Updates in Cutaneous Oncology from the 2026 AAD Annual Meeting: A Focus on Cutaneous Squamous Cell Carcinoma and Merkel Cell Carcinoma

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THE AMERICAN Academy of Dermatology (AAD) Annual Meeting represents the largest gathering of leaders in dermatology each year. The most recent conference in Denver, Colorado, provided several key updates in the management of high-risk cutaneous malignancies, specifically cutaneous squamous cell carcinoma (cSCC) and Merkel cell carcinoma (MCC). In this article, the authors highlight sessions at the 2026 Annual Meeting relevant to these areas.

UPDATES IN CUTANEOUS ONCOLOGY

There is a compelling need to stratify cSCC based on risk.[1] The Brigham and Women's Hospital (BWH) and American Joint Committee on Cancer (AJCC) staging systems have traditionally provided a framework to stratify this cancer. AI may serve as an additional tool to stratify cSCC. A prior study demonstrated that a large language model, trained on a comprehensive dataset, can derive a prognostic model that has higher sensitivity than both the BWH and AJCC systems.[2] AI-derived prognostic models may assist providers in determining which patients may benefit from sentinel lymph node biopsy or nodal imaging at baseline. Gene expression profiling is another promising tool for identifying high-risk tumors. A novel 14-gene expression profile was shown to have a sensitivity of 65.1% and a specificity of 80.5% for cSCC metastasis.[3]

For patients with virally mediated MCC, anti-MCPyV antibody titers (AMERK) may be used in surveillance. Roughly 50% of patients will have AMERK seropositivity at baseline.[4] Patients who are seropositive at baseline have lower recurrence risk than seronegative

> **There is a compelling need to stratify cSCC based on risk**

patients.[4] In seropositive patients, AMERK titers can be followed during surveillance. A meaningful decline in AMERK titer, at least a 30% reduction, was associated with a 99.3% likelihood of being recurrence-free in the subsequent 3 months, whereas a rising titer was associated with a 58% risk of recurrence within the year.[5]

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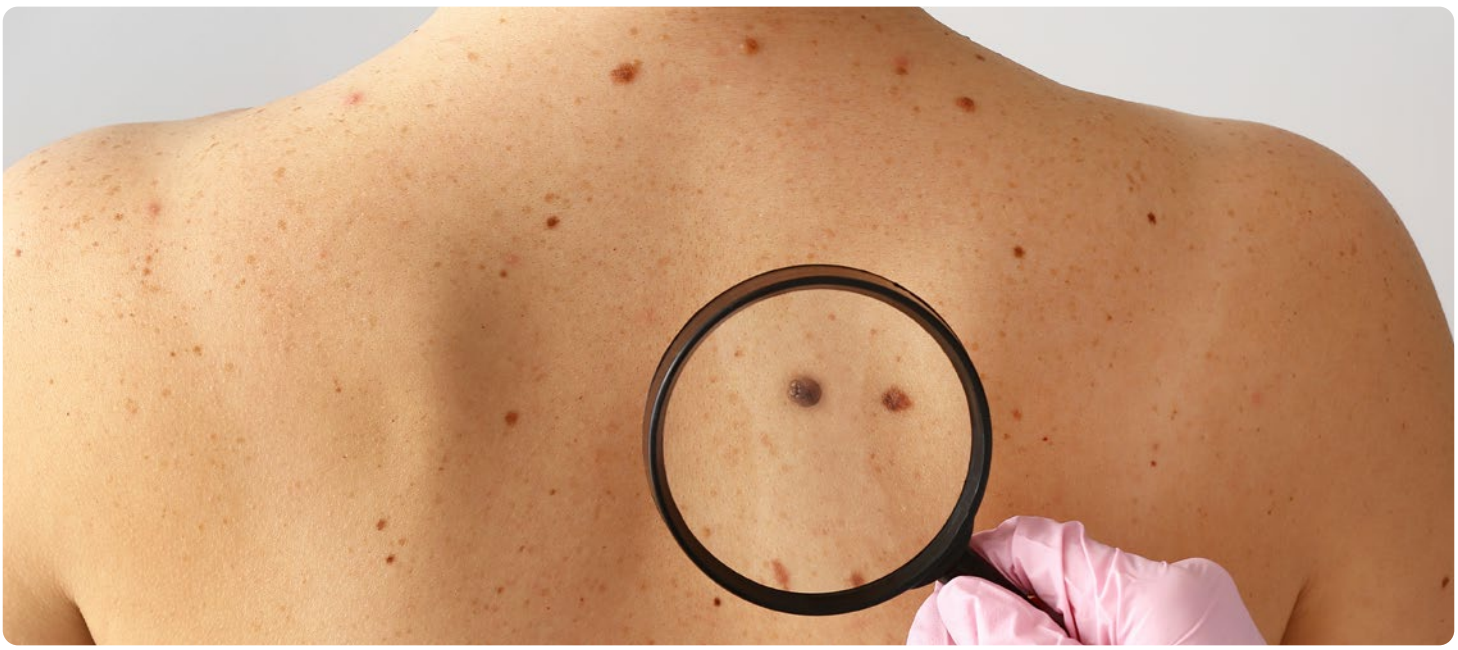
Circulating tumor DNA (ctDNA) is another promising biomarker for the detection of MCC recurrence. In a study of 319 patients with Stage I–IV MCC, a positive ctDNA test during surveillance was associated with increased recurrence risk, with a hazard ratio of 6.8.[6] In a subset analysis of 84 patients who underwent curative-intent treatment, a positive ctDNA test within 4 months after treatment was associated with a 1-year recurrence rate of 74%, compared with 21% in those for whom ctDNA was negative during the same interval.[6] A positive ctDNA value precedes clinical evidence of recurrence by a median of 2.7 months.[7]

