Progress in Alopecia Areata: Evolving Treatments and Patient-Centered Perspectives

JUNE 19 2025

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UNIVERSITY OF TORONTO, SICKKIDS HOSPITAL

Conflict of Interest Declaration

I, Cathryn Sibbald declare that in the past 2 years:

I have received direct financial payments from the following companies:

Abbvie, Amgen, Leo Pharma, Incyte, Novartis, Pfizer, Sanofi, Sun Pharma, UCB

I have been a member of an advisory board or equivalent with the following companies:

Arcutis, Eli Lily, Leo Pharma, Incyte, Pfizer, Sanofi, Sun Pharma, UCB

I have participated in a clinical trial for the following companies:

Amgen, BMS, Abbvie, Pfizer,

Learning Objectives

1. Describe the psychosocial impact of AA and its relevance to patient care
2. Summarize evidence for currently available treatments in AA
3. Outline emerging therapeutic targets under investigation for AA

OUTLINE

1. Quality of Life
2. Current treatments of interest
3. Treatments being studied

AA is associated with significant Burden of Disease

Stigma

Costs of wigs/
accessories/microblading

Absenteeism (work/school)

Costs of treatments

Mood disorders

Side effects
of treatments

Time spent at
appointments

Costs/time of monitoring of treatments

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Canadian Survey

	Age<18y (n=14)	Age 18y+ (n=115)
Sex, n/N (%)		
Male	1/14 (7.14)	44.2 (15.6)
Female	13/14 (92.86)	43 (18-94)
Age, years		
Mean, (SD)	13.1 (3.6)	22(25)
Median, (Range)	14.5 (6-17)	22 (25)
Age grouping, years, % (n)		17 (20)
5-11	28.57 (4)	22 (25)
12-17	71.43 (10)	17 (20)
Alopecia Areata Subtype, % (n)		
Scalp only	50 (7)	37.39 (43)
Alopecia Totalis	14.29 (2)	14.78 (17)
Alopecia Universalis	35.71 (5)	52.17 (60)

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JMIR 2022 5(4) e3916

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Audience Question 1

What do you think was the most common abnormal mental health concern?

1. ADHD
2. Depression
3. Anxiety
4. Adjustment disorder

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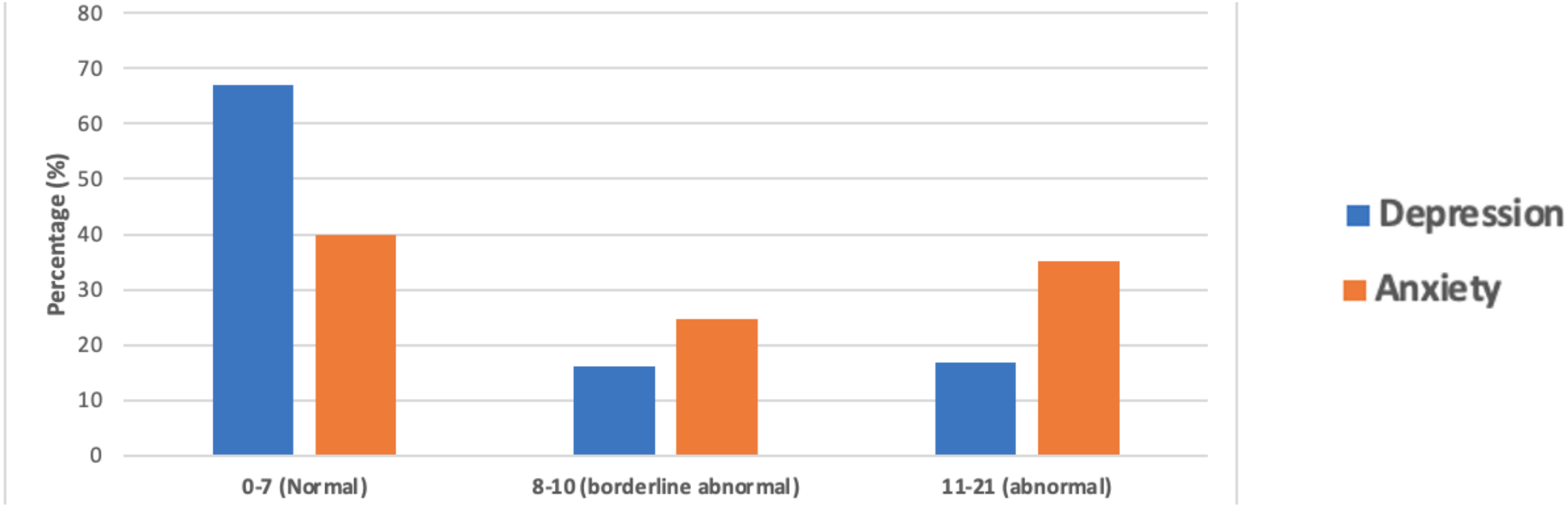
More respondents with Anxiety vs Depression

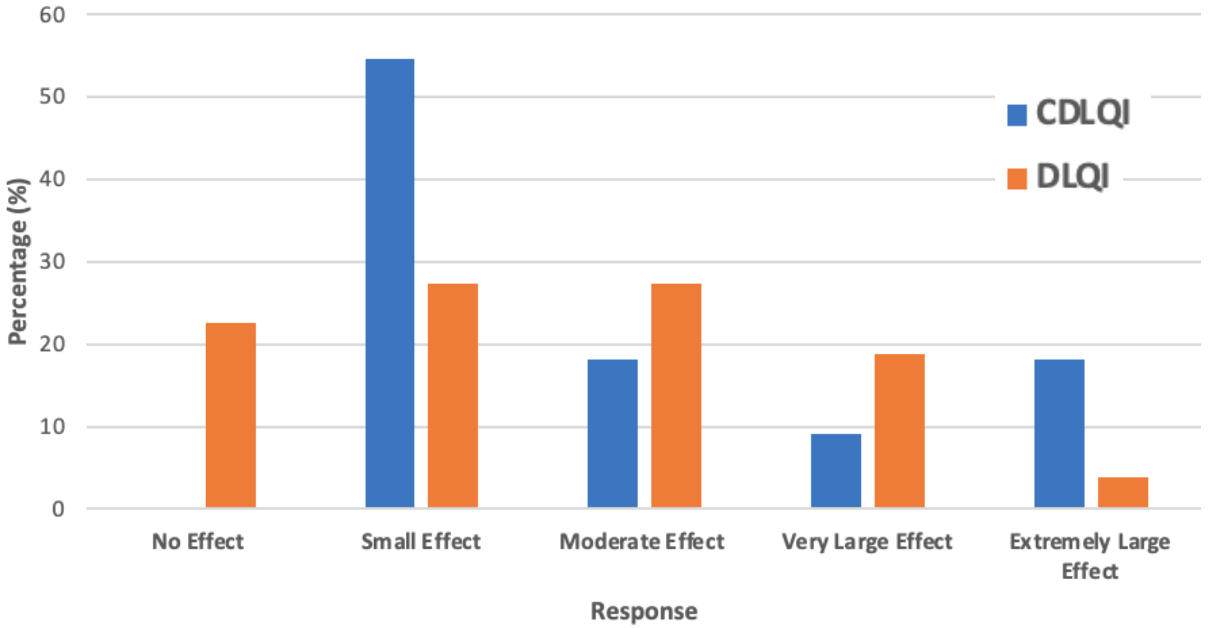


Hospital Anxiety and Depression Scale

Both the Anxiety and Depression scales have a total possible score of 21 from 7 questions.
Results are categorized based on total score: normal (0-7), borderline abnormal (8-10), abnormal (11-21)

Significant Impact on Quality of Life

- 95% felt uncomfortable or self-conscious about their appearance
- Avoidance of social events:
  - Pediatric: 61.5% (n=8)
  - Adult: 68.2% (n=75)
- Constant worry about new loss:
  - Pediatric: 61.5% (n=8)
  - Adult: 68.2% (n=75)

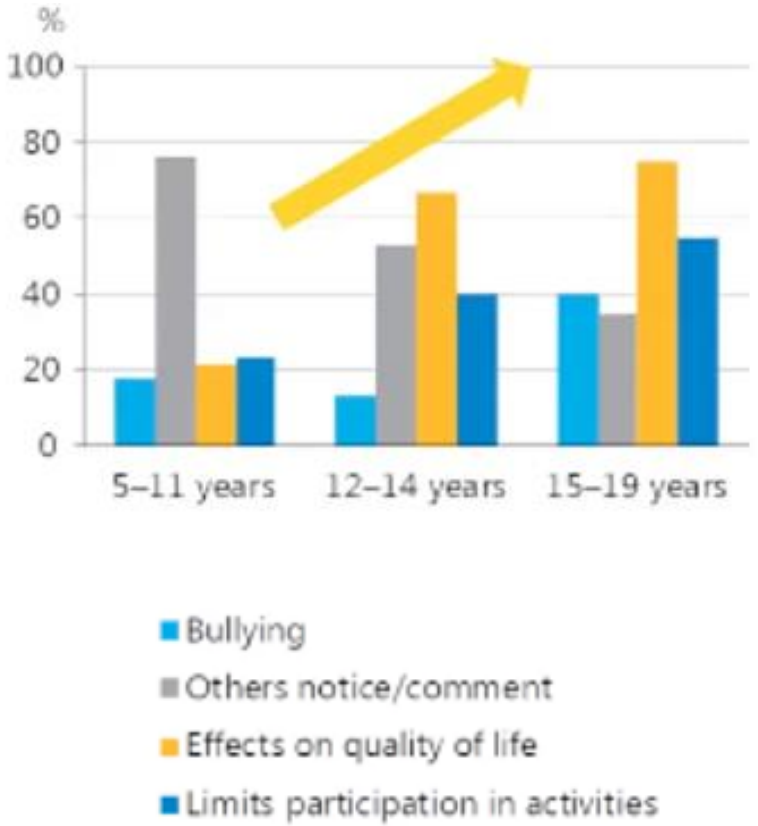


DLQI: Dermatology Life Quality Index
CDLQI: Children's Dermatology Life Quality Index

Score out of 30: no effect (0-1), small effect (2-6), moderate effect (7-12), very large effect (13-18), and extremely large effect (19-30)

Bullying also significant, especially in teens

- History of Bullying/teasing:
  - 46% of responders >18yrs old
  - **78% of adolescent 12-17yrs old**
  - 33% of children 5-11 yrs old

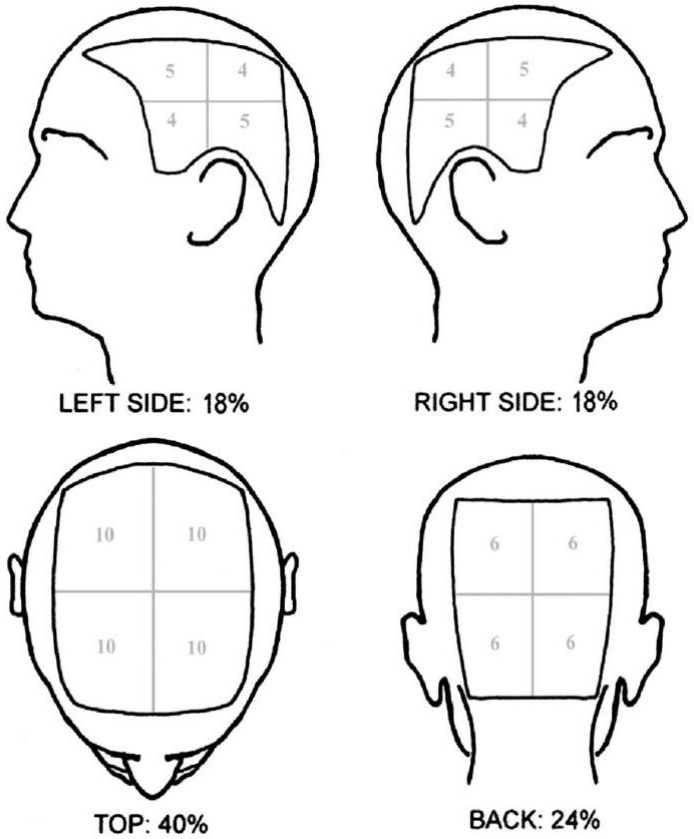


- 78% of adolescents reported that schools did not explain alopecia to classmates

Severity measures consider QOL

- **IGA / SALT score (Scalp)**
  - 0 = 0
  - 1 = 1-20%
  - 2 = 21-49%
  - **3 = 50-94% (severe)**
  - **4 = 95-100% (very severe)**

- **Severity "upgraders" (AASc)**
  - **Impact on psychosocial wellbeing**
  - Inadequate response (@6m)
  - Diffuse + pull test
  - Eyebrow/eyelash involvement



*Does NOT include **vellus hairs**

*Does NOT include **eyebrows/ eyelashes**

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Wyrwich et al. BJD 2020; 183(4)
Meah et al. JAAD 2021;84(6)

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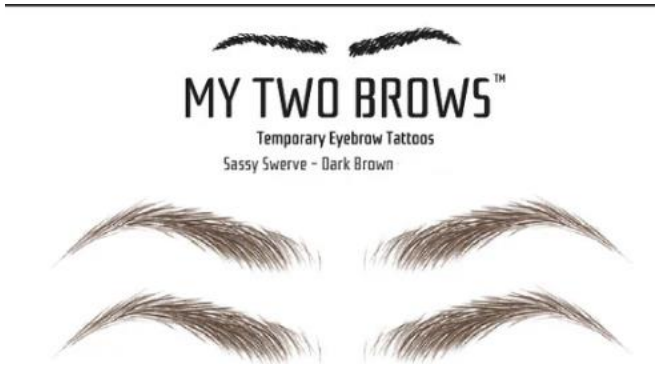
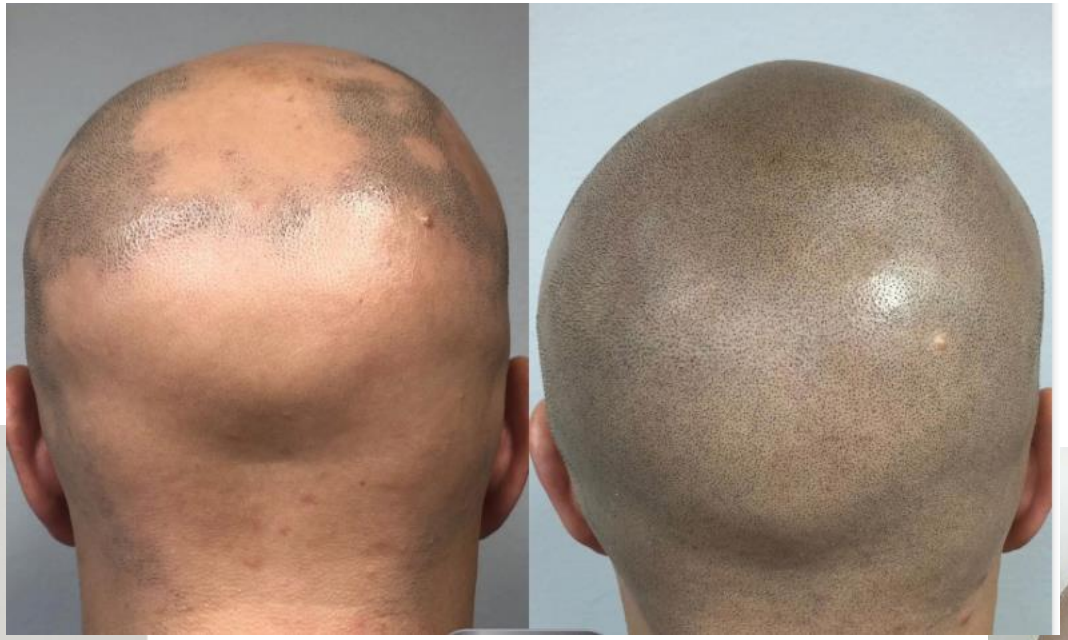
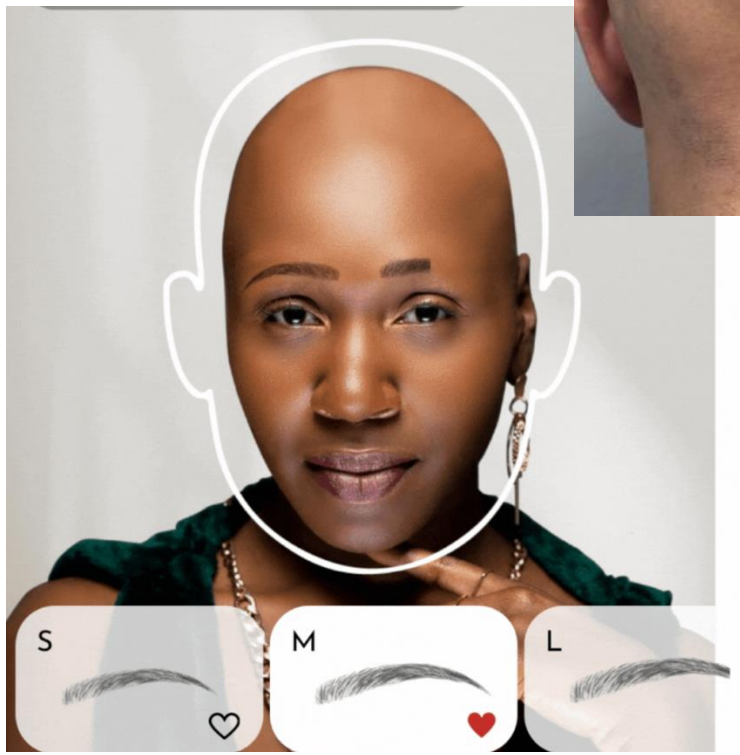
What I have found helpful

