SPEAKER 1: Now, we're going to have a little fun, again. So get your clickers ready, get them warmed up. Because we're going to present some cases and then discuss them a little bit. From the point of view of how you might use these approaches that we learned about, today, and integrate them into your practice setting.

So we have three cases. Here's the first case. This is the case I'm going to discuss. This is a more dermatological oriented case.

This is a 52-year-old female with a history of significant sun damage, who presents with a cutaneous squamous cell carcinoma, it means biopsy confirmed, poorly differentiated lesion on the right temple. So there's the picture of lesion. You can see it's a little more than a centimeter in size. It's been present for about a year, at least, by history. Maybe a little longer for this. So there is the lesion.

And if this patient presented to you, how would you manage this patient? Would you use just [INAUDIBLE] and curettage? Would you suggest excision? Would you try intralesional 5FU? Or would you refer this patient for Mohs to do this? I guess, we should have other on there. But at least for these four choices, these are your choices.

OK, and the results. All right, so most for Mohs, excision, I think, those would be the two choices. I probably would refer to Mohs. But not unreasonable to do that.

Now, a little more information about the case. The case is treated with Mohs. And the histopathology shows a neurotropic component. You can see that from the histology, there, going down the edge of the nerves. Certainly an important factor, as we talked about peri neural involvement before, as a risk for advanced squamous cell.

Now, that being the case, we have the next slide. What would your recommendation be for this patient, now?

OK, the results. Well, that's interesting. Again, most people are picking cemiplimab, which is the new drug that's been FDA approved for this.

So again, the data seems to suggest that would be the choice. I saw the music we just had before it was "Take Five," but five was not the answer most people pick there. A subliminal suggestion, there.

Now-- oh, I get the next one on here. Next-- hold on, one second, we missed one here. There we go. OK, so here's another question.

I just, actually, gave you the answer to that, by accident, I apologize. Let's see if people listened to what I had to say. Just vote this one, we'll get it over with. I can see a large impact I'm having on these presentations.

OK, good. Somebody didn't listen to what I had to say. No, but all kidding aside.

This is the [INAUDIBLE], NIH, the NCI, this is all recent, in the last month. And certainly, this is the new drug that has been approved, specifically. It is the PD-1 inhibitor that has been approved, specifically, for the treatment of cutaneous squamous cell carcinoma. Now, with that, let's go to case two.

SPEAKER 2: So this is a 73-year-old retired farmer, who came to see us from Kansas. He has a passed medical history of diabetes. But otherwise, he's in good health.

And he had a squamous cell carcinoma on the right forehead and right cheek, that was previously treated with Mohs surgery. The history was a little bit difficult to get from him. But they could not clear the margins during that surgery. And the area rapidly recurred and progressed.

And he was referred to a center in Denver for a surgical evaluation. He had CT scan on the face that demonstrated a right cheek mass that was inseparable from the mass of the muscle in the carotid gland. And he had a CT scan of his body that showed no evidence of disease outside of that area.

And this is him. So he had two separate, very low-- what I would consider, locally advanced squamous cell carcinomas. One above that right eyebrow, which was separate from the lesion on the right cheek.

And so the question. What would you choose is the best treatment option for this patient? Surgical resection, radiation therapy, concurrent chemo radiation, or other systemic therapy?

Concurrent chemo radiation won out. Any comments?

SPEAKER 3: I think, what we've seen, with the morbidity of chemo radiation, you may want to take a chance with one of these PD-1s, before going forward. They have a high response rate. Almost equivalent to the chemo rounds. Low morbidity, as we mentioned. And you're not going to lose, giving some time, here.

SPEAKER 1: I would agree with that. I think that's, probably, the most reasonable approach, there.

SPEAKER 2: So he was seen by a surgeon, who planned a radical and disfiguring resection. And it was, essentially, a hemi facetectomy he was he was facing. He was going to lose the entire right half of his face, his right eye, the right cheek, some of his jaw. So it was going to be a quite morbid surgery.

He, actually, did not undergo surgery. So I'm not sure what happened, there. So after he saw the surgeon, he got very apprehensive about that procedure. And found his way into our clinic.

And I guess, this question is, what would you do, monitor the results of the surgery and begin radiation therapy, initiate cemiplimab, initiate pembrolizumab, and or other systemic therapy?

So initiates cemiplimab. And we initiated PD-1 antibody for him. And so there on the left, is his baseline photo. And the enlarged photo is after one cycle of PD-1 antibody. And you can see that there's early, and rather dramatic, response to the therapy.

