

'Drumhead' Technique May Spare Alar Graft Depressions

ARTICLES BY
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PALM DESERT, CALIF. — A better method for skin grafting surgical defects of the nasal alar region may be what Dr. Bradley K. Draper calls a "drumhead" graft.

Deep alar defects can be difficult to graft without leaving a sunken depression, and a graft that fails can compromise nasal support and compromise breathing through that nasal passage, Dr. Draper said at the annual meeting of the American Society for Dermatologic Surgery.

So, he devised a technique in which gauze supports are attached to both sides of the graft and defect to pull the wound bed up to a tight graft, resulting in a better cosmetic and functional result.

Dr. Draper, a Mohs surgeon in Billings, Mont., described performing the graft on patients with Mohs defects that were up to 1 cm in depth, on the lower third of the nose.

To perform his drumhead

technique, Dr. Draper explained he harvests the graft tissue from either the postauricular region or below the earlobe for the best tissue match.

He fashions the graft so that it is slightly smaller than the defect, so that when it is sutured into place it is tight over the defect like a drumhead.

Once the graft is sutured into place, Dr.

Draper drives a 4.0 Prolene suture through the graft and the nasal mucosa into the nasal vestibule. He then returns the suture through the mucosa and the graft, leaving a loop. Into the loop, he puts a gauze bolster impregnated with antibiotic ointment, which is pulled up into the vestibule against the mucosa.

Dr. Draper explained that he next creates a strut out of the inner packing material of the suture package, and then ties that to the top of the graft.

The assembly of bolster and



Attaching a strut produces pressure on the back of the graft for 10 days.

COURTESY DR. BRADLEY K. DRAPER

strut "accomplishes two things," Dr. Draper said at the meeting. "It provides a suspensory effect over the surface of the graft, as well as pulls the intranasal bolster taut up against the graft bed so the bed comes into contact with the overlying skin graft."

The assembly remains in place for 10 days, which is the only real drawback of the technique.

"If you do this, tell your patients that you understand that they are not going to like having that intranasal bolster but that it is necessary," Dr. Draper said. ■

Know Section Thickness Prior to Mohs Surgery

SAN DIEGO — Since most Mohs surgeons want at least a 1-mm clear margin around a basal cell or squamous cell carcinoma, it is crucial to know how many slices were taken between frozen sections mounted for review, Dr. John Campbell said at a meeting sponsored by the American Society for Mohs Surgery.

Dr. Campbell, a San Diego pathologist with an interest in Mohs surgery, said that planning and consistency in how a block of tissue is sectioned by the cryostat's microtome is of the utmost importance to performing good Mohs surgery.

By averaging out the amount of tissue that disappears when the microtome slices a block of tissue, it appears that about 3 μm of tissue are lost for every 10 μm in most microtomes, Dr. Campbell said at the meeting.

Therefore, he recommends that the microtome be set to make slices every 7 μm, and that every 20th section get mounted on the slide. When the mounting is that consistent, then

it is easy to know exactly how many clear sections one must see before declaring a margin clear—in this case, five to six sections.

Dr. Campbell instructs the cryostat technicians he works with that he wants to see the first mounted tissue section within the first 100 μm of tissue whenever possible.

To be considered a proper and countable section, a section should have epithelium visible around 90% of the section edge.

Sometimes, though, when it is not possible to get a section without a hole in the middle, or skin all the way around the edge, it does not hurt to have incomplete sections mounted for the physician to at least see, he noted.

Although some surgeons claim to need less than a 1-mm clear margin around a tumor and that the amount of clear tissue necessary depends on the tumor type, 1 mm of clear tissue is a good, fairly conservative option for margins, Dr. Campbell said. ■

Before and After Photos Can Help Market a Mohs Practice

SAN DIEGO — When Dr. Edward Yob moved to Oklahoma 16 years ago, he became the first physician in that state to perform Mohs surgery. The dermatologists in Oklahoma, however, were not impressed.

They saw no need for such a fancy approach, Dr. Yob said at a meeting sponsored by the American Society for Mohs Surgery.

As a result, he learned to woo a constituency. One practice he has adopted is to take before and after pictures of his cases, and he sends them



"Show [referring physicians] how you can do small tumors and intricate locations."

DR. YOB

to the referring physician when he sends the patient back after Mohs, said Dr. Yob, who practices in Tulsa.

He sends the pictures along with a letter and his preprocedure and postprocedure reports. Dr. Yob uses a Nikon CoolPix 990 digital camera because it has a pivot hinge that lets one take pictures at any angle.

One purpose of the pictures is to advertise his skills, but another is to let the referring physicians know that a case does not have to be a huge tumor or be in an intricate location for Mohs referral. Those obviously are not the only cases a

Mohs surgeon wants to have to do, Dr. Yob noted.

"It's really just a marketing gimmick, even though that is not all it is," he said. "Show them how you can do small tumors and intricate locations."

The patient records should include a preprocedure report with a diagnosis and location.

The postprocedure report should include mention of any special techniques used, anything such as actinic keratoses in the region but left behind, and

a histology report.

The operative report should include the Mohs map used during the procedure with a code for the symbols depicting the inking colors used.

When physicians start a Mohs practice, they also need to keep in mind that referrals actually can drop off a little as one becomes established. That is not because one is doing anything wrong. Instead, many areas without a Mohs surgeon can have something of a backlog of cases, and once that backlog gets taken care of, business can drop off a bit, Dr. Yob said. ■

New to Mohs Surgery? Allot Plenty of Time to First Cases

SAN DIEGO — Neophyte Mohs surgeons should start with an easy case, ideally with a lesion located anywhere other than on the face, and, if possible, give the case an entire day on the schedule.

That was just one bit of advice given by Dr. Howard K. Steinman at a meeting sponsored by the American Society for Mohs Surgery.

Another tip provided by Dr. Steinman, one of the meeting's organizers, was that one should photograph the lesion on the day one first sees the patient, at the time of the evaluation.

Sometimes, a lesion readily apparent on the day of the evaluation is not so obvious on the day of surgery, and to illustrate his point, Dr. Steinman showed a picture of a biopsy-confirmed lesion that had almost completely disappeared when the patient showed up for surgery. It would have been difficult to find that lesion again if not for the picture, Dr. Steinman noted.

Some surgeons curette a lesion before taking the first Mohs stage, and some surgeons do not, Dr. Steinman pointed out, but he said it can be helpful in planning the procedure, particularly because it can give the surgeon a better idea of tumor depth.

In Mohs, when the surgeon takes the first stage, the blade should be angled at 45 degrees, not so much so the lesion can

be removed easily as so it will lay flat when being sectioned. And, the stage should be taken at a depth one tissue layer below the expected margin of the lesion.

The key to removing the lesion is marking it with reference marks before it is removed from the patient and with the different colors appropriately after it is removed.

Otherwise, it is too easy for the specimen to fall to the floor, or be turned inadvertently, or even flipped while being sliced in the cryostat, with the result that the surgeon becomes uncertain where the proper margin is, explained Dr. Steinman, who practices in Chula Vista, Calif.

The making of the reference marks around the lesion to be removed is, of course, up to the surgeon but a common practice is to use five, one at what is decided will be the 12 o'clock mark on the specimen, and one each at 9, 6, and 3 o'clock. The fifth mark goes immediately next to the 12 o'clock reference mark, usually, so that mark can be distinguished, he added.

Reasons for a second stage, in the absence of tumor that clearly crosses the edge of the section, include a hole in the section, misorientation because the section is not clearly marked, and/or dense inflammation at the edge of the section, which can indicate tumor, Dr. Steinman said. ■