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Patient Partners in NSCLC: Collaborating to Enhance Quality of Life and Outcomes With EGFRi-Associated Dermatologic Toxicities

Announcer:
Welcome to CME on ReachMD. This activity, titled “Patient Partners in NSCLC: Collaborating to Enhance Quality of Life and Outcomes With EGFRi-Associated Dermatologic Toxicities” is provided by Prova Education.

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Dr. Leventhal:
EGFR inhibitors are commonly used for treating non-small cell lung cancer. Do you have adequate knowledge to manage the dermatologic toxicities associated with this therapy?

This is CME on ReachMD, and I'm Dr. Jonathan Leventhal, director of the Onco-Dermatology Clinic at Yale Cancer Center.

Ms. Singh-Kandah:
And I'm Shanaz Singh-Kandah, an oncology nurse practitioner at Columbia University Medical Center.

Dr. Leventhal, can you provide an overview of the dermatologic toxicities that are associated with EGFR inhibitors and can occur in patients with non-small cell lung cancer?

Dr. Leventhal:
Absolutely. EGFR inhibitors are an important class of cancer medicine that's used to treat various cancers, especially non-small cell lung cancer. And these EGFR inhibitors block receptors on tumors that are also expressed on the skin, hair, and nails; that's why they result in dermatologic toxicities. And these cutaneous side effects are especially common. The ones that I think are most clinically relevant include the acneiform rash, and that presents with papules and pustules on the face, scalp, chest, and back. And it really could be widespread. In addition, patients can get paronychia infection of their nails, resulting in painful ingrown nails, and hypergranulation tissue, which we call pyogenic granulomas. Patients also can present with xerosis or dry skin as well as pruritus and hair changes, including hair thinning on the scalp and hirsutism of the face as well as eyelashes that can become elongated and curvy.

These toxicities can result in negative impact on quality of life. And in severe cases, the oncologist might even hold treatment or reduce the dose. That underscores why early intervention and treatment is really key to improve overall outcomes.

And the way we grade these rashes are based upon the CTCAE criteria, which basically is based upon body surface area of involvement for the rash and the severity or impact on quality of life. So for rashes that are mild or low grade, we treat the acneiform rash with topical steroids and topical antibiotics as well as oral antibiotics such as doxycycline. For rashes that are higher grade, we’ll use prednisone for a week or so and hold the cancer treatment. And for rashes that are really recalcitrant to therapy, we often use things like low-dose isotretinoin, which can be helpful in managing the acneiform rash.

And I think a key point is that there's a lot that we can do with patient education to help prevent the rash, including the use of these topical agents, sun protection, and oral antibiotics. And we know that this can improve patients’ quality of life and overall survival

outcomes.

Ms. Singh-Kandah:
Thank you. That was a super helpful overview, Dr. Leventhal.

So as a dermatologist, when a patient is having a skin toxicity, especially earlier on from an EGFR inhibitor, when do you prefer to see them in clinic?

Dr. Leventhal:
That's a great question. Oncologists do a very good job at managing dermatologic toxicities in their cancer patients, especially kind of the lower-grade reactions. But when patients present with higher-grade toxicities, so those on the Common Terminology Criteria for Adverse Events, the CTCAE criteria, that are grade 2 or 3, really impacting quality of life, or those that don't respond to first-line therapy with topical agents and supportive therapy, I think those are the patients that really should see dermatologists promptly.

Ms. Singh-Kandah:
Okay, great, that makes sense.

Dr. Leventhal:
Shahnaz, can you review some of the guidelines for preventing dermatologic toxicities associated with EGFR inhibitors?

Ms. Singh-Kandah:
Sure. So with more EGFR inhibitor medications on the market, it's super important for us to be proactive rather than reactive. So a proactive lifestyle to help reduce the risk of dermatologic toxicity is very important. In a systematic review of 13 studies using amivantamab, there was a 46% reduction in the risk of all-grade skin rash, just by using prophylactic antibiotics with or without topical skin therapies, and a 39% reduction in the risk of paronychia. So we do know that prophylactic treatment is very important, so we usually tend to recommend, based upon EGFR therapy, an oral antibiotic in the beginning, such as doxycycline, and a topical cream such as hydrocortisone, along with a rich moisturizer and a sunscreen daily. I also advise my patients to limit sun exposure during treatment and for a couple of months following treatment. And as advanced practice providers and nurses, it's super helpful for us to familiarize ourselves with what derm toxicity looks like with EGFR inhibitors and how to treat early. When we're familiar with the pattern on how it arises, when it arises, it's easier to educate patients on the warning signs.

Dr. Leventhal:
That's great. Shahnaz, can you tell us more about the important role that nurses and advanced practice providers play with patient care and education?

Ms. Singh-Kandah:
Yeah, sure. So nurses and advanced practice providers are usually involved in the education and the management of toxicities of EGFR inhibitors. At my practice, we do a thorough baseline visit, which I'll share a little bit more about later in this session, to take the time to really educate patients on potential toxicities and when to call. Spending this time in the very beginning really does help a lot, especially when toxicity arises, and it's honestly an ongoing discussion at every visit.

We work closely with pharmacists if a dose reduction is needed or getting a compound medication for the management of more advanced derm toxicity. So our pharmacy colleagues really do become super helpful when needing dose reduction or a more advanced medication.

Dr. Leventhal:
Great.

For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Jonathan Leventhal, and here with me today is Shahnaz Singh-Kandah. We're discussing the management of dermatologic toxicities associated with EGFR inhibitors in patients with non-small cell lung cancer.

