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TREATMENT OF LOCALLY ADVANCED CUTANEOUS SQUAMOUS CELL CARCINOMA WITH SEVERE COMORBIDITIES: A CASE REPORT

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Summary
Advanced cutaneous squamous cell carcinoma (aCSCC) presents a significant therapeutic challenge, especially in patients with severe comorbidities that limit treatment options. Traditional treatments such as surgery and radiation may be unfeasible in frail patients, necessitating alternative therapies like immunotherapy. We present the case of a 79-year-old male with a history of recurrent aCSCC, complicated by multiple severe comorbidities, including coronary artery disease, heart failure, chronic kidney disease, and hypothyroidism. After the development of facial nerve palsy and confirmation of metastatic disease, he was treated with cemiplimab, a PD-1 inhibitor, through an Early Access Program. Despite his complex medical status and fluctuating performance status (ECOG 2-3), the patient showed partial reduction in tumor size and improved quality of life, with no significant adverse effects. This case highlights the potential of cemiplimab as an effective therapeutic option for patients with aCSCC who are ineligible for conventional treatments due to comorbidities, offering an alternative approach to managing this challenging condition.

Case presentation

A 79-year-old male initially presented in August 2015 with a poorly differentiated non-keratinizing squamous cell carcinoma of the right ear, classified as pT2 G3. He underwent a right ear resection. In November 2015, a recurrence of the disease was noted, with multiple lesions affecting the same ear. The patient underwent another resection with reconstruction, and pathology confirmed multifocal non-invasive squamous cell carcinoma, or carcinoma in situ, classified as pT(m)is.

In March 2022, the patient developed a right facial nerve palsy, presenting with facial droop and weakness on the right side. A CT scan revealed suspected neoplastic changes in the right parotid salivary gland, as well as pathological lymph nodes in the right neck zone II.

He was referred to the National Cancer Institute in Vilnius for further evaluation. Presented with right facial nerve palsy, weakness, pain in upper right neck area; his ECOG was about 2-3.

His past medical history includes:

1. Coronary Artery Disease (CAD): Stable Class III Angina Pectoris. Previous myocardial infarction (anterior, Q+). Ischemic cardiomyopathy with impaired left ventricular systolic function. Left ventricular aneurysm. Status post left ventricular aneurysm plication with a Bioventrix device and thoracic artery bypass to the LAD (left anterior descending artery) (2013). Primary arterial hypertension, Stage II with elevated blood pressure. Ischemic-hypertensive cardiomyopathy with impaired left ventricular systolic function.
2. Cardiac Rhythm and Conduction Disorders: Wide QRS complex tachycardia. ICD implantation (2011). Replacement of ICD (implantable cardioverter-defibrillator) with a biventricular ICD (2 years after implantation). Battery depletion and replacement of the biventricular ICD generator (2016). Battery depletion and damage to the right atrial lead. Replacement of the biventricular ICD generator, with the pacemaker programmed to VVI mode (VVI mode delivers ventricular pacing at the programmed lower pacing rate, with inhibition when intrisic ventricular events are sensed.);(after 2 years of last ICD generator replacement). Reimplantation of the biventricular ICD (2018). Revision of the pacemaker system and change in lead localization (2019).
3. Heart Failure: Class C, NYHA (New York Heart Association) IV.

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4. Chronic Kidney Disease, Stage 4.
5. Hypothyroidism, inadequately compensated.
6. Hyperuricemia and Gout, in partial remission.

The patient was also on multiple medications to manage his comorbidities. His treatment regimen included Rivaroxabanum 15 mg with a reduced dose due to his creatinine clearance of 23 ml/h, indicating renal impairment. He was taking Bisoprolol 5 mg and Entresto (Sacubitrilum/Valsartanum) 24/26 mg to manage his cardiovascular condition, along with Torasemide 50-100 mg as a diuretic. Ranolazinum (Ranexa) 500 mg was prescribed for angina, and Rosuvastinum (Crestor) 5 mg was used for cholesterol management. Additionally, he was on Allopurinolum 50-100 mg for gout, Amiodarone 200 mg for arrhythmia control, and L-thyroxinum 75 μg for thyroid hormone replacement.

The patient has been under the regular surveillance of a nephrologist and cardiologist.

In April 2022, biopsies from the right parotid gland and the lymph nodes in the right neck zone II confirmed poorly differentiated squamous cell carcinoma, classified as G3.

A multidisciplinary team reviewed the case, and after discussing the risks and benefits of immunotherapy with the patient and his relatives, the decision was made to proceed with systemic therapy using cemiplimab.

In June 2022, cemiplimab was started through an Early Access Program. Baseline laboratory tests, including complete blood count, liver function tests, and electrolytes, were within normal limits. However, his creatinine level was elevated at 215 μmol/L (GFR 26), NT-proBNP was 3730 ng/L, and TSH was slightly elevated at 6.47 μIU/ml.

