

The Skin Check

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One of the most common dermatology office visits is for a patient who wants her or his “moles” checked. The importance of this ritual is stressed in all the media; but few patients know what lesions to really worry about and who is really at risk.

There are some simple facts that may help you. These are our opinions, formed from over 25 years of dermatology practice, but also idiosyncratic.

Who is at risk?

Light skinned whites have the greatest risk. There are six skin types. Of these Types I – II are most vulnerable to skin cancer. But, types III – IV can also develop skin cancer. Cutaneous malignancies are much less common in types V – VI skin.

Skin Type	Typical Features	Tanning Ability
I	Pale white skin, blue/hazel eyes, blond/red hair	Always burns/never tans
II	Fair Skin, blue eyes	Burns easily, tans poorly
III	Darker white skin	Tans after initial burn
IV	Light brown skin	Burns minimally/tans easily
V	Brown skin	Rarely burns, tans darkly
VI	Dark brown to black skin	Never burns, tans darkly

Common Skin Cancers

There are three common forms of skin cancer.

Basal Cell Carcinoma

Squamous Cell Carcinoma

Melanoma (the most serious kind and the one most patients request skin checks for)

You can read about these at: <http://www.dermnet.org.nz/lesions/skin-cancer.html>

Take-Home Messages

These are some of the important things that you should take away with you.

1. Who makes the diagnosis of skin cancer? (See Reference 1 for full information)

In Men: 42% of dx are made by the patient
23% are made by the wife or girlfriend
35% by the physician

In Women: 66% of dx are made by the patient
2% are made by the husband or boyfriend
32% by the physician

Stated differently, women find over 60% of self-detected lesions and over 90% of lesions discovered by a significant other. This has profound implications.

Recently, I saw a Catholic priest for a lesion on his forearm. A female parishioner said to him, “Father, you should get that spot on your arm looked at.” It turned out to be an early melanoma. It is clear is that women look at their partners differently than men. Indeed, around 10 times as many skin cancers are discovered in men by their partners than in women by theirs. I suspect that by making this information available some men may make an attempt to become better, more caring, observers.

2. What makes a lesion worrisome?

Here one needs to consider appearance and behavior. While appearance can be important, behavior trumps appearance. The same hold for people. Lesions that change over weeks to months are the most worrisome, As a rule, lesions which change over a few days are more likely traumatic or inflammatory; while lesions that grow slowly over years are usually benign. Of course, in medicine we say “never say never and never say “always.” Usually, a changing lesion could mean a new lesion especially in an individual over age 30, or an evolving preexisting lesion. **Change over weeks to month is the most important historical fact that patients need to be aware of and that dermatologists should consider.** By listening to a patient who relates a change in a lesion (either a new one or a preexisting spot) it is possible to pick up melanomas and other skin cancer at very early stages when cure approaches 100%.

3. **The Sun.** The media demonizes ultraviolet light all the time. Most patients feel guilty about the burns and tans they got as teenagers. Some doctors scold patients about this, too. We are not convinced that moderate sun exposure is bad; however, we are probably in the minority here. Frankly, it is too boring to sing the same tune 20 – 30 time a day, particularly when there is no good evidence for this across the board. Almost every white person got sunburns as a kid. It’s a forgone conclusion that you might not have been as careful as you should have been.

Epidemiological research has shown that after age 20, ultraviolet light is not a big risk factor for melanoma. For basal and squamous cell skin cancers, the more sun one gets the greater the risk. But keep in mind that most of these latter two skin cancers types are relatively easy to treat if picked up early. The common exceptions are lesions in certain areas: the nose, near the eyes and around the ears.

Dermatologists and sunscreen makers are obsessed with lathering on sunscreen every day. This is a personal choice and it depends on your skin type and where you live: the Northeast is not as “hazardous” as the South or Oceania. We have a sunscreen handout if you want one.

4. Family History.

Nonmelanoma skin cancer (basal and squamous types) run in families. If neither of your parents had these, your risk is to develop one is less.

