

Merkel Cell Carcinoma

DISEASE OVERVIEW

MCC is a rare, cutaneous malignancy **more frequently occurring in the elderly** that has a poor prognosis

Clinical Presentation



MCC is diagnosed **more often in men** than women, and its incidence is predicted to increase

Epidemiology



6 Factors that may influence outcome and disease burden

Risk Factors

MCC etiology is likely multifactorial



MCPyV infection



Immuno-suppression



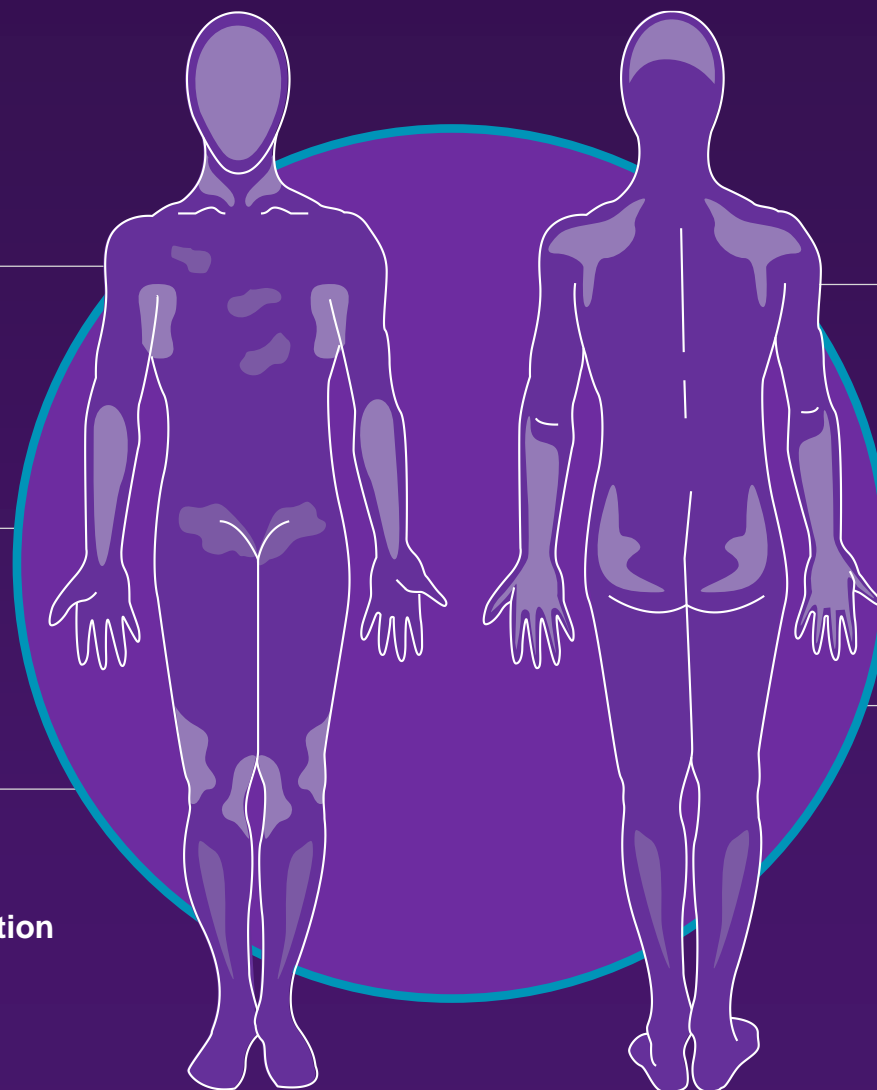
Solar radiation

MCC Etiology

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MCC is classified in stages

1 to 4

TNM Classification



3.1%

of patients with MCC have distant metastasis

53.5%

of patients with MCC are diagnosed at an early stage

Stages/Metastasis at Diagnosis



23%

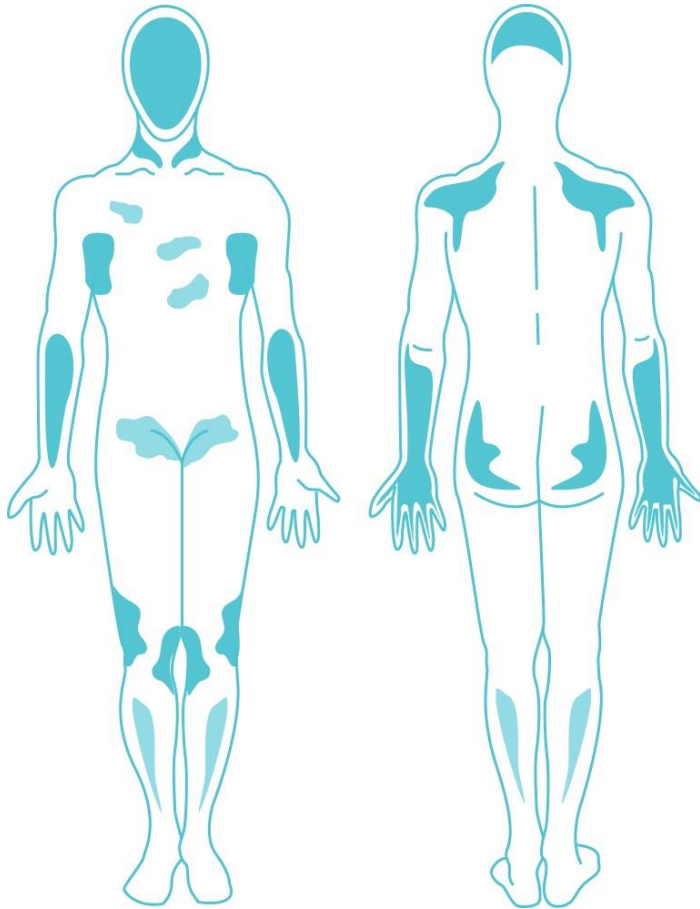
5-year relative survival rate for metastatic disease

Survival



Clinical Presentation

ANATOMICAL DISTRIBUTION OF MCC AT PRESENTATION¹



CLINICAL CHARACTERISTICS OF MCC¹

The acronym **AEIOU** is often used to summarize the classical clinical characteristics of MCC:

Asymptomatic

Expanding rapidly

Immune suppression

Older than 50 years of age

UV exposure on fair skin

- MCC is an ultra-rare neuroendocrine, cutaneous malignancy that occurs more frequently in elderly individuals and has a poor prognosis²
- Patients present with a firm, painless, rapidly enlarging, red-violet, cutaneous, dome-shaped tumor nodule²
- MCC nodules are often located in **sun-exposed areas** of the head and neck or upper extremities³
- MCC commonly occurs on the **face and neck** (40-60%), followed by the trunk (23%), and the extremities (10-20%)⁴

