

responsible for the analytic or statistical methodology employed, or the conclusions drawn from these data by the investigator. The NCDB is a joint project of the Commission on Cancer of the American College of Surgeons and the American Cancer Society.

Key words: dermatofibrosarcoma protuberans; Mohs micrographic surgery; NCDB; overall survival; positive margin; sex disparities.

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Conflicts of interest

None disclosed.

REFERENCES

1. Saiag P, Lebbe C, Brochez L, et al. Diagnosis and treatment of dermatofibrosarcoma protuberans. European interdisciplinary guideline - update 2024. *Eur J Cancer*. 2025;218:115265. <https://doi.org/10.1016/j.ejca.2025.115265>
2. Bordeaux J, Blitzblau R, Aasi SZ, et al. Dermatofibrosarcoma protuberans, version 1.2025, NCCN clinical practice guidelines in oncology. *J Natl Compr Canc Netw*. 2025;23(1):e250001. <https://doi.org/10.6004/jnccn.2025.0001>
3. Huis In 't Veld EA, van Coevorden F, Grünhagen DJ, et al. Outcome after surgical treatment of dermatofibrosarcoma protuberans: is clinical follow-up always indicated? *Cancer*. 2019;125(5):735-741. <https://doi.org/10.1002/cncr.31924>
4. Martin ECS, Vyas KS, Batbold S, Erwin PJ, Brewer JD. Dermatofibrosarcoma protuberans recurrence after wide local excision versus mohs micrographic surgery: a systematic review and meta-analysis. *Dermatol Surg*. 2022;48(5):479-485. <https://doi.org/10.1097/DSS.0000000000003411>
5. Lowe GC, Onajin O, Baum CL, et al. A comparison of mohs micrographic surgery and wide local excision for treatment of dermatofibrosarcoma protuberans with long-term follow-up: the Mayo Clinic experience. *Dermatol Surg*. 2017;43(1):98-106. <https://doi.org/10.1097/DSS.0000000000000910>

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Maintenance of response with icotrokinra, a targeted oral peptide, for the treatment of moderate-to-severe plaque psoriasis: Randomized treatment withdrawal in adults from the phase 3, ICONIC-LEAD study



Psoriasis is driven by proinflammatory cytokines including interleukin (IL)-23.¹ Icotrokinra, the targeted oral peptide that precisely blocks the IL-23

receptor and inhibits IL-23 pathway signaling,² is approved to treat moderate-to-severe plaque psoriasis in adults and pediatric patients (≥ 12 years, ≥ 40 kg).³ Icotrokinra demonstrated significant skin clearance through Week (W)16 in the phase 3 ICONIC-LEAD study of adults and adolescents with moderate-to-severe plaque psoriasis.⁴ The effect of icotrokinra on maintenance of clinical response was assessed among adults who entered randomized-withdrawal (W24-52). A companion report describes findings among ICONIC-LEAD adolescents through W52 of continuous icotrokinra.⁵

Adults ($N = 341$) who achieved Psoriasis Area and Severity Index (PASI) 75 or Investigator's Global Assessment (IGA) 0/1 response at W24 (icotrokinra responders) were rerandomized 1:1 to icotrokinra ($n = 169$) or withdrawal ($n = 172$) with retreatment upon losing $\geq 50\%$ of W24 PASI improvement (see Supplementary Methods, available via Mendeley at <https://data.mendeley.com/datasets/pb5r92n3yk/1>).

From W24-52, 162 (96%) and 161 (94%) participants rerandomized to continued icotrokinra and withdrawal, respectively, completed assigned treatment (Supplementary Fig 1, available via Mendeley at <https://data.mendeley.com/datasets/pb5r92n3yk/1>). Baseline characteristics of W24 icotrokinra responders were balanced across treatment groups, consistent with the overall ICONIC-LEAD population (Supplementary Table I, available via Mendeley at <https://data.mendeley.com/datasets/pb5r92n3yk/1>).

W24 icotrokinra responders continuing icotrokinra demonstrated superior maintenance of PASI response from W24 to 52 versus withdrawal (PASI 75 and PASI 90: 89% of 161 and 84% of 128 versus 30% of 166 and 21% of 129; multiplicity-adjusted $P < .001$), with median time-to-loss-of-response not reached with continued icotrokinra versus 16.9W (PASI 75; Supplementary Fig 2, available via Mendeley at <https://data.mendeley.com/datasets/pb5r92n3yk/1>) and 10.1W (PASI 90; Fig 1) following withdrawal (multiplicity-adjusted $P < .001$). Maintenance of IGA 0/1 response was consistent with PASI 90 findings (Fig 1). Achievement of clear skin (PASI 100 and IGA 0) at W24 was also maintained at high rates at W52 with continued icotrokinra (74% of 73 and 70% of 84) versus withdrawal (10% of 82 and 11% of 93, both nominal $P < .001$). Median time-to-loss of $\geq 50\%$ of W24 PASI improvement was 25.7W following withdrawal.

