SKIN DEEP – Multidisciplinary Skin Cancer Workshop

Saturday 9 November 2024

Clinical Skills Development Service

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Acknowledgement

Metro North Hospital and Health Service and Brisbane North PHN respectfully acknowledge the Traditional Owners of the land on which our services and events are located. We pay our respects to all Elders past, present and future and acknowledge Aboriginal and Torres Strait Islander people across the State.

The plan for today…

8.30am		**Welcome address**
		First session • A diagnostic approach to skin lesions • NMSC identification and management
10.10am		***Morning tea***
10.35am		**Second session** • Clinical considerations for referrals • Multidisciplinary management of complex patients • Multidisciplinary panel
12.45pm		***Lunch***
1.30pm		**Interactive skills stations/case studies** • Biopsy considerations and suturing challenges • Wound management and aftercare in General Practice • Non-surgical treatment of NMSC • Medical Oncology case study
3.10pm		**Last session** • Update on melanoma and immunotherapy
3.50pm		**Closing address & evaluations**

A diagnostic approach to skin lesions

Adj. A/Prof David B. Francis

Clinical Lead, Dermatology | RBWH

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Queensland Government
Metro North Health

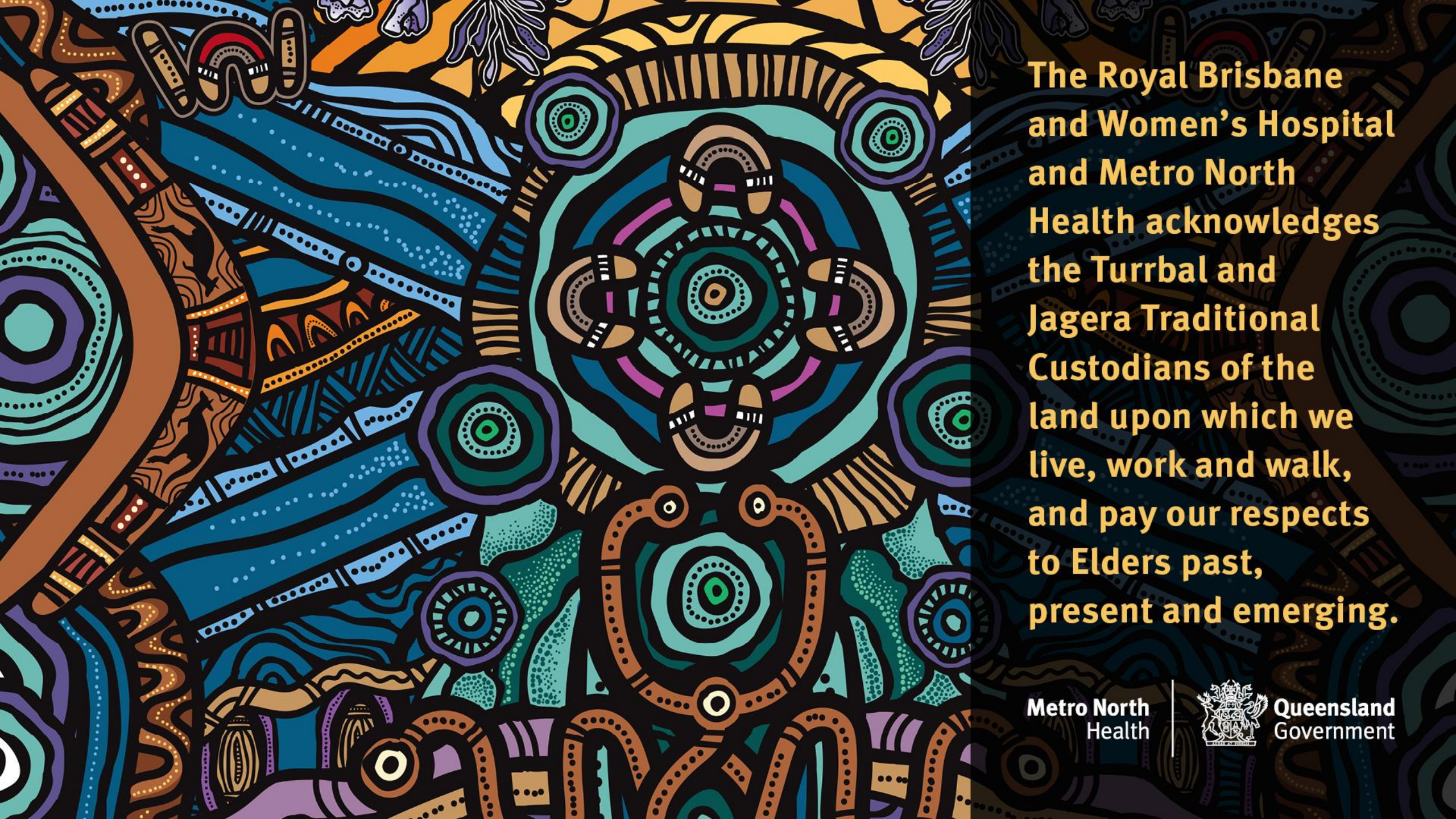
Skin Cancer

ADJ A/PROF DAVID B FRANCIS

MBBS FACD FACMS GAICD

CLINICAL LEAD RBWH DERMATOLOGY

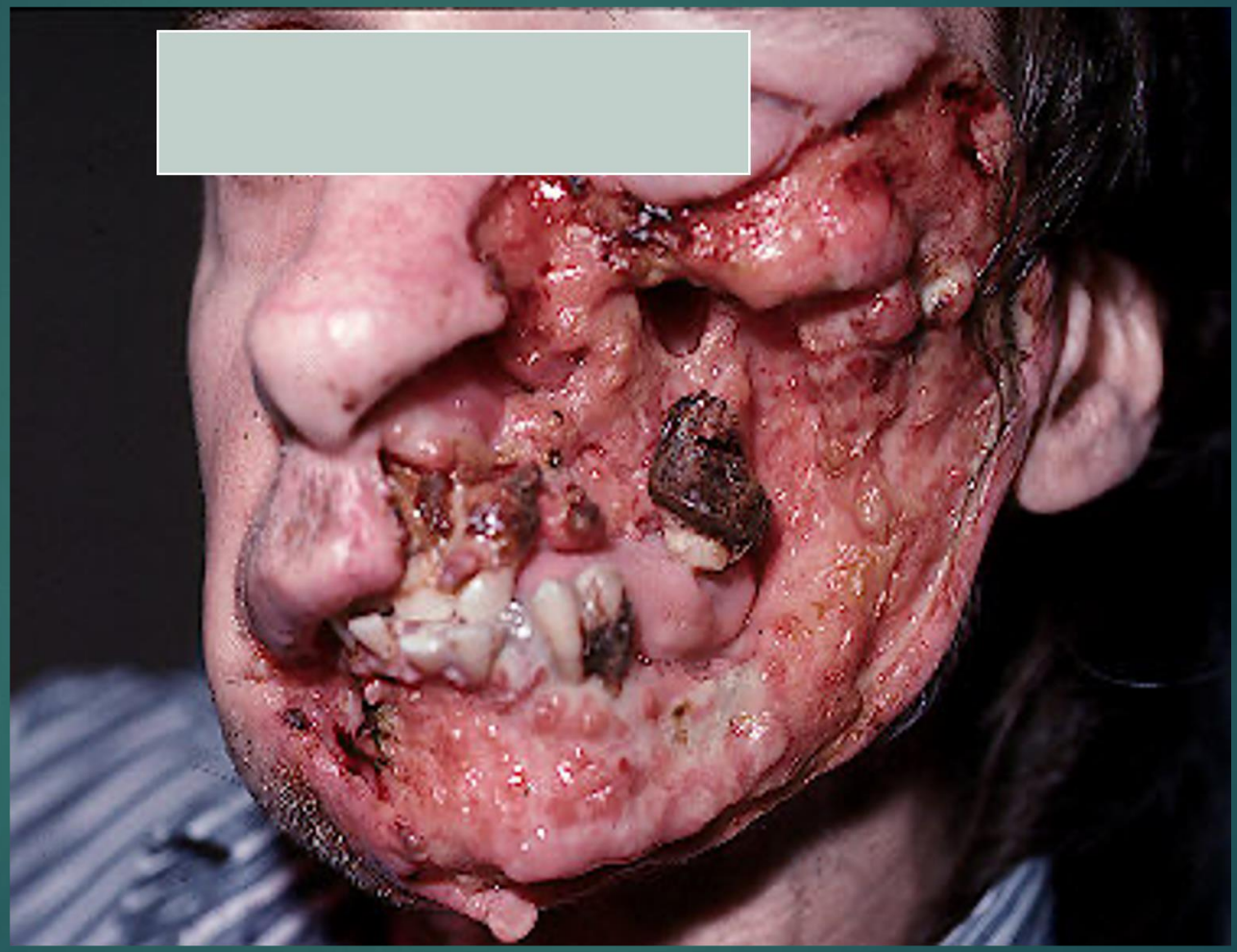
VMO PAH


The Royal Brisbane and Women's Hospital and Metro North Health acknowledges the Turrbal and Jagera Traditional Custodians of the land upon which we live, work and walk, and pay our respects to Elders past, present and emerging.
Metro North Health
Queensland Government

Why do we care ?

- 1455 deaths Melanoma 2021 (958 males, 497 females)
- $1.7 billion per year treating skin cancer
  (about 2 hospitals)
- 223,000 BCC per year
- 128,500 SCC per year
- 4180 Qld melanoma per year
- Skin cancer 1 in 3 by 50 years age, 2 in 3 by 70 years
- 840,000 GP skin check encounters per year
- Apart from pain, suffering , loss productivity etc

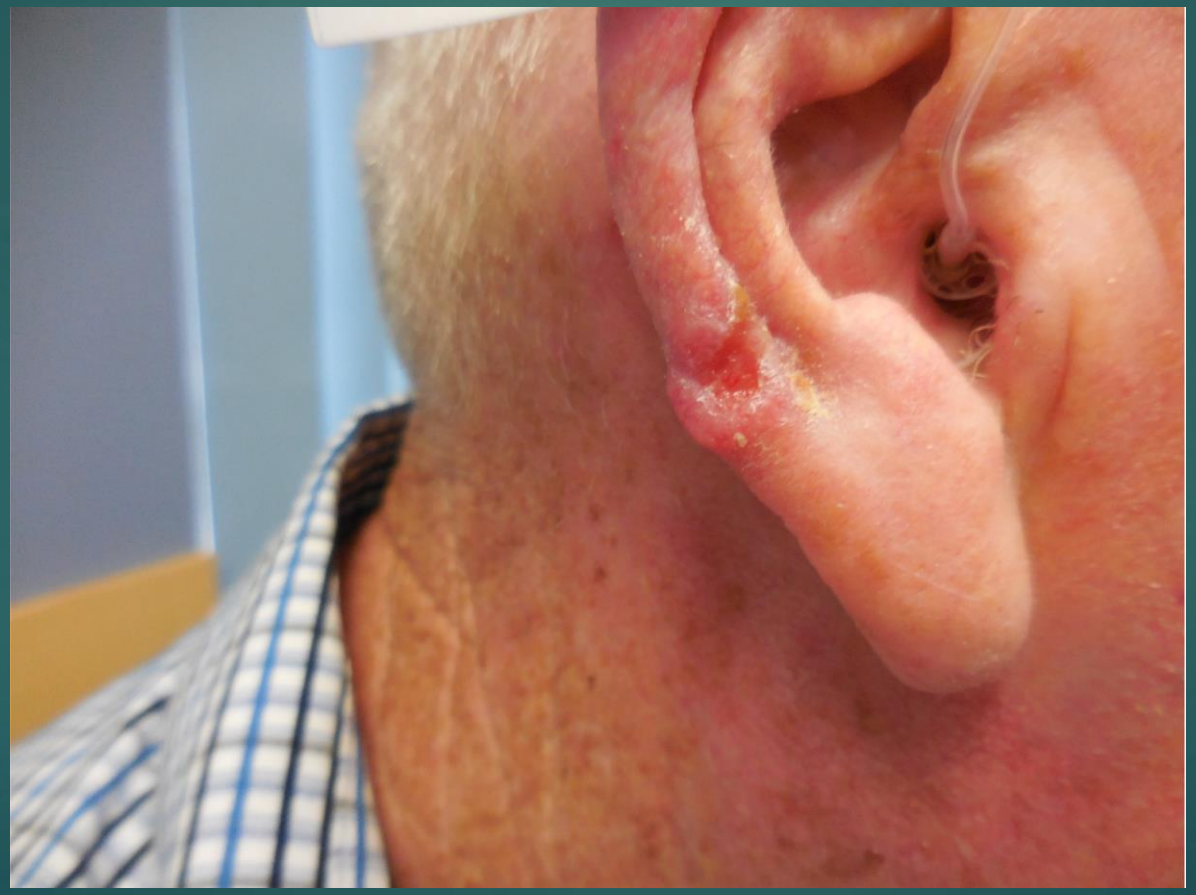
BCC



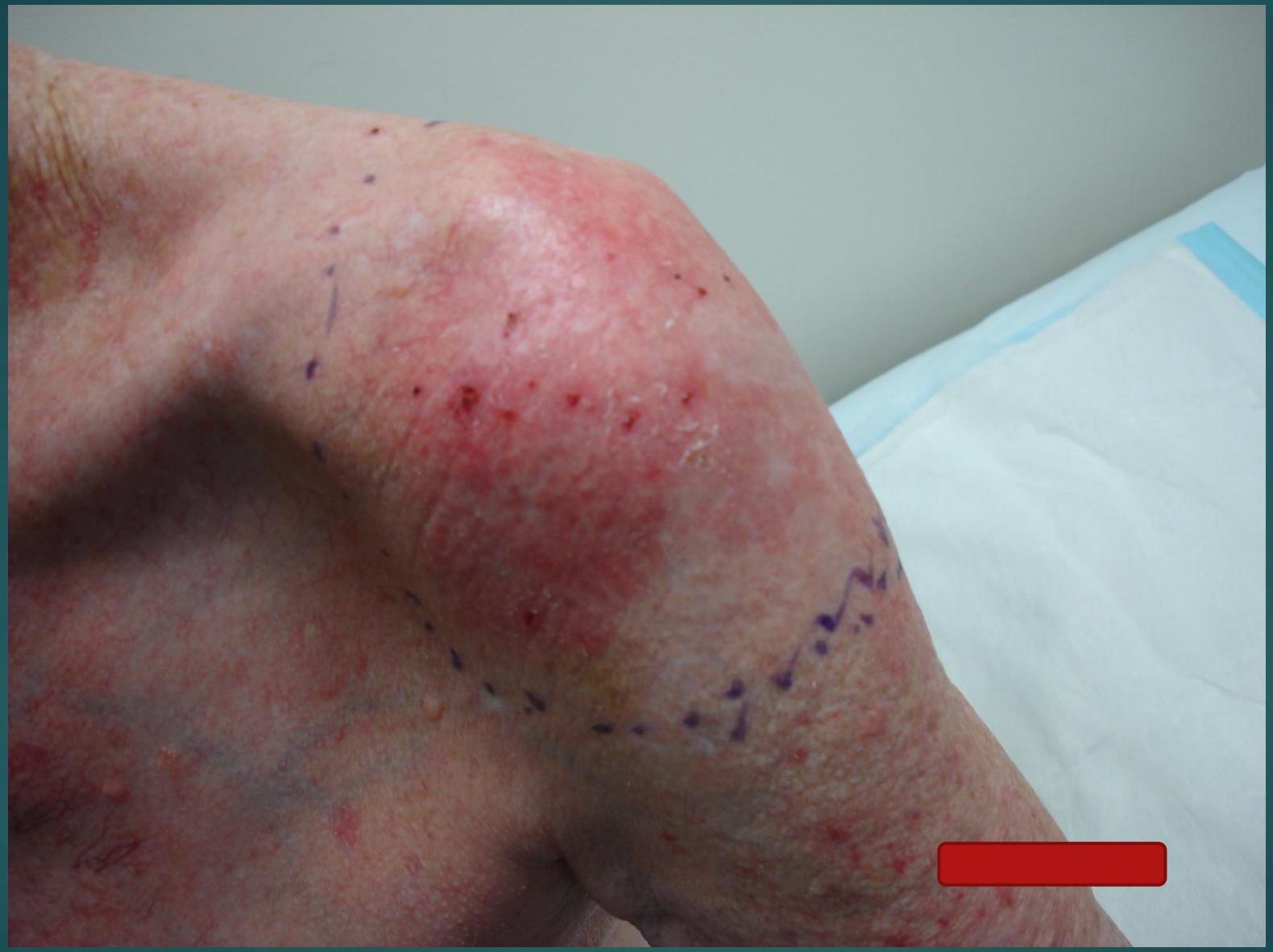
BCC

- Nodular Ulcerative (Rodent Ulcer)
- Multifocal Superficial
- Infiltrating
- Micronodular
- Morphoeic, Fibrosing
- Pigmented
- BCC w Squamous differentiation
- BCC with PNI
- Crust vs Scale

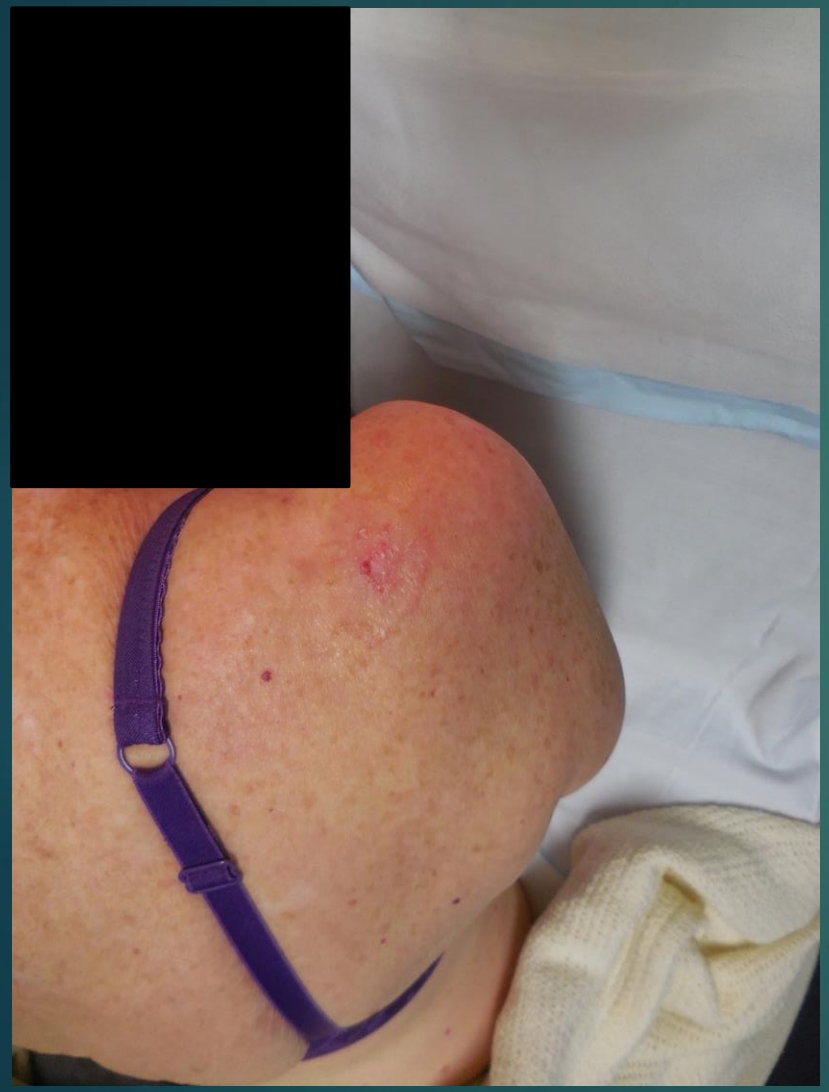
Nodulo ulcerative

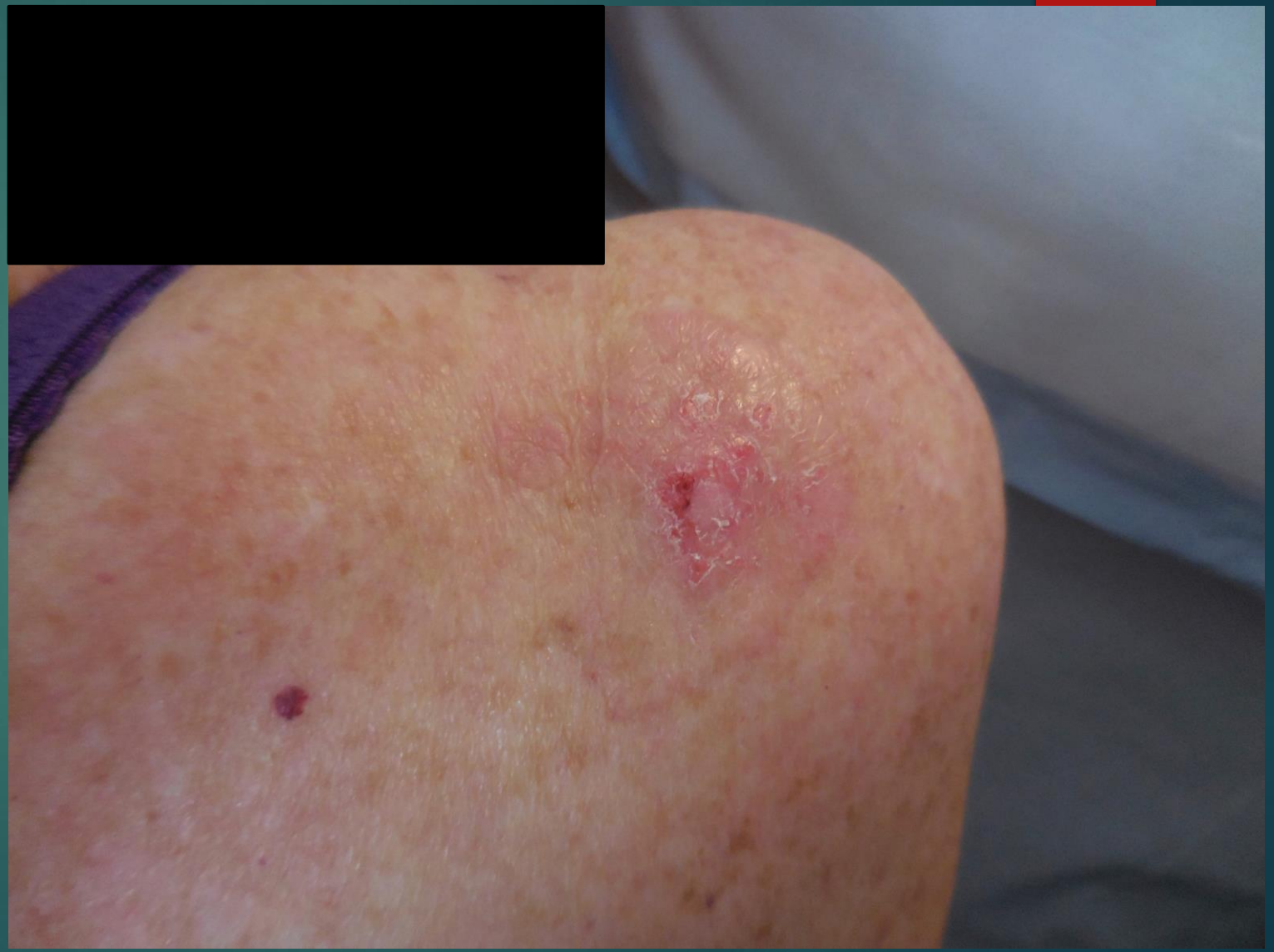


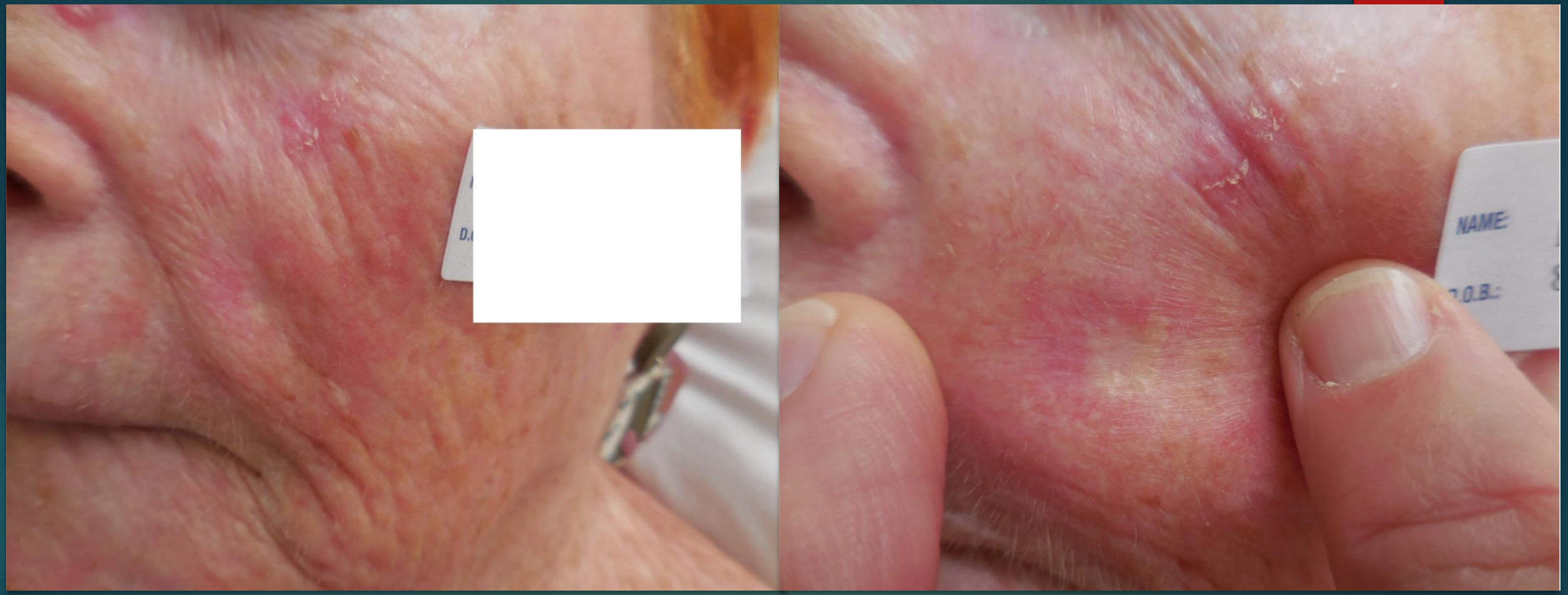
Superficial BCC



Multifocal Superficial

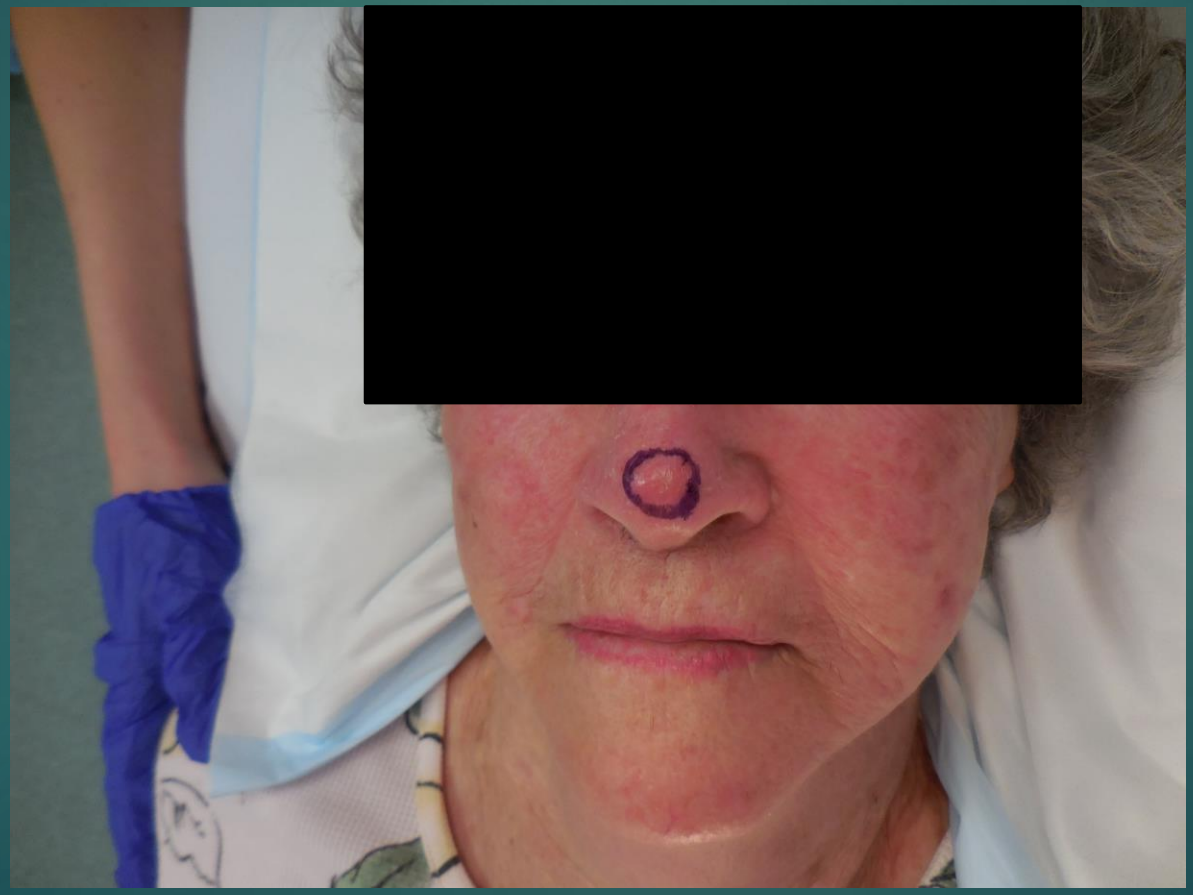






Morphoeic BCC

Infiltrating



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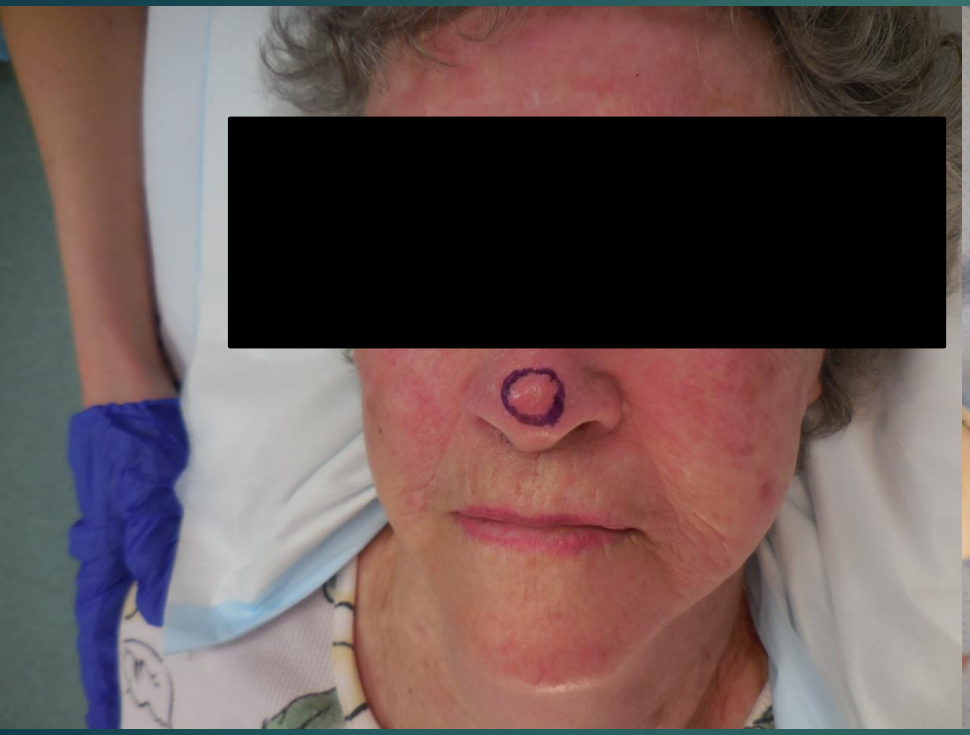
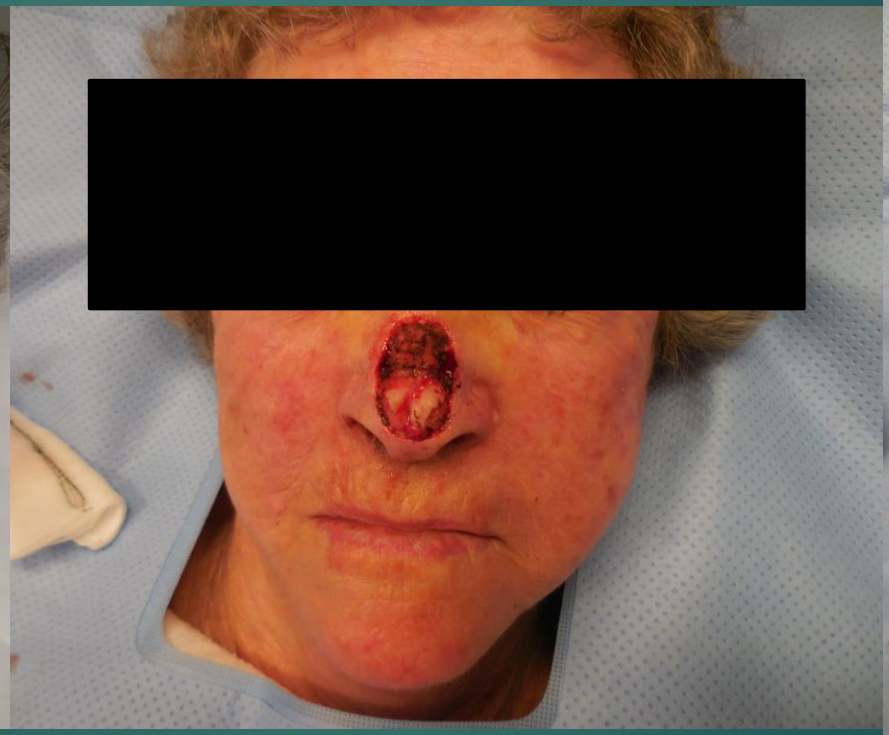
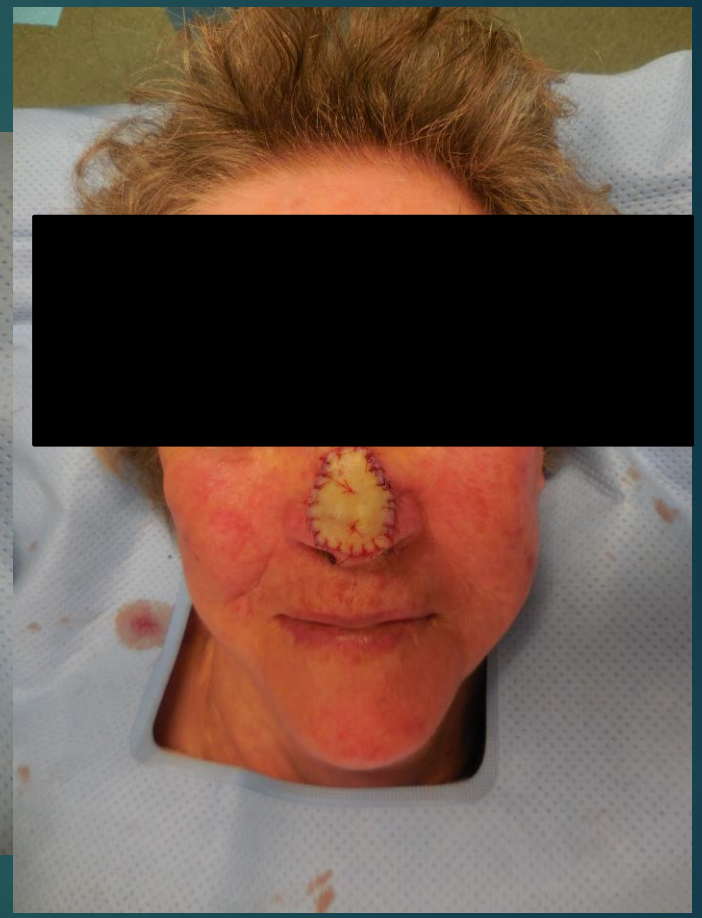
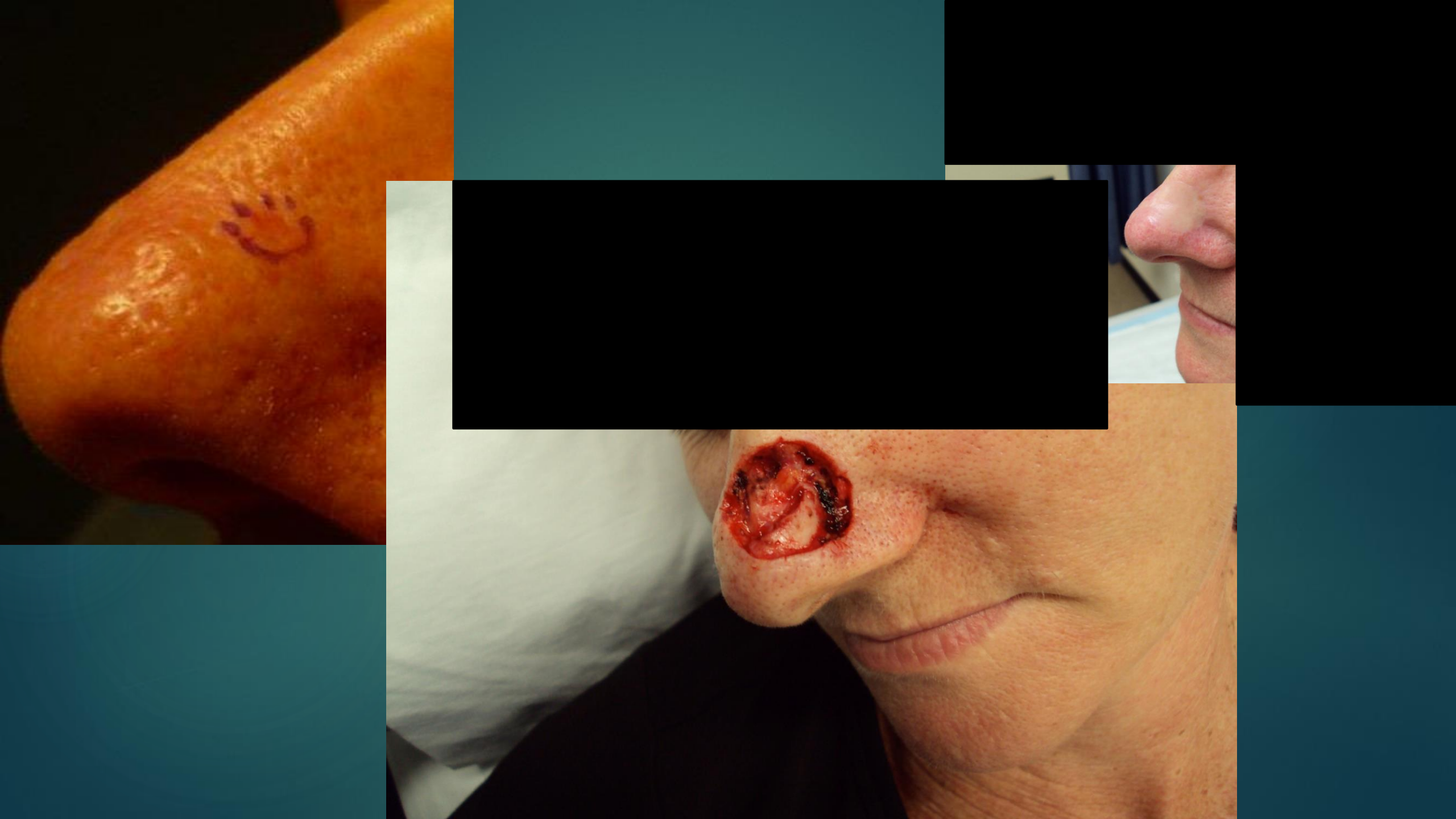
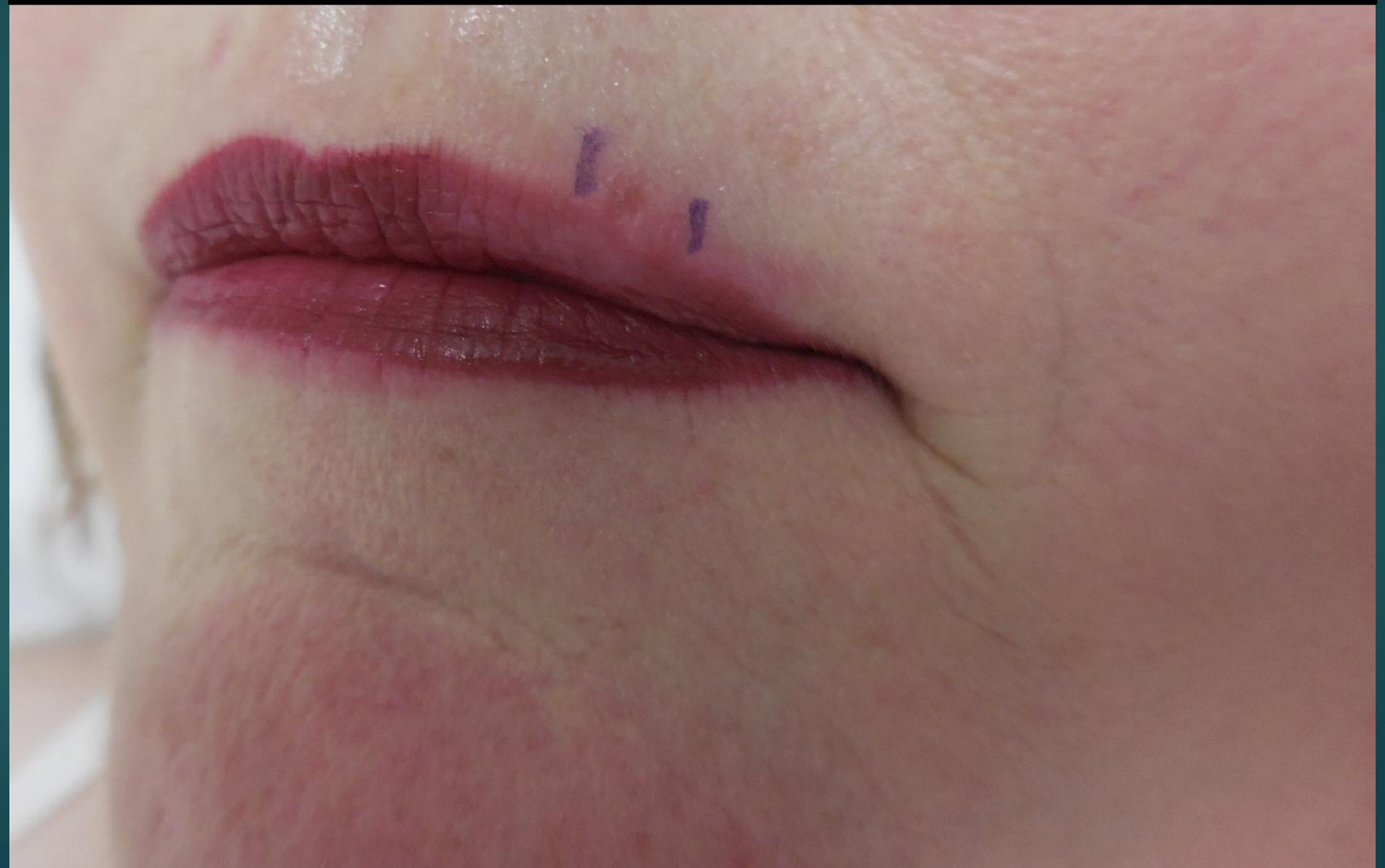
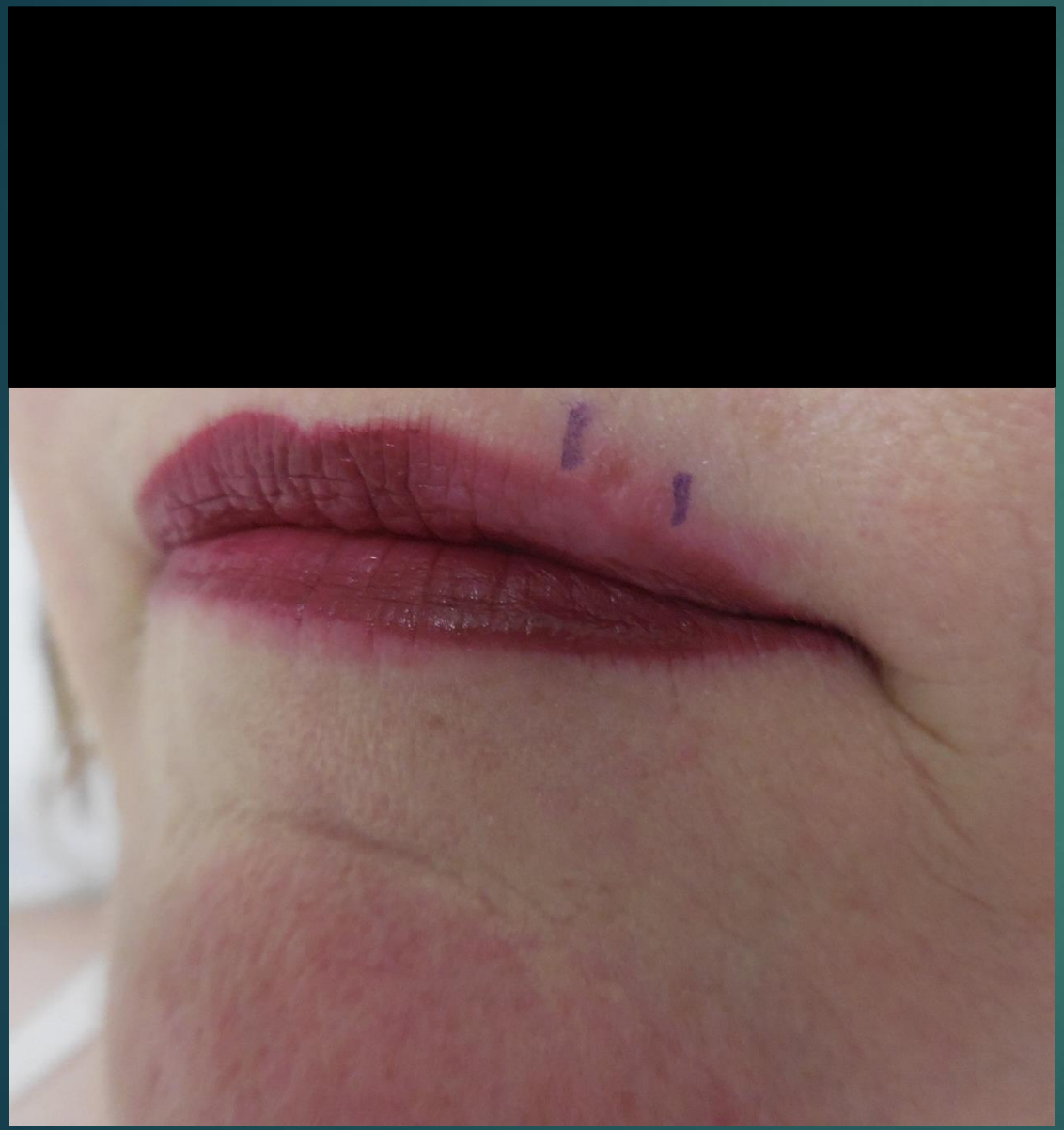
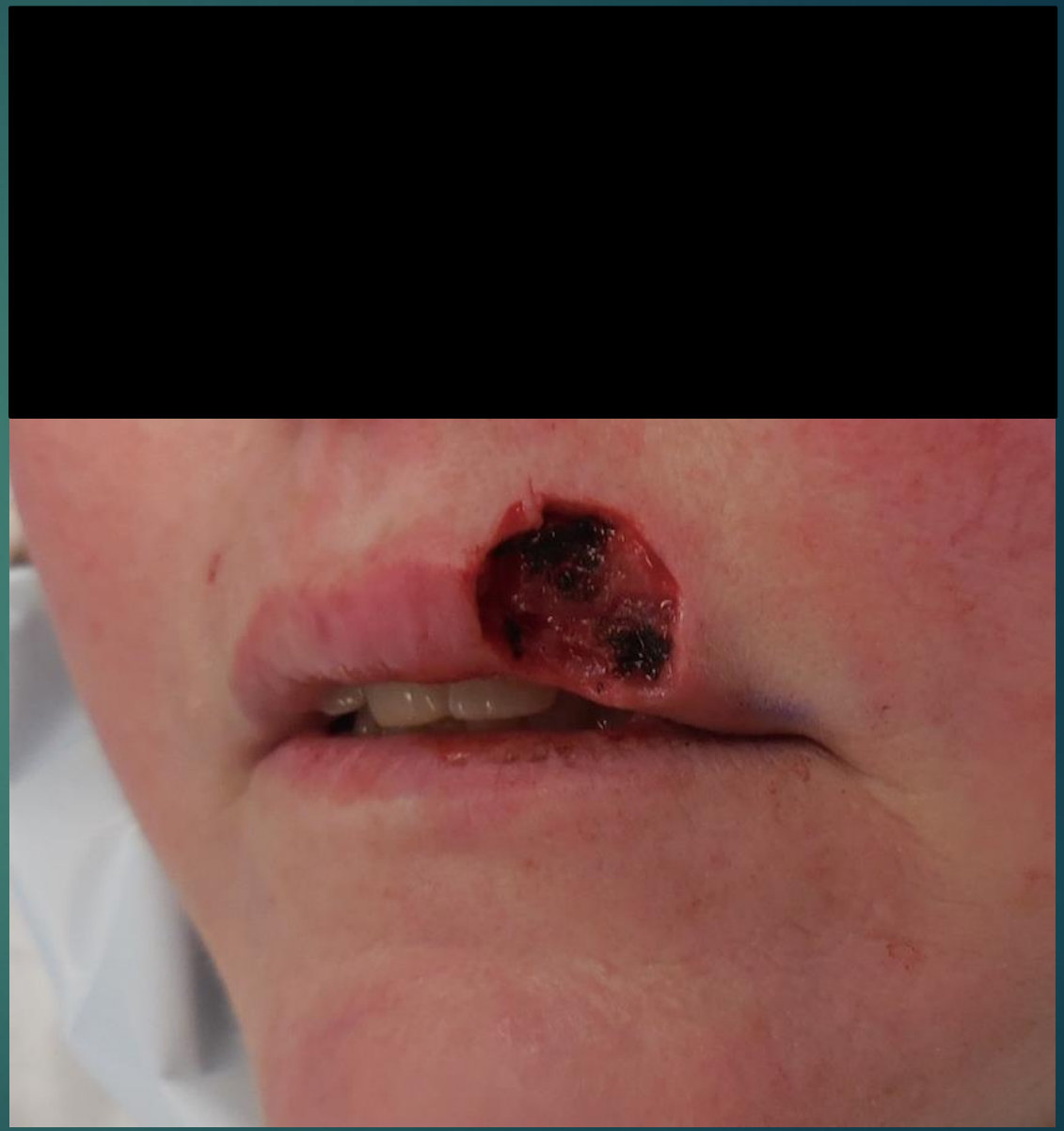