*MCC distribution evaluated in 195 patients: 168 patients with primary skin lesions and 27 patients with nodal involvement and no known primary lesions.

MCC, Merkel cell carcinoma.

1. Heath M et al. J Am Acad Dermatol. 2018;58(3):375–81; 2. Dellambra E et al. Biomedicines. 2021;9(7):718–41; 3. Smith VA et al. Laryngoscope. 2012;122(6):1283–90; 4. Medina-Franco H et al. Ann Surg Oncol. 2001;8(3):204–8.

MCC Epidemiology



MCC is a very rare form of skin cancer with an incidence rate of **0.7 cases per 100,000 PYs** in the US in 2013, corresponding to **2488 cases per year**¹



The number of reported MCC cases is rapidly growing, with **an increase of 95% from 2000 to 2013** according to a study of 6600 patients with MCC registered in the SEER database¹



Due to aging of the Baby Boomer generation, incidences of MCC in the US are **predicted to climb to 2835 cases per year in 2020 and 3284 cases per year in 2025**¹



MCC incidence **increases exponentially with age**, from 0.1 to 1.0 to 9.8 (per 100,000 PYs) among age groups 40-44 years, 60-64 years, and ≥85 years, respectively¹

- Consequently, MCC is primarily a **disease of the elderly with a median age of 76 years (1986 to 2004)**²



The **incidence of MCC is higher in men than in women**, as shown in a study of 3870 MCC cases identified in the SEER database between 1973 and 2006 (0.41 [95% CI: 0.38-0.43] per 100,000 PYs in men vs 0.18 [95% CI: 0.17-0.19] per 100,000 PYs in women; p<0.05)³



Patients with MCC are **mostly Caucasian (96.4%)**, with African American (1.2%) and people of Asian descent (0.8%) making up a very small portion⁴

MCC, Merkel cell carcinoma; PY, person-year; SEER, Surveillance, Epidemiology, and End Results Program; US, United States.

