Cancer Registry Report

Cancer Focus: Melanoma

In 2005, nearly 60,000 patients were diagnosed with melanoma, resulting in about 7800 deaths. Fortunately, melanoma is often diagnosed in an early stage when patients recognize changes in a mole, or by dermatological screening. When localized at presentation, the 5-year survival is more than 95%. However, once lymph nodes are involved, or cancer spreads to other organs, the prognosis substantially worsens. Patients with metastatic disease have a 5-year survival of 15% or less.

The major risk factor for melanoma is excessive exposure to U.V. irradiation including frequent sunburns and use of tanning booths. Other risk factors include family history, personal history of prior melanoma or dysplastic moles, and certain occupational exposures. The incidence is higher among those living in sunny southern areas of the U.S. The highest incidence in the world occurs in New Zealand and Australia.

Malignant melanoma is an uncommon cancer, representing less than 3% of cancers diagnosed at GBMC in 2005. Cutaneous melanoma accounted for over 90% of primary sites (see Table 1) including various histological types, but 10% of our patients had ocular, mucosal or other non-cutaneous sites of origin. The age at presentation reflects diagnosis usually after age 50 (see Table 2) with slightly higher incidence in men compared to women. However, melanoma is a disease which tragically may affect patients in their 20's ad 30's as well. As shown in Table 3, patients at GBMC and in The National Cancer Data Base (NCDB) are usually diagnosed at an early stage. The survival of patients at GBMC is comparable to those in the NCDB (Table 4) and slightly better than the national average in early stages.

The primary management of melanoma requires surgical excision with appropriate margins based on the depth of the initial tumor (Table 5). Sentinel node biopsy is also routinely performed at GBMC for eligible patients to identify microscopic or submicroscopic spread of tumor cells into lymph nodes. Melanoma is generally described as "relatively resistant" to standard treatment approaches using chemotherapy and radiation. Nevertheless, there is clearly a role for both of these modalities in some patients.

The introduction of interferon and interleukin which affect tumor immunity has revolutionized new experimental approaches to treating melanoma. More direct methods of manipulating the immune system using tumor vaccines have been promising in patients with certain HLA tissue types. Physicians at GBMC are participating in numerous clinical trials (see Table 6 below) from NCI, ECOG and the pharmaceutical industry hoping to change the dismal outlook for patients with metastatic disease. In additional to vaccine trials, GBMC participates in studies exploring some investigational targeted agents directed at novel cytotoxic mechanisms, immunity and angiogenesis.

In the meantime, we recommend sun block!

Table 1

Melanoma Histologies

HISTOLOGY	CASES	%OF TOTAL
In situ	14	33.3%
Melanoma, NOS	13	31.0%
Nodular melanoma	4	9.5%
Superficial spreading	5	11.9%
Spindle cell	2	4.8%
Other sites (mucosal, ocular, vaginal	4	9.5%
TOTAL	42	100.0%

