SUN AND MELANOMA
Consequences of saying sun is not major cause of melanoma

As a consultant dermatologist running two week wait cancer clinics and dealing with between four and eight melanomas a week (and numerous other skin cancers) at our multidisciplinary team meeting across the whole county, I find Shuster’s arguments that melanoma is not related to sun exposure irresponsible and beyond rational thought.¹

The references quoted in his article are not a fair representation of the body of scientific evidence available to us, and when mixed with selectivity and conjecture, they cannot be relied on to form concrete opinion. Shuster’s statements on increased malignant diagnosis of “benign” moles are dangerous and don’t help the patient in the clinic presenting with a changing atypical naevus, or a patient with diagnosed melanoma re-presenting with local metastatic spread. Does he expect us to tell patients whose melanoma has been histologically diagnosed that they have a benign disease and the histopathologist is wrong?

Shuster’s interpretations of research on sunbed use and ultraviolet A phototherapy are misguided. I find Menzies’s observations far more compelling, as I expect most dermatologists in the world would.² He is also concerned about Shuster’s article translating into an epidemic of non-melanoma skin cancer. Finally, he professes to be unaware of evidence that ultraviolet light may protect against some forms of cancer including melanoma, I will go and get my hat.

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Competing interests: None declared.

² Menzies SW. Is sun exposure a major cause of melanoma? Yes. BMJ 2008;337:a763. (22 July.)

Time to go get your hat

Cooper (previous letter) finds Menzies’s observations more compelling than Shuster’s, as he expects most dermatologists in the world would.¹ ² He is also concerned about Shuster’s article translating into an epidemic of non-melanoma skin cancer. Finally, he professes to be unaware of evidence that ultraviolet light may protect against some forms of cancer.

We would therefore direct him to our recent lesson of the week and its accompanying editorial.¹ ² The evidence linking major cancers—including breast, prostate, pancreas, and colon—to UVB light under-exposure is actually rather stronger than is the evidence linking melanoma (quantitatively responsible for an order of magnitude fewer deaths) to UVB over-exposure.¹ ²

This debate highlights how the more we as specialists doctor diverge from the common stem of general internal medicine that nurtured us, the greater the risk of our missing the bigger picture when an issue transcends specialty boundaries. Incompletely justified high profile media campaigns about sunlight and melanoma risk may well produce short term gain in respect of a fall in non-melanoma skin cancer, but is this an ethically justifiable end point of itself?

Doctors need to be open and honest with their patients and, if called on to do so, the general public. Where our opinion is founded largely on our own personal experience (however extensive), but where the hard evidence is incomplete or indirect, this needs to be made clear to our interlocutors, else we may in future years forfeit the professional trust bestowed on us.

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Competing interests: None declared.

² Menzies SW. Is sun exposure a major cause of melanoma? Yes. BMJ 2008;337:a763. (22 July.)

Use your head and put a hat on it

There is very good epidemiological evidence that melanoma is related to UV exposure that Shuster has not cited.³ Marks has shown that the public health campaign in Australia has shown not only a decrease in the incidence of melanoma but also an increase in the detection of early, treatable lesions.² Despite this positive progress, Queensland, a tropical region, has the dubious honour of having the world’s highest incidence of melanoma. Is it Shuster’s assertion that the white Anglo-Saxon and Celtic majority living in this area somehow have inherited genetically unstable melanocytes? Alternatively, is it his assertion that Queensland has a particularly overzealous and poorly trained group of pathologists?

The role of intermittent, high intensity exposure has been suggested as the mechanism by which UV light induces malignant change in melanocytes.¹ Intermittent ionising radiation is a well recognised and well documented model for inducing other cancers, most notably sarcomas.⁴ Shuster suggests that melanomas do not occur in anatomical sites with this pattern of exposure, yet the most common locations are the trunk for men and the lower limb for women. It is these same areas that are commonly sunburnt during the holiday season, particularly in childhood. We do not advocate that UV light is the sole cause of melanoma; Burd (next letter) highlights the occurrence of acral lentigious melanoma in non-white populations on non-exposed areas. However, the incidence of melanoma in these populations is very rare.

