ACHIEVING CURE, MAINTAINING FUNCTION, PRESERVING APPEARANCE

SCARS CENTER
SKIN CANCER AND RECONSTRUCTIVE SURGERY CENTER

the Skin Cancer Connection

Publication of SCARS Center

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CLINICAL FELLOWSHIPS AT SCARS CENTER

Our Center has been enriched by a multi-year collaboration with **UCLA's Oculoplastic Surgery Department** (Orbital and Ophthalmic Plastic Surgery Division). As a rotation site for the UCLA Oculoplastic fellows, SCARS Center has contributed to their education and experience. Recently, **Dr. Simon Madorsky** and Dr. Robert Goldberg, the chief of the UCLA program, have taught oculoplastic surgery fellows and SCARS Center surgeons the nuances of facial nerve anatomy in a cadaver dissection course.

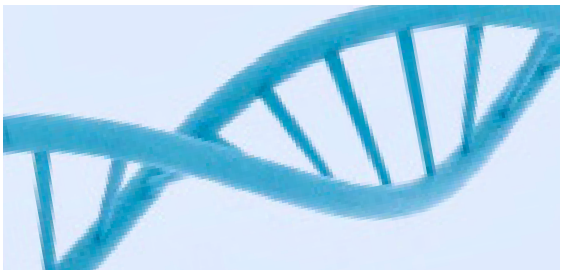
Dr. Justin Karlin, a UCLA clinical professor, and alumnus of this program, has joined SCARS Center and Appearance Center (the cosmetic component of our organization) as an oculoplastic surgeon. He also continues in an academic role, with a joint appointment with the Oculoplastic Surgery Department at UCLA. The collaboration has been an exciting cross-pollination of ideas and skills that greatly benefits our patients.

Dr. Madorsky (left) operating with Dr. Karlin (right).

MELANOMA STUDY

CAN CANCER GENE EXPRESSION PROFILE RESULTS SPARE THE PATIENT A SENTINEL LYMPH NODE BIOPSY?

A genetic test of melanoma cells can help predict if patients with early stage melanoma are at high or low risk of their cancer spreading. DecisionDX 31-gene expression profile (GEP) test classifies melanomas into low, intermediate, and high-risk for developing metastases within five years of diagnosis. DecisionDx-Melanoma test also can predict the risk of lymph node involvement.



Sentinel lymph node biopsies with melanomas are traditionally performed when the risk is 10% or higher and avoided when the risk is 5% or lower. DecisionDX is believed to reliably predict that risk. A multi-institutional study is being conducted to validate that claim. SCARS Center serves as a study site for evaluating the impact of the DecisionDx genomic test on sentinel lymph node biopsy decisions and clinical outcomes. **The goal is to spare patients unnecessary lymph node biopsies when there is genetic evidence of a lower risk melanoma.**

We are currently enrolling patients with newly diagnosed melanomas who are being considered for sentinel lymph node biopsy.

INSIDE THIS ISSUE

TOPICAL 5-FLUOROURACIL AND CALCIPOTRIENE

Many patients have diffuse actinic damage to areas with high sun exposure (i.e., face, scalp, chest, or arms) that requires treatment of the whole area. Traditional treatment options include a 2 to 4 week course of topical 5-fluorouracil (5-FU) or imiquimod. Alternatively, in-office photodynamic therapy (blue light treatment) can be done. At SCARS Center, we have taken a new approach to field treatment using topical 5-FU and calcipotriene.

5-FU is a pyrimidine antimetabolite that interferes with DNA synthesis to prevent cell proliferation and cause cell death.

Calcipotriene is a synthetic vitamin D3 analog, typically used in psoriasis management, which inhibits proliferation and enhances keratinocyte differentiation. A randomized controlled trial in 2016 found that four-day application of calcipotriene plus 5-FU versus Vaseline plus 5-FU led to an 87.8% versus 26.3% mean reduction in the number of actinic keratoses ($P < 0.0001$).*

The result is that our patients are able to achieve a more robust response with topical 5-FU and calcipotriene in a shorter amount of time. Most patients are treated for only 1-2 weeks.

Left arm at 2 weeks of 5-FU only.

Left arm at 1 week of 5-FU + Calcipotriene application.

Left arm at 2 weeks of 5-FU + Calcipotriene application.

*Randomized trial of calcipotriol combined with 5-fluorouracil for skin cancer precursor immunotherapy, *Journal of Clinical Investigation*, Published November 21, 2016.

CASE STUDIES

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

For more patient case studies, scan the QR code below.

SPLIT-THICKNESS SKIN GRAFTING (STSG) NOVEL SOURCE

Lower extremity cutaneous defects are often difficult to manage because lower legs have the propensity for poor vascularity and significant edema**. Adam Aronson, MD**, our Mohs dermatologist, has introduced a new reconstructive approach using occipital scalp split-thickness skin grafting (STSG). Dr. Aronson was first introduced to scalp STSG during his Mohs fellowship in New Zealand and has now brought the technique to SCARS Center.

