Journal of Inflammation Research

Dovepress
Taylor & Francis Group

Open Access Full Text Article

REVIEW

Inflammatory Skin Disease in Latin America: Treatment Challenges and Opportunities

Luis Daniel Mazzuoccolo[1,]*, Maria Valeria Angles[1], Maria Eugenia Cappetta[1], Enrique R Soriano[2,]*

[1]Department of Dermatology, Hospital Italiano de Buenos Aires, University Hospital Italiano de Buenos Aires, Buenos Aires, Argentina; [2]Rheumatology Section, Internal Medicine Service, Hospital Italiano de Buenos Aires, University Hospital Italiano de Buenos Aires, Buenos Aires, Argentina

*These authors contributed equally to this work

Correspondence: Enrique R Soriano, Hospital Italiano de Buenos Aires, Peron 4190 (1181), Buenos Aires, Argentina, Tel +54-11-61186468, Email enrique.soriano@hospitalitaliano.org.ar

---

Purpose: Inflammatory skin diseases, including psoriasis (PsO), atopic dermatitis (AD), hidradenitis suppurativa (HS), and alopecia areata (AA), are chronic immune-mediated disorders that substantially impair the quality of life and impose a growing socioeconomic burden. In Latin America (LA), these conditions unfold in the context of structural inequality, fragmented health systems, and limited epidemiological data. Our objective was to review the epidemiology, awareness, and treatment landscape of PsO, AD, HS, and AA in Latin America, highlighting regional guidelines, real-world studies, and unmet needs.

Methods: A narrative review was performed by integrating data from peer-reviewed publications, national and regional guidelines, registry analyses, and real-world studies published until 2025.

Results: The prevalence of PsO in LA ranges from 0.5% to 2%, AD affects 2–3% of adults, HS prevalence is estimated at 0.3–0.5%, and AA lifetime risk approximates 1–2%. Across conditions, awareness among patients and non-specialists remains low, contributing to delayed diagnosis and undertreatment. National guidelines, recently updated in Argentina, Brazil, Colombia, and Mexico, broadly align with international standards, adapting recommendations to local resource and reimbursement constraints. Biologic and targeted therapies have transformed disease management; however, access remains inequitable, limited by high costs, fragmented insurance systems, and slow regulatory approval processes. Emerging real-world evidence from registries such as MEASURE-AD, RENAAC (AA), and national HS cohorts confirms therapeutic benefit but highlights persistent disparities and data gaps.

Conclusion: Despite major advances in therapeutic innovation, LA faces continuing inequities in access and outcomes for inflammatory skin diseases. Coordinated regional registries, harmonized clinical guidelines, and policy reforms to accelerate drug approval and reimbursement are essential to achieve equitable dermatologic care.

Plain Language Summary:

Why we did this work?

Many people in Latin America live with long-lasting skin conditions such as psoriasis, eczema (atopic dermatitis), hidradenitis suppurativa, and alopecia areata (patchy hair loss). These conditions can affect comfort, confidence, work, and relationships. New medicines can help, but access is uneven. We wrote this review to explain what is known about these conditions in Latin America and to show where care can improve.

What we did and found?

We read studies, national clinical guidelines, and real-world reports from across the region. We looked at how common these conditions are, how they are recognized, and how they are treated.

- Awareness is low among the public and among some non-specialist clinicians. This leads to late diagnosis, especially for hidradenitis suppurativa.
- Countries have created clinical guidelines that broadly match international standards. These guidelines support step-by-step care, from creams and light therapy to tablets and new targeted medicines.
- Access to advanced treatments is still limited. Long approval timelines, costs, and gaps between public and private care delay treatment for many people.
- Real-world studies from Latin America show that targeted medicines can improve symptoms and quality of life when people can get them.

Received: 22 October 2025
Accepted: 16 December 2025
Published: 22 December 2025

What this means?

People in Latin America deserve timely, effective skin care no matter where they live or how much they earn. Clear guidelines now exist; the next step is to make them real in everyday clinics. Faster approval, fair insurance coverage, stronger primary-care training, and shared regional registries would help more people get the right treatment at the right time.

Keywords: inflammatory skin diseases, Latin America, psoriasis, atopic dermatitis, hidradenitis suppurativa, alopecia areata

Introduction

Inflammatory skin diseases encompass a broad spectrum of chronic, immune-mediated conditions characterized by recurrent inflammation that compromises skin integrity and profoundly affects quality of life.

The skin, the largest and most external organ of the body, acts as a critical barrier between the organism and the environment. Constantly exposed to microbial, chemical, and physical challenges, it relies on immune and barrier mechanisms to maintain homeostasis. When this balance is disrupted, maladaptive inflammatory responses can occur. A combination of external triggers, such as infections, pollutants, and climatic factors, and internal determinants, including genetic predisposition, immune dysregulation, microbiome alterations, stress, and lifestyle habits (diet, smoking, alcohol use, and sleep), contribute to disease onset and progression.

Although each inflammatory skin disease has unique pathogenic pathways, advances in immunology and molecular biology have revealed overlapping mechanisms, particularly involving T-helper (Th) cell subsets and cytokine networks, which have driven the development of highly targeted therapies.[1] These disorders not only cause visible and stigmatizing lesions but also lead to systemic inflammation, psychosocial distress, and substantial socioeconomic burden. Among them, psoriasis (PsO), atopic dermatitis (AD), hidradenitis suppurativa (HS), and alopecia areata (AA) are the most prevalent and clinically impactful worldwide. Each exhibit distinct immunopathogenic profiles but shares chronicity, visible manifestations, and the need for long-term, multidisciplinary care.

In Latin America, these diseases unfold in the context of marked structural inequality.[2] According to the United Nations, the region remains the most unequal in the world, with disparities deeply rooted in its historical, economic, and social foundations. Despite periods of economic growth and reform, exclusionary development models and fragile welfare structures have left broad sectors of the population with limited access to quality healthcare and education.[3] These inequities intersect with gender, ethnicity, and geography, disproportionately affecting women, Indigenous peoples, and Afro-descendant communities. The resulting social gradient continues to shape both living conditions and health outcomes, determining who receives timely diagnoses and effective treatments.

Within this unequal landscape, dermatological care epitomizes the broader paradox of health in LA, where cutting-edge therapies coexist with unmet basic needs. While biological and targeted agents have revolutionized management worldwide, access to these therapies in LA remains limited to a minority of patients, perpetuating diagnostic delays and therapeutic inequities.[4] In large, geographically diverse nations, such as Brazil and Argentina, the concentration of health infrastructure in metropolitan areas further widens these gaps (Figure 1). Furthermore, epidemiological data remain scarce, disease registries are underdeveloped, and awareness among primary care providers is limited, particularly regarding hidradenitis suppurativa.

Against this backdrop, this review examines the epidemiology, awareness, and treatment landscape of psoriasis, atopic dermatitis, hidradenitis suppurativa, and alopecia areata in LA. It highlights regional differences in disease burden, emerging national guidelines, real-world treatment data, and structural challenges that continue to limit equitable access to care. In this article, Latin America is defined as the group of countries and territories in the Americas where Spanish or Portuguese is the primary official language, including Mexico, the countries of Central and South America, and Spanish-speaking Caribbean territories. Most of the data summarized in this review come from Brazil, Chile, Argentina, and Colombia, reflecting where research output on inflammatory skin diseases is currently concentrated; information from other Latin American countries remains scarce.

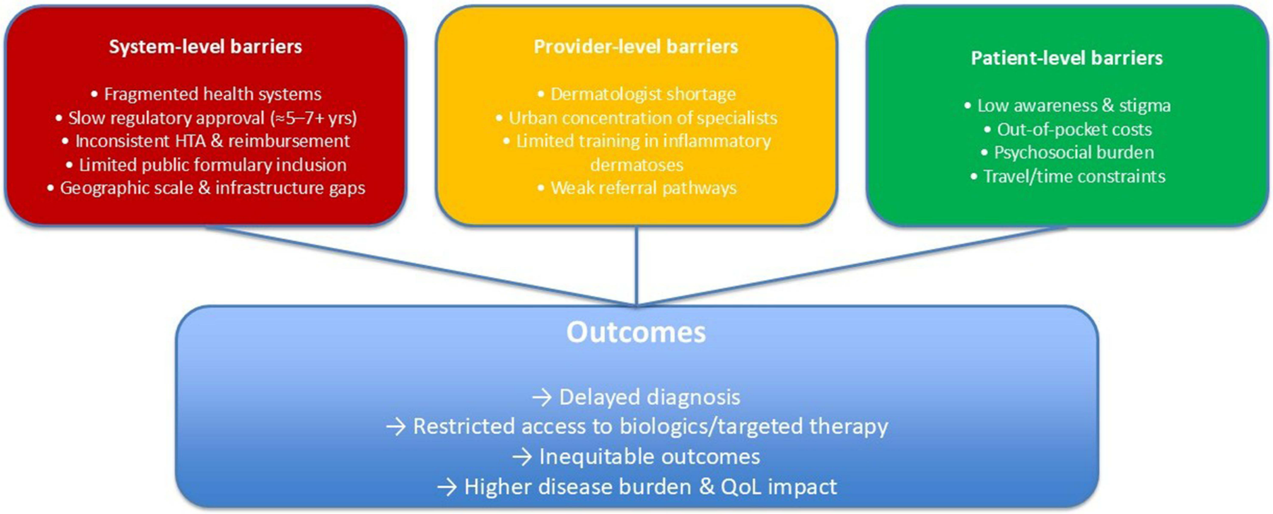

Figure 1 Structural barriers to equitable dermatologic care in Latin America. Conceptual framework illustrating how system-level (fragmented health systems, slow regulatory approval, inconsistent HTA and reimbursement, limited public formulary inclusion, and geographic infrastructure gaps), provider-level (dermatologist shortages, urban concentration of specialists, limited training in inflammatory dermatoses, weak referral pathways), and patient-level factors (low awareness and stigma, out-of-pocket costs, psychosocial burden, travel/time constraints) interact to produce delayed diagnosis, restricted access to biologic/targeted therapies, and inequitable outcomes, thereby amplifying disease burden and quality-of-life impact.
Abbreviations: HTA, health technology assessment; QoL, quality of life.

