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Dermo-aesthetic management in oncology supportive care

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Editorial

The development of supportive care has played an important role in the development of outpatient care in oncology, allowing better management of treatment-induced toxicities. For a great many patients, this translates into a better chance of maintaining social contact and relations with family and friends – contact which is weakened or even broken off due to the disease.

Skin toxicities play a particularly significant role in this regard; firstly because they are typically very visible, which reminds the patient of the disease and which is an outward sign –sometimes the only one– of the disease to others: dry skin (sometimes severe), various rashes (such as severe acne, for example), erythema, changes in body hair growth, hair loss, nail damage, etc. Further, this is a toxicity that is often underestimated by healthcare professionals because –since it is generally not life-threatening– it is considered as not very serious according to the usual evaluation criteria (WHO criteria, for example). Due to their chronic and visible nature, however, these toxicities can have a significant physical and psychological impact on patients and may cause problems with non-compliance, particularly in the case of oral treatments.

Dermatologists have become key partners for oncologists in this respect. The first priority is not to overlook or misjudge a severe toxicity (e.g. toxidermia), but for these skin toxicities it is also of the greatest importance to advise on appropriate care and to guide the efforts of the aestheticians and socio-aestheticians working with patients. In this context, skin, hair and nail care and aesthetic advice are not optional «comfort care» but are absolutely an integral part of the quality healthcare that our patients deserve.

Dr. Christine Matéus, onco-dermatologist at the Gustave-Roussy Institute, was one of the first together with Professor Caroline Robert to take an interest in this subject. Several years ago they opened a consultation specialising in the management of patients suffering from skin toxicities caused by cancer treatment. Her article gives an overview of this increasingly topical issue.

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Dermo-aesthetic management in oncology supportive care

The arsenal of treatments available in oncology has been revolutionised several times over in half a century. After the first alkylating agents, there followed the antifolates, the alkaloids, the taxanes and numerous families of cytotoxics. In the 1990s, research into cancer biology led to the emergence of potential molecular targets enabling therapeutic agents to specifically block tumour cells. These targeted treatments have supplanted the cellular poisons, and their arrival marks the beginning of "personalised" patient care. The third revolution saw the advent of immunotherapies. These molecules, capable of "re-educating" the immune system against malignant cells, may perhaps allow us to state not that a patient is in remission but that they are progressing towards being cured. Despite successive advances, however, side effects have not diminished. Toxicity has changed with the emergence of different families of drugs, but it is still a sometimes limiting factor and remains a problem with regard to patient compliance. Dermal toxicity, though often not severe, is common and constant across the range of treatments as a whole. Patients feel that they are not really being listened to or helped with regard to these side effects, which are both visible and uncomfortable or even painful. Thorough knowledge and better control of these side effects will facilitate maintenance during the long course of treatments that have now effectively become those of a chronic disease. The use of specialised and perfectly tolerated cosmetic products and make-up, with the advice of healthcare professionals and socio-aestheticians, will make it possible to support the patient's dermatological care as well as possible.


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> Onychopathies

• **Onycholysis** refers to a situation in which the nail is detached, to a greater or lesser extent, from the nail bed and the pulp. The pain that patients feel is due to the fact that the loose nail causes the matrix (the root of the nail) to move every time anything is handled. The detachment of the nail also promotes secondary infections, which cause pain. Toxicity has long been known to be an issue with the cytotoxics, in particular the taxanes, capecitabine, 5-fluorouracil and the anthracyclines, and it is common, affecting up to 30% of patients treated with docetaxel[1]. Targeted treatments and immunotherapy cause little onycholysis.

There are several hypothesis regarding the physiopathology concerned: modified angiogenesis of the extremities, direct toxicity to the nail bed of the cytotoxic agents, and neurological origin via sympathetic denervation. This last mechanism is supported by observation of its absence in limbs paralysed or impaired by destruction of the brachial plexus during the treatment of breast cancer, for example[2,3].

Management continues to be symptomatic. The most effective measure is to cut off

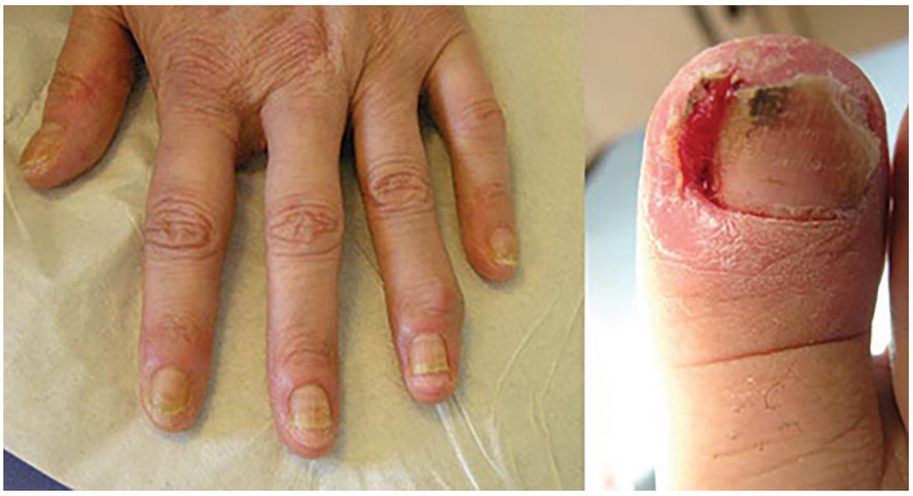

Figure 1. Left: onycholysis of the fingernails under treatment with taxanes. Podiatric treatment with clipping of detached nails.
Right: paronychia under treatment with an EGFR inhibitor treated with podiatric care, cutting the underlying nail and applying silver nitrate or dermocorticoids.

