Don't Ignore Changing Skin Lesions During Pregnancy

BY KATE JOHNSON
Montreal Bureau

SAN DIEGO — A pregnant patient's suspicious or changing skin lesion should be investigated as promptly and as thoroughly as the same lesion in a nonpregnant patient, Dr. Dina Massry said at a melanoma update sponsored by the Scripps Clinic.

Studies pointing to delayed diagnosis of melanoma among pregnant patients "clearly illustrate that physicians should treat changing nevi in pregnant women exactly the same as in their nonpregnant patients, and biopsy promptly," said Dr. Massry, head of the division of dermatology at the clinic's Green Hospital in La Jolla, Calif.

Although pregnancy itself does not increase a woman's risk of melanoma, the evidence consistently shows that pregnant women present with later-stage disease and more frequent nodal metastasis. This often occurs because suspicious lesions are dismissed as normal changes of pregnancy, she said in an interview.

"If you or your patient notes a changing mole, don't delay what you would normally do because she is pregnant, and don't ascribe the change as a normal phenomenon of pregnancy," she said.

As with nonpregnant patients, the prognosis for melanoma depends on the thickness of the lesion and evidence of ulceration. Surgical excision remains the best management. Late-stage melanoma can be lethal, however, and even though metastatic disease rarely has an impact on the fetus, treatment considerations in such cases must weigh the survival prognosis of both the mother and the fetus, she said.

"Consideration has to be given to whether the mother will even survive to delivery, as well as whether the cancer will metastasize to the placenta or the fetus," she said, adding that, in such rare cases, it might be reasonable to broach the topic of pregnancy termination with the patient.

"Also, the pregnancy itself is going to change the woman's treatment options. She could theoretically have more aggressive treatment if she were not pregnant," Dr. Massry noted.

Metastasis of melanoma to the fetus is extremely rare. Only 1 in 1,000 pregnancies is affected by cancer, and just 8% of these cancers are melanoma, she said. However, of all cancers, melanoma is the most likely to spread to the products of conception—with one-third metastasizing to either the placenta or the fetus.

In the most recent literature review of 87 cases of fetal or placental metastasis, 27 cases were attributed to melanoma. Six of those 27 cases actually affected the fetus, with the remaining 21 showing placental metastasis only (J. Clin. Oncol. 2003;21:2179-86).

Among the cases of fetal metastasis, five of the infants died within the first year of life; in the sixth infant, lung and soft tissue metastasis spontaneously regressed for at least 14 years, she said.

Among the cases of placental metastasis, three infants died within 2 days of birth from causes not directly related to metastatic melanoma. Follow-up of the other 18 cases showed no evidence of disease within a range of 47 days to 2 years.

The timing of pregnancy after treatment for melanoma has no impact on recurrence, Dr. Massry said.

Patients can be advised that disease recurrence is primarily related to tumor thickness. A study of 43 women who became pregnant within 5 years of a melanoma diagnosis found no difference in their survival, compared with age-matched controls who became pregnant more than 5 years after their diagnosis (Cancer 1985;55:340-4). ■

FDA Approves Once-Daily Topical Combo Of Steroid, Vitamin D for Psoriasis Tx

The Food and Drug Administration in January approved Taclonex, a new topical therapy for psoriasis.

The combined steroid and vitamin D_3 analogue ointment adds both choice and convenience to the currently available first-line treatments for the disease, Dr. Alan Menter said in an interview. "It's a nice additional drug that will be well received in the marketplace," he said.

'This drug is a significant advance in topical therapy for the U.S. market.'

DR. MENTER

The product, a combination of betamethasone dipropionate 0.064% and calcipotriene 0.005%, has been available in Europe as Daivobet since 2001 and in Canada as Dovobet since 2002, and will be marketed in the United States by Warner Chilcott and LEO Pharma.

"This drug is a significant advance in topical therapy for the U.S. market, although it is old hat for the European market," said Dr. Menter, chief of dermatology at Baylor University Medical Center in Dallas. He said that he had no conflict of interest involving this drug or its manufacturer. "It is certainly the most interesting and exciting new topical drug for the United States," he added, predicting Taclonex will renew interest in topical therapy and most likely improve compliance.

