Germany) and scanned as JPEG images. Lesions with poor image quality were excluded. The first 50 good-quality images in each category were included. These lesions were different from the ones in our group’s prior study.\(^1\)

The evaluators were 2 dermatology residents with less than 1.2 years of dermoscopic experience who had not participated in our group’s prior study.\(^1\) One had taken two 1-day dermoscopy courses, and the other had spent 2 months studying with Scott W. Menzies, MD. They had no other specific dermoscopic training.

The evaluators independently reviewed the paired clinical and dermoscopic images of the selected 150 lesions using 4 different dermoscopic algorithms in no particular order: CASH,\(^1\) ABCD,\(^2\) the Menzies method,\(^3\) and the 7-point checklist.\(^4\) Details of these algorithms can be found elsewhere.\(^1-4\) Both investigators were blinded to the diagnoses.

The outcome variable in this study was dichotomous (benign melanocytic nevus or malignant melanoma) for each study lesion. The sensitivities and specificities were calculated for each algorithm and were compared with those of CASH.

The sensitivities of all 4 algorithms ranged from 76% for the 7-point checklist to 92% for the Menzies method (Table). None showed a statistically significant difference compared with CASH. The sensitivity of CASH was similar to that of ABCD (87% vs 86%). However, CASH showed a significantly higher specificity than the Menzies method and the 7-point checklist. The CASH and ABCD algorithms did not have statistically significant different specificities.

As CASH and ABCD have higher specificities than the other two algorithms, they would be less likely to result in unnecessary biopsies.

**Comment.** Both CASH and ABCD use very similar criteria, so it is not surprising that the 2 algorithms performed similarly in our study. Both evaluate color, symmetry, and dermoscopic structures. The new feature that CASH introduces is architecture, which forces the user to make a judgment about the overall organization of the lesion. This is an important skill used in the more sophisticated, though difficult-to-learn, technique of pattern analysis, a technique used by expert dermatoscopists. The CASH algorithm provides a regimented way of teaching pattern analysis to the novice dermatoscopist. Another benefit of CASH is that it does not require any weighting factors to calculate a total score, making it quicker and easier to use.

We hope to repeat this study with a large number of evaluators to further validate the CASH algorithm in a consensus Internet meeting on dermoscopy.\(^3\)

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**Table. Sensitivities and Specificities of the Evaluated Dermoscopic Algorithms**

<table>
<thead>
<tr>
<th>Algorithm</th>
<th>Sensitivity, %(^a)</th>
<th>Specificity, %(^b)</th>
<th>Relative Sensitivity(^c)</th>
<th>(P) Value</th>
<th>Relative Specificity(^d)</th>
<th>(P) Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASH(^1)</td>
<td>87</td>
<td>67</td>
<td>1 [Reference]</td>
<td></td>
<td>1 [Reference]</td>
<td></td>
</tr>
<tr>
<td>ABCD(^2)</td>
<td>86</td>
<td>74</td>
<td>0.98</td>
<td>.84</td>
<td>1.10</td>
<td>.13</td>
</tr>
<tr>
<td>Menzies et al(^3)</td>
<td>92</td>
<td>38</td>
<td>1.05</td>
<td>.25</td>
<td>0.57</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Seven-point checklist(^4)</td>
<td>76</td>
<td>57</td>
<td>0.94</td>
<td>.33</td>
<td>0.85</td>
<td>.04</td>
</tr>
</tbody>
</table>

\(^a\) Sensitivity for each algorithm was defined as the number of correctly diagnosed melanomas divided by the total number of melanomas present in the study.

\(^b\) Specificity was defined as the number of correctly diagnosed benign nevi divided by the total number of benign nevi.

\(^c\) The sensitivity and specificity of each algorithm was divided by the sensitivity and specificity of CASH to derive the relative sensitivities and specificities.

\(^d\) Specificity was defined as the number of correctly diagnosed benign nevi divided by the total number of benign nevi.
Results. The intraclass correlation coefficients for interassessor agreement were 0.91 for PH3 and 0.89 for Ki67, indicating an excellent level of agreement.6 We found that similar to the correlation with mitotic rate, ROG was significantly associated with the Ki67 score (Spearman rank correlation coefficient, 0.44; P < .001) (Figure 1) and with the PH3 score (Spearman rank correlation coefficient, 0.46; P < .001) (Figure 2).

Comment. Although retrospective recall of events leading up to a diagnosis of melanoma is associated with several potential sources of error,2 clinical history remains the only practical tool to assess the evolution of melanomas from their inception. Herein, we have demonstrated a significant correlation between the patient-recall–based ROG and objective assessments of melanoma proliferation using immunohistochemical markers at the time of excision. One limitation of this comparison is that ROG examines the development of a melanoma over its whole course, whereas immunohistochemical markers examine only the state of proliferation at the time of removal.

These findings provide further evidence for the role of ROG in the clinical assessment of melanoma growth kinetics.

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Left-Sided Excess in the Laterality of Cutaneous Melanoma

A n unequal distribution of cancer laterality, particularly in paired organs, has long been documented and generally thought to be related to asymmetries in organ size or behavioral factors such as handedness.1 Recently in a large series patients with cancers in the left testis, right lung, and left ovary were found...