



University of Dundee

Effect of topical imiquimod as primary treatment for lentigo maligna

Marsden, Jeremy ; Fox, R; Boota, N M ; Cook, M; Wheatley, K ; Billingham, L J

Published in:
British Journal of Dermatology

DOI:
[10.1111/bjd.15112](https://doi.org/10.1111/bjd.15112)

Publication date:
2017

Document Version
Peer reviewed version

[Link to publication in Discovery Research Portal](#)

Citation for published version (APA):
Marsden, J., Fox, R., Boota, N. M., Cook, M., Wheatley, K., Billingham, L. J., Steven, N. M., NCRI Skin Cancer Clinical Studies Group, U.K. Dermatology Clinical Trials Network, & LIMIT-1 Collaborative Group (2017). Effect of topical imiquimod as primary treatment for lentigo maligna: the LIMIT-1 study. *British Journal of Dermatology*, 176(5), 1148-1154. <https://doi.org/10.1111/bjd.15112>

General rights

Copyright and moral rights for the publications made accessible in Discovery Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

1
2
3 **Title: Effect of topical imiquimod as primary treatment for lentigo maligna – the**
4 **LIMIT-1 study**
5

6
7 ***Manuscript word count: 3262***

8
9 J.R. Marsden¹, R. Fox², N.M. Boota³, M. Cook⁴, K. Wheatley², L.Billingham², N. Steven² on behalf
10 of the NCRI Skin Cancer Clinical Studies Group, the UK Dermatology Clinical Trials Network and
11 the LIMIT-1 Collaborative Group*
12

13
14
15 1 University Hospitals Birmingham NHS Foundation Trust

16
17 2 Cancer Research UK Clinical Trials Unit, University of Birmingham

18
19 3 Nottingham Clinical Trials Unit, University of Nottingham

20
21 4 Royal Surrey County Hospital, Guildford

22
23 *See acknowledgements for full details
24
25

26
27
28 ***Joint corresponding authors:***

29
30 Dr N.M. Steven

31
32 CR-UK Clinical Trials Unit, School of Cancer Sciences, The University of Birmingham, Edgbaston,
33 B15 2TT

34
35 Tel. 0121-414-4092

36
37 Fax. 0121-414-7471

38
39 Email: n.m.steven@bham.ac.uk

40
41 Dr J.R. Marsden

42
43 Queen Elizabeth Hospital, Edgbaston, Birmingham, B15 2TH

44
45 Tel: 0121 371 5120/5126

46
47 Fax: 01214605845

48
49 Email: jeremy.marsden@nhs.net

50
51 ***Funding sources:***

52
53 This trial was funded by the NIHR Research for Patient Benefit Programme
54

55
56 ***Conflicts of interest:***
57
58
59
60

1
2
3 *None*
4

5 **Bulleted statements required for the following questions (max 70 words)**
6
7

8
9 ***What's already known about this topic?***
10

11 Imiquimod can cause clinical regression of lentigo maligna (LM).
12

13 ***What does this study add?***
14

15 The pathological complete regression (pCR) rate is estimated for topical treatment with imiquimod for
16 LM.
17

18 The accuracy of clinical complete regression with targeted biopsies after imiquimod in predicting
19 pCR at subsequent resection of the treated site is investigated.
20
21

22 The pCR rate dermatologists regard as sufficient to justify the use of imiquimod for LM, adverse
23 events, the acceptability of treatment to patients, and patients' preferences for imiquimod versus
24 surgery are documented.
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Summary

Background

Topical imiquimod is sometimes used for lentigo maligna (LM) in-situ melanoma instead of surgery, but frequency of cure is uncertain. Pathological complete regression (pCR) is a logical surrogate marker for cure after imiquimod, although residual LM and atypical melanocytic hyperplasia may not be reliably distinguished. A trial comparing imiquimod versus surgery might be justified by a high imiquimod pCR rate.

Objectives

Primary: to estimate pCR rate for LM following imiquimod. Secondary: to assess accuracy of prediction of pCR, using clinical complete regression (cCR) plus negative post-treatment biopsies, tolerability, resource use, patients' preferences; and induced melanoma immunity.

Methods

This was a single arm phase II trial of 60 imiquimod applications over 12 weeks for LM then radical resection. A pCR rate $\geq 25/33$ would reliably discriminate between pCR rates $< 60\%$ and $\geq 85\%$. Clinical response was assessed and biopsies taken after imiquimod. Patients recorded adverse events in diaries. Patient preference was measured after surgery using a standard gamble tool.

Results

The pCR rate was 10/27 (37%, 95% CI 19%, 58%). The rate of cCR plus negative biopsies was 12/28 of whom 7/11 had pCR on subsequent surgery. Median dose intensity was 86.7%. Of surveyed patients, 8/16 preferred primary imiquimod over surgery if the cure rate for imiquimod was 80% and 4/16 if it was $\leq 50\%$.

Conclusions

The pCR rate was insufficient to justify phase III investigation of imiquimod versus surgery. Clinical complete response and negative targeted biopsies left uncertainty regarding pathological clearance. Some patients would trade less aggressive treatment of LM against efficacy.

