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Guideline and Conflicts of Interest

The Expert Panel was assembled in accordance with ASCO's Conflict of Interest Policy Implementation for Clinical Practice Guidelines ("Policy," found at https://www.asco.org/guideline-methodology). All members of the Expert Panel completed ASCO's disclosure form, which requires disclosure of financial and other interests, including relationships with commercial entities that are reasonably likely to experience direct regulatory or commercial impact as a result of promulgation of the guideline. Categories for disclosure include employment; leadership; stock or other ownership; honoraria, consulting or advisory role; speaker's bureau; research funding; patents, royalties, other intellectual property; expert testimony; travel, accommodations, expenses; and other relationships. In accordance with the Policy, the majority of the members of the Expert Panel did not disclose any relationships constituting a conflict under the Policy.

RESULTS

A total of 175 studies met the eligibility criteria of the systematic review and were pertinent to the development of the recommendations (Data Supplement, online only). Much of the evidence consisted of retrospective observational data in the form of case series and case reports. Such study designs represent low-quality evidence with an inherent risk of reporting bias, as only events of interest are described. Nonetheless, when describing a new entity in terms of its clinical manifestations, such reports provide important information to describe the range of phenotypes possible.[6] Other factors potentially contributing to the risk of bias in the included studies are the small sample sizes and retrospective nature of the evidence. Because of the limitations and low quality of the available evidence, the guideline panel developed expert opinion–based recommendations through an informal consensus process. Employment of formal consensus methodology was deemed unnecessary, favoring open discussion that allowed for the articulation of views and opinions instead.

RECOMMENDATIONS

All recommendations in this guideline are expert consensus–based; benefits outweigh harms; strength of recommendation: moderate.

Clinical Question

How should clinicians manage immune-mediated AEs in adult patients with cancer treated with immune checkpoint blockade antibodies?

1.0. Recommendations for identification, evaluation, and management of cutaneous toxicities. Immune-related cutaneous AEs are characterized as inflammatory dermatoses, bullous dermatoses, and severe cutaneous adverse reactions (SCARs), according to the CTCAE.[7] The median time to onset of skin toxicities is 4 weeks, but can range broadly from 2 to 150 weeks.[8-10] Rash or inflammatory dermatitis irAEs encompass erythema multiforme, lichenoid, eczematous, psoriasiform, morbilliform, and palmoplantar erythrodysesthesia, or hand-foot syndrome. Presenting symptoms related to immune therapy–induced rash or inflammatory dermatitis can vary but often include itch with or without rash, new or worsening skin lesions, including macules, papules, or plaques, and loss of skin pigmentation. For bullous dermatoses, presenting symptoms may also include new or worsening skin lesions, including bullae, persistent urticaria, or erosions on the skin or mucosal surfaces. SCAR includes Stevens-Johnson syndrome, toxic epidermal necrolysis, acute generalized exanthematous pustulosis (although note that acute generalized exanthematous pustulosis is not always severe), and drug reaction with eosinophilia and systemic symptoms or drug-induced hypersensitivity syndrome. Presenting symptoms related to immune therapy–induced