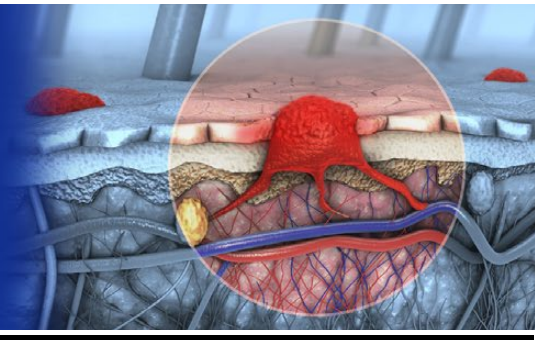
Melanoma Practice Review™



Making Education Easy

Issue 10 - 2022

In this issue:

Abbreviations used in this issue:

TGA = Therapeutic Goods Administration
MBS = Medical Benefits Schedule

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Welcome to the 10th issue of Melanoma Practice Review.

This Review covers news and issues relevant to clinical practice in melanoma. It will bring you the latest updates, both locally and from around the globe, in relation to topics such as new and updated treatment guidelines, changes to medicines reimbursement and licensing, educational, professional body news and more. And finally, on the back cover you will find our COVID-19 resources, and a summary of upcoming local and international educational opportunities including workshops, webinars, and conferences.

We hope you enjoy this new Research Review publication and look forward to hearing your comments and feedback.

Kind Regards,

Dr Janette Tenne

Editor

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Clinical Practice

Early detection of skin cancer in Australia – current approaches and new opportunities

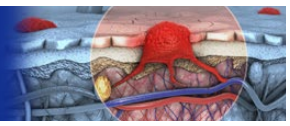
In this narrative review, the authors evaluate evidence related to current approaches and new opportunities for early detection of melanoma and other skin cancers. With population-based melanoma screening currently not recommended, early detection of melanoma is undertaken opportunistically. Concerns about this unstructured approach to skin cancer early detection include variable quality of care, sociodemographic inequalities in access to care and health outcomes, excision of many benign lesions, overdiagnosis, workforce training inadequacies, and healthcare system inefficiencies. However, interest in melanoma screening in Australia has been revitalised by a changing landscape of skin cancer early detection that includes increasing healthcare system costs for adjuvant therapies, advances in diagnostic technologies and artificial intelligence, the availability of validated risk-stratification tools, and consumer-driven digital technologies. The future of skin cancer early detection in Australia may incorporate a more structured approach to skin cancer risk assessment through the use of online risk calculators and invitations to screen, consumer-driven melanoma surveillance, and new technologies for diagnosis and monitoring of lesions.

Public Health Res Pract. 2022;32(1):3212204

Appraisal of international guidelines for cutaneous melanoma management using the AGREE II assessment tool

Advances in melanoma treatments are not necessarily reflected in current guidance. Recently, an expert panel in the UK called for updates to the well received 2015 National Institute for Health and Care Excellence (NICE) guideline for melanoma (NG14). The quality of guidelines can be assessed according to the Appraisal of Guidelines for Research and Evaluation II (AGREE II) assessment tool, a widely accepted and validated instrument for guideline quality appraisal. These researchers systematically appraised the quality of melanoma guidelines developed since the NG14 was published and compared these more recent alternatives to NG14, using the AGREE II criteria. From a total of 3,670 articles identified by the search strategy, 29 guidelines were included in the analysis. There was good concordance on determining which guidelines were of comparatively superior quality (Kendall's W for overall guideline score 0.88, $p<0.001$). Melanoma guidelines scored highly in the domains of 'scope and purpose' and 'clarity of presentation' but poorly in terms of the 'applicability' domain. NG14 achieved the best overall scores, mainly because it included additional elements such as patient and public involvement in guideline creation, external review of recommendations, auditing criteria, and support for guideline implementation. The researchers concluded that, even with melanoma treatment having advanced since NG14 was published, the NICE melanoma guideline is of higher quality than more recent alternatives. Updates to NG14 are planned for 2022.

