

Risk Profiles Differ for Single, Multiple BCCs

BY SHARON WORCESTER

FROM ARCHIVES OF DERMATOLOGY

The risk profiles for individuals who develop single vs. multiple basal cell carcinoma lesions differ, according to data from the Rotterdam Study.

Of the 10,820 eligible members of the two cohorts used for the large, Dutch, population-based study, 361 (3%) were diagnosed with a single initial basal cell carcinoma (BCC) lesion, and 163 (1.5%) were diagnosed with subsequent BCC lesions during the study period.

After adjusting for numerous factors such as sex, age, smoking history, and educational level, factors found to be significantly associated with developing a first BCC lesion were age (odds ratios of 1.39 and 1.01 for those aged 65-74 years and for those aged 75 years and older, respectively, vs. those younger than age 65 years), and red hair color (OR of 1.98 for red vs. brown or black hair), reported Dr. Ville Kiiski and colleagues at Erasmus Medical Center, Rotterdam, the Netherlands.

Factors associated with a significantly increased risk of developing multiple lesions were lesion location on an upper extremity (hazard ratio 1.49), age younger than 65 years (HRs of 0.58 and 0.65 for those aged 75 years and older and for those aged 65 to 74 years, respectively, vs. those younger than age 65 years), hair color (HR of 1.43 for red vs. brown/black hair), and education level (HR of 1.42 for high vs. low education level), the investigators found (*Arch. Dermatol.* 2010;146:848-55).

VITALS

Major Finding: Factors found to be significantly associated with developing a first basal cell carcinoma lesion were age (ORs of 1.39 and 1.01 for those aged 65-74 years and for those aged 75 years and older, respectively, vs. those younger than age 65 years), and red hair color (OR of 1.98 for red vs. brown or black hair). Factors found to be associated with a significantly increased risk of developing multiple lesions were lesion location on an upper extremity (HR 1.49), age younger than 65 years (HRs of 0.58 and 0.65 for those aged 75 years and older and for those aged 65 to 74 years, respectively, vs. those younger than age 65 years), hair color (HR of 1.43 for red vs. brown/black hair), and education level (HR of 1.42 for high vs. low education level).

Data Source: A large, prospective, population-based cohort study.

Disclosures: The investigators reported no financial disclosures.

This last finding “may be explained by the probability that people with higher levels of education (which correlates strongly with socioeconomic status) have different lifestyles,” such as more frequent exposure to ultraviolet rays for intermittent periods, they said. Also, people of higher socioeconomic status generally may be expected to live longer and, thus have more time to acquire lesions.

Patients were adults aged 55 years or older from the two Rotterdam Study cohorts, including one studied in 1990, and one studied in 1999. Participants were followed for a mean of 9.5 years.

The findings – particularly regarding increased risk among younger patients and red-heads – largely support those of previous studies, although in the current study men were not shown to be at significantly increased risk of developing a first lesion, which contrasts with findings from some prior studies, the investigators noted.

The differences in risk factor profiles for those who develop single vs. multiple BCC lesions, as seen in the current study, may suggest that phenotypic characteristics of patients are less important for determining risk once “cumulative environmental-genetic interaction has surpassed a certain threshold and resulted in a lesion,” Dr. Kiiski and colleagues wrote.

“The clinical relevance of this finding is that physicians’ risk assessment efforts should differentiate between patients at risk for a first lesion and those who have a history of BCC,” they said, noting that those with the identified risk factors for multiple lesions may require a more stringent follow-up regimen.

That’s not to say, however, that other BCC patients do not require follow-up. “In this sample of the general population, more than 30% of the patients with BCC developed subsequent skin cancer, emphasizing the need for annual follow-up for several years,” Dr. Kiiski and colleagues stressed. ■

All-Cause Mortality Differs Between BCC and SCC

BY BRUCE JANCIN

EXPERT ANALYSIS FROM THE
13TH WORLD CONGRESS ON
CANCERS OF THE SKIN

MADRID – All-cause mortality is substantially lower in patients with basal cell carcinoma than in those with squamous cell carcinoma, according to a large Danish national registry study.

“In general, patients with basal cell carcinoma are in fact healthier than their counterparts with squamous cell carcinoma or age-matched controls,” Dr. Gregor B.E. Jemec observed at the congress, which was sponsored by the Skin Cancer Foundation.

