

SKIN CANCER AND Reconstructive Surgery Center

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the Skin Cancer Connection

Publication of SCARS Center, Newport Beach

SCARS CENTER DOCTORS NAMED PHYSICIANS OF EXCELLENCE

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We are proud of our Center's commitment to education, a driving force behind its existence. Four of our physicians have been named 2019 Physicians of Excellence by the Orange County Medical Association. This award acknowledges education, teaching and mentoring by physicians.

Dr. Simon Madorsky was one of invited speakers at the International Symposium

of Facial Plastic Surgery. He presented in a prestigious panel on "Nasal Reconstruction After Mohs Surgery."

Dr. Jeffrey Joseph taught at the annual Orbital Trauma Course at the American Academy of Ophthalmology, and serves as clinical faculty at the University of California, Irvine.

Our center is a regular rotation site for UCLA Oculoplastic Surgery Fellows. It is also a rotation site for PA students from local Physician Assistant schools. **Dr. Steven Daines** mentors these students as well as high school students interested in careers in healthcare. He is also active in his local community as a Cub Scout leader.

SCARS Center and our physicians are committed to education and service of our local and medical community. We are proud to have four of our physicians recognized by the Orange County Medical Association.

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TRICHOEPITHELIOMA

Trichoepithelioma is a benign basaloid lesion arising from a pilosebaceous unit. Its basal cell proliferation is different from basal cell carcinomas pattern. It arises most commonly in the head and neck. Treatment is necessary due to its progressive growth.

Trichoepitheliomas are most commonly sporadic, presenting as a single lesion. Desmoplastic trichoepithelioma (DTE) variant is more unusual and has worrisome histologic features. It mostly presents in the faces of young to middle-aged women. Morphologically, it mimics morpheaform basal cell carcinomas and has an invasive nature.

Multiple familial trichoepitheliomas (MFT) is an autosomal dominant condition presenting classically in the face but can occur in other parts of the body. These tumors can eventually become disfiguring and functionally impairing.

Solitary lesions can be treated with laser ablation, cryoablation, and needle electrocautery. Surgical excision is the most common treatment of trichoepitheliomas. Mohs excision is the preferred method, especially for the invasive desmoplastic trichoepitheliomas (DTE). Topical imiquimod and tretinoin have been described for treatment of multiple lesions.

Differentiating isolated trichoepitheliomas from basal cell carcinomas does not change the surgical treatment plan for most patients. However, knowledge of the diagnosis of trichoepithelioma reduces the time-pressure for treatment and affords consideration for alternative treatment techniques.



Final Mohs defect of 0.6 cm followed by lateral nasal island flap reconstruction. Final aesthetic outcome 3-months post-op.

DEEPLY INVASIVE BASAL CELL CARCINOMA OF THE EAR CANAL

At SCARS Center we have been combining Mohs excision of the superficial cancer component and wide local resection for deep margin clearance. This deeply invading basal cell carcinoma of the ear canal was treated with such approach.

The limiting factors for Mohs surgery of deeply invasive carcinomas are local anesthesia, limited equipment availability in a clinic setting, Mohs assistants' skill limitations, and Mohs surgeon's technical limitations. In some cases, we overcome these limitations by performing Mohs surgery in the ASC operating room. ASC-based Mohs surgery provides anesthesia, advanced instrumentation (cautery, suction, lighting, instruments), and skilled surgical technologists. The ASC operating room extends the reach of Mohs surgery.

At a certain point, the Mohs surgeon hands the case over to the oncologic surgeon with deep margin involvement clearly outlined. For the oncologic surgeon, clear demarcation of deep margins allows for guided deep resection, limiting functional injury.

In our case, the Mohs excision under local anesthesia was performed to the mid ear canal. At that point, general anesthesia was induced. The facial plastic surgeon removed additional skin and cartilage margins from the cartilaginous and bony ear canal for Mohs processing. We were able to achieve clear margins within 5 mm of the tympanic membrane. Reconstruction of the ear canal was performed with a fasciocutaneous flap and a skin graft. The cancer was cleared, and the patient's hearing was preserved.

CASE STUDIES

The Skin Cancer **Connection** features summaries of cases presented at our monthly conference.

For more details on each article go to:

SCARSCENTER.COM



PATIENT CASE STUDIES









Basal cell carcinoma of left ear canal

Post-auricular transposition flap for ear canal reconstruction.

Skin graft for final closure.

ANTICOAGULANT USE IN CUTANEOUS SURGERY

Anticoagulant use in Facial and **Dermatologic Surgeries has become** more liberal in the last decade than it had been in the past. And that is for a good reason. Wound complications from the use of anticoagulants perioperatively is outweighed by the complications of stroke and myocardial

infarctions. But what is the real risk of the use of various anticoagulant drugs perioperatively?

