6th World Meeting of Interdisciplinary Melanoma Skin Cancer Centres

& 8th EADO Congress

14th - 17th November 2012

Barcelona, Spain

Hotel Fira Palace

Final Program Abstracts Book

www.melanoma2012.com

Under the auspices of
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Welcome Letter

Since the first World Meeting of Interdisciplinary Melanoma/Skin Cancer Centres, which took place in Barcelona, Spain, in September 2007, this congress became a success story. It is an opportunity where clinicians and researchers, who are part of multidisciplinary melanoma centers can interact, learn from one another, establish collaborations and set an agenda for the further evolution of multidisciplinary melanoma care and research. In November 2012, this meeting will be combined with the likewise well-established EADO congress, and the focus will be on melanoma, cutaneous lymphoma and epithelial skin cancers.

This conference is specifically designed to attract young investigators and skin cancer treating physicians in the field. All contributions submitted have to be presented as posters, and contributions will be additionally selected for presentation in the plenary sessions.

The Plenary Sessions will form the scientific backdrop for the meeting, and will highlight problem areas and opportunities in melanoma today. These Plenary Sessions will set the stage for a series of Breakout Sessions, designed to focus attention and lead to new collaborative approaches in key areas where melanoma/skin cancer centers should be taking the lead.

The Breakout Sessions will address the following topics:

- **Messages for Skin Cancer Prevention**
  - Goals: To develop the right messages for future prevention campaigns. Despite many prevention campaigns since decades the incidence of melanoma and other skin cancers still rises. The question must be asked, if we delivered the right messages in the past.

- **Guideline-Development and International Cooperation**
  - Goals: To develop strategies for an international cooperation in guideline development. This session shall primarily focus on melanoma. In several countries, guidelines for melanoma have been developed based on a systematic literature research and on a formal consensus process. The question shall be addressed, whether an international knowledge basis can be established, and how this can be continuously updated.

- **Building up internationally accepted documentation schedules and standards**
  - It is a standard for skin cancer/melanoma centers to document the patients in a way that allows evaluations for many questions of prognosis and management. It would be advantageous, to standardize the documentation schedules internationally.

- **Quality Criteria for Skin Cancer Centers**
  - Goals: To establish quality criteria for the work of skin cancer centers/programs which are internationally accepted. Skin cancer centers with interdisciplinary tumor boards have been developed in many countries, and in some countries already formal certification processes have been applied.

- **Pathway development for Skin Cancer Centers**
  - Goals: To exchange the experience of pathway development for melanoma and other skin cancers in different disease stages. Methods of the development, methods of implementation into clinical practice and major contents of these pathways shall be communicated.

- **Strategies for Melanoma Follow-up Examinations**
  - Goals: To develop recommendations for the follow-up of melanoma patients which could guide the practice in different countries and to consider clinical trials which could broaden the body of evidence for the melanoma follow-up or for giving up these examinations.

The results of the Outbreak Sessions will be presented by the chairpersons in the following sessions. Thus, all persons attending the conference will be informed on the very recent recommendations for burning questions in melanoma and skin cancer management.

The conference will as a main emphasis address new treatment developments for melanoma and other skin cancers. Already the first session will deal with new treatment options and new clinical trials. It is a major goal of this congress, to cover all new developments and to provide the possibility to discuss the new treatment approaches. A deep insight into the future advances in skin cancer therapy will also be provided by sponsored symposia by the pharmaceutical companies.

Furthermore, the different aspects of epidemiology and prevention, early detection and new diagnostic tools and of histopathologic diagnosis will be covered. Melanoma surgery and immunotherapy will be discussed in own sessions. Cutaneous lymphoma, actinic keratosis and advanced epithelial cancers are additional topics with own sessions. Thus, an update of all aspects of skin cancer is provided. We look forward to seeing you in Barcelona in November 2012!
Committees

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Claus Garbe. Tuebingen, Germany
Axel Hauschild. Kiel, Germany
Josep Malvehy. Barcelona, Spain
Vernon Sondak. Tampa, Florida, USA
John Thompson. Sydney, Australia

Local Scientific Committee

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Paula Aguilera. Barcelona, Spain
Pedro Arguis. Barcelona, Spain
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Rafael Botella. Valencia, Spain
Cristina Carrera. Barcelona, Spain
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Salvador Martín-Algarra. Pamplona, Spain
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Susana Puig. Barcelona, Spain
Joan-Anton Puig-Butillé. Barcelona, Spain
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Sergi Vidal-Sicart. Barcelona, Spain
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Ramón Vilella-Puig. Barcelona, Spain

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Francisco Camacho. Sevilla, Spain
Maria-Teresa Estrach. Barcelona, Spain
Pere Gascón. Barcelona, Spain

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Hospital Clinic, Barcelona
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María-Isabel Longo. Madrid, Spain

Josep Malvehy. Barcelona, Spain

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Giovanni Pellacani. Modena, Italy

Ketty Peris. l’Aquila, Italy

Caroline Robert. Paris, France

Eggert Stockfleth. Berlin, Germany

Georg Weinlich. Innsbruck, Austria

Iris Zalaudek. Reggio Emilia, Italy
Wednesday, November 14th

14.00 WELCOME ADDRESS  Verdi Meeting Room
Jean-Jacques Grob and Josep Malvehy

14.30 PLENARY SESSION 1  Verdi Meeting Room
14.30 NEW DRUGS AND NEW STUDIES
Chairpersons  Claus Garbe and Axel Hauschild
14.30-14:38  MAGE-3 ASCI  Brigitte Dreno
14.40-14.48  Conventional and pegylated interferon  Peter Mohr
14.50-14.58  PD-1 antibodies  Paolo Ascierto
15.00-15.08  Ipilimumab  Celeste Lebbe
15.10-15.18  Darleukin  Thomas Eigentler
15.20-15.28  T-VEC (OncoVexGM-CSF)  Axel Hauschild
15.30-15.38  Adoptive T-cell transfer  Benjamin Weide
15.40-15.48  Vemurafenib: BRIM-P  Axel Hauschild
15.50-15.58  Dabrafenib (BRAF inhibitor)  Claus Garbe

16.00 Coffee-break and visit to the Exhibition
16.30-16.38  Trametinib  Jean-Jacques Grob
16.40-16.48  C-KIT inhibitors  Carola Berking
16.50-16.58  Multi VEGF inhibitor (E7080)  Ralf Gutzmer
17.00-17.08  Vismodegib  Rainer Kunstfeld
17.10-17.18  nab-Paclitaxel  Axel Hauschild
17.20-17.28  Electrochemotherapy  Alessandro Testori

17.30 ROCHE SPONSORED SYMPOSIUM  Verdi Meeting Room
18.30 FROM CLINICAL TRIALS TO CLINICAL PRACTICE: AN EXPERT PANEL DISCUSSION ON TODAY’S MANAGEMENT OF METASTATIC MELANOMA
Chairperson  Jean-Jacques Grob
17.30-17.45  Today’s challenges in treating metastatic melanoma  Jean-Jacques Grob
17.45-18.15  Expert panel discussion on today’s management of BRAF mutation positive metastatic melanoma  Jean-Jacques Grob, Alex Hauschild and David Hogg
18.15-18.30  Metastatic melanoma: Future directions  Axel Hauschild

19.30 Transfer from the Congress Venue  L’Esferic BCN
Due to the general strike call foreseen for November the 14th there will be limited services of ground transportation. This is why we will go and come back on foot to the Welcome Reception Venue guided by hostesses and the walk will take about 35 minutes. Let us suggest you to wear casual clothes. Should you require further assistance (handicapped persons) please do not doubt to contact the Technical Secretariat in order to arrange some transfers by car.

20.00 WELCOME RECEPTION  L’Esferic BCN
Plaza Dante, Montjuïc - Jardins Joan Brossa - 08038 Barcelona
www.esferic.es
Thursday, November 15th

08.00 GUIDED POSTER TOUR 1
09.00 Experimental Studies from P01 to P11
   Chairpersons Nelleke Gruis, Dario Neri and María Soengas
   Case Reports from P12 to P30
   Chairpersons Antonio Tejera and Isabel Longo

09.00 PLENARY SESSION 2 Verdi Meeting Room
10.30 EPIDEMIOLOGY AND PREVENTION OF MELANOMA
   Chairpersons Véronique Del Marmol and Jean-Jacques Grob
   09.00-09.12 Incidence and mortality development: Have we reached a plateau or decrease? Ulrike Leiter
   09.15-09.27 Preventive measures, where do we stand? Véronique Del Marmol
   09.30-09.42 Early detection by lays: How to improve the performance? Jean-Jacques Grob
   09.45-09.57 Are we equal in prevention and diagnosis in Europe? Ana-Maria Forsea
   10.00-10.12 German screening: A first effect on mortality of a population based screening? Alexander Katalinic
   10.15-10.27 What is new in genetic epidemiology of melanoma? Susana Puig
   10.30-10.42 Discussion

10.30 Coffee-break and visit to the Exhibition

11.00 PLENARY SESSION 3 Verdi Meeting Room
12.30 NEW DIAGNOSTICS OF MELANOMA
   Chairpersons Josep Malvehy and Giovanni Pellacani
   11.00-11.12 What is new in dermoscopy of skin cancer? Josep Malvehy
   11.15-11.27 The strength of in-vivo confocal laser microscopy Giovanni Pellacani
   11.30-11.42 Serum tumor markers in melanoma Maja Hofmann
   11.45-11.57 Automated vision machines Allan Halpern
   12.00-12.08 Selected abstract C25 Evaluation of pigment lesion risk assessment by Smartphone applications Arjen F. Nikkels
   12.18-12.30 Discussion

12.30 KEYNOTE LECTURE 1 Verdi Meeting Room
13.00 Chairperson Susana Puig
THE HALL MARKS OF MELANOMAGENESIS AND ITS TARGETING María Soengas

13.00 BMS SPONSORED LUNCH SYMPOSIUM Verdi Meeting Room
14.00 NAVIGATING THE EVOLVING TREATMENT LANDSCAPE IN ADVANCED MELANOMA AND REDEFINING LONG-TERM SURVIVAL
   Chairperson Reinhard Dummer
   13.00-13.05 Welcome and introduction Reinhard Dummer
   13.05-13.20 Current data in advanced melanoma Claus Garbe
   13.20-13.35 Immunological markers for novel immunotherapies Ignacio Melero
   13.35-13.50 Patient selection and integration of new therapies Reinhard Dummer
   13.50-14.00 Panel discussion All

14.00 Coffee-break and visit the Exhibition
We are here, where you need us most

We are committed to the discovery and development of innovative immunotherapeutic approaches aimed at helping patients fight cancers, such as advanced melanoma. Together, we can make a difference.

Bristol-Myers Squibb
Thursday, November 15th

With regards to the rooms of the break-out sessions, we have requested your preferences through the website for information purposes only. We wish to point out that the fact of having indicated the preference will not guaranty a seat in the selected room. We advise you to go to the rooms with enough time in advance.

### 14.30 BREAKOUT SESSION I

#### 16.00 BS1. MESSAGES FOR PRIMARY AND SECONDARY SKIN CANCER PREVENTION

**Ambar Meeting Room**

**Chairperson**: Véronique Del Marmol

- **14.30-14.45** Skin cancer prevention in Europe ➔ Véronique Del Marmol
- **14.45-14.55** Sunbeds legislation in Europe: Status – gaps and needs ➔ Isabel Longo
- **14.55-15.05** Skin cancer prevention guidelines in Germany ➔ Carola Berking
- **15.05-15.15** Are there any messages which could really improve prevention? ➔ Jean-Jacques Grob
- **15.15-15.30** Skin cancer prevention in USA ➔ Allan Halpern

**Discussion**

**Key points for discussion**

Experience in education for skin cancer prevention: What we have learnt from the past

**Specific key points addressed for discussion**

- Impact of campaigns in skin cancer prevention: Are they changing behaviours? Are they saving lives?
- Do we know the correct messages and their target populations?
- How to communicate messages?: New media in education?
- Screen or not to screen in skin cancer campaigns?
- Quality control of prevention: Is it a reality?
- Is skin cancer screening justified in adult population?
- Who will pay the skin cancer prevention? Cost and coverage of educational programs: children, adults, elder?
- “The day after”: Accessibility to diagnosis, treatment and follow-up facilities in different health care models

### 14.30 BREAKOUT SESSION I

#### 16.00 BS2. GUIDELINE-DEVELOPMENT AND INTERNATIONAL COOPERATION

**Cristal + Coral Meeting Room**

**Chairperson**: John Thompson

- **14.30-14.40** Pros and cons of development and international melanoma guidelines ➔ John Thompson
- **14.40-14.50** Melanoma guidelines in Germany ➔ Annette Pflugfelder
- **14.50-15.00** Melanoma guidelines in France ➔ Philippe Saïag
- **15.00-15.10** Melanoma guidelines in USA ➔ Vernon Sondak
- **15.10-15.20** Melanoma guidelines in Australia/ New Zealand ➔ John Thompson
- **15.20-15.30** How to organize continuous updates of guidelines ➔ Claus Garbe

**Discussion**

**Key points for discussion**

Perspective in the elaboration of melanoma guidelines: what we have learnt from the past

**Specific key points addressed for discussion**

- Are international guidelines important?
- How to elaborate international guidelines?
- International guidelines vs local / nacional guidelines: Pros and cons
- Quality of existing melanoma guidelines
- The cost of high quality guidelines: Who will pay for it?
### Thursday, November 15th

**14.30**  **BREAKOUT SESSION I**
**16.00** **BS3. QUALITY ASSURANCE IN SKIN CANCER CENTER**  Diamante Meeting Room  
**Chairperson**  Jeffrey E. Gershenwald

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<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>14.30-14.40</td>
<td>Why do we need quality assurance in a melanoma/skin cancer center?</td>
<td>Jeffrey E. Gershenwald</td>
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<tr>
<td>14.40-14.50</td>
<td>Quality assurance in Germany: Accreditation of skin cancer centers</td>
<td>Stephan Grabbe</td>
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<tr>
<td>14.50-15.00</td>
<td>Quality assurance in European skin cancer centers: EADO perspective</td>
<td>Celeste Lebbe</td>
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<tr>
<td>15.00-15.10</td>
<td>Quality assurance of skin cancer centers in USA</td>
<td>Jeffrey E. Gershenwald</td>
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<td>15.10-15.20</td>
<td>International quality indicators in melanoma/skin cancer: Is it possible?</td>
<td>Peter Arenberger</td>
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<tr>
<td>15.20-16.00</td>
<td>Discussion</td>
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**Key points for discussion**  
Quality assurance in a melanoma /skin cancer center

**Specific key points addressed for discussion**
- Is the quality assurance relevant in melanoma /skin cancer centers?
- What are the requirements of quality assurance?
- Data bases: How I did it?
- How to audit quality assurance?
- International indicators of quality assurance and accreditation: Pros and cons
- The cost of quality assurance: Who will pay for it?

**14.30**  **BREAKOUT SESSION I**
**16.00** **BS4. STRATEGIES FOR PRIMARY MELANOMA DETECTION**  Verdi Meeting Room  
**Chairperson**  Giuseppe Argenziano

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<th>Time</th>
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<tr>
<td>14.30-14.40</td>
<td>Introduction</td>
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<td>14.50-15.10</td>
<td>Can GPs learn dermoscopy and why?</td>
<td>Iris Zalaudek</td>
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<td>15.10-15.20</td>
<td>How to decrease waiting time for a dermatologic consultation?</td>
<td>David Moreno</td>
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<td>15.20-15.30</td>
<td>What strategy to improve detection of early melanoma in dermatology setting?</td>
<td>Luc Thomas</td>
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<td>15.30-16.00</td>
<td>Discussion</td>
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**Key points for discussion**  
Strategies for primary melanoma detection (primary care and dermatology)

**Specific key points addressed for discussion**
- Role of general practitioners and dermatologists in early melanoma detection
- Role of melanoma centres in early melanoma detection
- Teledermatology in melanoma detection: Is it useful?
- Education in melanoma detection: State of the art and future trends
- Health care models: Accessibility to a skin cancer visit
- Massive screening in general population: Is it justified?
- Melanoma detection in high-risk patients: How I do it?
- Cost-effectiveness of melanoma detection: Who will pay for it?

**14.30**  **BREAKOUT SESSION I**
**16.00** **BS5. GENETIC COUNSELING IN MELANOMA**  Rudi + Zafir Meeting Room  
**Chairperson**  Susana Puig

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<tr>
<td>14.30-14.40</td>
<td>Introduction to genetic counseling in melanoma</td>
<td>Susana Puig</td>
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</table>
Thursday, November 15th

14.50-15.00 Benefits: Early diagnosis in high risk patients Cristina Carrera
15.00-15.10 Pending questions: Early diagnosis strategies for pancreatic carcinoma Nelleke Gruis
15.10-15.20 Experience in Sweden Johan Hansson
15.20-15.30 Experience in Switzerland Cristina Mangas
15.30-15.40 Experience in Latinamerica (Argentina, Brazil, Chile, Mexico, Uruguay) Susana Puig
15.40-16.00 Discussion and final remarks

Key points for discussion
Genetic counselling in melanoma

Specific key points addressed for discussion
- Pros and cons of genetic counseling in melanoma
- Why we should do it? Evidences for genetic counseling in different countries
- How to organise genetic counseling: The multidisciplinary team
- Costs of genetic counseling: Who is paying for it?

16.00 Coffee-break and visit to the Exhibition

16.30 FREE COMMUNICATIONS I Ambar Meeting Room
16.30-16.37 C01 Radical groin dissection - What is the best incision? Andre Molina
16.40-16.47 C02 Multiple primary melanomas: Do they look the same? Elvira Moscarella
16.50-16.57 C03 The emerging role of radiotherapy in melanoma is being defined by high quality randomised trials Gerald Fogarty
17.00-17.07 C04 Determination of survivin and VEGF levels in patients with melanoma Zejko Mijuskovic
17.10-17.17 C05 Serious skin toxicity for the combination of B-RAF inhibitors and radiotherapy Mareike Atter
17.20-17.27 C06 Pimasertib (MSC1936369B/AS703026), a selective oral MEK1/2 inhibitor, shows clinical activity in cutaneous and uveal metastatic melanoma in the phase I program Celeste Lebbe
17.30-17.37 C07 Study of potential genetic predisposition to cutaneous melanoma in southern Switzerland Cristina Mangas de Arriba
17.40-17.47 C08 Phase 3, randomized, open-label, multicenter trial of NAB-paclitaxel versus dacarbazine in chemotherapy-NAIVE patients with metastatic malignant melanoma Axel Hauschild
17.50-17.57 C09 Intravenous (IV) administration improves the anti-tumor activity of autologous MRNA electroporated dendritic cells (DC) as a single-agent cellular immunotherapy for patients with pretreated advanced melanoma Sofie Wilgenhof
18.00-18.07 C10 Amelanotic melanoma – A difficult diagnosis? Rodica Maria Cosgarea
18.10-18.17 C11 Overall survival, disease free survival and survival after recurrence across gender in melanoma patients: What has changed? Simone Ribero
18.20-18.27 C12 Who dies from melanoma? A population-based study of Irish patients Mary Bennett

16.30 PARALLEL SESSION 1 Verdi Meeting Room
18.00 HISTOPATHOLOGICAL AND MOLECULAR DIAGNOSIS OF MELANOMA

Chairpersons Jürgen Bauer and Jane Messina
16.30-16.45 Immunohistochemistry in the histopathology of melanoma Jane Messina
16.46-17.01 Molecular diagnosis of melanoma Jürgen Bauer
Thursday, November 15th

17.04-17.19 The evaluation of sentinel lymph node in 2012: Controversies and future trends  
Jeffrey E. Gershenwald

17.22-17.37 Tumour lymphangiogenesis and sentinel lymph node status  
Daniella Massi

17.37-18.00 Discussion

16.30 PARALLEL SESSION 2 > Rubí + Zafir Meeting Rooms
18.00 CONGENITAL NEVUS AND MELANOMA IN INFANCY  
Chairpersons > Susana Puig and Ash A. Marghoob
16.30-16.50 New insights in the evaluation, classification, prognosis and treatment of congenital melanocytic nevi  
Ash A. Marghoob
16.50-17.10 What we know and what we don’t know about melanoma in children  
Susana Puig
17.10-17.30 Clinical cases for the audience  
Cristina Carrera, Asunción Vicente and Gabriel Salerni

18.00 PHILOGEN PARALLEL SPONSORED SYMPOSIUM > Verdi Meeting Room
18.00-18.20 Combination of immunocytokines with cytotoxic drugs  
Raffaella Giavazzi
18.30-18.45 Systemic darleukin with dacarbazine in the treatment of metastatic melanoma  
Thomas Eigentler
18.48-19.00 Intratumoral darleukin in metastatic melanoma  
Benjamin Weide

18.00 ONCOSEC PARALLEL SPONSORED SYMPOSIUM > Rubí + Zafir Meeting Rooms
19.00 ELECTROGENETHERAPY: INTRALESIONAL IMMUNOTHERAPY APPROACH FOR SKIN CANCERS USING ELECTROPORATION  
Chairpersons > Adil Daud and Axel Hauschild
18.00-18.12 Application and versatility of electrogenetherapy  
Richard Heller
18.15-18.27 Clinical experience: Case presentation and discussion of intralesional injection of plasmid interleukin-12 with electroporation  
Adil Daud
18.30-18.42 Immune correlates and biomarkers: Immune related responses following intralesional injection of plasmid interleukin-12 with electroporation  
David Weiner and Edward Cha
18.45-18.57 Outlook on intralesional immunotherapies for the treatment of metastatic melanoma  
Adil Daud

19.00 REPORT FROM BREAKOUT SESSIONS > Verdi Meeting Room
19.00 Chairpersons > Cristina Carrera and Josep Malvehy
Friday, November 16th

07.30 GUIDED POSTER TOUR 2. Clinical Melanoma Studies › from P31 to P72B
09.00 Chairpersons › Rosa Martí and Friedeggund Meier

09.00 PLENARY SESSION 4 › Verdi Meeting Room
10.30 MELANOMA SURGERY
   Chairpersons › Alexander Eggermont and Vernon Sondak
   09.00-09.12 Postsurgical classification of melanoma: Present and future › Jeffrey E. Gershenwald
   09.15-09.27 Advanced surgery in complex primary melanoma (lentigo maligna, nail, acral..) › Roland Kaufmann
   09.30-09.42 Sentinel lymph node biopsy: Just a staging procedure? › Alexander Eggermont
   09.45-09.57 Role of metastasectomy in MM in 2012 (distant mets including brain mets) › Vernon Sondak
   09.59-10.11 Regional therapies for liver and extremity melanoma metastasis › John Thompson
10.14-10.30 Discussion

10.30 Coffee-break and visit to the Exhibition

11.00 PLENARY SESSION 5 › Verdi Meeting Room
12.30 TREATMENT OPTIONS FOR ADVANCED MELANOMA
   Chairpersons › Caroline Robert and Friedeggund Meier
   11.00-11.05 Presentation of AIM Project › Valerie Guild
   11.06-11.16 Adoptive T-cell transfer in melanoma therapy › Brigitte Dreno
   11.18-11.28 PD1 as targets for melanoma immunotherapy › Caroline Robert
   11.30-11.40 New targets in signaling pathways of melanoma › Friedeggund Meier
   11.42-11.52 Melanoma vaccination—an update › Gerold Schuler
   11.54-12.04 Prognostic relevance of functional NY-ESO-1 › Benjamin Weide
   12.06-12.16 Allovectin-7 › Sanjiv S. Agarwala
   12.16-12.30 Discussion

12.30 KEYNOTE LECTURE 2 › Verdi Meeting Room
13.00 Chairperson › Hubert Pehamberger
   What can we learn from preclinical mouse experiments for clinical development of antibody drugs? › Dario Neri

13.00 MSD SPONSORED LUNCH SYMPOSIUM › Verdi Meeting Room
14.00 Chairperson › Claus Garbe
   13.00-13.12 The current landscape of interferon adjuvant therapy in melanoma: What do we change and what we keep the same? › Jean-Jacques Grob
   13.15-13.27 Who should receive adjuvant therapy, is there a difference between melanoma and other malignancies? › Vernon Sondak
   13.30-13.42 Current and future therapies in adjuvant setting › Sanjiv S. Agarwala
   13.45-13.57 Case studies and discussion › Claus Garbe

14.00 Coffee-break and visit the Exhibition

14.30 BREAKOUT SESSIONS II
16.00 BS6. RISK AND BENEFITS OF SLNB IN 2012. CONTROVERSIES IN MALIGNANT MELANOMA SURGERY › Verdi Meeting Room
   Chairperson › David Moreno-Ramírez
   14.30-14.40 Introduction › David Moreno-Ramírez
   14.40-14.50 Surgery of the primary malignant melanoma. Controversies about excision margins › Vernon Sondak
Roche Personalized Healthcare

is the cornerstone of our innovation strategy
Friday, November 16th

14.50-15.00  Sentinel lymph node biopsy as a surgical procedure. Outweighing risk and benefits in certain clinical settings  › Roland Kaufmann

15.00-15.10  Surgery of lymphatic and in-transit metastases. Outweighing risk and benefits in certain clinical settings  › Roland Kaufmann

15.10-15.20  Surgery for distant metastatic malignant melanoma. Identifying candidates for surgery of the distant metastasis  › Vernon Sondak

15.20-16.00  Final conclusions  › David Moreno-Ramírez

Specific key points addressed for discussion

Surgery of the primary malignant melanoma. Controversies about excision margins  › Dr. V. Sondak

› Which factors should be potentially considered in margin recommendations?
› Risk and benefits of applying the recommended surgical margins in anatomic locations with high functional compromise (2 cm margin in head&neck, feet and hands, acral-subungueal melanoma, etc)
› Should the official recommendations always be applied in any of these cases?

Sentinel lymph node biopsy as a surgical procedure. Outweighing risk and benefits in certain clinical settings  › R. Kaufmann

› Surgical risks and complications of the standard SLNB
› Surgical risk of SLNB in “deep” basins: Parotid gland, iliac lymph nodes. Should harvesting of SLNs at these anatomic locations be always attempted?
› Risk and benefits of SLNB in aged patients. Should SLNB be performed?
› Risk and benefits of SLNB in childhood melanoma (& atypical Spitz nevus)
› Is there any role for pre-SLNB ultrasound currently?

Surgery of lymphatic and in-transit metastases. Outweighing risk and benefits in certain clinical settings  › R. Kaufmann

› Risk and benefits of lymphadenectomy in low burden positive SNLB (micrometastasis)
› Expected surgical complications after inguinal, axillary and neck dissection
› Risk and benefits of Iliac-obturator (deep pelvic)inguinal lymphadenectomy in metastatic superficial inguinal basin. Identifying candidates
› Risk and benefits of neck dissection. Defining complete neck dissection
› Risk and benefits of surgery for in-transit disease. Identifying candidates for surgery and defining non-resectable locoregional disease

Surgery for distant metastatic malignant melanoma. Identifying candidates for surgery of the distant metastasis  › V. Sondak

› Risk and benefits of surgery in the stage IV disease
› New concepts in surgery in distant metastasis. Defining non-resectable distant disease
› Identifying candidates for surgery of the lung, liver, brain, and other sites metastases
› The leading role of the surgeon in stage IV disease: Biobanking of metastases in the era of immunology and target therapies

14.30  BREAKOUT SESSIONS II

16.00  BS7. TESTING IN MELANOMA PATIENTS: EVIDENCE AND IMPACT OF STANDARD AND NEW TECHNOLOGIES IN THE DETECTION OF RECURRENCIES AND METASTASIS  › Rubi + Zafir Meeting Room

Chairperson  › Sergi Vidal-Sicart

14.30-14.40  Pros and cons of testing in melanoma follow-up  › Sergi Vidal-Sicart

14.40-14.50  Testing in melanoma in US  › Jeffrey E. Gershenwald

14.50-15.00  Testing in melanoma in Germany  › Ulrike Leiter

15.00-15.10  Testing in melanoma in France  › Philippe Saïag

15.10-15.20  Testing in melanoma in UK  › Jerry Marsden

15.20-15.30  Testing in melanoma in Australia  › John Thompson

15.30-16.00  Discussion
**Friday, November 16th**

**Key points for discussion**
Testing in melanoma patients: Evidence and impact of standard and new technologies in the detection of recurrences and metastasis

**Specific key points addressed for discussion**
- Evidence for the recommendations in follow-up in melanoma patients?
- Blood test in follow-up of melanoma patients?
- Imaging tests in follow-up: What test and when is it worthwhile?
- New technologies in the era of molecular biology: Who pays for it?

**14.30 BREAKOUT SESSIONS II**

**16.00 BS8. FASTER TRANSLATIONAL RESEARCH IN MELANOMA TREATMENT AND BIOMARKERS: IS IT POSSIBLE?**  Cristal + Coral Meeting Room

**Chairperson**  Christoph Hoeller

14.30-14.45  **Do we need a faster and cheaper translational research in melanoma?**  Christoph Hoeller
14.45-15.10  **What we did in the past in clinical studies is still valid in 2012?**  Alex Eggermont
15.10-15.30  **Individualised treatments of cancer in 2012: myth or reality?**  Antoni Ribas
15.30-16.00  **Discussion**

**Key points for discussion**
Faster translational research in melanoma treatment and biomarkers: is it possible?

**Specific key points addressed for discussion**
- Why do we need faster and cheaper development and studies of new drugs in melanoma?
- Translational research in new therapies: how to do it and in what centers?
- Combination of drugs to make melanoma a chronic disease from a scientific and practical perspective: myth or reality?
- More molecules for few patients: is it still interesting for companies?
- Translational research of new drugs: who will pay for it?