the detached nail, which offers the patient immediate relief and prevents infections *(figure 1)*. It is often necessary for this procedure to be carried out in a doctor›s surgery or in hospital, by a doctor, nurse or podiatrist.
The preventive use of chilled gloves and socks was found to have a beneficial effect on the onset of onycholysis and hand-foot syndrome under treatment with docetaxel in a randomized trial where patients were their own control[1]. This method, which is uncomfortable and whose indications are very limited, can only be used in patients undergoing short-term intravenous treatment.

The use of anti-UV nail-polish enriched with silicon and urea is very often recommended to protect the nails from possible onycholysis and to maintain their level of hydration, even though this practice is not yet clinically proven. It is important to inform the patient of factors that induce nail disorders, such as localised injury, manipulation, cutting the nail badly, etc.

• **Ungual dyschromia** (colour change) is described with the same cytotoxic molecules; this is reversible upon cessation of treatment. It is also described with some targeted therapies, including particularly imatinib.

• **Subungual haemorrhages** are described as occurring mainly with the anti-angiogenics. These flame-shaped or 'splinter' haemorrhages are probably linked to the weakening of distal capillaries subjected to chronic microtrauma, and they disappear spontaneously within a few weeks.

• **Beau's lines** represent a sudden cessation of growth of the nail, with a horizontal dystrophic line indicative of this transient «ischaemia» appearing when growth begins again. These lines are described as occurring during cytotoxic treatments[4].

• Anti-CTLA4 and anti-PD1/PDL1 immunotherapies may induce **nail dystrophies** or aggravate pre-existing ones in patients with psoriasis or lichen planus[5].

> Paronychia or perionyxis

Paronychia refers to an inflammation of the periphery of the nail with the formation of a fleshy bud giving the clinical appearance of an «ingrown nail». This symptom is common to cytotoxic drugs (taxanes, capecitabine, 5-fluorouracil, anthracyclines, bleomycin, cyclophosphamide, ifosfamide), but also to targeted therapies (EGFR, MEK and mTOR inhibitors). These extremely painful lesions appear after several weeks of treatment, primarily affecting the toes, and have a significant impact on everyday life (walking, wearing footwear, grasping objects due to the fingers being affected). Management is difficult because these lesions tend for the most part to be recurrent, developing with a chronic pattern of flare-ups and remissions. Management is based on the chemical or mechanical removal of the fleshy bud[6]. In case of limited inflammation, local treatments with dermocorticoids, silver nitrate or even trichloroacetic acid may be sufficient *(figure 1)*. If inflammation is severe or recurrent, surgical excision of the fleshy bud and the underlying band of nail together with its matrix is necessary. Consequently the nail will fail to re-grow on the site of this band, leaving the patient with a nail that is permanently narrower.
Nourishing creams or oils may be useful as a supplementary treatment.

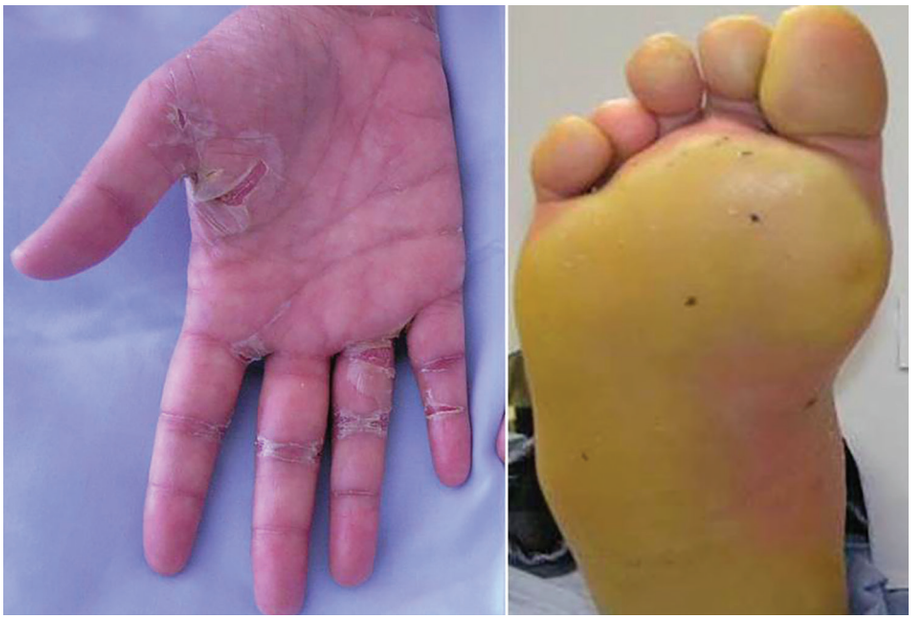

Figure 2. Left: hand-foot syndrome under treatment with anthracyclines.
Right: hyperkeratotic hand-foot syndrome under treatment with a BRAF inhibitor.

