

A “Shuriken-like” Pigmented Lesion?

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Dear editor,

We present an 82-year-old male patient consulted in the polyclinic of Dermatology on the occasion of a severe itching in his left forearm. Within the conducted dermatological examination a relatively large pigmented lesion was established – measuring 7 to 6 cm, located in the proximal to the middle part of the left forearm, asymmetrical, unclearly distinct from the healthy tissue in some border areas, with inconsistent color and light elevation areas. According to the patient’s history, the lesion has been presented more than 30 years, without any signs of size growth and elevation. Within the multiple examinations by dermatologists, a surgical excision is categorically refused, while active surveillance and regular benchmarking of pictures is recommended to the patient.

Clinical and dermatoscopically, the lesion corresponded perfectly to the criteria for superficial spreading malignant melanoma.

No clinical data, neither imaging diagnostic confirmed the infiltration of the muscles and underlying tissues. Conducted laboratory tests and imaging diagnostic procedures did not confirm the presence of locoregional metastases and the patient was referred for surgical treatment.

Of interest are some recent studies regarding the advanced stages of melanoma that proved 1) on the one hand the key role of T-cell immunity to the elimination of the neoplastic cell clones, and that 2) the duplication of the blocking of the “T-cell elimination” means CTLA-4 mediated block in combination with PD-1 receptor inhibitors are the most effective methods of treatment [1]. Obviously, the target treatment with BRAF inhibitors gives way to the systemic application of modern therapeutic schemes that involve the combined use of Ipilimumab and Nivolumab [2]. Undoubtedly raises interest and the fact that objective-response rate and the progression-free survival among patients with advanced melanoma who had not previously received treatment were significantly greater with nivolumab combined with ipilimumab than with ipilimumab monotherapy [2].

PD-1 inhibitors pembrolizumab and nivolumab are novel immunotherapies that were recently approved by the Food

and Drug Administration for the treatment of unresectable or metastatic melanoma in treatment-refractory patients [3]. Pembrolizumab and nivolumab are monoclonal antibodies that bind to the PD-1 receptor and prevent its interaction with its ligands programmed cell death receptor ligands 1 and 2 [3]. Inhibition of the PD-1 receptor allows for increased immune response and potentially increased anticancer immune activity [3]. Pembrolizumab is administered via continuous i.v. infusion over 30 minutes at a dose of 2 mg/kg of actual body weight every three weeks [3]. Nivolumab is administered as a continuous i.v. infusion over 60 minutes [3]. The recommended dose of nivolumab is 3 mg/kg of actual body weight administered every



Figure 1a,b,c,d: Clinical manifestation of a large pigmented lesion, measuring 7 to 6 cm, located in the proximal to the middle part of the left forearm in a 82-year-old male patient, which was clinically and dermatoscopic suspected for superficial spreading melanoma, resembling shuriken.

two weeks until disease progression or the development of intolerable toxicities [3]. Efficacy for the combination approach is seen across a wide array of subgroups and occurs regardless of BRAF mutation status [4,5].

Speculative and unclear is the circumstance that melanomas with size more than 6 cm do not tend to locoregional metastasis clinically, although this (described by us lesion) or a number of such lesions (based on literature data) in principle are mechanically irritating due to the presence of intense itching, reported by the patients themselves.

New data for the treatment of melanoma in an advanced stage suggests that congenital or acquired defects in T-cell immunity, resulting in one way or another to the persistence or delayed elimination of certain T-cell clones are probably the base for a better prognosis in patients with increased tumor thickness or size. This would probably explain the lack of appropriate rapid progression in the presence of melanomas with significant tumor size and thickness, similar to that described by us case.

References

1. Galluzzi L, Eggermont A, Kroemer G. Doubling the blockade for melanoma immunotherapy. *Oncoimmunology*. 2015;5(1):e1106127. DOI:10.1080/2162402X.2015.1106127
2. Postow MA, Chesney J, Pavlick AC, Robert C, Grossmann K, McDermott D, et al. Nivolumab and ipilimumab versus ipilimumab in untreated melanoma. *N Engl J Med*. 2015;372(21):2006-2017. DOI: 10.1056/NEJMoa1414428
3. Ivashko IN, Kolesar JM. Pembrolizumab and nivolumab: PD-1 inhibitors for advanced melanoma. *Am J Health Syst Pharm*. 2016;73(4):193-201. doi: 10.2146/ajhp140768.
4. Spain L, Larkin J. Combination immune checkpoint blockade with ipilimumab and nivolumab in the management of advanced melanoma. *Expert Opin Biol Ther*. 2016;16(3):389-396. doi: 10.1517/14712598.2016.1141195.
5. Wolchok JD, Kluger H, Callahan MK, Postow MA, Rizvi NA, Lesokhin AM, et al. Nivolumab plus ipilimumab in advanced melanoma. *N Engl J Med*. 2013;369(2):122-133. DOI: 10.1056/NEJMoa1302369.