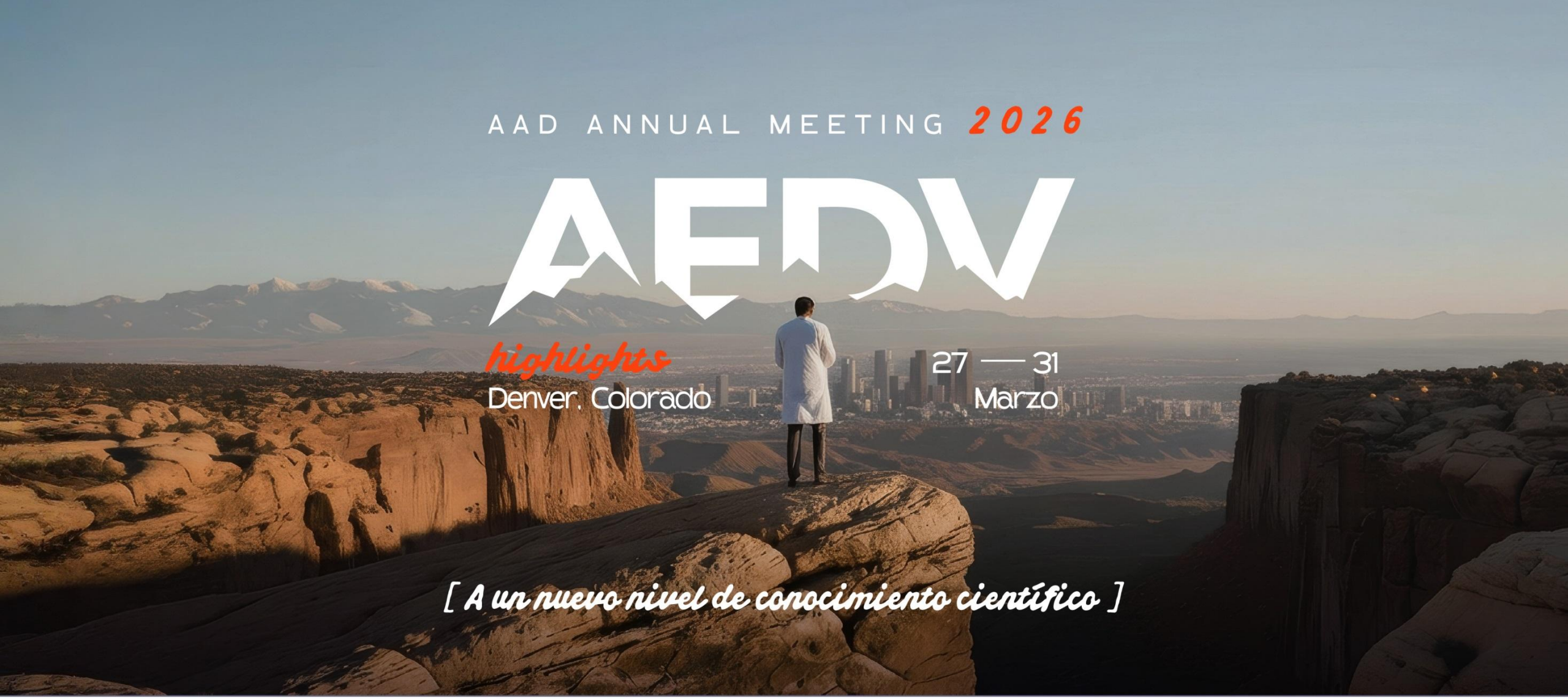


Una iniciativa de:

ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

FUNDACIÓN AEDV PIEL SANA

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Con el patrocinio de:

ucb

AAD ANNUAL MEETING 2026

AEDV

highlights

Denver, Colorado

27 — 31 Marzo

# Dermatología oncológica y cirugía

# Avanzando en la era de la inmunoterapia


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# NO TENGO CONFLICTOS DE INTERÉS

# CARCINOMA EPIDERMOIDE

- CLASIFICACIÓN DE CARCINOMAS DE ALTO RIESGO
- PAPEL DE LA INMUNOTERAPIA

# Estratificación y predicción de CEC de alto riesgo. BWH > AJCC

## Comparison of staging/risk stratification systems

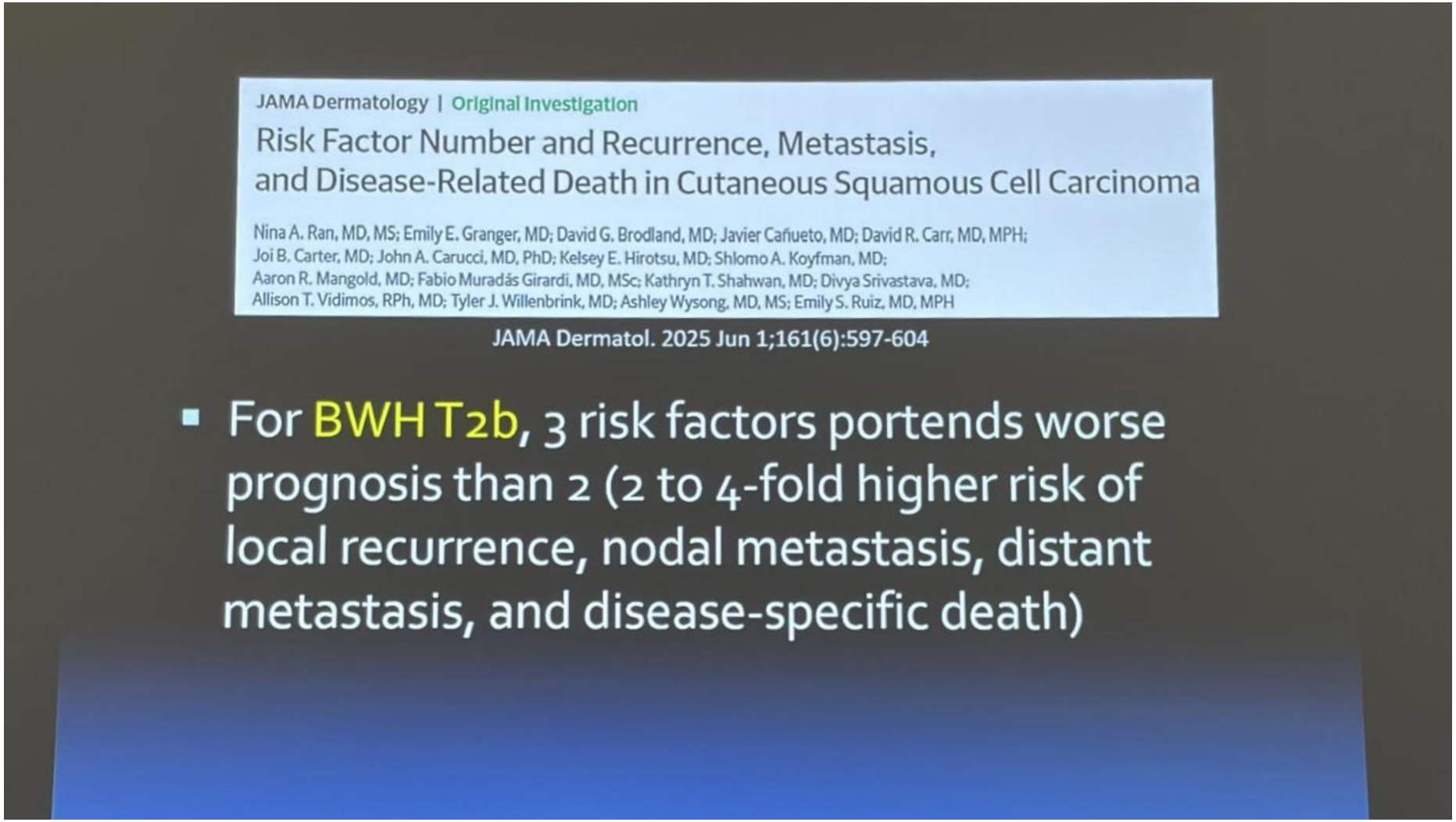
- Poor prognosis mainly associated with AJCC-7 T2, AJCC-8 T3, and BWH T2b/T3
- BWH offers superior specificity and positive predictive value in identifying high-risk tumors
- Current staging systems can be used to predict poor outcomes in cSCC off the head and neck

## BWH T staging system

| | |
|---|---|
| T1 | 0 high risk factors |
| T2a | 1 high risk factor |
| T2b | 2-3 high risk factors |
| T3 | 4 high risk factors |

- High risk factors:
  - Tumor diameter ≥ 2 cm
  - Tumor invasion beyond subcutaneous fat
  - Perineural invasion of nerves ≥ 0.1 mm in caliber
  - Poor differentiation

JAMA Dermatol. 2013 Apr;149(4):402-10.


JAMA Dermatology | Original Investigation
Risk Factor Number and Recurrence, Metastasis, and Disease-Related Death in Cutaneous Squamous Cell Carcinoma
Nina A. Ran, MD, MS; Emily E. Granger, MD; David G. Brodland, MD; Javier Cañueto, MD; David R. Carr, MD, MPH; Joi B. Carter, MD; John A. Carucci, MD, PhD; Kelsey E. Hirotsu, MD; Shlomo A. Koyfman, MD; Aaron R. Mangold, MD; Fabio Muradás Girardi, MD, MSc; Kathryn T. Shahwan, MD; Divya Srivastava, MD; Allison T. Vidimos, RPh, MD; Tyler J. Willenbrink, MD; Ashley Wysong, MD, MS; Emily S. Ruiz, MD, MPH
JAMA Dermatol. 2025 Jun 1;161(6):597-604
For BWH T2b, 3 risk factors portends worse prognosis than 2 (2 to 4-fold higher risk of local recurrence, nodal metastasis, distant metastasis, and disease-specific death)

JAMA Dermatology | Original Investigation | AI IN DERMATOLOGY

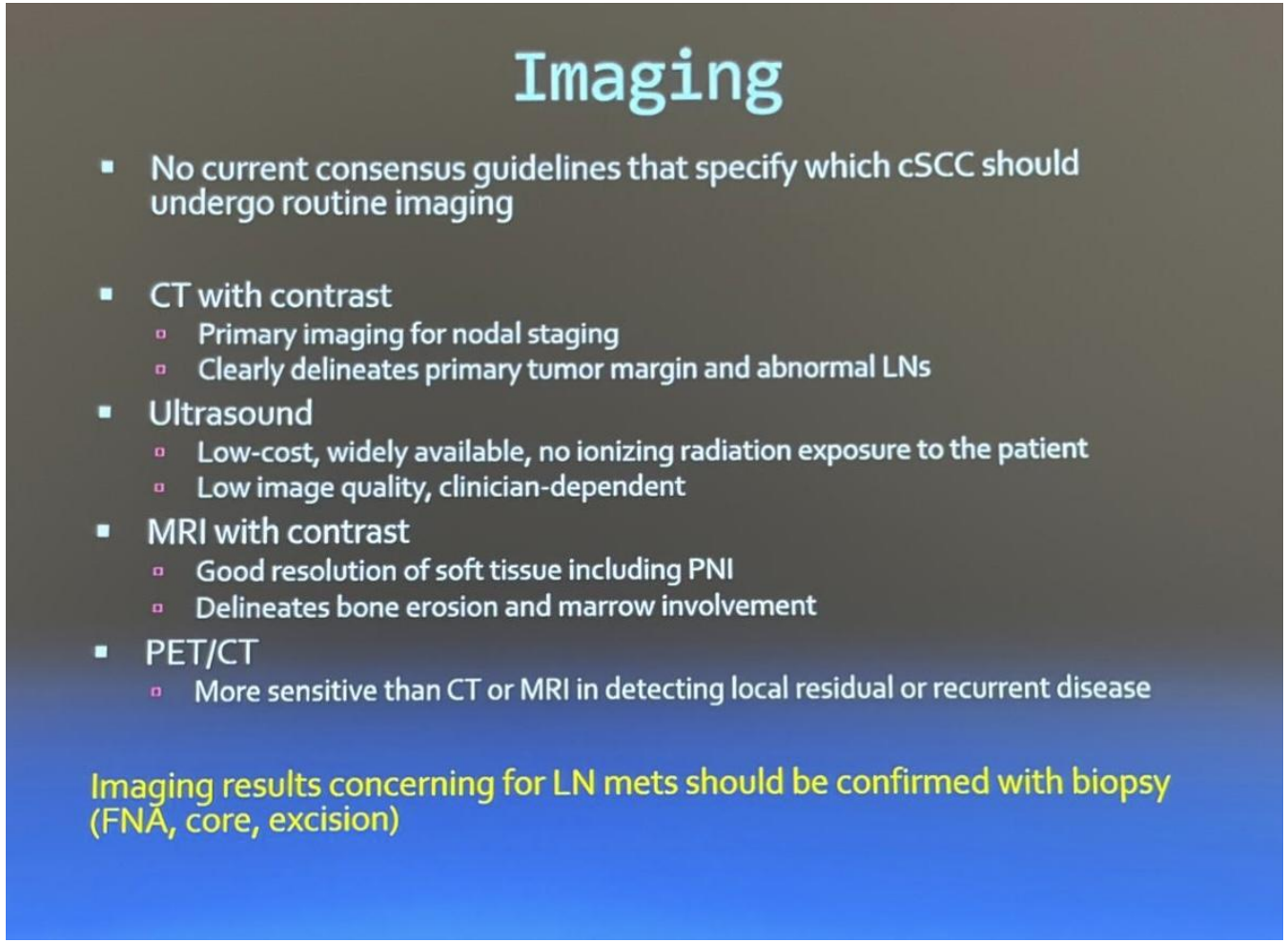
## Retrieval Augmented Generation–Enabled Large Language Model for Risk Stratification of Cutaneous Squamous Cell Carcinoma

Neil K. Jairath, MD; Vartan Pahalyants, MD, MBA; Shayan Cheraghlou, MD; Derek Maas, BS; Nayoung Lee, MD; Maressa C. Criscito, MD; Mary L. Stevenson, MD; Apoorva Mehta, BS; Zachary Leibovit-Reiben, BS; Alyssa Stockard, BS; Nicole Doudican, PhD; Aaron Mangold, MD; John A. Carucci, MD, PhD

JAMA Dermatol. 2025 Aug 1;161(8):796-804

- AI-derived risk score (AIRIS): GPT-based prognostication system based on systematic review of literature that addressed risk factors for poor outcomes in cSCC
- AI-enabled risk stratification (AIRIS system) showed enhanced discriminative capability compared to BWH and AJCC-8
- Potential of large language models to provide a more effective tool for predicting poor outcomes in cSCC

# PRUEBA DE IMAGEN EN TODO CEC DE ALTO RIESGO



# CEC avanzado

CK-301-101 trial (NCT03212404)