Table 2

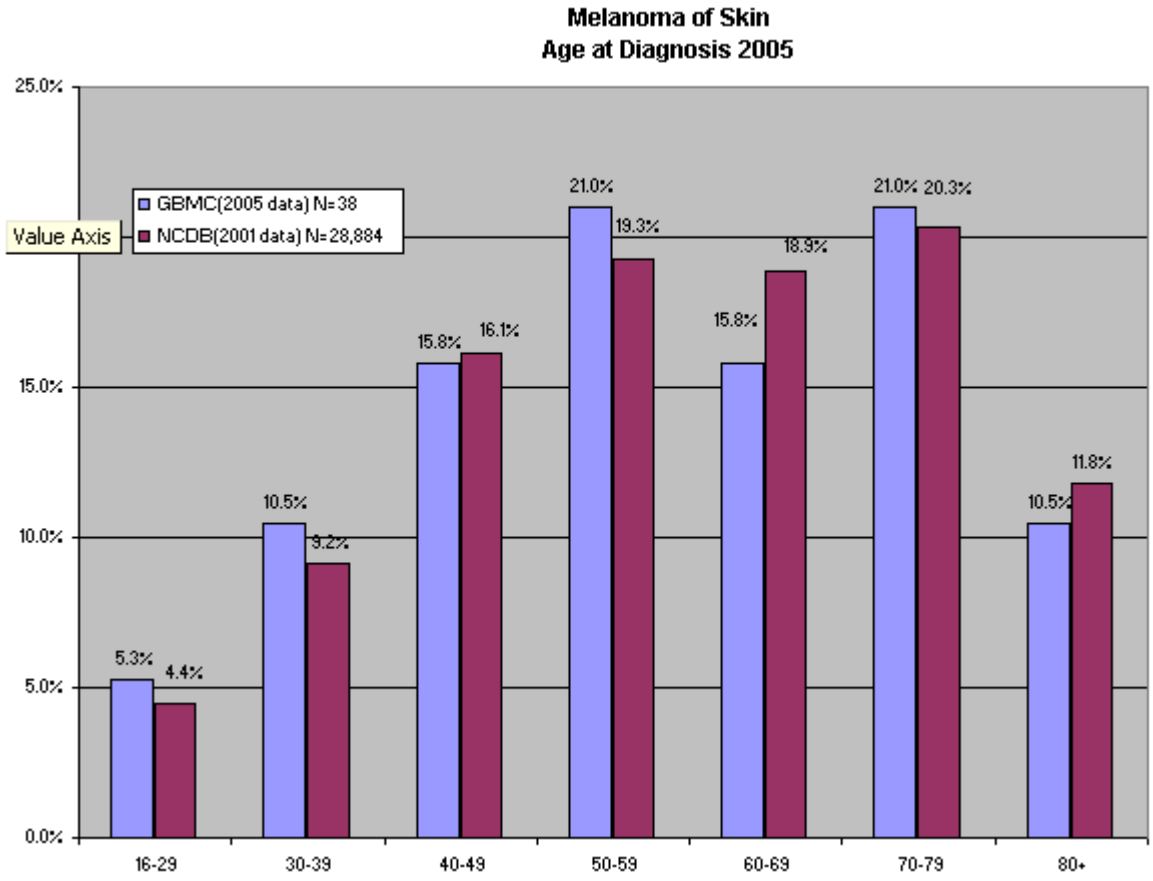
