The Committee will consider the following current petitions—

PE817 Petition by Elaine Black and Ewan Kennedy calling for the Scottish Parliament to reform the law of trust to ensure that where a trust has been set up for the benefit of any local community that local community is formally consulted by any party seeking to change the operation of the trust and the view of each member of that community is accountably considered before any change is made.

PE894 Petition by The Association of Caithness Community Councils calling for the Scottish Parliament to consider investment in infrastructure, rolling stock and timetabling as part of a strategic root and branch review of the provision of rail services between Inverness, Thurso and Wick, with unrestricted thinking on how best to shorten journey times and ensure the continuing future of the railway to these destinations. Thought should also be given to ensuring that the existing communities of the ‘Lairg loop’ are provided for.

PE931 Petition by Helen Irons, on behalf of Skin Care Campaign Scotland, calling for the Scottish Parliament to urge the Scottish Executive to review its policy on tackling the growing skin cancer epidemic in Scotland.

PE893 Petition by Paul Macdonald, on behalf of the Save our Swords Campaign, calling for the Scottish Parliament to oppose the introduction of any ban on the sale or possession of swords in Scotland which are used for legitimate historical, cultural, artistic, sporting, economic and religious purposes.

PE902 Petition by Dr John Crawford calling on the Scottish Parliament to urge the Scottish Executive to ensure that the national school curriculum recognises the importance of information literacy as a key lifelong learning skill.

PE941 Petition by Frank M Buckley, on behalf of the Society for the Protection of Salmon and Sea Trout, calling for the Scottish Parliament to urge the
Scottish Executive to ensure greater protection for the rivers, streams and lochs of Scotland, such as Loch Broom and the River Gruinard, from fish farms developments.

PE759 Petition by Robbie the Pict, on behalf of the Scottish Peoples Mission, calling for the Scottish Parliament to take the necessary steps to ensure that the names of judges serving on a judicial Bench are displayed and that a full-tape recording or short-hand record is kept of court proceedings which is available to any party involved.

PE855 Petition by Leslie Morrison, on behalf of Kirkside Area Residents, calling for the Scottish Parliament to urge the Scottish Executive to review the performance of all local authorities in Scotland in respect of maintaining and repairing roads, pavements and footpaths.
Public Petitions Committee – a template for public petitions

Should you wish to submit a public petition for consideration by the Public Petitions Committee please complete the template below. Please refer to the Guidance on submission of public petitions for advice on issues of admissibility before completing the template. You may also seek advice from the Clerk to the Committee whose contact details can be found at the end of this form.

Details of principal petitioner:
Please enter the name of person and organisation raising the petition, including a contact address where correspondence should be sent to, email address and phone number if available

Helen Irons

Text of petition:
The petition should clearly state what action the petitioner wishes the Parliament to take in no more than 5 lines of text, e.g.
The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS

'The petitioner asks the Scottish Parliament to urge the Scottish Executive to review its policy on tackling the growing skin cancer epidemic in Scotland.'

In support of the above, please find attached a paper by Dr Jamie Inglis entitled ‘Skin Cancer in Scotland 1973 – 2003’.

Additional information:
Any additional information in relation to your petition, including reasons why the action requested is necessary, should not be included here. However, it may be appended to the petition and will be made available to the Public Petitions Committee prior to its consideration of your petition. Please note that you should limit the amount of any additional information which you may wish to provide in support of your petition to no more than 4 sides of A4.
Action taken to resolve issues of concern before submitting the petition:
Before submitting a petition to the Parliament, petitioners are expected to have made an attempt to resolve their issues of concern by, for example, making representations to the Scottish Executive or seeking the assistance of locally elected representatives, such as councillors, MSPs and MPs. Please enter details of those approached below and append copies of relevant correspondence, which will be made available to the Public Petitions Committee prior to its consideration of your petition.

After a Skin Care Campaign Scotland Parliamentary Briefing on the issue of skin cancer earlier this year, Helen Eadie, MSP, suggested the route of the Public Petitions Committee to us during a meeting held with her on 25 August.

Petitioners appearing before the Committee
The Convener of the Committee may invite petitioners to appear before the Public Petitions Committee to speak in support of their petition. Such an invitation will only be made if the Convener considers this would be useful in facilitating the Committee's consideration of the petition. It should be noted that due to the large volume of petitions it has to consider, the Committee is not able to invite all petitioners to appear before the Committee to speak in support of their petition.

Please indicate below if you do NOT wish to make a brief statement before the Committee when it comes to consider your petition.

I do NOT wish to make a brief statement before the Committee

Signature of principal petitioner:
When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature .................................................................

Date 19 November, 2005 ................................................

Please note that any additional information, copies of relevant correspondence and additional signatures should be appended to this form and submitted to:

The Clerk to the Public Petitions Committee,
The Scottish Parliament,
Edinburgh
EH99 1SP
Tel: 0131 348 5186 Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk
Mr Jim Johnston  
The Clerk to the Public Petitions Committee  
The Scottish Parliament  
Edinburgh  
EH99 1SP

19 December, 2005

Dear Mr Johnston,

You may recall that I spoke with you last Friday regarding our petition. I have enclosed this along with a supporting document, which I also mentioned to you. This document is actually 9 pages long, but would be very difficult to cut down to the recommended 4 pages. It was, however, produced by Dr Jamie Inglis, Consultant in Public Health Medicine to the Scottish Executive, and is designed to be easily read by non-medics.

I have informed our team that the new date is Wednesday, 8 February.

I hope that the enclosed is satisfactory, but should there be any problems, please do not hesitate to contact me.

With kindest regards and best wishes for the holidays,

Yours sincerely,

Development Officer  
Skin Care Campaign Scotland

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Registered Office: 9 Bangholm Bower Avenue, Edinburgh EH5 3NS
Skin Cancer in Scotland
1975 - 2003

Summary

This review describes the changes in skin cancer epidemiology in Scotland since 1975 and also examines the underlying trends for both malignant melanoma and non-melanoma skin cancer.

Malignant or invasive melanoma is the least common skin cancer accounting for about 10% of all cases [650-700 cases year] but is the most dangerous resulting in 130-150 deaths in Scotland each year [60-70% of all deaths from skin cancer]. The term non-melanoma skin cancer covers basal cell carcinoma [BCC] and squamous cell carcinoma [SCC] and these two cancers make up about 90% of all skin cancer diagnosis in Scotland [about 6500 cases year]. Both types of non-melanoma skin cancer are very slow growing, tend not to metastasise and if treated are rarely fatal [about 50 deaths per year].

The most recent figures available demonstrate the scale and impact this has in Scotland with 7349 Scots diagnosed with skin cancer in 2001 and 197 Scots dying from skin cancer in 2003. Since 1975, cases of skin cancer in Scotland have increased over three times and deaths from skin cancer have increased by 40%. Cases of skin cancer have plateaued in the last five years following the peak in 1997, however deaths from skin cancer are probably still rising slowly.

The increase in cases has occurred almost equally in both sexes with men now accounting for slightly more diagnoses per year than women. The increase in deaths has occurred mostly in men who saw a 60% increase in deaths by comparison with a 9% increase in women such that deaths in men now outnumber deaths in women by a ratio of 5 to 4.

Registrations for malignant melanoma have increased almost threefold and deaths have doubled in the last 25 years. The increase has been greatest in men who have seen registrations increase over four times and deaths increase almost threefold. Despite the faster rise in men, registrations in women still outnumber those in men by a ratio of 4:3 but deaths in men now outnumber deaths in women.

