

Creative Customization Makes Offices Mohs Ready

BY HEIDI SPLETE
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SAN DIEGO — 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 start 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 calls for a different approach 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. 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. 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. 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 together a short 'Cliff's Notes' version of one or two pages with highlights of the basic office procedures," he said.

► **Area.** Ideally, a Mohs surgeon can design 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 other 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 extremely helpful in a Mohs surgical suite.

► **Coordination.** Think about how the patients, the staff, and the specimens will flow through the office. A separate waiting room is ideal, but a separate section of the waiting room is the next best thing. Be 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 is expensive, 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 is interpreting 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 inking 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 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 tenotomy scissors, Bishop-Harmon forceps, and blunt-edged dedicated undermining scissors. Some surgeons use sharp scissors for undermining.

Although many surgeons use disposable blades, Dr. Del Rosso recommends purchasing good quality blades and either sharpening them on-site 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. ■



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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 Occupational Safety and Health Administration and by the Clinical Laboratory Improvement 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 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 citations, 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, OSHA guidelines that are particularly relevant to Mohs surgery practices include those on the identification of hazardous materials in the office. OSHA requires a safety data sheet 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 transfer containers 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 to help 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 accurate, consistent results, confirm the quality and sterility of reagents and record the expiration dates and lot numbers. Document the cleaning and maintenance of microscopes and report the daily temperature of the cryostat. The cryostat should be cleaned regularly.

—Heidi Splete