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Commentary: Screening for melanoma risk is misguided

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With an incidence of malignant melanoma of 1 in 10 000 a year^{1,2} a general practitioner with a registered list of 2000 patients will see about one new case every five years. Risk factors for melanoma have been identified, and one strategy for prevention is to target those at higher risk for more intensive advice on reducing their exposure to the sun and on what to do if moles change. This study investigates in an "affluent practice" some aspects of the feasibility of such a strategy. But is the strategy worth investigating at all?

In this study 18% of adults were found to have high mole counts, while 5.5% had both freckling and high mole count. Five per cent of all adults reported "major" change in a mole in the preceding three months. Johnson *et al* estimate that at least 4% of a general practitioner's list have a fivefold or greater relative risk of developing a melanoma.³ Implementing a strategy of intensive counselling of high risk individuals therefore involves getting the entire population to count their moles and provide other information pertaining to melanoma risk, and then labelling around

5% of the adult population as having an increased risk of melanoma. Screening for disease may generate anxiety.⁴ This strategy would have significant adverse consequences in this respect.

No evidence yet exists that such a strategy would reduce mortality. Cochrane and Holland stated that as an ethical prerequisite for a screening programme there should be conclusive evidence that screening can alter the natural course of disease in a significant proportion of those screened.⁵ Johnson *et al*³ estimate that a randomised trial of this strategy aiming at detecting a 20% reduction in mortality would require 100 000 high risk adults in each arm and would need to involve all adults living in at least two health regions in Britain.

The implementation of this strategy would substantially increase the workload of practices. The screening process itself is complex, and the consultation rate in connection with pigmented lesions would increase. Given a 5% rate of reported major change in moles in the adult population every three months, the rate of their excision and submission for histology would increase substantially. The concept of prioritising practices for screening for melanoma risk according to the age or social class distribution of their patients is unacceptable.

The authors of this study have not made any assessment of the psychological effects of their screening method or assessed its effect on practice workload or health service costs. Feasibility studies of possible screening strategies that fail to address these issues should not be undertaken. Further research on the prevention of melanoma and death from melanoma should concentrate on finding better methods of communicating the message that sunburn is bad for you to the general population, and on improving doctors' skills in early diagnosis.

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A MEMORABLE PATIENT

My little girl

It is a little disconcerting to walk into a gynaecology ward hearing a hysterical woman scream, "You're trying to murder my little girl." It was even more disconcerting to realise that she had been admitted under my consultant's care. Soon the story unfolded. A 28 year old woman with a long history of primary subfertility had been admitted with six weeks' amenorrhoea, lower abdominal pain, and light vaginal bleeding. An ultrasound scan could not find any evidence of an intrauterine pregnancy and we were trying to persuade her to have a laparoscopy to exclude an ectopic pregnancy. She did not want this. "You want to kill my little girl," she insisted over and over again.

Finally, as her symptoms worsened, she agreed to a laparoscopy without uterine instrumentation. At operation she was found to have blood in the pouch of Douglas and an unruptured tubal ectopic. A laparotomy and salpingotomy were performed with evacuation of the ectopic pregnancy, which was confirmed on subsequent histological examination.

Afterwards the woman became extremely depressed and withdrawn although slightly calmer. She kept repeating, "I know my little girl is all right," despite our extensive counselling to her and her husband that she had had an ectopic pregnancy. Four days later she went home.

Her general practitioner sent her back to the clinic

10 days later. He was concerned about her mental state and thought that she was becoming psychotic. She was crying, depressed, agitated, and kept repeating, "I know my little girl is all right." After discussing matters with our psychiatric colleagues we organised a pelvic ultrasound to challenge her and prove that having had an ectopic pregnancy she could no longer be pregnant.

To our immense surprise the scan showed a seven week intrauterine pregnancy. This lady had had a concomitant pregnancy, one pregnancy developing in the fallopian tube and one in utero. Concomitant pregnancies are rare, occurring once every 30 000 to 50 000 pregnancies. Her mental state improved dramatically and she had a trouble free pregnancy. A normal delivery at term was complicated only by a retained placenta.

This woman taught me that no matter how absurd a clinical situation might be, no matter how odd or difficult the patients might seem, listen to what they are saying, even if, on the face of it, what they are suggesting might be apparently impossible. Rare things do happen rarely and listening to the patient can lead to the correct diagnosis being made. Oh, and by the way, she had a little girl.—
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