There are now 5000 more cases of skin cancer a year in Scotland than there were 25 years ago and most of these are a result of cosmetic tanning. The rise in foreign holidays and sunbathing at home and abroad has been the principal driving force of the epidemic coupled with the increasing numbers, and use of, sunbed parlours throughout Scotland.

The priorities now must be earlier diagnosis in an effort to reduce the increasing number of deaths from skin cancer and a substantial and sustained prevention campaign to reverse the epidemic that has already occurred in Scotland.

Keywords: skin cancer, Scotland, malignant melanoma, cosmetic tanning, sunbeds.
All Skin Cancer

The figures in Box 1 outline the scale of the skin cancer epidemic in Scotland. Comprehensive figures for all skin cancer diagnoses from 1975-2003 are available in the appendix Table 1 and these have been charted in Fig.1a registrations, Fig.1b deaths, Fig.1c. registrations in males and females, and Fig.1d. deaths in males and females.

**Box 1. All skin cancer**

<table>
<thead>
<tr>
<th></th>
<th>1975</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses</td>
<td>2113</td>
<td>7349</td>
</tr>
<tr>
<td>Deaths</td>
<td>139</td>
<td>197</td>
</tr>
</tbody>
</table>

A rise from 2113 diagnoses of skin cancer in 1975 to a total of 7349 diagnoses in 2001 represents a more than three-fold increase in this twenty-five year period. In a similar time period, deaths have risen from 139 in 1975 to 197 in 2003 representing a 40% increase. A substantial increase in deaths during that time but a modest increase by comparison with the increase in diagnoses.

The picture in Fig.1a. shows skin cancer registrations rising steadily from 1975 throughout the 1980s having doubled to 4273 by 1988 followed by a steeper increase through the early 1990s to reach a peak of 7346 cases in 1997. The last five years from 1997-2001 have seen a plateauing of cases ranging between 7100 and 7350 per year and averaging 7213 cases per year.

Deaths from skin cancer have also increased from 139 in 1975 to 197 in 2003 representing a 40% increase over that time period (Fig.1b). To remove the variation caused by examining single years three-yearly averages are used. The average number of deaths in the three years 1975-1977, was 141 and the average for the three-year period 2001-2003 was 197 deaths. This demonstrates a true and significant 40% increase over that time period but does represent a lower burden than would have been expected from the dramatic rise in skin cancer diagnoses seen in Figure 1.

When analysing skin cancer registrations by sex there has been a slight but noticeable change in the distribution between males and females. In the late 1970s and early 1980s, there were marginally more cases in females than in males (Fig. 1c.). In the last five years, there has been a noticeable alteration in the ratio of male to female cases. In 1997-2001, there were 18,296 diagnoses in males compared with 17,768 in females giving an average over the five-year period of approximately 3650 cases per year in men compared with 3550 cases per year in women. Approximately 100 more cases per year in men than women and this has remained stable for the last six or seven years.
The balance of skin cancer deaths between men and women has changed significantly over this twenty-five-year period (Fig.1d). In the five years from 1975-1979, there were 327 deaths from skin cancer in men and 381 deaths from skin cancer in women. An average of 65.4 deaths per year in men and 76.2 deaths per year in women. In the most recent five-year period from 1999-2003, there were 514 deaths in men and 416 deaths in women. An average of 102.8 deaths per year in men and 83.2 deaths per year in women. This represents an almost 60% increase in deaths from skin cancer in men by comparison with an increase of less than 9% in deaths occurring in women. There are now approximately 103 deaths per year in men and 83 deaths per year in women. An excess of twenty deaths per year in men now by comparison with an excess of ten deaths per year in women twenty-five years ago. The higher death rate in men is partly explained by the site of the cancers, the back being the most common site in men and on the legs for women. This less visible site and later presentation by men often means the cancer is more advanced and more difficult to treat.

Looking at the changes over time since 1975 when there were approximately 40 diagnoses of skin cancer every week in Scotland, by 2001 this had risen to 140 diagnoses of skin cancer every week. Similarly, in 1975 there were between two and three deaths from skin cancer every week and this has now risen to almost four deaths per week. In parliamentary constituency terms in 1975 there were roughly thirty diagnoses per constituency per year in Scotland and this number has risen to one hundred Scots diagnosed with skin cancer in every constituency in Scotland every year. In 1975, almost two deaths from skin cancer would be recorded in every constituency every year and this figure has risen to almost three deaths recorded in every constituency in Scotland every year.

A complete geographical analysis of registrations has not been undertaken but on simple pro rata calculations this would imply 1,160 cases of skin cancer per year in Greater Glasgow [population 886,000] 665 in Edinburgh [population 500,000] 140 in Borders [population 108,000] and 52 per year in Orkney and Shetland [population 40,000].

**Malignant Melanoma**

The changes in the epidemiology of malignant melanoma in Scotland are highlighted in Box 2 below and in greater detail in the appendix under Table 2 Trends in incidence of and mortality from Malignant Melanoma and figures 2a Registrations, 2b Deaths, 2c Registrations, broken down by sex and 2d Deaths from malignant melanoma by sex.

**Box 2. Malignant Melanoma**

<table>
<thead>
<tr>
<th></th>
<th>1975</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses</td>
<td>186</td>
<td>694</td>
</tr>
<tr>
<td></td>
<td>1975</td>
<td>2003</td>
</tr>
<tr>
<td>Deaths</td>
<td>67</td>
<td>144</td>
</tr>
</tbody>
</table>
The outline of the epidemic of malignant melanoma in Scotland demonstrated in Box 2 shows diagnoses rising from 186 registrations in 1975 to 694 registrations in 2001. Similarly, deaths have risen from 67 in 1975 to 144 in 2003.

Registrations for malignant melanoma are shown in more detail in Fig.2a rising from 186 registrations in 1975 to a peak of 701 registrations in 1997. The most recent five years have seen a plateau in new registrations of malignant melanoma with between 630-700 cases registered per year, an average of 655 registrations per year. This compares with a range of 180-270 registrations of malignant melanoma for the five-year period 1975-1979 and an average of 230 registrations per year. Malignant melanoma registrations in Scotland have increased almost threefold over this twenty-five year period.

Deaths from malignant melanoma are described in Fig.2b and are shown to rise from 67 deaths in 1975 to 144 in 2003. The average of the three years 1975-1977 was 69 deaths per year and in the three year period 2001-2003 there were 421 deaths as a result of malignant melanoma an average of 140 deaths per year. Deaths from malignant melanoma have doubled between 1975 and 2003. Although registrations for malignant melanoma have increased almost threefold during this period deaths have only risen twofold suggesting either earlier diagnosis or improved treatment and survival or both.

Registrations for malignant melanoma in males and females are depicted in Fig.2c and a very marked preponderance of cases in women is evident across the whole time period. In 1975, there were 127 diagnoses of malignant melanoma in women and 59 diagnoses of malignant melanoma in men. In 2001, there were 390 registrations of malignant melanoma in women and 304 registrations of malignant melanoma in men. In 1975, women accounted for 68% of all registrations of malignant melanoma and this had fallen to 56% in 2001. The ratio of 2:1 female: male registrations has changed significantly to 4:3 female: male registrations.

To gauge the change in male-female distribution more accurately a three-year average is employed. In the period 1975-1977 there were 428 diagnoses of malignant melanoma in women an average of 143 per year. In the period 1999-2001 there were 1135 diagnoses of malignant melanoma in women an average of 378 per year implying an increase of 2.6 times over this twenty-five year period. In men in the period, 1975-1977 there were 204 diagnoses of malignant melanoma an average of 68 per year. In the period 1999-2001 there were 856 diagnoses of malignant melanoma an average of 285 per year confirming an increase of 4.2 times in that twenty-five year period. New diagnoses of malignant melanoma in men have risen at a much faster rate than the increase in diagnoses in women. There also appears to be a significant reduction in female registrations of malignant melanoma in 1998, which has been sustained to a certain extent until 2001. The cause for this is unclear but it is the significant contributor to the plateauing of malignant melanoma registrations between 1997-2001.