> Hand-Foot Syndrome (HFS)

This symptom is well-known and common in patients treated with cytotoxic drugs (taxanes, anthracyclines –particularly pegylated anthracyclines– 5FU, capecitabine and cytarabine) and it is also the foremost element of skin toxicity observed in those treated with the new targeted therapies (antiangiogenic and BRAF inhibitor treatments)[7,8]. It appears after several weeks of treatment and evolves in 3 stages: dysaesthesia, followed by a hyperaemic phase with erythema and oedema; then the formation of cracks, of areas of detachment under treatment with cytotoxic drugs *(figure 2)* and, conversely, of hyperkeratotic patches in the pressure or friction areas in patients receiving targeted therapies *(figure 2)*.

Several mechanisms have been suggested to explain the occurrence of HFS, including particularly an inflammatory reaction or an immunoallergic reaction. The favoured mechanism is that of direct toxicity to the keratinocytes and eccrine glands. More recently, observation of extreme hyperkeratosis in HFS under treatment with a BRAF inhibitor, quite similar to that observed under treatment with sorafenib, could offer another explanation: direct attack of the keratinocytes via the paradoxical activation of the RAF kinase pathway, thus explaining its hyperkeratotic character. The BRAF inhibitors do indeed cause blocking of the RAF kinase activation pathway and inhibition of cell proliferation in cells carrying a V600 mutation of the BRAF gene. Conversely, proliferation of cells not carrying a BRAF mutation is observed due to paradoxical activation of the RAF kinase pathway. The non-BRAF-mutated keratinocytes are therefore likely to show accelerated proliferation under the effect of BRAF inhibitors, hence hyperkeratosis[9,10]. Localization of this phenomenon in the extremities could be explained by: faster renewal of the epidermis at this location, differences in microvascularisation, areas subjected to greater pressure and localised injury, and a high concentration of sweat glands, with the underlying assumption that cytotoxins are being excreted in the sweat. These mechanisms are confirmed by the appearance of HFS under treatment with anti-angiogenics. The hypothesis of neurogenic involvement has also been mentioned. Indeed, absence of the phenomenon in a paralysed limb has been described with regard to nail involvement as well as for HFS.

Treatment remains symptomatic, with the prescription of analgesics including neurological analgesics. Keratolytic or cicatrisation-promoting emollients are applied locally, depending on clinical appearance. Dermocorticoids may be useful, and analgesics in case of significant inflammation. Where the impact of this condition is severe, the only effective measure remains that of adjusting the doses or even temporarily discontinuing the patient's anticancer treatment. As a preventive measure, wearing comfortable shoes with orthopaedic soles makes it possible to minimize the symptoms by reducing the areas of friction and load-bearing pressure. Chilled gloves have proved capable of reducing the occurrence of HFS, but with the same limitations as for the prevention of nail damage.

> Folliculitis

Folliculitis, that is to say inflammations of the hair follicle, occurs within the first few days of treatment. Onset is more rapid when the treatment is administered intravenously rather than orally. The pustules

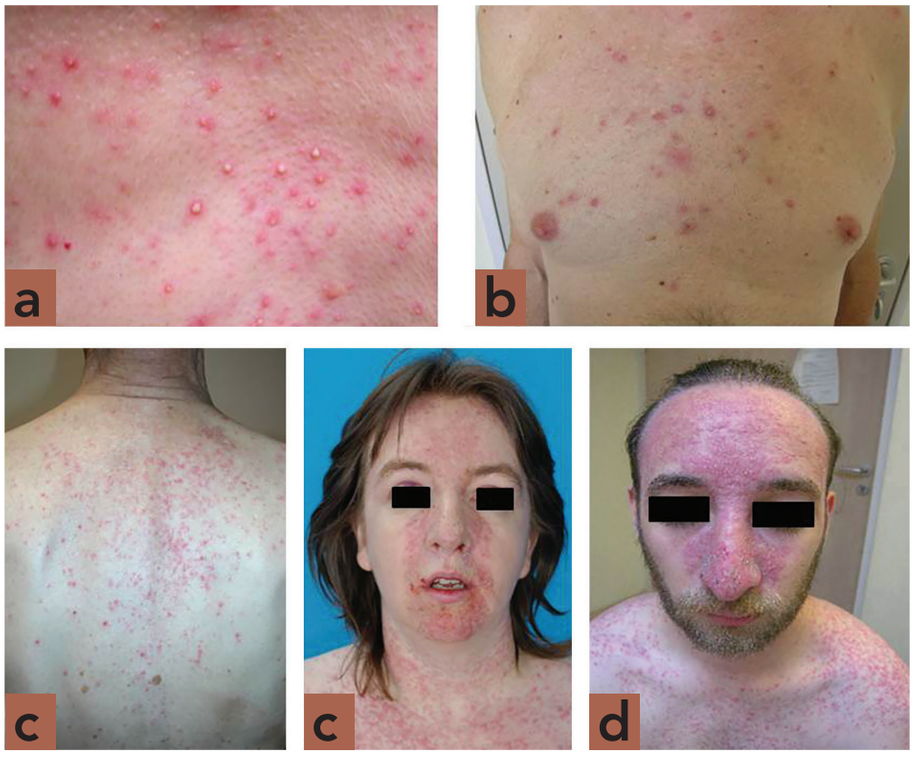

Figure 3.
a: folliculitis under treatment with corticosteroids comprising monomorphic 'pinhead' pustular elements occurring on the trunk, regressing on discontinuation of corticosteroids or with the use of antiseptics.
b: folliculitis under treatment with an anti-EGFR comprising papulopustular elements, most often appearing briefly during the first months of treatment, in the mid-facial area and on the upper trunk.
c: folliculitis under treatment with an anti-MEK similar to that occurring with an anti-EGFR, less common but often more intense and refractory
d: folliculitis under treatment with mTOR inhibitors comprising sparser but more inflammatory and nodular elements.

