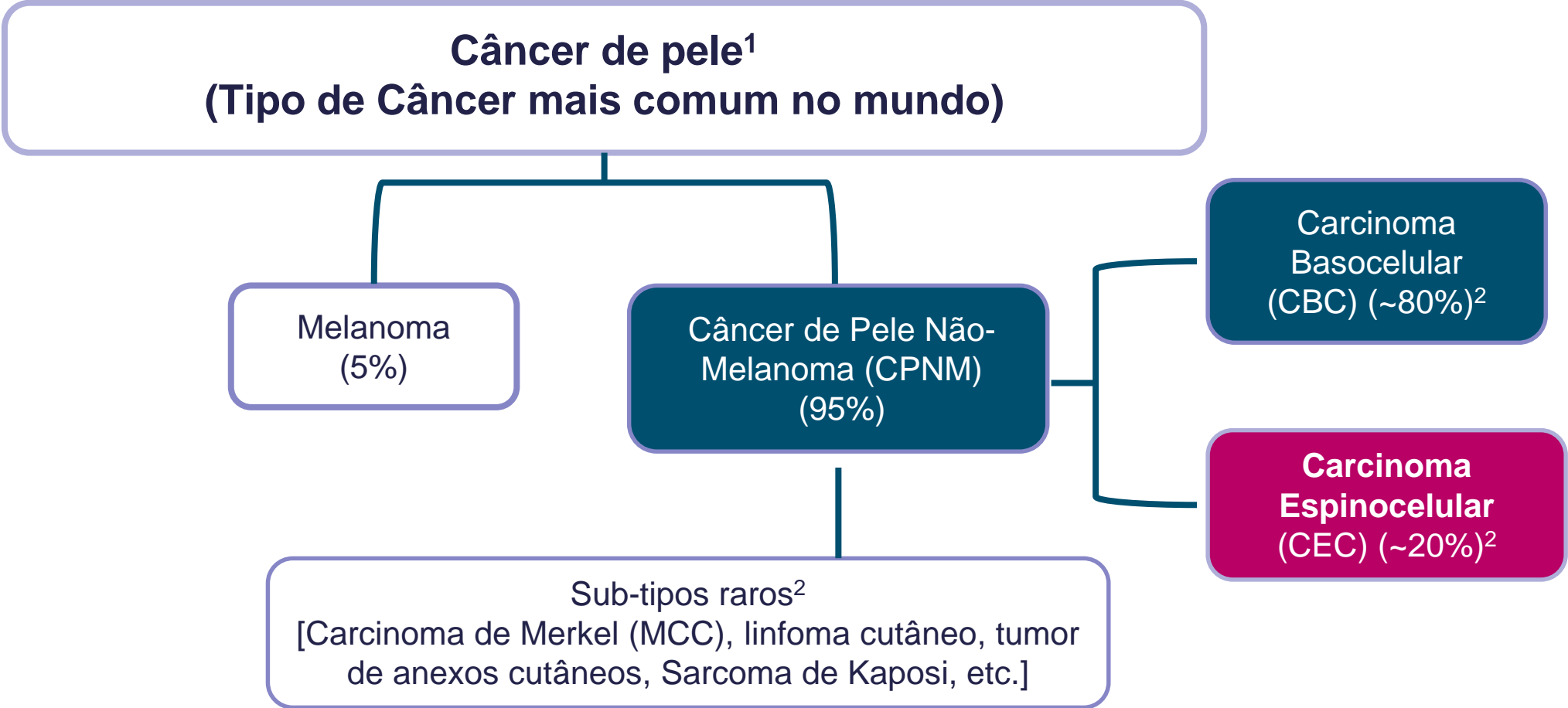# Prevenção, diagnóstico precoce e tratamento contra o câncer de pele