Deaths from malignant melanoma in Scotland are described in Fig.2d. Deaths from malignant melanoma in women have increased from 38 in 1975 to 66 in 2003. Similarly, deaths from malignant melanoma in men have increased from 29 in 1975 to
78 in 2003. In the mid 70s to the mid 80s deaths of women outnumbered deaths of men and twenty-five years later deaths from men now outnumber deaths from women.

In the period 1975-1977 there were 128 deaths from malignant melanoma in women an average of 43 per year. This had risen to 191 deaths in the period 2001-2003 an average of 64 deaths per year and an increase of 50% over the twenty-five year time period. In men in the period 1975-1977 there were 78 deaths an average of 26 per year and in 2001-2003 there were 230 deaths an average of 77 deaths per year implying an almost threefold increase in deaths from malignant melanoma in men in Scotland.

Non-Melanoma Skin Cancer

The figures in Box 3 outline the changes in non-melanoma skin cancer over the twenty-five year period. Comprehensive figures for all non-melanoma skin cancer from 1975-2003 are available in the appendix Table 3 and these have been charted in Fig.3a Registrations, Fig.3b Deaths, Fig.3c Registrations in males and females, and Fig.3d Deaths in males and females.

**Box 3. Non-malignant Melanoma**

<table>
<thead>
<tr>
<th></th>
<th>1975</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses</td>
<td>1927</td>
<td>6655</td>
</tr>
<tr>
<td></td>
<td>1975</td>
<td>2003</td>
</tr>
<tr>
<td>Deaths</td>
<td>72</td>
<td>53</td>
</tr>
</tbody>
</table>

Diagnoses have risen from 1927 in 1975 to 6655 in 2001 the most recent figure available. Deaths in that time have changed from 72 in 1975 to 53 in 2003 an apparently significant reduction. However, as will be described later this apparent fall is more likely to be a chance finding and not significant.

A classic epidemic curve is demonstrated in Fig.3a with diagnoses of non-melanoma skin cancer rising from 1927 in 1975 to 6645 in 1997. This classic epidemic has been followed by a plateau over the last five years from 1997-2001. During that time, there has been a relatively narrow range of new registrations of non-melanoma skin cancer ranging from 6450 per year to 6650 per year with that five year period seeing 32,739 diagnoses an average of 6550 registration per year. This compares with the five-year period from 1975-1979 when the number of registrations ranged more widely from 1900-2400 per year, the five-year period seeing a total of 10,855 registrations an average of 2171 per year. This gives an almost exactly threefold increase in registrations of non-melanoma skin cancer in the twenty-five years from 1975-2001.

Deaths from non-melanoma skin cancer are depicted in Fig.3b and appear to show a fall from 72 deaths in 1975 to 53 deaths in 2003. The three-year period from 1975-1977 appears unusual with seventy-two deaths per year and this is likely to be a
chance variation similar to that seen in 1984 when deaths appear to have fallen to half their normal level. By comparison, the three-year period 1978-1980 saw a total of 155 deaths an average of 52 deaths per year. Comparing this with the most recent three yearly period 2001-2003 which has seen a total of 169 deaths an average of approximately 56 deaths per year. Consequently, although there has been substantial variation between years over the twenty-five year period there has been very little change in the number of deaths from non-melanoma skin cancer in total during that period.

Registrations for non-melanoma skin cancers in males and females are described in Fig.3c and the classic epidemic curve is also apparent for both sexes. Registrations in men rose from 1002 in 1975 to a peak of 3418 in 1997. A similar pattern is seen in females with 925 registrations in 1975 rising to a peak of 3227 in 1997. The last five years has seen a plateau in both male and female registrations with male cases ranging over a relatively narrow range of 3330-3420 and with females ranging from 3100-3260 during 1997-2001.

Throughout the whole time period there has always been a modest but persistent excess of registrations amongst men. In the 1975-1979 period there was an average of 1118 registrations in men and 1053 registrations in women, an excess of 60-70 registrations per year in men. In the most recent period 1997-2001 there has been an average of 3376 registrations per year in men and 3171 registrations in females in the same period giving an excess of around 200 additional registrations in males per year. This modest excess of cases amongst men has remained consistent with roughly 51.5% of cases being in men throughout the entire period.

Deaths from non-melanoma skin cancer are described in Fig.3d and a more complex picture is apparent. The highest number of deaths were recorded in the 1975-1977 period and are due primarily to the largest number of male deaths recorded occurring in 1975-1977 accompanied by a high number of deaths in women particularly in 1975 and 1977. In general, the figure shows smaller numbers and greater year-to-year variation making it harder to establish any obvious trends. Notably in most years, male deaths will have exceeded female deaths although there are occasional years when there are more female deaths. In an attempt to ascertain any underlying trend, the most recent five-year figures for deaths are compared with the similar period twenty years ago just after the statistical outliers in 1975-1977. In the five years from 1979-1983 there were 133 deaths from non-melanoma skin cancer in males an average of twenty-seven deaths per year. In the same period there were 108 deaths in females an average of 21.6 deaths per year. In the most recent five year period twenty years later ie 1999-2003 there were 157 deaths from non-melanoma skin cancer in males an average of thirty-one per year and in the same period in females there were 106 deaths an average of just over twenty-one deaths per year. This analysis suggests that over the last twenty years non-melanoma deaths in males have increased slightly while non-melanoma deaths in women are the same as they were twenty years ago. At present there is now a ratio of 3:2 deaths in males compared with females.
Other Issues

Incomplete Registration
Registrations of skin cancer are known to be incomplete and to underestimate the true numbers that are diagnosed every year. This is less true of malignant melanoma where between 93% and 100% had been registered in surveys of completeness of case ascertainment but under-reporting is a noticeable feature of the registrations for non-melanoma skin cancer. If 95% of melanomas and 90% of non-melanomas are recorded then the adjusted figure for skin cancer in Scotland in 2001 would be 730 malignant melanomas and 7395 non-melanomas, a total of 8125 skin cancers. In addition second and subsequent basal cell carcinomas are not recorded and this policy is estimated to capture only two out of three BCCs. The true figure for BCC is therefore likely to be approximately 8150 in 2001. Combining the adjusted figures for malignant melanoma [730], basal cell carcinoma [8150] and squamous cell carcinoma [1950] suggests a more accurate estimate of 10,830 or approximately 11,000 diagnoses of skin cancer in Scotland in 2001.

Cosmetic Tanning
In 1975, there were approximately 2100 cases of skin cancer diagnosed in Scotland and twenty-five years later this had risen to 7300 cases in one single year. This additional excess of over 5000 cases per year will have primarily resulted from cosmetic tanning. Preventable cases of skin cancer are probably even higher with reliable estimates concluding that 90% of non-melanoma skin cancer and two thirds of melanoma may be attributed to excessive sunlight exposure.

