Clinical Case #1

A male in the 8th decade of life with recurrent cSCC

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Case #1

- A male in the eighth decade of life
- 5 months prior to presentation to the multidisciplinary clinic, he was diagnosed with a poorly differentiated periorbital cSCC
  - Several years earlier he had a cSCC of unclear size/differentiation status on his scalp, which was treated with Mohs micrographic surgery

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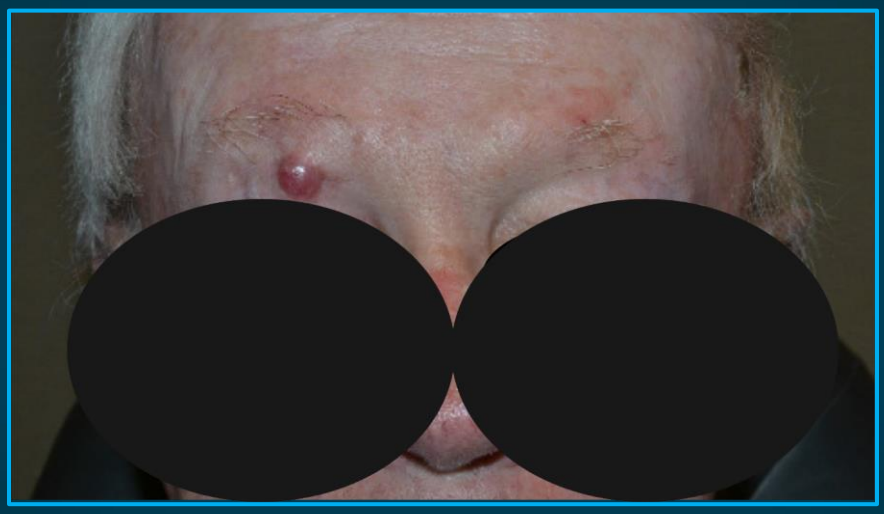
Case #1



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Case #1

- Physical exam demonstrated no regional or metastatic disease
- PET-CT demonstrated no regional or metastatic disease
- MRI demonstrated…

PET = positron emission tomography; MRI = magnetic resonance imaging.

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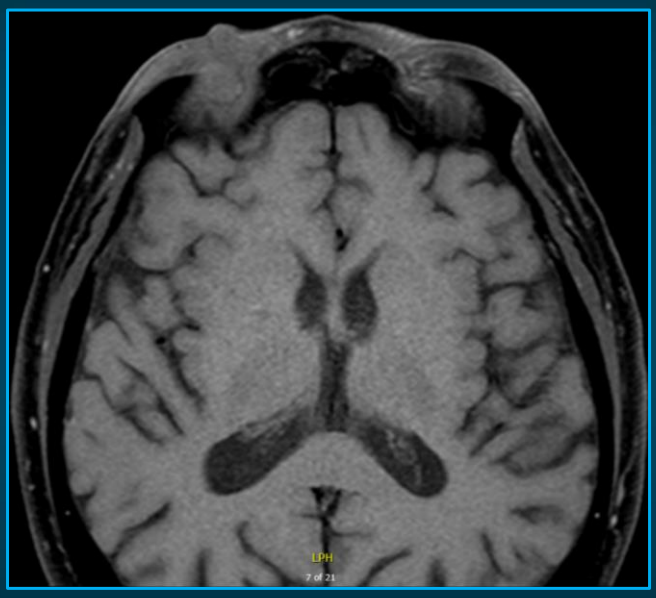
Case #1: T1 Weighted MRI Prior to Treatment



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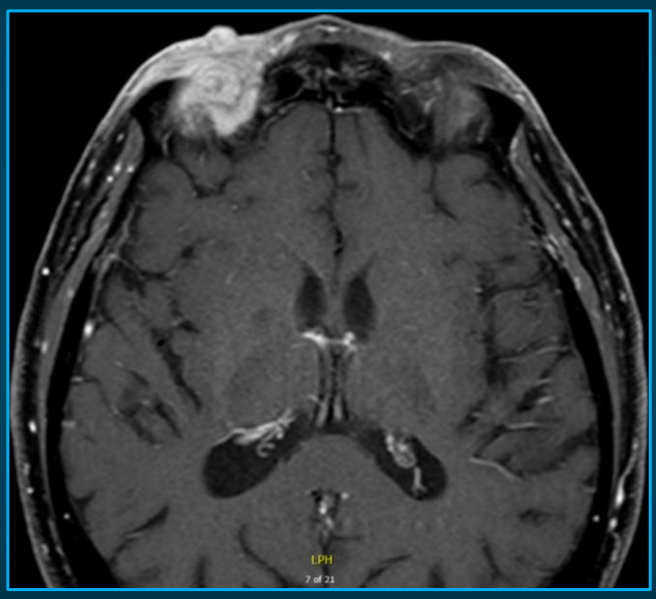
Case #1: T1 Weighted MRI Prior to Treatment



