

Partial Closure After Mohs Can Be Optimal Choice

Technique beneficial for high-tension areas and the monitoring of tumor recurrence.

BY DAMIAN McNAMARA
Miami Bureau

ORLANDO — Partial closure after Mohs surgery offers many benefits for some candidates, J. Robert Hamill Jr., M.D., said at the annual meeting of the Florida Society of Dermatologic Surgeons.

He suggested that dermatologic surgeons consider partial closure for:

► Surgical sites under high tension, including legs, scalp, and fingers. "Scalps can be tight and can be very painful," Dr. Hamill said. "When I first started I closed everything completely."

► Surgery confined to one anatomic unit, which facilitates a favorable cosmetic outcome. This applies in particular to the eyelids, nose, lips, and ears. "Keep this in mind because your surgical result will be better," Dr. Hamill said. "Anytime I can stay within an anatomical unit, I will do it."

► Sites where surgery might compromise function, especially the eyelids, lip, nose, and fingers.

► Surgical sites where complete closure

might cause ischemia or necrosis.

"Another benefit is monitoring for recurrence of tumor by not covering the defect," said Dr. Hamill, who is in private practice in Hudson, Fla. A partial closure decreases surgery time, he added.

"Many areas granulate well with no closure," Dr. Hamill said. For example, he partially closed a Mohs defect on a patient's chest and allowed the rest to granulate. Although the outcome was good, "patients like these have to be followed closely," he advised.

In addition, Dr. Hamill chose a partial closure for a patient who had squamous cell carcinoma on his ear.

"I could have done an extensive, two-stage procedure, but the patient wanted something simple," Dr. Hamill said.

"I let it granulate in. It was very functional, and the patient was very happy."

A patient with a small basal cell lesion on his scalp ended up with a large defect after Mohs surgery. "The patient was already thinning on top. You will have traction alopecia" if you do a complete clo-

sure, Dr. Hamill said at the meeting.

A partial closure yielded a good result at 2 weeks post operatively; 3 years post operatively there was no additional hair loss.

Lines of relaxed tension are the best place to hide surgical scars, Dr. Hamill said. Pull normal skin as tight as possible and anchor it onto subcutaneous tissue or cartilage with a partial closure, Dr. Hamill suggested. "It's a great trick to increase the chance of flap survival."

A simple advancement flap with partial closure works well for surgery on a digit,

Dr. Hamill said. Maintain a digit in a hyperextended position during surgery so the tightness is easily gauged, he suggested.

Partial closure can be handy for surgery close to the eyes to avoid ectropia. "Ectropia can be a problem, especially in the elderly," Dr. Hamill said. With a partial closure, the area with the highest tension can be removed and left to granulate in. "I have patients sit up so I can see if there is ectropia, he said. "There is no sense in doing the surgery and then having the patient sit up." ■

Dermoscopy Recommended Over Most Melanoma-Imaging Tools

BY TIMOTHY F. KIRN
Sacramento Bureau

NAPLES, FLA. — Several new technologies are becoming available to follow and visualize melanomas, but practicing dermatologists will be best served if they focus on learning dermoscopy, Harold S. Rabinovitz, M.D., said at the annual meeting of the Florida Society for Dermatology and Dermatologic Surgery.

Current estimates are that about 15% of U.S. dermatologists use dermoscopy, said Dr. Rabinovitz, of the department of dermatology at the University of Miami.

Even experienced dermatologists are not perfect at differentiating between malignant melanoma and benign melanocytic nevi, he said. Studies have found the overall diagnostic accuracy of dermatologists to be about 65%. Dermoscopy improves diagnostic accuracy over visual inspection by about 15%, Dr. Rabinovitz said.

Once dermoscopy technique is learned, it does not take much extra time to do, which makes it convenient and practical. The obstacle is learning to do dermoscopy well, he added.

"There is a steep learning curve," he said. "In dermoscopy, a little knowledge is worse than no knowledge. It is only a diagnostic aid, as pathology is the reference standard."

The other melanoma-diagnosing technologies that are available or in development, he said, are impractical or their future is uncertain.

For instance, total-body photography, even with today's digital photography and computer software, requires too much time to take and review the photographs. When Dr. Rabinovitz does total-body photography for appropriate, high-risk patients, he says he gives patients CD copies of the digital photos. When they have a concern about a particular nevus, they can compare it to the photographic record. "Full-body photography, in my opinion, is for the patients."

Confocal imaging, like dermoscopy, allows visualization of structures below the surface, but on the horizontal plane. This imaging system is being used in several studies, including one on tracking imiquimod treatment of in situ melanoma. But confocal imaging is a research tool and probably will remain one, he said, because dermoscopy is available, and because biopsy will remain the standard of diagnosis.

Image-analyzing computer programs for use with dermoscopy and photography are in development, and could have great promise because the computer might be able to pick up things the eye may miss, he said. But their introduction into the market is probably at least a few years away, even if problems in analyzing some histologic features can be worked out.

"My advice to you is to learn dermoscopy," Dr. Rabinovitz said. "Over the years, I believe this will be an important tool and aid for dermatologists in the management of their patients."

Dr. Rabinovitz said he knows of four companies that sell dermoscopy equipment. He did not recommend any one product, but he did advise that the best course of action is to buy the latest model of equipment. ■

Once dermoscopy technique is learned, it does not take much extra time to do, which makes it convenient. The obstacle is learning to do it well.

Salex™ (6% Salicylic Acid) Cream

Rx Only
FOR TOPICAL USE ONLY. NOT FOR OPHTHALMIC, ORAL OR INTRAVAGINAL USE.

