Case Studies in Immunotherapy for the Treatment of Melanoma
SITC CPG Webinar

Tina J Hieken MD FACS
Professor of Surgery
Mayo Clinic, Rochester, MN

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Case #1

• 65 year old RHD male presents with darkening skin lesion left arm
• PMH: Hypertension
• Diagnostic biopsy
  • Superficial spreading melanoma
  • Breslow depth 1.2 mm
  • Clark level IV
  • 2 mit/mm$^2$
  • No LVI, TILs non-brisk, no regression
Case #1

- Physical exam
- Healing biopsy site left arm
- No palpable cervical or axillary adenopathy
- Clinical stage T2a N0
- Recommendation
  - Wide local excision, lymphatic mapping, sentinel lymph node surgery
Case #1

• Surgical pathology
  • WLE: Breslow depth 4.2mm
  • SLN: 1 of 2 SLNs with 8 mm metastasis, without extranodal extension
  • T4a, N1a
• AJCC 8 pathologic stage IIIC
Case #1

AJCC 7th to 8th Edition Change
Case #1

• Next steps:
  • Equipoise for patients with cN0 disease with respect to MSS for nodal observation vs CLND per MSLT-2
• Medical oncology consultation
  • BRAF testing?
  • Imaging studies?
• Discussion
• Treatment recommendations
Panel Recommendations

• For patients with resected IIIA melanoma, adjuvant therapy with either anti-PD-1 IC (LE:2) or BRAF-targeted therapy (BRAFm disease) should be considered.

• For patients with resected stage III BRAFm melanoma both ICI and targeted therapies have shown similar RFS benefit, but no head to head prospective comparison data, therefore consider toxicity profile of either vs absolute benefit.
Case #2

• 50 yo RHD healthy female
• Right axillary mass, enlarging over past 2 months
• PMH: Negative for trauma, infection; no prior cancer
• Physical exam by PCP shows 5 cm right axillary mass
• Imaging
  • Negative mammogram
  • Axillary ultrasound
Case #2

• Percutaneous needle biopsy right axilla
  • Metastatic melanoma

• PET-CT
  • No distant disease
  • Dominant matted nodal mass right axilla
Case #2

• Multidisciplinary discussion
• Patient enrolled on clinical trial, NeoACTIVATE, NCT03554083, Arm C
• Other options?
Panel Recommendations

• For patients with resectable stage III to IV (without brain metastases) melanoma, while there were no approved neoadjuvant therapies at the time of manuscript publication, neoadjuvant pembrolizumab continued into the adjuvant setting demonstrated improved EFS compared with adjuvant therapy alone in a randomized, phase II trial (LE:2). Neoadjuvant approaches may be considered after multidisciplinary discussion for patients with high-risk stage III and resectable stage IV melanoma. Consideration for clinical trial enrollment is still preferred for eligible patients with high-risk stage III disease.
Case #2

- Patient completed 4 cycles of neoadjuvant atezolizumab + tiragolumab
- Physical exam showed marked improvement in matted axillary adenopathy
- Re-staging PET-CT showed iPR
Case #2

• Right axillary lymph node dissection
• Pathology showed pCR (necrosis and fibrosis without viable melanoma with treatment effect)

• Adjuvant therapy – per protocol 6 months atezolizumab
Case #2

- Unanswered questions re: neoadjuvant therapy
  - Selection of regimen
    - Immunotherapy over targeted therapy
    - Doublet vs monotherapy
  - When is adjuvant therapy need after neoadjuvant therapy?
  - Should it be response directed?
  - Can extent of operation be response directed?