Andréia Melo (CRM-RJ: 800589) – MD, PhD

Vice Presidente SBOC
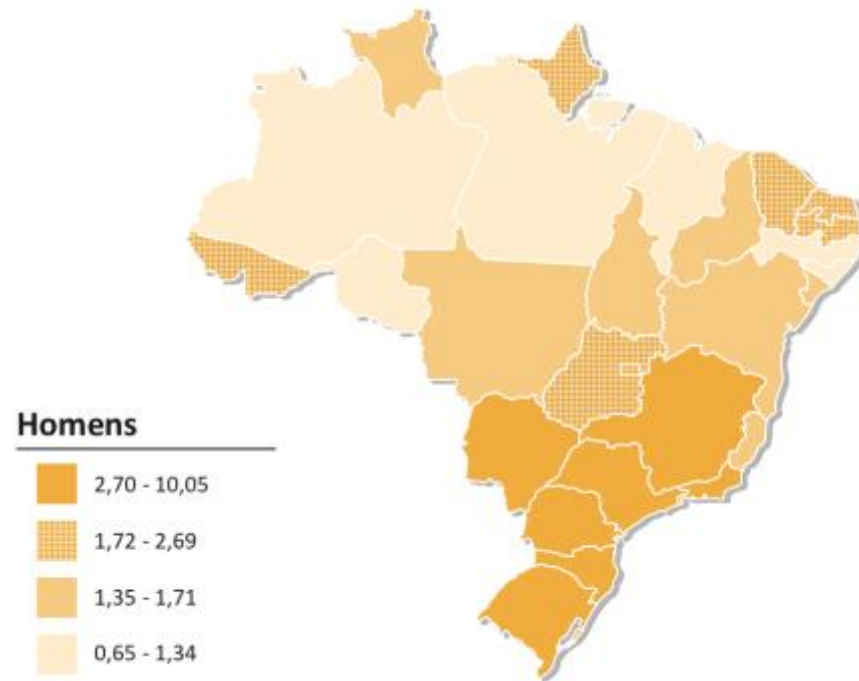
Câncer de Pele

Câncer de pele[1]
(Tipo de Câncer mais comum no mundo)

Melanoma
(5%)

Câncer de Pele Não-Melanoma (CPNM)
(95%)

Carcinoma Basocelular
(CBC) (~80%)[2]

**Carcinoma Espinocelular
(CEC) (~20%)[2]**

Sub-tipos raros[2]
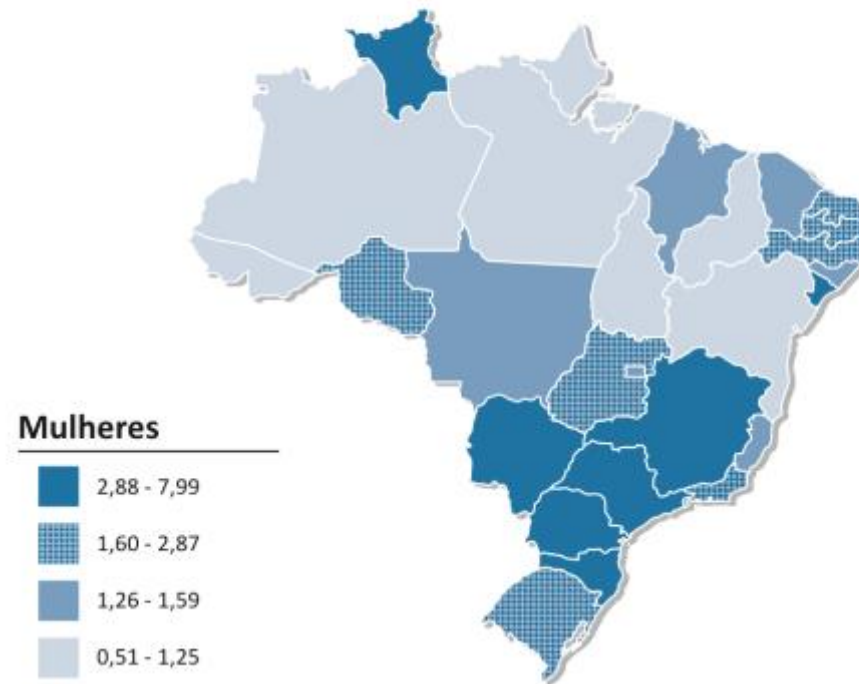[Carcinoma de Merkel (MCC), linfoma cutâneo, tumor de anexos cutâneos, Sarcoma de Kaposi, etc.]

