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Latin America Cutaneous Oncology Management (LACOM) II: A Practical Algorithm for Managing Skin Toxicities in Oncology Patients

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ABSTRACT

Background: Anticancer treatments are associated with cutaneous adverse events (cAEs) that can severely impact patients' quality of life (QoL) and interfere with treatment outcomes. LACOM aims to support clinicians in preventing and managing cAEs to optimize patient outcomes.

Methods: A panel of dermatologists, clinical oncologists, and radiation oncologists developed an evidence-based algorithm for the prevention and treatment of cancer treatment-related cAEs using a skincare regimen that includes hygiene, moisturization, sun protection, and camouflage products.

Results: The LACOM II algorithm discusses patient education before cancer treatment, appropriate skincare, triage, and the importance of treating emerging cAEs with a multidisciplinary team.

Conclusions: Integrating proactive education, safe and effective skincare, triage, and reaction-specific management of cAEs is essential to optimize the care of patients living with cancer. The LACOM II algorithm provides evidence- and opinion-based best-practice recommendations to support clinicians working with oncology patients throughout the continuum of care, achieving optimal outcomes and improving patients' QoL.

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INTRODUCTION

According to the GLOBOCAN Estimates of Incidence and Mortality Worldwide, approximately 1.5 million new cancer cases and 749,000 cancer deaths were estimated to occur in Latin America and the Caribbean in 2022. The age-standardized incidence rate was 199.9 for males, 177.4 for females, and 186.0 for both sexes.[1] The top three leading cancers for men in this region were prostate cancer, colorectal cancer, and lung cancer, while the three leading cancers for women were breast cancer, colorectal cancer, and cervical cancer.[1]

While breast cancer is the leading cause of cancer death among women in most Latin American countries, cervical cancer is the leading cause of cancer death among women in Belize, Honduras, and El Salvador in Central America and in Bolivia and Peru in South America. In males, prostate cancer is the leading cause of cancer death in most countries in this region, while lung cancer is the most frequent cause of cancer death in Argentina, Bolivia, Brazil, Cuba, and Uruguay.[2]

Several treatment options are available depending on the type and stage of cancer and patient-related factors. These options

include surgery, radiation, transplantation, chemotherapy, immunotherapy, targeted therapy, hormonal therapy, or combinations.[3] While advancements in therapy have improved survival rates, they have also led to an increase in patients living with cutaneous adverse events (cAEs) or sequelae of cancer treatments.[3,4]

Skin toxicities involving the skin, mucosa, hair, and nails are very common in patients undergoing cancer treatment and have been found to occur with all types of anticancer therapies.[5] Some cAEs are severe enough to warrant treatment interruption or permanent discontinuation of cancer treatment in some patients, translating to suboptimal outcomes.[5]

While cAEs can be debilitating for patients, they are often given a low priority compared to life-threatening side effects (eg, neutropenia). However, cAEs induced by cancer therapy negatively impact body image, physical, emotional, and functional well-being, and cancer treatment satisfaction.[6] They can lead to an impairment in interpersonal and emotional well-being, may be painful or disfiguring, and may lead to treatment dose reductions and treatment discontinuation, which can be detrimental to treatment outcome.[5] Furthermore, patients frequently report skin toxicities to be unanticipated and much worse than their initial beliefs.[6]

Managing cAEs is important not only to optimize the patient's QoL, psychological well-being, and treatment adherence, but also to prevent treatment interruption or discontinuation.[6] There is a need for more evidence-based management strategies for individuals experiencing cancer-treatment-related cAEs.

Why This Project?

The Latin American Cutaneous Oncology Management (LACOM) project offers clinical insights into cancer-treatment-related cAEs. The LACOM panel aims to provide evidence and opinion-based best practice recommendations for oncology skincare programs to support all stakeholders in the LATAM healthcare setting (Argentina, Chile, Colombia, Ecuador, Panama, Peru, and Mexico) working with oncology patients throughout the entire continuum of care to achieve optimal outcomes and improve cancer patients' and survivors' QoL. The LACOM project is supported by a member of the US Cutaneous Oncodermatology Management (USCOM) project, which is sharing experience.[3]

