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The Duty to Inspect the Skin and Counsel Those at Risk to Develop Melanoma

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Melanoma prognosis is directly related to stage at diagnosis with mortality directly related to the Breslow thickness of the primary lesion.[1] Early detection and surgical excision of melanoma in a curable stage is the most effective method to decrease mortality, which has remained relatively stable in recent years. Decreased survival is associated with later stage at the time of diagnosis, nodular or acral lentiginous histology, increased age, male sex, nonwhite race, and lower income.[1–3] In the United States, an estimated 62 480 individuals were expected to develop melanoma in 2008, which means 1 in 52 men and 1 in 77 women will develop this potentially lethal cancer during their lifetime.[4] Which patients would benefit from physician surveillance? Who are the patients that may benefit from physicians' recommendations to perform skin self-examination? Should physicians encourage patients to request assistance from their partners with skin self-examination?

An estimated one-fourth of all melanomas are discovered by physicians.[5] With approximately half of all US office visits being to the patient's primary care physician, these physicians have the opportunity to detect melanoma.[6] According to self-reports from primary care physicians, full-body skin examinations are performed in 60% of patients identified as having risk factors for melanoma.[7] Of patients diagnosed with melanoma, 63% report having extensive contact with their regular physician in the year prior to diagnosis, but only 20% reported receiving skin examinations.[8] A possible reason for this discrepancy is that primary care physicians are unable to identify risk factors.

When targeting a population for screening and skin self–examination counseling, clinicians seek to limit these tasks to patients who can be readily identified by a routine history and physical examination and for whom counseling will seem beneficial based on the patient's experience. Patients who should be targeted for physician surveillance for melanoma and skin self–examination counseling should include those with a personal history of melanoma or non–melanoma skin cancer; those with a family history of melanoma; men aged 55 years or older; and patients with many moles (<50 moles). If the net is cast too broadly for high-risk patients, such as fair-skinned men and women aged 65 years or older with atypical moles and those with more than 50 moles, screening becomes impossible.[9]

Melanoma recognition may occur during opportunistic screening by physicians. Older white men commonly have melanomas on the back, which may be observed during physical

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examinations (eg, as a physician listens to the chest). Two articles in the April issue of the *Archives of Dermatology* provide additional information regarding melanoma recognition. Geller et al[10] found that physicians detect back-of-the-body melanomas at an earlier stage than individuals self-detect them. Bradford et al[3] reported that acral lentiginous melanomas usually occur on the palms, soles, or subungual regions of dark-skinned patients and are often diagnosed in the seventh and eighth decades. Acral areas usually are not examined during physical examinations; thus opportunistic discovery is less likely to occur in nonwhite patients. The general medical examination is the most common reason for a physician visit; therefore, it is a unique opportunity to triage patients with suspected lesions and counsel them.

Patients with a personal or family history of melanoma have an increased risk of developing a melanoma in comparison with the general population. Because patients who have no training in performing skin self-examination report detecting between 44% and 57% of melanomas,[5,11] training those at risk for developing melanoma to perform skin self-examination and seek care for a suspicious lesion is a potentially important way to facilitate reduction in mortality. First-degree relatives of those with melanoma have a 2-fold to 8-fold increased risk of developing melanoma.[12] Almost 630 000 US individuals have survived invasive melanoma. Based on estimates of 2 siblings per case, there may be more than 1 million siblings of patients with melanoma in the United States.[13] If first-degree relatives are estimated to be an additional 2 per case, there may be another million at-risk individuals. Thus, as many as 2.6 million adults in the United States could benefit from their physicians communicating their risk of developing melanoma in a way that promotes performance of skin self-examination or partner-assisted skin examination to detect change in their nevi and take action by seeking physician surveillance.

Exploring how patients understand the risk of developing disease can assist in communicating this risk in a way that promotes skin self-examination among those with melanoma and their relatives. For example, with genetic risk factors, some patients may feel “doomed” and helpless when confronted with genetic risk, whereas others will feel empowered to change their “destiny.” The distinction between genetic predisposition to developing a disease and actually having the disease is missed by most patients. A concise explanation of patients' risks combined with preventive action by the physician can help patients feel they have some control over their health. For example, when counseling a patient with a family history of melanoma, a physician might say:

> Because your father had a melanoma, there is a chance that you could develop a melanoma, a form of skin cancer. There are many things you can do to reduce your risk of getting melanoma such as avoiding intentional outdoor or indoor tanning, using sunscreen, staying in the shade, and wearing hats and protective clothing. It also will be very helpful for you to check your skin once per month. By doing regular skin checks, individuals can feel peace of mind about their health because they are more likely to find a problem early. If the skin cancer is found early, it can be removed in the physician's office before it can spread to other parts of the body. You can find out more about how to check your skin at these Web sites (http://www.aad.org/public/exams/abcde.html or http://www.cancer.org/docroot/lrn/lrn_0.asp).

The diagnosis of melanoma has the potential to change many aspects of individuals' lives including their self-identity, perceived sense of well-being, and social relationships. By fostering healing relationships, the physician can help patients adjust to having a melanoma or the possibility of developing a melanoma by increasing social support. Couples' commitment to each other may be strengthened by working as teams to get through serious illnesses together. Encouraging patients to invite partners to help check moles in areas patients cannot see, such as the back, scalp, and behind the ears, may provide early recognition of a changing mole,

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promote emotional responsiveness between the partners, and attenuate the effects of uncertainty about developing a melanoma by enhancing self-efficacy and giving the partners a sense of control over the disease.[14] Partners and family members can be a great asset in promoting many types of behavioral change among patients. They can serve as exercise and diet partners, provide reminders for medication compliance, and are often a source of support. It is also important to realize it is difficult for patients to successfully change health behaviors without the support of their significant others, who are part of their daily routine.

Physicians' counseling of patients and their partners can positively shape melanoma detection practices.[15] Given the magnitude of the problem of melanoma, additional empirical research examining the benefits of tailored messages and training those at risk to perform skin self-examination with the assistance of their partners in seeking care at an early, potentially curable stage is important.

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