Clinical and Epidemiologic Profile of Melanoma Patients According to Sun Exposure of the Tumor Site

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Abstract. Introduction. Melanomas arising in areas with comparable levels of sun exposure have been shown to have similar genetic profiles. The aim of this study was to characterize the clinical features of melanoma patients according to the pattern of sun exposure: chronic, intermittent, or none.

Material and methods. From our melanoma database, we selected 789 consecutive patients with melanoma diagnosed in our center since January 2000. Epidemiologic data, phenotype, and personal and family history of cancer were retrieved. The observed frequency of each variable was compared.

Results. Most melanoma patients presented tumors on areas exposed intermittently to sunlight. In addition, these patients presented higher numbers of common and atypical melanocytic nevi and the melanoma very frequently arose in a pre-existing nevus. The second largest group was formed by patients with tumors on areas chronically exposed to sun and that had all the clinical lesions (solar lentigines and actinic keratoses) and epidemiologic characteristics typical of these areas. Finally, patients with melanomas on areas not exposed to sun were older, as occurred in the group with chronic exposure, and the diagnosis was made at more advanced stages of the disease.

Conclusions. There are many patients who did not fit these patterns of melanoma development. Clinical and biological characterization is therefore necessary to determine alternative pathways of development in order to establish specific preventive measures.

Key words: melanoma, sun exposure, epidemiology.
Introduction

Melanoma is a highly aggressive cancer, and its incidence worldwide has increased more than for any other kind of cancer. Although melanoma was originally considered to be a homogeneous entity with a uniformly poor prognosis, the gradual development of pigmented-lesion research groups and multidisciplinary melanoma study teams has resulted in the description of a number of melanoma subtypes with relatively well-differentiated clinical and pathological features. Melanoma subtyping has traditionally been based on primary tumor site, degree of exposure to the sun, and the duration of intraepidermal growth. To date, 4 subtypes have been described that account for the majority of melanomas: superficial spreading melanoma, nodular melanoma, lentigo maligna melanoma, and acral lentiginous melanoma. This classification is further underpinned by recent descriptions of molecular differences between these subtypes. Thus, for example, gene amplifications for acral melanomas tend to occur in a number of distinct loci, and these alterations can even be detected in histologically normal melanocytes in the skin surrounding a lesion. Furthermore, the frequency of somatic mutations in the BRAF and NRAS genes varies according to melanoma subtype. Nonetheless, a recently published study by Curtin et al has demonstrated that molecular alterations are not so much associated with the cutaneous melanoma subtype as with the type and degree of sun-induced damage to the skin where the melanoma is located.

Given the conclusions of the study by Curtin et al, there is an evident need to clinically characterize patients with cutaneous melanomas according to type and degree of sun-induced damage to the site where the melanoma develops.

The aim of this study was to describe and compare the clinical and epidemiologic characteristics of patients with cutaneous melanomas according to patterns of sun exposure of the tumor site.

Patients and Methods

A retrospective observational study was designed on the basis of data included in a cutaneous and mucosal melanoma database maintained by the dermatology department of the Instituto Valenciano de Oncología, Valencia, Spain.

The database, launched in 2000, has been regularly added to with data from patients diagnosed with melanoma (incident cases) and from follow-up patients with melanoma. Clinical, epidemiologic, and histologic data to be entered into the database is collected prospectively from the medical history and physical examination of patients, performed by dermatologists with experience in the follow-up of patients with melanoma. The database currently contains data on a total of 1265 patients.

For the purposes of this study, only patients diagnosed with cutaneous or mucosal melanoma from January 1, 2000 (when the database was launched) were included. In other words, the study only included incident cases for which data were introduced prospectively from January 1, 2000. Excluded from the study were patients with melanomas that had metastasized from an unidentified primary tumor, and also patients with multiple melanomas whose first melanoma had been diagnosed prior to January 1, 2000.

The independent variable was defined as the degree of sun exposure of the primary melanoma site (the site of the first diagnosed melanoma for cases of multiple melanomas). Degree of exposure to the sun was defined as follows: no exposure, intermittent (summertime) exposure, and continuous (year-round) exposure. Categories were assigned on the basis of data obtained from medical histories, physical examinations, and patient-reported data. It was preferred not to arrive at assumptions about exposure based solely on the melanoma site, given that people dress differently, and given the differences between the sexes.