1. Paulson KG et al. J Am Acad Dermatol. 2018;78(3):457-63.e2; 2. Lemos BD et al. J Am Acad Dermatol. 2010;63(5):751-61; 3. Albores-Saavedra J et al. J Cutan Pathol. 2010;37(1):20-7; 4. Harms KL et al. Ann Surg Oncol. 2016;23(11):3564-71.



Select Risk Factors Influencing Clinical Outcome



TUMOR STAGE

Patients with advanced disease (stage III and stage IV) have an increased risk of MCC-specific mortality compared with patients with stage I tumors^{1,2}

TUMOR HISTOLOGY & LOCATION

Lymphovascular invasion, tumor growth pattern, and lymph node number have all been shown to affect disease outcome^{1,3-5}

BIOMARKERS

PD-L1, p63, VEGFR-2, MMP, and KIT are predictive of a worse disease prognosis in patients with MCC^{2,6-11}

HOST FACTORS

Male sex, advanced age, CD8+ infiltration, vitamin D deficiency, and immunosuppression are prognostic host factors for MCC¹²⁻¹⁷

MCPyV INFECTION

MCPyV-negative MCC may represent a more aggressive subtype and may warrant closer clinical follow-up¹⁸

SECONDARY MALIGNANCIES

Patients diagnosed with MCC are at risk of developing secondary cancers¹⁹

Select Risk Factors



The etiology of MCC is likely multifactorial, with immunosuppression, UV-induced skin damage, and viral factors contributing to its development¹

MCPyV INFECTION



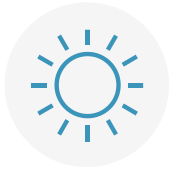
- MCPyV, a DNA virus, is detected in approximately 80% of MCC cases²
- Likely to be part of the normal skin flora, MCPyV DNA is nearly ubiquitous in the normal skin of healthy individuals³
- Infection likely occurs during childhood, but remains largely asymptomatic in adults^{4,5}
- The early gene region of MCPyV encodes ST and LT, both of which are independently required for modulation of the host cell and viral replication⁶
- The oncogenic potential of MCPyV is thought only to occur upon clonal integration into the host genome; spontaneously or through exogenous mutations in the 3' end of the LT^{3,7}
- ST appears to be the major transforming oncogene in MCC⁷

IMMUNOSUPPRESSION



- A key factor in the development of MCC, which appears to be associated with a worse prognosis^{8,9}
- The relative risk for MCC is approximately 13-fold higher in HIV and about 5-fold higher in solid organ transplantation recipients than the general population⁹

SOLAR RADIATION



- UV-B rays induce mutations in the tumor suppressor p53 and Ha-ras genes, increasing the risk of cancer⁸
- The UV-B index is positively associated with MCC incidence⁸
- MCPyV-negative tumors exhibit a high mutation burden associated with UV-induced DNA damage^{10,11}

HIV, human immunodeficiency virus; LT, large T antigen; MCC, Merkel cell carcinoma; MCPyV, Merkel cell polyomavirus; ST, small T antigen; UV, ultraviolet.

1. Saini AT, Miles BA. *Onco Targets Ther.* 2015;8:2157–67; 2. Feng H et al. *Science.* 2008;319(5866):1096–100; 3. Tothill R et al. *Am Soc Clin Oncol Educ Book.* 2015:e519–26; 4. Martel-Jantin C et al. *J Clin Virol* 2013;58(1):288–91; 5. Tolstov YL et al. *Emerg Infect Dis* 2011;17(8):1371–80; 6. Liu W, You J. *Annu Rev Virol* 2020; 7(1): 289-307; 7. Arora R et al. *Curr Opin Virol* 2012;2(4):489–98; 8. Ma JE, Brewer JD. *Cancers (Basel)* 2014;6(3):1328–50; 9. Desch L, Kunstfeld R. *J Skin Cancer* 2013;2013:327150; 10. Wong SQ et al. *Cancer Res* 2015;75(24):5228–34; 11. Harms PW et al. *Cancer Res* 2015;75(18):3720–7.