Quinton et al (previous letter) suggest that UV light may have a protective effect against some cancers. If this were as important as they suggest, Australians would be some of the healthiest around. An inspection of the readily available statistics shows that cancers of the breast, colon, and prostate kill with monotonous regularity in Australia and New Zealand as they do in western Europe (http://

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A more rational explanation is likely to be that vitamin D deficiency is a surrogate marker for poorer socioeconomic status and chronic risk factors for many diseases, including cancer. What is more, the mortality from melanoma in these countries is not quantitatively responsible for an order of magnitude fewer deaths but is actually the fourth most fatal cancer of the entire population. Quinton et al may be less dismissive of melanoma if they were to consider that in England and Wales, melanoma is the third most common cancer in 16-40 year olds (http://info.cancerresearchuk.org/healthyliving/sunsmart/skincancer/malignantmelanoma), the very cohort that are contributing taxes to pay for our government sponsored positions.

No skin cancer specialist would suggest that UV light is to be completely avoided, rather the sunburn it can cause. The Australians have taken a lead in educating the public about UV related skin cancers and have demonstrated its effectiveness. Perhaps it’s time we put our hats on and followed them.

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Competing interests: None declared.


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What about acral lentiginous melanoma?

I have just finished writing a short update review on cutaneous melanoma for a local journal, and a point of note is the ethnocentricity of the melanoma debate. I have no doubt that sun exposure but also major attacks on the immune system such as insect repellents—or a more compliant intake of newer and more convenient chemoprophylactic drugs (for example, atovaquone-proguanil).

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Competing interests: None declared.

4 World Health Organization Regional Office for Europe. Centralized information system for infectious diseases (CISID). http://data.euro.who.int/cisid
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Travel industry should highlight malaria prophylaxis

Smith et al reported an increase in cases of imported malaria in the UK. We recently reviewed travel brochures from 27 British tour operators which featured holidays to malarious African countries. Of the 27, in only 12 did we find any mention of malaria or the advisability of malaria prophylaxis. Only four brochures mentioned malaria on the same page as a holiday to a recognised malarious region.

Such literature would be an ideal place to target advice to travellers, and our results show that this opportunity is being missed.

More generally, the findings imply that the travel industry is failing to take the risk of malaria to travellers sufficiently seriously. We note that there is no specific guidance given by the Association of British Travel Agents (ABTA) to tour operators regarding malaria. Also, the airline industry trade association, the International Air Transport Association (IATA), advises member airlines on disinfection of aircraft to remove insects, but there are no recommendations regarding the offering of health advice to passengers.

Accordingly, people travelling independently to visit relatives in malarious countries the transmission of Plasmodium species by mosquito bites, either by adhering more strictly to personal protective measures—such as insect repellents—or a more compliant intake of newer and more convenient chemoprophylactic drugs (for example, atovaquone-proguanil).
are unlikely to be exposed to any relevant health advice at all prior to travelling.

We believe that the travel industry has an obligation to improve the quantity and quality of malaria advice it provides in its brochures and other promotional publications, with particular emphasis on malaria prevention where appropriate. For independent travellers, malaria advice should be provided by the airline—for example, on the ticket itself. This would help target those travelling on business or visiting friends and family in their country of origin.

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Competing interests: None declared.


3 Association of British Travel Agents. ABTA code of conduct 2008. Section 2F.


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BULLOUS PEMPHIGOID

Is the incidence of pemphigoid really increasing?

We found the data reported by Langan et al on the apparent increasing incidence of pemphigoid striking.

