All Patients Should Receive Complete Skin Exam

BY BRUCE K. DIXON
Chicago Bureau

CHICAGO — Dermatologists who conducted complete skin examinations of all their patients would detect more melanomas, and those cancers would be detected earlier, Dr. Jonathan Kantor said at the annual meeting of the American Society for Dermatologic Surgery.

"Full skin examination is a critical tool for detecting melanoma in patients visiting a dermatology or dermatologic surgery office," said Dr. Jonathan Kantor, who is in private practice in Jacksonville, Fla.

According to one published survey, only about 30% of dermatologists perform full skin examinations on all their patients, and half of respondents said that they screened only those patients deemed to be at increased risk (J. Am. Acad. Dermatol. 2002;46:710-4).

This survey "suggests that half of dermatologists are not screening patients at high risk of melanoma," said Dr. Kantor.

"Clearly, we cannot find all melanomas just by saying 'hello,' shaking the patient's hand, and talking to him about his acne. We know that when we screen patients actively, we're going to find melanomas at earlier stages," he said.

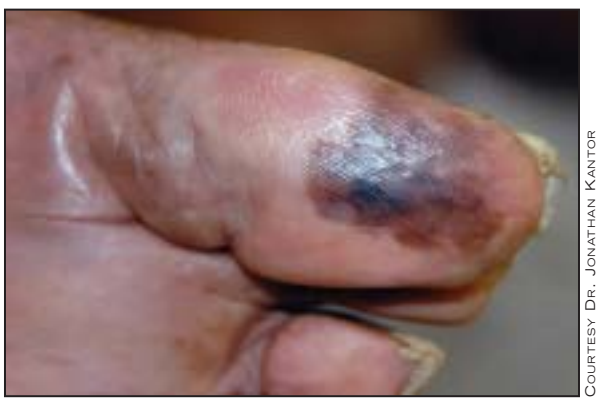
For this study, Dr. Kantor drew on 2 years of data on 76 consecutive patients who were diagnosed in an office setting, either with invasive melanoma (30) or melanoma in situ (46). Their average age was 60 years; 63% were men.

A total of 41 patients (54%) had made appointments because they saw something suspicious on their skin and thought it should be looked at. The remaining 35 (46%) came in for other reasons, such as acne, dry skin, warts, and other conditions, he explained.

Body locations for the melanomas were fairly evenly distributed among the head and neck, trunk, and extremities, with the lower extremities being slightly less represented. The trunk was the most common site of melanomas in men, but the legs were the most common site for women.

Dr. Kantor concluded that 46% of all the melanomas (43% of invasive melanomas and 48% of in situ lesions) may not have been found without the careful skin examination.

Physician-detected melanomas tended to be thinner, and at the in situ stage; although these trends were not statistically significant, they highlight the clinical validity of the study data. "It makes sense that screening finds melanoma earlier and at a stage where hopefully they're more likely to respond to treatment," Dr. Kantor said.



COURTESY DR. JONATHAN KANTOR

This melanoma in situ was found on the foot of an 88-year-old who presented with a complaint of dry skin. Her toe was saved with geometric excision.

Although he believes that this study has implications for both clinical practice and health policy—including screening recommendations—he conceded its important limitations. "Obviously, these data are not generalizable and this was a retrospective analytical case series, which limits further analysis. Also, there's the issue of screening versus examination. Those who are examined in a physician's office may be at higher risk than those who attend skin cancer screenings," he said.

Yet, he added, dermatologists should consider doing complete skin examinations on all patients and let future studies fill in the gaps left by this initial research.

The U.S. Preventive Services Task Force has concluded that there is insufficient evidence to recommend for or against routine screening for skin cancer using a total body examination.

"One of my main jobs as a dermatologist is to find melanoma and melanoma in situ, because early detection is an inconvenience while late detection becomes a tragedy," Dr. Kantor said, pointing out that the 10-year survival rate drops from 88% for a 1-mm melanoma to 32% for an ulcerated melanoma larger than 4 mm.

And melanoma in situ should never be underestimated, he added, explaining that in a study of 104 reassessed patients, almost a third of melanomas in situ were reclassified as invasive melanoma (Lancet 2002;359:1921-2). ■

Links Emerging Between Statins, NSAIDs, and Melanoma Prevention

BY DOUG BRUNK
San Diego Bureau

CORONADO, CALIF. — Some day patients may reach for Lipitor or Celebrex as a melanoma prevention agent, Dr. Michael E. Ming speculated at the annual meeting of the Pacific Dermatologic Association.

