Sociedad Andaluza de Oncología Medica

I Reunión de manejo de los efectos secundarios inmunomediados
Córdoba, 13 de noviembre de 2019

Salón de usos múltiples del Edificio IMIBIC, Hospital Universitario Reina Sofía.
- Avda. Menéndez Pidal s/n. 14004 Córdoba -

Manejo de las toxicidad cutáneas

Presentación del algoritmo de diagnóstico y tratamiento

Dra. Sara Estalella Mendoza

VOLUME 36 · NUMBER 17 · JUNE 10, 2018

JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline

Julie R. Brahmer, Christina Lacchetti, Bryan J. Schneider, Michael B. Atkins, Kelly J. Brassil, Jeffrey M. Caterino, Ian Chau, Marc S. Ernstoff, Jennifer M. Gardner, Pamela Ginex, Sigrun Hallmeyer, Jennifer Holter Chakrabarty

Puzanov *et al. Journal for ImmunoTherapy of Cancer* (2017) 5:95
DOI 10.1186/s40425-017-0300-z

Journal for ImmunoTherapy of Cancer

POSITION ARTICLE AND GUIDELINES Open Access

Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group

I. Puzanov[1†], A. Diab[2†], K. Abdallah[3], C. O. Bingham III[4], C. Brogdon[5], R. Dadu[2], L. Hamad[1], S. Kim[2], M. E. Lacouture[6], N. R. LeBoeuf[7], D. Lenihan[8], C. Onofrei[9], V. Shannon[2], R. Sharma[1], A. W. Silk[12], D. Skondra[10], M. F. Suarez-Almazor[2],

Annals of Oncology 28 (Supplement 4): iv119–iv142, 2017
doi:10.1093/annonc/mdx225

NCCN National Comprehensive Cancer Network®

ESMO

CLINICAL PRACTICE GUIDELINES

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Management of Immunotherapy-Related Toxicities

Version 2.2019 — April 8, 2019
NCCN.org
Continue

Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up†

J. B. A. G. Haanen[1], F. Carbonnel[2], C. Robert[3], K. M. Kerr[4], S. Peters[5], J. Larkin[6] & K. Jordan[7], on behalf of the ESMO Guidelines Committee*

	IPILIMUMAB	ANTI-PD1	COMBINACIÓN	G3-G4
RASH MACULOPAPULAR	24 %	15 %	40 %	<3% monot <5% comb
PRURITO	25%-35%	13%-20%	33 %	<2.5%
VITILIGO (melanoma)	raro	8% 25% pembrolizumab	8 %	
TOTAL	37-70%	17-40%	**>%** **> severa** **> precoz**	1-3%

