Treatment Approaches & Consensus Guidelines for Melanoma & Nonmelanoma Skin Cancer

Presented by Jose Lutzky, MD

The American Society of Clinical Oncology recommends sentinel lymph node biopsy (SLNB) for lesions T1b or greater. Complete lymph node dissection or careful observation with ultrasound are options for patients with low-risk micrometastatic disease. A variety of prognostic gene expression profiling (GEP) tests are under investigation. JAMA Dermatology advises that there is insufficient data to support routine use of currently available prognostic GEP tests to inform management of patients with melanoma. Further research to assess validity and applicability of existing and emerging GEP tests is necessary.

The melanoma treatment landscape has evolved tremendously with FDA approval of immunotherapy and targeted therapy. Immune-related adverse events resulting from treatment include rash, colitis, pneumonitis and hypophysitis. The mitogen-activated protein (MAP) kinase pathway is essential for the proliferation of melanoma, with approximately 50% of metastatic melanomas harboring a mutation of the BRAF gene. Talimogene laherparepvec (T-VEC) is a modified oncolytic herpesvirus which can be injected into the tumor resulting in lyses of the tumor cells, generating an immune response. It is indicated for the treatment of unresectable cutaneous, subcutaneous and nodal lesions in patients with recurrence after surgery.

With regard to advanced squamous cell carcinoma, treatment with cemiplimab or pembrolizumab are the preferred immunotherapies. For advanced merkel cell carcinoma, avelumab, nivolumab, or pembrolizumab have been approved. For advanced basal cell carcinoma, options include a multidisciplinary consultation with hedgehog pathway inhibitors, surgery, radiation therapy or novel clinical trials.

Epidemiology and Clinical Presentation of BCC and SCC
Presented by David Goldberg, MD, JD

Risk factors for nonmelanoma skin cancers such as basal cell carcinomas (BCCs) or squamous cell carcinomas (SCCs) include increasing age, male sex, Caucasian race, ultraviolet light exposure, and previous history of actinic keratoses (AKs). Medication- and workplace-related risk factors include photochemotherapy (PUVA) and ionizing radiation. Chemical exposure risk factors include pesticides, asphalt, tar, arsenic and polycyclic aromatic hydrocarbons. Immunosuppressed individuals such as organ transplant recipients experience higher rates of nonmelanoma skin cancers.

There are a variety of clinical presentations for SCC. Bowen's disease (SCC in situ) appears as an erythematous scaly patch or slightly elevated plaque. Invasive SCC commonly occurs on the scalp, face, neck or extremities and may be associated with hyperkeratosis, crusting or ulceration. Keratoacanthoma is a variant of SCC that develops as a rapidly enlarging papule and crateriform nodule with a keratotic core. SCC metastasis is highly dependent on thickness.

There are four major distinctive clinicopathologic types of BCC:

- Nodular
- Superficial
- Morpheaform
- Fibroepithelial