

# “Doctor, Do I Need a Skin Check?”

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Total-body skin examination (TBSE) is the bedrock on which most general dermatologists' clinic days are built. Primarily performed for all-cause skin cancer detection and prevention, the clinical data and advice imparted during the patient visit disseminate safety guidelines and behavioral patterns that can shape a community's approach to its risk factors and screening practices. Nonetheless, TBSE technique, frequency, and data-driven evidence of improvement in population morbidity and mortality comprise ongoing debate. When a patient asks, “Do I need a skin check?”, the answer is more complicated than one might imagine. For now, each clinician who screens for skin cancer must optimize the face-to-face opportunities with the patient to view as much as we can as often as clinically prudent. As said by Philip Roth, “Seeing is believing and believing is knowing and knowing beats unknowing and the unknown.” Recommendations are provided here for clinicians to address the clinical utility of the screening practices we adopt every day.

## What does your patient need to know at the first visit?

A patient may be scheduled for a total-body skin examination (TBSE) through several routes: primary care referral, continued cancer screening for an at-risk patient or patient transfer, or patient-directed scheduling for general screening regardless of risk factors. At the patient's first visit, it is imperative that the course of the appointment is smooth and predictable for patient comfort and for a thorough and effective examination. The nurse initially solicits salient medical history, particularly personal and family history of skin cancer, current medications, and any acute concerns. The nurse then prepares the patient for the logistics of the TBSE, namely to undress, don a gown that ties and opens in the back, and be seated on the examination table. When I enter the room, the conversation commences with me seated across from the patient, reviewing specifics about his/her history and risk factors. Then the TBSE is executed from head to toe.

## Do you broadly recommend TBSE?

Firstly, TBSE is a safe clinical tool, supported by data outlining a lack of notable patient morbidity during the examination, including psychosocial factors, and it is generally well-received by patients (Risica et al). In 2016, the US Preventative Services Task Force (USPSTF) outlined its recommendations regarding screening for skin cancer, concluding that there is insufficient evidence to broadly recommend TBSE. Unfortunately, USPSTF findings amassed data from all types of screenings,

including those by nondermatologists, and did not extract specialty-specific benefits and risks to patients. The recommendation also did not outline the influence of TBSE on morbidity and mortality for at-risk groups. The guidelines target primary care practice trends; therefore, specialty societies such as the American Academy of Dermatology issued statements following the USPSTF recommendation outlining these salient clarifications, namely that TBSE detects melanoma and keratinocyte carcinomas earlier than in patients who are not screened. Randomized controlled trials to prove this observation are lacking, particularly because of the ethics of withholding screening from a prospective study group. However, in 2017, Johnson et al outlined the best available survival data in concert with the USPSTF statement to arrive at the most beneficial screening recommendations for patients, specifically targeting risk groups—those with a history of skin cancer, immunosuppression, indoor tanning and/or many blistering sunburns, and several other genetic parameters—for at least annual TBSE.

The technique and reproducibility of TBSE also are not standardized, though they seem to have been endearingly apprenticed but variably implemented through generations of dermatology residents going forward into practice. As it is, depending on patient body surface area, mobility, willingness to disrobe, and adornments (eg, tattoos, hair appliances), multiple factors can restrict full view of a patient's skin. Recently, Helm et al proposed standardizing the TBSE sequence to minimize omitted areas of the body, which may become an imperative

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tool for streamlined resident teaching and optimal screening encounters.

### How do you keep patients compliant with TBSE?

During and following TBSE, I typically outline any lesions of concern and plan for further testing, screening, and behavioral prevention strategies. Frequency of TBSE and importance of compliance are discussed during the visit and reinforced at checkout where the appointment templates are established a year in advance for those with skin cancer. Further, for those with melanoma, their appointment slots are given priority status so that any cancellations or delays are rescheduled preferentially. Particularly during the discussion about TBSE frequency, I emphasize the comparison and importance of this visit akin to other recommended screenings, such as mammograms and colonoscopies, and that we, as dermatologists, are part of their cancer surveillance team.

### What do you do if patients refuse your recommendations?

Some patients refuse a gown or removal of certain clothing items (eg, undergarments, socks, wigs). Some patients defer a yearly TBSE upon checkout and schedule an appointment only when a lesion of concern arises. My advice is not to shame patients and to take advantage of as much as the patient is able and comfortable to show us and be present for, welcoming that we have the opportunity to take care of them and screen for cancer in any capacity. In underserved or limited budget practice regions, lesion-directed examination vs TBSE may be the only screening method utilized and may even attract more patients to a screening facility (Hoorens et al).

In the opposite corner are those patients who deem the recommended TBSE interval as too infrequent, which poses a delicate dilemma. In my opinion, these situations present another cohort of risks. Namely, the patient may become (or continue to be) overly fixated on the small details of every skin lesion, and in my experience, they tend to develop the habit of expecting at least 1 biopsy at each visit, typically of a lesion of their choosing. Depending on the validity of this expectation vs my clinical examination, it can lead to a difficult discussion with the patient about oversampling lesions and the potential for many scars, copious reexcisions for ambiguous lesion pathology, and a trend away from prudent clinical care. In addition, multiple visits incur more patient co-pays and time away from school, work, or home. To ease the patient's mind, I advise to call our office for a more acute visit if there is a lesion of concern; I additionally recommend taking a smartphone photograph of a concerning lesion and monitoring it for

changes or sending the photograph to our patient portal messaging system so we can evaluate its acuity.

### What take-home advice do you give to patients?

As the visit ends, I further explain that home self-examination or examination by a partner between visits is intuitively a valuable screening adjunct for skin cancer. In 2018, the USPSTF recommended behavioral skin cancer prevention counseling and self-examination only for younger-age cohorts with fair skin (6 months to 24 years), but its utility in specialty practice must be qualified. The American Academy of Dermatology Association subsequently issued a statement to support safe sun-protective practices and diligent self-screening for changing lesions, as earlier detection and management of skin cancer can lead to decreased morbidity and mortality from these neoplasms.

## Resources for Patients

American Academy of Dermatology's SPOT Skin Cancer  
<https://www.aad.org/public/spot-skin-cancer>

Centers for Disease Control and Prevention:  
 What Screening Tests Are There?  
[https://www.cdc.gov/cancer/skin/basic\\_info/screening.htm](https://www.cdc.gov/cancer/skin/basic_info/screening.htm)

## SUGGESTED READINGS

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