

Melanoma Incidence in Children Is On the Rise

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ORLANDO — Cancer already kills more children aged 1-14 years than does any other disease, and the incidence of childhood melanoma in the United States is on the rise, Dr. Jane M. Grant-Kels said at the annual meeting of the Florida Society of Dermatologic Surgeons.

A 2007 study showed that melanoma accounts for up to 3% of all pediatric ma-

lignancies, including about 2% of malignancies in those aged younger than 20 years, and 0.3%-0.4% of malignancies in prepubertal children. The study also showed that melanoma diagnoses are seven times more common between the ages of 10 and 20 years than between 0 and 10 years (J. Clin. Oncol. 2007;25:1363-8).

The National Cancer Institute's Surveillance Epidemiology and End Results database showed an increased incidence of nearly 3% a year during 1985-2003 in those

aged 1-19 years. Yet there remains a lack of awareness of the prevalence of melanoma in children. Those who believe that children don't get melanoma are doing their patients an injustice, and such thinking is largely to blame for the fact that diagnosis and treatment are delayed in 40% of childhood melanoma cases, said Dr. Grant-Kels, professor and chair of the dermatology department at the University of Connecticut Health Center, Farmington.

A review of 13 melanoma cases in chil-

dren younger than age 17 years showed that 85% of the cancers were nodular in type and had a mean thickness of 3.2 mm when diagnosed; 5-year survival was a mean of 59% in the children (J. Am. Acad. Dermatol. 2005;53:816-22). "The lack of awareness and reluctance to diagnose pediatric melanoma can lead to higher incidence of thick melanomas," wrote the authors.

In another study, a decrease in survival in up to 60% of cases was secondary to a delay in diagnosis attributable to lack of familiarity with pediatric melanoma, lack of vigilance in looking for melanoma in children, and lack of suspicion of melanoma in children.

In light of these findings, it is important to keep in mind that, although melanoma behaves similarly in adolescents and adults, this is not the case in prepubertal children, Dr. Grant-Kels noted.

In one study, melanoma in 33 children aged 14 years and younger was found to be amelanotic in half of the cases. Lesions were raised and resembled pyogenic granuloma in 73% of cases, and they were nodular in type in 27% of cases with a median thickness of 2.5 mm. Most were Clark IV-V lesions. Overall survival at 5 years was about 70% (Pediatrics 2005;115:649-54).

It also is important to keep in mind that childhood melanoma occurs most often in white patients, with only 6.5% of cases occurring in nonwhites, which is a higher percentage than seen in adults. Also, unlike adults, there is a higher predominance of cases in females, with 56%-61% of pediatric cases occurring in girls.

In one study of data from 3,158 patients in the National Cancer Data Base, that figure was 56% in those aged 1-19 years. There was a 90% female predominance among those older than age 10 years, whereas males and nonwhite patients predominated among those younger than age 10 with melanoma (J. Clin. Oncol. 2007;25:1363-8).

That study also showed that younger children tend to present more often with head and neck cancers: Of those aged 1-4 years, 39% presented with head and neck cancers, compared with 12% of those aged 5-19 years. Younger children in the study also were more likely to present with regional and distant metastases and to have poorer survival.

Other studies suggest that the incidence of melanoma is increasing at a faster rate in girls aged 10-19 years than among boys in that age group, which may reflect the popularity of tanning beds among girls, Dr. Grant-Kels suggested.

Some clinical findings that should prompt concern about possible melanoma in children younger than 12 years include a rapid increase in lesion size, bleeding, change in lesion color, nodular growth, pruritus, and lymphadenopathy. In children, 20% of cases occur on the head and neck, and 80% occur on the trunk or extremities, she said.

However, half of melanomas in children arise de novo. About a third arise from congenital melanocytic nevi, and about 20% arise from other melanocytic nevi, including dysplastic nevi, Dr. Grant-Kels said, noting the importance of having a dermatopathologist review all specimens from pediatric patients. ■



Brief Summary: For complete details, please see full Prescribing Information.

INDICATIONS AND USAGE: BYETTA is indicated as adjunctive therapy to improve glycemic control in patients with type 2 diabetes mellitus who are taking metformin, a sulfonylurea, a thiazolidinedione, a combination of metformin and a sulfonylurea, or a combination of metformin and a thiazolidinedione, but have not achieved adequate glycemic control.