Scope and Literature Search

This is a narrative rather than a systematic review. Our aim was to synthesize the most relevant evidence on epidemiology, comorbidities, treatment patterns, access and inequities in psoriasis, atopic dermatitis, hidradenitis suppurativa and alopecia areata in Latin America. We performed targeted searches in PubMed/MEDLINE, LILACS, SciELO and Google Scholar for articles published in English or Spanish from 2000 to April 2025, using combinations of disease-specific terms ("psoriasis", "atopic dermatitis", "hidradenitis suppurativa", "alopecia areata") with "Latin America". We also reviewed reference lists of key articles to identify national guidelines, consensus statements and other relevant documents. Given the narrative design, we did not apply formal systematic-review methodology or risk-of-bias assessment, but we believe that the main published evidence relevant to the topics covered has been captured.

Epidemiology and Awareness

Psoriasis

Psoriasis has been studied relatively better in LA than other inflammatory skin diseases, although the available data remain limited (Table 1). Population-based prevalence estimates for psoriasis in LA generally range from 0.5% to 2%, which is lower than the rates reported in Europe and North America. However, these figures are likely underestimated because of underreporting, lack of standardized methodologies, and diagnostic challenges in the region.[18–20] An epidemiological study estimated in 2017 a prevalence in adults of 1.10% in high income Southern LA (Argentina, Chile, Uruguay), of 0.69% in the Caribbean region, in the Andean Latin American region (Bolivia, Ecuador, and Peru), and in Central Latin America, and of 0.78% for tropical Latin America (Brazil and Paraguay).[5]

Interestingly, psoriasis and PsA appear to be almost absent among the native populations of the Andean region,[19,21] supporting the hypothesis that the disease may have been introduced during the European colonization of the Americas.[22] Another study from Colombia, using the national registry of the Colombian Ministry of Health and International Classification of Diseases (ICD) codes associated with psoriasis, found a prevalence of 0.2% in the general population.[6] A previous investigation using a similar methodology reported a prevalence of 0.069%.[7] The authors hypothesized that this discrepancy was related to improved data capture in the more recent national database, leading to more reliable diagnostic registration, although greater disease awareness in recent years may have also contributed to the higher prevalence.

Table 1 Epidemiology of Inflammatory Skin Diseases in Latin America

Disease	**Country/Key Studies**	**Prevalence (Range)**	**Incidence (If Available)**	**Female:Male Ratio**	**Key Observations**
Psoriasis (PsO)	Argentina, Chile, Colombia, Trinidad & Tobago[5–10]	0.5–2%	6 – 22 per 100,000 person-years	≈ 1: 1	Lower than Europe/North America; probable under-reporting; minimal data from Andean Indigenous populations
Atopic dermatitis (AD)	Argentina[11]	3% (adults)	NA	F > M	Adult AD underestimated; low awareness among physicians and public
Hidradenitis suppurativa (HS)	Brazil, Colombia, Argentina, Chile[12–15]	0.02–2.4%	NA	≈ 2: 1	Wide methodological variability; underdiagnosis; diagnostic delay 7–10 years globally
Alopecia areata (AA)	Colombia, Brazil, Mexico[16,17]	0.05–3.8%	NA	1.5: 1	Under-reported; patchy subtype ≈ 70%; frequent endocrine/dermatologic comorbidities

Abbreviations: PY, person-years; NA, not available; ≈, around.

Only a few studies have reported the incidence of psoriasis or psoriatic arthritis in Latin America. One study conducted in Trinidad and Tobago analyzed over 7,000 dermatology clinic records over five years and identified 379 psoriasis cases (5.1%), corresponding to an incidence of 1,020 per 100,000 patient-years.[8] Most cases occur between 20 and 69 years of age, with a peak incidence in the fifth decade. A study in Chile using an administrative database, the Waiting List Repository, found national incidence rates of psoriasis of 22.1 (95% CI: 21.1–23.1) and 22.7 (95% CI: 21.8–23.6) per 100,000 person-years in 2016 and 2017, respectively.[9] Psoriatic arthritis (PsA) is the most disabling systemic manifestation of psoriatic disease, leading to joint damage, functional limitation, work disability, and impaired quality of life. A study based on medical records from a private insurance program in Buenos Aires, Argentina, identified 35 new PsA cases among more than 138,000 individuals between 2000 and 2006, yielding an incidence of 6.3 per 100,000 person-years.[10] The mean age at diagnosis was 54 years, and two-thirds of patients were male.[10] Awareness of psoriasis in LA is generally low, with significant gaps in understanding, recognition, and knowledge of the disease among both the general population and healthcare providers. In Brazil, for example, a nationally representative Datafolha survey of the general adult population conducted across 130 cities reported that nearly 90% of respondents were unfamiliar with psoriasis or confused it with other conditions, and only 6% could correctly recognize the disease from images.[23] This lack of public awareness contributes to persistent stigma and misconceptions regarding contagion and disease severity.

General practitioners and non-dermatologist clinicians in LA often lack sufficient training and understanding of psoriasis and its systemic features, contributing to delayed diagnoses and suboptimal management. Several regional analyses have emphasized the need to strengthen educational initiatives and disseminate clinical guidelines among primary care providers. In Mexico, Queiroz-Vergara et al examined the factors contributing to delayed psoriasis diagnosis in 100 patients and found that only 42% were diagnosed within one year of symptom onset.[24] Most (89%) were ultimately diagnosed by a dermatologist, even though 61% first consulted a general practitioner, and only 31% initiated treatment within the first year.[24,25] These findings highlight limited dermatologic training and referral pathways in primary care, in contrast to the United Kingdom, where approximately 82% of psoriasis cases are managed entirely within general practice.[25] A qualitative patient survey from Brazil also identified low societal awareness and inadequate public education as major barriers to diagnosis and treatment.[26]

In many Latin American countries, limited awareness and training regarding PsA among dermatologists contribute to under-recognition of musculoskeletal symptoms, delayed referral to rheumatology, and prolonged time to diagnosis. Encouragingly, this appears to be improving in recent years, with increasing educational initiatives and the establishment of combined dermatology–rheumatology clinics in several centers.[27]

Despite these findings, few peer-reviewed studies have directly assessed public awareness of psoriasis in LA. Therefore, existing data underscore a substantial evidence gap and the need for population-based surveys to better quantify awareness and its impact on care. Increasing public education and clinician training could help reduce stigma, promote earlier diagnosis, and improve access to treatment across the region.

Atopic Dermatitis

AD is the most common chronic inflammatory skin condition worldwide, with childhood prevalence rates ranging from 10 to 25%, and is increasingly recognized in adults, although robust regional data are scarce.

Reliable data on the epidemiology of adult atopic dermatitis (AD) in LA remain limited and heterogeneous (Table 1). Estimates vary considerably depending on the study design, diagnostic criteria, and population assessed. In Argentina, a population-based study reported an adult prevalence of approximately 3%, with severe forms representing 0.3% of all cases.[11] In Mexico, while population prevalence data are lacking, an electronic survey of adults (≥18 years) reported 89% mild, 6% moderate, and 5% severe disease among respondents with AD.[28] Globally, approximately one in four AD cases begin in adulthood.[29] In Brazil, several case series published since the early 1990s have described the clinical characteristics of adult-onset AD.[30,31] However, these reports originate from tertiary referral centers and may not reflect the broader Latin American population accurately. Consequently, robust data on the incidence, prevalence, and overall burden of adult AD in the region remain lacking.Awareness and recognition of adult AD are also suboptimal. Reviews emphasize frequent underdiagnosis, inconsistent application of diagnostic criteria, and limited knowledge among non-specialist physicians, all of which contribute to diagnostic delays and undertreatment.[31,32] In one Argentinian survey, up to 60% of patients had to visit at least three physicians before receiving their AD diagnosis, and 25% of patients reported that their AD diagnosis was delayed by at least five years.[33] Public understanding is similarly low, further compounding stigma and care gaps. Collectively, these findings underscore the need for high-quality population-based epidemiological studies and educational initiatives targeting both healthcare providers and the general population in LA.

Hidradenitis Suppurativa

Population-based information on hidradenitis suppurativa (HS) in LA has expanded in recent years (Table 1). A nationwide Brazilian telephone survey of 8,650 individuals reported a prevalence of 0.41%, without regional differences across the country.[12] HS was more frequent among adolescents (0.57%) and adults (0.47%) than among children and older adults (< 0.03%; P = 0.04). There was a modest female predominance (0.49% vs 0.30%; P = 0.06), which became more pronounced with age (< 40 years: 0.46% vs 0.38%; > 40 years: 0.56% vs 0.23%; P = 0.03).[12]

In Colombia, an analysis of the national health registry (2013–2017) identified 3,667 HS cases, corresponding to a prevalence of 7.4 per 100,000 inhabitants (0.0074%).[13] Women accounted for 68% of cases (female-to-male ratio ≈ 2.1:1), with the highest prevalence in the 35–39-year age group; the department of Caldas showed the greatest burden, reaching 17 cases per 100,000 inhabitants.[13] These national health registries are continuously updated and are being used for ongoing epidemiologic and treatment-pattern analyses. In Argentina, a study using data from a private hospital-based health maintenance organization (HMO) estimated a prevalence of 0.02% in its affiliated population, with 65% women and a mean age of 37 years.[14] In Chile, a recent population-based study conducted as part of the Global Hidradenitis Suppurativa Atlas (GHiSA) reported an HS prevalence of 2.4%, which is notably higher than most previous estimates.[15] All identified cases were female, with a median age of 35.5 years, 25% were smokers, and the mean body mass index was significantly elevated. Chile was the only LAn country represented in the GHiSA initiative, which, in its accompanying meta-analysis, estimated a global HS prevalence between 0.67% and 1.46%, confirming considerable regional variation and a predominance of female sex as the main associated factor.[34] Chilean centers are currently contributing cases to this ongoing international registry. Although these figures appear highly divergent, they mainly reflect differences in methodology and case ascertainment rather than true regional variations. The Brazilian estimate was derived from a population survey capturing self-reported and milder disease, whereas the Colombian study was based on administrative registries, which likely underestimated community prevalence. The Argentinean study was based on a population from a private HMO, which, while providing a valid population denominator, may not be fully generalizable to the national population. Collectively, these findings suggest that the true prevalence of HS in LA is likely 0.3–0.5%, consistent with data from Europe and North America.Despite increasing recognition, HS remains underdiagnosed and frequently misclassified, leading to an average worldwide diagnostic delay of 7–10 years.[35] In LA, evidence suggests a shorter delay once medical care is accessed. In an Argentine study, the median diagnostic delay was 1 month and the mean was 14 months (range, 0–142), reflecting the interval between the first consultation for HS-related symptoms and

https://doi.org/10.2147/JIR.S540854

the final diagnosis.[14] Therefore, this measurement captures only the physician component of the delay and does not account for patient-related latency—the time from symptom onset to seeking medical evaluation—which is likely much longer and remains largely undocumented in the region.