Over the course of the next year and four months, the patient remained on cemiplimab. During this period, his ECOG performance status fluctuated between 2 and 3, though he reported feeling clinically better, particularly noting that the pain in the neck area had subsided. His creatinine levels were in the range of 180 to 225 μmol/L, and NT-proBNP levels ranged from 3080 to 3870 ng/L. Other blood tests remained within acceptable limits, and no significant adverse effects related to immunotherapy were observed. Imaging showed stable disease with a 20% reduction in tumor size, representing the best radiological response.

In November 2023, the patient unfortunately passed away due to complications from COVID-19 pneumonia. Despite the challenges associated with his squamous cell carcinoma and the subsequent treatments, he experienced a period of improved quality of life during his immunotherapy.

Discussion

Cutaneous squamous cell carcinoma is the second most common non-melanoma skin cancer, with rising incidence in aging populations [7]. While most cases are cured with surgery or radiotherapy, advanced disease poses substantial therapeutic challenges [8]. Locally advanced cSCC is generally defined as disease unlikely to be cured with surgery or radiation alone [8].

Cemiplimab has transformed systemic therapy for advanced cSCC. In phase II trials, objective responses were observed in nearly half of treated patients, with durable disease control and acceptable safety [1,2]. Based on these results, cemiplimab received regulatory approval for patients ineligible for curative surgery or radiotherapy.

Importantly, frail and multimorbid patients were underrepresented in pivotal trials. Observational cohorts demonstrate that treatment can be feasible in elderly and medically complex populations, with manageable toxicity and meaningful responses [4–6]. These findings suggest that performance status alone should not automatically preclude immunotherapy when no curative alternatives exist.

Our patient had ECOG 2–3, NYHA IV heart failure, stage IV chronic kidney disease, and multiple cardiovascular comorbidities. Despite this, he tolerated cemiplimab for over 16 months, achieved radiological stabilization with measurable tumor reduction, and experienced clinically relevant symptom improvement. No severe immune-related adverse events were observed.

This clinical course aligns with emerging real-world data supporting cautious but feasible use of PD-1 inhibition in selected frail patients [4–6]. Individualized risk–benefit assessment remains essential.

Conclusions

1. This case supports cemiplimab as an effective and well-tolerated treatment for advanced cutaneous squamous cell carcinoma, even in patients with multiple comorbidities and compromised performance status.

2. The patient's stable disease, clinical improvement (notably in pain reduction), and absence of severe adverse effects underscore the potential of cemiplimab as a viable option for those with limited treatment alternatives.

3. These findings align with retrospective studies, which confirm cemiplimab's safety and efficacy in real-world settings [4,5]. As a result, cemiplimab continues to play a pivotal role in the management of aCSCC, particularly for patients ineligible for traditional treatments.

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LOKALIAI IŠPLITUSIOS ODOS PLOKŠČIALĄSTELINĖS KARCINOMOS GYDYMAS PACIENTUI, TURINČIAM SUNKIŲ GRETUTINIŲ LIGŲ: KLINIKINIS ATVEJIS

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Raktažodžiai: imunoterapija, pažengusi odos plokščialąstelinė karcinoma, cemiplimabas, gretutinės ligos.

Santrauka

Lokaliai pažengusi odos plokščialąstelinė karcinoma (aCSCC) kelia reikšmingų gydymo iššūkių, ypač pacientams, turintiems sunkių gretutinių ligų, kurios riboja gydymo galimybes. Įprasti gydymo metodai, tokie kaip chirurginis gydymas ar spindulinė terapija, silpnesnės būklės pacientams gali būti netinkami, todėl reikia svarstyti alternatyvius metodus, pavyzdžiui, imunoterapiją. Straipsnyje pristatomas 79 metų vyro klinikinis atvejis. Pacientui diagnozuota pasikartojanti pažengusi odos plokščialąstelinė karcinoma, kartu nustatytos kelios sunkios gretutinės ligos, įskaitant išeminę širdies ligą, širdies nepakankamumą, lėtinę inkstų ligą ir hipotirozę. Išsivysčius veidinio nervo parezei ir patvirtinus metastazinę ligą, pacientas buvo gydytas cemiplimabu – užprogramuotos ląstelių žūties baltymo-1 (PD-1) inhibitoriumi – taikant ankstyvos prieigos programą. Nepaisant sudėtingos klinikinės būklės ir svyruojančio funkcinio statuso (ECOG 2–3), stebėta dalinė naviko regresija ir gyvenimo kokybės pagerėjimas, reikšmingų nepageidaujamų reiškinių nenustatyta. Šis klinikinis atvejis parodo, kad cemiplimabas gali būti veiksminga gydymo alternatyva pacientams, sergantiems pažengusia odos plokščialąsteline karcinoma, kai dėl sunkių gretutinių ligų negalima taikyti įprastų gydymo metodų.

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