Reply to 'Skin cancer, photoprotection, and skin of color'

To the Editor: We thank Dadzie et al for their interest in our article on "Skin Cancer and Photoprotection in People of Color."[1] We would like to respond to points raised in the letter:

1. Dadzie et al indicated that our article was geared toward an American audience. While we trust our article adds to the literature and provides useful information for the global community, the focus of our article was indeed the health care providers and patients in the United States. As outlined in the introduction, the evolving US demographics with an increasing people of color (POC) population, along with elevated rates of morbidity and mortality from skin cancer in POC in the United States, is the backdrop for this important discussion. This article appeared in the "From the Academy" section of the journal because it is the result of the deliberation of the American Academy of Dermatology (AAD) Photoprotection for Skin of Color Work Group.

   We acknowledge that not all the recommendations in our manuscript are easy for patients with scarce financial means or restricted access to health care; however, some of the recommendations are broadly applicable (such as seeking shade or performing self-skin exams).
2. Dadzie et al disagreed with the racial categories used in our article. The definition that we used for this very complex issue was the definition adopted by the United States Census Bureau in 2010; this was clearly stated in the first paragraph of our article.
3. Dadzie et al also commented on the wide variability of skin tones comprised by POC. Recognizing the varied genotypes and phenotypic appearance of individuals of the same racial category, we highlighted, for example, the differences in squamous cell carcinoma in Asian Indians and East Asians (p 751), and in Chinese, Malays, and Asian Indians (p 752). We agree, as noted in our article, that exposure to UV plays less of a role in skin cancer development in darker skin types and that there is a lack of data in regard to sunscreen recommendations in people of color.[1] However, data indicate that even darkly pigmented skin exposed to ultraviolet (UV)A/UVB suffers DNA damage.[2] Therefore, until more definitive data are available, it is our recommendation that patients take reasonable measures to protect their skin from UV radiation and monitor their skin for signs of skin cancer. Risk factors and common locations for skin cancer in POC are noted in Table III of our article.[1]
4. Dadzie et al raised the issue of conflict of interest. As members of an AAD Work Group, all authors' conflicts of interest were disclosed to the AAD and are listed in the publication. It should be emphasized that no industry representative participated in any part of the discussion or in the preparation of this manuscript.

The intent of the AAD Work Group was to heighten awareness and provide practical recommendations for physicians, other health care providers, and patients on this important topic. We are delighted that this article has stimulated discussion among our colleagues around the world, which should lead to better care for patients globally.

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Associates, and Viviscal. Dr Taylor founded T2 Skincare, for which she receives other financial benefit and serves in other roles. She receives grants as an investigator for Hisamitsu Pharmaceutical, Medicis Pharmaceuticals, Noven Pharmaceuticals, and Pfizer. Dr Taylor has received honoraria as a speaker from Allergan, Johnson & Johnson, Kao USA, Merz Pharmaceuticals, and Neostrata. Dr Lim serves as a consultant for Ferndale and La Roche-Posay, for which he receives honoraria. All other doctors have no conflicts of interest to declare.

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Psoriasis or obesity is a risk factor for nonalcoholic fatty liver disease

To the Editor: We read with interest the article by van der Voort et al: "Psoriasis is independently associated with nonalcoholic fatty liver disease in patients 55 years old or older: Results from a population-based study."[1] Their large prospective population-based cohort study (part of Rotterdam study) enrolled elderly participants (>55 years) using validated methods for the diagnosis of fatty liver disease by abdominal ultrasonography in the absence of other diseases. Indeed, the authors demonstrated that the prevalence of non-alcoholic fatty liver disease was 46.2% in psoriasis patients compared with 33.3% in the reference group without psoriasis ($P = .005$).

An alternative explanation for their observation should be entertained. The authors note a high percentage – 13.9% – of subjects in the psoriasis group have abdominal obesity (waist circumference greater than 88 cm in women or 102 cm in men) compared with the control group ($P = .004$). Moreover, 29% of study participants in the psoriasis group have body mass index greater than 30 kg/m^2 compared with only 22% in the control group. Note that these differences in obesity characteristics were not used as controls in the modeling.

The authors could conclude that obese people with psoriasis are more likely to have non-alcoholic fatty liver disease than those in the less obese nonpsoriasis population. The authors should consider a better suited control group or subgroup analysis to support their contentions.

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Surgical margins for possibly malignant melanocytic lesions

To the Editor: We read with interest the Melanocytic Pathology Assessment Tool and Hierarchy for Diagnosis (MPATH-Dx) reporting schema for melanocytic lesions.[1] We found the inclusion of treatment recommendation in all proposed reports problematic. This commentary alters clinical practice,[2] and situations of discordance create a dilemma for the clinician.

The lack of support for their proposed treatments is of most concern. The authors acknowledge the "complexity in the histologic continuum from benign to unequivocally malignant melanocytic lesions," noting differences in classification between pathologists. Despite diagnostic uncertainty and lack of supporting evidence, a treatment algorithm would accompany all MPATH-Dx reports. This algorithm is based on the authors' consensus opinion and grouped by an assumption of risk. Clinical decisions would be reduced to checking a box in a corresponding column.

The error lies in suggesting a margin halfway between benign and malignant. In reality, benign