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MSD

melACTION meeting summary: Evolving roles & patient pathways with adjuvant immunotherapy

Friday 8th September 2023

Job code: GB-OOC-00632
Date of preparation: November 2023

melACTION 2023 meeting highlights:

Evolving roles & patient pathways with adjuvant immunotherapy

On Friday, 8th September 2023, 33 delegates and 9 speakers from Melanoma MDTs across the UK gathered in London for a day of interactive discussions on adjuvant melanoma therapy and how the multidisciplinary care pathways supporting adjuvant therapy can be optimised.

Oncologists, Dermatologists, Surgeons, Pharmacists, Nurses and CNSs in attendance made this a truly multidisciplinary meeting. Led by an expert speaker panel and chaired by Dr Heather Shaw, this immersive full-day programme of plenary sessions, panel discussions and breakout activities, allowed for deep and valuable discourse on the role each speciality has to play in optimising the patient experience in melanoma.

Contents

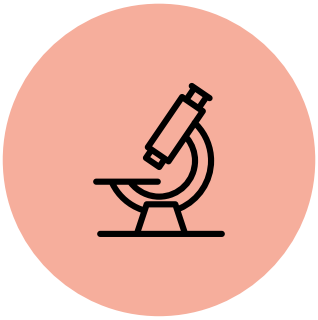
Time	Topic	Presenter(s)
10.00	**Arrival and registration**	
10.30	**Welcome | 'Why are we here?'** *Hear from the panel*	**All speakers** **Chair: Dr Heather Shaw** Medical Oncology Consultant, Mount Vernon Cancer Centre, London
11.00	**Adjuvant immunotherapy treatment in Stage IIB–C melanoma**	**Dr Heather Shaw**
11.30	**The evolving role of the Dermatologist**: *Past, present and future*	**Dr Khushboo Sinha** Consultant Dermatologist, St John's Institute of Dermatology, Guy's and St Thomas' NHS Trust
12.00	**Break**	
12.15	**An Oncologist and Surgeon discuss** *The adjuvant melanoma patient pathway*	**Dr Ricky Frazer** Consultant Medical Oncologist and Honorary Lecturer at Cardiff University **Mr Jonathan Pollock** Consultant Plastic Surgeon, Nottingham University Hospitals NHS Trust
13.15	**Lunch**	
14.00	**Management of adverse events** *Model of care and case study overview*	**Ms Trudy Guinan** Nurse Consultant in Immuno-Oncology, The Clatterbridge Cancer Centre **Ms Emily Keen** Macmillan Lead Nurse for Immunotherapy at Royal Free London NHS Foundation Trust
14.30	Individualised care and the patient conversation	**Prof. James Larkin** Consultant Medical Oncologist at The Royal Marsden Hospital NHS Trust
15.15	**Breakout sessions:**	
	Breakout room 1: Princess Gate *The interface between surgery and adjuvant therapy. MDT considerations from a surgical perspective*	**Mr Amer Durrani** Consultant Plastic and Reconstructive Surgeon at Cambridge University Hospitals NHS Foundation Trust
	Breakout room 2: G.4.5 *Pathway optimisation | Importance of the CNS*	**Ms Jackie Hodgetts** Nurse Clinician at The Christie NHS Foundation Trust
16.00	**Panel discussion**	**All speakers** **Chair: Dr Heather Shaw**

Attendees

14 Nurses

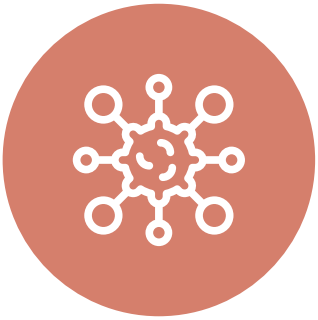
24 Physicians

3 Pharmacists



1 Histopathologist

Across a range of specialities:



17 Oncology specialists

15 Dermatology specialists

8 Plastic Surgery specialists

1 Elderly Care specialist

1 Histopathology specialist

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Faculty

Dr Ricky Frazer

Consultant Medical Oncologist and Honorary Lecturer

Cardiff University, UK

Dr Heather Shaw

Medical Oncology Consultant with specialist interest in skin cancer and early phase trials

University College London Hospital and Mount Vernon Cancer Centre, London, UK

Mr Jonathan Pollock

Consultant Plastic Surgeon

Nottingham University Hospitals NHS Trust, UK

Dr Khushboo Sinha

Consultant Dermatologist with specialist interest in skin cancer

St John's Institute of Dermatology, Guy's and St Thomas' NHS Trust, London, UK

Ms Jackie Hodgetts

Nurse Clinician

The Christie NHS Foundation Trust, Manchester, UK

Ms Trudy Guinan

Nurse Consultant in Immuno-Oncology

The Clatterbridge Cancer Centre, Liverpool, UK

Ms Emily Keen

Macmillan Lead Nurse for Immunotherapy

Royal Free London NHS Foundation Trust, UK

Professor James Larkin

Consultant Medical Oncologist

The Royal Marsden Hospital NHS Trust, London, UK

Mr Amer Durrani

Consultant Plastic and Reconstructive Surgeon

Cambridge University Hospitals NHS Foundation Trust, UK

Today's meeting will definitely impact on how I collaborate with my colleagues from now on. There was a lot of information that we received; for example, the importance of liaising with the Plastic Surgeons and Oncologists, that gave me a great idea on how to improve the patient journey.

Nangisai Rungwandi,
Skin Cancer CNS,
Luton and Dunstable University Hospital

Adjuvant immunotherapy treatment in Stage IIB–C melanoma

Dr Heather Shaw

Medical Oncology Consultant at University College London Hospital and Mount Vernon Cancer Centre

In this session, meeting Chair Heather Shaw provided her perspective on the current landscape with regard to adjuvant melanoma treatment and highlighted the risk of disease recurrence across Stage IIB/C and III melanoma before moving onto data from KEYNOTE-716.

What do we already know?

Dr Shaw began the session with a historical overview of how patients with melanoma have been evaluated, considering factors such as the American Joint Committee on Cancer Staging Manual and the risk of recurrence in patients with resected Stage II and III melanoma.

Evidence has shown that patients with Stage IIB/C melanoma have a significant risk of recurrence.[1–3] The results from KEYNOTE-716 highlight that adjuvant therapy has the potential to address an unmet need in this patient population.