**14.30 BREAKOUT SESSIONS II**

**16.00 BS9. COST-BENEFIT OF NEW MEDICAL TREATMENTS IN MELANOMA**  Ambar Meeting Room

**Chairperson**  Salvador Martín Algarra

14.30-14.45  **New medical treatments in melanoma: are they affordable?**  Salvador Martín Algarra
14.45-15.00  **Evidence of cost-effectiveness and other barriers to patient access to new treatments for melanoma in US**  Sanjiv S. Agarwala
15.00-15.45  **Evidence of cost-effectiveness and other barriers to patient access to new treatments for melanoma in UK**  Paul Lorigan
15.45-16.00  **Evidence of cost-effectiveness and other barriers to patient access to new treatments for melanoma in Continental Europe**  Alessandro Testori

16.00-16.30  **Discussion**

**Key points for discussion**
Cost-benefit of new medical treatments in melanoma

**Specific key points addressed for discussion**
- What are the barriers for melanoma patients to access to new treatments?
- Cost-efficacy in new treatments with clinical benefit: What is acceptable?
- Are different alternatives for reimbursement possible?
- The perspective of the doctor: Ethical dilemmas
- The perspective of the associations of patients?
- The perspective of the pharmaceutical companies?
- The perspective of the government?
### BREAKOUT SESSIONS II

#### 14.30
**BREAKOUT SESSIONS II**

**BS10. DIAGNOSTICS AND TREATMENT OF MELANOMA BRAIN METASTASIS**

**Chairperson**

- Carles Conill

**14.30-14.45**

**Strategies of follow-up for detection of brain metastasis and prognostic factors**

- Thomas K. Eigentler

**14.45-15.00**

**Neurological evaluation and imaging tests in the study of brain metastasis**

- Gerard Conesa

**15.00-15.15**

**The multidisciplinary treatment of melanoma brain metastasis**

- Gerald Fogarty

**15.15-15.30**

**New paradigms in the treatment of brain metastasis in the era of new melanoma drugs**

- Friedeggund Meier

**15.30-16.00**

**Discussion**

**Key points for discussion**

- Diagnostics and treatment of melanoma brain metastasis

**Specific key points addressed for discussion**

- What is the best strategy for follow-up of patients at risk for brain metastasis?
- Prognostic factors: Are they reliable?
- Surgery vs radiosurgery: Pros and cons
- Hole brain radiotherapy: Is still an option?
- Are the new drugs changing the paradigms of management of brain metastasis?

#### 16.00

**Coffee-break and visit to the Exhibition**

#### 16.30

**FREE COMMUNICATIONS II**

**Chairpersons**

- Eduardo Nagore and María González-Cao

**16.30-16.37**

**C13 High-definition optical coherence tomography: New imaging technique for non-melanoma skin cancer**

- Marc Boone

**16.40-16.47**

**C14 Dermatofibrosarcoma protuberans: Analysis of markers of cell proliferation, invasiveness and apoptosis, study of fusion COL-1A1/PDGF-B by FISH and correlation with relapse**

- Andre Molina

**16.50-16.57**

**C15 Sex-related location of head and neck melanoma strongly argues for a major role of sun exposure in cars and photoprotection by hair**

- Candice Lesage

**17.00-17.07**

**C16 Background: α2b-Interferonotherapy is currently the standard of care for patients with high risk for relapse. α2b-IFN has shown disease-free survival benefits but no significant improvement in overall survival. Here we report clinical result**

- Mariia Kukushkina

**17.10-17.17**

**C17 Clinicopathological features and prognosis in BRAF mutated metastatic melanoma - A single center analysis**

- Lidija Kandolf-Sekulovic

**17.20-17.27**

**C18 Clinical benefit assessment of patients with advanced basal cell carcinoma (ABCC) treated with vismodegib**

- Brigitte Dreno

**17.30-17.37**

**C19 Vitamin D receptor gene polymorphisms are associated with increased melanoma risk**

- Katarina Željić

**17.40-17.47**

**C20 Epithelial-mesenchymal transition in metastatic cutaneous squamous cell carcinomas**

- Agustí Toll

**17.50-17.57**

**C21 Acral melanoma in Spain; retrospective study of 275 cases in a referral center**

- Cristina Carrera

**18.00-18.07**

**C22 Procedural and therapeutic outcomes of isolated limb infusion for inoperable limb cancer**

- Ashish Sharma

**18.10-18.17**

**C23 Applicability of dermoscopy for evaluation of treatment outcome in superficial basal cell carcinoma**

- Zoie Apalla

**18.20-18.27**

**C24 The incidence of metastatic basal cell carcinoma (MBCC) in Denmark, 1997-2010**

- Mary Nguyen Nielsen

**18.30-18.40**

**C26 Melanoma diagnostic index – A new tool to assess diagnostic accuracy of melanoma diagnosis**

- Jonathan Bowling
Friday, November 16th

16.30 PARALLEL SESSION 1 ▶ CUTANEOUS LYMPHOMA ▶ Verdi Meeting Room

18.00 Chairpersons ▶ Teresa Estrach and Reinhard Dummer

16.30-16.47 Lymphocytic differentiation and classification of cutaneous lymphoma ▶ Martine Bagot

16.50-17.07 Clinical end points and response criteria in mycosis fungoides and Sézary syndrome ▶ Reinhard Dummer

17.10-17.27 Mycosis fungoides: Biomarkers and treatment ▶ Rudolf Stadler

17.30-17.47 Sezary’s syndrome: Biomarkers and treatment ▶ Ramón Pujol

17.50-18.00 Discussion

16.30 PARALLEL SESSION 2 ▶ ADVANCED EPITHELIAL CANCER ▶ Rubí + Zafir Meeting Rooms

18.00 Chairpersons ▶ Jürgen Becker and Alexander J. Stratigos

16.30-16.47 Merkel cell carcinoma ▶ Jürgen Becker

16.50-17.07 Surgery in complex skin carcinoma ▶ James Langtry

17.10-17.27 Systemic therapy in SCC and BCC ▶ Alexander J. Stratigos

17.30-17.47 Dermatofibrosarcoma protuberans: Diagnosis, treatment and prognosis in 2012 ▶ Onofre Sanmartín

17.50-18.00 Discussion

18.00 IGEA PARALLEL SPONSORED SYMPOSIUM ▶ Rubí + Zafir Meeting Rooms

19.00 ELECTROCHEMOTHERAPY WORLDWIDE PERSPECTIVE

Chairpersons ▶ Axel Haushild and Jerry Marsden

18.00-18.10 When and where using ECT in a skin cancer/melanoma center? ▶ Josep Malvehy

18.12-18.22 ECT experience at LMU Munich: Cases presentation and discussion ▶ Christian Kunte

18.24-18.34 Beyond the experience: A multimodal approach with ECT for not so simple clinical cases ▶ Victor Farricha

18.36-18.46 ECT: A new therapy integrated approach in hospital ▶ Nicola Mozzillo

18.48-18.58 ECT: The US perspective and prospects for the future ▶ Vernon Sondak

18.00 MEDAPHARMA PARALLEL SPONSORED SYMPOSIUM ▶ Rubí + Zafir Meeting Rooms

19.00 LMAX: A NEW CONCEPT IN DERMATO-ONCOLOGY

Chairperson ▶ Alexander J. Stratigos

18.00-18.15 The new Lmax parameter: Definition and results with imiquimod 3.75% ▶ Eggert Stockfleth

18.20-18.35 Optical coherence tomography (OCT): A new tool for evaluating AK ▶ Marc Boone and Véronique Del Marmol

18.40-18.55 Integration of Lmax into daily practice ▶ Agustín Alomar

19.00 REPORT FROM BREAKOUT SESSIONS ▶ Verdi Meeting Room

19.30 Chairpersons ▶ Ana-María Arance and María González-Cao
Saturday, November 17th

08.00 GUIDED POSTER TOUR 3. Clinical Non Melanoma Studies ➔ from P73 to P92
09.00 Chairpersons ➔ Thomas K. Eigentler and Caterina Longo

09.00 LEO SPONSORED SYMPOSIUM 6 ➔ Verdi Meeting Room

10.00 WHY ACTINIC KERATOSES REQUIRED FIELD THERAPY
Chairperson ➔ Günther Hofbauer
09.00-09.15 Field-directed treatment of UVB-damaged skin ➔ Günther Hofbauer
09.20-09.35 Demonstration of confocal microscopy ➔ Martina Ullrich + patient. Live demonstration on an AK patient
09.40-09.55 Human mechanism of action studies in AK-what do we know today? ➔ Eggert Stockfleth

10.00 ALMIRALL SPONSORED SYMPOSIUM 7 ➔ Verdi Meeting Room

11.00 ACTINIC KERATOSES: NEW FACES OF AN OLD DISEASE
Chairperson ➔ Josep Malvehy
10.00-10.15 New approaches in the diagnosis and treatment of actinic keratoses ➔ Josep Malvehy
10.20-10.35 Evidence-based management of field cancerization ➔ Eggert Stockfleth
10.40-10.55 Novel Lesion-directed treatment for actinic keratoses ➔ Thomas Dirschka

11.00 Coffee-break and visit to the Exhibition

11.30 ROCHE SPONSORED SYMPOSIUM 8 ➔ Verdi Meeting Room

12.30 TRANSFORMING THE FACE OF ADVANCED BASAL CELL CARCINOMA
Chairpersons ➔ Claus Garbe and Susana Puig
11.30-11.35 Welcome and introduction ➔ Claus Garbe and Susana Puig
11.35-12.00 The Hedgehog pathway as the underlying cause of basal cell carcinoma and clinical development in advanced BCC ➔ Nicole Basset-Seguin
12.00-12.25 Clinical experiences of advanced BCC ➔ Nicole Basset-Seguin, Claus Garbe and Susana Puig
12.25-12.30 Questions and answers ➔ Faculty

12.30 KEYNOTE LECTURE 3 ➔ Verdi Meeting Room
Chairperson ➔ Josep Malvehy
THE FUTURE OF INVIDIDUALIZED CANCER THERAPY ➔ Antoni Ribas

13.30 CLOSING CEREMONY & PRESENTATION OF AWARDS ➔ Verdi Meeting Room
Chairperson ➔ Claus Garbe and Josep Malvehy

AFTERNOON SCHEDULED COURSES

14.00 COURSE 1. INTERACTIVE QUIZ OF DERMOSCOPY (Medium level) ➔ Diamante Meeting Room
Chairpersons ➔ Ashfag A. Marghoob and Susana Puig
The aim of this dermoscopy course is to improve the knowledge of the technique incorporating new criteria and new concepts based on a better understanding of morphology. The course is focused on the case-based learning, with selected cases discussed by dermoscopists and pathologists and a series of cases to be diagnosed by the audience and discussed by experts. It is a great opportunity to enjoy and learn dermoscopy and histopathology.
14.00-14.25 How to learn and how to teach dermoscopy ➔ Ashfag A. Marghoob
14.30-14.55 Dermoscopy of flat lesions on the face ➔ Wilhelm Stolz
15.00-15.25 Fast growing melanoma: How to recognise ➔ Susana Puig
15.30-15.55 Multiple faces of regression structures in dermoscopy ➔ Ashfag A. Marghoob
16.00-16.10 Coffee-break
16.10-16.35 Integration of dermoscopy and pathology ➔ Susana Puig
16.40-17.05 Cases I. Dermoscopic and histopathologic correlation ➔ Paula Aguilera, Joel Claveau, Gerardo Ferrara, David Moreno, José Luis Rodriguez-Peralto and Wilhelm Stolz
17.10-17.35 Cases II. Dermoscopic and histopathologic correlation ➔ Paula Aguilera, Joel Claveau, Gerardo Ferrara, David Moreno, José Luis Rodriguez-Peralto and Wilhelm Stolz
17.40-18.05 Dermoscopic quiz for the audience ➔ Ashfag A. Marghoob and Susana Puig
Saturday, November 17th

14.00  COURSE 2. CONFOCAL MICROSCOPY FOR SKIN CANCER (Basics)  Cristal + Coral Meeting Room

19.00  Chairpersons  Salvador González and Giovanni Pellacani

14.00-14.25  Introduction and technical principles  Salvador González
14.30-14.55  Patterns in melanocytic nevi  Rainer Hofmann-Wellenhof
15.00-15.25  Melanoma features  Caterina Longo
15.30-15.55  Interactive cases on melanocytic lesions  Rainer Hoffman-Wellenhof and Caterina Longo
16.00-16.10  Coffee-break
16.10-16.35  Features for basal cell carcinoma diagnosis  Salvador Gonzalez
16.40-17.05  Features of non-melanocytic tumours, others that basal cell carcinoma  Martina Ulrich
17.00-17.35  Interactive cases on melanocytic lesions  Salvador Gonzalez, Virginia Sanchez and Martina Ulrich
17.40-18.05  Two-step method for confocal diagnosis  Sonia Segura
18.10-18.35  Confocal diagnosis integrated in clinical practice  Giovanni Pellacani
18.40-19.05  Interactive cases - miscellaneous  Ivette Alarcón and Sonia Segura

Saturday, November 17th

LEO Pharma Satellite Symposium
Saturday November 17th, 9:00 -10:00

By using field therapy for visible AKs as well as the surrounding skin areas, both the clinical and sub clinical lesions are treated¹.

But how can we address the sub clinical lesions and what do they look like?
LEO Pharma welcomes you to learn more about sub clinical AK lesions by giving you an update on the topic by Chairman Dr. Günther Hofbauer, Department of Dermatology, University Hospital of Zürich.

Dr. Martina Ulrich, Universitätsmedizin Charité, Berlin, Department of Dermatology, will provide a live patient demonstration using confocal microscopy to visualise sub clinical AK lesions.

Furthermore, Prof. Dr. Eggert Stockfleth, Universitätsmedizin Charité, Berlin, Department of Dermatology, will elaborate on human Mechanism of Action studies conducted on AK patients.

Why Actinic Keratoses requires field therapy

- Welcome by Chairman
  Dr. Günther Hofbauer

- Field-Directed Treatment of UVB-Damaged Skin
  Dr. Günther Hofbauer

- Demonstration of Confocal Microscopy
  Dr. Martina Ulrich + Patient
  - Live demonstration on an AK patient

- Human Mechanism of Action studies in AK - what do we know today?
  Prof. Dr. Eggert Stockfleth

- Closing by Chairman
  Dr. Günther Hofbauer

Parallel Society / Group Meetings

**Wednesday, November 14th**

**15.00** EX-VIVO INTERNATIONAL CONFOCAL ▶ Diamante Meeting Room
**19.00** MICROSCOPY WORKING GROUP
Kindly sponsored by MAVIG GmbH, Vivoscope Systems, Munich, Germany
Caliber Imaging and diagnostics Inc., Rochester, USA

**Description of the Workshop**
The main goals of the session will be addressed in the format of presentations and discussion with the audience.
During the session the following goals will be addressed:
1. Description, standardisation and quality assurance of ex vivo fluorescence laser scanning microscopy; surgical procedure; tissue handling; sampling; staining; reading; reporting
2. Consensus guidelines
3. Technical improvements: Hard / software requirements
4. Multicenter clinical studies
5. Next steps in ex-vivo fluorescence laser scanning microscopy

**Chairpersons** ▶ Salvador González, Giovanni Pellacani and Josep Malvehy

**Part I. Definition of RFM**

15.00 **Introduction** ▶ Josep Malvehy
15.10 **Fundamentals of fluorescence laser scanning microscopy** ▶ Salvador González
15.25 **New developments in fluorescence confocal microscopy and practical cases** ▶ Milind Rajadyahksjacta and Christi Alessi-Fox

**Part II. Discussion forum of fluorescence confocal microscopy. From the laboratory to the operating room. Standardisation and quality assurance**

16.15-17.00 **Surgical procedure, tissue handling and staining in fluorescence laser scanning microscopy** ▶ Antoni Bennassar
17.00-17.30 **Reading in fluorescence laser scanning microscopy** ▶ Caterina Longo
17.30-18.00 **Report in fluorescence laser scanning microscopy and legal issues** ▶ Susana Puig
18.00-18.30 **Other applications of fluorescence laser scanning microscopy** ▶ Giovanni Pellacani and Moira Ragazzi
18.30-19.00 **Final remarks and next steps** ▶ Salvador González

**Friday, November 16th**

**07.00** EUROPEAN ASSOCIATION OF ▶ Diamante Meeting Room
**09.00** DERMATO ONCOLOGY BOARD MEETING

**Friday, November 16th**

**16.00** GRUPO ESPAÑOL MULTIDISCIPLINAR ▶ DE MELANOMA BOARD MEETING
**17.00** GRUPO ESPAÑOL MULTIDISCIPLINAR ▶ DE MELANOMA BOARD MEETING
**19.00** GRUPO ESPAÑOL MULTIDISCIPLINAR ▶ Diamante Meeting Room
**21.00** DE MELANOMA MEETING
MSD Oncology is proud to support...

6th World Meeting of Interdisciplinary Melanoma/Skin Cancer Centres in conjunction with the 8th EADO Congress
# Congress Faculty

<table>
<thead>
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Almirall bringing new dermatology medicines for your patients

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Weiner, David B. (USA)
Chair of Gene Therapy and Vaccine Program, University of Pennsylvania School of Medicine, Abramson Cancer Center, Philadelphia, Pennsylvania.

Zalaudek, Iris (Austria)
Dermatology Department, Medical University of Graz.
**FREE COMMUNICATIONS I**

_Ambar Meeting Room_  
Thursday, November 15th  
16.30-16.37 h.

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**C01**

**RADICAL GROIN DISSECTION—WHAT IS THE BEST INCISION?**

_Molina, Andre³; Duprat, Joao¹; Bertoldi, Eduardo; Gomes, Eduardo¹; Fegnani, Jose³; Stavanela, Paulo²; Fegnani, Jose³_  
(1) Hospital A.C. Camargo, Brazil; (2) Hospital de Câncer de Barretos, Brazil

**Introduction:** Radical Groin dissection (RGD) is an important step in the melanoma treatment, among other tumors. High rates of desiccation (WD) and wound infection (WI), ranging from 40% to 60%, justify efforts for risks stratification and technical refinement.

**Objective:** To compare the longitudinal incision in “S” (SI) to the double transverse incision (DI), examining their rates of WD and WI and the number of dissected nodes. Determine the impact of age, body mass index (BMI), smoking and diabetes on the occurrence of these complications.

**Materials and Methods:** Retrospective analysis of patients undergoing RGD, in this service, from 2000 to 2010, through consultation of medical records. Those patients whose incisions were not SI or DI, as well as those with extended resections (muscle and skin) were excluded. One hundred and three patients, 58 with SI and 45 with DI were selected. The Fisher exact test and Chi-square test were used to compare the groups. Statistical significance was assumed at p < 0.05.

**Results:** WD occurred in 50% of the SI and in 28.89% of the DI (p=0.024). WI occurred in 37.85% of the SI and in 31.11% of the DI (p=0.352). The number of lymph nodes dissected was 97.57 with SI, and 11.51 with DI (p=0.503). Age had no impact on WD, observed in 43.33% of patients over 60 years and in 39.73% of those with up to 45 years (p=0.48). There was 51.14% of WD in patients with BMI greater than 25, against 29.51% in those with BMI less than or equal to 25 (p=0.005). In the latter group, SI evolved with 39.67% of WD and DI 13.04% (p=0.026). In the obese population, DI had 45.45% of WD and IS, 70% (p=0.098). WD occurred in 71.43% of diabetic patients (p=0.05) and 58.33% of smokers (p=0.59).

**Conclusion:** DI is twice superior than SI, for WD and that difference becomes greater in non-obese population. WI rates were similar in the two incisions. Diabetes and smoking showed no statistical significance impact on this study. The number of dissected lymph nodes did not differ between the two types of incision.

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**C02**

**MULTIPLE PRIMARY MELANOMAS: DO THEY LOOK THE SAME?**

_Moscarella, Elvira¹; Robinviton, Harold²; Puig, Susanna²; Zalaudek, Iris²; Pellacani, Giovanni²; Longo, Caterina²; Argenziano, Giuseppe³_  
(1) University of Modena and Reggio Emilia, Modena, Italy; (2) Private skin cancer clinic, Plantation, Florida; (3) Hospital Clinic, Barcelona, Spain; (4) Medical University of Graz, Austria; (5) Dermatology and Skin Cancer Unit, IRCCS, Reggio Emilia, Modena, Italy

**Aim of the Investigation:** A series of studies have investigated epidemiological, clinical and genetic characteristics of multiple primary melanoma (MPM) patients. However, a comparison of the clinical and dermoscopic features of MPM within a given individual have been described only in case reports. Knowing that a trend toward similar appearing subsequent MPMs exist, may translate into earlier recognition of new melanomas. The objective of our study was to describe the dermoscopic features of MPM for each given patient, and to evaluate the characteristics eventually associated with the similar or dissimilar appearance.

**Materials, Subjects and Methods:** From the databases of three pigmented lesion clinics in US, Italy, and Spain we evaluated the dermoscopic images of melanomas in patients diagnosed with MPM.

**Results:** Among 58 patients with MPM, we found 53.5% of patients having dermoscopically similar melanomas and 46.5% of patients having dermoscopically different melanomas. In older patients (≥55 years), 24.11% of melanomas were dermoscopically similar vs 46.9% in younger patients (p=0.377). Similar thickness was associated with the occurrence of dermoscopically similar melanomas (19 cases; 63.3%) (p=0.039). Most (65.4%) of the synchronous lesions were similar, compared to 35.7% of non-synchronous lesions (p=0.029), and most (89%) of the melanomas on sun-damaged skin were similar, vs 36.7% of melanomas on non sun-damaged skin (p=0.015). The synchronous lesions had a diagnostic cut off point of 1.11-13.98. The percentage of dermoscopically different melanomas was higher in patients with a family history of melanoma (66.7% vs 47.7%).

**Conclusions:** MPM in a given patient have almost the same chance to look dermoscopically similar or different. However, a subset of elderly patients with sun-damaged skin may present multiple, similar thin melanomas characterized by pigment network and regression structures.

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**C03**

**THE EMERGING ROLE OF RADIOTHERAPY IN MELANOMA IS BEING DEFINED BY HIGH QUALITY RANDOMISED TRIALS**

_Fogarty, Gerald¹; Hong, Angela³; Burmeister, Bryan³; Foote, Matthew²; Paton, Elizabeth³; Thompson, Andrew²_  
(1) Melanoma Institute Australia, Sydney; (2) Princess Alexandra Hospital; (3) Australia and New Zealand Melanoma Trials Group

**Introduction:** The general perception in the medical community is that melanoma is radio-resistant. However, there is strong evidence that radiotherapy is an important treatment modality in the management of melanoma.

**Methods:** Under the auspices of the Australian and New Zealand Melanoma Trials Group (ANZMTG) and the Trans-Tasman Radiation Oncology Group (TROG), four randomised trials investigating the role of radiation therapy in different scenarios of melanoma have been either completed (1), are ongoing (2), or are in development (1).

**Results:** The results of the first ANZMTG trial were published this year. The addition of radiotherapy (48 Gy in 20 fractions) was associated with a significant reduction in nodal failure from 32% to 18% compared with observation following lymphadenectomy for high risk AJCC Stage 3 disease. A second randomised trial is investigating the role of whole brain radiotherapy with at least 30 Gy in 10 fractions following local treatment for patients with up to three brain metastases. This trial has accrued 89 of a planned 200 patients in three years. A third trial is assessing the role of adjuvant radiotherapy following resection of primary neurotropic melanoma with 15 of 100 patients randomised to ipro. A proposed trial comparing radiotherapy with imiquimod for lentigo maligna mapped with reflectance confocal microscopy is in development, with a target of 280 patients.

**Conclusion:** The emerging role of radiotherapy in melanoma is being defined by high quality randomised trials. The current perception that melanoma is radio-resistant is not evidence-based. At melanoma centres radiation oncologists need to be part of the multidisciplinary management team so that melanoma patients can access effective evidence based treatments.

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**C04**

**DETERMINATION OF SURVIVIN AND VEGF LEVELS IN PATIENTS WITH MELANOMA**

_Mijuskovic, Zeljko¹; Kandof, Ssekulovic, Lidija²; Zecvic, Rados³; Rajoic, Milica²; Jovic, Milena²; Gacevic, Milomir (Clinic for Plastic Surgery, Military Medical Academy, Belgrade, Serbia; Zolotarevski, Lidija; Stanojevic, Ivan²; Vovkovic, Danilo³_  
(1) Department of Dermatology, Faculty of Medicine, Military Medical Academy, Belgrade, Serbia; (2) Clinic for Plastic Surgery, Military Medical Academy, Belgrade, Serbia; (3) Institute of Medical Research, Military Medical Academy, Belgrade, Serbia

**Aim of the Investigation:** A series of studies have investigated mechanisms that govern disease development. Although elevated levels of survivin and VEGF in melanoma patient samples comparing to healthy control group. Istock et al. (2010) have been described only in cancer tissues. The highest established levels were from patients in IIc and IV clinical stage, and patients in IV clinical stage had significantly higher VEGF levels than patients who had no disease stage. Correlation of survivin and VEGF levels in individual samples demonstrated significant interconnection which was most prominent in patients who were in llc clinical stage. Survivin level was significantly higher in melanoma patient samples comparing to healthy control group. Gradual increase of survivin and VEGF could be attributed to biological mechanisms that govern disease development. Although elevated levels of survivin and VEGF represent consequences of different biological processes, we found evidence that at least at one stage, apoptosis resistance and vasculogenesis are significantly associated in melanoma progression.

**Materials, Subjects and Methods:** Patient group consisted of melanoma patients who were treated and monitored in our hospital. Patient serum samples (n=177) were obtained at control exams. Age and sex matched healthy control samples (n=64), were acquired, from blood volunteers. Survivin and VEGF levels were determined by commercial ELISA tests.

**Results:** Comparing to control samples, average survivin level was significantly higher in all examined patient samples. Although the highest average value was established in melanoma patients with llc and IV clinical stage, survivin levels did not differ significantly between patients from other clinical stages. Comparing to control samples, average VEGF level was significantly higher in all examined patient samples. The highest established levels were from patients in llc and IV clinical stage, and patients in llc clinical stage had significantly higher VEGF levels than patients who had no disease stage. Correlation of survivin and VEGF levels in individual samples demonstrated significant interconnection which was most prominent in patients who were in llc clinical stage.

**Conclusions:** Survivin and VEGF levels were significantly higher in melanoma patient samples comparing to healthy control group. Gradual increase of survivin and VEGF could be attributed to biological mechanisms that govern disease development. Although elevated levels of survivin and VEGF represent consequences of different biological processes, we found evidence that at least at one stage, apoptosis resistance and vasculogenesis are significantly associated in melanoma progression.
SERIOUS SKIN TOXICITY FOR THE COMBINATION OF BRAF INHIBITORS AND RADIOTHERAPY

Alter, Mareike; Satzger, Imke; Kapp, Alexander; Gutzmer, Ralf
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Newly introduced B-Raf-inhibitors like vemurafenib and dabrafenib are effective in patients with metastatic melanoma harbouring B-Raf-V600 mutations, but after a median time of approximately 6 months disease progression occurs. In case of a local progression of pre-existing or newly developing metastatic lesions, radiotherapy could be a feasible option. In vitro data suggest that the susceptibility of B-Raf mutant melanoma cell lines to ionizing radiation is enhanced by treatment with vemurafenib. We report here on the experience of our first 4 metastatic melanoma patients with localized progression during B-Raf-inhibitor therapy (dabrafenib 150mg b.i.d. or vemurafenib 960mg b.i.d., respectively). After 2-8 month patient developed a localised progression (metastatic lesions in bones, lymphnodes or subcutaneous tissue). Additional to treatment with B-Raf-inhibitor three-dimensional conformal radiotherapy was performed.

Radiotherapy was conventionally fractionated with 2 Grays (Gy) daily, all patients received the cumulative target dose initially planned, sedation or analgesia was not applied.

All 4 cases concurrently treated with the combination of radiotherapy and BRAF inhibitors showed an increased skin toxicity (radiodermatitis, NCI-CTCAE grade 2-3). Weekly dermatologic controls were performed, radiation dermatitis was treated with fucidic acid impregnated ointment (radiodermatitis, NCI-CTCAE grade 2-3). Weekly dermatologic evaluations were performed, radiation dermatitis was treated with fucidic acid impregnated ointment (radiodermatitis, NCI-CTCAE grade 2-3). Weekly dermatologic evaluations were performed, radiation dermatitis was treated with fucidic acid impregnated ointment (radiodermatitis, NCI-CTCAE grade 2-3). Weekly dermatologic evaluations were performed, radiation dermatitis was treated with fucidic acid impregnated ointment (radiodermatitis, NCI-CTCAE grade 2-3). Weekly dermatologic evaluations were performed, radiation dermatitis was treated with fucidic acid impregnated ointment (radiodermatitis, NCI-CTCAE grade 2-3). Weekly dermatologic evaluations were performed, radiation dermatitis was treated with fucidic acid impregnated ointment (radiodermatitis, NCI-CTCAE grade 2-3). Weekly dermatologic evaluations were performed, radiation dermatitis was treated with fucidic acid impregnated ointment (radiodermatitis, NCI-CTCAE grade 2-3).

Radiotherapy was conventionally fractionated with 2 Grays (Gy) daily, all patients received the cumulative target dose initially planned, sedation or analgesia was not applied.

In all 4 cases the metastatic lesions progressed after radiotherapy. In conclusion, our cases suggest possible increased skin toxicity in melanoma patients concurrently treated with the combination of radiotherapy and BRAF inhibiting therapy. The mechanisms are unclear and require further investigations. Future studies with concomitant therapy of B-Raf inhibitors and radiotherapy need careful dermatologic controls.

PHASE 3, RANDOMIZED, OPEN-LABEL, MULTICENTER TRIAL OF NAB-PACLITAXEL VERSUS DACABRINE IN CHEMOTHERAPY-NAIVE PATIENTS WITH METASTATIC MALIGNANT MELANOMA

Hauschild, Axel1; Del Vecchio, Michele2; Brown, Michael P3; Petrucci, Richard2; Loqui, Carmen1; Testori, Alessandro3; Bhatia, Shalender4; Gutzmer, Ralf2; Conry, Robert5; Haydon, Andrew6; Robert, Caroline7; Clausen, Alicia1; Elaia, Leonardo8; Renschler, Markus F.9; Blessing, Thomas9; Gutzmer, Ralf7; Conry, Robert8; Haydon, Andrew9; Robert, Caroline10; Hauschild, Axel1

Materials, Subjects and Methods: Chemotherapy-naïve patients with stage IV MMM, no brain metastasis, and LDH ≤ 2 xULN received nab-paclitaxel 150mg/m² on days 1, 8, and 15 every 4 weeks or dacarbazine 1000mg/m² every 3 weeks. The primary endpoint was progression-free survival (PFS) based on independent radiologic review of CT scans obtained every 8 weeks, evaluated per RECIST. The secondary endpoint was OS; other endpoints included objective response rate (ORR), disease control rate (DCR), and safety/tolerability. 514 patients provided adequate power to detect a hazard ratio of 0.750 for PFS. At the time of the primary PFS analysis an interim analysis of OS was conducted.