CONTRAINDICATIONS: BYETTA is contraindicated in patients with known hypersensitivity to exenatide or to any of the product components.

PRECAUTIONS: General—BYETTA is not a substitute for insulin in insulin-requiring patients. BYETTA should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis.

Postmarketing cases of acute pancreatitis have been reported in patients treated with BYETTA. Patients should be informed that persistent severe abdominal pain, which may be accompanied by vomiting, is the hallmark symptom of acute pancreatitis. If pancreatitis is suspected, BYETTA and other potentially suspect drugs should be discontinued, confirmatory tests performed and appropriate treatment initiated. Resuming treatment with BYETTA is not recommended if pancreatitis is confirmed and an alternative etiology for the pancreatitis has not been identified.

Patients may develop anti-exenatide antibodies following treatment with BYETTA, consistent with the potentially immunogenic properties of protein and peptide pharmaceuticals. Patients receiving BYETTA should be observed for signs and symptoms of hypersensitivity reactions. In a small proportion of patients, the formation of anti-exenatide antibodies at high titers could result in failure to achieve adequate improvement in glycemic control.

The concurrent use of BYETTA with insulin, D-phenylalanine derivatives, meglitinides, or alpha-glucosidase inhibitors has not been studied.

BYETTA is not recommended for use in patients with end-stage renal disease or severe renal impairment (creatinine clearance <30 mL/min; see Pharmacokinetics, Special Populations). In patients with end-stage renal disease receiving dialysis, single doses of BYETTA 5 mcg were not well tolerated due to gastrointestinal side effects.

There have been rare, spontaneously reported events of altered renal function, including increased serum creatinine, renal impairment, worsened chronic renal failure and acute renal failure, sometimes requiring hemodialysis. Some of these events occurred in patients receiving one or more pharmacologic agents known to affect renal function/hydration status and/or in patients experiencing nausea, vomiting, and/or diarrhea, with or without dehydration. Concomitant agents included angiotensin converting enzyme inhibitors, nonsteroidal anti-inflammatory drugs, and diuretics. Reversibility of altered renal function has been observed with supportive treatment and discontinuation of potentially causative agents, including exenatide. Exenatide has not been found to be directly nephrotoxic in preclinical or clinical studies.

BYETTA has not been studied in patients with severe gastrointestinal disease, including gastroparesis. Its use is commonly associated with gastrointestinal adverse effects, including nausea, vomiting, and diarrhea. Therefore, the use of BYETTA is not recommended in patients with severe gastrointestinal disease.

Hypoglycemia—In the 30-week controlled clinical trials with BYETTA, a hypoglycemia episode was recorded as an adverse event if the patient reported symptoms associated with hypoglycemia with an accompanying blood glucose <60 mg/dL or if symptoms were reported without an accompanying blood glucose measurement. When BYETTA was used in combination with metformin, no increase in the incidence of hypoglycemia was observed. In contrast, when BYETTA was used in combination with a sulfonylurea, the incidence of hypoglycemia was increased over that of placebo in combination with a sulfonylurea. Therefore, patients receiving BYETTA in combination with a sulfonylurea may have an increased risk of hypoglycemia (Table 1).

Table 1: Incidence (%) of Hypoglycemia* by Concomitant Antidiabetic Therapy

	BYETTA			BYETTA			BYETTA		
	Placebo BID	5 mcg BID	10 mcg BID	Placebo BID	5 mcg BID	10 mcg BID	Placebo BID	5 mcg BID	10 mcg BID
	With Metformin			With a Sulfonylurea			With MET/SFU		
N	113	110	113	123	125	129	247	245	241
Hypoglycemia	5.3%	4.5%	5.3%	3.3%	14.4%	35.7%	12.6%	19.2%	27.8%

* In three 30-week placebo-controlled clinical trials. BYETTA and placebo were administered before the morning and evening meals. Abbreviations: BID, twice daily; MET/SFU, metformin and a sulfonylurea.

