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LETTER TO THE EDITOR

Supportive oncodermatology practices in Europe and the USA

Dear Editor,

Supportive oncodermatology (SOD) is an emerging specialized field that focuses on managing dermatologic adverse effects (dAEs) of cancer therapies.[1] This study aims to explore the current state of SOD in Europe and the USA to identify challenges and opportunities and propose strategies to improve oncologic patient outcomes.

This study received institutional review board approval. We conducted an anonymous online survey of 296 dermatologists including, those practicing SOD, chiefs of service and chiefs of postgraduate programmes who provided SOD services. Participants were recruited through officials SOD societies, the EADV Task Force of Dermatology for cancer patients and the American Oncodermatology Society; mailed surveys were answered via branching logic. We followed the AAPOR best practices for survey research.

Out of the 195 dermatologists (66.7% female) who responded to the survey (65.9% response rate), 163 (83.6%) were from European countries, and 168 (86.1%) practiced in cancer referral centres, with 52.8% having a specialized SOD clinic. Eighty (41.1%) held positions as chiefs of service or dermatology programme training directors, and 105 (53.9%) were dermatologists practicing SOD (Table 1).

The main barriers reported by chiefs of service in establishing SOD services were limited infrastructure (41.3%) and lack of funding (36.2%), followed by the absence of national/international guidelines (25%). The importance of a dedicated programme for SOD (93.7%) and access to training on SOD (95%) were recognized as essential for optimizing cancer patient care. However, limited SOD training collaboration was reported for nurses and oncologists (28.8%) (Table 2).

SOD specialists offered care of acute dAEs within the next available day (67.2%) and the same-day consultation (66.4%). Patients with dAEs from stem cell transplant (55.5%), cytotoxic chemotherapy (42.9%) and immunotherapy (37.5%) posed significant management challenges. SOD specialists often faced disagreements with oncologists regarding managing dAEs (53.9%) (Table 2). SOD specialists in Europe reported encountering more difficulties in SOD training (28.4% compared to 3.8%, $p < 0.05$). Although, European chiefs of service expressed a higher interest in SOD training (97.3% vs. 82.4%, $p < 0.05$).

This study provides valuable insights into the current situation of SOD services, highlighting both challenges and opportunities for improvement. The high recognition of access to SOD training (95%) reflects the understanding of the specialized knowledge and skills required in managing dAEs, resulting in recent guidelines from the American and European SOD societies.[2,3] However, the limited

TABLE 1 Survey responses (195) from participants on demographics and oncodermatology practice features.

Demographic and general information	*n* (%)
Age group (years)	
<35 years	53 (27.2)
35–55 years	115 (59)
>55 years	27 (13.8)
Sex	
Male	65 (33.3)
Female	130 (66.7)
Territory	
Europe	163 (83.6)
USA	32 (16.4)
Is your centre a referral for medical oncology?	
Yes	168 (86.1)
No	27 (13.9)
Supportive oncodermatology is a specialized clinic in your centre	
Yes	103 (52.8)
No	92 (47.2)
Mean consults per week of dermatologic adverse events at your centre	
<30	139 (72.3)
31–50	39 (20)
51–100	7 (3.6)
>100	10 (5.1)
Total number of dermatology visits at your dermatology service	
<50	15 (7.7)
51–150	45 (23.1)
151–250	22 (11.3)
251–400	27 (13.9)
400+	86 (44)
Dermatology position[a]	
Practicing supportive oncodermatology	128 (65.6)
Chief of Service or programme training directors with or without experience in supportive oncodermatology	80 (41.1)

[a]23 Chief of Service or programme training directors also were practicing supportive oncodermatology, percentage do not go up to 100.

TABLE 2 Survey responses by chief of service or dermatology programme training directors and supportive oncodermatology specialists.

Chief of service or dermatology programme training directors	***n*** **= 80 (%)**
Territory	
EU	63 (78.7)
USA	17 (21.3)
Would you agree with 'A dedicated programme for dermatologic care in cancer patients, or a dedicated clinician would contribute to optimizing cancer care'	
Strongly disagree + Disagree + Neutral	5 (6.3)
Agree + Strongly agree	75 (93.7)
Would you agree that access to consultants with supportive oncodermatology training is a significant advantage in caring for patients with dermatologic complications of oncologic treatment?	
Agree + Strongly agree	76 (95)
Strongly disagree + Disagree + Neutral	4 (5)
If educational materials on dermatologic conditions in cancer patients (online module, lectures, CME meetings, academic meetings) were available to your staff or fellows, how likely is it that you would encourage the use of these materials?	
Strongly disagree + Disagree + Neutral	5 (6.3)
Agree + Strongly agree	75 (93.7)
What are the greatest barriers or challenges to an oncodermatology supportive care programme at your centre?[a]	
Limited infrastructure	33 (41.3)
Limited funds	29 (36.2)
No barriers, we have a robust clinical service	21 (26.3)
No national/international guidelines or statements on this topic and/or Limited educational opportunities	20 (25)
Difficult or no collaboration with medical oncology or radiotherapy services	14 (17.5)
Limited interest/perceived value by dermatologists	9 (11.3)
Other	7 (8.8)
Do you train visiting dermatologists or dermatology residents at your centre on dermatologic adverse events of oncologic therapies?	
Never + Rarely + Sometimes	26 (32.5)
Always + Often	54 (67.5)
Do you train visiting oncology residents, oncologists or oncology nurses on dermatologic adverse events of oncologic therapies at your centre?	
Never + Rarely + Sometimes	57 (71.2)
Always + Often	23 (28.8)
Supportive oncodermatology specialists	***n*** **= 128 (%)**
Questions responses	
Territory	
EU	102 (79.7)
USA	26 (20.3)
How promptly do you see referred patients with adverse events of oncologic therapies? (Always + Often responses %)[a]	
Same-day consultations	85 (66.4)
Next available day	86 (67.2)
Within 7 days	79 (61.7)
I also see chronic (persistent or permanent) adverse events	
Sometimes + Rarely + Never	34 (26.6)
Always + Often	94 (73.4)
Are you regularly asked by oncologists about holding oncologic therapy due to dermatologic adverse events?	
Sometimes + Rarely + Never	56 (43.8)
Always + Often	72 (56.2)
Do you usually agree with the dermatologic management of adverse events with the oncologists?	
Sometimes + Rarely + Never	69 (53.9)

