

Guselkumab Demonstrates Superior Effectiveness Compared With Secukinumab in Overweight/Obese Psoriasis Patients: Results Through 84 Weeks From the Non-Interventional German G-REAL Study

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Background

- Psoriasis (Pso)** is a chronic, immune-mediated inflammatory disease characterized by erythematous, scaly plaques, driven by dysregulation of the interleukin (IL)-23/IL-17 axis¹
- Overweight and obesity are common among patients with Pso²
- Guselkumab (GUS)**
- A fully human, dual-acting monoclonal antibody that selectively inhibits the IL-23 p19 subunit and binds to CD64 on IL-23-producing inflammatory monocytes³
 - Previously showed superior efficacy over secukinumab (SEC), an IL-17A inhibitor, in patients with moderate-to-severe Pso in the Phase 3 randomized comparator-controlled ECLIPSE trial⁴
 - Demonstrated high effectiveness in achieving skin and health-related quality of life (HRQoL) outcomes irrespective of body mass index (BMI) subgroups^{5,6}
- G-REAL** is a prospective, multicenter, non-interventional study evaluating the long-term effectiveness and HRQoL outcomes of GUS and SEC in patients with moderate-to-severe Pso across different treatment lines in routine clinical practice in Germany
- Previous analyses demonstrated superior effectiveness of GUS vs SEC in the total G-REAL population⁷

Objective

Evaluate skin response, HRQoL outcomes and pain through Week (W) 84 with GUS and SEC across treatment lines in overweight/obese G-REAL patients

Methods G-REAL Study

- Adult patients with moderate-to-severe plaque Pso and baseline PASI >5
- Patients were treated with GUS or SEC according to label and per routine care
 - Shortly after study start, the SEC label was updated to allow higher maintenance dosing in patients weighing ≥90 kg
- Data were collected at W0, W4, W12, W20, W28, W52, and W84

Current Analysis

- A total of 669 patients were enrolled; 501 (75%) were overweight/obese (BMI≥25 kg/m²) and had analyzable data at baseline, with at least ≥1 post-baseline visit (GUS: 378; SEC: 123)
 - Overweight/obese patients were stratified by biologic treatment history:
 - Bionai ve (GUS: 183; SEC: 71)
 - ≥1 prior biologic (GUS: 195; SEC: 52)

Outcome Measures

- Response rates were reported through W84:
 - Treatment targets based on the German S3 guideline⁸
 - PASI <2
 - DLQI 0/1 (indicating no effect of skin disease on patient's HRQoL)
 - Combined achievement of PASI <2 and DLQI 0/1
 - PSSD Pain score=0 (complete pain relief)^{9,a}

