

Addressing Disparities in Melanoma Recognition in Skin of Color

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INTRODUCTION

Melanoma is the third most common skin malignancy across all racial groups in the United States.¹ While non-Hispanic white patients comprise the overwhelming majority of cases, morbidity and mortality remain disproportionately higher in minority populations.^{1,2} This discrepancy has been clearly demonstrated by the 5 year melanoma survival rates among African Americans and Caucasians, which are estimated to be 74.1% and 92.9%, respectively.² Despite this persistent trend over recent decades, research and awareness of racial disparities in melanoma outcomes continue to lag.

Delayed detection of melanoma within communities of color results from a number of knowledge gaps among both physicians and patients. One primary concern relates to atypical presentation in patients with skin of color (SOC). In the White population, more than 90% of primary melanomas occur in sun-exposed areas such as the trunk or lower extremity.^{1,3} Conversely, in SOC, melanoma most frequently develops in acral locations such as the palms or soles.^{1,3} The variation in anatomic distribution is particularly problematic with respect to early diagnosis and treatment. Melanomas in these unusual sites are often overlooked during skin self-examinations and health maintenance screenings, resulting in more advanced disease stage at presentation and poorer prognosis.³ It is of utmost importance to emphasize the undue burden of disparities in diagnostic recognition, as melanoma is largely curable if diagnosed early.

A second concern regarding delayed detection of melanoma in darker skin populations results from the inaccurate perceptions of skin cancer risks in SOC. The inherent properties of melanin in darker skin have been well-established to confer a degree of protection from UV radiation in SOC.⁴ However, the misconception that darker skin provides complete protection from skin cancers not only fails to recognize the heterogeneity of skin of color but may also mislead sun protective attitudes and lifestyle behaviors. Additionally, many public education initiatives are primarily directed toward White patients, emphasizing the typical high-risk phenotype as fair-skinned with blue eyes and blonde or red hair.⁵ Other well-advertised risk factors include a tendency to burn rather than tan, a personal or family history of skin cancers, actinic keratosis, and number of benign or atypical nevi. This poses a challenge for patients of color who may not identify with this clinical portrayal or exhibit classic risk factors for melanoma. Similarly, bias among physicians, including dermatologists, further contributes to a

misunderstanding of melanoma risks in darker skin patients. Inadequate training in recognizing dermatologic conditions in skin of color leads to a lack of confidence and awareness that ultimately shapes clinical practice and outcomes for patients of color.

By the year 2050, it is projected that minority groups will represent over 50% of the US population.⁶ As such, now is the time to join collaborative efforts in order to expand outreach initiatives. Further, there is a need for educational programs specifically targeted toward communities of color. Patient education emphasizing the ABCD melanoma features must go one step further to encourage skin self-examinations of atypical sites affected in people with SOC.

Expanded educational efforts should also take form through alliances with community organizations, schools, churches, hair salons, and barbershops to promote melanoma recognition, photoprotection, and seeking dermatologic evaluation when concerns arise. Similarly, physicians should maintain a high index of suspicion for melanoma regardless of a patient's race or ethnicity. Education regarding skin cancer in patients of color must be addressed at the medical school level and further reinforced in dermatology residency training in order to improve quality care for patients of diverse racial and ethnic backgrounds. Moving forward, a better understanding of dermatologic health disparities is critical for developing effective initiative programs.

DISCLOSURES

The authors have no conflicts of interest to declare.

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