Vai trò bác sĩ da liễu trong quản lý tác dụng phụ trên da do thuốc điều trị ung thư

ThS.BS Đặng Thị Hồng Phượng

International Agency for Research on Cancer
World Health Organization

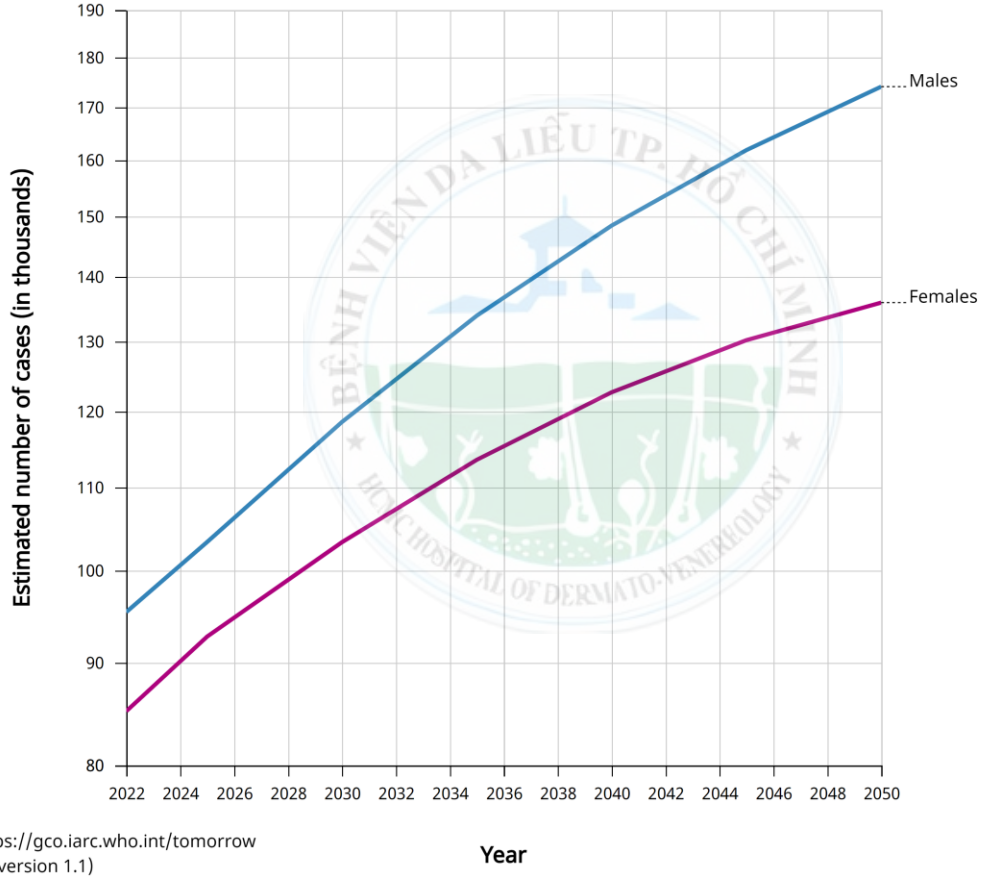
GLOBAL CANCER OBSERVATORY

CANCER TODAY
GLOBOCAN 2022

VIET NAM

Number of new cases	Number of deaths	Number of prevalent cases (5-year)
180 480	120 184	409 144

Estimated number of new cases from 2022 to 2050, Males and Females, age [0-85+]
All cancers
Viet Nam




CANCER TREATMENT OPTIONS
HORMONE THERAPY
IMMUNOTHERAPY
SURGERY
RADIATION THERAPY
BONE MARROW TRANSPLANTATION
TARGETED THERAPY
CHEMOTHERAPY

