The incidence rates of melanoma in Hispanics are on the rise, and melanoma presents at a more advanced stage among Hispanics than other ethnic groups. Delay in diagnosis may be owing to a low index of suspicion for melanoma in Hispanics among both medical professionals and the Hispanic population. It has previously been shown that comprehensive skin self-examination (SSE) may lead to earlier melanoma diagnosis. Despite this evidence, the percentage of patients in the Hispanic population performing SSE has been reported to be low, 15% compared with 32% in non-Hispanic whites (NHWs). Several studies have reviewed skin cancer screening practices among Hispanics, but these studies have all been retrospective, and the conclusions are mainly speculative. Our objectives were to determine the percentage of Hispanics who undergo skin examination by a physician and perform regular SSE and to explore reasons why they might not. Additional focus was placed on participants older than 40 years because skin cancer screenings are recommended for patients in this age group owing to increased risk of melanoma with older age.

Methods. Design Setting and Participants. Patients of Hispanic descent (N=301) were recruited from the Piedmont Health Services in Carrboro, North Carolina; the University of North Carolina (UNC) Dermatology Clinics; and the Hispanic advocacy group El Pueblo in Raleigh, North Carolina. All self-reported Hispanics from any Hispanic country of origin and older than 18 years were invited to complete a survey. The study was approved by the institutional review board of the UNC at Chapel Hill.

Questionnaire and Statistical Analysis. Surveys were prepared using Teleform software (Autonomy/Cardiff) and scanned using a Scantron machine. Data analysis was performed using GraphPad Prism).

Results. Most of our patients were women (72%), with a mean age of 33 years (Table). Most of the participants reported their country of origin as Mexico, although 9 other countries were also represented. Of the Hispanics in our study, 23% reported knowing the risk factors for skin cancer; 9% received a regular skin examination; and 22% performed SSEs. No difference was seen in the group older than 40 years.

Of 273 subjects who did not get regular skin examinations (91%), 32% felt that they did not have ample time with the physician, and an additional 32% reported that they did not think to ask or did not know how to ask for a skin examination, partly because a skin examination was not the primary reason for the visit. It should be mentioned that all the physicians at Piedmont Health Services and some at the UNC Dermatology clinic are fully bilingual. Of the 236 participants who did not perform an SSE yearly (78%), most responded either that they were not told to do so (49%) or that they did not know what to look for (29%).

Comment. Although a disparity has been reported in knowledge and sun-protective behaviors among Hispanics and NHWs, we know of no published literature discussing the reasons why Hispanics do not perform regular SSEs or ask their physician for a skin examination at their regular visits. This study addresses those questions and stresses the importance of education to this growing population. Cultural perceptions of modesty, especially among female patients, were not a significant factor, reported by only 7% of participants. Physicians should take a more active role in educating their patients about...
safe skin practices, including sun avoidance and SSE. Safe skin practices are as important as regular exercise and smoking cessation and should be included in routine health education counseling.

With evidence suggesting the importance of SSE, it is concerning that most of the Hispanic participants did not report performing them. Physicians should educate their patients, demonstrate for them how to perform a proper SSE, explain what to look for, and provide resources with examples. Physicians should also teach their Hispanic patients to pay particular attention to acral areas and extremities because there is a higher incidence of melanoma on those areas in Hispanics.2

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Methods. This institutional review board–approved study prospectively evaluated response to systemic therapy in patients with CLE using the CLE Disease Area and Severity Index (CLASI)3 and the Skindex-29.4 The CLASI is a validated clinical tool that quantifies disease activity and damage separately, with higher scores indicating more severe disease. The Skindex-29 is a validated, skin-specific quality of life measure that calculates 3 subscale scores: Emotions, Functioning, and Symptoms, with higher scores indicating worse quality of life.3

Patients with cutaneous lupus erythematosus (CLE) have very poor quality of life.1 When compared with those with other skin diseases, patients with CLE are among those most severely affected by their condition. Psychologic aspects of quality of life in CLE are similar to, or worse than, what is experienced by patients with chronic hypertension, congestive heart failure, type 2 diabetes mellitus, and recent myocardial infarction. In considering this, we were interested in assessing whether patients who demonstrated response to treatment also experienced change to their quality of life.

Patients with CLE using the CLASI and Skindex-29 scores were measured. Patients with a diagnosis of systemic lupus erythematosus (SLE) were included. Details regarding the identification of eligible patients have been discussed previously.5,6 From among the eligible patients, those who had been initiated on antimarial therapy (hydroxychloroquine, hydroxychloroquine-quinacrine, chloroquine, or chloroquine-quinacrine) or antimalobile therapy (methotrexate, mycophenolate, or azathioprine) were identified. Twenty-seven patients were initiated on antimarial therapy. Hydroxychloroquine was dosed at 200 to 400 mg/d, and chloroquine was dosed at 250 mg/d for 5 to 7 days per week, based on ideal body weight. Quinacrine was dosed at 100 mg/d. Twelve patients were initiated on antimolatile therapy. Antimalobile treatment was initiated at a low dose, and the dose was increased until the lowest effective and tolerated dose was achieved. The median (interquartile range [IQR]) dose for methotrexate was 13.8 (10.6-16.3) mg/wk; for mycophenolate, it was 2000 (1750-2500) mg/d; for azathioprine, 100 (75-125) mg/d. For 6 of 39 patients included in this study, data were available for initiation of two systemic therapies. In these cases, data from the first therapy that was initiated were included, and the remainder were excluded.

Consistent with previous work,5,6 response was defined as either a 4-point or 20% decrease in CLASI activity score and determined by comparing the score at the pretreatment visit with the first posttreatment visit. The first posttreatment visit occurred at least 2 months following the pretreatment visit. For patients with more