- Open ended dialogue
  - How do you feel about your hair loss
  - What are your goals
  - Do you want to try to regrow the hair?
- Address stigma, common untruths upfront
  - this is not contagious and not cancer
- Anxiety screen:
  - Do you consider yourself a worrier? Are you on edge more more often than not?







Microblading

Scalp Tattoos

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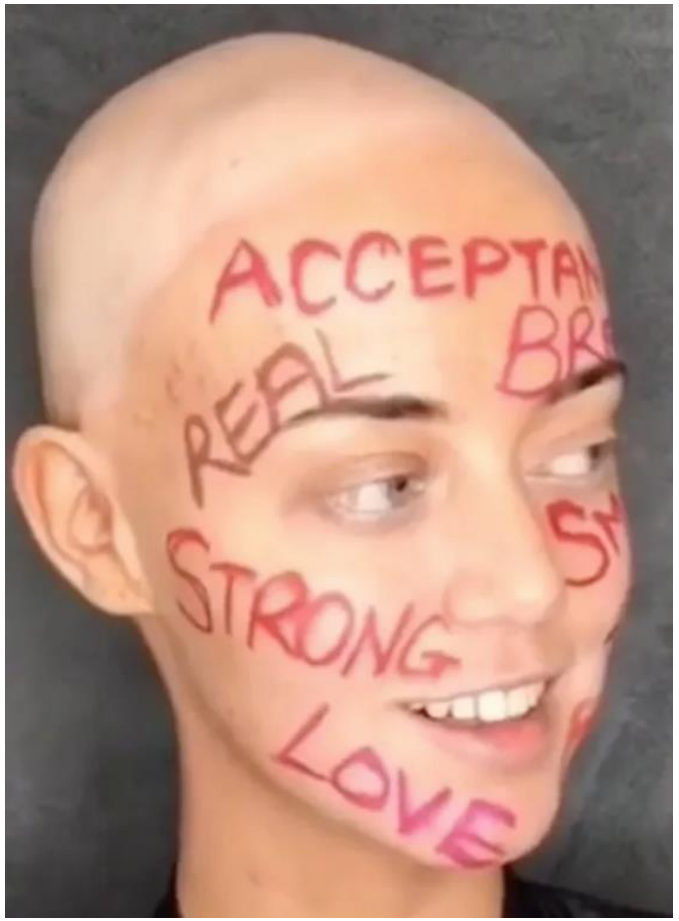
Positive role models can help in messaging



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OUTLINE

1. Quality of Life
2. Current treatments of interest
3. Treatments being studied

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Adjuncts

Antihistamines
Minoxidil

Steroids

Topical
intralesional
Oral

Systemics

Methotrexate
Dupilumab
JAK Inhibitors

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Antihistamines may help!

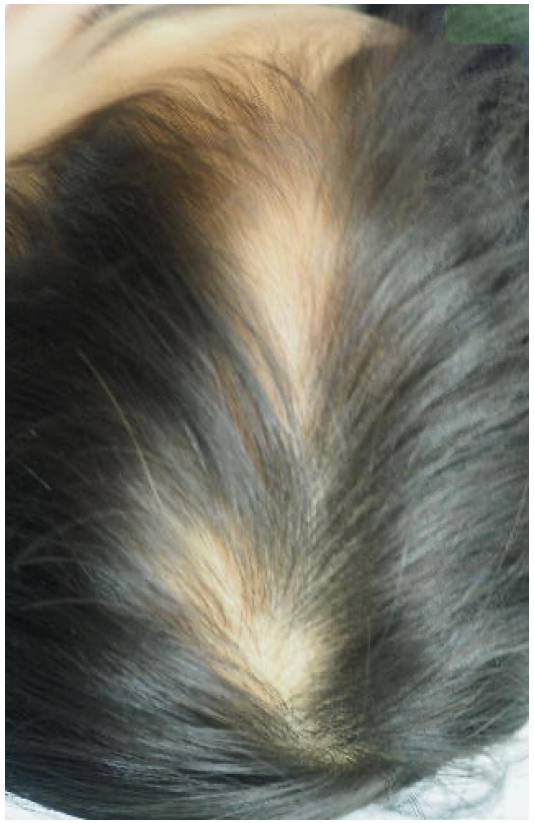
- Lower immune cell activity
  - Olopatadine, desloratadine, fexofenadine
- May prevent immune cell migration
  - ↓ CXCL10, ↓ IL15
- Fexofenadine may affect IFN gamma

For seasonal allergies:

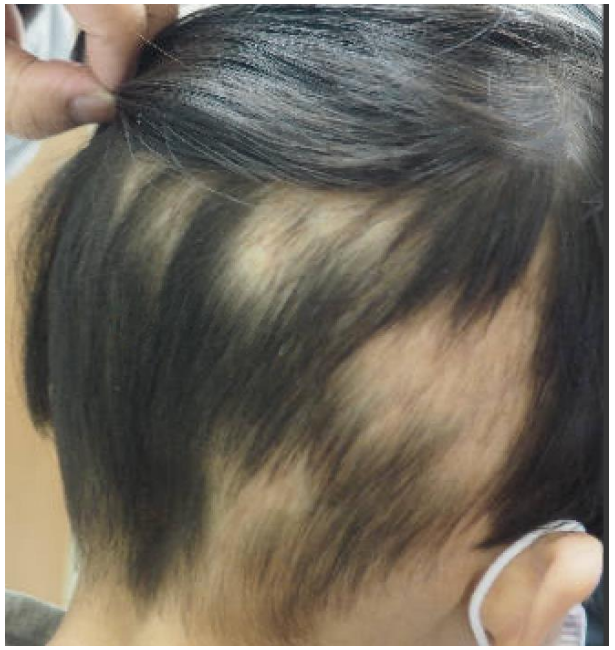
Dosing
(Per label,
Not a prescription)

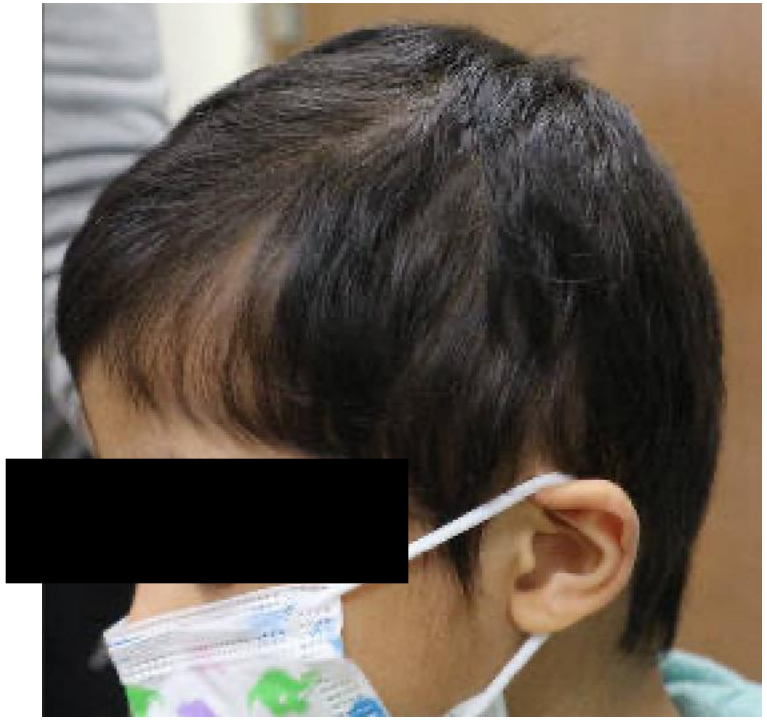
Age 2-12y:
30mg every 12 hrs
Age 12y+:
60mg every 12 hrs

- Widely used in Japan based on "C1" evidence (11 studies)
  - Regrowth: oxatamide (n=152), cimetidine (n=1), hydroxyzine hydrochloride (n=1)
  - **Fexofenadine** (n=133) –helped in patients being treated with immunotherapy

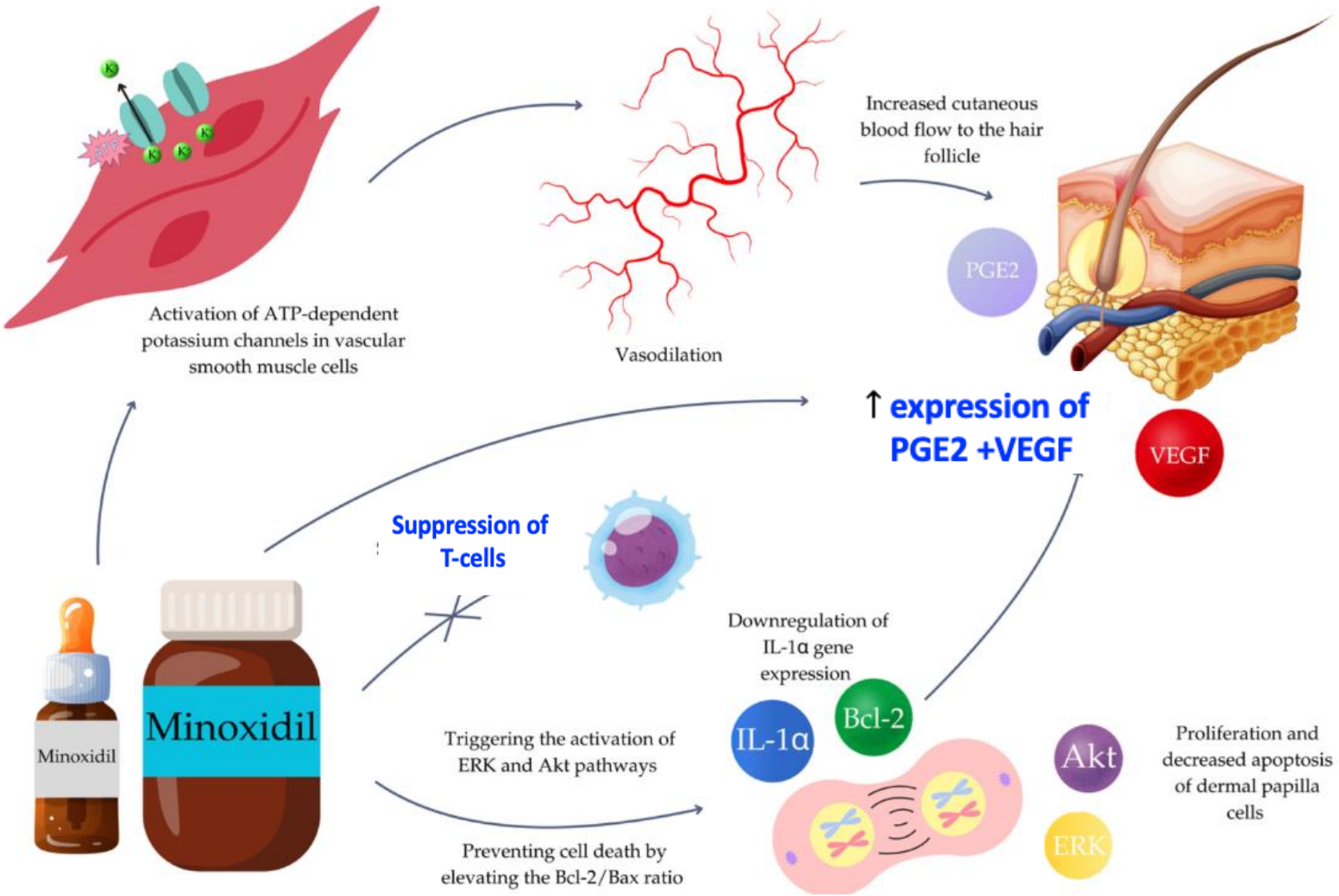


Fexofenadine





Minoxidil has many proposed mechanisms in AA



J. Clin. Med. 2024, 13, 7712

Audience Question 2

In the recent consensus recommendations for Low Dose Oral minoxidil, for what ages was minoxidil recommended?

1. 6yrs+
2. 9yrs+
3. 12yrs+
4. 18yrs+

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Consensus on LDOM Prescribing age 12y+

JAMA Dermatology | Consensus Statement

Low-Dose Oral Minoxidil Initiation for Patients With Hair Loss
An International Modified Delphi Consensus Statement

- 43 hair loss specialist dermatologists, 12 countries
- Adolescents (age 12yrs+) and Adults
  - LDOM can be considered in these age groups
  - May provide direct benefit for AA (81%)
    - Females: 1.25mg starting dose, 0.625-2.5mg/day range
    - Males: 2.5mg starting dose, 1.25-5mg/day range
    - Adolescents – consider starting at 50% above doses
  - Earliest efficacy at 3 months, possibly not until 6 months (74%, 84%)

Evidence exists for minoxidil in AA for all ages!

- **Large clinical experience, and under-reported in literature**
- **Topical minoxidil (5% best)**
  - Adult SR: n=338 (5% in 174, response rate 82%, CI 0.7-0.93)
  - ~44% response (n=7), other studies with pediatric patients and good response
- **Oral Low Dose Minoxidil (5mg/day)**
  - Adult study: n=34 x5mg/day, 82% response
  - 2024 SR in peds: improved hair growth, Doses 0.5-5mg/day
    - No D/Cs (N=>52 for AA / 373 peds), Hypertrichosis in 12.1%, Hypotension 5.6%

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J. Clin. Med. 2024, 13, 7712 , JAAD review 2024 Vol2, Dermatol Ther (Heidelb)2024;14(7):1709.