Trial registration: clinicaltrials.gov identifier: NCT01161888

Key words: *Lentigo maligna; lentigo maligna melanoma; imiquimod; surgery; pathological complete response;*

Introduction

Lentigo maligna (LM) in-situ melanoma characteristically presents as a slowly developing brown or dark brown macule on chronically sun-exposed skin in people over 50 years. In UK guidelines, complete surgical resection is recommended with curative intent¹. Five percent of patients with typical LM may actually have early invasive melanoma, and the risk of progression to invasive lentigo maligna melanoma (LMM) is poorly quantified². Reported outcomes following surgery vary, including a 30% probability of recurrence at 66-98 months and 1.5% probability of transformation to LMM for 81 patients³, a crude failure rate (recurrence plus incomplete excision) of 8/102 following resection excision with 2mm margins⁴, and crude recurrence rates of 16/269 (5.9%) following wide local excision and 3/154 (1.5%) following Mohs micrographic surgery⁵. LM occurs most frequently on the head and neck so surgery can cause significant functional and cosmetic disability and, in some cases, might not be feasible.

In 2001, a UK survey showed that the most widely used treatments for LM were surgery, cryotherapy, radiotherapy and observation respectively, with non-surgical approaches possibly associated with higher recurrence rates and used more for patients >70 years⁶. Radiotherapy may have a place in LM management, with the aim of trading less invasive intervention and better function and cosmesis, against a possibly higher risk of recurrence or progression to melanoma⁷⁻¹⁰. No trials have been undertaken comparing the outcomes of surgery and radiotherapy or other non-surgical treatments¹¹.

Imiquimod is a synthetic imidazoquinolin nucleoside analogue available as a 5% strength topical formulation with low systemic availability. Skin application induces local inflammation with intensity related to frequency of application. The use of topical imiquimod as a non-surgical treatment for LM has increased following an initial case report in 2000 of disease control for 9 months after treatment for 7 months¹². Treatment duration is not defined, but 12 weeks is widely used¹³; any benefit of longer treatment is unclear. An effect against LM has been confirmed in subsequent case reports and small uncontrolled trials, and in a systematic review¹⁴, with response rates of 77-90%. These studies lacked long term follow up to substantiate disease control and post treatment histology: the majority of cases involved biopsy only, with the possibility of sampling error¹⁵⁻²². One small study used complete surgical excision following imiquimod treatment, and reported complete responses in 4 out of 6 patients recruited²³. A recent retrospective series reported recurrence of LM following imiquimod alone in 6/22 patients versus 2/36 having surgery plus imiquimod with mean follow up around 40 months¹³.

The routine use of imiquimod as primary therapy for LM requires proof of efficacy in a large trial compared to the outcomes of surgical excision. We reasoned that, to justify this investment, imiquimod treatment should be shown to have a high probability of achieving pathological complete

1
2
3 response (pCR). Patients and clinicians might take into account the probability of cure with
4 imiquimod and avoiding surgery for a pre-malignant condition, assuming progression is susceptible to
5 surveillance. We surveyed UK dermatologists' opinion regarding what threshold of pCR rate would
6 justify routine use of imiquimod instead of surgery. We then designed a single arm trial to justify
7 progression to a larger randomised trial. We sought opinion from trial participants regarding what
8 threshold of efficacy they would trade against avoiding surgery, using a structured questionnaire.
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For Peer Review

Patients and Methods

Participants

This study was coordinated through the Nottingham Clinical Trials Unit (NCTU), approved by Nottingham Research Ethics Committee 2 and eight hospitals recruited between October 2010 and August 2011

To be eligible, patients had to give informed written consent, have a clinical diagnosis of primary untreated LM (acquired pigmented macule present >12 months, no change in skin surface texture or contour, no palpability, diameter >10 mm, sited on the head or neck) and histologically confirmed LM without invasive melanoma in one or more 4mm punch biopsies(s) from the darkest area, reported by a pathologist member of a recognised NHS skin cancer Multi-Disciplinary Team. The LM had to be suitable for complete surgical excision using a 5mm lateral margin, and to be easily definable visually around its entire circumference. Patients had to be aged >45 years age, fit and willing for surgery, without co-existing or adjacent melanoma or non-melanoma skin cancer that might compromise study treatment; neither pregnant nor breastfeeding, without hypersensitivity to imiquimod or excipients, not taking immunosuppressive medication or participating in another intervention study.

Treatment and follow-up

Trial interventions and investigations are detailed in figure 1. The pre-treatment lesion was photographed, tattooed at 360, 90, 180 and 270 degrees, outlined in ink and traced on a transparency. Training in mapping and tattooing was provided. Patients applied imiquimod (Aldara®; MEDA Pharmaceuticals) 5 days per week to the visible lesion plus a 2cm margin of normal surrounding skin for approximately 8 hours (overnight) and washed off with soap and water as defined in the Patient Information Leaflet. After 12 weeks' treatment, lesions were remapped, biopsied and excised with central pathological reporting. The User Opinion Questionnaire Patient was undertaken 12 weeks post-surgery by the first 16 patients.

Outcome Measures

The primary outcome measure was pCR, i.e. absence of LM in both post treatment biopsies and resected LM. Imiquimod is an experimental treatment in which post-treatment biopsies would be part of assessment of clearance. Resection is standard of care and, in this trial, permits assessment of LM clearance in the whole lesion. Other pathological outcomes were partial regression (pPR – atypical melanocytes present in the epidermis with abnormal distribution and number, but insufficient features to define LM), no change (pNC – presence of LM) or progressive disease (pPD – invasive melanoma).