He cited a study in which investigators at Aarhus (Denmark) University Hospital analyzed causes of death among patients with nonmelanoma skin cancer who were entered into the comprehensive Danish Cancer Registry in 1978-2001. The study population included all 82,837 Danes with basal cell carcinoma (BCC) and the 13,453 with squamous cell carcinoma (SCC) during the study years.

The all-cause mortality rate was 3% lower in the BCC cohort than the standardized rate in the general Danish population, whereas overall mortality in the SCC group was 30% greater than in the general population.

The increased all-cause mortality for patients with SCC was mainly due to excess deaths from chronic obstructive pulmonary disease, cardiovascular disease, cancer, and infectious diseases.

In contrast, patients with BCC had below-average mortality from COPD, diabetes, and cardiovascular disease (*Br. J. Dermatol.* 2008;159:419-25).

The investigators speculated that the observed mortality benefit among patients with BCC might result in part from the salutary effects of increased serum vitamin D levels on a variety of chronic diseases. BCC is a marker for increased sun exposure, which boosts serum vitamin D levels, which in turn has been linked in a growing number of epidemiologic studies to reduced risks of cardiovascular disease and other major causes of death. However, the Danish registry didn’t include data on vitamin D levels, so this is supposition.

Mortality from nonmelanoma skin cancer itself is quite limited. Investigators at the Danish Cancer Registry, using national data for 1984, estimated lethality rates to be 4.3% for SCC and 0.12% for BCC (*Br. J. Dermatol.* 1991;125:580-2), noted Dr. Jemec of the University of Copenhagen.

Nearly 74,000 deaths in the United States from 1969 to 2000 were attributed to nonmelanoma skin cancer, according to an analysis by investigators at Brown University in Providence, R.I.

Almost 29,000 of these deaths were caused by nonmelanoma skin cancers that arose on genital skin, with a nearly 3:1 ratio of deaths attributed to vulvar and penile-scrotal cancers (*J. Invest. Dermatol.* 2007;127:2323-7).

Dr. Jemec reported having no conflicts of interest. ■

Most Tanning-Bed Users Know About Devices’ Cancer Risks

BY MICHELE G. SULLIVAN

FROM WONCA 2010,
THE CONFERENCE OF THE WORLD
ORGANIZATION OF FAMILY DOCTORS

CANCUN, MEXICO – Knowledge doesn’t necessarily mean power when it comes to tanning beds.

The results of a small British survey show that the majority of patients in a dermatology clinic who used tanning beds for purely cosmetic reasons were

(60%) were older than 40 years.

Thirty-four patients admitted to using tanning beds. Most of these (27) were women, meaning that 42% of the women surveyed admitted to using the devices. But they weren’t alone: 18% of the men surveyed also said they used tanning beds.

Most of the users (88%) said that they had started visiting tanning salons before they turned 35 years old—a period considered crucial in developing an increased risk of skin cancers. “More disturbingly, 58% said they began tanning at age 17-25, and 18% of the users started at younger than 16 years,” Dr. Ninan said.

Although most reported occasional use, 38% of the tanners said they visited a tanning bed weekly. Most used tanning beds at their local beauty salon, but 9% said they had the de-

vices at home. “Six percent also said they tanned at their gym. Having [tanning] beds at gyms and other health centers really sends a mixed message,” Dr. Ninan said.

Coin-operated tanning beds were also popular among the group, with 16% reporting use. This trend is particularly disturbing, Dr. Ninan said, because it circumvents what little control there may be over exposure.

And although the United Kingdom recently passed a law forbidding teens to use tanning beds, no one can prevent them from accessing the coin-operated types, she added. ■

VITALS

Major Finding: 94% of clinic patients knew the cancer risk associated with tanning beds; one-third of patients surveyed used the devices.

Data Source: Survey of 102 patients in a university dermatology clinic.

Disclosures: Dr. Ninan had no financial conflicts.

well acquainted with the risks.

Ninety-four percent of the patients surveyed were aware of the link between tanning bed use and skin cancer, and even volunteered that they knew other risks, Dr. Tina Ninan said.

“Knowing the risks does not deter patients from engaging in this risky behavior,” said Dr. Ninan, a general practice physician in Newcastle upon Tyne, England.

She distributed some simple surveys to 102 patients waiting in a dermatology clinic at the University Hospital of North Durham. Most of the respondents (65%) were women, and most