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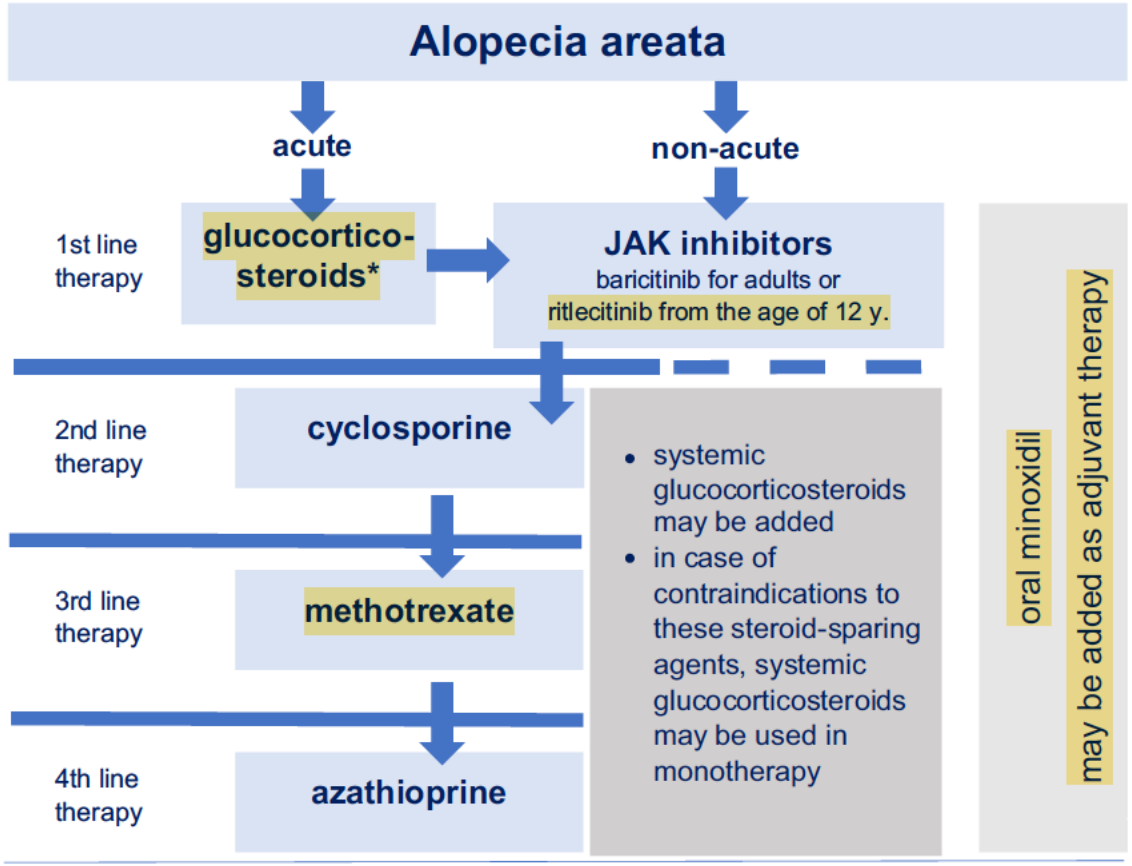
Received: 7 October 2023 | Accepted: 27 November 2023
DOI: 10.1111/jdv.19768

REVIEW ARTICLE

JEADV JOURNAL OF THE EUROPEAN ACADEMY OF DERMATOLOGY & VENEREOLOGY

European expert consensus statement on the systemic treatment of alopecia areata

Consensus for AA: minoxidil recommended as adjunct to all systemics!



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JEADV 2024;38:631–632.

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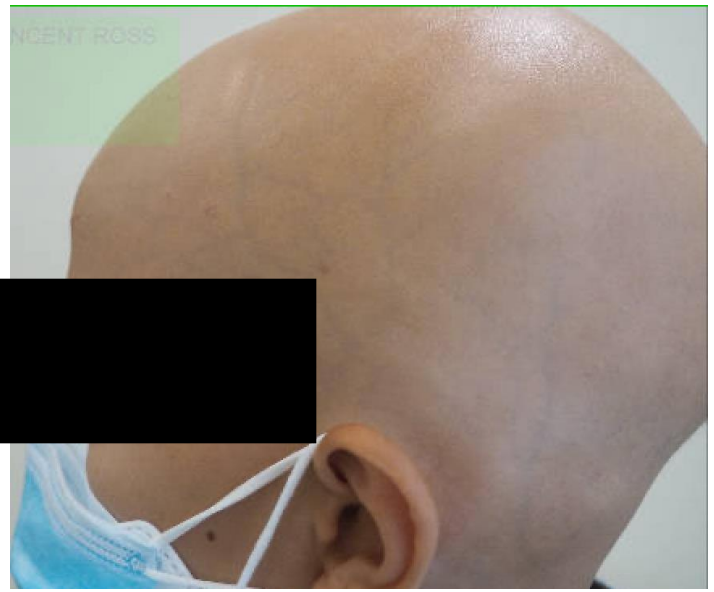
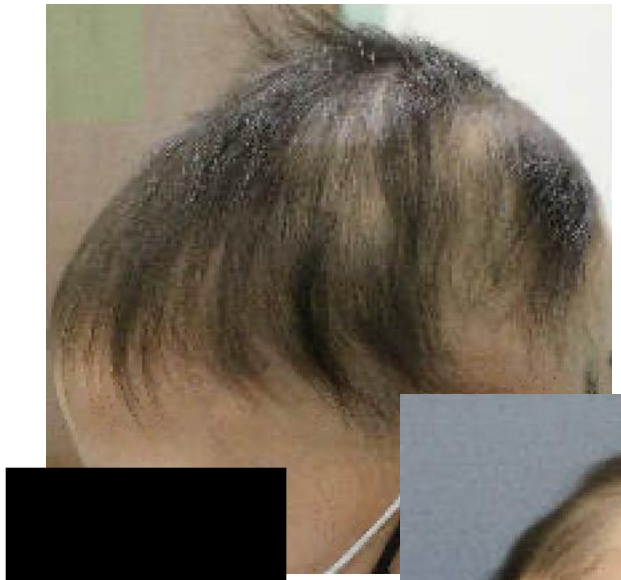
Minoxidil: how I do it

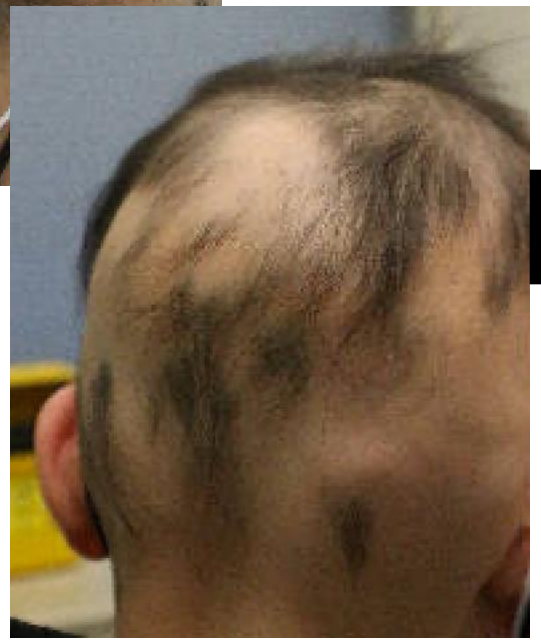
- **Topical: 5% once daily**
  - Either Foam or Solution
    - Foam can leave film
      - not good if infrequent washing
    - Solution: More contact dermatitis
      - Propylene glycol
- **Oral: once daily at night**
  - 5mg/day if 18y+
  - 2.5mg/day if 12y+
    - 1.25mg if <12yrs or female*

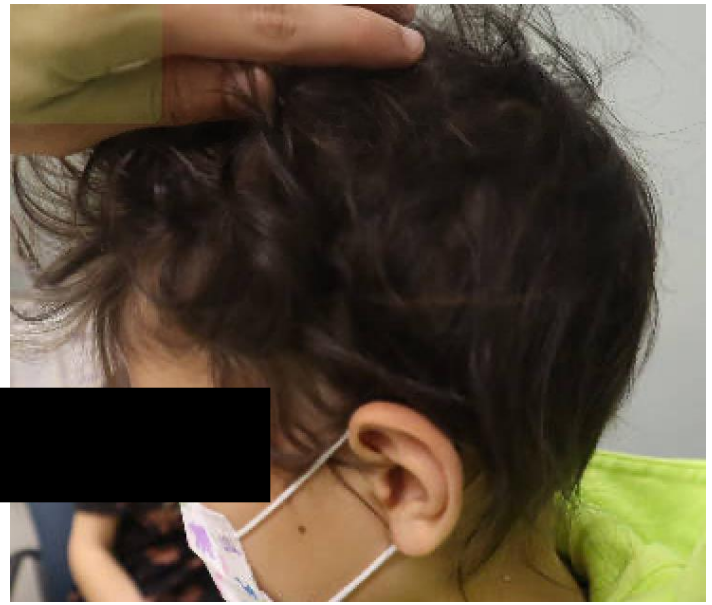
- **Review Side effects:**
  - Irritation (solution)
  - Hypertrichosis (reversible)
  - Hypotension/tachycardia
  - Toxicity to cats and dogs
- **Assessments**
  - 3-4 months: initial effect
  - 1 year: maximal effect

Minoxidil:









Initially Clobetasol alone

Added minoxidil 2.5mg daily

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Messenger et al, BJD 2004; 150(2)
Gupta et al, Derm Treat 2022;33(4)
Sharma et al. Int J Derm 2020;59(8)

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Adjuncts

Antihistamines
Minoxidil

Steroids

Topical
intralesional
Oral

Systemics

Methotrexate
Dupilumab
JAK Inhibitors

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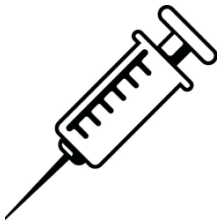
Steroids as 1st line in consensus paper

Age	SALT 0-30		SALT 31-50		SALT >50	
	Acute	Chronic	Acute	Chronic	Acute	Chronic
0-6	TOPICAL					
7-12						
13 +	Topical OR **ILK**	**ILK**	Topical OR **ORAL**		Topical +/- **ORAL**	Topical



- ✓ 2.5-5mg/ml*
- ✓ 0.1mL , 1cm apart, dermis/SC
- ✓ Areas with active disease
- ✓ Max 10-20mg/session (adult)

- ✓ Prednisolone preferred
- ✓ Daily administration
- ✓ 0.4-0.6mg/k/d taper over 12wks
- ✓ (adults: >12wks)

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JAAD. 2020;83(1):123-130.

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Topical steroids have evidence

- **Potent topical/ intralesional steroids**
  - SR: Response: ~81% (n=52), ILK response 75% (n=280)
  - Caution: folliculitis w/ ointments, absorption potential

- **Combinations**
  - **Mometasone+ calcipotriol** (n=50): SALT 6.05 → 2.66 at 6m
    - mometasone (n=50) HS: SALT 7.22 → 2.98
  - **Betamethasone Diproprionate +calcipotriol** (n=20 SALT <25)→ 53% dec SALT
    - Clobetasol (n=20) → 49% decrease SALT, more SEs

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JEADV 35: 1299-1308; Int J Trichology. 2019;11(3):123-127.
J Cosmet Dermatol. 2023;22:1297–1303.

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Calcipotriol/Betamethasone diproprionate

2 cycles later
(4 months)

BID x 4 wks – daily x 2wks –off x2 wks

Intralesional steroids: 5mg/mL seems best

Meta-Analysis of ILK in AA → regrowth + atrophy

First author	Study design	Level of evidence	Total no. of subjects	Intralesional steroid dose and frequency	Treatment duration	Definition of response, hair regrowth, %	Response rate (%)	Adverse effects
Amirnia et al,* 2015	Retrospective cohort	3	120	5 mg/mL every 3 wk	12 wk	>60	100/120 (83.3)	4/120 skin atrophy
Devi et al,† 2015	Randomized controlled trial	1	113	10 mg/mL every 3 wk	12 wk	Undefined	84/113 (74.3)	Not reported
Kaur et al,‡ 2015	Prospective cohort	2	40	2.5 mg/mL every 3 wk	6 wk	>50	27/40 (67.5)	Not reported
Kuldeep et al,§ 2011	Randomized controlled trial	2	25	10 mg/mL every 3 wk	12 wk	>50	18/25 (72)	6/25 skin atrophy
Mallick et al,‖ 2018	Prospective cohort	2	100	10 mg/mL once monthly for 3 mo	3 mo	>50	75/100 (75)	Not reported
Sanga et al,¶ 2015	Prospective cohort	2	46	5 mg/mL every 3 wk	6 mo	>50	33/46 (71.7)	Not reported
Ustuner et al,** 2017	Randomized controlled trial	2	89	3.33, 5, or 10 mg/mL every 4 wk	6 mo	>75	18/32 (56.3) with 3.33 mg/mL, 29/33 (87.9) with 5 mg/mL, and 33/34 (97) with 10 mg/mL	6/34 skin atrophy with 10 mg/mL

Atrophy:

5mg/ml:
3.3%

10mg/mL
24% (n=25)
17.6% (n=34)

Yee et al. JAAD 2020(82)4

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Systemic Steroids: effective but high relapse

- **The evidence (pulses)**
  - SR: CR in 43% (466/1078), relapses in 17%
  - Peds: CR in 51%, relapses in 60%
  - AEs: 21% (peds 12%) –acne, weight gain, GI, edema

- **How I do it:**
  - **Dexamethasone** PO Sat/Sun
    - 2mg age <14y, 4 mg 14y+
    - 12 weeks, +/- repeat x 1
  - **Prednisone** (tabs or 5mg/mL vs **prednisolone** 1mg/mL)
    - 1 mg/kg/day x 1 wk → 0.5mg/kg x 1wk → 0.25mg/kg x 1wk

Name	Equivalent dose (mg)	Anti-inflammatory potency	Duration of action (hrs)*
Cortisol (hydrocortisone)	20	1	8-12
Cortisone	25	0.8	8-12
Prednisone	5	4	12-36
Prednisolone	5	4	12-36
Methylprednisolone	4	5	12-36
Triamcinolone	4	5	12-36
Betamethasone	0.75	25	36-72
Dexamethasone	0.75	25	36-72
Fludrocortisone†	—	10	12-36

Data from Axelrod[1] and Nierman.[12]
*Short acting, 8-12 hours; intermediate acting, 12-36 hours; and long acting, 36-72 hours.
†Not used for glucocorticoid effects.
J Am Acad Dermatol January 2017

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Shrebeck-Hassidim et al. JAAD 2016: 74(2)
Gallaga et al. Ped Derm 2022, Ped Derm. 2023 Mar;40(2):276-281

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Adjuncts

Antihistamines
Minoxidil

Steroids

Topical
Oral

Systemics

Methotrexate
Dupilumab
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Methotrexate works (our first JAKi!)