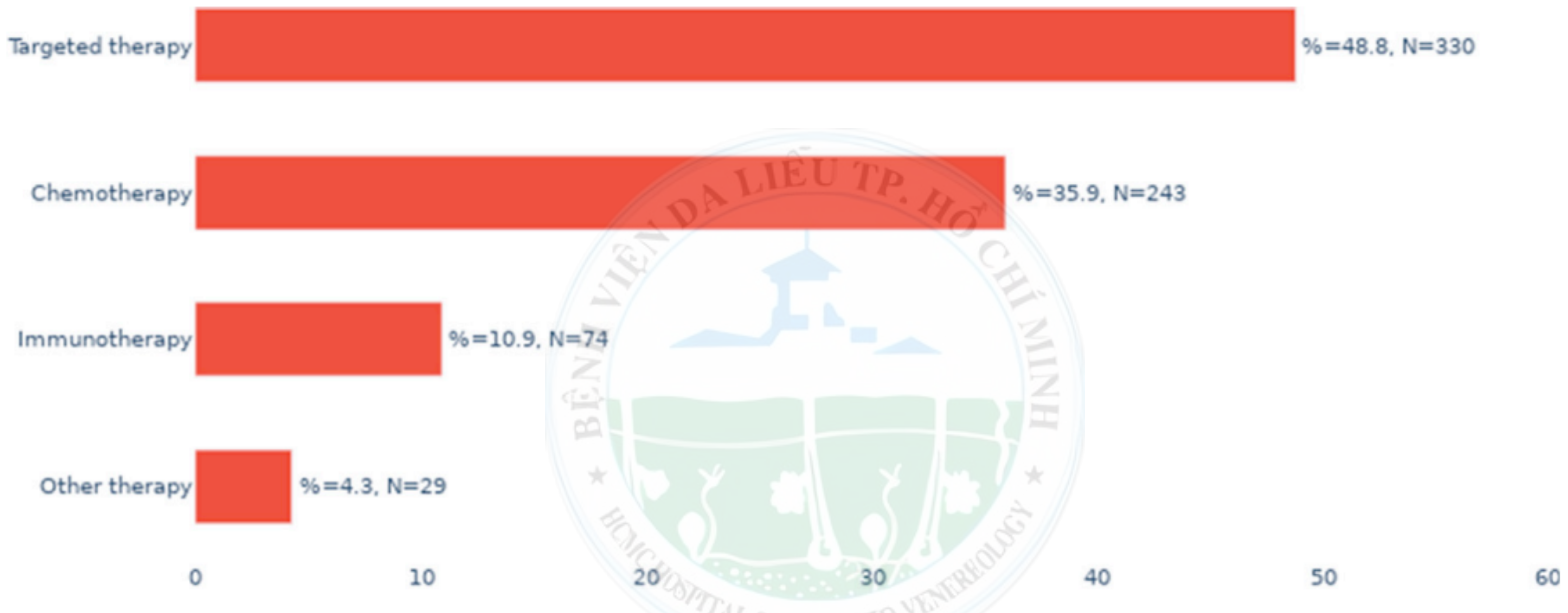


Fig 2. Distribution of significant anticancer drug-skin adverse events (AEs) associations by type of anticancer therapy.

Journal of the American Academy of Dermatology (2024)

DOI: 10.1111/j.1468-3083.2012.04466.x JEADV

ORIGINAL ARTICLE

The impact of dermatological toxicities of anti-cancer therapy on the dermatological quality of life of cancer patients

Table 2 Characteristics of skin toxicities after anti-cancer therapy

65,8% người bệnh có độc tính trên da từ cấp độ 1 trở lên trong vòng 3 tháng điều trị ung thư

Hyperpigmentation	78 (97.5)	2 (2.5)	–	54 (74.0)	18 (24.7)	1 (1.4)	0.000
Nail changes	80 (100)	–	–	66 (90.4)	7 (9.6)	–	0.125
Photosensitivity	80 (100)	–	–	73 (100)	–	–	–
Pruritus	77 (96.3)	3 (3.7)	–	66 (90.4)	7 (9.6)	–	0.453
Papulopustular eruption	78 (97.5)	2 (2.5)	–	68 (93.2)	3 (4.1)	2 (2.7)	0.688
Hand-foot syndrome	80 (100)	–	–	69 (94.5)	3 (4.1)	1 (1.4)	0.250
Mucostitis	80 (100)	–	–	70 (95.9)	3 (4.1)	–	0.168

Journal of the European Academy of Dermatology and Venereology 27.1 (2013): e53-e59.

