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Missed melanomas – comment

All of us must sympathise with Peter Foreman's story of the tragic delay in diagnosis and subsequent loss of his son from melanoma.[1] It is not possible to know whether earlier treatment would have been lifesaving. The history of growth over a short period of months is characteristic of nodular melanoma, an uncommon subtype of the disease, which is particularly aggressive when arising in the scalp and frequently leads to death of the patient. Unfortunately they are misdiagnosed in 50% of cases, as they often have no distinctive clinical features.

However, we disagree with his assertion that an adversarial medical-legal system will be beneficial. The resultant defensive practices would inevitably lead to huge increases in costs and innumerable unnecessary surgeries with accompanying complications.

The management of melanoma in New Zealand (NZ) is generally very good. Overall, for all melanomas, NZ outcome results are similar to those in Australia or Canada, with NZ 5-year survival rates for recent patients being 94% for women, and 88% for men. US results are marginally better, but their data does not include the whole population, as ours does. But in all these countries, there are types of melanoma that are much more difficult to detect and treat, including melanomas on the scalp, and nodular melanoma. Melanoma death rates in NZ in those diagnosed up to age 45 have been decreasing slowly, although rates at older ages continue to increase.[2]

Early detection is most effective for common melanomas such as superficial spreading melanoma, which often develop slowly, giving good opportunities for detection. But nodular and some other melanomas may grow more rapidly and may not be benefitted by earlier detection efforts. For every melanoma that occurs, there are many other non-cancer lesions that appear similar, so more intensive detection efforts come at a cost in unnecessary biopsies and anxiety for patients. While we hope earlier detection efforts are worthwhile, and we work on that basis, the extent of its benefits is uncertain.

It is highly likely that mortality from melanoma will be unchanged; rates of death from melanoma have continued to rise, despite annual increases in reported incidence of melanoma.[2] The majority of excised melanomas are in situ or thin (defined as less than 1 mm in thickness). We do not know if "early detection means increased survival rates"—we can only hope that this is true and do our best to identify and remove the aggressive tumours before they have metastasised.

We are engaged in reviewing melanomas diagnosed in the Waikato Region during 2010–2012. Breslow thickness is the most important prognostic feature for melanoma. In our database of 577 invasive melanomas, median depth is 0.8 mm. There are 80 nodular melanomas, which have a median depth of 2.8 mm, and 334 superficial spreading melanoma, with a median depth of 0.65 mm.

The prognosis for thick melanoma is abysmal (10-year survival 60–67%[3,4]; and unfortunately a high proportion of scalp tumours are thick at presentation.[5] Scalp

location has been reported to be an independent predictor of recurrence[6] and fatality.[7] As a recent retrospective review concludes, "Further research is needed to characterise the environmental, microenvironmental, and genetic causes of the increased aggressiveness of scalp melanoma and to identify more effective treatment and surveillance methods."[6]

The Ministry of Health has recently published *Provisional Standards of Service Provision for Melanoma Patients in New Zealand*.[8] These recognise the need to (a) improve education of health professionals in the recognition of melanoma, and, (b) to provide rapid and expert specialist support in diagnosis and management.

We urge District Health Boards to implement the recommendations.

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