Systemic adjuvant melanoma treatment: Implications for UK melanoma services

Oliver Cassell,[1] Catherine Harwood,[2] Melanie Hovey,[3] Miranda Payne[1]

[1]Oxford University Hospitals NHS Foundation Trust, Oxford, UK; [2]Centre for Cell Biology and Cutaneous Research, Blizard Institute, Barts and the London School of Medicine and Dentistry, Queen Mary University of London; Barts Health NHS Trust, London, UK; [3]Novartis Pharmaceuticals UK Ltd, Frimley, UK

Introduction

- For patients with resected stage III melanoma, surveillance is the current UK standard of care.[1]
- Following recent publication of positive results from several randomised clinical trials,[2,3,4] the National Institute for Health and Care Excellence (NICE) has made adjuvant dabrafenib and trametinib available for patients with resected stage III BRAF mutant melanoma. Decisions about anti-PD-1 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 (SSMDT).
- The UK Melanoma Adjuvant Pathway Survey (UK MAPS) was a UK-wide survey of health care professionals (HCPs) involved in the management of patients with primary 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 (NOTE: a total of 51 HCPs were represented as two of the interviews were conducted jointly with two HCPs; however, the main results are presented out of 49).
- 614 potential respondents were invited to participate by email; all 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 (1-6 interview responses per Trust/Health Board).
- The data were 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 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/limbs and 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 there to be changes in the HCPs/specialties involved in follow-up; most notably, oncology involvement is expected to increase and plastic surgery/dermatology involvement is expected to decrease.
- The stage in the care pathway at which patients are referred to an oncologist (current vs anticipated future practice) 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**).

Figure 1: Standardised BRAF mutation testing guidelines?

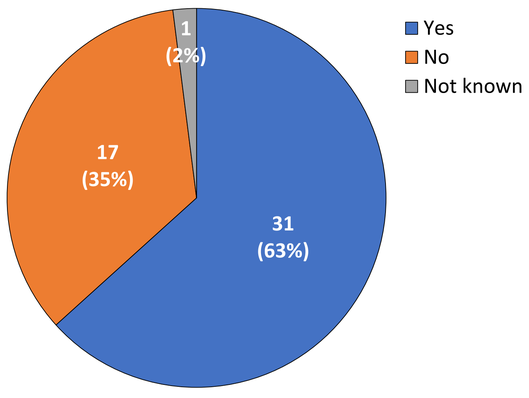


Figure 2: Sentinel lymph node biopsies (SLNBs) carried out on site?

