Referring clinicians for the dermatopathology data comprised more than 95% of dermatologists in private practice, with few samples from dermatologists in academic or surgical settings. The HIRD sample is representative of commercially insured populations.

The predictive value of any test depends on both diagnostic accuracy and disease prevalence, and the latter is very low for melanomas before age 18 years. The very high NNB is also likely attributable to reliance on “change” as an important criterion for recognizing melanoma. Evolution of nevi is common in childhood, and hence change is a poor predictor of melanoma in this age group. The development of novel noninvasive diagnostic tools, is important in helping to reduce unnecessary biopsies, health care costs, and morbidity in this age group.

Susan A. Oliveria, ScD, MPH
Nandini Selvam, ScD, MPH
Darius Mehregan, MD
Michael A. Marchetti, MD
Hozea A. Divan, PhD
Bahar Dasgeb, MD
Allan C. Halpern, MD, MS

Author Affiliations: Dermatology Service, Department of Medicine, Memorial Sloan Kettering Cancer Center, New York, New York (Oliveria, Marchetti, Dasgeb, Halpern); Government and Academic Research, HealthCore Inc, Alexandria, Virginia (Selvam, Divan); Wayne State University School of Medicine, Dearborn, Michigan (Mehregan).

Corresponding Author: Susan A. Oliveria, ScD, MPH, Dermatology Service, Department of Medicine, Memorial Sloan Kettering Cancer Center, 160 E 53rd St, New York, NY 10022 (oliveri1@mskcc.org).

Accepted for Publication: October 21, 2014.


Author Contributions: Drs Oliveria and Selvam had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Oliveria, Selvam, Marchetti, Dasgeb, Halpern.

Acquisition, analysis, or interpretation of data: Oliveria, Selvam, Mehregan, Marchetti, Divan, Dasgeb.

Drafting of the manuscript: Oliveria, Marchetti, Dasgeb, Halpern.

Critical revision of the manuscript for important intellectual content: Oliveria, Selvam, Mehregan, Marchetti, Divan, Dasgeb.

Obtained funding: Halpern.

Administrative, technical, or material support: Oliveria, Selvam, Mehregan.

Study supervision: Oliveria, Selvam, Mehregan, Halpern.

Conflict of Interest Disclosures: None reported.

Funding/Support: This study was supported in part by the National Institute of Arthritis and Musculoskeletal and Skin Diseases of the National Institutes of Health under award R01-AR049342.

Role of the Sponsor: The funder had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Disclaimer: The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Additional Contributions: Ashfaq Marghoob, MD, Dermatology Service, Department of Medicine, Memorial Sloan Kettering Cancer Center, provided input on the study design and analysis, as well as feedback during manuscript preparation. He was not compensated for his contributions.

Trends in Indoor Tanning Among US High School Students, 2009-2013

Indoor tanning increases the risk of skin cancer, particularly among frequent users and those initiating use at a young age. While previous research has demonstrated that indoor tanning is common among youth, to our knowledge, this study provides the first national estimates of indoor tanning trends among this population.

Methods | We used data from the 2009, 2011, and 2013 national Youth Risk Behavior Surveys, which used independent, nationally representative samples of public and private US high school students in grades 9 through 12 (http://www.cdc.gov/HealthyYouth/yrbs/index.htm). Indoor tanning was defined as using an indoor tanning device (eg, sunlamp, sunbed, tanning booth, excluding a spray-on tan) at least once during the 12 months before each survey period. Frequent indoor tanning was defined as using an indoor tanning device 10 or more times during the same period. The Youth Risk Behavior Survey had a student sample size of 16 410 in 2009, 15 425 in 2011, and 13 583 in 2013; overall response rates were 71%, 71%, and 68%, respectively. Data were weighted to account for oversampling of black and Hispanic students and nonresponse. The Youth Risk Behavior Survey protocol was approved by the Centers for Disease Control and Prevention's Institutional Review Board. The Youth Risk Behavior Survey is conducted in accordance with parental permission procedures in each locality.

We stratified our analyses by sex because of differences between sexes in indoor tanning behavior. Temporal changes were examined using logistic regression that controlled for age and race/ethnicity. Linear time variables were treated as continuous and were coded using orthogonal coefficients. Data were analyzed using SUDAAN, version 10.1 (RTI International).

