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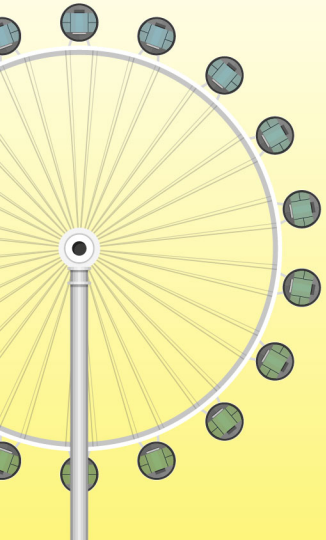

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HIGHLIGHTS

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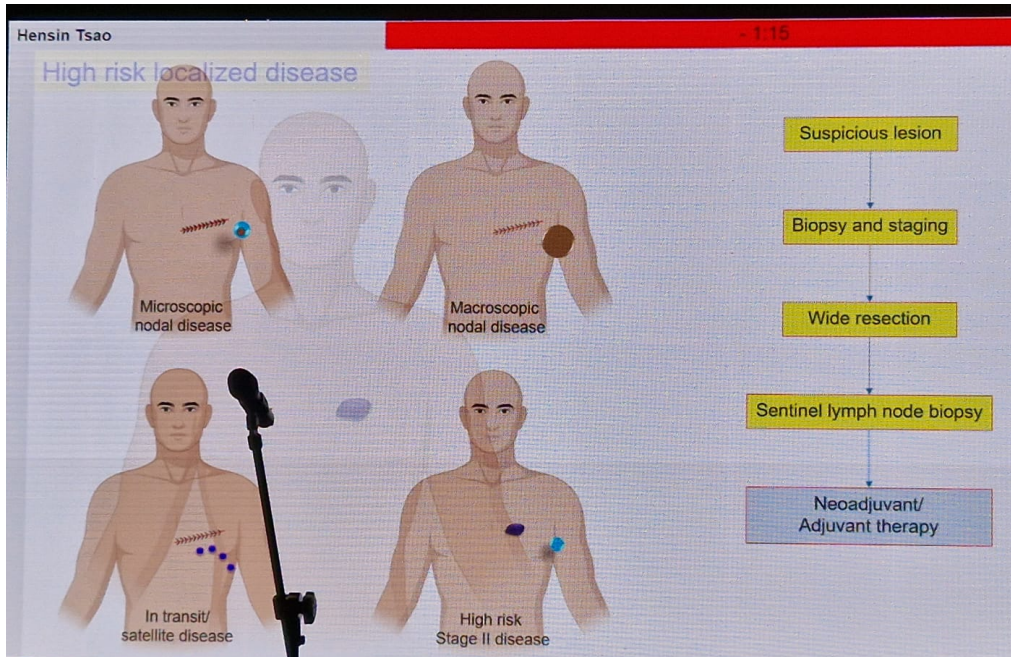

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-Adyuvancia:
-Pembrolizumab
-Vacunas
-Combinación inmunoterapia en melanoma avanzado (incluyendo neoadyuvancia)
-Pembrolizumab en neoayuncia +adyuvancia frente a adyuvancia sólo
-TIL frente a Ipilimumab en melanoma refractario a anti-PD1

ARTICLES | VOLUME 399, ISSUE 10336, P1718-1729, APRIL 30, 2022

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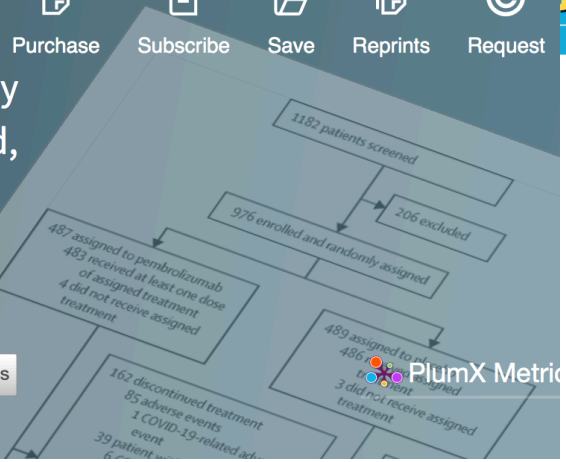
Pembrolizumab versus placebo as adjuvant therapy in completely resected stage IIB or IIC melanoma (KEYNOTE-716): a randomised, double-blind, phase 3 trial

Jason J Luke, MD • Prof Piotr Rutkowski, MD • Paola Queirolo, MD • Michele Del Vecchio, MD • Prof Jacek Mackiewicz, MD • Vanna Chiarion-Sileni, MD • et al. Show all authors • Show footnotes

Published: March 31, 2022 • DOI: https://doi.org/10.1016/S0140-6736(22)00562-1 • Check for updates



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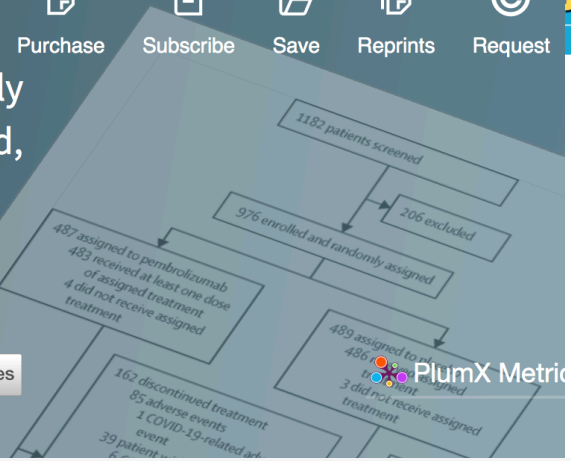

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ARTICLES | VOLUME 23, ISSUE 11, P1378-1388, NOVEMBER 2022

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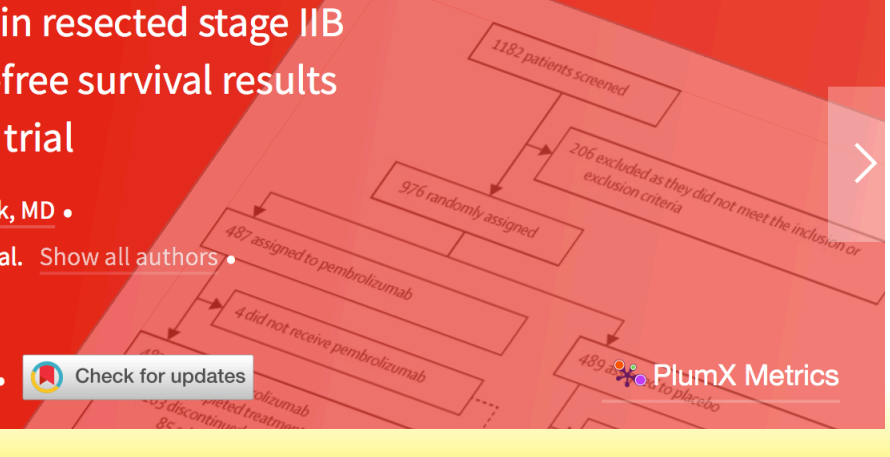
Pembrolizumab versus placebo as adjuvant therapy in resected stage IIB or IIC melanoma (KEYNOTE-716): distant metastasis-free survival results of a multicentre, double-blind, randomised, phase 3 trial

Prof Georgina V Long, MD * • Jason J Luke, MD * • Prof Muhammad A Khattak, MD • Luis de la Cruz Merino, MD • Michele Del Vecchio, MD • Prof Piotr Rutkowski, MD • et al. Show all authors • Show footnotes

Published: October 17, 2022 • DOI: https://doi.org/10.1016/S1470-2045(22)00559-9 • Check for updates



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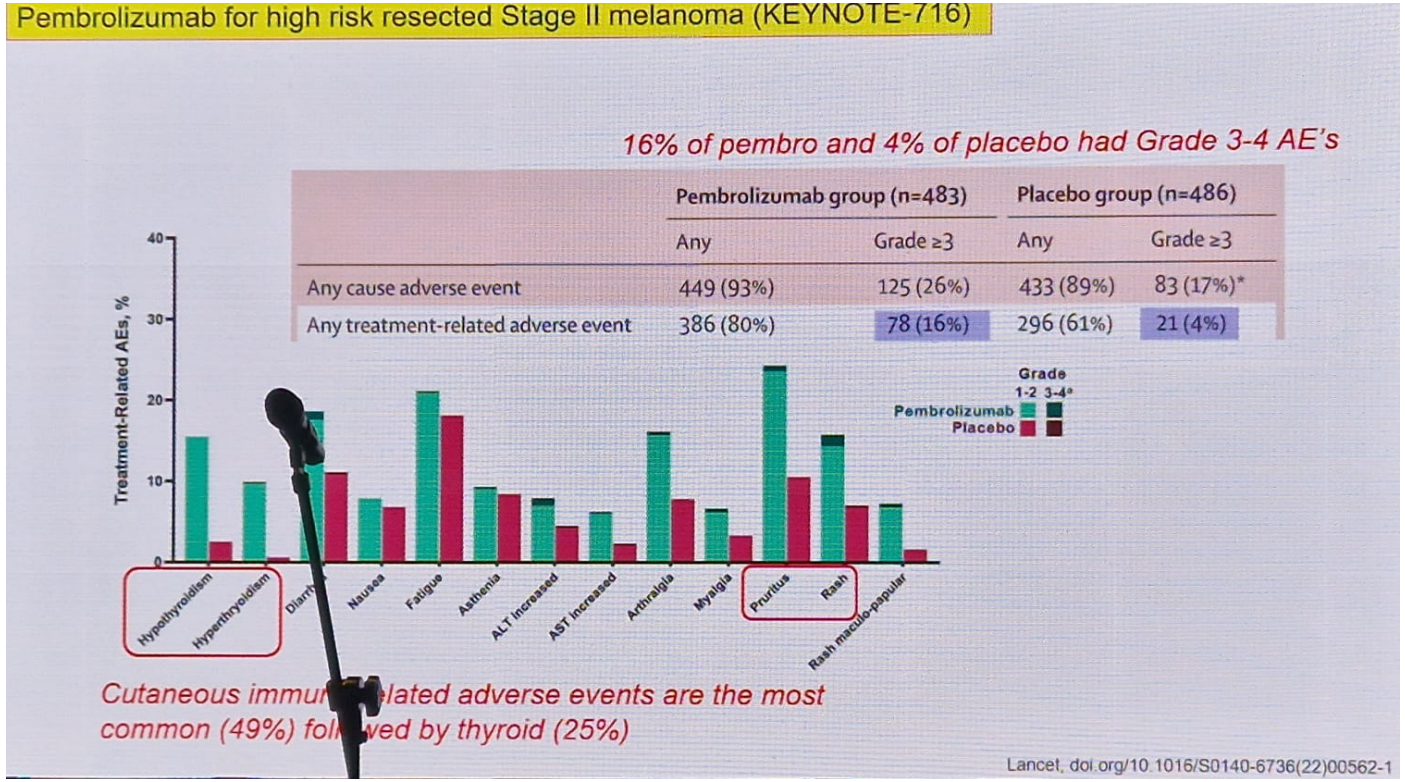

Efectos secundarios similares a otras series, controlables.


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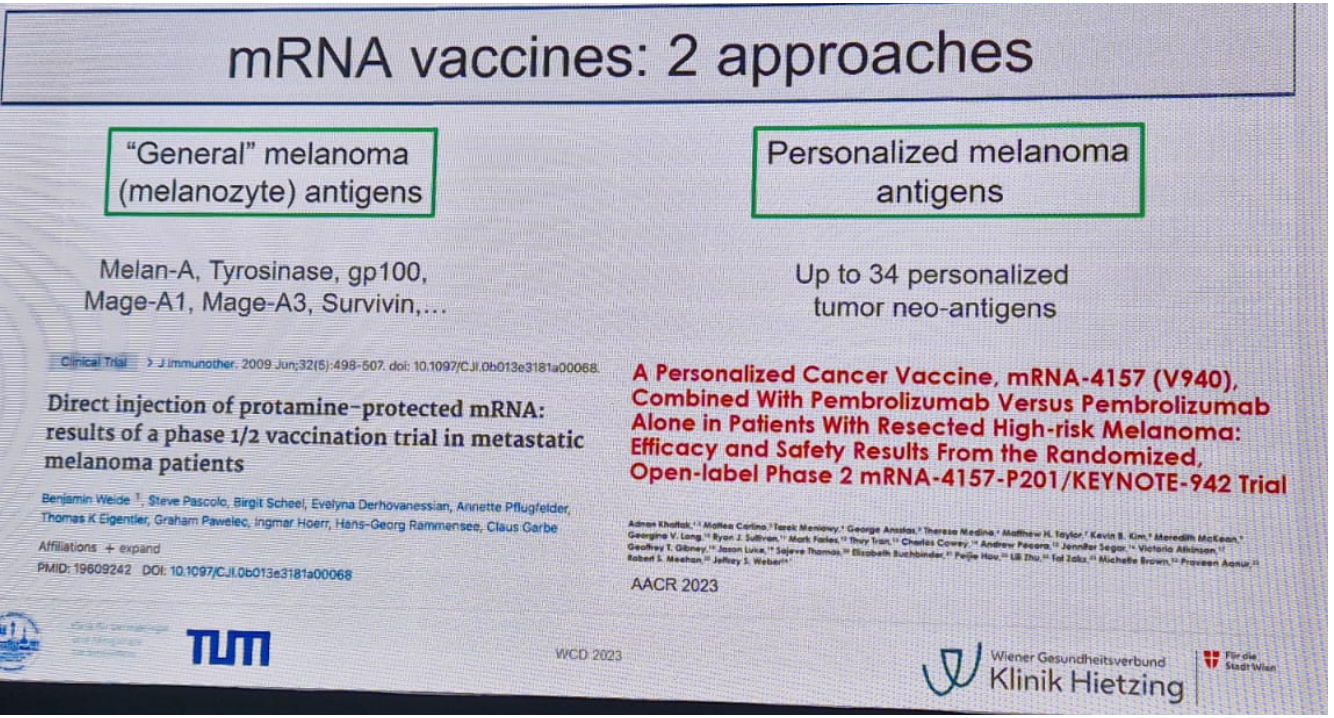
ILDS
New therapeutic approaches in skin cancer treatment
Christian Posch MD PhD
Head of Dermatology, Vienna Healthcare Group, Austria


mRNA vaccines: 2 approaches
"General" melanoma (melanozyte) antigens
Melan-A, Tyrosinase, gp100, Mage-A1, Mage-A3, Survivin,…
Personalized melanoma antigens
Up to 34 personalized tumor neo-antigens
Clinical Trial
J Immunother. 2009 Jun;32(5):498-507. doi: 10.1097/CJI.0b013e3181a00068.
Direct injection of protamine-protected mRNA: results of a phase 1/2 vaccination trial in metastatic melanoma patients
Benjamin Weide, Steve Pascolo, Birgit Scheel, Evelyna Derhovanessian, Annette Pflugfelder, Thomas K Eigentler, Graham Pawelec, Ingmar Hoerr, Hans-Georg Rammensee, Claus Garbe
Affiliations + expand
PMID: 19609242 DOI: 10.1097/CJI.0b013e3181a00068
A Personalized Cancer Vaccine, mRNA-4157 (V940), Combined With Pembrolizumab Versus Pembrolizumab Alone in Patients With Resected High-risk Melanoma: Efficacy and Safety Results From the Randomized, Open-label Phase 2 mRNA-4157-P201/KEYNOTE-942 Trial
AACR 2023
WCD 2023
Wiener Gesundheitsverbund
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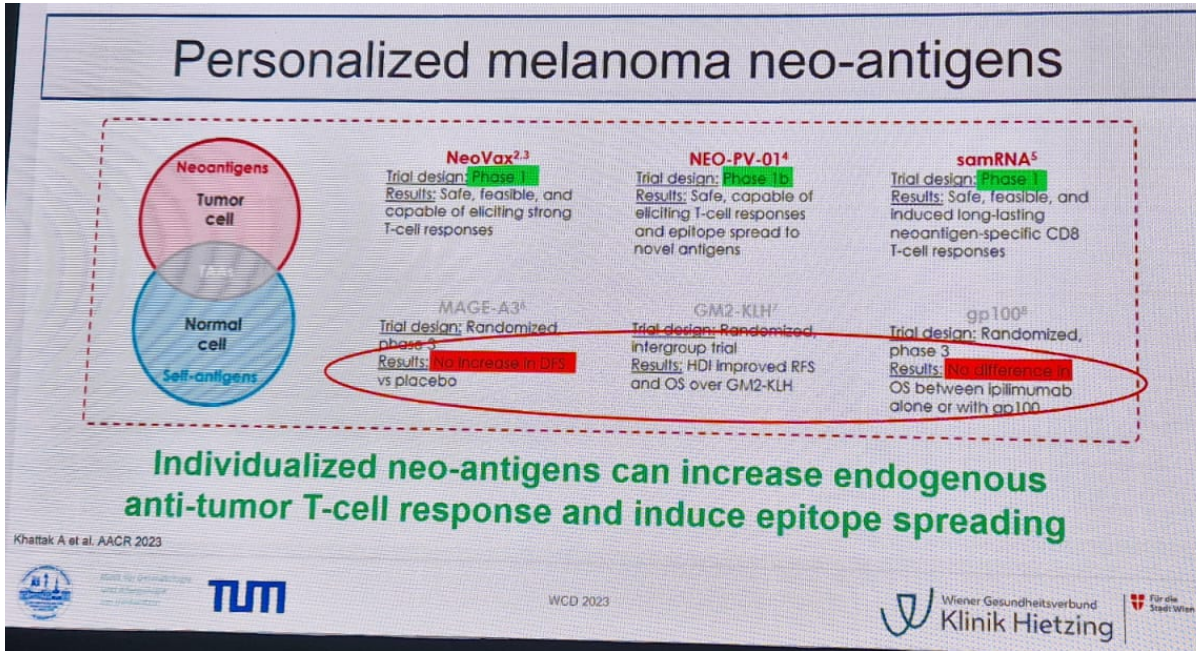
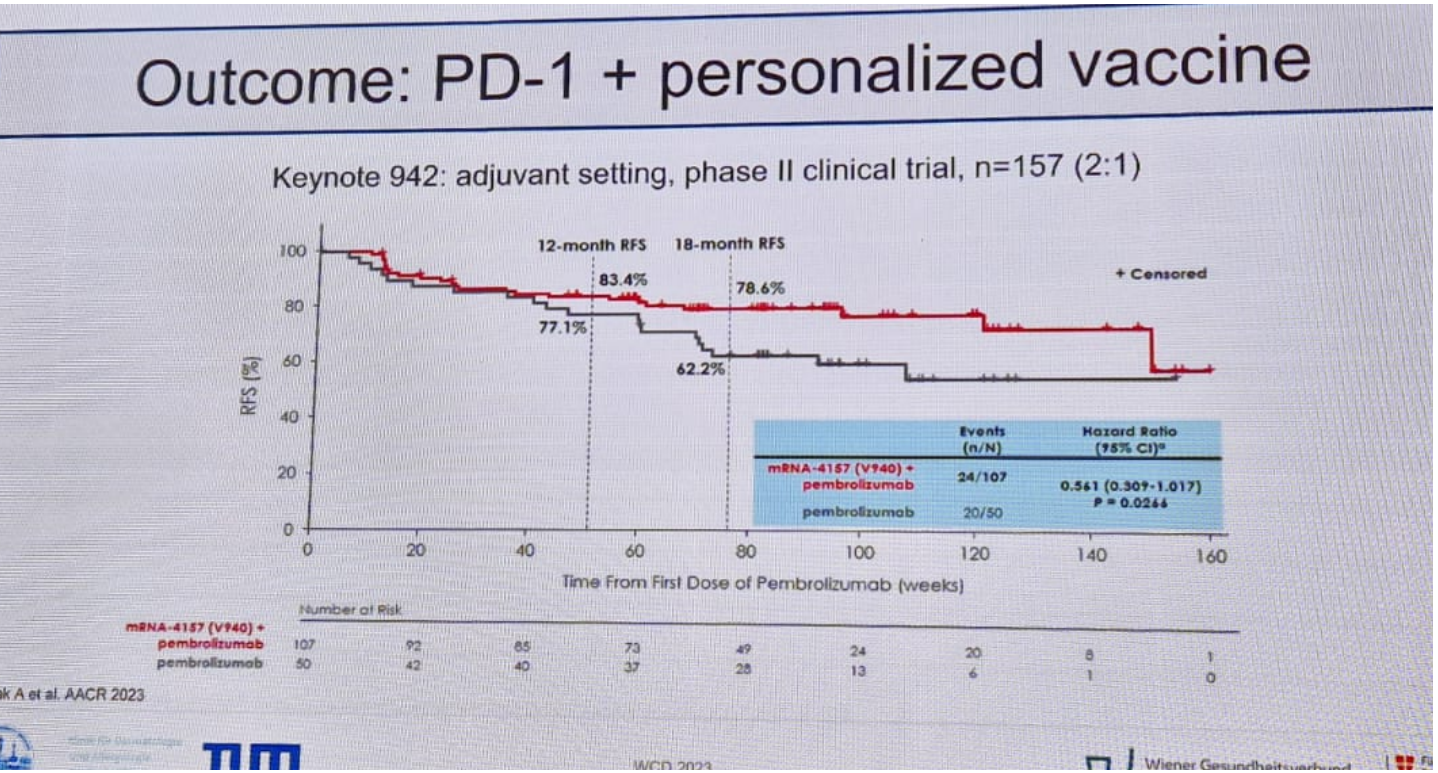
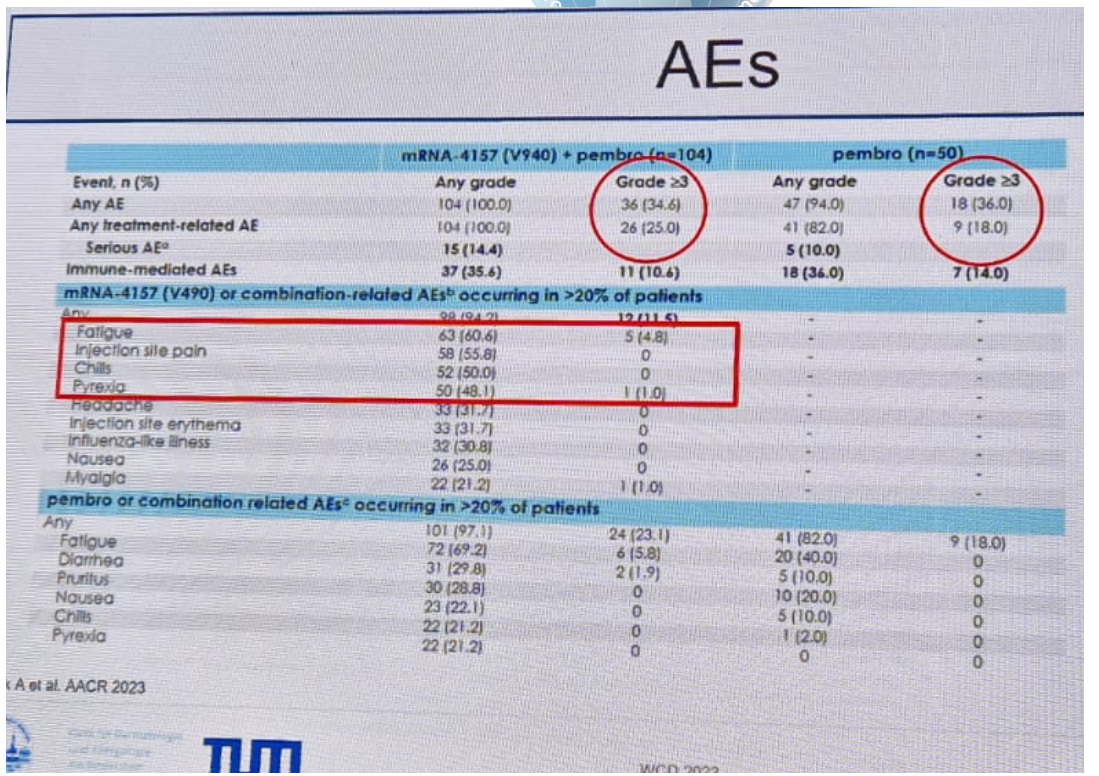

