
Incidental melanomas detected in veterans referred to dermatology

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Background: Early detection of melanoma is integral to preventing morbidity and mortality.

Objective: We sought to characterize and compare incidental versus consult melanomas detected in veterans referred to the Minneapolis, MN, Department of Veterans Affairs Medical Center dermatology clinic.

Methods: We retrospectively reviewed charts of all dermatology consults between January 2004 and March 2012.

Results: Of the 28,405 consults sent during the study period, 17,174 met inclusion criteria. There were 231 melanomas identified in 221 patients. In all, 144 melanomas were identified on the consult and 87 melanomas were discovered incidentally. The incidental melanoma detection rate was 0.5% (84/17,174). Consult melanomas were more likely to be invasive than incidental melanomas (relative risk 1.51, 95% confidence interval 1.23-1.86, $P < .0001$) and less likely to have a Breslow depth of less than 1.00 mm (relative risk 0.73, 95% confidence interval 0.61-0.88, $P = .0036$). Incidental melanomas were smaller than consult melanomas (mean diameter 0.98 vs 1.3 cm, respectively) and thinner (mean Breslow depth 0.64 vs 1.74 mm). Consult melanomas were more likely to be detected on the head/neck (relative risk 1.25, 95% confidence interval 1.03-1.52, $P = .0295$).

Limitations: Nondiverse patient population is a limitation.

Conclusion: Melanomas detected during an in-person skin examination by a dermatologist were more likely to be detected at an earlier stage of disease. (J Am Acad Dermatol 2016;74:462-9.)

Key words: cutaneous malignancy; dermatology consults; detection; incidental lesions; melanoma; skin cancer.

Melanoma is currently the fifth leading cause of cancer in the United States, excluding nonmelanoma skin cancer.¹ However, if detected in its early stages, treatment of melanoma is relatively straightforward with favorable outcomes. In fact, the 20-year survival for patients with melanoma of a Breslow depth less than 1 mm is approximately 96%.²

Several studies have documented that melanomas are detected more commonly by patients than health care providers.³⁻⁶ Unfortunately, patient-detected melanomas are associated with thicker Breslow depths^{3,6-8} and higher likelihood of invasive disease.^{3,7,8} Patient factors associated with thinner melanomas at the time of diagnosis include conducting self-skin examinations⁵ and having

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established care with a dermatologist.⁷ However, detection by a dermatologist remains the single best determinant in identifying thinner melanomas.⁵ Furthermore, patients with dermatologist-detected melanomas have better survival, lower overall mortality, and lower cancer-related mortality.⁹

Although several studies have demonstrated that dermatologists more accurately diagnose pigmented skin lesions than other providers,¹⁰⁻¹² only a few have quantified the potential for missed malignancies without an in-person skin examination by a dermatologist.¹³⁻¹⁵ The purpose of this study was to, first, quantify the incidence of incidental melanomas detected during an in-person skin examination by a dermatologist for patients sent via consult to dermatology for other skin concerns; and second, to characterize the incidental melanomas based on depth, size, and location. Based on the aforementioned studies, we hypothesized that more melanomas would be detected by dermatologists versus nondermatologists and that melanomas detected by dermatologists would be both thinner and in body locations typically covered with clothing. To our knowledge, this study uses the largest cohort to date and is the first to include referrals for any reason, not only for “suspicious” lesions, in evaluation of incidentally detected melanomas.

METHODS

Overview, institutional review board, and setting

This is an in-depth analysis of melanomas identified in a larger study.¹³ This retrospective chart review was approved by the Human Studies Subcommittee of the Minneapolis, MN, Department of Veterans Affairs (VA) Medical Center. The dermatology service at the Minneapolis VA Medical Center employs 2 full-time staff dermatologists, several part-time staff dermatologists, and 7 dermatology residents who conduct approximately 16,000 outpatient visits per year. Most visits include a waist-up skin examination unless the patient’s history necessitates a total body skin examination (eg, history of melanoma or dysplastic nevi). Dermoscopy is routinely used to evaluate pigmented lesions.

Inclusion/exclusion

Inclusion criteria included: (1) consult dated between January 1, 2004, and March 31, 2012, to the Minneapolis VA Dermatology Service; and (2) an in-person visit at the Minneapolis VA Dermatology Clinic within 18 months of the initial consult date. Patients with an in-person skin examination by a dermatologist (VA or non-VA) in the 18 months before consult date were excluded from this study. Previously biopsied and histologically confirmed melanomas referred to the VA for treatment were also excluded from the study.

Extracted data

Data from the medical record were extracted from the referring provider’s consult, dermatology notes, and pathology reports. The data extracted for each consult included: reason for consult, source of referral, patient demographics, status of the lesion (consult or incidental), and any melanomas found during the initial dermatologic examination (including lesion location and size, histopathologic diagnosis, and Breslow depth). A consult lesion was defined as any lesion identified in the referring provider’s consult. An incidental lesion was defined as any lesion biopsied by the dermatologist during the initial consultation visit that was not identified in the referring provider’s consult. We were conservative in assigning “incidental” status, deferring to “consult” status whenever in doubt.

Quality control

Data were extracted from the VA electronic medical record and manually entered using software (Microsoft Excel, Microsoft Corp, Redmond, VA). For quality control, 2 investigators manually verified all malignant biopsied incidental lesions. One investigator extracted all melanoma-specific data (lesion size, histopathologic diagnosis, and Breslow depth) and manually entered it using software (Microsoft Excel, Microsoft Corp). Lesion size was recorded as largest clinical diameter; on the rare occasions when the clinical diameter was not documented, measurements from the gross pathology description was used. Final histopathologic diagnosis and Breslow depth were confirmed by

CAPSULE SUMMARY

- Early detection and treatment of melanoma is key to preventing morbidity and mortality.
- Melanomas detected during an in-person skin examination by a dermatologist were smaller, thinner (Breslow depth), and more likely to be in situ.
- Thorough dermatologic examination, regardless of reason for consultation, is essential for early identification of melanoma.

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