Creative Customization Makes Offices Mohs Ready

S AN D I E G O — Most Mohs surgeons don’t have the luxury of designing an ideal office from scratch—they must work with their preexisting office space, said Dr. James Del Rosso at a meeting sponsored by the American Society for Mohs Surgery.

Think of the acronym SPACE: Skills, Personnel, Area, Coordination, and Equipment, said Dr. Del Rosso of the University of Nevada, Las Vegas.

► Skills. To succeed as a Mohs surgeon, build on your basic surgical skills, and remember to stay slow, small, and safe, Dr. Del Rosso said. Mohs involves a change in surgical technique with regard to removing skin cancer; the difference is in the conceptualization of lesion removal. Mohs surgeons consider tangential margin control, which is a patient-centered approach, more important than a standard surgical excision. A dermatology residency, attendance at Mohs surgery courses, and observation of Mohs colleagues during procedures will help refine your skills.

► Personnel. Educate the office staff about Mohs surgery, what it involves, and why you have decided to offer it. Consider cross-training staff members so that they know how to cut tissue sections if the regular technician calls in sick, for example. Division of responsibility is crucial. You will also need to hire laboratory staff. Designate individuals for certain paperwork responsibilities, including logs on patient care and on instrument maintenance, and designate backup staff for all duties. In addition, educate staff about anatomical landmarks. “Make sure that everyone who is documenting procedures uses the same terminology,” Dr. Del Rosso said.

Train patients to be observers, and notice other problems.

Define office procedures, and document them in office manuals. “I recommend having someone in the office put together a short ‘Cliff’s Notes’ version of one or two pages with highlights of the basic office procedures,” he said. Ideally, a Mohs surgeon can design an office space to specifications, but most surgeons work with the space they have. However, a standard surgery room that will be used for Mohs surgery should have eyewash stations, appropriately sized containers for fluids, and sharps containers.

► Administration. Think about how the patients will be waiting with bandages before, during, and after Mohs surgery. “Make sure that staff members know which patients are waiting between surgical sections, and that these patients are monitored and kept comfortable. “These patients will be waiting with bandages between layers, they may bleed and contaminate other patients, or they could faint, or become vasovagal,” Dr. Del Rosso said.

► Equipment. The equipment for Mohs surgery and equipment maintenance goes without saying. “It is penny wise and pound foolish not to buy good surgical tools,” Dr. Del Rosso said. “The way to save money is to make sure that equipment is properly cared for in the future.”

Establishing a Mohs laboratory—with its unique processing of specimens and methods of record keeping—is one of the biggest challenges for beginning Mohs surgeons, as Dr. Del Rosso explained the sections.

“I would plan for two cryostats, even if you don’t have two in the beginning,” he said. “You will also need to allow for an ink station.” Use color-coded glass slides for different stages to help keep samples organized.

Keep a prepared tray with the entire collection of surgical equipment ready, including small cups with saline and peroxide to soak the instruments between sections. Make sure the trays are organized so that the instruments are easy to locate, and encourage staff to toss gauze on the trays and obscuring the instruments.

“Hemostats should be on every tray, whether it is a repair tray or a Mohs tray,” Dr. Del Rosso noted.

His favorite instruments include tenotomy scissors, Bishop-Harmon forceps, and blunt-edged dedicated undermining scissors. Some surgeons use sharp scissors to cut through the tissue, while others use disposable blades.

Although many surgeons use disposable blades, Dr. Del Rosso recommends purchasing good quality blades and either sharpening them themselves or sending them out for regular sharpening. “If your knives aren’t kept sharp, you will have problems with the quality of your sections,” he explained.

Reusable blades are more cost effective and allow the surgeon greater control over the blade quality.

Regulatory Diligence Today May Keep OSHA Inspectors Away

S AN D I E G O — The best way to avoid safety and quality violations is to stay abreast of guidelines prescribed by the Occupational Safety and Health Administration and by the Clinical Laboratory Improvement Amendments, Dr. Richard Hoang explained at a meeting sponsored by the American Society for Mohs Surgery.

The lack of an up-to-date plan for control of blood-borne-pathogen exposure was among the most common violations for which Mohs surgeons were cited by OSHA during the period from January to August 2003, said Dr. Hoang, a dermatologist and dermatologic surgeon in private practice in San Diego.

“There are always unusually high fines for blood-borne-pathogen exposure control-plan violations, so make sure yours is updated annually,” Dr. Hoang said.

OSHA inspections are typically prompted by complaints or accidents. If an OSHA citation is given, there is always an opportunity to contest the violation, he noted.

In addition to the need for a blood-borne-pathogen-exposure-control-plan citation, two OSHA guidelines that are particularly relevant to Mohs surgery practices include those on the identification of hazardous materials in the office. OSHA requires a standard worksheet for each chemical. Also, surgeons who work with hazardous materials must label all chemical containers and, when transferring chemicals to other containers, make sure all transfers and contaminants reflect the original information about the chemical, Dr. Hoang said.

The Clinical Laboratory Improvement Amendments (CLIA), first published in 1992, were prompted by the poor quality of Pap smear results produced by large laboratories. CLIA classifies laboratory tests based on levels of complexity, and ranks Mohs histopathology tests as highly complex, Dr. Hoang said. Because of that ranking, Mohs practices must apply for a certificate, pay the required fees, and participate in proficiency testing.

The manual includes directions for performing tests. “All you have to do is make any revisions to the basic manual that are specific to your lab, and update it annually,” Dr. Hoang explained.

In the section on specimen collection and handling, for example, Mohs surgeons should note that the surgeon will correlate the tissue with the Mohs map. Any tests performed should be documented with a test requisition in the patient’s chart. In addition to this required documentation, Dr. Hoang recommends keeping a special Mohs log with the patient’s name, the site worked on, and the number of slides that helped the surgeon create an operative report.

Quality control in a Mohs practice—defined as the monitoring of testing procedures to achieve accurate, consistent results—also falls under CLIA requirements. To achieve acceptable results, consistent results must confirm the quality and sterility of reagents and record the expiration dates and lot numbers. Document the cleaning and maintenance of equipment to report the daily temperature of the cryostat. The cryostat should be cleaned regularly.

—heidi splete