The following 5 variables were considered in the comparative analysis of patient characteristics according to sun-exposure patterns:

1. Epidemiologic variables: age at diagnosis, sex, reason for the consultation that led to diagnosis (finding on self-examination, finding in a general medical examination, sign/symptom, nevus follow-up, or another person’s observation), clinical staging, and tumor site (head/neck, upper limb, trunk, lower limb, hand/foot, or mucosa).
2. Phenotype: skin phototype, hair color, eye color, number of nevi (up to 20, 20–50, 51–100, or more than 100 nevi), presence of clinically atypical nevi, presence of solar lentigines, presence of actinic keratosis, and presence of solar lentigines at the melanoma site.
3. Environmental factors: chronic work-related sun exposure (10 years or more), intermittent intensive sun exposure, number of severe sunburn episodes resulting in blistering or tenderness lasting for at least 48 hours (0, 1–5, 6–10, or more than 10 episodes), and previous sunburn of the melanoma site (no sunburn, mild sunburn, or at least 1 case of severe sunburn).
4. Personal or family history of cancer: a personal history of epithelial (basal or squamous cell) skin cancer or of other nonskin neoplasms, and/or a history of melanoma or other neoplasms among first-degree relatives.
5. Histologic data: histologic type (superficial spreading melanoma, nodular melanoma, lentigo maligna melanoma, or other subtypes).

Acknowledgments

This work was supported by research project number PI040515 from the Instituto de Salud Carlos III (Ministerio de Sanidad y Consumo, Madrid, Spain). Dr. E. Carrasco is a recipient of a research contract holder from the Instituto de Salud Carlos III (Ministerio de Sanidad y Consumo, Madrid, Spain). The study was conducted in the dermatology department of the Instituto Valenciano de Oncología, Valencia, Spain.
melanoma, acral lentiginous melanoma, or other), Breslow tumor thickness, ulceration, and remains of a preexisting melanocytic nevus lesion in the tumor specimen.

Differences between the distributions of the variables in each category were evaluated using the Pearson \( \chi^2 \) test for qualitative variables, and the Kruskal-Wallis test for quantitative variables. Statistical significance was defined as \( P < 0.05 \). Statistical analyses were performed using SPSS version 12 (SPSS, Chicago, Illinois, USA).

**Results**

Of a total of 826 eligible patients (defined as patients attending a first in-hospital melanoma consultation in the specified study period), 37 patients were excluded: 19 (2.3%) patients with melanomas that had metastasized from an unidentified primary tumor; 15 (1.8%) patients for whom no information was available on the kind of sun exposure of the melanoma site; and 3 patients with ocular melanomas. The final sample used for the study was thus composed of 789 patients with skin or mucosal melanomas (representing 95.5% of the total of eligible patients). The group included 408 women (51.7%) and 381 men (48.3%), and mean age at diagnosis was 56 years (interquartile range, 42-68 years). Most patients had localized disease at diagnosis, as follows: 84 (10.6%) patients with melanoma in situ; 586 (74.3%) patients with stage I or II melanomas; 96 (12.2%) patients with stage III melanomas; and 7 (0.9%) patients with distant metastasis. The most frequent tumor sites were as follows: the trunk in 299 patients (37.9%); the head and neck in 156 patients (19.8%); the lower limbs in 149 patients (18.9%); acral areas in 69 patients (8.7%); and the mucosa in 10 patients (1.3%). In regard to the degree of exposure of the skin where the melanoma had developed, continuous exposure was reported (or was patently evident) in 172 cases (21.8%), intermittent exposure in 533 cases (67.6%), and no exposure in 84 cases (10.6%).

The differences encountered between the 3 sun-exposure groups are summarized in Tables 1, 2 and 3. Statistically significant—and obvious—differences were encountered in terms of melanoma distribution by site: head and neck for continuous exposure, trunk for intermittent exposure, and acral parts for nonexposure. The same occurred with histologic type: the proportion of lentigo maligna melanomas was much higher on continuously exposed skin, 75% of the tumors on intermittently exposed skin were superficial spreading melanomas, and the highest proportion of acral lentiginous melanomas was found on nonexposed skin (Table 1). Melanomas in nonexposed skin occurred to a noticeably high degree in women (64%); the equivalent percentages for intermittently and continuously exposed skin were 54% and 38%, respectively. Melanomas in nonexposed and continuously exposed skin presented mainly in older patients (58% and 63% of patients aged over 60 years, respectively), whereas just 30% of this age group—compared to 41% of patients aged between 40 and 60 years—had melanomas in intermittently exposed skin. There were no differences between the 3 sun-exposure categories in regard to the reason for the consultation leading to the diagnosis (typically a sign or symptom of the lesion).