JPRAS Open. 2021;31:114–122



Clinical models to define response and survival with anti-PD-1 antibodies alone or combined with ipilimumab in metastatic melanoma

Although immune checkpoint inhibitors, anti-programmed cell death protein 1 (anti–PD-1) alone or in combination with anticytotoxic T-cell lymphocyte-4 (ipilimumab [IPI]; anti–PD-1 + IPI), have advanced the treatment of advanced melanoma, most patients eventually progress and half still die of melanoma. Robust biomarkers of response to and survival with immune checkpoint inhibitors in advanced melanoma are needed. On the basis of an integrative analysis of a wide array of baseline pre-treatment clinicopathologic factors derived from 1,644 patients with metastatic melanoma treated with anti-PD-1 ± IPI at 16 centres from Australia, the US, and Europe, these researchers developed validated multivariable models of response, progression-free survival, and overall survival to anti–PD-1 monotherapy and combination anti–PD-1 + IPI, and their respective nomograms. The practical relevance of these nomograms is that they accurately forecast clinical outcome from checkpoint inhibitor immunotherapy in metastatic melanoma and can be used in discussions with patients about prognosis and may help to inform the decision of whether to treat with anti–PD-1 monotherapy or anti–PD-1 combined with IPI.

J Clin Oncol. 2022;40(10):1068–1080

Perception of information to Swedish melanoma patients in routine clinical practice - a cross-sectional survey

This cross-sectional study was conducted to determine how Swedish melanoma patients perceive information provided in routine clinical practice and investigate the correlation between satisfaction with information, symptoms and functioning scales, and quality of life. European Organization for Research and Treatment of Cancer Quality of Life Questionnaire Core 30 version (EORTC QLQ-C30), EORTC QLQ Information Module 25 (EORTC QLQ-INFO25), and esEuroQoL 5-dimension 3-Level (EQ-5D-3L) questionnaires were sent to 1,213 patients by post. A total of 792 patients responded, giving a response rate of 65.3%. Only 0.5% of patients reported that they wanted to receive less information. The quantity of information received and the satisfaction with that information was age-dependent: older patients reported receiving less information than younger patients; and middle-aged patients were more satisfied with the information received than were younger and older patients. Men and women expressed similar satisfaction with information received. The perception of having received sufficient information correlated negatively with anxiety or depression. Higher satisfaction with the information correlated positively with scores for functioning scales and negatively with degree of symptoms. No difference in information levels perceived based on disease stage were detected apart from the 'information about other services' scale for which patients with more severe disease reported receiving more information

BMC Cancer. 2022;22(1):159

European consensus-based interdisciplinary guideline for melanoma. Part 2: treatment – update 2022

Multidisciplinary experts from the European Dermatology Forum (EDF), the European Association of Dermato-Oncology (EADO), and the European Organization of Research and Treatment of Cancer (EORTC) collaborated to formulate recommendations on cutaneous melanoma diagnosis and treatment, based on systematic literature reviews and the experts' clinical experience. The guideline covers surgical therapy, radiotherapy, adjuvant therapy, neoadjuvant therapy, and systemic therapy for metastatic disease. Surgical recommendations include cutaneous melanomas excised with 1 cm (≤2 mm tumour thickness) or 2 cm (>2 mm tumour thickness) safety margins and sentinel lymph node dissection performed as a staging procedure in patients with tumour thickness ≥1.0 mm or ≥0.8 mm with additional histological risk factors. Radiotherapy of the primary tumour is rarely indicated; however, radiotherapy can be applied with curative intent in elderly or frail patients or where the surgical procedure will result in severe disfigurement. In patients with stage III/IV melanoma, therapeutic decisions should be made by an interdisciplinary oncology team. Adjuvant therapies can be proposed in stage III/completely resected stage IV patients, primarily programmed cell death protein 1 (PD-1) antibodies, independent of mutational status, or alternatively dabrafenib plus trametinib for BRAF mutant patients. Systemic treatment is always indicated for patients with distant metastases (stage IV), whether resected or not. For first-line treatment, particularly in BRAF wild-type patients, immunotherapy with PD-1 antibodies alone or in combination with cytotoxic T-lymphocyte-associated protein 4 (CTLA-4) antibodies should be considered. In stage IV melanoma with a BRAF-V600 E/K mutation, first-line therapy with BRAF/MEK inhibitors is an alternative to immunotherapy. This therapy should be offered as second-line therapy in patients with primary resistance to immunotherapy and harbouring a BRAF-V600 E/K mutation. Given that systemic therapy in stage III/IV melanoma is a rapidly evolving field, it is likely that these recommendations may change in the near future. Levels of evidence were graded according to the Oxford classification and recommendations were based on the level of best quality available evidence.