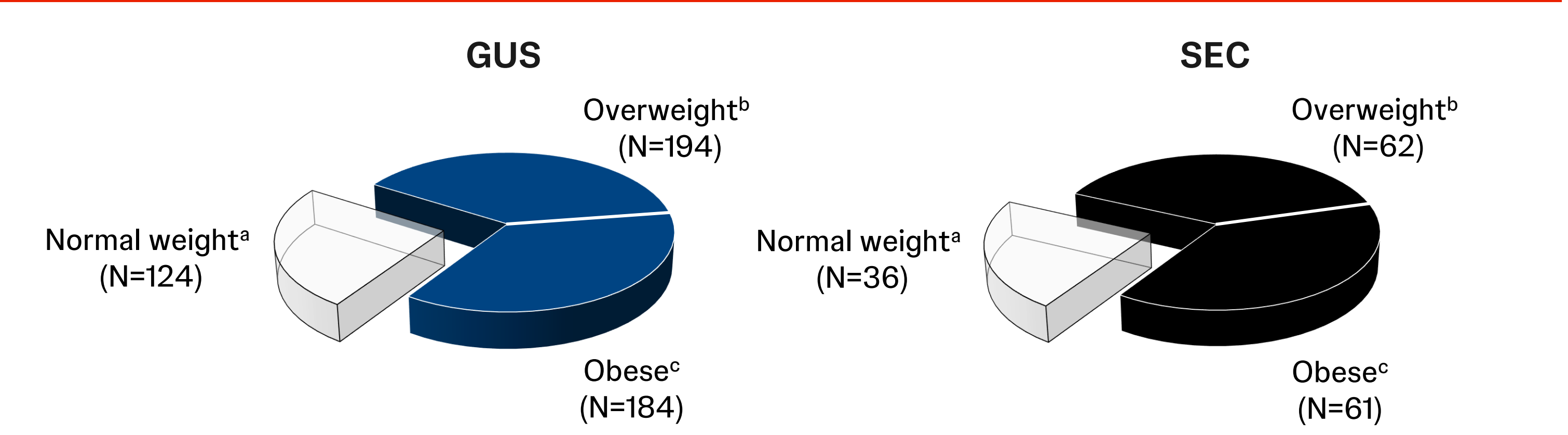
Statistical Analysis

- Data were analyzed using nonresponder imputation after applying treatment failure rules^b
- Nominal p-values are reported

^aIn the current analysis, only patients having considerable pain at baseline (PSSD pain ≥2) were included. ^bPatients were considered treatment failures when (1) GUS or SEC was discontinued due to lack of effectiveness, loss of effectiveness, or an AE of psoriasis worsening, or (2) a new therapy other