Results: 529 patients were randomized to nab-paclitaxel (n=264) or dacarbazine (n=265) between 04/2009 and 06/2011. Baseline patient characteristics were well balanced. The majority of the patients were males (66%), had an ECOG status of 0 (71%), and had M1c stage (63%). ...

Material Test have identified a CDKN2A mutation (p.V126D) associated to MPM without family history. Pancreatic cancer was found in 7 families. Until July 2012, 55 patients (40 families) were included with 6 (12%) patients (2 families) carrying a germline mutation in high melanoma-associated genes (CDKN2A and CDK4) and 2 (4%) patients (1 family) with MPM without family history of the disease. We designed a study to evaluate for the first time the genetic predisposition to MM in Ticino an Italian region. In order to achieve our goal we selected patients with personal or familial history of the disease. The majority of the patients were males (66%), had an ECOG status of 0 (71%), and had M1c stage (63%).
FREE COMMUNICATIONS I  Thursday, November 15th 17.40-17.47 h.

C10

AMELANOTIC MELANOMA – A DIFFICULT DIAGNOSIS?
Cosgarea, Rodica Maria; Ungureanu, Loredana; Senila, Simona
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Aim of the study: The amelanotic melanoma has a low frequency, 2-8% of all melanomas and a low survival rate because it has a later diagnosis compared with the pigmented melanoma. We planned to evaluate the dermoscopic structures with the highest frequency in amelanotic melanoma in comparison with some benign or malignant amelanotic or hypomelanotic lesions and to corroborate these structures with the thickness of AHM.

Subjects and Method: From the 282 patients with melanomas that were diagnosed and treated from 2007 to 2012 in the Department of Dermatology Cluj-Napoca, we evaluated the dermoscopies of 27 lesions that were amelanotic or hypomelanotic melanomas (AHM) confirmed by the pathological examination. We compared these lesions with the thickness of 25 amelanotic/hypomelanotic benign lesions/AHBL (dysplastic nevi, acinic keratosis, irritated seborrhoeic keratosis, hemangiomata) and 23 amelanotic/hypomelanotic malignant nonmelanocytic lesions/AHM/NML (basal cell carcinoma, Bowen disease). We considered too the dermoscopic structures in accordance with the thickness of melanomas.

Results: We found a higher prevalence of milky-red areas, dotted vessels, polimorphous vessels and blue-whitish veil in the melanoma group compared with the AHBL and AHM/NML. The irregular “hair-pinn” vessels and scar-like structures were found in melanomas with lower prevalence but still superior to those found in the other two groups. The dermoscopic structures significant associated with AHM were: blue-whitish veil, blue-grey dots, irregular depigmentation, ir-regular globules. The most frequent structures associated with thin AHM were dotted vessels, irregular blue-grey dots and globules, irregular depigmentation and blue-whitish veil. The thick melanomas had milky-red areas and irregular vessels. More than 50% of AHM were symmetric lesions.

Conclusions: By dermoscopic evaluation of amelanotic or hypomelanotic lesions, we can distinguish very often the amelanotic melanoma from other lesions with few pigment dots due to some strucutures which are encountered with higher prevalence.

FREE COMMUNICATIONS I  Thursday, November 15th 18.00-18.07 h.

C11

OVERALL SURVIVAL, DISEASE FREE SURVIVAL AND SURVIVAL AFTER RECURRENT ACROSS GENDER IN MELANOMA PATIENTS: WHAT HAS CHANGED?
Riberio, Simone; Quaglini, Pietro; Saniorenzo, Martina; Osella Abate, Simona; Marenco, Federica; Nardo, Tiziana; Bernengo, Maria Grazia
Department of Medical Sciences, Dermatologic Clinic, University of Turin, Turin, Italy

Aim: To highlight how are changed differences across gender in melanoma patients from 1975 to nowadays in a large monocentric casistic.Materials:We studied 4879 stage I-IIAJCC patients that had been previously treated and followed-up in our institution. The difference of gender parameter on Overall survival (OS), disease free survival (DFS) and survival after first recurrence (SUR) and its role corrected for the principal melanoma features were analysed. Two time periods (after/1999 before 2000) and diseases were considered. This cut-off was posed at the moment of equalisation in male/female ratio and at the introduction of Sentinel lymph node biopsy.

Results: A female prevalence was observed until 1999, thereafter the male/female ratio approached 1 (period 1999-2003) with a subsequent increasing tendency suggesting a male prevalence. Males resulted older and more often with thick ulcerated and on trunk localization. “In situ” melanoma was higher in females, whereas male patients showed a higher number of multiple primary melanomas and also a more frequent presence of regression. Progression was higher in males (33.2%) than in females (27.2%) (p<0.001). Both sexes shared a prevalence of regional metastases, nevertheless males developed more frequently the first metastasis in a distant site (28.13%; p=0.03). Moreover multiple visceral sites occurred as first recurrence in males (39.8%) than females (23%) (p<0.05).Before and after 1999 male gender maintained an unfavourable role as to OS, whereas in patients diagnosed after 1999, gender did not play any role on DFS. Although DFS and OS improvement in the two periods was higher in males.

Conclusions: This study highlight the prognosis improvement in men in last years compared with previous one. The knowledge what happens in the past in melanoma history, could help to well interpret nowadays therapeutic options.

FREE COMMUNICATIONS I  Thursday, November 15th 17.50-17.57 h.

C09

INTRAVENOUS (IV) ADMINISTRATION IMPROVES THE ANTITUMOR ACTIVITY OF AUTOLOGOUS MRNA ELECTROPORATED DENDRITIC CELLS AS A SINGLE-AGENT CELLULAR IMMUNOTHERAPY FOR PATIENTS WITH PRETREATED ADVANCED MELANOMA
Wilgenhof, Sofie1; Van Nuffel, An2; Benteyen, Daphné2; Cortals, Jurgen1; Heirman, Carlo2; Van Riet, Ivan2; Aerts, Cindy2; Bonehill, Aude2; Thielemans, Kris2; Nortier, J-L2,3
(1) Medical Oncology, UZ Brussel, Belgium; (2) Laboratory of Molecular & Cellular Therapy, Vrije Universiteit Brussel; (3) Clinical Hematology, UZ Brussel

Background: Autologous monocyte-derived DC electroporated with synthetic mRNA encoding CD40 ligand, as a constitutive active TLR4, and CD70 (TriMix-DC) have superior in vitro T-cell stimulatory capacity. TriMixDC-MEL is a mixture of TriMix-DC co-electroporated with mRNA encoding a fusion of DC-LAMP and 1 or 4 melanoma associated antigens (MAGE-A3, MAGE-C2, gp100, tyrosinase).

Methods: In a pilot clinical trial TriMixDC-MEL 24.106 DC were administered solely by the intradermal (ID) route. Subsequently a phase IB was conducted to investigate the safety of administering TriMixDC-MEL by the IV and ID-route. The ratio of ID/IV administered DC was: Cohort-1: 20.106/4.106 DC [2pts] vs -2: 12.106/12.106 DC [3pts], -3: 4.106/20.106 [6pts], and -4: 0/24.106 DC [4pts]; DC were administered 4x q2w, and a 5th administration on week 16.

Results: Local skin reactions (grade 1-2) were observed in all pts receiving DC-ID, flu-like symptoms (< grade 2) were observed in 1/20 pts, no treatment related adverse events were reported in >10% patients were peripheral neuropathy (nab-paclitaxel: 25% versus dacarbazine:0%, P<0.001) and neutropenia (nab-paclitaxel:20% versus dacarbazine:10%, P=0.004). The median time to neuropathy improvement was 28 days.

Conclusions: nab-Paclitaxel produced statistically significant improvement in PFS (primary endpoint), a trend toward improved OS, and a manageable safety profile compared with dacarbazine in chemo-naive patients with MMM.

FREE COMMUNICATIONS I  Thursday, November 15th 18.10-18.17 h.

C08

In the intent-to-treat population, the median PFS was 4.8 and 2.5 months with nab-paclitaxel and dacarbazine, respectively (HR=0.972, 95.1%CI:0.631, 0.992, P=0.044).

Interim OS was 12.8 and 10.7 months with nab-paclitaxel and dacarbazine, respectively (HR=0.972, 95.1%CI:0.631, 1.196, P=0.004), 73% patients received subsequent therapies, which were well balanced between the 2 arms. Independent assessed ORR was 15% versus 11% (P=0.239) and DCR was 39% versus 27% (P=0.004) with nab-paclitaxel versus dacarbazine, respectively. The most common grade ≥3 treat-ment-related adverse events reported in >10% patients were peripheral neuropathy (nab-paclitaxel: 25% versus dacarbazine:0%, P<0.001) and neutropenia (nab-paclitaxel:20% versus dacarbazine:10%, P=0.004). The median time to neuropathy improvement was 28 days.

Conclusions: nab-Paclitaxel produced statistically significant improve-ment in PFS (primary endpoint), a trend toward improved OS, and a manageable safety profile compared with dacarbazine in chemo-naive patients with MMM.
**WHO DIES FROM MELANOMA? A POPULATION-BASED STUDY OF IRISH PATIENTS**

**Bennett, Mary**; Walsh, Paul; Comber, Harry; Deady, Sandra; Murphy, Michelle

(1) Department of Dermatology, South Infirmary Victoria University Hospital, Cork, Ireland; (2) National Cancer Registry of Ireland

**Background:** Historically, studies have shown that the incidence of melanoma tends to be higher among patients from more affluent backgrounds. Interestingly, survival from melanoma also tends to be higher in that group. Gender has also been shown to influence survival, with women having better outcomes in some studies. In this study we sought to identify factors that were significantly influencing patient survival.

**Methods:** We assessed disparities in cause-specific survival for melanoma patients diagnosed in Ireland during 1994-2008, and selected results are presented here. Descriptive statistics on incidence, stage, survival, and survival variations were assessed by Cox modelling.

**Results:** We found that in situ melanomas were less frequent proportionately in the most deprived compared to the least deprived group (29% v 32%), as were stage I melanomas (42% v 47% of invasive cases). Five-year survival from invasive melanoma averaged 81% for the most deprived compared with 86% for the least deprived group overall (age-sex-adjusted hazard ratio 1.33, 95% CI 1.11-1.58), in men, 71% v 73% (HR 1.47, CI 1.16-1.84); in women, 88% v 90% (HR 1.17, CI 0.89-1.52). Depreciation-related disparities in survival appeared to occur throughout the study period, and appeared less marked for women. Significant disparities remained for the most deprived group after adjustment for stage, overall (HR 1.22, CI 1.01-1.45) and in men (HR 1.35, 1.06-1.72). A high proportion of deaths from melanoma occurred among farm owners, farm managers and horticulturists or their spouses.

**Discussion:** We found significantly poorer survival outcome for those from the most deprived areas, particularly in males and those in the 50-99 year age group. Stage explained about a third of excess mortality risk in the highest deprivation stratum. Several other factors may be at play here, including other unidentified prognostic, lifestyle or treatment-related factors. Occupation may reflect some of these factors. It is important when planning a national cancer strategy, screening programmes and public education to consider these potential discrepancies in incidence and survival and tailor campaigns to those at greatest risk.

**HIGH-DEFINITION OPTICAL COHERENCE TOMOGRAPHY: NEW IMAGING TECHNIQUE FOR**

**Boone, Marc**; Norrenberg, Sarah; Jemec, Gregor; Del Marmol, Véronique

Université Libre de Bruxelles, Belgium

**Background:** With the development of non-invasive therapies for non-melanoma skin cancer such as photodynamic therapy and immune therapies, the non-invasive diagnosis and monitoring become increasingly relevant. High-definition optical coherence tomography (HD-OCT) is an imaging tool, with cellular resolution up to a depth of around 570 μm.

**Objective:** We sought to determine firstly the feasibility of detecting basal cell carcinoma (BCC) and distinguishing between different BCC subtypes and secondly the utility of detecting and grading of actinic keratosis (AK) by this technique using criteria defined for reflectance confocal microscopy and conventional optical coherence tomography and compared to histology.

**Method:** Skin lesions of 21 patients with a histologically proven BCC and 17 patients with AK were imaged by HD-OCT just before excision and images analysed qualitatively.

**Results:** Features for 4 different BCC subtypes were described in both transversal and axial direction. In general these features were subepidermal or intradermal aggregations of cells. These islands were surrounded by a less refractile border corresponding with palisading and perpendicularly mucin production. There was a pronounced architectural disarray of the epidermis. A variably refractile stratum together with abundant dilated peritumoral blood vessels were present. In AK an atypical honeycomb pattern in variable degree or a disarranged epidermal pattern could be observed. A good correlation between the dimension of atypia and/or disarrangement of the spirous-granular layer or en face images and the histopathological grading could be demonstrated. Relevant cross-sectional imaging criteria could be defined for the different histopathologic variants and grading of AK.

**Conclusion:** Using features already suggested by reflectance confocal microscopy and conventional optical coherence tomography, these studies imply that HD-OCT not only facilitates in vivo diagnosis of BCC and the distinction between different BCC subtypes, it also permits in vivo diagnosis of AK and grading of AK lesions for increased clinical utility.

**DERMATOFIBROSARCOMA PROTUBERANS: ANALYSIS OF MARKERS OF CELL PROLIFERATION, INVASIVENESS AND APOPTOSIS, STUDY OF FUSION COL-1A1/PDGFB-J BY FISH AND CORRELATION WITH RELAPSE**

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**Introduction:** Dermatofibrosarcoma protuberans is a tumor of low incidence and present controversies in its management. It is not usually lethal but treatment can be mutilating to patient.

**Objectives:** Evaluate immunohistochemical markers of invasiveness, apoptosis and cell proliferation, the presence of fusion genes COL-1A1/PDGFβ-J by FISH and correlate with relapse.

**Results:** Of 61 patients, only 6 had relapses. No patient operated with a safety margin of at least 3 cm had recurrence. There was only one recurrence in patients treated with surgical margins of at least 2 cm. Among patients operated on HACC, those who received the first treatment at HACC had lower relapse rate than patients relapsed after treatment at other hospitals, but there was no statistical significance. The frequency of recurrences in these patients was 77.8%.

Patients with the translocation had recurrence of 5.7%, while patients without the translocation had recurrence of 30%. The immunohistochemical markers did not correlate with the recurrence rate, but when considering only patients treated with lower margins than 3 cm there was relation with the expression of FASL.

**Conclusion:** The surgical margins smaller than 2 cm are associated with higher recurrence rate. Among the immunohistochemical markers studied, the FASL correlated with recurrence rate in patients treated with lower margins than 3 cm. The presence of chromosomal translocation seems to influence prognosis.

**SEX-RELATED LOCATION OF HEAD AND NECK MELANOMA STRONGLY ARGUES FOR A MAJOR ROLE OF SUN EXPOSURE IN CARS AND PHOTOPROTECTION BY HAIR**

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(1) Service de Dermatologie, Hôpital Robert Debé, Reims, France; (2) Unité d’Aide Méthodologique, Hôpital Robert Debé, Reims, France; (3) Unité d’Aide Méthodologique, Hôpital Maison Blanche, Reims, France; (4) Service de Médecine du Travail et Pathologies Professionnelles, Hôpital Sébastopol, Reims, France

**Aim of the investigation:** Head and neck melanomas (HNM) are frequent and have a poorer prognosis than melanomas at other sites. Photoprotection in these locations is difficult. We wanted to study the topographical distribution of head and neck melanomas (HNM) and to compare it between men and women to clarify their pathogenesis.

**Materials and Methods:** Retrospective population-based study in a French region between 2004 and 2009.

**Results:** 279 HNM were diagnosed and major differences were found between genders. A clear-cut, sex-related distribution was found between a “peripheral” area (scalp, forehead, temples, ears, neck) and a “central” one (other parts of the face), with 56.7% of HNM being located in the peripheral area in men, versus 79.3% in the central area in women (p<0.0001). Moreover, HNM located in the peripheral area occurred on the left side in 57.6% of men and on the right in 73.1% of women (p=0.009). Peripheral HNM differed from central HNM by a higher proportion of invasive tumors, nodular or superficial spreading melanomas and a lower proportion of lentigo maligna melanomas. We hypothesized that this differential distribution between men and women could be explained mostly by a major role of long-term photoprotection by hair and sun exposure in a car.

**Conclusions:** Important public-health messages could result from these observations, such as the role of hair in photoprotection and the importance of reducing sun exposure in a car, particularly in professional drivers.
BACKGROUND: alpha2B-INFONEROTHERAPY IS CURRENTLY THE STANDARD OF CARE FOR PATIENTS WITH HIGH RISK FOR RELAPSE. alpha2B-INFN HAS SHOWN DISEASE-FREE SURVIVAL BENEFITS BUT NO SIGNIFICANT IMPROVEMENT IN OVERALL SURVIVAL. HERE WE REPORT CLINICAL RESULTS

Kukushkina, Mariia; Korovin, Sergii; Fil'chakov, Fedosoy; Kukushkina, Svetana; Shumilina, Katerina; Palvets, Andriy; Lon, Anna; National Cancer Institute, UKR

Background: alpha2b-interferonotherapy is currently the standard of care for patients with high risk for relapse, alpha2b-INFN has shown disease-free survival benefits but no significant improvement in overall survival. Here we report clinical results of combined r- and alpha2b- interferonotherapy in stage IB-IIIC cutaneous melanoma patients.

Methods: The study was performed in the period since 2008 to 2010 and included 71 patients with stage IB-IIIC cutaneous melanoma after wide excision of primary tumor without sentinel lymph node biopsy (median age 50.4 years, age range 18-68 years, 20 male). Group I consisted of 33 patients, who were administered 0.5 MU r-INFN on 1, 3, 5, 7, 9 days around the postoperative scar, then subcutaneous administration of recombinant alpha2b-INFN in a dose of 3 MU three times a week for 12 months. The expression of activation antigens and the functional activity of peripheral blood lymphocytes were investigated during the treatment in the both groups.

Results: Toxicity was manageable and reversible in both groups. 2-years disease-free survival in Group I is 84.8±6.2 %, in Group II 78.9±6.6 %; overall survival in Group I is 93.9±4.1 %, in Group II is 86.8±5.4 %. Mitogenic-induced proliferation in vitro of peripheral blood lymphocytes was increased in Group I, but decreased in Group II (p<0.05). The expression of the anti-apoptosis (Bcl-2) gene was increased in Group II. In the both groups wasn't detected essential influence on the activation of antigen expression in peripheral blood lymphocytes.

Conclusions: Therefore, the results obtained were more favorable in Group I. However, differences in 2-year survival percentage between the groups were not statistically significant (p>0.05). But in our opinion, the combined successive use of r- and alpha2b-INFN requires further research.

CLINICAL BENEFIT ASSESSMENT OF PATIENTS WITH ADVANCED BASAL CELL CARCINOMA (aBCC) TREATED WITH VISMODEGIB

Dreno, Brigitte1; Schadendorf, Dirk; Bassett-Seguin, Nicole2; Caro, Ivo3; Rajovic, Milica3; Zolotarevski, Lidija4; Mijuskovic, Zeljko1; Rajovic, Milica1; Ivor4; Yue, Huibin4

(1) CHU-Nantes, Nantes, France; (2) Universitätsklinikum Essen, Essen, Germany; (3) Hôpital Saint-Louis, Paris, France; (4) Genentech Inc, 1 DNA Way, South San Francisco, CA, USA

Aim: In the pivotal ERIVANCE BCC trial, patients with metastatic and locally advanced BCC (laBCC) received 150 mg oral vismodegib daily. The primary endpoint (objective response rate [ORR]) was achieved and 12-month updated data (to 28 November 2011), minimum potential doubling time of 21 months, confirmed the clinical benefit of vismodegib in aBCC through durable response. An Independent Panel Review (IPR) consisting of 3 clinicians with experience treating aBCC reviewed patient photographs to further validate the clinical benefit of vismodegib treatment for patients with laBCC.

Methods: The IPR performed an individual review of baseline disease severity (BDS) for patients with laBCC (scored from 5 [very severe] to 1 [mild]) and the duration of clinical benefit of treatment obtained by each patient (scored from 5 [significant clinical benefit] to 1 [significant worsen]), followed by consensus review using a pre-defined charter.

Results: All but 2 efficacy-evaluable patients (n=63) had photographs from all assessment timepoints. By consensus review, 71.4% of patients had BDS of 5 or 4 (very severe: 58.7%, moderately severe: 12.7%). A clinical benefit score (CBS) of 5 or 4 was observed in 76.2% of patients (significant clinical benefit: 65.1%; some clinical benefit: 11.1%). Inter-reader variability was low, with a maximum difference among the 3 reviewers of ±1 in 65.1% and 87.9% cases for BDS and CBS. Only 1 patient was considered unevaluable due to lack of agreement between reviewers. The CBSs showed good concordance with the IPR-specified independent review facility for assessment of response.

Conclusions: These data are consistent with efficacy results for patients with laBCC from the ERIVANCE study (ORR, duration of response, disease control rate, and duration of clinical benefit of treatment obtained by each patient). The clinical benefit assessment by an independent review of experts based on clinical judgement provides strong supporting evidence that treatment with vismodegib results in clinically-meaningful responses in patients with laBCC.

VITAMIN D RECEPTOR GENE POLYMORPHISMS ARE ASSOCIATED WITH INCREASED MELANOMA RISK

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Aim of the investigation: It has been reported that genetic polymorphisms in vitamin D receptor gene (VDR) are associated with the occurrence of various cancers including melanoma. The aim of this study was to investigate the association of VDR gene polymorphisms (FokI, EcoRV, TaqI and Apal) with melanoma risk.

Methods: The study group consisted of 76 patients (9 male, 37 female, median 52, range 23-83 years) treated from 2009-2012 were assessed in samples from stage IV melanoma patients. 51 patients with superficial spreading melanoma (SSM) and 19 with nodular melanoma (NM). Patients with other melanoma subtypes were excluded. Control group consisted of 91 healthy individuals of the same ethnicity, matched in gender and age. VDR gene polymorphisms FokI, EcoRV, TaqI and Apal were determined using the Real Time PCR method. Obtained data were statistically analyzed and all associations were considered as significant when p values were less than 0.05.

Results: The statistically significant differences in the frequencies of the VDR genotypes were observed between the patients and control group for the FokI polymorphism (p<0.001, OR=2.19, 95% CI=1.12-4.27). After adjustments with the potential confounders, statistically significant increase of melanoma risk was observed for heterozygote genotype F1 of FokI polymorphism (OR=2.499, p=0.000), in comparison with wild type FF genotype. In contrast, FF was associated with 10-fold increased melanoma risk compared with the wild type (OR=10.878, p=0.000). Significantly increased risk for melanoma was noticed for heterozygote Eco RV genotype (OR=2.527, p=0.022) compared with common ee genotype. In addition, EcoRV polymorphism was associated with the clinicopathological type of melanoma (SSM vs. NM, p=0.000).

Conclusions: Our findings indicate that FokI and EcoR poly- morphisms in vitamin D receptor gene may be considered as potential biomarkers for melanoma susceptibility. Also, different genotypes were observed for superficial spreading and nodular melanoma.
EPITHELIAL-MESENCHYMAL TRANSITION IN METASTATIC CUTANEOUS SQUAMOUS CELL CARCINOMAS

Toll, Agustí1; Hernández, M. Inmaculada2; Hernández, M. Eugenia1; Fernández-Pulido, Carolina3; Mastererr, Emil1; Yévenes, Mireia4; Jaka, Ana5; Víllegas, Carla6; Mora, Anna4; Sarro, Teresa4; Gimeno, Javier1; García-Patos, Vicenç1; Pujol, Ramon M1

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Objective: The aim of the study was to evaluate the clinical and dermoscopic characteristics of metastatic cutaneous squamous cell carcinoma (cSCC) compared to locally advanced metastatic cutaneous SCC. Metastatic cSCC is a rare but serious disease with poor prognosis.

Methods: A retrospective study was conducted on all patients diagnosed with metastatic cSCC at the Department of Dermatology of the Hospital de la Mar, Barcelona, between January 2004 and December 2014. Both clinical and dermoscopic data were collected.

Results: A total of 122 patients were included, of whom 111 had metastatic cSCC and 11 had non-metastatic cSCC. The median age was 68 years (range: 18-95) and 69% of the patients were male. The most common site of metastasis was the lymph nodes (60%). The median time from diagnosis of the primary lesion to the diagnosis of metastasis was 36 months (range: 0.1-216). The most common clinical features were redness (83%), scaling (66%), and ulceration (58%). The most common dermoscopic features were irregular pigment network (59%), plaque-like appearance (48%), and hypo-reflective color change (40%).

Conclusions: Metastatic cSCC is a serious disease with a high morbidity and mortality. Early diagnosis and appropriate treatment are crucial to improve outcomes. Further research is needed to identify better prognostic markers and develop more effective treatment strategies.

FREE COMMUNICATIONS II
Ambar Meeting Room
Friday, November 18th
17.40-17.47 h.
Results: Ninety-eight lesions from 56 patients were finally included. At the post treatment evaluation, in 25 of 58 lesions, one or more of the RDPC were identified dermoscopically and a histopathologic examination confirmed the existence of residual disease. In 45 of the 73 remaining lesions, dermoscopy revealed presence of red/white structureless areas and/or superficial fine telangiectasias, while 28 lesions did not exhibit any discernable criterion of sBCC. The lesions of the two latter categories entered follow-up. The disease recurred in only twelve lesions until the end of the study period.

Conclusions: RDPC can accurately predict the existence of residual disease. Absence of dermoscopic criteria of sBCC safely predicts complete histopathologic clearance. In case of post-treatment presence of red/white structureless areas and/or superficial fine telangiectasias, lesions should be closely monitored to recognize early recurrence.

Aim of the Investigation: Emergence of novel therapies for mBCC highlights the need to understand mBCC epidemiology. Estimating mBCC incidence is difficult due to: 1) rarity of mBCC; 2) lack of a systematic reporting for BCC and mBCC in population-based cancer registries. In the literature, mBCC incidence among BCC patients ranges widely (0.0028%-0.55%) and estimates are from small, selected case series (Wadhera, 2008). We conducted a retrospective analysis to identify and describe mBCC occurrence in Denmark. To our knowledge, this is the first mBCC incidence estimate from nationwide population-based data.

Subjects and Methods: Multiplicationwise medical registries were leveraged to identify mBCC patients: Danish National Patient Register (DNPR), Danish Cancer Registry (DCR), National Pathology Registry (PR) and Cause of Death Registry (CDR). Individual-patient data were linked across registries. We designed four clinical algorithms to identify mBCC patients: 1) mBCC diagnosis in PR; 2) BCC diagnosis in DCR and metasteses diagnosis in DNPR; 3) BCC diagnosis associated with a likely topographic site of metastases in PR; 4) BCC registered as a cause of death. We calculated the cumulative incidence proportion (CIP) and incidence rate (IR) of mBCC in the Danish population. The CIP for mBCC among BCC patients (n=126,627) was also calculated.

Results: We identified 5-170 mBCC cases (depending on the algorithm) from 1997 through 2010. The 14-year CIP was 0.00010% to 0.00327%. The IR ranged from 0.00635-0.22194 per 100,000 person-years. Among patients already diagnosed with BCC during the study period, the 14-year CIP of mBCC ranged from 0.0039% to 0.1343%. Only 4.3% (5/117) of the PR-identified cases were confirmed as mBCC upon pathologist review.

Conclusions: mBCC incidence among patients with BCC in this population-based study was consistent with the lower range of incidences reported in the literature.
**P01**

**NOVEL ROLES OF THE MATRIX METALLOPROTEINASE MT1-MMP AS A METASTASIS DRIVER IN MELANOMA**

Shaverdashvili, Khvaramzee; Wong, Poki; Bedogni, Barbara  
Case Western Reserve University, USA

Our lab identified Membrane Type 1 Matrix metalloproteinase (MT1-MMP) as a key tumor promoting and prometastatic gene whose expression changes dramatically during progression from normal nevi to primary tumors and to fully metastatic cancer. MT1-MMP belongs to a large family of enzymes called matrix metalloproteinases (MMPs). Their main function is to digest the proteins that compose the intricate mesh of the extracellular environment and that create what is known as the extracellular matrix (ECM).

Indeed, our data show MT1-MMP affects melanoma invasion and metastasis, but can also influence melanoma cell growth. These observations, in conjunction with the fact that the increase in MT1-MMP expression demarcates the transition zone between thin melanomas and melanoma with intermediate Breslow’s thickness, has led us to speculate that MT1-MMP is a novel metastasis driver able to control multiple aspects of the pathogenesis of melanoma.

The goal of my research is to investigate the mechanisms by which MT1-MMP promotes melanoma progression and metastasis. Metastasis is very difficult to study in human due to its complex nature. Therefore, it is necessary to create animal models that enable us to mimic this process. We engineer shRNAs in malignant melanoma cells against MT1-MMP and inject in mice subcutaneously and study distant tumor formation.

We found MT1-MMP knock down not only inhibits melanoma invasion and abrogates metastasis, but also affects melanoma cell growth. Mechanistically, MT1-MMP is able to activate a number of growth, survival and embryonic pathways and to inhibit the expression of tumor suppressor genes that contributes to pathogenesis of different cancers.

We hypothesize that MT1-MMP operates as a metastasis driver by coupling its pro-metastatic functions to pro-growth and pro-survival activities, overall contributing to malignant melanoma. The ultimate goal of our research is to translate this knowledge into new therapeutic strategies for the effective treatment of melanoma.

**P02**

**HIGH EXPRESSION OF FOX-P3 IN PRIMARY MELANOMA IS ASSOCIATED WITH TUMOR PROGRESSION**

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Tumor thickness according to Breslow and nodal status are the most important prognostic factors for melanoma.

