Journal Pre-proof

Management of Moderate-to-Severe Psoriasis in Patients with Cancer: Guidance from the International Psoriasis Council

Paolo Gisondi, MD, José-Manuel Carrascosa, MD, PhD, Seong Jin Jo, MD, PhD, Lluís Puig, MD, PhD, Caitriona Ryan, MD, Tiago Torres, MD, PhD, Peter van de Kerkhof, MD, PhD, Matthew D. Vesely, MD, PhD, Matías Maskin, MD

PII: S2950-1989(26)00093-0

DOI: https://doi.org/10.1016/j.jdrv.2026.08.004

Reference: JDRV 265

To appear in: *JAAD Reviews*

Received Date: 12 July 2026

Revised Date: 7 August 2026

Accepted Date: 7 August 2026

Please cite this article as: Gisondi P, Carrascosa JM, Jo SJ, Puig L, Ryan C, Torres T, van de Kerkhof P, Vesely MD, Maskin M, Management of Moderate-to-Severe Psoriasis in Patients with Cancer: Guidance from the International Psoriasis Council, *JAAD Reviews* (2026), doi: https://doi.org/10.1016/j.jdrv.2026.08.004.

Article Type: Opinion and commentary

Management of Moderate-to-Severe Psoriasis in Patients with Cancer: Guidance from the International Psoriasis Council

Paolo Gisondi, MD[1], José-Manuel Carrascosa, MD, PhD[2], Seong Jin Jo, MD, PhD[3], Lluís Puig, MD, PhD[4], Caitriona Ryan, MD[5], Tiago Torres, MD, PhD[6], Peter van de Kerkhof, MD, PhD[7], Matthew D. Vesely, MD, PhD[8], Matías Maskin, MD[9]

Authors affiliations:

[1]Department of Medicine Section of Dermatology and Venereology, University of Verona, Verona, Italy

[2]University Hospital Germans Trias i Pujol; Autonomous University of Barcelona, IGTP, Badalona, Spain

[3]Seoul National University College of Medicine, Seoul, Republic of Korea

[4]Hospital de la Santa Creu i Sant Pau, Autonomous University of Barcelona, Barcelona, Spain

[5]Charles Institute of Dermatology, University College Dublin, Ireland

[6]University of Porto, Porto, Portugal

[7]Radboud University Nijmegen Medical Centre, Nijmegen, Netherlands

[8]Department of Dermatology, Yale University, New Haven, Connecticut, United States

[9]CEMIC University, at Buenos Aires, Buenos Aires, Argentina

Corresponding author

Paolo Gisondi

Department of Medicine

Section of Dermatology and Venereology,

University of Verona,

Piazza A. Stefani 1

CAP 37126 Verona, Italy

Email: paolo.gisondi@univr.it

Funding sources: None

Conflicts of Interest

[1] Gisondi P has received honoraria as consultant and/or speaker for AbbVie, Almirall, Bristol-Myers Squibb, Eli Lilly, LEO Pharma, Janssen, Novartis, Pfizer, Takeda andUCB.

[2] JM Carrascosa has received consultancy/speaker's honoraria from and/or participated in clinical trials sponsored by Abbvie, Almirall, Amgen, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, , J&J Innovative Medicine, Novartis, Pfizer, Galderma, Sanofi, Leo-Pharma, Lilly, Novartis, Pfizer and UCB.

[3] SJ Jo has acted as advisor, speaker, or consultant for and/or received research grants from AbbVie, Boehringer Ingelheim, Bristol Myers Squibb, Celltrion Healthcare, Daewoong, Eli Lilly and Company, Green Cross Laboratories, Janssen, Kolon Pharma, LEO Pharma, Novartis, Pfizer, Sanofi, Takeda, UCB, and Yuhan.

[4] L. Puig has received consultancy/speaker's honoraria from and/or participated in clinical trials sponsored by Abbvie, Almirall, Amgen, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, Fresenius-Kabi, Horizon (DSMB), J&J Innovative Medicine, Leo-Pharma, Lilly, Novartis, Pfizer, Samsung-Bioepis, STADA, Sun-Pharma, Takeda, and UCB.

[5] C Ryan has served as a consultant, advisor or speaker for Abbvie, Allergan, Bristol Myers Squibb, UCB, FIDE, Janssen, Leo and Lilly.

