Recognizing and Managing Dermatologic irAEs

A Clinical Reference Guide

Dermatologic irAEs are the most common irAE overall, with a median onset of 3 weeks; they are mostly mild to moderate and manageable.

Be sure to educate your patients about irAEs and when to call your office about them.

Dermatology Role

- Grade severity and biopsy when the diagnosis is unclear (eg, lichenoid vs psoriasiform)
- Treat Grade 1/2 presentations directly in most cases; largely reversible within 2 weeks
- Communicate a clear **continue/hold/discontinue** recommendation back to the oncology team

Oncology Will Refer Back to Dermatology For

- Grade 3/4 disease of any type (>30% BSA, bullous, or life-threatening features)
- Any SJS/TEN features
- Bullous disease with systemic symptoms or mucosal involvement
- Diagnostic uncertainty affecting the oncology team's continue/hold decision

Grading and Management per NCCN Guidelines®

INCREASING SEVERITY/BODY SURFACE AREA INVOLVEMENT →

Maculopapular Rash

G1	G2	G3
Macules/Papules covering <10% BSA	Macules/Papules covering 10%–30% BSA; iADLs limited	Macules/Papules covering >30% BSA or life-threatening; ADLs limited
Management Topical emollient + moderate-potency topical steroids; consider oral antihistamines	**Management** Topical emollient + moderate- to high-potency topical steroids; consider oral antihistamines; if unresponsive to topical within 1–2 weeks, consider prednisone; consider dermatology consult	**Management** High-potency topical steroids; prednisone/IV methylprednisolone; urgent dermatology consult, consider biopsy; consider inpatient care
Continue ICI	Continue ICI	Hold ICI

Pruritus

G1	G2	G3
Mild/Localized	Intense/Widespread (intermittent); skin changes from scratching; limiting iADLs	Intense/Widespread (constant); limiting self-care ADLs or sleep
Management Oral antihistamines; moderate-potency topical steroids; consider OTC topical anesthetic/anti-itch creams	**Management** Oral antihistamines; prednisone/IV methylprednisolone; consider gabapentinoids–if no response in 1 month, consider dupilumab, omalizumab, or NB-UVB; urgent dermatology consult	
Continue ICI	Hold ICI	

ADL, activity of daily living; BSA, body surface area; G, grade; iADL, instrumental ADL; ICI, immune checkpoint inhibitor; irAE, immune-related adverse event; IV, intravenous; NB-UVB, narrow-band ultraviolet light B; NCCN, National Comprehensive Cancer Network; OTC, over the counter; SJS, Stevens-Johnson syndrome; TEN, toxic epidermal necrolysis.

Geisler AN, et al. *J Am Acad Dermatol*. 2020;83(5):1255-1268; NCCN®. 2025. https://www.nccn.org/professionals/physician_gls/pdf/ici_tox.pdf.

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Grading and Management per NCCN Guidelines®

INCREASING SEVERITY/BODY SURFACE AREA INVOLVEMENT →

Lichenoid Disease and Psoriasiform Rash

Mild	Moderate	Severe
<10% BSA	10%–30% BSA or not responsive to high-potency topical steroids	>30% BSA

Lichen Planus/Lichenoid Disease

Mild	Moderate	Severe
Management High-potency topical steroid or topical tacrolimus	**Management** High-potency topical steroid/tacrolimus; oral antihistamines; prednisone; consider referral to dermatology; NB-UVB if available; if not responsive, treat as severe	**Management** High-potency topical steroid/tacrolimus; prednisone/IV methylprednisolone; consider referral to dermatology, steroid-sparing immunosuppressants, dupilumab, or acitretin
Continue ICI	Hold ICI	Hold ICI

Psoriasis/Psoriasiform Disease

Mild	Moderate	Severe
Management High-potency topical steroid; consider nonsteroidal topical therapies (eg, tacrolimus or calcipotriene) for long-term management in intertriginous areas or facial location	**Management** High-potency topical steroid; consider nonsteroidal topical therapies for long-term management in intertriginous areas or facial location; NB-UVB; consider apremilast, acitretin, or approved biologics; if not responsive, treat as severe; refer to dermatology	**Management** High-potency topical steroid; consider nonsteroidal topical therapies for long-term management in intertriginous areas or facial location; NB-UVB; consider apremilast, acitretin, cyclosporine, methotrexate, or approved biologics; if not responsive, treat as severe; refer to dermatology
Continue ICI	Hold ICI	Hold ICI

Bullous Dermatitis and SJS/TEN

Grade 1	Grade 2	Grade 3/4	SJS/TEN[a]
<10% BSA, asymptomatic	10%–30% BSA; painful blisters; iADLs limited	>30% BSA; limiting self-care ADLs; associated with fluid or electrolyte abnormalities	
Management High-potency topical steroid	**Management** Prednisone/IV methylprednisolone; if no improvement after 3 days, urgent dermatology consult (if no access to dermatology, consider inpatient care); if bullous pemphigoid confirmed by biopsy or serology, consider rituximab or dupilumab	**Management** Prednisone/IV methylprednisolone; if bullous pemphigoid confirmed, use dupilumab as steroid-sparing measure; consider alternative steroid-sparing options (eg, IVIG) as an adjunct to rituximab; inpatient care required; urgent dermatology consult	**Management** Prednisone/IV methylprednisolone; evaluate entire medication list for alternative culprit drug; urgent dermatology, ophthalmology and urology consults; consider IVIG; other immunosuppressive therapies; inpatient care required
Consider Holding ICI	Hold ICI Until <G1	Discontinue ICI	Discontinue ICI

IVIG, intravenous immunoglobulin.

[a]NCCN grades SJS/TEN as an extension of severe (grade 3/4) bullous dermatitis, so management escalates along one continuous scale.

NCCN®. 2025. https://www.nccn.org/professionals/physician_gls/pdf/ici_tox.pdf.

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