



Skin Malignancies

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Skin malignancies are among the most common form of cancer. Dark-skinned individuals of African descent are far less likely than fair-skinned individuals to develop skin cancer. Significant differences in the pattern of skin malignancy have also been observed in different regions of the world. The pattern of skin cancer in sub-Saharan Africa shows a sharp contrast to that seen in Caucasians populations. Effective policies on public education and implementation of preventive and therapeutic strategies should be developed based on evidence of research in various regions and not on adapted models as risk factors vary among Caucasians in Europe, North America, and Australia compared to the darkly pigmented in Africa [1].

Major dermatologic malignancies encountered in Calabar, Southern Nigeria accounted for 10% of all malignancies, and this was comparable to rates of 12.3% reported in Zaria, Northern Nigeria in sub-Saharan Africa [2]. This is in sharp contrast to the rates in lightly pigmented races in North America, Europe, and Australia where skin cancer is the most common form of cancer. Eighty percent of invasive skin cancer is basal cell carcinoma (BCC) while 20% are squamous cell carcinoma (SCC) in Caucasian population. This contrasts with the experience in sub-Sahara Africa where SCC is the most common skin cancer. Halder and Bridgeman-Shah in the United States of America also reported more cases of SCC in African Americans than white counterparts did [3].

Lower levels of protective cutaneous melanin in Caucasians render them more vulnerable to carcinogenesis from solar radiation. Sun exposure is the major etiologic factor in the Caucasians, a factor

consistent with skin cancer seen in African albinos. However, the commonest skin cancer in African albinos is SCC and not BCC. The reason for this requires further evaluation. Skin cancer in albinos presented about 2-3 decades earlier than the darkly pigmented, hence the need for early institution of solar preventive measures. Non-solar factors, chronic ulcers, trauma, and infection/inflammation appear to be the leading risk factors for SCC, Kaposi sarcoma, and melanoma in the darkly pigmented. These malignancies are common on the lower limbs in consistence with non-solar aetiopathogenesis. Plantar melanoma is a common mode of presentation in sub-Sahara Africa and the risk factor is non-solar.

In the darkly pigmented, lesions that affect the head and neck, appear not to be of solar aetiology as they often lack evidence of exposure to solar radiation when compared to the albinos whose lesions show the presence of solar keratoses found on the sun exposed parts of the head and neck and upper limbs.

In the Caucasian population, solar radiation is a major risk factor for all forms of skin cancer. This experience is exemplified only in African albinos. Non-solar factors are the predominant risk factor in the darkly pigmented. The pattern of skin cancer in Caucasians contrast sharply with the darkly pigmented in Africa. Prevention holds the key to a reduction in the prevalence of skin malignancy and should be modelled based on the prevalent risk factors, which vary with race and environment.

References

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