All Wales Dermatitis Management Guideline

GIG CYMRU NHS WALES | Rhwydwaith Canser Cancer Network

Mild (Grade 1)

- Localised Macular/Papular eruption
- Asymptomatic

Management Plan

Exclude other causes e.g. viral illness, infection, other drug rash

Treatment
- Emollient (e.g. Cetraben®/ Diprobase, Aveeno, Epaderm)
- Consider anti-histamines: regular chlorpheniramine 4mg qds tablet or cetirizine HCL 10mg od (non-drowsy)

Actions:
- Regular monitoring
- Avoid skin irritants and sun exposure

Continue Immunotherapy

Symptoms: WORSEN

Moderate (Grade 2)

- Rash affecting ≤ 50% skin surface
- Itchy
- Affecting ADL's/sleep

Management Plan

As for mild

Investigations:
- Vital signs
- FBC, U&Es, LFTs, Cortisol, TFT's, CRP and glucose
- Photograph rash
- Measure lesions

Treatment:
- Anti-histamines – chlorpheniramine 4mg tablets qds or Cetirizine 10mg od

Localised rash:
- Topical steroid cream (Betnovate, Elocon cream or Dermovate cream BD)
- Emollient (eg Cetraben®/ Diprobase, Aveeno, Epaderm)

Extensive rash:
- Prednisolone 0.5-1mg/kg/day (max. 60mg/day Prednisolone) + PPI.
- If evidence of infection consider antibiotics as per local protocol.
- Topical steroid cream (Betnovate, Elocon cream or Dermovate cream BD)
- Emollient (eg Cetraben®/ Diprobase, Aveeno, Epaderm)

Actions:
Consider referral to local dermatology team
- Consider admission but with daily review if worsening and extensive
- Consider biopsy

If Admitted refer to **ACUTE ONCOLOGY SERVICE (refer to IO TOX service if available)**

Withhold Immunotherapy

Symptoms: resolve or improve to mild
See Steroid Tapering Guidance

Symptoms: PERSIST (≥5 days) or **WORSEN** or **RELAPSE**

Severe or Life Threatening (Grade 3 + 4)

Is defined as any of the following:

- >50% skin surface
- Generalised
- Exfoliative
- Ulcerative
- Bullous dermatitis

Inc. Toxic Epidermal Necrolysis or Steven Johnson Syndrome

Management Plan

Admit Patient
As for moderate
Vasculitis may also be present with purpuric rash

Investigations
- Vital signs
- FBC, U&Es, LFTs, Cortisol, TFT's, CRP and glucose
- Photograph rash
- Measure lesions
- Antibiotics are not indicated unless there is a concern of recurrent infections, raised infective markers, and/or recommended by treating clinician

Treatment:
- IV Methylprednisolone 2mg/kg/day + PPI.
- Consider increasing to 4mg/kg/day if clinical improvement is unsatisfactory. Consider increasing methylprednisolone dose as advised by dermatology.
- If evidence of infection consider antibiotics as per local protocol.
- Regular vital signs and fluid balance
- Anti-histamines - Chlorpheniramine 4mg QDS or Cetirizine 10mg od.
- Can add in fexofenadine Hydrochloride 120mg OD
- Emollient to 50:50 white soft paraffin (liquid paraffin)

Actions:
- **Discuss with dermatology team about consideration of steroid sparing agents for immune suppression.**
- **Monitor daily**

Discontinue Immunotherapy

Symptoms: Resolve or improve to mild

Management Plan

- Discontinue immunotherapy permanently
- See Steroid Tapering Guidance

If the patient is admitted to A&E, the General Medical or General Surgical Wards, please ensure referral to the ACUTE ONCOLOGY TEAM IF AVAILABLE OR THE TREATING TEAM ON ADMISSION.