1
2
3 Clinical outcomes were complete regression (cCR – complete disappearance of abnormal
4 pigmentation), partial regression (cPR – reduction in size of pigmented area or obvious reduction in
5 its intensity), no change (cNC – appearance identical to that pre-treatment) and progressive disease
6 (cPD – increased size or intensity of pigmentation or development of a papule or nodule within LM).
7 Targeted biopsies were scored as for the resection specimen, above. For each individual, the
8 prediction of pCR using clinical examination of the mapped regions (weeks 22-24) plus targeted pre-
9 surgical biopsies was compared with the pathological response in the whole post-treatment resected
10 lesion, including any LM outside the clinically mapped margins of disease.
11
12
13
14

15 Patients kept weekly diaries through 12 week's treatment of adverse reactions, numbers of treatments,
16 treatment acceptability on a visual analogue scale and reasons for treatment withdrawal. The number
17 of consultations was recorded.
18
19

20 Following surgery, the participants completed a questionnaire selecting between “I want to have
21 imiquimod as first treatment” versus “I want to have surgery now” for 15 hypothetical trial results
22 ranging from “imiquimod cures 100% of people; surgery cures 95% of people” to “imiquimod cures
23 10% of people; surgery cures 95% of people”. The explanation included that imiquimod treatment
24 included surveillance and deferred surgery in the event of progression.
25
26
27

28 Whole blood samples, 40ml, were harvested before and after imiquimod treatment and sent by first
29 class post to the Human Biomaterials Resource Centre, Birmingham where peripheral blood
30 mononuclear cells (PBMC) were isolated by differential centrifugation and cryopreserved in the
31 vapour phase of nitrogen. Circulating T lymphocyte responses against melanocyte differentiation
32 antigens melan A, gp100, tyrosinase and against cancer testis antigens MAGE A1, MAGE A3 and
33 NYESO were measured using an ex vivo ELIspot assay²⁴, using overlapping peptides covering the
34 whole of each antigen.
35
36
37
38
39

40 ***Statistical Design and Analysis***

41
42 In 2009 all consultant members of the British Association of Dermatologists were asked to mark on a
43 visual analogue scale the pCR rate for imiquimod below which “I do not think that imiquimod has any
44 potential at all to be used for primary treatment for lentigo maligna” and the pCR rate above which “I
45 would be persuaded that imiquimod definitely should be used in the primary treatment of lentigo
46 maligna”.
47
48
49

50 This was a single arm phase II trial with a sample size of 33, requiring pCR in 25 participants to
51 justify progression to phase III (A'Hern's method $p_0=60\%$, $p_1=85\%$, $\alpha=5\%$, $1-\beta=95\%$)²⁵. The bounds
52 (p_0 and p_1) were derived from the upper quartile of pCR thresholds for dermatologists responding to
53 the two questions above. The recruitment target was 40 participants to account for attrition.
54
55
56
57
58
59
60

1
2
3 The primary intent-to-treat (ITT) analysis included patients who discontinued imiquimod treatment
4 early but proceeded to surgery as per protocol requirements. The pCR rate for patients undergoing
5 surgery after imiquimod was estimated with 95% confidence intervals.
6
7

8 The accuracy of clinical assessment was reported as proportion of cases where cCR plus negative
9 biopsies correctly predicted pCR in the subsequent surgical resection specimen.
10

11 Imiquimod dose intensity was calculated from patient diary returns, assuming 60 applications (i.e. 5
12 days/week for 12 weeks) to be 100%.
13
14

15 Patients' opinions are presented descriptively as the proportion of patients preferring imiquimod over
16 surgery in relation to a range of hypothetical cure rates for imiquimod compared to a cure rate for
17 surgery of 95%.
18
19

20 Analyses were performed using Stata v12.
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Results

Responses from 174 UK consultant dermatologists each identified a lower pCR rate below which they considered imiquimod to have no potential to treat LM (median 40%; interquartile range (IQR) 30-60%), and an upper pCR rate above which they could definitely be persuaded of the potential of imiquimod to treat LM (median 80%; IQR 60-85%). This was interpreted as indicating only 25% of clinicians would reject further investigation of imiquimod as a treatment for LM even if the pCR rate was $\geq 60\%$, and only 25% of clinicians would demand a pCR rate $\geq 85\%$ to justify further investigation of imiquimod. We determined that an observed pCR threshold rate of $\geq 25/33$ would reliably exclude a true pCR rate $< 60\%$ and be powered not to miss a true pCR rate $\geq 85\%$ (see statistical design).

Twenty-nine patients consented; one withdrew consent and 28 were evaluable. Median age was 72 years (IQR 65, 79), 18 male, median size of LM 14mm (IQR 12, 22; range 10-70mm), located on the cheek (11), ear (4), forehead (4), nape of neck (1), nose (7) and scalp (2). The median dose intensity over 12 weeks was 86.7%, including three patients stopping treatment early after 4, 8 and 11 weeks, and 27 underwent surgical excision post imiquimod (see figure 1).

Twenty-seven patients were evaluable for the primary outcome. Ten achieved complete pathological regression i.e. pCR (37%, 95% CI 19, 58). None showed LM at the surgical margins. The patients with pCR had achieved imiquimod dose intensity below (7) and above (3) the median of 86.7%.

Central review of a single pre-treatment section did not confirm diagnosis of LM in three patients: reporting epidermal hyperpigmentation without melanocyte atypia; compound melanocytic naevus; and pigmentation and elongated rete ridges without melanocyte atypia. The pCR rate was 8/24 (33%, 95% CI 16, 55) if these patients are excluded. However, priority was given to the fuller clinicopathological diagnosis made by the multidisciplinary team at the site.

Post-treatment resection specimens from a further 9 patients were scored as pPR (i.e. abnormal features falling short of defining persistent LM – see methods), 7 had definite residual LM in the resection specimen and one had evidence of LMM.

