check Program

Dear Editor

Well done on the excellent **check** Program on skin cancer (January/February 2007). I particularly liked the descriptions of some of the emerging nonsurgical options in managing cutaneous oncology. I was concerned, however, that some experimental management ideas were portrayed as if they were more established and some were even recommended. The treatments in question were: using imiquimod for Bowen disease (SCC in situ), using PDT on mucous membranes of the lips, and using methotrexate for intralesional treatment for keratoacanthoma. In each of these cases, the usage falls outside of TGA guidelines and in each case the evidence base for the suggested usage is limited.

The most studied of these approaches is the usage of imiquimod for Bowen disease. In the three largest reports so far, 29 out of 35 people treated developed a short term response (82%).[1–3] There has been no large trial or long term trial so far. Further, there is an Australian report of SCC in situ being managed with imiquimod followed by immediate local recurrence and nodal disease shortly thereafter.[4]

The TGA guidelines and manufacturer's recommendations for imiquimod clearly do not endorse its usage for any SCC, including SCC in situ. There may be a future role, but not yet. The evidence for the usage of imiquimod for superficial BCCs is, by contrast, quite impressive.[5–8]

Regarding methotrexate for keratoacanthoma, there are a number of case reports in the literature. The largest concerns nine cases.[9] There are a number of isolated case reports dating back to 1973.[10–12] There are no formal trials.

I am not aware of any trials of PDT to the mucous membranes of the lip. There are barely a few isolated case studies.[13,14]

These three usages should have been made clear in each case that: the treatment was outside of TGA approval, was at best experimental, and that treatment is not recommended until formal trials are completed to the satisfaction of the Australian regulatory authorities. Current usage of these modalities for the conditions discussed should be limited to formal ethics approved trials designed and approved for such human experimentation.

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Reply

Dear Editor

I agree with Dr Dixon that there is limited evidence for the use of intralesional methotrexate in keratoacanthoma. I have indicated in answer 5 that it is difficult to treat keratoacanthomas in this position and that urgent referral to a dermatologist is usually required. This is the case when surgical options are relatively contraindicated. Therefore, in the main, it would be a specialist dermatologist that would be undertaking intralesional methotrexate therapy. Despite the lack of large studies as to the effectiveness of this treatment, it is commonly employed by dermatologists throughout Australia.

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It is true that there are no large studies indicating the outcomes of using PDT on patients with cancers involving the mucocutaneous border. However, PDT therapy is commonly used in this type of lesion and there is no evidence of any particular concern regarding significant inflammation involving these areas with PDT (outside of that type of inflammation that one would normally expect). There have been no postmarketing reports of adverse events associated with the use Metvix PDT on mucous membranes according to the most recent Periodic Safety Update Report for Metvix (Galderma). It has been reported in the use of anogenital and vulval extramammary Paget disease[1,2] and there has been a reports of its use in actinic chelitis.[3–6]

Hexvix PDT is a solution of methyl aminolevulinate (160 mg/g) which has been used as a diagnostic tool in the treatment of bladder cancer also with some success (personal communication). In other words PDT is not of specific concern with areas involving the mucocutaneous junction. With Efudix and imiquimod cream however, significant inflammation in these areas is more of a problem.

Indeed the use of imiquimod in Bowen disease is outside the TGA approval as I, in fact, did state in the **check** Program. This is an 'off label' indication. There are a number of small studies and case reports indicating its effectiveness and I would therefore dispute Dr Dixon's comment that the evidence for the suggested usage is limited. Indeed it could be argued that the use of PDT or imiquimod for areas of Bowen disease in these cosmetically significant areas are, in practice, approaching first line treatments. Dr Dixon's insistence on formal trials before treatments are recommended becomes problematical if surgical excision is considered. Surgery is often considered advantageous due to the ability to document excision margins. However, despite being one of the most established therapies, to date there are no randomised, comparative trials published confirming its superiority. To date no single therapeutic option has been unequivocally proven to be superior to any other.[7] According to a recent article on the management of this condition 'Choosing the appropriate therapy for a given patient will depend on factors such as patient preference, availability of therapy, the clinical situation and the clinician's expertise'.[8] I discussed in the **check** Program the various options available for treating these lesions in Australia at the present time. Indeed, as Dr Dixon suggests, some of these treatment options have less robust evidence for their use but this does not detract from the fact that they are commonly used in dermatological practice.

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Biomedical models

Dear Editor

I'm not very bright: I've obviously missed something in the recent articles by Sturmberg, and Khong and Choy (*AFP* March 2007). Both talk about 'biomedical' models and more complex or holistic approaches to management. I don't know what a 'Newtonian reductionist paradigm' is. I just do history, examination, investigations and diagnosis. I resent and reject the implication that this is somehow narrow or not holistic. 'History' includes (when necessary; it often isn't) past and family history and every aspect of past and present social, family, work and personal situation and function. So 'John' in Sturmberg's article can be handled by dealing with the various risk factors or by asking a few more questions and trying to deal with the stress. Clearly this is not always done or not done well, at least by me, but I don't know that it has anything to do with paradigms or systems.

Khong and Choy make some sensible comments about specialists and generalists, although these laments are not new. However, how is this related to the biomedical model? We cannot set up subspecialists who concentrate on relatively narrow fields and expect them not to miss other stuff. This is quite independent of our mental approach to our work.

In particular the anecdote they mention doesn't even prove that the psychiatrists got it wrong (hindsight is always 20/20!) It certainly doesn't tell us what model they use or how that is deficient. Things will be missed or misinterpreted in any system. Was not the former GP who diagnosed the angina using a 'biomedical model'? One could very well argue that the urge to treat every physical symptom in psychiatric patients as a new problem is inappropriate while the attempt to fit these into the patients' overall biopsychosocial milieu is commendable. This didn't work in this case. So what? Indeed, one is constantly faced with this problem with psychiatric patients in general practice: is their physical symptom caused by a new disease or is it a delusion, or somatising?

Finally, Khong and Choy would be more useful if they suggested a mechanism of generalist involvement: the six they list don't seem very useful. Indeed if they want GPs to second guess specialists as in their anecdote, they'll need funding for them to attend ward rounds. The anecdote doesn't support the need for generalists in the hospital, as it implies that specialists can't even be trusted to distinguish between their own stuff and those of other specialities (not proven by one incident). If the psych team had called in a cardiologist, would this have underlined the need for a generalist on the team?

Better arguments for generalists include: the patient on say the psych unit who has to have a dermatologist for his rash and a gastroenterologist for his indigestion and a respiratory physician for his asthma, when a GP could handle everything; and [eg.] the dialysis patient whose psychosocial needs are not met.

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