than the therapy at baseline was started. DLQI= Dermatology Life Quality Index; PASI=Psoriasis Area and Severity Index; PSSD=Psoriasis Symptoms and Signs Diary.

Results

Of the full G-REAL study population (N=669), 501 (75%) participants with BMI≥25kg/m² (overweight/obese) were included in this analysis



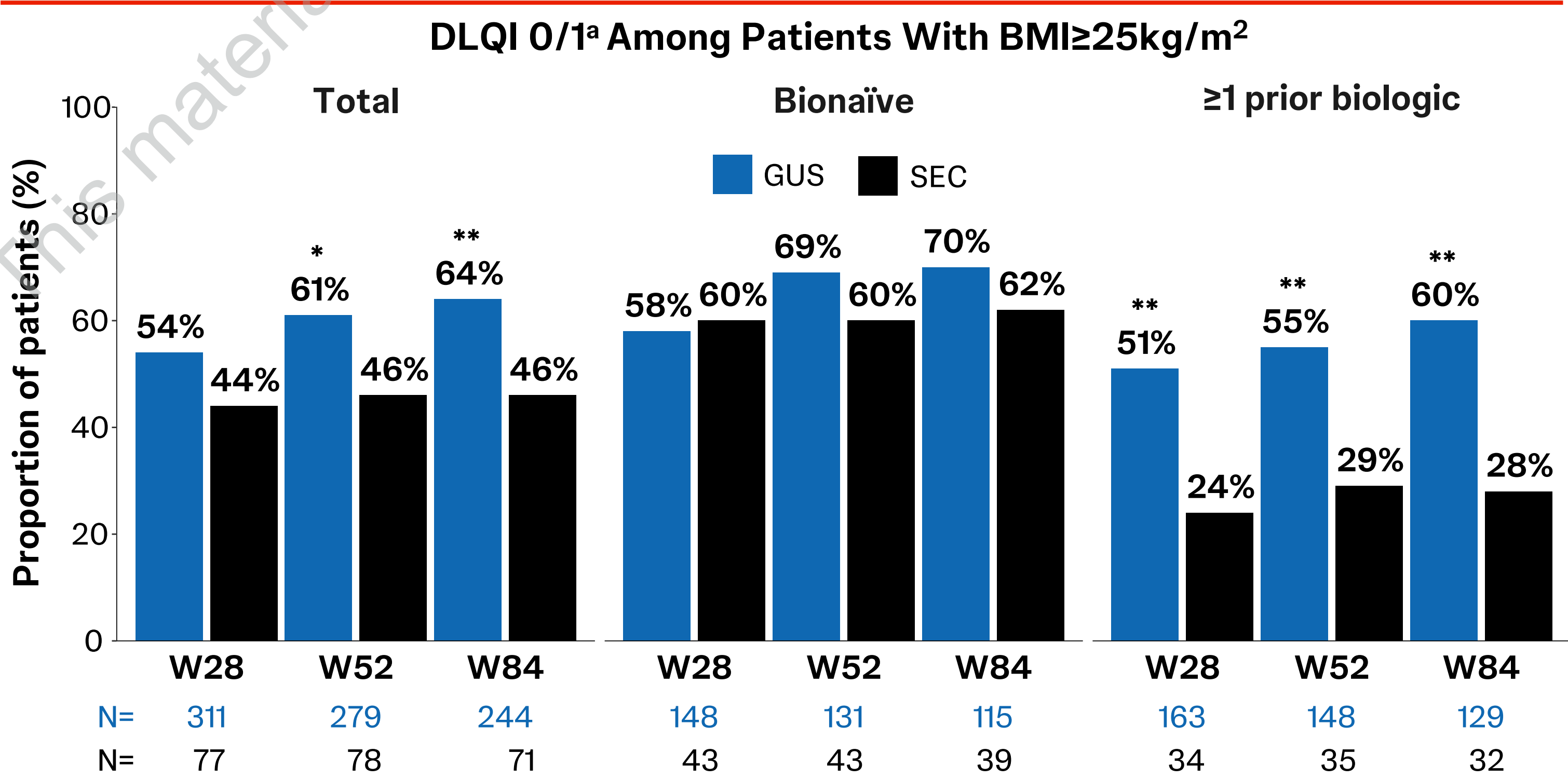
^aPatients with BMI<25kg/m² were not included in the present analysis. ^bDefined as BMI≥25kg/m² and ≤30kg/m². ^cDefined as BMI>30kg/m².