As for melanoma characteristics, tumors were significantly thicker in nonexposed skin (mean, 4 mm) and, to a lesser extent, in continuously exposed skin (mean, 2.6 mm), compared to intermittently exposed skin (mean, 1.9 mm). As would be expected, ulceration was more common in sites with thicker tumors, with a frequency of 53% in nonexposed skin, 37% in continuously exposed skin, and 19% in intermittently exposed skin. Clinical stage was most advanced in nonexposed skin, with almost 20% of patients having locoregional disease and 4% having metastatic disease at diagnosis. Melanomas in continuously exposed skin were staged as carcinoma in situ in 19% of the cases. A pre-existing melanocytic nevus was encountered in 39% of the melanomas in intermittently exposed skin, compared to 25% and 22% in continuously exposed and nonexposed skin, respectively. All these differences were statistically significant.

As for patient phenotypes (Table 2), no statistically significant differences were found in relation to phototype, hair color, or eye color. The total number of melanocytic nevi was significantly greater in patients with melanomas occurring in intermittently exposed skin, and likewise for the presence of at least 1 clinically atypical nevus. Solar lentigines occurred more frequently in continuously exposed skin (93%), compared to intermittently (86%) and nonexposed (77%) skin, and actinic keratoses were also more frequent in continuously exposed skin. Lentigines at the melanoma site were particularly common in continuously exposed skin (75%) and, to a lesser degree, in intermittently exposed skin (53%). In regard to the melanomas that developed in intermittently exposed skin, the absence of lentigines, which are clinical indicators of sun-induced damage, correlated to a statistically significant degree with lower numbers of melanocytic nevi (Table 4).

Finally, there were more patients with a history of smoking and of melanoma site sunburn in the groups with melanomas in continuously and intermittently exposed skin (Table 3). Patients whose exposure to the sun was work-related mostly had melanomas in continuously exposed skin, and, to a lesser degree, in nonexposed skin. Patients with melanomas in intermittently exposed skin had the highest rate of intermittent exposure to the sun, at 97%,
compared to 72% and 78% of the patients with melanomas in non-exposed and continuously exposed skin, respectively. All these differences were statistically significant.

No differences were observed in melanoma frequency in patients with a personal or family history of non-melanoma skin or other cancers.

**Discussion**

It should be noted that the results discussed below are based on unprocessed data, compiled prospectively, and reflecting just a single institution. Only patients diagnosed with melanoma at the time of the first consultation were included in the study. Biased recall in patients must be assumed in regard to details of past sunburn episodes, whether in a general sense or in regard to the site where the melanoma developed.

Our study reveals clinical and epidemiologic differences between patients when classified according to whether the site where their melanoma developed was unexposed to the sun or continuously or intermittently exposed, suggesting that there is no single route to developing a melanoma.
Published studies indicate that, biologically speaking, melanomas have a number of genetic patterns, and studies also provide evidence of at least 2 different routes of development for melanomas. The first route is through ultraviolet-radiation stimulation of skins that are particularly sensitive to the sun (for example, fair- or red-haired people, and susceptible phototypes), with the skin eventually showing signs of chronic sun-induced damage and other skin tumors. The second route operates in nevus-prone individuals who may have a predisposition to melanocytic proliferation. In such patients, ultraviolet radiation is likely to play a less significant etiopathogenic role than in the first route (merely acting as an initiator). Assumed—and widely accepted in regard to both routes—is that exposure to sun is a primary cause of melanoma. Nonetheless, although these 2 routes explain the development of many melanomas, they fail to explain the development of melanomas in areas with little exposure (soles, anal region, or armpits) or no exposure (mucosa) to ultraviolet light, and which, moreover, show different genetic profiles.

Using our series of patients, we present a clinical characterization of subtypes of melanoma studied from a genetic perspective and classified according to degree of exposure to the sun.