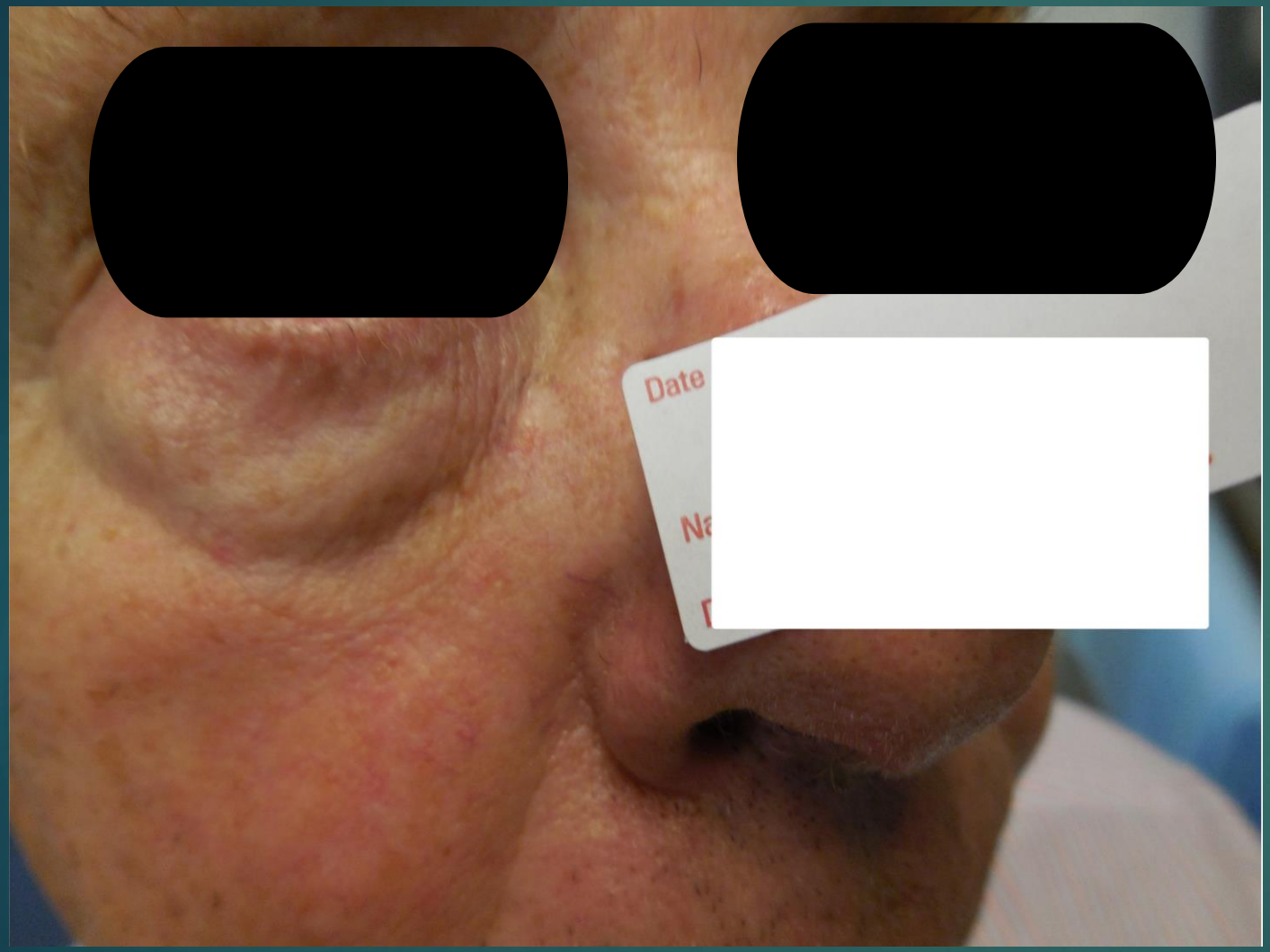


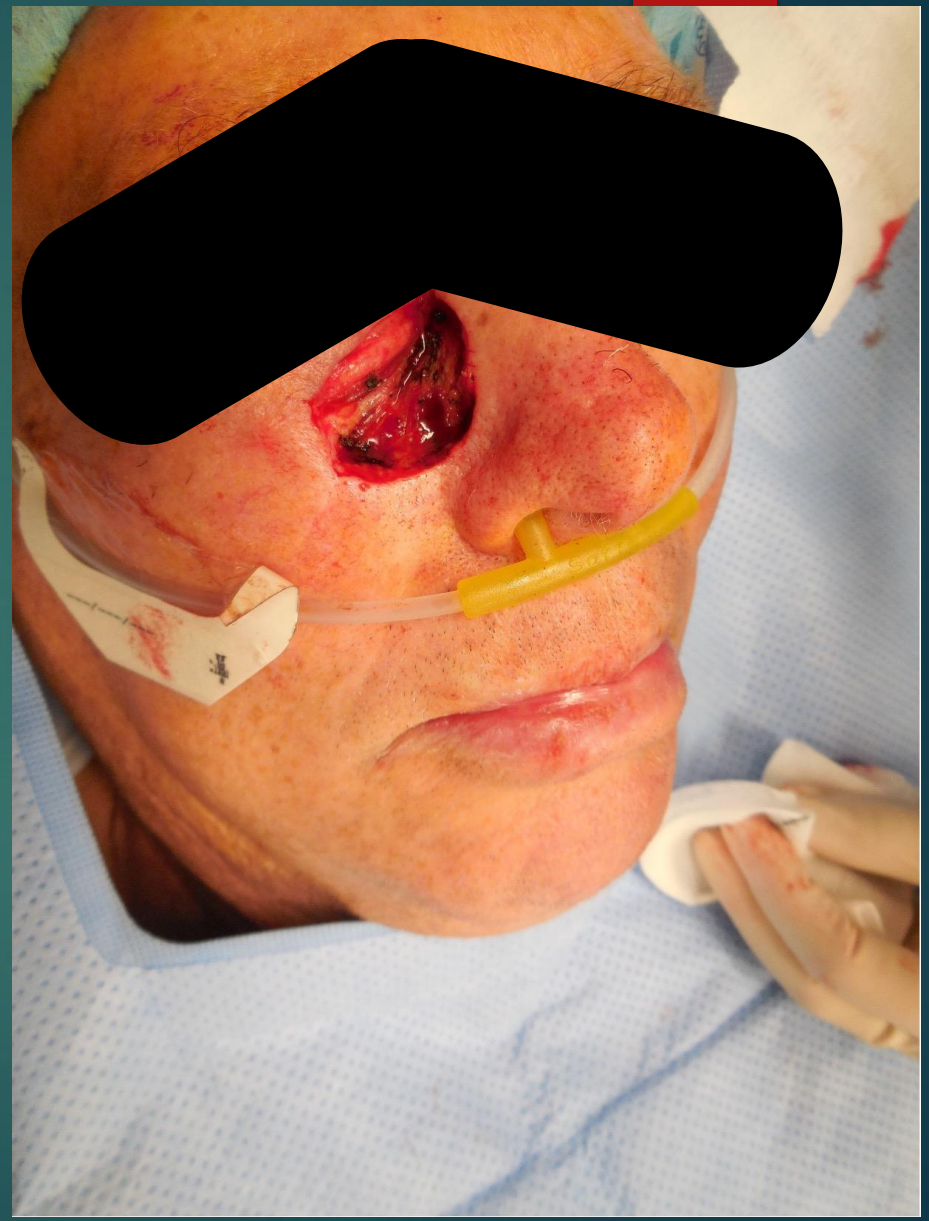




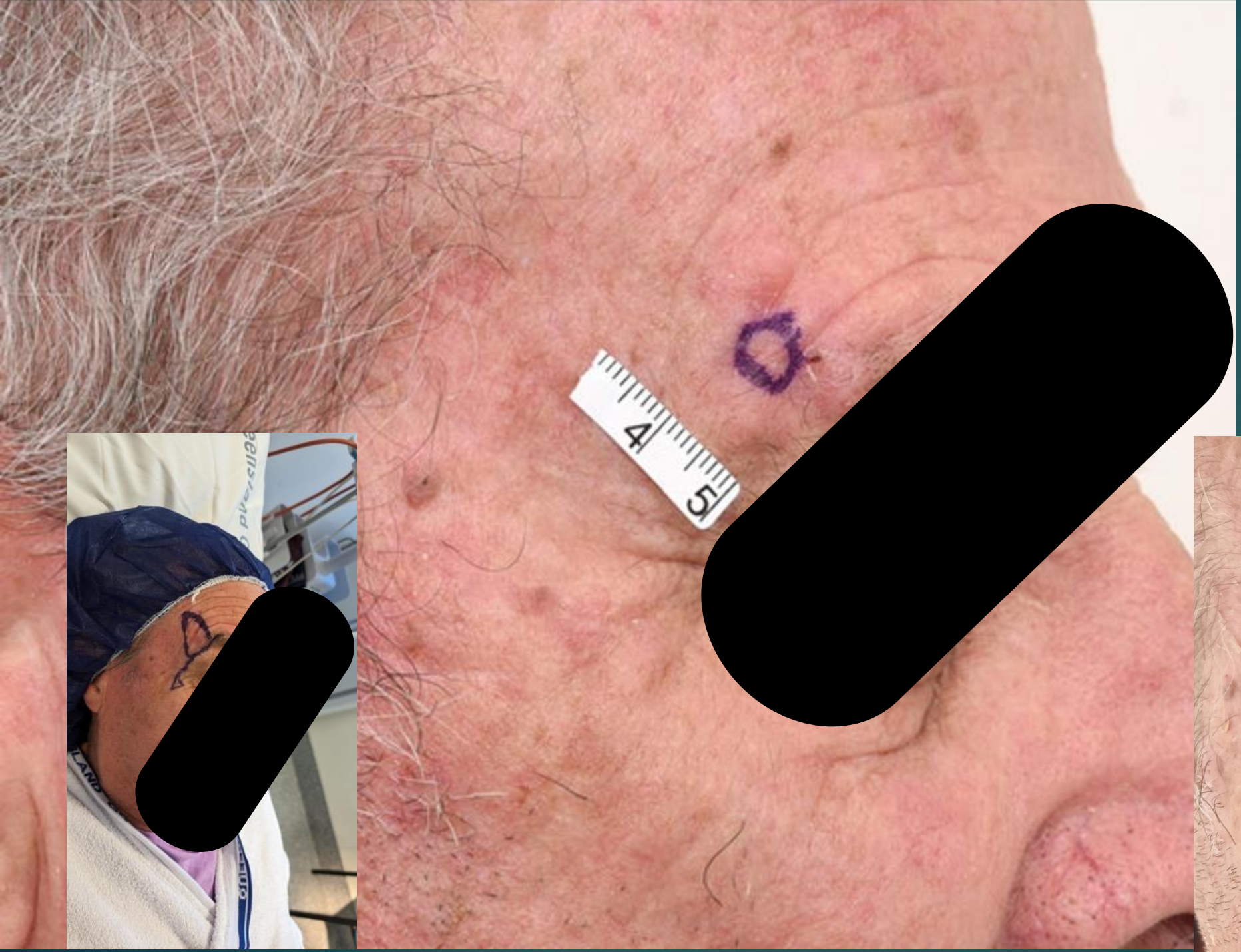


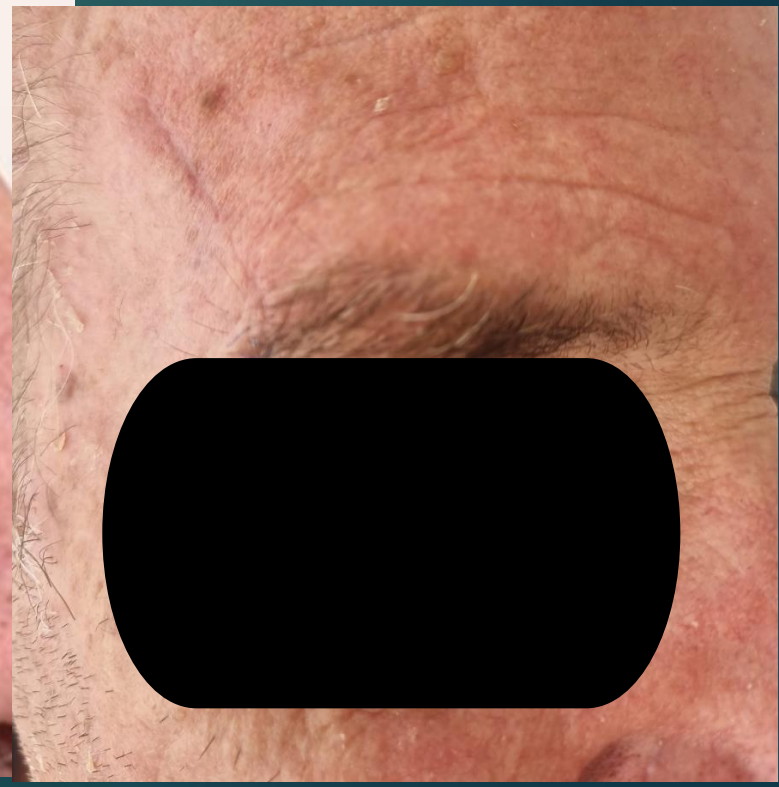
Micronodular/mixed

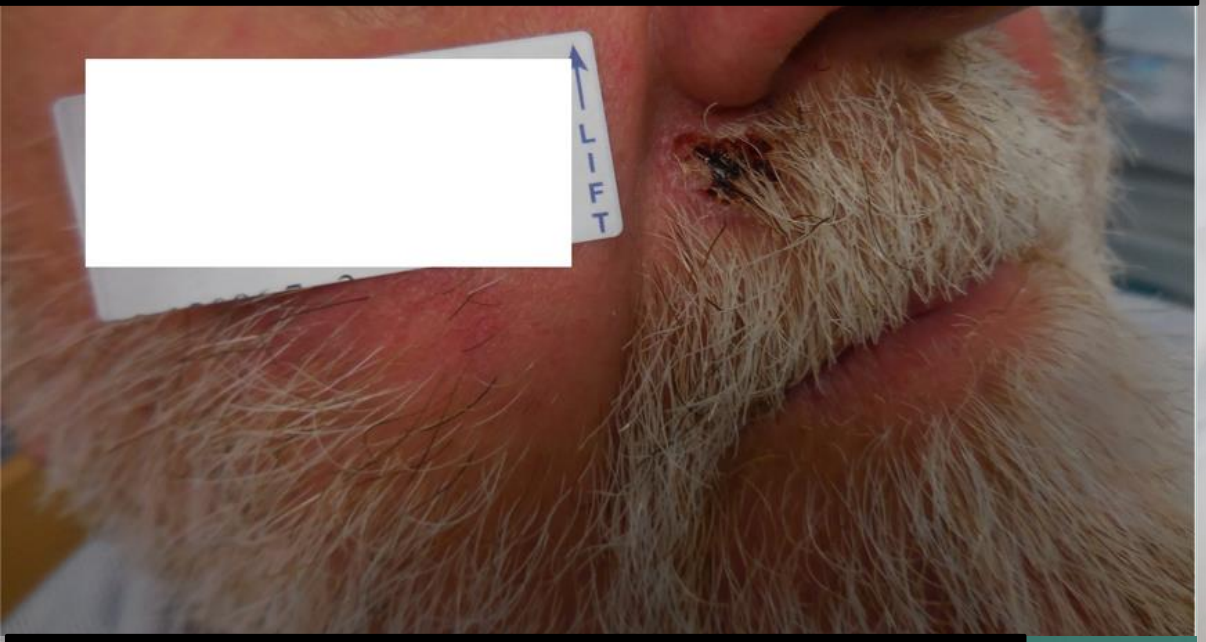


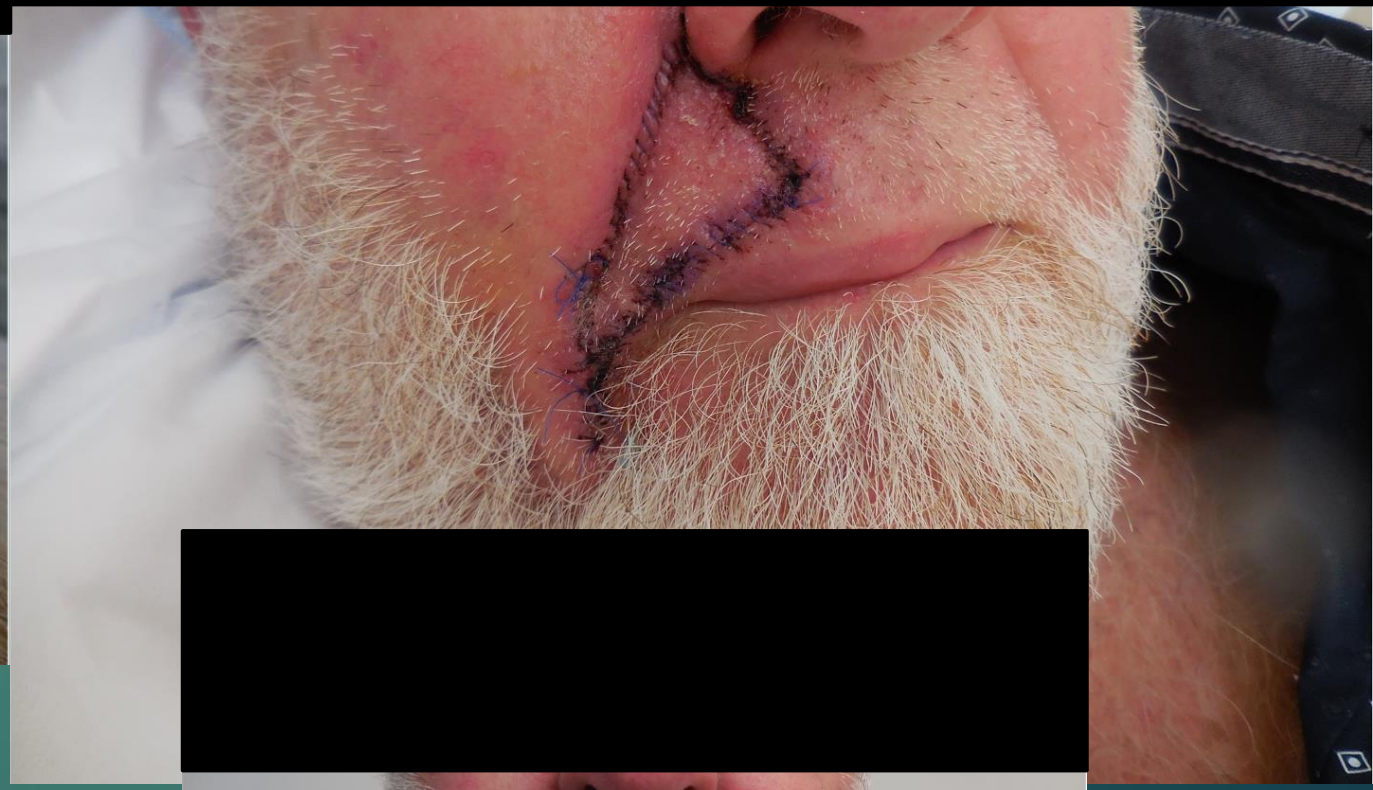


Mixed









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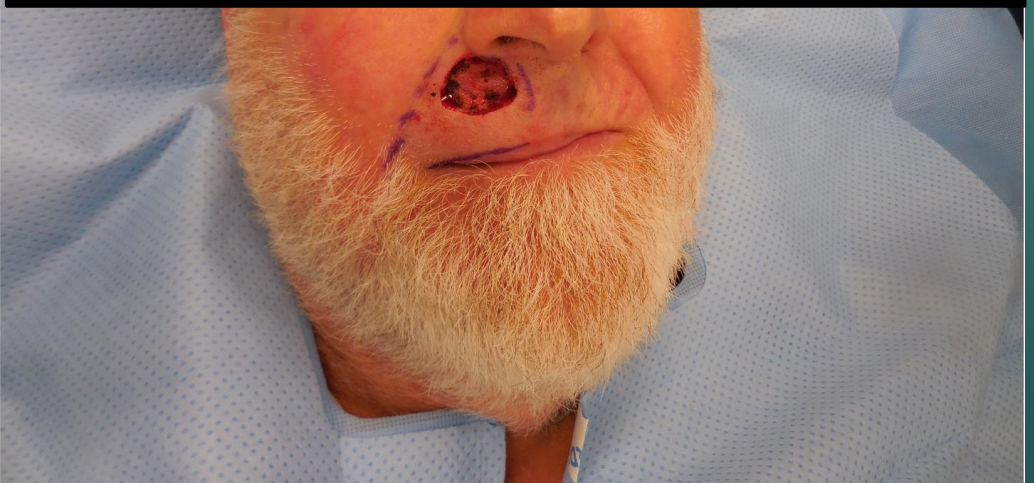
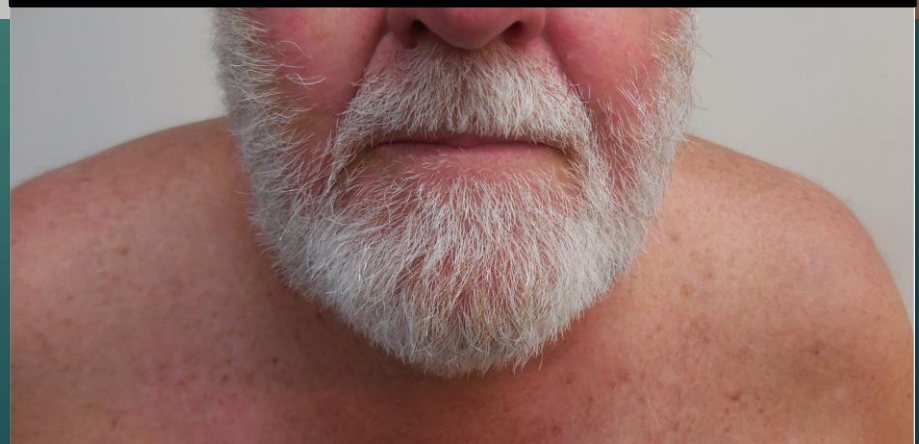
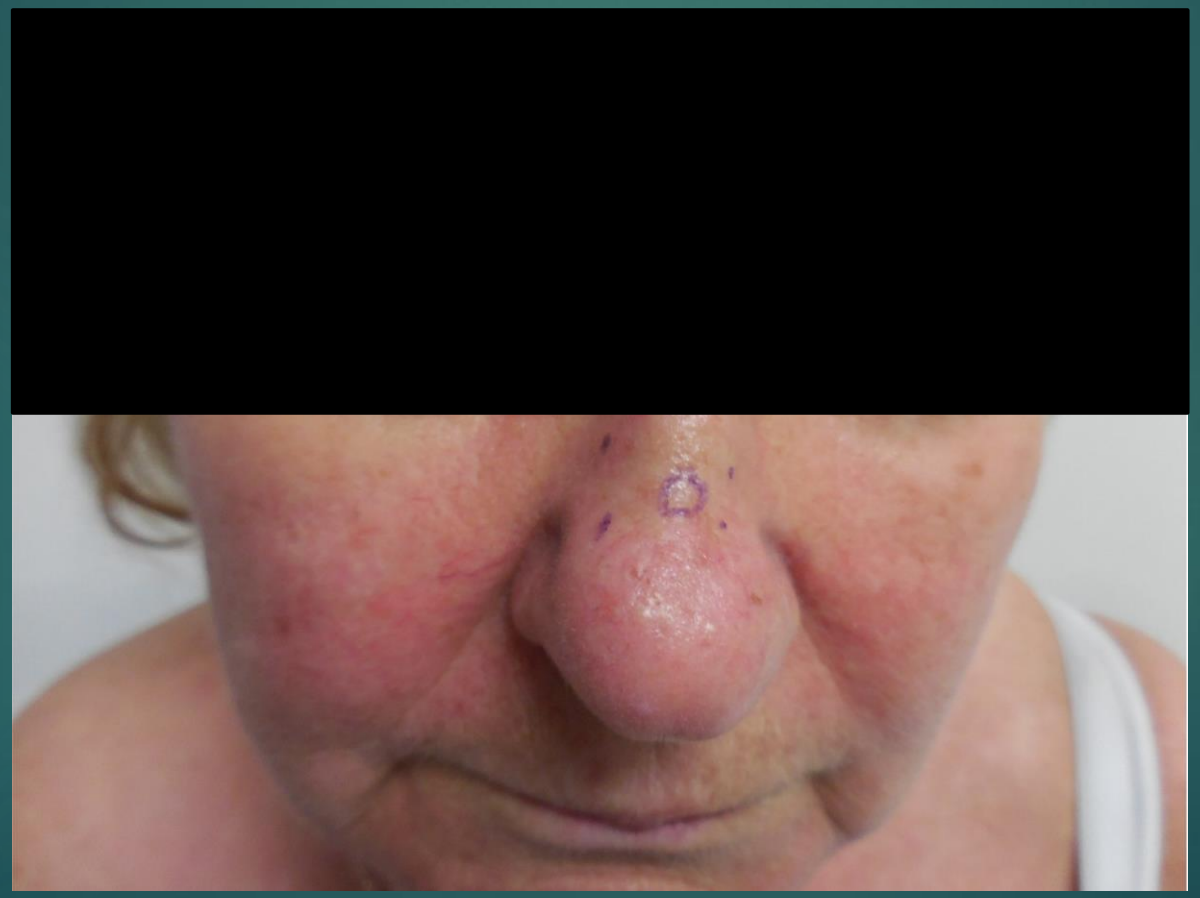
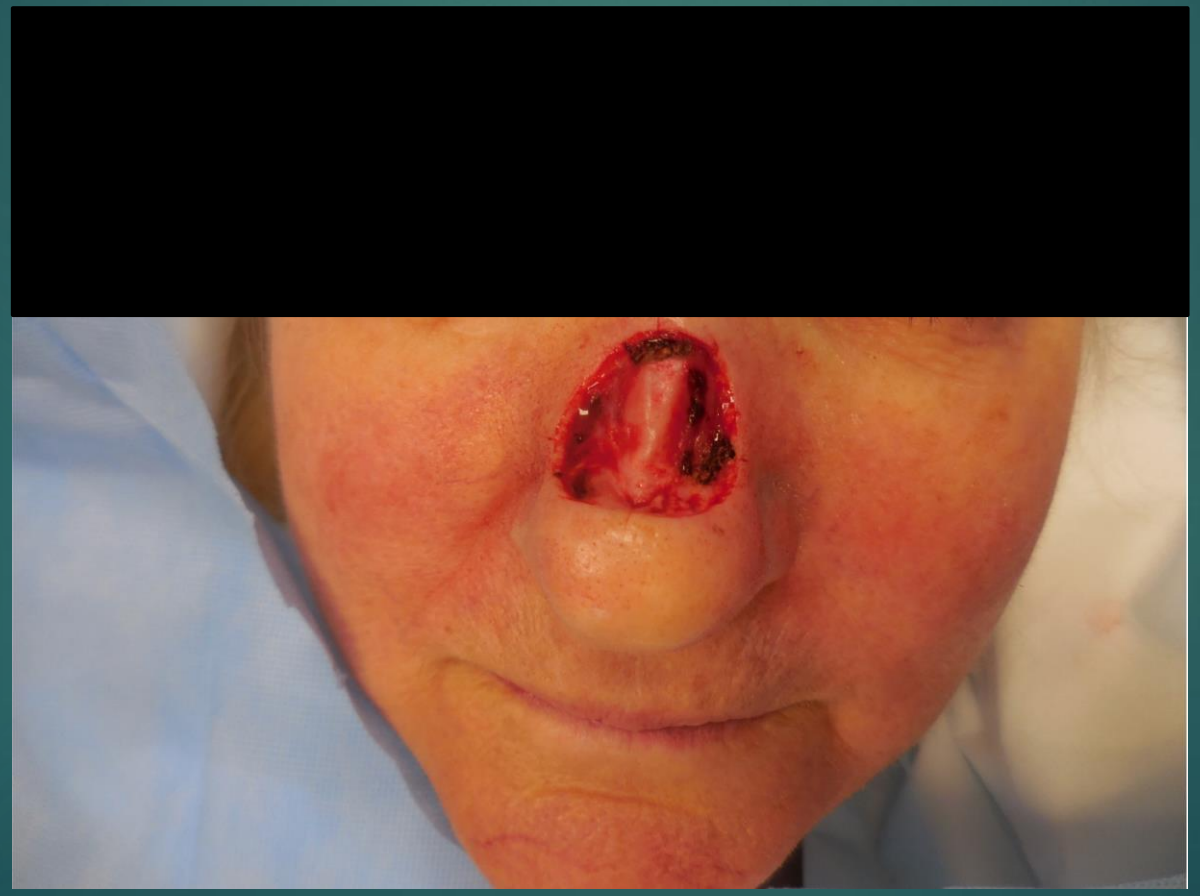
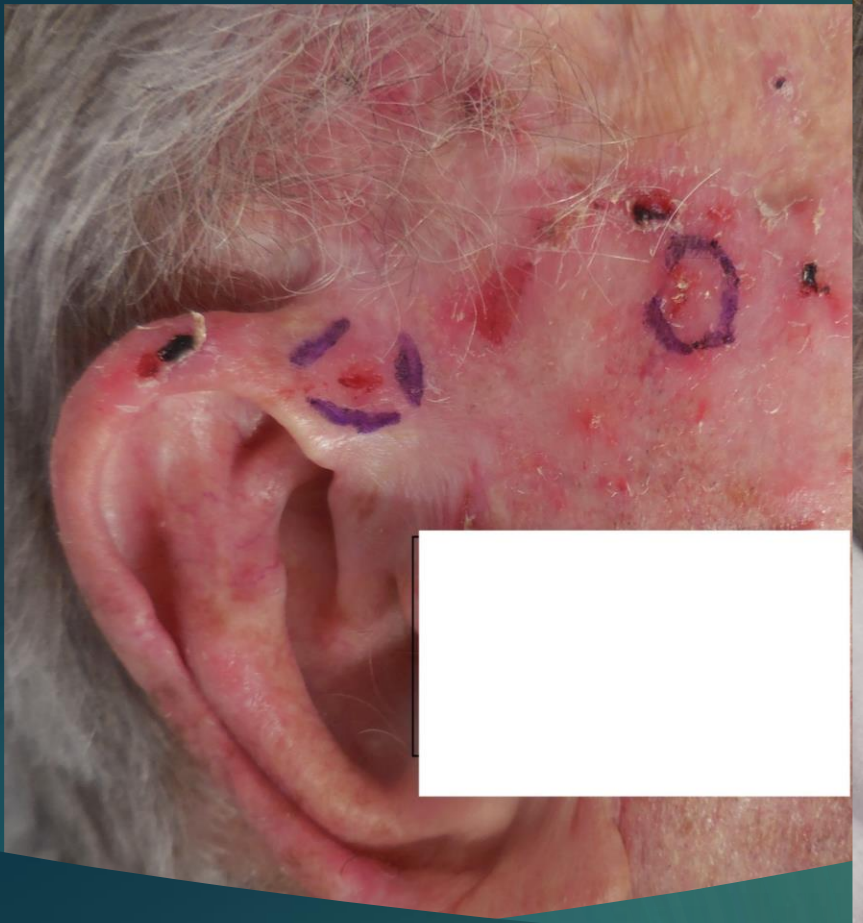
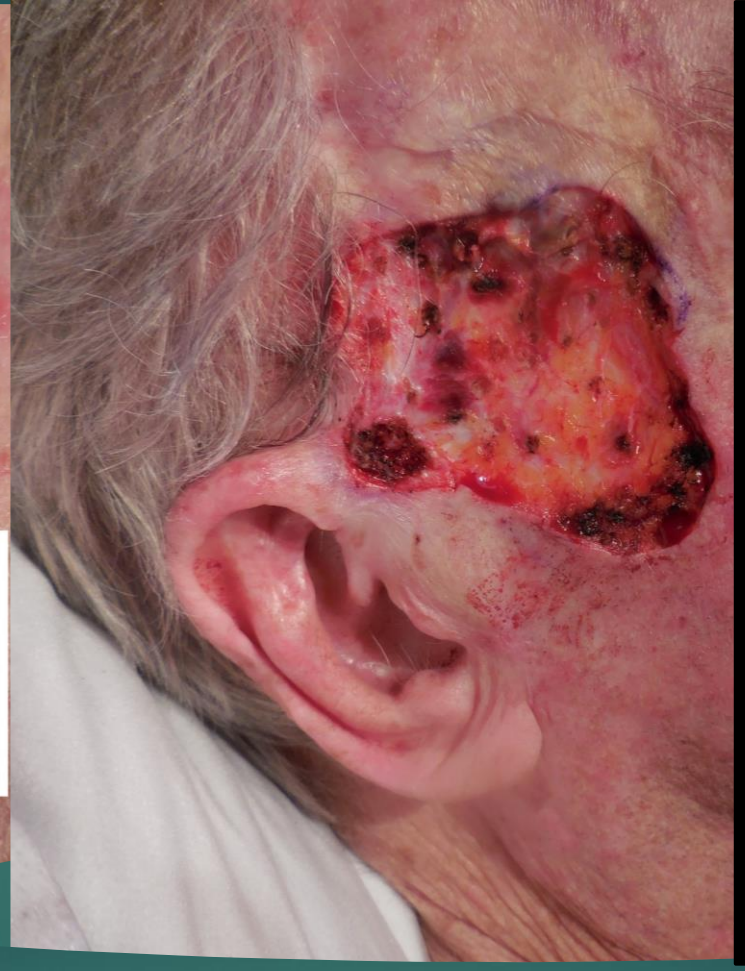


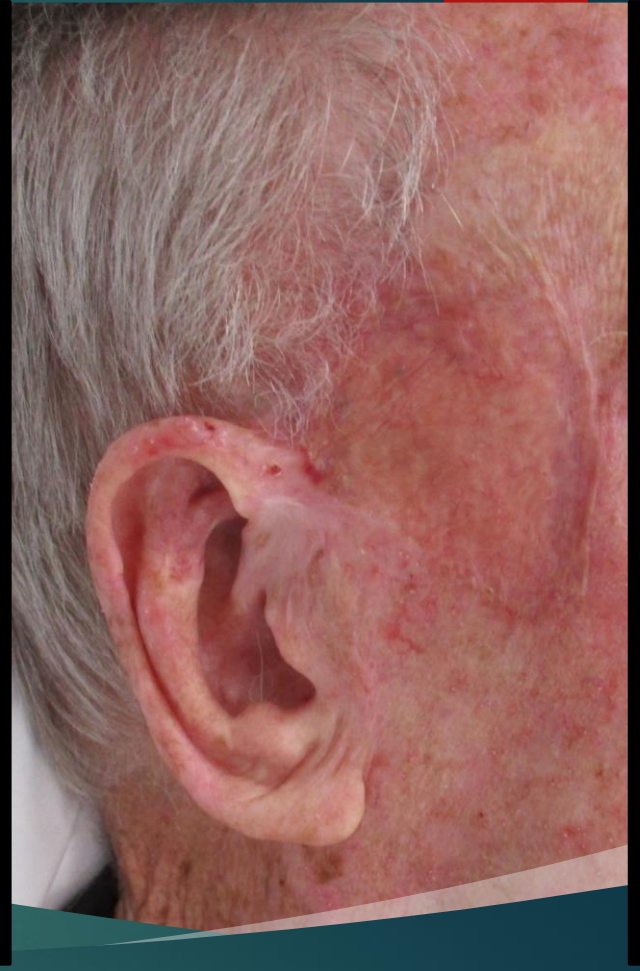






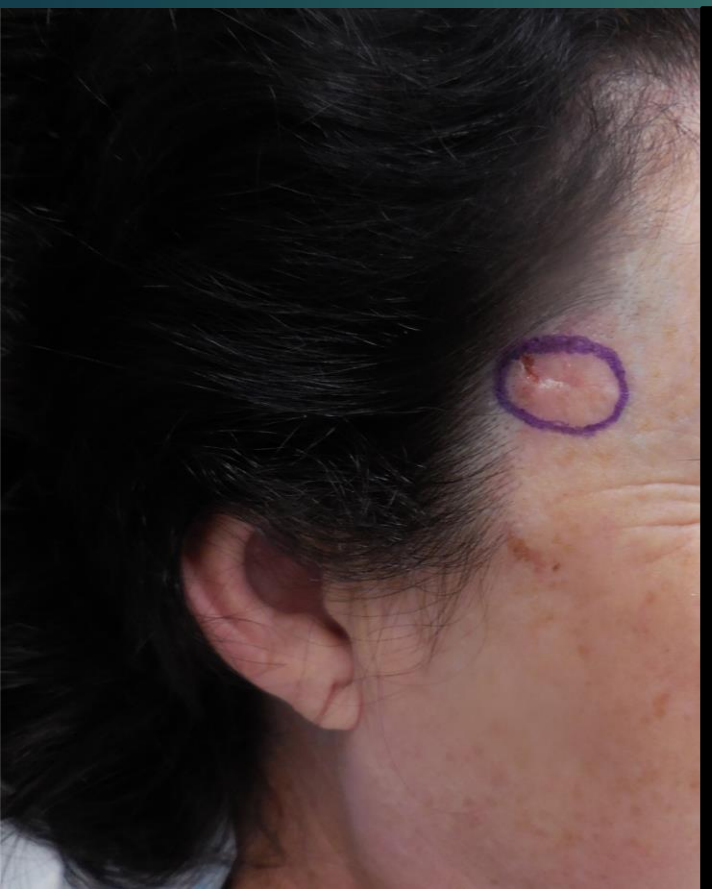


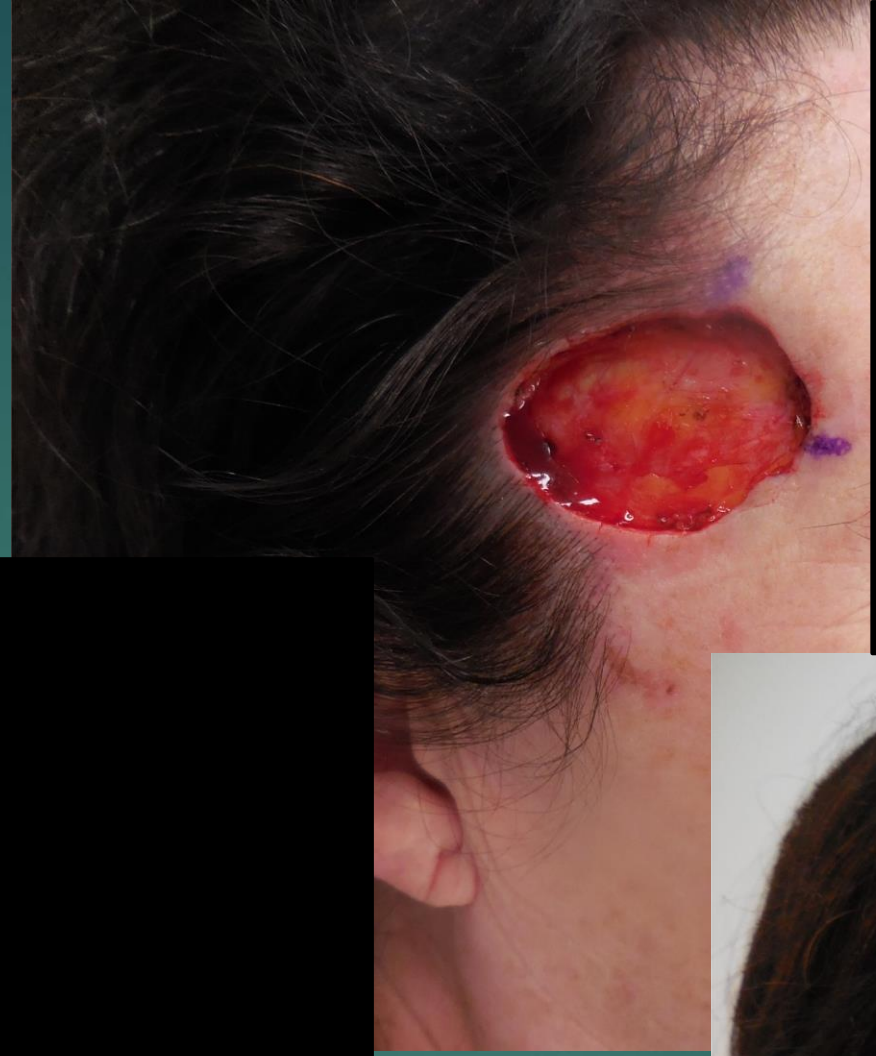


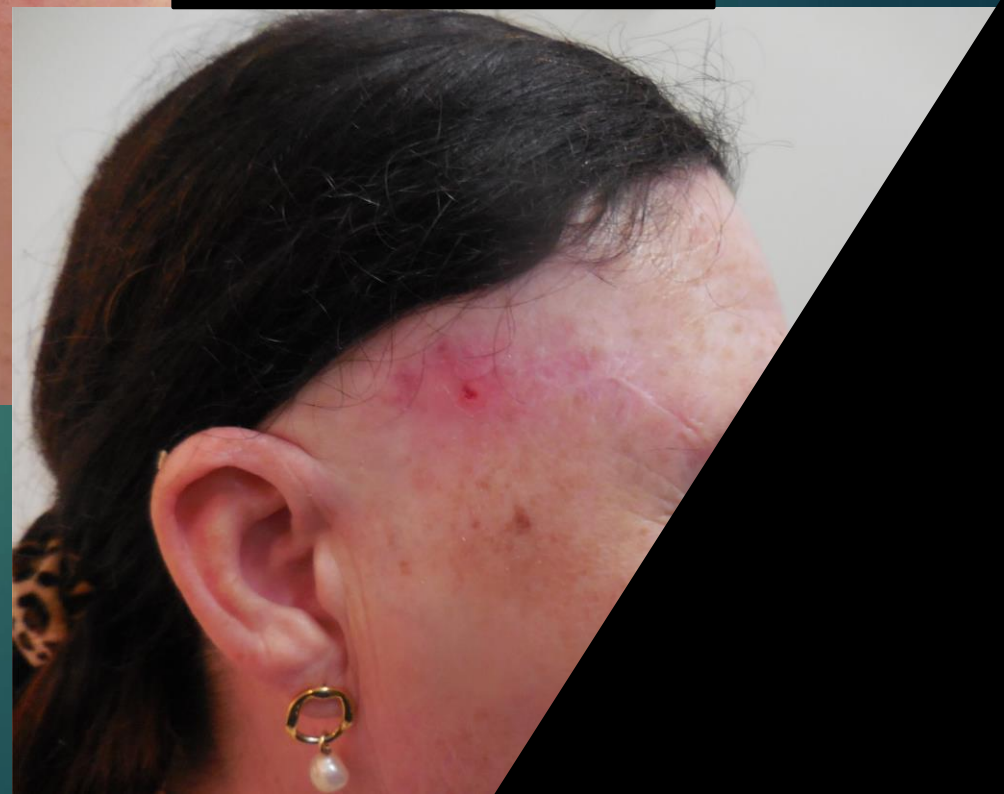


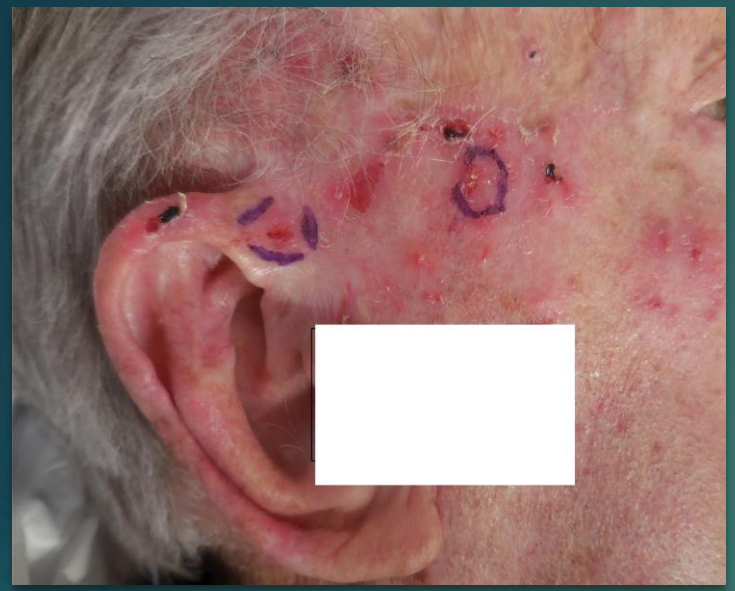
Multifocal etc

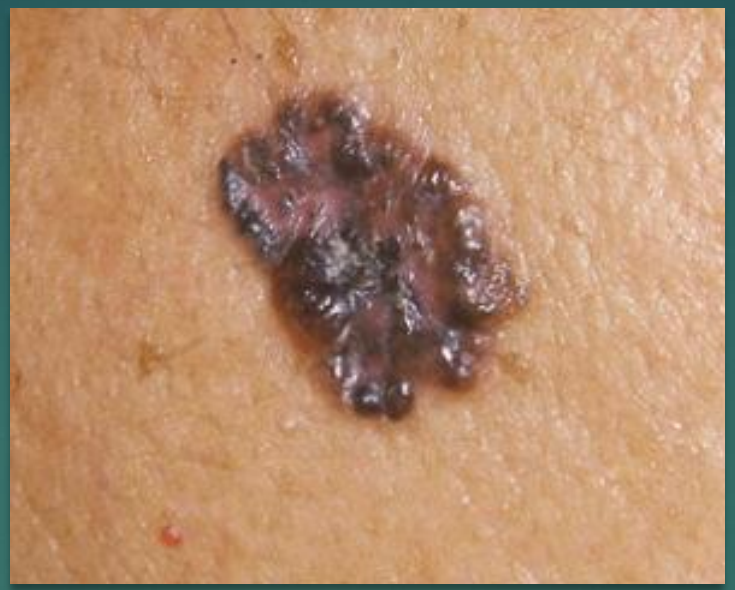
BCC with PNI

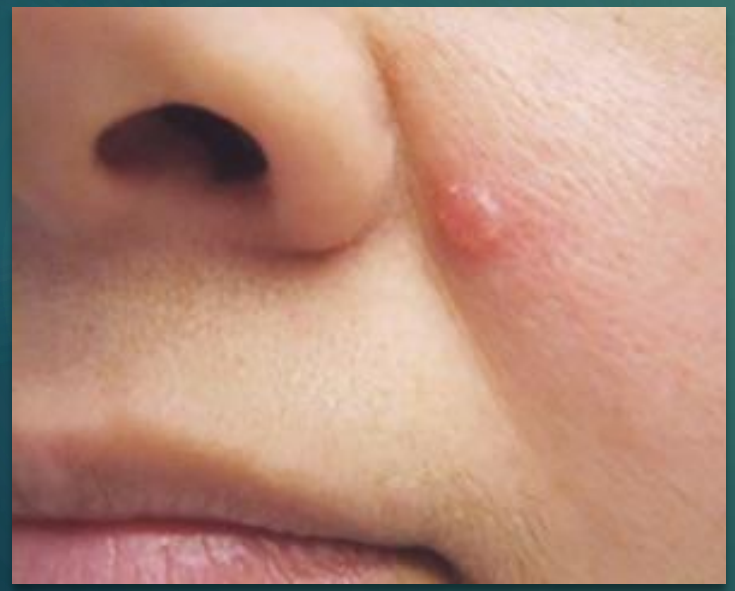


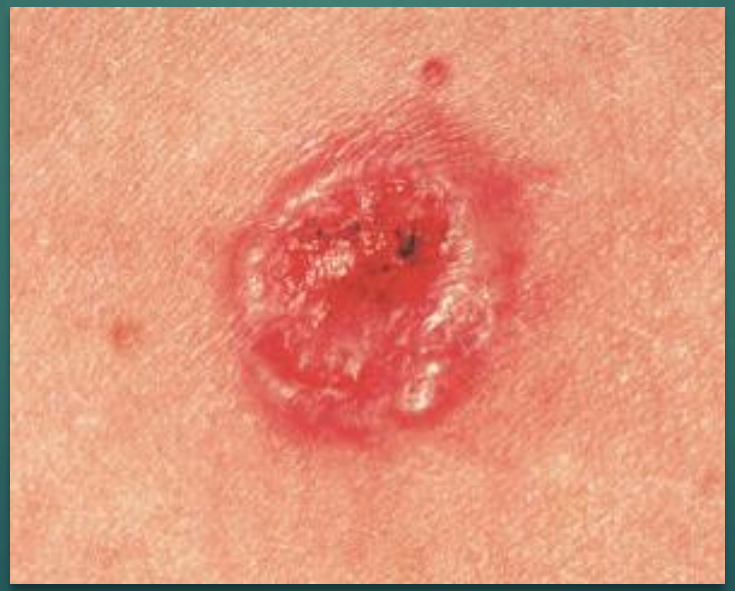










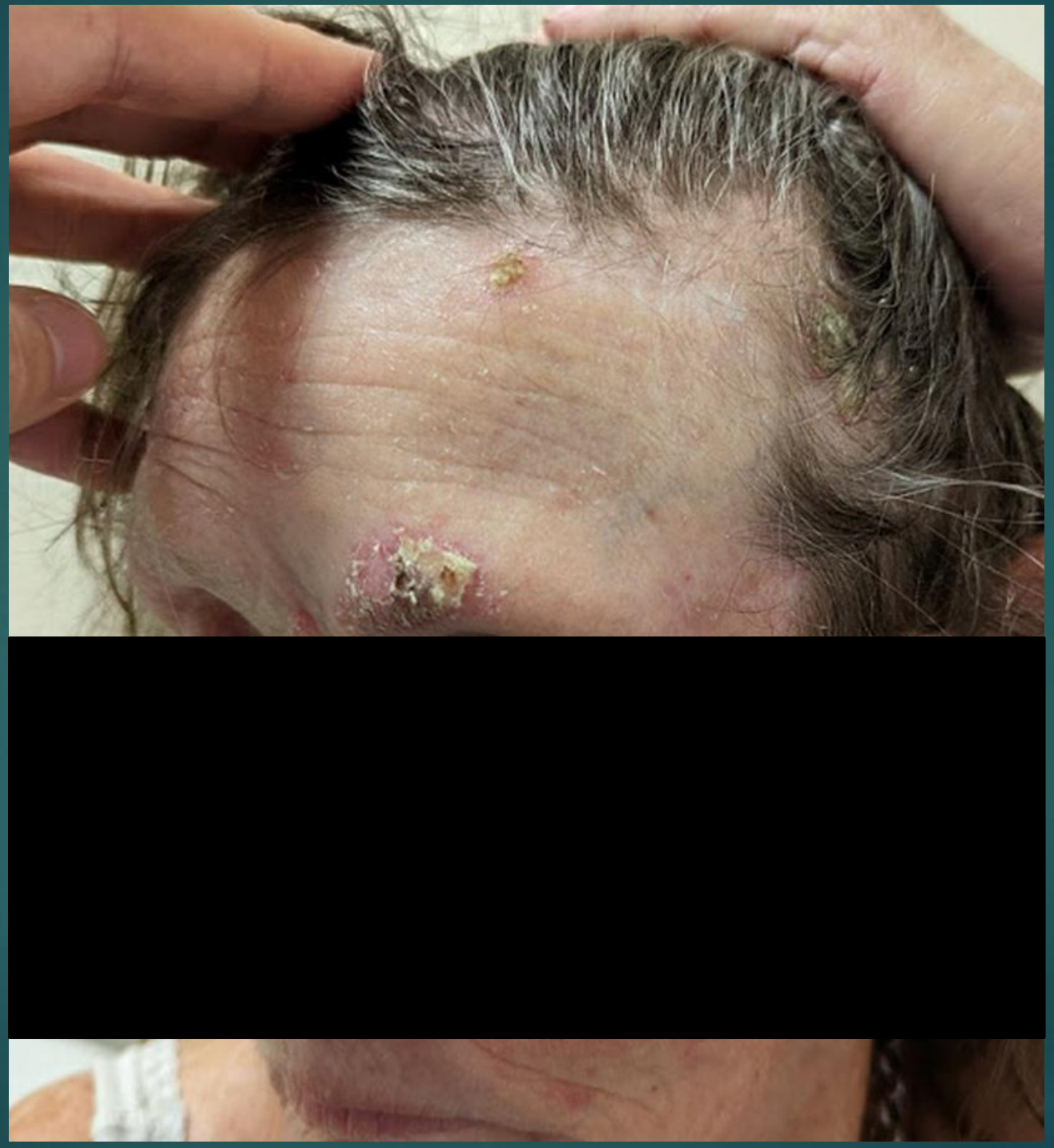


BCC

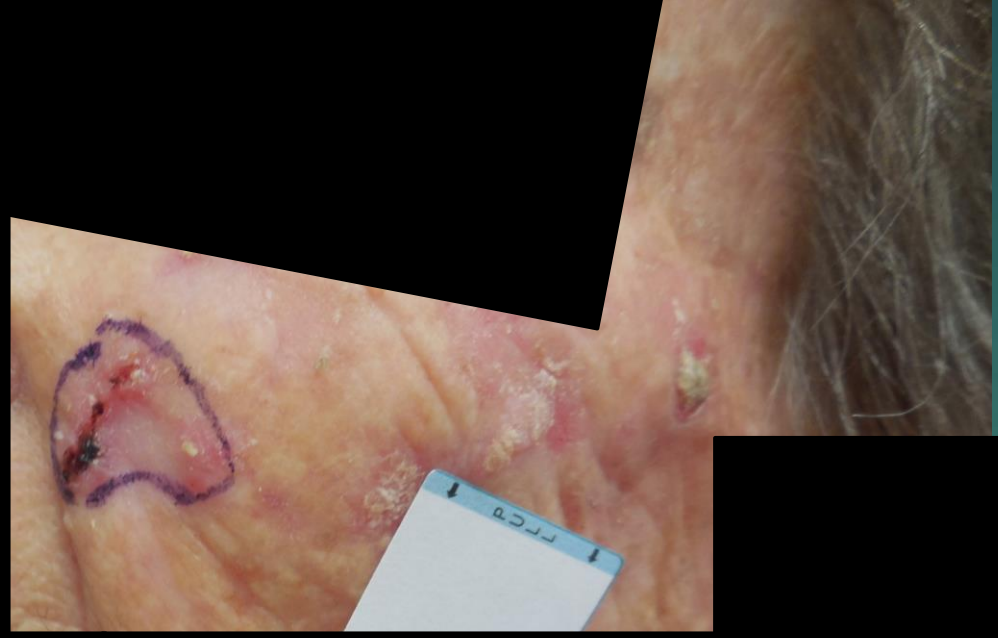
IEC :