Most episodes of hypoglycemia were mild to moderate in intensity, and all resolved with oral administration of carbohydrate. To reduce the risk of hypoglycemia associated with the use of a sulfonylurea, reduction in the dose of sulfonylurea may be considered (see DOSAGE AND ADMINISTRATION). When used as add-on to a thiazolidinedione, with or without metformin, the incidence of symptomatic mild to moderate hypoglycemia with BYETTA was 11% compared to 7% with placebo.

BYETTA did not alter the counter-regulatory hormone responses to insulin-induced hypoglycemia in a randomized, double-blind, controlled study in healthy subjects.

Information for Patients—Patients should be informed of the potential risks of BYETTA. Patients should also be fully informed about self-management practices, including the importance of proper storage of BYETTA, injection technique, timing of dosage of BYETTA as well as concomitant oral drugs, adherence to meal planning, regular physical activity, periodic blood glucose monitoring and HbA_{1c} testing, recognition and management of hypoglycemia and hyperglycemia, and assessment for diabetes complications.

Patients should be advised to inform their physicians if they are pregnant or intend to become pregnant.

The risk of hypoglycemia is increased when BYETTA is used in combination with an agent that induces hypoglycemia, such as a sulfonylurea (see PRECAUTIONS, Hypoglycemia).

Patients should be advised that treatment with BYETTA may result in a reduction in appetite, food intake, and/or body weight, and that there is no need to modify the dosing regimen due to such effects. Treatment with BYETTA may also result in nausea (see ADVERSE REACTIONS). Patients should be informed that persistent severe abdominal pain, which may be accompanied by vomiting, is the hallmark symptom of acute pancreatitis and be instructed to contact their physician if this symptom occurs (see PRECAUTIONS).

Drug Interactions—The effect of BYETTA to slow gastric emptying may reduce the extent and rate of absorption of orally administered drugs. BYETTA should be used with caution in patients receiving oral medications that require rapid gastrointestinal absorption. For oral medications that are dependent on threshold concentrations for efficacy, such as contraceptives and antibiotics, patients should be advised to take those drugs at least 1 h before BYETTA

injection. If such drugs are to be administered with food, patients should be advised to take them with a meal or snack when BYETTA is not administered. The effect of BYETTA on the absorption and effectiveness of oral contraceptives has not been characterized.

Warfarin: Since market introduction there have been some spontaneously reported cases of increased INR with concomitant use of warfarin and BYETTA, sometimes associated with bleeding.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 104-week carcinogenicity study was conducted in male and female rats and benign thyroid C-cell adenomas were observed in female rats at all exenatide doses. The incidences in female rats were 8% and 5% in the two control groups and 14%, 11%, and 23% in the low-, medium-, and high-dose groups with systemic exposures of 5, 22, and 130 times, respectively, the human exposure resulting from the maximum recommended dose of 20 mcg/day.

In a 104-week carcinogenicity study in mice, no evidence of tumors was observed at doses up to 250 mcg/kg/day, a systemic exposure up to 95 times the human exposure resulting from the maximum recommended dose of 20 mcg/day.

Exenatide was not mutagenic or clastogenic, with or without metabolic activation, in the Ames bacterial mutagenicity assay or chromosomal aberration assay in Chinese hamster ovary cells.

Pregnancy—Pregnancy Category C—Exenatide has been shown to cause reduced fetal and neonatal growth, and skeletal effects in mice at systemic exposures 3 times the human exposure resulting from the maximum recommended dose of 20 mcg/day. Exenatide has been shown to cause skeletal effects in rabbits at systemic exposures 12 times the human exposure resulting from the maximum recommended dose of 20 mcg/day. There are no adequate and well-controlled studies in pregnant women. BYETTA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

In pregnant mice an increased number of neonatal deaths were observed on postpartum days 2-4 in dams given 6 mcg/kg/day, a systemic exposure 3 times the human exposure resulting from the maximum recommended dose of 20 mcg/day.

Nursing Mothers—It is not known whether exenatide is excreted in human milk. Caution should be exercised when BYETTA is administered to a nursing woman.

Pediatric Use—Safety and effectiveness of BYETTA have not been established in pediatric patients.

Geriatric Use—BYETTA was studied in 282 patients 65 years of age or older and in 16 patients 75 years of age or older. No differences in safety or effectiveness were observed between these patients and younger patients.

