Lessons to be learnt from real world studies on immune-related adverse events with checkpoint inhibitors: a clinical perspective from pharmacovigilance

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Electronic Supplementary Material

Management of irAEs. Adapted from Esfahani et al. [1]. General recommendations are based on main international guidelines [2-5].

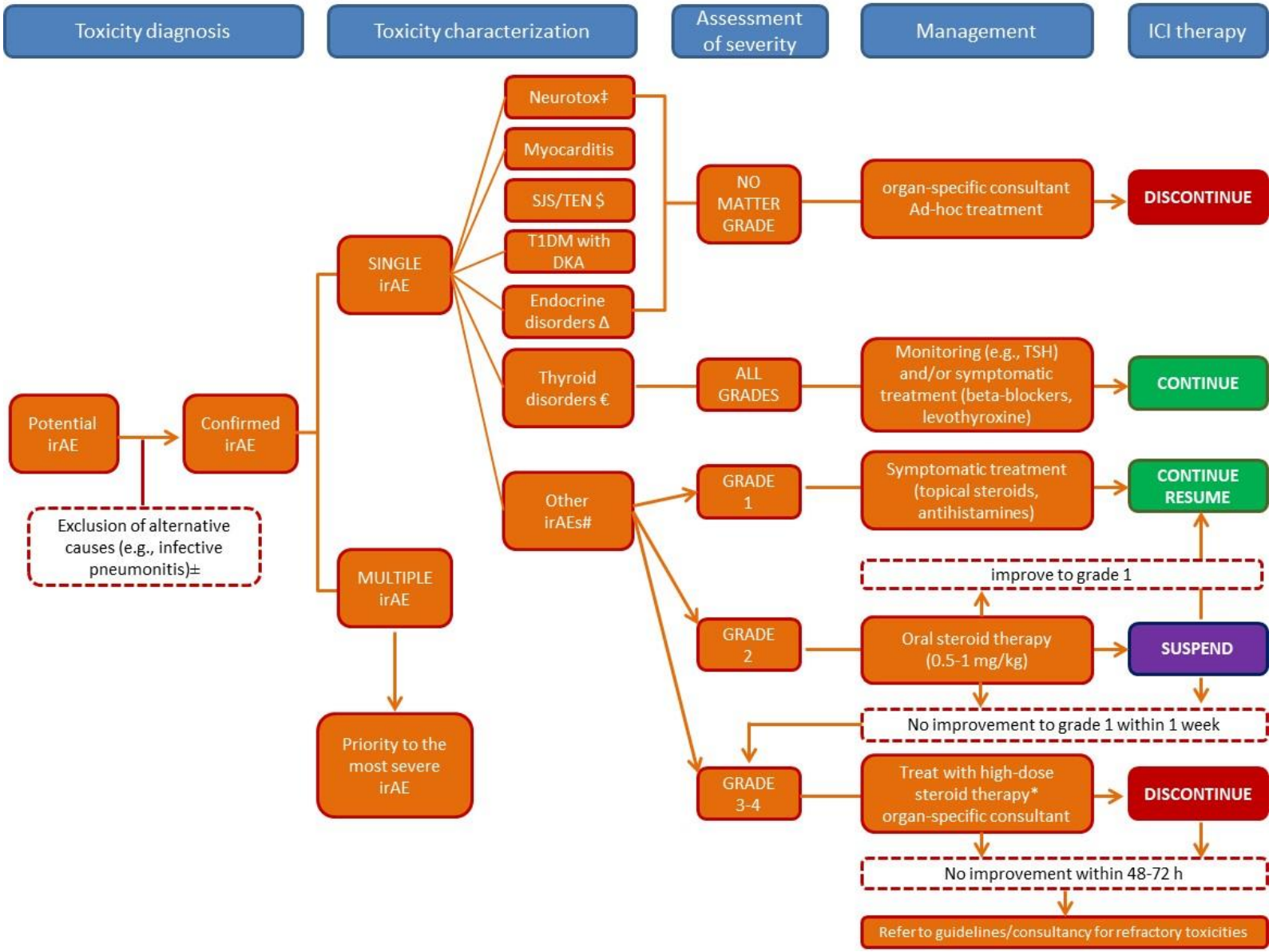

Figure footnote.

± clinical, imaging and laboratory baseline assessment is warranted prior to initiating treatment, and patient counseling on the warning signs and symptoms of irAEs.

* prednisone or methylprednisolone 1-2 mg/kg/day.

$ SJS and TEN should be treated as G3-4 toxicities (permanent discontinuation and high-dose steroids).

bullous dermatological toxicity requires urgent dermatology consultation. Bullous dermatitis should be managed according to the severity (G2 requires discontinuation and standard dose steroids).

Drug discontinuation can be considered also for grade 1 diarrhea/colitis and pneumonitis, renal failure).

‡ Guillain Barrè Syndrome, Myastenia Gravis, Trasverse myelitis require permanent discontinuation.

Δ Primary adrenal insufficiency, central hypothyroidism, hypophysitis

€ Clinical primary hypothyroidism, asymptomatic/subclinical hypothyroidism, Thyrotoxicosis (interruption only if symptomatic).

DKA: diabetic ketoacidosis; SJS: Stevens Johnson Syndrome; TEN: Toxic Epidermal Necrolysis, T1DM: type 1 diabetes mellitus.

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