Of the 51 adults who were nonresponders at W24, 51% and 31% achieved PASI 75 and IGA 0/1 response rates, respectively at W52 with continued icotrokinra (Supplementary Fig 3, available via Mendeley at <https://data.mendeley.com/datasets/pb5r92n3yk/1>). Among participants with W16 placebo-to-icotrokinra transition, skin responses were

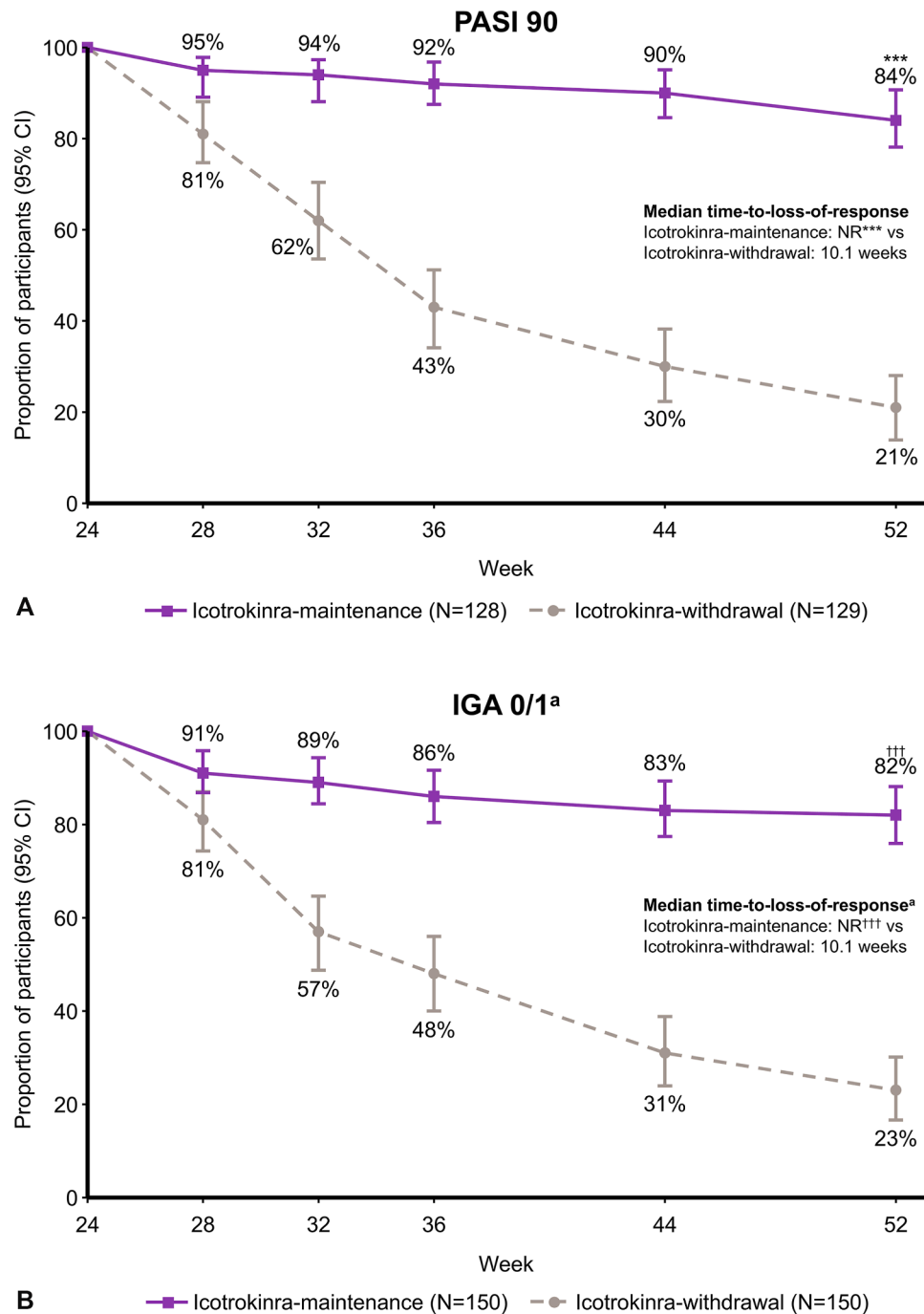


Fig 1. Proportions of participants maintaining PASI 90 (**A**) and IGA 0/1^a (**B**) responses through W52 among adult W24 PASI 90 and IGA 0/1^a icotrokinra responders, respectively, rerandomized to continue icotrokinra (maintenance) or to receive placebo (withdrawal) at W24 and the median time-to-loss of these responses. Participants who discontinued study treatment due to lack of efficacy, an adverse event of worsening psoriasis or who initiated a prohibited medication that could impact psoriasis, or those with loss of $\geq 50\%$ of W24 PASI improvement for withdrawal group, were considered as nonresponders after the event. Observed data were used for participants who discontinued study treatment for other reasons. After accounting for these events, participants with missing data were considered nonresponders for binary endpoints and not imputed for time-to-event endpoints. ^aDefined as IGA 0/1 and ≥ 2 grade reduction from baseline. ***Multiplicity-adjusted $P < .001$ versus placebo. †††Nominal $P < .001$ versus placebo. *CI*, Confidence interval; *IGA*, Investigator's Global Assessment; *NR*, not reached; *PASI*, Psoriasis Area and Severity Index; *W*, week.