Personalized melanoma neo-antigens
Neoantigens
Tumor cell
Normal cell
Self-antigens
NeoVax[2,3]
Trial design: Phase 1
Results: Safe, feasible, and capable of eliciting strong T-cell responses
NEO-PV-01[4]
Trial design: Phase 1b
Results: Safe, capable of eliciting T-cell responses and epitope spread to novel antigens
samRNA[5]
Trial design: Phase 1
Results: Safe, feasible, and induced long-lasting neoantigen-specific CD8 T-cell responses
MAGE-A3[6]
Trial design: Randomized, phase 3
Results: No increase in DFS vs placebo
GM2-KLH[7]
Trial design: Randomized, intergroup trial
Results: HDI improved RFS and OS over GM2-KLH
gp100[8]
Trial design: Randomized, phase 3
Results: No difference in OS between ipilimumab alone or with gp100
Individualized neo-antigens can increase endogenous anti-tumor T-cell response and induce epitope spreading
Khattak A et al. AACR 2023
WCD 2023
Wiener Gesundheitsverbund
Klinik Hietzing





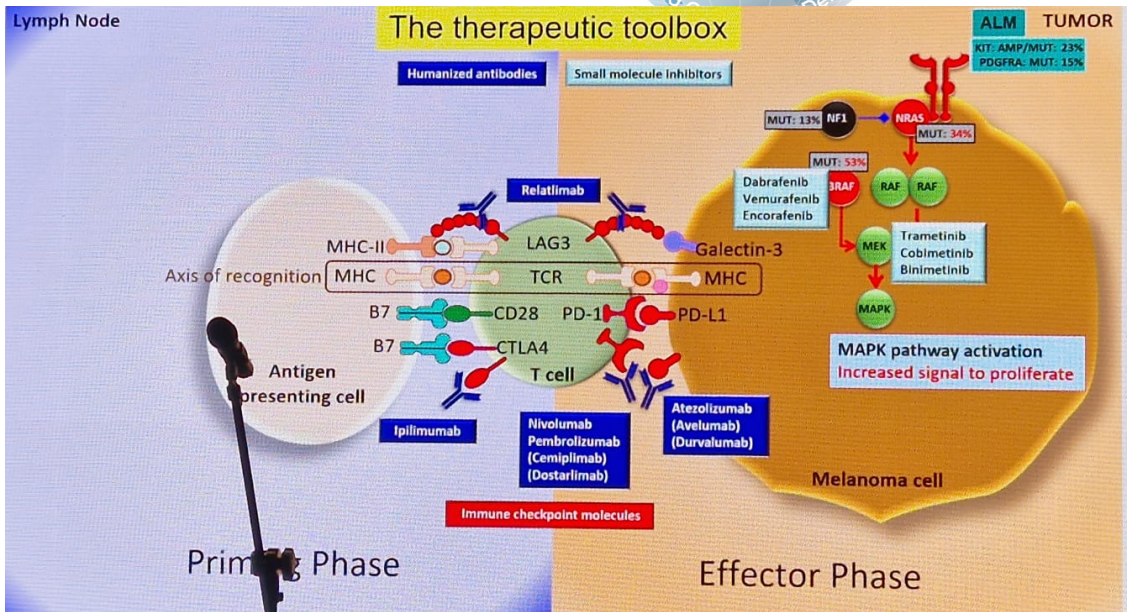
Ensayo clínico fase IIb KEYNOTE-942
La vacuna mRNA 4157/V940 + PEMBROLIZUMAB es una potencial terapia adyuvante para melanoma de alto riesgo.
Los ptes tratados con la combinación tuvieron un riesgo significativamente menor de recurrencia respecto al PEMBRO sólo.
La combinación no aumenta significativamente los efectos adversos.
(Cancer Discov 2023)

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

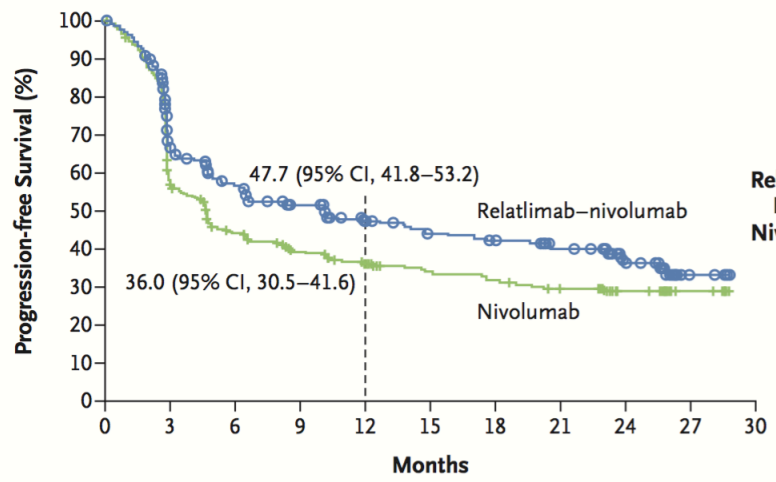
Relatlimab and Nivolumab versus Nivolumab in Untreated Advanced Melanoma

Hussein A. Tawbi, M.D., Ph.D., Dirk Schadendorf, M.D., Evan J. Lipson, M.D., Paolo A. Ascierto, M.D., Luis Matamala, M.D., Erika Castillo Gutiérrez, M.D., Piotr Rutkowski, M.D., Ph.D., Helen J. Gogas, M.D., Christopher D. Lao, M.D., M.P.H., Juliana Janoski De Menezes, M.D., Stéphane Dalle, M.D., Ph.D., Ana Arance, M.D., Ph.D., Jean-Jacques Grob, M.D., Shivani Srivastava, M.D., Mena Abaskharoun, Pharm.D., Melissa Hamilton, M.P.H., Sarah Keidel, M.B., Ch.B., Katy L. Simonsen, Ph.D., Anne Marie Sobiesk, Ph.D., Bin Li, Ph.D., F. Stephen Hodi, M.D., and Georgina V. Long, M.D., Ph.D., for the RELATIVITY-047 Investigators*



CONCLUSIONS

The inhibition of two immune checkpoints, LAG-3 and PD-1, provided a greater benefit with regard to progression-free survival than inhibition of PD-1 alone in patients with previously untreated metastatic or unresectable melanoma. Relatlimab and nivolumab in combination showed no new safety signals. (Funded by Bristol Myers Squibb; RELATIVITY-047 ClinicalTrials.gov number, NCT03470922.)



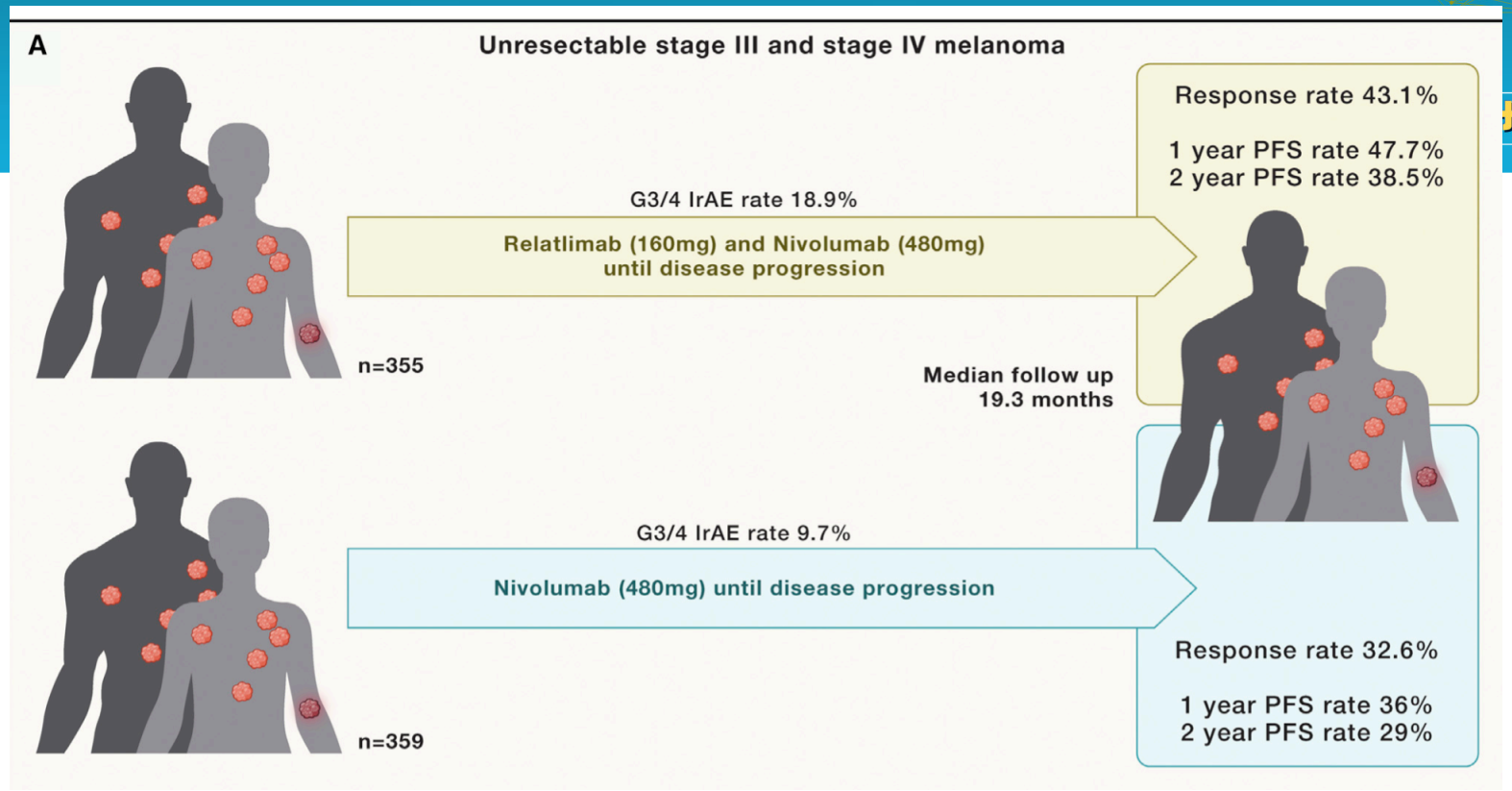
	No. of Patients	Median Progression-free Survival (95% CI)
		mo
Relatlimab–Nivolumab	355	10.12 (6.37–15.74)
Nivolumab	359	4.63 (3.38–5.62)

Hazard ratio for progression or death, 0.75 (95% CI, 0.62–0.92)
P=0.006

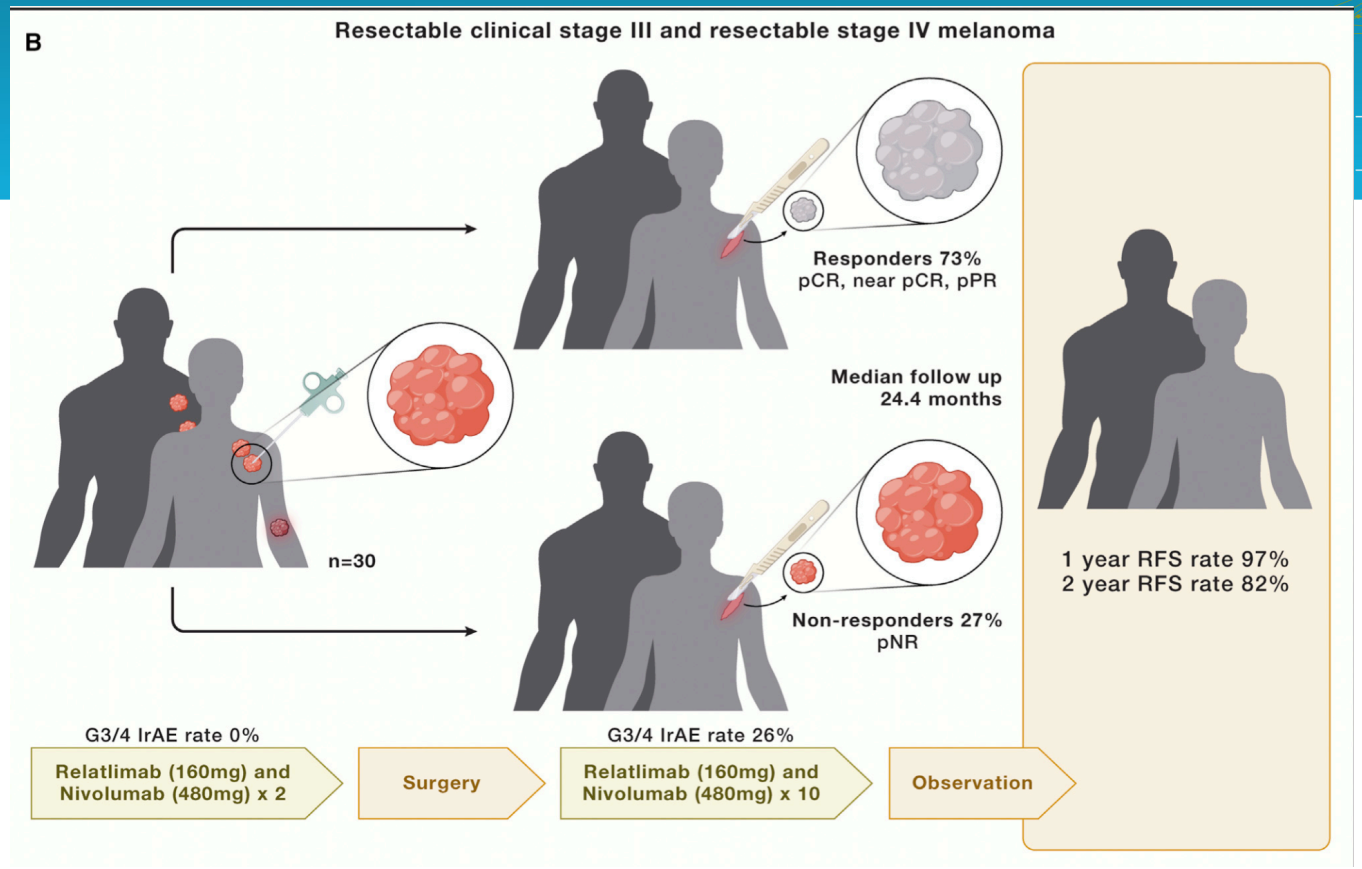
No. at Risk											
Relatlimab–nivolumab	355	201	163	132	99	81	75	67	30	6	0
Nivolumab	359	174	124	94	72	61	57	49	27	6	0

Table 2. Summary of Adverse Events.

