

Time Constraints Limit Full-Body Skin Exams

BY MARY ANN MOON

FROM THE ARCHIVES OF DERMATOLOGY

A majority of dermatologists, internists, and family physicians routinely perform full-body examinations for skin cancer – but time constraints and patient reluctance are common barriers to better exam rates, according to a recent report.

A total of 81% of dermatologists, 56% of internists, and 60% of family physicians in a nationally representative sample reported that they routinely perform skin cancer examinations.

All three groups of physicians also identified barriers to performing skin examinations more often, but the barriers varied by specialty, said Susan A. Oliveria, Sc.D., of Memorial Sloan-Kettering Cancer Center's dermatology service, New York, and her associates (*Arch. Dermatol.* 2011;147:39-44).

The investigators assessed skin cancer screening practices because little is known about the subject, and a better understanding both of the obstacles and of the facilitating factors could help improve pri-

mary and secondary screening.

To examine the issue, the researchers used data from a survey to which 1,669 physicians in group or solo private practice responded. The respondents included 679 dermatologists, 431 internists, and 559 family physicians. Most reported that they saw 200-600 patients per month, and most were aged 41-60 years.

Approximately 54% of internists and family physicians reported that time constraints prevented them from doing full-body skin exams more frequently, compared with 31% of dermatologists. Half of the internists and family physicians also said that "competing comorbidities" often took priority over skin exams, compared with only 16% of dermatologists.

In contrast, significantly more dermatologists (44%) identified patient embarrassment or reluctance as a barrier to performing full-body skin exams, compared with internists (33%) or family physicians (31%). That is likely because most patients see a dermatologist for an

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Major Finding: 81% of dermatologists, 56% of internists, and 60% of family physicians report that they routinely perform full-body examinations for skin cancer.

Data Source: Survey of a representative sample of 679 dermatologists, 431 internists, and 559 family physicians.

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isolated skin condition such as a wart or rash, the investigators noted, and do not expect to undress for a full-body exam.

In contrast, patients expect to undress for an internist or family physician, because disrobing for pelvic or rectal exams often is part of their annual physical examinations. Moreover, primary care physicians "have years to build up relationships with their patients," the study authors explained, while dermatologists typically do not.

To overcome that barrier, "dermatologists could educate their patients ... by providing them with written material to read and establishing a comforting physi-

cian-patient relationship," Dr. Oliveria and her colleagues said.

All the physicians said that they were more likely to screen for skin cancer in patients who had one or more risk factors, but only 87% of dermatologists, 65% of internists, and 70% of family physicians reported that they performed full-body exams in most high-risk patients.

Another common reason for performing a full-body skin cancer screen was the same for all three specialties: having a patient ask to have such an exam or to have a suspicious mole checked. That shows that it is important to maintain public education programs encouraging patients to request such exams, the researchers said.

Fewer internists (56%) and family physicians (54%) than dermatologists (78%) reported that their skill and expertise at performing skin exams and diagnosing skin cancer facilitated their screening practices. That finding suggests that enhanced dermatologic training in medical school and continuing medical education programs would be beneficial, they added. ■

Early Treatment Strategy Boosts Onychomycosis Cure Rate

BY BRUCE JANCIN

FROM THE ANNUAL CONGRESS OF THE EUROPEAN ACADEMY OF DERMATOLOGY AND VENEREOLOGY

GOTHENBURG, SWEDEN – Onychomycosis remains a difficult disorder to treat and cure, even with modern antifungal agents. But the chances of success can be greatly enhanced through application of several proven, evidence-based strategies.

A recent study identified multiple baseline factors associated with a low cure rate following a standard 3-month course of oral terbinafine for onychomycosis. One preemptive strategy in patients possessing several of these poor-prognosis factors is to consider combination therapy from the outset. Alternatively, the standard 3 months of terbinafine could be stretched for 5-6 months, Dr. Bardur Sigurgeirsson said at the meeting.