MATERIALS AND METHODS

LACOM II used a modified Delphi approach to develop an evidence-based algorithm for the prevention and treatment of cancer treatment-related cAEs, using a skincare regimen that incorporates hygiene, moisturization, sun protection, and camouflage products. The algorithm aims to support clinicians working with oncology patients throughout the entire continuum of care to achieve optimal outcomes, improving cancer patients' and survivors' QoL. The LACOM panel of dermatologists, clinical oncologists, and radiation oncologists who treat cAEs developed, discussed, and reached a consensus on an evidence and opinion-based practical algorithm for oncology skincare programs aiming to support all stakeholders in the Latin American healthcare setting working with oncology patients and cancer survivors such as medical oncologists, radiation oncologists, family practice/internal medicine specialists, dermatologists, oncology nurses, advanced practice providers (nurse practitioners/physician assistants), and pharmacists.

The published LACOM I article[3] informed the development of the algorithm. The process entailed preparing the project, selecting the panel, and conducting scoping literature searches. This was followed by a panel meeting on November 21, 2024, in Cartagena, Colombia, to discuss the literature review results addressing non-prescription skincare for prevention, treatment, and maintenance of cAEs, and develop an algorithm on skincare for the prevention and treatment of cancer treatment-related cAEs using evidence coupled with the expert opinion and experience of the panel. An online process was used to fine-tune the evidence and opinion-based practical algorithm and to prepare and review the publication.

Literature Review

The LACOM group explored clinical insights into addressing cAEs in oncology patients, focusing on skincare regimens that incorporate hygiene, moisturization, sun protection, and camouflage products. Searches were conducted on October 3, 2024, by two reviewers (AA and HA) on PubMed and Google Scholar (secondary source) for articles in English and Spanish, published from 2010 to October 2024, describing current best practices for preventing and managing cAEs using skincare in Argentina, Chile, Colombia, Ecuador, Panama, Peru, and Mexico (LATAM countries). The titles of publications were first reviewed, followed by abstracts, and then the full articles.

The search terms and other details are listed in Table 1. Searches identified literature on current best practices for cancer-treatment-related cAEs involving nonprescription skin care. The selected literature was clinically relevant to oncodermatology in LATAM countries and addressed efficacy, safety, QoL, handling and comfort, adherence to treatment, and the availability of the skincare regimen (Table 1).

Clinical trials, case series, consensus papers, data mining studies, guidelines, meta-analyses, retrospective chart reviews, systematic reviews, and reviews were included. Publications were excluded if they were not on skin care for cAEs, were not peer-reviewed, or were published in a language other than English or Spanish.

The Algorithm

The algorithm begins with counselling patients before initiation of cancer treatment (education, skincare, behavioral measures, risk stratification), followed by administration of cancer treatment. If the patient develops cAEs, the algorithm proceeds to in-person triage and dermatologist assessment of severity and risk, followed by reaction-specific management (Figure 1).

Education Before Starting Cancer Treatment

Before initiating anticancer treatment, the treating physician and nurse, or other multidisciplinary oncology team member, should have a detailed conversation with the patient addressing the treatment protocol, potential cAEs, hospital visits, diagnostic tests, management of cAEs, and preventative measures.[6,7] In addition to verbal information, clinicians should provide the

TABLE 1.

Terms Used for the Literature Searches	
Inclusion Criteria	**Exclusion Criteria**
Guidelines, consensus papers, and reviews describing current best practices in cancer treatment-related adverse events (cAEs) using non-prescription skincare, as well as clinical research studies published in the English language from 2010 to October 2024.	Publications not related to skincare for the prevention and treatment of cAEs, and publications in languages other than English or Spanish.
Search Terms	**Strategy**
Incidence of cancer in the Latin American population Cancer-treatment-related cAEs AND Radiation treatment; OR chemotherapy; OR targeted therapy; OR immunotherapy; OR Hormonal treatment; OR Health-related quality of life; OR skincare and prevention; OR* skincare and treatment; OR* adjunctive skincare; OR* non-prescription skincare; OR* skincare adherence, concordance; OR* skincare efficacy, safety, tolerability, skin irritation OR* staff and patient education.*	First title, then abstract, then full article Searches on PubMed and Google Scholar on 3 October 2024 were done by two reviewers (AA and AH)

*Argentina, Chile, Colombia, Ecuador, Panama, Peru, and Mexico
cAEs, cutaneous adverse events.

FIGURE 1. Literature review results.

