing to the non-responder profile. These findings suggest that tryptophan metabolism and gut microbiome-associated pathways may be relevant to immunotherapy response.

The findings are preliminary and require validation in larger patient cohorts before clinical application. Nevertheless, combining plasma profiling with fingertip sweat analysis could provide a less invasive approach to investigating treatment-associated biological changes and may support earlier identification of non-responders. Further research will be needed to establish the predictive accuracy and clinical utility of these candidate biomarkers.

Dupilumab Partially Normalises Skin Lipids in Atopic Dermatitis

DUPILUMAB treatment improved disease severity and partially normalised skin lipid composition in patients with atopic dermatitis (AD), although differences between lesional and nonlesional skin persisted after 16 weeks, according to a study presented at EADV 2026 that investigated changes in the skin barrier and their relationship with staphylococcal colonisation. The findings suggest that clinical improvement with dupilumab may not fully resolve the underlying lipid abnormalities associated with AD.[9]

Researchers investigated changes in the stratum corneum lipid profile before and after dupilumab treatment. Tape-strip samples were collected from lesional and nonlesional skin in 27 patients at baseline and after 16 weeks of treatment. Lipidomic profiling was performed using liquid chromatography–mass spectrometry, with results assessed alongside staphylococcal abundance and disease severity measured using the Eczema Area and Severity Index (EASI).

At baseline, lesional skin had a higher relative abundance of cholesterol and altered ceramide composition compared with nonlesional skin. Although several short-chain ceramide subclasses were increased, long-chain ester-linked omega-hydroxy fatty acid sphingosine (EOS) ceramides were reduced, highlighting differences in the lipid profile of affected skin.

Dupilumab treatment was associated with a mean 70.0% reduction in EASI score. Clinical improvement coincided with increases in long-chain ester-linked omega-hydroxy fatty acid (EO) ceramides, including EOS and esterified omega-hydroxy 6-hydroxysphingosine (EOH). The number of lipids differing between lesional and nonlesional skin also decreased from 244 before treatment to 105 afterwards, suggesting partial normalisation of the lipidomic profile.

However, analyses showed that samples clustered primarily according to sampling site rather than treatment status. Lesional and nonlesional skin therefore remained distinct, indicating that local disease activity continued to influence lipid composition despite systemic IL-4 receptor α inhibition.

Changes in several ceramide subclasses, particularly reductions in non-hydroxy-fatty acid [N] 6-hydroxy-sphingosine [H] (NH) and non-hydroxy fatty acid + sphingosine (NS) ceramides, also correlated with treatment-associated improvement. These findings point to a complex relationship between clinical response and skin barrier lipid composition.

The researchers found no significant correlations between *Staphylococcus aureus* abundance and ceramide levels. By contrast, *Staphylococcus lugdunensis* abundance was associated with specific ceramide subclasses, showing an inverse correlation with EOS ceramides and positive correlations with NS ceramides.

Overall, the findings suggest that changes in staphylococcal colonisation do not fully explain the lipid abnormalities observed in AD. Although dupilumab improved disease severity and partially normalised the skin lipid profile, persistent differences between affected and unaffected skin highlight the potential importance of complementary skin barrier-targeted interventions.

The study's small sample size and observational design mean that the findings should be interpreted cautiously. Further research is needed to clarify how lipid changes relate to treatment response and whether targeted barrier interventions can address abnormalities that persist during dupilumab therapy.

> **"The findings suggest that clinical improvement with dupilumab may not fully resolve the underlying lipid abnormalities associated with AD"**

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Skin Symptoms Linked to Severe Bullous Pemphigoid

EROSIONS, itching, and urticaria are independently associated with severe bullous pemphigoid in older adults, according to a multicentre study presented at EADV 2026. The findings suggest that clinical features, supported by selected inflammatory blood markers, could help clinicians identify patients with greater disease activity.[10]

Bullous pemphigoid predominantly affects older adults and carries substantial morbidity. Researchers examined clinical characteristics and inflammatory biomarkers in 797 patients aged 65 years or older with biopsy and/or direct immunofluorescence-confirmed disease diagnosed between 2015–2025. The median age was 77 years, 58.8% were female, and 82.3% had at least one comorbidity.

Disease severity was assessed using the Bullous Pemphigoid Disease Area Index (BPDAI). Among the 705 patients with available severity data, 216 had mild disease, 316 had moderate disease, and 173 had severe disease. Neither age nor disease duration correlated with disease activity scores.

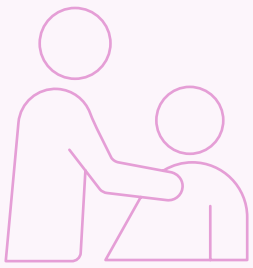
Erosions, pruritus, and urticaria remained independently associated with severe disease after adjustment. Erosions were associated with approximately 3.8-fold higher odds of severe disease (odds ratio [OR]: 3.779; 95% CI: 2.374–6.016), while pruritus was associated with approximately 3.4-fold higher odds (OR: 3.393; 95% CI: 1.549–7.432). Urticaria was also independently associated with severity (OR: 1.616; 95% CI: 1.061–2.462).

