Summary of 2009 MMIG Meeting
(Merkel cell carcinoma Multi-center Interest Group)

Friday March 6, 2009
American Academy of Dermatology Annual Meeting
San Francisco, CA
Prepared by Drs. Jayasri Iyer & Paul Nghiem

Speakers/Topics (detailed in following pages):

1) "A Near-Final Version of the MCC Staging System of the AJCC & UICC"
Dr. Paul Nghiem, U Washington, Seattle

2) "The first MCC-specific 'Checklist' for pathology features by the College of American Pathologists"
Dr. Bonnie Balzer, Cedars Sinai, Los Angeles

3) "New ICD-9 Codes Specific for MCC"
Dr. Jayasri Iyer, U Washington, Seattle

4) "Multi-modality MCC Management in Ann Arbor & per the revised NCCN Guidelines"
Dr. Chris Bichakjian, U Michigan, Ann Arbor

5) "Developing a Randomized Trial for Adjuvant Chemotherapy in MCC"
Dr. Jerry Marsden, University Hospital, Birmingham, UK

6) "Challenging Cases of MCC for Management Discussion"
Dr. Siegrid Yu, UCSF, San Francisco

Goals of the Merkel cell carcinoma Multi-center Interest Group (MMIG)

- Promote communication and collaborative studies on MCC
- Enhance access to patient data and specimens
- Expand evidence-based care for MCC

The homepage for MMIG contains photos, meeting summaries and more at:
http://merkelcell.org/MMIG.html

MMIG is funded in part by a grant from the Jerry Wachter Fund of the American Cancer Society (www.jw.org).

Please note that in some cases these summaries reflect unpublished data and are provided to help MMIG members manage their patients and give an overview of what is being done at different centers for care and research.

1) "A Near-Final Version of the MCC Staging System of the AJCC & UICC"

Dr. Paul Nghiem, U Washington, Seattle

Dr. Nghiem presented a late stage **proposed** unified staging system that will likely be adopted by both the AJCC and the UICC worldwide. Publication is anticipated in late 2009 for adoption on Jan 1, 2010. **It is not appropriate to officially use this system until publication because it is not yet final and there is no appropriate citation at this point.** The major changes from existing systems are inclusion of sub-stages for method of nodal evaluation (clinical evaluation vs. pathologic evaluation) and for clinically apparent vs only microscopic nodal involvement. Also, 2.0 cm tumors are now included in Stage I rather than Stage II (this is consistent with the prior AJCC system but differs from other common systems). The outline of the ***proposed*** staging system is as follows:

Stage I: **Local, ≤ 2cm**
Ia: Nodes microscopically negative and not clinically detectable
Ib: Nodes not clinically detectable (no pathologic eval of nodes done)

Stage II: **Local, > 2cm**
IIa: Nodes microscopically negative and not clinically detectable
IIb: Nodes not clinically detectable (no pathologic eval of nodes done)
IIc: Primary tumor invading bone/muscle/fascia/cartilage

Stage III: **Regional Nodal Disease**
IIIa: Micrometastasis
IIIb: Macrometastasis (clinically detectable)

Stage IV: **Distant Metastatic Disease**

2) "The first MCC-specific 'Checklist' for pathology features by the College of American Pathologists"

Dr. Bonnie Balzer, Cedars Sinai, Los Angeles

Together with Dr. David Frishberg, a new, specific set of required pathologic features will be published online in the next few months. The Checklist will be available via the CAP website (http://www.cap.org/apps/cap.portal). Major pathology centers will follow these guidelines that will standardize required and optional features that should be included in pathology reports for MCC. The Checklist has been coordinated with the new AJCC/UICC staging system and also with the pathologic features that will be collected by tumor registrars when recording MCC cases for future studies.

3) "New ICD-9 Codes Specific for MCC"

Dr. Jayasri Iyer, U Washington, Seattle

Based on suggestions from other MMIG group members, Drs. Iyer & Nghiem led an effort in 2008-09 in which we petitioned the CDC and appropriate World Health Organization entities to create ICD-9 codes that are specific for MCC. Currently, MCC is coded with malignant neoplasms of skin (173.x) which includes BCC and dozens of other skin cancers. This petition was reviewed in a variety of steps in 2008 and then at a formal meeting in January 2009 in Maryland where it was accepted. We were particularly pleased that they granted EIGHT CODES specific to MCC as summarized below. These codes are similar in nature to those for melanoma. **Beginning in October 2009, MCC should be reported using these new codes that will go into the use around the world.** This will greatly improve our ability to obtain insurance approval for procedures for MCC patients, as well as track costs, incidence, etc for this cancer.

