Oncology and surgery
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Novel therapies for cutaneous malignancies: What’s new and What’s ahead:
Merkel carcinoma

P. Nghiem

• More lethal than melanoma: 40% more mortality
• Incidence has multiplied x5 since 1986
• Increasing maybe because immunosupression is more frequent
• Management:
  • Surgery and radiotherapy: >95% response but 50% recurrences.
  • In 3-4 cm around the initial tumor
Merkel carcinoma
P. Nghiem

- Polyomavirus is integrated in 80% of tumors
- Those without polyomavirus have many UVR mutations
- Viral oncoprotein antibodies as a marker for recurrences of Merkel cell carcinoma (Cancer 2016)
Serology test for Merkel cell carcinoma

Baseline serology test

Pos
Follow w/serology. Fewer scan

Neg
42% higher risk or recurring. Track closely/scans
Serology test for Merkel carcinoma

- **Serology test**
  - **Decrease (88%)**
    - did not have current disease
    - Repeat in 3 months.
  - **Increase (88%)**
    - have or develop disease
    - Scan Exam
    - Repeat test shortly
Merkel cell carcinoma
Response to therapy

• Chemotherapy: 55% CRR
• Avelumab (Anti-PD-L1) 56% CRR
• Pembrolizumab (anti-PD1): 56% CRR
• Nivolumab (anti-PD1): 79% CRR

• All in first line an nivolumab also in second line therapy
Cutaneous lymphomas
CTCL stage I Guidelines

• Skin directed therapies are more effective than systemic therapies.
• 1st line: topical corticosteroids.
• Other:
  • Topical mechlorethamine 0.02% gel:
    • 76.7% response.
    • Side effects: more frequent local irritation (associated to complete response).
  • Phase I Clinical trial: microneedle array – doxorubicin
CTCL stage I Guidelines

- Topical carmustine 0.04% ointment.
  - 36 months 92% CR (T1) and 64% (T2)
  - Specialy interesting for folliculotropic MF.
  - Side effects telangiectasias.


- Topical retinoids: use rarely
  - Tazaroten: not FDA aproved. More interesting in limited lesions of folicular MF with alopecia.
CTCL stage I Guidelines

- Remetinostat 1% (histone deacetylase inhibitor) topical (twice/d) improves pruritus but modest results.
- Resiquimod (agonist Toll like receptors 7 and 8):
  - RR: 75%
  - 4/5 folicular MF improve.
- Imiquimod 5% in limited disease.
  - Post-transplant limited recurrence.
  - HTLV-1 papules.
  - Low grade B cell lymphoma***.
- Calcineurin inhibitors: Useful in face lesions.
- Phototherapy:
  - Patch stage PUVA and UVB-BE equally effective.
  - Plaque stage: PUVA.
  - Re-PUVA is faster than PUVA.
Treatment of advance MF/SS

- **Bexarotene**: long time treatments (300 mg/m2).
  - Overall response 54% early stage.
  - ORR: 45% advanced stage.
- **Vorinostat oral and Romidepsin IV** (inhibidores de histona deacetilasa)
  - Not long time treatment.
  - Side effects: cytopenias, QT prolongation, nausea, weight loss, diarrhea.
- **Brentuximab**: in stages IIB, IIIA, IIIB, IVA better response
  - Side effect: periphery neuropathy
- **Mogalizumab** which is superior
- **Bone marrow transplant**:
  - Very selective for poor prognostic patients.
  - Treatment related mortality in 2 years 10-17%
  - Overall survival 4 years 51%
Brentuximab Vedotin for CD30 expressing CTCL vs physician choice (Methotrexate of bexarotene)

- Brentuximab ORR 56%
- Other treatment: ORR 12.5%
- Skindex-29 also significantly better improvement
- CD30 expression is not correlated with the efficacy of the drug.
- More important side effect neuropathy (67%)
- FDA approval nov 2017

- Example of patient with ulcerative and tumoral lesions with a significant improvement after 9 months of treatment.
Mogamulizumab

- Monoclonal antibody against CCR4:
  - CCR4 is expressed in all stages of MF
    - In MF cells
    - In Treg homing
  - Very effective
  - Mogamulizumab significantly better than vorinostat
- Side effects: infusion reactions and cutaneous eruptions
Thank you for your attention