

Current trends in Mohs micrographic surgery for the treatment of lentigo maligna and melanoma

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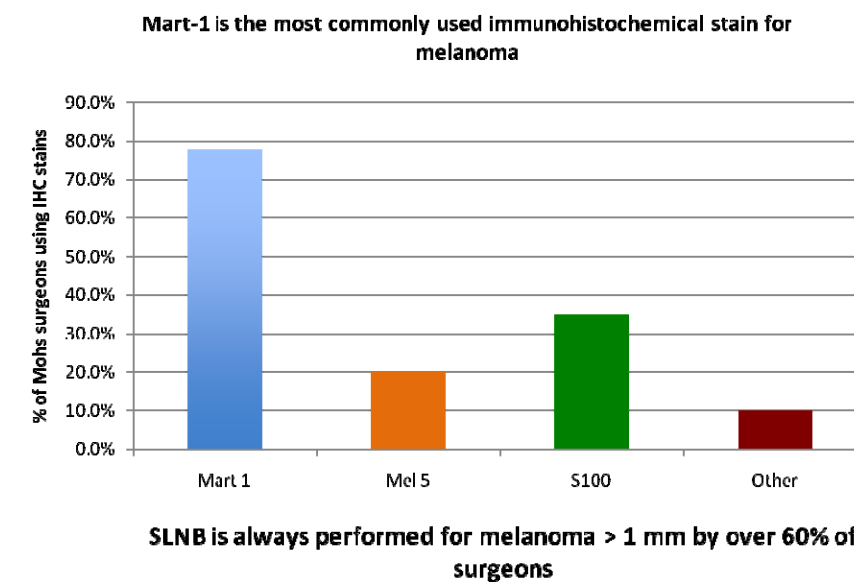
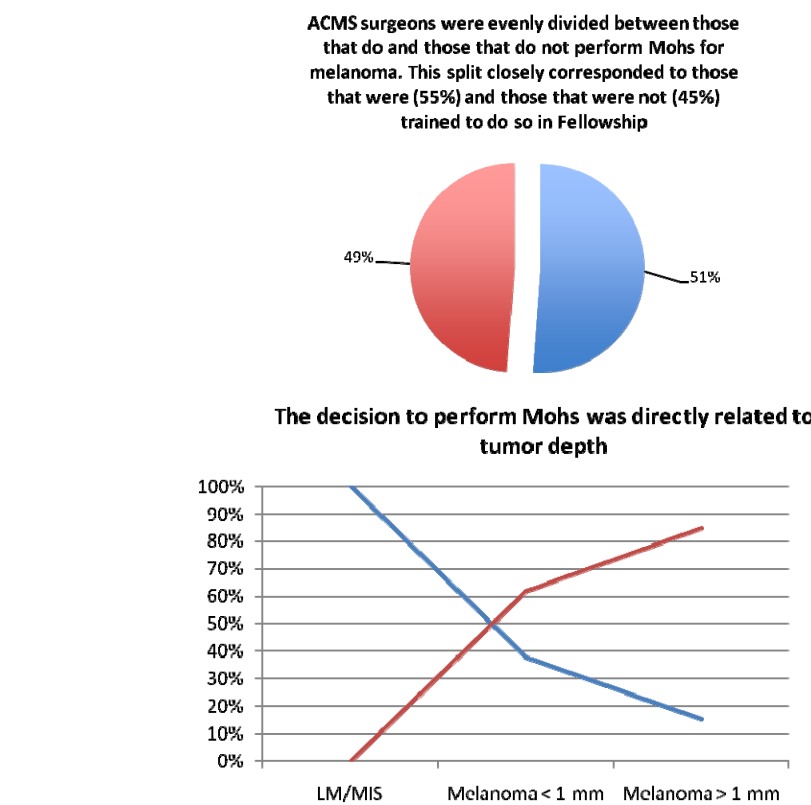
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INTRODUCTION

Surgical excision is the standard of care for melanoma and melanoma in-situ. The optimal surgical method employed is a subject of much debate in the medical literature even among those of the same specialty. Dermatologists and dermatologic surgeons are trained in the diagnosis and management of cutaneous melanocytic tumors and are often the first physicians to diagnose melanoma. Given the discrepancy over the optimal surgical treatment method and the negative implications of suboptimal staging and treatment for this potentially lethal malignancy, investigation into the current practices of members of the American College of Mohs Surgery has become relevant to improving outcomes and moving towards meaningful comparative trials that could drive a consensus statement supporting the optimal surgical method for treating melanoma. This poster presents the results of a web-based survey of the members of the ACMS covering current practice trends in the treatment of melanoma and melanoma in-situ.

METHODS

Using a well-established Internet-based survey platform (surveyMonkey.com), we developed a survey consisting of 25 questions. After obtaining exemption from the Institutional Review Board at Vanderbilt University, we sent the survey electronically to 816 members of the American College of Mohs Surgery enrolled as of March 2009. Analysis of the data was then performed, taking into account minor differences in surgical or diagnostic methodologies noted by members in open-ended, comment-type questions. Those members who do not have an associated email address did not receive the survey. Results were reported via the internal statistical analysis code available within the surveyMonkey website and later interpreted into meaningful data.

