

Partial Closures May Yield Better Results Post Mohs

Preliminary data suggest that partial closures may be associated with a reduced risk of infection.

BY MIRIAM E. TUCKER
Senior Writer

LUCAYA, BAHAMAS — Partial closure is an underutilized technique that can improve the outcome of surgical reconstruction after Mohs surgery for many patients, Dr. J. Robert Hamill Jr. said at a meeting of the American Society for Mohs Surgery.

Indeed, closing only part of the wound and leaving the rest to granulate on its own is advantageous in a wide variety of situations. Surgical sites to consider for partial closure include:

- ▶ Tumor sites that need to be monitored for recurrence.
- ▶ Surgical sites under high tension, including the leg, scalp, and fingers.
- ▶ Sites where function may become compromised, especially the eyelid, lip, nose, and finger.

▶ Sites where complete closure may cause ischemia or necrosis.

"You don't have to close every defect," said Dr. Hamill of the department of dermatology at the University of South Florida, Tampa, who also has a private dermatology practice in Hudson, Fla.

Many areas granulate well without any closure, especially in the concave areas on the nose, eyelid, ear, and temple—the so-called NEET areas (J. Am. Acad. Dermatol. 1983;9:407-15).

Surgical scars will have the best results when they are kept within anatomical units (especially the eyelids, nose, lips, and ears), and are best hidden within the lines of relaxed tension. Indeed, an overriding principle is that "the best surgical scar is the one you don't need to extend," he said.

Partial closures allow you to shorten a scar and to decrease overall surgery time, a particularly important consideration in elderly patients.

Some preliminary data even suggest that partial closures—by not creating a dead space—may be associated with a reduced risk of postsurgical infection. Avoiding infection is becoming especially critical in

this era of methicillin-resistant *Staphylococcus aureus*, Dr. Hamill said.

It's important to warn patients that there will be a small hole or wound in the area you've partially closed, which may take up to 2-3 weeks to completely heal. During this time, there may be crusting or oozing that may require cleaning. Depending on their comfort level, patients can either clean the wound themselves or come back to your office.

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"Patients are very receptive to partial closures as long as you tell them up front what to expect," said Dr. Hamill.

Partial closure is also the best option any time there is a risk for ectropion. "If a closure results in pulling, I always adjust the flap by placing the patient in a seated position and removing sutures, [thereby] creating a partial closure so there is no ectropion immediately after suturing," he noted.

In some cases, it may even make sense to consider a partial closure after a complete one in areas of high tension, such as the leg or scalp. If you've done a complete closure in such an area, try waiting 5 minutes, he advised.

If the area looks white and ischemic, you may want to take out a few sutures to create a partial closure. This will allow the flap to completely take and is always better than partial necrosis. A clinical pearl is to debride the new partial defect every 2 weeks so that the defect heals from within, thus preventing a depressed scar, he said.

And another clinical pearl: When using a simple transposition flap, it may be possible to subdivide the defect to create two separate but smaller areas of granulation, rather than one larger area. Doing so may reduce the healing time and produce a smaller scar. This technique is especially useful on the nose if a complete closure pulls the tip and results in congested breathing.

"You can make a very complex closure simple and prevent functional deficit," Dr. Hamill said.

Overall, the aim is to "keep it simple and work with nature," he said. ■



This patient had ectropion that resulted from the closure of a lateral advancement flap used to repair a defect on her lower eyelid.



The partial closure was created by removing the medial superior sutures until the ectropion was no longer present.



One month after surgery, there is no ectropion with only minimal swelling, which eventually resolved over the next few months.

PHOTOS COURTESY DR. J. ROBERT HAMILL JR.

Plastic Surgeon Offers Different Specialty Perspective on Biopsy

BY KAREN DENTE
Contributing Writer

NEW YORK — Plastic surgeons' approach to nevi in challenging anatomical locations may differ from that of dermatologists, said Dr. Barry Zide at a dermatology conference sponsored by New York University.

"When I look at nevi, I have questions that have to be asked: Can it be shaved? What residual or abnormal pigment will occur,

and why? How many aesthetic units are involved? What ancillary methods can be used? How many steps will it take?" said Dr. Zide, professor of plastic surgery at New York University, New York.

One thing to avoid is scab formation after shaving. This can be prevented by not allowing the shaved area to dry out. "Patients have to keep [an adhesive bandage] on for 7-10 days postop," Dr. Zide said.

"A bulky nevus of the nose has a minimal tendency to be malignant, so you can leave some nevus without taking the whole thing off," said Dr. Zide, referring to a case in which he did not have to biopsy the whole lesion but worked with shaving, abrasion, and electrolysis to manage the lesion. The advantage to this approach is that it leaves no reconstructive defect.

For dark lesions located above the tip of the nose, skin grafting

is an option. "It is important to think in terms of aesthetic units," he said, adding, "The best place for a graft of the nose is the forehead. It has good color." A patch and edges are not perfect, so sanding the units post dermabrasion over a wide area that is not just limited to the actual skin graft is important. "Think big on dermabrasion, even though the graft can be small."

When confronted with a big nevus in a very young child, re-

member that in babies younger than 4 months old, there is a lot of skin to work with because their skin on the head hasn't yet firmly bound to the scalp. "You can take a lot of skin and do a straight excision in some cases, or a W-plasty," Dr. Zide explained.

Sometimes multiple steps are needed. Patients should always be informed of and prepared for the biopsy of a nevus to entail several steps. ■