And we continued on the immunotherapy. And he continued to improve. I forget exactly where in the course this photo was taken. But significant reduction in that cheek lesion, still with an area of ulceration. The eye hasn't gotten quite as a dramatic response as the cheek, but still looks like it's improving.

And there he is, after about a year of PD-1 antibody therapy. He still has a defect in that eye. There's a skin flap, there. But he's had scouting biopsies both above that right orbit, as well as biopsies in that cheek, where there's that scar area. Because it's hard to say whether there's residual tumor, or whether that's just scar tissue. And all of the biopsies have come back negative.

So the question is, the patient with subsequently started on cemiplimab. And he had a rapid response to therapy. And a clinical complete response after about one year of therapy. What would you do now? Continue the cemiplimab, radiation therapies to areas of previous known disease, or stop the systemic therapy and follow the patient?

So, predominance was 50-50 between continuous cemiplimab or stop systemic therapy and follow the patient. And both of those are correct, in my opinion. And the reason both of those are correct is, we don't know what to do for these responders to immunotherapy. We're not sure we can stop the PD-1 antibody, or not.

If you look at the melanoma data, it appears that these patients, who have very good responses and then stop after one or two years of therapy, the vast majority of those patients do maintain their response without further infusions. Now, whether that's going to be true of other cutaneous malignancies, like squamous cell carcinoma, we don't know. But again, very hopeful.

And he had no clear evidence of disease. Now, the scanning biopsies were negative. But we don't know, we just missed that, in terms of sampling error. So whether to continue or to stop was a dilemma.

SPEAKER 1: I don't think we really had-- I agree with you. We don't have the data. I think this is analogous to the hedgehog inhibitors for advanced basal cell. Where nobody knows how long you have to treat yet.

There's just not enough data. And you have to treat for a while, I would describe it that way. I agree, either of those answers could be correct.

SPEAKER 2: And so it's something that we need to get a better handle on. Now, honestly, my plan was not to stop the patient. My plan was to continue on the therapy.

But he decided for us. Because he was on therapy for about a year, when he was in an accident that was unrelated to treatment. As I said, he was a farmer, and he was burning some stuff on his farm, and he fell into the fire. And developed significant burns. And he had a prolonged hospitalization and rehab therapy.

And so it was decided not to resume the therapy after he was discharged from the hospital, just to watch him. And he's been without recurrence for about a year and 1/2 after stopping the treatment. So I don't know that I would have made that decision if he didn't have the accident. Whether we would have continued him on the therapy or not.

He tolerated it well. But he did stop and he's maintained that response without further infusions.

SPEAKER 1: OK, let's go to case three.

SPEAKER 2: All right. Let's see what we got here. This is a 72-year-old man with a rapidly growing lesion on the left side of the head for about a year. That's what we usually see with some of these patients who allow things to grow.

He had a history of a B cell lymphoma, which was in remission following chemotherapy for 10 years prior. The lesion started as a small, red, dry patch. And it progressively enlarged to a disfiguring 2.4 by 2 centimeters. And he presented to the dermatology department for further evaluation. How would you manage this patient?

All right.

SPEAKER 1: I'd probably go with Mohs surgery. I think, initially, for that, because of the location. But excision, you could do. [INAUDIBLE], I think, also. I think it may be a little premature to start PD-1.

SPEAKER 3: Right, so at this point, if you're interested in using PD-1 for these people, I would say that there are multiple upcoming adjuvant trials. Looking at a randomization between placebo, and cemiplimab, Or other PD-1 therapies.

And number five would be excision and transition to PD-1 checkpoint inhibitor trial. There are high risk features of this tumors, et cetera. But I would say that 5 would be an error without that caveat.

So the skin biopsy confirmed a moderately differentiated cutaneous squamous cell carcinoma, positive deep margin. Due to his histology size, partly differentiated borders, the patient was referred for treatment with MMS. And the lesion was removed in a total of two stages and four sections.

In addition to a proliferation of spindloid tumor cells, seen during surgery, consistent with cutaneous squamous cell carcinoma, an intervascular component was noted, despite clear margins after the surgery. What do you recommend for this point?

Very good, I think. We're making a point, there, that there's an unresectable tumor being treated by a standard, FDA approved therapy, here.

SPEAKER 1: And I think it's also important that the histopathology shows there's high risk factors to it. So it's more than just a [INAUDIBLE] it's up there.

SPEAKER 2: Yeah.