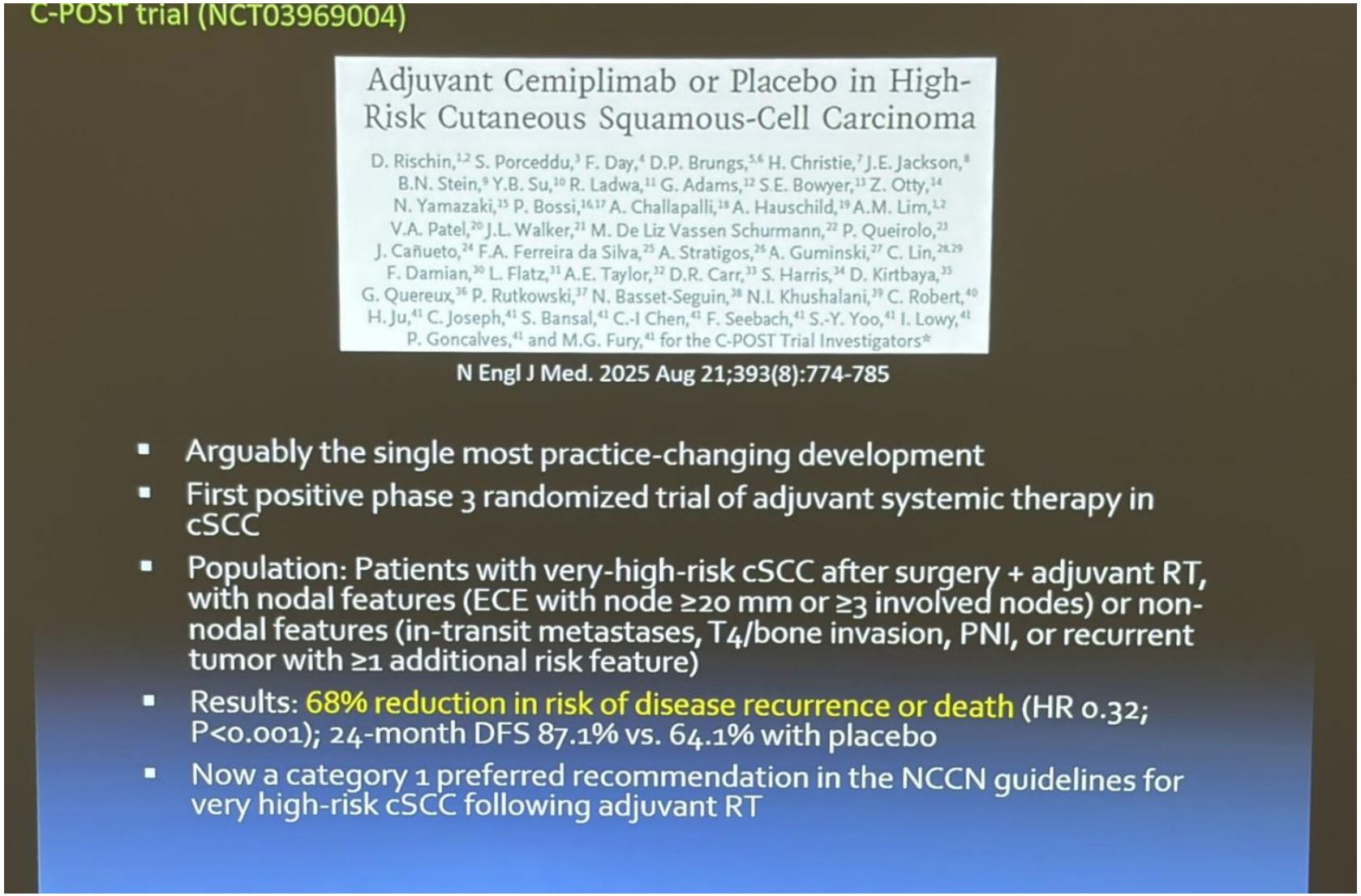
Efficacy and safety of cosibelimab in advanced cutaneous squamous cell carcinoma: Results from a Pivotal Open-label Study with a median follow-up of ≥2 years

Emily S. Ruiz, MD,[a] Eva Muñoz-Couselo, MD, PhD,[b] Henri Montaudié, MD, PhD,[c] Miguel Angel Berciano-Guerrero, MD, PhD,[d] Maria del Carmen Álamo de la Gala, MD, PhD,[e] Julie Charles, MD, PhD,[f] Gaëlle Quéreux, MD, PhD,[g] Charlée Nardin, MD, PhD,[h] Ricardo Yaya Tur, MD, PhD,[i] Stéphane Dalle, MD, PhD,[j] Marie Beylot-Barry, MD, PhD,[k] Rahul Ladwa, MBChB, MPhil,[l,m] Margaret McGrath, MBBS,[m,n] Daniel Brungs, MBBS, PhD,[o] Dean Harris, MBChB, FRACP,[o] Hong Shue, MBBS, FRACP,[p] Andrea Tazbirkova, MD, FRACP,[q] Samuel Fourie, MBChB, MMed,[r] Daniel R. Malan, MSc Pharm Med, MPhil,[s] James Oliviero, CFA,[s] Lauren Neighbours Wilcoxen, PhD, RAC,[s] W. Garrett Gray,[t] and Philip Clingan, DSc (HC), MBBS, FRACP[u]

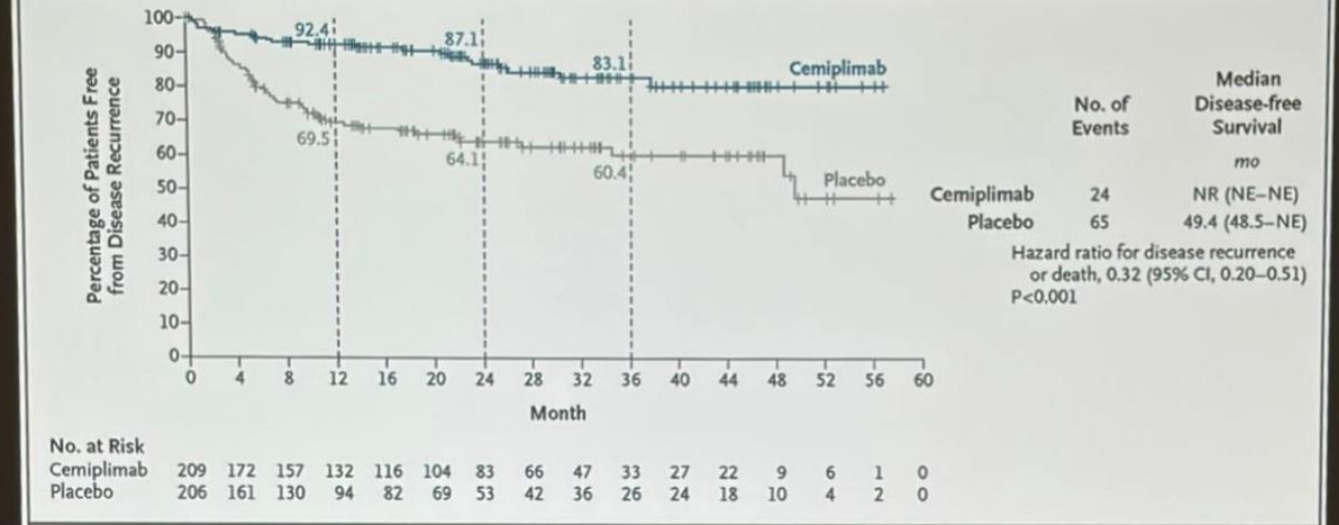
J Am Acad Dermatol. 2026 Jan;94(1):48-56

- Cosibelimab (Unloxcyt, Checkpoint Therapeutics)
- High-affinity programmed death-ligand 1 (PD-L1) blocking antibody that blocks PD-L1 interaction with PD-1 and B7-1 receptors
- FDA approved Dec 2024 for treatment of metastatic cSCC or locally advanced cSCC in patietns not candidates for curative surgery or radiation
- Locally advanced cSCC: ORR was 54.8% (CR 25.8%)
- Metastatic cSCC: ORR was 50% (CR 12.8%)
- Immune-related adverse event rate was 27.6%

# ADYUVANCIA → GUÍAS NCCN



The Kaplan-Meier curve from the C-POST trial powerfully illustrates the magnitude of benefit:




| | No. of Events | Median Disease-free Survival |
|---|---|---|
| | | *mo* |
| Cemiplimab | 24 | NR (NE–NE) |
| Placebo | 65 | 49.4 (48.5–NE) |

Hazard ratio for disease recurrence or death, 0.32 (95% CI, 0.20–0.51)
P<0.001

**Figure 1. Disease-free Survival.**

Analyses of disease-free survival were based on the Kaplan–Meier method, with stratification according to high-risk tumor (head and neck vs. non–head and neck) and geographic region (North America vs. Australia or New Zealand vs. the rest of the world). The threshold for significance was set to 0.00455 on the basis of the O'Brien–Fleming alpha spending function. The P value was based on a stratified proportional-hazards model. Second primary cutaneous squamous-cell carcinoma tumors were not included as events in the primary end-point analysis of disease-free survival. Tick marks indicate censored data. NE denotes could not be evaluated, and NR not reached.

The risk of disease recurrence or death was 68% lower with cemiplimab than with placebo with an estimated 24-month disease-free survival of 87% in cemiplimab and 64% in placebo.

# Beyond the Surgery: Cutaneous SCC Management in the Era of Immunotherapy and Personalized Medicine

Gaurav Singh MD, MPH, FACMS

City of Hope Cancer Center
Chicago Medical School

Chicago, IL

# FDA Indications for PD-1 and PD-L1

| | |
|---|---|
| Cemiplimab | • Metastatic cSCC or locally advanced cSCC for patients who are not candidates for curative surgery or curative radiation<br>• Adjuvant treatment of adult patients with cSCC at high risk of recurrence after surgery and radiation |
| Cosibelimab | • Adults with metastatic cSCC or locally advanced cSCC who are not candidates for curative surgery or curative radiation |
| Pembrolizumab | • Recurrent or metastatic cSCC or locally advanced cSCC that is not curable by surgery or radiation |
| Nivolumab | • Patients with recurrent or metastatic squamous cell carcinoma of the head and neck with disease progression on or after a platinum-based therapy. |

https://www.accessdata.fda.gov

# Efficacy of Immunotherapies for Advanced cSCC

| Immunotherapy | Mechanism | Efficacy Endpoints | |
|---|---|---|---|
| **Cosibelimab**<br>- 1,200 mg IV q3w | • PD-L1 antibody<br>• Induces antibody-dependent cellular cytotoxicity | **mCSCC[1]**<br>• ORR: 50%<br>• CR: 13%<br>• PR: 37% | **laCSCC[1]**<br>• ORR: 55%<br>• CR: 26%<br>• PR: 29% |
| **Cemiplimab**<br>- 350 mg IV q3w | • PD-1 antibody | **mCSCC[2]**<br>• ORR: 51%/46%<br>• CR: 20%<br>• PR: 31%/27% | **laCSCC[2]**<br>• ORR: 45%<br>• CR: 13%<br>• PR: 32% |
| **Pembrolizumab**<br>- 200 mg IV q3w<br>- 400 mg IV q6w | • PD-1 antibody | **r/mCSCC[3]**<br>• ORR: 35%<br>• CR: 11%<br>• PR: 25% | **laCSCC[3]**<br>• ORR: 50%<br>• CR: 17%<br>• PR: 33% |

CR, complete response; cSCC, cutaneous squamous cell carcinoma; IV, intravenous; laCSCC, locally advanced cSCC; mCSCC, metastatic cSCC; ORR, objective response rate; PD-1, programmed cell death protein-1; PD-L1, programmed cell death ligand-1; PR, partial response; q2w, every 2 weeks; q3w, every 3 weeks; q6w, every 6 weeks; r/m, recurrent/metastatic.

1. Cosibelimab (UNLOXCYT) Prescribing Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761297s001lbl.pdf. Accessed 12/10/25.

2. Cemiplimab (LIBTAYO) Prescribing Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761097s032lbl.pdf. Accessed 12/10/25.

3. Hughes BGM, et al. *Ann Oncol*. 2021;32(10):1276-1285.

AAD annual MEETING

GW School of Medicine & Health Sciences

# Safety of Immunotherapies for Advanced cSCC

| Immunotherapy | Mechanism | Safety | |
|---|---|---|---|
| **Cosibelimab**<br>- 1,200 mg IV q3w | • PD-L1 antibody<br>• Induces antibody-dependent cellular cytotoxicity | **Common TRAEs:**<br>• Fatigue, rash, anemia<br>• Grade 3 TRAEs: 10.3%<br>• Grade 4/5 TRAEs: none | • irAEs: 23.1%<br>• Grade 3: 2.6%<br>• Grade 4/5: none |
| **Cemiplimab**<br>- 350 mg IV q3w | • PD-1 antibody | **Common TRAEs:**<br>• Fatigue, diarrhea, nausea, pruritus<br>• Grade ≥3: 45.5%-49.2% | • irAEs: 57.1%<br>• Grade ≥3: 12.5% |
| **Pembrolizumab**<br>- 200 mg IV q3w<br>- 400 mg IV q6w | • PD-1 antibody | **Common TRAEs:**<br>• Pruritus, fatigue, asthenia, rash, diarrhea<br>• Grade ≥3: 11.9% | • irAEs: 22.6%<br>• Grade ≥3: 8.2% |

cSCC, cutaneous squamous cell carcinoma; IV, intravenous; irAE, immune-related adverse event; PD-1, programmed cell death protein 1; PD-L1, programmed cell death ligand-1; q3w, every 3 weeks; q6w, every 6 weeks; TRAE, treatment-related adverse event.

Burshtein J and Schlesinger T. J Clin Aesthet Dermatol. 2025;18(11):21–23.; Cosibelimab [UNLOXCYT] Prescribing Information.
https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761257s001lbl.pdf. Accessed 12/10/25.; Cemiplimab [LIBTAYO] Prescribing Information.
https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761097s033lbl.pdf. Accessed 12/10/25.; Pembrolizumab [KEYTRUDA] Prescribing Information.
https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/125514s168 /10/25.

AAD annual MEETING

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#AEDVenAAD2026

# Phase I and Phase II Trial Data Synthesis (76 patients)

- Comparative analysis (of cosibelimab) with pembrolizumab and cemiplimab showed similar efficacy
- Cosibelimab demonstrated a favorable safety profile, with predominantly mild to moderate adverse events.
- Overall survival and long-term data needed

The rate of severe irAEs reported in this (cosibelimab) study (3.6%) is lower than those reported in studies with PD-1–targeting agents (pembrolizumab: 8.8%; cemiplimab: 10.7% to 19.2%).

