Melanoma

Is More Diagnosis Better?

As melanoma has become more common and health care costs increase, it is useful to evaluate the nonspecialist's ability to act as a "first line of defense" for the general public. Chen et al.¹ have compared the diagnostic acumen of dermatologists and primary care practitioners (PCPs) for melanoma. The good news from this evaluation is that the PCP diagnostic abilities—while not as good as the experts, the dermatologists—are actually *very* good: Area under the curve: 0.80 versus the 0.89 of dermatologists for diagnosis and 0.76 versus 0.84 for management of pigmented lesions. Further good news is that the dermatologists did, as anticipated, perform better.

It is helpful to compare diagnostic acumen between dermatologists and PCPs in order to appropriately advise individuals worried about pigmented lesions. Chen et al.¹ conducted careful analyses to evaluate the diagnosis and care of these worrisome lesions. Owing to the inherent difficulty in discrimination among malignant lesions, precursor lesions, and signs of aging (such as seborrheic keratoses), common wisdom suggests that dermatologists are the best practitioners from whom to seek care. Although this is generally true, the fact that dermatologists are in short supply makes it difficult for many patients to see a dermatologist. Therefore, the data shown here are all the more optimistic—in general, the PCP will do a good job of diagnosing and following melanomas.

Melanoma, as indicated in the article, has become highly prevalent and if diagnosed at late stage, the survival rate is dismal. Although it makes good sense that early detection will prevent late stage melanoma, to date there is no substantive proof that this is so.² Our own work published in 1996³ shows a potential trend for a protective effect of skin self-examination in preventing mortality from melanoma, but this trend was not significant at 5-year follow-up. We are currently conducting 15-year follow-up and expect to address that question more precisely in the near future, but the data—not yet final by any means—do not yet support the notion that early detection by means of skin self-examination will improve survival from melanoma. To my knowledge, there are no other data that will support this concept. Unfortunately, a randomized trial of physician screening and skin self-examination for melanoma in Queensland was unable to obtain full funding and so, although that study is obtaining valuable data, it is not useful for evaluating the effect of screening on mortality from melanoma.

A further important consideration is that while the incidence of melanoma has increased dramatically during the past 35 years, the mortality rate has increased slowly and is now relatively flat, in men for more than 20 years and in women for more than 30 years.⁴ One conclusion that can be drawn from this is that the melanomas we are now finding are due to greater surveillance; that is, we are looking harder. In fact, Chen et al.^{5,6} suggested that this might be the case. They suggested that it is likely that the dramatic increase in incidence with a concomitant improvement in the prognosis might "simply be a consequence of removing biologically benign pigment-

ed tumors that are inadvertently classified as malignant." If, in fact, this is the case, then the issue is not so much one of finding the lesions in the first place but rather coming up with accurate diagnoses—the purview of the pathologist.

The pathologists are often, however, under intense scrutiny by the legal profession for identifying a lesion as malignant and so, based on anecdotal evidence, the pathologist is now in the defensive position of making sure that any hint at all of malignancy has been noted. Therefore, it is highly likely that not only are we biopsying more lesions than necessary, but also that we are calling more of these lesions melanoma.⁷ Indirect support for the notion that increased level of biopsy is leading to increased melanoma incidence is supplied by Qin et al.⁸ They compared melanomas diagnosed between 2 time periods and reported that as many as 40% of lesions that were diagnosed as melanoma in 1988 would not have been so diagnosed in 1978. In other words, lesions that would never have been called to the attention of the practitioner in the past are now being biopsied and identified as melanoma.

Therefore, although dermatologists are the best diagnosticians, and although the PCP performs well, it is unclear whether additional education for primary care practitioners to bring them to the same level as dermatologists is feasible or useful.—**Marianne Berwick, PhD, MPH**, *Cancer Research and Treatment Center, Department of Internal Medicine, University of New Mexico, Albuquerque, NM, USA.*

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