

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, melanoma accounts for the majority of skin cancer deaths. Melanoma can be successfully treated at an early stage, but unlike basal or squamous cell skin cancers, melanoma often spreads to other parts of the body and becomes less treatable.

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

Melanoma of the skin is 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 3.4 for 2003 was 36% above the Healthy People 2010 target of 2.5 deaths per 100,000. 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.

IN 2003, THE OREGON MELANOMA MORTALITY RATE WAS 26% HIGHER THAN THE NATIONAL RATE.

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 2003, 1,472 Oregonians were diagnosed with melanomas, of which, 789 were invasive. Melanomas were the cause of death for 127 Oregonians.
2. Oregon's melanoma incidence has decreased 0.5% annually while mortality has increased 3% over the past five years. Nationally, melanoma incidence and mortality trends have been unchanged over the last five years.
3. Oregon's age-adjusted 2003 incidence rate of 21.2 was 23% higher than the national rate of 17.3. Similarly, the Oregon 2003 mortality rate was 26% higher than the national rate in 2003.
4. The majority, nearly 94%, of melanomas were diagnosed at an early (*in situ* or localized) stage in 2003.
5. During 1999-2003, Oregon's M/I ratio for melanomas was 0.14, suggesting a good prognosis for this disease. Melanomas are responsible for 887 YPLL each year among Oregonians.

MELANOMAS OF THE SKIN FAST FACTS

FIGURE VII-E-1

MELANOMAS OF THE SKIN FAST FACTS				
YEAR 2003				
Oregon	All Sexes¹	Male	Female	
CANCER INCIDENCE				
All Cases Total	1472	778	694	
<i>In Situ</i>	683	352	331	
Localized	660	343	317	
Regional	52	28	24	
Distant	32	25	7	
Unstaged	45	30	15	
Incidence Rates				
Oregon Crude	22.2	24.1	20.3	
Oregon Age-adjusted	21.2	24.6	19.1	
Oregon Current Annual Trend (1999-2003)	-0.5	-1.1	+0.4	
US SEER Age-adjusted ²	17.3	21.8	14.1	
US SEER Annual Trend (1999-2003) ²	0.0	-0.3	0.3	
CANCER MORTALITY				
Total Deaths	127	85	42	
Mortality Rates				
Oregon Crude	3.6	4.8	2.3	
Oregon Age-adjusted	3.4	4.8	2.0	
Oregon Current Annual Trend (1999-2003)	2.2	3.6	-0.8	
US Age-adjusted ³	2.7	3.9	1.7	
US Annual Trend (1999-2003) ³	0.0	0.2	-0.5	
PROGNOSIS AND BURDEN⁴				
Prognosis: M/I Ratio	0.14	0.17	0.11	
Burden: YPLL before age 65	887	577	310	

Incidence and death rates are per 100,000 and age-adjusted to the 2000 US Standard Population (19 age group)

* Indicates a statistically significant trend

¹ All Sexes counts may exceed male/female combined due to additional sex coding

² SEER 13 Registry Data, SEER Stat 6.2.3 (See *Technical Section, National Data*, for a description of SEER 13)

³ National Center for Health Statistics (NCHS) US Mortality Public Use Data

⁴ Calculations based on combined years 1999-2003

M/I = Mortality-to-Incidence Ratio

YPLL = Years of Potential Life Lost

STAGE AT DIAGNOSIS

Sun avoidance, including wearing protective clothing and avoiding the sun during high intensity hours, may help prevent melanomas. In 2003, the last year for which the Oregon Behavioral Risk Factor Surveillance System (BRFSS) data are available, 37% 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 melanoma.

The majority of melanomas diagnosed in 2003 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.

