Nail Melanomas, Benign Lesions Look Similar

BY KATE JOHNSON
Montreal Bureau

SAN DIEGO — A longitudinal pigmented streak beneath the nail could either be a benign melanonychia striata or a far-from-benign subungual melanoma, but despite the vast difference in prognosis, the two conditions are very difficult to tell apart clinically, Dr. Constance Nagi said at a melanoma update sponsored by the Scripps Clinic.

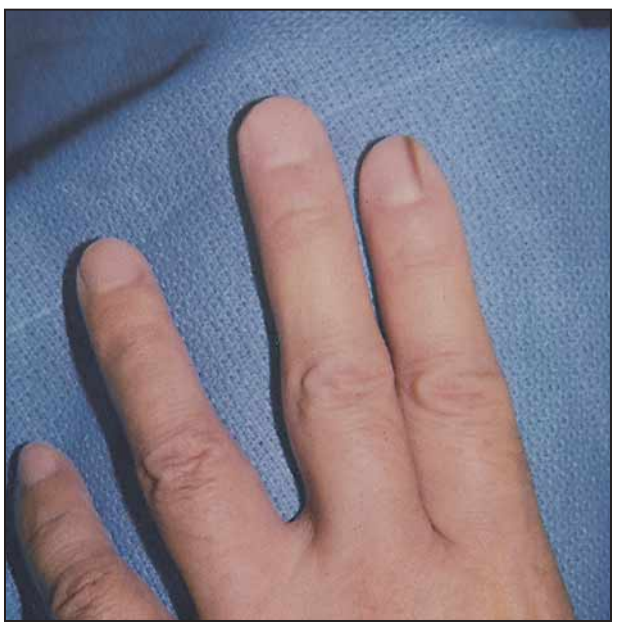
"When it's melanoma, patients often present with late-stage disease, because there is frequently a delay in the correct diagnosis," she warned, adding that late-stage subungual melanoma carries a 5-year survival rate of 16%-61%. The delay often occurs because it is mistaken for infection or inflammation resulting from trauma.

To add to this confusion, both types of lesions can develop as a result of trauma, and thus both are more commonly seen on thumbs, index fingers, and great toes. Furthermore, melanonychia striata can sometimes be an early sign of melanoma, she noted. Despite these similarities, there are some key clues that distinguish melanonychia striata from subungual melanoma, said Dr. Nagi, clinical professor of medicine/dermatology at the University of California, San Diego.

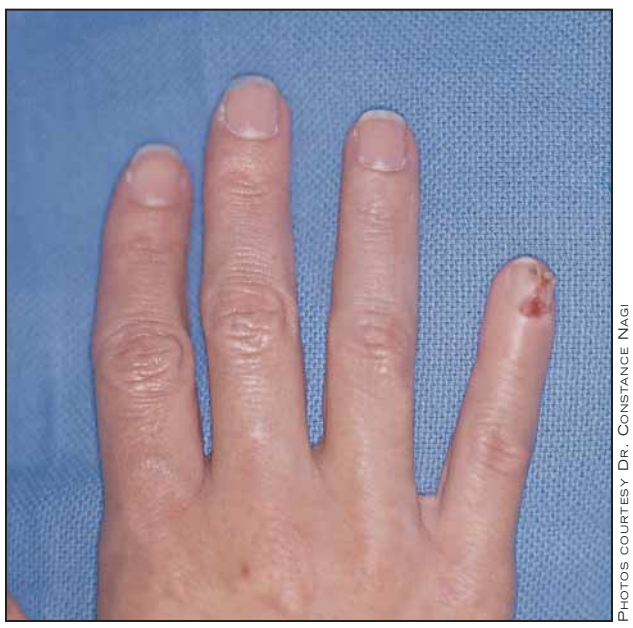
Hutchinson's sign, though not always present, is a valuable clue to melanoma diagnosis. This periungual spread of pigmentation to the proximal or lateral nail folds is usually a late sign of melanoma, though absence of it does not imply a benign lesion, she said.

Be suspicious of benign melanonychia striata—usually occurring as a black, brown, or tan longitudinal streak within the nail—if it suddenly darkens or widens, or if it has blurred lateral borders. Additionally, the presence of nail dystrophy, either partial or complete, is a suspicious sign, she pointed out. The sudden appearance of a nail streak in a single digit in adult life also warrants careful examination; this is especially true for patients who are at increased risk for melanoma or have a history of it.

Dr. Nagi warned that subungual melanoma is often asymptomatic and that up to 25% of cases can be amelanotic, so it is easily mistaken for pyogenic granuloma, chronic granulation tissue, or mycobacterial infection with nail dystrophy.



A melanonychia striata in a patient's index finger; on biopsy the striata showed a benign melanocytic lesion.



This melanotic melanoma on a patient's fingertip presented as a pyogenic granulomalike lesion.

PHOTOS COURTESY DR. CONSTANCE NAGI

"When in doubt, biopsy," she advised, adding that complete excision of the lesion should be considered, if feasible. Patients should be informed preoperatively about the possibility that the biopsy could result in permanent nail dystrophy.

