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Nivolumab reactivation of hypertrophic lichen planus, a case report and review of published literature.

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Abstract

We report a case of nivolumab-induced lichen planus (LP) reactivation that was previously in remission following chemotherapy for non-small-cell lung cancer (NSCLC). Chemotherapy-induced immunosuppression allowed for complete resolution of the patient’s pre-existing LP, a T-cell mediated autoimmune process. When the patient was switched to nivolumab immunotherapy owing to progression of NSCLC, PD-1 inhibition led to an overwhelming T-cell response that seemed to have provoked a severe LP reactivation. Although lichenoid reactions have been reported with nivolumab, to our knowledge, this is the first reported case of nivolumab monotherapy causing LP reactivation in a patient with a strong personal and family history of the disease that was previously in remission after chemotherapy.

Keywords: PD-1 inhibitor; nivolumab; lichen planus

Introduction

Nivolumab is a humanized monoclonal antibody that competitively binds to T-cell Programmed Death 1 (PD-1) receptors and PD-Ligand 1 (PDL-1) on tumor cells. This interaction impedes T-cell anergy, enhancing immunogenic response against malignant cells [1, 2]. Cutaneous reactions from PD-1 inhibitors are believed to relate to T-lymphocyte activation. They occur in 30-40% of patients on PD-1 inhibitors [2] and include maculopapular rash, pruritus, psoriasis, oral mucositis, and bullous pemphigoid [1], with lichenoid reactions, eczema, and vitiligo being the most common [3].

Case Synopsis

A 51-year-old man treated with nivolumab for stage IV non-small-cell lung cancer (NSCLC) presented with multiple pruritic hypertrophic purple-red polygonal papules with lichenification over ankles and feet. Two years prior to NSCLC diagnosis, he reported a biopsy-proven lichen planus (LP) eruption, partially controlled with fluocinonide ointment. Two infusions of cisplatin, pemetrexed, and bevacizumab coincided with LP resolution. As NSLC progressed, he was switched to nivolumab monotherapy. Within two weeks, LP recurred aggressively on his hands, feet (Figure 1A), and genitals. Histopathologic examination of skin biopsy confirmed the diagnosis (Figure 1B, C). Within 1 month, clobetasol ointment therapy made lesions thinner and minimally pruritic, allowing for uninterrupted nivolumab therapy.

Case Discussion

Hofmann et al. reported that primary adverse dermatologic events occur within 1-75 weeks after treatment initiation in 8.7% of patients receiving anti-PD-1 therapy for melanoma [4]. Mild cutaneous adverse reactions include vitiligo, alopecia, pruritus, eczema, lichen sclerosis; moderate reactions include lichen planus mucosae, erysipelas-like inflammation, hyperkeratosis; severe reactions include lichenoid skin reaction, lichen ruber mucosae, and Sweet syndrome [4].

Shi et al. reported that new-onset lichenoid interface dermatitis occurs in 94% of patients treated with nivolumab for lung carcinoma [5]. Hwang et al.
reported lichenoid reactions in 17.1% of metastatic melanoma patients receiving pembrolizumab [3]. The 5-fold difference in the incidence of lichenoid reactions between lung cancer and melanoma patients may be due to PD-1 drug variability, or the varying immunogenic responses of malignancies.

More severe cutaneous cases presented earlier (at 1-21 weeks) following initiation of pembrolizumab, whereas mild cutaneous reactions occurred later (at 40 or more weeks), Table 1. Twenty-five percent of Hwang et al.’s cohort developed lichenoid reactions within 8.3 months [3]. Our patient’s LP reaction occurred 2 weeks after initiating nivolumab. This short latency period may be attributed to a strong personal and family history of mucosal and cutaneous LP in his mother and brother.