✓**Appropriate for tx of severe AA in age 13 +**

Dose: 0.4mg/kg/week (adults: 15-20mg weekly)

Adult: CR 45.7% (165/371), with steroids 72.7%

relapse 52% (100/192), AEs 24% (GI, liver/heme)

Peds: good/CR 50% (34/68)

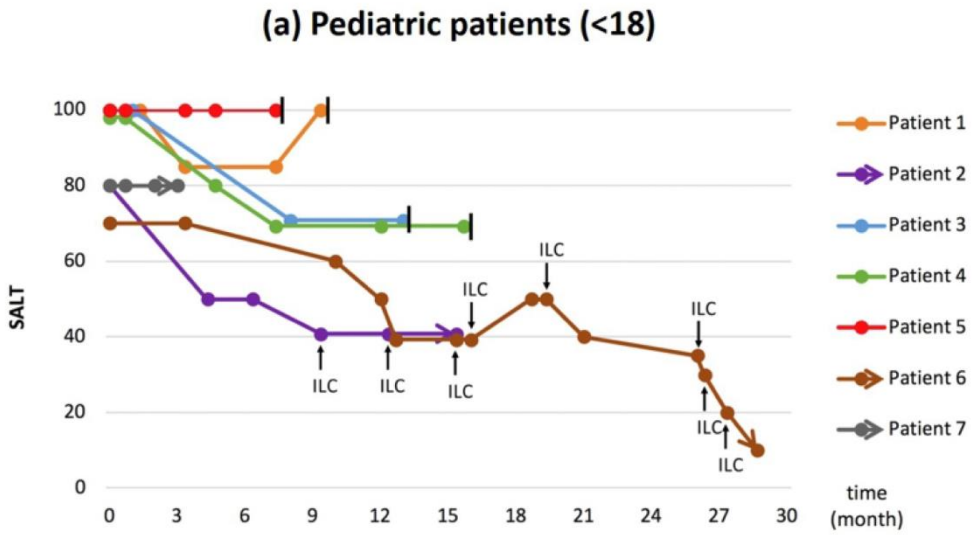
relapse 32% AEs 15%

Adult RCT 2023 (n=89 AU/AT, CR <=SALT10)

MTX alone 12m CR 0%

MTX 12m + pred 6m CR 31%

AEs fatigue 7% nausea 14%



Minimal information on duration of tx or risk of relapse

Landis et al. J Derm Treat 2018(29)2
Royer et al. BJD 2011(165)2
Lucas et al. Acta Derm Venereol 2016; 96: 102

Methotrexate: How I use it

- Counsel 50% response by 6 months
  - Continue for 1 yr if response then R/A

Received: 19 December 2022 | Accepted: 26 March 2023
DOI: 10.1111/pde.15327

PEDRA ORIGINAL ARTICLE

Pediatric Dermatology WILEY

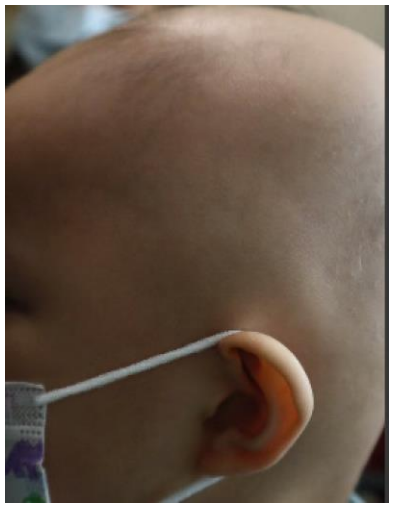
Methotrexate for inflammatory skin disease in pediatric patients: Consensus treatment guidelines

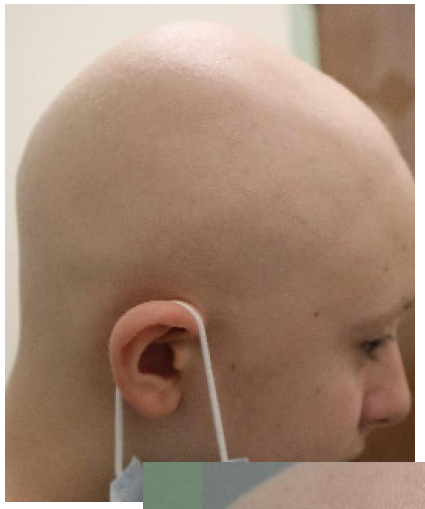
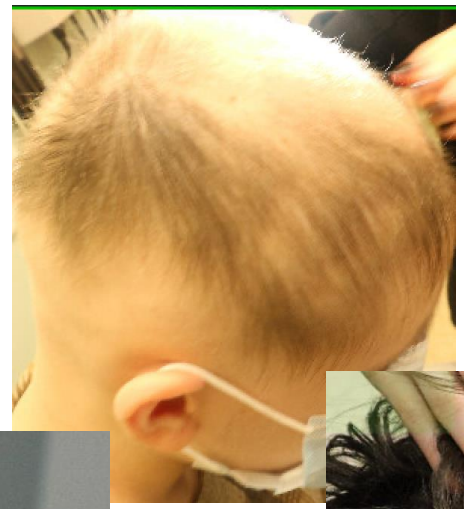
- 0.5mg/kg/week, max 15 mg to start
  - Concurrently with systemic steroids +/- minoxidil
    - PO (pills or solution in pre-filled syringes) → SC
    - Folic acid 1mg/day or 5mg 1x weekly
  - Labs at 1month then q3months
  - Hold: febrile illness + 2 wks after non-live vaccines

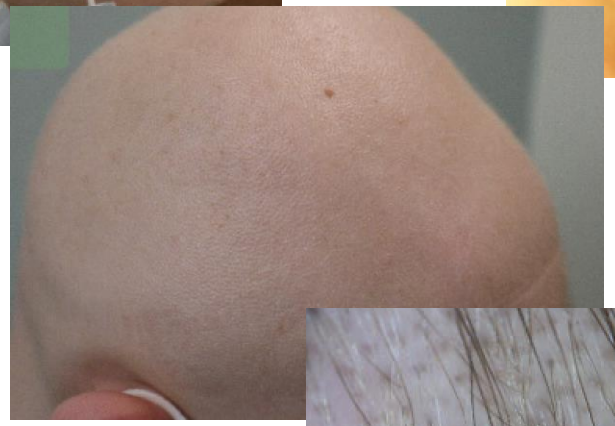
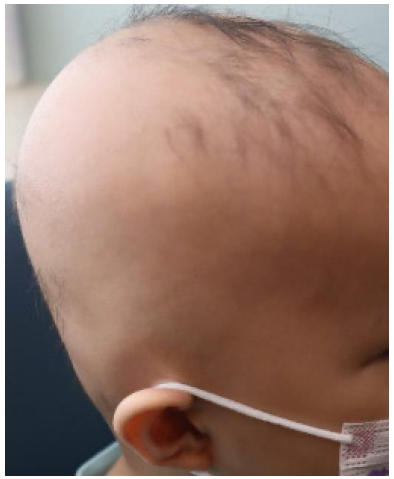
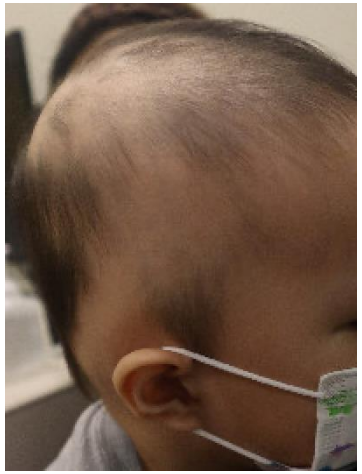
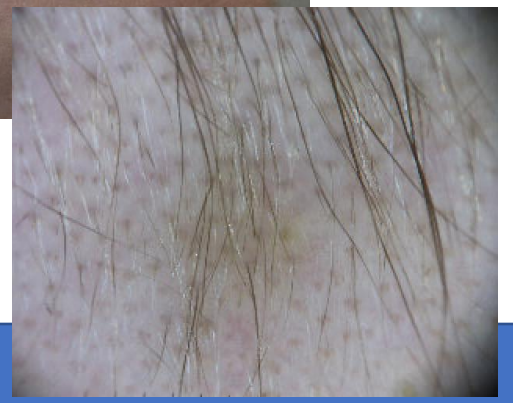
www.pedsderm/net --> handouts

7.5 mg MTX PO (syringes) weekly
0.5mg/kg/week, max 15 mg to start

50 mg Prednisone x 1 week→ 25 mg → 12.5 mg
MTX weekly + 2.5mg minoxidil PO daily (3 month→9 months



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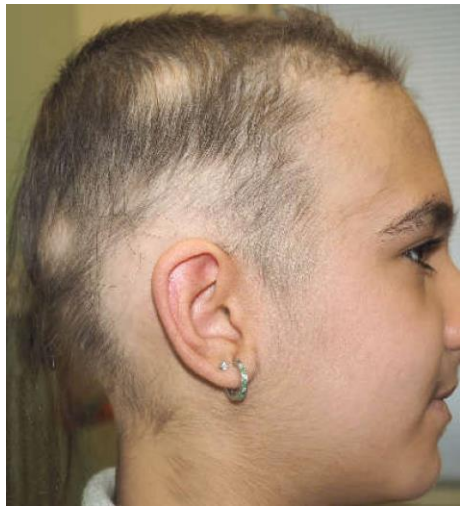
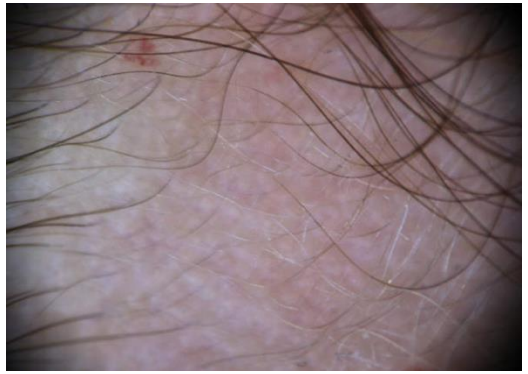
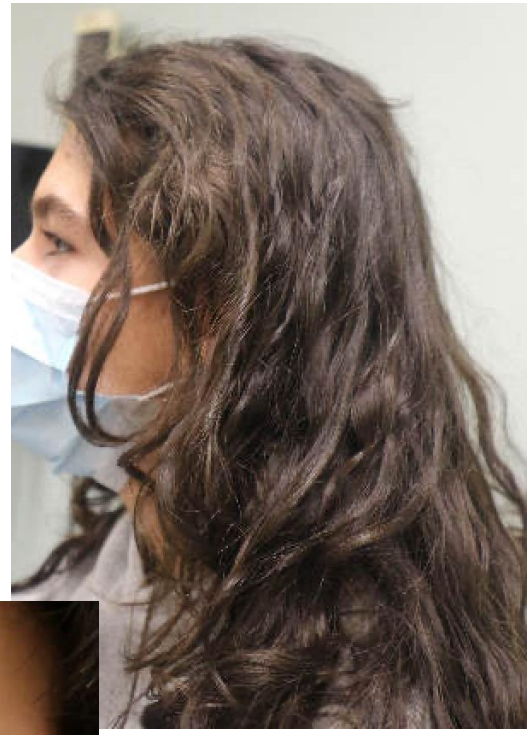
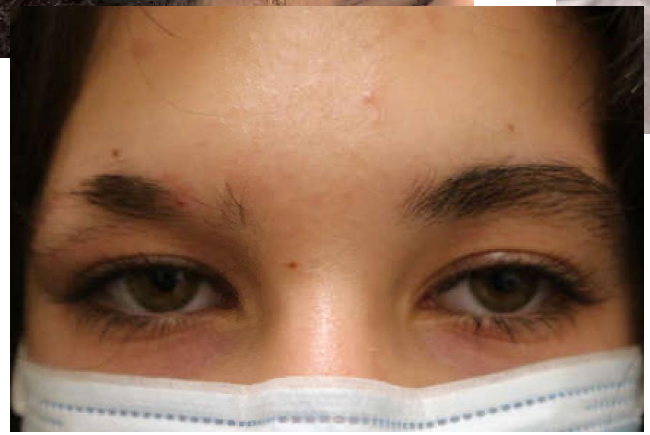
50 mg Prednisone x 1 week→ 25 mg → 12.5 mg
MTX 15mg weekly





Added LDOM
ILK to patches





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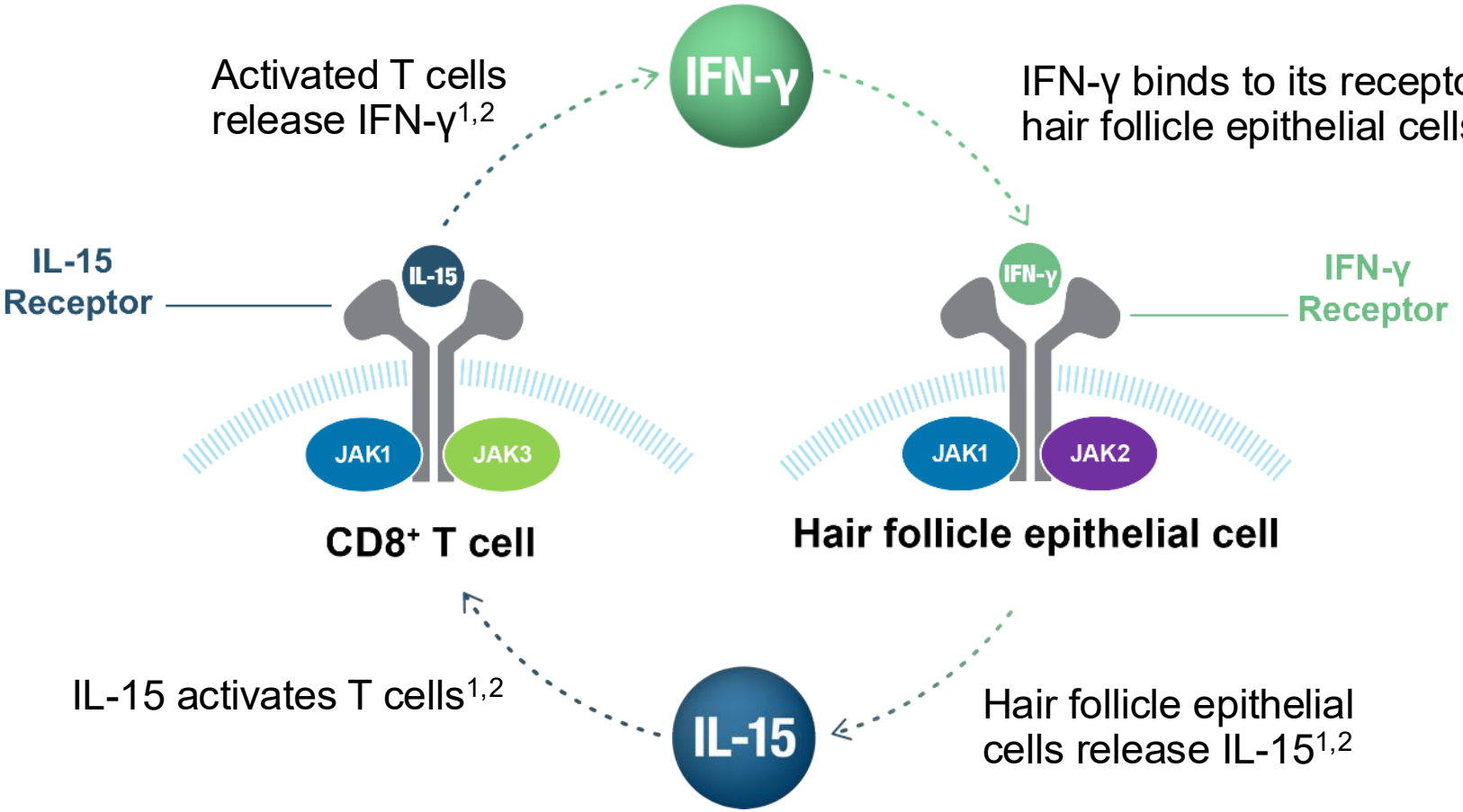
Janus Kinase Inhibition has changed AA



Illustrative, created by Pfizer.

