

Template for Reporting Results of Biomarker Testing of Specimens From Patients With Melanoma

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CAP Melanoma Biomarkers Template Revision History

Version Code

The definition of version control and an explanation of version codes can be found at www.cap.org (search: cancer protocol terms).

Version: MelanomaBiomarkers 1.0.0.1

Summary of Changes

+ RESULTS

The following note was added:

Note: If a marker is tested by more than one method (eg, polymerase chain reaction and immunohistochemistry), please document the additional result(s) and method(s) in the Comments section of the report.

+ METHODS

Formatting changes were made to the following data elements:

- + ***BRAF* Mutational Analysis Testing Method**
- + ***NRAS* Mutational Analysis Testing Method**
- + ***KIT* Mutational Analysis Testing Method**

“Specify marker” was added to the following data element:

- + **Testing Method for Other Markers**

Melanoma Biomarker Reporting Template

Template web posting date: June 2015

Completion of the template is the responsibility of the laboratory performing the biomarker testing and/or providing the interpretation. When both testing and interpretation are performed elsewhere (eg, a reference laboratory), synoptic reporting of the results by the laboratory submitting the tissue for testing is also encouraged to ensure that all information is included in the patient's medical record and thus readily available to the treating clinical team.

MELANOMA

Select a single response unless otherwise indicated.

Note: Use of this template is optional.

+ RESULTS

Note: If a marker is tested by more than one method (eg, polymerase chain reaction and immunohistochemistry), please document the additional result(s) and method(s) in the Comments section of the report.

+ **BRAF** Mutational Analysis (Note A)

- + No mutations detected
- + *BRAF* V600E (c.1799T>A) mutation
- + *BRAF* V600K (c.1798_1799GT>AA) mutation
- + *BRAF* V600R (c.1798_1799GT>AG) mutation
- + *BRAF* V600D (c.1799_1800TG>AT) mutation
- + Other *BRAF* mutation (specify): _____
- + Cannot be determined (explain): _____

+ **NRAS** Mutational Analysis (Note B)

- + No mutations detected
- + *NRAS* Q61R (c.182A>G) mutation
- + *NRAS* Q61K (c.181C>A) mutation
- + *NRAS* Q61L (c.182A>T) mutation
- + *NRAS* Q61H (c.183A>T) mutation
- + *NRAS* G12R (c.34G>C) mutation
- + *NRAS* G12S (c.34G>A) mutation
- + *NRAS* G12D (c.35G>A) mutation
- + *NRAS* G12V (c.35G>T) mutation
- + *NRAS* G13R (c.37G>C) mutation
- + *NRAS* G13S (c.37G>A) mutation
- + Other *NRAS* mutation (specify): _____
- + Cannot be determined (explain): _____

+ **KIT** Mutational Analysis (Note C)

- + No mutations detected
- + *KIT* L576P (c.1727T>C) mutation
- + *KIT* K642E (c.1942A>G) mutation
- + *KIT* V559A (c.1676T>C) mutation
- + *KIT* W557R (c.1669T>A) mutation
- + Other *KIT* mutation (specify): _____
- + Cannot be determined (explain): _____

+ Data elements preceded by this symbol are not required.

+ Other Markers Tested

- + Specify marker: _____
- + Specify results: _____

+ METHODS

+ BRAF Mutational Analysis Testing Method

- + ___ Cobas 4800 BRAF V600 mutation test
- + ___ THxID BRAF assay
- + ___ Allele-specific/real time polymerase chain reaction
- + ___ Direct Sanger sequencing
- + ___ Pyrosequencing
- + ___ SnapShot
- + ___ Mass spectrophotometry genotyping (Sequenom)
- + ___ Next-generation sequencing
 - + ___ Amplicon
 - + ___ Hybrid capture
- + ___ Other (specify): _____

- + BRAF assay sensitivity (specify): _____

Note: Assay sensitivity should be defined as lowest acceptable tumor percentage in a sample according to the pathologist's estimate.

+ NRAS Mutational Analysis Testing Method

- + ___ Direct Sanger sequencing
- + ___ Pyrosequencing
- + ___ SnapShot
- + ___ Mass spectrophotometry genotyping (Sequenom)
- + ___ Next-generation sequencing
 - + ___ Amplicon
 - + ___ Hybrid capture
- + ___ Other (specify): _____

- + NRAS assay sensitivity (specify): _____

Note: Assay sensitivity should be defined as lowest acceptable tumor percentage in a sample according to the pathologist's estimate.

+ KIT Mutational Analysis Testing Method

- + ___ Direct Sanger sequencing
- + ___ SnapShot
- + ___ Mass spectrophotometry genotyping (Sequenom)
- + ___ Next-generation sequencing
 - + ___ Amplicon
 - + ___ Hybrid capture
- + ___ Other (specify): _____

- + KIT assay sensitivity (specify): _____

Note: Assay sensitivity should be defined as lowest acceptable tumor percentage in a sample according to the pathologist's estimate.