The principal contributors to this cosmetic tanning element include the rise in foreign holidays throughout the 1970s, 1980s and 1990s. The number of flights from the UK to Europe [principally Spain] increased over six times in the twenty years from 1975-1995. The 1990s onwards has also seen the addition of budget flights to the Mediterranean destinations. This is coupled with the dramatic rise in the availability of sunbed facilities in Scotland with some estimates suggesting a tenfold increase in the number of premises in the period 1980-2000. A Royal Environmental Health Institute of Scotland [REHIS] survey in 2003 identified 794 sunbed parlours in Scotland of which more than 50 were unmanned and unsupervised. Scotland has more sunbed salons per head of population than any other part of the United Kingdom and the local authorities reported a wide range of registered complaints. Glasgow city has the highest concentration with 181 salons including 27 unstaffed. There will also be a contribution from cosmetic tanning in Scotland principally during the summer months. The exact contribution that each of these elements contributes to the 5000 extra cases of skin cancer resulting from cosmetic tanning per year in Scotland requires further research and investigation.

With almost three quarters of young adults and nearly half of all ages intending to get a sun tan when they go on holiday prevention efforts still have a long way to go.

Skin Cancer in Younger Adults
Skin cancer generally tends to be a diagnosis made in older members of the population partly as a result of the twenty to thirty year lag between exposure and development of visible disease. A separate analysis not included here of changes in the epidemiology of skin cancer in under fifty year olds over the last twenty years
suggests similar changes have been seen in the younger population as have been seen in the population in total. An epidemic of skin cancer has unfolded in the younger members of the population as well.

Discussion
An epidemic of skin cancer has unfolded in Scotland throughout the 1970s, 1980s, and 1990s, rising from 2113 registrations in 1975 to 7346 registrations in 1997. Subsequently the five years from 1997 onwards have seen a plateau in the number of new registrations ranging between 7100 and 7350 cases averaging 7200 per year. The reason for this plateau and the probable future course of the skin cancer epidemic requires further research and investigation. Over the same time period deaths from skin cancer remained reasonably stable during the late 1970s and early 1980s ranging between 110 and 150 deaths per year. Since the mid-1980s deaths from skin cancer have risen slowly from an average of 141 deaths per year in the late 1970s to an average of 197 deaths per year in 2001-2003 representing a 40% increase in deaths over this period. Almost all of this increase in deaths has occurred in males. Deaths amongst females have increased only slightly during this period. Similarly, a small excess of cases amongst females has over the twenty-five year period become a small excess of cases amongst men averaging 100 more cases of skin cancer per year in men than women.

Registrations of malignant melanoma have also shown a classic epidemic curve between 1975 and 1997 rising from 186 registration in 1975 to 701 registrations (the highest number to date) in 1997 followed by a similar five year plateau. The last five years has seen an average of 665 registrations per year compared with 230 registrations in the late 1970s an increase of almost threefold during the twenty-five year period. During that period, deaths have doubled from an average of 69 per year in the mid-1970s to 140 per year from 2001-2003. This implies that earlier diagnosis and more effective treatment have prevented the number of deaths rising inline with the number of registrations. Registrations of malignant melanoma in women have exceeded those in men throughout this period and have grown just over two-and-a-half times. By comparison, registrations in men have increased over fourfold and this has altered the previous ratio, which saw 68% of registrations in women in 1975 now reduced to 56% of registrations in 2001. The most striking change over this period has been the reversal of the burden of deaths, which initially saw more deaths in women than men but now sees more deaths in men than women. Deaths in women have risen significantly by almost 50% over this twenty-five year period however deaths in men have increased almost threefold during the twenty-five year period.

For non-malignant melanoma, a similar epidemic is seen from the mid-1970s to 1997 when cases peaked. In the five years from 1997 onwards an average of 6550 cases are registered each year within a relatively narrow range plus or minus 50-100 per year. There has been an almost exactly threefold increase in non-melanoma skin cancer during this period. During this same period deaths from non-melanoma skin cancer have remained essentially stable in women but have risen slightly in men and now account for a ratio of 3:2 deaths in males to females or alternatively there are 50% more deaths in men than women each year from non-melanoma skin cancer.
Conclusions

An epidemic of skin cancer developed in Scotland from at least the mid-1970s until 1997 when cases of skin cancer trebled in Scotland and deaths from skin cancer increased by approximately 40% to a total of 7349 registrations in 2001 and 197 deaths in 2003. This epidemic appears to have plateaued over the last four or five years but further research and investigation is required to understand the cause of this plateau and whether this is a temporary situation likely to increase or decrease in the future. Even if the epidemic has plateaued it still exerts a tremendous burden of mortality and morbidity on the Scottish population with 140 diagnoses of skin cancer and almost four deaths occurring every week. Over 85% of these skin cancers are considered preventable suggesting almost 6500 cases could be prevented each year. Similarly given the nature of the factors contributing to the epidemic it is likely that at least 5000 or more cases per year occur as a result of cosmetic tanning. The priorities now must be earlier diagnosis in an effort to reduce the increasing number of deaths from skin cancer and a substantial and sustained prevention campaign to reverse the epidemic that has already occurred in Scotland.

Dr James Inglis
Consultant in Public Health Medicine
NHS Health Scotland
17 May 2005

Acknowledgements

All of the data used in this review has been provided by ISD Scotland, part of NHS National Services Scotland and is available on their website www.isdscotland.org. My thanks to Dr David Brewster, CPHM and Head of Cancer Programme at ISD Scotland for very helpful comments on the manuscript and in particular help with the estimates of actual numbers of skin cancers diagnosed in Scotland. My thanks also to Patricia Gray at NHS Health Scotland for invaluable help preparing the manuscript, tables and figures.
Dear Michael

Thank you for inviting me to provide to comment on petition PE931, submitted by Helen Irons, Skin Cancer Campaign Scotland. This called on the Parliament to urge the Executive to review its policy on tackling the rising incidence of skin cancer in Scotland, and to provide an outline of the Executive’s position in relation to European policy relevant to this issue. I will also comment on issues that were raised during discussions by the Public Petitions Committee (PPC) on 8 February 2006.

Incidence and Mortality Rates for Skin Cancer in Scotland

There was discussion about incidence and mortality from skin cancer and it is important to distinguish between the two main types of skin cancer. Malignant melanoma of the skin, particularly if diagnosed late, may spread to other organs and prove fatal. It was the 8th most common cancer in Scotland with 832 cases in 2002 accounting for just over 3% of all cancers. Non-melanoma skin cancers are rarely life threatening, are often detected early and can be treated on an outpatient basis.

It is recognised that all types of skin cancer have been increasing in the last two decades. It is also the case, however, that 5-year survival rates for melanoma have increased by 28% for males (from 53% in 1977–1981 to 81% in the period 1997–2002). Over the same period, the survival rates for women increased by 18%, from 72% to 90%. This trend may reflect an increase in diagnosis of early stage disease following the adoption of health education programmes aimed at encouraging earlier presentation and referral.

Public Awareness

The Scottish Executive Health Department is very aware of the health risks from exposure to ultraviolet radiation and are active in raising awareness and education to highlight the risk of getting skin cancer and to promote how to minimise that risk. Along with the other UK Health Departments, the Scottish Executive funds the SunSmart campaign, which is co-ordinated by Cancer Research UK and has been running since 2003.
SunSmart is entering its fourth year of campaigning that this year will focus on:

- Providing information for the public and professionals through their website
- Giving briefings to journalists to raise awareness of key skin cancer issues in the media
- Supplying printed resources for professionals to use in local health promotion activities
- Campaigning to raise awareness of the dangers of skin cancer amongst men and outdoor workers
- Helping schools to develop their own sun protection policies using SunSmart school guidelines

Evaluation studies confirm that last year’s campaign reached 74% of all UK adults as well as a lot of media interest and over 943 published articles. By working with other Health Departments across the UK we have secured a greater impact than might otherwise have been the case with available resources.

