New Melanoma Metastases Risk Factors Identified

BY NANCY WALSH
New York Bureau

NOORDWIJK, NETHERLANDS — The list of risk factors associated with the development of metastases in melanoma should be expanded by two, Jeremy Brauer wrote in a prizewinning poster presented at a conference on melanoma sponsored by Imedex Inc.

In a nested case-control study of melanoma patients presenting with only local disease between 1972 and 2005, the investigators found an odds ratio of 1.95 for the development of metastases in patients with a past history of nonmelanoma skin cancer and an odds ratio of 2.51 for cancer other than skin, said Mr. Brauer, a fellow in the department of dermatology at the University of Pennsylvania, Philadelphia.

Previously identified risk factors for metastatic disease include male gender, body site, Breslow thickness, Clark's level, vertical growth phase, microscopic satellites, and ulceration.

The study included 549 patients who developed metastases at least 6 months after definitive excision. For each case, there was a control patient with melanoma who did not develop metastases. Aside from the two new factors, multivariate analyses confirmed that patients who developed metastases were more likely to be male, to have lesions of greater thickness, and to have lesions characterized by ulceration.

The study also revealed that differences may exist in risk factors for early versus late metastases. "Although previous investigations have found that between 65% and 81% of melanoma metastases will occur within 3 years, metastases may occur at any time, even 10 or more years later," Mr. Brauer wrote.

Various time intervals following diagnosis have been seen in other cancers, such as gastric carcinoma (Cancer 2000;89:255-61). "However, to the best of our knowledge no prior study of early versus late metastases has been performed that examined a large number of clinical and tumor characteristics," wrote Mr. Brauer.

A total of 320 patients developed their first metastasis within 3 years after surgery; these were classified as early metastases. In 70 patients, metastases did not develop until after 8 years; these were termed late metastases. Patients with early metastasis were more likely to have lesions of greater thickness, with an odds ratio of 2.35, and to have ulcerated lesions, with an odds ratio of 3.58.

The early metastasis patients also were more likely to have a past medical history of nonmelanoma skin cancer, compared with late metastasis patients. The odds ratio associated with this last factor was 4.83.

"Identification of these risk factors is important in gaining a better understanding of disease progression for the purposes of risk stratification in clinical trials and for patient management and treatment," Mr. Bauer explained. ■

Partial Regression Seen in 10%-35% Of Melanomas

NEW YORK — The incidence of regression is higher in malignant melanoma than in other neoplasms, Dr. Hideko Kamino said at a dermatology conference sponsored by New York University.

Regression is more common in men, in thin melanomas less than 1.5 mm, and in lesions on the trunk, said Dr. Kamino of the departments of dermatology and pathology at New York University.

Regressing melanomas present with a history of a changing lesion that is typically a patch of plaque of variegated brown, black, red, blue, gray, or white. Blue, black, or gray areas usually mean a proliferation of small blood vessels, a histopathologic sign of late regression. An inflammatory infiltrate is generally seen early in regression.

"The incidence of regression in melanoma depends on whether it is partial, focal, or complex," she said. Partial regression is seen in 10%-35% of melanomas, complete regression in about 5%. Histologic regression of less than 1.5 mm is most common, seen in 46% of melanomas. Regression of 1.5 to 3 mm occurs in about 32% of lesions.

Regression may be induced by treatment with interleukin-2, interferon-α, vaccines, and imiquimod, she pointed out.

—Karen Dente