[6] T. Torres has received consultancy and/or speaker's honoraria from and/or participated in clinical trials sponsored by AbbVie, Amgen, Almirall, Apogee Therapeutics, Arena Pharmaceuticals, Biocad, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, Celgene, Fresenius-Kabi, Johnson & Johnson Innovative Medicine, LEO Pharma, Eli Lilly, MSD, Mylan, Novartis, Oruka, Pfizer, Samsung-Bioepis, Sanofi-Genzyme, Sandoz, STADA, Takeda, and UCB.

[7] Peter van de Kerkhof received fees for consultancy services or lectureships from Almirall, Eli Lilly, Novartis, Janssen Pharmaceutical, Bristol-Myers Squibb, UCB, Boehringer Ingelheim, Celltrion and Sandoz.

[8] M. Vesely has received consulting fees from SunPharma and Priovant.

[9] Matias Maskin has received consultancy/speaker's honoraria from and/or participated in clinical trials sponsored by Abbvie, Amgen, Boehringer Ingelheim, Bristol Myers Squibb, MSD, Adium, L'Oreal, J&J Innovative Medicine, Lilly, Pfizer, Cantabria labs, Celldex, Takeda, and Sanofi.

Reprint requests: Peter CM van de Kerkhof

Manuscript word count: 499

References: 5

Tables: 1

Figures: 1

Keywords: Psoriasis, cancer, malignancy, neoplasm, biologics

Patient Consent: Not applicable

Statement on the use of Artificial Intelligence: Not used

The management of moderate-to-severe psoriasis in patients with cancer is challenging due to concerns that systemic treatments may adversely affect tumor behavior, increasing the risk of progression and/or recurrence. Evidence to guide decision-making remains limited, as these patients are excluded from clinical trials and available data are limited to observational studies.[1] Here, the International Psoriasis Council (IPC) provides guidance on treatment selection for psoriasis patients with cancer.

Therapeutic decisions are made collaboratively with the oncologist and are guided by the patient's overall clinical and oncologic status. Key considerations include the presence of treatment- or disease-related leukopenia or lymphopenia, the impact of systemic corticosteroids on immune function and psoriasis, and scenarios in which psoriasis either worsens or newly appears as an immune-related adverse event during oncologic immunotherapy.

The first decision for the dermatologist is whether and when to initiate systemic therapy for psoriasis in patients with current or prior malignancy. These criteria should be consistent with those established by IPC (**Table 1**).

There is no evidence that systemic therapies for moderate-to-severe psoriasis increase the risk of tumor progression or recurrence in patients with cancer, with the exception of cyclosporine, which is associated with increased risk of non-melanoma skin cancer (NMSC)[2]. However, it is reasonable to preferentially select therapies with lower immunosuppressive potential (**Figure 1**).

Phototherapy is a safe option, except for patients with melanoma and NMSC history. Acitretin, methotrexate, dimethyl-fumarate, and apremilast could be considered, although their efficacy and tolerability/safety profiles are less favorable than those of biologics.

Regarding biologics, IL-12/23, IL-17, and IL-23 inhibitors have not been associated with increased risk of malignancy.[3] Mouse models provide circumstantial evidence that inhibition of IL-17 and IL-23 may reduce tumor progression and that IL-12 contributes to tumor immune surveillance. A slight increase in the risk of lymphoma and NMSC is associated with TNF inhibitors, but this is possibly disease- and not drug-related.[3-4] Also, in randomized clinical trials, lymphoma and NMSC have been reported in patients treated with deucravacitinib (www.ema.europa.eu/en/documents/assessment-report/sotyktu-epar-public-assessment-

report_en.pdf). According to the summary of product characteristics, active malignancy is not a contraindication to any biologic; cautious use is advised with TNF and IL-12/IL-23 inhibitors.

In our opinion, IL-17 and IL-23 inhibitors (including the oral peptide icotrokinra) should be considered first-line, although recommendation for icotrokinra is based on its mechanism of action rather than on clinical evidence. With lower efficacy, acitretin, methotrexate, apremilast, and phototherapy may be considered, particularly if first-line treatments are unavailable. Ustekinumab and deucravacitinib may represent third-line options, owing to IL-12 inhibition and Type 1 interferon impairment and the still-limited long-term data for deucravacitinib. A slight increase of NMSC and lymphoma have been reported in patients treated with TNF inhibitors.[3,4] Cyclosporine should be avoided because of its broad immunosuppressive effects. In a recent IPC survey, apremilast, IL-17 inhibitors, and IL-23 inhibitors were the preferred therapies in patients with active malignancy.[5]

In conclusion, dermatologists, aiming to improve diminished quality of life related to skin disease, play a critical role in caring for cancer patients requiring systemic therapy for their skin disease.

