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Clinical case discussion on non melanoma skin cancers - Part Two

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A case of a rare and highly aggressive primary skin cancer that arises in the eccrine sweat glands treated with immunotherapy combination

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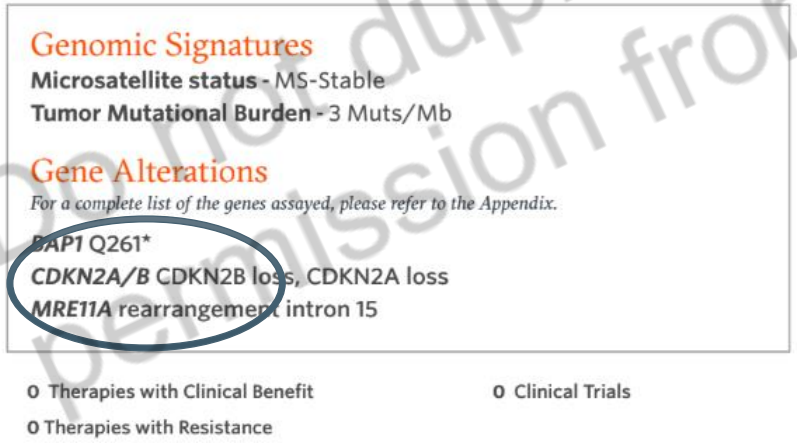
DISCLOSURE SLIDE

No disclosure to declare

MEDICAL HISTORY AND DIAGNOSIS

- 28yo female, ECOG PS 0
- No comorbidities or ongoing treatment
- Born in Romania (Geography does matter in these kind of rare cancer?)
- On 23JUL21, 30JUL21, 10SEP21 and 10OCT21 multiple biopsies revised in IRCCS Pascale -> Hidroadenocarcinoma (skin neoplasm that arises in the eccrine sweat glands), p40+, CK 5/6, EMA+, Mart1 -, S100-, CK7-, CK20-, CD117-, CD5-, Synaptofisina-.
- PET/CT Oct 21: right arm lesion (SUV 20), Xyphoid region (SUV 26.7), right leg (SUV 18.9)
- Foundation One NGS evaluation:


Genomic Signatures

Microsatellite status - MS-Stable

Tumor Mutational Burden - 3 Muts/Mb

Gene Alterations

For a complete list of the genes assayed, please refer to the Appendix.

BAP1 Q261*

CDKN2A/B CDKN2B loss, CDKN2A loss

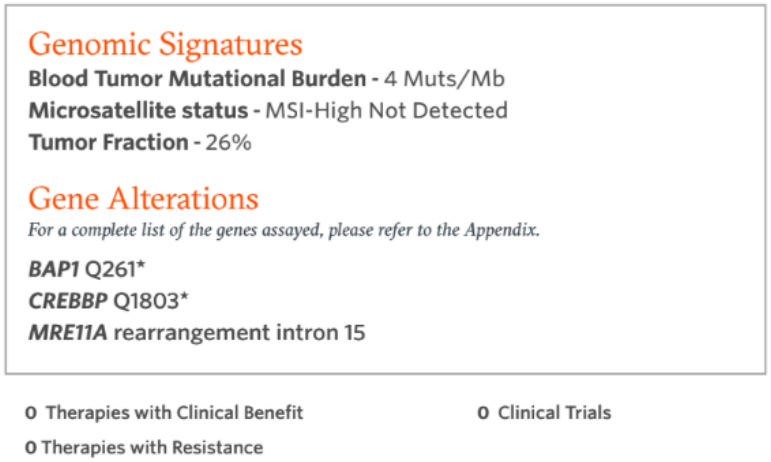
MRE11A rearrangement intron 15

0 Therapies with Clinical Benefit

0 Clinical Trials

0 Therapies with Resistance

NGS Block


Genomic Signatures

Blood Tumor Mutational Burden - 4 Muts/Mb

Microsatellite status - MSI-High Not Detected

Tumor Fraction - 26%

Gene Alterations

For a complete list of the genes assayed, please refer to the Appendix.

BAP1 Q261*

CREBBP Q1803*

MRE11A rearrangement intron 15

0 Therapies with Clinical Benefit

0 Clinical Trials

0 Therapies with Resistance

NGS Liquid

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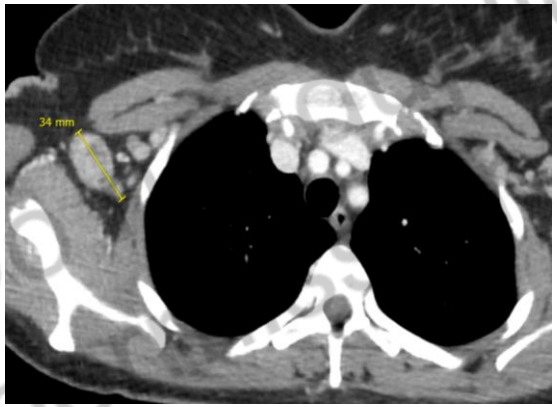
- **A Phase II Basket Trial of Dual Anti-CTLA-4 and Anti-PD-1Blockade in Rare Tumors (DART SWOG 1609) in Patients with Non-Pancreatic Neuroendocrine Tumors (**NCT02834013)
- Korbi S, Rachdi H, El Benna H, Mejri N, et al. **Objective Clinical and Radiological Response under Sunitinib in a Case of Thigh Hidradenocarcinoma**. Case Rep Oncol Med. 2020 Feb 25;2020:9656475.
- Panigrahy D, Kaipainen A, Butterfield CE, et al. **Inhibition of tumor angiogenesis by oral etoposide**. Exp Ther Med. 2010 Sep;1(5):739-746.