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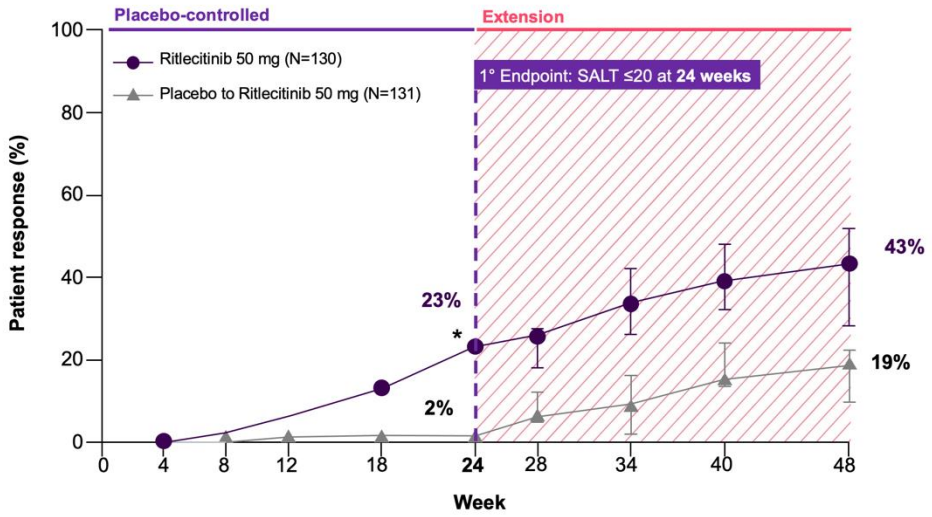
Ritlecitinib (JAK3/TEK)

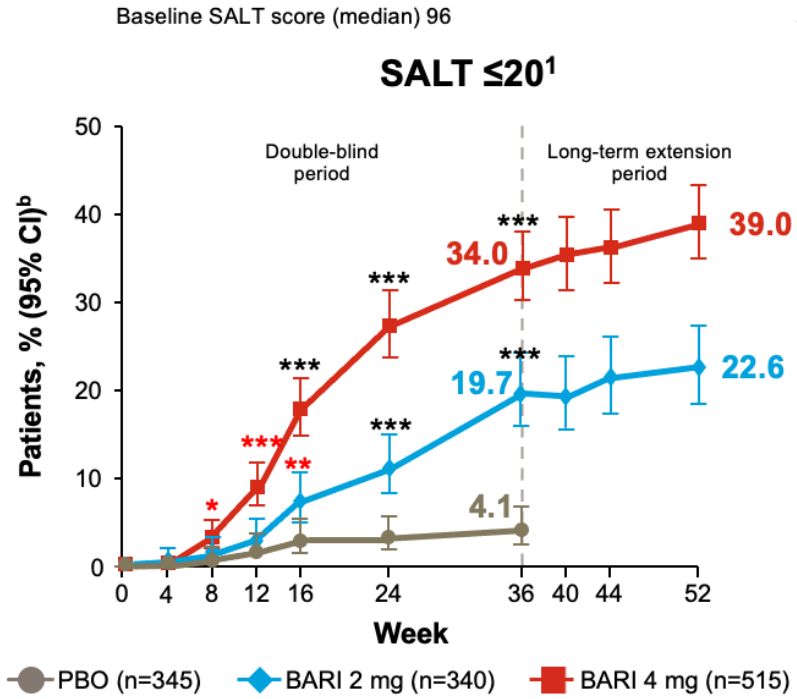


SALT ≤20:

20% at 24 weeks

47% at 48 weeks

Baricitinib (JAK1/2)

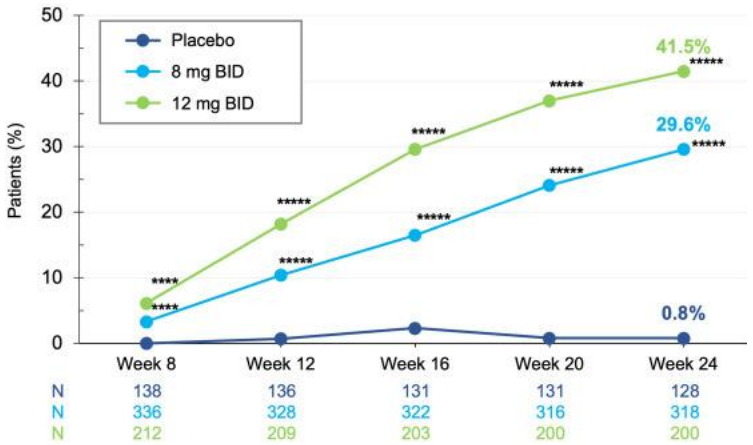


SALT ≤20:

28% at 24 weeks

39% at 52 weeks

Deuruxolitinib (JAK1/2)



SALT ≤20:

42% at 24 weeks

All used SALT50 for inclusion

Baricitinib: 2 dose options

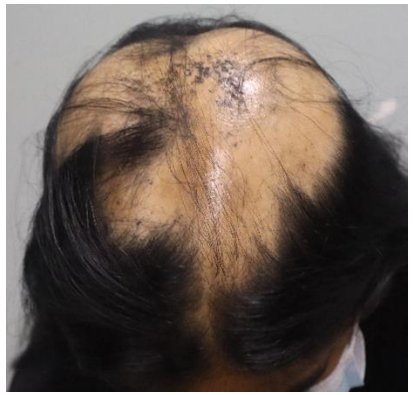
Ritlecitinib: No VTE or MACE in black box

4% urticaria, 10% diarrhea

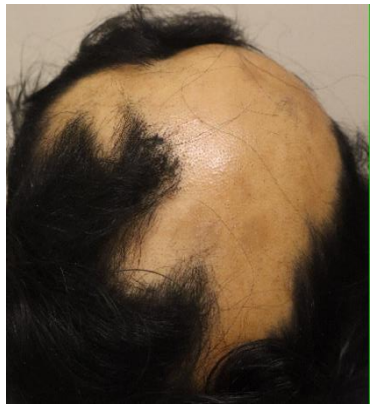
NO lipid derangements, more low platelets

Deuruxolitinib: BID dosing, ?fastest onset, no HC yet

Ritlecitinib 50mg daily



April 2024
Ritlecitinib 50 + minox 2.5

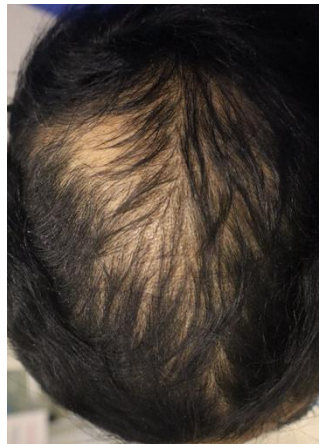


July 2024

No pic

No change
Pred 50x1wk
then 25 x1wk
then 12.5 x1wk

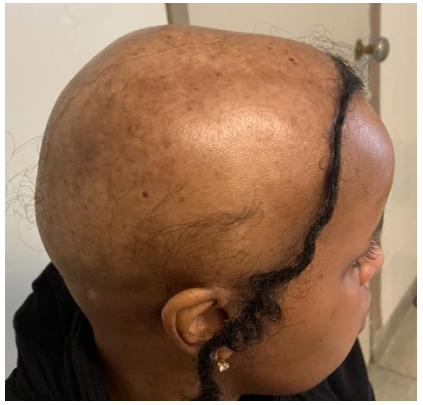
Oct 2024



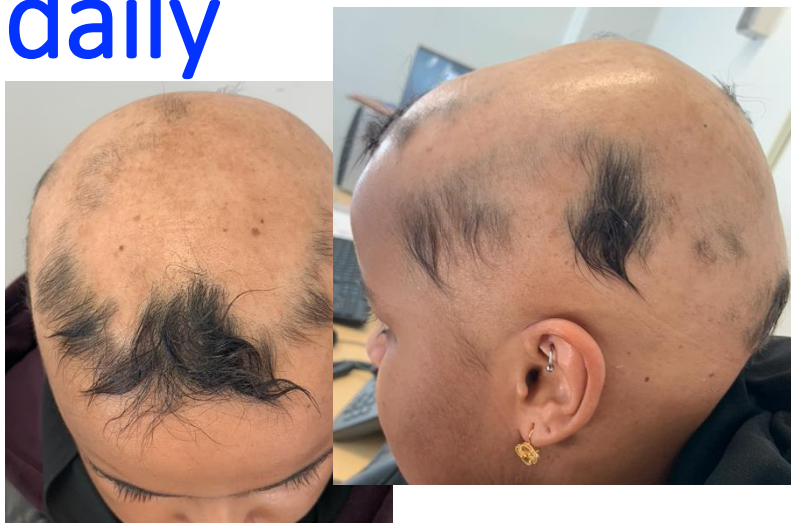
Jan 2025

May 2025

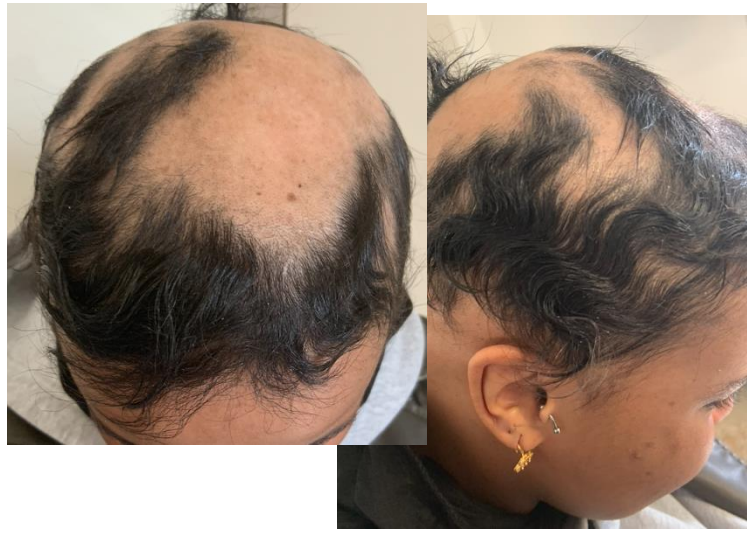
Baricitinib 4mg daily



May 2024



Nov 2024



March 2025

Tofacitinib (JAK1/3) also works! FDA 2y+ JIA

Characterizing Tofacitinib Response in Pediatric Alopecia Areata: A Retrospective Review

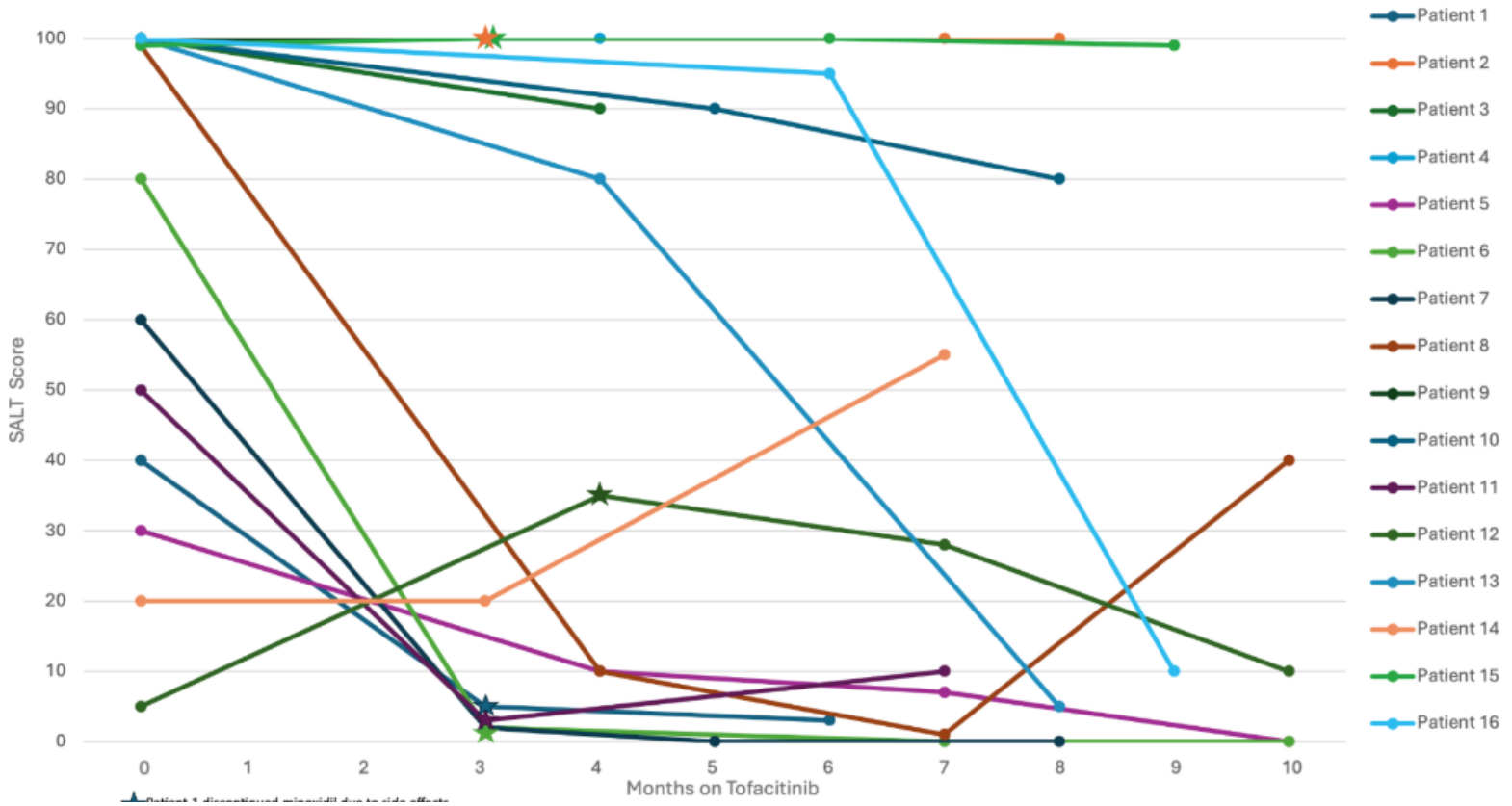
Michal Moshkovich, BHSc, Cinthiya Sugumar, BHSc, and Cathryn Sibbald, MD

