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PET Scans as Evaluation of DC Vaccinations in Patients With Malignant Melanoma

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Background: Therapy-induced changes in tumour glucose metabolism by positron emission tomography (PET) with the glucose analog [18F]fluorodeoxyglucose (FDG-PET) may overcome the limitation of morphological imaging techniques. Measurements of tumour metabolism have been successfully applied to monitor tumour response after chemo- and chemo-radiotherapy. In this study we investigate whether FDG-PET can add information on the mechanisms and effect of the immune-therapy.
Material and Methods: Patients with advanced progressive melanoma were treated with DC vaccinations evaluated by PET/CT (Gemini dual slice PET/CT, Philips Medical, The Netherlands, 370 MBq 18F FDG, acquisition time 2 min per bed position /CT scan with iodine-containing IV contrast, according to body-weight, Iomeron 350 mg/ml, Bracco Italy and watery PO contrast 2% solution, Omnipaque, GE Healthcare) at baseline and after 6 vaccinations. The patients received 4 weekly DC vaccinations followed by 2 fortnightly vaccinations. If the patient achieved stable disease according to RECIST, additional vaccinations were given. The PET scans were evaluated according to the guidelines from EORTC. Survival was determined as time from the first vaccine to death.
Results: Thirteen patients had a PET-/CT scan after 6 vaccinations (2−3 months). According to RECIST four patients achieved SD and nine patients progressed. Two patients achieved partial metabolic response (PMR), 6 patients achieved stable metabolic disease (SMD) and 4 patients had progressive metabolic disease (PMD). One patient had complete metabolic response (CMR) of the 2 index lesions but a new lesion appeared, i.e. a mixed response. This patient had a superior survival of 1060 days. The patients with PMR had mean survival of 478 days whereas the rest of the patients survived for mean 175 days (97–296) with no difference between SMD and PMD. Five of the patients with PD had PMR and PMD of single lesions at the same time.
Conclusion: We found that PMR or CMR of single lesions correlated to a prolonged survival in 3 patients. The CT scan and the PET scan did not correlate in all patients, as some patients with PD had SMD. This could suggest that some of the morphological increases could be due to oedema or immune-infiltrates and not progression of the disease. Adding PET scan to the CT evaluation of patients treated with DC vaccines leads to a more detailed picture of the single lesions and could usefully be performed in upcoming immunotherapeutic trials.

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Memorial Sloan-Kettering Cancer Center (MSKCC) Single-Institutional Vulvovaginal Mucosal Melanoma (VVMM) Experience From 1995–2010

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Introduction: Mucosal melanoma (MM) of the female genital tract is rare and has poor outcomes. Vaginal and vulvar melanomas are distinct in presentation, clinical course and outcome. Current knowledge is limited by their rarity.
Material and Methods: Following IRB approval, MSKCC databases were queried for pts with VVMM diagnosed between1995–2010. The following pt and treatment characteristics were examined: age, Ballantyne stage (I = localized, II = nodal, III = distant), melanoma AJCC stage, ethnicity, surgical resection extent, radiation(RT) and adjuvant therapy, median recurrence free survival (RFS) and median disease specific survival (DSS), 3 and 5 year DSS.
Results: 105 pts were identified (66 vulvar, 39 vaginal). Median age was 62 y. 94% Caucasian. Ballantyne stage was similar at presentation in both groups (Table). Pts with vulvar melanoma were more likely to undergo surgery with curative intent and negative surgical margins. 13(12%) and 7(7%) pts received adjuvant and definitive RT respectively. 15% received systemic adjuvant therapy. Recurrence was more common for vaginal melanoma (84% vs 47% p = 0.011). Median follow up was 64m (range 0–140m). Median RFS for resected Ballantyne Stage I vulvar and vaginal melanoma were 38m and 12m respectively (p = 0.006). This difference remained when those with positive surgical margins were excluded. Median DSS for Ballantyne Stage I and II vulvar and vaginal melanomas were 127m vs 29m (p = 0.001) and 29m vs 13m (p = 0.016). AJCC stage was prognostic for vulvar but not vaginal disease. 5 y DSS were 55% and 18% for invasive vulvar and vaginal melanoma respectively.
Conclusions: This study is the largest single institutional series describing the outcomes of VVMM reported to date. Vaginal melanoma demonstrates increased recurrence rates and inferior RFS and DSS when compared to vulvar melanoma. Survival for vulvar melanoma is encouraging when compared to previous reports. Therapeutic nihilism is not warranted in this disease.

	Vulvar		Vaginal	
Median age (range), y	63 (25−88)	60 (38−87)		
Stage at diagnosis, n/N				
in situ	8/66	(12%)	0	
Ballantyne Stage I	49/66	(74%)	30/39	(77%)
Ballantyne Stage II	8/66	(12%)	7/39	(18%)
Ballantyne Stage III	1/66	(2%)	2/39	(5%)
Surgery, n/N	63/66	(95%)	29/39	(74%)
Negative margin	47/63	(75%)	14/29	(48%)
Median RFS (mo)				
Ballantyne Stage I (95% CI)	38	(22−54)	12	(7−17)
Ballantyne Stage II (95% CI)	10	(0−20)	5	(4−6)
Median DSS (mo)				
Ballantyne Stage I (95% CI)	127	(44–210)	29	(19−39)
Ballantyne Stage II (95% CI)	29	(0−66)	13	(10−16)
3 year DSS	71%		33%	
5 year DSS	55%		18%	

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Patient Characteristics and Treatment Patterns in Advanced Basal Cell Carcinoma (aBCC) in Oncology Community Setting

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Background: Information on aBCC patient demographics, or clinical and treatment characteristics is limited. This study characterizes aBCC patients receiving care within the US Oncology (USO) network.
Materials and Methods: We define aBCC as (1) locally advanced BCC (inoperable or surgery contraindicated) with disease progression after radiation (unless radiation contraindicated), or (2) metastatic BCC or through AJCC staging 6th ed (Stage III, IV),and $\geqslant$3 visits within the USO network. aBCC patients were identified between July 1, 2006 to June 30, 2010. Patients were followed to end of data record or death. Detailed Electronic Medical Records (EMR) and chart reviews were conducted to evaluate clinical and treatment patterns.
Results: 41 patients were treated at USO clinics for aBCC. Mean age was 71.6 years, males comprised 68.3%, and the mean Charlson Comorbidity Score was 0.97. Sites of advanced disease were in the head/neck area (54%), extremities (10%), trunk (5%) and other (32%). 11 (27%) patients developed metastases. Location of BCC metastases were mainly to the bone (21%), lung (21%), orbit (14%) sinus (11%) and other (32%). These patients saw various physicians, namely radiation oncologists (34%), medical oncologists (29%), Mohs surgeons (11%), dermatologists (10%), ENT specialists (6%), plastic surgeons (4%), primary care physicians (4%) and surgical oncologists (1%). Before progression to aBCC, patients received BCC-related surgery (29%), radiation (22%) and chemotherapy (2%); whereas when aBCC occurred, patients received surgery (59%), radiation (68%) and chemotherapy (32%), where each patient could have more than one procedure. Among 20 chemotherapy regimens for aBCC, 15 were platinum based.
Conclusions: This study is the first characterization of real world treatment patterns of aBCC patients in a US national oncology community setting. Prior to progression, treatment usually included surgery and radiation. After progression to locally advanced or metastatic BCC, chemotherapy was often added. The wide variation in selected regimens suggests a lack of consensus on agents likely to be effective. We are exploring similar patterns of care and outcomes in dermatology settings.