SYSTEMIC TREATMENT TIMELINE

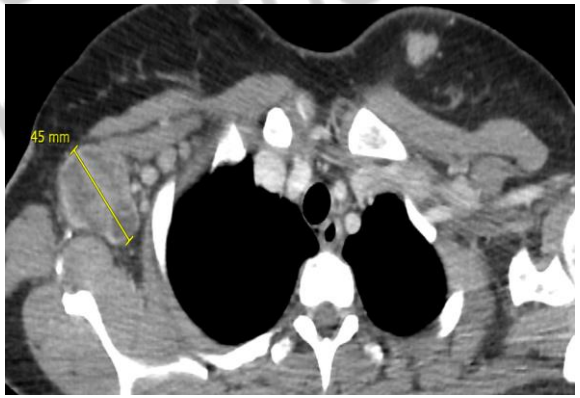
OCT21 - NOV21
I LINE TREATMENT:
CBDCA+PACLITAXEL

DEC21-FEB22
II LINE NIVOLUMAB
240 mg (OFF LABEL)

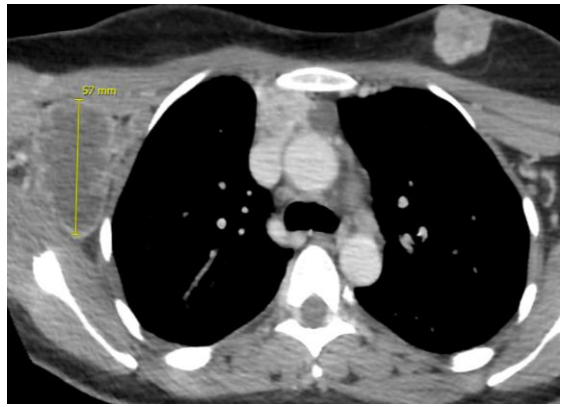
FEB22- AUG22
NIVOLUMAB 240 mg + IPILIMUMAB 1 mg/Kg
(COMPASSIONATE USE)



OCT 2021:
BASAL



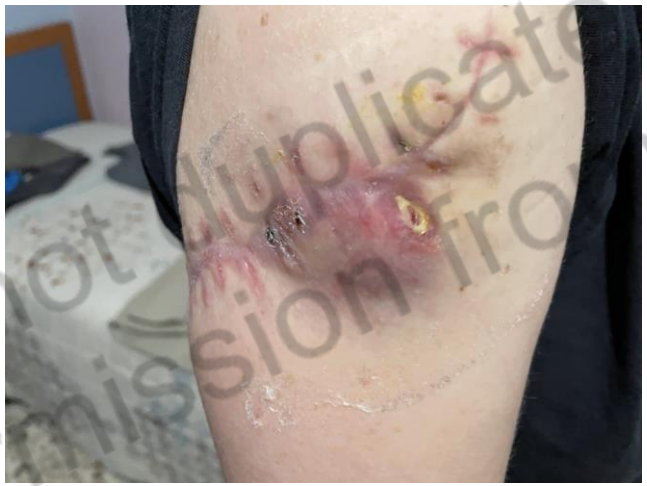
DEC 2021:
FIRST EVALUATION AFTER CT ->PD



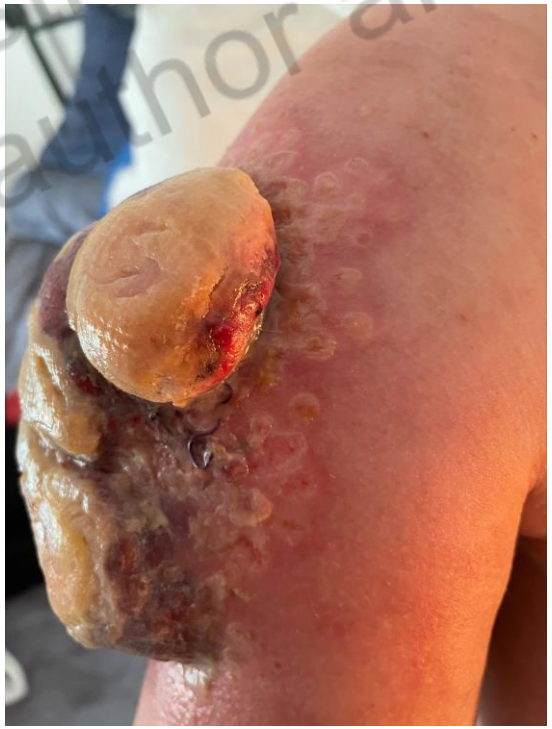
MAR 2022:
EVALUATION DURING IO COMBO
-> BR: SD

LOCOREGIONAL TREATMENT TIMELINE

- NOV 21: Surgical excision of the lesion of right arm for palliative purposes
- FEB 22: RT right arm and right axilla (30 Gy)
- MAR 22: ECT right arm and left mammary region
- JUN 22: RT right leg, inguinal right node and supraclavicular (30 Gy)
- MAY 22: ECT right arm
- JUL 22: ECT Xyphoid region