+ Testing Method for Other Markers

- + Specify marker: _____
- + Specify method: _____

+ Data elements preceded by this symbol are not required.

+ COMMENT(S)

Gene names should follow recommendations of The Human Genome Organisation (HUGO) Nomenclature Committee (www.genenames.org; accessed February 10, 2015).

All reported gene sequence variations should be identified following the recommendations of the Human Genome Variation Society (www.hgvs.org/mutnomen/; accessed February 10, 2015).

Explanatory Notes

The incidence of melanoma has increased 2% per year over the last decade, with a concomitant 1% increase per year in mortality in the same period.¹ Melanoma is unique among human tumors in its tendency to give rise to metastatic disease even when only a few millimeters in size and at low primary stage.² Historically, there were few effective therapies for metastatic melanoma; however, recent breakthroughs in targeted therapies against commonly activated oncogenes have led to improvements in response rates and survival. In most melanomas, oncogenic growth/proliferation signaling appears to be driven by alterations in the RAS/RAF/MAPK and PI3K pathways, with 70% to 80% of cutaneous melanomas containing somatic oncogenic mutations in 1 of 3 oncogenes and 2 tumor suppressors—*BRAF*, *NRAS*, *KIT*, *PTEN*, *NF1*—highlighting the importance of the ERK and AKT pathways in this disease.³ Only *BRAF* activating mutations are currently validated for use in clinical practice as a predictive marker of response for approved therapies, but this field is rapidly evolving.

A. *BRAF* Mutational Analysis

BRAF mutations occur in up to 50% of melanomas. Of these mutations, 95% occur at amino acid 600, most commonly as Val600Glu (V600E) or sometimes Val600Lys (V600K), and lead to constitutive MAPK pathway activation.⁴ A randomized phase III trial of a targeted inhibitor of V600E mutated *BRAF*, vemurafenib, was first published in 2011. This trial was limited to *BRAF* V600-mutated melanomas and demonstrated a significant improvement in overall survival at 6 months in patients treated with vemurafenib as compared to dacarbazine, the only chemotherapeutic agent approved for treatment of metastatic melanoma at the time.⁵ Approximately 50% of patients in this trial demonstrated a rapid objective response to therapy (as compared to 5% in the dacarbazine arm); however, subsequent trials with longer follow-up demonstrated a median duration of response of less than 7 months.⁶ Similar results have been reported for a randomized phase III trial of the *BRAF* inhibitor dabrafenib.⁷ In the majority of cases, tissues taken at relapse show increased ERK activation via phosphorylation; genomic profiling at relapse has demonstrated acquired mutations in *MEK1* and *NRAS* in a subset of cases, though additional biochemical adaptations in signaling have also been noted.⁸ MEK inhibition with trametinib has also shown a significant benefit in *BRAF*-mutant melanoma as compared to chemotherapy in a randomized phase III trial that included patients with either *BRAF* V600E or V600K-mutant melanoma.⁹ Trials combining *BRAF* inhibitors with MEK and other pathway inhibitors are ongoing. Trials combining MEK and *BRAF*-inhibitors may result in superior disease control compared with single use of either agent as measured by percentage response and progression-free survival of the cohorts.^{10,11} The majority of patients enrolled in these trials had tumors harboring the *BRAF* V600E mutation; however, a small number of patients had V600K-mutant tumors, which can also respond to *BRAF* and MEK inhibitors. There are limited case reports of patients with V600R mutated tumors showing objective responses to *BRAF* inhibitors.¹² Several clinical trials of combination therapy with both targeted and immune therapies are available for patients with *BRAF*-mutant melanoma. Much less commonly encountered are non-*BRAF* V600 cases that include exon 15 mutations in codons surrounding V600 and additional mutations in exon 11. Many of these are weaker activators of the MEK/ERK pathway than are the V600 mutants. Responses of these cases to *BRAF* and MEK inhibitors are an active area of investigation, and in many cases their responses are less impressive than those in the V600-mutated cases. There are now a large number of publications demonstrating excellent correlation between *BRAF* V600E (VE1)-mutation specific immunohistochemistry and molecular-based analysis.⁴ However, in the absence of established proficiency testing or clear regulatory guidelines, laboratories utilizing this immunohistochemistry assay should perform rigorous validation and have available confirmatory molecular testing.

B. *NRAS* Mutational Analysis

NRAS is mutated in approximately 20% of melanomas, with approximately 80% of mutations occurring in exon 3 at codons 60 and 61 and approximately 20% in exon 2 at codons 12 and 13.¹³ To date, direct inhibitors of *NRAS* have not demonstrated significant clinical activity. In untreated tumors, *NRAS* and *BRAF* V600 mutations generally occur in a mutually exclusive fashion. Clinical trials of single-agent targeted therapies and combinations are an active area of clinical investigation for patients with *NRAS*-mutant melanoma.