Nail streaks, both benign and malignant, are more common in dark-skinned people than in whites, Dr. Nagi said. Benign melanonychia striata is uncommon in whites but occurs in virtually 100% of African Americans by age 50 years. ■

Trial Targets Siblings of Melanoma Patients

BY MARY ELLEN SCHNEIDER
New York Bureau

Providing telephone counseling and targeted educational materials to the siblings of recently diagnosed melanoma patients can help improve the rate and quality of skin self-screening, according to the results of new research.

In a randomized controlled trial that included 494 siblings of melanoma patients, those who received the study intervention were more likely to examine all of their moles, including those on the back, compared with siblings who had received usual care (odds ratio 1.76).

Teaching skin self-examination to those who recognize their personal risk can improve the quality of the exam.

DR. ROBINSON

Those receiving targeted education also were more likely to compare all of their moles to see if one stood out (odds ratio 2.20).

Alan C. Geller, R.N., of Boston University, and his colleagues contacted 667 siblings of recently diagnosed melanoma patients. Of this group, 494 consented to participate in the study and completed a baseline survey. The siblings were randomized to receive either the study intervention or usual care, which in the study was a suggestion by the dermatologist that siblings be screened for melanoma. A total of 314 siblings completed the 12-month survey (Cancer 2006;107:806-14).

The intervention included a motivational telephone session with a health educator, tailored print materials at various points in the first 6 months, three additional telephone counseling sessions, and information about free screening programs.

The calls and materials were customized to the particular needs or concerns of the siblings. Study participants who said they had difficulty checking for moles on their back, for example, were given information on how to include that as part of their self-exam.

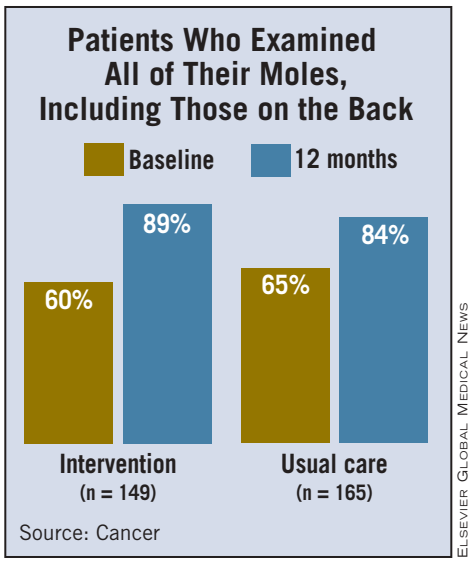
The researchers assessed the efficacy of the intervention by whether the siblings had a skin cancer screening exam by a dermatologist within 12 months of completing the baseline survey, whether they conducted a personal skin self-exam within 12 months, and whether they had always or often used sunscreen with SPF 15 or more during the past summer when spending more than 15 minutes in the sun.

Although the siblings in the intervention arm showed greater improvement in self-screening, both arms showed similar results in terms of obtaining an exam from a dermatologist within a year and routinely using sunscreen.

At baseline, about 28% of participants in both groups had been to a dermatologist for an exam in the last year. That figure rose to about 68% after 12 months. About 56% of participants in both groups reported routinely using sunscreen at baseline and that figure rose to 66% for the usual-care group and 67% for the intervention group after 12 months.

Dr. June K. Robinson of Chicago, editor of the Archives of Dermatology, praised the study. Teaching skin self-examination to those who recognize their personal risk can help to improve the performance and quality of the exam, she said in an interview.

The lesson for clinicians making a diagnosis of melanoma is to ask patients to inform their first-degree relatives so they can be examined by a dermatologist. "One of the most important motivators for the patient is for the physician to tell them to do something," Dr. Robinson said. ■



ELSEVIER GLOBAL MEDICAL NEWS

Is It Melanoma? Pigmented Lesions Give Few Clues

SAN FRANCISCO — Pigmented lesions revealed few clues as to their true histologic identities in a 5-year retrospective study, Dr. Roland M. Strauss said in a poster presentation at the annual meeting of the American Academy of Dermatology.

Of 434 excised lesions, nearly half proved to be benign melanocytic nevi, but more than 100 were invasive melanomas or displayed severely dysplastic features or in situ melanoma.

Telling the difference proved difficult, even for specialists at a pigmented lesion clinic at Leeds (England) General Infirmary. The best predictors of melanoma in the study were older patient age, larger lesion diameter, blue or blue-gray lesion hue, and male sex, said Dr. Strauss of the infirmary.

Only advanced age was predictive of severe histologic dysplasia or in situ melanoma vs. nevi with mild to moderate atypia, he said in his poster presentation.

"Our results confirm the difficulty experienced by dermatologists in distinguishing atypical nevi with mild to moderate histologic atypia from those with severe histologic dysplasia or melanoma in situ," Dr. Strauss wrote. "In order not to miss any lesions with severe dysplasia/melanoma in situ, the excision of a number of benign lesions with only mild to moderate dysplastic features will therefore have to be accepted," he suggested.

—Betsy Bates