Sickkids experience:
16 patients

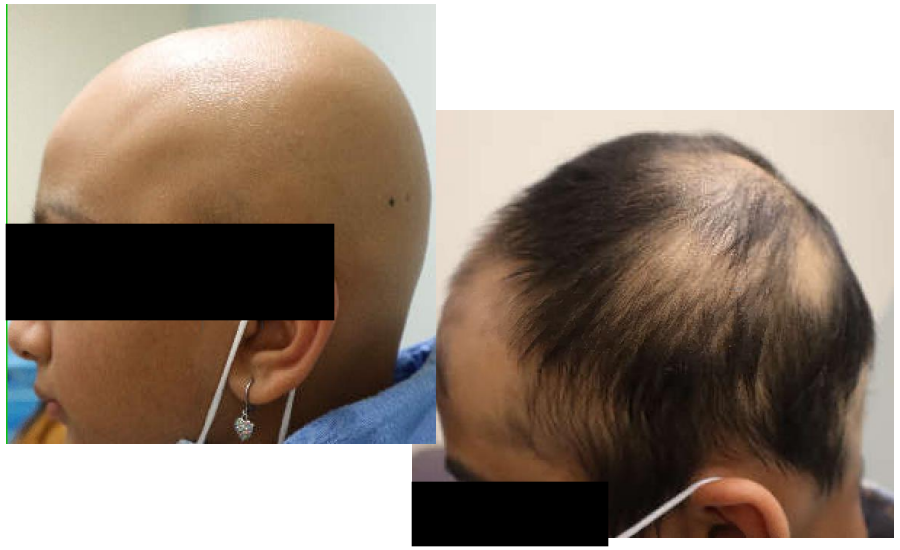
SALT <20:
- 46% at wk 20-28
- 60% at wk 32-40

JCMS 2025.
doi:10.1177/12034754251347577

Fig 4. SALT score progression in pediatric AA patients (<17 years old) on tofacitinib

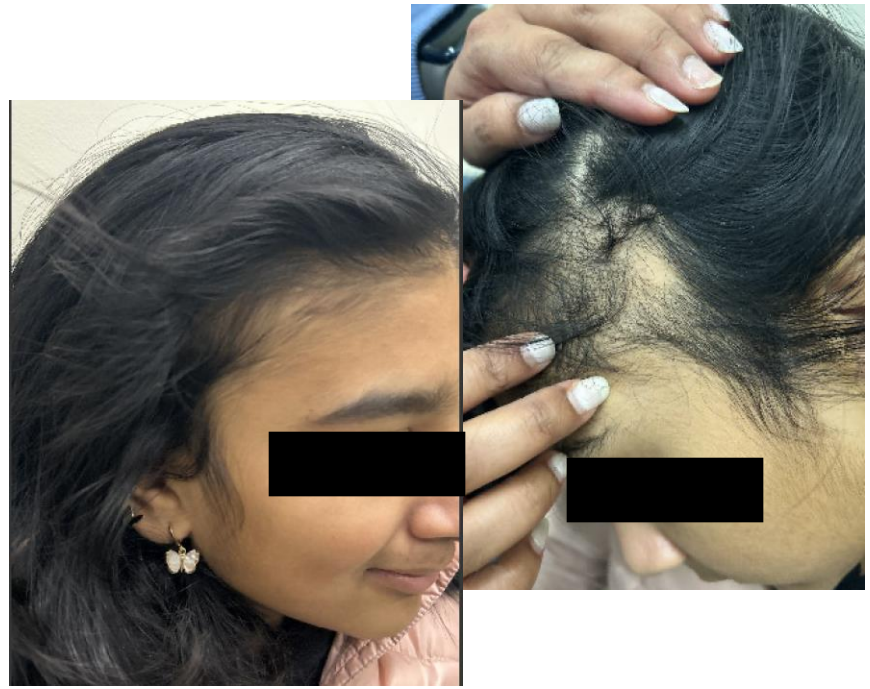


Tofacitinib (JAK1/3) 5mg BID



1 year

2 years

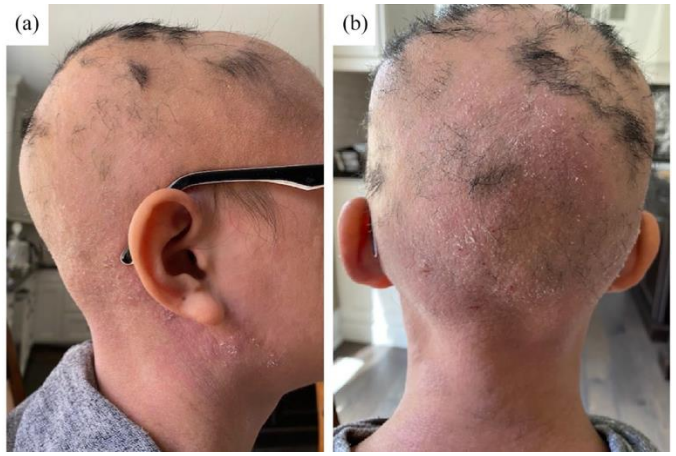


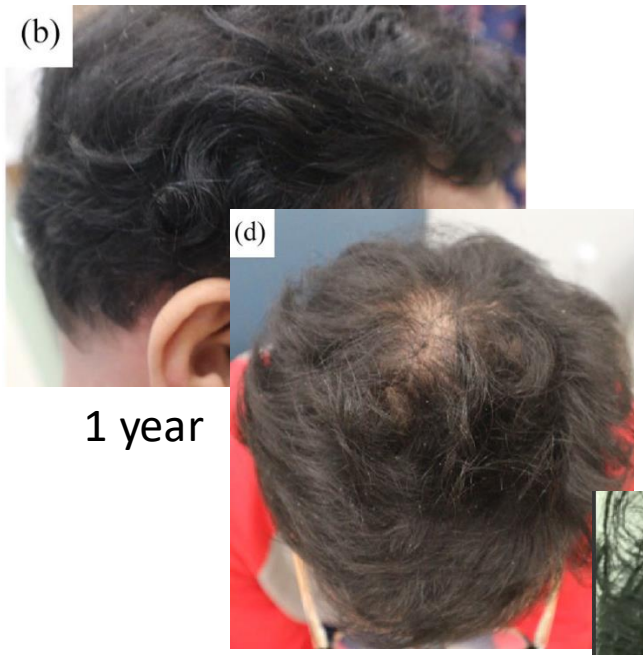
5mg PO BID (Generic)

- 4mg BID if 20-<40kg, 3.2mg BID if <20kg
- 1x/day if liver/renal dz OR CYP3A4/2C19 inhibitors
- Monitor: neutropenia, hypertriglyceridemia

Tofacitinib 5mg BID
+ Minoxidil 2.5mg daily
+ intermittent steroids

Upadacitinib (JAK1) also may help, Atopic 12y+





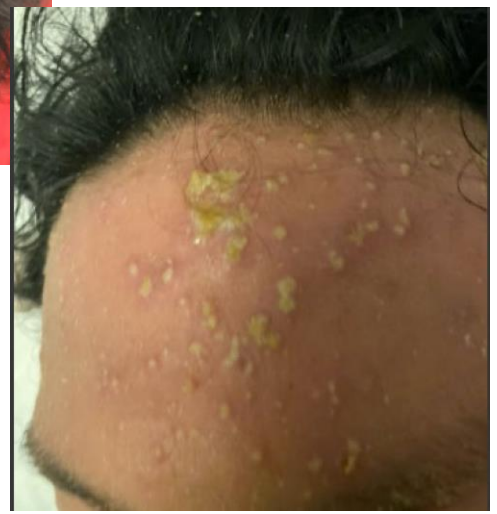
1 year

Phase 3 trial ongoing!
(NCT06012240)
-12-63y with SALT50+

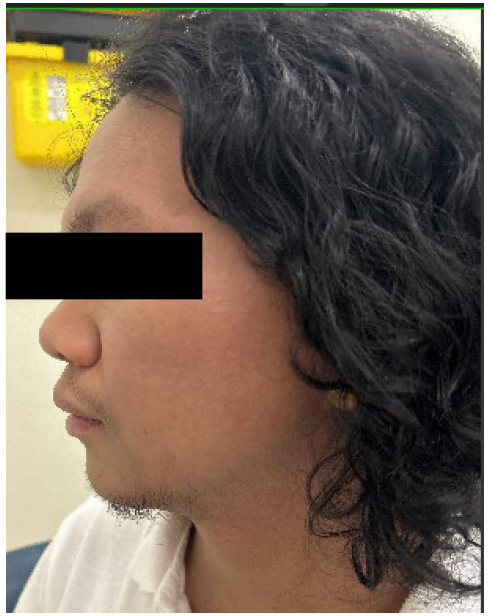
-1399 patients enrolled
-expected completion 2028

- 15mg daily

- AE monitoring
  - Hyperlipidemia
  - Infections (HSV/VZV, **Strep**/staph)



Strep pustulosis

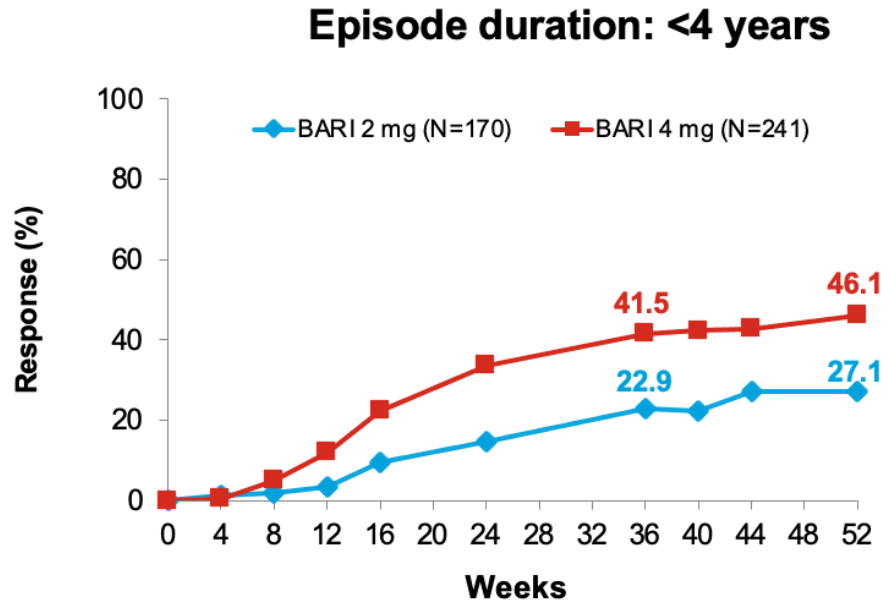


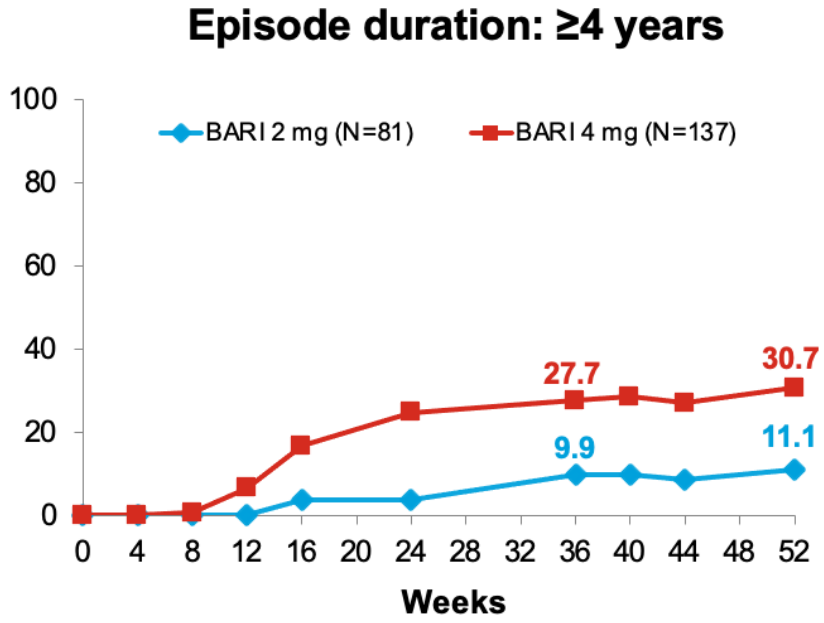
2.5 years

Many Factors can affect Response to JAKi

Baricitinib data:

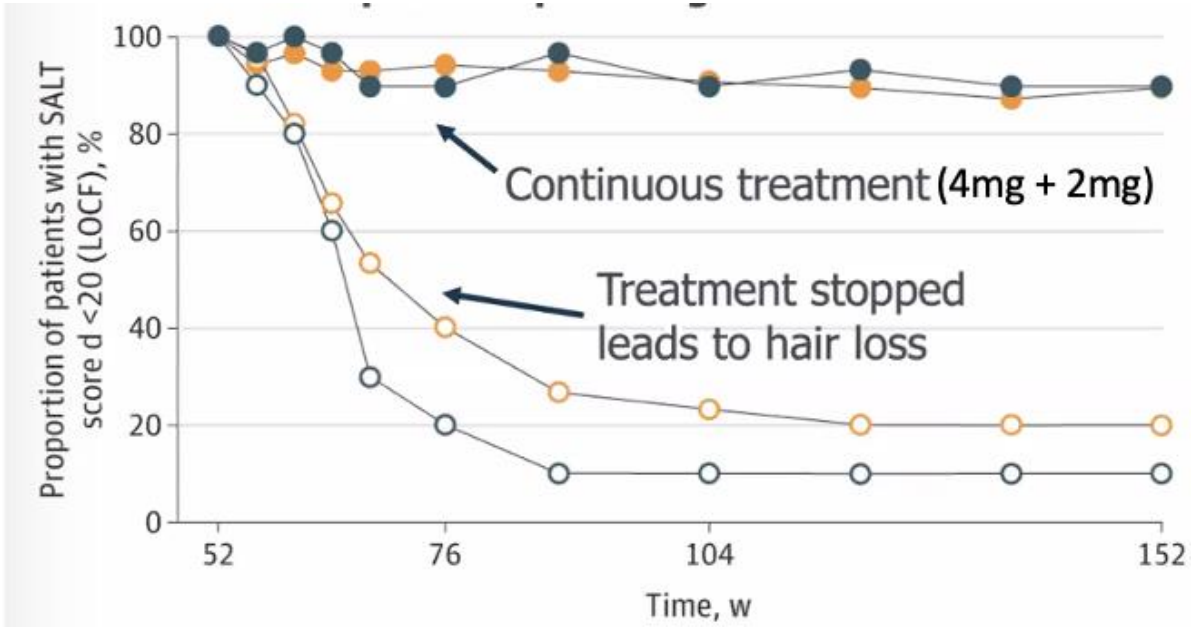
- Dose (4mg better than 2mg)
- Baseline Severity
  - (salt 50-95 better than salt 96-100)
- Duration of Disease (<4yrs vs 4y+)
- Adjuvant minoxidil

