Incisional Biopsy Best When Uncertain,Expert Says

BY DOUG BRUNK
San Diego Bureau

San Diego — If you’re confident that a primary lesion is melanoma, do an excisional biopsy and send the entire specimen for evaluation. If you’re less certain about the diagnosis, you can do an incisional biopsy of the tumor and send the specimen for evaluation, Dr. Avis B. Yount said at an update on melanoma sponsored by the Scripps Clinic. “The goals of biopsy are to establish the diagnosis, determine the best treatment and prognosis for the patient, and determine the type of melanoma, acral lentiginous or superficial spreading, and the ulceration and regression,” said Dr. Yount of the department of dermatology at the Medical College of Georgia, Augusta.

Incisional biopsies are a fullthickness biopsy that conservatively excises the entire lesion; its margin is 2-3 mm around the lesion and includes subcutaneous fat. “I try to orient the excision to facilitate wide excision while maintaining optimal cosmetic and functional results,” she said.

Wide excision is not recommended because “the lesion may be benign, the excision may be insufficient because of the tumor thickness, and it may interfere with further treatment such as a sentinel node biopsy,” she says.

If the lesion is located where complete removal would cause substantial disfigurement or a skin graft or flap would be needed for repair, consider proceeding with incisional biopsy. “You can do an elliptical incision through part of the lesion, giving the pathologist that part of the lesion that allows the best diagnosis, or you can do a punch biopsy or a sauerization type biopsy,” she said. Recent studies have suggested that sauerization might be the most effective type of biopsy (J. Am. Acad. Dermatol. 2005;52:798-802).

For incisional biopsy, you “want to biopsy the most nodular or deeply invasive area into the subcutaneous fat,” said Dr. Yount, who also practices in Augusta and Evans, Ga. “Biopsy by shaving, scissor excision, or curettage is not recommended.”

She pointed out that there is no evidence that an incisional biopsy has a detrimental influence on the survival of the patient or the rate of metastases.

When Dr. Yount contacts a suspicious lesion on the nail, she removes the entire plate and subungual tissue to the pathologist.

“You want to do a transverse biopsy in the nail matrix and a longitudinal biopsy in the nail bed,” she said. “Before I remove the nail plate I mark the area of pigment, so that I don’t lose the lesion after the nail plate is removed.

Biopsies that are too small create certain challenges. “They may compromise histological assessment, including the accurate assessment of Breslow depth,” she said. “You may see a dysplastic or congenital naevus but not the melanoma. I’ve had seborrhoeic keratoses about an melanoma.”

Another problem of small biopsies is that in situ melanoma might coexist with an unidentified invasive component.

“After you’ve done the biopsy then you need to proceed with excision,” Dr. Yount said. “The goals of excision are to cure the patient with low-risk disease, provide local control in patients with possible incurable disease, minimize functional impairment, and minimize cosmetic disfigurement.”

Treatment is based primarily on the Breslow depth. “Use judgment in determining margins according to tumor thickness, anatomical location, and skin laxity,” Dr. Yount said. She had no relevant conflicts of interest to disclose.

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