ESMO Preceptorship Programme

IMMUNOTHERAPY : METASTATIC MALIGNANT MELANOMA

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Disclosure: nil
Sept 2015: 32 years male with complaints of bilateral neck swelling & loss of weight for 2 months

Past medical history: nil
Addiction: nil
Family history: nil.
Low SE status

On Examination:
ECOG: 1

Investigations:
Serology: nil
CT scan: localised neck disease only.
HP: melanoma, pTXN3M0, BRAF+, C-KIT-
Treatment: B/L LYMPHADENECTEMY 70GY, 33# RT & 6 Cycles TMZ.
Vemurafenib advised: Not available.

Feb 2016: PET CT no recurrence.
June 2017 disease progression, b/l neck nodes, b/l multiple chest nodules & abdominal nodes, liver mets. Case discussed in MDT- advised Immunotherapy with pt support program & Hosp foundation.

5 cycles of Nivolumab


8th cycles of Nivolumab - PET CT (05/12/2017): stable ds

11th cycles of Nivolumab: disease progression clinically & on CT scan. Ipulimab & Vemurafenib option given- not available & not affordable - Chemo-Immunotherapy planned.

15 cycles of Nivolumab + 4 cycles chemo Nabpacli + Carbo.

PET CT (Jan 2018): stable ds.

Feb 2018: Excessive weakness, diarrhoea, febrile neutropenia-treated with basic supportive care. Chemotherapy w/h.

Only Nivolumab continued.

19th cycle by May 2018

July 2018: 3 cycles of chemo.

12th August 2018: came to ER with excessive weakness, progressive drowsiness, not responding to verbal commands.

ICU care started. LFT deranged with raised ammonia level. Brain mets suspected. Poor prognosis explained to patient family who opted for best supportive care with no interventions.

19th August 2018: patient died.
Questions/ Suggestions

✙ How to differentiate pseudo progression & real progression during IO treatment?
✙ How to diagnose primary site of melanoma in this type of occult cases?
✙ Clinical trial should be distributed equally to all the developed & developing countries in order to benefit poor patients.
✙ Newer drugs should be made readily available to developing countries.
THANK YOU !!!