KEYNOTE-716 is an international, double-blind, randomised, placebo-controlled, Phase 3 study of KEYTRUDA® versus placebo as adjuvant therapy in patients with completely resected, high-risk histologically confirmed Stage IIB or Stage IIC cutaneous melanoma without regional lymph node involvement. Patients were randomly assigned (1:1) to intravenous KEYTRUDA® or placebo every 3 weeks for up to one year or until disease recurrence or unacceptable toxicity.[4]

The primary endpoint was investigator-assessed recurrence-free survival (defined as time from randomisation to recurrence or death) in the intention-to-treat population. Safety was assessed in all patients randomly assigned to treatment who received at least one dose of study treatment.[4]

For full KEYNOTE-716 safety and efficacy results, please scan or click the QR code:

By following this link, you will be taken to an MSD promotional website.

KEYTRUDA® is associated with immune-mediated adverse events. Please refer to the Summary of Product Characteristics for full details about adverse events and their management.[5]

Relevance to clinical practice

Regarding patient care, there are essential factors to consider beyond the data; these include:

- Ensuring that all eligible patients in the clinic are given the opportunity to receive adjuvant therapy
- Streamlining pathways
- Managing capacity issues, side effect algorithms and resource allocation
- Involving patients in decision-making
- Encouraging patients to actively participate in their own treatment with available support and resources

What actions should we take moving forward?

Dr Shaw concluded that in order to make well-informed choices and deliver optimal care it is important to:

- Recognise the importance of the MDT throughout the patient journey
- Consider capacity implications and the ever-increasing need for close collaboration between different specialities, particularly in light of rising patient numbers and the data showing risk of recurrence in patients with Stage IIB/C melanoma
- Weigh the potential benefits against the potential side effects of adjuvant therapy when such treatment is considered
- Factor in each patient's unique needs and circumstances when considering adjuvant therapy

I think meetings like this are important because clinicians and specialist nurses unfortunately don't have the time to keep up to date with all the information out there. In medicine, there's so many advances and it's difficult to keep up with everything... Therefore, this time is an important time to reflect and learn about developments in melanoma management, and be conscious and prepared to offer our patients the best possible care.

Keith Wu,
Dermatologist,
York Teaching Hospital

References
1. Garbe C, et al. J Clin Oncol. 2022;40(32):3741–9; **2.** Lee AY, et al. Ann Surg Oncol. 2017;24(4):939–46; **3.** Mohr P, et al. Melanoma Manag. 2019;6(4):MMT33; **4.** Luke JJ, et al. Lancet. 2022;399:1718–2; **5.** KEYTRUDA® (pembrolizumab). Summary of Product Characteristics. Available at: GB SmPC https://www.medicines.org.uk/emc/product/2498/smpc#gref and NI SmPC https://www.emcmedicines.com/en-gb/northernireland/medicine?id=ce680467-8438-4e60-ab4f-dfab6767ccbe&type=smpc

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The evolving role of the Dermatologist: Past, present and future

Dr Khushboo Sinha

Consultant Dermatologist at St John's Institute of Dermatology, Guy's and St Thomas' NHS Trust

Dermatologist Dr Khushboo Sinha shared her insights on how the role of Dermatologists has evolved and adapted in recent years, primarily due to developments in melanoma care. Dr Sinha provided an overview of the unchanged core principles of her role as well as how things are likely to change in the future.

The transition of past to present

In years gone by, the Dermatologist's primary responsibility in the context of melanoma care was diagnosing and recognising melanoma, and involved following standard procedures, such as inquiring about the patient's past dermatological history and completing a physical examination. The Dermatologist may also perform an ocular inspection or a dermoscopic assessment to magnify and illuminate lesions to facilitate recognition.

Today, the role of the Dermatologist is expanding in some centres beyond diagnosis to include treatment for complex patient groups, and providing dermatological expertise at various points in the melanoma pathway. As a result, Dermatologists are involved in:

- Primary and secondary prevention
- MDT coordination (leading and guiding)
- Surgical treatment of thinner melanoma (primary excision, minor local excision, post-operative management)
- Surveillance (skin monitoring based on the stage of melanoma, and frequency and duration of surveillance)

Post-treatment surveillance is another area of the melanoma pathway that has been evolving over recent years, owing in part to increasing patient numbers. This post-treatment surveillance handover varies from trust to trust but is critical in managing capacity and workload between specialities.

The future

Dr Sinha elaborated on the future responsibilities of Dermatologists, which include providing patients with up-to-date information on adjuvant treatments and helping patients understand their potential treatment pathway.

Dermatologists must remain adaptable and flexible to provide optimal care in a changing landscape. To assist with this, Guy's and St Thomas' NHS Trust has implemented a Joint Care Model, which promotes collaborative care by breaking down traditional role boundaries, providing consistent education and encouraging knowledge sharing among all staff.

The Joint Care Model

- A 'buddy system' – Oncologists partner with Dermatologists to identify patients who may benefit from joint consultation. It also encourages an 'open-door policy' to facilitate open communication between MDT members in a literal sense
- Cross-speciality training – educates on critical aspects of delivering adjuvant IO care
- An MDT training programme – aims to standardise knowledge across Dermatologists, CNSs and Surgeons. These training courses focus on the melanoma treatment landscape as well as detailing patient resources. Such training can empower the MDT to contribute positively to patient care

To effectively implement the Joint Care Model, MDT members need to consider practical factors such as having a designated physical space for meetings, the use of hot desking, staying up-to-date through activities such as journal clubs, ensuring that the IT system supports the Joint Care Model, and facilitating regular team updates and pathways for information sharing.