Clinical evaluation showed that 13/28 patients had complete disappearance of the LM after imiquimod, i.e. cCR (46%, 95% CI 28, 66). Of these, on the post-treatment biopsies, 12 were negative for LM and one showed probable residual LM. Thus clinical and targeted pathological evaluation yielded a response rate of 12/28 (43%, 95% CI 24, 63). Of the 12, one declined resection, and 7/11 (64%, 95% CI 31, 89) had pCR on the resection specimen. Three of 15 who did not achieve cCR were observed nonetheless to have pCR (figure 2). Regarding the 3 with pathological evidence falling short of LM on central review of a single diagnostic slide, the outcomes were cCR+pCR, cCR+pPR and cPR+pCR.

1
2
3 Eleven of 29 (38%) patients had a severe local site reaction over the study period; 10 (35%) a
4 moderate reaction; 8 (27%) had mild or no reaction. This peaked at week 4, when 24%, 48%, and
5 14% had mild, moderate or severe reactions respectively. By week 12, 11% and 15% respectively
6 still had moderate or severe reactions. Nine of 19 (47%) patients having a moderate or severe local
7 site reaction had a pCR, whereas 1/8 (13%) patients with mild or no reaction had a pCR. Scores for
8 acceptability of imiquimod through 12-weeks treatment were reported by 24/29 patients. Dose
9 reductions occurred in 5/12 reporting consistently good tolerance and 8/12 reporting variably poor
10 tolerance.
11

12
13
14
15
16 There were 143 adverse events of which 84 (59%) were definitely related to treatment. Medication
17 was provided for 117 (82%) of adverse events, and 140 (98%) resolved. There was no additional
18 health service use for 18/29 (62%), 1 unscheduled visit for 8 (28%) and >1 unscheduled visit for 3
19 patients (10%).
20

21
22 Sixteen patients completed the treatment preference survey having experienced both treatments
23 (figure 3). One expressed a strong preference for immediate surgery even with a hypothetical cure
24 rate of 100% for imiquimod and 4 strongly preferred imiquimod, tolerating hypothetical cure rates for
25 imiquimod $\leq 40\%$ as against 95% for surgery. Half of patients stated they would opt for surgery if the
26 cure rate for imiquimod was $\leq 85\%$.
27
28
29

30
31 Imiquimod might work by inducing immune responses against proteins characteristic of melanoma
32 cells. We tested blood samples from 16 patients for such responses of whom 11 had paired samples
33 analysed about three months apart. Target proteins were a number of proteins characteristic of
34 melanoma (melan A, gp100, tyrosinase, NYESO1, MAGE A1 and MAGE A3) and, to confirm the
35 patients' cells were working, proteins made by common infections (termed CEPT). Positive
36 recognition of target proteins was defined conventionally as a number of reacting immune cells
37 against target proteins that was more than double background immune reactivity. Twenty seven
38 samples from 16 patients were tested and of these 18 from 12 patients made a clear positive
39 recognition of the CEPT control. Of the 18 samples with a positive CEPT response, 3 samples from 2
40 patients exhibited recognition of a melanoma antigen – both MAGE A1. Only 6 patients had paired
41 samples with positive CEPT recognition on both samples – and of these, 1/6 (who had pPR and cPR)
42 showed an amplified response over time, defined as the later recognition value being double that on
43 the earlier reading.
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Discussion

It is reasonable to try to spare patients surgery for LM; it can impair function, be disfiguring, and may not be feasible. Non-surgical approaches need not equal surgery in efficacy, provided treatment failure could be recognised and surgery undertaken before progression to invasive melanoma.

Imiquimod promotes an inflammatory state through the activation of macrophages and antigen-presenting cells via Toll-like receptor 7 signalling, and this localised inflammation can result in regression of neoplastic cells²⁶. We undertook a single arm phase II trial to determine whether investment is justified in a phase III trial comparing imiquimod with surgery. Clinical regression following imiquimod treatment can be followed by relapse³. Therefore, pCR, measured by detailed histological examination of LM resected after imiquimod therapy, was selected as surrogate outcome measure for possible long term disease control.

The pCR rate of LM to imiquimod was estimated as 37% (10/27) with confidence intervals indicating a true pCR rate >60% was unlikely and >85% very unlikely. Even had accrual continued to target, the highest possible observed pCR rate would have been 16/33, falling short of the pre-planned efficacy threshold of 25/33.

It is improbable that we missed a true effect. Firstly, 27/29 patients completed the study and were available for analyses. Second, 21 of 29 patients had moderate or severe skin inflammation, similar to imiquimod toxicity described in case reports of apparently successful imiquimod treatment. Third, median dose intensity was 87% and reduced dose intensity across 12 weeks did not obviously associate with lower probability of achieving pCR. Our pCR rate by detailed pathological examination is lower than the >75% regression rate judged by clinical inspection and biopsies in a systemic review of predominantly retrospective series and cases. Note that these case reports and series lacked consistent definition and were susceptible to selection and publication bias¹⁴. Recently, another trial observed a pCR rate of 20/38 assessable patients with LM treated with imiquimod for 12 weeks¹⁹. A further study compared topical imiquimod with topical imiquimod plus topical tazarotene, followed by Mohs excision of the treatment site, with pCR rates of 57 versus 66% respectively¹⁸.

