ORIGINAL ARTICLE

Compliance with serial dermoscopic monitoring: An academic perspective

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Background: For even seasoned practitioners, early melanomas can be difficult to distinguish from melanocytic nevi. Although serial digital dermoscopy is considered by many to be the gold standard for monitoring patients at high risk, poor compliance can seriously alter efficacy. In 2014, a concerning compliance rate of 25% was reported from a single, private clinic. Information is currently limited regarding the determinants of compliance and whether patients at high risk return at an acceptable rate.

Objective: We sought to determine the compliance rate within the pigmented lesions clinic at our academic institution and identify demographic variables that may influence adherence.

Methods: A retrospective review was conducted using 120 patient charts.

Results: An overall compliance rate of 87.5% was observed with 63.3% of patients returning within 1 month of the recommended interval. The most notable risk factor for noncompliance was patient age between 20 and 29 years. Factors promoting adherence include a personal history of melanoma, greater than 5 serially monitored nevi, and a personal history of atypical nevi.

Limitations: The external validity is limited and the sample size is small.

Conclusion: These findings contradict concerns that adherence to serial monitoring is unacceptably poor and demonstrate that compliance is highest for patients with the greatest inherent risk. (J Am Acad Dermatol http://dx.doi.org/10.1016/j.jaad.2016.07.012.)

Key words: compliance; dermoscopy; digital dermoscopy; melanoma; nevi; serial dermoscopy.

The use of sequential dermoscopic imaging is considered by many to be the gold standard for monitoring patients at high risk as it increases the likelihood of detecting a "featureless melanoma" while minimizing the excision of benign nevi.[1] Serial dermoscopy of flat, atypical lesions is a cost-effective surrogate for clinical behavior and—in experienced hands—increases the sensitivity and specificity of the complete skin examination.[2] Critics of this technique caution that its efficacy is highly dependent on patient compliance. In 2014, Gadens[3] published the experience of a single, private dermatology clinic. Of concern, only 25% of patients were found to return for continued surveillance. Compliance rates among international academic institutions have been variable with an overall paucity of published data.[4-6] As inadequate patient adherence undermines the efficacy of digital dermoscopic monitoring, it is the aim of this study to: (1) determine the compliance rate within the pigmented lesions clinic (PLC) at our academic institution in Detroit, MI, and (2) identify demographic variables that may influence patient noncompliance.

METHODS

A retrospective chart review of patients who underwent digital dermoscopic monitoring within the Henry Ford Hospital PLC was conducted after approval by the institutional review board. The PLC is entirely referral based and—although inclusion

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Funding sources: None.
Conflicts of interest: None declared.
Accepted for publication July 7, 2016.
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Published online September 21, 2016.
0190-9622/$36.00
© 2016 by the American Academy of Dermatology, Inc.
http://dx.doi.org/10.1016/j.jaad.2016.07.012

criteria for the clinic are not strictly defined—referred patients typically have 1 of the following characteristics: numerous dysplastic nevi/atypical mole syndrome, a personal history of melanoma in the setting of atypical nevi, those with multiple primary melanomas, or a familial melanoma syndrome. The clinic is conducted approximately 6 to 7 times per month with limited (0-2) openings per clinic for new referrals. Included in the study were all patients seen in the PLC between March 2013 and December 2015 who, after completing initial examination, were recommended for at least 1 follow-up appointment. Patients were excluded if their recommended follow-up date was after December 31, 2015. Patients were discharged after their initial visit if they exhibited low-risk historical and clinical features that did not necessitate serial dermoscopic monitoring. In addition to serial dermoscopy, most patients maintained within the clinic underwent full-body photography. The severity and number of atypical lesions, and recent history of melanoma, determined recommended surveillance intervals. Short-term monitoring was defined as re-evaluation at 2 to 4 months, whereas medium- and long-term monitoring were defined as 6- and 12-month intervals, respectively. Compliance was quantified in 2 ways. Strict compliance was defined as whether a patient returned within 1 month on either side of the physician-recommended follow-up appointment. Overall compliance was defined as any patient who returned to the PLC regardless of whether or not they adhered to the recommended interval.

A thorough chart review was conducted to extract patient demographic data—such as personal history of melanoma, personal history of atypical nevi, family history of melanoma, and number of nevi being monitored (<5, 5-10, or >10). Each patient's distance from the clinic was also assessed using their documented home address. Of note, all patients enrolled in the Henry Ford Hospital PLC receive a handout upon their first encounter that states the clinic's mission, including—but not limited to—the importance of adhering to follow-up appointments. Patients are able to schedule appointments at the time of the visit up to 3 months in advance. If able to schedule an appointment, a reminder card is provided at the end of their visit. An automated system will also send notifications via US mail and a secure electronic messaging system reminding them of their upcoming appointment. The PLC does not currently send reminder letters, send text messages, or make telephone calls to patients who are unable to schedule follow-up on the day of their encounter.

CAPSULE SUMMARY

- Although serial digital dermoscopy is considered effective for monitoring patients at high risk with numerous nevi, compliance has not been reliably established.
- This investigation demonstrates that acceptable compliance is attainable and identifies variables influencing adherence.
- Dermoscopic monitoring should be considered for all patients at high risk; however, individual factors may impact the practical utility.

RESULTS

A total of 120 patient charts were included in this review (demographic data presented in Table I). The overall compliance rate was 87.5% with a total of 15 patients lost to follow-up. Among those who returned, 63.3% were strictly compliant with physician-recommended follow-up screening.

Compliance by age and sex

Included in the study were 66 female and 54 male patients. There was no statistically significant difference in either the overall or strict compliance rates based on sex. Compliance with regard to patient age was also assessed (Fig 1). The overall compliance rate for individuals older than 30 years was 89.4% with no difference between groups when separated by decade. Seven of the 120 patients included in the study were between the ages of 20 and 29 years. Only 4 (57.1%) returned for further monitoring within the study period, 3 of whom were strictly compliant. When comparing 20- to 29-year-old patients with all others there was a statistically significant decline in the overall compliance rate (odds ratio 0.16, 95% confidence interval [CI] 0.03-0.79). No statistically significant difference was noted with regard to strict compliance.

Compliance by recommended interval

Of the 103 patients to whom short-term monitoring was recommended, 63.1% were strictly compliant and 88.3% were compliant overall. A total of 12 patients were lost to follow-up. Of the 26 patients who did not meet criteria for strict compliance but returned for further evaluation, 11 presented to the clinic within 2 months of the advised interval. Medium-term follow-up was recommended for 16 patients and 68.8% were strictly compliant (81.3% compliant overall). Long-term follow-up was recommended for only 1 patient who did not return, as advised, but did present at a later date.

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