Real-world tactics to address health inequities in melanoma care

CMEO Podcast Transcript

Edith Mitchell:

Hello. I'm Dr. Edith Mitchell and on behalf of CME Outfitters I would like to welcome you to today's educational activity that is entitled “Real-world Tactics to Address Health Inequities in Melanoma Care.” Today's activity is brought to you by CME Outfitters, an award-winning jointly accredited provider of continuing medical education for clinicians worldwide and is supported by an educational grant from the Johnson and Johnson Institute and the Johnson and Johnson family of companies.

Now let's introduce our faculty for today. I have previously introduced myself. I'm Dr. Edith Mitchell. I'm Clinical Professor of Medicine and Medical Oncology in the Department of Medical Oncology and Director of the Center to Eliminate Cancer Disparities. I'm also Associate Director of Diversity Affairs at the Sidney Kimmel Cancer Center at Jefferson Health in Philadelphia, and I am the 116th president of the National Medical Association.

Joining me today is my colleague, Dr. Susan Taylor. She is the Bernett L. Johnson Endowed Professor of Dermatology, Vice Chair for Diversity, Equity and Inclusion in the Department of Dermatology at the Perelman School of Medicine at the University of Pennsylvania, and founder of the Skin of Color Society in Philadelphia, Pennsylvania.

So let's start by reviewing some of our learning objectives for today's session. After participating in today's activities, clinicians should be better able to recognize the impact of health inequities on patients with melanoma and craft individual treatment strategies for optimal outcomes.

We recognize that in White populations, melanoma is rather common. However, in non-White populations, individuals can and actually do develop melanomas. Today, we'll be discussing the importance of regular total body skin examinations, the role of biomarker testing in patients with melanoma, and we'll end with some important discussions on emerging therapies.

So Dr. Taylor, I believe you've had a recent case that can demonstrate some of these points that I've just mentioned. So will you go ahead, please?

Susan Taylor:

Absolutely. Well, thank you very much, Dr. Mitchell, for that wonderful introduction. And it's so very important for everyone to understand that melanoma can and does occur in people with skin of color, people with darker skin tones, and this case really exemplifies that. And the case is of Malik. He is a 51-year-old black male. Physically fit, regular exercise, no history of smoking. He's just moderately adherent to his annual primary care health visits. Goes about every two years. He works as a computer engineer.

Susan Taylor:

Now, Malik visited his primary care physician with a complaint of a 0.5 centimeter dark lesion on his left heel that was causing some discomfort when he walked. His primary care physician felt that the diagnosis was a benign wart and he recommended that Malik apply an over-the-counter wart remover and then cover the lesion with a Band-Aid.

Now, this brings up I think a very important point, and that first point is the failure to screen. Malik did not have a total body skin examination, and we know that total body skin examinations have increased only among the non-Hispanic White population, despite increasing melanoma. And in fact, Black patients are less likely to have total body skin exams than any other group. Hispanic people are 20% less likely than non-Hispanic White people to perform home total body skin exams and primarily Spanish-speaking Hispanic people are three times less likely to report having a total body skin exam completed by a physician compared to in English-speaking Hispanic populations.

Now, we also know, Dr. Mitchell, that our Black patients place less emphasis on the importance of regular skin exams. Many Black patients don't know the importance that they need to have a skin exam at least once a year, and they don't know that this is really an important method to detect skin cancer early. Now, both low levels of knowledge about cutaneous melanoma prior to diagnosis and poor understanding of melanoma treatment are associated with greater tumor thickness. And Black patients as well as Hispanic patients appear to be less knowledgeable and present with much more severe disease.

Now, Malik returned three months later. The lesion was not only still present, but it was larger. At that visit, it was 2.5 centimeters. Also, the edges were noted to be uneven. At that time, a wide excision of the lesion was performed and it revealed a T3b acral lentiginous melanoma. Further workup unfortunately revealed that the lesion was Breslow's depth 3.2 millimeters with pockets of ulceration and microscopic satellites in the wide excision and this does not bode well for his prognosis. Dr. Mitchell, would you comment on how typical or not this type of presentation is among our patients?

Edith Mitchell:

Oh, absolutely. When we recognize that melanomas are not as common in individuals who have dark skin, still for lentiginous acral melanoma, they are more common in our Black patients as well as other individuals with dark skin.

So let's talk a little bit more about the types of melanoma so we understand how acral lentiginous melanomas are more frequently seen in African Americans and unfortunately are later stage at the time of diagnosis.

Susan Taylor:

So I think that when people think about melanoma, what comes to mind is the most common type, which is superficial spreading melanoma. And that accounts for 70% of all melanomas, and it's the most common type seen in non-Hispanic White people, Hispanic people, as well as young people. And with the superficial spreading type of melanoma, we see a flat or slightly raised irregular patch or plaque with various shades of color. It can be tan or brown, blue, black. Sometimes there's red, pink, or even white.

Another hallmark of superficial spreading melanoma is that it is asymmetric. If you cut the lesion in half in your mind's eye, the right does not look like the left, nor does the top look like the bottom. And the borders are irregular, often with jagged borders.

