ANZMTG Australia and New Zealand Melanoma Trials Group

NEWSLETTER|ISSUE 15|Spring 2014

Inside this issue

We extend a warm welcome to our members to the spring edition of the ANZMTG newsletter.

Invitation to the ANZMTG Annual Scientific Meeting 2014

We kindly invite all ANZMTG members to attend this year's ANZMTG Annual Scientific Meeting (ASM) which is taking place on **Thursday 9th October at the Harry Perkins Institute of Medical Research, Perth, WA**. It promises to be an interesting day with a number of new melanoma research proposals being presented, as well as updates being given regarding current trials and those currently being developed.

The meeting will coincide with the **SKMRC National Melanoma Conference** which will also be held in Perth from **Friday 10th October – 11th October**. The ANZMTG ASM will commence at 12pm and conclude at 5pm in time for the SKMRC Welcome Function which is being held on the Thursday evening.

If you wish to attend or would like further information, then please email anzmtg@melanoma.org.au or call +61 9911 7200.

We look forward to welcoming as many of you as possible on the day.

New therapies: Anti-PD1 Brain Collaboration – The ABC Trial

When melanoma has spread to the brain, patients often become ineligible to enrol into any of the major clinical trials. Needless to say, this is frustrating for both clinicians and patients, as up to half of the patients with stage IV melanoma develop brain metastases at some point during their illness. Existing treatment options for brain metastases are surgery, stereotactic radiosurgery and/or whole brain radiotherapy. Systemic chemotherapy historically has shown little effect in brain metastases and patients with brain metastases have been excluded from most systemic therapy clinical trials. In Australia, clinicians spearheaded the studies of BRAF inhibitors in patients with active brain metastases, with successful results (*Long GV et al Lancet Onc 2012*). They are now applying the same research vigour to the anti-PD1 immunotherapy nivolumab, which has been extensively investigated in patients without brain metastases. The first immunotherapy trial assessing nivolumab and nivolumab plus ipilimumab specifically in patients with active brain metastases (MIA CA 209-170 / ANZMTG 01.14 ABC Study) is a Melanoma Institute Australia (MIA)-initiated trial and is expected to open in October 2014 at the MIA, Sydney, the Princess Alexandra Hospital, Brisbane and the Peter MacCallum Cancer Centre, Melbourne.

Nivolumab, an anti-PD1 antibody, is a new immunotherapy which builds on the success of ipilimumab, the first immunotherapy to show a survival benefit in metastatic melanoma compared with chemotherapy (*Robert C et al NEJM 2011*). Both drugs activate the immune system, specifically T cells, to induce tumour-cell death.

These drugs were developed based on the idea that tumour cells can be recognised and attacked by the immune system of a patient. Sometimes this occurs naturally; for instance when a primary melanoma partly or completely disappears without any medical intervention. However, tumour cells are able to adapt and evade detection by the immune system. For example, a patient may present with a melanoma that has spread to internal organs but no primary melanoma of the skin can be found. In these cases, it is believed that the primary melanoma was effectively fought by the immune system but some tumour cells adapted to this attack and were able to spread through the body.

How do treatments such as ipilimumab and nivolumab work?

T-cells or T-lymphocytes are the fighter cells of the immune system, and can be switched on and off by various molecules engaging with their surface receptors, for example CTLA4 or PD1 receptors on T cells. Cytotoxic T-Lymphocytes (CTLs) are able to recognise and destroy cancer cells. They are activated when Antigen-Presenting Cells (APCs) present 'foreign antigens' – e.g. little pieces from tumour cells – to receptors on the surface of the CTLs. However, along with this activating signal a simultaneous inhibitory signal may be produced as well which then prevents the T-cell from becoming active. This signal finds its way to the T-cell via CTLA-4, a protein receptor also on the cell surface of T-cells. Ipilimumab is an antibody designed to block this CTLA-4 protein receptor (Figure 1) so the T-cell cannot be switched off. Monoclonal antibodies like ipilimumab are specifically designed immune system proteins which fit certain other proteins in the body, much like a key fitting a lock.

