serve as a useful learning and assessment tool to enhance dermatology resident education.

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Results | The sample (N = 139) was mostly female (n = 97 [70%]) and non-Hispanic white (n = 135 [97%]). The median age was 48 years; most patients had only 1 FDR with melanoma (n = 128 [92%]) and no personal melanoma history (n = 110 [79%]). Approximately half (n = 76 [55%]) had a sun-sensitive phenotype (skin type I/II, indicating skin prone to burning). Baseline discussion rates did not differ by experimental conditions (P > .05 for all).

At baseline, frequency of melanoma risk discussions across all family member types was higher, on average, among women than men (I² = 2.34, P < .05), but did not differ based on whether they had 1 or more FDRs with melanoma, whether they had a personal history of melanoma, or whether they had a sun-sensitive phenotype (skin type I/II) or not (P > .05 for all). The GEE model–estimated intentions were higher if the participant received positive (n = 128 [92%]) rather than negative (n = 100 [72%]) feedback (χ² = 11.98, P = .001). There were no significant differences by feedback type, nor a significant interaction (risk level by feedback type). As reported in the Figure, discussion with all family members increased signifi-
Genetic testing for melanoma risk presents multiple opportunities for family risk awareness and prevention.6 Findings indicate that FDRs of patients with melanoma are likely to talk with a range of family members about melanoma risk and that positive risk feedback (high-risk mutation, gene environment, and nongenetic) increases intended discussions more than negative feedback. Increased communication with siblings and children, in particular, may be a worthwhile outcome of melanoma genetic testing. Specific guidance on the importance of family communication and risk reduction may be particularly important in the provision of negative genetic testing information.

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