This may be due to preservation of the PD-L2/PD-1 interaction

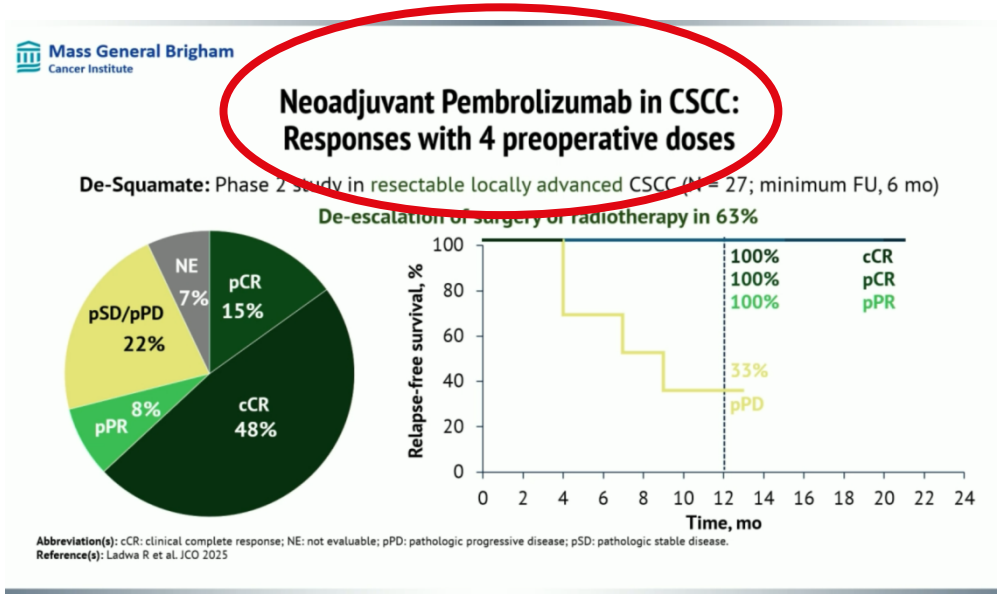
Decreased blockade of the negative inhibitory signal

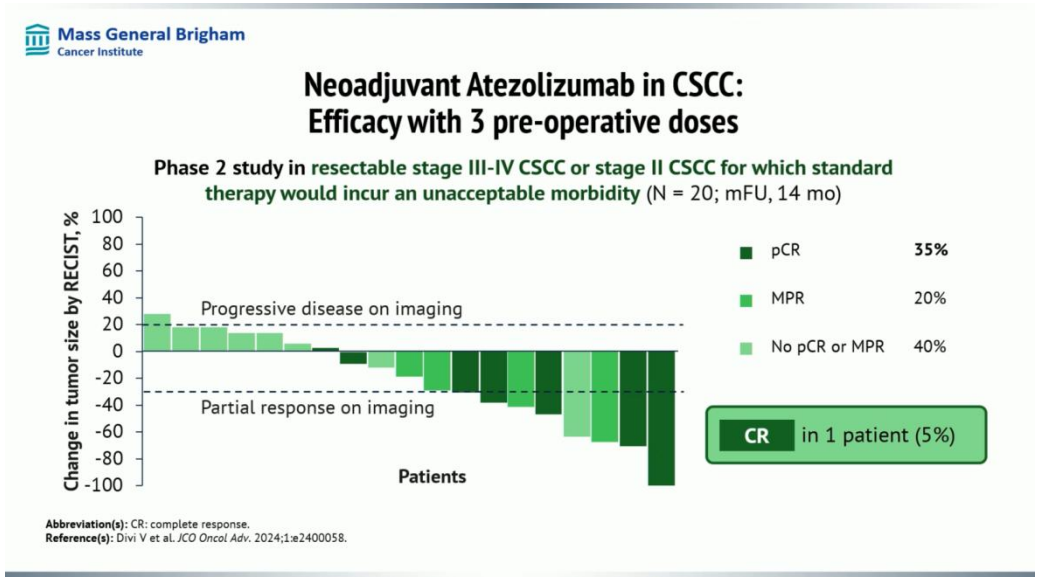
? Active Fc Region engages NK cells

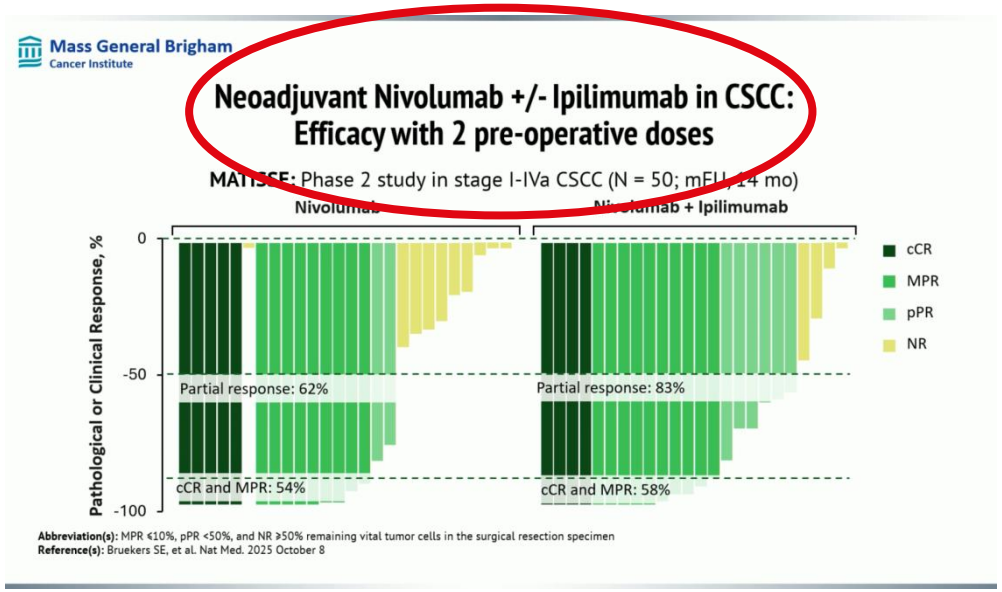
Cosibelimab may be considered for patients who are at "higher risk of toxicities, such as solid organ transplant recipients/autoimmune disease"

Ruiz ES, Muñoz-Couselo E, Montaudié H, et al. Efficacy and safety of cosibelimab in advanced cutaneous squamous cell carcinoma: Results from a Pivotal Open-label Study with a median follow-up of ≥2 years. *J Am Acad Dermatol*. Published online September 29, 2025:S0190-9622(25)02791-4. doi:10.1016/j.jaad.2025.09.009

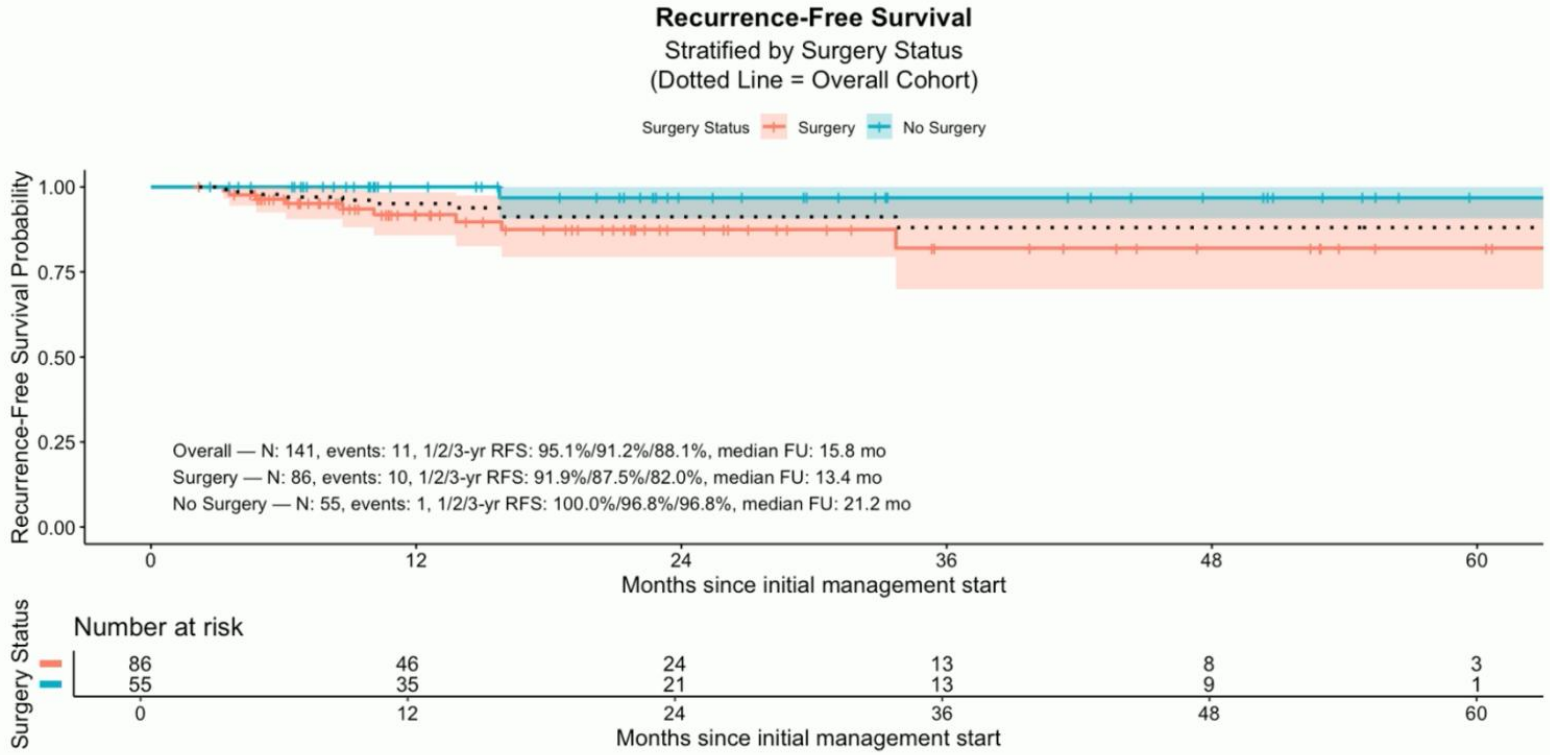
# Nuevas opciones en neoadyuvancia



Mass General Brigham
Cancer Institute




**Reference(s):** Miller et al, unpublished data (under review at JITC)

# NCCN Guidelines for Very High-Risk CSCC With Significant Risk of Extensive Local Recurrence, Nodal, or In-Transit Metastasis

- MDC consultation at center with specialized expertise to discuss options
- Radiologic staging
  - MRI with and without contrast or CT with contrast and/or ultrasound
  - Abnormal lymph nodes identified by imaging studies

or

**TREATMENT PLANNING**

Consider SLNB in cases that are recurrent or with multiple high-risk features

and

Consider neoadjuvant therapy with Cemiplimab-rwlc if:

- Nonreactive non-keratoacanthomatous rapid growth tumors
- In-transit metastasis
- Borderline resectable
- Surgery alone may not be curative or may result in significant functional limitation

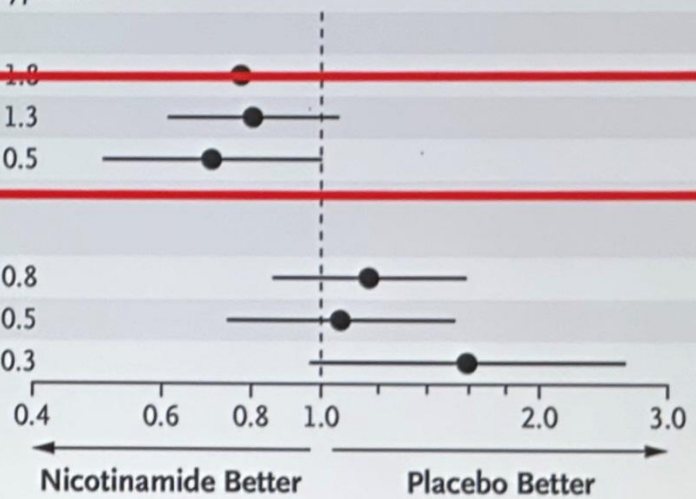
# CARCINOMA BASOCELULAR

- GORLIN
- MANEJO DE ENFERMEDAD AVANZADA

# Nicotinamide (NAM)

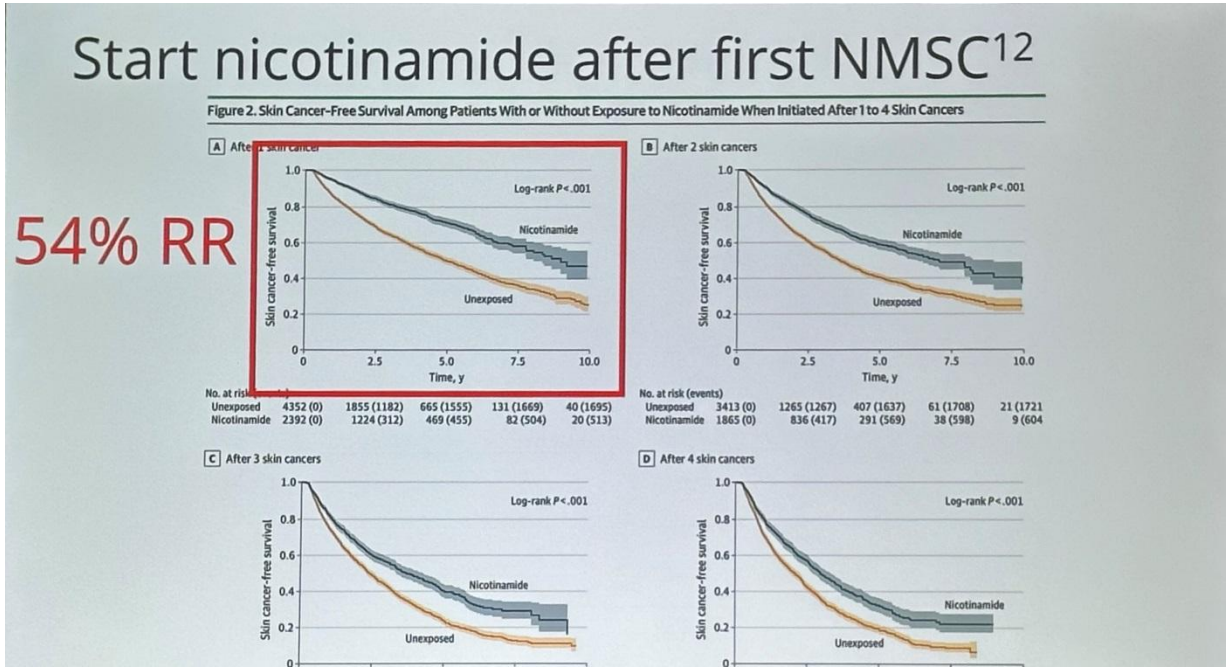
- NAM enhances DNA repair and decreases UV induced immunosuppression[11]
- 500 mg BID—20% reduction in BCC lesions
- Effect did not last beyond treatment period

| Subgroup | Placebo (mean no. of lesions/person) | Nicotinamide (mean no. of lesions/person) | Relative Difference, % (95% CI) | P Value |
|---|---|---|---|---|
| 12-mo intervention period | | | | |
| ~~NMSCs~~ | ~~2.4~~ | ~~1.8~~ | ~~23 (4 to 38)~~ | ~~0.02~~ |
| BCCs | 1.7 | 1.3 | 20 (−6 to 39) | 0.12 |
| SCCs | 0.7 | 0.5 | 30 (0 to 51) | 0.05 |
| 6-mo postintervention period | | | | |
| NMSCs | 0.8 | 0.8 | −17 (−59 to 14) | 0.33 |
| BCCs | 0.6 | 0.5 | −6 (−53 to 26) | 0.73 |
| SCCs | 0.3 | 0.3 | −59 (−163 to 4) | 0.07 |