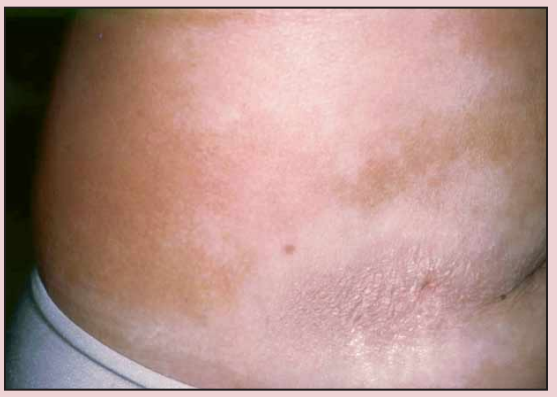
"This agent is approved for once-a-day use, which I think is very important, because most patients will not use a topical agent twice a day on a long-term basis," he said. The combination of both a steroid and a vitamin D analogue in one ointment also should help compliance, he predicted.

There have been no clinical trials of the product in the United States, said Dr. Menter, but a European-industry–sponsored trial comparing continuous and intermittent therapy with the combined drug vs. calcipotriol monotherapy showed greater improvement in psoriasis area and severity index scores (73%) in the continuous therapy group, compared with 68% in the intermittent group and 64% in the monotherapy group. Overall treatment success rates were 66%, 57%, and 51% for the continuous, intermittent, and monotherapy groups, respectively.

—Kate Johnson

DERM DX

A 56-year-old woman presented with a 7-month history of discolored, painful, tender round marks on her legs and neck that rapidly increased in size to cover large areas of her trunk and legs. Arthralgias and diffuse hair loss ensued. What's your diagnosis?



When the woman was admitted, the differential diagnosis was between scleroderma and eosinophilic fasciitis (also known as generalized morphea profunda), according to Dr. Irwin M. Braverman, who presented the case at the Fall Clinical Dermatology Conference.

The woman had plaques of morphea covering her entire body. The edema also affected her breasts but spared the areolae and nipples. She had large plaques on her abdomen. Histology showed deep dermal fibrosis with fibrosis of fat septa extending down to a thickened fascial layer, which is confirmatory for eosinophilic fasciitis, said Dr. Braverman, professor of dermatology at Yale University, New Haven, Conn.

"We have seen about a half-dozen patients with this syndrome in the last 4 years," he added. "This starts suddenly with patients coming in with tender, painful swelling of the arms, legs, and trunk."

The woman was started on 20 mg prednisone t.i.d. and tapered to 15 mg once a day over the course of 12 months. The dose was then reduced by 2.5 mg every 6 months. The regimen yielded a prompt decrease in induration, swelling, and pain.

She is currently taking 5 mg prednisone once a day, and her skin has returned almost to normal.

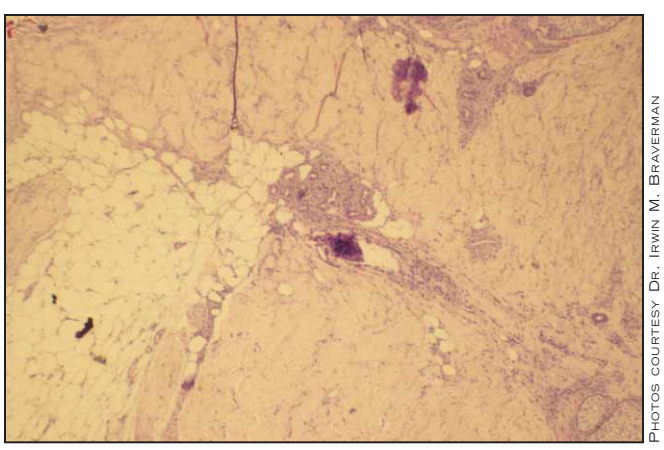
"She will continue to be tapered 2.5 mg every 8 weeks if she shows continued improvement," Dr. Braverman said at the meeting, which was sponsored by the Center for Bio-Medical Communications, Inc.

He emphasized that eosinophilic fasciitis "is very responsive to steroids. After starting oral prednisone, within a week this woman was feeling no pain and the edema had subsided. It's taken almost 4 years, but over the course of a slow taper, her skin has returned essentially to normal."

The steroid therapy regimen for eosinophilic fasciitis that has been most effective for his patients is as follows:

1. Start with 60 mg/day (20 mg t.i.d.) prednisone for 2 weeks tapering to 25 mg per day (10/10/5 mg) over 6 weeks.
2. Taper 2.5 mg every other week until you reach 15 mg/day (5 mg t.i.d.).
3. Taper 2.5 mg every 4 weeks (t.i.d. dosing) until you reach 10 mg/day.
4. Remain on 10 mg/day in a single morning dose for 2 months.
5. Taper 2.5 mg every 8 weeks.

—Doug Brunk



PHOTOS COURTESY DR. IRWIN M. BRAVERMAN