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% versus 93% for men. (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

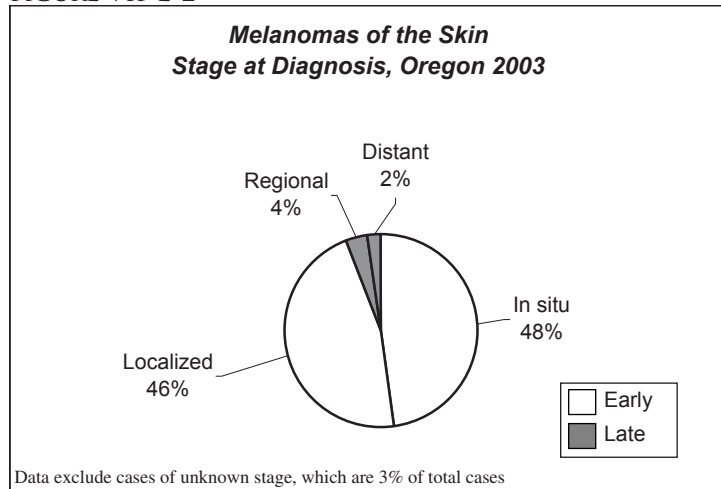


FIGURE VII-E-3

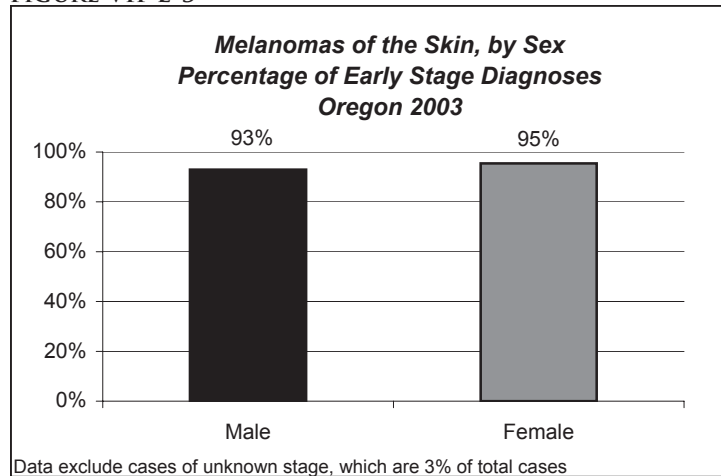
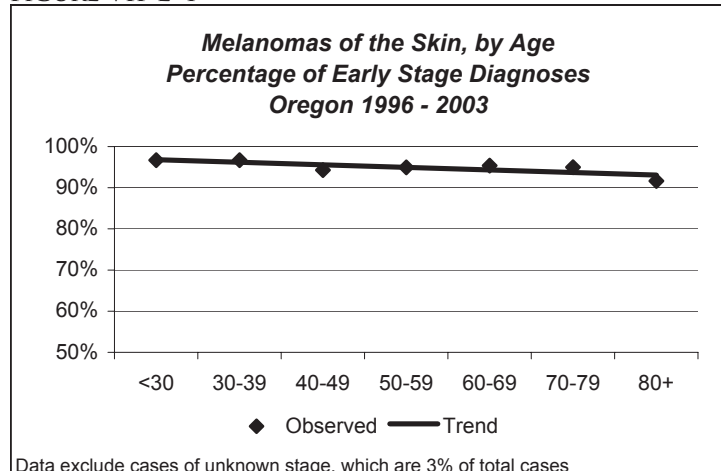
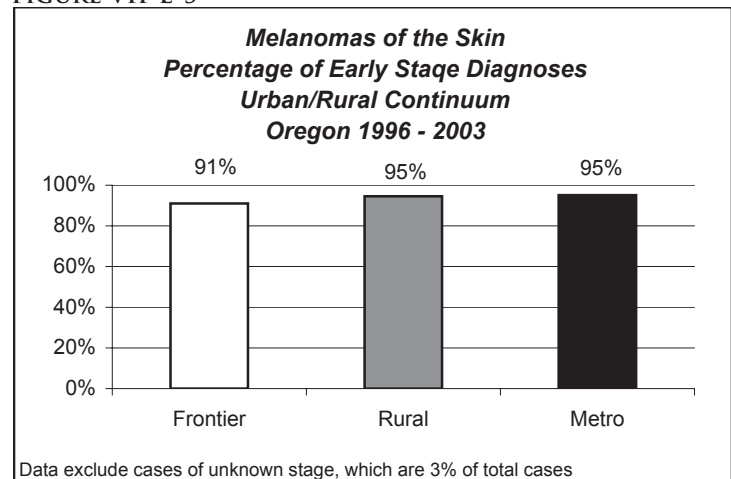


