European Journal of Cancer 111 (2019) 59–60

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Letter to the Editor

Letter to the editor: Comments on 'A case of pembrolizumab-induced autoimmune haemolytic anaemia with polymyalgia rheumatica'

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Received 30 October 2018; accepted 11 November 2018
Available online 28 February 2019

Dear Editor,

We read with interest the report by Robilliard et al. [1] of a pembrolizumab-induced immune-related adverse event (irAE). We applaud them for bringing attention to polymyalgia rheumatica (PMR) as a rheumatic irAE after immune checkpoint inhibitor therapy and would like to add some comments and conclusions.

One point of note was the suggested approach to corticosteroid therapy for PMR. Classical PMR reliably responds to an initial corticosteroid dose of prednisone 15–25 mg daily, much lower than that suggested by the authors [2,3]. Although some patients experiencing PMR-like irAEs do require higher doses for symptomatic relief, in our experience, the majority respond as a patient with classical PMR would [4]. Indeed, it remains unclear whether the disease which afflicts non-responders represents de novo PMR or a different disease entity entirely [5]. We, therefore, suggest that trialling prednisolone 15 mg daily rather than a higher dose in the first instance represents the most appropriate course of action for a patient presenting with a PMR-like irAE.

A careful approach to prescribing moderate doses of prednisone is important in light of evidence suggesting corticosteroids may diminish the efficacy of PD-1 inhibitor therapy [6]. In the case described by the authors, the therapeutic impetus was for a higher corticosteroid dose due to autoimmune haemolytic anaemia. By contrast, patients with PMR-like irAEs alone might be able to avoid higher doses of corticosteroids and any consequent impairment of antitumour response. Rheumatic irAEs may also be mimicked by non-inflammatory phenomena where corticosteroid use is not necessarily justified [7]. It is, therefore, imperative that suspected adverse events are clearly elucidated, so as to ensure that appropriate management can be instituted.

In differentiating phenomena, one potentially useful modality is whole-body positron-emission tomography/computed tomography (PET/CT) [8], where classical PMR exhibits a distinctive pattern of abnormal 18F-fluorodeoxyglucose (18F-FDG) uptake [9,10]. PMR-like irAEs may accordingly be detected on PET/CT scanning being performed for oncological staging purposes [11].

DOI of original article: https://doi.org/10.1016/j.ejca.2018.07.318.
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https://doi.org/10.1016/j.ejca.2018.11.034
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We consequently wonder whether the patient described in the case may have possessed characteristic features of PMR on the simultaneously performed PET.

In the context of these points, we cannot help but emphasise the sentiment from the authors that the emergence of irAEs increases the importance of collaboration between oncologists and other medical specialists. The involvement of rheumatologists in the assessment of rheumatic irAEs may help guide both diagnosis and therapy [12]. We would encourage oncologists to turn to their rheumatological colleagues for this purpose and for rheumatologists to likewise make themselves readily available to their oncology peers.

Author contributions

David Liew developed the initial manuscript and finalised for submission. All authors substantially contributed to revising the article, critically regarding important intellectual content, approving the final version and agreeing to be accountable for the integrity of the work.

Conflict of interest statement

None declared.

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