FROM THE DESK OF MEDICAL DIRECTOR

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Our Center’s passion for continuing learning and teaching is reflected in this newsletter. We are restarting this quarterly publication with this issue after a several year hiatus.

During that time we have been busy creating a web based portal for learning at SCARScenter.com. This website is designed and written specifically for physicians and healthcare professionals interested in skin cancer and skin reconstruction.

This newsletter is a distillation from highlight articles of recent website publications. For more in-depth reading go to SCARScenter.com/SkinCancerConnection.

For an even deeper dive, go to the origin of most of our articles - the SCARS Foundation Monthly Skin Cancer Conference. This stimulating and erudite meeting is attended by many of OC’s skin cancer thought leaders including Ronald Barr, MD, Ken Linden, MD, and Alex Miller, MD. Join us every 3rd Tuesday night at 6 pm with dinner and up to 2 hours of CME’s provided.

On behalf of our team of dedicated skin cancer specialists, we welcome you to our community of lifetime learners and invite you to participate in our purpose: elevating the standards of skin cancer management.

RECONSTRUCTION OF LARGE FOREHEAD DEFECTS

The reconstructive goals of large forehead defect include preservation of brow position and replacement of central and lower forehead skin with similar skin. Avoidance of skin grafts on the forehead is imperative due to poor color and texture match. Secondary intention healing is often an acceptable alternative with insufficient donor skin, avoiding skin grafts at all costs.

BCC of Right Forehead Following Mohs Excision

Reconstruction of the large forehead defect with multiple flaps, right paramedian forehead flap transposed to the eyebrow area to protect the upper eyelid from retraction.

Additional skin was recruited laterally with a rotation flap.

Lentigo Maligna of Left Forehead, Eyebrow, and Upper Eyelid

Reconstruction of left forehead and eyebrow defect with paramedian forehead sliding flap, reconstruction of the upper forehead donor site with local rotation flap and V-Y plasty.

RECEIVE NOC CUR, MAINTAINING FUNCTION, PRESERVING APPEARANCE

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Malignant spindle neoplasms of the skin, also called pleomorphic dermal sarcomas, demonstrate similar histology to benign spindle cell neoplasms. Atypical fibroxanthoma (AFX) is a benign spindle cell tumor that presents in sun-exposed regions of elderly. It is a superficial lesion that is treated with local excision, Mohs excision, or even curettage. However, it has an identical histologic appearance to a highly malignant spindle cell neoplasm. Invasion of dermis and subcutaneous tissues defines the spindle cell tumor.

Pleomorphic dermal sarcoma invades the dermis and can be treated with wide local resection. Undifferentiated pleomorphic dermal sarcoma, the most aggressive skin spindle cell tumor, invades into subcutaneous tissues such as fat or muscle fascia and is associated with hematogenous and lymphatic spread. It is treated with wide local resection and radiation. This subtype is what has been known previously as malignant fibrous histiocytoma (MFH) of the skin. MFH terminology is being abandoned in favor of pleomorphic sarcoma, which is a class of fibrohistiocytic tumors. Treatment requires a wide local resection of the tumor followed by radiation therapy to minimize the risk of recurrence.

Immunohistochemistry differentiates theses spindle cell tumors as sarcomas due to CD10 and CD68 staining. S100 and S100 would define the spindle cell neoplasm as melanoma, while cytokeratin would define the spindle cell neoplasm as a squamous cell carcinoma.

In summary, to reach > 80% cure rate with 5-fluorouracil (5-FU), 10 weeks is necessary for BCC and 8 weeks for Bowen’s disease. Studies have shown that the real magic of 5-FU for skin cancers occurs between 6 weeks and 10 weeks of treatment. A notable exception for indications for 5-FU is superficially invasive SCC’s - there is no evidence to support that treatment needs to be at least 6 weeks with superficial BCC’s to reach an 80% cure rate, and 12 weeks to surpass 90% cure rate. For SCC in situ, 12 weeks are needed to reach 75-90% cure rates. Again, there is a lack of studies in this case of those cases.

Imiquimod (Aldara) has also been shown to achieve up to 90% cure rates. The duration of imiquimod treatment needs to be at least 8 weeks with 5-fluorouracil (5-FU) to achieve 90% cure rate. Imiquimod (Aldara) is a topical therapy for treatment of skin cancer. The primary application of fluorouracil (5-FU) by clinicians is for precancerous actinic keratoses (AK). It is effective in clearing AK’s in as little as 2 weeks in 1 to 2 applications. However, it takes up to 12 weeks to surpass 90% cure rate in superficial BCC’s. Studies have shown that the real magic of 5-FU for skin cancers occurs between 6 weeks and 10 weeks of treatment. A notable exception for indications for 5-FU is superficially invasive SCC’s - there is no evidence to support that treatment needs to be at least 6 weeks with superficial BCC’s to reach an 80% cure rate, and 12 weeks to surpass 90% cure rate. For SCC in situ, 12 weeks are needed to reach 75-90% cure rates. Again, there is a lack of studies in this case of those cases.

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