MELANOMA AND MELANOCYTIC NAEVI

CUTANEOUS TOXICITIES ASSOCIATED WITH IMMUNE CHECKPOINT BLOCKADE THERAPY IN ADVANCED MELANOMA – EXPERIENCES FROM A TERTIARY ONCOLOGY CENTRE

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Introduction: Immune checkpoint blockade therapy (ICB) have transformed outcomes in patients with metastatic melanoma (MM) but immune-related toxicities affecting the skin are commonly reported.

Objective: To characterise cutaneous toxicities in MM patients treated with ICB therapy.

Materials and Methods: Retrospective review of ICB-treated MM patients at a tertiary oncology centre (Nov 2015 – Nov 2018). Demographic and clinicopathological data were collected for all patients presenting with cutaneous toxicity.

Results: Overall, 117 MM patients received ICB therapy (61M:56F; median age 67 years, range 21 – 88). Median follow-up was 12 months (range 0.3 – 38). Cutaneous toxicity was recorded in 41/117 (35%) Median time to onset for anti-CTLA-4/anti-PD1 combination treatment (n=20) was 21 days, compared to 70 days for patients treated with anti-PD1 inhibitors (n=21). Pruritus was the commonest symptom reported (n=28). Non-specific 'maculopapular' rash was reported in 24, vitiligo in 3 and bullous pemphigoid in 3 patients. No cases of mucosal involvement were reported. Skin biopsies were performed in 5/41 cases, 58% patients were referred to a Dermatologist, mean time to seeing Dermatology was 27 days (range 0 – 175 days). 27 (66%) patients with cutaneous toxicity experienced one or more concurrent toxicities (colitis:14, hepatitis:10, endocrinopathies:14, arthritis:4). Skin toxicities were predominantly low-grade (Grade 3 toxicity n=2). Management included emollients (n=18), oral antihistamines (n=16), topical steroids (n=19), oral steroids (n=7) and mycophenolate mofetil in 1. Three patients discontinued ICB therapy due to cutaneous toxicity, 6 patients interrupted ICB therapy due to multiple organ toxicities. Median time to resolution of rash was 28 days (range 7 – 35 days).

Conclusions: Cutaneous toxicity is a common early complication of combination ICB

therapy. Most cases are low-grade, do not require skin biopsy and can be managed effectively without delaying ICB therapy. However, to detect rare autoimmune manifestations, prompt referral to Dermatology is warranted for optimal management.