People are overusing sunbeds

EDITOR,—David Shuttleworth drew attention to the question of whether sunbeds that emit ultraviolet A radiation cause skin cancer.¹ To determine the prevalence of use of sunbeds during 1994 the Department of Health commissioned the omnibus survey of the Office of Population Censuses and Surveys to interview British adults, who were randomly selected and stratified by socioeconomic variables. A balanced response rate of 76% was achieved, producing 2017 interviews. Of the 284 respondents aged 16-24, 68 (24%) had used a sunbed during the year, as had 106 (10%) of the 1056 respondents aged 25-54; the overall ratio of men to women who had used a sunbed was 7:11.

A total of 184 people had used sunbeds. Half had used them at home (ratio of hired to privately owned equipment 1:2), and half had used commercial facilities, with about one fifth of the total use of sunbeds occurring on local authority premises.

Information regarding use of sunbeds is available from, among others, the Health and Safety Executive (existing guidance is under revision),² the British Standards Institution,³ and the Institute of Sport and Recreation Management. The current view of the British Photodermatology Group is that "the use of ultraviolet A sunbeds for cosmetic tanning should be discouraged... people who, despite this advice, want to use ultraviolet A sunbeds should not exceed two courses a year, each of no more than 10 sessions."⁴ Evidence from the survey showed that this advice was not adhered to: of 61 male and 123 female users, five (9%) and 30 (24%) respectively had had more than 20 sessions in the year, 17 (9% of both sexes equally) had used a sunbed for a session of more than 30 minutes, and two (3%) men and nine (7%) women had developed painful skin after use.

How many sessions are deemed to be safe and the degree to which any person is at risk of skin cancer may well be important when someone decides whether to move from occasional use of a sunbed perhaps in a salon, to more frequent use at home. There is thought to be no threshold for the risk induced by radiation, so the British Photodermatology Group's guidelines are pragmatic. Whether the information and advice should be altered to be more or less prescriptive is open to debate.

The omnibus survey collects full socioeconomic details from respondents, and any associations of these with the variables, or association between the

variables, need to be further explored. The crude data on disk are available on request.

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- 1 Shuttleworth D. Sunbeds and the pursuit of the year round tan. *BMJ* 1993;307:1508-9.
- 2 Health and Safety Executive. *Commercial ultraviolet tanning equipment*. London: HMSO, 1982. (Guidance note GS18.)
- 3 *Specification for safety of household and similar electrical appliances: ultraviolet and infrared radiation skin treatment appliances for household and similar use*. London: British Standards Institution, 1995. (BS EN 60335-2-27:1995.)
- 4 Diffey BL, Farr PM, Ferguson J, Gibbs NK, deGrujil FR, Hawk JL, et al. Tanning with ultraviolet A sunbeds. *BMJ* 1990;301:773-4.

Accuracy of local data on skin cancer

Skin cancer registry data may greatly underestimate cases

EDITOR,—Clive Richards and colleagues highlight the problem of underregistration of skin cancer: when they compared the South Western Cancer Registry's data with data obtained direct from pathology departments they found that the registry had missed 13% of cases of malignant melanoma.¹ It is known that many cancer registries do not obtain data from all possible sources, including pathology laboratories and outpatient departments.²

John N Newton and Julia Redburn show that registration of malignant melanoma in women fell dramatically from 11.41/100 000 in 1988 to 7.53/100 000 in 1992.³ Although it is hoped that this decrease in registration represents a true decrease in incidence, the change is so dramatic that additional artefactual elements could be exaggerating this trend.

In West Glamorgan we have seen an increase in the proportion of women presenting with lesions less than 1.5 mm deep so that over the past three years 67% of all women presented with thin lesions compared with 52% of men. Most of these patients now have their lesions excised as outpatients and could easily be missed by the cancer registry if information was not obtained direct from the outpatient clinic or from the pathology department. If these lesions, mainly in women, were missed then the rate of registration of malignant melanoma could show an artificial reduction in women compared with men. Before any firm conclusions are made regarding the apparent dramatic reduction in the incidence of malignant melanoma in women it is important to know if the validation of completeness of registration of melanoma in Richards and colleagues' study included a search through the computer data of all the pathology laboratories in the area.

One source of annoyance and potential confusion in the paper by Richards and colleagues is the persistent interchange of "malignant melanoma" and "skin cancer." Surely the authors are aware that not all skin cancers are malignant melanoma, so phrases such as "the relative low annual incidence of skin cancers" are nonsensical because non-melanoma skin cancers are the commonest cancers in Britain.

The *Health of the Nation* key area handbook on cancer makes clear that the recommendations

apply to all skin cancers and not just malignant melanoma.⁴ If the initiative to reduce the incidence of skin cancer is to have any meaning then attempts must be made to ensure that all skin cancers, including malignant melanoma, are recorded accurately and in a standard format by the cancer registries of Britain.

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- 1 Richards C, Richards H, Pheby D. Skin cancer: how accurate are local data? *BMJ* 1995;310:503. (25 February.)
- 2 Craven NM, Roberts DL. Skin cancer registration in the United Kingdom. *Br J Dermatol* 1994;131(suppl 44):30-1.
- 3 Newton JN, Redburn J. Incidence of melanoma in four English counties, 1989-92. *BMJ* 1995;310:502-3.
- 4 Department of Health. *The health of the nation key area handbook. Cancers*. London: DoH, 1993.

Inaccurate data may lead to insufficient resources

EDITOR,—We agree with Clive Richards and colleagues that accurate ascertainment is a problem for cancer registries.¹ One of us (ACB) recently completed an audit of skin cancer care in the former South East Kent health district.

Index cases of melanoma were identified, by date of diagnosis, from histology records for inpatients and outpatients at the district's three hospitals for the year starting 1 April 1991. A small number of cases from general practitioners was also identified from the same source. Thirty six cases of primary cutaneous melanoma were identified. For the calendar year 1991 the Thames Cancer Registry recorded 19 cases of melanoma. The sampling frame for the local study accounted only for lesions verified histologically, but the cancer registry includes lesions not verified histologically. When this factor is taken into account the registry recorded only 16 cases of melanoma confirmed histologically, which is a substantial difference.

All cancer registries have slightly different methods of collecting data, and the 12 month data collection periods for the local study and the Thames Cancer Registry do not correspond precisely. Nevertheless, the more than twofold difference between the registered figures and the figures ascertained locally is of concern. Even if account is taken of cases generated in the private sector—found to be 23% in Richards and colleagues' study—the difference between the figures is considerable. It is unlikely to be explained simply by the difference in time frames.

An increase in the use of "ambulatory" surgery can substantially reduce hospital financial and opportunity costs.^{2,3} In the South East Kent study one consultant dermatologist personally performed the definitive surgery for a fifth of the people with malignant melanomas in the outpatient department, the remainder being admitted under general surgeons. This, plus the effect of cases generated in the private sector and a lag between diagnosis and registration,¹ might contribute to the differences found.

Monitoring of the trends in the incidence of skin cancer will be more accurate if data are collected at regional level.¹ Health service commissioners should note, however, that, because of the likely underestimation by registries, if they use such data to assess needs and thereby determine local

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