

Who detects melanoma? Impact of detection patterns on characteristics and prognosis of patients with melanoma

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Background: Despite the importance of early diagnosis, patients with cutaneous melanoma often seek consultation at advanced stages of the disease. The impact on prognosis according to who first detects the primary tumor has not been established.

Objective: This study aims to determine who first detects melanoma, the reasons that patients with melanoma consult a doctor, and the impact of detection patterns on the characteristics and prognosis of melanoma.

Methods: Seven hundred eighty-three patients with cutaneous melanoma who were diagnosed between 1996 and 2012 were included. Associations between who first noticed the melanoma (ie, self-detected, relatives, health care workers, or dermatologists), epidemiology, clinical presentation, histology, and patient outcomes were analyzed.

Results: Most melanomas were self-detected (53%). Among these patients, 32% consulted because of bleeding, itching/pain, or nodule enlargement. There were more melanomas self-detected among women than among men, and these had a better prognosis. Men had significantly more melanomas on non—easily visible locations than women did. Among melanomas noticed by dermatologists, 80% were incidental findings. Self-detected melanomas were thicker and more frequently ulcerated, developed metastases more often, and were associated with more melanoma-related deaths.

Conclusions: Patients with melanomas detected by dermatologists had better prognoses than patients with self-detected melanomas. Patients with melanomas that were self-detected by women had better prognoses than those that were self-detected by men, especially for patients >70 years of age. This group might therefore be a logical target for melanoma detection education. (J Am Acad Dermatol <http://dx.doi.org/10.1016/j.jaad.2016.07.009>.)

Key words: cutaneous melanoma; diagnosis; epidemiology; gender; pattern detection; prognosis; skin cancer; tumor thickness.

INTRODUCTION

Cutaneous melanoma is responsible for most skin cancer—related deaths. Incidence and mortality rates of melanoma have been rising worldwide in recent decades.¹ In 2014, an estimated 76,100 patients were diagnosed and approximately 9710 patients died of melanoma in the United States.² Melanoma is the

cancer with the highest cost per death and the highest loss of productive-life years in Europe.³

Secondary prevention campaigns have the primary aim of improving the early recognition of cutaneous melanoma, including systematic skin cancer screening projects that provide standardized whole-body examinations performed by dermatologists or trained

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general practitioners. These campaigns appear to have led to higher incidence rates at the expense of thinner melanomas and could have reduced melanoma-related mortality rates in some studies.⁴ Although the proportion of patients diagnosed with thick melanomas decreased as more thin melanomas were diagnosed, the absolute number of patients with thick melanoma remained the same.^{5,6}

Melanoma is usually a slow-growing tumor.^{7,8} However, patients with melanoma delay consultation and, therefore, diagnosis for years despite most melanomas being on the skin surface and, thus, likely seen by the patient, relatives, or general practitioners.^{9,10}

Despite the importance of the early diagnosis of cutaneous melanoma, there are few studies analyzing the reasons that led patients with melanoma to seek consultation. The impact on prognosis according to who first detects melanoma has not been established. The present study aims to determine who first detected melanoma in a representative sample of the population. Reasons that led patients with melanoma to consult a doctor were identified. Moreover, associations between who first noticed the melanoma and patient characteristics, clinical and histologic tumor features, and the impact on patient outcomes were analyzed.

METHODS

Data were retrospectively collected from clinical records of patients who had a histologic diagnosis of primary cutaneous melanoma and who were seen in our department between January 1, 1996 and December 31, 2012. All patients had at least 3 years of follow-up. Patients were asked who first noticed the melanoma and the reason that led them to seek consultation during the first consultation. All patients were adults (≥ 18 years of age) and all were white.

Descriptive analyses were performed. Variables considered in this study were classified according to 4 categories: detection patterns, patient characteristics, tumor characteristics, and patient outcomes.

Detection patterns

We defined 4 subgroups according to who first noticed the melanoma: 1) self-detected; 2) relatives or friends; 3) health care workers (eg, nurses,

pharmacists, and physiotherapists) and nondermatologist physicians; and 4) dermatologists.

None of the patients in our study performed skin self-examinations routinely, so all melanomas included in the self-detected category were incidental findings. Reasons that led patients to consult a doctor were analyzed for self-detected melanomas and for those in whom melanomas were first noticed by a dermatologist.

CAPSULE SUMMARY

- Patients with cutaneous melanoma often seek consultation in advanced stages of the disease, and we analyzed the influence on prognosis based on who initially detected the melanoma.
- Patients with self-detected melanomas had a poorer prognosis than patients with melanomas that were detected by dermatologists.
- Melanomas that were self-detected by women had better prognosis than those self-detected by men, especially elderly men.

Patient characteristics

Patient characteristics included the patient's age at diagnosis, sex, and either their personal or family history of melanoma.

Tumor characteristics

Tumor characteristics included melanoma location, which was grouped as easily visible or non—easily visible (eg, the scalp, back, and buttocks), diameter (in mm), tumor thickness (ie, Breslow index), and histo-

logic ulceration.

Patient outcomes

Patient outcomes included metastasis development (eg, micro- and macro- metastasis in sentinel node biopsy), first location of metastasis, and death caused by melanoma at the end of the study (December 2015).

Patients with a diagnosis of metastatic melanoma without a known primary tumor, soft tissue melanoma, mucosal melanoma, or intraocular melanoma were excluded. Patients with xeroderma pigmentosum and other familial melanoma syndromes were also excluded.

Statistical analyses were performed using SPSS software (version 14; SPSS Inc, Chicago, IL). Univariate analysis for qualitative variables was performed using the Pearson chi-square test. Comparative studies of quantitative variable means among categorical variable subgroups were performed using Student's t-test, settled by the Bonferroni post-hoc test if required. Statistical significance was considered if $P < .05$.

RESULTS

Seven hundred eighty-three patients met the inclusion criteria for our study. The mean duration of follow-up was 89 months (range, 36-240 months).

The epidemiologic analysis focused on determining who was the first person to notice the

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