



POSITION STATEMENT

Screening and early detection of skin cancer

* Endorsed by the Australasian College of Dermatologists

The Cancer Council Australia and the Australasian College of Dermatologists do not endorse the practice of skin checks in public places as a screening method, but recognise the value in promotional or educational activity that raises awareness of early detection or skin cancer prevention.

Recommendations

- The general public, particularly those aged 40 and over, should be encouraged to check all areas of their skin, including skin not normally exposed to the sun. Look for changes in shape, colour or size of a pigmented lesion or a new lesion regularly (every three months). Individuals should seek assistance from others to check difficult to see areas such as their back.
- Individuals who are concerned about skin cancer risk or skin changes should seek advice from a medical practitioner and discuss their skin cancer risk and need for medical checks or self-examination.
- Outdoor workers should be encouraged to regularly check their skin for suspicious spots. It is important that workers know what their skin looks like normally so changes will be noticed.

Screening

Screening involves testing members of the community who do not have symptoms of a specific disease for the purpose of identifying individuals who may have the disease.¹ The term “screening” specifically excludes the investigation of people with symptoms.¹

There are three approaches to screening:

- Mass (or population) screening: the comprehensive testing of the entire population within a certain age group;
- Selective screening: screening of selected population groups in high risk categories (Appendix 2); and
- Opportunistic screening: offered to people being examined for other reasons as part of a routine medical check-up.(also called 'case finding').

Screening for non-melanocytic skin cancer (NMSC) does not meet the recognised criteria for the implementation of screening (Appendix 1), because the disease in the vast majority of cases is not life-threatening or serious enough to cause long term illness.

In addition, screening for melanoma does not meet the recognised criteria for the implementation of screening (Appendix 1) for the following reasons:

- Research indicates that current diagnostic practices for melanoma are not optimal in terms of accuracy or cost-effectiveness.²
- Currently there is insufficient evidence that screening the general population for melanoma offers reduced morbidity and mortality.

Screening recommendations

The Cancer Council Australia and the Australasian College of Dermatologists:

- Do not recommend mass or population-based screening for NMSC or melanoma;
- Recommend that general practitioners develop surveillance programs for patients at high risk (Appendix 2); and
- Recommend that general practitioners assess patients who are concerned and develop appropriate management programs depending on their level of risk; and
- Recommend that General Practitioners who identify risk factors for skin cancer in patients presenting for other reasons to inform patients about sun protection measures and offer them opportunity for a full body examination and an appropriate management plan (i.e. case finding with follow up).

Early detection

Melanoma

Tumour thickness is the most important factor in survival after a melanoma diagnosis. Melanoma has a poor prognosis if the tumour is diagnosed at an advanced stage, underscoring the need for early detection. There is some evidence that promotion of early detection of melanoma has resulted in thinner tumours being diagnosed and an increase in survival rates.^{3,4,5}

NMSC

Although early treatment for non-melanocytic skin cancers (NMSC) may reduce morbidity, costs of treatment and mortality, to date, no research has evaluated whether screening or other forms of early detection improve the outcomes for these cancers.⁶

Self-examination for skin cancer

At present there is no specific self-examination technique or recommended frequency of self-examination that has been shown to reduce morbidity or mortality from skin cancer.

There is evidence, however, that a significant number of melanomas are discovered by people themselves or by a family member.⁷

Early detection in the workplace

Currently there is no evidence to support skin cancer screening in the workplace. The Cancer Council Australia recommends workplaces focus their health surveillance activities on encouraging workers to examine their own skin and providing information to help identify a mole or freckle that has changed in size, shape or colour. However, some workplaces want to provide skin cancer checks within their regular medical examination activities. (Workplaces should also ensure that appropriate measures are in place to protect workers from unsafe levels of UV radiation.)

The decision to provide a skin cancer check service for employees should be carefully considered for reasons such as:

- Skin cancer can grow quickly. There is a danger workers will come to rely on skin cancer checks provided by their workplace and therefore fail to notice a skin cancer that appears in the interim
- A focus on skin cancer checks may result in workers becoming complacent about the use of sun protection control measures to prevent skin cancer
- The experience and expertise and therefore the quality of service providers vary
- Employers' legal obligations may not be met unless there is a clear emphasis on workers knowing how to regularly examine their own skin
- If skin cancer checks are conducted on a voluntary basis, early detection messages, if delivered, will not reach workers who choose not to attend.