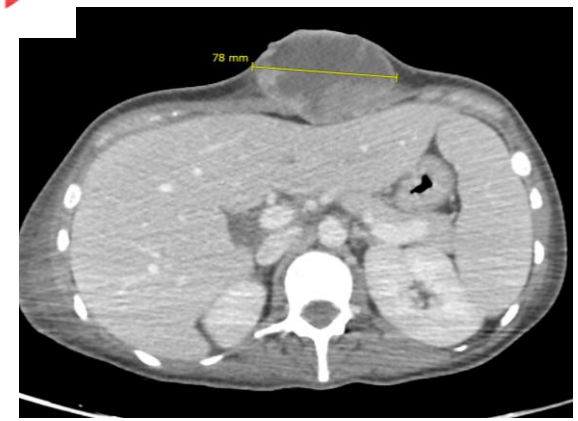
DEC21: scar tissue after surgery

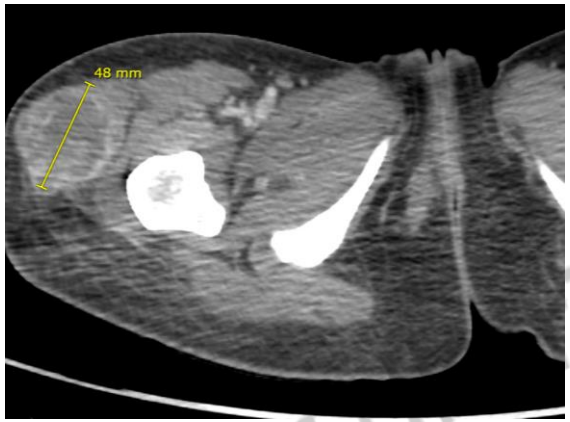


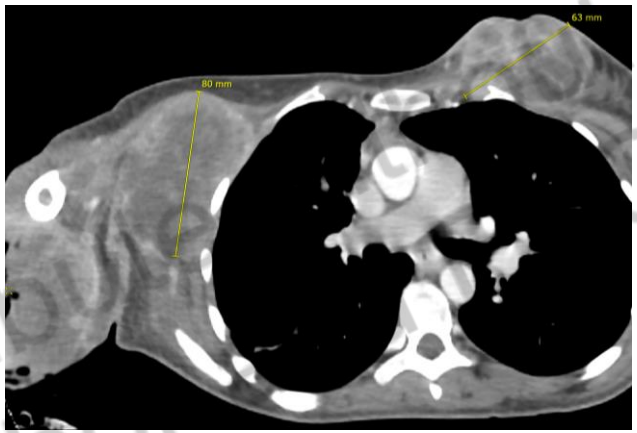
MAR21: right arm relapse

SEPTEMBER 2022 ASSESSMENT

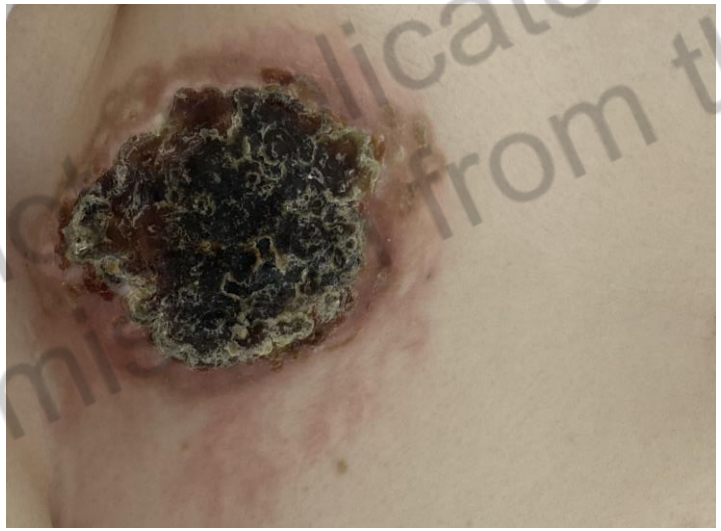
CT SCAN 01 SEP 2022



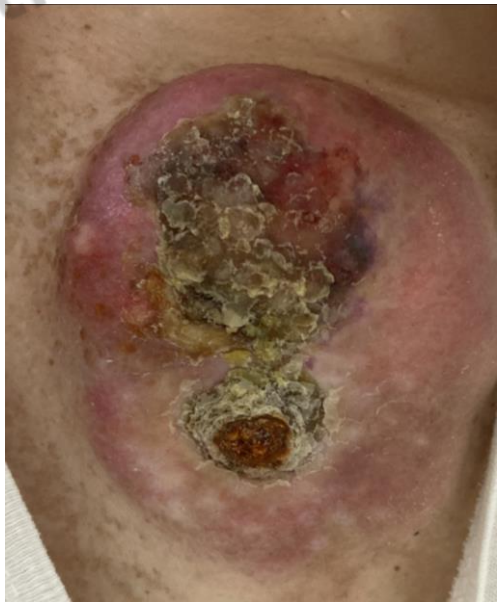




CLINICAL VISIT SEP21



Xyphoid region (8 cm)



Supraclavicular (6 cm)

CLINICAL CONDITION SEPTEMBER 2022

Clinical status:

- ECOG PS 2
- On treatment with morphine 10 mg 7 f/48h

OPTIONS?

- ETOPOSIDE
- anti-angiogenic drugs -> SUNITINIB

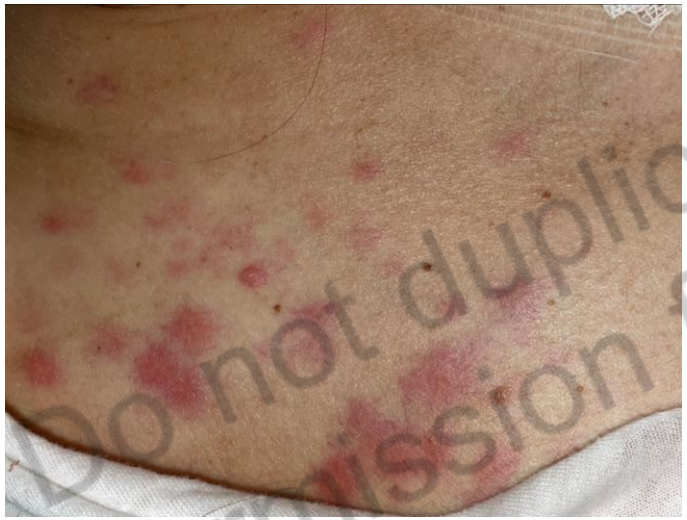
Case report: “Objective Clinical and Radiological Response under Sunitinib in a Case of Thigh Hidradenocarcinoma”

- ADRIAMYCIN
- CAPECITABINE

Our team decided… Etoposide waiting for approval of Sunitinib off label

LATEST UPDATE

- Oct- Nov 22: Oral Etoposide 50 mg/daily g1-g21 q28
  AE: nausea G1
- Nov 22: Oral Sunitinib at 50mg/daily 4w therapy + 2w pause
  AE: oral mucositis G2 and skin rash G1



Unfortunately after 1 cycle of Sunitinib patient died due to disease progression and worsening of clinical conditions.

QUESTIONS

- IO +/- locoregional strategies or IO +/- chemotherapy are valid options for this disease?
- How can we study IO in rare cancer given the difficulty to design large clinical trials? Basket trial may be an opportunity?
- Which therapeutic option is the best in your opinion taking into account the NGS assessment? Would you have repeated NGS at progression?

THANK YOU FOR YOUR ATTENTION!

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ISTITUTO NAZIONALE TUMORI
IRCCS – Fondazione Pascale

A Case of Metastatic Merkel Cell Carcinoma treated with Immunotherapy in Elderly Patient

Topic:(Complex non-melanoma skin cancers)

Dr. MENNA FOUDA *(MD, MSc, SCE Oncology)*

Medical Oncologist

Royal Marsden NHS Trust ,UK

Skin Cancers & Melanoma Unit

History

A 94 year -old male patient

Medical history

- Hypertension
- Transient ischaemic attack 2017
- Subdural haematoma 1990
- Parkinson's (Not diagnosed /not on treatment)

ECOG (1)

Sept 2019: At age of **91 years** ,he presented with rapidly growing lesion in the left lateral forehead

PET scan: No Distant metastases
US neck: No cervical Lymphadenopathy

- Biopsy: Merkle cell carcinoma
- **Recommended Management** was …..Wide excision & staging of neck with SLN followed by neck dissection

- **With age and comorbidities** :The patient had WLE for primary site only (2 cm margin)
- **Histopathology** :

➢ **pT4** Merkle cell carcinoma, left temple 2.3cm x 2.3cm. With invasion of the local muscle underlying, Clear margin but CIS(carcinoma in situ) at the peripheral edge ,LVI +ve

➢ Chromogranin +ve, Synaptophysin +ve,CD56 +ve,CK8/18 +ve,S100 –ve,AE1/AE3 +ve

- 11.09.2019: Surgical resection with a 2cm radial margin and 4mm
- 11.09.2019: Right pinna BCC

Question 1 :
What treatment option should be next?

- A) Radiotherapy
- B) Chemo-radiotherapy
- C) Chemotherapy
- D) Surgery

- Skin MDT: **Post operative Radiotherapy**
- 50Gy in 25# radiotherapy to surgical bed and to preauricular and level 2 lymph nodes, completed 5th December 2019
- Fatigue, but he has tolerated treatment fairly well
- The main radiotherapy reaction around the left eye has settled and the irritation of the left eye has improved in 1 month .
- End of treatment MRI scan (Feb 2019) …shown no definite evidence of disease relapse
- **July 2020 CT scan** :There are a few small sub-centimetric left sided neck nodes.

March 2021

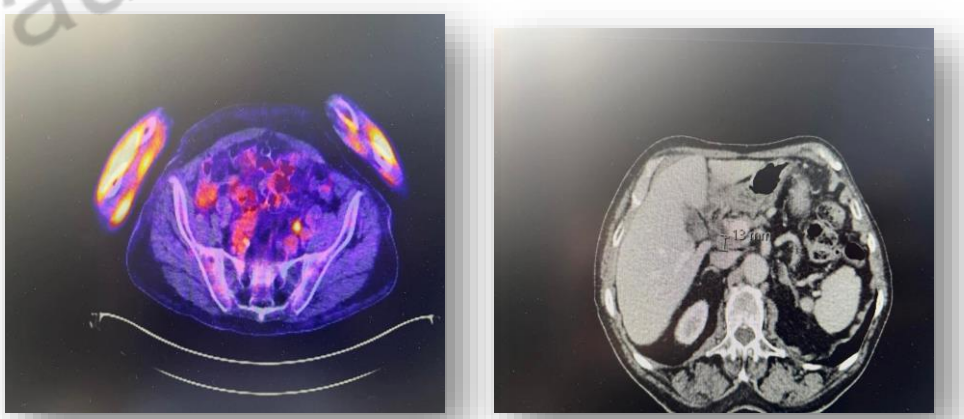
- Concern about a lesion on his right hand & temporal lesion
- 1.5 cm firm nodule at dorsum of his right hand .
- Right hand squamous cell carcinoma excised with clear margins March 2021.
- Right temporal nodular cystic basal cell carcinoma excised with positive margins March 2021.
- On the basis of his co-morbidities and health, we would not offer post-operative radiotherapy to this area.
- Continue to monitor …

March 2021

- CT scan has shown a new 33 mm porto-caval lymph node with necrosis which is highly suggestive of a metastatic process.
- (We will have to assume that this is most likely Merkel cell although the time duration between treatment and the site of relapse is unusual)
- March 2021..PET-CT shows the portocaval node 33mm as solitary site of activity.
- PS (2)
- MDT …Discuss systemic treatment options?

- What could be the next treatment option?

- A) Radiotherapy
- B) Chemo-radiotherapy
- C) Chemotherapy
- D) Surgery



The Skin MDM Outcome

- PET-CT - portocaval LN only site of disease (percutaneous biopsy was very challenging)
- The Skin MDM agreed this to be unlikely related to his recent BCC and SCC diagnosis, concerning for relapsed Merkel Cell carcinoma.

➢Skin MDM April 2021 - Medical oncology review for fitness to decide if systemic therapy suitable. For Single agent **Avelumab**

- The patient could not imagine to have a life long immunotherapy.
- Treatment breaks (ideally the treatment is given every two weeks, but we are allowed to give a break in treatment to allow recovery from side effects for up to 12 weeks)

Cycle 5 Avelumab

- **July 2021 :**CT shows partial response to treatment with reduction in the portocaval node(32….15mm)
- **Nov 2021 CT TAP** shows portacaval node is stable with maintained response to treatment
- **January 2021..** Main issue is poorly-controlled Parkinson disease & worsening resting tremors, Difficulties with his mobility.
- From an avelumab perspective he is well, with no symptoms concerning for immune-related adverse events.
- MRI brain : no metastatic disease
- Referred for neurological review

Neuro review April 2022

- The patient had tremors for at least 3 years, ,Over time his walking has deteriorated, he has started to shuffle and he has some drooling. There has been no change in his speech.
- Features of both essential tremor, and possible underlying a kinetic rigid syndrome also. Started on trial for careldopa , 62.5 mg
- After 2 months, there was no benefit, dose been increased …predominantly a central tremor rather than any underlying akinetic rigid syndrome.
- **June 2022 after C 24…We discontinued Avelumab after 24 cycles**
- As his Merkel cell carcinoma is in remission and a dominant issue is now tremors

Questions

- **Q1 :Would we consider radiotherapy?**
- **Q 2 :After cycle 24 , Shall we continue the treatment?**
- **Q3 :Do you think the patient was overtreated?**

THANK YOU FOR YOUR ATTENTION!

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Management of an advanced squamous-cell carcinoma of the head and neck in elderly patient

Ilhomiddin Niyazov, MD, PhD

National Cancer Research Center Republic of Tajikistan Dept. of Head and Neck Cancers

Avicenna Tajik State Medical University, Dept. of Oncology and Diagnostic Imaging

Mentors: Professor Sanginov J.R.,

Professor Huseynzoda Z.H.

Patient`s history

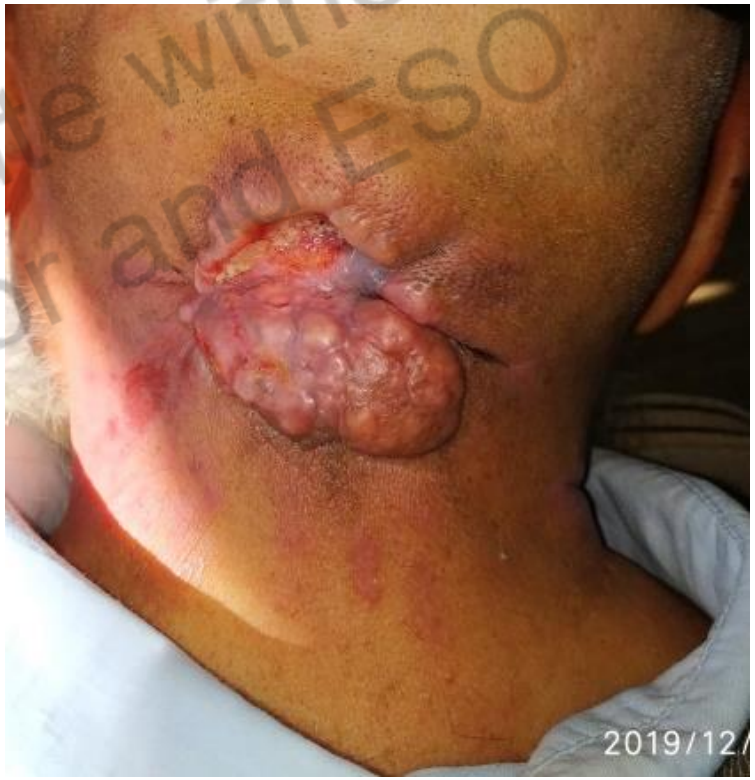
- **Patient S.,** 77 year-old man
- **Comorbidity:** Hypertension grade 2., ECOG - 0
- ***1st admition (May 2012)*** DS: SC carcinoma of skin of borderline of occipital region posterior of the neck T3N0M0

- **Treated:** Radiotherapy 2 Gy per fraction – Total 40 Gys
- **Effect of treatment:** partial tumor regression
- **Follow-up:** Did not come for the further treatment

- ***2nd admition:*** *December 10, 2019*
- **Complains:** tumor of the skin on the occipital region with transition to the posterior of his neck. Pain and bloody discharge from tumor, persistent for several (7) years

Diagnostic work-up

- 6,5x5,0x3,2cm tumor of occipital region and posterior of the neck. Crater-shaped ulcerative surface in the center, with bloody discharge, painful on palpation, fixed with underlying tissues.
- **Neck ultrasound:** Persistent 1,5x1,0 cm enlarged right occipital lymph node
- **Imaging:** Locally-advanced tumor. With no evidence of the spread of tumor.
- **Pathology:** Non-keratinizing SC- Carcinoma, Grade II.
- **Regional LN Status:** Enlarged right occipital 1,5x1,0 cm lymph node.
- **FNAB cytology:** Cells with hyperplasia and nuclei polymorpism. Suggestive for Metastatic? Inflammatory?



- MDTB Diagnosis: Non-keratinizing SCC of skin of posterior of the neck and occipital region T4cN1M0, Stage IV

Queston 1.
What is the best treatment option for this patient?

- Diagnosis: **Non-keratinizing SCC of skin of posterior of the neck and occipital region T4N1M0, Stage IV**

- A) Radiotherapy
- B) ChemoRadiotherapy
- C) Chemotherapy
- D) Surgery

Tumor-Board decision

- A) Radiotherapy
- B) Chemo-Radiation
- C) Chemotherapy
- D) Surgery

Further Treatment - Chemotherapy

- 25 Dec 2019 – 20 Jan 2020
- **ChT regimen:** Cisplatin+5FU – 2 cycles
- **Effect:** Partial response

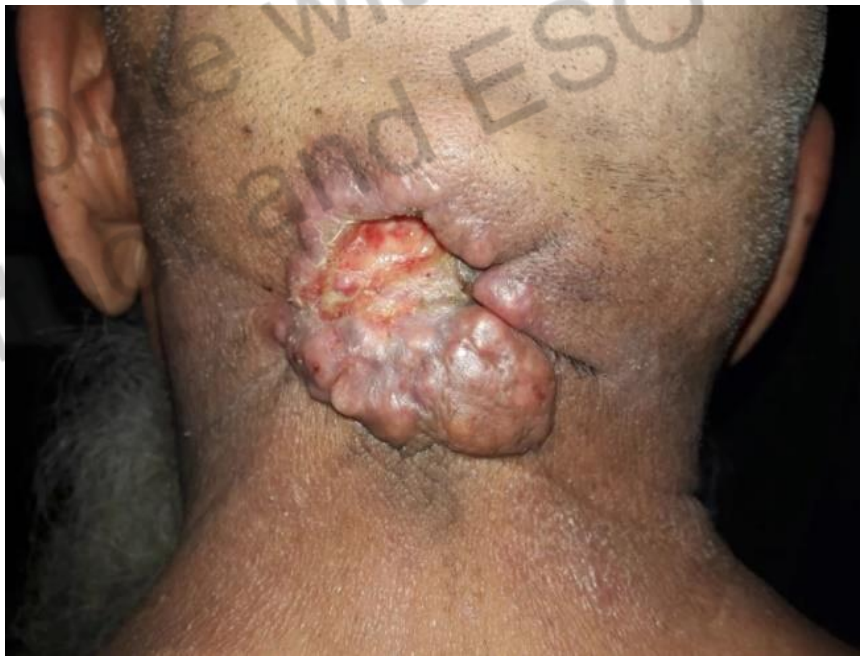


Figure 2. Tumor after 2 cycles of platinum-based chemotherapy.

Question 2.
What treatment option should be next?

- A) Radiotherapy
- B) Chemoradiation
- C) Chemotherapy
- D) Surgery
- E) Other

Decision was made to operate

- A) Radiotherapy
- B) Chemoradiation
- C) Chemotherapy
- D) Surgery
- E) Other

Diagnosis: Non-keratinizing SCC of skin of posterior of the neck and occipital region T4N1M0, Stage IV, condition after radiotherapy (40Gys) and 2 cycles of chemotherapy (Cisplatin+5FU). Partial tumor regression.

Surgery plan

February 27, 2020

- Functional neck dissection on the right. Wide excision of the tumor.
- Reconstruction of the defect with a regional fasciocutaneous pedicle flap from the right suprascapular region.