ADVANCES IN THE MANAGEMENT OF CUTANEOUS ONCOLOGY

Pre-operative management of cSCC, specifically the use of neoadjuvant immunotherapy, is an area of significant research. The MATISSE trial, which consisted of 40 patients who had an indication for extensive surgery, found that neoadjuvant nivolumab yielded major pathologic response in 40% of patients, whereas neoadjuvant combination immunotherapy (nivolumab with ipilimumab) yielded major pathologic response in 53%.[8] Notably, nine patients declined surgery with or without adjuvant radiotherapy due to self-reported remission after neoadjuvant immunotherapy, and all nine remained disease-free in follow-up.[8] Any potential benefit of neoadjuvant immunotherapy must be weighed carefully against risks, specifically immune-related adverse events. Further study is needed to elucidate the dose response to neoadjuvant immunotherapy, helping providers identify the minimum dose required to yield durable benefit.



There are parallels in the emerging understanding of neoadjuvant immunotherapy between cSCC and MCC. In a prospective study of 39 patients with Stage IIA-IV resectable MCC who received at least one pre-operative dose of nivolumab before resection, approximately half of the patients achieved a pathologic complete response.[9] Both pre-operative radiographic reduction in tumor burden by ≥30% and a pathologic complete response were associated with longer recurrence-free survival.[9]

LILA AND MURRAY GRUBER MEMORIAL CANCER RESEARCH AWARD AND LECTURESHIP

The management of advanced MCC has undergone significant transformation in the past decade.[10] Cytotoxic chemotherapy used to be the standard of care for advanced MCC. However, responses to chemotherapy were typically not durable, with a median progression-free survival of 3 months.[11] Immunotherapy has revolutionized care for patients with advanced MCC. In 2016, a prospective trial demonstrated that pembrolizumab yielded a 62% response rate among virus-positive MCC and a 44% response rate among virus-negative MCC.[12] Since 2017, three immune checkpoint inhibitors have been approved for advanced MCC, including avelumab, pembrolizumab, and retifanlimab.[13] On a population-level, the introduction of immune checkpoint inhibitors has aligned with an at least two-fold increase in survival for advanced MCC.[14] Further study is needed to determine therapeutic options for the roughly 50% of patients with advanced MCC who do not have a sustained response to immune checkpoint inhibitor therapies.

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