Melanoma healthcare and outcome disparities

Warren R. Heymann, MD
Marlton, New Jersey

Every dermatologist understands that the most important prognostic factor in melanoma is Breslow thickness; the sooner melanoma is diagnosed, the better. Every day, I examine patients' pigmented lesions, perform dermoscopy, biopsy suspicious lesions, and occasionally order molecular studies in an effort to recognize thin melanomas; having thicker melanomas necessitates a discussion on sentinel node biopsies and targeted therapies, depending on the stage.

In this issue of the *Journal of the American Academy of Dermatology*, there are 7 articles addressing health care disparities in melanoma and how they adversely affect melanoma outcomes.

Zheng et al[1] performed a SEER database cohort study on Asians and Pacific Islanders, who have a significantly lower risk of developing melanoma compared to Whites, confirming that Asians and Pacific Islanders have poorer overall and disease-specific survival than Whites, primarily due to late diagnosis and treatment. Koblinski et al[2] performed a retrospective analysis of 27,727 patients with cutaneous melanoma from the Arizona Cancer Registry. White Hispanics were found to have 2.53 times greater odds of presenting with regional stage melanoma and 5.37 times greater odds of presenting with distant-stage melanoma compared with White non-Hispanics. In their multivariate analysis of 12,113 veterans, Hartman et al[3] found that older, Black race, Hispanic ethnicity, North Atlantic/Pacific residency, and extratruncal locations were associated with increased odds of thick melanoma (≥2 mm). Qian et al[4] analyzed 381,035 patients with melanoma encompassing 3 periods from the SEER database (before 2000, 2000-2010, and after 2010) and determined that across all minority groups, patients with localized disease suffered increasing disparity with worsening of melanoma-specific survival.

Socioeconomic factors also affect melanoma prognosis. Zafar et al[5] identified 12,991 patients with melanoma in Iowa from the SEER database. Rural patients with decreased odds of being an ethnic minority also had a greater risk of metastatic disease. Straker et al,[6] in a quasi-experimental, difference-in-differences retrospective cohort analysis of 83,322 patients from the National Cancer database, found that after risk adjustment, Medicaid expansion (through the Affordable Care Act) was associated with a significant decrease in the diagnosis of T1b stage (or higher) American Joint Committee on Cancer (AJCC), Eighth Edition staging system for melanoma.

Cortez et al[7] tied this together in their systematic review of melanoma disparities by stating the following: "Disparities in melanoma care exist in the United States. Disparities in provider type, patient demographics, place of residence, insurance status, socioeconomic status, race/ethnicity, and age impact melanoma outcomes. Melanomas detected by dermatologists are thinner at an earlier stage and have better survival outcomes compared with detection by primary care providers or patients. Lower socioeconomic status, race/ethnicity, and place of residence are associated with decreased access to and/or utilization of dermatologists and more advanced melanomas at diagnosis. Additionally, uninsured and publicly insured individuals are more likely to present with late-stage melanomas, resulting in worse outcomes."

Dermatologists perform crucial services on behalf of our individual patients with melanoma on a microlevel. In order to improve melanoma outcomes for all citizens, it is imperative that dermatologists support efforts toward eliminating health care disparities on a macrolevel through organizations such as the American Academy of Dermatology.

From the Division of Dermatology, Cooper Medical School of Rowan University, Marlton, New Jersey.
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Correspondence to: Warren R. Heymann, MD, 100 Brick Road—Suite 306, Marlton, NJ 08053. E-mail: wrheymann@gmail.com.
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Conflicts of interest

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