1. Rogers et al., JAMA Dermatol. 2015;151(10):1081-1086. 2015; 2. ACS, 2016. 2. Karia PS, et al. J Am Acad Dermatol. 2013; 68(6):957-966
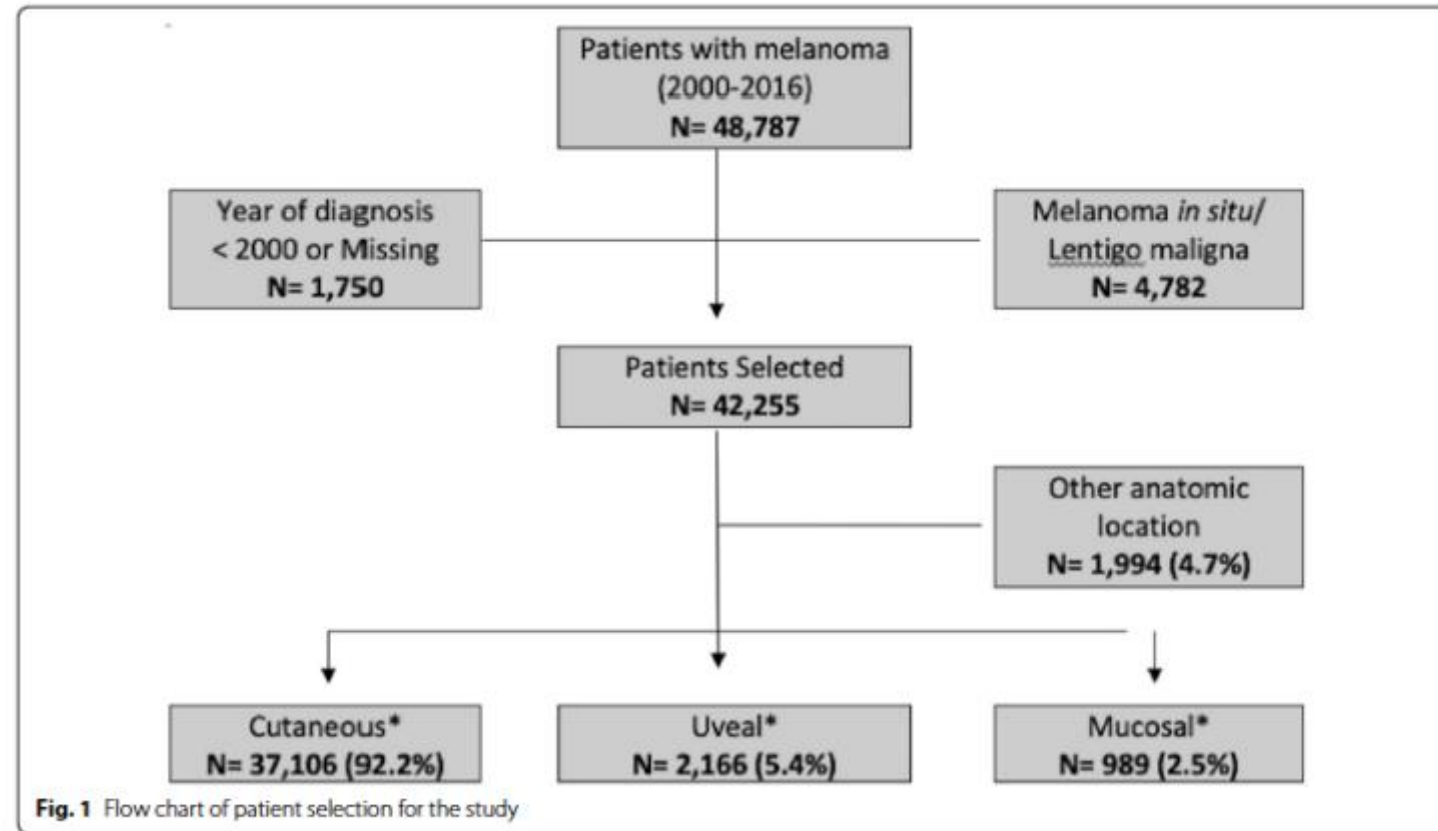
Incidência no Brasil - 8450 novos casos

Representação espacial das taxas ajustadas[a] de incidência por 100 mil homens, estimadas para o ano de 2020, segundo Unidade da Federação (melanoma maligno da pele)

Representação espacial das taxas ajustadas[a] de incidência por 100 mil mulheres, estimadas para o ano de 2020, segundo Unidade da Federação (melanoma maligno da pele)