**Aim of the Investigation:** We aim to define new prognostic markers for malignant melanoma.

**Materials, Subjects and Methods:** 191 routinely paraffin embedded primary melanomas were immunohistochemically stained with monoclonal antibodies against the markers granzyme B, TIA-1, Foxp3 and langerin. Marker expression was assessed using a digital analysis system and compared to conventional counting under a light microscope. Marker expression was then correlated with the clinical outcome (median follow up time 7.3 years).

**Results:** There was a good correlation between marker assessment by digital image analysis system and conventional counting. Foxp3 and TIA-1 was significantly higher expressed in primary melanoma which showed tumor progression. Granzyme B was also slightly increased in these tumors whereas langerin expression in the epidermis and dermis was slightly lower. However, the differences for these markers were not significant.

**Conclusions:** The use of different immunohistochemical markers may give us more information about the prognosis of melanoma. High expression of Foxp3 in the primary tumor may indicate early tumor progression.

**P03**

**THE ROLE OF GALECTIN-3 IN PRIMARY CUTANEOUS MELANOMA**

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**Aims of the investigation:** Galactin-3, one of the β-galactoside-binding lectins, has been suggested as a marker of disease progression in melanoma patients because of its overexpression observed in recent studies. However, prognostic value of galectin-3 in primary cutaneous melanoma (PCM) has not been clearly defined. The aim of the study is to analyze whether the intensity of galectin-3 expression can predict survival in patients with PCM.

**Methods:** Galectin-3 expression was evaluated by immunohistochemistry in 104 PCM samples, including 71 (68.2 %) superficial spreading (SSM) and 33 (31.8 %) nodular melanomas (NM). Results: Significant difference of galectin-3 expression between SSM and NM was determined (p<0.001). Increased galectin-3 expression was positively correlated with tumour thickness (p<0.001), Clark (p<0.001) and Breslow (p<0.001) stage, mitotic rate (p<0.001), presence of ulceration (p<0.001), lymphatic invasion (p<0.001), positive sentinel lymph node (p=0.025), and location of tumour on upper extremities (p<0.001). Kaplan-Meier analysis showed an association between increased galectin-3 expression and reduced recurrence-free survival (RFS) (p=0.001) and reduced disease-specific survival (DSS) (p=0.013). In Cox proportional hazards regression analysis significant predictors of reduced RFS were: positive sentinel lymph node (p=0.025), and lymphovascular invasion (p=0.1), whereas predictors of DSS were: tumour thickness (p=0.012), lymphovascular invasion (p=0.047), Clark stage (p=0.029), and location of tumour on upper extremities (p=0.024).

**Conclusions:** Our results support the potential role of galactin-3 in PCM development, progression and metastasis. Moreover, galectin-3 could serve as an additional prognostic marker that might help in further stratifying the risk of disease progression and metastasis in patients with PCM.

**P04**

**T-TYPE CALCIUM CHANNEL BLOCKERS PROMOTE APOPTOSIS OF MELANOMA CELLS BY INHIBITING AUTOPHagy**

Marti, RM1; Das, A1; Herrera, J1; Pushpaajai, C1; Vitella, R1; Portero, M1; Pamplona, R1; Matias-Guiu, X2; Cantí, C3  
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(3) Department of Pathology and Molecular Genetics, Hospital Universitari Arnau de Vilanova, University of Lleida, IRB Lleida, Lleida, Spain

**Aim of the Investigation:** We have recently reported that human melanoma cells express a variety of voltage-gated calcium channels, including low voltage-activated T-type channels which play a significant role in cell cycle progression. Here we challenged melanoma cells with T-type channel blockers of clinical use and carried out an in-depth study about their effects on cell viability and homeostasis.

**Materials, Subjects and Methods:** We used seven malignant metastatic melanoma cell lines, which were challenged with the T-type channel blockers mibefradil and pimozide. The effects of T-type channel blockers on cell viability were examined by metabolic assays, BrDU incorporation and cell cycle analysis by propidium iodide. The induction of apoptosis was investigated by activation of caspases 9 and 3 in Western Blot analysis. The implication of the Upf1 unfolded Protein Response and macroautophagy was demonstrated by WB determinations of different molecular chaperones and effectors of these pathways. The molecular targets of T-type channel blockers were confirmed by sirNA-mediated knockdown of genes encoding T-type channels isoforms.

**Results:** The viability of metastatic melanoma cells was dramatically reduced after 24 hours treatments with mibefradil and pimozide, which exerted a dual effect: 1) reduction of the proliferation rate and 2) induction of the intrinsic cell death pathway. An in-depth analysis of the death process showed that the apoptotic pathway is preceded by ER-stress and subsequent inhibition of the basal macroautophagy active in melanoma cells. Furthermore, we identified Ca3.1 and Ca3.2 T-type Ca2+ channel isoforms as the targets of T-type channel blockers-mediated effects.

**Conclusion:** These results identify T-type channels as new molecular targets to deregulate autophagy in melanoma cells and provide a basis for a new pharmacological and/or gene silencing approach towards tackling melanoma metastasis.
**GUIDED POSTER TOUR 1**

**Thursday, November 15th**

**P05**

**DIFFERENTIATION OF MELANOMA CELL LINES BY CONDITION MEDIUM AND MELANOMA ASSOCIATED FIBROBLASTS**

Kodet, Ondrej1; Lacina, Lukas1; Dvorankova, Barbora1; Stork, Jiri1; Dvorak, Petr1; Smetana, Karel1

1) Institute of Anatomy, First Faculty of Medicine, Charles University Prague, Czech Republic; 2) First Faculty of Medicine, Charles University in Prague and General University Hospital in Prague, Czech Republic; 3) Institute of Medical Biology, UTAR, Singapore; 4) Department of Biology, Faculty of Medicine, Masaryk University, Brno, Czech Republic

**Aim of the study:** Complexity of the tumor microenvironment significantly influences the function of tumors and contributes to the progression of cancer. Tumor associated fibroblasts are one component of the tumor microenvironment. The function of stromal fibroblasts is well documented in tumors derived from squamous epithelium from head and neck. Similar mechanisms can be also expected in other tumors such as melanoma.

**Materials and Methods:** In this study we focused on cell culture of melanoma lines under different condition and co-culture system with melanoma associated fibroblast. Expression of specific differentiation melanoma markers studied by immunocytological analysis.

**Results:** We had two phenotypically similar melanoma lines, which were negative for typical differential melanocytic markers like HMB45, tyrosinase and melan-A/ MART-1. We used melanoma associated fibroblasts and this melanoma lines in indirect culture with aim to monitor changes at the level of differentiation markers. The results was in induction expression of the differential melanocytic markers in melanoma lines, but only in short culture for 3 days. Studied lines lost this ability during prolong culture for 14 days. When we used condition medium from human embryonic cells in this system indirect culture, we were able to detect the expression of specific markers even in prolong culture for 14 day. It was interesting that the conditioned medium was able to induce uniform changes compared with melanoma associated fibroblasts.

**Conclusion:** The result of this study demonstrated the function of melanoma associated fibroblasts, their possible influence to the expression of differential melanocytic markers and a certain similarity to the embryonic microenvironment. The biological activities of melanoma associated fibroblasts may be crucial to keep the tumor microenvironment.

**GUIDED POSTER TOUR 1**

**Thursday, November 15th**

**P06**

**EPITHELIAL-MESENCHYMAL INTERACTION IN CANCER AS POTENTIAL TARGET FOR ANTICANCER THERAPY**

Szabo, Pavol1; Smetana, Karel1; Dvorankova, Barbora1; Kodet, Ondrej1; Kolar, Michal1; Strnad, Hynek1

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Many results demonstrate that cancer cells need for their growth and spread through organize a specific microenvironment-the tumor stroma. Tumor stroma contains, except the mesenchyme, also blood vessels, which are important in nutrition of tumor cells and the inflammatory cells. We focused our research on most abundant cell component of cancer stroma on cancer-associated fibroblasts (CAF). They are producers of extracellular components, which are necessary to formation bioactive cancer microenvironment and are able to influence the biology of tumor predominantly the differentiation status of tumor cells and their migratory potential.

We have isolated CA from malignant tumors (squamous cell carcinoma, basal cell carcinoma (BCCF), melanoma, and skin metastasis of breast cancer) and have shown that these CA are able to influence the differentiation status of co-cultured cells from normal squamous or breast cancer epithelium. The results were compared with control experiments using normal human dermal fibroblasts, 3T3 mouse fibroblasts, and 3T3 fibroblasts influenced by the fibroblasts prepared from the breast carcinoma. Our results demonstrated that expression of luminal marker keratin 8 was influenced only by CAF prepared from any tested tumors. In contrast, all tested types of fibroblasts showed a strong stimulatory effect on the expression of basal/myoepithelial cell keratin 14. Since keratin 14 is a marker of basal myoepithelial cells and keratin 8 is a marker of luminal cells, these double-positive cells can be considered for precursor cells with properties close to stem cells. Their presence in clinical samples indeed signals very poor prognosis in cancer-suffering patients. In conclusion, our data indicate that CAFs are able to influence the phenotype of a breast cancer cell line and this effect is based on a tumor type-unspecific mechanism.

**ROLE OF CPI-17 GENE IN RECONSTITUTION OF SKIN HOMEOSTASIS IN AK LESIONS**

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Actinic keratoses (AK) are precancerous lesions which are caused in part by the carcinogenic effect of the UV genotoxic photoproducts cyclobutane pyrimidine dimmers CPD and 6-4 photoproducts (6-4PPs). Photoactivation is a repair mechanism carried out by photolyases which specifically recognize and repair either CPDs or 6-4PPs. Beneficial effect of such enzyme into AK treatment has been recently postulated. The aim of the study was to analyze the molecular effect of a film-forming medical device containing photolyase and UV filters in 7 AK patients using expression array approach and bioinformatics methods.

Skin recovery after treatment was confirmed in all patients by histopathological and molecular data with found overrepresentation of genes involved in cell-cell communication, cell adhesion and homeostasis. The AK response was associated to overexpression of CPI-17 gene and determined by the initial expression level of the gene (P-value=0.001). Low levels of CPI-17 were directly associated to proinflammatory genes such as TNF (P-value=0.012) and IL-1B (P-value=0.07). Gene set analysis found that skin recovery was associated to biological process involved in tissue homeostasis and cell maintenance. This study suggests a role of CPI-17 gene in restoring skin homeostasis in AK lesions.

**YES-ASSOCIATED PROTEIN 1 (YAP1) PROMOTES MELANOMA METASTASIS**

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YAP1 protein, the transcription cofactor acting downstream in the Hippo pathway for tissue homeostasis. The AK response was associated to overexpression of CPI-17 gene and determined by the initial expression level of the gene (P-value=0.001). Low levels of CPI-17 were directly associated to proinflammatory genes such as TNF (P-value=0.012) and IL-1B (P-value=0.07). Gene set analysis found that skin recovery was associated to biological process involved in tissue homeostasis and cell maintenance. This study suggests a role of CPI-17 gene in restoring skin homeostasis in AK lesions.
GUIDED POSTER TOUR 1
Thursday, November 15th
Experimental Studies

P10
CAPTURING THE BIOLOGICAL IMPACT OF THE STATUS OF CDKN2A AND MC1R GENES IN COCULTURED HUMAN KERATINOCYTES AND MELANOCYTES: IDENTIFICATION OF Deregulated PATHWAYS
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Individuals carrying germline mutations in CDKN2A gene and/or non functional RHCs (RHC) in MC1R gene show an increased susceptibility to develop melanoma. To date, the effect of germlinal CDKN2A mutation and RHC MC1R variants in skin cells has been poorly studied. Melanocyte growth and behaviour is controlled by keratinocytes through a complex system of paracrine growth factors and cell–cell adhesion molecules which regulate the epidermal homeostasis. Thus, in-vitro studies focused exclusively on melanocytes not reflect the in-vivo conditions. The aim of the study was to identify molecular networks associated to presence of either germline mutations in CDKN2A or RHC variants in MC1R genes which may be related with the biological impact of both genes into melanoma susceptibility.

Keratinocytes and melanocytes were obtained from two pairs of siblings belonging from two familial melanoma pedigrees regarding their germinal status of both genes. After enzymatic digestions cells were co-cultured and the global RNA was analyzed by expression arrays. Differential gene expression data (1535 transcripts deregulated in CDKN2A mutated cells and 3570 in MC1R carriers variants) was analyzed by the web-based tool SNOW.

Statistically significant networks were identified among down regulated transcripts. Overall, 24.7% of genes in CDKN2A mutants and 27.8% in MC1R carriers variants were connected into molecular networks. The network cores were genes involved in autophagy vacuole formation (GABARAPL2, MAP1LC3A, ULK1) or co-regulators of autophagy and/or apoptosis (BAX, BCL2L11, Sestrin1, Sestrin3, PRKAA1, LC3D).

28.5% of upregulated transcripts in RHC MC1R cells carrying variants were in a network in which the core was composed by genes playing a role in oxidative phosphorylation and mitochondrial ribosome (GBAS, ICT1 and PRKAA1).

Our results suggest that variants in both genes promote autophagy deregulation in skin cell types. Also, we have identified genes involved in the cellular levels of reactive oxygen species in MC1R carrier variants. In summary, key molecular functions and/or pathways that are deregulated such as Parkinson’s, Alzheimer and Huntington. In contrast, downregulated genes were associated to lysosome and endocytosis pathways which are directly related with melanosome transfer from melanocytes to surrounding keratinocytes or with biological functions linked to melanin synthesis and angiogenesis. Therefore, in-vivo studies should be involved in initiation/ progression of the disease.

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Experimental Studies

P11
DISTRIBUTION OF MC1R VARIANTS AMONG MELANOMA SUB-TYPES: PR163Q IS ASSOCIATED WITH LENTIGINOUS MALIGNA MELANOMA IN A MEDITERRANEAN POPULATION
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Melanoma tumour is classified into clinico-histopathological subtypes which is associated with different genetic and host factors. Few studies have focused on the role of MC1R gene beyond the study of melanoma risk in individuals.

The aim was to analyze whether certain MC1R variants are associated to particular melanoma subtypes with specific clinico-histopathological features.

Clinico-pathological data of primary melanoma tumours derived from 1679 patients and the germinal status of MC1R gene were included in the study. We detected 53 MC1R variants (11 synonymous and 43 non-synonymous). Recurrent non-synonymous variants were p.V96L (29.9%), p.v92M (11.7%), p.D929H (4.9%), p.R151C (8.8%), p.R160W (6.2%), p.R163Q (4.2%) p.R142H (3.3%), p.I155T (3.8%), p.V122M (1.5%) and p.D146E (1%). Melanoma subtypes showed differences in number of total MC1R variants (P-value=0.028) and number of Red hair colour variants (P-value=0.035).

Furthermore, an association was observed between the p.R163Q variant and lentigo maligna melanoma subtype was de- tected under a dominant model of heritance (OR: 2.16 95%IC: 1.07-4.37; P-value=0.044). No association was found between p.R163Q and skin phenotype, eye colour or skin colour indicating that the association was independently of the role of MC1R in pigmentation. No association was observed between MC1R polymorphisms and the other melanoma subtypes.

Our findings suggest that certain MC1R variants could increase the melanoma risk by means of their impact in pathways other than pigmentation and therefore be linked to specific etiopathological melanoma subtypes.

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Thursday, November 15th
Case Reports

P12
PROLIFERATING PERINEAL ULCERATIONS
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CHU Sart Tilman, Belgium

Background: Rapidly proliferating squamous cell carcinoma (SCC) is a rare, but the most feared complication of hidradenitis suppurativa (HS) of the anogenital region.

Case report: A 43-year-old man presented painful proliferations on his buttocks, progressively increasing in size. The lesions affected particularly the borders of the ulcerations of the longstanding HS. Besides multiple cutaneous cysts, recurring perianal abscesses, multiple perianal sinuses, extensive scar tissue and facial acne scars, his prior medical history was unremarkable. Clinical examination revealed multiple and easily bleeding tumors. Bilateral inguinal painful lymphadenopathies were evaluated. A PET SCAN showed hyperfixation of both inguinal lymph node areas. MRI revealed subcutaneous extensive tumor mass which is directly related with melanosome transfer from melanocytes to surrounding keratinocytes or with biological functions linked to melanin synthesis and angiogenesis. In summary, key molecular functions and/or pathways that are deregulated due to alterations in melanoma susceptibility gene have been elucidated using a co-culture system which in turn, could be involved in initiation/ progression of the disease.
ATYPICAL SPITZ TUMOR AND METASTATIC MALIGNANT MELANOMAS ARISING IN GIANT CONGENITAL MELANOCYTIC NEVUS: A CASE REPORT

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Purpose: A variety of malignancies have been reported to arise within congenital melanocytic nevi (CMN), but rarely atypical spitz tumor with metastatic malignant melanoma. We report a very unusual case of atypical spitz tumor with metastatic malignant melanoma arising in giant CMN.

Methods: A 25-year-old female presented with a protruding nodule (3 cm x 2 cm x 1.5 cm) that developed within a giant CMN on her left gluteal region and flank region. After excision, histopathologic evaluation showed atypical spitz tumor with spitzoid features distinguished from malignant melanoma. We recommended further evaluation and proper management but, she refused following our counsel.

Results: 9 months later, multiple palpable masses were found on the left shoulder and both thighs, and diagnosed as metastatic malignant melanoma. We thought that giant CMN was the origin of metastatic malignant melanoma, so wide excision on left gluteal and flank region and reconstruction were performed with palliative chemotherapies. Despite 5 years of therapies, metastatic melanomas were found continuously and patient died.

Conclusion: We experienced 25-year-old female who had atypical spitz tumor and metastatic malignant melanoma arising in giant CMN, which is very uncommon. So, we report an very uncommon case of atypical spitz tumor and metastatic malignant melanomas arising in giant CMN to discuss about our experience with relevant journal discussion.

EFFECTIVE CLEARANCE OF ACTINIC KERATOSIS WITH IMIQUIMOD 3.75%: CASE STUDY CONFIRMING THE NEED FOR REPEAT IMMUNE STIMULATION WITH TWO TREATMENT CYCLES

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Aim of the investigation: Imiquimod 3.75% is a new large field treatment for actinic keratosis (AK). Imiquimod stimulates an immune response and destroys clinically visible lesions in the treated area and can also reveal and treat sub-clinical lesions that were previously not detectable. To fully assess the efficacy of imiquimod 3.75%, novel efficacy parameters such as the reduction in lesion count from Lmax (maximum lesion count during treatment) have been introduced which take into account the clearance of clinical and subclinical lesions. The aim of this case study was to confirm the need for two treatment cycles with imiquimod 3.75% to ensure effective clearance of both clinical and subclinical AK lesions.

Materials, Subjects and Methods: The patient was treated with imiquimod 3.75% as part of a vehicle-controlled, double-blind study. The patient applied 2 sachets of treatment to the affected area each day for two weeks. This was followed by a period of two weeks without treatment, and then a second cycle of treatment. The patient was followed-up for a further eight weeks.

Results: This patient was white, male, 78.7 years old and had Latino ethnicity. The patient had 12 lesions at baseline with an increase to an Lmax of 30 during the first treatment cycle. By week 4 the patient had no clinical lesions; however during the second treatment cycle, 12 lesions became detectable which cleared by week 10 with no further lesions developing during the study.

Conclusions: Imiquimod 3.75% is currently the only treatment which can detect and treat both clinical and subclinical AK lesions on the entire face or balding scalp. For complete clearance of all lesions, including all subclinical lesions, two treatment cycles are required. These treatment cycles may lead to a more sustained long-term effect and possibly the best prevention of invasive squamous cell carcinoma.

AN IMMUNE-RELATED, RARE ADVERSE EFFECT OF IPILUMIMAB: AUTOIMMUNE NEPHRITIS; A CASE REPORT

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Ipiilumab is the first immunotherapeutic agent with survival prolonging effect in metastatic melanoma. Its adverse effects are related to the immune system. We present a patient with autoimmune nephritis that is a rare side effect in the course of ipilimumab therapy. According to the medical history of the 72-year old male patient a nodular melanoma (Clark V, Breslow 5 mm) was removed from the right shoulder region. Both lesions were treated with adjuvant low dose interferon-a. Chest CT in December 2009 visualized multiple pulmonary metastases. Chemotherapy was initiated. In spite of DTIC monotherapy followed by different combinations of chemotherapy the progression of the pulmonary status was associated with adrenal and osseal propagation by June 2011. Since no other relevant diseases had been recorded in his history and the patient was in a good physical condition, 3mg/kg/cycle ipilimumab therapy was started within the frame of the Expanded Access Programme (Bristol-Myers-Squibb). Double cerebral metastases developed having completed the first cycle of therapy, which was treated by stereotactic irradiation. Subsequent to the third ipilimumab treatment cycle, we observed Grade 2 dermatitis, diarrhea and febrile state that responded to oral and local steroids. We omitted the fourth treatment cycle because Grade 3 immune-originated nephritis developed. Blood chemistry resulted creatinine 2007 µmol/L, carbamide 42.8 µmol/L. 250 mg/day methylprednisolom turned to be ineffective so the patient needed continuous haemodialysis. Imaging studies performed in November 2011 did not identify progression, nevertheless multiple cerebral metastases were detected in March 2012. The most frequent immune-related adverse events of ipilimumab are dermatologic, gastrointestinal or endocrine, however other autoimmune diseases cannot be excluded, either. Our patient suffered from serious, haemodialysis-dependent nephritis while the basic disease was not progressing for 9 months.

AUTOIMMUNE NEPHRITIS; A CASE REPORT

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Introduction: Merkel cell carcinoma (MCC) is a rare neuroendocrine tumor of the skin. MCC from an unknown primary origin (MCCUP) can present a diagnostic and therapeutic challenge. When it happens within the lymph nodes in the absence of a primary site, it is even more rare and has only been reported sporadically.

Objectives: To describe a MCC of unknown origin presented as nodal disease, initially diagnosed as melanoma

Case report: We present a 68 years old male patient who developed groin lymphadenopathy. No cutaneous lesions were found. Fine needle aspiration (FNA) biopsy revealed malignant melanoma. No other site of disease was found during staging and we performed groin and iliac lymphadenectomy, in which 5 from 20 lymph nodes had metastatic disease, also reported as melanoma. The patient developed wound-healing problems and during its treatment he presented with a cervical node. FNA was unable to define the etiology so we performed excisional biopsy of the node. The immunohistochemistry (IHC) revealed MCC, which lead to a review of previous diagnosis and they were all considered MCC. Re-staging revealed metastatic disease in retroperitoneum and in right adrenal gland. The patient was referred to chemotherapy.

Discussion: There’s a controversy in literature about MCC form a regressed or unknown primary versus lymph nodal MCC. Nevertheless, it represents a very aggressive disease. In our case, it’s important to discuss the importance of HQ in the differential diagnosis between MCC and melanoma.
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Case Reports

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MELANOMA INDUCED AFTER 2 YEARS OF RITUXIMAB MAINTENANCE THERAPY
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Aim of the investigation: Rituximab is an anti-CD20 monoclonal antibody used in hematology and rheumatology, not associated with a known increased risk of cancer. We report an original case of invasive melanoma appeared after 2 years of rituximab maintenance therapy for a non-Hodgkin lymphoma (NHL).

Subject: A 45 year-old man developed a scalp tumour with a rapid evolution. Histological examination concluded to an ulcerated nodular melanoma, with a Breslow index of 4.8 mm. His main risk factors were his profile type 2 and 16 years of professional sun exposure as farmer. He was treated for 8 years for a NHL with successively, tonsil radiotherapy, 4 courses of weekly rituximab 4 years earlier, 6 courses of R-CHOP followed by rituximab maintenance therapy every 4 weeks for 2 years.

Discussion: Only one case of melanoma under rituximab had been previously published, but 14 additional cases have been collected in the European pharmacovigilance database. Rituximab targets B-cells, which play a key role in the control of proliferation and dissemination of malignant melanocytes: B-cells have antitumorigenic effects through antigen-presentation, enhancement of T cell response and direct antibody-independent cytotoxicity. In our patient, NLH itself (3-fold increase in the risk of developing a melanoma) and previous treatment with chemotherapy could have facilitated the development of melanoma under rituximab. Our observation raises the question of an increased risk of melanoma after a long-term use of rituximab in a maintenance therapy. Interestingly, recent articles reported promising results of use of rituximab in the treatment of melanoma, based on the discovery of tumour stem cells over-expressing CD20.

Conclusion: We report a case of primary melanoma with a fast growth, appeared after a maintenance therapy with rituximab for a NHL. Furthermore, our work has permitted to identify 14 additional unpublished European cases of melanoma under rituximab.

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METASTASIZING SQUMOUS CELL CARCINOMA DEVELOPED AFTER A METASTASIZING HIRADENOCARCINOMA: A CASE REPORT
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We report a 60-year old male patient. In 2005 a tumour diagnosed as a basal cell carcinoma was removed from his right scapular area. In 2008 a second tumour was removed from the same anatomical region. Microscopic examination of the biopsy revealed a recurrent hidradenocarcinoma with positive surgical margins. Re-excisional histology confirmed a recurrent hidradenocarcinoma extending to the deep surgical margin. The tumour infiltrated extensively the striated musculature, adipose tissue, invaded lymphatic vessels. Therefore the biopsy of 2005 was required for second opinion. The histologic review revealed an infiltrating and metatypical basal cell carcinoma and an eccrine carcinoma showing focal squamous cell metaplasia. Surgery was followed by irradiation. In 2010 several enlarged lymph nodes appeared on the right side of the neck. FNAB findings were consistent with metastatic hidradenocarcinoma. Block dissection of the right cervical lymph nodes was carried out, histology verified metastases of hidradenocarcinoma, infiltrating the lymph node capsule, spreading to the adipose tissue. Postoperative irradiation and combined chemotherapy followed. In 2011, a dense nodule appeared in the surgical scar of the cervical block dissection, a bleeding tumour in the right temporal region. The tumour of the scalp was removed, the histology revealed poorly differentiated squamous cell carcinoma showing perineural infiltration, invasion to the blood and lymphatic vessels. A sample excision was taken from the right side of the neck, which were consistent with metastatic squamous cell carcinoma. Immuno-histochemistry ruled out eccrine origin. The tumour was Her2 negative and almost 100% EGFR positive. Polyc chemotherapy was initiated. Chemotherapy associated with severe neuro- and nephropathy and local progression of the disease on the right side of the neck necroisated change to Erbitux therapy. The applied therapy has led to 2 weeks, then the tumour locally progressed. Distant metastases are still not known. We reported this case because of the simultaneous occurrence of two tumours, their metastasis formation to the same anatomical region and targeted therapy based on receptor determination.

P19

SEVERE TOXIC HEPATITIS AFTER FIVE WEEKS OF TREATMENT WITH VEMURAFENIB (ZELBORA®)
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The therapy with vemurafenib requires in 38% of patients due to side effects a dose modification or interruption of treatment (5%). The effect of concomitant drugs which are mostly metabolized by CYP1A2 and accordingly CYP3A4 can be increased or decreased by vemurafenib.

A 53-year-old patient with unresectable IIIC melanoma (metastases in the left axilla, parotid/intercostal muscles) received a treatment with vemurafenib in the beginning of 2012 as first-line therapy in context of an expanded access program. The metastases in the axilla shrunk during weeks significantly.

After 33 days the patient was hospitalized due to significant elevated liver enzymes (CTC grade 2-3). The treatment with vemurafenib was interrupted. The differential diagnosis included liver metastases, which were ruled out, a drug induced effect of vemurafenib alone or an interaction with the antiplatelet comedication (Levetiracetam, Oxcarbazepin, Gabapentin). A liver biopsy showed a portal, lobular, partial granulomatous hepatitis with involvement of the biliary tracts and a fibrosis of the portal fields. In conclusion we suspected a drug induced genesis (CTCAE grade 3).

A treatment with prednison and ursodesoxycholacid resulted in a fast decrease of transaminases and cholestatic parameters. The tumor assessment showed a nearly complete remission. Since we couldn’t clarify which drug or interaction caused the hepatitis the patient was not reexposed to vemurafenib. In order to achieve an improved local tumor control the axilla was treated by radiotherapy additionally. The patient showed a complete remission over a period of three months without any systemic treatment. In July 2012 we detected progressive axillary metastases and new visceral metastases.

The case demonstrates that even a short time treatment with vemurafenib can result in a significant therapeutic benefit. In case of severe side effects possible interactions of vemurafenib with a known concomitant medication should be considered. Especially patients with a known liver dysfunction should be monitored carefully.

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TWO CASES OF SPITZ NEVI ARISING IN THE CONTEXT OF FAMILIAL MELANOMA
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Aim of the Investigation: The aim of this poster is to report two cases of Spitz nevi occurring in a family with a history for melanoma. All of the patients were first degree relatives.

Materials, Subjects and Methods: A 7 year old patient presented with a pink papular lesion on her right thigh which was surgically removed and was later diagnosed as a classic Spitz nevus. The patient’s mother developed a pigmented lesion in her left lower leg six years later, which was also diagnosed as an atypical Spitz nevus. A year later, the grandfather of the patient, who was under immunosuppressive therapy due to a kidney transplant, developed malignant melanoma, located on the chest area. Follow up information including questionnaires on demographic and clinical-histopathologic data was obtained for all three patients.

Conclusions: The three family members developed different lesions which, for many authors, are considered as parts of the same disease spectrum, with the classic Spitz nevus on one side of the spectrum and malignant melanoma on the other. Although there are indications that Spitz nevi may be considered as true precursor lesions to melanoma and that their occurrence may a risk factor for its appearance, their malignant potential is considered very low. So, these patients are currently being followed up by regular clinical and histopathologic examinations. More studies are needed in order to clarify which drug or interaction caused the hepatitis the patient was not reexposed to vemurafenib. In order to achieve an improved local tumor control the axilla was treated by radiotherapy additionally. The patient showed a complete remission over a period of three months without any systemic treatment. In July 2012 we detected progressive axillary metastases and new visceral metastases.