The Cancer Council's *Sun Protection in the Workplace* position statement available at www.cancer.org.au provides further information for employees and employers on workplace sun protection issues.

Early detection promotional activities

Skin checks in public places or 'Spot Check' promotions usually involve consultation with a medical practitioner about a spot of concern to the consumer rather than a full body examination. Some public skin check programs have shown that recruitment for screening based on the presence of a number of risk factors is effective in attracting high risk individuals to screening programs.⁸

However, there are still concerns about the effectiveness of skin checks in public places:

- At skin checks in public places, examinations may take place in less than ideal circumstances. Poor lighting, lack of privacy and insufficient time may result in a less than optimal examination. This may increase the risk of malignant lesions being missed;
- There may not be adequate follow up and referral; and
- Although promoted as awareness raising events, anecdotal evidence suggests the general public perceive skin check promotions as a screening service. This

may engender a false sense of security in clients about their overall skin cancer risk.

The Cancer Council Australia and the Australasian College of Dermatologists do not endorse the practice of skin checks in public places as a screening method, but recognise the value in promotional or educational activity that raises awareness of early detection or skin cancer prevention.

Further information about checking your skin for skin cancer contact:

- The Cancer Council Australia – www.cancer.org.au
GPO Box 4708, Sydney NSW 2001
Ph: (02) 9036 3100 Fax: (02) 9036 3101
- The Cancer Council Helpline – 13 11 20
- The Australasian College of Dermatologists – www.dermcoll.asn.au

Revised August 2007

APPENDIX 1: Criteria for screening

The accepted criteria for instituting a screening program⁹ are:

Disease: Serious

- High prevalence of preclinical stage
- Natural history understood
- Long period between first signs and overt disease

Diagnostic test: Sensitive and specific

- Simple and cheap
- Safe and acceptable
- Reliable

Diagnosis and treatment: Facilities are adequate

- Effective, acceptable and safe treatment available

APPENDIX 2: Categories of skin cancer risk

The Royal Australian College of General Practitioners (2005) has identified three categories of risk for skin cancer:

Average risk

- People with light skin without past history of skin cancer

Increased risk

- Family history of melanoma in first degree relative
- Fair complexion, a tendency to burn rather than tan, the presence of freckles, light eye colour, light or red hair colour
- Age over 30 years (> 50 years of age most at risk)
- Presence of solar lentigines
- Past history of non-melanoma skin cancer (<40 years of age higher risk)
- People with childhood high levels of UV exposure and episodes of sunburn in children

High risk

- People with multiple atypical or dysplastic naevi who have a history of melanoma in themselves or in one or more first degree relative (usually >15 years of age).

References

1. National Health and Medical Research Council, Colorectal Cancer Screening - A Report of the Australian Health Technology Advisory Committee, December 1992, p2.
2. Burton R, Aspects of Screening for Skin Cancer, Cancer Forum Special Edition 1996; 20 (3): 243-246.
3. Roder DM, Luke CG, McCaul KA and Esternan AJ. Trends in prognostic factors of melanoma in South Australia, 1981-1992: implications for health promotion, Medical Journal of Australia, 1995; 62:25-29.
4. Jelfs P, Giles G, Shugg D, Coates M, Durling G, Fitzgerald P, Ring I. Cutaneous malignant melanoma in Australia, 1989, Medical Journal of Australia, 1994; 161:182-187.
5. Giles G, Armstrong B, Burton R, Staples M, Thursfield V. Has mortality from melanoma stopped rising in Australia? Analysis of trends between 1931 and 1994. British Medical Journal 1996 312:1121-1125.
6. Helfand M, Mahon SM, Eden KB, Frame PS, Orleans CT. Screening for skin cancer. American Journal of Preventative Medicine 2001;20(3S):47-58.
7. Koh H K, Miller DR, Geller AC, Clapp RW, Mercer MB, Law RA, Who discovers melanoma? Journal of American Academy Dermatology 1992; 26: 914-919.
8. Willams HA, Fritshchi L, Beauchamp D and Katris P. Evalauting the usefulness of self-reported risk factors in a skin cancer screening program. Melanoma Research 2006, 16 (4) p341-345
9. Beaglehole R, Bonita R, Kjellstrom T. Basic Epidemiology, World Health Organisation 1993, Geneva, p94.
10. The Royal Australian College of General Practitioners. *Guidelines for preventative activities in general practice*. September, 2005, p47.