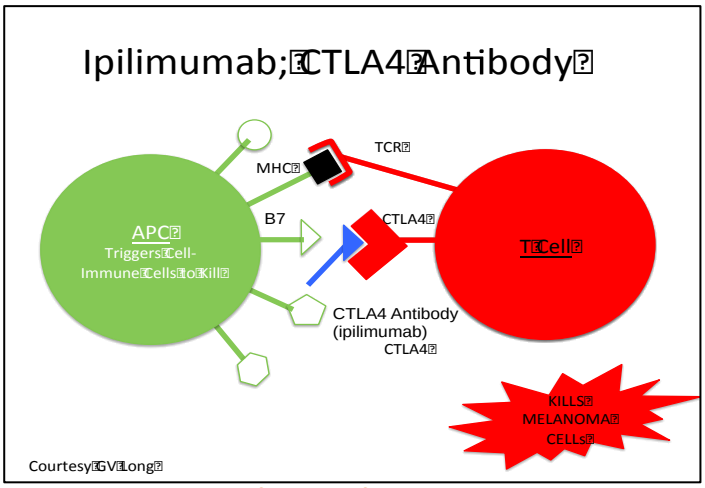


Figure 1: Mechanism of action of ipilimumab

Nivolumab works in a similar way but fits another target protein (Figure 2). Tumour cells may be able to inactivate T-cells by connecting the PDL-1 ligand on their surface to the PD-1 receptor on the surface of the T-cells. Nivolumab is an antibody directed against the PD-1 receptor. When nivolumab is attached to the PD-1 receptor, the lock is blocked and so the key (the PD-L1 ligand on the tumour cell) can no longer fit and the T-cells remain active.

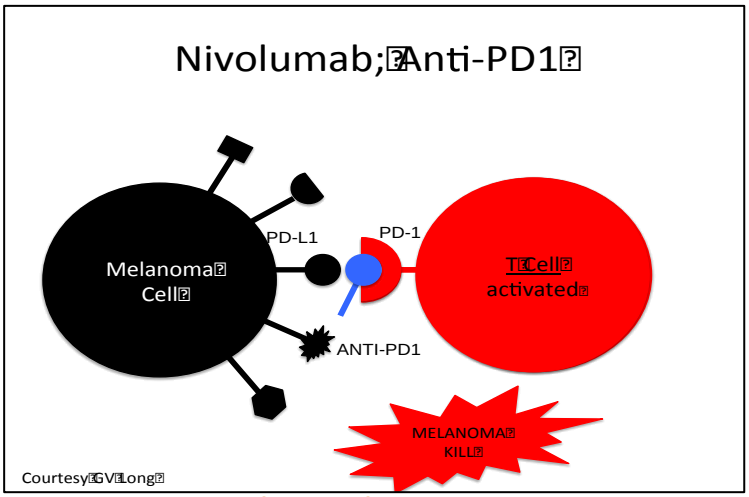


Figure 2: Mechanism of action of nivolumab

The ABC Study is a phase II study and aims to determine the effectiveness of nivolumab alone and in combination with ipilimumab in adult patients with melanoma that has spread to the brain. Patients will be allocated to different cohorts depending on symptoms and previous local treatment of their brain metastases. Further details regarding the study can be found at http://www.anzmtg.org/trialdetails.aspx?trialno=21

Clinical Trial Registries

A clinical trials registry (CTR) is an official platform and catalogue for registering a clinical trial, meaning 'any research study that prospectively assigns human participants to one or more health related intervention to evaluate the effects on health outcomes'[1]. These registries are predominantly at national or cross-national levels, although the World Health Organisation (WHO) encourages an international registry via its International Clinical Trials Registry Platform, which brings together all trials registered on CTRs. The WHO regards trial registration as 'the publication of an internationally-agreed set of information about the design, conduct and administration of clinical

[1] http://www.anzctr.org.au/Faq.aspx

trials'[2]. Some registries, such as the Australia and New Zealand Clinical Trials Registry (ANZCTR), are voluntary whilst others, such as Clinicaltrials.gov in the United States, have a compulsory requirement that all trials be registered.
The primary purpose of a clinical trials registry is to ensure transparency of clinical trials being conducted and to ensure the clinical trial information is available in an easy to understand, unbiased format. This information can assist both patients and health practitioners to understand the treatment choices available and consider whether they might wish to participate in a clinical trial. These registries are highly important in terms of reducing unnecessary duplication of research efforts, achieving high recruitment rates of trial participants and better compliance through a more timely disclosure of results. Overall, registries provide a clear picture of the types of trials being conducted and allows evidence for a new treatment, drug, medical device or therapy to be publically available[3].

In Australia the ANZCTR (Australian New Zealand Clinical Trials Registry) serves as the primary registry for all clinical trials being operated. Established in 2005, the ANZCTR catalogues trials from a wide area including pharmaceuticals, surgical procedures, devices and complementary therapies. Registration is now a condition for any trials wishing to publish their research and to date over 9000 trials have been registered[4]. Clinicaltrials.gov, a U.S. based organisation, is the largest clinical trials registry in the world and currently lists over 170,000 studies with locations in all 50 U.S states and in 187 countries[5].

All trials which are co-ordinated by ANZMTG are registered with the ANZCTR and clinicaltrials.gov, and the table below summarises the trials currently registered and their corresponding reference number, should you wish to look them up.