The case demonstrates that even a short time treatment with vemurafenib can result in a significant therapeutic benefit. In case of severe side effects possible interactions of vemurafenib with a known concomitant medication should be considered. Especially patients with a known liver dysfunction should be monitored carefully.
Melanocytoma seems to be a misleading terminus. It is a rare, usually benign lesion that occurs in the skin or mucous membranes. However, it can also become malignant, evolving into melanoma. The patient described here was a 13-year-old girl with a cranial tumor measuring 7 cm in diameter. This tumor grew through the calotte bone and extended as a visible tumor at the scalp. It was a cranial tumor with necrotic areas. Immunohistochemistry showed Melan-A and other melanocytic markers in the tumor, consistent with melanocytic proliferations. Histopathological evaluations showed a melanocytic pleomorphic tumor with necrotic areas. The differential diagnoses were melanocytoma/melanoma versus desmoplastic melanoma and a lentigo maligno. The related case has clinical diagnostic of BDHS however other mutations on FCLN gene were not identified. The FCLN mutation can be observed in 84%-88% of patients with BDHS. CDKN2A is the main locus associated with melanoma susceptibility. In patients with multiple melanoma, CDKN2A mutations are detected in 8.3% to 15% of cases. In association with BDHS, the presence of melanoma was reported by Welsch et al and Toro et al. Coccione et al reported a 58-year-old man with BDHS that developed two desmoplastic melanomas and a lentigo maligno. Establishing incidence vs coincidence for malignant associations with rare conditions like BDHS is difficult. Although the question of whether mutated folliculin in BDHS predisposes patients to melanoma requires further investigation, it raises the possibility of the potential use of mTOR inhibitors in BDHS as a treatment option for the range of associated malignant neoplasms.

Case report: A 49-year-old woman presented with multiple asymptomatic facial benign neoplasm (fibrofolliculomas) of adult onset raising the possibility of BDHS. She also had a history of spontaneous pneumothoraces and the investigation demonstrated multiple lung cysts. The patient underwent genetic testing for mutations on CDKN2A gene that was also negative.

Discussion: The related case has clinical diagnostic of BDHS however germline mutations on FCLN gene were not identified. The FCLN mutation can be observed in 84%-88% of patients with BDHS. CDKN2A is the main locus associated with melanoma susceptibility. In patients with multiple melanoma, CDKN2A mutations are detected in 8.3% to 15% of cases. In association with BDHS, the presence of melanoma was reported by Welsch et al and Toro et al. Coccione et al reported a 58-year-old man with BDHS that developed two desmoplastic melanomas and a lentigo maligno. Establishing incidence vs coincidence for malignant associations with rare conditions like BDHS is difficult. Although the question of whether mutated folliculin in BDHS predisposes patients to melanoma requires further investigation, it raises the possibility of the potential use of mTOR inhibitors in BDHS as a treatment option for the range of associated malignant neoplasms.

MELANOCYTOMA OR MELANOMA: A CASE OF MENINGEAL MELANOCYTOMA WITH FATAL OUTCOME

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Introduction: Melanocytic proliferations of the meninges are designated as melanocytoma preferentially in the neurological literature and the diagnosis of melanoma has been described as ambiguous. Such a case is described in the following with its entire course.

Patient and methods: 13-year-old girl was diagnosed with melanocytoma. Imaging examinations and histopathological evaluations as well as the course of the disease are reported.

Results: The 13-year-old patient presented with an extensive intra-cranial tumor measuring 7 cm in diameter. This tumor grew through the calotte bone and extended as a visible tumor at the scalp. It was completely surgically removed without any remaining neurological defects. The differential diagnoses were melanocytoma/melanoma. Histopathological evaluations showed a melanocytic pleomorphic tumor with necrotic areas. Immunohistochemistry showed Melan-A - A positivity with low proliferative activity (MIB-1 Index <1%). There was no expression of protein S-100 and no clear expression of HMB-45 in the tumor tissue. A sequencing of the tumor revealed a GNAQ Q202R mutation, whereas no GNA11 mutation was detected. Additionally, comparative genomic hybridization was performed. This showed multiple aberrations, partly typical for melanoma. After a time period of 5 months, multiple recurrences around the previous tumor bed, addition to meningeal dissemination along the conus medullaris and the cauda equina, were detected by brain imaging. These were no longer resectable and rapidly progressing. The patient died after another 5 months after having developed a disorder of liquor circulation.

Conclusion: The pathological examinations, the comparative genomic hybridization and the course of the disease are clearly in favor of melanoma which has developed from a melanocytic nevus. Melanocytoma seems to be a misleading term.

DERMOSCOPIC ROSETTES AS A CLUE FOR PIGMENTED ACRAL MELANOMA IN SITU

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Introduction: Melanocytic proliferations of the meninges are designated as melanocytoma preferentially in the neurological literature and the diagnosis of melanoma has been described as ambiguous. Such a case is described in the following with its entire course.

Patient and methods: 13-year-old girl was diagnosed with melanocytoma. Imaging examinations and histopathological evaluations as well as the course of the disease are reported.

Results: The 13-year-old patient presented with an extensive intra-cranial tumor measuring 7 cm in diameter. This tumor grew through the calotte bone and extended as a visible tumor at the scalp. It was completely surgically removed without any remaining neurological defects. The differential diagnoses were melanocytoma/melanoma. Histopathological evaluations showed a melanocytic pleomorphic tumor with necrotic areas. Immunohistochemistry showed Melan-A - A positivity with low proliferative activity (MIB-1 Index <1%). There was no expression of protein S-100 and no clear expression of HMB-45 in the tumor tissue. A sequencing of the tumor revealed a GNAQ Q202R mutation, whereas no GNA11 mutation was detected. Additionally, comparative genomic hybridization was performed. This showed multiple aberrations, partly typical for melanoma. After a time period of 5 months, multiple recurrences around the previous tumor bed, addition to meningeal dissemination along the conus medullaris and the cauda equina, were detected by brain imaging. These were no longer resectable and rapidly progressing. The patient died after another 5 months after having developed a disorder of liquor circulation.

Conclusion: The pathological examinations, the comparative genomic hybridization and the course of the disease are clearly in favor of melanoma which has developed from a melanocytic nevus. Melanocytoma seems to be a misleading term.
P25

IPILIMUMAB INDUCED SIMULTANEOUS REGRESSION OF MELANOCYTIC NEVI AND MELANOMA METASTASES

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Background: Ipilimumab blocks the cytotoxic T-lymphocyte-associated antigen 4 (CTLA-4), hence potentiating the anti-melanoma T-cell host response. Ipilimumab improved overall survival in patients with previously treated metastatic melanoma. CTLA-4 antibodies generate immune responses to the melanoma-associated antigens Melan-A, NY-ESO-1, and gp100 in metastatic melanoma. Digitalized epiluminescent light microscopy (DELM) is a non-invasive method permitting the monitoring of the morphology of melanocytic lesions over time.

Observation: A 50-years-old man with metastatic melanoma received 4 ipilimumab injections after failure of DTIC chemotherapy. A PET scanner evidenced regression of pulmonary metastases. Simultaneously, DELM showed regression of several melanocytic nevi. Histology of regressing nevi revealed prominent CD68+, CD4+ and CD3+ positive lymphohistiocytic infiltrates, whereas non-regressing nevi were almost exempt of inflammatory infiltrate.

Conclusion: The expression of melanoma-associated antigens in benign melanocytic nevi may explain nevus regression by ipilimumab. DELM could represent a valuable non-invasive method to monitor ipilimumab efficacy.

P26

TREATMENT OF BALANITIS XEROTICA OBLETERNANS FROM LICHER SCLEROSUS WITH TOPICAL TACROLIMUS

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Introduction and Objectives: Anogenital lichen sclerosus (LS), causes tightening of the foreskin in males, resulting in balanitis xerotics obliterans (BXL). This involves with urethral obstruction and significant psychosexual morbidity. Treatment options include circumcision and potent topical corticosteroids.

Materials and Methods: We describe a patient who was successfully treated with topical 0.1% tacrolimus ointment. A 30-year-old Indian gentleman presented with multiple asymptomatic white lesions on his penis for 4 months. He had received a course of oral doxycycline, topical antifungals and topical mometasone furoate cream without improvement. Examination revealed multiple white sclerotic areas over the glans penis, with part of the prepucce adherent to the glans. Histopathology was consistent with lichen sclerosus. He was started on topical tacrolimus under foreskin occlusion.

Results: Clinical review at 2 months and 5 months showed excellent improvement with a high level of patient satisfaction.

Conclusion: Lichen sclerosus is characterized by increased T-cell reactivity to basement membrane proteins and autoantibodies to the extracellular matrix protein. Tacrolimus works by inhibiting interleukin-2 production and subsequent T-cell activation. Our positive experience suggests that tacrolimus may be a useful steroid sparing alternative in the treatment of genital lichen sclerosus.

P27

ADJUVANT TREATMENT WITH TOPICAL 5% IMIQUIMOD CREAM FOR RESECTED STAGE IIIIB MELANOMA

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In-transit skin metastases represent a well-recognized event in the natural history of melanoma. First line treatment of limited disease is local excision, but the occurrence of multiple in-transit lesions may limit this approach. In these instances, the treatment depends on the location and number of lesions, and the age and general health conditions of the patients. Topical imiquimod has been used for treating multiple or inoperable skin metastases, but little is known about the efficacy of imiquimod as an adjuvant treatment to prevent new skin metastases in resected stage IIIib melanoma.

We present a 72-year-old man who was followed-up for 6 years due to a primary scalp melanoma (Breslow thickness 1mm, no ulceration) excised with 1 cm margins and direct closure. Two years after the excision of the primary lesion, in-transit metastases started to develop and were continuously excised. Considering the development of multiple loco-regional skin metastases and additional presence of multiple actinic keratoses, an adjuvant treatment with topical imiquimod 5% was initiated, with the cream scheduled 5 times a week for 16 weeks. After 16 weeks of treatment, the scalp showed no evidence of suspicious lesions and during the following 3 years of clinical and radiographic follow-up, the patient was free of metastases.

In contrast to previous reports related to the use of imiquimod for the treatment of non-resectable skin metastases, in our patient this medication was used in an adjuvant setting to prevent the development of new skin metastases. Although no definitive conclusions can be drawn from a single case, this novel approach might be promising if confirmed by further studies.

P28

EFFICACY OF SMOOTHED INHIBITORS IN BASAL CELL CARCINOMAS IN A PATIENT WITH XEROADERMA PIGMENTOSUM

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Background: Xeroderma pigmentosum is an autosomal recessive disease with a genetic DNA excision repair deficiency and is associated with a high frequency of skin cancer already in younger patients.

Materials, Subjects and Methods: We report the case of a 51 year old woman with Xeroderma pigmentosum and multiple local basal cell carcinomas, who is one of the first patients worldwide to be treated with two different Smoothed inhibitors.

Since her youth the patient has developed several basal cell carcinomas, predominantly on the head and neck. Over the years the patient was treated for approximately 50 basal cell carcinomas with surgery as well as with crototherapy, photodynamic therapy and local immune modulators. By the development of a targeted therapy, the inhibitors of the Hedgehog pathway, a new era of medical treatment for patients with advanced basal cell carcinomas was initiated.

Results: Our patient was first treated with the Smoothened inhibitor LDE 225 1500mg QD (well above the maximum tolerated dose of 800mg QD) during the phase I study of LDE225X2101 (EUDRACT 2008-005603-26). After one months of therapy all basal cell carcinomas started to vanish, but unfortunately, the treatment was first interrupted and then permanently discontinued due to elevation in creatinine phosphokinase and blood myoglobin after 11 weeks of treatment. Six weeks later they had resolved to normal.

After the following 6 months, while the patient was without any treatment, old and new basal cell carcinomas recurred on her face. We started therapy with vismodegib (GDC-0449), a Smoothened inhibitor, in a clinical trial setting, the global vismodegib safety study (EUDRACT 2011-000195-34), with 150mg QD. Already four weeks later the lesions started to show a decrease in in size and the patient is still on treatment after 8 months.

Conclusion: Smoothed inhibitors are considered a promising treatment option for genetic disorders associated with skin cancer such as Xeroderma pigmentosum.
DYPHENICPRONE AS A THERAPEUTIC OPTION IN CUTANEOUS MELANOMA. CASE REPORTS AND LITERATURE REVIEW

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Introduction: Metastatic melanoma is very resistant to standard treatment modalities, including chemotherapy and radiotherapy. Dypenycprone (DPCP) is a contact sensitizer with immunomodulator effects, commonly used for alopecia areata and warts. Anyhow, topical dypenycprone (DPCP) immunotherapy has been shown to cause regression of extensive, rapidly growing recurrent and cutaneously metastatic melanoma when surgery is not feasible.

Objectives: To describe two cases of cutaneous melanoma treated with DPCP at the A.C. Camargo Hospital and their clinical outcomes.

Case report: Our first case is a 84 years old male patient with several clinical comorbidities who presented with extensive melanoma and in transit metastasis in face and scalp, where surgical approach wouldn’t be possible. There was no evidence of lymphatic or systemic disease, so radiotherapy wouldn’t be helpful either, so we started topical DPCP. After three months, new biopsies revealed no residual disease and re-staging remains without metastatic disease. Our second case is a 64 years old woman initially treated as a clinical stage III, who attempted wide local excision and groin dissection. She presented with in transit recurrence one year late and due to clinical aspects of the patient we couldn’t manage isolated limb perfusion or perfusion. We decided to start topical DPCP. We also performed new biopsies after three months, and only in one of the lesions there was evidence of residual melanoma. There’s no evidence of systemic disease and she remains in treatment.

Conclusion: There’s short but positive evidence in literature about the use of DPCP in melanoma. We present two cases in which we were able to reproduce the good results either in primary disease such as in recurrence, with minor side effects. DPCP may play a role even in patients with bulky disease or without clinical conditions for surgery.

PREOPERATIVE ASSESSMENT OF MELANOCYTIC SKIN TUMOURS ACCORDING TO DIFFERENT FREQUENCIES OF THE ULTRASOUND

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Aim: To determine the correlation between the structure of melanocytic skin tumours (MST) and the thickness, which were assessed by different ultrasound transducers and histology.

Methods: 45 patients with MST (n=61) have participated in this prospective study. After histological examination we have excluded 9 lesions thicker than >1 mm. Images of MST raw data have been acquired using the ultrasound (US) with the frequency from 1 kHz up to 35 MHz. Various non-recursive type band-pass filters were applied in order to get a better visualization of the tumour thickness and the structure at different frequencies: lower (8.16MHz), middle (14.22MHz), higher (20.28MHz) and compared with 22MHz frequency US. The mean thickness of the MST was 0.513mm (CI 0.450–0.576) by the Breslow index, using Pearson’s correlation coefficient (r) and the Bland-Altman analysis.

Results: The mean thickness of the MST was 0.513mm (CI 0.450–0.576) by the Breslow index, compared with 0.569mm (using Bland-Altman analysis). The mean thickness of the MST investigated using the band-pass filters was 0.510mm (CI 0.464–0.557, r=0.495) by lower frequency US, correspondingly by middle 0.487mm (CI 0.439–0.535, r=0.503) and by higher 0.469mm (CI 0.387–0.546, r=0.506) frequency US. Average of MST histological infiltrate in melanomas cases was 0.117mm (CI 0.023–0.270, correspondingly in nevi - 0.933, CI 0.004–0.152 mm).

Conclusion: The measured thicknesses of the MST lesions using 22MHz US, were compared with histopathology with moderate accuracy and was relatively higher than US measurements obtained on lower (8.16MHz), middle (14.22MHz), higher (20.28MHz) frequencies. The mean difference between the Breslow thickness and the US measurements of MST was equal to 0.98mm (using Bland-Altman plot). The Bland-Altman US is very useful in the prediction of tumour thickness, particularly in thinner primary lesions (<1mm), which allows us to determine the surgical margins.

SELF LIMITING SERIOUS RETINOPATHY-LIKE TOXICITY DURING MEK KINASE INHIBITION

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Background: Inhibition of the MAPK/ERK kinase pathway by allosteric MEK inhibitors showed substantial clinical efficacy in patients with advanced melanoma. MEK162 is a small-molecule MEK1/2 inhibitor showing efficacy in N-RAS and B-RAF mutant advanced melanoma. Ocular and skin toxicities have been reported with MEK inhibitors.

Materials and methods: We studied the eye toxicity in patients treated with MEK162 (Novartis CMEK162X2201 trial). Repeated full ophthalmological examinations were performed at baseline, day 15 of the first cycle and the beginning of every subsequent cycle. 12 patients were treated with two different dose levels of MEK162: 5 patients treated at 45mg bid, 7 patients at 60mg bid.

Results: Retinal disorders have been observed in 7 patients. The ophthalmoscopical findings were grey-yellowish spots, similar to the findings in central serous retinopathy (CSR). Accordingly the optical coherence tomography (OCT) showed serous detachment and thickening of the pigment epithelium and photoreceptor complex. One of the 5 patients treated with 45mg bid, developed asymptomatic retinopathy. Six of the 7 patients treated with 60mg bid, showed retinal changes; only one of them was symptomatic. Symptoms described were short lasting visual reductions and metamorphopsias. In 6 of the 7 patients, the retinal disorders were observed on day 15 of the first cycle. The retinal disorders resolved spontaneously without any dose modification or interruption of MEK162 in 3 patients with 60mg bid. In one patient they resolved after termination of treatment. Post treatment, 5 patients showed mild macular thickening of the pigment epithelium and photoreceptor complex. No association between ocular and skin toxicity was observed.

Conclusion: Ocular toxicities of MEK inhibitors are transient and resolve even during continuation of MEK therapy. The onset is in the first 2 weeks and may be dose-dependent. No lasting damage was observed. A close monitoring of the retina with a specific mark on sub-retinal exudates is highly recommended.
REFLECTANCE CONFOCAL MICROSCOPY: IMPACT ON CLINICAL DECISION-MAKING

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Introduction: Reflectance confocal microscopy (RCM) is a non-invasive imaging technique that allows in vivo examination of the epidermis and papillary dermis at a cellular resolution comparable with histology. The purpose of this study was to retrospectively analyze the application of this technique on the management of skin tumours and to determine the real impact of RCM on clinical practice.

Methods: Retrospective observational study carried out in the Melanoma Unit at a referral hospital. All patients referred for RCM evaluation over a one year period were included. According the therapeutic decision made, the real impact of RCM was estimated.

Results: A total of 627 consecutive examinations (470 lesions belonging to 414 patients) were included in the analysis. These were classified as: 1. Confocal performed for documentation of a malignant tumour already diagnosed by clinical/dermoscopy/pathology: 113 cases (24%). 2. Confocal performed to decide management: 270 cases (57%). 3. Confocal performed in the context of a clinical trial or research study: 54 cases (11%). 4. Pre-surgical mapping or selection of biopsy site: 10 cases (2%). 5. To monitor response to non-surgical treatment: 5 cases (1%). Concerning the management, in 175 (65%) of the cases referred to decide biopsy, there was a change in clinical/dermoscopic diagnosis, with a modification of the final therapeutic decision in 37% of them (n=99). In those cases, biopsy was dismissed in 33% (89 cases). For all excised lesions the pathology was included. For lesions not excised, a follow up of at least 12 months was performed to rule out malignancy. None of the lesions excluded for biopsy or excision resulted malignant after 12 months of follow-up.

We conclude that RCM modified the pre-surgical diagnosis of the patient (theoretical impact of RCM) and also had an impact on final therapeutic management (real impact of RCM).

SHINY WHITE STRAIGHTS IN MALIGNANT MELANOMA: A SIGN OF THICK TUMOURS

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Introduction: In the context of melanocytic tumours white shiny streaks (SWS) or chrysoids have been related to malignant melanoma. It still remains unclear the biological significance of this dermoscopic criterion.

Methods: Systematic study of SWS in 125 melanomas (56% in situ; 44% invasive with mean Breslow 1.7 mm (48%-11mm)) and 305 melanocytic nevi consecutively excised in a Melanoma Unit of a referral Hospital in Barcelona.

Results: SWS were present in 5 nevi (4.87%) compared to 41 melanomas (36.32%) (24 SSSM (36.5%), 11 LMM (26.8%), 3 NM (7.4%), 3 others (7.3%)). The presence of SWS correlated with a 10.33 fold risk of harboring a diagnosis of invasive melanomas when compared to in situ melanomas (OR: 10.33, IC 95% 3.812-28.014, p<0.005). Among invasive melanoma, SWS had a 4.46 fold risk to be thick melanomas (Breslow>1mm) (OR 4.46, IC95% 1.444-13.792 p<0.005). SWS were also observed more frequently in MM with black (p<0.05), gray, white or red colours (p<0.001); structureless area, blueblueish veil, regression, atypical blotch, multicomponent (all p<0.001) or unspecific pattern (p<0.05), polymorphic vessels and milky red globules (both p<0.001) but not with dotted vessels (p =0.792). The mean TDS score for melanomas with SWS was 6.61 and without SWS 5.62 (p<0.05). SWS were more frequently in MM with black (p<0.05), gray, white or red colours (p<0.001) and with polimorphic vessels (p<0.001) but not with dotted vessels (p =0.792). The mean TDS score for melanomas with SWS was 6.61 and without SWS 5.62 (p<0.05). SWS were also observed in 3 cases with TDS <4.75 (3.8%).

Conclusions: SWS in the context of a melanocytic tumour is associated to malignancy, and to invasive melanoma, with a higher Breslow thickness and higher TDS. In some few cases the presence of SWS was seen in MM with TDS of benignity.

OUR EXPERIENCE IN GENETIC COUNSELLING AND CDKN2A MUTATIONS IN CHILDREN FROM HIGH RISK FAMILIES FROM SPAIN

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Aim of the Investigation: To explain our experience in genetic counselling and genetic testing in children belonging to high risk families for melanoma.

Material, Subjects and Methods: Children from 1 to 18 years old belonging to known CDKN2A mutation carrier families were selected. Genetic counseling visit was done and parents were asked to perform genetic testing. All parents agree to study their children after the risk-benefits explanation.

Results: A total of 30 children belonging to 14 families with known CDKN2A mutation were collected and we found CDKN2A mutation in 16 (53.3%). Two of them were found to be double heterozygous mutation carriers (-34G>T / G101W). During the clinical-dermoscopic surveillance program 2 lesions have been excised in 2 children due to atypia on dermoscopy.

Conclusion: After explanation to the parents of the potential risk and benefits of knowing test results, all of them agree to study their children. Predictive genetic testing of minors is advocated only when there is a clear medical benefit and in melanoma there is clearly.

CLINICAL INVESTIGATION OF VULVAR AND VAGINAL MELANOMAS IN JAPANESE PATIENTS: AN ANALYSIS OF 30 CASES AT A SINGLE INSTITUTION

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Aim of the Investigation: Melanoma of the female genitalia is extremely rare in Japanese. Patients with this unusual tumor are referred to the National Cancer Center Hospital from all over Japan. We have described the features of vulvar and vaginal melanomas in our hospital.

Materials, Subjects, and Methods: During the period from January 1999 to December 2011, thirty Japanese women with melanoma of the vulva and vagina were examined in our department. Fourteen patients underwent any therapy for melanoma. We investigated the clinical characteristics, results of treatment, and outcome of the two groups.

Results: Of the 8 patients with vulvar melanoma, the primary site was a labium in 3 cases and vaginal vestibule in 3 cases, and the primary lesion spanned these two sites in 2 cases. Surgery was performed in the initial treatment in 6 cases and not performed in the other 2 cases, and the procedure in the surgically treated cases was pelvic exenteration in 1 case, radical vulvectomy in 3 cases, and simple tumor excision in 2 cases. Median survival time was 87 months in the complete resection cases, and was significantly longer than median survival time of 9.5 months in the incomplete resection or unresectable cases. Of the 6 patients with vaginal melanoma, the primary site was the posterior 1/3 of the vagina in 5 cases and the ventral 1/3 of the vagina in 1 case. The procedure in the initial surgical treatment was pelvic exenteration in 5 cases and simple tumor excision in 1 case. Complete resection was possible in all 6 cases. Median survival time in the 6 cases was 73.5 months.

Conclusions: The prognosis for vulvar and vaginal melanoma is very poor, but a better outcome was observed in the successful surgical resection cases than in the incomplete resection cases.
GUIDED POSTER TOUR 2
Clinical Melanoma Studies
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THIN CUTANEOUS MELANOMA—DESCRIPTIVE EPIDEMIOLOGICAL STUDY OF 469 PATIENTS DIAGNOSED OF 1990 TO 2010 IN DERMATOLOGY SERVICE A.C. CAMARGO HOSPITAL IN SAO PAULO – BRAZIL

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Aim of the investigation: To study the occurrence of thin cutaneous melanoma and describe clinical and histopathological variables and their correlation with patient survival.

Materials, subjects and methods: Retrospective cohort study in which it was analyzed medical records and pathologic reports of 469 patients between 1990 and 2010. Distributions of absolute and relative frequencies were presented for qualitative variables or mean (standard deviation) for quantitative variables (k-2 test). The follow-up period was between 44 months. Results: Five of the seven patients were women and two were men. The mean age was 54.57 ± 11.18 years. The most frequent histological subtype was acral lentiginous melanoma (3/7) with a Breslow ranging from 0.8 to 3.9 mm. All patients had been treated previously with chemotherapy and immunotherapy. Six of the seven patients received a total of 4 induction cycles of ipilimumab at 3mg/kg dosage. Response at the end of treatment was: partial remission (1/6), stable disease (2/6), and disease progression (3/6). All of the six patients, as well as those in partial remission showed progression of the disease in the following 3 months. Three of the seven patients are still alive. Survival since the beginning of treatment with ipilimumab has been 3 to 13 months. Ipilimumab was well tolerated by all patients. Dermatological toxicity (5/7)–mainly vitiligo– was the most frequent irAEs

Conclusions: The efficacy of drugs used to treat malignant melanoma is limited; ipilimumab was well tolerated in our patients and represents a therapeutic alternative in advanced melanoma.

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CLINICAL AND HISTOLOGICAL FEATURES OF PATIENTS WITH CUTANEOUS MELANOMA WHO DEVELOPED RECURRENCE AFTER A NEGATIVE RESULT IN SENTINEL LYMPH NODE BIOPSY

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Introduction: The pathologic status of the sentinel node is the most important prognostic factor of cutaneous melanoma progression. Objective: To study the clinical and pathologic characteristics of patients who had developed recurrence after a negative result in the sentinel lymph node biopsy (SLNB). Results: During the period from 1996-2010 we performed SLNB in 485 primary melanoma patients with a negative result in the SLNB (1996-2010). We compared both clinical and histological features of melanomas, which had relapsed versus those who had not relapsed.

Results: During the period from 1996-2010 we performed SLNB in 485 patients with CM. A negative result was found in 384 of the cases (79.17%). During the follow-up there was a recurrence of the disease in 47 patients (12.2%). An increased thickness of the MC, the presence of ulceration and the tumors located in head and neck area were the most frequent findings in patients with progression of melanomas.

Conclusions: Despite a negative result in the SLNB being an indicator of good prognosis in melanoma, care must be taken with those patients with aggressive features in the primary MC or in patients with tumors located in the head and neck area. In our study, both features are linked with the progression of the disease.

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FOLLOW-UP OF PATIENTS WITH DYSPLASTIC NEVUS SYNDROME (DNS) EMPLOYING SIASCOPY AS A DIAGNOSTIC TOOL FOR MELANOMA (MM) DIAGNOSIS. FISH ANALYSIS OF REMOVED LESIONS. PRELIMINARY RESULTS

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Aim of the investigation: Patients with DNS have numerous atypical nevi, an increased risk of MM and can be associated to multiple primary (MM/MM) and/or familiar MM (FMM). The aim of this study was to assess the usefulness of SIAscopy for MM diagnosis in DNS patients using Molgreen and Molive view softwares (Dermetrics™)

Material and methods: Total body maps were registered and the most atypical melanocytic lesions were selected, linked to their SIAscopy pictures and compared every 6-12 month. Lesions with striking changes in size and structure of color pictures were removed and submitted to pathological examination. Basal appearance and changes in melanin, deep melanin, blood and collagen pictures have been evaluated retrospectively. Removed lesions were studied by FISH (Vysis LSI RREB1/LSI MYBL/LSI CCND1/CEP 6; Abbot Molecular Inc.).

Results: From April 2007 to March 2012 (mean follow-up=44 months) 99 patients (61 men, 38 women, median age: 38 years) were enrolled. 60 had familiar history of dysplastic nevi (DN), 15 of one relative with MM, and none from FMM. 8 had personal history of MM (2 with FMMM). None was a known carrier of MM susceptibility gene mutations, 39 lesions from 27 patients were removed and diagnosed as 3 MM in situ, 17 DN, 18 benign melanocytic lesions and 1 pigmented basal cell carcinoma. FISH studies were done in 24/39 lesions. 2 biopsies diagnosed as DN had FISH criteria of MM.

Conclusions: SIAscopy seems to be useful to detect changes in melanocytic lesions in DNS patients. However, for being a cost effective method for early MM diagnosis, probably DNS patients at higher risk to develop MM should be selected. FISH analysis of removed lesions gives a useful additional information to differential diagnosis between DN and in situ MM.
PHENOTYPIC CHARACTERIZATION OF MELANOMA SYNDROME
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Introduction: Familial Melanoma Syndrome (FMS) may be characterized by multiple members affected at the same branch of the family and/or patient with multiple primary melanomas.

Aim: To characterize and compare the phenotype characteristics (PCs) of patients with the FMS (group A), carriers and non-carriers of CDKN2A mutation; and compare to the other two groups, sporadic melanoma (SM – group B) and healthy people (group C).

Patients and methods: We included 59 individuals with FMS, 54 with SM and 74 healthy people. PCs evaluated: eye and hair color, iris pigmentation, skin type, freckles density, common and atypical mole count, sunburn, atypical mole syndrome (AMS), mutation status on CDKN2A gene, association was not observed with in the analyzed features. Comparison between groups A, B and C showed prevalence on group A of freckles in the lower arm (p=0.026), freckles in the trunk, great number of nevi, AMS, skin type I/II and 66% history of sunburn. Concerning mutation status on the CDKN2A gene, association was not observed.

