Scalp cooling to prevent alopecia after chemotherapy can be considered safe in patients with breast cancer

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Viewpoints and debate

Scalp cooling probably diminishes the cytotoxic damage of hair root cells through vasoconstriction and a reduced biochemical activity of the cytotoxic agents and their metabolites [1]. It is mainly used in Western Europe by breast cancer patients and prevents severe chemotherapy-induced alopecia (CIA) in half of them [2]. Scalp cooling is usually applied continuously about 30 min before, until 90 min after chemotherapy infusion [1], lowering scalp skin temperature to a mean of 18 °C (range 12–25 °C) (unpublished results). But can hypothermia by scalp cooling also promote outgrowth of scalp skin metastases?

This risk is particularly important for patients without metastases at primary diagnosis (M0), as in metastatic disease (M1) a scalp skin metastasis will rarely be unique, nor lethal. If after adjuvant chemotherapy scalp skin metastases would occur more frequently with than without scalp cooling, this supportive care modality might affect that risk. We now discuss the incidence of (scalp) skin metastases in different groups of breast cancer patients according to treatment with chemotherapy and/or scalp cooling.

**Incidence of scalp skin metastases in non scalp-cooled breast cancer patients**

Without scalp cooling the incidence of skin metastases in patients with breast cancer varied between 2 and 30% in retrospective patient file studies [3–5] and 3% in a German cancer registry [6] (Table 1). In addition, it varied between 9 and 32% in autopsy studies before chemotherapy was used [7–10]. These broad ranges may be caused by the distinction between true distant metastasis and local chest wall involvement, selection of microscopically confirmed metastases or may be differences in incidence determined by race [4]. Skin metastases are rarely the first presenting sign of distant metastatic breast cancer [11–15], also when patients did not undergo systemic treatment after primary local treatment [16]. The majority (53–84%) of skin metastases are detected on the trunk or near the scar of the primary neoplasm [3,12,15,17,18].

The incidence of skin metastases alone has been studied among 33,771 M0 breast cancer patients in the Munich Cancer Registry (MCR) in the periods 1978–84, 1985–94 and 1994–2003 [6]. Combining all periods, skin metastases were prevalent in 929 (3%) patients and skin metastases alone in 191 (0.6%) patients. In this last group, 27% of the patients had received adjuvant chemotherapy as initial treatment. Skin metastases alone became prevalent later in follow up than other single sites or combinations of metastases [6].

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In 20% of these patients they were diagnosed >10 years after initial diagnosis. The sub-site of skin metastases alone as well type of systemic treatment after metastases were unknown.

Active follow up of the frequency of scalp skin metastases in breast cancer patients without scalp cooling showed the incidence to vary between 0.03 and 3% [3,11,12,19–22], remaining low in a study population of high risk patients only [20], even in M1 patients [3,11,12] or when the study was prospective [19]. Incidence rates were not associated with time since diagnosis (110 months) [20] or receiving no adjuvant chemotherapy [12]. One study showed that also scalp skin metastases occurred at the same time or later than non-skin metastases elsewhere [20].

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### Incidence of scalp skin metastases in scalp-cooled breast cancer patients that were systematically followed

Active follow up of the frequency of scalp skin metastases in scalp-cooled breast cancer patients showed an incidence below 1% [19,22,28] (Table 2). Lemieux et al. described at a follow up of 5.8 years six patients (1%) with stage II and III breast cancer (n = 553) who had developed scalp skin metastases, but never as an isolated site of relapse [22]. Besides, two breast cancer patients were reported in whom seven and nine years after diagnosis scalp skin metastases were detected as first metastatic site [28], but scalp cooling most likely had not affected the prognosis unfavourably; The first patient only had used scalp cooling for two out of four cycles and lost her hair. A few months after detection of the scalp skin metastases many other metastases were found. The second patient used scalp cooling during one out of six cycles of chemotherapy. Six years later she received another six cycles without scalp cooling and two years later the scalp skin metastases were diagnosed.

### Incidence of scalp skin metastases in scalp-cooled breast cancer patients that were not systematically followed

Literature research of the frequency of scalp skin metastases in scalp-cooled patients (n = 2315), at least 49% with breast cancer, led to 38 original articles carried out during 1970–2012 [1,29], and four additional studies [30–33]. At least 37% of these patients had received adjuvant chemotherapy. These studies never assessed scalp skin metastases systematically and follow up was mostly short (2–46 months) or unknown (n = 30). Overall 17 studies addressed scalp skin metastases, which were detected in nine patients (0.4%). Seven of these patients had advanced disease and scalp skin metastases were never the first and only site of relapse. For two patients the course of disease was unknown [26].