Table 1: Trials registered by ANZMTG

ANZMTG Trial Number	Trial Name	ANZCTR	Clinicaltrials.gov
ANZMTG 01.02	A randomised clinical trial of surgery versus surgery plus adjuvant radiotherapy for regional control in patients with completely resected macroscopic nodal metastatic melanoma (Adj RT)	ACTRN12607000063415	NCT00287196
ANZMTG 01.07	Whole Brain Radiotherapy following local treatment of intracranial metastases of melanoma – A randomised phase III trial (WBRT Mel)	ACTRN12607000512426	NCT01503827
ANZMTG 01.09	A Randomised Trial of Post-Operative Radiation Therapy Following Wide Excision of Neurotropic Melanoma of the Head and Neck (RTN2)	ACTRN12610000478011	NCT00975520
ANZMTG 01.10	Phase I Study of safety and immune effects of an escalating dose of autologous GD2 chimeric antigen receptor-expressing peripheral blood T cells in patients with metastatic melanoma (CARPETS)	ACTRN12613000198729	N/A
ANZMTG 02.09	Vitamin D following primary treatment of melanoma at high risk of recurrence - a pilot placebo controlled randomised phase II trial (Mel-D)	ACTRN12609000351213	N/A
ANZMTG 01.12	Inguinal or Ilio-inguinal Lymphadenectomy for patients with metastatic melanoma to groin lymph nodes and no evidence of pelvic disease on PET/CT Scan - A randomised phase III trial (EAGLE FM)	ACTRN12614000721606	NCT02166788
ANZMTG 03.12	A Phase III, multi-centre, multi-national randomised control trial investigating 1cm v 2cm wide excision margins for primary cutaneous melanoma (MelMarT)	ACTRN12614000667617	NCT01457157
ANZMTG 01.13	A randomised controlled trial of a psycho-educational intervention for melanoma survivors at high risk of developing new primary disease	ACTRN12613000304730	In progress

[2] http://www.who.int/ictrp/en/
[3] http://www.anzctr.org.au/Faq.aspx
[4] http://www.anzctr.org.au/Support/Statistics.aspx
[5] https://clinicaltrials.gov/ct2/resources/trends

Q&A with Dr. Thanuja Thachil

Cancer services within the Northern Territory (NT) have significantly strengthened in recent years. This is in large part due to the opening of the Alan Walker Cancer Care Centre (AWCCC) in 2010. Here we talk to Dr. Thanuja Thachil, a Radiation Oncologist, learning a little about what she does, what she thinks of the improvement in cancer services within the NT and even a little of what she likes to do when she is not treating patients.

Dr. Thachil, please could you outline your role (how you came to be a Radiation Oncologist, what your main duties are and what types of cancer you see/specialise in)?

As a medical student and intern I had the opportunity to work in various fields of Oncology including Radiation Oncology and Palliative care. My heart was soon captured by Radiation Oncology as I enjoyed the challenge of an interesting specialty which required a blend of skills. I am currently a Radiation Oncologist in Darwin, where I treat a variation of cancer subtypes, although predominantly Head and Neck and Gynaecological cancers.

How long have you worked within cancer services? Have you always worked within a remote region?

I have worked in the field of Oncology for almost 14 years, mostly in large tertiary referral centres. I had not experienced working in rural and remote areas until my positive experience in Darwin. I am determined to "bridge the gap" and I have a special interest in improving treatment outcomes for Indigenous patients from the NT.

What main differences do you notice, in terms of diagnosis rate and access to cancer treatment/care, between metropolitan and remote regions?

I tend to see more advanced/late stage cancers in Darwin. These patients are particularly disadvantaged due to poor nutritional status and multiple co-morbidities. The Indigenous patients also suffer from disparities in the level of cancer awareness and lack of access to primary health care.

What changes have you seen in recent years within the NT regarding cancer services, particularly with the opening of AWCCC?

Before the opening of AWCCC, all cancer patients had to travel interstate for radiotherapy which had a significant impact on cost, inconvenience and detachment from family and friends during a very testing time in the patient's life. In 2009, 265 patients travelled interstate for cancer treatment. Within the 1st year of opening of AWCCC, 350 patients received chemo/radiotherapy locally. With the dedicated clinical trials unit at the AWCCC, there is increasing recruitment of patients to many National and International clinical trials.

You have worked hard to ensure that the ANZMTG 01.07 WBRTMel trial is now open at the AWCCC, allowing patients within the NT access to a melanoma trial. How many melanoma patients do you see each year? Are any other clinical trials available for melanoma patients within the NT?

As per the NT cancer registry, 50-60 patients are diagnosed with melanoma annually. Of these, approximately 5-10 patients are seen per year by the Radiation Oncology team at the AWCCC. There are no other competing clinical trials currently recruiting Melanoma patients in NT.

What do you find are the main barriers in bringing clinical trials to remote regions and what would you like to see change in the next 5 years?