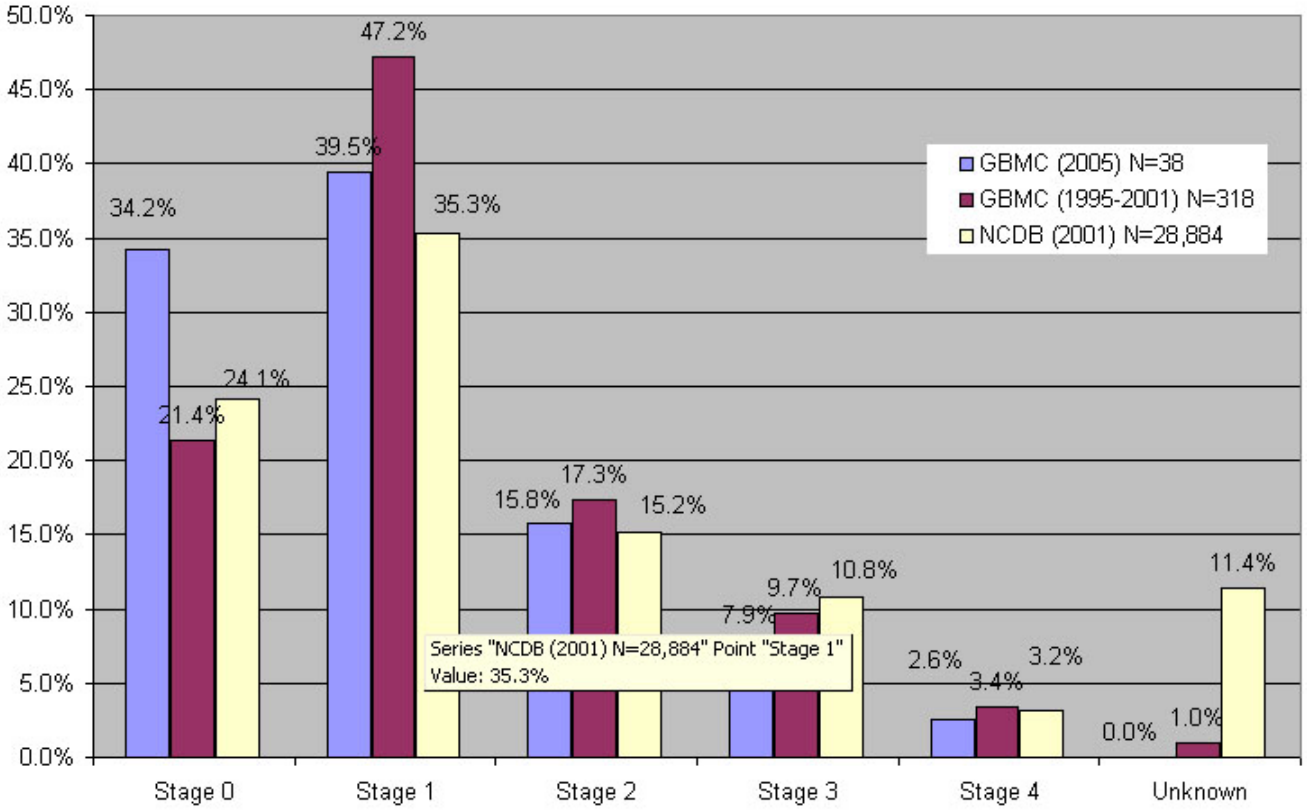