Baseline characteristics were generally comparable across GUS and SEC treatment lines in overweight/obese patients (BMI≥25kg/m²)

Baseline characteristics of G-REAL patients with BMI≥25 kg/m ²	GUS total (N=378)	GUS bionai�ve (N=183)	GUS ≥1 prior biologic (N=195)	SEC total (N=123)	SEC bionai�ve (N=71)	SEC ≥1 prior biologic (N=52)
Demographics						
Mean age, years	48.6 (13.1)	47.9 (13.1)	49.3 (13.2)	49.2 (12.4)	49.5 (13.1)	48.8 (11.4)
Male, n (%)	65%	70%	60%	63%	65%	60%
Mean BMI, kg/m ²	31.4 (5.6)	31.4 (5.7)	31.3 (5.5)	31.5 (5.5)	31.0 (4.8)	32.3 (6.3)
Disease Characteristics						
Mean Pso duration, years	16.9 (12.9)	14.1 (13.2)	19.5 (12.1)	15.6 (14.9)	14.4 (15.9)	17.4 (13.3)
Mean DLQI (0-30)	14.1 (7.4)	14.2 (7.0)	13.9 (7.8)	14.1 (7.9)	14.0 (7.8)	14.4 (8.0)
Mean PASI (0-72)	15.5 (8.8)	17.6 (9.3)	13.4 (7.7)	14.6 (7.6)	15.0 (8.0)	14.1 (7.1)
Concomitant Diseases ^a , n (%)						
Hypertension	34%	32%	35%	30%	30%	31%
PsA	26%	18%	34%	33%	25%	42%
Hyperlipidaemia	12%	12%	12%	13%	16%	10%
Diabetes	10%	10%	10%	14%	17%	10%
Depression	6%	4%	7%	11%	11%	10%

^aThe 5 most frequent concomitant diseases are shown. PsA=psoriatic arthritis, SD=standard deviation.

GUS demonstrated higher DLQI 0/1^a rates vs SEC from W28 to W84 in the total and ≥1 prior biologic overweight/obese patients (BMI≥25kg/m²)



Nominal *p<0.05, **p<0.01 GUS versus respective SEC group. ^aIndicating no effect of skin disease on patient's HRQoL.