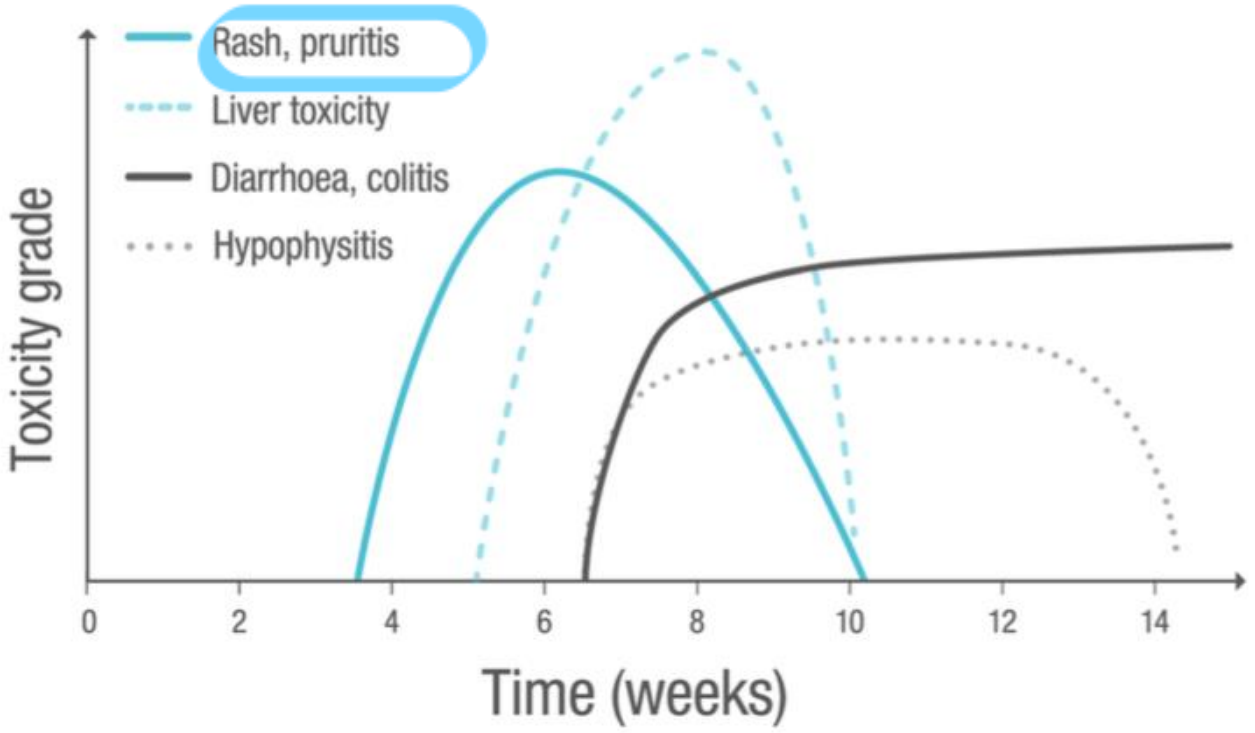
Alopecia
Rosácea
Repigmentación capilar
Psoriasiformes
Liquenoides
Eczematosas
Fotosensibilidad
Dermatitis bullosa
Sd Stevens-Johnson
Sd DRESS
Vasculitis

- Historia clínica: AP de enfermedades inflamatorias dermatológicas
- Exploración de piel y mucosas completa (de rutina en pacientes con AP)
- Monitorizar estado general del paciente, tipo de lesiones y BSA que ocupa.
- Descartar causa infecciosa, tóxico-medicamentosa o sistémica (hemograma, función hepática y renal)
- Valorar biopsia si hay dudas
- ¿Tomar fotografía?

CLINICAL PRACTICE GUIDELINES

Incidence and epidemiology

Time to onset and resolution of occurrence of immuno-related adverse events following Ipilimumab treatment