Homens

- 2,70 - 10,05
- 1,72 - 2,69
- 1,35 - 1,71
- 0,65 - 1,34

Mulheres

- 2,88 - 7,99
- 1,60 - 2,87
- 1,26 - 1,59
- 0,51 - 1,25

www.inca.gov.br/estimativa

Epidemiology of uveal melanoma in Brazil

Evandro Lucena [*] [iD], Daniel Cohen Goldemberg, Luiz Claudio Santos Thuler and Andreia Cristina de Melo

Fig. 1 Flow chart of patient selection for the study

Melanoma signature in Brazil: epidemiology, incidence, mortality, and trend lessons from a continental mixed population country in the past 15 years

Andréia C. de Melo[a], Alberto J.A. Wainstein[b], Antonio C. Buzaid[c,d] and Luiz C.S. Thuler[a]

Fig. 1

(a) Adjusted incidence rate per 100 000 of melanoma in Brazil (2000–2013). (b) Adjusted mortality rate per 100 000 of melanoma in Brazil (2000–2014). IR, incidence rate; MR, mortality rate.
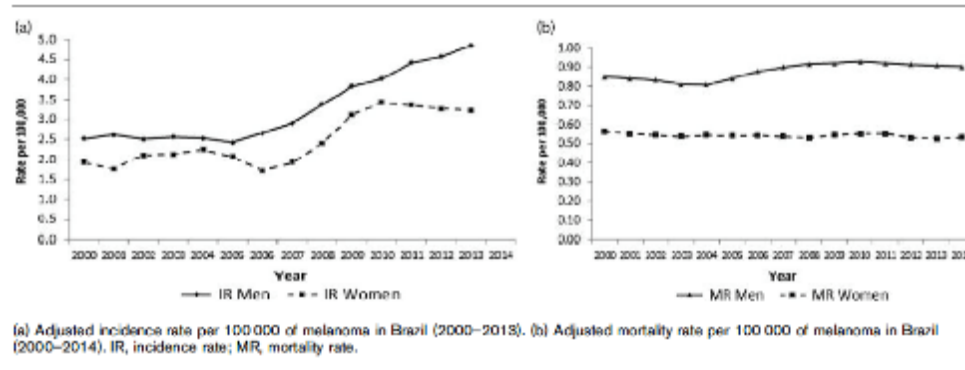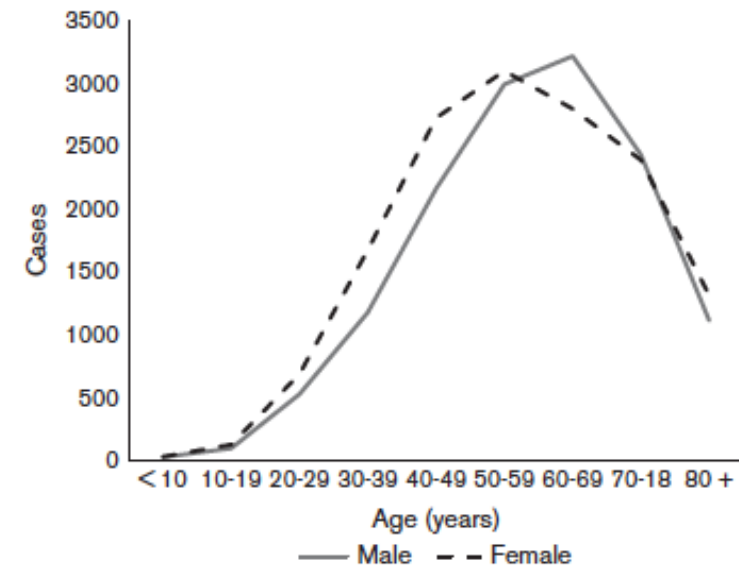

Fig. 2

Age at diagnosis of melanoma by sex in Brazil (2000–2014).