Firstly, most melanomas develop in skin that is intermittently exposed to sun light (68% of cases). Recent meta-analyses have demonstrated intermittent sun exposure to be a risk factor in developing a melanoma, especially in patients with multiple common and atypical nevi who recall having been sunburned at the site where the melanoma developed. The resulting tumors are mainly superficial spreading melanomas; they are slow growing, tend to be diagnosed reasonably early (as evidenced by the fact that they are less thick at diagnosis), and are likely to have developed from an existing nevus. Melanomas associated with a nevus have been shown to occur at different sites and to have different risk factors than de novo melanomas. The possible link between nevi and melanomas may be explained by the fact that BRAF mutation patterns are similar for both lesions in melanomas that develop in intermittently sun-exposed skin. Nonetheless, in our study, nearly half (47%) of the patients with melanoma had no solar lentigines; in other words, there was no evidence of sun-induced damage in the area of skin where the melanoma developed. This absence of

### Table 2. Epidemiologic and Histologic Characteristics According to Skin Exposure to Sun

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Nonexposed Skin (n = 84)</th>
<th>Intermittently Exposed Skin (n = 533)</th>
<th>Continuously Exposed Skin (n = 172)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>Phototype</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I or II</td>
<td>29</td>
<td>38.2</td>
<td>179</td>
<td>34.6</td>
</tr>
<tr>
<td>III or IV</td>
<td>47</td>
<td>61.8</td>
<td>339</td>
<td>65.4</td>
</tr>
<tr>
<td><strong>Hair color</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dark</td>
<td>59</td>
<td>81.9</td>
<td>377</td>
<td>76.9</td>
</tr>
<tr>
<td>Fair</td>
<td>12</td>
<td>16.7</td>
<td>93</td>
<td>19.0</td>
</tr>
<tr>
<td>Red</td>
<td>1</td>
<td>1.4</td>
<td>20</td>
<td>4.1</td>
</tr>
<tr>
<td><strong>Eye color</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brown/dark</td>
<td>48</td>
<td>64.0</td>
<td>316</td>
<td>63.2</td>
</tr>
<tr>
<td>Blue/green</td>
<td>27</td>
<td>36.0</td>
<td>184</td>
<td>36.8</td>
</tr>
<tr>
<td><strong>Number of nevi</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 20</td>
<td>45</td>
<td>77.6</td>
<td>274</td>
<td>62.6</td>
</tr>
<tr>
<td>20-50</td>
<td>6</td>
<td>10.3</td>
<td>67</td>
<td>15.3</td>
</tr>
<tr>
<td>51-100</td>
<td>5</td>
<td>8.6</td>
<td>64</td>
<td>14.6</td>
</tr>
<tr>
<td>&gt; 100</td>
<td>2</td>
<td>2.4</td>
<td>33</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>Atypical nevi</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>60</td>
<td>87.0</td>
<td>399</td>
<td>78.5</td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>13.0</td>
<td>109</td>
<td>21.5</td>
</tr>
<tr>
<td><strong>Solar lentigines</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>23.3</td>
<td>68</td>
<td>13.8</td>
</tr>
<tr>
<td>Yes</td>
<td>46</td>
<td>76.7</td>
<td>423</td>
<td>86.2</td>
</tr>
<tr>
<td><strong>Actinic keratoses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>47</td>
<td>88.7</td>
<td>410</td>
<td>91.7</td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>11.3</td>
<td>37</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Abbreviation: NS, nonsignificant.
sun-induced damage was associated particularly with melanomas that developed in areas of intermittent exposure with fewer nevi, suggesting the possibility of another development route for melanomas that is neither associated with nevi nor with a high degree of exposure to the sun.

Secondly, some melanomas develop in parts of the skin that are chronically exposed to the sun. Signs of chronic sun-induced damage—such as lentigines and actinic keratosis—were observed in patients who were generally older when melanoma was diagnosed. These patients generally had few nevi, had a personal background of chronic occupational exposure, and had experienced sunburn episodes affecting the melanoma site. Although not statistically significant, there was a greater prevalence of low phototype skin and a noticeably low frequency of a family history of melanoma in these patients. This profile coincides with that described by Whiteman and coworkers as reflecting 1 of the 2 possible routes for the development of melanoma.7,15

Finally, we characterized patients with melanomas arising on areas of the body with very little or no exposure to the sun. A very high proportion of these patients (92%)
reported never having been sunburned in the melanoma site. These predominantly female patients aged over 60 years had few risk factors for developing cancer, and did not appear to be susceptible to sun exposure or to be nevus-prone, yet had a high proportion of acral lentiginous melanomas that were diagnosed late. Despite the fact that such patients may be viewed as having different kinds of melanomas (mucosa, soles, etc), the genetic profile for these melanomas has, in fact, been characterized as similar.5

In conclusion, although some development routes for melanomas have been well defined, there are other possible routes that require study and genetic and clinical characterization.

Conflicts of Interest
The authors declare no conflicts of interest.

References