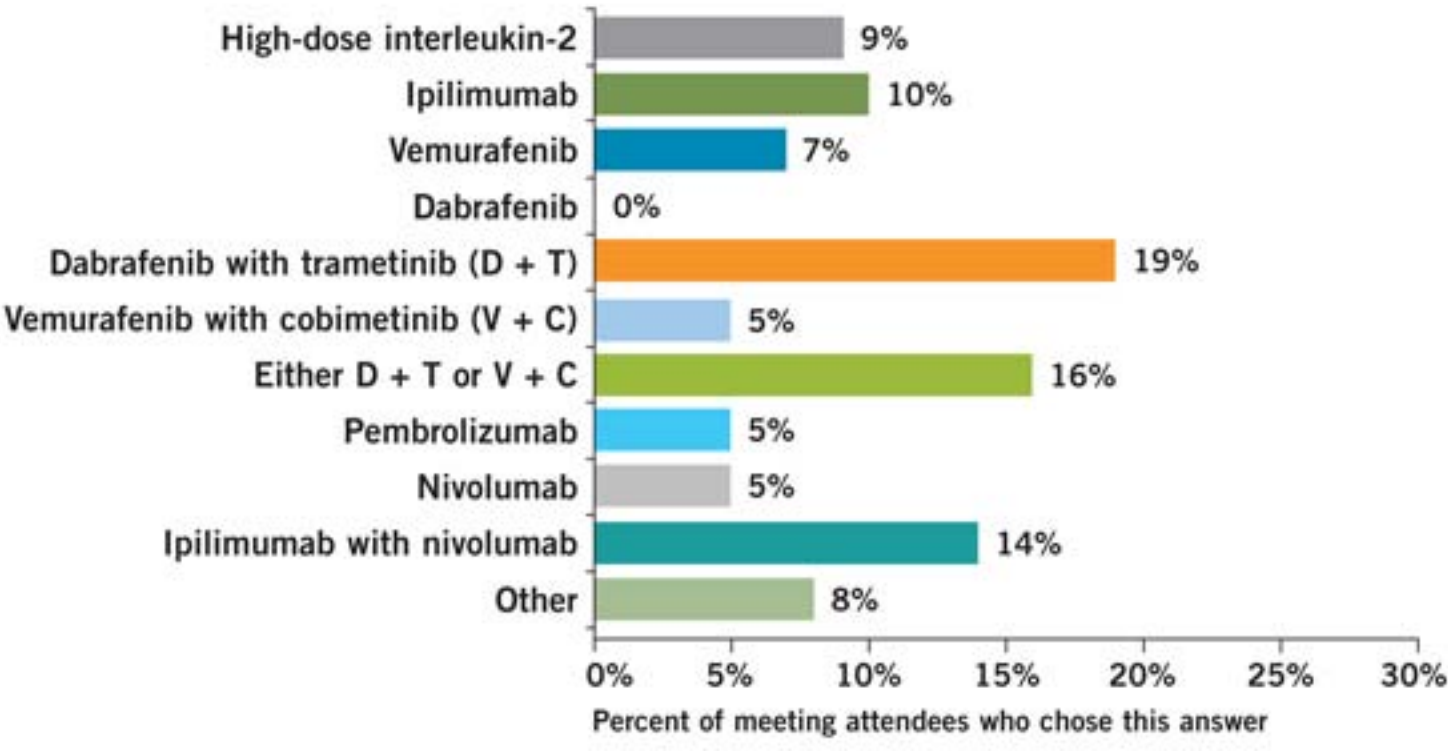
Year in Review

Proceedings from a Multitumor CME Symposium Focused on the Application of Emerging Research Information to the Care of Patients with Common Cancers

Treatment of Patients with Advanced BRAF V600-Mutant Melanoma, Basal Cell Carcinoma and Merkel Cell Carcinoma — Evan J Lipson, MD

A 54-year-old asymptomatic patient with a surgically excised primary melanoma is found 1 year later to have several small bilateral metastases in the lung on routine follow-up, confirmed to be BRAF V600E-positive. PS = 0. In general, what would you recommend as first-line systemic treatment?