pISSN 1598-2998, eISSN 2005-9256

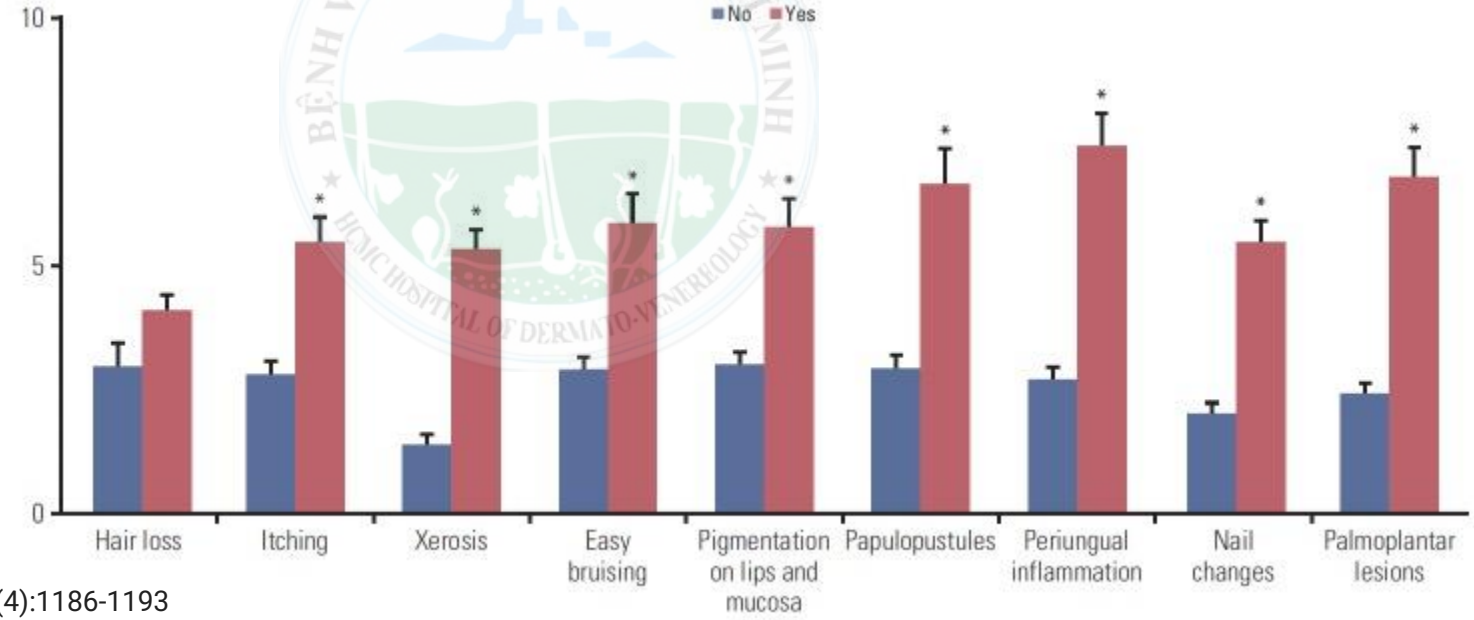
Cancer Res Treat. 2018;50(4):1186-1193

https://doi.org/10.4143/crt.2017.435

Original Article

Open Access

The Impact of Skin Problems on the Quality of Life in Patients Treated with Anticancer Agents: A Cross-Sectional Study



ABSTRACT ONLY · Volume 76, Issue 6, Supplement 1, AB45, June 2017

Anticancer therapy interruption and diagnostic concordance between referring clinicians and dermatologists at Memorial Sloan Kettering Cancer Center

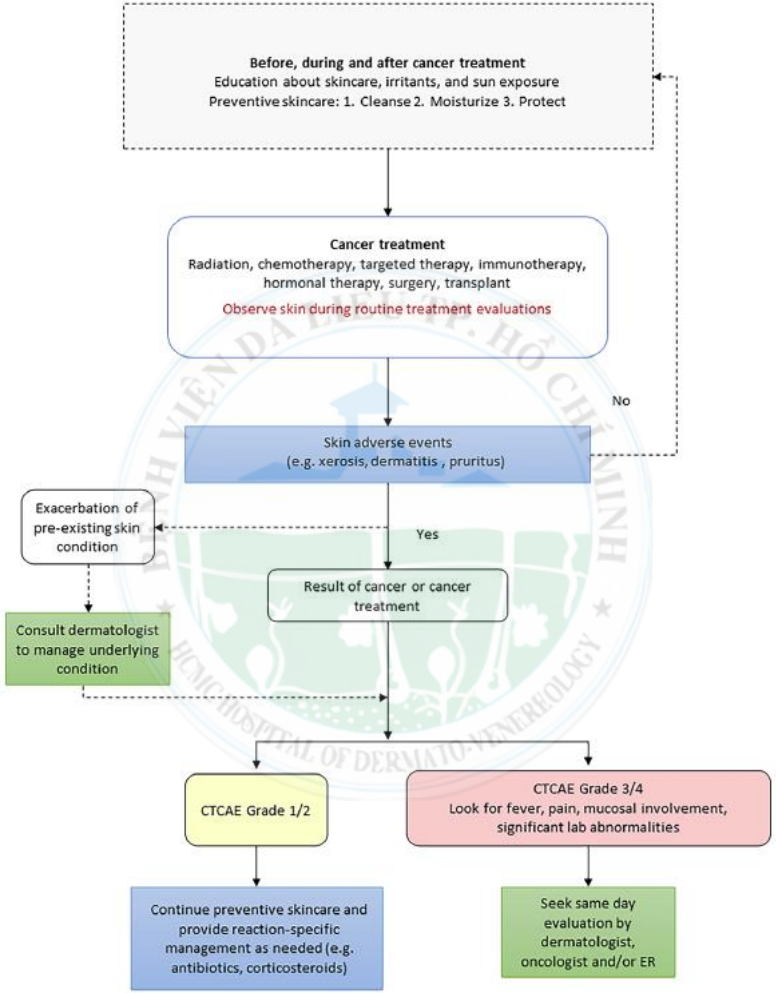
Có 52% bệnh nhân điều trị bằng liệu pháp ức chế tế bào và nhắm trúng đích đã ngưng sử dụng thuốc do tác dụng phụ trên da

Journal of the American Academy of Dermatology, Volume 76, Issue 6, AB45

Multidisciplinary team
Nhóm đa chuyên ngành

2006

oncodermatology


Before, during and after cancer treatment
Education about skincare, irritants, and sun exposure
Preventive skincare: 1. Cleanse 2. Moisturize 3. Protect
Cancer treatment
Radiation, chemotherapy, targeted therapy, immunotherapy, hormonal therapy, surgery, transplant
Observe skin during routine treatment evaluations
No
Skin adverse events
(e.g. xerosis, dermatitis , pruritus)
Exacerbation of pre-existing skin condition
Yes
Result of cancer or cancer treatment
Consult dermatologist to manage underlying condition
CTCAE Grade 1/2
CTCAE Grade 3/4
Look for fever, pain, mucosal involvement, significant lab abnormalities
Continue preventive skincare and provide reaction-specific management as needed (e.g. antibiotics, corticosteroids)
Seek same day evaluation by dermatologist, oncologist and/or ER