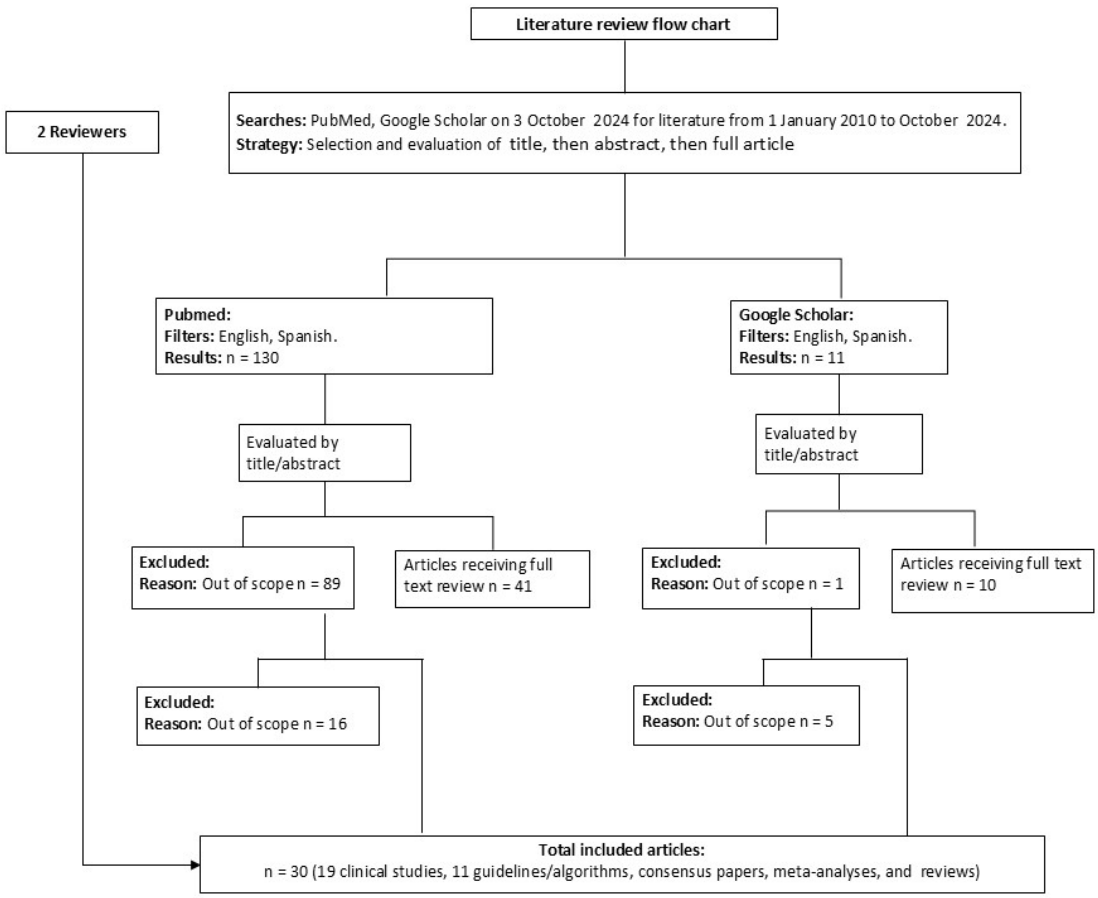
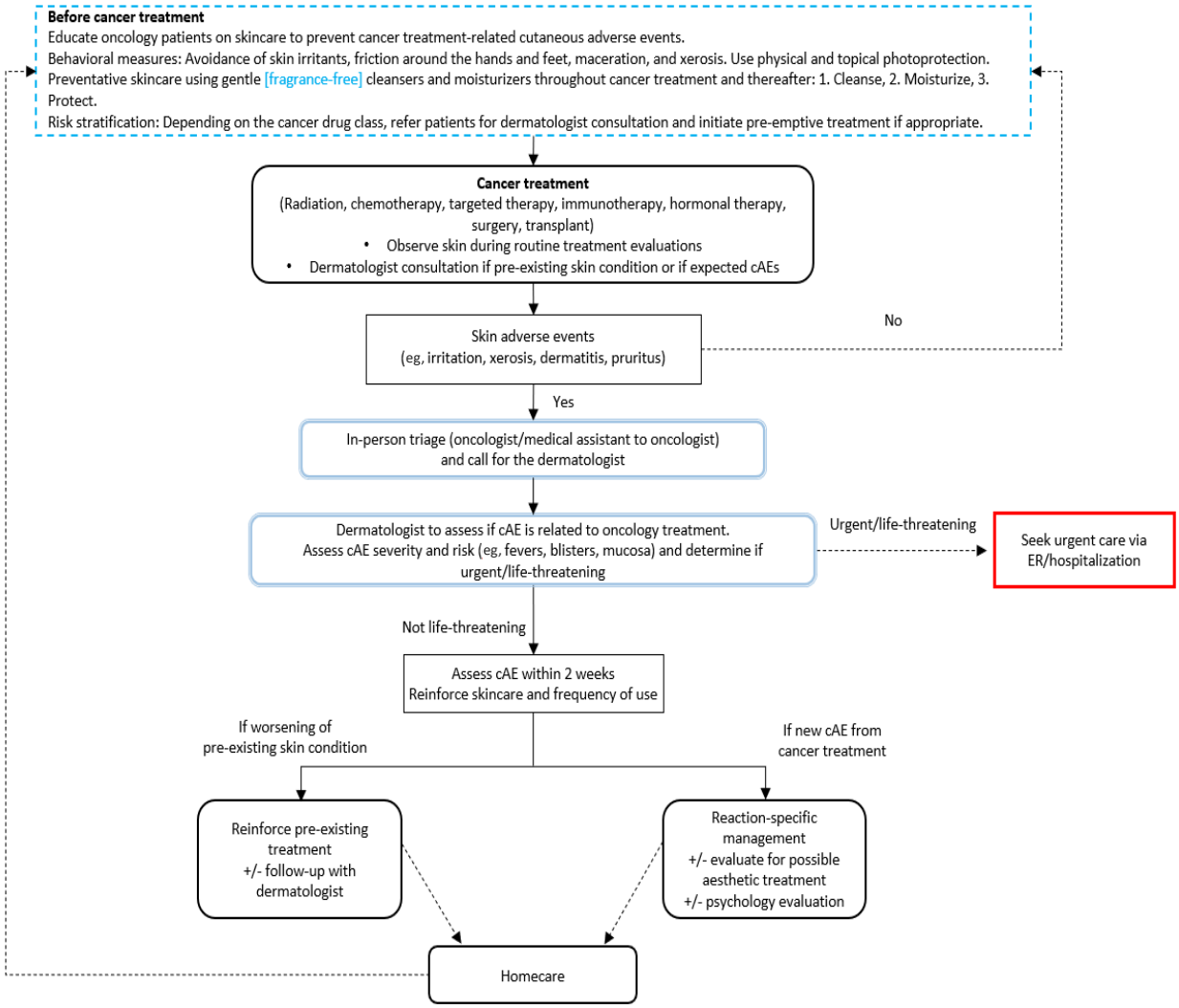