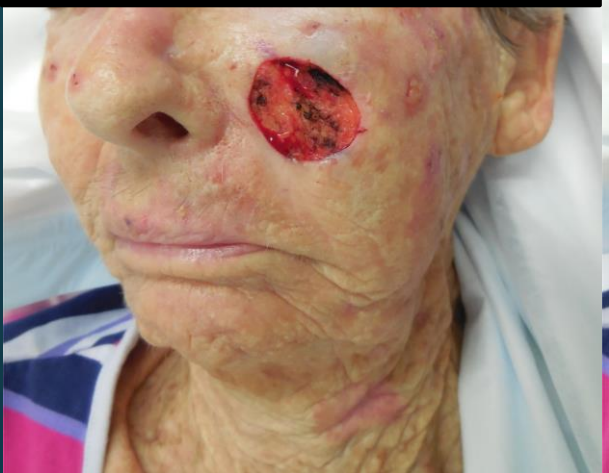
- Intrepidermal Squamous cell Carcinoma
- In situ SCC
- Bowen's Disease

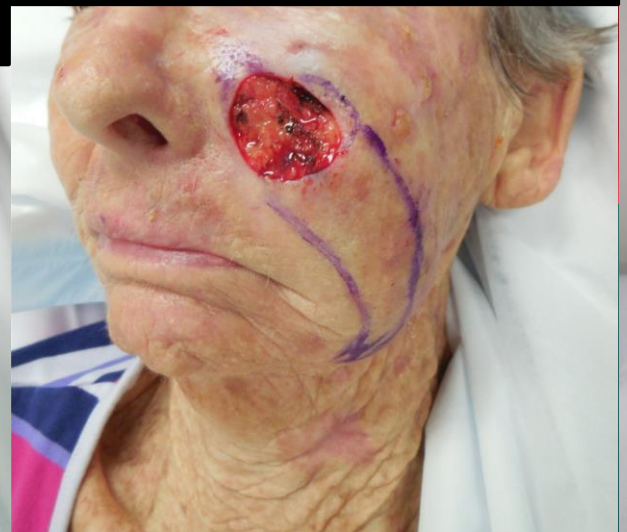
IEC

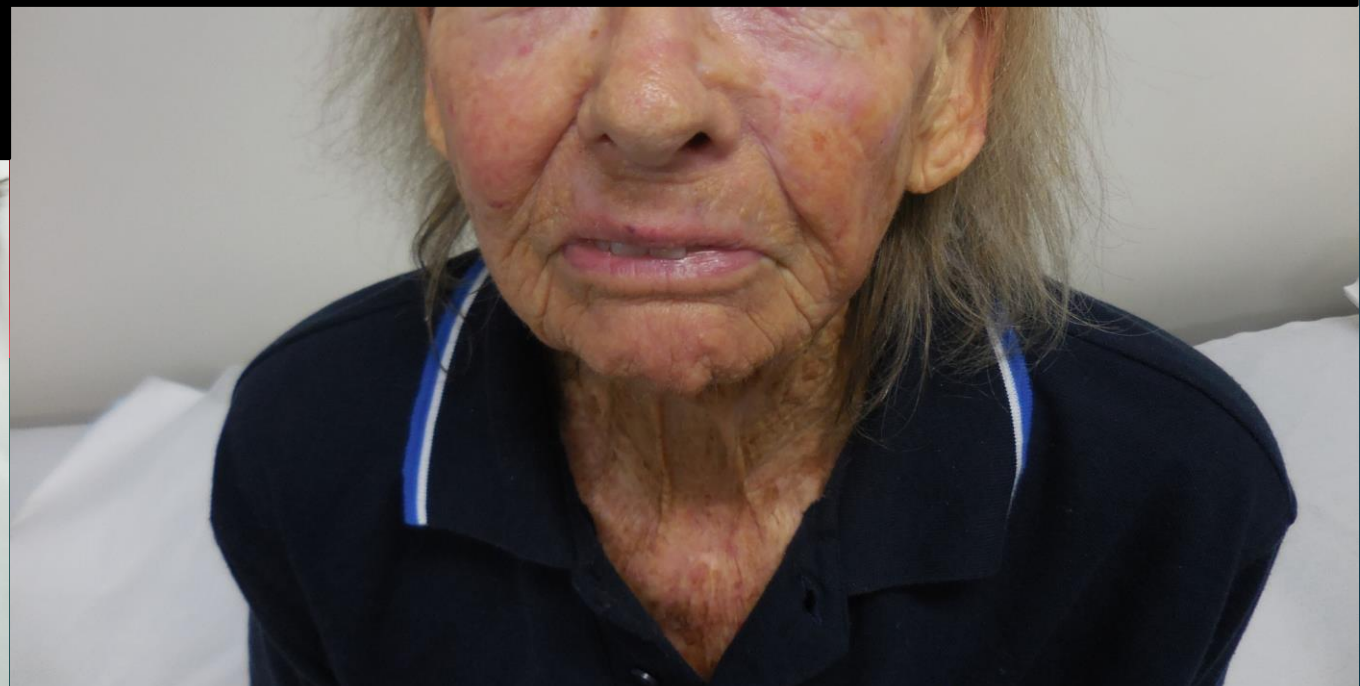


IEC

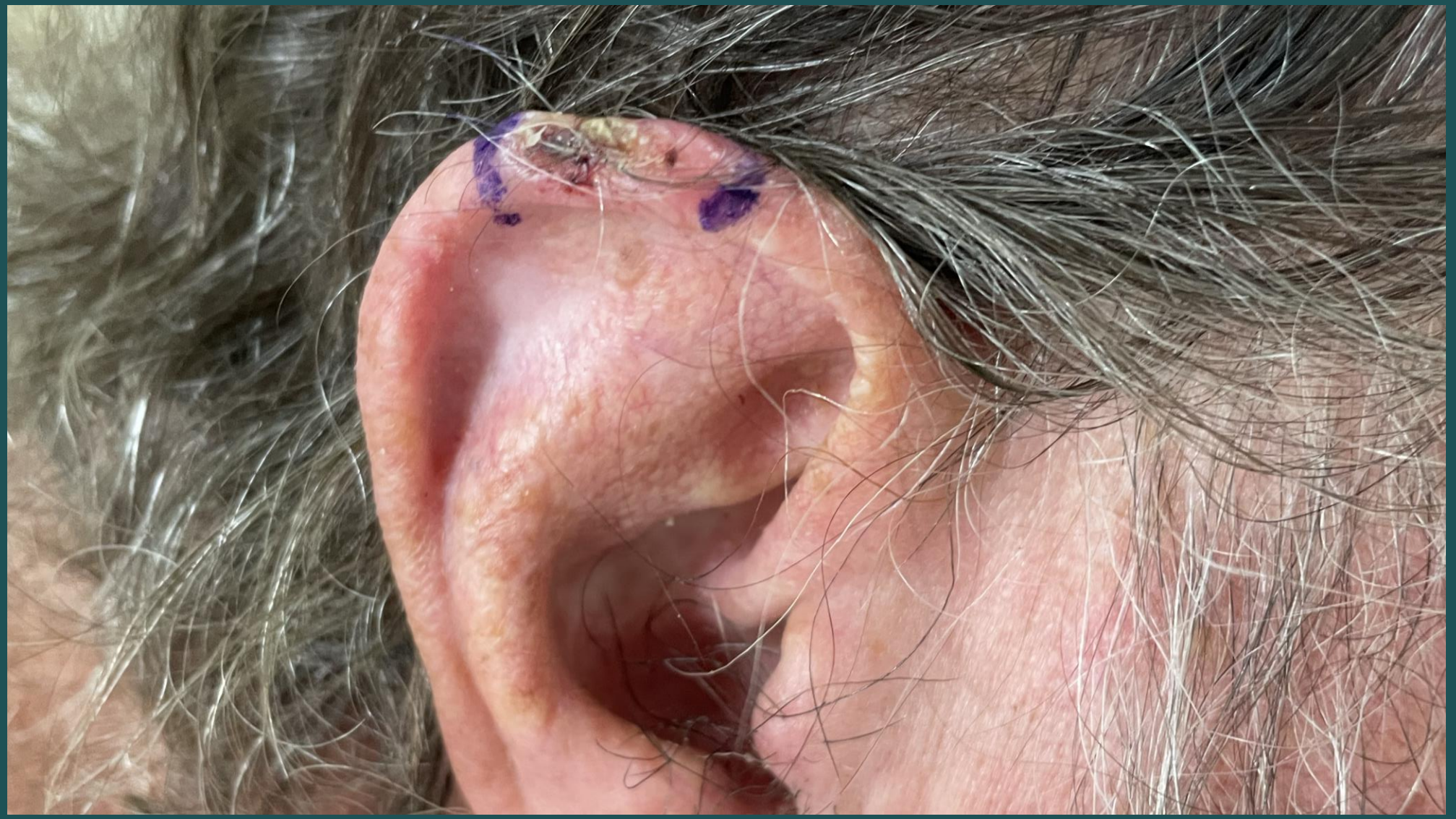


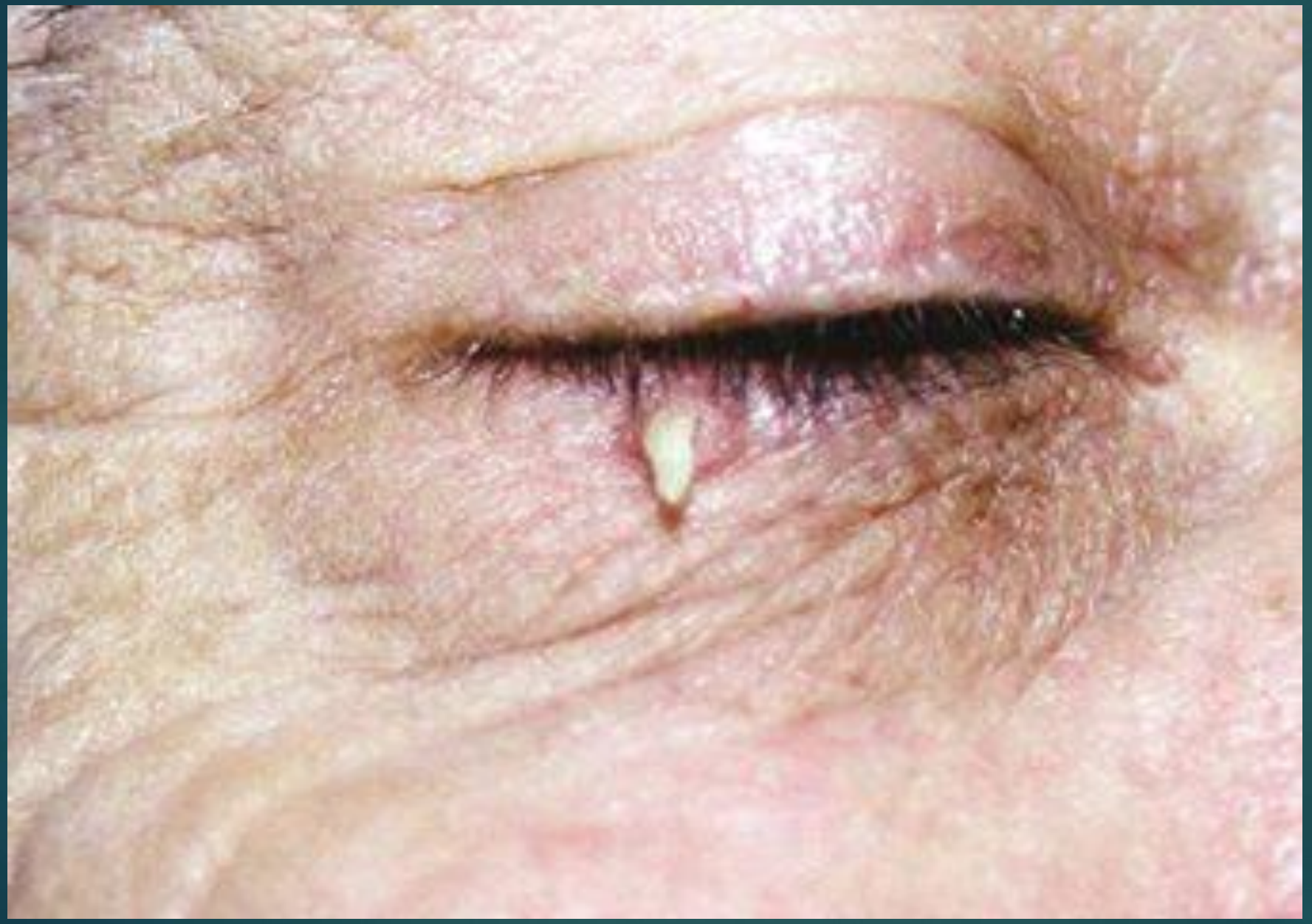


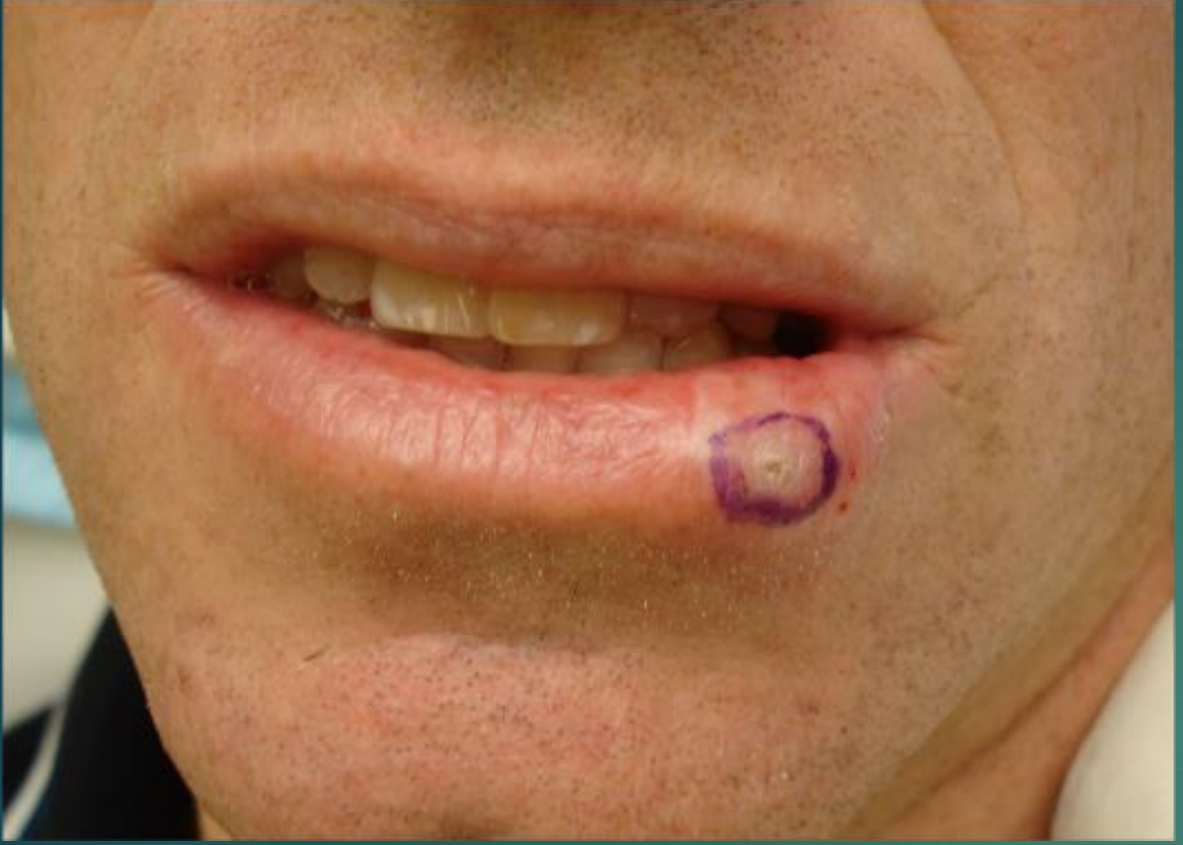


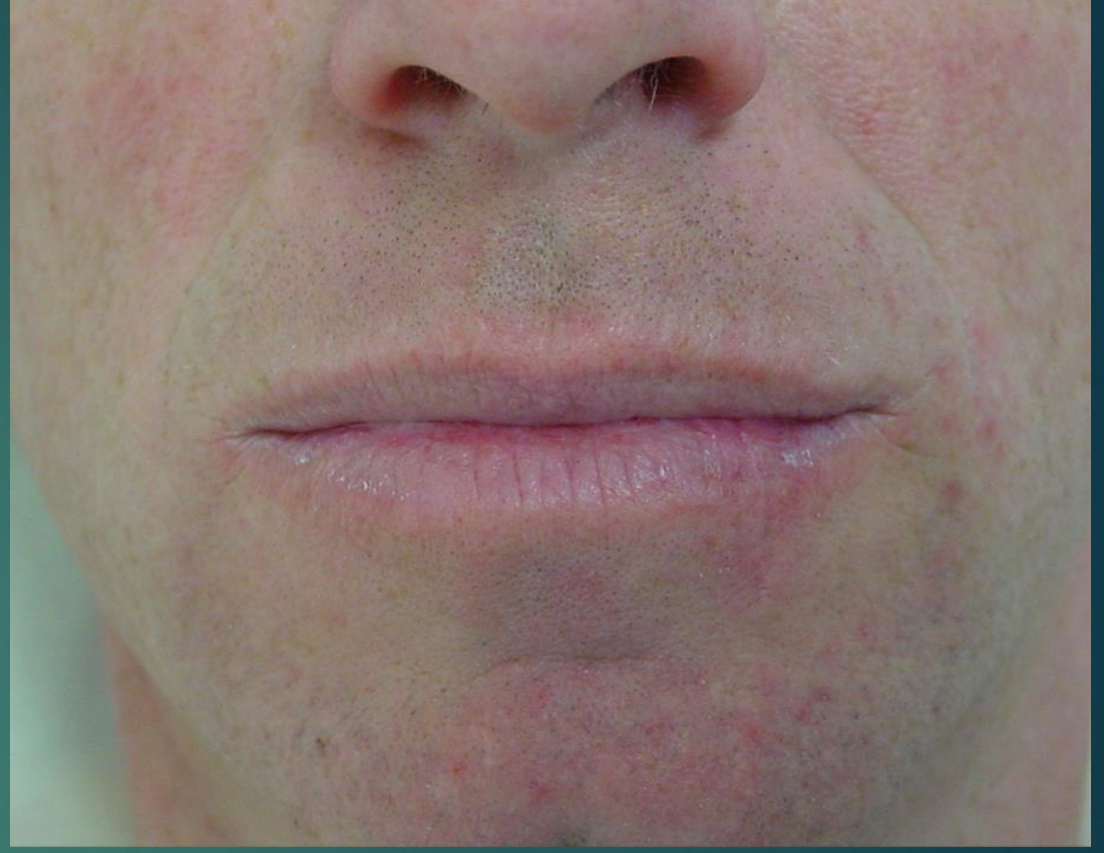


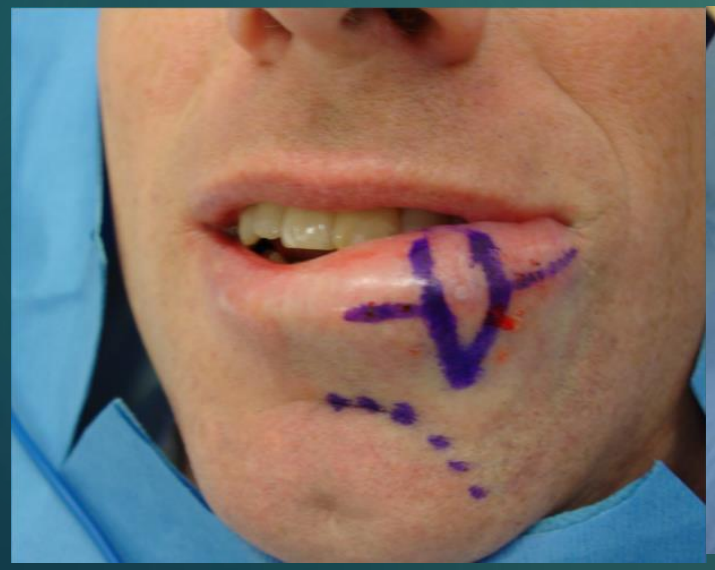
Squamous Cell Carcinoma : SCC

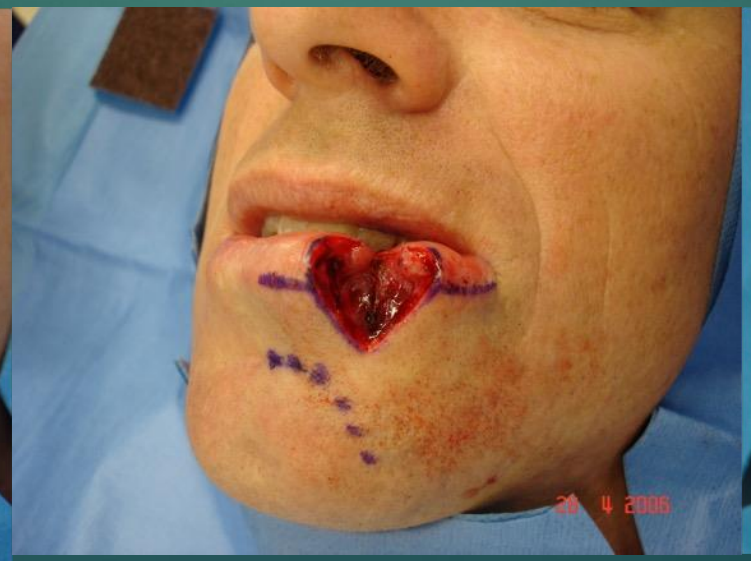








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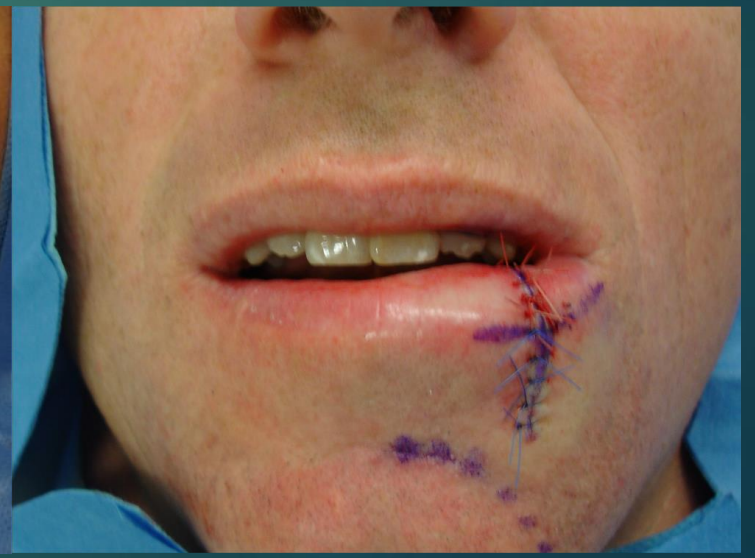
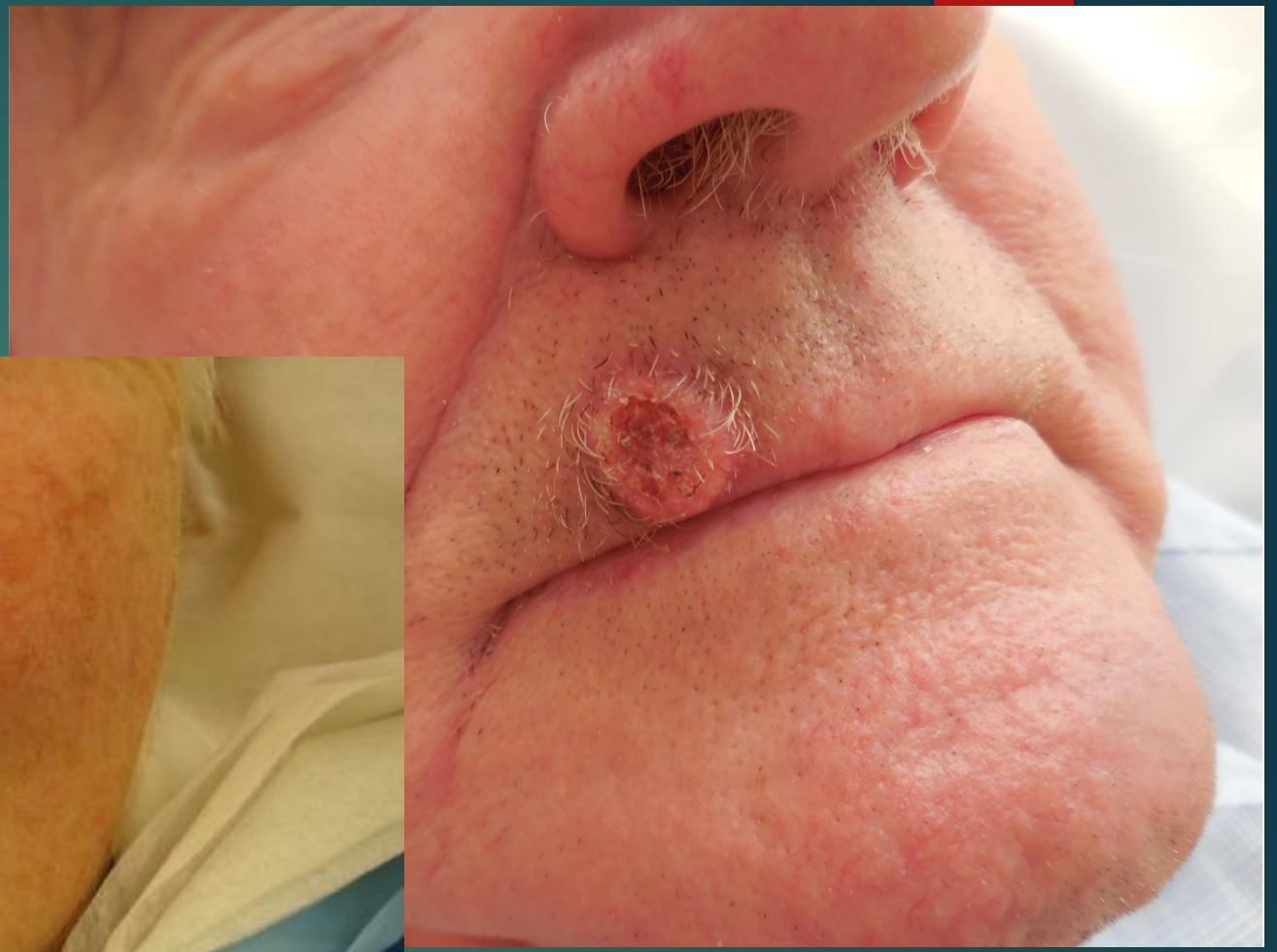
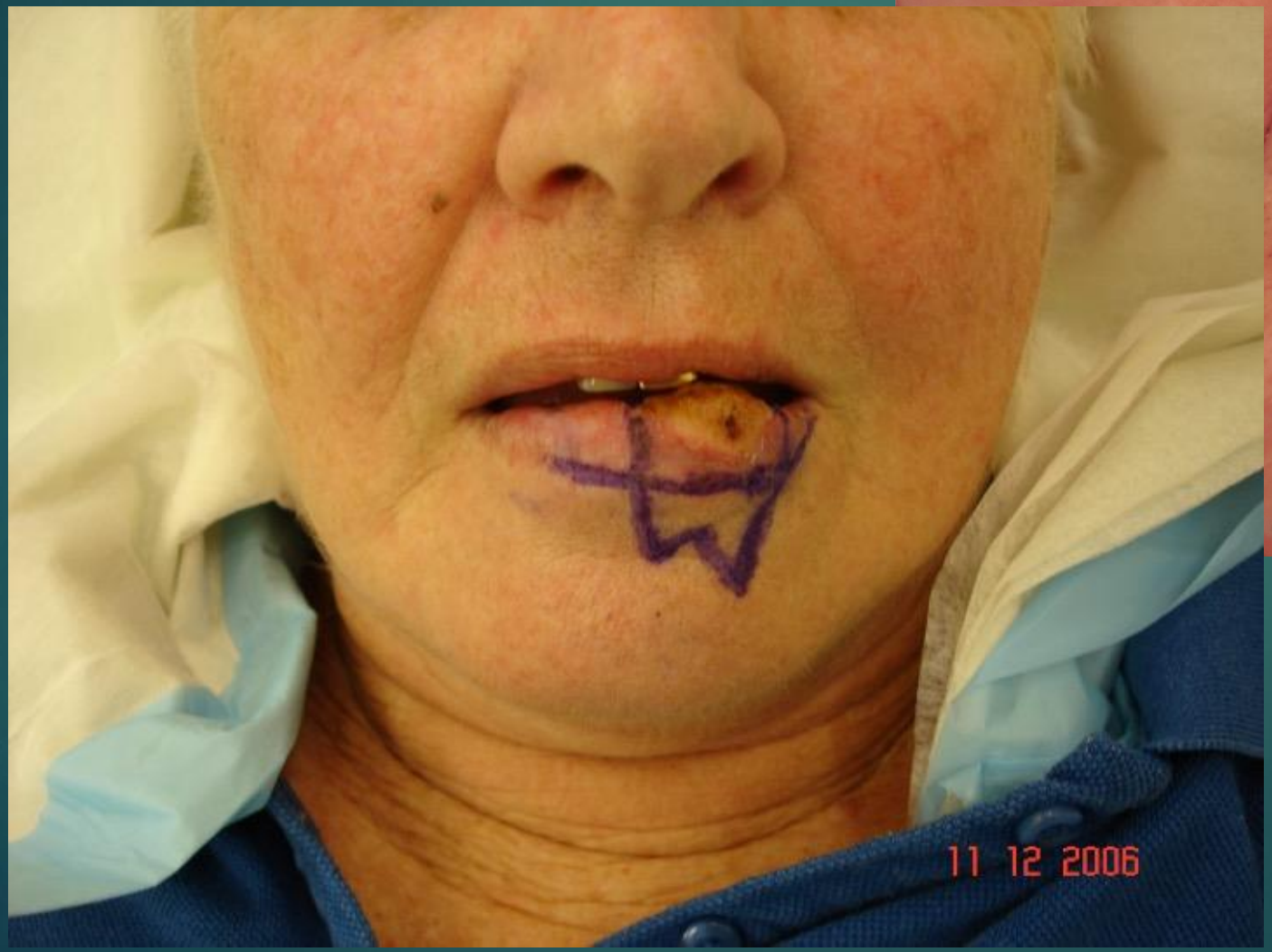
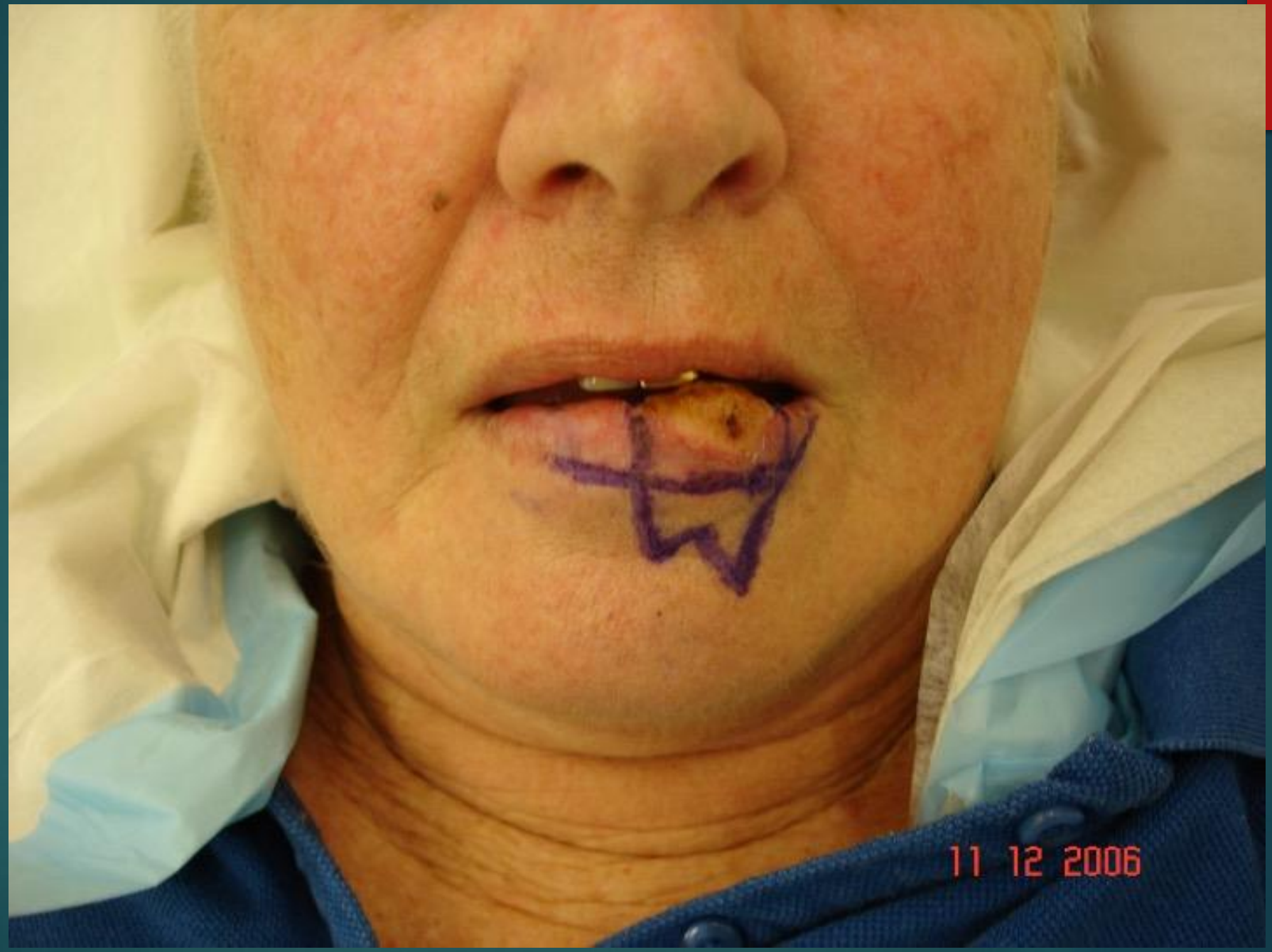