Clinical Guideline for the Management of Skin Toxicity associated with Systemic Anti-Cancer Therapy (SACT) in Adult Patients

BODY

- Recommend good fluid intake.
- Avoid wearing tight clothes.
- Use lukewarm water to bathe and avoid long periods in the bath or shower
- Avoid soap, use perfume free soap substitute products e.g.BP emulsifying ointment or Zerobase® cream.
- Use regular emollients ideally 2 -3 times per day, apply in the direction of hair growth to reduce the risk of folliculitis.
- Avoid alcohol based or irritant antibacterial skin products, use oils rather than gels.
- Dry skin gently with a soft towel by patting the skin.
- Use hypoallergenic make up products.
- Consider using non-biological washing detergents.
- If shaving is required, use an electric razor.
- Do not scratch itchy skin.
- Avoid sun exposure and cover sun exposed areas with light clothing. If sun exposure cannot be avoided, then a sunscreen of at least SPF30 with protection against UVA and UVB must be applied 30 minutes pre-exposure.

HAIR

- Use mild shampoo for washing hair e.g. baby shampoo.
- Avoid using hairdryers, straighteners or hot rollers.
- Avoid permanent colouring or perming.

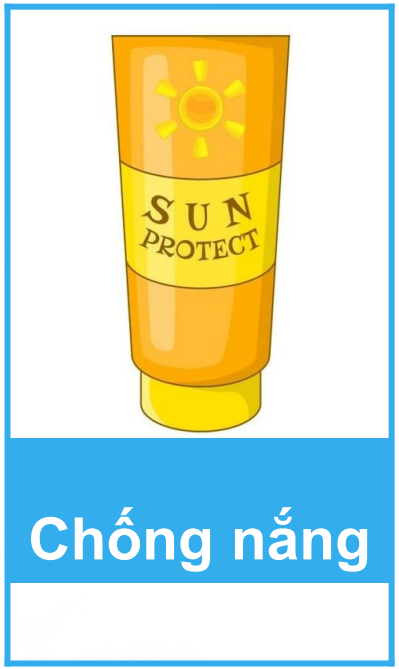
HANDS AND FEET

- Keep nails clean and trimmed.
- Avoid pushing back cuticles or tearing the skin around the nail.
- Ensure to dry between the toes after bathing.
- Wear loose fitting shoes to avoid pressure on the nail.
- Avoid Shellac® or gel nail polish.
- Wear gloves when washing dishes or using chemical agents.
- Vaseline® around the nail beds can act as a barrier.

Chăm sóc da hàng ngày

Điều trị tác dụng phụ thường gặp

CHĂM SÓC DA



Support Care Cancer **31**, 672 (2023)

CHĂM SÓC DA

- Làm sạch da nhẹ nhàng.
- Các chất tẩy rửa tổng hợp (syndets), có độ pH là 5,5

Support Care Cancer **31**, 672 (2023)

CHĂM SÓC DA

Các chất dưỡng ẩm có chứa lipid, chứa panthenol có khả năng thẩm thấu tốt

J Drugs Dermatol. 2021;20:9(Suppl):s3-19.)

CHĂM SÓC DA

Support Care Cancer **31**, 672 (2023)

Làm sạch

Dưỡng ẩm

- Chất gây dị ứng và chất gây kích ứng (chất bảo quản, hương liệu, nước hoa)
- Các sản phẩm làm sạch có tính kiềm (đặc biệt là có độ pH từ 7 trở lên)
- Axit alpha hydroxy (axit lactic, axit glycolic)

Support Care Cancer 31, 672 (2023)
Journal of Drugs in Dermatology : JDD, 01 Sep 2021, 20(9):3ss-s19


ASCO
American Society of
Clinical Oncology


ESMO
GOOD SCIENCE
BETTER MEDICINE
BEST PRACTICE
European Society for Medical Oncology

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

ANNALS OF ONCOLOGY driving innovation in oncology

SPECIAL ARTICLE

Prevention and management of dermatological toxicities related to anticancer agents: ESMO Clinical Practice Guidelines☆

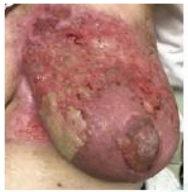
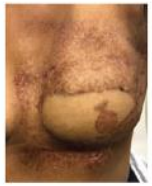
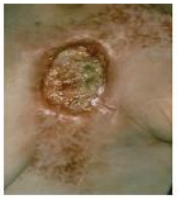
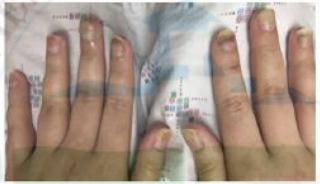
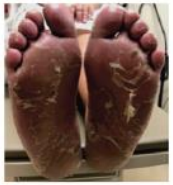
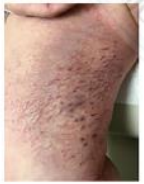
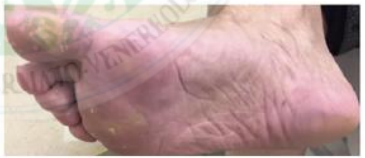
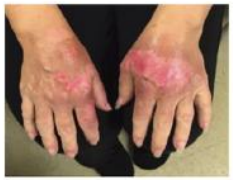
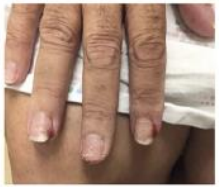
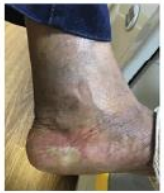
ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