Ms. Singh-Kandah:
So, Dr. Leventhal, can you describe interprofessional best practices for managing dermatologic toxicities associated with EGFR inhibitors?

Dr. Leventhal:
Yeah, I think a really important component is multidisciplinary collaborative care, integrating dermatologic assessment with the overall oncology care. And I think that can be challenging in various practice settings. So something that's really important to consider is that oncologists should seek dermatology allies who they can rely on to help coordinate urgent referrals and really close communication

between recommendations of dermatologic care and oncologic treatment. And I think that tertiary care centers and large cancer hospitals, this happens more regularly. In the community, my advice is for oncologists to really seek partners and dermatologists who can really help provide multidisciplinary care.

And regarding the best practices for managing EGFR inhibitor dermatologic toxicities really depends on the grade and following the recommended guidelines. So for grade 1 and 2 rashes, topical steroids and doxycycline, as we discussed. For grade 3, adding prednisone for a week can really be helpful. And patients who present with severe superinfection and grade 4 often require hospitalization, IV antibiotics, and supportive care. And as I mentioned earlier, in patients who have recalcitrant acneiform rash, we often use low-dose isotretinoin, and that can be super helpful. For treating the paronychia, we'll often use topical antibiotics and antiseptic soaks, like dilute vinegar soaks. We can also treat the pyogenic granulomas that are quite painful with local destructive modalities, this includes silver nitrate, timolol gel, and in really recalcitrant cases, nail avulsion by dermatologist, a surgeon, or podiatrist can be curative.

Ms. Singh-Kandah:
Thank you for that overview. And honestly, I can't overemphasize how important the collaboration is between medical oncology and dermatology, especially when it comes to managing these toxicities that, outside of medical oncology, it definitely becomes more difficult. So having a relationship with a dermatologist, having someone who can evaluate them early on is so helpful, especially when the rash is not mitigated by standard therapy, as you mentioned.

Dr. Leventhal:
Yeah. And I think something that you spoke about earlier is so important. Nurses and advanced practice providers often have the ability to spend a great deal of time with patients, checking in on patients, going over checklists of adverse events. And I think that they play such a crucial role in managing and educating patients who are undergoing treatment with an EGFR inhibitor.

Ms. Singh-Kandah:
Absolutely.

Dr. Leventhal:
Shahnaz, can you provide some real-world recommendations to promote guideline adherence and patient engagement?

Ms. Singh-Kandah:
Sure. So I found that creating a comprehensive checklist of items that you want to review with patients at the beginning of EGFR inhibitor therapy is so helpful. So I have a background in clinical research, and part of that is enrolling patients onto trials and doing a thorough pretreatment visit which includes explaining to them what the therapy is and toxicities to look out for. So in addition to getting their medical history, we are also looking to see if they've had a history of past skin disorders, or have they had skin reactions to other treatments? Patients that are on trials are monitored more closely because it is investigational therapy. So we find that we're able to treat toxicities earlier on because we're in regular communication with patients and they know when to call when a toxicity arises.

And I say that the same can be true for standard of care patients. Encouraging them to reach out when a derm toxicity arises, rather than waiting for their next scheduled visit, can potentially reduce the severity of toxicity and allow them to maximize their time on therapy.

In addition, EGFR inhibitor medications such as amivantamab may cause a scalp rash in some patients that is managed differently than skin rash. So educating patients on these particular side effects and being rigorous with prophylactic treatment is critical. Also letting patients know that if they've developed any sort of scalp rash or a rash outside of what they've already experienced or reported, to notify their teams immediately.

And we found that these thorough baseline visits, along with the taking the time to educate patients and showing them what a potential rash looks like, when it could arise, and what to look out for outside of your typical EGFR inhibitor rash, really does help minimize the severity of these rashes because we're introducing therapies and management of these toxicities earlier on.

Dr. Leventhal:
Such great points. Patient education, checklists, frequent communication. I would add that it is so critical to manage these side effects promptly and preemptively; it allows these cancer patients to remain on their lifesaving treatments. They can stay on their treatments longer. They have reduced chances of having to hold or reduce the dose of their treatments. And this is really crucial in achieving better clinical outcomes.

Ms. Singh-Kandah:
Definitely.

Dr. Leventhal:
Well, this has certainly been a fascinating conversation, but before we wrap up, Shahnaz, can you share your one take-home message with our audience?

Ms. Singh-Kandah:
Sure. I would say that our goal as providers is always for the patients to have a great quality of life while treating their cancer. Many of these patients we're treating are continuing to work and live their life per usual, so it's great to make that as easy and seamless as possible for them.

Nurses and advanced practice providers play a big role in helping patients have a great quality of life by encouraging the patient to reach out early when toxicity arises, the why behind using prophylactic treatment and being compliant with it, and also working closely with our colleagues, such as dermatology. Taking these measures can help us maximize patients' time on therapy.

Dr. Leventhal:
Such great points. I would say, for me, I would echo that and also emphasize the importance of multidisciplinary care to not only improve quality of life, but really to improve overall clinical outcomes and survival as cancer patients with non-small cell lung cancer are able to remain on their EGFR inhibitor therapies.

And that's all the time we have today. So want to thank our audience for listening in and thank you, Shahnaz, for joining me and for sharing all of your valuable insights. It was great speaking with you today.

Ms. Singh-Kandah:
My pleasure. Thank you for having me.

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