Summary

- With the evolving melanoma landscape and different treatment options, Dermatologists are now playing a more collaborative and involved role in the early stages of the melanoma patient journey to provide the best care and achieve optimal patient outcomes
- The role of the Dermatologist has become increasingly important owing to the complexity of cases and the need for their expertise throughout the melanoma pathway
- Undertaking a collaborative approach is key to enhancing patient care in the future

An Oncologist and Surgeon discuss: The adjuvant melanoma patient pathway

Mr Jonathan Pollock

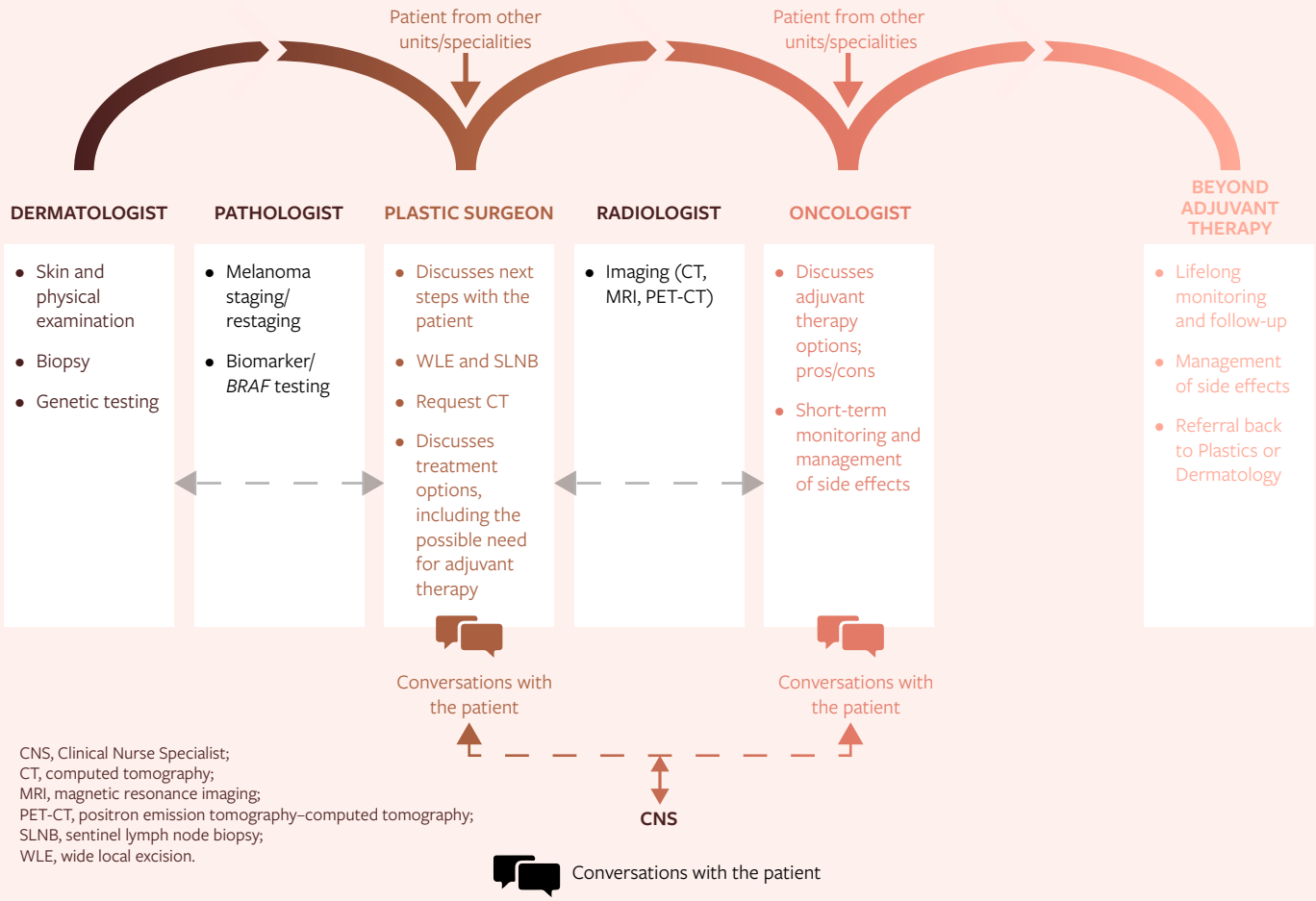
Consultant Plastic Surgeon,
Nottingham University Hospitals NHS Trust

Dr Ricky Frazer

Consultant Medical Oncologist and
Honorary Lecturer at Cardiff University

In this interactive session, Dr Ricky Frazer and Mr Jonathan Pollock, representing their respective disciplines of Oncology and Plastic Surgery, explored the complex patient pathway in melanoma (Figure 1) and how MDT collaboration can improve the patient experience with regard to adjuvant therapy.

Figure 1: Example of a patient pathway in melanoma including adjuvant therapy



CNS, Clinical Nurse Specialist;
CT, computed tomography;
MRI, magnetic resonance imaging;
PET-CT, positron emission tomography–computed tomography;
SLNB, sentinel lymph node biopsy;
WLE, wide local excision.

Pathway

The speakers discussed considerations from a surgical, oncology and overall MDT perspective, starting with a patient presenting with Stage IIB/IIC/III melanoma.

Appropriate timings were explored for staging, scanning and *BRAF* testing, with thought given to what elements can be completed upstream in order to prevent downstream delays.

I've loved all of it. I've learned so much. I've really been impressed and inspired by lots of the other speakers about what's going on throughout the country, and I got some ideas I can take back home to my clinic.

Dr Kushboo Sinha,
Consultant Dermatologist at St John's Institute of Dermatology, Guy's and St Thomas' NHS Trust

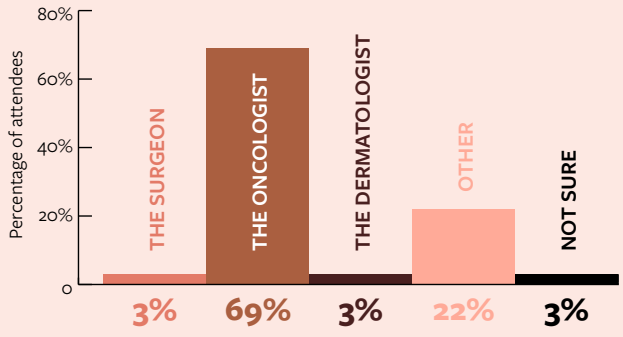
Adjuvant therapy | The patient conversation

There is also the question as to which HCP is the first to open the dialogue on adjuvant therapy with the patient. It was acknowledged how important this first conversation can be to set and manage patient expectations. Among the audience, results varied regarding who typically initiates the first conversation on adjuvant therapy.

