

Extracutaneous Melanomas Can Be Easily Missed

The scalp, nail beds, interdigital folds, and perianal skin deserve close inspection during a routine exam.

BY DOUG BRUNK
San Diego Bureau

SAN DIEGO — Extracutaneous melanomas are rare—they make up only 15% of all melanomas—but small primary lesions can be easily overlooked during a routine skin exam, according to one expert.

Sites that require close inspection include the scalp, nail beds, interdigital folds, and perianal skin. These areas “are easily accessible to clinical exam and can make a big difference for your patients,” Dr. Terence C. O’Grady said at an update on melanoma sponsored by the Scripps Clinic.

The most commonly affected sites for extracutaneous melanoma include the ocular or juxtacutaneous mucosal membranes, said Dr. O’Grady, who directs the

dermatology residency program at the University of California, San Diego.

The three most common metastatic locations include the lungs (70%), the liver (68%), and the bowels (58%). Other sites include the pancreas (50%), the adrenal gland (50%), the heart (49%), kidneys (45%), brain (39%), thyroid (39%), and spleen (36%), he said.

Melanoma can metastasize to these sites in a number of ways. A melanoma could have been completely removed without histologic examination.

“You could also have a completely regressed melanoma at another site that was not treated,” he said.

“This can be a real problem because there is no evidence of a pre-existing lesion. In our clinic, if we don’t see a primary lesion we do a Wood’s light exam and look for hypopigmented areas that

may represent previously regressed lesions. Unfortunately, when you biopsy these regressed areas, the only thing you usually see is pigment incontinence on the histology, so there’s no evidence that the melanoma was ever there,” Dr. O’Grady said.

Because it’s rare to find primary melanomas in these locations, he continued, “it’s more probable that these lesions are metastatic to that site rather than being a primary lesion.”

The five most common locations of primary extracutaneous melanoma include the eye (79%), the vulva (7%), soft tissues (3%), anorectum (2%), and the vagina (2%), according to Dr. O’Grady. “Many of us loathe to do an exam of the genitalia, but [lesions in this area] do occur,” he said. “I usually tell patients that have had a melanoma or are at high risk for melanoma to bring this point up with other physicians they [may see], so they can have those areas examined.”

Dr. O’Grady said that he begins his skin

examinations at the scalp and works his way down to the feet.

“I always tell patients who wear nail polish to have that removed for the exam so I can see the nail bed,” he said. “I look at the interdigital folds and at the bottom of the feet. Patients always wonder, ‘What are you looking for in between my toes?’ I tell them, ‘You can get pigmented lesions in those areas. You can also get melanomas in those areas.’”

He also emphasized the importance of biopsying lesions detected in subungual areas. “These lesions can be impossible to diagnose without a biopsy, but a lot of [clinicians] don’t feel comfortably doing a nail biopsy,” said Dr. O’Grady.

“Not only is that a problem, but when you send it to pathology and you don’t have someone who knows how to handle nail specimens, you’re going to end up with a very nondiagnostic specimen. You want to see the skin on top of the nail, the nail plate, and the subungual tissue,” he said. ■

Total Body Photography Helps Reduce Unnecessary Biopsies

BY SHARON WORCESTER
Southeast Bureau

SAN ANTONIO — The use of total body photography as a surveillance tool for melanoma has great potential to reduce the number of unnecessary biopsies, Dr. Allan C. Halpern said at the annual meeting of the American Academy of Dermatology.

When used appropriately in conjunction with self-examination and regular follow-up, total body photography (TBP) can also increase the likelihood of detecting thinner melanomas, said Dr. Halpern, chief of dermatology at Memorial Sloan-Kettering Cancer Center, New York.

Although it does have some disadvantages—namely the possibility of raising the threshold for removal of lesions in favor of follow-up in patients who may not return for follow-up—it also has a number of possible advantages for both patients and physicians, he said.

The key is to use TBP cautiously. The first visit is not the time to raise the threshold for removing a suspicious lesion in anticipation of using TBP for surveillance. Instead, build a relationship before relying on the patient to perform self-evaluations and come in for routine follow-up visits. Once a relationship is established and the patient is compliant, TBP can be a great tool for engaging patients in their own care and increasing patient satisfaction, he noted.

The sensitivity and specificity of TBP for melanoma are increased in those who do come back. Studies have shown that patients who are engaged in their care because they receive copies of the photos and are asked to do monthly self-examinations by comparing lesions with the photos are more likely to do self-examinations and are more likely to be effective when performing self-examinations than are patients who do not receive photos, Dr. Halpern said.

As a result, the use of TBP is increasing. A survey of AAD members showed 63% of 105 residency programs use TBP and 49% of AAD members use it at least some of the time in patients with dysplastic nevi. Furthermore, 83% of programs with specialized pigmented lesions clinics and 49% of those without such a clinic are using TBP.

Those who don’t use TBP cite perceived logistical difficulties, financial constraints, and doubt about its benefits as reasons for not using it, he said.

The use of TBP requires only a digital camera of at least 6-12 megapixels (although he uses one with 40 megapixels), a computer, and a space with good lighting and the availability of a blue or black backdrop, Dr. Halpern ex-

plained, also noting that a CPT code for TBP exists.

As for benefits, one small study showed no difference in detection of melanoma for those who used and didn’t use TBP. It did show an increase in sensitivity and specificity for detection of nonmelanomas, and another showed that twice as many patients who received photos were compliant with recommended care, including self-examination, than those who were not.

The actual taking of the photographs can be uncomfortable for the patient, so it is a good idea to perform a physical examination first. Dr. Halpern always starts with the patient facing away from him to allow the patient time to acclimate to the discomfort of the situation and to allow himself time to regain composure before facing the patient should he encounter an alarming lesion.

Photos can be taken by the physician, a specially trained nurse, or a medical photographer. Some practices have a photographer on staff, and hospitals may employ photographers and be accommodating when it comes to TBP services. “You can achieve very high-quality pictures if you nail down a system and use it in a sufficiently standardized fashion,” Dr. Halpern said, noting that there are papers in the literature to provide guidance for using TBP.

Basically, as much of the body surface as possible should be photographed, and positioning should be chosen to allow this.

Side-by-side (photos and patient) examinations can then be conducted at follow-up visits. He recommended examining patients while they are standing, which makes it easier to compare lesions against those in the photos.

Patient privacy needs to be carefully protected, so photos kept on office computers should be encrypted, he said.

Patients should be provided with hard copies and a compact disk along with a photo-marking pen that they



Patients who receive copies of their photos, and are asked to do monthly self-exams, are more likely to do the exams and be effective in doing so, said Dr. Allan C. Halpern.

can use to mark the photographs if they find something of concern on their monthly self-examination.

It is important to inform patients that their role in performing self-examinations is not meant to be anxiety provoking; rather it should be an exercise in becoming familiar with the big picture so they can recognize obvious changes and fast-growing lesions that might be of concern.

Dr. Halpern used a night-sky analogy to describe how patients should view their photos. If they become familiar with their own “constellations,” they will notice when something new appears in the field, or if something other than the North Star is shining brightest. The patient’s job is to notice the obvious changes; the physician’s job is to find the subtle changes, he said.

As for which patients are the best candidates for TBP, he suggested using it for those with dysplastic nevi who have undergone many excisions and those with a familial or personal history of melanoma. No prospective data exist to guide how often patients should be seen, but every 6 months has been a good interval in Dr. Halpern’s experience. “We do find the vast majority of melanomas in surveillance with these patients. ... This is one of the major reasons for doing total body photograph.” ■