Can we rationally offer imiquimod as first line treatment for LM, reserving surgery for treatment failure? Persistent or progressive clinical abnormality after imiquimod might reasonably be taken to indicate proceeding to surgery because only 3/15 such patients had pCR on the resected specimen. Conversely, apparent cCR and negative biopsy was an unreliable predictor of pCR, with only 7/11 cases with cCR plus negative biopsies confirmed as pCR on examination of the excision specimen. We recognise that pPR as defined in this study is indistinguishable from actinic melanocytic hyperplasia, likely to be present in chronically sub damaged skin²⁷. Thus there is uncertainty whether

1
2
3 pPR induced by imiquimod might also be a marker for long term clinical remission, which was not
4 addressed in our study.
5

6
7 The efficacy threshold to justify phase III evaluation had been selected to exclude, at the 5%
8 probability level, proceeding to phase III despite a true pCR rate of <60% and rejecting further
9 investigation despite a true pCR rate >85%. These thresholds were based on a survey of a large group
10 of UK dermatologists. However, reported opinions were diverse. Only half would definitely reject
11 imiquimod treatment even if the true pCR rate was <40% and a quarter would have settled for a true
12 pCR rate <60% to definitely proceed to phase III. Offering imiquimod treatment for a pre-malignant
13 condition, with surgery reserved for progression, is a credible strategy for some clinicians despite a
14 low pCR rate. How might patients view this issue? We surveyed the opinion of the first sixteen
15 consecutive patients after each had experienced both imiquimod and surgery and again observed
16 diversity of opinion including 4/16 who would still have opted for imiquimod even with the
17 probability of cure $\leq 40\%$. However, we had not expected the very high early attrition on accrual in
18 which only a fifth of identified patients enrolled for the trial. This might cause bias favouring
19 imiquimod because this attrition itself may reflect patients' preference for surgery.
20
21
22
23
24
25

26
27 Destroyed cells in a pro-inflammatory milieu might act as an autologous vaccination against
28 melanoma, resulting in systemic immunity. However, we observed our participants generally had a
29 frequency of circulating activated T cells recognising melanoma differentiation or cancer germline
30 antigens below the limit of detection with the ex vivo ELISpot assay ($\sim 50/10^6$ PBMC) even after
31 imiquimod treatment. A larger sample would be needed to confidently estimate the immune response
32 rate and this would also require assays able to detect and measure lower abundance immune
33 reactivities.
34
35
36

37
38 In summary, imiquimod causes local skin adverse reactions which are variably tolerated by patients
39 and can be managed by adjusting the frequency of applications. We estimated the pCR rate of LM to
40 imiquimod to be 37%. This fell short of our pre-defined endpoint that would justify progression to
41 randomised comparison versus surgery, assuming that pCR is a prerequisite for term disease control.
42 The uncertainty over the interpretation of pPR and the possibility that imiquimod given for a longer
43 duration might convert pPR to pCR might still justify such a trial. We observed that clearance of LM
44 clinically and on targeted biopsies missed patients in whom LM was either pathologically persistent
45 or in whom pathological persistence was, at best, uncertain. Based on this, without a larger long term
46 trial, the use of imiquimod cannot be recommended as standard first line treatment for LM outside
47 exceptional circumstances.
48
49
50
51
52
53
54
55
56
57

Contributors***LIMIT-1 Collaborative Group***

Nottingham Clinical Trials Unit Coordinating Team: N Boota (Trial Management), D Simpkins (Data Management), D Whitham ,

UK Dermatology Clinical Trials Network: J Chalmers

Chief Investigator

J Marsden

Trial Design

N Steven, L Billingham

Statistical analysis

R Fox, K Wheatley

Trial Steering Committee

C Bunker (Chair), S Wharton (Independent Member), S Brothwell (Patient Representative), L Hague (Patient Representative)

Data Monitoring Committee

C Harwood (Chair), N Ives (Independent Statistician), H Ramsay (Independent Member)

Active LIMIT-1 Collaborators

Salisbury District Hospital (7): L Burrows; Ninewells Hospital (6): C Proby; University Hospital of Wales (5): R Motley; Selly Oak Hospital (3): J Marsden; Norfolk and Norwich University Hospital (3): N Levell; Royal Cornwall Hospital (2): T Lucke; Solihull Hospital (2): I Zaki; Monklands Hospital (1): G Gupta.

Histopathology

Professor M Cook

L Collucci and the histopathology team at the Royal Surrey County Hospital, Guildford

Translational sub-study

NIHR Clinical Research Facility, Birmingham and Birmingham Experimental Cancer Medicine Centre: N Steven, J Williams, J Steele

Sponsor

13

1
2
3 University Hospital Birmingham NHS Foundation Trust
4

5 ***Funding***
6

7 NIHR Research for Patient Benefit programme. The funder undertook peer review of the proposal.
8 Study design, data collection, data analysis, manuscript preparation and publication decisions were
9 undertaken exclusively by the authors.
10
11

12 ***Disclaimer***
13

14 This report presents independent research funded by the National Institute for Health Research
15 (NIHR). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR
16 or the Department of Health
17
18

19 ***Acknowledgements***
20

21 Clinical Trials Pharmacy Team at Nottingham University Hospitals
22

23 We would like to thank our participants without whom we would not have been able to complete this
24 study
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