are aseptic but may nevertheless become subject to impetigo. Although already described in patients under treatment with cytotoxic drugs (dactinomycin, 5FU, methotrexate, liposomal anthracyclines) and corticosteroids, this toxicity has been brought back to the forefront in terms of skin symptoms with the emergence of the anti-EGFRs but also of the mTOR and MEK inhibitors[11]. Each family of molecules nevertheless has its own particularities. Corticosteroid folliculitis occurs in the days following the bolus, and appears around the neckline. It is rapidly controlled by taking antiseptic showers for a few days *(figure 3a)*. Folliculitis is more common under treatment with targeted therapies than with cytotoxic drugs, affecting nearly 100% of patients on anti-EGFRs, one-third of patients on anti-MEKs and somewhat fewer of those on mTOR inhibitors. Outbreaks of this condition are usually short-lived in patients on anti-EGFRs *(figure 3b)*; it regresses over the first 3 to 6 months of treatment, whereas it is more refractory –and its development is characterised by flare-ups and remissions– in patients on anti-MEKs *(figure 3c)* and mTOR inhibitors. The lesions are mainly located on the face, in the mid-facial area, and may extend to the trunk and limbs, especially on mTOR inhibitors *(figure 3d)*.
The suggested treatments attempt to block follicular inflammation and relieve the patient in order to improve their compliance[11]. This supportive management can benefit from the contribution of socio-aestheticians who will advise and teach patients about camouflage techniques. Local care may be sufficient in case of a limited or mild attack. Topical products rely on copper- and zinc-based emollients and soothing agents, dermocorticoids and antibiotics. Alcohol-based lotions should be avoided. Preference should be given to creams, milks or balms. Copper and zinc-based emollients can be used over long periods of time. Dermocorticoids and antibiotics, on the other hand, should only be applied for a few days to weeks in the case of very inflamed lesions. Dermocorticoids promote secondary infections, and their prescription should be monitored. In case of extensive lesions or significant impact on the patient›s daily life, general antibiotic treatment with first-line cyclins (100 to 200 mg/day) becomes necessary; these are photosensitizing, however, and may exacerbate the diarrhoea already common in patients on targeted therapies. In case of very severe attacks or those refractory to treatment with general antibiotics and to local care, it is essential to adjust the dosage of the patient's anti-cancer treatment or even temporarily to discontinue it, as this toxicity is dose-dependent. After improvement, which is often rapid within a few days, it is possible to reintroduce the molecule at a reduced dose or even at the full dose without as severe a recurrence of the patient's folliculitis.
In terms of preventive care, copper and zinc-based emollients and soothing agents make it possible to reduce the patient's discomfort and limit the inflammation of the skin.

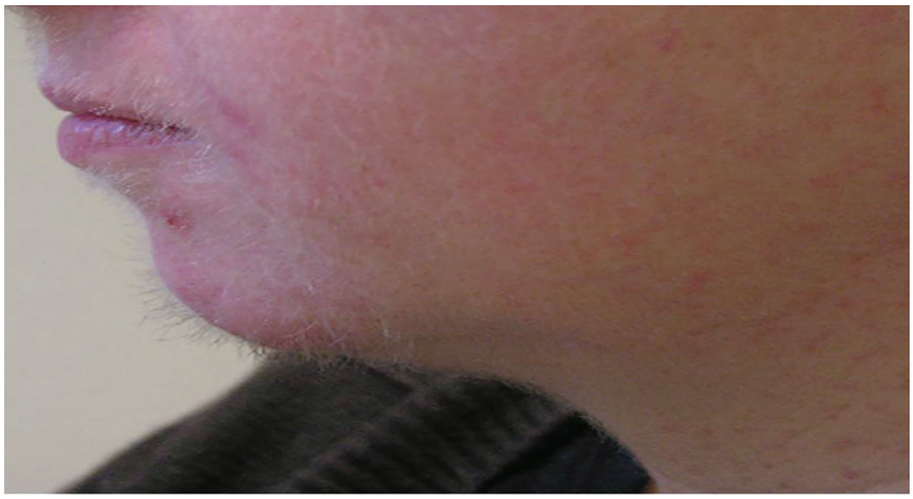

Figure 4. Hypertrichosis under treatment with an anti-EGFR.

> Changes in hair growth

Hair loss is the toxicity most feared by patients, particularly women, but doctors often neglect it. It is of course neither serious nor painful and does not worry clinicians, but it causes real psychological suffering.

The most common change is the loss of body hair often associated with alopecia. It is only very rarely a problem for patients, unlike the hypertrichosis reported in patients on anti-EGFR treatment *(figure 4)*, cyclosporin or corticosteroids. We do not have any preventive or curative treatments apart from depilation as a suspensive measure, or stopping treatment. Anarchic regrowth of the eyebrows and eyelashes (ciliary trichomegaly) appears within a few weeks under treatment with anti-EGFRs and also considerably alters the patient's appearance. The texture of body hair is altered, as is that of the hair on the scalp, which gives the eyebrows a bushy appearance *(figure 5)*; this condition causes keratitis of the eyelashes, rendering them curly. It is therefore important to trim the eyelashes and pluck the eyebrows to give them a more natural structure. The use of suitable high-tolerance makeup products (mascara, eyebrow pencils) enables the patient to restore their appearance.