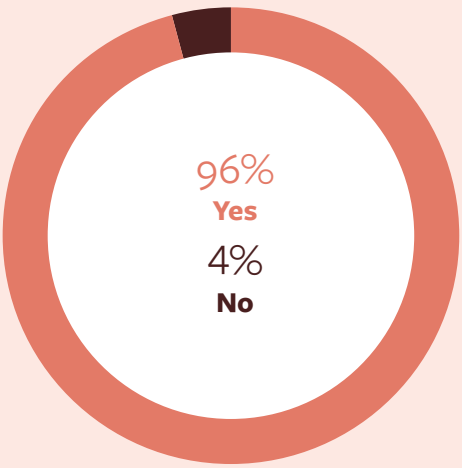
However, it is not only the responsibility of Surgeons and Oncologists to initiate these conversations. In this regard, the speakers highlighted the vital role of the **CNS**. In an ideal world, the process is a shared responsibility; the Surgeon might prime the patient by initially discussing the possibility of adjuvant therapy, the Oncologist would pick this up at the next stage with further information to support the patient's decision, and throughout, the CNS has a crucial role in providing more in-depth information, context and support.

The CNS is likely to be most familiar with the patient, highly aware of their needs and circumstances and can provide an invaluable source of education as well as constancy while the patient receives care in various departments. A key consideration for Surgeons and Oncologists must be how they can adapt their practice to best enable the CNS to carry out this important work.

In your centre, who is responsible for discussing the potential role of adjuvant therapy with patients?



Would having a CNS specialised or knowledgeable in immunotherapy and its associated adverse events be beneficial earlier in the pathway?



Results are from live audience polls and do not reflect the views of the speakers or MSD.

Summary

In their closing remarks, the speakers reflected that in their opinion, while all centres work in different ways, there is a need for clear guidance on when *BRAF* testing, as well as SLNB, should be performed, who should be involved in these discussions with patients and which speciality is leading post-treatment surveillance. While it's not possible to stick to a 'one-size-fits-all' pathway, working together and communicating with the patient is vital. This communication needs to be adapted to the individual needs of each patient, irrespective of what pathways are undertaken, and patients need to be equipped with knowledge on their treatment options and the associated benefits and risks in order to make supported, informed choices.

Audience Q&A

Q: Can you provide some insight about the level of certainty regarding the OS benefits of adjuvant therapy for Stage II melanoma?

Jonathan Pollock: It is important to educate and empower patients, emphasising that low risk does not mean zero risk. Patients should be informed about the signs and symptoms of recurrence and encouraged to report any concerns promptly.

When discussing OS with patients in the clinic, we can explain that adjuvant therapy can reduce the chances of recurrence, but we are not yet certain how much it impacts OS. Patients appreciate this explanation and we try not to push them too strongly in one direction or the other.

Ricky Frazer: It's important to understand what matters to patients for them to feel comfortable with the decision they make. Some patients want assurance that everything possible has been done. We can't be certain about the effect of adjuvant therapy on survival, but we do know that if the patient is not treated and the melanoma returns after a few years, it won't be possible to revisit the decision. Therefore, it's crucial to communicate what we know and what we don't know, so patients can make informed choices.

Management of adverse events | Model of care and case study overview

Ms Emily Keen

Macmillan Lead Nurse for Immunotherapy,
The Royal Free London NHS Foundation

Ms Trudy-Jane Guinan

Nurse Consultant in Immuno-Oncology,
The Clatterbridge Cancer Centre

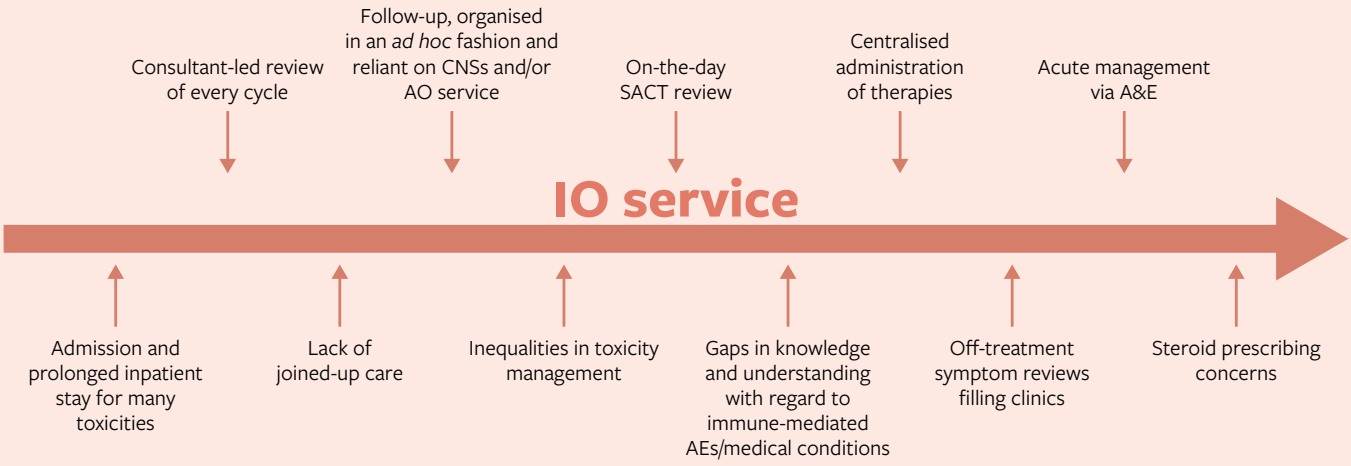
This session focussed on models of care that have been adopted by The Clatterbridge Cancer Centre and The Royal Free Hospital NHS Foundation Trust. Emily Keen and Trudy Guinan shared the history, implementation and outcomes resulting from centralising the IO toxicity service in their respective trusts.

The Clatterbridge Cancer Centre in the north west is one of the UK's largest providers of non-surgical cancer treatment, caring for 7,600 inpatients and receiving >150,000 outpatient visits annually, while The Royal Free is the largest provider of IO in North Central London.

The 'why': Challenges prior to IO service implementation

Prior to the inception of the IO service, a number of pathway challenges existed, particularly concerning toxicity management **(Figure 1)**, while IO patient numbers continued to increase across both centres. A need was identified for a service that encompassed IO education, management guidance, collaborative working with acute services and medical specialities, and nurse-led follow-up, which would help to eliminate bottlenecks relating to consultant reviews and inpatient hospital treatment.

Figure 1: Challenges in the delivery of IO prior to establishing the IO service



The list above is not exhaustive.
A&E, Accident and Emergency; AE, adverse event; AO, Acute Oncology; CNS, Clinical Nurse Specialist; IO, Immunotherapy; SACT, systematic anti-cancer therapy.

