Transcript Details

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Recognizing and Addressing Rheumatic irAEs from Cancer Immunotherapies

Announcer:
You're listening to *Living Rheum* on ReachMD. On this episode, Dr. Laura Cappelli will discuss adverse rheumatological effects of cancer immunotherapy. She's an Associate Professor of Medicine and Oncology at the Johns Hopkins University School of Medicine, and she spoke on this topic at the 2025 Congress of Clinical Rheumatology East conference. Let's hear from Dr. Cappelli now.

Dr. Cappelli:
The most common immune-related adverse event that I see as a rheumatologist is by far inflammatory arthritis—so patients who did not previously have any autoimmune disease or inflammatory arthritis who then receive immune checkpoint inhibitor therapy for cancer and develop new inflammatory arthritis. That is definitely the most common. I think second most common is sicca syndrome from checkpoint inhibitors, and that's immune-mediated dry mouth and dry eyes, which has some similarity to primary Sjögren's syndrome. And then another immune-related adverse event that we really want to keep track of as rheumatologists, even though it's less common, is myositis—so inflammation of the muscles—and we really want to make sure that we are not missing myositis because when it occurs due to immune checkpoint inhibitor therapy, it could be associated with myocarditis or myasthenia gravis. And both of these are very serious complications when they happen and can even lead to mortality.

When you're thinking about cancer immunotherapy and which are more associated with rheumatologic complications, it's not really about a specific drug, but it is about combination therapy versus monotherapy or therapy with one drug alone. So we know that for most immune-related adverse events, combination therapy with drugs that block PD1 and drugs that block CTLA4, such as the combination of nivolumab and ipilimumab, that leads to the greatest rates of immune-related adverse events. And this is also true for our rheumatic immune-related adverse events, like inflammatory arthritis and myositis. So really taking note of the combination therapy is more important than which specific anti-PD-1 or anti-PD-L1 therapy the patient is getting, because for all of those therapies, when used alone, the rates of immune-related adverse events are similar.

The decision to halt or adjust the immunotherapy is always really a multidisciplinary decision. Taking care of these folks is really a team sport, and so we work together with the oncologists and the patient to decide whether patients might need to take a pause or entirely discontinue their immunotherapy for their cancer. If patients are near the end of the scheduled amount of immunotherapy they're going to receive and they're having significant symptoms that are affecting their activities of daily living and their ability to get around and take care of themselves, often the oncologists will stop the immunotherapy and say they probably had enough, even if it's not quite to the completion date. Now, for patients where immunotherapy is the only option, sometimes we are forced to treat their immune-related adverse events while they're still getting the immunotherapy. And again, that requires careful consideration with the oncologist and the patient to figure that out. And finally, there are some immune-related adverse events that are so severe that they require pausing and permanently discontinuing therapy, and that's things like myositis when it comes with myocarditis or myasthenia gravis.

I think that the collaboration between rheumatology and oncology is incredibly important for successful outcomes for these patients, and so it really depends on the setup, the healthcare setting that the patient's receiving the immunotherapy, and how these collaborations best work. For us, we see patients who are treated at our own center or patients who are referred in from elsewhere for immune-related adverse events, and so it really starts by making a connection with the patients' oncologists either electronically or the old-fashioned way via the phone and making sure that the oncologist is in agreement with the plan that you're proposing for the patient. And I often tell patients at the end of the visit, "This is the tentative plan, but we're going to confirm with your oncologists that they are also on board with this plan before we enact it. And so this is what I think the plan is going to be, and I will prescribe you this medication for your immune-

related adverse event, but wait until you hear back from me or the oncologist before you start so we make sure we're all on the same page." And I find that patients are very happy that you're reaching out to their oncologists, and they want their doctors to talk to each other, so if they have to wait a day or two for that to take place, they're definitely willing to do that, to have their team all on the same page.

Announcer:
That was Dr. Laura Cappelli discussing adverse rheumatological effects of cancer immunotherapy. To access this and other episodes in our series, visit *Living Rheum* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!