Melanoma also is more frequent if one has a first degree relative with a melanoma. This is especially true if one has a first degree relative who developed a melanoma

before age 40. First degree relative means parent or sibling. There are rare persons with uncommon familial melanoma syndromes who have two first degree relatives with melanoma and many atypical moles. These individuals are at greatly elevated risk for melanoma, but these they are few in number. **We recommend a complete skin exam for everyone who has a first degree relative with melanoma. In addition, a recent study has found that persons with a family history of melanoma have a higher rate of prostate, breast, and colon cancers, non-Hodgkin's lymphoma, and multiple myeloma².** These persons should be screened for these tumors as well.

Summary

These are some of the salient facts as we see it. Other dermatologists may disagree. Nothing is written in stone. Some of these “facts” may change. Remember, a skin scan is non-invasive and should be atraumatic. It may help to bring your partner along with you since ideally at least 25% of skin cancers can be found by a significant other.

Hopefully, this document will demystify the “Skin Check” and help you to understand which lesions are worrisome and what the risks are. Please feel free to direct further questions to either of us. Your feedback will help us to improve this handout.

References:

1. Who discovers melanoma? Patterns from a population-based survey.

Koh HK, Miller DR, Geller AC, Clapp RW, Mercer MB, Lew RA.

J Am Acad Dermatol. 1992 Jun;26(6):914-9.

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BACKGROUND: Melanoma is external and potentially detectable by many persons but little is known about who first discovers these lesions. An understanding of discovery patterns can shape future public and professional education programs.

OBJECTIVE: Our purpose was to assess patterns of melanoma discovery and to determine the patients' role in finding their own lesions. **METHODS:** With a written, mailed questionnaire, we conducted a population-based statewide survey of 216 incident cases of melanoma in Massachusetts. **RESULTS:** Approximately half (53%) of melanomas were self-discovered, whereas the remainder were detected by medical providers (26%), family members (17%), and others (3%). Nearly one third of persons said they could not see their own lesions easily. Compared with men, women were more likely to discover their own lesions (66% vs 42%, $p = 0.001$) and those on their spouses (23% vs 2%, p less than 0.001). **CONCLUSION:** Improving early detection and reducing mortality of melanoma will require both public and professional education programs, with particular emphasis on targeting men at highest risk of this disease.

2. Melanoma Statistics Fact Sheet

Available from Surveillance Epidemiology and End Results (SEER)
Cancer Fact Sheets <http://seer.cancer.gov/>

Race/Ethnicity	Men	Women
All Races	23.2 per 100,000	14.7 per 100,000
White	26.5 per 100,000	17.3 per 100,000
Black	1.1 per 100,000	0.9 per 100,000
Asian/Pacific Islander	1.6 per 100,000	1.2 per 100,000
American Indian/Alaska Native+	^ per 100,000	^ per 100,000
Hispanic	4.4 per 100,000	4.4 per 100,000

These rates differ in many parts of the country. They indicate the number of melanomas diagnosed per year in the U.S. population. Thus, the rates in whites are 6 – 25 times higher than in other ethnic groups.

3. Population-Based Assessment of Non-Melanoma Cancer Risk in Relatives of Cutaneous Melanoma Proband.

Larson AA, Leachman SA, Eliason MJ, Cannon-Albright LA.
J Invest Dermatol. 2006 Aug 10; [.

Using the unique Utah Population Database we examined risks for other cancers among relatives of 4,079 melanoma cases. Age- and sex-specific rates for 35 different cancer sites were calculated, and used to estimate relative risks among relatives. In addition to the well-recognized risk for melanoma among first-degree relatives, we found significantly increased risks for prostate, breast, and colon cancers, non-Hodgkin's lymphoma, and multiple myeloma, ranging from 32 to 72% increased risk. Among second-degree relatives, in addition to increased risk for melanoma, we identified significantly increased risks for prostate cancer and multiple myeloma (27 and 53% increase, respectively). Among first-degree relatives of melanoma cases diagnosed before the age of 40 years, we found significantly elevated risks for cutaneous melanoma (380% increase) and prostate cancer (83% increase). Significantly increased risks for prostate cancer and multiple myeloma in both first- and second-degree relatives of melanoma cases are suggestive of heritable cancer syndromes. The increased risks for five additional cancer types in first-degree relatives of melanoma cases suggest that individuals with a family history of melanoma should strictly adhere to recommended screenings for all cancers.