SCC vs Keratoacanthoma

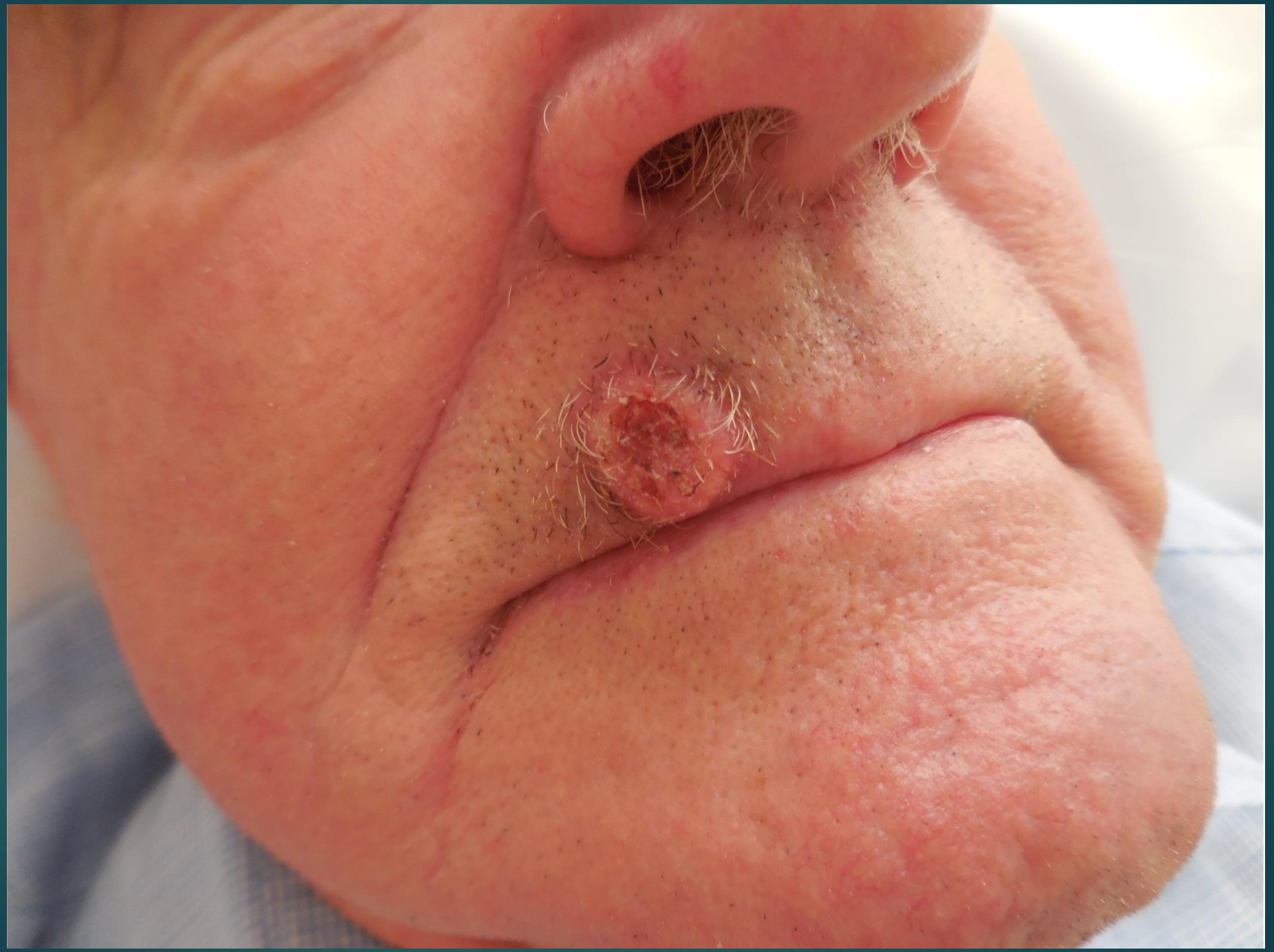




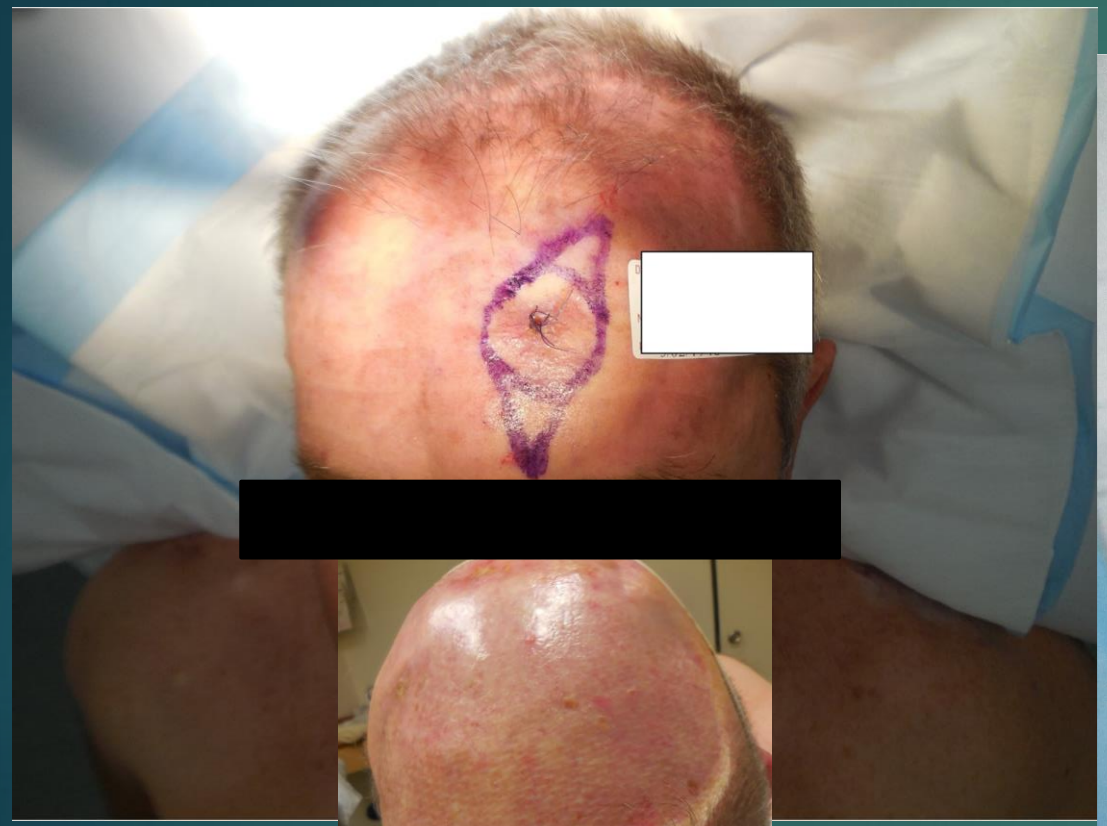
SCC

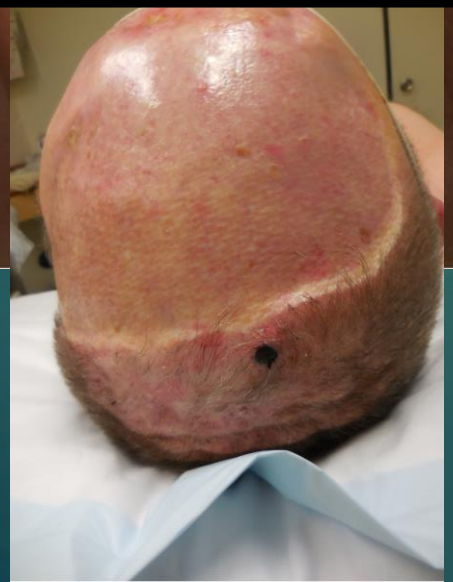


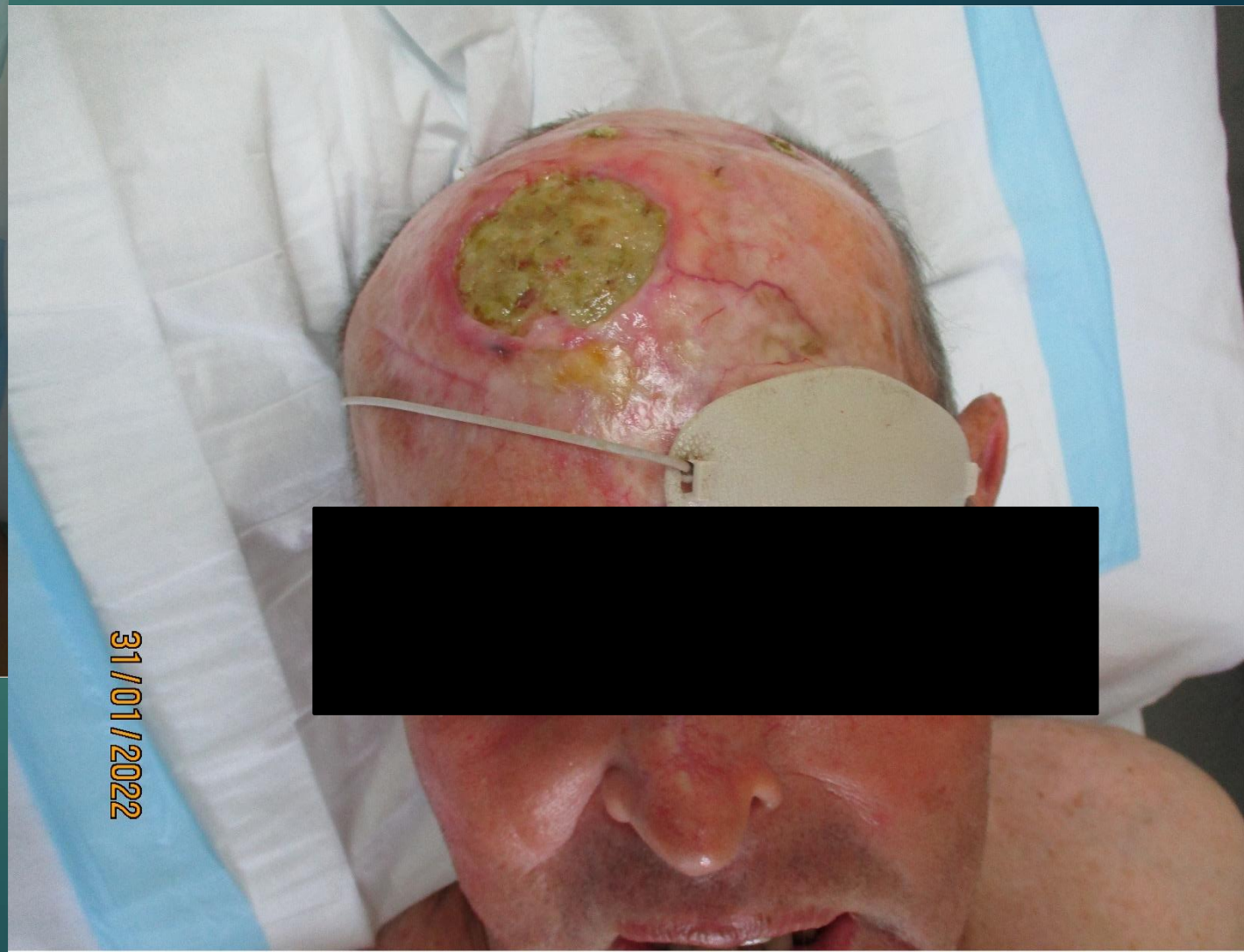
KA



SCC with PNI

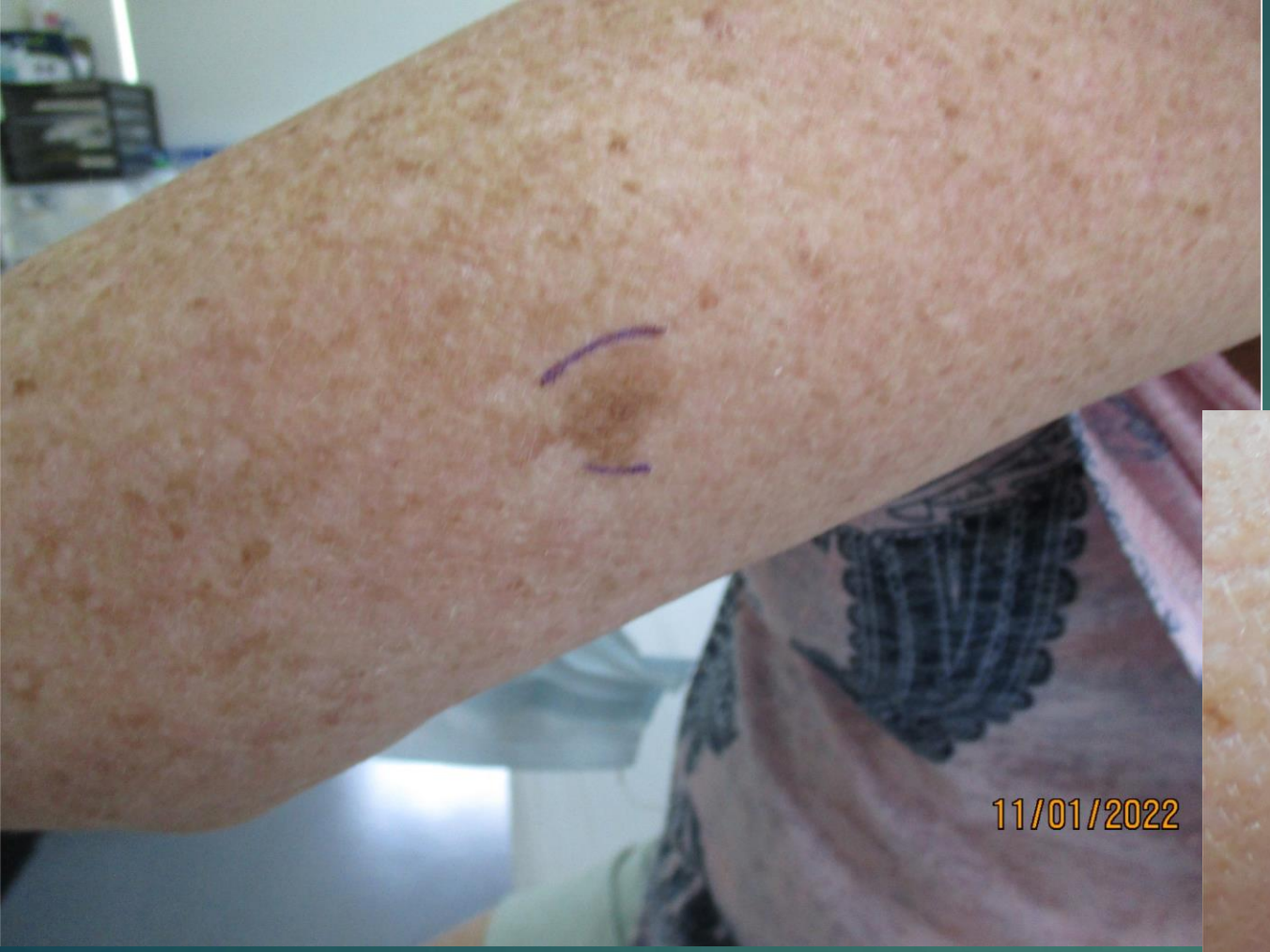






Melanoma

- In Situ, Level !,
- Hutchinson,s Melanotic Freckle (HMF) =
- Lentigo Maligna
- Lentigo Maligna Melanoma
- Superficial Spreading Melanoma
- Nodular melanoma
- Desmoplastic melanoma
- Neurotropic Melanoma
- Acral Lentiginous melanoma
- Subungual Melanoma
- Amelanotic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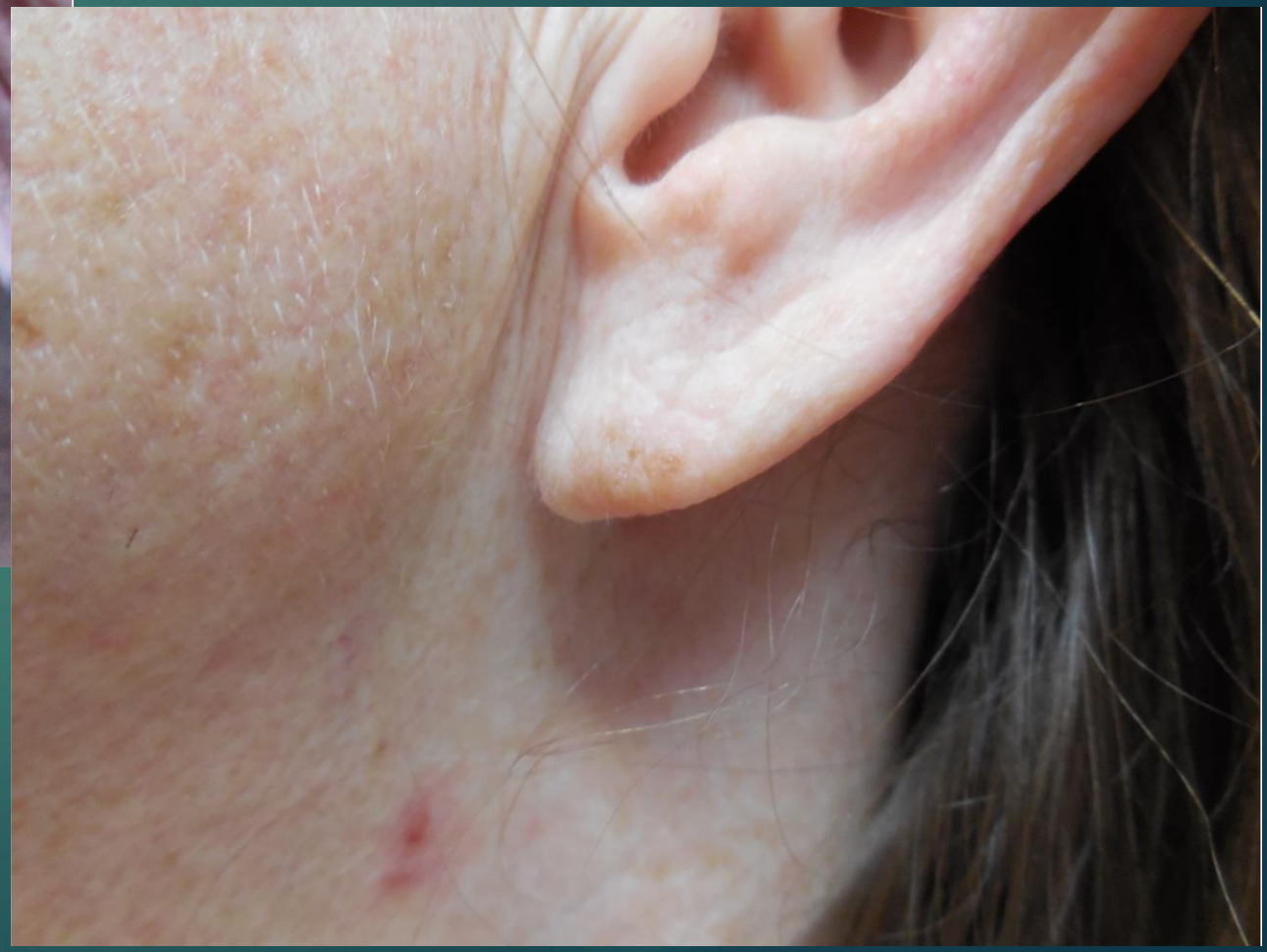
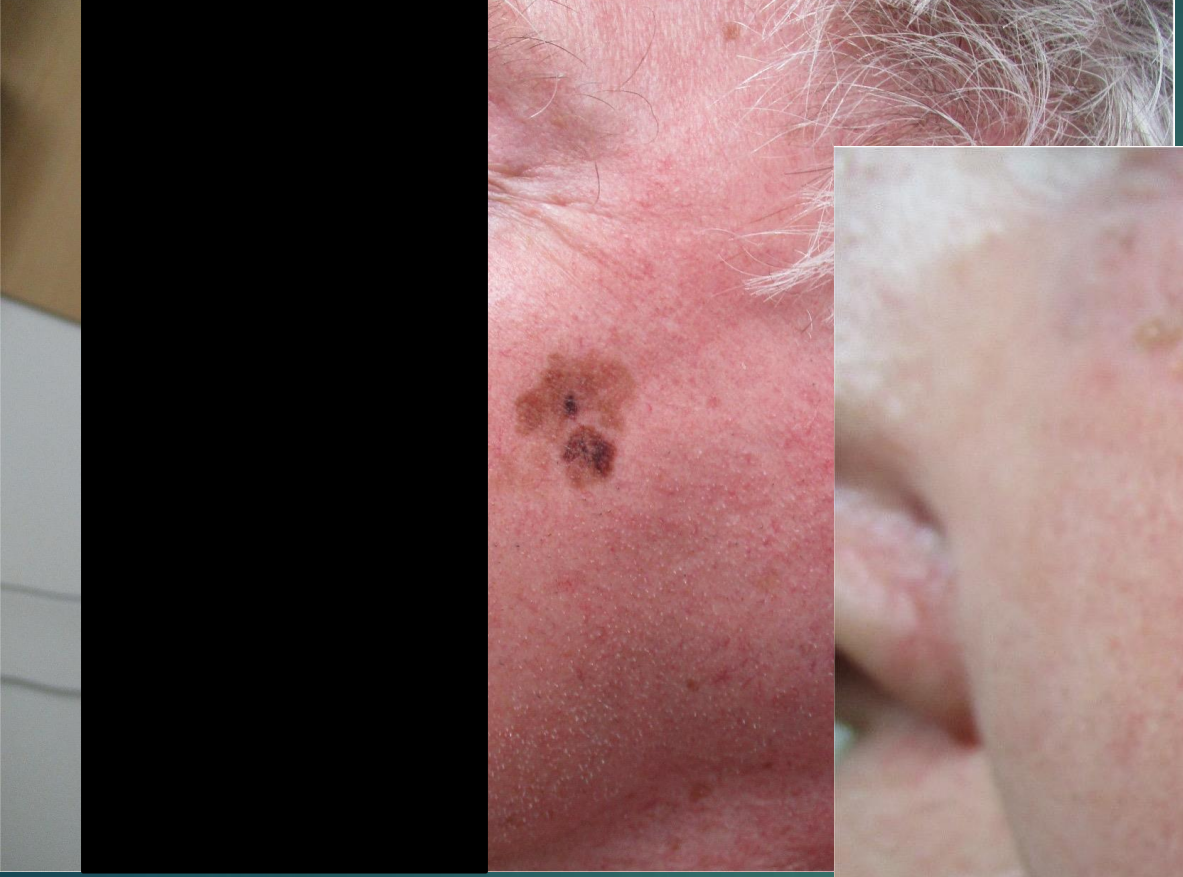
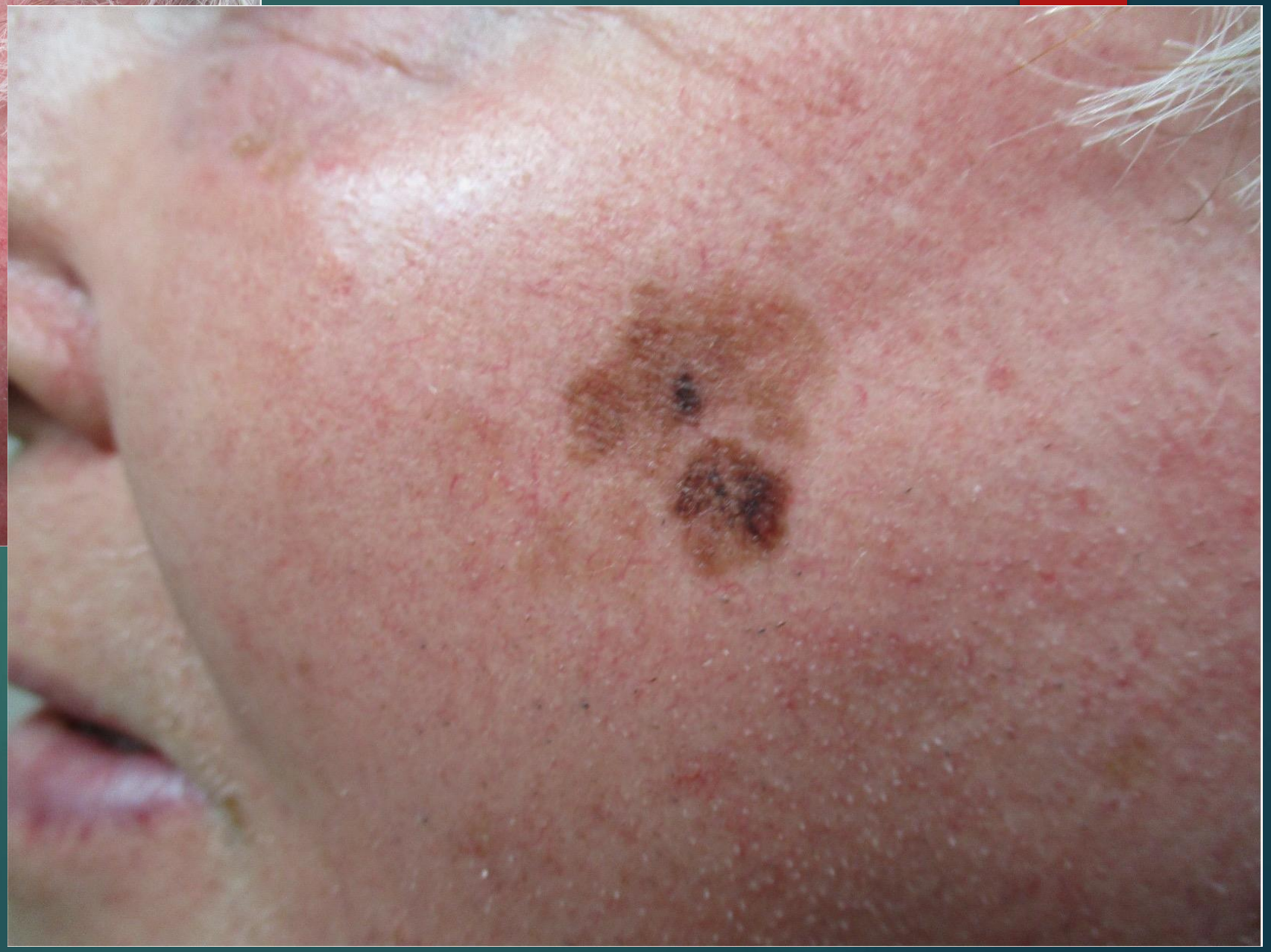
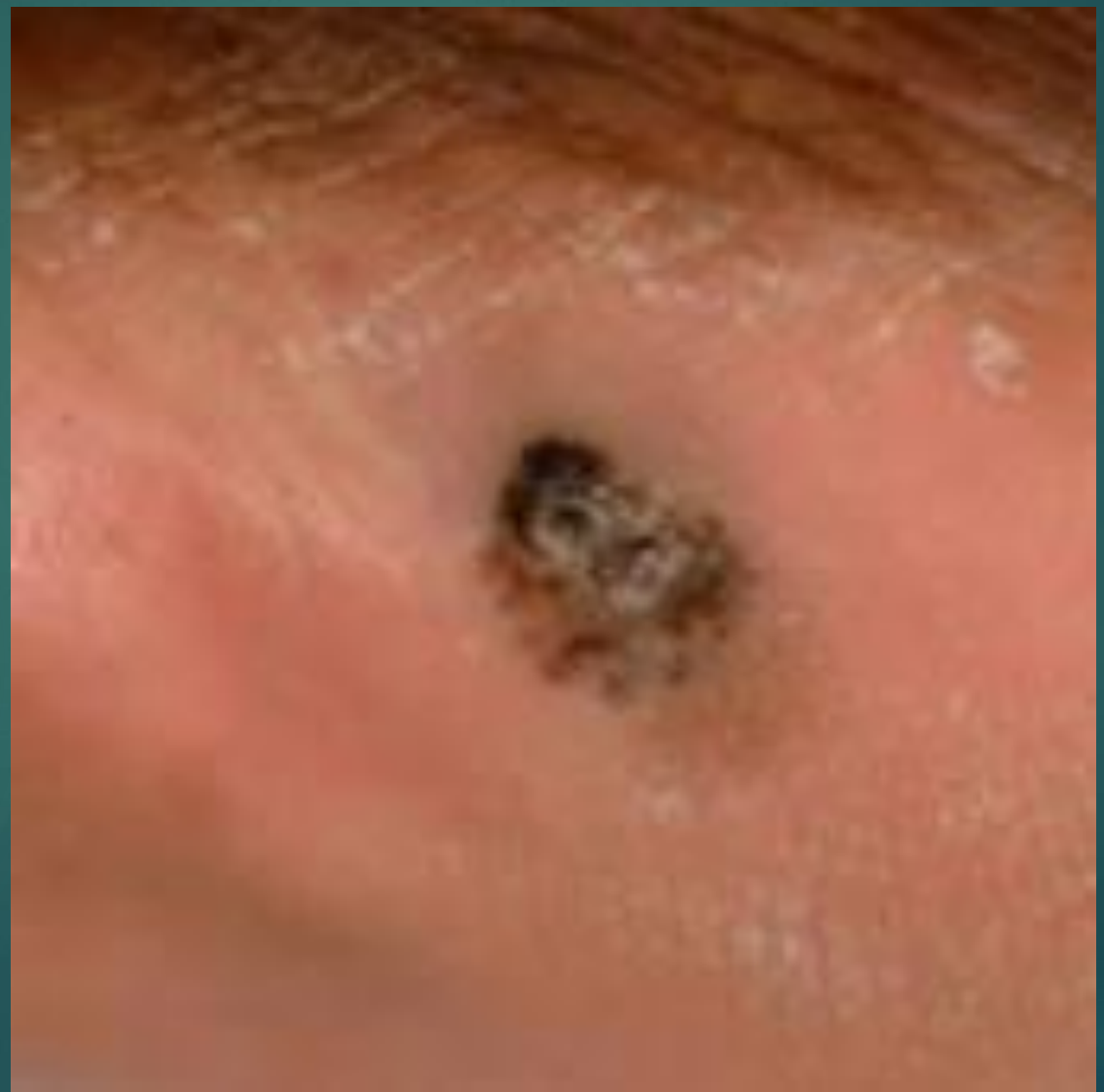


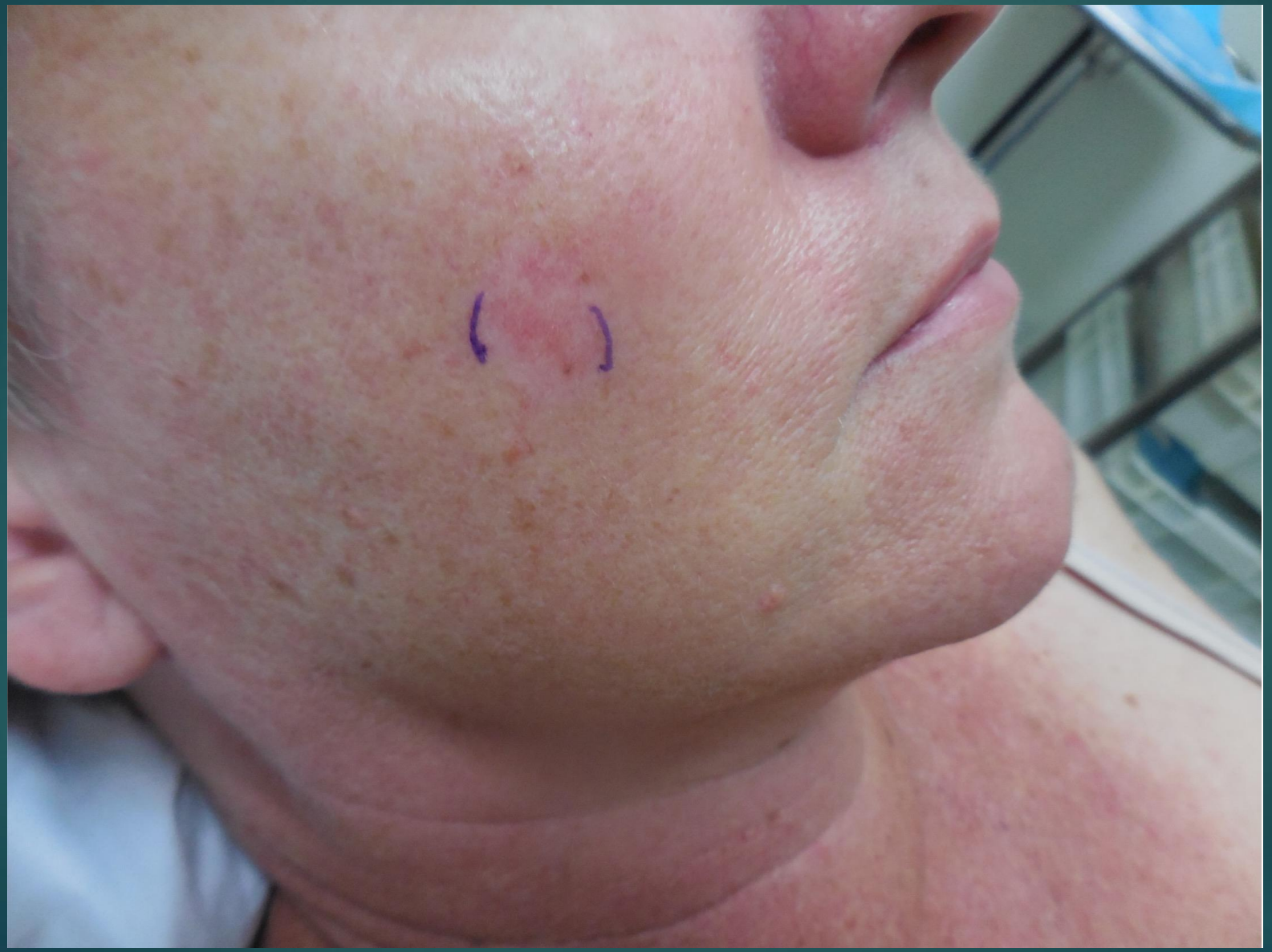


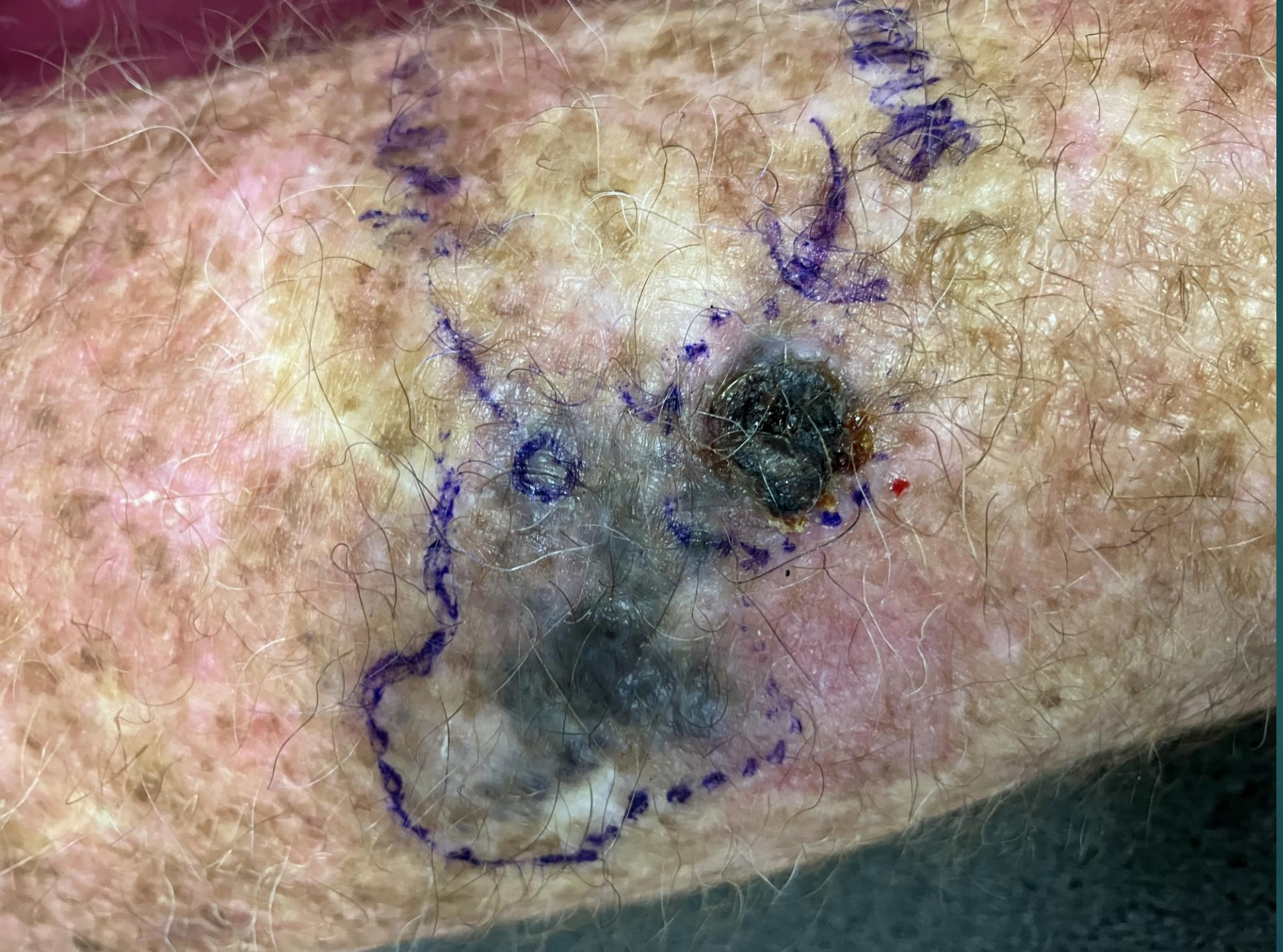


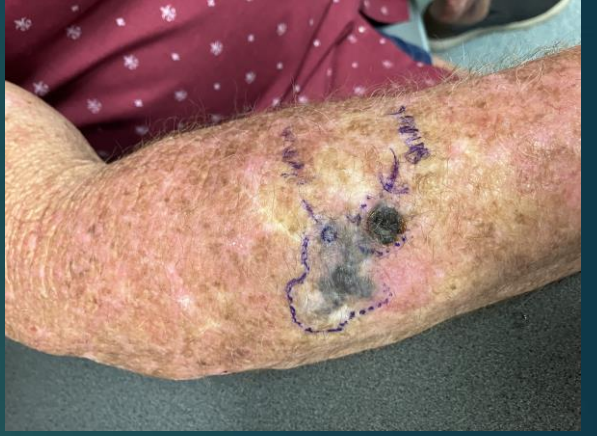
Acral Lentiginous Melanoma

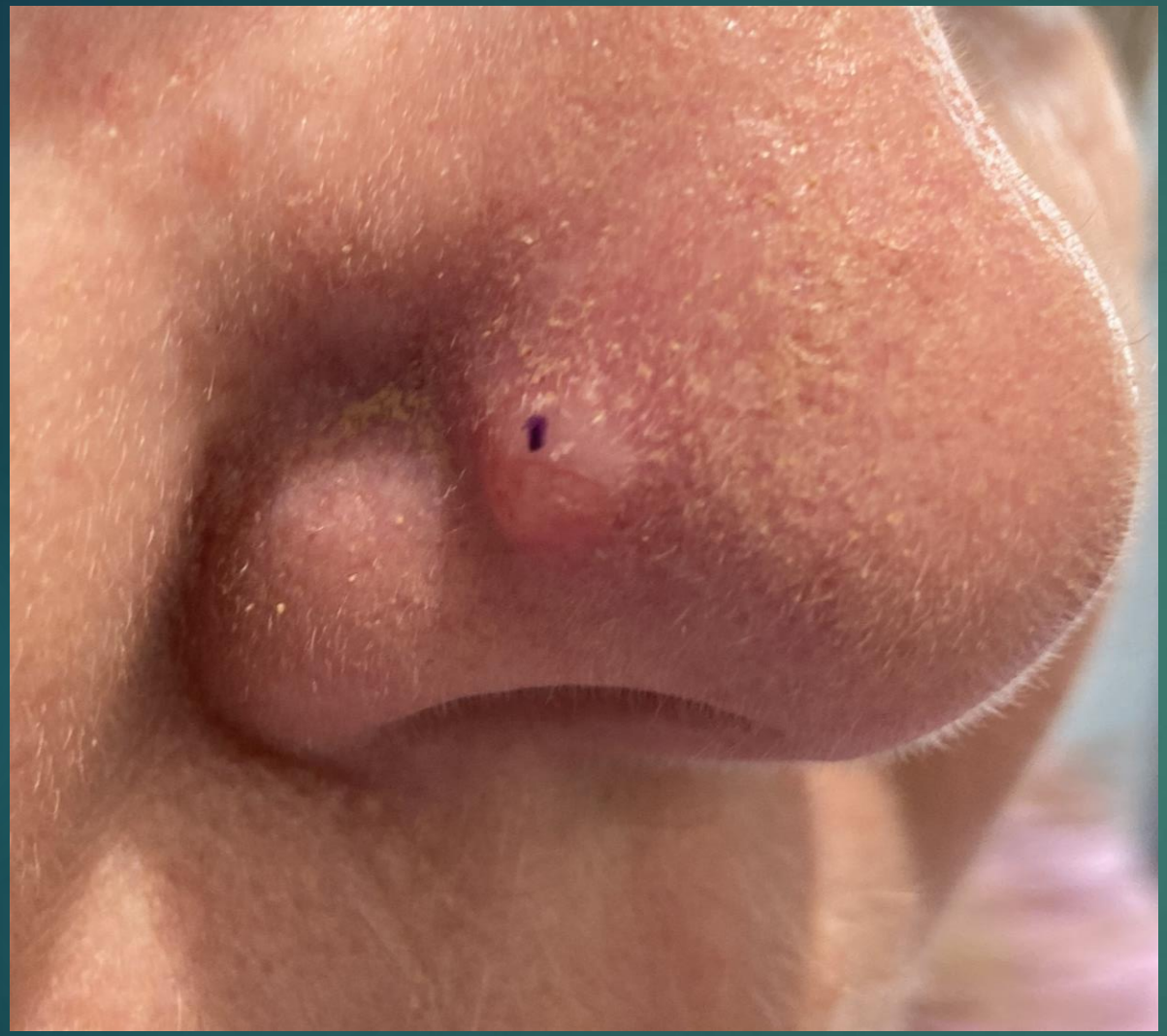


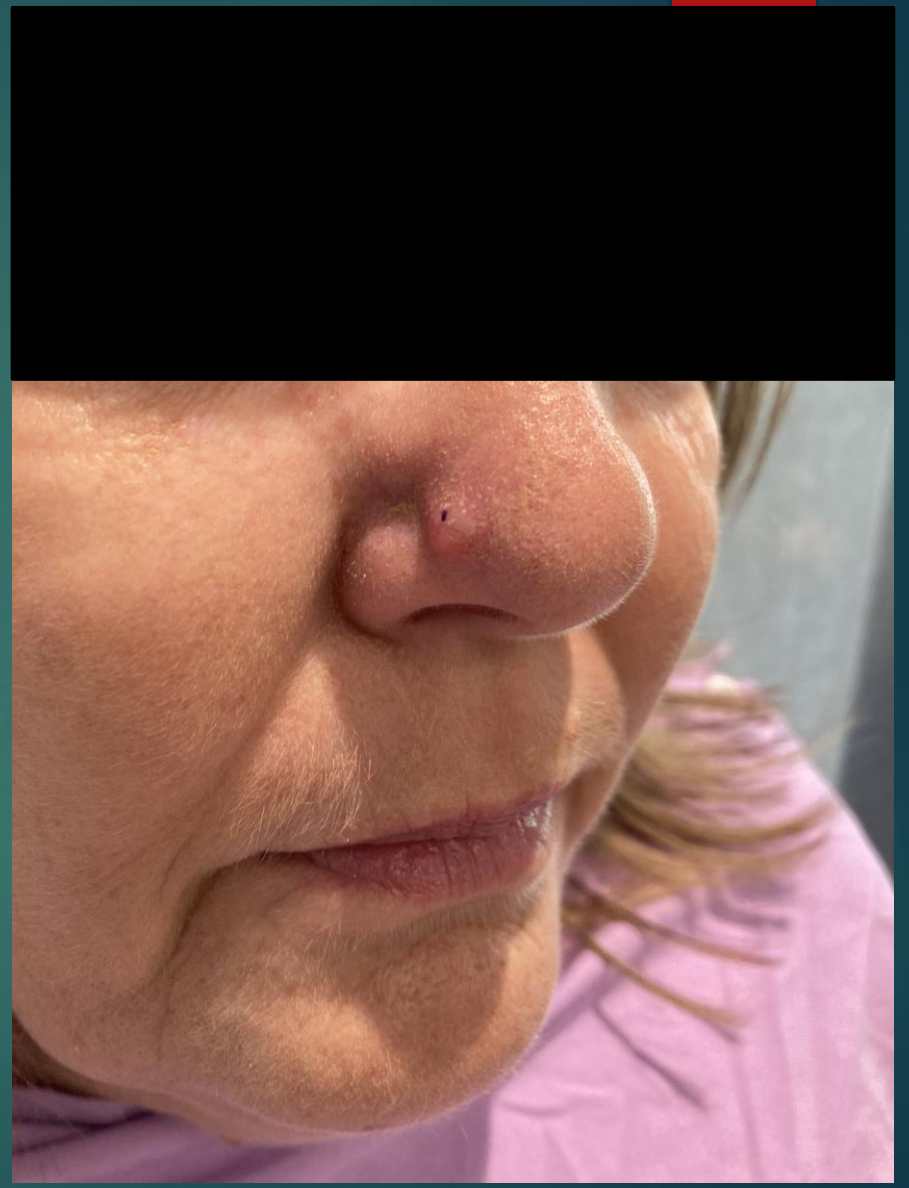
AMM

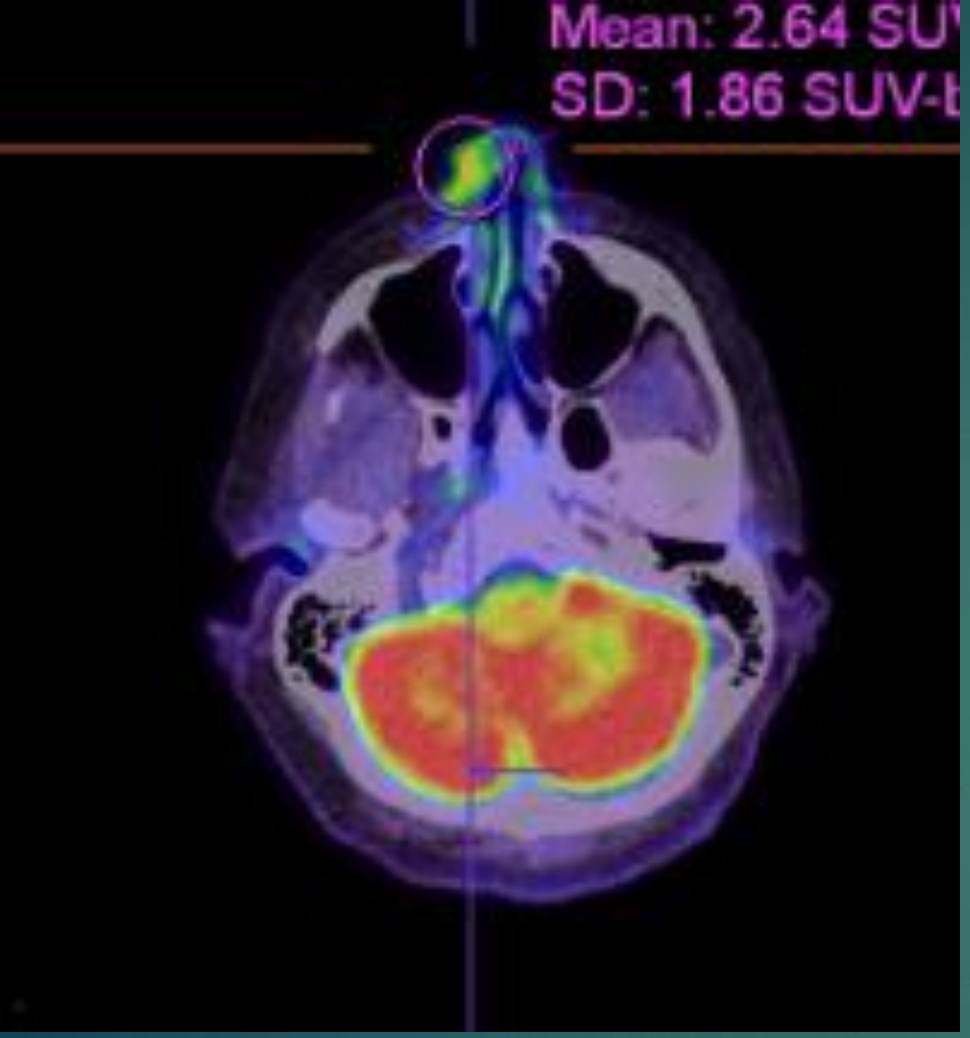


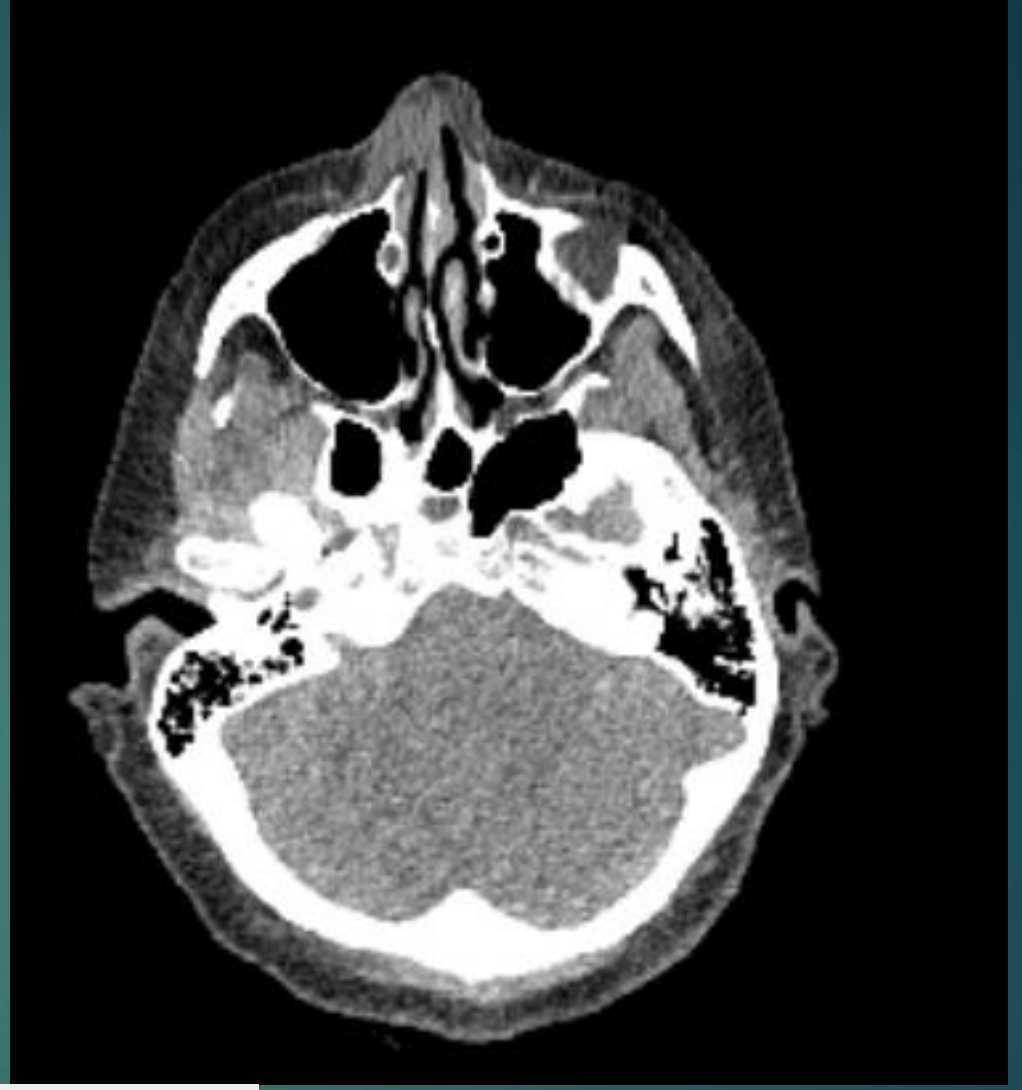












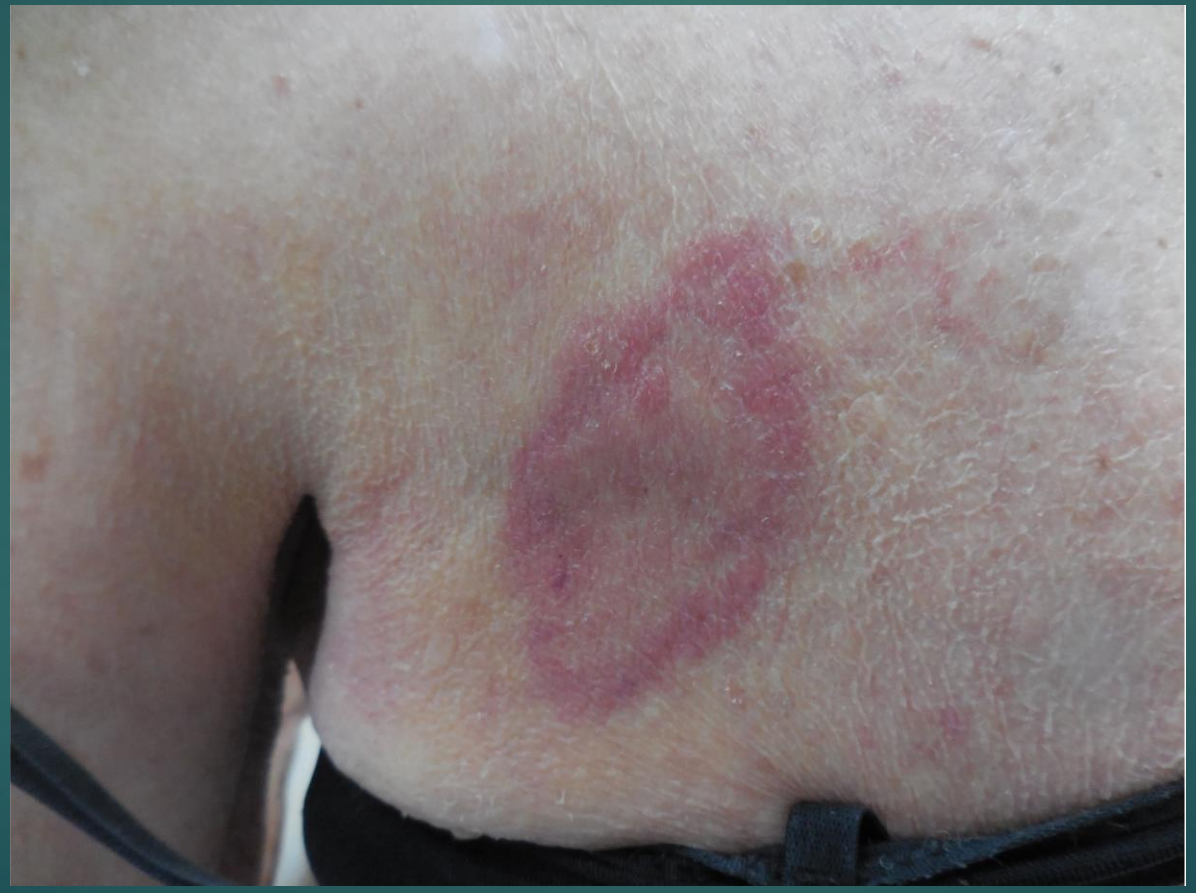
Comment:
1. Intense FDG avidity of the right nasal alar biopsy confirmed melanoma. FDG avidity of the bilateral nasolabial folds and nasal septum is likely physiological, although cannot be discerned from the metabolically active right nasal alar lesion. Local disease extent is better characterised on MR face 03/10/2024.
2. No FDG avid nodal or metastatic disease.
3. Intense FDG avidity of the larynx and upper cervical oesophagus is non-specific and may be inflammatory/infective. Clinical correlation is suggested. Direct endoscopy may be indicated.

MICROSCOPIC
R nose: The punch biopsy of skin incorporates epidermis to deep reticular dermis. Almost the entire dermis is infiltrated by a poorly differentiated malignancy. The tumour is composed of pleomorphic cells with enlarged, hyperchromatic nuclei with occasional distinct nucleoli. Binucleate and multinucleate tumour cells are present. Two (2) atypical mitoses per square millimetre is seen.
The lesional cells show strong diffuse positivity for SOX10. They show a variable pattern of staining for S100 protein; with strong nuclear positivity in the papillary dermis nests, and weak patchy granular cytoplasmic reactivit in the deep dermal area. There is focal and patchy 1+ staining with PRAME.
SMA, CD10 and CK34 are negative.
INI-1 and H3K27me3 are retained in the nuclei with a normal pattern.
No surface ulceration, regression, neurotropism, desmoplasia, perineural invasion, lymphovascular space permeation, tumour infiltrating lymphocytes, associated benign melanocytic lesion or microsatellite nodule can be identified.
The lesion is transected at the peripheral and deep aspects of the biopsy.
BRAF immunohistochemistry is being obtained and a supplementary report will follow.

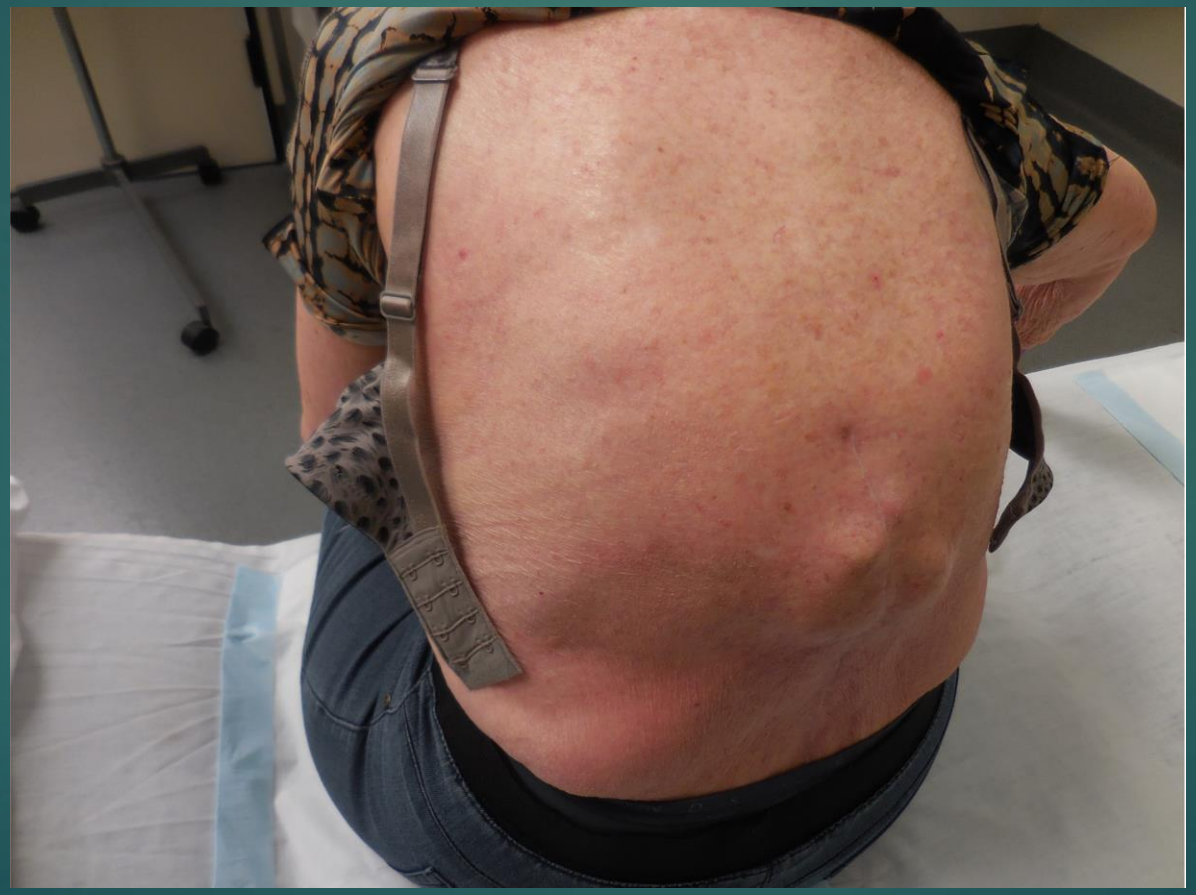
Histo

SUMMARY
R nose: Dermal melanoma (at least 1.5mm thick); BRAF immunohistochemistry pending.

Metastatic breast cancer



Metastatic Skin Cancer..after Rx



Referral

- Pre biopsy or excision photo…also post photo if flap etc
- Good light , IN FOCUS
- 5cm (What is it),

…. 10 cm, 30 cm (Where is it)..and send most helpful ?all

- Diagram if need
- History..speed of growth etc…timeline?
- What do you want?..lesion for treatment, solar damage for assessment etc
- Why refer…eg you have already done etc etc
- Helpful info..eg immunosuppressed, on blood thinner , immobile, lives alone etc etc

Key points

- Very common
- Be alert..history may mislead
- Good light and magnification (Dermatoscope)
- ABCDE (Assymetry, Border, Colour variation, Diameter (6mm), Evolving…size/ shape /colour)
- Suspect until proven otherwise : Refer/Biopsy..does it look like it shouldn't be there!
- PLS take photo pre biopsy..5,10, 30 cm..good light, check in focus!
- Lymph nodes

Nonsurgical Management of NMSC

Adj A/Prof David Francis

MBBS FACD FACMS GAICD

Accredited in Mohs Micrographic Surgery

Clinical Lead
Dept of Dermatology
RBWH

Acknowledging :

Nonsurgical Treatments

- Topical 5Fluorouracil
- (Salicylic Acid, Chemo wraps, Calcipotriol, topical retinoid)
- Topical Imiquimod
- Photodynamic therapy
- Cryotherapy? Curette and cautery
- Radiotherapy
- Systemic drugs – immunotherapy, retinoids, vitamin B3, interferon
- Laser Therapy
- etc

Suitable for nonsurgical treatment

- Solar keratosis
- IEC (Bowens disease, SCC in situ)
- Superficial BCC
- Some nodular BCC
- Mixed presentation/pre-operative cleanup when delay in surgical treatment is acceptable
- Avoidance of surgical morbidity
- No inappropriate delay in inevitable surgical treatment eg. sclerotic BCC
- (? HMF..Imiquimod)

Patient Assessment

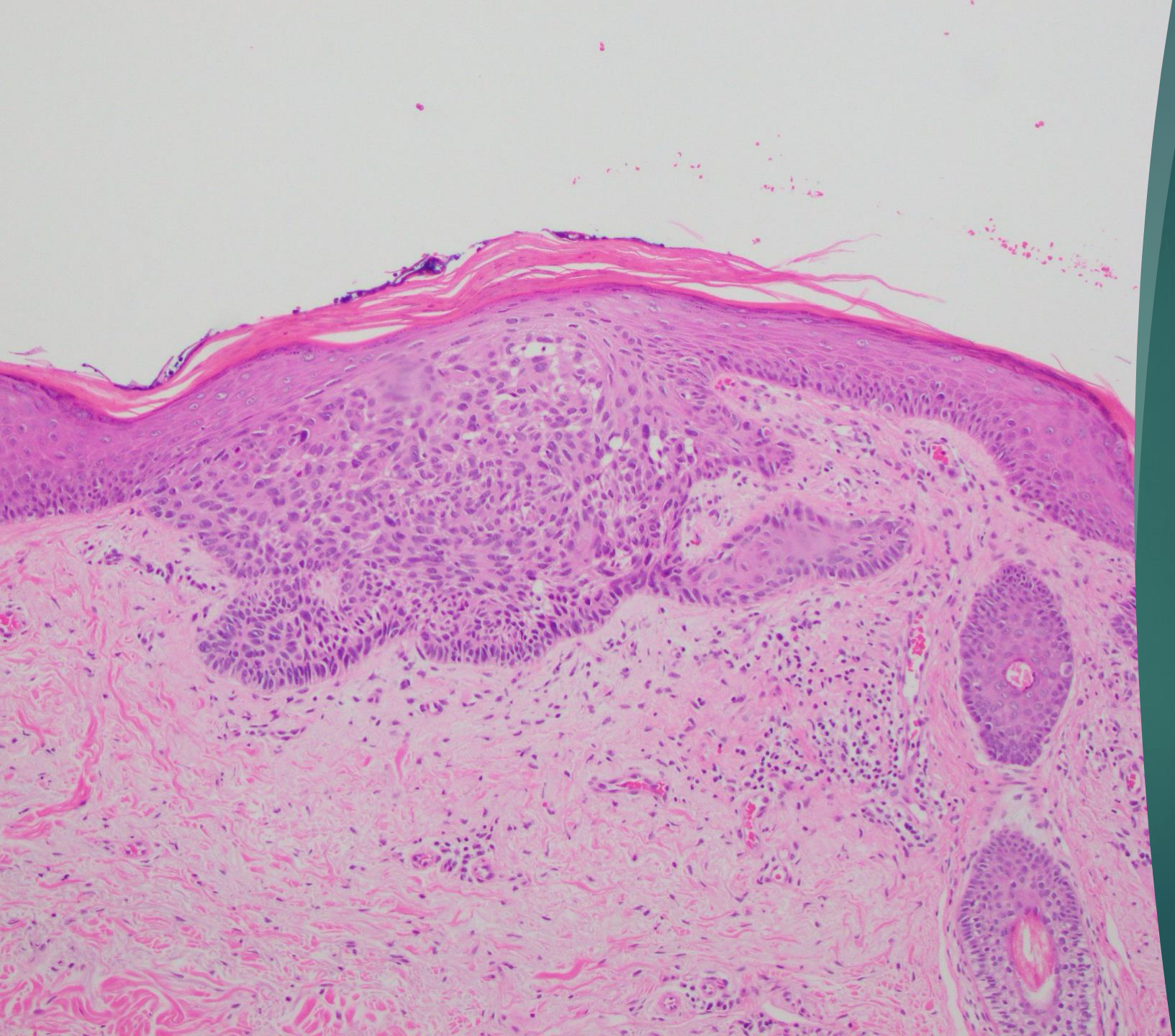
- Age
- Co-morbidity/general health/immunosuppression
- Anatomical site
- Histology
- Clinicopathological correlation
- Consideration of down-side of non-surgical treatment against down-side of surgical treatment
- Treatment failure of non-surgical treatments..What are outcomes of recurrence
- Likely simple or complicated surgical plan
- Unnecessary morbidity associated with surgical treatment
- How much trouble can I get myself into if it doesn't work!