SunSmart is the latest part of an ongoing campaign of awareness raising, that has in the past included television advertising by NHS Health Scotland. NHS Health Scotland also produces the “Sun Safe Protection Tips” publication, which is widely distributed throughout Scotland (see below). Last year NHS Health Scotland also sponsored the “Fresh” supplement in the Sunday Herald, aimed at secondary school children which focused on skin cancer connected with sunbathing and sunbeds.

Over the last six years NHS Health Scotland has also promoted the sun safe message with accompanying expenditure of over £150,000, although their priorities have shifted in the last two years to accommodate the SunSmart campaign and they have not been carrying out advertising on skin cancer. However, NHS Health Scotland continues to print and distribute its Sun Safe Protection Tips booklet to Health Boards, GP practices, Passport Offices, Thomas Cook and Post Offices.

NHS Board Health Promotion Departments are also active in the promotion of healthy lifestyles including the provision of information and advice on sun safety and safe use of tanning beds. Many also participate in Sun Awareness Week, a national campaign organised by the British Association of Dermatologists which this year has been scheduled for the week commencing 15 May.

**Sunscreen**

SunSmart advises that it is the Sun Protection Factor (SPF) that is important when choosing a sunscreen. They say that higher factor creams can be more expensive yet do not give much more protection than factor 15 and recommend that an SPF of at least factor 15 can give the best balance between protection and cost. SunSmart also advises that sunscreen should not be used in order to spend longer in the sun. Although sunscreen is an important part of protecting against skin cancer, it is only one aspect. Staying out of the sun when it is at its hottest, making sure not to burn and keeping skin covered are also important. There is more information about being SunSmart available on the Cancer Research UK website at [www.cancerresearchuk.org/sunsmart/](http://www.cancerresearchuk.org/sunsmart/).

**Sunbed legislation**

Regarding sunbed legislation, there is no model which currently exists that absolutely bans sunbeds, however, a European Union ‘low voltage’ Directive (73/23/EEC) regulates sunlamp emission and contains mandatory standards covering sunbed products.
The European Commission's Scientific Committee on Consumer Products has recently published its 'Opinion on biological effects of ultraviolet radiation relevant to health with particular reference to sun beds for cosmetic purposes' which can be viewed at the following address:


The Commission, in consultation with the Committee, invited interested stakeholders to submit comments on this document by 17 March 2006.

The 'opinion' document will be finalised after consideration of the replies to this public consultation and the Commission will then consider the appropriate risk management measures. Such measures might include: additional design requirements; information to the public on the precautions to be taken in relation to the use of sun beds; warnings to the users of sun beds on the risks of exposure to UV radiation in case of risk factors; development or improvement of the criteria and guidance to be applied by operators of tanning centres; and appropriate operating and safety instructions to be provided by manufacturers of sun beds.

In Scotland, regulation of sun tanning parlours and the control of exposure is subject to health and safety legislation. Awareness-raising campaigns aimed at highlighting the risk of unnecessary exposure are undertaken by local health services and NHS Health Scotland, and the public are urged to consider this advice.

In 1998, the Health Education Board for Scotland (now NHS Health Scotland) adopted the evidence-based position that there is 'no safe level of use' for artificial tanning devices. In 1999, they worked with COSLA to issue guidance to all councils to remove devices from council owned premises.

Ken Macintosh MSP had prepared a draft consultation document to add a Statutory Instrument to the Civic Government Act which would add cosmetic tanning industries to trades which are registered to councils. This work, under the proposed Sunbeds Licensing (Scotland) Bill, fell in November 2004. I understand that there is an intention to re-introduce the Bill, however, no specific date for that has been decided.

The World Health Organisation (WHO) also highlighted in March last year that sunbed use posed a risk of skin cancer. WHO did not recommend a total ban but advised that sunbeds should not be used by persons under the age of 18, and should be supervised by trained personnel.

I hope this information is helpful.

ANDY KERR
Response by
NHS Health Scotland

to

Public Petition PE931
"The Petitioner asks the Scottish Parliament to urge the Scottish Executive to review its policy on tackling the growing skin cancer epidemic in Scotland."

NHS Health Scotland welcomes the opportunity to address this important topic.

The problem
1. There are two main types of skin cancer. The more dangerous is malignant or invasive melanoma which accounts for about 10% of all cases of skin cancer in Scotland but about 60% to 70% of all consequent deaths. Non-melanoma skin cancer covers basal cell carcinoma and squamous cell carcinoma which together account for about 90% of all skin cancer diagnoses. Both types of non-melanoma skin cancer grow slowly, tend not to spread to other parts of the body and are rarely fatal if treated. Most skin cancers of both types are thought to be caused by exposure to ultraviolet light, in most cases from the sun but potentially also from artificial sources such as sun beds and UV lamps.

Dr Inglis' paper
2. The paper by Dr Jamie Inglis, "Skin Cancer in Scotland 1975 to 2003" sets out very clearly what has been happening over the past 30 years. Between 1975 and 1997, the annual number of cases of skin cancer diagnosed in Scotland more than tripled and deaths increased by 40%. In 2003, there were almost 200 deaths from skin cancer in Scotland. This represents about 0.4% of all deaths in Scotland. Over the past 30 years, there have been substantially more cases of malignant melanoma among women than men, although the ratio has somewhat reduced. However, the proportion of deaths due to malignant melanoma has reversed so that in most years since 1988, deaths among males have outnumbered those in females.

Update on Dr Inglis' Paper
3. Since Dr Inglis wrote his paper, a further year of data has become available. In 2002 there were 832 registrations for melanoma and 7,074 registrations for non-melanoma skin cancer, both higher than any previous year. In 2004 there were 151 deaths due to melanoma (the highest ever total) and 50 deaths due to non-melanoma skin cancer (slightly lower than the previous three years).

4. Deaths from non-melanoma skin cancer are almost all in people aged over 50. In 2004 there were 50 deaths from non-melanoma skin cancer, none of which were among people aged under 50. However, deaths from melanoma are more common among younger people. Among the 151 deaths in 2004, 24 were among people aged under 50.

Why the increase?
5. It has been estimated that 90% of non-melanoma skin cancer and 2/3 of melanomas may be attributed to excessive sunlight exposure. Melanoma is more likely to develop several years after severe sunburn, particularly in people with a large number of moles. Non-melanoma skin cancer can occur as a result of accumulated exposure
over many years. There is no evidence that general and occupational exposure to UV light has increased in Scotland over the past 30 years. It is thus likely that most, if not all, of the increase in skin cancer over this period is due to exposure to sunlight during foreign holidays or to artificial UV light from sunbeds or other UV lamps. During the period 1975 to 1995, the number of flights from the UK to Europe, mainly Spain, increased more than six fold (Mayor et al 2004). Since then, the expansion of low cost flights has further increased the numbers heading south. During the same period there has been a large increase in the number of sunbed facilities in Scotland. A survey in 2003 found almost 800 sunbed parlours in Scotland including 50 which were unmanned and unsupervised (REHIS 2003).

Risk due to sunbeds
6. It has proved difficult to assess the exact risk of skin cancer from using sunbeds and sunlamps: relatively little research having addressed this question. Several research reviews or multi-centre studies have concluded that sunlamp or sunbed exposure does increase the risk of melanoma (Autier et al 1994; Chen et al 1998; Gallacher et al 2005). However, not all the studies showed an increased risk (Bataille et al 2005). One study found the risk of melanoma was greater among people aged under 30 (Westerdahl 1994), another that it increased with ten or more sunburns and the use of a sunbed by young subjects with fair skin (Bataille et al 2004). The methodological weaknesses of some of the studies have been pointed out, casting some doubt on the validity of their findings (Swerdlow and Weinstock 1998). Based on the available evidence, it appears reasonable to conclude that heavy use of sunbeds does increase the risk of melanoma and that younger people are at relatively higher risk.