Conclusions: PCs of FMS group: dark eyes and hair, high density of freckles in the trunk, < 50 moles, phenotype I/II and history of sunburn. It was not possible to establish a predominant phenotype for those who carry the mutation. A higher risk PCs related to melanoma was observed in the FMS group.

PREVALENCE OF LYMPHEDEMA IN PATIENTS WITH LymphadeneCTOMY FOR TREATMENT OF CUTANEOUS MELANOMA DiAGNOSED BY OPTO-ELECTRONIC VOLUMEy VERSUS MANUAL PERIMETRY
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Aim: To assess the prevalence of lymphedema in upper and lower limbs through opto-electronic volumetry (through Perimeter) and manual perimeter in patients with radical lymphadenectomies as a treatment for cutaneous melanoma.

Materials and Methods: We studied 95 patients who underwent axillary (48) and inguinal or iliolinguinal lymphadenectomy (47) between 1990 to 2012. It was excluded patients with amputation limb or bilateral dissection. The measurement volumes had been made by manual perimeter applied to truncated cone formula and opto-electronic volumetry. The difference between the volumes was checked by the Wilcoxon test.

Results: The prevalence of lymphedema in upper limb was 23.9% for both methods, but for lower limbs the prevalence was different: 65.3% in perimeter and 71.4% in opto-electronic volumetry. There was a difference of volume in the lower limbs when compared the measurement techniques (p = 0.028).

Conclusions: Perimeter provides more precise, practical and fast measurements and it is compatible with manual perimeter for upper limb, but for lower limbs, opto-electronic volumetry diagnosed more cases than perimeter.

WHAT IS OUR PRECISION IN MELANOMA DIAGNOSIS? A RETROSPECTIVE STUDY OF NEVI AND MELANOMA EXCISED IN A UNIVERSITY HOSPITAL
Sabadant andreu, mirèia; saëz artacho, empar; costa trachsel, irigmard; orellana fernández, ruth; romaní de garol, jorge; fernández-chico, natàlia; yèbenes marsal, mirèia; leal canosa, lorena; ribera pibernat, miquel; duarte vega, irene; casals andreu, miquel; pfarr torra, montserrat; nelmo aguilar, Jesús
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Aim of the investigation: The need of early melanoma treatment lead us to excise pigmented lesions that in some times do not correspond to melanoma. The number of benign pigmented lesions excised for each melanoma (number needed to treat or NNT), represents a quality indicator in melanoma diagnosis. Moreover, the histology of melanocytic nevi in elderly patients is different from young adult nevi. The aims of our study are: a) to retrospectively analyze the melanoma precision diagnosis in our hospital, b) to show the distribution of nevi type and the dysplasia according to the age.

Materials, subjects and methods: Retrospective study of 1776 lesions excised from january to december 2011 with the histologic diagnosis of melanocytic nevi and melanoma.

Results: We analyze 776 lesions (906 men and 470 women). A total of 730 benign lesions and 46 melanoma. Omitting the atypical nevi excised for aesthetic reasons, we calculated a number of benign pigmented lesions excised for each melanoma (number nedded to treat or NNT), represents a quality indicator in melanoma diagnosis. Moreover, the histology of melanocytic nevi in elderly patients is different from young adult nevi. The aims of our study are: a) to retrospectively analyze the melanoma precision diagnosis in our hospital, b) to show the distribution of nevi type and the dysplasia according to the age.

Conclusions: The NNT for dermatologists ranges from 4 to 12, depending on the publication. The NNT observed in our study (9.24) is inside this interval, although we should be able to improve it. The NNT was higher in women and in youngest patients, decreasing with the age, as observed in other published studies. The most frequent nevi type in older than 60 years was the intradermic nevi, according to literature. We did not find statistically significative differences in the percentage of dysplastic nevi in the different groups of age. We realize its presence in older than 60 years (mostly junctional nevi), so we consider that they can correspond to melanoma precursor lesions.
CHARACTERISTICS OF PRIMARY CUTANEOUS MELANOMA AT THE NATIONAL CANCER INSTITUTE 2000-2010 IN BOGOTA, COLOMBIA
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Objectives: To describe the main features of cutaneous melanoma at the National Cancer Institute, a National Reference Cancer Center in Bogota, Colombia.

Materials and Methods: A descriptive, retrospective study was carried out, about clinical and demographic characteristics of patients with histological diagnosis of primary cutaneous melanoma at the National Cancer Institute of Colombia, between 2006 and 2010.

Results: A total of 599 patients were included. Of these, 57.4% were females (n = 344) and 42.6% males (n=255). The mean age time of diagnosis was 60.8 years. Most cases were from Bogota with 56.3% (n=329). It was more common the urban area as usual residence site (n = 500). The mean annual rate was 115 new cases per year. Of the tumors, 42.2% (n=235) were located on acral sites as hands and feet, followed by head and neck (n = 186). Consistent with the lesion site, the most common subtype was acral lentiginous melanoma with 43.7% (n = 262), followed by lentigo maligna. With regard to the depth, an equal frequency was observed for in situ melanomas and melanomas with Breslow> 4mm, both with 19% of cases. It was found that most of the lentigo maligna 75% (n=108), had an in situ Breslow or were microinvasive melanomas (Breslow ≤ 1mm); by contrast, acral–lentiginous and nodular melanomas had a Breslow more than 4mm with greater occurrence (26.3% n=69 y 45.4% n=10, respectively) Stage III was the most frequent, with 28.2% of the cases (n=157).

Conclusions: It was found a higher percentage of melanomas in women, and increased frequency of acral melanomas. The latter, shows a difference with those reported in other Latin American series. A significant number of patients were at an advanced stage, so that further action is required for the early detection of melanoma.

EXCISION MARGINS FOR MELANOMA IN RADIAL GROWTH PHASE
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Hospital Clinic, Barcelona, Spain

Aim of the Investigation: Cutaneous melanoma in radial growth phase (RGP) is an early lesion confined to the epidermis and papillary dermis with little biologic potential for metastasis. The aim of this preliminary retrospective analysis was to explore outcomes in patients with primary RGP melanoma.

Materials, Subjects and Methods: We examined 114 consecutive RGP melanomas treated at single institution from January 1999 to December 2002 with a 5 mm excision margin analysing loco-regional relapse, distant metastases and survival.

Results: Despite the narrow width of surgical excision, the incidence of adverse events was very low. There were three local recurrence and two regional lymph-node metastases as the only unfavourable events after a median follow-up of 10 years. Five-year relapse-free survival was 96.4% and five-year overall survival resulted to be 98.7%. One death was melanoma-related. The evidence of regression in the primary tumor was significantly associated with a poorer prognosis; also the presence of a nevus associated to primary melanoma appeared related to worsened relapse-free survival, although differences were not significant due to the low number of events.

Conclusions: Long-term prognostic for patients with RGP melanoma treated by narrow surgical excision (5-mm margin) are excellent, in terms of loco-regional and distant control rates as well as survival. Cases with evidence of regression or associated with a nevus should receive a wider excision.

AUTOMATIC SEGMENTATION OF SKIN LESIONS USING MULTISCALE SKELETONS
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Aim of the Investigation: Automatic analysis of skin lesions such as naevi or melanoma has become an increasingly important method for improving the efficiency and effectiveness of medical diagnosis and prognosis of melanocytic diseases. A crucial step in the process is the segmentation of the tumour area from healthy surrounding tissue. However, fully automation of this process is a rather complex task, given the large variability in tumour morphology, skin pigmentation and image acquisition parameters.

Materials, Subjects, and Methods: We present here a novel method for the automatic segmentation of naevi from surrounding healthy skin tissue. In contrast to existing techniques which employ local image neighbour-hood analysis, we propose a global approach; First, we quantize the entire image in 255 so-called “threshold sets”, (T), each set encoding the image content to a given luminance value (l), 0 ≤ l ≤ 255. Secondly, we capture the shape and morphology of each set T, using a new technique based on shape skeletons (medial axes). Finally, we determine the skin tumour border employing the statistical analysis of the variability of skeletal shape descriptors http://www.cs.rug.nl/Shapes/skinImaging

Results: We have tested our method on 50 images (2448 x 3264 pixels) acquired with a handyscope imaging device. The images cover a wide range of naevi types. The automatic segmentations were compared against ground-truth segmentations produced by a dermatologist in a double-blind fashion. We observe a strong similarity between our automatic and manual segmentations, even for complex images where the imaged structures have a complex morphology, fuzzy appearance, low contrast, luminance contrast, presence of occluding hairs and variable resolution. Our method can be run fully automatically and works in near-real-time (2 seconds/image) on a modern PC.

Conclusions: Current results open new ways for segmentation of melanocytic structure image segmentations. Our multiscale approach can be further extended to measure relevant diagnostic parameters, e.g. the ABCDE criteria, quantification of the tumour ramification, automatic classification of tumours and can be also used for quantitative analysis of other skin lesion types.

DESMOPLASTIC MELANOMA ON THE NOSE; A MORE FREQUENT PITFALL THAN EXPECTED.ELECTROCHEMOTHERAPY AS AN ALTERNATIVE TREATMENT TO LOCAL CONTROL OF NON-SURGICAL
Barreiro-Capurro, Alicia1; Carrera, Cristina2; Bennassar, Antoni; Dalle, Stephane; Vilalta, Antoni; Fuentes, Irene; Alos, Llucia; Puig, Susana; Thomas, Luc; Malvehy, Josep
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Introduction: Desmoplastic melanoma (DMM) is a rare and often misdiagnosed type of melanoma. Delayed detection on complicated anatomical locations can lead to the necessity of alternative therapies.

Methods: Retrospective review of a case series of eight pathologically proven DMM on the nose from two referral centres with a mean follow-up of 69 ± 40.5 months.

Results: According to a single centre experience, there is more than a 70-fold increased risk of MM on the nose being desmoplastic (<.0005, CI99% 16.3-317.3). Clinical and pathological misdiagnoses were frequent, only three out of the eight cases were properly diagnosed and treated and indeed they did not experience relapses. Due to non-clinical suspicion and superficial biopsies, three cases were initially pathologically misdiagnosed as basal cell carcinomas and a nevus. Atypical vellus and remnants of pigment on dermoscopy are indicative traits even in non-pigmented cases. Although not significant, the mean disease-free-survival differed between cases with a correct initial management (four cases, 66.7± 57.3 months) in contrast to incorrect (four cases, 16.2±18.9 months). Electrochemotherapy achieved a complete local control of disease in two primary tumours unsuitable for surgery.

Conclusions: Use of dermoscopy and correct selected biopsy of lesions on the face is mandatory to improve early diagnosis of DMM. Improper management of challenging cases implies a more complicated therapy and loco-regional invasion risk. Electrochemotherapy could be a promising therapy in local advanced tumors.
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NECESSITY OF FULL SKIN EXAMINATION IN A PIGMENTED LESION CLINIC?
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Full skin examination (FSE) is generally considered to be useful in the detection of early melanoma. However, currently, the US Preventive Services Task Force does not recommend routine FSE, citing a lack of evidence for its efficacy in reducing mortality. The Pigmented Lesion Clinic (PLC) at our centre accepts GP referrals of patients with suspicious pigmented lesions. The lesions (in) question is examined by a consultant dermatologist and full skin examination is performed only in selected at risk patients. The purpose of this study was to assess the safety of our practice and determine whether there were lesions we were likely to miss. We randomised patients referred to the clinic to either a full skin examination versus lesion-directed examination. Those randomly selected to undergo a FSE had the examination performed by a dermatologist specialist registrar, following their standard dermatology consultant assessment. 506 patients were randomised to FSE. Incidental findings on FSE included a biopsy-proven superficial BCC and inflammatory dermatoses. To date, no additional melanomas have been detected that would otherwise have been missed by use of the standard protocol. Our study suggests that in carefully selected patients attending a PLC, the possibility of missed incidental cutaneous malignancies would be low, using lesion-directed examination. In previous studies, dermatologists report patient embarrassment and time constraints as the main barriers associated with skin cancer screening. This study suggests that the average time to undressing to fully dressed in our study was four minutes. In contrast, lesion-directed examination took on average 30 seconds. Given this large time differential, with lesion-directed examination you could see 8 times more patients than with FSE. This is the first prospective study of this kind conducted in a PLC clinic and it may indicate that a different approach can be used compared to general dermatology clinics. This may be due in part to referral bias in PLC patients, whereby patients have presented themselves to their GP following self-examination and also their GP may have already conducted a FSE.

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PRELIMINARY ANALYSIS OF A PHASE II TRIAL OF INTRATUMORAL DELIVERY OF PLASMIID INTERLEUKIN-12 (pIL-12) WITH IN VIVO ELECTROPORTATION IN PATIENTS WITH METASTATIC MELANOMA
Cha, Edward1; Algazi, Alain2; Farries, Mark3; Molina, Manuel4; Bhata, Shailender5; Botholfse, Rebecca6; Takamura, Toshimi7; Diep, Tu8; Kitt, Ernest9; Heiler, Richard2; Fong, Lawrence6; Daud, Adi10; (1) University of California, San Francisco, USA; (2) John Wayne Cancer Center; (3) Lakeland Comprehensive Cancer Center; (4) University of Washington; (5) OncoSec Medical Inc; (6) Old Dominion University

Background: In a previous Phase I trial, intratumoral pIL-12 with in vivo electroportation resulted in regression or stabilization of distant untreated metastases following a single cycle of treatment (Daud et al 2008). As a follow-on study, a Phase II trial in patients with in-transit cutaneous metastatic melanoma was initiated.

Methods: Thirteen subjects were enrolled at the time of this preliminary analysis. One treatment cycle consisted of three treatments applied to up to four lesions on days 1, 5 and 8 with a maximum dose of 1.5 mg pIL-12 per treatment cycle. Eligible subjects may receive up to four cycles. Electroportation was applied immediately after each pIL-12 injection. Pre and post-treatment biopsies and peripheral blood were obtained to determine IL-12 protein levels and systemic immune responses. Response of treated lesions was assessed at Day 39, 90, and 180. Overall objective response (ORR) of untreated lesions was assessed at Day 180.

Results: Eleven subjects were evaluable at Day 39, six at Day 90, and two at Day 180. All treated lesions demonstrated response at Day 39 (10% SD, 50% PR, 40% CR), at Day 90 (44% PR, 56% CR), and at Day 180 (43% PR and 57% CR). At Day 180, two subjects were evaluable for ORR. One patient has a confirmed stable disease. The second patient has a near complete response of all treated and untreated lesions. In this patient, treatment transiently decreased Tregs and increased activated CD69+ CD8 T cells. Adverse events were generally limited to transient pain related to electroporation treatment. To date, six subjects have withdrawn from the study, of which four had progression of untreated lesions.

Conclusions: This Phase II interim analysis supports key findings from the Phase I trial. Enrollment is on-going and long-term follow-up will assess durability of response.

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EXPLORATORY 12-WEEK SURVIVAL ANALYSIS OF PATIENTS WITH UNRESECTABLE OR METASTATIC MELANOMA TREATED WITH IPILIMUMAB IN A PHASE 3 TRIAL (MDX010-20)
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Aim of the Investigation: The immune-based mechanism of action of ipilimumab can result in delayed clinical effects. The phase 3 MDX010-20 trial compared the efficacy of ipilimumab 3 mg/kg plus gp100 vaccine versus ipilimumab 3 mg/kg alone versus gp100 alone in patients with unresectable or metastatic (advanced) melanoma who had received prior therapy. In each treatment arm, median overall survival (OS) was 10.0, 10.1 and 6.4 months, respectively. Survival benefit with ipilimumab was reported across all patient subgroups with some patients achieving long-term outcomes. The aim of this exploratory analysis was to look at survival outcomes among patients surviving at least 12 weeks post treatment-initiation.

Materials, Subjects and Methods: In MDX010-20, patients were treated with ipilimumab plus gp100 (n=403), ipilimumab alone (n=137), or gp100 alone (n=136). Treatment was administered every 3 weeks over a 12-week induction period. A post-hoc analysis investigated survival outcomes for all patients from the start of treatment and those patients surviving beyond the 12-week time point. Results are presented here for the two monotherapy arms.

Results: For the overall study population, the HR for death with ipilimumab compared with gp100 alone was 0.66 (95% CI: 0.51–0.87), indicating a 43% reduction in the risk of death (p=0.003). This phase IV trial was able to provide evidence of a survival benefit with ipilimumab compared with gp100 alone in patients with high-risk of disease.

Conclusions: These data suggest that pretreated patients with advanced melanoma who subsequently receive ipilimumab and are still alive at 12 weeks have enhanced potential for an improved global survival. This may be because they have completed the full course of ipilimumab (i.e. all 4 doses) and/or had disease characteristics that favoured a life-expectancy of ≥3 months.

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EPIDEMIOLOGY, CLINICOPATHOLOGICAL CHARACTERISTICS, DIAGNOSIS AND TREATMENT OF MELANOMA IN SERBIA – THE MELANO-MA FOCUS STUDY
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(1) Military Medical Academy; (2) Institute for Oncology and Radiology of Serbia; (3) Clinical Center Nis; (4) Institute for Oncology of Vojvodina; (5) Clinical Hospital Center Bezanjica Kosa; (6) Clinical Center of Vojvodina; (7) Study Coordinator

Aim of the investigation: Epidemiology data and clinicopathological and diagnostic data as well as treatment protocols data, both collected from structured survey performed in Serbian tertiary oncology centers.

Materials, subjects and methods: Hospital databases of melanoma patients from six referent oncology centers of Serbia in 2011 were analyzed.

Results: A total of 986 patients were analyzed, 565 females and 421 males (ratio 1: 4:1). The median age was 62 years. The melanomas were located on the skin in 877 patients (92.4%), mucosal 13 (1.4%), eyes 24 (2.6%). The median age was 62 years. The melanomas were located

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RESULTS OF SCREENING PROGRAM FOR MELANOMA AND SKIN CANCERS IN KUJAWSKO-POMORSKIE PROVINCE IN POLAND
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Aim of the Investigation: Each year the incidence of melanoma and other skin cancers increases. Despite the progress in treatment, mortality from skin cancer is still high. Therefore it is vital to increase patients awareness about those diseases and implementing screening programmes for skin cancer. Raising public awareness is the main factor in primary prevention. Any disturbing skin lesion should make the patient seek help from a professional. Moreover, patients should know that the proper use of sunscreen preparations, protective clothing, sunglasses and seeking shade during peak sun may reduce the risk of skin cancer. But prevention includes also screening tests that are designed to detect cancerous skin changes in the early stages of development.

Materials and Methods: An important component of secondary prevention is to introduce screening programmes at local and national level. We present the results of the “Regional Programme for Early Detection of Skin Cancer.” The aim of the project was to conduct dermatoscopic examination of one of polychrome views in 41,167 pts (1,368,895 controls) between 2007 and 2011. Patients were examined by doctors fully experienced in dermatoscopy. The research was carried out in both large cities and small towns where access to specialists is difficult. 9000 patients were examined in the programme. Suspicion of melanoma was diagnosed in 52 cases, and suspicion of skin cancers (basal cell carcinoma and squamous cell carcinoma) was detected in 120 cases. The results should be an inspiration for local authorities to take similar actions in health promotion.

Conclusions: Implementation of preventative measures still face many difficulties. These include: lack of interest in prevention of governing institutions, low funding of health care and health lifestyles of polish society. More actions should be focused on prophylaxis because it is easier to prevent than to cure.

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IPILOMUB USE IN A NAMED-PATIENT PROGRAM IN METASTATIC MELANOMA: EXPERIENCES AND PRELIMINARY DATA IN 198 PATIENTS
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Background: The monoclonal antibody ipilimumab (ip) showed a survival benefit in patients (pts) with unresectable metastatic melanoma leading to its approval in 2011.

Methods: ip was available in Germany before its approval in a Named-Patient Program for pts with unresectable stage IV melanoma. Pts were eligible if they failed at least one prior systemic treatment or were intolerant and did not suffer from auto-immune diseases. ip was administered at a dosage of 3mg/kg iv (4 cycles, q21). A re-induction was possible in case of progressive disease after initial clinical benefit.

Results: Data from 198 pts (121 male; 77 female, median age: 59 [18-87]Y) of 14 German centers was evaluated. 187 pts actually received ipilimumab (113 pts received all 4 cycles). Reasons for early termination were: Reduced general condition, tumor progression, toxicity or wish of pts, and incompliance. Response was evaluable in 174 pts; objective response was observed in 21 pts (1 CR+20 PR), SD in 20 pts (disease control rate 23.5%). PD was diagnosed in 133 pts. Median survival for all pts was 6.8 months, 1-year overall survival was 36.2%, 2-year overall survival was 25.2%. Median survival for pts which received the full dosage of 4 cycles was 13 months compared to 2 months for pts which received less. Treatment was generally well tolerated. Severe (Grade 3+4) auto-immune related toxicities to 2 months for pts which received the full dosage of 4 cycles was 13 months compared to 2 months for pts which received less. Treatment was generally well tolerated. Severe (Grade 3+4) auto-immune related toxicities

Conclusion: Data coming from these 187 patients appear to be consistent with safety and efficacy profiles determined in phase 3 clinical trials. Tumor responses were induced in a subset of pts and associated with prolonged survival.

TRENDS IN EARLY DIAGNOSIS OF MELANOMA IN ANDALUSIA. PRELIMINARY RESULTS OF THE TEDIMEL-A STUDY.
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Introduction: TEDIMEL project is a multicenter study to analyze the trend of primary skin melanoma diagnosis in Andalusia (the second largest in area of the autonomous communities of Spain). Objectives: The objective in the first part of the project is to describe the evolution of the diagnosis of primary skin melanoma in Andalusia during the decade 2000-2009.

Methodology: An observational, descriptive, multicenter consecutive incident cases of primary cutaneous melanoma obtained from the pathology records of 14 centers in Andalusia. The included patients had the following inclusion criteria: primary melanoma in situ or invasive diagnostic pathology service issued by a participant Pathology, histopathological diagnosis issued during the period 1 January 2000 to December 31st 2009. Study variables collected were: center, age, sex, Breslow, diameter, T stage, location and histologist subtype.

Results: During the study period included 3,644 cases of melanoma with an increase in the frequency of cases of +6.50% from the beginning to the end of the study period (range: 268-501). The largest increases in frequency were observed in groups of 31-50 years (+7.91%) and 51-70 years (+13.87%). The average age of people with melanoma has been an increase during the study period (53.72 vs. 57.92 years, p = 0.009). The greatest increase in the frequency of cases has been observed for melanomas with stage T0 and T1, remaining stable frequency of T2, T3, and T4 tumors. There have been increases in frequency in all types of centers. No differences were observed in the frequency of cases in hospital areas.

Conclusions: Preliminary results from the descriptive phase of TEDIMEL-A confirmed the following findings: 1) Increase the frequency of cases of melanoma in Andalusia during the decade 2000-2009. 2) Increase in melanoma cases with good prognosis (stage T0-T1) with respect to poor prognosis (T3-T4). 3) Increase discrete but statistically significant, age of diagnosis of melanoma There have been increases in frequency in all types of centers. 4) Stabilization diagnosis of melanoma in young people (0-30 years), an increase in middle age (31-50years) and advanced (51-70 and 70+ years).
The outcome of a significant proportion of these patients. IIC malignant melanoma for metastases with CT scanning will result in

Conclusion:

and 5 patients (5%) with other primary malignancies. had suspicious scans that were clear on subsequent follow-up. IIB or IIC disease in the twelve months prior to the change in our

Methods:

The last 102 patients who had a staging CT scan for stage thickness greater than 2mm with ulceration (stage IIB) or greater than 4mm (stage IIC) are no longer offered a staging CT scan. We audited the impact this change will have on the patients within our specialist group of patients. Limitations This study was conducted in a single institution and is limited by the small number of cases.

Conclusions: Selective BRAF inhibitor therapy is associated with some skin events, including photosensitivity, keratoacanthoma-like squamous cell carcinomas, verrucous keratoses, papillomas and others. These patients need several dermatologic follow-up consultations in order to treat these reactions and to biopsy new growths.

THE IMPACT OF NO LONGER PERFORMING STAGING CT SCANS ON STAGE IIIB/C MELANOMA PATIENTS  Varey, Alex; Kissane, Jaye; Jones, Dylan; Sarginson, Julia; Rafiq, Sadia; Orlando, Antonio Department of Plastic Surgery, Frenchay Hospital, Bristol, UK

Introduction and Aims: The change in the UK guidelines for patients diagnosed with malignant melanoma recommends patients without evidence of metastatic disease who have a tumour with Breslow thickness greater than 2mm with ulceration (stage IIB) or greater than 4mm (stage IIC) are no longer offered a staging CT scan. We audited the impact this change will have on the patients within our specialist skin MDT.

Methods: The last 102 patients who had a staging CT scan for stage IIIB or IIIC disease in the twelve months prior to the change in our management protocols had the results of their CT scan reviewed.

Results: 78 patients (76%) had no evidence of disease and 11 (11%) had suspicious scans that were clear on subsequent follow-up. However, 5 patients (5%) were diagnosed with melanoma metastases and 5 patients (5%) with other primary malignancies.

Conclusion: Ceasing routine screening of patients with stage IIB and IIIC malignant melanoma for metastases with CT scanning will result in 10% of patients having their metastatic or other primary malignancy diagnosis being delayed. This change may therefore adversely affect the outcome of a significant proportion of these patients.

OUTPATIENT DRAIN SERVICE FOR MALIGNANT MELANOMA PATIENTS WHO UNDERWENT GROIN AND AXILLARY DISSECTION FOR POSITIVE SENTINEL LYMPH NODES  Szmidt, Mateo1; Beck, Debbie2; Sofos, Stratos3; Goodenough, Jenny4; Brackley, Phil (1) CST-2 Plastic Surgery; (2) Dissection Out-Reach Nurse; (3) Clinical Fellow Plastic Surgery; (4) Spr Plastic Surgery; (5) Consultant Plastic Surgeon, Whiston Hospital, Liverpool, UK

Introduction: Groin and Axillary node dissections are procedures performed for Melanoma Patients who have positive sentinel lymph node biopsies. Many argue that this procedure is aggressive and patients spend numerous days in hospital with drains.

Our aim is to show that our Drain Outreach Service (D.O.S.) reduces complications and saves in hospital days.

Methods: A retrospective case study. We looked at patients who underwent dissections before and after the development of the DOS and analyzed their complication rates. We compared expected hospital days with the actual hospital days spent and calculated a figure of days and money saved.

Results: A total of 118 patients underwent groin or axillary dissection of which all had surgical drains placed. 54 of them had groin dissections and 64 had axillary dissections. By having the outreach drain service we saved 156 in hospital days, giving savings of £37,760. There was a significant difference in complication rates between the two groups: Cellulitis in DOS group 15%, Cellulitis in group with out DOS 21%. Seroma occurrence that required drainage in DOS group 10%, Seroma in group with out DOS 34%.

Conclusion: The DOS service reduces seroma and cellulitis occurrence in patients who undergo Groin and Axillary dissections. Centers who perform these procedures should be encouraged to set up their own Outpatient Drain Service to decrease costs and allow patients to quickly return home.
LYMPHOSCINTIGRAPHY AND SENTINEL LYMPH NODE BIOPSY IN PATIENTS WITH CUTANEOUS MELANOMA: “NON CLASSICAL” DRAINAGE SITES

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Aim: Sentinel lymph node (SLN) biopsy is used as staging procedure in cutaneous melanoma patients. We report the results on patients scheduled for preoperative lymphoscintigraphy and SLN biopsy in our Institution, during last 18 months.

Method: 54 patients (26 males, 28 females) median age 51.5 years, with primary cutaneous melanoma were enrolled. Lymphoscintigraphy was performed using dual head camera, after 3-4 intradermal injection of 5MBq of Technetium-99m Nanocoll®. Dynamic study was obtained acquiring ten 60 seconds/frames over the site of injection; static studies (300 seconds/frame) over the regional basins of drainage; SPECT study added in selected cases.

Results: Trunk was the primary melanoma site in 50% of patients, lower extremity, head/neck, upper extremity and acral localization in 18.5; 16.7; 9.3; and 5.6% respectively. The SLN identification rate was 98.1%. The mean number of SLN on lymphoscintigraphy was 1.94 (range 1-6) per patient. In 49 patients (80.7%) one lymphatic basin was identified. Axilla was the site of SLN in 51%, followed by groin, laterocervical and other location in 30.6; 16.3 and 2.0% respectively. SLNs were identified on atypical sites in seven patients: epitrochlear in two, popliteal and paravertebral area in a single case and chest wall in two patients. In one neck melanoma patient, SLN was visualized in cervical basin on the opposite site, with failure of intraoperative detection. Hystopathologically, SNL positivity rate was 27.7% (15 of 54 patients). Micrometastases were present in 33.3% of positive SLNs. SLN biopsy was successful in 27/28 uncommon SLNs (epitrochlear and popliteal localization) revealing (micro)metastases in both. Uncommon SNL was the only positive node in one case.

Conclusion: Preoperative lymphoscintigraphy enables the precise identification of SLN in unexpected sites. Our results on limited number of patients, suggest that uncommon SLN located in epitrochlear and popliteal area, should be removed as it can present the only positive node.

THE BRAZILIAN EXPERIENCE WITH TUMORAL NECROSIS FACTOR (TNF) ASSOCIATED TO MELPHALAN IN ISOLATED LIMB PERFUSION (ILP)

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Introduction: Isolated limb perfusion (ILP) is a well-established method that allows the regional administration of chemotherapy in patients with advanced melanoma and other malignant neoplasias restricted to the limb. The association of Tumoral Necrosis Factor (TNF) with Melphalan as chemotherapeutic agents has shown good results especially in unresectable lesions or in transit metastasis, that would lead to amputation. In Brazil, TNF was approved for use in January 2012.

Objectives: To describe and evaluate the first series of cases of patients treated with TNF and Melphalan in ILP at A.C. Camargo Hospital in 2012 by the Skin Cancer Department of this Institution.

Results: From January 2012 until now we have performed four ILP with TNF associated to Melphalan (Table 1). There were three cases of melanoma and one epithelioid hemangioendothelioma. Three patients were men, and the mean age was 58 years. There were no major postoperative complications, and all patients were classified as Wieberdink II regarding to limb evolution. The average intensive care unit stay was 3 days and 7 days in nursery. Only one patient presented recurrence in the same limb, but above the tourniquet line. This patient was referred to the Clinical Oncology Department and is currently in pleimumab protocol.