Some of the barriers for clinical trial participation in remote areas are the lack of patient/clinician understanding/awareness regarding current trials. Melanoma awareness needs to be improved, as does cancer care co-ordination. The tyranny of distance is always an issue in the NT as it is a large geographical area with a low population density. A greater number of telehealth services would be beneficial, as would ensuring better access to primary health care in remote areas.

Finally, when you aren't hard at work, treating and supporting patients, what do you like to do in your free time?

I enjoy exploring Darwin, watching the crocodiles and bird life at Kakadu. I love to spend time with family and friends, listen to music and relax via meditation and prayer. I am also a keen photographer and the wildlife in Darwin provides plenty of opportunities for interesting photos.

ANZMTG Current Trials Update

ANZMTG 01.07 Whole Brain Radiotherapy (WBRT) following local treatment of intracranial metastases of melanoma - A randomised phase III trial *(Acronym: WBRTMel)*

Chief Investigator: Prof Gerald Fogarty
Status: Open to recruitment
Current accrual: 150 patients
Target accrual: 200 patients over 5 years

For further information on the trial, contact ANZMTG on +61 2 9911 7354 or email wbrt@melanoma.org.au

ANZMTG 01.09 A randomised trial of post-operative radiation therapy following wide excision of neurotropic melanoma of the head and neck *(Acronym: RTN2)*

Chief Investigator: Dr Matthew Foote; Trial Co-ordinator: Alan Lucas (ANZMTG)
Status: Open to recruitment
Current accrual: 26 patients
Target accrual: 100 patients over 5 years

For further information on the trial, contact Alan Lucas on +61 2 9911 7352 or email alan.lucas@melanoma.org.au

ANZMTG 01.11 Phase I Study of safety and immune effects of an escalating dose of autologous GD2 chimeric antigen receptor-expressing peripheral blood T cells in patients with metastatic melanoma *(Acronym: CARPETS)*

Chief Investigator: Prof Michael Brown; Trial Coordinator: Anne Milton
Status: In development (Royal Adelaide Hospital only)

For further information on the trial, email anne.milton@health.sa.gov.au or contact ANZMTG on +61 2 9911 7354 or email anzmtg@melanoma.org.au

ANZMTG 02.09 Vitamin D following primary treatment of melanoma at high risk of recurrence - a pilot placebo controlled randomised phase II trial *(Acronym: Mel-D)*

Chief Investigator: Dr Robyn Saw; ANZMTG Trial Co-ordinator: Alan Lucas
Status: Closed to recruitment (Melanoma Institute Australia only)
Current accrual: 75 patients
Target accrual: 75 patients over 2 years

For further information on the trial, contact Alan Lucas on +61 2 9911 7352 or email alan.lucas@melanoma.org.au

A phase III multicenter randomized trial of sentinel lymphadenectomy and complete lymph node dissection versus sentinel lymphadenectomy alone, in cutaneous melanoma patients with molecular or histopathological evidence of metastases in the sentinel node *(Acronym: MSLT II)*

Chief Investigator: Dr Mark Faries; Trial Co-ordinator: Lisa van Kreuningen
Status: Closed to Recruitment
Current accrual: 1932 patients (worldwide) – *Trial is now closed to recruitment.*
Target accrual: 1925 patients over 7 years

The MSLTII study is now fully recruited, and the study team would like to thank all collaborators for their hard work and perseverance on the study. The team are looking forward to the important follow up period now and the continued collaboration and support from the investigators. For further information on the trial, contact Lisa van Kreuningen on +1 310 5827053 or email lvk@jwci.org.

ANZMTG 01.13 – A randomised controlled trial of a psycho-educational intervention for melanoma survivors at high risk of developing new primary disease

Chief Investigator: Dr Anne Cust
Status: Open to recruitment

For further information on the trial, contact ANZMTG on +61 2 9911 7352 or email alan.lucas@melanoma.org.au

ANZMTG Trials Approved for Development Update

ANZMTG 01.12 - Evaluation of Groin Lymphadenectomy Extent for Metastatic Melanoma *(*Acronym: *EAGLE FM)*
Chief Investigator: A/Prof Andrew Spillane
ANZMTG Trial Co-ordinator: Alan Lucas
Status: Pending Activation

For further information on the trial, contact Alan Lucas on +61 2 9911 7352 or email alan.lucas@melanoma.org.au

ANZMTG 02.12 – RADiotherapy or Imiquimod in Complex lentigo mALigna *(*Acronym: *RADICAL)*
Chief Investigator: Dr Pascale Guitera
Status: In development

For further information on the trial, contact ANZMTG on +61 2 9911 7354 or email radical@melanoma.org.au

ANZMTG 03.12 - Randomised controlled trial of 1cm versus 2 cm excision margins for 1-4 mm thickness primary invasive cutaneous melanoma *(*Acronym: *MelMarT)*
Chief Investigator: Prof Michael Henderson / Dr Marc Moncrieff
Status: Pending Activation