Adverse Event	Relatlimab–Nivolumab (N=355)		Nivolumab (N=359)	
	Any grade	Grade 3 or 4	Any grade	Grade 3 or 4
	number of events (percent)			
Any adverse event	345 (97.2)	143 (40.3)	339 (94.4)	120 (33.4)
Treatment-related adverse event	288 (81.1)	67 (18.9)	251 (69.9)	35 (9.7)
Led to discontinuation of treatment	52 (14.6)	30 (8.5)	24 (6.7)	11 (3.1)
Treatment-related adverse event in ≥10% of patients in the relatlimab–nivolumab group				
Pruritus	83 (23.4)	0	57 (15.9)	2 (0.6)
Fatigue	82 (23.1)	4 (1.1)	46 (12.8)	1 (0.3)
Rash	55 (15.5)	3 (0.8)	43 (12.0)	2 (0.6)
Arthralgia	51 (14.4)	3 (0.8)	26 (7.2)	1 (0.3)
Hypothyroidism	51 (14.4)	0	43 (12.0)	0
Diarrhea	48 (13.5)	3 (0.8)	33 (9.2)	2 (0.6)
Vitiligo	37 (10.4)	0	35 (9.7)	0
Immune-mediated adverse event*				
Hypothyroidism or thyroiditis	64 (18.0)	0	50 (13.9)	0
Rash	33 (9.3)	2 (0.6)	24 (6.7)	5 (1.4)
Diarrhea or colitis	24 (6.8)	4 (1.1)	11 (3.1)	5 (1.4)
Hyperthyroidism	22 (6.2)	0	24 (6.7)	0
Hepatitis	20 (5.6)	14 (3.9)	9 (2.5)	4 (1.1)
Adrenal insufficiency	15 (4.2)	5 (1.4)	3 (0.8)	0
Pneumonitis	13 (3.7)	2 (0.6)	6 (1.7)	2 (0.6)
Hypophysitis	9 (2.5)	1 (0.3)	3 (0.8)	1 (0.3)
Nephritis and renal dysfunction	7 (2.0)	4 (1.1)	5 (1.4)	4 (1.1)
Hypersensitivity	4 (1.1)	0	4 (1.1)	0

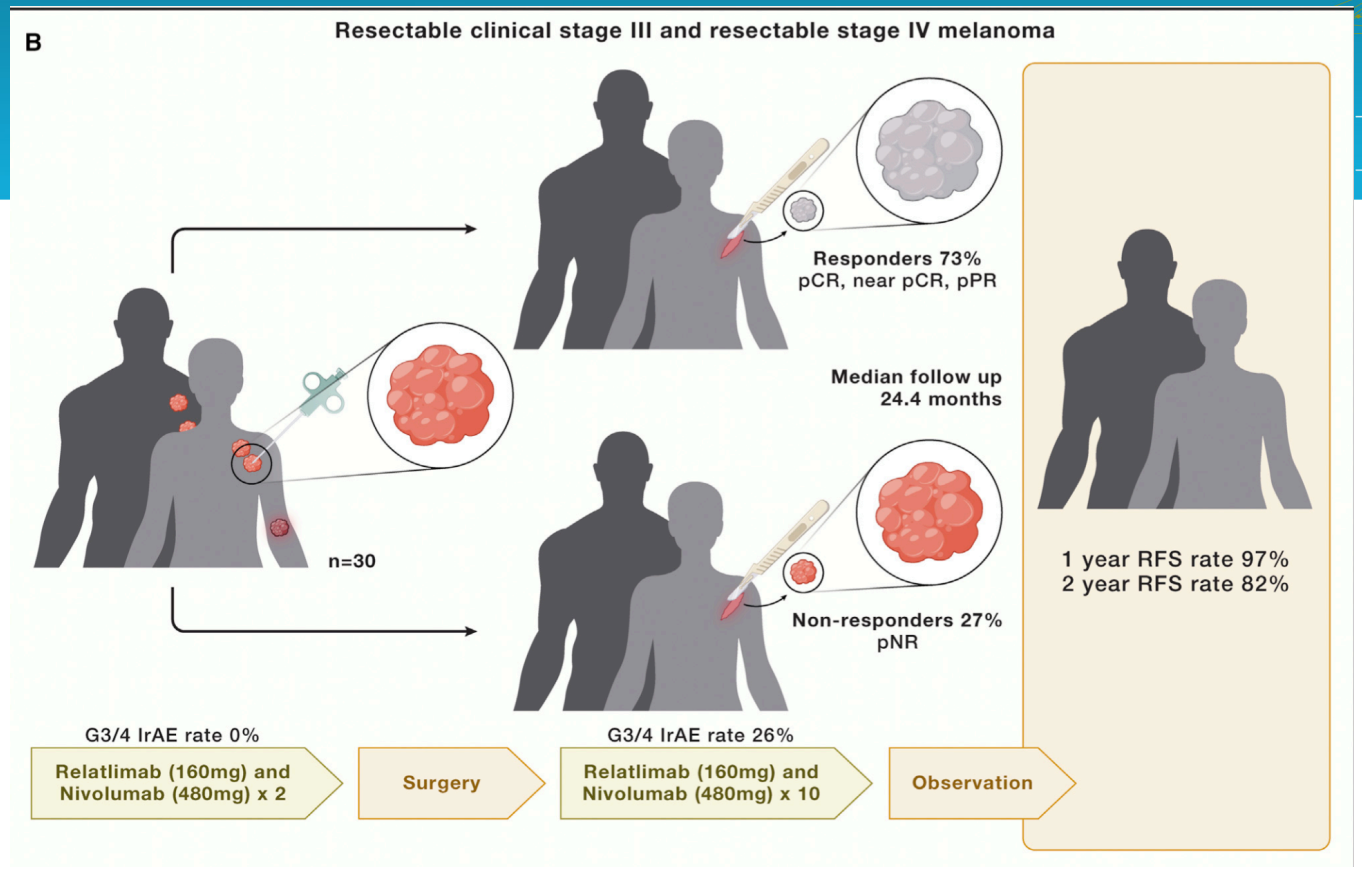


(A) Dos brazos de tratamiento que evalúan relatlimab (anti-LAG-3) y nivolumab (anti-PD-1) frente a nivolumab en pacientes con melanoma irresecable en estadio III y IV. El criterio principal de valoración fue la supervivencia libre de progresión (PFS).



RFS: supervivencia libre de recaídas.

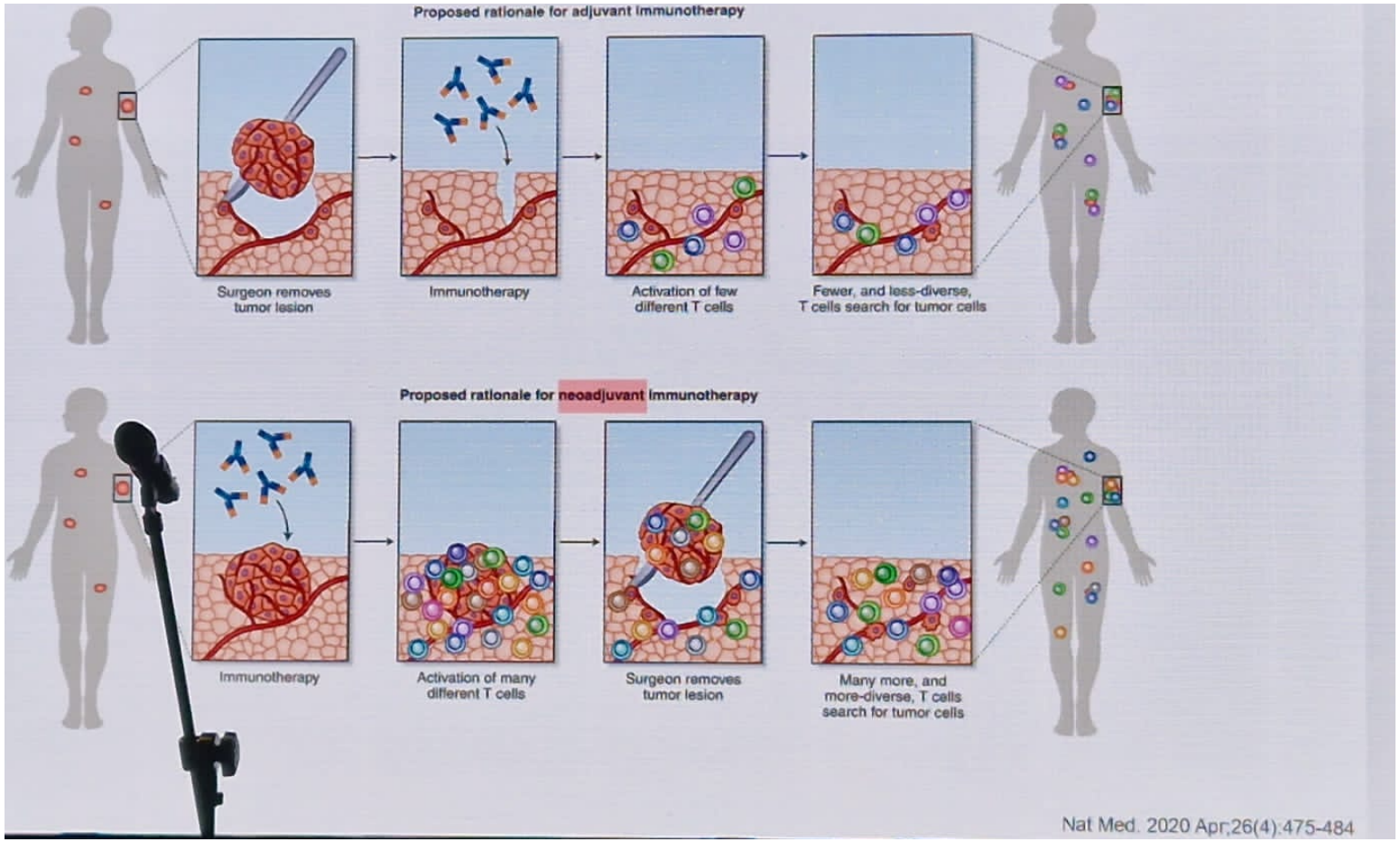
(B) Estudio de un solo brazo que evalúa relatlimab y nivolumab neoadyuvantes.



RFS: supervivencia libre de recaídas.

(B) Estudio de un solo brazo que evalúa relatlimab y nivolumab neoadyuvantes.

En resumen, el bloqueo combinado de LAG-3/PD-1 es una nueva opción de terapia potencial tanto en el melanoma en estadio temprano como en estadio tardío. Cada vez hay más pruebas del beneficio de la neoadyuvante en el melanoma en estadio III. Sin embargo, aunque el relatlimab-nivolumab neoadyuvante parece eficaz, el diseño del estudio de un solo brazo, el pequeño tamaño de la cohorte y la falta de datos de seguimiento a largo plazo son limitantes.


Proposed rationale for adjuvant immunotherapy
Surgeon removes tumor lesion
Immunotherapy
Activation of few different T cells
Fewer, and less-diverse, T cells search for tumor cells
Proposed rationale for neoadjuvant immunotherapy
Immunotherapy
Activation of many different T cells
Surgeon removes tumor lesion
Many more, and more-diverse, T cells search for tumor cells
Nat Med. 2020 Apr;26(4):475-484

ORIGINAL ARTICLE

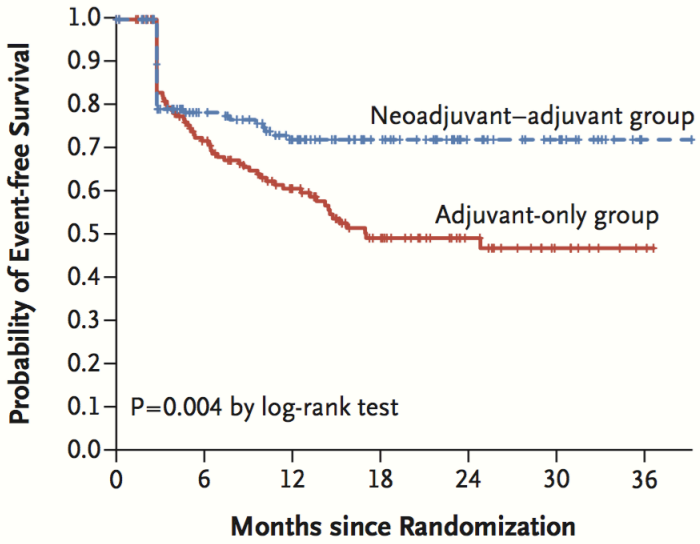
Neoadjuvant–Adjuvant or Adjuvant-Only Pembrolizumab in Advanced Melanoma

S.P. Patel, M. Othus, Y. Chen, G.P. Wright, Jr., K.J. Yost, J.R. Hyngstrom, S. Hu-Lieskovan, C.D. Lao, L.A. Fecher, T.-G. Truong, J.L. Eisenstein, S. Chandra, J.A. Sosman, K.L. Kendra, R.C. Wu, C.E. Devoe, G.B. Deutsch, A. Hegde, M. Khalil, A. Mangla, A.M. Reese, M.I. Ross, A.S. Poklepovic, G.Q. Phan, A.A. Onitilo, D.G. Yasar, B.C. Powers, G.C. Doolittle, G.K. In, N. Kokot, G.T. Gibney, M.B. Atkins, M. Shaheen, J.A. Warneke, A. Ikeguchi, J.E. Najera, B. Chmielowski, J.G. Crompton, J.D. Floyd, E. Hsueh, K.A. Margolin, W.A. Chow, K.F. Grossmann, E. Dietrich, V.G. Prieto, M.C. Lowe, E.I. Buchbinder, J.M. Kirkwood, L. Korde, J. Moon, E. Sharon, V.K. Sondak, and A. Ribas

Pembrolizumab en neoadyuvancia y adyuvancia, ¿mejor que sólo en adyuvancia?

CONCLUSIONS

Among patients with resectable stage III or IV melanoma, event-free survival was significantly longer among those who received pembrolizumab both before and after surgery than among those who received adjuvant pembrolizumab alone. No new toxic effects were identified. (Funded by the National Cancer Institute and Merck Sharp and Dohme; S1801 ClinicalTrials.gov number, NCT03698019.)

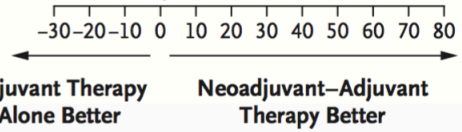


No. at Risk

Neoadjuvant–adjuvant group	154	96	69	46	25	17	1
Adjuvant-only group	159	98	67	40	22	10	2

72% vs 49% supervivencia libre de recaidas a los 2 años (p=0.004)

Subgroup	Adjuvant-Only Group	Neoadjuvant–Adjuvant Group	Difference in 2-Yr Event-free Survival (95% CI)
	no. of events/total no. of patients		*percentage points*
All patients	67/159	38/154	23 (11 to 35)
Age			
≤65 yr	37/92	23/77	14 (–2 to 30)
>65 yr	30/67	15/77	35 (17 to 53)
Sex			
Female	15/48	16/62	9 (–12 to 29)
Male	52/111	22/92	29 (15 to 43)
Zubrod's performance-status score			
0	49/125	24/113	25 (12 to 38)
1 or 2	17/33	14/40	16 (–10 to 42)
LDH level			
Low or normal	58/138	34/132	22 (10 to 35)
High	9/21	4/22	26 (–6 to 58)
Disease stage			
IIIB	24/64	19/62	11 (–8 to 30)
IIIC	34/74	14/69	32 (16 to 49)
IIID	6/10	4/9	9 (–40 to 58)
IV	3/11	1/14	42 (–6 to 89)
Ulceration			
Yes	30/46	16/56	41 (22 to 60)
No	22/58	11/50	21 (0 to 41)
Unknown	15/55	10/46	10 (–10 to 30)
BRAF mutation status			
Mutated	21/38	11/41	31 (9 to 53)
Wild-type	25/64	16/62	16 (–3 to 35)
Unknown	21/57	11/50	25 (4 to 45)



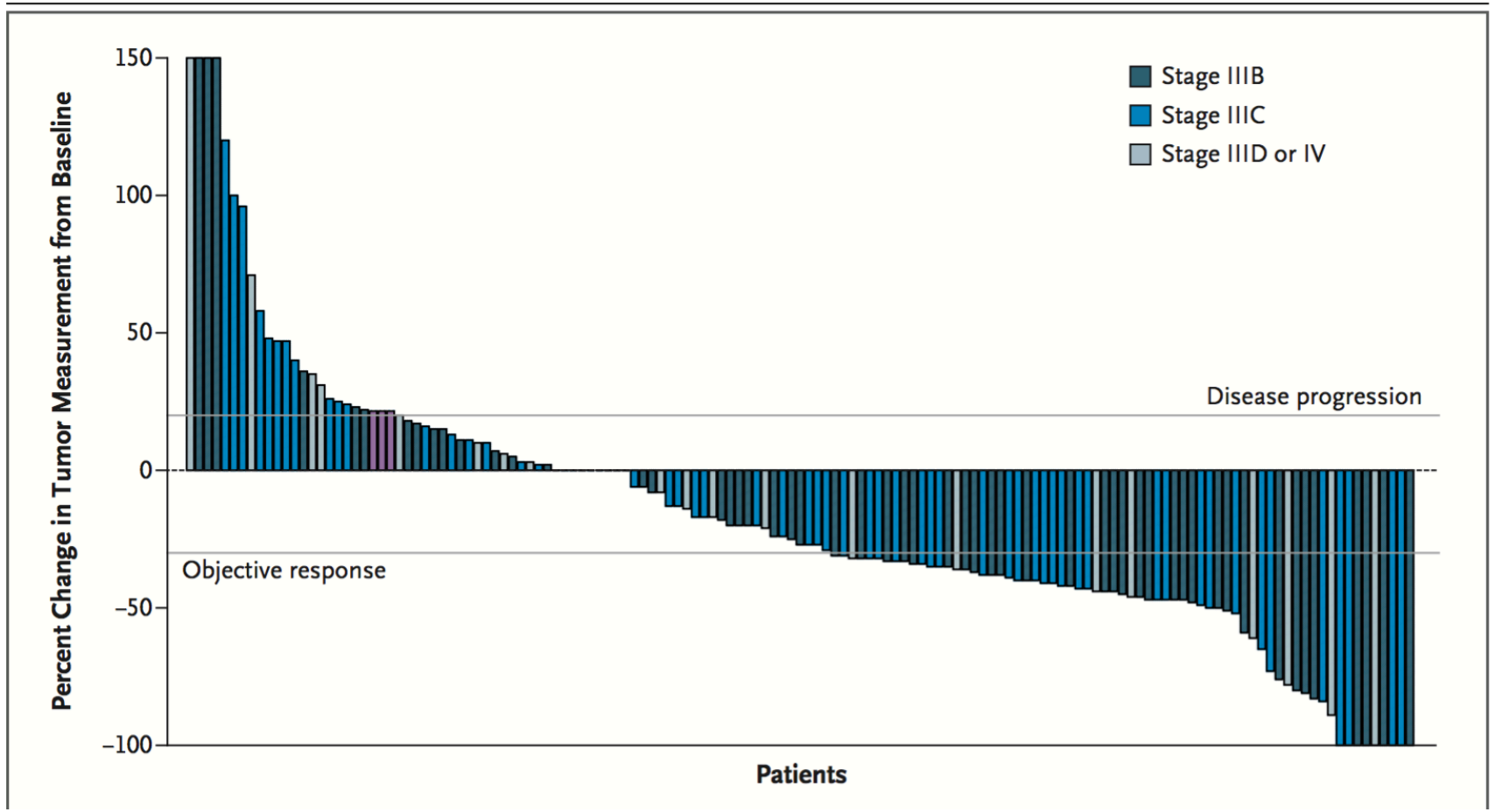

Percent Change in Tumor Measurement from Baseline
150
100
50
0
−50
−100
Stage IIIB
Stage IIIC
Stage IIID or IV
Disease progression
Objective response
Patients

Table 2. Highest Grade of Adverse Events Attributed by the Treating Physician to Pembrolizumab or to Surgery.

