Annual Melanoma Follow-Up Found Sufficient

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WAIKOLOA, HAWAII — Dermatologic surveillance following diagnosis of a primary melanoma is often overly intensive, Dr. Daniel G. Coit asserted at the annual Hawaii dermatology seminar sponsored by Skin Disease Education Foundation.

"The key recommendation for melanoma patients is that they ought to go on lifetime dermatologic surveillance. But I'm here to help you, not to hurt you. We find a lot of patients who are fairly low risk undergoing dermatologic surveillance every 3 months for the rest of their lives. I think this needlessly imposes an unreasonable burden on the shoulders of my teammates in dermatology," noted Dr. Coit, a surgeon who is coleader of the melanoma disease management team at Memorial Sloan-Kettering Cancer Center in New York and a member of the American Joint Committee on Cancer melanoma staging committee.

"You don't need to follow up everybody three or four times a year," he emphasized. Indeed, annual skin surveillance is entirely appropriate in melanoma patients who are not in a subgroup at elevated risk for another primary melanoma, he said.

And who are these high-risk subgroups? Most notably, melanoma patients who have dysplastic nevi, who have a positive family history for melanoma, or who have already been diagnosed with a second primary tumor, Dr. Coit continued.

Several years ago he and his Sloan-Kettering colleagues examined this issue of second primary melanomas in detail. They reported on 4,484 patients with primary melanoma followed prospectively at the tertiary cancer center; 8.6% went on to have two or more primary melanomas. Patients with more than one primary melanoma averaged 2.3.

The estimated cumulative 5-year risk of a second primary melanoma was 11.4%. Fifty-nine percent of patients presented with their second primary tumor within 1 year of their first. After that first year, the incidence in patients without a family history of dysplastic nevi leveled off at about 0.3% per year, less than many physicians might expect. Interestingly, that low long-term annual rate was quite similar to the figure reported in an earlier analysis of the Duke University (Durham, N.C.) melanoma database, Dr. Coit noted (Surgery 1993;113:330-9).

Not only were the majority of second primary melanomas detected during the first year of surveillance in the Sloan-Kettering series, but most of those diagnosed in the first year were found at the time the initial primary was diagnosed.

"With the heightened awareness created by finding a primary melanoma, these patients undergo a complete and very thorough review, and other suspicious lesions are biopsied. After that the slope of the curve [of incident second primary melanoma] is actually pretty flat," according to Dr. Coit.

This was not the case, however, in the high-risk subgroups. In such patients, a case can be made for lifetime dermatologic surveillance more often than annually, he said.

In the Sloan-Kettering study, the subgroup of melanoma patients at highest risk of another primary tumor consisted of patients who had already been diagnosed with a second primary melanoma; they had a 15.6% incidence of a third primary tumor within 1 year of their second and a 31% probability of developing a third primary within 5 years (JAMA 2005;294:1647-54).

Forty-nine percent of patients had their second primary melanoma on the same body site as their first. The greatest site concordance was 60% for lesions on the extremities.

Dr. Keith T. Flaherty observed that the risk over time is not linear. It depends, instead, upon the stage of the first primary melanoma. The risk is greatest early on for those with high-risk disease and much more spread out over time in patients with early-stage disease.

"That needs to inform our surveillance," said Dr. Flaherty, who is a medical oncologist at the University of Pennsylvania in Philadelphia.

Dr. Coit concurred. "I'd go so far as to say that almost no one with early-stage disease recurs early, and almost no one with late-stage disease recurs late," he added.

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