



ORIGINAL ARTICLE

Reconstructive methods in Mohs micrographic surgery in Uruguay: A bidirectional descriptive cohort analysis



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Received 29 December 2016; accepted 14 October 2017

KEYWORDS

Mohs micrographic surgery;
Skin cancer;
Basal cell carcinoma;
Squamous cell carcinoma;
Esthetics

Abstract

Background and objectives: The primary goal of Mohs micrographic surgery (MMS) is to completely excise a cancerous lesion and a wide range of reconstructive techniques of varying complexity are used to close the resulting wound. In this study, we performed a descriptive analysis of patients who underwent MMS, with a focus on wound closure methods.

Material and methods: We conducted a bidirectional descriptive cohort analysis of all MMS procedures performed by a single surgeon between November 2013 and April 2016. Cosmetic outcomes were photographically assessed by a dermatologist after a minimum follow-up of 90 days.

Results: We analyzed 100 MMS procedures in 71 patients with a median age of 73 years. The tumors were basal cell carcinoma (70%), squamous cell carcinoma (29%), and dermatofibrosarcoma protuberans (1%); 75% were located on the head and neck. The reconstructive techniques used were flap closure (48%), simple closure (36%), closure by second intention (11%), and other (5%). Cosmetic outcomes were assessed for 70 procedures (47 patients) and the results were rated as excellent in 20% of cases, very good in 40%, good in 20%, moderate in 17%, and bad/very bad in 2.9%. No significant associations were observed between cosmetic outcome and sex, Fitzpatrick skin type, hypertension, diabetes mellitus, or smoking. Worse outcomes, however, were significantly associated with larger tumor areas and defects, location on the trunk, and flap and second-intention closure.

Conclusions: Although there was a tendency to use simple wound closure for lesions located on the trunk and surgical defects of under 4.4 cm², the choice of reconstructive technique should be determined by individual circumstances with contemplation of clinical and tumor-related factors and the preference and experience of the surgeon.

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PALABRAS CLAVE

Cirugía micrográfica de Mohs;
Cáncer de piel;
Carcinoma;
Basocelular;
Carcinoma espinocelular;
Estética

Métodos reconstructivos en cirugía micrográfica de Mohs en Uruguay: una cohorte bidireccional descriptiva

Resumen

Introducción y objetivos: El principal objetivo cirugía micrográfica de Mohs es la excisión completa del cáncer de piel, dando lugar a una gran variedad de métodos reconstructivos de distinta complejidad. Objetivo: describir nuestros pacientes operados con cirugía de Mohs, enfocados a métodos de cierre.

Materiales y métodos: Cohorte bidireccional descriptiva de todas las cirugías de Mohs operadas por un mismo cirujano desde noviembre 2013 hasta abril 2016. Tiempo mínimo de 90 días de seguimiento para calificar estética, por un dermatólogo usando fotografías.

Resultados: Setenta y un pacientes y 100 cirugías individuales. Mediana para la edad: 73 años. 70% carcinoma basocelular, 29% carcinoma espinocelular y 1% dermatofibrosarcoma protuberans. 75% en cabeza y cuello. Métodos reconstructivos: colgajos 48%, cierre simple 36%, segunda intención 11%, otros 5%. 70 cirugías (en 47 pacientes) completaron seguimiento a largo plazo para evaluación de resultado estético: 20% excelente, 40% muy bueno, 20% bueno, 17% regular y 2.9% malo/muy malo. No hubo diferencias estadísticamente significativas entre resultado estético y el sexo, fototipo, hipertensión, diabetes mellitus o tabaquismo. Vimos una asociación estadísticamente significativa para peor resultado estético en mayores áreas y defectos, localización en tronco, reconstrucción con colgajo y segunda intención.

Limitaciones: Treinta pacientes se perdieron durante el seguimiento para calificar su resultado estético a los 90 días, el tiempo de evaluación fue altamente variable y no se registró la opinión del paciente.

Conclusiones: Aunque hubo una tendencia por escoger el cierre simple en tronco y defectos <4.4 cm², la decisión debe ser individualizada, considerando las características clínicas/tumorales y preferencia/experiencia del cirujano.

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Introduction

Mohs micrographic surgery (MMS) is a technique for the excision of skin cancer, with histologic examination of 100% of the surgical margins, achieving the highest cure rate with the maximum preservation of surrounding healthy tissue.^{1,2} It is used mainly for basal cell carcinoma (BCC) and squamous cell carcinoma (SCC), however, it is potentially useful in almost any type of skin tumor.

Oncological skin surgery has two clear stages, the first and most important has a curative purpose, in which the tumor must be excised completely. The second is the closure of this defect, which may require complex reconstruction techniques. In a MMS that is properly performed, we have the advantage of knowing we are not covering possible remaining tumor cells under healthy skin from another location (e.g. flaps, grafts). Every Mohs surgeon must have clear knowledge of the different methods of closure, their indications, complications and long-term results.

When choosing between the different reconstructive techniques, the surgeon has to bear in mind numerous factors, such as the anatomic location, size of the tumor, tumor biology as well as the size of the defect. Patient factors must also be considered, including age, esthetic expectations, skin qualities, comorbidities and response to previous interventions (if any). Mohs surgeon factors have a role when it comes to experience and personal preference.³ This choice may change during surgery, since defect size may end up being different than expected upon initial evaluation.

Recurrent/aggressive histology tumors, those with a diameter larger than 1 cm, and location on the nose or ear are more likely to prove surgically complex.⁴

There is a tendency to choose primary closure for smaller defect areas, and more complex closure methods are preferred in larger defects, as well as in esthetically sensitive areas.

The objective of this study was to describe the patients in which MMS was performed in our Dermatologic Surgery Unit, focused mainly on methods of closure.

Materials and methods

We performed a bidirectional cohort descriptive analysis of all the patients that underwent MMS by a single Mohs surgeon in our Dermatologic Surgery Unit since the beginning of this procedure in November 2013 up to April 2016.

Epidemiological and clinical data was obtained (sex, age, skin phototype, comorbidities and smoking habit), tumor characteristics (anatomical location, size, histopathology, primary or recurrent, and risk level accordingly), as well as management criteria (defect size, method of closure, timing of reconstruction and complications).

Smoking habit was labeled as: current smoker (any amount six months before and/or after surgery), past smoker (at least six months before surgery) or never smoked.

Topographically, four big groups were defined: head and neck, upper extremities, lower extremities and trunk. Locations were further subcategorized in head and neck as:

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