Event	Neoadjuvant–Adjuvant Group		Adjuvant-Only Group	
	Grade 3	Grade 4	Grade 3	Grade 4
	number of patients/total number			
Event attributed to neoadjuvant therapy				
Alanine aminotransferase level increased	2/152	1/152	NA	NA
Anemia	1/152	0	NA	NA
Aspartate aminotransferase level increased	2/152	0	NA	NA
Diarrhea	1/152	0	NA	NA
Fever	1/152	0	NA	NA
Hyperglycemia	1/152	1/152	NA	NA
Hypertension	1/152	0	NA	NA
Hypokalemia	1/152	0	NA	NA
Myocarditis	1/152	0	NA	NA
Neutrophil count decreased	0	1/152	NA	NA
Sepsis	0	1/152	NA	NA
Syncope	1/152	0	NA	NA
Urinary tract infection	1/152	0	NA	NA
White-cell count decreased	1/152	1/152	NA	NA
Event attributed to surgery				
Adrenal insufficiency	1/127	0	0	0
Alanine aminotransferase level increased	0	11/127	0	0
Aspartate aminotransferase level increased	1/127	0	0	0
Chest-wall pain	0	0	1/141	0
Fall	1/127	0	0	0
Infections or infestations — other	1/127	0	1/141	0
Maculopapular rash	1/127	0	0	0
Seroma	1/127	0	1/141	0
Skin infection	1/127	0	1/141	0
Surgical or medical procedures — other	1/127	0	0	0
Syncope	1/127	0	0	0
Thromboembolic event	0	0	1/141	0
Wound dehiscence	1/127	0	0	0
Wound infection	1/127	0	0	0
Event attributed to adjuvant therapy				
Alanine aminotransferase level increased	2/113	0	2/131	0
Alkaline phosphatase level increased	1/113	0	0	0
Arthritis	0	0	1/131	0
Aspartate aminotransferase level increased	2/113	0	2/131	0
Blood or lymph disorder — other	0	0	1/131	0
Cardiac disorder — other	0	1/113	1/131	0
Cognitive disturbance	0	0	1/131	0
Dehydration	1/113	0	0	0
Diarrhea	0	0	1/131	0
Fatigue	0	0	2/131	0

Table 2. (Continued.)

Event	Neoadjuvant–Adjuvant Group		Adjuvant-Only Group	
	Grade 3	Grade 4	Grade 3	Grade 4
	number of patients/total number			
Gallbladder infection	0	0	1/131	0
Headache	1/113	0	0	0
Hepatobiliary disorders — other	0	0	1/131	0
Hyperglycemia	0	0	2/131	0
Hypertension	0	0	1/131	0
Hypokalemia	1/113	0	0	0
Hyponatremia	1/113	0	0	0
Lung infection	0	1/113	0	0
Lymphocyte count decreased	1/113	0	2/131	0
Maculopapular rash	1/113	0	4/131	0
Metabolism or nutrition disorders — other	0	0	1/131	0
Nausea	2/113	0	0	0
Platelet count decreased	0	0	0	1/131
Pneumonitis	1/113	0	0	0
Pruritus	1/113	0	2/131	0
Skin or subcutaneous tissue disease — other	1/113	0	0	0
Soft-tissue infection	1/113	0	0	0
Stroke	1/113	0	0	0
Syncope	0	0	1/131	0
Urinary tract infection	1/113	0	1/131	0
Vomiting	1/113	0	3/131	1/131

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 8, 2022 VOL. 387 NO. 23

Tumor-Infiltrating Lymphocyte Therapy or Ipilimumab in Advanced Melanoma

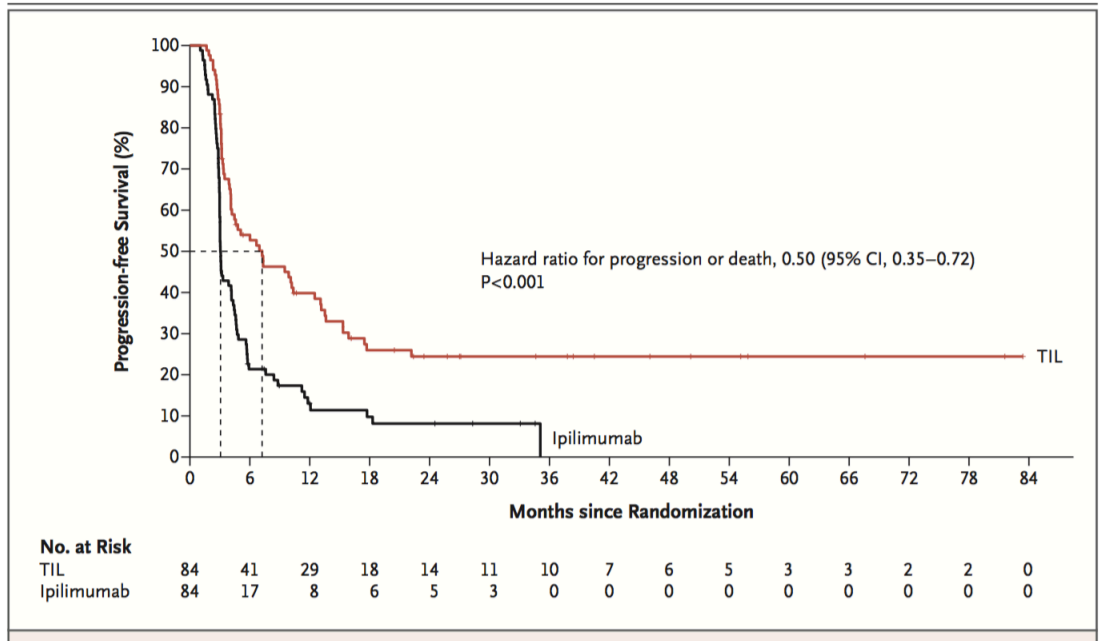
M.W. Rohaan, T.H. Borch, J.H. van den Berg, Ö. Met, R. Kessels, M.H. Geukes Foppen, J. Stoltenborg Granhøj, B. Nuijen, C. Nijenhuis, I. Jedema, M. van Zon, S. Scheij, J.H. Beijnen, M. Hansen, C. Voermans, I.M. Noringriis, T.J. Monberg, R.B. Holmstroem, L.D.V. Wever, M. van Dijk, L.G. Grijpink-Ongering, L.H.M. Valkenet, A. Torres Acosta, M. Karger, J.S.W. Borgers, R.M.T. ten Ham, V.P. Retèl, W.H. van Harten, F. Lalezari, H. van Tinteren, A.A.M. van der Veldt, G.A.P. Hospers, M.A.M. Stevense-den Boer, K.P.M. Suijkerbuijk, M.J.B. Aarts, D. Piersma, A.J.M. van den Eertwegh, J.-W.B. de Groot, G. Vreugdenhil, E. Kapiteijn, M.J. Boers-Sonderen, W.E. Fiets, F.W.P.J. van den Berkmortel, E. Ellebaek, L.R. Hölmich, A.C.J. van Akkooi, W.J. van Houdt, M.W.J.M. Wouters, J.V. van Thienen, C.U. Blank, A. Meerveld-Eggink, S. Klobuch, S. Wilgenhof, T.N. Schumacher, M. Donia, I.M. Svane, and J.B.A.G. Haanen

CONCLUSIONS

In patients with advanced melanoma, progression-free survival was significantly longer among those who received TIL therapy than among those who received ipilimumab. (Funded by the Dutch Cancer Society and others; ClinicalTrials.gov number, NCT02278887.)

Table 1. Baseline Characteristics of the Patients.*

Characteristic	TIL Group (N=84)	Ipilimumab Group (N=84)	Total (N=168)
Sex — no. (%)			
Male	47 (56)	53 (63)	100 (60)
Female	37 (44)	31 (37)	68 (40)
Median age (range) — yr	59 (26–74)	59 (30–77)†	59 (26–77)
WHO performance-status score — no. (%)‡			
0	69 (82)	70 (83)	139 (83)
1	15 (18)	14 (17)	29 (17)
BRAF mutation status — no. (%)			
V600 mutation	37 (44)	36 (43)	73 (43)
Wild-type	47 (56)	48 (57)	95 (57)
Treatment center — no. (%)			
NKI	66 (79)	66 (79)	132 (79)
CCIT-DK	18 (21)	18 (21)	36 (21)
Disease stage at trial entry — no. (%)§			
Unresectable stage IIIC	2 (2)	2 (2)	4 (2)
Stage IV	82 (98)	82 (98)	164 (98)
M1a	13 (15)	18 (21)	31 (18)
M1b	7 (8)	17 (20)	24 (14)
M1c	56 (67)	40 (48)	96 (57)
Liver metastases	20 (24)	9 (11)	29 (17)
M1d	6 (7)	7 (8)	13 (8)
Lactate dehydrogenase level — no. (%)			
≤ULN	67 (80)	70 (83)	137 (82)
1–2 × ULN	17 (20)	14 (17)	31 (18)
Smoking status — no. (%)			
Yes	9 (11)	11 (13)	20 (12)
No	46 (55)	49 (58)	95 (57)
Previous systemic therapy — no. (%)			
Yes	75 (89)	74 (88)	149 (89)
No	9 (11)	10 (12)	19 (11)
Type of previous systemic therapy — no. (%)			
Adjuvant anti–PD-1 therapy	17 (20)	23 (27)	40 (24)
First-line anti–PD-1 therapy	56 (67)	49 (58)	105 (62)
Other	2 (2)	2 (2)	4 (2)



La mediana de supervivencia libre de progresión fue de 7,2 meses en el grupo de TIL y de 3,1 meses en el grupo de ipilimumab.
El 49 % y el 21 % de los pacientes, respectivamente, tuvieron una respuesta objetiva.
La mediana de supervivencia general fue de 25,8 meses en el grupo de TIL y de 18,9 meses en el grupo de ipilimumab.

Table 3. Most Common Treatment-Related Adverse Events.*

Adverse Event	TIL Group (N=80)				Ipilimumab Group (N=82)	
	Chemotherapy		TILs and Interleukin-2		Ipilimumab	
	Any Grade	≥Grade 3	Any Grade	≥Grade 3	Any Grade	≥Grade 3
	number of patients (percent)					
Neutrophil count decreased	80 (100)	80 (100)	—	—	—	—
Platelet count decreased	73 (91)	71 (89)	—	—	—	—
Anemia	73 (91)	16 (20)	—	—	—	—
Nausea	69 (86)	2 (2)	41 (51)	0	30 (37)	2 (2)
Febrile neutropenia	69 (86)	69 (86)	59 (74)	59 (74)	—	—
White-cell count decreased	57 (71)	57 (71)	—	—	—	—
Fatigue	49 (61)	4 (5)	54 (68)	7 (9)	37 (45)	1 (1)
Hypophosphatemia	49 (61)	20 (25)	57 (71)	48 (60)	—	—
Alopecia†	37 (46)	0	—	—	—	—
Diarrhea	36 (45)	2 (2)	36 (45)	2 (2)	37 (45)	12 (15)
Hypocalcemia	36 (45)	1 (1)	29 (36)	0	—	—
Hypoalbuminemia	27 (34)	0	31 (39)	0	—	—
Vomiting	26 (32)	2 (2)	15 (19)	0	11 (13)	1 (1)
Headache	20 (25)	0	19 (24)	0	22 (27)	1 (1)
Hypokalemia	20 (25)	2 (2)	12 (15)	0	—	—
Elevated AST level	18 (22)	4 (5)	26 (32)	8 (10)	18 (22)	7 (9)
Rash	18 (22)	2 (2)	37 (46)	9 (11)	28 (34)	4 (5)
Weight gain	17 (21)	0	28 (35)	0	—	—
Elevated ALT level	14 (18)	7 (9)	25 (31)	8 (10)	22 (27)	8 (10)
Elevated alkaline phosphatase level	14 (18)	3 (4)	17 (21)	3 (4)	12 (15)	4 (5)
Anorexia	13 (16)	1 (1)	—	—	14 (17)	1 (1)
Dizziness	12 (15)	0	—	—	—	—
Increased γ-glutamyltransferase level	11 (14)	6 (8)	12 (15)	6 (8)	—	—
Fever	11 (14)	1 (1)	74 (92)	36 (45)	11 (13)	2 (2)
Dysgeusia	11 (14)	0	—	—	—	—
Hypomagnesemia	11 (14)	0	—	—	—	—
Dyspnea	10 (12)	2 (2)	63 (79)	15 (19)	—	—
Constipation	9 (11)	0	—	—	—	—
Edema limbs	8 (10)	0	23 (29)	0	—	—
Chills	—	—	67 (84)	6 (8)	—	—
Pruritus	—	—	—	—	34 (41)	0
Sinus tachycardia	—	—	40 (50)	1 (1)	—	—
Colitis	—	—	—	—	20 (24)	16 (20)
Abdominal pain	—	—	—	—	19 (23)	1 (1)
Hypotension	—	—	33 (41)	6 (8)	—	—
Malaise	—	—	—	—	13 (16)	0

Table 3. (Continued.)

Adverse Event	TIL Group (N=80)				Ipilimumab Group (N=82)	
	Chemotherapy		TILs and Interleukin-2		Ipilimumab	
	Any Grade	≥Grade 3	Any Grade	≥Grade 3	Any Grade	≥Grade 3
	number of patients (percent)					
Creatine kinase level increased	—	—	29 (36)	9 (11)	—	—
Dry mouth	—	—	—	—	9 (11)	0
Pulmonary edema	—	—	26 (32)	1 (1)	—	—
Capillary leak syndrome	—	—	24 (30)	1 (1)	—	—
Hypoxia	—	—	19 (24)	5 (6)	—	—
Hypertension	—	—	15 (19)	11 (14)	—	—
Myalgia	—	—	12 (15)	1 (1)	—	—
Blurred vision	—	—	9 (11)	0	—	—
Skin hypopigmentation	—	—	9 (11)	0	—	—

* Included are the most common treatment-related adverse events of any grade and those of grade 3 or higher, as defined according to the National Cancer Institute Common Terminology Criteria for Adverse Events, version 4.03, that occurred in at least 10% of the patients who received chemotherapy and TILs or at least one dose of ipilimumab (the safety analysis population). Dashes indicate that the adverse events did not occur in at least 10% of the patients. All the patients had more than one adverse event. ALT denotes alanine aminotransferase, and AST aspartate aminotransferase.

† Transient alopecia totalis occurred in all patients in the TIL group after chemotherapy. However, this event was not systematically reported in medical records and thus cannot be reported.

Journal of SURGICAL ONCOLOGY

RESEARCH ARTICLE

Are the MIA and MSKCC nomograms useful in selecting patients with melanoma for sentinel lymph node biopsy?

Sharif Hosein BS, Harrison M. Drebin BA, Nicholas R. Kurtansky BS, Roger Olofsson Bagge MD, PhD, Daniel G. Coit MD, Edmund K. Bartlett MD, Michael A. Marchetti MD

First published: 11 March 2023 | https://doi.org/10.1002/jso.27231

El uso de estos nomogramas no tiene beneficio clínico para los pacientes

Background and Methods

The Melanoma Institute of Australia (MIA) and Memorial Sloan Kettering Cancer Center (MSKCC) nomograms were developed to help guide sentinel lymph node biopsy (SLNB) decisions. Although statistically validated, whether these prediction models provide clinical benefit at National Comprehensive Cancer Network guideline-endorsed thresholds is unknown. We conducted a net benefit analysis to quantify the clinical utility of these nomograms at risk thresholds of 5%–10% compared to the alternative strategy of biopsying all patients. External validation data for MIA and MSKCC nomograms were extracted from respective published studies.

Results

The MIA nomogram provided added net benefit at a risk threshold of 9% but net harm at 5%–8% and 10%. The MSKCC nomogram provided added net benefit at risk thresholds of 5% and 9%–10% but net harm at 6%–8%. When present, the magnitude of net benefit was small (1–3 net avoidable biopsies per 100 patients).

Conclusion

Neither model consistently provided added net benefit compared to performing SLNB for all patients.

Discussion

Based on published data, use of the MIA or MSKCC nomograms as decision-making tools for SLNB at risk thresholds of 5%–10% does not clearly provide clinical benefit to patients.

Ann Surg Oncol (2023) 30:4321–4328
https://doi.org/10.1245/s10434-023-13220-0

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ORIGINAL ARTICLE – MELANOMA

A Clinical Decision Tool to Calculate Pretest Probability of Sentinel Lymph Node Metastasis in Primary Cutaneous Melanoma

Raghav Tripathi, MD, MPH[1], Karen Larson, PhD[2], Graham Fowler, MS[3], Dale Han, MD[3], John T. Vetto, MD[3], Jeremy S. Bordeaux, MD, MPH[4], and Wesley Y. Yu, MD[5]

[1]Department of Dermatology, Johns Hopkins Medicine, Baltimore, MD; [2]Insight Data Science Program, Boston, MA; [3]Department of Surgery, Oregon Health and Science University, Portland, OR; [4]Department of Dermatology, University Hospitals Cleveland Medical Center/Case Western Reserve University, Cleveland, OH; [5]Department of Dermatology, Oregon Health and Science University, Portland, OR

ELMO: "RESULTADO ESPERADO DE METASTASIS LINFÁTICA, ¿otro nomograma con mejores perspectivas?

Métodos: se utilizaron datos del Registro de Vigilancia, Epidemiología y Resultados Finales (SEER) de 2000 a 2017 y de la Base de Datos Nacional del Cáncer (NCDB) de 2004 a 2015 para desarrollar y validar internamente un modelo predictivo de regresión logística de cresta para la positividad de SLNB. La validación externa se realizó con 1568 pacientes en un gran centro de referencia terciario. Resultados: La cohorte de desarrollo incluyó 134.809 pacientes y la cohorte de validación interna incluyó 38.518 pacientes. ELMO (AUC 0,85) dio como resultado una tasa de reducción de SLNB del 29,54 % y una mayor sensibilidad para predecir el estado de SLNB para tumores T1b, T2a y T2b que los modelos anteriores. En la validación externa, ELMO tuvo una precisión de 0,7586 y AUC de 0,7218. Las limitaciones de este estudio son posibles errores de codificación, factores de confusión no contabilizados y modificación del efecto.

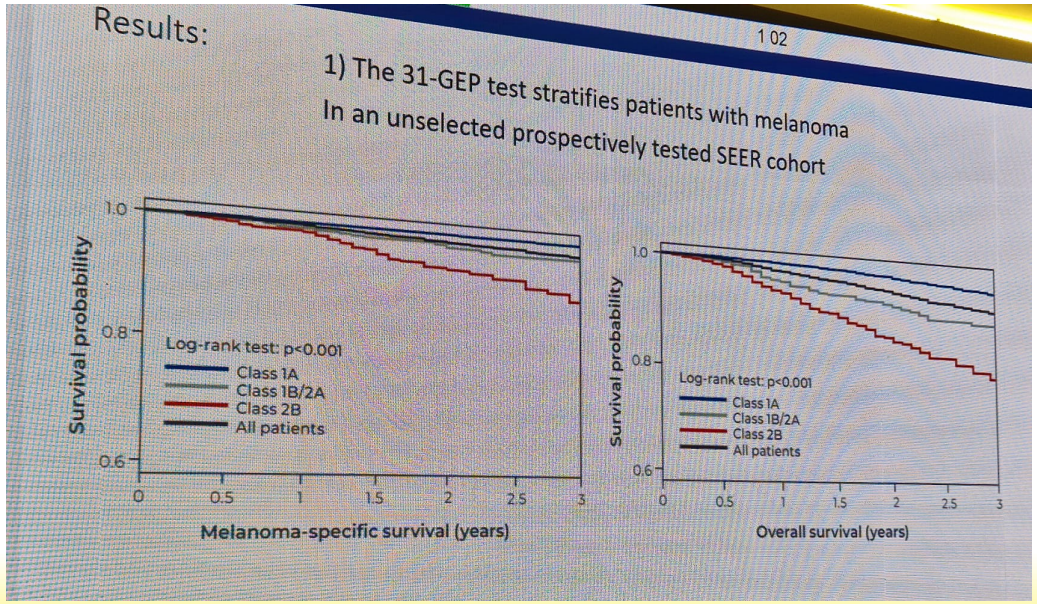
Conclusiones: ELMO (https://melanoma-sentinel.herokuapp.com/) ha sido desarrollado y validado (interna y externamente) utilizando el conjunto de datos más grande disponible públicamente de pacientes con melanoma y se encontró que tiene una alta precisión en comparación con otros modelos publicados y pruebas de expresión génica. Las estimaciones de riesgo individualizadas para la positividad de SLNB son fundamentales para facilitar la toma de decisiones exhaustiva para los proveedores de atención médica y los pacientes con melanoma.

