

NEW: EULAR points to consider for the diagnosis and management of rheumatic immune-related adverse events due to cancer immunotherapy with checkpoint inhibitors

8 May, 2020, Kilchberg, Switzerland – The European League Against Rheumatism, EULAR, has published recommendations around rheumatic immune-related adverse events caused by cancer treatment with checkpoint inhibitors.

These points to consider are designed to raise awareness and to assist rheumatologists to improve the diagnosis and the management of patients who develop side effects from checkpoint inhibitor drugs: rheumatic and musculoskeletal immune-related adverse events (irAEs) are observed in about 10% of cancer patients receiving immune checkpoint inhibitors (ICI). Based on evidence from a systematic literature review and expert opinion, a EULAR multidisciplinary task force formulated four overarching principles and ten points to consider, which have been published in the EULAR Journal, the Annals of the Rheumatic Diseases, ARD.

The four overarching principles are:

- Rheumatic and musculoskeletal immune-related adverse events can occur in people receiving immunotherapy with checkpoint inhibitors.
- Management of these immune-related adverse events should be based on a shared decision-making process between patients, oncologists and rheumatologists
- Rheumatologists should engage with oncologists to contribute to the inter-disciplinary care of patients presenting with musculoskeletal signs and symptoms
- The role of rheumatologists is to assist oncologists in differential diagnosis and to relieve rheumatic and musculoskeletal symptoms to an acceptable level enabling patients to maintain effective cancer immunotherapy.

The 10 points to consider give detailed and practical guidance for rheumatologists:

- Rheumatologists should be aware of the wide spectrum of clinical presentations of rheumatic immune-related adverse events that often do not fulfil traditional criteria of RMDs
- Oncologists should be encouraged to consult rheumatologists promptly when rheumatic symptoms are suspected due to immunotherapy, and rheumatologists should provide facilitated access for these patients
- Metastases, paraneoplastic syndromes or unrelated rheumatic diseases might look like immune-related adverse events. Clinical evidence, laboratory tests, imaging and if needed biopsies should be collected to search for inflammation and exclude differential diagnoses
- Local and/or systemic steroids should be considered for immune-related rheumatic or systemic symptoms, and then tapered to the lowest effective dose to control the symptoms once improvement is achieved
- csDMARD should be considered in patients with insufficient response to acceptable dose of glucocorticoids or requiring glucocorticoid-sparing

- bDMARDs should be considered for patients with severe rheumatic and systemic immune-related adverse events or those with insufficient response to csDMARDs, with TNF or IL-6 inhibitors being the preferred options for inflammatory arthritis
- The decision to hold or to continue cancer immunotherapy should be made with the patient, and based on the severity of rheumatic adverse events, the required immunosuppressive regimen, the tumour response and duration, as well as the future oncology treatment plan
- Myositis may be a severe condition, and immunotherapy withdrawal needs to be discussed. If there are life-threatening symptoms, high dose of glucocorticoids plus other treatment options should be used instead
- Cancer immunotherapy can be used in patients with pre-existing autoimmune rheumatic and/or systemic disease, and baseline immunosuppressive regimen should be kept at the lowest dose possible (for glucocorticoids, below 10 mg prednisone per day if possible)
- Before starting cancer immunotherapy, there is no indication to test every patient for the presence of autoantibodies., but a complete rheumatological assessment should be performed in case of rheumatic, musculoskeletal or systemic symptoms

The EULAR points to consider advise that early consultation and strong collaboration between the referring oncologist, the treating rheumatologist, potentially other organ specialists and the patient are all required for optimal irAEs management. All these statements provide the basis of an EULAR consensus on the diagnosis and the management of rheumatic and systemic irAEs which represent a new and rapidly expanding field.

Citation

Kostine M, et al. *Annals of the Rheumatic Diseases*. Published online first 23 April 2020. doi: 10.1136/annrheumdis-2020-217139

About EULAR

The European League against Rheumatism (EULAR) is the European umbrella organisation representing scientific societies, health professional associations and organisations for people with rheumatic and musculoskeletal diseases (RMDs). EULAR aims to reduce the burden of RMDs on individuals and society and to improve the treatment, prevention and rehabilitation of RMDs. To this end, EULAR fosters excellence in education and research in the field of rheumatology. It promotes the translation of research advances into daily care and fights for the recognition of the needs of people with RMDs by the EU institutions through advocacy action.

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Notes to Editors

EULAR Recommendations: https://www.eular.org/recommendations_home.cfm

EULAR Strategy: https://www.eular.org/eular_strategy_2018.cfm

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