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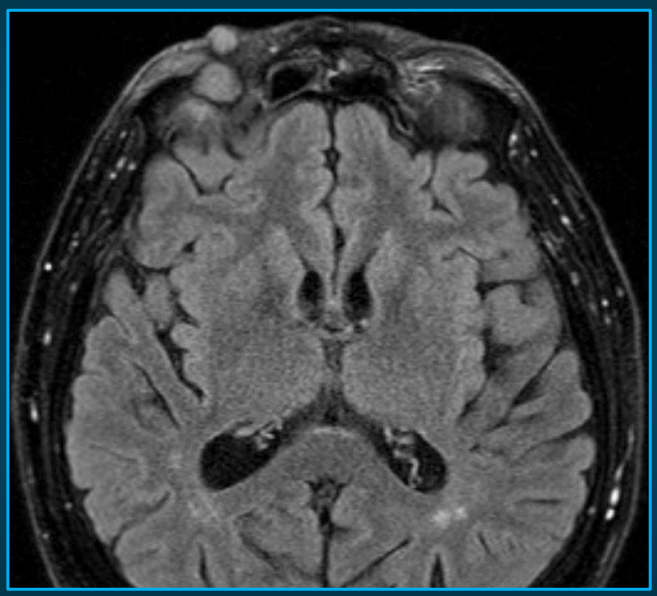
Case #1: T2 Weighted MRI



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Case #1: Question #2

What treatment would you recommend?

a. Surgical excision
b. Radiation
c. Chemoradiation
d. Anti-PD-1 therapy
e. Other

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Case #1: Question #2

What treatment would you recommend?

a. Surgical excision
b. Radiation
c. Chemoradiation
d. Anti-PD-1 therapy
e. Other

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Case #1: Question #2

What treatment would you recommend?

Answer d. Anti-PD-1 therapy

Surgery, while likely yielding the highest chance of cure, would require exenteration of the orbit. Radiotherapy would likely lead to significant impairment of vision. Therefore, proceeding with a systemic therapy option for locally advanced disease is very reasonable. Both cemiplimab-rwlc and pembrolizumab are FDA-approved for locally advanced cSCC.

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Case #1

The patient consented to start cemiplimab-rwlc.

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Case #2: Treatment With Cemiplimab-rwlc

Prior to treatment | After 1 cycle | After 2 cycles | After 6 cycles

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Case #1: Follow-Up

- Patient received 10 cycles of anti-PD-1 every 3 weeks
- Therapy was stopped secondary to the COVID-19 pandemic
- No evidence of recurrence >2 years since starting anti-PD-1 and >1 year after stopping therapy

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Case #2

- A male in the seventh decade of life
- 30 years prior to presentation he was diagnosed and treated for a BCC on the left inferior eyelid
- 10 years later he had a recurrence and had Mohs surgery performed
- Nearly 18 years following the first recurrence, he presented with another recurrence

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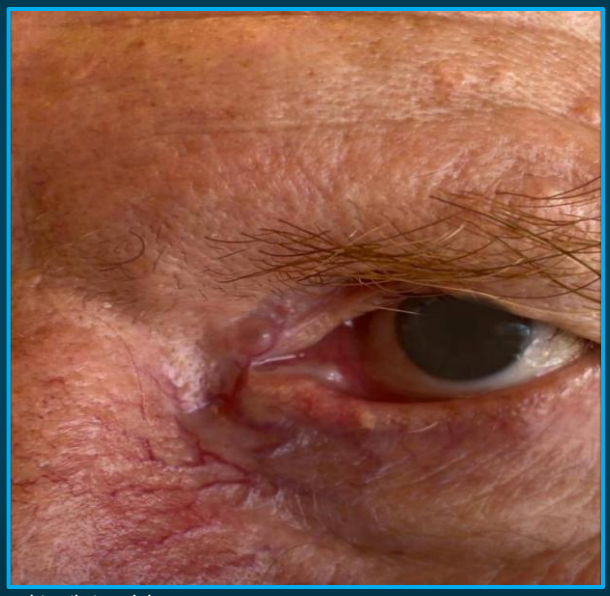
Case #2: Clinical Photo