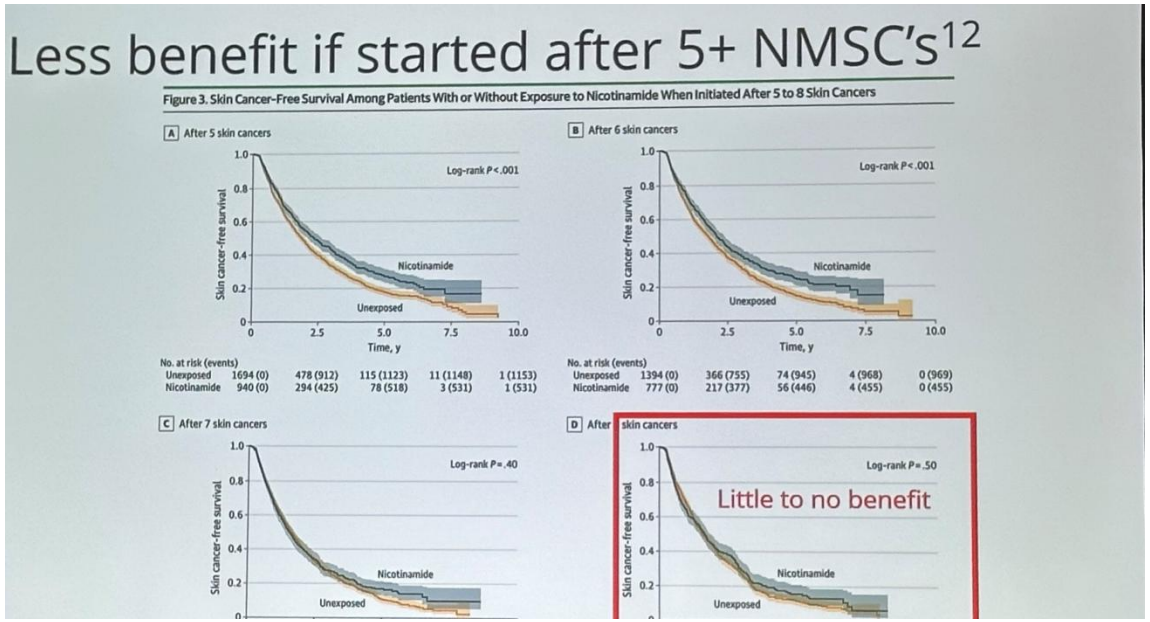


## Start nicotinamide after first NMSC[12]

54% RR




## Less benefit if started after 5+ NMSC's[12]



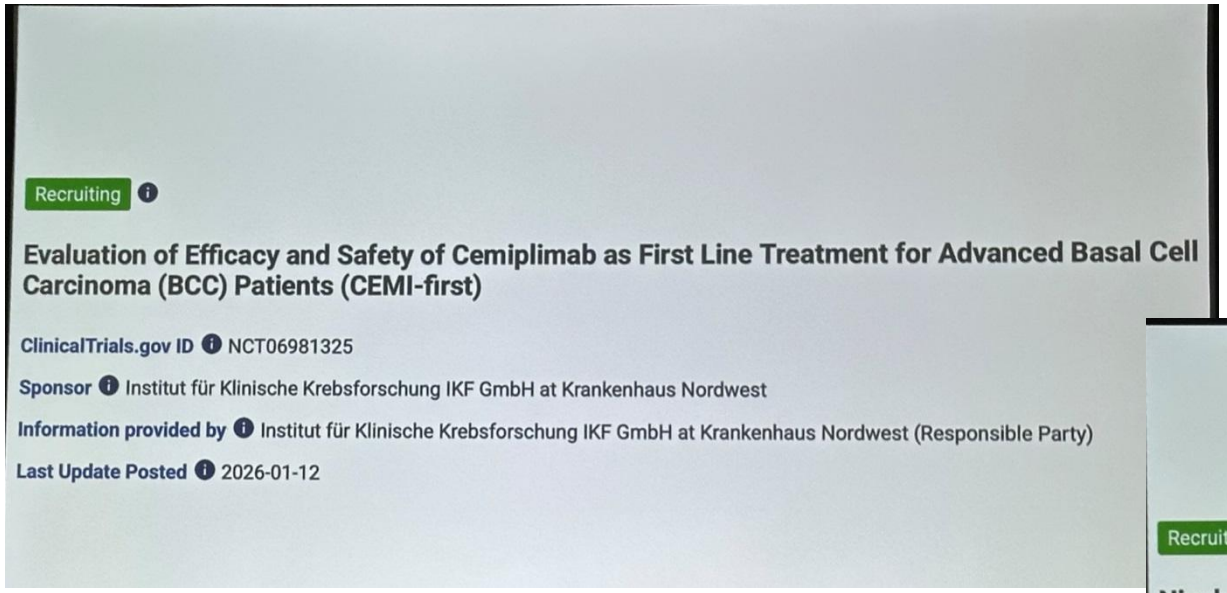

# NO elevación de RCV

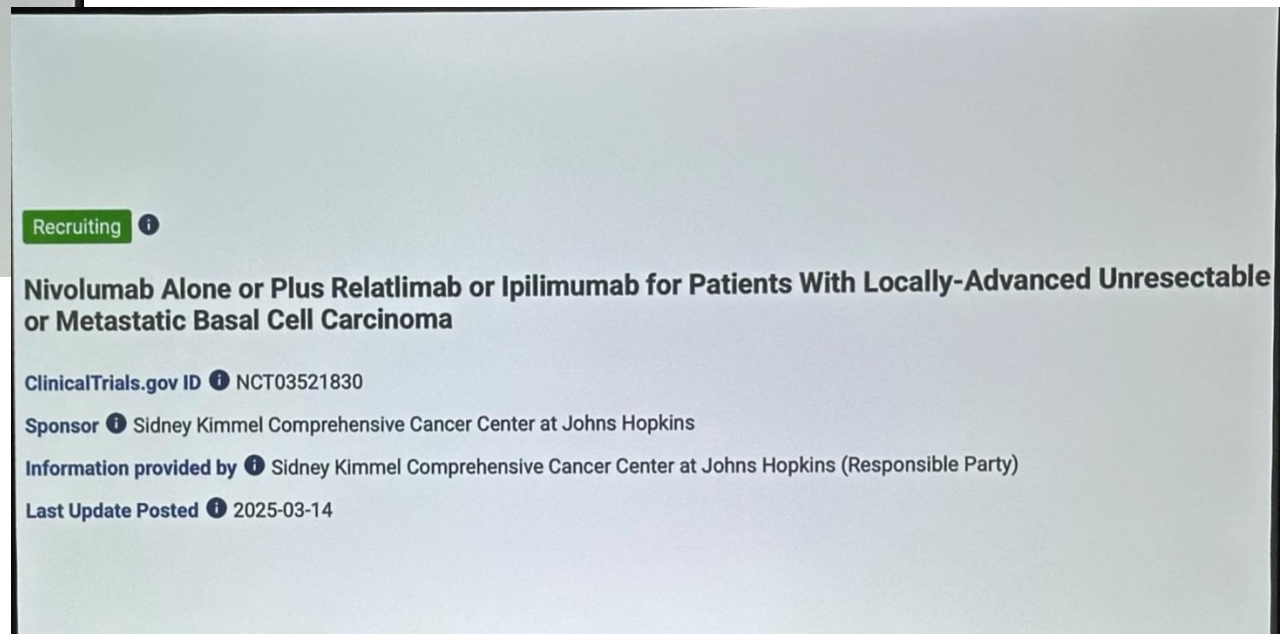
# Inhib Hedgehog: alta tasa EA → alternativas

## Phase II Patidegib Trial

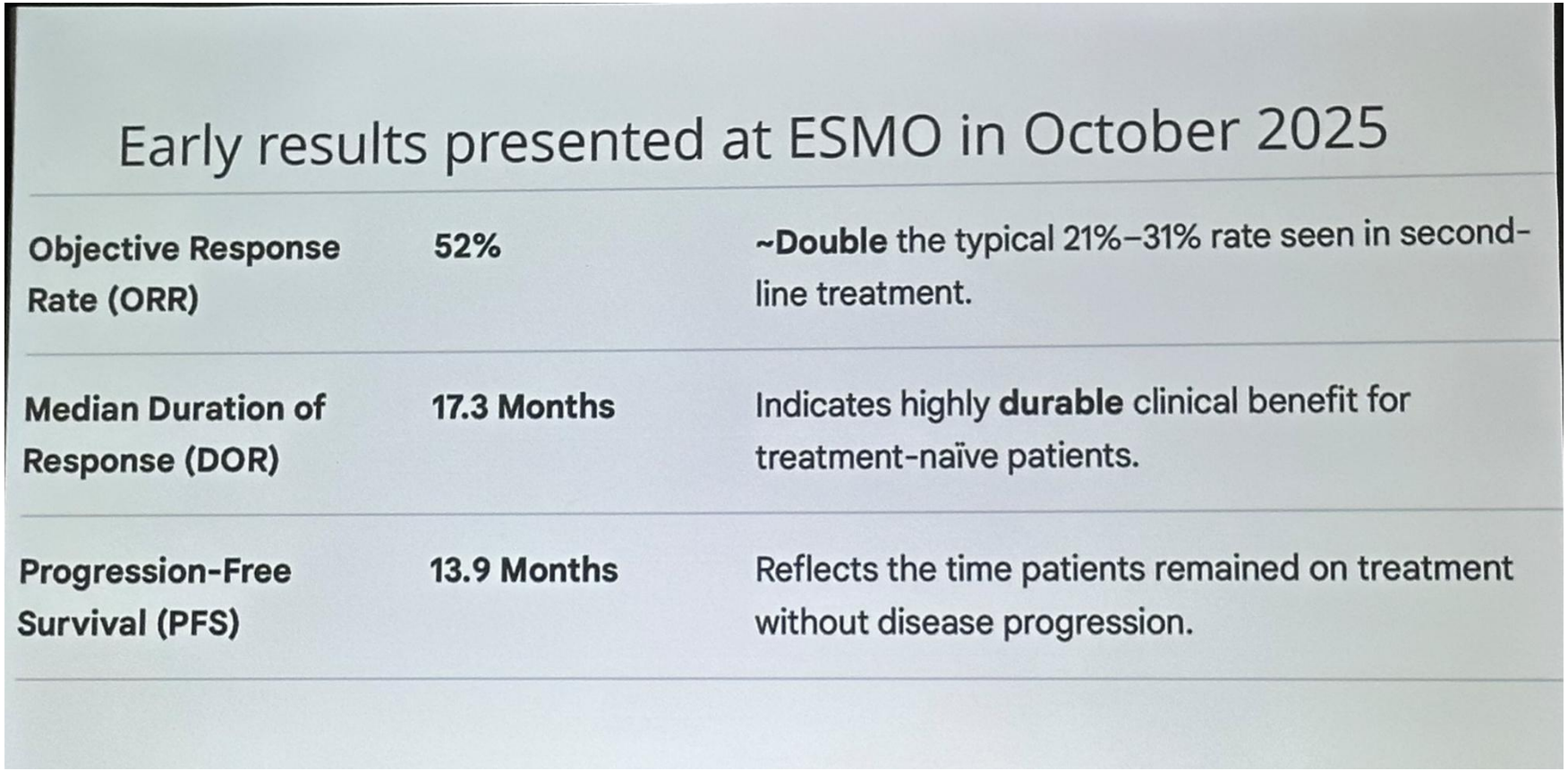
- 17 adults with BCNS (Gorlin's)
- 2% gel, 4% gel, or Vehicle applied **twice daily** for 26 weeks
- **51.3% reduction** in the number of new BCC tumors (2% gel group)
- **25%** of existing BCCs achieved a **Complete Clinical Response**
- **~56% reduction** in *GLI1* mRNA

# Inhib Hedgehog: alta tasa EA → alternativas



# Primeros indicios de posicionamiento de inmunoterapia (cemiplimab) como mejor alternativa en CBC avanzado



Early results presented at ESMO in October 2025

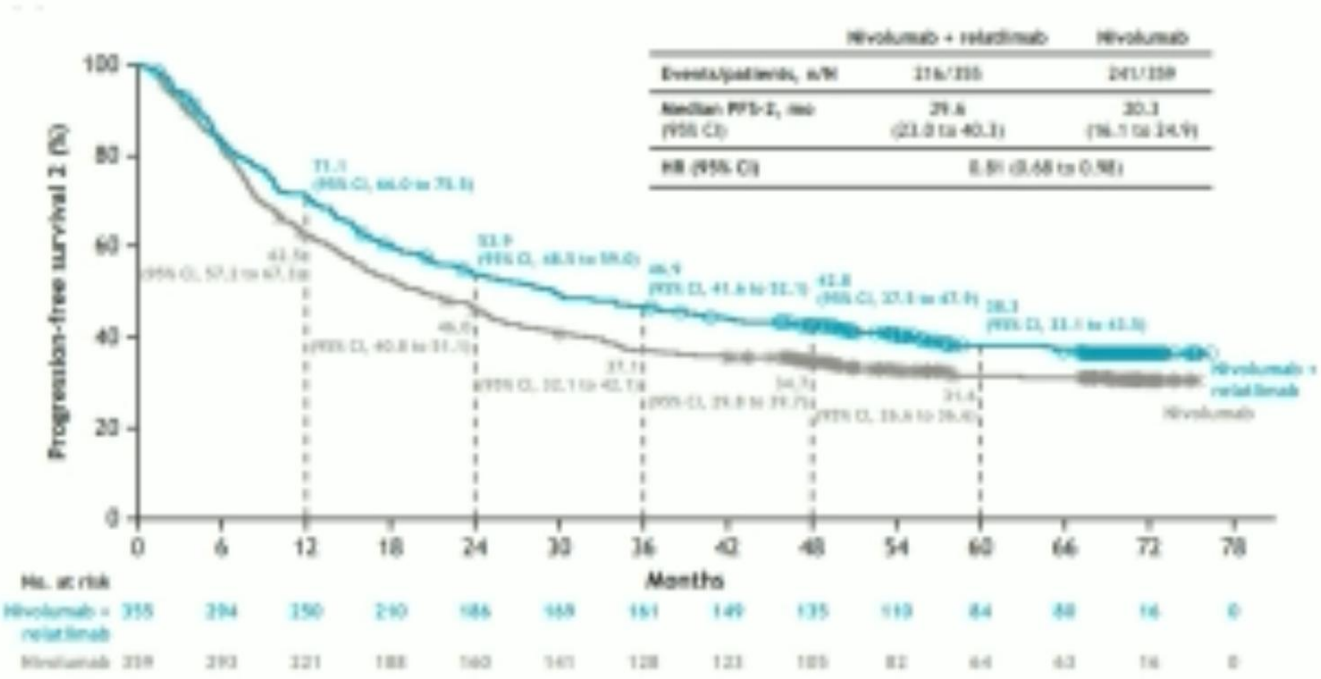
| | | |
|---|---|---|
| **Objective Response Rate (ORR)** | **52%** | **~Double** the typical 21%–31% rate seen in second-line treatment. |
| **Median Duration of Response (DOR)** | **17.3 Months** | Indicates highly **durable** clinical benefit for treatment-naïve patients. |
| **Progression-Free Survival (PFS)** | **13.9 Months** | Reflects the time patients remained on treatment without disease progression. |

*Nivolumab +- relatlimab/ipilimumab*

# MELANOMA

- Predicción de riesgo - diagnóstico
- Nuevos datos en terapias sistémicas

# Nivolumab + Relatlimab (Relativity 047) 4 yr update




OS, MSS, and ORR also higher for NIVO+RELA than for NIVO alone

Grade 3 or 4 TRAEs occurred in 22.3 % of patients treated with NIVO + RELA and 12.0 % with NIVO alone

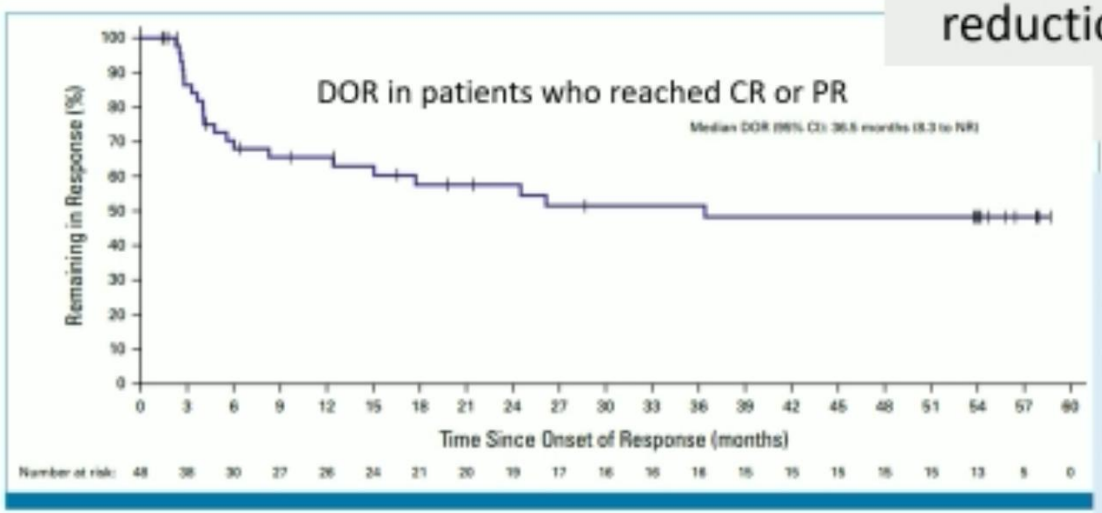
Treatment related deaths: 1.1% (NIVO+RELA and 0.6% NIVO alone)

Eur J Cancer. 2025 Jul 25;225:115547.

# Terapia con linfocitos infiltrantes de tumores (TIL) autólogos

**Long-Term Efficacy and Safety of Lifileucel Tumor-Infiltrating Lymphocyte Cell Therapy in Patients With Advanced Melanoma: A 5-Year Analysis of the C-144-01 Study**

J Clin Oncol. 2025 Nov 20;43(33):3565-3572.