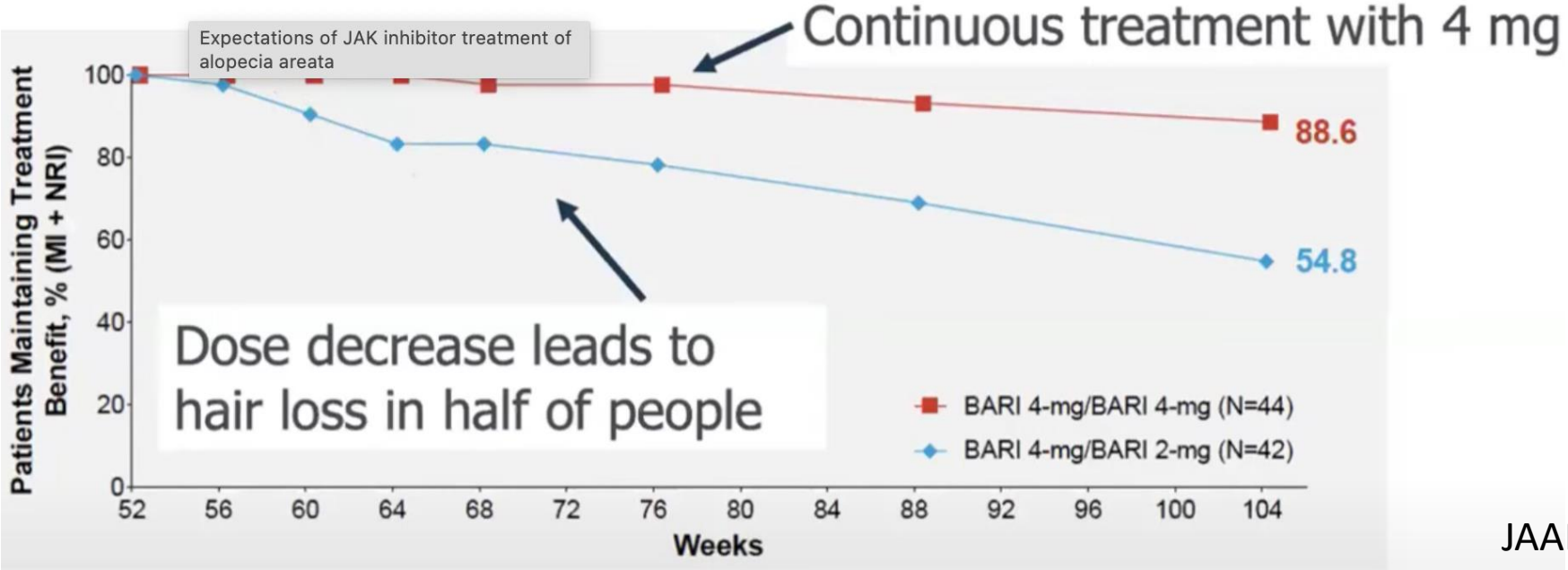




Am J Clin Derm 2023, **24**, 443

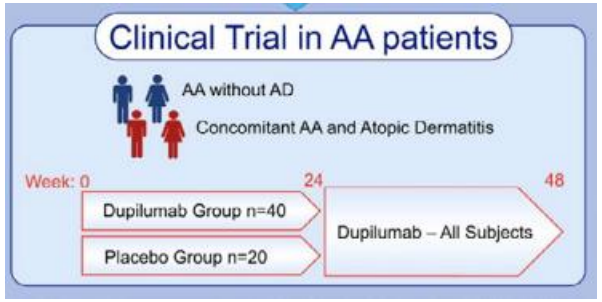
Hair loss is common when JAKis are stopped





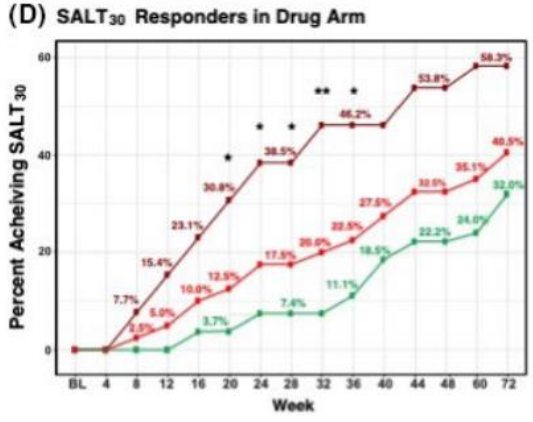
JAAD 2025 V 92, I 2, 299

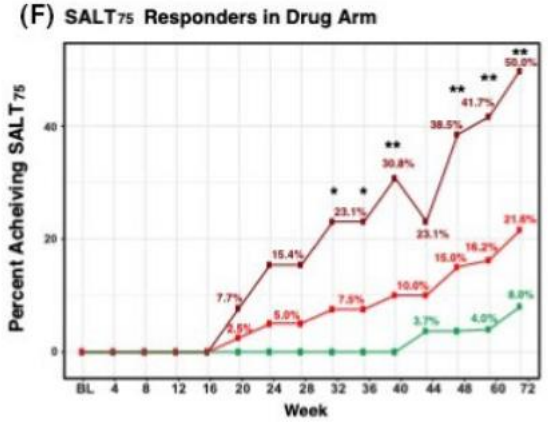
Dupilumab weekly: regrowth in adult AA with history of atopy +/or high IgE

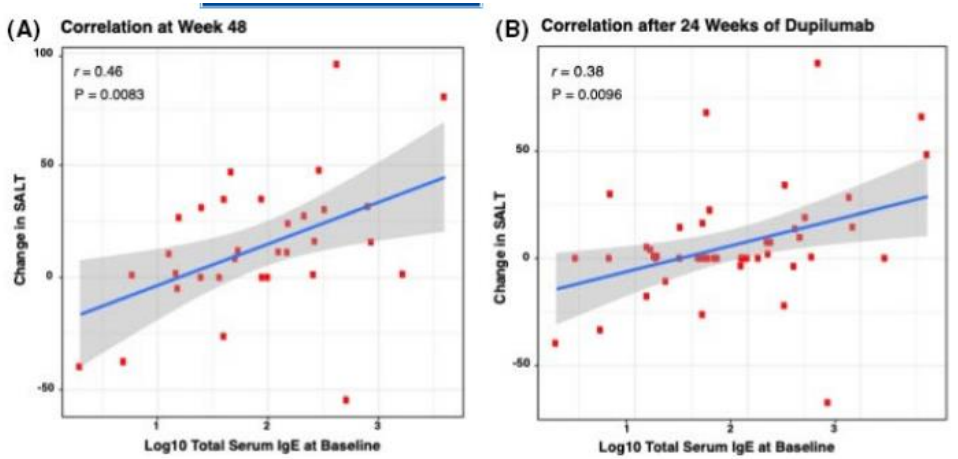


Dupilumab dosing:
300mg weekly

SALT30 in 90%
(vs 31% w/ no atopy bkgd)







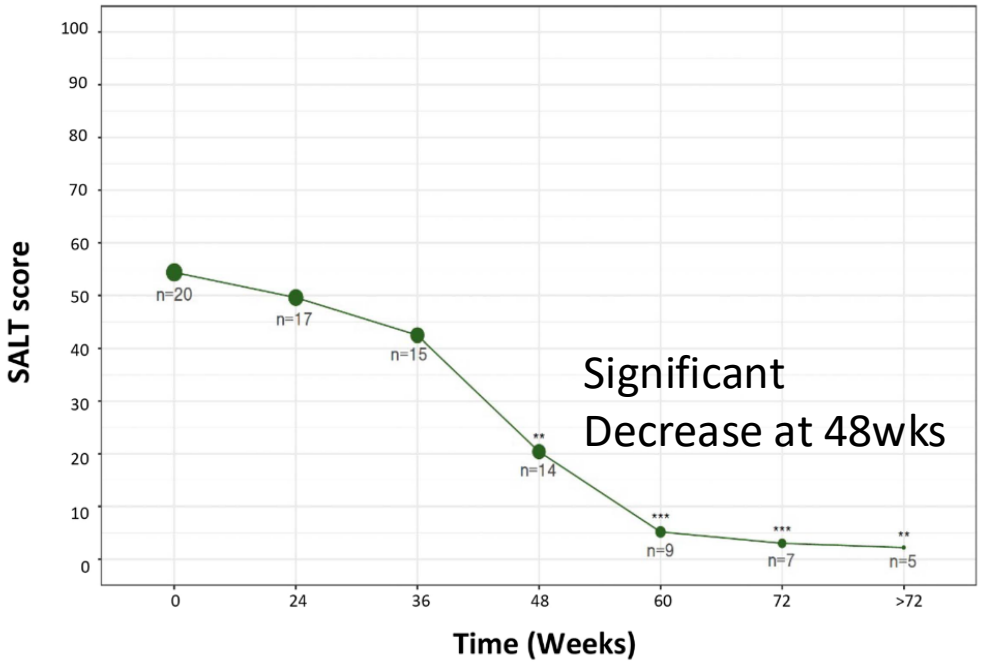
High IgE at Baseline and Background Atopy Predict Dupilumab Response

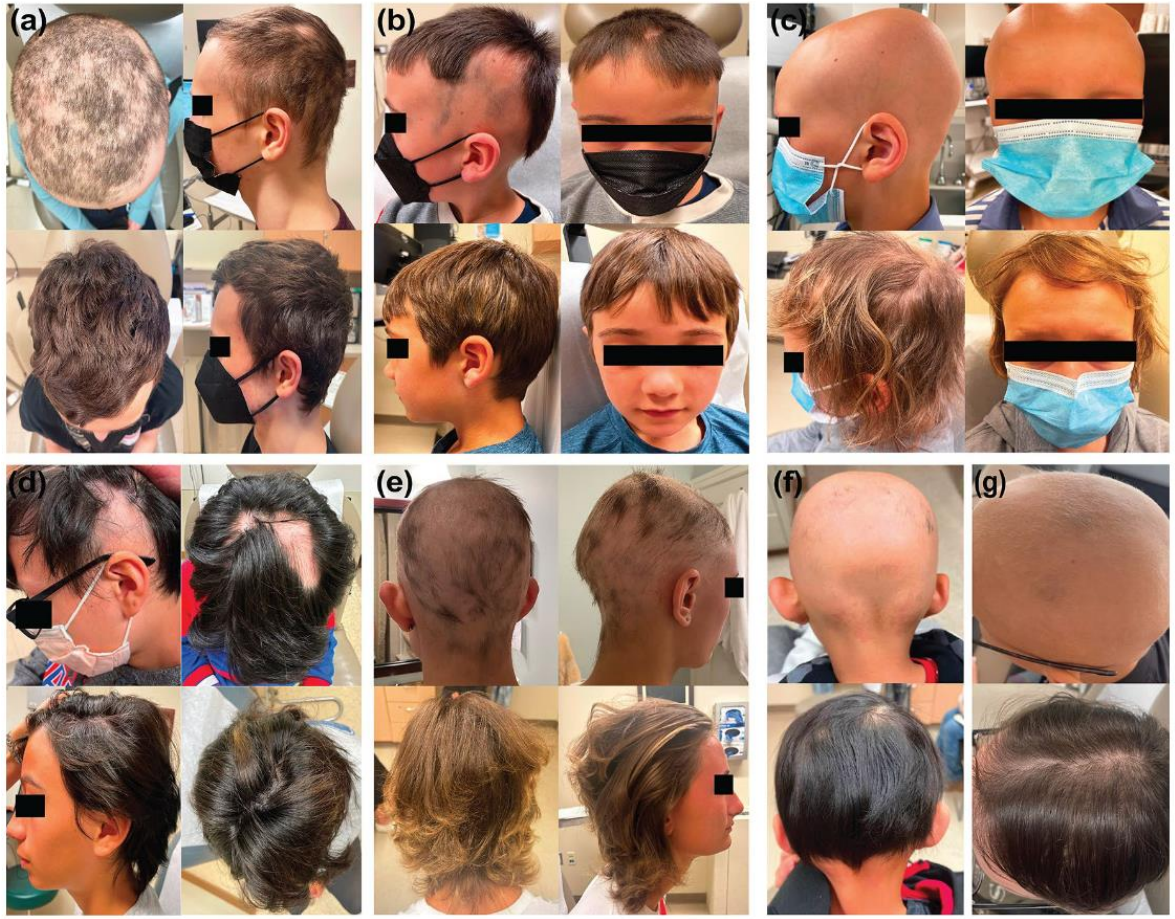
History of AD: 38%
Active AD: 12%
Family Hx: 45%

Guttman-Yassky et al. Allergy 2021

Dupilumab in Pediatric AA with AD: **those with IgE>200 responded earlier**

N=20, mean age 10yrs, 100% with AD
SALT 54.4, EASI 42.9, 40% had IgE>200

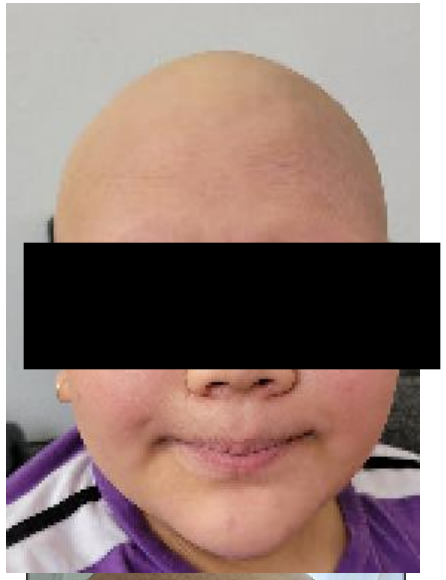


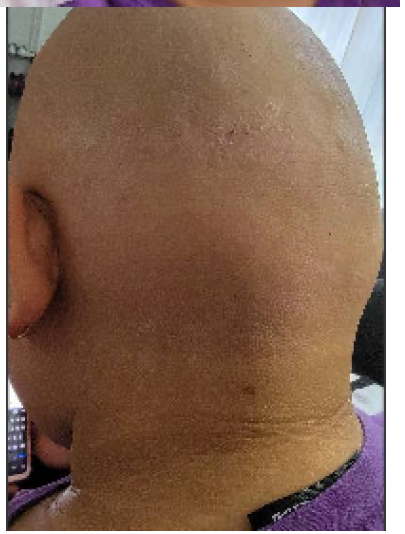


Baseline EASI + SALT did not correlate w. response
AEs: 1x self-limited joint pain (?growth spurt)
1x facial rash at 16 mons, lasted 3 months

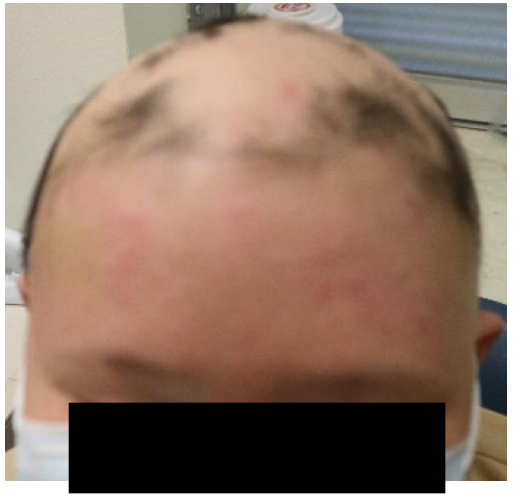
Arch Derm Research (2024) 316:487

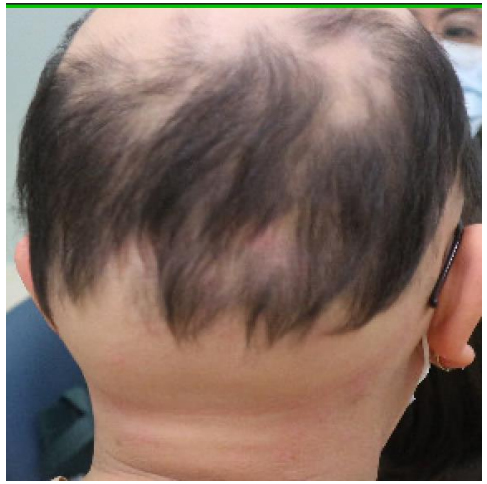
Dupilumab 300mg q2wks



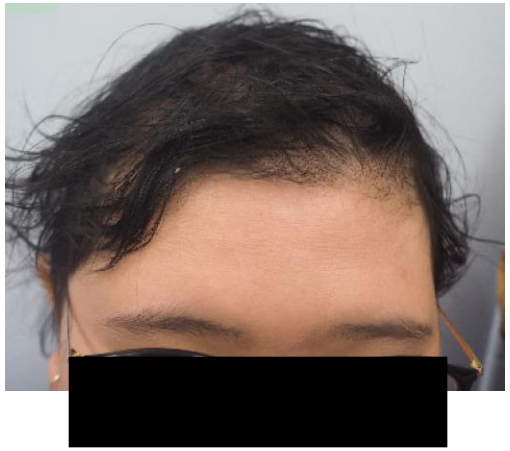


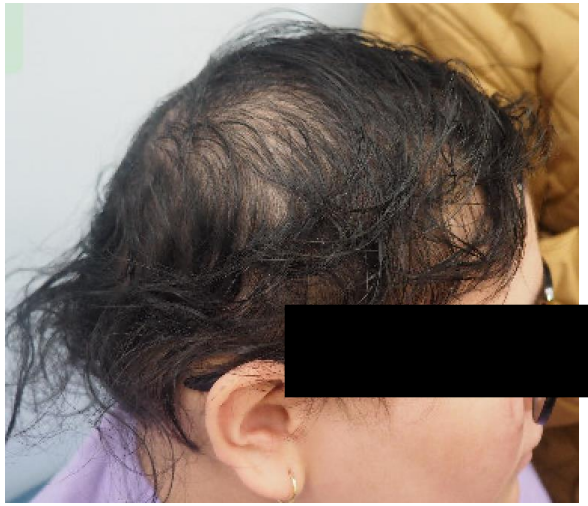
Baseline
(IgE Nr, 83)