The host-related prognostic factors were identified in Dr. Sigurgeirsson's recent secondary retrospective analysis of 3-year outcomes in 199 Icelandic participants in a large international randomized trial of continuous versus intermittent terbinafine (*J. Eur. Acad. Dermatol. Venereol.* 2010;24:679-84).

Several of the prognostic factors were already known, but the study provided the first-ever supporting data validating their legitimacy, said Dr. Sigurgeirsson of the University of Iceland, Reykjavik.

In the multivariate, logistic, regression analysis, baseline factors associated with a negative outcome at 72 weeks of follow-up – that is, failure to achieve mycologic or clinical cure – included matrix involvement, lateral nail edge involvement, and dermatophytoma. Slow nail growth from screening to baseline was another predictor of lack of cure; this makes sense, as patients with faster-growing nails are likely to shed the infected part sooner, he noted.

Other factors enabling physicians to select good candidates for up-front combination or extended therapy were being over age 65 years, being male, having a history of prior fungal toe infection, and having a positive culture at 24 weeks' follow-up, even if the nails look good at that point.

Several factors in popular dermatologic lore to predict poor outcome were not borne out in the study. The extent of infection involvement, the number of infected toenails, duration of infection, and presence of spikes were unrelated to the 72-week cure rate. The greatest likelihood of cure at 72 weeks' follow-up after the standard 3 months of oral terbinafine was seen in younger female patients with fast nail growth.

An earlier, randomized, multi-



White superficial onychomycosis is seen on the surface of the toenails.

center study by Dr. Sigurgeirsson and coworkers made the case for up-front combination therapy with amorolfine hydrochloride 5% nail lacquer and oral terbinafine for treating onychomycosis in patients with terbinafine monotherapy lack-of-cure risk factors. The trial involved 249 patients; one of the strongest predictors of poor outcome was baseline nail matrix involvement. The success rate at 18 months was 59% for combination therapy, compared with 45% for oral terbinafine monotherapy. The cost per cure was significantly less with combination therapy (*Br. J. Dermatol.* 2007;157:149-57).

Onychomycosis is best viewed as a chronic relapsing condition, as evidenced by a 5-year, blinded, prospective follow-up study Dr. Sigurgeirsson and colleagues conducted in terbinafine- or itraconazole-treated patients (*Arch. Dermatol.* 2002;138:353-7). The mycologic relapse rates were 53% in the itraconazole arm and 48% with terbinafine.

In a subsequent study of nearly 4,000 patients, the investigators identified a number of risk factors for recurrent onychomycosis: cancer, 3.4-fold increased risk; psoriasis, 2.4-fold increased risk; tinea pedis interdigitalis, 3.9-fold increased risk; moccasin form of tinea pedis, 4.3-fold increased risk; and having a spouse, parents, or children with onychomycosis, 2.5- to 3.5-fold increased risk (*J. Eur. Acad. Dermatol. Venereol.* 2004;18:48-51).

Prophylactic therapy is worth considering following cure of onychomycosis in patients at increased risk for relapse based upon their risk factor profile, Dr. Sigurgeirsson said. He and his coworkers recently showed that amorolfine nail lacquer applied once every 2 weeks is safe and effective for this purpose (*J. Eur. Acad. Dermatol. Venereol.* 2010;24:910-5).

Many of his studies of terbinafine for onychomycosis were supported by research grants from Novartis. ■

Predictors of Failure to Cure Onychomycosis With 3 Months of Terbinafine

Baseline clinical factor	Increase in odds of clinical cure not being achieved at 72 weeks
Age greater than 65 vs. 18-40 years	3.7
Dermatophytoma	2.9
Positive culture at 24 weeks	2.7
Male gender	2.6
Nail matrix involvement	2.5
Lateral nail edge involvement	2.4
Prior nail infection	2.3
Age greater than 65 vs. 41-65 years	2.3
Positive microscopy at 24 weeks	1.8
Baseline length of nail growth	1.5

Source: Dr. Sigurgeirsson