



SKIN CANCER AND
RECONSTRUCTIVE SURGERY
CENTER

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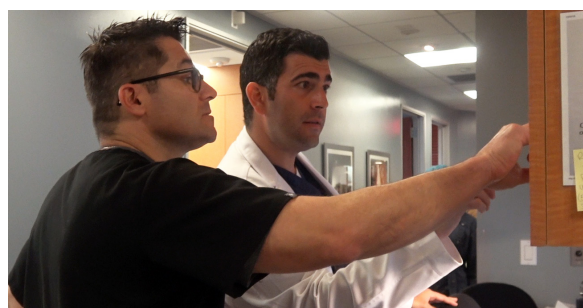
the Skin Cancer Connection

Publication of SCARS Center, Newport Beach

FROM THE DESK OF THE MEDICAL DIRECTOR SIMON MADORSKY, M.D.

Since joining the team at SCARS Center over 2 years ago, Dr. Jeffrey Joseph, our Oculoplastic surgeon, has exemplified multispecialty collaboration in patient care. Whether it is a team approach to complex eyelid cancer management or cosmetic surgery, Dr. Joseph provides optimal results.

Our center's patients have the opportunity to be evaluated by multiple specialists during a single office visit. For difficult cancer management, Dr. Joseph and a Facial Plastic surgeon can brainstorm a surgical approach to an advanced skin cancer. He can also coordinate complex Mohs surgery with the dermatologist directly.



Dr. Baron (left) and Dr. Joseph (right) coordinate a Mohs and reconstruction case

In a similar spirit of cooperation, our Center's surgeons can collaborate on cosmetic procedures. While Dr. Joseph performs a blepharoplasty with ptosis repair, Dr. Daines - our facial plastic surgeon - can perform a facelift, all during the same anaesthetic.

With the resources available at Skin Cancer And Reconstructive Surgery Center in Newport Beach, Dr. Joseph is able to deliver world class oculoplastic surgical care for his patients.

EVALUATION OF EYELID LESIONS

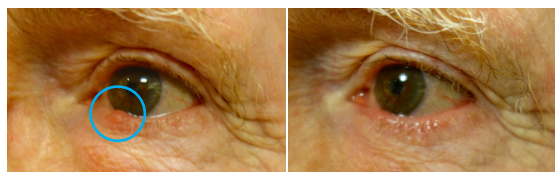
By Jeffrey Joseph, MD

Lesions of the eyelid margin can cause irritation, foreign body sensation, trichiasis (mis-directed lashes), and cosmetic problems. In addition, 5% to 10% of all skin cancers occur on the eyelids. This means even small asymptomatic eyelid margin lesions deserve careful clinical evaluation.

Biopsy of the eyelid margin presents unique challenges to the physician. Lesions in this area present close to, and often in contact with the ocular surface. There is potential for globe injury both during the biopsy and after, if the posterior lamella of the lid is disrupted.

Anesthetizing the eyelid margin can be difficult. It is helpful to infiltrate both anteriorly (subcutaneously) and posteriorly (subconjunctivally). The area should be disinfected with 5% Beta-

dine solution which limits irritation of the ocular surface when compared to the regular 10% solution. To protect the ocular surface, a corneal shield can be placed, or a chalazion clamp can be placed over the lid. The skin should then be incised with a #15 blade or a fine scissor such as a Wescott spring scissor. Lash follicles or Meibomian gland orifices should be avoided if possible. The eyelid margin heals well via secondary intention. Patching of the eye after a biopsy may be necessary due to bleeding in the first couple of hours.



Left lower eyelid sebaceous adenoma before

Left lower eyelid sebaceous adenoma after

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GET INVOLVED

To be evaluated at SCARS Center for skin lesions or reconstructive surgery contact us today

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SPITZOID NEVI

The photo below is an atypical Spitz nevus in a 24-year-old woman that required excision. Spitz nevi are spindle / epithelioid cell nevi or tumors that are predominantly identified in younger age groups and pose a diagnostic and therapeutic challenge.



