

Use Mohs Surgery Selectively for Invasive Skin Ca

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PHOENIX, ARIZ. — Locally invasive skin cancers with histologies amenable to frozen section are candidates for Mohs surgery, Neil A. Swanson, M.D., said at a clinical dermatology conference sponsored by Medicis.

But the exacting technique is not always appropriate.

Physicians should consider multiple fac-

tors in deciding which therapy to use, said Dr. Swanson, chair of dermatology at Oregon Health and Science University in Portland.

"Mohs is not indicated for every cancer but for the ones that are high risk," he said.

Dr. Swanson described a strategy outlining how to decide whether to use the surgical technique for various melanoma and nonmelanoma skin cancers.

Basal cell carcinomas that recur or have

been incompletely excised would be treated with Mohs surgery, which Dr. Swanson described as the "penultimate margin control."

For low-risk basal cell carcinoma, he favored excision, curettage and electrodesiccation, cryosurgery, or radiation.

Most basal cell carcinomas will be low-risk, according to Dr. Swanson.

To identify the few cancers that are high risk, he suggested considering the following four factors:

► **Location.** Tumors could be more aggressive in certain facial areas.

► **Histology.** Mohs surgery would be indicated for morpheaform (sclerotic) and for keratotic (metatypical) basal cell tumors.

For noduloulcerative and superficial types, he recommended choosing one of the alternative therapies.

► **Size.** Use Mohs surgery when a basal cell tumor is 2 cm or greater.

Smaller tumors can be treated with another therapy.

► **Clinical nature.** Mohs surgery would be indicated for a tumor that has ill-defined borders, is multicentric, or evidences immunosuppression.



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In some large and aggressive cases, he suggested the dermatologist work cooperatively with a specialist.

"One of the most time-consuming things in the operating room is [figuring out] what is this margin going to be," he commented.

"The day before, we do the peripheral margin. We leave the center of the tumor. It is going to be removed anyway by the surgeon."

For melanoma, Dr. Swanson recommended Mohs surgery as an option in head and neck cases; these are often positioned in difficult anatomic sites where tissue preservation is a concern.

He said he always starts with a Wood's light, which he finds especially useful for defining margins.

"I outline the tumor clinically," Dr. Swanson said. "I turn the lights off, and I shine the Wood's light, and I find the margin changes."

After removing the center scar and residual lesions, he will create a standard Mohs rim and repeat frozen sections until the area is "clear." He recommended that the permanent rim always have an additional 2-mm margin.

Nonmelanoma fibrous tumors are also candidates for Mohs surgery. "These are tumors that look fairly small and end up fairly large," he said.

With Merkel cell carcinoma, however, the choice of therapy is difficult to make. "Mohs may or may not be indicated," said Dr. Swanson.

"Leave to the head and neck surgeon to take margins, and hit it with everything you have in the first go-around," he suggested.

Mohs surgery can be effective for leiomyosarcoma and carcinomas in the eyelid, he continued.

Angiosarcoma has very a poor prognosis, however. Although some physicians have attempted to treat it with Mohs surgery, Dr. Swanson said he has not and will not do so. ■

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