

The skin check

Panicked by media stories about premature death from metastatic melanoma and reminded about the dangers of skin cancer by various interests, patients will often ask their doctor to check their skin for suspicious lesions. Basal cell carcinomas and early squamous cell carcinomas rarely pose a life-threatening risk, so the 'skin check' is aimed at early detection of malignant melanoma, the single most important step in improving prognosis.

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What about community screening?

Authorities on skin cancer and epidemiologists have determined that community screening for melanoma is not a worthwhile exercise. However, since melanoma is greatly increased in at-risk subgroups, checking these people would be sensible.

Patients most at risk are those with:

- Large numbers of naevi (>50).
- A family history of melanoma.
- A history of previous melanoma (second primary melanomas are common).
- Sun-damaged skin (amongst older men).

If skin checks are focussed on these groups, the melanoma yield will be significant.

With good lighting and a suitably undressed patient, a full body check may only take 5-10 minutes. In some patients, this is longer than the time taken to undress and redress, so time efficient examination will require a dedicated space or room, gown or sheet to protect the privacy of women, and rotation of other tasks during any wait period.

What to look for

During skin examination, focus on the "ugly duckling" – the pigmented lesion that looks like no other.

Ask the patient if they think any of their moles have changed. Never ignore a patient's opinion on change.

If you use a dermatoscope look for asymmetry and colour variation – the most important predictive features of melanoma. The "blue-grey veil" in dermoscopy is an ominous sign. This is the milky film-like appearance on dermoscopy that usually signifies melanoma (although it can be seen occasionally in benign lesions).

Many doctors are daunted by the complexities of dermatoscopic examination of pigmented skin lesions as detailed in texts and teaching sessions but concentrating on these three features will ensure melanomas are rarely missed:

- Asymmetry – the lesion is asymmetrical about two axes.
- Colour variation – usually three or more colours.
- The 'blue-grey veil'.

Photography and computer assisted diagnosis

Patients with large numbers of irregular naevi are frequently labelled Dysplastic Naevus Syndrome. The large odd-looking moles are markers of melanoma risk rather than being melanoma precursors themselves as there is no way to predict which naevi are most likely to progress to melanoma. For that reason, photo surveillance of only a few "suspicious" naevi alone is a futile exercise as melanomas

can arise from normal skin or from tiny insignificant naevi. Full body surveillance (or photography) is required.

In trained hands, computer aided diagnosis has not been shown to be more accurate than dermoscopy. Some of these apparatus have alarming false positive detection rates and their promotion as an essential aid to skin cancer diagnosis is misguided.



■ Patient with early melanoma on the back.



■ As seen through the dermatoscope.

Where mistakes are made

General practitioners remove about half of all melanomas in WA. Our average thickness of melanoma in WA (and hence prognosis) is one of the thinnest in the world, which indicates that detection in this state is very early.

Services such as the WA Melanoma Advisory Service at St John of God Hospital, Subiaco, ensure doctors have access to prompt advice and management, which goes some way to explaining why melanoma management in WA is first class.

When occasional mistakes are made, two scenarios feature most often:

1. The patient tells their doctor a lesion is changing but they are inappropriately reassured and the melanoma grows until diagnosis is obvious and the prognosis has worsened, and

2. Punch biopsy of a pigmented lesion returns normal histology, which results in faulty reassurance because other parts of the lesion contains growing melanoma.

Appropriate referral

Although some patients demand referral to a dermatologist, as a general rule, unless they fit into one of the four categories of at-risk patients, routine skin checks are not recommended by the Australian Cancer Network and the state Cancer Foundations.

Prior skin cancers of any sort increase the risk of further cancers – regular surveillance in more experienced hands may be reassuring for both referring doctor and patient alike. For those high-risk patients with dozens of odd looking naevi, specialist surveillance should result in patients having less surgery in the long run. Although one cannot really argue with the adage, "When in doubt, cut it out", if unnecessary surgery can be avoided it is in the patient's best interests. ■

Tips for Skin Cancer Checks

Best biopsy method. Either deep shave biopsy that included all the lesion or an ellipse excision clearing the naevus by 1mm.

Choice of pathologist. Some labs have a special interest in melanoma but most pathologists are happy to consult colleagues for difficult cases.

Screening after prior melanoma. Should be done yearly because second primary melanoma risk is ~10% in 5 years. Patients with significant risk of metastases are seen more often.

What to tell patients for self-reporting. Especially those in higher risk categories - mole change as per article, or any new mole.

Risk sites. While melanoma in the midline has a worse prognosis for metastases, the scalp is significantly worse. Melanoma on the hands and feet tend to present later, so prognosis can be worse.

Common myths. Irritation is mostly a late sign and early melanoma is symptomless.

Skin cancer figures for WA, 2006

Invasive melanoma	1052
In situ melanoma	640 est
Skin biopsies (all reasons)	42,198
Benign skin lesion excisions	45,933