The speakers presented guiding principles for the management of mild, moderate and severe toxicities, but emphasised that the key to optimal management of patients at risk of toxicity is **maintaining adequate follow-up and contact** – one of the key objectives of the novel IO service. Refer to the KEYTRUDA® Summary of Product Characteristics for information on adverse events and their management.[1]

The 'how': Setting up the IO services

Development of the services was directed by a multitude of patient-, therapy- and trust-related questions; ease of implementation and re-organisation, prioritisation of challenges, balancing cost with demand and envisioning intended outcomes were all considerations in the design of the service.

The IO service at The Clatterbridge Cancer Centre was established at the end of 2018, while at The Royal Free, the role of IO Lead Nurse was created in 2020. Both services are built around a nurse-led model for the management of IO-related toxicities, running outpatient clinics to reduce inpatient admissions and ensuring early follow-up with close monitoring to avoid preventable admissions.

1. **IO Lead Nurse and IO Consultant roles were created** to facilitate development of expertise in management of IO, including implementation of latest guidance, and allow complete focus on patients and on internal and external education
2. **MDT collaboration** is at the heart of the services, allowing efficient dissemination of learnings on the management of patients with IO toxicity, and integration of the IO team into relevant medical specialities
3. **Outpatient pathways:** At The Clatterbridge Cancer Centre, key outpatient pathways include a Pan-Tumour IO clinic and pathways for specific drugs
4. **Nurse prescribing** may take place within the clinics, and some intravenous-based therapies can be delivered to outpatients under the supervision of the IO nursing team, thus reducing the length of inpatient stay

Outcomes

The benefits of the IO services are manifold. Improvements in toxicity management pathways for both inpatients and outpatients have led to reductions in inpatient care, reduced time to toxicity identification and improved collaborative MDT working. Consistency of care has been improved through the use of guidelines and staff education, while audits keep key performance indicators on course. Most importantly, the patient experience has been improved; patients are equipped with more information, having access to purpose-made materials and pre-IO counselling sessions, and are supported throughout their care with dedicated toxicity clinics and nursing support.[2]

My highlight of today's meeting is getting to know what other experts such as Dermatologists and Surgeons do with the patients before I meet them.

Ms Emily Keen,
Lead Nurse for Immunotherapy,
The Royal Free London NHS Foundation Trust

The highlight of the meeting to me has been learning about other people's experience with this group of patients who are quite challenging, particularly as we have had to develop our service in isolation, as everybody else has, because of COVID.

Mr Amer Durrani,
Consultant Plastic and Reconstructive Surgeon,
Cambridge University Hospitals NHS Foundation Trust

References 1. KEYTRUDA® (pembrolizumab). Summary of Product Characteristics. Available at: GB SmPC https://www.medicines.org.uk/emc/product/2498/ smpc#gref and NI SmPC https://www.emcmedicines.com/en-gb/northernireland/medicine?id=ce680467-8438-4e60-ab4f-dfab6767ccbe&type=smpc; **2.** Data from internal hospital data audit.

Individualised care and the patient conversation

Prof. James Larkin

Consultant Medical Oncologist at
The Royal Marsden Hospital NHS Trust

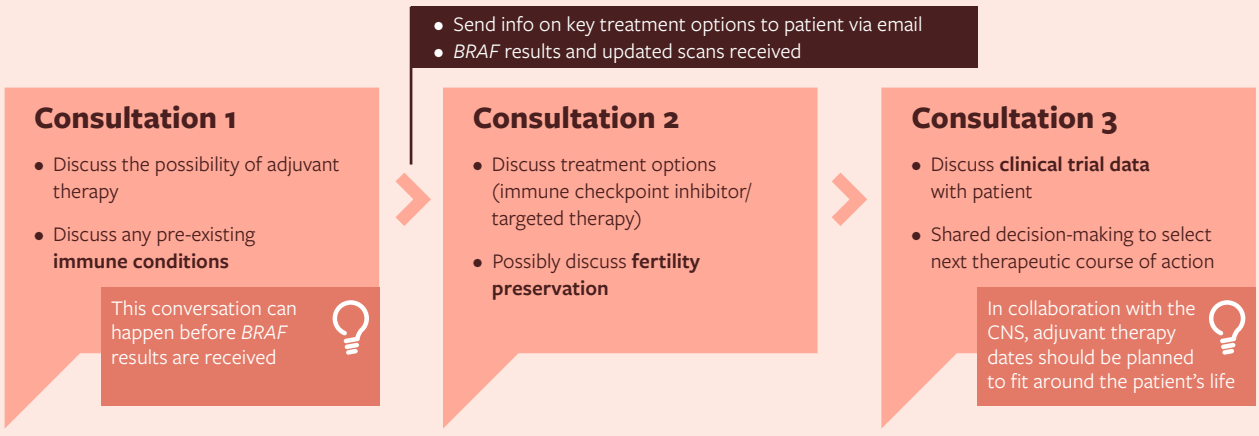
During this presentation, Prof. James Larkin discussed the typical conversations that occur between patients and HCPs throughout the melanoma journey, and shared strategies to enhance these conversations for an improved patient experience. The significant roles of key stakeholders such as Oncologists, Surgeons and CNSs in the patient discussion was also analysed.

Optimising the dialogue for improved patient experience

When discussing melanoma treatment options with patients, it is important to understand that it is rare for a patient to be able to fully absorb all necessary information within one consultation **(Figure 1)**.

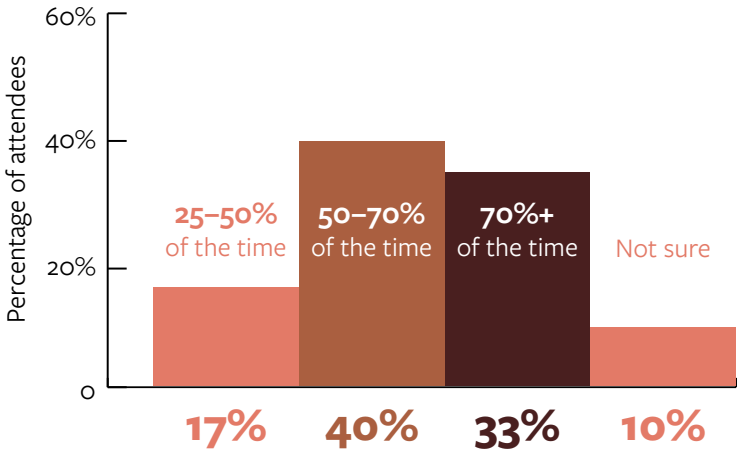
- Multiple discussions may be necessary for patients to fully understand the concept and implication of adjuvant therapy
- It is important not to overwhelm the patient with information, whilst ensuring there is an understanding of risk reduction as well as potential side effects

Figure 1: The evolving dialogue – example stages of shared decision-making for adjuvant therapy



CNS, Clinical Nurse Specialist.