Annals of Oncology 28 (Supplement 4): iv119–iv142, 2017
doi:10.1093/annonc/mdx225

CLINICAL PRACTICE GUIDELINES

Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up†

- Palmar-plantar erythrodysaesthesia (PPE) or hand-foot syndrome (HFS)
- Acneiform rash
- Hair changes
- Pruritis
- Nail changes – paronychia
- Finger and heel fissures

Treatment	Cutaneous Adverse Events
Radiotherapy	RD may present as dry or moist desquamation, erythema, pruritus, bleeding atrophy, necrosis, and ulceration Fig 4-1:  Grade 4 RD with moist desquamation  RD of the right breast with erythema and dry desquamation  RD, ulceration, atrophy, pain, necrosis, and hyperpigmentation
Cytotoxic Chemotherapy with Various Types of Drugs	cAEs may present as alopecia (reversible and permanent), HFS/PPE, nail changes (onycholysis, pigmentary alteration, brittle nails), Phototoxicity, PATEO, Paronychia (± pyogenic granulomas), and urticaria  Onycholysis with sublingual hemorrhage from taxane/AC chemo in breast cancer patient  HFS capecitabine with aural erythema/ hyperkeratosis
Targeted Therapies	cAEs may present as papulopustular (acneiform) eruption, alopecia (reversible), pruritus, nail changes, paronychia (± pyogenic granulomas), phototoxicity, trichomegaly, hirsutism, keratoacanthoma, keratosis-pilaris like reaction, morbilliform eruption, and dermal hypersensitivity  Eczema craquele from cetuximab/ afatinib  HFS reaction from sorafenib  Phototoxic reaction from vemurafenib in patient with melanoma  Paronychia with pseudopyogenic granuloma from cetuximab/afatinib for head and neck cancer  HFS from TKI in a patient with CML

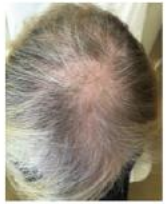
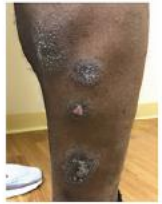
Immunotherapy	cAEs may present as non-specific maculopapular rash, pruritus, eczema/spongiosis, lichenoid reactions, psoriasis, pityriasis lichenoides-like reaction, exfoliative pyoderma gangrenosum, Grover's disease, vitiligo, bullous pemphigoid, dermatitis herpetiformis, prurigo nodularis, vasculitis, dermatomyositis, Sjögren's syndrome, Sarcoidosis, Sweet's Syndrome, acneiform rash/papulopustular rosacea, eruptive keratoacanthomas, actinic keratoses and squamous cell carcinoma, erythema nodosum-like panniculitis, radiosensitization, photosensitivity, urticaria, alopecia, alopecia areata, hair repigmentation, sclerodermoid reaction, nail changes, xerostomia  Lichenoid dermatitis from pembrolizumab for lung cancer
Hormonal Therapy	cAEs may present as alopecia (reversible); flushing; vulvovaginal dryness/atrophy  Anastrazole associated alopecia (endocrine TX)  Nummular eczema in a patient with prostate cancer receiving hormonal TX  Xerosis and nummular eczema in a patient with prostate cancer receiving hormonal TX

Table 2. HFSR from MEKis: prevention and treatment

Severity (CTCAE v5.0)	Intervention	LoE	GoR
Grade 0 prevention	Behavioural aspects and skin care: • Avoid irritation to the hands and feet: avoidance of mechanical stress (e.g. long walks or heavy carrying without gloves and socks/cushioned shoes) • Avoid chemical stress: skin irritants, solvents or disinfectants • Treatment of predisposing factors before anticancer therapy (e.g. apparent hyperkeratosis)	IV	B
	Urea 10% cream t.i.d.	II	B
Grade 1 and grade 2 treatment Minimal skin changes or dermatitis Skin changes with pain; limiting instrumental ADLs	Continue drug at current dose and monitor for change in severity • Topical high-potency steroid b.i.d. • Lidocaine 5% patches or cream Reassess after 2 weeks (either by health care professional or patient self-report); if reactions worsen or do not improve, proceed to next step	IV	C
Grade ≥3 or intolerable grade 2 treatment Severe skin changes with pain; limiting self-care ADLs	Interrupt treatment until severity decreases to grade 0-1; and continue treatment of skin reaction with the following: Continuation or initiation of: • Topical high-potency steroid b.i.d. • Lidocaine 5% patches or • Possibly topical keratolytics (e.g. with salicylic acid 5%-10% or urea 10%-40%) cream • Possibly antiseptic solutions (e.g. silver sulfadiazine 1%, polyhexanide 0.02%-0.04%) cream Reassess after 2 weeks; if reactions worsen or do not improve, dose interruption or discontinuation per protocol may be necessary	IV	C

ADL, activity of daily living; b.i.d., twice daily; CTCAE, Common Terminology Criteria for Adverse Events; GoR, grade of recommendation; HFSR, hand-foot skin reaction; LoE, level of evidence; MEKis, mitogen-activated protein kinase inhibitors; t.i.d., three times daily.

