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Melanoma is malignant, moles are benign

LEDER

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Pigmented skin lesions must be excised when malignancy is suspected. If there is no such suspicion, moles should generally be left alone.

Many people are afraid of developing melanoma, which has a high risk of metastasis and a fatal outcome when the lesion exceeds a certain thickness (1). About two-thirds of all melanomas in the skin develop from melanocytes in the skin outside moles, i.e. outside pigmented naevi (2). It is therefore misleading and inadvisable in the Norwegian language to call melanoma *føflekkreft*, literally mole cancer. The expression promotes a misconception that moles are precursors of cancer (3).

The two most important questions a doctor must ask a patient who wants a mole check for possible melanoma are: Have you noticed the appearance of one new mole that is different from your other moles? Have you noticed whether one mole has changed, i.e. grown, changed colour or edges or become different from the others? If the patient says there is something strange about precisely *this* mole, the doctor should pay extra attention. The risk factors for melanoma, such as family history, light skin type, sunburn or previous skin cancer, must also be established in each case.

Pigmented skin lesions should be checked clinically by means of simple visual inspection. The much used ABCDE rule – i.e. asymmetry (A), irregular border (B), irregular colour, often with black portions (C), width > 6 mm (D) and evolution (E) – is useful in cases where a superficial spreading melanoma is suspected, but is not as effective at picking up a nodular melanoma, which may be symmetrical, with a sharp, regular border and an even, black colour. One useful sign is the so-called *ugly duckling sign*, i.e. that one lesion clearly differs in appearance from the patient's other pigmented naevi (4). Dermatoscopy can be helpful (5), but few general practitioners master this technology.

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Many people visit doctors to have moles checked and one or more removed. These consultations can take up a not inconsiderable amount of GPs' and dermatologists' work days. There are 'Mole Clinics' and doctors who cite 'mole removal' as one of the procedures they offer. As a result, a large number of excisions of pigmented skin lesions are carried out

on very weak indication, with the resectate being sent to the country's often overburdened pathology departments for histological diagnosis, which can delay the results of other tests. Several studies, including one from Sweden, show that only a small fraction of these resectates prove to be melanomas (6). Removing obviously benign pigmented naevi in order to prevent cancer is not the way to go.

This does not mean that all excisions of pigmented naevi that prove to be benign have been removed unnecessarily, because a melanoma diagnosis may be difficult to make, both clinically and histologically. It is not a good thing to overlook a melanoma. But it brings to mind the following: skin lesions should only be excised after weighing potential benefit and risk of not performing the procedure against drawbacks and possible complications.

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Skin excisions will *always* leave scars, often cosmetically disfiguring, sometimes in the form of a hypertrophic scar or keloid. A mole should therefore not simply be removed at a patient's request. The doctor must consider the pros and cons. A clearly benign pigmented naevus should not be removed 'for safety's sake'. If the doctor, based on the patient's medical history and the appearance of the lesion, suspects that the lesion may be a melanoma, it must be excised. Fear of cancer – carcinophobia – may be a legitimate reason, but only in exceptional cases. The same applies to an elevated pigmented naevus that is in the way of a bra strap or belt, or where there are other grounds that make it reasonable to remove it. If the suspicion of melanoma is weak, the patient can be referred to a dermatologist for an assessment.

Berg-Knudsen et al. are currently publishing in the *Journal of the Norwegian Medical Association* a clinical review with good tips and instructions for the excision of skin lesions (7). The authors' advice is relevant not only for pigmented skin lesions suspected of being melanomas, but also for other skin lesions with an uncertain diagnosis, for example on suspicion of basal cell carcinoma. I hope this article will be read, uploaded and used by many GPs, specialty registrars and medical students. A good doctor must know when *not* to cut, *when* to cut, and *how* to cut.

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