In your centre, roughly how often does the patient's *BRAF* test result come back prior to the patient meeting with their Oncologist for an adjuvant treatment discussion?



Results are from a live audience poll and do not reflect the views of the speakers or MSD.

Conversations between the patient and the Oncologist

Discussions on adjuvant therapy should occur early in the patient pathway, and it is imperative that these occur in a way that ensures the patient is well informed and comfortable. Considerations may include:

- Ensuring the patient understands that adjuvant therapy may be recommended after surgery
- Having a clear discussion on the possible scenarios regarding disease recurrence and the rationale for giving adjuvant therapy without knowing whether a relapse will occur
- If the patient decides to proceed with adjuvant therapy, provide clear information regarding the potential benefits and risks
  - This is not limited to only the direct risks of treatment, but also includes irreversible side effects such as some of the immune-mediated adverse events; these must be explained in detail
  - Patients should be made aware of factors that may affect the balance between benefit and risk, such as certain comorbidities

Conversations between the patient and the Surgeon

Although the Oncologist typically engages in the most detailed discussions with the patient, it can be very beneficial for the Surgeon to introduce the idea of adjuvant therapy beforehand. This is particularly important for patients undergoing SLNB, as it is invasive and its primary function is risk stratification for adjuvant therapy. Patients need to understand the implications of the results of SLNB in relation to their risk of recurrence so they can make an informed decision on adjuvant therapy.

Conversations between the patients and the CNS

The CNS is a key point of contact for the patient, coordinates with specialists and other CNSs and plays a crucial role in the patient's psychosocial care. Prof. Larkin outlined that, while some patients don't have any issues with committing to repeated clinic visits to receive adjuvant therapy, for others this can be a deal breaker. In addition, CNSs primarily oversee adjuvant therapy scheduling and follow-up, ensuring that the timing of adjuvant therapy factors in surgical recovery as well as the patient's personal commitments.

Summary

- Optimising patient understanding involves having multiple discussions, as well as considering factors affecting the benefit–risk ratio of treatment to ensure informed decisions
- Benefits and risks need to be carefully discussed with every patient at the level of detail appropriate to their needs, understanding and health literacy
- Collaboration among MDTs ensures effective communication with patients by providing them with necessary details, addressing their psychosocial needs and promoting continuity of care between specialists

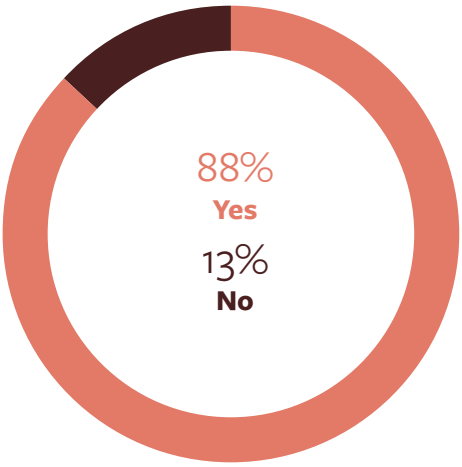
The interface between surgery and adjuvant therapy | MDT considerations from a surgical perspective

Mr Amer Durrani

Consultant Plastic and Reconstructive Surgeon, Cambridge University Hospitals NHS Foundation Trust

In this breakout session, Mr Amer Durrani discussed various topics related to adjuvant melanoma therapy from a Surgeon's perspective, such as the considerations for SLNB, its availability following the COVID-19 pandemic and the Surgeon's role within the treatment pathway as well as helping patients understand next steps for treatment.

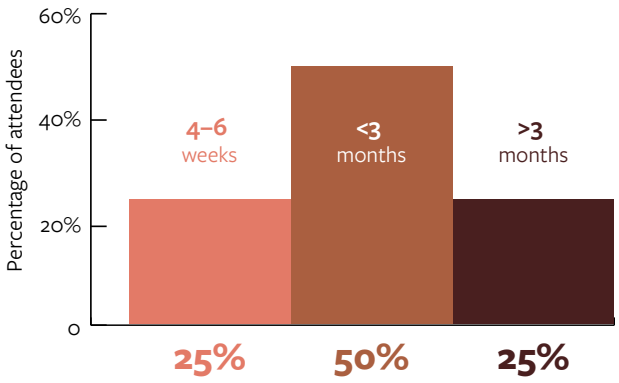
Are patients with Stage IIB/IIC melanoma being discussed/referred for treatment in your unit?



SLNB

SLNB plays a crucial role in accurately staging the disease, decreasing the likelihood of regional lymph node recurrence in patients with positive SLNB results, and the results can be part of an informed conversation with patients regarding the possible need for adjuvant therapy based on their risk of recurrence. However, the COVID-19 pandemic has resulted in long wait times for SLNB, which can be up to 2–3 months in some units.

What is the waiting time for SLNB in your unit?



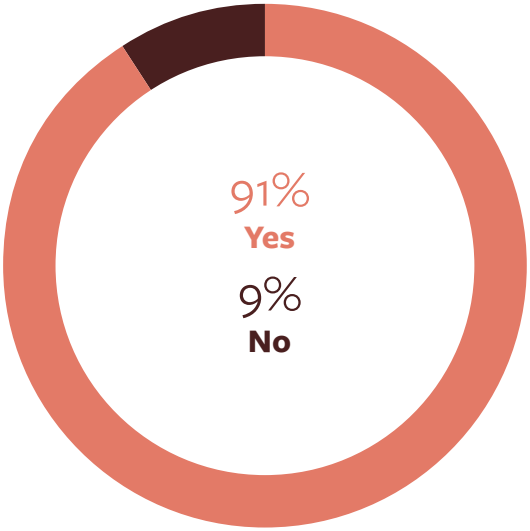
Percentages are rounded to the nearest whole number. Results are from live audience polls and do not reflect the views of the speakers or MSD.

The current indication for SLNB per NICE guidance was reviewed.[1] There is currently no international clinical trial that involves UK Surgeons, leading to a lack of consensus (particularly in the UK) on whether SLNB should be undertaken for intermediate or thin melanoma (<2 mm Breslow thickness).