Annals of Oncology, Volume 32, Issue 2, 2021, Pages 157-170

Table 3. PPES from capecitabine: prevention and treatment

Severity (CTCAE v5.0)	Intervention	LoE	GoR
Grade 0 prevention	Behavioural aspects and skin care: • Avoid irritation to the hands and feet: avoidance of mechanical stress (e.g. long walks or heavy carrying without gloves and socks/cushioned shoes) • Avoid chemical stress (skin irritants, solvents or disinfectants) • Treatment of predisposing factors before anticancer therapy (e.g. apparent hyperkeratosis)	IV	B
	Urea 10% cream t.i.d.	II	B
	Celecoxib 200 mg b.i.d.	II	C
Grade 1 and grade 2 treatment Minimal skin changes or dermatitis Skin changes with pain; limiting instrumental ADLs	Continue drug at current dose and monitor for change in severity Topical high-potency steroid b.i.d. Reassess after 2 weeks (either by health care professional or patient self-report); if reactions worsen or do not improve, proceed to next step	IV	C
Grade ≥3 treatment (or intolerable grade 2) treatment Severe skin changes with pain; limiting self-care ADLs	**Interrupt treatment** until severity decreases to grade 0-1; and continue treatment of skin reaction with the following: Topical high-potency steroid b.i.d. Reassess after 2 weeks; if reactions worsen or do not improve, dose discontinuation per protocol may be necessary	IV	C

ADL, activity of daily living; b.i.d., twice daily; CTCAE, Common Terminology Criteria for Adverse Events; GoR, grade of recommendation; LoE, level of evidence; PPES, palmar-plantar erythrodysesthesia syndrome; t.i.d., three times daily.

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Table 1. Papulopustular exanthema (acneiform rash) from EGFRis, MEKis and mTOR inhibitors: treatment

Severity (CTCAE v5.0)	Intervention	LoE	GoR
Grade 1 and 2 treatment Papules and/or pustules covering 10%-30% BSA, symptoms of pruritus or tenderness; psychosocial impact; limiting instrumental ADLs	Continue drug at current dose and monitor for change in severity Continuation or initiation of • Oral antibiotic for 6 weeks (doxycycline 100 mg b.i.d. OR minocycline 50 mg b.i.d. OR oxytetracycline 500 mg b.i.d.) **AND** • Topical low/moderate steroid Reassess after 2 weeks (either by health care professional or patient self-report); if reactions worsen or do not improve, proceed to next step	II II	B B
Grade ≥3 (or intolerable grade 2) treatment Papules and/or pustules covering >30% BSA, symptoms of pruritus or tenderness; limiting self-care ADLs; associated with local superinfection	Interrupt until G0/1; obtain bacterial/viral/fungal cultures if infection is suspected Continuation or initiation of • Oral antibiotic for 6 weeks (doxycycline 100 mg b.i.d. OR minocycline 50 mg b.i.d. OR oxytetracycline 500 mg b.i.d.) **AND** • Topical low/moderate steroid • Systemic corticosteroids (e.g. prednisone 0.5-1 mg/kg body weight for 7 days) • ± isotretinoin[a] at low doses (20-30 mg/day) Reassess after 2 weeks; if reactions worsen or do not improve, dose interruption or discontinuation per protocol may be necessary	II II II IV	B B B C

ADL, activity of daily living; b.i.d., twice daily; BSA, body surface area; CTCAE, Common Terminology Criteria for Adverse Events; EGFRi, epidermal growth factor receptor inhibitor; GoR, grade of recommendation; LoE, level of evidence; MEKis, mitogen-activated protein kinase inhibitors; mTOR, mammalian target of rapamycin.

[a] Not in conjunction with tetracyclines, risk of cerebral oedema. If considering the use of isotretinoin, a dermatologist should be consulted.

