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Commentary I: Skin Cancer: Clear Skies Sometimes Help

Skin cancer and the myriad of lesions that can be confused with skin cancer is now the largest single diagnostic category for most dermatologists. In the UK, only forty years or so ago, this group of disorders accounted for perhaps only 5% of referrals from generalist primary care physicians to specialist dermatologists based in hospitals. Today over 50% of referrals now fall in the skin cancer group. This shift in practice is so pronounced that it seems to alarm some, worried that 'surgical dermatology' will impair the health of the traditional practitioner, so much so that in the UK, 'medical dermatology' now wishes to be recognised as a special interest group within the dermatology profession. There are however more serious consequences.

The main risk factors for most types of skin cancer are lack of melanin, and exposure to ultraviolet radiation. The interaction between these two factors means that the chief characteristic of skin cancer (like most cancers) is that the incidence rate rises sharply with age. Given the widespread changes in the the demographic patterns in many European populations the rise in skin cancer cases seen over the last 4 decades will only accelerate. UK figures suggest that for melanoma at least, there will be a doubling of cases over the next quarter century: for non-melanoma skin cancer the increase will be even larger. It is of course not merely the number of cases that is the issue, but that for every genuine case, many patients will need to be seen and reassured that the suspect lesion is not skin cancer. There are therefore major workload issues that need to be addressed, and in times of heightened financial constraints, such changes cause even more angst for funders of national health care services.

Workload aside, the second issue is that although in many ways research has (arguably) allowed us to say that we understand the biology of many types of skin cancer better than many other solid tumours of man, there are still large lacunae in our ability to intervene in the natural history of many cancer types. Here, we are thinking particularly of the lack of effective therapies for late stage melanoma, Merkel cell carcinoma, and cutaneous lymphoma.

The current edition of Acta is focused on skin oncology and we hope you enjoy its variety. Below we present some personal highlights – not because these papers are better than others – but because of our own interests and foibles.

Quint and colleagues (p. 587–592) have looked at the dermoscopic characteristics of suspicious pigmented lesions in patients who not only harbour CDKN2 Leiden mutations but also have melanocortin 1(MC1R) mutations. They have used a dermoscopic scoring system rather than pattern gestalt, but their conclusions extend beyond what is a relatively uncommon group of patients. What they show is that risk scoring depends on MC1R status. The takeaway message is simple: just as those whose practice is largely amongst pale-skinned persons need to retune their dermatological eyes to the varied clinical signs in deeply pigmented skin, so do those of us who routinely see a large proportion of individuals with red hair and suspicious moles. Who knows, in a few years maybe we will see specialist dermatological texts dealing with this group of individuals!

Patients receiving immunosuppression following organ transplantation are of course at increased risk of various types of skin neoplasia, and in this edition, several papers deal with this topic. Ingvar and colleagues (p. 609–614) make use (again) of the excellent record linkage data available in the Scandinavian countries to examine the relation between infections, HLA and the risk of squamous cell carcinoma. Their conclusions in one sense are negative but interesting because of this: they find no link between squamous cell carcinoma (SCC) risk and post transplant infections, nor to specific HLA types. This highlights once again that we understand less than we think of the relation between immune status and skin cancer.

The paper by Zachariae and colleagues (p. 615–618) is on quality of life (QoL) and warts in patients with kidney transplants. The topic of course is important for its own sake, but there are broader implications to their results so I hope QUALY/DLQI aficionados will read their paper carefully. In essence, they find that the QoL scores for patients with warts or skin cancer are remarkably low. They express some surprise at this but perhaps they shouldn't. It is one of the central findings of the QoL literature that many individuals who have suffered major illnesses or accidents adapt almost completely to their changed health status. QoL scores are not the inverse of disability. As the authors of the current paper point out, compared with acquiring a functioning renal allograft after having been in renal failure, such skin disease states are viewed as relatively minor influences on formal calculations of QoL. It is all too often forgotten that QoL is not something tangible like say mass or distance, but rather a quality that does not normally obey the simple laws of mathematics in that it cannot be simply added and subtracted much as cardinal qualities like mass or distance can be.

Kis and colleagues (p. 648–651) describe their experience of using electrochemotherapy (ECT) for treatment of basal cell carcinomas in patients with Gorlin-Goltz syndrome (Nevoid Basal Cell Carcinoma syndrome). This is a technique neither author of this piece have first hand experience of, but if this modality of treatment becomes more common we hope the abbreviation ECT can somehow be modified otherwise we fear linguistic confusion and perhaps worse amongst our patients (ECT in the UK normally refers to electroconvulsive therapy). "Are you treating my BCC with ECT doctor? Would antidepressants or psychotherapy be an alternative?"

Finally, we cannot help but cast an envious eye on the paper from Lasse Braathen (p. 652–653) on daylight photodynamic therapy in patients with actinic keratoses, based on his experience in private practice in Bern, Switzerland. In this modality, patients are treated with Metvix or equivalent, but instead of being exposed to the light source in hospital, they are told to expose themselves to natural sunlight later in the day. The advantage is that pain would appear to be less than when the light is delivered in more intense exposure. We note however that treatments were not administered on rainy days. We cannot see this treatment catching on in the British and Irish Isles then!

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