

Primary Care Physicians Often Mistake Lesions

BY MARY ELLEN SCHNEIDER
Senior Writer

NEW ORLEANS — Dermatologists diagnosed nearly twice the number of neoplastic and cystic skin lesions correctly than did nondermatologist physicians, according to research presented at the annual meeting of the American Academy of Dermatology.

Dermatologists were right 75% of the time when diagnosing neoplastic and cystic skin lesions, compared with nondermatologist physicians, who were right about 40% of the time. The research was conducted by Klaus Sellheyer, M.D., and Wilma Bergfeld, M.D., of the Cleveland Clinic Foundation.

The researchers reviewed 4,451 skin

specimens submitted to their dermatopathology clinic between Jan. 1, 2004, and March 31, 2004. The specimens were submitted by 37 dermatologists and 162 nondermatologists, including plastic surgeons, family physicians, internists, pediatricians, surgeons, and others.

The clinical diagnosis by family physicians for neoplastic and cystic skin lesions matched the histopathologic diagnosis in 26% of cases, the researchers found.

Plastic surgeons, who performed the largest number of cutaneous surgical procedures among the nondermatologists, did better in recognizing skin tumors but still had a diagnostic accuracy rate of 45%.

For inflammatory skin diseases, dermatologists were correct in their diagnoses in about 71% of cases, compared with non-

dermatologists, who were right in about 34% of cases, the researchers found.

The researchers recommended that nondermatologists continue to perform skin biopsies, but only if they have acquired enough knowledge of basic dermatology and dermatopathology. This type of knowledge is important not only in correctly performing skin biopsies, they said, but in avoiding unnecessary invasive biopsy procedures.

Mary Frank, M.D., president of the American Academy of Family Physicians, said it's key for family physicians to be able to recognize whether a skin lesion is suspicious and should be biopsied. Having that level of suspicion is key to ensuring the right diagnosis and treatment, she said.

But she said it's less important that fam-

ily doctors pinpoint the right diagnosis before sending the results off to the lab.

Physicians should be able to recognize suspicious lesions that could be skin cancer or those that may point to another health problem, such as the skin changes associated with lupus, she said.

Dr. Frank agreed it is important for family physicians and other nondermatologists to be appropriately trained in dermatology and skin biopsy. But she said dermatology and biopsy techniques are already part of family medicine residency training.

In addition, if a family physician isn't comfortable performing a biopsy on a lesion of concern, he or she should refer the patient to another physician—such as a family physician colleague, a dermatologist, or another subspecialist. ■

Dark-Skinned Patients Are Still At Risk for Skin Cancers

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

NEW ORLEANS — Melanoma and other skin cancers in blacks and Hispanics are likely to be discovered at a more advanced stage and are associated with significantly poorer survival rates, researchers said at the annual meeting of the American Academy of Dermatology.

Blacks and Hispanics—and their primary care physicians—may believe that darker skin protects against these cancers, said Susan Taylor, M.D. As a result, these patients don't perform frequent skin self-exams, aren't taught the warning signs of skin cancers, and don't see pigmented lesions as a concern. These problems, coupled with the fact that skin cancers often occur in atypical or sun-protected areas, contribute to their poorer prognosis.

"Develop a high index of suspicion for melanoma in the black population and fully evaluate any suspected lesion," advised Dr. Taylor, director of the Skin of Color Center at St. Luke's-Roosevelt Hospital Center, New York. "The standard of care must include the performance of a complete cutaneous examination emphasizing the palms, soles, fingers, all web spaces, subungual regions, and mucosal surfaces."

Additionally, she said, physicians should tell dark-skinned patients that they are at risk for melanoma, must wear sunscreen, and should perform monthly skin exams.

Malignant melanoma is about 10 times more common in whites than in blacks. Dark skin transmits only about 7.4% of ultraviolet B and 17.5% of ultraviolet A, while white skin transmits more than 55% of UVB and 29% of UVA, said Rebat Halder, M.D., of Howard University, Washington. "As a result of this additional filtering, black skin has a natural SPF of about 13.4," he added.

But this natural protection isn't enough,

noted Shasha Hu, M.D., of the University of Miami. Dr. Hu presented the results of a population-based study of skin cancer registries in six states: California, Texas, Florida, New Jersey, Illinois, and New York. Her results showed that increasing ultraviolet index and decreasing latitude were both significantly associated with invasive melanoma in blacks and Hispanics, especially among women.

