



ORIGINAL ARTICLE

# Conventional Surgery Compared With Slow Mohs Micrographic Surgery in the Treatment of Lentigo Maligna: A Retrospective Study of 62 Cases<sup>☆</sup>

H. Hilari, D. Llorca, V. Traves, A. Villanueva, C. Serra-Guillén, C. Requena, B. Llombart, O. Sanmartín, C. Guillén, E. Nagore\*

*Servicio de Dermatología, Instituto Valenciano de Oncología, Valencia, Spain*

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## KEYWORDS

Lentigo maligna;  
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Mohs surgery;  
Surgical margin;  
Recurrence

## Abstract

**Introduction:** Surgical excision with margins of 0.5 cm is the standard treatment for lentigo maligna (LM). Excision, however, is often incomplete as many of these tumors have indistinct borders.

**Objective:** To identify clinical predictors of subclinical extension in primary and recurrent LM of the head and thereby determine which lesions might require wider surgical margins.

**Material and methods:** We reviewed the clinical records of patients with LM of the head treated definitively with conventional surgical excision or slow micrographic Mohs surgery (MMS) at the dermatology department of Instituto Valenciano de Oncología between January 1993 and April 2011.

**Results:** Surgical margins larger than 0.5 cm were required in 69.2% of recurrent LM and 26.5% of primary LM. Factors associated with the need for wider margins were prior treatment that might have interfered with the clinical delineation of the border, lesions in the center of the face, and skin phototypes III to V.

**Conclusions:** Surgical margins of 0.5 cm are inadequate for the treatment of a considerable number of LM lesions located on the head, particularly if these are recurrent. Slow MMS using paraffin-embedded sections appears to be the treatment of choice in such cases, particularly for recurrent lesions or lesions with poorly defined borders or possible subclinical extension.

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\* Corresponding author.

E-mail address: [eduyame@meditex.es](mailto:eduyame@meditex.es) (E. Nagore).

**PALABRAS CLAVE**

Lentigo maligno;  
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Margen quirúrgico;  
Recidiva

## Tratamiento quirúrgico del lentigo maligno: cirugía convencional vs. Mohs diferida. Estudio retrospectivo de 62 casos

**Resumen**

**Introducción:** El tratamiento estándar del lentigo maligno (LM) es la escisión quirúrgica con márgenes de 0,5 cm. Sin embargo, dada la mala delimitación de muchos tumores, es frecuente que esta exéresis sea incompleta.

**Objetivo:** identificar parámetros clínicos que puedan predecir qué LM localizados en la cabeza, extirpados de forma primaria o tras recidivar, se extienden más allá de los límites visibles y por tanto, puedan requerir márgenes quirúrgicos más amplios.

**Material y métodos:** se revisó retrospectivamente la información clínica de los pacientes con LM localizado en la cabeza cuyo tratamiento quirúrgico definitivo, mediante cirugía convencional o cirugía de Mohs diferida, fue realizado en el Servicio de Dermatología del Instituto Valenciano de Oncología (IVO) entre enero de 1993 y abril de 2011.

**Resultados:** un 69,2% de los LM recidivados y un 26,5% de los tumores primarios requirieron márgenes de más de 0,5 cm. La administración previa de tratamientos que puedan interferir en la delimitación clínica, la localización centrofacial y las lesiones que se presentan en pacientes con fototipos altos (III-V) fueron los factores asociados a la necesidad de márgenes quirúrgicos más amplios.

**Conclusiones:** la utilización de márgenes de 0,5 cm para el tratamiento del LM es insuficiente para un número importante de casos localizados en la cabeza, especialmente los recidivados. La cirugía de Mohs diferida, con el estudio de todos los márgenes en parafina, parece el tratamiento de elección en particular para los casos recidivados o en los que la delimitación clínica pueda verse dificultada.

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**Introduction**

Lentigo maligna (LM) is a subtype of melanoma in situ that develops in older patients, typically appearing in sun-exposed skin that has suffered chronic actinic damage.<sup>1</sup> The standard treatment for LM is surgical excision of the tumor with margins of 0.5 cm. Excision is often incomplete, however, as many of these tumors have indistinct borders.<sup>2-5</sup> Between 6% and 20% of LM melanomas recur, probably because tumor cells have spread beyond the clinically apparent border and because conventional histology evaluates only 5% of the margin removed.<sup>6-8</sup> The subclinical extension of the LM seems to be related to tumor size and some authors have therefore suggested that when larger tumors are removed, larger margins should be taken to ensure complete excision.<sup>9</sup> In fact, the latest recommendations of the National Comprehensive Cancer Network state that margins wider than 0.5 cm may be necessary for complete removal and that it is advisable to perform complete circumferential peripheral and deep margin assessment.

Various surgical techniques, such as Mohs surgery in its different forms, facilitate the evaluation of 100% of the tumor margin while minimizing the removal of healthy surrounding tissue.<sup>10</sup> Several retrospective studies have shown that these methods can reduce LM recurrence to between 0.5% and 3%.<sup>9,11-15</sup> Most authors prefer some version of slow Mohs surgery in which paraffin-embedded tissue is processed because it is difficult to identify melanocytes in frozen sections even with the aid of immunohistochemical staining.<sup>6,16-19</sup> We have also observed fewer recurrences since we implemented the Mohs technique in our practice. In most cases the tumor can be removed in a single stage, but more than 2 stages may be required in some patients.

The size of the LM melanoma, and perhaps other clinical features, potentially affect the margin width that would be adequate for curative excision. We hypothesized that there may be a correlation between certain clinical LM features and the likelihood of subclinical spread. If so, we think that identifying such features would allow us to plan the most appropriate approach, whether using conventional surgery with preestablished margins or slow Mohs surgery.

The main aim of this study was to identify the clinical variables that can predict which primary or recurrent LM melanomas located on the head are likely to have spread beyond the visible borders and therefore require us to remove wider margins. The second aim was to determine the ideal surgical margin required for a cure, according to the selected clinical variables.

**Methods**

The patients included had LM melanomas on the head that were definitively treated with conventional or slow Mohs surgery by the dermatology department of the Instituto Valenciano de Oncología between January 1993 and April 2011. All patient and lesion data as well as images related to these cases were extracted from the institute's melanoma database<sup>20</sup> for retrospective analysis.

Conventional surgery consisted of excision of the visible tumor plus a margin extending 0.5 cm from the visible border followed by conventional histology, in which lateral and deep margins were sliced thinly and evaluated separately. In the slow Mohs procedure the paraffin-embedded tissue is sectioned and processed according to the usual Mohs procedure. All portions of the margins are examined and the

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