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TO CUT OR NOT TO CUT?

A common misconception is that removing moles reduces melanoma risk.

There is no doubt that having a lot of moles increases the risk of developing melanoma. However, melanoma experts now believe that it is impossible to predict which moles will turn malignant. In other words, we know which patients are at higher risk, but not necessarily which moles are at greatest risk.

Consider this:-

- Many people believe that all melanomas come from moles. In fact, only around 40% of melanomas arise from moles – the rest develop in normal skin.
- The lifetime risk of a benign mole turning into a melanoma is somewhere between 1 in 3000 to 1 in 10 000.

Therefore, the removing of benign moles is unnecessary. It has a negligible impact on reducing your melanoma risk. Even if every mole on your body was removed you would only halve your risk because 60% of melanomas don't come from moles. The lifetime risk of a woman developing breast cancer is about 1 in 14. We wouldn't consider removing breasts to reduce the risk of cancer. Why would we remove a mole that has a risk of 1 in 3000 or less?

Dysplastic Moles

There is a type of mole known as a *dysplastic mole* which deserves special consideration. Dysplastic moles tend to be larger and more irregular than most moles. About 20% of the population will have one or more of these moles. Traditionally dysplastic moles were considered to be at higher risk of turning into melanoma. However, recent studies have suggested that the lifetime risk of a dysplastic mole becoming a melanoma is less than 1 in 1000.

There is good evidence that people who have more than 5 dysplastic moles are at higher risk of developing melanoma. However, that is not to say that it will necessarily be one of the dysplastic moles which will turn into melanoma. Melanoma experts now believe that people with multiple dysplastic moles have a predisposition to abnormal melanin production in their skin which increases the risk of developing melanoma at any site – not just within the dysplastic moles. Removing the dysplastic moles has a small impact on reducing risk of melanoma.

Recommendations

In reality, melanoma diagnosis is an art as well as a science. Various factors need to be taken into consideration eg. recent change in a mole, previous history of melanoma or a family history. In addition, many people have a particular type of mole pattern – almost like a fingerprint. A particular type of mole may look perfectly benign and normal on one patient and totally out of place on another. Therefore, the decision to remove a mole is based on many variables.

However, the facts still remain. There should be a good clinical reason to remove a mole. Mole removal does have potential complications such as bleeding, infection and significant scarring.

In summary, my recommendations are as follows:

- People at risk should have an annual skin check.
- After a thorough examination moles which have diagnostic criteria for melanoma are removed. In skilled hands, 92% of melanomas can be diagnosed on initial examination.
- Suspicious moles with no definite features of melanoma should be photographed and rechecked in 3 months. If they change they are removed. This includes moles that the patient has noticed change in but look benign clinically.
- People with multiple dysplastic moles should be checked every 6 months and have long-term photographing and monitoring of their suspicious moles.