# Melanoma in Veterans: Higher Risk, Delayed Diagnosis, and Evolving Solutions

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**Veterans face a markedly higher risk** of melanoma than civilians.[1] Prevalence is estimated to be 2.2% in veterans versus 0.6% in civilians.[1] Veterans are also more likely to be diagnosed with regional or distant (stage III/IV) disease, contributing to lower survival rates compared to civilians.[1,2]

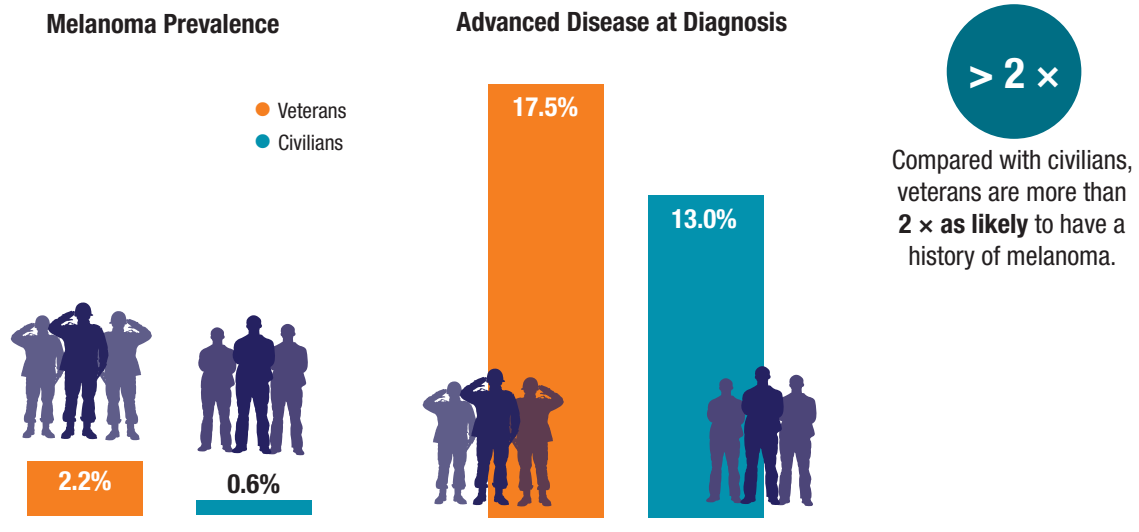
A 2025 study of teledermatology for melanoma care in the VHA demonstrated that remote consultations substantially expand access and support early evaluation for many patients. While face-to-face dermatology continues to provide the most rapid treatment pathway, teledermatology effectively connects patients to specialty input and timely intervention, especially for those in underserved or rural areas. Both care models play important roles in melanoma management as part of an evolving system of dermatologic care.[3]

Further, recent treatment breakthroughs include cellular therapy to fight melanoma with lifileucel, a personalized form of immunotherapy which has been in research and development for nearly four decades. On the heels of that arrived the two-year update on neoadjuvant nivolumab plus ipilimumab, which highlights that neoadjuvant immunotherapy is superior to adjuvant therapy alone for resectable stage III melanoma.[4-6]

For veterans, who face disproportionately higher rates of melanoma (eg, from service-related UV exposure), these advances translate to VHA-accessible therapies and response-adaptive protocols that increase cure rates, lessen treatment burden, and provide hope for formerly untreatable cases. With ongoing VA-funded research into risk factors for clinically aggressive melanoma in veterans, targeted interventions are enhancing early detection and improving outcomes in this high-risk population.[7]

## Melanoma in Veterans: Higher Risk and Worse Outcomes[1,2]

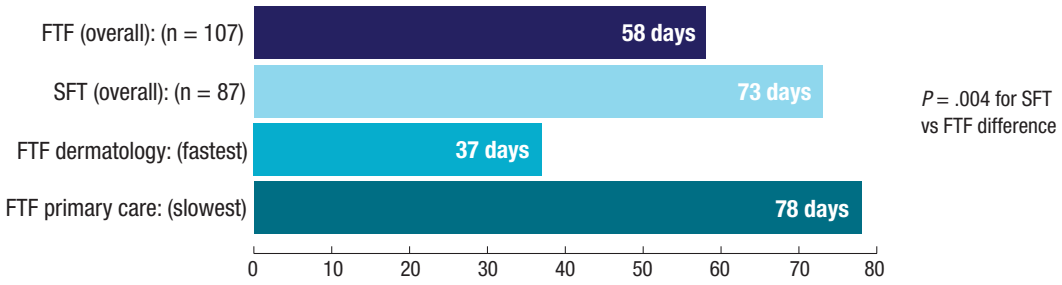
**Veterans have a higher prevalence of melanoma** and are more likely to be diagnosed with advanced-stage disease compared with civilians. After adjusting for demographic factors, veterans showed a significantly increased likelihood of melanoma diagnosis and lower melanoma-specific survival rates.



