

Overview:

Skin cancer is the most common form of human cancer with as many as one in six Americans developing the condition during their lifetime. Approximately 700,000 Americans are diagnosed with skin cancer each year. Most skin cancers are believed to be caused by overexposure to sunlight, especially when it has resulted in sunburns. Severe sun burns in childhood increases the likelihood of developing skin cancers as an adult. Fair skinned individuals with red or blonde hair are at greatest risk. A family history of skin cancer, as well as the presence of dysplastic nevi (atypical moles) also increase the likelihood of skin cancer development. There are three broad classifications of skin cancer:

Basal cell carcinoma is the most common form of skin cancer. It frequently presents itself as a small skin nodule that slowly grows in size. As this cancer is frequently diagnosed early, it is often removed surgically soon after development. Even though recurrence is common, basal cell carcinoma typically does not spread to other tissues and thus has little impact on mortality.

Squamous cell carcinoma may present itself as a red patch or nodule. Surgical excision is the typical treatment. Recurrence is common. Unfortunately, this cancer has a greater likelihood of spread than basal cell carcinoma. About 10% of individuals with squamous cell carcinoma develop cancer elsewhere.

Malignant melanoma is the rarest and most deadly form of skin cancer. About 42,000 Americans are newly diagnosed with the condition each year; about 1 in 80 Americans are afflicted by the disease. Melanoma is also among the most deadly forms of all cancers, with over 7,000 deaths per year in the late 1990s.

Melanoma is often curable if the skin lesion is found and treated early, usually by surgical removal of the cancer and the tissues surrounding the affected area. Prognosis of malignant melanomas depends on the depth of invasion and the vertical thickness of the tumor, as measured by *Clark Level* and *Breslow Scale* respectively.

Impact on Life Underwriting:

Basal cell carcinomas are not typically relevant to life underwriting and preferred rates are usually available. Preferred rates may be unavailable with multiple recurring basal cell carcinomas, especially in young individuals.

Squamous cell carcinoma sometimes spreads to other tissues and is underwritten more cautiously. Life insurance offers vary with the number of lesions involved, the aggressiveness of the cancer cells reviewed in the pathology report, and any kind of staging done for the cancer. Life insurance offers range from standard to a low table, either with or without temporary flat extra for a few years post the date of last treatment. Declines are rare but possible with evidence of metastasis.

Malignant melanomas are the skin cancers of greatest concern to life underwriting. This type of cancer often penetrates more deeply into the layers of skin than the other skin cancers. The seriousness of a melanoma is usually staged with a *Clark's Level*, which describes the level of invasion into the skin, and a *Breslow Scale*, which describes the vertical thickness. If the two measurements are inconsistent, more weight is given to the degree of vertical thickness (Breslow Scale) as this variable carries the strongest correlation with the likelihood of spread. Melanomas are almost always treated with surgical removal. The patient is typically told that he or she has been "cured" and that all of the cancer has been removed. Unfortunately, even though the removal of the cancer seems complete at the time of the surgery (and it often is) only the test of time can prove that the cancer has indeed not spread. Postponements and flat extras are thus common during the years immediately following surgical removal of the melanoma. If at all possible, please help us quote your case accurately and fax to us the 1-2 page pathology report discussing the melanoma in detail. SB 04/16/2001

Clark Level (Level of Invasion)	Extent of Disease	Breslow Scale (Vertical Thickness)	Likely underwriting action:
I	In-situ; confined to epidermis.	In-situ	Standard
II	Involvement of papillary dermis.	.74 mm or less	\$7 to \$10/\$1,000 for 5 Years
III	Extends through papillary-reticular junction.	.75 mm to 1.50 mm	\$7 to \$15/\$1,000 for 5 to 7 Years. Possibly PP 3 Years.
IV	Invades reticular dermis.	1.51 mm to 4.00 mm	PP at least 5 years, then possibly \$15 for 5 years +.
V	Invades to subcutaneous tissues.	4.01 mm +	Risk Not Acceptable