Solar Keratosis

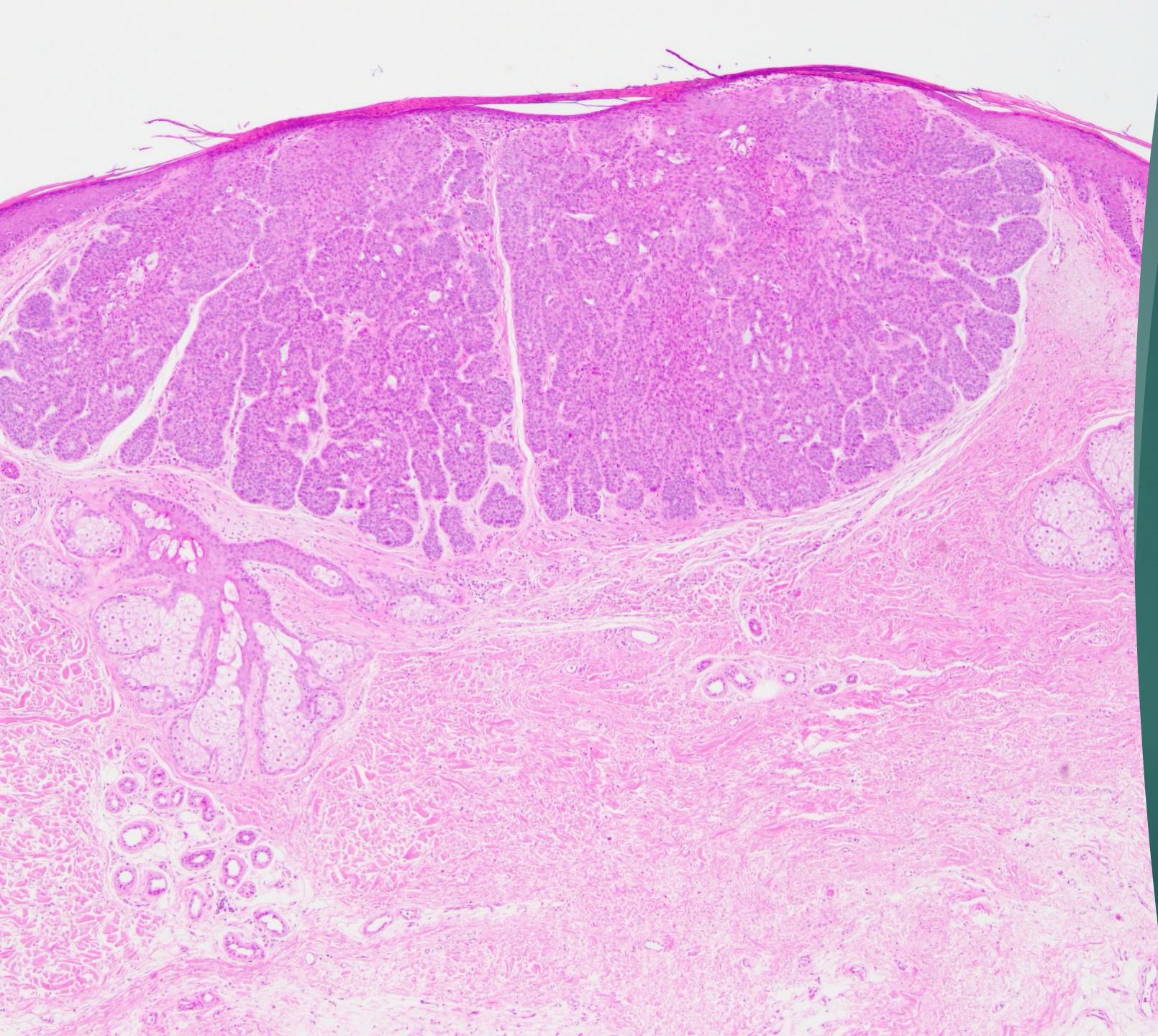
- Approximately 1 in 100 per year become SCC
- Not a skin cancer but frequently associated with BCC/SCC/IEC
- ?masking more important lesions
- A few or Field issue..

Basal Cell Carcinoma

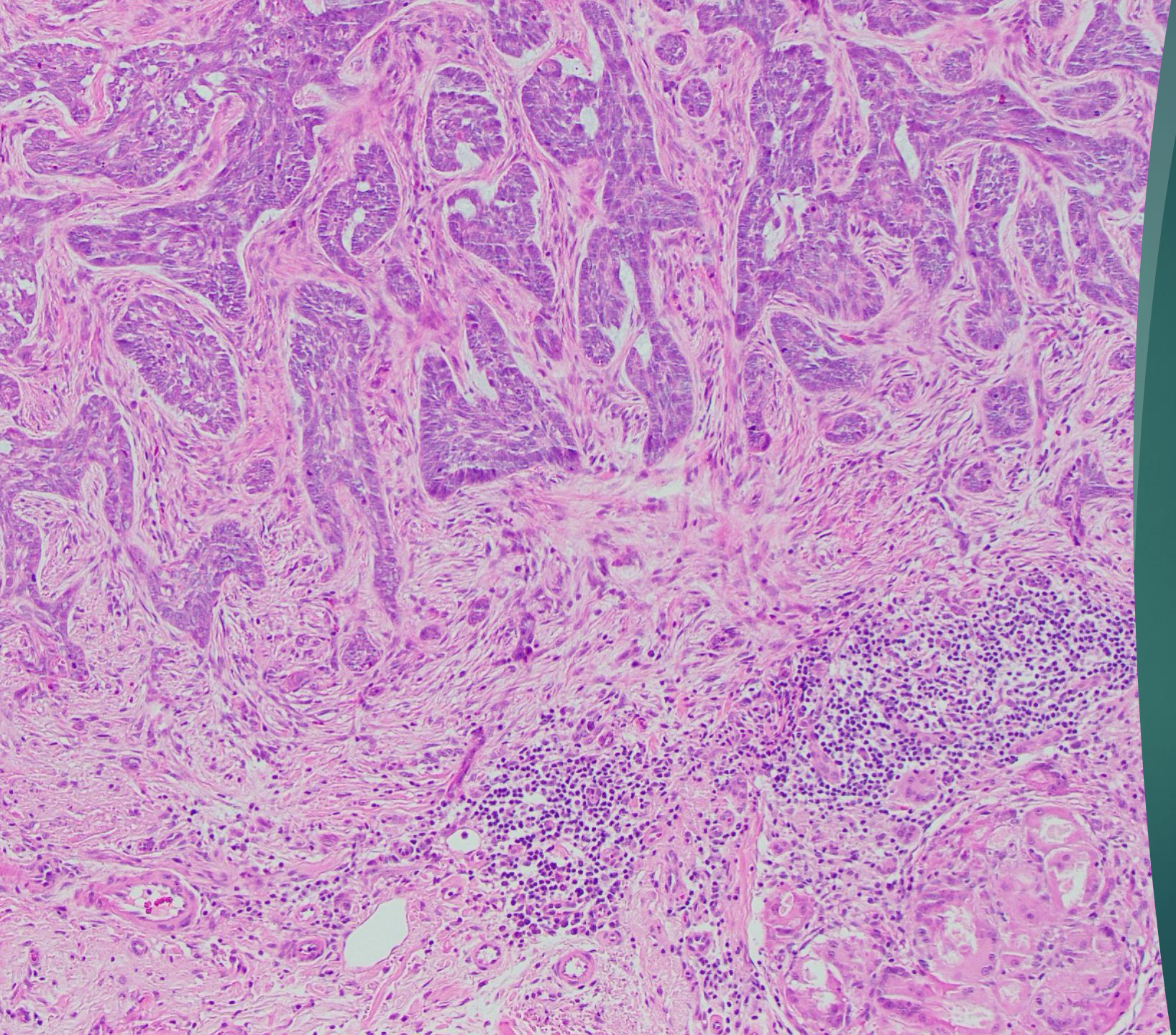
- 70% of skin tumours
- Approximately half of all Australians will develop a BCC before the age of 70 ……(?1 in three by age 50)
- Superficial, nodular, cystic, micro-nodular, pigmented, adenoid, infiltrating, sclerosing, keratotic, infundibulocystic, basisquamous, appendageal variants
- Rarely metastatic (0.05%)
- Epidermal/superficial dermal involvement = clinical changes
- Excision margin involvement likely recurrence
- Remember eyelids, behind ears, scalp etc



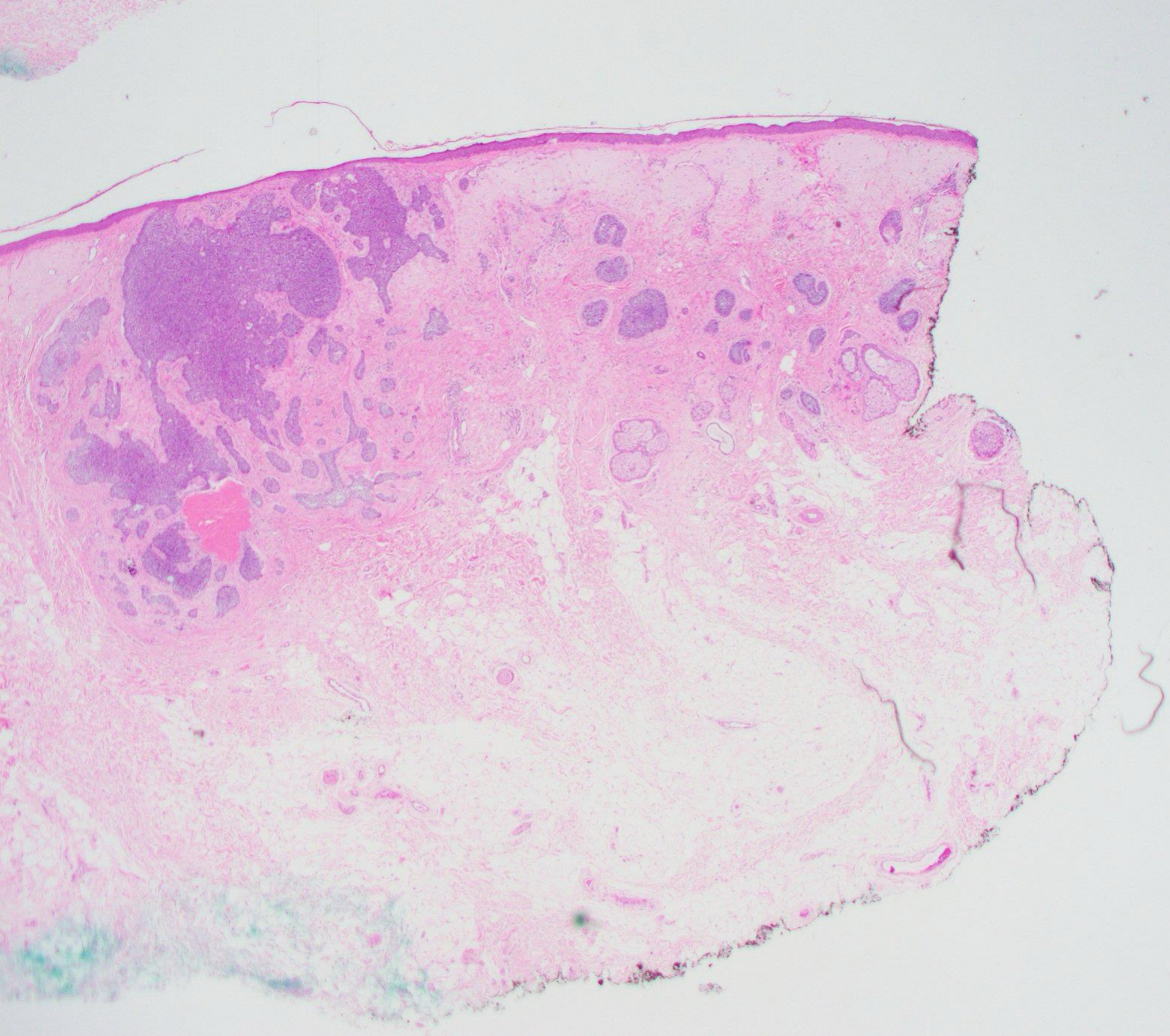
Superficial BCC



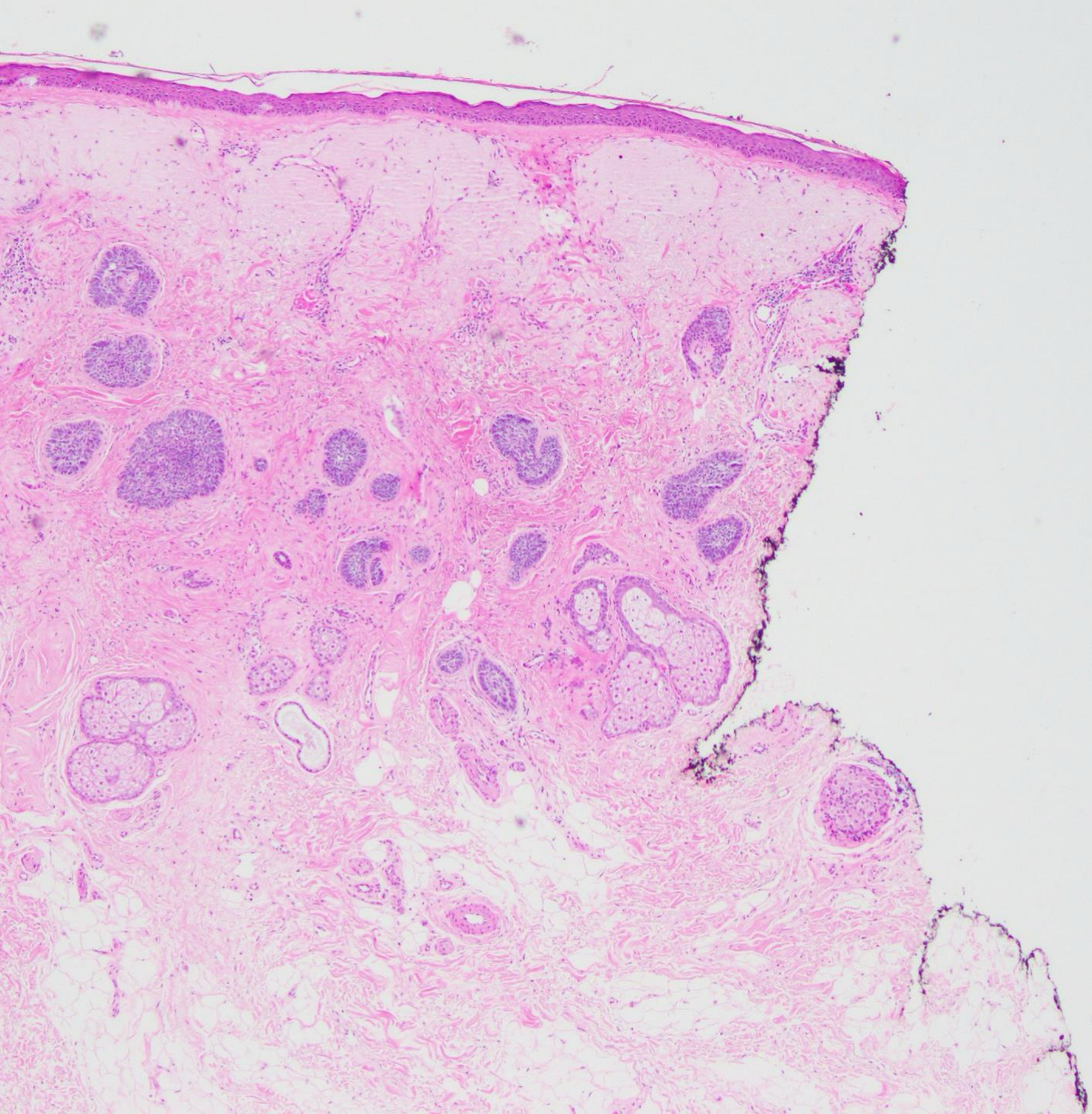
Nodular BCC



Infiltrative BCC



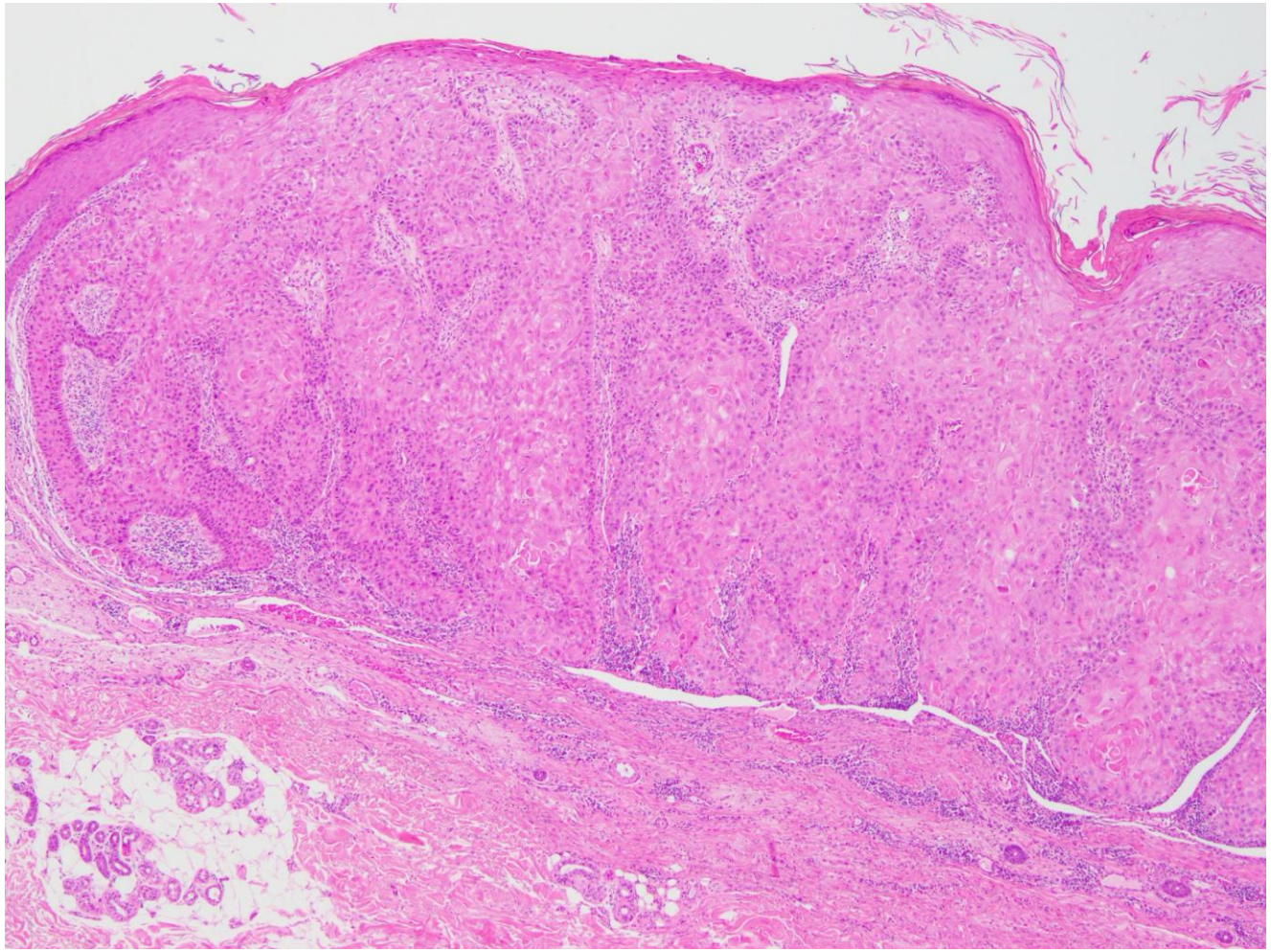
Solid and micronodular BCC



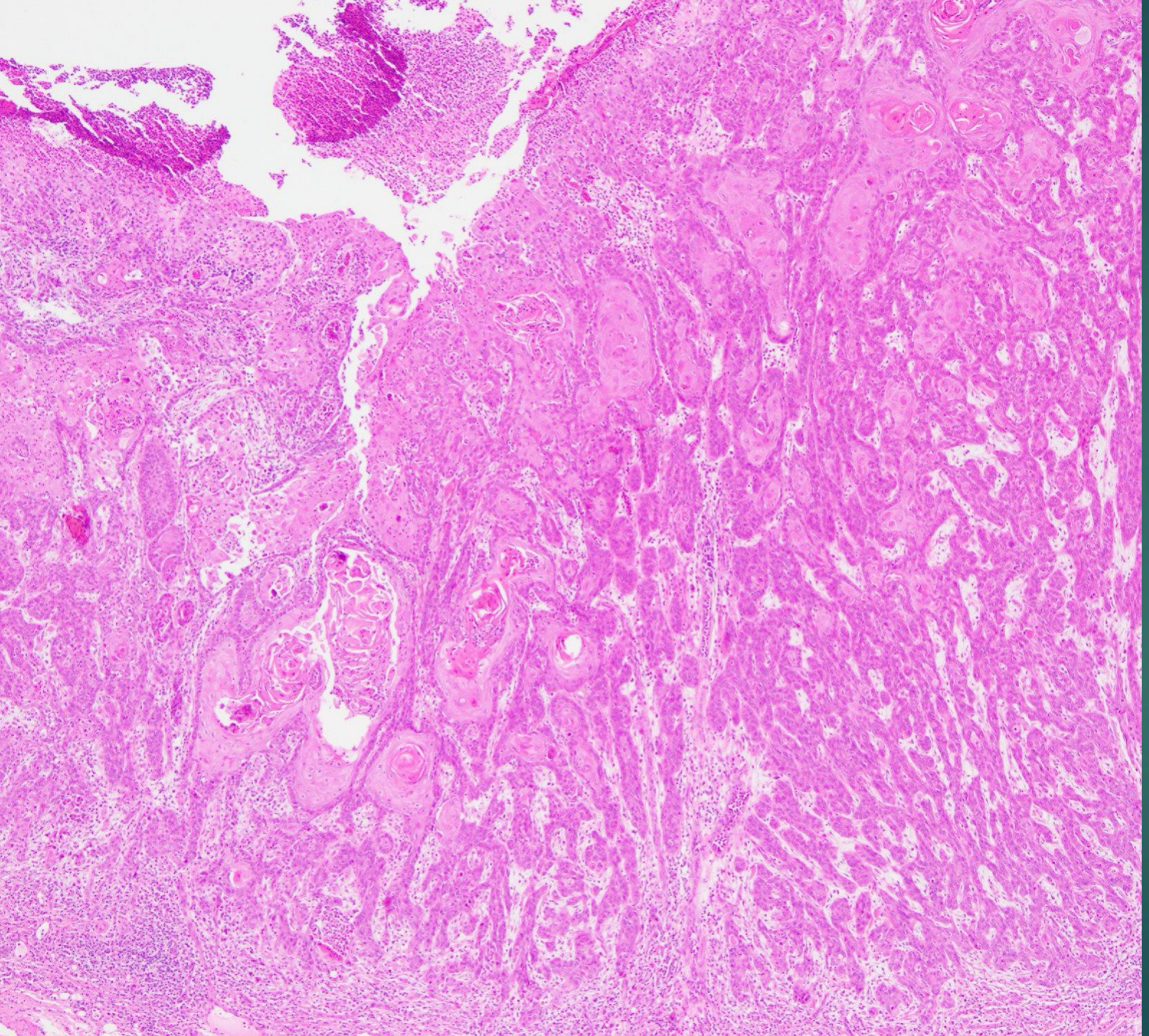
Margin involvement

Squamous Cell Carcinoma

- Second most common form of skin cancer in white people
- UVR, carcinogens (eg. Arsenic), HPV, radiation, burns/scarring
- Australia has highest incidence approximately 170 per 100,000/population
- Metastatic rate varies between 0.5% and 16%; higher rates in poor differentiation, thickness of the primary lesion (>4-5mm), PNI, arising in Bowen's Disease, head and neck, (especially lip), non-sun exposed areas, incomplete excision, immunosuppression – transplant patients
- In-situ (Bowen's, IEC)
- Well-differentiated
- Poorly-differentiated
- Keratocanthoma



Well differentiated SCC

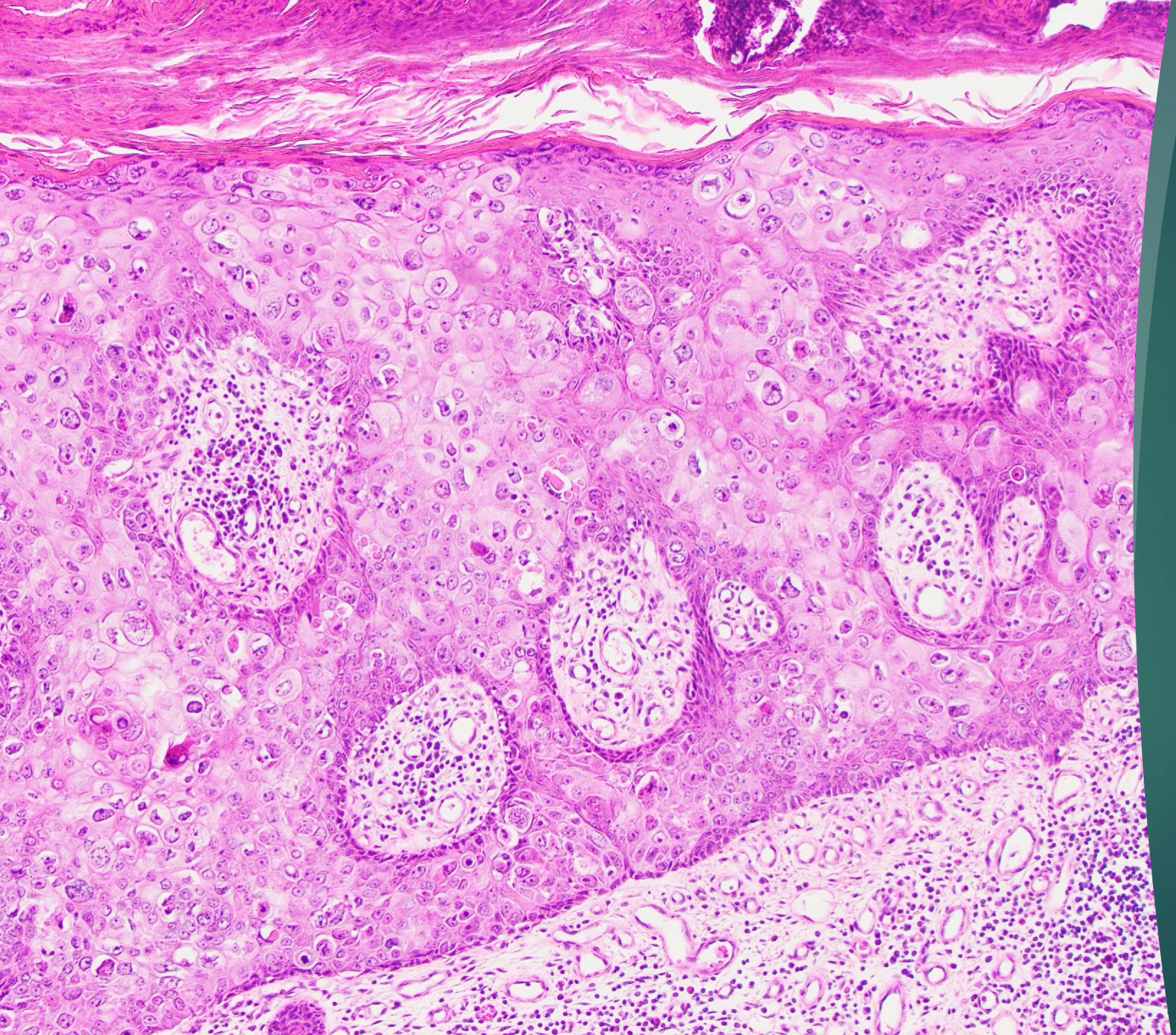


Moderately differentiated SCC

Intraepidermal Carcinoma

(Bowen's, SCC in Situ)

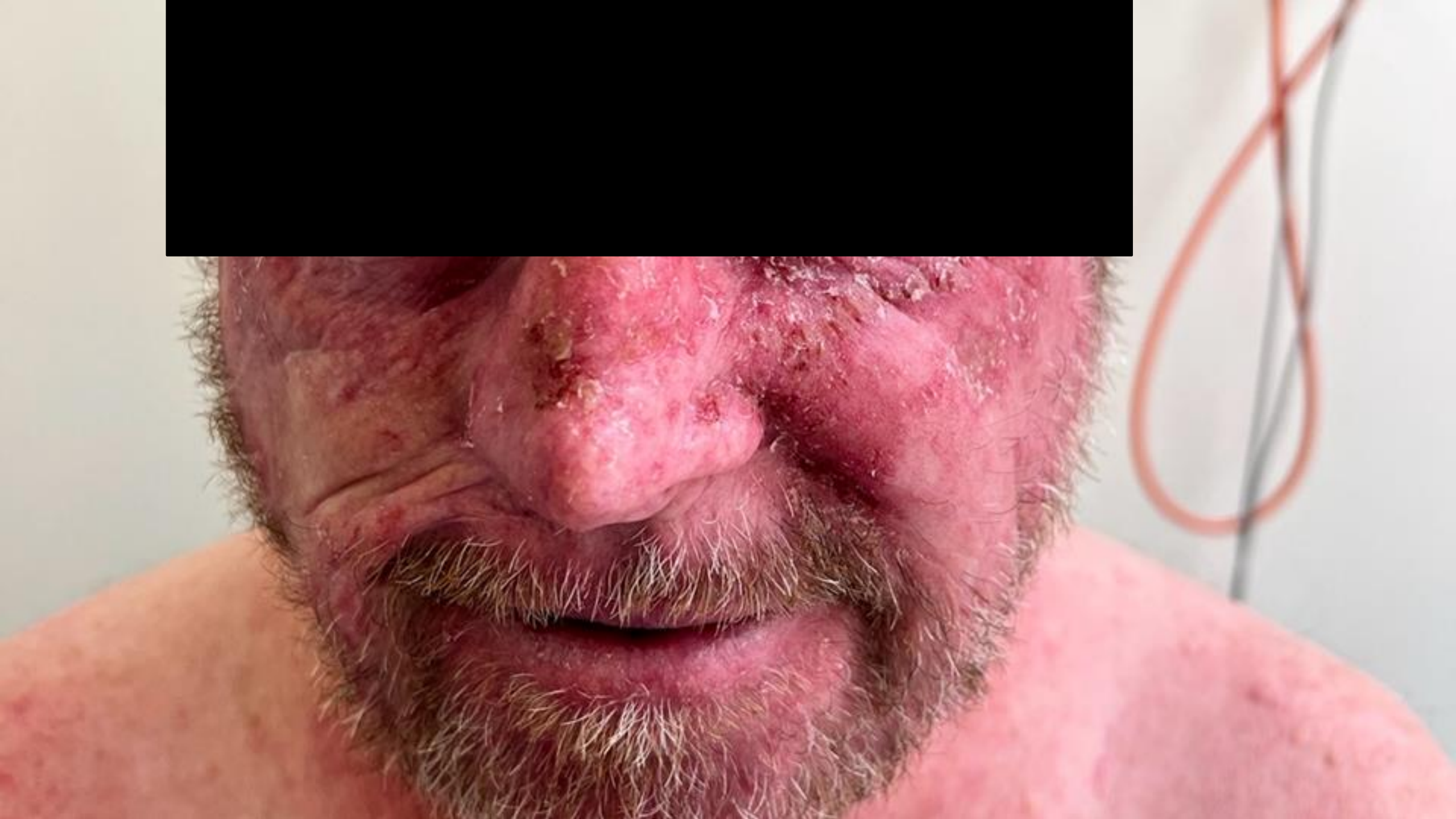
- Superficial, accessible
- Follicular involvement (proven or likely/hair-bearing site)…adnexal
- Clinical presentation – flat, thick, indurated, hyperkeratotic
- Progress to invasive SCC, around 3-5% incidence
- If invasive disease develops, metastasis 2-5%

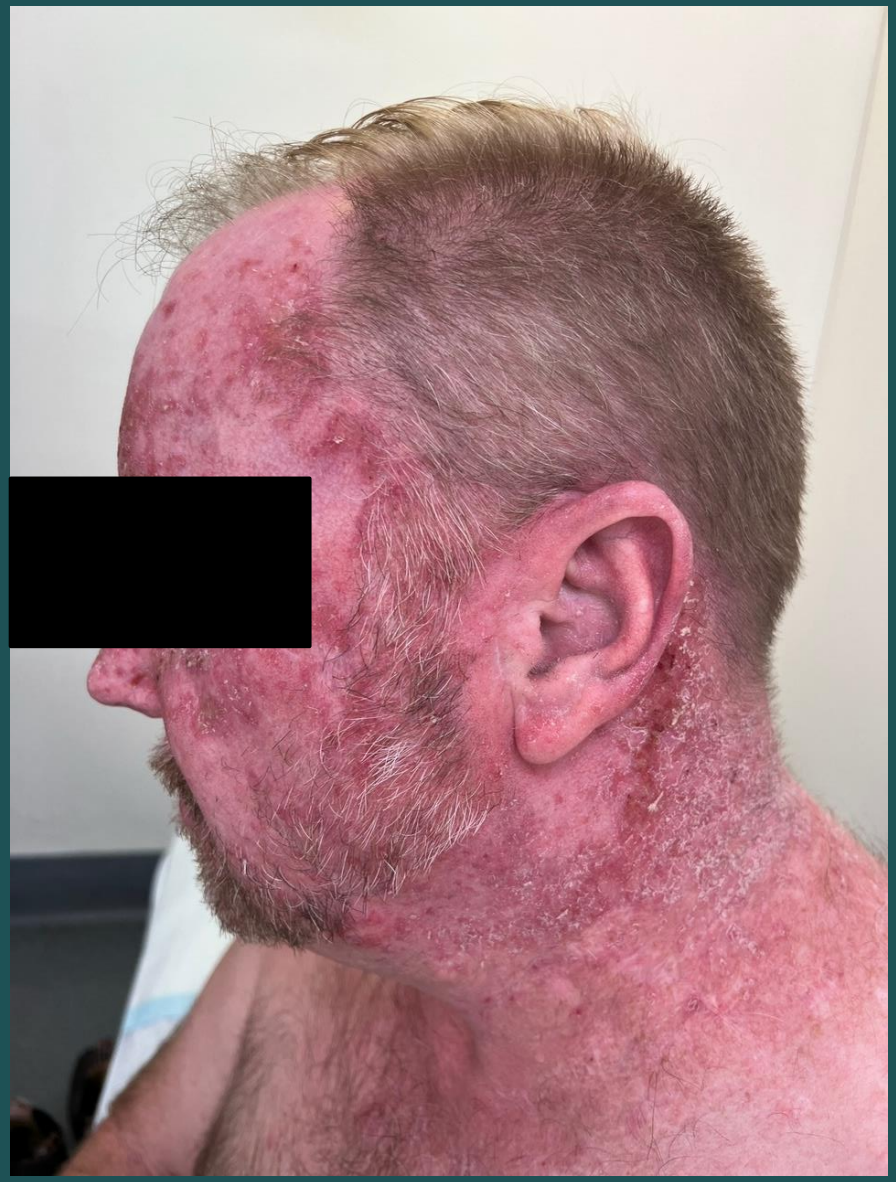


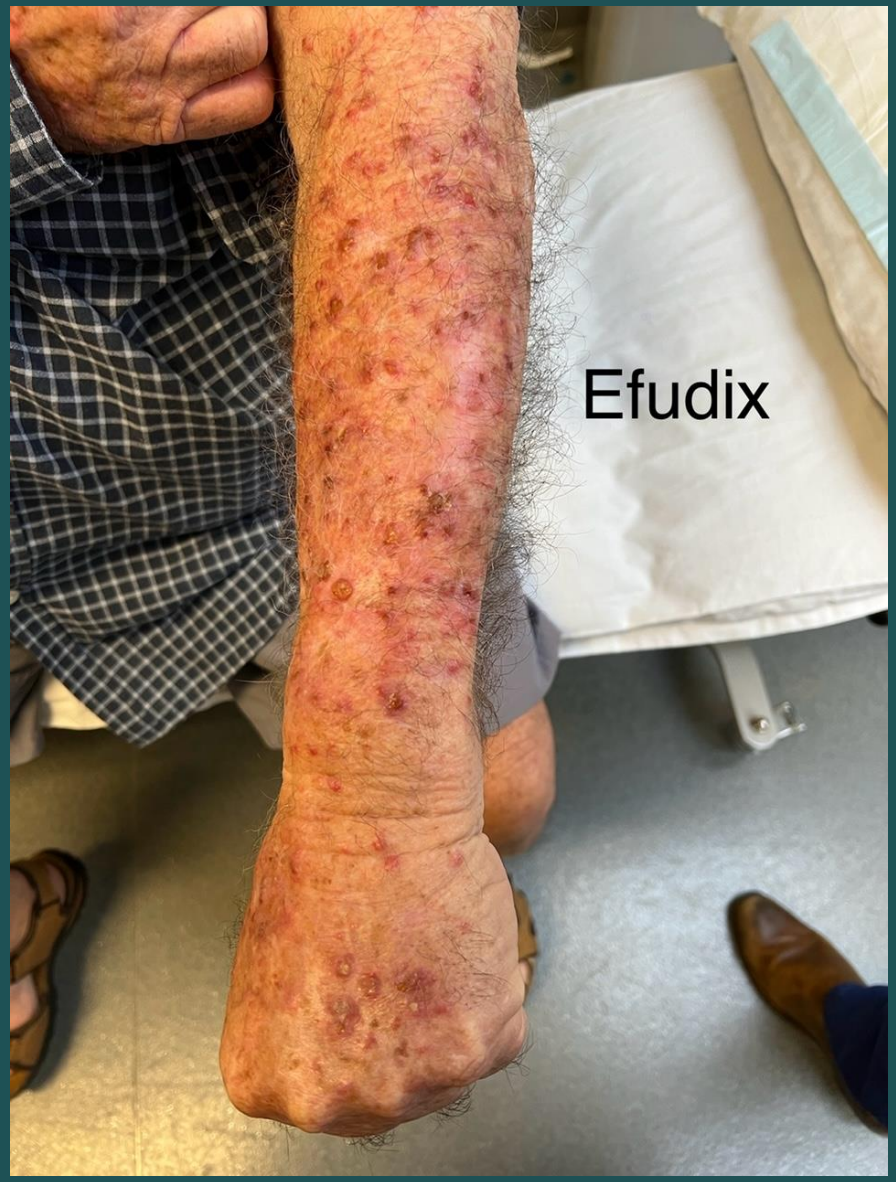
IEC

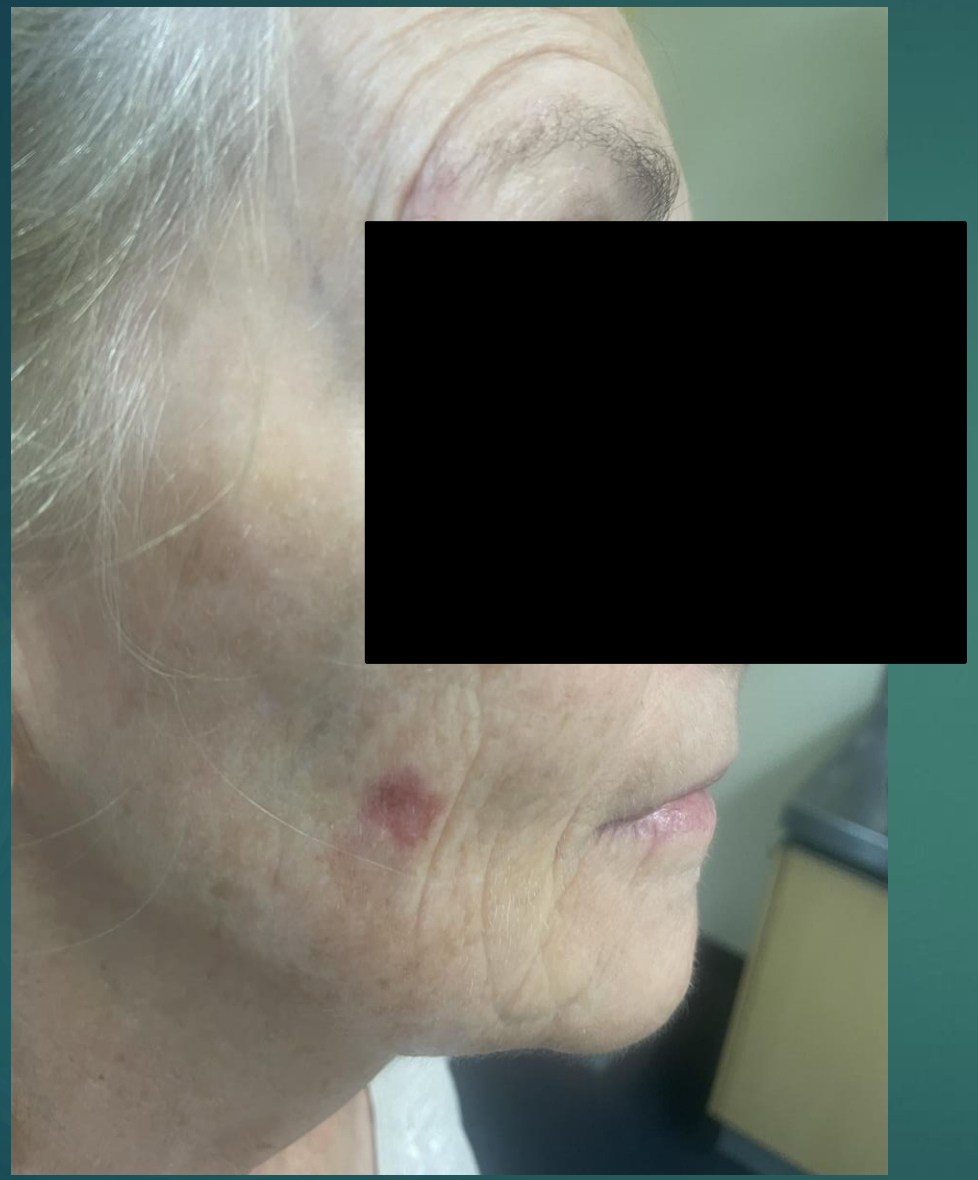
Topical 5FU 80% Effective

- Pyrimidine analogue of uracil that is incorporated into RNA and disrupts RNA synthesis.
- Binds within a cell to thymidylate synthetase.
- Adjuvant agents – cryotherapy, trichloroacetic acid (25-45%), salicylic acid (10%), calcipotriol (Daivonex 0.005%)
- Regimen varies..twice daily , thin smear, avoid grooves, not at bedtime or if going to smear into eyes , not pregnancy…check weekly, stop if not coping and call…its not a test of your character!..its a medical treatment not a torture treatment!..handout and followup…NOT a set and forget treatment
- "healing ointment"..for a week …Hydrocortisone or stronger
- Variable response dependent on site eg. face responds more quickly than dorsal hands
- Thickness of lesion and hyperkeratosis important
- Inflammatory effects begin day 5-10
- Inflammation lasts 4-6 weeks
- Photosensitivity
- Allergy < 1% (5FU and vehicle)
- Secondary infection (staph, HSV)
- Can get textural change and persistent erythema

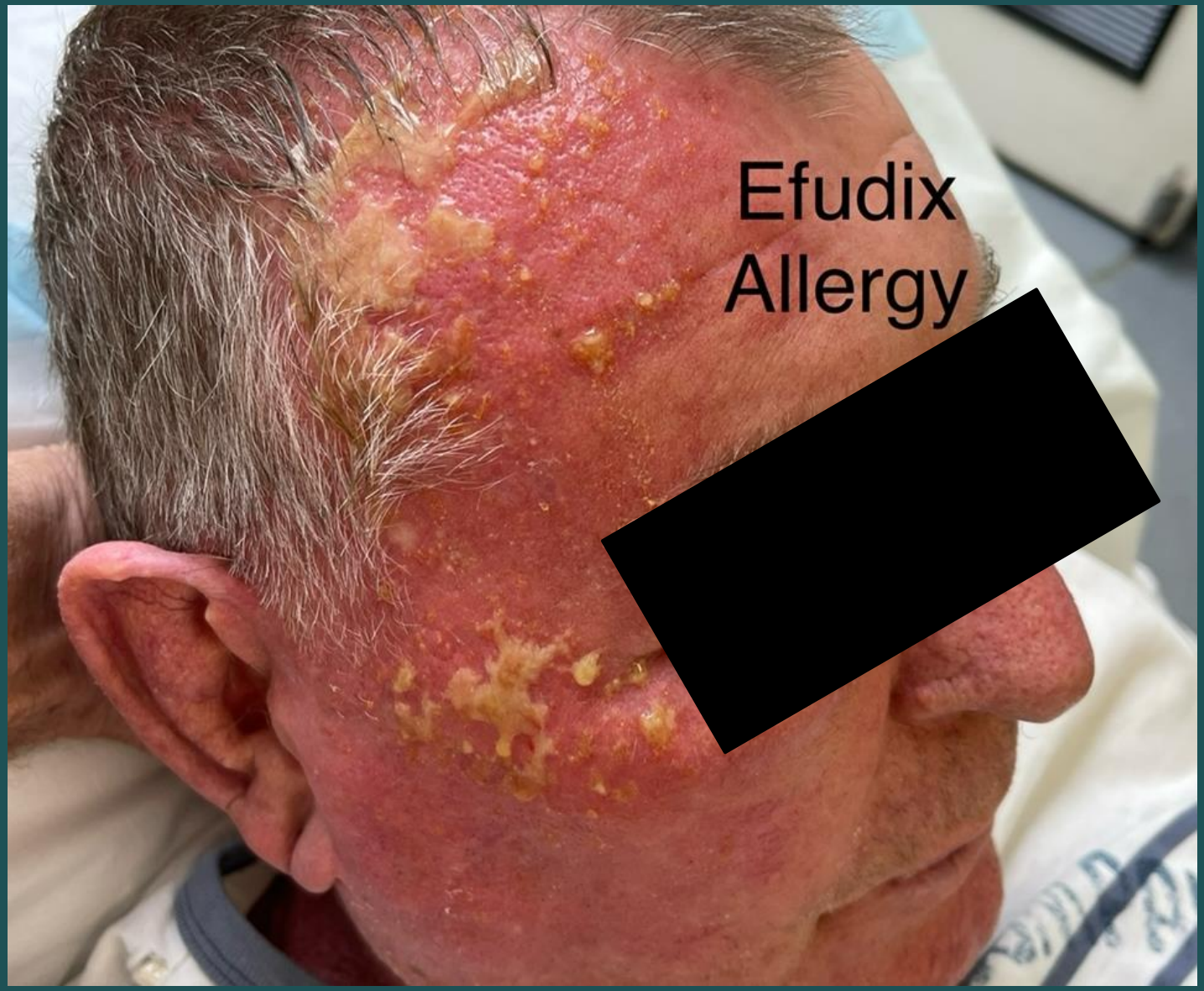





Efudix



IEC :5FU – 10 days


Efudix
Allergy

Topical Imiquimod (5% Aldara)

- Anti-tumour and anti-viral (first used for HPV)
- Acts on the innate and the adaptive immune responses both directly and indirectly.
- Direct action by binding toll-like receptors (TLR) on white blood cells and by inducing apoptosis
- Indirect action by inducing cytokines (IL-12, TNF α, INF γ) which increase cytotoxic T-cells and NK cells
- May block hedgehog signaling pathway which plays a role in BCC development
- Solar keratoses – up to 25cm^2 2-3 times weekly, up to 16 weeks
- In-situ SCC – daily, up to 16 weeks
- Superficial BCC - 5 days/week for 6-12 weeks
- Case reports of clearance of infiltrative and sclerotic BCCs – isolated cases and follow up is poor..more work required
- New and potent Imiquimod analogue - Resimiquimod

Photodynamic Therapy

(PDT)

Methylaminolevulinate (MAL) (Metvix 16%)

5-aminolevulinic acid (ALA) (Compounded)

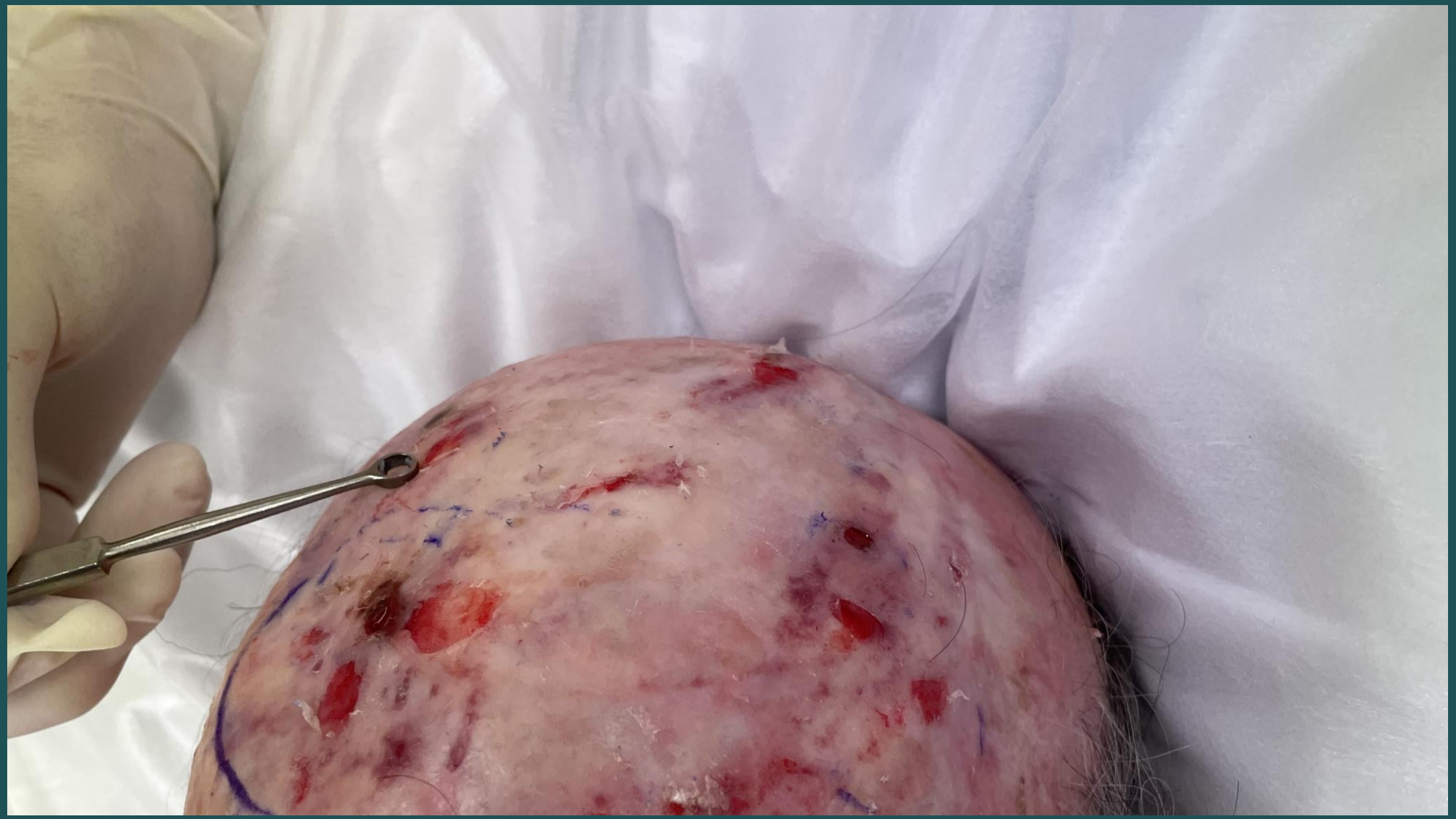
- Dermatologists have been treating a photosensitive condition called porphyria for a long time, protophorphyrin IX (PpIX) responsible
- PDT takes advantage of the photosensitive properties of PpIX
- ALA is a pre-cursor in the haem synthesis pathway and is the rate-limiting step when ALA is administered, it is taken up in cells and metabolized into PpIX
- Accumulation of PpIX in tumour cells may occur because of increased activity of a deaminase which increases conversion of ALA to PpIX and a decreased activity of ferrochelatase which converts PpIX to haem
- ALA penetration of tumour cells is also enhanced if the tumour has poorly formed stratum corneum or if the stratum corneum is altered by the proceduralist.