Effectiveness of prevention
7. The risk of skin cancer due to exposure to ultraviolet light has been known for many years. Public awareness has been raised through considerable discussion in the media. There is now much more public knowledge about sunblock creams and they are widely available. Is there any evidence that specific public information campaigns have made a difference? Among the systematic effectiveness reviews in the Cochrane Library, there was only one focusing on the prevention of skin cancer (Harvey et al 1995). This found that there was reasonably strong evidence that knowledge about skin cancer and its prevention can be increased by health promotion campaigns. However, there was little evidence that actual exposure to the sun or artificial UV light has been reduced by such campaigns. Ideally, more research should be done to assess the effectiveness of such campaigns. However, such research is difficult and expensive to conduct.

Preventive work by NHS Health Scotland and other organisations in Scotland
8. In recent years, skin cancer has not been identified as a major health improvement priority in Scotland. The focus has been on health problems causing death and ill health among large numbers of the population. For example, there are about 13,000 tobacco related deaths each year compared with around 200 due to skin cancer. Thus the current priorities include smoking, alcohol, diet and nutrition and physical activity. Health Scotland's predecessor organisation, the Health Education Board of Scotland produced and distributed leaflets about sun safe protection tips and included skin cancer in a booklet about practical ways to reduce the risk of cancer. For a period in the 1990's, short TV ads about protecting against sunburn were shown during periods of sunny summer weather, but they ceased some years ago. Health Scotland currently stocks sun safety leaflets, fliers and posters. Over 25,000 leaflets and fliers were distributed last year but very few posters.
Future Priorities

9. In the light of the clear evidence for increasing rates of skin cancer in Scotland and their link to exposure to UV light, Health Scotland recognises the importance of taking action in an attempt to reduce the risk and prevent future cases.

10. We support the efforts to regulate sunbed parlours. Measures could include prohibiting their use by under 18’s (on the grounds that young skin is particularly susceptible to UV damage); making it unlawful to operate unsupervised sunbed parlours where UV exposure cannot be easily controlled; and requiring sunbed operators to provide all customers with clear information about the potential risks of sunbed use.

11. Health Scotland also recognises there is an argument in favour of ongoing public information campaigns, both to discourage excessive exposure to natural or artificial u-v light and to inform people, particularly men about the importance of regular self-examination of the skin and how to recognise a melanoma. However, such campaigns are much more effective in raising awareness than changing behaviour. Nevertheless, we would be happy to discuss developing such a campaign with the Scottish Executive as a possible part of our work programme for 2007/2008, alongside other major and potentially competing priorities. Before proceeding, further groundwork would be needed: a more detailed assessment of the available evidence for effectiveness, a prior assessment of current public awareness and discussion with other stakeholders such as the travel industry and community pharmacies. It would also be helpful if we could piggy-back onto a larger UK-wide campaign, as the same issues are relevant to the whole of the UK. This would require discussion with the Department of Health.

Dr Laurence Gruer
Director of Public Health Science
For and on behalf of NHS Health Scotland
June 7, 2006

References


FROM THE OFFICE OF
THE CHIEF EXECUTIVE
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Dr James Johnston
Clerk to the Public Petitions Committee
TG.01
Parliamentary Headquarters
Edinburgh EH99 1SP

29 March 2006

Dear Dr James Johnston,

Thank you for your letter of 22 February, inviting Cancer Research UK to submit comments to the Public Petitions Committee on the issues raised in petition PE931 introduced by Helen Irons, of the Skin Care Campaign Scotland.

The petition calls for the Scottish Parliament to urge the Scottish Executive to review its policy on tackling the growing skin cancer epidemic in Scotland.

We welcome the opportunity to submit comments to the Committee on this petition.

Background

Cancer Research UK\(^1\) is the world’s largest independent organisation dedicated to cancer research, with an annual research spend of over £217 million.

Half of all cancers could be prevented by changes to lifestyle. We encourage individuals to protect themselves from the sun and harmful UV radiation, in order to minimise their risk of developing skin cancer.

**Scotland is experiencing a skin cancer epidemic.** Incidence of skin cancer has tripled in the last thirty years. There were over 7,000 cases of skin cancer diagnosed in 2001, up from around 2,200 in 1975. Higher rates of melanoma incidence have been reported in Scotland than in the rest of the UK.

In the age group 20-39 years, malignant melanoma is the second most common cancer in the UK. This is an unusually young age distribution for an adult cancer and emphasises the importance of its prevention and early treatment to avert the potential loss of many years of life. On average, about 20 years of life are lost for each melanoma death in the UK.\(^2\)

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\(^1\) Registered charity no. 1089464

Cancer Research UK position

Cancer Research UK strongly supports the sentiments expressed in the petition and in the supporting information provided by Dr Jamie Inglis.

Policies aimed at tackling growing skin cancer rates in Scotland have not been effective to date, and we believe that a Scottish Executive review of its approach to tackling skin cancer is urgently needed.

We support the priorities for action outlined in the supporting information; the need for earlier diagnosis in an effort to reduce the increasing number of deaths from skin cancer and the need for a substantial and sustained prevention campaign to reverse current skin cancer trends.

Prevention Campaigns

Cancer Research UK runs the national skin cancer prevention campaign, SunSmart. The campaign provides resources to support regional and local work in early detection and primary prevention, aiming to raise awareness of skin cancer and encourage people to protect their own and their children's skin in the sun.

We know that sustained public health promotion has helped to cut deaths from and initiate a reduction in incidence of malignant melanoma in the younger generations in Australia. This has been achieved by raising awareness, influencing attitudes, facilitating behaviour change and encouraging people with early curable disease to seek treatment.

We believe that long-term skin cancer prevention campaigns are necessary to increase public knowledge, alter attitudes and affect the behavioural changes needed to reverse the trends in skin cancer incidence across Scotland.

The SunSmart campaign is currently being funded by all UK Health Departments through the Section 64 grant scheme. This 3 year funding arrangement will be completed in March 2007. Given that skin cancer has one of the fastest growing incidences of all cancers, we believe that a more comprehensive approach needs to be taken for future funding of the SunSmart campaign from core Government funds.

We hope that the Scottish Executive, along with the other UK Health Departments, will support efforts in this area.

Skin cancer in men

The petition's supporting evidence highlights that rates of both malignant and non-malignant melanoma have increased more in men than women over the 25 year period analysed, and that more men than women now die of the disease. We agree that the higher death rates in men can partly be explained by the less visible site of the cancers, and that later presentation by men often means the cancer is more advanced and difficult to treat.

The focus of this year’s SunSmart campaign is men and outdoor workers. We know that outdoor workers are exposed to 3-4 times more UV radiation than indoor workers. It is crucial that men and outdoor workers receive targeted messages about how to reduce their risk of skin cancer, and the importance of early presentation.

Sunbeds

Perceptions of cosmetic tanning as desirable, and the increasing use of sunbeds for cosmetic purposes go a significant way to accounting for the stark rise in skin cancer incidence in Scotland since the 1970s. Cancer Research UK is very concerned by the current high level of use of tanning devices, and especially the reported increasing use by children.

We strongly advise children (under 16 years of age) never to use sunbeds. We also recommend that those with fair or freckly skins, a lot of moles, who have had skin cancer in the past, with a family history of melanoma and/or those using medication that increases sensitivity to UV, do not use sunbeds for cosmetic purposes.

Cancer Research UK would support Scottish Executive action to regulate the operation of sunbed salons.