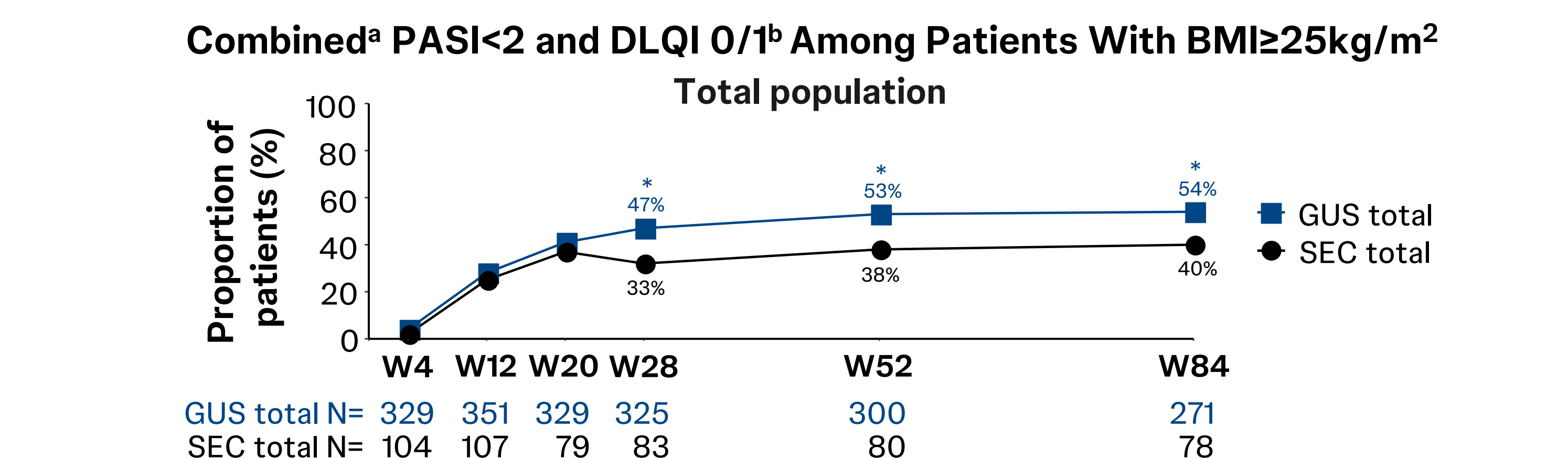
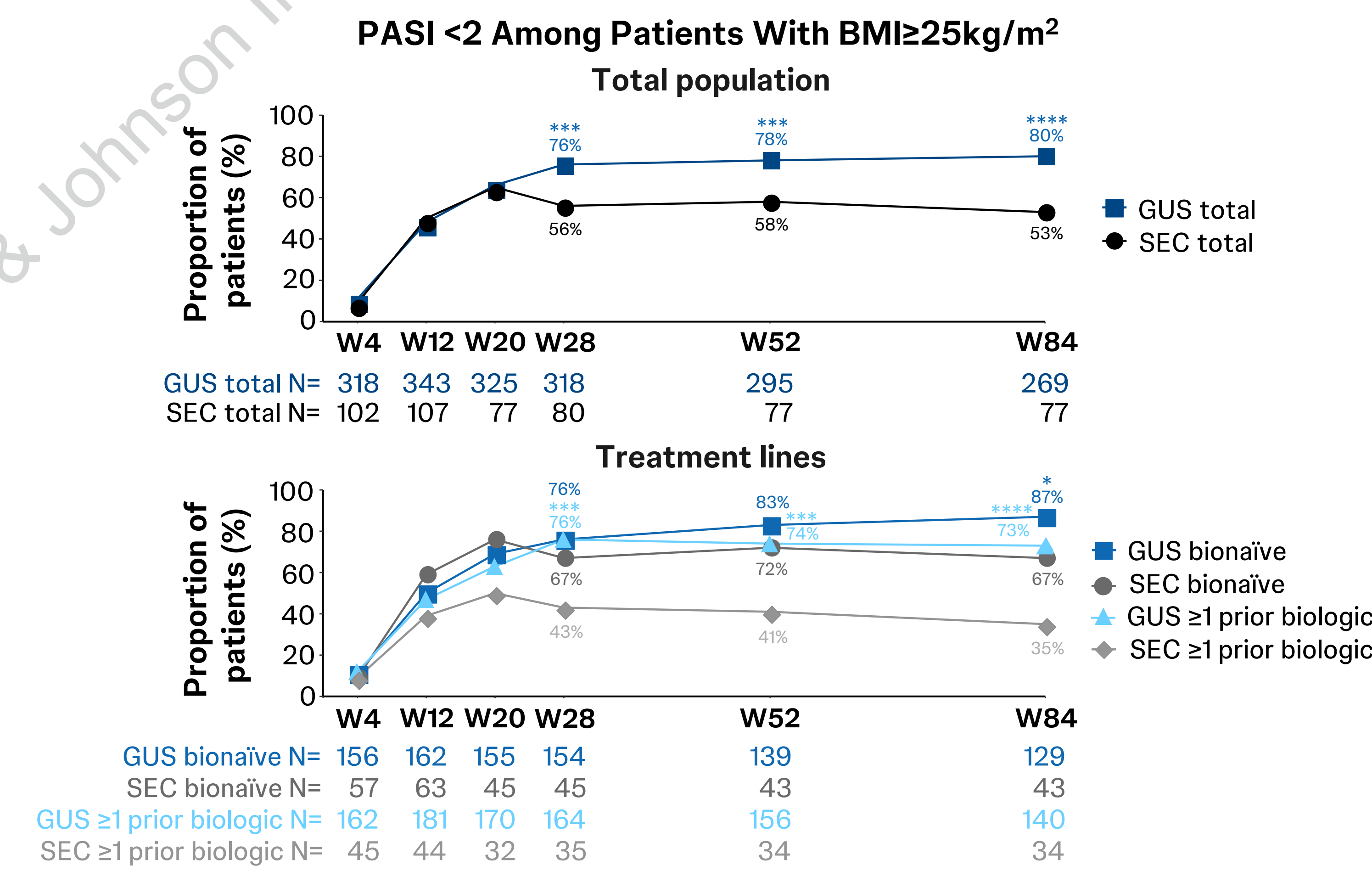
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Key Takeaways

