

# Managing folliculitis in daily practice

SKIN AND ONCOLOGY

FOCUS

## Folliculitis: the most common reaction to systemic therapy

Folliculitis, better known as rash, occurs in 43% to 85% of patients treated with targeted chemotherapy; it follows a typical chronological pattern that peaks in severity during the first 1–2 weeks of treatment.<sup>1,2</sup> Three phases are described:<sup>3</sup>



Papulopustular follicular rash is defined as a form of acne since it primarily involves the face's seborrheic areas, scalp and chest and less frequently the extremities and back. The eruption is accompanied by extremely irritating pruritus and can be complicated by bacterial over-infections, albeit short-lived. Its peculiar characteristic is the association of a typical sebaceous gland disease with marked xerosis, indicating that the main pathogenetic factor is not the cutaneous adnexa but the keratinocyte itself.<sup>4</sup>

Folliculitis can have a significant impact on patients' QoL, particularly their emotional wellbeing.

This may result in poor compliance, which could be detrimental to treatment outcome.<sup>1,5</sup>

Moreover, a survey found that:

**32%** of oncology practitioners discontinued therapy  
**76%** modified the dose due to severe rash.<sup>1,5</sup>

### GOING FURTHER

## Folliculitis classification according to the National Cancer Institute CTCAE v4.0

**Grade 1:** Papules and/or pustules covering <10% body surface area (BSA), which may or may not be associated with symptoms of pruritus or tenderness

**Grade 2:** Papules and/or pustules covering 10–30% BSA, which may or may not be associated with symptoms of pruritus or tenderness; associated with psychosocial impact; limiting instrumental activities of daily living (ADL)

**Grade 3:** Papules and/or pustules covering >30% BSA, which may or may not be associated with symptoms of pruritus or tenderness; limiting self-care ADL; associated with local superinfection with oral antibiotics indicated

**Grade 4:** Papules and/or pustules covering any % BSA, which may or may not be associated with symptoms of pruritus or tenderness and are associated with extensive superinfection with IV antibiotics indicated; life-threatening consequences

**Grade 5:** Death

## Managing folliculitis: a key role for tailored dermocosmetic supportive care<sup>1</sup>

All cancer therapy-related cutaneous adverse effects are linked to skin barrier dysfunction. Therefore, maintaining the skin's barrier function using appropriate skincare products may control the severity of symptoms.

As skin changes are particularly visible, the use of cosmetics may also improve self-image and decrease anxiety.

### GRADE 1 FOLLICULITIS

- It has been successfully managed with emollients and tailored skin cleansers or topical antibiotics and antiseptic soap.
- In the current absence of consistent clinical trials in subjects with severe rash, the use of mild skincare and photoprotection is advised.

### TO COVER GRADE 1 AND 2 FOLLICULITIS

- Non-occlusive makeup with high pigment concentration needed to conceal scars and lesions is recommended, while avoiding allergenic over-the-counter products.
- Makeup should be removed with a dermatologist-approved, low-irritant, nonalcohol-based hypoallergenic remover.

Over-the-counter acne products have not proven to be useful because they dry the skin and may cause burning, stinging, and irritation with no effect on treating rash. Using oil-in-water creams and avoiding treatments containing alcohol has been suggested when treating rash.

USE	AVOID
Gentle skin cleansers Proactive emollient application Photoprotection Non-occlusive makeup	Potentially allergenic products Acne treatments: benzoyl peroxide, tretinoin, tazarotene, adapalene

Adjunctive dermocosmetics for the management of folliculitis due to systemic therapy<sup>7</sup>

### Bibliography

1 - Bensaoudon R-J., Humbert P., Krutman J., et al. Daily baseline skin care in the prevention, treatment, and supportive care of skin toxicity in oncology patients: recommendations from a multinational expert panel. *Can Manag Res.* 2013;5:401–8.  
[View the link to the free full text](#)

2 - Lupu I., Voiculescu V.M., Bacalbasa N., et al. Cutaneous complications of molecular targeted therapy used in oncology. *J Med Life* 2016;9(1):19–25.  
[View the link to the free full text](#)

3 - Ouwerkerk J., Boers-Doets C. Best practices in the management of toxicities related to anti-EGFR agents for metastatic colorectal cancer. *Eur J Oncol Nurs* 2010;14:337–349.  
[View the link to the free full text](#)

4 - Fabbrocini G., Cameli N., Romano M.C., et al. Chemotherapy and skin reactions. *J Exp Clin Cancer Res.* 2012;31(1):50.  
[View the link to the free full text](#)

5 - Lacouture M.E., Anadkat M.J., Bensaoudon R-J., et al. Clinical practice guidelines for the prevention and treatment of EGFR inhibitor-associated dermatologic toxicities. *Support Care Cancer* 2011;19:1079–95.  
[View the link to the free full text](#)

6 - Robert C., Soria J.C., Spatz A., et al. Cutaneous side-effects of kinase inhibitors and blocking antibodies. *Lancet Oncol* 2005;6:491–500.  
[View the link to the abstract](#)

7 - Perez-Soler R., Saltz L. Cutaneous adverse events with HER1/EGFR-targeted agents: is there a silver lining? *J Clin Oncol* 2005;23:5235–46.  
[View the link to the free full text](#)