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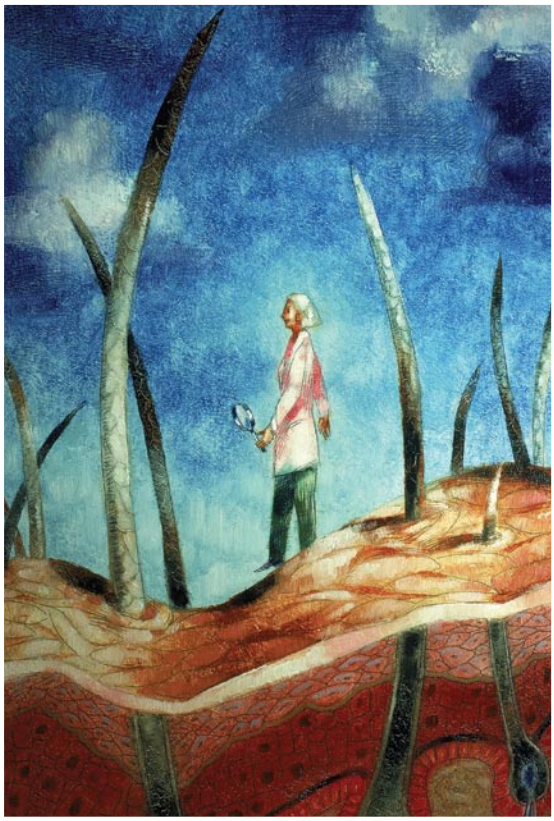

SUPPLEMENT for AIM at Melanoma

Official Journal of the Society of Dermatology Physician Assistants

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EDITORIAL MISSION: The JDPA is the official clinical journal of the Society of Dermatology Physician Assistants. The mission of the JDPA is to improve dermatological patient care by publishing the most innovative, timely, practice-proven educational information available for the physician assistant profession.

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From The Patient's Perspective
Melanoma is a Tricky Disease

By Jackie Doss

Sometime in 2000, when I was forty years old, my gynecologist noticed a mole on my upper back and suggested I get it checked out because it exhibited several of the characteristics of melanoma. I hadn't been sick a day in my life, and I was just "too busy" to fit another doctor visit into my schedule. Here, of course, was mistake number one! A year and a half later, my husband had a physical. His doctor wanted to biopsy a suspicious mole on his back, and it reminded me that there was one on my back that needed attention. So in April of 2002, we had our moles removed on the same day. My husband's mole was normal. I wasn't so lucky.

> *"I have lost many friends to melanoma and it is a constant reminder of a disease that doesn't seem to give up. So I won't give up either."*

My mole turned out to be a melanoma, Clark level III, Breslow depth 0.68mm, and no ulceration. The PA who removed the mole did a great job of getting clear margins. Still, I had to have a wide local excision by a plastic surgeon, and was referred to an oncologist and a dermatologist for follow-up. The dermatologist scheduled me for the customary three-month checkups. The oncologist took my history, looked at my pathology reports, said that he'd probably never need to see me again, and that I was one of the lucky ones who "caught it early." At that time, my biggest concern was the big ugly scar on my back.

Less than two years later, I felt a pain under my arm. I thought I had pulled a muscle. But it didn't go away. In January of 2004, I saw the PA at our family practice because the pain had increased significantly even after taking a course of steroids for a cyst on my hand. I told him that one armpit felt a bit different from the other one. He said, "You mean this lump?" I hadn't thought of it as a lump! He scheduled me for a mammogram and sonogram, and said that because of my melanoma history, we needed to rule out metastasis. After the tests, which confirmed a mass in my left axilla, I was referred to a general surgeon whose normal practice was breast surgery. A needle biopsy confirmed that it was melanoma, so she scheduled me for surgery. This, I believe, was mistake number two.

Rather than getting a second opinion from a melanoma specialist, I simply had the surgery and trusted that between the general oncologist and general surgeon, I was being appropriately treated. The 4cm mass was removed in February 2004, along with eleven additional lymph nodes. Meanwhile, I had been doing some research and found that there were clinical trial options besides the Interferon that my oncologist had recommended. I wanted to explore all of these options, so I investigated the Cancervax clinical trial and referred myself to MD Anderson Cancer Center in Houston on the advice of a friend's cousin, a radiation oncologist. By the time I got to MD Anderson that April, I had multiple metastases in the same axilla.

The surgical oncologist at MD Anderson told me that if I had come there first, they would have removed all of the lymph nodes in the axilla and followed up with radiation treatment because the tumor was large enough to burst and spread to surrounding tissue. I had a complete lymph node dissection in May of 2004, followed by radiation. I then continued my search for a clinical trial for adjuvant therapy. I went to Pittsburgh to see if I qualified for the Mel-43 trial. After waiting the customary time for follow-up scans, and "jumping through the hoops" to see if I qualified for the trial, I had to do one more set of scans in October before starting the trial. Unfortunately, a tumor was found in the fatty tissue on my left flank, so I did not qualify for the trial.