C. *KIT* Mutational Analysis

KIT is a receptor tyrosine kinase expressed at the cell surface that binds stem cell factor (SCF) and triggers downstream MAPK, PI3K, JNK, and JAK/STAT pathways leading to cell growth, proliferation, migration, and differentiation.¹⁴ *KIT* is mutated in fewer than 5% of melanomas and most frequently occurs in melanomas arising

in mucosal, acral, and chronically sun-damaged skin. These mutations are scattered throughout the kinase domain in a pattern similar to that described in gastrointestinal stromal tumors (GIST), except that missense mutations are predominant and deletions and insertion/duplications are rare. In addition, the mutations are more commonly seen in KIT exons 13 and 17 than in GIST. The most common alterations occur in exons 11 and 13, with L576P and K642E accounting for close to 50% of melanoma-specific mutations in this gene.⁴ Small insertions and deletions in exon 11 are rare in melanoma. Targeted inhibitors of KIT and related tyrosine kinase receptors have demonstrated some efficacy in *KIT*-mutated but not in *KIT*-wild type melanomas in case reports and clinical trials, with best response documented most consistently in patients with tumors harboring mutations in the L576 and K642 hotspots. *KIT* copy number gain, including gene amplification alone, does not appear to independently predict response to KIT inhibitors in clinical trials.^{15,16} No KIT inhibitors are currently approved for melanoma; clinical trials are available for patients with *KIT*-mutant melanoma.

References

1. Jemal A, Simard EP, Dorell C, et al. Annual Report to the Nation on the Status of Cancer, 1975-2009, featuring the burden and trends in human papillomavirus (HPV)-associated cancers and HPV vaccination coverage levels. *J Natl Cancer Inst.* 2013;105(3):175-201.
2. Balch CM, Gershenwald JE, Soong SJ, et al. Final version of 2009 AJCC melanoma staging and classification. *J Clin Oncol.* 2009;27(36):6199-6206.
3. The Cancer Genome Atlas Data Portal. Data Matrix. <https://tcga-data.nci.nih.gov/tcga/dataAccessMatrix.htm>. Accessed February 10, 2015.
4. Bradish JR, Cheng L. Molecular pathology of malignant melanoma: changing the clinical practice paradigm toward a personalized approach. *Hum Pathol.* 2014;45(7):1315-1326.
5. Chapman PB, Hauschild A, Robert C, et al. Improved survival with vemurafenib in melanoma with BRAF V600E mutation. *N Engl J Med.* 2011;364(26):2507-2516.
6. Sosman JA, Kim KB, Schuchter L, et al. Survival in BRAF V600-mutant advanced melanoma treated with vemurafenib. *N Engl J Med.* 2012;366(8):707-714.
7. Hauschild A, Grob JJ, Demidov LV, et al. Dabrafenib in BRAF-mutated metastatic melanoma: a multicentre, open-label, phase 3 randomised controlled trial. *Lancet.* 2012;380(9839):358-365.
8. Trunzer K, Pavlick AC, Schuchter L, et al. Pharmacodynamic effects and mechanisms of resistance to vemurafenib in patients with metastatic melanoma. *J Clin Oncol.* 2013;31(14):1767-1774.
9. Flaherty KT, Robert C, Hersey P, et al. Improved survival with MEK inhibition in BRAF-mutated melanoma. *N Engl J Med.* 2012;367(2):107-114.
10. Flaherty KT, Infante JR, Daud A, et al. Combined BRAF and MEK inhibition in melanoma with BRAF V600 mutations. *N Engl J Med.* 2012; 367(18):1694-1703.
11. Larkin J, Ascierto PA, Dréno B, et al. Combined vemurafenib and cobimetinib in BRAF-mutated melanoma. *N Engl J Med.* 2014; 371(20):1867-1876.
12. Klein O, Clements A, Menzies AM, O'Toole S, Kefford RF, Long GV. BRAF inhibitor activity in V600R metastatic melanoma. *Eur J Cancer.* 2013;49(5):1073-1079.
13. Buehler AD, Syklawer E, Jakob JA, et al. Clinical characteristics and outcomes with specific BRAF and NRAS mutations in patients with metastatic melanoma. *Cancer.* 2013;119(21):3821-3829
14. Bastian BC, Esteve-Puig R. Targeting activated KIT signaling for melanoma therapy. *J Clin Oncol.* 2013;31(26):3288-3290.
15. Hodi FS, Corless CL, Giobbie-Hurder A. et al. Imatinib for melanomas harboring mutationally activated or amplified KIT arising on mucosal, acral, and chronically sun-damaged skin. *J Clin Oncol.* 2013;31(26):3182-3190
16. Carvajal RD, Antonescu CR, Wolchok JD, et al. KIT as a therapeutic target in metastatic melanoma. *JAMA.* 2011;305(22):2327-2334.