- Among overweight/obese (BMI≥25kg/m²) patients with moderate-to-severe Pso in the G-REAL study
 - GUS-treated patients achieved higher PASI <2 (German S3 guidelines⁸) response rates vs SEC from W28 to W84
 - GUS-treated patients reported higher rates of DLQI 0/1 (no impact on HRQoL) and more weeks of complete pain relief vs SEC through W84
 - Higher rates of combined German S3 guideline⁸ treatment targets (PASI <2 and DLQI 0/1) were achieved with GUS vs SEC from W28 to W84
 - Results are consistent with those observed among the full G-REAL population
- GUS demonstrated robust, durable, and superior real-world effectiveness vs SEC in overweight/obese patients with Pso

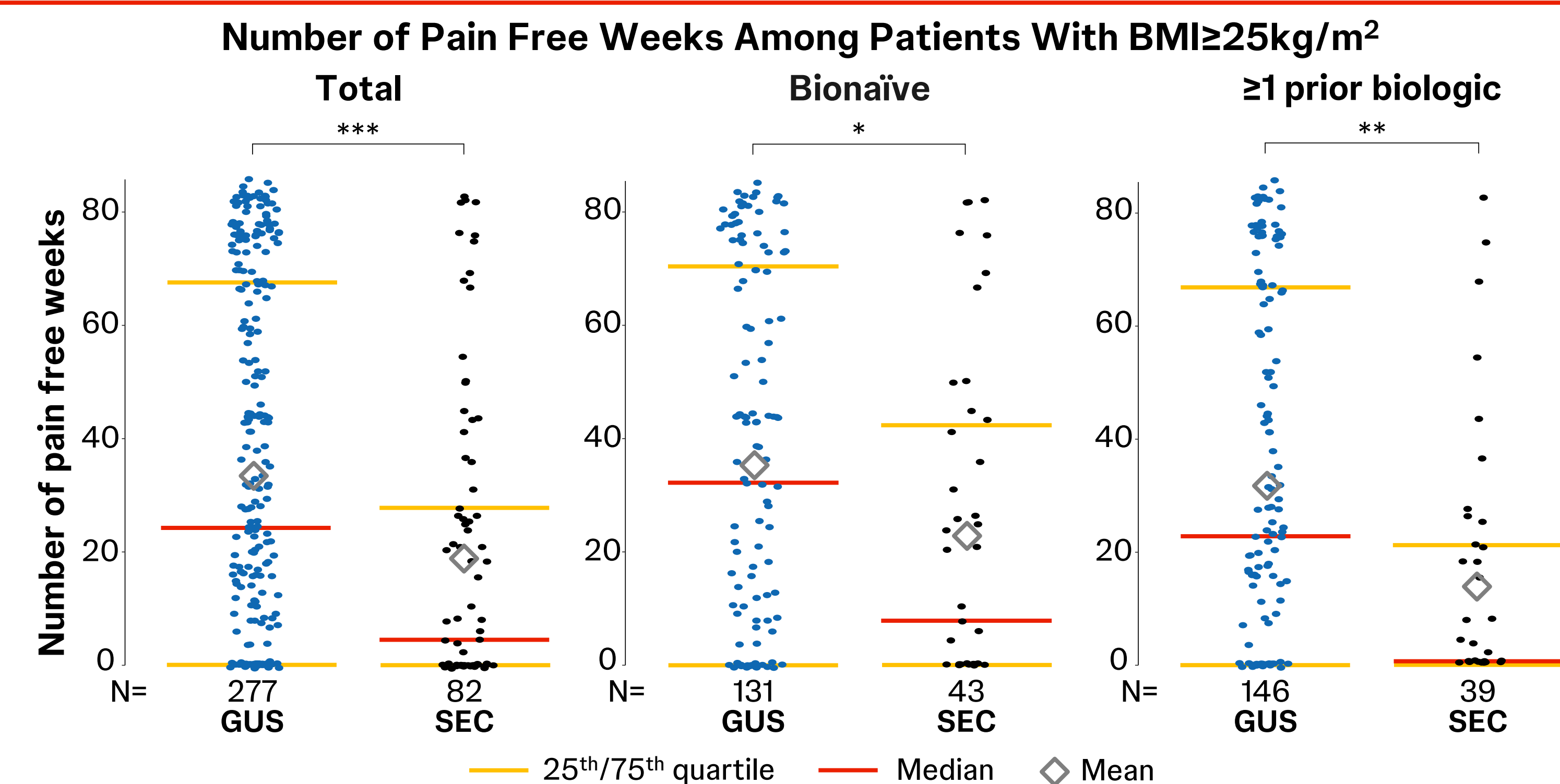
GUS demonstrated higher PASI <2 response rates vs SEC through W84 across all treatment lines in overweight/obese patients (BMI≥25kg/m²)

- PASI <2 response rates were significantly higher with GUS vs SEC at W28, W52 and W84 in the total and ≥1 prior biologic populations
- At W84, all GUS treatment lines showed significantly higher PASI <2 response rates vs SEC
- Combined response rates were higher with GUS vs SEC through W84 in the total population



Nominal *p<0.05, ***p<0.001, ****p<0.0001 GUS versus respective SEC group. ^aCombined criteria represents meeting both S3 German guideline criteria. ^bIndicating no effect of skin disease on patient's HRQoL.

In patients (BMI≥25kg/m²) with considerable baseline pain^a, GUS treatment resulted in significantly more weeks with complete pain relief (PSSD pain score=0) vs SEC



Nominal, *p<0.05, **p<0.01 ***p<0.001 GUS versus respective SEC group. ^aPSSD pain≥2.

