vitamin D levels has been attributed to the inflammatory milieu created by IL-17.5

In conclusion, the current study highlights the possible role played by Th17 cells and vitamin D insufficiency in the complex pathogenesis of psoriasis; however, their intertwined relationship could not be clearly verified. It would be interesting to examine the effect of systemic vitamin D supplementation on IL-17 levels and to investigate the immune-regulatory role it plays in psoriasis.

Hesham Abd El-Moaty Zaher, MD,a Mohamed Hussein Medbat El-Komy, MD,a Rehab Aly Hegazy, MD,a Heba Amr Mohamed El Khashab, MBChb,b and Hanaa Hamdy Ahmed, MDb

Department of Dermatology, Faculty of Medicine, Cairo University,a Departments of Dermatologyb and Biochemistry,b National Research Centre, Cairo, Egypt

Funding sources: None.

Conflicts of interests: None declared.

Correspondence to: Mohamed Hussein Medhat El-Komy, MD, 5 Falaky Square Bab EL-Louk, Cairo, Egypt
E-mail: komy_m@yahoo.com

REFERENCES

Partner involvement in conduct of skin self-examinations remains low following CDKN2A/p16 genetic test reporting and counseling

To the Editor: A pathogenic CDKN2A/p16 mutation inherited in a familial context confers approximately 70% lifetime risk of melanoma in the United States. Members of high-risk families are recommended to perform monthly skin self-examinations (SSEs) because more thorough SSEs are associated with thinner tumors.1 Patients with available partners are more likely to perform SSEs,2 and little is known about whether high-risk adults involve partners when performing exams. Partners can help by examining hard-to-see areas and providing input on whether moles appear suspicious or changed.3 We examined partner involvement in SSE performance among members of high-risk families before and after melanoma genetic counseling and test reporting.

Sixty-one adults (31.2% with melanoma history; 54.1% male), all of whom received SSE instruction including recommendations for partner involvement through participation in previous CDKN2A/p16 identification studies, completed a baseline questionnaire and received melanoma genetic counseling and test results.4 Thirty-seven (60.7%; 11 affected carriers with a melanoma history, 10 unaffected carriers, 16 noncarriers; 54.1% male) completed a questionnaire 2 years later. Carriers received counseling specifying their 35- to 70-fold increased risk; noncarriers were counseled on their 1.7-fold increased risk. All participants received verbal recommendations from a genetic counselor to perform monthly SSEs. These recommendations were reiterated in a follow-up letter, but no additional SSE instruction was given. Analyses are restricted to respondents completing at least 1 exam in the past 6 months (n baseline = 50, n2-year = 32).

The frequency of partner involvement was equally low across groups and did not increase over time (R(2,29) = 2.01, P = .906; Fig 1). Age, gender, income, and education were not significantly correlated with partner involvement at either assessment. Participants reporting greater logistic barriers to SSE (hard to remember, time-consuming) reported less frequent partner involvement at baseline (r = −0.33, P = .020), but not at 2 years.

At 2 years, 21 respondents provided qualitative reasons for not regularly involving a partner in SSEs. Six reported that their partner was not available,
reliable, or convenient, and 4 reported that their partner felt unwilling or unqualified to help. Four forgot to ask for help, 3 were too busy, 3 thought that risk was too low to warrant screening, 2 used mirrors instead, 1 only elicited help after noticing skin changes, and 1 felt uncomfortable asking for help.

As shown in Fig 2, SSE thoroughness differed by partner involvement. At baseline, patients who involved partners more frequently checked more body sites ($r = 0.29, P = .044$), were more likely to check their scalp ($r = 0.37, P = .008$) and bottoms of feet ($r = 0.29$, $P = .043$), and marginally more likely to check their chest ($r = 0.24, P = .089$). At 2 years, participants checked significantly more body sites than at baseline, with no differences by partner involvement.

Interventions should promote more consistent partner involvement in SSEs. These interventions could increase partners’ sense of efficacy to assist with exams, stress the importance of thorough monthly exams, and increase motivation to perform thorough exams. Furthermore, dyadic learning interventions have improved SSE performance and self-efficacy among melanoma survivors. Finally, because affected carriers infrequently involve partners, interventions should aim to improve partner involvement among melanoma survivors at high recurrence risk.

Jennifer M. Taber, MS,a Lisa G. Aspinwall, PhD,a Samantha L. Leaf, PhD,b Wendy Kohlmann, MS, CGC,c and Sancy A. Leachman, MD, PhDb,c

Department of Psychology,a Department of Dermatology,b University of Utah; and Huntsman Cancer Institute,c Salt Lake City, Utah

Funding sources: This work was supported by a Funding Incentive Seed Grant, Office of the Vice President for Research, University of Utah, and a Cancer Control and Population Sciences Pilot Project Award from the Huntsman Cancer Institute awarded to Lisa G. Aspinwall and Sancy A. Leachman. Support was also received from the Huntsman Cancer Foundation (HCF), the Tom C. Mathews, Jr, Familial Melanoma Research Clinic endowment, the Pedigree and Population Resource of Huntsman Cancer Institute, and the Utah Population Database. This research was supported by the Utah Cancer Registry, which is funded by contract NO1-PC-35141 from the National Cancer Institute SEER Program with additional support from the Utah State Department of Health and the University of Utah. The authors acknowledge the use of core facilities supported by the National Institutes of Health through National Cancer Institute (NCI) Cancer Center Support Grant 5P30CA420-14 awarded to Huntsman Cancer Institute, the genetic counseling core facility supported by the Huntsman Cancer Foundation, and National Center for Research Resources grant 1KL2RR025763-01 awarded to the University of Utah by the National Institutes of Health Office of the Director.

Conflicts of interest: None declared.

Correspondence to: Lisa G. Aspinwall, PhD, Department of Psychology, University of Utah, 380 South 1530 East, Room 502, Salt Lake City, UT 84112-0251

E-mail: lisa.aspinwall@utah.edu

REFERENCES


http://dx.doi.org/10.1016/j.jaad.2013.06.048

**IMPORTANT NOTICE REGARDING JAAD GRAND ROUNDS**

As we are no longer able to offer CME credit for JAAD Grand Rounds, that feature will be discontinued when our current inventory of cases runs out. New manuscripts are no longer being accepted for that section. A similar selection of great cases can be found online in the Case Letters section of each month’s edition of JAAD that can be accessed at http://www.jaad.org.