## Evaluating Process Timing for Melanoma Care for Veterans: Teledermatology vs In-Person Visits[3]

**This study analyzed** whether store-and-forward teledermatology (SFT) offers melanoma patients the same timeliness of treatment as traditional face-to-face (FTF) care. While SFT improved access, FTF dermatology—especially when first consulted—provided the fastest timelines to melanoma excision, and process enhancements could help reduce delays in SFT care.

### Median Timeline for Melanoma Treatment: Entry to Definitive Excision

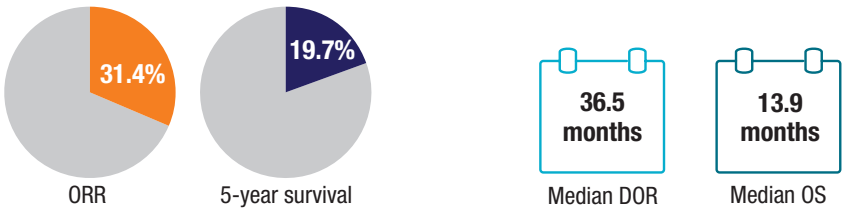



**FTF dermatology care provided faster access** to melanoma treatment compared to SFT with a median of 15 days of delay. Handoff efficiency within the SFT process is vital in closing the gap in treatment timelines.

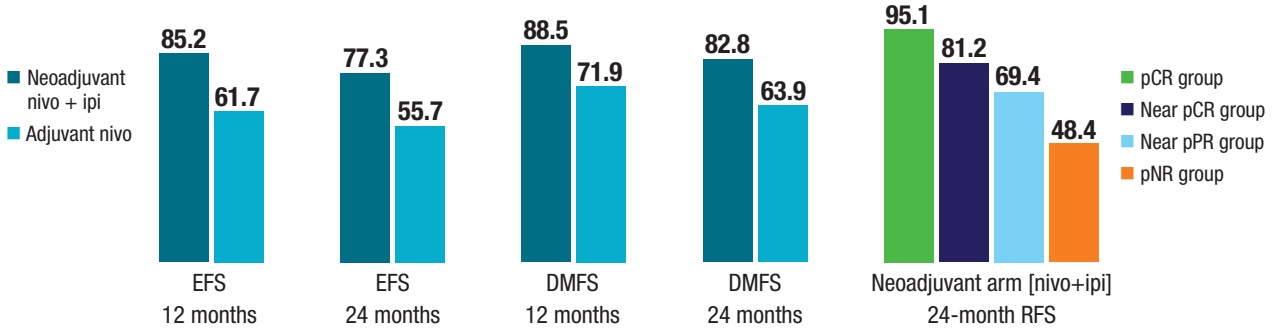
## Long-Term TIL Therapy Survival and Neoadjuvant Immunotherapy Optimization[4-6]

Lifileucel, the first FDA-approved autologous TIL therapy, delivers long-term benefit for advanced melanoma after checkpoint or BRAF/MEK inhibitor failure as seen in the C-144-01 TIL trial, with manageable, short-term adverse effects. The NADINA trial established neoadjuvant nivolumab plus ipilimumab as another standard of care option for resectable, macroscopic stage III melanoma, with sustained benefits in event-free survival at 2 years of follow-up compared to adjuvant therapy. **Together, these advances improve outcomes and survival across melanoma stages.**

### C-144-01 TIL Trial




### NADINA Trial: 2 Year Follow Up: Core Efficacy, %




BRAF/MEK, B-Raf proto-oncogene/mitogen-activated protein kinase; DMFS, distant metastatic free survival; DOR, duration of response; EFS, event-free survival; IPI, ipilimumab; NIVO, nivolumab; ORR, objective response rate; OS, overall survival; pCR, pathologic complete response; pPR, pathologic partial response; pNR, pathologic non-response; RFS, recurrence-free survival; TIL, tumor-infiltrating lymphocytes