It is estimated that most patients remain undiagnosed and without access to adequate treatment in Brazil, and this is probably true for the rest of LA.[36] Based on the HS consensus of the Brazilian Society of Dermatology, continuous multidisciplinary actions are required to manage HS at all stages of the disease.[37] To address these challenges, recent initiatives have proposed structured outpatient pathways integrating dermatology, surgery, and nursing for coordinated multidisciplinary treatment of HS.[36]

Taken together, these findings show that HS in LA broadly mirrors global epidemiological patterns—with female predominance, onset in early adulthood, and comparable prevalence—but persistent underdiagnosis and incomplete awareness continue to delay appropriate management. Strengthening registries, expanding primary care training, and developing coordinated HS networks are essential to reduce the burden of this chronic and stigmatizing disease across the region.

Alopecia Areata

The lifetime risk of alopecia areata (AA) is estimated to be approximately 1.7%.[38] A recent US population-based study reported an AA prevalence of approximately 0.2% and an incidence of 90 cases per 100,000 person-years, with higher rates among women and adults.[39] Severe phenotypess,such as alopecia totalis and alopecia universalis, represent 5–10% of cases and are associated with profound psychosocial distress and the greatest impairment in quality of life.

In LA, epidemiological data are limited (Table 1). The National Registry of Alopecia Areata in Colombia (RENAAC), the largest regional dataset to date, reported 562 patients across five major cities, of whom 59.4% were women, predominantly aged 15–49 years.[16] The patchy subtype accounted for 71.4% of cases, with a mean disease duration of 1.7 years, and approximately one-third of patients presented with additional dermatologic or endocrine comorbidities.[16]

Despite these advances, most countries in the region still lack standardized surveillance systems and national registries. The estimated prevalence varies from 0.2% to 3.8% in Mexico, 0.1–0.2% in Peru, and 0.05% in Colombia, figures that are broadly consistent with global estimates but likely underreported.[17] This deficit in epidemiological information contributes to under-recognition of AA as a public health concern across LA.

AA is not merely a cosmetic disorder. Although not life-threatening, it has profound psychological and social impacts. The unpredictable pattern of hair loss and regrowth can trigger anxiety, depression, and social stigma, particularly in women and younger patients.[17] Limited awareness among patients, families, and physicians perpetuates the misconception that AA is a “cosmetic” issue, delaying care and compounding psychosocial burden. Therefore, addressing the psychological dimension of AA should be an integral part of management strategies in the region.

Educational gaps also contribute to delayed diagnosis and inconsistent management. Many primary-care physicians and non-specialists misinterpret AA as a fungal infection or telogen effluvium, delaying referral to dermatologists. Fragmented referral systems and limited access to specialists remain major barriers to timely care. Even within dermatology, the use of clinimetric tools is less familiar than that for other inflammatory skin diseases. The Brazilian Society of Dermatology Consensus recommends the standardized use of the Severity of Alopecia Tool (SALT) for disease grading and follow-up, emphasizing a structured assessment to guide therapy.[40] Strengthening medical education and tele-dermatology initiatives could reduce diagnostic delays and improve patient outcomes.

Patient self-help and advocacy organizations are important partners in the care of chronic inflammatory skin diseases, providing education, psychosocial support, peer networks and help navigating fragmented health systems. Patient self-help and advocacy groups are active in several Latin American countries, particularly in psoriasis, where national associations (eg AEPSO in Argentina and FUNDAPSO in Colombia) are linked through the Red Latinoamericana de Psoriasis (SOLAPSO).[41] For atopic dermatitis, patient organizations have emerged in Argentina (Asociación de Dermatitis Atópica Argentina) and other countries, and similar foundations now support patients with hidradenitis suppurativa, psoriasis and other chronic dermatoses in Chile and elsewhere.[42] However, these groups remain unevenly distributed across the region and are mostly concentrated in large urban centers, leaving many patients without structured peer support or advocacy.

Regional Challenges in the Management of Inflammatory Skin Diseases in Latin America

Effective management of inflammatory skin diseases in LA is impeded by systemic, geographic, economic, and educational challenges. Some of the key barriers across the region are as follows:

Fragmented Health Systems and Limited Access to Dermatologic Care

Health systems across LA are highly segmented, with services divided among public, private, and social security sectors that frequently operate independently.[43] The scope and quality of coverage vary substantially among these providers and across regions, and many individuals move between systemsor receive care from several simultaneouslydepending on their eligibility or employment status. This fragmentation produces marked inequities in access, continuity, and quality of care, particularly between urban and rural populations, and remains one of the principal challenges to achieving universal health coverage in the region.

These systemic weaknesses are compounded by a shortage and uneven distribution of dermatologists and related specialists. Dermatology services are heavily concentrated in large metropolitan centers, leaving many rural and peripheral regions without adequate coverage. In an ecologic study from Brazil in 2014, dermatologists were present in only 9.1% of municipalities, which together represented 56.2% of the national population.[4] Furthermore, a regional consensus among experts in AD from Argentina, Brazil, Chile, Colombia, and Peru determined that only Argentina and Brazil met the World Health Organization's minimum recommendation of four dermatologists per 100,000 inhabitants.[44]

This imbalance contributes to diagnostic delays, increased disease severity at presentation, and limited follow-up, particularly for chronic inflammatory skin diseases such as psoriasis, atopic dermatitis, and hidradenitis suppurativa. Patients in remote areas often face long travel distances, high out-of-pocket costs, or dependence on non-specialist physicians for initial assessments.

A recent Latin American review of psoriasis identified restricted access to dermatologists and medications as one of the most frequent barriers to optimal care.[45] Approximately one-third of the included studies cited health system fragmentation and judicialization of therapy—patients resorting to legal action to access biologic drugs—as structural obstacles to effective management. Similar issues have been documented in atopic dermatitis and hidradenitis suppurativa, where shortages of specialists, long waiting times, and discontinuous coverage hinder timely diagnosis and access to adequate treatment.[36]

Overall, the combination of fragmented health systems and insufficient specialist availability perpetuates major inequities in dermatologic care across LA. Strengthening referral networks, expanding specialist training programs, and integrating dermatology within primary care frameworks are essential steps to improve access and reduce disparities in the management of inflammatory skin diseases.

Economic Barriers and Limited Reimbursement

Recent analyses have highlighted the magnitude of regulatory and market access delays affecting innovative treatments in LA. An IQVIA study reviewing 403 drugs, including several for immune-mediated diseases, found that patients in the region wait an average of more than five years to access new therapies after international approval.[46] Delays ranged from 59 months in Argentina to 83 months in Costa Rica, underscoring the structural inefficiency of national regulatory systems and the absence of accelerated or fast-track pathways for high-impact drugs.[46] These prolonged lags not only postpone clinical benefits but also exacerbate inequities, as higher-income patients and better-resourced providers often obtain access years before new drugs are available through standard formularies.

Even after regulatory approval, economic and structural barriers continue to restrict the use of advanced therapy. High treatment costs, fragmented insurance schemes, and inconsistent reimbursement policies limit access to biologics and small-molecule drugs across the region. In many countries, these therapies remain largely confined to specialized referral centers, with delayed or incomplete coverage in routine care. Consequently, inequalities in access mirror broader socioeconomic disparities, with therapeutic options determined more by patients' financial capacity than by clinical indications.

For psoriasis, evidence from Colombia shows that in 2019, among 100,823 patients, about 5% received biologic therapy.[6] This figure aligns with global estimates, as only a minority of patients, those with moderate-to-severe disease, require such treatment. Colombia stands out in the region because all biologics approved by the FDA and EMA are available and reimbursed through its nearly universal healthcare system, which covers 98.6% of the population.[6] However, access remains uneven elsewhere in LA. Ina cross-sectional survey of dermatologists from Brazil and Chile, 81% of Brazilian and 65% of Chilean moderate-to-severe psoriasis patients were reported to have access to systemic nonbiologic drugs, but only 37% and 27%, respectively, were receiving biologic therapy. Lack of availability and/or lack of insurance reimbursement for biologics was cited as a barrier in 22.2% of Brazilian and 68% of Chilean cases.[47]. This study demonstrated that although nonbiologic treatments for moderate-to-severe psoriasis were available in both LA countries, there was a high need for improvement in access to more effective psoriasis treatments, including biologics. Similarly, a Brazilian multicenter study (n = 188) found that 34.8% of patients reported difficulties in obtaining prescribed medications, with 12.8% resorting to judicialization to acquire treatment. The primary reasons were drug unavailability (43.1%) and financial issues (38.5%).[48] In Argentina, access to biologics often depends on healthcare coverage, and judicialization,legal appeals to obtain treatment,remains a frequent pathway for patients in the public sector. In the private sector access to biologics is more available. A study in a large population of patients with PsO without PsA in a private hospital in Argentina showed a prevalence of biologic use of 6%.[49] In Mexico, biologics are approved but are mainly restricted to insured patients treated in specialized centers, with only approximately 40% of the population having access to biologics.[20] These figures contrast with those of high-income countries, where a higher proportion of patients with psoriasis receive biologics, reflecting more adequate therapeutic penetration among eligible patients.[50]

Biologic and JAKi therapies for atopic dermatitis, such as dupilumab, baricitinib, upadacitinib, and abrocitinib, are being progressively adopted across Latin America as more countries authorize their use in clinical practice. Notably, Argentina and Brazil have extended the approval of dupilumab to children aged ≥ 6 years (32). Janus kinase (JAK) inhibitors, including upadacitinib and baricitinib, have also been approved in several countries in the region (32). However, real-world access remains limited because of high treatment costs, differences between public and private insurance coverage, and the absence of standardized and objective measures of disease severity that are often required for reimbursement approval. In addition, some patients turn to alternative or complementary therapies despite the lack of randomized controlled trials supporting their efficacy in atopic dermatitis (32). In Brasília, Brazil, one study found that 63.5% of children with AD had used such approaches, mainly homeopathy or phytotherapy, as part of their management.[51]

Biologic therapy for hidradenitis suppurativa (HS) has progressed substantially, although real-world access remains limited in LA. Adalimumab remains the most widely used biologic; however, recent regulatory developments have expanded treatment options, and secukinumab has been approved for HS in Argentina and Brazil. Bimekizumab, although approved for HS in the United States and European Union, is not currently authorized for this use in any Latin American country. Despite these advances, high costs, fragmented reimbursement pathways, and limited inclusion of HS in national formularies continue to restrict patient access. As a result, many individuals rely on prolonged antibiotic regimens, hormonal therapy, or surgery before receiving biologic treatment. The Brazilian Society of Dermatology consensus underscores that most patients with HS remain undiagnosed or undertreated within public health systems and calls for multidisciplinary care models and broader therapeutic availability to improve outcomes.[37]

The advent of Janus kinase (JAK) inhibitors has transformed the therapeutic landscape of AA, providing effective options for severe and refractory cases. Baricitinib is now approved by both ANVISA (Brazil, Agência Nacional de Vigilância Sanitária: Brazilian Health Regulatory Agency) and ANMAT (Argentina; Administración Nacional de Medicamentos, Alimentos y Tecnología Médica: National Administration of Drugs, Food and Medical Devices) for the treatment of adults with severe alopecia areata. Ritlecitinib, another JAK inhibitor, was approved by ANVISA in Brazil in 2024 for severe AA but remains under review in most other Latin American countries.[40]

Despite these regulatory advances, high costs and lack of reimbursement still limit access to innovative therapies. Expanding drug access and accelerating national approvals represent key regional challenges.

