BACKGROUND
Interleukin-17A is considered to be central to the pathogenesis of psoriasis. We evaluated secukinumab, a fully human anti–interleukin-17A monoclonal antibody, in patients with moderate-to-severe plaque psoriasis.

METHODS
In two phase 3, double-blind, 52-week trials, ERASURE (Efficacy of Response and Safety of Two Fixed Secukinumab Regimens in Psoriasis) and FIXTURE (Full Year Investigative Examination of Secukinumab vs. Etanercept Using Two Dosing Regimens to Determine Efficacy in Psoriasis), we randomly assigned 738 patients (in the ERASURE study) and 1306 patients (in the FIXTURE study) to subcutaneous secukinumab at a dose of 300 mg or 150 mg (administered once weekly for 5 weeks, then every 4 weeks), placebo, or (in the FIXTURE study only) etanercept at a dose of 50 mg (administered twice weekly for 12 weeks, then once weekly). The objective of each study was to show the superiority of secukinumab over placebo at week 12 with respect to the proportion of patients who had a reduction of 75% or more from baseline in the psoriasis area- and-severity index score (PASI 75) and a score of 0 (clear) or 1 (almost clear) on a 5-point modified investigator’s global assessment (coprimary end points).

RESULTS
The proportion of patients who met the criterion for PASI 75 at week 12 was higher with each secukinumab dose than with placebo or etanercept: in the ERASURE study, the rates were 81.6% with 300 mg of secukinumab, 71.6% with 150 mg of secukinumab, and 4.5% with placebo; in the FIXTURE study, the rates were 77.1% with 300 mg of secukinumab, 67.0% with 150 mg of secukinumab, 44.0% with etanercept, and 4.9% with placebo (P<0.001 for each secukinumab dose vs. comparators). The proportion of patients with a response of 0 or 1 on the modified investigator’s global assessment at week 12 was...
higher with each secukinumab dose than with placebo or etanercept: in the ERASURE study, the rates were 65.3% with 300 mg of secukinumab, 51.2% with 150 mg of secukinumab, and 2.4% with placebo; in the FIXTURE study, the rates were 62.5% with 300 mg of secukinumab, 51.1% with 150 mg of secukinumab, 27.2% with etanercept, and 2.8% with placebo (P<0.001 for each secukinumab dose vs. comparators). The rates of infection were higher with secukinumab than with placebo in both studies and were similar to those with etanercept.

CONCLUSIONS
Secukinumab was effective for psoriasis in two randomized trials, validating interleukin-17A as a therapeutic target. (Funded by Novartis Pharmaceuticals; ERASURE and FIXTURE ClinicalTrials.gov numbers, NCT01365455 and NCT01358578, respectively.)

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Drs. Langley and Elewski contributed equally to this article.

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A complete list of the investigators in the Efficacy of Response and Safety of Two Fixed Secukinumab Regimens in Psoriasis (ERASURE) and the Full Year Investigative Examination of Secukinumab versus Etanercept Using Two Dosing Regimens to Determine Efficacy in Psoriasis (FIXTURE) Study Groups is provided in the Supplementary Appendix, available at NEJM.org.

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