It might reasonably be expected that a fivefold increase in incidence of pemphigoid would be apparent to physicians caring for patients with the disorder. Blistering disorders are perhaps unusual among skin conditions in that they are nearly always reported to dermatologists, and specialised testing is required to establish the diagnosis. A straw poll among dermatological colleagues last week did not support the view that pemphigoid had been seen more often, and to examine this further we reviewed the incidence of positive tissue diagnoses of pemphigoid in our laboratory over the period 1994-2004. Such diagnostic biopsies tend to be taken only once, and generally at the onset of the disease. They therefore represent a surrogate marker of incidence of the condition.

Currently we receive over 2000 samples annually, and in the period 1994-2003 (for which we have easily accessible data) we made 1656 new diagnoses of pemphigoid using direct immunofluorescence on skin biopsy material. Although the number of pemphigoid diagnoses increased from 71 in 1994 to 245 in 2003, when we normalised these crude data to the number

of tissue specimens received or to the frequency of unconnected diagnoses (mean frequency of diagnosis of discoid lupus erythematosus and dermatitis herpetiformis, we found no increase in incidence of pemphigoid using either technique (figure).

Reconciling our experience and diagnostic data with that of Langan et al is difficult. While our samples are received predominantly from London and the southeast, the authors reported no association between pemphigoid incidence and geographical area; thus this ought not to have a role. Although it is possible that dermatologists are preferentially avoiding our laboratory for the diagnosis of pemphigoid, this seems unlikely.

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PAYMENT TO LOOK AFTER HEALTH

Incentive mechanisms require deeper understanding

Cookson and Popay make some important points about the merits and problems of using cash incentives to change health behaviour in disadvantaged populations.1 2

Cookson makes three moral arguments and one prudential argument. Firstly, cash incentives provide an inducement to recipients to change their behaviour to lessen harm to third parties. We could go further and consider direct coercion, for instance, through criminal sanctions. We would then need an argument about why paying people is the approach to take rather than direct coercion.

Secondly, cash incentives create an obligation on recipients to change their behaviour in ways that minimise the burden on fellow citizens. However, benefit schemes that incur an obligation on donors have a history of producing resentment in welfare recipients, which might undermine the scheme’s effectiveness.

Thirdly, Cookson holds that the paternalistic motive for incentivising behaviour change is not acceptable. This is somewhat surprising, given that the trend in public health and public health ethics seems to be in the direction of Sunstein and Thaler’s “libertarian paternalism,”3 4 in which autonomous choices are shaped using paternalistic techniques. Finally, he has a prudential argument: this sort of scheme often works. We need more evidence to understand when, for whom, and how these schemes work.

Popay’s arguments against Cookson’s position contain many suggestions about the mechanisms involved in incentivised behaviour change. Both she and Cookson agree that these schemes have greater impact on the disadvantaged, but disagree about whether this is necessarily a good thing.

We are starting a five year Wellcome Trust funded programme of research in ethics, psychology, and economics, which will provide some of the answers to the questions Cookson and Popay have so helpfully framed.4

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Competing interests: REA, TMM, and AO recently received funding from the Wellcome Trust for a strategic award in biomedical ethics to carry out ethical, economic, and psychological studies on the use of personal incentives to promote public health.

1 Cookson R. Should disadvantaged people be paid to take care of their health? Yes. BMJ 2008;337:140. (8 July)

2 Popay J. Should disadvantaged people be paid to take care of their health? No. BMJ 2008;337:141. (8 July)


Cite this as: BMJ 2008;337:a1135
Family payments: a cautionary tale for policy makers

Much observational evidence shows that children in wealthier families are healthier and have improved life chances.1,2 However, a cautious approach should be taken to adopting conditional payments as a means to increase family wealth and children’s wellbeing.

Ashcroft et al (previous letter) rightly call for empirical as well as moral reasoning to be considered when judging the merits of this approach. We need to pull together what we know in a context dependent way.

