

E. MELANOMAS OF THE SKIN

Although basal and squamous cell cancers of the skin, which are not reportable to the Registry, account for the vast majority of skin cancers, melanomas account for the majority of skin cancer deaths. Unlike basal and squamous cell cancers, which are nearly always curable, melanomas are a serious disease. Melanomas can be successfully treated in an early stage, but unlike basal or squamous cell skin cancers, melanomas often spread to other parts of the body and become less treatable.

Sun exposure is the primary risk factor for melanomas of the skin. Having certain types of moles is also a risk factor for developing melanomas. Although anyone can develop melanomas, the risk of melanoma is much higher for Whites than African Americans.

Melanomas of the skin are the 6th most common invasive cancer diagnosed in Oregon and the 6th leading cause of cancer-related death among Oregonians. Oregon's melanoma mortality rate of 29.4 for 2002 was 2% above the Healthy People 2010 target of 28.8 deaths per 100,000 men. Despite a lack of agreement on population-based screening guidelines, the Oregon Partnership for Cancer Control has identified reducing melanoma mortality as a priority because of the high incidence and mortality in the state.

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MELANOMAS OF THE SKIN FAST FACTS OVERVIEW

A brief overview of Oregon's melanoma data shows the following: (See Figure VII-E-1.)

1. In 2002, 1,613 Oregonians were diagnosed with melanomas, of which, 831 were invasive. Melanomas were the causes of death for 123 Oregonians.
2. Melanoma incidence and mortality in Oregon has increased 2% annually over the past five years. These trends are similar to the national trends.
3. Oregon's age-adjusted 2002 incidence rate of 22.8 was 22% higher than the national rate of 18.7. Additionally, the Oregon 2002 mortality rate was 27% higher than the national rate for 2002.
4. Of the 50 states, Oregon tied for 2nd for melanoma mortality in 1999-2002.
5. The majority, nearly 95%, of melanomas were diagnosed at an early (*in situ* or localized) stage in 2002.
7. During 1998-2002, Oregon's M/I ratio for melanomas was 0.14, suggesting a good prognosis for this disease. Melanomas are responsible for 873 YPLL each year among Oregonians.

MELANOMAS OF THE SKIN FAST FACTS

FIGURE VII-E-1

Melanomas of the Skin Fast Facts				
Oregon 2002				
	All Sexes¹	Male	Female	
Cancer Incidence				
All Cases Total	1,613	840	773	
In situ	782	388	394	
Localized	725	383	342	
Regional	57	36	21	
Distant	24	17	7	
Unstaged	25	16	9	
Invasive Rates				
Oregon Crude	23.6	25.8	21.4	
Oregon Age-adjusted	22.8	26.7	20.3	
Oregon Current Annual Trend (5-Year)	+2.0	+2.2	+2.4	
US SEER Age-adjusted ²	18.7	23.1	15.6	
US SEER Annual Trend (5-Year) ^{2a}	*+1.6	*+1.9	+1.3	
Cancer Mortality				
Total Deaths	123	77	46	
Mortality Rates				
Oregon Crude	3.5	4.4	2.6	
Oregon Age-adjusted	3.3	4.8	2.3	
Oregon Current Annual Trend (5-Year)	1.6	2.1	2.7	
US Age-adjusted ³	2.6	3.8	1.7	
US Annual Trend ⁴	n/a	*+3.1	*+2.2	
Prognosis and Burden⁵				
Prognosis: M/I Ratio	0.14	0.17	0.11	
Burden: YPLL before age 65	873	575	298	

* Indicates a statistically significant trend
M/I = Mortality-to-Incidence Ratio
YPLL = Years of Potential Life Lost
¹ All Sexes counts may exceed male/female combined due to additional sex coding
² Year 2001, SEER 9 Registry data, SEERSTAT 5.2.2
^{2a} Years 1997-2001, SEER 9 Registry data, SEERSTAT 5.2.2
³ 2002 mortality rate calculated from CDC Wonder: <http://wonder.cdc.gov>
⁴ *Annual Report to the Nation on the Status of Cancer*, most current trend of 3 years or more
⁵ Calculations based on combined years 1998-2002

STAGE AT DIAGNOSIS

Sun avoidance, including wearing protective clothing and avoiding the sun during high intensity hours, may help prevent melanomas. In 1999, the last year for which data are available, 38% of Oregonians reported getting a sunburn within the last 12 months.

As with other cancers, mortality due to melanomas can be reduced through early detection. Melanomas can be found early through self-exam and physician exams. However, there are no national screening recommendations for melanomas.

