SKIN CANCER SCREENING: A SENSITIVE SCREENING TEST

■ *To the Editor:* During 3 days in May 1992, The Cleveland Clinic Foundation offered employees a free, voluntary skin cancer screening. Staff physicians and residents of the Cleveland Clinic dermatology department performed the skin examinations. A reporting form supplied by the American Academy of Dermatology was used to record the findings. If any suspicious skin lesions were found, the person was counseled to arrange for further evaluation by his or her health care provider. Each participant was provided with a copy of the reporting form. The results of this screening are shown in the *Table.*

TABLE
RESULTS OF THE CLEVELAND CLINIC FOUNDATION 1992 SKIN CANCER SCREENING

Number of participants:	127
Clinical diagnoses	
Actinic keratoses	7 (5.5%)
Basal cell carcinoma	9 (7.1%)
Squamous cell carcinoma	0
Malignant melanoma	1 (0.8%)
Dysplastic nevi	23 (18.1%)

Nonmelanomatous skin cancer—basal cell and squamous cell carcinoma—is the most common form of cancer in the United States, and an estimated 500,000 new cases will be diagnosed each year. Furthermore, 32,000 new cases and 6,700 deaths due to melanoma were predicted for 1992.[1] Early detection and treatment can reduce morbidity and mortality of melanoma and nonmelanomatous skin cancers, and a visual skin examination is an inexpensive, effective, and safe method for early detection of these lesions. A recent study evaluated the effectiveness of American Academy of Dermatology-supported melanoma and skin cancer screening programs in Massachusetts in 1986 and 1987.[2] The investigators contacted participants who had been counseled to seek further evaluation of possible skin cancers. The sensitivity of the screening examination was 89% to 97%, with a positive predictive value of 35% to 75%. This compared favorably with other screening tests, such as mammography (sensitivity 75%, predictive value 18%), fecal occult blood testing (sensitivity 69%, predictive value 18% to 50%), and the Papanicolaou test (sensitivity 78%).[2] Primary health care providers and dermatologists should be encouraged to offer this simple, safe, and inexpensive examination to their patients.

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1. Boring CC, Squires TS, Tong T. Cancer statistics 1992. CA 1992; **42:**19–38.
2. Koh HK, Caruso A, Gage I, et al. Evaluation of melanoma/skin cancer screening in Massachusetts: preliminary results. Cancer 1990; **65:**375–379.

SUPERIOR VENA CAVA SYNDROME

■ *To the Editor:* It was with great interest and pleasure that I read the article, "Superior vena cava syndrome after open heart surgery," by Dr. Maggiano (Cleve Clin J Med 1992; **59:**93-95). Certainly, it is true that urgent or emergency treatment of acute superior vena cava syndrome is difficult and often unsatisfactory. I would call your readers' attention to the article, "Extracorporeal venous shunt in the treatment of superior vena cava obstruction," (Feld AW. Am J Med 1962; **32:**625-630), which describes the use of a temporary shunt procedure to achieve prompt decompression while providing time for other more elective therapeutic maneuvers.

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