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Table 5. Pruritus: prevention and treatment

Severity (CTCAE v5.0)	Intervention	LoE	GoR
Grade 0 prevention	Gentle skin care instructions given	V	B
Grade 1 treatment Mild or localised	Continue drug at current dose and monitor for change in severity Topical moderate/high-potency steroids Reassess after 2 weeks (either by health care professional or patient self-report); if reactions worsen or do not improve, proceed to next step	V	C
Grade 2 treatment Intense or widespread; intermittent; skin changes from scratching; limiting instrumental ADLs	Continue drug at current dose and monitor for change in severity Topical moderate/high-potency steroid OR Oral antihistamines OR GABA agonists (pregabalin/gabapentin) Reassess after 2 weeks (either by health care professional or patient self-report); if reactions worsen or do not improve, proceed to next step	V V	C C
Grade ≥3 (or intolerable grade 2) treatment Intense or widespread; constant; limiting self-care ADLs or sleep	Interrupt treatment until G0/1; and continue treatment of skin reaction with the following: Topical moderate/high-potency steroid OR Oral antihistamines OR GABA agonists Reassess after 2 weeks; if reactions worsen or do not improve, discontinuation per protocol may be necessary	V V	C C

ADL, activity of daily living; CTCAE, Common Terminology Criteria for Adverse Events; GABA, gamma aminobutyric acid; GoR, grade of recommendation; LoE, level of evidence.

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Table 6. Paronychia: prevention and treatment

Severity (CTCAE v5.0)	Intervention	LoE	GoR
Grade 0 prevention	Gentle skin care instructions given	IV	B
	Recommend wearing comfortable shoes, wearing gloves while cleaning, and avoiding biting nails or cutting nails too short; preventive correction of nail curvature; avoid repeated friction and trauma/ excessive pressure; use of antimicrobial soaks and washing with cleansers and water; daily application of topical emollients to cuticles and periungual tissues	IV	B
	Biotin to improve nail strength	V	C
Grade 1 treatment Nail fold oedema or erythema; disruption of the cuticle	Continue drug at current dose and monitor for change in severity		
	Topical povidone iodine 2%, topical antibiotics/corticosteroids	III	B
	Reassess after 2 weeks (either by health care professional or patient self-report); if reactions worsen or do not improve, proceed to next step		
Grade 2 treatment Nail fold oedema or erythema with pain; associated with discharge or nail plate separation; limiting instrumental ADLs	Continue drug at current dose and monitor for change in severity; obtain bacterial/viral/fungal cultures if infection is suspected		
	Topical povidone iodine 2%/topical beta-blocking agents/topical antibiotics and corticosteroids and/OR	III	B
	Oral antibiotics	IV	B
	Reassess after 2 weeks (either by health care professional or patient self-report); if reactions worsen or do not improve, proceed to next step		
Grade ≥3 (or intolerable grade 2) treatment Surgical intervention or antibiotics indicated; limiting self-care ADLs	Interrupt until G0/1; obtain bacterial/viral/fungal cultures if infection is suspected; and continue treatment of skin reaction with the following:		
	Topical povidone iodine 2%/topical beta-blocking agents/topical antibiotics and corticosteroids and/ OR	III	B
	Oral antibiotics OR	IV	B
	Consider partial nail avulsion	V	B
	Reassess after 2 weeks; if reactions worsen or do not improve, dose interruption or discontinuation per protocol may be necessary		

ADL, activity of daily living; CTCAE, Common Terminology Criteria for Adverse Events; GoR, grade of recommendation; LoE, level of evidence.

Annals of Oncology, Volume 32, Issue 2, 2021, Pages 157-170

KẾT LUẬN:

- Nhiều phương pháp điều trị ung thư: xạ trị, độc tế bào, các liệu pháp nhắm trúng đích và liệu pháp miễn dịch có liên quan đến các tác dụng phụ, trong đó tác dụng phụ trên da là phổ biến nhất.
- Các tác dụng phụ trên da do thuốc điều trị ung thư gây ảnh hưởng đến chất lượng cuộc sống của người bệnh, và có thể dẫn đến giảm hoặc ngừng điều trị các thuốc ung thư
- Bác sĩ da liễu có vai trò là quan trọng và cần thiết trong nhóm đa chuyên ngành khi điều trị các bệnh nhân ung thư, nhằm giúp bệnh nhân được chăm sóc toàn diện hơn.

CÁ THỂ HÓA TRONG QUẢN LÝ TÁC DỤNG PHỤ TRÊN DA DO THUỐC ĐIỀU TRỊ UNG THƯ

Save The Date

ĐÀO TẠO LIÊN TỤC TIỀN HỘI NGHỊ DA LIỄU MIỀN NAM

TIẾP CẬN ĐA PHƯƠNG THỨC TRONG DA LIỄU THẨM MỸ

Thời gian: Thứ bảy, ngày 28/9/2024

Địa điểm: Trung tâm hội nghị GEM
(Số 8 Nguyễn Bỉnh Khiêm, P. Đa Kao, Q.1)

HỘI NGHỊ DA LIỄU MIỀN NAM 2024

NHỮNG TIẾN BỘ HIỆN NAY TRONG CHUYÊN NGÀNH DA LIỄU

(INNOVATIONS IN DERMATOLOGY)

