Partial Closure After Mohs Can Be Optimal Choice

Technique beneficial for high-tension areas and the monitoring of tumor recurrence.

BY DAMIAN McNAMARA
Miami Bureau

ORLANDO — Partial closure after Mohs surgery offers women good results for some candidates, J. Robert Hamill Jr., M.D., said at the annual meeting of the Florida Society of Dermatologic Surgeons.

He suggested that dermatologic surgeons consider partial closure for:

► Surgical sites under high tension, including legs, scalp, and fingers. "Scalps can be tight and can be very painful," Dr. Hamill said. "When I first started I closed everything completely."

► Surgery confined to one anatomic unit, which facilitates a favorable cosmetic outcome in particular areas, especially the eyelids, nose, lips, and ears. "Keep this in mind because your surgical result will be better," Dr. Hamill said. "Anyone I can stay with in an anatomic unit, I will do it."

► Sites where surgery might compromise function, especially the eyelids, lip, nose, and fingers.

► Surgical sites where complete closure might cause ischemia or necrosis.

"Another benefit is monitoring for recurrence of tumor by not covering the defect," said Dr. Hamill, who is in private practice in Hudson, Fla. A partial closure decreases surgery time, he added.

"Many areas granulate well with no closure," Dr. Hamill said. For example, he partially closed a Mohs defect on a patient’s chest and allowed the rest to granulate. Although the outcome was good, "patients like these have to be followed closely," he advised.

In addition, Dr. Hamill chose a partial closure for a patient who had squamous cell carcinoma on his ear.

"I could have done an extensive, two-stage procedure, but the patient wanted something simple," Dr. Hamill said.

"I let it granulate. It was very functional, and the patient was very happy with him."

A patient with a small basal cell lesion on his scalp sealed up with a large defect after Mohs surgery. "The patient was already tanning on top. You will have tractions alopecia if you do a complete closure, Dr. Hamill said at the meeting.

A partial closure yielded a good result at 2 weeks post operatively; 3 years post operatively there was no additional hair loss. Lines of relaxed tension are the best place to hide surgical scars, Dr. Hamill said. Pull normal skin as tight as possible and anchor it onto subcutaneous tissue or cartilage with a partial closure, Dr. Hamill suggested. "It’s a great trick to increase the chance of flap survival."

A simple advancement flap with partial closure works well for surgery on a digit.

Dr. Hamill said. Maintain a digit in a hyperextended position during surgery so the tightness is easily gauged, he suggested.

Partial closure can be handy for surgery close to the eye to avoid ectropia. "Ectropia can be a problem, especially in the elderly," Dr. Hamill said. With a partial closure, the area with the highest tension can be removed and left to granulate in. "If you have patients sit up so I can see if there is ectropia, he said. "There is no sense in doing the surgery and then having the patient sit up."

Dermoscopy Recommended Over Most Melanoma-Imaging Tools

BY TIMOTHY F. KIRN
Sacramento Bureau

NAPLES, Fla. — Several new techniques becoming available to follow and visualize melanomas, but practicing dermatologists will be best served if they focus on learning dermoscopy, Harold S. Rabinovitz, M.D., said at the annual meeting of the Florida Society for Dermatology and Dermatologic Surgery.

Current estimates are that about 15% of U.S. dermatologists use dermoscopy; use dermoscopy, Dr. Rabinovitz, of the department of dermatology at the University of Miami, said. Even experienced dermotologists are not perfect at differentiating between malignant melanoma and benign melanocytic nevi, he said. Studies have found the overall diagnostic accuracy of dermatologists to be about 65%. Dermoscopy improves diagnostic accuracy over visual inspection by about 55%, Dr. Rabinovitz said.

Once dermoscopy is learned, it does not take much extra time to do, which makes it convenient and practical. The obstacle is learning to do dermoscopy well, he added.

"There is a steep learning curve," he said. "In dermoscopy, a little knowledge is worse than no knowledge. It is only a diagnostic aid, as pathology is the reference standard."

"The other melanoma-diagnosing technologies that are available or in development, he said, are impractical or their future is uncertain.

For instance, total-body photography, even today’s digital total-body photography and computer software, requires too much time to take and review the photographs. When Dr. Rabinovitz does total-body photography for appropriate, high-risk patients, he says he gives patients CD copies of the digital photos. When they have a concern about a particular nodule, they can compare it to the photographic record.

"Full-body photography, in my opinion, is for the patients.

Once dermoscopy technique is learned, it does not take much extra time to do, which makes it convenient and practical. The obstacle is learning to do dermoscopy well.

Confocal imaging, like dermoscopy, allows visualization of structures below the surface, but on the horizontal plane. This imaging system is being used in several studies, including one on tracking immunotherapy treatment in situ melanoma. But confocal imaging is a research tool and probably will remain one, he said, because dermoscopy is available, and because biopsy will remain the standard of diagnosis.

Image-analyzing computer programs for use with dermoscopy and photography are in development, and could have great promise because the computer might help to pick up things the eye may miss. But their introduction into the market is probably at least a few years away, even if problems in analyzing some histologic features can be worked out.

"My advice to you is learn dermoscopy," Dr. Rabinovitz said. "Over the years, I believe this will be an important tool and aid for dermatologists in the management of their patients."

Dr. Rabinovitz said he knows of four companies that sell dermoscopy equipment. He did not recommend any one product, but he did advise that the best course of action is to buy the latest model of equipment.

Dermatologic Surgery

SKIN & ALLERGY NEWS • November 2005

SMART PHYSICIANS SMART CHOICES

Saffiliate.com