have undergone a prior allogeneic organ or bone marrow transplant, should receive targeted therapy.

The other cohort where treatment is not established is stage IIIA disease with small lymph node metastases (<1 mm diameter). (The eighth edition of the AJCC Staging Manual now classifies primary tumors that are >2 mm and involve sentinel lymph nodes as IIIB instead of IIIA.) Patients with this volume of disease have not been included in any of the recent trials and likely have a low risk for recurrence and death, while therapy may have a risk-benefit ratio that makes observation preferable. In the future, adjuvant therapy will lead to scenarios where anti-PD-1 or targeted therapy has been administered and the patient relapses.

The question is who will benefit from retreatment in these instances, and how long will the disease-free period have to last to begin retreatment?

Given the promising data that have emerged for the new adjuvant therapies, further research into novel combinations of these agents as well as ongoing and future trials that directly compare targeted therapies to immunotherapy regimens will provide additional information on when best to use which agents in high-risk patients.

### References


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