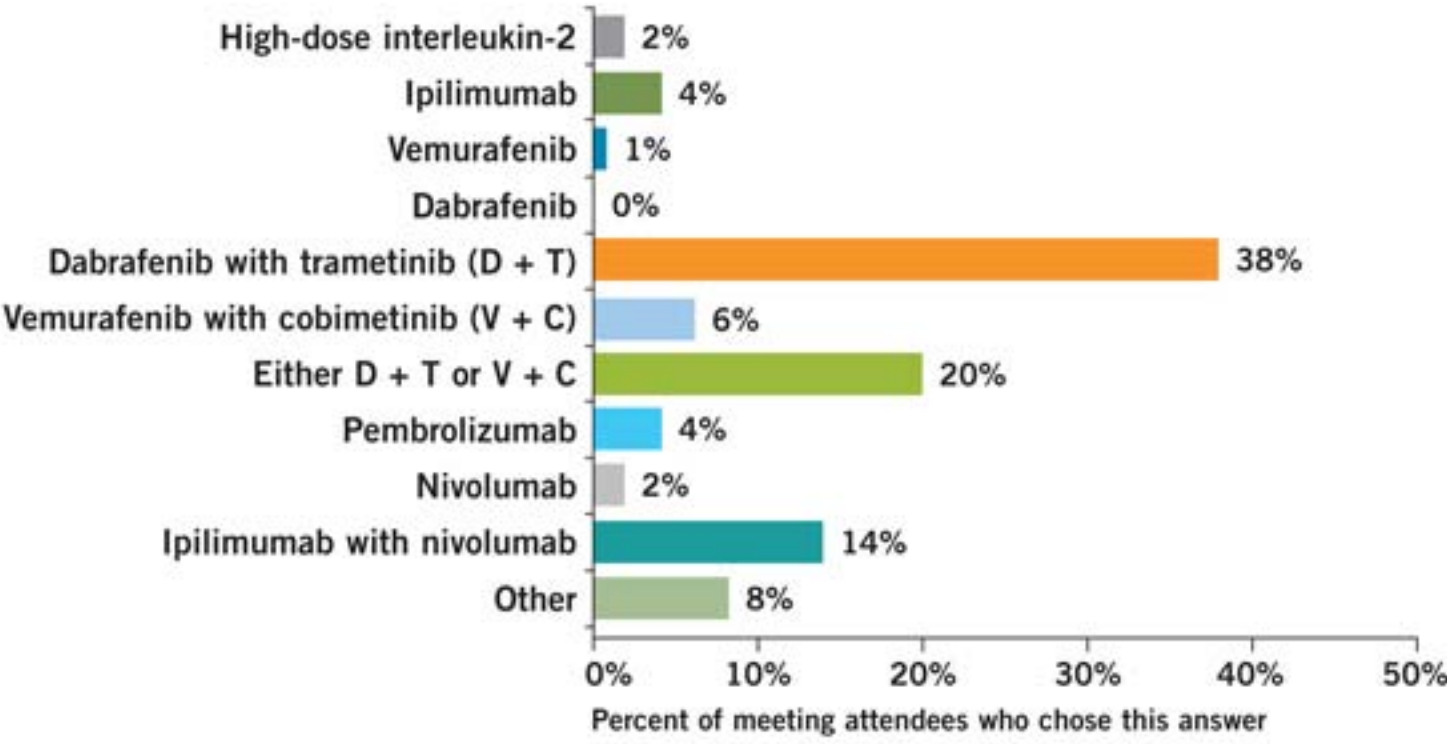
DR LOVE: Evan, we presented a young patient who's asymptomatic, kind of similar scenario we talked about before, but now BRAF V600E-positive, performance status 0, 54 years old. What would you be thinking about? Most people here would be thinking about dabrafenib and trametinib in this asymptomatic patient. Do you agree?

