Merkel cell carcinoma most likely to recur within 2 years of diagnosis

PORTLAND, ORE. – The first 2 years after diagnosis are crucial when conducting surveillance for recurrence of Merkel cell carcinoma (MCC), Aubriana McEvoy said at the annual meeting of the Society for Investigative Dermatology.

Regardless of stage at diagnosis, the risk of recurrence peaked at about 1 year and leveled off by about year 2 in a retrospective cohort study, according to Ms. McEvoy, a medical student at the University of Washington, Seattle, who conducted the study with colleagues under the mentorship of Paul Nghiem, MD, PhD, professor and head of the division of dermatology. The study also inversely linked primary MCC stage with subsequent recurrence-free survival, highlighted the role of imaging for surveillance of patients who have advanced primary disease, and linked distant metastatic recurrence with significantly worse survival, compared with local or nodal recurrence.

“Patients with Merkel cell carcinoma always ask about recurrence,” Ms. McEvoy said. “Now, for the first time, we have the data to answer their questions.”

Surveillance of MCC is increasingly important, she said: The “treatment landscape is evolving quickly, and immunotherapies such as pembrolizumab can have a good response rate, especially in the setting of lower burden of disease.” But follow-up is costly on several fronts, making it crucial to aim for “enough” and not “too much” surveillance, she added.

“Imaging often costs thousands of dollars, and that’s only one piece of the pie. There’s also the cost of office visits, time spent by the patient and their

family, and the emotional investment and uncertainty a patient goes through every time they have to come for a follow-up visit and scan," Ms. McEvoy said.

Comprehensive, stage-specific guidelines can help clinicians and patients balance the benefits and costs of surveillance, but are lacking in MCC because no published study has characterized recurrence by stage, she said. To fill this gap, she and her associates analyzed 10 years of longitudinal MCC surveillance data on 468 patients who underwent pathologic staging and were followed at the Nghiem laboratory.

The risk of recurrence was highest within the first 2 years after diagnosis, regardless of whether patients had local (pathologic stage I–II) or nodal (stage III) MCC. However, the probability of recurrence-free survival correlated inversely with pathologic stage of primary MCC ($P = .003$). Median recurrence-free survival time was not reached by the 186 patients with local disease and small (2-cm maximum dimension) primary lesions, or by 135 patients with clinically occult nodal disease.

In contrast, median recurrence-free survival was about 6 years among 84 patients with local disease and lesions measuring more than 2 cm; was less than 2 years among 35 patients with clinically apparent, pathologically confirmed nodal disease or in-transit metastases; and was less than 1 year among patients with distant metastatic disease.

The researchers also investigated the risk of distant metastatic recurrence to confirm which patients need most intensive follow-up. Among 138 individuals with available data, 40% of stage I primary MCC patients developed a distant metastatic recurrence, as did 60% of patients with stage IIA or stage IIB primary MCC. And 80% of recurrences among patients with stage IIIA or stage IIIB primary disease were distant metastases. "I think it's safe to say that stage III patients should receive appropriate, if not vigilant,

surveillance," Ms. McEvoy said. The site of recurrence also was significantly (*P* less than .001) tied to the risk of subsequent death from recurrent MCC; median survival time was not reached when recurrence was local or nodal, but was less than 2 years when it was distant or metastatic.

Early in 2018, the American Joint Committee on Cancer will update its MCC staging system to distinguish clinical versus pathologic staging. "This is important, because pathologic staging remains the gold standard, providing a much more in-depth view of the patient's disease," Ms. McEvoy commented. Ideally, clinicians would use more information to help predict the prognosis of MCC, including sex and immune and viral status, she noted. "But we hope these data provide information for more consistency across the country, so we can catch recurrences earlier, and avoid unnecessary visits and imaging scans for lower-risk patients."

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