Weber JS et al. J Clin Oncol 2012;30:2691–2697.
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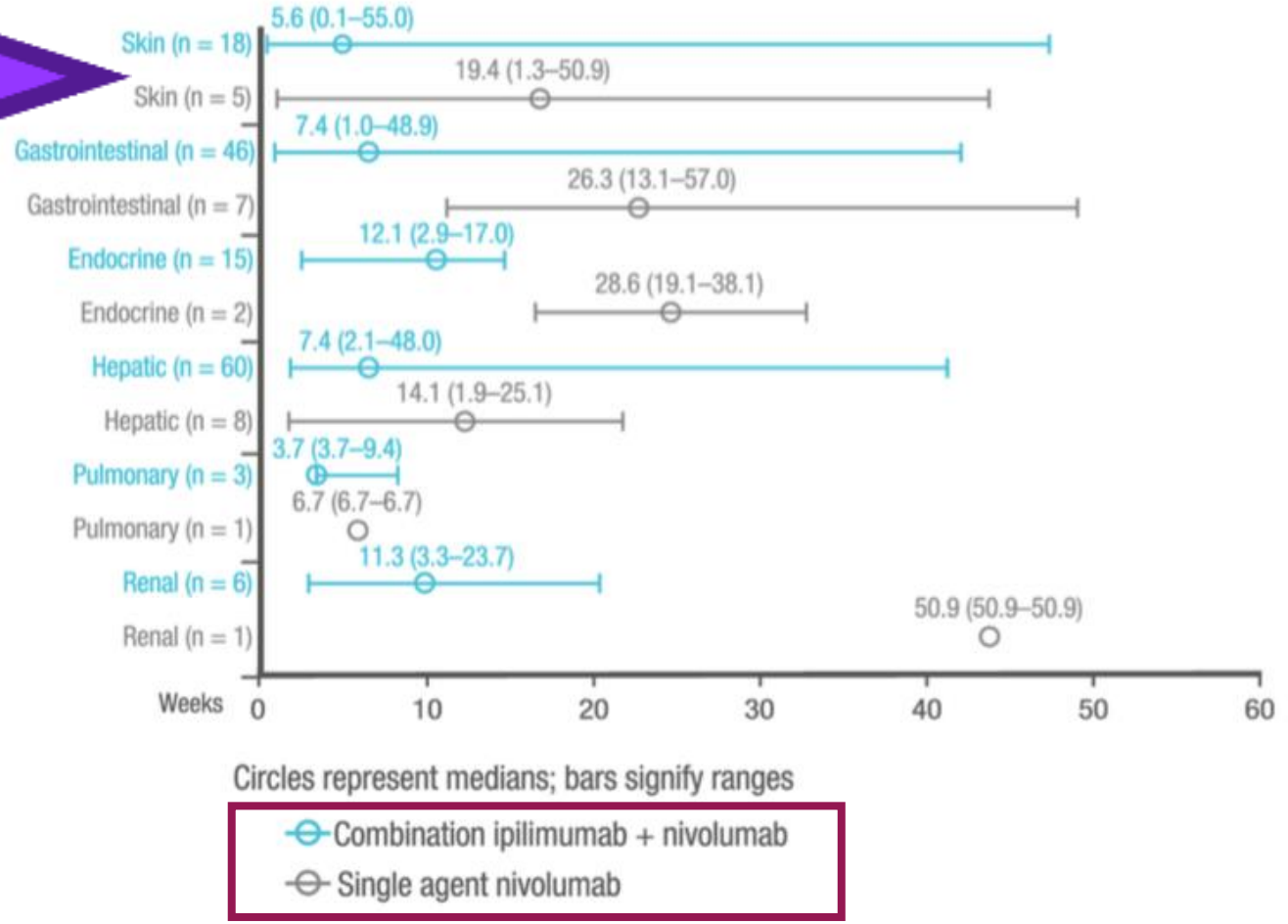
CLINICAL PRACTICE GUIDELINES

Incidence and epidemiology