Taking the STSG from the scalp ensures a subtle donor site that heals quickly and with minimal pain versus the traditional full-thickness skin grafts (FTSG) taken from the arm, thigh or abdomen and leave a noticeable scar. Traditional STSG's from the thigh can leave a tender discolored scar. The STSG integrates efficiently into the defect and requires a less robust blood supply. Because the STSG splits the skin above the level of the hair follicle, the scalp donor site has no permanent hair loss, and the graft does not grow hair once placed in the defect. Our patient was very pleased with her recovery and results using occipital scalp STSG on her foot.

Left foot Mohs defect (far left); occipital scalp donor site at 2-weeks post procedure (center); healed skin graft (right).

WOUND HEALING WITH UNNA BOOT

When dealing with high tension closures of cutaneous defects of the lower extremities, it is critical to address the possibility of impaired or slowed wound healing, dehiscence and edema. To address these concerns, SCARS Center often uses a simple compression dressing, Unna Boot. Unna Boot is a gauze roll impregnated with zinc oxide, thereby providing an important anti-bacterial component and additionally helping to ease skin irritation and maintain a moist environment. It is traditionally used to cover open wounds or ulcers such as venous stasis ulcers. In addition to the anti-bacterial component, **the static compression of the Unna Boot prevents swelling or lymphedema and subsequent wound dehiscence of high tension closures.**

There are multiple ways to approach the application of the Unna Boot. Typically, the Unna Boot is wrapped with approximately a 50% overlap and is then covered with a self-adhering Coban dressing resulting in a clean, controlled dressing. The Unna Boot can be worn for up to a week, but to minimize patient discomfort it is best removed and reapplied after approximately 3-4 days, which also allows for close follow-up and management of these patients.

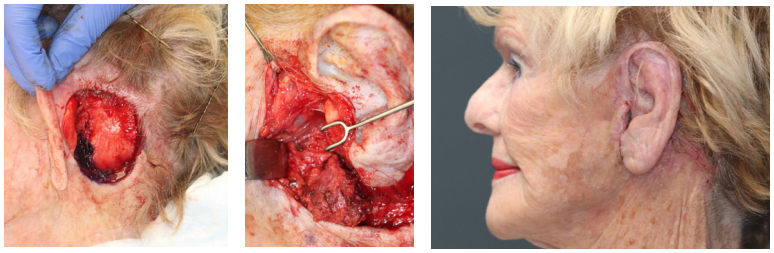
SIGN UP FOR MONTHLY EMAILS

Subscribe to **The Skin Cancer Connection** to receive research updates, blog posts, and invitations to our monthly conference.

ADVANCED CANCER MANAGEMENT

MOHS GUIDED WIDE LOCAL RESECTION

This SCARS Center patient was referred for management of a left post-auricular poorly differentiated carcinoma growing rapidly. During the course of Mohs surgery, extensive deep tissue involvement was found. Three stages of Mohs surgery resulted in a 5.5 x 5.5 cm defect extending to the bone.



Mohs excision and reconstruction showed carcinoma of the left postauricular skin extending to the scalp and parotid gland.

Clear margins were obtained except for the anterior margin, where tumor was involving the parotid gland. At this point, the area of residual tumor was marked with blue ink and the patient was transferred to the SCARS Center operating room under the care of our surgical oncology team.

Additional resection of the invaded parotid gland with facial nerve identification and preservation was performed under IV sedation anesthesia. The cancer had spread within millimeters of the trunk of the facial nerve. Whole body PET/CT identified additional lymph node involvement in the neck. The patient was presented at the SCARS Center Conference. Based on the recommendations, she will be undergoing biological therapy with Libtayo.

These types of cases are frequent enough in our center that Dr. Simon Madorsky and Dr. Matthew Goodman are collaborating on an article reviewing the SCARS Center experience with Mohs guided wide local resection.

Unlike traditional oncologic resections, Mohs guidance allows the oncologic surgeon to more precisely localize deep tissue cancer involvement. Thus critical structures such as the facial nerve can be more effectively spared. This approach requires the level of collaboration present at the SCARS Center, the one-stop shop for skin cancers in Southern California.

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SCARS FOUNDATION

EDUCATION. RESEARCH. INNOVATION.

The Skin Cancer And Reconstructive Surgery (SCARS) Foundation offers a monthly skin cancer management conference. It is an accredited activity offering up to two hours of CME credits. To attend, go to our website or call the center to register.

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

Dermatopathology

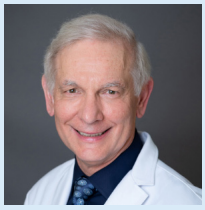
Ronald Barr, MD

Dermatology & Mohs Surgery

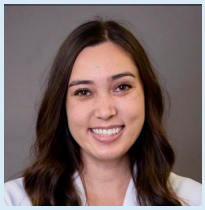
Adam Aronson, MD

Jonathan Baron, MD

Matthew Goodman, MD

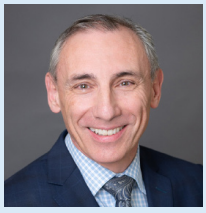


Alexander Miller, MD



Alyssa Flanders, PA-C

Plastic & Reconstructive Surgery



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