JCO Precision Oncology > List of Issues > Volume 7 >

ORIGINAL REPORTS | Precision Medicine

31-Gene Expression Profile Testing in Cutaneous Melanoma and Survival Outcomes in a Population-Based Analysis: A SEER Collaboration

Christine N. Bailey, MPH[1]; Brian J. Martin, PhD[1]; Valentina I. Petkov, MD, MPH[2]; Nicola C. Schussler, BS[3]; Jennifer L. Stevens, BS[3]; Suzanne Bentler, PhD[4]; ...



Brief Report

April 27, 2022

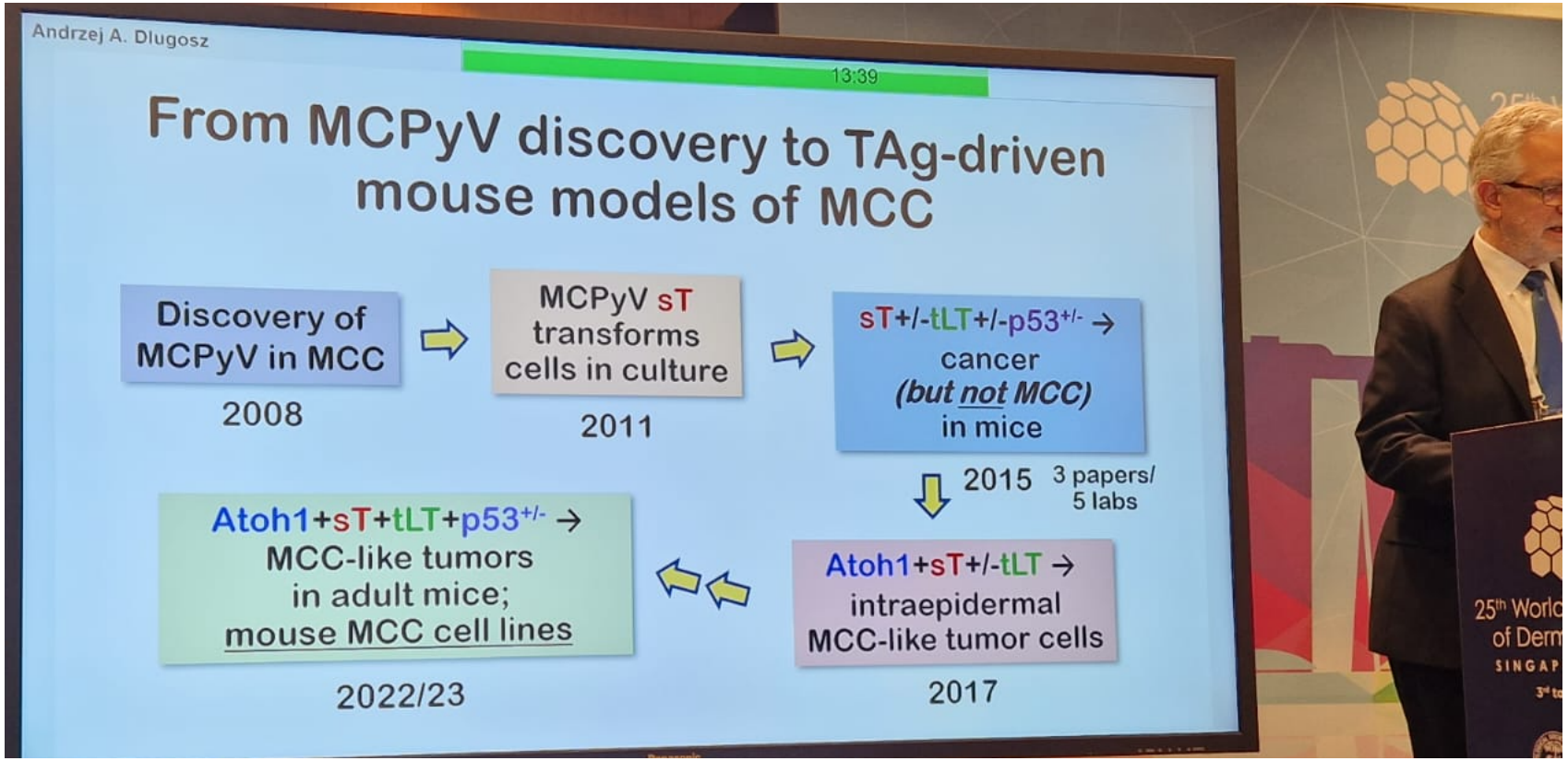
Utility of a Model for Predicting the Risk of Sentinel Lymph Node Metastasis in Patients With Cutaneous Melanoma

Michael A. Marchetti, MD[1]; Stephen W. Dusza, DrPH, MPH[1]; Edmund K. Bartlett, MD[2]

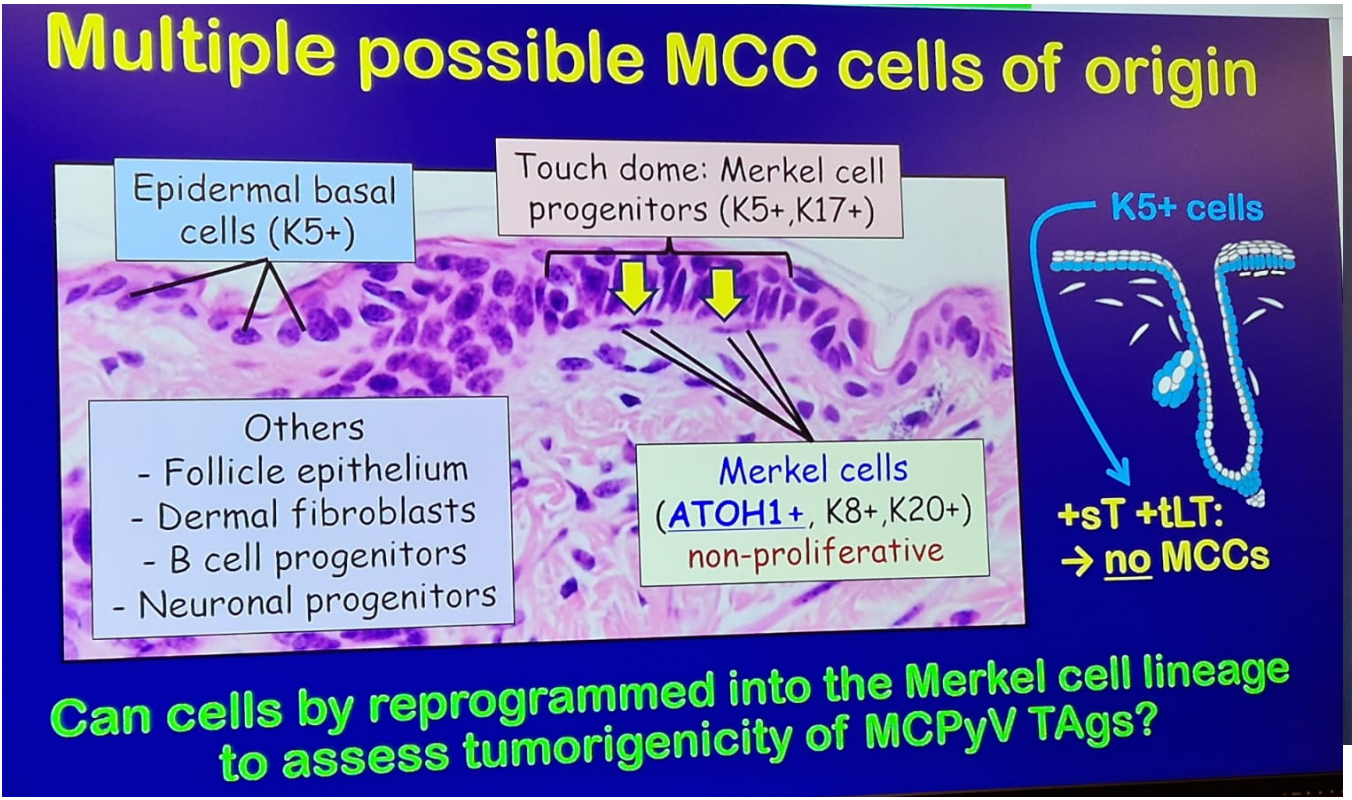
» Author Affiliations

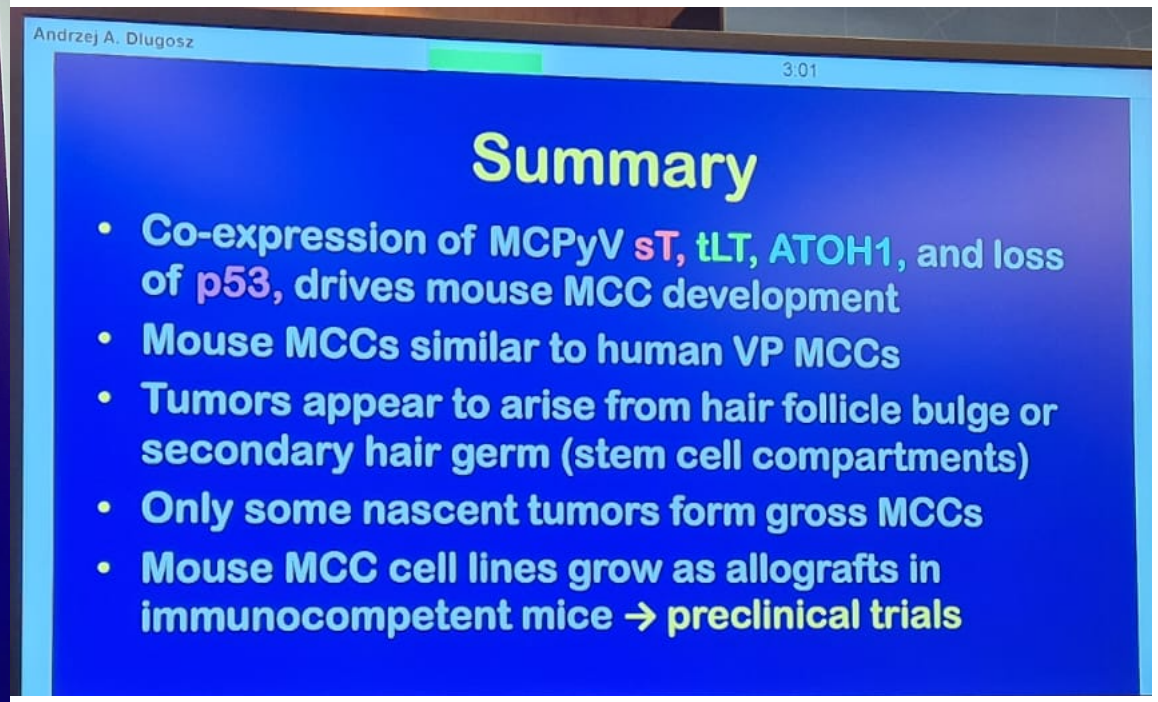
JAMA Dermatol. 2022;158(6):680-683. doi:10.1001/jamadermatol.2022.0970

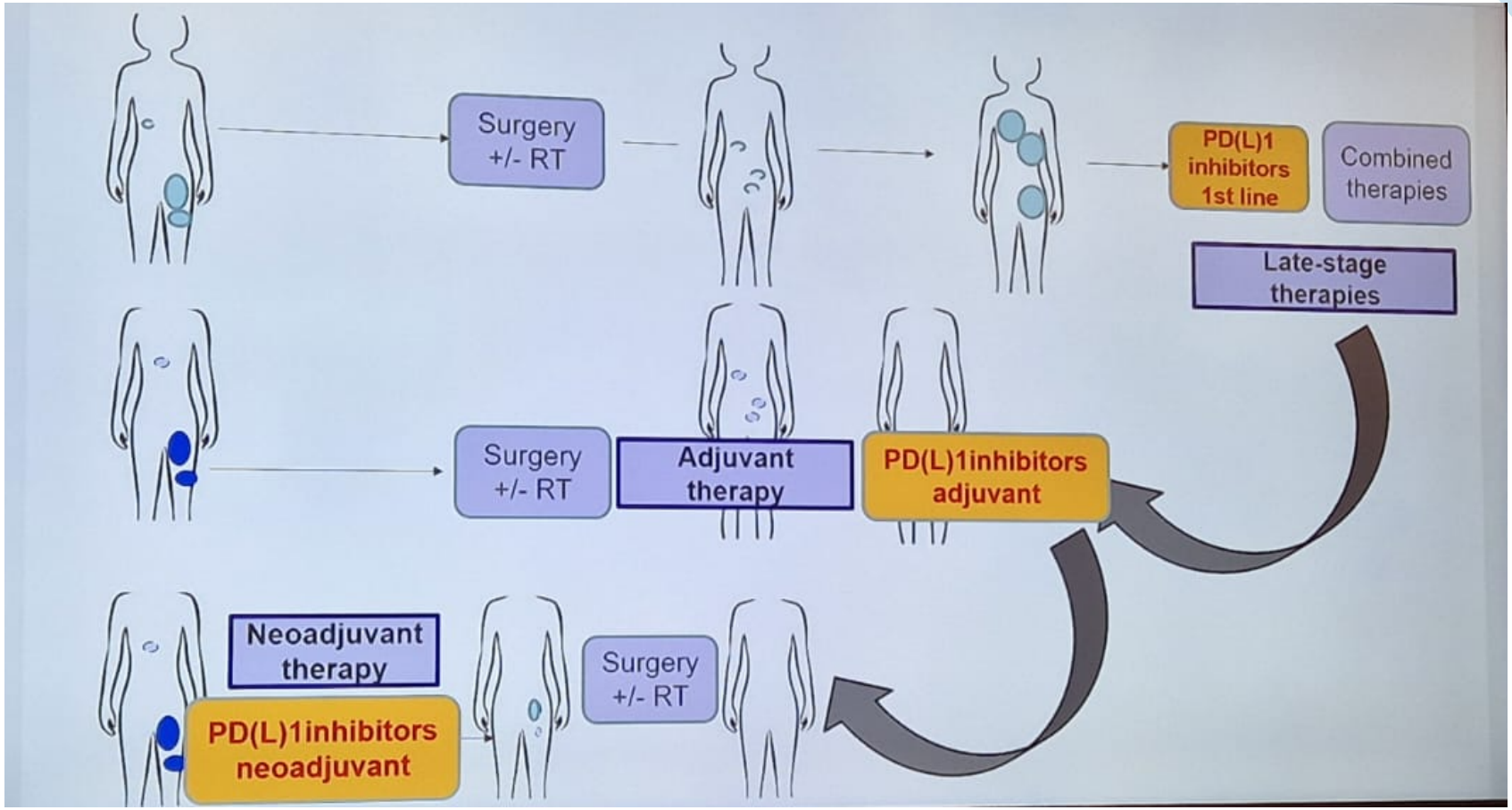
En una cohorte de melanoma clínicamente probada basada en la población, el 31-GEP estratificó a los pacientes según su riesgo de morir de melanoma.


Andrzej A. Dlugosz
13:39
From MCPyV discovery to TAg-driven mouse models of MCC
Discovery of MCPyV in MCC
2008
MCPyV sT transforms cells in culture
2011
sT+/-tLT+/-p53+/- → cancer (but not MCC) in mice
2015
3 papers/ 5 labs
Atoh1+sT+/-tLT → intraepidermal MCC-like tumor cells
2017
Atoh1+sT+tLT+p53+/- → MCC-like tumors in adult mice; mouse MCC cell lines
2022/23

