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 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 biography 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 it is harder to 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 the surgeon become certain where the proper margin is, explained Dr. Steinman, who practices in Chula Vista, Calif.

“Our practice is to use five, one at what is desired, another near the lesion to be removed is, of which the surgeon becomes uncertain where the proper margin is, explained Dr. Steinman, who practices in Chula Vista, Calif.

The key to removing the lesion is marking it with reference marks before it is removed and the patient and 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.

Making 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 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 specimen, include a hole in the section, misorientation because the section is not correctly marked, and the presence of inflammation at the edge of the section, which can indicate tumor, Dr. Steinman said.

‘Drumhead’ Technique May Spare Alar Graft Depressions

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 developed a technique in which gauze supports are attached to both sides of the graft and defect to pull the wound 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 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 then creates a strut out of the packing material of the graft, and then ties that to the top of the graft. The assembly of bolster and 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.