Treatment Landscape

Clinical Guidelines in Latin America

Over the last decade, several Latin American countries have developed national or regional clinical practice guidelines (CPGs) for inflammatory skin diseases that are largely aligned with international standards. Nevertheless, local adaptation is often needed to reflect resource availability, reimbursement frameworks and regional disease burden. Below we summarize the current guideline landscape for psoriasis, atopic dermatitis (AD), hidradenitis suppurativa (HS) and alopecia areata across Latin America (Table 2).

Psoriasis

Latin America has made notable progress in developing region-specific frameworks. The earliest was the CILAD–SOLAPSO Latin American Consensus on Psoriasis Treatment (2009), which outlined a pragmatic stepwise approach compatible with resource-limited settings while aligning with European and North American standards.[61]

Since then, several national and regional guidelines have been established. The Argentine (2024),[52] Brazilian (2020),[53] and Colombian[54] (2022) guidelines provide comprehensive, evidence-based recommendations covering diagnosis, severity classification, and treatment sequencing. In addition, a Mexican expert consensus published in 2020 focused specifically on the appropriate use of biologics, offering detailed guidance on patient selection, safety monitoring, and therapeutic switching.[55]

All Latin American guidelines adopt comparable severity definitions based on *Body Surface Area (BSA), Psoriasis Area and Severity Index (PASI)*, and *Dermatology Life Quality Index (DLQI)*, typically classifying moderate-to-severe disease as PASI or BSA ≥ 10 or DLQI > 10, or when special-site involvement significantly affects function or psychosocial well-being. They agree on a stepwise management algorithm beginning with topical corticosteroids (±vitamin D analogs), followed by phototherapy and conventional systemic agents such as methotrexate, cyclosporine, or acitretin. Within this stepwise approach, phototherapy, particularly narrowband UVB, is positioned between optimized topical therapy and systemic agents, and remains a key option for patients with extensive or refractory plaque disease, especially where access to biologic drugs is limited. Biologic or targeted synthetic agents, including TNF-α, IL-12/23, IL-17, and IL-23 inhibitors, are reserved for moderate-to-severe or refractory cases.

Table 2 National and Regional Clinical Practice Guidelines for Inflammatory Skin Diseases in Latin America

Disease	Country/Year	Organization/Issuing Body	Methodology	Key Recommendations/Highlights
Psoriasis (PsO)	Argentina (2024);[52] Brazil (2020);[53] Colombia (2022);[54] Mexico (2020)[55]	SAD; SBD; ACAD; Gac Med Mex consensus	Evidence-based / Delphi	Stepwise therapy; IL-23 prioritized; treat-to-target (PASI 90); regional consensus on severity and tapering (2025)
Atopic dermatitis (AD)	Argentina (2024);[56] Brazil (2023);[57] Colombia (2024)[58]	SAD + AAAeIC; SBD; Acta Med Colomb	GRADE / PCDT	Dupilumab first-line for moderate–severe AD; inclusion of JAK inhibitors; holistic care emphasized
Hidradenitis suppurativa (HS)	Argentina (2019 and 2024);[59,60] Brazil (2019)[37]	SAD; SBD	Consensus-based	Hurley & IHS4 scoring; adalimumab and secukinumab approved; multidisciplinary approach
Alopecia areata (AA)	Brazil (2020)[40]	SBD	Delphi consensus	SALT scoring; intralesional corticosteroids first-line; JAK inhibitors for severe or refractory cases; call for regional harmonization

Abbreviations: SAD, Sociedad Argentina de Dermatología; SBD, Sociedade Brasileira de Dermatologia; ACAD, Asociación Colombiana de Dermatología; AAAeIC, Asociación Argentina de Alergia e Inmunología Clínica; PCDT, *Protocolo Clínico e Diretrizes Terapêuticas*; IL, interleukin; GRADE, Grading of Recommendations Assessment, Development and Evaluation; PASI, Psoriasis Area and Severity Index; IHS4, International Hidradenitis Suppurativa Severity Score System; SALT, Severity of Alopecia Tool; JAK, Janus kinase.

Recent consensus initiatives have added further regional harmonization. A 2025 Latin-American Delphi consensus established uniform criteria for severity classification, reaffirming PASI, BSA, and DLQI as the core assessment tools while acknowledging practical adaptations for heterogeneous healthcare systems.[62] Another 2025 regional consensus addressed tapering of biologic therapy, proposing cautious dose reduction in patients achieving sustained remission (eg, PASI ≤ 2, PGA ≤ 1),[63] supported by observational data from a Colombian cohort in which 88% maintained control over eight months after tapering of biologic therapy (including TNF, IL-12/23, IL-17 and IL-23 inhibitors).[64] Minor differences between national guidelines mainly reflect reimbursement and formulary access issues. The Brazilian consensus provides the most structured algorithm, with clear definitions of treatment failures to escalate therapy.[53] The Argentine guideline recommends considering all systemic therapies as first-line options, formalizes treat-to-target goals (absolute PASI <3, DLQI 0/1, PASI 90, and PGA 0/1), and emphasizes individualized selection of advanced therapy based on patient characteristics and comorbidities.[52] The Colombian guideline prioritized the use of IL-17i or IL-23i over TNFi or IL-12/23i in patients with moderate to severe psoriasis that failed systemic non-biologic therapies.[54] They also emphasize cost-effectiveness and biosimilar use.[54] The Mexican consensus complements these by focusing on biologic safety and sequencing strategies in real-world practice.[55]

In routine practice, comorbidities frequently complicate the management of psoriasis and influence treatment selection. Latin American cohort and database studies from Brazil, Argentina, Mexico and Chile consistently report a high burden of cardiometabolic and mental-health comorbidities (obesity, metabolic syndrome, hypertension, diabetes, dyslipidaemia and depression), with prevalences broadly comparable to, and in some series higher than, those described in Europe and North America.[65–68] This profile reinforces the need for systematic comorbidity screening and multidisciplinary collaboration when applying guideline-based treatment algorithms in the region.Overall, current Latin American psoriasis guidelines show broad scientific convergence, increasingly mirroring international standards while incorporating region-specific solutions to disparities in drug access and healthcare infrastructure.

Atopic Dermatitis

Clinical practice guidelines for atopic dermatitis (AD) in LA have expanded significantly over the past decade, paralleling the global introduction of biologic and targeted therapies. The earliest comprehensive guidance was the 2019 Argentine national guideline, which established diagnostic criteria, severity scoring, and a stepwise therapeutic approach.[69] This was recently updated through the 2024 Argentine Therapeutic Clinical Practice Guideline, jointly developed by the Sociedad Argentina de Dermatología (SAD) and the Asociación Argentina de Alergia e Inmunología Clínica (AAAeIC), incorporating new evidence on biologics and JAK inhibitors.[56] Similarly, in Brazil, the SBD (Brazilian Society of Dermatology) 2023 consensus provides clinical recommendations for phototherapy and systemic/advanced therapies in moderate-to-severe AD.[57] By contrast, the current Ministry of Health Clinical Protocol and Therapeutic Guideline (PCTD, approved Dec 20, 2023) for AD excludes topical calcineurin inhibitors, conventional systemic immunosuppressants, dupilumab, and JAK inhibitors from SUS (Sistema Único de Saúde) coverage.[70] This underscores the gap between evidence-based expert guidelines and budget-constrained public policy, whereby scientifically endorsed therapies remain inaccessible within public systems, despite demonstrated benefit. The Colombian guideline, updated in 2024, follows an evidence-based framework and adapts GRADE methodology to local epidemiology and resource availability.[58]

All three guidelines converge on diagnostic and severity assessment principles. Diagnosis is clinical, based on the Hanifin–Rajka or UK Working Party criteria, complemented by validated scoring systems such as EASI (Eczema Area and Severity Index), SCORAD (Scoring Atopic Dermatitis), and POEM (Patient-Oriented Eczema Measure). Disease severity was defined as EASI >21, SCORAD >50, or substantial quality-of-life impairment (DLQI >10). Each guideline stresses a comprehensive evaluation of comorbid allergic conditions, infection risk, and psychosocial impact.

Treatment recommendations follow a stepwise approach. The basic management of AD includes continuous emollient use, skin care education, and trigger avoidance. Topical corticosteroids and calcineurin inhibitors remain the mainstays for mild-to-moderate disease, whereas narrowband UVB phototherapy is recommended for widespread or refractory cases, typically as an intermediate step between optimized topical care and systemic immunomodulators.

https://doi.org/10.2147/JIR.S540854

For moderate-to-severe AD, systemic immunomodulators, such as cyclosporine, methotrexate, and azathioprine, are endorsed as short- or medium-term options when conventional therapy fails.