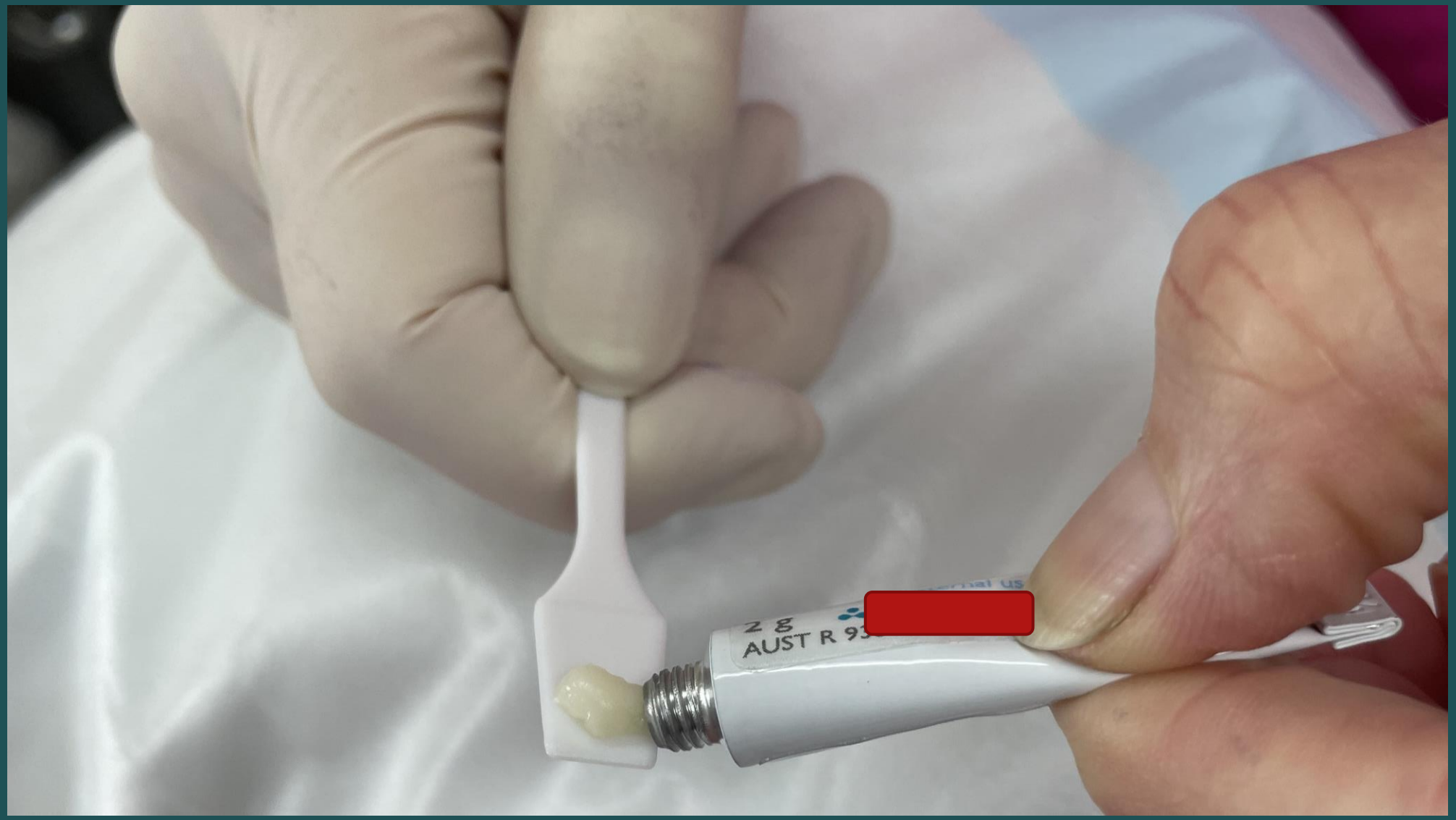
PDT Light Source

- Absorbed well by the photosensitiser – corresponds to a peak of the porphyrin excitation spectrum in tissues
- PpIX excitation peaks – 410nm (Violet) and 635nm (Red)
- Lights available emits heat-free visible red light at a peak wavelength of 630nm or close to
- Penetrate a desirable depth – 630nm light penetrates up to 5mm

PDT Technique

- Lesion prepared – gentle curettage, sandpaper, peeling agent
- Local anaesthetic usually required (painful procedure)…in some pain seems disproportionate
- ALA cream applied under opaque occlusive dressing
- After 3 hours, dressing and cream removed. Local anaesthetic repeated
- Light source (630nm) – red light – approximately 8 minutes
- Emollient applied
- Sometimes oral pain relief prescribed
- Post procedure instructions are given – expected healing time 7-10 days
- Daylight PDT mild to moderate solar keratoses??

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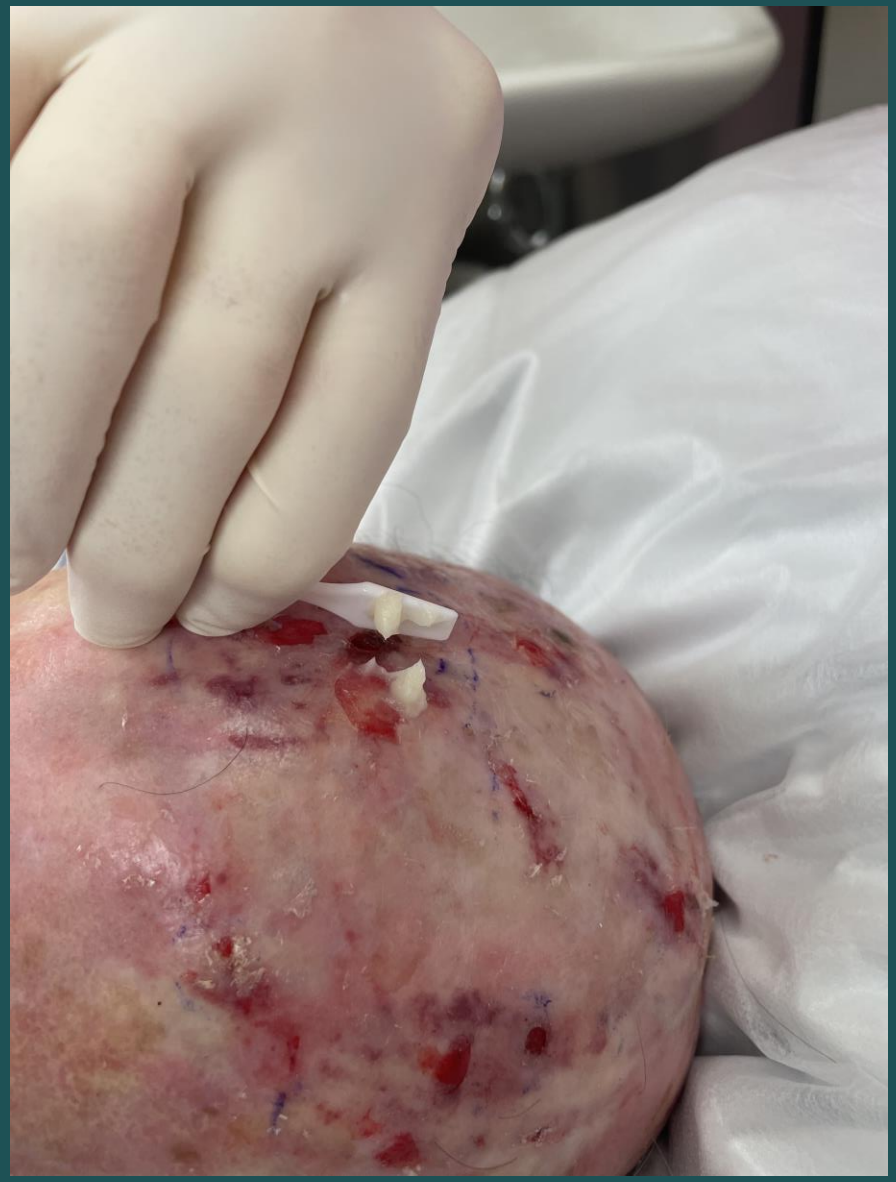
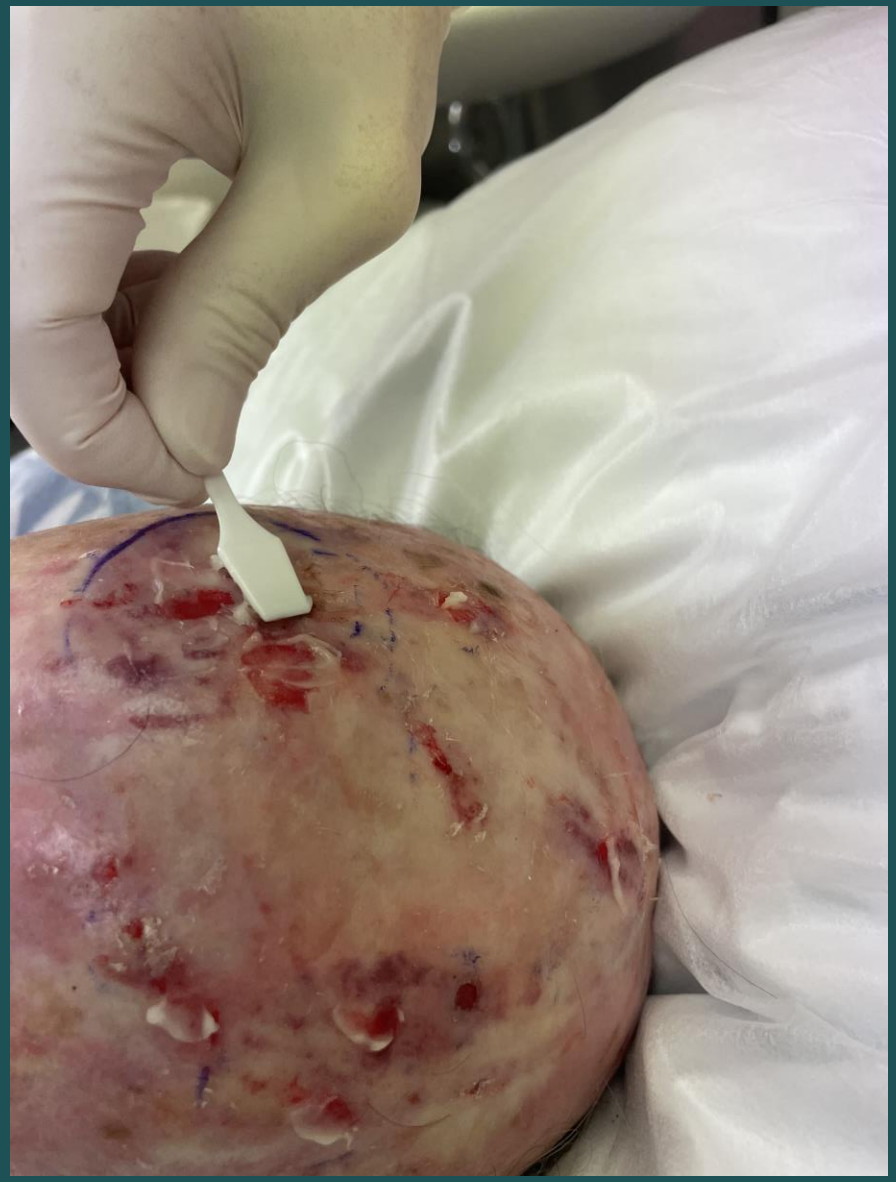
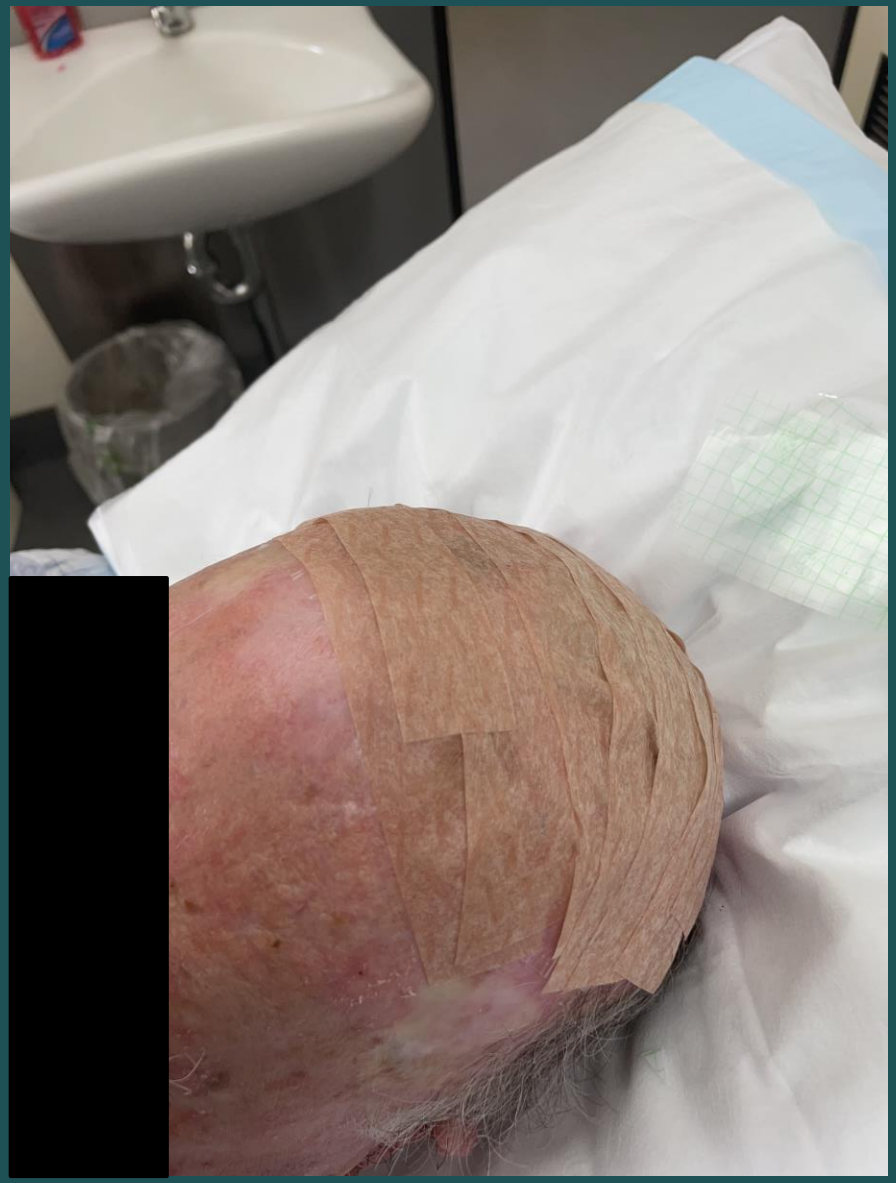
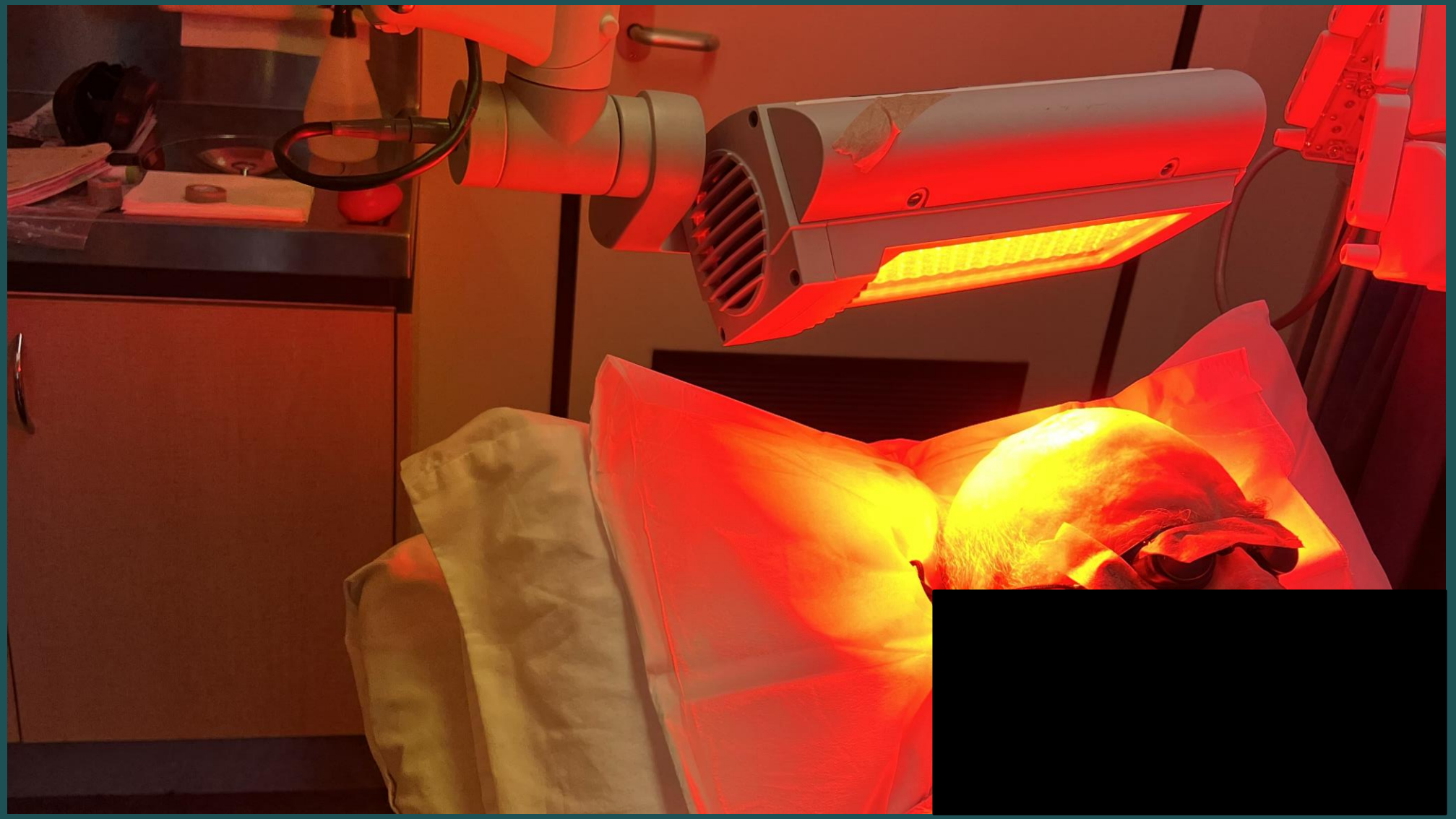








Practical Consent Issues - Specific

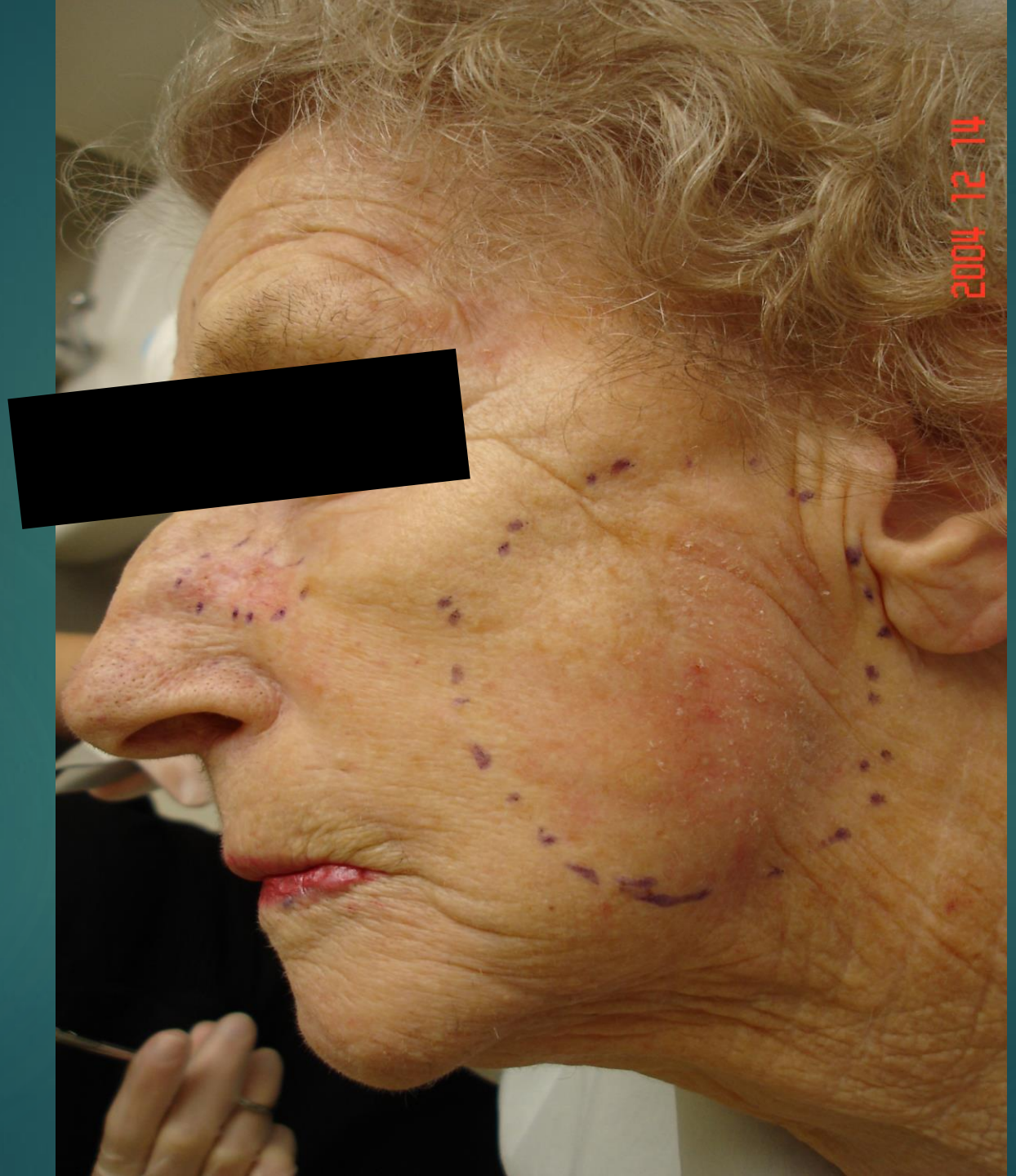
- INFORMATION about PDT and what is going to happen including Anaesthesia
- Pre care and after care
- Side effects : usual and less usual
- Outcomes : likely and less likely
- Comparison and cost
- Recurrence and consequences of them
- Follow-up…emphasize
- Consent form..in writing and info
- Don't guild the lily
- – cure rate not 100%

DERMATOLOGY SPECIALIST CENTRE

PDT Complications

- Pain
  - esp large areas
  - group of patients 'disproportional' pain..be aware!
- Pustular inflammation
  - Face..upper lip and nose
  - Culture negative
  - Within 48 hrs, settles over 48 hours
- Swelling (esp periorbital) , erythema, erosion lower legs
- Recurrence – further treatment including surgery may be needed

DERMATOLOGY SPECIALIST CENTRE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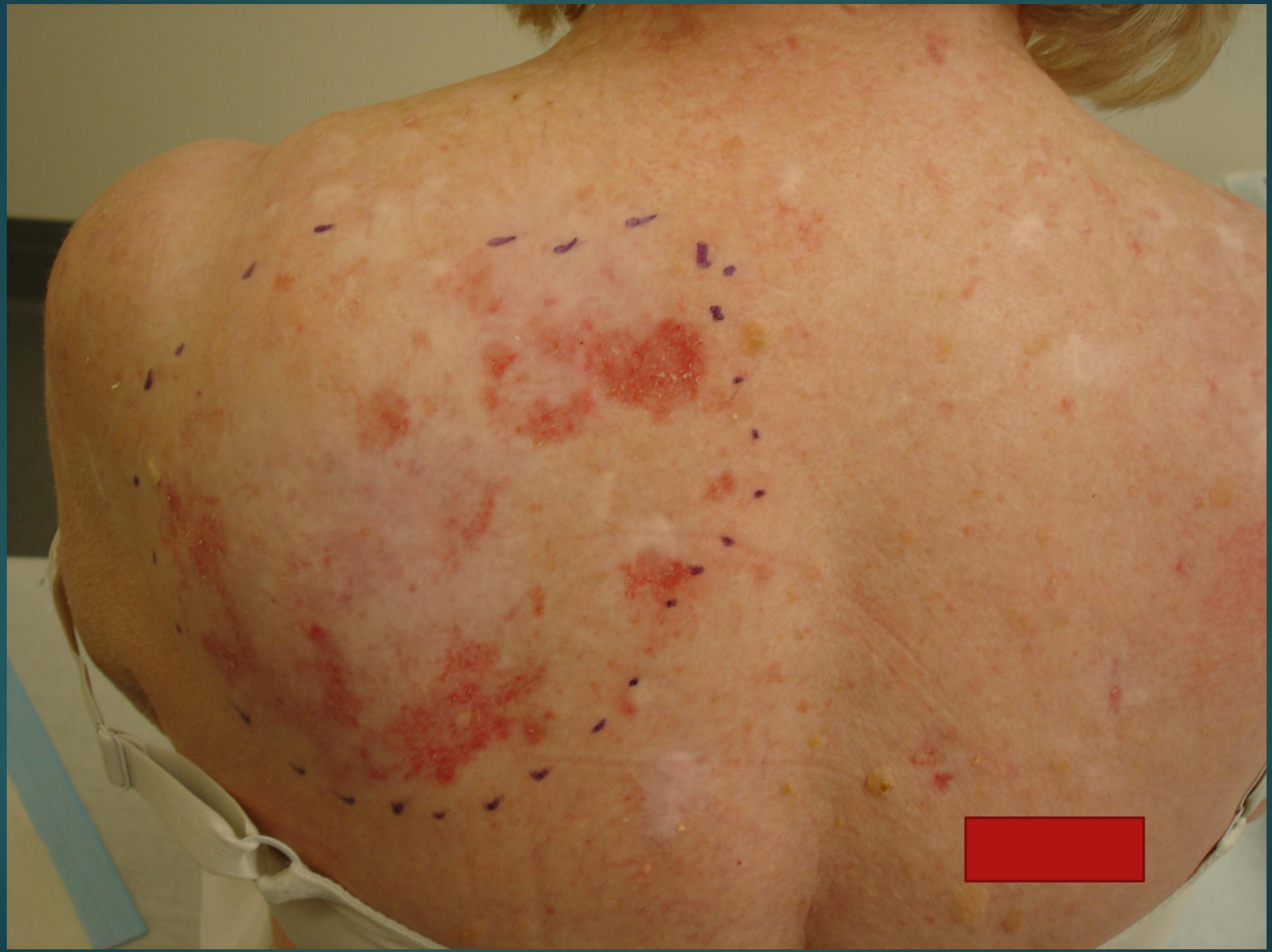

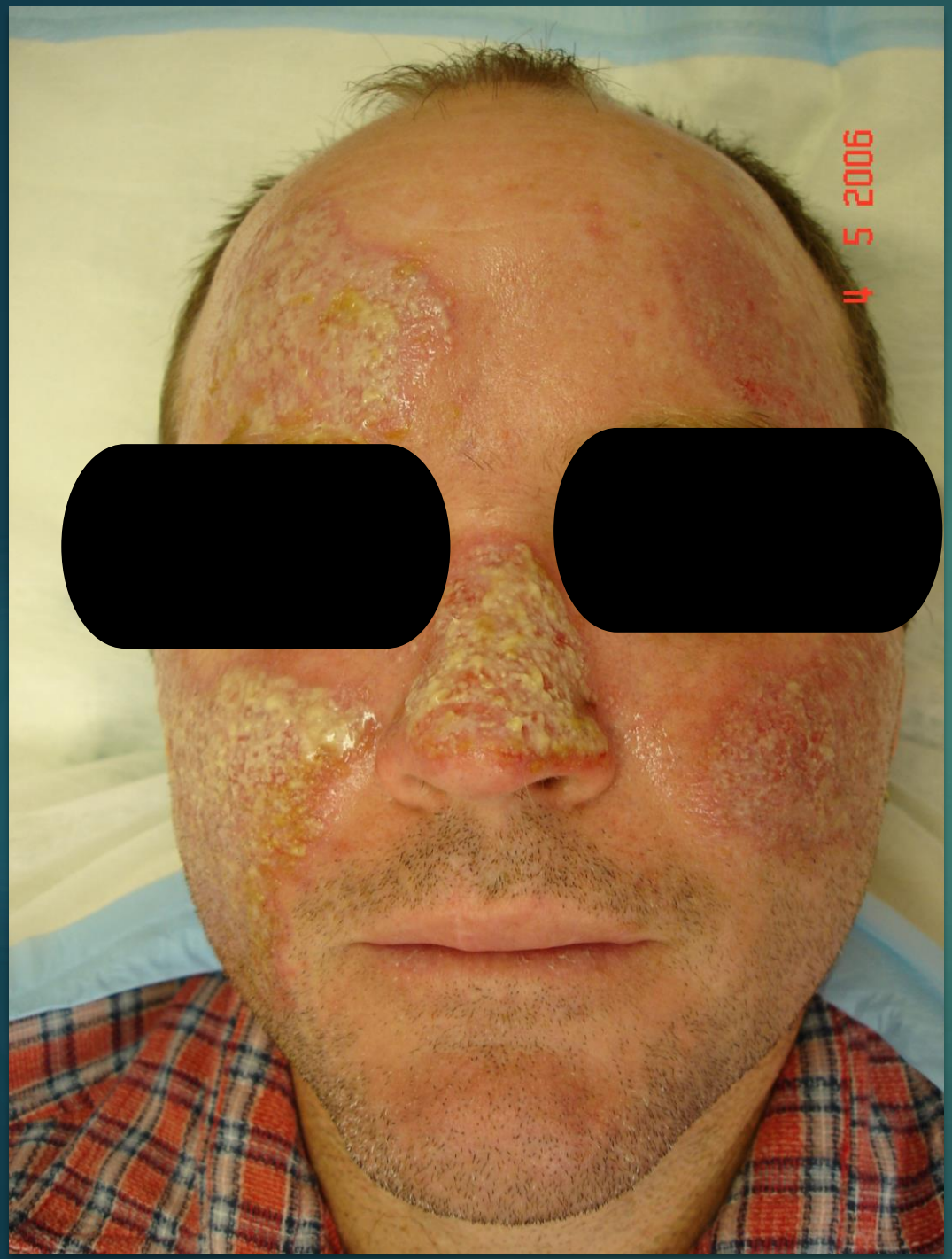
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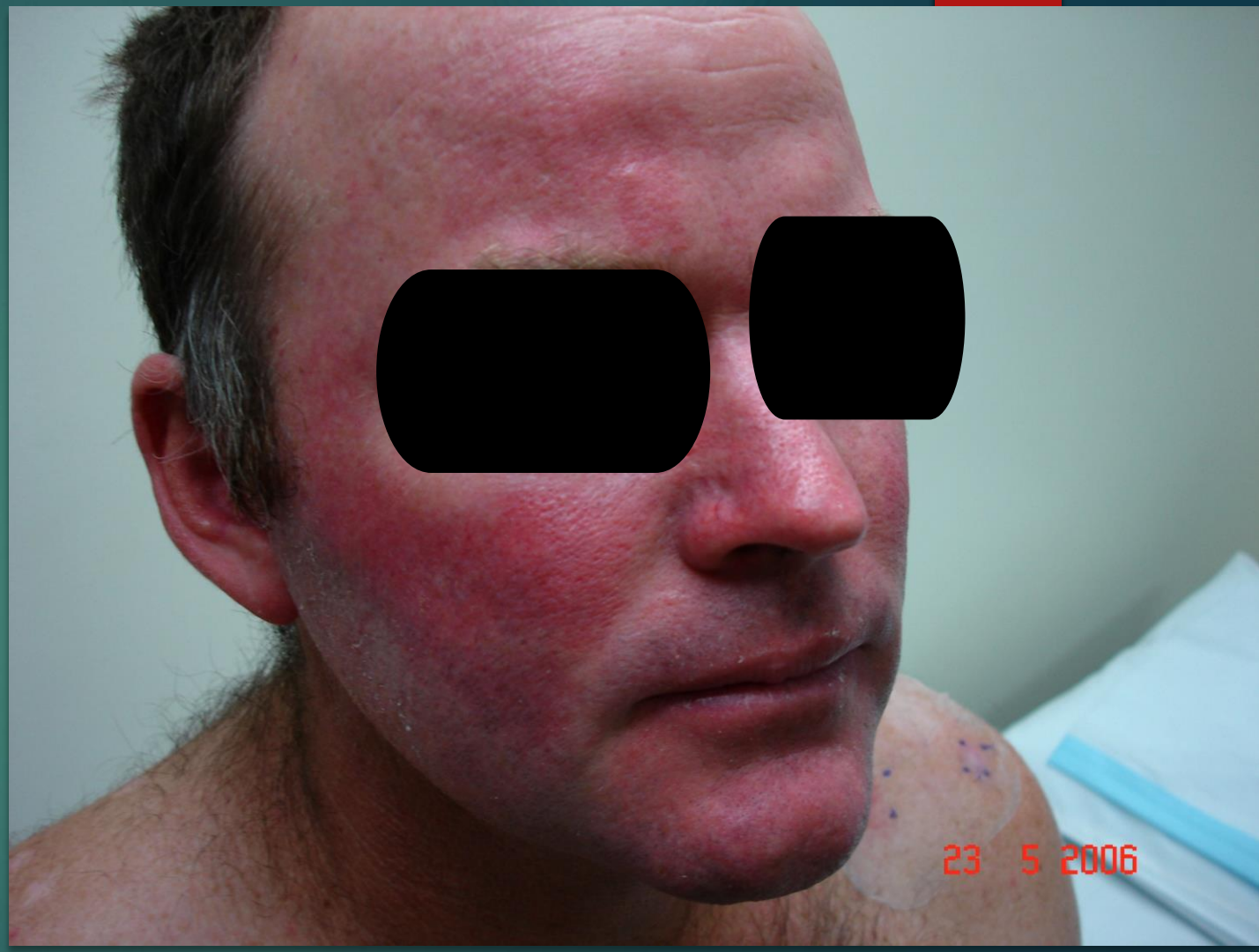
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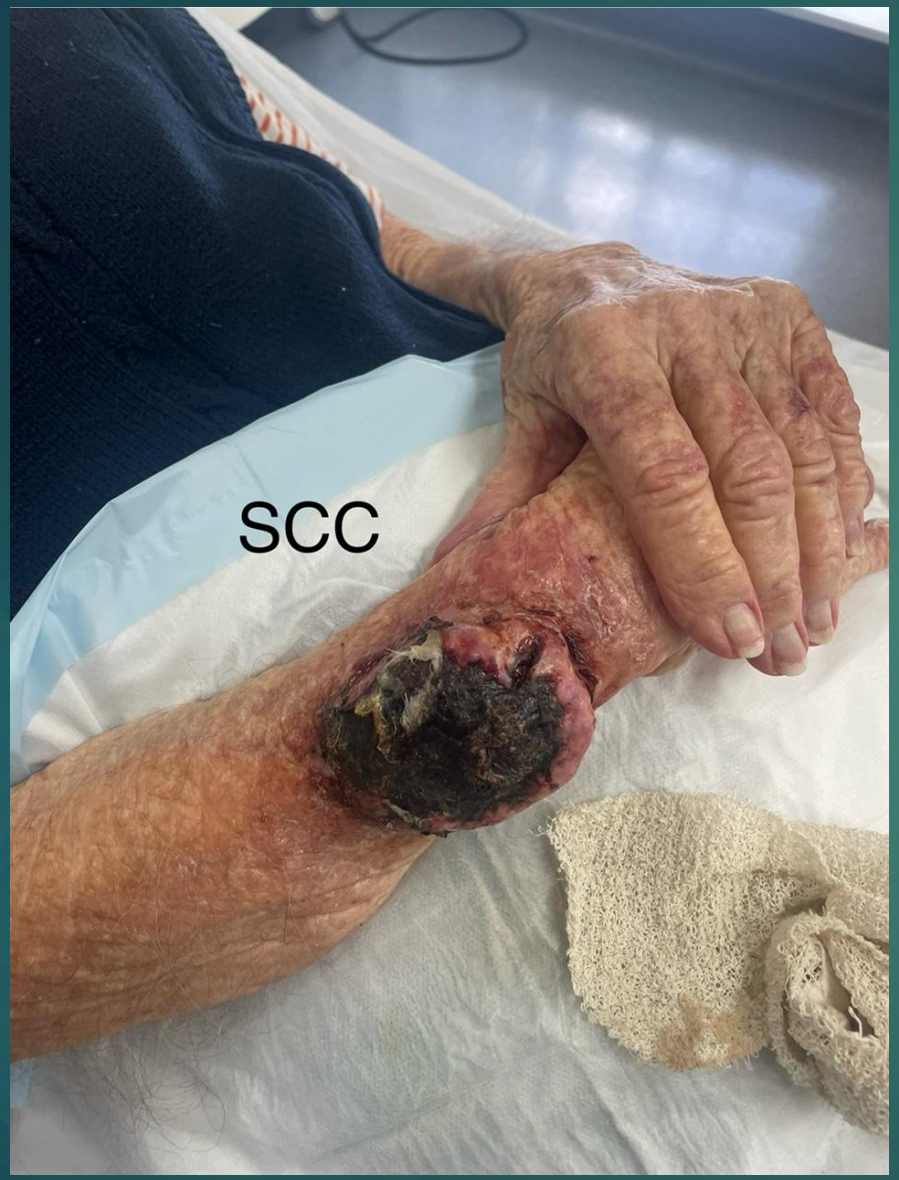

Any Questions?

Clinical considerations for referrals

Dr Andrew Lewandowski

Plastic & Reconstructive Surgeon | RBWH

Dr Srishti Dutta

GPLO

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Refer your patient

Refer your patient

Information for GPs and health professionals to help refer patients and find services available at Metro North Health.

Latest updates

Multilingual translated videos are now available for Gastroenterology patients explaining about colonoscopy & endoscopy procedures for the following locations:

- RBWH Gastroenterology and Hepatology
- STARS Gastroenterology & Endoscopy Services
- Caboolture Hospital Gastroenterology
- Redcliffe Hospital Gastroenterology & Hepatology

Rapid Access Services

Rapid Access Clinics and Services – Local GPs can refer patients requiring escalation of care to these services for urgent assessment and treatment within a few days to provide an alternative to an emergency presentation.

Specialist outpatient services

Specialist outpatient referrals are coordinated through the Metro North Health Central Patient Intake Unit for hospitals in the region.

Find outpatient referral guidelines by speciality or referred condition below:

Plastic and Reconstructive Surgery Go | Skin Cancer/Skin Lesion Go

GP Referrals Enquiry Line: **1300 364 938**

Community Health Services

Select a service

Enquiry hotline:

1300 658 252

Fax: 3360 4822

Clinical advice services

Virtual Emergency Care Service
1300 847 833
Monday to Sunday
8am-10pm

Metro North Clinical Advice Line
1800 569 099
Monday to Friday
8.30am-4pm

Residential Aged Care District Assessment and Referral Service (RADAR)
1300 072 327
Monday to Sunday
8.00am – 8.00pm

- Rapid Access Services
- Voluntary Assisted Dying
- Mental Health services
- Oral Health services
- Sexual Health & HIV Service
- Alcohol & Drug Service
- Residential Aged Care District Assessment and Referral Service (RADAR)
- Behavioural Emergency Response Team (BERT)
- Children's Health Queensland

- Smart Referrals
- Brisbane North Health Pathways
- Health Provider Portal
- Update GP practice details
- GP Liaison (GPLO) Program
- GP and primary care education & events
- Specialists list

Does your patient reside in the Metro North Health catchment?

In most cases, referrals are only accepted from patients residing in the Metro North Health catchment.

Type your patient's suburb or postcode

GO

Resources for GPs

Central Patient Intake Fact Sheet (PDF)

Central Patient Intake FAQ's (PDF)

Chronic Wounds Directory

Queensland Government

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Metro North Health

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Home / Refer your patient / Plastic and Reconstructive Surgery

Plastic and Reconstructive Surgery

Conditions

Please note this is not an exhaustive list of all conditions for outpatient services and does not exclude consideration for referral unless specifically stipulated in the out of scope section.

- Dupuytren's Contracture
- Facial Fractures
- General Plastic Surgery
- Head and Neck Mass
- Lower Limb Reconstruction
- Peripheral entrapment neuropathies including CTS
- Post-Burn Reconstruction and Scar Management
- Reconstructive Breast Surgery
- Reconstructive Hand Surgery
- Skin Cancer/Skin Lesion

Paediatric services

Referrals for children and young people should follow the Children's Health Queensland referral guidelines.

Emergency department referrals

All urgent cases must be discussed with the on call Plastic and Reconstructive Surgery Registrar. Contact through Royal Brisbane and Women's Hospital (07) 3646 8111 to obtain appropriate prioritisation and treatment.

Urgent cases accepted via phone must be accompanied with a written referral and a copy faxed immediately to the Central Patient Intake Unit: 1300 364 952.

If any of the following are present or suspected arrange immediate transfer to the emergency department.

- Hand fractures (open or closed)
- Acute fingertip injuries
- Tendon Injuries
- Airway compromise
- Uncontrolled sepsis including hand infections
- Threat to limb viability
- Acute burns
- Lacerations and wounds not suitable for primary health management e.g. lip lacerations, large facial lacerations

Send referral

Hotline: 1300 364 938

Electronic:
GP Smart Referrals (preferred)
eReferral system templates
Medical Objects ID: MQ40290004P
HealthLink EDI: qldmnhhs

Mail:
Metro North Central Patient Intake
Aspley Community Centre
776 Zillmere Road
ASPLEY QLD 4034

Health pathways

Access to Health Pathways is free for clinicians in Metro North Brisbane.

For login details email:
healthpathways@brisbanenorthphn.org.au

Login to Brisbane North Health Pathways:
brisbanenorth.healthpathwayscommunity.org

Locations

Royal Brisbane and Women's Hospital

Skin Cancer/Skin Lesion

Emergency department referrals

All urgent cases must be discussed with the on call Plastic and Reconstructive Surgery Registrar. Contact through Royal Brisbane and Women's Hospital (07) 3646 8111 to obtain appropriate prioritisation and treatment.

Urgent cases accepted via phone must be accompanied with a written referral and a copy faxed immediately to the Central Patient Intake Unit: 1300 364 952.

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Lacerations and wounds not suitable for primary health management e.g. lip lacerations, large facial lacerations, lacerations with altered sensation, large skin defects.

Does your patient wish to be referred?

Minimum referral criteria

Does your patient meet the minimum referral criteria?

Category 1
Appointment within 30 days is desirable
	• skin lesion highly suspicious for melanoma or excision biopsy proven melanoma
	• rapidly growing skin lesions especially on the face
	• complex non-melanoma skin malignancies and any of the following:
	  ◦ ulceration and bleeding
	  ◦ rapidly enlarging
	  ◦ neurological involvement
	  ◦ lymphadenopathy
	  ◦ poorly differentiated or infiltrative tumour on biopsy
	• other subcutaneous and deep tissue malignancies e.g. Merkel cell carcinoma, sarcoma
	• skin lesion causing substantial obstruction to vision
	• suspicion of malignant liposarcoma
	• Confirmed SCC
	• Prior malignancy at the same site

Category 2
Appointment within 90 days is desirable
	• Uncomplicated non melanoma skin malignancies (BCC/SCC/IEC)
	• Skin lesions with any of the following:
	  ◦ causing functional problems or significant disfigurement
	  ◦ diameter exceeds ≥ 5cm in size or rapid growth over short period of time
	• significant persistent pain that is not solely pressure related
	  ◦ fixed to deep tissues, i.e. muscle or fascia
	  ◦ recurring after a previous excision
	  ◦ prone to recurrent infection
	  ◦ diagnosis in doubt or needs confirmation

Category 3 Appointment within 365 days is desirable	• Benign soft tissue lesions e.g. lipoma, ganglion not suitable for primary health management • Clinically significant benign lesion

If your patient does not meet the minimum referral criteria

Consider other treatment pathways or an alternative diagnosis.

If you still need to refer your patient:

- Please explain why (e.g. warning signs or symptoms, clinical modifiers, uncertain about diagnosis, etc.)
- Please note that your referral may not be accepted or may be redirected to another service

Other important information for referring practitioners

Not an exhaustive list

- Refer to HealthPathways for assessment and management information if available
- Advise patient regarding sun avoidance and appropriate use of sun screens
- Educate patient on skin cancer surveillance and arrange annual skin checks

Referral requirements

A referral may be rejected without the following information.

– Essential referral information

- Features of pigmented lesions: size, shape, colour, inflammation, oozing, change in sensation
- Biopsy results unless clinically contraindicated – excision biopsy is the preferred method for suspected melanoma
- Smoking status
- History of anticoagulant therapy

Additional referral information (useful for processing the referral)

- Photograph – with patient's consent, where secure image transfer, identification and storage is possible
- USS lesion result (for a suspicious lipoma)

+ Other Plastic and Reconstructive Surgery conditions

Send referral

Hotline: 1300 364 938

Electronic:
GP Smart Referrals (preferred)
eReferral system templates
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HealthLink EDI: qldmnhhs

Mail:
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Locations

Royal Brisbane and Women's Hospital

Brisbane North

Search HealthPathways

HealthPathways

Brisbane North

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- COVID-19
- About HealthPathways
- Brisbane North Localised Pathways
- Acute Services
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- Child and Youth Health
- End of Life
- Investigations
- Lifestyle and Preventive Care
- Medical
- Mental Health
- Older Adults' Health
- Pharmacology
- Public Health
- Reproductive Health
- Specific Populations
- Surgical
  - Cardiothoracic Surgery
  - Dentistry
  - ENT Head and Neck Surgery
  - General Surgery
  - Neurosurgery
  - Ophthalmology
  - Oral and Maxillofacial Surgery
  - Orthopaedics / Musculoskeletal
  - Surgery - Child
  - Plastic and Reconstructive Surgery
    - Breast Surgery
    - Burn Injuries
    - Ear Anomalies
    - Excess Skin Removal Surgery
    - Subcutaneous Foreign Bodies
    - Hand and Wrist (Plastics)
    - Skin Cancer

Brisbane North

HEALTHPATHWAYS

Health Alert

7 August: 4 new confirmed cases of Mpox in Queensland. Clinicians are advised to be alert and test for Mpox in patients with compatible signs and symptoms, particularly in MSM, with a low threshold for testing.

There is currently an outbreak of dengue fever in the Torres Strait and there is an ongoing risk of dengue to travellers in Indonesia. Notify your local public health unit immediately on suspicion of dengue infection (6 June 2024).

Latest News

21 October
GP News Link - 17 October

See the latest GP Link update from your PHN. Read more...
To receive the newsletter in your email inbox, subscribe here.

18 October
Notifications for internal Queensland Health referrals

GPs may receive notifications via qhRefer when their patient is referred. These are delivered by SWT to practice management software. Practices not using STS may receive a letter. Update your details to receive the correspondence electronically.

18 October
Health Provider Portal (HPP) changes

The QGov system used to log in to the Health Provider Portal (HPP) will be transitioned to a new digital identity provider called Queensland Digital Identity (QDI) in early 2025. Read more ...

11 October
GP News Link – 10 October

See the latest GP Link update from your PHN. Read more...
To receive the newsletter in your email inbox, subscribe here.

4 October

Pathway Updates

Updated – 18 October
Osteoporosis

Updated – 11 October
Lactation Support Services

Updated – 9 October
Sick Day Management in Diabetes

Updated – 8 October
Abnormal Vaginal Discharge

NEW – 27 September
Aboriginal and Torres Strait Islander Mental Health

VIEW MORE UPDATES...

About HealthPathways

What is HealthPathways?
How do I use HealthPathways?
How do I send feedback on a pathway?

- HEALTH PROVIDER PORTAL
- METRO NORTH HHS
- PHN
- LOCAL RESOURCES
- CLINICAL RESOURCES
- PATIENT RESOURCES
- GP EDUCATION
- NHSD

Skin Cancer

Background

About skin cancer

Assessment

1. Take a history for risk factors for skin cancer, and consider:
   - any lesion with suspicious features.
   - EFG rule for melanoma.
   - ABCDE criteria for melanoma.
2. If patient with personal history of melanoma, check for signs or symptoms of recurrent or metastatic melanoma.
3. Examination:
   - Perform a thorough examination of the skin, including dermoscopy. Follow suggested protocol for conducting skin checks and consider a chaperone.
   - Check each lesion for features of malignancy (e.g., enlarging, changing in shape, size, colour, non-healing.)
   - If patient with a lesion suspicious for malignancy, consider checking for regional lymphadenopathy (particularly for large or long-standing squamous cell carcinomas (SCCs), SCCs of the head or neck, or melanomas.)
4. Consider possible diagnosis based on skin lesions' features:
   - Basal cell carcinoma (BCC)
   - Squamous cell carcinoma (SCC)
   - Melanoma, including amelanotic and hypomelanotic melanoma. See Dermnet NZ – Dermoscopy of Malignant Melanoma.
   - Benign or premalignant skin lesions
5. Arrange investigations as required:
   - Perform or arrange an adequate biopsy of the lesion.
   - If any suspicion of lymph node metastasis, request:
     - CT or ultrasound of relevant lymph node basin, and
     - Imaging-guided fine needle aspiration biopsy.
   - If suspected brain metastasis, request MRI or CT brain.