Several inflammatory blood markers differed across severity categories. Procalcitonin provided the strongest discrimination among the laboratory variables assessed, with an area under the curve of 0.733 (95% CI: 0.636–0.830). At the study-derived cut-off of 0.105, sensitivity was 72.7% and specificity was 62.8%, indicating that its ability to distinguish severe disease was imperfect. Composite inflammatory indices offered limited additional value.

Diabetes, dipeptidyl peptidase-4 (DPP-4) inhibitor use, and clopidogrel were associated with severe disease in univariate analyses, but these associations did not reach statistical significance after adjustment.

The retrospective design, variable-specific missing data, and likely differences in management between centres limit interpretation. The final statistical model also had modest explanatory power, indicating that the assessed factors captured only part of the variation in disease severity.

The findings support combining careful assessment of skin features and symptoms with selected inflammatory biomarkers when evaluating older adults with bullous pemphigoid. They highlight the importance of bedside assessment while suggesting a potential supporting role for procalcitonin in severity stratification.



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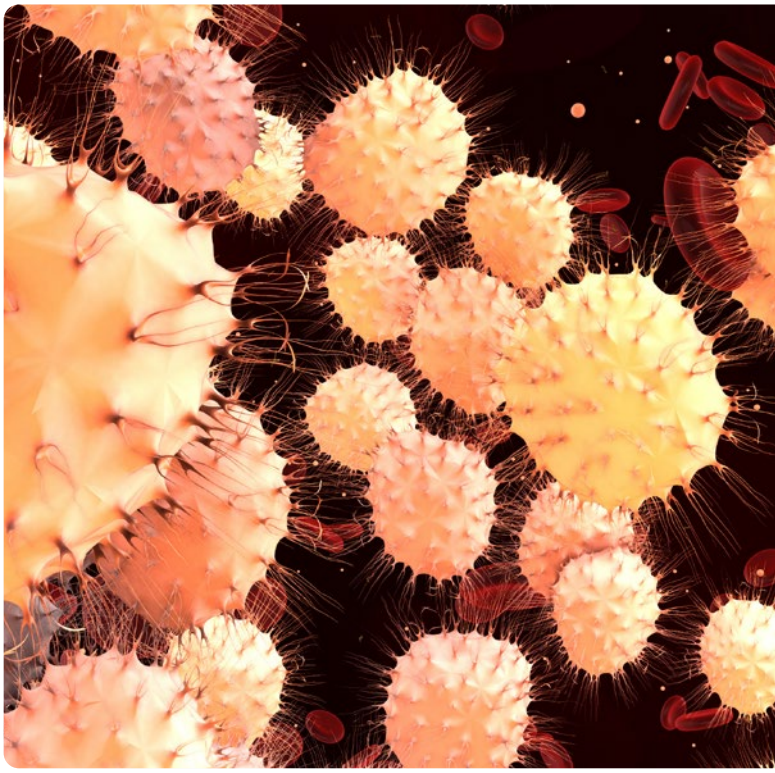
Evaluating Treatment Effectiveness in Mycosis Fungoides and Sézary Syndrome

ADVANCED-STAGE mycosis fungoides and Sézary syndrome are challenging cutaneous T cell lymphomas characterised by progressive disease and heterogeneous clinical presentations. Treatment decisions are complicated by disease stage, previous therapies, and the absence of a universally accepted standard of care. Understanding real-world treatment patterns and effectiveness is essential to inform clinical decision-making and optimise therapeutic sequencing. A study presented at EADV 2026 provided valuable evidence on treatment use and outcomes across advanced-stage disease using prospectively collected treatment data from the PROCLIPI study.[11]

This analysis included 509 patients with advanced-stage mycosis fungoides and Sézary syndrome and treatment data collected prospectively across 44 centres. A total of 2,472 treatment lines were reviewed and reconciled against site records. Patients were classified by disease stage at diagnosis, and treatment patterns were assessed across first- and second-line settings. Time to next systemic treatment (TTNsT) was measured from initiation of first-line treatment to commencement of the next systemic therapy. Overall response rates (ORR), defined as complete or partial responses, were evaluated to compare treatment effectiveness.

At a median follow-up of 67 months, patients received a median of three treatment lines (range: 1–19). First-line management comprised systemic therapy in 70% (n=358), skin-directed therapies alone in 28% (n=142), and expectant management in 2% (n=9). Extracorporeal photopheresis (ECP), methotrexate, interferon-α, and bexarotene accounted for 71.7% of first-line systemic treatments. ECP achieved the longest median TTNsT at 19.0 months (interquartile range: 7.1–28.7), while gemcitabine produced the highest first-line ORR (78%). Combination regimens represented 64% (262/410) of first-line systemic treatments, with ORRs of 46%, compared with 44% for monotherapy. Overall, 81% of patients proceeded to second-line treatment. Mogamulizumab achieved the highest second-line ORR (79%; n=29), with a median TTNsT of 11.6 months.

These findings highlight the importance of stage-adapted treatment selection and individualised therapeutic sequencing in clinical practice. ECP demonstrated durable disease control, while mogamulizumab showed promising second-line response rates. However, treatment heterogeneity, sequential therapies, potential confounding, and the observational design limit direct comparisons and attribution of outcomes to individual agents. Further studies incorporating longer follow-up and confounder-adjusted analyses are needed to strengthen treatment recommendations and improve outcomes.



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