Conclusion: TNF has been recently approved for use in clinical practice in Brazil. Although we have been using TNF for a short period of time, we present it as a safe and effective treatment modality for melanoma and other cutaneous neoplasias with multiple in transit metastasis or bulky disease.

NON-INVASIVE MELANOMA DIAGNOSIS USING MULTISPECTRAL IMAGING

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Aim: The project objective was to develop a new method to diagnose melanoma lesions with a multispectral imaging system. The characteristic multispectral features of melanoma lesions were analyzed by a support vector machine (SVM) classifier.

Materials, Subjects and Methods: A set of melanoma images and clinical diagnoses were used to train the SVM classifier. The SVM classifier was then applied to a set of images not used for training.

Results: The SVM classifier achieved a classification accuracy of 98.1% for the set of images used for training. The classifier was able to correctly classify 98.1% of the images in the test set.

Conclusion: The SVM classifier achieved a high accuracy in the classification of melanoma lesions using multispectral imaging. This method has the potential to be used as a non-invasive diagnostic tool for melanoma.
P65

**REFLECTANCE CONFOCAL MICROSCOPY TO AID IN THE DETECTION OF LENTIGO MALIGNA RECURRENCE AFTER TREATMENT**

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**Aim of the investigation:** Clinical and dermoscopic diagnosis of lentigo maligna (LM) is usually challenging, as prior therapies and interventions further difficult the diagnosis of recurrent LM due to postinflammatory pigmentation and scarring. We aimed to evaluate the utility reflectance confocal microscopy (RCM) in this clinical setting.

**Materials, Subjects and Methods:** We included 10 consecutive lesions that showed pigmentation in areas previously treated for LM. We evaluated already described RCM features for LM diagnosis and performed a 4 mm punch biopsy of imaged area. Correlation between RCM findings and histopathology/immunohistochemistry was performed.

**Results:** We studied 10 lesions from 9 patients. Previous treatment included radiotherapy (5), surgery (2), cryotherapy (2), CO2 laser (1). Mean time since last treatment was 2.5 years (range: 6 months-6 years). Three patients had received subsequent treatment for multiple recurrences. After RCM examination recurrence was suspected in 8 cases and confirmed in 2 cases. In 3 RCM positive cases histological correlation could not demonstrate any recurrence. These cases exhibited widespread dendritic and some round intrapidermal cells mimicking abortive infiltration. In the remaining 7 cases the RCM diagnosis was histologically confirmed.

**Conclusions:** RCM can be useful in the monitoring of LM after treatment. In sun-damaged skin, the visualization of widespread dendritic cells in basal and suprabasal layers by RCM may mimic a recurrence of LM. These structures correlate with activated melanocytes which also may be a pitfall in the confocal evaluation of these lesions.

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**SENTINAL LYMPH NODE STATUS CLINICOPATHOLOGICAL AND PROGNOSTIC ASSOCIATIONS - INITIAL EXPERIENCE FROM THE SINGLE CENTER**

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**Objective:** Sentinel lymph node (SLN) status is essential for adequate staging of melanoma, selection of patients for adjuvant therapy, and for the regional disease control. AIM: Evaluation of detection rate of SLNB using blue dye/lymphoscintigraphy combined technique and correlation of SLN status with clinicopathological characteristics and disease outcome.

**Materials and Methods:** From December 2010 to October 2012 SLNB was performed in 69 melanoma patients (63 males, 36 females, age 24-81, median 52.2 years) according to EORTC/ENMAM recommendations. Median follow-up time was 15.5 (6-23) months. Results: Detection rate of lymphoscintigraphy was 98%, while the detection rate of blue dye was 74.5%. Micrometastases were found in 18/69 (26.7%) patients. The highest rate of SLN positivity was found in acral melanomas (4/4, 100%, p=0.0038 vs. non-acral), melanomas on head and neck (4/12, 33.3%) and lower extremities (5/15, 33.3%). Mean Breslow thickness was 4.28±3.85 mm in SLN positive, and 2.99±2.89 mm in SLN negative patients. This difference was significant for superficial spreading melanoma subgroup (3.93±4.1 vs. 1.98±1.64 mm, p=0.008). There were no differences found in clinicopathological type and regression between groups. However, mitotic rate was higher in SLN positive nodular melanoma patients compared to SLN negative NM group (7.6±4.8 vs. 3.46±3.88, p=0.07). Ulceration was associated with SLN positivity (7/40, 17.5% vs. 30/37, 31.1%, p=0.09). Median overall survival was shorter in SLN positive patients (22 months vs. 36 months, p=0.03). A trend toward shorter median survival was found in SLN positive patients with NM compared to SSMM patients, and ulcerated vs. non-ulcerated tumors (13 vs. 22 months, p=0.08). In SLN positive patients, complete lymph node dissection revealed presence of metastases in non-sentinel nodes in 5/18 patients (12.4%).

**Conclusion:** SLN positivity was associated with thick melanomas, ulcerated tumors with higher mitotic rates and was followed by finding of non-sentinel metastases in regional lymph basin. Also, SLN status was a strong prognostic factor in this study, as previously reported.

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**MELPHALAN DISPOSITION DURING ISOLATED LIMB INFUSION AND THE EFFECT OF NORMALISED BODY MASS ADJUSTMENT DEFLTY, Clare 1; Sharma, Ashish 1; George, Stephen2; Howles, Allison; Marsden, Jerry1**

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Isolated limb infusion (ILI) with melphalan and actinomycin is increasingly used for regional chemotherapy in patients with unresectable limb cancer. Toxicity is predominantly due to myelosuppression and neurotoxicity in muscle. Conventional dosimetry is associated with large variance in peak melphalan level and area under the concentration-time curve (AUC). We tested whether adjusting melphalan dosage for nor - malised body mass (NBMA) would reduce variance and toxicity.

59 consecutive patients (20 male, 39 female) had ILI with a standard 30 minute drug exposure using melphalan 7.5mg/L limb volume and actinomycin 75mcg/L. Limb volume was measured using a limb cast (n=29) or computer modelling (n=30). NBMA was made in 45 patients. Limb melphalan concentrations were measured by high performance liquid chromatography at 0, 5, 10, 15, 20, 25 and 30 minutes; systemic levels were measured at 10, 20 and 30 minutes during ILI, and at 10 and 30 minutes after tourniquet release. Toxicity was measured daily by validated clinical grading (Weberlink) from 1 (nil) to 5 (severe) and creatinine kinase (CK) levels. Melphalan elimination was a single first order process, with mono-exponential drug clearance. NMBa reduced peak melphalan concentration (16403±5230) to 14500±780 (p<0.001, AUC<sub>0-30</sub>). We tested whether adjusting melphalan dosage for nor - malised body mass (NBMA) would reduce variance and toxicity. 59 consecutive patients (20 male, 39 female) had ILI with a standard 30 minute drug exposure using melphalan 7.5mg/L limb volume and actinomycin 75mcg/L. Limb volume was measured using a limb cast (n=29) or computer modelling (n=30). NBMA was made in 45 patients. Limb melphalan concentrations were measured by high performance liquid chromatography at 0, 5, 10, 15, 20, 25 and 30 minutes; systemic levels were measured at 10, 20 and 30 minutes during ILI, and at 10 and 30 minutes after tourniquet release. Toxicity was measured daily by validated clinical grading (Weberlink) from 1 (nil) to 5 (severe) and creatinine kinase (CK) levels. Melphalan elimination was a single first order process, with mono-exponential drug clearance. NMBa reduced peak melphalan concentration (16403±5230) to 14500±780 (p<0.001, AUC<sub>0-30</sub>). We tested whether adjusting melphalan dosage for nor - malised body mass (NBMA) would reduce variance and toxicity.

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**S100B AND LDH LEVEL ANALYSIS OF BRAF MUTANT AND BRAF/ NRAS WILDCYPE ADVANCED MELANOMA PATIENTS: A SINGLE CENTER EXPERIENCE**

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**Aim of the Investigation:** S100B is an acidic calcium binding protein used as a marker for immunohistochemical identification as well as for disease evaluation. Furthermore LDH has been incorporated into the current AJCC staging system for stage IV melanoma patients and its use as a prognostic factor for disease progression has been widely discussed. The current study sought to determine associations between these markers and clinical outcome in regard of the BRAF mutation status in a retrospective cohort of melanoma patients.

**Materials, Subjects and Methods:** S100B and LDH values of 47 patients with BRAF mutated melanoma and of 22 patients with BRAF/NRAS wild-type melanoma were retrospectively analyzed by the time point of the first distant metastasis. Patients in both groups were treated with Vemurafenib, Iplimumab or Sorafenib. All BRAF wild type melanoma patients were also NRAS wild type.

**Results:** None difference between the S100B mean levels and the mutation status was determined (BRAF pos=1.33, BRAF/NRAS wt=1.29, p=0.96). Overall the LDH levels of 38 BRAF mutant and 17 BRAF/NRAS wild-type patients were available in the time point of distant metastasis. The LDH levels were significantly higher in the wild type (LDH mean=685U/L) than in the BRAF mutant population (mean=423U/L, p<0.01). There was no statistically significant difference between the median overall survival (OS) of the BRAF mutant versus BRAF/NRAS wild-type (1.2 years vs 0.89 years, p=0.77) melanoma patients. Amongst the BRAF mutant subpopulation, no difference between the median OS of patients treated with the BRAF inhibitor versus other treatments could be demonstrated (1.12 vs 1.21, p=0.9).

**Conclusions:** Although determination of serum biomarkers such as LDH and S100B may have a prognostic value in stage IV melanoma especially since the latter reflects the dynamic of the disease, it does not translate into a survival benefit in regard of the BRAF mutation status in the retrospective setting. To better address this issue, further investigation with larger patient cohort is required.
P69

ONE-YEAR FOLLOW-UP OF A COHORT OF PATIENTS PARTICIPATING IN A TARGETED SCREENING FOR MELANOMA

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Context: Promoting a targeted screening for melanoma is limited by the lack of scientific data on its feasibility and its impact on morbidity.

Aim: To describe the care course of patients at high risk of melanoma during the 12 months following their inclusion in a targeted screening procedure. To identify sociodemographic factors associated with a poor adherence to the procedure.

Method: Design: Prospective cohort study. Subjects: Patients at high risk of melanoma were included, thanks to the use of the Self Assessment Melanoma risk Score. Course: 80 GP’s were asked to undertake a total skin examination of all enrolled patients. When a suspicious lesion was identified, the patient was referred to a dermatologist. The dermatologist could conclude either that the lesion was benign, or suggest a follow-up, or orientate the patient toward an exeresis. Main outcomes measures: Staff reduction between the different steps of the screening, consultation courses, and non-adherence rate.

Results: On 3953 patients at risk, 909 consulted a dermatologist, 100 had an exeresis, 8 had a melanoma. All melanomas detected had a Breslow less than 1 mm. The median consultation time with the dermatologist was 84 days. The median time before melanoma exeresis was 79 days. 40% of patients referred to the dermatologist did not undertake an exeresis referral toward a dermatologist would increase the adherence (OR=2.13, p<0.001). Living in a rural area was associated with a lower adherence (OR=2.27, p<0.001).

Conclusions: The benefit of a targeted screening might be important. The observed prevalence in the high risk population appeared to be 6 times higher than the prevalence in the general population. Future studies should focus on the reasons for which some patients do not comply with the screening procedure proposed.

P70

SENTINEL LYMPH NODE MICROMETASTASIS AS A PROGNOSTIC FACTOR: AN ANALYSIS OF 368 SLNB

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Introduction: Sentinel lymph node biopsy (SLNB) is widely accepted to be a staging procedure for evaluating locoregional spread in patients with cutaneous malignant melanoma (MM). Since the status of regional lymph nodes is a key prognostic factor, the identification of patients with a high risk of SLNB involvement has been added by AJCC in the N-category in tumor staging. Our study focuses on the correlation between in sentinel lymph node status and additional nodal metastases in the completion lymph node dissection(CLND); moreover, it analyses the rates of recurrent/metastatic disease and mortality among patients with positive SLNB compared with those with negative SLNB.

Methods: From 2000 to 2010 SLNB was performed on 388 patients, preceded by lymphoscintigraphy with 99mTc Nanocoll. Patients were divided into three groups according to Sentinel node status: Group A (248 patients; Negative SLNB), Group B (34 patients; Micrometastatic (<2mm) disease in the SLNB) and Group C (86 patients; Macro-metastatic disease (>2mm) in the SLNB). Follow-up was performed every three/months for two to eleven years with clinical examination and ultrasound (eventually chest X-ray, CT or PET). Fisher’s exact and Chi-square tests were used to compare the incidence of recurrent/metastatic disease and mortality among SLNB-positive and -negative patients.

Results: SLNB resulted negative in 248/368 (67.3%) patients (Group A); mortality and recurrent or metastatic disease was significantly lower in this group (respectively 11/248; 14.5% and 36/248 14.5%). In Groups with positive SLNB, patients in Group C had a higher rate positive CLND (22/86; 25.96%) compared with Group B (4/34; 11.7%). In Group B, 12/34 (35.29%) patients had a recurrence or metastasis were diagnosed, compared with an incidence of secondary events and mortality of 37/86 (42.9%) and 19/86 (22%) in patients in Group C.

Discussion: Our experience confirms the positive correlation between metastatic involvement of SLNB and the higher incidence of recurrent or metastatic disease and mortality. Moreover it shows that CLND is more likely to be positive if a macro-metastatic involvement of SLNB is found. Notwithstanding, our data suggest no significant difference between Micro and Macro-metastasist in the SLNB as a prognostic index for recurrent or metastatic disease and mortality.

P71

SUN, NAEVI AND SUNSCREENS: HOW A MESSAGE CAN STRAY

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Background: Sunscreen use is generally recommended in order to prevent skin cancer development. Erroneous patterns of sunscreen use were reported, including the selective application on melanocytic naevi.

Objectives: To assess prevalence and determinants of selective sunscreen application on naevi and participants’ behavioural risk profile overall.

Methods: A multilingual, dichotomous, funnel-designed questionnaire about sun exposure/protection habits and perceived naevus count was administered to patients attending 5 Dermatology Departments in 3 countries (Italy, France, Spain). Multivariate logistic regression models were used to determine independent predictors of each answer.

Results: Among the1816 subjects surveyed (58.3% females, age 14-90 (median 43) years 44.7% Italy), 1273 (70.1%) reported intentional sun exposure and 1109/1273 (87.1%) reported sunscreen use. Among the latter, 1086 (97.9%) stated they have moles on their skin; 582/1086 (52.4%) reported a high naevus count. Fifty-one/1086 (4.7%) reported selective sunscreen application on naevi. Reported information sources were: dermatologist (49.0%), personal belief (14.9%), internet (14.7%); relative/friend (10.8%), relative (7.8%), media (7.8%), paediatrician (2.0%). Increasing age (p<0.05) and being female (p<0.01) were associated with a lower adherence (OR=2.27, p<0.001).

Conclusions: Selective sunscreen application on naevi was more common than expected. It is of concern that this was recommended by a physician in >50% of the cases. There is a need to educate patients, non-expert clinicians, media and the sunscreen industry on this matter.

P72

CONFOCAL MICROSCOPY FOR MONITORING RESPONSE TO IMIQUIMOD IN LENTIGO MALIGNA MELANOMA

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Lentigo maligna melanoma (LMM) often presents as an ill-defined lesion on sun-exposed areas in elderly. It is frequent the need of alternative non-invasive therapies due to location, extension and age of patients. Our aim was to evaluate the utility of reflectance confocal microscopy (RCM) to monitor response of LMM to nonsurgical treatment with topical imiquimod 5%.

Subjects and Methods: Prospective study of 20 patients affected by LMM treated with topical imiquimod 5% at the Melanoma Unit in the Hospital Clinic of Barcelona. All patients were digitally monitored by means of digital dermoscopy and in vivo RCM before and following the completion of their treatment course (mean time of follow up: 26.7 months).

Results: A good correlation between RCM and histopathologic findings was demonstrated in all cases examined. Imiquimod cream was initiated in all patients, with a 90% of compliance. The main cause of abandonment was important local signs of inflammation. Treatment efficacy was estimated as high as 85% and was assessed using RCM and confirmed by biopsy in most of the cases. Interestingly, RCM allowed recognizing the persistence of LMM even in achromic areas or in cases with apparent clearance after clinical and dermoscopic inspection, detecting subclinical disease before the recurrent lesion became evident. Likewise, in cases with clinical or dermoscopic suspicion of recurrence, RCM helped to rule out disease persistence, and this was confirmed by biopsy.

Conclusion: RCM can play a significant role in monitoring response of LMM to topical imiquimod 5%. As RCM can navigate on a noninvasive tool for nonsurgical treatment of LMM.
**GUIDED POSTER TOUR 2**

**Clinical Melanoma Studies**

**P72B**

**ADDITIONAL VALUE OF SENTINEL LYMPH NODE MAPPING WITH SPECT/CT OVER ROUTINARY LYPHOSCINTICGRAPHY IN HEAD AND NECK MELANOMA**

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**Background:** Pre-surgical lymphatic mapping have been shown to be crucial for detection of sentinel lymph node (SLN) in head and neck melanoma. The additional value of single photon emission computed tomography with CT (SPECT/CT) over planar lymphoscintigraphy (LS) alone for detection and localization of SLN in patients with head and neck melanoma has been previously reported.

**Methods:** Thirty-eight consecutive patients with head and neck melanoma who were scheduled for SLN biopsy underwent both conventional planar LS and subsequently SPECT/CT. Epidemiological information as well as atomic site of tumor and lymph nodes, extra SLN undetected by LS, surgical approach and number of node recurrences were evaluated.

**Results:** LS visualized a mean of 2.75 SLN per patient (range, 1-9). SPECT/CT depicted additional SLN in 35% of the patients and clearly showed the exact anatomic location of the hot nodes in all 37 patients. The mean number of extra SLN depicted by SPECT/CT was 3.2 per patient. The surgical approach was adjusted on the basis of SPECT/CT images in 70% of the patients due to a better anatomical location versus the planar LS images. During surgery, 124 SLNs were harvested. This number was similar than that assessed by SPECT/CT (121 nodes) and higher than the number ascertainment by planar images (102 lymph nodes).

**Conclusion:** SPECT/CT visualizes more SLN than conventional planar LS images and shows their anatomic location improving the surgical mapping, planning and approach. Routine SPECT/CT is recommended in patients with head and neck melanoma who undergo SLN biopsy.

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**GUIDED POSTER TOUR 3**

**Clinical Non Melanoma Studies**

**P73**

**PHOTODYNAMIC THERAPY AND 3% DICLOFENAC IN 2.5% SODIUM HYALURONATE GEL (SOLARAZE®) IN COMBINATION WITH THE TREATMENT OF PRECANCEROUS AND NONMELANOMA SKIN CANCER: PRELIMINARY RESULTS**

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**Aim:** To evaluate whether photodynamic therapy (PDT) in combination with 3% diclofenac in 2.5% sodium hyaluronate gel (DIC/HA) is a beneficial combination for the treatment of actinic keratosis (AK), positively affecting the incidence of recurrence with a reduction in the number of admissions to hospital for PDT.

**Methods:** 27 patients with multiple recurrent AK were subjected to 8-week home therapy with two applications daily of DIC/HA, followed by PDT sessions at times 0, 7, 14 (for an average of three sessions). Dermoscopic evaluations were performed before therapy began, after 8 weeks of home therapy with DIC/HA and at follow-up visit 32 weeks after last PDT treatment.

**Results:** In dermoscopic examinations prior to topical therapy with DIC/HA there were obvious areas of regression with a vascular hairpin pattern. An average of 25 lesions were treated per patient. In 70% cases, after 8 weeks DIC/HA therapy the number of lesions detected was reduced to an average of 15 and complete healing was noticed at the end of PDT. For these patients there was complete healing of all lesions and no relapses occurred after 32 weeks. In the remaining 30% cases, the results showed a reduction in the number of lesions and their vascular component after DIC/HA therapy and a further significant reduction, if not complete healing, at the end of PDT. At follow-up in these patients the average number of lesions dropped by 82% compared to initial examinations. The combination therapy was well tolerated. There were no cases of discontinuation due to side effects such as itching, local irritation and allergic contact dermatitis.

**Conclusions:** At 8 months after suspension of combination treatment with DIC/HA and PDT, very positive results were observed with a reduction and absence of precancerous lesions but in particular no recurrence for a period of more than 6 months.

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**GUIDED POSTER TOUR 3**

**Clinical Non Melanoma Studies**

**P74**

**USEFULTNESS OF SENTINEL LYMPH NODE BIOPSY FOR EXTRAMAMMARY PAGET DISEASE**

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**Background:** Extramammary Paget disease (EMPD) usually present as carcinoma in situ. However, invasive EMPD is sometimes associated with regional lymph node metastasis and may develop distant metastasis. Despite this poor prognosis, the effectiveness of sentinel lymph node biopsy (SLNB) for EMPD has not been fully evaluated.

**Objectives:** To evaluate the usefulness of SLNB for EMPD.

**Materials and Methods:** Thirty patients with genital EMPD who underwent SLNB between 2005 and 2012 were prospectively studied. The excised sentinel lymph nodes (SLNs) were evaluated by hematoxylin and eosin staining and immunohistochemical stainings for carcinoembryonic antigen and cytokeratin 7. If the SLNs contained metastases, an inguinal lymph node dissection (ILND) was subsequently performed.

**Results:** Eleven of the 30 patients (36.7%) had positive SLNs. Seven of these patients underwent additional ILND; the remaining four patients refused the procedure. No patients had any morbidity associated with SLNB such as infection, lymphocele, and lymphedema. Five of the seven patients who underwent ILND were free of disease during the follow-up period and four of the five patients had fewer than three positive lymph nodes. In contrast, each of the five patients who died of the disease or who are alive with the disease had more than three positive lymph nodes. A nodal recurrence was detected in only one of the 19 patients (5.3%) with negative SLNs. The remaining 18 patients had no evidence of regional or distant metastases.

**Conclusions:** SLNB for EMPD was safe and the rate of false-negative results was relatively low. The prognosis for patients with positive SLNs may be favourable if the SLN metastases are detected at an early stage. However, the therapeutic value of SLNB remained uncertain in this study, and collection of more data is necessary.

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**P75**

**IMPROVEMENT OF THE SENTINEL LYMPH NODE IDENTIFICATION RATE OF CERVICAL SENTINEL LYMPH NODE BIOPSY USING REAL-TIME FLUORESCENCE NAVIGATION WITH INDOCYANINE GREEN IN HEAD AND NECK SKIN CANCER**

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**Aim of the investigation:** The standard technique using lymphoscintigraphy, blue dye, and a gamma probe has established a reliable method for sentinel lymph node biopsy (SLNB) for skin cancer. However, the identification of cervical sentinel lymph nodes (SLNs) is generally lower than that of inguinal or axillary SLNs because of the complexity of lymphatic drainage in the head and neck region and the shine-through phenomenon. Recently, indocyanine green (ICG) fluorescence imaging has been reported as a new method to identify SLNs.

**Materials and Methods:** We hypothesized that fluorescence navigation with ICG in combination with the standard technique would improve the identification rate of cervical SLNs. We performed cervical SLNBs using the standard technique in 20 basins of 18 patients (group A) and cervical SLNBs using fluorescence navigation in combination with the standard technique in 12 basins of 8 patients (group B).

**Results:** The mean number of SLNs was 1.8 per basin (range, 1-4) in group A and 2.4 per basin (range, 1-5) in group B. The SLN identification rate was 85.7% (30/35) in group A and 93.1% (27/29) in group B. The false negative rate was 9.1% (1 of 11 patients) in group A and 0% in group B. Only 1 patient in group B had transient facial nerve paresis postoperatively, which resolved 8 weeks after surgery.

**Conclusions:** Fluorescence navigation with ICG may improve the cervical SLN identification rate. However, greater collection of data regarding the usefulness of cervical SLNB using ICG is necessary.
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SHINY WHITE STreakS: A SIGN OF MALIGNANCY IN SKIN TUMORS
González-Alvarez, Tatiana; Carrera, Cristina; Shitara, Danielle; Ishioka, Priscila; Palacios-Bejarano, Leyla; Malohen, Josep; Puig, Susana
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Introduction: Shiny White Streaks (SWS) are a new dermoscopic criteria detected under polarized light that have been associated to melanoma and other skin tumours.

Methods: Analysis of 800 dermoscopic images for the evaluation of the presence of SWS in the diagnosis of malignant skin tumours.

The data set comprised 123 melanomas, 133 basal cell carcinomas (BCC), 305 melanocytic nevi, 49 seborrheic keratoses, 36 actinic keratoses, 21 squamous cell carcinomas (SCC), 19 solar lentigines, 11 dermatofibromas, 9 lupoidokeratosis, 1 neuroendocrine carcinoma, and 44 benign tumours (hemangiomas, benign keratomas).

Results: SWS were observed in 107 tumors (13.37%); 41 melanomas (38.32%), 41 BCC (38.32%), 5 nevi (4.67%), 6 dermatofibromas (56.1%), 4 actinic keratosis (3.74%), 3 SCC (2.06%), 2 lupoidokeratosis (1.87%), 1 neuroendocrine carcinoma (0.93%). Only 1.6% of all nevi presented SWS. The presence of SWS suggested a 10-fold risk of malignancy, BCC (melanocytic and neuroendocrine carcinoma) (OR: 10.534 IC 95% 6.357-17.455 p<0.0005).

Conclusions: The presence of SWS in a skin tumour is associated to malignancy. Except in the case of dermatofibromas, this criterion is rarely seen in benign cutaneous tumours.

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LMAX, A NEW EFFICACY PARAMETER FOR FIELD-DIRECTED ACTINIC KERATOSIS TREATMENTS: RESULTS WITH IMIQUIMOD 3.75%
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Aim of the investigation: Actinic keratoses (AK) treatments should ideally target both the clinically evident lesions and the invisible “subclinical” lesions which are present in the surrounding cancerous field. Current efficacy endpoints for AK treatments (e.g. complete and partial lesion clearance rates from baseline) do not capture the clearance of subclinical lesions and so underestimate the true efficacy of field-directed therapies. Consequently, the reduction of lesions from Lmax, the maximum lesion count during treatment, has been proposed as a novel efficacy concept for AK therapies. The aim of this investigation was to evaluate this concept for assessing the efficacy of imiquimod 3.75%, a new therapy for large field treatment of AK which can detect and treat subclinical and clinical AK lesions.

Materials, Subjects and Methods: This pooled analysis included data from two identical 14-week, vehicle-controlled, double-blind studies. Patients applied ≤2 sachets of treatment/day to the affected area for two treatment cycles over two weeks separated by a two-week treatment-free interval. End of study (EOS) was eight weeks after the last application.

Results: This analysis included 319 patients who had a median of 10 AK lesions at baseline. Lmax for the imiquimod and placebo groups (treatment Week 2) was 22 and 13, respectively. Imiquimod 3.75% was associated with a greater absolute median reduction in lesion counts from Lmax to EOS (18 vs 5) and a greater median percentage reduction from Lmax to EOS (92.2% vs 39.3%).

Conclusions: The reduction in lesions from Lmax is a novel efficacy parameter that should become the standard for assessing field-directed AK therapy as it takes into account the clearance of both subclinical and clinical lesions, in contrast to traditional efficacy endpoints. Imiquimod 3.75% makes subclinical lesions visible and effectively treats up to 92% of all AK lesions. Together, Lmax and imiquimod 3.75% set a new standard in AK management.

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RISK OF PROGRESSION TO SQUAMOUS CELL CARCINOMA FROM ACTINIC KERATOSIS: CASE STUDIES OF POTENTIAL BENEFIT WITH IMIQUIMOD 3.75%
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Aim of the investigation: Patients who present with multiple actinic keratoses (AK) lesions have a higher risk of developing invasive squamous cell carcinoma (SCC). All lesions (including clinical and subclinical lesions) should be treated, since it is impossible to predict which will progress to invasive SCC. The reduction of lesions from Lmax, the maximum lesion count during treatment, is a new concept to assess the efficacy of AK therapy against subclinical and clinical lesions. The aim of these case studies was to illustrate how imiquimod 3.75% effectively treated AK lesions in two patients with different baseline lesion counts.

Materials, Subjects and Methods: Patients applied ≤2 sachets of treatment/day to the affected area for two treatment cycles over two weeks separated by a two-week treatment-free interval and were followed-up for eight further weeks as part of a clinical study.

Results: Patient 1 was white, female, 56.6 years old and had five AK lesions at baseline (i.e., low SCC risk). The lesion count increased to an Lmax of 16 during the first treatment cycle and subsequently decreased to zero by Week 10. Patient 2 was white, male, 78.9 years old and had 20 lesions at baseline (i.e., high SCC risk) increasing to an Lmax of 40 lesions during the first treatment cycle. Over the following 12 weeks, the number of lesions decreased to four, i.e., a reduction of 36 lesions from Lmax.

Conclusions: By detecting subclinical lesions, imiquimod 3.75% makes a patient’s full AK lesion burden evident and reveals their true SCC risk profile. By targeting subclinical and clinical lesions, imiquimod 3.75% may reduce the risk of invasive SCC in high-risk patients and those who may appear to have a lower risk when only visible lesions are considered. Therefore, imiquimod 3.75% should be considered a drug of choice for AK management.

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IMIQUIMOD 3.75% VERSUS OTHER ACTINIC KERATOSIS TREATMENTS: INDIRECT EFFICACY COMPARISON
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Aim of the investigation: Imiquimod 3.75% is an AK treatment which detects and treats both clinical and subclinical lesions on large areas of sun-exposed skin, i.e. entire face or scalp. This investigation compared the efficacy of imiquimod 3.75% with imiquimod 5% and diclofenac sodium 3%. Since traditional efficacy endpoints compare the reduction in clinically visible lesions from baseline to study end, without considering subclinical lesions which may become detectable during treatment, we assessed the efficacy of imiquimod using the lesion reduction from Lmax (maximum lesion count during treatment). This new concept assesses the efficacy of AK therapies against subclinical and clinical lesions.