Firstly, we need to ask, “Will it work here?” We are used to considering whether evidence from wealthier countries will translate to low and middle income countries or whether it will transfer between different high income countries. In this case we are asked to consider whether evidence will transfer from poor to rich. To understand the impact of wealth on health we have to consider that once basic needs are met the relationship is not direct. In high income countries absolute poverty is rare, but health inequalities still exist.3 In this context we need to consider the likely impact of conditionality itself on the social and financial circumstances of the families targeted. In experimental studies in wealthier countries the impact for children of such conditional payments has been poor.4 This may have been attributable either to the stress of meeting the work conditions, or to the low value of additional funds. Either of these explanations should lead us to at least question the expansion of conditional schemes as a means of addressing inequalities.

Secondly, we need to think carefully about pinning benefits for children to parental behaviour. We spend considerable energy trying to ensure that welfare systems target their behaviour. We spend considerable energy pinning benefits for children to parental behaviour. Of addressing inequalities.

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INTERNET AND HEALTH CARE

iwantgreatcare: problems

There are numerous problems with the concept behind iwantgreatcare.org, and many have already been highlighted by Cohen’s blog.1 With regard to the website, it is claimed that there are measures in place to identify abuse such as multiple posts by a single person.2 However, what is to stop a grudge bearing patient or an overly tempted doctor from logging in as different users and swaying the overall reviews to one side? As a public health professor from my epidemiology module would say, the results and reviews for each doctor will be greatly biased in that only patients who are proficient in using the internet will be able to contribute. Perhaps the computer literate population has different expectations of a doctor than people not trained in information technology—notably, elderly patients.

Although 96% of the reviews on the website were positive in the first week, I still believe that the website will attract a greater number of negative reviews in the long run. I certainly have a tendency to make greater effort when criticising something rather than commending it (as evidenced by this letter), and I believe the patient population contributing to the reviews will have similar priorities. Logically this may lead doctors to ask their patients to post good reviews for them—in effect, marketing their skills to the wider (internet) patient population. I think I prefer the old, modest practitioner.

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LEAGUE OF DISRUPTIVE SPECIALTIES

Disruptive, neurologists?

Rather belatedly, I have tracked down the neurology article referred to in Minerva (final paragraph), which stated that neurologists had the most disruptive behaviour of non-surgical specialists.1 Knowing that we are, by and large, a rather quiet, polite, and studious bunch, I was surprised, but now outraged that Minerva has misquoted so badly, and thus sullied the reputation of an entire specialty.

The actual results were that the most frequently mentioned non-surgical specialties regarded as disruptive were cardiology (7%), gastroenterology (6%), and neurology (4%), with all others less than 3% (specialties not specified). Of course, we physicians were quite feeble by comparison with the surgeons, with general surgery leading the pack at 31%, cardiac surgeons 21%, neurosurgeons 15%, and orthopods 7%. Apart from the rather unfeasibly low rate of orthopaedic disruptive behaviour, these data certainly sit well with my own long held prejudices. I feel a (polite, meek, non-disruptive) request for an apology from Minerva is appropriate.*

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Bush telegraph more effective

I decided to use the website iwantgreatcare to identify a good general practitioner in my area.1 I typed in “general practice” and my London suburb, and got a list of six doctors (out of some 50 individuals whom I know to be practising as GPs in that area). One of the six is not a GP at all; one left the country five years ago; one is well known to have been the subject of repeated complaints from dissatisfied patients; and one has retired. Not a single one had any “ratings” listed from patients.

On the other hand, I was in Waitrose the other day and heard two people behind me talking. One, who was new to the area, had asked the other to recommend a good GP for a young family. The second individual immediately passed on clear and (I felt) accurate information about which local surgeries gave good care, and named two popular and sympathetic GPs who had an interest in young children.

What can we conclude? Perhaps nothing—but an important hypothesis remains to be tested. The bush telegraph is likely to be a better and more up to date source of relevant knowledge about “good doctors” than either Web 2.0 or any official league table yet produced.

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Competing interests: None declared.

1 Cross M. How the internet is changing health care. BMJ 2008;337:a883. (22 July.)

Cite this as: BMJ 2008;337:a11137

*You have one: see p 360 — Ed.