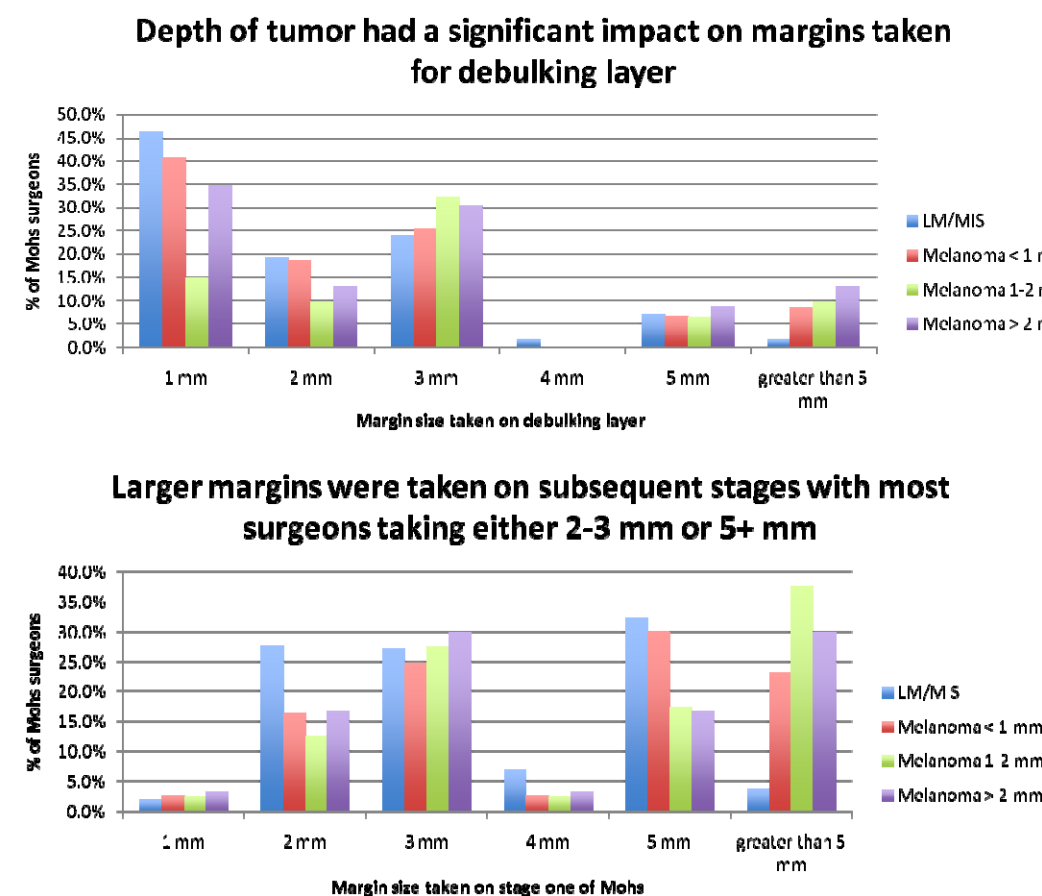


RESULTS

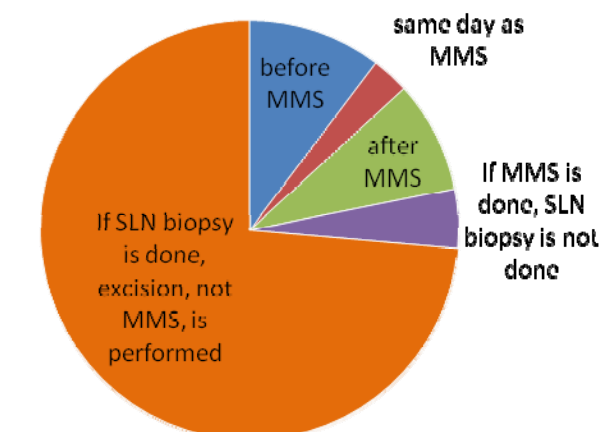
Three hundred fourteen members (38.5%) completed the survey. There was an almost even split among ACMS members that do and do not (51.1% vs. 48.9%) perform Mohs surgery for melanocytic lesions. As expected, the percentage of surgeons performing Mohs surgery declined as the thickness of melanoma increased. Of those that do perform Mohs for melanocytic lesions, the mean number of annual melanoma cases performed was 45.1.

Other findings:

- Nearly 80% of surgeons send debulking layer for permanent sectioning
- Over 80% of surgeons use permanent sectioning after debulking
 - 53% exclusively and 47% as adjunct to frozen
 - 73% process permanents horizontally
 - 96% are read by a pathologist or dermatopathologist
- For melanoma > 1mm deep, over 60% always perform SLNB
 - 47% perform the SLNB prior to and 40% after Mohs
- If debulking layer = invasive melanoma > 1 mm deep, >75% refer for SLNB
- Other surgical modalities employed for melanoma:
 - Slow Mohs
 - Square Technique
 - Staged serial excision



75% of Mohs surgeons do not perform Mohs if SLNB is needed; there is variability if nodal biopsy is performed



CONCLUSIONS

- There is general agreement among Mohs surgeons that Mohs surgery is appropriate and effective for melanoma in-situ. However, this survey evoked strong opinions on using Mohs surgery for invasive melanoma.
- Fellowship trained Mohs surgeons are treating melanoma in-situ and thin melanomas using predominately horizontal sectioning to obtain complete margin analysis, but there is significant disparity among methods used in both the processing of tissue and the use of immunostains. This lack of standardization underlies the difficulty in comparing "Mohs surgery" to conventional surgical excision for the treatment of melanoma. Many surgeons employ what has become known as "slow Mohs", using formalin fixation to glean improved resolution of melanocytes at the possible costs of increased processing time and patient inconvenience.
- Information gleaned from this survey may help to narrow the practice variability among those treating melanoma. As this discrepancy narrows, general agreement on the best way to treat these lesions may emerge. Then perhaps we will be better prepared in designing high-powered, multicenter, long-term, randomized, controlled clinical research comparing methods of treating cutaneous melanocytic tumors.