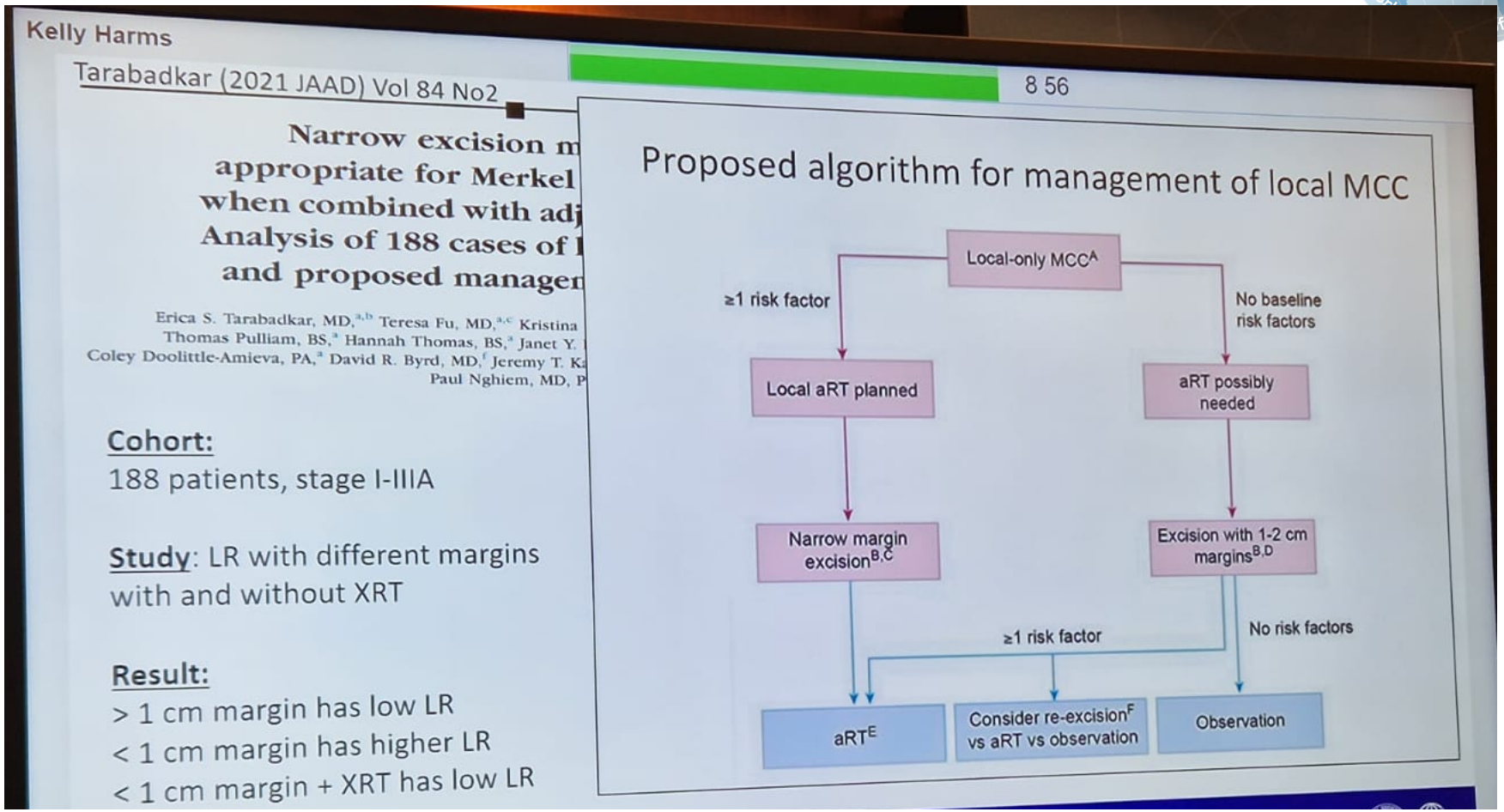
Dr. A Dlugosz

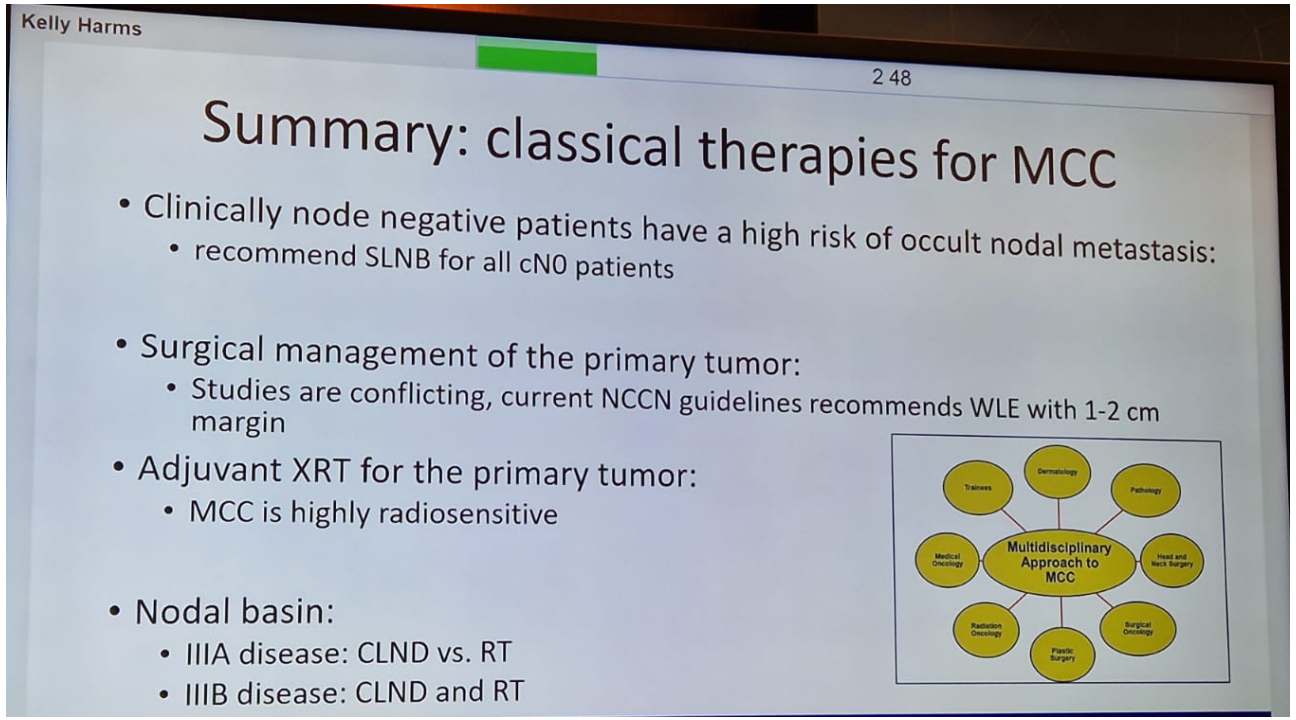

Multiple possible MCC cells of origin
Epidermal basal cells (K5+)
Touch dome: Merkel cell progenitors (K5+,K17+)
K5+ cells
Others
- Follicle epithelium
- Dermal fibroblasts
- B cell progenitors
- Neuronal progenitors
Merkel cells
(ATOH1+, K8+,K20+)
non-proliferative
+sT +tLT:
→ no MCCs
Can cells by reprogrammed into the Merkel cell lineage to assess tumorigenicity of MCPyV TAgs?

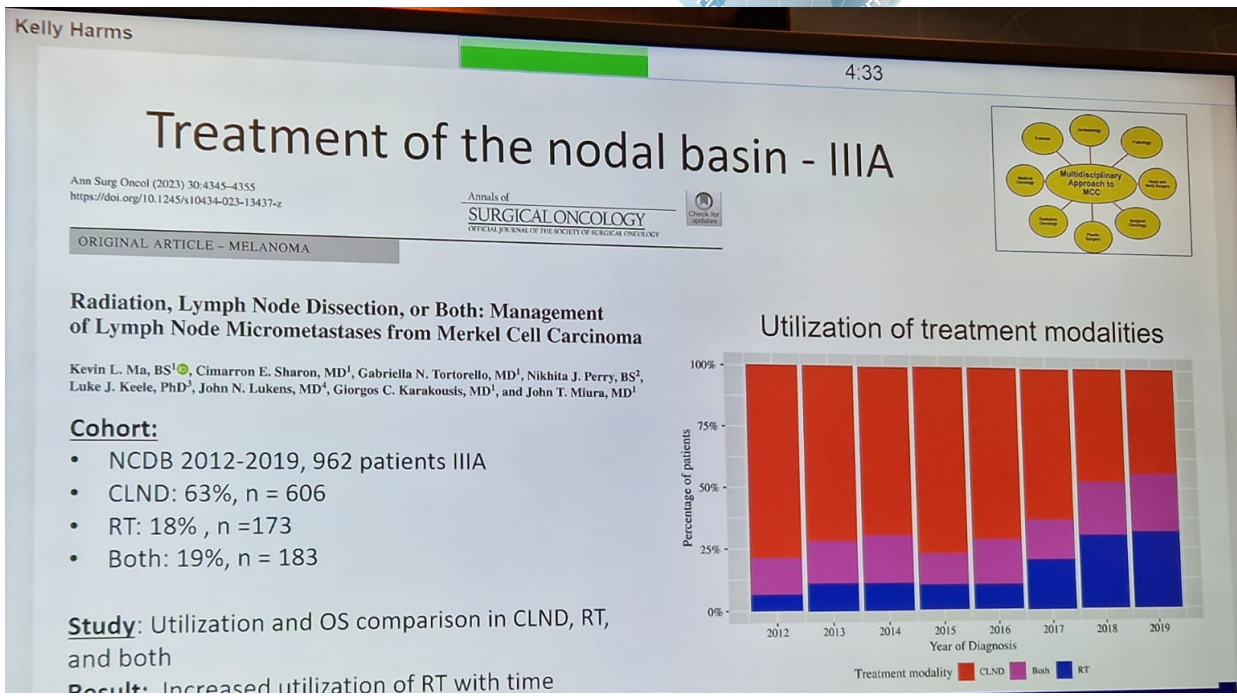

Andrzej A. Dlugosz
3:01
Summary
• Co-expression of MCPyV sT, tLT, ATOH1, and loss of p53, drives mouse MCC development
• Mouse MCCs similar to human VP MCCs
• Tumors appear to arise from hair follicle bulge or secondary hair germ (stem cell compartments)
• Only some nascent tumors form gross MCCs
• Mouse MCC cell lines grow as allografts in immunocompetent mice → preclinical trials


Surgery
+/- RT
PD(L)1
inhibitors
1st line
Combined
therapies
Late-stage
therapies
Surgery
+/- RT
Adjuvant
therapy
PD(L)1inhibitors
adjuvant
Neoadjuvant
therapy
PD(L)1inhibitors
neoadjuvant
Surgery
+/- RT

Dra. Kelly Harms





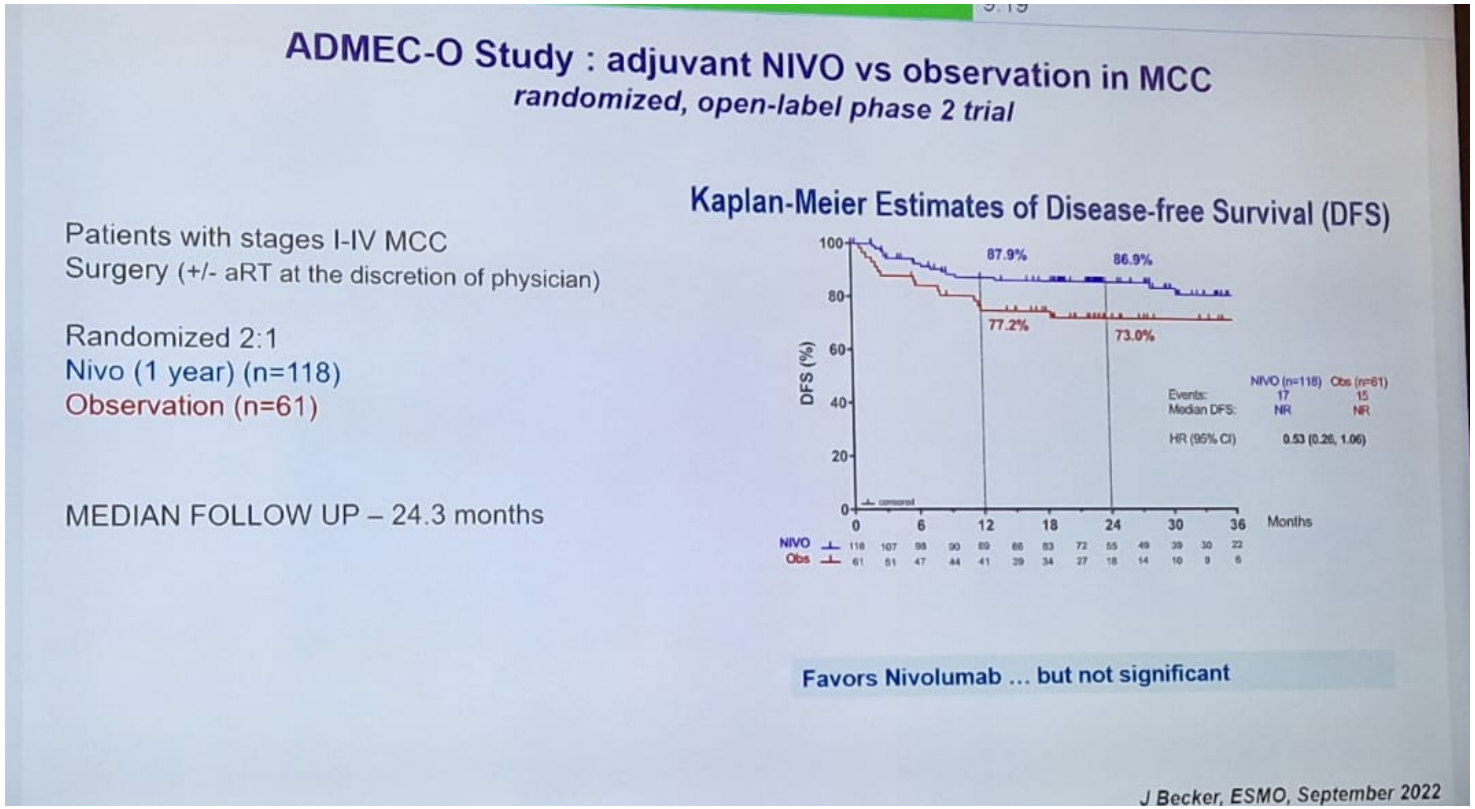


Dra. Kelly Harms

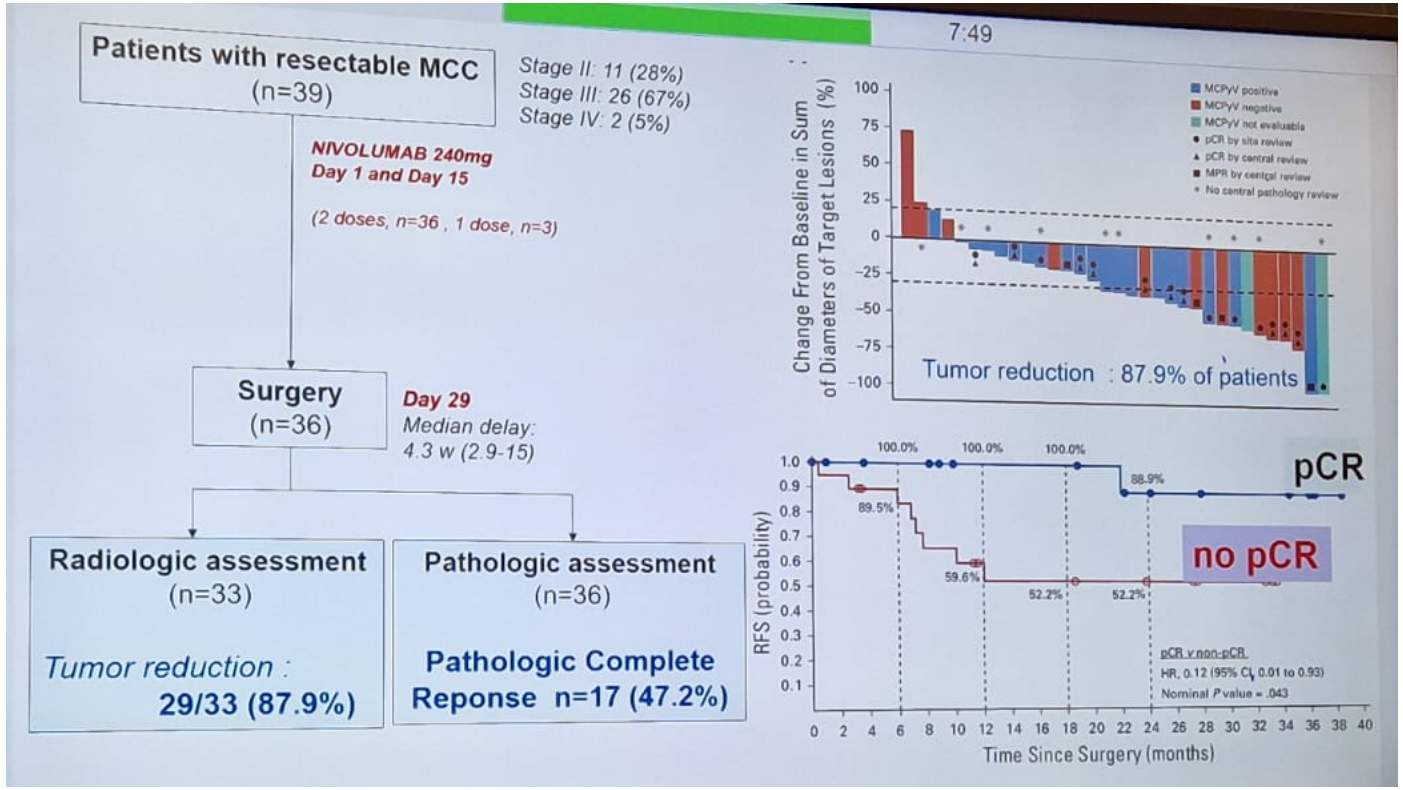
Dra. Mahtab Samimi

PD-1/PD-L1 blockade for advanced MCC: current possibilities

	Avelumab (anti-PDL1)		Pembrolizumab (anti-PD1)	Retifanlimab (anti-PD1)
Approval	FDA, Japan, Australia, EMA 2017		FDA 2018	FDA 2023 March 22
Line	≥ 2nd line	1st line	1st line	1st line
ORR	33%	45%	58%	51%
3 y OS rates	32%	44%	59%	unknown
Reference	Kaufman, 2016 Kaufman, 2018 D'Angelo, 2019 D'Angelo, 2020	D'Angelo, 2018 D'Angelo, 2019-2021	Nghiem, NEJM 2016 Nghiem, J Clin Oncol 2018 Nghiem, JITC 2021	Grignani, JITC 2021

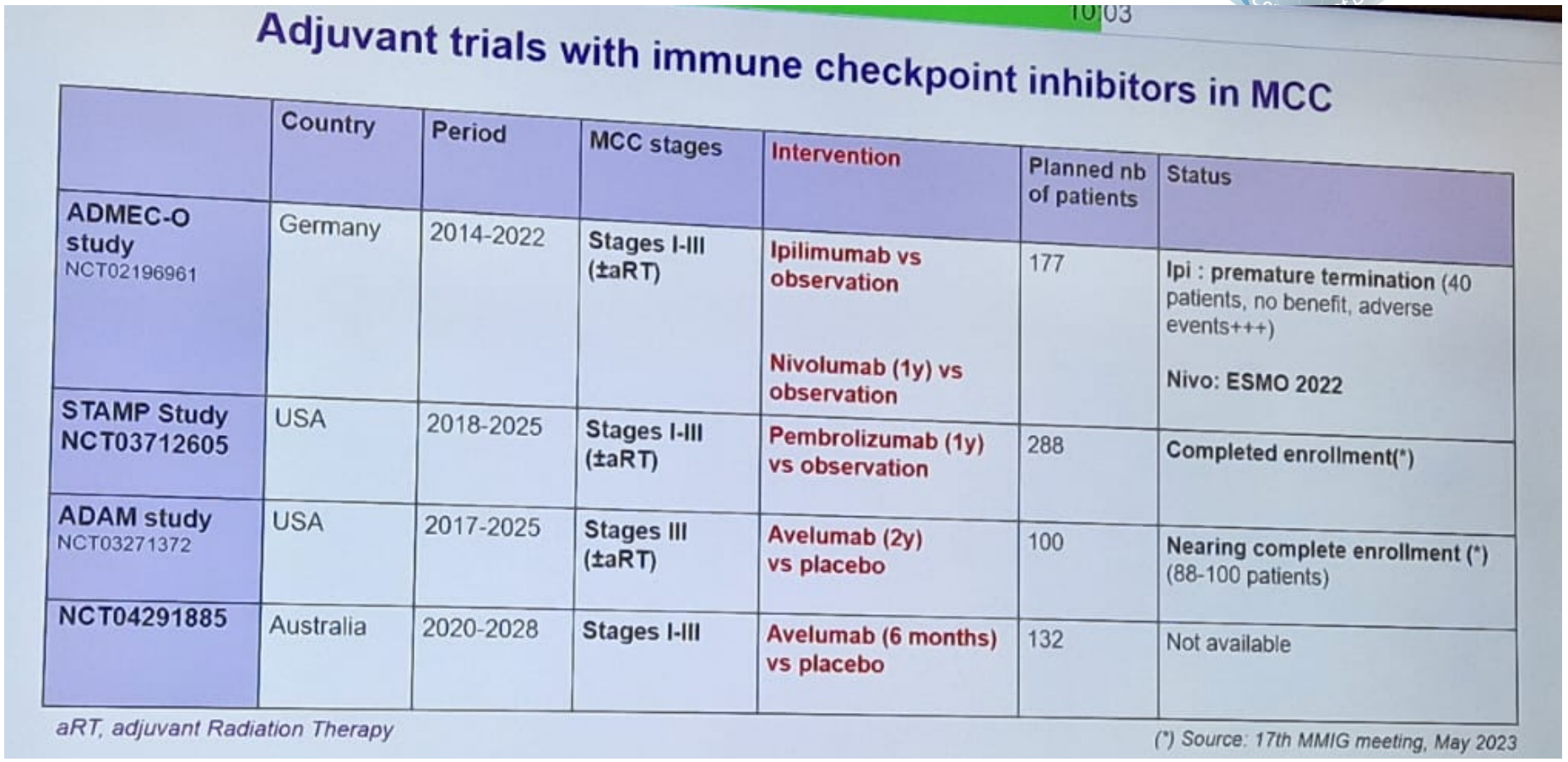


Nivolumab en adyuvancia



Nivolumab en neoadyuvancia

Dra. Mahtab Samimi



Adjuvant trials with immune checkpoint inhibitors in MCC

	Country	Period	MCC stages	Intervention	Planned nb of patients	Status
ADMEC-O study NCT02196961	Germany	2014-2022	**Stages I-III (±aRT)**	**Ipilimumab vs observation** **Nivolumab (1y) vs observation**	177	**Ipi : premature termination** (40 patients, no benefit, adverse events+++) **Nivo: ESMO 2022**
STAMP Study NCT03712605	USA	2018-2025	**Stages I-III (±aRT)**	**Pembrolizumab (1y) vs observation**	288	**Completed enrollment(*)**
ADAM study NCT03271372	USA	2017-2025	**Stages III (±aRT)**	**Avelumab (2y) vs placebo**	100	**Nearing complete enrollment (*)** (88-100 patients)
NCT04291885	Australia	2020-2028	**Stages I-III**	**Avelumab (6 months) vs placebo**	132	Not available