The most comprehensive review of facial plastic surgical cases at the University of Michigan (2015) made some interesting observations. Aspirin and clopidogrel (Plavix) do not

increase the risk of bleeding in cutaneous and facial surgeries. While warfarin (Coumadin) and the use of multiple anticoagulants increase the risk of bleeding and infections.

The newer direct oral anticoagulants (DOACs) such as Pradaxa (dabigatran),

Xarelto (rivaroxaban), and Eliquis (apixaban), and Lixiana (edoxoban) offer the advantage of a short half-life. This allows brief termination of their use, thus minimizing thromboembolic complications. A summary article published in 2018 in Research and Practice in Thrombosis and Haemostasis provides recommendations



for perioperative interruption of DOACs. For low bleeding risk procedures, which would encompass most cutaneous and facial plastic surgeries, stopping DOACs one day before and the day of the operation is considered an acceptable risk.

For minimal bleeding risk procedures, continuation of these drugs perioperatively is recommended. For high bleeding risk procedures, interruption begins two days pre-op and the anticoagulant is restarted post-op day three.

GIANT BOWEN'S DISEASE OF THE SCALP

This patient presented with a many-year history of progressively enlarging scalp dermatitis. A biopsy found this to be Bowen's disease (squamous cell carcinoma in situ) measuring 11 cm in diameter.

Treatment of this giant Bowen's disease has to address the risk of possible invasion within unbiopsied area. Although Mohs excision is an option, its role must be limited to peripheral margin control, while the majority of the central specimen demands FFPE histologic evaluation. In our case, excision with 5 mm margin was performed, clearing the tumor. The tissue was processed with permanent FFPE histology and not Mohs surgery.

Topical modalities are an option, but they are not able to definitively rule out invasion. In addition to topical imiquimod and 5-fluorouracil, other non-surgical treatment options include electrodessication and curettage (ED&C), photodynamic therapy (PDT), cryotherapy, and radiation therapy. However, these are not the preferred treatment options for this giant scalp Bowen's disease in our center.

Bowen's disease in thick hair-bearing skin extends deeply into subcutaneous tissues along the epidermal basement membrane of hair follicles. Treatment in the scalp must address this deep extension. This proves difficult for modalities such as PDT, cryotherapy, and ED&C. In hair-bearing scalp, eradication of disease with non-surgical management will result in alopecia. Our treatment plan was directed toward restoration of hair in the temple of this young woman. After clear margins were confirmed, large fasciocutaneous scalp transposition flap was used to cover the temple defect. Primary surgical management in this case resulted in hair restoration, rapid disease eradication, and ruling out of invasion.



Giant Bowen's disease of the scalp.



Specimen submitted in sections for accurate localization of potential invasion.



Closure with a temporary xenograft.



Reconstruction with scalp fasciocutaneous transposition flap.

GET INVOLVED

We highly encourage physicians to share their skin cancer and reconstruction cases at our monthly Skin Cancer Conference. To present a case, contact:

Erin Williams erin@scarscenter.com

RECURRENT BOWEN'S DISEASE OF THE TEMPLE

A 63-year-old man presented with a recurrent Bowen's disease of right sideburn 2 years after a Mohs excision. This poorly demarcated multicentric lesion is best treated with a field therapy. Topical agents such as 5-fluorouracil or imiguimod are effective in addressing this "field cancerization." This is caused by a diffuse carcinogenic injury due to UV or other carcinogens. As such, the clinically visible lesion represents a portion of the damaged area. Histologically, atypical cells taper off from obviously involved margins. These cells outside of the surgical margins are at high risk of progression into clinically obvious lesions and invasive cancers. Thus, surgical management of in situ lesions in areas of "field cancerization" is not as effective as topical management.

In addition to 5-fluorouracil and imiquimod, photodynamic therapy (PDT) is also an effective treatment for a larger field as this. Some studies had shown PDT to be more effective with fewer adverse outcomes than topical creams. Curettage or cryotherapy can be equally effective, albeit with worse cosmetic outcome and in some cases prolonged healing.





Top: Patient undergoing photodynamic therapy (PDT).

Left: Patient 7 days post



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UPCOMING SCARS FOUNDATION MONTHLY SKIN CANCER CONFERENCE DATES:

JANUARY 15 FEBRUARY 19 MARCH 19 APRIL 23

RSVP Online at www.SCARSFoundation.org

The Skin Cancer Connection and SCARSCenter.com are your source for diagnostic dilemmas, treatment challenges, and reconstructive issues for challenging skin cancer cases.



EDUCATION. 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 subspecialities 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.