Time to onset of grade 3-4 treatment-related select adverse events



Larkin J et al. Presented at ECC 2015;Abs330.
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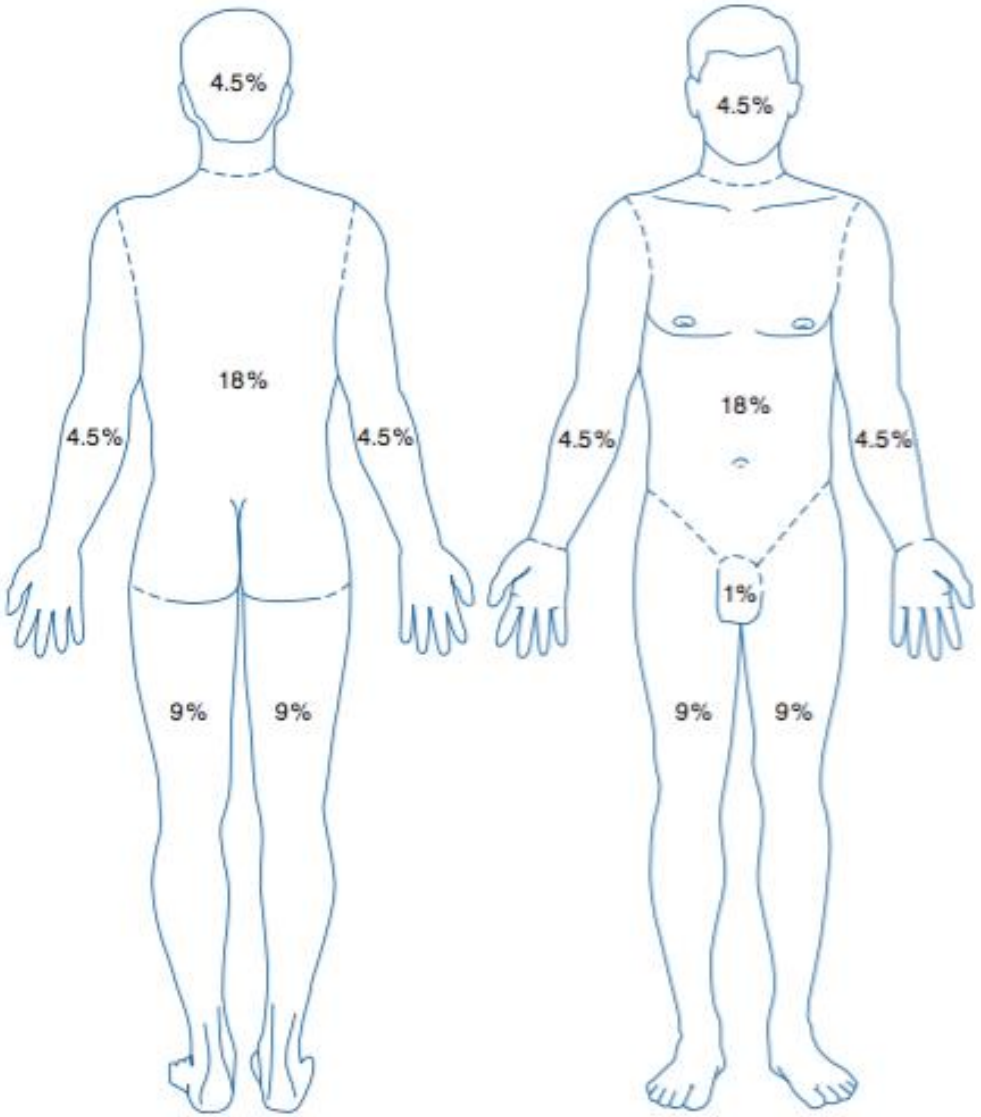

