Focus Session U003
Merkel cell carcinoma:
Updates in Practice Management

THE CRITICAL ROLE OF THE DERMATOLOGIST IN THE WORKUP & MANAGEMENT OF MCC

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Clinical Presentation

Workup

Surveillance
Clinical Presentation

- Typical population:
  - Elderly (median age ~75)
  - Immunosuppressed pt
  - White >>> Skin of color

- Hallmarks:
  - Firm, nontender
  - Rapid growth

- Variable appearance:
  - Pink, red, violaceous, or flesh colored
  - Exophytic, dome-shaped, or Dermal/Subcutaneous
# Clinical differential diagnosis

<table>
<thead>
<tr>
<th>Malignant Tumors</th>
<th>Benign Tumors</th>
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<tr>
<td>Amelanotic melanoma</td>
<td>Epidermoid cysts</td>
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<tr>
<td>Non-melanoma skin cancer</td>
<td>Acneiform lesions</td>
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<tr>
<td>Lymphoma</td>
<td>Lipoma</td>
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<tr>
<td>Metastatic carcinoma</td>
<td>Dermatofibroma / fibroma</td>
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<td>DFSP/Other Sarcomas</td>
<td>Vascular lesion</td>
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<td>Leukemia Cutis</td>
<td>Adnexal tumors</td>
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<td>Pyogenic granuloma</td>
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At biopsy, most MCCs are presumed to be:
- Benign (56%)
- A cyst or acneiform lesion (32%)

Pearls for derm eval if you suspect MCC

- Measure and record the clinical diameter
  - Critical for T (tumor) staging
- Inspect and palpate the surrounding skin to look for in-transit metastases
- For a subcutaneous nodule, hub your punch biopsy because tumors are often centered in the deep dermis or fat
Clinical Presentation

Workup

Surveillance
You made the diagnosis, now what?
Staging Workup

• **Full skin and lymph node exam**
  - To identify in-transit mets and regional lymphadenopathy (present in 25% of pts)
  - Palpation is key

• **Radiographic examination**
  - PET/CT (scalp to toes) or CT scan

• **Sentinel lymph node biopsy**
  - To identify microscopic LN metastases not seen on imaging
  - All clinically node-negative MCCs warrant consideration of SLNB, regardless of tumor size. Upstaging will occur in 25-32% of pts.

The Dermatology To Do List:

- **Immediate appt with YOU**
  - Full skin and lymph node exam

- **Prompt referrals**
  - Call to ensure speedy consultation (ideally within 1-2 weeks)
  - Tertiary Care Center ideally for multidisciplinary management
    - Experience Counts in MCC
    - Co-manage with you
  - Radiation Oncology & Surgical Oncology

- **Order baseline imaging**
  - Or confirm your referred colleagues will

- **AMERK antibody testing**
  - Draw ASAP to ensure a true baseline and aid in long term surveillance
Value of imaging

- Patient with 1cm (T1) primary on right dorsal hand
- PET scan detected non-palpable metastatic right epitrochlear and axillary lymph nodes
Clinical Presentation
Workup
Surveillance
## Surveillance plan

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<th>2</th>
<th>3</th>
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<td><strong>Full skin and lymph node exam</strong>&lt;br&gt;• Every 3-6 months for the first three years&lt;br&gt;• Every 6-12 months thereafter</td>
<td><strong>Imaging</strong>&lt;br&gt;• Routine imaging for high risk patients&lt;br&gt;• Symptom-directed imaging for low risk patients</td>
<td><strong>AMERK</strong>&lt;br&gt;• Every 3 months for the first 2-3 years, in patients who were seropositive at diagnosis&lt;br&gt;• A rising titer may be an early indicator of recurrence</td>
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Paulson, et al. 2017 Cancer 123(8) 1464-74
In-transit recurrence

*Dermatologists are essential to the MCC Care Team!*

Careful skin exam is key

*Palpate!*
Take home points:

**MCC is a dermatology problem, and we are irreplaceable for optimal management**

- Diagnosis can require a high index of suspicion
  - Deep punch biopsy often necessary
- **Remember your derm workup checklist:**
  - Appt with you
  - Speedy referrals
  - Imaging
  - AMERK
- **All MCC patients should have routine derm f/u**
  - Palpation in addition to visual inspection