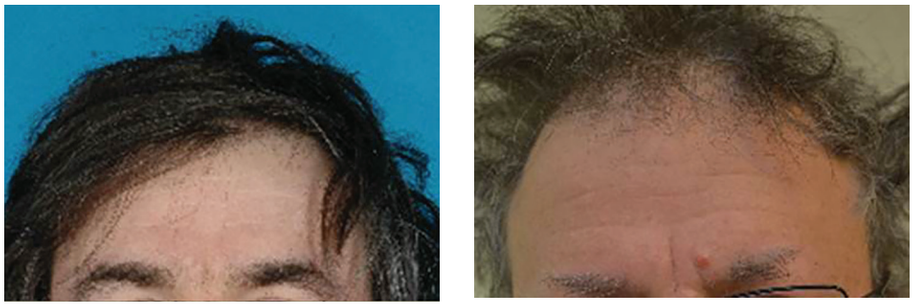

Figure 5. Alopecia under treatment with anti-EGFRs and anti-BRAFs is not a constant; however a change in hair and body-hair texture is, with the hair becoming unmanageable and the eyebrows bushy.

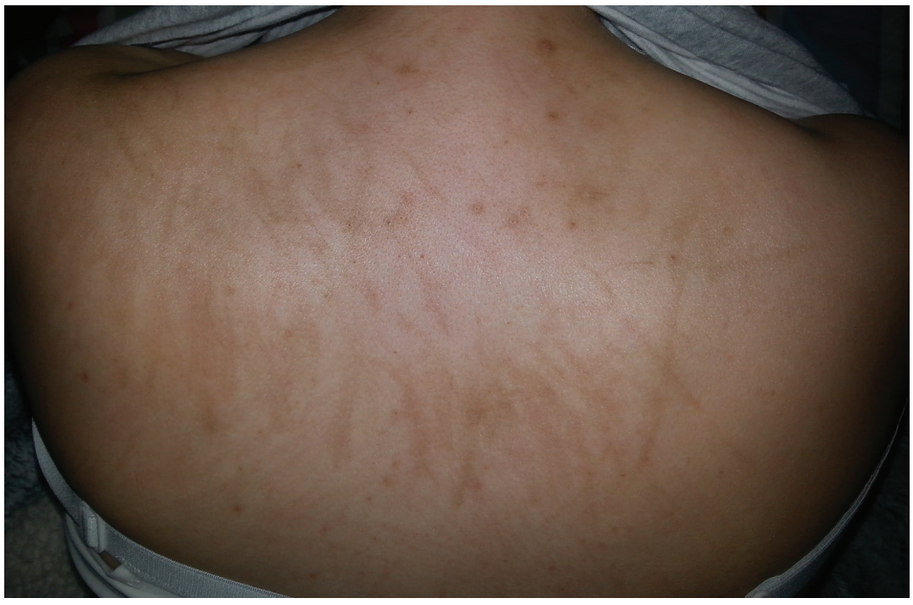

Figure 6. Hyperpigmentation occurring with each injection, leaving "whip-marks" known as flagellate dermatitis under treatment with bleomycin. This hyperpigmentation disappears only gradually when the treatment is discontinued.

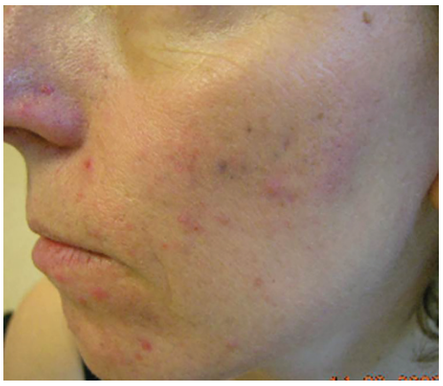

Figure 7. "Maculae ceruleae" or bluish spots occurring in areas of folliculitis under treatment with vandetanib, continuing to spread during the treatment period.

> Pigment disorders

Dyschromia elicits many questions from patients who are concerned about its reversibility. It can affect the skin, but also the hair and body hair, and usually disappears gradually although sometimes over months or even years. These skin colour anomalies are most commonly due to abnormal pigmentation, which is either localised (serpentine dermatitis in patients on fotemustine, flagellate dermatitis in patients on bleomycin *(figure 6)*, palmoplantar in those on taxanes and platinum salts) or more diffuse in patients on busulfan, cyclophosphamide or imatinib.

In patients on vandetanib, «maculae ceruleae» or bluish spots occurring on the folliculitis sites (the face and trunk) are reported after several weeks of treatment and show no tendency to improve or may even worsen constantly with continued treatment *(figure 7)*. These elements gradually disappear when vandetanib is discontinued.