The introduction of biologic and targeted synthetic therapies represents the most relevant advancement. Dupilumab is recognized as first-line advanced therapy for adults and children meeting severity criteria in all three countries, while Upadacitinib, baricitinib and abrocitinib are incorporated according to local regulatory approvals. Access remains uneven across systems; public-coverage constraints in Brazil and payer-dependent access in Argentina and Colombia continue to limit real-world uptake.[56–58]

Across documents, there is consistent emphasis on infection prevention, vaccination assessment, mental health support, and long-term laboratory monitoring (CBC, LFTs, lipids, and viral screening for JAK inhibitors). The 2024 Argentine and Colombian updates also highlight patient education, multidisciplinary management, and structured follow-up as critical components of sustained disease control.

In summary, Latin American AD guidelines show high methodological quality and strong alignment with international standards, particularly in therapeutic sequencing and biologic use. The principal differences lie in the integration with national reimbursement policies—most explicit in Brazil—and in the implementation capacity across heterogeneous healthcare systems.

Hidradenitis Suppurativa

Latin American HS guidance is grounded in national consensuses rather than a single regional clinical practice guideline. Argentina has two society-endorsed documents—the original 2019 consensus and a comprehensive 2024 update from the Sociedad Argentina de Dermatología.[59,60] The 2024 Argentine consensus places high-frequency ultrasound at the center of routine assessment to map subclinical tunnels and abscesses, define disease extent beyond the physical exam, distinguish inflammatory from fibrotic components, guide surgical planning, and monitor response. It also broadens assessment beyond structural staging by formally incorporating Hurley, the International Hidradenitis Suppurativa Severity Score System (IHS4), and Hidradenitis Suppurativa Clinical Response (HiSCR), among other validated measures, to standardize baseline severity and set measurable treatment targets.[59] Within this framework, care is organized around four complementary pillars operating in parallel: (i) education and risk modification (counseling, smoking cessation, weight management, structured skin/wound care); (ii) medical therapy (from topical agents and systemic antibiotics to hormonal therapy in selected women and, for moderate-to-severe disease, biologic therapy including adalimumab and secukinumab); (iii) procedural/surgical management (preferentially deroofing, limited or wide excision, and laser; avoiding simple incision-and-drainage as definitive treatment); and (iv) systematic screening and treatment of comorbidities, with referral pathways for metabolic, psychological, and pain management needs.[59] In contrast, the Brazilian SBD 2019 consensus presents a stepwise escalation algorithm—lifestyle and topical care followed by systemic antibiotics and/or hormonal therapy, reserving biologics for refractory or severe disease, and surgery for moderate-to-severe HS with tunnels and scarring (typically Hurley II–III) when there is substantial tissue damage.[37] The Brazilian document recommends adalimumab as the first-line biologic for moderate-to-severe HS, with secukinumab, infliximab, and ustekinumab as potential alternatives;[37] secukinumab is now approved for HS in both Brazil and Argentina, although reimbursement pathways are still evolving.

Alopecia Areata

Formal clinical practice guidelines for alopecia areata (AA) are scarce in Latin America. The only comprehensive document to date is the Brazilian Society of Dermatology Consensus, developed through a Delphi process involving national experts and published in 2020.[40] It provides structured recommendations for diagnosis, severity assessment, and treatment, classifying disease extent according to the Severity of Alopecia Tool (SALT) and emphasizing standardized evaluation for monitoring response. The consensus recommends intralesional corticosteroids as first-line therapy for localized disease and systemic corticosteroids or immunosuppressants (eg, methotrexate, azathioprine) for more extensive forms. JAK inhibitors are recognized as the best choice for severe and refractory cases, although their use remains limited by cost and regulatory approval status.

Beyond Brazil, no national guidelines have been formally issued, although regional expert discussions have highlighted the need for harmonized recommendations, inclusion of psychosocial aspects, and equitable access to emerging therapies.[17] In practice, management across LA still relies largely on expert opinion and off-label use, underscoring the need for multicountry collaboration to establish regionally adapted guidance that aligns with current global standards.

Treatment Studies from Latin America

Despite the growing availability of biologics and targeted therapies, real-world evidence on treatment outcomes for inflammatory skin diseases in LA remains limited but steadily increasing. Most data derive from single-country observational studies, registry-based analyses, or regional subsets of global cohorts, reflecting both the diversity and fragmentation of healthcare systems in the region.

For psoriasis, several multicenter and national studies have provided insight into therapeutic effectiveness and persistence under routine conditions. A Latin American sub-analysis of the PURE registry, a multinational non-interventional cohort including sites from Brazil, Argentina, and Mexico, demonstrated substantial clinical improvement and quality-of-life gains among patients with moderate-to-severe plaque psoriasis treated with secukinumab, consistent with global outcomes.[71] This registry remains active in the region and continues to enroll and follow patients. In Colombia, a real-world cohort study assessed the persistence of biologic therapies in psoriasis, identified a drug survival rate of 79% at two years, with better drug survival for Ixekizumab (IL-17i) and guselkumab (IL-23i).[72] The study highlighted that the previous use of two or more biologics was associated with poorer drug survival. Regional participation in the PSoHO observational study, which compared anti–IL-17A agents with other biologics in routine practice, confirmed similar effectiveness trends across Latin American centers.[73] In a specialized-center cohort from Colombia, patients with psoriasis in sustained remission for ≥12 months underwent a biologic optimization (dose-spacing /taper) strategy.[64] After eight months of follow-up on tapered biologic regimens (TNF, IL-12/23, IL-17 and IL-23 inhibitors), 86% remained relapse-free, and no new safety signals emerged (57). These low relapse rates support optimization as a safe, cost-saving approach that can reduce drug exposure and potentially expand access to high-cost therapies. Fernández et al analyzed biologic use and costs for psoriasis in Colombia and found that ustekinumab, adalimumab, and secukinumab were the three most frequently prescribed agents.[6] The annual per-patient cost was approximately USD 12,880 for ustekinumab, USD 7,130 for adalimumab, and USD 6,825 for Secukinumab, figures substantially lower than reported in the United States.[6] The authors attribute this difference largely to centralized price regulation for high-cost medicines in Colombia, which enables the government to negotiate more favorable prices and contain expenditures.[6] In Brazil and Chile, biologics serve only 37% and 27% of moderate-to-severe patients, while in Argentina, access often requires legal action and remains restricted in public systems.[47] In many settings, methotrexate is the dominant systemic option.[18] Together, these findings support the external validity of international psoriasis treatment data within regional clinical practice.

Evidence for atopic dermatitis (AD) treatment has expanded more recently, following the introduction of biologic and JAK inhibitor therapies. The MEASURE-AD study, conducted in Brazil, Mexico, and Argentina, characterized real-world management of moderate-to-severe AD and confirmed the high disease burden and unmet therapeutic need under standard care (4). Sixty-six % of the patients were receiving systemic therapy, including 25% receiving dupilumab.[74] The MEASURE-AD program is ongoing and continues to collect longitudinal real-world data in these countries. Complementary Brazilian case series have described favorable outcomes with dupilumab, demonstrating rapid improvement in disease severity and pruritus scores among adults refractory to conventional immunomodulators.[75] Results from studies in Argentina and Brazil show that 40.5% of patients were not satisfied with their treatment regimen, and 33.7% of patients discontinued their medication due to poor effectiveness.[30,33] These reports emphasize the benefit of advanced therapies when available, while regional reviews underscore persistent disparities in access and continuity of care across LA.[32]

In hidradenitis suppurativa (HS), data remains scarce but are gradually increasing in parallel with the development of national guidelines. A recent bibliometric review found that LA accounted for only about 2% of all HS publications in the past decade, highlighting the region's limited research visibility and the need for stronger local evidence.[76]

The Argentine 2024 HS consensus incorporated an analysis of national clinical experience, reporting favorable real-world outcomes with adalimumab and early adoption of secukinumab following its approval for HS.[59] Brazilian studies similarly describe a gradual integration of biologics into clinical practice, typically after extended antibiotic or surgical management, reflecting systemic delays in referral and restricted access to advanced therapy.[37,77] In Uruguay, a retrospective series of seven patients treated with wide surgical excision reported recurrence in two cases.[78] In Puerto Rico, a case series of 46 patients treated with adalimumab achieved a 30.4% HiSCR response and a 13% improvement in Physician Global Assessment at 26 weeks.[79] Despite the limited sample sizes, these studies consistently demonstrate meaningful clinical improvement once biologic therapy is initiated, aligning with global evidence and supporting their integration into regional treatment algorithms.

Real-world data on alopecia areata (AA) in LA remain limited but are gradually emerging. The most robust evidence comes from the National Registry of Alopecia Areata in Colombia (RENAAC), which included 562 patients across five major cities.[16] Most were women (59.4%), aged 15–49 years, and the patchy subtype predominated (71.4%). Mean disease duration was 1.7 years, and approximately one-third of patients presented with concomitant dermatologic or endocrine disorders.[16] RENAAC remains an active national registry and is progressively expanding its dataset. In Brazil, a cross-sectional analysis of dermatology clinic visits reported that AA accounted for 1.2% of consultations, ranking third among alopecia types after androgenetic alopecia and telogen effluvium.[80] Another study in Brazil found that AA was more frequent in women and severe forms in men, contrary to the literature.[81] A Mexican genetic study of 30 AA cases identified three HR-gene variants, including one previously undescribed, suggesting population-specific genetic susceptibility.[82]

Regional narrative reviews consistently highlight the underrepresentation of Latin America in AA literature, persistent barriers to specialist care, and the need for multicountry registries and longitudinal cohorts.[17] Collectively, these studies highlighted that while AA's epidemiological profile in LA mirrors global trends, systematic real-world outcome data remain scarce, reinforcing the urgency for coordinated research and registry initiatives across the region.

Collectively, these emerging Latin American studies provide valuable regional evidence confirming the efficacy, tolerability, and therapeutic value of biologics and targeted agents across psoriasis, AD, HS, and AA. However, they also highlight persistent inequities in drug access, heterogeneity in treatment pathways, and the need for larger, registry-based studies to better capture real-world outcomes across the region's diverse healthcare settings.