Melanoma signature in Brazil: epidemiology, incidence, mortality, and trend lessons from a continental mixed population country in the past 15 years

Andréia C. de Melo[a], Alberto J.A. Wainstein[b], Antonio C. Buzaid[c,d] and Luiz C.S. Thuler[a]

Table 1   Patient and tumor characteristics

Variables	N^a (%)
Sex	
Male	13767 (48.1)
Female	14857 (51.9)
Age (years)	
< 20	305 (1.0)
20–29	1223 (4.3)
30–39	2857 (10.0)
40–49	4888 (17.1)
50–59	6095 (21.3)
60–69	6007 (21.0)
70–79	4817 (16.8)
≥ 80	2432 (8.5)
Ethnicity/skin color	
White	14849 (75.0)
Brown	4346 (21.9)
Black	478 (2.4)
Yellow/Indigenous	138 (0.7)
Education level (years)	
< 8	10700 (50.4)
≥ 8	10535 (49.6)
Geographical area of the cancer center	
Southeast	13544 (47.3)
South	9646 (33.7)
Northeast	4405 (15.4)
North/Middle-West	1029 (3.6)
Origin of referral to the cancer center	
Public system	13570 (77.1)
Private facility	4030 (22.9)
Period of diagnosis	
2000–2003	4204 (14.7)
2004–2007	7151 (25.0)
2008–2011	9636 (33.7)
2012–2016	7633 (26.7)
Clinical stage (TNM)	
I	4558 (32.0)
II	3024 (21.2)
III	2941 (20.6)
IV	3726 (26.1)
Primary site	
Head and neck	5444 (19.0)
Trunk	7757 (27.1)
Upper limbs, including shoulders	3998 (14.0)
Lower limbs, including hips	7499 (26.2)
Other	3926 (13.7)
Histology	
Malignant melanoma, not otherwise specified	22350 (78.1)
Nodular melanoma	2923 (10.2)
Superficial spreading melanoma	1188 (4.1)
Acral lentiginous melanoma	812 (2.8)
Lentigo maligna	549 (1.9)
Amelanotic melanoma	260 (0.9)
Spindle cell melanoma, not otherwise specified	146 (0.5)
Other	396 (1.4)
Total	28624 (100.0)

[a]Differences are due to missing information.

Can innovation increase the therapeutic options but accentuate the inequalities in the healthcare system?

Ana Paula Drummond-Lage[a], Cassia Rita Pereira da Veiga[b], Claudimar Pereira da Veiga[b,*], Andreia Cristina de Melo[c], Alberto Julius Alves Wainstein[a]
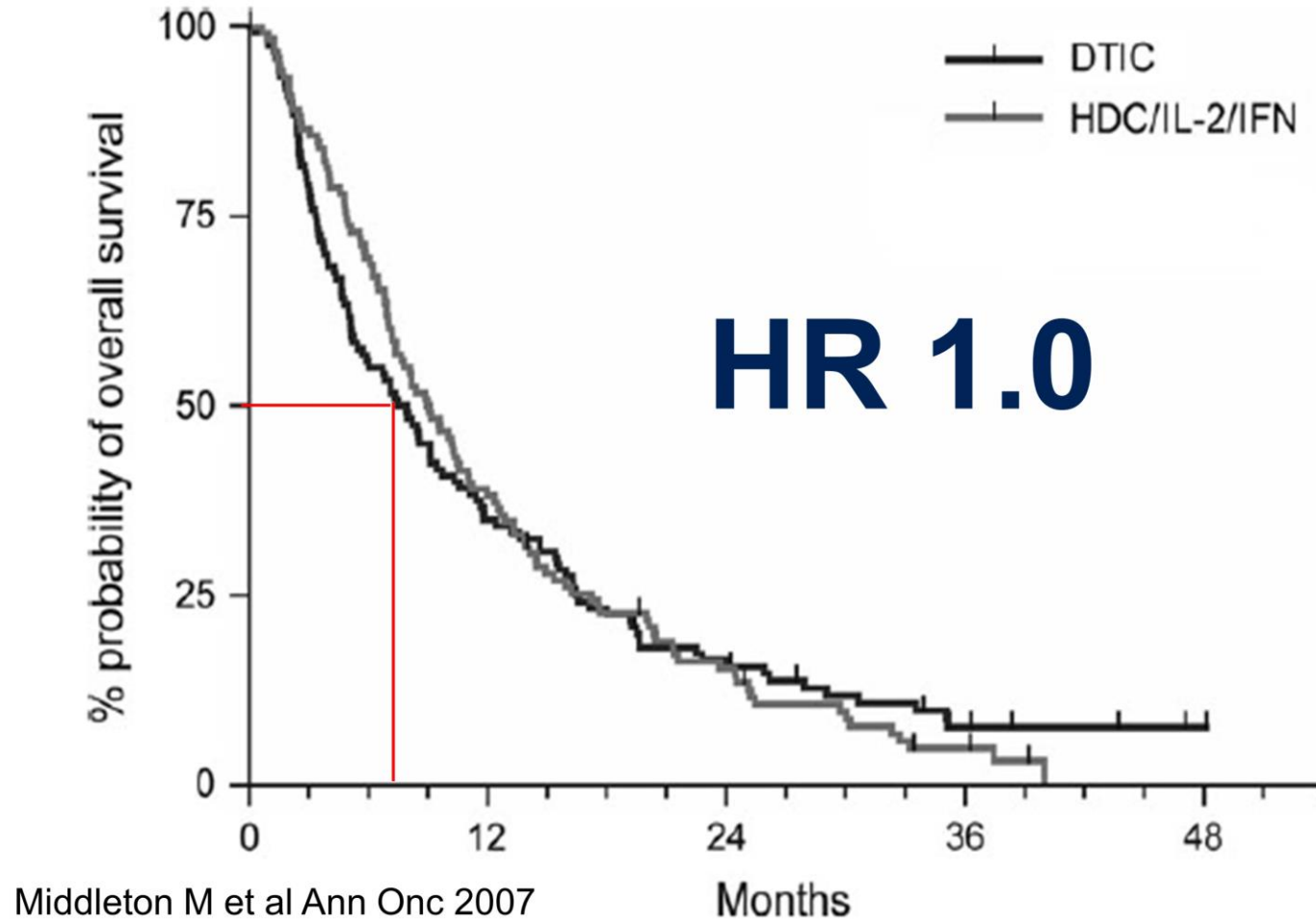
ABSTRACT

