

The A, B, C's of black death

Melanoma is a pigmented mole most often found on the skin. It is second only to cancer of the lung in women, and is the fastest increasing malignancy known in America today.

Recently I had dinner with Dr. Robert Dirk Noyes, a melanoma expert from the University of Utah, who reviewed this bad cancer. The

lifetime risk of melanoma was 1 in 1500 in 1935, 1 in 150 in 1985, and in 2000 it was 1 in 74! The risk factors for melanoma include

exposure to large amounts of sun, family history, fair complexion, red hair, freckling, severe childhood sunburn and large, pigmented skin blemishes.

Melanoma can appear suddenly as a new mole, or it can develop slowly in or near an existing one. In men melanomas develop between

the shoulders and hips as well as the head and neck. In women they develop in the lower legs also. For the last 20 years, doctors have been using the A, B, C's and D's of diagnosing melanoma. A is for Asymmetry -- the mole is irregular in shape (benign ones are typically round and symmetrical). B is for Border -- melanomas have an uneven ragged or notched border (benign moles have a smooth, even border). C is for Color -- melanomas contain many shades of brown, black and red (moles are usually a single shade). D is for Diameter -- this cancer is larger than 6 cm in diameter and the size of a pencil eraser (benign moles are smaller).

In addition to the A, B, C's, the doctor sometimes uses other terms, such as nodular, superficial spreading, lentigo maligna, acral lentiginous, and desmoplastic. These are big words and are not as important as how deep the lesion is in the skin. Forty years ago, Dr. Clark described his classification, based on how thick the lesions were under the skin. In addition, factors that indicate the outlook also include how many

lymph nodes are involved, the site of the cancer, and whether the skin is ulcerated. For example, if melanoma is on a mucus surface, such as the mouth, vagina, or anus, the prognosis is far worse. Additionally, the longer the person has had a lesion, the more likely it will have metastasized (traveled to other areas).

For the last two years, doctors have determined nodal involvement by injection of a blue dye into the melanoma, together with the use of radioactive injection into the lesion. Using these techniques, the surgeon knows if the lesion can just be locally excised or if a larger dissection needs to be performed. In the last year, the drug Intron A, which is a type of Interferon has greatly helped to extend the quantity and quality of survival. Monthly examinations of the skin, using a mirror to view parts not easily seen, and consultation with a knowledgeable physician if abnormality is noted, will ensure early diagnosis and a cure.

(Editor's Note: Views and ideas of this column do not reflect on the ideas of The Coffeyville Journal.)



**DR. J.E.
BLOCK**

ALL THINGS
MEDICAL