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Detecting Early Signs of Melanoma

EARLY DETECTION OF MELANOMA AND NON-MELANOMA SKIN CANCERS

Skin cancer. How can a physician detect the early sign of melanoma and non-melanoma.

You are listening to ReachMD XM 157, the channel for medical professionals. Welcome to the clinician's roundtable. I am Dr. Mary Leuchars and joining me today from New York is Dr. Desiree Ratner, Associate Clinical Professor of Dermatology at Colombia University Medical Center. Dr. Ratner is board certified dermatologist who specializes in Mohs micrographic surgery and she is also a director of Dermatologic Surgery at Colombia Medical Center.

Today we are discussing the early detection of melanoma and non-melanoma skin cancers and how physicians can better recognize and treat these conditions.

DR. MARY LEUCHARS:

Welcome Dr. Ratner.

DR. RATNER:

Thank you for having me.

DR. MARY LEUCHARS:

Can we start by defining the spectrum of non-melanoma skin cancers?

DR. RATNER:

The most common form of non-melanoma skin cancer is basal cell carcinoma and that comprises about 80% of the skin cancers that we see. The second most common is squamous cell carcinoma, which comprises probably 15% to 20%, not quite 20% of what we see, and then melanoma, of course is the smallest percentage, but is a skin cancer that causes the greatest mortality.

DR. MARY LEUCHARS:

And what is the incidence in the United States of melanoma skin cancer?

DR. RATNER:

In the year 2008, just in the US, it is estimated that there will be over 116,000 new cases of melanoma diagnosed and of those, over 62,000 will be invasive and 54,000 will be noninvasive or in situ.

DR. MARY LEUCHARS:

Is the incidence of melanoma rising in the United States?

DR. RATNER:

Yes. It is rising every year.

DR. MARY LEUCHARS:

And what about the incidence of basal cell carcinomas, BCCs, and squamous cell carcinomas, SCCs?

DR. RATNER:

For a basal cell carcinoma, it is definitely over 1 million and may be even as high as 2 million cases in the US every year. As far as squamous cell carcinoma, it is over 250,000 cases per year.

DR. MARY LEUCHARS:

And the incidences of rising of both cancers as well?

DR. RATNER:

Yes, but not as quickly as the rising incidence of melanoma.

DR. MARY LEUCHARS:

And can you define me at-risk population of non-melanoma skin cancers?

DR. RATNER:

The at-risk population principally consists of people who have fair skin and light eyes and those are the people who are most susceptible to the burning rays of the sun. It is individual who has had a lot of ultraviolet light exposure that principally develop basal cell carcinoma. However, patients who have had history of radiation therapy or history of immunosuppression are also at significant risk of developing basal cell carcinoma or squamous cell carcinoma.

DR. MARY LEUCHARS:

And for melanoma, who are the at-risk population? How do they differ?

DR. RATNER:

The melanoma population again is at risk due to UV exposure, but there are some other risk factors as well. Patients who have a first-degree relative with a history of melanoma have a higher risk. Patients who are specifically redheaded or blond have a higher risk, with blue or green eyes and the chances increase significantly if you have many moles or a larger atypical mole or if you had a previous melanoma.

DR. MARY LEUCHARS:

And how much do sun exposure during childhood affect the incidence of both non-melanoma and melanoma skin cancer?

DR. RATNER:

That actually affects the incidence significantly as the vast majority of our destructive or noxious sun exposure is received before the age of 21.

DR. MARY LEUCHARS:

And how often is dermatologic screening necessary?

DR. RATNER:

Oh! It really depends on the patient. For someone with a previous history of skin cancer, they are obviously going to require much more frequent visits than someone with no history. So, if it is purely a screening visit for someone with no personal or family history of skin cancer, about once a year visit is probably sufficient.

DR. MARY LEUCHARS:

And when do you recommend a patient start getting screened, is there any particular age that you can use is a rough guideline?