comparable to those in icotrokinra-randomized participants as early as W12 following icotrokinra initiation and were consistent through W52 (Supplementary Fig 4, available via Mendeley at <https://data.mendeley.com/datasets/pb5r92n3yk/1>).

Icotrokinra safety through W52 in the overall ICONIC-LEAD population was consistent with that through the placebo-controlled period,⁴ with no increase in exposure-adjusted rates of adverse events (AEs) or serious AEs with continued icotrokinra, or following W16 placebo-to-icotrokinra transition (Supplementary Table II, available via Mendeley at <https://data.mendeley.com/datasets/pb5r92n3yk/1>). No new malignancy and no tuberculosis cases were reported through W52 of icotrokinra. During the randomized-withdrawal and retreatment period, rates of AEs and serious AEs were similar across rerandomized groups (Supplementary Table III, available via Mendeley at <https://data.mendeley.com/datasets/pb5r92n3yk/1>).

Continuous icotrokinra demonstrated superior maintenance of skin responses versus placebo through W52 in adults with moderate-to-severe plaque psoriasis, indicating that once-daily icotrokinra can achieve and maintain skin clearance with a favorable safety profile. Participants withdrawing from icotrokinra had a median time-to-loss of $\geq 50\%$ of W24 PASI improvement of >6 months, suggesting durable IL-23 pathway modulation with once-daily oral icotrokinra.

Declaration of generative AI and AI-assisted technologies in the writing process

Not applicable.

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Key words: adults; ICONIC-LEAD; icotrokinra; oral peptide; psoriasis; responder; retreatment; withdrawal.

