Melanoma Updates 2021

Leptomeningeal Disease/ Brain Mets in Melanoma

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Dr. Roman Groisberg: I'm Dr. Roman Groisberg from the Rutgers Cancer Institute of New Jersey. I'm a medical oncologist in the department of melanoma and sarcoma, medical oncology, and I specialize in treating melanomas. And with that, I'm going to transition and talk about another topic. That's very important in the management of melanoma. And I would say this is the exact extreme opposite of talking about adjuvant therapy. Which is the presence of melanomas with brain metastases, or even extending that into something called leptomeningeal disease or LMD. Melanomas have an extreme propensity for metastasis or traveling to the brain and taking root there. And this is so much so that fully 10% of all cancer patients across the spectrum of all cancers, fully 10% of cancer patients who develop brain metastasis or involvement in the brain of their cancer, actually have melanoma. So this is kind of a big problem within the melanoma treatment community.

And this has historically been a very difficult patient population to treat. Mostly because traditionally in the old days, when we used chemotherapy to treat melanoma, chemotherapy really didn't cross into the brain at all. And so there was really no way of delivering any kind of therapy to the brain besides surgery, or maybe some radiation. Thankfully the same immunotherapies and targeted therapies that we now use for the adjuvant setting or in the metastatic setting, also work across the blood brain barrier and actually crossing in, are effective in the brain. There's a couple of notable studies and I will say that the targeted therapies, these B RAF inhibitors, they are they're very effective at treatment of brain metastases. And can really improve symptoms from these brain metastases very quickly and, and really achieve you know, a very good result, very fast.

And so those are a great option now for patients who have a B RAF mutation. And for those that don't have a B RAF mutation, or that choose not to use these targeted therapies, the immunotherapy is also work in the brain. Now, I will tell you that a single drug like nivolumab or pembrolizumab, does not have very good efficacy in the brain on

its own. It needs a little bit of help by combining that immunotherapy with a second immunotherapy, that older drug that we had mentioned earlier called ipilumamab. And so, the combination of a drug like ipilumamab, that older immunotherapy with the newer agent such as nivolumab actually is very potent in the brain. And works just as well as it does in the body. And I think very important, we there's a chance for long-term control remissions that are durable beyond even the treatment period.

So those patients have a really good response to these immunotherapies. They can actually stop taking them and the melanoma doesn't come back. Even though it has spread to a very sensitive site such as the brain. And so with that, I'm going to pass things on to the other participants in this in this panel. And thank you for your time. Again, I'm Dr. Roman Groisberg from the Rutgers Cancer Institute, in the department of melanoma and sarcoma medical. Thank you.