DR LIPSON: I don't disagree. I would probably stick with ipilimumab plus nivolumab for an asymptomatic patient, even with a BRAF mutation. Certainly, the overall survival data for using both of the drugs, dabrafenib plus trametinib, in combination are pretty good. As I said before, I think I would choose the immune therapy approach for the possibility of an extended survival, especially in a 54-year-old. But, certainly, starting with D and T would not be wrong.

DR LOVE: What do you think about the answer of vemurafenib, Adil? Is that an acceptable, evidence-based decision?

DR DAUD: No, it isn't. I think for the last couple of years, that's not been an acceptable option. Dabrafenib/trametinib, or soon to be cobimetinib and vemurafenib, are much better — longer recurrence-free or longer PFS, better OS, less side effects even in some critical areas like skin toxicity and secondary squamous cell. So, no, I don't think vem is, or dabrafenib monotherapy. I don't think either one of those is a reasonable option in this case.

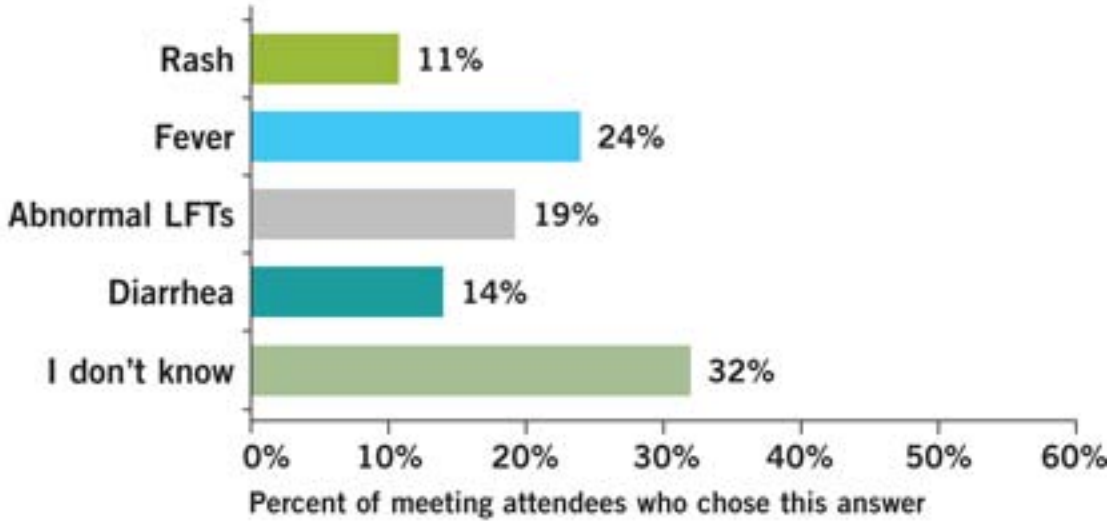
A 54-year-old symptomatic patient with a surgically excised primary melanoma is found 1 year later to have metastatic disease in the lung and liver, confirmed to be BRAF V600E-positive melanoma. In general, what would you recommend as first-line systemic treatment?



DR LOVE: Just to see if we can carve out the algorithm here — what we've done in the past when we do these surveys, we say, "Okay, now the patient's symptomatic." And now we see people flipping over toward the combination. Evan, any comments about this?

DR LIPSON: The combination of dabrafenib and trametinib is going to improve upon what was a good response in vemurafenib or dabrafenib monotherapy. In those cases, almost without exception, we use the combination. I think the symptomatic part here is important. BRAF inhibition plus MEK inhibition is going to, in most cases, give you the antitumor response you need, at least for a time, and that bridge should be enough to get you to immune therapy.

What is the most common complication requiring treatment interruption of dabrafenib in combination with trametinib?



How would you compare the risk-benefit ratio of dabrafenib/trametinib to vemurafenib/cobimetinib?