References

- 1 Marsden JR, Newton-Bishop JA, Burrows L *et al*. Revised U.K. guidelines for the management of cutaneous melanoma 2010. In: *Br J Dermatol*, Vol. 163. England. 2010; 238-56.
- 2 Weinstock MA, Sober AJ. The risk of progression of lentigo maligna to lentigo maligna melanoma. *British Journal of Dermatology* 1987; **116 (3)**: 303-10.
- 3 Osborne JE, Hutchinson PE. A follow-up study to investigate the efficacy of initial treatment of lentigo maligna with surgical excision. In: *Br J Plast Surg*, Vol. 55. England: 2002 The British Association of Plastic Surgeons. Published by Elsevier Science Ltd. 2002; 611-5.
- 4 P.W. Preston PM, D.S.A. Sanders and J.R. Marsden. Surgical treatment of lentigo maligna using 2-mm excision margins. *British Journal of Dermatology* 2003; **149**: 109-10.
- 5 Hou JL, Reed KB, Knudson RM *et al*. Five-year outcomes of wide excision and Mohs micrographic surgery for primary lentigo maligna in an academic practice cohort. *Dermatol Surg* 2015; **41**: 211-8.
- 6 Mahendran RM, Newton-Bishop JA. Survey of U.K. current practice in the treatment of lentigo maligna. In: *Br J Dermatol*, Vol. 144. England. 2001; 71-6.
- 7 Farshad A, Burg G, Panizzon R *et al*. A retrospective study of 150 patients with lentigo maligna and lentigo maligna melanoma and the efficacy of radiotherapy using Grenz or soft X-rays. *British Journal of Dermatology* 2002; **146 (6)**: 1042-6.
- 8 Orten SS, Waner M, Dinehart SM *et al*. Q-switched neodymium:yttrium-aluminum-garnet laser treatment of lentigo maligna. *Otolaryngology - Head and Neck Surgery* 1999; **120**: 296-302.
- 9 Schmid-Wendtner MH, Brunner B, Konz B *et al*. Fractionated radiotherapy of lentigo maligna and lentigo maligna melanoma in 64 patients. *Journal of the American Academy of Dermatology* 2000; **43 (3)**: 477-82.
- 10 Tsang RW, Liu FF, Wells W *et al*. Lentigo maligna of the head and neck: Results of treatment by radiotherapy. *Archives of Dermatology* 1994; **130 (8)**: 1008-12.
- 11 Tzellos T, Kyrgidis A, Mocellin S *et al*. Interventions for melanoma in situ, including lentigo maligna. *Cochrane Database Syst Rev* 2014; **12**: Cd010308.
- 12 Ahmed I, Berth-Jones J. Imiquimod: a novel treatment for lentigo maligna. *British Journal of Dermatology* 2000; **143**: 843-5.
- 13 Swetter SM, Chen FW, Kim DD *et al*. Imiquimod 5% cream as primary or adjuvant therapy for melanoma in situ, lentigo maligna type. *J Am Acad Dermatol* 2015; **72**: 1047-53.
- 14 Mora AN, Karia PS, Nguyen BM. A quantitative systematic review of the efficacy of imiquimod monotherapy for lentigo maligna and an analysis of factors that affect tumor clearance. *J Am Acad Dermatol* 2015.
- 15 Mahoney MH, Joseph MG, Temple C. Topical imiquimod therapy for lentigo maligna. *Annals of Plastic Surgery* 2008; **61 (4)**: 419-24.
- 16 Naylor MF, Crowson N, Kuwahara R *et al*. Treatment of lentigo maligna with topical imiquimod. *British Journal of Dermatology* 2003; **149 Suppl 66**: 66-70.
- 17 Powell AM, Robson AM, Russell-Jones R *et al*. Imiquimod and lentigo maligna: a search for prognostic features in a clinicopathological study with long-term follow-up. *British Journal of Dermatology* 2009; **160**: 994-8.
- 18 Powell AM, Russell-Jones R, Barlow RJ. Topical imiquimod immunotherapy in the management of lentigo maligna. *Clinical & Experimental Dermatology* 2004; **29**: 15-21.
- 19 Rajpar SF, Marsden JR. Imiquimod in the treatment of lentigo maligna. *British Journal of Dermatology* 2006; **155**: 653-6.
- 20 Spenny ML, Walford J, Werchniak AE *et al*. Lentigo maligna (Melanoma in situ) treated with imiquimod cream 5%: 12 Case reports. *Cutis* 2007; **79 (2)**: 149-52.

- 1
2
3 21 P.Ormond CB, N.Leonard and C.M.Lawrence. Treatment of lentigo maligna with
4 imiquimod. *British Journal of Dermatology* 2002; **147**: 57.
5 22 Wolf IH, Cerroni L, Kodama K *et al.* Treatment of lentigo maligna (melanoma in
6 situ) with the immune response modifier imiquimod. *Archives of Dermatology*
7 2005; **141 (4)**: 510-4.
8 23 Fleming CJ, Bryden A, Evans RS *et al.* A pilot study of treatment of lentigo
9 maligna with 5% imiquimod cream. *British Journal of Dermatology* 2004; **151**
10 **(2)**: 485-8.
11 24 Hui EP, Taylor GS, Jia H *et al.* Phase I trial of recombinant modified vaccinia
12 ankara encoding Epstein-Barr viral tumor antigens in nasopharyngeal carcinoma
13 patients. *Cancer Res* 2013; **73**: 1676-88.
14 25 [Tan SH. Sample Size Tables for Clinical Studies Software Program. In: *Sample*](#)
15 [Size Tables for Clinical Studies, 3rd edition \(Machin D, Campbell MJ, Tan SB *et*](#)
16 [al., eds\): Wiley. 2009.](#)
17 26 De Giorgi V, Salvini C, Chiarugi A *et al.* In vivo characterization of the
18 inflammatory infiltrate and apoptotic status in imiquimod-treated basal cell
19 carcinoma. *Int J Dermatol* 2009; **48**: 312-21.
20 27 Glass LF, Raziano RM, Clark GS *et al.* Rapid frozen section immunostaining of
21 melanocytes by microphthalmia-associated transcription factor. *Am J*
22 *Dermatopathol* 2010; **32**: 319-25.
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

