Techniques Can Improve Mohs Surgery Outcome

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SANTA ANA PUEBLO, N.M. — The first step in considering Mohs surgery for melanoma is a detailed informed consent, Dr. Kenneth G. Gross advised at a meeting of the American Society for Mohs Surgery.

He uses the consent form "to counsel the patient, tell them about the tumor, and what I expect to do," said Dr. Gross, a dermatologic surgeon practicing in San Diego.

For example, his standard Mohs consent form is modified to include the possibility of taking an additional rim of tissue beyond the ostensibly clear Mohs margin, the possible need for immunohistochemistry, and the inclusion of postoperative therapy with imiquimod.

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DR. GROSS

Dr. Gross photographs the melanoma lesions prior to surgery and also documents cross-measurements from adjacent anatomical areas to localize the melanoma. "I have had patients referred to me for a melanoma, but neither the patient, nor the referring doctor, nor I could find the site," he said. "That's a very embarrassing thing."

At the time of biopsy and/or when the patient is first seen for preoperative evaluation, and again on the day of surgery, the clinical status of the regional nodes should be evaluated and documented. "My note includes a statement such as: 'The regional nodes were negative or bilaterally negative to palpation.' "

He went on to share his clinical approach to Mohs surgery for melanoma:

► Outline the melanoma using magnification with and without a Wood's lamp, plus an additional margin of 3-5 mm. Dermoscopy "may be helpful in delineating the margins," he said.

► Excise the lesion using standard Mohs technique to below the hair follicles, if possible.

Dr. Gross uses Dr. John A. Zitelli's criteria to determine positive margins, defined as nests of three or more atypical melanocytes, melanocytes above the dermal-epidermal junction, or nonuniform contiguous melanocytic hyperplasia at the dermal-epidermal junction.

Other suspicious findings include confluent atypical melanocytes down the adnexa, increased numbers of melanophages, brisk inflammation, and dermal scarring.

He noted that one recent study found that about 25% of in situ melanomas on biopsy are upstaged to invasive melanoma if step cross-sections were done. "So I think cross-sectioning has to be part of your overall way of doing things," he said. "In our office, after the Mohs margins are assessed using standard Mohs technique, then the blocks are partially thawed and cross-sectioned by frozen section processing. This allows both assessment of invasion and another look at how closely the tumor approaches the 'clear' margins. It influences whether we take an additional rim of tissue—processed by permanent section technique—past our Mohs margin."

► Be capable of producing high-quality Mohs slides. "You want 2- to 4-mcm wafers of high quality," said Dr. Gross, who is also with the department of medicine at the University of California, San Diego.

► Consider double-reading the slides with a pathologist. "I'm not completely comfortable reading these slides myself," he said. "If you're a dermatopathologist, you may be comfortable reading these slides on your own. But for the rest of us, if you have an association with a dermatopathologist or pathologist, double-reading the slides gives you a tremendous advantage."

Dr. Gross uses hematoxylin and eosin (H&E) staining for his frozen section slides, and every second or third slide is left unstained for immunohistochemistry (IHC) if needed.

► When clear margins are achieved, close the wound. Starting on postoperative day 25, Dr. Gross begins imiquimod cream b.i.d. for 6 weeks, titering the effect to produce a brisk immune response.

Dr. Gross said there is now a consensus among leading surgical oncologists that sentinel node biopsy is the standard of care for primary cutaneous melanoma measuring 1.0-3.5 mm thick. ■

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