aRT, adjuvant Radiation Therapy

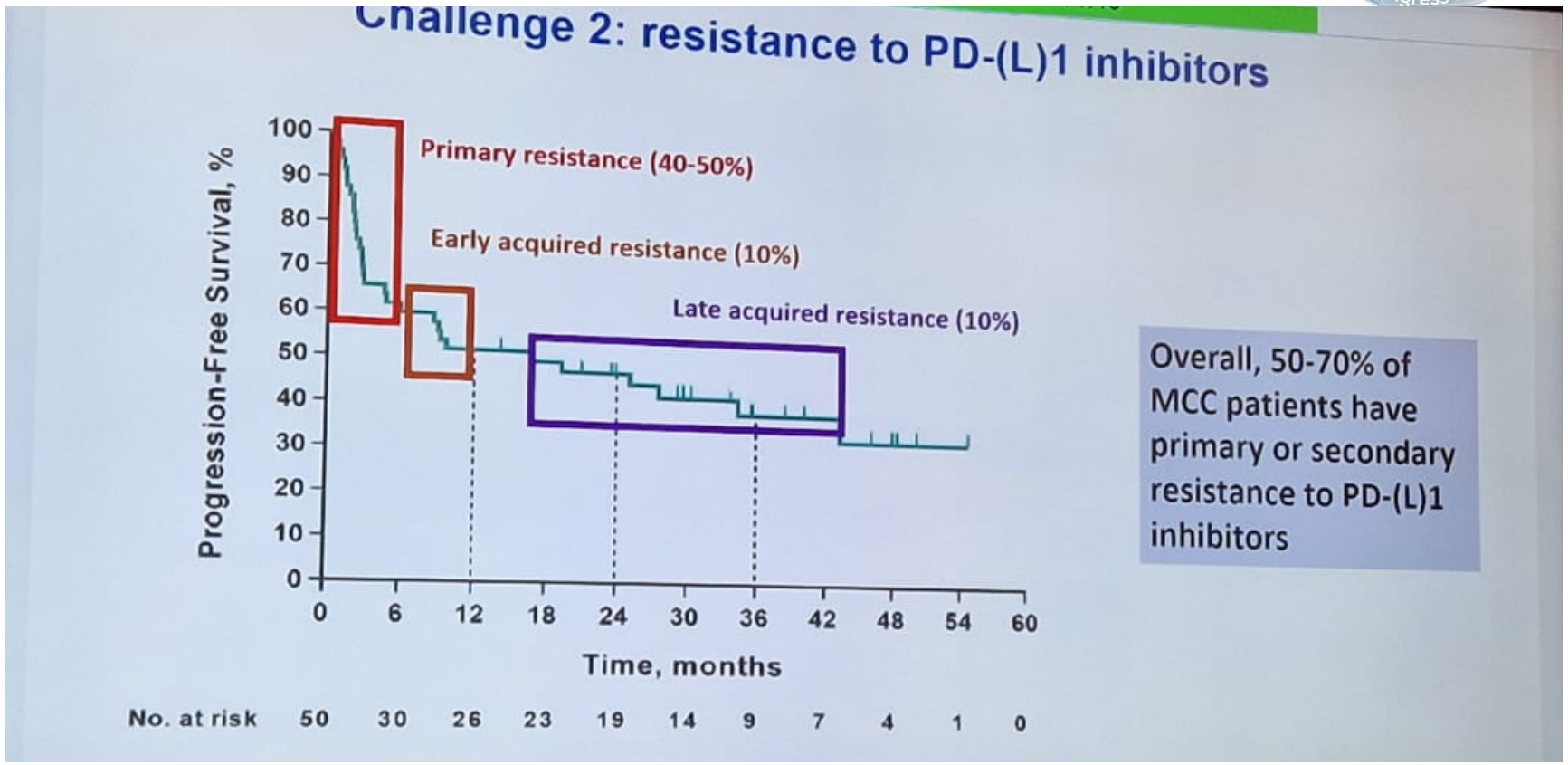
(*) Source: 17th MMIG meeting, May 2023

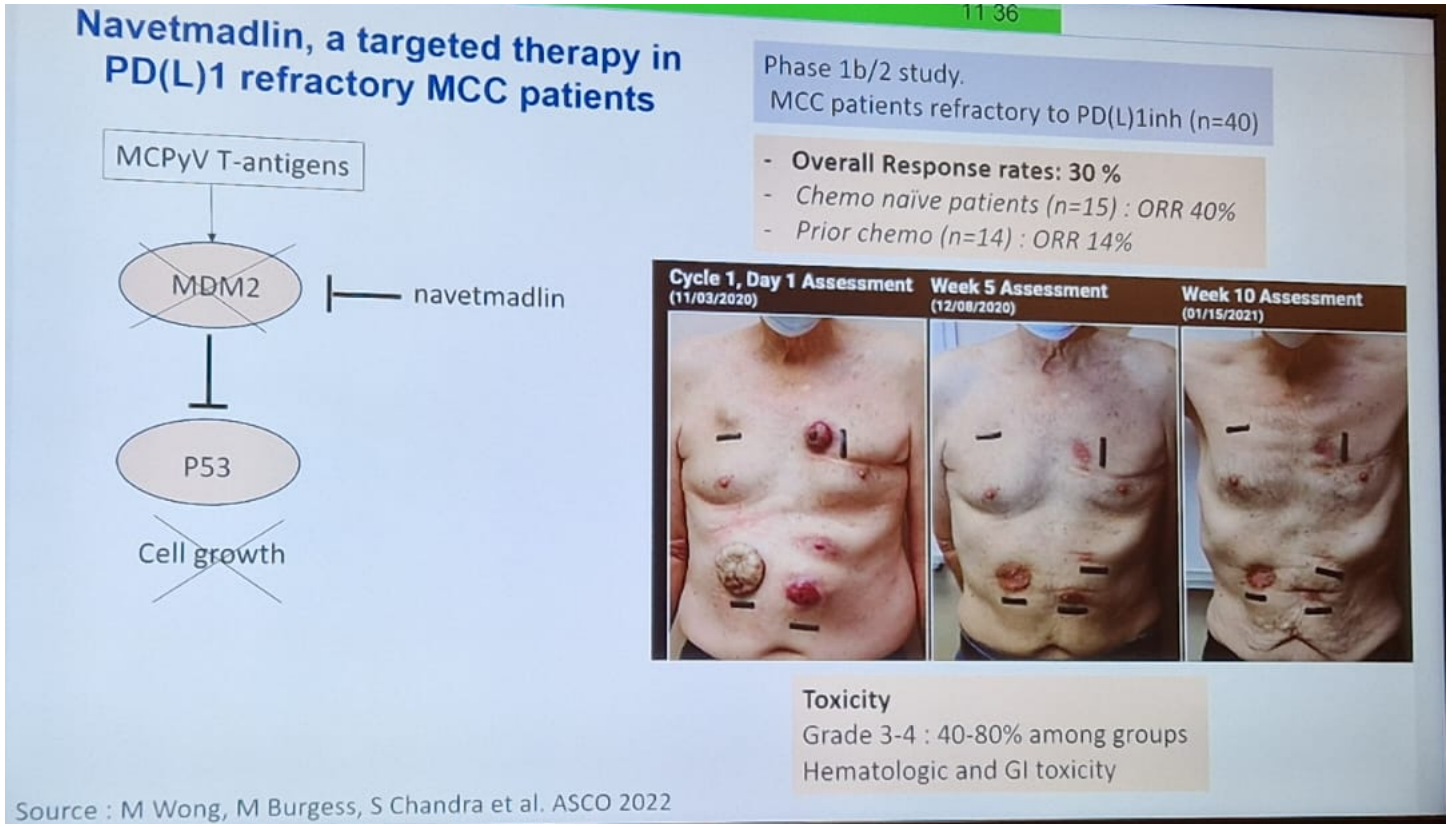
Combining Ipilimumab and Nivolumab in advanced MCC

Source	Design	Patients	Previous therapy	ORR (CR + PR)	Grade 3-4 Tox
Shalout. J Immunother 2022	Retrospective Monocenter	N=13	**PD(L)1 inh (n=13)** *Chemo (n=5)*	**0**	4/13 (**31%**)
Glutsch JITC 2022	Retrospective Multicenter	N=14	**Avelumab (n=14)** *Chemo (n=4)*	7/14 (**50%**)	4/14 (**28%**)
Kim Lancet 2022	RCT multicenter	N= 50 *25: IPI NIVO* *25: IPI NIVO + SBRT*	**PD(L)1 refractory (n=26)** **PD(L)1 naive (n=22)**	8/26 (**31%**) 22/22 (**100%**)	18/50 (**36%**)

IPI/NIVO is a promising strategy in patients who are resistant to PD(L)1 inhibitors
IPI/NIVO as first line treatment in selected patients?

Dra. Mahtab Samimi





Navtemandlin (KRT-232), un inhibidor de MDM2


Connie Zhong
14:40
25th World Congress of Dermatology
SINGAPORE 2023
DERMATOLOGY BEYOND BORDERS
SCIENCE · CARE · COMMUNITIES
ILDS
Clinical Factors Associated with Skin Neoplasms in Individuals with Lynch Syndrome
Connie S. Zhong, MD, MSc, Miki Horiguchi, PhD, Hajime Uno, PhD, Chinedu Ukaegbu, MBBS, MPH, Anu Chittenden, MS, LGC, Nicole R. LeBoeuf, MD, MPH, Sapna Syngal, MD, MPH,* Vinod E. Nambudiri, MD, MBA, EdM,* Matthew B. Yurgelun, MD*
Brigham & Women's Hospital, Boston, MA 02215
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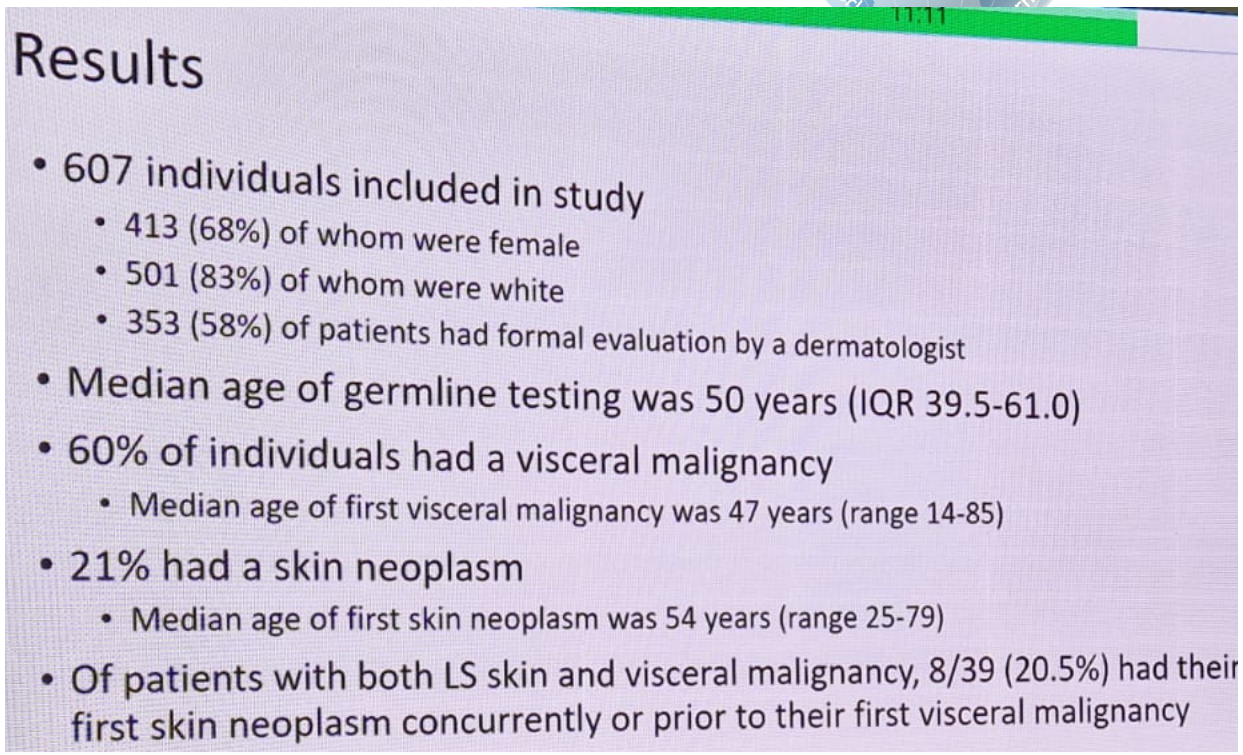
Dana-Farber Cancer Institute, Boston, MA 02215
*Co-senior authors
RS07 Melanoma and naevi/Oncology and Transplant dermatology (including CADR to novel chemo and
www.wcd2023singapore.org

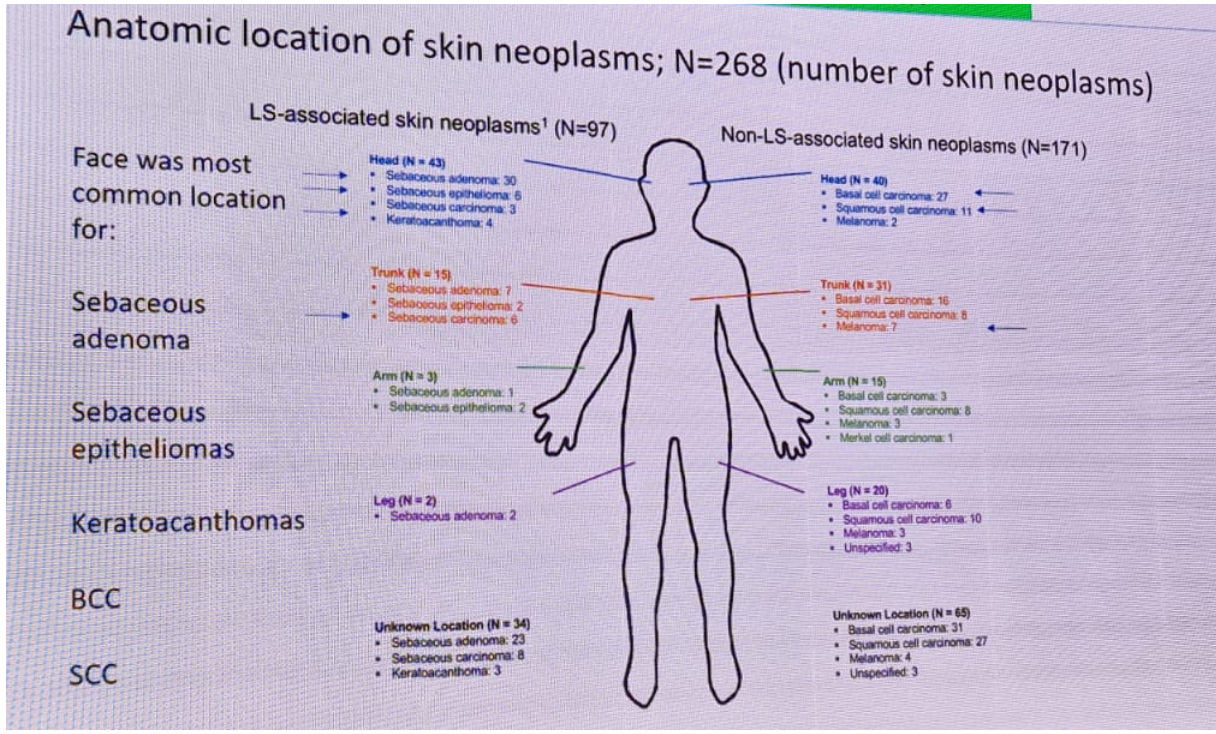

Results
• 607 individuals included in study
• 413 (68%) of whom were female
• 501 (83%) of whom were white
• 353 (58%) of patients had formal evaluation by a dermatologist
• Median age of germline testing was 50 years (IQR 39.5-61.0)
• 60% of individuals had a visceral malignancy
• Median age of first visceral malignancy was 47 years (range 14-85)
• 21% had a skin neoplasm
• Median age of first skin neoplasm was 54 years (range 25-79)
• Of patients with both LS skin and visceral malignancy, 8/39 (20.5%) had their first skin neoplasm concurrently or prior to their first visceral malignancy

Number of Lynch syndrome carriers (N) with specific skin neoplasms

36/128 (28%) patients had multiple histologic types of skin neoplasms

Type of skin neoplasm	N=607 (%)
No skin neoplasm	479 (78.9)
Any Lynch-associated skin neoplasm	56 (9.2)
Sebaceous adenoma	44 (7.2)
Sebaceous carcinoma	14 (2.3)
Sebaceous epithelioma	7 (1.2)
Keratoacanthoma	4 (0.7)
Any Non-Lynch-associated skin neoplasm	91 (15.0)
Basal cell carcinoma	55 (9.1)
Squamous cell carcinoma	35 (5.8)
Melanoma	17 (2.8)
Merkel cell carcinoma	1 (0.2)
Unspecified skin neoplasm	3 (0.5)

Anatomic location of skin neoplasms; N=268 (number of skin neoplasms)



BOONE DERMATOLOGY CLINIC

Serpiginous Pigmentation in Pigmented Squamous Cell Carcinoma In-situ

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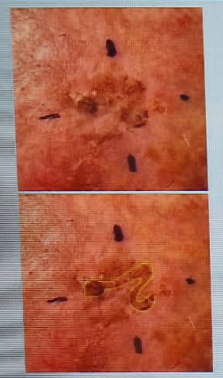
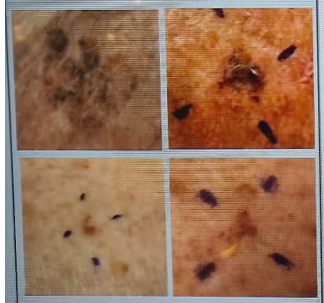


Figures 1-2: Serpiginous Pigmentation identified and outlined within a predominantly erythematous pigmented SCCIS.



Figures 3-6: Serpiginous Pigmentation within predominantly hyperpigmented and predominantly hyperkeratotic pigmented SCCIS.

Introduction: Pigmented squamous cell carcinoma in-situ is a commonly occurring skin cancer also known as pigmented Bowen's disease. Although frequently described as rare in the literature, these lesions are a frequent occurrence at many dermatology clinics. Pigmented squamous cell carcinoma in-situ often has clinical features that may overlap with benign skin lesions such as seborrheic keratoses, lentigines and melanocytic nevi. Well-formed clinical diagnostic criteria for pigmented squamous cell carcinoma in-situ are currently lacking. We propose the presence of "serpiginous pigmentation," as defined by wavy, undulating, or snake-like pigmentation within the lesion, as an important diagnostic clue for pigmented squamous cell carcinoma in-situ.

Objectives: To examine the frequency that serpiginous pigmentation exists clinically within biopsy-proven pigmented squamous cell carcinoma in-situ.

Materials and Method: The pathology records of a large, suburban dermatology practice were reviewed between August 2018 and August 2022. Each pathologic diagnosis of pigmented squamous cell carcinoma in-situ was made independently by the same dermatopathologist. Photographs of each lesion were independently reviewed by two board-certified dermatologists for the presence or absence of serpiginous pigmentation. If the two reviewers disagreed about the presence or absence of serpiginous pigmentation, a third board-certified dermatologist reviewed the case photos in order to fully classify the lesion. The primary endpoint was presence or absence of serpiginous pigmentation. The lesions were further stratified into categories based on their anatomic location and predominant morphologic appearance. A secondary analysis was performed to compare the practice outcomes of a dermatologist actively evaluating for serpiginous pigmentation (Author 1) with the remaining 8 providers at the same dermatology practice at baseline. Secondary endpoints included numbers of diagnoses of pigmented squamous cell carcinoma in-situ made, and the diagnostic accuracy. Diagnostic accuracy was assessed by the presence of pigmented squamous cell carcinoma in-situ or pigmented actinic keratosis within the differential diagnosis submitted to pathology.