TNM Classification: MCC Is Classified in Stages I to IV

The **consensus staging system** for MCC was introduced by the AJCC in 2010¹ and updated in 2018 to help clinicians better stratify patients into groups based on their predicted survival, emphasizing the difference between clinically and pathologically determined staging^{2,3}

I **STAGE I**
Primary tumor size ≤2 cm

II **STAGE II**
Primary tumor size >2 cm

III **STAGE III**
Positive nodal disease

IV **STAGE IV**
Distant metastasis

CLINICAL STAGE GROUPS (cTNM)

STAGE	T	N	M
0	Tis	N0	M0
I	T1	N0	M0
IIA	T2-3	N0	M0
IIB	T4	N0	M0
III	T0-4	N1-3	M0
IV	T0-4	Any N	M1

PATHOLOGICAL STAGE GROUPS (pTNM)

STAGE	T	N	M
0	Tis	N0	M0
I	T1	N0	M0
IIA	T2-3	N0	M0
IIB	T4	N0	M0
IIIA	T1-4	N1a(sn) or N1a	M0
	T0	N1b	M0
IIIB	T1-4	N1b-3	M0
IV	T0-4	Any N	M1

Part 1

Part 2

AJCC, American Joint Commission on Cancer; **M**, metastasis; **MCC**, Merkel cell carcinoma; **N**, node; **T**, tumor.

1. Edge SB et al. AJCC Cancer Staging Manual. 7th ed. 2010; 2. Harms KL et al. Ann Surg Oncol. 2016;23(11):3564–71; 3. American Joint Committee on Cancer. Merkel Cell Carcinoma. In: AJCC Cancer Staging Manual. 8th ed. New York, NY: Springer; 2017:549.



TNM Classification: MCC Is Classified in Stages I to IV, cont'd

The **consensus staging system** for MCC is classified by tumor, node, and metastasis criteria

T	N	M	
Tx, primary tumor cannot be assessed	cNx, regional lymph nodes cannot be clinically assessed (eg, previously removed for another reason, body habitus)	pNx, regional lymph nodes cannot be assessed (eg, previously removed for another reason) or not removed for pathological evaluation	M0, no distant metastasis
T0, no primary tumor	cN0, no regional lymph node metastasis by clinical or radiological evaluation	pN0, no regional lymph node metastasis detected on pathological evaluation	M1, distant metastasis
Tis, in situ primary tumor	cN1, clinically detected regional nodal metastasis	pN1a(sn), clinically occult nodal metastasis identified only by sentinel lymph node biopsy	M1a, metastases to distant skin, distant subcutaneous tissue, or distant lymph nodes
T1, primary tumor ≤2 cm	cN2, in-transit metastasis without lymph node metastasis	pN1a, clinically occult regional lymph node metastasis following lymph node dissection	M1b, metastasis to lung
T2, primary tumor >2 cm but ≤5 cm	cN3, in-transit metastasis with lymph node metastasis	pN1b, clinically or radiologically detected regional lymph node metastasis, pathologically confirmed	M1c, metastasis to all other visceral sites
T3, primary tumor >5 cm		pN2, in-transit metastasis without lymph node metastasis	
T4, primary tumor invades fascia, muscle, cartilage, or bone		pN3, in-transit metastasis with lymph node metastasis	

Part 1

Part 2

AJCC, American Joint Commission on Cancer; c, clinical; M, metastasis; MCC, Merkel cell carcinoma; N, node; p, pathologic; T, tumor. Harms KL et al. Ann Surg Oncol. 2016;23(11):3564–71.



MCC Stage at Diagnosis and Sites of Metastasis

MCC

Percentage of patients with MCC per clinical stage, as presented at diagnosis^{1,*}

STAGE	PATIENTS, %
I	53.5
II	21.4
III	13.8
IV	3.1
Unknown	8.2

- MCC develops at an exponential rate on chronically sun-damaged skin, with a doubling time of 5 days to 12 days^{2,3}
- MCC grows in an infiltrating manner in the initial stages of disease, and satellite metastases may occur early in development of the disease⁴

METASTATIC MCC

Common metastatic sites of MCC^{5,6}

METASTATIC SITE	PATIENTS, %
Lymph nodes	60
Skin	30
Lung	23
CNS	18
Bone	15

- Progression to metastatic disease is a frequent phenomena post locally advanced disease and typically observed within the first 2 years following diagnosis⁷
- Recurrence in MCC is high, particularly in patients with a positive SLNB⁸

*Based on 159 patients with a median age of 75 years treated for MCC between 2002 and 2020 at a single institution.