***Jackie Doss** lives in Dallas, Texas and has been diagnosed with stage IV melanoma. Jackie reminds us that melanoma is a tricky disease. It behaves differently in different people. For a stage IV melanoma patient, she considers herself quite fortunate, considering that the average survival time without recurrence is seven months. Her story is one of hope.*

From The Patient's Perspective

Rather than removing the tumor right away, I decided to do a clinical trial for systemic treatment. The trial compared DTIC with a breast cancer drug. My arm of the trial was DTIC. I did two rounds, but there was no effect on the tumor. I then did a trial called Celingitide, which was a drug that inhibited blood vessel formation. This trial didn't seem to be working either, so I was scheduled for surgery in February of 2005. Interestingly, the surgeon said that the tumor was partially dead. While the tumor seemed to have grown based on the CT scan, the trial drug may have actually affected it.

After that surgery, I didn't seem to be bouncing back very fast. I was short of breath and very tired when I should have been fully recuperated. I also had severe stomach cramps. It turned out that there were metastases in my small intestine. I had surgery five weeks after the previous surgery and two or three tumors were removed along with 6in of my small intestine.

Then I *finally* qualified for a clinical trial for adjuvant therapy! I started the Mel-44 trial in July of 2005. I received a vaccine injection at two sites, my right upper leg and my right upper arm. The vaccine was administered subdermally and subcutaneously. Ouch! The schedule began as once a week, then once a month, then once every three months. Fifteen months after my surgery, I had only one more vaccine left when I started having the familiar symptoms of dark stool and shortness of breath.

A pill camera was used to take pictures in my small intestine, and it didn't look promising. There was one large tumor near the end of my small intestine. But even more disturbing than the tumor was the fact that there were pigmented areas seen throughout my small intestine. My surgeon didn't believe he could get it all. Thankfully, the outcome of the surgery in August 2006 was so much better than expected! The pigmented areas turned out to be benign. They don't know for sure, but they believe it's possible that the Mel-44 vaccine helped my body to fight off the cancer cells as they were trying to form.

Since the removal of the last tumor, I was again NED (No Evidence of Disease), and I have remained so for over three years. I am currently receiving no treatment or adjuvant therapy, and I'm very thankful to be alive! So, although the beginning of my story (a <1mm lesion progressing to advanced disease) is atypical, thankfully the updated story is also atypical. Not too many Stage IV melanoma patients are as blessed as I am to be alive and cancer-free after so many recurrences. While I know that doctors expect my disease to return… I don't!

At times my life is a roller coaster, but I feel blessed to be here. I have lost many friends to melanoma and it is a constant reminder of a disease that doesn't seem to give up. So I won't give up either. I won't give up fighting. I won't give up hope. I won't give in to fear. I will do whatever I can to get the word out about melanoma prevention so that future generations don't have to face this fear.

TAKE HOME POINTS for DERM PAs:

By Steven K. Shama, MD, MPH

- Jackie Doss is one amazing person and sets an example for all of us. She remains full of hope when many of us would have given up after the first round of treatments. We should not forget to tell Jackie's story when we have a patient whose treatments seem to be failing.
- Jackie gives me the impression that she was ultimately in charge of her care. I strongly believe that she was the one who decided that she wanted to try another protocol when the local hospital's protocols had been exhausted. Let us celebrate her passion to be cured and always support patients who seem to take control by asking if there is something else they can try. After all, it is their life. It is their right to fight!
- I reread Jackie's first paragraph where she mentions that her gynecologist wanted her to see a specialist about the mole on her back. While her physician's recommendation was sufficient, it reminds us that we should make sure that patients follow up with our recommendations, especially when there is a possibility of something significant being found. I truly believe that we need to do that follow-up and we need to do it more often!

Dermatology Physician Assistants

Physician Assistants (PAs) in dermatology play a number of varied and vital roles.

PAs are medical providers licensed to practice medicine with physician supervision. From patient care and education, to skin surgery, treatment of chronic skin conditions, and cosmetic procedures, PAs are dynamic members of the healthcare team. PAs practice in every medical and surgical specialty and have been collaborating with dermatologists for 30 years, providing a wide variety of services. These include diagnosing, prescribing medications, ordering and interpreting lab tests, wound suturing, and medical or surgical treatment of a wide variety of clinical diseases. As with all PAs, dermatology PAs are legally and ethically bound to practice only under physician supervision.

PAs are trained in intensive, accredited education programs.

Because of the close working relationship that PAs have with physicians, PAs are educated in the medical model designed to mirror and complement physician training. PAs take a national certification examination and to maintain their certification, they must complete 100 hours of continuing medical education every two years and take a recertification exam every six years. Graduation from an accredited PA program and passage of the national certifying exam are required for state licensure.

How a PA practices dermatology varies with training, experience, and state law. In addition, the scope of the PA's responsibilities corresponds to the supervising physician's scope of practice. In general, a PA will see many of the same types of patients as the physician. Referral to the physician, or close consultation between the PA and physician, is based on the dynamic relationship between the physician and PA.

The Society of Dermatology Physician Assistants (SDPA) is a non-profit professional organization, composed of members who provide dermatologic care or have an interest in the medical specialty of dermatology. Fellow members provide medical services under the supervision of a board certified dermatologist.

More information can be found at **www.dermpa.org** and **www.aapa.org**.