For further information on the trial, contact ANZMTG on +61 2 9911 7354 or email melmart@melanoma.org.au

ANZMTG 01.14 – A phase II study of nivolumab and nivolumab in combination with ipilimumab in patients with melanoma brain metastases *(Acronym: ABC)*
Chief Investigator: Associate Professor Georgina Long
Status: Pending activation

For further information on the trial, contact ANZMTG on +61 2 9911 7352 or email anzmtg0114@melanoma.org.au

ANZMTG 02.14 – CombiRT in Metastatic Melanoma
Chief Investigator: Dr Tim Wang
Status: In development

For further information on the trial, contact ANZMTG on +61 2 9911 7352 or email anzmtg0214@melanoma.org.au

One final reminder….do not forget that the ANZMTG Annual Scientific Meeting is taking place in Perth on Thursday 9th October. Please contact the ANZMTG team to secure your place at the meeting: anzmtg@melanoma.org.au

Clinical Trial Consent Videos

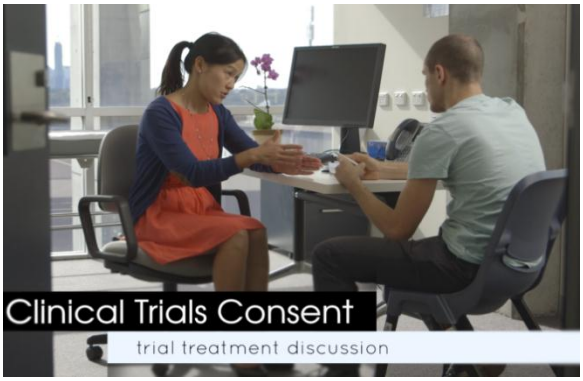
Freely given informed consent should be obtained from every subject prior to clinical trial participation[1]. This is one of the 13 key basic principles in conducting a clinical trial as outlined in the ICH Good Clinical Practice Guidelines. A number of challenges are encountered by the researchers and patients in the clinical trial consent process including the perceptions of patients about clinical trials, the emotional state of the patient at the time of consent, clinical trial terminologies, the amount of information and many others.

Professor Fran Boyle AM, Director of the Patricia Ritchie Centre for Cancer Care and Research, in collaboration with other Investigators and Cancer Collaborative Groups has identified the need to address some of the challenges in the clinical trial consent process, particularly in the area of improving communication between the researchers and participants. Often the reasons for non-participation are due to barriers with communications including the researcher's inability to effectively convey clinical trial information.

The group has commenced work in creating materials which aim to provide resources in helping cancer researchers feel confident in discussing complex trials, including those with placebo arms. Building on experience gained in small group workshops with actors staged by the Pam McLean Communications Centre, a number of videos suitable for larger group training have been produced with the assistance of a Cancer Australia grant.

The video scenarios show common challenges faced by clinicians, nurses and research coordinators including randomisation, discussion of placebos, tissue banking and withdrawal of consent. Some common questions which require extra attention on behalf of the researcher include:

- Can you make sure I get the active drug?
- If you were me, what would you choose?
- How will I find out about trial results?
- How will my tissue be used?
- Will I benefit? Or my family?



With the completion of these videos, plans are underway to pilot these materials for evaluation and potentially be recognised nationally as a training tool across different disciplines involving the clinical trial consent process.

1 ICH Harmonised Tripartite Guideline – Guideline For Good Clinical Practice E6 (R1) dated 10 June 2006

News from the Melanoma Network of New Zealand (MelNet)

Established in 2008, MelNet is a New Zealand-based network of nearly 700 health professionals working in melanoma. MelNet's objectives are to facilitate communication and collaboration between professionals and promote education the advancement of best practice in melanoma prevention, diagnosis, treatment, care and research.

NZ Standards of Service Provision for Melanoma Patients

A number of MelNet Executive Committee and MelNet members were actively involved in the development of recently published *Standards of Service Provision for Melanoma Patients in New Zealand – Provisional*. (http://www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme/faster-cancer-treatment-programme/tumour-standards). The Standards were developed by a multidisciplinary working group chaired by

Richard Martin, a surgical oncologist and member of both the ANZMTG Executive and the MelNet Executive Committee.

Molecular Characteristics of Melanoma Pilot Project

Progress continues to be made in implementing a pilot project, the need for which was identified at a 2013 meeting of researchers coordinated by MelNet and chaired by Professor Mike Eccles of the University of Otago.

The project involves the collective analysis of a range of mutations, including BRAFV600E, BRAFV600K, NRAS and TERT, of hundreds of melanoma cases from around New Zealand.