Eur J Cancer. 2022;170:256–284

Skin cancer education interventions for primary care providers: a scoping review

Primary care physicians (PCPs) are often the first line of defence against patient mortality due to skin conditions. However, most PCPs do not receive comprehensive training in skin conditions, which may lead to reduced diagnostic accuracy compared with dermatologists, unnecessary procedures, or inappropriate specialist referrals. This scoping review was undertaken to assess data on previously reported skin cancer screening interventions for PCPs. A structured literature search identified 523 unique records, of which 51 studies, describing 37 unique educational programmes, were included in the review. Melanoma diagnosis instruction featured in all 37 programmes but only 23 (67%) addressed non-melanoma skin cancer diagnosis. Additional instruction included epidemiology in 21 programmes (57%), management in 24 (65%), and counselling in 12 (32%). Fourteen (38%) of the programmes included dermoscopy instruction and 19 (51%) described instruction of a clinical or dermoscopic algorithm in their training programme. The programmes varied widely in format, including literature-based interventions, live teaching sessions, and online courses with durations ranging from 5 min to 24 months. Although several interventions demonstrated improvements in PCP skin cancer knowledge and competency by written exams, only a few demonstrated positive clinical practice changes by biopsy review or referral analysis. In summary, the review highlights the variety of skin cancer educational initiatives available for PCPs but difficulties in translating gains in knowledge into practice change were also evident.

J Gen Intern Med. 2022;37(9):2267–2279

Association between melanoma detected during routine skin checks and mortality

Against a backdrop of a lack of evidence that melanoma screening, such as having routine skin checks, reduces mortality, these investigators assessed melanoma-specific and all-cause mortality associated with melanomas detected via routine skin checks, incidentally or patient detected. This prospective, population-based, cohort study included patients in New South Wales, Australia, who were diagnosed with melanoma over 1 year in the Melanoma Patterns of Care Study and followed-up for a mean duration of 11.9 years, via use of linked mortality and cancer registry data. Of the 2,452 patients included in the analyses, 858 patients (35%) had their melanoma detected during a routine skin check, 1,148 (47%) self-detected their melanoma, 293 (12%) had their melanoma discovered incidentally when checking another skin lesion, and 153 (6%) reported 'other' presentation. Routine skin-check detection of invasive melanomas was associated with 59% lower melanoma-specific mortality ($p<0.001$) and 36% lower all-cause mortality ($p<0.001$), adjusted for age and sex, compared with patient-detected melanomas. After adjusting for prognostic factors including ulceration and mitotic rate, melanomas diagnosed through routine skin checks were associated with significantly lower all-cause mortality ($p=0.006$) but not melanoma-specific mortality ($p=0.13$). Factors associated with higher odds of routine skin-check melanoma detection included being male (vs female, $p=0.003$), having previous melanoma (vs none, $p<0.001$), having many moles (vs not, $p=0.02$), age ≥50 years (e.g., 50–59 years vs <40 years, $p<0.001$), and living in non-remote areas (e.g., remote or very remote vs major cities, $p=0.003$).

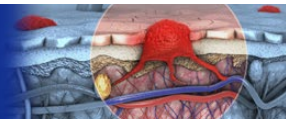
JAMA Dermatol. 2021;157(12):1425–1436

Regulatory News

TGA – Australian prescription medicine decision summary

Tebentafusp (Kimmtrak) has been approved for the treatment of HLA-A*02:01-positive adult patients with unresectable or metastatic uveal melanoma.