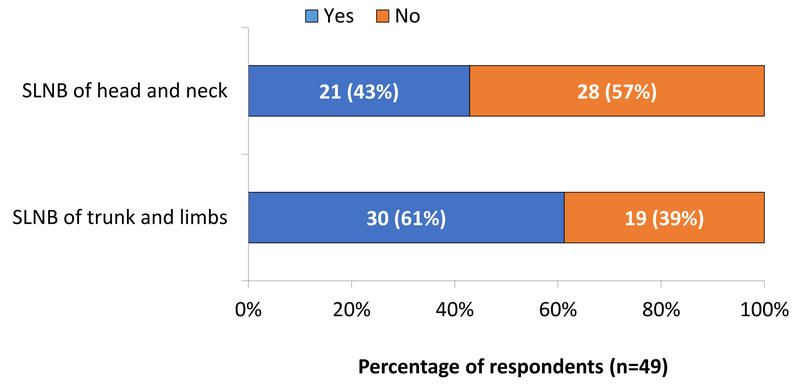
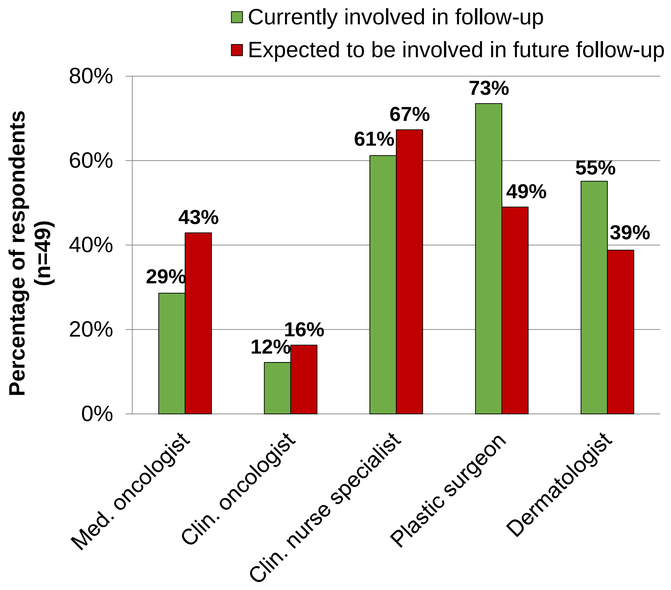
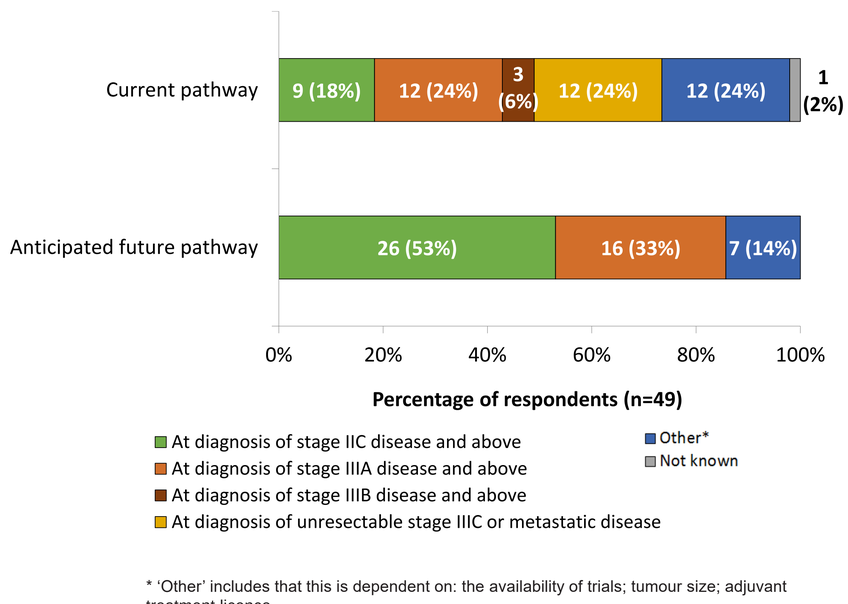


Figure 3: Health Care professionals (HCPs) involved in patient follow-up: current vs anticipated future practice



Results for follow-up of patients with resected stage IIIB melanoma are shown for illustrative purposes; results for stage IIIA and IIIC were similar overall (+/- 1 respondent)

Figure 4: At what stage in the care pathway are patients referred to an oncologist?



* 'Other' includes that this is dependent on: the availability of trials; tumour size; adjuvant treatment licence.

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

Implications	No. (%) respondents identifying (n=49)	Example themes
Staffing	39 (80%)	Likely to need more CNS, pharmacy and oncology resource; More time needed to discuss options; more follow up appointments.
Training	32 (65%)	Training of new oncologists and dermatologists; Education on new drugs and eligibility criteria for adjuvant therapy; Training for MDT members to ensure timely (<12 weeks) referral to oncology; More isolated surgeries and SLNBs.
Commissioning	23 (47%)	Funding of new staff, clinics, treatments and training will be required; Extra admissions (for immuno-oncology or other intravenous therapies); Commissioning of SLNB.
Local guidelines	40 (82%)	Time to develop, circulate and agree new guidelines; Development of new working practices within MDT.
Service structure	38 (78%)	More capacity required in chemotherapy suite; Requirement for increased clinic time and space; Will require service redesign and changes in management to accommodate different referral patterns, referral time frames and capabilities; Increased burden on local labs, radiology, and acute oncology services.
Increased requirement for patient psychological support	30 (61%)	Increased support and counselling to manage changing expectations of treatment, and to deal with disappointment; Will affect patients' ability to return to normal post-surgery; More active support will be required during treatment; Patients receiving adjuvant therapy may perceive that that there is more of a problem that with a watch and wait approach; Increased CNS support for adverse event management.

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 SSMDTs may need to review their current melanoma service provision and implement the appropriate guidelines and infrastructure to be able to deliver adjuvant therapy.

References

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Presenter email address: Miranda.Payne@ouh.nhs.uk