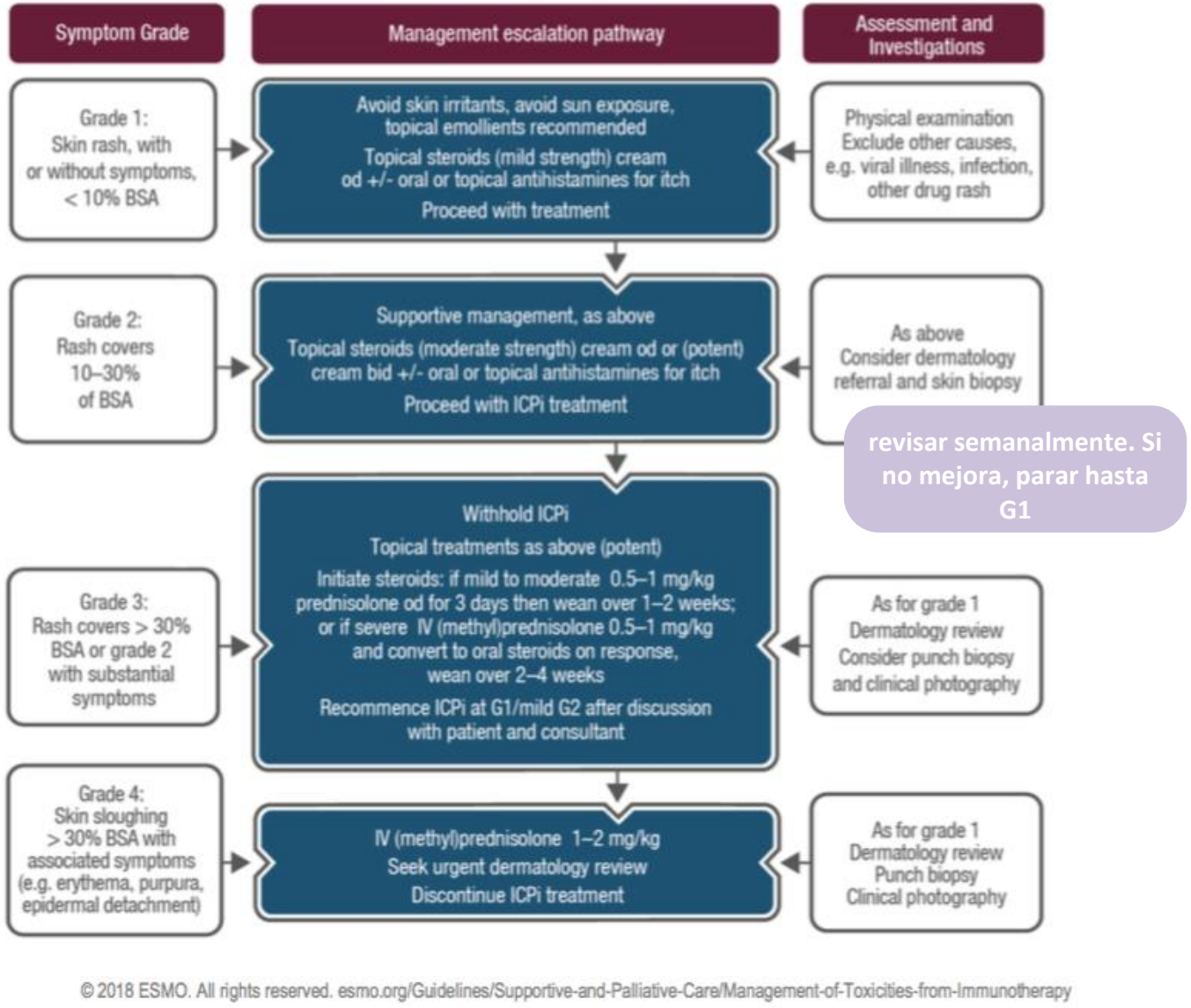

revisar semanalmente. Si no mejora, parar hasta G1

Pruritus*

CTCAE 4.0

Grade	Description
1	Mild or localized; topical intervention indicated
2	Intense or widespread; intermittent; skin changes from scratching (e.g., edema, papulation, excoriation, lichenification, oozing/crusts); oral intervention indicated; limiting instrumental ADL
3	Intense or widespread; constant; limiting self-care ADL or sleep; oral corticosteroid or immunosuppressive therapy indicated

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2019
Management of Immune Checkpoint Inhibitor-Related Toxicities

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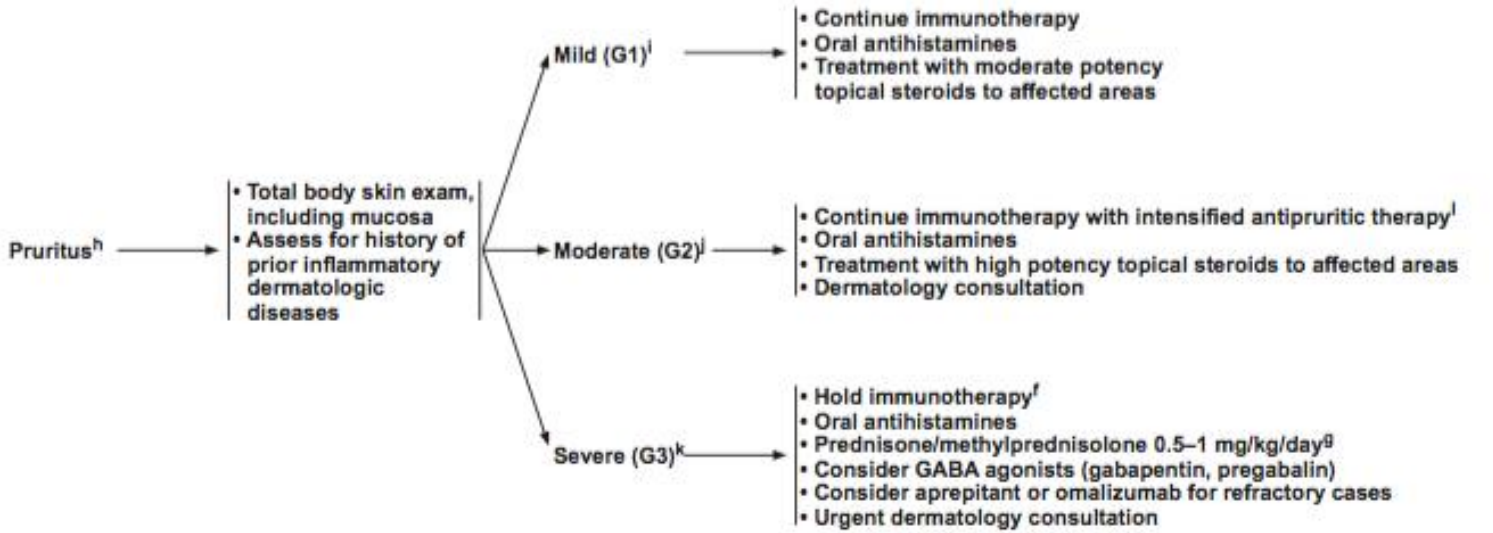