The superficial spreading melanomas commonly affect intermittently sun exposed areas of the skin, areas of the skin that had received sunburns during childhood. And the most common locations include the upper back of men and the lower legs of women. Superficial spreading melanoma is not a common type of melanoma in people with skin of color.

Nodular melanoma, on the other hand, occurs in 10% to 15% of all melanomas. The most common site of the nodule melanoma include the trunk, the head, as well as the neck. Now, these lesions are large. They're raised above the surface of the skin. They have a bulbus appearance to them. They can have a blue-black or blue-red, even a blue-pink color of the nodule, although 5% lack any pigmentation and they're amelanotic. Now, unfortunately, nodular melanoma is the most rapidly growing and the most aggressive type of melanoma.

Now, in contrast, lentigo maligna melanoma counts for about anywhere between 4% and 15% of melanomas. And it's most commonly found on sun damaged skin, particularly the head and the neck of elderly White patients. It is rather slow growing initially. It begins as an irregular tan or brown area that can expand peripherally. It can develop multiple shades of tan and brown. And unlike nodular melanoma where the growth is very rapid, very quick, the lentiginous maligna melanoma is very slow growing, and it can grow anywhere between five and 15 years before becoming invasive.

And then the final type is the type that Malik had, which is the acral lentiginous melanoma. Now, this is a somewhat rare type of melanoma. It occurs on the palms, the soles, the fingernails, and the toenails, and it presents as a brown or black discoloration in those locations. It can evolve from a radial to a vertical growth phase where it then infiltrates and invades. And we know that the proportion of acral lentiginous melanoma among melanoma subtypes is greater in people of color and it accounts for 36% of all cutaneous malignant melanomas in Black people, 18% in Asian or Pacific Islander people, 9% in Hispanic White people, and only 1% in non-Hispanic White people. So quite significant differences in who develops acral lentiginous melanoma. So I think that's a very important point.

Susan Taylor:

Another important point... And I'd like for you to comment on it, Dr. Mitchell. Is related to biomarker testing. Now, we said a little bit earlier the Breslow thickness is really prognostic. It hearkens a poor prognosis in patients. So then we need to turn to and start to think about our treatments and being able to identify the biomarkers on tumors is critically important, particularly for the treatments that one can have. So I'm going to ask you to comment, if you would, on what happens if we skip biomarker testing for some of these patients with acral lentiginous melanoma.

Edith Mitchell:

Certainly. And precision oncology is an area that is rapidly growing. It's very important. And therefore selecting therapeutic interventions for not only melanoma but for other cancers as well is very important.

Now, what are some of these markers? These markers actually can measure genetic alterations in the tumor and can account for what we call driver mutations. And these driver mutations influence the growth of the tumor, the rapidity of metastases to other organs, as well as the selection criteria for treatment. So some of these are related to the names, and you may hear of BRAF. It's B-R-A-F. BRAF is one of the most important ones for melanoma, but there's also the KIT, the K-I-T. There is also NRAS, N-R-A-S, the NTRK. That's N-T-R-K. And these can be fusions that are the more important one. And then we have PD-L1, which is also very important. And then we have tumor mutation burden, which means how many mutations or growth patterns do we see in the melanoma... In the tumor that is.

So appropriate excision and then evaluation in the laboratory not only of the cells and the cellular types, but also these mutations. And these mutations allow us to select therapy, to select how that therapy is given, how long it's given, which is very important for the patient. Making sure we choose the right therapy at the right time and that is the initial treatment and that we continue it appropriately based on the markers and the level of those markers.

So absolutely it's important and therefore we recommend that all melanoma patients, if they're not treated at a major center, at least have a consultation in the center so the latest advice and the latest therapeutic indications from the National Cancer Institute and other pharma companies can be incorporated into the patient's initial therapeutic plan. So every patient with a recently diagnosed melanoma should have the appropriate diagnostic panel accomplished prior to the initiation of therapeutic interventions.

Susan Taylor:

Yes. That is critically important.

Edith Mitchell:

So tell us, Dr. Taylor, about Malik. Or do you have additional information regarding his therapeutic plan?

Susan Taylor:

Yes, we do. And remember, Malik had a very, very deep melanoma. 3.2 millimeters, right. There was ulceration, which again has a poor prognosis. And based on Malik's analysis, he was started on nivolumab. He was initially dosed at 240 milligrams every two weeks but because of scheduling difficulties, he chose to receive the therapy at 480 milligrams every four weeks. So a little bit of an adjustment. Unfortunately, he developed grade three colitis and nivolumab had to be held for about six weeks. It was, however, resumed successfully at biweekly dosing. And he had a clinical response that lasted 14 months, and we think that is quite remarkable.

Immunotherapy has really been a game changer that I've had the pleasure of observing throughout my career and can make a significant difference for our patients. There are, however, some barriers in accessing immunotherapies—barriers on the patient level, barriers on the provider level, the systemic level, the societal level I should say. And there are barriers assessing and adhering to immunotherapies. You made an excellent point that if your particular hospital is not equipped to make those assessments, you can partner with colleagues at other institutions. There are barriers to managing adverse events. And in Malik's case, the agent was held for his colitis but then restarted and he did have a good clinical response. So although there can be barriers, there are multitude of ways to be creative and to address those particular barriers.

