

Informed Choices: Advanced Systemic Therapy in Moderate-to-Severe Atopic Dermatitis

1 When to Switch: Tolerability or Treatment Fit

Act when the balance changes

Consider a switch whenever adverse effects, treatment burden, or route outweigh the benefit.

THREE COMMON PATHWAYS TO AN ORAL JAK INHIBITOR



From a Biologic: Treatment-Related Adverse Events^{1,2}

Persistent ocular surface disease or conjunctivitis; Head/neck dermatitis or facial erythema, arthralgia, or psoriasis; Injection reaction, hypersensitivity, or administration intolerance



From Conventional Systemic Therapy: Toxicity or Burden^{1,3,4}

Cyclosporine: Hypertension or renal dysfunction; Methotrexate/azathioprine: Hepatic or hematologic toxicity; SCS: MACE, VTE, sepsis, or fracture^{3,4}; Monitoring burden, drug interactions, cumulative toxicity

Systemic corticosteroid exposure qualifies the patient for consideration of an oral JAK inhibitor



Patient Preference or Treatment Fit¹

Preference for oral rather than injectable therapy; Injection aversion, administration burden, or limited access; Treatment goals and lifestyle favor a different route after shared decision-making

2 What to Choose: Guideline-Concordant Options

Injectable Biologics⁵⁻⁷

Strong recommendation · moderate certainty

Dupilumab (≥6 mo)

Tralokinumab, lebrikizumab, nemolizumab (≥12 y)

Oral Immunosuppressants⁵⁻⁷

Conditional recommendation · low/very low certainty

Methotrexate (≥2 y)

Azathioprine, mycophenolate mofetil, cyclosporine (≤18 y) (For refractory disease)

Oral JAK Inhibitors⁵⁻⁷

Strong recommendation · moderate certainty

Upadacitinib, abrocitinib (≥12 y) (After other systemic therapy failure or when those therapies are inadvisable)

Baricitinib*

Systemic Corticosteroids⁵⁻⁷

Recommendation against

Short-term bridge to steroid-sparing therapy in cases of acute, severe flares only; not for maintenance

*Evidence-based, off-label use since baricitinib is not approved in the US for atopic dermatitis management.

JAK, Janus kinase; mo, months of age; y, years of age

This handout is current as of October 2026.

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3 Evidence-Based Patient Counseling: JAK Inhibitor Long-Term Safety

ADVERSE EVENTS OF SPECIAL INTEREST: COMPARISON BETWEEN CLINICAL AND REAL-WORLD INCIDENCE¹⁻³

Events per 100 patient-years	Upadacitinib (7 years)		Abrocitinib (~6.5 years)		Real-world AD reference cohort
	15 mg	30 mg	100 mg	200 mg	Kaiser Permanente (95% CI)
Patients, n	1337	1346	1053	1999	8197
Exposure, patient-years	4641	4983	2567	4508	Not reported
MACE	0.2	<0.1	0.3	0.3	0.3 (0.2, 0.3)
VTE	0.1	0.2	0.1	0.3	0.2 (0.2, 0.3)
Malignancy (excl. NMSC)	0.3	0.4	0.2	0.4	0.5 (0.4, 0.6)

This table does not represent a head-to-head comparison; instead, it represents 2 clinical development programs and 1 observational cohort. Herpes zoster incidence rates (not shown here) were numerically higher with higher doses of upadacitinib and abrocitinib.

COUNSELING TALKING POINTS

Long-term rates of MACE, VTE, and malignancy (excl. NMSC) were low and overlapped with real-world rates in patients with AD¹⁻³

JAK inhibition has been linked to real-world improvements in myocardial function⁵ and reduced systemic inflammation among patients with AD⁶ in clinical studies

Upadacitinib was effective for immune checkpoint inhibitor-related dermatitis and reported without serious adverse events in patients with comorbid cancer⁹

Long-term rates of MACE, VTE, and malignancy were comparable between a JAK inhibitor and a biologic⁴

Occurred ≠ Increased Risk
Supported by post marketing data and real-world evidence; JAK inhibitor boxed warnings reserve “increased risk” for serious infections only^{7,8}

Clinical evidence shows that JAK inhibition could improve immunotherapy outcomes for patients with cancer^{10,11}

AD, atopic dermatitis; CI, confidence interval; JAK, Janus kinase; MACE, major adverse cardiovascular event; NMSC, nonmelanoma skin cancer; VTE, venous thromboembolism

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1. Guttman E, et al. 2026 Winter Clinical Dermatology Conference. Maui, HI, USA.; 2. Simpson EL, et al. 2025 EADV Congress. Paris, France.; 3. Hedderson MM, et al. *BMJ Open*. 2023;13:e071172.; 4. Bunick C, et al. *B/D*. 2024;190(Supplement_2):ii35-6.; 5. Corrao S, et al. *Front Immunol*. 2026;17:1867314.; 6. Bunick C, et al. 2026 Winter Clinical Dermatology Conference. Maui, HI, USA.; 7. RINVOQ (upadacitinib) Prescribing Information. 2026.; 8. CIBINQO (abrocitinib) Prescribing Information. 2026.; 9. Chen C, et al. *JAMA Oncol*. 2026;12(5):526-528.; 10. Mathew D, et al. *Science*. 2024;384(6702):eadf1329.; 11. Zak J et al. *Science*. 2024;384(6702):eade8520.

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