

Transcript Details

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Rethinking Risk in T1a Melanoma with New Data on Age, Prognosis, and Gene Expression Profiling

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My name is Hamza Bhatti. I'm a board certified Mohs surgeon. I'm based out of New York City. I work for Schweiger Dermatology, and I'm also a volunteer attending over at Mount Sinai Hospital. I'm also the co-director of Dermatological Surgery at New York Medical College at Metropolitan Hospital, where we teach all the residents.

The new T1a data that was recently presented in JAAD was very interesting findings that we were looking at. So it was able to break up melanomas that we were looking at into a low risk and high risk category that they had characterized themselves. Low risk being greater than 42-year-old, Breslow thickness less than 0.5 millimeters, and a mitotic rate of less than two millimeters. So based off the cohort that we're looking at, the high risk features that they were looking at were age less than 42, head and neck location, Breslow greater than 0.5 millimeter, and a mitotic rate of greater than or equal to two millimeters squared.

Based off this, what they did was there were some data before that came out that said T1a's, there was no indication that they were ever necessary to be tested, whereas another study with GreenShield saw that only 85% of those came back as class 1A. What they wanted to look at was the SEER data and how we can link that data to see what's going on with the T1a tumors. Based off the SEER data, there was a total of 3,513 pT1a tumors that they had identified, and they were split into two groups. Low risk for pT1a was about 1,060 and high risk for pT1a was 2,319. And what this study actually showed was something very interesting that based off low risk T1a tumors, none of them, zero out of the 53 that were considered class 1A patients died from melanoma. For high risk patients, the high risk pT1a patients, 90% of the class 1A tumors were class 1A. That means around 10% were not considered to be class 1A, and that had a hazard ratio of 5.72 times higher of a melanoma specific death in those high risk patients.

Within the high risk, what was interesting that they found was age greater than 42 was predicted to be an outcome of worse survival, higher than either mitotic rate, depth, Breslow thickness, or head and neck site combined. The new data that was presented helps me guide management for my patients because it allows me to realize that age does play a very important factor when it comes to which melanomas go on to be bad actors and causing melanoma suspect death, whereas other ones that can be considered to be low risk. They had stratified high risk as age less than 42, head and neck location, Breslow thickness greater than 0.5 millimeter, and a mitotic rate of two or higher.

In the data, what it showed was actually age greater than 42 had a higher hazard ratio for predicting melanoma specific survival as opposed to head and neck location, Breslow thickness and mitotic rate. Which is interesting because when I'm dealing with my own patients, I want to be able to tell them information that is very relevant in coming up with a genetic gene expression profile score that will allow them to make an educated decision of whether a tumor needs to be increased in management or decreased in surveillance of management over here. So what does that mean? That basically means are we going to be following these patients a lot more closely and getting more imaging to prevent any type of recurrence or melanoma specific death with them? Or are we going to be able to follow the standard of care guidelines and just be able to monitor them according to those guidelines?

In terms of Castle testing, I'm a firm believer of Castle testing. I believe they do increase and help identify the bad actors. I think given the information recently about an age greater than 42 for patients that were linked with higher melanoma specific death, I think that is a great resource and we should be able to use that information to determine, OK, these are the patients we should be focusing on a little more closely as opposed to what their Breslow thickness or mitotic rate may be because they have been associated with a higher risk of melanoma specific death based off the study.