

Practice and Educational Gaps in Surgery for Skin Cancer



Murad Alam, MD, MSCI, MBA^{a,b,c,*}, Abigail Waldman, MD^a,
Ian A. Maher, MD^d

KEYWORDS

• Practice gaps • Educational gaps • Skin cancer • Surgical treatment

KEY POINTS

- This article defines the current practice in surgical treatment of skin cancers by dermatologists, gaps in practice, and mechanisms to improve current surgical practice.
- Although treatment of more common nonmelanoma skin cancers is standardized, differential access and availability of specialty services and a lack of guidelines for several rare skin cancers can result in inconsistent treatment.
- Affiliations or referral to academic or larger medical centers for the treatment of complex skin cancers and the development of best practice guidelines for aggressive or rare tumors may remedy the shortcomings in current practice.
- Additionally, education in dermatologic surgery and management of skin cancer is improved by exposing residents to more cases of complex tumor management during training, including simulation of complex tumor cases, continuity clinics, and encouraging postresidency training when appropriate.

Surgery for skin cancer is a major part of clinical dermatology, and the largest single component of dermatologic surgery practice. In general, residency training in dermatology provides comprehensive training in the theory and practice of skin cancer surgery. Practicing dermatologists are similarly expert in this area, and frequently assist other medical and surgical services by managing and coordinating the care of patients with skin cancer. Even so, there are some minor gaps in training and practice that bear scrutiny and are amenable to rectification.

PRACTICE GAPS IN CLINICAL DERMATOLOGY PRACTICE

Best Practices

Best practices for surgery for skin cancer vary based on the histologic type of cancer, clinical features of the cancer, and patient-specific factors. Still, there are some common elements in appropriate care (**Box 1**).

Before surgery, key data pertaining to the case are obtained, collated, and reviewed. Relevant information includes the biopsy reports and any other laboratory tests or diagnostic imaging.

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^a Department of Dermatology, Feinberg School of Medicine, Northwestern University, 676 North St. Clair Street, Suite 1600, Chicago, IL 60611, USA; ^b Department of Otolaryngology, Feinberg School of Medicine, Northwestern University, 676 North St. Clair Street, Suite 1600, Chicago, IL 60611, USA; ^c Department of Surgery, Feinberg School of Medicine, Northwestern University, 676 North St. Clair Street, Suite 1600, Chicago, IL 60611, USA; ^d Department of Dermatology, Saint Louis University, 1755 South Grand Blvd., St Louis, MO 63104, USA

* Corresponding author. Department of Dermatology, 676 North St. Clair Street, Suite 1600, Chicago, IL 60611. E-mail address: m-alam@northwestern.edu

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Box 1**Surgery of the skin: practice gaps***Best Practice*

- Before surgery, key data pertaining to the case are obtained, collated, and reviewed. Additional diagnostic tests or confirmatory reads of existing raw data by additional specialized authorities (eg, dermatopathology, radiology) may be required.
- Staging of the tumor, if appropriate, is performed in accordance with American Joint Committee on Cancer criteria and other clarifying literature. Reference to clinical practice guidelines, including those promulgated by the National Comprehensive Cancer Network and relevant specialty societies (eg, American Academy of Dermatology, American Society for Dermatologic Surgery), is considered.
- Appropriate referral when medically necessary.
- Appropriate follow-up care to monitor for recurrence or new primary tumors.

How Current Practices Differ from Best Practice

- Differential access and availability of other specialty services that may be required to manage complex or aggressive skin cancers.
- No available guidelines of care for several rare skin cancers resulting in inconsistent treatments across centers.

Barriers to Best Practice Implementation

- Atomized nature of dermatology practice that may not be in proximity to referral centers or other specialists' offices.
- Barriers to development of more detailed practice guidelines and guidelines for the management of rare circumstances include limitations in the medical evidence.

Strategies to Overcome Barriers

- Affiliations with local academic medical centers or multispecialty practices may help overcome this barrier. Provisions for such alliances will likely need to overcome financial and regulatory disincentives to collaboration.
- Development of large prospective databases documenting patient care parameters by the American Academy of Dermatology and the American College of Mohs Surgery Formation of consensus groups to develop practice guidelines for management of aggressive or rare skin tumors.

Unusual findings on diagnostic tests may suggest the need for additional tests, or confirmatory reads of existing raw data by additional specialized authorities (eg, dermatopathology, radiology). Staging of the tumor, if appropriate, is performed in accordance with American Joint Committee on Cancer criteria and other clarifying literature. Reference to clinical practice guidelines, including those promulgated by the National Comprehensive Cancer Network and relevant specialty societies (eg, American Academy of Dermatology, American Society for Dermatologic Surgery), is considered. Aspects of care where guidance is unavailable or ambiguous can be determined by consideration of patient-specific factors; discussion with the patient, patient's family, and other members of the medical team; and if appropriate, via a formal ethics board or tumor board consultation. When care in addition to dermatologic surgery may be necessary, additional referrals may be made to other specialists (eg, surgical oncology, plastic surgery, head and neck surgery,

urogynecological surgery, transplant medicine or surgery, medical oncology, and radiation oncology). After surgery, appropriate follow-up care to monitor for recurrence or new primary tumors is implemented. Dysfunction or disfigurement resulting from prior surgeries is managed (eg, treatment of hypertrophic or symptomatic scars, treatment of functional asymmetry).

Current Practice

Current practice is variable. Treatment of primary and recurrent basal cell carcinomas and squamous cell carcinomas of small to moderate size and low to moderate risk is consistent at many centers. Higher risk lesions are addressed by Mohs surgery, with lower risk tumors treated by excision, electrodesiccation and curettage, or other methods. In general, National Comprehensive Cancer Network guidelines are observed.

Treatment of higher risk tumors, including locally advanced or metastatic basal cell

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