Value of Skin Cancer Screenings Lacks Evidence

BY KERRI WACHTER
Senior Writer

The U.S. Preventive Services Task Force still cannot recommend for or against whole-body skin examination by a primary care physician or by patient self-examination for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer in the adult general population.

The task force concluded that there is not enough evidence to assess the benefits and harms from such examinations in its latest recommendations (Ann. Int. Med. 2009;150:188-93).

The previous recommendation came in 2001, when the group also concluded that there was insufficient evidence to recommend for or against routine whole-body skin examination for skin cancer screening.

"This is not to say that studies have shown that it's not effective; what they're saying is that there are just no studies out there," commented Dr. Darrell S. Rigel, a clinical professor of dermatology at New York University.

"If you talk to people who have had melanomas detected during screenings, they are very happy. They think screening is great because you basically have saved their lives," he said.

The task force did note two critical gaps in knowledge. First, there is insufficient evidence (a lack of studies) to determine whether early detection of skin cancer reduces morbidity or mortality from skin cancer. Second, there is insufficient evidence to determine the magnitude of harms from screening for skin cancer.

The task force found no randomized studies that examined whether screening by clinicians is associated with improved clinical outcomes. Screening appears to consistently identify thinner melanomas on the average than those found during usual care, the task force noted. However, it's not known whether the detection of the thinner lesions leads to decreased morbidity or mortality.

There is insufficient evidence (a lack of studies) to determine whether early detection of skin cancer reduces morbidity or mortality from skin cancer.

Based on the current review, the USPSTF noted that there is fair evidence that screening by clinicians is moderately accurate in detecting melanoma. They determined primary care physicians to be moderately accurate in diagnosing melanoma—with sensitivity ranging from 42% to 100% and specificity ranging from 70% to 98%.

"What I recommend to primary care physicians is to incorporate the screening as part of the full-body exam. … The marginal cost is nothing," Dr. Rigel said.

The task force noted that the recommendation applies only to the adult general population without a history of premalignant or malignant lesions. They did not assess outcomes related to surveillance of patients at extremely high risk.

Primary care clinicians should be aware that fair-skinned men and women older than 65 years, patients with atypical moles, or those with more than 50 moles are groups that are known to be at a substantially increased risk for melanoma.

The task force urged primary care clinicians to remain alert for skin lesions with malignant features that are noted during physical examinations performed for other purposes. The ABCD criteria—asymmetry, border, color, and diameter—or rapidly changing lesions are features associated with an increased risk for cancer, they noted. Biopsy of suspected lesions is warranted.

The American Academy of Dermatology offers free skin examinations by volunteer dermatologists for the general public through its Melanoma/Skin Cancer Screening Program (www.aad.org/public/exams/screenings/index.html).

"The academy has screened almost 2 million people now—this is the 25th year of the program coming up this year—and there have been tens of thousands of melanomas picked up and lots more nonmelanoma skin cancers," he said. ■