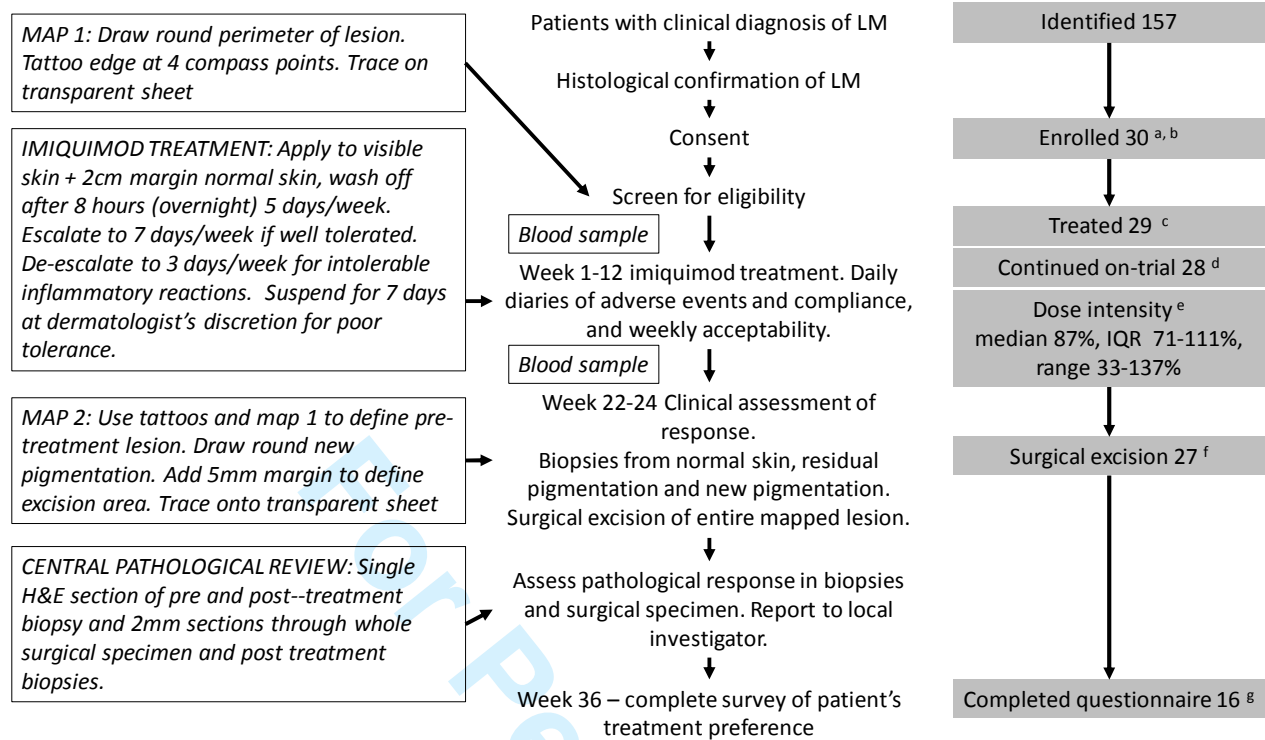


Figure 1. Trial design and recruitment.

The sample size was constituted 28 patients evaluated on an intention to treat basis and 27 treated patients with post-treatment surgical specimens: (a) 75 patients were ineligible, most commonly because LM size <10mm, invasive or recurrent disease, not on head or neck, LM histology not conclusive, steroid treatment, ill-defined lesion, inadequate surgical clearance, LM present <12 months; (b) 52 patients declined trial entry: the most common reasons were burden of travelling (10) or time involved (15), delay in surgery (13), and concerns over side effects (3) or lack of efficacy (2) of imiquimod; (c) one patient withdrew consent before starting imiquimod; (d) one patient withdrew consent after 5.3 weeks treatment; (e) dose intensity was number of imiquimod applications as a proportion of expected 60 applications over 12 weeks (f) one treated patient declined surgery post imiquimod; (g) the questionnaire was completed by the first 16 patients on trial.