- Patients with advanced melanoma that progressed on systemic therapy
- ORR = 31.4% (CR, 5.9%; PR, 25.5%)
- 5 yr OS 19.7%
- 79.3% of patients had tumor burden reductions

Deaths due to AE in 7.7%

What's next? Ongoing ph2 study, patients with ICI-naive melanoma who received lifileucel plus pembrolizumab had an ORR of 65.2% (CR, 30.4%)

# Virus oncolíticos

## RP1 Combined With Nivolumab in Advanced Anti–PD-1– Failed Melanoma (IGNYTE)

### IGNYTE Study – Design & Outcomes

Phase 1/2, open-label, multicenter

140 patients with unresectable/metastatic melanoma with confirmed progression on prior anti–PD-1 therapy

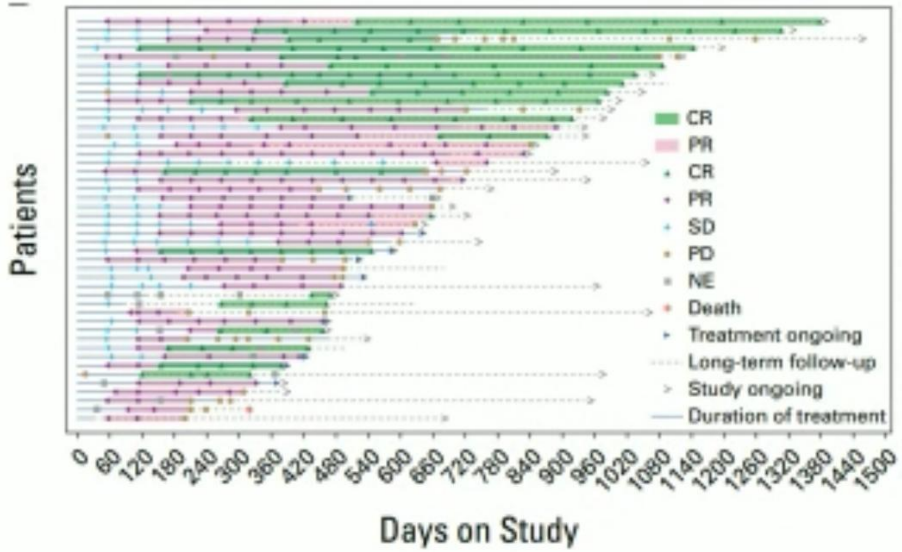
- 48.6% with Stage IV M1b/c/d disease
- 65.7% with primary anti–PD-1 resistance
- 56.4% were PD-L1 negative
- 46.4% had prior anti–CTLA-4 treatment

Patients received intratumoral RP1 (up to 8 doses) in combination with nivolumab for up to 2 years.

J Clin Oncol. 2025 Nov 20;43(33):3589-3599.

# Virus oncolíticos

## RP1 Combined With Nivolumab in Advanced Anti–PD-1– Failed Melanoma (IGNYTE)




| BOR | All Patients (N = 140) |
|---|---|
| CR, No. (%) | 21 (15.0) |
| PR, No. (%) | 25 (17.9) |
| SD, No. (%) | 31 (22.1) |
| PD, No. (%) | 54 (38.6) |
| NE, No. (%) | 9 (6.4) |
| ORR (95% CI) | 32.9 (25.2 to 41.3) |

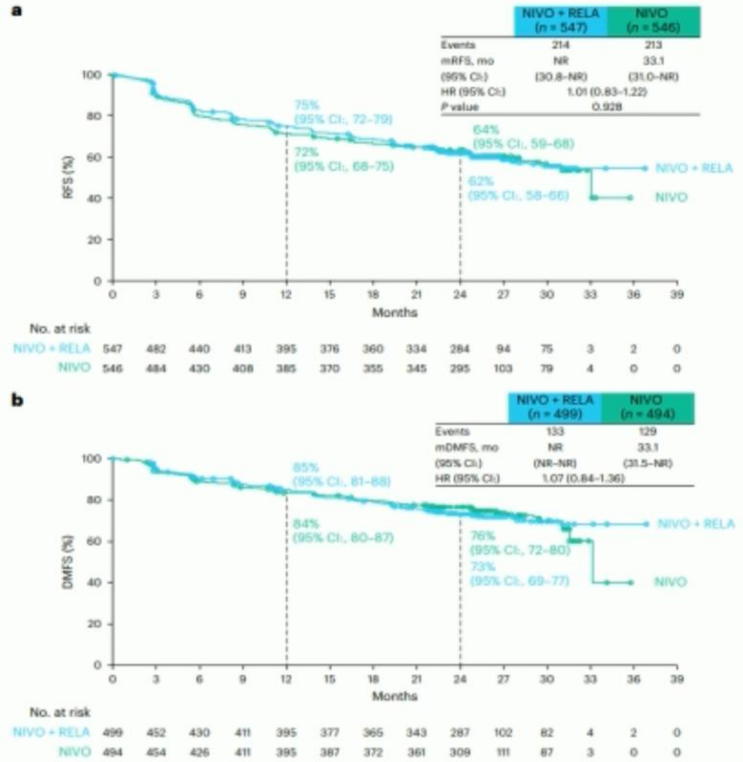
- ✓ Higher response rate in PD1+ tumors
- ✓ Significant response in injected AND noninjected tumor
- ✓ Response in visceral tumors

Median duration of response of 33.7 months, with a 2-year survival of 63.3%

J Clin Oncol. 2025 Nov 20;43(33):3589-3599.

# Relativity 098: Adjuvant nivolumab+relatlimab for resected stage III/IV melanoma

- 1,093 patients. Post surgery, randomized to nivolumab plus relatlimab or nivolumab alone (q4weeks for ≥1 yr)
- **No difference** in RFS, DMFS
- Comparing biomarker results RELATIVITY-098 and RELATIVITY-047 suggests that the **presence of tumor and associated higher levels of LAG-3+ T cells in the blood may be necessary to derive additional clinical benefit** with nivolumab plus relatlimab over nivolumab




Nature Medicine | Volume 31 | December 2025 | 4301–4309

# Evaluating i31-GEP Clinical Utility

- **Prediction of sentinel node status**
  - **912 patients underwent i31-GEP**
  - **430 *selected* patients underwent SLNB**
    - **SLN positivity rate was 2.6% (3/114) in those with <5% i31 predicted risk versus 21.4% in those with >10% predicted risk**

Beard et al, *Future Oncology* 2026; epub

# The integrated 31-gene expression profile test identifies low-risk patients with cutaneous melanoma who can forego the SLNB procedure: results from a prospective, multicenter trial

Future Oncology, DOI: 10.1080/14796694.2026.2640227


Table 1. Patient demographics.

| Factor | n = 912 | SLN Assessed (n = 430) | SLNB Not Performed (n = 482) | p-value |
|---|---|---|---|---|
| **Age (years)**, median (range) | 65 (20–90) | 65 (20–90) | 66 (20–90) | 0.001 |
| **Breslow thickness (mm)**, median (range) | 0.8 (0.1–12) | 1 (.08–12) | 0.7 (.08–5) | <0.001 |
| **Ulceration status**, n (%) | | | | <0.001 |
| Absent | 814 (89.3%) | 361 (84.0%) | 453 (94.0%) | |
| Present | 82 (9.0%) | 62 (14.4%) | 20 (4.2%) | |
| Unknown | 16 (1.8%) | 7 (1.6%) | 9 (1.9%) | |
| **Transected base**, n (%) | | | | 0.009 |
| Absent[a] | 526 (57.7%) | 226 (52.6%) | 300 (62.2%) | |
| Yes | 386 (42.3%) | 204 (47.4%) | 182 (37.8%) | |
| **Mitotic rate[b] (per mm$^2$)**, median (range) | 1 (0–26) | 1 (0–26) | 1 (0–11) | <0.001 |
| **T-stage**, n (%) | | | | <0.001 |
| T1a[c] | 335 (36.7%) | 84 (19.5%) | 251 (52.1%) | |
| T1b | 330 (36.2%) | 157 (36.5%) | 173 (35.9%) | |
| T2a | 162 (17.8%) | 118 (27.4%) | 44 (9.1%) | |
| T2b | 24 (2.6%) | 20 (4.7%) | 4 (0.8%) | |
| T3a | 23 (2.5%) | 19 (4.4%) | 4 (0.8%) | |
| T3b | 16 (1.8%) | 13 (3.0%) | 3 (0.6%) | |
| T4a | 7 (0.8%) | 6 (1.4%) | 1 (0.2%) | |
| T4b | 15 (1.6%) | 13 (3.0%) | 2 (0.4%) | |
| **i31-SLNB predicted risk**, n (%) | | | | <0.001 |
| <5% | 474 (52.0%) | 114 (26.5%) | 360 (74.7%) | |
| 5–10% | 294 (32.2%) | 185 (43.0%) | 109 (22.6%) | |
| >10% | 144 (15.8%) | 131 (30.5%) | 13 (2.7%) | |
| **SLN status**, n (%) | | 430 (47.1%) | 482 (52.9%) | N/A |
| Negative | – | 386 (89.8%) | N/A | |
| Positive | – | 44 (10.2%) | N/A | |

912 patients

Median Breslow =0.8 mm

- ✓ 36.7% T1a
- ✓ 36.2% T1b
- ✓ 17.8% T2a

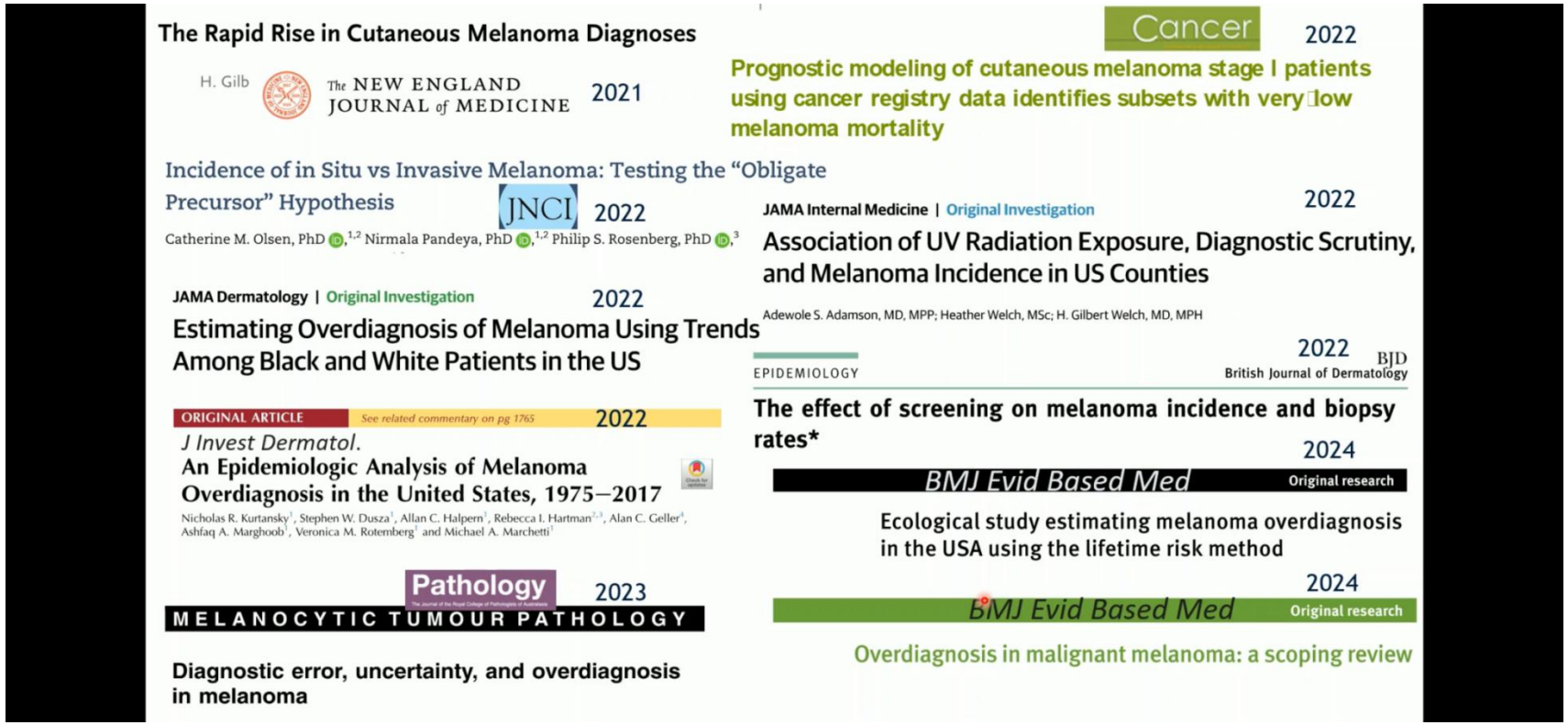
} 72.9% T1

430 had SLNB performed

- ✓ 10.2% had +SLN

52% had <5% SLN+ risk and of those 76% decided to forgo SLNB

# ¿Sobrediagnóstico?




## F052 Approach to Melanoma Diagnosis

**OBJECTIVES**

1. Evaluate the current trends in the epidemiology of melanoma
2. Recognize the various diagnostic issues of melanoma
3. Summarize the strategies to achieve a patient-centered approach to melanoma detection

**DESCRIPTION**

Transitioning to a more patient-centered approach to melanoma detection requires a critical understanding of the current knowledge and issues surrounding the epidemiology of melanoma, precursors of melanoma, and clinical and histologic diagnosis of melanoma as they are related to limitations of the diagnostic gold standard, under- and over diagnosis of melanoma, and advances in molecular diagnostics. Faculty members will present data and analysis of their respective expertise, providing strategies for more optimal patient-centered management of melanocytic lesions. The session is geared toward all levels of trainees and practicing clinicians.