Immunotherapy treatments induce vitiligo which may be localised or diffuse, or sometimes vitiligo universalis *(figures 8 and 9)*. This symptom is thought to be more common in patients treated

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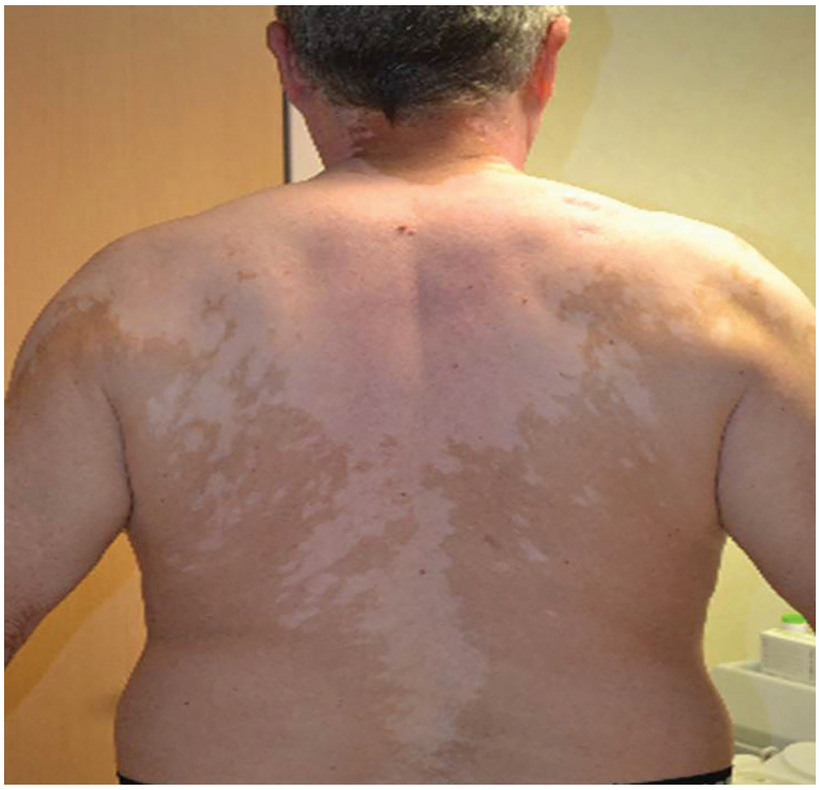

Figure 8. Cutaneous vitiligo appearing under anti-PD1 immunotherapy. Vitiligo is often extensive, both cutaneous and affecting the body hair; more rarely, vitiligo universalis.

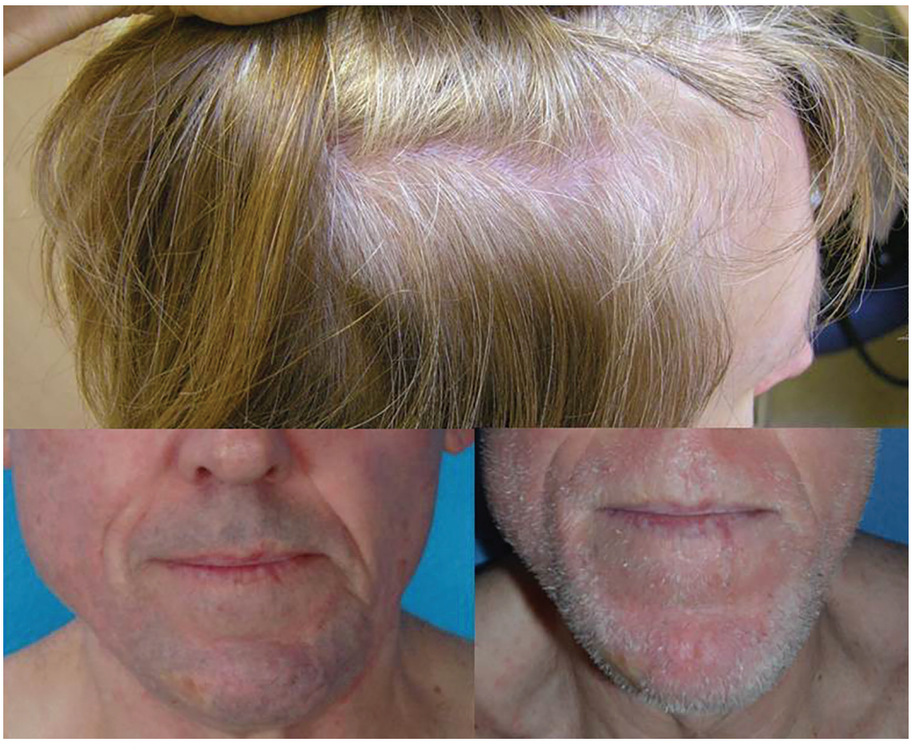

Figure 9. **Top:** Colour-loss in the hair under treatment with KIT inhibitors, occurring during the treatment period and with normal colour returning as soon as treatment is discontinued.
Bottom: vitiligo of the body hair in a patient undergoing anti-PD1 immunotherapy, with colour-loss in the beard after several weeks or even months of treatment.

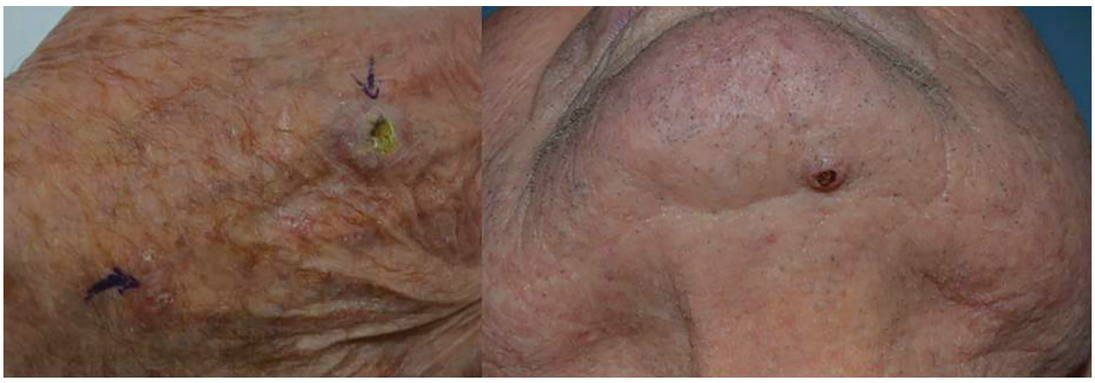

Figure 10.
Left: benign keratotic lesion occurring under treatment with BRAF inhibitors, or true keratoacanthoma.
Right: Squamous cell carcinoma induced by anti-BRAFs.