Management

1. If not confident obtaining an adequate biopsy or managing skin cancer, arrange skin cancer specialist assessment (e.g., general practitioner with special interest, general surgeon, plastic surgeon, dermatologist).
2. If metastatic disease suspected, request non-acute oncology assessment and mark as urgent.
3. If non-melanoma skin cancer with high-risk clinical features of a BCC or SCC or high-risk histological features of a BCC or SCC, consider requesting skin cancer specialist assessment (e.g., GP with special interest, general surgeon, plastic surgeon, dermatologist.
4. Manage other non-melanoma skin cancer according to histology:
   - Intraepidermal carcinoma (i.e., SCC in situ or Bowen's disease)
   - SCC and keratocanthoma
   - BCC

Search HealthPathways

Skin Cancer

5. Manage melanoma skin cancer according to histology:
   - Melanoma in situ, including lentigo maligna
   - Invasive melanoma
6. For all patients diagnosed and treated for skin cancer, provide:
   - counselling regarding recurrence rates and risk.
   - education about prevention and risk reduction for other cancers.
7. Arrange regular follow-up.
8. If patient with chronic immunosuppression, consider arranging skin cancer specialist assessment (e.g., general practitioner with special interest, general surgeon, plastic surgeon, dermatologist) for closer monitoring.
9. If any concerns, seek skin cancer specialist advice (e.g., general practitioner with special interest, general surgeon, plastic surgeon, dermatologist).

Request

- If metastatic disease suspected, request non-acute oncology assessment and mark as urgent.
- If non-melanoma skin cancer with high-risk clinical features of a BCC or SCC or high-risk histological features of a BCC or SCC, consider requesting skin cancer specialist assessment (e.g., GP with special interest, general surgeon, plastic surgeon, dermatologist).
- If high-risk melanoma, request non-acute plastic surgery assessment (and mark as urgent), non-acute dermatology assessment (and mark as urgent), or non-acute general surgery assessment and mark as urgent for consideration of:
  - further management.
  - sentinel lymph node (SLN) biopsy before wider excision.
- If treating intraepidermal carcinoma with fluorouracil:
  - consider arranging punch biopsy if in doubt about possible invasive component.
  - arrange surgical excision if lesion/s persist at 3 months.
- Seek radiation oncology advice for consideration of radiotherapy if SCC, keratoacanthoma, or BCC, and surgery cannot be performed.
- If patient with chronic immunosuppression, consider arranging skin cancer specialist assessment (e.g., general practitioner with special interest, general surgeon, plastic surgeon, dermatologist) for closer monitoring.
- If not confident obtaining an adequate biopsy or managing skin cancer, arrange skin cancer specialist assessment (e.g., general practitioner with special interest, general surgeon, plastic surgeon, dermatologist).
- If any concerns, seek skin cancer specialist advice (e.g., general practitioner with special interest, general surgeon, plastic surgeon, dermatologist).

Information

For health professionals

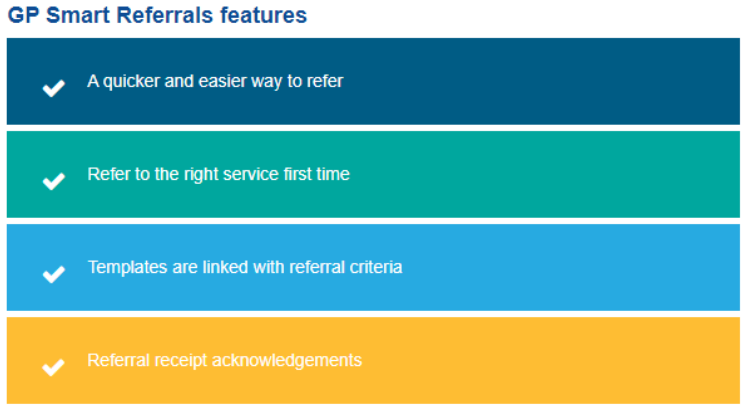
For patients

Smart Referrals

Why should I use Smart Referrals?

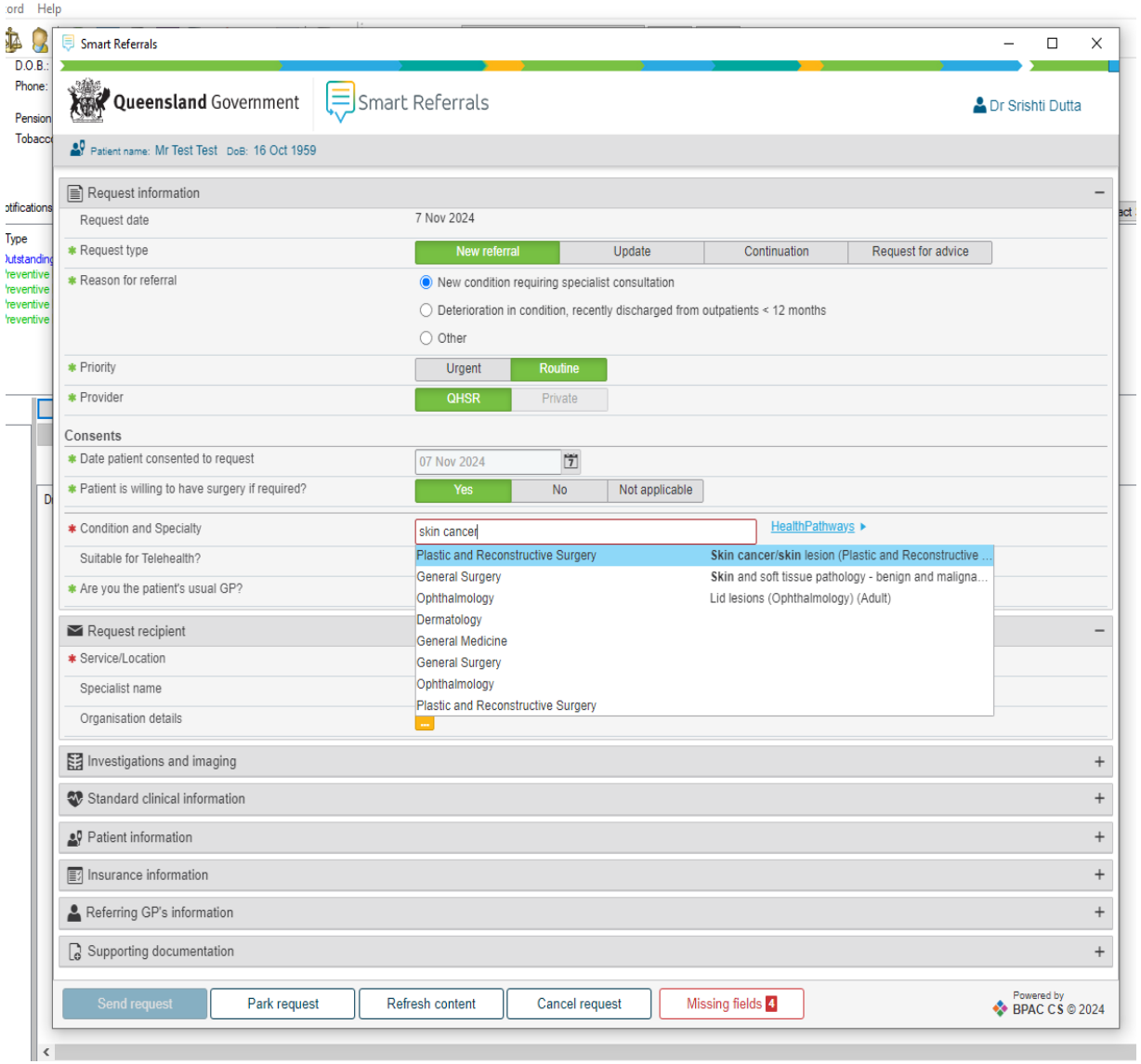
1. Allows you to attach test results, imaging reports and other clinical documents (e.g. ECGs, photos) from the patient's clinical record or your PC
2. Supports you to provide essential referral information
3. Integrated service directory identifies the speciality closest to home
4. Can be used for *Request for Advice (RFA)*
5. Shows where the referral is in the system (received, accepted, not accepted)
6. Shows appointment date linked to the referral
7. Includes an increasing number of allied health and community services

Smart Referrals



- Integrated with *Best Practice* and *Medical Director*
- Aligned with state-wide referral guidelines to prompt essential referral information required for triage, decreasing the number of referrals returned requesting additional clinical information.

Brisbane North PHN Digital Health Support Officers
GPSR@brisbanenorthphn.org.au


Smart Referrals
Queensland Government
Smart Referrals
Dr Srishti Dutta
Patient name: Mr Test Test DoB: 16 Oct 1959
Request information
Request date
7 Nov 2024
Request type
New referral
Update
Continuation
Request for advice
Reason for referral
New condition requiring specialist consultation
Deterioration in condition, recently discharged from outpatients < 12 months
Other
Priority
Urgent
Routine
Provider
QHSR
Private
Consents
Date patient consented to request
07 Nov 2024
Patient is willing to have surgery if required?
Yes
No
Not applicable
Condition and Specialty
skin cancer
HealthPathways
Suitable for Telehealth?
Are you the patient's usual GP?
Plastic and Reconstructive Surgery
Skin cancer/skin lesion (Plastic and Reconstructive ...
General Surgery
Skin and soft tissue pathology - benign and maligna...
Ophthalmology
Lid lesions (Ophthalmology) (Adult)
Dermatology
General Medicine
General Surgery
Ophthalmology
Plastic and Reconstructive Surgery
Request recipient
Service/Location
Specialist name
Organisation details
Investigations and imaging
Standard clinical information
Patient information
Insurance information
Referring GP's information
Supporting documentation
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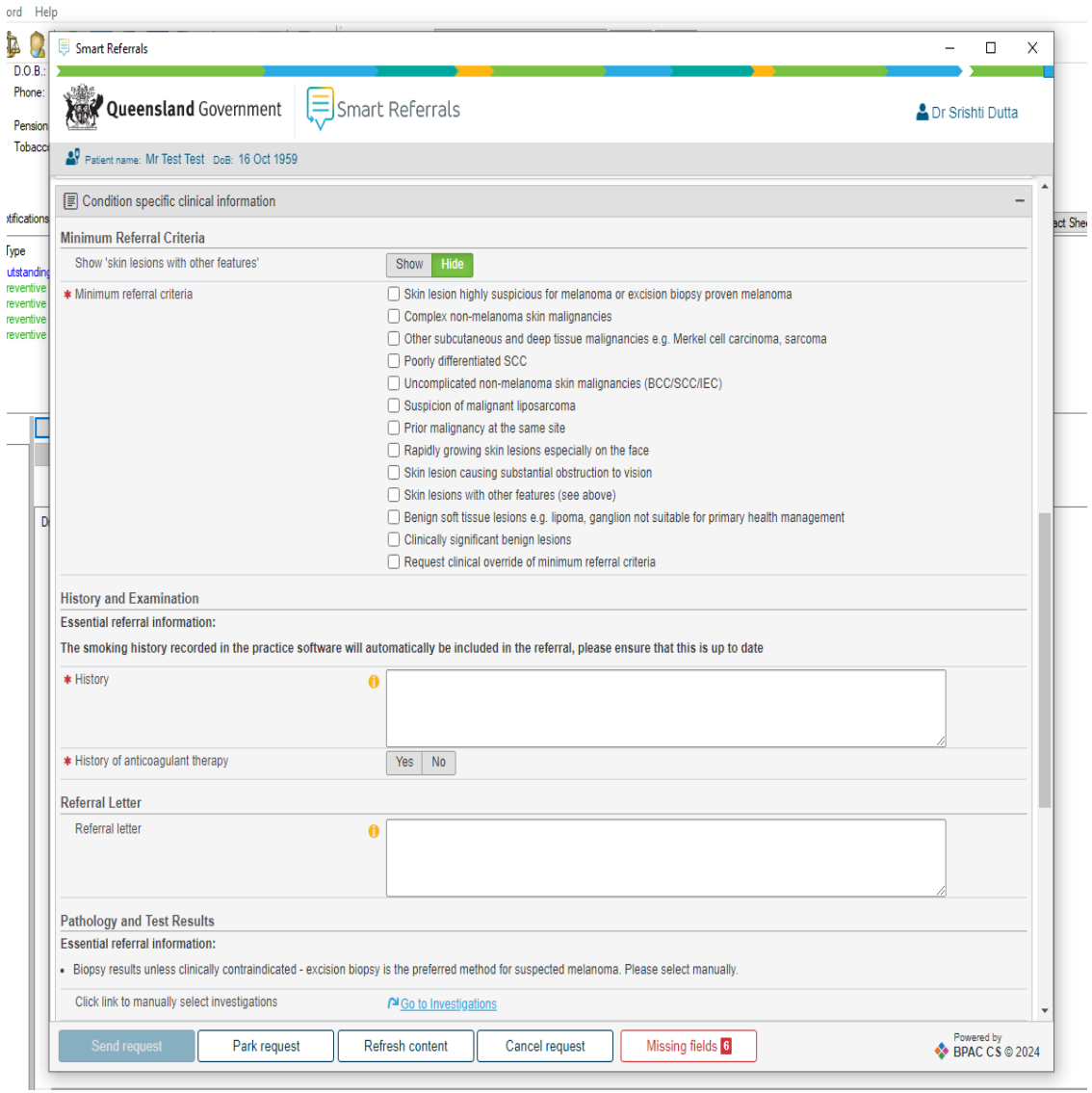
Smart Referrals
Queensland Government
Smart Referrals
Dr Srishti Dutta
Patient name: Mr Test Test DoB: 16 Oct 1959
Condition specific clinical information
Minimum Referral Criteria
Show 'skin lesions with other features'
Show
Hide
Minimum referral criteria
Skin lesion highly suspicious for melanoma or excision biopsy proven melanoma
Complex non-melanoma skin malignancies
Other subcutaneous and deep tissue malignancies e.g. Merkel cell carcinoma, sarcoma
Poorly differentiated SCC
Uncomplicated non-melanoma skin malignancies (BCC/SCC/IEC)
Suspicion of malignant liposarcoma
Prior malignancy at the same site
Rapidly growing skin lesions especially on the face
Skin lesion causing substantial obstruction to vision
Skin lesions with other features (see above)
Benign soft tissue lesions e.g. lipoma, ganglion not suitable for primary health management
Clinically significant benign lesions
Request clinical override of minimum referral criteria
History and Examination
Essential referral information:
The smoking history recorded in the practice software will automatically be included in the referral, please ensure that this is up to date
History
History of anticoagulant therapy
Yes
No
Referral Letter
Referral letter
Pathology and Test Results
Essential referral information:
Biopsy results unless clinically contraindicated - excision biopsy is the preferred method for suspected melanoma. Please select manually.
Click link to manually select investigations
Go to Investigations
Send request
Park request
Refresh content
Cancel request
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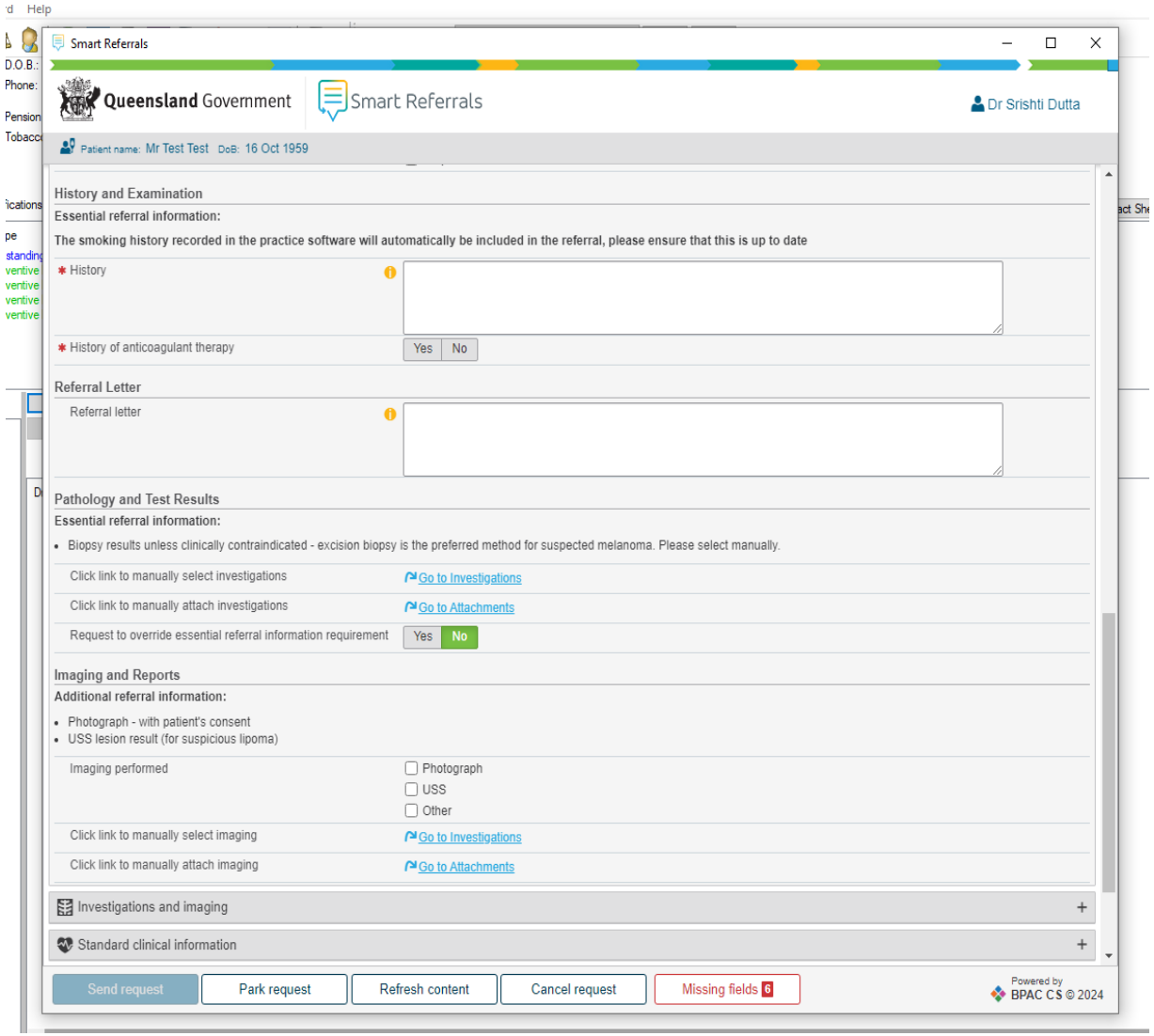
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Click link to manually select investigations
Go to Investigations
Click link to manually attach investigations
Go to Attachments
Request to override essential referral information requirement
Yes
No
Imaging and Reports
Additional referral information:
Photograph - with patient's consent
USS lesion result (for suspicious lipoma)
Imaging performed
Photograph
USS
Other
Click link to manually select imaging
Go to Investigations
Click link to manually attach imaging
Go to Attachments
Investigations and imaging
Standard clinical information
Send request
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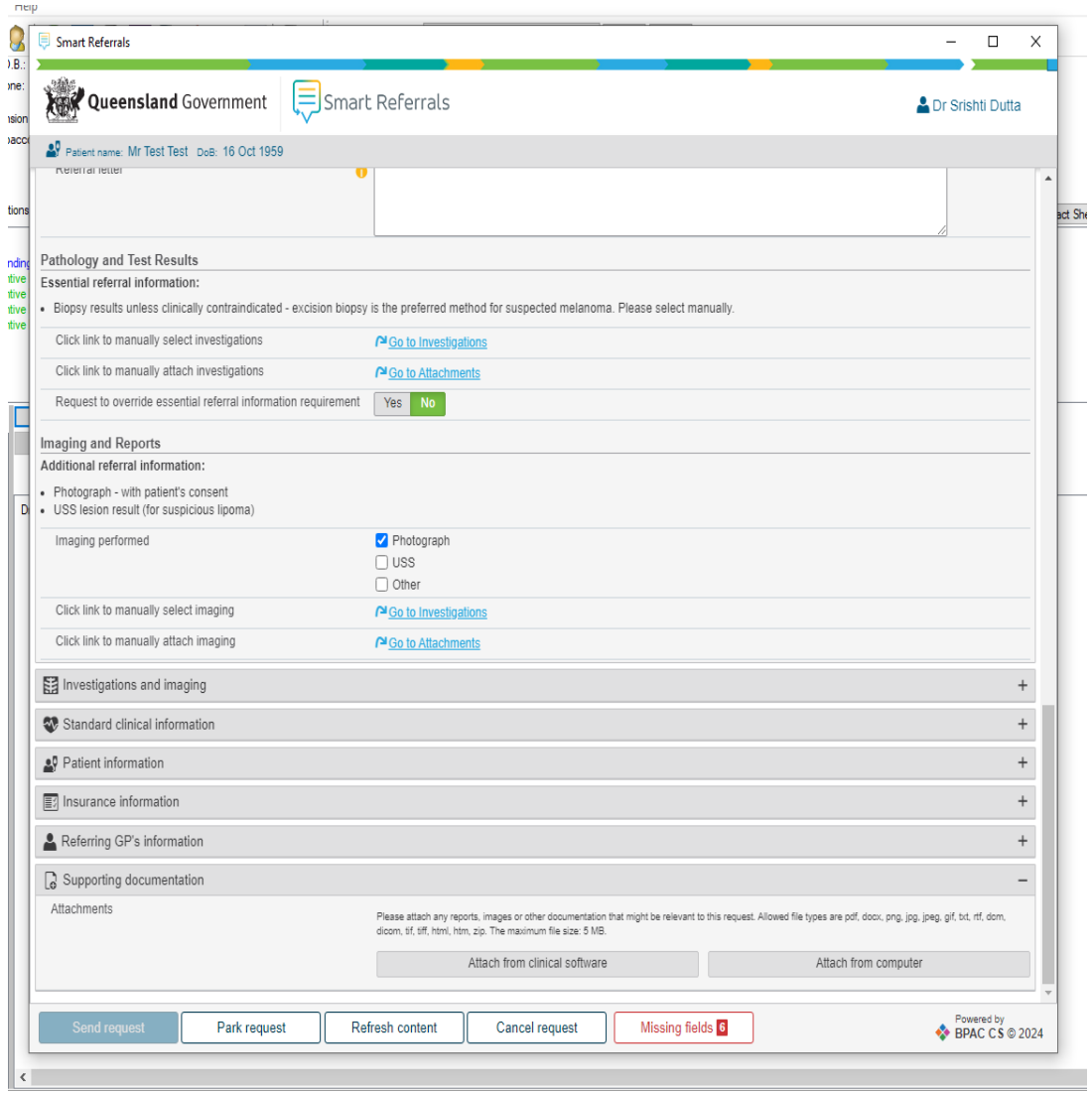
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Photograph
USS
Other
Click link to manually select imaging
Go to Investigations
Click link to manually attach imaging
Go to Attachments
Investigations and imaging
Standard clinical information
Patient information
Insurance information
Referring GP's information
Supporting documentation
Attachments
Please attach any reports, images or other documentation that might be relevant to this request. Allowed file types are pdf, docx, png, jpg, jpeg, gif, txt, rtf, dcm, dicom, tif, tiff, html, htm, zip. The maximum file size: 5 MB.
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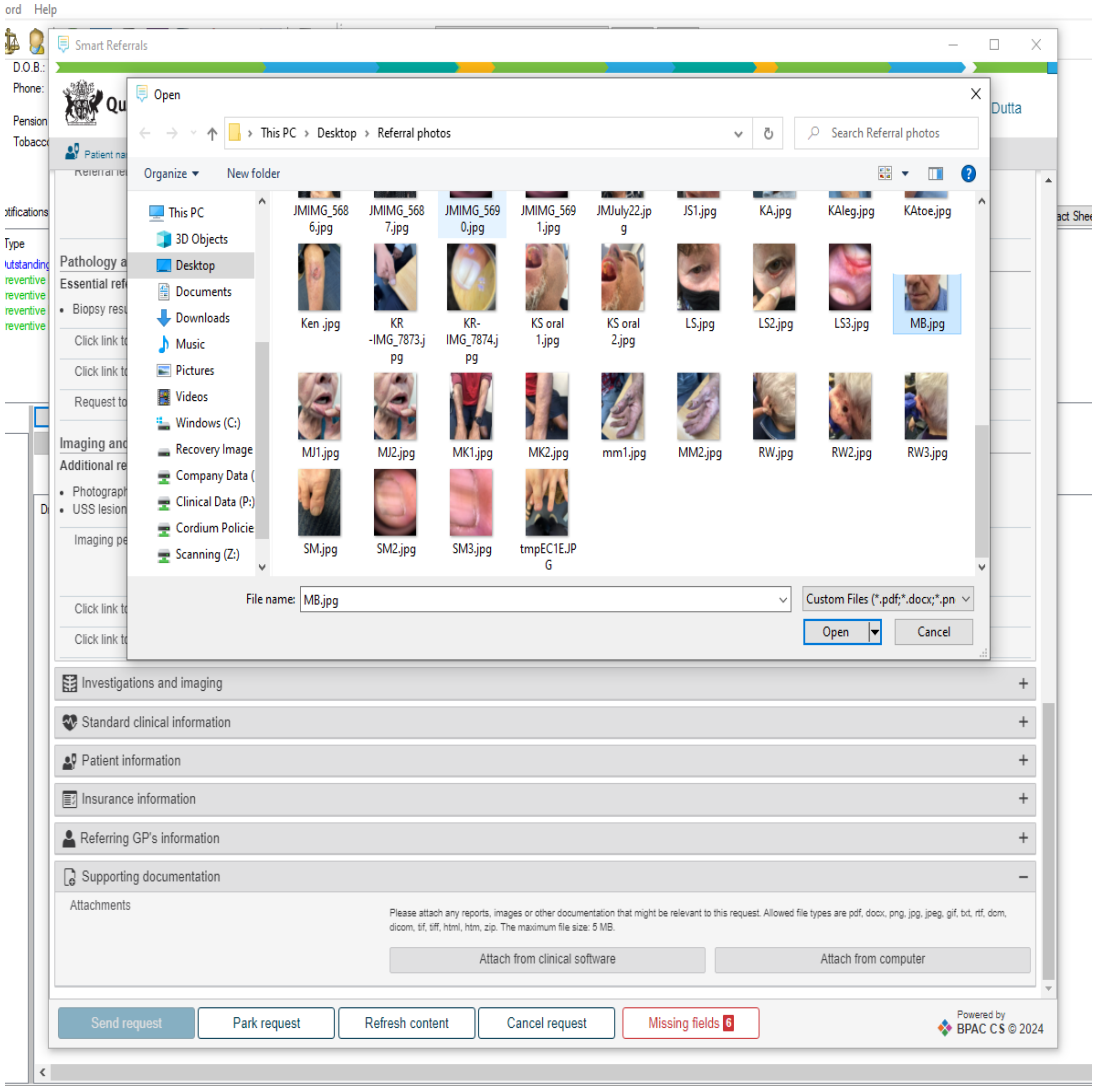
Smart Referrals
Open
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Search Referral photos
Organize
New folder
This PC
3D Objects
Desktop
Documents
Downloads
Music
Pictures
Videos
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Company Data (
Clinical Data (P:)
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Scanning (Z:)
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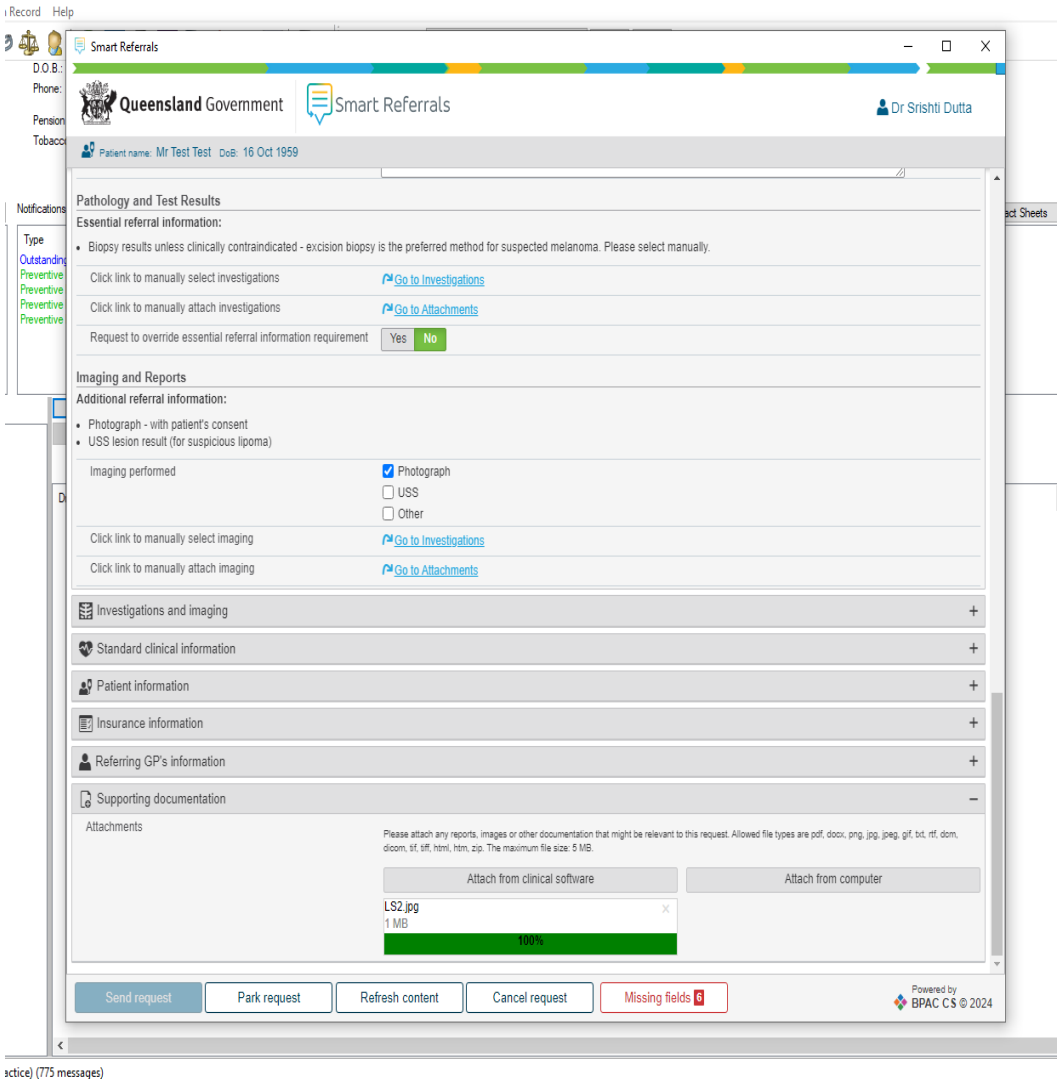
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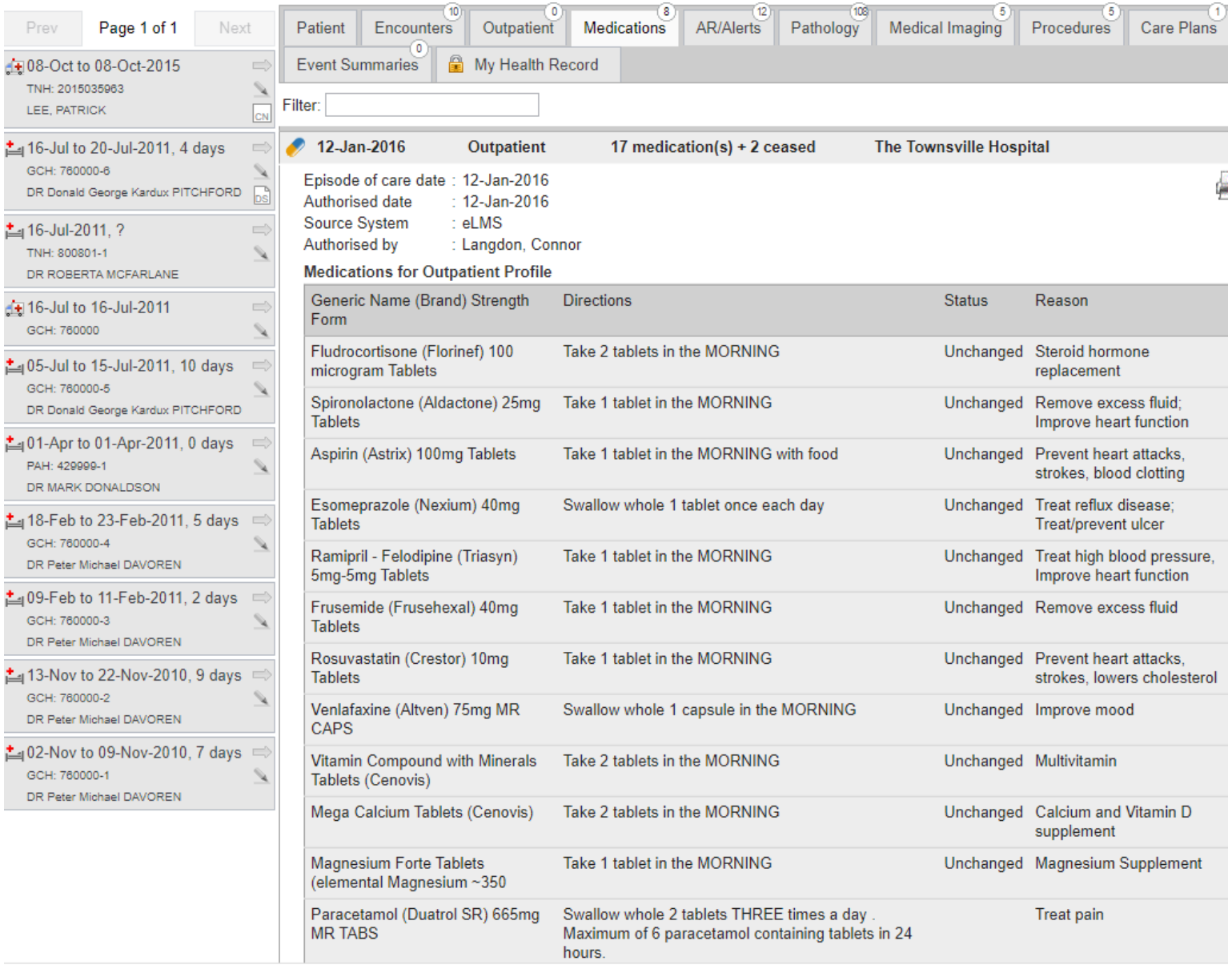
Health Provider Portal

- **Provides *eligible Queensland health practitioners (HPs) secure online access to their patients' Queensland Health records.**
- **Read-only online access allows HPs to view public hospital information including appointments, clinic letters, inpatient & ED discharge summaries, radiology & pathology reports, and medications.**

*** Queensland AHPRA registered GPs, nurses, midwives, optometrists, paramedics & pharmacists**



Clinical Photography considerations

Key points

General considerations

- Know your obligations under the law with regard to the collection, disclosure and storage of clinical photos in the jurisdiction of your practice (refer to Section 1)
- Check your practice's policy with regard to the use of personal mobile devices for clinical photos (refer to Section 2)
- Obtain informed consent from the patient prior to collecting photos (refer to Section 3)
- Report data breaches if they occur (refer to Section 4)

Collecting photos (refer to Section 5)

- Take care when using clinical photography apps
- Ensure the device has a high-resolution camera
- Capture only what is required
- Remove metadata when de-identifying photos, where applicable

Storing photos (refer to Section 6)

- Use strict privacy settings on the device
- Store photos in the patient's health record
- Always delete the photos from the device
- Avoid third-party storage options and prevent automated back-ups
- Treat photos sent by others as if you took them yourself

Disseminating photos (refer to Section 7)

- Take measures to transmit photos securely where possible
- Never share photos outside of a professional context
- Be wary of social media sharing

Clinical photography has become a boon to the world of medicine.[1] Table 1 outlines the numerous uses of clinical photography in the medical field. Regard must be had for the legal and ethical obligations of practitioners to uphold a patient's right to privacy, confidentiality and autonomy to consent to the use of photographs.[2] Current research focuses on the use of clinical photography by dermatologists.[3–5] However, clinical photography is also a valuable tool for general practitioners (GPs), who are often the first to assess skin conditions. It is therefore important for GPs to be aware of their ethical and legal obligations.

Table 1. Primary categories and uses of clinical photography of skin lesions

Category	Uses
Clinical	• Documentation of condition • Teledermatology • Tracking patient progress • Evidence in case of future legal action
Academic	• Visual aid that supports verbal clinical descriptions to benefit medical students • Assists professionals to obtain a better understanding of skin conditions and lesions
Research	• Photographs are mandatory for most research work as they help to substantiate findings; this contributes to the spread of knowledge and improvement in healthcare provision
Commercial	• Advertisements to generate public awareness about various conditions and the treatment options available

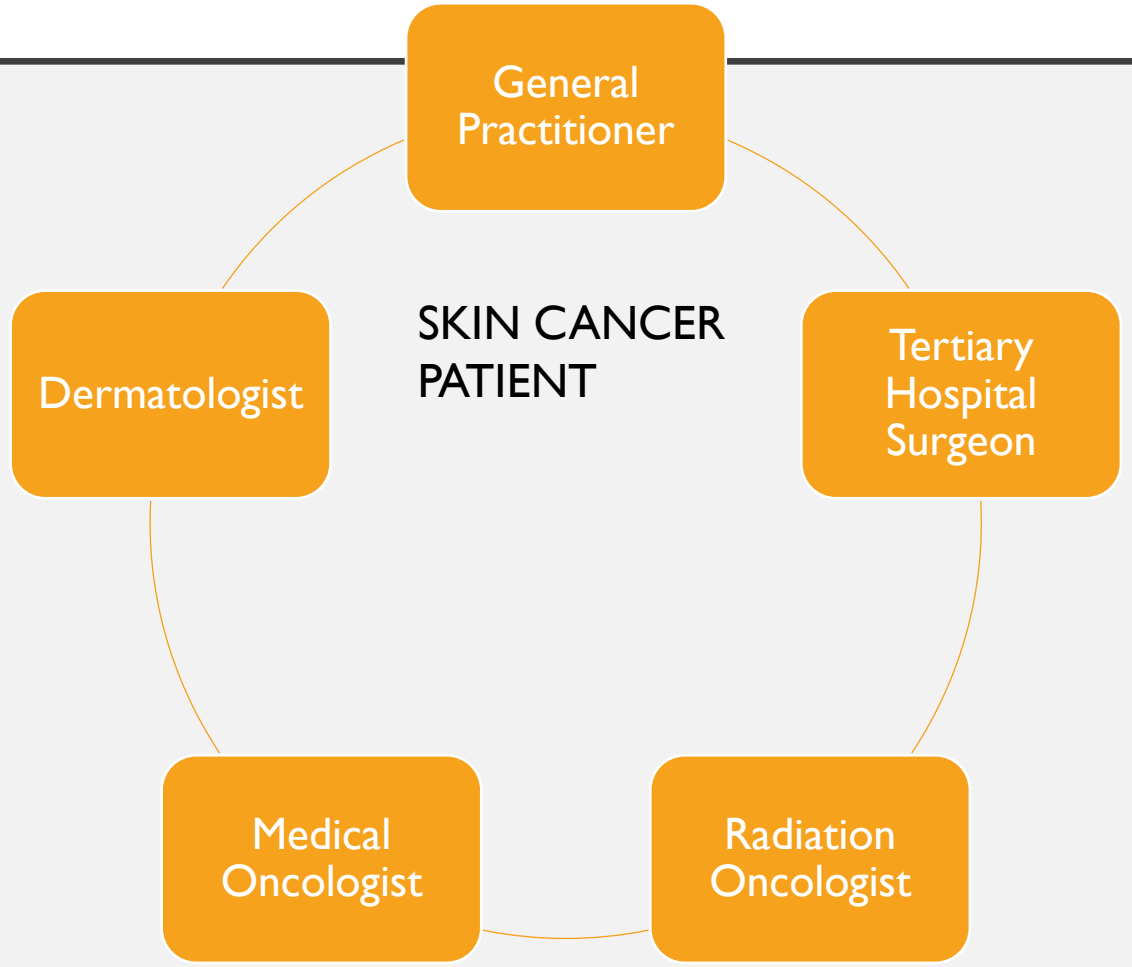
SKIN CANCER REFERRALS

Dr Andrew Lewandowski

Plastic and Reconstructive Surgeon

Royal Brisbane and Womens Hospital

THE THERAPEUTIC ALLIANCE



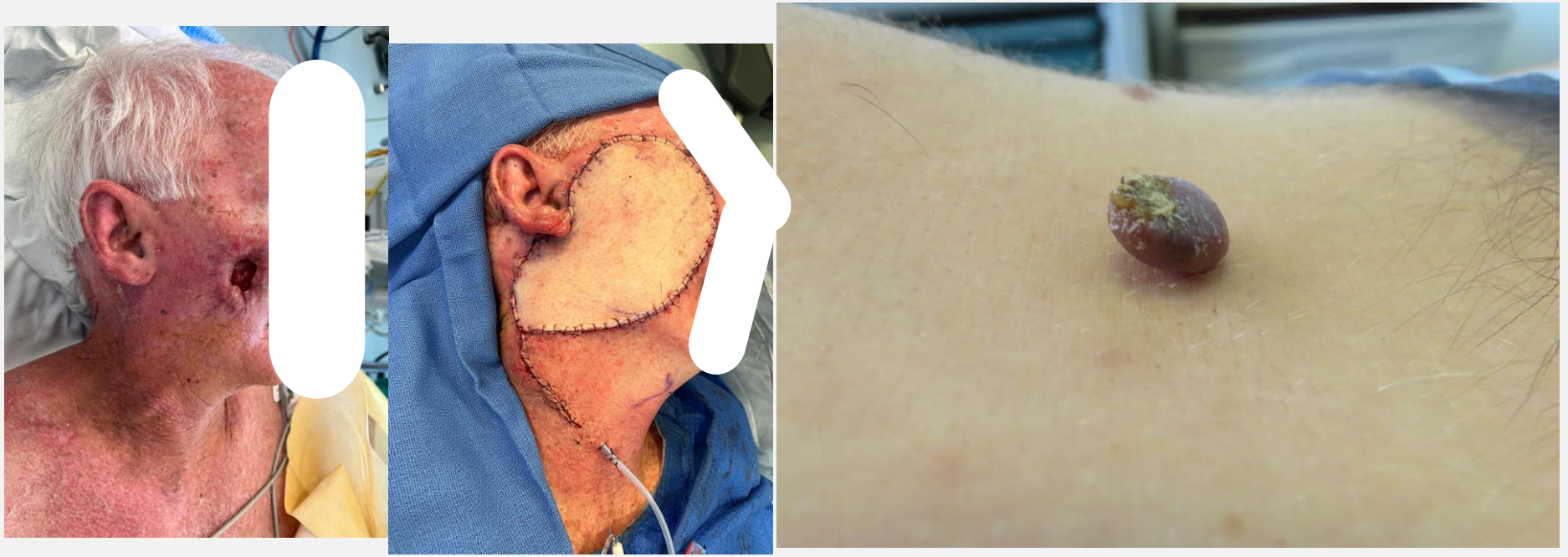
HOW DO WE IMPROVE ALLIANCE

- Communication via referral / correspondence
- Urgent vs non-urgent
- Finite resources to manage everything – need to stratify

URGENT VS NON-URGENT

- Iceberg
- Difficult to differentiate sometimes
  - Patients stoic
  - Others not…stoic
- Small lesion may have iceberg extension into deeper tissues
- Large fungating tumours may actually be pedunculated and not significantly invasive

ICEBERG VS UMBRELLA



KEY TERMS / INFORMATION

- Symptoms suggestive of adverse features
  - Formication (latin *formica* – "ants" crawling under skin)
  - Lymphadenopathy
  - B symptoms – weight loss, fevers
  - Rapid growth
- Biopsy features
  - Clinical size of lesion
  - Proximity to important structures (eyes, nose, lips)
  - PNI / LVI
  - IEC – adnexal growth vs not (suitability for non-operative)
- Radiology
  - CT / USS reporting lymphadenopathy suspicious for metastasis

Relevant Medical Information

- Necessary for triaging into correct service
  - Main clinic
  - See and Treat Rapid Access Clinics
- Comorbidities
  - Major cardiac / respiratory
  - Blood thinners
  - T2DM
  - Immunosuppression (higher risk)
- Accessibility
  - Mobile
  - Wheelchair bound
  - Nursing home in a bed requiring Ambulance transport

WHAT HAPPENS – ROYAL SURGERY

- Melanoma generally standalone surgical clinic
  - Staffed by Jason Miller (general surgery), Brendan Louie & Andrew Lewandowski (PRS)
  - See patients ideally within 2 weeks
- Melanoma causes significant stress and anxiety given its social stigma
- Also see Merkel Cell, Dermal Sarcoma (AFX/PDS) urgently
- Thinner MIS or T1a melanomas where sentinel node not generally indicated go out to other consultants – still relatively urgently (2-4 weeks)

WHAT HAPPENS – ROYAL SURGERY

- Main plastic surgical clinic
  - Average half day clinic ~ 30 patients of varying complexity, generally 5-10 new per consultant
  - See variety of presentations for NMSC, general reconstruction (some sub-specialty areas)
  - Makes up to ~ 30 new patients per week
- Lesions on limbs / trunk – offered to General Surgery as well – unless significant size / complexity
- Utilising SuperClinics – getting every consultant in unit and every registrar in on a Saturday – see 150 patients
- Newly setup NewCase clinics seeing 25/week to get on top of waitlist

THE WAITLIST IS GROWING

- I'm not here to say we don't want your patients, we DO want to see them
- I'm not here to preach
- I think its important for you all to hear DIRECTLY from the source – we WANT to be contacted and annoyed if your patient comes back with increased size, worsening features/symptoms
- If something doesn't feel right – call us and escalate
- GP are primary point of contact and manage vast majority of skin cancer in community
  - When it is in difficult areas, has a significant surface area, has escalated to a point where not treatable in community OR multiple involved margins – good reason to send to us

Update on melanoma and immunotherapy

Dr Melissa Eastgate

Operations Director & Senior Medical Oncologist, Cancer Care Services | RBWH

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Update on Melanoma and immunotherapy

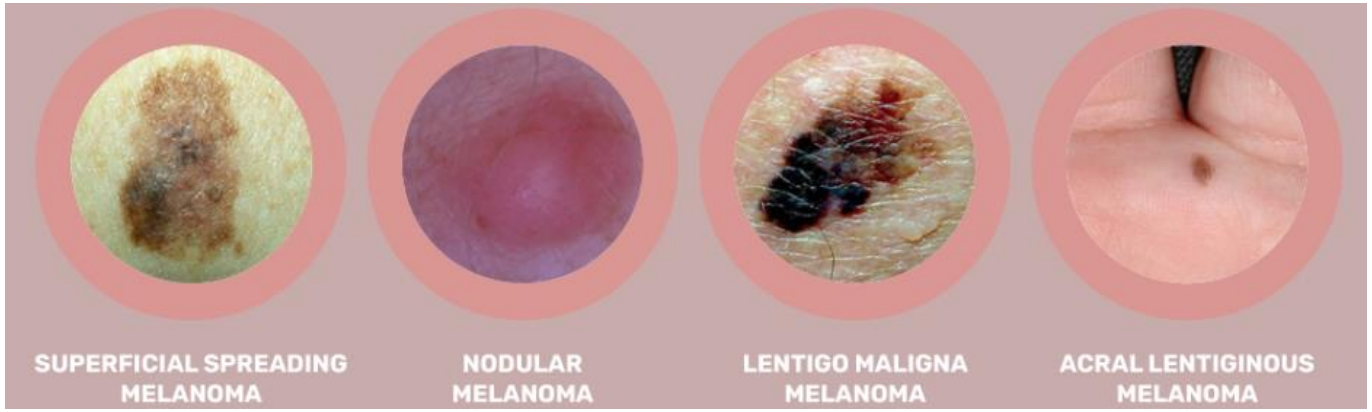
A/Prof Melissa Eastgate

Operations Director, CCS

Senior Medical Oncologist

Melanoma –Australian Stats

- Australia and NZ have the highest rates of melanoma in the world
- 4180 new cases in Qld each year
- 1 Australian Dx every 30 minutes
- 2nd most common cancer in men and women



SUPERFICIAL SPREADING MELANOMA	NODULAR MELANOMA	LENTIGO MALIGNA MELANOMA	ACRAL LENTIGINOUS MELANOMA
55-60% of cases age < 40 yrs Can start as new brown/black spot or an existing spot that demonstrates change Trunk, slow growing	10-15% of cases age > 65 yrs Round, raised firm lump that is pink /red / brown / black. Can have crusty surface w/ tendency to bleed Head and neck, fast growing	10-15 % of cases age > 40 yrs Large coloured spot in sun-damaged skin. Face, ears, neck, head. Can grow slowly and superficially	1-2% of cases age > 40 yrs Palms, soles, fingernails/toenails. Colourless or lightly coloured, long streak of pigment in nails.