FIGURE 2. Algorithm.



patient with printed or digital material to allow the patient to clarify and process the information.[6,7]

During this time, clinicians should review potential skin changes that may occur due to treatment. They should give patients contact information and explain who to contact, when, and why.[7] Patients should also be encouraged to always report skin changes, regardless of severity. Clinicians must educate on skincare and behavioral measures that may help prevent cAEs (Table 2), and to reinforce that prevention and early treatment of cAEs can lead to better cancer-treatment outcomes and QoL.[5,7,8]

Prevention is a key element of managing skin toxicities.5 Initiating a simple skincare regimen involving hygiene, moisturization, and sun protection is the first step in preventing or reducing cutaneous toxicities (Table 3).[5-7] The skincare regimen should be started before initiating anticancer treatment and continued throughout cancer therapy. Skincare formulations for patients undergoing cancer therapy should be free of additives, fragrances, perfumes, and sensitizing agents, and have a near-physiologic (skin surface) pH. In addition, skincare should be cosmetically pleasant and easy to apply.[5,6]

In a study by Berger et al, a skincare regimen of thermal water-containing products, a cleanser, emollient, healing cream, and sunscreen was used during the 6 weeks of radiation treatment. Individuals who used skincare daily experienced fewer cAEs than those who used less skincare.[9] Despite the growing body of evidence on the benefits of a skincare regimen for the prevention and treatment of cAEs for patients undergoing anticancer treatment and cancer survivors, evidence on specific ingredients is scarce.

