5 things I now know about melanoma

Suzanne Wolfe

More than 2 million people in the United States will receive a diagnosis of skin cancer in 2013. A few months ago, I became one of them.

Ironically, I'd gone to see my dermatologist because I thought my *dad* had skin cancer. He had admitted that the large mole on his head had changed in recent months, but he was not inclined to do anything about it, leaving the worrying to my mother and me. I was finally able to cajole him into going to the doctor by scheduling a joint appointment—I would have a preventive body check, and he would have the mole examined.

When the office visit was over, my father walked out with the assurance that his mole was benign. I walked out with an ache in my foot where the doctor had just sliced off a piece of skin. A week later, I received the biopsy results: melanoma.

I was concerned, of course, but not as much as I might have been had the news of the diagnosis been delivered in a different way. My dermatologist, while making clear that I needed to seek surgical treatment without delay, spoke to me in the same low-key, easy manner she always had. I appreciated that, and it helped me to digest the news.

Although melanoma is the least common form of skin cancer, it is also the most deadly. Mine was detected at stage 1, so I count myself among the lucky ones. Now, at 53 years old, I am wiser to the ways of melanoma. Here is what I've come to know.

1 Melanoma does not necessarily look that bad The photos of skin cancer I remember seeing in educational brochures practically screamed "Cancer!" But the mole my dermatologist shaved off looked like a plain old mole to me. It did not seem to fit the ABCDE skin cancer mnemonic (Asymmetry, Border irregularity, Color variation, Diameter greater than 6 mm, Evolving). Turns out, the *asymmetry* in the left and right sides of the mole was there, but it was subtle and visible only when viewed through a magnifying lens. The mole met the *evolving* criterion, too, having become more elevated in the 3 years since my last skin check; I just had not paid enough attention to how it used to look to notice the change. Recognizing even a single change in a mole may be crucial to detecting the cancer early, because some melanomas meet only one or two of the ABCDE criteria.

2 Melanoma can occur where the sun doesn't do much shining My melanoma was sandwiched between two toes. Other potential sites that do not get much, if any, sun exposure include the soles of the feet, palms of the hands, fingernails or toenails, and genital area. Melanomas that are not in plain sight can be among the most deadly because the patient may not notice the cancer until it is well progressed.

3 Removing a mole for biopsy is not the same as removing the cancer The type of biopsy my dermatologist performed, one of several techniques commonly used, was quick and simple but not deep and wide. I did not realize

that once the visible mole was removed, the full thickness of skin beneath it and a wide margin of skin around it would need to be surgically excised. Further treatment might be needed based on results of the postsurgical tissue analysis, which would definitively stage the cancer, as well as on other medical findings. In my case, the 'tween-the-toes location made removal of the melanoma complicated and necessitated the hands of an expert plastic surgeon, who excised the area and then placed a skin graft during an hour-long operation. In the weeks that followed, I would be doing twice-daily dressing changes, hopping around on crutches, and later walking with the aid of a cane as the foot healed and my mobility returned.

4 More than one specialist may need to be involved, even if the melanoma is thin My skin cancer was diagnosed by a dermatologist, treated by a plastic surgeon, and reviewed by an oncologist, who examined me for evidence of spread to lymph nodes—an examination that helped determine whether I needed to undergo a lymph node biopsy before the melanoma was removed. Thankfully, I did not, but I felt good for having been checked out and relieved that I had an oncologist in place should the postop pathology tests indicate I needed one. The oncology nurse who was present during my examination, and who was clearly an integral part of the care team, exuded warmth, kindness, and optimism—a combination that did much to overcome my discomfort at finding myself in the unexpected role of cancer patient.

5 Dermatologic check-ups belong on the preventive-health short list Like many women, I am vigilant about going for mammography every year. But having had no unusual findings in past dermatologic body checks, an annual examination fell off my to-do list, especially since I believed myself to be at low risk (all those summers *not* going to the beach!). My must-do list sure has changed. Because my risk for developing melanoma again is about 9 times greater than someone who has never had melanoma before, I will be going for check-ups every few months for the next few years.[1] And I plan to keep going as often as advised, knowing that the risk will never completely go away. Indeed, a recent study found that recurrence of melanoma more than 10 years after initial treatment is not uncommon.[2]

Suffice it to say, I have a newfound appreciation for the importance of body checks—such a simple, low-tech preventive measure—and the need to become familiar with one's own skin. A message whose importance, I've come to realize, is much more than skin deep. ■

Suzanne Wolfe is scientific director/senior editorial manager for PRI Healthcare Solutions, New York, New York.

REFERENCES

1. Bradford PT, Freedman M, Goldstein AM, Tucker MA. Increased risk of second primary cancers after a diagnosis of melanoma. *Arch Dermatol.* 2010;146(3):265-272.
2. Faries MB, Steen S, Ye X, Sim M, Morton DL. Late recurrence in melanoma: clinical implications of lost dormancy. *J Am Coll Surg.* 2013;217(1):27-34.