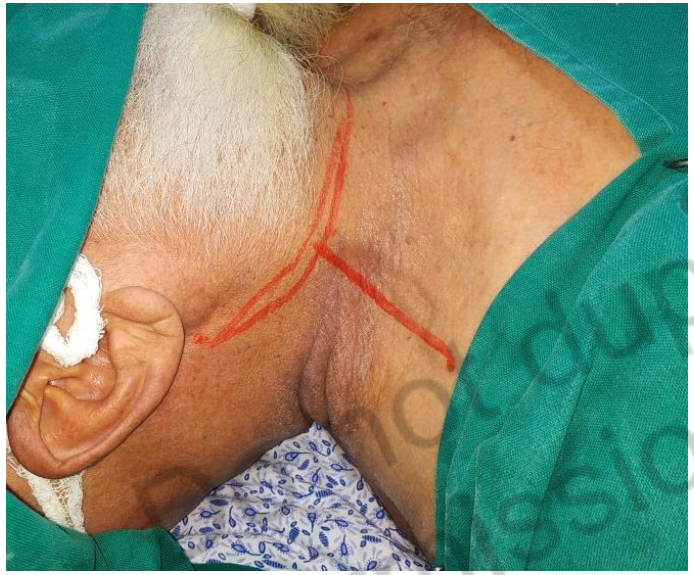


Figure 3. Neck dissection incision line

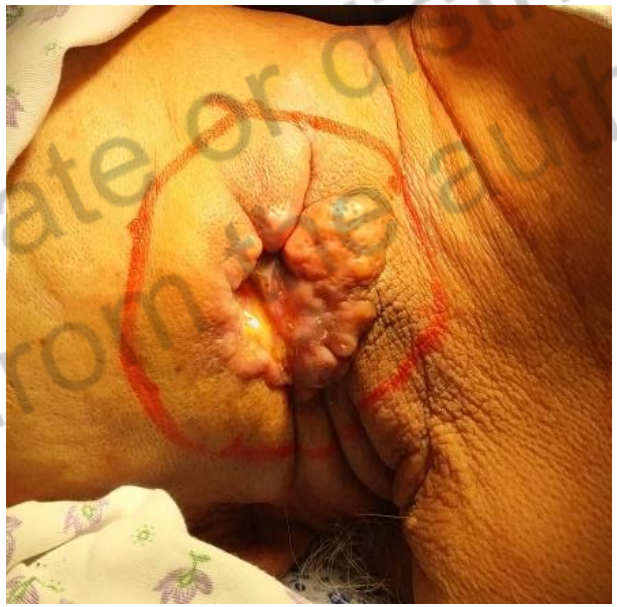


Figure 4. Tumor excision boundaries

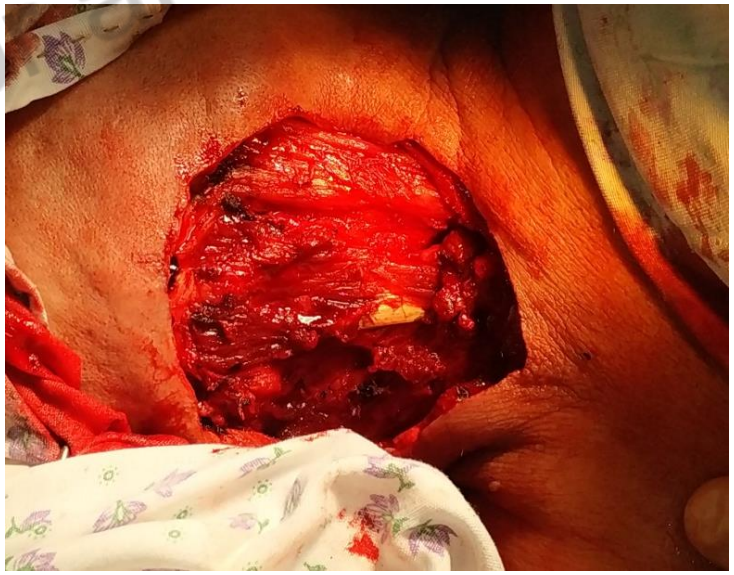


Figure 5. The surgical defect

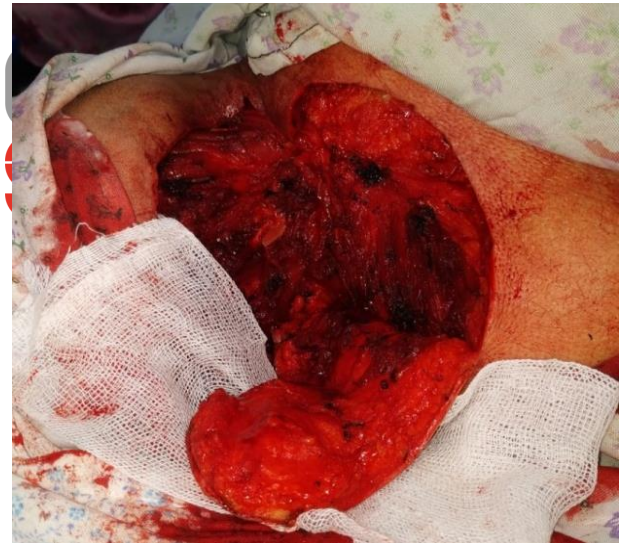
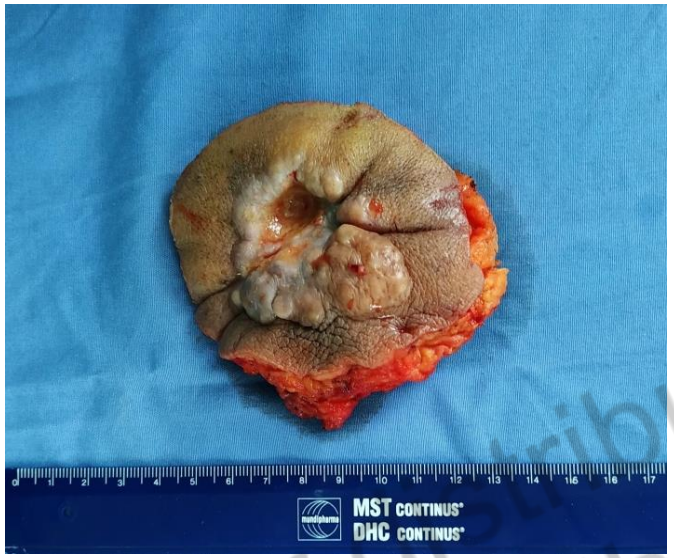
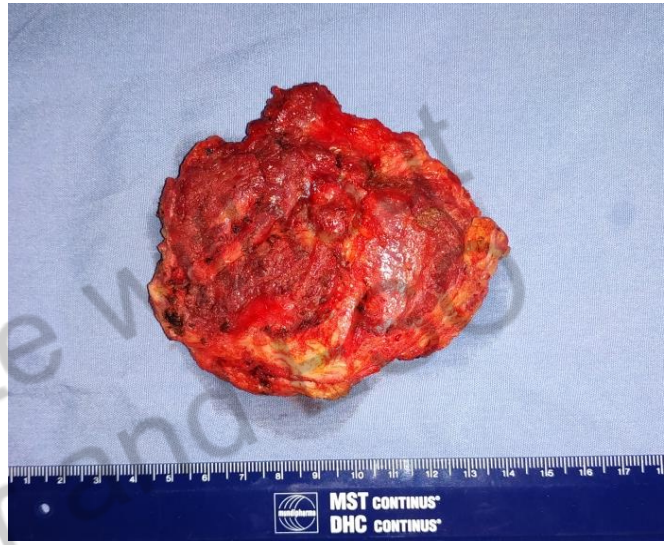


Figure 6. Fasciocutaneous flap raised to close the defect





Figures 8, 9. Surgical specimen - excised tumor with resection of involved muscles.