Biosimilars Access in Latin America

Biosimilars are increasingly used across Latin America and, when effectively implemented, can reduce acquisition costs and expand access to biologic therapies for inflammatory skin and rheumatic diseases. However, penetration and management of biosimilars differ markedly between countries. In Argentina, access to high-cost biologics is largely mediated by a fragmented mix of provincial public programs, social security schemes, and private insurers, each of which negotiates prices and contracts with manufacturers separately. By contrast, several countries have introduced national or centralized purchasing mechanisms for high-cost medicines, often including biosimilars. In Brazil, the Ministry of Health carries out centralized procurement of many biologics and distributes them through the Specialized Pharmaceutical Care Component (CEAF) of the Unified Health System. In Colombia, legislation has mandated central negotiation and purchasing of selected high-cost medicines by the Ministry of Health to protect the financial sustainability of the health system. Chile relies on the CENABAST (Central de Abastecimiento del Sistema Nacional de Servicios de Salud), a national procurement agency that consolidates public-sector purchases and, under Law 21.198, can also intermediate purchases for private pharmacies to secure lower prices. In Mexico, consolidated tenders for medicines and medical devices have been organized at the federal level (initially with the UNOPS (United Nations Office for Project Services) and now via BIRMEX (Laboratorios de Biológicos y Reactivos de México) for major public purchasers such as the IMSS (Instituto Mexicano del Seguro Social) and the ISSSTE (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado) alongside reverse-auction tenders in which originator and biosimilar products compete. These heterogeneous procurement models, together with local regulatory and pricing policies, largely determine the real-world uptake of biosimilars and the magnitude of cost savings achieved in the region.

Ethnic Diversity and Inequities in Care in Latin America

Latin America is characterized by marked ethnic diversity, including Indigenous, Afro-descendant, mestizo, and European-descendant populations, with a wide range of skin phototypes. This diversity may influence both the clinical expression of inflammatory skin diseases (eg, less visible erythema and greater burden of post-inflammatory hyperpigmentation or scarring in darker phototypes) and the way disease is recognized and diagnosed. However, very few studies from the region have systematically evaluated ethnic differences in disease burden or outcomes.

In psoriatic disease, limited evidence suggests that ethnicity may play a role in disease expression and severity. A Brazilian series including both African-descendant and white Brazilians showed that psoriasis is also frequent among African-descendant individuals, challenging the traditional perception of psoriasis as a disease predominantly affecting lighter phototypes.[83] A small Peruvian report comparing indigenous (Quechua/Aymara) and mestizo patients suggested more severe and long-standing psoriatic arthritis among indigenous patients.[84] Although these studies are single-center and involve small samples, they illustrate the potential impact of ethnicity on psoriatic disease in Latin America and highlight the need for larger, systematically collected data.

For atopic dermatitis, recent regional reviews emphasize the ethnoracial heterogeneity of Latin America but also underscore how few primary studies report outcomes stratified by ethnicity or skin color.[45] An ongoing pilot study from a Brazilian university referral hospital in adults with AD is evaluating clinical features, skin-barrier protein expression in cutaneous and ocular epithelia, and in situ Th17/Th22 immune profiles. Preliminary findings suggest distinct patterns of skin-barrier protein expression in cutaneous and ocular epithelia with variation across ethnic/racial profiles (unpublished data).[45] These emerging data reinforce the importance of systematically recording ethnicity and skin phototype in future AD cohorts from the region.[44]

In contrast to data from North America and Europe, where population-based and cohort studies have shown that hidradenitis suppurativa (HS) disproportionately affects Black and other racial/ethnic minority populations, with higher prevalence and greater disease severity and health-care utilization compared with White patients,[85–87] HS studies from Latin America almost never include ethnicity or skin phototype, and none have formally compared outcomes across ethnic groups. This represents a major knowledge gap given the high proportion of Afro-descendant and mixed-ancestry populations in several Latin American countries.

Beyond biological and phenotypic differences, Indigenous and Afro-descendant communities, as well as people living in rural or marginalized urban areas, often face structural barriers to dermatologic care, including limited specialist availability, lower health-insurance coverage, and discrimination within health systems. Most of the studies included in this review do not report results disaggregated by ethnicity, skin phototype, or key social determinants of health, which limits our ability to quantify ethnic differences in disease burden and outcomes or to document inequities in access to care. Future research in inflammatory skin diseases in Latin America should systematically collect and report these variables, include under-represented populations, and explicitly address both biological and social contributors to inequity.

For alopecia areata, epidemiologic data from Latin America are limited, and existing series from Mexico, Peru, Colombia, Brazil and Chile do not report outcomes stratified by ethnicity or skin phototype.[17] A recent regional review emphasizes that most information on racial/ethnic differences in AA comes from UK and US cohorts, where AA appears more prevalent in Black populations than in white or Asian individuals, but comparable analyses are not yet available from Latin America.[17]

Conclusion

Inflammatory skin diseases in LA—psoriasis, atopic dermatitis, hidradenitis suppurativa, and alopecia areata—mirror global trends in immunopathogenesis and therapeutic innovation but remain deeply shaped by structural inequities. National and regional guidelines are increasingly evidence-based and aligned with international standards; however, their implementation is limited by economic, regulatory, and infrastructural barriers. Although real-world data are emerging, they remain fragmented and country-specific. Expanding multicenter registries, strengthening training in primary and dermatologic care, and developing regionally adapted, resource-sensitive treatment pathways are critical next steps in this regard. Achieving equitable access to biologic and targeted therapies will depend not only on scientific progress but also on coordinated health policies that address the social and systemic determinants of inequality in LA.

This narrative review did not aim to exhaustively catalogue all national policies, regulatory frameworks or clinical trials across Latin America; instead, we prioritized peer-reviewed evidence and widely cited regional or national documents that illustrate the main structural barriers and opportunities. Future studies should systematically compare access, treatment patterns and outcomes in Latin America with those in other middle-income regions and high-income countries to better contextualize the inequities described in this review.

Future studies should systematically compare access, treatment patterns and outcomes in Latin America with those in other middle-income regions and high-income countries to better contextualize the inequities described in this review.

Data Sharing Statement

Data sharing is not applicable to this article as no data were created or analyzed in this study.

Acknowledgments

The authors employed ChatGPT-5 and Paperpal exclusively for editorial refinement (grammar, style, and clarity). Elicit AI assisted in the literature search, in addition to PubMed and SciELO; selection and verification of sources were performed by the authors. Responsibility for the content rests solely with the authors.

Author Contributions

Conceptualization: LDM, ERS. Methodology: LDM, ERS. Investigation: MVA, MEC. Data curation: MVA, MEC. Writing – original draft: LDM, ERS. Writing – review and editing: LDM, MVA, MEC, ERS. Supervision: ERS.

All authors made a significant contribution to the work, took part in drafting or critically revising the article, gave final approval of the version to be published, agreed on the journal of submission, and agreed to be accountable for all aspects of the work.

Funding

No funding was received.

Disclosure

LDM: received advisory board fees, speaker fee from Abbvie, BMS, Raffo, Sanofi, Novartis and UCB. MVA: received speaker fee from Abbvie, Sanofi, L´oreal and BMS. MEC: received fees from Pfizer, Eli Lilly, and Raffo. ERS: received advisory board fees, speaker fees, and grants from AbbVie, Johnson & Johnson, Amgen, BMS, GSK, Janssen, Lilly, Novartis, Pfizer, Roche, Sandoz, Sanofi, and UCB.

References

1. Shirley SN, Watson AE, Yusuf N. Pathogenesis of Inflammation in Skin Disease: from Molecular Mechanisms to Pathology. *Int J Mol Sci*. 2024;25(18):10152. doi:10.3390/ijms251810152
2. UNDP. Trapped? Inequality and economic growth in Latin America and The Caribbean, 2025. 2025. Available from: https://www.undp.org/latin-america/publications/trapped-inequality-and-economic-growth-latin-america-and-caribbean?utm_source=chatgpt.com. Accessed Oct 17, 2025.
3. PAHO ECfLAatCEPAHO. The urgency of investing in health systems in Latin America and the Caribbean to reduce inequality and achieve the Sustainable Development Goals. 2025. Available from: https://www.paho.org/sites/default/files/2024-10/2400869esespecialhealthreport-web.pdf?utm_source=chatgpt.com. Accessed Oct 17, 2025.
4. Schmitt JV, Miot HA. Distribution of Brazilian dermatologists according to geographic location, population and HDI of municipalities: an ecological study. *An Bras Dermatol*. 2014;89(6):1013–1015. doi:10.1590/abd1806-4841.20143276
5. Parisi R, Iskandar IYK, Kontopantelis E, Augustin M, Griffiths CEM, Ashcroft DM. National, regional, and worldwide epidemiology of psoriasis: systematic analysis and modelling study. *BMJ*. 2020;369:m1590. doi:10.1136/bmj.m1590
6. Fernández-ávila DG, Prada-Vanegas JD, De la Espriella MC, Barahona-Correa JE, Charry LP, Cuellar I. Frequency of use and annual costs of biological therapy for psoriasis in Colombia in 2019. *Int J Dermatol*. 2024;63(11):e296–e301. doi:10.1111/ijd.17377
7. Fernández-Ávila DG, Charry Anzola LP, González-Cardona P. Prevalencia de psoriasis en Colombia según datos del Registro Nacional en Salud. *Actas Dermosifiliogr*. 2022;113(3):339–341. doi:10.1016/j.ad.2020.09.015
8. Suite M. The epidemiology of psoriasis in a dermatology clinic in a general hospital in Port-of-Spain, Trinidad and Tobago, West Indies. *West Indian Med J*. 2006;55(6):399–402. doi:10.1590/s0043-31442006000600006