Melanoma of Skin
Age at Diagnosis 2005
25.0%
15.0%
10.0%
5.0%
0.0%
Value Axis
GBMC(2005 data) N=38
NCDB(2001 data) N=28,884
5.3%
4.4%
10.5%
9.2%
15.8%
16.1%
21.0%
19.3%
15.8%
18.9%
21.0%
20.3%
10.5%
11.8%
16-29
30-39
40-49
50-59
60-69
70-79
80+

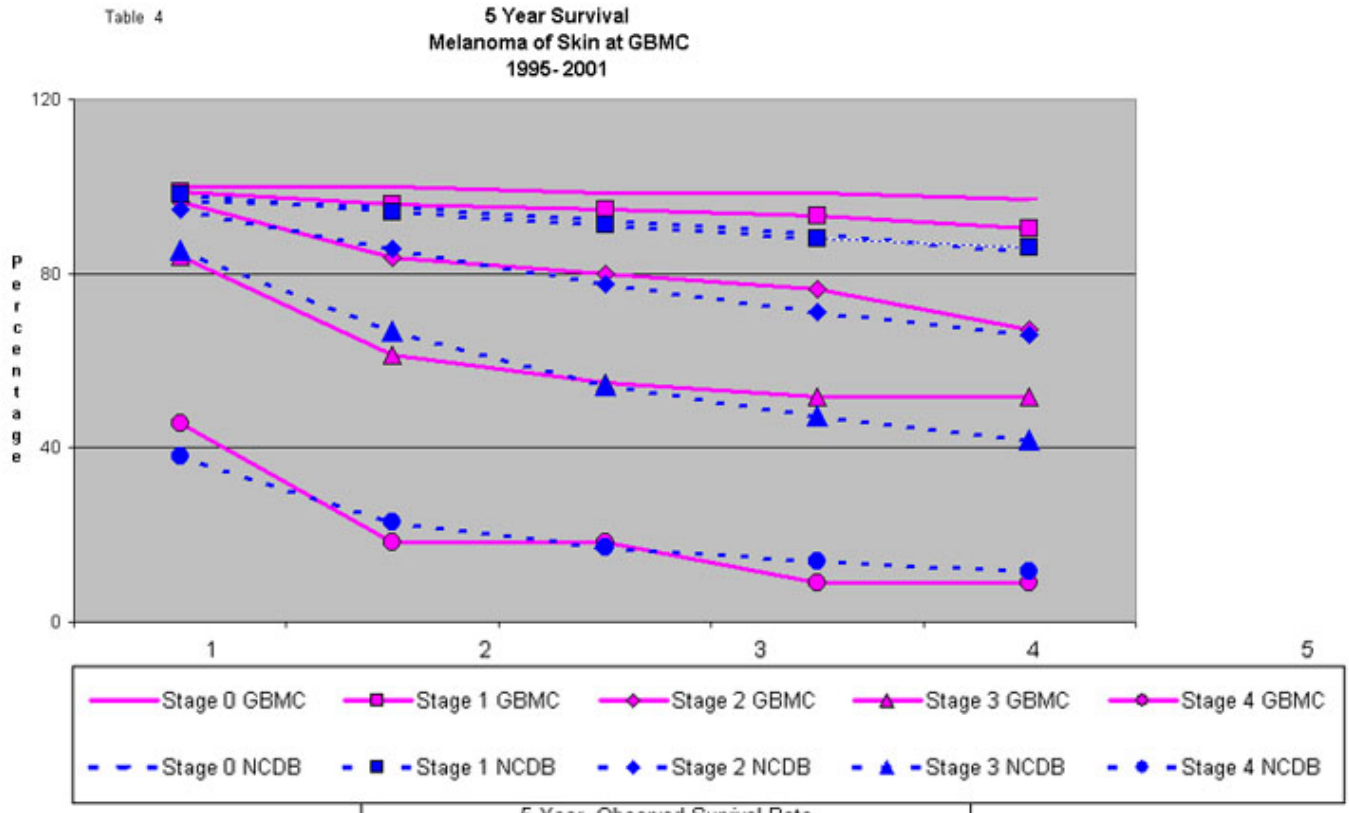
Table 3

Melanoma of Skin
Comparison of AJCC Staging



Source:GBMC Cancer Registry and NCDB,CoC, ACoS Benchmark Reports v2.0

Table 4



5 Year Observed Survival Rate				
	GBMC		NCDB*	
Stage 0	N=68	97.0%	N=8,250	85.7%
Stage 1	N = 150	91%	N = 17,710	86.0%
Stage 2	N = 55	67.0%	N=9,299	65.9%
Stage 3	N = 31	51.6%	N = 2,492	41.9%
Stage 4	N = 11	9.1%	N=1,796	11.6%

