Short Incisions, Careful Suture Choice Can Improve Cosmesis

BY MARY ELLEN SCHNEIDER
New York Bureau

NEW YORK — Every dermatologist should be able to perform excisional surgery and leave only a fine line scar on the patient’s face, Dr. William Hanke said at a meeting on medical and surgical dermatology sponsored by Mount Sinai School of Medicine.

Dermatologists who are not able to leave only a fine line scar are falling behind some of the family physicians who are doing excisional surgery, he said. And a scar that is long and noticeable is poor marketing for the physician.

Dr. Hanke, a dermatologic surgeon in Carmel, Ind., who founded the Mohs Micrographic Surgery Unit at Indiana University, Indianapolis, offered several techniques for achieving superior results with excisional surgery.

Make incisions in normal anatomic boundary lines or relaxed skin tension lines to hide scars. “That’s where you want your scars to be so that they don’t look like scars,” he said.

Handle tissue atramatically by avoiding touching the skin surface with fingers, instead, grab tissue from the bottom.

Make scars as short as possible. A scar longer than 2 cm will be much more noticeable than will shorter scars. By using an M-plasty, the incision can be shortened by about a third.

Don’t bury unnecessary suture material. Tying the appropriate number of knots on buried sutures allows you to keep the amount of buried foreign material to a minimum. “The wound doesn’t have to work as hard to heal with that smaller volume of foreign material,” he said.

Avoid more than one layer of suture material to reduce trauma and choose simple closures over complex ones. “If you do a complex closure in a case where you could have done a simple closure and there’s a complication, you’ve got a big complication.”

Undermine appropriately to relieve wound tension and facilitate wound edge eversion. Some dermatologists do a lot of unnecessary undermining and others never do it, but the right balance is likely somewhere in between, he said.

Use appropriate methods of hemostasis. Dr. Hanke said he does some su- ture ligature and uses a lot of electrocoagulation. Electrocautery is needed sometimes for patients with pacemaker. Pressure also is important, he said.

Use “tie-over” sutures to relieve tension and don’t tie sutures tightly. Doing so can result in strangulated tissue that won’t be evident until suture remo- val.

Be a student of dog-ear repair and close wounds roundly. The medical liter- ature shows that wounds that stay open for more than an hour or 2 have a higher rate of infection.

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Nest M-Plasty

BY TIMOTHY F. KIRN
Sacramento Bureau

PALM DESERT, CALIF. — Use of the “nested” M-plasty technique makes it possible to further shorten round wounds when closing Mohs defects, Dr. Ravi Krishnan said at the annual meeting of the American Society for Dermatologic Surgery.

The technique involves making two Ms, instead of one, in the M portion of the closure. Dr. Krishnan, director of dermatologic surgery at Indiana University, Indianapolis, said he uses a No. 11 blade to remove the Burton’s triangles because that blade gives better precision.

“The M portion closes as a broken line, which, as we know, is less noticeable than a straight line,” he said.

Dr. Krishnan said he uses the technique primarily when he does not want the closure excisions to extend into an adjacent cosmetic unit, or when he does not want to interrupt a structure such as the eyebrow or the nose.

Dr. Krishnan said he did not know whether his technique was unique, but it has not been de- scribed in the dermatology literature.

“Use it extremely easy to execute and involves cut- ing out less skin,” Dr. Krishnan added.

BK7 Stain Aids Mohs in Extramammary Paget’s

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN DIEGO — Dr. Daniel Siegel applied the zinc chloride paste developed by Dr. Frederic E. Mohs to melanomas the day before he removes them as a kind of “booster” to reduce the risk of recurrence.

Zinc Paste May Help Halt Mohs Recurrences, Despite Its Dangers

BY TIMOTHY F. KIRN
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Be a student of dog-ear repair and close wounds roundly. The medical literature shows that wounds that stay open for more than an hour or 2 have a higher rate of infection.

Dr. Krishnan said he uses the technique primarily when he does not want the closure excisions to extend into an adjacent cosmetic unit, or when he does not want to interrupt a structure such as the eyebrow or the nose.

Dr. Krishnan said he did not know whether his technique was unique, but it has not been described in the dermatology literature.

“Use it extremely easy to execute and involves cutting out less skin,” Dr. Krishnan added.

“Do I know this is helping? I absolutely do not. [But] we are killing and immobilizing cells and that their lymph nodes are sore. He then does a wide excision despite the paste, he said.

It is important to warn patients not to touch the lesion and get the paste in an eye. “You have to be very careful and fearful,” he said. “Paste can be dangerous.”

Despite that, it may be advan- tageous to use the paste for pa- tients who may be infectious, such as those who are HIV positive, because it probably minimizes in- fection agents ‘platter,’ he added.

Most importantly, there is no reason to believe that the use of the paste may be harmful, since the tumor is being removed any- way, Dr. Siegel said.

In fact, he is the only Mohs surgeon who uses the paste for melanoma cases.

Dr. Kenneth Gross of San Diego, one of the organizers of the Mohs course, said that he has used it for patients who are hav- ing a sentinel node procedure.

“Do I know this is helping? I ab- solutely do not,” he said. “We are killing and immobilizing cells and I don’t see how that could be any problem,” he said.

Dr. Siegel applies a 50% trichloroacetic acid solution to the lesion before applying the paste, which is painful. Patients often come in the next day com- plaining that they have a tempera- ture and that their lymph nodes are sore. He then does a wide excision despite the paste, he said.

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