The majority of melanomas diagnosed in 2002 were diagnosed at an early, treatable stage. (See Figure VII-E-2.) This high percentage likely has contributed to the good prognosis of these cancers.

Regardless of the absence of national screening recommendations, there are several patterns in the percentage of early stage diagnoses for melanomas by sex, age, and population density.

Although the percentages are both over 90%, women have a higher percentage of early stage diagnoses, 95% for men and 97% for women. (See Figure VII-E-3.)

Although the decline is slight, the percentage of melanomas diagnosed at an early stage decreases with age. (See Figure VII-E-4.)

FIGURE VII-E-2

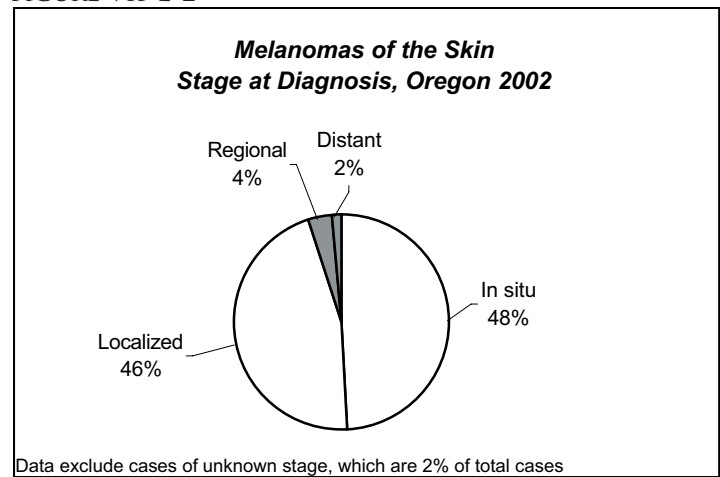


FIGURE VII-E-3

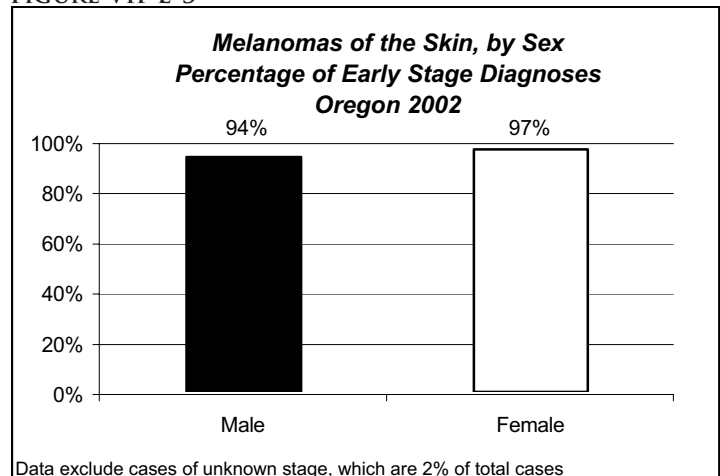
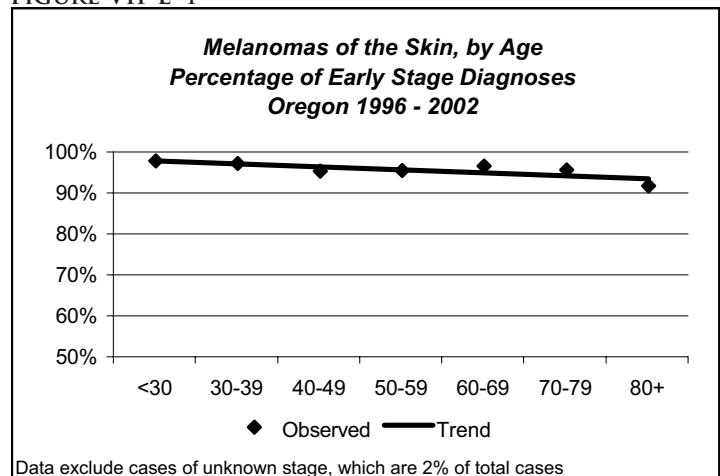
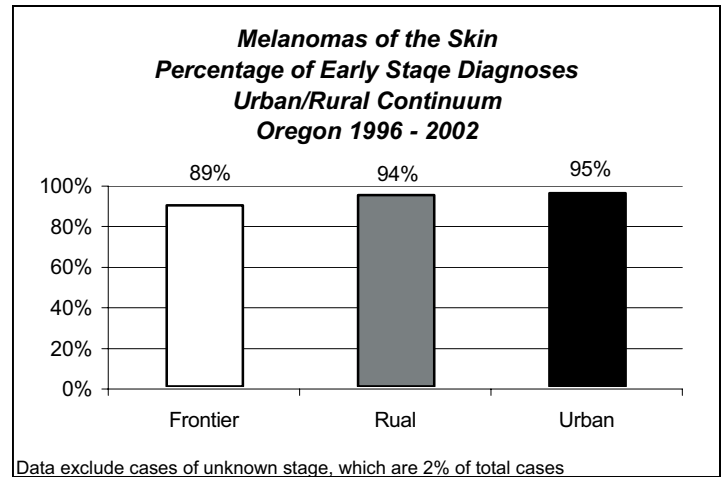