CNS, central nervous system; MCC, Merkel cell carcinoma; SLNB, sentinel lymph node biopsy.

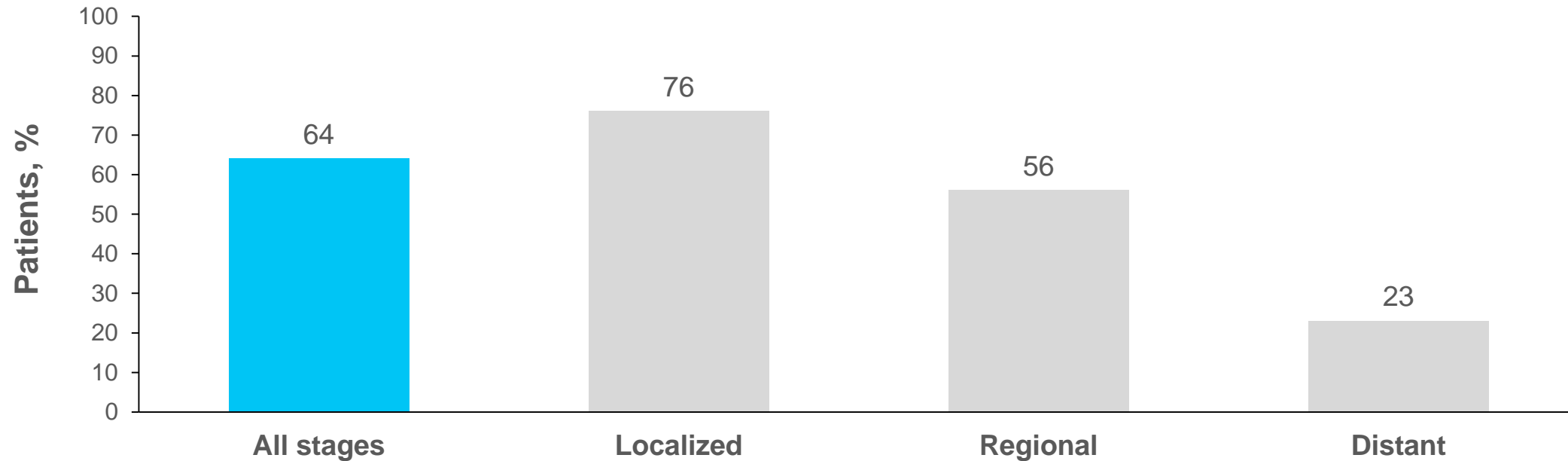
1. Esposito A et al. Ann Surg Oncol. 2022;29(1):415–24; 2. Poulsen M. Drugs Aging 2005;22(3):219–29; 3. Swann MH, Yoon J. Semin Oncol 2007;34(1):51–6; 4. Becker JC. Ann Oncol 2010;21(suppl 7):vii81–5; 5. Medina-Franco H et al. Ann Surg Oncol 2001;8(3):204–8; 6. Voog E et al. Cancer 1999;85(12):2589–95; 7. Allen PJ et al. J Clin Oncol 2005;23(10):2300–9; 8. Gupta SG et al. Arch Dermatol 2006;142(6):685–90.



MCC 5-year Survival by Stage at Diagnosis

- MCC exhibits aggressive clinical features and is associated with a poorer prognosis and lower survival compared with other aggressive skin malignancies, such as melanoma¹⁻⁴
- According to an analysis of data from the SEER database between 2011 and 2017, tumor stage significantly affects survival, with higher mortality rates with more advanced disease⁵

FIVE-YEAR RELATIVE SURVIVAL BY MCC STAGE AT DIAGNOSIS, 2011-2017⁵



MCC, Merkel cell carcinoma; SEER, Surveillance, Epidemiology, and End Results Program.

1. Saini AT, Miles BA. *Onco Targets Ther* 2015;8:2157-67; 2. Chen MM et al. *JAMA Otolaryngol Head Neck Surg* 2015;141(2):137-41; 3. Smith VA et al. *Laryngoscope* 2012;122(6):1283-90; 4. Grabowski J et al. *Clin Med Oncol* 2008;2:327-33; 5. American Cancer Society. Survival Rates for Merkel Cell Carcinoma. Accessed May 31, 2022. <https://www.cancer.org/cancer/merkel-cell-skin-cancer/detection-diagnosis-staging/survival-rates.html>.