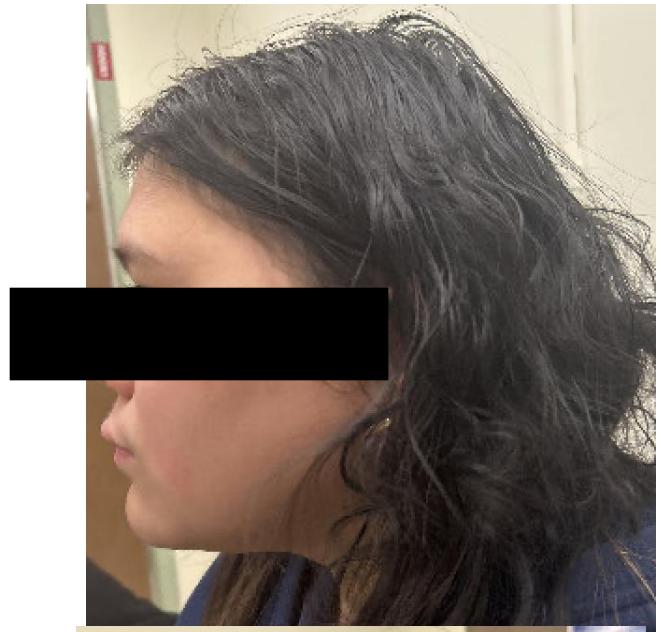


8 months



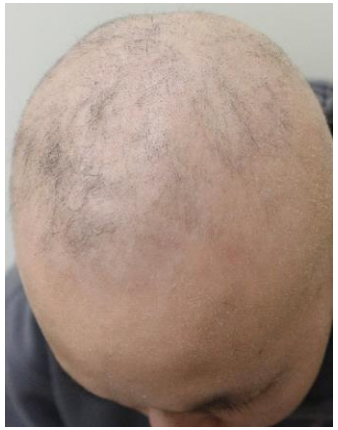


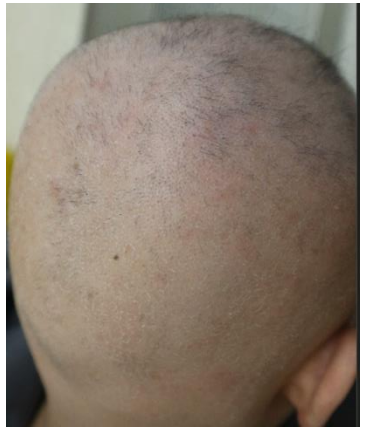
12 months



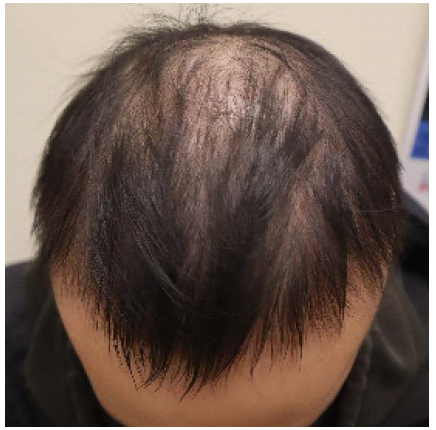
24 months

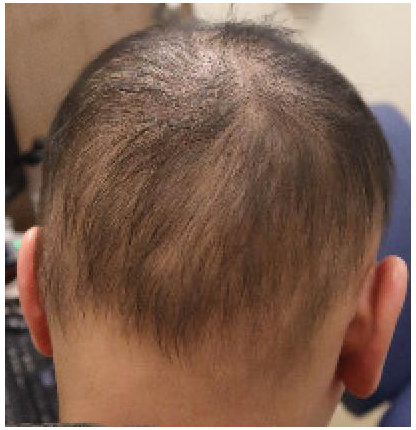
16yM, Sept 2023
Suboptimal MTX response
Started dupi 300mg q2wk
IgE 136



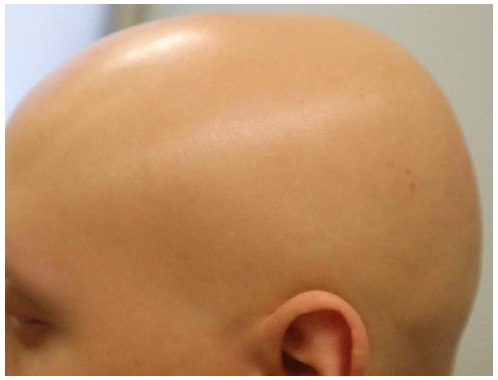


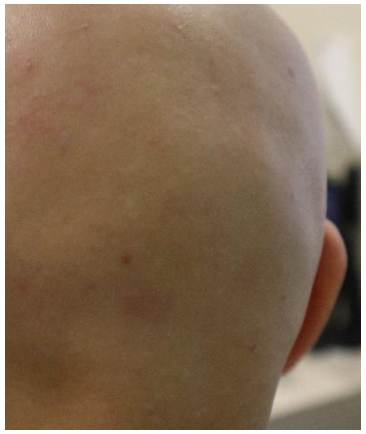
March 2024
(7 months)



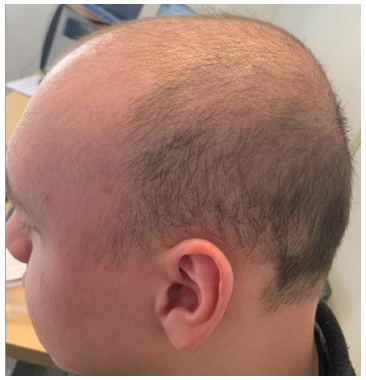


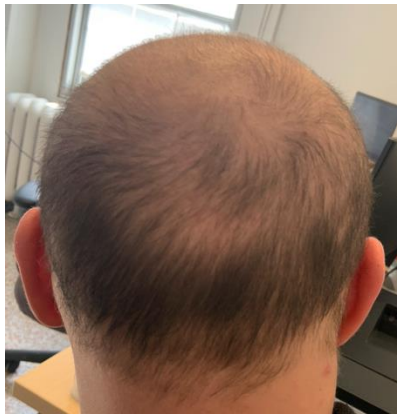
17yM, Nov 2023
Prev MTX +LDOM, no response
Started dupi 300mg q2wk
(by allergist for asthma)
IgE 351





March 2025
(15 months)





SickKids
THE HOSPITAL FOR SICK CHILDREN

UNIVERSITY of TORONTO

OUTLINE

1. Quality of Life
2. Current treatments of interest
3. Treatments being studied

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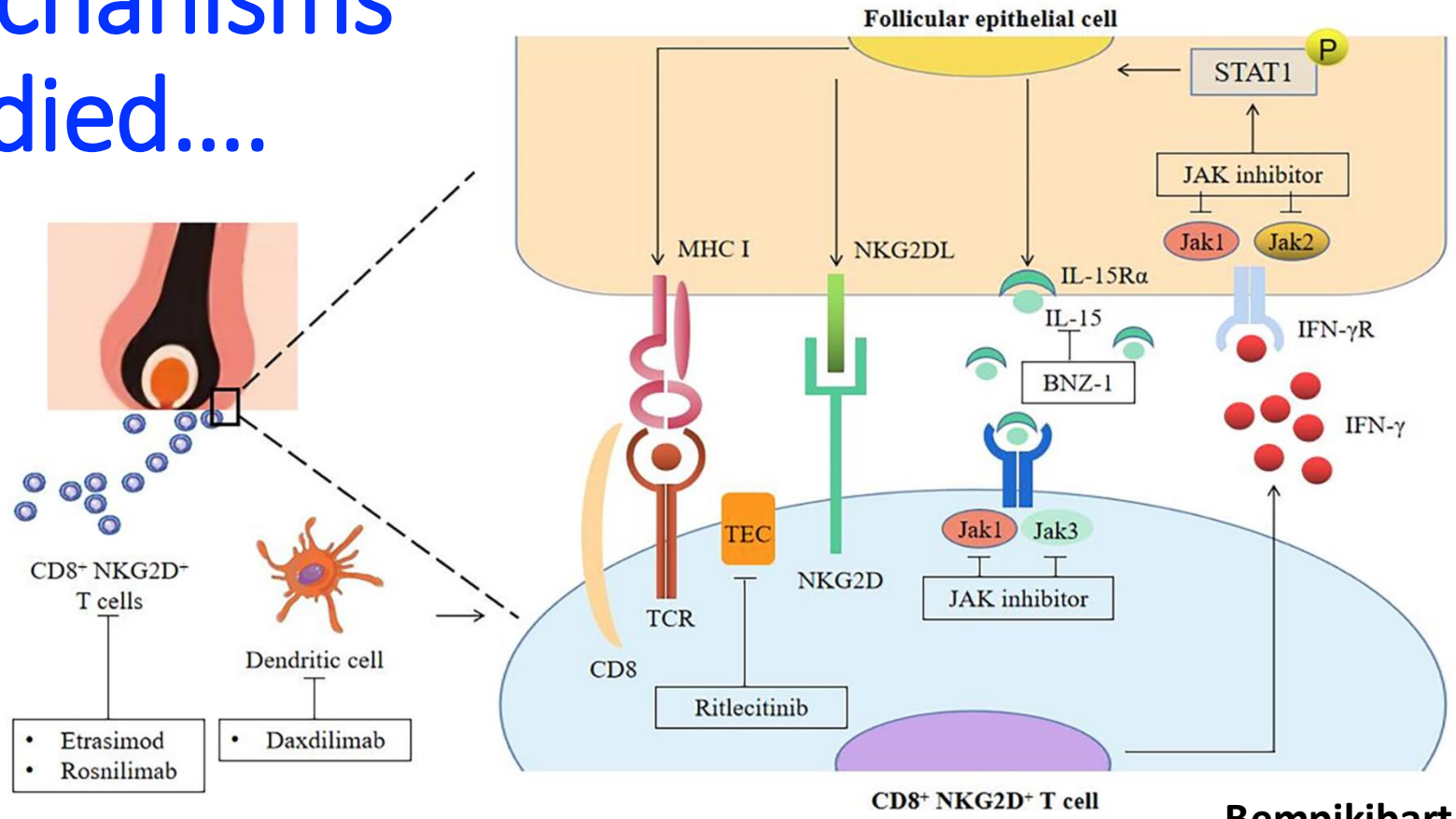
Audience Question 3

Which of the following is NOT a mechanism being currently pursued in Phase 2 or higher studies?

1. Sphingosine-1-phosphate (S1P) receptor modulator
2. Monoclonal antibody to immunoglobulin-like transcript 7 (ILT7)
3. Anti-PD-1 monoclonal antibody
4. Human anti-IL-7 receptor alpha (IL-7Rα) antibody

Many mechanisms being studied….

Am J Clin Derm (2023) 24:895



Estrasimod
(sphingosine 1-phosphate receptor modulator, PO)
Phase 2: N=80 adults
Improved SALT but did <u>not</u> meet endpoints

Rosnilimab (PD-1 Ab, SC)
Depletes PD1+ Tcells
Phase 2 ongoing

Daxdilimab (blocks ILT7: PDC)
* depletes PDC (initiate AA)
* dec IFN activity
Phase 2: ongoing , SC monthly
(NCT05430854)

BNZ (cytokine inhibitor)
* Dec IL2, 9, 15
Phase 2: ongoing, IV q2wk
(NCT03532958)

Bempikibart (Il7Ra inhibitor)
* Dec IL7 + TSLP signaling
* SC q2wks
Phase 2: N=27 x24wks then off
* Mean SALT dec 17-24% wk 24
* Further dec (~5%) wk 36

PDC: plasmacytoid dendritic cells
ILT: Ig-like Transcript

AA associated with decreased mortality

Table II. Mortality risk for patients with alopecia areata according to sex, age, Charlson comorbidity index, and presence of end-organ disease

	Alopecia areata*	Matched control*	aHR (95 % CI)	*P* value
Overall	212 (2094/98,828)	416 (4119/98,956)	0.498 (0.473-0.526)	<.0001
Sex				
Female	224 (1362/60,673)	452 (2749/60,773)	0.485 (0.466-0.518)	<.0001
Male	193 (675/34,958)	407 (1,424/34,986)	0.464 (0.433-0.519)	<.0001
Age (y)				
<40	531 (275/51,815)	877 (455/51,861)	0.603 (0.519-0.701)	<.0001
40-59	132 (364/27,568)	247 (682/27,593)	0.528 (0.464-0.606)	<.0001
>60	697 (1454/20,858)	1440 (3022/20,918)	0.444 (0.415-0.512)	<.0001
CCI				
0	35.8 (210/58653)	68.7 (403/58684)	0.52 (0.44-0.614)	<.0001
1 or more	946 (1440/15,211)	1700 (2,589/15,253)	0.51 (0.48-0.55)	<.0001
End-organ disease				
Absent	75.1 (635/84,609)	155 (1316/84,696)	0.479 (0.436-0.527)	<.0001
Present	1100 (1626/14,748)	1930 (2848/14,786)	0.519 (0.486-0.555)	<.0001

aHR, Adjusted hazard ratio; *CCI*, Charlson comorbidity index.
*Mortality outcomes reported as incidence rate of mortality per 10,000 person-years; (number of events/person-years).

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JAAD March 2025 Vol 92; 3, 558-559

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Takeaways

1. The psychosocial burden of AA is significant

2. Systemic JAK inhibitors, dupilumab and oral low dose minoxidil have data to support efficacy as monotherapies or combination therapies

3. Multiple new targets are being investigated for targeted treatments of AA

THANK YOU!!

Rising star trainees

- Michal Moshkovich
- Cinthiya Sugumar
- Jenna Mistry
- Dea Metko
- Shanti Mehta
- Samiha Mohsen
- Megan Park
- Emma Price
- Eric McMullen
- Matt Akiska
- Anthony Gilding
- Hiba Zaaroura

Mentors and collaborators

- Leslie Castelo-Soccio
- Jeff Donovan
- Elena Pope
- Britt Craiglow

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