ASSOCIATION OF COMMUNITY CANCER CENTERS

IMMUNO-ONCOLOGY INSTITUTE

IO SUBSPECIALTY INSIGHT SERIES

Managing Dermatologic Adverse Events From Immunotherapy

JOSHUA ARBESMAN, MD

Dermatologic side effects, including various types of rash and pruritus, are among the most commonly occurring adverse events in patients being treated with immunotherapy. Immunotherapy rashes can not only include less serious conditions, such as limited eczematous or lichenoid reactions, but also can be quite severe, including significant psoriasis flares, bullous pemphigoid, and erythroderma secondary to multiple skin conditions. Critical to the successful management of these side effects is continuous communication among patients, their treating oncologists, and their dermatologists. This interaction can provide the foundation of a streamlined care management plan that takes into account specific patients' treatment goals and preferences. Often, this involves early intervention by dermatologists who focus on cutaneous immune-related adverse event (irAE) management—oncodermatologists—as part of the oncology team.

Oncodermatology is a rapidly developing field that is attracting significant interest and generating new literature in the context of cancer treatment strategies. It is important that dermatologists consult with their patients' oncologists when managing the skin side effects of cancer care, as the specific goals of immunotherapy (e.g., metastatic disease management vs. adjuvant therapy) often affects the dermatologic management of patients with cancer. Having this background early on prepares dermatologists to best meet individual patients' needs.

Each patient may have different expectations for their skin, hair, and nails during cancer treatment. It is valuable for dermatologists to establish at initial office visits the goals of care of specific patients and their expected toleration of skin disease persistence during their treatment. How patients view their goals of care guides the individualized approach to dermatologic management. While some patients are okay with having some skin reactions, others want their skin to clear faster. Especially when, for example, they have significant itch. This can mean choosing different dermatologic therapies for different patients (e.g., topical vs. systemic therapy), which can affect the length of immunotherapy treatment (e.g., prednisone use may necessitate immunotherapy cessation).

Also critical when treating patients with cancer is teaching them which skin signs to look for during treatment (particularly blisters on the skin) and when to contact a dermatologist. Some immunotherapy-related rashes can spread incredibly quickly, so patients should know to contact their dermatologist as soon as they start to notice significant changes to their skin. This allows us to initiate care faster, and potentially more aggressively.

Open communication between oncologists and dermatologists is especially critical in the case of potentially serious irAEs, such as bullous pemphigoid induced by immunotherapy, where early diagnosis is critical to providing proper management. In such cases, it is important that oncologists and dermatologists collaborate to obtain a skin biopsy prior to corticosteroid initiation, as this can interfere with biopsy results and compromise individual care plans based on those results.

At the Cleveland Clinic, I recently observed how regular communication among oncologists and dermatologists (via group emails, EMR messages, and communications through our multidisciplinary irAE board) accelerated a patient's approval for and receipt of rituximab for bullous pemphigoid, while also balancing the management of the patient's recurrent cancer. This proved to be an exceptional example of how effective communication among all parties involved in a patient's care is critical for supporting the dermatologic care of oncology patients.

Joshua Arbesman, MD, is a dermatologist and physician-investigator at the Cleveland Clinic. His clinical focus is on managing patients with high-risk skin cancers and melanoma and providing dermatologic care for the side effects of cancer treatment.

The ACCC Immuno-Oncology Institute is supported by Bristol-Myers Squibb (charitable donation) and Merck & Co, Inc. (educational grant).