Making a Case for Melanoma Screening: Look, Listen and Feel

In researching the topic of evidence-based practice for ambulatory medicine, I found a recent study from Mayo Clinic\(^1\) aimed at defining the top ten reasons for office visits. They reviewed a patient registry of over 142,000 patients from the Rochester Epidemiology Project in Olmsted County, Minnesota, with age, race, and gender distribution essentially identical to rest of the United States. Surprisingly, they found skin disorders to be the most common reason for the office visit.

My surprise over these findings was also a validation. I had been teaching office dermatology workshops for internal medicine residents and internists for the past 15 years. I discuss the importance of performing routine skin examinations and teach skin biopsy techniques in the early detection of melanoma. It then occurred to me; I had never really examined the evidence for this topic. What I found was a United States Preventative Services Task Force guideline published in 2009,\(^2\) They concluded: ‘current evidence is insufficient to assess the balance of benefit and harms of using whole body skin exam by a primary care clinician or patient skin self-examination for the early detection of cutaneous melanoma’. On further examination, I found that the lack of evidence is largely due to the lack of randomized controlled trials; hence, the USPSTF conclusion at that time was correct. But is this the end of the story for skin examination and early detection of melanoma?

Melanoma is the fifth leading US cancer with respect to number of new cases annually. The National Cancer Institute Surveillance, Epidemiology and End Results Program\(^3\) provide these data. Of the seven most common cancers in the US only melanoma is increasing in incidence, with three-fold increase since 1975. Melanoma is one of only three cancers whose mortality rate in men is rising. Current lifetime risk is estimated at 1:35 for men and 1:54 for women. These rates are predicted to rise, yet our guidelines lead us away from skin examination. Multiple studies indicate physicians find melanomas with a lower average thickness than nonphysicians.\(^4,5\) Mortality in melanoma is directly linked to two factors: Thickness of the cancer and regional spread at the time of diagnosis. There is clearly an opportunity to make a difference in melanoma as studies have shown benefit in early detection that translate to lower mortality.\(^5,6\) So why are physicians not more concerned with prevention of the fifth leading cause of cancer in our country?

The dilemma is to follow the guidelines and not perform routine skin examinations or how do we look at our patients and their skin. Evidence-based practice guidelines derived from systematic internal medicine. The intent being a guide, not dictate the practice of medicine, and help physicians practice a higher quality of care for their patients. There is a sense of angst for many physicians despite this intent. The angst is derived from a sense of controlling how the art of medicine is practiced. I maintain we should realize that the lack of evidence does not imply that the evidence does not exist. I remember when the evidence showed beta blockers to be harmful in patients treated for heart failure. I also remember a slogan form basic life support classes in the 1980s. The slogan was ‘look, listen and feel’. Until we have better evidence and research we are left to practice our art…. the art of healing. To look at our patients….to listen to our patients….to feel for our patients.

So I continue my message in my skin biopsy workshops. Look at your patient’s skin, you can make a difference, maybe save a life. We need to look at our patient’s skin. We need to counsel on skin protection and to avoidance of sunburns. We need to do better in the early detection of melanoma.

We can do better.

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