Lichenoid eruptions are generally tolerable and rarely require interruption of therapy. Several treatment modalities have been effective in treating cutaneous reactions, including topical corticosteroids, topical antiseptic therapy, urea- and acetylsalicylic acid-containing ointments, analgesic and antihistamine therapy. Pausing or discontinuing the PD-1 inhibitor has occasionally been required. Topical corticosteroids were most effective in clearing mild reactions. For severe reactions, addition of prednisolone (1 mg/kg)
Table 1. Cutaneous side-effects of PD-1 inhibitors for treatment of metastatic melanoma and lung cancer.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Drug</th>
<th>Cancer</th>
<th>Occurrence after initiation</th>
<th>Treatment</th>
<th>Outcome of side effect</th>
<th>Clinical tumor response to anti-PD-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Case</td>
<td>N</td>
<td>NSCLC</td>
<td>0.5 months</td>
<td>Topical corticosteroids</td>
<td>Improved</td>
<td>Complete resolution</td>
</tr>
<tr>
<td>1: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>12.8 months</td>
<td>Topical corticosteroids</td>
<td>Improved</td>
<td>Complete resolution</td>
</tr>
<tr>
<td>2: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>1.8 months</td>
<td>Topical corticosteroids</td>
<td>Improved</td>
<td>Partial response</td>
</tr>
<tr>
<td>3: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>1.2 months</td>
<td>Topical corticosteroids + minocycline</td>
<td>Improved</td>
<td>Progression of disease</td>
</tr>
<tr>
<td>4: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>4.6 months</td>
<td>Topical corticosteroids</td>
<td>Improved</td>
<td>Partial response</td>
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<tr>
<td>5: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>0.8 months</td>
<td>Topical corticosteroids</td>
<td>Improved</td>
<td>Complete resolution</td>
</tr>
<tr>
<td>6: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>10.2 months</td>
<td>Topical corticosteroids + Valcyclovir</td>
<td>Improved</td>
<td>Partial response</td>
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<tr>
<td>7: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>2.5-6 months</td>
<td>Topical corticosteroids</td>
<td>Improved</td>
<td>Partial response</td>
</tr>
<tr>
<td>8: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>4.5 months</td>
<td>Topical corticosteroids</td>
<td>Improved</td>
<td>Partial response</td>
</tr>
<tr>
<td>9: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>1.5 months</td>
<td>Topical corticosteroids</td>
<td>Improved</td>
<td>Progression of disease</td>
</tr>
<tr>
<td>10: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>1.3-2.3 months</td>
<td>Topical corticosteroids</td>
<td>Improved</td>
<td>Partial response</td>
</tr>
<tr>
<td>11: Lichenoid interface dermatitis</td>
<td>N</td>
<td>Lung cancer</td>
<td>3.1 months</td>
<td>Topical corticosteroids</td>
<td>Improved</td>
<td>Partial response</td>
</tr>
<tr>
<td>12: Lichenoid skin reaction</td>
<td>P</td>
<td>MM</td>
<td>0.25 months</td>
<td>Prednisolone 1 mg/kg/d; pause of PD-1</td>
<td>Resolved</td>
<td>Progression of disease</td>
</tr>
<tr>
<td>13: Lichenoid skin reaction</td>
<td>P</td>
<td>MM</td>
<td>13.5 months</td>
<td>No treatment</td>
<td>Resolved</td>
<td>Partial response</td>
</tr>
<tr>
<td>14: Lichenoid skin reaction</td>
<td>P</td>
<td>MM</td>
<td>9.5 months</td>
<td>Topical corticosteroids</td>
<td>Not resolved</td>
<td>Partial response</td>
</tr>
<tr>
<td>15: Lichen Planus</td>
<td>P</td>
<td>MM</td>
<td>5.25 months</td>
<td>Topical corticosteroids and urea-and acetylsalicylic acid-containing ointments; systemic levocetirizine 5mg/d</td>
<td>Improved</td>
<td>Partial response</td>
</tr>
<tr>
<td>16: Lichen planus mucosae</td>
<td>P</td>
<td>MM</td>
<td>0.25 months</td>
<td>Prednisolone 60 mg/d PO over 3 days; cetirizine PO</td>
<td>Improved</td>
<td>N/A</td>
</tr>
</tbody>
</table>

N: Nivolumab
P: Pembrolizumab
MM: malignant melanoma
New-onset LP occurs in 0.4% patients undergoing pembrolizumab treatment for stage III/IV melanoma [4]. Despite reports of PD-1 inhibitor-induced lichenoid reaction in the literature, there is only one case of LP related to nivolumab with concurrent radiation therapy. The authors suggested that combination therapy predisposes to more adverse autoimmune reactions. LP is a T-cell-mediated cutaneous condition. LP-affected keratinocytes strongly express PD-L1 [6]. Anti-PD-1 therapy may trigger an LP flare through T-cell recruitment, contributing to increased incidence in patients using PD-1 inhibitors. In our patient, chemotherapy-induced immunosuppression likely prevented T-cell recruitment and subsequent remission of LP.

**Conclusion**

To our knowledge, this is the first reported case of LP reactivation related to nivolumab monotherapy. Specifically, LP manifestation closely followed the patient's immune status: chemotherapy-induced immunosuppression led to LP resolution, whereas immune activation by PD-1 inhibitors triggered LP recurrence. Clinicians should be aware of the potential for new-onset and recurrent LP in patients undergoing immunotherapy.

**References**