TABLE 2.

reventive Skincare and Behavioral Measures		
Reaction	**Skincare (Prevention)**	**Behavioral Measure**
Xerosis/Pruritus	Regular emollient use Acidic (pH 5.5) cleanser Sunscreen with SPF 30+	Avoid harsh soaps and basic pH cleansers Limit shower time and avoid hot water
Acneiform Rash	Twice daily moisturizer use (particularly moisturizers with 5% to 10% urea) Sunscreen with SPF 30+ Low-dose cyclines Topical dapsone gel *Avoid topical retinoids, benzoyl peroxide, and azelaic acid due to potential for burning/irritation*	Avoid sun exposure and frequent washing with hot water
Nail Changes	Topical emollients Nail lacquers	Minimize pressure, trauma, and friction on the nails Avoid irritants (eg, frequent/prolonged water exposure, aggressive manicures, nail biting, washing dishes without protective gloves, artificial nails)
Hand And Foot Syndrome	Apply a skin repairing balm or urea-based cream once or twice daily Use creams containing urea or salicylic acid	Avoid irritants to hands and feet, long walks, and walking barefoot
Acute Radiation Dermatitis	Sunscreen with SPF 30+ Topical treatments with hyaluronic acid, niacinamide, panthenol, glycerin, allantoin, or squalene	Sun protection measures (avoid peak UV hours, wear hats and protective clothing)
Vaginal Atrophy	Water-based gel, hyaluronic acid gel/vaginal suppositories can be used routinely to improve moisture and pH Hormone-free vaginal lubricant can be used as needed before intercourse	--

SPF, sun protection factor; UV, ultraviolet.

TABLE 3.

Key Characteristics of a Skincare Regimen	
Skincare	**Key Characteristics**
Cleanser	Gentle cleanser (pH 4.0–7.0) daily
Moisturizer	Moisturizing cream or skin repairing balm once or twice daily Moisturizing creams should support skin barrier function, maintenance, and repair
Sun protection	SPF 30+ Anti-UVA/anti-UVB Apply sunscreen every 2 hours in case of sun exposure
Camouflage products	Gentle makeup

SPF, sun protection factor; UVA, ultraviolet A; UVB, ultraviolet B.

Cleansers should have a pH close to that of skin (~5). Educate patients to avoid cleansers with an alkaline pH (>7) as they can remove skin lipids and elevate skin surface pH, triggering inflammation and reducing skin microbiome diversity.[5]

Moisturizers can help maintain skin hydration, restore skin elasticity, sustain skin homeostasis, and control transepidermal water loss (TEWL).[6] Skin hydration not only relieves symptoms but also reduces the risk of xerosis induced by treatments.[5]

Although patients were historically advised to avoid skin creams in the hours before radiation treatment, recent findings demonstrated that skincare applications do not increase the radiation dose to the skin. Therefore, topical creams can be used in moderation before radiation therapy.[10]

Broad-spectrum, high SPF sunscreens are an essential component of sun protection, along with protective clothing, sunglasses, and sun avoidance. Patients should be advised to use a broad-spectrum sunscreen with an SPF of 30 or higher, and to reapply it every two hours.[7]

Gentle makeup may help cover lesions and improve patients' QoL and self-esteem. A study of 39 female patients with

TABLE 4.