Table. Dermo-aesthetics: pathologies, their

Symptoms	Molecules involved	Preventive measures	Curative measures	
Onycholysis	• *Taxanes, capecitabine, 5-fluorouracil, anthracyclines*	• Chilled gloves/socks Protection from impact and detergents • Nail-polish, photoprotection	• Cutting detached nails • Hygiene with gentle brushing • Diluted non-irritant antiseptics	
Paronychia	• *Taxanes, capecitabine, 5-fluorouracil, anthracyclines* • Anti EGFR, anti-MEK anti-mTOR	• Cutting nails straight • Hygiene and moisturising protection against impact and detergents	• ***Chemical removal:*** dermocorticoids, silver nitrate, trichloroacetic acid • ***Surgical removal of the lateral nail plate:*** as for an ingrown nail	
Hand-foot syndrome	• *Taxanes, capecitabine, 5-fluorouracil, anthracyclines* • AAnti-angiogenics anti-BRAF	• Podiatry assessment and, if necessary, wearing a sole designed to distribute load-bearing areas • Comfortable shoes • Keratolytic creams • Chilled gloves/socks	• Podiatric care • Keratolytic creams • Dermocorticoids in case of significant inflammation • Analgesics • Local application of xylocaine	
Folliculitis	• *Dactinomycin, methotrexate, anthracyclines, 5FU* • Corticosteroids • Anti-EGFR, anti-MEK, anti-mTOR	• Moisturising creams ± Cu and Zn • Syndet cleansers, including for the scalp • Doxycycline 100mg/day or tetracycline 300mg/day	• Doxycycline 100 to 200mg/day or tetracycline 300mg/day • Short course of dermocorticoids in case of inflammation • Non-irritant non-drying antibiotic creams • Moisturising creams ± Cu and Zn	
Xerosis	All treatments	• Moisturising milk, cream or balm Superfatted 'surgras' or syndet cleansers, liquid or in bars • Lukewarm showers • Starch baths	• Antihistamines sometimes effective in case of pruritus • Moisturising cream ± urea • Dermocorticoids if there is eczematisation of the skin • Cerate, barrier cream or cream for cracked skin, protective film	

Continued from page 7

for melanoma. The cellular target in melanoma patients is a melanocyte that has undergone malignant transformation, so it is not surprising to see the immune system attack not only the cancerous cells but also normal melanocytes at the same time. Vitiligo is also a predictive sign of response to treatment[12]. The skin does seem to be able to re-pigment itself very gradually, but only some time after the cessation of treatment.

Chromonychia (pathological staining of the nails) is common in patients on cytotoxic drugs (taxanes, anthracyclines, 5FU, capecitabine), usually in the form of a pigmented band. They disappear slowly, and can sometimes persist and become permanent.

In patients on sunitinib and pazopanib, the hair rapidly loses colour - probably by means of a particular mechanism regulating the Kit receptor - but it regains its natural colour as soon as treatment is discontinued *(figure 10)*. With sequential treatments, colour-loss takes the form of stripes known as the «flag sign,» as previously described with methotrexate[13].

The use of suitable foundation offers an effective solution to mask depigmentation.

> Xerosis and healing disorders

Dry skin is constant and may be more or less severe with the different treatments. It is usually improved by local care, simple emollients, or those containing urea or salicylic acid in case of severe or extensive squamous flaking. Patients should be advised to avoid contributing factors (overly hot showers, astringent soaps) and to favour instead mild soap-free bases, using emollients after showering and applying them to moist skin for better absorption and faster and more effective application. Patients should also be advised to wear cotton underwear to avoid irritation. Despite local care, xerosis causes pruritus, which can be disabling, and can develop into eczematisation requiring the prescription of antihistamines and dermocorticoids. Skin fissures are another complication of cutaneous xerosis. They mainly tend to affect the pads of the fingers, the regions around the nail, the interphalangeal joints and the heels. They can become painful, make it difficult to function (grip, walking) and have a significant impact on patients' quality of life. Many topical products are suggested to heal these lesions and reduce pain. These topicals rely on applying a protective film. "Friars' Balsam" (also known as "Tinctura Balsamica or Balsamum Commendatoris" is an old pharmacists' compound that remains effective and relevant today.

management and development.

