

# When to refer to a Dermatologist

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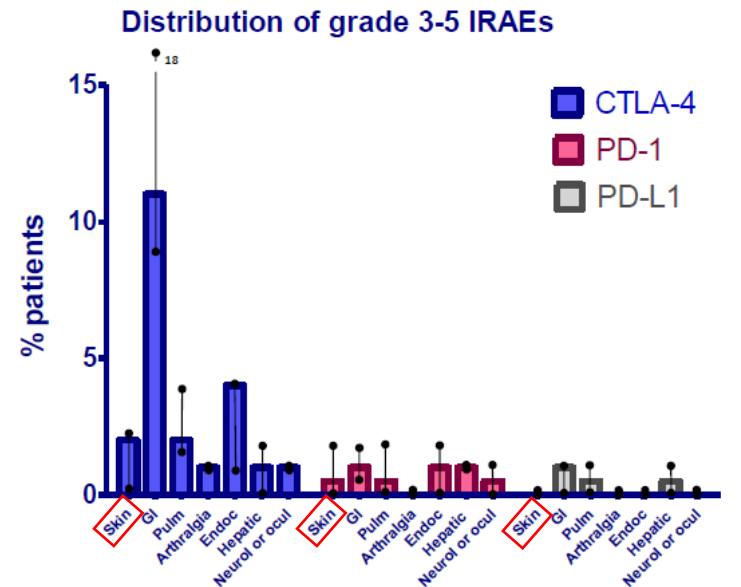
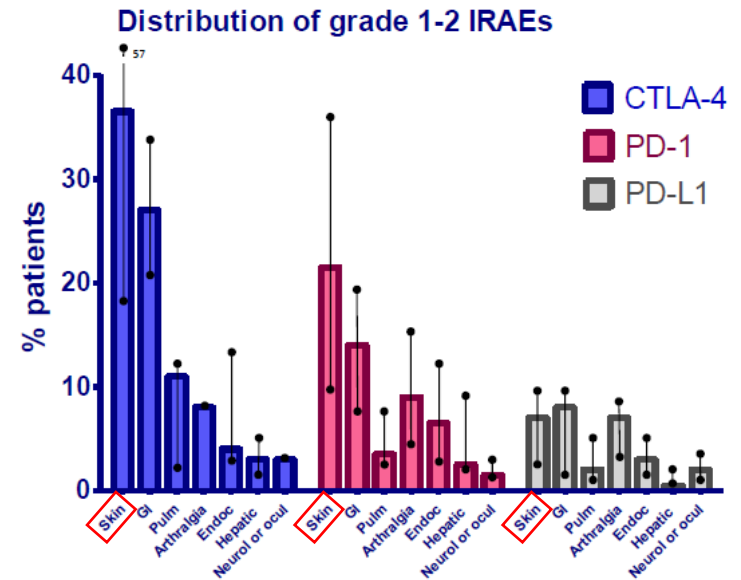


# Disclosures

- No relevant financial relationships to disclose
- I *will not* be discussing non-FDA approved indications during my presentation.

# Cutaneous adverse events

- All grade: 35-50%
- Grade 3 or more: 2%
- 20% experience skin AE-related interruption of therapy
- More reaction with anti-CTLA-4 than with anti-PD1/PDL1
- Onset of rash typically occurs around 3 weeks post-exposure



# National Cancer Institute Grading of Skin AEs

Grade	Skin lesion	BSA %	Symptomatic
1	Macules, papules	< 50%	No
2	Macules, papules	< 50%	Yes (pruritus, other)
3	Macules, papules, blisters	> 50%	Yes (pruritus, other)
4	Exfoliation, ulcer, blisters		Yes (pruritus, other)
5	Death		

Minkis, et al. "The risk of rash associated with...." JAAD. 2013.