We believe that the use of artificial tanning devices should be restricted to over-16s and unmanned coin-operated sunbeds should be phased out. In addition, we would support the mandatory introduction of notices in salons describing those most at risk from skin cancer and advising them against sunbed use. We would also like to see all sunbeds manufactured and sold in the EU bearing a permanent statement warning of the risks associated with use. Adults are free to make their own decisions about using sunbeds, but they should do so knowing the risks involved.

Cancer Research UK has been working with Ken Macintosh MSP, on a proposal to introduce a sunbed salon licensing scheme in Scotland. The proposal, in the early stages of development, would require local authorities to license sunbed salons. Premises not holding a licence would not be permitted to trade. We are supportive of the proposal in principle and would encourage the Executive to engage with Ken Macintosh’s work in this area.

To discuss this submission further, or for additional information or clarification on any point raised in this response, please contact the Cancer Research UK Public Affairs Department at publicaffairs@cancer.org.uk or on 020 7061 8360.

Yours sincerely,

Alex Markham
Chief Executive, Cancer Research UK
PETITION PE931

SUBMISSION BY THE SUNBED ASSOCIATION

The Sunbed Association, established in 1995, is the trade association for the UK sunbed industry representing manufacturers and distributors of lamps and sunbeds and sunbed operators (tanning salons, health clubs, leisure centres etc. – any establishment which provides sunbed facilities). One of the main aims of the Association is to promote good practice throughout the industry and members are committed to working to the requirements of The Sunbed Code of Practice and must demonstrate compliance with the Code through inspections of their premises. In addition, the Association also offers dedicated training programmes, a sunbed insurance policy, health and safety merchandise etc.

Skin Cancer in Scotland 1975 - 2003
Report by Dr. James Inglis, Consultant in Public Health Medicine, NHS Health Scotland

The report describes the substantial increase in the incidence of skin cancer and mortality in Scotland during the period 1975 to 2003. Since 1975, cases of skin cancer have increased over three times and deaths from skin cancer have increased by 40%. Although this development has to be viewed as very serious, it must be stated that it isn't a specific problem to Scotland. Throughout Europe and worldwide, a similar rise in the incidence of skin cancer has been seen especially in industrialized countries and, to this day, the causes are not clearly obvious.

The author compares the total numbers of skin cancer cases in the named time period and only differentiates with regard to non-melanoma skin cancer and malignant melanoma as well as the sex of the persons affected. This is a simple way of evaluation but less suitable to establish clear trends. To take into account the increased life expectancy of the population during the examined time (around one generation), among other things for example, age adjusted data should be used at least to be able to recognize clear trends. Nevertheless, the figures show a clear increase of skin cancer cases and their cause and an examination is surely worthwhile to be able to consider possible measures to counteract this development. In this connection, the reported conclusions seem too simple or remain completely open. For example, the report provides no references to why the increase appears considerably higher in males than in females.

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The author simplifies the cause of skin cancer, stating that 90% of all non-melanoma skin cancer and two thirds of melanoma may be attributed to excessive sun exposure. Solar exposure is recognized as the main environmental factor in the development of non-melanoma skin cancer (basal cell carcinoma, BCC, and squamous cell carcinoma, SCC) which form the majority of skin cancers (approx. 90%). These lesions result in a high level of morbidity with only occasional mortality from infrequent metastatic SCC. There is evidence that BCC is associated with intermittent exposure, whereas SCC is associated with chronic UV exposure and is more common in people undertaking outdoor occupations. Skin type is an important factor in the risk of BCC and SCC with skin types I and II, which appear frequently in the Scottish population, at greater risk than skin types III and IV.

Although there is strong evidence that sun exposure, especially sunburn in childhood, is causal for melanoma, the definitive role of UV radiation concerning melanoma development remains unproven. Obviously the presence of multiple risk factors in an individual increases the relative risk of melanoma. In this context, fair skin, multiple naevi as well as a family history, has to be mentioned. With regard to solar radiation, it seems to be that there may be more than one route to melanoma: one associated with low or intermittent sun exposure and for which numerous naevi is a risk factor, and another with chronic over-exposure.

The complexity of possible reasons for skin cancer and the influence of different exposure patterns to the skin cancer risk make the conclusion, that cosmetic tanning alone is responsible, extremely doubtful. Of course the change in behaviour of the population regarding more frequent holidays to sunny countries plays a considerable role because this provides the opportunity for increased sunbathing. Such exposures contain a certain risk because the skin is often not exposed to the sun during other times of the year due to the circumstances of normal life (eg indoor occupations).

Tanning salons are viewed as contributing to the increase of skin cancer in Scotland. Even if the number of the tanning facilities in Scotland is higher than elsewhere, this doesn't represent any proof since user behaviour and the popularity of sunbed use must be considered. Also, it is important to consider the fact that in European countries with a lower number, or even no tanning salons, the increase of skin cancer shows a similar course. The correlation between sunbed use and skin cancer must be assessed as considerably more lower compared with sun exposure. Moreover, it has to be taken into account that skin tanning achieved with sunbeds is a natural protection against UV over-exposure to the sun. Therefore, sensible sunbed exposure reduces the risk of over-exposure to UV during foreign holidays and counteracts intermittent sun exposure. Contrary to the opinion of the author, these consequences of sunbed use can be interpreted as offering a decreased risk of skin cancer.

Cont/.........
From 1997 onwards, a plateau has been seen in the number of new registrations of skin cancer. Although the author points out that the reason for this plateau requires further research and investigation, it is disappointing that he offers no explanation particularly since it appears of high importance. Unlike the assumptions as to the cause of the increase of skin cancer incidence, he does not offer any possible reason. To argue that reduced cosmetic tanning will decrease the incidence of skin cancer is not in line with the current holiday behaviour of the Scottish population or with the high number of tanning facilities. Once more, this shows a too simple philosophy by the author.

In the report, the increase of skin cancer in Scotland is described as an epidemic. From the medical point of view an epidemic is an increased occurrence of certain infectious diseases in local and temporal demarcation. Skin cancer is neither an infectious disease nor does the incidence develop locally over a restricted time period. The term epidemic is non-scientific and incorrect but is used to draw greater attention to the issue.

The author makes reference to unmanned tanning salons (around 50 in Scotland). The Association views these outlets as potentially dangerous. They are not permitted membership of the Association since they are unable to meet the requirements of The Sunbed Code (one requirement being that sunbeds must be used under supervision of appropriately trained staff and another requirement being that the frequency and maximum number of annual exposures must be recorded, monitored and controlled).

THE SUNBED ASSOCIATION
4 APRIL 2006
Petition PE 931: Skin cancer Petition

Dear Dr Johnston

Thank you for asking the Scottish Dermatological Society (SDS) to contribute to this debate.

Members of the SDS are mainly doctors - consultant dermatologists, dermatologists in training, and those in primary care who have a major interest in dermatology. In addition, there are a smaller number of dermatology nurses with an academic interest in the speciality and allied scientific staff. The active membership is mainly from Scotland, but about a quarter of the membership works in the NHS in England and Wales.

The main activity of the SDS is ensuring excellence in dermatology in Scotland. Three clinical and research meetings are held each year rotating between departments. The society has a leading role in audit and clinical governance issues relating to skin health and disease. In relation to skin cancer, a subcommittee, the SDS Skin Cancer Group meets regularly. This concerns itself with setting and monitoring standards in skin cancer care.