	Cosmetic measures	Development during treatment	Measures concerning treatment
	Nail-polish	Persistent	Discontinue and/ or reduce doses if grade 3
	After surgery, application of artificial nails after healing in order to mask shortening of the nail	Flare-ups and remissions	Discontinue and/ or reduce doses if grade 3
		Flare-ups and remissions	Discontinue and/ or reduce doses if grade 3
	• Camouflage: Green base to mask redness, followed by foundation • Moisturising mask	Spontaneous regression within a few months despite continuing with treatment	Discontinue and/ or reduce doses if grade 3
	Moisturising milk, cream or emollient balm	Permanent	No action possible

> Conclusion

Skin reactions occurring in a cancer patient receiving chemotherapy often present diagnostic and management problems. In addition to treatment-related toxicity, in fact, it is vital that we should not overlook or misjudge other aetiologies such as paraneoplastic syndrome, a deficiency dermatitis, an infection, or graft-versus-host disease.

Skin side effects associated with the different chemotherapies are common, and have a significant impact on quality of life. In this context, supportive care is no longer «pre-palliative» care but a key element in the management of cancer patients. With their treatments, patients embark on a chronic disorder with a series of successive therapies. All treatments are responsible for significant toxicities, particularly with regard to the skin. Sometimes neglected by prescribers, the psychological or physical pain secondary to skin involvement sometimes leads to poor patient compliance. Improved knowledge and prevention are simple and effective elements of management to favour better patient acceptance in continuing to pursue treatments.

Cosmetic care and make-up especially formulated for fragile skin represents an important complement in the management of dermatological side effects.

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Management of the skin, hair and nails

• Protecting the nails

– Ultra vernis silicium-urea

Rich in organic silicon which **strengthens and protects the nail**, and in urea to **combat drying**, this **anti UVA-UVB** formulation is suitable for all nails, even the most fragile, and is recommended in certain **radiotherapy and chemotherapy treatments** to prevent nail loss). Its long-lasting texture is very **easy to apply, dries quickly and is resistant to shocks.** Its formulation is fragrance-free and contains no toluene, formalin, rosin, preservatives, parabens or nickel. Available in 44 shades.

– Strengthening oil nail and cuticle

A high-tolerance product to **strengthen fragile or brittle nails and their contours or those subject to allergies.** This combination of 3 plant oils, vitamin E and silicon **nourishes** the nail, strengthens its rigidity and **structure**. Castor oil **regenerates and protects**, apricot kernel oil nourishes and **softens**, and macadamia oil **restores** the tissues of the nail and cuticles.

• Eyelashes and eyebrows: getting your look back

– Infini-Cils

Activates and stimulates eyecils and eyebrow growth for visible results.

The originality of Infini-Cils lies in its unique combination of two active ingredients, T.D.C. and Biotinyl, which both **extend the life-cycle of the eyelashes and improve the duration of growth.** Eyelashes are visibly denser and longer, and the new lashes are thicker and stronger.

Furthermore, Infini-Cils can be applied to the root of the eyelashes (as an eyeliner) as well as on the eyelashes or eyebrows (as a mascara).

This very high-tolerance formula is **free of prostaglandin and derivatives** and reinforced with organic silicon and panthenol, suitable for even the most sensitive or allergic skin and eyes.

– Waterproof eyebrow liner

High-tolerance waterproof eyebrow liner: eyebrow make-up for **sensitive or allergy-prone eyes.**

Organic silicon-enriched formula, preservative-free and waterproof with excellent hold under all circumstances. **Gives colour and re-draws sparse eyebrows.**

EYE CARE COSMETICS:
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Taking care of one's skin

• Moisturising

Balancing skin care moisturizer

With a high concentration of moisturising active ingredients such as urea, jojoba oil and honey extract, this fluid sensitive-skin face cream visibly **moisturises and nourishes the skin.** Soothed with an extract of peach leaves and protected from free radicals by vitamin E, the skin is also kept **matte and shine-free** thanks to enantia chlorantha extract, which regulates the activity of the sebaceous glands to eliminate shine. The face is **left soft and velvety** once more, **with a pleasant feeling of comfort.**

• Relieving redness

Anti-Redness cream

Formulated to protect and relieve **fine and reactive** skins with fragile blood vessels, this sensitive skin care product offers a comprehensive, immediate and lasting answer to **redness, rosacea and flushing.** Upon application, its green creamy texture immediately **neutralizes and masks redness.**

• Brightening the complexion

– Complexion radiance cream

This high-tolerance formula is rich in dermo-vitamins (A, C, E, F, B5, PP), hyaluronic acid, urea and Jojoba and Macadamia plant oils to leave the skin **supple and toned, offering incomparable comfort.** Enriched with naturally-sourced pigments, this cream **brightens the skin** and immediately restores all its **radiance. Ideal for dull and tired complexions,** this high-tolerance formulation is suitable for even the most sensitive or allergic skin.

– Bronzer powder

This bronzing powder brings sunshine to the complexion, offering a suntanned look without exposure to the elements. **Enriched with the radiance of fine nacre**, its fine, soft texture is ultra-micronised for even the most sensitive or allergic skins.
Available in 2 shades.

Box Rose®

Contapharm laboratories are partnered with numerous anti-cancer supportive care centres, thanks to their high-tolerance Eye Care Cosmetics brand.
They have launched the Box Rose®, a complete selection of supportive cosmetic care products to alleviate the most commonly encountered side effects: dry skin, weakened nails, disturbances in hair and nail growth, and impaired complexion.

The Box Rose® includes a moisturising cream, a Ultra vernis silicum-urea nail-polish, a protective silicon base-coat for nails, a nail strengthening oil, a waterproof eyebrow pencil, an Infini-Cils mascara for the growth of eyelashes and eyebrows, a Complexion radiance cream and a Bronzer powder.

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