UNDER MY SKIN

Monkey See

BY ALAN ROCKOFF, M.D.

Call me callous, but Sybil really did look like a lizard. Lifelong eczema had turned her face an alarming reddish-purple. Scabs covered her hands. It didn't help that her job as a pharmacist put her in daily contact with dozens of people.

"We haven't seen you in a while," I said. "How often do you use your triamcinolone?"

"I don't use it," she said. "I'm afraid of atrophy."

"You've had a couple of courses of oral antibiotics," I said, "and one of your doctors suggested cyclosporine. Let's try the triamcinolone four times a day for a week, just to see what happens."

Sybil agreed.

A week later Sybil was back, with a big smile on a face now several shades lighter. Her hands were almost healed, too. Medicines work so much better when you use them.

"Do your customers make comments about your eczema when it's out of control?" I asked.

"You bet," said Sybil. "Last week I was giving a man a bottle of hydroxyzine. He looked at my hands and said, 'Take those pills back. I'm not swallowing them if you touched them.'"

Patients with visible disease report that kind of hurtful remark all the time. Although it's easy to be critical of people tactless enough to talk that way, perhaps we should be more understanding of why they do. Though it's just speculation, I have a theory.

Back in 1994, I leased my first pulsed-dye laser, the kind that left deep purple bruises for 10-14 days. Despite counseling showing photos of what to expect, and guaranteeing that the purpura always goes away, patients routinely dissolved into whimpering puddles when they saw what they looked like right after treatment.

One day, Marilyn asked me to treat her facial telangiectases. "I need to stay afterward to apply makeup," she said. "I train monkeys for the blind. If they see me with spots on my face, they'll get upset and start pointing."

That sounded a lot like my patients. I called Marilyn's supervisor to talk this over, but she wasn't interested since I'm not in her field. I asked a friend who teaches biology to put me in touch with his university's primate research center. Such centers don't publish their contact information, fearful of animal rights activists bent on blowing them up.

The Ph.D. student who called me sounded apprehensive. "Who are you?" he whispered.

"Just a dermatologist," I explained. "I was wondering whether this tendency to point agitatedly at red spots might be part of primate behavior that people and monkeys share."

"Are you writing a paper?" he asked. I explained that I was just interested. This threw him a bit, but he promised to send me some references, which turned out to be off point.

I therefore offer only an experienced hunch, but it seems to me that pointing out obvious spots, marks, and other visible but unexpected changes on other humans is a basic impulse. The veneer of civilized tact that helps us suppress this urge often peels right off. Consider how you feel when the person sitting across from you has a piece of food dangling from her lip. Don't you feel overwhelmed with the need to flick it off, or at least point it out? How come?

If you see a shiner on someone's eye, why is it so hard to suppress the compulsion to say, "Look, look, you have a bruise on your eye!" (As though he didn't already know it.) Somehow, redness seems to be a source of special alarm. Ruddy people are routinely greeted with cries of, "You're all red! Are you all right?!" That's perhaps a big reason people find rosacea, which ought to be trivial, so disturbing; pointing with alarm at your own face can't be much fun.

It seems to me that this instinctive impulse is what drives people to point out to others lumps and bumps, dark spots, rashes, and any number of other visible symptoms (coughs, limps, tremors, and so on.) Sometimes this helps get people to seek the help they need. Most other times it's just embarrassing, leaving the pointee feeling stigmatized and ashamed.

People like Sybil will never look entirely normal. We can't stop people from commenting on her appearance, just as we can't prevent pool attendants and fellow swimmers from handing out hurtful guff to patients with widespread psoriasis. Education goes only a short way, whether with humans or our simian cousins.

If we can, it's perhaps better to make her skin change as invisibly as possible so there's nothing to point at.

Sometimes treatment helps people, especially if they use it. ■

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POINT/COUNTERPOINT

Should patients with Merkel cell carcinoma be treated with postoperative adjuvant therapy?

Studies point to greater survival with radiation.

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Survival and recurrence rates for patients with Merkel cell carcinoma (MCC) are not good with surgical treatment alone. Without further treatment after surgery, the cancer locally recurs in 26%-44% of patients within an average of 4 months, and 50%-75% of these patients have regional node metastasis in an average of 7-8 months. Distant metastasis develops in about half of patients in an average of 18 months, and the 5-year survival ranges from 30% to 64%.

Survival for patients with stage IA disease is about 70% at 5 years, but half of those who die do so within 36 months (J. Clin. Oncol. 2005;23:2300-9).

No prospective studies have evaluated the effect of adjuvant radiation therapy to the site of the MCC and its draining lymph nodes, but retrospective studies appear to indicate that surgery and radiation improve 5-year survival.

A review of 100 patients found that surgery and adjuvant radiotherapy improved prognosis (Arch. Dermatol. 2003;139:1641-3).

In a study of data from the Surveillance, Epidemiology, and End Results (SEER) registry, 1,187 patients with MCC had no distant disease at presentation and underwent cancer-directed surgery; 477 of these patients also received adjuvant radiation therapy, partly because some of them had a higher stage of disease (J. Clin. Oncol. 2007;25:1043-7).

Patients who underwent radiation therapy had a significantly improved median survival, compared with those who received surgery alone (63 months vs. 45 months). This improvement in median survival was most prominent in patients who had tumors larger than 2 cm (50 months vs. 21 months). The median survival of patients who received both surgery and radiation also was significantly higher among those with tumors smaller than 1 cm (93 months vs. 48 months) and between 1 and 2 cm (86 months vs. 52 months), compared with patients who underwent surgery alone.

To determine the best regimen of radiation, patients should talk with a radiation oncologist about what effects can be expected from the irradiation of the lymph node basin and other areas that are possibly involved. ■

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Reserve radiation for later-stage, severe disease.

JOHN M. STRASSWIMMER, M.D., PH.D.

Merkel cell carcinoma often locally recurs following surgery. The prognosis may be bad for some, suggesting a need for adjuvant radiation, but others may have early-stage disease, small tumors, and no palpable lymphadenopathy. These patients with earlier disease could obtain a clearer prognosis with a sentinel lymph node biopsy (SLNB).

SLNB may be more technically challenging in MCC patients than in melanoma patients because there may be a lower rate of finding sentinel nodes, but if a sentinel node is found negative in patients with stage IA MCC, their 5-year survival is 97% (J. Clin. Oncol. 2005;23:2300-9).

An adjuvant radiation therapy regimen of 40-50 Gy for 4-6 weeks in a small, early MCC would be similar to that of primary basal or squamous cell carcinoma. Some MCC researchers advocate irradiating the tumor site, the nodes, and the draining lymphatics, which would not be practical in some areas, such as the legs. This radiation course also is expensive, costing about $5,000-$7,000.

A recent meta-analysis found that surgery and adjuvant radiation significantly reduced local and regional MCC recurrence, compared with surgery alone, but this did not translate into an advantage in disease-specific and overall survival (Arch. Dermatol. 2006;142:693-700).

The recent study of SEER registry data appears to support the use of adjuvant radiation therapy, but the conclusions are limited by a lack of randomization and data on the completeness of the resection, SLN status, margin width, receipt of chemotherapy, and the radiation therapy regimen.

The major confounder in the SEER data is that the survival differences might be completely the result of the difference in ages of the groups and not clinically relevant. Patients with longer survival had a mean age of 72 years, compared with 74 years for those with shorter survival. The registry also may include confounding factors such as a bias in which sick patients did not receive radiation therapy because of surgical morbidity (patients couldn't get to their series of treatments or they died before getting treatment) or a comorbidity that prevented them from receiving the treatment. ■

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