The SDS agrees that too little attention has been given to skin cancer and strongly supports the petitioners. In particular, public education and primary prevention of skin cancer have been neglected and we strongly support increased attention to this. There has been some success in achieving earlier detection but the practical implications of providing rapid and high quality services for patients with skin cancers are challenging in view of the increasing incidence and volumes involved. Potential skin cancer referrals have also adversely affected services for other forms of skin disease. A sensible approach to skin cancer necessitates recognition that the epidemic will continue for many years whatever preventive measures are introduced. The organisation and resourcing of services, and in particular appropriate training of practitioners to whom skin cancer may present, is of critical importance.
Prevention

Sunscreens
There was much discussion of sunscreens at the meeting. The SDS agrees with petitioners that encouraging sensible behaviour is more important than sunscreen use. Sunscreens are good at preventing sunburn but may produce a false sense of security. Studies have shown that we usually only put on about 1/3rd of the amount we need. There is limited evidence to suggest that they offer any protection against squamous cancer, and virtually none to suggest they prevent basal cell carcinoma or melanoma. As Polly Buchanan emphasised it is much more important to focus on use of clothing, hats, shade and avoiding the middle of the day. This can only be achieved by better public awareness and education.

Sunbeds
The evidence given to the committee highlights the grave concerns we have about sunbed use. The lamps now used now are much more powerful than those used 10-15 years ago. They contain more UVB, the most powerful and carcinogenic of the ultraviolet rays. The literature supports the contention that sunbeds double the risk of non-melanoma skin cancer, most notably squamous cancers.

The World Health Organisation has stated that sunbeds should not be used by those less that 18 years of age, but it is obvious that young people are using them. One recent study from the USA indicated that 1 in 4 teenagers were users and in a study closer to home a survey done by school nurses in Primary schools in Wishaw- in the First Ministers’ constituency - indicated that 1 in 10 schoolchildren were using sunbeds.

As well as better public education about the dangers of sunbeds, the Scottish Dermatological Society would strongly support legislation to protect children, who may be at particular risk from the carcinogenic effects of UVR.

Vitamin D
One of the most important functions of the skin is formation of Vitamin D following sunlight exposure. This vitamin is important for bone health and severe deficiency can cause rickets or weakened bones. More recent literature suggests a protective effect of Vitamin D against a range of internal cancers. This issue has been seized upon by the sunbed industry but there is little evidence of a generic benefit of sunbed use. The SDS supports Prof Ferguson’s comments: if it is felt that currently accepted Vitamin D levels are too low, approaches such as Vitamin D supplementation are simpler to deliver to the population than ultraviolet radiation, and do not carry the risks of sunbed use or excessive sun exposure.

Primary prevention campaigns
In view of the vitamin D debate we have to be careful that primary prevention campaigns are appropriate to the Scottish situation at the right level – Australian type campaigns may be inappropriate for a Scottish climate.

Scotland has many individuals with fair, sun-sensitive skin, who constitute the majority of those presenting with skin cancer in later life. They need to be aware of their special vulnerability. Public health messages delivered as part of primary education, and perhaps targeted at those children with the fairest skin, may offer the best opportunity to alter behaviour in later life.
Published studies indicating adequate Vitamin D formation following sun exposure and sunscreen use were all from sunnier climates such as Australia and California. We need studies assessing the impact of Sunsmart advice in Scotland, including on Vitamin D status at all ages and across all skin types.

Early detection of skin cancers

The petition called on the Parliament to tackle the growing skin cancer epidemic. The discussion centred on prevention. Reduction the numbers of skin cancer cases by primary prevention will be a considerable achievement, but any benefit will not be seen for many years because of the long latent period between exposure and the appearance of the cancer. In the meantime it is vital that the existing caseload is dealt with effectively, particularly to ensure early detection.

Managing the skin cancer epidemic

Currently, up to 50% of the 85,000 referrals to hospital Dermatology Departments in Scotland each year are lesions that may be skin cancers. The attempt to meet cancer targets for this volume of referrals has had a negative impact on our ability to deal rapidly with other equally deserving but more chronic conditions. However many of the lesions referred as possible skin cancer should be within the competence of every primary care practitioner to diagnose and treat or offer confident reassurance. Conversely, too often real skin cancers, including melanomas, are not referred soon enough or with sufficient clarity to ensure appropriate urgency. Skin disorders are the commonest single presentation to GPs, but their effective management in primary care has hitherto not formed part of the Quality Outcomes Framework. The consequence is skin problems are do not receive enough attention or are passed on to secondary care unnecessarily.

Recent NICE guidelines propose an integrated approach to management of skin cancer between primary and secondary care. These proposals, yet to be adopted in Scotland, are nonetheless consistent with the principles in the Kerr report of a more distributed competence, but investment in training and resources will be needed to provide services to the proposed standard in hospitals and the community.

The SDS asks the Parliament to ensure that in the implementation of Delivering for Health, better management of skin cancer and other skin disease is given the priority and resources it deserves.

Education of practitioners

It remains the case that the majority of primary care practitioners have not had enough education in dermatology to be able reliably to recognise, let alone deal surgically with, the common skin cancers. Few GPs have education in dermatology beyond the average and often notional 5 days of undergraduate training. By comparison with the accreditation measures put in place to ensure quality in screening for cervical carcinoma (thanks to which mortality is falling to less than that of skin cancer), the lack of means by which the public can be sure that a practitioner is able to give a valid opinion is worrying. We are only just beginning to train practitioners with special interest in dermatology for whom continuing education and accreditation will offer some reassurance of competence.

Better public and practitioner education is needed to ensure the earliest possible detection. Many factors – not least the short term pressures provided by the need to
meet targets, including for cancer – conspire to mean that dermatologists in hospitals are not spending enough time educating patients and colleagues.

The SDS asks the Parliament to ensure that the key role of dermatologists in providing education and training in the early recognition of skin cancer is prioritised.

If you wish clarification any of these points please do not hesitate to contact me.

Kind regards

Yours sincerely

Dr David Bilsland
Consideration of Petition PE931

'The petitioner asks the Scottish Parliament to urge the Scottish Executive to review its policy on tackling the growing skin cancer epidemic in Scotland'.

COSLA wishes to support the above petitioner’s request that the Scottish Parliament urge the Scottish Executive to review its policy on tackling the growing skin cancer epidemic in Scotland. We believe it is vitally important that the public’s health is protected from the adverse affects of over exposure to UV rays to reduce skin cancer in the country.

We suggest that the Parliament also takes note of the proposed Bill by Kenneth Mackintosh MSP to regulate Sunbed Parlours. This proposed Bill could significantly cut the risk to people from over exposure to UV rays by removing e.g. unmanned premises throughout Scotland, where there is currently no control over use by users. It could also regulate the use of sunbed parlours in numerous other ways.

Local authorities would be best placed to regulate cosmetic sunbed premises, given the existing role of councils in public health protection discharged through the Environmental Health Service. Environmental Health Officers in councils are also best placed to regulate either directly or through their licensing sections, depending on the local authority. That said, this regulation would require additional resources to Environmental Health Services to implement and maintain this new form of regulation.

Other methods that could be used to make people more aware of the detrimental effects of tanning and the resultant risks of skin cancer are as follows:-

- Education in schools and publicity to outdoor workers and the general public;
- National skin cancer awareness campaigns.
- The provision of leaflets advising on the need to guard against sun exposure in certain outdoor work activities;
- The promotion of alternative means of achieving a tanned look to deter people from over exposing themselves to UVA rays;
- The employment of methods to warn people e.g. media campaigns, persuading the fashion industry to assist with this aim.

The savings to the Scottish economy and public services particularly the NHS in reducing the need for treatment through prevention of skin cancer would be significant. Therefore, COSLA would provide full support to this petition.