Preliminary results, which are likely to have significant implications for the control of melanoma in New Zealand, will be presented at the New Zealand Society of Oncology conference 21-23 October 2014. The results also have formed the basis of several successful funding applications, manuscripts for publication in international scientific journals and a Masters thesis.

Melanoma Summit 2015: 6-7 November 2015

Mark your calendars now for the 4th national Melanoma Summit to be held in Auckland 6-7 November 2015. The two-day multidisciplinary meeting will feature:

- **Professor Charles Balch**, Johns Hopkins University - a surgical oncologist and one of the leading melanoma experts in the world
- **Associate Professor Cliff Rosenthal**, University of Queensland – a primary care practitioner with expertise in skin cancer and dermatoscopy
- **Professor Antoni Ribas**, UCLA Jonsson Comprehensive Cancer Center - a physician-scientist conducting laboratory and clinical research in melanoma
- Other authorities on melanoma prevention, diagnosis, treatment, care and research
- Primary care and other discipline-specific workshops.

Further information about MelNet and the Melanoma Summit is available on the MelNet website: www.melanoma.org.nz/melnet or by contacting Betsy Marshall, the MelNet Coordinator: melnet@melanoma.org.nz

Consumer Corner

Clinical Trials: Collecting Safety Data

When clinical trials are conducted in order to enhance our understanding of the impacts of various forms of treatment on melanoma, the disease cannot be examined in isolation of the experiences of the patient. Collecting safety data on patients participating in clinical trials is fundamental to developing an understanding of the impacts of a treatment on patients' overall health and quality of life, enabling us to gain a holistic understanding of the potential effects of a treatment.

Health professionals regularly monitor patients' experiences by noting any changes in laboratory findings, new symptoms, diseases or changes to general wellbeing. Any development or worsening from a patient's pre-treatment condition, whether or not it is considered treatment related, may be recorded as an 'Adverse Event' in a clinical trial scenario. In Australia, these events and changes are most commonly classified according to the Common Terminology Criteria for Adverse Events (CTCAE), and graded by their level of severity. This information is collated and analysed in order for the short and long-term impacts of a treatment to be determined. It is therefore extremely valuable that patients inform their clinician and nursing staff of any changes they have experienced to their health, no matter how significant or insignificant they may think it is.

If a patient experiences a change to their health which is considered life threatening, then this is recorded as a 'Serious Adverse Event' in a clinical trial setting. These events are classified in the same way as Adverse Events, but a range of organisations are made aware of the incident, including other trial sites, Human Research Ethics Committees and the Australian regulatory agency (the Therapeutic Goods Administration (TGA)). This ensures that any risks and safety concerns are shared quickly and that the most appropriate course of action is taken to ensure the well-being of all patients involved in the clinical trial is protected.

The table below summarises the meanings and key reporting requirements for Adverse and Serious Adverse Events.

Table 1: Adverse and Serious Adverse Events

Adverse Events (AEs)	
Definition	Any untoward medical occurrence in a patient administered a treatment which does not necessarily have a causal relationship with this treatment. This includes any unfavourable or unintended sign, symptom, or disease temporally associated with the treatment, whether or not considered related to the treatment.
Reporting Requirements	• Patients are assessed by Trial Site Staff for the appearance or worsening of AEs • All noted events are recorded and submitted to ANZMTG • ANZMTG collates and analyses this information
Serious Adverse Events (SAEs)	
Definition	Any untoward medical occurrence or effect that results in death, is life threatening, requires hospitalisation/prolongation of hospitalisation, results in persistent or significant disability, is a congenital abnormality or birth defect and is medically important.
Reporting Requirements	• Patients are assessed by Trial Site Staff for the appearance or worsening of AEs • If considered serious, Trial Site Staff complete an SAE Form and submit to ANZMTG within 24 hours of becoming aware of the event. • If ANZMTG consider the SAE to be possibly, probably or definitely related to trial treatment, then this information is forwarded to the main Human Research Ethics Committee for the trial and other organisations including the Therapeutic Goods Administration (TGA) and other trial sites. • The information is reviewed by an independent person responsible for trial safety in order to provide guidance as to whether there is a relationship between the SAE and the trial treatment.

Melanoma Staging Explained

After a patient has been diagnosed with melanoma, the next crucial step is the process of staging, which enables doctors to determine the size of the tumour and assess whether or not it has moved from its original position in the skin to the lymph nodes or to other parts of the body[6]. This provides an indication of how limited or advanced the melanoma is[7], which is crucial in terms of developing the most suitable treatment plan and assists doctors in determining the patient's prognosis as accurately as possible[8].

Melanoma can be staged using two different methods[9]. The first is known as 'microstaging', which is based on the findings gained from examining the biopsy specimen under a microscope. Through this a number of features are assessed, such as the Breslow thickness (vertical depth) of the tumour and the type of cell which is abnormally proliferating. The second method is known as 'clinical staging'; this involves a physical examination of patients in order to identify any other lesions on the skin which may be of concern. Additionally the lymph node groups that relate to the site of the primary melanoma are assessed to determine whether any spread of cancer cells has occurred, and a biopsy can be performed in order to examine any suspicious lymph nodes.