Thời gian: Chủ nhật, ngày 29/9/2024

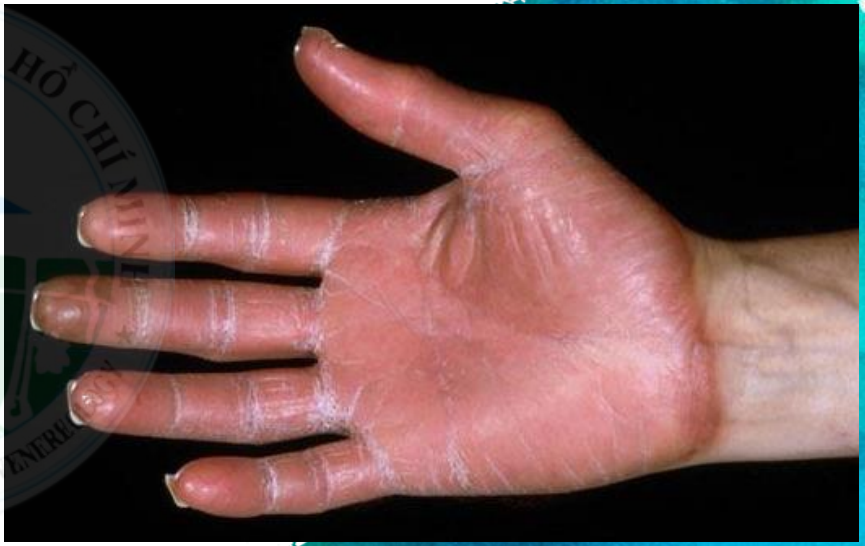
Địa điểm: Trung tâm hội nghị GEM
(Số 8 Nguyễn Bỉnh Khiêm, P. Đa Kao, Q.1)


THANK YOU

Ca lâm sàng

Palmar-plantar erythrodysesthesia và hand-foot skin reaction

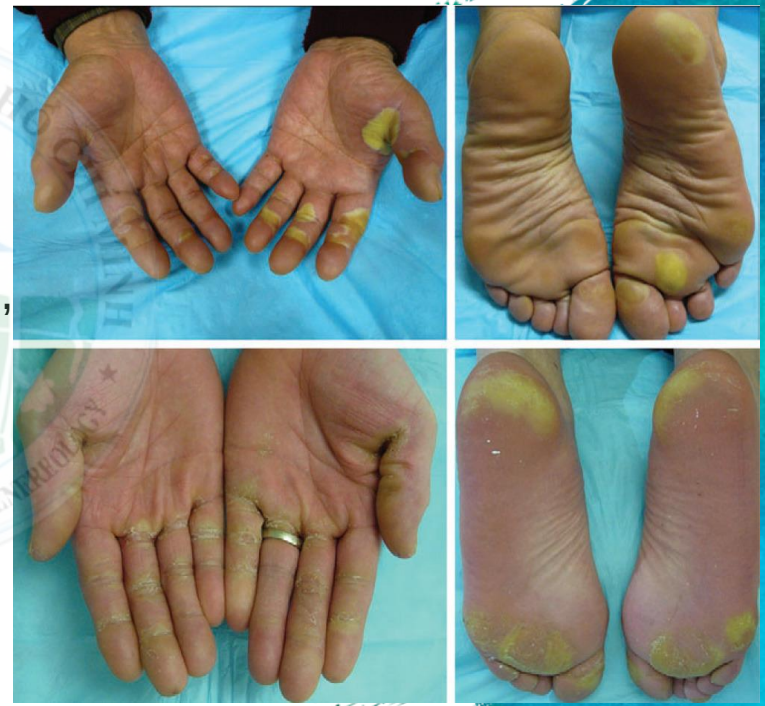
- Ban đỏ mất cảm giác ở lòng bàn tay-bàn chân (PPES) hay còn gọi là hội chứng tay-chân (HFS)
- PPES có liên quan: 5-fluorouracil (5-FU), (6-34%), capecitabine (50-60%), doxorubicin (22-29%), PEGylated liposomal doxorubicin (40-50%), docetaxel (6-58%) và cytarabine (14-33%)
- Mức độ 3/4 ở 5-10% các trường hợp



Annals of Oncology, Volume 32, Issue 2, 2021, Pages 157-170

Palmar-plantar erythrodysesthesia và hand-foot skin reaction

- Hand – foot skin reaction (HFSR): thường do chất ức chế thụ thể tăng trưởng nội mô mặch máu đa kinase (VEGFR) như sorafenib (10-62%), cabozantinib, (40-60%), sunitinib (10-50%), regorafenib (47%)
- Mức độ 3/4 ở 5-20% các trường hợp
- Độ nặng và tái phát của HFS và HFSR ≈ đáp ứng điều trị



Annals of Oncology, Volume 19, Issue 11, 2008,Pages 1955-1961

Phát ban dạng mụn trứng cá (phát ban dạng sẩn mủ)

- Thường gặp nhất đối với EGFR, bao gồm thuốc ức chế thụ thể tyrosine kinase phân tử nhỏ (TKI) erlotinib, afatinib, dacomitinib, osimertinib, lapatinib và gefitinib hoặc các kháng thể đơn dòng như cetuximab, necitumumab, pertuzumab hoặc panitumumab
- 75 - 90% (tất cả các mức độ bệnh) và 10-20% (mức độ 3, 4)
- Vài ngày đến vài tuần sau điều trị
- Sự xuất hiện và mức độ nghiêm trọng ≈ đáp ứng điều trị