# MIS Obligate Precursor to Invasive Melanoma?

- If a precursor, MIS would occur before invasive melanoma
- Studies consistently show MIS diagnosed after invasive melanoma
- Based on the epidemiology data, **MIS rarely progresses to invasive melanoma**

Incidence of in Situ vs Invasive Melanoma: Testing the "Obligate Precursor" Hypothesis

Catherine M. Olsen, PhD,[1,2] Nirmala Pandeya, PhD,[1,2] Philip S. Rosenberg, PhD,[3] David C. Whiteman, MBBS, PhD[1,2,*]

Olsen CM. JNCI, 2022

**Trends in the diagnosis and clinical features of melanoma in situ (MIS) in US men and women: A prospective, observational study**

Erin X. Wei, MD,[a] Abrar A. Qureshi, MD, MPH,[b,d,e] Jiali Han, PhD,[b,f,g] Tricia Y. Li, MD, MS,[b] Eunyoung Cho, ScD,[b,d,e] Jennifer Y. Lin, MD,[c] and Wen-Qing Li, PhD[d,e]

*Miami, Florida; Boston, Massachusetts; Providence, Rhode Island; and Indianapolis, Indiana*

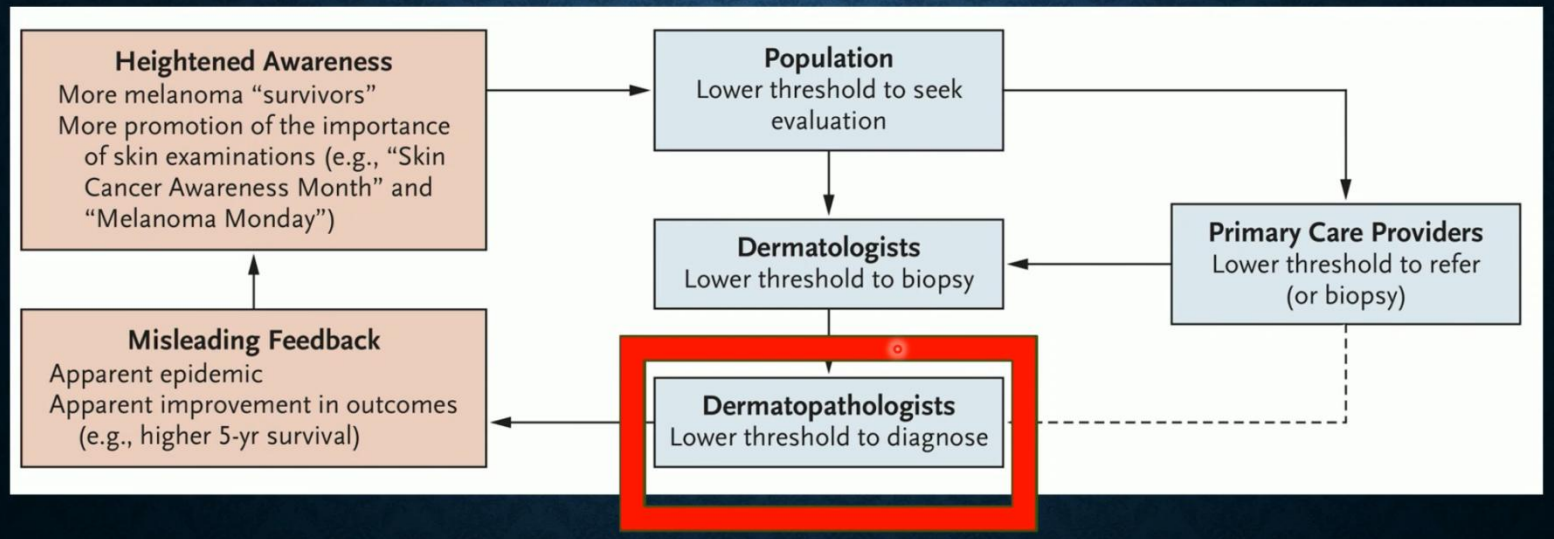
Wei EX. J Am Acad Dermatol 2016

## Overdiagnosis (or Misdiagnosis) should be suspected...

- Nevus with severe atypia, melanoma in situ cannot be excluded
- Nevoid melanoma in situ
- Nevoid melanoma in situ, Probable
- Early early evolving melanoma in situ

- When lesions are small and clinically benign with these sign-outs, they should be decoded as benign
- Consider second opinion
- Excision with narrow margins should be performed

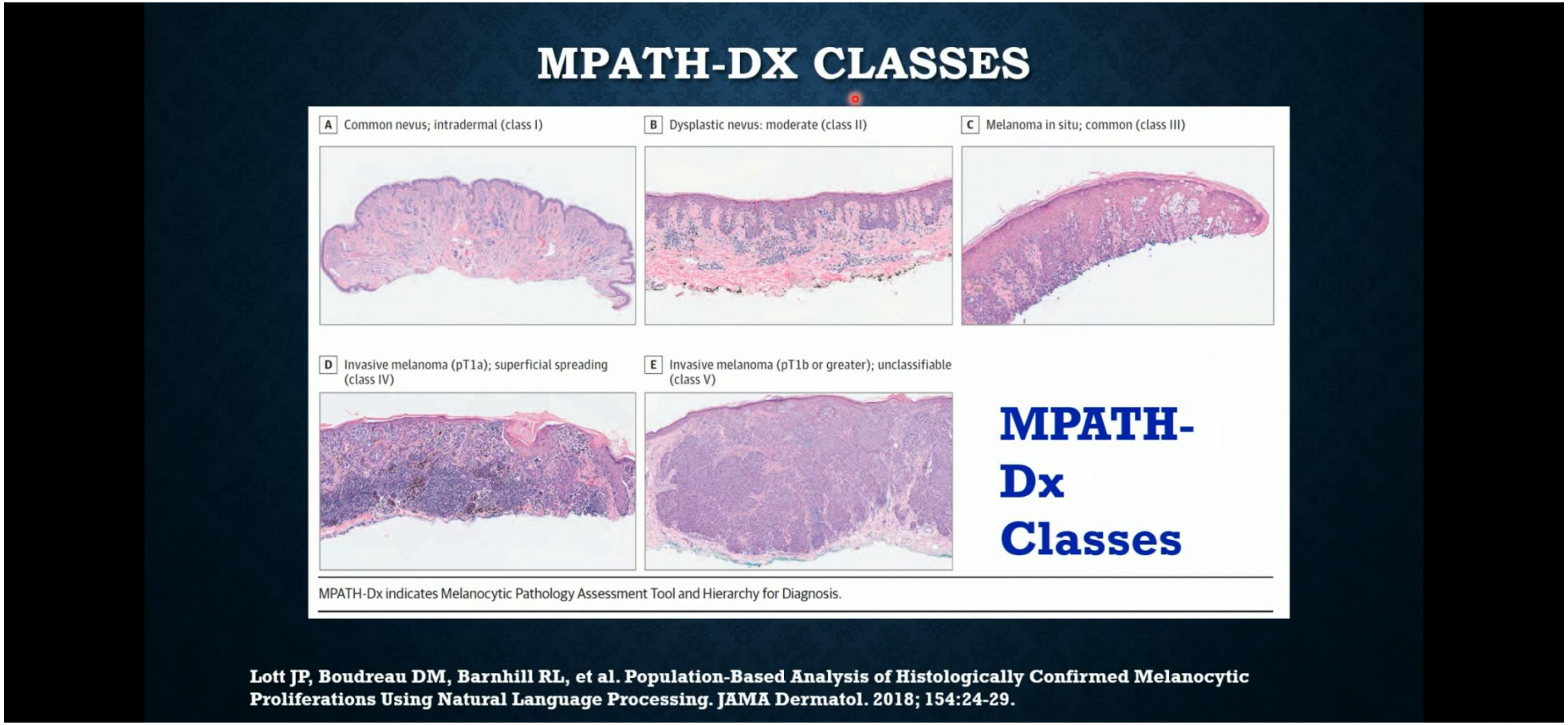
# RAPID RISE IN MELANOMA DIAGNOSIS




Welch HG, Mazer BL, Adamson AS. The Rapid Rise in Cutaneous Melanoma Diagnoses. N Engl J Med. 2021 Jan 7;384(1):72-79.

# Melanocytic Pathology Assessment Tool and Hierarchy

## ZONA GRIS: DISTINCIÓN CLASE II Y III



# WHAT CAN BE DONE?

- Second-opinion reviews
- Recalibrating histopathologic thresholds for diagnosis of melanoma
- Consistent histopathologic criteria for diagnosis of melanoma and nevi
- Clinicopathologic correlation
- Interpret PRAME expression using more stringent thresholds
- Molecular techniques including NGS
- Deep learning
- ***Redefine MIS***

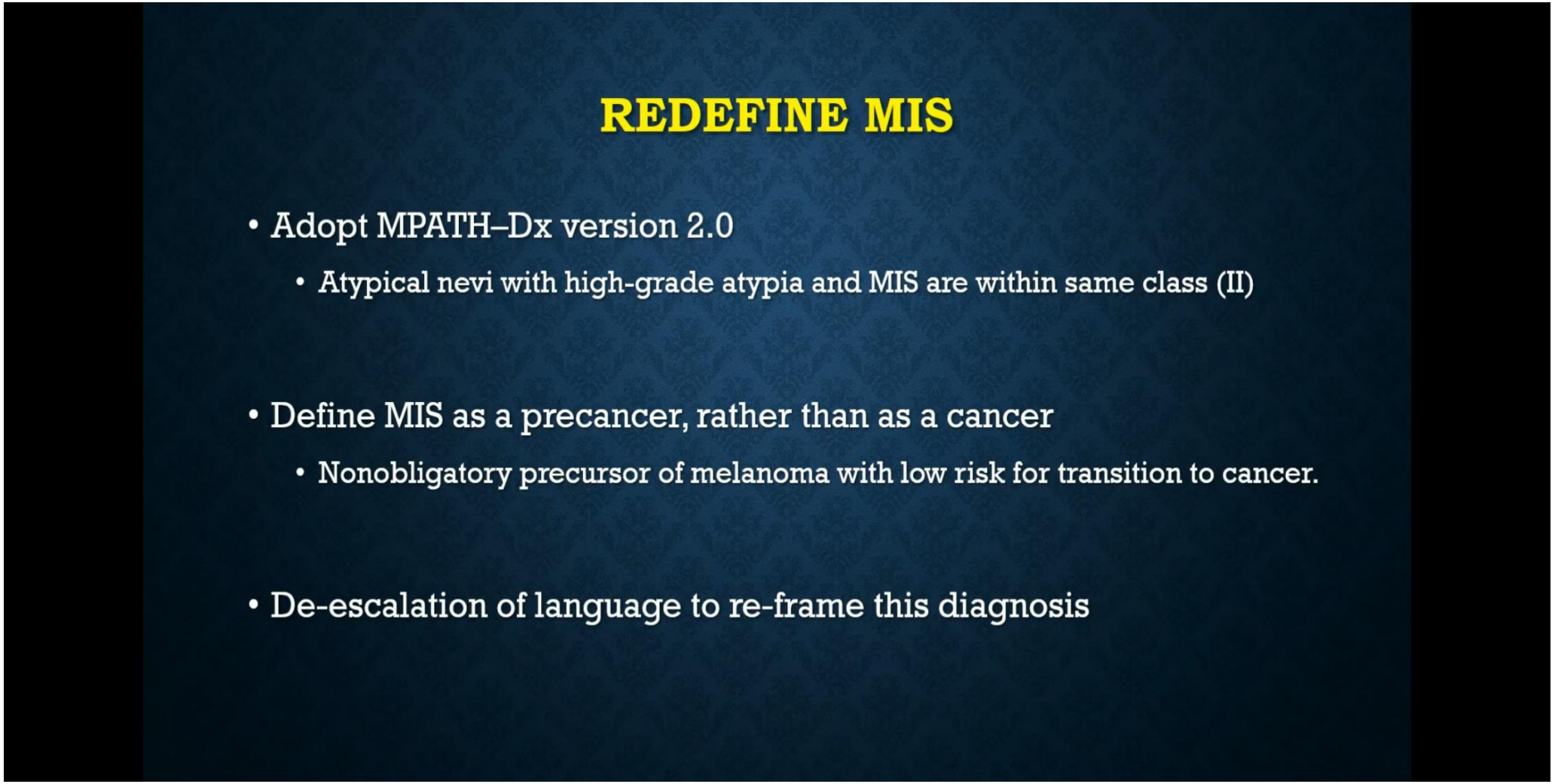
Sheerin J, Collgros H, Chamberlain A, Ferguson P, Gouveia BM, Guitera P, Mar V, Whiteman DC, Caccetta T. A Clinical Perspective on Melanoma Overdiagnosis. Australas J Dermatol. 2025 Nov;66(7):388-395. doi: 10.1111/ajd.14581. Epub 2025 Aug 12.

# PRAME AND MIS

- PRAME-positive cells not uncommon in lentigines and in non-lesional sun-damaged skin
- Solar lentigo (SL) and non-lesional sun damaged skin: ≤ 10 cells/mm (mean 1.2)
  - Almost all cases 0 or 1+ staining
- MIS: ≥ 16 cells/mm (mean 75)
  - Almost all cases 3+ or 4+ staining

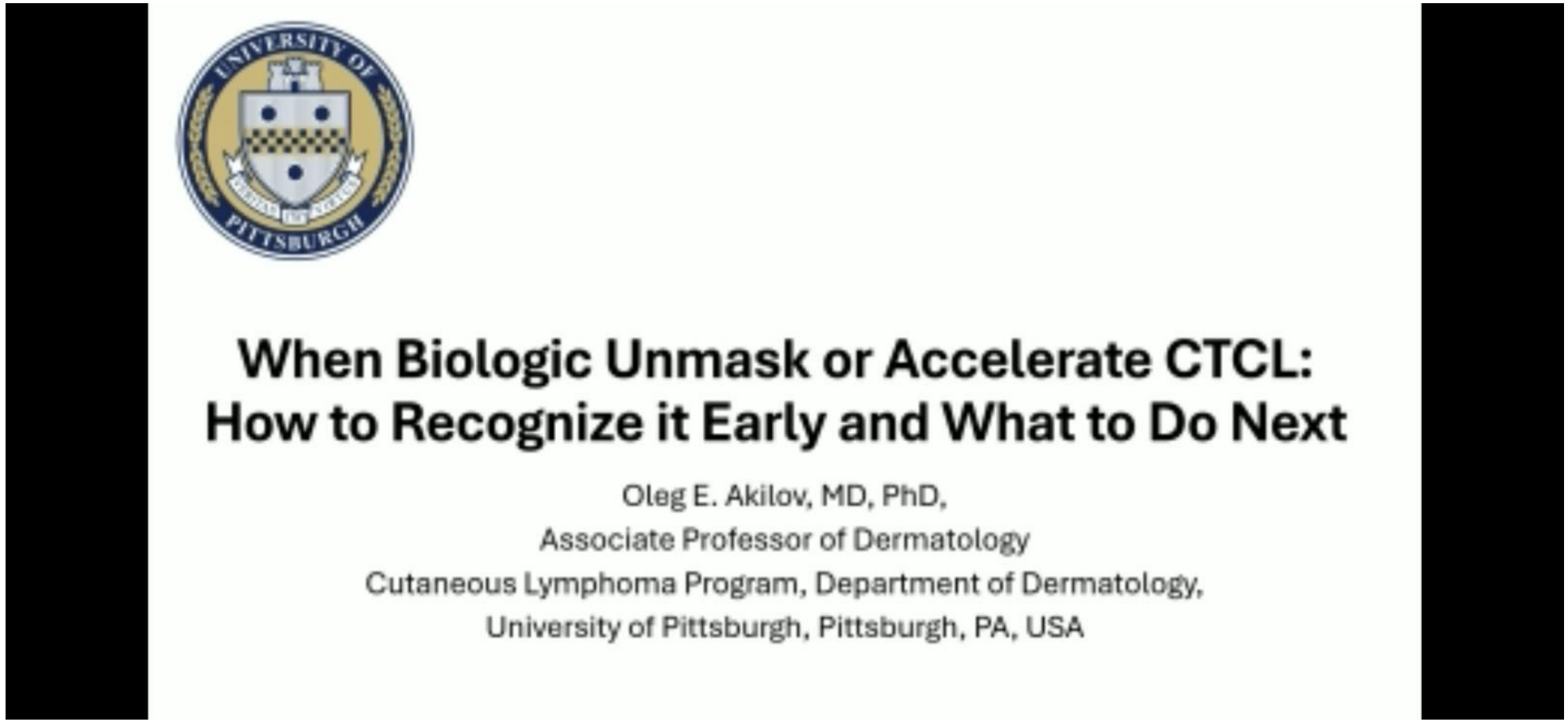
- **Using a threshold of 10 cells per mm → specificity of 97.9%**
- *May reduce overcalling of MIS or AJMP in SL and hyperplasia in sun-damaged skin*

**Olds H, Utz S, Abrams J, Terrano D, Mehregan D. Use of PRAME immunostaining to distinguish early melanoma in situ from benign pigmented conditions. J Cutan Pathol. 2022 Jun;49(6):510-514.**


REDEFINE MIS
• Adopt MPATH–Dx version 2.0
• Atypical nevi with high-grade atypia and MIS are within same class (II)
• Define MIS as a precancer, rather than as a cancer
• Nonobligatory precursor of melanoma with low risk for transition to cancer.
• De-escalation of language to re-frame this diagnosis

