UNEXPECTED CAUSE OF RASH

Alberto Hernando
Vall d’Hebron University Hospital (Barcelona)
64 year old woman.

Past medical history:
- Moderate asthma.
- No autoimmune disorders.
- No chronic treatments.

First symptom: Nodule in breast self examination in October 2016.

Complementary exams:
- Ultrasonography: 20 mm nodule.
- CT scan: No visceral metastases.
- Core biopsy: TNBC: T2N0M0.

Neoadjuvant therapy:
- Anti-PD-1+Carboplatin/Nab-paclitaxel by 6 cycles (27/10/2016 - 29/12/2016).
- Adriamycin cyclophosphamide by 1 cycle (31/1/2017).
PRESENT ILLNESS

- **First evaluation (31/12/2016):**
  - Symptoms: G1 Diarrhea+ G1 Rash (CTCAE 4.0).
  - Discharged with topical corticosteroids treatment.

  *Adriamycin cyclophosphamide by 1 cycle (31/1/2017).*

- **Current evaluation (13/2/2017):**
  - Symptoms: G3 Rash.
  - Physical examination: Photodistributed rash with erythematous papules.
PRESENT ILLNESS
DIAGNOSIS

- Differential diagnosis:
  - Erythema multiforme.
  - Subacute cutaneous lupus erythematosus.
  - Taxanes induced cutaneous eruption.
  - Viral exanthems.
  - Lichenoid drug reaction.

Courtesy of Ferrer B. MD PhD. Anatomic-Pathology Department. Hospital Vall D’Hebron.
DIAGNOSIS

- Compatible with subacute cutaneous lupus erythematosus (SCLE) associated with Anti-PD1:
  - No previous oral medications.
  - Laboratory exams:
    - ANA and Anti-Ro/SSA positive antibodies.
    - Negative Antihistone antibodies.
  - Anatomopathological findings:
    - Interface dermatitis.
    - Mucin deposition.
    - Lymphocytic infiltrate.

<table>
<thead>
<tr>
<th>Table 3: Serological and histological parameters of the various subtypes of cutaneous lupus erythematosus (CLE)*.</th>
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</thead>
<tbody>
<tr>
<td><strong>CLE subtype</strong></td>
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<tr>
<td>Serology (autoantibodies)</td>
</tr>
<tr>
<td>ANA</td>
</tr>
<tr>
<td>Anti-ds-DNA</td>
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<tr>
<td>Anti-Sm</td>
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<tr>
<td>Anti-Ro/SSA</td>
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<td>Anti-La/SSB</td>
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<tr>
<td>Histologic characteristics</td>
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<tr>
<td>Orthohyperkeratosis</td>
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<td>Interface dermatitis</td>
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<tr>
<td>Thickened basement membrane zone</td>
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<td>Lymphocytic infiltrate</td>
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<tr>
<td>Intercstitial mucin deposition</td>
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<td>Direct immunofluorescence (DIF)</td>
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<tr>
<td>Lesional</td>
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<td>non-lesional, non-sunexposed</td>
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</tbody>
</table>

Sticherling M et al. Diagnostic approach and Treatment of cutaneous lupus erythematosus. JDDC.
TREATMENT AND EVOLUTION

October 2016
Nov 16

November 2016
December 2016
January 2017
February 2017
March 2017

Diagnosis
Anti-PD-1+Carboplatin/Nab-paclitaxel 6C
AC 1C
Hospitization
Outpatient evaluation

CTC 1MG/KG
CTC 2MG/KG
TAPERING 1 MONTH

Diagnosis

BREAST SURGERY

Anti-PD-1+Carboplatin/Nab-paclitaxel 6C
AC 1C
Hospitization
Outpatient evaluation

CTC 1MG/KG
CTC 2MG/KG
TAPERING 1 MONTH

Diagnosis

BREAST SURGERY

CTC 1MG/KG
CTC 2MG/KG
TAPERING 1 MONTH

Diagnosis

BREAST SURGERY
DERMATOLOGIC TOXICITIES AS IMMUNE RELATED ADVERSE EFFECTS (irAE)

- Skin rash is the most common irAE, typically after 2nd cycle of Anti-PD-1.
- 30% of patients treated with Anti-PD-1 develop dermatologic toxicities.
- A maculopapular rash is most frequently observed.
- Less common rashes have been described (pemphigoid, lichenoid dermatitis, psoriatic rash…)
- Treatment is based on topical or systemic corticosteroids depending on severity.
- Dermatologic evaluation is recommended.

DISCUSSION

• More expertise is needed for optimal management of irAEs.

• Cutaneous AE may correlate with response.

• Previously SCLE induced by taxanes have been described with resolution after drug interruption.

• Our case was clinically and pathologically compatible with **SCLE**.

• To our knowledge this is the first reported case in the literature of **SCLE** associated with Anti-PD1.