PRESENTED AT: European Academy of Dermatology and Venerology (EADV), September 30 – October 3, 2026, 2026; Vienna, Austria. REFERENCES: 1. Menter A. *Dermatol Ther (Heidelb)*. 2021;11:385-400. 2. Takeshita J. *J Am Acad Dermatol*. 2017;76:393-403. 3. Sachen K. *Front Immunol*. 2025;15:32852. 4. Reich K. *Lancet*. 2019;394:831-839. 5. Gerdas S. Guselkumab improves psoriatic skin and HRQoL outcomes across BMI subgroups, including patients with involvement of hard-to-treat areas: results from the real-world PERSIST study. Abstract (5179) presented at AAD2024. 6. Gerdas S. Guselkumab improves psoriatic skin, quality of life, sexual health, and perceived stigmatization across BMI subgroups: results from the real-world G-EPOSS study. Abstract (3798) presented at EADV 2024. 7. von Kiedrowski R. Guselkumab shows better long-term effectiveness and drug survival compared to secukinumab through 84 weeks in patients with moderate-to-severe plaque psoriasis - Results from the German non-interventional G-REAL study. Abstract (72716) presented at AAD2026. 8. Nast A. 2025. https://register.aawm.org/assets/guidelines/DIG-001e_S3_Therapie-Psoriasis-vulgaris_2025-08.pdf. 9. Feldmann SR. *J Dermatol Dermatol Surg*. 2016;20:19-26. Acknowledgements: Medical writing support was provided by J&S Medical Research, Inc. under the direction of the authors in accordance with Good Publication Practice guidelines *Ann Intern Med*. 2022;175:1258-1304. This presentation was sponsored by Johnson & Johnson. Disclosures: RWK: With his service company CMS GmbH, Dr. von Kiedrowski provides consulting services, registry research, activities as an investigator in interventional and non-interventional studies, other services and scientific lectures: AbbVie, ALK Scherax, Almirall Hermal, Amgen, Biogen, Bristol Myers Squibb, Boehringer Ingelheim, Celgene, Celtrion HC, Eli Lilly, Fresenius Kabi, Galderma, Heine Opto-Technik, Hexal, Johnson & Johnson, LEO Pharma, Medac, Menlo, Moonlake, MSD, NIA Health, Novartis, Pfizer, Regeneron, Sanofi, Stiefel GSK, and UCB. DGK: Advisor and/or received speakers' honoraria and/or participated in clinical trials: AbbVie, Almirall Hermal, Galderma, Janssen-Cilag, LEO Pharma, Novartis, and Merz. AW: Speaker, advisor and researcher for AbbVie, Almirall Hermal, Galderma, Janssen-Cilag, LEO Pharma, Novartis, Pfizer, Sanofi, and UCB. RO: Almirall Hermal, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, LEO Pharma, Medac, Menlo, Moonlake, MSD, NIA Health, Novartis, Pfizer, Regeneron, Sanofi, Stiefel GSK, and UCB. DGK: Consultant, registry research, principal investigator interventional and non-interventional studies, and other services for AbbVie, Almirall Hermal, Amgen, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, LEO Pharma, Medac, Menlo, Moonlake, MSD, NIA Health, Novartis, Pfizer, Regeneron, Sanofi, Stiefel GSK, and UCB. FT: Owns Taut Science and Service GmbH, a consultancy specializing in clinical development and medical affairs, and is receiving consultancy fees from Johnson & Johnson. SJ, JB, NS: Employees of Johnson & Johnson; may own stock/stock options in Johnson & Johnson. MH: Advisory board member, consultant, speaker and/or investigator and/or honoraria and/or grants: AbbVie, Almirall, Biofrontera, Bristol Myers Squibb, Dermapharm, Dermasense, Eli Lilly, Forward, Galderma, Incyte, Johnson & Johnson, Kiniksa, LEO Pharma, L'Or al, MSD, Nektar Therapeutics, Novartis, Pfizer, PierreFabre, Sanofi, Schering-Plough, Smerud Medical Research, Stallergenes Greer, Viartis, and UCB.