Results | Among female high school students during 2013, a total of 20.2% engaged in indoor tanning and 10.3% engaged in frequent indoor tanning. Among male high school students, 5.3% engaged in indoor tanning and 2.0% engaged in frequent in-
Indoor tanning. Indoor tanning was most common among non-Hispanic white female students (Table). From 2009 to 2013, indoor tanning significantly decreased among female students (from 25.4% to 20.2%, \( \beta = –0.22, P = .03 \)), non-Hispanic white female students (from 37.4% to 30.7%, \( \beta = –0.24, P = .03 \)), and non-Hispanic black male students (from 6.1% to 3.2%, \( \beta = –0.50; P = .02 \)) (Figure). Linear trends in frequent indoor tanning were not significant.

**Discussion** These decreases in indoor tanning may be partly attributable to increased awareness of its harms. In 2009, the World Health Organization classified indoor tanning devices as carcinogenic to humans, and several studies have demonstrated that indoor tanning increases the risk of skin cancer.\(^1\)\(^–\)\(^4\) Furthermore, 40 states implemented new laws or strengthened existing laws between 2009 and 2013; of those, 11 states prohibited indoor tanning among those younger than 18 years.\(^5\) Evidence suggests that such laws are associated with lower rates of indoor tanning.\(^6\) In addition, a 10% excise tax on indoor tanning services was implemented in 2010, the effects of which are largely unknown.\(^4\)

Despite these reductions, indoor tanning remains common among youth. The 2013 national Youth Risk Behavior Survey data suggest that an estimated 1.5 million female and 0.4 million male high school students engage in indoor tanning; most (1.6 million) are younger than 18 years. Early intervention is vital to prevent initiation and promote cessation of indoor tanning. The Surgeon General has highlighted the importance of reducing the harms from indoor tanning.\(^4\) Approaches include the US Food and Drug Administration reclassification of tanning devices from low to moderate risk and requiring a warning against the use of tanning devices by those younger than 18 years, limiting deceptive health and safety claims, and counseling fair-skinned individuals aged 10 to 24 years to avoid indoor tanning.\(^4\)

Limitations of this study include its reliance on self-reported data, which are subject to bias. In addition, the Youth Risk Behavior Survey data are generalizable only to high school students and may not represent all persons in this age group. Despite these limitations, this study provides nationally representative estimates allowing for the evaluation of trends over time and progress toward protecting US youth from the harms of indoor tanning.

Gery P. Guy Jr, PhD, MPH
Zahava Berkowitz, MSc, MSPH
Sherry Everett Jones, PhD, MPH, JD
Dawn M. Holman, MPH
Erin Garnett, MPH
Meg Watson, MPH
Author Affiliations: Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia (Guy, Berkowitz, Holman, Watson); Division of Adolescent and School Health, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, Atlanta, Georgia (Everett Jones); Advanced Technology Logistics, Inc, Atlanta, Georgia (Garnett).

Accepted for Publication: October 23, 2014.

Corresponding Author: Gery P. Guy Jr, PhD, MPH, Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Hwy NE, MS F-76, Atlanta, GA 30341 (irm2@cdc.gov).


Author Contributions: Dr Guy and MS Berkowitz had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Guy, Berkowitz, Holman, Garnett, Watson.

Acquisition, analysis, or interpretation of data: Guy, Berkowitz, Everett Jones, Holman, Garnett.

Drafting of the manuscript: Guy, Berkowitz, Everett Jones, Garnett, Watson.

Critical revision of the manuscript for important intellectual content: Guy, Berkowitz, Holman, Watson.

Statistical analysis: Guy, Berkowitz, Everett Jones.

Administrative, technical, or material support: Guy, Garnett, Watson.

Study supervision: Guy.

Conflict of Interest Disclosures: None reported.

Disclaimer: The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

The Risk of Melanoma in Pilots and Cabin Crew: UV Measurements in Flying Airplanes

Recently, a meta-analysis reported an increased incidence of melanoma in pilots and cabin crew, which was possibly due to occupational exposures.1 Cabin crews’ exposure to cosmic radiation was assessed in different studies and always found below the allowed dose limit.2 However, the cumulative...