Misdirection in Melanoma Diagnosis
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(Note: This is an early draft. Please do not disseminate)

I spend my days sifting through the melanoma registry of over 1400 patients that I have been accumulating over the past six years. I became interested in melanoma following the first Hot Spots meeting circa 1987 when the formidable Scottish Professor of Dermatology Dr. Rona MacKie spoke. At the time, she was the Editor-in-Chief of the British Journal of Dermatology and had a big interest in melanoma. Only in 2009, did I start putting my data together and two years ago transferred it to a computer program.

I gather information on 25 separate fields which contain the usual demographics, but also include information on the presence or absence of red hair, freckles, multiple moles, family history, the use of tanning beds, etc. I have started to see patterns emerging that might indicate some Misdirection in the way melanomas are detected.

In the Blue Journal, April 2015, there is an article by Hensin Tsao, that Wunderkind of Melanoma and his task force for the ABCDEs of Melanoma. It is hard to believe that nearly 30 years has elapsed since the introduction of this tool.

ABCDE is widely known and it would be hard to find a physician or medical student who is not well-versed in this melanoma alphabet . The purpose of Dr. Tsao's article was to evaluate where are we now with this thing.

The ABCDE is not useful in evaluating several types of melanoma.
1. Nodular melanomas which form 15-20% of cases .
2. Amelanotic melanomas, about 7% of cases .
3. Desmoplastic lesions
4. Acral melanomas (possibly)
5. Mucosal melanomas
6. Lentigo Maligna/ lentigo maligna melanoma .

All of this is acknowledged by the Task Force.

It seems to me that there are two questions to ask about the ABCDEs
1. Is this tool useful for patients to detect their own melanomas given that 40 to 47% of melanoma self-detected?
2. Does this tool identify risk groups for screening.

The answer I believe is yes and no.

It may be that this tool has placed all of its emphasis on the presence of nevi. Most of our patient information on melanoma is about nevi. So are all our media soundbites "See Spot. See Spot change. See your dermatologist." Our sound bites follow the same theme.

Armed with ABCDE we have been very successful at diagnosing ever more numbers of early melanoma and what with Melanoma Mondays, beach patrols, Sun Awareness Weeks, etc. we have been very successful.

Patients also have not been idle, Clutching their cards with images of melanoma in glorious chocolate hues with a few smarties thrown in for good measure, they have been discovering these early melanomas.

But something seems to be wrong with this neatly wrapped-up concept, Do we find that early melanoma detection early save lives?   For despite the so called epidemic of melanoma, there has been no reduction in mortality. Still, 15-20% of all melanomas patients die from this disease. Early detection does not translate into reduced mortality. This disappointing situation was pointed out some years ago by the legendary giant of English Dermatology, Professor Sam Shuster.

It appears that we have failed to determine those at risk for aggressive disease using the ABCDEs except in one category, the Atypical Mole Syndrome (AMS).

When I look at my rather lily white population of patients, I see that over 50% of them do not have any recognizable risk factors that we currently can detect. Thirty percent of them have red hair and freckles and only 16% have the Atypical Mole Syndrome.

All this time and effort has gone into informing the general population about moles, their assessments, screening and follow up with total disregard for the

fact that, certainly in my population of patients, it only applies 16% of the time.

Do we hear about Red Hair Mondays or Freckle Fridays? We need to broaden the message to include those other groups who are at significant risk.

I attended a very interesting talk at the EADO in Nantes France three years ago given by Prof . Jean Jacque Grobe from Marseille. He told us that patients with the AMS represent:
<1% of the population.
10% of our melanomas arise in this group and they account for ~1% of our melanoma deaths
To detect one melanoma in this group of AMS patients, it cost 150 times what it costs to detect melanoma in the remaining population which represents 80% of the population who have 40% of the melanomas and 70% of the deaths.

This cost is generated by
1. Frequent office visits
2. Technology driven gadgetry
        Confocal microscopy
        Mole Max machines
        MelaFind, etc

These are wonderfully useful instruments but they sure use a lot of health care dollars. This expenditure needs to be justified.

Hensin Tsao's article concluded with the statement that the ABCDE remains a valuable component of the early detection campaign against melanoma. True, but other alternatives were not mentioned or even hinted at.
There is more out there including the Australian mnemonic BLINK (or BLINCK) that explores the indications for biopsy or removal of a pigmented lesion.

We need a wider scoped approach in melanoma detection.

By all means mind your moles, but don't ignore your freckles .