9. Lecaros C, Dunstan J, Villena F, et al. The incidence of psoriasis in Chile: an analysis of the National Waiting List Repository. *Clin Exp Dermatol*. 2021;46(7):1262–1269. doi:10.1111/ced.14713
10. Soriano ER, Rosa J, Velozo E, et al. Incidence and prevalence of psoriatic arthritis in Buenos Aires, Argentina: a 6-year health management organization-based study. *Rheumatology*. 2011;50(4):729–734. doi:10.1093/rheumatology/keq369
11. Angles MV, Antonietti CA, Torre AC, Juszkiewicz Franze E, Mazzuoccolo LD, Parisi CAS. Prevalence of atopic dermatitis in adults. *An Bras Dermatol*. 2022;97(1):107–109. doi:10.1016/j.abd.2020.10.016
12. Ianhez M, Schmitt JV, Miot HA. Prevalence of hidradenitis suppurativa in Brazil: a population survey. *Int J Dermatol*. 2018;57(5):618–620. doi:10.1111/ijd.13937
13. Fernández-Ávila DG, Anzola LC, Cardona LPG. Prevalence of Hidradenitis Suppurativa in Colombia According to Data from the National Health Registry. *Skinmed*. 2021;19(5):369–373.
14. Zimman S, Comparatore MV, Vulcano AF, Absi ML, Mazzuoccolo LD. Hidradenitis Suppurativa: estimated Prevalence, Clinical Features, Concomitant Conditions, and Diagnostic Delay in a University Teaching Hospital in Buenos Aires, Argentina. *Actas Dermo-Sifiliográficas*. 2019;110(4):297–302. doi:10.1016/j.adengl.2019.03.016
15. Reyes-Baraona F, Matas C, Bouazzi D, Medianfar CE, Christensen R, Jemec GBE. Hidradenitis Suppurativa Prevalence in Santiago, Chile. *Dermatology*. 2025;241(Suppl. 1):30–34. doi:10.1159/000538423
16. Pineda JC, Alvis-Zakzuk NR, Moyano-Támara L, et al. Clinical and Sociodemographic Features of Alopecia Areata in Five Colombian Cities: an Analysis of the RENAAC Registry. *Actas Dermosifiliogr*. 2024;115(9):845–851. doi:10.1016/j.ad.2024.02.018
17. Velásquez-Lopera MM, Hernández N, Jansen AM, et al. Alopecia Areata in Latin America: where are We and Where are We Going? *Dermatol Ther*. 2023;13(1):95–114. doi:10.1007/s13555-022-00845-4
18. Hernandez-Vasquez A, Molinari L, Larrea N, Ciapponi A. Psoriasis in Latin America and the Caribbean: a systematic review. *J Eur Acad Dermatol Venereol*. 2017;31(12):1991–1998. doi:10.1111/jdv.14393
19. Espinoza LR, Toloza SM, Valle-Onate R, Mease PJ. Global partnering opportunities and challenges of psoriasis and psoriatic arthritis in Latin America: a report from the GRAPPA 2010 annual meeting. *J Rheumatol*. 2012;39(2):445–447. doi:10.3899/jrheum.111246
20. Chouela E, Amaya M, Londoño A, et al. Psoriasis in Latin America. *Dermatol Online J*. 2016;22(9):1.
21. Toloza SM, Valle-Onate R, Espinoza LR. Psoriatic arthritis in South and Central America. *Curr Rheumatol Rep*. 2011;13(4):360–368. doi:10.1007/s11926-011-0185-7
22. Gamarra AI, Peñaranda E, Hernando P, et al. Historia de la Artritis Psoriática. Primera parte. Desde Alibert hasta V. Wright. *Revista Colombiana de Reumatología*. 2010;17(1):22–34. doi:10.1016/S0121-8123(10)70090-6
23. folhadelondrina. DIPnspdpn. Preconceito é desafio para pacientes com psoríase. 2025. Available from: https://www.folhadelondrina.com.br/saude/preconceito-e-desafio-para-pacientes-com-psoriase-3040118e.html. Accessed Oct 12, 2025.
24. SPd L-RJCQ-VMAM-SGC-RYL-VML-P-PFJ-S. Late diagnosis of psoriasis: reasons and consequences. *Gac Med Mex*. 2017;153:305–312.
25. Ossanai Schoenardie B, Oliveira Almeida R, Hanemann T, Ossanai Schoenardie A, Ribeiro AL, Catucci Boza J. Unmet needs in the management of psoriasis in Latin America: a systematic review. *An Bras Dermatol*. 2024;99(2):244–258. doi:10.1016/j.abd.2023.04.006
26. Silva JBD, Wright AK, Carvalho AVE, Griffiths CEM, Ashcroft DM. Experience of living with psoriasis in Brazil: a Global Psoriasis Atlas online survey. *Int J Dermatol*. 2025;64(2):325–332. doi:10.1111/ijd.17387
27. Soriano ER, Marin J, Acosta-Felquer ML. Psoriatic arthritis: new evidence for old concepts. *Curr Opin Rheumatol*. 2018;30(1):87–93. doi:10.1097/bor.0000000000000468
28. Herrera-Sanchez DA, Hernandez-Ojeda M, Vivas-Rosales IJ. Epidemiological study on atopic dermatitis in Mexico. *Rev Alerg Mex*. 2019;66(2):192–204. doi:10.29262/ram.v66i2.591
29. Silverberg JI. Adult-Onset Atopic Dermatitis. *J Allergy Clin Immunol Pract*. 2019;7(1):28–33. doi:10.1016/j.jaip.2018.09.029
30. Arruda LK, Yang AC, Aoki V, et al. Clinical Features and Disease Management in Adult Patients With Atopic Dermatitis Receiving Care at Reference Hospitals in Brazil: the ADAPT Study. *J Investig Allergol Clin Immunol*. 2021;31(3):236–245. doi:10.18176/jiaci.0478
31. Orfali RL, Shimizu MM, Takaoka R, et al. Atopic dermatitis in adults: clinical and epidemiological considerations. *Rev Assoc Med Bras*. 2013;59(3):270–275. doi:10.1016/j.ramb.2012.12.004
32. Sánchez J, Ale I-S, Angles MV, et al. Healthcare Disparities in Atopic Dermatitis in Latin America: a Narrative Review. *Dermatol Ther*. 2023;13(2):399–416. doi:10.1007/s13555-022-00875-y
33. Echeverría C, Angles MV, Larralde M, Luna PC, Mazzuoccolo LD, Moreno P. Impact of atopic dermatitis on quality of life: a large web-based survey from Argentina. *Rev Fac Cien Med Univ Nac Cordoba*. 2022;79(4):369–373. doi:10.31053/1853.0605.v79.n4.36743
34. Bouazzi D, Nielsen SM, Hagan PG, et al. Prevalence of Hidradenitis Suppurativa: a Meta-Analysis of Global Hidradenitis Suppurativa Atlas Studies. *JAMA Dermatol*. 2025;161(10):1022–1028. doi:10.1001/jamadermatol.2025.2373
35. Aparício Martins I, Figueira Vilela B, Cabete J. Diagnostic Delay in Hidradenitis Suppurativa: still an Unsolved Problem. *Skin Appendage Disord*. 2024;10(2):129–132. doi:10.1159/000534845
36. Bellei EA, Shirozaki MEM, Puglia ALP, et al. Requirements for Brazilian Outpatient Centers of Excellence in Hidradenitis Suppurativa: Consensus Co-Creative Study. *Clin Cosmet Invest Dermatol*. 2023;16:2029–2044. doi:10.2147/ccid.S420750
37. Magalhaes RF, Rivitti-Machado MC, Duarte GV, et al. Consensus on the treatment of hidradenitis suppurativa - Brazilian Society of Dermatology. *An Bras Dermatol*. 2019;94(Suppl 1):7–19. doi:10.1590/abd1806-4841.20198607
38. Juárez-Rendón KJ, Rivera Sánchez G, Reyes-López M, et al. Alopecia Areata. Current situation and perspectives. *Arch Argent Pediatr*. 2017;115(6):e404–e411. doi:10.5546/aap.2017.eng.e404
39. Mostaghimi A, Gao W, Ray M, et al. Trends in Prevalence and Incidence of Alopecia Areata, Alopecia Totalis, and Alopecia Universalis Among Adults and Children in a US Employer-Sponsored Insured Population. *JAMA Dermatol*. 2023;159(4):411–418. doi:10.1001/jamadermatol.2023.0002
40. Müller Ramos P, Anzai A, Duque-Estrada B, et al. II Consensus of the Brazilian Society of Dermatology for the treatment of alopecia areata. *An Bras Dermatol*. 2025;100(2):328–341. doi:10.1016/j.abd.2024.10.001
41. SOLAPSO. 2025. Available from: https://solapso.com/pacientes/?utm_source=chatgpt.com. Accessed 3, December 2025.
42. Globalskin. 2025. Available from: https://globalskin.org/member-community/communities-2/90-meet-the-member/393-meet-the-member-asociacion-de-dermatitis-atopica-argentina-adar?utm_source=chatgpt.com. Accessed 3, December 2025.