Source:NCDB, Commission on Cancer, ACoS/ACS Survival Report v2.0

Table 5

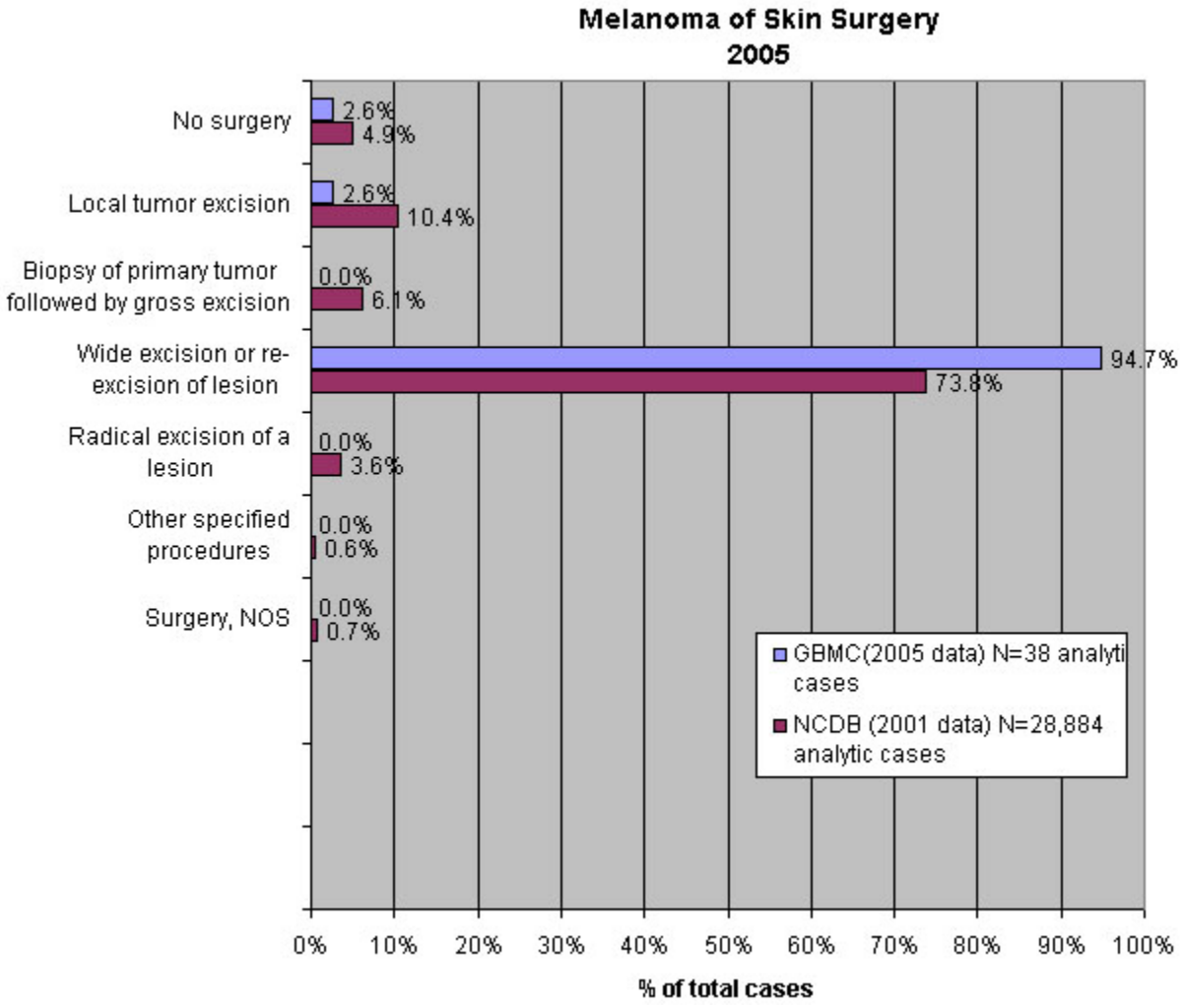

Melanoma of Skin Surgery
2005
No surgery
2.6%
4.9%
Local tumor excision
2.6%
10.4%
Biopsy of primary tumor followed by gross excision
0.0%
6.1%
Wide excision or re-excision of lesion
94.7%
73.8%
Radical excision of a lesion
0.0%
3.6%
Other specified procedures
0.0%
0.6%
Surgery, NOS
0.0%
0.7%
GBMC(2005 data) N=38 analyti cases
NCDB (2001 data) N=28,884 analytic cases
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
% of total cases

Table 6:

CLINICAL TRIALS FOR MELANOMA AT GBMC

CC0509	A Multi-center Single Arm Phase II Study of MDX-010 (BMS-734016) Monotherapy in Patients with Previously Treated Unresectable Stage III or IV Melanoma (Opening Late June)
E1697	A Randomized Study of Four Weeks of High Dose IFN-alfa 2b in Stage T3-T4 or N1 Melanoma
E4697	A Randomized, Placebo-Controlled Phase III Trial of Yeast Derived GM-CSF VS Peptide Vaccine VS GM-CSF Plus Peptide Vaccination vs. Placebo in Patients With "No Evidence of Disease" after Complete Surgical Resection of "Locally Advanced" and/or Stage IV Melanoma
ES0008	A Phase III Trial of High Dose Interferon Alpha-2b versus Cisplatin, Vinblastine, DTIC Plus IL-2 and Interferon in Patients with High Risk Melanoma
CC0403	A Phase III Study of Taxoprexin Injection vs Dacarbazine in Patients with Metastatic Malignant Melanoma
E1602	Randomized Phase II Trial of Multi-Epitope Vaccination with Melanoma Peptides from Cytotoxic T Cells and Helper T Cells for Patients with Metastatic Melanoma
E2603	Double-blind, Randomized, Placebo Controlled Phase III Trial of Carboplatin, Paclitaxel and BAY 43-9006 (Sorafenib) versus Carboplatin, Paclitaxel and placebo in Patients with Unresectable Locally Advanced or Stage IV Melanoma
CC0606	A Randomized, Double-Blind, Multicenter Study of Denosumab Compared With Zoledronic Acid in the Treatment of Bone Metastases in Subjects with Advanced Cancer (Supportive care study)