Melanoma is the most dangerous type of skin cancer, and pre 2011 the prognosis of metastatic melanoma was very poor. In developing countries, such as Brazil, a vast majority of patients do not have access to the opportunity of an early, curative melanoma approach and this leads to metastatic disease. In this sense, the purpose of this paper is to illustrate the distinct lack of access to innovative melanoma treatments, based on immunotherapy and target therapy, in the public and private health sectors in Brazil. We analyzed the Brazilian health regulatory system and the incorporation of health technologies in the public and private health settings. At present, for patients being treated within the public health system, only dacarbazine is available. Whereas, immune-oncology agents and target therapies are available for patients being treated within the private health sector. In this scenario, we concluded that the introduction of innovations could accentuate the existing inequalities in the delivery of healthcare in Brazil.
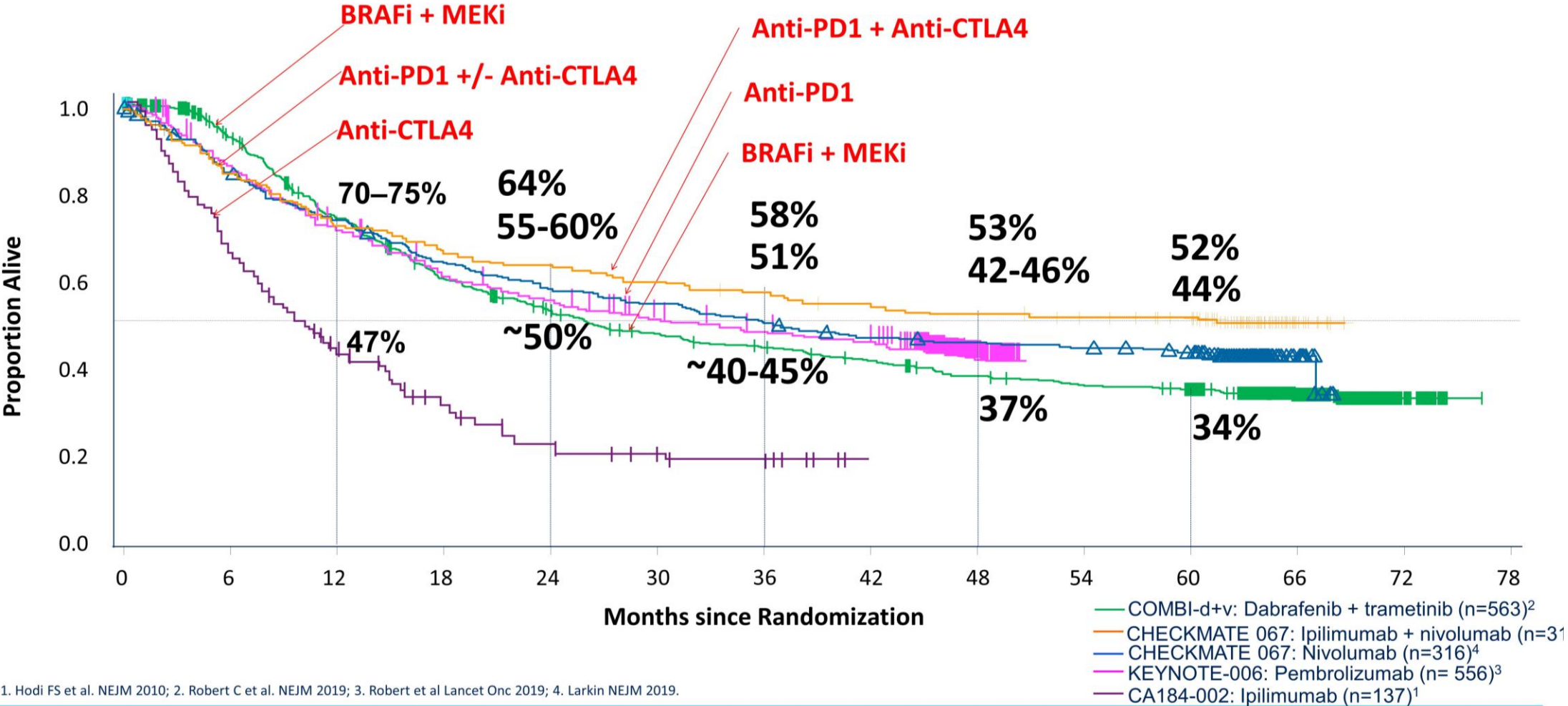
Fig. 1. Timeline of drugs approved by ANVISA for MM treatment.

