All-Star Player Shares Story of Melanoma Dx

BY DOUG BRUNK
San Diego Bureau

CORONADO, CALIF. — As a two-time all-star Major League Baseball player, Mark Loretta knows a thing or two about how to handle pressure.

But nothing could prepare the second baseman for the curve ball diagnosis of melanoma he received in the summer of 2004 during a routine skin screening program sponsored by Major League Baseball and the American Academy of Dermatology.

Mark Loretta's encounter with stage I melanoma inspired him to use his fame to impart a simple message to fans: Get to a physician and get checked for skin cancer.

There, a dermatologist noticed a mole on the center of his chest.

"It's something I felt had there for a long time, but the doctor said, 'This looks a bit precarious. It looks like a bad actor. We probably don't need to take it off today, but after the season's over why don't you have it looked at?' " Mr. Loretta said at an update on melanoma sponsored by the Scripps Clinic.

In October of that year he had the lesion biopsied and it came back positive for stage I melanoma. A month later the lesion was removed in a wide excision operation performed by Dr. Hubert T. Greenway Jr., director of cutaneous oncology at the Ida M. and Cecil H. Green Cancer Center at Scripps Clinic, La Jolla, Calif.

The lesion "was the size of a large piece of sushi," said Mr. Loretta, who signed with the Houston Astros in January after playing for the Boston Red Sox last year. "I didn't expect such a large piece to be taken out."

His current follow-up regimen involves clinical exams every 3 months.

He went on to note that two aspects of his diagnosis and treatment proved difficult from a patient standpoint. One was the anxiety of "not knowing what you're dealing with," he said, explaining that you can get on the Internet "and get bits of information [about melanoma] here and there, and all of a sudden your head starts spinning. You start reading about sentinel node biopsy, about chemotherapy and radiation."

Mr. Loretta, who grew up in Southern California and had an uncle who died from melanoma, also said that he underestimated what the wide excision procedure was going to entail.

That "was probably based on where the tumor was, in the center of my chest, which doesn't have a lot of meaty tissue," he said. "I also underestimated the time it would take for me to recover."

During public speaking engagements to raise awareness of skin cancer, Mr. Loretta said that he imparts a simple message: "Get in and get checked. "A skin exam, he noted, is "not very invasive." ■

Melanoma Screens Deemed Cost Effective

BY MARY ANN MOON
Contributing Writer

One-time melanoma screening in the general population for those aged 50 years and older was found to be very cost effective—comparable with screening for breast, cervical, and colorectal cancer—in a computer simulation model.

Similarly, the screening of siblings of melanoma patients every other year also was found to be cost effective, reported Elena Losina, Ph.D., of Boston University School of Public Health, and her associates. Siblings of melanoma patients are considered to be at risk.

"Melanoma is the only cancer for which [incidence and mortality] are rising unabated, while screening, the potential means for reducing the burden of disease, continues to be underused," the researchers said (Arch. Dermatol. 2007;143:21-8).

Several national committees have debated the usefulness of population-based melanoma screening, but have never included it in recommended guidelines because there is no conclusive evidence that skin examination by clinicians reduces skin cancer morbidity or mortality. This, in turn, may stem from the fact that no randomized clinical trials of the issue have been conducted because of prohibitive costs and logistic complexity, Dr. Losina and her associates said.

"Cost-effectiveness analysis is particularly useful when randomized controlled trials cannot be done because of ethical or logistic considerations. In the case of melanoma, the low overall disease prevalence and incidence would require more than 360,000 study participants [followed] for 10 years to identify statistically significant differences in the outcome of screening," they said.

The investigators developed a computer simulation model to assess the cost-effectiveness of four different strategies for melanoma screening. The first was background screening only (skin examination at a routine primary physician visit, followed by referral to a dermatologist if necessary). The second strategy was a one-time screening by a dermatologist. They also measured the cost-effectiveness of once per year as well as once every other year screening by a dermatologist.

The screening of at-risk siblings of melanoma patients every other year had a cost-effectiveness ratio of $35,500 per each quality-adjusted life year gained.

All strategies commenced at age 50 years.

These strategies were applied to three patient populations: a general population; siblings of melanoma patients; and siblings with at least two first-degree relatives with melanoma, considered to be at high risk.

The simulation relied on unproven assumptions about melanoma progression; rates of recurrence and mortality; and costs of treatment for local, regional metastatic, and diffuse metastatic disease, the investigators noted.

One-time screening of the general population by a dermatologist had a cost-effectiveness ratio of $10,100 per quality-adjusted life year (QALY) gained, Dr. Losina and her associates said.

Meanwhile, screening of at-risk and high-risk siblings of melanoma patients every other year had a cost-effectiveness ratio of $35,500 per QALY gained.

"Interventions in the United States are generally considered cost effective at less than $50,000 per QALY gained," the researchers noted.

In comparison, the cost-effectiveness ratio is $30,500 per QALY for mammography every other year, $24,100 per QALY for annual Pap tests, and $47,400 per QALY for colorectal cancer screening every 5 years, the researchers said. ■