Consider All Angles Before Advising Mohs Surgery

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SAN DIEGO — If you recommend Mohs surgery for a melanoma patient, remember that you are one point along a spectrum of medical and emotional care for that person, Duane C. Whitaker, M.D., advised at a melanoma update sponsored by the Scripps Clinic.

Consider yourself part of a multiphysician treatment team that may include a pathologist, oncologist, surgical oncologist, and a primary care physician.

More important than proficiency in the technical details of Mohs surgery "is the ability to properly evaluate, prognosticate, follow the patient, educate the patient, and have consultations," said Dr. Whitaker, professor of surgical dermatology at the University of Iowa, Iowa City. "Working with high-risk melanoma as part of a team is key."

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DR. WHITAKER

He said dermatologists can consider Mohs surgery for melanoma when:

▶ The adequate surgical margin of a tumor is unknown.

▶ The tumor can be evaluated properly by microscopy and frozen section.

▶ The tumor is accessible to a staged surgical approach.

▶ Local tumor growth is thought to be contiguous.

The benefits of Mohs surgery include tissue sparing, precise margin determination, immediate reconstruction, minimal wound and repair, and the opportunity to initiate other therapies immediately.

"There is no evidence that patients who have undergone Mohs surgery are at higher risk for metastasis or have increased local recurrence, but it is evident that less surgical morbidity is a benefit in certain cases," Dr. Whitaker said.

A prospective study of 553 primary melanomas treated with Mohs found local or distant recurrence equivalent to or better than historical controls (J. Am. Acad. Dermatol. 1997;37:236-45). Clear margins were achieved in 85% of patients with a 6-mm margin.

In another study, investigators who used Mohs for treating both lentigo maligna melanoma and lentigo maligna found that no predetermined excisional margin could be established (Arch. Dermatol. 2004; 140:1087-92). They employed frozen section margin control and found 2% recurrence at a mean follow-up of 38 months.

A more recent study found that melanomas of the head and neck commonly have subclinical extension (J. Am. Acad. Dermatol. 2005;52:92-100). Mohs surgery achieved 5-year disease-free rates equivalent to or better than historical data.

Physicians should consider these factors before recommending Mohs surgery:

▶ **Surgical experience.** "I do not advocate Mohs surgery for melanoma across the board," Dr. Whitaker said. "I think the physician's knowledge of the disease, experience with Mohs surgery, and comfort with reading frozen sections are key."

▶ **Facial or critical anatomy where the benefit of tissue conservation is substantial.** Examples include melanomas of the foot, hand, or genital areas.

▶ **Patient and consultant comprehension.** "The patient needs to understand what you're doing," he noted. "There is not a huge body of literature to support the idea of Mohs surgery for melanoma. You may be criticized for performing it, but if it's looked at in the whole of the treatment plan, I think there is a rationale for it."

▶ **Review of alternatives and adjunctive therapy.** Any time you make a diagnosis as serious as melanoma, "it's part of your obligation to tell the patient what every option is in terms of evaluation, treatment, and what the known benefits are," he said. "If the patient has an in situ melanoma or a thin melanoma, Mohs surgery with good assessment and evaluation may be the only treatment that needs to be done."

Mohs surgery "will continue to be employed in the management of melanoma when the managing physician identifies benefits for the patients and has something to offer that would be hard to equal in any other way," he concluded. ■