[e] See Principles of Immunosuppression (IMMUNO-A).
[f] See Principles of Immunotherapy Rechallenge (IMMUNO-C).
[g] Treat until symptoms improve to Grade ≤1 then taper over 4–6 weeks.
[h] Characterized by an intense itching sensation.
[i] Mild or localized.
[j] Intense or widespread; intermittent; skin changes from scratching (eg, edema, papulation, excoriations, lichenification, oozing/crusts); limiting iADLs.
[k] Intense or widespread; constant; limiting self-care ADLs or sleep. Assess serum IgE and histamine; consider oral antihistamines for increased histamine and omalizumab for increased IgE.
[l] Consider holding in select cases.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

ICI_DERM-2

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DERMATOLOGIC ADVERSE EVENT(S)	ASSESSMENT/GRADING		MANAGEMENT[e]
Bullous dermatitis[j,m]	Urgent dermatology consultation	Mild (G1)[o]	• Hold immunotherapy[f] • High potency topical steroids to affected areas
		Moderate (G2)[p]	• Hold immunotherapy until <G1[f] • Prednisone/methylprednisolone 0.5–1 mg/kg/day[g]
Stevens-Johnson syndrome (SJS)[n] Toxic epidermal necrolysis (TEN)[n]	Urgent dermatology consultation	Severe (G3)[q] OR Life-threatening (G4)[r]	• Permanently discontinue immunotherapy[f] • Prednisone/methylprednisolone 1–2 mg/kg/day[g] • Inpatient care required • Urgent dermatology, ophthalmology, and urology consultation

[e] See Principles of Immunosuppression (IMMUNO-A).
[f] See Principles of Immunotherapy Rechallenge (IMMUNO-C).
[g] Treat until symptoms improve to Grade ≤1 then taper over 4–6 weeks.
[j] Intense or widespread; intermittent; skin changes from scratching (eg, edema, papulation, excoriations, lichenification, oozing/crusts); limiting iADLs.
[m] Characterized by inflammation of the skin and the presence of bullae, which are filled with fluid.
[n] Stevens-Johnson syndrome/toxic epidermal necrolysis (SJS/TEN) should be treated as grade 3–4 bullous dermatitis. SJS, overlapping SJS/TEN, and TEN are characterized by separation of the dermis involving <10%, 10%–30%, and >30% BSA, respectively. The syndrome is thought to be a hypersensitivity complex affecting the skin and the mucous membranes.
[o] Asymptomatic; blisters covering <10% BSA.
[p] Blisters covering 10%–30% BSA; painful blisters; limiting iADLs.
[q] Blisters covering >30% BSA; limiting self-care ADLs.
[r] Blisters covering >30% BSA; associated with fluid or electrolyte abnormalities; intensive care unit (ICU) care or burn unit indicated.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

ICI_DERM-3

CONSULTA DERMATOLOGÍA URGENTE:
Ampollas >1% BSA
Rash con afectación de mucosas
Cualquier rash que afecte >30% BSA
Rash doloroso con/sin ampollas
Sospecha de vasculitis
Sospecha de SJS/TEN o DRESS

Potencia según clasificación europea		
CORTICOIDES TÓPICOS	Potencia I-II	*Hidrocortisona*
	Potencia II	*Fluocortina* *Clobetasona* *Fluocinolona al 0,01%*
	Potencia III	*Betametasona* *Metilprednisolona* *Mometasona* *Prednicarbato* *Fluocinolona al 0.025%*