The recognition and treatment of pigmented lesions: a survey of New Zealand beauty therapists

Intense pulsed light (IPL) and laser devices are readily accessible to beauty therapists in New Zealand for the treatment of pigmented skin lesions. However, their usage is unregulated as these instruments do not fulfil the local legislative definition of a medical device.¹ The concern is that these devices may be used inadvertently for the treatment of malignant skin lesions such as melanoma by personnel who do not have formal training in the recognition of skin cancers. This survey questioned New Zealand beauty therapists about training in skin cancer and management of pigmented lesions.

A standardised questionnaire was formulated by the New Zealand Beauty Therapy Association (NZBTA) and the Dermatology Department of Middlemore Hospital. These were distributed to all 700 members of the NZBTA as an insert in the “Beautynz” magazine. The anonymous questionnaire contained 16 questions including four unlabelled photographs of pigmented lesions.

The four photographs were of a “classic” superficial spreading malignant melanoma, a subtle melanoma in situ, a lentigo and a naevus. The superficial spreading melanoma and the melanoma in situ were histologically confirmed. Ethics Committee approval was obtained for this study.

79 questionnaires (11% of questionnaires sent out) were returned. 39% (n=31) of respondents did not receive any formal training in the identification of skin cancer. 51% (n=24) of those who had formal instruction spent less than a day on this aspect of training. Most respondents were taught about skin cancer identification by other beauty therapists (53%, n=38) while 28% (n=20) received teaching from doctors or nurses. 12.5% (n=9) were self-taught from sources ranging from magazines to the internet.

When asked what they would do if a client was concerned about a skin pigmentation from ultraviolet exposure on the skin, the majority (90%, n=70) would refer to a doctor. Most therapists also reported that they would not treat a blemish if they themselves had concerns about it (87%, n=67).

The questionnaire asked the therapists if they would treat the “classic” superficial spreading malignant melanoma and the more subtle melanoma in situ. For the “classic” melanoma, 97% (n=76) would not and 3% (n=2) were unsure. By comparison, when shown the “subtle” melanoma, 29% (n=22) would have treated the lesion, 49% (n=38) would not and 22% (n=17) were unsure.

The therapists were asked if they knew the meaning of the ABCD guide to melanoma and 60% (n=46) replied “no”. The majority of them (94%, n=74) were keen to receive formal training in the identification of skin cancer. More than half the respondents (64%, n=50) did not have access to a registered medical practitioner or registered nurse in their practice.
Beauty therapists are commonly requested by the public to treat pigmented lesions and they may be the first treatment providers that patients seek. Professionally-trained beauty therapists have formal instruction in the recognition of skin cancers and understand the importance of communicating with medical professionals when faced with pigmented lesions about which they have concerns. There is no regulatory body overseeing the usage of IPL and lasers; the potential exists for unqualified personnel to use these devices unintentionally on malignant melanoma.

The diagnosis of malignant melanoma relies on an accurate history and careful examination. Dermatoscopy and comparison of serial images adds to diagnostic accuracy. Nonetheless the diagnosis can, at times, be challenging even for the experienced practitioner. This survey demonstrated that a large number of the respondents received no training in skin cancer recognition. The majority was not aware of the ABCD guide to melanoma. Reassuringly, most respondents managed to accurately identify the “classic” melanoma. However, some beauty therapists would have treated the subtle melanoma in situ.

Where practical, surgical excision remains the standard treatment for primary melanoma. The use of a Nd:YAG and Alexandrite lasers is reported in the treatment of melanoma in situ however long term clearance was achieved in only 12 out of 22 patients. Laser treatment is associated with a high recurrence rate perhaps related to protection of atypical melanocytes within appendageal structures and the presence of amelanotic cells beyond the visible pigmented margin.

Almost all the beauty therapists participating in the survey realise the need for formal training in skin cancer identification. With the high incidence of melanoma in New Zealand this aspect of training is essential for anyone involved in treating skin lesions. This study was limited by the low response rate and that the management response was based on image recognition alone. A larger survey, particularly examining those who chose not to return the survey would be preferable.

We propose that all users of IPL and lasers undergo appropriate standardised and mandatory training in the recognition of skin cancer to limit the potential risk of an adverse outcome to patients.

Kenneth Kien Siang Wong
Dermatology Registrar
Department of Dermatology
Middlemore Hospital, Auckland.

Judy West
Elite Beauty Therapy School
Auckland

Paul Jarrett
Consultant Dermatologist
Department of Dermatology
Middlemore Hospital, Auckland.

References:
