

Table I. Willingness to pay to decrease scar size from 8 inches to a smaller length and to decrease appearance of scar from obvious to barely visible

Scenario	Level name, inches	WTP to decrease scar size, \$		WTP to make scar barely visible, \$	
			90% CI, \$		90% CI, \$
Cheek cancer with 1% risk of metastasis	1	1023	850-1231	932	769-1149
	2	680	560-830		
	5	254	193-328		
Cheek cancer with 20% risk of metastasis	1	1121	935-1357	1103	935-1328
	2	914	747-1125		
	5	588	487-717		
Back cancer with 1% risk of metastasis	1	386	332-450	332	288-387
	2	322	273-378		
	5	2	-30 to 33		
Back cancer with 20% risk of metastasis	1	633	501-834	279	214-363
	2	466	355-627		
	5	186	119-272		

CI, Confidence interval; WTP, willingness to pay.

The study was completed by 912 patients. In all scenarios, patients desired smaller scars (Fig 1) and scars that were barely visible (Fig 2). The WTP for a smaller or less noticeable scar was higher when on the face than on the back, regardless of metastasis risk (Figs 1 and 2). Table I summarizes the actual WTP and confidence intervals to change scar length or appearance across all 4 scenarios.

Consistent with prior literature, this study demonstrates that patients assign high value to appearance after skin cancer treatment⁵ and provides additional insight into how the relative values assigned to cosmetic outcome vary by tumor location and risk. Minimizing scar length and appearance are very important to patients, especially when the scar is on the face. Because scar size and appearance are related to the initial defect size, using tissue-sparing techniques, such as Mohs micrographic surgery, to treat skin cancer is one way to achieve patient goals.

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Intralesional sodium stibogluconate under inhaled anesthesia for the treatment of cutaneous leishmaniasis in children: A retrospective cohort



To the Editor: Cutaneous leishmaniasis (CL) due to infection with *Leishmania major* and *Leishmania tropica* is endemic in Israel.¹ Children represent a substantial portion of the infection burden.^{2,3}

Limited data are available regarding therapies for CL in children, and most publications refer to children and adults together.⁴ Topical paromomycin shows variable efficacy (39%-82% cure rates), with lower response rates in *L. tropica* infection.^{5,6} Liquid nitrogen treatment is painful and may cause scarring. Intralesional (IL) antimonial injections, such as sodium stibogluconate (SSG), are considered effective (83% cure rate)⁴ but are extremely painful and are therefore problematic in children⁵ unless performed under anesthesia. Systemic pentavalent antimony requires admission and can have significant toxicity. Intravenous (IV) liposomal amphotericin is expensive, has systemic adverse effects, and in our experience has shown variable efficacy.

The aim of this study was to document the efficacy and safety of IL SSG under anesthesia for CL in children.

In this single-center, retrospective, open, observational study, children aged 0-18 years with CL confirmed by polymerase chain reaction or smear, who were treated with IL SSG under general anesthesia with inhaled sevoflurane between 2013 and 2017, were included. Treatment consisted of repeated IL SSG injections until clinical and laboratory resolution. Data collected (after institutional review board approval) included demographic details, location, number and morphology of lesions, previous treatments, number of treatments with IL SSG, interval between treatments, response to treatment, and adverse effects.

A total of 48 patients with a total of 133 lesions were included. Demographic and clinical data are shown in Table I. Data regarding type of lesions and treatment with SSG are shown in Table II. The average number of lesions per patient was 2.8 ± 2.1 . A mean of 0.9 mL (range 0.2-2.6 mL) of 100 mg/mL of SSG was injected per session. The average interval between injection sessions was 2.3 ± 1.2 weeks.

Complete clinical resolution of CL was achieved in 45 of 48 patients (93.8%) after an average of 4.6 ± 1.8 IL SSG injection sessions (Fig 1). Ulcerated or nodular lesions required slightly more injections than papules and plaques. The average follow-up period was 2.2 months (range 1 week-16 months).

There were 3 treatment failures: 2 were due to lymphangitic spread or facial swelling, and these patients subsequently responded to IV SSG; the third patient had little improvement after 7 IL SSG injections. An additional patient had lymphangitic spread that resolved after further IL SSG injections.

Other adverse effects included mild dyspigmentation, atrophic scars (in 12 patients), and an ala nasi

Table I. Cutaneous leishmaniasis in children: Patient characteristics

Characteristic	Total cohort, n = 48
Age group, n (%)	
≥ 5 years old	33 (69)
<5 years old	15 (31)
Sex, n (%)	
Male	26 (54)
Female	22 (46)
Location of lesion(s), n (%)	
Face	45 (94)
Lips	20 (41.7)
Cheeks	19 (39.6)
Nose	14 (29.2)
Limbs only	3 (6)
Likely <i>Leishmania</i> species based on endemic geographic area, n (%) [*]	
<i>L. tropica</i>	40 (83.3)
<i>L. major</i>	5 (10.4)
Either <i>L. tropica</i> or <i>L. major</i>	2 (4.2)
Previous treatment, n (%)	
None	31 (65)
Paromomycin	7 (15)
Other topicals	4 (8)
PDT	7 (15)
Cryotherapy	1 (2)
Systemic therapy	4 (8)
IV SSG	2 (4)
Miltefosine	1 (2)
IV liposomal amphotericin B	1 (2)

IV, Intravenous; PDT, photodynamic therapy; SSG, sodium stibogluconate.

^{*}Four *L. tropica* and 1 *L. major* cases were confirmed by polymerase chain reaction.

Table II. Number of intralesional sodium stibogluconate injection sessions needed per lesion type

Lesion type	Patients (lesions) treated	Injection sessions needed, mean (SD)
Total	48 (133)	4.6 (1.8)
Nodules	19 (57)	5.3 (1.8) [*]
Ulcers	16 (28)	4.9 (1.9)
Crusted papules/plaques	16 (48)	4 (1.2)

SD, Standard deviation.

^{*}This includes 2 patients with clinical clearance and a negative scraping after 5 injection sessions, who had recurrences of CL in the treated area 3 and 9 months later, which responded to 2-4 additional injection sessions.

notch in 1 patient. Of note, dyspigmentation and scarring are common sequelae of CL itself. No anesthesia-related adverse events were documented.

Our study's limitations include its retrospective design, small cohort, and lack of a control group.



Fig 1. Pediatric cutaneous leishmaniasis. Large ulcer on the upper lip of a 7.5-year-old boy with significant swelling (A) before and (B) after a series of six intralesional sodium stibogluconate injections, leaving a nearly unnoticeable scar after treatment.

Nevertheless, this is the largest cohort evaluating the efficacy and safety of IL SGG under anesthesia in children. Our results are promising, and controlled clinical trials are needed to further evaluate IL SSG under anesthesia by inhaled sevoflurane in children with CL.

We thank the patient photographed in Fig 1 and his parents for their permission to publish clinical photographs.

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Skin cancer risk factors and screening among sexual minority and heterosexual women



To the Editor: Sexual minority persons—including lesbian, gay, and bisexual persons—face unequal cancer risks and are a National Institutes of Health—designated health disparity population.¹ Although multiple studies have demonstrated higher prevalence of skin cancer and associated risk factors in gay and bisexual men,²⁻⁴ 2 studies have shown that sexual minority women (SMW) had a lower prevalence of indoor tanning and skin cancers compared with heterosexual women.^{4,5} Scant data exist on additional skin cancer risk behaviors among SMW.

To address this critical knowledge gap, our study examined the prevalence of multiple skin cancer risk factors and screening in SMW using the 2015 National Health Interview Survey, a cross-sectional survey representative of the United States civilian population. Emory University institutional review exemption was obtained.

We restricted the analysis to adult women aged ≥ 18 years self-identifying as “lesbian or gay” or “bisexual” (SMW) and as “straight, that is, not lesbian or gay” (heterosexual women). Prevalence of ≥ 1 sunburns, indoor tanning device use, and skin cancer screening examination within the past 12 months were compared between SMW and heterosexual women using Rao-Scott χ^2 tests and benchmarked against Healthy People 2020 targets. Survey sample weights were applied and all estimates met a priori reliability standards. Multivariable logistic regression adjusted for significant socio-demographic confounders. Two-sided tests with Bonferroni-corrected $P < .005$ were considered significant for 9 outcomes. Stata 12.1 software (StataCorp LLC, Collage Station, TX) was used.

Among 18,601 women respondents, 464 SMW (2.5%), comprising 263 gay or lesbian (1.4%) and 201 bisexual (1.1%) women, and 17,340 heterosexual