SAN DIEGO — Most Mohs surgeons don’t have the luxury of designing an iden-
tical 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 remem-
ber to start slow, small, and safe. Dr. Del Rosso said. Mohs involves a change in surgical technique with regard to remov-
ing skin cancer; the difference is in the con-
ceptualization of lesion removal. Mohs surgeons consider tangential margin control, which is different than a standard surgical excision. A der-
atology residency, attendance at Mohs surgery courses, and observation of Mohs colleagues during procedures will help re-
fine your skills.

► Personnel. Educate the office staff about Mohs surgery, what it involves, and why you have decided to offer it. Consid-
er 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. De-
nigate individuals for certain paperwork re-
sponsibilities, including logs on patient care and on instrument maintenance, and designate backup staff for all duties. In ad-
dition, educate staff about anatomical landmarks. “Make sure that everyone who is document-
ning procedures uses the same terminology,” Dr. Del Rosso said. Also, 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 togeth-
er a short ‘Cliff’s Notes’ version of one or two pages with highlights of the basic of-

cice procedures,” he said. Ideally, a Mohs surgeon can de-
sign an office space to specifications, but most surgeons work with the space they have. However, a standard surgical room that will be used for Mohs surgery should have eyewash stations, appropriately sized adjustable chairs for both the doctor and patient, and step stools for nurses or oth-
er staff who need a higher view of the

procedures. If you have a step stool, make this rule: The person who uses it moves it out of the way when he or she is done. Kick buckets—buckets on wheels that can be moved with the feet while the surgeon is gloved during a procedure—are ex-
tremely helpful in a Mohs surgical suite.

► Coordination. Think about how the pa-

tients, the staff, and the specimens will flow through the office. A separate wait-
ing room is ideal, but a separate section of the waiting room is the next best thing. Be sure that staff members know which pa-

tients are waiting between surgical sec-
tions, and that these patients are moni-
tored and kept comfortable. “These patients will be waiting with bandages be-

between layers, they may bleed and cont-

aminate other patients, or they could faint, or become vasovagal,” Dr. Del Rosso said.

► Equipment. The equipment for Mohs surgery must be adjustable and kept comfortable. “These

equipment and instruments are expensive, and equipment maintenance and, when transferring chemicals to oth-


er materials must label all chemical containers, record the expiration dates and lot numbers. Document the cleaning and maintenance procedures to help you maintain the equipment and keep track of the daily temperature of the cryostat. The cryostat should be cleaned regularly.

“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

inking station.” Use color-coded glass slides for different stages to help keep samples organized.

Keep a prepared tray with the entire col-

lection of surgical equipment ready, in-

cluding small cups with saline and perox-
side to soak the instruments between sections. Make sure the trays are organized so that the instruments are easy to locate, and discourage staff from tossing 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 teno-
tomy scissors, Bishop-Harmon forceps, and blunt-edged dedicated undermining scissors. Some surgeons use sharp scissors for undermining.

Although many surgeons use dispos-
able blades, Dr. Del Rosso recommends purchasing good quality blades and ever sharpening 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 ef-

f ective and allow you to have greater con-
trol over the blade quality.

Regulatory Diligence Today May Keep OSHA Inspectors Away

SAN DIEGO — The best way to avoid safety and quality violations is to stay abreast of guidelines prescribed by the Oc-

cupational Safety and Health Administra-
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ion and by the Clinical Laboratory Im-

provement Amendments, Dr. Richard Hoang said at a meeting sponsored by the American Society for Mohs Surgery.

The lack of an up-to-date plan for con-
trol 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 dermatol-


gist and dermatologic surgeon in private practice in San Diego.

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

OSHA inspections are typically prompt-
ed by complaints or accidents. If an OSHA citation is given, there is always an opportu-

nity to contest the violation, he noted.

In addition to the need for a blood-

borne-pathogen-exposure control plan, OSHA guidelines that are particularly re-

levant to Mohs surgery practices include those on the identification of hazardous materials in the office. OSHA requires a sub-
ailed sheet for each chemical. Also, sur-

geons who work with hazardous ma-

terials must label all chemical containers and, when transferring chemicals to oth-

er containers, make sure all transfer con-
tainers 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 high-

ly complex. Dr. Hoang said. Because of that ranking, Mohs tests must apply for a certificate, pay the required fees, and participate in proficiency testing.

The manual includes directions for per-

forming tests. “All you have to do is make any revisions to the basic manual that are specific to your lab, and update it annual-

ly,” 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 ad-

dition 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 to help keep the log create an operative report.

Quality control in a Mohs practice—de-
ned as the monitoring of testing proce-
dures to achieve accurate, consistent re-
sults—also falls under CLIA requirements.

To achieve accurate, consistent results, confirm the quality and sterility of reagents and record the expiration dates and lot numbers. Document the cleaning and maintenance procedures to help keep them.

“Treat the Mohs lab like a clinical lab,” Dr. Hoang recommended.