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Case #2: MRI on Presentation

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Case #2: Question 1

Would you consult with, or refer to, other healthcare professionals before making treatment recommendations/ initiating treatment?

a. Dermatology and Medical Oncology
b. Radiation Oncology and Medical Oncology
c. Surgical Oncology and Medical Oncology
d. Head and Neck Surgery, Medical Oncology, and Radiation Oncology

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Case #2: Question 1

Would you consult with, or refer to, other healthcare professionals before making treatment recommendations/ initiating treatment?

a. Dermatology and Medical Oncology
b. Radiation Oncology and Medical Oncology
c. Surgical Oncology and Medical Oncology
d. Head and Neck Surgery, Medical Oncology, and Radiation Oncology

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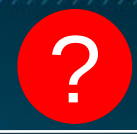
Case #2: Question 1



Would you consult with, or refer to, other healthcare professionals before making treatment recommendations/ initiating treatment?

Answer: d. Head and Neck Surgery, Medical Oncology, and Radiation Oncology

A multidisciplinary conversation with a head and neck surgeon, radiation oncologist, and medical oncologist would be very appropriate to help formulate the treatment recommendations for this complex case.

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Case #2: Question 2

What treatment plan would you recommend?

a. Surgical resection
b. Radiotherapy
c. Smoothened inhibitor
d. Anti-PD-1 therapy
e. Other

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Case #2: Question 2

What treatment plan would you recommend?

a. Surgical resection
b. Radiotherapy
c. Smoothened inhibitor
d. Anti-PD-1 therapy
e. Other

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Case #2: Question 2

What treatment plan would you recommend?

Answer: c. or d.

Surgery, while likely yielding the highest chance of cure, would require exenteration of the orbit. Radiotherapy would likely lead to significant impairment of vision. Therefore, proceeding with a systemic therapy option is very reasonable. Smoothened inhibitors are the FDA-approved first-line therapy for BCC. Anti-PD-1 therapy could be used if the patient progressed on first-line therapy.

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Case #2

- Patient was started on vismodegib
- Tolerated daily dosing for 4 months
- Transitioned to alternate day dosing

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Case #2: MRI After 1.5 Years on Alternate Dosing Vismodegib

The MRI findings demonstrate progression of disease.

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Case #2: Question 3

What treatment plan would you recommend?

a. Surgical resection
b. Radiotherapy
c. Change to another smoothened inhibitor
d. Anti-PD-1 therapy
e. Other

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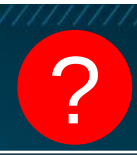
Case #2: Question 3



What treatment plan would you recommend?

a. Surgical resection
b. Radiotherapy
c. Change to another smoothened inhibitor
d. Anti-PD-1 therapy
e. Other

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Case #2: Question 3

What treatment plan would you recommend?

Answer: d. Anti-PD-1 therapy

Given the lesion's refractoriness to first-line vismodegib, transitioning to an FDA-approved anti-PD-1 therapy would be reasonable. Again, surgery, while likely yielding the highest chance of cure, would require exenteration of the orbit, and radiotherapy would likely lead to significant impairment of vision.

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Case #2: Follow-Up

- The patient is transitioned to anti-PD-1 therapy with cemiplimab-rwlc
- The patient is tolerating the therapy well and has stable disease for 12 months

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Case #2: Question 4

What treatment plan would you recommend?

a. Continue cemiplimab
b. Radiotherapy
c. Change to another smoothened inhibitor
d. Change to another anti-PD-1 therapy
e. Exenteration

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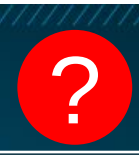
Case #2: Question 4



What treatment plan would you recommend?

a. Continue cemiplimab
b. Radiotherapy
c. Change to another smoothened inhibitor
d. Change to another anti-PD-1 therapy
e. Exenteration

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Case #2: Question 4

What treatment plan would you recommend?

Answer: a. Continue cemiplimab

Given that the patient is tolerating the therapy well and has maintained disease control, maintaining the current regimen would be very reasonable. There is no evidence that transitioning to another anti-PD-1 therapy or another smoothened inhibitor would provide clinical benefit. Surgery and radiation would incur the same morbidities as discussed earlier in the case.

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