He described the ideal chemopreventive agent for melanoma as one that is effective, has an acceptable toxicity profile, and is already widely available.

'These intermediate products may activate proteins important in cell growth and cell cycle progression.'

DR. MING

One class of agents that could potentially meet those criteria if effectiveness in humans can be demonstrated is statins, which may prevent melanoma by decreasing production of intermediate products such as farnesyl pyrophosphate and geranylgeranyl pyrophosphate in the pathway from 3-hydroxy-3-methylglutaryl coenzyme A (HMG CoA) to cholesterol.

"These intermediate products may activate proteins important in cell growth and cell cycle progression, so decreased production of these products may lead to decreased activity of mutant forms of those proteins," said Dr. Ming, director of the pigmented lesion clinic at the University of Pennsylvania, Philadelphia.

Supportive evidence comes from several laboratory studies on melanoma cell lines and in mice, and from one clinical trial with melanoma as a secondary outcome (JAMA 1998;279:1615-22), and from a Dutch case-control study of statins and cancer in general (J. Clin. Oncol. 2004;22:2388-94). Other studies, however, have not shown a link between melanoma and statins, including meta-analyses and systematic reviews (JAMA 2006;295:74-80 and Cochrane Database Syst. Rev. 2005:CD003697), and it is difficult to say at this time whether statins are effective preventive agents against melanoma.

Nonsteroidal anti-inflammatory drugs (NSAIDs) represent another class of agents that may protect against melanoma, most likely through inhibition of cyclooxygenase-2 (COX-2), which in turn reduces prostaglandin production, Dr. Ming said.

Supportive evidence comes from a few laboratory studies on melanoma cell lines, including one case-control study in women (Oncol. Rep. 2001;8:655-7) and one case-control study in patients who already had melanoma (Dermatol. Surg. 2005;31:748-52). So far, though, the body of literature on this topic is too small and inadequate to state definitively that there is a link between NSAID use and lower rates of melanoma. In addition, some studies fail to show that COX-2 is expressed in all melanomas (Melanoma Res. 2001;11:587-99).

Other available agents that might help prevent melanoma include vitamins A, C, D, and E, but the current evidence in the medical literature is unclear, and it is difficult to draw meaningful conclusions, said Dr. Ming, who had no relevant conflicts of interest to disclose.

He emphasized that no candidate agent has been definitively established as having chemopreventive properties against melanoma. "Are there agents we can use against melanoma?" he asked. "The answer you have to say right now is not yet, but maybe soon." ■

Merkel Cell Ulceration May Indicate Metastasis

BY FRAN LOWRY
Orlando Bureau

TORONTO — Ulceration and depth of invasion should be included in the staging of Merkel cell cancers, as they are for the staging of melanoma, because of the strong similarities between the two types of neoplasm, Dr. Ralph L. George and Dr. A. McGuire said in a poster presented at the annual meeting of the Canadian Association of Thoracic Surgeons.

As with melanoma, ulceration in a primary Merkel cell cancer appears to be an indication that the tumor has spread.

An analysis of 14 Merkel cell cancer cases found that ulceration was significantly associated with metastatic disease. Depth of invasion was also a sign of advanced disease that "approached but did not achieve statistical significance," Dr. George said in an interview.

Merkel cell cancer is a rare form of cutaneous neuroendocrine neoplasm that is known to have a poor prognosis, but there is limited information on staging Merkel cell cancer and no data on the prognostic significance of ulceration, wrote Dr. George and Dr. McGuire of Kingston (Ont.) Regional Cancer Centre, Queen's University.

After noticing that patients coming to their clinic with either of the cancers had the same risk factors, the physicians decided to compare the prognostic and etiologic characteristics of 232 melanoma cases with those of the Merkel cases.

They documented several important similarities. Like melanoma, Merkel cell cancer was most common in type I, II, and III skin and on sun-exposed areas of the body. In fact, Merkel cell cancer's relationship with sun exposure was "even stronger than that of the melanomas, with a *P* value equal to .026 for the comparison," Dr. George said.

Like melanoma, Merkel cell cancer occurred more in older patients and showed a propensity for full-thickness skin invasion, metastases to regional lymph nodes, and systemic failure.

These data are preliminary and need to be confirmed in a larger study. "Knowing about the staging [may] lead to better treatment. We have systemic treatment for melanoma but we do not have . . . an effective systemic treatment for Merkel at this time. If we can predict a group who are likely to fail, we can perhaps target them with adjuvant therapy," Dr. George said. ■

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