Three classification categories exist:

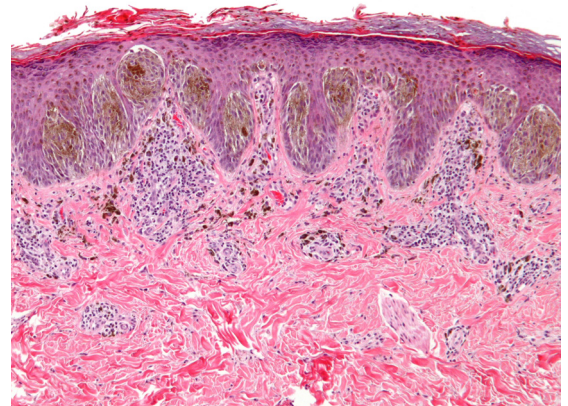
- Classic Spitz nevus (CSN) - without atypicality
- Atypical Spitz tumor (AST)
- Spitzoid malignant melanoma (SMM)

Unfortunately, pathologic diagnosis discordance plagues these lesions. Even expert dermatopathologists fail to agree on objective criteria to classify each nevus in a subtype. In many cases, even malignant diagnosis cannot be agreed upon.

Malignant Spitz nevi have been described as juvenile malignant melanomas because the lesions are not fatal despite frequent lymph node metastases. An impressive review of Massachusetts General Hospital records over the course

of 30 years found no lethality from any Spitz tumors. The review included 144 cases mostly split between CSN and AST, but also included 13 Spitz-associated melanomas. Interestingly, 5 of 14 (40%) sentinel lymph node biopsies performed found metastases.

Another notable finding of the Mass General Study was the 8-fold increase in risk of melanoma in patients with either classic Spitz nevus (CSN) or atypical Spitzoid tumors (AST). The authors raise the hypothesis that the early presence of Spitz tumors may be a possible risk marker for subsequent melanomas. So, it makes sense to treat Spitz nevi as any other dysplastic nevus with complete but conservative excision and long term surveillance for new onset melanomas. The margin of excision should be 2-5 mm.



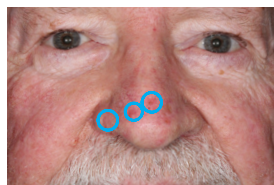
Intermediate magnification micrograph of a Spitz nevus
By Nephron, from Wikimedia Commons

MULTIPLE NASAL BASAL CELL CARCIOMAS

Superficial radiotherapy (SRT) is an office-based radiation therapy that is greatly underutilized for skin cancer treatment. We treated this 81-year-old man with three separate basal cell carcinomas in the nasal tip and ala. All three lesions were treated simultaneously with two adjoining SRT fields. The course was completed with 15 treatments in three weeks.

This patient represents an excellent candidate for radiation therapy. Mohs surgery would have created an extensive nasal defect requiring complex reconstructive surgery. Radiation offered a better alternative for this patient. Weeping superficial erosions developed one week after completion of therapy. The skin epithelialized completely by 3.5 weeks after radiation completion.

Final cosmetic outcome with radiation therapy can be superior to that of surgery in complex nasal tip carcinomas. Superficial ulceration can be minimized by extending the radiation course to five weeks with smaller doses per fraction.



Three basal cell carcinomas of the nasal tip and ala



2.5 weeks after completion of radiation - still with superficial erosions



4 weeks after completion of radiation. Epithelialization completed



6 months after radiation to nose

SUBTOTAL EAR RECONSTRUCTION WITH ALLOPLAST



Medpor ear implant

Subtotal ear reconstruction is a challenging surgical task that often requires non-traditional techniques. This particular patient was treated with an alloplastic implant and rib cartilage grafts. We utilized Medpor Helical Rim implant, a porous polyethylene material used for microtia reconstruction. The implant was used for its elegantly curved helix. The rib cartilage was used to project the reconstructed ear away from the head.

The magic, however, is in the TPF flap (temporoparietal fascia). Its robust blood supply arises in the superficial temporal artery. It is used to wrap the Medpor ear helix implant. A skin graft is placed on its outer surface. The thin nature of the TPF flap shows the curvature of the implant while its great blood supply supports the skin



Ear defect after cancer removal



TPF flap



Implant in place with rib cartilage graft



6 weeks after second stage

graft. Two stages were required to achieve the desired results.