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Conflicts of interest

Soung, Cui, Bissonnette, Lebwohl, González-Cantero, Pinter, Rich, Prajapati, Miller-Kassamali, Cafone, Jiang, Li, Yang, and Pink disclosed the following conflicts of interest: Soung is a speaker, consultant, advisory board member, and/or investigator for AbbVie, Amgen, Arcutis, Aslan, Bristol Myers Squibb, Coval Biopharma, Dermavant, Eli Lilly, Johnson & Johnson, KoBio Labs, National Psoriasis Foundation, Novartis, Ortho Dermatologic, Oruka, Pfizer, Regeneron/Sanofi, and UCB. Cui declared no conflicts of interest. Bissonnette is an advisory board member, consultant, speaker, and/or investigator for, and has received honoraria and/or grants from, AbbVie, Alumis, Amgen, AnaptysBio, Arcutis, Bristol Myers Squibb/Celgene, Dermavant, Eli Lilly, Johnson & Johnson, LEO Pharma, Nimbus, Takeda, UCB, VentyxBio, Vyne, Xencor, Zai Lab, and Zurabio; he is also an employee and shareholder of Innovaderm Research. Lebwohl is an employee of Mount Sinai; has received research funding from AbbVie, Arcutis, Avotres Therapeutics, Boehringer Ingelheim, Bristol Myers Squibb, Cara Therapeutics, Clexio, Dermavant Sciences, Eli Lilly, Incyte, Inozyme, Johnson & Johnson, Oruka, Pfizer, Sanofi-Regeneron, and UCB; and serves as a consultant for AbbVie, Added Health, Aikium, Almirall, AltruBio Inc, Alumis, Amgen, Apogee, Arcutis Inc, AstraZeneca, Atomwise, Avotres Therapeutics, Boehringer Ingelheim, Bristol Myers Squibb, Castle Biosciences, Celltrion, CorEvitas, Dermavant Sciences, Dermsquared, Edesa Biotech, Eli Lilly, Evommune, Inc, Facilitation of International Dermatology Education, Forte Biosciences, Galderma, Genentech, Johnson & Johnson, Incyte, LEO Pharma, Mayne Pharmaceuticals, Meiji Seika Pharma, Mindera, Mirium Pharmaceuticals, Moonlake, Oruka, Pfizer, Sanofi-Regeneron, Revolo, Seanergy, Strata, Sun Pharma, Takeda, Trevi, and Verrica. González-Cantero serves as a consultant for, and has received grants and/or other payments from, AbbVie, Almirall, Amgen, Apogee, Bristol Myers Squibb, Boehringer Ingelheim, Celgene, Cerave, Innovaderm, Johnson & Johnson, LEO Pharma, Eli Lilly, L'Oréal, Novartis, and Organon. Pinter has served as an advisor and/or received speaker's honoraria and/or grants and/or participated in clinical trials for AbbVie, Almirall Hermal, Amgen, Biogen Idec, BioNTech, Boehringer Ingelheim, Celgene, Celltrion, Eli Lilly, Galderma, GSK, Hexal, Johnson & Johnson, Klinge Pharma, LEO Pharma, MC2, Medac, Merck Serono, Mitsubishi, MSD, Novartis, Pascoe, Pfizer, Regeneron, Roche, Sandoz Biopharmaceuticals, Sanofi Genzyme, Schering-Plough, Tigercat Pharma, UCB, and Zuellig Pharma. Rich is a principal investigator for AbbVie, Acelyrin, Alfasigma, Allakos, Amgen, Arcutis, Aslan, Atacama, Brickell, Bristol Myers Squibb, Dermibiont, Dermavant, Dong-A, Eli Lilly, Galderma, Hallux, Incyte, Johnson & Johnson, LEO Pharma, Moberg, Ortho, Pfizer, Sun, Technoderma, and UCB; serves on advisory boards for Cara, Ortho Dermatologics, Bristol Myers Squibb, and La Roche-Posay; and acts as a consultant for Bristol Myers Squibb and Hexima. Prajapati is an advisor, consultant, and/or speaker for AbbVie, Actelion, Amgen, Apogee Therapeutics, Aralez, Arcutis, Aspen, Bausch Health,

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REFERENCES

1. Menter A, Krueger GG, Paek SY, et al. Interleukin-17 and interleukin-23: a narrative review of mechanisms of action in psoriasis and associated comorbidities. *Dermatol Ther (Heidelb)*. 2021;11:385-400.
2. Fourie AM, Cheng X, Chang L, et al. JNJ-77242113, a highly potent, selective peptide targeting the IL-23 receptor, provides robust IL-23 pathway inhibition upon oral dosing in rats and humans. *Sci Rep*. 2024;14:17515.
3. Janssen Biotech, Inc. ICOTYDE (icotrokinra) [package insert]. Johnson & Johnson website, 2026. Accessed March 30, 2026. <https://www.jnjlabels.com/package-insert/product-monograph/prescribing-information/ICOTYDE-pi.pdf>
4. Bissonnette R, Soung J, Hebert AA, et al. Oral icotrokinra for plaque psoriasis in adults and adolescents. *N Engl J Med*. 2025; 393:1784-1795.
5. Soung J, Cui Y, Bissonnette R, et al. Durability of Clinical Response and Patient-Reported Outcomes with the Targeted Oral Peptide Icotrokinra in Adolescents with Moderate-to-Severe Plaque Psoriasis: One-Year Results from the ICONIC-LEAD Study. Brief report submitted. 2026. <https://doi.org/10.1016/j.jaad.2026.05.035>

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Staging imaging reveals clinically significant comorbidities in primary cutaneous marginal zone lymphoma: A retrospective study



Primary cutaneous marginal zone lymphoma (PCMZL) is a rare, low-grade B-cell lymphoma. In 2022, reclassification by the International Consensus