ADVERSE REACTIONS: Use with metformin and/or a sulfonylurea—In the three 30-week controlled trials of BYETTA add-on to metformin and/or sulfonylurea, adverse events with an incidence $\geq 5\%$ (excluding hypoglycemia; see Table 1) that occurred more frequently in patients treated with BYETTA (N = 963) vs placebo (N = 483) were: nausea (44% vs 18%), vomiting (13% vs 4%), diarrhea (13% vs 6%), feeling jittery (9% vs 4%), dizziness (9% vs 6%), headache (9% vs 6%), and dyspepsia (6% vs 3%).

The adverse events associated with BYETTA generally were mild to moderate in intensity. The most frequently reported adverse event, mild to moderate nausea, occurred in a dose-dependent fashion. With continued therapy, the frequency and severity decreased over time in most of the patients who initially experienced nausea. Adverse events reported in ≥ 1.0 to <5.0% of patients receiving BYETTA and reported more frequently than with placebo included asthenia (mostly reported as weakness), decreased appetite, gastroesophageal reflux disease, and hyperhidrosis. Patients in the extension studies at 52 weeks experienced similar types of adverse events observed in the 30-week controlled trials.

The incidence of withdrawal due to adverse events was 7% for BYETTA-treated patients and 3% for placebo-treated patients. The most common adverse events leading to withdrawal for BYETTA-treated patients were nausea (3% of patients) and vomiting (1%). For placebo-treated patients, <1% withdrew due to nausea and 0% due to vomiting.

Use with a thiazolidinedione—In the 16-week placebo-controlled study of BYETTA add-on to a thiazolidinedione, with or without metformin, the incidence and type of other adverse events observed were similar to those seen in the 30-week controlled clinical trials with metformin and/or a sulfonylurea. No serious adverse events were reported in the placebo arm. Two serious adverse events, namely chest pain (leading to withdrawal) and chronic hypersensitivity pneumonitis, were reported in the BYETTA arm.

The incidence of withdrawal due to adverse events was 16% (19/121) for BYETTA-treated patients and 2% (2/112) for placebo-treated patients. The most common adverse events leading to withdrawal for BYETTA-treated patients were nausea (9%) and vomiting (5%). For placebo-treated patients, <1% withdrew due to nausea. Chills (n = 4) and injection-site reactions (n = 2) occurred only in BYETTA-treated patients. The two patients who reported an injection-site reaction had high titers of anti-exenatide antibody.

Spontaneous Data—Since market introduction of BYETTA, the following additional adverse reactions have been reported. Because these events are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. **General:** injection-site reactions; dysgeusia; somnolence, INR increased with concomitant warfarin use (some reports associated with bleeding). **Allergy/Hypersensitivity:** generalized pruritus and/or urticaria, macular or papular rash, angioedema; rare reports of anaphylactic reaction. **Gastrointestinal:** nausea, vomiting, and/or diarrhea resulting in dehydration; abdominal distention, abdominal pain, eructation, constipation, flatulence, acute pancreatitis (see PRECAUTIONS). **Renal and Urinary Disorders:** altered renal function, including acute renal failure, worsened chronic renal failure, renal impairment, increased serum creatinine (see PRECAUTIONS).

Immunogenicity—Consistent with the potentially immunogenic properties of protein and peptide pharmaceuticals, patients may develop anti-exenatide antibodies following treatment with BYETTA.

OVERDOSAGE: Effects of an overdose include severe nausea, severe vomiting, and rapidly declining blood glucose concentrations. In the event of overdose, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms.

DOSAGE AND ADMINISTRATION: BYETTA therapy should be initiated at 5 mcg per dose administered twice daily at any time within the 60-minute period before the morning and evening meals (or before the two main meals of the day, approximately 6 hours or more apart). BYETTA should not be administered after a meal. Based on clinical response, the dose of BYETTA can be increased to 10 mcg twice daily after 1 month of therapy. Each dose should be administered as a SC injection in the thigh, abdomen, or upper arm.

Rx ONLY

Manufactured for Amylin Pharmaceuticals, Inc., San Diego, CA 92121
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