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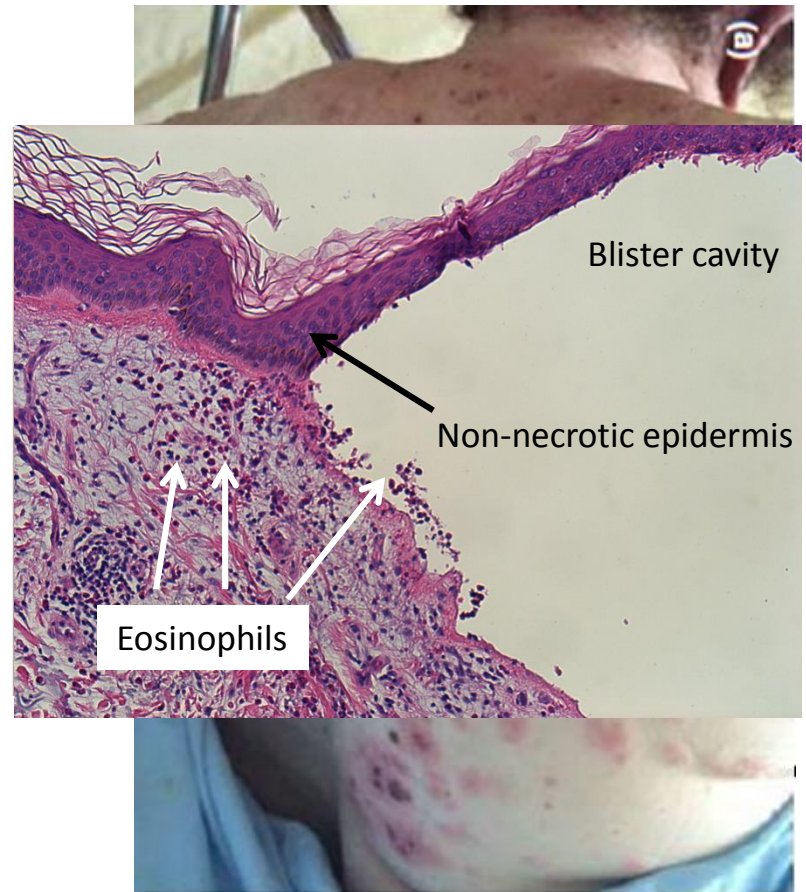
# Macules & papules

- “Morbilliform”
- Typically responds to topical steroids
- Considered grade 3 if BSA > 50%
- If not improved with topical steroids, would refer to Derm



# Bullous Pemphigoid

- Autoimmune blistering disorder
- Antibodies against basement membrane
- Treatment: **Topical** vs. oral steroid



Rofe, et al. "Severe bullous pemphigoid...." Clin and Exp Derm. 2016.

Joy, et al. "A comparison of oral and topical steroids...." NEJM. 2002.