Materials, Subjects and Methods: For imiquimod 3.75%, data were pooled from two clinical studies. Patients applied ≤2 sachets of treatment/day for 2 two-week treatment cycles separated by two-week treatment-free interval. Data for other products were obtained from published studies. For diclofenac sodium, efficacy was assessed using lesion reduction from baseline since there is no evidence it can detect and treat subclinical lesions.

Results: Mean (median) absolute reduction of lesions from Lmax to study end was 21.8 (18) with imiquimod 3.75% vs 6.3 (5) for placebo, and 6.3 (6) with imiquimod 5% vs 2.3 (1) for placebo. Mean lesion reduction from baseline to study end was 3.3 for diclofenac sodium and 2.0 for placebo. Lesion clearance from Lmax to study end was 86.6% with imiquimod 3.75%, 54.6% for diclofenac sodium, and 80.3% for imiquimod 5%.

Conclusions: Using the Lmax concept, imiquimod 3.75% is more effective at reducing AK lesions than imiquimod 5% and much more effective than diclofenac sodium. These results need confirming in direct comparative studies. Given its ability to effectively target and clear subclinical and clinical lesions and that it can be applied to large areas of sun-exposed skin, imiquimod 3.75% could be considered an AK field treatment of choice.
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12-MONTH UPDATE OF THE ERIVANCE BASAL CELL CARCINOMA (BCC) STUDY: EFFICACY AND SAFETY OF THE HEDGEHOG PATHWAY INHIBITOR VISMODEGIB IN PATIENTS WITH METASTATIC AND LOCALLY ADVANCED BCC
Hauschild, Axel1; Migden, Michael R2; Grob, Josua-Jacques3; Loupy, A4; Hassan, Nicolas5; Ascenso, Pedro6; Pawlik, Garbe, Claus7; Mitchell, Lada6; Starnawski, Michal8; Hauschild, Axel9
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Aims: Limited therapies are available for patients with locally advanced (LA) or metastatic (M) BCC. Abnormal Hedgehog (HH) pathway signalling underlies the pathogenesis of the majority of BCCs and vismodegib is an HH pathway inhibitor. In the pivotal ERIVANCE BCC trial, the primary endpoint (objective response rate [ORR]) by Independent Review Facility (IRF) was met. Here we present results of an additional 12 months’ follow-up (to 28 November 2011).

Methods: In this multicentre, non-randomised study, 104 patients with mBCC (radiographically measurable) and histologically confirmed laBCC (inoperable, multiply recurrent or for whom surgery would be disfiguring or result in morbidity) received 150 mg oral vismodegib daily until disease progression or intolerable toxicity. Endpoints assessed by IRF and investigators (INV) included ORR, duration of response (DOR), and progression-free survival (PFS); overall survival (OS) and safety were also assessed.

Results: In efficacy evaluable patients with mBCC (n=33) and laBCC (n=63), ORR was 33.3% and 47.6% by IRF; 48.5% and 60.3% by INV, respectively. ORRs were similar to the primary analysis. Median DOR was 7.6 months and 9.5 months by IRF; 14.7 months and not estimable by INV, respectively. Median PFS was 9.5 months by IRF for both cohorts; and was 9.3 and 12.9 months by INV for mBCC and laBCC, respectively. Median OS was 24.1 months and not estimable, with 1- and 2-year survival rates of 78% and 60% (mBCC), and 85% and 85% (laBCC). The adverse event (AE) profile was consistent with that previously reported for the primary analysis, with AEs reported in >30% of patients including muscle spasms, alopecia, dysgeusia, weight loss, fatigue, hæsema and amenorrhoea (in women of childbearing potential).

Conclusions: This 12-month update confirms the durability of response observed in vismodegib-treated patients with advanced BCC, and provides further evidence of vismodegib as an effective treatment for this population.

INTERIM ANALYSIS OF STEVIE, A SINGLE-ARM, OPEN-LABEL, MULTICENTRE STUDY TO EVALUATE THE SAFETY OF THE HEDGEHOG PATHWAY INHIBITOR VISMODEGIB IN PATIENTS WITH ADVANCED BASAL CELL CARCINOMA (BCC)
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Aim of the Investigation: While most cases of BCC can be managed by surgery, some progress to such advanced stage that surgery is inappropriate. Vismodegib (Erivedge®) is a first-in-class Hedgehog pathway inhibitor approved for advanced BCC (aBCC: locally advanced or metastatic) in the US, based on the pivotal study ERIVANCE BCC. STEVIE is a pre-approval safety study of vismodegib in aBCC.

Materials, Subjects and Methods: A BCC patients receive oral vismodegib 150 mg, once-daily until progressive disease, unacceptable toxicity or withdrawal. Safety is assessed by Common Terminology Criteria for Adverse Events v4.0. Overall response rate is assessed according to Response Evaluation Criteria in Solid Tumours, v1.1. Recruitment is ongoing.

Results: This analysis (data cutoff: 17 May 2012) included 150 patients with locally advanced (n=138) or metastatic (n=12) BCC with potential for ≥3-month follow-up, from six European countries and Canada. Locally advanced patients had lesions considered inoperable (54.3%), or surgery contraindicated (45.7%). Median duration treatment was 144 days (range, 2–32). The most common treatment emergent adverse events (TEAEs, ≥20% of patients) included muscle spasms (53.3%), ...

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... alopecia (42.7%), dysgeusia (36.0%), ageusia (27.3%), and asthenia (26.7%). Most TEAEs were mild or moderate in severity. Serious TEAEs occurred in 22 patients (14.7%). Patients discontinued treatment for ≥30% and 60% (mBCC), and 93% and 85% (laBCC). The adverse event (AE) profile was consistent with that previously reported for the primary analysis, with AEs reported in >30% of patients including muscle spasms, alopecia, dysgeusia, weight loss, fatigue, hæsema and amenorrhoea (in women of childbearing potential).

Conclusions: This 12-month update confirms the durability of response observed in vismodegib-treated patients with advanced BCC, and provides further evidence of vismodegib as an effective treatment for this population.

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Conclusions: This 12-month update confirms the durability of response observed in vismodegib-treated patients with advanced BCC, and provides further evidence of vismodegib as an effective treatment for this population.

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BEDSIDE PATHOLOGY WITH EX VIVO FLUORESCENCE CONFOCAL MICROSCOPY TO GUIDE MOHS SURGERY
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Background: Real-time high-resolution imaging of human skin is possible with a confocal microscope. Ex vivo fluorescence confocal mosaicing microscopy (FCM) offers an attractive alternative to frozen histopathology during Mohs surgery since nuclear and cellular morphology may be observed in real time and directly in freshly excised tissue similar to that in conventional histology. An application of interest is rapid detection of residual basal cell carcinoma (BCC) in skin excisions during Mohs surgery.

Objectives: 1) To evaluate the overall sensitivity (Se), specificity (Sp), positive predictive value (PPV) and negative predictive value (NPV) of ex vivo imaging with FCM for the detection of residual BCC in Mohs fresh tissue excisions. 2) To describe and validate FCM criteria for the diagnosis of BCC.

Methods: Seventy-five consecutive patients from our Mohs Surgery Unit with eighty surgically removed BCCs were prospectively enrolled in the present study. All lesions underwent Mohs surgery. One hundred and twenty skin samples were prospectively collected during Mohs surgery, consisting of excisions with and without residual BCC of all major subtypes. The tissue was stained with acridine orange and imaged with an ex vivo FCM. Each mosaic was divided into 2 or 4 subsections, resulting in 400 submosaics for study. The Mohs surgeon and two dermatopathologists independently assessed the confocal images and the frozen sections respectively, recording the presence or absence of BCC.

Results: 1) The overall Se, Sp, PPV, NPV of ex vivo FCM detecting residual BCC was 88%, 99%, 98% and 97% respectively. 2) Seven different BCC criteria for FCM were described and evaluated including, fluorescence, demarcation, nuclear crowding, clefting, nuclear pleomorphism and enlarged nuclear to citoplasm ratio. The correlation with conventional histology was very good (Kappa: 0.69). 3) Moreover the new technique took half time when compared with the processing with conventional hematoxilin & eosin frozen sections.

Conclusions: The results demonstrate the feasibility of confocal mosaicing microscopy in fresh tissue toward rapid surgical bedside pathology to potentially guide Mohs surgery.

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P83 EVALUATION OF MYC STATUS IN ORAL LICHEN PLANUS IN PATIENTS WITH PROGRESSION TO ORAL SQUAMOUS CELL CARCINOMA

Segura, Sonia; Rozas-Muñoz, Eduardo; Toll, Agustí; Martín-Ezqueru, Gemma; Masferrer, Emili; Espaní, Blanca; Martinez, Mairà; Baró, Teresa; Barranco, Carole; Pujió, Ramon M

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Aim of the investigation: To determine MYC status by fluorescence in situ hybridization (FISH) and immunohistochemistry (IHC) in OLP lesions from patients with progression to OSCC (Group II) and compare with OLP lesions from control patients (Group I).

Materials, Subjects and Methods: We constructed two tissue microarrays with 11 OSCC samples (Group IA), 17 OLP samples from patients of group II, 13 OLP specimens from control patients (Group I). IHC evaluation of the MYC expression was determined in 100 non-overlapping nuclei per sample. FISH evaluation was determined by calculating percentage C-MYC expression in the epithelial cells.

Results: OSCC showed MYC copy number gains and C-MYC overexpression in 91% and 73% of cases, respectively. MYC gains were detected in 47% of samples from group IB and were absent in all samples from group II. C-MYC was overexpressed in 87% of cases from group IA and in only 44% of control specimens (group IB). The differences in MYC status between group IA and IB were statistically significant.

Conclusions: OLP lesions in patients with progression to OSCC show MYC gains and C-MYC overexpression. In patients with severe OLP, determining MYC status may predict a subgroup of patients with higher risk to progress to OSCC.

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P84 INTERIM ANALYSIS OF AN OPEN LABELED, SINGLE ARM MULTICENTER STUDY OF ELECTROCHEMOTHERAPY IN SKIN CANCER

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Background: Surgical resection of skin cancers can pose significant challenges in achieving local control while preserving normal tissue and function. Electrochemotherapy involves the combined use of electroporation with intratumoral injection of low dose bleomycin to treat local tumors. This Phase IV study was designed as an open-labeled study to measure local control and pharmaco-economic parameters for electrochemotherapy in primary or recurrent squamous cell carcinoma of the skin, basal cell carcinoma as well as recurrent metastatic melanoma.

Methods: Patients with primary or recurrent histologically confirmed tumors with no evidence of brain metastases were eligible for enrollment. Safety and local control were measured. Patients received local injection of bleomycin followed by electroporation. Concomitant therapy was permitted when warranted.

Results: The study was conducted at 15 clinical centers across Western Europe, 88 patients were enrolled and received treatment. At the time of analysis, 69/88 (78.4%) patients were evaluable at the 6-month follow up. Of the 69 patients, 22 had metastatic, 33 primary and 14 recurrent tumors. For primary tumors 24/33 (72.7%) had a complete response; 5/14 had disease progression and 1/14 a local recurrence. The complete response rate at 6 months among basal cell carcinomas was 92.8% and 70% among squamous cell carcinomas. Response rate of melanoma was not calculated since multiple tumors were treated with concomitant therapy. The treatment was well tolerated. The most frequent treatment related AEs were pain, infection, and insomina. All were transient and manageable.

Conclusion: Electrochemotherapy appears to provide local control with the potential advantage of preserving normal tissue and therefore warrants further exploration as an alternative or even adjuvant treatment in cutaneous skin cancers.

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P85 USEFULNESS OF DERMOSCOPY FOR THE EARLY DIAGNOSIS OF NON MELANOMA SKIN CANCER

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Aim of the investigation: The primary objective was to evaluate the usefulness of dermoscopy in the early diagnosis of skin tumours. The secondary objective was to describe the most significant dermoscopic findings in non-melanoma skin cancer.

Subjects, Materials and Methods: We conducted a prospective observational study selecting patients with history of multiple previous non-melanoma skin tumours. All minimally suspicious lesions were biopsied and clinical and dermoscopic pictures were obtained.

Results: For the preliminary analysis, 78 patients with 91 lesions were included. The median size of the lesions was 7 mm (range 1–30 mm). The mean number of previous non-melanoma skin tumours was 5.3 per patient. The diagnoses were as follows: 44 basal cell carcinomas (BCC), 8 actinic keratoses (AK), 7 squamous cell carcinoma in situ (SCC), 8 squamous cell carcinomas (SCC), 3 thin melanomas (one amelanotic), 1 dysplastic nevus and 2 benign lesions.

The agreement between dermoscopic and clinical diagnosis was very good (kappa > 0.8). In addition to the typical features of BCC (90.9% had a positive Menzies score), 14 lesions showed brown globules and we observed a milky-pink background in 53.1%. In 13 BCC, a white rim surrounding the lesions was detected (positive predictive value of 87%). Over 70% of the lesions with white shine structures were BCC. The most significant dermoscopic features of SCC and AK were glomerular vessels and a red pseudo-network, respectively.

Conclusion: In the present study we have shown that dermoscopy allows for the early detection of non melanoma skin tumours which has a significant impact in the quality of life and direct costs as it reduces morbidity from surgical treatment. Further description of dermoscopic features of non melanoma skin cancer may aid in a better characterization of these lesions for early diagnosis.

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P86 POSTOPERATIVE ULTRASOUND DIAGNOSIS OF RELAPSES IN BASALOSALOMAS

Szalai, Klára; Hatvani, Zsófia; Artner, Attila; Tóth, Kláudia; Harsány, Judit; Wikonkál, Norbert; Bottlik, Gyula; Somlai, Beáta; Kárpáti, Sarolta Semmelweis University, Budapest, Hungary

Hypothesis: Differentiation of relapses after surgery of basalosalamas in the scar tissue is difficult. Sonography however gives a precise morphological map on the relapses. Recidive disease and scar tissue can be characterized optimally with the use of high frequency probes, therefore strong indication may be erected for surgery radiation treatment and for chemotherapy with the use of sonography.

Material and Methods: Between april 2011 and july 2012 17 patients with clinical signs of of recidive disease were examined. All patients went through dermascopic and palpation evaluation. These examinations supported the suspicion of presence of recidive disease. Sonographic evaluation was performed with 18 MHz probes. Vascularity, structure and elasticity of the lesions were examined. On sonography recidive disease was characterized as poor echogeneity normal structure with hypervascularity within the dermis showing hard elastographic feature. Recitve tissue showed also poor echogengicity with regular contour. It was however characterized by hypovascularisation and soft elastogram.

Results: Among operated patients in 7 cases sonography showed the morphological criteria of recidive disease, in 2 cases vascularity was suspicious to recidive disease, in 8 cases however sonography showed scar tissue characteristics. Histology confirmed those lesions as recidivas that were suspected on sonography, as well as lesions that were suspected as scar tissue verified as scat tissue. In 2 cases histology found granulation tissue.

Conclusion: Ultrasoundography is an accurate an feasable imaging modality for diagnosing relapses in operated basalosalam patients. Sonography should be applied in cases clinically suspect for recidive disease. It can make decision making more accurate toward appropiate disease, or can exclude the presence of recidive disease.
MEASURING THE RESPONSE TO TOPICAL TREATMENT WITH SOLARAZE (TOPICAL DICLOFENAC 3% GEL). PRELIMINARY REPORT. ON A NOVEL APPROACH USING COMPUTER VISION TECHNIQUES

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Skin cancerization is a common oncological problem and its therapeutic management includes topical treatments. Diclofenac 3% gel stands among the topical options available. The response to this treatment is usually presented as a reduction of the number of actinic keratoses. However, cancerized skin does not only present keratotic lesions but include a vascular component not quantified in the studies reported so far. We propose a novel non-invasive approach using computer vision techniques, capable to quantify both keratotic and vascular damage as well as post-treatment improvement.

A group of 16 patients with sun damage was chosen to be treated with Solaraze (Topical diclofenac 3% gel). Photography was done with a Canon G11 camera before starting the treatment and at the end of it. The topical treatment was applied by the patient at home twice a day for three months in selected areas with sun damage (of the 16 patients, the face area was chosen in 15 cases and the scalp area in 6 cases). Images before and after treatment were automatically aligned in order to make them comparable. A custom image processing software identified the background, combined the color channels as (G-B)/R and used a locally adapted threshold to identify the keratotic areas. Highly reddish areas were used to characterize the vascular damage. Both processes produced binary masks which allowed to quantify the damage and the improvement after treatment. Clinician’s manual corrections were required to remove peripheral wrongly detected areas. We present some of our preliminary results.

Skin cancerization can be quantified using computer vision techniques. We are developing a software that allows us to determine the extent of the damage and quantify the improvement after topical treatment with Solaraze (Topical diclofenac 3% gel). With the application of specific image processing techniques we have been able to quantify skin cancerization and improvement after topical treatment with Solaraze.

EX VIVO MEASUREMENT OF SKIN TUMORS USING 22 MHZ HIGH RESOLUTION ULTRASOUND (TPM)

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High frequency ultrasound is an under-utilized non-invasive technique that allows to visualize skin tumor. The previous knowledge of the tumor’s depth and length facilitates the choice of treatment. Ex vivo evaluation of surgically removed lesions allows the surgeon to know in advance if the tumor has been totally removed. A group of basal cell and squamous cell carcinomas diagnosed clinically and dermoscopically were visualized with a 22 MHZ ultrasound (US) (Taberna ProMedicum). Preexcision and ex vivo, US were taken. Measurements of the preauricular US, histological sample size and ex vivo ultrasound were compared.

High frequency ultrasound has showed to be is excellent non-invasive technique that gives the surgeon the possibility to know if a tumor has been completely removed.

VASCULAR FEATURES OF NONPIGMENTED SKIN TUMORS ASSESSED BY IN VIVO REFLECTANCE CONFOCAL MICROSCOPY

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Introduction: Nonmelanoma skin cancers (NMSC) are the most common tumors in the white population, with rising incidence rates reported in recent years. Consequentially, it has been proposed that reflectance confocal microscopy (RCM) represents an excellent tool for the early diagnosis and subsequent monitoring of nonpigmented tumoral lesions. Besides tumor paranchyma and stroma typical changes in vasculature seem to be a diagnostic significance in preoperative diagnosis.

Objective: The purpose of this study is to define vascular morphology in nonpigmented tumoral lesions. Design: We examined 60 tumoral lesions for vascular features by dermoscopy and in vivo RCM prior to surgical excision.

Results: The preoperative in vivo RCM analysis revealed 6 type of vascular morphology as; round vessels, curved linear vessels, straight linear vessels, arborizing vessels, tubular vessels and polymorphic/ atypical vessels. Round vessels were seen in 56.7% of seborrheic keratoses and %66.7 of squamous cell carcinoma (SCC). All SCC lesions had straight linear and curved linear vessels. Arborizing vessels were mostly seen in BCC lesions (%87.5%). Atypical/polymorphous vessels were identified in %31.7 of all nonpigmented skin tumors but mostly in basal cell carcinoma (BCC) lesions. Additionally all Bowen and SCC lesions showed atypical/polymorphous type vessels.

Conclusion: In vivo RCM is a valuable tool for evaluating vasculature of skin tumors in addition to dermoscopy.
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LONG TERM EFFICACY AND RECURRENCE OF TOPICAL 0.5% 5-FLUOROURACIL WITH 10% SALICYLIC ACID FOR ACTINIC KERATOSIS COMPARED TO CRYOTHERAPY. A PROSPECTIVE, ACTIVE CONTROLLED, RANDOMIZED, EXPLORATORY STUDY

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 Aim of the Investigation: To explore the efficacy of LAS 41005 (5-fluorouracil 0.5%, salicylic acid 10% solution; 5FU/SA) compared to cryotherapy (cryo) in patients suffering from 4 to 10 actinic keratosis (AK) lesions grade II and III in their face and forehead or on their bald scalp (maximum sum of lesions of 25 cm², including a 5 mm ring to treat surrounding area).

 Materials, Subjects and Methods: Exploratory, open-label, randomized, active controlled phase II study with blind histological assessment. 5FU/SA daily treatment for 6 weeks compared to one cryotherapy session with an additional session if necessary 3 weeks after. Histological status as primary efficacy assessment, and lesion count, size and response, physician’s and patient’s assessment, and cosmetic outcome as secondary variables.

 Results: Total 66 treated patients in 4 sites, 87.9% males, and 77.3% aged ≥ 65 yrs with median 5 years having AK. Baseline assessment showed 16.7% AKI patients, 69.7% AKII, and 13.6% AKIII. A high overall rate of histological clearance (82.1%) at the 14 weeks assessment was shown after only 6 weeks with 5FU/SA, statistically higher than the 41.9% obtained with cryo (p=0.019), with 87.9% of these last receiving 2 cryo treatments within a one-week interval. As much as 84.8% of lesions recurred with cryo compared to the statistically lower recurrence of 39.4% with 5FU/SA (p<0.001). Both groups showed a similar safety profile. Most frequent 5FU/SA local skin reactions included burning sensation (9.1%) and application site erythema (6.1%), and impaired healing (3%) for cryotherapy.

 Conclusions: LAS 41005 (5FU/SA) showed an early statistically higher efficacy rate after just 6 weeks of treatment, and a lower recurrence of lesions during the study compared to cryotherapy. Histological changes were in line with the available phase III results, but already after only half the treatment period of the phase III study (12 weeks).

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REFLECTANCE CONFOCAL MICROSCOPY EVALUATION OF THE CHANGES INDUCED BY THE TREATMENT WITH SOLARAZE® (DICLOFENAC 3% IN 2.5% HYALURONIC ACID GEL) IN THE ACTINIC FIELD CANCERISATION

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(1) Melanoma Unit, Dermatology Department, Hospital Clinic, Barcelona, Spain; (2) Almirall, Barcelona, Spain; (3) Pathology Department, Hospital Clinic, Barcelona, Spain

 Introduction: Reflectance confocal microscopy is a non-invasive imaging technique that allows the observation of skin changes at a cellular level in Actinic keratosis (AK) and subclinical AK without the need of biopsies. RCM allows the dynamic study of the effect of treatments in the skin.

 AIM: To assess the effects of topical application of Solaraze® (Diclofenac sodium 3% in 2.5% hyaluronic acid), in male volunteers affected with AK and subclinical-AK on the bald scalp.

 Subjects and Methods: 14 Caucasian volunteers (Fitzpatrick skin phototype II–III), older than 50 years with an area larger than 3,6x3,6 cm affected by AK and subclinical-AK on the bald scalp. RCM evaluation was conducted before (t1), during (3 weeks after the beginning of treatment t2), 6-8 weeks after the start of treatment (t3) and 2 weeks after the end of the treatment (t4). Histological study confirmed the presence of AK and subclinical-AK with correlation with the RCM changes before the treatment.

 Results: RCM evaluations showed that the presence of scaling (p=0.001) and atypia of the honeycomb pattern (p=0.001) decreased during and after the treatment whereas detached corneocytes and polygonal nucleated cells in the stratum corneum increased at t2 and t3 (p=0.004, p=0.003, respectively); these changes persisted in a lower degree 2 weeks after the end of the treatment. At the end of treatment, thickening of collagen bundles in the upper reticular dermis was observed.

 Conclusions: RCM is a useful tool for the dynamic study in vivo of the changes induced in the skin by topical treatments. RCM showed a significant improvement of the epidermal atypia and the scale in clinical and subclinical AKs in response to topical 3% diclofenac sodium treatment. Dermal collagen thickening was observed in RCM examination at the end of treatment.
General Information

Congress Venue

Hotel Fira Palace****S
Conference Centre
Av. Rius i Taulet, 1-3
08004 Barcelona, Spain
Tel. +34 934 262 223
Fax +34 934 248 679
www.fira-palace.com

Registration and Information desk
The registration desk is situated at the ground floor of the Fira Palace Hotel to the right of the reception.

Secretariat opening hours

<table>
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<tr>
<th>Day</th>
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<tbody>
<tr>
<td>Wednesday 14th November</td>
<td>12:00 – 19:30</td>
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<tr>
<td>Thursday 15th November</td>
<td>07:00 – 19:30</td>
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<tr>
<td>Friday 16th November</td>
<td>07:30 – 19:30</td>
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<tr>
<td>Saturday 17th November</td>
<td>07:30 – 18:30</td>
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Please wear your name tag during the whole Congress as it is required for accessing the lectures

Transportation and distances

Distance from the hotel to:
International Airport Barcelona "El Prat": 12 km/15-20 minutes approximately by car.
Central Railway Station "Sants": 1,5 km/6 minutes.
Bus and Underground Terminal: "Plaça d’Espanya": 5 minutes walking.
Shopping & entertainment centre: "Arenas de Barcelona" and "Creu Coberta" shopping street: 5 minutes walking.

How to get to the hotel from the airport
By car. Take the Castelldefels Motorway (C-31) towards Barcelona up to Plaça d’Espanya. Turn right into Avenida Maria Cristina and drive up until you see the National Palace. Turn left into Avenida Rius i Taulet and carry on straight until Lleida Street. The hotel is right on the corner.
Public transport. Taxi: Barcelona has 11.500 taxis easy to identify by their yellow and black colour. It takes 15/20 minutes, depending on traffic.
Aerobus. This special service is clearly signposted at the stops outside the terminal and it takes you to different parts of the city, the Plaça d’Espanya stop is the closest to the hotel, 5 minutes walk approximately.
Train. The station is located to the west of the terminal. Trains go to "Sants" Station. From here you can take either the Metro - 2 stops to Plaça d’Espanya and then 10/15 minutes walk-or by taxi.

Language and Translation
Organized by an International Scientific Society, all presentations will be given in English. Simultaneous interpretation will not be provided.

Exhibition
A commercial exhibition will be held at the Congress Venue, close to the main meeting rooms (see Venue Plan).

Exhibition opening hours

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<tr>
<td>Wednesday 14th November</td>
<td>14:00 – 19:00</td>
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<td>Thursday 15th November</td>
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<td>Friday 16th November</td>
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<td>Saturday 17th November</td>
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CME Credits
The 6th World Meeting of Interdisciplinary Melanoma/Skin Cancer Centers in conjunction with the 8th EADO Congress was granted 19 European CME credits (ECMEC) by the European Accreditation Council for Continuing Medical.
General Information

European Accreditation
The 6th World Meeting of Interdisciplinary Melanoma/Skin Cancer Centers in conjunction with the 8th EADO Congress is designated for a maximum of (or “for up to”) 19 hours of European external CME credits. Each medical specialist should claim only those hours of credit that he/she actually spent in the educational activity. European Accreditation is granted by the EACCME in order to allow participants who attend the above-mentioned activity to validate their credits in their own country. The EACCME is an institution of the European Union of Medical Specialists (UEMS), www.uems.net

Through an agreement between the European Union of Medical Specialists and the American Medical Association, physicians may convert EACCME credits to an equivalent number of AMA PRA Category 1 Credits™. Information on the process to convert EACCME credit to AMA credit can be found at www.ama-assn.org/go/internationalcme.

Live educational activities, occurring outside of Canada, recognized by the UEMS-EACCME for ECMEC credits are deemed to be Accredited Group Learning Activities (Section 1) as defined by the Maintenance of Certification Program of The Royal College of Physicians and Surgeons of Canada.

Breakout Sessions
With regards to the rooms of the break-out sessions, we have requested your preferences through the web site for information purposes only. We wish to point out that the fact of having indicated the preference will not guaranty a seat in the selected room. We advise you to go to the rooms with enough time in advance.

Certificates of Attendance, CME, Free Communications and Posters
The certificates will not be handed-over during the congress. They will be available for downloading from two different web pages from December the 3rd. If you have any problem, you can contact us and we shall send it to you via email in a pdf format.

Free Communications and Posters Certificates
In order to download your certificate we will send you a personal username, password from December the 3rd and a link.

Attendance, Faculty and CME Credits Certificates
In order to download your certificate, would you please click on this link http://www.melanoma2012.com
Enter the code number written down on your badge and introduce your Family name.

Fees

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<th>Description</th>
<th>On site</th>
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<tbody>
<tr>
<td>Full Delegates</td>
<td>560 €</td>
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<tr>
<td>Residents &amp; Eastern European Countries*</td>
<td>242 €</td>
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<tr>
<td>Day Ticket</td>
<td>280 €</td>
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<tr>
<td>Courses (each one)</td>
<td>110 €</td>
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<tr>
<td>Nurses*</td>
<td>230 €</td>
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* Appropriate documentary evidence
Due to VAT changes in Spain from September 1st, registration’s VAT is now 21%, Registration Fees has changed.

Registration fee includes: Admission to the scientific session and to the Exhibition Area, coffee breaks, Congress documents (Final Program, Congress Bag ...), certificate of attendance and Welcome Reception.

Cancellation Policy
Before September 15th ▶ 50% refund; Before October 15th ▶ 75% refund; After November 1st ▶ NO refund.
The participant acknowledges that he/she has no right to lodge damage claims against the organizers should the holding of the meeting be hindered or prevented by unexpected, political or economic events or generally by force majeure, or should the nonappearance of speakers or other reasons necessitate programme changes. With registration, the participant accepts this proviso. The cancellations received will have administrative costs of 30 €.
Abstracts Awards
The awards will be presented during the Closing Ceremony on Saturday at 13:30 at Verdi Meeting Room.

Two Oral Presentation awards, 500 € each one. First one in Free Communication I Session and the second in Free Communication II Session.

Three Posters awards, 500 € each one. One for Experimental Studies and Case Reports, second for Clinical Melanoma Studies and the third one for Clinical Non Melanoma Studies.

Publication of Abstracts
Successful oral and poster abstracts will be distributed to all delegates attending the meeting.

Insurance
The Organizer do not accept liability for any hindrance or disruption of Congress proceedings arising from political, social, health travel or economic events or any other unforeseen incidents beyond their control. The congress cancellation conditions shall apply in any case. Registration of a participant entails acceptance of the cancellation conditions. Participants are strongly advised to make their own arrangements in respect to health & travel insurance.

Passport and Visa
For most nationalities visa are not required for entering Spain. For further information about visa and passport please contact the Spanish embassy in your country.