FIGURE VII-E-4



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

FIGURE VII-E-5

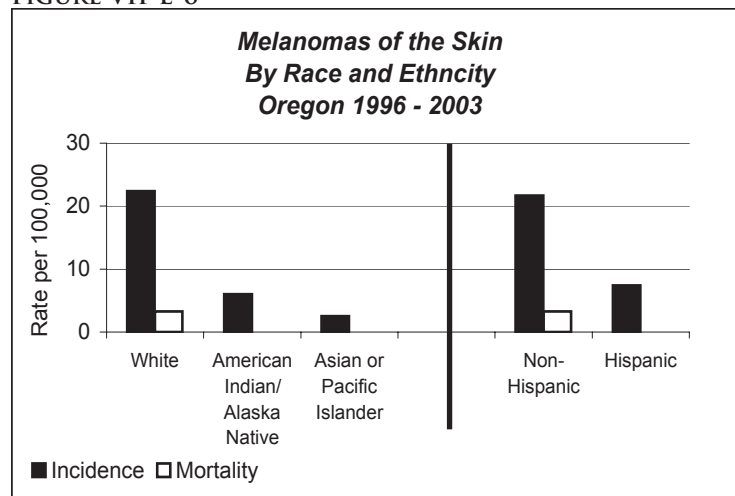


RACE AND ETHNICITY

Although race and ethnicity data need to be interpreted cautiously due to reporting issues (please see the *Technical Section* for additional details), melanoma cancer rates vary by race and ethnicity. (See Figure VII-E-6.) Whites have the highest rate of melanoma incidence, and Asian/Pacific Islanders have the lowest incidence rates in Oregon. Hispanics in Oregon have lower melanoma cancer incidence 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.

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

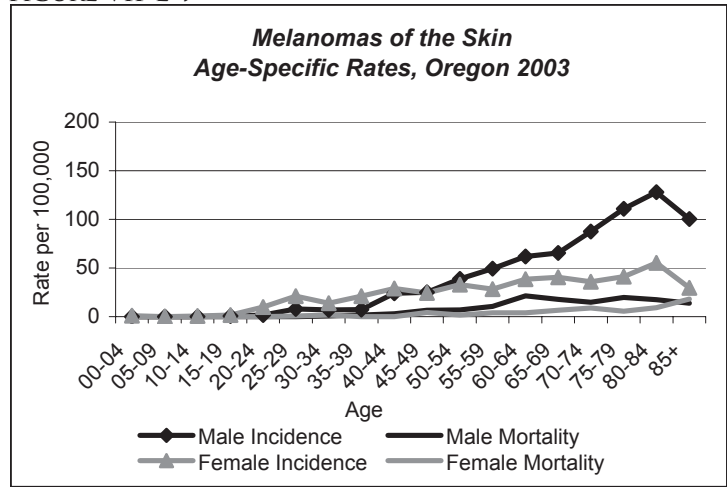
FIGURE VII-E-6



AGE-SPECIFIC INCIDENCE AND MORTALITY

As with other types of cancer, the risk of developing melanoma 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 rates fluctuate for women under 50; it then increases with age until the rate begins to drop after age 75. With the exception of the 15- to 50-year-old age groups, men have higher melanoma incidence rates than women. In general, mortality due to melanoma is higher for men than women. As seen with incidence, mortality due to melanoma increases steadily with age for men but is more variable for women.