Following this examination a staging system is utilised in order for the degree to which a cancer has developed and/or spread to be assessed according to widely agreed standards. The **American Joint Commission on Cancer (AJCC) TNM system**[10] is most commonly used by health professionals, which contains the following three key pieces of information:

[6] http://www.melanoma.org.au/about-melanoma/diagnosis/staging-melanoma.html
[7] http://www.melanomapatients.org.au/just-diagnosed/staging-of-melanoma
[8] http://www.cancer.org/cancer/skincancer-melanoma/detailedguide/melanoma-skin-cancer-staging
[9] http://www.melanoma.org.au/about-melanoma/diagnosis/staging-melanoma.html
[10] http://www.cancer.org/cancer/skincancer-melanoma/detailedguide/melanoma-skin-cancer-staging

1) **T** stands for **tumour**: This category is assigned a number (from 0 to 4) based on the depth of the tumour in the skin. The mitotic rate is also measured to count the number of cells in the process of dividing, and indications of ulceration are assessed;
2) **N** stands for spread to lymph **nodes**: This category is assigned a number (from 0 to 3) based on the degree to which the melanoma cells have spread to lymph nodes or are found in the lymphatic channels connecting the lymph nodes; and
3) **M** stands for whether the melanoma has **metastasised** (spread): This category is based on which organs the tumor has spread to (if any) and on the blood levels of a substance called LDH (a type of enzyme which can indicate the presence of disease).

The information from the T, N and M groups is then combined in order to give an overall stage, using Roman numerals I to IV (1 to 4) and sometimes subdivided using capital letters. For example, a stage I melanoma is less than 1mm in thickness and has not been found in distant lymph nodes or organs. This stage is then divided into a stage IA tumor, which is not ulcerated and has a mitotic rate of less than 1/mm², and a stage IB tumor, which is ulcerated and has a mitotic rate of at least 1/mm². The table below outlines the staging system.

Staging information assists doctors to develop the best treatment plan possible for melanoma patients. The most common form of treatment for localised melanoma is surgery, whilst melanoma which has spread to other parts of the body may require treatments such as chemotherapy, radiotherapy, immunotherapy or molecular medicine[11].

For more information please visit: http://www.anzmtg.org/content.aspx?page=whatmelanoma.

Table 1: Melanoma AJCC Staging system

Stage I	
IA Tumour	<1.00 mm without ulceration; no lymph node involvement, no distant metastases.
IB Tumour	<1.00 mm with ulceration or Clark level IV or V tumour 1.01 – 2.0 mm without ulceration; no lymph node involvement; no distant metastases.
Stage II	
IIA Tumour	1.01 – 2.0 mm with ulceration; tumour 2.01 – 4.0 mm without ulceration; no lymph node involvement; no distant metastases.
IIB Tumour	2.01 – 4 mm with ulceration.
IIB Tumour	> 4.0 mm without ulceration; no lymph node involvement; no distant metastases.
IIC Tumour	> 4.0 mm with ulceration; no nodal involvement; no distant metastases.
Stage III	
IIIA	Tumour of any thickness without ulceration with 1 positive lymph node and micrometastasis or macrometastasis.
IIIB	Tumour of any thickness without ulceration with 2-3 positive lymph nodes and micrometastasis or macrometastasis.
IIIC	Tumour of any thickness and macrometastasis OR in-transit met(s)/satellite(s) without metastatic lymph nodes, OR 4 or more metastatic lymph nodes, matted nodes or combinations of in-transit met(s)/satellite(s), OR ulcerated melanoma and metastatic lymph node(s).
Stage IV	
IV	Tumour of any thickness with any nodes and any metastases

Source: http://www.melanoma.org.au/about-melanoma/diagnosis/staging-melanoma.html

[11] http://www.melanoma.org.au/about-melanoma/treatment.html

Melanoma Consumer and Support Groups

Being diagnosed with melanoma can be overwhelming and difficult to process. In Australia and overseas, various consumer and support groups are available for patients, their family, friends and caregivers. Some of these groups are funded by the government; others have been set up by survivors or relatives of patients who have lost their battle against melanoma. This article describes their important role in the current melanoma scene.

A common denominator among various groups is the provision of information and support to patients and relatives. This is being mediated online through websites and/or discussion forums but also through regular face-to-face meetings at various locations. Apart from explaining melanoma and its treatment, support groups often offer guidance in terms of psychological support, information about legal issues and nutritional advice. Many groups also aim to raise awareness - specifically in prevention and the importance of early diagnosis of melanoma - and raise funding for these awareness projects, as well as funding for clinical trials.