Both Dr. Halder and Dr. Taylor advised physicians to look for suspicious lesions in unexpected areas of the body. A chart review of 649 melanoma patients at Washington Hospital Center found that while 90% of melanomas in whites occurred on sun-exposed skin, only 33% of those in blacks occurred on sun-exposed skin. The most common site of melanoma for black patients was the foot. Almost 40% of melanomas on blacks occurred there, vs. 2.4% of the melanomas on whites.

This same study found significant differences in stage and survival rates between the groups (*J. Am. Acad. Dermatol.* 2004;50:21-4). Stage I occurred in 60% of whites and 39% of blacks. Stage III or IV occurred in 33% of blacks but only 13% of whites. Five-year survival rates were about 59% for blacks and 85% for whites.

Other skin cancers have similar characteristics when they occur in blacks, Dr. Rebat said.

Squamous cell carcinoma is the most frequently seen skin cancer in blacks, but 65% of cases occur on sun-protected skin, frequently in the anus (15% of SCC overall, and 25% of SCC in black females). SCC also is associated with a later diagnosis and a more aggressive form of the disease. "SCC on covered skin has a greater potential for metastasis," Dr. Halder said.

SCC is more common in blacks with light or albino skin and on skin that has been damaged by burns, chronic ulcers or inflammation, chemical exposure, or lupus. ■

5-FU Cream Well Tolerated for Superficial Basal Cell Carcinoma

BY NANCY A. MELVILLE
Contributing Writer

SCOTTSDALE, ARIZ. — Although 5% 5-fluorouracil cream received Food and Drug Administration approval for treatment of superficial basal cell carcinoma nearly 4 decades ago, the cream is underused for that indication today, even though it is very well tolerated and is particularly beneficial as an alternative to surgery for many patients, Leon H. Kircik, M.D., said at a meeting sponsored by the Skin Disease Education Foundation.

The cream was first approved by the FDA based on a study showing a 93% cure rate among 54 patients with 113 superficial basal cell carcinoma lesions after an average treatment period of about 6 weeks.

To take a fresh look at the treatment, Dr. Kircik, a dermatologist in Louisville, Ky., conducted a study treating 25 patients with 27 lesions with the 5-FU brand Efidex and found remarkably similar results.

The study showed a cure rate that was just the same—93%, with the average cure time in Dr. Kircik's study of about 10 weeks. Four lesions were cured by week 6, 5 lesions were cured by week 9, and 16 were cured by week 12.

Just as remarkable, however, were findings on patient-reported tolerability, pain, and satisfaction. On a tolerability scale of 1-4, with 1 being "very painful" and 4 being "not painful" at all, the ratings were consistently between 3.5 and 3.8 over the 15-week course.

"Most patients did not complain, and this is unusual," Dr. Kircik said. "With 5-FU cream use on actinic keratosis patients, there are often many more complaints of pain and discomfort."

Inclusion criteria in Dr. Kircik's study included lesion diameter greater than 0.5 cm and less than 2.0 cm. Criteria for exclusion included treatment for skin cancer within the last month,

pregnancy, or a known sensitivity to the treatment.

Scarring was minimal, with scarring levels between 0.22 and 0.38 on a scale of 0 (no scarring) to 3 (severe scarring). And, in what Dr. Kircik said was the most telling reading, most patients indicated they would be willing to repeat the therapy.

"If you ask this of an actinic keratosis patient, their response is often 'no way,' but there was a very different profile with these patients," Dr. Kircik said. "There were no serious adverse events, the medication was well tolerated, and there was little to no pain during the course of the treatment."

Dr. Kircik said he believes that in addition to a relatively high cost, some physicians may shy away from 5-FU cream for superficial BCC treatment because of the higher pain problems they've heard reported by actinic keratosis patients.

The treatment, however, is particularly beneficial for patients such as the elderly, whose overall health could make them poor candidates for surgery, and younger patients with cosmetic concerns, since the treatment has an excellent cosmetic outcome.

Studies furthermore show that 5-FU cream's 93% cure rate is similar to that of other treatments including excision (about 90%) and curettage (93%), Dr. Kircik said.

"Considering that these therapies all have similar cure rates, [you] should consider patient tolerability and the excellent cosmetic outcome factors when considering 5-FU cream," he said.

Dr. Kircik disclosed that he has received funding either as a consultant or as an investigator from Valeant Pharmaceuticals International, the maker of Efidex, and other pharmaceutical companies.

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