By Bruce Jancin

San Francisco — The use of moderate to large volumes of dilute lidocaine for tumescent anesthesia during Mohs surgery on the face and neck was free of signs of lidocaine toxicity, according to Dr. Murad Alam.

The pattern of rising plasma lidocaine levels over time documented in this study suggests that peak levels in patients undergoing Mohs surgery above-the-shoulders occur 3-5 hours after the start of surgery, he added.

Melanoma Incidence Climbs Quickly Between 1992 and 2004

By Kate Johnson

Montreal — The incidence of melanoma in the United States increased rapidly over a 10-year period, regardless of tumor thickness and socioeconomic status, reported Dr. Eleni Linos.

“We found parallel increases across all socioeconomic groups and thicknesses, representing a true increase in clinically significant tumors,” she said.

From Ice to Surgicel, Tips to Help Control Mohs Bleeding

By Damian McNamara

Miami Beach — Minimizing bleeding during and after Mohs surgery can be a challenge, according to Dr. Susan H. Weinkle.

“Consider using flesh-colored bandages, and provide written instructions to leave them on for 48 hours. Other strategies to prevent or manage postoperative bleeding include the application of ice, direct pressure for 15 minutes, and the use of Surgicel Absorbable Hemostat (Ethicon Inc.).”

Surgical hemostasis is important; do your best to maintain a dry field in particular, she said.

Students should be required to spend at least a day in the operating room to see what Mohs surgery is, and dermatologic surgeons should continue to “promote our reputation as the experts that the public has more confidence in the brand ‘plastic surgery’ than the brand ‘dermatology’ when it comes to cutaneous surgeries,” he said.

Public Rates Plastic Surgeons As Best for Cutaneous Repair

By Alicia Ault

Austin, Tex. — The public does not appear to perceive that Mohs surgeons are as capable as plastic surgeons when it comes to removing cutaneous lesions and repairing facial defects, according to a survey of 467 patients.

“We found parallel increases across all socioeconomic groups and thicknesses, representing a true increase in clinically significant tumors,” she said.

“More diagnoses of thin, clinically nonaggressive tumors are being made. The vast majority of melanomas that are diagnosed are thin, and that is why we have not seen such a dramatic increase in mortality rates,” she explained. Overall mortality rose by 0.4% annually.

Melanoma trends were examined according to socioeconomic status to determine whether the findings could be explained by better screening in those with a higher status. Similarly, tumor thickness was examined to determine whether the increased incidence could be explained by more diagnoses of thin, clinically insignificant tumors.

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Cutaneous Oncology

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Montreal — The incidence of melanoma in the United States increased rapidly over a 10-year period, regardless of tumor thickness and socioeconomic status, reported Dr. Eleni Linos.

“This has implications for preventive screening and primary care,” she said at the annual meeting of the Society for Investigative Dermatology.

Dr. Linos and her co-investigators examined data from the Surveillance, Epidemiology, and End Results (SEER) registry between 1992 and 2004 (J. Invest. Derm. 2009 Jan. 8 [doi:10.1038/jid.2008.423]). They focused on non-Hispanic white patients, in whom 90% of melanomas occur, said Dr. Linos, who declared having no conflicts of interest. They identified 70,596 cases.

During the study period, the incidence of melanoma of all thicknesses increased from 18 per 100,000 in 1992 to 26 per 100,000 in 2004—a 44% annual increase of 3%, said Dr. Linos of Stanford (Calif.) University. The steepest increase was seen in men aged 65 years and older, in whom the incidence rose from 73 to 126 new cases per 100,000. “The vast majority of melanomas that are diagnosed are thin, and that is why we have not seen such a dramatic increase in mortality rates,” she explained. Overall mortality rose by 0.4% annually.

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