Another point discussed was the role of SLNB within the Stage IIB/IIC *BRAF* wild-type (i.e. Stage pT3b–pT4b) patient population, and to what extent the Surgeon should discuss the option of adjuvant therapy with the patient vs leaving this to the Oncologist. The results of KEYNOTE-716 can be discussed with patients to demonstrate that adjuvant therapy can effectively treat melanoma in patients with negative SLNB.[2]

It was noted that although KEYTRUDA® is now available for patients at high risk of disease recurrence,[3] it is important to consider whether it should be provided to all patients at high risk of disease recurrence, since it can be challenging to identify which patients will benefit.

Is adjuvant therapy for resected Stage IIB/IIC disease being offered via your MDT?



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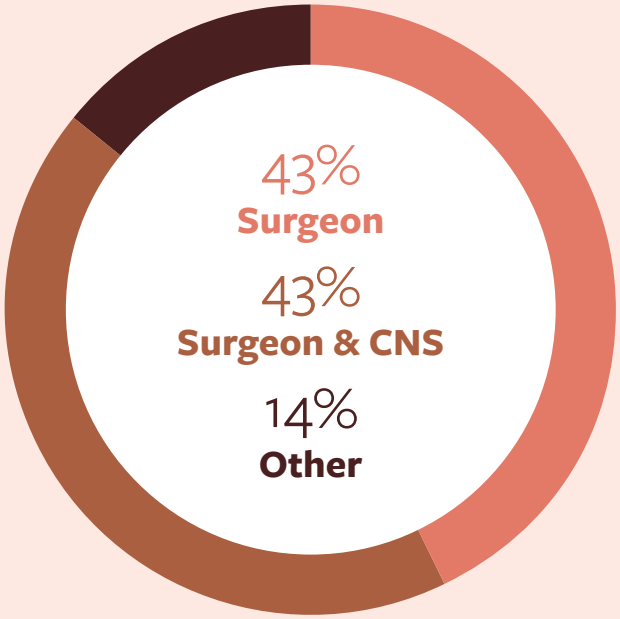
I thought it was really fun. What I took from it is the importance of walking through the melanoma pathway with other peers, thinking about the fact that the disease is not linear and it has lots of people involved in different stages, and highlighting the importance of using the same language with the ultimate goal of making life and management easier for patients.

Dr Ricky Frazer,
Consultant Medical Oncologist and Honorary Lecturer at Cardiff University

Role of the CNS

Mr Durrani emphasised the pivotal role of CNSs in helping patients fully understand their options and make informed decisions. CNSs are critical in connecting the Surgeon and Oncologist and ensuring a seamless pathway that respects patient preferences. The results of the audience poll regarding which HCP delivers SLNB results to patients indicated that Surgeons and CNSs are collaborating closely in this regard.

Who gives the results to the patient in your unit?



Results are from a live audience poll and do not reflect the views of the speakers or MSD.

Elderly patients*

There are important considerations for Surgeons regarding the management of elderly patients owing to:

- Concerns regarding comorbidities
- Uncertainty of whether SLNB is suitable for thin melanomas with low positivity rates
- Patient fitness for adjuvant treatment

Consideration should be given to whether SLNB is necessary for elderly patients, as many may not be eligible for adjuvant IO.

Audience discussion

Q: How can we improve the care we give to our patients with the limited resources available?

A: Everyone comes to work and wants to do a good job for the patient. If we can be physically in the same space, we can learn from each other; the sharing of knowledge in casual conversations is difficult to quantify but is nonetheless very significant.

Many of us tend to be self-critical about our services not meeting our expectations. Improving communication is a challenge, especially when we are short on time.

Q: How can one have a conversation with the patient about adjuvant therapy early in the pathway before all the necessary information is available?

A: It is not a matter of telling the patient what can or cannot be done, but what is important is to determine their level of knowledge and understanding without interfering with the Oncologist's role.

However, the situation can become more complex if the SLNB is delayed. It is perfectly normal to feel confused, but MDT colleagues are there to support in effective patient communication.

References

1. NICE guideline [NG14]. Last updated: 27 Jul 2022. Available at: https://www.nice.org.uk/guidance/ng14 Accessed 01 Oct 2023;
2. Luke JJ, et al. Lancet. 2022;399:1718–29;
3. KEYTRUDA® (pembrolizumab). Summary of Product Characteristics. Available at: GB SmPC https://www.medicines.org.uk/emc/product/2498/smpc#gref and NI SmPC https://www.emcmedicines.com/en-gb/northernireland/medicine?id=ce680467-8438-4e60-ab4f-dfab6767ccbe&type=smpc

*Section reflects the opinion of the speaker and is not related to clinical trial data.

Summary

The management of melanoma has undergone significant changes in the past 10 years. The COVID-19 pandemic has resulted in availability issues with SLNB, and there is a lack of consensus regarding whether SLNB should be undertaken for thinner melanomas. The role of Surgeons in guiding patients through their treatment journey is evolving over time. This is due in part to the increasing involvement of the CNS as well as the evolving melanoma journey, meaning that Surgeons now play a role in introducing the potential role of adjuvant therapy to patients too.

Pathway optimisation | Importance of the CNS

Ms Jackie Hodgetts

Nurse Clinician at The Christie
NHS Foundation Trust

This breakout session, facilitated by Jackie Hodgetts, focussed on sharing how the adjuvant melanoma patient pathway at The Christie NHS Foundation works, and within this, the role of the CNS.

The Christie NHS Foundation Trust is the largest single-site cancer centre in Europe, based in Manchester. Ms Hodgetts described the implemented workstream that aims to improve the treatment pathway in melanoma. Key elements of the redesigned pathway include:

- Regular remote contact by treatment centre nurses (vs a face-to-face appointment with a consultant/nurse clinician)
- Review and tests prior to starting therapy administered by nurses in the community rather than in-clinic (with referral to the medical team if results fall outside of protocol ranges), and electronic prescriptions confirmed
- Treatment can be performed at the patient's local oncology centre, rather than at The Christie
- Patients have the option to contact CNSs directly if they have any problems or concerns

At The Christie, the CNS has a key driving role throughout the melanoma adjuvant therapy pathway. It is the responsibility of the CNS to identify eligible patients within the Plastics clinic; relevant assessments would be requested to assess eligibility before referring the patient to Medical Oncology for further discussions. These would include the rationale for adjuvant therapy along with the benefits and potential toxicities. The patient is provided with written information on adjuvant therapy to review in their own time, and the CNS will follow up via phone a few days later to verify the patient's understanding, answer any questions and confirm their preference on next steps. If the patient decides not to proceed, at this point they would be referred back to Plastics and Dermatology.

