

POSITION STATEMENT

SCREENING AND EARLY DETECTION OF SKIN CANCER

This position statement has been approved by The Cancer Council Australia and the Australasian College of Dermatologists.

SCREENING

The National Health and Medical Research Council definition of screening is:

'Screening for a disease involves performing tests in members of the community without symptoms of that disease, in order to identify individuals who may have the disease and who therefore require further, more specific investigation. The term "screening" specifically excludes the investigation of people with symptoms.'

There are three approaches to screening:

- mass (or population) screening: the comprehensive testing of the entire population within a certain age group
- screening of selected population groups in high risk categories
- case finding, offered as part of a routine medical check-up.

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

Screening for melanoma does not meet the recognised criteria for the implementation of screening (see 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.

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 (see Appendix 2)
- recommend that General Practitioners assess patients who are concerned and develop
- appropriate management programs depending on their level of risk
- recommend that General Practitioners who identify risk factors for skin cancer in patients
- presenting for other reasons, inform patients about sun protection measures and offer them opportunity for a full body examination and an appropriate management plan (ie 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 disfigurement 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

Recommendations

- The general public, particularly men aged 50 and over, be encouraged to check all areas of their skin, including skin not normally exposed to the sun, for changes as described in the *How to check for skin cancers* leaflet at least six-monthly. They should seek assistance from another individual to check difficult to see areas such as their back.
- Individuals who are concerned about skin changes suggestive of skin cancer should seek advice from a medical practitioner.

Early detection in the workplace

Occupational Health and Safety legislation requires that employers provide opportunities for outdoor workers to be informed about the risk factors associated with skin cancer, skin changes that might indicate a potential skin cancer, and the need to seek early medical attention should they notice any such changes. Currently there is no evidence to support skin cancer screening in the workplace.

Some workplaces provide regular medical check ups for their employees. If skin cancer examinations are undertaken, they should be provided for workers at high or average risk (see Attachment 2). A full body examination should be undertaken by a medical practitioner.

Early detection promotional activities

Skin checks in public places or 'Spot Check' promotions usually involve a consultation with a medical practitioner about a spot of concern to the consumer rather than a full body examination.

There have been no thorough evaluations of these activities but the following concerns have been raised:

- 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.
- 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.

Recommendation

The Cancer Council Australia and the Australasian College of Dermatologists do not endorse the practice of skin checks in public places.

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APPENDIX 1: Criteria for screening

The accepted criteria for instituting a screening program are:

Disease	Serious High prevalence of preclinical stage Natural history understood
Diagnostic test	Long period between first signs and overt disease Sensitive and specific Simple and cheap Safe and acceptable
Diagnosis and treatment	Reliable Facilities are adequate Effective, acceptable and safe treatment available

APPENDIX 2: Categories of skin cancer risk

The National Health and Medical Research Council has identified three categories of risk for skin cancer:

High risk

- have a family history of skin cancer/melanoma, have a large number of acquired or dysplastic naevi (moles), and/or have a previous history of melanoma
- have white skin, which burns rather than tans, are aged 50 or more and have solar keratoses
- are immunosuppressed or have xeroderma pigmentosa.

Average risk

- have skin that burns or burns then tans and a history of sunburns
- have skin that burns or burns then tans and work outdoors
- have skin that burns or burns then tans and are aged 50 or over.

Concerned individuals

- Individuals who, in response to public education programs, perceive themselves to be susceptible to developing skin cancer.

References

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 - 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, *Med J Aust*, 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, *Med J Aust*, 1994; 161:182-187.
 - ⁵ Giles G, Armstrong B, Burton R, Staples M, Thursfield V. Has mortality from mleanoma stopped rising in Australia? Analysis of trends between 1931 and 1994. *BMJ* 1996 312:1121-1125.
 - ⁶ Helfand M, Mahon SM, Eden KB, Frame PS, Orleans CT. Screening for skin cancer. *Am J Prev Med* 2001;20(3S):47-58.
 - ⁷ Koh H K, Miller DR, Geller AC, Clapp RW, Mercer MB, Law RA, Who discovers melanoma? *J Am Acad Dermatol* 1992; 26: 914-919.
 - ⁸ Beaglehole R, Bonita R, Kjellstrom T. *Basic Epidemiology*, World Health Organisation 1993, Geneva, p 94.
 - ⁹ National Health and Medical Research Council, *Preventive Interventions in Primary Health Care - Cardiovascular and Cancer, Report of the Assessment of Preventive Activities in Health Care System Initiative*, December 1996, p69.
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