# LINFOMAS CUTÁNEOS

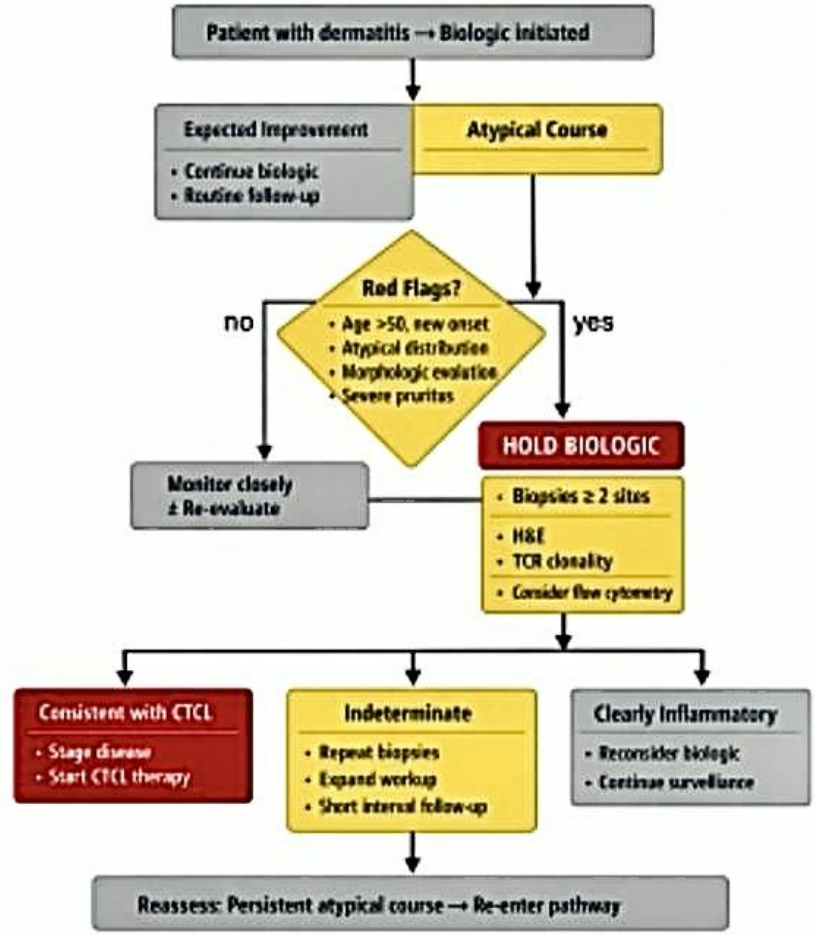
- Pronóstico MF
- Nuevas terapias


When Biologic Unmask or Accelerate CTCL:
How to Recognize it Early and What to Do Next
Oleg E. Akilov, MD, PhD,
Associate Professor of Dermatology
Cutaneous Lymphoma Program, Department of Dermatology,
University of Pittsburgh, Pittsburgh, PA, USA

# DIAGNOSTIC APPROACH

## If concern arises

- Multiple biopsies (different body sites)
- TCR clonality (different skin sites ± blood)
- Peripheral blood flow cytometry to r/o Sezary cells
- Repeat over time if needed




### RED FLAGS **BEFORE** STARTING BIOLOGICS

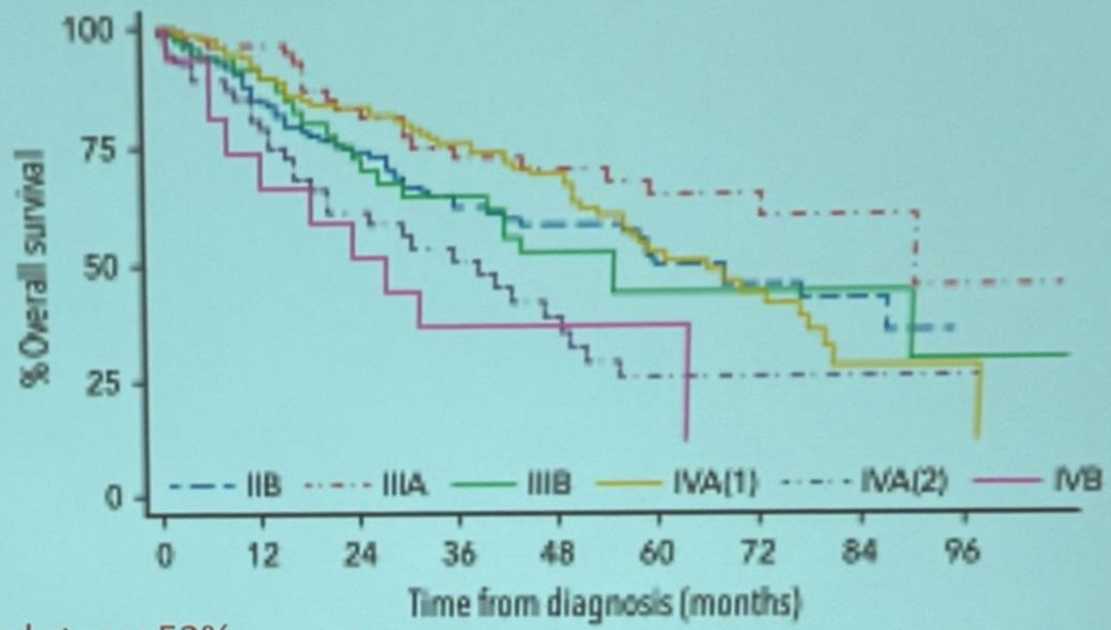
- Age > 50
- New "AD" Dx
- Atypical distribution
  - non-flexural, bathing trunk
- Chronic treatment-resistant "dermatitis"
- Nonspecific biopsies

# Overall survival of advanced stage (IIB-IV) MF/SS patients

N=552, 46 international MF/SS centers
(PROCLIPI study)

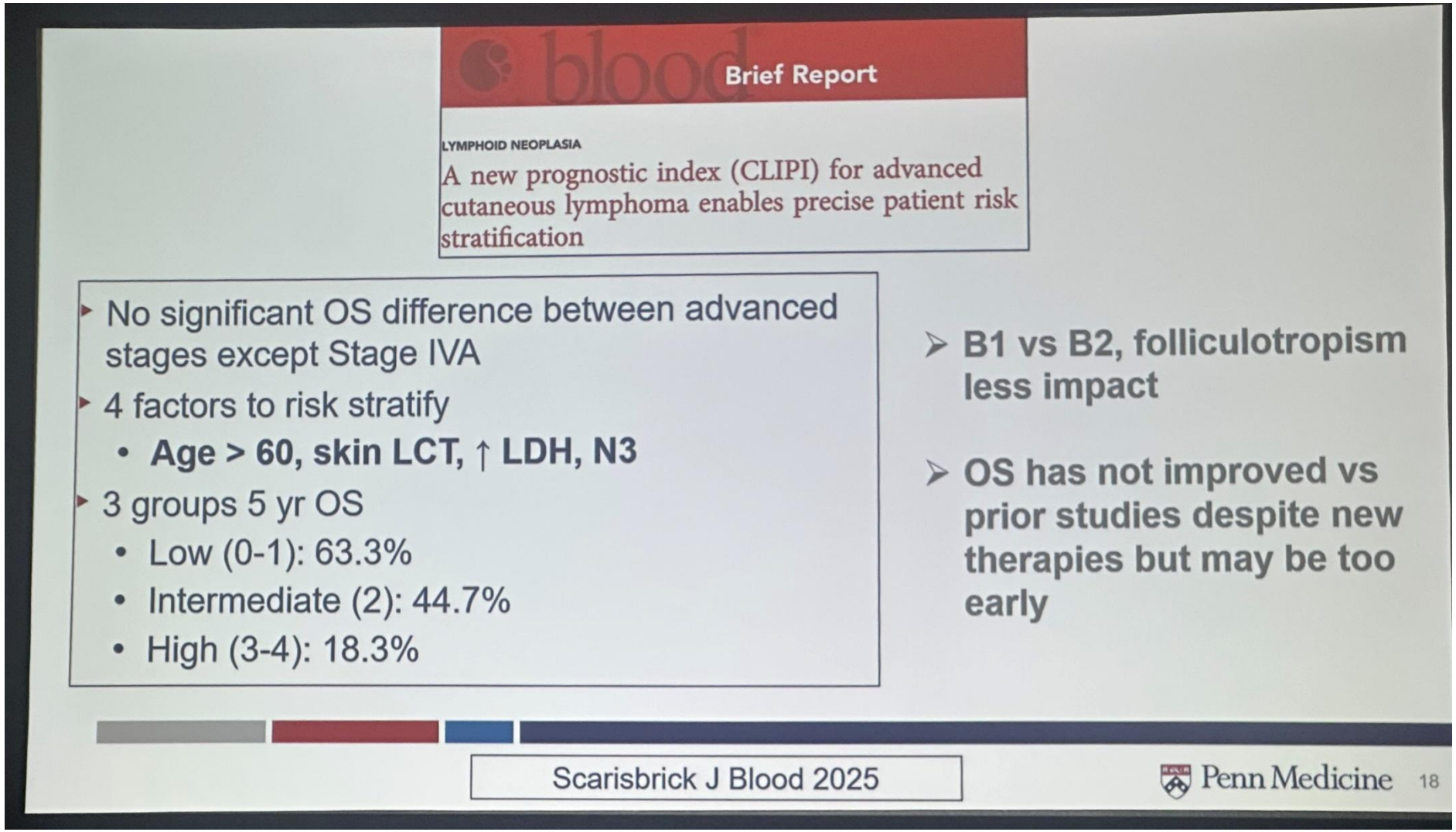
**5 year OS**

| | |
|---|---|
| IIB | 50% |
| IIIA | 64.8% |
| IIIB | 43.9% |
| IVA1 | 50.8% |
| IVA2 | 25.9% |
| IVB | 36.9% |



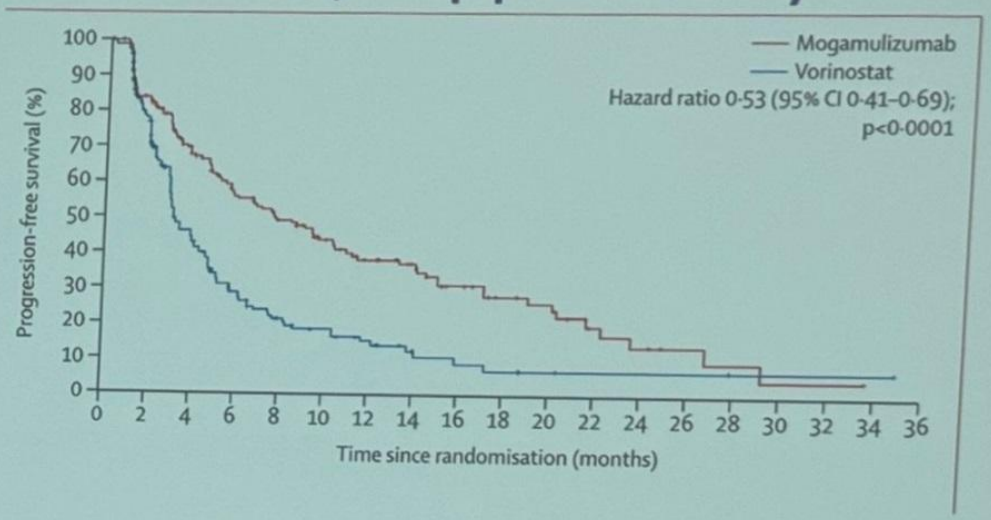

Median 5-year OS for advanced stage: 52%
IIIA (erythrodermic, no blood involvement) better OS than other advanced stages

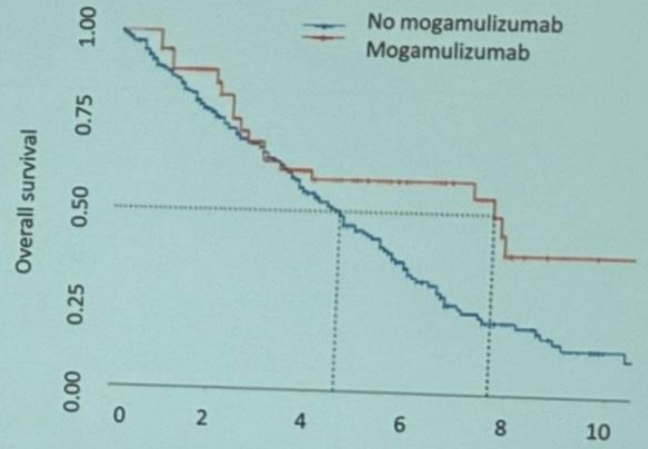
Scarisbrick et al. *Blood* 2025


blood
Brief Report
LYMPHOID NEOPLASIA
A new prognostic index (CLIPI) for advanced cutaneous lymphoma enables precise patient risk stratification
No significant OS difference between advanced stages except Stage IVA
4 factors to risk stratify
Age > 60, skin LCT, ↑ LDH, N3
3 groups 5 yr OS
Low (0-1): 63.3%
Intermediate (2): 44.7%
High (3-4): 18.3%
B1 vs B2, folliculotropism less impact
OS has not improved vs prior studies despite new therapies but may be too early
Scarisbrick J Blood 2025
Penn Medicine
18

# Mogamulizumab remains central, supported by PROCLIPI data

- PROCLIPI – international, multi-center registry to determine prognostic index for MF/SS (global database of 2000 patients across 50 centers in 20+ countries)
- 371 advanced MF/SS pts [Median OS]
  - 64 mo with moga
  - 54 mo without
- 96 Sezary pts [Median OS]
  - 6.5 years with moga
  - 3 years without



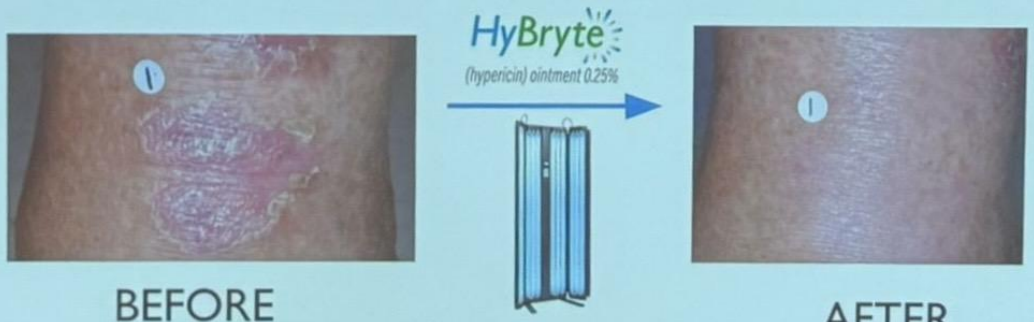




Kim et al, *Lancet* 2018
Bozonnet et al, *eClinicalMedicine* 2024
Data from EORTC-CLTG Annual Meeting, Oct 2025

# Soligenix HyBryte (topical 0.25% hypericin) PDT

## Photodynamic therapy for early-stage CTCL

- Mechanism
  - Synthetic hypericin + visible light (≈585–595 nm)
  - Generates reactive oxygen species → apoptosis
  - Selective uptake in malignant T cells