TABLE 1 (Continued)

Supportive oncodermatology specialists	*n* = 128 (%)
Always + Often	59 (46.1)
Do you have patients support groups and education available for your oncologic patients regarding skin care?	
No	90 (70.3)
Yes	38 (29.7)
Do you consider oncologists to be aware of the specific prevention strategies for dermatologic adverse events of oncologic therapies?	
Moderately + Slightly + Not at all aware	77 (60.2)
Extremely aware + Very aware	51 (39.8)
Do you consider oncologists to be aware of permanent or persistent dermatologic adverse events of oncologic therapies?	
Moderately + Slightly + Not at all aware	102 (79.7)
Extremely aware + Very aware	26 (20.3)
Are you familiar with the Common Terminology Criteria for Adverse Events (CTCAE) Version 5.0?	
Slightly + Not at all familiar	24 (18.8)
Moderately + Very + Extremely familiar	104 (81.2)
How difficult do you consider managing dermatologic adverse events of the following oncologic therapies? (Responses referring to Difficult + Very difficult)[a]	
Stem cell transplant	71 (55.5)
Cytotoxic chemotherapy	55 (42.9)
Immunotherapy	48 (37.5)
Targeted therapy	43 (33.6)
Radiotherapy	39 (30.5)
Endocrine therapy	28 (21.9)
Surgery	18 (14.1)

[a]Respondent able to select multiple answers.

collaboration for training on SOD with nurses and oncologists (28.8%) underlines the need for multidisciplinary cooperation and shared expertise to ensure comprehensive care for cancer patients.

SOD specialists demonstrated a commitment to prompt care and management of dAEs; this approach has shown to be beneficial in outpatients and hospitalized cancer patients.[4,5] While significant progress has been made, patients undergoing stem cell transplants, cytotoxic chemotherapy and immunotherapy remain particularly vulnerable due to dAEs management challenges.

Delayed and incorrect diagnosis hinders the timely management of dAEs.[5] In this study, high disagreements between SOD specialists and oncologists regarding dAEs management shows the importance of effective communication and the inclusion of SOD in cancer patient care.

While the overall similarities in responses from European and the USA participants may indicate a unified global commitment to enhancing cancer patient care, few differences were noted. The European SOD specialists reported more specialized training challenges that may suggest regional disparities in educational resources and opportunities. These findings emphasize the significance of tailoring SOD strategies to regional contexts.

We suggest the establishment of regular meetings, shared educational sessions, standardized protocols and integrated care plans involving oncologists and nurses. Utilizing virtual platforms for rapid consultations, prioritizing patient-centred approaches and investing further in training and infrastructure, ultimately optimizing SOD, may lead to improved patient care and outcomes in the field of oncology.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study will be deidentified and available from the corresponding author upon reasonable request.

ETHICAL APPROVAL

Approved by the Hospital Quirón Salud Fundación Jiménez Díaz IRB, Spain.

Azael Freites-Martinez[1]
Zoe Apalla[2]
Davide Fattore[3]
Monika Fida[4]
Alexander S. Bang[5]
Janellen Smith[6]
Shahab Babakoohi[7]
Mario Lacouture[5]
Vincent Sibaud[8]

[1]*Oncodermatology Clinic, Hospital Ruber Juan Bravo and Universidad Europea, Madrid, Spain*
[2]*Second Dermatology Department, Medical School, Aristotle University of Thessaloniki, Thessaloniki, Greece*
[3]*Section of Dermatology, Department of Clinical Medicine and Surgery, University of Naples Federico II, Naples, Italy*
[4]*Dermatology Department, University of Medicine of Tirana, Tirana, Albania*
[5]*Dermatology Service, Department of Medicine, Memorial Sloan Kettering Cancer Center, New York, New York, USA*
[6]*UC Irvine School of Medicine, Irvine, California, USA*
[7]*Atrium Health Levine Cancer, Wake Forest School of Medicine, Winston-Salem, North Carolina, USA*
[8]*Oncodermatology Department, Institut Universitaire du Cancer, Toulouse Oncopole, Toulouse, France*

Correspondence
Azael Freites-Martinez, Dermatology Service, Hospital Ruber Juan Bravo, Calle Juan Bravo 49d, Second Floor, Madrid, Spain.
Email: azaelfreites@yahoo.com

ORCID

Azael Freites-Martinez https://orcid.org/0000-0002-3121-5667
Zoe Apalla https://orcid.org/0000-0002-9255-8196
Davide Fattore https://orcid.org/0000-0002-1925-1243
Monika Fida https://orcid.org/0000-0001-8026-8995
Mario Lacouture https://orcid.org/0000-0002-4818-3710
Vincent Sibaud https://orcid.org/0000-0003-2585-6633

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