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Behind the Breakout: Acne as a Meaningful Side Effect of JAK Inhibitors for IBD

**Ryan Quigley:**
Janus kinase, or JAK, inhibitors have transformed care for patients with inflammatory bowel disease, also known as IBD, as they offer powerful, targeted control of inflammation when other therapies fall short. But as their use expands, so does recognition of a distinct and often unexpected side effect: acne.

This is *AudioAbstracts* on ReachMD, and I'm Ryan Quigley.

Until now, clinicians have had limited real-world data to guide counseling and management for JAK inhibitor–associated acne. That's why in a new international study published in *Clinical Gastroenterology and Hepatology*, investigators set out to better define how often JAK inhibitor–associated acne occurs in IBD, what it looks like clinically, and how it's managed in practice.

This was a large, multicenter, retrospective cohort study spanning 25 tertiary IBD centers across Europe and Asia. Investigators reviewed outcomes from more than 2,000 adults with Crohn's disease or ulcerative colitis who were treated with a JAK inhibitor between 2019 and 2024. The drugs included upadacitinib, tofacitinib, and filgotinib. Among these patients, the team identified 272 individuals who developed acne after starting therapy, creating the largest cohort of JAK inhibitor–induced acne described to date.

So, just how common was it?

Overall, new-onset acne developed in about one in nine JAK inhibitor–treated patients. But the risk varied substantially by drug and dose. Upadacitinib stood out, with a prevalence of nearly 16 percent, compared with just over four percent for tofacitinib and under two percent for filgotinib. For both upadacitinib and tofacitinib, higher doses were associated with higher acne rates, highlighting a clear dose-dependent relationship.

And from a clinical standpoint, acne most often appeared early. The median time to onset was about seven weeks after starting a JAK inhibitor, and nearly 70 percent of cases occurred within the first three months. Lesions typically involved the face, followed by the back and chest, and were most often papules and pustules. Importantly, the majority of cases were mild to moderate. Only eight percent met criteria for severe disease, defined as involvement of more than 30 percent of body surface area.

But severity on paper didn't always tell the full story.

About one-third of patients reported a negative impact on psychological well-being, and nearly one in 10 described reduced adherence to their IBD therapy because of acne. Patients with nodular or cystic lesions, or those with extensive involvement, were more likely to experience scarring or pigmentary changes. Interestingly, a prior history of acne vulgaris emerged as a key risk factor, increasing the odds of severe acne nearly five-fold and the risk of dermatologic complications almost four-fold.

In terms of treatment, management strategies varied widely across study centers. Roughly 40 percent of patients received pharmacologic treatment for acne, most commonly topical agents such as antibiotics, benzoyl peroxide, or retinoids. And about half of those treated topically experienced improvement or resolution. Systemic therapies, including oral antibiotics and isotretinoin, were reserved for more refractory cases and were generally effective.

Now, it's important to note that 18 percent of patients required dose reduction or discontinuation of the JAK inhibitor because of acne. And strikingly, most of those patients did not have objectively severe disease, underscoring how even mild to moderate skin toxicity can drive major treatment decisions.

So, why does this study matter for everyday practice?

Well, first, these findings confirm that acne is not a rare nuisance side effect, especially with upadacitinib, but a common and clinically meaningful issue. Second, they highlight the importance of proactive counseling. Patients should know that acne often develops early, is usually manageable, and does not necessarily signal treatment failure. Third, identifying patients with a history of acne vulgaris may help clinicians anticipate who is at higher risk for severe or complicated disease.

However, the authors also acknowledge key limitations that are important to consider. This was a retrospective study relying on routine clinical documentation, so milder cases may have been underreported. Most patients were treated at tertiary centers, which may limit generalizability, and the cohort was predominantly White, underscoring the need for more diverse representation. And finally, the study could not establish true incidence rates or causal mechanisms.

But even with these limitations, this work fills an important knowledge gap, and the take-home message is clear: JAK inhibitor–induced acne is common, often dose-related, and carries a real psychological burden. Early recognition, patient education, timely use of topical therapies, and collaboration between gastroenterologists and dermatologists can help keep patients on effective IBD treatment, while minimizing the impact of this visible side effect.

This has been an *AudioAbstract*, and I'm Ryan Quigley. To access this and other episodes in our series, visit ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!

**Reference:**

Honap S, Temido MJ, Shakweh E, et al. Janus Kinase (JAK) Inhibitor-Induced Acne in Inflammatory Bowel Disease: An International, Multicenter, Retrospective Cohort Study. *Clin Gastroenterol Hepatol*. Published online June 11, 2025. doi:10.1016/j.cgh.2025.04.031