FIGURE VII-E-4



Moreover, although the percentage of melanomas diagnosed at an early stage is similar for Urban and Rural counties, Frontier counties (extremely rural with <6 persons per square mile) have a lower percentage. Frontier counties have 89% of melanomas diagnosed at an early stage while Rural and Urban counties have, respectively, 94% and 95% diagnosed at an early stage. (See Figure VII-E-5.)

FIGURE VII-E-5

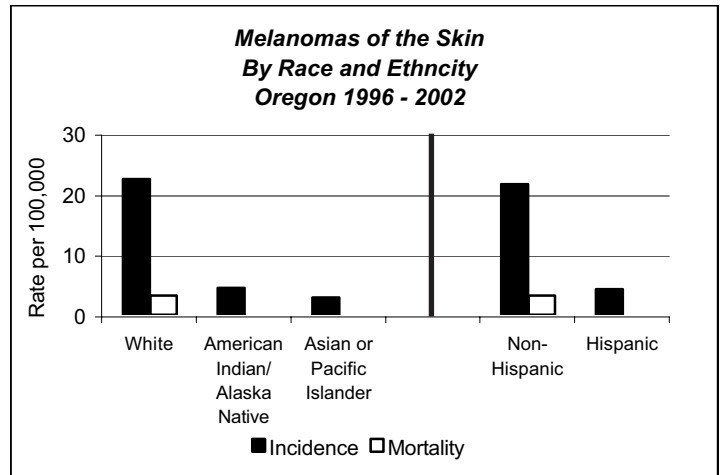


RACE AND ETHNICITY

Although race and ethnicity data need to be interpreted cautiously due to reporting issues (please see the *What's New in 2002?* and the *Technical Section* for additional details), melanoma cancer rates vary by race and ethnicity. (See Figure VII-E-6.) African Americans (AA) have too few cases of melanomas to calculate incidence or mortality rates. Among the three other race categories, Whites have the highest rate of melanoma cancer incidence, and Asian/Pacific Islanders have the lowest incidence rates in Oregon. Hispanics in Oregon have lower melanoma cancer incidence and mortality rates than Non-Hispanics. There are too few cases to calculate stable mortality rates for any race or ethnic group besides Whites and Non-Hispanics.

tendency to freckle or burn easily are at highest risk. However, anyone, regardless of skin color, can develop melanoma.

FIGURE VII-E-6

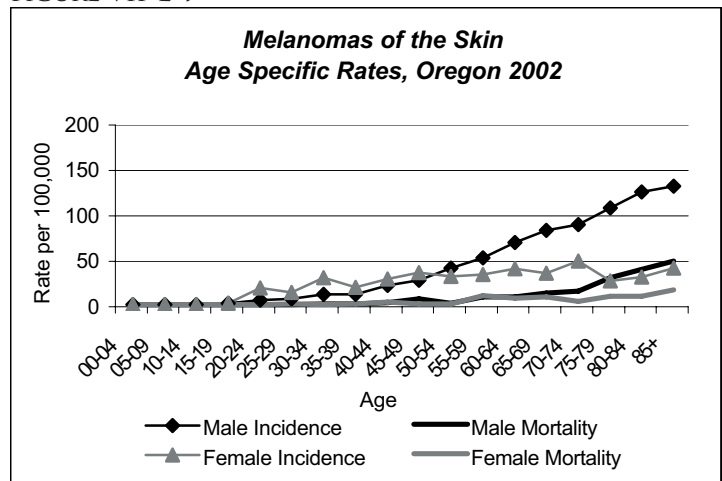


The difference in rates of melanomas by race and ethnicity is principally genetic. Because skin pigment has a protective effect, the risk of melanomas of the skin is about 20 times higher for Whites than for AA. Particularly, those with fair skin with a

AGE-SPECIFIC INCIDENCE AND MORTALITY

As with other types of cancer, the risk of developing melanomas increases with age. Figure VII-E-7 shows the age-specific incidence and mortality rates for melanoma. Oregon's age-specific incidence steadily increases for men with increasing age. The age-specific melanoma incidence fluctuates for women under 50 then increases with age until the rate begins to drop after age 75. With the exception of the 15-50 age groups, men have higher melanoma incidence rates than women. In general, mortality due to melanomas is higher for men than women. As seen with incidence, mortality due to melanomas increases steadily with age for men but is more variable for women.