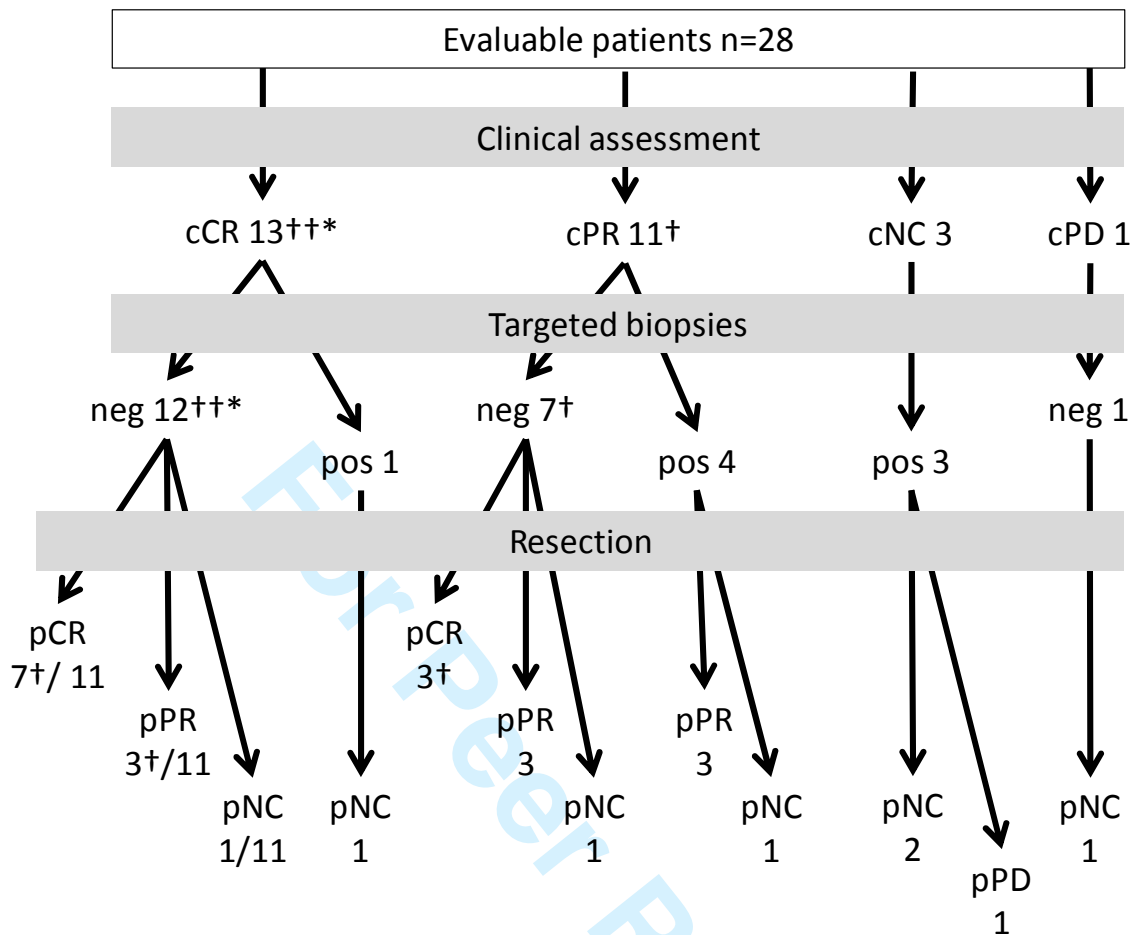


Figure 2. Clinical and pathological responses to treatment

cCR = clinical complete response; cPR = clinical partial response i.e. clinical evidence of improvement in the LM falling short of complete regression; cNC = clinical no change; cPD = clinical progressive disease; pCR = pathological complete response; pPR = pathological partial response; pNC = pathological no change i.e. continuing evidence of LM in specimen; pPD = development of LMM.

† marks a patient whose local diagnosis of LM was not confirmed on central review of the pre-treatment biopsy; * marks a patient who declined resection of LM post imiquimod.

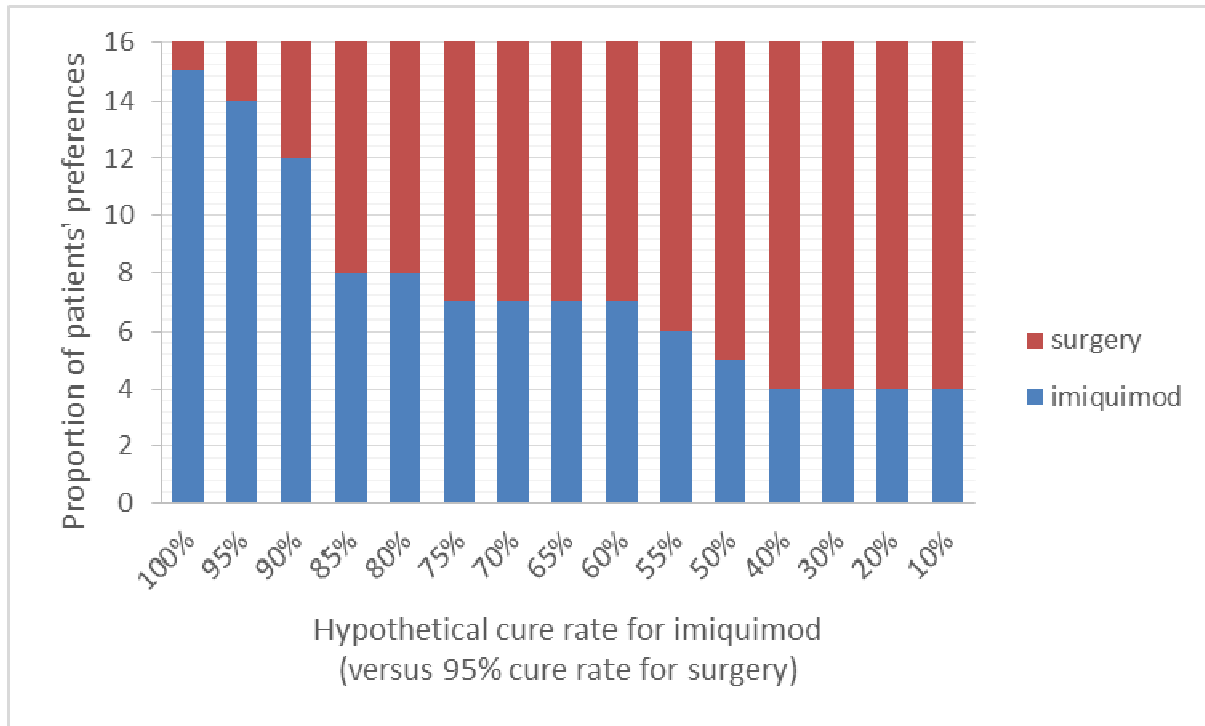


Figure 3 –User Opinion Questionnaire

Bar chart depicting the number of patients (y-axis) reporting preference for either surgery (red) or imiquimod (blue) for varying hypothetical imiquimod cures rates (x-axis) versus a fixed surgical cure rate of 95%. Patients were surveyed having experienced both treatments.