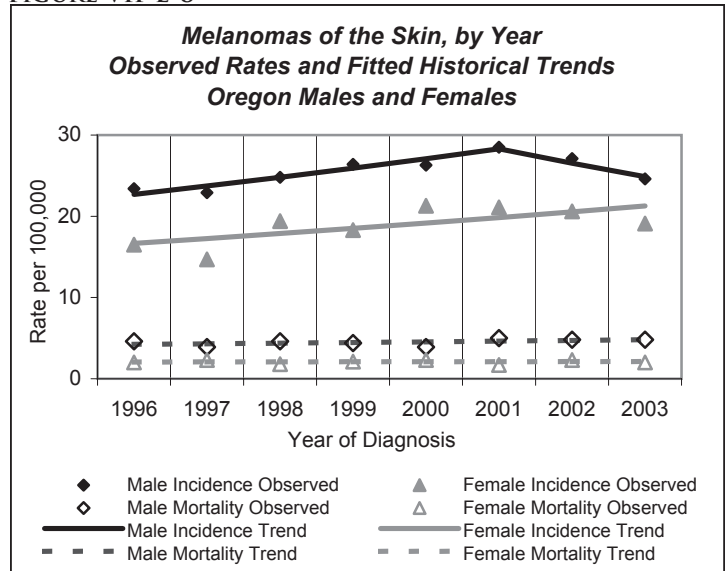
FIGURE VII-E-7



HISTORICAL TRENDS (1996-2003)

Incidence rates for melanoma have been increasing for both men and women since 1996, but the annual rate of increase has been greater for women (3% versus 2% for men). (See Figure VII-E-8). For mortality due to melanomas, rates have been decreasing 0.3% a year for women and increasing 2% a year for men.

FIGURE VII-E-8



REGIONAL VARIATION (COMBINED EIGHT-YEAR RATES: 1996-2003)

Regional variation for melanoma incidence is difficult to interpret because any potential variation could be due to the 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.) Eastern Oregon and Clatsop, Columbia, and Lincoln Counties have rates of melanoma incidence that are lower than are seen nationally. The remainder of the state has rates higher than the rates seen nationally.

The geographic pattern for mortality is similar to incidence. (See Figure VII-E-10.) In general, melanoma-specific mortality is higher than is seen nationally in southern, western, and central Oregon. Lincoln County has a melanoma mortality rate lower than the nation. The rest of the state has melanoma mortality rates that are similar to the national rate.

FIGURE VII-E-9

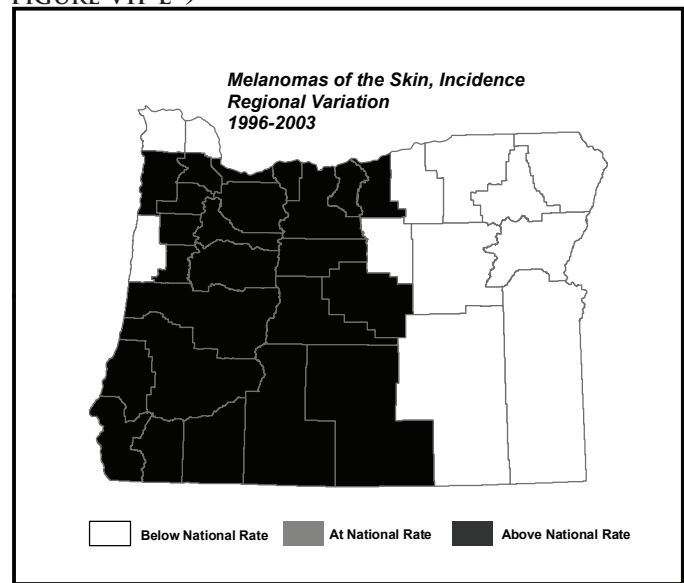


FIGURE VII-E-10