Data of >2000 Dutch scalp-cooled patients have been analysed in our studies from 2004 to 2012 [23–37]. Of >1800 (87%) female breast cancer patients 77% were treated in the adjuvant setting, mainly with anthracyclines or taxanes. In one patient, a scalp skin metastasis had been spontaneously reported, after the first treatment cycle with docetaxel monotherapy for liver metastases and previous chemo- and hormonal therapy. However, scalp skin metastases were not systematically assessed.

### Discussion

This overview shows that the incidence of scalp skin metastases in breast cancer patients seems to be comparable for scalp-cooled (0.04–1%) and for non scalp-cooled patients (0.03–3%). Despite the high vascularisation and immobile environment of the scalp skin [38], the low incidence indicates that it is not a site where metastases seed easily. The limited occurrence probably cannot be attributed to the effectiveness of chemotherapy. Firstly, because the incidence of scalp skin metastases was also low when chemotherapy was not yet available [7–10,12]. Secondly, the MCR exhibited the proportion of skin metastases not to differ in the periods 1978–84, 1985–94 and 1994–2003, despite changes in systemic treatment and stage distribution [6]. This would indicate that scalp cooling does not pose a risk for development of scalp skin metastases.

Of all patients receiving chemotherapy, only patients who have proliferating micro-metastases in the scalp skin, which survive
Although medical professionals may be more alert of scalp skin metastases due to systemic treatment, are at risk for scalp skin metastases due to scalp cooling. If metastases develop as a result of primary resistance to chemotherapy [40], or in case of late relapses from micrometastases in a dormant state for many years after cytotoxic treatment [41,42], scalp cooling cannot cause any additional harm. However, as long as the risk of scalp skin metastases before and after adjuvant systemic therapy cannot be predicted accurately, the potential -but likely low- harmful effect of scalp cooling for an individual patient remains unknown and needs to be acknowledged.

Scalp skin metastases are usually detected later than or concurrent with metastases at other sites, possibly due to intrinsic mechanisms that initiate late relapses of dormant cells [39,41]. Cutaneous metastases might thus often be an indication for other distant metastases elsewhere in the body [43].

During scalp cooling cytotoxics do reach the scalp skin, but with a decrease of scalp skin perfusion of approximately 20% at a local temperature of around 20 °C [23]. After chemotherapy infusion the concentration of the cytotoxic agents and its metabolites decreases gradually, remaining there when scalp cooling is ceased. Thus, hair follicle cells of scalp-cooled patients are probably damaged, but able to recover. Therefore, hair production is temporarily diminished, resulting in a small constricted section of the skin. And indeed, mostly there is some additional hair loss in the period between chemotherapy cycles [25]. Furthermore, two studies reported independently that pre-existing scalp skin metastases regressed during chemotherapy despite scalp cooling [26,27]. One patient preserved the hair, while the other lost it.

Should the low risk for scalp skin metastases be taken for granted from the existing medical literature? Firstly, the follow up of most studies is short. However, the first peak of relapses in breast cancer occurs one to two years after clinical diagnosis [41,44]. Nevertheless, scalp cooling might change the time to the emergence of scalp skin metastasis. Secondly, it is likely that the incidence of scalp skin metastases has been underreported, as the patient is often asymptomatic and physical examination of the scalp is on demand only, on the patients indication [13,18]. Thirdly, it seems rather complicated to measure micro-metastases in the highly vascularised scalp skin.

Although medical professionals may be more alert of scalp skin metastases in a scalp-cooled patient, they might still be overlooked because of their low incidence. (Concurrent) skin metastases at other sites or other life threatening metastases elsewhere that kill the patient probably before the detection of a scalp skin metastasis. The true proportion of these patients is unknown, also because in autopsy studies the skin is often excluded [45]. But this also indicates that these metastases are mostly not clinically important [22].

In conclusion, in patients with solid tumours, an unfavourable development of the disease due to scalp cooling has never been documented. It is therefore unlikely that the local efficacy of chemotherapy is decreased to such an extent, that the extremely low baseline risk increases. It is never a reason to omit scalp cooling with palliative treatment, which also seems safe for the adjuvant chemotherapy setting. Most Dutch medical oncologists currently consider the risk so low that they provide scalp cooling in the adjuvant setting in 80% of the >70 Dutch scalp cooling hospitals. Remaining doubts might be addressed by studying a large cohort of scalp-cooled patients [36] using a cancer registry and prospectively compare survival between scalp-cooled and non-scalp-cooled patients.

Conflict of interest statement

None declared.

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