Medical Dermatologic Society Mentorship

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Mentor: Dr. Jennifer Nam Choi; Northwestern University Department of Dermatology

Working with Dr. Jennifer Nam Choi at Northwestern University through the Medical Dermatologic Society (MDS) mentorship program is one of my most memorable experiences thus far during residency. Dr. Choi recently transitioned from Yale University to Northwestern and is now Chief of the Division of Oncodermatology at Robert H. Lurie Comprehensive Cancer Center where she specializes in providing skin care for patients undergoing cancer treatment. The primary goal of my mentorship was to gain experience diagnosing and treating a wide-range of patients with a variety of cutaneous adverse events from anticancer therapies. I spent three half days of clinic a week working with Dr. Choi in the Cancer Center and the rest of the week in her general dermatology outpatient clinics. I attended inpatient consult rounds and was present for all research meetings. During my rotation, I had the opportunity to see many patients with classical presentations as well as several atypical or even novel presentations of cutaneous adverse events from cancer therapies. One patient developed multiple keratinizing skin tumors in the setting of anti-Programmed cell Death 1(PD1) therapy; which was previously seen predominantly with BRAF therapy, such as vemurafenib. Additionally, we saw one patient with a history of adenocarcinoma and systemic lupus erythematosus (SLE) who developed subacute cutaneous lupus erythematosus (SCLE) while on treatment with capecitabine. Drug-induced SCLE from capecitabine has infrequently been reported; however, this is the first case in a patient with known underlying SLE. We are currently working on writing up these case for submission to dermatology or oncology journals. I additionally gained knowledge on managing patients with chronic graft versus host disease and spent time with Dr. Jaehyuk Choi in the photopheresis suite where he treats many patients with GVHD as well as other cutaneous and systemic diseases. Several patients at Northwestern were being treated with the newer anti-melanoma therapies, including TVEC; which I saw administered in a patient with multiple localized cutaneous metastases. Not only was I working directly with Dr. Choi, but I also had the privilege of working alongside all of the wonderful Northwestern Dermatology residents and faculty. Overall, the MDS mentorship program provided me with a unique clinical experience and I grateful for the lifelong mentorship I have developed with Dr. Choi and look forward to working with her again in the future.

Abstract:

Capecitabine-Induced Subacute Cutaneous Lupus Erythematosus

A 68-year-old female with colon adenocarcinoma presented to dermatology 8 weeks after starting capecitabine with a rash on her upper body. Her past medical history was significant for systemic lupus erythematosus (SLE), for which she was taking hydroxychloroquine 200 mg twice daily. Physical exam revealed several thin pink annular scaly papules and plaques on her forearms, posterior neck and anterior chest in a photodistribution. Similar scaly papules were seen on her upper lip and bilateral cheeks. Patches of scarring alopecia in the scalp were also appreciated. Of note, the patient reported worsening of the rash in the sun. A biopsy was obtained from her left forearm and the patient was prescribed topical triamcinolone 0.1% ointment twice daily to the affected areas. Histopathology showed an interface lymphocytic infiltrate with basal vacuolar changes and necrotic keratinocytes. Dermal edema and telangiectasias with a perivascular lymphocytic infiltrate were also appreciated. Laboratory values showed a rise in her anti-DNA antibody to 498, up from 396 before starting capecitabine. Her complement C3 and C4 levels also fell from 79 to 66 and 14 to 10, respectively. Additionally, her blood work demonstrated weakly positive anti-Ro, anti-smith, and anti-histone antibodies. These values had not been checked previously, so no comparative data were available. All other laboratory data were unremarkable. At 2- week follow up, the patient's rash had significantly improved with topical corticosteroids and sun protection. The patient was diagnosed with drug-induced subacute cutaneous lupus erythematosus (SCLE) and the decision was made to stop capecitabine therapy. The possibility of a flare of her underlying SLE with cutaneous involvement was also considered. Given the resistive nature of the patient's malignancy, and the fact that she had failed multiple anticancer therapies, the decision was made to genetically profile her tumor to determine the next best course of treatment. Drug-induced SCLE from capecitabine has infrequently been reported; however, this is the first case in a patient with known underlying SLE. Patients should be counseled on the risk of developing SCLE during treatment with capecitabine but additional research is needed to determine if there is a true association of developing drug-induced SCLE in patients with underlying SLE or known positive antinuclear antibodies.

References:

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