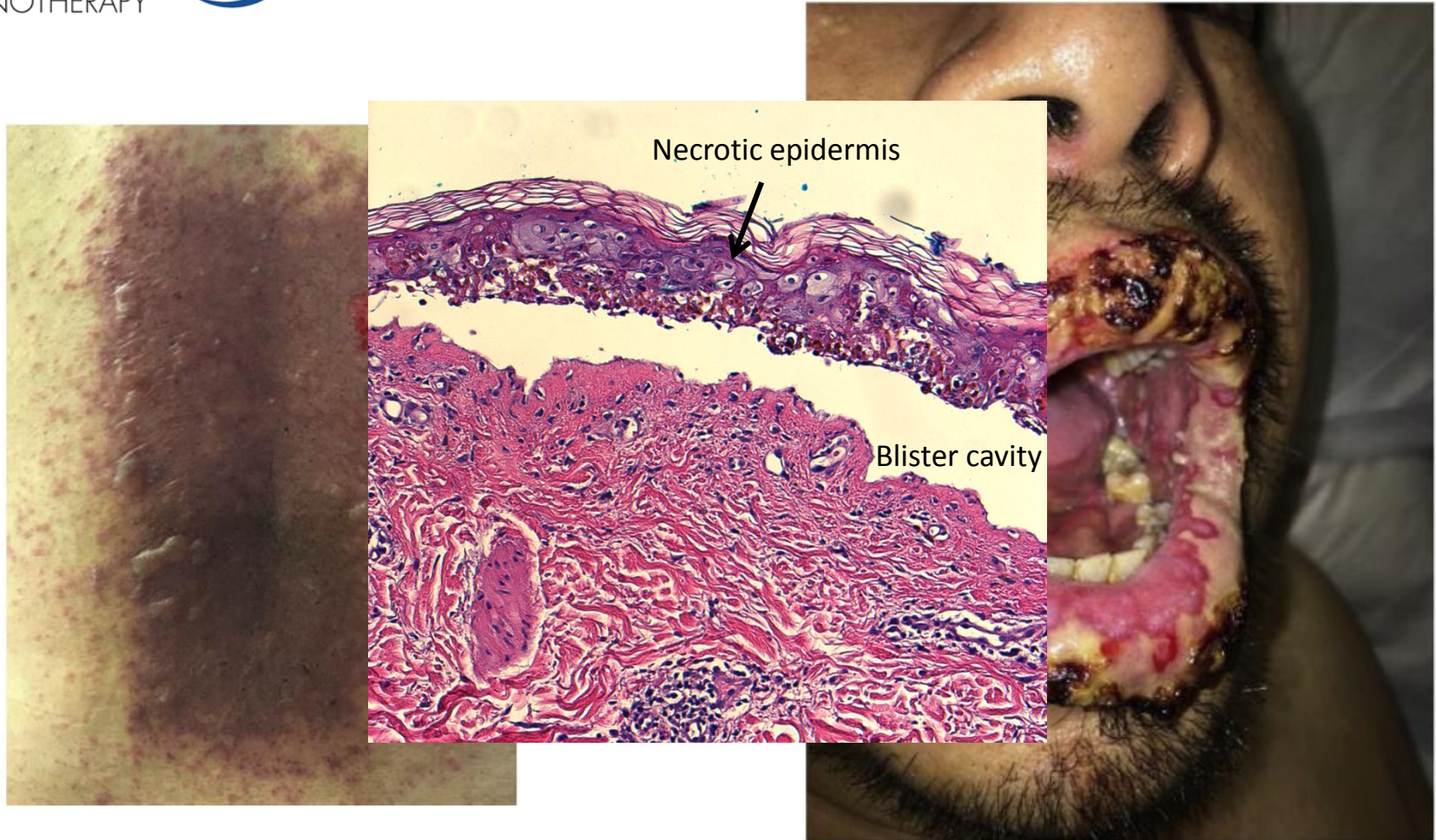


# Before & after treatment





# Stevens-Johnson Syndrome



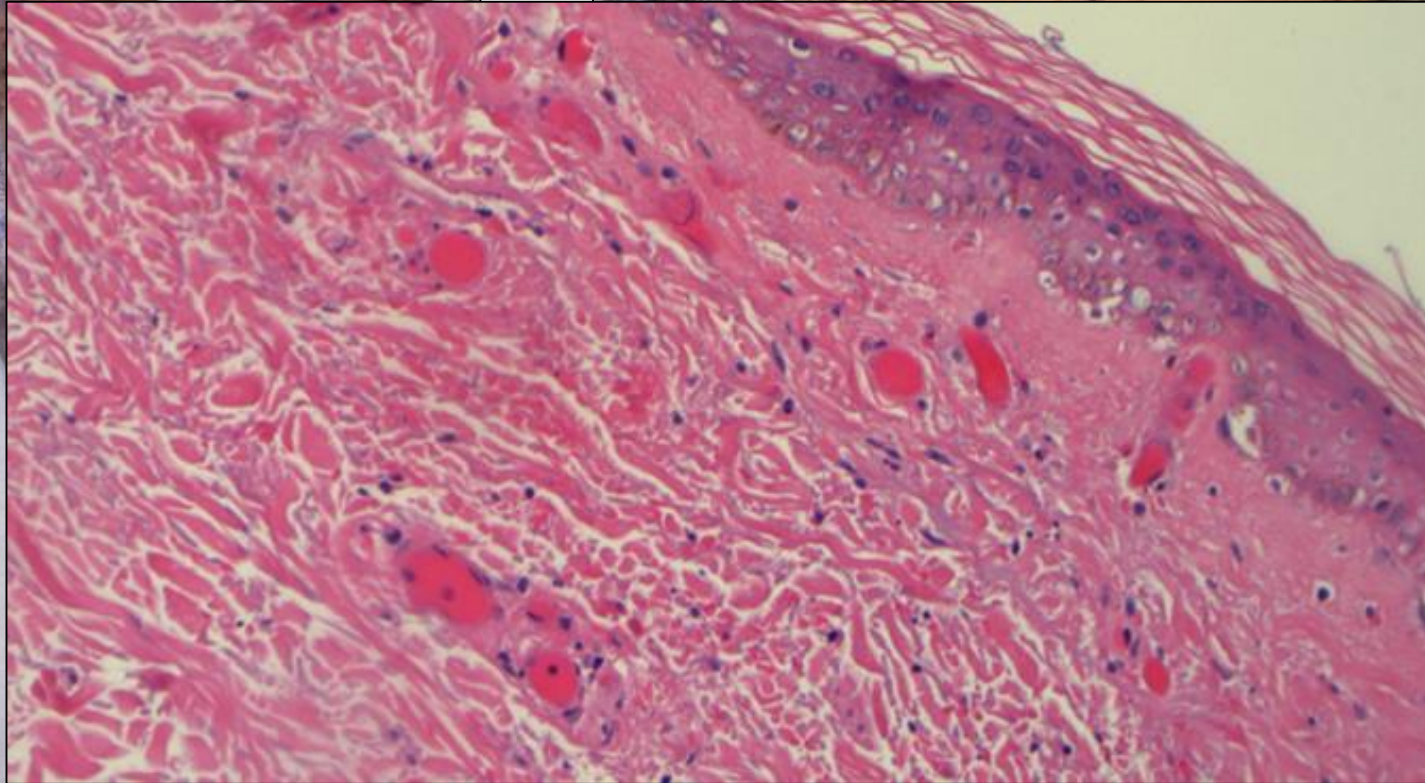
Saw, et al. "Pembrolizumab-induced SJS...." Eur J Cancer. 2017.