References

1. Nast A, Smith C, Spuls PI, Avila Valle G, Bata-Csörgö Z, Boonen H, De Jong E, Garcia-Doval I, Gisondi P, Kaur-Knudsen D, Mahil S, Mälkönen T, Maul JT, Mburu S, Mrowietz U, Reich K, Remenyik E, Rønholt KM, Sator PG, Schmitt-Egenolf M, Sikora M, Strömer K, Sundnes O, Trigos D, Van Der Kraaij G, Yawalkar N, Dressler C. EuroGuiDerm Guideline on the systemic treatment of Psoriasis vulgaris - Part 2: specific clinical and comorbid situations. J Eur Acad Dermatol Venereol. 2021 Feb;35(2):281-317. doi: 10.1111/jdv.16926. PMID: 33547728.
2. Hojo M, Morimoto T, Maluccio M, Asano T, Morimoto K, Lagman M, Shimbo T, Suthanthiran M. Cyclosporine induces cancer progression by a cell-autonomous mechanism. Nature. 1999 Feb 11;397(6719):530-4. doi: 10.1038/17401. PMID: 10028970.
3. Jung JM, Kim YJ, Chang SE, Lee MW, Won CH, Lee WJ. Cancer risks in patients with psoriasis administered biologics therapy: a nationwide population-based study. J Cancer Res Clin Oncol. 2023 Dec;149(19):17093-17102. doi: 10.1007/s00432-023-05387-6. Epub 2023 Sep 27. PMID: 37755577; PMCID: PMC11796492.
4. van Lümig PP, Menting SP, van den Reek JM, Spuls PI, van Riel PL, van de Kerkhof PC, Fransen J, Kievit W, de Jong EM. An increased risk of non-melanoma skin cancer during TNF-inhibitor treatment in psoriasis patients compared to rheumatoid arthritis patients probably relates to disease-related factors. J Eur Acad Dermatol Venereol. 2015 Apr;29(4):752-60. doi: 10.1111/jdv.12675. Epub 2014 Sep 17. PMID: 25229823.
5. Bowe S, Murphy M, Bourke J, Ryan C. Prescribing practices among psoriasis experts for patients with concomitant malignancy: a survey of International Psoriasis Council members. Clin Exp Dermatol. 2025 Aug 22;50(9):1818-1826. doi: 10.1093/ced/llaf198. PMID: 40390599.

161 **Table 1.** Criteria for systemic psoriasis therapy in patients with cancer^

According to the International Psoriasis Council, patients that meet **one** or more of the following criteria are candidates for systemic therapy:	
1	Psoriasis lesions on 10% or more of body surface
2	Psoriasis lesions on high-impact sites (i.e., hands/feet, face, genitals, scalp)
3	Topical therapy failed to control symptoms: inability to achieve clear/nearly clear skin (BSA ≤1%, PGA 0 or 1) after two consecutive 4-week topical therapy courses, per guidelines. Strong consideration should be given when a patient self-reports moderate or severe psoriasis, despite a provider's mild assessment, and experiences significant physical, psychological, or social impact.

162 ^https://psoriasiscouncil.org/ipc-resources/disease-severity

163

Legend to figure 1

Therapeutic options in patients with psoriasis and active and/or history of cancer according to IPC guidance (https://psoriasiscouncil.org/therapeutic-options-for-cancer/). A green box indicates a first-line option; a yellow box indicates a second-line option; an orange box indicates a third-line option; a red box indicates a contraindication.

Therapeutic options in patients with psoriasis and cancer	IPC guidance	Preferred line of therapy
Acitretin		2nd
Cyclosporine		
Dimethyl fumarate		2nd
Methotrexate		2nd
TNF- inhibitors		3rd
IL-17 inhibitors		1st
IL-12/IL-23p40		3rd
IL-23p19 inhibitors		1st
Apremilast		2nd
Deucravaticinib		3rd
Phototherapy		2nd