

The Lesion Didn't Bother Him— Just Everyone Else

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After 40 hard-fought years, a 60-year-old man has finally gotten tired of everyone—family, friends, and even his health care provider—hounding him to get the lesion on his face checked. For decades, there were no significant changes to its appearance; recently, however, parts of the lesion have begun to darken and become more raised. This prompts him to seek evaluation.

The patient spends a great deal of time outdoors. He can easily gain and keep a tan for the entire summer, rarely burning. However, family history is positive for skin cancer—although only in fairer-skinned relatives.

Physical examination reveals a 4×3.5-cm lesion, located on his left lateral cheek, that is roughly round and dark brown. Although largely uniform in color, it has focal areas of much darker skin and 2 raised dark nodules consistent with possible seborrheic keratosis.

The patient's skin shows modest evidence of sun damage. No nodes are felt in the adjacent head or neck nodal drainage areas.

Of the following, which is the clearly inappropriate course of action to take?

- Perform a single 4-mm punch biopsy
- Refer the patient to dermatology or surgery
- Perform an incisional biopsy, incorporating the darkest, most irregular portion of the lesion
- Obtain 2 or 3 deep shave biopsies from different areas of the lesion

ANSWER

The incorrect course of action would be to perform a single 4-mm punch biopsy (choice "a").

DISCUSSION

The concern about a single biopsy lies in the possibility of focal malignant transformation—in particular,



melanoma. Unfortunately, it's impossible to determine from the surface of the lesion if (or where) this has occurred; thus, it is critical to procure samples of adequate size and scope of location. A single 4-mm punch could easily miss a cancer, leaving the patient falsely reassured.

With smaller yet worrisome lesions, the gold standard is to simply remove the entire lesion for pathologic examination. But excising a lesion as large as this patient's would be a major undertaking that requires a graft to close—and leaves a sizable scar.

Using an incisional biopsy to remove a 2.5×1-cm crescent-shaped sample would be preferable. Then the defect could be designed and closed with skin tension lines. This procedure has a good chance of finding any cancer.

Ordering a series of 2 or 3 deep-shave biopsies of different areas in the dermis could be adequate if it's the only practical option available. But it might be a better *last* option, as the procedure would leave significantly unattractive scars.

Even if the biopsies were negative, this lesion—which is almost certainly benign—would still need to be watched for changes. For the case patient, the initial biopsy is still pending.

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