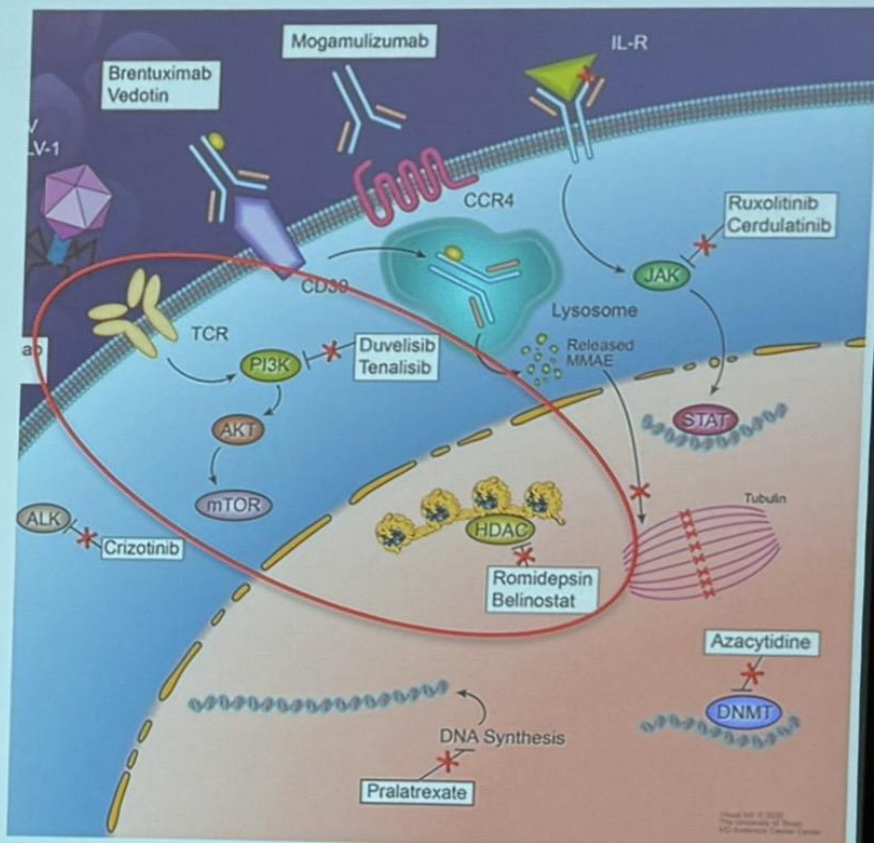



- Phase III FLASH Study (n=169)
  - Early-stage MF (IA–IIA)
  - ORR: ~49% vs 16% placebo
  - Safe, well tolerated
  - No systemic immunosuppression
- Key Advantages
  - Skin-directed, non-immunosuppressive
  - Minimal cumulative toxicity
  - Potential long-term maintenance strategy

# Duvelisib moved closer to mainstream use in CTCL

(especially in combo with romidepsin)

- NCCN Category 2A
- Single-agent – modest activity
- Combo (duvelisib + romidepsin) (PI3Ki + HDACi)
  - ORR 55-60%
  - CR up to 40%
- AEs – generally well tolerated; cytopenias and transaminitis seen in some
- Role: later-line / bridge therapy




Ford et al. *Blood Adv* 2025
Horwitz et al. *Nat Med* 2024

# CIRUGÍA

## S019 How Would You Reconstruct It

**OBJECTIVES**

1. Recognize there are a variety of closures for any given defect
2. Describe the reasoning behind why one closure was chosen over another
3. Discuss what goes into the decision making of outstanding surgical reconstruction

**DESCRIPTION**

This is essentially a Masters of Reconstruction panel. Each of the speakers presents two or three interesting cases that have multiple options for closure. The panel then discusses how they would approach the defect. The speaker then reveals how they closed the wound and why it worked or did not work and what they learned from the case.

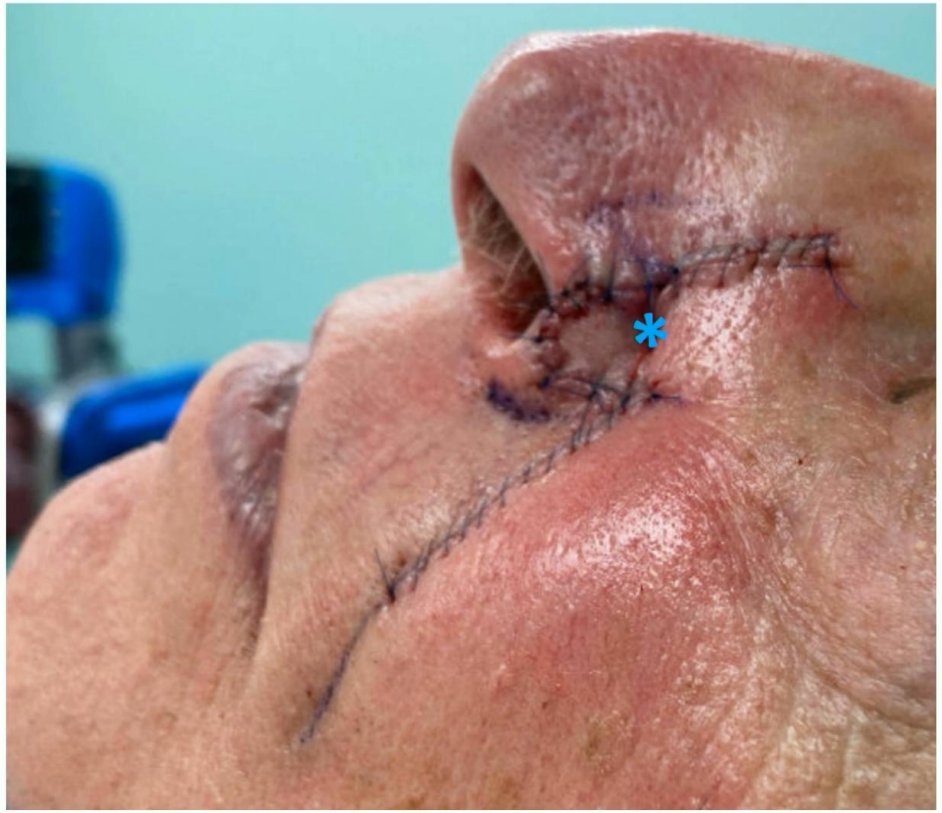
## S021 Pearls from the Masters of Dermatological Surgery

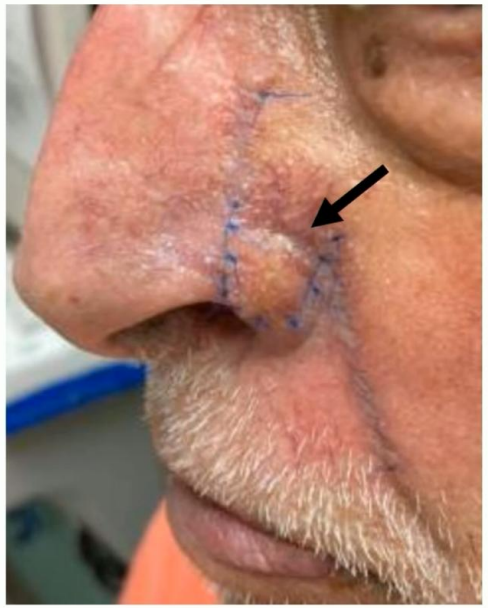
**OBJECTIVES**

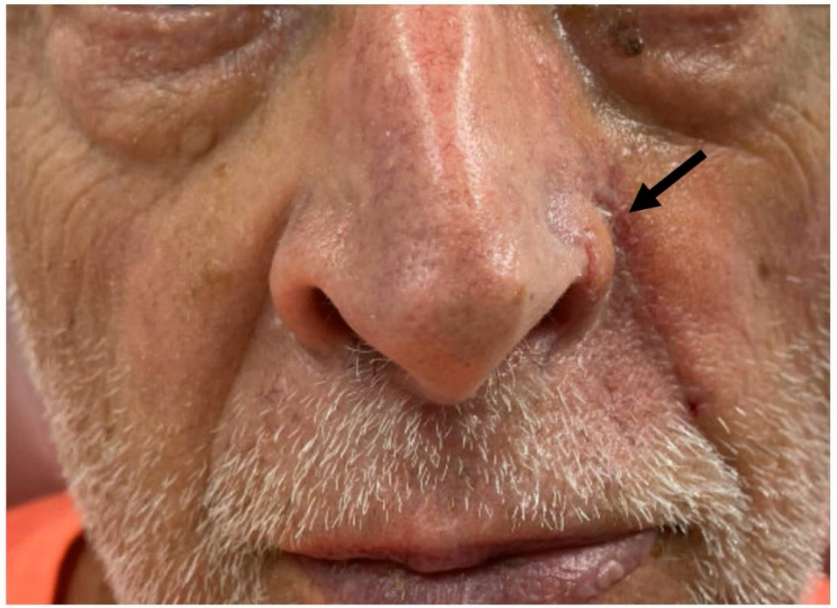
1. Demonstrate new concepts in dermatologic oncology, laser dermatology and cosmetic dermatology.
2. Discuss the advantages/disadvantages of various treatments utilized in dermatologic surgery.
3. Describe new surgical repairs and solutions for dermatologic problems in clinical practice.

**DESCRIPTION**

This fast-moving session is highly popular with attendees and speakers. Each speaker will present 1-3 pearls and has been selected for their experience and teaching reputation in dermatologic oncology/laser surgery or cosmetic dermatology. The pearls are all designed to be immediately relevant to clinical practice. Please join us for this highly practical and interactive session.







7 day suture removal:
4-0 polyglactin 910 remains x 3-4 weeks

# Pearl 5. Redesigned Chalazion Clamp

## Redesigning the Chalazion Clamp: A Concave Approach for Curved Mucocutaneous Surfaces*

**Latoni, David[1], Li, Helen Yiwen[2], Harvey, David[2,3]**

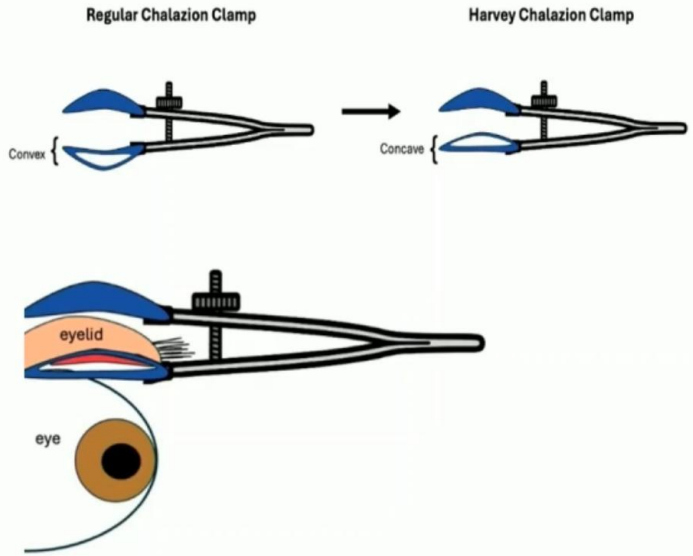
[1] University of Puerto Rico
[2] Emory University School of Medicine
[3] Anne Arundel Dermatology

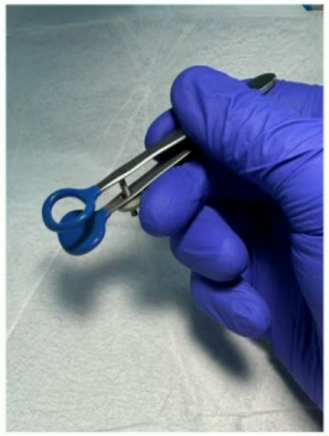
Dr. Helen Li

Dr. Dave Latoni

*Submitted for publication Derm Surgery Dec 2025
We received no royalties from this redesign.

# Pearl 5. Redesigned Chalazion Clamp



***We received no royalties for this instrument redesign*

# Pearl 6. Modified Instruments with Integrated Rulers

## Modified Needle Holder and Undermining Scissors with Integrated Rulers to Streamline Mohs Reconstruction

**David I Latoni, MD, MPH[1*]; David T Harvey, MD, FAAD, FACMS [2,3*†]; Helen Li[3], MD, Megan M. Cronin, MD, FAAD[4,5]; Terrence A. Cronin, Jr., MD, FAAD[4,5]**

1.Department of Dermatology, University of Puerto Rico School of Medicine, San Juan, Puerto Rico
2.Anne Arundel Dermatology, Newnan, Georgia
3.Department of Dermatology, Emory University School of Medicine, Atlanta, Georgia
4.Cronin Skin Cancer Center, Melbourne, Florida
5.Voluntary Professor, University of Miami Frost Department of Dermatology and Cutaneous Surgery

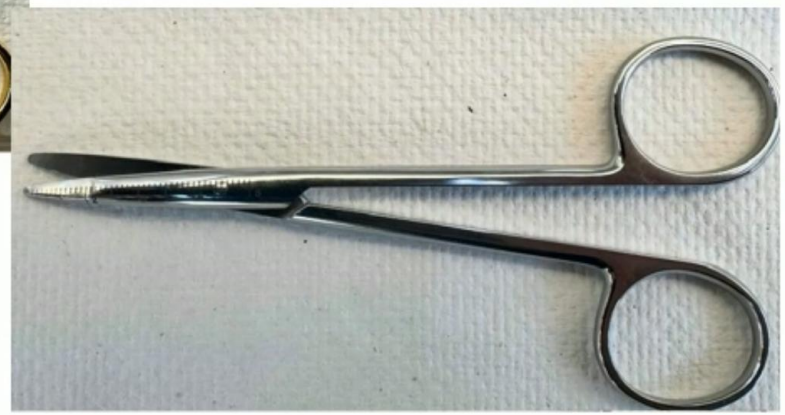
Dr. Dave Latoni

Dr. Helen Li

*Accepted for publication in Derm Surgery March 2026*
***We received no royalties for these instruments redesign*

Drs. Megan and Terry Cronin

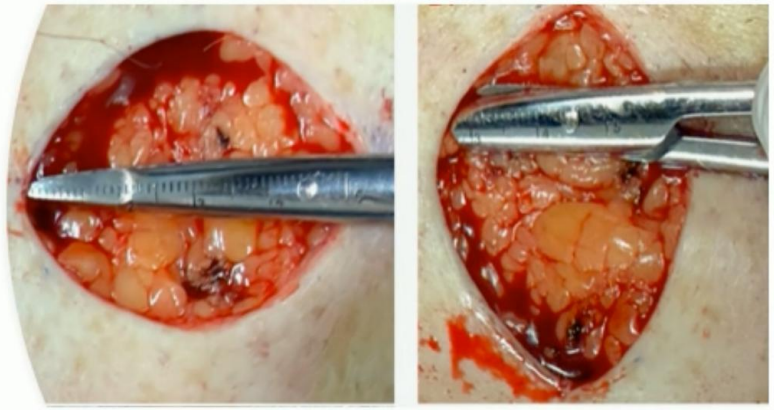
# Pearl 6. Modified Needle Holder and Undermining Scissors with Integrated Rulers



# Pearl 6. Modified Needle Holder and Undermining Scissors with Integrated Rulers

**Reconstructive Measurements Made Efficient:**

- **Flap Design**
  - Advancement flap length vs defect length
  - Rotation flap arc length
  - Bilobed flap lobe proportions
- **Mohs Staging**
  - Measuring delicate defects (eyelid, genital skin)
  - Immediate post-stage defect assessment
- **Undermining Depth**
  - Standardizing undermining radius
  - Comparing bilateral undermining symmetry



*Defect measurement on left; Undermining depth estimation on right (3 cm) is greater than width of the defect (2.8 cm), allowing for complex repair billing.*

# MENSAJES PARA CASA

1. Avance imparable de la inmunoterapia en sSCC : indicación de adyuvancia en muy alto riesgo y más evidencias en neoadyuvancia. Identificación de pacientes de alto riesgo

2. Epidemia diagnóstica de melanoma: necesidad de redefinir concepto de MIS y establecer criterios diagnósticos y pronósticos renovados

3. Cambio de paradigma pronóstico y de estadiaje en MF: peor pronóstico IIB, variables CLIPI


AAD ANNUAL MEETING
2026

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Denver, Colorado

27 — 31
Marzo

highlights

*A un nuevo nivel de conocimiento científico*

Una iniciativa de:

AEDV 1909 ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

FUNDACIÓN AEDV PIEL SANA ACADEMIA ESPAÑOLA DE DERMATOLOGÍA Y VENEREOLOGÍA

# GRACIAS

AAD ANNUAL MEETING 2026

# AEDV

*highlights*

Denver, Colorado

27 — 31 Marzo

Con el patrocinio de:

ucb