An integral part yet perhaps less well known aspect of these groups are the advocacy activities that they conduct. Through lobbying all levels of government melanoma groups are trying to advocate patient rights, sun protection regulations and access to new drugs. A famous example is the successful journey of stage III melanoma survivor Jay Allen, whose relentless efforts and campaigning resulted in the upcoming sunbed ban throughout Australia. He is now pushing this further, hoping to impose the same ban within New Zealand. Slightly different is the advocacy approach of the Australian Melanoma Consumer Alliance. They initiated the "Tissue is the Issue" conference in Melbourne in 2012 to highlight a need to increase awareness of tissue donation to both patients and health care providers, to streamline the process of tissue collection consent and to highlight a need to share tissue research among relevant health professionals, getting the most out of the tissues being donated.

Another role to mention is the input groups can have in the design and conduct of new clinical trials, ensuring that the needs of patients are being considered and that information is presented in a way that can be understood. The Australian Melanoma Consumer Alliance (AMCA) is currently working closely together with ANZMTG to provide relevant input into a range of ANZMTG activities.

If you wish to seek more information, please visit the websites of various melanoma consumer and support groups (based in Australia, the USA and Europe) which are listed below:

- Melanoma Patients Australia (MPA) - http://www.melanomapatients.org.au
- Australian Melanoma Consumer Alliance (AMCA) / Melbourne Melanoma Project Consumer Reference Group (MMP CRG) - http://melbournemelanomaproject.com
- NSW support groups via MIA - http://www.melanoma.org.au/patients/support-groups.html
- Sunbedban - http://sunbedban.com

- Melanoma Patients Information Page (MPIP) - oldest online community - http://www.melanoma.org/find-support/patient-community/mpip-melanoma-patients-information-page part of Melanoma Research Foundation (MRF) - http://www.melanoma.org/find-support
- Aim at melanoma - http://www.aimatmelanoma.org

- MelanomaUK - http://www.melanomauk.org.uk
- Melanoma Patient Network Europe - http://www.melanomapatientnetworkeu.org

Calendar of Events – 2014

Date	Name of Event	Location	Website
September			
14 - 20	Australian and Asia Pacific Clinical Oncology Research Development (ACORD) workshop	Sunshine Coast, Australia	http://www.acord.org.au/
18 - 21	1st Euro-Asian Melanoma Congress	Sarajevo, Bosnia and Herzegovina	http://www.eurolink-tours.co.uk/Dermatology_congress/1st-euro-asian-melanoma-congress--1890.html
19 - 20	Perspectives in Melanoma XVIII	Dublin, Ireland	http://imedex.com/perspectives-melanoma-conference/
26 - 30	European Society for Medical Oncology	Madrid, Spain	http://www.esmo.org/Conferences/ESMO-2014-Congress
October			
2 - 4	Neurosurgical Society of Australasia Annual Scientific Meeting	Sydney, Australia	http://www.nsa.org.au/events/category/annual-scientific-meeting
9	ANZMTG Annual Scientific Research Meeting	Perth, Australia	http://www.anzmtg.org
10 - 11	SKMRC 2nd National Melanoma Conference	Perth, Australia	http://www.skmrc.org.au/
17	3rd Annual Innovations in Cancer Treatment and Care Conference	Sydney, Australia	http://www.cancerinstitute.org.au/events/i/innovations-in-cancer-treatment-and-care-2014
21 – 23	New Zealand Society for Oncology 2014 Conference	Tauranga, New Zealand	http://www.nzsoncology.org.nz/conference_2014
November			
13 - 16	11th Society for Melanoma Research 2014 International Congress	Zurich, Switzerland	http://www.melanomacongress.com/
16 - 19	The Australian Health and Medical Research Congress	Melbourne, Australia	http://www.ahmrcongress.org.au/
22	Great Debates & Updates in Melanoma	Phoenix, Arizona	http://imedex.com/melanoma-debate-conference/index.asp
26 - 28	Sydney Cancer Conference 2014	Sydney, Australia	http://sydney.edu.au/cancer-research/SCC2014/
December			
2 - 4	Clinical Oncological Society of Australia 41st Annual Scientific Meeting	Sydney, Australia	http://www.cosa2014.org/
3 - 6	World Cancer Congress	Melbourne, Australia	http://www.worldcancercongress.org/melbourne-2014
5 - 7	9th Annual Practical Course in Dermoscopy and Update on Malignant Melanoma	Phoenix, Arizona	http://www.mayo.edu/cme/dermatology-2014s402

For more information on other upcoming oncology meetings and events please visit the ANZMTG website under the 'Events' tab. We are always interested in any new meetings which may be scheduled, so please contact the ANZMTG office if you would like to include any other upcoming meetings in this listing.