DR. RATNER:

You know that is a good question. The age at which I am seeing people develop skin cancers ends up now being younger and younger. I am seeing more and more people in their 20s and 30s. So, I would say it is reasonable to have the first screening between the ages of 18 and 21 unless a specific lesion is noted prior to that and then that patient should be seen before hand.

DR. MARY LEUCHARS:

And are there particular areas of the United States that people are at risk, I mean I am assuming people from California who go up to the beach or people from the southern areas. Is there a good guideline to go by?

DR. RATNER:

Its true that patients who have a greater degree of sun exposure, saying California or Florida, have a significant incidence, but people move around so much these days that someone may be living in Maine and summering in Florida and going back to Maine. So, I do not think it is quite as dependent upon geographic locations.

If are you just joining the discussion, your listening to the clinicians roundtable on ReachMD XM 157, the channel for medical professionals. I am your host Dr. Mary Leuchars and joining me today is Dr. Desiree Ratner. We are discussing the early detection of melanoma and non-melanoma skin cancers.

DR. MARY LEUCHARS:

Dr. Ratner, how effective is the sunscreen in preventing sun related skin lesions?

DR. RATNER:

Sunscreen is tremendously effective in preventing skin lesions. The essential features of screener, the presence of UVA and UVD block and then as high an SPF or sun protection factor as possible. I generally recommend an SPF of 30 or higher which blocks out approximately 97% of the UV rays.

DR. MARY LEUCHARS:

Are there any public health protocols in the US that are addressing this at the moment or is that somewhat that still needs to be done in this area.

DR. RATNER:

I think we are doing a much better job of educating the public about the risks of skin cancer. There is an advertising campaign going on by the American Academy of Dermatology, which is basically public service announcements to educate patients about their risks. Every year, the American Academy of Dermatology has skin cancer screenings during the month of May, which is melanoma month and at that time awareness of skin cancer is heightened than as a big public education push.

DR. MARY LEUCHARS:

Do you think there is any difference when choosing a brand of sunscreen between one and another?

DR. RATNER:

I don't think so. I think the principal features as I said are to have high SPF with UVA and UVD block. The problem is that there are so many ingredients and people have so many allergies that it is very difficult to recommend one over another. The only thing that may be important to mention at this point is the fact that physical block such as zinc oxide and titanium dioxide tend to have a lower risk of allergy than some of the other sunscreen agents.

DR. MARY LEUCHARS:

Is there any evidence for systemic absorption of titanium? I know some people with children ask questions about that when choosing a sunscreen.

DR. RATNER:

I have actually never heard about that and I have used sunscreen on my kids for years. It is actually the first that I have heard of.

DR. MARY LEUCHARS:

That <_____>. So, if a physician is seeing patient, what are some tips that you can give family practitioners, who are the first to screen their patients with skin cancer?

DR. RATNER:

On terms of non-melanoma skin cancer, most often those lesions tend to crust or bleed or not heal and they tend to be located in sun-exposed areas, most often waist up, but not always. These are generally spots that bleed at the slightest touch and tend to be somewhat friable in their appearance. There can also be scaly lesions that haven't responded to over-the-counter medications or even prescription topical medications as they are thought to be eczema or psoriasis and if they don't respond to those medications, then chances are going to be something else and this should be considered for skin cancer. As far as melanoma skin cancer goes, we talked about the A B, C, D, and E of melanoma and these are pigmented lesions, A stands for asymmetry where one-half of the lesion doesn't match with the other. B is for border irregularity. When a lesion has notched borders instead of smooth borders that tends to be more characteristic.

Color differences, if a lesion has many different colors as opposed to being a single uniform color that is important and then diameter is bigger or smaller than a pencil eraser. If it is bigger than a pencil eraser, chances are that it's a higher risk lesion and E can stand for either elevation or evolution. So, when a lesion becomes raised or changes after having been relatively stable for a long period of time that should be a warning sign as well.

DR. MARY LEUCHARS:

Can we talk a little about solar keratosis, the definition and what physicians need to know about how they progress to potential skin cancer?