TOTAL EAR RECONSTRUCTION WITH OSSEOINTEGRATED PROSTHESIS



Right ear canal after cancer resection



Screws inserted into bone with low torque

Total ear reconstruction after radical skin cancer resection can be treated with prosthetic rehabilitation. Optimally, osseointegrated fixation of a prosthesis is employed. This patient was treated with complete ear amputation and post-operative radiation. His prosthetic rehabilitation was a SCARS Center team effort between Simon Madorsky, M.D. and Mark George, D.D.S., a prosthodontist.

Three osseointegrated screw anchors are placed in thickest bone guided by a CT scan. These implants are placed with great precision and care to avoid bone injury by the heat of drilling. Uninjured bone allows the screws to be osseointegrated with it. Osseointegration means that the bone grows flush with the metal surface of the screw, preventing fluid and bacteria collection in the space. At the second stage, the screws are exposed, and abutments that



The abutments are allowed to penetrate the overlying skin

traverse through the skin are attached to the screws. After the screws and abutments heal and solidify sufficiently, a bar is created across the abutments to which the prosthetic ear is attached with magnets. The ear can be easily removed for sleeping and bathing and just as easily reattached. The osseointegrated technique is a great quality of life improvement for patients requiring a facial prosthesis.



A bar is placed across the abutments



The prosthesis is attached with magnets

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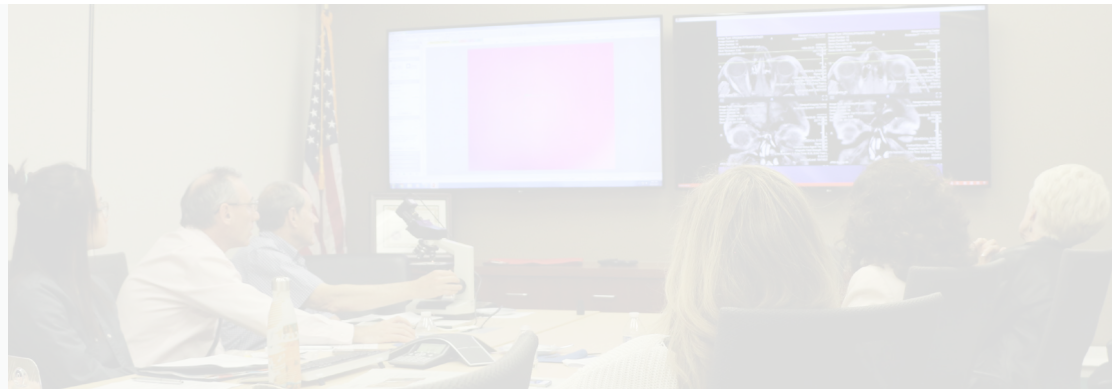
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UPCOMING SCARS FOUNDATION MONTHLY SKIN CANCER CONFERENCE DATES

Your source for diagnostic dilemmas, treatment challenges, and reconstructive issues for challenging skin cancer cases.

SEPTEMBER 25
OCTOBER 23
NOVEMBER 20
DECEMBER 18

RSVP Online at
www.SCARSFoundation.org



EDUCATE. RESEARCH. SERVICE.

The Skin Cancer And Reconstructive Surgery (SCARS) Foundation offers specialized educational opportunities to the medical and scientific community who strive to achieve new knowledge in skin cancer management.

ACCREDITED ACTIVITY

The Continued Medical Education (CME) program we offer has been established as a high quality, evidence based CME program that is independent, fair, objective, relevant, and consists of prominent physicians representing various subspecialties including Head and Neck Surgical Oncology, Mohs Dermatology, Dermatopathology, Radiation Oncology, Medical Oncology, ENT, and Facial Reconstructive Surgery.

Each CME activity will be evaluated to see measure the program's impact on our learners to see if our expected results have been met, including pre and post activity surveys and tests, and self reporting changes in practice by physicians.