Common cAEs Associated With Various Anticancer Treatments

Type of Treatment	Common Skin Toxicities
Radiation	Up to 90–95% of patients experience some form of skin reaction (erythema, pruritus, dryness, desquamation). About 15–25% develop moist dermatitis (grade 2–3) and fewer than 5% present with severe grade 4 lesions, such as ulceration or necrosis.
Traditional Chemotherapy	cAEs can present as alopecia (reversible and permanent), HFS, PPE, nail changes (onycholysis, pigmentary alteration, brittle nails), phototoxicity, paronychia (+/- pyogenic granulomas), inflammation of actinic keratoses, and urticaria.
Targeted Therapy	The most common cAE is acneiform (papulopustular) rash (45–100%), which primarily affects the sebaceous areas in the scalp, face, or upper trunk. Other common cAEs include nail changes (discoloration, pitting, paronychia, swollen and cracked lateral nail folds and cuticles, ingrowth of the nails, and partial or complete loss of nails), hyperkeratotic hand-foot syndrome, phototoxicity, trichomegaly, hirsutism, keratosis-pilaris-like reaction, morbilliform eruption, and alopecia.
Immunotherapy	cAEs may present as nonspecific maculopapular rash, pruritus, eczema, lichenoid reactions, psoriasis, pityriasis lichenoides-like reaction, Grover's disease, vitiligo-like lesions, bullous pemphigoid, dermatitis herpetiformis, prurigo nodularis, vasculitis, dermatomyositis, Sjögren's syndrome, sarcoidosis, photosensitivity, alopecia, sclerodermoid reaction, nail changes, xerostomia.
Hormonal Therapy	cAEs may present as xerosis, pruritus, alopecia (reversible), flushing, and vulvovaginal dryness/atrophy

cAE, cutaneous adverse event; HFS, Hand-Foot Syndrome; PPE, Palmar-Plantar Erythrodysesthesia

cancer treatment-related skin changes who self-administered camouflage makeup found that camouflage makeup was able to conceal almost all skin changes, improving QoL scores regardless of age, diagnosis, and site of skin changes.[11]

Risk Stratification

Table 4 lists common cAEs associated with various anticancer treatments.[8,12-16] While there is a risk for cAEs with all types of cancer treatment, the likelihood is higher with certain classes of medication.

Up to 90 and 95% of patients experience some type of skin reaction (erythema, pruritus, dryness, scaling). Between 15 and 25% develop moist dermatitis (grades 2–3), and less than 5% present with severe grade 4 lesions, such as ulceration or necrosis. Grade 3–4 radiation dermatitis can be painful, carries a risk of infection, and can negatively affect the patient's quality of life. Managing these cAEs during and after treatment is an important aspect of cancer care.[13]

Cutaneous toxicities appear to be one of the most prevalent adverse events from immunotherapy, both with anti-PD-1 and anti-CTLA-4 agents or with anti-PD-L1 agents. More than one-third of patients treated with immunotherapy experience cAEs, most commonly maculopapular rashes and pruritus. Early recognition and adequate management are essential to prevent exacerbation of lesions, limit treatment interruptions, and minimize impairment of QoL.[16] Furthermore, dermatologic evaluation in patients with cutaneous immune-related adverse events (cirAEs) is associated with a higher likelihood of immunotherapy resumption and improved progression-free and overall survival.[17]

Alopecia is one of the most common chemotherapy-related cAEs. A study found that 58% of patients considered chemotherapy-induced hair loss to be the most distressing side effect of cancer treatment, and 8% stated that they would refuse chemotherapy due to their fear of losing their hair.[6] This highlights the key role of clinicians in discussing aids, such as hats, scarves, or wigs, before treatment. Automated scalp cooling systems can be used in breast cancer patients receiving anthracycline and taxane-containing chemotherapies to minimize chemotherapy-related alopecia, but not for hormone therapy-related alopecia.[8]

The LACOM panel recommends referring all high-risk patients to a dermatologist for cAE evaluation before starting cancer treatment. Pre-emptive treatment can be initiated if appropriate.

Assessing Emerging cAEs Using the CTCAE Grading System

In some cases, cAEs may still develop despite preventative therapy. Recognizing cAEs and managing them appropriately and in a time-efficient manner is essential. The LACOM panel recommends in-person triage by the oncologist or medical assistant to the oncologist, with a call for the dermatologist if necessary. The dermatologist will assess if the cAE is related to oncology treatment and determine the severity of the skin reaction using the Common Terminology Criteria for Adverse Events (CTCAE) grading system v.5 (Table 5).[18] While the CTCAE contains gradings for specific cAEs such as alopecia, bullous dermatitis, and eczema, it is important to note that not all 5 grades will apply to all cAEs.[18]

TABLE 5.

CTCAE Grading System

Grade	Description
Grade 1	Mild
Grade 2	Moderate, minimal, local, or noninvasive intervention indicated
Grade 3	Severe, medically significant but not immediately life-threatening
Grade 4	Life-threatening consequences urgent intervention indicated
Grade 5	Death related to the cAEs

cAEs, cutaneous adverse events.