DR. RATNER:

I think the solar keratoses as a marker of significant sun exposure and when I see those on the patient I think of them as being at high risk for developing a skin cancer. As far as the risk of any individual lesion of transforming into a skin caner that is actually very, very low and there is considerable disagreement about the numbers, but it is probably less than 5% immediate and less than 1% for any individual lesion. These are patients who may have so many lesions that they need to be treated as a group either with a topical medication or with some kind of resurfacing procedure and the reason for doing that is if those lesions are clear, then often times the lesions that don't respond are the skin cancers that have been hiding among the solar keratoses.

DR. MARY LEUCHARS:

We talked earlier about the at-risk population for both non-malignant and malignant skin lesions. Are there any particular job categories or 6 differences that physicians look out for in their patients, that might alert them for risk of skin cancer?

DR. RATNER:

As far as sex differences go, I don't think if there is any significant one between male and female. As far as occupations go, people who have outdoor occupation such as construction workers or farmers, tend to be at higher risk. People who handle insecticide or metal ores, can be handling chemicals that may put them at risk. Transplantation is not a profession, although it can become one depends how these patients have to go through are also at significantly higher risk of developing skin cancer.

DR. MARY LEUCHARS:

Are there other patients who are immunosuppressed for other reasons that are also at risk?

DR. RATNER:

Absolutely. Patients with leukemia and lymphoma are at high risk for developing skin cancer as are patients with HIV/AIDS.

DR. MARY LEUCHARS:

I would like now to talk about what topical preparations are available that can potentially treat non-melanomas skin lesions.

DR. RATNER:

You know the topical preparations tend to work best for actinic keratosis, which are, as I said, the precursors. There is a medication called imiquimod, which as been FDA approved for the treatment of superficial basal cell carcinomas of the trunk and extremities. It is important to note that this is only an 80% to 85% cure rate, which is not nearly as good as any of the other procedural modalities that we have and right now that is the only FDA approved medication for skin cancer.

DR. MARY LEUCHARS:

Are there significant side effects of that medication?

DR. RATNER:

Yes. Significant crusting, scaling, oozing, at times bleeding, it is not a comfortable medication to apply.

DR. MARY LEUCHARS:

Is there a risk of allergy on the basis of that?

DR. RATNER:

I have never seen anyone developing an allergy. The only thing that the caveat that the company provides is that too significant absorption of the drug can cause flu-like symptoms. So, this is meant only to be applied to small areas, not large ones.

DR. MARY LEUCHARS:

And is there any duration of treatment that is recommended in terms of the timeframe?

DR. RATNER:

Essentially 3 times a week for 6 weeks, 6 to 8 weeks is the timeframe for basal cell carcinomas.

DR. MARY LEUCHARS:

What is role, if any, of chemical peels, particularly the facial area in treating non-melanoma skin lesions?

DR. RATNER:

I don't think chemical peels have a role in treating skin cancer. As I mentioned earlier, they may be helpful in sort of clearing the fields so that those lesions can be detected at an earlier stage.

DR. MARY LEUCHARS:

Is there anywhere that physicians or the public can go to learn more about skin cancer in general and early detection and also prevention.

DR. RATNER:

Absolutely. The American Academy of Dermatology website, which is www.aad.org would be an excellent place to start.

DR. MARY LEUCHARS:

And in terms of training for the family practitioner, where would be a good place that a family practitioner could go to gain practical skills in detecting and managing these lesions before they refer it to a specialist?

DR. RATNER:

Just to get a basic introduction, I would actually suggest that they take a look at the e-medicine online textbook. There is an entire dermatology textbook, which has sections on skin cancer, which has digital images and this would actually be helpful in horning those basic skills.

DR. MARY LEUCHARS:

Thanks very much Dr. Ratner for giving us your expertise and we have been talking today about the early detection of melanoma and non-melanoma skin cancer and how as physicians can better understand and recognize these conditions.

I am Dr. Mary Leuchars; you have been listening to the clinician's roundtable on ReachMD XM 157, the channel for medical professionals. We welcome your comments and questions through our website at ReachMD.com, which now features our entire medical show library and on-demand podcasts.

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