

## Across the Medical Editor's Desk

### Prevention of Skin Cancer

Everyone would agree that preventing cancer is even more important than developing better methods of diagnosing and treating the disease. Paradoxically, though, whenever medical investigation determines the etiology of certain malignancies and establishes sure methods of preventing or reducing the incidence of these cancers, a substantial percentage of the population will not utilize these new guidelines to health. For example, cigarette smoking is still prevalent in this country despite definitive documentation of its association with lung cancer. Similarly, the demonstration that excessive alcohol ingestion is associated with high rates of intraoral cancer has not led to dramatic changes in drinking habits.

Another well-established carcinogenic factor is excessive exposure to sunlight, which has been linked with cancer of the skin. It has been recognized for years that prolonged exposure to the sun increases the incidence of both basal cell and squamous cell carcinoma of the skin. More recently, the association of excessive sunlight and the development of melanoma has been clearly established. The incidence of melanoma has been rising steadily in the United States, at a rate of about 8 percent per year. The more fanciful members of the epidemiologic community have dubbed this a "melanoma epidemic." Almost certainly, the increase in cases results from changes in the lifestyle of Americans, who now have more leisure time to spend in the sun and wear less clothing to protect their skin.

Basal cell and squamous cell cancers are relatively trivial neoplasms. The same cannot be said for melanoma, which carries a substantial mortality rate. All skin cancers occur with higher frequency in fair-skinned, blue-eyed blonds and redheads, although no element of the population is immune to these tumors.

Common-sense precautions should be observed to minimize the effect of ultraviolet irradiation. An attractive tan can be achieved without hours of baking in the sun. Individuals at increased risk because of their fair complexion should try to avoid exposure to sunlight between the hours of 10 a.m. and 2 p.m., when the sun is directly overhead and its rays are filtered by only 15 miles of atmosphere. Earlier in the morning and later in the afternoon, the sun is lower in the horizon and its rays are filtered by many more miles of atmosphere.

Wearing protective clothes and broad-brimmed hats, seeking shelter under beach umbrellas and applying sun-blocking skin lotions are all effective anti-cancer measures. These precautions are almost uniformly ignored by the young and the young-at-heart seeking an enhanced body image. The only admonition which seems to be effective is the warning that prolonged sun exposure will prematurely age the skin. The sun worshiper will wind up at a relatively early age with an integument that resembles a prune. Ironically, this prospect may prompt more patients to avoid excessive sunlight than warnings about skin cancer.

### Guest Editorial

#### Psychologic Aspects of Mitral Valve Prolapse

Anxiety disorders are frequently encountered in the family physician's office. However, despite efforts to include mitral valve prolapse syndrome (MVPS) in the differential diagnosis of these disorders, few medical reviews of MVPS mention that the syndrome often presents with symptoms suggesting anxiety neurosis. Similarly, the third edition of *Diagnostic and Statistical Manual of Mental*

*Disorders* (DSM-III) does not include MVPS as part of the diagnostic differential for panic or anxiety disorders.

The presenting symptoms of MVPS may include nervousness, irritability, depressed mood, palpitation, dyspnea, insomnia, diminished energy and libido, rapid breathing, increased heart rate, trembling, light-headedness, feelings of unreality, fear of dying, phobias and sleep disorders. Since this profile is also consistent with anxiety disorders, anxiety and panic secondary to MVPS may be confused with a primary anxiety disorder. In many cases presenting to the family physician as free-floating, diffuse anxiety, hypochondriacal verbalizations and behavior or discrete panic episodes, undiagnosed MVPS may be the culprit.

We have recently documented 14 such cases, including nine women and five men. The youngest patient was a 10-year-old girl and the oldest was a 55-year-old woman. In most of these cases, a fairly consistent pattern has been identified. Usually, there is a long history of vague, anxiety-type symptoms, without successful treatment or resolution. Once the diagnosis of MVPS is established by echocardiography and, at times, the use of propranolol (Inderal®), there is often a marked decrease in functional symptoms—especially in premature ventricular contractions (PVCs) and palpitation.

The clinical findings in these cases have important implications for treatment and patient management. Patients labeled as chronic hypochondriacs or chronically anxious patients may be dramatically helped by the discovery that the symptoms they have presented to physicians over the years have a basis in reality. When a diagnosis of MVPS has been made in a patient with anxiety, panic or hypochondriacal behavior, the family physician's first efforts at treatment should be directed toward reassurance and supportive education of the patient and the family. (Counseling of patients with MVPS

should include information about the importance of obtaining specific medication to prevent subacute bacterial endocarditis when undergoing dental work.)

In the face of continued symptoms, propranolol may be prescribed. In addition, various techniques of behavioral control—for example, relaxation training or systematic desensitization—may be appropriate. Thus, instead of responding to MVPS symptoms with feelings of anxiety and panic ("I may die" or "I am losing control"), the patient can be taught to use the same sensations as cues for relaxation and for calming self-instructions. Desensitizing the patient to the onset of symptoms may be another means of reducing negative expectations and anticipatory anxiety.

The family as well as the patient can benefit from the physician's efforts at training and education. In the cases mentioned earlier, appropriate diagnosis and management have led the family to show greater warmth and understanding toward the patient. The discovery of MVPS forces family members to redefine their view of the patient and to relinquish their resigned tolerance or irritated impatience at the "neurotic demands" of the patient. The family should also be educated to avoid reinforcing or rewarding conditioned panic responses which the patient may have developed in reaction to physical symptoms.

In summary, the patient management opportunities that are available in a family practice setting can yield positive results for improvement in the symptoms and psychologic aspects of MVPS. It is important to consider the diagnosis of MVPS in appropriate cases. A thorough history and physical examination, followed by an echocardiogram to confirm the diagnosis, may give both the patient and the family a new lease on life.

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