Results: 117 cases of pigmented squamous cell carcinoma in-situ were identified during the review period. 7 lesions were excluded from the study due to the lack of a photograph. 90% (99/110) of the lesions reviewed were positive for the presence of serpiginous pigmentation. When stratified by anatomic location, lesions appearing on the head and neck (32/38, 84.2%), trunk (27/29, 93.1%) and extremities (40/43, 93.0%) had the presence of serpiginous pigmentation. When stratified by predominant morphologic appearance, lesions appearing as predominantly hyperpigmented (60/63, 95.2%), predominantly erythematous (36/43, 83.7%) and predominantly hyperkeratotic (3/4, 75.0%) had the presence of serpiginous pigmentation. Secondary analysis concluded that Author 1 diagnosed 48.2% of the pigmented squamous cell carcinoma in-situs (53/110) with a diagnostic accuracy of 56.5% (30/53) when evaluating for serpiginous pigmentation. The remaining 8 providers within the dermatology practice diagnosed 51.8% of the pigmented squamous cell carcinoma in-situs with a diagnostic accuracy of 17.5% (10/57).

Discussion: Serpiginous pigmentation, as manifested clinically by wavy, snake-like or undulating pigmentation within the lesion appears to be a highly associated with pigmented squamous cell carcinoma in-situ. Clinically, pigmented squamous cell carcinoma in-situ starts as small macules or papules that slowly enlarge to patches or plaques, frequently with serpiginous pigmentation. Dermoscopy may also assist in the discovery and evaluation of serpiginous pigmentation within suspicious lesions. The serpiginous pigmentation in pigmented squamous cell carcinoma in-situ lacks a melanocytic pigment pattern on dermoscopy. Other dermoscopic features associated with pigmented squamous cell carcinoma such as linear brown dots and structureless zones may also be present. Histologically, pigmented squamous cell carcinoma in-situ shows full thickness atypia of the epidermal keratinocytes.

Pigmented squamous cell carcinoma in-situ may be a more common malignancy than what is suggested by the preponderance of the medical literature. Given the tendency of this malignancy to manifest with features of benign lesions, they may go unnoticed until larger in size. Our secondary analysis showed that the dermatology providers who were not actively assessing for serpiginous pigmentation diagnosed pigmented squamous cell carcinoma with very low accuracy. The real-world implications of evaluating for serpiginous pigmentation were shown by Author 1 who found a significantly greater percentage of the pigmented squamous cell carcinoma in-situs within the practice, with improved diagnostic accuracy (56.5% vs. 17.5%).

The rationale for including pigmented actinic keratosis for the purposes of the diagnostic accuracy assessment is two-fold. There is significant clinical overlap between pigmented actinic keratosis and pigmented squamous cell carcinoma in-situ both clinically and histologically. In addition, our electronic medical record did not include pigmented squamous cell carcinoma in-situ as a diagnosis for a significant portion of the study period. Of note, the most commonly included incorrect differential diagnoses were seborrheic keratosis, lentigo, dysplastic nevus and lentigo maligna. In addition, although the dermatology literature often cites pigmented squamous cell carcinoma in-situ as a malignancy more commonly seen in pigmented skin, our study shows that this malignancy is also common in our patient population, which is predominantly Caucasian.

Limitations: This was a retrospective study. In addition, as mentioned above, the patient population was predominantly Caucasian, and may not extrapolate exactly to a more diverse population.

Conclusions: Serpiginous pigmentation appears to be an important clinical diagnostic feature of pigmented squamous cell carcinoma in-situ. This sign is present in a high percentage of these malignancies regardless of anatomic location and predominant morphologic appearance. Understanding this utility and carefully evaluating lesions with serpiginous pigmentation may allow dermatology providers to find more pigmented squamous cell carcinoma in-situs with a much higher rate of diagnostic accuracy.

Primary Endpoints

Site	Positive	Negative	Percentage
Trunk	27	2	93.10%
Extremities	40	3	93.00%
Head/Neck	32	6	84.20%
Total	99	11	90.00%

Morphology	Positive	Negative	Percentage
Hyperpigmented	60	3	95.23%
Erythematous	36	7	83.72%
Hyperkeratotic	3	1	75.00%
Total	99	11	90.00%

Secondary Analysis

Observer	pSCCIS Diagnosed	DDX+	DDX-	Diagnostic Accuracy
Author 1	53	30	23	56.60%
All Other Providers	57	10	47	17.50%

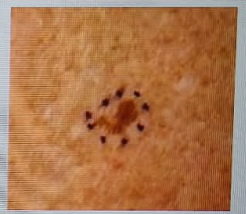
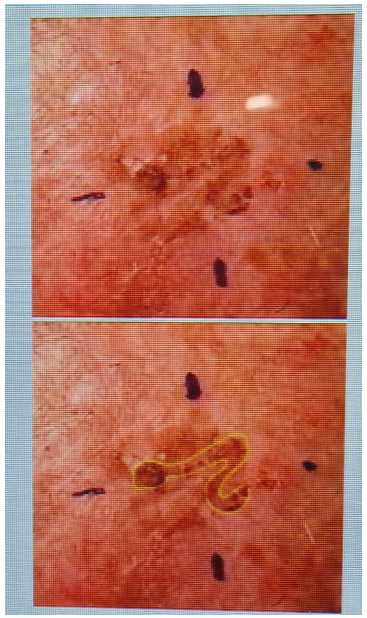
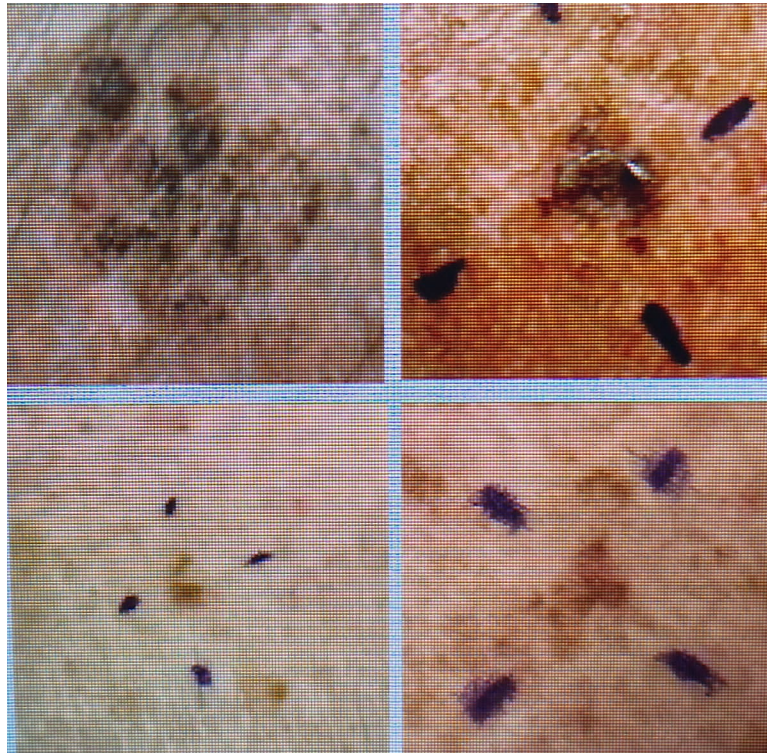


Figure 7: Serpiginous Pigmentation completely encompassing a predominantly hyperpigmented variant of pigmented SCCIS.

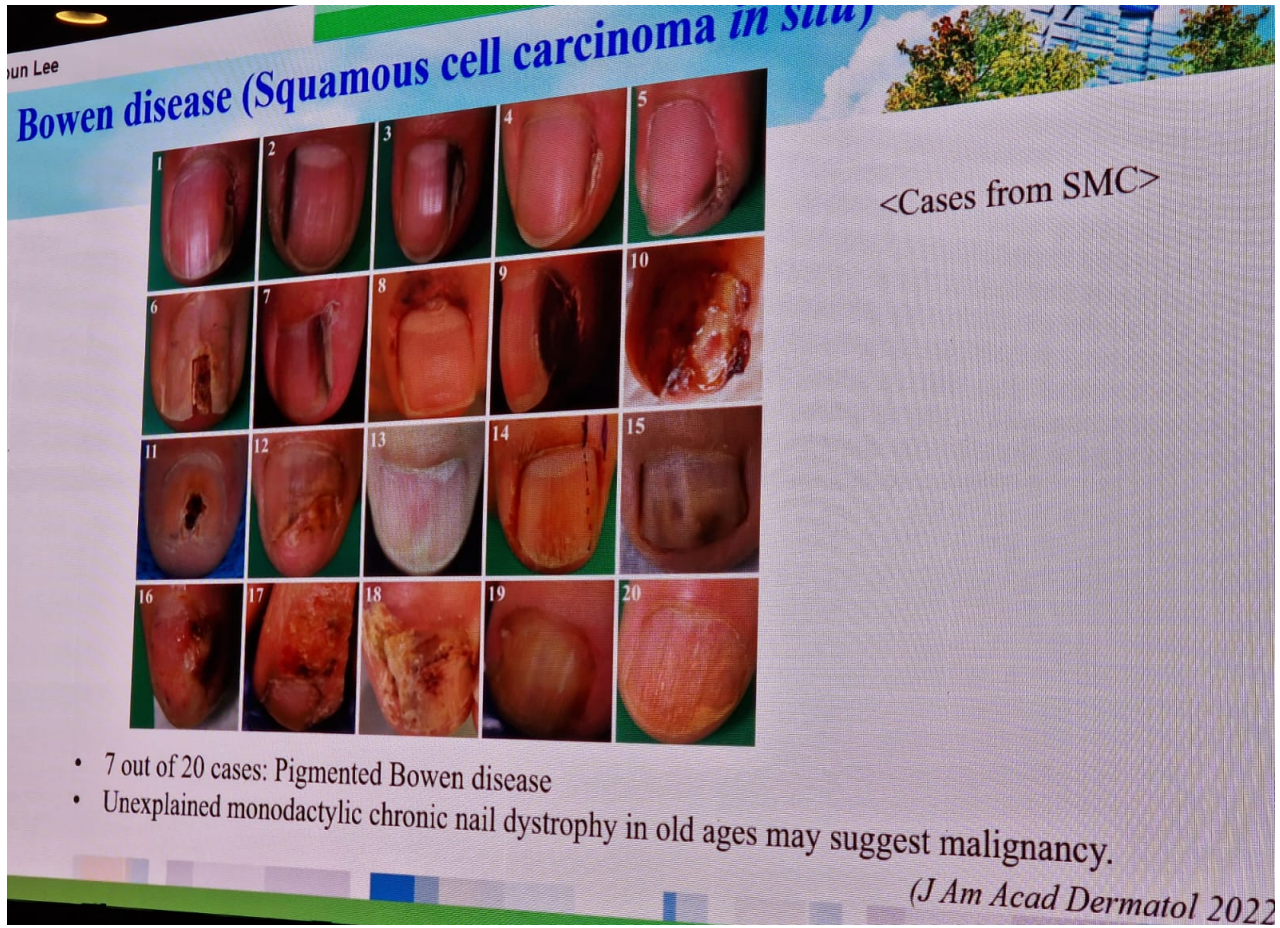
References:

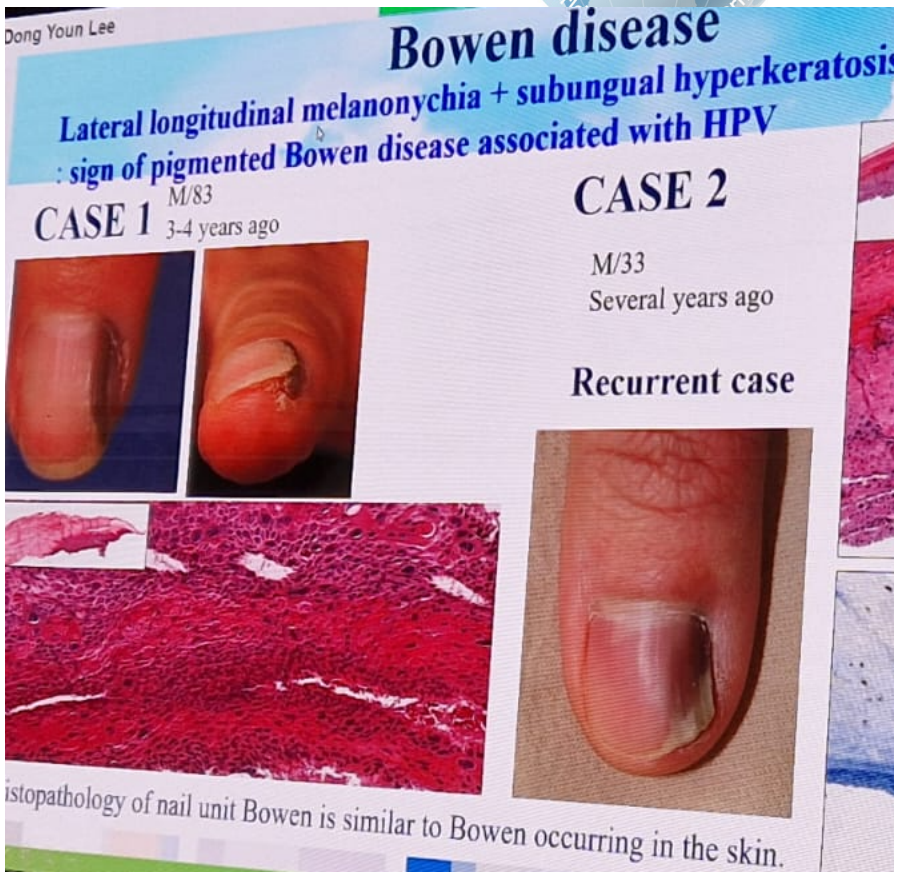
1. Chung, E., Marchetti, M. A., Pulitzer, M. P., & Marghoob, A. A. (2015). Streaks in pigmented squamous cell carcinoma in situ. *Journal of the American Academy of Dermatology, 72*(1), S84-S85.
2. Krishnan, R., Lewis, A., Orengo, I. F., & Rosen, T. (2001). Pigmented Bowen's disease (squamous cell carcinoma in situ): a mimic of malignant melanoma. *Dermatologic Surgery, 27*(7), 673-674.
3. Zalaudek, I., & Argenziano, G. (2015). Dermoscopy of actinic keratosis, intraepidermal carcinoma and squamous cell carcinoma. In *Actinic Keratosis* (Vol. 48, pp. 70-76). Karger Publishers.
4. Woo, T., Naert, K., & Chia, J. C. (2022). Pigmented squamous cell carcinoma in situ with amyloid deposition mimicking melanoma. *JAAD Case Reports, 27*, 137-139.





Pigmentación serpiginosa en CE in situ
127 pacientes
Se ve en el 90%





20 pacientes con enfermedad de Bowen periunguel. 7 con “melanoniquia”

Comparison of full-thickness skin graft & punch grafting in reconstruction of plantar defects

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Background

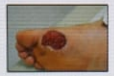
Acral lentiginous melanoma
- Most common melanoma subtype in Koreans
- Weight-bearing areas : known to be predominant sites
- Postsurgical defects in these areas cause significant distress to patients
- NO CONSENSUS on the best method for reconstruction

Potential methods for reconstruction?
- Free flap, medial plantar artery perforator flap
- Split-thickness skin graft (STSG), Full-thickness skin graft (FTSG)
- Secondary intention healing with or without negative pressure wound therapy (NPWT)
- Punch grafting with NPWT
- In our experience, NPWT + FTSG and NPWT + punch grafting yielded best scar results, both cosmetically and functionally

✓ NPWT
- Used to manage diabetic ulcers
- Occlusive dressing with absorbing layer
- Negative pressure with a portable pump

✓ FTSG
- Full thickness of epidermis and dermis
- From lower abdomen

✓ Punch grafting
- 3 mm sized punch
- Epidermis + superficial dermis
- From insole



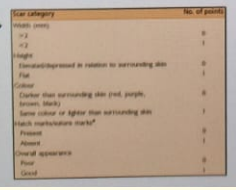
Objective

To compare outcome of FTSG and punch grafting in patients with plantar defects after surgery for acral melanoma

Materials and Methods

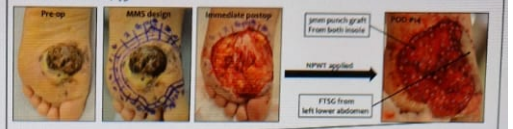
I. Materials
- ✓Electronic medical records and clinical photographs of two patients who underwent surgical excision for melanoma on the plantar area
- ✓Two patients both underwent FTSG for the non-weight-bearing defect and punch grafting for the weight-bearing defect

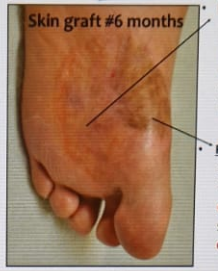
II. Methods
- ✓Retrospective review
- ✓Compared scar outcome at postoperative 6 months, according to the Stony Brook Scar Evaluation Scale (SBSES)
- ✓SBSES : developed to measure cosmetic outcome of wounds, yielding a score ranging from 0 (worst) to 5 (best)



Results & Discussion

✓ Patient #1 : F/45





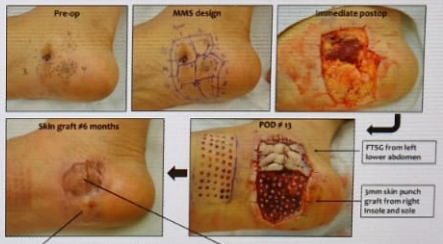
Punch grafting scar
- Scar width < 2 mm
- Height : flat
- Color : same
- Suture marks : absent
- Overall appearance: good

5

FTSG scar
- Scar width < 2 mm
- Height : flat
- Color : darker
- Suture marks : absent
- Overall appearance : poor

3

✓ Patient #2 : F/68



Punch grafting scar
- Scar width < 2 mm
- Height : flat
- Color : same
- Suture marks : absent
- Overall appearance: good

5

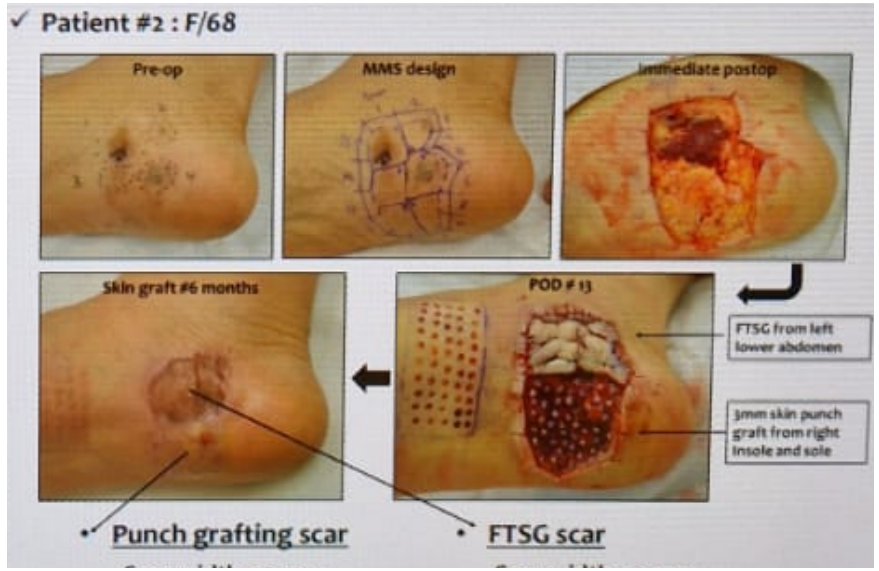
FTSG scar
- Scar width < 2 mm
- Height : depressed
- Color : darker
- Suture marks : present
- Overall appearance : poor

1

- ✓Punch grafting scar scored a 5 (best) in both patients
- ✓Punch grafting scars : flat, of the same color as surrounding skin, had overall pleasing appearances
- ✓FTSG scar scored a 3 and 1, respectively
- ✓FTSG scars tended to be darker and different from surrounding skin

Conclusion

Punch grafting is more suitable for reconstruction of plantar defects, especially in weight-bearing areas.



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HIGHLIGHTS

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