

Cutaneous head and neck melanoma (CHNM): A population-based study of the prognostic impact of tumor location

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Background: Most studies of cutaneous head and neck melanomas (CHNM) have reported poorer survival in CHNM compared with other sites, especially on the scalp/neck.

Objective: We sought to compare patient and tumor characteristics between CHNM and cutaneous trunk and extremity melanomas and between CHNM locations (face/ear vs scalp/neck, anterior vs posterior), and to study prognostic factors in patients with CHNM.

Methods: We studied all CHNM (n = 1074) from 8120 cases of cutaneous melanomas diagnosed in Norway in 2008 to 2012.

Results: Compared with cutaneous trunk and extremity melanomas, CHNM were more frequently found in men, more often nodular and lentigo maligna cutaneous melanomas, and diagnosed at higher T stage ($P \leq .01$). CHNM located on posterior sites were diagnosed at significantly higher T stage, and were significantly more often diagnosed with ulceration and at more advanced stage compared with CHNM located on anterior sites ($P < .001$). T stage and clinical stage were the only significant prognostic factors for melanoma-specific and overall death in the multivariable analysis ($P < .001$).

Limitations: Low number of cases and the relatively high frequency of missing values are limitations.

Conclusion: More advanced CHNM were diagnosed on posterior compared with anterior locations, but location was not a significant prognostic factor for cutaneous melanoma-specific or overall death in the multivariable models. (J Am Acad Dermatol <http://dx.doi.org/10.1016/j.jaad.2016.06.048>.)

Key words: head and neck melanoma; mortality; population-based; prognostic factors; scalp/neck location; visibility.

Cutaneous head and neck melanomas (CHNM) are biologically diverse, and they constitute 12% to 27% of all cutaneous melanomas (CM).^{1,2} CHNM are more frequently found in older patients. Studies suggest a worse prognosis from these tumors compared with cutaneous trunk and extremity melanomas (CTEM).³⁻⁵

Few population-based studies of CHNM have described survival by sublocation. Two large studies from the US Surveillance, Epidemiology, and End

Abbreviations used:

CHNM:	cutaneous head and neck melanoma
CI:	confidence interval
CM:	cutaneous melanoma
CTEM:	cutaneous trunk and extremity melanoma
HR:	hazard ratio
LMM:	lentigo maligna melanoma
NM:	nodular malignant melanoma
SEER:	Surveillance, Epidemiology, and End Results

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Results (SEER) database studied survival after scalp/neck CM (n = 3271) versus CM located at other sites⁴ and differences between tumor locations of the CHNM (n = 27,097).³ These studies concluded that scalp/neck CM had poorer CM-specific survival compared with other CHNM and CTEM. Furthermore, a study of CHNM (n = 2218) from Ontario, Canada,⁵ found excess mortality after scalp/neck CM compared with face CM. On the other hand, a smaller European study of CHNM (n = 469) in the Stockholm-Gotland area of Sweden¹ found that only tumor thickness was a prognostic factor for CM-specific survival, regardless of the location of the CHNM.

Since 2008 the population-based Norwegian Malignant Melanoma Registry has recorded clinical and histopathological data for each diagnosed CM case. The registry is part of the Cancer Registry of Norway, ensuring a high level of data completeness and quality.⁶ This gives rise to an opportunity to characterize CHNM, to compare patient and tumor characteristics between CHNM and CTEM and between the CHNM sublocations (face/ear vs scalp/neck, anterior vs posterior), and to study prognostic factors in patients with CHNM.

METHODS

Patients

All patients given a diagnosis between 2008 and 2012 in Norway with first-time, invasive CHNM were included (n = 1074). Data on sex, age, tumor location (including laterality), histopathological type, Breslow thickness, T stage, ulceration, stage of disease, place of residence, and vital status were collected from the Norwegian Malignant Melanoma Registry at the Cancer Registry of Norway. Information on vital status and causes of death were given from the Cause of Death Registry. End of follow-up was December 31, 2012. All data were de-identified before analyses.

Definition of variables

Location of CHNM was given by *International Classification of Diseases for Oncology, Third Edition* codes (440: lip; 441: eye canthus and lids; 442: ear auricle, lobe, and meatus; 443: face [except 440, 441, and 442]; 444: scalp and neck). All neck cases were categorized as either front of neck or back of neck

(divided by sternocleidomastoid muscle) after a manual review of pathology reports. Cases were further categorized as either anterior (face, ear, and front of neck) or posterior (scalp and back of neck). Anterior lesions were expected to be more easily seen by the patient than posterior lesions. Histopathological types were also categorized

according to *International Classification of Diseases for Oncology, Third Edition* codes: superficial spreading malignant melanoma (M87433), nodular malignant melanoma (M87213), lentigo maligna melanoma (LMM) (M87423), melanoma unspecified (M87203), and other (M87453/M87803/M87613). Stages of disease were categorized according to the coding practice for metastases at the Cancer Registry of Norway: local

(no metastases), regional (metastases in regional lymph nodes, satellites and in transit metastases), and distant (organ metastases and nonregional lymph node metastases) disease. Cases without information about metastases were categorized as unspecified.

Statistical analysis

Descriptive analyses are presented as frequencies (percent) and medians (ranges). In further analyses, age was dichotomized (<70 and ≥70 years). Patients with unspecified tumor location were excluded (n = 4). Histopathological type categories “unspecified” (n = 287) and “other” (n = 27) were merged. Unspecified ulceration (n = 480) was defined as no ulceration.

Logistic regression analysis was conducted to compare patient and tumor characteristics between CHNM and CTEM, between face/ear and scalp/neck CM, and between anterior and posterior CHNM. Univariable and sex-/age-adjusted odds ratios with 95% confidence intervals (CI) were estimated.

Cumulative incidence of CM-specific death and death as a result of other causes were estimated by nonparametric method accounting for presence of competing risk events.⁷

Cox regression with calendar year as the time scale was conducted to study the association between prognostic variables and CM-specific death, death as a result of other causes, and overall death. CM cases were followed up from the dates of diagnosis until death, emigration, or end of

CAPSULE SUMMARY

- Poor outcomes have been documented in cutaneous head and neck melanomas.
- Patients with melanomas on the scalp and back of the neck were given a diagnosis of more advanced disease, but in multivariable models location was not a significant prognostic factor.
- Careful inspection of the scalp and back of the neck should be a part of melanoma screening.

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