

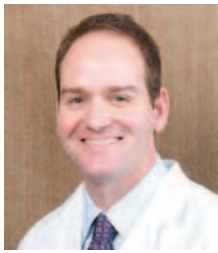
Clinical practice

Dermatologists treat most cases of NMSC that occur in Ontario

■ Data shows OHIP claims for non-melanoma skin cancer rose at annual rate of almost 6% from 2003 to 2009

by LOUISE GAGNON,
Correspondent, The Chronicle

There has been a documented rise in the number of cases of non-melanoma skin cancer (NMSC) in Ontario, and dermatologists are the physicians who primarily treat NMSC, according to Dr. Adam Mamelak, who presented data on NMSC Ontario Health Insurance Plan (OHIP) claims during a presentation at this year's annual meeting of the Canadian Dermatology Association (CDA) in Ottawa.



Dr. Adam Mamelak

OHIP claims for NMSC climbed about 6% per year between 2003 and 2009, but in the same time period, the cost of NMSC rose at two times that rate, said Dr. Mamelak, in a presentation at the Young Investigators Symposium at the CDA meeting.

The treatment modalities that saw the largest increases in the time period were in radiation therapy and Mohs surgery, with a

10.5-fold increase in the number of Mohs surgery claims, said Dr. Mamelak, a dermatologist, Mohs surgeon, and assistant professor of medicine, division of dermatology, University of Ottawa, and a dermatologist at Sanova Dermatology in Austin, Tex.

"We have to recognize that as dermatologists, we are in the forefront of treating this disorder," said Dr. Mamelak.

Tumour registry would provide more info

Because of the absence of a tumour registry for NMSC cases, the incidence and management of NMSC is not well-defined, according to Dr. Mamelak.

"Until we establish a formal tumour registry for tracking NMSC in this province, we will not be able to evaluate the efficacy of treatment or to allocate resources in a better way to treat the disease or control costs," said Dr. Mamelak.

Another analysis demonstrated that dermatologists, of all medical specialists, submitted 43% of the NMSC claims between 2003 and 2009, followed by family physicians

and then plastic surgeons.

Dermatologists primarily relied on electrodesiccation and curettage (EDC) to treat NMSC, but their reliance on this method fell during the period from 2008 to 2009. This corresponded to the opening of the second Mohs surgery clinic in Ontario.

Plastic surgeons performed most excisions

Plastic surgeons were responsible for the majority of surgical excision claims, followed by their dermatologist colleagues. The proportion of surgical procedures performed by dermatologists rose significantly from 2003 (14%) to 2009 (21%). Radiation oncologists were the only physicians who billed for radiation therapy.

Interestingly, the number of Ontario claims for NMSC between 2003 and 2009 outpaced the growth in the Ontario physician workforce substantially, at a rate of 2.8 times faster: the number of OHIP claims for NMSC rose by over 36% between 2003 and 2009

while the number of physicians in Ontario rose by a little more than 13% between 2003 and 2009, with an average growth of close to 500 physicians annually.

The OHIP claims do not capture if NMSC is being diagnosed at an early stage, noted Dr. Mamelak.

"We can't

answer from these data if patients are coming to see us earlier," said Dr. Mamelak.

Another area that is not currently being captured in OHIP claims is recurrent disease, noted Dr. Mamelak.

"There is the issue of recurrent disease which we are not tracking and we have no idea what it is costing us," Dr. Mamelak told meeting attendees.

The treatment modalities that saw the largest increases in the time period were in radiation therapy and Mohs surgery, with a 10.5-fold increase in the number of Mohs surgery claims.

—Dr. Adam Mamelak

But, what do you think?

A question for our readers: The data provided in this report is from the Ontario Health Insurance Plan. What's been the experience of dermatologists in your province? Let your colleagues know how you feel. Send us your clinical impressions and your opinions
health@chronicle.org

BIACNA is indicated for the topical treatment of acne vulgaris characterized by comedones, inflammatory papules/pustules, with or without an occasional nodule in adults and children 12 years or older. BIACNA is not indicated for the treatment of pustular and deep cystic nodular acne varieties (acne conglobata and acne fulminans).

BIACNA is contraindicated in patients with regional enteritis, ulcerative colitis or history of antibiotic-associated colitis; and in patients who have a history of hypersensitivity to BIACNA or any preparations containing clindamycin, lincomycin, tretinoin or to any ingredient in the formulation or component of the container.

Avoid contact with eyes and mucous membranes.

Systemic absorption of clindamycin has been demonstrated following topical use of BIACNA. *Clostridium difficile*-associated disease (CDAD) has been reported with the use of topical, oral and parenteral administration of clindamycin. CDAD may range in severity from mild diarrhea to fatal colitis. If the diagnosis of CDAD is expected or confirmed, appropriate therapeutic measures should be initiated.

BIACNA should be given to women of childbearing years only after contraceptive counseling. BIACNA should not be given to a pregnant woman unless the benefits outweigh the possible risks.

Because of heightened susceptibility to UV radiation as a result of using tretinoin, patients should avoid exposure to the sunlight, including sunlamp during the use of BIACNA. Daily uses of sunscreen products with a SPF of at least 30 and protective apparel (e.g., a hat) are recommended and patients with sunburn are advised not to use BIACNA until fully recovered. Patients who may be required to have considerable sun exposure due to occupation and those with inherent sensitivity to the sun should exercise particular caution. If sunburn occurs, discontinue therapy with BIACNA until the severe erythema and peeling subside.

Concomitant topical acne therapy is not recommended because a possible cumulative irritancy effect may occur.

The majority of drug-related adverse reactions were mild or moderate in severity. The most frequent drug-related adverse reactions were application site reactions, such as dryness, pruritus and rash. The most common drug-related adverse reaction was application site dry skin/dryness (1.7%).

Please see Product Monograph for complete warnings, precautions and adverse reactions.¹

Reference: 1. BIACNA Product Monograph. Valeant Canada Limited, November 29, 2010.



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