43. Ruano AL, Rodríguez D, Rossi PG, Maceira D. Understanding inequities in health and health systems in Latin America and the Caribbean: a thematic series. *Int J Equity Health*. 2021;20(1):94. doi:10.1186/s12939-021-01426-1
44. Borzutzky A, Larco JI, Luna PC, et al. Atopic Dermatitis in Latin America: a Roadmap to Address Data Collection, Knowledge Gaps, and Challenges. *Dermatitis*. 2022;33(6s):S83–s91. doi:10.1097/der.0000000000000904
45. Soares GB, Orfali RL, Averbach BL, Yosipovitch G, Aoki V. Atopic Dermatitis in Latin America: considerations on Epidemiology, Clinical and Laboratory Features, Ethnic/Racial Variations, and Therapeutic Management. *J Clin Med*. 2023;12(10):3419.
46. IQVIA. FIFARMA Patient W.A.I.T. Indicator 2025 — Latin America. 2025. Available from: https://fifarma.org/wp-content/uploads/2025/05/FIFARMA-PATIENT-WAIT-INDICATOR-2025.pdf. Accessed Oct 16, 2025.
47. Maul JT, Fröhlich F, Maul LV, et al. Access to psoriasis treatment in Brazil and Chile: a cross-sectional multicentre Global Healthcare Study on Psoriasis. *Br J Dermatol*. 2023;188(4):533–541. doi:10.1093/bjd/ljac128
48. Lopes N, Suzuki C, Machado P. PSY136 - Access To Psoriasis Drug Treatment Among Brazilian Patients. *Value Health*. 2017;20(9):A568. doi:10.1016/j.jval.2017.08.963
49. Acosta Felquer ML, LoGiudice L, Galimberti ML, Rosa J, Mazzuoccolo L, Soriano ER. Treating the skin with biologics in patients with psoriasis decreases the incidence of psoriatic arthritis. *Ann Rheum Dis*. 2022;81(1):74–79. doi:10.1136/annrheumdis-2021-220865
50. Takeshita J, Gelfand JM, Li P, et al. Psoriasis in the US Medicare Population: prevalence, Treatment, and Factors Associated with Biologic Use. *J Invest Dermatol*. 2015;135(12):2955–2963. doi:10.1038/jid.2015.296
51. Aguiar Júnior Ndos R, Costa IM. The use of alternative or complementary medicine for children with atopic dermatitis. *An Bras Dermatol*. 2011;86(1):167–168. doi:10.1590/s0365-05962011000100033
52. Aea L. Consenso Nacional de Psoriasis. Available from: https://sad.org.ar/wp-content/uploads/2024/08/CONSENSO-NACIONAL-PSORIASIS-2024.pdf. Accessed Dec 20, 2025.
53. Romiti R, Carvalho AVE, Duarte GV. Brazilian Consensus on Psoriasis 2020 and Treatment Algorithm of the Brazilian Society of Dermatology. *An Bras Dermatol*. 2021;96(6):778–781. doi:10.1016/j.abd.2021.03.007
54. Ayarza JRC. Guía de práctica clínica para el tratamiento de la psoriasis en Colombia. Available from: https://psoriasiscouncil.org/wp-content/uploads/2025/04/2022-Colombia_gui%C2%B4as_basadas_en_la_evidencia_para_el_manejo_de_la_psoriasis_en_colombia_-_es.pdf. Accessed Dec 20, 2025
55. Podoswa-Ozerkovsky N, Amaya-Guerra M, Barba-Gómez JF, et al. Expert recommendations for biological treatment in patients with psoriasis. *Gac Med Mex*. 2020;156(5):446–453. doi:10.24875/gmm.M20000441
56. Angles MV. Guía Argentina De Práctica Clínica Orientada A La Terapéutica De Niños/As, Adolescentes Y Adultos Con Dermatitis Atópica. 2025. Available from: https://sad.org.ar/wp-content/uploads/2024/04/Guia-Argentina-de-practica-clinica-orientada-a-la-terapeutica-de-ninosas-adolescentes-y-adultos-con-Dermatitis-Atopica-2024.pdf. Accessed Oct 15, 2025.
57. Orfali RL, Lorenzini D, Bressan A, et al. Consensus on the therapeutic management of atopic dermatitis – Brazilian Society of Dermatology: an update on phototherapy and systemic therapy using e-Delphi technique. *An Bras Dermatol*. 2023;98(6):814–836. doi:10.1016/j.abd.2023.04.003
58. Arenas-Soto C, Sanclemente G, Yepes-Nuñez J, et al. Diagnóstico y tratamiento de la dermatitis atópica en Colombia. Actualización de la guía de práctica clínicaDiagnosis and treatment of atopic dermatitis in Colombia: update of the clinical practice guideline. *Revista de la Asociación Colombiana de Dermatología y Cirugía Dermatológica*. 2024. doi:10.29176/2590843X.2040
59. Cea G. CONSENSO NACIONAL HIDRADENITIS SUPURATIVA GUÍA DE TRATAMIENTO Actualización 2024. 2025. Available from: https://sad.org.ar/wp-content/uploads/2024/10/CONSENSO-NACIONAL-HIDRADENITIS-SUPURATIVA-2024-GF.pdf. Accessed Oct 17, 2025.
60. Lavieri A. Consenso Nacional de Hidradenitis Supurativa. 2025. Available from: https://sad.org.ar/wp-content/uploads/2019/12/Consenso-Hidradenitis-Supurativa-2019-14112019.pdf. Accessed Oct 17, 2025.
61. SOLAPSO. Consenso Latinoamericano de Psoriasis Guías de Tratamiento. 2025. Available from: https://soarpso.org/recursos/archivos/consenso_lat_psoriasis.pdf. Accessed Oct 15, 2025.
62. Londoño-García AM, Castro-Ayarza JR, Franco Franco MD, et al. Latin American consensus on psoriasis severity classification. *An Bras Dermatol*. 2025;100(3):539–547. doi:10.1016/j.abd.2024.09.010
63. Londoño-García A, Castro-Ayarza J, Franco M, et al. Latin American consensus on tapering of biological therapy in psoriasis. *Anais brasileiros de dermatologia*. 2025;100:501134. doi:10.1016/j.abd.2025.501134
64. Castro-Ayarza JR, Barbosa-Rengifo M, Franco-Franco M, et al. Biological therapy optimization in patients with psoriasis by reducing the dose or increasing the time interval. *Revista Colomb Reumatol*. 2023;30:S65–S69. doi:10.1016/j.rcreue.2023.02.008
65. Espinoza Hernández CJ, Lacy Niebla RM, Soto López ME, Kresch Tronik NS, Vega-Memije ME.Prevalence of metabolic syndrome in patients with psoriasis. *Gac Med Mex*. 2014;150(4):311–316.
66. Rodríguez-Zúñiga MJM, Cortez-Franco F, Quijano-Gomero E. Association of Psoriasis and Metabolic Syndrome in Latin America: a Systematic Review and Meta-Analysis. *Actas Dermo-Sifiliográficas*. 2017;108(4):326–334. doi:10.1016/j.adengl.2017.03.008
67. Valenzuela F, De La Cruz C, Lecaros C, et al. Comorbidities in Chilean patients with psoriasis: a Global Healthcare Study on Psoriasis. *Clin Exp Dermatol*. 2022;47(12):2234–2241. doi:10.1111/ced.15384
68. Anselmi CLG ML, De Luca DA, Torre AC:, Giors GV, Galimberti RL. Psoriasis: prevalencia de comorbilidades cardiovasculares en la población del Plan de Salud del Hospital Italiano de Buenos Aires. Estudio de corte 2010. *Dermatol Argent*. 2012;18(3):239–244.
69. Jea M. Guías para el Diagnóstico y Tratamiento de la Dermatitis Atópica 2019. 2025. Available from: https://alergia.org.ar/pdfs/guias_argentinas_dermatitis_atopica_2019.pdf. Accessed Oct 15, 2025.
70. Mdssdaeà S. Protocolo Clínico E Diretrizes Terapêuticas Dermatite Atópica. Accessed 19/Oct/2025, 2025. Available from: https://www.gov.br/conitec/pt-br/midias/protocolos/portaria-conjunta-saes-sectics-no-34-pcdt-dermatite-atopica.pdf?. Accessed Oct 19, 2025.
71. Papp KA, Gooderham M, Dei-Cas I, et al. Effectiveness and Safety of Secukinumab in Latin American Patients with Moderate to Severe Plaque Psoriasis: PURE Registry 12-Month Data. *Dermatol Ther*. 2023;13(1):269–283. doi:10.1007/s13555-022-00849-0
72. Castro Ayarza J. Persistencia de la terapia biológica en una cohorte de pacientes con diagnóstico de psoriasis en un centro especializado en Colombia. 2025. Available from: https://hdl.handle.net/1992/73173. Accessed Oct 17, 2025.
73. Pinter A, Puig L, Schäkel K, et al. Comparative effectiveness of biologics in clinical practice: week 12 primary outcomes from an international observational psoriasis study of health outcomes (PSoHO). *J Eur Acad Dermatol Venereol*. 2022;36(11):2087–2100. doi:10.1111/jdv.18376

74. Pérez CR, Aoki V, Criado RF, et al. The real-world burden of atopic dermatitis: MEASURE-AD results from Brazil, Mexico, and Argentina. *An Bras Dermatol*. 2025;100(3):470–486. doi:10.1016/j.abd.2024.05.011
75. Costa CDD, Dortas SD, Lupi O. A real-world study in Brazilian patients with atopic dermatitis treated with dupilumab who previously received methotrexate and cyclosporine. *Allergol Immunopathol*. 2025;53(4):149–152. doi:10.15586/aei.v53i4.1311
76. Shih T, Seivright J, Thompson AM, Atluri S, Shi VY, Hsiao JL. Hidradenitis suppurativa publication trends from Latin America from 2009 to 2019: a bibliometric analysis. *Int J Womens Dermatol*. 2022;8(1):e007. doi:10.1097/jw9.0000000000000007
77. Rivitti-Machado MC, Ferreira Magalhães R, Souto da Silva R, et al. Therapies for hidradenitis suppurativa: a systematic review with a focus on Brazil. *Drugs Context*. 2022;11:1. doi:10.7573/dic.2021-9-6
78. Vogel Agoglia C, Machado S, Bazzano C, Magliano J. Tratamiento quirúrgico en la hidradenitis supurativa: análisis de una serie de casos. *Piel*. 2022;2022:1.
79. Figueroa-Diaz A, Medina-Figueroa M, Rivera-Criado M, Cruz-Santana A. 44310 Safety and Efficacy of Adalimumab for Hidradenitis Suppurativa in a Hispanic Population. *J Am Acad Dermatol*. 2023;2023:2.
80. Miot HA, Penna GO, Ramos AMC, et al. Profile of dermatological consultations in Brazil. *An Bras Dermatol*. 2018;93(6):916–928. doi:10.1590/abd1806-4841.20188802
81. Lopes ASA, Santos LDN, Razé MC, Lazzarini R. Alopecia areata: descriptive analysis in a Brazilian sample. *An Bras Dermatol*. 2022;97(5):654–656. doi:10.1016/j.abd.2021.04.016
82. Ortiz-Ramírez A, Hernández-Jiménez MC, Guardiola-Avila IB, et al. HR Gene Variants Identified in Mexican Patients with Alopecia Areata. *Curr Issues Molecular Biol*. 2023;45(4):2965–2971.
83. Porto Ferreira C, Martins CJ, Issa PR, de Vasconcellos Carvalhaes de Oliveira R, Da-Cruz AM. Psoriasis affects individuals of African descent and white Brazilians similarly. 10.1016/j.ad.2009.09.008. *Actas Dermo-Sifiliográficas*. 2010;101(3):230–234. doi:10.1016/j.ad.2009.09.008
84. Toloza SM, Vega-Hinojosa O, Chandran V, Valle Onate R, Espinoza LR. Psoriasis and psoriatic arthritis in Peruvian aborigines: a report from the GRAPPA 2011 annual meeting. *J Rheumatol*. 2012;39(11):2216–2219. doi:10.3899/jrheum.120828
85. Edigin E, Kaul S, Eseaton PO, Albrecht J. Racial and Ethnic Distribution of Patients Hospitalized With Hidradenitis Suppurativa, 2008–2018. *JAMA Dermatol*. 2021;157(9):1125–1127. doi:10.1001/jamadermatol.2021.2999
86. Jaleel T, Mitchell B, Burge R, et al. Exploring racial and ethnic disparities in the hidradenitis suppurativa patient disease journey: results from a real-world study in Europe and the USA. *J Dermatol*. 2024;51(12):1547–1558. doi:10.1111/1346-8138.17386
87. Sachdeva M, Shah M, Alavi A. Race-Specific Prevalence of Hidradenitis Suppurativa. *J Cutan Med Surg*. 2021;25(2):177–187. doi:10.1177/1203475420972348