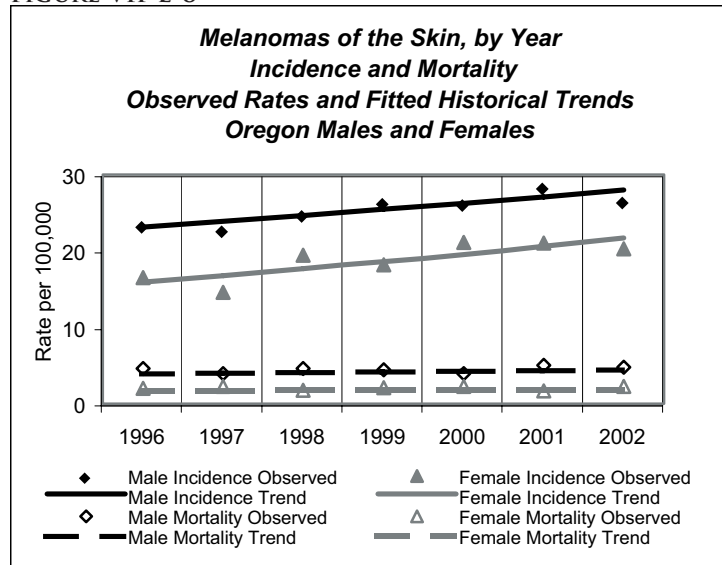
FIGURE VII-E-7



HISTORICAL TRENDS (1996-2002)

Incidence rates for melanomas have been increasing for both men and women since 1996, but the annual rate of increase has been greater for women (5% for women and 3% for men). (See Figure VII-E-8). For mortality due to melanomas, rates have also been increasing (2% for women and 1% a year for men).

FIGURE VII-E-8



REGIONAL VARIATION (COMBINED FIVE-YEAR RATES: 1998-2002)

Regional variation for melanomas is difficult to interpret because any potential variation could be due to individual climate of the region as well as individual behaviors, such as sun avoidance or seeking medical care early. With this in mind, incidence of melanoma has an East/West gradient across Oregon. (See Figure VII-E-9.) Much of Eastern Oregon has rates of melanomas incidence that are lower than are seen nationally. The remainder of the state has rates higher than the rates seen nationally.

The geographic pattern seen with incidence is not as clear for mortality due to melanomas. (See Figure VII-E-10.) In general, the rate of mortality due to melanomas is higher than is seen nationally in the southern part of Oregon as well as along the central gorge. In addition to Eastern Oregon, the North Coast, and most of the Portland Metropolitan area, the Willamette Valley, and Central Oregon, have lower melanoma mortality rates than are seen nationally.

FIGURE VII-E-9

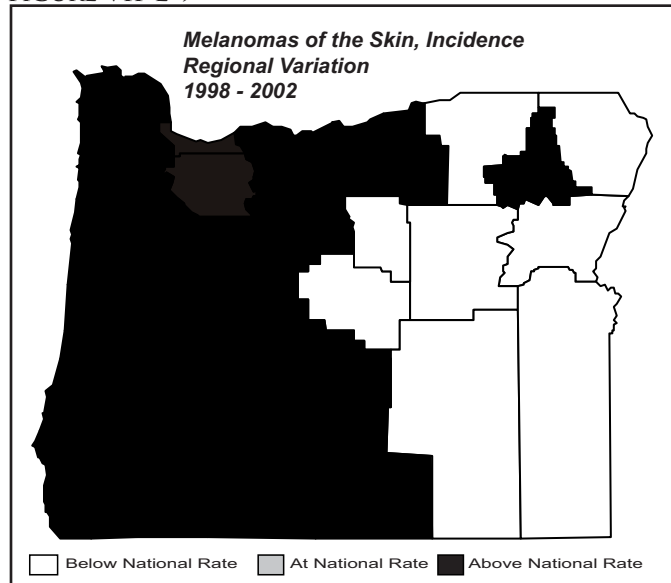


FIGURE VII-E-10