Edith Mitchell:

Oh, absolutely. And recall that Malik was started on a lower dose initially, but there are programs that give higher doses for longer intervals between therapy. However, with the higher doses, there is also the risk of developing side effects as result of therapies. And I tell patients there's no treatment that we can give that has no side effects, and we must monitor patients extremely carefully as we give therapies and look for signs of toxicities.

And interestingly with nivolumab, the skin sometimes with a redness or an irritation can be the first sign that the patient is developing a side effect from the treatment. There can also be other side effects in other organs, particularly the thyroid or the lungs or other organs. The GI tract is a major area of intolerance to the medications. And usually with withholding the medicines for a short period of time, a few weeks usually, the patient can resume therapy again.

And the increase in the number of agents that we have available that give really good responses in melanoma, not only in the primary site as Malik had on his heel, but in other sites of metastasis as well... We have heard about former President Carter... And this is not releasing proprietary information. He has been on CNN and other news media indicating the response of his metastatic melanoma, which was reported at least by CNN in the liver and in the brain. And he has done well for years since that time. So one should no longer, as we did many years ago, see advanced melanoma as a deadly disease, at least initially, if the appropriate therapeutic regimen is instituted and follow-up of the patient carefully so that if there are any side effects, they can be addressed appropriately. So newer treatments in melanoma have allowed for patients to have much better treatment outcomes.

Susan Taylor:

Yes, and there has been a real change in terms of therapy, particularly with immunotherapy, but it behooves us not to miss the diagnosis, to understand that melanoma can occur in anyone, of any race, any gender, any ethnicity. In order to make that diagnosis, one has to be proactive in detection and really the hallmark or the key, the fundamental aspect of that, is your total body skin exam. It has to start with the patient and also with the physician or the provider. For people of color where acral lentiginous melanoma can present in different places, not necessarily the back or the legs, but palms and soles, fingernails, toenails, in between the fingers and the toes, the interdigital spaces. Those are all areas, along with the mucus membrane, that must be examined in all patients, and particularly our patients with darker skin tones. And this will allow us to make the diagnosis, hopefully make the diagnosis early. We know that we have safe and effective treatment.

It is important for dermatologists as well as family practitioners when they see their patients... Everyone is confined in terms of time, but it's critically important that you have that patient remove their shoes, remove their socks. Really examine every inch, every nook and cranny. This is critically important for the detection of melanoma. Patients need to know... Patients who are White and Black and of Asian descent, et cetera, that if they see a growth, a growth that's new or that changes, they need to see their doctor immediately. And then the final aspect, which is particularly important for people with lighter skin tones, is the use of photo protection, specifically sunscreens with an SPF 30 or higher, as I said particularly for individuals with lighter skin tones.

So I think our case demonstrated the importance of early detection, complete exam, making the right diagnosis, and then once the diagnosis is made, the importance of our newer therapies in regard to clinical response for melanoma. We are very hopeful now and we are very excited about future advances in the treatment of this once deadly disease.

Edith Mitchell:

So thank you, Dr. Taylor, for that outstanding presentation. It is very important that clinicians and other healthcare providers report and examine patients and ask the patients about any growths or changes in the color of the skin or development of nodules. So very important.

So let me give some SMART goals as we close our program today. And these are smart—one for the clinician—but also measurable, attainable, relevant, and timely. And that is be suspicious of any lesions on the hands, on the feet, and certainly under the nails of both the hands and feet and sometimes on the mucus membranes as well. Make sure that if a biopsy is planned, that the laboratory accepting the biopsy is able to evaluate the biomarkers in addition to telling the clinician what kind of lesion this is and whether it's malignant or not, but also accomplish the biomarker testing, specifically the ones that I mentioned earlier, and the most important being that of PD-L1. Sometimes laboratories process the tumor tissue and do not do the characteristic biomarkers and this needs to be accomplished later and therefore allow for delay in appropriate diagnosis. So the biomarker analysis... Very important in order to decide which of the newer therapies or combination of therapies might be important for the patient. So it's individualizing therapeutic interventions.

Edith Mitchell:

So be cognizant, all clinicians, to the fact that there can be barriers to treatment access and insurance, which allows for sometimes poor adherence to therapy. So one also has to be cognizant of the social determinants of health that might interfere with appropriate therapy access. And if the patient does not have insurance coverage, we also have to sometimes utilize other community networks that might allow for assistance in treatment access so every patient should get the most important therapy for them on an individualized basis.

So with that, Dr. Taylor, this has been a very comprehensive and important study on melanoma. I'd also lastly want to say please visit the CME Outfitters Oncology Hub to access additional activities on relevant oncology topics and Diversity and Inclusion Hub for discussions of disparities in healthcare, as well as other resources for clinician education as well as patient education materials. And you can also follow us on Twitter, @CMEOutfitters. Again, thank you so much, Dr. Taylor, for our discussion today.

Susan Taylor:

Thank you.

Edith Mitchell:

And thank you to the audience for listening and joining us today. Thank you very much and have a good evening.

