Patient Education for Melanoma Skin Cancer

Incidence Trends in Melanoma

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TRANSCRIPT

Now, the good news is the outlook for melanoma treatment is better than ever. There are two ways to improve the outcome for melanoma. Well, three, we could prevent it altogether, we could change our behavior and have fewer cases of melanoma, but you just heard that we're going in the wrong direction. The second thing is, we could find it earlier and we could have better outcomes because we find the melanoma before it has spread.

The next way we could do better is with better treatments. And fortunately, we've made a huge amount of progress with these new treatments. And what you see here on this screen is the timeline of the approval of new drug treatments for melanoma by the FDA from about 2021 through around a year ago. What you will see is the first drug for melanoma, a chemotherapy drug called dacarbazine or DTIC was in 1974. Then there weren't any others until interferon and interleukin in the late ‘90s. And nothing until 2011 when a new form of interferon, but more importantly, the new drugs that really changed the playing field starting with ipilimumab, BRAF-targeted treatments, and then the anti-PD-1 drugs and combinations. And all of this has happened since 2011. So, over the last 11 years, all those new drugs. And it hasn't just stopped in 2011, we are continuing to improve.

And I want you to see just what we're talking about in terms of how effective these treatments are. When we go back to the 1990s or early 2000s, the average length of time that a patient would survive with advanced melanoma was only seven or eight months. And only about 25% of people even made it to the one-year point after a diagnosis of metastatic melanoma.

With the new drugs we have, we are talking about huge increases, not minor, huge increases. What do I mean? Look here at this clinical trial in which patients were randomized between one of three treatment arms: Ipilimumab, the first new immune treatment, nivolumab, or the combination. And this particular slide just looks at those patients who have a BRAF mutation. And what we see is that 60%, more than half of the patients who were randomized to the “nivo and ipi” combination arm were still alive five years later. 60% alive at five years, compared to 25% alive at one year in the past. That's remarkable.

And as I said, we're not stopping there, we just had another new drug approved: the combination nivolumab and relatlimab. We call it NivoRela, but its trade name is opdualag. And that was just approved by the FDA in March. So, even this year, we continue to see new drugs, and I expect within the next six to 12 months additional approvals of drugs for cutaneous melanoma and melanomas of the eye where we haven't made nearly as much progress, but we at least do have one new drug approved for eye melanomas.

So, I've mentioned three different ways already how we could do better with melanoma, but what I'm really going to talk about today is how we can do better in another way with the drugs that we have. This particular slide shows all the different drugs put together. The previous slide just showed three different drugs, ipi-nivo, here you see all the drugs we have charted out in the same way: the BRAF drugs, the anti-PD-1, and so forth.

The good news is this isn't just one drug. And if it doesn't work, we're out of luck. This is a lot of different options. And now we've got to figure out, how can we do better. Can we use these drugs just by the way we use them to get a better outcome for our patients?