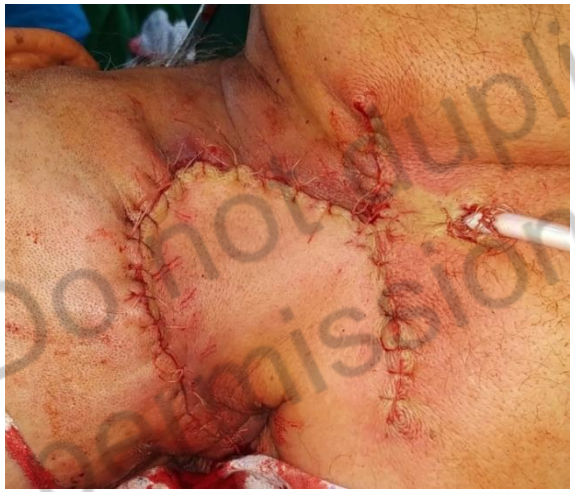


Figure 7. Final view of the surgical wound

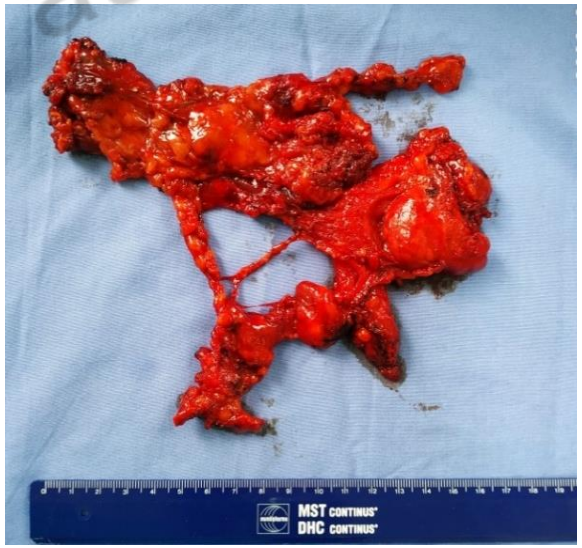


Figure 10. Removed neck tissue with lymph nodes

Treatment Outcome

- The surgical wound and flap healed primarily. No signs of flap necrosis in postoperative period.
- Post-OP Pathology report: **Non-keratinizing Squamous-cell carcinoma, G2. The tumor was removed radically (R0). No cancer cells were found in removed 15 lymph nodes.**
- Discharged on the 10th day postoperative period.
- **Follow-up:** Being monitored by the local oncologist.

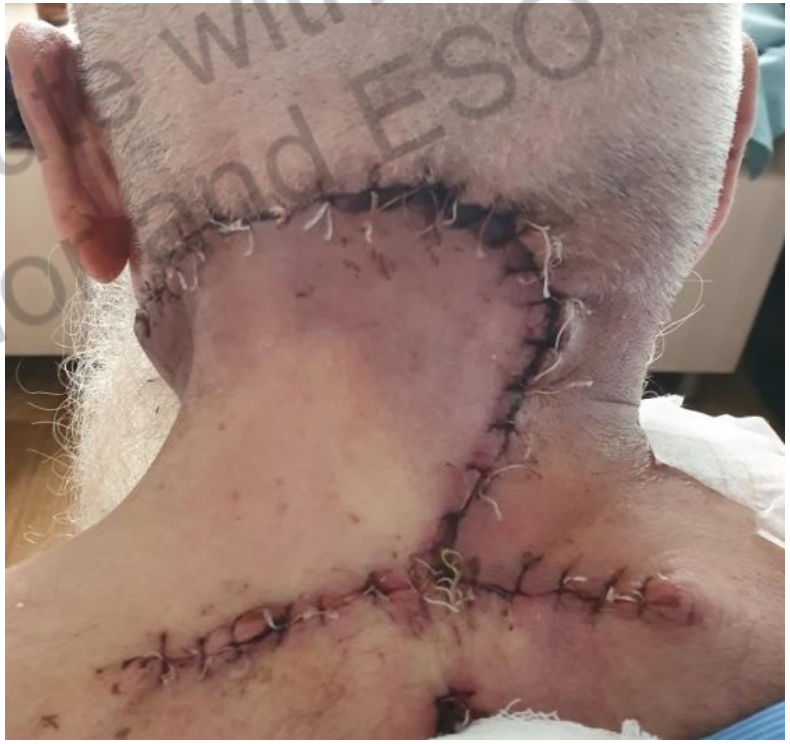


Figure 11. View of the flap on the 6th day after surgery.

Question #3.
What do you think about the treatment?

- A) Was the patient overtreated, since the treatment plan included the neck dissection?

- B) What can we do to differentially diagnose between clinically and pathologically nodal metastases?

Thank you for your attention!

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