Situations That Warrant a Dermatology Consult in Oncology Patients

Early identification of severe cAEs is essential to ensure the patient receives prompt inpatient or ICU-level care. Symptoms that may indicate severe cAEs include fever, widespread rash, skin pain, skin sloughing, facial or upper-extremity edema, bullae, erosions, or mucosal involvement.[12] Patients with grade 3 reactions may need to withhold anti-cancer therapy; this decision should be made in consultation with an oncologist and/or dermatologist. However, those with grade 4 (life-threatening) reactions require immediate treatment discontinuation, in addition to urgent care and hospitalization.[8,18]

Managing cAEs Associated With Cancer Treatment

Importance of a multidisciplinary team

The LACOM panel recommended treating cAEs within multidisciplinary teams that include oncologists, dermatologists, and nurses. While the structure of a multidisciplinary team can differ from country to country, the core of the team consists of oncologists, including medical, surgical, and radiation oncologists, as well as oncology nurses. Dermatologists can be a strong asset to the multidisciplinary care team. Not only can dermatologists manage cAEs with appropriate topical and/or systemic therapy, thereby improving the patient's QoL, but they can also identify and assist in managing life-threatening cutaneous toxicity.[6] Barrios et al showed that involving dermatologists with the oncology care team increased the rate of positive outcomes, decreased the potential for skin toxicity recurrence, and decreased interruption of anticancer therapy.[12,19] Dermatologic services should be readily available for all patients undergoing anticancer treatments.

Each team member's role should be clear and must be accepted by all team members and health care providers involved in the patient's cancer care.[12] For example, nurses may be best positioned to counsel patients before treatment and answer their questions about their medication, potential skin reactions, how to apply skincare, etc. The panel also noted the importance of optimizing communication between oncodermatologists and oncologists. They supported having dermatologists work together with oncologists to demonstrate the necessity of important non-drug treatments for insurance and other companies that fund care.

If the worsening of a pre-existing condition

Worsening of a pre-existing condition should prompt reinforcement of the patient's pre-existing treatment and the principles of their skincare regimen, while a consultation with the dermatologist should be scheduled for further assessment, supportive care, and reaction-specific management.

If a new cAE from cancer treatment

If patients develop new cAEs from cancer treatment, prompt and effective intervention is crucial. If not managed effectively, skin toxicities may cause significant discomfort, be disfiguring, lead to severe morbidities that severely affect the QoL, and can lead to anticancer treatment interruption or discontinuation.[6]

Management strategies differ depending on the cAE and may include topical therapy or systemic treatment. In addition, some patients may seek aesthetic treatments (e.g., laser therapy for scar remodeling, neuromodulators, or dermal fillers to improve facial rhytids or correct atrophy secondary to radiation therapy). Such interventions can improve patients' quality of life; therefore, they should be advised by a qualified physician who can ensure compatibility with ongoing oncologic treatments.[4] Reaction-specific management is beyond the scope of this paper.

Supportive care to improve quality of life

Supportive care, defined as care given to improve the quality of life of people who have an illness or disease by preventing or treating, as early as possible, the symptoms of the disease and the side effects caused by treatment of the disease, includes physical, psychological, social, and spiritual support for patients and their families. Many types of supportive care are available, including pain management, nutritional support, psychological evaluation and counselling, exercise, music therapy, meditation, and palliative care.[20] Supportive care is a key component of a patient's cancer journey from diagnosis, through treatment, to care after treatment.[20] It should be offered to all people with cancer, irrespective of their personal circumstances, their type of cancer, their stage of cancer, or their anticancer treatment.[20]

Limitations

There is a gap in skincare recommendations in oncodermatology guidelines and literature. More data is needed regarding cAEs in Latin America. The recommendations in this paper were developed from a panel of expert clinicians and are supported by peer-reviewed literature.

CONCLUSION

Cancer-treatment-related cAEs are common and can severely impact patients' QoL and interfere with anticancer treatment outcomes.[3] To reduce the incidence of skin toxicities, clinicians should initiate a skincare regimen consisting of gentle cleansers, moisturizers, and sunscreen before anticancer treatment.[6] By integrating proactive education and skincare into cancer treatment, clinicians can help improve patient QoL, treatment adherence, and patient outcomes.

DISCLOSURES

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All authors contributed to the manuscript, reviewed it, and agreed with its content and publication.

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