Read more here



News in Brief

Consumer preference and willingness to pay for direct-to-consumer mobile teledermoscopy services in Australia

Australian consumers are willing to pay out of pocket to access mobile teledermatology services that incorporate attributes such as a dermatologist review, improved accuracy, and fewer excisions. Consumers who were taking part in a randomised controlled trial comparing mobile teledermoscopy with skin self-examination were asked to complete a survey to determine their willingness to pay for mobile teledermoscopy services in Australia and their overall service preferences. A total of 199 consumers completed the survey and the results showed that consumers would prefer a trained medical professional to be involved in their skin cancer screening. They were willing to pay $AUD 41 to change from a general practitioner reviewing their lesions in-person to having a dermatologist review teledermoscopy images. In addition, the consumers were willing to pay for services that had shorter waiting times, that reduced the time away from their usual activities, and that have higher accuracy and lower likelihood of unnecessary excision of a skin lesion.

Dermatology. 2022;238(2):358–367

Durable response to vemurafenib and cobimetinib for the treatment of BRAF-mutated metastatic melanoma in routine clinical practice

In this small, retrospective, observational, multicentre study, combination treatment with vemurafenib/cobimetinib was found to have an important impact on long-term survival in real-world settings, leading to a steady complete response in one-third of the patients. In terms of differential characteristics in patients associated with durable responses, body mass index (BMI) was the only differential factor (with higher BMI associated with a non-durable response). All patients with durable response adhered to treatment compared with two-thirds of those with non-durable responses.

Onco Targets Ther. 2021;14:5345–5352

BRAF mutation testing for patients diagnosed with stage III or stage IV melanoma: practical guidance for the Australian setting

With targeted therapy (BRAF inhibitor plus MEK inhibitor) being one of the treatments available for patients with BRAF mutation-positive stage III or stage IV melanoma, prompt BRAF mutation testing is important to help ensure that the optimal choice of systemic treatment is initiated with minimal delay in patients diagnosed with stage III or IV melanoma. These authors offer guidance on when and how BRAF mutation testing should be conducted when patients are diagnosed with melanoma in Australia. Notably, they recommend that DNA-based BRAF mutation testing always be performed if available and practicable, and regardless of whether immunohistochemistry-based testing is also conducted.

Pathology. 2022;54(1):6–19

Melanoma: how and when to consider clinical diagnostic technologies

Novel non-invasive melanoma detection techniques are emerging to facilitate the early detection of melanoma and avoidance of unnecessary biopsies. However, it is not always clear how best to incorporate these technologies into clinical practice based on their supporting studies alone. This first article in a continuing medical education series provides practical advice on how and when to use various non-invasive melanoma detection techniques in clinical practice.

J Am Acad Dermatol. 2022;86(3):503–512

COVID-19 Resources

The Australasian College of Dermatologists
Clinical Oncology Society of Australia
Cancer Australia
European Academy of Dermatology and Venereology
American Academy of Dermatology
European Society of Medical Oncology
American Society of Clinical Oncology

Conferences, Workshops and CPD

Please click on the links below for upcoming local and international melanoma meetings, workshops and CPD.

The Australasian College of Dermatologists - Events
DermNet New Zealand - Conferences
COSA - Events
MOGA - Events
COMS - Conferences and Meetings on Dermatology

Research Review Publications

Melanoma Research Review
with Professor Michael Henderson and Peter Hersey
https://tinyurl.com/y95oloy7

Skin Cancer Research Review
with Dr David Simpson
https://tinyurl.com/y9v4htzj

Dermatology Research Review
with Dr Warren Weightman and Clinical Assoc Prof Saxon D Smith
https://tinyurl.com/y7b6m4e3

AAD 2022 Conference Review
https://tinyurl.com/mrxna7c6

ACD 2022 Conference Review
https://tinyurl.com/mrxjkfja

Study Review – Using a pyrexia management algorithm in melanoma patients
https://tinyurl.com/y2setv4m

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