Systemic adjuvant melanoma treatment: Implications for UK melanoma services

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Introduction

- For patients with resected stage III melanoma, surveillance is the current UK standard of care.
- Following recent publication of positive results from several randomised clinical trials, the National Institute for Health and Care Excellence (NICE) has adopted the immunotherapy dacarbazine and trametinib available for patients with resected stage III BRAF mutant melanoma. Decision about anti-PD-I monotherapy are anticipated by 2019.
- Systemic adjuvant melanoma treatment represents a significant potential change in the management of patients with resected stage III high risk melanoma and will affect all members of the specialist skin cancer multidisciplinary team (SSIMDT).
- The UK Melanoma Adjuvant Pathway Survey (UK MAPS) was designed to capture the current UK standards of care for patients with stage III melanoma, and was designed to capture information about current and anticipated future care pathways.

Aim

- To identify: current care pathways for patients with resected stage III melanoma; expected changes in management when systemic adjuvant treatments become available; implications for UK melanoma services.

Methods

- Between April and May 2018, 49 interviews were conducted with UK HCPs with a specific responsibility for the management of patients with stage III melanoma (N=49). A total of 51 HCPs were represented as two of the interviews were conducted jointly with two HCPs; however, the main researcher was presented separately (N=49).
- 614 potential respondents were invited to participate by email; of those who expressed an interest and were available for interview within a 4 week period were included.
- Interviews were conducted either face-to-face or by telephone using a structured questionnaire, which was designed in collaboration with a medical oncologist, a dermatologist and a plastic surgeon.
- Respondents were from secondary and tertiary care centres across England (n=41), Scotland (n=3), Wales (n=4) and Northern Ireland (n=3), representing a total of 34 National Health Service (NHS) Trusts / Health Boards (16 interview responses per Trust/Health Board).
- The data was analysed descriptively using quantitative and qualitative methodologies.

Results

- The respondents comprised 18 medical oncologists, 11 clinical nurse specialists (CNS), 9 dermatologists, 7 plastic surgeons and 5 clinical oncologists (1 other HCP). The overall breakdown between specialties (N=49 interview responses) was 28 (57%) oncology, 12 (24%) dermatology and 9 (18%) plastic surgery.
- The respondents reported that they expect to see between 1 and 35 patients per month (median 5) who will be eligible for adjuvant therapy.
- Currently, only 31 (63%) respondents include standardised BRAF mutation testing for primary melanoma in their local guidelines (Figure 1). There was a wide variability in the HCPs responsible for requesting BRAF mutation tests and the stage at which tests are requested.
- 30 (61%) respondents are from centres offering sentinel lymph node biopsies (SLNBs) on-site after excision of melanoma from the trunk (63%); 21 (43%) after excision of head/neck melanoma (Figure 2). Referral to another centre for SLNB (if not carried out on site) is not always offered.
- The HCPs/specialties involved in the current follow-up of patients with resected stage III melanoma and those expected to be involved when systemic adjuvant treatments become available, are shown in Figure 3. Overall, 30 (61%) respondents expect that there will be changes in the HCP/specialties involved in follow-up; most notably, oncology involvement is expected to increase and plastic surgery involvement is expected to decrease.
- The stage in the care pathway at which patients are referred to an oncologist (current vs anticipated future pathway) is shown in Figure 4.
- The introduction of systemic adjuvant treatments is predicted to have significant impacts on staffing, training, commissioning, local guidelines, service structure and patient psychological support requirements (Table 1).

Conclusions

- The anticipated introduction of systemic adjuvant melanoma treatments has wide ranging implications for the commissioning, organisation and delivery of melanoma services in the UK NHS.
- The respondents interviewed expect to see a median of 5 new patients per month who will be eligible for adjuvant therapy, equating to at least one patient per week.
- BRAF testing of primary melanomas and SLNBs are not currently universal; this has implications for the identification of patients who may be eligible for adjuvant therapy.
- The role of oncology departments in patient care is expected to increase when adjuvant therapies become available and is likely to be required earlier in the patient pathway. Psychological support needs for patients with stage III melanoma are also likely to change.
- To ensure equitable and efficient patient access, UK SSIMDTs may need to review their current care pathway specification and implement the appropriate structuring to be able to deliver adjuvant therapy.

References

1. NICE technology appraisal guideline. NICE technology appraisal guideline; 2013. Available at: https://www.nice.org.uk/TA244

Disclosures

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  - The Novartis UK Medical Team; who contributed to the design of the survey and collection of data.
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Figure 1: Standardised BRAF mutation testing guidelines?

Table 1: Anticipated implications of the introduction of systemic adjuvant therapy for UK melanoma services

<table>
<thead>
<tr>
<th>Implications</th>
<th>Expected (% of respondents identifying (n=49))</th>
<th>No. (%) respondents identifying</th>
</tr>
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<tbody>
<tr>
<td>Staffing</td>
<td>Expected to be involved in follow-up</td>
<td>39 (80%)</td>
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<tr>
<td>Training</td>
<td>Training new oncologists and dermatologists</td>
<td>32 (65%)</td>
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<tr>
<td>Commissioning</td>
<td>Funding of new staff, clinics, treatments and training will be required</td>
<td>25 (47%)</td>
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<td>Local guidelines</td>
<td>Time to develop, circulate and agree new guidelines</td>
<td>40 (82%)</td>
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<td>Service structure</td>
<td>More capacity required in chemotherapy suite</td>
<td>36 (78%)</td>
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<td>Increased requirement for patient psychological support</td>
<td>Increased support and counselling to manage changing expectations of treatment, and to ensure patients can deal with disappointment; will affect patients' ability to return to normal post-palliative care.</td>
<td>30 (61%)</td>
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