a significant 14% reduction in the population-based incidence of all melanomas larger than 0.76 mm and a 40% reduction in melanomas larger than 3 mm. We also showed a significant 38% higher risk of invasive melanoma less than 0.75 mm, many of which may be overdiagnosed.

Currently, we do not have a randomized clinical trial of melanoma screening underway. In 1992, 30 years ago, one of us wrote2: “if such studies are not started soon the situation is likely to become more complex in the future,” and “the cost of a randomized trial should realistically be considered as an extra cost of evaluation, however, as the major cost—that of the screening program itself—is likely to be incurred whether or not an evaluative study is done.”

We now have extensive opportunistic screening for melanoma in many countries, but with little evaluation or quality control. In the absence of a trial, cohort and case-control studies, while much weaker, can give valuable information if well designed and analyzed. Formal programs may have been rejected because of the lack of randomized clinical trial evidence of mortality benefit. Screening could now be based on risk stratification by phenotype and genotype, and imaging and molecular profiling of lesions, aided by artificial intelligence5; a trial of a targeted program may still be feasible. But at present, we have to make decisions about programs and clinical practice on other types of evidence, as in any other area of medicine in which randomized clinical trial evidence is lacking.

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CORRECTION

Updated Link and Survey Tool Added to Supplement: In the article titled “The Multidimensional Burden of Atopic Dermatitis Among Adults: Results From a Large National Survey”1 published online June 29, 2022, and in the August print issue of JAMA Dermatology, the link in the Methods section has been updated. In addition, the survey tool used in the study has been added to the Supplement. This article was corrected online.


In Reply I thank Elwood et al for highlighting their previous efforts to develop more robust evidence to guide melanoma screening efforts.1,3 However, their work found similar findings as Matsumoto et al,4 with increased thin melanoma ascertainment in patients who had undergone screening skin examinations. While they modeled possible associations with mortality based on thickness data, their work did not look at actual mortality, either all cause or melanoma related.

I agree that we must make decisions about programs and clinical practices in areas of medicine in which randomized trial evidence is lacking. As I noted in my Editorial,5 this is no longer an “inside baseball” issue. These decisions should not be made without patient input. The uncertainty and lack of evidence supporting the mortality benefit of ad hoc and untargeted screening needs to be shared with those we encourage to seek this type of care. In the absence of evidence demonstrating mortality benefit, I believe the default message to patients should be unambiguous. To my knowledge, there has been no mortality benefit demonstrated.

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