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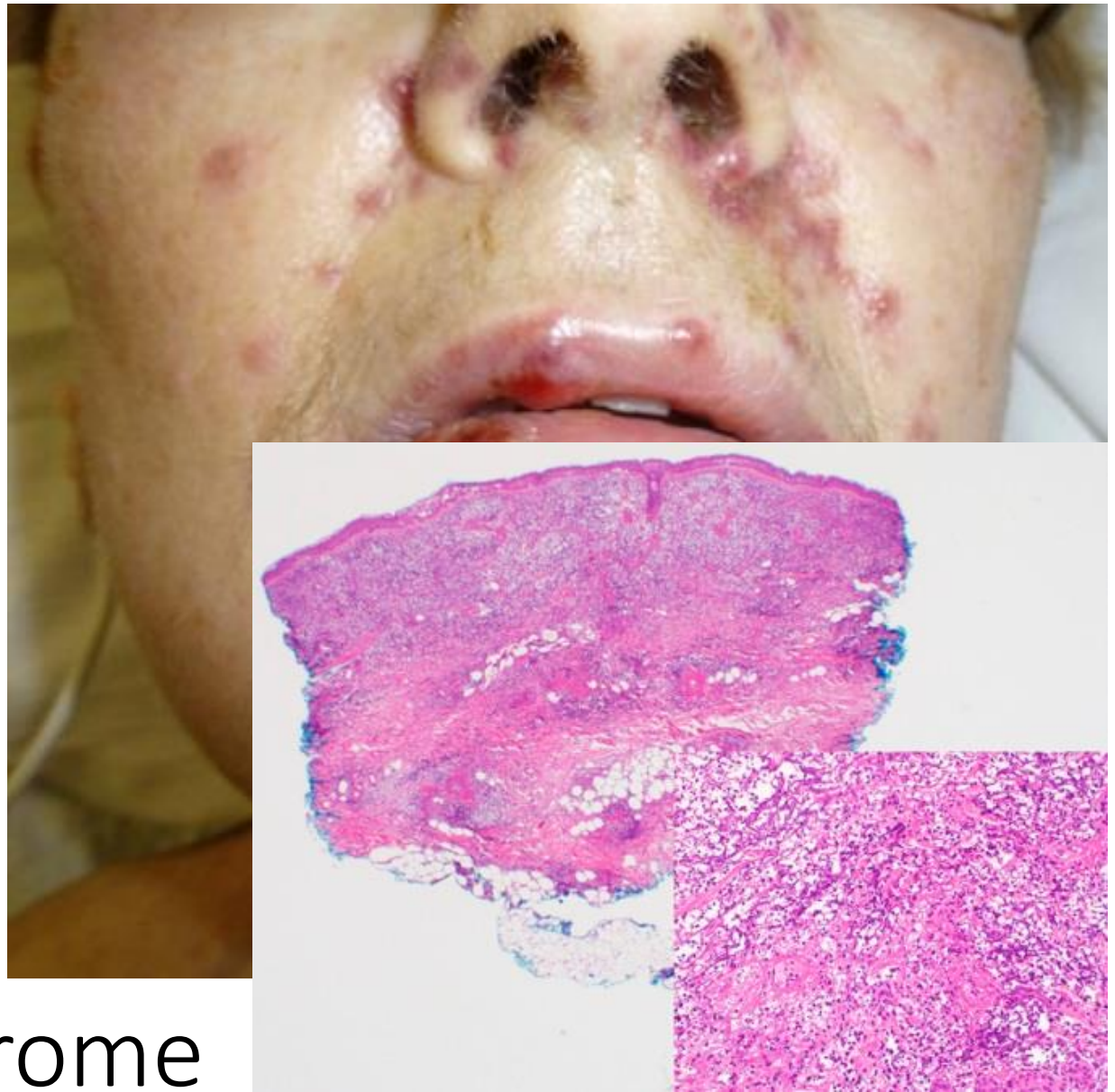
# Pembrolizumab-induced vasculopathy



Brown, et al. "Pembrolizumab induced ischemic vasculopathy." *in press*.

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# Sweet syndrome

Kyllo, et al. "Ipilimumab-associated Sweet syndrome...." JAAD. 2013.

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# When to refer

- Clinical symptoms that should trigger a referral
  - Blisters
  - Skin pain
  - Mucosal surface involvement
  - Fever or clinically toxic
- Other reasons to refer
  - Skin biopsy needed
  - Unclear diagnosis
  - Not responding to initial treatment
  - If you are considering prescribing oral steroids



# Thank you

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