For patients who do decide to proceed with adjuvant therapy, Ms Hodgetts summarised the process and protocols used for nurse-led care and follow-up. A 'STOP/GO' checklist **(Figure 1)** is used by the administering nurse to ensure the patient is fit and well to proceed with adjuvant

therapy. The checklist includes all key assessments that may indicate a need for further investigation by the medical team ('STOP'); if the findings of all these assessments are normal, the patient can proceed with adjuvant therapy ('GO'). This system also means that care can take place in the patient's home and proceed with subsequent treatment cycles without the need for additional review by the medical team. Similarly, checklists are provided that outline considerations for pre-, during and post-adjuvant therapy. These checklists also contain reminders to ensure robust record keeping at each stage.

Figure 1: Immunotherapy STOP/GO checklist at The Christie NHS Foundation Trust

Signs and symptoms
GO if:

- Grade 1 or no toxicity
- No admissions since last treatment
- No change in medication
- No deterioration of symptoms and/or new symptoms
- Less than 5 kg weight change
- Patient feels well
- FBC results normal
- Thyroid function normal
- Cortisol level normal
- AST and bilirubin normal
- Blood glucose normal
- No rash or Grade 1 rash
- No colitis signs
- No pneumonitis signs/symptoms
- No hepatitis signs
- No nephritis signs
- No endocrine symptoms
- No neurological symptoms
- No ocular symptoms

STOP and seek further information/advice if any of these criteria are NOT met

AST, aspartate aminotransferase; FBC, full blood count. Refer to the KEYTRUDA® Summary of Product Characteristics for information on adverse events and their management.[1]

Audience discussion

Q: Who identifies which patients are suitable for adjuvant therapy?

A: At The Christie, generally, this is the responsibility of the Plastics Nurses/CNSs (alongside the consultant) who are very keen to be increasingly involved with all the investigations. They also liaise with patients whose cases are complex.

Q: Do you take on any examinations or surveillance?

A: During melanoma clinic reviews, the CNS reviews the scans. CNSs are not trained to check for lesions, though primary lesions are usually already removed by the time the nurse sees the patient. If a patient has significant skin damage or numerous moles, they are recommended to see the Dermatologist who will continue the surveillance while the patient is on treatment.

Reference
1. KEYTRUDA® (pembrolizumab). Summary of Product Characteristics. Available at: GB SmPC https://www.medicines.org.uk/emc/product/2498/ smpc#gref and NI SmPC https://www.emcmedicines.com/en-gb/northernireland/ medicine?id=ce680467-8438-4e60-ab4f-dfab6767ccbe&type=smpc

Panel discussion and audience Q&A

Q: How do you treat any toxicity that does arise; is this managed by an IO service lead, or is there a joint approach?

Ricky Frazer: At the Velindre Cancer Centre, anything of Grade 3 and above would be managed within the IO service until resolution. There are two consultant-led MDT meetings a week, including an IO Endocrine MDT (the first in the UK).

Trudy Guinan: Anything of Grade 2 and above would be managed within The Clatterbridge Cancer Centre IO service. Grade 1 toxicities have recently been pushed back to treating clinicians owing to capacity issues, which allows the IO service to focus on more complex cases. This works well in indications such as melanoma, where teams are familiar with treating toxicities.

Emily Keen: Most, but not all patients are referred to me for management of IO toxicity at The Royal Free; at the very least I consult all patients who are admitted and provide an advice plan.

Khushboo Sinha: It can be unnerving as a Dermatologist managing skin toxicities associated with IO without the support of an MDT, and thus collaboration is crucial.

Q: Should IO services be mandated at all trusts in a similar way to the inception of AOS?

Trudy Guinan: In my opinion, in an ideal world this should be implemented, but this may not be realistic. At the least, centres should be set up to support effective management of IO toxicity.

James Larkin: Different set-ups work in different places; while the examples shown today are excellent, a national mandate may not be appropriate considering local need and capacity.

Heather Shaw: AOS is already set up as a mandated service and should be able to support IO delivery and management, since IO is an acute oncology therapy. However, it is crucial to ensure that AOSs are educated on IO toxicity and equipped to deal with it.

Q: What can Oncologists do for Surgeons in an MDT setting or education setting to facilitate patient communication?

Jonathan Pollock: CNSs are pivotal for this, and can act as an educator and point of continuity between MDT colleagues. Patient information leaflets are an extremely useful resource.

Amer Durrani: As resource constraints prevent some trusts from forming joint clinics, communications within the monthly Melanoma MDT meetings are vital, especially for managing complex patients and as an educational opportunity.

Q: If a patient does not undergo SLNB, would you do ultrasound surveillance of their sentinel node basin?

Jonathan Pollock: We would conduct an ultrasound if the patient has undergone an attempted SLNB that has failed. However, in the case that a patient is not suitable for SLNB they are also unlikely to tolerate the subsequent therapies that follow afterward; therefore, there may not be notable value in performing an ultrasound. The decision is very nuanced, and this is where a CNS can be crucial – they will be familiar with the patient before they are presented and will be aware of any factors that would make SLNB inappropriate.

Khushboo Sinha: We would also offer ultrasound as a surrogate to patients in whom physical examination of the lymph nodes by palpation is difficult; for example, if the patient had obesity.

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I've really enjoyed the interactive discussions between the Surgeons and the Oncologists on the pathway of patients through the MDT and on their treatment and management decisions. Also, hearing about our Dermatology colleagues has been interesting, since it brought up the importance of thinking about treatment and management of patients in a wider sense as we go forward with adjuvant management for melanoma.

Dr Heather Shaw,
Medical Oncology Consultant,
University College London Hospital
and Mount Vernon Cancer Centre

Abbreviations

AOS	Acute Oncology service
CNS	Clinical Nurse Specialist
COVID-19	Coronavirus disease 2019
HCP	Healthcare professional
IO	Immunotherapy
IT	Information technology
MDT	Multidisciplinary team
NHS	National Health Service
NICE	UK National Institute for Health and Care Excellence
OS	Overall survival
SLNB	Sentinel lymph node biopsy

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