ICD-9 CODE	DISEASE
209	Neuroendocrine tumors
209.3	Malignant poorly differentiated neuroendocrine tumors
209.31	MCC, face, ear, eyelid, including canthus, lip
209.32	MCC scalp/neck
209.33	MCC Upper limb
209.34	MCC lower limb
209.35	MCC trunk
209.36	MCC other unspecified sites, MCC genital, buttock
209.37	MCC unknown primary site, Nodal presentation, Visceral metastatic
V10.91	Personal history of malignant neuroendocrine tumor (which would include history of MCC)

4) "Multi-modality MCC Management in Ann Arbor & per the revised NCCN Guidelines"

Dr. Chris Bichakjian, U Michigan, Ann Arbor

Dr Bichakjian summarized the major changes in the National Comprehensive Cancer Network (NCCN) guidelines for 2009 for MCC. These changes mostly focused on radiation and chemotherapy. The guidelines are annually update, multi-disciplinary, reflective of practice across the major cancer centers in the US and can be found at:

http://www.nccn.org/professionals/physician_gls/PDF/mcc.pdf

5) "Developing a Randomized Trial for Adjuvant Chemotherapy in MCC"

Dr. Jerry Marsden, University Hospital, Birmingham, UK

Dr. Marsden has proposed a randomized trial for MCC that would be a feasibility trial to start in the UK. A final decision on availability of funding (nearly $1M) will be determined in a few months. If it is funded, it will randomize patients with local or nodal MCC to receive standard therapy alone or standard therapy plus cisplatin/etoposide.

6) "Challenging Cases of MCC for Management Discussion"

Dr. Siegrid Yu, UCSF, San Francisco

Dr. Yu led a spirited discussion about complex cases of MCC she has managed. Several of the relevant points from these cases are listed in the discussion points below. In particular, her presentation led to discussions on the WIDE variation in practice habits across institutions in obtaining scans and use of radiation.

Summary of Discussions & Plans For Future:

Lack of Consensus in MCC Management

Drs. Schmultz & Berg suggested performing a mail-in survey of doctors who care for MCC patients across all relevant specialties around the country and perhaps around the world. As we all know, there are VAST differences in how MCC patients are managed based on individual- and specialty-associated biases. Documenting the extent and nature of these discrepancies would be of interest and would serve to emphasize the variability of management of this disease and the need for studies to determine best management practices.

PET/CT scans

There was vast discrepancy in the extent to which PET/CT scanning was performed in early stage MCC. Some centers perform it on 100% of patients, others on 0%. Dr. Wang has been formally studying the utility of PET/CT scanning in over 140 instances of its use and we hope she will update us on that next year as her study progresses.

Consider establishing an email ListServ

Dr. Berg suggested we do this because a ListServ has been very helpful for SCC management consultations.

MMIG meetings should include non-dermatologists

We all agree that this is desirable, and Drs. Dan Coit (Surgery) & Larry Margolis (Rad Onc) have kindly joined us for past MMIG meetings. The problem is money. MMIG meets at the AAD because it is economical. We will attempt to invite surgical, medical, & radiation oncologists to future meetings based on the AAD meeting venue. Next year's AAD will be in Miami & we plan to invite our colleagues from Florida in 2010.

Isolated limb infusion vs perfusion

Drs. Bichakjian, Marsden & Wang discussed their experiences (mostly favorable) with these techniques that are available only at select centers. We hope to have a formal presentation at next year's MMIG meeting on the relative advantages and disadvantages of these approaches.

Brachytherapy for extensive regional cutaneous MCC.

Dr Wang noted extremely low morbidity from this technique that involves only 2 treatments. We hope to have this presented in greater detail next year.

Clinical Research on MCC.

We would be happy to send our "data intake form" and our clinical database structure (in Excel or Filemaker Pro) to any groups around the world that are interested in setting up their own clinical research database for MCC for their own studies or possible future multi-institutional collaborative studies.

In attendance at the 2009 MMIG meeting:

Maryam Asgari (Kaiser)
Evans Bailey (Michigan)
Daniel Berg (UW)
Chris Bichakjian (Michigan)
Jeremy Bordeaux (Case Western Reserve University)
Erv Epstein (UCSF)
Jayasri Iyer (UW)
Nanette Liegeois (Hopkins)
Jerry Marsdan (Birmingham, UK)
Mollie MacCormack (Lahey)
Paul Nghiem (UW)
John Olerud (UW)
Faramarz Samie (Thomas Jefferson)
Chrys Schmults (DFCI)
Thomas Stasko (Vanderbilt)
Rob Stern (Harvard)
Martina Ulrich (Berlin, Germany)
Linda Wang (DFCI/BWH)
Siegrid Yu (UCSF)
Nathalie Zeitouni (Roswell Park)
Fiona Zwald (Emory)