Metastatic melanoma

up to 10% have unknown 1^0

M1a: mets to distant skin, subcutaneous or LN sites

M1b: lung mets

M1c: non-CNS visceral mets

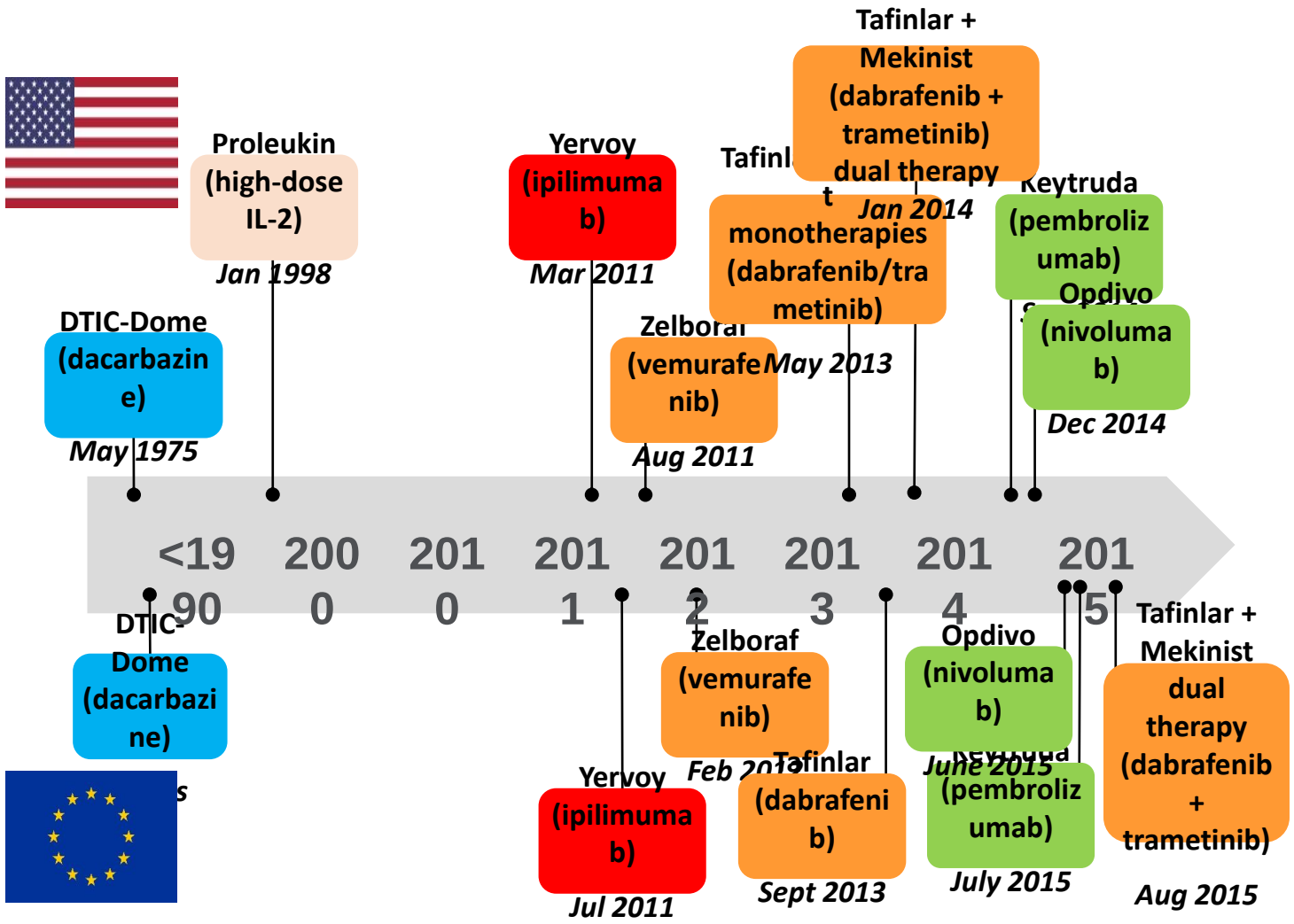
M1d: CNS mets with/without other sites involved

Prognosis:

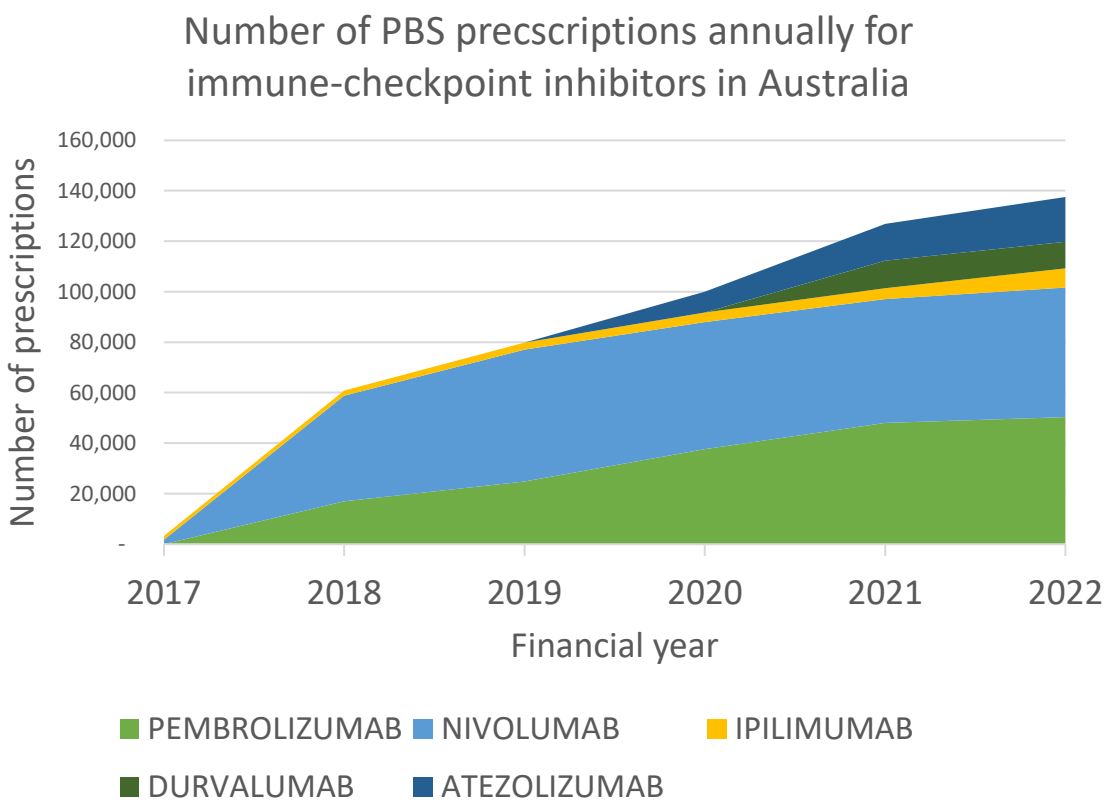
- mOS of untreated stage IV melanoma: <12 mo, 5yr OS: 10%
- M1a Prognosis: up to 15 mo
- M1c Prognosis: 6-9 mo
- M1d Prognosis: ~ 3 months
- Poor prognostic features: high tumour burden, elevated LDH, poor PS

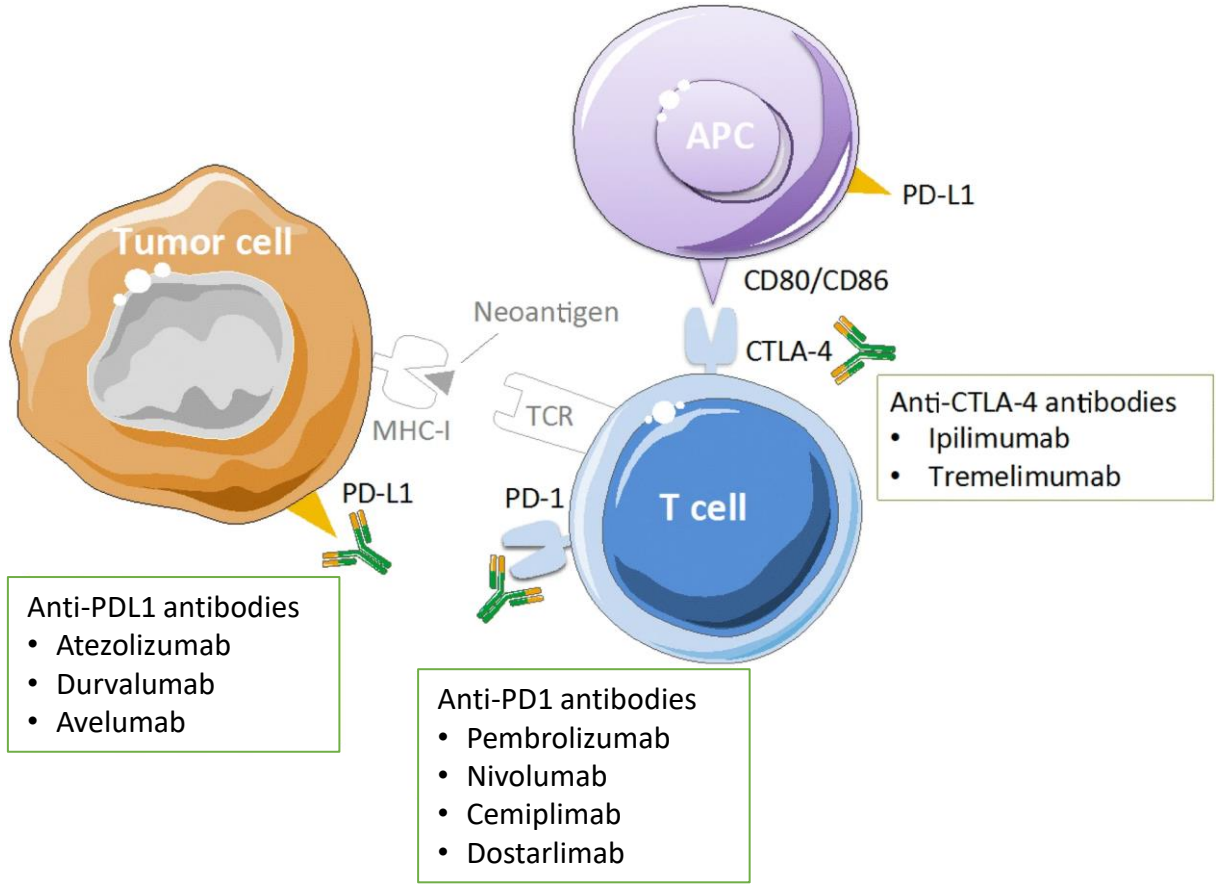
1. DeVita et al
2. Davies et al. Prognostic factors for survival in melanoma patients with brain mets. Cancer 2011; 117(8):1678-96
3. Vecchio et al. The treatment of melanoma brain mets before the advent of targeted therapies. Melanoma Res. 2014;24(1):61-7.

Metastatic melanoma treatments



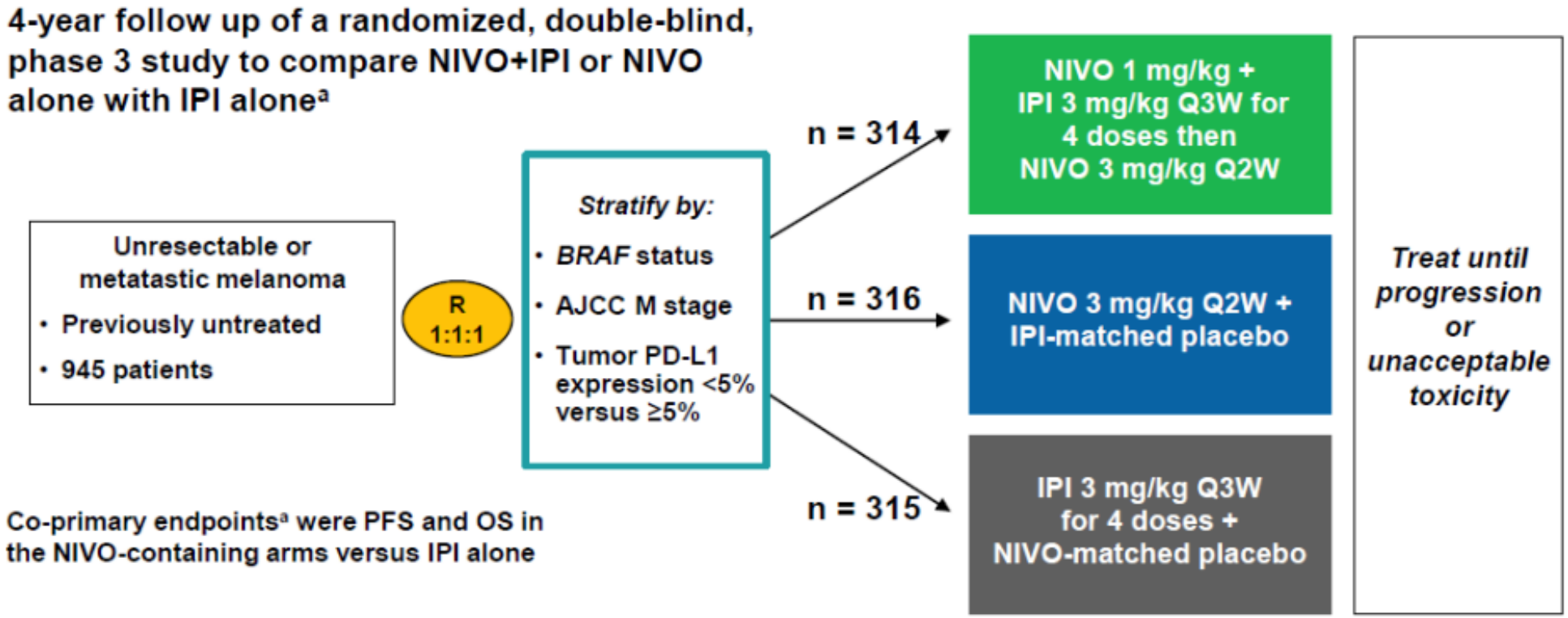
Immune checkpoint inhibitors





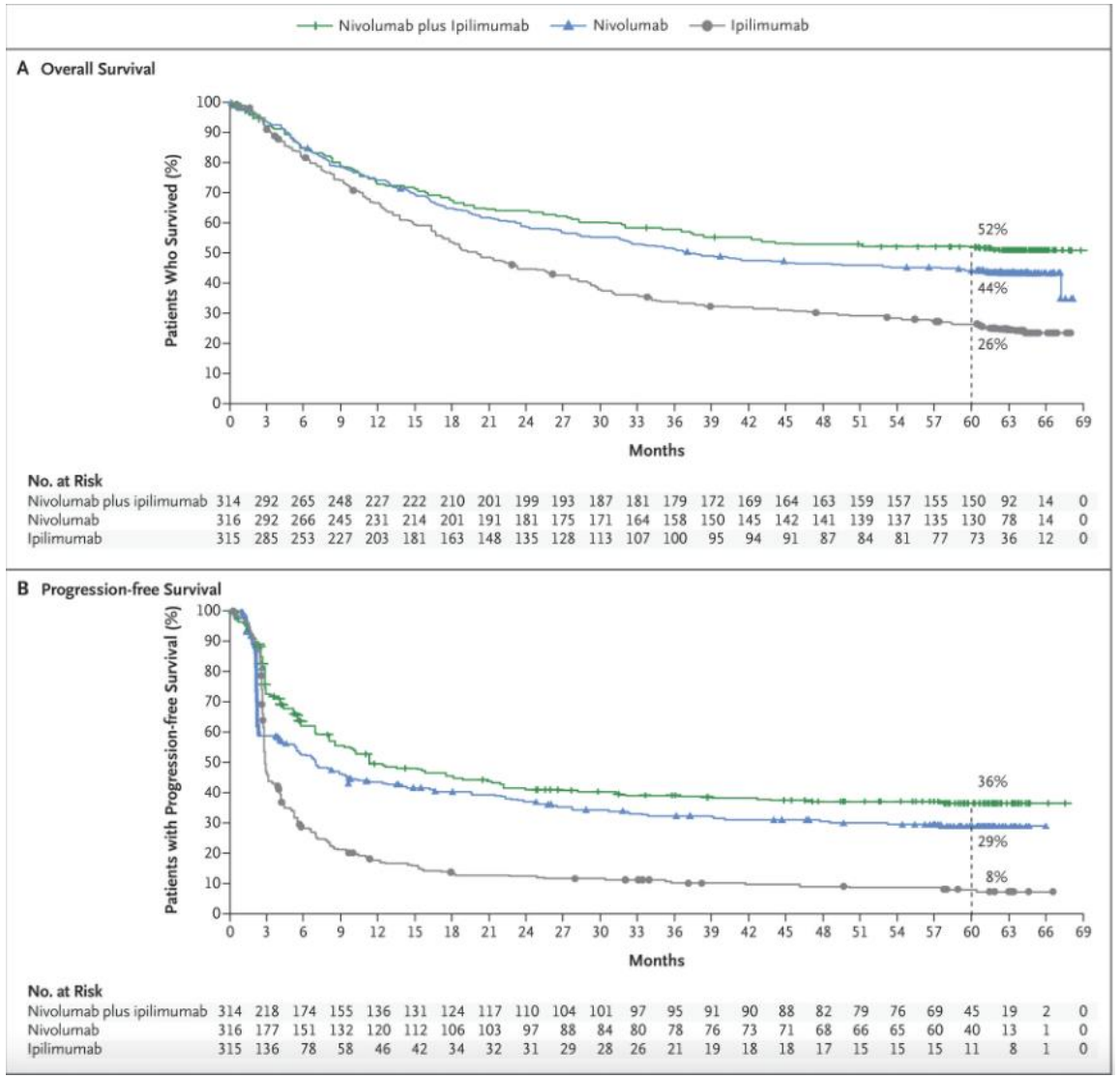
Rouanne et al, *World J Urology*, 2018

Met melanoma, BRAF WT
Checkmate 067 trial (2017, 2019)



Checkmate 067 (2017, 2022) - Efficacy

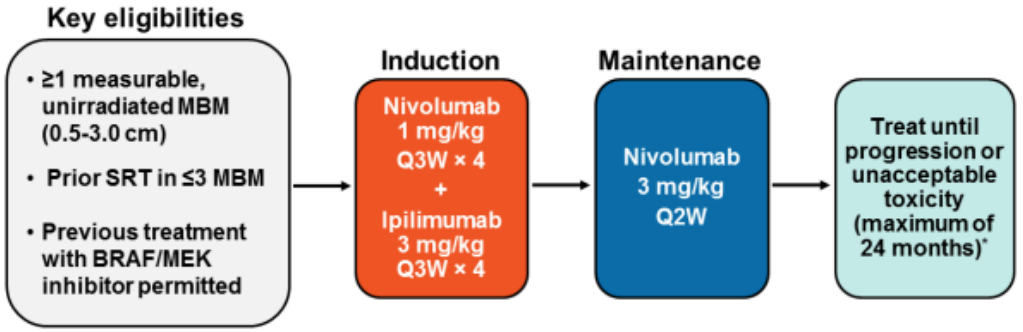
	Ipi + Nivo	Nivo	Ipi
mOS (mo)	72.1	36.9	19.9
PFS (mo)	11.5	6.9	2.9
5yr OS	52%	44%	26%
6.5yr MSS	NR	58.7	21.9
ORR	58%	45%	19%
CR	23%	19%	6%
PR	36%	26%	13%
SD	12%	9%	22%
PD	24%	38%	50%
mDOR (mo)	NR (61.9-NR)	NR (45.7 –NR)	19.2 (8.8 – 47.4)



M1d Melanoma –Brain mets

- mOS of melanoma brain mets (MBM): 2.8-4 mo
- 2 trials: ABC (n=76) and CM 204 (n=94)
- ABC-X trial underway: Ipi/Nivo + SRT vs Ipi/Nivo

CM 204 schema



A: asymptomatic brain mets, no local Rx: Ipi/Nivo then Nivo
B: asymptomatic brain mets, no local Rx: Nivo
C: brain mets failed local Rx, neuro Sx, leptomeningeal disease: Nivo

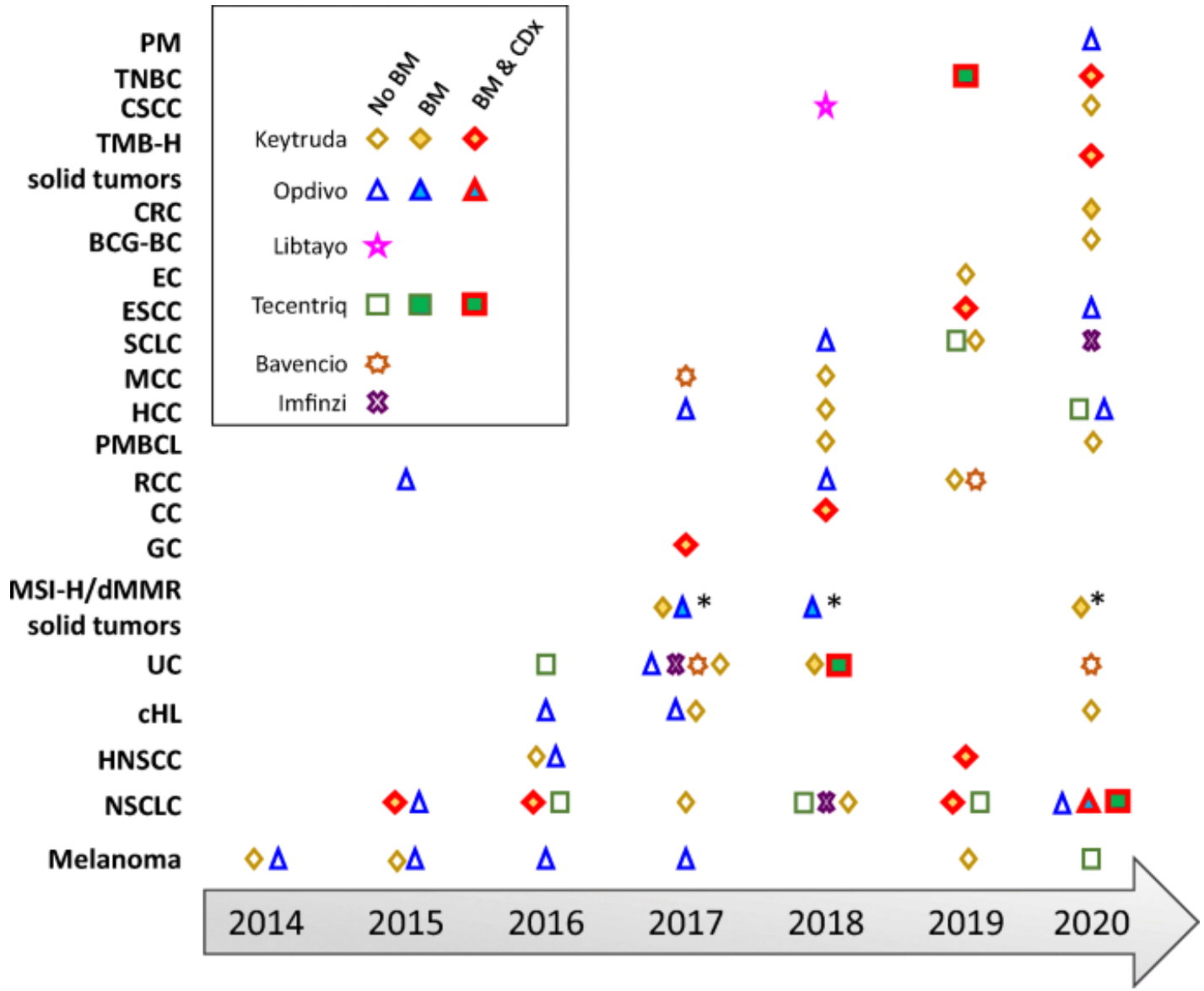
	A (ipi+nivo)	B (nivo)	C (nivo)
All patients	n=35	n=25	n=16
ICR	51%	20%	6%
5-yr IC PFS	46%	15%	6%
5-yr OS	51%	34%	13%
Rx naïve	n=27	n=19	n=4
ICR (Rx naïve)	59%	21%	25%
5-yr IC PFS (Rx naïve)	52%	14%	.
5-yr OS (Rx naïve)	55%	40%	25%
TRAE G3/4	63%	20%	13%

Table 2. Response to Treatment.

Variable	Intracranial (N=94)	Extracranial (N=94)	Global (N=94)
Best overall response — no. (%)*			
Complete response	24 (26)	7 (7)	8 (9)
Partial response	28 (30)	40 (43)	40 (43)
Stable disease for ≥6 mo	2 (2)	6 (6)	5 (5)
Progressive disease	31 (33)	28 (30)	33 (35)
Could not be evaluated†	9 (10)	13 (14)	8 (9)
Objective response‡			
No. of patients	52	47	48
Percent of patients (95% CI)	55 (45–66)	50 (40–60)	51 (40–62)
Clinical benefit§			
No. of patients	54	53	53
Percent of patients (95% CI)	57 (47–68)	56 (46–67)	56 (46–67)

ABC trial: https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(18)30139-6/abstract

Increasing indications



Stage 3 melanoma

2024 ASCO ANNUAL MEETING

Long-Term Follow-Up for Adjuvant Dabrafenib Plus Trametinib in Stage III BRAF-Mutated Melanoma: Final Results of the COMBI-AD Study

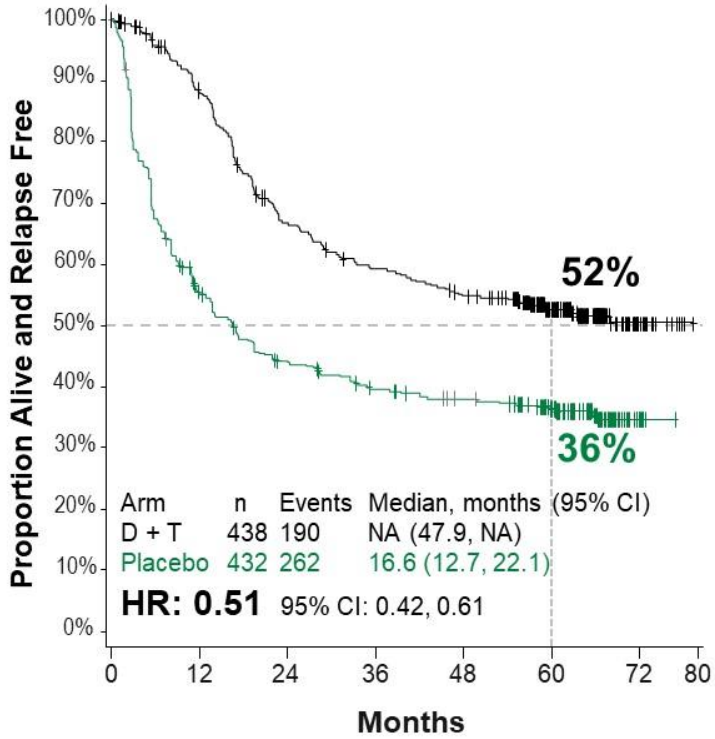
Axel Hauschild, Reinhard Dummer, Mario Santinami, Victoria Atkinson, Mario Mandala, Barbara Merelli, Vanna Chiarion-Sileni, Andrew Mark Haydon, Jacob Schachter, Dirk Schadendorf, Thierry Lesimple, Elizabeth Ruth Plummer, James Larkin, Monique Tan, Sachin Bajirao Adnaik, Paul Burgess, Tarveen Jandoo, Georgina V. Long

Scan to obtain

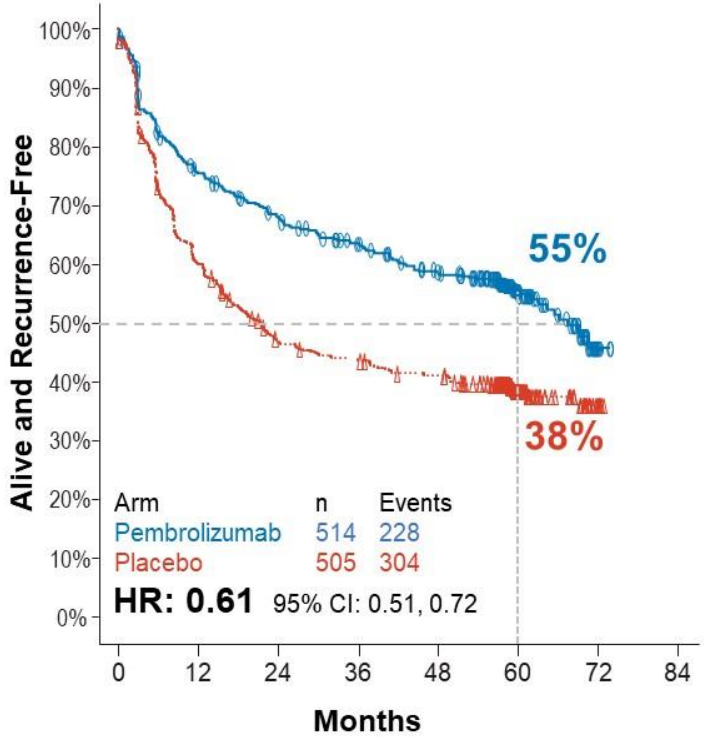
- Presentation

https://bit.ly/Hauschild9500

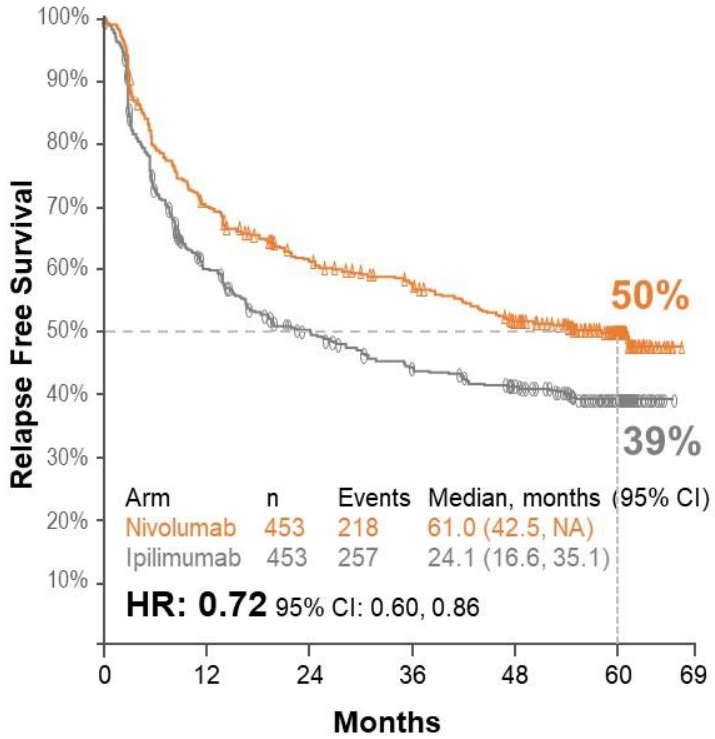
Adjuvant Therapy in Resected Melanoma in 2024
RFS at 5 Years of Follow-Up



COMBI-AD[1]
Dabrafenib plus trametinib vs placebo



KEYNOTE-054[2]
Pembrolizumab vs placebo



CHECKMATE-238[3]
Nivolumab vs ipilimumab

1. Dummer R, et al. *N Engl J Med*. 2020;383:1139-1148. 2. Eggermont A, et al. *NEJM Evidence*. 2022;1:EVIDoa2200214. 3. Larkin J, et al. *Clin Cancer Res*. 2023;29:3352-3361.

Survival Endpoints at 5 Years of Follow-Up

Endpoint	COMBI-AD[1]	KEYNOTE-054[2]	CHECKMATE-238[3]
Population	Dabrafenib + trametinib (n=438) vs placebo (n=432) *BRAF* V600E/K only	Pembrolizumab (n=514) vs placebo (n=505)	Nivolumab (n=453) vs ipilimumab (n=453)
Melanoma stage	AJCC 7th edition Stage IIIA-C	AJCC 7th edition Stage IIIA-C	AJCC 7th edition Stage IIIB-C/IV
RFS	52% vs 36% HR: 0.51 95% CI: 0.42, 0.61	55% vs 38% HR: 0.61 95% CI: 0.51, 0.72	50% vs 39% HR: 0.72 95% CI: 0.60, 0.86
DMFS	65% vs 54% HR: 0.55 95% CI: 0.44, 0.70	61% vs 44% HR: 0.62 95% CI: 0.52, 0.75	58%[a] vs 51%[b] HR: 0.79 95% CI: 0.63, 0.99
OS	Not analyzed[c]	Not analyzed	76% vs 72% HR: 0.86 95% CI: 0.66, 1.12

[a]n=370; [b]n=366; [c]Inadequate number of events to trigger the final analysis.

1. Dummer R, et al. *N Engl J Med*. 2020;383:1139-1148. 2. Eggermont A, et al. *NEJM Evidence*. 2022;1:EVIDoa2200214. 3. Larkin J, et al. *Clin Cancer Res*. 2023;29:3352-3361.

Neoadjuvant therapy

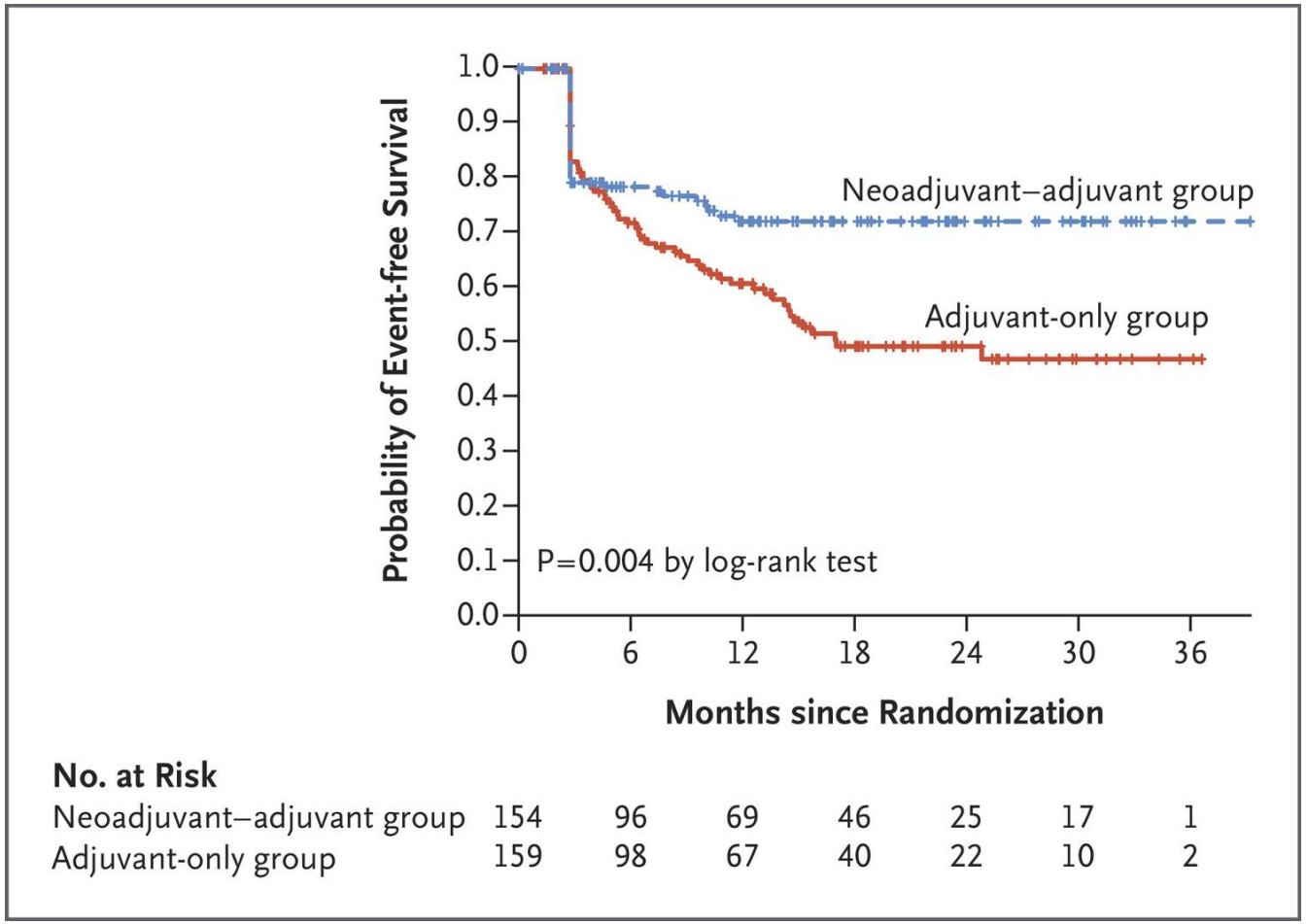
ORIGINAL ARTICLE

Neoadjuvant–Adjuvant or Adjuvant-Only Pembrolizumab in Advanced Melanoma

Authors: Sapna P. Patel, M.D., Megan Othus, Ph.D., Yuanbin Chen, M.D., Ph.D., G. Paul Wright, Jr., M.D., Kathleen J. Yost, M.D., John R. Hyngstrom, M.D., Siwen Hu-Lieskovan, M.D., Ph.D., +45, and Antoni Ribas, M.D., Ph.D. Author Info & Affiliations

Published March 1, 2023 | N Engl J Med 2023;388:813-823 | DOI: 10.1056/NEJMoa2211437 | VOL. 388 NO. 9

Neoadjuvant therapy



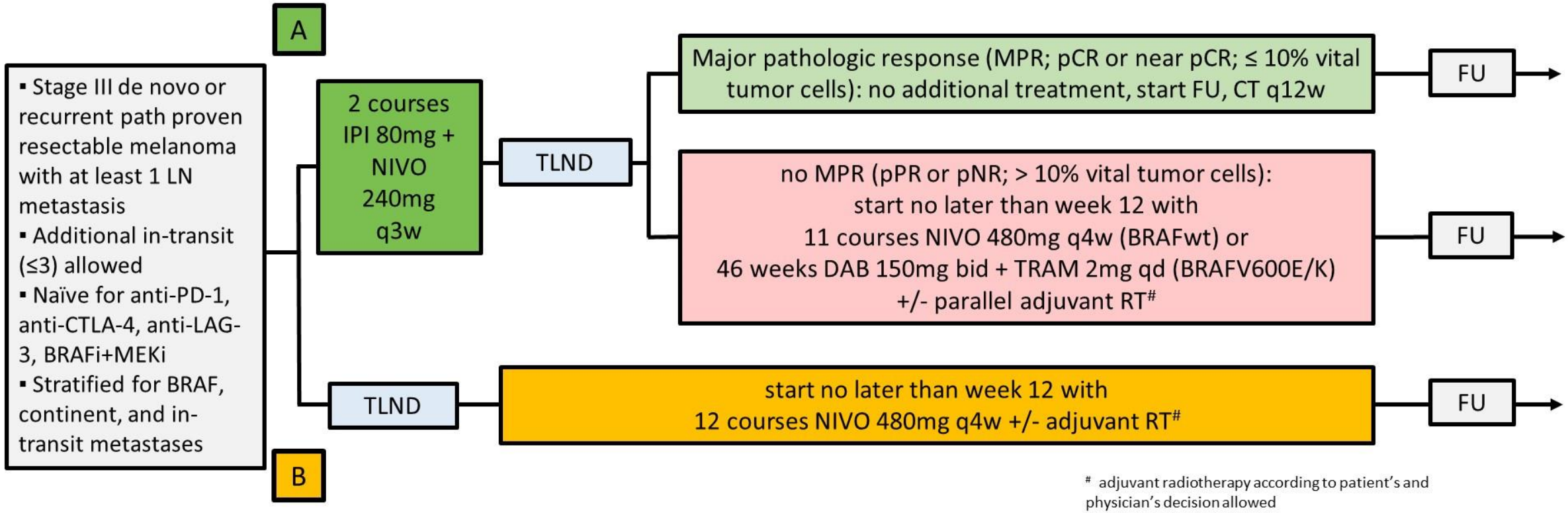
2024 ASCO ANNUAL MEETING

Neoadjuvant Nivolumab Plus Ipilimumab Versus Adjuvant Nivolumab in Macroscopic, Resectable Stage III Melanoma: The Phase 3 NADINA Trial

Christian U. Blank, M.W. Lucas, R.A. Scolyer, B.A. van de Wiel, A.M. Menzies, M. Lopez-Yurda, A.C.J. van Akkooi, W.J. van Houdt, R.P.M. Saw, A. Torres-Acosta, S.N. Lo, G.A.P. Hospers, M.S. Carlino, J.W.B. de Groot, E. Kapiteijn, K.P.M. Suijkerbuijk, P. Rutkowski, S. Sandhu, A.A.M. van der Veldt, G.V. Long

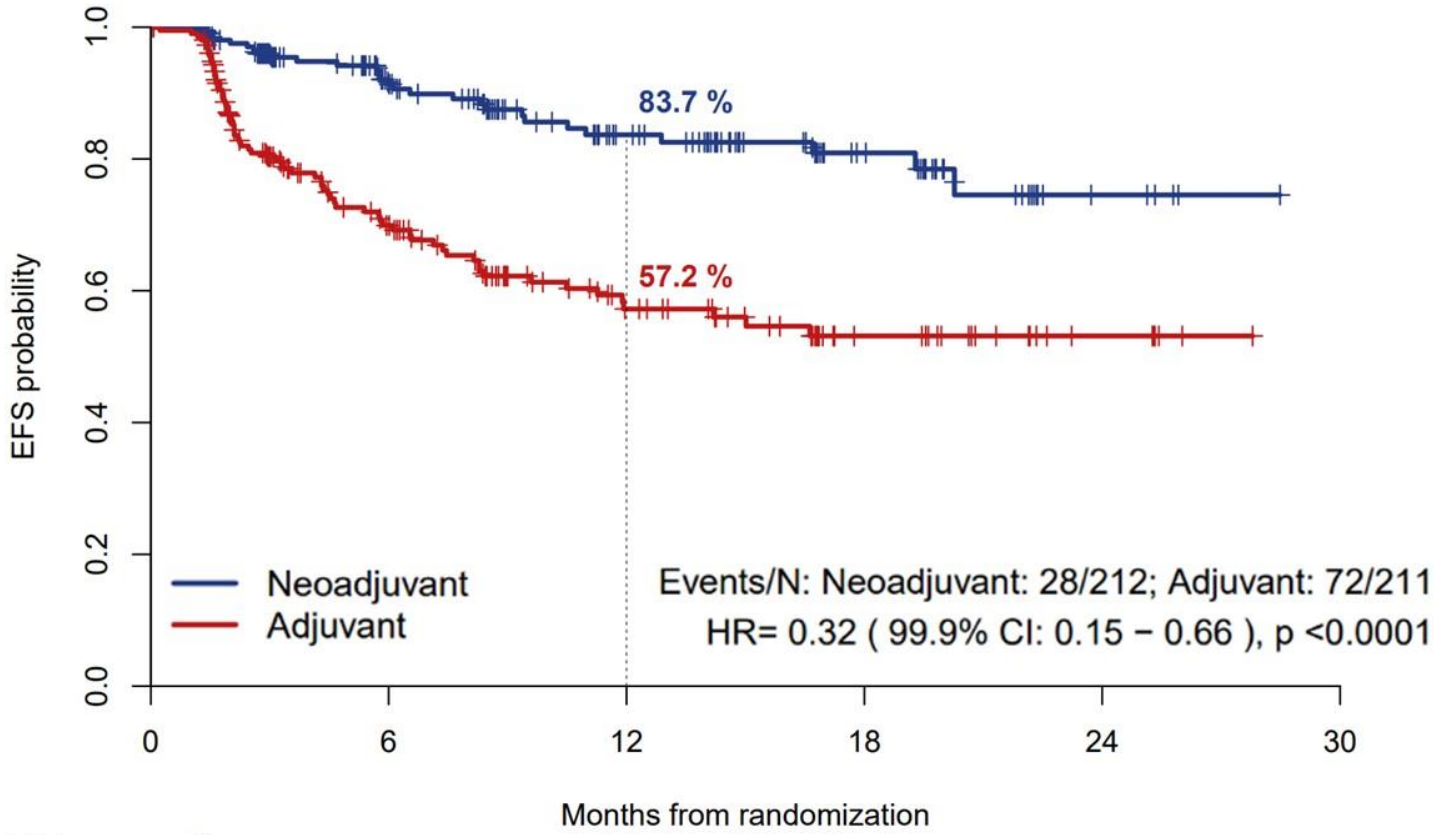
lay abstract

NADINA - Trial Design



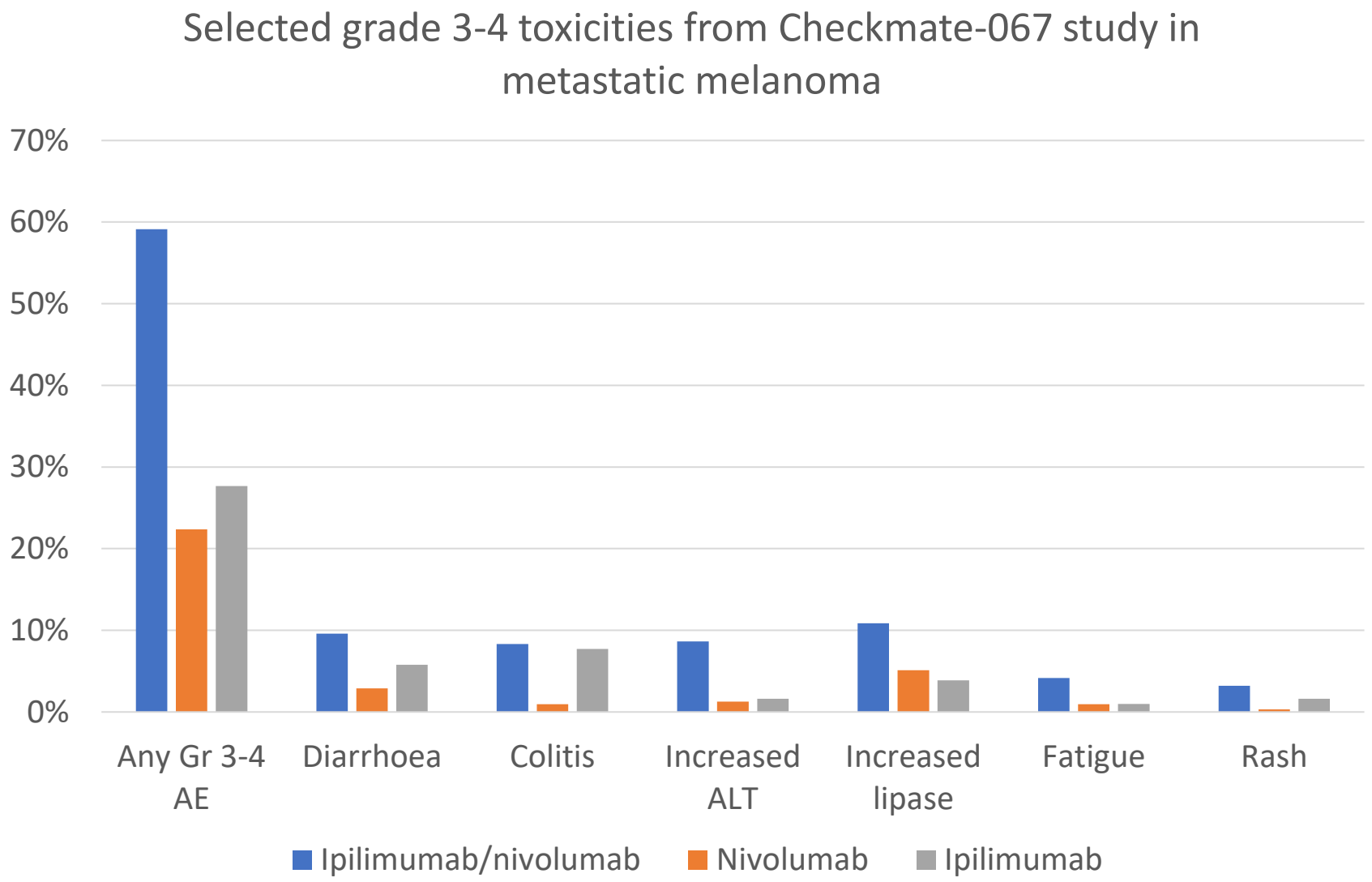
PRESENTED BY: Christian U. Blank, MD PhD

NADINA – Primary Endpoint: Event-Free Survival (EFS)



# at risk (censored)										
Neoadjuvant	212	(0)	126	(71)	77	(111)	34	(152)	5	(179)
Adjuvant	211	(0)	100	(57)	53	(89)	23	(116)	6	(133)

Immune checkpoint inhibitors



Gastritis/duodenitis

- Much less common than lower GI toxicity; can occur together
- Incidence unclear, case reports/series; estimated <1%
- Symptoms include:
  - Nausea/vomiting (50-100%)
  - Abdominal pain (30-75%)
  - Dyspepsia (38%)
  - Bleeding (18% in one case series)
  - Concomitant lower GI symptoms eg. diarrhoea up to 50%
- Management guided by case series - as for lower GI toxicity with steroids and anti-TNF-α agents in refractory cases

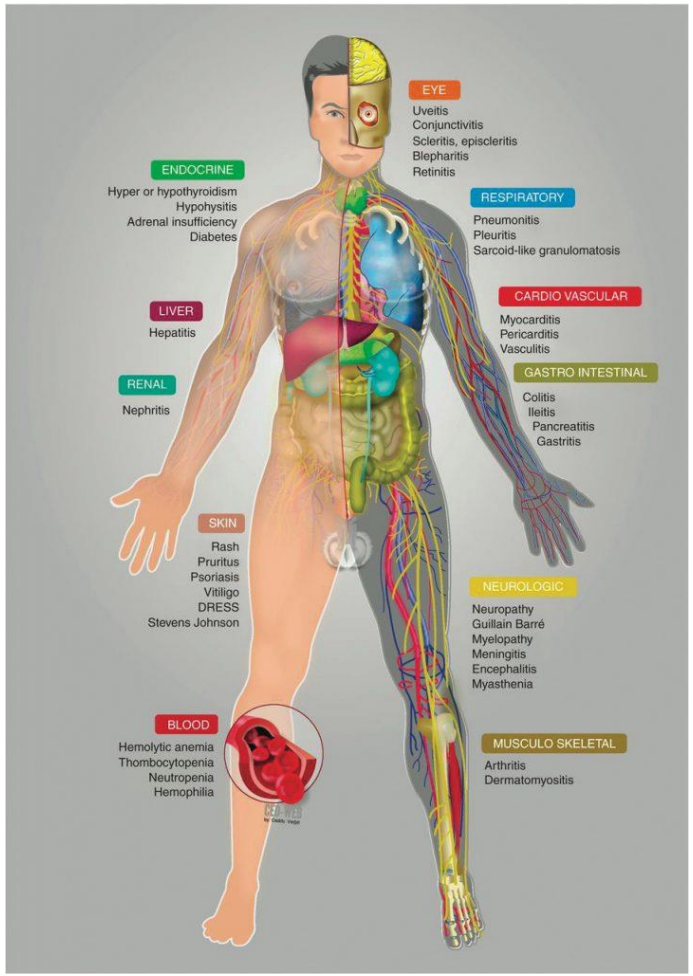
Endocrinopathies

- Clinically significant endocrinopathies in up to 10% patients
  - Most commonly hypothyroidism
  - Can include: hypoadrenalism, hypopituitarism / hypophysitis, diabetes
  - Incidence of ICI-associated diabetes <1%
- Irreversible
- Steroids rarely indicated
- Do not preclude further immunotherapy

Fever and systemic inflammatory syndromes

- Fever and systemic inflammatory complications of immunotherapy can occur including cytokine release syndrome (CRS) and haemophagocytic lymphohistiocytosis (HLH)
- Requires usual workup to exclude infectious causes
- Limited data to guide management but can be steroid responsive

Summary



Champiat et al, Ann Oncol, 2016

Metastasectomy

- For palliation of symptoms
- May be associated with improved long-term survival following complete curative resection
- Generally, best outcomes in pts with indolent disease, fewer metastatic sites and metasatatic disease that can be completely resected
- In pts with major response to systemic therapy, complete resection of residual mets may contribute to improved DFS and potential for cure
- Lung: 22% 5 yr survival, 16% 10 yr survival cf 0% after incomplete resection, SBRT is an option
- Liver: mOS 24.8mo vs 8mo (highly selected group, n= 58/1078)

Summary

- Metastatic Melanoma outcomes have vastly improved since IO + TT became available
- BRAF WT Melanoma:
  - Ipi / Nivo
  - Relatlimab / Nivo –available on PBS
  - Nivo
- BRAF MT Melanoma
  - IO then TT > TT then IO (Dream-Seq, SECOMBIT)
  - ? Ipi /Nivo over Relat/Nivo
  - D+T; Enco / Bini; Vemurafinib + Cobimetinib
- Brain mets
- Metastasectomy
- Questions:
  - Ipi / Nivo vs Rela / Nivo
  - Does Ipi / Nivo still have activity following PD on Relat/Nivo (currently not allowed on PBS)

Summary

- Systemic therapies are moving further forward in the patient journey

Thank you!