A evolução do tratamento do melanoma metastático

Middleton M et al Ann Onc 2007

A evolução do tratamento do melanoma metastático

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Melanoma is the most dangerous type of skin cancer, and pre 2011 the prognosis of metastatic melanoma was very poor. In developing countries, such as Brazil, a vast majority of patients do not have access to the opportunity of an early, curative melanoma approach and this leads to metastatic disease. In this sense, the purpose of this paper is to illustrate the distinct lack of access to innovative melanoma treatments, based on immunotherapy and target therapy, in the public and private health sectors in Brazil. We analyzed the Brazilian health regulatory system and the incorporation of health technologies in the public and private health settings. At present, for patients being treated within the public health system, only dacarbazine is available. Whereas, immune-oncology agents and target therapies are available for patients being treated within the private health sector. In this scenario, we concluded that the introduction of innovations could accentuate the existing inequalities in the delivery of healthcare in Brazil.

Fig. 1. Timeline of drugs approved by ANVISA for MM treatment.

RELATÓRIO DE RECOMENDAÇÃO

Para a garantia da disponibilização das tecnologias incorporadas no SUS, está estipulado no Decreto n° 7.646/ 2011 o prazo de 180 dias para a efetivação de sua oferta à população brasileira.

Recomendação final: Os membros da Conitec presentes na 88ª reunião ordinária, no dia 08 de julho de 2020, deliberaram, por unanimidade, por recomendar a incorporação no Sistema Único de Saúde da classe anti-PD1 (nivolumabe ou pembrolizumabe), para tratamento de primeira linha do melanoma avançado não cirúrgico e metastático, conforme modelo da assistência oncológica no SUS. Foram levadas em consideração as novas propostas de preços apresentadas pelas empresas fabricantes dos medicamentos anti-PD1 avaliados (nivolumabe e pembrolizumabe) além dos satisfatórios perfis de eficácia e segurança demonstrado pelos dois medicamentos. Discutiu-se que o custo mensal do tratamento de ambos os medicamentos deveriam ainda ser reduzidos conforme valor de referência de 3 PIB/per capita para uma razão de custo-efetividade incremental favorável. Foi discutida também a possibilidade de criação de um valor máximo para o procedimento na tabela SIGTAP com a recomendação da classe terapêutica. Foi assinado o Registro de Deliberação nº 533/2020.

Cenário atual

Obrigada!

Melo.andreia@uol.com.br