

## Registry and the Registration No. of the study/trial

Not applicable.

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## Editorial Comment

### Editorial Comment on Seronegative rheumatoid arthritis after combination therapy with Ipilimumab and Nivolumab for postoperative pancreatic and liver metastases from renal cell carcinoma

In recent years, several first-line therapies for advanced or metastatic renal cell carcinoma have been approved. Among these therapies, immune checkpoint inhibitor (ICI) combination therapy consisting of Ipilimumab and Nivolumab has shown improved clinical efficacy compared to tyrosine kinase inhibitor (TKI) monotherapy.<sup>1</sup> This combination has a high overall response rate of over 40%. However, treatment-related adverse events (TRAE) > grade 3 occurred in 46% of patients. Therefore, clinicians must be aware that this therapy may induce severe adverse events, including systemic autoimmune reactions, and must appropriately manage these adverse events that are different from those caused by TKI.

Nishimura *et al.* reported a very rare arthritis adverse event case in their recent paper.<sup>2</sup> The latest NCCN guidelines classify inflammatory arthritis using three grades and provide

instructions for the management of each grade.<sup>3</sup> However, there are no clear instructions on the optimal timing of ICI discontinuation or resumption. In clinical practice, we encounter some relatively rare immune-related adverse events (irAEs), and most physicians are not familiar with the management of these irAEs. Even in this case, seronegative rheumatoid arthritis after ICI therapy has only been reported in one case report.<sup>4</sup> Additionally, we should be careful not to induce an immunosuppressive effect on cancer progression caused by excessive steroid induction.<sup>5</sup> Therefore, I strongly suggest that when irAEs occur, a specialist is consulted rapidly to manage patients carefully before providing steroid-based therapy.

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## Conflict of interest

The author declares no conflict of interest.

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