INDICATIONS AND USAGE

For Dermatologic Use: Salex™ Cream is a topical aid in the removal of excessive keratin in hyperkeratotic skin disorders, including verrucae, and the various ichthyoses (vulgaris, sex-linked and lamellar), keratosis palmaris and plantaris, keratosis pilaris, pityriasis rubra pilaris, and psoriasis (including body, scalp, palms and soles).

For Podiatric Use: Salex™ Cream is a topical aid in the removal of excessive keratin on dorsal and plantar hyperkeratotic lesions. Topical preparations of 6% salicylic acid have been reported to be useful adjunctive therapy for verrucae plantares.

CONTRAINDICATIONS

Salex™ Cream should not be used in any patient known to be sensitive to salicylic acid or any other listed ingredients. Salex™ Cream should not be used in children under 2 years of age.

WARNINGS

Prolonged use over large areas, especially in children and those patients with significant renal or hepatic impairment, could result in salicylism. Concomitant use of other drugs which may contribute to elevated serum salicylate levels should be avoided where the potential for toxicity is present. In children under 12 years of age and those patients with renal or hepatic impairment, the area to be treated should be limited and the patient monitored closely for signs of salicylate toxicity: nausea, vomiting, dizziness, loss of hearing, tinnitus, lethargy, hyperpnea, diarrhea, and psychic disturbances. In the event of salicylic acid toxicity, the use of Salex™ Cream should be discontinued. Fluids should be administered to promote urinary excretion. Treatment with sodium bicarbonate (oral or intravenous) should be instituted as appropriate.

Due to potential risk of developing Reye's syndrome, salicylate products should not be used in children and teenagers with varicella or influenza, unless directed by a physician.

PRECAUTIONS

For external use only. Avoid contact with eyes and other mucous membranes.

DRUG INTERACTIONS

The following interactions are from a published review and include reports concerning both oral and topical salicylate administration. The relationship of these interactions to the use of Salex™ Cream is not known.

I. Due to the competition of salicylate with other drugs for binding to serum albumin the following drug interactions may occur:

DRUG	DESCRIPTION OF INTERACTION
Sulfonylureas	Hypoglycemia potentiated.
Methotrexate	Decreases tubular absorption; clinical toxicity from methotrexate can result.
Oral Anticoagulants	Increased bleeding.

II. Drugs changing salicylate levels by altering renal tubular reabsorption:

DRUG	DESCRIPTION OF INTERACTION
Corticosteroids	Decreases plasma salicylate level; tapering doses of steroids may promote salicylism.
Acidifying Agents	Increases plasma salicylate level.
Alkalinizing Agents	Decreases plasma salicylate levels.

III. Drugs with complicated interactions with salicylates:

DRUG	DESCRIPTION OF INTERACTION
Heparin	Salicylate decreases platelet adhesiveness and interferes with hemostasis in heparin-treated patients.
Pyrazinamide	Inhibits pyrazinamide-induced hyperuricemia.
Uricosuric Agents	Effect of probenecid, sulfipyrazone and phenylbutazone inhibited.

The following alterations of laboratory tests have been reported during salicylate therapy:

LABORATORY TESTS	EFFECT OF SALICYLATES
Thyroid Function	Decreased PBI; increased T ₁ uptake.
Urinary Sugar	False negative with glucose oxidase; false positive with Clintest with high-dose salicylate therapy (2-5g q.d.).
5-Hydroxyindole acetic acid	False negative with fluorometric test.
Acetone, ketone bodies	False positive FeCl ₃ in Gerhardt reaction; red color persists with boiling.
17-OH corticosteroids	False reduced values with > 4.8g q.d. salicylate.
Vanilmandelic acid	False reduced values.
Uric acid	May increase or decrease depending on dose.
Prothrombin	Decreased levels; slightly increased prothrombin time.

Pregnancy (Category C): Salicylic acid has been shown to be teratogenic in rats and monkeys. It is difficult to extrapolate from oral doses of acetylsalicylic acid used in these studies to topical administration as the oral dose to monkeys may represent six times the maximal daily human dose of salicylic acid when applied topically over a large body surface. There are no adequate and well-controlled studies in pregnant women. Salex™ Cream should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Because of the potential for serious adverse reactions in nursing infants from the mother's use of Salex™ Cream, a decision should be made whether to discontinue

nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No data are available concerning potential carcinogenic or reproductive effects of Salex™ Cream. It has been shown to lack mutagenic potential in the Ames *Salmonella* test.

ADVERSE REACTIONS

Excessive erythema and scaling conceivably could result from use on open skin lesions.

OVERDOSAGE

See Warnings.

DOSE AND ADMINISTRATION

The preferable method of use is to apply Salex™ Cream thoroughly to the affected area and occlude the area at night. Preferably, the skin should be hydrated for at least five minutes prior to application. The medication is washed off in the morning and if excessive drying and/or irritation is observed a bland cream or lotion may be applied. Once clearing is apparent, the occasional use of Salex™ Cream will usually maintain the remission. In those areas where occlusion is difficult or impossible, application may be made more frequently; hydration by wet packs or baths prior to application apparently enhances the effect. Unless hands are being treated, hands should be rinsed thoroughly after application.

HOW SUPPLIED

Salex™ Cream is available in 400 gram (NDC 0064-4010-13) bottles.

Store at controlled room temperature 20° - 25°C (68° - 77°F). Do not freeze.

Salex™
(6% Salicylic Acid)
Cream

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